

LOUISIANA
FY 10-11

**Community Mental Health
Services Block Grant
Application**

FY 2011 Plan

September 1, 2010

Approved October 28, 2010

**Office of Mental Health
Department of Health and Hospitals**

**LOUISIANA
FY 2011**

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT APPLICATION

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LOUISIANA FY 2011 BLOCK GRANT PLAN

Part A

Context & Overview of FY 2011 Application

PART A: FACE SHEET

FISCAL YEARS COVERED BY THE PLAN (Please check as appropriate)

√ FY 2011

STATE NAME: Louisiana

DUNS#: 809927064

I. AGENCY TO RECEIVE 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. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: Kathy Kliebert TITLE: 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

III. STATE FISCAL YEAR

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

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Cathy Orman Castille, PhD, MP

TITLE: Block Grant Planner,

Division of Planning, Data Management, & Compliance

AGENCY: Office of Mental 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: Cathy.Castille@LA.GOV

EXECUTIVE SUMMARY

LOUISIANA FY 2011 - ADULT & CHILD/ YOUTH PLAN

The Louisiana Department of Health and Hospitals (DHH), Office of Behavioral Health (OBH) Block Grant Plan for FY 10-11 provides direction and implementation strategies for further development of the state's comprehensive, community-based mental health system. The core belief inherent in this Plan is that *treatment works*: people with mental illness recover and become productive citizens. The underlying values of the service system include the expectation that the system be *consumer and child centered*. The mental health program in Louisiana focuses on *education, prevention and recovery while teaching and enhancing resilience*. The locus of services, management, and decision making continues to rest at the *community level*. The goal to offer individualized, evidence-based, culturally competent services in a seamless manner that assures adequate and equitable service access continues. Quality, efficiency, data-based decision making, and demonstrated positive client outcomes are basic expectations within the system.

As in recent years, many challenges and changes continue in the governance of the agency responsible for the health needs of the state. In early 2008, Louisiana began a new administration at all levels (Governor, Department of Health and Hospitals, and the Office of Mental Health). The Secretary of DHH, Mr. Alan Levine, resigned as of August 1, 2010. He will be succeeded by Bruce Greenstein, Ph.D., effective September 13th. Healthcare redesign has resulted in the combining of the Office of Mental Health and the Office for Addictive Disorders into the new Office of Behavioral Health (OBH). This legislatively mandated change was preceded by months of work, and took place officially on July 1st, 2010. The Assistant Secretary (i.e., Commissioner) of the new Office of Behavioral Health, Ms. Kathy Kliebert, was previously the Assistant Secretary of the Office for Citizens with Developmental Disabilities, also within DHH.

Following several years of hurricanes and recovery, for those who live along the coastal region, yet another critical blow has been dealt by the explosion of the British Petroleum Deepwater Horizon oil rig and the resulting oil spill. The oil spill has devastated the businesses and industries along the coast, from the seafood industry to the tourism industry; not to mention the incomprehensible impact on the wetlands and wildlife. As oystermen and shrimp boats sit idle, communities of fishermen are without income. Beginning with the historic hurricanes of 2005 and 2008, and currently the massive oil spill in the Gulf of Mexico, the citizens of Louisiana have experienced high levels of stress and anxiety. Discussion of the direction of Louisiana after August, 2005 cannot be undertaken without reflection on the effects of these catastrophic events. While the Southern part of the state sustains the most direct damage from these tragedies, the rest of the State also experiences repercussions. Following the 2005 storms, the sense of community changed for all citizens, including Louisiana's children and elderly. Now, those living along the coast find their lives challenged once again. The common thread through each of these disasters is the loss of community, and for those with mental illness, this is perhaps the most profound loss of all.

The national economy and multiple budget reductions have also impacted the citizens of the state. However, adversity also presents the *opportunity* for re-examination and transformation. It is with this optimism, hope, and enthusiasm that the FY 2011 Plan is presented.

LOUISIANA FY 2011 BLOCK GRANT PLAN

Part B

Administrative Requirements, Fiscal Planning Assumptions, & Special Guidance

LOUISIANA FY 2011 BLOCK GRANT PLAN

Part B Section I

Federal Funding Agreements, Certifications and Assurances

BOBBY JINDAL
GOVERNOR



OFFICE OF THE GOVERNOR

Post Office Box 94004
Baton Rouge, LA 70804-9004

July 27, 2010

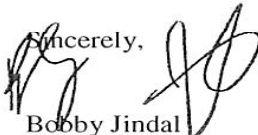
Ms. Barbara Orlando
Grants Management Office
Division of Grants Management
OPS, SAMHSA
1 Choke Cherry Road
Room 7-1091
Rockville, MD 20857

Dear Ms. Orlando:

This letter is to serve as formal authorization for Ms. Kathy Kliebert, Assistant Secretary of the Office of Behavioral Health, to have the power of signature for the Community Mental Health Block Grant Application, as well as recognition of Ms. Kliebert as the appropriate authority to receive the Louisiana Community Mental Health Block Grant funds.

If you have any questions, or need additional information, please call Ms. Kliebert at 225-342-2540.

Thank you.

Sincerely,

Bobby Jindal
Governor

(225) 342-7015 ♦ Fax (225) 342-7099 ♦ www.gov.state.la.us

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2011

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.]

Section 1911:

Subject to Section 1916, the State¹ 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.

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].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2006, 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).

21. The term State shall hereafter be understood to include Territories.

(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.

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.

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.

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.

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.

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 Stated 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).

Section 1943:

- (a) The State will:
- (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.

Kathy Kliebert

August 17, 2010

Governor or Governor Designee

Date

Kathy Kliebert
Assistant Secretary
Office of Behavioral Health
Louisiana Department of Health & Hospitals

For Governor Bobby Jindal

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, dis-pensing, 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;

<p>(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 –</p> <ul style="list-style-type: none"> (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; <p>(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).</p> <p>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:</p> <p>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</p> <p>3. CERTIFICATION REGARDING LOBBYING</p> <p>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:</p> <ul style="list-style-type: none"> (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any 	<p>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.</p> <ul style="list-style-type: none"> (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. <p>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.</p> <p>4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)</p> <p>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.</p>
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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.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL

Kathy Kliebert

TITLE

Assistant Secretary

APPLICANT ORGANIZATION

LA Department of Health & Hospitals, Office of Behavioral Health

DATE SUBMITTED

August 17, 2010

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 subagreements.

Approval Expires: 08/31/2007

10. 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.
11. 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).
12. 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.
13. 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.).
14. 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.
15. 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.
16. 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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL <i>Kathy Kliebert</i>	Title: Assistant Secretary
Applicant Organization Submitted: LA Department of Health & Hospitals, Office of Behavioral Health	Date Submitted: <i>August 17, 2010</i>

**PUBLIC COMMENTS ON THE CONTENT OF THIS PLAN ARE
WELCOMED AND MAY BE SUBMITTED TO :**

LOUISIANA OFFICE OF BEHAVIORAL HEALTH

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Public Comments on the Block Grant Plan are encouraged through a variety of means. The public is invited to submit comments to the Office of Behavioral Health after reviewing the document.

The Planning Council, consisting of 40 members representing all geographic areas of the State, is instrumental in developing priorities and directions for the Block Grant Plan each year. Input is

solicited from consumers, family members, providers, and state employees who are all members of the Planning Council.

Each year, the Block Grant Plan is available for review via the Office of Behavioral Health website. Email notices are sent to the Regional Managers, LGE Executive Directors, and Planning Council members when the Block Grant 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.

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 are now submitted via the SAMHSA Web-based Block Grant Application System (BGAS), which provides 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. It is emphasized that public comment is encouraged, and feedback and suggestions for improvements are welcomed. The mechanism to enable this process is included, with contact information for the State Block Grant State Planner, the Planning Council Liaison, and the Planning Council.

LOUISIANA FY 2011 BLOCK GRANT PLAN

Part B Section II & III

CHILDREN'S SET-ASIDE AND MAINTENANCE OF EFFORT

States are required to provide systems of integrated services for children with serious emotional disturbances (SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Set-Aside for Children's Mental Health Services

Data Reported by: State FY July 1, 2009 – June 30, 2010

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2009	Estimated/ Actual FY 2010
\$1,202,120	\$15,825,056	\$8,503,100

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. Maintenance of Effort (MOE) Report

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained 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.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion. States are required to submit State expenditures in the following format:

MOE Information Reported by: State FY July 1, 2009 – June 30, 2010

State Expenditures for Mental Health Services

Actual FY 2008	Actual FY 2009	Actual / Estimate FY 2010
\$98,282,261	\$98,748,314	\$92,365,601

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

LOUISIANA FY 2011 BLOCK GRANT PLAN

Part B Section IV

STATE MENTAL HEALTH PLANNING COUNCIL REQUIREMENTS

**STATE MENTAL HEALTH PLANNING COUNCIL REQUIREMENTS -
PLANNING COUNCIL CHARGE, ROLE, & ACTIVITIES
LOUISIANA FY 2011 - ADULT & CHILD/ YOUTH PLAN**

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 Council fully embraces the vision statement in the *President's New Freedom Commission Report (2003)* “*We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community.*”

The Council is responsible for review of the annual Block Grant Application/ State Mental Health Plan together with Office of Behavioral Health (OBH) staff dedicated to this function. 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 Council is geographically representative of the state, and includes members from diverse backgrounds and ethnicities. The Planning Council includes four standing committees (Membership, Finance, Advocacy, and Programs and Services) that oversee each of the functions entrusted to the Council. Through the work of the membership as a whole, as well as through the committees, the Council is an active participant in leading the Office of Behavioral Health into the future.

In addition to reviewing 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 function includes continued efforts toward public education, education of its members, and endeavors to reduce the stigma of mental illness throughout the state.

As the Local Governing Entities take the place of 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.

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).

A Planning Council Liaison continues to work full time, promoting 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 attends RAC meetings throughout the state and provides onsite training and assistance to assure that all 10 RACs are viable, functioning organizations. 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. With the addition of the Liaison, communication between the Regions/LGEs, the Office of Behavioral Health and the Planning Council has improved significantly in the past few years.

In the past, Block Grant funds were distributed across Regions unevenly, based on practices and a rationale that was rooted in a history that no longer has any real relevance that resulted in some Regions/LGEs receiving significantly more Block Grant funds than others. At the May, 2009 Planning Council meeting, a resolution was passed to appoint a Special Committee to make recommendations to the 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. This choice was heavily influenced by the fact that the statewide impact (to any of the regions/ LGEs) would be less detrimental than allocating by population. Another factor that was considered was that the more rural Regions, while not having as large a population, generally have more difficulty with access to services, transportation, and recruitment of staff. Additionally, funding based on population could vary significantly, particularly in a state that has already experienced much population shift due to hurricane displacement. The Assistant Secretary took the Special Committee's recommendation under advisement, and decided to accept their recommendation. Therefore, on June 29, 2009 a memo was sent to each Regional Manager and LGE Executive Director informing them of the reallocation that would take place gradually over three years, beginning with the 2011 Block Grant. Changes are outlined in Appendix A.

Members of the Planning Council have also discussed 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 is an initiative that has continued, and each RAC reports on regional activities at quarterly Planning Council meetings.

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; however, in the past year, the committee has been dormant, due in part to other priorities within the office, and loss of staff members responsible for providing information to this committee. 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.

Requests from the Finance Committee for more detailed information from the Central Office of OBH regarding the expenditures of Block Grant monies were not fulfilled; again due to staffing shortages. Rather than providing the information requested at the state level, the Committee was referred back to the RAC level where the Intended Use Plans and contracts are actually developed and monitored. At this level, detailed information would be more meaningful, and could include such things as goals and performance measures for contracts and programs. In responding to this request, the Assistant Secretary applauded the Planning Council's diligence and dedicated interests in monitoring Block Grant funds.

The activities presented above highlight the interactive and valuable relationship between the Planning Council and the Office of Behavioral Health. Within this document, the Planning Council's membership is listed, along with the duties, responsibilities, roles and charge as described in the Planning Council By-Laws and Rules.

Louisiana Mental Health Planning Council Membership List – 2010 - 2011

Revised –08-02-10

KEY (By Federal Regulation, ALL MEMBERS must be categorized according to these groupings):					
State Employee	Consumers/ Survivors/ Ex-patients	Family Members of Children with SED	Family Members of Adults with SMI	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.				
Office of 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 225-342-2563 (work) 225-342-1984 (Fax) Ann.Darling@LA.Gov
Education	2	Schaff, Robert	State Employee	La Department of Education 1201 N. 3rd Street, 4 th Floor P.O. Box 9064 Baton Rouge, LA 70804-9064 225-219-0367 225-219-4454 (Fax) Robert.Schaff@La.Gov
Vocational Rehabilitation	3	Martin, Mark	State Employee	La Rehabilitation Services 3651 Cedarcrest Baton Rouge, LA 70816 225-295-8900 225-295-8966 (Fax) MMartin@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.stae.la.us

Criminal Justice	6	Larisey, Sue	State Employee	Dep't of Public Safety & Corrections 660 N. Foster Drive Baton Rouge, LA 70806 225-922-1300 225-291-9349 (Fax) Sue.Larisey@La.Gov
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STATE AGENCY MEMBERS INVOLVED IN DEVELOPMENT OF BLOCK GRANT PLAN

State Planner	7	Castille, Dr. Cathy	State Employee	Office of Behavioral Health 628 N. 4 th Street P.O. Box 4049 Baton Rouge, LA 70821-4049 225-342-9528 225-324-1984 (Fax) Cathy.Castille@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 225-342-9528 225-324-1984 (Fax) Randall.Lemoine@LA.Gov

STATE AGENCY MEMBERS MANDATED IN STANDING RULES

Medicaid	9	Brown, Pamela G.	State Employee	Bureau of Health Services Financing POB 91030 628 N. 4 th Street Baton Rouge, LA 70821-9030 225-342-6255 225-376-4662 (Fax) Pamela.Brown@LA.Gov
Alcohol & Drug Abuse	10	Beck, Michele	State Employee	Office for Addictive Disorders 628 N. 4 th Street P.O. Box 3868 Baton Rouge, LA 70821 225-342-9354 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	Wightkin, Dr. Joan	State Employee	Maternal and Child Health Program 1010 Common St. Suite 2710 New Orleans, LA 70112 504-568-3506 504-568-3503 (Fax) Joan.Wightkin@La.Gov
ADVOCACY ORGANIZATIONS MANDATED IN STANDING RULES				
Meaningful Minds of Louisiana	13	Glover, Carole	Other (not state employee or provider)	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	Other (not state employee or provider)	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 <u>Council Chair</u>	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	Other (not state employee or provider)	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	Family Member of Child with SED	122 Raymond Drive Monroe, LA 71203 318-388-6088 318-388-6872 (Fax) theextramile@bellsouth.net

REGIONAL ADVISORY COUNCIL REPRESENTATIVES

These individuals are either RAC Chairs or other representatives from the RAC One person per Region/ LGE

MHSD	19	Miller, Rev. Donald <u>Council Vice Chair</u>	State Employee	5121 Easterly Circle New Orleans, LA 70128 985-626-6318 985-626-6640 (Fax) Donald.Miller@La.Gov
CAHSD	20	Jack, Nina	Other (not state employee or provider)	2124 Wooddale Blvd. Baton Rouge, LA 70806 225-925-2372 (work) 225-317-1246 (cell) NJack@voagbr-clvs.org
Region 3	21	Hadley, Joyce	Family Member of Child with SED	157 Twin Oaks Drive Raceland, LA 70394 985-537-6823 (work) 985-226-0584 (cell) Joyce.Hadley@LA.Gov
Region 4	22	Nobles, Denver	Consumer/ Survivor/ Ex-patient	P.O. Box 1264 Scott, LA 70583 337-849-6764 lafayetteredneck@yahoo.com
Region 5	23	Griffin, Carolyn B.	Family Member of Adult with SMI	2700 General Moore Ave. Lake Charles, LA 70615 337-477-8897 cargri@suddenlink.net
Region 6	24	Dennis, Jr. Victor B.	Other (not state employee or provider)	257 Stilley Road Pineville, LA 71360-5934 318-473-2273 318-623-4547 (cell) vdennisj@bellsouth.net
Region 7	25	Bradley, Debra	Consumer/ Survivor/ Ex-patient	934 Unadilla Street Shreveport, LA 71106 318-868-6964 318-564-2853 DBradl6@bellsouth.net
Region 8	26	Goldsberry, Kristi	Family Member of Child with SED	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	Other (not state employee or provider)	100 Saint Anne Circle Covington, LA 70433 985-626-6538 (work) 877-361-1631 (fax) NRichard@namisttammany.org

JPHSA	28	Noble, Rubye	Family Member of Adult with SMI	POB 8857 Metairie, LA 70011 504-835-5427 504-835-5424 (fax) rubyenoble@ren.nocoxmail.com
INDIVIDUAL REPRESENTATIVES These individuals <u>can</u> be on the RAC, but do not have to be. <u>One person per Region/ LGE</u>				
MHSD	29	Sweeney, Vanessa	State Employee	3316 New Orleans, LA 70117 520-245-3131 (work) 504-450-1401 (cell) Vanessa.Sweeney@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	Consumer/ Survivor/ Ex-Patient	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	Mullen, Joy	Consumer/ Survivor/ Ex-Patient	Duson, LA 70529 337-988-4043 337-349-7417 Joy4recovery@cox.net
Region 5	33	McMahon, LaShanda	Family Member of Child with SED	Fenton, LA 70640 337-756-9210 lashandam@centurytel.net
Region 6	34	Cobb, Cynthia	Family Member of Child with SED	Alexandria, LA 71307 318-484-6264 (w) 318-443-1554 (h) Ccobblaff6@yahoo.com
Region 7	35	Davis, Gloria	Family Member of Child with SED	Shreveport, LA 71107 318-868-6964 Davi6814@bellsouth.net
Region 8	36	Bias, Yolanda	Family Member of Child with SED	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	Family Member of Child with SED	6416 Kawanee Evenue Metairie, LA 70003 504-343-9014 (cell) Ramsllc@yahoo.com

INDIVIDUAL MEMBERS AT-LARGE				
At-large (CAHSD)	39	Kauffman, Steve	Consumer/ Survivor/ Ex-Patient	Advocacy Center 8225 Florida Blvd., Ste. A Baton Rouge, LA 70806 225- 925-8884 225-281-6131 (cell) skauffman@advocacyla.org
At-large (Region 5)	40	Raichel, Clarice	Family Member of Adult with SMI	POB 1824 Lake Charles, LA 70602 337-433-0219 337-433-1860 (fax) namiswla@bellsouth.net

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Louisiana Mental Health Planning Council

Composition by Type of Member – 2010 – 2011

Revised 08/02/10

Type of Membership	Number & Percentage of Total Membership	
TOTAL MEMBERSHIP	<u>40 #</u>	<u>100 %</u>
Consumers/ Survivors/ Ex-patients (C/S/X)	5	
Family Members of Children with SED	8	
Family Members of Adults with SMI	3	
Vacancies (C/S/X & family members)	0	
Others (not state employees or providers)	8	
Total C/S/X, Family Members & Others	<u>24 #</u>	<u>60 %</u>
State Employees	16	
Providers	0	
Vacancies	0	
Total State Employees & Providers	<u>16 #</u>	<u>40 %</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 $16/40 = 40\%$.

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 August 4, 2008

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. Should a regular meeting date fall on or within three days of a state holiday, the executive committee may reschedule the meeting subject to 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 an OMH 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 August 4, 2008 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 OMH 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 Mental Health (OMH)
 - (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 for Addictive Disorders (OAD)
 - (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 OMH regional advisory councils (RAC):

Ten members, one from each RAC.

B. Individual Members

Ten members, one from each OMH 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.

Adopted November 5, 2007

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.

Revised November 5, 2007

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.

Revised November 5, 2007

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 November 5, 2007

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.



Louisiana Mental Health Planning Council

August 9, 2010

Ms. Barbara Orlando
Grants Management Officer
Division of Grants Management
OPS, SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20850

Dear Ms. Orlando:

The Louisiana Mental Health Planning Council (LMHPC) was presented with the Center for Mental Health Services (CMHS) Community Mental Health Services Block Grant Application for the fiscal year 2010-2011 at their regular quarterly meeting on August 2, 2010. Members were encouraged to formally review the plan, ask questions, and make comments. Additionally, the plan, in draft format has been available on the Planning Council website, which is available to council members as well as the general public.

Members of the LMHPC continue to take an active role in monitoring the funding of mental health services in the state. Members have also expressed interest in obtaining more data regarding outcomes of services, and they encourage the use of evidence-based practices. Council members serve a vital role in advocating for consumers of mental health services and striving to improve quality of care.

We as a Council believe the plan is an important document in that it serves as a guidepost in the goal of transforming the mental health system in the state.

Sincerely,

Jennifer Jantz

Jennifer Jantz, Chair
Louisiana Mental Health Planning Council
Executive Director, NAMI Louisiana

5534 Galeria Drive - P.O. Box 40517 - Baton Rouge, LA 70816
225-291-6262 (phone) - 225-291-6244 (Fax)

ADULT & CHILD/ YOUTH – ADMINISTRATIVE REQUIREMENTS,
FISCAL PLANNING ASSUMPTIONS, AND SPECIAL GUIDANCE

PLANNING COUNCIL LETTER

LOUISIANA FY 2011 BLOCK GRANT PLAN

Part C STATE PLAN Section I

Adult & Child/ Youth

Description of the State Service System

**SECTION I – DESCRIPTION OF STATE SERVICE SYSTEM
OVERVIEW, REGIONAL RESOURCES, LEADERSHIP
LOUISIANA FY 2011 - ADULT & CHILD/ YOUTH PLAN**

INTRODUCTORY COMMENTS

There are many challenging factors influencing the mental health system in Louisiana today. After several years of dealing with hurricanes and the aftermath of some very destructive storms, the Gulf Coast region is now confronted with a man-made disaster in the form of an oil spill. The long-term impact of this spill is going to be tremendous in terms of the loss of a livelihood for many families living and working along the coast. The repercussions of this one oil spill affect 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. This on the heels of the tragedy and devastation experienced by the state in the form of Hurricanes Katrina and Rita in 2005 and Hurricane Gustav and Ike in 2008. Gustav made landfall three days after the Block Grant Plan was submitted, reflecting eerily on the history of having Katrina hit three days after the Plan was submitted in 2005. Hurricane Gustav made a direct hit the capital city of Baton Rouge, effectively dealing a blow to the governmental sector, with electrical power out to more than 90% of the city following the storm, and many homeowners and businesses were without power for 3-4 weeks. Following Gustav, Hurricane Ike affected the area of the state that had previously been devastated by Hurricane Rita. While the southern region of the state sustains the most direct damage each time a hurricane hits, the entire state experiences the repercussions of these storms, both emotionally and financially. Louisianians are by nature a resilient group, but each time that progress is made towards recovery, it seems that yet another catastrophe occurs. Recovery is particularly difficult given that there are also budgetary crises to deal with. As true today as it was when it was written in the *President's New Freedom Commission on Mental Health Report*:

Recovery is the Goal of a Transformed System.

Over the last several years, it has become imperative to constantly re-evaluate priorities; including Block Grant goals, targets and indicators in order to realistically reflect the capabilities of a strained and in some cases a temporarily incapacitated system. The fiscal realities that Louisiana is experiencing both as the consequence of disasters and the national economy are of concern; and the effects long term are simply not predictable with any measure of certainty. Fortunately, we do believe in the principle that *people recover*. The FY 2011 Block Grant Application is presented in the context of, and with an awareness of the continuing stressors the state is enduring. It is impossible to discuss most areas of the plan without reference to the effects of the catastrophes and the legacy that these catastrophes impose on the State and its citizens.

OVERVIEW OF MENTAL HEALTH SYSTEM IN LOUISIANA

The Office of Mental Health and the Office for Addictive Disorders were joined into one entity on July 1, 2010. The newly formed Office of Behavioral Health (OBH) is governed by the Assistant Secretary (e.g., Commissioner) who is the appointing authority for the agency, and reports to the Secretary of the Department of Health and Hospitals. The Office of Behavioral Health (OBH) operates within the Department of Health and Hospitals (DHH) alongside agencies of the Office of

Public Health, the Office for Citizens with Developmental Disabilities, the Office of Management and Finance (including the State Medicaid agency), and the Office of Aging and Adult Services.

The 2009 Regular Session of the Louisiana legislature, passed into law ACT No. 384 creating the Office of Behavioral Health. ACT 384 dissolved the Office of Mental Health and the Office for Addictive Disorders, and merged the administration and planning functions of each office into one. This move was made in order to allow for best practices in the treatment of individuals with mental illness, addictive disorders, and co-occurring disorders, while maximizing available funding. With time, the consolidation of the administration of the offices of mental illness and addictive disorders into the Office of Behavioral Health will offer less redundancy and greater benefits to Louisiana citizens in need of these services. It is also anticipated that in the future, the merger will lead to a strengthening of the link to primary care.

In order to assist the reader in understanding the State mental health care system, a map of Louisiana that illustrates the geographic Regions or Local Governing Entities (LGEs), and the organizational chart of DHH are included in this section. At the time of this writing, the organizational chart for the new OBH had not been finalized. It should be noted that the Mental Health Planning Council will occupy a prominent place in the formal OBH organizational chart. Since 2004 the Planning Council Liaison has acted as an important and effective link between the Planning Council and OMH and will continue to fulfill this role with OBH.

State Agency Leadership & Description of Regional Resources

The Office of Behavioral Health (OBH) is the state agency currently responsible for planning, developing, operating, and evaluating public mental health services and addictive disorder services for the citizens of the State. Mental health services are targeted to adults with a severe mental illness, children and adolescents with a serious emotional/behavioral disorder, and all people experiencing an acute mental illness. While there is no separate state-wide division for children's services, the provision of Child / Youth Best Practices has recently occupied a prominent position in the functioning of the agency. Regions and LGEs must maintain Regional Advisory Councils officially linked to the State Mental Health Planning Council in order to qualify to receive Block Grant funding.

Legislation has mandated that the administration of the Louisiana mental health care system change from interrelated geographic *Regions* to a system of independent health care Districts or Authorities (also referred to as *Local Governing Entities or LGEs*) under the general administration of OBH. As of July, 2010, there are five LGEs in operation and five that are in various stages of the transition to becoming LGEs. With the movement towards more LGEs comes the importance of developing mechanisms to assure continuity of care and consistency of statewide standards of care that are responsive to needs of consumers.

In the past, the Community Mental Health Clinic (CMHC) and State Hospital programs were all directly operated by state civil servants with direct line of authority from the administrative central office. The LGEs are (and will be) legislatively mandated as the 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 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 transition to local governing entities, the role of the Office of Behavioral Health (OBH) will also transition to provide resources and assistance that enables the LGEs to carry out service delivery. 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). 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 outcomes. With the trend towards more local governing entities comes the importance of developing mechanisms to assure continuity of care and consistency of standards of care that are responsive to needs of consumers. Legislation has established roles and accountability mechanisms for DHH's relationship with LGEs.

The original local Governing Entity, the Jefferson Parish Human Service Authority, has operated all public mental health, substance abuse, and developmental disability services for that parish since 1989. A second LGE, the Capital Area Human Service District, was authorized by the legislature in 1998. This LGE includes several parishes, and integrates mental health, substance abuse, developmental disability, and public health services in one regional system of care. Two LGEs became operational in July of 2004, the Florida Parishes Human Services Authority and the Metropolitan Human Services District. The South Central Louisiana Human Services Authority (Region 3) officially transitioned from a Region to an LGE on July 1st of 2010.

There are currently a total of 45 Community Mental Health Clinics (CMHCs), and 27 Outreach locations that are operational in the State. The CMHCs provide 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. OBH also provides additional community-based services either directly or through contractual arrangements, including supported living, supported employment, family/consumer support services (e.g., case management, respite, drop-in centers, consumer liaisons), and school based mental health services. OBH (including the LGEs) has many contracts with private agencies, funded by the Block Grant to provide a wide array of additional community-based services. Historically, OMH operated as a managed care agent of the state Medicaid agency to authorize and monitor quality and outcomes for mental health rehabilitation services operated through private Medicaid provider agencies statewide. As of July 1, 2009, the Mental Health Rehabilitation program was moved out of OMH and now operates under the Bureau of Health Services Financing/ Medicaid Services, within DHH.

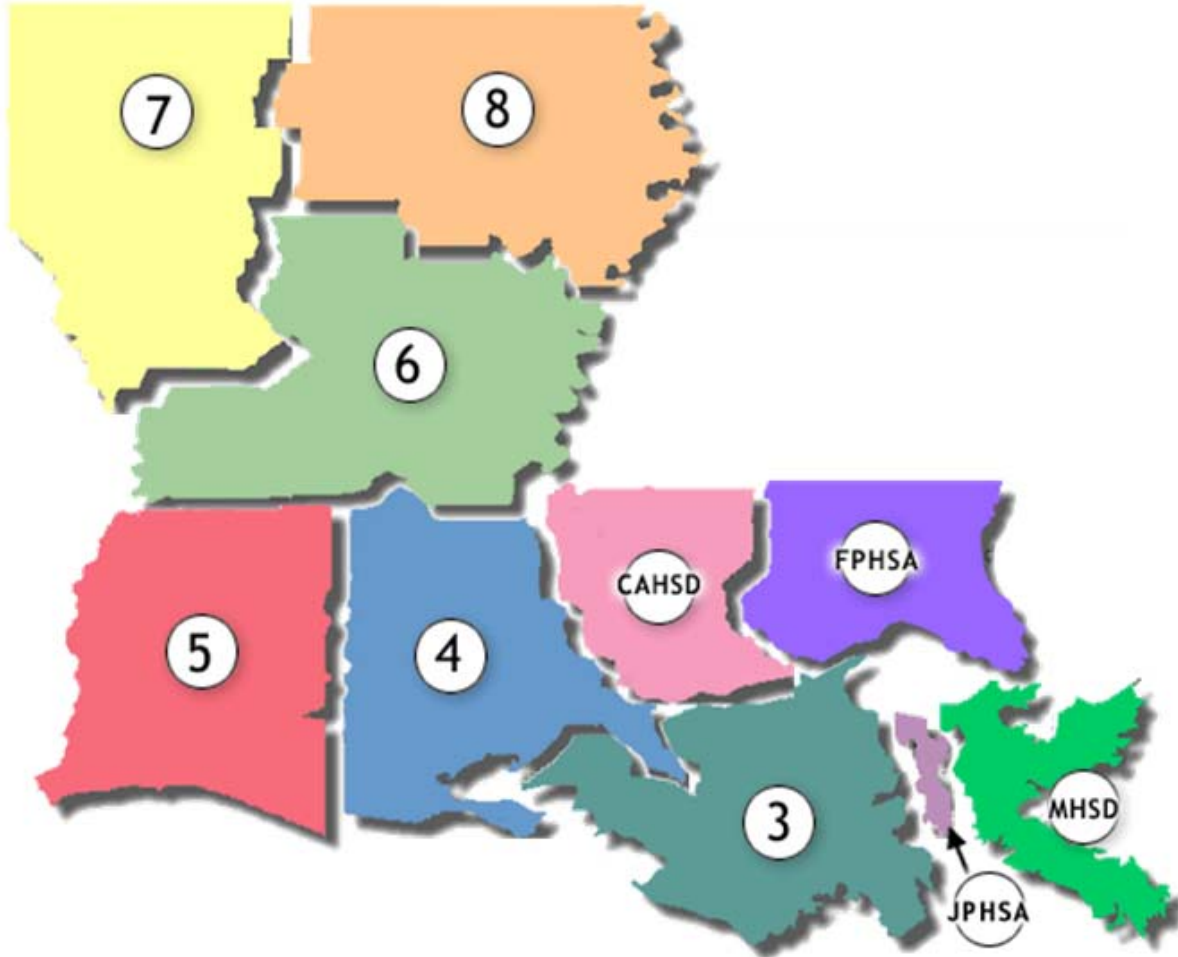
OBH provides for a continuum of care process to facilitate access to acute and/or intermediate/long-term hospital placements. There are three state-operated intermediate/long term inpatient care psychiatric hospitals that have a total of 322 Adult Civil Intermediate care beds: Southeast Louisiana Hospital (SELH) in Mandeville, Eastern Louisiana Mental Health System (ELMHS) in Jackson and Greenwell Springs, and Central Louisiana State Hospital (CLSH) in Pineville. One hospital (ELMHS) includes a division that is solely designated for the treatment of the forensic population; this setting has a total of 379 adult (intermediate) forensic beds. New Orleans

Adolescent Hospital was closed in 2009, with the goal of optimizing outpatient care for the state's children and youth. Two new outpatient Behavioral Health Clinics were opened in the New Orleans area to allow for improved mental health services in the area specifically for children and youth. Statewide, there are 50 beds dedicated to Children/ Youth. There are several facilities in the state that are operated by the Louisiana State University Medical schools that have acute mental health beds. For a more detailed picture of the bed count across the state, see Criterion 5, Table *State Psychiatric Facilities Statewide Staffed Beds*.

In keeping with System of Care principles and the need for a comprehensive continuum of care, the Office of Behavioral Health has improved the array of community based services operated through the hospitals and geographic regions. Persistent efforts have been successful in establishing more community-based services operated through the hospitals (e.g., day hospitals, rehabilitation programs). The community and hospital system of care emphasize continuity of care and treatment in the least restrictive environment appropriate to the person's needs. There is an emphasis on a close liaison between the regional service system, the LGEs, state hospitals, community provider agencies, and consumer and family support and advocacy systems. OBH supports consumer and family involvement in the planning, development, delivery, and evaluation of services. OBH provides funding for regional consumer resource centers, various family support programs, and regional consumer liaisons. OBH also trains and employs consumer and family members and parents of emotionally disturbed children as quality of service evaluators. It is anticipated that with the implementation of new Office of Behavioral Health framework, there will be a positive impact on service delivery, and the basic care that individuals receive will be improved. Towards that end, new Vision and Mission statements have been recommended by the OBH Implementation Advisory Committee that will guide the administration and day-to-day provision of services.

Statewide planning and development towards a comprehensive, community-based system of care is guided through the efforts of the State Mental Health Planning Council originally established under PL 99-660 guidelines with full consumer/ family representation from throughout the State. The Planning Council is responsible for Block Grant planning, together with OBH staff dedicated to this function. The membership of the Planning Council includes 40 members who are primary consumers, family members, parents of children with emotional/ behavioral disorders, advocates, Regional Advisory Council chairs, and human service agency (LGE) representatives. The council is geographically representative of the state. Included within the Council governance is the Programs and Services Committee that addresses matters related to planning, development, monitoring, and evaluation of mental health programs and services in the state. The OBH consumer survey process, C'est Bon, and the C/Y family survey process, La Fete, were developed by and are monitored by this committee of the Council. The Planning Council and consumers have been very active in service system performance evaluation.

Readers are referred to the State Maps and Organizational Charts, and tables that are provided in this section.



OBH Mental Health Regions
Regions 4 through 8*

DHH – Local Governing Entities (LGEs)

Metropolitan Human Services District (MHSD)
Capital Area Human Services District (CAHSD)
Florida Parishes Human Services Authority (FPHSA)
Jefferson Parish Human Services Authority (JPHSA)

*Region 3 =
South Central Louisiana Human Services Authority (7/1/2010)



OBH REGIONS & LOCAL GOVERNING ENTITIES, INCLUDING PARISHES SERVED

- Region I** Metropolitan Human Services District (MHSD)
- Region II:** Capital Area Human Services District (CAHSD)
- Region III:** South Central Louisiana Human Services Authority (SCLHSA)
- Region IV** *(will become Acadiana Area Human Services District)*
- Region V**
- Region VI**
- Region VII**
- Region VIII:** *(will become Northeast Delta Human Services Authority)*
- Region IX:** Florida Parishes Human Services Authority (FPHSA)
- Region X** Jefferson Parish Human Services Authority (JPHSA)

(See accompanying text for a full description of Region and Local Governing Entities)

This section includes a detailed listing of all community mental health facilities and state psychiatric hospitals statewide as of August, 2010, including both the OMH Regional and Local Governing Entity (LGE) facilities. In summary:

- The community mental health programs include:
 - 45 Community Mental Health Clinics (CMHCs), that are full service, full time, licensed, fixed-site mental health programs. The regional CMHC is the hub of service provision and administration and fiscal services of the region
 - 27 Outreach locations that are satellites providing services off-site, part-time, under the license of a clinic, and through the providers of that program

Note: This listing does not include the additional community services that are provided by each region under professional and social services contracts

- There are three OBH state psychiatric hospitals providing acute, intermediate, and specialized inpatient care; including one forensic division. During the summer of 2009, the services previously provided at a fourth hospital, New Orleans Adolescent Hospital (NOAH) were transferred under the umbrella of Southeast Louisiana Hospital (SELH). As previously mentioned, with the closure of NOAH, two new clinics designed to address the needs of Children and Adolescents in the New Orleans area were opened.

Note: Acute psychiatric inpatient units are short-term (generally less than 14-day) programs utilized to stabilize persons in mental health persons showing emergency need so as to return them back to community functioning as soon as possible. State Psychiatric hospitals include an acute unit but generally provide more intermediate to long-term length of care beyond the acute phase of a person's illness

MENTAL HEALTH CLINICS AND OUTREACH LOCATIONS (7/2010)

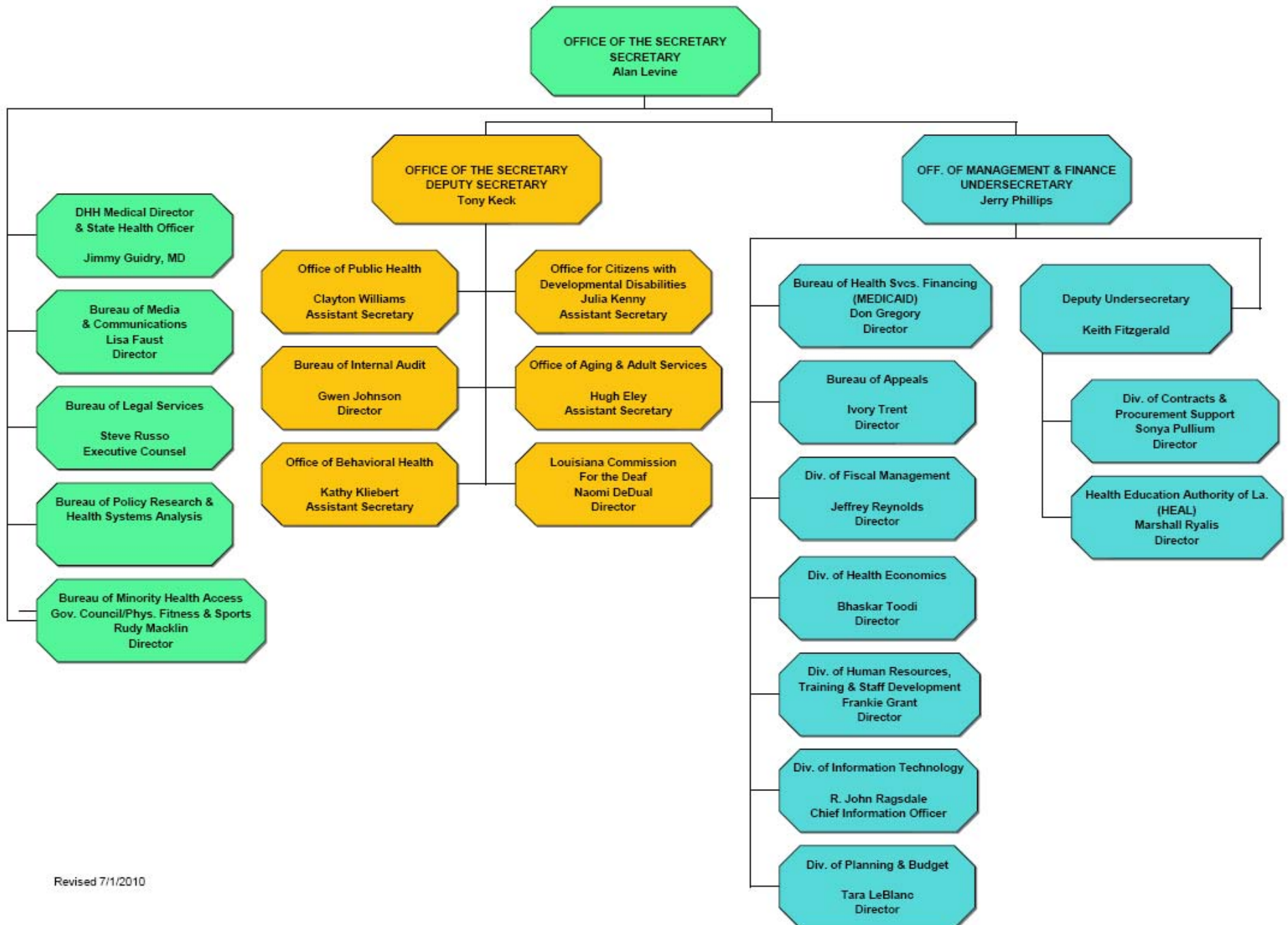
MHSD (Region 1)	Location / Status
Plaquemines Behavioral Health Clinic	Belle Chase
Chartres-Pontchartrain Behavioral Health Clinic	New Orleans
St. Bernard Behavioral Health Clinic	St. Bernard
Central City Behavioral Health Clinic	New Orleans
New Orleans East Behavioral Health Clinic	New Orleans East
Mid-Town Child/Adolescent Behavioral Health Center	New Orleans
Algiers Child/Adolescent Behavioral Health Center	Algiers
Algiers-Fischer Outreach	Algiers
CAHSD (Region 2)	
Baton Rouge Mental Health Clinic	Baton Rouge
Gonzales Mental Health Clinic	Gonzales
Margaret Dumas Mental Health Clinic	Baton Rouge
Clinton Outreach	Clinton
Donaldsonville Outreach	Donaldsonville
New Roads Outreach	New Roads
Plaquemine Outreach	Plaquemine
Port Allen Outreach	Port Allen
St. Francisville Outreach	St. Francisville
REGION 3	
Terrebonne Mental Health Clinic	Houma
Lafourche Mental Health Clinic	Raceland
South Lafourche Mental Health Clinic	Galliano
River Parishes Mental Health Clinic	LaPlace
St. Mary Mental Health Clinic	Morgan City
Assumption Mental Health Clinic	Labadieville
Lutcher Outreach	Lutcher
Vacherie Outreach	Vacherie
REGION 4	
Dr. Joseph Henry Tyler MH Clinic	Lafayette
New Iberia Mental Health Clinic	New Iberia
Crowley Mental Health Clinic	Crowley
Ville Platte Mental Health Clinic	Ville Platte
Opelousas Outreach Clinic	Opelousas
Abbeville Outreach	Abbeville
St. Martinville Outreach	St. Martinville
Eunice Outreach	Eunice
Kaplan Outreach	Kaplan
Church Point Outreach	Church Point
Mamou Outreach	Mamou
REGION 5	
Lake Charles Mental Health Clinic	Lake Charles
Allen Mental Health Clinic	Oberlin

Beauregard Mental Health Clinic	DeRidder
REGION 6	
Mental Health Clinic of Central LA.	Pineville
Leesville Mental Health Clinic	Leesville
Avoyelles Mental Health Clinic	Marksville
Jonesville Outreach Clinic	Jonesville
Bunkie Outreach	Bunkie
Winnfield Mental Health Outreach	Winnfield
Simmsport Outreach	Simmesport
REGION 7	
Shreveport Mental Health Clinic	Shreveport
Natchitoches Mental Health Clinic	Natchitoches
Minden Mental Health Clinic	Minden
Mansfield Mental Health Clinic	Mansfield
Many Mental Health Clinic	Many
Red River Mental Health Clinic	Coushatta
Arcadia Outreach	Arcadia
Logansport Outreach	Logansport
REGION 8	
Monroe Mental Health Clinic	Monroe
Ruston Mental Health Clinic	Ruston
Jonesboro Mental Health Clinic	Jonesboro
Richland Mental Health Clinic	Rayville
Tallulah Mental Health Clinic	Tallulah
Bastrop Mental Health Clinic	Bastrop
Columbia Outreach (& Winnsboro Clinic- merged)	Columbia
Farmerville Outreach	Farmerville
Delhi Outreach	Delhi
Lake Providence Outreach	Lake Providence
Oak Grove Outreach	Oak Grove
St. Joseph Outreach	St. Joseph
FPHSA	
Lurline Smith Mental Health Clinic	Mandeville
Bogalusa Mental Health Clinic	Bogalusa
Rosenblum Mental Health Clinic	Hammond
Slidell Mental Health Outreach	Slidell
JPHSA	
East Jefferson Mental Health Clinic	Metairie
West Jefferson Mental Health Clinic	Marrero

HOSPITALS

Central Louisiana State Hospital (CLSH)		Pineville
Eastern Louisiana Mental Health System (ELMHS)	Greenwell Springs Division	Greenwell Springs
	Forensic Division	Jackson
	East Division	Jackson
Southeast Louisiana Hospital (SELH)		Mandeville

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS



*As of the date of the writing of the 2011 Block Grant application,
the Organizational Chart for the newly created*

Office of Behavioral Health

had not been finalized.

SECTION I – DESCRIPTION OF STATE SERVICE SYSTEM
NEW DEVELOPMENTS & ISSUES
LOUISIANA FY 2011 - ADULT & CHILD/ YOUTH PLAN

**NEW DEVELOPMENTS AND ISSUES THAT WILL AFFECT MENTAL HEALTH DELIVERY
IN FY 10-11**

The legislated merger of the Office of Mental Health with the Office for Addictive Disorders to become the Office of Behavioral Health (OBH) has been a major focus over the last year, and will continue to be a priority as the new organizational structure is further developed. The merger was mandated in the 2009 Regular Session of the Louisiana Legislature to occur on the first day of the state fiscal year, July 1, 2010. These changes are further described in the *Overview of the Mental Health System* in Section I. Although not without controversy, the move to OBH is anticipated to result in more seamless and coordinated care, while eliminating redundancies at the administrative level.

Emergency preparedness, response and recovery have become a part of every healthcare provider's job description, and employees have learned that every disaster is different, be it a hurricane or an oil spill, always requiring new learning and flexibility. All employees of OBH are now on standby alert status should a hurricane threaten the state, and all employees are expected to be active during a crisis. Louisiana families are encouraged to "*Get a game plan*" (<http://getagameplan.org/>) in order to be prepared for a hurricane, or other disaster, should one strike.

Funding to healthcare in the state budget was significantly reduced in the just ended legislative session. Since education and healthcare budgets are areas that are not constitutionally protected in the Louisiana State Constitution, they are often the areas that are hardest hit when revenue is down. In a state that is known for high levels of poverty, high rates of chronic illness, and a high percentage of school drop-out rates, these cuts are significant.

The Louisiana Medicaid Behavioral Health Section was launched within Medicaid's Medical Vendor Administrative section on July 1st 2009, and is responsible for the oversight, management and administration of all Medicaid-funded behavioral health services. This new section works collaboratively with other health care service agencies within the state to improve access to medically necessary behavioral health services. Under this new section, Louisiana is seeing a continued migration toward managed behavioral health care and greater utilization tracking, review and utilization management of all services. This new section, although not within the Office of Behavioral Health, works towards achieving goals previously established by the state's mental health authority. Such goals include increasing access to services, decreasing fragmentation of services, increasing evidence based services, increasing quality standards, and decreasing reliance on utilization of jails, emergency rooms, and inpatient psychiatric hospitals, while increasing access to more community-based mental health services. It is also expected that this section will work toward integrating substance abuse services into the system of care.

Multi-systemic Therapy (MST) was approved under state plan and allowed reimbursement beginning July 1, 2008. MST is a state plan service in Louisiana under the rehab option and is an open access service provided exclusively to Medicaid eligible youth. The primary goals of MST

are to reduce youth criminal activity, reduce antisocial behavior, and achieve these outcomes as a cost savings by decreasing rates of incarcerations, hospitalizations, and out of home placements. Medicaid has developed and maintained close collaborative relationships with both the Office of Community Services and the Office of Juvenile Justice, and anticipates additional requests and opportunities to develop evidence based mental health services for youth within Medicaid. These positive collaborations will likely also result in increased utilization of available Medicaid behavioral health services by recipients assisted by those agencies.

The transition of the Office of Mental Health and the Office for Addictive Disorders into one Office of Behavioral Health will result in increasing access to evidence based services for those adults with severe and persistent mental health issues, youth with emotional/behavioral disorders and those of all ages affected by substance abuse issues. Similarly, Louisiana's movement toward the medical home model should help with integration of primary medical and behavioral health services, improving the system of care and coordination of services.

Block Grant funds were reduced by 11.7% for the 2009 (and 2010) fiscal year, followed by another reduction of \$142,012 in 2010 (and 2011). In an attempt to understand the reductions, it is believed that it is a result of several converging elements that occurred after the hurricanes in 2005. The devastation in the Gulf Coast area caused an infrastructure and housing shortage which lead to a temporary post-hurricane boom in construction jobs as well as a temporary influx of money from government sources and industry. In addition, there was a temporary decrease in the numbers of people living in Louisiana. The reality is that these changes were indeed temporary, and the resultant cut has meant a reduction in needed services that had been previously supported by Block Grant money. Louisiana has also faced significant budget cuts in the Medicaid allowance in the 2011 fiscal year. In 2011, the federal stimulus package also ends, and Louisiana is indeed facing some lean economic times.

**SECTION I – DESCRIPTION OF STATE SERVICE SYSTEM
LEGISLATIVE INITIATIVES & CHANGES
LOUISIANA FY 2011 - ADULT & CHILD/ YOUTH PLAN**

LEGISLATIVE INITIATIVES AND CHANGES

Implementation of several legislative initiatives from last year's legislative session, the *2009 Fiscal Only Regular Session of the Louisiana Legislature* included:

- ACT 384: Completed. Transfers the office of mental health and office for addictive disorders into a newly-created office of behavioral health..
- ACT 230: Completed. Allows the Department of Health and Hospitals, upon court order, to use restraints on certain children during transport..
- ACT 251: Completed. Transfers the regulation of medical psychologists from the State Board of Examiners of Psychologists to the Louisiana State Board of Medical Examiners and provides for requirements for and rights acquired by licensure, prescribing drugs, and other regulations for such profession..
- Within the fiscal budget bill was contained language that allowed OMH to close the New Orleans Adolescent Hospital (NOAH). This was completed last year by moving the few child and adolescent patients to Southeast Louisiana Hospital (SELH) and also the adult acute unit patients at NOAH were moved to the adult acute units at SELH. The savings in operational costs allowed for the opening of three new community mental health clinics for children and adolescents in locations convenient to consumers in the New Orleans area.

The *2010 Regular Session of the Louisiana Legislature* that ended June 21, 2010, had 2,301 bills filed and 849 resolutions. Bills that passed the 2010 Louisiana Legislature that may impact persons with mental illness are as follows:

- ACT 419: Provides relative to standards for inpatient hospitalization at Feliciana Forensic Facility when a person is charged with certain felonies and misdemeanors.. In this case, this law modifies under what circumstances a person can be determined to be incompetent to proceed to trial and receive competency restoration services in an outpatient setting rather than being required to be hospitalized in the forensic hospital. It also establishes criteria by which a person determined not to be restorable can be released to the community vs. being required to be hospitalized.
- HSR5: Requests the House Committee on Health and Welfare to study potential reforms to this state's system of child and adolescent psychiatric care.
- ACT 894: Provides relative to the conduct of examinations and execution of emergency commitment certificates in certain parishes. Actually permits the coroner in one LA parish to perform evaluations for an emergency certificate via teleconference under certain circumstances.
- ACT 907: Create a Coroner's Strategic Initiative for a Health Information and Intervention Program in the office of the coroner in each parish. Actually only allows for the creation of a community service arm of the coroner's office in one LA parish. Requires hospitals within this parish to provide information of this service to persons being discharged.

- In addition, language in current legislation allows DHH and OBH to contract with private providers for the provision of services that are now currently being provided by the state hospitals. DHH is currently in the process of releasing RFPs for the operation of secure forensic facilities (SFF) that are step-down residential programs for individuals who have been adjudicated not guilty by reason of insanity (NGBRI) to prepare them for potential discharge to the community if certain conditions are met.

LOUISIANA FY 2010 BLOCK GRANT PLAN

Part C STATE PLAN Section II

Adult & Child/ Youth

IDENTIFICATION & ANALYSIS OF THE SERVICE SYSTEM'S STRENGTHS NEEDS & PRIORITIES

**SECTION II – IDENTIFICATION & ANALYSIS OF SERVICE SYSTEM’S STRENGTHS,
NEEDS, & PRIORITIES
SERVICE SYSTEM’S STRENGTHS & WEAKNESSES
LOUISIANA FY 2011 - ADULT & CHILD/ YOUTH PLAN**

The *President’s New Freedom Commission Report* found that the mental health care system needs to be fundamentally transformed to become recovery oriented, to integrate programs that are fragmented across levels of government and different agencies, and to replace unnecessary institutional care with efficient, effective community services. The Office of Behavioral Health is fully aware of these issues and is in the process of transformative action.

Mental health care in Louisiana has been burdened by a lack of adequate infrastructure, an insufficient workforce, and declining funding. Louisiana historically has had a fragmented mental health system and access to care has been inadequate. The downturn in the economy has created further problems with individuals losing health care benefits; whether because of industry cutbacks or by loss of employment.

Even those individuals in the state who have insurance are not immune from problems in obtaining adequate mental health care. The Louisiana Office of Group Benefits, the largest insurer in the state of Louisiana, offers group health insurance benefits to state employees and employees of many local government entities. Sadly, this organization has elected to exempt these government-sponsored health plans from the parity requirement of the federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) law, such that mental health and substance use disorder benefits continue to be more restrictive than those applicable to medical and surgical benefits covered by the plan. As of the 2010 fiscal year, a separate mental health deductible will no longer be required and limits on outpatient treatment and inpatient hospital stays are in effect, but employees have been notified that the health insurance plan “may not meet all technical requirements of the interim federal rules and regulations.”

On March 23, 2010, President Obama signed into law the historically significant *Affordable Care Act*. The law puts into place comprehensive health insurance reforms that promise to hold insurance companies more accountable and lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans. Some of these reforms take place over time, while others take effect immediately. Parity for all health conditions including mental health is expected to improve.

Extensive programmatic review of Louisiana’s mental health systems and services has been undertaken during previous administrations. The ensuing reports have identified inadequacies and have provided specific recommendations for improvement. The most recent report, *A Roadmap for Change* was published in June, 2006, and continues to provide a useful schema to follow in examining transformation efforts.

A Roadmap for Change:
Bringing the Hope of Recovery to Louisianians with Mental Health Conditions

Prior to the hurricanes, the Louisiana Department of Health and Hospitals (DHH) commissioned a programmatic systems and services review of mental health care in Louisiana, resulting in a document that was published in June, 2006, and did include evaluation of the system post-Katrina

and Rita. The final document, *A Roadmap for Change: Bringing the Hope of Recovery to Louisianians with Mental Health Conditions* was the result of this review, and included recommendations for transformation. A synopsis of the major findings highlighted fifteen focus areas. While the study is a thorough critique of the system, it is also aspirational. The administration continues to utilize the findings of the report in studying and setting priorities, and evaluating recommendations made therein. A summary of the *Roadmap* findings is found in a Table in this section.

It has been previously acknowledged that in order for meaningful progress to occur, reform must take a broad coordinated approach involving federal, state, and local governments, public/ private partnerships and citizens coming together. The recognition by the public that mental illness is a real and treatable health disorder continues to be a challenge.

As stated in the final *President's New Freedom Commission Report*, successful transformation of the mental health service delivery system to promote recovery rests on two key principles:

- 1) Services & treatments must be consumer- and family- driven; geared to give consumers real and meaningful choices about treatment options and providers, and not oriented to the requirements of bureaucracies.
- 2) Care must focus on increasing individuals' ability to cope successfully with life's challenges, on facilitating recovery, and on building resilience, not just on managing symptoms.

SYNOPSIS OF MAJOR FINDINGS BASED ON *ROADMAP* SYSTEMS AND SERVICES REVIEW*

	FOCUS AREA	FINDING
1.	Vision & Mission	Louisiana has no widely understood or accepted and shared vision to guide the delivery of mental health services to adults, children, and families.
2.	Leadership	Key leadership positions in DHH have experienced turnovers, and some are filled by persons in “acting” roles.
3	Service Delivery Structures; State (DHH) / District Governing Relationship	While progress has been made to provide health care services under a District/ Authority model, much of the State’s structures providing public mental health, substance abuse and developmental disability services currently operate under a variety of differing geographic and process models.
4	Organization and Role of Office of Mental Health	Louisiana’s increasing move toward a district model for delivering services in the community will necessitate the role and function of the OMH to change from that of principally a service provider to one where the office is the coordinator of a more distributive and integrative model of service delivery.
5	Financing & Budget	Louisiana has an inadequate financing strategy to ensure access to appropriate mental health services. Louisiana lacks a comprehensive framework to use for understanding and assessing the adequacy of its financial investment in mental health services. Louisiana has not taken sufficient steps to secure existing financial resources nor to fully seize opportunities to increase resources for mental health services.
6	Evidence-based Practices	Louisiana currently makes very limited use of evidence-based and best practices and in only isolated areas of the State, never seeming to be brought to a statewide scale. Where these practices do exist, soon after Federal or other grant dollars that helped to initiate them end, they can no longer be afforded or otherwise supported, and are abandoned.
7	Acute Care/ Crisis Response Network	Louisiana lacks alternatives to traditional crisis services thus creating an even greater shortage of the State’s acute, inpatient bed capacity.
8	Suicide Prevention and Response	Louisiana ranks 38 th in the nation in terms of suicide rates. There is much uncertainty and concern across the State as to whether the suicide rate has increased in the aftermath of the hurricanes. The data needed to draw these conclusions is incomplete.
9	Cultural Competence and Eliminating Disparities	The capacity of Louisiana’s State Departments, agencies and providers are challenged in meeting the mental health care needs of the State’s highly diverse, heterogeneous populations.
10	Workforce Development	As is the situation in every state, Louisiana is facing a serious shortage of professionals and para-professionals trained in providing evidence-based and best practice mental health services for children, adults, and older adults.
11	Children, Youth, and Families	In Louisiana, only 7-14% of children with mental health disorders are receiving services and only 13% of the Office of Mental Health’s budget is spent on children’s services.
12	Primary Care Integration	The primary healthcare needs of Louisiana communities are well understood, however, DHH lacks a process to assess behavioral health needs at the community level, thus missing opportunities for significant integration and collaboration.
13	Homelessness and Housing	Serious mental illness and substance abuse are the two most significant factors contributing to homelessness in Louisiana. The State faces a serious lack of affordable housing, especially for people with disabilities, a situation exacerbated by the impact of Hurricanes Katrina and Rita.
14	Employment	Adults and youth with mental disorders are drastically unemployed and underemployed in Louisiana. Effective policy and service strategies have recently been clearly identified and, if implemented, could significantly improve rates of employment for mental health consumers.
15	Criminal Justice	Mental health services for those individuals and families who come before the State’s criminal, family, and juvenile court system are woefully inadequate.

**taken from A Roadmap for change: Bringing the Hope of Recovery to Louisianans with Mental Health Conditions: Recommendations for Transformation Based on Findings from a Review of Mental Health Systems and Services. Prepared for: Louisiana Department of Health and Hospitals. Prepared by: Behavioral Health Policy Collaborative, Alexandria, VA; Technical Assistance Collaborative, Boston, MA. June, 2006.*

Cornerstone Quality Management Initiative

Previous administrations initiated the Cornerstone Project in 2005, as a way of developing and implementing the infrastructure necessary to move forward with redesigning mental health services and to address more contemporary service delivery utilization management needs. The four ‘Cornerstones’ listed below continue to provide the overall framework and processes for operations of the system of care and continue to develop to the present.

Recovery and Resiliency Cornerstone: Under the Cornerstone initiative, the Office of Mental Health has embraced a recovery and resiliency philosophy of care. Over the past few years, OBH conducted extensive staff training in this philosophy of care and has also sent staff to observe programs in other states that have exemplary programs. A major focus of the activities under this Cornerstone this past year has been further development of peer support services statewide and in pursuit of efforts to obtain Medicaid funding for these services. Over 740 Peer Support Specialists were trained, certified, and are now working within the outpatient clinics of the system. The Local Governing Entities (LGEs) and the OBH clinics employ these certified Peer Support Specialists as support staff to assist consumers who arrive for their regular clinic appointments. Employment of certified peer support specialists significantly advances the recovery/ resiliency philosophy of care. However, it is noteworthy that the viability of this program has been severely affected by the budget cuts, and the future of the program is uncertain at this time.

Utilization Management Cornerstone: OBH operates a strong utilization management (UM) system for the OBH clinics and for those LGEs who wish to participate, and this has become a focus of current mental health re-design efforts discussed previously. This UM system assures that OBH is serving persons most in need and assures that persons served receive the right type and amount of services based on their level of need. OBH has established standardized target population definitions for service eligibility criteria, service definitions, client profiles, intensity of need criteria, electronic centralized scheduling, service priority determination, authorization criteria, and service packages as part of a robust UM system. Productivity standards for service delivery staff have been defined according to UM standards and are monitored. To assist clinics to use the productivity data to make data-based decisions for their clinics, OBH utilizes the on-line analytical system, Service Process Quality Management (SPQM), and monthly staff webinars with David Lloyd, a national accountable care expert. The current focus has been on service productivity management and improvement and utilization of Level of Care Utilization System (LOCUS) ratings to determine and assign level of service (e.g., assign client to medication management clinics vs. specialty service clinics). This is a major focus of the mental health redesign initiative described in another section of this plan.

All OBH clinics have completed a UM Readiness Survey and a UM Implementation plan, and are now in the implementation phase of the UM / Accountable Care process. The UM process is under the direction of the Central Office Division Director for Policy, Standards, and Quality Assurance. There are UM teams in each OBH Region and a statewide UM committee. The UM Central Office Director conducts monthly webinars with the Committee and provides ongoing technical assistance where needed to support the continued implementation of UM / Accountable Care. The UM team is currently monitoring the implementation of the mental health re-design initiative and the status of the new service components of access to care, medication management, and specialty clinics.

Credentialing and Privileging Cornerstone: In addition to the traditional credentialing model that has been utilized in the state psychiatric hospitals, a credentialing plan and competency assessment

program for other licensed treatment staff is now in progress. The completion of this cornerstone will result in a credentialing for all licensed independent practitioners. The current focus is on credentialing prescribers. A contractor is engaged to establish the policies and perform the initial credentialing of clinical staff. Credentialing is being monitored and maintained through this contractor. During creation of the UM implementation plans, the OBH consultant assisted staff in the regions to construct competency requirements for each of the UM Core Services. Centralized credentialing is being developed with regional staff involvement.

Performance Improvement Cornerstone: The foundation for this critical Cornerstone is now being established through use of Service Process Quality Management (SPQM) utilizing the comprehensive data set in the OBH data warehouse as part of an ongoing performance improvement process. OBH has established and monitors productivity measures such as the number of direct service hours actually delivered by clinical staff, the number of cancellations by clients and providers, and the number of missed appointments (“no-shows”). Mr. David Lloyd, accountable care expert, has provided extensive consultation on productivity measures, standards, and strategies for monitoring and improving staff productivity through use of centralized scheduling procedures and specialized calculators he has provided in Excel. OBH continues to develop comprehensive performance improvement plan. OBH also continues to utilize its On-line decision support system which includes a report card of quality performance indicators and access to data for performance improvement monitoring (refer to the section description of OBH information management and decision support systems).

The President’s New Freedom Commission on Mental Health - Achieving the Promise: Transforming Mental Health Care in America, and the OBH Policy for Block Grant Proposals and Allocations

The *President’s New Freedom Commission* Goals were utilized in the development of the framework for the Intended Use Plans and allocations of Block Grant monies. Of significance in priority setting, all proposed expenditures in each Intended Use Plan are listed according to established categories. These categories have been cross-walked with the six Goals of the *New Freedom Commission* to promote awareness of the needs in each category, as well as to emphasize these categories as priorities. The Crosswalk Tables are below, separated into Adult and Child/ Youth categories. The reader is also referred to the Appendix to see the actual monetary allocations in each of the Intended Use Service Types; as well as to Adult Section, Criterion 5, Table C.

**PRESIDENT'S NEW FREEDOM COMMISSION &
LOUISIANA OBH INTENDED USE CATEGORIES
- ADULT SERVICES CROSSWALK -**

NEW FREEDOM COMMISSION		LOUISIANA OBH POLICY	
Goal #	Goal	Adult Service Category	Intended Use Service Types
2	Mental Health Care is Consumer & Family Driven	Adult Employment	Employment Programs; Employment Development & Services
2	Mental Health Care is Consumer & Family Driven	Advisory Council Support	Regional Advisory Council (RAC) Support
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	Assertive Community Treatment	Assertive Community Treatment (ACT) and ACT-like Outreach Services
1	Americans Understand that Mental Health is Essential to Overall Health	Consumer Advocacy and Education	Consumer Education; Advocacy and Education; Family Organization Support; Supported Adult Education
2	Mental Health Care is Consumer & family driven		
2	Mental Health Care is Consumer & family driven	Consumer Liaisons	Consumer Liaisons
2	Mental Health Care is Consumer & family driven	Consumer Monitoring and Evaluation	Management Information System; Consumer-Directed Service System Monitoring; Consumer Liaisons
5	Excellent Mental Health Care is Delivered & Research is Accelerated		
6	Technology is Used to Access Mental Health Care & Information		
2	Mental Health Care is Consumer & family driven	Consumer Support Services	Consumer Initiated Programs; Community Care Resources; Community Resource Centers; Case Management; Consumer Support; Medicaid Enrollment; Consumer-Education, Support and Empowerment
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice		
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	Crisis Response Services	Crisis Line; Crisis Stabilization; Crisis 24 hour screening & assessment; Mobile crisis response

NEW FREEDOM COMMISSION		LOUISIANA OBH POLICY	
Goal #	Goal	Adult Service Category	Intended Use Service Types
1	Americans Understand that Mental Health is Essential to Overall Health	Mental Health Treatment Services	Psycho-social Day Treatment; Forensic Program; Co-occurring Disorders Treatment
3	Disparities in Mental Health Services are Eliminated		
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice		
2	Mental Health Care is Consumer & family driven	Planning Operations and System Development	Planning Operations: Staffing for Bureau of Planning, Performance Partnerships and Stakeholder Involvement; Planning Council Office: Support Staff; Office Operations; Member Travel & Training; Regional Advisory Council Training; Management Information Services
6	Technology is Used to Access Mental Health Care & Information		
2	Mental Health Care is Consumer & family driven	Residential / Housing	Housing Development and Services; Housing; Foster Care; Group Homes; Supervised Apartments; 24-Hour Residential Housing Support Services
1	Americans Understand that Mental Health is Essential to Overall Health	Respite	Respite Services and Supports
5	Excellent Mental Health Care is Delivered & Research is Accelerated	Staff Development	OBH Workforce Recruitment, Development and Retention; Staffing for Bureau of Workforce Development
2	Mental Health Care is Consumer & family driven	Transportation	Community / Rural Transportation
3	Disparities in Mental Health Services are Eliminated		
3	Disparities in Mental Health Services are Eliminated	Other Contracted Services	Comprehensive Mental Health Services; Management Information System; Infrastructure Development; PODS (Public Outreach Depression Screening); Forensic Services
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice		
6	Technology is Used to Access Mental Health Care & Information		

**PRESIDENT’S NEW FREEDOM COMMISSION &
LOUISIANA OBH INTENDED USE CATEGORIES
- CHILD/ YOUTH/ FAMILY SERVICES CROSSWALK -**

NEW FREEDOM COMMISSION		LOUISIANA OBH POLICY	
Goal #	Goal	C/Y Service Category	Intended Use Service Types
2	Mental Health Care is Consumer & Family driven	Advisory Council Support	Regional Advisory Council (RAC) Support
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	Assertive Community Treatment	Assertive Community Treatment (ACT) and ACT-like Outreach Services
1	Americans Understand that Mental Health is Essential to Overall Health	Consumer Advocacy and Education	Consumer Education; Advocacy and Education; Family Organization Support
2	Mental Health Care is Consumer & Family driven		
2	Mental Health Care is Consumer & Family driven	Consumer Liaisons	Consumer Liaisons
2	Mental Health Care is Consumer & family driven	Consumer Monitoring and Evaluation	Management Information System; Consumer-Directed Service System Monitoring; Consumer Liaisons
5	Excellent Mental Health Care is Delivered & Research is Accelerated		
6	Technology is Used to Access Mental Health Care & Information		
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	Crisis Response Services	Crisis Line; Crisis Stabilization; Crisis 24 Hour Screening & Assessment; Mobile Crisis Response
2	Mental Health Care is Consumer & family driven	Family Support Services	Family Support Services; Wraparound; Medicaid Enrollment; Family Support Liaison and Program; Parent Liaisons; Family Training; Parent / Family Mentoring; Nurse Visitation Program; Community Care Resources; Rural Mobile Outreach Programs; Therapeutic Camp
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice		

NEW FREEDOM COMMISSION		LOUISIANA OBH POLICY	
Goal #	Goal	C/Y Service Category	Intended Use Service Types
2	Mental Health Care is Consumer & Family driven	Planning Operations and Systems Development	Planning Operations: Staffing for Bureau of Planning, Performance Partnerships and Stakeholder Involvement; Planning Council Office: Support Staff; Office Operations; Member Travel & Training; Regional Advisory Council Training; Management Information Services
6	Technology is Used to Access Mental Health Care & Information		
2	Mental Health Care is Consumer & Family driven	Residential / Housing	Housing Development and Services; Housing; Foster Care; Group Homes; Supervised Apartments; 24-Hour Residential Housing Support Services
1	Americans Understand that Mental Health is Essential to Overall Health	Respite	Respite Programs
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	School-Based Mental Health Services	School-Based Clinics; School-Based Services; School Violence Prevention
5	Excellent Mental Health Care is Delivered & Research is Accelerated	Staff Development	OBH Workforce Recruitment, Development and Retention; Staffing for Bureau of Workforce Development
2	Mental Health Care is Consumer & Family driven	Transportation	Community / Rural Transportation
3	Disparities in Mental Health Services are Eliminated		
3	Disparities in Mental Health Services are Eliminated	Other Contracted Services	Comprehensive Mental Health Services; Nurse Home Visitation Program; Management Information Services; Infrastructure Development; PODS (Public Outreach Depression Screening)
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice		
6	Technology is Used to Access Mental Health Care & Information		

**SECTION II – IDENTIFICATION & ANALYSIS OF SERVICE SYSTEM’S STRENGTHS,
NEEDS, & PRIORITIES**
UNMET SERVICE NEEDS & PLANS TO ADDRESS UNMET NEEDS
LOUISIANA FY 2011 - ADULT & CHILD/ YOUTH PLAN

Criterion 1: Comprehensive Community-based Mental Health Services

The effort to provide an improved and seamless system of services is an ongoing goal for the Office of Behavioral Health. Service and system integration at the local level as well as the organizational level continues. This is shown most poignantly in the merging of the Offices of Mental Health and Addictive Disorders described earlier in this document. Additionally, the integration of the acute psychiatric inpatient hospital units with the various community based programs continues, utilizing the Louisiana State University (LSU) Medical Center administration’s help and commitment. OBH and the LSU hospitals have implemented statewide and local agreements that govern the roles and responsibilities of the two organizations in their collective efforts at developing a more comprehensive range of acute care services for adults. This agreement addresses budgetary, clinical, and human resource issues.

Mental health services for individuals and families who come before the State’s criminal, family, and juvenile court systems are inadequate. Civil psychiatric beds continue to be used for forensically-involved persons, thereby limiting access to inpatient psychiatric care for the general population. More than a majority of the existing civil inpatient service capacity is constricted by the demand for forensic inpatient services. Despite the addition of forensic beds for competency restoration and the implementation of competency restoration services in the parish prisons and the implementation of a juvenile competency restoration program, the lack of community based resources for managing the forensic population prevents discharging a sufficient number of those in the forensic facility who would otherwise be eligible. Judicial restraint on approving such releases also creates a ‘back door’ barrier which directly affects access and creates a sustainable and growing forensic waiting list.

Access to medications has historically been difficult due to the limited number of psychiatrists working in the clinics. OBH now has a policy that allows non-physician professionals who have prescriptive authority to prescribe within OBH facilities. The inclusion of Medical Psychologists and Advance Practice Nurse Practitioners allows patients and consumers greater access to the care they need. Several mental health clinics have taken advantage of this added resource to the benefit of their clients.

The Office of Behavioral Health has a formulary that includes all of the newer antipsychotic agents, antidepressants, and mood stabilizers; however the cost of these medications is often high. Thanks to the efforts of outpatient clinic employees, the Office of Mental Health has capitalized on the available Patient Assistance Programs (PAP) to offset the cost of providing medications to OBH outpatient clinic clients. The cost of 70% of outpatient medications is underwritten by PAP. Staff members have also assisted all clients who are eligible with obtaining Medicare Part D or Medicaid benefits. In the past few years, these efforts have resulted in a savings of several million dollars each year from the six Regions alone. It is estimated that OBH pharmacies have dispensed almost \$9 million worth of prescriptions from Patient Assistance Programs and sample medications during each of the last two years; and that local community pharmacies have dispensed medications valued at roughly an estimated \$20 million utilizing Medicaid and Medicare funding to OBH clients.

In 2008-09 OBH restructured its psychotropic medication formulary in another attempt to reduce costs. The Pharmacy and Therapeutics Committee along with a special committee composed of Regional Medical Directors developed a step-wise algorithm for the use of medications from various classes. The current algorithm is detailed below:

**OBH ALGORITHM FOR THE USE OF ANTIPSYCHOTIC, MOOD STABILIZERS, AND
ANTIDEPRESSANT MEDICATIONS**

ANTIPSYCHOTICS

- Preferred
 - Generics
 - First generation antipsychotics (FGAs) when possible
- Medical Director approval required
 - Use of 2 atypicals
 - Criteria for approval: 1) a trial of 3 single atypicals for sufficient length(s) of time; 2) a trial of a single atypical and FGA for sufficient length(s) of time
 - Invega
 - Criteria for approval: 1) a trial of 3 single atypicals for sufficient length(s) of time, including risperidone; 2) trial of at least 1 combination of an atypical and a typical
 - Abilify (>30 mg)
 - Criteria for approval: 1) sufficient trial of Abilify (<30 mg); 2) sufficient trial of generic atypical or FGA
 - Zyprexa (>40 mg/day)
 - Criteria for approval: 1) sufficient trial of generic or FGA
 - Seroquel
 - Not approved for use under 200 mg
 - Criteria for approval over 200 mg: 1) sufficient trial of generic or FGA
 - Geodon
 - Criteria for approval: 1) Sufficient trial of generic or FGA
 - Risperdal Consta
 - Inpatient: only for patients preparing to be discharged
 - Outpatient:
 - Criteria: Sufficient trial of generic or FGA
 - Rapid oral Second Generation Antipsychotics (SGAs)
 - Zydis
 - M Tab

MOOD STABILIZERS

- Preferred
 - Generics
- Medical Director approval:
 - Topamax (seizure disorder only)
 - Neurontin (seizure disorder only)
 - Depakote ER

ANTIDEPRESSANTS (for anxiety, depression, ADHD)

- Preferred
 - Generics
 - Fluoxetine
 - Sertraline
 - Bupropion
 - Citalopram

- Etc.
- Medical Director approval
 - All other antidepressants

PROCEDURES

- Hospital and regional medical directors must approve all medications and specific usages of medications noted above within the “Medical Director approval required” categories.
 - Medical directors will keep records for each contact requesting approval for specific medication use
 - Medical directors will report each month to the OBH medical director requests for specific use and outcome of each action on the specific UM form that has been developed for monitoring these reviews
 - OBH medical director will review each action and will work closely with medical directors in the implementation of these procedures
- Hospital medical directors will develop a system of “rounds” attended by treating physicians/prescribers and pharmacy directors, among others, to ensure that information about medication cost and the cost of possible alternatives is available to the clinician.
 - Patients admitted to OBH clinics taking (previously prescribed) medications requiring medical approval or prohibited will be allowed to continue the medications without medical director approval for 3 months, during which time the physician/prescriber will work with the patient to discontinue the prohibited medication (transfer to a non prohibited medication) and, as much as possible, the medications that require medical director approval.
- Specific budgetary targets will be developed for each region and hospital. Progress toward achieving expected targets will be monitored during the course of the fiscal year so that additional formulary changes can be made, if necessary.

A significant administrative change occurred with the Mental Health Rehabilitation (MHR) program that removed the oversight of the program out from the Office of Mental Health after June 30th, 2009; when the oversight and management of the program was transferred to the DHH Bureau of Health Services Financing/ Medicaid. All staff, equipment, materials, contracts, purchase orders, processes and personnel were transferred. Starting with the new fiscal year, Medicaid began to provide all utilization management, prior authorization, training, monitoring, network, and member service activities. Under the new oversight, services remain the same as previously, and include services in the community to adults with serious mental illness and to youth with emotional and behavioral disorders. The available services include Assessment, Reassessment, Community Support, Group Psychosocial Skills Training, Counseling, and Medication Management. Optional services for children/ youth are Parent Family Intervention-Intensive, which provides intensive home-based services to assist children who are at-risk of being placed out of their homes. All authorized providers in the network are required to be accredited by JCAHO, CARF, or COA.

Cultural and diversity needs in the service delivery system 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.

The Office of Mental Health’s (OMH) statewide Cultural and Linguistic Competence Planning Committee began its work with an initial meeting in April 2005. Soon after the hurricanes of 2005, the committee agreed to focus on hurricane related cultural and linguistic competence issues across the State. The National Alliance of Multi-Ethnic Behavioral Health Associations (NAMBHA)

pledged on-going *pro-bono* consultation to assist Louisiana in developing cultural and linguistic competencies. NAMBHA utilized the Center for Mental Health Services' nine guiding principles for cultural competence in disaster mental health programs as their guide, as well as data and information gathered from focus groups. One of the primary learning objectives was to train staff that cultural and linguistic competence is a journey and a process; and the most ardent champion spends a lifetime acquiring skills that continue to make them more culturally competent. Unfortunately, due to budgetary constraints and loss of personnel, this committee has for all practical purposes become dormant. It is hoped that in the near future, the committee will become active once again.

OBH continues to explore its ability and capacity to expand the provision of evidence-based practices (EBPs). The state has isolated pockets where evidence-based practices are in place, but in the past, the practices have not been brought to a state-wide scale. In an effort to ameliorate this problem, during 2009-10, statewide EBP trainings have been offered to educate clinicians on such topics as Dialectical Behavior Therapy and Cognitive Behavior Therapy.

Crisis intervention and the development of resiliency in children and youth is an important area of need. In an effort to begin to address this need, the Child/Adolescent Response Team (CART) was developed. The CART response process is a time-limited series of crisis intervention steps. The six phases of the CART approach to crisis intervention consists of a cluster of services available to children and families initiated through a crisis phone line. The crisis plan establishes a time-line addressing all necessary elements (i.e., least restrictive setting issues, family supports, transportation, etc.) and includes a plan to link the family back to any pre-existing resources or new resources as needed. There are now crisis services for children statewide, although two LGEs (JPHSA and FPHSA) utilize their own model of crisis intervention for children.

The Louisiana Department of Health and Hospitals and the American College of Obstetricians and Gynecologists – Louisiana Section has a relatively new program designed to address poor birth outcomes in Louisiana. The Louisiana Screening, Brief Intervention, Referral, and Treatment (SBIRT) – Health Babies Initiative is designed to reduce the use of alcohol, tobacco and illicit drug use during pregnancy. The program also screens and provides appropriate referral for domestic violence, depression in pregnancy and inadequate parenting. The initiative is different from, but designed to work in concert with, specialized or traditional treatment. Historically, the primary focus of specialized treatment has been targeted toward persons with more severe substance use or those who have met the criteria for a Substance Use Disorder. SBIRT, however, targets those individuals with non-dependent substance use and provides effective strategies for intervention prior to the need for more extensive or specialized treatment. Mechanisms are also in place to refer those with the greatest addiction severity to specialized treatment. A pregnant woman's concern for her unborn child often motivates her to respond positively to her medical provider's advice. Therefore, the long-term goals of the Louisiana SBIRT initiative are to screen all pregnant Louisiana women at the site of prenatal care within both, public and private health facilities; and incorporate screening as a routine part of prenatal care. The Louisiana SBIRT-Healthy Babies Initiative began as a partnership with the Office of Addictive Disorders and the Office of Public Health within the Louisiana Department of Health and Hospitals, the American College of Obstetricians and Gynecologists (ACOG), March of Dimes, Fetal Infant Mortality Review and The Louisiana Campaign for Tobacco-Free Living.

Additional programs are also in place that address the need for a more integrated approach to care. Although the separation of treatments for mental illness and substance abuse is still all too common in the state, the reorganization of the two separate offices into the Office of Behavioral Health is

expected to be the foundation for promoting better integration at the clinical level. In several areas throughout Louisiana, local clinics have independently reorganized their services into a more integrated model. Many of the local areas have embraced evidence-based practices and have recognized that integrated care should be the standard. Local areas have also acknowledged the cost savings that occurs with integrated care; this is particularly inviting given the state's economic problems.

Adequate, safe, and affordable housing, already a problem in the state, became a major obstacle after the 2005 hurricanes, and to a lesser, but significant degree after the 2008 hurricanes. Serious mental illness and substance abuse continue to be the two most significant factors contributing to homelessness in the State. There is a lack of affordable housing, especially for people with disabilities. The need for rental subsidies to assist people with disabilities who are homeless due to the skyrocketing of housing costs is evident. The decrease in FEMA-funded housing has again put people into the homeless category who were housed in motels and trailers for several years after Hurricanes Katrina/ Rita. Aside from the dire need to create a new stock of affordable housing to replace that lost in the hurricanes, there is a considerable need for community based support services to assist people with mental illness in attaining and retaining their housing. 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. Funding through the 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.

The availability of a statewide system of Strengths Based Case Management would be a significant improvement in the quality of community based supports available to persons with mental illness. Efforts to increase available and appropriate housing for persons with mental illness through training and recruitment of housing providers, increased access to existing housing stock, and expansion of resources for housing development and support services continues. OBH and mental health advocates have been extremely active in efforts to insure that people with disabilities are included in housing and rebuilding efforts. These efforts have resulted in some success; for instance, the commitment to the development of 3,000 units of permanent supportive housing. Permanent supportive housing is a best practice and offers the greatest degree of consumer choice.

A lack of appropriate education directly impacts the ability of adults and youth with mental health disorders to find employment, and these individuals are oftentimes unemployed and underemployed. OBH remains invested in providing school-based mental health and health-related services in academic settings. OBH has a Memorandum of Understanding with the Special School District #1 of the Department of Education to provide educational services to children and youth hospitalized in an OBH facility.

Educational services are also offered through the Early Childhood Supports and Services program (ECSS) - located in CAHSD, MHSD, FPHSA as well as Regions 3, 4, 7, and 8 and Louisiana Youth Enhancement Services (LaYES - located in MHSD). Services offered that improve parent- child relations, who assist students with job-related skills, such as social skills, safety practices in the work place, and a broad range of issues related to behavioral, emotional, and mental health that are fundamental to adolescent development and educational attainment. Referrals are routinely made to assist youth maintain their educational goals, by the the Mental Health Rehabilitation (MHR)

program, case management, and ACT-type programs, Multisystemic Therapy (MST) is being integrated into the state system of care, having been approved as a Medicaid reimbursable service. The MST program does not directly provide educational services, but it supports them through social skills training, and the removal of family and environmental barriers preventing a client from achieving educational goals.

An increase in the number of suicide attempts and completed suicides among victims of the hurricanes has been noted, increasing the urgency and importance of addressing the hopelessness that precedes suicide. The Louisiana Partnership for Youth Suicide Prevention, funded by a SAMHSA grant serves as the governing body to undertake the oversight, development, monitoring, and evaluation of program activities to reduce youth suicides and suicide attempts in LA. The project targets 15,000 youth and young adult ages 10 to 24 years old consisting of middle, high, and college students and professionals (such as OMH, DOE, 211 providers, Veterans ADM. staff) that serve this population. 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 abuse disorders that may lead to suicide or a 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 at-risk youth population will increase their competence and awareness of youth suicide risk.

Better coordination of mental health, medical, housing, recreational and employment services for consumers with mental illness is necessary to fit the needs and individual aspirations of persons with severe mental illness. Interagency agreements, proactive use of legislation, the utilization of outside funding to build full service, regional resources for mental health consumers, with the ability to provide, coordinate, and adjust services needed by that population will improve the care that citizens with mental illness will receive.

Criterion 2: Mental Health System Data Epidemiology

Review of the number of persons served relative to estimated national prevalence rates is the most common means to determine the extent to which services are covering the need in terms of gross numbers of persons served. Services to adults are a critical area of need in the OBH system. Prevalence estimates indicate that only a small proportion of the need is being met by existing OBH services. Of the 87,586 adults with serious mental illness (SMI) in Louisiana, OBH reported a caseload of 32,907 adults in 2010 (as of 6/30/10, this year including JPHSA). It should be noted that SMI is a national designation that includes only those individuals suffering from the most severe forms of mental illness. The inclusion of individuals who have *any* type of mental illness would increase the population figures, but not the numbers of individuals served, as the facilities are designated to serve only those individuals with SMI as the term is used in Louisiana. Creative and cost-effective ways of reaching increased numbers of Louisiana citizens in need must be found.

Although services directed towards children and adolescents are improving, they also remain a critical area of need in the OBH system. Prevalence estimates indicate that only a small proportion of this population is being met by existing OBH services. Of the 101,105 children with serious emotional/ behavioral disorders (SED) or Emotional Behavioral Disorders (EBD) in Louisiana, OBH reported a caseload of 5,947 children and youth in 2010 (as of 6/30/10, this year including JPHSA).

SED/ EBD is a national designation that includes only those individuals suffering from the most severe forms of behavioral disorders. As reflected with the adult figures above, those who have any type of behavioral problem would increase the population figures, but not the numbers of individuals served, as our facilities are designated to serve those individuals with SED/ EBD.

Information with which to effectively plan and distribute resources is collected in numerous ways in OBH. Database upgrades that will combine information currently found in existing, separate databases into one efficient and comprehensive system is ongoing. With progressive implementation of the Office of Mental Health Integrated Information System (OMH-IIS) legacy systems are being phased out in favor of one, comprehensive, integrated web-based information system.

There also exist program specific data systems that are supported by OBH. These include the CRIS data system for the Child and Adolescent Response Team (CART), the ECSS-MIS web-based system for the Early Childhood Supports and Services (ECSS), the RiteTrack (proprietary) information system supporting the Louisiana Youth Enhancement Services (LaYES) in New Orleans, and data system supporting the Louisiana Spirit Crisis Program. In each case, these specialized service programs have unique database needs that have been established by either building a suitable database “in-house” or in the case of LaYES, purchasing a compatible commercial data management system. In each of these cases, efforts have been made to make sure that whatever system is being used, the structure and data formats are compatible with OMH-IIS such that key clinical information can be uploaded to OMH-IIS which is the primary repository of this information for OBH.

DHH is continuing to merge and to consolidate information technology within the department and to establish a participatory governance structure for managing, allocating, and supporting information collection, analysis, and use. DHH has established an executive Governance Board, a Project Management and Resource Allocation Committee, a Customer Relations Manager Committee, a Health Information Exchange Committee, and Information Management Committee. DHH is also establishing use of Microsoft SharePoint as a web-based communication and team collaboration tool to share information and facilitate the activities of workgroups. DHH is also establishing use of Microsoft Performance Point, a component of SharePoint, to enhance the agencies analytical and reporting capacity. Performance Point provides dashboards, score cards, key performance indicator reports, and other features. Whereas DHH continues to advance the availability and access to contemporary information technology, the human resources to utilize this technology still lags far behind and continue to be constrained by the budget deficit and hiring freezes. Many basic functions must be carried out through contracted resources which while needed and beneficial provides limited capacity building for the agency.

The variety and extent of data collected provides rich and unique opportunities for objectively evaluating and improving the mental health care system in Louisiana. The C'est Bon and LaFete Surveys are the consumer-to-consumer methodology developed by Louisiana for collecting information to measure access, quality and outcome indicators

The “C'est Bon” adult consumer survey has resulted in interviews of over one thousand consumers during FY10 and has repeatedly been a rich source of information regarding needs from a consumer and family perspective. Called “La Fete”, a comparable survey from parents and families of children with emotional/behavioral disorders was initiated in 2002 and continues. Since 2007, the state has been using the standard MHSIP survey for adults and the standard YSS and YSS-F surveys for youth and families respectively. A further enhancement to the state's consumer survey process was made to

add items of social connectedness and functionality on the C'est Bon Survey and LaFete surveys; and school attendance on the LaFete survey starting in July of 2008. Due to the low sample sizes obtained for the LaFete Child/Parent surveys during the last two fiscal year cycles, OBH will begin using a new technology to capture data for the entire quantitative portion of the LaFete survey which should improve the ability to collect adequate survey samples per clinic and also allow data collection state-wide annually, which has not been possible under the current LaFete survey process. This new methodology for collecting information on client satisfaction and outcomes will use the Telesage Outcome Measurement System (TOMS). The TOMS was implemented July 1, 2010 as an objective of the Data Infrastructure Grant (DIG). This on-line tool allows multiple methods of data entry including direct entry by staff, voice entry, or touch screen. Plans are to have parents of youth who are receiving services at the mental health clinics complete a YSS-F satisfaction survey twice per year of service by accessing TOMS using touch-screen kiosks in the waiting rooms of the clinics. This process will not allow for collection of the qualitative information that had been collected by the survey teams in the past. But, since this method has had a decreasing yield over the last two years, it was necessary to move to a more reliable method for collecting information even if it meant losing some of the richness of the in-person survey method. The quantitative data is required for URS and NOMS reporting, so it was felt that using the TOMS would provide OBH with the necessary data for mandatory reporting and losing the qualitative information was an acceptable trade-off.

OBH will continue to use live survey teams to collect both quantitative and qualitative information for the adult C'est Bon survey. The adult teams have been together since around 2002 and provide a stable and experienced workforce for this important function. The TOMS will be used to collect information on the MHSIP adult survey as a supplement to the live surveys. This will be especially helpful in surveying some of the more rural and smaller clinics around the state where the live survey teams can only survey every two to three years.

Called the Survey of Regions and Districts, and the Survey of Hospitals, standardized survey forms are used to gather extensive information from the OBH hospitals and the Regions/ LGEs statewide. Information gathered is available for inclusion in the annual Block Grant Application and other grant proposals, as well as for planning of resources, workforce delivery, etc. The instrument was carefully crafted and is continually updated with the goal of both increasing the validity of the information reported. This survey form is completed annually and submitted electronically.

The Office of Behavioral Health continually reviews several sources of data for determining gaps and unmet needs. In the past, the Assistant Secretary of OMH has requested and has been provided with key dashboard indicators on a monthly basis. These indicators include the number of staffed beds and occupancy rates at each of the state psychiatric hospitals; the top services provided to adults; the top sources of payment for adults; the top three diagnoses for adults and for youth; the number of services delivered in the previous month compared to the month before; the number of positions filled vs. the number of vacancies by discipline; and the number of service episodes provided by each category of licensed professional by region as a measure of productivity. In addition, the Medical Director receives a monthly count of services received and services provided for both adults and youth broken out by region/LGE for the most recent past month and the two prior months. Specific data requests can be made via Data Quest, the web-based ad hoc analysis/reporting system developed by OMH for decision support or by SPQM which is also a web based query engine that allows staff to construct data tables on the fly using variables uploaded from the OMH warehouse and that are targeted to information necessary for making data-based decisions for clinic operations based on accountable care principles.

The Office of Behavioral Health is developing a customized Sharepoint site is being designed to function as the new office Intranet. The Sharepoint site will have three major folders, with standard folder structure under each:

- Office of Behavioral Health (OBH)
- OBH - Mental Health
- OBH - Addictive Disorders

In this way, policies, standards, procedures, etc. which remain focused on only mental health or addictive disorders could be listed under their respective areas, and any items pertaining to OBH as a whole, under the OBH heading, with the goal that more of the separate items would integrate and migrate to the OBH folder. Currently, Addictive Disorders and Mental Health have a different organizational schema for these areas, and the new Intranet functions will begin the process of combining functions, policies, planning, etc.

Some of the categories of the Intranet being considered are:

- Executive Leadership
- Policy & Legislative Initiatives
- Continuous Quality Improvement
- Workforce Development
- Research & Grant Writing
- Data Management
- System of Care
- Operational Framework
- Planning, Partnerships & Linkages
- Special Initiatives
- Emergency Preparedness
- LGE & Direct Service Operations
- Program Monitoring & Compliance

Since the Office of Behavioral Health is shifting to a District model, the role of the office will be changing over the next few years to one of “monitoring the monitor” while still providing some direct services.

Criterion 3 - Child/ Youth (Criterion 3 not applicable to Adults)

Meeting the mental health care needs of children and youth in Louisiana continues to be a high priority, as they represent the future of our state. As a result, there are many programs developing across the state that target the needs of this population.

Louisiana Spirit was the project name of Louisiana's hurricane crisis counseling recovery program that began after the 2005 hurricanes and operated under the Gustav Crisis Counseling Program (CCP) grant from October 2008 through January 12, 2010. Louisiana Spirit outreach crisis counseling services for children and youth included disseminating information and educating the public on signs of distress and how to handle these. It also included a short term series of face to face meetings with children, youth and their families focused on assisting the family to cope with their trauma and return to their previous levels of coping. Crisis counselors provided education and information to parents and caregivers about signs of distress to be aware of in children as well as how to handle them, and how to make referrals to appropriate mental health resources. On a present-focused, short-term basis, children, youth, parents and caregivers were supported and empowered as they recovered from the impact of the hurricanes.

Louisiana Spirit sought to "communicate, coordinate, collaborate, and cooperate" with other agencies providing mental and behavioral health services to children and youth. Louisiana Spirit reached out to entities providing services to children and youth to offer crisis counseling services. When more intense mental health treatment was appropriate, referrals were made. The Office of Mental Health provided administrative oversight and guidance for this program, with direct services being administered at the regional level through Service Areas that are administered through the State instead of providers.

Beginning May 21, 2010, the State of Louisiana began providing crisis counseling services for residents impacted by the oil spill that occurred off the coast on April 20, 2010. The current program utilizes funds from British Petroleum to provide crisis counseling in the areas of mental health, substance abuse and emotional and behavioral health counseling for those whose lives were disrupted. The Recovery program has worked closely with local resources and other response entities. To date, the program has provided few services to children and youth impacted by the spill. It is anticipated that more services will be provided to children and youth as the oil spill continues to impact residents in the months to come.

Mental health services are also offered throughout the public school system, through School based health clinics (SBHC), which include programs such as the Early Childhood Supports and Services program (ECSS) and Louisiana Youth Enhancement Services (LaYES). School Based Health Clinics are funded by the Maternal and Child Health (MCH) Block Grant and state legislative appropriations. For the fiscal year 2009-10 Louisiana received a decrease in the MCH Block Grant from \$480,000 to \$300,000 but increased operation to 65 SBHCs. An SBHC is required to offer comprehensive preventive and primary health services that address the physical, emotional and educational needs of its student population. Each SBHC must execute cooperative agreements with community health care providers to link students to support and specialty services not provided at the school site. SBHC services provide convenient access to comprehensive, primary and preventive physical and mental health services for public school students at the school site, since students spend a significant

portion of their day on school grounds. SBHCs are accessible, convenient, encourage family and community involvement, reduce student absenteeism, reduce parental leave from work for doctor visits, and work with school personnel to meet the needs of students and their families.

DHH has also begun working with the Department of Social Services, the Department of Education and the Office of Juvenile Justice to create a Coordinated System of Care (CSoc) for at risk youth - an evidence-based approach that is part of a national movement to keep children at home, in school, and out of the child welfare and juvenile justice system.

Louisiana continues to have two specialized programs specifically designed for children and their families. These programs are known as Early Childhood Supports and Services (ECSS) and LaYES. ECSS is a multi-agency prevention and intervention program that promotes a positive environment for learning, growth, and relationship building for children. ECSS provides infant mental health screening and assessment, counseling, therapy, child abuse and domestic violence prevention, case management, behavior modification, parent support groups, and the use of emergency intervention funds. ECSS also serves to build the infrastructure of the Parishes it serves by training human services professionals, agency personnel, educational and childcare personnel as well as family members and advocates in the specialized area of Infant Mental Health assessment and intervention. ECSS serves children from birth through 5 years of age and their families who have been identified as at risk for developing social, emotional, and/or developmental problems. Risk factors include abuse, neglect, and exposure to violence, parental mental illness, parental substance abuse, poverty, and having developmental disabilities.

The Children's Initiative Grant (LA-YES Louisiana Youth Enhanced Services Consortium and System of Care) incorporates a comprehensive and coordinated system of care for children with serious emotional disorders. LA-YES provides a community-based service system that is child centered, family focused, and culturally and linguistically competent. The program incorporates a comprehensive and coordinated system of care for children, ages 3-21 with serious emotional behavioral disorders, and their families in Orleans, Jefferson, Plaquemines, St. Bernard, and St. Tammany parishes. LA-YES is governed by the LA-YES Consortium, with membership representing family members, community agencies, mental health professionals, teachers and other individuals working with children. Family involvement is an integral part of the LA-YES Consortium. This involvement refers to the identification, outreach efforts, and engagement of diverse families receiving system of care services so that their experiences and perspectives collectively drive the planning, implementation, and evaluation of the system of care. The Consortium meets monthly and provides many educational and informative resources, supports, and services to individuals working with youth with special mental health needs.

The LA-YES system of care confronts the access barriers to improve the needs of children: racial and ethnic disparities, fragmentation of services, an over-reliance on end-stage care, a lack of coverage, and agency-focused rather than child-centered care. LA-YES has joined with community partners to work with families and youth addressing children's mental health. Critical collaboration partners include mental health, juvenile justice, child welfare, education, health, local universities, and human services (social services) areas. Service integration may start in family courts or in schools, or from a wide variety of other community portals. Services are characterized by coordination, multi-disciplinary teams, comprehensive array of services, community-based, culturally and linguistically competent, evidence-based, and outcome oriented. This "wraparound" approach

itself is an evidence-based model based on national evaluations funded to evaluate all federally funded systems of care.

Due to Louisiana's monumental need for systems reform, the Office of Juvenile Justice (OJJ), formerly the Office of Youth Development (OYD) began implementation of a plan to address juvenile justice reform and adopt models of change, as well as evidence based interventions. Multi-systemic Therapy (MST) is one such evidence based therapy that is provided by LA-YES partners, and specifically recommended by OJS. This evidence-based practice, now adopted by the Louisiana Office of Behavioral Health and the state's Medicaid Office, was designed to work with youngsters to alter the trajectory away from incarceration toward adaptive functioning in society. MST is a choice intervention because youth with behavioral and emotional disorders and juvenile justice involvement account for a significant percentage of the LA-YES referral base. Other evidence based interventions delivered by the LA-YES Provider Network include cognitive behavior therapy, and trauma focused cognitive behavior therapy.

Interagency collaboration through the Interagency Service Coordination (ISC) Program is defined as "formal arrangements" between child serving agencies. Ten Local Governing Entities (Regions/Districts) Interagency Service Coordination teams are currently operating in Louisiana. These teams include permanent members who make recommendations that may resolve problems with service delivery for children who have unique needs that are difficult to meet. Team members include mental health, education, developmental disabilities, child welfare, public health, and juvenile justice. Other members of a team include the parent/caretaker, child/youth whenever appropriate, and other key person's involved in the child and family's life and services. The local teams may request assistance from the State Interagency Team for individuals who require resources unavailable to the local ISCs. Many of the families served reside in rural areas with few mental health and other resources, and the agencies coordinate to improve access to quality care in many ways including video conferencing, coordinated services, and educating families where and how to get care.

There is an increase in youth with multiple needs who are developmentally delayed, mentally ill, chemically addicted and who are living in poverty. More juvenile judges are ordering local ISC teams to meet and collaborate with other agencies to create appropriate placements where there are none. Approximately 95% of the ISC service plans successfully provide a stable placement and wraparound services to maintain the individual in the community. Those plans that failed required additional local ISC and State ISC meetings to locate and create appropriate resources to meet the needs of these youth.

The Families In Need of Services (FINS) became effective in all courts having juvenile jurisdiction on July 1, 1994, as Title VII of the Louisiana Children's Code. FINS is an approach designed to bring together coordinated community resources for the purpose of helping families (troubled youth and their parents) to remedy self destructive behaviors by juveniles and/or other family members. The goals of FINS are to reduce formal juvenile court involvement while generating appropriate community services to benefit the child and improve family relations. The child and family are not adjudicated unless there is failure by family members to cooperate with the mandates of the service plan. FINS has been successful in the following ways: 1) facilitating the receipt of needed services, 2) coordinating the cooperation of the community and its resources, and 3) decreasing involvement in the Judicial System.

Some progress toward a better understanding of agencies' resources, current policies and procedures, systemic concerns, and potential problems has occurred between the juvenile courts and DHH agencies. Through the Interagency Service Coordination (ISC) and Families in Need of Services (FINS), the DHH agencies, Office of Family Services, Office of Youth Development, Department of Education, and juvenile courts are beginning to plan more effectively for placement and development of community resources to keep children out of institutions.

Criterion 4: Targeted Services to Rural and Homeless and Older Adult Populations

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. Estimates by the US Census Bureau indicate that there are 1,135,163 persons living in rural areas out of the 4,492,076 citizens in Louisiana. This amounts to greater than 25% of the total population who live within these 56 rural parishes. Consumer surveys consistently rate transportation as a major impediment to the receipt of mental health services. Attempts to ameliorate this problem include the provision of transportation through contracts with transportation providers and the establishment of satellite clinics in underserved and rural areas. Satellites often operate with non-traditional hours in order to provide greater access to services.

The lack of transportation resources not only limits access to mental health services, but also limits access to employment and educational opportunities. The resulting increased social isolation of many OBH consumers with SMI 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 have seen increases in both.

In an attempt to alleviate access problems, OBH has available teleconferencing systems at 66 sites, including Mental Health clinics, ECSS sites, Mental Health Hospitals, LA Spirit, and OBH Central Office. Some sites have multiple cameras. Some of these cameras are dedicated to Telemedicine (doctor/client session) while the others are used for Teleconferencing (meetings, education, etc). The other sites use their cameras for both Telemedicine and Teleconferencing.

There is a need for rental subsidies, and for community-based support services to assist people with mental illness in attaining and retaining their housing. At a minimum, an increase in available outreach programs 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. Funding through 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.

The Department of Social Services (DSS) annual Needs Assessment/ Shelter Survey is an unduplicated statewide count of the numbers of homeless individuals served by the homeless shelters in the state for the year. The State DSS is responsible for the state's Emergency Shelter Grant funds. As part of the Department's grantee responsibilities, DSS compiles an annual report on the unduplicated numbers served in shelters across the state. The survey is a twelve month unduplicated count of persons using the state's shelter system. It also includes a point-in-time count that examines the subpopulations represented in the shelter count and the reasons for homelessness. For this report, the 2008 Shelter Survey data was used. There are 153 shelters in the DSS database. In 2008, the number of shelters that reported was 119 or 78% of the total. The data revealed that the yearly total

of homeless persons served was 32,112. 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%)

Rural services, transportation, and services for the homeless populations will continue to be priorities for the State. Local transportation issues have become more pronounced as a result of budget cuts, with decreases in the availability of public transportation and rising costs. 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.

Services to older persons with SMI are a statewide area of need. The Department of Health and Hospitals recognized this need in recent years, and developed the Office of Aging and Adult Services (OAAS). Although this new Office is not limited to serving the mentally ill population, collaboration is common among all Divisions within DHH. As the population ages, the number of persons with Dementia of the Alzheimer's Type and other dementias are predicted to increase. The Office of Behavioral Health has no specific treatment programs for these conditions, although the office was a participant in a recent interagency Alzheimer's disease task force mandated by the legislature to study and make recommendations for the future. 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.

Criterion 5: Management Systems

The development of a system of Local Governing Entities (LGEs) has been legislatively mandated state-wide. LGEs have expanded to cover five of the state's ten regions, and other regions are continuing to evaluate their readiness to become LGEs. This transformation will necessarily lead to changes in the historic role of OBH. The challenges of such a system-wide change are many, including allocation of funding in an equitable and cost-effective way for consumers of mental health services, and the provision of a consistent quality standard for services.

At the request of the Planning Council, and with the leadership of the Assistant Secretary, a study of the allocation of Block Grant funds was made in the spring of 2009. An *ad hoc* committee of the Planning Council was formed to study and make recommendations concerning the allocation of Block Grant funds. It had been recognized that within the state, Block Grant funding patterns to the Regions/ LGEs had little or no relevance to the services or needs of each Region/ LGE. Rather, the distribution of funding had its basis in a history that may have had a rationale at the time, but no longer made sense. The committee held two meetings and studied various options. The option that was ultimately recommended consists of dividing the amount of funding given to the Regions/ LGEs

into ten equal amounts (i.e., 1/10th of the funding would go to each Region/ LGE). The Assistant Secretary approved the proposal, and these changes are being phased in over a three year period, beginning with the 2011 Block Grant.

The Office of Behavioral Health Workforce Development Bureau has provided the OBH staff with a variety of best practice/ continuing education opportunities. The goal of these activities is to ultimately enhance the quality of services provided to clients. The Workforce Development Bureau has continued to serve in the role of strengthening community-based services by enhancing capacity, and utilization of best practices. The Bureau has accomplished several trainings each year. The Bureau also works to provide OBH staff with continued education. There is a mechanism in place for Psychologists, Social Workers, and Licensed Professional Counselors to earn Continuing Education Units for appropriate workshops and learning experiences in order to maintain licensure by their respective licensing boards.

Inequitable opportunities for continuing education and learning have lead to the initiation of a learning management system, *Essential Learning*. The system provides online training, provision of continuing education credits and a learning management system to track training. *Essential Learning*, while originally funded through the Co-Occurring State Incentive Grant (COSIG), has been maintained for ongoing use. It has been utilized by staff members wishing to obtain the Certified Co-Occurring Disorder Professional credential offered by Louisiana Association of Substance Abuse Counselors and Trainers (LASACT). Another major project utilizing *Essential Learning* was the online registration and evaluation for the Level of Care Utilization System (LOCUS) training provided in 2009. Skills development, credentialing, and competency reviews are seen as important for the continuing development and expansion of an effective, efficient workforce. Emphasis is on the implementation of evidence based practices within OBH.

A continuing critical gap is in the level of crisis response services for adults, children, youth and their families. It has long been recognized that this basic service component needs to be further augmented to meet the demand. The unprecedented recent crises that have occurred in Louisiana have drawn further attention to this need, and measures have been taken to improve the available services and emergency response. Each community region has maintained the basic elements of a twenty-four hour crisis response system in the form of hotlines, crisis evaluation, and regional acute inpatient units. However, resources are not at a sufficient level to meet the need, and mobile crisis response services are very limited or unavailable. The capacity to respond to bio-terrorism and/or disasters of any type is inadequate, but has improved substantially with the initiation of several training programs that have been offered to OBH employees. In addition, the State has administered the Louisiana Spirit Crisis Counseling Program (CCP) under the Hurricane Katrina/ Rita and Hurricane Gustav, CCP grants. OBH is now providing services to the communities along the Gulf that are impacted by the oil spill resulting from the explosion of the British Petroleum Deepwater Horizon oil rig.

National Incident Management System (NIMS) training has been made a requirement of employment by OBH. OBH maintains a registry of appropriately credentialed behavioral health professionals who are able to provide assistance in disaster mental health, stress management, and multiphase response to disaster incidents. This registry includes both OBH employees and health professionals from the private sector.

The OBH service delivery system includes a comprehensive array of services organized to meet the needs of adults with serious mental illness, and children/youth with emotional/behavioral disorder and their families in each region of the state. However, each of the components of the comprehensive service system exists at a level that is far below that required to satisfactorily meet the demand in each region. This is due mainly to fiscal and workforce constraints, and is not due to a lack of awareness about needs, nor due to lacking the will to establish a maximally responsive and comprehensive system of care.

Fiscal and workforce constraints have created a situation where there is demand for services beyond what the system is able to supply. For example, insufficient numbers of direct service providers to address basic treatment and support needs of the community service population continues to be problematic. 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. 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. A lack of healthcare providers continues to be a pressing concern statewide, and is particularly critical in some areas.

Additional steps are being taken to increase access to qualified prescribers in the community mental health system. OBH has developed a policy that now will permit local CMHCs to contract with or employ Medical Psychologists (MPs) and Nurse Practitioners (NPs) who can prescribe psychotropic medications. This policy is designed to ease the burden on the limited number of psychiatrists who are available in the state, particularly in the more rural areas that have found it difficult if not impossible to recruit and retain these medical specialists. There are several regions in the state that have begun to successfully utilize non-physician prescribers.

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 mental health programs. Efforts to ease the fiscal needs of the system require a continuously adapting and flexible workforce. Although certainly not yet widespread, and in itself an area of need, the implementation of evidence-based practice provides a framework for the future and a direction for the training of healthcare providers.

Early intervention and prevention programs are essential in meeting the mental health and substance abuse needs of the children/youth and their families. Generally speaking, youth in the custody of the child welfare and juvenile justice system receive mental health and substance abuse treatment in restrictive settings. The private sector provides mainly outpatient services and is not generally a rich resource for the population that OBH serves. Although there have been significant strides made in the implementation of a continuum of care for children and youth that is based on best-practices and evidence-based programs, there is no argument that the population of child/youth with EBD is substantially underserved; and the OBH capacity to serve this population is grossly under-funded and inadequate to meet the continually growing mental health and substance abuse needs.

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.

SECTION II – IDENTIFICATION & ANALYSIS OF SERVICE SYSTEM’S STRENGTHS, NEEDS, & PRIORITIES

RECENT SIGNIFICANT ACHIEVEMENTS LOUISIANA FY 2011 - ADULT & CHILD/ YOUTH PLAN

The Office of Behavioral Health (formerly the Office of Mental Health) continues to be presented with new challenges and opportunities. The efforts listed below support the continuing goal of reforming the mental health system as well as meeting the recently implemented legislative mandate to combine the former Office for Addictive Disorders (OAD) and Office of Mental Health (OMH) into the Office of Behavioral Health (OBH). It should be noted that these OBH mental health objectives support achievement of both historically significant movements within the state and country: Louisiana’s Plan for Access to Mental Health Care and the President’s New Freedom Commission Goals. While there are also many mental health system reform activities and initiatives underway statewide, the challenge to the state is to bring these efforts together into a comprehensive mental health plan for Louisiana that provides quality services that are effective and efficient within the resources available to the state. There are many examples of achievements that are discussed in detail in other sections of the Block Grant Plan, but a few are highlighted here.

OMH Redesign

Since 2004, OMH has been working on increasing access to mental health services and increasing quality of care by providing consultation and technical assistance to the mental health clinics by which they would be able to apply for Joint Commission accreditation. This initiative evolved into the Cornerstone Project which included 4 components that are key to high quality service delivery: Operating with a recovery / resiliency philosophy; applying utilization management (UM) principles; establishing a workforce development plan with credentialing and privileging; and using a performance improvement approach to quality development. For the last several years, OMH has successfully instilled a recovery / resiliency philosophy into its treatment model. It became a part of the Mission and Vision of OMH. Prior to becoming OBH, OMH had re-organized its organizational chart to include a Bureau of Workforce Development under the Division of Policy, Standards, and Quality Assurance. The Bureau Chief has organized a workgroup that has developed competency standards for staff within the agency and this will be used to construct mandatory ‘curricula’ within the OBH Learning Management System, operated by Essential Learning, to which all staff have access. Courses will be auto-assigned and tracked for completion. Performance improvement activities have been initiated and include application of best practices for variance analysis including use of root cause analyses for evaluation of critical incidents. Finally, UM has been implemented in the clinics based on an initial readiness assessment conducted by central office staff and a consultant from the National Council for Community Behavioral Healthcare. Based on those assessments, each region of the state developed a strategic plan for using existing resources in a more efficient manner based on data to increase access by more effectively using clinicians to provide direct services. The data that is being used for this project is being provided through the use of a web-based query portal, SPQM (Service Process Quality Management), that was purchased by OMH and includes the services of a national expert on UM and Accountable Care principles. Through the use of this technology and accompanying TA, OBH staff can construct cross-tabbed data tables that examine variables which affect clinic and clinician performance. Using this information, clinic managers can make changes in duty assignments and clinic operations to maximize using clinician time for direct care services and decrease lost time caused by client cancellations and failures to arrive for appointments. At the present time, all regions/LGEs have established some form of medication management service in clinics and most have developed and instituted a designated access process.

Regions/LGEs are now constructing their array of specialty recovery services to support individuals who are being discharged from the intermediate care hospitals and to provide enhanced services in the community that will avoid unnecessary hospitalizations. This effort to redesign and realign community services is being implemented in concert with a parallel initiative to provide opportunities to increase the numbers of individuals who can be discharged from intermediate care facilities and reduce the number of beds in these hospitals. This is part of the current OBH initiative to shift the focus of treatment from expensive inpatient treatment to more cost-effective outpatient treatment.

Implementation of the Office of Behavioral Health

The 2009 legislative session created the statutory authority to combine the Office of Mental Health (OMH) and Office for Addictive Disorders (OAD) into the Office of Behavioral Health (OBH). The process for implementation has been ongoing since that time and involved the development of a state-wide advisory committee, the OBH Implementation Advisory Committee, composed of stakeholders at all levels. This advisory committee formed 5 workgroups to address the necessary issues to be considered when combining two state agencies. These workgroups formulated recommendations to the overall advisory committee which in turn issued a final report with summarized recommendations to the DHH Secretary at the beginning of this year. The Secretary made a report to the legislature prior to the start of the 2010 legislative session. The report was accepted and the legislature approved the implementation of OBH as of July 1, 2010. As part of this process, a new Assistant Secretary for OBH has been appointed and the Central Office administration is currently undergoing reorganization to address the mission of the new agency. The process of implementation has been made easier as a result of the state's experience being in the first recipient cohort of the SAMHSA funded Co-occurring State Infrastructure Grant (COSIG) program. The state completed its participation in 2008 and since that time has used what was developed during the grant period to maintain a focus on integration of mental health and substance abuse services and building capacity within clinics and by the workforce to address the needs of those individuals who have co-occurring disorders and present to our clinics for treatment. OBH staff experts who directed the grant project and formed the state-level evaluation team continue to share their expertise with other states that are current COSIG grantees during monthly multi-state conference calls and through TA to those states on the use of a fidelity tool that measures a program's capability to provide co-occurring treatment. Recently, two OBH staff members were invited to attend the 6th Annual COSIG Grantee Meeting in Bethesda, MD to present their data on the results achieved by Louisiana in enhancing capability for treating co-occurring disorders.

Louisiana Spirit Coastal Recovery Counseling Program

After the Deep Water Horizon/British Petroleum Oil Spill off the Louisiana coastline on April 20, 2010, the State of Louisiana anticipated that the slowly unfolding disaster would have mental, emotional and behavioral health tolls on the lives of residents' who had been impacted. The State decided initially to utilize 1.1 million of the 25 million dollars given to each coastal state through the Oil Spill Liability Trust Fund to provide crisis counseling services to those impacted. The decision was made to utilize a program design similar to what had been funded by the Robert T. Stafford Disaster Relief and Emergency Assistance Act. The Louisiana Spirit Coastal Recovery Counseling Program design was modeled after the successful Louisiana Spirit Hurricane Recovery Program which is further described in Criterion One of this document. Underscoring the seriousness of this disaster, DHH Secretary Alan Levine wrote to DHHS Secretary Kathleen Sebelius:

“Studies conducted after the Exxon Valdez spill definitively showed the long-lasting psychological impact of this kind of technological disaster, particularly on those who rely on

the ecosystem for their livelihoods as do so many coastal Louisiana families. In its paper, "Coping With Technological Disasters: A User Friendly Guidebook," the Prince William Sound Regional Citizens Advisory Council writes, "Results of Exxon Valdez oil spill studies indicate that mental health impacts still persist 10 years post-spill. These impacts include disruption of family structure and unity, family violence, depression, alcoholism, drug abuse and psychological impairment." This was reaffirmed at the recent meeting of the Institute of Medicine in New Orleans, at which mental health concerns emerged as the priority health issue of this disaster. Our Louisiana Spirit crisis counseling teams have already engaged and counseled more than 2,000 individuals and are reporting increases in anxiety, depression, stress, grief, excessive and earlier drinking and suicide ideation. Community-based organizations report similar findings. We know that, left untreated, these symptoms can quickly develop into behavioral health problems that lead to the breakdown of the familial structures, domestic violence, abuse and neglect. We also know that Louisianians are suffering uniquely from the compounding effects of the disasters they have faced. Those disasters have taught us much about how insidious the effect of parental stress, anger, anxiety, substance abuse and mental illness are on children. Following Hurricane Katrina, an Urban Institute Paper found that "if parents remain in limbo themselves, and particularly if sadness, stress, or depression continues to color their interactions with their children, the risks of derailing children's development deepen." (*Friday, July 9, 2010*)

Information Technology and Decision Support

The Division of Planning, Information Management and Performance Accountability is dedicated to the ongoing development and use of information technology in support of quality improvement, performance accountability, and data-based decision-making statewide, and for each OMH Region, LGE, and state hospital. With progressive implementation of the Office of Mental Health Integrated Information System (OMH-IIS), legacy systems are being phased out in favor of one, comprehensive, integrated web-based information system. Additional OMH-IIS modules have been implemented, including Assessment; Admission/Discharge/Transfer, and a Service Ticket/ Progress note module this past fiscal year. Plans and training are also underway for the acquisition and implementation of a statewide Electronic Behavioral Health Record system. The Division has continued to enhance the OMH data Warehouse and decision support system (Decision Support On-line) for statewide client-level administrative data, and the consumer quality-of-care survey program (using standard MHSIP-based questionnaires). OMH continues to implement systems to support the Cornerstone Utilization Management Program, including the Level of Care Utilization System (LOCUS/CALOCUS), electronic Centralized Appointment Scheduling, and the Telesage Outcome Measurement System (TOMS), which provides client-level treatment outcome data. OMH employs the web-based Service Process Quality Management (SPQM) System and monthly consultation with David Lloyd, national expert on accountable care, to develop staff competencies in data-base decision making, with a focus on provider productivity measurement and improvement.

Judicially involved children and youth who require mental health services are addressed

The Office of Behavioral Health recognizes that there is a large number of youth with EBD/SED directly involved in the juvenile judicial system. In fact, many of those youth are either being serviced by two or more state agencies or are in joint custody of two state agencies. In a few cases, youth are transferred to the adult judicial system secondary to the nature and severity of their offenses; however, procedures are in place in order to provide for sanity and competency hearings for those identified juveniles. Those juveniles are directly assisted with age-appropriate methods in the determination and restoration of their capacity to proceed to trial. The Department of Health and

Hospitals has developed and continues to revise rules and regulations for certifying juvenile competency restoration providers, and has developed and recently revised a training module patterned after national best practices. Sixty-eight licensed mental health professionals were trained and certified as competency providers in 2009-2010. An additional sixteen unlicensed mental health professionals were trained to work with youth who are incompetent due to lack of education rather than behavioral health issues. The state continues to closely study issues relating to juvenile competency and to review programs in other states. The Office of Behavioral Health received a \$40,000 grant in June 2010 to implement a pilot program in Orleans, St. Bernard, Plaquemines, Jefferson and Caddo parishes for youth found incompetent to stand trial who 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 wrap-around services, including but not limited to individual, group and family therapy. In addition, the state's Law Institute Subcommittee on the Children's Code continues to meet in order to study the same issues while developing additional legislation regarding training as well as the protection of children's rights.

Additionally, the Office of Behavioral Health in collaboration with the Metropolitan Human Services District and the Orleans Parish Juvenile Court are in the process of developing a Court Clinic which will screen, evaluate and provide treatment or refer for additional services youth who are charged with crimes and housed at the Youth Study Center, the local detention center in New Orleans. This will ensure that judicially involved youth in need of mental health or substance abuse services will be identified quickly and referred for appropriate services.

Louisiana Youth Suicide Prevention

The Louisiana Partnership for Youth Suicide Prevention (LPYSP) is a program that is geared towards reducing child and adolescent suicide; however, adults have benefitted from the program also. 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 Specialist 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 educators, law enforcement, mental health professionals, clergy, medical professionals, administrators, volunteers, and anyone else who might be interested in adding suicide intervention to their list of skills. The program has been made available to all government agencies, consumer/advocacy agencies, emergency service providers, schools and families to help reduce the incidence of suicide in Louisiana. A 20-member training group has conducted ASIST, Safe Talk, and Suicide Talk Trainings statewide. This series of evidenced-based trainings has reached over 2,500 people. Through the successful development of five suicide prevention coalitions in Shreveport, Lake Charles, Lafayette, Jefferson and Baton Rouge, 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.

Office of Client Affairs

This office continues to actively work towards the development and statewide implementation of Peer Support Specialists, Wellness Recovery Action Planning (WRAP) and other initiatives that seek to encourage consumer/family choice and empowerment throughout the system of care as Louisiana moves towards a recovery modality. As of 2010, the Office of Behavioral Health has implemented Peer Support Services throughout the majority of Louisiana, using the curriculum developed by Recovery Innovations. Currently, there are 101 trained and certified Peer Support Specialists, 52 of whom are now employed in a variety of capacities throughout the system of care. Examples of job duties include conducting Peer Support and WRAP groups, working with clients on an individual basis to develop goals and serving as a bridge for clients when first entering the clinic. In addition to the Peer Support program, the Office of Behavioral Health has also actively been integrating WRAP within the system of care. Currently, there are 69 trained WRAP Facilitators many of whom are conducting groups across the state. Since the inception of the WRAP it is approximated that over 1000 individuals have been introduced to the concepts of WRAP in some capacity. For 2010-2011, it is the goal of the Office of Behavioral Health to continue to fully support and certify peers and to ultimately train peers as trainers for both WRAP and Peer Support so that the programs can achieve long-term sustainability.

Transition to Local Governing Entities (LGEs)

Legislation was passed during the 2006 legislative session calling for DHH to develop a plan to facilitate the remaining geographic regions to transition to local governing health care districts or authorities. Act 373 of the 2008 regular legislative session provided for a specific process for the remaining regions of the state to become LGEs (Local Governing Entities). Based on this law, staff of the then OMH Division of Policy, Standards, and Quality Assurance developed a complete Readiness Assessment Toolkit. This toolkit contained flowcharts, copies of the applicable law and regulatory agreements, documents that guide the development of a governing board, policies/procedures, and a Readiness Assessment fidelity tool and user manual. The Director of the Division along with the Bureau Chief for Workforce Development within the Division formed the leads for a Readiness Assessment team consisting of representatives of OAD, OMH, OCDD, DHH legal division, and DHH fiscal and policy departments. Using the toolkit, the Readiness Assessment team completed a Phase I, II, and III assessment of a region and as of July 1, 2010, the former Region 3 consisting of the Houma/Terrebonne area of the state begins Phase IV of the LGE transition process as South Central Louisiana Human Services Authority (SCLHSA). That makes five LGEs, with five Regions remaining that are in various stages of preparation to become LGEs. Local governing entities (LGEs) have the responsibility for providing services to persons with mental illness, substance use and abuse disorders, developmental disabilities, and some functions of public health. The newly created Office of Behavioral Health will modify the organizational structure at the administrative level and align leadership to achieve strategic directions and support transition to Human Service Districts.

Provision of Appropriate Medications

OBH now has a policy that allows non-physician professionals who have prescriptive authority to prescribe within OBH facilities. The inclusion of Medical Psychologists and Advance Practice Nurse Practitioners allows patients and consumers greater access to the care they need. Several mental health clinics have taken advantage of this added resource to the benefit of their clientele. The pharmacy continues to offer an unrestricted formulary of medications for mental illness, which includes all of the newer antipsychotics, antidepressants, and mood stabilizers. The ability to offer

this variety is due to the emphasis on the use of Patient Assistance Programs (PAP) that have decreased costs for the OBH pharmacies while making maximum usage of free and reduced-cost medications. In recent years, the cost of 70% of outpatient medications has been underwritten by PAP. Staff members have also assisted all clients who are eligible with obtaining Medicare Part D or Medicaid benefits. OBH has recently restructured its psychotropic medication formulary in another attempt to reduce costs. The Pharmacy and Therapeutics Committee along with a special committee composed of Regional Medical Directors developed a step-wise algorithm for the use of medications from various classes which is included in this document.

Multi-Systemic Therapy

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 abuse hospitalization 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 Region IV, Region V, and JPHSA. With continued efforts to improve the Mental Health Rehabilitation (MHR) optional Medicaid program, a number of new Multisystemic Therapy (MST) providers were certified by Medicaid during the year. Medicaid added 11 new MST providers during the fiscal year, resulting in 22 MST providers enrolled, including 32 MST teams. During the fiscal year, 1364 youth were served in MST throughout the state.

Early Childhood Supports and Services

The Early Childhood Supports and Services (ECSS) program is a multi-agency prevention and intervention program that promotes a positive environment for learning, growth, and relationship building for children. ECSS provides infant mental health screening and assessment, counseling, therapy, child abuse and domestic violence prevention, case management, behavior modification, parent support groups, and the use of emergency intervention funds. ECSS also serves to build the infrastructure of the Parishes it serves by training human services professionals, agency personnel, educational and childcare personnel as well as family members and advocates in the specialized area of Infant Mental Health assessment and intervention. ECSS serves children from birth through 5 years of age and their families who have been identified as at risk for developing social, emotional, and/or developmental problems. Risk factors include abuse, neglect, and exposure to violence, parental mental illness, parental substance abuse, poverty, and having developmental disabilities. The program has two main components to serve families: Infant Mental Health (IMH) and Temporary Assistance to Needy Families (TANF). Both services are provided in accordance with family needs. IMH assists with the development of the child and the attachment between parent and child. TANF services assist families during emergency times of crisis. All clinicians are advanced trained IMH Specialists. Clinicians within ECSS provide an excellent repertoire of behavioral management, and therapeutic intervention for both parents and children.

Louisiana Youth Enhanced Services for Mental Health (LaYES)

LA-YES is a system of care established for children and youth with serious emotional and behavioral disorders funded through a cooperative agreement between the Substance Abuse and Mental Health Services Administration (SAMHSA), the Louisiana Department of Health and Hospitals, and the Office of Behavioral Health. LA-YES builds upon prior federal initiatives partnering with state and local public mental health programs for improving mental health services for children and youth.

Nearing the end of the sixth year extension of the grant, LA-YES has achieved several major milestones.

LA-YES project accomplishments include:

- LA-YES received approval from the IRS for non-profit 501 (c) 3 status.
- LA-YES Board of Directors was elected.
- The Administrative Services Organization infrastructure has experienced a steady development while operating in a post-Katrina environment.
- The project began service delivery in Orleans Parish in December 2004; approximately 578 youth have received services from January 2006 when the program returned to the New Orleans area following program interruption due to Hurricane Katrina until the end of June, 2010.
- At the end of the sixth year extension of the grant, the project delivered services to roughly 1619 children and families in a five-parish area in and around New Orleans, LA, and has substantially implemented expansion of services to the remaining two parishes (St. Tammany and St. Bernard) in its target area.
- LA-YES has continued to operate a School-Based initiative that targets students in charter schools in the greater New Orleans area.

Permanent Supportive Housing Program

The housing plan for people with disabilities, called the Permanent Supportive Housing Program (PSH), is in effect and gaining momentum. This program developed by the Louisiana Recovery Authority following the hurricanes will provide access to affordable housing in the Gulf Coast areas where housing was destroyed. While not a direct initiative of OMH, input from the office and consumer groups was received and acted upon. The program is designed for 3,000 units of permanent supportive housing to be developed for households with special needs such as: the frail elderly; those transitioning out of foster care; and those with disabilities, including mental illness, as well as households with disabled children in the Gulf Opportunity Zone (GO Zone). Due to the post-disaster increased cost of housing, the state requested and received 3,000 rental subsidies for the program last summer. These subsidies are in the process of being implemented and the pace of placement is picking up. As anticipated, a large number of participants have a mental illness.

STATE'S VISION FOR THE FUTURE
LOUISIANA FY 2011 - ADULT & CHILD/ YOUTH PLAN

The Office of Behavioral Health Implementation Plan Recommendations were presented in January of 2010 by the OBH Implementation Advisory Committee, pursuant to ACT 384 of the 2009 Legislature.

The committee used two key concepts to frame their work:

- 1) People can recover from both mental illness and addictive disorders when given the proper care and a supportive environment
- 2) The consequences of mental illness and addictive disorders affect all citizens of Louisiana

While not officially adopted by the administration of OBH, the OBH Implementation Advisory Committee recommended the following Mission, Vision, and Guiding Principles after review and consideration of the core mission and vision of each of the two previously separate offices. It is anticipated that the new administration will work with these statements to develop the core identity of the organization.

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

- 1) We can and will make a difference in the lives of children and adults in the state of Louisiana.
- 2) People recover from both mental illness and addiction when given the proper care and a supportive environment.
- 3) The services of the system will respond to the needs of individuals, families and communities, including culturally and linguistically diverse services
- 4) Individuals, families and communities will be welcomed into the system of services and supports with a “no wrong door” approach.
- 5) We respect the dignity of individuals, families, communities and the workforce that serves them.
- 6) 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
- 7) We will utilize the unique skills of professionals with appropriate competencies, credentials and certifications
- 8) 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
- 9) 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
- 10) 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
- 11) We will measure our results to demonstrate both improved outcomes for the people we serve and fiscal responsibility to our funders
- 12) 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

LOUISIANA FY 2011 BLOCK GRANT PLAN

Part C STATE PLAN Section III

PERFORMANCE GOALS AND ACTION PLANS TO IMPROVE THE SERVICE SYSTEM

ADULT PLAN

CRITERION 1
COMPREHENSIVE COMMUNITY-BASED MENTAL HEALTH SERVICES
SYSTEM OF CARE & AVAILABLE SERVICES
LOUISIANA FY 2011 - ADULT PLAN

EMERGENCY RESPONSE

The State of Louisiana continues to recover from hurricanes that have changed the way that mental healthcare is delivered in the state. The state was obviously challenged by Hurricanes Katrina and Rita in 2005. Then after a short reprieve, the Louisiana gulf coast was hit again in September of 2008 by Hurricane Gustav. Gustav hit the region to the west of New Orleans, squarely targeting the metropolitan Baton Rouge area; including the Office of Mental Health administrative headquarters and the heart of the government for the entire state. Following on the heels of Gustav, Hurricane Ike impacted the southwest area of the state previously affected by Hurricane Rita. Most recently, the explosion of the Deep Water Horizon/British Petroleum oil rig resulting in the catastrophic oil spill off the coast of Louisiana has once again tested the resolve of Louisiana citizens.

Emergency preparedness, response and recovery have become a part of every healthcare provider's job description, and employees have learned that every disaster is different, often requiring new learning and flexibility. As an example, employees of OBH are now on standby alert status should a storm threaten the coast, and all employees are expected to be active during a crisis. All Louisiana families are encouraged to "*Get a Game Plan*" (<http://getagameplan.org/>) in order to be prepared for a crisis, should one strike. Clinicians in mental health clinics have made a point of discussing disaster readiness with clients to ensure that they have needed medications and other necessities in the case of an evacuation or closed clinics.

Although 'Emergency Response' in the state had become somewhat synonymous with hurricane response, the lessons learned from the hurricanes apply to disaster response of any kind.

Louisiana Spirit Hurricane Recovery Crisis Counseling Program

Louisiana Spirit was a series of FEMA/SAMHSA service grants funded through the Federal Emergency Management Agency and administered through the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. The Louisiana Office of Mental Health was awarded a federal grant for the Crisis Counseling Assistance and Training Program (CCP) in Louisiana, which focused on addressing post hurricane disaster mental health needs and other long term disaster recovery initiatives, in coordination with other state and local resources. Crisis Counseling Programs are an integral feature of every disaster recovery effort and Louisiana has used the CCP model following major disasters in the state since Hurricane Andrew in 1992. The CCP is implemented as a supplemental assistance program available to the United States and its Territories, by the Federal Emergency Management Agency (FEMA). Section 416 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 1974 authorizes FEMA to fund mental health assistance and training activities in areas which have been Presidentially declared a disaster.

These supplemental funds are available to State Mental Health Authorities through two grant mechanisms: (1) the Immediate Services Program (ISP) which provides funds for up to 60 days of services immediate following a disaster declaration; and (2) The Regular Services Program (RSP) that provides funds for up to nine months following a disaster declaration. Only a State or federally-recognized Indian tribe may apply for a crisis counseling grant.

In the fall of 2008, upon receiving the Presidential disaster declaration for Hurricane Gustav, OMH conducted a needs assessment to determine the level of distress being experienced by disaster survivors and determined that existing State and local resources could not meet these needs. Fifty-three parishes were declared disaster areas for Gustav; they were awarded in four separate declarations as the State appealed the decisions. Louisiana immediately applied for a Crisis Counseling grant for Gustav while in the process of phasing down the Katrina and Rita grants. The grant was awarded in late September of 2008. Disaster mental health interventions include outreach and education for disaster survivors, their families, local government, rescuers, disaster service workers, business owners, religious groups and other special populations. CCPs are primarily geared toward assisting individuals in coping with the extraordinary distress caused by the disaster and connecting them to existing community resources.

The CCP did not provide long term, formal mental health services such as medications, office-based therapy, diagnostic and assessment services, psychiatric treatment, substance abuse treatment or case management; survivors were referred to other entities for these services. CCPs provided short-term interventions with individuals and groups experiencing psychological reactions to a major disaster and its aftermath. In this model, community outreach is the primary method of delivering crisis counseling services and it consists primarily of face-to-face contact with survivors in their natural environments in order to provide disaster-related crisis counseling services. Crisis counseling services include: Information/Education Dissemination, Psychological First Aid, Crisis/Trauma Counseling, Grief & Loss Counseling, Supportive Counseling, Resiliency Support, Psychosocial Education, and Community Level Education & Training.

The Louisiana Spirit Hurricane Recovery program operated under the Gustav grants (DR-1786-LA ISP and DR-1786-LA RSP), from October 2008 through mid January 2010; the program employed a diverse workforce of up to 276 staff members. Management and oversight of the program was provided by a state-level executive team dedicated to the support of all operations of the project.

Louisiana Spirit was designed to facilitate integration with other recovery initiatives, rather than compete with them. The Louisiana Spirit state-level organizational structure was designed to continuously be in contact with recovery initiatives throughout Louisiana and coordinate its activities with these other recovery operations. After Hurricane Gustav, there were fewer resources available to assist with hurricane related needs than were available after Hurricane Katrina in 2005. Each service area continuously strived to keep up with changing community resources to share with survivors and other community entities.

The goal of Louisiana Spirit is to deliver services to survivors who are diverse in age, ethnicity, and needs. Extensive ongoing evaluation of the program included assessment of the services provided, the quality of the services provided, the extent of community engagement, and monitoring of the health and recovery of the entire population. The evaluation plan for Louisiana Spirit is multifaceted to reflect the ecological nature of the program seeking to promote recovery among individuals, communities, and the entire population of Louisiana. The assessment component of Louisiana Spirit strived to answer the question of the absolute number of people served and how the services were distributed across geographic areas, demographic groups, risk categories and time. To this end, each of the state-level administrative staff members was responsible for ensuring fidelity to the CCP model and expectations as directed by SAMHSA/ FEMA.

SAMHSA/FEMA also required CCPs to collect information to provide a narrative history—a record of program activities, accomplishments and expenditures. Louisiana Spirit collected data on a weekly basis from all providers which was analyzed by the Quality Assurance Analyst and also sent to SAMHSA for further analysis and comparison with data from all the other Immediate Services Program and Regular services Program Crisis Counseling Programs in the nation. The different service areas also compiled a narrative report to Louisiana Spirit headquarters on a bi-weekly basis. From Gustav's inception in September 2008 through January 12, 2010 a total of 514,535 face-to-face services were provided. 97,681 of these were individual contacts lasting over 15 minutes, 335,650 of these were brief contacts lasting less than 15 minutes and 81,204 contacts were classified as participants in groups.

To help to monitor geographic dispersion/reach/engagement, the number of individual and group counseling encounters for a given week/month/quarter were tallied by zip code and displayed graphically as a check of whether communities were being reached in accord with the program plan and community composition. To monitor demographic dispersion/reach/engagement, the individual encounter data was broken down by race, ethnicity and preferred language as one indicator of how well the program was reaching and engaging targeted populations.

Federal funding for the Louisiana Spirit Gustav program ended June 30, 2010; all direct services ceased January 12, 2010. The time from mid-January through June was spent fiscally and programmatically closing out the program.

Louisiana Spirit Oil Spill Recovery Program

After the Deep Water Horizon/British Petroleum Oil Spill off the Louisiana coastline on April 20, 2010, the State of Louisiana anticipated that the slowly unfolding disaster would have mental, emotional and behavioral health tolls on the lives of residents who had been impacted. The State decided to utilize 1.1 million of the 25 million dollars given to each coastal state through the Oil Spill Liability Trust Fund to provide crisis counseling services to those impacted. The decision was made to utilize a program design similar to what had been funded by the Robert T. Stafford Disaster Relief and Emergency Assistance Act. The Louisiana Spirit Coastal Recovery Counseling Program design was modeled after the successful Louisiana Spirit Hurricane Recovery Program which is described above.

The Louisiana Spirit Coastal Recovery Counseling Program utilized dyad teams to reach out to residents and workers who were dealing with the aftermath of the oil spill. Community outreach is the primary method of delivering crisis counseling services and it consists primarily of face-to-face contact with survivors in their natural environments in order to provide disaster-related crisis counseling services. Crisis counseling services include: Information/Education Dissemination, Psychological First Aid, Crisis/Trauma Counseling, Grief & Loss Counseling, Supportive Counseling, Resiliency Support, Psychosocial Education, and Community Level Education & Training. In addition to the crisis counseling and information and referral sources, the program also utilized the media to provide messaging regarding services available after 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 and Terrebonne. The sites where workers who were impacted were seen included: oil spill claims centers, oil spill recovery sites where workers congregated, animal recovery sites, emergency operations centers, resource distribution sites, businesses which

had lost revenue because of the spill, and various community events where residents were likely to be present.

As with previous Louisiana Spirit programs, this project is designed to work with existing programs and resources. These resources include: the Department of Social Services, the Governor's Office of Homeland Security Emergency Preparedness, the local governmental entities such as parish presidents and police juries as well as the local non-governmental entities such as non-profit and faith based organizations.

To date, the program has 45 field employees. This includes six team leaders, 15 crisis counselors who have at a minimum a master's degree in a counseling related field, 12 outreach workers with a minimum of a bachelors' degree, three community cultural liaisons familiar with the local populations, five first responders and four stress managers. Additional program staff include a program director and two administrative assistants.

From May 21 through July 20, more than eight thousand five hundred (8,500) direct face-to-face contacts have been provided. These contacts included individual crisis counseling sessions lasting more than fifteen minutes, brief educational and supportive encounters lasting fifteen minutes or less and group participants. A public/private community advisory group is being established to ensure culturally responsive services that are transparent and specific to address the local needs of the affected communities.

At the time of the writing of the 2011 Block Grant Application, the recovery program continues to unfold and is ongoing.

The BEST (formerly Access)

The Access Program was a community-based counseling program that operated through the Department of Health and Hospitals, Office of Mental Health. The program was originally created during the review and evaluation of the state's mental health disaster response, post-Katrina; and was a direct response to the lingering mental health crisis. The program evolved into the Behavioral & Emotional Support Team (BEST) which is funded with State General Funds. This program now provides services to persons affected by the BP Deepwater Horizon oil spill in the Gulf of Mexico who are in need of emotional and behavior health services. The BEST team members provide emotional and behavioral health specialized crisis counseling services, including individual and group counseling support services for citizens who typically would not have direct access to emotional and behavioral health services, due to being uninsured, underinsured, poor, homeless / at risk of becoming homeless, elderly, single and pregnant, adjudicated (youth & adults), substance abusers and/or wayward at-risk youth.

The program was in the process of transitioning into a *child and youth only* services model in May, 2010 in anticipation of the new OBH administration. Once the oil spill in the Gulf occurred the Best program was commissioned to reassign its activities to perform duties consistent with the former LA Spirit Hurricane Recovery Program. The expectation is that the program will regroup and continue its efforts in meeting the mental health needs of children and youth in the New Orleans area once the LA Spirit Coastal Recovery Counseling program concludes its services to the community.

The goal of BEST is to serve citizens (including children, youth and families) in the community, acting as a transition between the initial crisis and through the waiting period, prior to receiving

assessment and treatment services for mental health related issues. The BEST Program also has provided citizens with a swift support service response that often prevents emotional crises from escalating, while often negating the need for hospitalization. BEST accepts referrals from recovery organizations, community centers, public health clinics and the private sector.

The program uses a team approach, using dyads consisting of a master's level Crisis Counselor, specializing in social work or counseling, and a paraprofessional Resource Linkage Coordinator. Together these dyads provide immediate crisis intervention support and resource information; with a focus on empowering the client to regain control of their life, develop self-help skills to manage future crises, and avoid disruptive and costly hospitalization. All of the services provided by the Access team take place in the client's home or in a community-based location.

The BEST (and previously ACCESS) has established networks with homeless and domestic violence shelters/ missions, public health clinics, youth training centers, community centers, churches, residential facilities, juvenile justice programs, public schools, food banks and many other community support organizations.

Louisiana Spirit ACCESS/BEST services staff completed the following services in Jefferson, Orleans, Plaquemines and St. Bernard Parishes from December, 2008 through February, 2010, prior to the oil spill:

Crisis Counseling Assistance and Training Program (CCP) Grant:

- 3,582 individual crisis counseling sessions with 2,560 survivors (at least 15 minutes each)
- 716 group crisis counseling sessions with a total of 7,737 participants (average of 11 participants per group)
- 214 public education sessions with a total of 4,151 participants (average of 19 participants per group)
- 22,141 brief educational or supportive contacts (less than 15 minutes each)
- 27,181 materials distributed
- 4,598 community networking efforts
- 10,458 phone calls
- 791 emails

The following demographic information describes the 2,489 survivors seen by Access/ B.E.S.T. during CCP individual crisis counseling sessions:

AGE		
0 to 5 years:	6	0.2%
6 to 11 years:	87	3.4%
12 to 17 years:	78	3.0%
18 to 39 years:	1,447	56.5%
40 to 64 years:	776	30.3%
65+ years:	157	6.1%
Age unknown:	9	0.4%

RACE/ ETHNICITY		
Latino:	279	10.9%
Asian:	14	0.5%
Black:	1,346	52.6%

Pacific Islander:	2	0.1%
White:	498	19.5%

The data collected showed that the most common hurricane-related risk factors were: displacement from home for one week or more; damage to home; financial loss; prolonged separation from family; unemployed; situation exacerbated by past trauma; evacuated quickly with no time to prepare.

HEALTH, MENTAL HEALTH, MH REHABILITATION SERVICES & CASE MANAGEMENT FY 2011 - ADULT PLAN

Individuals with Serious Mental Illnesses 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. The Office of Mental Health continues to develop holistic initiatives that offer comprehensive and blended services for vulnerable children and adults experiencing psychiatric and physical trauma, including those in acute crisis. In addition, 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. Over the past few years, OMH's acute psychiatric inpatient services have been moved under the Louisiana Health Sciences Center-Health Care Services Division (LSUHSC-HCSD), and LSU Shreveport public general hospitals. It is believed that continuity of care is often better served under LSU and that those persons admitted with acute psychiatric problems might then receive the best *physical* assessment and treatment as well as care for their psychiatric problems. Adults who are clients of state operated mental health clinics or Medicaid funded Mental Health Rehabilitation (MHR) Services also benefit from a systematic health screening. Further, MHR providers who provide services to children, youth, and adults must assure through their assessment and service plan process that the whole health needs of their clients are being addressed in order to get authorization for the delivery of services through the Medicaid Behavioral Healthcare Unit. The OBH clinics work very closely with private health providers as well as those within the LSUHSC-HCSD.

Outpatient mental health services have historically been provided through a network of approximately 45 licensed community mental health clinics (CMHCs) and their 27 outreach clinics. These are located throughout OBH geographic regions and LGEs. The CMHC facilities provide an array of services including: screening and assessment; emergency crisis care; individual evaluation and treatment; medication administration and management; clinical casework services; specialized services for children and adolescents; and in some areas, specialized services for those in the criminal justice system.

The CMHCs serve as the single point of entry for acute psychiatric units located in public general hospitals and for state hospital inpatient services. All CMHCs operate at least 8 a.m. - 4:30 p.m., five days a week, while many are open additional hours based on local need. CMHCs provide additional services through contracts with private agencies for services such as Assertive Community Treatment (ACT) type programs, case management, consumer drop-in centers, etc. OBH is cognizant of the fact that some of these services are limited and not available statewide, and efforts to improve access are constantly being made.

Although the CMHC's operate with somewhat traditional hours, crisis services are provided on a 24-hour basis. These services are designed to provide a quick and appropriate response to individuals 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 Mental Health Rehabilitation (MHR) program continues to provide services in the community to adults with serious mental illness and to youth with emotional and behavioral disorders. As of July 1, 2009, the oversight and management of the MHR program was transferred to the Bureau of Health Services Financing (Medicaid) within DHH. All staff, equipment, materials, contracts, purchase orders, processes and personnel were transferred. Starting on that date, Medicaid began to provide all utilization management, prior authorization, training, monitoring, network, and member service activities.

During the just ended fiscal year, the MHR program continued to refine its operation, oversight and management activities to align itself with industry standard Administrative Service Organization functions, including Member Services, Quality Management, Network Services (Development and Management), Service Access and Authorization, as well as Administrative Support and Organization.

Efforts to improve the Mental Health Rehabilitation optional Medicaid program continued through FY 2009 -2010. Continued collaboration with the Office for Community Services (OCS) and the Office of Juvenile Justice (OJJ) resulted additional staff trainings and pilot projects across the state to increase access to medically necessary mental health services for eligible adults and children served by those agencies. The MHR program and newly formed Medicaid Behavioral Health Section also participated in and led several Coordinated Systems of Care planning efforts, in collaboration with OCS, OJJ, OBH, DOE, as well as family members, advocates, and other invested stakeholders. Additional policies and procedures governing the processes of certification and recertification were refined, as were policies and procedures related to complaints, grievances and events.. The MHR program continued to add new MHR providers during the year, and a number of new Multisystemic Therapy (MST) providers were also certified by Medicaid during the year.. During FY 09-10, as of the date of this summary, nine additional MHR providers have enrolled, expanding the network of qualified providers to 69. The total number of MHR recipients served has continued to increase accordingly, resulting in approximately 9,632 unduplicated recipients having been served during the fiscal year. Medicaid added 11 new MST providers during the fiscal year, resulting in 22 MST providers enrolled, including 32 MST teams. During the fiscal year, 1364 youth were served in MST throughout the state.

Beginning June 2010, the MHR program began statewide implementation of its new Provider Performance Indicator reviews. The Clinical Documentation/Utilization Management Monitoring module (covering screening, initial assessments, reassessments, initial and ongoing treatment planning, crisis planning, discharge planning and service delivery domains) and its Covered Services Module (monitoring Assessment and Service Planning, Community Support, Counseling, Individual, Group and Family Interventions, as well as Psychosocial Skills Training and Parent/Family Interventions) 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. In addition, enhancements to the Behavioral Health Section's website included more service and referral information for

recipients/members, as well as enhanced on-line training, post-tests, and provider resources on the Provider side of the website.

Quarterly sessions with providers were continued via telecommunication, and all authorized providers in the network remain accredited by The Joint Commission, CARF, or COA, a requirement of the program that began on March 31, 2006.

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

EMPLOYMENT SERVICES

FY 2011 - ADULT PLAN

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. Additionally, there has been turnover in staff, leaving individuals functioning in this capacity without formal training. Both of these issues have 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 also 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 7th 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.

Louisiana Work Incentive Planning and Assistance (LAWIPA)

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. CMHC 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 pushing 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.

OBH continues to work on the implementation of recommendations outlined by several employment workgroups through policy/program development and collaboration with community partners. The workgroups include the Louisiana Commission on the Employment of Mental Health Consumers; and although the Commission was sunsetted in 2007, the recommendations continue to be relevant.

Act 378 funds for adults are limited to those who have been hospitalized for at least 18 months and are ready for discharge. These funds 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 – FY 2010
year ending 6/30/2010

REGION / LGE	TYPE OF EMPLOYMENT SERVICE	NUMBER SMI SERVED	NUMBER SMI PLACED
MHSD	Employment/Pre-Employment Training Transitional Employment	1,008	n/a
CAHSD	Supported Employment Individual Placement and Support (IPS)	48	27
III	Employment Referral, Employment/Pre-Employment Training, Supported Employment	90	90
IV	Consumer Micro Enterprise, Employment Referral, Transitional Employment	675	123
V	Employment Referral Employment/Pre-Employment Training	137	unknown
VI	Employment Referral Employment/Pre-Employment Training, Individual Placement and Support (IPS)	160	10
VII	Employment Referral Employment/ Pre-employment Training Supported Employment Transitional Employment, Individual Placement and Support (IPS)	106	23
VIII	Employment Training/Pre-Employment Individual Placement and Support (IPS)	201	79
FPHSA	Employment Referral	15	0
JPHSA	Supported Employment	124	70
TOTAL*		2564	422

**PROFILE OF PERSONS SERVED CMHC,
ADULT CLIENTS BY EMPLOYMENT STATUS**
Louisiana OMH Outpatient Data PERSONS SERVED Unduplicated -- FY09-10

	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)	188	146	4,710	2,945	128	55	5,026	3,146	8,172
Unemployed	230	230	3,901	3,490	51	40	4,182	3,760	7,942
Not in Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc)	568	596	14,318	9,548	914	353	15,800	10,497	26,297
Employment Status Not Available	203	219	4,135	2,671	122	36	4,460	2,926	7,386
TOTAL	1,189	1,191	27,064	18,654	1,215	484	29,468	20,329	49,797

Employment status at admission. Data source: OMHHS and JPHSA. Unduplicated across regions/LGE by client.
URS Table 4. URS Table 4 Profile of Persons Served CMHC, Adult Clients by Employment Status

HOUSING SERVICES

FY 2011 - ADULT PLAN

OMH has recently been combined with the Office for Addictive Disorders to form the new Office of Behavioral Health in an effort to utilize strengths and services of each to effectively address the needs of mental health and addictive disorders jointly. As new methodologies and strategies are used to redesign the mental health system of care to engage mental health and other co-occurring disorders with a Housing First model, it is important to realize that appropriate support services are essential to this transition. The overall framework of the Housing First Model is that housing is a necessity and the primary need is to obtain housing first without any pre-conditions to services. The impact for prevention of the causes that created homelessness should be addressed with a client-centered approach to sustain homeless and at-risk homeless populations from repeating cycles of homelessness. 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 United States Department of Housing and Urban Development and considered to be an evidence-based practice and a solution to addressing the chronically homeless.

The Olmstead Decision of 1999 is a critical legal victory and supports the right of institutional mental health consumers and other disability populations to have access to housing and support services that is necessary to sustain community treatment and services after reaching treatment objectives. Unjustified institutionalization violates the ADA and to that end creates a pathway to therapeutic residential housing. With employment services described elsewhere, the MHR, Intensive Case Management, ACT and FACT programs are very involved in assisting consumers and families with opportunities to secure and maintain adequate housing. Furthermore, in keeping with the use of best practices and consumer and family choice OBH has a strong commitment to keeping families together and to increasing the stock of permanent supportive housing; and consequently has previously withstood pressure to fund large residential treatment centers. Instead, 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 consumer care resources provide highly individualized services that assist families in their housing needs. OBH, in partnership with other offices in DHH, disability advocates, and advocates for people who are homeless, has 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. Congress approved funding for 3,000 rental vouchers to go to participants in the PSH program, furthering the goal of serving 3,000 people and their families. Because people with mental illness are present to a high degree in all of the targeted subpopulations of this initiative, it is likely that they will benefit significantly. This initiative also targets the aging population so those persons with mental illness who are in that subpopulation will have targeted housing.

In 2008, a plan was developed by the Department of Health and Hospitals to provide immediate assistance to the mental health delivery system in New Orleans that had continued to struggle post-Hurricane Katrina. One of the items in the plan was a rental assistance program that funded 300 housing subsidies for individuals; some of whom are homeless with serious mental illness and co-occurring disorders. Of particular note has been the OMH pursuit of State General Funds for housing and support services. OMH was 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 FY 2008-09. The program participants were successfully transitioned to the federally funded PSH that had been previously advocated for in the United States Congress. The Department of Housing and Urban Development administers the PSH housing program with a subsidy administrator.

The state has continued to pursue housing resources through the HUD funding streams such as the Continuum of Care for the Homeless program and the Section 811 and Section 8 programs over the past ten years. 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 the potential provide widespread relief. Louisiana received over \$26,000,000 in HPRP funding with DCFC Administering \$13.5 million and the other funds going to direct allocation to existing community providers. Our goal is to collaborate 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. OMH 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 units set-asides. It is essential and critical that housing development continue with particular emphasize 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 needs 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.

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 2010

Region/ LGE	# of Programs	# Referred Unduplicated	# Placed Unduplicated
MHSD*	5 programs	unk	unk
CAHSD	3 programs	63	60
Region III	4 programs	49	26
Region IV	6 programs	149	483
Region V	10 programs	63	35
Region VI	7 programs	157	78
Region VII	4 programs	124	102
Region VIII	7 programs	177	118
FPHSA	5 programs	Unk	Unk
JPHSA	11 programs	678	453

Although the hurricanes of 2005 displaced a record number of people to localities outside of Louisiana, the number of homeless people with mental illness is not reduced along with the reduction of the general population. Instead, the number of homeless individuals is slightly larger than pre-disaster estimates would indicate. An already critical shortage of affordable housing was exacerbated by the hurricanes. This is true of the general population in Louisiana and the resulting demand has escalated housing costs further.

The annual reports from Louisiana Projects to Assist in Transition from Homelessness (PATH) providers show that 4,385 homeless persons with mental illness were served in the fiscal year 2009 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 2009 was 1,315 (unduplicated count). This is less than the number identified through the shelter system with one possible explanation being that PATH is not a statewide program. UNITY of Greater New Orleans, a non-profit organization for the homeless, estimates that there are approximately 12,000 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 4,800 have a mental illness.

This is in stark contrast to the most recent Point in Time (PIT) survey (2007), in which 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 PIT survey was a statewide count of homeless persons done during the 24-hour period between noon, January 30th and noon, January 31st.

UNITY states their estimation was based upon a multi- factorial analysis including the PIT results, outreach statistics, and agency-reported requests for services as well as the demand for services identified by the homeless population. 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.

The face of homelessness changed in the New Orleans area due to the aftermath of Hurricanes Katrina and Rita in 2005, and Gustav and Ike in 2008. 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 severe problems, as do other areas affected by the hurricanes.

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 \$788 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 \$15.00 per hour is required.

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.

In summary, the need for housing services has increased, and available community placements have decreased in some cases. It is also noted that many homeless/ evacuees are living with friends or family while waiting for housing.

NOTE: Please see *Criterion 4: Homeless Outreach* in this application, where many related issues, programs, and initiatives related to housing are discussed.

EDUCATIONAL SERVICES

FY 2011 - ADULT PLAN

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). In keeping with Goal #1 of the *President's New Freedom Commission Report*, stating that Americans understand that mental health is essential to overall health, supported education became a part of the disability program at LSU forcing recognition that mental health is as important as physical health to the well-being of college students. 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 OMH Block Grant monies to establish a Supported Education Advisor position within each university's existing services for students with disabilities. The Supported Education Advisor only serves those students identifying themselves as persons with Serious Mental Illness (SMI) emphasizing that mental health care is consumer and family driven.

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. These goals fall in line with the President's New Freedom Commission for Mental Health through its call for quality community based services, improved transition services and promotion of innovative and effective services such as supported education which are specifically targeted towards individuals with SMI.

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 working.

Each university historically agreed to contribute in-kind resources for the program and to continue the programs funding once the OMH "seed money" ends, as well as to assist the transfer of supported education technology to other Louisiana institutions of higher learning. This growth will be supported through OBH via educational and technical assistance opportunities.

**SERVICES FOR PERSONS WITH CO-OCCURRING DISORDERS
(SUBSTANCE ABUSE/ MENTAL HEALTH) AND
OTHER SUBSTANCE ABUSE SERVICES
FY 2011 - ADULT PLAN**

The Office for Addictive Disorders (OAD), once a sister agency to OMH, traditionally offered treatment services to both adults and child /youth OMH consumers. As described earlier in this document, 2009 legislation creates the Office of Behavioral Health, combining the functions of the Office of Mental Health and the Office for Addictive Disorders. In some parts of the state the two offices already jointly deliver services to people with co-occurring mental and substance disorders. While parallel or sequential treatment is still a common occurrence, the Louisiana Integrated Treatment Services (LITS) Model has been implemented in an increasing number of treatment facilities; and the restructuring of the Offices will aid in this treatment model becoming the norm. Co-occurring treatment ensures that emphasis is placed on early mental health screening, assessment and referral to services, and eliminating disparities in mental health services. Through the COSIG Grant, coordinated and even integrated care is improving, with the commitment from each agency to work towards improving treatment for co-occurring disorders. OBH services include the following:

Outpatient Outpatient treatment services are defined as either:

outpatient or intensive outpatient based on the intensity of the services provided by the particular outpatient program.

Outpatient Treatment (Non-Intensive)

Treatment/recovery/aftercare or rehabilitation services are provided, but the client does not reside in a treatment facility. Clients receive alcoholism and/or drug abuse treatment services including counseling and supportive services, and medication as needed.

Intensive Outpatient Treatment/Day Treatment

Services provided to a client that last three or more hours per day for three or more days per week. A minimum of 9 treatment hours per week must be provided.

Inpatient This modality provides non-acute care and includes a planned and professionally implemented regime for persons suffering from alcohol and/or other addiction problems. It operates 24/7 and provides medical and psychiatric care as warranted.

Residential This is strictly a psychosocial model, based on a 12-step program with no medical or psychiatric care. The program functions 24 hours a day, seven days a week.

Detoxification There are two types of detoxification offered:

Medical detoxification

24/7 medical service providing immediate acute care for the alcoholic/substance abuser at extreme health risk (either from an illness/health problem co-morbid with the substance abuse problem, or from medical problems resulting from the process of detoxifying).

Social Detoxification

24/7 service designated for patients who need immediate substance abuse detoxification treatment but are not facing any urgent health problems.

Community-Based Services

Halfway House Services

Provides community-based care and treatment for alcohol/drug abusers in need of transitional arrangements, support and counseling, room and board, social and recreational activities, and vocational opportunities in a moderately structured drug-free environment

focused on re-socialization and encouragement to resume independent living and functioning in the community.

Three-Quarter Way House Services

Less structured than a halfway house but provides a support system for the recovering alcoholic and/or substance abuser. Clients are able to function independently in a work situation. The three-quarter-way house functions as a source of peer support and supportive counseling. This level of service is designed to promote the maintenance of the client's level of functioning and prepare him/her for independent living.

Therapeutic Community (TC)

Highly structured environment designed to treat substance abusers that have demonstrated a pattern of recidivism or a need for long-term residential treatment. It is a unique program in that it relies on the social environment to foster change in the client while promoting self-reliance and positive self-image. In general, this program requires a minimum of 12 months duration.

Recovery Homes

Recovery homes are self-run and self-supported houses for recovering substance abusers. OAD supports this continuum of care by contracting with Oxford House, Inc., to establish and manage houses within designated areas of the State. In addition, OAD offers a revolving loan program to support the houses with start-up expenses.

Gambling Services

The Office for Addictive Disorders provides services to problem and compulsive gamblers. These services include the Compulsive Gambling Help Line, outpatient and inpatient treatment services, and compulsive gambling prevention services. The office also provides for research, training and program evaluation for the gambling addiction treatment and prevention community.

Louisiana has been a recipient of one of the Co-occurring State Infrastructure Grants (COSIG) offered through SAMHSA. In addition, Louisiana has participated as one of ten states to participate in the first National Policy Academy on Co-Occurring Mental and Substance Abuse Disorders. The result of these initiatives has been a strategic plan to guide the development of co-occurring informed services throughout all service delivery inclusive of both adult and children services. Included in the action plan is the expectation that Louisiana citizens will be provided with an co-occurring system of healthcare that encompasses all people, who will easily access the full range of services, in order to promote and support their sustained resilience and recovery.

Initial, critical first steps in moving toward a co-occurring system of care included the development of a productive partnership between the Office of Mental Health and the Office of Addictive Disorders. The Louisiana version of the statewide co-occurring initiative is the Louisiana Integrated Treatment Model (LITS). The Louisiana Integrated Treatment Model (LITS) is organized around nine Core Principles (see below) originally delineated by Minkoff and Cline. According to this model, clinics are expected to adjust the delivery of their services across seven dimensions including: Program Structure, Program Milieu, Screening & Assessment, Treatment, Continuity of Care, Staffing, and Training.

The following nine guiding principles have been adopted to direct provision of services:

1. Dual diagnosis is an expectation, not an exception.

2. All individuals with co-occurring psychiatric and substance disorders (ICOPSD) are not the same; the national consensus four quadrant model for categorizing co-occurring disorders can be used as a guide for service planning on the system level (NASMHPD, 1998).
3. Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties.
4. Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting.
5. When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.
6. Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" (Minkoff, 1989) with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change.
7. There is no single correct intervention for ICOPSD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.
8. Clinical outcomes for ICOPSD must also be individualized, based on similar parameters for individualizing treatment interventions.
9. The system of care operates in partnership with consumers, family members and concerned significant others and a continuous effort is made to involve the individual and the family at the system, program and individual levels.

The overarching goal of LITS is to move all ten of the major service delivery systems in Louisiana to a "Co-occurring Capable" status. "Co-occurring Capable" represents a measurable standard of care that was identified as a significant improvement, which can be designed and implemented locally through additional technical assistance and support. A "Co-occurring Capable" system would be created without significant clinical operational cost and could be reliably assessed through routine program evaluation with the identified fidelity instrument, Dual Diagnosis Capability in Addiction and Mental Health Treatment (DDCAT/ DDCMHT). The DDCAT/ DDCMHT provided an objective structure by which components of a co-occurring system could be defined and operationalized. The critical elements defined co-occurring capable program management, milieu, assessment, treatment, staffing patterns, and training. Use of the DDCAT/ DDCMHT provided a critical structure for local providers to objectively assess their current status, develop individual strategic plans, and establish an implementation plan.

A critical aspect of the COSIG/ LITS initiative was the development of an effective working relationship between the Office of Addictive Disorders and the Office of Mental Health at the state central office level, at local governance levels, and at the clinic level, culminating in the formation of the Office of Behavioral Health. Local steering committees comprised of mental health and addictive disorders staff were established at the local governance level to lead local planning, identify technical assistance needs, and guide implementation of integrated treatment services. System-wide and individual beliefs and barriers have been identified. Each group has evaluated the ability of the system to provide enhanced co-occurring informed services. Stakeholders are involved through the establishment of the Client Advisory Board, membership on the Behavioral Healthcare Task Force, and projects with community based organizations. Funding streams are

being investigated to support drug screens conducted within the OMH system, and increased physician and medication access in the OAD system. Clinical core competency standards are being developed to support integrated treatment, and on-going specialized support and training will be provided. Integrated management of information and program evaluation systems, including a web-based client tracking system, were developed but have not been implemented. Changes in the organization, management, and structure of DHH IT systems is setting the stage for the ability to centralize selected access to DHH-wide legacy data systems using unique patient identifiers that will allow for a much broader capacity to link what is now individual agency data on the same person. This will allow for a greater capacity to share critical clinical data across agencies that may be involved in the integrated care of a given individual. Cross agency efforts have been made to include in each screening and assessment the ability to detect and identify individuals who may need co-occurring services, including the ability to document two primary diagnoses, and to make the appropriate referrals or be able to provide the necessary services,

Anticipating the Office of Behavioral Health, OAD and OMH have jointly developed a specialized Co-occurring residential unit. This unit serves to fill a significant void for services that specifically address the complex and acute needs of persons with the combination of severe mental health and severe substance abuse disorders, otherwise conceptualized as the Quadrant IV persons on the Co-occurring Quadrant Model. In addition, some of the inpatient units within the existing state hospitals have taken on the challenge of creating a more co-occurring informed care delivery system. The Access to Recovery (ATR) electronic voucher program provides clients with freedom of choice for clinical treatment services and recovery support. Louisiana's ATR funds served all eligible citizens with special emphasis upon women, women with dependent children, and adolescents.

Beginning with the summer of 2005 approximately 1,915 LGE and regional staff members from OBH participated in the Louisiana Integrated Treatment Services (LITS) Basic Orientation and Training course on treatment of individuals with co-occurring disorders. In the summer of 2006, the series of Advanced LITS trainings was completed. To date over 2,000 LGE and regional staff members have participated. These trained individuals have an impact on the ability of the direct service agencies to screen, assess, diagnose, treat and refer clients as needed. The summer of 2006 also marked the completion of the baseline fidelity assessments at each of the approximate 40 clinics throughout the state. This was followed up with a LITS State Summit that assisted with the development of local strategic plans for each of the 10 LGEs or Regions. OBH has purchased a learning management system that is shared with OCDD that provides a continued mechanism to provide core curriculum on recovery, integrated care, co-occurring knowledge base in addition to a wide variety of other behavioral health issues.

The following is a list of relevant updates to COSIG:

- In the 2009 legislative session, legislation was promulgated to integrate the Office of Mental Health with the Office for Addictive Disorders, creating an integrated Office of Behavioral Health. Coming out of the 2009 session an interagency behavioral health advisory committee was established that spawned 5 workgroups designed to study and provide recommendations to the parent committee about the key areas needed to be addressed as part of the implementation of OBH. These recommendations were provided in a report to the Secretary of DHH for that agency's report to the legislature on the implementation plan for OBH. This plan was accepted and as of July 1, 2010. OAD and OMH are officially now OBH. As a result of the effectiveness of the various COSIG activities, the process of

integrating administration and operation of the two agencies has been facilitated. The experience, training, and lessons learned by staff of both agencies during COSIG will enhance and support the current initiatives for OBH.

- Since 2008, the last year of the COSIG grant in LA, staff of both OMH and OAD who had been directly involved with the operations of COSIG annually attend the SAMHSA sponsored COSIG annual grantee meetings held in the Washington, DC area. The most recent meeting (6th Annual held in June 2010) was attended by the COSIG program manager and the head of the DDCAT/DDCMHT evaluation team. They presented the results of the baseline and follow-up fidelity assessments and especially addressed the key issues necessary for sustainability of the co-occurring initiative after the termination of the grant based on their experience with the process in LA.
- Most recently, each of the 10 local Regions/Districts have undergone the follow-up DDCAT/DDCMHT assessments in order to measure the successful implementation of their LITS strategic plans. Results have also revealed areas of continuing need and future areas for co-occurring informed program development. Many of the local regions have continued to operate and maintain their LITS committees in order retain their focus on the continuing need to develop co-occurring informed care and to assist with future integration of OAD and OMH.
- Results of the follow-up DDCAT/ DDCMHT confirmed that overall the state showed forward movement in reaching the goal of having all clinics reach the Co-occurring Capable status. Over 50% of the programs reached the status of Co-occurring Capability. Several of the programs, especially those associated with locally governed districts, had adopted a fully integrated model and were well on the way to attaining the Co-occurring Enhanced status, which reaches beyond the Co-occurring Capable status.

The following Table reflects information gathered from each of the Regions and LGEs regarding their programs related to Co-occurring disorders.

**Total Numbers of Persons Served by Category and Region/ LGE
(unduplicated) -- FY 2010**

Region/ LGE	Screen	Assess	Diagnose	Treat	Refer
MHSD	unavailable	unavailable	unavailable	unavailable	unavailable
CAHSD	15,599	3,847	2,667	2,507	11,999
SCLHSA	unavailable	unavailable	unavailable	unavailable	unavailable
IV	4,480	2,781	2,781	2,781	913
V	1,843	1,029	1,056	3,217	657
VI	307	307	792	820	X
VII	5,506	1,278	1,271	1,291	3,387
VIII	1,765	1,765	1,765	915	852
FPHSA	4,384	4,384	4,384	562	149
JPHSA	5437	1842	890	554	31
CLSH	unavailable	unavailable	unavailable	unavailable	unavailable
ELMHS	unavailable	unavailable	unavailable	unavailable	unavailable
SELH	515	434	431	424	431

MEDICAL & DENTAL HEALTH SERVICES

FY 2011 - ADULT PLAN

The Office of Mental Health attempts to offer a comprehensive array of medical, psychiatric and dental services to its clients. As noted in the *President's New Freedom Commission Report*, mental health is essential to overall health, and as such a holistic approach to treating the individual is critical in a recovery and resiliency environment.

The location of the acute units within or in the vicinity of general medical hospitals allows patients who are hospitalized to have access to complete medical services. State-run hospitals all have medical clinics and access to x-ray, laboratory and other medically needed services. Outpatient clients are encouraged to obtain primary care providers for their medical care. Those who do not have the resources to obtain a private provider are referred to the LSU system outpatient clinics. Adults who are clients of state operated mental health clinics or Medicaid funded Mental Health Rehabilitation services also benefit from health screenings with referrals, as needed.

Proper dental care is increasingly demonstrated to have an important role in both physical and mental health. Dental services are provided at intermediate care hospitals by staff or consulting dentists. Referrals for oral surgery may be made to the LSU operated oral surgery clinics. Some examples of low or no-cost dental services/resources available to OMH outpatient consumers include the Louisiana Donated Dental Services program, the David Raines Medical Clinic in Shreveport, the LSU School of Dentistry, the Lafayette free clinic, and the Louisiana Dental Association.

The LSU School of Dentistry (LSUSD) located in New Orleans is now fully operational. It had sustained severe damage from flooding from Hurricane Katrina, and was forced to close, re-opening in the fall of 2007. In addition, various school-based dental clinics in MHSD that offered a full range of services also were destroyed but most have re-opened. As a result, dental clinics opened in other parts of the state. Some of these clinics have remained open, although in smaller scale. The LSUSD campus serves primarily residents from the greater New Orleans area; however, LSUSD satellite clinics serve citizens in other areas of the state. In addition, Earl K. Long Hospital in Baton Rouge provides routine dental care.

Certain healthcare services are provided to pregnant women between the ages of 21 and 59, who are eligible for full Medicaid benefits. The LaMOMS program is an expansion of Medicaid coverage for pregnant women with an income up to 200 percent of the Federal Poverty Level. Through this program, pregnant women of working families, either married or single, have access to no-cost dental and healthcare coverage. Medicaid will pay for pregnancy-related services, delivery and care up to 60 days after the pregnancy ends including doctor visits, lab work/tests, prescription medicines and hospital care.

The LSU operated hospitals struggle to meet the needs of Louisiana citizens. The state continues to debate whether to rebuild a large teaching hospital in New Orleans to replace Charity Hospital, which was destroyed during Hurricane Katrina. Louisiana is planning to develop a medical home model for health care. The medical home model will serve the primary care needs of Louisiana citizens and will ensure proper referral for specialty services.

Following the hurricanes, there was an exodus of healthcare providers from the state. This initially resulted in long waiting periods for patients, who then often experience increased anxiety and higher

levels of emotional and physical pain. Emergency Department waiting times dramatically increased. As a response to this problem, in some regions, hospitals have begun offering some on-site medical services at the mental health clinics to patients who do not have transportation; and nursing staff is often available for general nursing consultation and referrals. The interruption in services that Louisiana experienced following the 2005 hurricane season has been addressed. Medical services now surpass pre-Katrina, pre-Rita levels in some areas.

Some clinics continue to integrate primary care activities into their main clinics along with smoking cessation programs, diabetes screenings, and hypertension and cholesterol screenings in the parish Public Health Units. Wellness Clinics and Medication Management Clinics are becoming commonplace in Regions/ LGEs. Some regions have specialized health programming for senior citizens; for instance in Region 5, eye exams and prescription assistance are offered. Assistance with hearing aids and dentures are other services offered in some Regions.

SUPPORT SERVICES

FY 2011 - ADULT PLAN

Support Services are broadly defined as services provided to consumers that enhance clinic-based services and aid in consumers' reintegration into society as a whole. Louisiana's public mental health system is grounded in the principle that persons with serious mental illness can and do recover. OBH has taken an approach that is consistent with the *President's New Freedom Commission Report* emphasizing that mental health care is consumer and family driven. The Office of Consumer Affairs, created in 2004, has strived for an array of services and supports that enhance, empower, and promote consumer recovery throughout the community. The full-time director of the office is a self-identified consumer. Currently, the Office is focusing on issues of client choice and inclusion through initiatives that will enable choice, empowerment, and in certain instances, employment. With a focus on choice and inclusion this office continues to actively work towards the development of peer support programs, resource or drop-in-center development, coordination of a statewide advocacy network, and other initiatives that encourage consumer and family independence in all aspects of care. For example, in Fiscal Year 2010, Louisiana has continued to develop and implement a Peer Specialist Employment Program for consumers funded initially by Block Grant dollars. *Recovery Innovations, formally META Services*, was identified as the curriculum provider for the initial implementation phase. As a result of this training initiative, 101 mental health consumers have been certified as Peer Support Specialists, 52 of whom who are now employed across the statewide system of care.

Additionally, the Office of Mental Health was awarded a grant to implement Wellness Recovery Action Planning (WRAP™), under the auspices of the Copeland Center for Wellness and Recovery. As a result, 69 consumers have been trained as Certified WRAP Facilitators and are now teaching classes that empower adult consumers to dictate their individual life roles and goals. As further evidence of Louisiana's commitment to these programs, additional trainings in WRAP and Peer Support will be offered in the coming year, thereby increasing the cadre of recovery specialists the state can employ in its workforce. Peer Support Specialists are being used in the clinics; for instance, in Region 7 Peer Support Specialists are making 'engagement calls' to clients providing encouragement to attend aftercare appointments, are actively facilitating groups and serve as a welcoming "bridge" for clients seeking services for the first time.

In the area of consumer empowerment, OBH has supported a variety of activities that aid consumers and their families. These supported activities include employment, housing, and education as described earlier. Activities also include the provision of financial and technical support to consumer and family organizations and their local chapters throughout the state. Self-help educational programs and support groups, funded by the Mental Health Block Grant are organized and run by consumers or family members on an ongoing basis. For example, BRIDGES, modeled after the Journey of Hope program for family members, is a consumer-run enterprise, providing education classes and support programs throughout the State of Louisiana.

In addition to the above activities, OBH hires parents of EBD children and adult consumers into State jobs as either consumer or family liaisons. These individuals assist other consumers and families to access services as well as provide general education and supportive activities such as accessing consumer and/or family care resources. Consumer resources include flexible funds that families and consumers can utilize to address barriers to care and recovery, in unique ways for that individual or family situation.

The Office of Behavioral Health partially or fully funds numerous Consumer Resource Centers (also called Drop-In Centers) that provide not only socialization opportunities, but activities designed to enhance both social and pre-vocational skills. Job Clubs that prepare consumers to seek employment by offering classes on job search, resume-writing, interview role-playing, etc. are a feature at many of the Resource Centers. Technical skills, such as computer literacy are also offered at Resource Centers. Outreach and homeless services, recovery and education classes, case management are often a part of the offerings at the centers. Many of these Consumer Resource Centers are consumer run or administered; and further, all consumer focused services are consumer and family driven.

Consumer Resource Centers FY 2010

Region/ LGE	# of Consumer Resource Centers	Block Grant Funds	Total Funding Includes SGF & other sources	FY 08-09 #served unduplicated
MHSD	1 Center	0	\$66,394	756
CAHSD	1 Center	\$27,700	\$130,000	81
III	2 Centers	\$70,836	\$292,974	250
IV	2 Centers	\$47,550	\$97,550	188
V	2 Centers	\$29,700	\$35,690	189
VI	3 Centers	\$32,646	\$123,555	535
VII	1 Center	0	\$249,984	88
VIII	3 Centers	\$61,160	\$187,051	438
FPHSA	1 Center	0	\$200,000	38
JPHSA	1 Center	0	\$28,356	84
Totals:	17 Programs	\$208,432	\$1,411,554	2647

OTHER ACTIVITIES LEADING TO REDUCTION OF HOSPITALIZATION FY 2011 - ADULT PLAN

OBH has begun an intermediate care hospital discharge initiative for FY 2010. The State of Louisiana has approximately 500 persons hospitalized in three civil state intermediate care hospitals (East Louisiana State Hospital (ELSH), Central Louisiana State Hospital (CLSH), and South East Louisiana State Hospital (SELH)). Louisiana has historically relied on a greater proportion and inpatient services, and the agency's budget has been disproportionately in favor of hospital care versus community based services. With the intent of (i) re-aligning mental health services, (ii) creating a broader system of care that supports persons in the community, and (iii) developing a system that is able to take advantage of available funding streams outside of hospital reimbursement, the Office of Mental Health launched a system redesign initiative. The Mental Health Redesign initiative has proposed to transfer funding to support the expansion of community-based services including Assertive Community Treatment, Intensive Case Management, and Therapeutic Housing Supports, which are evidence-based practices that prevent/ reduce reliance on inpatient care and can provide services that are able to divert individuals from entering into inpatient care. In conjunction with the expansion of intensive community-based services, there is a corresponding decrease in hospital-based services.

The Office of Behavioral Health set a goal of discharging approximately 20% of the civil inpatient population from intermediate levels of hospital care to less restrictive levels of care in the community as a portion of the Mental Health Redesign. A collaborative continuity of care process has been designed to ensure that the hospital and community providers work in an integrated manner to develop an integrated discharge plan that supports the individuals' functional needs in the communities. The discharged patients are being monitored post discharge and specific outcomes are being tracked in an attempt to measure the effectiveness of this discharge initiative and reduce the possibility of risk. This aspect of the Mental Health Redesign initiative has been implemented in coordination with the support for the Olmstead discharge initiative. Fiscal support from the Olmstead project has been interwoven to assist persons being discharged with additional needs. As anticipated, housing needs have been a significant component of this initiative. The Office of Behavioral Health has developed a partnership with housing coordinators within the Department of Health and Hospitals to support and utilize Permanent Supportive Housing (PSH) program to support the specific housing needs of individuals leaving institutional care.

This intermediate care hospital discharge initiative began in earnest during FY 2010. Last year, the State of Louisiana had approximately 360 adults hospitalized in three state intermediate care hospitals. The intermediate hospital discharge initiative provided a strategic Continuity of Care (COC) Process plan for patients identified by clinical hospital discharge teams as meeting discharge criteria for community level of care. The goal of the initiative was to discharge a minimum of 118 patients to the community with appropriate community resources to achieve and maintain person centered residency in the community and to reduce the number of intermediate level of care beds. Community COC teams were identified for each region and LGE. A Patient Biographical Data form was designed with biographical data elements identified by a workgroup to provide the community COC teams with critical data to facilitate appropriate person centered discharge planning. The Level of Care Utilization System (LOCUS) instrument was utilized to provide a score to guide the COC teams in the level of community services needed for a successful discharge. The COC teams from the community and the hospital began COC discharge planning meeting at a minimum of 90 days

prior to community residency. This time frame allowed adequate time for patients to apply for benefits needed for community residency for their physical and behavioral health needs as well as housing and specialty service needs. Community specialty services funded by the Department of Health and Hospitals (DHH) included Assertive Community Treatment, Intensive Case Management, and Therapeutic Residential Housing vouchers. OBH collaborates with several offices in order to facilitate the transition from the hospital into the community. These offices include the:

- Office of Medicaid -to facilitate access to benefits for patients exiting the intermediate hospitals.
- Office of Vital Records -to secure birth certificates as source documents to facilitate access to housing programs and other entitlements.
- Office for Citizens with Developmental Disorders (OCDD) -to identify those patients who meet the criteria for community services provided by programs within that office.

The strategic COC process provided a framework for the successful discharge of patients to the community. The Office of Behavioral Health COC plan includes a method of tracking discharged clients for a follow up period of nine months to ensure successful discharge.

Through the Mental Health Redesign initiative, OBH is also developing and evaluating alternate strategies and different service systems to support the forensic patient population in intermediate care. Currently, the office provides forensic services to 235 individuals in the Feliciana Forensic Facility that is affiliated with East Louisiana Mental Health System (ELMHS). As in other states, the local court systems and the ever expanding population of forensic patients often place significant pressures on state inpatient services. In fact, as this population expands and local judges often control individuals' discharges, the forensic inpatient population comes to occupy aspects of the civil hospital system. As a component of the Mental Health Redesign initiative, the Office of Behavioral Health is creating alternative levels of care for a portion of the forensic inpatient population. Increased capacity is being built in community-based forensic aftercare programming and Forensic Assertive Community Treatment teams. Different levels of residential care, known as Secure Forensic Facilities, are being developed for those individuals, who have reached some degree of clinical stability and no longer require hospital-levels of care, but may not be eligible for release through the courts.

In the event of crisis, hospitalization is a last resort, after community alternatives are tried and/or ruled out prior to inpatient hospitalization in a state inpatient facility. Implementation of the statewide Continuity of Care policy continues to enhance joint hospital-community collaboration with the goals of improved outcomes post-discharge including reduced recidivism. They also address the problems of acute and long term care; specifically assessing existing capacities and shortages coupled with delivering appropriate acute care services.

Another avenue of care that has succeeded in reducing hospitalization rates is the Mental Health Rehabilitation (MHR) program. MHR allows greater flexibility of services; and the ability to cover additional services such as ACT and MST, which are consumer driven and recovery-focused. The previously discussed move of the MHR program into the DHH Medicaid Office should improve the availability of resources and flexibility to an even greater extent. Each OMH Region/ LGE also has specific initiatives aimed at reducing hospitalization and/or shortening hospital stays.

Utilization of state hospital beds dropped significantly with the introduction of community-based Mental Health Rehabilitation (MHR) services and the development of brief stay psychiatric acute

units within general public hospitals. Moreover, Louisiana and OMH have a network of services that provide alternatives to hospitalization for consumers and families in Louisiana through a broad array of community support services and consumer-run alternatives. Housing, employment, educational, rehabilitation, and support services programs, which take into account a recovery-based philosophy of care, all contribute to reductions in hospitalization.

As an adjunct to current services, Mental Health Emergency Room Extension (M-HERE) Units have been established in most Regions/ LGEs. M-HEREs 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/resource need. The M-HERE provides the opportunity for rapid stabilization in a safe, quiet environment, increasing the person's ability to recognize and deal with the situations that may have initiated the crisis while working to increase and improve the network of community and natural supports. All patients receive a medical screening exam and appropriate medical evaluation.

M-HERE services include crisis stabilization and intervention; crisis risk assessment; nursing assessments; extended psychiatric observation and evaluation; behavioral health co-occurring evaluations; emergency medication; crisis support and counseling; information, liaison, advocacy consultation, and linkage to other crisis and community services. The M-HERE model provides the opportunity for close supervision, observation and interaction with patients. The treatment team staff can make involuntary commitment decisions secondary to the behavioral health need of the individual. The mix and frequency of services is based on each individual's crisis assessment and treatment needs.

The Mental Health Emergency Room Extension (M-HERE) includes:

- 24/7 on site nursing coverage
- Psychiatric physician on call availability
- Social Work coverage necessary to assessment and development of discharge plans
- Security services
- Close patient observation and supervision

Discharge from the M-HERE is to one of the following: (1) an acute inpatient unit, (2) a detox unit or co-occurring unit, (3) other community based crisis services (i.e., respite), or (4) other community resources if continued crisis services are not indicated. The goal is to have at least one M-HERE in each Region/ LGE. In addition, several Regions/ LGEs have at least one mobile crisis team, and adult and child crisis respite. The status of the MHERE initiative is as follows:

MHSD: University Hospital

CAHSD: Earl K Long Hospital (recently opened)

Region 3: Chabert Hospital

Region 4: University Medical Center

Region 5: Memorial Hospital (This service is not funded for FY 2010)

Region 6: Huey P. Long Hospital –contract ended– never opened and never staffed.

Region 7: none

Region 8: none

FPHSA: none

JPHSA: West Jefferson Hospital (pending)

In CAHSD the Mobile Outreach team is expanding to include a crisis prevention component that will address high rates of no show for aftercare and intake appointments by individuals who are frequent utilizers of local emergency departments. This team will also be available to admit individuals within 72 hours of discharge from the MHERE. The Adult Mobile Outreach team provides evidence-based therapeutic tools.

Fiscal legislation passed in the 2009 legislative session allowed OMH to close one of its state hospitals, New Orleans Adolescent Hospital (NOAH), and transfer the child/adolescent and adult acute beds to Southeast Louisiana Hospital (SELH); and with the savings in operational costs, has allowed for the opening of two new community mental health clinics in locations convenient to consumers in the New Orleans area. The goal is to increase community outreach programs and outpatient clinics thereby reducing the need for inpatient services.

CRITERION 2
MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY –
INCIDENCE & PREVALENCE ESTIMATES
LOUISIANA FY 2011 ADULT & CHILD/ YOUTH PLAN

OBH continues to make great strides in upgrading information technology and in establishing electronic client data systems to meet the growing and changing needs for management information. These systems provide the means of comparing the number and characteristics of persons served relative to the estimated prevalence of need in the general population, but more importantly provide data to support service system planning, management, quality improvement, and performance accountability.

OBH currently operates several statewide computerized information and 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; and service provider characteristics. OBH is progressively moving towards one, integrated, web-based system to serve the reporting and electronic client record needs of the agency, sequentially retiring legacy systems and modernizing features at each step along the way. As the agency moves towards establishing the Office of Behavioral Health this fiscal year, merging and integrating the now separate organizational functions of the Office of Mental Health and Office for Addictive Disorders, planning is underway for one integrated, electronic behavioral health record system in keeping with contemporary EHR standards. This initiative is described in further detail below.

The *Office of Mental Health Integrated Information System (OMH-IIS)* is the current major information management system now used by OMH and all LGEs, with one exception, Jefferson Parish Human Services Authority (JPHSA), that operates its own proprietary electronic client record system, Anasazi. JPHSA uploads client-level data regularly to OMH, enabling full coverage for client-level data across the state. OMH-IIS is a state-of-the-art, web-based information system operating in an integrated fashion over the DHH wide-area network (WAN) on central SQL servers. The system provides for electronic admission/discharge, screening and assessment, service event recording, and concurrent electronic progress notes (a feature added this past fiscal year) for all persons served in community mental health clinics (CMHCs), state psychiatric hospitals, and regional acute psychiatric inpatient units. OMH-IIS provides an electronic Continuity-of-Care document, and electronic client record which provides a snapshot of the client's diagnosis, medications, and clinical needs at the time of discharge for purposes of information sharing and service coordination with the next level of care (be it hospital, acute unit, or CMHC). OMH-IIS also performs electronic Medicaid and Medicare billing for all programs. OMH-IIS has undergone several phases of a series of planned, sequenced enhancements, documented in previous Block Grant plans and now serves several features of an electronic behavioral health client record. At each step of the way the corresponding functions of the legacy LAN-based information systems are being "retired" as these have been added and augmented in OMH-IIS.

This past fiscal year, OMH added a number of enhancements to OMH-IIS to improve data collection and reporting of persons served, to support utilization management and to further provide outcome measurement. The Service Ticket/ Progress Note, the most recently implemented module, moves OMH-IIS ever closer to establishing the foundation for an electronic behavioral health record. Staff

no longer need use paper service tickets or progress notes. In addition, a new feature of this function is the launch of the coder role. A coder in OMH-IIS will be able to enter selected service ticket and progress note information for a provider who is in the field or unable to directly enter this information directly on the day the service is provided. The provider will be required to verify and electronically sign and approve the information entered by the coder before it becomes part of the record and before a ticket is sent for billing. As of July 1, 2010, OMH-IIS now has the capacity to track persons served by contractors of the regional MHCs. The Contract Client Registry (CCR) module in OMH-IIS allows contract monitors at the clinics to enter the names of their contract service providers into OMH-IIS and then each contractor will enter data on each person served which will be used to report on persons served through contracted services. Clinics are currently loading the CCR with contractor information and then each contractor will be given a secure ID and password which will allow them to enter service data. Heretofore, OMH-IIS reporting was limited to state funded, CMHC programs only. This function now provides an unduplicated count of all persons served across all CMHC and contract programs and also provides the means for tracking of the number of persons served through contracted evidenced-based services programs, such as Assertive Community Treatment, Intensive Case Management, and Support Housing, which were never before tracked. This new OMH-IIS function will significantly enhance the states capacity for reporting the number of persons served through contemporary service delivery under the community re-design efforts now underway. The plan for further development of OMH-IIS is to sequentially replace the remaining separate, non-integrated LAN-based legacy systems now operating statewide by extending the functionality of the expanding OMH-IIS system. OMH-IIS reporting has also been significantly augmented to provide better access to the reports of the number and characteristics of persons served by clinic, region, and the state as a whole, and to enable better management through monitoring and tracking of clients served. In addition, OBH plans to add centralized appointment scheduling integrated into the system and the addition of service recording and Medicaid billing for the Early Childhood Supports and Services program. Additional modules planned include: Provider credentialing & privileging (in conjunction with the current central provider registration); Expanded assessments and quality management functions, including capacity for contemporary performance & outcome measures and a continuity-of-care record; Tracking clients enrolled in evidenced-based treatments; and a central program registration system. While the current OMH-IIS employs current information technologies, rapidly changing technology and the development of standards requires its updating to serve as the core for the new system development.

OBH utilizes the electronic Level of Care Utilization System (LOCUS) as a foundational component of the Cornerstone Utilization Management program, integrated into OMH-IIS. LOCUS is a well-established clinical rating instrument that will be used to determine target population eligibility and intensity of need over the course of treatment. Data submitted is uploaded into the OMH data warehouse (described below) allowing LOCUS data to be linked to all existing clinical information within the warehouse, enabling a broad range of performance comparisons. These data are now being utilized to identify populations targeted for Medication Management Clinics in the Mental Health Redesign process based on their level of care. OMH also procured CA-LOCUS to determine Child and Adolescent Level of Care and has integrated it into OMH-IIS in the fiscal year 2009-10. Soon data from CA-LOCUS will be part of the data warehouse from which data can be pulled for ad hoc analyses through one of the existing query portals. Thus, there is now client-level level of care assessment data for both adults and children statewide.

Another recent major addition has been the implementation of the Telesage Outcome Measurement System (TOMS) integrated into OMH-IIS, which provides ongoing measures of client-level outcomes for adults and children/ youth (described further below). This will significantly enhance

the capacity for local, state, and federal reporting. OMH began implementation of the Telesage Outcome Measurement (TOMS) system statewide in March, 2010. This initiative is funded under the CMHS Data Infrastructure Grant (DIG). The TOMS system utilizes standardized client self-report outcome surveys and allows providers the means to monitor client treatment outcomes at repeated intervals over the course of treatment. This electronic outcome measurement system will transfer data into the OMH data warehouse where it will be combined with the existing clinical data allowing analysis of client outcomes from treatment. The Telesage system also provides the means of collecting consumer quality of care surveys for use in local, state, and national (URS/NOMS) reporting.

OMH operates a comprehensive data warehouse / decision support system to provide access 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 significantly enhances local planning, monitoring, and evaluation. DS On-line 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. DS Online also includes DataQuest, an easy to use (point-&-click) *ad hoc* reporting tool, which provides virtually unlimited views of the wide range of OMH performance data, displayed in easy-to-read, comparative (relative percentage) tables, with drill-down capability from the regional to facility and service provider levels. OMH has been implementing executive dashboards to display key performance indicators for periodic monitoring by leadership and managers. DS Online provides access to performance score cards and reports of consumer quality of care surveys by region/LGE and CMHC.

Another major decision support tool has been the continuing use of the Service Process Quality Management (SPQM) system, a proprietary web-based analytical system developed by MTM Services, Inc. SPQM utilizes standardized client dataset uploads from the OMH data warehouse and displays it through graphic dashboards and cross-tables for data-based decision making and program performance improvement by state managers (OMH regions and LGEs). 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. The focus of these webinars is often on improving access-to-care and direct care staff productivity, thus enhancing the Utilization Management Accountable Care program of OBH operations.

OBH has also launched a major initiative to establish an electronic behavioral health record system (EBHR) to address the needs of both mental health and addictive disorders service delivery and reporting. The goal of this initiative is to provide planning, education, and consensus building to identify and implement one integrated EBHR statewide, rather than each region/LGE implementing their own. This approach will be important to keeping statewide data reporting and comparisons uniform. OMH contracted with the National Data Infrastructure Improvement Consortium (NDIIC) to provide the needed technical assistance, consultation and training. An executive steering committee and multi-agency, multi-site stakeholder group was formed and participated in the initiative. The project activities included a comprehensive needs assessment, demonstrations and

reviews of proprietary and open-source systems, analyses of the pros and cons of various approaches to an EBHR, consultations with other states and a readiness assessment of the human and technical infrastructure needed to implement a system. Five approaches to an EBHR were reviewed: 1.) To continue to build and to integrate state-custom built systems; 2.) to procure a commercial system; 3.) to procure an open source system; 4.) to implement a hybrid of an open source and proprietary system; 5.) to allow each region/ LGE establish its own system. The pros and cons of each approach were reviewed in terms of cost of acquisition and implementation, the implementation timeline, and important features such as interoperability, certification, and infrastructure requirements. Priority system features were identified. It was determined that OBH should consider pursuing an open source/ hybrid solution as the most cost effective approach. OMH participated in two national meetings facilitated by NDIIC and dialogued with other states regarding implementation strategies in coordination with a national SAMHSA effort to develop a model for an EBHR. Based on analyses, NDIIC recommended that OBH proceed with establishing the necessary project staffing and conduct a Request for Information (RFI) for candidates that fit the identified prioritized state needs. The responses to the RFI will provide cost estimates to be determined that would enable OBH to prepare a budget for the coming fiscal year and an RFP to procure the desired system. The LA EBHR initiative is laying a firm foundation for the agency to make strides forward towards an integrated electronic client record in the coming fiscal year as the Office of Behavioral Health is operationalized.

As information technology advances, OMH continues to operate several legacy systems until these are systematically replaced by OMH-IIS or by an integrated electronic record system. These legacy systems continue to provide needed performance data for service system planning and monitoring. OMH legacy systems are largely custom-built, LAN-based, and compliant with national data standards (e.g., Mental Health Statistics Improvement Program - MHSIP). These legacy systems include:

PIP/PIF/ORYX. The Patient Information Program, implemented in 1992, operates in each of the state hospitals and regional acute units, providing a comprehensive array of data on all inpatients served. Together with OMH-IIS, it is the primary source of counts of persons served, diagnoses, lengths of stay, and bed utilization. The financial module (PIF), implemented in 1994, supports billing and accounts receivables, and the ORYX module, implemented in 1999, supports performance reporting for Joint Commission accreditation. PIP has been upgraded to include collection and reporting of the new Joint Commission 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 OMH-IT strategic plan identifies PIP/PIF/ORYX to be the next legacy system to be integrated into OMH-IIS. The state hospital and regional inpatient units are also included in plans for an integrated electronic behavioral health record system.

MHR/ MHS & UTOPIA. The Mental Health Rehabilitation/Mental Health Services system, implemented in 1995, supports client, assessment, and service data collection and reporting for Medicaid mental health rehabilitation provider agencies (MHR) and for some OMH contracted mental health service program providers (mainly case management) (MHS). The Utilization, Tracking, Oversight, and Prior Authorization (UTOPIA) system supports prior authorization of services and utilization and outcomes management at the state and area levels. The system is now being utilized in OMH in the PASSR program providing data on mental health needs in the nursing homes. MHR/MHS & UTOPIA both run in Visual Fox Pro. As of July 1, 2009, the Mental Health Rehabilitation Services Unit has been transferred to the Medicaid Office in DHH. As such, the MHR version of MHR/MHS is being maintained and further developed within the Medicaid Integrated Data

System. It has not yet been decided how the coordination of data between Medicaid and OMH will take place.

iPHARMACY SYSTEMS. OMH now operates the proprietary Health Care Systems (HCS) Medics pharmacy software system in each of the seven regional community pharmacies and each of the state psychiatric hospitals. This software automates prescription processing and management reporting, especially statewide monitoring of the utilization and costs of pharmaceuticals. These data have been critical for providing data to the OMH Pharmacy and Therapeutics Committee and in reviewing and managing the cost of pharmaceuticals statewide. Data are regularly uploaded to the OMH data warehouse. HCS interfaces with PIP in the hospitals to capture patient admission data. This past fiscal year, OMH began to replace the HCS system with the PRISM (NewTech, Inc.) software system in the regional community settings in order to upgrade system technology and operations to be more in keeping with the LA Board of Pharmacy requirements. Statewide implementation is underway. Pharmacy will be included in the requirements of the electronic behavioral health record system, at which time the PRISM system will be discontinued.

OTHER INFORMATION MANAGEMENT SYSTEMS. In addition to the above listed OMH data systems, there exist program specific data systems that are supported by OMH. These include the CRIS data system for the Child and Adolescent Response Team (CART), the ECSS-MIS supporting the Early Childhood Supports and Services (ECSS), and RiteTrack, a proprietary information system supporting the Louisiana Youth Enhancement Services (LA-YES). In each case, these specialized service programs have unique database needs that have been addressed by either building a suitable database in-house or in the case of LA-YES, purchasing a compatible commercial data management system. In each of these cases, efforts have been made to make sure that whatever system is being used, key clinical information can be uploaded to the OMH data warehouse which is the primary repository of this information for OMH.

Data Definitions & Methodology

SMI and EBD Definitions:	OMH 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:	OMH 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.
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.

Adult Target Population

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, schizoaffective 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.

OMH is in the process of revising and refining the definition of the Target Population to include such things as clients' functional status.

Child/Youth Target Population

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.

POPULATION ESTIMATES.

According to the *2009 Annual Estimates of the Resident Population 7/1/2009 State Characteristics, Population Estimates Division, U.S. Census Bureau (released June 22, 2010)*, the total number of adults in Louisiana is 3,368,690. Of these, according to national benchmarks, 2.6% are expected to have Serious Mental Illness (SMI). That translates into a total of 87,586 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 1,123,386. Of these, according to national benchmarks, 9% are expected to have an Emotional or Behavioral Disorder (EBD). That translates into a total of 101,105 children and youth with an EBD in Louisiana based on national prevalence rates.

Statistics show that 41,536 adults with SMI received outpatient services under the OMH umbrella in FY 2010 through both Mental Health Clinics and the Mental Health Rehabilitation (MHR) program. The Mental Health Rehab (MHR) program served 2,712 adults in FY 2010. Of the total number of adults served, both with and without SMI (54,021), 77% met the definition of Seriously Mentally Ill (SMI). Statistics show that 15,558 children and youth with EBD received outpatient services under the OMH umbrella in FY 2010 through both Community Mental Health Clinics and the Mental Health Rehabilitation (MHR) program. The MHR program served 7,784 children and youth. Of the total number of children and youth served (19,484), 80% met the definition of EBD.

As has been true since the hurricanes, many individuals who were in acute crises were seen in MHCs as a result of the aftermath of the hurricanes, and did not meet the more strict criteria of SMI or EBD. Strict comparisons between years are not feasible since some years Jefferson Parish Human Services Authority (JPHSA) data is included, and other years it is not; due to changes in the data systems.

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 and 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.

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 7/1/2009 - State Characteristics Population Estimates (Released June 22, 2010)*. 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 2009 numbers indicate that there were 4,492,076 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. It is important to note that population figures continue to be in flux, making estimates difficult and somewhat unreliable. Challenges continue, now with the devastating oil spill in the Gulf of Mexico.

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, 2009 - (Released June 22, 2010)

	Child/ Youth 9%		Adult 2.6%		Total	
	Pop Count	Prev Count	Pop Count	Prev Count	Pop Count	Prev Count
State-wide	1,123,386	101,105	3,368,690	87,586	4,492,076	188,691

* Annual Estimates of the Population for Parishes of Louisiana: April 1, 2000 to July 1, 2009 (cc-est2009-agesex-22csv)

Estimates Source: Population Division, US Census Bureau. Release Date: June22, 2010. <http://www.census.gov/popest/datasets.html>.

Prev. 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/District and Parish (July 1, 2009 Pop Est)***

Region/District	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, 2009	TOTAL PREVALENCE ESTIMATE
1-METROPOLITAN HUMAN SERVICE DISTRICT and NOAH Outpatient clinics	Orleans	76343	6,871	278507	7,241	354,850	14,112
	Plaquemines	5701	513	15241	396	20,942	909
	St. Bernard	10889	980	29766	774	40,655	1,754
Total for 1-MHSD		92,933	8,364	323,514	8,411	416,447	16,775
2-CAPITAL AREA HUMAN SERVICE DISTRICT	Ascension	29957	2,696	74865	1,946	104,822	4,643
	East Baton	104315	9,388	330318	8,588	434,633	17,977
	East Feliciana	4488	404	16482	429	20,970	832
	Iberville	7500	675	25005	650	32,505	1,325
	Pointe Coupee	5428	489	17019	442	22,447	931
	West Baton Rouge	5682	511	16956	441	22,638	952
	West Feliciana	2527	227	12528	326	15,055	553
Total for 2-CAHSD		159,897	14,391	493,173	12,822	653,070	27,213
3-SOUTH CENTRAL LOUISIANA MENTAL HEALTH AUTHORITY	Assumption	5446	490	17428	453	22,874	943
	Lafourche	22920	2,063	70762	1,840	93,682	3,903
	St. Charles	13858	1,247	37753	982	51,611	2,229
	St. James	5616	505	15438	401	21,054	907
	St. John the Baptist	13034	1,173	34052	885	47,086	2,058
	St. Mary	13772	1,239	37043	963	50,815	2,203
	Terrebonne	29235	2,631	80056	2,081	109,291	4,713
Total for 3-SCLMHA		103,881	9,349	292,532	7,606	396,413	16,955
Region 4	Acadia	16602	1,494	43493	1,131	60,095	2,625
	Evangeline	9757	878	25573	665	35,330	1,543
	Iberia	20827	1,874	54274	1,411	75,101	3,286
	Lafayette	52785	4,751	158169	4,112	210,954	8,863
	St. Landry	25444	2,290	66882	1,739	92,326	4,029
	St. Martin	13932	1,254	38285	995	52,217	2,249
	Vermilion	14813	1,333	41328	1,075	56,141	2,408
Total for Region 4		154,160	13,874	428,004	11,128	582,164	25,003

Region/District	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, 2009	TOTAL PREVALENCE ESTIMATE
Region 5	Allen	6008	541	19628	510	25,636	1,051
	Beauregard	9195	828	26224	682	35,419	1,509
	Calcasieu	48353	4,352	139201	3,619	187,554	7,971
	Cameron	1502	135	5082	132	6,584	267
	Jefferson Davis	8569	771	22528	586	31,097	1,357
Total for Region 5		73,627	6,626	212,663	5,529	286,290	12,156
Region 6	Avoyelles	10847	976	31664	823	42,511	1,799
	Catahoula	2544	229	7916	206	10,460	435
	Concordia	4907	442	14082	366	18,989	808
	Grant	5194	467	14970	389	20,164	857
	La Salle	3532	318	10432	271	13,964	589
	Rapides	34893	3,140	99044	2,575	133,937	5,716
	Vernon	12639	1,138	33977	883	46,616	2,021
	Winn	3427	308	11904	310	15,331	618
Total for Region 6		77,983	7,018	223,989	5,824	301,972	12,842
Region 7	Bienville	3423	308	11306	294	14,729	602
	Bossier	28647	2,578	82845	2,154	111,492	4,732
	Caddo	63531	5,718	190092	4,942	253,623	10,660
	Claiborne	3383	304	12735	331	16,118	636
	De Soto	6673	601	19728	513	26,401	1,113
	Natchitoches	9671	870	29584	769	39,255	1,640
	Red River	2452	221	6551	170	9,003	391
	Sabine	5988	539	17745	461	23,733	1,000
	Webster	9695	873	30849	802	40,544	1,675
Total for Region 7		133,463	12,012	401,435	10,437	534,898	22,449

Region/District	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, 2009	TOTAL PREVALENCE ESTIMATE
Region 8	Caldwell	2420	218	8019	208	10,439	426
	East Carroll	2137	192	5965	155	8,102	347
	Franklin	4987	449	14820	385	19,807	834
	Jackson	3460	311	11603	302	15,063	613
	Lincoln	9134	822	34152	888	43,286	1,710
	Madison	3103	279	8282	215	11,385	495
	Morehouse	7021	632	21202	551	28,223	1,183
	Ouachita	40117	3,611	111385	2,896	151,502	6,507
	Richland	5308	478	15114	393	20,422	871
	Tensas	1369	123	4240	110	5,609	233
	Union	5272	474	17312	450	22,584	925
	West Carroll	2724	245	8605	224	11,329	469
Total for Region 8		87,052	7,835	260,699	6,778	347,751	14,613
9-FLORIDA PARISHES HUMAN SERVICES AUTHORITY	Livingston	33952	3,056	89374	2,324	123,326	5,379
	St. Helena	2532	228	8019	208	10,551	436
	St. Tammany	59772	5,379	171723	4,465	231,495	9,844
	Tangipahoa	30378	2,734	88310	2,296	118,688	5,030
	Washington	11708	1,054	33961	883	45,669	1,937
Total for 9-FPHSA		138,342	12,451	391,387	10,176	529,729	22,627
10-JEFFERSON PARISH HUMAN SERVICES AUTHORITY	Jefferson	102048	9,184	341294	8,874	443,342	18,058
STATE TOTAL		1,123,386	101,105	3,368,690	87,586	4,492,076	188,691

<http://www.census.gov/popest/datasets.html>

Annual Estimates of the Population for Parishes of Louisiana: April 1, 2000 to July 1, 2009 (cc-est2009-agesex-22.csv 1)

Source: Population Division U.S. Census Bureau

Release Date: June 22, 2010

Prev. 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).

**POPULATION STATISTICS
FY 2011 - ADULT & C/ Y PLAN**

POPULATION BY AGE

State's Population By Age Range*		
Age Range	Number of Persons	Percentage of State's Population
0-17	1,123,386	25%
18+	3,368,690	75%
TOTAL	4,492,076	100%

*Based on Annual Resident Population Estimates: Annual State Population Estimates by Demographic. File: 7/1/2009
County Population Estimates Source: Population Division, US Census Bureau. Release Date: June 22, 2010.

**LOUISIANA OMH COMMUNITY MENTAL HEALTH CLINICS DATA
UNDUPLICATED COUNT OF PERSONS RECEIVING SERVICES FROM
JULY 1, 2009 TO JUNE 30, 2010 (OMHIIS & JPHSA)**

	UNDUPLICATED PERSONS RECEIVING SERVICES		TOTAL
	CHILD (0-17)	ADULT (18+)	
REGION			
REGION 1 CHILD/YOUTH CLINICS	629	.	629
MHSD	25	7,530	7,555
CAHSD*	2,399	6,533	8,932
REGION 3	519	6,839	7,358
REGION 4	713	5,030	5,743
REGION 5	355	1,722	2,077
REGION 6	722	3,026	3,748
REGION 7	861	2,631	3,492
REGION 8	434	3,297	3,731
FPHSA	1,738	5,927	7,665
JPHSA	2,312	6,562	8,874
TOTAL	10,707	49,097	59,804

Data Source: OMHIIS 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.

Louisiana Community Mental Health Clinics
ADULTS – CMHC PERSONS SERVED
UNDUPLICATED WITHIN REGIONS/LGEs FY09-10

Regions / LGEs	Adults with SMI Served (persons served)	Total Adults Served	% SMI
1-MHSD	7,584	11,350	67%
2-CAHSD	6,224	7,151	87%
REGION 3	6,246	7,057	89%
REGION 4	4,071	5,402	75%
REGION 5	1,464	1,691	87%
REGION 6	2,015	3,224	63%
REGION 7	2,303	2,495	92%
REGION 8	2,582	2,709	95%
9-FPHSA	3,607	3,903	92%
10-JPHSA	2,728	6,327	43%
MHR	2,712	2,712	100%
TOTAL	41,536	54,021	77%

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	28	48	58%
REGION 1 CHILD/YOUTH CLINICS	1,092	1,363	80%
2-CAHSD	2,387	2,904	82%
REGION 3	413	446	93%
REGION 4	746	923	81%
REGION 5	334	363	92%
REGION 6	299	672	44%
REGION 7	729	776	94%
REGION 8	375	396	95%
9-FPHSA	815	1,132	72%
10-JPHSA	584	2,725	21%
MHR	7,784	7,784	100%
TOTAL	15,558	19,484	80%

Data Source: OMHIIS, JPHSA, and MHR

**INPATIENT & OUTPATIENT CASELOAD ON JUNE 30, 2010
WITH SMI/EBD; PERCENTAGE OF SMI/EBD**

CASELOAD ON June 30, 2010 CMHC/PIP	ADULT: SMI	CHILD: SED	OTHER		TOTAL
	COUNT	Percent	COUNT	Percent	
Age 0-17	3,966	66%	2,022	34%	5988
Age 18+	24,368	72%	9,352	28%	33,720
.	6	67%	3	33%	9
TOTAL	28,340	71%	11,377	29%	39,717

Data from CMHC OMHIIS, PIP and JPHSA . CMHC unduplicated within Regions.

NOTE: Prior to the FY 2009 MHBG, totals have not included data from Jefferson Parish Human Service Authority (not available)

CMHC ADULT CASELOAD SIZE ON LAST DAY OF FY2009 & FY2010

	FY08-09			FY09-10		
	Age 18-64	Age 65+	TOTAL 18+	Age 18-64	Age 65+	TOTAL 18+
REGION						
CAHSD	4620	276	4896	4954	251	5205
REGION 3	4887	274	5161	4841	268	5109
REGION 4	3744	175	3919	3785	174	3959
REGION 5	849	29	878	1171	31	1202
REGION 6	2099	92	2191	1925	63	1988
REGION 7	1522	48	1570	1417	29	1446
REGION 8	1923	90	2013	1758	79	1837
FPHSA	2453	134	2587	2757	135	2892
JPHSA	4210	125	4335	3470	108	3578
MHSD	8846	368	9214	5454	237	5691
TOTAL	35153	1611	36764	31532	1375	32907

Data from CMHC ARAMIS (2009), OMHIIS and JPHSA (2010). CMHC unduplicated within Regions.

CMHC CHILD/ YOUTH CASELOAD SIZE ON LAST DAY OF FY2009 & FY2010

	FY08-09			FY09-10		
	Age 0-11	Age 12-17	TOTAL 0-17	Age 0-11	Age 12-17	TOTAL 0-17
REGION						
CHILD/YOUTH CLINICS	358	533	891	299	290	589
CAHSD	855	866	1721	816	1080	1896
REGION 3	66	147	213	74	200	274
REGION 4	226	260	486	227	286	513
REGION 5	45	63	108	82	105	187
REGION 6	154	211	365	126	137	263
REGION 7	146	215	361	138	177	315
REGION 8	72	98	170	47	100	147
FPHSA	294	287	581	349	346	695
JPHSA	580	803	1383	461	599	1060
MHSD	2	8	10	.	8	8
TOTAL	2798	3491	6289	2619	3328	5947

Data from CMHC ARAMIS (2009), OMHIIS and JPHSA (2010). CMHC unduplicated within Regions.

**CASELOAD SERVED BY OMH COMPARED
TO PREVALENCE ESTIMATES AND CENSUS DATA
FY 2010 - ADULT & CHILD/ YOUTH PLAN**

Age Range	LA Population Estimated*	National Prevalence Rate	Est. Number of persons in LA Population with SMI/EBD
Child/ Youth* 0-17	1,123,386	9%	1,123,386 X .09= 101,105
Adult** 18+	3,368,690	2.6%	3,368,690 X .026= 87,586
Total	4,492,076	-----	188,691

*Based on Annual Resident Population Estimates: Annual State Population Estimates by Demographic. File: 7/1/2009
County Population Estimates Source: Population Division, US Census Bureau. Release Date: June 22, 2010.

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	101,105	3,966	3,966 / 101,105= 3.9 %
Adult 18+	87,586	24,368	24,368 / 87,586= 27.8 %
Total	188,691	28,334	28,334 / 188,691= 15 %

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, which served
2,712 adults and 7,784 children and youth.

Prev. 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).

CRITERION 2
MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY – QUANTITATIVE TARGETS
LOUISIANA FY 2011 ADULT & CHILD/ YOUTH PLAN

Setting quantitative goals to be achieved for the numbers of adults who are seriously mentally ill and children and youth who are emotionally or behaviorally disordered, who are served in the public mental health system is a key requirement of the mental health block grant law.

The Office of Mental Health has set a goal to increase access to mental health services to persons with SMI/ EBD. Quantitatively, this means increasing the numbers of new admissions of persons with SMI/ EBD. Quantitative targets relate to the National Outcome Measure (NOMS) Performance Indicator “Increased Access to Services”. Louisiana reported this indicator in the past as the percentage of prevalence of adults who have a serious mental illness who receive mental health services from the Office of Mental Health during the fiscal year. The measure of the NOMS is now requested to be reported as simply the number of persons who have a mental illness and receive services.

The figures below 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. Given the numerous catastrophes and data problems that have occurred in the state in recent years, perhaps more than any other criteria, the Indicators for Criterion #2 continue to be the most difficult to predict or plan for.

NOTE: The data are more accurate this year than in the past. 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 that actually were. A new process in the clinics automatically cleans out information relating to clients who have not been seen for 9+ months.

This change will cause the numbers of persons on the caseload to appear to be smaller than in past years.

ADULT POPULATION

Previously, the measure was reported as a percentage:

- Numerator: Estimated unduplicated count of adults who have serious mental illness and who receive mental health services during the fiscal year (7/1-6/30) in an OMH community or inpatient setting.
- Denominator: Estimated 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 2005 25,297/ 84,475 X 100 = 29.95%
FY 2006 24,667/ 71,294 X 100 = 34.6%
FY 2007 25,604/ 71,294 X 100 = 35.9%
FY 2008 27,619/ 83,555 X 100 = 33.05%
FY 2009 29,189 / 85,873 X 100 = 33.9%
FY 2010 24,368 / 87,586 X 100 = 27.8 % (see **NOTE** above)

CHILD/ YOUTH POPULATION

Previously, the measure was reported as a percentage:

- Numerator: Estimated unduplicated count of children / youth who have serious mental illness and who receive mental health services during the fiscal year (7/1-6/30) in an OMH community or inpatient setting.
- Denominator: Estimated prevalence of children / youth in Louisiana with serious mental illness 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 2005 3,765/ 109,975 X 100 = 3.43%
FY 2006 3,552/ 85,223 X 100 = 4.17%
FY 2007 3,818/ 85,223 X 100 = 4.5%
FY 2008 4,286/ 97,160 X 100 = 4.4%
FY 2009 4,317 / 99,718 X 100 = 4.3 %
FY 2010 3,966 / 101,105 X 100 = 3.9 % (see **NOTE** above)

- For specific information on the quantitative targets that are now reported only as the unduplicated count of adults (i.e., the Numerator only) who have serious mental illness and who receive mental health services during the fiscal year (7/1-6/30) in an OMH community or inpatient setting see the Performance Indicator section of this document.

CRITERION 4
TARGETED SERVICES TO RURAL, HOMELESS, AND OLDER ADULT POPULATIONS –
OUTREACH TO HOMELESS
LOUISIANA FY 2011 - ADULT PLAN

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. The primary focus of the Act was to stimulate the economy by providing a boost in these difficult times and to create jobs, restore economic growth and strengthen America's Middle class. The stimulation of the economy is designed to modernize the nation's infrastructure, jump start America's energy independence, expand high quality educational opportunities, improve access to affordable health care and protect those in greatest need. The lack of affordable housing with appropriate support and the ability to provide basic necessities are changing the faces of homelessness. 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. In the past few years, Louisiana has advocated successfully with the United States Congress to provide 3000 units of Permanent Supported Housing (PSH) to address the housing demand for affordable housing with support services in response to hurricanes Katrina and Rita. The units are designed to assist some of our most vulnerable homeless and disability populations. In addition, PATH (Project in Assistance to the Transition from Homelessness) expanded services to 8 of the 10 geographical regions/LGEs demonstrating efforts to provide homeless outreach and housing assistance to mental health individuals with other co-occurring disorders. The Olmstead decision of 1999 recently made a ten year anniversary and has been a driving force along with other budget restraints in our decision to change the state's mental health intermediate hospital system of care as OBH embraces a community model of care using best practice like Housing First and Therapeutic Residential Housing. The Olmstead program has been particularly affected in assisting persons with mental illness transition into the community with appropriate supports to sustain housing and services in the community.

There is no doubt that hurricanes continue to have a tremendous impact on housing and homelessness in the state however, it is not the only factor. 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 storms 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 a multiplicity of barriers including changes in development costs at all levels and local resistance to affordable housing development.

The Louisiana Interagency Council on Homelessness that participated in the United States Interagency Council was not reauthorized by the current state administration. The State Department of Children and Family Services is responsible for the state's Emergency Shelter Grant funds. As part of the Department's grantee responsibilities, the department surveys shelters and compiles an annual report on the unduplicated numbers served in shelters across the state. The DCFS Shelter Survey is a twelve month unduplicated count of persons using the state's shelter system. It also includes a point in time count that examines the subpopulations represented in the shelter count and the reasons for homelessness. The shelter information is current through 2008. There are 153

shelters in the DCFS database. In 2008, the number of shelters reporting was 119 or 78% of the 153. The data revealed that the yearly total of homeless persons served was 32,112.

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 Table below. 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	

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 2008 showed that 4,385 homeless persons with mental illness were served.

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.

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 abuse and mental health 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.

For the federal PATH funding, Louisiana relies on in-kind and contractual contributions as its federal match. For FY 10 the match amount is \$499,083.00. 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 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 is being 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 more 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.

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 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.

Homeless Coalition

There are multiple providers of homeless programs in each area of the state. 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.

Clients Reporting Being Homeless as of 6/30/2010 Compared to 6/30/2009

Region/ LGE	Total number reporting homelessness as of 6/30/09	Of total number, how many were displaced by hurricanes/ disaster (6/30/2009)	Total number reporting homelessness as of 6/30/10	Methodology used to arrive at these figures*
MHSD	4423	4423	8725	Point in time survey
CAHSD	38,800**	unknown	1022	Point in time survey
Region III	565	126	397	HMIS Data
Region IV	170	unknown	7332	HMIS Data
Region V	123	unknown	115	Point in time survey
Region VI	162	51	46	HMIS Data
Region VII	973	0	3633	HMIS Data
Region VIII	276	n/a	228	Point in time survey
FPHSA	379	unknown	357	Point in time survey
JPHSA	553	434	331	HMIS Data

NOTES:

*HMIS: Homeless Management Information System Data

** The extremely large jump in homelessness is due to the removal of FEMA housing supports

For further discussion of related aspects of homelessness, the reader is referred to *Section III, Criterion 1, Housing Services*.

CRITERION 4
TARGETED SERVICES TO RURAL, HOMELESS, AND OLDER ADULT POPULATIONS –
RURAL ACCESS TO SERVICES
LOUISIANA FY 2011 - ADULT PLAN

A *Rural Area* has been defined by OMH using the 1990 U.S. Bureau of the Census 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.

RURAL TRANSPORTATION PROGRAMS FOR SMI / EBD 2009-2010

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	29
III	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	9
IV	Medicaid Transportation, City/Parish Transportation, Local Providers	9
V	Medicaid Transportation; City/Parish Transportation; Local Providers, Other	15
VI	Medicaid Transportation, City/Parish Transportation,, Local Providers, Others	13
VII	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	23
VIII	Medicaid Transportation, City/Parish Transportation, Local Providers	6
FPHSA	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	28
JPHSA	Medicaid Transportation	6
TOTAL		142

RURAL MENTAL HEALTH PROGRAMS FOR SMI / EBD 2009-2010

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	Satellite Clinics	10	6
III	CMHC, Satellite Clinics, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	15	7
IV	CMHC, Satellite Clinics, Outreach Sites, ACT Teams, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	21	6
V	Satellite Clinics, Outreach Sites, Mobile Outreach, Drop-in Centers, MHR Agencies, Support Groups, Other	20	11
VI	CMHC, Satellite Clinics, Outreach Sites, Mobile Outreach, Drop-In Centers, MHR, Support Groups, Other	24	11
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	25	22
FPHSA	CMHC, Outreach Sites, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	27	12
JPHSA	Outreach Sites	0	1

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

The capacity for telemedicine, tele-networking, and teleconferencing throughout the state has resulted in better access to the provision of mental health services in rural areas. All state hospitals and approximately almost all CMHC's have direct access. This system addition is actively used for conferencing, consultation and direct care.

In an attempt to alleviate access problems, OBH has available teleconferencing systems at 66 sites, including Mental Health clinics, ECSS sites, Mental Health Hospitals, LA Spirit, OBH regional offices, and OBH Central Office. Some sites have multiple cameras. Some of these cameras are dedicated to Telemedicine (doctor/client session) while the others are used for Teleconferencing (meetings, education, etc). The other sites use their single cameras for both Telemedicine and Teleconferencing. The sites have begun to buy High Definition Cameras per DHH regulations. These cameras provide better quality but also take up more bandwidth.

Telecommunication has become the primary mode for communication within OMH. In an average week there are 20 different meetings conducted through teleconferencing including regular meetings of the Regional and Area Management Teams, Medical Directors, Quality Council, and the Pharmacy and Therapeutics Committee. DHH now also has desktop video conferencing. The new software interface allows participation into the existing video network from individual desktop PCs. Sites now have the ability to do on demand conferencing inside their region. Regional Meeting rooms were setup for telemed and standard conferencing that can

be launched from the sites anytime or day of the week. This is especially helpful in an emergency that happens outside normal work hours. The system is also used for training and other administrative purposes. Forensic patients at ELMHS are being linked with Tulane University psychiatrists in New Orleans through telemedicine. Telemedicine has resulted in more efficient communication between various sites across the state.

OMH Video Conferencing Sites - July, 2010			
	<u>Site</u>	<u>Parish</u>	<u>City</u>
1	Allen Mental Health Clinic	Allen	Oberlin
2	Assumption Mental Health Clinic	Assumption	Labadieville
3	Avoyelles Mental Health Clinic	Avoyelles	Marksville
4	Bastrop Mental Health Clinic	Morehouse	Bastrop
5	Beauregard Mental Health Clinic	Beauregard	DeRidder
6	CLSH (Education Room 103)	Rapides	Pineville
7	CLSH (Education Room 128)	Rapides	Pineville
8	CLSH (Admin Bldg)	Rapides	Pineville
9	Central Louisiana Mental Health Clinic	Rapides	Pineville
10	Crowley Mental Health Clinic	Acadia	Crowley
11	Delta ECSS	Richland	Delhi
12	Dr. Joseph Tyler MHC / Auditorium 1	Lafayette	Lafayette
13	Dr. Joseph Tyler MHC / Auditorium 2	Lafayette	Lafayette
14	Dr. Joseph Tyler MHC / Auditorium 3	Lafayette	Lafayette
15	Dr. Joseph Tyler MHC / Conference Room	Lafayette	Lafayette
16	ELMHS (Center Bldg.)	East Feliciana	Jackson
17	ELMHS (Clinic	East Feliciana	Jackson
18	ELMHS (Forensic)	East Feliciana	Jackson
19	ELMHS (Greenwell Springs)	East Baton Rouge	Greenwell Springs
20	Jonesboro Mental Health Clinic	Jackson	Jonesboro
21	Jonesville Mental Health Clinic	Catahoula	Jonesville
22	Lafourche Mental Health Clinic	Lafourche	Raceland
23	Lake Charles MHC / Regional	Calcasieu	Lake Charles
24	Lake Charles MHC / Room 105	Calcasieu	Lake Charles
25	Lake Charles MHC / Small Group Room	Calcasieu	Lake Charles
26	LA Spirit	East Baton Rouge	Baton Rouge
27	LA Spirit Orleans	New Orleans	Orleans
28	LA Spirit Orleans (Desktop)	New Orleans	Orleans
29	Leesville Mental Health Clinic	Vernon	Leesville
30	Mansfield Mental Health Clinic	De Soto	Mansfield
31	Mansfield Mental Health Telemed	De Soto	Mansfield
32	Many Mental Health Clinic	Sabine	Many

33	Many Mental Health Telemed	Sabine	Many
34	Minden Mental Health Clinic	Webster	Minden
35	Minden Mental Health Telemed	Webster	Minden
36	Monroe Mental Health Clinic / Auditorium	Ouachita	Monroe
37	Monroe Mental Health Clinic / Regional	Ouachita	Monroe
38	Natchitoches Mental Health Clinic	Natchitoches	Natchitoches
39	Natchitoches Mental Health Telemed	Natchitoches	Natchitoches
40	New Iberia Mental Health Clinic	Iberia	New Iberia
41	NOAH / Shervington Conference Room	Orleans	New Orleans
42	NOAH / HR Conference Room	Orleans	New Orleans
43	OMH Headquarters	East Baton Rouge	Baton Rouge
44	Opelousas Mental Health Clinic	St. Landry	Opelousas
45	Region 3 Office	Terrebonne	Houma
46	Red River Mental Health Clinic	Red River	Coushatta
47	Red River Mental Health Telemed	Red River	Coushatta
48	Richland Mental Health Clinic	Richland	Rayville
49	River Parishes Mental Health Clinic	St. John the Baptist	LaPlace
50	Ruston Mental Health Clinic	Lincoln	Ruston
51	SELH / Admin. Bldg	St. Tammany	Mandeville
52	SELH / Education Bldg	St. Tammany	Mandeville
53	SELH / Telemed	St. Tammany	Mandeville
54	SELH / Youth Services	St. Tammany	Mandeville
55	Shreveport MHC / Room 111	Caddo	Shreveport
56	Shreveport MHC / Room 145	Caddo	Shreveport
57	Shreveport MHC / System of Care	Caddo	Shreveport
58	Shreveport MHC / Room 214	Caddo	Shreveport
59	Shreveport MHC / Room 216	Caddo	Shreveport
60	South Lafourche MHC	Lafourche	Galliano
61	St. Mary Mental Health Clinic	St. Mary	Morgan City
62	St. Tammany ECSS	St. Tammany	Mandeville
63	Tallulah Mental Health Clinic	Madison	Tallulah
64	Terrebonne Mental Health Clinic	Terrebonne	Houma
65	Ville Platte Mental Health Clinic	Evangeline	Ville Platte
66	Winnsboro Mental Health Clinic	Franklin	Winnsboro

CRITERION 4
TARGETED SERVICES TO RURAL, HOMELESS, AND OLDER ADULT POPULATIONS –
SERVICES FOR OLDER ADULTS
LOUISIANA FY 2011 - ADULT PLAN

The Office of Mental Health recognizes that access and utilization of mental health care by older adults is an important statewide area of need, and it is imperative to place new emphasis in this area. As noted previously, the Department of Health and Hospitals now has an Office of Aging and Adult Services (OAAS). Although the OAAS is not limited to serving the mentally ill population, collaboration is the norm between OBH and OAAS. The Office of Mental Health also was a participant in a legislatively authorized Study Group on Adult Abuse and Neglect examining protective services, access to these services for both the elderly and adult populations, and legislation that impacts protective service delivery; the work of this group has already influenced service provision.

A task force was created out of the 2008 Legislative Session and made recommendations to the Legislature in late 2009 concerning the current and future impact of Alzheimer's disease and related dementias on Louisiana citizens. OMH had a seat on this task force along with representatives from approximately 25 state agencies, advocacy and professional organizations and service related industries. The plan considered the type, cost and availability of dementia services, and the capacity of the state system to care for persons with dementia. Quality of care and quality of life issues were emphasized in the plan through the provision of clear and coordinated services and supports to persons and families living with Alzheimer's disease and related disorders.

An Older Adult Initiative was planned by OBH for fiscal year 2010. OBH identified approximately 1,500 older adults, as defined by age 65 and older who are being served within the statewide system of care. The goal of the initiative was to have collaboration between the OBH treatment team and the primary care provider for these persons, to assure best practice of medication management, and quality of life satisfaction for this subset of the population. This initiative was to focus on the quality and variety of preventive, therapeutic and supportive services for older adults served by OBH. Unfortunately, this initiative was put on hold due to many unforeseen tasks that took precedence, such as the budget cuts and the Redesign and Discharge Initiative. In spite of the delay, the Office of Behavioral Health remains committed to aligning service delivery with the NASMHPD guidelines. For example, emphasis is on compiling and disseminating educational information about the status of programs for older persons with mental illness; informing treatment teams of current and prospective legislation and funding of services for older persons; and advocating for access to quality services for this subset of the population. The first phase of the initiative was to determine data integrity within our public statewide database. The second phase was to work toward achieving 100% collaboration on each client between the OBH treatment teams and primary care providers. The final phase of the project was to evaluate quality of life issues within this population, in order to aid in making improvements.

Activities have been provided for the elderly through services offered by OBH through the Louisiana Spirit (LA Spirit) Hurricane Recovery Crisis Counseling Program. The LA Spirit program began providing services immediately after the hurricanes of 2005 and continued to

provide expanded crisis services and education for survivors of Hurricane Gustav during the last fiscal year. Louisiana Spirit services included the provision of crisis counseling and resource referral services to priority populations, including older adults. Given that the elderly are considered one of the priority populations in the State, a special emphasis was placed on reaching out to this population. LA Spirit counselors worked with entities as varied as local Councils on Aging, Senior Living and Assisted Living sites, Senior Centers, Nursing Homes, and Transitional Living Sites where many individuals lived after being evacuated after the storms. LA Spirit functioned effectively as a bridge between the elderly and the communities in which they are currently residing.

As discussed in the Housing Services Section of Criterion 1 and previously in this Criterion (see Outreach to Homeless), there are several initiatives to assist the elderly with housing. OBH, in partnership with other offices in DHH, disability advocates, and advocates for people who are homeless, has actively pursued the inclusion of people with disabilities in the 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 with Low Income Housing Tax Credits to go to low income people with special needs, including the elderly population. Because people with mental illness are present to a high degree in all of the targeted subpopulations of this initiative, it is likely that they will benefit significantly. This initiative also targets the aging population so those persons with mental illness who are in that subpopulation will have targeted housing, emphasizing that disparities in mental health services be eliminated.

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 to deliver specialized health needs to the elderly population, and other regions provide enhanced nursing services for this population. In some regions, there are interagency support groups for Alzheimer's disease.

Informal collaborative agreements exist with the Federally Qualified Health Care Centers (FQHCs) regarding persons with SMI over the age of 65. Mobile outreach teams provide therapeutic respite and linkage to community services for adults. In an example of a collaborative agreement, a local hospital provides on-site medical care at the Baton Rouge Mental Health Center on a monthly basis. In addition, the Council on Aging works with clinics in the provision of food, transportation, and sitter services. Some regions have specialized programming for elderly that include geriatric inpatient psychiatric units and four geriatric day programs. Outpatient counseling is also available specifically for this population.

Specific clinical staffing and enhanced nursing services are also noted as ways of meeting the needs of elderly persons with SMI. Other specialized initiatives and relationships mentioned include home health agencies, meals on wheels, Elderly Protection Services, Senior Citizens Centers, Council on Aging, Veterans Administration, Governor's Office of Elderly Affairs and Housing Authority for Senior Citizens. In one innovative situation, an LGE reported that the American Association of Retired Persons (AARP) volunteers assist in clinics and offices as needed.

CRITERION 5
MANAGEMENT SYSTEMS – RESOURCES, STAFFING, TRAINING OF PROVIDERS
LOUISIANA FY 2011 - ADULT & CHILD/YOUTH PLAN

The Community Mental Health Block Grant for the FY 2011 now stands at the lowest it has for many years: \$5,293,123. Several years of budget cuts have occurred. In FY 2009 the amount was \$5,435,135 representing an 11.7% decrease from the original FY 08-09 of \$6,155,074, which was decreased 2.4% from the FY 07-08 of \$6,309,615 following an increase from \$5,902,412 in FY 05-06; which was reduced from the FY 04-05 level of \$6,338,989. Block Grant money is used by OMH to finance innovative programs that help to address service gaps and needs in every part of the state. The Block Grant funds are divided almost equally between Adult and C/Y programs. The OMH FY 2010-2011 budget (initial appropriation) was \$282,790,258. The total appropriation for the community is \$78,515,396.

The following tables provide additional budgetary information, including a breakdown of federal funding for mental health services. The following pages contain further information about staffing resources, etc.

OFFICE OF MENTAL HEALTH INITIAL APPROPRIATION FOR FY 10-11			
BUDGET SUB-ITEM	SUB-ITEM DIVISIONS	TOTAL(S)	% of TOTAL
Community Budget	CMHCs (a)	\$40,707,612	14%
	Acute Units (b)	\$2,905,622	1%
	Social Service Contracts	\$34,902,162	12%
	Community Total	\$78,515,396	28%
Hospital Budget	Central Louisiana State Hospital	\$23,354,926	8%
	Eastern Louisiana Mental Health System (c)	\$91,840,429	32%
	Southeast Louisiana Hospital (d)	\$50,875,953	18%
	Hospital Total	\$166,071,308	59%
State Office Budget	Central Office Total (e)	\$38,203,554	13%
TOTAL		282,790,258	100%
(a) Excludes budgets for Capital Area Human Services District, Florida Parishes Human Services Authority, Metropolitan Human Services District, Jefferson Parish Human Services Authority, and South Central Louisiana Human Services Authority .			
(b) Does not include \$ 137,720 for operation of the Washington-St. Tammany acute units that are located in OMH 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) Actual appropriation is \$38,203,554 of which \$1,136,085 is BP Oil Spill money; and \$714,480 is Residential Therapeutic money.			

MENTAL HEALTH FACILITIES, BEDS, FUNDING

FY 2008 – 2011 (as of first day of fiscal year)

HOSPITAL SYSTEM

	FY 2008 (7/1/07)	FY 2009 (7/1/08)	FY 2010 (7/1/09)	FY2011 (7/1/10)
Total Adult/Child State Hosp. Beds (a)	842	810	804	761
State General Funds(b) (c)(\$)	79,834,630	89,500,010	8,020,486	90,152,175
Federal Funds (\$)	101,469,932	106,781,722	113,196,757	69,482,287

COMMUNITY SYSTEM

Acute Units

	FY 2008 (7/1/07)	FY 2009 (7/1/08)	FY 2010 (7/1/09)	FY2011 (7/1/10)
Total Number of Acute Beds	215	283	155	115
State General Funds (\$)	0	0	-0-	0
Federal Funds (\$)	9,429,275	5,113,592	2,905,622	2,905,622

NOTE: 2008 figures exclude GSH (transferred to ELSH).
 2009 figures include LSU staffed Acute Units.
 2010 figure includes NOAH Acute, SELH Acute, ELSH Acute, Moss, Wash-St.Tammany and UMC Acute Units.
 2011 figure includes SELH, ELSH, Moss and UMC Acute Units. NOAH was closed and Wash-St.Tammany transferred to LSU.

CMHCs

	FY 2008 (7/1/07)	FY 2009 (7/1/08)	FY 2010 (7/1/09)	FY 2011 (7/1/10)
Total Number of CMHCs*	41	43	43	45
State General Funds (\$)***	34,767,708	37,993,999	35,575,211	44,242,442
Federal Funds (\$)	7,539,648	8,159,082	13,180,987	6,006,737

*Includes Clinics only – (including LGEs)

*** does not include LGEs

CONTRACT COMMUNITY PROGRAMS

	FY 2008 (7/1/07)	FY 2009 (7/1/08)	FY 2010 (7/1/09)	FY 2011 (7/1/10)
State General Funds (\$)	12,830,006	31,144,944	28,236,120	22,698,372
Federal Funds (\$)	12,871,215	3,346,292	2,221,512	3,686,170

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 were provided through the Medicaid agency: Mental Health Rehabilitation Option

(c) State General Funds amounting to \$60,745,784 were replaced by Social Services Block Grant monies for FY 2010.

State Psychiatric Facilities Statewide Staffed Beds
(6/30/2010)

	Facility		Adult Acute Beds	Adult Civil Intermediate Beds	Adult Forensic Beds	Child and Adolescent Beds	TOTAL
OMH HOSPITALS	Central State Hospital		0	60	56	12	128
	Eastern Louisiana Mental Health System	Jackson and Greenwell Springs Campus	51	179	88	0	318
		Feliciana Forensic Facility	0	0	235	0	235
		Total for ELMHS	51	179	323	0	553
	New Orleans Adolescent hospital		0	0	0	0	0
	Southeast Louisiana Hospital (Mandeville, LA)		35	94	0	38	167
LSU-New Orleans/ Staffed by OMH	University Medical Hospital		20	0	0	0	20
	Moss Hospital		14	0	0	0	14
TOTAL STAFFED BEDS			120	333	379	50	882

Data from Daily Census Report.

OBH does not get data from the LSU operated/ staffed facilities

**TOTAL NUMBERS OF HOSPITAL INTERMEDIATE CARE BEDS
BY FACILITY (6/30/2010)**

	Licensed Beds on 6/30/2010	Staffed Beds on 6/30/2010	% Staffed Average for Fiscal Year	% Occupancy Average for Fiscal Year
CLSH*	196	128	66.6%	95.9%
ELSH	362	268	81.8%	97.6%
SELH	139	132	47.9%	91.9%
FFF	235	235	100%	100%
TOTAL	932	762	--	--

*Based from PIP Patient Population Movement Report. NOAH was closed August 2009 to

Numbers of Community Professional Staff Members by Discipline on June 30, 2010

Discipline	Psychiatry	Psychology		Social Work		Registered Nurse			Other		Other Physician/PharmD
Region/LGE		Doctoral*	Masters	DSW	Masters	Masters	Bachelors	Associate	Masters	Bachelors	
MHSD	9	1 0 MP	0	0	7	0	12	0	11	2	0
CAHSD	18(9.7 FTE)	2(1 FTE) 3 MP (2 FTE)	2	0	94(48 FTE)	3 (2 FTE)	19 (10 FTE)	4 (2 FTE)	12 (6.53 FTE)	29 (15.51 FTE)	0
III	10	3(2.6 FTE) 0 MP	2	0	11	1	3	8	9	8	0
IV	10(6.8 FTE)	3 (.60 FTE) 2 MP(.30 FTE)	6	0	33	0	0	10	2	7	4(1.4 FTE)
V	6(2.4 FTE)	0 1 MP(0.2 FTE)	4	0	10	0	5	0	3 (2.2 FTE)	7	3(.26 FTE)
VI	4	0 0 MP	5	0	9	0	5	5	1	8	0
VII	8(6.6 FTE)	0 0 MP	0	0	13	0	3	3	10	6	0
VIII	5(3.8 FTE)	2(0.5 FTE)/ 2 MP(0.5 FTE)	0	0	19	0	2	7	9	5	2(1.8 FTE)
FPHSA	11(6.4 FTE)	1(.15 FTE) 1 MP	0	0	33	0	1	4	2	3	1(.4 FTE)
JPHSA	13(10.6 FTE)	3(2.7 FTE) 0 MP	0	0	57(54.7FTE)	3	7	3	13(12.4FTE)	15(14.95FTE)	1
Total By Discipline	94 (69.3 FTE)	15(8.55 FTE) / 9(4 FTE) MP	19	0	286 (244.7 FTE)	7 (6 FTE)	54 (48 FTE)	44 (42 FTE)	72 (65.13 FTE)	90 (76.46 FTE)	11 (4.86 FTE)

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

Numbers of OMH Hospital Professional Staff Members by Discipline on June 30, 2010

Discipline	Psychiatry	Psychology		Social Work		Registered Nurse			Other		Other Physician/Doctorate
Hospital		Doctoral & Medical Psych	Masters	DSW	Masters	Masters	Bachelors	Associate	Masters	Bachelors	
CLSH	unavailable	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
ELMHS	21	7 3MP	2	0	41	6	64	62	8	45	12
SELH	8	15	1	0	26	4	28	39	8	17	0
Total by Discipline											

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

OMH Community Total Prescribing Workforce on June 30, 2010

Psychiatric Type	Total Number FTE Psychiatrists		Of Total Psychiatry FTE, Number Certified Child Psychiatrists		Total Number FTE Medical Psychologists		Total Number FTE Nurse Practitioners	
Region/ LGE	Civil Service	Contract	Civil Service	Contract	Civil Service	Contract	Civil Service	Contract
MHSD	8	2	0	0	0	0	0	0
CAHSD	14.6	6.1	2	1	0	0	1	0
3	5	1.65	1	0.75	0	0	1	0
4	5.5	1.3	1	0.5	0	0.3	0	0
5	1.4	0.8	0.6	0	0.2	0	0	0
6	4	3	1	1	0	0	0	1
7	5.8	0.8	0	0.4	0	0	0	0
8	2	1.8	0	0	0	0	0	0
FPHSA	4.0	2.4	1	1	0	0	0	0
JPHSA	9.79	0.82	2.44	0.30	0	0	0	0
TOTAL	60.09	20.67	9.04	4.95	0.2	0.3	2	1

OMH Hospital Psychiatric Workforce on June 30, 2010

Psychiatric Type	Number FTE Psychiatrists Serving Adults/ Children		Number FTE Certified Child Psychiatrists		Hospital FTE Total Psychiatrists
Hospital	Civil Service	Contract	Civil Service	Contract	
CLSH	Not available	N/A	N/A	N/A	N/A
ELMHS	0	21	0	0	
SELH	8	5	2		
Totals*	--	--	--	--	--

KEY: CLSH = Central Louisiana State Hospital

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

SELH = Southeast Louisiana Hospital

*Totals not computed due to missing data.

OMH Community Staff Liaisons on June 30, 2010

Region/ LGE	FTE Child/Youth Family Liaisons	FTE Adult Consumer Liaisons
MHSD	1	0.5
CAHSD	1	1
III	0	0
IV	.8	0
V	.8	.8
VI	0	.60
VII	.50	0
VIII	0	0
FPHSA	0	0
JPHSA	1.0	0

Includes civil service and contract employees

Training for the delivery of Evidence based practices (EBPs) has been a focus statewide. For instance, a series of Trainings on Dialectical Behavior Therapy was recently begun statewide, and workshops on Cognitive Behavior Therapy and Interpersonal Therapy have also been offered. In spite of the positive things happening with the workforce, the difficulty of delivering services with decreased funding and numbers of clinicians has become an urgent priority.

Due to budget reductions, there were a significant number of positions that were cut in the various clinics. The OMH Redesign Project provided an opportunity to implement a business reorganization plan to better utilize the limited workforce to meet the needs of the residents of the state.

Rural areas continue to have a shortage of psychiatric coverage. Hiring freezes have made a difficult situation even more so. Some clinics are using technical school internship positions to offset staff shortages.

All Regions/ LGEs report difficulties providing necessary services due to a workforce shortage. In addition to the usual problems, the economy is putting an increasing strain on workforce delivery. Previously, it had been noted that many healthcare professionals left state government jobs or literally left Louisiana after the hurricanes, for better pay and better working conditions. Hiring freezes have been the norm since Governor Bobby Jindal was inaugurated in January of 2008; and with the downturn in the economy, layoffs and furloughs have become all too common in healthcare and state government in general. Workforce vacancies have affected all aspects of direct service: medical, nursing, counseling, and clerical. The shortage has caused challenges for clinicians on the front lines with an impact on the number of clients seen, the length of time from first contact to psychiatric evaluation, medication management, and counseling.

Reports from Regions/ LGEs indicate struggles with keeping qualified clinical staff. Recruitment efforts have included using interns and residents from nursing and medical schools, contacting medical recruitment agencies, advertisements in professional journals, and newspapers. To fill the gaps in prescribers, some regions have successfully contracted with non-physician prescribers, specifically, Medical Psychologists and/or Nurse Practitioners. Others have used locum tenens physicians.

Reports from the field indicate that due to budget cuts dictated by the recent legislative sessions, the workforce has been reduced. Job positions are being combined to try to compensate for the budget conditions without lessening the impact on quality centered patient care. In Region 5, the loss of 7 full time positions and several job vacancies have affected all areas of direct service. There is a serious effect on the numbers of clients seen, the length of time from first contact to psychiatric evaluation, medication management, and counseling; and there is a serious shortage of community resources to fill the service gaps.

CRITERION 5
MANAGEMENT SYSTEMS – EMERGENCY SERVICE PROVIDER TRAINING
AND EMERGENCY SERVICE TRAINING TO MENTAL HEALTH PROVIDERS
LOUISIANA FY 2011 - ADULT & CHILD/YOUTH PLAN

OBH makes available a variety of mental health training to providers of emergency services, *as well as* emergency services trainings to behavioral health providers. LGEs and Regions have partnered with and participated in numerous trainings with the Office of Public Health, FEMA, community agencies, and local emergency command centers. Modifications to preparedness training have included better delineation of responsibilities between offices, staff/ volunteer roles, locations of services, and other technicalities. Evacuation procedures and plans have been more closely detailed in the event of a crisis. Collaboration with other state agencies, non-profit agencies, and other organizations on parish and local levels has occurred. Continuity of operations plans for all OBH facilities have been developed and discussion with tabletop meetings conducted to determine feasibility of these plans.

Effective emergency management and incident response activities encompasses a host of preparedness activities conducted on an ongoing basis, in advance of any potential incident. Preparedness involves an integrated combination of planning, procedures and protocols, training and exercises. The Division 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. A variety of disaster related trainings are also offered to emergency service providers, as well as emergency response trainings to behavioral health providers to support efforts to strengthen the state's emergency response capabilities while reducing the psychological impact of a disaster statewide.

OBH regularly updates Call Rosters for pre-assigned personnel to staff medical special needs shelters in the event of a natural or man-made disaster, and conducts routine training and drills activating deployment procedures in these procedures. Additional required training for all OBH staff includes FEMA sponsored National Incident Management System (NIMS) training. At a minimum, all employees are required to take 2 NIMS courses. Each OBH agency has adopted plans to ensure training compliance by new hires annually. 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).

The following documents activities by the Office of Mental Health and/or its affiliates. All trainings are culturally competent and age/gender-specific to the population served.

- Hurricane preparedness and Shelter-in-Place tabletop exercises are regularly conducted as a training exercise with OBH hospitals and mental health clinics across the State. These drills provide a learning venue for service providers to help them better understand the impact of disasters on persons with mental illness and to increase their skill capability to respond to emergencies in the behavioral health care community, including inpatient and outpatient environments.
- OBH jointly with the Office of Public Health and the Governor's Office of Homeland Security and Emergency Preparedness provides ongoing training to parish level police/fire/EMS workers charged with disaster response duties, i.e., critical incident management, mental health disaster services, bio-terrorism preparedness, mental health response to mass casualties,

coordination of mental health and first responders training, stress management for first responders, and Psychological First Aid training.

- OBH works in partnership with key community organizations to provide training on crisis intervention techniques to first responders, and assists with outreach needs in crisis events through its federally funded crisis counseling program (i.e., LA Spirit programs).
- Behavioral health trainings are provided routinely at the state Emergency Operations Center (EOC) to emergency operations personnel prior to and during a declared disaster.

Other agency sponsored services include:

- Stress management and self-care education and skill building to the first responder's network continued throughout the state, via the LA Spirit program. Over the last few years, LA Spirit has hosted a series of Disaster Mental Health training for first responders. These trainings focus on raising awareness among first responders of psychological issues and trauma experienced during catastrophic events. First Responders and Crisis Counselors are trained to use the FOCUS model in working with families of first responders.
- The Louisiana Partnership for Youth Suicide Prevention (LPYSP) is a program that is geared towards reducing child and adolescent suicide; however, adults have benefitted from the program also. 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 Specialist 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 educators, law enforcement, mental health professionals, clergy, medical professionals, administrators, volunteers, and anyone else who might be interested in adding suicide intervention to their list of skills. The program has been made available to all government agencies, consumer/advocacy agencies, emergency service providers, schools and families to help reduce the incidence of suicide in Louisiana. A 20-member training group has conducted ASIST, Safe Talk, and Suicide Talk Trainings statewide. This series of evidenced-based trainings has reached over 2,500 people. Through the successful development of five suicide prevention coalitions in Shreveport, Lake Charles, Lafayette, Jefferson and Baton Rouge, 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.

Please see Criterion 1 for information about the *Louisiana Spirit Hurricane Recovery Program*, and the *Louisiana Spirit Oil Spill Recovery Program*. These programs are focused on addressing post-disaster mental health needs and other long term disaster recovery initiatives.

Although in recent years, crisis response has focused on hurricanes, the state also has worked towards developing a well-defined response plan for bioterrorism, pandemic flu, and other mass disasters,

which has been put to the test with the current response to the oil spill caused by the explosion of the British Petroleum rig in the Gulf. Collaborative relationships exist with local chapters of the Red Cross, Office of Homeland Security, Emergency Preparedness, the Office of Public Health, and the National Guard as well as other emergency management organizations. Regions/ LGEs have conducted statewide drills, meetings, and exercises with these entities to ensure an understanding of roles, responsibilities, and operations.

In examples of more specific service offerings, OBH provides staff members to all state-administered hospital emergency rooms. These staff members perform mental health screening as part of the admission process. OBH coordinates in-service training for emergency room doctors, nurses and other professional and para-professional staff. OBH also trains teachers and school administrators in disaster response procedures.

OBH, jointly with the Office of Emergency Preparedness, provides training to parish level police/ fire/ EMS workers charged with disaster response. Such training includes:

- 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.

Regions and LGEs report that they are very engaged and involved in activities involving crisis and emergency planning, and they are linked with cooperative agreements to other agencies. First responder teams have been developed in some regions, and regions have plans and procedures for staffing medical special needs shelters in the event of a crisis that requires evacuation. Communication needs for staff have resulted in extensive uses of technology. Many staff members have been issued cell phones and blackberries that can be used in emergencies. In addition, 800 Mhz radios are available for use in disasters. Employees have access to electronic bulletin boards or websites that allow communication between staff, supervisors, and administration

Evaluation of the effectiveness of crisis response is on-going, and most recently emphasized in the response to the oil spill. Some areas of the state (i.e., Regions 3, 4, and 5) have suffered through the consequences of all four hurricanes in three years, and now are dealing with the impact of the oil spill and have had an opportunity to exercise the lessons learned. Regions were successful in making improvements in their regional response following Katrina/ Rita, and their response to Gustav/ Ike proved to be excellent, in spite of severe damage to some of their clinics.

Crisis Intervention Training (CIT) for law enforcement has been well established in several regions/ LGEs to address behavioral health crises. Crisis Intervention Training (CIT) readies officers and dispatchers to assess and respond appropriately to calls involving adults with SMI and children with EBD. The CIT curriculum is being modified to incorporate specific components for adolescents/ youth. Many 911 emergency operators and dispatchers have been trained to provide essential information and linkages to services. Unfortunately, some programs have been dealt severe budget cuts.

Some regions/ LGEs have conducted specific training on co-occurring developmental disabilities and behavioral health disorders to community professionals, first responders, and emergency room (ER) staff. Continued dialogue with ER staff includes information on the utilization of community resources to maintain wellness and avoid crises.

Regions also have offered very specific trainings to hospital Emergency Department staff on topics such as: Psychiatric Assessment, Mental Status Exams, anxiety and depression, and dealing with risk in persons with personality disorders.

The Applied Suicide Intervention Skills Training (ASIST) that is described in Criterion 1 has resulted in trainings to suicide helpline staff, primary care physicians, contract providers, CMHC staff, and other interested stakeholders.

CRITERION 5
MANAGEMENT SYSTEMS – GRANT EXPENDITURE MANNER
LOUISIANA FY 2011 - ADULT & CHILD/YOUTH PLAN

INTENDED USE PLAN BY SERVICE CATEGORY
ADULT PLAN

ADULT INTENDED USE CATEGORIES & ALLOCATIONS

Service Category	Types of Services	Region/ LGE	Central Office/ State wide	Total Allocation
Adult Employment	Employment Programs; Development & Services	\$35,000	10,000	\$ 45,000
Advisory Council Support	RAC Support	\$30,436		\$ 30,436
Assertive Community Treatment (ACT)	ACT Outreach Services	\$75,948		\$ 75,948
Consumer Advocacy and Education	Consumer Education; Advocacy and Education; Family Organization Support, Supported Adult Education	\$1,500	\$40,000	\$ 41,500
Consumer Liaisons	Consumer Liaisons (not in contracts)	\$72,863		\$ 72,863
Consumer Monitoring and Evaluation	MIS; Consumer-Directed Service System Monitoring, Consumer Liaisons:	0	\$63,484	\$ 63,484
Consumer Support Services	Consumer Initiated Programs, Consumer-Education, Community Care Resources; Community Resource Centers, Case Management; Consumer Support; Medicaid Enrollment; Support and Empowerment	\$627,807	\$442,000	\$1,069,807
Crisis Response Services	Crisis Line, Crisis Stabilization, Crisis 24 hour screening & assessment, Mobile crisis response	\$36,380		\$ 36,380
Mental Health Treatment Services	Psycho-social Day Treatment; Forensic Program, Co-occurring Disorders Treatment	\$56,117		\$ 56,117
Planning Operations & System Development	Staffing for Bureau of Planning, Performance Partnerships and Stakeholder Involvement; Planning Council Office: Support Staff, Office Operations, member travel and training, MIS	0	\$160,546	\$ 160,546
Residential / Housing	Housing Development and Services; Foster Care; Group Homes Supervised Apartments; 24-hour residential Housing Support Services	\$222,106		\$ 222,106
Respite	Respite Services and Supports	0		
Staff Development	OMH Workforce Recruitment, Development and Retention, Staffing for Bureau of Workforce Development	0	\$165,971	\$ 165,971
Transportation	Community / Rural Transportation	\$32,892		\$ 32,892
Other Contracted Services	Comprehensive Mental Health Services; MIS Infrastructure Development; PODS (Public Outreach Depression Screening)	\$110,804	\$486,720	\$ 597,524
TOTAL		\$1,301,853	\$1,368,721	\$2,670,574

CRITERION 5
MANAGEMENT SYSTEMS – GRANT EXPENDITURE MANNER
LOUISIANA FY 2011 - ADULT & CHILD/YOUTH PLAN

INTENDED USE PLAN BY SERVICE CATEGORY
CHILD/YOUTH PLAN

C/ Y/ F INTENDED USE CATEGORIES & ALLOCATIONS

Service Category	Types of Services	Region/ LGE	Central Office/ State wide	Total Allocation
Advisory Council Support	RAC Support	\$30,500	0	\$30,000
Assertive Community Treatment		\$278,698	0	\$278,698
Consumer Advocacy and Education	Consumer Education; Advocacy and Education; Family Organization Support	\$1,500	\$111,400	\$112,900
Consumer Liaisons	Consumer Liaisons (not in contracts)	\$27,287	\$36,275	\$63,562
Consumer Monitoring and Evaluation	MIS; Consumer-Directed Service System Monitoring, Consumer Liaisons:	\$6,381	\$63,302	\$69,683
Crisis Response Services	Crisis Line, Crisis Stabilization, Crisis 24 hour screening & assessment, Mobile crisis response	\$193,106	0	\$193,106
Family Support Services	Family Support Services; Wraparound; Family Mentoring Program; Family Support Liaison and Program; Medicaid Enrollment; Parent Mentoring; Nurse Visitation Program, Parent Liaisons, Mentoring, Community Care Resources; Rural Mobile Outreach Programs, Family Training, Therapeutic Camp	\$621,123	\$123,936	\$745,059
Planning Operations and Systems Development	Staffing for Bureau of Planning, Performance Partnerships and Stakeholder Involvement, Planning Council Office: Support Staff, Office Operations, member travel and training, MIS	0	\$94,046	\$94,046
Residential / Housing	Housing Development and Services; Foster Care; Group Homes; Supervised Apartments Housing 24-hour residential Housing Support Services	0	0	0
Respite	Respite Programs	\$183,559	0	\$183,559
School-Based Mental Health Services	School-Based Clinic; School-Based Services, School Violence Prevention	\$80,920	0	\$80,920
Staff Development	OMH Workforce Recruitment, Development and Retention, Staffing for Bureau of Workforce Development	0	\$134,000	\$134,000
Transportation	Community / Rural Transportation	\$10,000	0	\$10,000
Other Contracted Services	Comprehensive Mental Health Services, Nurse Home Visitation Program, MIS Infrastructure Development, PODS (Public Outreach Depression Screening)	\$533,266	\$93,250	\$626,516
TOTAL		\$1,966,340	\$656,209	\$2,622,549

CRITERION 5
MANAGEMENT SYSTEMS – GRANT EXPENDITURE MANNER
LOUISIANA FY 2011 - ADULT & CHILD/YOUTH PLAN

INTENDED USE PLAN SUMMARY
BY REGION / LGE / CENTRAL OFFICE- STATE WIDE

FY 2011	Adult	C/Y	Intended Use Total
MHSD	\$ 90,414	\$ 295,656	\$ 386,070
CAHSD	\$ 126,645	\$ 253,373	\$ 380,018
SCLHSA	\$ 171,174	\$ 177,918	\$ 349,092
Region 4	\$ 170,415	\$ 190,247	\$ 360,662
Region 5	\$ 107,728	\$ 246,044	\$ 353,772
Region 6	\$ 114,983	\$ 230,706	\$ 345,689
Region 7	\$ 143,532	\$ 174,245	\$ 317,777
Region 8	\$ 157,426	\$ 171,276	\$ 328,702
FPHSD	\$ 145,681	\$ 153,020	\$ 298,701
JPHSA	\$ 73,855	\$ 73,855	\$ 147,710
Reg/ LGE Total	\$ 1,301,853	\$ 1,966,340	\$ 3,268,193
Central Office (State-wide)	\$ \$1,368,721	\$ 656,209	\$ 2,024,930
Grand Totals	\$ 2,670,574	\$ 2,622,549	\$ 5,293,123

Percentage of Block Grant Dollars Allocated to Adults:	50.45%
Percentage of Block Grant Dollars Allocated to Children/ Youth :	49.55%

<p style="text-align: center;">Intended Use Plan Notes</p> <p>If circumstances occur that prohibit expenditure of any portion of the Block Grant funds as intended, OBH will utilize the remaining funds for the purchase of Block Grant related equipment and supplies (e.g. computers, printers, software, projectors, tele-communication equipment/infrastructure/staff, etc.) and/or Phase IV medications and/or other appropriate expenditures.</p> <p>Beginning in FY 2010, the Area budgets (Areas A, B, & C) were folded into Central Office, since the Area structure does not exist anymore.</p> <p>The allocation to the Jefferson Parish Human Services Authority appears inconsistent with other regions because when the Authority was created their Block Grant dollars were replaced with State General Funds. Since then, this situation has been considered when new Block Grant dollars have been awarded or when funding has been decreased. Starting with FY 2011, all Regions/ LGEs will move towards an equal distribution over a three year period (1/10th of the funding allocated) See Planning Council Activities in Part B, Section IV and Appendix for details.</p>
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Complete details of the Intended Use Plans submitted from each Region, LGE, and Central Office is included in Appendix A of this document.

CRITERION 5
MANAGEMENT SYSTEMS – TRANSFORMATION ACTIVITIES
LOUISIANA FY 2011 - ADULT & CHILD/YOUTH PLAN

Table C
MHBG FUNDING FOR TRANSFORMATION ACTIVITIES -

	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the <i>actual or estimated</i> amount of MHBG funding that will be used to support this transformation goal in FY 2010.	
		Actual	Estimated
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	✓	N/A	\$279,465
GOAL 2: Mental Health Care is Consumer and Family Driven	✓	N/A	\$1,642,231
GOAL 3: Disparities in Mental Health Services are Eliminated	✓	N/A	\$448,165
GOAL 4: Early Mental Health Screening, Assessment, and referral to Services are Common Practice	✓	N/A	\$1,999,204
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	✓	N/A	\$344,360
GOAL 6: Technology Is Used to Access Mental Health Care and Information	✓	N/A	\$579,698
Total MHBG Funds		N/A	\$ 5,293,123

*Goal 5 of the Final Report of the *President's New Freedom Commission on Mental Health* states: *Excellent mental Health Care is Delivered and Research is Accelerated*. CMHS is authorized to conduct evaluations of programs and not research.

DESCRIPTION OF TRANSFORMATION ACTIVITIES

NOTE: Transformation activities are emphasized in the *New Freedom Commission & OMH Intended Use Categories Service Crosswalk* in Section II. This crosswalk highlights the efforts that Louisiana has taken to ensure that all Goals of the New Freedom Commission are addressed.

LOUISIANA FY 2011 BLOCK GRANT PLAN

Part C STATE PLAN Section III

PERFORMANCE INDICATORS, GOALS, TARGETS AND ACTION PLANS

ADULT PLAN

ADULT – GOALS TARGETS AND ACTION PLANSTransformation Activities **XX****Name of Performance Indicator:** Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	27,619	29,189	24,368	24,368
Numerator	--	--	--	
Denominator	--	--	--	

Table Descriptors:

Goal:	Adults who have been identified as having serious mental illness will have access to state mental health services
Target:	Access to mental health services will be provided for a greater number of adults with serious mental illness
Population:	Adults diagnosed with a Serious Mental Illness
Criterion:2:	Mental Health System Data Epidemiology
Indicator:	The number of adults who have a serious mental illness who receive mental health services from the Office of Mental Health during the fiscal year. NOMS Indicator # 1
Measure:	Estimated unduplicated count of adults (on caseload on the last day of the fiscal year) who have serious mental illness and who receive mental health services during the fiscal year (7/1 - 6/30) in an OMH community or inpatient setting.
Sources of Information:	CMHC-OMHIIS, JPHSA, PIP
Special Issues:	<p>NOTE: In the past, this indicator has been reported as the percentage of prevalence of adults who have a serious mental illness who receive mental health services from the Office of Mental Health during the fiscal year. These numbers are discussed in Criterion 2 of the Plan. In order to be consistent with NOMS Indicators, the measure is now reported as a number rather than as a percentage.</p> <p>The explanation of the reduction in numbers in FY 2010 is related to two very important changes:</p> <p>1) The Acute Units have moved out from under the OMH umbrella into the LSUHSC system, and as a result, it was anticipated that the numbers would be reduced in the fiscal year; however, as a target OMH attempted to maintain the number reported for FY 2009, which turned out to be unrealistic.</p> <p>2) OMHIIS now closes cases with no activity for nine months, resulting in what appears to be a reduction in the outpatient caseload. Previously, there were cases that had essentially no activity that were being counted within this statistic, artificially inflating the number.</p> <p>The FY 2010 actual figure is 24,368.</p>
Significance:	Setting quantitative goals to be achieved for the numbers of adults who are seriously mentally ill to be served in the public mental health system is a key requirement of the mental health Block Grant law
Action Plan:	See Special Issues. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Attempts to provide improved access to services is a priority for Louisiana.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	3.7%	5.8%	1.2%	1.2%
Numerator	10	13	4	
Denominator	274	226	327	

Table Descriptors:

Goal:	The Office of Mental Health will improve the quality of care that is provided.
Target:	The percentage of adults who are discharged from a state hospital and then re-admitted will either decrease or be maintained (30 days).
Population:	Adults diagnosed with Serious Mental Illness
Criterion:	1: Comprehensive Community-Based Mental Health Service Systems
Indicator:	The percentage of consumers discharged from state psychiatric hospitals and re-admitted to an Office of Mental Health inpatient program within thirty (30) days of discharge. NOMS Indicator #2
Measure:	30 Day Rates of Discharge and Re-admission Numerator = # Readmits to PIP Inpatient program within 30 days Denominator = # Patients Discharged from PIP State Hospital (not-unduplicated) Calendar year (Jan 1 - Dec 31)
Sources of Information:	Patient Information Program (PIP)
Special Issues:	Comparisons from year to year are difficult given changes in data collection that seem to re-occur even with attempts to make data collection standardized and consistent. In past years, different patient populations, (i.e., acute unit patients) have been included or excluded for various reasons. Beginning with FY 2008, <i>all</i> acute unit discharges (within hospital and free-standing) were excluded. The difference between the 2008 and 2009 numbers can be explained by noting that the number of readmits only rose by 3 while the denominator decreased significantly. Beginning in FY 2010, OMH undertook a hospital discharge initiative that has clearly been effective, as demonstrated by the 2010 statistics. FY 2010 Actual: $4 / 327 \times 100 = 1.2\%$
Significance:	Recidivism is one measure of treatment effectiveness.
Action Plan:	This target will improve or remain steady with the increased emphasis on the provision of EBPs in the community. The increase in the number of outpatient supports and services, statewide during the next fiscal year should continue to positively impact this indicator. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Attempts to provide improved services are a priority for Louisiana.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	12%	10.6%	9.2%	9.2%
Numerator	33	24	30	
Denominator	274	226	327	

Table Descriptors:

Goal:	The Office of Mental Health will improve the quality of care that is provided.
Target:	The number of adults who are discharged from a state hospital and then re-admitted will either decrease or be maintained (180 days).
Population:	Adults diagnosed with Serious Mental Illness
Criterion:	1: Comprehensive Community-Based Mental Health Service Systems
Indicator:	The percentage of consumers discharged from state psychiatric hospitals and re-admitted to an Office of Mental Health inpatient program within 180 days of discharge. NOMS Indicator #2
Measure:	180 Day Rates of Discharge and Re-admission Numerator = # Readmits to PIP Inpatient program within 180 days Denominator = # Patients Discharged from PIP State Hospital (not-unduplicated) Calendar year (Jan 1 - Dec 31)
Sources of Information:	Patient Information Program (PIP)
Special Issues:	Comparisons from year to year are difficult given changes in data collection that seem to re-occur even with attempts to make data collection standardized and consistent. In past years, different patient populations, (i.e., acute unit patients) have been included or excluded for various reasons. Beginning with FY 2008, <i>all</i> acute unit discharges (within hospital and free-standing) were excluded. Beginning in FY 2010, OMH undertook a hospital discharge initiative that has clearly been effective, as demonstrated by the 2010 statistics. FY 2010 Actual: $30/327 \times 100 = 9.2\%$.
Significance:	Recidivism is one measure of treatment effectiveness.
Action Plan:	This target will improve or remain steady with the increased emphasis on the provision of EBPs in the community. The increase in the number of outpatient supports and services, statewide during the next fiscal year should continue to positively impact this indicator. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Attempts to provide improved services are a priority for Louisiana.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based – Number of Practices

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	7	7	7	7
Numerator				
Denominator				

Table Descriptors:

Goal:	Adults served by the Office of Mental Health will be provided with appropriate recovery/resiliency-oriented, and evidence-based mental health services.
Target:	The number of evidence based practices (EBPs) available in the State will be maintained.
Population:	Adults diagnosed with a Serious Mental Illness
Criterion:	1: Comprehensive Community-Based Mental Health Service Systems
Indicator:	The number of accepted evidence-based practices offered in the State. NOMS Indicator #3.
Measure:	The number of accepted EBPs offered to OMH Adult consumers in the State
Sources of Information:	Annual Survey of Regions and Districts
Special Issues:	There are currently seven SAMHSA accepted Adult EBPs, including: 1. Supported Housing, 2. Supported Employment, 3. Assertive Community Treatment, 4. Illness Management & Recovery, 5. Medication Management, 6. Family Psycho-education, 7. Co-occurring Disorders. Each of these EBPs is offered in some geographic areas in the state, but they are not available state-wide. Since there are seven accepted EBPs, emphasis is not so much on increasing the numbers of EBPs offered, but on increasing the Regions/ LGEs in which these services are provided. Information from the Survey is based on Region and LGE report, and EBPs are not always evaluated for fidelity. Other promising practices are being developed and offered in various areas of the state. Actual: FY 2010 = 7.
Significance:	Evidence based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.
Action Plan:	See Special Issues. The EBPs that have been offered and that were reported on the Surveys have not all been held to fidelity. Because measurement of EBPs not held to fidelity may not be meaningful, education on EBPs, proper treatment focus, and accurate measurement continues to be emphasized. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Attempts to provide improved services are a priority for Louisiana.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based – Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	0.19%	0.81%	1.41%	1.41%
Numerator	68	305	533	
Denominator	35,002	37,735	37,885	

Table Descriptors:

Goal:	Adults served by the Office of Mental Health will be provided with appropriate recovery/resiliency-oriented mental health services.
Target:	The percentage of adults with SMI who receive supported housing when appropriate, as treatment goals dictate, will be maintained or increase.
Population:	Adults diagnosed with a Serious Mental Illness
Criterion:	1: Comprehensive Community-Based Mental Health Service Systems
Indicator:	The percentage of adults with SMI who receive Supported Housing services. NOMS Indicator #3
Measure:	Numerator: Number of adults with SMI who receive Supported Housing services. Denominator: Number of adults with SMI served (unduplicated)
Sources of Information:	Survey of Regions and Districts and Survey of Hospitals, OMHIIS, JPHSA, PIP
Special Issues:	Information from surveys is based on Region & LGE report, and EBPs are not evaluated for fidelity. The reason for the different figures by year may have to do with the fluctuations in housing initiatives post-hurricanes, such as the FEMA housing villages, and programs such as the Road Home and LA Spirit; as well as the lack of fidelity. There has been an increased emphasis on housing since the hurricanes affected so much of the available housing stock. MHSD did not collect data on EBPs , although they have been using Supported Housing. $FY2010 \text{ Actual} = 533 / 37,855 \times 100 = 1.41\%$
Significance:	Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.
Action Plan:	The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. It is believed that an improved emphasis on fidelity is resulting in better data, and education on the EBPs, proper treatment focus, and accurate measurement will continue to be a focus. Data collected from OMHIIS will be qualitatively better than that collected on the Survey of Regions and Districts/ Hospitals. This data source will be utilized starting in FY2011, so that EBP data will not rely solely on the Surveys. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	0.25%	0.52%	0.75%	0.75%
Numerator	86	195	284	
Denominator	35,002	37,735	37,885	

Table Descriptors:

Goal:	Adults served by the Office of Mental Health will be provided with appropriate recovery/resiliency-oriented mental health services.
Target:	The percentage of adults with SMI receiving Supported Employment will be maintained or increase
Population:	Adults diagnosed with a Serious Mental Illness
Criterion:	1: Comprehensive Community-Based Mental Health Service Systems
Indicator:	The percentage of adults with SMI who receive Supported Housing services. NOMS Indicator # 3
Measure:	Numerator: Number of adults with SMI who receive Supported Employment services. Denominator: Number of adults with SMI served (unduplicated)
Sources of Information:	Survey of Regions & Districts, Survey of Hospitals, OMHIIS, JPHSA, PIP
Special Issues:	Information from surveys is based on Region and LGE report, and EBP's are not evaluated for fidelity. The reason for the different figures by year may have to do with the fluctuations in employment initiatives post-hurricanes; and the lack of fidelity. Supported Employment initiatives as described in the Employment section have been successful in increasing the number of persons receiving this service. Although identified as an Adult Indicator, some employment programs are available to youth seeking employment. MHSD did not collect data for EBPs. FY2010 Actual = $284 / 37,855 \times 100 = 0.75\%$.
Significance:	Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes
Action Plan:	The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. It is believed that an improved emphasis on fidelity is resulting in better data, and education on the EBPs, proper treatment focus, and accurate measurement will continue to be a focus. Data collected from OMHIIS will be qualitatively better than that collected on the Survey of Regions and Districts/ Hospitals. This data source will be utilized starting in FY2011, so that EBP data will not rely solely on the Surveys. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	0.45%	1.22%	0.81%	1.22%
Numerator	158	459	307	
Denominator	35,002	37,735	37,885	

Table Descriptors:

- Goal:** Adults served by the Office of Mental Health will be provided with appropriate recovery/resiliency-oriented mental health services.
- Target:** The percentage of adults with SMI receiving Assertive Community Treatment will be maintained or increase
- Population:** Adults diagnosed with a Serious Mental Illness
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** The percentage of adults with SMI who receive Assertive Community Treatment services. NOMS Indicator #3
- Measure:** Numerator: Number of adults with SMI who receive Assertive Community Treatment services. Denominator: Number of adults with SMI served (unduplicated)
- Sources of Information:** Survey of Regions & Districts, Survey of Hospitals, OMHIIS, JPHSA, PIP
- Special Issues:** Information from surveys is based on Region & LGE report and EBP's are not evaluated for fidelity. JPHSA began to utilize ACT services during the fiscal year, resulting in a dramatic increase in this number in FY 2009. In addition, statewide trainings have occurred; however, continued workforce shortages have continued to be problematic in the field. Another factor that greatly influences the result is that **MHSD did not collect data for EBPs.**
FY 2010 Actual = $307 / 37,855 \times 100 = 0.81\%$.
- Significance:** Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.
- Action Plan:** Assertive Community Treatment is an EBP that has become a priority in the Regions and LGEs. As discussed in the FY 2009 plan, new ACT teams have been developed and have begun to operate. The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. It is believed that an improved emphasis on fidelity is resulting in better data, and education on the EBPs, proper treatment focus, and accurate measurement will continue to be a focus. Data collected from OMHIIS will be qualitatively better than that collected on the Survey of Regions and Districts/ Hospitals. This data source will be utilized starting in FY2011, so that EBP data will not rely solely on the Surveys. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	0.55%	3.75%	0.75%	0.75%
Numerator	192	1,417	285	
Denominator	35,002	37,735	37,885	

Table Descriptors:

- Goal:** Adults served by the Office of Mental Health will be provided with appropriate recovery/resiliency-oriented mental health services.
- Target:** The percentage of adults with SMI receiving Family Psychoeducation will be maintained or increase
- Population:** Adults diagnosed with a serious mental illness
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of adults with SMI who receive Family Psychoeducation
NOMS Indicator #3
- Measure:** Numerator: Number of adults with SMI who receive Family Psychoeducation services.
Denominator: Number of adults with SMI served (unduplicated).
- Sources of Information:** Survey of Regions & Districts, Survey of Hospitals, OMHIIS, JPHSA, PIP
- Special Issues:** Information from surveys is based on Region and LGE report, and EBP's are not evaluated for fidelity. There was a large increase in this number in FY 2009 due to the EBP being offered through ELMHS, thus inflating the number for FY 2009. Another factor that may influence the result is that **MHSD did not collect data for EBPs**. FY 2010 Actual = $285 / 37,855 \times 100 = 0.75\%$.
- Significance:** Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.
- Action Plan:** The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. It is believed that an improved emphasis on fidelity is resulting in better data, and education on the EBPs, proper treatment focus, and accurate measurement will continue to be a focus. Data collected from OMHIIS will be qualitatively better than that collected on the Survey of Regions and Districts/ Hospitals. This data source will be utilized starting in FY2011, so that EBP data will not rely solely on the Surveys. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator:

Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders (MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	2.96%	5.09%	3.15%	3.15%
Numerator	1,037	1,921	1194	
Denominator	35,002	37,735	37,885	

Table Descriptors:

Goal:	Adults served by the Office of Mental Health will be provided with appropriate recovery/resiliency-oriented mental health services.
Target:	The percentage of adults with SMI receiving Integrated Treatment of Co-Occurring Disorders - Mental Illness / Substance Abuse (MISA) will be maintained or increase
Population:	Adults diagnosed with a Serious Mental Illness
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems
Indicator:	The percentage of adults with SMI who receive Integrated Treatment of Co-Occurring Disorders. NOMS Indicator #3
Measure:	Numerator: Number of adults with SMI who receive Integrated Treatment of Co-Occurring Disorders; Mentally ill / Substance abuse (MISA) services. Denominator: Number of adults with SMI served (unduplicated).
Sources of Information:	Survey of Regions & Districts, Survey of Hospitals OMHIIS, JPHSA, PIP
Special Issues:	Information from surveys is based on Region & LGE report, and EBP's are not evaluated for fidelity. The fidelity of this EBP is improving. With the passage of legislation creating the Office of Behavioral Health, this number is expected to increase. A factor that may influence the result is that MHSD did not collect data for EBPs . FY 2010 Actual = 1194/ 37,855 X 100 = 3.15%.
Significance:	Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.
Action Plan:	The consolidation of the offices of Mental Health and Addictive Disorders into the Office of Behavioral Health will improve the identification and treatment of co-occurring disorders. The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. It is believed that an improved emphasis on fidelity is resulting in better data, and education on the EBPs, proper treatment focus, and accurate measurement will continue to be a focus. Data collected from OMHIIS will be qualitatively better than that collected on the Survey of Regions and Districts/ Hospitals. This data source will be utilized starting in FY2011, so that EBP data will not rely solely on the Surveys. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	3.27%	8.46%	1.57	1.57%
Numerator	1,146	3,191	595	
Denominator	35,002	37,735	37,885	

Table Descriptors:

- Goal:** Adults served by the Office of Mental Health will be provided with appropriate recovery/resiliency-oriented mental health services.
- Target:** The percentage of adults with SMI receiving Illness Self-Management (Illness Management and Recovery) will be maintained or increase
- Population:** Adults diagnosed with a Serious Mental Illness
- Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems
- Indicator:** The percentage of adults with SMI who receive Illness Management and Recovery services. NOMS Indicator #3
- Measure:** Numerator: Number of adults with SMI who receive Illness Self-Management services.
Denominator: Number of adults with SMI served (unduplicated).
- Sources of Information:** Survey of Regions & Districts, Survey of Hospitals, OMHIIS, JPHSA, PIP
- Special Issues:** Information from surveys is based on Region & LGE report and EBP's are not evaluated for fidelity. The fidelity of this measure is improving; yet due to fiscal constraints, the target was not met. Another factor that may influence the result is that **MHSD did not collect data for EBPs**. FY 2010 Actual = $595 / 37,885 \times 100 = 1.57\%$.
- Significance:** Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.
- Action Plan:** The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. It is believed that an improved emphasis on fidelity is resulting in better data, and education on the EBPs, proper treatment focus, and accurate measurement will continue to be a focus. Data collected from OMHIIS will be qualitatively better than that collected on the Survey of Regions and Districts/ Hospitals. This data source will be utilized starting in FY2011, so that EBP data will not rely solely on the Surveys. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	3.11%	22.50%	4.74	4.74
Numerator	1,090	8,492	1795	
Denominator	35,002	37,735	37,885	

Table Descriptors:

- Goal:** Adults served by the Office of Mental Health will be provided with appropriate recovery/resiliency-oriented mental health services.
- Target:** The percentage of adults with SMI who receive Medication Management services will be maintained or increase.
- Population:** Adults diagnosed with serious mental illness
- Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems
- Indicator:** The percentage of adults with SMI who receive Medication Management services.
NOMS Indicator #3
- Measure:** Numerator: Number of adults with SMI who receive Medication Management services.
Denominator: Number of adults with SMI served (unduplicated).
- Sources of Information:** Survey of Regions & Districts, Survey of Hospitals, OMHIIS, JPHSA, PIP
- Special Issues:** Information from surveys is based on Region and LGE report, and EBP's are not evaluated for fidelity. Due to fiscal and workforce constraints, the Target was not met. Another factor that may influence the result is that **MHSD did not collect data for EBPs**, although they report having used Med Management. FY 2010 Actual = 1795/ 37,885= 4.74%.
- Significance:** Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.
- Action Plan:** The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. It is believed that an improved emphasis on fidelity is resulting in better data, and education on the EBPs, proper treatment focus, and accurate measurement will continue to be a focus. Data collected from OMHIIS will be qualitatively better than that collected on the Survey of Regions and Districts/ Hospitals. This data source will be utilized starting in FY2011, so that EBP data will not rely solely on the Surveys. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	99%	99%	99%	99%
Numerator	1067	1394	1209	
Denominator	1080	1407	1223	

Table Descriptors:

- Goal:** Adults served by the Office of Mental Health will be provided with appropriate recovery/resiliency-oriented mental health services.
- Target:** Consumers will rate the quality and appropriateness of care they are being provided by the Office of Mental Health positively
- Population:** Adults diagnosed with a Serious Mental Illness
- Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems
- Indicator:** The percentage of Office of Mental Health consumers who rate the quality and appropriateness of services as positive. NOMS Indicator # 4
- Measure:** Numerator: Number of OMH consumers surveyed during the fiscal year (7/1 - 6/30) through C'est Bon process that report an overall grade of C or better. Denominator: Total number of OMH consumers surveyed.
- Sources of Information:** C'est Bon Survey/ MHSIP # 10, 12-16, 18-20
- Special Issues:** This indicator continues to hold steady, and is robust with regard to the numbers of clients surveyed. The indicator is suggested by CMHS resulting in data appropriate for national comparisons.
 Definitions: C'est Bon: Consumer Evaluation of Service Team
 C'est Bon Process: Consumer-to-consumer administered survey adapted from MHSIP Report Card prototype and piloted in Louisiana
 The target will remain high, given the importance of this measure.
 FY 2010 Actual: $1,209 / 1223 \times 100 = 99\%$
- Significance:** Persons receiving mental health services should be satisfied with those services; and evaluation of quality and appropriateness of care are valid measures of satisfaction
- Action Plan:** The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Attempts to continue to obtain greater satisfaction with mental health care will remain a priority for Louisiana.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Increase/ Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	N/A	N/A	19.5%	19.5%
Numerator	N/A	N/A	8,332	
Denominator	N/A	N/A	42,820	

Table Descriptors:

- Goal:** Adults served by the Office of Mental Health and who have a serious mental illness will be able to be employed and maintain their employment.
- Target:** A greater number of individuals with serious mental illness who are receiving mental health services from the Office of Mental Health will be able to secure a job and if working, be able to retain their employment.
- Population:** Adults diagnosed with a Serious Mental Illness
- Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems
- Indicator:** The percentage of adults who have a serious mental illness who receive mental health services from the Office of Mental Health who are capable of working and who have a job. NOMS Indicator # 5; Table 4 of URS
- Measure:** Numerator: Number of Persons Employed: Competitively Employed Full or Part-time (Includes Supported Employment). Unduplicated within program (community)
Denominator: [Employed: Competitively Employed Full or Part-time (includes Supported Employment) + Unemployed + Not in Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc.)] Note: This excludes persons whose employment status was “Not Available”.
- Sources of Information:** OMHIIS
- Special Issues:** This was a new indicator for the state. The initial data collected will be used as a baseline. Currently, this data is primarily ascertained at admission only; and therefore, the impact of treatment at an OMH facility is not being captured. Employment programs have been severely impacted by both the hurricanes, and the high levels of unemployment due to the economic crisis. FY 2010 Actual: $8,332 / 42,820 \times 100 = 19.5\%$
- Significance:** Measuring the number of adults with serious mental illness who are able to work and remain in the workforce, as a result of receiving mental health services, is a significant component of the Recovery movement.
- Action Plan:** The reporting of this information at each re-assessment/ update or discharge will need to be emphasized in order to give meaning to this Indicator. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Increased employment and retained employment are important issues that warrant a high priority, and supported employment programs are even more critical and will be promoted.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	N/A	N/A
Denominator	N/A	N/A	N/A	N/A

Table Descriptors:

- Goal:** Adults served by the Office of Mental Health and who have serious mental illness will not require the intervention of law enforcement.
- Target:** The number of individuals with a serious mental illness and are arrested, who are receiving mental health services from the Office of Behavioral Health will decrease.
- Population:** Adults diagnosed with Serious Mental Illness
- Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems
- Indicator:** The percentage of adults who have a serious mental illness who receive mental health services from the Office of Mental Health who are arrested in the year subsequent to receiving services compared to the percentage arrested in the year prior to receiving services. NOMS Indicator # 6; URS Table 19A.
- Measure:** Numerator: Number of people who were arrested in T1 who were not rearrested in T2 (new and continuing clients combined).
Denominator: Number of people arrested in T1 (new and continuing clients combined).
- Sources of Information:** MHSIP Consumer Survey
- Special Issues:** This is a new indicator for the state that involves reporting on changes in client status over time. OMH plans to use the Telesage Outcome Measurement System (TOMS) to accomplish this. The TOMS is scheduled for implementation as an objective of the Data Infrastructure Grant (DIG). Data was not collected during Fiscal Year 2010. For Fiscal Year 2011, data will be collected via TOMS, and baselines set thereafter.
- Significance:** Measuring the number of adults with serious mental illness who have decreasing exposure to arrest/ incarceration is a significant factor contributing to improved community function.
- Action Plan:** See special issues. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	N/A	N/A	2.9%	2.9%
Numerator	N/A	N/A	1,293	
Denominator	N/A	N/A	44,228	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will live in safe, secure, stable housing.

Target: A decreasing number of individuals with serious mental illness who are receiving mental health services from the Office of Mental Health will need to use shelters for temporary residence or are homeless.

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of adults who have a serious mental illness who receive mental health services from the Office of Mental Health who are homeless or who have been living in shelters. NOMS Indicator # 7; URS Table 15.

Measure: Numerator: Number of Persons Homeless.

Denominator: From URS Table, all persons with living situation, excluding (minus) persons with Living Situation Not Available.

Sources of

Information: OMHIIS, JPHSA and PIP. Persons served unduplicated within and across programs.

Special Issues: This is a new indicator for the state. The initial data collected will be used as a baseline. Currently, this data is primarily ascertained at admission only; and therefore, the impact of treatment at an OMH facility is not being captured. $FY\ 2010\ Actual = 1,293 / 44,228 \times 100 = 2.9\%$

Significance: Measuring the number of adults with serious mental illness who are homeless or in shelters will assist in developing resources to provide adequate housing opportunities for individuals, a significant component of the Recovery movement.

Action Plan: The reporting of this information at each re-assessment/ update or discharge will need to be emphasized in order to give meaning to this Indicator. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Housing stability is an important issue that warrants a high priority.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Increased Social Supports/ Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	N/A	75%	73%	73%
Numerator	N/A	1,057	892	
Denominator	N/A	1,414	1,230	

Table Descriptors:

- Goal:** Adults with severe mental illness served by the Office of Mental Health will have adequate social support.
- Target:** Adults with serious mental illness who report that they agree or strongly agree that they are happy with their interpersonal relationships and feelings of being connected with their community will increase.
- Population:** Adults diagnosed with a Serious Mental Illness
- Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems
- Indicator:** The percentage of adults who have a serious mental illness who receive mental health services from the Office of Mental Health that report agreeing or strongly agreeing with statements on the MHSIP consumer survey related to social connectedness. NOMS Indicator #8.
- Measure:** Estimated number of adults who have serious mental illness, who are receiving services during the fiscal year (7/1 – 6/30) who report that they agree or strongly agree (score 1 or 2) with statements on the MHSIP survey addressing social connectedness (#33 to 36) divided by the total number of consumers sampled, expressed as a percentage.
- Sources of Information:** MHSIP standard consumer survey/ C'est Bon Survey
- Special Issues:** This was a new indicator for the state in 2009, and as a baseline measurement, the target was set as maintaining the 2009 number.
FY 2010 Actual = $892 / 1,230 \times 100 = 73\%$ (95% Confidence Interval 70% - 75%)
FY 2009 Actual = $1057 / 1414 \times 100 = 75\%$ (95% Confidence Interval 72% - 77%)
The 95% confidence intervals overlap indicating that the difference in the two years is not statistically significant.
- Significance:** Measuring the number of adults with serious mental illness who experience good social connectedness will be an important indicator of the prognosis for recovery.
- Action Plan:** The NOMS questions, including social connectedness were first included in the C'est Bon survey in July, 2008. This indicator is recognized as being important and with further data, the plan for improvement will be developed. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	N/A	76%	72%	72%
Numerator	N/A	1068	879	
Denominator	N/A	1414	1,230	

Table Descriptors:

- Goal:** Adults with severe mental illness served by the Office of Mental Health will report having an improved ability to take care of themselves and independently manage their affairs.
- Target:** Adults with serious mental illness who report that they agree or strongly agree that they are better able to manage themselves and situations to meet their needs will increase.
- Population:** Adults diagnosed with a Serious Mental Illness
- Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems
- Indicator:** The percentage of adults who have a serious mental illness who receive mental health services from the Office of Mental Health that report agreeing or strongly agreeing with statements on the MHSIP consumer survey related to improved level of functioning. (NOMS Indicator #9, in Development.)
- Measure:** Estimated number of adults who have serious mental illness, who are receiving services during the fiscal year (7/1 – 6/30) who report that they agree or strongly agree (score 1 or 2) with statements on the MHSIP survey addressing functionality (#28 to 32) divided by the total number of consumers sampled, expressed as a percentage.
- Sources of Information:** MHSIP standard consumer survey. / C'est Bon Survey
- Special Issues:** This was a new indicator for the state in 2009, and as a baseline measurement, the target was set as maintaining the 2009 number.
FY 2010 Actual = $879 / 1,230 \times 100 = 72\%$ (95% Confidence Interval 69%- 74%)
FY 2009 Actual = $1068 / 1414 \times 100 = 76\%$ (95% Confidence Interval 73% - 78%)
The 95% confidence intervals overlap indicating that the difference in the two years is not statistically significant.
- Significance:** Measuring the number of adults with serious mental illness who experience improved functional ability will be an important indicator of the prognosis for recovery. It is also a NOMS measure.
- Action Plan:** The NOMS questions, including level of functioning, were first included in the C'est Bon survey in July, 2008. This indicator is recognized as being important, and with further data, the plan for improvement will be developed. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Consumer Housing/ Homeless Access (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	92%	86%	88%	88%
Numerator	996	635	422	
Denominator	1080	741	478	

Table Descriptors:

- Goal:** People with serious mental illness have assistance with their housing needs as part of access to appropriate, adequate mental health services
- Target:** Consumers who report they were satisfied with the assistance given to them by OMH in improving their housing situation will increase.
- Population:** Adults diagnosed with Serious Mental Illness
- Criterion:** 4: Targeted Services to Rural, Homeless, and Older Adult Populations
- Indicator:** The percentage of OMH consumers who rate the assistance they received in improving their housing with a 'C' or better.
- Measure:** Numerator: the number of OMH and MHR consumers surveyed who give C'est Bon Survey Questionnaire a grade of 'C' or better during the fiscal year (7/1- 6/30). Denominator: Total number of OMH and MHR consumers surveyed. (Item #24 - *How would you grade how well the services have helped you improve your housing situation?*)
- Sources of Information:** C'est Bon Survey
- Special Issues:** The numerator and denominator are noted to be different when comparing the actual statistics, due in part to difficulties hiring/ keeping consumer interviewers, costs of travel, difficulties in finding motel accommodations, etc. in the state. This has resulted in a varying sample sizes. This performance indicator was remarkably consistent until FY 2009, after the FEMA post-hurricane housing assistance was stopped. FY 2010 Actual: 422 / 478 X 100= 88 %
- Significance:** Safe, stable housing is a key factor in successful community living.
- Action Plan:** OMH housing coordinators continue to attempt to alleviate the problems encountered in each Region by improved collaboration with community and faith-based organizations. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Continuity of Care (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	8.3	8.5	8.7	8.7
Numerator	631	598	575	
Denominator	76	70	66	

Table Descriptors:

- Goal:** Adults served by the Office of Mental Health will be provided with appropriate recovery/resiliency-oriented mental health services.
- Target:** The average number of days between a consumer's discharge from a psychiatric hospital and a follow-up visit to a community mental health clinic (CMHC) will be at the lowest level possible in order to maintain continuity of care
- Population:** Adults diagnosed with a Serious Mental Illness
- Criterion:** 2: Mental Health System Data Epidemiology
- Indicator:** Average number of days between a state psychiatric hospital discharge and a CMHC aftercare appointment
- Measure:** Days reported
Average = Number of days until follow-up divided by number of discharges
Numerator = sum of days from discharge to CMHC admit
Denominator = Discharges with aftercare visit within 45 days
Time period (Lag fiscal year) - April 1 - March 31
- Sources of Information:** OMHIIS, JPHSA, PIP
- Special Issues:** This data now *excludes data from all acute units*. The numbers reported for 2008 have been adjusted to provide for accurate comparisons. In previous years reporting, the data included acute units within hospitals, because these numbers had not been separated out. At discharge, patients are routinely given 3 weeks supply of medications, so 21 days is the absolute limit for clients to be seen in the outpatient setting. Although this target was not technically met, the difference is very minor, and not particularly meaningful when comparisons are made between 8.5 days and 8.7 days. This target was set very conservatively at a maintenance level due to budgetary and workforce constraints, including layoffs of personnel and a hiring freeze. FY 2010 Actual = $575 / 66 = 8.7$ (average)
- Significance:** One of the strongest predictors of community success after discharge from a state hospital is continuity of care
- Action Plan:** Efforts to decrease the number of days between discharge and follow-up aftercare will continue to be made, and should improve with the availability of more outpatient services. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Planning Council Satisfaction (percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	100%	100%	86% (note below)	86%
Numerator		23	49	
Denominator		23	57	

Table Descriptors:

Goal:	Consumers, family members, and other stakeholders are involved in the policy decisions, planning, and monitoring of the mental health system
Target:	Individuals who represent adults on State Planning Councils should regard and report their participation as a positive experience
Population:	Adults Diagnosed with a Serious Mental Illness
Criterion:	5: Management Systems
Indicator:	The percentage of Louisiana Mental Health Planning Council members giving positive feedback regarding their involvement in the Council
Measure:	*In the past, this was the percentage of Louisiana Mental Health Planning Council members who rate their involvement in the Council with a grade of 'C' or better. Beginning with FY2010, the Planning Council voted to change this Target to 80% with a grade of 'B' or better.
Sources of Information:	Planning Council meeting evaluation surveys, Planning Council Executive Committee Reports
Special Issues:	Because this indicator has been met for two years, a change was made to the measure (see 'Measure' above). FY 2010 Actual: $49/57 \times 100 = 86\%$.
Significance:	If council members report that they are involved, it is likely that OMH is providing an environment conducive to stakeholder partnership
Action Plan:	The Planning Council will continue to survey its members at each meeting and request suggestions for improvement. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Regional Advisory Councils

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	90	100	100	100
Numerator	9	10	10--	
Denominator	10	10	10--	

Table Descriptors:

- Goal:** Consumers, family members, and other stakeholders are involved in the policy decisions, planning, and monitoring of the mental health system
- Target:** All local and Regional Advisory Councils will be fully constituted, trained, active, and formally linked to the Louisiana Mental Health Planning Council
- Population:** Adults diagnosed with a Serious Mental Illness
- Criterion:** 5: Management Systems
- Indicator:** The percent of fully constituted and trained Regional Advisory Councils (RAC's) formally linked to the Louisiana Mental Health Planning Council.
 Numerator: number of fully constituted and trained RACs formally linked to the Planning Council
 Denominator: number of Regions / LGEs (10)
- Measure:** Count of fully constituted, trained, active Regional Advisory Councils on June 30 of the fiscal year as verified by Planning Council Regional Advisory Council training staff
- Sources of Information:** Regional Advisory Councils, Planning Council Executive Committee Reports, Survey of Regions & Districts, and Survey of Hospitals
- Special Issues:** The Planning Council Liaison has been working diligently with the regions/ LGEs to have fully functioning and engaged RACs. The help offered has been warmly accepted and it is recognized that the progress made thus far will require continued effort. FY 2010 Actual: $10/10 \times 100 = 100\%$
- Significance:** Local planning and advocacy is the cornerstone of statewide system change and progress
- Action Plan:** The Planning Council Liaison will continue to provide training and support to RACs, reporting to OBH and the Planning Council when there are problems. LGEs have been made aware that a RAC is necessary in order to be recipients of Block Grant funding. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

LOUISIANA FY 2011 BLOCK GRANT PLAN

Part C STATE PLAN Section III

PERFORMANCE GOALS AND ACTION PLANS TO IMPROVE THE SERVICE SYSTEM

CHILD/ YOUTH PLAN

CRITERION 1
COMPREHENSIVE COMMUNITY-BASED MENTAL HEALTH SERVICES
SYSTEM OF CARE & AVAILABLE SERVICES
LOUISIANA FY 2011 - CHILD/YOUTH

EMERGENCY RESPONSE

The State of Louisiana continues to recover from hurricanes that have changed the way that mental healthcare is delivered in the state. The state was obviously challenged by Hurricanes Katrina and Rita in 2005. Then after a short reprieve, the Louisiana gulf coast was hit again in September of 2008 by Hurricane Gustav. Gustav hit the region to the west of New Orleans, squarely targeting the metropolitan Baton Rouge area; including the Office of Mental Health administrative headquarters and the heart of the government for the entire state. Following on the heels of Gustav, Hurricane Ike impacted the southwest area of the state previously affected by Hurricane Rita. Most recently, the explosion of the Deep Water Horizon/British Petroleum oil rig resulting in the catastrophic oil spill off the coast of Louisiana has once again tested the resolve of Louisiana citizens.

Emergency preparedness, response and recovery have become a part of every healthcare provider's job description, and employees have learned that every disaster is different, often requiring new learning and flexibility. As an example, employees of OMH are now on standby alert status should a storm threaten the coast, and all employees are expected to be active during a crisis. All Louisiana families are encouraged to "*Get a Game Plan*" (<http://getagameplan.org/>) in order to be prepared for a crisis, should one strike. Clinicians in mental health clinics have made a point of discussing disaster readiness with clients to ensure that they have needed medications and other necessities in the case of an evacuation or closed clinics.

Although 'Emergency Response' in the state had become somewhat synonymous with hurricane response, the lessons learned from the hurricanes apply to disaster response of any kind.

Louisiana Spirit Hurricane Recovery Crisis Counseling Program

Louisiana Spirit was a series of FEMA/SAMHSA service grants funded through the Federal Emergency Management Agency and administered through the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. The Louisiana Office of Mental Health was awarded a federal grant for the Crisis Counseling Assistance and Training Program (CCP) in Louisiana, which focused on addressing post hurricane disaster mental health needs and other long term disaster recovery initiatives, in coordination with other state and local resources. Crisis Counseling Programs are an integral feature of every disaster recovery effort and Louisiana has used the CCP model following major disasters in the state since Hurricane Andrew in 1992. The CCP is implemented as a supplemental assistance program available to the United States and its Territories, by the Federal Emergency Management Agency (FEMA). Section 416 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 1974 authorizes FEMA to fund mental health assistance and training activities in areas which have been Presidentially declared a disaster.

These supplemental funds are available to State Mental Health Authorities through two grant mechanisms: (1) the Immediate Services Program (ISP) which provides funds for up to 60 days of services immediate following a disaster declaration; and (2) The Regular Services Program (RSP)

that provides funds for up to nine months following a disaster declaration. Only a State or federally-recognized Indian tribe may apply for a crisis counseling grant.

In the fall of 2008, upon receiving the Presidential disaster declaration for Hurricane Gustav, OMH conducted a needs assessment to determine the level of distress being experienced by disaster survivors and determined that existing State and local resources could not meet these needs. Fifty-three parishes were declared disaster areas for Gustav; they were awarded in four separate declarations as the State appealed the decisions. Louisiana immediately applied for a Crisis Counseling grant for Gustav while in the process of phasing down the Katrina and Rita grants. The grant was awarded in late September of 2008. Disaster mental health interventions include outreach and education for disaster survivors, their families, local government, rescuers, disaster service workers, business owners, religious groups and other special populations. CCPs are primarily geared toward assisting individuals in coping with the extraordinary distress caused by the disaster and connecting them to existing community resources.

The CCP did not provide long term, formal mental health services such as medications, office-based therapy, diagnostic and assessment services, psychiatric treatment, substance abuse treatment or case management; survivors were referred to other entities for these services. CCPs provided short-term interventions with individuals and groups experiencing psychological reactions to a major disaster and its aftermath. In this model, community outreach is the primary method of delivering crisis counseling services and it consists primarily of face-to-face contact with survivors in their natural environments in order to provide disaster-related crisis counseling services. Crisis counseling services include: Information/Education Dissemination, Psychological First Aid, Crisis/Trauma Counseling, Grief & Loss Counseling, Supportive Counseling, Resiliency Support, Psychosocial Education, and Community Level Education & Training.

The Louisiana Spirit Hurricane Recovery program operated under the Gustav grants (DR-1786-LA ISP and DR-1786-LA RSP), from October 2008 through mid January 2010; the program employed a diverse workforce of up to 276 staff members. Management and oversight of the program was provided by a state-level executive team dedicated to the support of all operations of the project.

Louisiana Spirit was designed to facilitate integration with other recovery initiatives, rather than compete with them. The Louisiana Spirit state-level organizational structure was designed to continuously be in contact with recovery initiatives throughout Louisiana and coordinate its activities with these other recovery operations. After Hurricane Gustav, there were fewer resources available to assist with hurricane related needs than were available after Hurricane Katrina in 2005. Each service area continuously strived to keep up with changing community resources to share with survivors and other community entities.

The goal of Louisiana Spirit is to deliver services to survivors who are diverse in age, ethnicity, and needs. Extensive ongoing evaluation of the program included assessment of the services provided, the quality of the services provided, the extent of community engagement, and monitoring of the health and recovery of the entire population. The evaluation plan for Louisiana Spirit is multifaceted to reflect the ecological nature of the program seeking to promote recovery among individuals, communities, and the entire population of Louisiana. The assessment component of Louisiana Spirit strived to answer the question of the absolute number of people served and how the services were distributed across geographic areas, demographic groups, risk categories and time. To this end, each of the state-level administrative staff members was responsible for ensuring fidelity to the CCP model and expectations as directed by SAMHSA/ FEMA.

SAMHSA/FEMA also required CCPs to collect information to provide a narrative history-a record of program activities, accomplishments and expenditures. Louisiana Spirit collected data on a weekly basis from all providers which was analyzed by the Quality Assurance Analyst and also sent to SAMHSA for further analysis and comparison with data from all the other Immediate Services Program and Regular services Program Crisis Counseling Programs in the nation. The different service areas also compiled a narrative report to Louisiana Spirit headquarters on a bi-weekly basis. From Gustav's inception in September 2008 through January 12, 2010 a total of 514,535 face-to-face services were provided. 97,681 of these were individual contacts lasting over 15 minutes, 335,650 of these were brief contacts lasting less than 15 minutes and 81,204 contacts were classified as participants in groups.

To help to monitor geographic dispersion/reach/engagement, the number of individual and group counseling encounters for a given week/month/quarter were tallied by zip code and displayed graphically as a check of whether communities were being reached in accord with the program plan and community composition. To monitor demographic dispersion/reach/engagement, the individual encounter data was broken down by race, ethnicity and preferred language as one indicator of how well the program was reaching and engaging targeted populations.

Federal funding for the Louisiana Spirit Gustav program ended June 30, 2010; all direct services ceased January 12, 2010. The time from mid-January through June was spent fiscally and programmatically closing out the program. While not directly addressing the needs of children, the influence of this program on families and children cannot be denied.

Louisiana Spirit Oil Spill Recovery Program

After the Deep Water Horizon/British Petroleum Oil Spill off the Louisiana coastline on April 20, 2010, the State of Louisiana anticipated that the slowly unfolding disaster would have mental, emotional and behavioral health tolls on the lives of residents who had been impacted. The State decided to utilize 1.1 million of the 25 million dollars given to each coastal state through the Oil Spill Liability Trust Fund to provide crisis counseling services to those impacted. The decision was made to utilize a program design similar to what had been funded by the Robert T. Stafford Disaster Relief and Emergency Assistance Act. The Louisiana Spirit Coastal Recovery Counseling Program design was modeled after the successful Louisiana Spirit Hurricane Recovery Program which is described above.

The Louisiana Spirit Coastal Recovery Counseling Program utilized dyad teams to reach out to residents and workers who were dealing with the aftermath of the oil spill. Community outreach is the primary method of delivering crisis counseling services and it consists primarily of face-to-face contact with survivors in their natural environments in order to provide disaster-related crisis counseling services. Crisis counseling services include: Information/Education Dissemination, Psychological First Aid, Crisis/Trauma Counseling, Grief & Loss Counseling, Supportive Counseling, Resiliency Support, Psychosocial Education, and Community Level Education & Training. In addition to the crisis counseling and information and referral sources, the program also utilized the media to provide messaging regarding services available after 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 and Terrebonne. The sites where workers who were impacted were seen included: oil spill claims centers, oil spill recovery sites where workers congregated,

animal recovery sites, emergency operations centers, resource distribution sites, businesses which had lost revenue because of the spill, and various community events where residents were likely to be present.

As with previous Louisiana Spirit programs, this project is designed to work with existing programs and resources. These resources include: the Department of Social Services, the Governor's Office of Homeland Security Emergency Preparedness, the local governmental entities such as parish presidents and police juries as well as the local non-governmental entities such as non-profit and faith based organizations. Within these various agencies, not only are adults targeted, but children and youth as well.

To date, the program has 45 field employees. This includes six team leaders, 15 crisis counselors who have at a minimum a master's degree in a counseling related field, 12 outreach workers with a minimum of a bachelors' degree, three community cultural liaisons familiar with the local populations, five first responders and four stress managers. Additional program staff include a program director and two administrative assistants.

From May 21 through July 20, more than eight thousand five hundred (8,500) direct face-to-face contacts have been provided. These contacts included individual crisis counseling sessions lasting more than fifteen minutes, brief educational and supportive encounters lasting fifteen minutes or less and group participants. A public/private community advisory group is being established to ensure culturally responsive services that are transparent and specific to address the local needs of the affected communities.

At the time of the writing of the 2011 Block Grant Application, the recovery program continues to unfold and is ongoing.

The BEST (formerly Access)

The Access Program was a community-based counseling program that operated through the Department of Health and Hospitals, Office of Mental Health. The program was originally created during the review and evaluation of the state's mental health disaster response, post-Katrina; and was a direct response to the lingering mental health crisis. The program evolved into the Behavioral & Emotional Support Team (BEST) which is funded with State General Funds. This program now provides services to persons affected by the BP Deepwater Horizon oil spill in the Gulf of Mexico who are in need of emotional and behavior health services. The BEST team members provide emotional and behavioral health specialized crisis counseling services, including individual and group counseling support services for citizens who typically would not have direct access to emotional and behavioral health services, due to being uninsured, underinsured, poor, homeless / at risk of becoming homeless, elderly, single and pregnant, adjudicated (youth & adults), substance abusers and/or wayward at-risk youth.

The program was in the process of transitioning into a *child and youth only* services model in May, 2010 in anticipation of the new OBH administration. Once the oil spill in the Gulf occurred, the Best program was commissioned to reassign its activities to perform duties consistent with the former LA Spirit Hurricane Recovery Program. The expectation is that the BEST program will continue its efforts in meeting the mental health needs of children and youth in the New Orleans area once the LA Spirit Coastal Recovery Counseling program concludes its services to the community.

The goal of BEST is to serve citizens (including children, youth and families) in the community, acting as a transition between the initial crisis and through the waiting period, prior to receiving assessment and treatment services for mental health related issues. The BEST Program also has provided citizens with a swift support service response that often prevents emotional crises from escalating, while often negating the need for hospitalization. BEST accepts referrals from recovery organizations, community centers, public health clinics and the private sector.

The program uses a team approach, using dyads consisting of a master's level Crisis Counselor, specializing in social work or counseling, and a paraprofessional Resource Linkage Coordinator. Together these dyads provide immediate crisis intervention support and resource information; with a focus on empowering the client to regain control of their life, develop self-help skills to manage future crises, and avoid disruptive and costly hospitalization. All of the services provided by the Access team take place in the client's home or in a community-based location.

The BEST (and previously ACCESS) has established networks with homeless and domestic violence shelters/ missions, public health clinics, youth training centers, community centers, churches, residential facilities, juvenile justice programs, public schools, food banks and many other community support organizations.

Louisiana Spirit ACCESS/BEST services staff completed the following services in Jefferson, Orleans, Plaquemines and St. Bernard Parishes from December, 2008 through February, 2010, prior to the oil spill:

Crisis Counseling Assistance and Training Program (CCP) Grant:

- 3,582 individual crisis counseling sessions with 2,560 survivors (at least 15 minutes each)
- 716 group crisis counseling sessions with a total of 7,737 participants (average of 11 participants per group)
- 214 public education sessions with a total of 4,151 participants (average of 19 participants per group)
- 22,141 brief educational or supportive contacts (less than 15 minutes each)
- 27,181 materials distributed
- 4,598 community networking efforts
- 10,458 phone calls
- 791 emails

The following demographic information describes the 2,489 survivors seen by Access/ B.E.S.T. during CCP individual crisis counseling sessions:

AGE

0 to 5 years:	6	0.2%
6 to 11 years:	87	3.4%
12 to 17 years:	78	3.0%
18 to 39 years:	1,447	56.5%
40 to 64 years:	776	30.3%
65+ years:	157	6.1%
Age unknown:	9	0.4%

RACE/ ETHNICITY

Latino:	279	10.9%
Asian:	14	0.5%

Black:	1,346	52.6%
Pacific Islander:	2	0.1%
White:	498	19.5%

Child and Adolescent Response Team (CART)

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 (Child and Adolescent Response Team) Program and are available in all Regions/LGEs. There is a nomenclature difference in the Florida Parishes Human Service Authority, where these services are called Children's Crisis Services and in Jefferson Parishes Human Service Authority, where they are called the Children's Mobile Crisis Response Team. These 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, 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.

CART services consist of CART Crisis System Screenings (100%); CART Clients Receiving Face to Face Assessments (75%); Clients staffed for Additional Services (e.g., in-home, out of home, intensive respite) (25%); and Hospitalized (10%). In the preceding fiscal year, statewide implementation indicates that there were 4,122 (100%) crisis system screenings, and 1,751 (42%) resulted in face-to-face assessments, and only 128 (3%) resulted in the child or youth's psychiatric hospitalization. In addition, 39% (1606) 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 by Family Functional Therapy (FFT), Multi-Systemic Therapy and Intensive Case Management. Additional services are available via referral sources include psychological evaluations, Interagency Service Coordination, high acuity respite care and consideration of placement in Dialectical Behavior Therapy treatment groups.

HEALTH, MENTAL HEALTH, MENTAL HEALTH REHABILITATION SERVICES & CASE MANAGEMENT FY 2011 – Child/Youth

Individuals with Serious Mental Illnesses 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. The Office of Mental Health continues to develop holistic initiatives that offer comprehensive and blended services for vulnerable children and adults experiencing psychiatric and physical trauma, including those in acute crisis. In addition, 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. Over the past few years, OMH's acute psychiatric inpatient services have been moved under the Louisiana Health Sciences Center-Health Care Services Division (LSUHSC-HCSD), and LSU Shreveport public general hospitals. It is believed that continuity of care is often better served under LSU and that those persons admitted with acute psychiatric problems might then receive the best *physical* assessment and treatment as well as care for their psychiatric problems. Adults who are clients of state operated mental health

clinics or Medicaid funded Mental Health Rehabilitation (MHR) Services also benefit from a systematic health screening. Further, MHR providers who provide services to children, youth, and adults must assure through their assessment and service plan process that the whole health needs of their clients are being addressed in order to get authorization for the delivery of services through the Medicaid Behavioral Healthcare Unit. The OBH clinics work very closely with private health providers as well as those within the LSUHSC-HCSD.

Outpatient mental health services have historically been provided through a network of approximately 45 licensed community mental health clinics (CMHCs) and their 27 outreach clinics. These are located throughout OBH geographic regions and LGEs. The CMHC facilities provide an array of services including: screening and assessment; emergency crisis care; individual evaluation and treatment; medication administration and management; clinical casework services; specialized services for children and adolescents; and in some areas, specialized services for those in the criminal justice system.

The CMHCs serve as the single point of entry for acute psychiatric units located in public general hospitals and for state hospital inpatient services. All CMHCs operate at least 8 a.m. - 4:30 p.m., five days a week, while many are open additional hours based on local need. CMHCs provide additional services through contracts with private agencies for services such as Assertive Community Treatment (ACT) type programs, case management, consumer drop-in centers, etc. OBH is cognizant of the fact that some of these services are limited and not available statewide, and efforts to improve access are constantly being made.

Although the CMHC's operate with somewhat traditional hours, crisis services are provided on a 24-hour basis. These services are designed to provide a quick and appropriate response to individuals 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 Mental Health Rehabilitation (MHR) program continues to provide services in the community to adults with serious mental illness and to youth with emotional and behavioral disorders. As of July 1, 2009, the oversight and management of the MHR program was transferred to the Bureau of Health Services Financing (Medicaid) within DHH. All staff, equipment, materials, contracts, purchase orders, processes and personnel were transferred. Starting on that date, Medicaid began to provide all utilization management, prior authorization, training, monitoring, network, and member service activities.

During the just ended fiscal year, the MHR program continued to refine its operation, oversight and management activities to align itself with industry standard Administrative Service Organization functions, including Member Services, Quality Management, Network Services (Development and Management), Service Access and Authorization, as well as Administrative Support and Organization.

Efforts to improve the Mental Health Rehabilitation optional Medicaid program continued through FY 2009 -2010. Continued collaboration with the Office for Community Services (OCS) and the Office of Juvenile Justice (OJJ) resulted additional staff trainings and pilot projects across the state to increase access to medically necessary mental health services for eligible adults and children served by those agencies. The MHR program and newly formed Medicaid Behavioral Health Section also participated in and led several Coordinated Systems of Care planning efforts, in

collaboration with OCS, OJJ, OBH, DOE, as well as family members, advocates, and other invested stakeholders. Additional policies and procedures governing the processes of certification and recertification were refined, as were policies and procedures related to complaints, grievances and events. The MHR program continued to add new MHR providers during the year, and a number of new Multisystemic Therapy (MST) providers were also certified by Medicaid during the year. During FY 09-10, as of the date of this summary, nine additional MHR providers have enrolled, expanding the network of qualified providers to 69. The total number of MHR recipients served has continued to increase accordingly, resulting in approximately 9,632 unduplicated recipients having been served during the fiscal year. Medicaid added 11 new MST providers during the fiscal year, resulting in 22 MST providers enrolled, including 32 MST teams. During the fiscal year, 1364 youth were served in MST throughout the state.

Beginning June 2010, the MHR program began statewide implementation of its new Provider Performance Indicator reviews. The Clinical Documentation/Utilization Management Monitoring module (covering screening, initial assessments, reassessments, initial and ongoing treatment planning, crisis planning, discharge planning and service delivery domains) and its Covered Services Module (monitoring Assessment and Service Planning, Community Support, Counseling, Individual, Group and Family Interventions, as well as Psychosocial Skills Training and Parent/Family Interventions) 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. In addition, enhancements to the Behavioral Health Section's website included more service and referral information for recipients/members, as well as enhanced on-line training, post-tests, and provider resources on the Provider side of the website.

Quarterly sessions with providers were continued via telecommunication, and all authorized providers in the network remain accredited by The Joint Commission, CARF, or COA, a requirement of the program that began on March 31, 2006.

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

EMPLOYMENT SERVICES

FY 2011 – Child/Youth

Historically, there have been multiple initiatives centered around the employment of individuals with psychiatric disabilities. Some of these include the Louisiana Commission on the Employment of Mental Health Consumers and the Louisiana Plan for Access to Mental Health Care. Both initiatives developed recommendations for collaboration and programs intended to improve transition and employment outcomes for individuals with psychiatric disabilities. These groups convened a variety of stakeholders and collaborative partners to work on implementation of various goals related to the service spectrum for individuals with mental illness. Additionally, the collaborative workgroups focused on employment for adults also relate to programs for youth. As stated in the adult section, these workgroups include: 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.

Louisiana Work Incentive Planning and Assistance (LAWIPA)

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. CMHC 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.

Through the Mental Health Rehabilitation (MHR) program, case management, and ACT-type programs, referrals are routinely made to assist youth and families of children to secure and maintain employment. Additionally, every Region / LGE has access to consumer care resources (flex-funds) that are frequently used to assist youth and family members in finding and maintaining employment.

Multisystemic Therapy (MST)

Multisystemic Therapy (MST) is being integrated into the state system of care, having been approved as a Medicaid reimbursable service. Though this program does not directly provide employment services, it could support such services on an individualized basis if obtaining or maintaining a job was determined to be an important component of the client's recovery or rehabilitation. At that point, the therapist could work with the client on those social skills as well as family and environmental barriers preventing a client from getting or maintaining a job.

Workforce Investment Board Youth Council

In the Metropolitan Human Services District (MHSD), 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 mental health clinics, mental health rehabilitation programs, and case management agencies. Additionally, the Interagency Services Coordination Program (ISC) for children, the Inter-Disciplinary Staffings (IDS) for adults, and Act 378 programs also assist the persons with SMI/EBD in securing and maintaining employment.

Act 378

Act 378 funds are used on the child / adolescent side to assist families in emergency situations and to help with transportation that allows family members to find and maintain jobs. Additionally, services are offered through the Early Childhood Supports and Services program (ECSS - located in CAHSD, MHSD, FPHSA as well as Regions 3, 4, 7, and 8) and Louisiana Youth Enhancement Services (LaYES - located in MHSD). Through these programs, links are made to a variety of resources, including employment assistance, emergency funds, respite services, and other services that enable youth and families to access jobs. Adolescents in school-based health clinics have access to clinical social workers who assist students with job-related skills, such as social skills, safety practices in the work place, and a broad range of issues related to behavioral, emotional, and mental health that are fundamental to adolescent development and readiness to work skills. These issues are of particular importance at high schools that focus on vocational/technical training.

Examples of Regional Employment Services for Youth

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. 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 that 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. Region III serves ages 16-18 through Career Solutions: The Work Connection by assisting youth who are looking for job placement and career enchantment. In Region IV, Louisiana Rehabilitation Services assist individuals with disabilities to obtain job training or education. 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 assist 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 hold transition fairs and offers resources from area agencies to youth in grades 11 and 12. In Region VII, Special Education Transition Team helps special education students connect with vocational services, trainings, and sheltered workshops. In FPHSA, The Youth Career Development Project is funded by a grant from the US Department of Labor to teach 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. 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.

The overall goal of OMH employment initiatives is to create a system within the Office of Mental 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.

HOUSING SERVICES

FY 2011 – Child/Youth

While there are by some measures a limited number of available alternative housing resources for children and adolescents with an emotional or behavioral disorder, the philosophy of the Office of Mental Health has been to preserve the family system in their natural setting while delivering appropriate and effective mental health services. In keeping with that philosophy, the housing efforts of OBH have been directed toward resources that will impact families rather than separating children into segregated housing. Overall, the movement in housing nationally has been away from segregated congregate living and toward permanent supportive housing, providing supportive services to individuals and families in the housing of their choice.

OMH has recently been combined with the Office for Addictive Disorders to form the new Office of Behavioral Health in an effort to utilize strengths and services of each to effectively address the needs of mental health and addictive disorders jointly. As new methodologies and strategies are used to redesign the mental health system of care to engage mental health and other co-occurring disorders with a Housing First model, it is important to realize that appropriate support services are essential to this transition. The overall framework of the Housing First Model is that housing is a necessity and the primary need is to obtain housing first without any pre-conditions to services. The impact for prevention of the causes that created homelessness should be addressed with a client-centered approach to sustain homeless and at-risk homeless populations from repeating cycles of homelessness. 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 United States Department of Housing and Urban Development and considered to be an evidence-based practice and a solution to addressing the chronically homeless.

The Olmstead Decision of 1999 is a critical legal victory and supports the right of institutional mental health consumers and other disability populations to have access to housing and support services that is necessary to sustain community treatment and services after reaching treatment objectives. Unjustified institutionalization violates the ADA and to that end creates a pathway to therapeutic residential housing. With employment services described elsewhere, the MHR, Intensive Case Management, ACT and FACT programs are very involved in assisting consumers and families with opportunities to secure and maintain adequate housing. Furthermore, in keeping with the use of best practices and consumer and family choice OBH has a strong commitment to keeping families together and to increasing the stock of permanent supportive housing; and consequently has previously withstood pressure to fund large residential treatment centers. Instead, 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 consumer care resources provide highly individualized services that assist families in their housing needs. OBH, in partnership with other offices in DHH, disability advocates, and advocates for people who are homeless, has 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. Congress approved funding for 3,000 rental vouchers to go to participants in the PSH program, furthering the goal of serving 3,000 people and their families. Because people with mental illness are present to a high degree in all of the targeted subpopulations of this initiative, it is likely that they will benefit significantly. This initiative also targets the aging population so those persons with mental illness who are in that subpopulation will have targeted housing.

In 2008, a plan was developed by the Department of Health and Hospitals to provide immediate assistance to the mental health delivery system in New Orleans that had continued to struggle post-Hurricane Katrina. One of the items in the plan was a rental assistance program that funded 300 housing subsidies for individuals; some of whom are homeless with serious mental illness and co-occurring disorders. Of particular note has been the OMH pursuit of State General Funds for housing and support services. OMH was 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 FY 2008-09. The program participants were successfully transitioned to the federally funded PSH that had been previously advocated for

in the United States Congress. The Department of Housing and Urban Development administers the PSH housing program with a subsidy administrator.

The state has continued to pursue housing resources through the HUD funding streams such as the Continuum of Care for the Homeless program and the Section 811 and Section 8 programs over the past ten years. 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 the potential provide widespread relief. Louisiana received over \$26,000,000 in HPRP funding with DCFC Administering \$13.5 million and the other funds going to direct allocation to existing community providers. Our goal is to collaborate 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. OMH 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 units set-asides. It is essential and critical that housing development continue with particular emphasize 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 needs 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.

The housing development efforts for the homeless carried out by the Region and LGE Housing Coordinators have been largely through their involvement with the local continuums of care for the homeless also known as Homeless Coalitions. These coalitions develop a variety of housing programs that can be both transitional and permanent in length of stay. The type of programs they develop is determined by the assessment of local needs; this assessment is performed locally through the coalitions. The programs developed can serve both individual adults as well as families, many of which will have children and youth with an emotional or behavioral disorder. Families experiencing homelessness often have a multiplicity of events impacting their lives. There are programs that are directed specifically toward homeless youth and transitional age individuals. Programs that target the prevention of family homelessness will obviously also benefit children and youth with an emotional or behavioral disorder.

Mental Health Rehabilitation (MHR), ACT, FFT, and case management programs are very involved in assisting families with opportunities to secure and maintain adequate housing. OMH has a strong commitment to keeping families together and consequently has previously withstood pressure to fund large residential treatment centers. Instead, effort and dollars have been put into Family Support Services throughout the state. The state chapter of the Federation of Families has developed both respite and mentoring models which are used extensively by Louisiana families. The Consumer Care Resources provide highly individualized services that assist families in their

housing needs. The State also has numerous HUD housing programs, many of which serve families with children and youth.

In an effort to support families who have children with EBD in the home, the services of CART (Child and Adolescent Response Team) are available. CART is a child-centered, family-focused, strengths based model that engages families as partners to resolve a crisis in the family with community based treatment and access to resources in the community. Once CART's intervention is complete (lasting no longer than seven days) and stabilization has occurred, the family has an understanding of what caused the original crisis, and how to prevent any future crises. If further family stabilization services are needed, the family is referred to an agency for a longer period of intense in-home services.

In the event that a child or youth requires alternative living arrangements, the State contracts with numerous group homes for children and adolescents as well as Emergency Shelters. There are also transitional living programs that will accept emancipated seventeen-year-olds. Various contractual programs include therapeutic foster care arrangements with the Office of Community Services (OCS) and the Office of Youth Development (OYD) to serve OBH clients, respite care for hospital diversion, as well as recreational and psychological respite.

There is much activity around assisting individuals with SMI, and families with children with EBD 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 2010

Region/ LGE	# of Programs	# Referred Unduplicated	# Placed Unduplicated
MHSD*	5 programs	unk	unk
CAHSD	3 programs	63	60
Region III	4 programs	49	26
Region IV	6 programs	149	483
Region V	10 programs	63	35
Region VI	7 programs	157	78
Region VII	4 programs	124	102
Region VIII	7 programs	177	118
FPHSA	5 programs	241	162
JPHSA	11 programs	678	453

NOTE: Please see *Criterion 4: Homeless Outreach* in this application, where many related issues, programs, and initiatives related to housing are discussed.

EDUCATIONAL SERVICES FY 2011 – Child/Youth

Please refer to Criterion 3: Children's Services, Educational Services, including services provided under IDEA for this information.

**SERVICES FOR PERSONS WITH CO-OCCURRING DISORDERS
(SUBSTANCE ABUSE / MENTAL HEALTH) AND
OTHER SUBSTANCE ABUSE SERVICES
FY 2011 – Child/Youth**

As described earlier in this document, 2009 legislation created the Office of Behavioral Health, combining the functions of the Office of Mental Health and the Office for Addictive Disorders. In some parts of the state OMH and OAD already jointly deliver services to people with co-occurring mental and substance disorders. Co-occurring treatment ensures that emphasis is placed on early mental health screening, assessment and referral to services, and eliminating disparities in mental health services as noted in *The President's New Freedom Commission Report* Goals #3 and #4.

Louisiana Integrated Treatment Model (LITS)

The Louisiana Integrated Treatment Model (LITS) initiative was funded through the SAMHSA supported Co-occurring State Incentive Grants, which in its conception was designed to target the adult population with co-occurring mental health and substance use disorders. However, the Behavioral Health Taskforce (the LITS executive leadership committee) later identified co-occurring disorders in children and youth as a long-term priority. The LITS model is organized around nine Core Principles (*please refer to the Adult Section on Services for Persons with Co-Occurring Disorders [Substance Abuse / Mental Health] and Other Substance Abuse Services*) and includes ten service domains which are provided throughout four Treatment and Recovery Phases. Conceptually, the locus of care is determined through a severity grid. In 2004, Louisiana was chosen by SAMHSA as one of 10 states to participate in the first National Policy Academy on Co-Occurring Mental and Substance Abuse Disorders. At the Academy, the Louisiana Team used the current LITS grant as a foundation, but broadened the scope of work to include children and youth, as well as partnerships with primary care. The outcome of the Academy was the draft of an action plan that has been used to help guide the initiative. Included in the action plan is the expectation that Louisiana citizens will be provided with an integrated system of healthcare that encompasses all people, including individuals with co-occurring mental and addictive disorders regardless of age, who will easily access the full range of services, in order to promote and support their sustained resilience and recovery. The recent creation of the Office of Behavioral Health will aid in this treatment model becoming the norm.

Implementation of services for children and youth with co-occurring disorders include:

- Establishment of a workgroup to develop long-range plans for serving children with co-occurring disorders.
- Screening of children of parents who are seen in a co-occurring program to be implemented with a New Orleans' Drug Court Program (pilot program).
- Screening of parents seen in the Early Childhood Services and Supports Program for co-occurring disorders.
- The continuation of Louisiana Youth Enhanced Services (LA-Y.E.S.) as a system of care initiative has been instrumental in coordinating a variety of agencies including mental health and addictive disorders services into the community array to support co-occurring disorders in children.

Louisiana Screening, Brief Intervention, Referral, and Treatment (SBIRT)

The Louisiana Department of Health and Hospitals and the American College of Obstetricians and Gynecologists – Louisiana Section has a relatively new program designed to address poor birth outcomes in Louisiana. The Louisiana Screening, Brief Intervention, Referral, and Treatment (SBIRT) – Health Babies Initiative is designed to reduce the use of alcohol, tobacco and illicit drug use during pregnancy. The program also screens and provides appropriate referral for domestic violence and depression in pregnancy. The initiative is different from, but designed to work in concert with, specialized or traditional treatment. Historically, the primary focus of specialized treatment has been targeted toward persons with more severe substance use or those who have met the criteria for a Substance Use Disorder. SBIRT, however, targets those individuals with non-dependent substance use and provides effective strategies for intervention prior to the need for more extensive or specialized treatment. Mechanisms are also in place to refer those with the greatest addiction severity to specialized treatment.

A pregnant woman's concern for her unborn child strongly motivates her to respond positively to her medical providers' advice. Therefore, the long-term goals of the Louisiana SBIRT initiative are to:

- Screen all pregnant Louisiana women at the site of prenatal care within both, public and private health facilities.
- Incorporate screening as a routine part of prenatal care.

The Louisiana SBIRT-Healthy Babies Initiative is a partnership with the Office of Addictive Disorders and the Office of Public Health within the Louisiana Department of Health and Hospitals, the American College of Obstetricians and Gynecologists (ACOG), March of Dimes, Fetal Infant Mortality Review and The Louisiana Campaign for Tobacco-Free Living.

Previously, the Office of Addictive Disorders (OAD) has offered treatment services through fifteen inpatient/residential facilities; five social detoxification, two medical detoxification, and four medically supported facilities; seventeen community-based facilities (halfway and three-quarter houses); and sixty-eight outpatient clinics. Current and future efforts have a focus on increasing the continuity of care within the newly legislated Office of Behavioral Health and internally enhancing services within all facilities.

The following are treatment facilities that specifically serve youth:

- The Springs of Recovery Inpatient Treatment Center provides a total of 54 adolescent (38 male and 16 female) residential inpatient treatment beds, 30 intensive treatment and 8 transitional beds for adolescent males, 16 intensive treatment adolescent beds for females. Forty-seven of the beds are Federal Block Grant funded and seven are funded by OAD's Access to Recovery Grant. Clients who complete the 45-60 day intensive treatment program may continue in the transitional program for 45 days to six months.
- The Inpatient Treatment - Gateway Adolescent Treatment Center - Cenla Chemical Dependency Council, Inc. provides 26 beds for adolescents aged 12-17 (20 male and 6 female) funded by Federal Block Grant with inpatient chemical dependency treatment program.
- The Cavanaugh Center in Bossier City is an inpatient, licensed, 24 bed (allocated to males and females as needed) adolescent primary treatment unit. All beds are Federal Block Grant funded. The facility provides structured, supervised, adolescent (ages 12-17) inpatient treatment. Cavanaugh Center's halfway house provides 20 beds funded by FBG (allocated to males and females as needed).

Other examples of services provided to youth with substance abuse include:

CAHSD has twenty-two substance abuse prevention contracts that include services for adolescents.

The Access to Recovery (ATR) electronic voucher program provides clients with freedom of choice for clinical treatment services and recovery support. Louisiana's ATR funds served all eligible citizens with special emphasis upon women, women with dependent children, and adolescents.

The following projects serve pregnant women and women with dependent children ages 0-12:

- CENLA Chemical Dependency Council, Halfway House Services to Women and their Dependent Children
- Louisiana Health and Rehabilitation Options, Residential Treatment to Women with Dependent Children
- Odyssey House of Louisiana, Inc. - High Risk Pregnancy - The Family Center, Residential Treatment to Women and their Dependent Children as well as Pregnant Women
- Grace House of New Orleans, Residential and Halfway House
- Family House in Jefferson Parish
- Family Success Institute in Region VII, Shreveport
- Claire House in Morgan City - St. Mary Parish

MEDICAL AND DENTAL HEALTH SERVICES

FY 2011 – Child/Youth

The Office of Mental Health attempts to offer a comprehensive array of medical, psychiatric, and dental services to its clients. As noted in the *President's New Freedom Commission Report* Goal #1, mental health is essential to overall health, and as such, a holistic approach to treating the individual is critical in a recovery and resiliency environment.

The location of the acute units within or in the vicinity of general medical hospitals allows patients who are hospitalized to have access to complete medical services. State-run hospitals all have medical clinics and access to x-ray, laboratory and other medically needed services. Outpatient clients are encouraged to obtain primary care providers for their medical care. Those who do not have the resources to obtain a private provider are referred to the LSU system outpatient clinics. Children and adolescents who are clients of state operated mental health clinics or Medicaid funded Mental Health Rehab services also benefit from health screenings with referrals as needed.

Proper dental care is increasingly demonstrated to have an important role in both physical and mental health. Dental services are provided at intermediate care hospitals by staff or consulting dentists. Referrals for oral surgery may be made to the LSU operated oral surgery clinics. Some examples of low or no-cost dental services/resources available to OMH outpatient consumers include the Louisiana Donated Dental Services program, the David Raines Medical Clinic in Shreveport, the LSU School of Dentistry, the Lafayette free clinic, and the Louisiana Dental Association.

The LSU School of Dentistry (LSUSD) located in New Orleans is now fully operational. It had sustained severe damage from flooding from Hurricane Katrina, and was forced to close, re-opening in the fall of 2007. In addition, various school-based dental clinics in MHSD that offered a full range of services also were destroyed but most have re-opened. As a result, dental clinics opened in

other parts of the state. Some of these clinics have remained open, although in smaller scale. The LSUSD campus serves primarily residents from the greater New Orleans area; however, LSUSD satellite clinics serve citizens in other areas of the state. In addition, Earl K. Long Hospital in Baton Rouge provides routine dental care.

A recent increase in the reimbursement rates for treating children who receive Medicaid benefits coincided with an influx of mobile dental clinics. House Bill 687 of the Regular Session of the 2010 Louisiana Legislature was the Louisiana Dental Association-supported bill that addressed dentistry in public schools, citing that nonpermanent dental clinics were unsanitary and discouraged parental involvement in their children's dental care. Initially, the bill sought to prohibit all dentistry on school grounds. Critics of the bill argued that elimination of dental services by mobile units or those offered in the schools would deny poor children access to dental care. After much debate, the final piece of legislation, ACT 429 charged the Louisiana State Board of Dentistry with addressing such vital issues as maintenance of equipment; minimal standards; disposal of infectious waste; requiring appropriate consent form from the parent or guardian prior to providing dental services to a minor; parental consultation/involvement regarding dental services provided to a minor; and inspection by the licensing board.

HB 881, one of the state's supplementary appropriations bills, included \$3,141,257 to restore cuts that had been made to the Early and Periodic Screening, Diagnosis and Testing Services (EPSDT) dental services. The EPSDT Dental Program provides coverage for a range of services including preventive and restorative care. The Louisiana Foundation of Dentistry for the Handicapped (also known as Donated Dental Services) received \$115,000 in funding for the 2009-2010 fiscal year. Unfortunately, no new funds were appropriated for fluoridation efforts simply because of a lack of state funds for new projects. The Louisiana Dental Association will continue to work with the American Dental Association, the Healthy Smiles Coalition and the Department of Health and Hospitals (DHH) to search for funds for community water fluoridation.

The LSU operated hospitals struggle to meet the needs of Louisiana citizens. The state continues to debate whether to rebuild a large teaching hospital in New Orleans to replace Charity Hospital, which was destroyed during Hurricane Katrina. Louisiana is planning to develop a medical home model for health care. The medical home model will serve the primary care needs of Louisiana citizens and will ensure proper referral for specialty services.

Following the hurricanes, there was an exodus of healthcare providers from the state. This initially resulted in long waiting periods for patients, who then often experience increased anxiety and higher levels of emotional and physical pain. Emergency Department waiting times dramatically increased. In some regions, hospitals have begun offering some on-site medical services at the mental health clinics to patients who do not have transportation; and nursing staff is often available for general nursing consultation and referrals.

The Louisiana Youth Enhanced Services (LaYES) Children's Initiative, which paid special attention to planning, developing and implementing a collaborative network of primary health care providers, including family physicians, pediatricians, and public health nurses, will have completed its seventh and final year as a SAMHSA grant awardee in September 2010.

MHSD has offered expanded school based Health Clinics through partnerships with Tulane and LSU. The Infant, Child, and Family Center (ICFC) in MHSD received grant funding from the Pennington Family Foundation in December 2008 to expand Occupational Therapy services

provided to clinic clients. The ICFC added Speech Therapy Services through an MOU with Southern University Speech-Language Pathology Program, beginning June 2008. Because of a change in funding, MHSD has decided to discontinue its school-based services as of July 2010. However, MHSD is now working in partnership with OBH to provide clinic-based services to children and adolescents in the New Orleans area through the development of three clinics, which are now fully operational and are serving over 1000 youth in the area. OBH and MHSD are also developing a court-based clinic to provide mental health services to clients of the Youth Study Center, a juvenile justice detention center in the city. The court-based clinic should be fully operational in September 2010.

Expanded Healthcare Services for Pregnant Women (EDSPW) and LaMOMS

Certain healthcare services are provided to pregnant women between the ages of 21 and 59, who are eligible for full Medicaid benefits. The LaMOMS program is an expansion of Medicaid coverage for pregnant women with an income up to 200 percent of the Federal Poverty Level. Through this program, pregnant women of working families, either married or single, have access to no-cost dental and healthcare coverage. Medicaid will pay for pregnancy-related services, delivery and care up to 60 days after the pregnancy ends including doctor visits, lab work/tests, prescription medicines and hospital care.

LaCHIP

LaCHIP is Louisiana's version of the national Children's Health Insurance Program (CHIP), authorized under Title XXI of the Social Security Act. CHIP enables states to implement their own health insurance programs with a mix of federal and state funding. LaCHIP stands for "Louisiana Children's Health Insurance Program." LaCHIP is a health insurance program designed to bring quality health care including dental care to currently uninsured children and youth up to the age of 19 in Louisiana. Children enrolled in LaCHIP are also Early Periodic Screening, Diagnosis and Treatment (EPSDT) eligible; therefore eligible for the dental services covered in the EPSDT Dental Program. Children can qualify for coverage under LaCHIP using higher income standards. LaCHIP provides Medicaid coverage for doctor visits for primary care as well as preventive and emergency care, immunizations, prescription medications, hospitalization, home health care and many other health services. LaCHIP provides health care coverage for the children of Louisiana's working families with moderate and low incomes. Children must be under age 19 and not covered by health insurance. Family income cannot be more than 250 percent of the federal poverty level (about \$4,417 monthly for a family of four). Children enrolled in LaCHIP will maintain their eligibility for 12 continuous months no matter how much their family's income increases during this period. This is being done to ensure children receive initial and follow-up care. A renewal of coverage is done after each 12 month period. The Office of Mental Health is responsible for the provision of mental health services through LaCHIP.

Following the hurricanes, there was an exodus of healthcare providers from the state. This had resulted in long waiting periods for patients, who then often experience increased anxiety and higher levels of emotional and physical pain. Emergency Department waiting times dramatically increased. As a response to this problem, in some regions, hospitals have begun offering some on-site medical services at the mental health clinics to patients who do not have transportation; and nursing staff is often available for general nursing consultation and referrals. The interruption in services that Louisiana experienced following the 2005 hurricane season has been addressed. Medical services now surpass pre-Katrina, pre-Rita levels in some areas.

SUPPORT SERVICES

FY 2011 – Child/Youth

Support Services are broadly defined as services provided to consumers that enhance clinic-based services and aid in consumers' reintegration into society as a whole. Louisiana's public mental health system is well grounded in the principle that children, youth, and families impacted by an emotional or behavioral disturbance (EBD) are resilient. OBH has traditionally supported a variety of activities that aid children, youth, and their families. These activities include both indirect and direct support such as providing financial and technical support to consumer and family organizations. There are self-help educational programs and support groups that are organized and run by family members on an ongoing basis. These concepts are integral to the President's New Freedom Commission emphasizing that services are consumer and family driven in terms of leadership and outreach.

The charge of the OBH Division of Child/Youth Best Practices is to support and develop more inclusive services for all those affected by mental health issues in Louisiana. The Office works to sustain issues of client choice and inclusion through initiatives that will enable choice, empowerment, and in certain instances, employment. To this end, the Office was recently able to support the position of State-Wide Child/Youth Parent Support Liaison. With a focus on choice and inclusion OBH continues to actively work towards the development of peer support programs, resource or drop-in-center development, coordination of a statewide advocacy network, and other initiatives that encourage consumer and family independence in all aspects of care.

In the area of consumer empowerment, OBH has supported a variety of activities that aid consumers, including children/ youth and their families. These supported activities include employment, housing, and education as described earlier. Activities also include the provision of financial and technical support to consumer and family organizations and their local chapters throughout the state. Self-help educational programs and support groups, funded by the Mental Health Block Grant are organized and run by consumers or family members on an ongoing basis. In the last year, Keeping Recovery Skills Alive (KRSA) is a program that was trained and implemented state-wide. This initiative supports the notion of wellness recovery among staff, consumers and the community alike.

In addition to the above activities, OBH hires parents of EBD children and adult consumers as either consumer or family liaisons or peer-support specialists. These individuals assist other family members in accessing services as well as providing general education, advocacy and supportive activities. Among resources currently available to consumers and families within the public mental health system include flexible funds that can be utilized to address barriers to care and recovery. There are also services available to assist youth and families of children to secure and maintain employment via such means as consumer care resources (flex-funds). Consumer Care Resources can also be used to pay for respite, utility bills, clothing, food, and unanticipated expenditures (e.g., car repairs).

Increasing the presence of and ensuring that once vacant family liaison positions are now filled, all family liaisons are included in the same training classes as peers and all liaisons are linked together

through formal and informal networks of support. There continues to be an increased effort to ensure that family voices are empowered and educated about services and supports available for both themselves and their children/families. It is the goal that more programs will become available for family members throughout the state as the recovery modalities are continuing to be developed and implemented.

OBH places a priority on family support and services that keep children and youth in their natural or foster home setting. In addition to supports and services discussed in the previous sections on employment, housing, and rehabilitation services, parents of children and youth with an emotional or behavioral disturbance are also supported through three state-wide organizations providing assistance to families: Federation of Families, Families Helping Families, and NAMI-LA. The Federation of Families' parent mentoring program, developed and operated through a contract with OBH, links parents who have experience with working with their own emotionally or behaviorally disturbed child to other similar parents with support and advocacy activities. These early intervention services are inherent to Goal 4 of the President's New Freedom Commission Report which specifically advocates for services for children and ultimately their families before a crisis stage is reached.

The following are specific examples of support services occurring within the state:

In the Orleans area, MHSD works with the Children's Bureau who offers family preservation school monitoring and advocacy. Consumer Care resources and Cash Subsidy programs are also available. Gulf Coast Teaching Families offers therapeutic respite/personal care attendant services. Additionally, services have been expanded to include support for MST teams in the area and are being expanded to include assessment services for justice involved youth. Training for Dialectical Behavioral Therapy has been instituted in this area and in other regions. CAHSD provides support for in-home, intensive therapy by a multi-disciplinary team (ACT); respite; crisis services; intensive behavior management services; consumer care resources; and flexible funds. These are utilized to enhance family functioning; family preservation; and in-home family intervention services. Region 3 offers FINS, a pre-delinquency intervention program that provides interagency services to assist families in identifying risk factors in lieu of court adjudication; its goal is to halt problematic behaviors; LA Federation of Families - Family Mentoring Services; CART Crisis Intervention Services; and therapeutic respite. In Region 4, there is mental health rehabilitation which provides intensive therapeutic and case management services including medication management; consumer care emergency funds for youth's basic or special needs, to enhance their recovery or prevent decompensation; and the Extra Mile that provides therapy services for adoptive/foster children.

In Region V, the Educational and Treatment Council, Inc. provides crisis intervention services to children, youth, and their families in crisis to prevent or reduce the need for hospitalization. These services include after-hours crisis systems coordination, face-to-face screenings, in-home crisis stabilization services, and out-of-home crisis respite services. Education and Treatment Council, Inc. provides services for children and adolescents, using a team approach (family, doctor, therapist, and outreach worker) with OBH via three clinics. The focus is to provide more intensive treatment services in the home, school, and community, which should reduce the need for hospitalization; provide supports; and ease the re-entry of hospitalized children/adolescents into their home community. Respite Services provides family support in the form of planned respite and out-of-home crisis respite services; transportation for respite services is provided; summer day camps; and various recreational outings. In addition, Volunteers of America provides a wide range of instructional and intervention services to assist EBD children/youth and their families in obtaining

the supports necessary to achieve, maintain, or improve home/community based living situations. A Help-Point Coordinator facilitates the Interagency Service Coordination (ISC) process, teaches parenting classes based on the Boys Town Common Sense Parenting model for different age groups, and manages Consumer Care Resources to provide wraparound services for families as needed. For those CMHC clients who cannot financially afford private laboratories, contractual arrangements with private labs are in place to provide lab work for the Allen and Beauregard MH clinics and Moss Regional Hospital performs lab work for LCMHC.

In Region VI, there is the Child Consumer Care Resource Program that provides monetary assistance for addressing unmet needs of EBD children and youth. The funds are used for purchase of goods or services such as, but not limited to: tutoring services, transportation assistance, household supplies. The Family Support Program remains viable and is for families who have children and youth with an EBD. Its purpose is to promote the nurturing abilities of families; to help them utilize existing resources; and to assist them in creating or taking part in family network of support. Planned Respite Services provide temporary relief for families or caregivers of EBD youth. It is facility-based and offers respite on certain days at certain periods of time. The "Whatever It Takes" program is designed to assist children and their families in obtaining the necessary supports to achieve, maintain, or improve home/community based living situation. Services are mobile and are delivered in the most appropriate, naturalistic environment and during non-traditional office hours. The FINS Program is designed to identify child and family risk factors and to refer to the appropriate services.

Region VII offers numerous adjunctive services via contracts. They are able to fund resources for children in a step-down partial hospitalization program and also provide assistance to families in applying for LaCHIP funding for medical services. There are home-based interventions designed as wraparound services to supplement clinic-based services - individualized with the consumer/family and clinician. It can also include individual, group, and family interventions as well as case management services. There is crisis stabilization in an inpatient psychiatric setting. Planned, unplanned (crisis), or camp services are available. Region VII also funds monies for two Family Liaisons. These individuals attend all ISC meetings with families, help plan for interventions and attend to the various educational resources in the community. The Region also funds through some block grant monies a Mental Health Assessment Center staffed by Dialectical Behavioral Therapy trained mental health professionals. This center works with the Caddo Parish Juvenile court to provide family and group based counseling. A psychologist and psychiatrist are also available. During the last year, the Region has been able to increase the number of families who are served through its Case Management Program.

Consumer Care Resources enhances access to needed supports, services, or goods to achieve, maintain, or improve individual/family community living status and level of functioning in order to continue living in the community. Examples include financial assistance with rent/utility bills or purchase of school uniforms. It can also include extracurricular activities to improve the child/youth's self esteem.

Case management services are provided at six levels of intensity: Level 0: Prevention and Health Maintenance - Four (4) hours of contacts; Level 1: Recovery Maintenance and Health Management- Eight (8) hours of contacts; Level 2: Low Intensity Community Based Services - Ten (10) hours of contacts; Level 3: Moderate Intensity Community Based Services - Twelve (12) hours of contacts; Level 4: High Intensity Community Based Services - Fourteen (14) hours of contacts. Priority groups include youth who are at risk for placement in residential programs - referred to a

local interagency team or for a client who's needs require multiple services with 24 hour availability; Level 5: Sixteen (16) hours of contacts. Priority groups include youth who are at risk for placement in residential programs - referred to local interagency team or for a client whose needs require multiple services with 24 hour availability.

Individualized Deferred Disposition (IDD) – Diversion services for youth with/mental health issues involved in the Juvenile Court in Caddo Parish.

SERVICES PROVIDED UNDER THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT FY 2011 – Child/Youth

Please refer to Criterion 3: Children's Services, Educational Services, including services provided under IDEA for information on this topic.

TRANSITION OF YOUTH TO ADULT SERVICES FY 2011 – Child/Youth

The Office of Behavioral Health, Department of Education, and Department of Social Services are working with transitional age youth to identify and implement a strategic plan to provide peer supports and community resourced for successful transition to secondary educational settings.

Summarized below are representative programs from each Hospital and Region / LGE in the state that facilitate the smooth transition of youth to adult services.

SELH:

- Developmental Neuropsychiatric Program (Inpatient Services) includes social skills training, family therapy, and behavior management, parent training, and medication management to persons with co-occurring disorders
- Developmental Neuropsychiatric Program (Outpatient Services) includes parent training, home/school behavior management, medication management to persons with co-occurring disorders
- Challenges Program – Day treatment which offers therapeutic, educational, and behavioral treatments as well as medication interventions, 5 days a week
- Youth services (Inpatient) – 24 hr. a day, 7 days a week individual, group and family therapy, parent training, medication management, special education, and competency restoration

ELMHS:

- Spring House - A group home/residential treatment program for teenage girls in the custody of the Office of Community Services

MHSD:

- Interagency Service Coordination (ISC) is offered to children between the ages of 7 and 18 to coordinate services/resources

CAHSD:

- East Baton Rouge Parish Resource Fair provided resource information for transitional age youth
- The Transition Forum provides resource information to transitional age youth
- The Instructional resource Center provides resource information to parents and transitional youth
- Elm Grove Church provides information to transitional age youth and adults.

Region III:

- Lafourche MHC - The child psychiatrist continues working with clients until they are able to receive services from an adult provider.
- St. Mary Transition Team - Manager sits on transition team which includes members from various agencies to assist those with disabilities leaving the school system
- Bayou Land Families Helping Families – family resources center that helps parents and children with transition services
- Federation of Families - Family liaison works with families to provide mentoring and educational guidance

Region IV:

- CART - provides assistance to children and their families in times of crisis

Region V:

- CMHC C/Y Units: Clinicians may see client up to age 21 if they are receiving special education services through CPSB, or up to age 19 if enrolled in school full time.
- ETC Housing-Transitional Housing program for transitional age youth
- Transitional Team Monthly meetings

Region VI:

- FINS (Families in Need of Services) offers pre-court, legally sanctioned intervention for youth exhibiting anti-social behaviors.
- The Consumer Care Resource program assists children and families with meeting their basic needs.
- OMH Cottage Respite offers out of home planned respite services.
- “Whatever It Takes Program” assists families to obtain, coordinate, and advocate for needed services.
- Development and implementation of advanced training for CIT Law Enforcement Officers in the region on Juvenile Mental Health Issues.
- ISC (Interagency Service Coordination) links state agencies with community-based programs.
- Recreational Planned Respite offers planned recreational camp activities for youth and children. OMH Cottage Respite provides out of home planned respite services for children and youth.

Region VII:

- Special Education Transition Team helps special education students connect with vocational services, trainings, and sheltered workshops.
- Co-occurring group focuses on topics specifically geared towards addressing substance use and recovery

- Juvenile Court-Drug Court provides screening group counseling in Caddo and Webster Parish
- Teen Court in Caddo parish allows for teens with minor charges to take the roles of jury, judge, and attorney
- Mental Health Court in Caddo parish provides individual deferred disposition and services for youth with mental health diagnoses
- Sliding scale fee agencies in Caddo, Bossier, Webster, and Sabine parishes offer specialized groups for parenting, anger, and teen moms

Region VIII:

- Regular Clinic Services provide individual treatment planning and service provision for transitional age persons.
- CBT Specialty Clinics provide individual and group therapy using EBPs
- MST Specialty Clinics provide individual and group therapy using EBPs
- Medication Management Clinic provides medication management services only

FPHSA:

- SELH-DNP/In-Patient and Out-Patient Services assist with transitional age individuals with dual diagnosis of mental illness and developmental disabilities.
- Louisiana Rehabilitation Services provides supportive employment for transitional age individuals.
- Public school system offers various on-the-job trainings set up with students in special classes and local businesses (ages 15-18)
- Permanent Supportive Housing programs for individuals age 15-26
- Family in Need of Services monitors families of children up to age 18 to ensure the families are receiving the appropriate services.
- Transition Age Committees take place in the schools of all five parishes (St. Tammany, Washington, St. Helena, Livingston, and Tangipahoa). FPHSA participates in these meetings to educate transitional age individuals and their parents on available services to help them plan for the adult world.
- OCS/CFCIP Independent Living Skills Providers- goal of helping individuals transition out of foster care by helping individuals become self-sufficient
- St. Tammany Transition Age Committee - multiple service agencies and high schools meet with parents of special education students to review services available

JPHSA:

- JPHSA Child & Family Services- Individual, group, and family interventions for youth ages 15-18.

OTHER ACTIVITIES LEADING TO REDUCTION OF HOSPITALIZATION FY 2011 – Child/Youth

A system of care incorporates a broad, flexible array of services and supports organized into a coordinated network integrating care planning and management across multiple levels, and building meaningful partnerships with families and youth. An important goal is the reduction of highly restrictive out of home placements through the creation and maintenance of coordinated and effective community based services. Coordinated systems of care operating in other states have

significantly reduced school drop-out rates, decreased hospitalization, and decreased recidivism among at-risk youth.

Utilization of state hospital beds dropped significantly with the introduction of community-based Mental Health Rehabilitation (MHR) services and the development of brief stay psychiatric acute units within general public hospitals. Moreover, Louisiana and OBH have a network of services that provide alternatives to hospitalization for children/ youth in Louisiana through a broad array of community support services and consumer-run alternatives. Housing, employment, educational, rehabilitation, and support services programs, which take into account a recovery-based philosophy of care, all contribute to reductions in hospitalization.

In the event of crisis, hospitalization is a last resort, after community alternatives are tried and/or ruled out prior to inpatient hospitalization in a state inpatient facility. Implementation of the statewide Continuity of Care policy continues to enhance joint hospital-community collaboration with the goals of improved outcomes post-discharge including reduced recidivism.

Another avenue of care that has shown to reduce hospitalization rates is the Mental Health Rehabilitation (MHR) program that allows greater flexibility of services; and the ability to cover additional services such as FFT and MST, that are consumer driven and recovery-focused. The previously discussed move of the MHR program into the DHH Medicaid Office should improve the availability of resources and flexibility to an even greater extent. Each OMH Region/ LGE also has specific initiatives aimed at reducing hospitalization and/or shortening hospital stays.

Many other programs previously discussed have either directly or indirectly had an impact on the utilization of inpatient services. For example the Louisiana Integrated Treatment Services (LITS) model for persons with Co-occurring Mental and Substance Disorders has resulted in increasing access to community services and reducing the need for hospitalization. The development of crisis services throughout the state is another example of programming that has resulted in decreased hospital utilization. The expanding use of telemedicine has also shown great promise and results.

Fiscal legislation passed in the 2009 legislative session allowed OMH to close one of its state hospitals, New Orleans Adolescent Hospital (NOAH), and transfer the child/adolescent and adult acute beds to Southeast Louisiana Hospital (SELH); and with the savings in operational costs, allowed for the opening of two new community mental health clinics in locations convenient to consumers in the New Orleans area. On March 11, 2010, Department of Health and Hospitals' Secretary Alan Levine joined fellow Louisianans in celebrating the opening of two new community-based outpatient mental health care clinics for children, adolescents and their families in the Greater New Orleans area. The opening of Midtown and West Bank Clinics mark another milestone in the state's creation of a robust, community-based mental health system statewide.

The Midtown and West Bank clinics will annually provide public outpatient mental health care for 1,200 children and adolescents from birth to 18 years of age, and their families. The clinics also serve as a home base for other public mental health care services that can be delivered in homes, schools and other locations throughout the community. Services include Multi-Systemic Therapy; Dialectical Behavior Therapy; individual, group and family therapy; and medication management services.

In addition to the two new outpatient clinics for children and adolescents, DHH's Office of Behavioral Health works with Family Service of Greater New Orleans to provide 24-hour mental

health care for children with the Child-Adolescent Response Team (CART) in Orleans, St. Bernard and Plaquemines parishes.

Other activities leading to reduction of hospitalization that have been discussed previously include FFT, MST, family support mentoring, respite, flexible fund services, and the Mental Health Rehabilitation (MHR) program. Through the Intensive Community Respite Program, contract providers have been educated and assisted to feel more comfortable with children and adolescents with more serious problems than are usually placed in Community Respite Programs. Over the past several years, educational and recreational activities have been added to the Intensive Crisis Respite Community Program so that those enrolled in the program have a more structured schedule.

Regional emphasis on FFT programs, that include intensive home/school/community-based services, has reduced the number of children going into hospitals. The utilization of family-focused services by supporting the court system and other systems with the ISC (Interagency Service Coordination) process has also been effective, allowing for more wrap-a-round services to be placed where the child and/or family need it the most.

The Louisiana Integrated Treatment Services (LITS) model for persons with Co-occurring Mental and Substance Disorders has resulted in increasing access to community services and reducing the need for hospitalization. The advent of using effective co-occurring capable services is intertwined with Goal 4; Recommendation 3 of the *President's New Freedom Commission Report* that calls for the linking of mental health and substance abuse treatment. The development of crisis services throughout the state is another example of programming that has resulted in decreased hospital utilization. The expanding use of telemedicine has also shown great promise and results.

Interagency Service Coordination (ISC)

Efforts continue to enhance communication and collaboration with providers and other stakeholders through the Interagency Service Coordination (ISC) process, the utilization of telemedicine services for treatment team staffings and provision of family and individual therapeutic sessions, and other continuity of care processes; these initiatives have resulted in an overall improved System of Care for children and youth and their families. Continued efforts to educate the community and OBH staff regarding these additional supports and services has resulted in increased utilization of these alternatives to hospitalization and increased community awareness to the System of Care philosophy and principles.

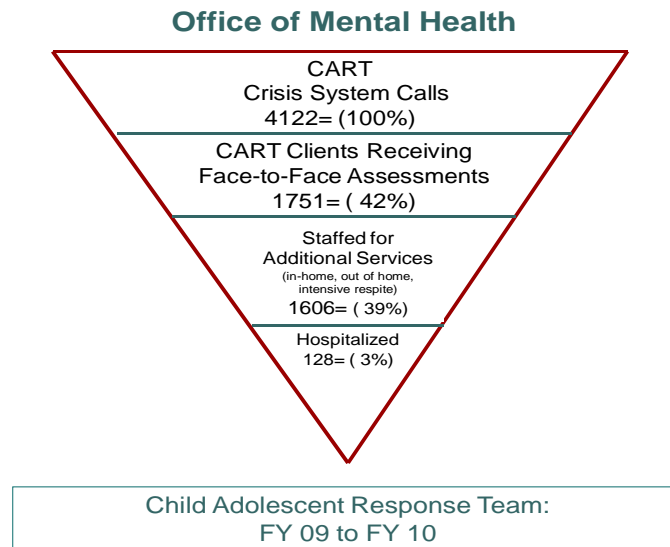
Louisiana Integrated Treatment Services (LITS)

The Louisiana Integrated Treatment Services (LITS) model for persons with Co-occurring Mental and Substance Disorders has advanced the use of the model to include addressing the needs of children/youth in the Integrated Treatment Team staffing, resulting in increasing access to community services and reducing the need for hospitalization.

Child and Adolescent Response Team (CART)

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. The CART program provides daily accesses to parents/teachers or other community persons who identify a child who is experiencing a crisis. This program continues to provide services that present alternatives to hospitalization and prevent unnecessary hospitalizations. There is Crisis Care Coordination and face-to-face assessments by a clinician who is available after hours, weekends and holidays to handle crisis calls. CART also provides crisis

stabilization in the home, away from home, and at alternate site crisis stabilization (respite). In some regions, for example, comprehensive services can eventually include Clinical Case Management, Consumer Care Resources, and Multi-systemic Therapy if it is indicated. Although some regions do not have the advantage of planned respite, any child/adolescent can obtain crisis respite through CART regardless of their status with the community mental health center. Outreach activities in the regions are available to local and parish governments, school systems, and the juvenile justice system to increase their awareness of the CART Program prevention services as well as the OBH child and adolescent services resulting in an increase in service utilization.



Juvenile Justice

Crisis Intervention Training (CIT) for law enforcement has been well established in several regions/ LGEs to address behavioral health crises. Crisis Intervention Training (CIT) readies officers and dispatchers to assess and respond appropriately to calls involving adults with SMI and children with EBD. Training law officials to identify and understand the mental health needs of children and youth with EBD is yet another way to reduce the need for hospitalization of youth experiencing mental health crises.

Region 6 initiated a Juvenile Justice Diversion program toward the end of FY 07 supervised by Judge Koch's office who has participated in the CIT training in Memphis. This program has continued to be an exemplary CIT program in the state. The Louisiana Models for Change is currently working toward establishing child and youth CIT programs throughout the state. Juvenile Drug Court and Mental Health Court available in several regions also assist the juvenile justice system in diverting youth from the corrections and hospital systems into the mental health community-based system.

The Office of Behavioral Health central office has obtained a grant from the Louisiana Commission on Law Enforcement that will provide therapeutic foster homes for youth found not guilty by reason of insanity who are in need of intensive supervision and would previously have been ordered to DHH custody resulting in hospitalization. This is a pilot project for Orleans, Jefferson, St. Bernard, Plaquemines and Caddo parishes where youth are most in need of these services.

CRITERION 2
MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY –
INCIDENCE & PREVALENCE ESTIMATES
LOUISIANA FY 2011 ADULT & CHILD/ YOUTH PLAN

OBH continues to make great strides in upgrading information technology and in establishing electronic client data systems to meet the growing and changing needs for management information. These systems provide the means of comparing the number and characteristics of persons served relative to the estimated prevalence of need in the general population, but more importantly provide data to support service system planning, management, quality improvement, and performance accountability.

OBH currently operates several statewide computerized information and 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; and service provider characteristics. OBH is progressively moving towards one, integrated, web-based system to serve the reporting and electronic client record needs of the agency, sequentially retiring legacy systems and modernizing features at each step along the way. As the agency moves towards establishing the Office of Behavioral Health this fiscal year, merging and integrating the now separate organizational functions of the Office of Mental Health and Office for Addictive Disorders, planning is underway for one integrated, electronic behavioral health record system in keeping with contemporary EHR standards. This initiative is described in further detail below.

The *Office of Mental Health Integrated Information System (OMH-IIS)* is the current major information management system now used by OMH and all LGEs, with one exception, Jefferson Parish Human Services Authority (JPHSA), that operates its own proprietary electronic client record system, Anasazi. JPHSA uploads client-level data regularly to OMH, enabling full coverage for client-level data across the state. OMH-IIS is a state-of-the-art, web-based information system operating in an integrated fashion over the DHH wide-area network (WAN) on central SQL servers. The system provides for electronic admission/discharge, screening and assessment, service event recording, and concurrent electronic progress notes (a feature added this past fiscal year) for all persons served in community mental health clinics (CMHCs), state psychiatric hospitals, and regional acute psychiatric inpatient units. OMH-IIS provides an electronic Continuity-of-Care document, and electronic client record which provides a snapshot of the client's diagnosis, medications, and clinical needs at the time of discharge for purposes of information sharing and service coordination with the next level of care (be it hospital, acute unit, or CMHC). OMH-IIS also performs electronic Medicaid and Medicare billing for all programs. OMH-IIS has undergone several phases of a series of planned, sequenced enhancements, documented in previous Block Grant plans and now serves several features of an electronic behavioral health client record. At each step of the way the corresponding functions of the legacy LAN-based information systems are being "retired" as these have been added and augmented in OMH-IIS.

This past fiscal year, OMH added a number of enhancements to OMH-IIS to improve data collection and reporting of persons served, to support utilization management and to further provide outcome measurement. The Service Ticket/ Progress Note, the most recently implemented module, moves OMH-IIS ever closer to establishing the foundation for an electronic behavioral health record. Staff

no longer need use paper service tickets or progress notes. In addition, a new feature of this function is the launch of the coder role. A coder in OMH-IIS will be able to enter selected service ticket and progress note information for a provider who is in the field or unable to directly enter this information directly on the day the service is provided. The provider will be required to verify and electronically sign and approve the information entered by the coder before it becomes part of the record and before a ticket is sent for billing. As of July 1, 2010, OMH-IIS now has the capacity to track persons served by contractors of the regional MHCs. The Contract Client Registry (CCR) module in OMH-IIS allows contract monitors at the clinics to enter the names of their contract service providers into OMH-IIS and then each contractor will enter data on each person served which will be used to report on persons served through contracted services. Clinics are currently loading the CCR with contractor information and then each contractor will be given a secure ID and password which will allow them to enter service data. Heretofore, OMH-IIS reporting was limited to state funded, CMHC programs only. This function now provides an unduplicated count of all persons served across all CMHC and contract programs and also provides the means for tracking of the number of persons served through contracted evidenced-based services programs, such as Assertive Community Treatment, Intensive Case Management, and Support Housing, which were never before tracked. This new OMH-IIS function will significantly enhance the states capacity for reporting the number of persons served through contemporary service delivery under the community re-design efforts now underway. The plan for further development of OMH-IIS is to sequentially replace the remaining separate, non-integrated LAN-based legacy systems now operating statewide by extending the functionality of the expanding OMH-IIS system. OMH-IIS reporting has also been significantly augmented to provide better access to the reports of the number and characteristics of persons served by clinic, region, and the state as a whole, and to enable better management through monitoring and tracking of clients served. In addition, OBH plans to add centralized appointment scheduling integrated into the system and the addition of service recording and Medicaid billing for the Early Childhood Supports and Services program. Additional modules planned include: Provider credentialing & privileging (in conjunction with the current central provider registration); Expanded assessments and quality management functions, including capacity for contemporary performance & outcome measures and a continuity-of-care record; Tracking clients enrolled in evidenced-based treatments; and a central program registration system. While the current OMH-IIS employs current information technologies, rapidly changing technology and the development of standards requires its updating to serve as the core for the new system development.

OBH utilizes the electronic Level of Care Utilization System (LOCUS) as a foundational component of the Cornerstone Utilization Management program, integrated into OMH-IIS. LOCUS is a well-established clinical rating instrument that will be used to determine target population eligibility and intensity of need over the course of treatment. Data submitted is uploaded into the OMH data warehouse (described below) allowing LOCUS data to be linked to all existing clinical information within the warehouse, enabling a broad range of performance comparisons. These data are now being utilized to identify populations targeted for Medication Management Clinics in the Mental Health Redesign process based on their level of care. OMH also procured CA-LOCUS to determine Child and Adolescent Level of Care and has integrated it into OMH-IIS in the fiscal year 2009-10. Soon data from CA-LOCUS will be part of the data warehouse from which data can be pulled for ad hoc analyses through one of the existing query portals. Thus, there is now client-level level of care assessment data for both adults and children statewide.

Another recent major addition has been the implementation of the Telesage Outcome Measurement System (TOMS) integrated into OMH-IIS, which provides ongoing measures of client-level outcomes for adults and children/ youth (described further below). This will significantly enhance

the capacity for local, state, and federal reporting. OMH began implementation of the Telesage Outcome Measurement (TOMS) system statewide in March, 2010. This initiative is funded under the CMHS Data Infrastructure Grant (DIG). The TOMS system utilizes standardized client self-report outcome surveys and allows providers the means to monitor client treatment outcomes at repeated intervals over the course of treatment. This electronic outcome measurement system will transfer data into the OMH data warehouse where it will be combined with the existing clinical data allowing analysis of client outcomes from treatment. The Telesage system also provides the means of collecting consumer quality of care surveys for use in local, state, and national (URS/NOMS) reporting.

OMH operates a comprehensive data warehouse / decision support system to provide access 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 significantly enhances local planning, monitoring, and evaluation. DS On-line 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. DS Online also includes DataQuest, an easy to use (point-&-click) *ad hoc* reporting tool, which provides virtually unlimited views of the wide range of OMH performance data, displayed in easy-to-read, comparative (relative percentage) tables, with drill-down capability from the regional to facility and service provider levels. OMH has been implementing executive dashboards to display key performance indicators for periodic monitoring by leadership and managers. DS Online provides access to performance score cards and reports of consumer quality of care surveys by region/LGE and CMHC.

Another major decision support tool has been the continuing use of the Service Process Quality Management (SPQM) system, a proprietary web-based analytical system developed by MTM Services, Inc. SPQM utilizes standardized client dataset uploads from the OMH data warehouse and displays it through graphic dashboards and cross-tables for data-based decision making and program performance improvement by state managers (OMH regions and LGEs). 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. The focus of these webinars is often on improving access-to-care and direct care staff productivity, thus enhancing the Utilization Management Accountable Care program of OBH operations.

OBH has also launched a major initiative to establish an electronic behavioral health record system (EBHR) to address the needs of both mental health and addictive disorders service delivery and reporting. The goal of this initiative is to provide planning, education, and consensus building to identify and implement one integrated EBHR statewide, rather than each region/LGE implementing their own. This approach will be important to keeping statewide data reporting and comparisons uniform. OMH contracted with the National Data Infrastructure Improvement Consortium (NDIIC) to provide the needed technical assistance, consultation and training. An executive steering committee and multi-agency, multi-site stakeholder group was formed and participated in the initiative. The project activities included a comprehensive needs assessment, demonstrations and

reviews of proprietary and open-source systems, analyses of the pros and cons of various approaches to an EBHR, consultations with other states and a readiness assessment of the human and technical infrastructure needed to implement a system. Five approaches to an EBHR were reviewed: 1.) To continue to build and to integrate state-custom built systems; 2.) to procure a commercial system; 3.) to procure an open source system; 4.) to implement a hybrid of an open source and proprietary system; 5.) to allow each region/ LGE establish its own system. The pros and cons of each approach were reviewed in terms of cost of acquisition and implementation, the implementation timeline, and important features such as interoperability, certification, and infrastructure requirements. Priority system features were identified. It was determined that OBH should consider pursuing an open source/ hybrid solution as the most cost effective approach. OMH participated in two national meetings facilitated by NDIIC and dialogued with other states regarding implementation strategies in coordination with a national SAMHSA effort to develop a model for an EBHR. Based on analyses, NDIIC recommended that OBH proceed with establishing the necessary project staffing and conduct a Request for Information (RFI) for candidates that fit the identified prioritized state needs. The responses to the RFI will provide cost estimates to be determined that would enable OBH to prepare a budget for the coming fiscal year and an RFP to procure the desired system. The LA EBHR initiative is laying a firm foundation for the agency to make strides forward towards an integrated electronic client record in the coming fiscal year as the Office of Behavioral Health is operationalized.

As information technology advances, OMH continues to operate several legacy systems until these are systematically replaced by OMH-IIS or by an integrated electronic record system. These legacy systems continue to provide needed performance data for service system planning and monitoring. OMH legacy systems are largely custom-built, LAN-based, and compliant with national data standards (e.g., Mental Health Statistics Improvement Program - MHSIP). These legacy systems include:

PIP/PIF/ORYX. The Patient Information Program, implemented in 1992, operates in each of the state hospitals and regional acute units, providing a comprehensive array of data on all inpatients served. Together with OMH-IIS, it is the primary source of counts of persons served, diagnoses, lengths of stay, and bed utilization. The financial module (PIF), implemented in 1994, supports billing and accounts receivables, and the ORYX module, implemented in 1999, supports performance reporting for Joint Commission accreditation. PIP has been upgraded to include collection and reporting of the new Joint Commission 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 OMH-IT strategic plan identifies PIP/PIF/ORYX to be the next legacy system to be integrated into OMH-IIS. The state hospital and regional inpatient units are also included in plans for an integrated electronic behavioral health record system.

MHR/ MHS & UTOPIA. The Mental Health Rehabilitation/Mental Health Services system, implemented in 1995, supports client, assessment, and service data collection and reporting for Medicaid mental health rehabilitation provider agencies (MHR) and for some OMH contracted mental health service program providers (mainly case management) (MHS). The Utilization, Tracking, Oversight, and Prior Authorization (UTOPIA) system supports prior authorization of services and utilization and outcomes management at the state and area levels. The system is now being utilized in OMH in the PASSR program providing data on mental health needs in the nursing homes. MHR/MHS & UTOPIA both run in Visual Fox Pro. As of July 1, 2009, the Mental Health Rehabilitation Services Unit has been transferred to the Medicaid Office in DHH. As such, the MHR version of MHR/MHS is being maintained and further developed within the Medicaid Integrated Data

System. It has not yet been decided how the coordination of data between Medicaid and OMH will take place.

iPHARMACY SYSTEMS. OMH now operates the proprietary Health Care Systems (HCS) Medics pharmacy software system in each of the seven regional community pharmacies and each of the state psychiatric hospitals. This software automates prescription processing and management reporting, especially statewide monitoring of the utilization and costs of pharmaceuticals. These data have been critical for providing data to the OMH Pharmacy and Therapeutics Committee and in reviewing and managing the cost of pharmaceuticals statewide. Data are regularly uploaded to the OMH data warehouse. HCS interfaces with PIP in the hospitals to capture patient admission data. This past fiscal year, OMH began to replace the HCS system with the PRISM (NewTech, Inc.) software system in the regional community settings in order to upgrade system technology and operations to be more in keeping with the LA Board of Pharmacy requirements. Statewide implementation is underway. Pharmacy will be included in the requirements of the electronic behavioral health record system, at which time the PRISM system will be discontinued.

OTHER INFORMATION MANAGEMENT SYSTEMS. In addition to the above listed OMH data systems, there exist program specific data systems that are supported by OMH. These include the CRIS data system for the Child and Adolescent Response Team (CART), the ECSS-MIS supporting the Early Childhood Supports and Services (ECSS), and RiteTrack, a proprietary information system supporting the Louisiana Youth Enhancement Services (LA-YES). In each case, these specialized service programs have unique database needs that have been addressed by either building a suitable database in-house or in the case of LA-YES, purchasing a compatible commercial data management system. In each of these cases, efforts have been made to make sure that whatever system is being used, key clinical information can be uploaded to the OMH data warehouse which is the primary repository of this information for OMH.

Data Definitions & Methodology

SMI and EBD Definitions:	OMH 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:	OMH 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.
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.

Adult Target Population

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, schizoaffective 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.

OMH is in the process of revising and refining the definition of the Target Population to include such things as clients' functional status.

Child/Youth Target Population

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.

POPULATION ESTIMATES.

According to the *2009 Annual Estimates of the Resident Population 7/1/2009 State Characteristics, Population Estimates Division, U.S. Census Bureau (released June 22, 2010)*, the total number of adults in Louisiana is 3,368,690. Of these, according to national benchmarks, 2.6% are expected to have Serious Mental Illness (SMI). That translates into a total of 87,586 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 1,123,386. Of these, according to national benchmarks, 9% are expected to have an Emotional or Behavioral Disorder (EBD). That translates into a total of 101,105 children and youth with an EBD in Louisiana based on national prevalence rates.

Statistics show that 41,536 adults with SMI received outpatient services under the OMH umbrella in FY 2010 through both Mental Health Clinics and the Mental Health Rehabilitation (MHR) program. The Mental Health Rehab (MHR) program served 2,712 adults in FY 2010. Of the total number of adults served, both with and without SMI (54,021), 77% met the definition of Seriously Mentally Ill (SMI). Statistics show that 15,558 children and youth with EBD received outpatient services under the OMH umbrella in FY 2010 through both Community Mental Health Clinics and the Mental Health Rehabilitation (MHR) program. The MHR program served 7,784 children and youth. Of the total number of children and youth served (19,484), 80% met the definition of EBD.

As has been true since the hurricanes, many individuals who were in acute crises were seen in MHCs as a result of the aftermath of the hurricanes, and did not meet the more strict criteria of SMI or EBD. Strict comparisons between years are not feasible since some years Jefferson Parish Human Services Authority (JPHSA) data is included, and other years it is not; due to changes in the data systems.

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 and 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.

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 7/1/2009 - State Characteristics Population Estimates (Released June 22, 2010)*. 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 2009 numbers indicate that there were 4,492,076 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. It is important to note that population figures continue to be in flux, making estimates difficult and somewhat unreliable. Challenges continue, now with the devastating oil spill in the Gulf of Mexico.

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, 2009 - (Released June 22, 2010)

	Child/ Youth 9%		Adult 2.6%		Total	
	Pop Count	Prev Count	Pop Count	Prev Count	Pop Count	Prev Count
State-wide	1,123,386	101,105	3,368,690	87,586	4,492,076	188,691

* Annual Estimates of the Population for Parishes of Louisiana: April 1, 2000 to July 1, 2009 (cc-est2009-agesex-22csv)

Estimates Source: Population Division, US Census Bureau. Release Date: June22, 2010. <http://www.census.gov/popest/datasets.html>.

Prev. 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/District and Parish (July 1, 2009 Pop Est)***

Region/District	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, 2009	TOTAL PREVALENCE ESTIMATE
1-METROPOLITAN HUMAN SERVICE DISTRICT and NOAH Outpatient clinics	Orleans	76343	6,871	278507	7,241	354,850	14,112
	Plaquemines	5701	513	15241	396	20,942	909
	St. Bernard	10889	980	29766	774	40,655	1,754
Total for 1-MHSD		92,933	8,364	323,514	8,411	416,447	16,775
2-CAPITAL AREA HUMAN SERVICE DISTRICT	Ascension	29957	2,696	74865	1,946	104,822	4,643
	East Baton	104315	9,388	330318	8,588	434,633	17,977
	East Feliciana	4488	404	16482	429	20,970	832
	Iberville	7500	675	25005	650	32,505	1,325
	Pointe Coupee	5428	489	17019	442	22,447	931
	West Baton Rouge	5682	511	16956	441	22,638	952
	West Feliciana	2527	227	12528	326	15,055	553
Total for 2-CAHSD		159,897	14,391	493,173	12,822	653,070	27,213
3-SOUTH CENTRAL LOUISIANA MENTAL HEALTH AUTHORITY	Assumption	5446	490	17428	453	22,874	943
	Lafourche	22920	2,063	70762	1,840	93,682	3,903
	St. Charles	13858	1,247	37753	982	51,611	2,229
	St. James	5616	505	15438	401	21,054	907
	St. John the Baptist	13034	1,173	34052	885	47,086	2,058
	St. Mary	13772	1,239	37043	963	50,815	2,203
	Terrebonne	29235	2,631	80056	2,081	109,291	4,713
Total for 3-SCLMHA		103,881	9,349	292,532	7,606	396,413	16,955
Region 4	Acadia	16602	1,494	43493	1,131	60,095	2,625
	Evangeline	9757	878	25573	665	35,330	1,543
	Iberia	20827	1,874	54274	1,411	75,101	3,286
	Lafayette	52785	4,751	158169	4,112	210,954	8,863
	St. Landry	25444	2,290	66882	1,739	92,326	4,029
	St. Martin	13932	1,254	38285	995	52,217	2,249
	Vermilion	14813	1,333	41328	1,075	56,141	2,408
Total for Region 4		154,160	13,874	428,004	11,128	582,164	25,003

Region/District	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, 2009	TOTAL PREVALENCE ESTIMATE
Region 5	Allen	6008	541	19628	510	25,636	1,051
	Beauregard	9195	828	26224	682	35,419	1,509
	Calcasieu	48353	4,352	139201	3,619	187,554	7,971
	Cameron	1502	135	5082	132	6,584	267
	Jefferson Davis	8569	771	22528	586	31,097	1,357
Total for Region 5		73,627	6,626	212,663	5,529	286,290	12,156
Region 6	Avoyelles	10847	976	31664	823	42,511	1,799
	Catahoula	2544	229	7916	206	10,460	435
	Concordia	4907	442	14082	366	18,989	808
	Grant	5194	467	14970	389	20,164	857
	La Salle	3532	318	10432	271	13,964	589
	Rapides	34893	3,140	99044	2,575	133,937	5,716
	Vernon	12639	1,138	33977	883	46,616	2,021
	Winn	3427	308	11904	310	15,331	618
Total for Region 6		77,983	7,018	223,989	5,824	301,972	12,842
Region 7	Bienville	3423	308	11306	294	14,729	602
	Bossier	28647	2,578	82845	2,154	111,492	4,732
	Caddo	63531	5,718	190092	4,942	253,623	10,660
	Claiborne	3383	304	12735	331	16,118	636
	De Soto	6673	601	19728	513	26,401	1,113
	Natchitoches	9671	870	29584	769	39,255	1,640
	Red River	2452	221	6551	170	9,003	391
	Sabine	5988	539	17745	461	23,733	1,000
	Webster	9695	873	30849	802	40,544	1,675
Total for Region 7		133,463	12,012	401,435	10,437	534,898	22,449

Region/District	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, 2009	TOTAL PREVALENCE ESTIMATE
Region 8	Caldwell	2420	218	8019	208	10,439	426
	East Carroll	2137	192	5965	155	8,102	347
	Franklin	4987	449	14820	385	19,807	834
	Jackson	3460	311	11603	302	15,063	613
	Lincoln	9134	822	34152	888	43,286	1,710
	Madison	3103	279	8282	215	11,385	495
	Morehouse	7021	632	21202	551	28,223	1,183
	Ouachita	40117	3,611	111385	2,896	151,502	6,507
	Richland	5308	478	15114	393	20,422	871
	Tensas	1369	123	4240	110	5,609	233
	Union	5272	474	17312	450	22,584	925
	West Carroll	2724	245	8605	224	11,329	469
Total for Region 8		87,052	7,835	260,699	6,778	347,751	14,613
9-FLORIDA PARISHES HUMAN SERVICES AUTHORITY	Livingston	33952	3,056	89374	2,324	123,326	5,379
	St. Helena	2532	228	8019	208	10,551	436
	St. Tammany	59772	5,379	171723	4,465	231,495	9,844
	Tangipahoa	30378	2,734	88310	2,296	118,688	5,030
	Washington	11708	1,054	33961	883	45,669	1,937
Total for 9-FPHSA		138,342	12,451	391,387	10,176	529,729	22,627
10-JEFFERSON PARISH HUMAN SERVICES AUTHORITY	Jefferson	102048	9,184	341294	8,874	443,342	18,058
STATE TOTAL		1,123,386	101,105	3,368,690	87,586	4,492,076	188,691

<http://www.census.gov/popest/datasets.html>

Annual Estimates of the Population for Parishes of Louisiana: April 1, 2000 to July 1, 2009 (cc-est2009-agesex-22.csv 1)

Source: Population Division U.S. Census Bureau

Release Date: June 22, 2010

Prev. 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).

**POPULATION STATISTICS
FY 2011 - ADULT & C/ Y PLAN**

POPULATION BY AGE

State's Population By Age Range*		
Age Range	Number of Persons	Percentage of State's Population
0-17	1,123,386	25%
18+	3,368,690	75%
TOTAL	4,492,076	100%

*Based on Annual Resident Population Estimates: Annual State Population Estimates by Demographic. File: 7/1/2009
County Population Estimates Source: Population Division, US Census Bureau. Release Date: June 22, 2010.

**LOUISIANA OMH COMMUNITY MENTAL HEALTH CLINICS DATA
UNDUPLICATED COUNT OF PERSONS RECEIVING SERVICES FROM
JULY 1, 2009 TO JUNE 30, 2010 (OMHIIS & JPHSA)**

	UNDUPLICATED PERSONS RECEIVING SERVICES		TOTAL
	CHILD (0-17)	ADULT (18+)	
REGION			
REGION 1 CHILD/YOUTH CLINICS	629	.	629
MHSD	25	7,530	7,555
CAHSD*	2,399	6,533	8,932
REGION 3	519	6,839	7,358
REGION 4	713	5,030	5,743
REGION 5	355	1,722	2,077
REGION 6	722	3,026	3,748
REGION 7	861	2,631	3,492
REGION 8	434	3,297	3,731
FPHSA	1,738	5,927	7,665
JPHSA	2,312	6,562	8,874
TOTAL	10,707	49,097	59,804

Data Source: OMHIIS 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.

Louisiana Community Mental Health Clinics
ADULTS – CMHC PERSONS SERVED
UNDUPLICATED WITHIN REGIONS/LGEs FY09-10

Regions / LGEs	Adults with SMI Served (persons served)	Total Adults Served	% SMI
1-MHSD	7,584	11,350	67%
2-CAHSD	6,224	7,151	87%
REGION 3	6,246	7,057	89%
REGION 4	4,071	5,402	75%
REGION 5	1,464	1,691	87%
REGION 6	2,015	3,224	63%
REGION 7	2,303	2,495	92%
REGION 8	2,582	2,709	95%
9-FPHSA	3,607	3,903	92%
10-JPHSA	2,728	6,327	43%
MHR	2,712	2,712	100%
TOTAL	41,536	54,021	77%

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	28	48	58%
REGION 1 CHILD/YOUTH CLINICS	1,092	1,363	80%
2-CAHSD	2,387	2,904	82%
REGION 3	413	446	93%
REGION 4	746	923	81%
REGION 5	334	363	92%
REGION 6	299	672	44%
REGION 7	729	776	94%
REGION 8	375	396	95%
9-FPHSA	815	1,132	72%
10-JPHSA	584	2,725	21%
MHR	7,784	7,784	100%
TOTAL	15,558	19,484	80%

Data Source: OMHIIS, JPHSA, and MHR

**INPATIENT & OUTPATIENT CASELOAD ON JUNE 30, 2010
WITH SMI/EBD; PERCENTAGE OF SMI/EBD**

CASELOAD ON June 30, 2010 CMHC/PIP	ADULT: SMI	CHILD: SED	OTHER		TOTAL
	COUNT	Percent	COUNT	Percent	
Age 0-17	3,966	66%	2,022	34%	5988
Age 18+	24,368	72%	9,352	28%	33,720
.	6	67%	3	33%	9
TOTAL	28,340	71%	11,377	29%	39,717

Data from CMHC OMHIIS, PIP and JPHSA . CMHC unduplicated within Regions.

NOTE: Prior to the FY 2009 MHBG, totals have not included data from Jefferson Parish Human Service Authority (not available)

CMHC ADULT CASELOAD SIZE ON LAST DAY OF FY2009 & FY2010

	FY08-09			FY09-10		
	Age 18-64	Age 65+	TOTAL 18+	Age 18-64	Age 65+	TOTAL 18+
REGION						
CAHSD	4620	276	4896	4954	251	5205
REGION 3	4887	274	5161	4841	268	5109
REGION 4	3744	175	3919	3785	174	3959
REGION 5	849	29	878	1171	31	1202
REGION 6	2099	92	2191	1925	63	1988
REGION 7	1522	48	1570	1417	29	1446
REGION 8	1923	90	2013	1758	79	1837
FPHSA	2453	134	2587	2757	135	2892
JPHSA	4210	125	4335	3470	108	3578
MHSD	8846	368	9214	5454	237	5691
TOTAL	35153	1611	36764	31532	1375	32907

Data from CMHC ARAMIS (2009), OMHIIS and JPHSA (2010). CMHC unduplicated within Regions.

CMHC CHILD/ YOUTH CASELOAD SIZE ON LAST DAY OF FY2009 & FY2010

	FY08-09			FY09-10		
	Age 0-11	Age 12-17	TOTAL 0-17	Age 0-11	Age 12-17	TOTAL 0-17
REGION						
CHILD/YOUTH CLINICS	358	533	891	299	290	589
CAHSD	855	866	1721	816	1080	1896
REGION 3	66	147	213	74	200	274
REGION 4	226	260	486	227	286	513
REGION 5	45	63	108	82	105	187
REGION 6	154	211	365	126	137	263
REGION 7	146	215	361	138	177	315
REGION 8	72	98	170	47	100	147
FPHSA	294	287	581	349	346	695
JPHSA	580	803	1383	461	599	1060
MHSD	2	8	10	.	8	8
TOTAL	2798	3491	6289	2619	3328	5947

Data from CMHC ARAMIS (2009), OMHIIS and JPHSA (2010). CMHC unduplicated within Regions.

**CASELOAD SERVED BY OMH COMPARED
TO PREVALENCE ESTIMATES AND CENSUS DATA
FY 2010 - ADULT & CHILD/ YOUTH PLAN**

Age Range	LA Population Estimated*	National Prevalence Rate	Est. Number of persons in LA Population with SMI/EBD
Child/ Youth* 0-17	1,123,386	9%	1,123,386 X .09= 101,105
Adult** 18+	3,368,690	2.6%	3,368,690 X .026= 87,586
Total	4,492,076	-----	188,691

*Based on Annual Resident Population Estimates: Annual State Population Estimates by Demographic. File: 7/1/2009
County Population Estimates Source: Population Division, US Census Bureau. Release Date: June 22, 2010.

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	101,105	3,966	3,966 / 101,105= 3.9 %
Adult 18+	87,586	24,368	24,368 / 87,586= 27.8 %
Total	188,691	28,334	28,334 / 188,691= 15 %

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, which served
2,712 adults and 7,784 children and youth.

Prev. 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).

CRITERION 2
MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY – QUANTITATIVE TARGETS
LOUISIANA FY 2011 ADULT & CHILD/ YOUTH PLAN

Setting quantitative goals to be achieved for the numbers of adults who are seriously mentally ill and children and youth who are emotionally or behaviorally disordered, who are served in the public mental health system is a key requirement of the mental health block grant law.

The Office of Mental Health has set a goal to increase access to mental health services to persons with SMI/ EBD. Quantitatively, this means increasing the numbers of new admissions of persons with SMI/ EBD. Quantitative targets relate to the National Outcome Measure (NOMS) Performance Indicator “Increased Access to Services”. Louisiana reported this indicator in the past as the percentage of prevalence of adults who have a serious mental illness who receive mental health services from the Office of Mental Health during the fiscal year. The measure of the NOMS is now requested to be reported as simply the number of persons who have a mental illness and receive services.

The figures below 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. Given the numerous catastrophes and data problems that have occurred in the state in recent years, perhaps more than any other criteria, the Indicators for Criterion #2 continue to be the most difficult to predict or plan for.

NOTE: The data are more accurate this year than in the past. 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 that actually were. A new process in the clinics automatically cleans out information relating to clients who have not been seen for 9+ months.

This change will cause the numbers of persons on the caseload to appear to be smaller than in past years.

ADULT POPULATION

Previously, the measure was reported as a percentage:

- Numerator: Estimated unduplicated count of adults who have serious mental illness and who receive mental health services during the fiscal year (7/1-6/30) in an OMH community or inpatient setting.
- Denominator: Estimated 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 $23,954 / 84,475 \times 100 = 28.36\%$
FY 2005 $25,297 / 84,475 \times 100 = 29.95\%$
FY 2006 $24,667 / 71,294 \times 100 = 34.6\%$
FY 2007 $25,604 / 71,294 \times 100 = 35.9\%$
FY 2008 $27,619 / 83,555 \times 100 = 33.05\%$
FY 2009 $29,189 / 85,873 \times 100 = 33.9\%$
FY 2010 $24,368 / 87,586 \times 100 = 27.8\%$ (see **NOTE** above)

CHILD/ YOUTH POPULATION

Previously, the measure was reported as a percentage:

- Numerator: Estimated unduplicated count of children / youth who have serious mental illness and who receive mental health services during the fiscal year (7/1-6/30) in an OMH community or inpatient setting.
- Denominator: Estimated prevalence of children / youth in Louisiana with serious mental illness during a twelve month period.

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

FY 2004 $3,571 / 109,975 \times 100 = 3.25\%$
FY 2005 $3,765 / 109,975 \times 100 = 3.43\%$
FY 2006 $3,552 / 85,223 \times 100 = 4.17\%$
FY 2007 $3,818 / 85,223 \times 100 = 4.5\%$
FY 2008 $4,286 / 97,160 \times 100 = 4.4\%$
FY 2009 $4,317 / 99,718 \times 100 = 4.3\%$
FY 2010 $3,966 / 101,105 \times 100 = 3.9\%$ (see **NOTE** above)

- For specific information on the quantitative targets that are now reported only as the unduplicated count of adults (i.e., the Numerator only) who have serious mental illness and who receive mental health services during the fiscal year (7/1-6/30) in an OMH community or inpatient setting see the Performance Indicator section of this document.

CRITERION 3
CHILDREN'S SERVICES -- SYSTEM OF INTEGRATED SERVICES
FY 2011 – Child/Youth

EMERGENCY RESPONSE

Louisiana Spirit Hurricane Recovery Crisis Counseling Program (CCP) – Gustav Child and Youth Services

Louisiana Spirit was the project name of Louisiana's hurricane crisis counseling recovery program that began after the 2005 hurricanes and operated under the Gustav Crisis Counseling Program (CCP) grant from October 2008 through January 12, 2010. It provided short-term, community-based crisis intervention, support, and referral services to individuals and families impacted by Hurricane Gustav. The Office of Mental Health provided administrative oversight and guidance for this program. Direct services were provided via quasi-state entities. The regional entities were designated as Service Areas 1-7, with each area covering specific parishes. Louisiana Spirit outreach crisis counseling services for children and youth included disseminating information and educating the public on signs of distress and how to handle these. It also included a short term series of face to face meetings with children, youth and their families focused on assisting the family to cope with their trauma and return to their previous levels of coping. Crisis counselors provided education and information to parents and caregivers about signs of distress to be aware of in children as well as how to handle them and referrals to appropriate Mental Health resources. On a present-focused, short-term basis, children, youth, parents and caregivers were supported and empowered as they recovered from the impact of the hurricane. Although outreach crisis counseling services were community based, the services were not appropriate for life threatening or mandated reporting situations.

Under the Gustav grant, some of the children provided Crisis Counseling Program Services transitioned into Specialized Crisis Counseling Services (SCCS) to assist in meeting their ongoing psychosocial and educational needs. Counselors provided basic psycho-education sessions on coping, problem solving, social skills, anger management, trauma reactions, conflict management, adjustment, and other identified skill development areas of which children require more intensive support.

The Specialized Crisis Counseling component of Louisiana Spirit's CCP was instrumental in focusing counseling and resource linkage efforts on specific needs of children and their families. This program afforded children and their families opportunities to deal more assertively with the various problems that were hurricane related or problems that were exacerbated by the hurricane experience. The approach by counselors and resource linkage coordinators was one of a strengths-based, empowerment and solution-focused approach. Children and their families were taught the necessary skills needed to deal effectively with the various problems they presented with and how to work on manageable goals that enhanced their overall well-being while moving them closer to improved psychosocial and emotional recovery.

Louisiana Spirit sought to "communicate, coordinate, collaborate, cooperate*" with other agencies providing mental and behavioral health services to children and youth. Louisiana Spirit reached out to entities providing services to children and youth to offer crisis counseling services on a short-term basis. When more intense mental health treatment was appropriate, referrals were made to these entities by Louisiana Spirit. Child and youth agency providers were also referring children and youth needing hurricane related crisis counseling and support to Louisiana Spirit.

Resource linkage coordinators and crisis counselors reached out to children in a variety of places during the program. Some of the places included: the FEMA transitional living sites, schools, after school programs, summer camp programs, library summer reading & activity programs, summer youth activities such as ball parks, fairs and festivals that included children's activities and issues, church youth groups, organizations like scouting and boys and girls clubs. Methods included: purposeful play activities focused on handling intense emotions like fear, anxiety, anger, and sadness, as well as increasing children and youth's coping skills. Education was also offered on the connections between thoughts, feelings and behaviors and how making changes in one area impacts another area. Some of the children reported using their 'magic triangle' of thoughts, feelings and behaviors to manage their feelings and behaviors: frequently holding their thumbs and forefingers in a triangle shape as a portable visual reminder.

Under DR-1786-LA, Gustav Louisiana Spirit ISP and RSP grants, there was a total of 1, 512 individual crisis counseling sessions with children and youth (ages 0-17) under the Crisis Counseling Program. There were 29 assessments completed with 20 children under the Specialized Crisis Counseling Services of the program. There were at least 687 children and youth group participants during the Gustav CCP; age was only indicated on the data form if age was the common identify of the group. For the Gustav ISP, there were 756 individual sessions and 172 group sessions with children and youth; under the Gustav RSP, there were 756 individual sessions and 515 group sessions. Overall, there was a decline in the total number of children seen during the Gustav Crisis Counseling Program. Compared to hurricanes Katrina and Rita, Gustav tended to have less of a traumatic impact on children and youth. The schools and community entities were less inclined to identify problematic behaviors in the children that they associated with the hurricane. Under Gustav, more emphasis was placed on working with families as a unit and fewer services were provided for children and youth sans guardians in school and community settings.

The Federal funding for DR-1786-LA, Gustav Crisis Counseling Program Regular Services Program ended June 30, 2010. Direct services of the program ceased January 12, 2010. Programmatic and fiscal closeout activities continued through June 30, 2010.

*the phrase used by the Volunteer Organizations Active in Disasters (VOADs) groups

Louisiana Spirit Oil Spill Recovery Program

Beginning May 21, 2010, the State of Louisiana began providing crisis counseling services for residents impacted by the oil spill that occurred off the coast on April 20, 2010. The current program utilizes funds from British Petroleum to provide crisis counseling in the areas of mental health, substance abuse and emotional and behavioral health counseling for those whose lives were disrupted. The Recovery program has worked closely with local resources and other response entities. To date, the program has provided few services to children and youth impacted by the spill. It is anticipated that more services will be provided to children and youth as the oil spill continues to impact residents in the years to come.

SOCIAL SERVICES

FY 2011 – Child/Youth

The Children's Cabinet is a policy office in the Office of the Governor created by Act 5 of the 1998 Extraordinary Session of the Louisiana Legislature. The Cabinet's primary function is to coordinate children's policy across the five departments that provide services for young people: Departments of Education, Health and Hospitals, the Louisiana Workforce Commission, Public Safety and Corrections, and Social Services. Each year, the Cabinet makes recommendations to the Governor on funding priorities for new and expanded programs for children and youth. These programs emphasize the President's New Freedom Commission on Mental Health goals to have disparities in mental health services eliminated and to ensure that mental health care is consumer and family driven.

The Cabinet is responsible for recommendations to the Children's Budget, a separate section of the General Appropriation Act enacted by the Legislature. The Children's Budget includes a compilation and listing of all appropriations contained in the Act which fund services and programs for children and their families. The Children's Cabinet Advisory Board was created to provide information and recommendations from the perspective of advocacy groups, service providers, and parents to the Children's Cabinet.

Interagency collaboration through the Interagency Service Coordination (ISC) Program is defined as any of the “formal arrangements” between child serving agencies. Ten Interagency Service Coordination teams (one per Region/ LGE) are currently operating in Louisiana. These teams include permanent members who make recommendations that may resolve problems with service delivery for children who have unique needs that are difficult to meet. Team members include mental health, education, developmental disabilities, child welfare, public health, and juvenile justice. Other members of a team include the parent/caretaker, child/youth whenever appropriate, and other key persons who may be involved in the child and family's life and services. The local teams may request assistance from the State Interagency Team for individuals who require resources unavailable to the local ISCs. Many of the families served reside in rural areas with few mental health and other resources, and the agencies coordinate to improve access to quality care in many ways including video conferencing, coordinated services, and educating families where and how to get care.

There is an increase in youth with multiple needs who are developmentally delayed, mentally ill, chemically addicted and who are living in poverty. More juvenile judges are ordering local ISC teams to meet and collaborate with other agencies to create appropriate placements where there are none. Approximately 95% of the ISC service plans successfully provide a stable placement and wraparound services to maintain the individual in the community. Those plans that failed required additional local ISC and State ISC meetings to locate and create appropriate resources to meet the needs of these youth.

The Families In Need of Services (FINS) became effective in all courts having juvenile jurisdiction on July 1, 1994, as Title VII of the Louisiana Children's Code. FINS is an approach designed to bring together coordinated community resources for the purpose of helping families (troubled youth and their parents) to remedy self destructive behaviors by juveniles and/or other family members.

The goals of FINS are to reduce formal juvenile court involvement while generating appropriate community services to benefit the child and improve family relations. The child and family are not adjudicated unless there is failure by family members to cooperate with the mandates of the service plan. FINS has been successful in the following ways: 1) facilitating the receipt of needed services, 2) coordinating the cooperation of the community and its resources, and 3) decreasing involvement in the Judicial System.

FINS parallels Interagency Service Coordination (ISC) by creating an opportunity for all agencies to pool resources to decrease illegal behavior by youth. FINS and ISC combine their efforts to create unique plans for youth and push to transform the existing system of care. OMH participates in these interagency meetings as one means of decreasing the high profile, high risk court cases tracked by the Juvenile Justice Clearinghouse.

EDUCATIONAL SERVICES, INCLUDING SERVICES PROVIDED UNDER IDEA FY 2011 – Child/Youth

The Office of Behavioral Health recognizes the importance of early intervention in a variety of settings, including schools, as outlined in the *President's New Freedom Commission Report* which addresses early mental health screening, assessment, and referral to services. It is recognized that poor social and emotional skills as well as illiteracy, predict early school failure. Literacy interventions specific for children with emotional and behavioral disorders (EBD) must be available in all learning settings for children at the earliest ages possible.

School-based Health Clinics (SBHCs)

OBH supports school-based mental health and health-related services in academic settings. OBH clinicians believe that youth with emotional and behavior problems can become high school graduates, if given the proper supports and services. School based health clinics that provide mental health services are utilizing positive means of supporting appropriate school behavior. Early identification and assistance for families with children at risk for educational and behavioral problems are an essential part of helping children and youth lead satisfying and productive lives in the community.

In 1990, as policy makers became concerned about the high morbidity and mortality rates of adolescents, the Louisiana Legislature asked the Office of Public Health (OPH) to determine the feasibility of opening school-based health centers. As a result, the Adolescent School Health Initiative was enacted in 1991. The 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 public schools. The role of the Office of Public Health's Adolescent School Health Program is to provide technical assistance to School Based Health Centers (SBHCs); establish and monitor compliance with standards, policies, and guidelines for school health center operation; provide financial assistance; and encourage collaboration with other agencies and other potential funding sources.

School Based Health Clinics are funded by the Maternal and Child Health (MCH) Block Grant and state legislative appropriations. For the fiscal year 2009-10 Louisiana received a decrease in the MCH Block Grant from \$480,000 to \$300,000 but increased operation to 65 SBHCs. An SBHC is required to offer comprehensive preventive and primary health services that address the physical, emotional and educational needs of its student population. Each SBHC must execute cooperative agreements with community health care providers to link students to support and specialty services

not provided at the school site. A SBHC provides convenient access to comprehensive, primary and preventive physical and mental health services for public school students at the school site, since students spend a significant portion of their day on school grounds. SBHCs are accessible, convenient, encourage family and community involvement, reduce student absenteeism, reduce parental leave from work for doctor visits, and work with school personnel to meet the needs of students and their families. Parental consent must be obtained prior to seeing a student as a patient.

Staffing in the SBHC include, at a minimum a primary care provider (physician, physician assistant, or nurse practitioner), a medical director, a registered nurse, a master's level mental health provider, an administrator, and an office assistant.

Services include:

- Primary and preventive health care including: comprehensive exams, and sports physicals, immunizations, health screenings, acute care for minor illness and injury, and management of chronic diseases such as asthma;
- Mental health services;
- Health education and prevention programs;
- Case management;
- Dental services;
- Referral to specialty care; and
- Louisiana Children's Health Insurance Program (LaCHIP) application centers.

In examples of specific collaborative agreements:

- Staff members at clinics facilitate access to emergency and evaluative mental health services for referrals from SBHC social work staff;
- SBHCs have provided in-school mental health counseling for students and/ or their parents who do not meet the stricter requirements for treatment through the clinics;
- the Psychiatry Department of LSU Health Sciences Center has provided psychiatry services to SBHCs in New Orleans;
- Metropolitan Human Services District has partnered with SBHCs locally to provide a part-time psychiatrist and full time behavioral health professional to provide services;
- Southeast Louisiana State Hospital has an agreement with the St. Tammany School System that allows adolescents in the Developmental Neuropsychiatric Program (DNP) to attend public school with an accompanying behavior shaping specialist.
- The “Evolutions Program” at Greenwell Springs Campus in the Eastern Louisiana Mental Health System has close ties to the East Baton Rouge and surrounding parish school systems for referrals and support.
- Central Louisiana State Hospital also has a program that has been involved with local school systems.

During the most recent time frame for which data is available, there were 43,767 students registered at SBHCs and 29,711 students received services at SBHCs (2008-2009 school year).

Positive Behavioral Interventions and Supports (PBIS)

PBIS is a major national initiative to assist schools in developing more proactive approaches for addressing challenging behavior and supporting appropriate behavior for all students. Louisiana ranks seventh nationwide in the number of schools implementing PBIS. There are at least 1,025 of the 1,501 public schools trained in School Wide Positive Behavior Support (SWPBS) in Louisiana, representing approximately 68% of all public schools in the state (including all types of charter

schools), that have functional PBIS teams that are coordinating the implementation of a positive behavioral approach, PBIS, at their respective schools.

Schools implementing PBIS have shown a decrease in suspensions and expulsions. Some school districts utilize site-based Behavior Intervention Specialists. School and educational related initiatives including home character education, bullying prevention, and drug free programs provide evidence of the integration of public mental health services with educational services for youth. When compared to control groups, PBIS groups show an increase in social skills by 20 percent based on pre- and post-measures. While not directed specifically to the EBD population, these programs significantly benefit children and youth with EBD. Training opportunities and materials to support PBS implementation may be found on the website: www.lapositionbehavior.com.

Individuals with Disabilities Act (IDEA)

The Louisiana school system is in full compliance with the Individuals with Disabilities Education Act (IDEA), and subsequent amendments to the IDEA under P.L. 105-117. In order to address the IDEA amendments in Louisiana, many significant changes were made in education policies and procedures.

Since the implementation of the IDEA in 1998, it is recognized that youth with emotional or behavioral disorders (EBD) are capable of and should be able to receive high school diplomas. Children and youth with EBD do not necessarily have cognitive disorders, and therefore with appropriate accommodations can learn and can earn a diploma. The development of Alternative Schools and Structured Learning Programs (SLP) in alternative school settings allow middle and high school students with EBD to receive intensive services to modify the behaviors that interfere with the individual's ability to learn. Similarly, on elementary school campuses, there is a Structured Learning Class (SLC) where children with EBD are placed with additional resources available to them.

Educational Supports by Region/ Local Governing Entity:

Metropolitan Human Services District (MHSD)

- 2,495 students received mental health services at SBHCs

Capital Area Human Services District (CAHSD)

- 28 SBHCs in the seven parish District
- 685 students received mental health services at SBHCs
- Via the School Based Therapy program, approximately 761 clients were served (354 elementary, 243 middle, 164 high school)
- 2993 students were reached during Children's Mental Health Week in May, which focused on SAMHSA's recommended topic, "My Feelings are My World."
- 27 schools are effectively utilizing PBIS

Region III

- 719 students received mental health services at SBHCs

Region IV

- Early Childhood Supports & Services (ECSS) - provides specialized therapeutic and case management services for young children ages 0-5 and their parents, including behavioral intervention and skills training.

- Approximately 3888 (duplicated) students, and 1504 (nonduplicated) students received mental health services at SBHCs in the most recent fiscal year. These are not contract hours but the number of students served or visits for last year.
- School-based Behavioral Health Services, available in many schools in the area, provided screening, clinical evaluation, individual and group therapy, in school counseling, family counseling, and case management, as well as substance abuse education for students, family, and the community.
- Lafayette Parish School System- School Based Therapy, Assessment, and Referrals (STARS), provides on site services by a master's level clinician at Parish schools, funded through District general funds.
- Iberia Parish: 16th Judicial District Family services Program, funded through the District Attorney's Office.

Region V

- OMH has contracts for school based mental health services and served 378 youth for over 6,042 hours of direct service during the fiscal year 2009-10
- Services included individual and group therapy, education and consultation
- School based mental staff include licensed social workers and licensed professional counselors
- Every school in the Region has implemented PBIS at some level
- Families of SWLA- Training, Support, & Advocacy to assist
- LaPTIC provides information, referral, and assistance with educational issues
- CPSB Behavior Team offers school wide support services for students with behavioral issues.
- Calcasieu Alternative School is an alternative school for grades 6-12, utilizes the Boys Town Behavior program and offers onsite counseling.
- Beauregard Alternative School is a boot camp style alternative school, utilizes PBIS and has an onsite social worker for counseling.

Region VI

- 4,966 students received mental health services at SBHCs
- Services were primarily evaluation and counseling

Region VII

- 2,063 students received mental health services at SBHCs
- PBIS offered in many schools
- Webster Parish School Board has a School Psychologist who assists with IEPs, behavior plans, targeted interventions, and PBIS contract staff at various schools
- Claiborne Parish School Board offers anger management and social skills groups

Region VIII

- For the fiscal year 2009-10, 779 students received mental health services at the SBHCs, for a total of 2,177 contact hours

Florida Parishes Human Service Authority (FPHSA)

- Florida Parishes have 6 SBHCs

- Covington Pathways/St. Tammany Schools – alternative school for behavior, disordered youth. Structured, trained teachers
- Slidell Pathways/ St. Tammany Schools - alternative school for behavior, disordered youth. Structured, trained teachers
- Operation JumpStart / St. Tammany Schools – Alternative school for individuals that were expelled due to drug use or weapons/assault
- Bogalusa City Schools / Washington Schools offers positive behavioral supports; noncategorical, nongraded special education, speech and occupational therapy
- Northwood High/Tangipahoa Schools is an alternative school addressing behavioral concerns
- Franklinton Alternative School/Washington Schools offers specialized student support services to resolve complicated situations involving student discipline
- Livingston Parish School / Livingston Schools – counselors provide a guidance program linking agencies to provide developmentally appropriate services
- Options III/Livingston Schools is an alternative school for students to work towards a LA equivalency Diploma and/or skills certificate; pre-GED training
- Numerous schools have PBIS
- ECSS provides services

Jefferson Parish Human Service Authority (JPHSA)

- JPHSA has 33 SBHCs, where 796 students received mental health services, for a total of 3,458.39 contact hours
- 504 Modifications and a variety of special education services are offered.

Educational services have also been available to youth in OBH psychiatric hospitals through a Memorandum of Understanding with the Special School District #1 of the Department of Education to provide educational services to children and youth who are hospitalized. In sum, students in psychiatric hospitals receive education, and students in schools receive mental health services; thereby addressing the needs of all students including those who are at risk for serious behavior problems.

JUVENILE JUSTICE SERVICES FY 2011 – Child/Youth

The Juvenile Justice Clearinghouse project was created the fall of 1997 in order to develop a less adversarial and more cooperative relationship with the court by providing a more consistent and organized response from the Department of Health and Hospitals to the juvenile courts' orders and requests. These juveniles are high-profile, high-risk court cases with multiple diagnoses (psychiatric disorders, developmental disabilities, substance abuse, and/or major medical issues) and require services from multiple state departments or agencies. This project advances access to and accountability for mental health services to youth.

The DHH Juvenile Justice Clearinghouse does not have access to funding, nor does it perform any clinical or program function. Its purpose is to assist in the implementation and coordination of services and programs already in place throughout the state and to encourage agencies to combine resources and create unique plans for placement of youth who fail to fit into the existing system of care. This effort requires a fundamental transformation in the state's approach to mental health care for these youth.

Some progress toward a better understanding of agencies' resources, current policies and procedures, systemic concerns, and potential problems has occurred between the juvenile courts and DHH agencies. Through the Interagency Service Coordination (ISC) and Families in Need of Services (FINS), the DHH agencies, Office of Family Services, Office of Youth Development, Department of Education, and juvenile courts are beginning to plan more effectively for placement and development of community resources to keep children out of institutions.

It has long been recognized that many of the state's youth are entering the judicial system with undiagnosed or unaddressed mental health concerns. There have been numerous attempts to remedy this situation, which include mental health screenings upon initial contact with the juvenile justice system as well as attempts to develop and implement electronic health or other record systems and universal databases; many of these types of systems are still under study, development, and review.

The following regional programs offer examples of available preventative and/or intervention type Juvenile Justice Services:

MHSD:

- Juvenile Court Liaison in Orleans parish provides a social worker in court setting to triage clients for SED and AD
- Juvenile Court Liaison in Plaquemines parish provides resources to courts to coordinate care for clients.

CAHSD:

- Juvenile Drug Court completes CASI assessment and group treatment for substance use.

Region III:

- Regional School Based DARE Program promotes substance awareness and prevention in school
- LaFourche Juvenile Justice Facility (LJFF) provides shelter, group home, and detention along with ROPES course
- Juvenile Justice Program offers ROPES challenge course for children and youth age 11-18.
- St. Mary's Parish Juvenile Drug Court is a program in the community that although does not target EBD population, it does provide mental health services
- Trackers Program is a daily monitoring of youth involved with OJJ, administered by GCTFS

Region IV:

- FINS offers interagency assistance, support, and collaboration for youth at risk of juvenile justice system involvement
- Juvenile Drug Court is a 4 phase program that includes drug screens, individual, group, and family counseling.
- Juvenile Day Reporting Center provides a safe, structured alternative day program for expelled and out of school youth.
- St. Martin Juvenile Detention Center-Mental Health Services offers assessment, treatment, and aftercare services for youth incarcerated in St. Martin Juvenile Detention center.

Region V:

- Truancy Assessment and Service Center (TASC) provides services to students in 1st through 5th grade, identified or at risk for truancy. Program focuses on early intervention.
- ISC (Mental Health Program) provides a forum for local agencies to meet with families to provide resources support and linkage.
- Drug Court is an intensive counseling and substance abuse treatment program designed to address adolescent substance abuse and juvenile justice issues.
- Mental Health Court is a program designed to assist EBD child/youth who are involved in the juvenile justice system.
- FINS is a program designed to identify child and family risk factors and refer to service.

Region VI:

- FINS (Families In Need of Services) is a pre-court, legally sanctioned intervention for youth exhibiting anti-social behaviors
- JWRAP (Juvenile Wellness Recovery Action Plan) assists families and youth in carrying out FINS plans.
- Multi-Systemic Therapy (MST) offers individualized and intensive family and community based treatment.
- Functional Family Therapy (FFT) offers a flexible prevention/intervention service delivery program for youth and families that occurs in stages.
- Mental Health Rehab Agencies provide services to children and youth, age 17 and under

Region VII:

- FINS - Families In Need of Services (FINS) is an intervention process aimed at preventing formal juvenile court involvement which provides interventions through development of a family service plan. This plan outlines support services and linkages to community agencies, thus reducing the number of youth in the juvenile court system and securing the youth in the home and community. Referrals can be made by the parents, school officials, district attorneys, judges, or concerned citizens.
- Juvenile Court Drug Court provides screenings and counseling to youth who are involved in the juvenile justice system.
- Mental Health Court offers individual deferred disposition and service for youth with mental health diagnosis. Although the court is not a provider of mental health services, the purpose of this specialized section is to utilize a treatment-oriented disposition whenever possible, ensuring that the specific needs of juveniles with serious biologically based brain disorders and cognitive disabilities are addressed appropriately. The goals of this specialized program are to ensure that seriously mentally ill juvenile offenders are treated humanely within the context of their illness, while ensuring community safety, and reducing the risk of recidivism.
- Teen Court is a program in Caddo parish that allows teens to take on the role of judge, jury, and attorney for youth with minor charges.
- Red River Marine Institute is a day treatment/education program combining an academic and adventure based environment to prevent and/or reduce delinquency.
- STAR-Specialized Treatment and Rehabilitation program is structured for in-school prevention, intervention, and follow up services.
- Volunteers for Youth Justice is an empowering and mentoring program for at risk/court involved youth.

- The Truancy Center is an early intervention program for children in kindergarten through 5th grade who have had excessive unexcused absences, tardies, and suspensions.
- Soldiers of Compassion is a faith based program that provides mentor family education as well as drug and alcohol recovery
- Curfew Center- Shreveport: minors out after curfew are brought to the center and counseled regarding current law and consequences, parental counseling also offered

Region VIII:

- FINS targets ages 6-18 to assist at-risk youth/families in order to prevent involvement with law-enforcement and other legal entities.
- DARE (ages 6-18) educate youth in schools/community settings on dangers of alcohol/drug use.
- Children's Coalition TEENSCREEN is a program to identify suicidality and other mental health issues in school-aged children and connect with appropriate services.

FPHSA:

- Slidell Drug Court offers counseling, monitoring, and drug testing
- FINS/Youth Services Bureau provides group treatment, anger management and in home family treatment
- Options/Youth Services Bureau offers drug treatment and testing
- TASC/FINS provides truancy monitoring and referrals for services
- CASA provides court appointed Special Advocates to assure youth are receiving needed services
- New Directions/MMO is an inpatient unit for juvenile sexual perpetrators
- Florida Parishes Juvenile Detention Center offers tours of the facility and programs to deter behavior that would lead to placement
- Possibilities for a Better Tomorrow is a part school, part community based services for adolescents
- Juvenile Drug Court offered in 21st JDC

JPHSA:

- JP Juvenile Drug Court provides intensive treatment utilizing the Multi-systemic Therapy model
- JP Juvenile Services/ Functional Family Therapy (FFT) provides FFT to youth on probation
- JP Juvenile Services/Treatment Services has a variety of treatment contracts to serve youth on probation
- JP FINS Strengthening Families Program offers family group intervention for youth involved in FINS court
- Truancy Assessment Center (TASC) provides services for children and families who have been identified by high number of unexcused absences from school

SUBSTANCE ABUSE SERVICES FY 2011 – Child/Youth

Please refer to Criterion 1 of the Child/Youth section on Services for Persons with Co-Occurring Disorders (substance abuse/mental health) for information on this topic.

HEALTH AND MENTAL HEALTH SERVICES

FY 2009 – Child/Youth

The Office of Mental Health (OMH) has informally collaborated with the Office of Public Health (OPH) in providing consultation, monitoring and assuring quality health and mental care in state funded school-based health centers across Louisiana. This partnership is reflective of the understanding that mental health is essential to overall health.

OBH clinical staff members in each locale expedite access to emergency and evaluative mental health services for referrals from School Based Health Clinic (SBHC) staff as part of OBH's informal collaborative efforts. SBHCs have followed up with OBH's recommended in-school mental health counseling for elementary, middle, and high school students and / or their parents who are not eligible for early mental health intervention services in OBH clinics. OBH and OPH encourage their clinical staff to attend appropriate training and educational programs by OPH or OBH. OBH, the Office for Citizens with Developmental Disabilities (OCDD), Medicaid, and the Bureau of Community Supports and Services also have an MOU to provide wraparound Medicaid waiver supports and services to children/ youth who have both a developmental disability and a mental illness.

Early Childhood Supports and Services (ECSS)

The Early Childhood Supports and Services (ECSS) program is a multi-agency prevention and intervention program that promotes a positive environment for learning, growth, and relationship building for children. ECSS provides infant mental health screening and assessment, counseling, therapy, child abuse and domestic violence prevention, case management, behavior modification, parent support groups, and the use of emergency intervention funds. ECSS also serves to build the infrastructure of the Parishes it serves by training human services professionals, agency personnel, educational and childcare personnel as well as family members and advocates in the specialized area of Infant Mental Health assessment and intervention. ECSS serves children from birth through 5 years of age and their families who have been identified as at-risk for developing social, emotional, and/or developmental problems. Risk factors include abuse, neglect, and exposure to violence, parental mental illness, parental substance abuse, poverty, and having developmental disabilities.

ECSS now serves the Delta Region of the State, known as Louisiana's most impoverished area, as well as having added Caddo parish in the 2009-10 fiscal year. ECSS provides or will provide Intensive Infant Mental Health training to 21 or more service providers, who will in turn provide infant mental health intervention to children 0 through 5 in ten sites, providing services in fourteen parishes. During the past year, ECSS screened over 1,800 children between the ages of 0 through 5 for risk factors that may lead to social/ emotional problems later in life.

Using emergency intervention funds, ECSS purchased services or supports for families in the amount of \$240,685. These services would not have been otherwise available. ECSS joins local public, private, and non-profit agencies and organizations into Networks that provide coordinated, cross-agency screening, evaluation, referral, and treatment. Local ECSS Networks include collaborative relationships between the DHH Office of Mental Health, the Department of Social Services, and the Office of Family Services. Other agencies participating in the networks include Head Start, Early Head Start, local school systems, Department of Education, and the DHH Offices

of Public Health, and Citizens with Developmental Disabilities. Elements of the ECSS Program include integrated and comprehensive local systems of care for young children, early identification and intervention, state and local collaboration, healthy brain development, and school readiness. ECSS provides infant mental health screening and assessment, counseling, therapy, child abuse and domestic violence prevention, case management, behavior modification, parent support groups, and use of emergency intervention funds to purchase supports and services that are not otherwise available.

Louisiana Youth Enhanced Services (LA-Y.E.S.) Project

LA-Y.E.S. is a system of care established for children and youth with serious emotional and behavioral disorders funded through a cooperative agreement between the Substance Abuse and Mental Health Services Administration (SAMHSA), the Louisiana Department of Health and Hospitals, and the Office of Behavioral Health, formerly the Office of Mental Health. LA-Y.E.S. builds upon prior federal initiatives partnering with state and local public mental health programs for improving mental health services for children and youth. It is a Louisiana cooperative agreement between the Center for Children's Mental Health Services of SAMHSA and local partners where the values and principles of systems of care are implemented. The stated values of LA-Y.E.S. are as follows: "Services are youth guided and family focused, community-based, and culturally and linguistically competent." The principles include: Access to comprehensive array of services; individualized service plans; services delivered in the least restrictive environment; family participants in all aspects of service planning; service systems integration; all children and families receive care management; children's problems are identified early; youth entering adulthood transitioned into adult care; the rights of service recipients are protected; and services are non-discriminatory.

LA-Y.E.S. has joined with community partners to work with families and youth addressing children's mental health. Critical collaboration partners include mental health, juvenile justice, child welfare, education, health, local universities, and human services (social services) areas. Service integration may start in family courts or in schools, or from a wide variety of other community portals. Services are characterized by coordination, multi-disciplinary teams, comprehensive array of services, community-based, culturally and linguistically competent, evidence-based, and outcome oriented. This "wraparound" approach itself is an evidence-based model based on national evaluations funded to evaluate all federally funded systems of care. LA-Y.E.S. is a child-focused and family-driven organization that aims to meet the mental health needs of youth, ages 3-21, and their families in Orleans, Jefferson, Plaquemines, St. Bernard, and St. Tammany parishes.

The LA-Y.E.S. system of care aims to address three main obstacles that citizens of Louisiana, including children and adolescents with mental illness, face when getting the care they need:

- The stigma associated with mental illness;
- The unfair treatment limitations and financial requirements placed on receiving care; and
- The fragmented mental health service delivery system.

Due to Louisiana's monumental need for systems reform, the Office of Juvenile Justice (OJJ), formerly the Office of Youth Development (OYD) began implementation of a plan to address juvenile justice reform and adopt models of change, as well as evidence based interventions. Multi-systemic Therapy (MST) is one such evidence based therapy that is provided by LA-Y.E.S. partners, and specifically recommended by OJJ. This evidence-based practice, now

adopted by the OBH and the state's Medicaid Office, is designed to work with youngsters to alter their trajectory away from incarceration toward adaptive functioning in society. MST is a choice intervention because youth with behavioral and emotional disorders and juvenile justice involvement account for a significant percentage of the LA-Y.E.S. referral base. Other evidence based interventions delivered by LA-Y.E.S. Provider Network include cognitive behavior therapy, and trauma focused cognitive behavior therapy.

Additionally, there are several other LA-Y.E.S. initiatives that are scheduled for implementation in FY 10-11. They are:

- Operating non-profit 501(c)3 organization [IRS approved 501(c)3 request in 2010]
- Further development of the LA-Y.E.S. Board of Directors
- Expansion of the LA-Y.E.S. Training Institute
- Mental Health Rehabilitation Provider
- Expansion of the School-Based Initiative
- Expansion of the LA-Y.E.S Consortium
- Crisis Respite for Families

Nearing the end of the sixth year extension of the grant, LA-Y.E.S. has achieved several major milestones. Although the project continues to move toward meeting all initial goals and objectives, the impact of Hurricane Katrina in August 2005 continues to pose major infrastructural and systems issues that are unique to communities that are rebuilding in the affected parishes. The high level of structural reorganization, community and organizational development, loss of mental health professionals, agency personnel changes, as well as mental and behavioral health needs of the families and children are continually being assessed and changes made accordingly. LA-Y.E.S. project accomplishments include:

- The project began service delivery in Orleans Parish in December 2004; approximately 578 youth have received services from January 2006 when the program returned to the New Orleans area following program interruption due to Hurricane Katrina until the end of June, 2010.
- At the end of the sixth year extension of the grant, the project delivered services to roughly 1619 children and families in a five-parish area in and around New Orleans, LA, and has substantially implemented expansion of services to the remaining two parishes (St. Tammany and St. Bernard) in its target area.
- LA-Y.E.S. has continued to operate a School-Based initiative that targets students in charter schools in the greater New Orleans area.
- The establishment of the LA-Y.E.S Consortium allows for children, families, and stakeholders to have their voices heard. The consortium is the governing body of the Louisiana Youth Enhanced Services Project that meets monthly. Its membership represents family members, community agencies, mental health professionals, teachers and other individuals working with children. Family involvement is an integral part of the LA-Y.E.S. Consortium. This involvement refers to the identification, outreach efforts, and engagement of diverse families receiving system of care services so that their experiences and perspectives collectively drive the planning, implementation, and evaluation of the system of care.

CRITERION 4
TARGETED SERVICES TO RURAL & HOMELESS POPULATIONS –
OUTREACH TO HOMELESS
FY 2011 – Child/Youth

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. The primary focus of the Act was to stimulate the economy by providing a boost in these difficult times and to create jobs, restore economic growth and strengthen America's Middle class. The stimulation of the economy is designed to modernize the nation's infrastructure, jump start America's energy independence, expand high quality educational opportunities, improve access to affordable health care and protect those in greatest need. The lack of affordable housing with appropriate support and the ability to provide basic necessities are changing the faces of homelessness. 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. In the past few years, Louisiana has advocated successfully with the United States Congress to provide 3000 units of Permanent Supported Housing (PSH) to address the housing demand for affordable housing with support services in response to hurricanes Katrina and Rita. The units are designed to assist some of our most vulnerable homeless and disability populations. In addition, PATH (Project in Assistance to the Transition from Homelessness) expanded services to 8 of the 10 geographical regions/LGEs demonstrating efforts to provide homeless outreach and housing assistance to mental health individuals with other co-occurring disorders. The Olmstead decision of 1999 recently made a ten year anniversary and has been a driving force along with other budget restraints in our decision to change the state's mental health intermediate hospital system of care as OBH embraces a community model of care using best practice like Housing First and Therapeutic Residential Housing. The Olmstead program has been particularly affected in assisting persons with mental illness transition into the community with appropriate supports to sustain housing and services in the community.

There is no doubt that hurricanes continue to have a tremendous impact on housing and homelessness in the state however, it is not the only factor. 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 storms 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 a multiplicity of barriers including changes in development costs at all levels and local resistance to affordable housing development.

The Louisiana Interagency Council on Homelessness that participated in the United States Interagency Council was not reauthorized by the current state administration. The State Department of Children and Family Services is responsible for the state's Emergency Shelter Grant funds. As part of the Department's grantee responsibilities, the department surveys shelters and compiles an annual report on the unduplicated numbers served in shelters across the state. The DCFS Shelter Survey is a twelve month unduplicated count of persons using the state's shelter system. It also includes a point in time count that examines the subpopulations represented in the shelter count and

the reasons for homelessness. The shelter information is current through 2008. There are 153 shelters in the DCFS database. In 2008, the number of shelters reporting was 119 or 78% of the 153. The data revealed that the yearly total of homeless persons served was 32,112.

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 Table below. 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	

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 *outreach* activity as well as other support services. The annual reports from Louisiana PATH providers for 2009 showed that 4,385 homeless persons with mental illness were served.

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.

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 abuse and mental health 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.

For the federal PATH funding, Louisiana relies on in-kind and contractual contributions as its federal match. For FY 10 the match amount is \$499,083.00. 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 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 is being 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 more 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.

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 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.

Homeless Coalition

There are multiple providers of homeless programs in each area of the state. 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.

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 that have been or 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 abuse services to those youth meeting eligibility criteria as an in kind match for the grant application.

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. START Corp. also works with families with SED children. The region would like to expand their ability to assist these organizations through referral, case management, and enhanced respite but there are no funds for this at this time.

Runaway children and youth in Region III have been identified who are in need of housing, medical, mental health, and substance abuse 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. Until that time, the needs of the families involved are provided by referral to substance abuse treatment, mental health counseling, and respite, as needed.

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 CoC. 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

Within the scope of the Child and Adolescent Response Team (CART), children and families in crisis who are also homeless, are assessed and their needs are prioritized. The CART clinician assists the children/ youth and families to locate the resources necessary to establish temporary or permanent housing. Although resources are limited, homeless shelters and agencies that specifically cater to the needs of the homeless population are located throughout the State. Additionally, CART will assist the children and families with other resources necessary to stabilize the children/ youth and families' mental health and social needs.

The HUD Continuum of Care funding serves many children and youth, both those in families and those who are unaccompanied youth. This funding provides transitional and permanent housing and an array of case management, counseling, educational and other services.

Clients Reporting Being Homeless as of 6/30/2010 Compared to 6/30/2009

Region/ LGE	Total number reporting homelessness as of 6/30/09	Of total number, how many were displaced by hurricanes/ disaster (6/30/2009)	Total number reporting homelessness as of 6/30/10	Methodology used to arrive at these figures*
MHSD	4423	4423	8725	Point in time survey
CAHSD	38,800**	unknown	1022	Point in time survey
Region III	565	126	397	HMIS Data
Region IV	170	unknown	7332	HMIS Data
Region V	123	unknown	115	Point in time survey
Region VI	162	51	46	HMIS Data
Region VII	973	0	3633	HMIS Data
Region VIII	276	n/a	228	Point in time survey
FPHSA	379	unknown	357	Point in time survey
JPHSA	553	434	331	HMIS Data

NOTES:

*HMIS: Homeless Management Information System Data

** The extremely large jump in homelessness is due to the removal of FEMA housing supports

For further discussion of related aspects of homelessness, the reader is referred to *Section III, Criterion I, Housing Services*.

CRITERION 4
TARGETED SERVICES TO RURAL & HOMELESS POPULATIONS –
RURAL ACCESS TO SERVICES
FY 2011 – Child/Youth

A *Rural Area* has been defined by OMH using the 1990 U.S. Bureau of the Census 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. All rural programs are within the catchment area of a CMHC that serves children and youth.

Although OBH has placed many effective programs in rural areas, including the Child Adolescent Response Team (CART mobile crisis program); 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.

RURAL TRANSPORTATION PROGRAMS FOR SMI / EBD 2009-2010

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	29
III	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	9
IV	Medicaid Transportation, City/Parish Transportation, Local Providers	9
V	Medicaid Transportation; City/Parish Transportation; Local Providers, Other	15
VI	Medicaid Transportation, City/Parish Transportation,, Local Providers, Others	13
VII	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	23
VIII	Medicaid Transportation, City/Parish Transportation, Local Providers	6
FPHSA	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	28
JPHSA	Medicaid Transportation	6
TOTAL		142

RURAL MENTAL HEALTH PROGRAMS FOR SMI / EBD 2009-2010

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	Satellite Clinics	10	6
III	CMHC, Satellite Clinics, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	15	7
IV	CMHC, Satellite Clinics, Outreach Sites, ACT Teams, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	21	6
V	Satellite Clinics, Outreach Sites, Mobile Outreach, Drop-in Centers, MHR Agencies, Support Groups, Other	20	11
VI	CMHC, Satellite Clinics, Outreach Sites, Mobile Outreach, Drop-In Centers, MHR, Support Groups, Other	24	11
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	25	22
FPHSA	CMHC, Outreach Sites, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	27	12
JPHSA	Outreach Sites	0	1

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

The capacity for telemedicine, tele-networking, and teleconferencing throughout the state has resulted in better access to the provision of mental health services in rural areas. All state hospitals and approximately almost all CMHC's have direct access. This system addition is actively used for conferencing, consultation and direct care.

In an attempt to alleviate access problems, OBH has available teleconferencing systems at 66 sites, including Mental Health clinics, ECSS sites, Mental Health Hospitals, LA Spirit, OBH regional offices, and OBH Central Office. Some sites have multiple cameras. Some of these cameras are dedicated to Telemedicine (doctor/client session) while the others are used for Teleconferencing (meetings, education, etc). The other sites use their single cameras for both Telemedicine and Teleconferencing. The sites have begun to buy High Definition Cameras per DHH regulations. These cameras provide better quality but also take up more bandwidth.

Telecommunication has become the primary mode for communication within OMH. In an average week there are 20 different meetings conducted through teleconferencing including regular meetings of the Regional and Area Management Teams, Medical Directors, Quality Council, and the Pharmacy and Therapeutics Committee. DHH now also has desktop video conferencing. The new software interface allows participation into the existing video network

from individual desktop PCs. Sites now have the ability to do on demand conferencing inside their region. Regional Meeting rooms were setup for telemed and standard conferencing that can be launched from the sites anytime or day of the week. This is especially helpful in an emergency that happens outside normal work hours. The system is also used for training and other administrative purposes. Forensic patients at ELMHS are being linked with Tulane University psychiatrists in New Orleans through telemedicine. Telemedicine has resulted in more efficient communication between various sites across the state.

OMH Video Conferencing Sites - July, 2010			
	<u>Site</u>	<u>Parish</u>	<u>City</u>
1	Allen Mental Health Clinic	Allen	Oberlin
2	Assumption Mental Health Clinic	Assumption	Labadieville
3	Avoyelles Mental Health Clinic	Avoyelles	Marksville
4	Bastrop Mental Health Clinic	Morehouse	Bastrop
5	Beauregard Mental Health Clinic	Beauregard	DeRidder
6	CLSH (Education Room 103)	Rapides	Pineville
7	CLSH (Education Room 128)	Rapides	Pineville
8	CLSH (Admin Bldg)	Rapides	Pineville
9	Central Louisiana Mental Health Clinic	Rapides	Pineville
10	Crowley Mental Health Clinic	Acadia	Crowley
11	Delta ECSS	Richland	Delhi
12	Dr. Joseph Tyler MHC / Auditorium 1	Lafayette	Lafayette
13	Dr. Joseph Tyler MHC / Auditorium 2	Lafayette	Lafayette
14	Dr. Joseph Tyler MHC / Auditorium 3	Lafayette	Lafayette
15	Dr. Joseph Tyler MHC / Conference Room	Lafayette	Lafayette
16	ELMHS (Center Bldg.)	East Feliciana	Jackson
17	ELMHS (Clinic)	East Feliciana	Jackson
18	ELMHS (Forensic)	East Feliciana	Jackson
19	ELMHS (Greenwell Springs)	East Baton Rouge	Greenwell Springs
20	Jonesboro Mental Health Clinic	Jackson	Jonesboro
21	Jonesville Mental Health Clinic	Catahoula	Jonesville
22	Lafourche Mental Health Clinic	Lafourche	Raceland
23	Lake Charles MHC / Regional	Calcasieu	Lake Charles
24	Lake Charles MHC / Room 105	Calcasieu	Lake Charles
25	Lake Charles MHC / Small Group Room	Calcasieu	Lake Charles
26	LA Spirit	East Baton Rouge	Baton Rouge
27	LA Spirit Orleans	New Orleans	Orleans
28	LA Spirit Orleans (Desktop)	New Orleans	Orleans
29	Leesville Mental Health Clinic	Vernon	Leesville

30	Mansfield Mental Health Clinic	De Soto	Mansfield
31	Mansfield Mental Health Telemed	De Soto	Mansfield
32	Many Mental Health Clinic	Sabine	Many
33	Many Mental Health Telemed	Sabine	Many
34	Minden Mental Health Clinic	Webster	Minden
35	Minden Mental Health Telemed	Webster	Minden
36	Monroe Mental Health Clinic / Auditorium	Ouachita	Monroe
37	Monroe Mental Health Clinic / Regional	Ouachita	Monroe
38	Natchitoches Mental Health Clinic	Natchitoches	Natchitoches
39	Natchitoches Mental Health Telemed	Natchitoches	Natchitoches
40	New Iberia Mental Health Clinic	Iberia	New Iberia
41	NOAH / Shervington Conference Room	Orleans	New Orleans
42	NOAH / HR Conference Room	Orleans	New Orleans
43	OMH Headquarters	East Baton Rouge	Baton Rouge
44	Opelousas Mental Health Clinic	St. Landry	Opelousas
45	Region 3 Office	Terrebonne	Houma
46	Red River Mental Health Clinic	Red River	Coushatta
47	Red River Mental Health Telemed	Red River	Coushatta
48	Richland Mental Health Clinic	Richland	Rayville
49	River Parishes Mental Health Clinic	St. John the Baptist	LaPlace
50	Ruston Mental Health Clinic	Lincoln	Ruston
51	SELH / Admin. Bldg	St. Tammany	Mandeville
52	SELH / Education Bldg	St. Tammany	Mandeville
53	SELH / Telemed	St. Tammany	Mandeville
54	SELH / Youth Services	St. Tammany	Mandeville
55	Shreveport MHC / Room 111	Caddo	Shreveport
56	Shreveport MHC / Room 145	Caddo	Shreveport
57	Shreveport MHC / System of Care	Caddo	Shreveport
58	Shreveport MHC / Room 214	Caddo	Shreveport
59	Shreveport MHC / Room 216	Caddo	Shreveport
60	South Lafourche MHC	Lafourche	Galliano
61	St. Mary Mental Health Clinic	St. Mary	Morgan City
62	St. Tammany ECSS	St. Tammany	Mandeville
63	Tallulah Mental Health Clinic	Madison	Tallulah
64	Terrebonne Mental Health Clinic	Terrebonne	Houma
65	Ville Platte Mental Health Clinic	Evangeline	Ville Platte
66	Winnsboro Mental Health Clinic	Franklin	Winnsboro

CRITERION 5
MANAGEMENT SYSTEMS – RESOURCES. STAFFING, TRAINING OF PROVIDERS
LOUISIANA FY 2011 - ADULT & CHILD/YOUTH PLAN

The Community Mental Health Block Grant for the FY 2011 now stands at the lowest it has for many years: \$5,293,123. Several years of budget cuts have occurred. In FY 2009 the amount was \$5,435,135 representing an 11.7% decrease from the original FY 08-09 of \$6,155,074, which was decreased 2.4% from the FY 07-08 of \$6,309,615 following an increase from \$5,902,412 in FY 05-06; which was reduced from the FY 04-05 level of \$6,338,989. Block Grant money is used by OMH to finance innovative programs that help to address service gaps and needs in every part of the state. The Block Grant funds are divided almost equally between Adult and C/Y programs. The OMH FY 2010-2011 budget (initial appropriation) was \$282,790,258. The total appropriation for the community is \$78,515,396.

The following tables provide additional budgetary information, including a breakdown of federal funding for mental health services. The following pages contain further information about staffing resources, etc.

OFFICE OF MENTAL HEALTH INITIAL APPROPRIATION FOR FY 10-11			
BUDGET SUB-ITEM	SUB-ITEM DIVISIONS	TOTAL(S)	% of TOTAL
Community Budget	CMHCs (a)	\$40,707,612	14%
	Acute Units (b)	\$2,905,622	1%
	Social Service Contracts	\$34,902,162	12%
	Community Total	\$78,515,396	28%
Hospital Budget	Central Louisiana State Hospital	\$23,354,926	8%
	Eastern Louisiana Mental Health System (c)	\$91,840,429	32%
	Southeast Louisiana Hospital (d)	\$50,875,953	18%
	Hospital Total	\$166,071,308	59%
State Office Budget	Central Office Total (e)	\$38,203,554	13%
TOTAL		282,790,258	100%
(a) Excludes budgets for Capital Area Human Services District, Florida Parishes Human Services Authority, Metropolitan Human Services District, Jefferson Parish Human Services Authority, and South Central Louisiana Human Services Authority .			
(b) Does not include \$ 137,720 for operation of the Washington-St. Tammany acute units that are located in OMH 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) Actual appropriation is \$38,203,554 of which \$1,136,085 is BP Oil Spill money; and \$714,480 is Residential Therapeutic money.			

MENTAL HEALTH FACILITIES, BEDS, FUNDING FY 2008 – 2011 (as of first day of fiscal year)

HOSPITAL SYSTEM

	FY 2008 (7/1/07)	FY 2009 (7/1/08)	FY 2010 (7/1/09)	FY2011 (7/1/10)
Total Adult/Child State Hosp. Beds (a)	842	810	804	761
State General Funds(b) (c)(\$)	79,834,630	89,500,010	8,020,486	90,152,175
Federal Funds (\$)	101,469,932	106,781,722	113,196,757	69,482,287

COMMUNITY SYSTEM

Acute Units

	FY 2008 (7/1/07)	FY 2009 (7/1/08)	FY 2010 (7/1/09)	FY2011 (7/1/10)
Total Number of Acute Beds	215	283	155	115
State General Funds (\$)	0	0	-0-	0
Federal Funds (\$)	9,429,275	5,113,592	2,905,622	2,905,622

NOTE: 2008 figures exclude GSH (transferred to ELSH).
 2009 figures include LSU staffed Acute Units.
 2010 figure includes NOAH Acute, SELH Acute, ELSH Acute, Moss, Wash-St.Tammany and UMC Acute Units.
 2011 figure includes SELH, ELSH, Moss and UMC Acute Units. NOAH was closed and Wash-St.Tammany transferred to LSU.

CMHCs

	FY 2008 (7/1/07)	FY 2009 (7/1/08)	FY 2010 (7/1/09)	FY 2011 (7/1/10)
Total Number of CMHCs*	41	43	43	45
State General Funds (\$)***	34,767,708	37,993,999	35,575,211	44,242,442
Federal Funds (\$)	7,539,648	8,159,082	13,180,987	6,006,737

*Includes Clinics only – (including LGEs)

*** does not include LGEs

CONTRACT COMMUNITY PROGRAMS

	FY 2008 (7/1/07)	FY 2009 (7/1/08)	FY 2010 (7/1/09)	FY 2011 (7/1/10)
State General Funds (\$)	12,830,006	31,144,944	28,236,120	22,698,372
Federal Funds (\$)	12,871,215	3,346,292	2,221,512	3,686,170

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 were provided through the Medicaid agency: Mental Health Rehabilitation Option

(c) State General Funds amounting to \$60,745,784 were replaced by Social Services Block Grant monies for FY 2010.

State Psychiatric Facilities Statewide Staffed Beds
(6/30/2010)

	Facility		Adult Acute Beds	Adult Civil Intermediate Beds	Adult Forensic Beds	Child and Adolescent Beds	TOTAL
OMH HOSPITALS	Central State Hospital		0	60	56	12	128
	Eastern Louisiana Mental Health System	Jackson and Greenwell Springs Campus	51	179	88	0	318
		Feliciana Forensic Facility	0	0	235	0	235
		Total for ELMHS	51	179	323	0	553
	New Orleans Adolescent hospital		0	0	0	0	0
	Southeast Louisiana Hospital (Mandeville, LA)		35	94	0	38	167
LSU-New Orleans/ Staffed by OMH	University Medical Hospital		20	0	0	0	20
	Moss Hospital		14	0	0	0	14
TOTAL STAFFED BEDS			120	333	379	50	882

Data from Daily Census Report.

OBH does not get data from the LSU operated/ staffed facilities

**TOTAL NUMBERS OF HOSPITAL INTERMEDIATE CARE BEDS
BY FACILITY (6/30/2010)**

	Licensed Beds on 6/30/2010	Staffed Beds on 6/30/2010	% Staffed Average for Fiscal Year	% Occupancy Average for Fiscal Year
CLSH*	196	128	66.6%	95.9%
ELSH	362	268	81.8%	97.6%
SELH	139	132	47.9%	91.9%
FFF	235	235	100%	100%
TOTAL	932	762	--	--

*Based from PIP Patient Population Movement Report. NOAH was closed August 2009 to

Numbers of Community Professional Staff Members by Discipline on June 30, 2010

Discipline	Psychiatry	Psychology		Social Work		Registered Nurse			Other		Other Physician/PharmD
Region/LGE		Doctoral*	Masters	DSW	Masters	Masters	Bachelors	Associate	Masters	Bachelors	
MHSD	9	1 0 MP	0	0	7	0	12	0	11	2	0
CAHSD	18(9.7 FTE)	2(1 FTE) 3 MP (2 FTE)	2	0	94(48 FTE)	3 (2 FTE)	19 (10 FTE)	4 (2 FTE)	12 (6.53 FTE)	29 (15.51 FTE)	0
III	10	3(2.6 FTE) 0 MP	2	0	11	1	3	8	9	8	0
IV	10(6.8 FTE)	3 (.60 FTE) 2 MP(.30 FTE)	6	0	33	0	0	10	2	7	4(1.4 FTE)
V	6(2.4 FTE)	0 1 MP(0.2 FTE)	4	0	10	0	5	0	3 (2.2 FTE)	7	3(.26 FTE)
VI	4	0 0 MP	5	0	9	0	5	5	1	8	0
VII	8(6.6 FTE)	0 0 MP	0	0	13	0	3	3	10	6	0
VIII	5(3.8 FTE)	2(0.5 FTE)/ 2 MP(0.5 FTE)	0	0	19	0	2	7	9	5	2(1.8 FTE)
FPHSA	11(6.4 FTE)	1(.15 FTE) 1 MP	0	0	33	0	1	4	2	3	1(.4 FTE)
JPHSA	13(10.6 FTE)	3(2.7 FTE) 0 MP	0	0	57(54.7FTE)	3	7	3	13(12.4FTE)	15(14.95FTE)	1
Total By Discipline	94 (69.3 FTE)	15(8.55 FTE) / 9(4 FTE) MP	19	0	286 (244.7 FTE)	7 (6 FTE)	54 (48 FTE)	44 (42 FTE)	72 (65.13 FTE)	90 (76.46 FTE)	11 (4.86 FTE)

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

Numbers of OMH Hospital Professional Staff Members by Discipline on June 30, 2010

Discipline	Psychiatry	Psychology		Social Work		Registered Nurse			Other		Other Physician/Doctorate
Hospital		Doctoral & Medical Psych	Masters	DSW	Masters	Masters	Bachelors	Associate	Masters	Bachelors	
CLSH	unavailable	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
ELMHS	21	7 3MP	2	0	41	6	64	62	8	45	12
SELH	8	15	1	0	26	4	28	39	8	17	0
Total by Discipline											

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

OMH Community Total Prescribing Workforce on June 30, 2010

Psychiatric Type	Total Number FTE Psychiatrists		Of Total Psychiatry FTE, Number Certified Child Psychiatrists		Total Number FTE Medical Psychologists		Total Number FTE Nurse Practitioners	
Region/ LGE	Civil Service	Contract	Civil Service	Contract	Civil Service	Contract	Civil Service	Contract
MHSD	8	2	0	0	0	0	0	0
CAHSD	14.6	6.1	2	1	0	0	1	0
3	5	1.65	1	0.75	0	0	1	0
4	5.5	1.3	1	0.5	0	0.3	0	0
5	1.4	0.8	0.6	0	0.2	0	0	0
6	4	3	1	1	0	0	0	1
7	5.8	0.8	0	0.4	0	0	0	0
8	2	1.8	0	0	0	0	0	0
FPHSA	4.0	2.4	1	1	0	0	0	0
JPHSA	9.79	0.82	2.44	0.30	0	0	0	0
TOTAL	60.09	20.67	9.04	4.95	0.2	0.3	2	1

OMH Hospital Psychiatric Workforce on June 30, 2010

Psychiatric Type	Number FTE Psychiatrists Serving Adults/ Children		Number FTE Certified Child Psychiatrists		Hospital FTE Total Psychiatrists
Hospital	Civil Service	Contract	Civil Service	Contract	
CLSH	Not available	N/A	N/A	N/A	N/A
ELMHS	0	21	0	0	
SELH	8	5	2		
Totals*	--	--	--	--	--

KEY: CLSH = Central Louisiana State Hospital

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

SELH = Southeast Louisiana Hospital

*Totals not computed due to missing data.

OMH Community Staff Liaisons on June 30, 2010

Region/ LGE	FTE Child/Youth Family Liaisons	FTE Adult Consumer Liaisons
MHSD	1	0.5
CAHSD	1	1
III	0	0
IV	.8	0
V	.8	.8
VI	0	.60
VII	.50	0
VIII	0	0
FPHSA	0	0
JPHSA	1.0	0

Includes civil service and contract employees

Training for the delivery of Evidence based practices (EBPs) has been a focus statewide. For instance, a series of Trainings on Dialectical Behavior Therapy was recently begun statewide, and workshops on Cognitive Behavior Therapy and Interpersonal Therapy have also been offered. In spite of the positive things happening with the workforce, the difficulty of delivering services with decreased funding and numbers of clinicians has become an urgent priority.

Due to budget reductions, there were a significant number of positions that were cut in the various clinics. The OMH Redesign Project provided an opportunity to implement a business reorganization plan to better utilize the limited workforce to meet the needs of the residents of the state.

Rural areas continue to have a shortage of psychiatric coverage. Hiring freezes have made a difficult situation even more so. Some clinics are using technical school internship positions to offset staff shortages.

All Regions/ LGEs report difficulties providing necessary services due to a workforce shortage. In addition to the usual problems, the economy is putting an increasing strain on workforce delivery. Previously, it had been noted that many healthcare professionals left state government jobs or literally left Louisiana after the hurricanes, for better pay and better working conditions. Hiring freezes have been the norm since Governor Bobby Jindal was inaugurated in January of 2008; and with the downturn in the economy, layoffs and furloughs have become all too common in healthcare and state government in general. Workforce vacancies have affected all aspects of direct service: medical, nursing, counseling, and clerical. The shortage has caused challenges for clinicians on the front lines with an impact on the number of clients seen, the length of time from first contact to psychiatric evaluation, medication management, and counseling.

Reports from Regions/ LGEs indicate struggles with keeping qualified clinical staff. Recruitment efforts have included using interns and residents from nursing and medical schools, contacting medical recruitment agencies, advertisements in professional journals, and newspapers. To fill the gaps in prescribers, some regions have successfully contracted with non-physician prescribers, specifically, Medical Psychologists and/or Nurse Practitioners. Others have used locum tenens physicians.

Reports from the field indicate that due to budget cuts dictated by the recent legislative sessions, the workforce has been reduced. Job positions are being combined to try to compensate for the budget conditions without lessening the impact on quality centered patient care. In Region 5, the loss of 7 full time positions and several job vacancies have affected all areas of direct service. There is a serious effect on the numbers of clients seen, the length of time from first contact to psychiatric evaluation, medication management, and counseling; and there is a serious shortage of community resources to fill the service gaps.

CRITERION 5
MANAGEMENT SYSTEMS – EMERGENCY SERVICE PROVIDER TRAINING
AND EMERGENCY SERVICE TRAINING TO MENTAL HEALTH PROVIDERS
LOUISIANA FY 2011 - ADULT & CHILD/YOUTH PLAN

OBH makes available a variety of mental health training to providers of emergency services, *as well as* emergency services trainings to behavioral health providers. LGEs and Regions have partnered with and participated in numerous trainings with the Office of Public Health, FEMA, community agencies, and local emergency command centers. Modifications to preparedness training have included better delineation of responsibilities between offices, staff/ volunteer roles, locations of services, and other technicalities. Evacuation procedures and plans have been more closely detailed in the event of a crisis. Collaboration with other state agencies, non-profit agencies, and other organizations on parish and local levels has occurred. Continuity of operations plans for all OBH facilities have been developed and discussion with tabletop meetings conducted to determine feasibility of these plans.

Effective emergency management and incident response activities encompasses a host of preparedness activities conducted on an ongoing basis, in advance of any potential incident. Preparedness involves an integrated combination of planning, procedures and protocols, training and exercises. The Division 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. A variety of disaster related trainings are also offered to emergency service providers, as well as emergency response trainings to behavioral health providers to support efforts to strengthen the state's emergency response capabilities while reducing the psychological impact of a disaster statewide.

OBH regularly updates Call Rosters for pre-assigned personnel to staff medical special needs shelters in the event of a natural or man-made disaster, and conducts routine training and drills activating deployment procedures in these procedures. Additional required training for all OBH staff includes FEMA sponsored National Incident Management System (NIMS) training. At a minimum, all employees are required to take 2 NIMS courses. Each OBH agency has adopted plans to ensure training compliance by new hires annually. 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).

The following documents activities by the Office of Mental Health and/or its affiliates. All trainings are culturally competent and age/gender-specific to the population served.

- Hurricane preparedness and Shelter-in-Place tabletop exercises are regularly conducted as a training exercise with OBH hospitals and mental health clinics across the State. These drills provide a learning venue for service providers to help them better understand the impact of disasters on persons with mental illness and to increase their skill capability to respond to emergencies in the behavioral health care community, including inpatient and outpatient environments.
- OBH jointly with the Office of Public Health and the Governor's Office of Homeland Security and Emergency Preparedness provides ongoing training to parish level police/fire/EMS workers charged with disaster response duties, i.e., critical incident management, mental health disaster services, bio-terrorism preparedness, mental health response to mass casualties,

coordination of mental health and first responders training, stress management for first responders, and Psychological First Aid training.

- OBH works in partnership with key community organizations to provide training on crisis intervention techniques to first responders, and assists with outreach needs in crisis events through its federally funded crisis counseling program (i.e., LA Spirit programs).
- Behavioral health trainings are provided routinely at the state Emergency Operations Center (EOC) to emergency operations personnel prior to and during a declared disaster.

Other agency sponsored services include:

- Stress management and self-care education and skill building to the first responder's network continued throughout the state, via the LA Spirit program. Over the last few years, LA Spirit has hosted a series of Disaster Mental Health training for first responders. These trainings focus on raising awareness among first responders of psychological issues and trauma experienced during catastrophic events. First Responders and Crisis Counselors are trained to use the FOCUS model in working with families of first responders.
- The Louisiana Partnership for Youth Suicide Prevention (LPYSP) is a program that is geared towards reducing child and adolescent suicide; however, adults have benefitted from the program also. 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 Specialist 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 educators, law enforcement, mental health professionals, clergy, medical professionals, administrators, volunteers, and anyone else who might be interested in adding suicide intervention to their list of skills. The program has been made available to all government agencies, consumer/advocacy agencies, emergency service providers, schools and families to help reduce the incidence of suicide in Louisiana. A 20-member training group has conducted ASIST, Safe Talk, and Suicide Talk Trainings statewide. This series of evidenced-based trainings has reached over 2,500 people. Through the successful development of five suicide prevention coalitions in Shreveport, Lake Charles, Lafayette, Jefferson and Baton Rouge, 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.

Please see Criterion 1 for information about the *Louisiana Spirit Hurricane Recovery Program*, and the *Louisiana Spirit Oil Spill Recovery Program*. These programs are focused on addressing post-disaster mental health needs and other long term disaster recovery initiatives.

Although in recent years, crisis response has focused on hurricanes, the state also has worked towards developing a well-defined response plan for bioterrorism, pandemic flu, and other mass disasters,

which has been put to the test with the current response to the oil spill caused by the explosion of the British Petroleum rig in the Gulf. Collaborative relationships exist with local chapters of the Red Cross, Office of Homeland Security, Emergency Preparedness, the Office of Public Health, and the National Guard as well as other emergency management organizations. Regions/ LGEs have conducted statewide drills, meetings, and exercises with these entities to ensure an understanding of roles, responsibilities, and operations.

In examples of more specific service offerings, OBH provides staff members to all state-administered hospital emergency rooms. These staff members perform mental health screening as part of the admission process. OBH coordinates in-service training for emergency room doctors, nurses and other professional and para-professional staff. OBH also trains teachers and school administrators in disaster response procedures.

OBH, jointly with the Office of Emergency Preparedness, provides training to parish level police/ fire/ EMS workers charged with disaster response. Such training includes:

- 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.

Regions and LGEs report that they are very engaged and involved in activities involving crisis and emergency planning, and they are linked with cooperative agreements to other agencies. First responder teams have been developed in some regions, and regions have plans and procedures for staffing medical special needs shelters in the event of a crisis that requires evacuation. Communication needs for staff have resulted in extensive uses of technology. Many staff members have been issued cell phones and blackberries that can be used in emergencies. In addition, 800 Mhz radios are available for use in disasters. Employees have access to electronic bulletin boards or websites that allow communication between staff, supervisors, and administration

Evaluation of the effectiveness of crisis response is on-going, and most recently emphasized in the response to the oil spill. Some areas of the state (i.e., Regions 3, 4, and 5) have suffered through the consequences of all four hurricanes in three years, and now are dealing with the impact of the oil spill and have had an opportunity to exercise the lessons learned. Regions were successful in making improvements in their regional response following Katrina/ Rita, and their response to Gustav/ Ike proved to be excellent, in spite of severe damage to some of their clinics.

Crisis Intervention Training (CIT) for law enforcement has been well established in several regions/ LGEs to address behavioral health crises. Crisis Intervention Training (CIT) readies officers and dispatchers to assess and respond appropriately to calls involving adults with SMI and children with EBD. The CIT curriculum is being modified to incorporate specific components for adolescents/ youth. Many 911 emergency operators and dispatchers have been trained to provide essential information and linkages to services. Unfortunately, some programs have been dealt severe budget cuts.

Some regions/ LGEs have conducted specific training on co-occurring developmental disabilities and behavioral health disorders to community professionals, first responders, and emergency room (ER) staff. Continued dialogue with ER staff includes information on the utilization of community resources to maintain wellness and avoid crises.

Regions also have offered very specific trainings to hospital Emergency Department staff on topics such as: Psychiatric Assessment, Mental Status Exams, anxiety and depression, and dealing with risk in persons with personality disorders.

The Applied Suicide Intervention Skills Training (ASIST) that is described in Criterion 1 has resulted in trainings to suicide helpline staff, primary care physicians, contract providers, CMHC staff, and other interested stakeholders.

CRITERION 5
MANAGEMENT SYSTEMS – GRANT EXPENDITURE MANNER
LOUISIANA FY 2011 - ADULT & CHILD/YOUTH PLAN

INTENDED USE PLAN BY SERVICE CATEGORY
ADULT PLAN

ADULT INTENDED USE CATEGORIES & ALLOCATIONS

Service Category	Types of Services	Region/ LGE	Central Office/ State wide	Total Allocation
Adult Employment	Employment Programs; Development & Services	\$35,000	10,000	\$ 45,000
Advisory Council Support	RAC Support	\$30,436		\$ 30,436
Assertive Community Treatment (ACT)	ACT Outreach Services	\$75,948		\$ 75,948
Consumer Advocacy and Education	Consumer Education; Advocacy and Education; Family Organization Support, Supported Adult Education	\$1,500	\$40,000	\$ 41,500
Consumer Liaisons	Consumer Liaisons (not in contracts)	\$72,863		\$ 72,863
Consumer Monitoring and Evaluation	MIS; Consumer-Directed Service System Monitoring, Consumer Liaisons:	0	\$63,484	\$ 63,484
Consumer Support Services	Consumer Initiated Programs, Consumer-Education, Community Care Resources; Community Resource Centers, Case Management; Consumer Support; Medicaid Enrollment; Support and Empowerment	\$627,807	\$442,000	\$1,069,807
Crisis Response Services	Crisis Line, Crisis Stabilization, Crisis 24 hour screening & assessment, Mobile crisis response	\$36,380		\$ 36,380
Mental Health Treatment Services	Psycho-social Day Treatment; Forensic Program, Co-occurring Disorders Treatment	\$56,117		\$ 56,117
Planning Operations & System Development	Staffing for Bureau of Planning, Performance Partnerships and Stakeholder Involvement; Planning Council Office: Support Staff, Office Operations, member travel and training, MIS	0	\$160,546	\$ 160,546
Residential / Housing	Housing Development and Services; Foster Care; Group Homes Supervised Apartments; 24-hour residential Housing Support Services	\$222,106		\$ 222,106
Respite	Respite Services and Supports	0		
Staff Development	OMH Workforce Recruitment, Development and Retention, Staffing for Bureau of Workforce Development	0	\$165,971	\$ 165,971
Transportation	Community / Rural Transportation	\$32,892		\$ 32,892
Other Contracted Services	Comprehensive Mental Health Services; MIS Infrastructure Development; PODS (Public Outreach Depression Screening)	\$110,804	\$486,720	\$ 597,524
TOTAL		\$1,301,853	\$1,368,721	\$2,670,574

CRITERION 5
MANAGEMENT SYSTEMS – GRANT EXPENDITURE MANNER
LOUISIANA FY 2011 - ADULT & CHILD/YOUTH PLAN

INTENDED USE PLAN BY SERVICE CATEGORY
CHILD/YOUTH PLAN

C/ Y/ F INTENDED USE CATEGORIES & ALLOCATIONS

Service Category	Types of Services	Region/ LGE	Central Office/ State wide	Total Allocation
Advisory Council Support	RAC Support	\$30,500	0	\$30,000
Assertive Community Treatment		\$278,698	0	\$278,698
Consumer Advocacy and Education	Consumer Education; Advocacy and Education; Family Organization Support	\$1,500	\$111,400	\$112,900
Consumer Liaisons	Consumer Liaisons (not in contracts)	\$27,287	\$36,275	\$63,562
Consumer Monitoring and Evaluation	MIS; Consumer-Directed Service System Monitoring, Consumer Liaisons:	\$6,381	\$63,302	\$69,683
Crisis Response Services	Crisis Line, Crisis Stabilization, Crisis 24 hour screening & assessment, Mobile crisis response	\$193,106	0	\$193,106
Family Support Services	Family Support Services; Wraparound; Family Mentoring Program; Family Support Liaison and Program; Medicaid Enrollment; Parent Mentoring; Nurse Visitation Program, Parent Liaisons, Mentoring, Community Care Resources; Rural Mobile Outreach Programs, Family Training, Therapeutic Camp	\$621,123	\$123,936	\$745,059
Planning Operations and Systems Development	Staffing for Bureau of Planning, Performance Partnerships and Stakeholder Involvement, Planning Council Office: Support Staff, Office Operations, member travel and training, MIS	0	\$94,046	\$94,046
Residential / Housing	Housing Development and Services; Foster Care; Group Homes; Supervised Apartments Housing 24-hour residential Housing Support Services	0	0	0
Respite	Respite Programs	\$183,559	0	\$183,559
School-Based Mental Health Services	School-Based Clinic; School-Based Services, School Violence Prevention	\$80,920	0	\$80,920
Staff Development	OMH Workforce Recruitment, Development and Retention, Staffing for Bureau of Workforce Development	0	\$134,000	\$134,000
Transportation	Community / Rural Transportation	\$10,000	0	\$10,000
Other Contracted Services	Comprehensive Mental Health Services, Nurse Home Visitation Program, MIS Infrastructure Development, PODS (Public Outreach Depression Screening)	\$533,266	\$93,250	\$626,516
TOTAL		\$1,966,340	\$656,209	\$2,622,549

CRITERION 5
MANAGEMENT SYSTEMS – GRANT EXPENDITURE MANNER
LOUISIANA FY 2011 - ADULT & CHILD/YOUTH PLAN

INTENDED USE PLAN SUMMARY
BY REGION / LGE / CENTRAL OFFICE- STATE WIDE

FY 2011	Adult	C/Y	Intended Use Total
MHSD	\$ 90,414	\$ 295,656	\$ 386,070
CAHSD	\$ 126,645	\$ 253,373	\$ 380,018
SCLHSA	\$ 171,174	\$ 177,918	\$ 349,092
Region 4	\$ 170,415	\$ 190,247	\$ 360,662
Region 5	\$ 107,728	\$ 246,044	\$ 353,772
Region 6	\$ 114,983	\$ 230,706	\$ 345,689
Region 7	\$ 143,532	\$ 174,245	\$ 317,777
Region 8	\$ 157,426	\$ 171,276	\$ 328,702
FPHSD	\$ 145,681	\$ 153,020	\$ 298,701
JPHSA	\$ 73,855	\$ 73,855	\$ 147,710
Reg/ LGE Total	\$ 1,301,853	\$ 1,966,340	\$ 3,268,193
Central Office (State-wide)	\$ 1,368,721	\$ 656,209	\$ 2,024,930
Grand Totals	\$ 2,670,574	\$ 2,622,549	\$ 5,293,123

Percentage of Block Grant Dollars Allocated to Adults:	50.45%
Percentage of Block Grant Dollars Allocated to Children/ Youth :	49.55%

Intended Use Plan Notes

If circumstances occur that prohibit expenditure of any portion of the Block Grant funds as intended, OBH will utilize the remaining funds for the purchase of Block Grant related equipment and supplies (e.g. computers, printers, software, projectors, telecommunication equipment/infrastructure/staff, etc.) and/or Phase IV medications and/or other appropriate expenditures.

Beginning in FY 2010, the Area budgets (Areas A, B, & C) were folded into Central Office, since the Area structure does not exist anymore.

The allocation to the Jefferson Parish Human Services Authority appears inconsistent with other regions because when the Authority was created their Block Grant dollars were replaced with State General Funds. Since then, this situation has been considered when new Block Grant dollars have been awarded or when funding has been decreased. Starting with FY 2011, all Regions/ LGEs will move towards an equal distribution over a three year period (1/10th of the funding allocated) See Planning Council Activities in Part B, Section IV and Appendix for details.

Complete details of the Intended Use Plans submitted from each Region, LGE, and Central Office is included in Appendix A of this document.

LOUISIANA FY 2011 BLOCK GRANT PLAN

Part C STATE PLAN Section III

PERFORMANCE INDICATORS, GOALS, TARGETS AND ACTION PLANS

CHILD/ YOUTH PLAN

CHILD – GOALS TARGETS AND ACTION PLANS

Transformation Activities **XX**

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	4,286	4,317	3,966	3,966
Numerator	--	--	--	--
Denominator	--	--	--	--

Table Descriptors:

Goal: Children and youth with an emotional or behavioral disorder, and their families, will have access to state mental health services

Target: Access to mental health services will be provided for a greater number of children and youth with an emotional or behavioral disorder.

Population: Children and youth diagnosed with an emotional or behavioral disorder

Criterion: 2: Mental Health System Data Epidemiology; 3: Children's Services

Indicator: The number of children and youth who have an emotional or behavioral disorder who receive mental health services from the Office of Mental Health during the fiscal year. NOMS Indicator #1

Measure: Estimated unduplicated count of children and youth (on the caseload the last day of the fiscal year) who have an emotional or behavioral disorder and who receive mental health services during the fiscal year (7/1-6/30) in an OMH community or inpatient setting

Sources of Information: CMHC-OMHIIS (FY 2011), JPHSA, Patient Information Program (PIP)

Special Issues: NOTE: In the past, this indicator has been reported as the percentage of prevalence of children/youth who have an emotional or behavioral disorder who receive mental health services from the Office of Mental Health during the fiscal year. These numbers are discussed in Criterion 2 of the Plan. In order to be consistent with NOMS Indicators, the measure is now reported as a number rather than as a percentage.

The explanation of the reduction in numbers in FY 2010 is related to a very important change: OMHIIS now **closes cases** with no activity for nine months, resulting in what **appears to be** a reduction in the outpatient caseload. Previously, there were cases that had essentially no activity that were being counted within this statistic, artificially inflating the number.

The FY 2010 actual figure is 3,966.

Significance: Setting quantitative goals to be achieved for the numbers of children who are EBD to be served in the public mental health system is a key requirement of the mental health Block Grant law

Action Plan: See Special Issues. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Attempts to provide improved access to services is a priority for Louisiana.

CHILD – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	3.5%	4.7%	4.8%	4.8%
Numerator	7	8	8	--
Denominator	198	171	165	--

Table Descriptors:

Goal: The Office of Mental Health will improve the quality of care that is provided.

Target: The number of children and youth who are discharged from a state hospital and then re-admitted will either decrease or be maintained (30 days).

Population: Children and youth diagnosed with an emotional or behavioral disorder

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems; 3: Children's Services

Indicator: The percentage of children and youth consumers discharged from state psychiatric hospitals and re-admitted to an Office of mental health inpatient program within thirty days (30) days of discharge
NOMS Indicator #2

Measure: Thirty Day Rate of Discharge and Re-admission.
Numerator = # Readmits to PIP inpatient program within 30 days
Denominator = # Patients Discharged from PIP State Hospital (not-unduplicated)
Calendar year (Jan 1 - Dec 31)

Sources of Information: CMHC-OMHIIS (FY 2011), Patient Information Program (PIP)

Special Issues: Comparisons from year to year are difficult given changes in data collection that seem to re-occur even when data collection is standardized and consistent. An increase in outpatient programs is underway, as is the increased use of EBPs to reduce the rate of hospitalization/ re-hospitalization. While the number of readmissions has remained the same, the reduction in the denominator has resulted in the difference in overall percentage rate not being significant. This target is again being set conservatively.

FY 2010 Actual: $8 / 165 \times 100 = 4.8\%$

Significance: Recidivism is one measure of treatment effectiveness.

Action Plan: This target will improve with the increased emphasis on the provision of EBPs in the community. The increase in the number of outpatient supports and services, statewide should positively impact this indicator. The Block Grant indicators will be monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Attempts to provide improved services are a priority for Louisiana.

CHILD – GOALS TARGETS AND ACTION PLANS**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 180 days

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	11%	14%	9.7%	9.7%
Numerator	22	24	16	--
Denominator	198	171	165	--

Table Descriptors:**Goal:** The Office of Mental Health will improve the quality of care that is provided.**Target:** The number of children and youth who are discharged from a state hospital and then re-admitted will either decrease or be maintained (180 days).**Population:** Children and youth diagnosed with an emotional or behavioral disorder**Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems; 3: Children's Services**Indicator:** The percentage of children and youth consumers discharged from state psychiatric hospitals and re-admitted to an Office of mental health inpatient program within 180 days of discharge. NOMS Indicator #2**Measure:** 180 Day Rate of Discharge and Re-admission.Numerator = # Readmits to PIP inpatient program within 180 days.Denominator = # Patients Discharged from PIP State Hospital (not unduplicated)
Calendar year (Jan 1 - Dec 31)**Sources of Information:** Patient Information Program (PIP)**Special Issues:** Comparisons from year to year are difficult given changes in data collection that seem to re-occur even when data collection is standardized and consistent. An increase in outpatient programs, as well as the increased use of EBPs should continue to reduce the rate of hospitalization/ re-hospitalization.FY2010 Actual: $16 / 165 \times 100 = 9.7 \%$ **Significance:** Recidivism is one measure of treatment effectiveness**Action Plan:** This target will improve with the increased emphasis on the provision of EBPs in the community. The increase in the number of outpatient supports and services, statewide should positively impact this indicator. The Block Grant indicators will be monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Attempts to provide improved services are a priority for Louisiana.

CHILD – GOALS TARGETS AND ACTION PLANS**Name of Performance Indicator:** Evidence Based – Number of Practices

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	6	3	3	3
Numerator				--
Denominator				--

Table Descriptors:

Goal: Children and youth with an emotional or behavioral disorder, and their families, will be provided with appropriate recovery/ resiliency-oriented, and evidence-based mental health services.

Target: The number of evidence based practices (EBPs) available in the State will be maintained.

Population: Children and youth diagnosed with an emotional or behavioral disorder

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems 3: Children's Services

Indicator: The number of accepted evidence-based practices offered in the State. NOMS Indicator #3.

Measure: The number of accepted EBPs offered to OMH children and youth consumers in the State

Sources of Information: Annual Survey of Regions and Districts

Special Issues: In FY 07 Louisiana monitored 6 evidence-based practices (therapeutic foster care, assertive community treatment, illness management and recovery, family psycho-education, multisystemic therapy, and functional family therapy). However, because all six are not considered by SAMHSA to be EBPs for children, only 3 are being measured at this time (therapeutic foster care, multisystemic therapy, and functional family therapy). Each of these EBPs is offered in some geographic areas in the state, but they are not available state-wide. Since there are 3 EBPs offered, emphasis is not so much on increasing the number of EBPs offered, but on increasing the number of Regions/LGEs in which these services are provided. Information from the Survey is based on Region and LGE report, and as of yet, EBPs are not always evaluated for fidelity. Other promising practices are being developed and offered in various areas of the state.

Actual: FY 2010 = 3.

Significance: Evidence based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.

Action Plan: **See Special Issues.** The EBPs that have been offered and that were reported on the Surveys have not all been held to fidelity. Because measurement of EBPs not held to fidelity may not be meaningful, education on EBPs, proper treatment focus, and accurate measurement will be emphasized. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Attempts to provide improved services are a priority for Louisiana.

CHILD – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based – Children with SED Receiving Therapeutic Foster Care (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	0.21%	0.44%	0.36%	0.36%
Numerator	16	31	26	--
Denominator	7,632	7,092	7,197	--

Table Descriptors:

Goal:	Children and youth with an emotional or behavioral disorder, and their families, will be provided with appropriate recovery/ resiliency-oriented mental health services.
Target:	The percentage of children and youth with an emotional or behavioral disorder who receive Therapeutic Foster Care services will be maintained or increased.
Population:	Children and youth with an emotional or behavioral disorder
Criterion:	1: Comprehensive Community-Based Mental Health Service Systems 3: Children's Services
Indicator:	The percentage of children and youth who receive Therapeutic Foster Care services will be maintained or increase. NOMS Indicator #3
Measure:	Numerator: Number of children/ youth with EBD who receive Therapeutic Foster Care services. Denominator: Number of children/ youth with EBD served (unduplicated)
Sources of Information:	Survey of Regions and Districts and Survey of Hospitals, JPHSA, PIP, OMHIIS (FY 2011)
Special Issues:	Information from Survey is based on Region & LGE report, and all EBP's are not currently evaluated for fidelity. TFC is available in 3 Regions/LGEs, although FPHSA indicated that the program in their area is provided by other agencies, and do not have the data available. While the number of children/youth receiving Therapeutic Foster Care did not decrease significantly, the overall number of children/youth served increased, resulting in a small decrease in overall percentage. Statewide trainings have occurred in the effort to increase services; however, continued workforce shortages have continued to be problematic in the field. *MHSD/Region 1 did not collect data on EBPs. FY 2010 actual = $26 / 7,197 \times 100 = 0.36\%$.
Significance:	Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes
Action Plan:	The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. It is believed that an improved emphasis on fidelity is resulting in better data, and education on the EBPs, proper treatment focus, and accurate measurement will continue to be a focus. Data collected from OMHIIS will be qualitatively better than that collected on the Survey of Regions and Districts/ Hospitals. This data source will be utilized starting in FY2011, so that EBP data will not rely solely on the Surveys. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Attempts to provide improved services are a priority for Louisiana.

CHILD – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based – Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	0.96%	1.10%	1.08%	1.08%
Numerator	73	78	78	--
Denominator	7,632	7,092	7,197	--

Table Descriptors:

Goal: Children and youth with an emotional or behavioral disorder, and their families, will receive appropriate evidence-based treatment services

Target: The percentage of children and youth with an emotional or behavioral disorder, and their families, who receive Multi-Systemic Therapy will be maintained or increased.

Population: Children and youth with an emotional or behavioral disorder and their families.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems; 3: Children's Services

Indicator: The percentage of children and youth and their families who receive Multi-Systemic Therapy.
NOMS Indicator #3

Measure: Numerator: Number of children/ youth with EBD who receive Multi-Systemic Therapy services.
Denominator: Number of children/ youth with EBD served (unduplicated)

Sources of Information: Survey of Regions and Districts, Survey of Hospitals, JPHSA, PIP OMHIIS (FY 2011)

Special Issues: In FY 09, JPHSA was the only LGE offering MST. During the past year, MST was offered in Regions 4 and 5 as well as JPHSA. Regions 7 and 8, along with FPHSA indicated that MST is available in their areas, but that it is offered by contracted providers, and thus do not have the data available. While the number of individuals receiving MST has remained the same, the increase in total served has resulted in a small decrease in overall percentage. This target is again being set conservatively. ***MHSD/Region 1 did not collect data on EBPs.**

FY 2010 Actual = $78 / 7,197 \times 100 = 1.08\%$

Significance: Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.

Action Plan: The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. It is believed that an improved emphasis on fidelity is resulting in better data, and education on the EBPs, proper treatment focus, and accurate measurement will continue to be a focus. Data collected from OMHIIS will be qualitatively better than that collected on the Survey of Regions and Districts/ Hospitals. This data source will be utilized starting in FY2011, so that EBP data will not rely solely on the Surveys. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Attempts to provide improved services are a priority for Louisiana.

CHILD – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based – Children with SED Receiving Family Functional Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	0.79%	4.74%	5.3%	5.3%
Numerator	60	336	381	--
Denominator	7,632	7,092	7,197	--

Table Descriptors:

- Goal:** Children and youth with an emotional or behavioral disorder, and their families, will receive appropriate evidence-based treatment services
- Target:** The percentage of children and youth with an emotional or behavioral disorder, and their families, who receive Functional Family Therapy will be maintained or increased.
- Population:** Children and youth with an emotional or behavioral disorder and their families.
- Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems; 3: Children's Services
- Indicator:** The percentage of children and youth and their families who receive Functional Family Therapy. NOMS Indicator #3
- Measure:** Numerator: Number of children/ youth with EBD who receive Functional Family Therapy services.
Denominator: Number of children/ youth with EBD served (unduplicated)
- Sources of Information:** Survey of Regions and Districts, Survey of Hospitals, JPHSA, PIP, OMHIIS (FY 2011)
- Special Issues:** FFT is now offered in 5 Regions/LGEs, whereas it was offered in only 4 LGEs (JPHSA, FPHSA, Region III and Region V) during the previous fiscal year. This indicator was reported as a number (the numerator only) in FY 2007. Information from surveys is based on Region and LGE report, and not all EBP's are evaluated for fidelity. ***MHSD/Region 1 did not collect data on EBPs.**
- FY 2010 Actual = $381 / 7,197 \times 100 = 5.3\%$.
- Significance:** Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes
- Action Plan:** The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. Because measurement of EBPs not held to fidelity may not be meaningful, education on the EBPs, proper treatment focus, and accurate measurement will be a focus. The expectation is that data collected on EBPs held to fidelity will be more useful. Data collected from OMHIIS will be qualitatively better than that collected on the Survey of Regions and Districts/ Hospitals. This data source will be utilized starting in FY2011, so that EBP data will not rely solely on the Surveys. The Block Grant indicators will be monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Attempts to provide improved services are a priority for Louisiana.

CHILD – GOALS TARGETS AND ACTION PLANS**Name of Performance Indicator:** Client Perception of Care

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	97	98	N/A	98
Numerator	72	53		--
Denominator	74	54		--

Table Descriptors:

- Goal:** Children, youth, and their families served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.
- Target:** Consumers will rate the quality and appropriateness of care they are being provided by the Office of Mental Health positively.
- Population:** Children and youth diagnosed with an emotional or behavioral disorder
- Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems; 3: Children's Services
- Indicator:** The percentage of Office of Mental Health consumers who rate the quality and appropriateness of services as positive. NOMS Indicator #4
- Measure:** Numerator: Number of OMH parents with children and youth with an emotional or behavioral disorder surveyed during the fiscal year (7/1- 6/30) through the LaFete (YSS-F) Survey process that report an overall grade of "C" or better on items numbered 1, 4, 5, 7, 10 and 11. Denominator: Total number of OMH parents of children and youth with an emotional or behavioral disorder surveyed.
- Sources of Information:** La Fete Survey, YSS-F (Youth Services Survey for Families)
Telesage Outcome Measurement System (TOMS) (System Pending)
- Special Issues:** The LaFete survey team was discontinued in FY 2010 in favor of use of the TOMS for reporting these data. The LaFete survey will continue to be used as an instrument in the Telesage Outcome Measurement System (TOMS). However, the TOMS was not fully implemented until August 2010 and this data will be reported in 2011.
- Significance:** Persons receiving mental health services should be satisfied with those services; and evaluation of quality and appropriateness of care are valid measures of satisfaction
- Action Plan:** See special issues. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

CHILD – GOALS TARGETS AND ACTION PLANS**Name of Performance Indicator:** Child – Return to / Stay in School

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2011 Actual	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	--	--	--	--
Denominator	--	--	--	--

Table Descriptors:

Goal:	Children and youth who have been identified as having an emotional or behavioral disorder will have improved school attendance.
Target:	Children and youth who have an emotional or behavioral disorder who are receiving mental Health services will have fewer school absences.
Population:	Children and youth diagnosed with an emotional or behavioral disorder
Criterion:	1: Comprehensive Community-Based Mental Health Service Systems; 3: Children's Services
Indicator:	The percentage of children and youth who have an emotional or behavioral disorder who receive mental health services from the Office of Mental Health that report more days in school after beginning mental health services compared to before starting to receive services. NOMS Indicator #5. URS Table 19B.
Measure:	<u>Numerator:</u> The number of parents reporting improvement in child's school attendance (both new and continuing clients). <u>Denominator:</u> The total responses (excluding Not Availables) (new and continuing clients) combined.
Sources of Information:	Telesage Outcome Measurement System (TOMS) (System Pending)
Special Issues:	This is a new indicator for the state that involves reporting on changes in client status over time. OBH plans to use the Telesage Outcome Measurement System (TOMS) to accomplish this. The TOMS is an objective of the Data Infrastructure Grant (DIG). Data was not collected during Fiscal Year 2010. For Fiscal Year 2011, data is being collected via TOMS, and baselines will be set thereafter.
Significance:	Measuring the number of children and youth with an emotional or behavioral disorder who are able to improve their school attendance is a significant factor contributing to improved educational opportunities leading to improved capacity to qualify for further education and/or job placement.
Action Plan:	See special issues. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

CHILD – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Child – Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	--	--	--	--
Denominator	--	--	--	--

Table Descriptors:

Goal:	Children and youth who have been identified as having an emotional or behavioral disorder will not require the intervention of law enforcement.
Target:	The number of arrests of children and youth with an emotional or behavioral disorder who are receiving mental health services from the Office of Behavioral Health will decrease.
Population:	Children and youth diagnosed with an emotional or behavioral disorder
Criterion:	1: Comprehensive Community-Based Mental Health Service Systems; 3: Children's Services
Indicator:	The percentage of children and youth who have an emotional or behavioral disorder who receive mental health services from the Office of Mental Health who are arrested in year subsequent to receiving services compared to the percentage arrested in the year prior to services. NOMS Indicator #6. URS Table 19A.
Measure:	<u>Numerator:</u> Number of people who were arrested in T1 who were not rearrested in T2 (new and continuing clients combined). <u>Denominator:</u> The number of people arrested in T1 (new and continuing clients combined).
Sources of Information:	Telesage Outcome Measurement System (TOMS) (System Pending)
Special Issues:	This is a new indicator for the state that involves reporting on changes in client status over time. OMH plans to use the Telesage Outcome Measurement System (TOMS) to accomplish this. The TOMS is an objective of the Data Infrastructure Grant (DIG). Data was not collected during Fiscal Year 2010. For Fiscal Year 2011, data is being collected via TOMS, and baselines will be set thereafter.
Significance:	Measuring the number of children and youth with an emotional or behavioral disorder who have decreasing exposure to arrest/incarceration is a significant factor contributing to improved community function.
Action Plan:	See special issues. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

CHILD – GOALS TARGETS AND ACTION PLANS**Name of Performance Indicator:** Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	N/A	0.48%	0.3%	0.3%
Numerator	--	37	31	--
Denominator	--	7,665	8,872	--

Table Descriptors:

Goal: Children, youth, and their families served by the Office of Mental Health will live in safe, secure, stable housing.

Target: A decreasing number of children and youth diagnosed with an emotional or behavioral disorder and their families who are receiving mental health services from the Office of Mental Health will need to use shelters for temporary residence or be homeless.

Population: Children and youth diagnosed with an emotional or behavioral disorder

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems 3: Children's Services

Indicator: The percentage of children and youth diagnosed with an emotional or behavioral disorder and their families who receive mental health services from the Office of Mental Health who are homeless or who have been living in shelters. NOMS Indicator # 7; URS Table 15.

Measure: Numerator: Number of Persons Homeless.

Denominator: From URS Table, all persons served with living situation, excluding (minus) persons with Living Situation Not Available.

Sources of

Information: Survey of Regions and Districts, Survey of Hospitals, JPHSA, PIP, OMHIIS (FY 2011)

Special Issues: Currently, this data is primarily ascertained at admission only; and therefore, the impact of treatment at an OBH facility is not being captured.

FY 2010 Actual = $31/8,872 \times 100 = 0.3\%$

Significance: Measuring the number of children and youth diagnosed with an emotional or behavioral disorder and their families who are homeless or in shelters will assist in developing resources to provide adequate housing opportunities for individuals, a significant component of the recovery movement.

Action Plan: The reporting of this information at each re-assessment/ update or discharge will need to be emphasized in order to give meaning to this Indicator. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Housing stability is an important issue that warrants a high priority.

CHILD – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Child – Increased Social Supports / Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	N/A	91%	N/A	91%
Numerator	--	48		--
Denominator	--	53		--

Table Descriptors:

Goal:	The parents of children and youth with an emotional or behavioral disorder will have adequate social support.
Target:	The parents of children and youth with an emotional or behavioral disorder who report that they agree or strongly agree that they are happy with their interpersonal relationships and feelings of being connected with their community.
Population:	Children and youth diagnosed with an emotional or behavioral disorder
Criterion:	1: Comprehensive Community-Based Mental Health Service Systems; 3: Children's Services
Indicator:	The percentage of the parents of children and youth with an emotional or behavioral disorder who receive mental health services from the Office of Mental Health that report agreeing or strongly agreeing with statements on the YSS-F consumer survey related to social connectedness. NOMS Indicator #8.
Measure:	Estimated number of children or youth who have an emotional or behavioral disorder, who are receiving services during the fiscal year (7/1 – 6/30) who report that they agree or strongly agree (score 4 or 5) with statements on the YSS-F survey addressing social connectedness (#23 to #26) divided by the total number of consumers sampled, expressed as a percentage.
Sources of Information:	La Fete Survey, YSS-F (Youth Services Survey for Families) Telesage Outcome Measurement System (TOMS) (System Pending)
Special Issues:	The LaFete survey team was discontinued in FY 2010 in favor of use of the TOMS for reporting these data. The LaFete survey will continue to be used as an instrument in the Telesage Outcome Measurement System (TOMS). However, the TOMS was not implemented until August 2010 and will be reported in 2011.
Significance:	Measuring the number of children and youth with an emotional or behavioral disorder who experience good social connectedness will be an important indicator of the prognosis for recovery.
Action Plan:	See special issues. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

CHILD – GOALS TARGETS AND ACTION PLANS**Name of Performance Indicator:** Child - Improved Level of Functioning

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	55	82	N/A	82
Numerator	41	41		--
Denominator	74	50		--

Table Descriptors:

- Goal:** The parents of children and youth with an emotional or behavioral disorder will report that these children/ youth have an improved ability to take care of themselves and independently manage their affairs.
- Target:** The parents of children and youth with an emotional or behavioral disorder who report that they agree or strongly agree that their children/ youth are better able to manage themselves and situations to meet their needs.
- Population:** Parents of children and youth diagnosed with an emotional or behavioral disorder
- Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems;3: Children's Services
- Indicator:** The percentage of the parents of children and youth with an emotional or behavioral disorder who receive mental health services from the Office of Mental Health that report agreeing or strongly agreeing with statements on the YSS-F consumer survey related to improved functioning. NOMS Indicator #9.
- Measure:** Estimated number of parents with children and youth with an emotional or behavioral disorder who are receiving services during the fiscal year (7/1 – 6/30) who report a grade of B or A (score 3 or 4) that they agree or strongly agree (score 4 or 5) with statements on the YSS-F survey addressing functionality (#'s 16, 17, 18, 20, and 22) divided by the total number of consumers sampled, expressed as a percentage.
- Sources of Information:** La Fete Survey, YSS-F (Youth Services Survey for Families)
Telesage Outcome Measurement System (TOMS) (System Pending)
- Special Issues:** The LaFete survey team was discontinued in FY 2010 in favor of use of the TOMS for reporting these data. The LaFete survey will continue to be used as an instrument in the Telesage Outcome Measurement System (TOMS). However, the TOMS was not implemented until August 2010 and will be reported in 2011.
- Significance:** Measuring the number of the parents of children and youth with an emotional or behavioral disorder who experience improved functional ability will be an important indicator of the prognosis for recovery.
- Action Plan:** See special issues. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

CHILD – GOALS TARGETS AND ACTION PLANS**Name of Performance Indicator:** Child / Youth Budget

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	19%	19%	16%	16%
Numerator	51,214,342	51,472,395	34,369,783	--
Denominator	269,060,700	275,848,740	221,642,483	--

Table Descriptors:

Goal: Children and youth with an emotional or behavioral disorder and their families served by OMH will be provided with mental health services consistent with the System of Care principles.

Target: Expenditures for children and youth programs will be maintained at current levels or improved when compared to the Office of Mental Health's total budget.

Population: Children and youth diagnosed with an emotional or behavioral disorder

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of the Office of Mental Health total budget that is allocated to children and youth programs

Measure: Numerator: The actual dollar value of resources expended annually on C/Y
Denominator: The total dollar value of resources expended annually

Sources of Information: OMH Fiscal Report

Special Issues: Budgetary crises and the need to deliver more appropriate care to children and youth lead to the closing of New Orleans Adolescent Hospital (NOAH), and the provision of more outpatient, family and child-centered services. This reorganization of service delivery resulted in a cost savings for the state, with additional efficiencies in delivering appropriate mental health care to children and adolescents. FY 10 Actual = \$34,369,783 / \$221,642,483 X 100 = 16%.

Significance: Providing support to children and youth with an emotional or behavioral disorder can contribute to healthy families and communities

Action Plan: Appropriate expenditures and accurate accounting will continue to be provided ensuring the proper usage of Block Grant funds according to the allocations specified in the Intended Use Plans. The Block Grant indicators will be monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Attempts to provide improved services are a priority for Louisiana, but with the economic and workforce crisis in the state, it is important to be realistic when setting targets.

CHILD – GOALS TARGETS AND ACTION PLANS**Name of Performance Indicator:** Continuity of Care / CY

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	9.2	8.1	11.7	11.7
Numerator	607	420	328	--
Denominator	66	52	28	--

Table Descriptors:

Goal:	Children and youth with an emotional or behavioral disorder and their families served by OMH will be provided with appropriate recovery/ resiliency-oriented mental health services.
Target:	The average number of days between a consumer's discharge from a psychiatric hospital and a follow-up visit to a community mental health clinic (CMHC) will be at the lowest level possible in order to maintain continuity of care.
Population:	Children and youth diagnosed with an emotional or behavioral disorder
Criterion:	1: Comprehensive Community-Based Mental Health Service Systems
Indicator:	The average number of days between a state psychiatric hospital discharge and a community mental health clinic aftercare appointment
Measure:	Days reported on OMH- Integrated Information System (OMH-IIS) Average = Number of days until follow-up divided by number of discharges <u>Numerator</u> = sum of days from discharge to CMHC admit <u>Denominator</u> = Discharges with aftercare visit within 45 days Time period (Lag fiscal year) - April 1- March 31
Sources of Information:	CMHC-OMHIIS (FY 2011), JPHSA, Patient Information Program (PIP)
Special Issues:	This data now excludes data from all acute units. The numbers reported for 2008 have been adjusted to provide for accurate comparisons. At discharge, patients are routinely given 3 weeks supply of medications, so 21 days is the absolute limit for clients to be seen in the outpatient setting. FY 2010 Actual = $328 / 28 = 11.7$
Significance:	One of the strongest predictors of community success after discharge from a state hospital is continuity of care
Action Plan:	Efforts to decrease the number of days between discharge and follow-up aftercare will continue to be made, and should improve with the availability of more outpatient services. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

CHILD – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Parent / Caretaker Involvement in Treatment

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target
Performance Indicator	97	100	N/A	100
Numerator	68	54		--
Denominator	70	54		--

Table Descriptors:

Goal: Children and youth with an emotional or behavioral disorder and their families served by the Office of Mental Health will be provided with mental health services consistent with the System of Care principles.

Target: Families reporting a sense of empowerment and enhanced advocacy services for children and youth with an emotional or behavioral disorder will increase.

Population: Children and youth diagnosed with an emotional or behavioral disorder

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of parents / caretakers surveyed who report being actively involved in decisions regarding their children's treatment. Client Perception of Care: NOMS Indicator # 4

Measure: Numerator: Number of parents / caretakers surveyed giving a grade of "C" or better to Items #2, 3, and 6 on the La Fete Survey.

Denominator: Total Number of parents responding to items #2, 3, and 6

Sources of Information: La Fete Survey, YSS-F (Youth Services Survey for Families)
Telesage Outcome Measurement System (TOMS) (System Pending)

Special Issues: The LaFete survey team was discontinued in FY 2010 in favor of use of the TOMS for reporting these data. The LaFete survey will continue to be used as an instrument in the Telesage Outcome Measurement System (TOMS). However, the TOMS was not fully implemented until August 2010 and will be reported in 2011.

Significance: Active involvement of parents in treatment generally assures that intervention is appropriate to child and family needs, more effective, and more likely to result in family stability and improved child functioning

Action Plan: See special issues. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

CHILD – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Planning Council Member Satisfaction / CY

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual* See Below*	FY 2011 Target
Performance Indicator	100	100	89	89
Numerator	15	17	50	
Denominator	15	17	56	

Table Descriptors:

Goal: Consumers, family members, and other stakeholders, are involved in policy decisions, planning, and monitoring of the mental health system

Target: Individuals who represent children and youth on state Planning Councils should regard and report their participation as a positive experience.

Population: Children and youth diagnosed with an emotional or behavioral disorder

Criterion: 5: Management Systems

Indicator: The percentage of Louisiana Mental Health Planning Council members giving positive feedback regarding their involvement in the Council

Measure: ***In the past, this was** the percentage of Louisiana Mental Health Planning Council members who rate their involvement in the Council with a grade of 'C' or better. Beginning with FY2011, the Planning Council voted to change this Target to **80% with a grade of 'B' or better.**

Sources of Information: Planning Council meeting evaluation surveys, Planning Council Executive Committee reports

Special Issues: Because this indicator has been met for two years, a change was made to the measure (see above). FY 2010 Actual = 89 %.

Significance: If council members report that they are involved it is likely that OMH is providing an environment conducive to stakeholder partnership

Action Plan: The Planning Council will continue to survey its members at each meeting and request suggestions for improvement. The Block Grant indicators are monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

LOUISIANA FY 2011 BLOCK GRANT PLAN

SEPTEMBER 1, 2010

APPENDIX A

DETAILED INTENDED USE PLANS

JULY 30, 2010

**Intended Use Plan Allocations
Summary
FY 2011**

FY 2010	Adult	C/Y	Intended Use Total
MHSD	\$ 90,414	\$ 295,656	\$ 386,070
CAHSD	\$ 126,645	\$ 253,373	\$ 380,018
Region 3	\$ 171,174	\$ 177,918	\$ 349,092
Region 4	\$ 170,415	\$ 190,247	\$ 360,662
Region 5	\$ 107,728	\$ 246,044	\$ 353,772
Region 6	\$ 114,983	\$ 230,706	\$ 345,689
Region 7	\$ 143,532	\$ 174,245	\$ 317,777
Region 8	\$ 157,426	\$ 171,276	\$ 328,702
FPHSD	\$ 145,681	\$ 153,020	\$ 298,701
JPHSA	\$ 73,855	\$ 73,855	\$ 147,710
Reg/ LGE Total	\$ 1,301,853	\$ 1,966,340	\$ 3,268,193
Central Office (State-wide)	\$ 1,368,721	\$ 656,209	\$ 2,024,930
Grand Totals	\$ 2,670,574	\$ 2,622,549	\$ 5,293,123

Percentage of Block Grant Dollars Allocated to Adults:	50.45%
Percentage of Block Grant Dollars Allocated to Children/ Youth :	49.55%

**Block Grant Application FY 2011
ADULT Intended Use Plan Summary**

ADULT Service Category	MHSD	CAHSD	SCLHSA	Region 4	Region 5	Region 6	Region 7	Region 8	FPHSA	JPHSA	Reg/ LGE Grand Total	Central Office — State-wide*	Grand Total
Adult Employment					\$6,000	\$9,000				\$20,000	\$35,000	10,000	\$ 45,000
Advisory Council Support	\$2,500	\$4,000	\$2,500	\$2,500	\$2,936	\$4,000	\$3,000	\$4,000	\$2,500	\$2,500	\$30,436		\$ 30,436
Assertive Community Tx						\$29,302		\$46,646			\$75,948		\$ 75,948
Consumer Advocacy & Education										\$1,500	\$1,500	\$40,000	\$ 41,500
Consumer Liaisons	\$11,843	\$14,504			\$6,529	\$12,869		\$11,892	\$15,226		\$72,863		\$ 72,863
Consumer Monitoring & Evaluation											0	\$63,484	\$ 63,484
Consumer Support Services	\$76,071	\$20,700	\$102,650	\$51,419	\$12,070	\$59,811	\$34,587	\$94,888	\$127,955	\$47,655	\$627,807	\$442,000	\$1,069,807
Crisis Response Services		\$21,380					\$15,000				\$36,380		\$ 36,380
Mental Health Tx Services			\$30,610		\$25,507						\$56,117		\$ 56,117
Planning Op & System Dev											0	\$160,546	\$ 160,546
Residential & Housing		\$66,061	\$35,414		\$49,686		\$70,945				\$222,106		\$ 222,106
Respite											0		\$ -
Staff Dev											0	\$165,971	\$ 165,971
Transportation				\$5,692	\$5,000		\$20,000			\$2,200	\$32,892		\$ 32,892
Other Contracted Serv				\$110,804							\$110,804	\$486,720	\$ 597,524
Other													0
Totals	\$90,414	\$126,645	\$171,174	\$170,415	\$107,728	\$114,983	\$143,532	\$157,426	\$145,681	\$73,855	\$1,301,853	\$1,368,721	\$2,670,574

***NOTE: Budgets for Areas A, B, and C were absorbed into Central Office beginning in Fiscal Year2010**

**Block Grant Application FY 2011
CHILD/ YOUTH/ FAMILY Intended Use Summary**

CHILD Service Category	MHSD	CAHSD	SCLHSA	Region 4	Region 5	Region 6	Region 7	Region 8	FPHSA	JPHSA	Reg/ LGE Grand total	Central Office State-wide	Grand Total
Advisory Council Support	\$2,500	\$4,000	\$2,500	\$2,500	\$3,000	\$4,000	\$3,000	\$4,000	\$2,500	\$2,500	\$30,500	0	\$30,500
Assertive Community Tx		\$55,000	\$89,992					\$133,706			\$278,698	0	\$278,698
Consumer Advocacy & Edu										\$1,500	\$1,500	\$111,400	\$112,900
Consumer Liaisons	\$21,528							\$5,759			\$27,287	\$36,275	\$63,562
Consumer Monitoring & Eval						\$6,381					\$6,381	\$63,302	\$69,683
Crisis Response Services			22,813			\$104,028	\$40,000		26,265		\$193,106	0	\$193,106
Family Support Services	\$57,000	\$194,373	\$35,663		\$117,977	\$116,297	\$33,067	\$27,811		\$38,935	\$621,123	\$123,936	\$745,059
Planning Op & System Dev											0	\$94,046	\$94,046
Residential & Housing											0	0	0
Respite	\$55,892		\$17,600		\$75,067				\$35,000		\$183,559	0	\$183,559
School-based MH Services					\$50,000					\$30,920	\$80,920	0	\$80,920
Staff Development											0	\$134,000	\$134,000
Transportation									\$10,000		\$10,000	0	\$10,000
Other Contracted Services	\$158,736		\$9,350	\$187,747			\$98,178		\$79,255		\$533,266	\$93,250	\$626,516
Totals	\$295,656	\$253,373	\$177,918	\$190,247	\$246,044	\$230,706	\$174,245	\$171,276	\$153,020	\$73,855	\$1,966,340	\$656,209	\$2,622,549

***NOTE: Budgets for Areas A, B, and C were absorbed into Central Office beginning in Fiscal Year 2010.**

**RE-ALLOCATION OF BLOCK GRANT FUNDS - EQUAL SHARES –
BASED ON FY 2011 ALLOCATION FIGURES**

Region/ LGE	Original 2010 BG \$ Allocation	Actual 2010 BG Allocation	Projected 2011 BG Allocation	Projected 2012 BG Allocation	Projected 2013 BG Allocation
MHSD	\$428,606	\$386,070	\$386,070	\$356,445	326,819
CAHSD	\$419,528	\$380,018	\$380,018	\$353,419	326,819
SCLHSA	\$373,139	\$349,092	\$349,092	\$337,956	326,819
Region 4	\$390,494	\$360,662	\$360,662	\$343,741	326,819
Region 5	\$380,159	\$353,772	\$353,772	\$340,296	326,819
Region 6	\$368,034	\$345,689	\$345,689	\$336,254	326,819
Region 7	\$326,166	\$317,777	\$317,777	\$322,298	326,819
Region 8	\$342,553	\$328,702	\$328,702	\$327,760	326,819
FPHSA	\$297,552	\$298,701	\$298,701	\$312,760	326,819
JPHSA	\$71,065	\$147,710	\$147,710	\$237,264	326,819
Total	\$3,397,296	\$3,268,193	\$3,268,193	\$3,268,191	\$3,268,190

Original Plan Approved by *Jennifer Kopke* 6/29/2009

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name **Metropolitan Human Services District** **Adult Services**
 Address 400 Poydras St., Suite 1800
 New Orleans, LA 70130

Contact Person Charlotte Cunliffe Date Reviewed
 Phone (504) 568-3130 by RAC:
 Email charlotte.cunliffe@la.gov Date Prepared: 6/8/2010

ADULT SERVICES		BLOCK GRANT INTENDED USE PLAN FY 2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#
Adult Employment			
Advisory Council Support	Advisory Council -- ARC	\$ 2,500	Contract
Assertive Community Treatment (ACT)			
Consumer Advocacy & Education			
Consumer Liaisons (not in contracts)	Consumer Liason	\$ 11,843	HR
Consumer Monitoring and Evaluation			
Consumer Support Services	Consumer Care -- ARC	\$ 76,071	Contract
Crisis Response Services			
Mental Health Treatment Services			
Planning Operations and System Development			
Residential / Housing			
Respite			
Staff Development			
Transportation			
Other Contracted Services (Specify)			
TOTAL Adult Services		\$ 90,414	
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>			

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name **Metropolitan Human Services District** **Child/Youth Services**
 Address 400 Poydras St., Suite 1800
 New Orleans, LA 70130

Contact Person Charlotte Cunliffe Date Reviewed
 Phone (504) 568-3130 by RAC:
 Email charlotte.cunliffe@la.gov Date Prepared: 6/8/2010

CHILD/YOUTH SERVICES	BLOCK GRANT INTENDED USE PLAN	FY 2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#
Advisory Council Support	RAC Support / ARC	\$ 2,500	Contract
Assertive Community Treatment (ACT)			
Consumer Advocacy & Education			
Consumer Liaisons (not in contracts)	Consumer Liason (41D1) position	\$ 21,528	HR
Consumer Monitoring and Evaluation			
Crisis Response Services			
Family Support Services	Family Support -- ARC	\$ 12,000	Contract
	Child/Adolescent Consumer Care -- ARC	\$ 45,000	Contract
Planning Operations and System Development			
Residential / Housing			
Respite	Children's Bureau –Family Preservation	\$ 55,892	Contract
School-based Mental Health Services			
Staff Development			
Transportation			
Other Contracted Services (Specify)	Court-based assessment & triage services-provider TBD	\$158,736	HR
TOTAL Child/Youth Services		\$ 295,656	
ADD lines as necessary, but DO NOT add or change Service Categories			

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name **Capital Area Human Services District (CAHSD)** **Adult Services**
 Address 4615 Government Street
 Baton Rouge, La 70806

Contact Person Stanley Mong **Date Reviewed**
 Phone 225-925-1768 **by RAC:**
 Email smong@dhh.la.gov **Date Prepared:** 4/14/2010

ADULT SERVICES		BLOCK GRANT INTENDED USE PLAN	FY 2009-2010
Service Category	Provider Name/ Service Type	Amount	CFMS#
Adult Employment			
Advisory Council Support	Support for regional advisory council	\$4,000	
Assertive Community Treatment (ACT)			
Consumer Advocacy & Education			
Consumer Liaisons (not in contracts)	CAHSD Consumer Liaison	\$14,504	
Consumer Monitoring and Evaluation			
Consumer Support Services	Consumer drop in center	\$20,700	
Crisis Response Services	Crisis telephone line	\$21,380	
Mental Health Treatment Services			
Planning Operations and System Development			
Residential / Housing	Community housing support (Emergency subsistence funds)	\$3,361	
	Community housing support (Independent living funds)	\$62,700	
Respite			
Staff Development			
Transportation			
Other Contracted Services (Specify)			
TOTAL Adult Services		\$126,645	
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>			

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name Capital Area Human Services District (CAHSD)
 Address 4615 Government Street
 Baton Rouge, La 70806

Contact Person Stanley Mong Date Reviewed
 Phone 225-925-1768 by RAC:
 Email Stanley.Mong@la.gov Date Prepared 4/12/2010

CHILD/YOUTH SERVICES	BLOCK GRANT INTENDED USE PLAN	FY 2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#
Advisory Council Support	support for Regional Advisory Council - children	\$4,000	
Assertive Community Treatment (ACT)	CAHSD – ACT social worker	\$55,000	
Consumer Advocacy & Education			
Consumer Liaisons (not in contracts)			
Consumer Monitoring and Evaluation			
Crisis Response Services			
Family Support Services	family support services	\$24,373	
	Police mentor	\$15,000	
	Police mentor	\$7,500	
	Police mentor	\$7,500	
	CAHSD - family preservation (1 nurse, 2 social workers)	\$140,000	
Planning Operations and System Development			
Residential / Housing			
Respite			
School-based Mental Health Services			
Staff Development			
Transportation			
Other Contracted Services (Specify)			
TOTAL Child/Youth Services		\$253,373	
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>			

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name	South Central Louisiana Human Services Authority	Adult Services
Address	6907 Alma Street Houma LA 70364	
Contact Person	Karen O. Schilling	Date Reviewed
Phone	985-876-8877	by RAC: 4/9/2010
Email	karen.schilling@la.gov	Date Prepared 4/14/2010

ADULT SERVICES		BLOCK GRANT INTENDED USE PLAN 2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#
Adult Employment			
Advisory Council Support	Options for Independence - RAC	\$ 2,500	635177
Assertive Community Treatment (ACT)			
Consumer Advocacy & Education			
Consumer Liaisons (not in contracts)			
Consumer Monitoring and Evaluation			
Consumer Support Services	START Corp - Drop-in Center	\$ 22,375	634653
	Options for Independence-Drop in Center	\$ 34,404	634661
	Options for Independence-St. Mary Recovery Ctr	\$ 26,000	
	Options for Independence - CCR	\$ 19,871	635177
Crisis Response Services			
Mental Health Treatment Services	START Corp- Peer to Peer Support Specialists	\$ 30,610	
Planning Operations and System Development			
Residential / Housing	START Housing	\$ 35,414	
Respite			
Staff Development			
Transportation			
Other Contracted Services (Specify)			
TOTAL Adult Services		\$ 171,174	
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>			

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name	South Central Louisiana Human Services Authority	Child/Youth Services
Address	6907 Alma Street Houma LA 70364	
Contact Person	Karen Schilling	Date Reviewed
Phone	985-876-8877	by RAC
Email	karen.schilling@la.gov	Date Prepared 4/14/2010

CHILD/YOUTH SERVICES		FY2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#
Advisory Council Support	Gulf Coast Teaching Family Services - RAC	\$ 2,500	634970
Assertive Community Treatment (ACT)	Options for Independence-Functional Family Therapy	\$ 89,992	
Consumer Advocacy & Education			
Consumer Liaisons (not in contracts)			
Consumer Monitoring and Evaluation			
Crisis Response Services	CART	\$ 22,813	
Family Support Services	Federation of Families – Family Support	\$ 8,315	634154
	START Corporation--CCR	\$ 27,348	634970
Planning Operations and System Development			
Residential / Housing			
Respite	Gulf Coast Teaching Family Services - Therapeutic Respite Camp	\$ 17,600	634972
School-based Mental Health Services			
Staff Development			
Transportation			
Other Contracted Services (Specify)	Overcomers, Inc. –youth support services	\$ 9,350	
TOTAL Child/Youth Services		\$ 177,918	
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>			

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name **REGION 4 Adult Services**

Address 302 Dulles Drive
 Lafayette, Louisiana 70506

Contact Person Ellen Deaton

Phone 337-262-4190

Email ellen.deaton@la.gov

Date Reviewed

by RAC: 4/5/2010

Date Prepared 4/12/2010

ADULT SERVICES		BLOCK GRANT INTENDED USE PLAN FY 2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#
Adult Employment			
Advisory Council Support		\$2,500	
Assertive Community Treatment (ACT)			
Consumer Advocacy & Education			
Consumer Liaison(s)			
Consumer Monitoring and Evaluation			
Consumer Support Services	Extra Mile Lafayette Parish Drop-In Centers	\$31,419	
	Extra Mile Peer Support Specialists	\$20,000	
Crisis Response Services			
Mental Health Treatment Services			
Planning Operations and System Development			
Residential / Housing			
Respite			
Staff Development			
Transportation	VOA / community and rural transportation	\$5,692	
Other Contracted Services (Specify)	VOA / Adult Comprehensive Mental Health Services	\$79,204	
	VOA / Medicaid Eligibility Program	\$31,600	
TOTAL Adult Services		\$170,415	
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>			

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name **REGION 4 Child/Youth Services**

Address 302 Dulles Drive
 Lafayette, Louisiana 70506

Contact Person	Ellen Deaton	Date Reviewed	
Phone	337-262-4190	by RAC:	4/5/2010
Email	ellen.deaton@la.gov	Date Prepared	4/12/2010

CHILD/YOUTH SERVICES	BLOCK GRANT INTENDED USE PLAN	FY 2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#
Advisory Council Support		\$2,500	
Assertive Community Treatment (ACT)			
Consumer Advocacy & Education			
Consumer Liaison(s)			
Consumer Monitoring and Evaluation			
Crisis Response Services			
Family Support Services			
Planning Operations and System Development			
Residential / Housing			
Respite			
School-based Mental Health Services			
Staff Development			
Transportation			
Other Contracted Services (Specify)	Case Mgt/Consumer Care Resources/ EBP – Contractor TBD	\$156,147	
	VOA / Medicaid Eligibility Program	\$31,600	
TOTAL Child/Youth Services		\$190,247	
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>			

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name **REGION 5 Adult Services**

Address 4105 Kirkman St.	Date Reviewed
Lake Charles, LA 70607	by RAC: 4/7/10

Contact Person Susan Fry, Regional Director

Phone 337-475-8022

Email susan.fry@LA.GOV	Date Prepared 3/29/2010
--	----------------------------

ADULT SERVICES	BLOCK GRANT INTENDED USE PLAN	FY 2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#
Adult Employment	VOA-GBR*- assist in job skill development & job placement	\$ 6,000	*639280
Advisory Council Support	VOA-GBR*-Support for RAC	\$ 2,936	*639280
Assertive Community Treatment (ACT)			
Consumer Advocacy & Education			
Consumer Liaisons (not in contracts)	OMH-V Consumer Liaison position	\$ 6,529	OMH
Consumer Monitoring and Evaluation			
Consumer Support Services	VOA-GBR-Center that provides social, educational, employment opportunities	\$ 12,070	*639280
Crisis Response Services			
Mental Health Treatment Services	Cam Melville, Ph.D.-expansion of integrated tx for co-occurring disorders	\$ 25,507	663572
Planning Operations and System Development			
Residential / Housing	VOA-GBR*-Community Housing Consumer Care Resources, Housing Development through Regional Housing Coordinator position	\$ 49,686	*639280
Respite			
Staff Development			
Transportation	VOA-GBR-transportation	\$ 5,000	*639280
Other Contracted Services (Specify)			
TOTAL Adult Services		\$ 107,728	
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>			

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name	REGION 5 Child/Youth Services		
Address	4105 Kirkman St.		
	Lake Charles, LA 70607	Date Reviewed	
		by RAC:	4/7/2010
Contact Person	Susan Fry, Regional Director		
Phone	337-475-8022		
Email	Susan.fry@LA.GOV	Date Prepared	3/29/2010

CHILD/YOUTH SERVICES	BLOCK GRANT INTENDED USE PLAN	FY 2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#
Advisory Council Support	VOA- GBR- Support of RAC	\$ 3,000	*639280
Assertive Community Treatment (ACT)			
Consumer Advocacy & Education			
Consumer Liaisons (not in contracts)			
Consumer Monitoring and Evaluation			
Crisis Response Services			
Family Support Services	Education and Treatment Council Inc.- comprehensive support services	\$ 107,282	639275
	VOA-GBR- Wraparound Flex Funds- Consumer Care Resources	\$ 10,695	*639280
Planning Operations and System Development			
Residential / Housing			
Respite	ETC Crisis Respite Services	\$ 75,067	651392
School-based Mental Health Services	Sisters of Emmanuel - school based counseling at middle and elementary schools	\$ 50,000	643544
Staff Development			
Transportation			
Other Contracted Services (Specify)			
TOTAL Child/Youth Services		\$ 246,044	
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>			

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name **Region 6 Adult Services**

Address P.O. Box 7473

Alexandria, LA 71306

Contact Person Ingrid Cannella, Acting Regional Director

Date Reviewed

Phone (318) 484-6850

by RAC:

Email Ingrid.Cannella@LA.GOV

Date Prepared 4/21/2010

ADULT SERVICES		BLOCK GRANT INTENDED USE PLAN		FY 2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#		
Adult Employment	The Extra Mile, Consumer Employment	\$ 9,000	661640		
Advisory Council Support	TEM, Consumer Initiative	\$ 1,000	661637		
	TEM Community Ed (Workshop)	\$ 3,000			
Assertive Community Treatment (ACT)	VOA - CIAS	\$ 29,302	681736		
Consumer Advocacy & Education					
Consumer Liaisons	TEM, Consumer Liaisons	\$ 12,869	661637		
Consumer Monitoring and Evaluation					
Consumer Support Services	VOA - Red River Employment	\$ 27,166	664119		
	TEM / Drop In Center	\$ 32,646	661418		
Crisis Response Services					
Mental Health Treatment Services					
Planning Operations and System Development					
Residential / Housing					
Respite					
Staff Development					
Transportation					
Other Contracted Services (Specify)					
TOTAL Adult Services		\$ 114,983			
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>					

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name **REGION 6 Child/Youth Services**

Address P.O. Box 7473

Alexandria, LA 71306-7473

Contact Person Ingrid Cannella, Acting Regional Director

Phone (318) 484-6850

Email Ingrid.Cannella@la.gov

Date Reviewed

by RAC: 4/23/10

Date Prepared 4/23/2010

CHILD/YOUTH SERVICES		BLOCK GRANT INTENDED USE PLAN		FY 2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#		
Advisory Council Support	The Extra Mile –Consumer Initiative	\$ 1,000	661637		
	The Extra Mile-Comm. Ed	\$ 3,000			
Assertive Community Treatment (ACT)					
Consumer Advocacy & Education					
Consumer Liaisons (not in contracts)					
Consumer Monitoring and Evaluation	The Extra Mile – Consumer Initiative	\$ 6,381	661637		
Crisis Response Services	Family Counseling Agency / In-home Counseling	\$ 104,028	662318		
Family Support Services	Federation of Families / Parent Liaison	\$ 27,961	662452		
	VOA of America / WIT	\$ 61,170	677233		
	VOA - Red River Employment	\$ 27,166	669119		
Planning Operations and System Development					
Residential / Housing					
Respite					
School-based Mental Health Services					
Staff Development					
Transportation					
Other Contracted Services (Specify)					
TOTAL Child/Youth Services		\$ 230,706			
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>					

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name **REGION 7 Adult Services**

Address Shreveport Mental Health Center

1310 N. Hearne Avenue

Shreveport, LA 71137

Contact Person Wendy M. Goad, LCSW

Date Reviewed

Phone 318.676.5110

by RAC: 4/21/2010

Email Wendy.Goad@LA.GOV

Date Prepared 3/29/2010

ADULT SERVICES		BLOCK GRANT INTENDED USE PLAN		FY 2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#		
Adult Employment					
Advisory Council Support	RAC	\$ 3,000			
Assertive Community Treatment (ACT)					
Consumer Advocacy & Education					
Consumer Liaisons					
Consumer Monitoring and Evaluation					
Consumer Support Services	Easter Seals of LA-Case Management	\$ 20,000			
	VOA of North LA- Medicaid Enrollment	\$ 14,587			
Crisis Response Services	Mobile Adult Crisis Screening Response	\$ 15,000			
Mental Health Treatment Services					
Planning Operations and System Development					
Residential / Housing	VOA of N. LA / Housing Development and Services, Housing Support Services and Supervised Apartment	\$ 43,200			
	VOA of N. LA / Housing Development and Services, Housing Support Services and Supervised Apartment	\$ 27,745			
Respite					
Staff Development					
Transportation	Community Support Programs- Transportation Services	\$ 20,000			
Other Contracted Services (Specify)					
TOTAL Adult Services		\$ 143,532			
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>					

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name **REGION 7 Child/Youth Services**

Address Shreveport Mental Health Center

1310 N. Hearne Avenue

Shreveport, LA 71137

Contact Person Wendy M. Goad, LCSW

Phone 318.676.5110

Email Wendy.Goad@LA.Gov

Date Reviewed

by RAC: 4/21/2010

Date Prepared 3/29/2010

CHILD/YOUTH SERVICES		BLOCK GRANT INTENDED USE PLAN		FY 2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#		
Advisory Council Support	RAC	\$ 3,000			
Assertive Community Treatment (ACT)					
Consumer Advocacy & Education					
Consumer Liaisons					
Consumer Monitoring and Evaluation					
Crisis Response Services	Child/Adolescent Mobile Crisis Screening	\$ 40,000			
Family Support Services	Parent/Family Liaisons, Community Care Resources, Family Training, Support Groups, Advocacy	\$ 33,067			
Planning Operations and System Development					
Residential / Housing					
Respite					
School-based Mental Health Services					
Staff Development					
Transportation					
Other Contracted Services (Specify)	Caddo Parish Commission – Mental Health Assessment Center	\$ 55,000			
	Evidence Based Practices training, services in clinics	43,178			
TOTAL Child/Youth Services		\$ 174,245			
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>					

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name	REGION 8 Adult Services		
Address	Monroe Mental Health Center		
	PO Box 1843		
	Monroe, LA 71210		
Contact Person	Mark S. DeBord, LCSW	Date Reviewed	(By email)
Phone	318-362-3339	by RAC:	3/31/2010
Email	Mark.DeBord@LA.GOV	Date Prepared	3/31/2010

ADULT SERVICES		BLOCK GRANT INTENDED USE PLAN		FY 2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#		
Adult Employment					
Advisory Council Support	The Extra Mile - RAC	\$ 4,000	621310		
Assertive Community Treatment (ACT)	Monroe Area Guidance Center - Supportive Living	\$ 46,646	621452		
Consumer Advocacy & Education					
Consumer Liaisons	The Extra Mile - Consumer Initiative	\$ 11,892	634426		
Consumer Monitoring and Evaluation					
Consumer Support Services	VOA - SSI (Medicaid Enrollment)	\$ 26,694	634430		
	The Extra Mile - Consumer Care Resources	\$ 7,034	647847		
	The Extra Mile - Peer Support Centers	\$ 61,160	634425		
Crisis Response Services					
Mental Health Treatment Services					
Planning Operations and System Development					
Residential / Housing					
Respite					
Staff Development					
Transportation					
Other Contracted Services (Specify)					
TOTAL Adult Services		\$ 157,426			
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>					

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name **REGION 8 Child/Youth Services**

Address **Monroe Mental Health Center**
PO Box 1843
Monroe, LA 71210

Contact Person **Mark S. DeBord, LCSW** Date Reviewed (by email)
 Phone **318-362-3339** by RAC: 3/31/2010
 Email **mark.debord@la.gov** Date Prepared 3/31/2010

CHILD/YOUTH SERVICES		BLOCK GRANT INTENDED USE PLAN FY 2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#
Advisory Council Support	The Extra Mile - RAC	\$ 4,000	621310
Assertive Community Treatment (ACT)	Positive Forces - ACT	\$ 133,706	621314
Consumer Advocacy & Education			
Consumer Liaisons	The Extra Mile – Peer Support Specialists	\$ 5,759	674310
Consumer Monitoring and Evaluation			
Crisis Response Services			
Family Support Services	VOA - SSI (Medicaid Enrollment)	\$ 26,694	634430
	The Extra Mile - Wraparound	\$ 1,117	621311
Planning Operations and System Development			
Residential / Housing			
Respite			
School-based Mental Health Services			
Staff Development			
Transportation			
Other Contracted Services (Specify)			
TOTAL Child/Youth Services		\$ 171,276	
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>			

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name **Florida Parishes Human Services Authority** **Adult Services**
 Address 11236 Hwy 16
 Amite, LA 70422

Contact Person Melanie Watkins Date Reviewed
 Phone 985-748-2220 by RAC:
 Email Melanie.Watkins@LA.GOV Date Prepared: 04/12/10

ADULT SERVICES		BLOCK GRANT INTENDED USE PLAN		FY 2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#		
Adult Employment					
Advisory Council Support	VOA-GNO Regional Advisory Council Support	\$ 2,500			
Assertive Community Treatment (ACT)					
Consumer Advocacy & Education					
Consumer Liaisons		\$ 15,226			
Consumer Monitoring and Evaluation					
Consumer Support Services	VOA-GNO Consumer Care Resources (\$33,765) VOA-GNO Case Management	\$ 127,955			
Crisis Response Services					
Mental Health Treatment Services					
Planning Operations and System Development					
Residential / Housing					
Respite					
Staff Development					
Transportation					
Other Contracted Services (Specify)					
TOTAL Adult Services		\$ 145,681			
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>					

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name **Florida Parishes Human Services Authority** **Child/ Youth Services**
 Address 11236 Hwy 16
 Amite, LA 70422

Contact Person Melanie Watkins Date Reviewed
 Phone 985-748-2220 by RAC:
 Email Melanie.Watkins@LA.GOV Date Prepared 04/12/10

CHILD/YOUTH SERVICES		BLOCK GRANT INTENDED USE PLAN	FY 2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#	
Advisory Council Support	SEL-AHEC-Regional Advisory Council Support	\$2,500		
Assertive Community Treatment (ACT)				
Consumer Advocacy & Education				
Consumer Liaisons (not in contracts)				
Consumer Monitoring and Evaluation				
Crisis Response Services				
Family Support Services	SEL-AHEC-Wraparound (CCR)	\$26,265		
Planning Operations and System Development				
Residential / Housing				
Respite	VOA-GNO Saturday Day Camp	\$35,000		
School-based Mental Health Services				
Staff Development				
Transportation	SEL-AHEC-Wraparound (Transportation Voucher)	\$10,000		
Other Contracted Services (Specify)	New Horizons Youth Services Bureau-Pathways (Family Preservation)	\$79,255		
TOTAL Child/Youth Services		\$153,020		
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>				

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name	Jefferson Parish Human Services Authority	Adult Services
Address	5001 West Bank Expressway	
	Marrero, LA 70072	
Contact Person	Mke Teague, Exec Director, JPHSA	Date Reviewed
Phone	(504) 838-5700	by RAC:
Email	mteague@jphsa.org	Date Prepared

ADULT SERVICES		BLOCK GRANT INTENDED USE PLAN	FY 2009-2010
Service Category	Provider Name/ Service Type	Amount	CFMS#
Adult Employment	JPHSA Employee/ Employment Specialist	\$ 20,000	
Advisory Council Support	The Extra Mile	\$ 2,500	
Assertive Community Treatment (ACT)			
Consumer Advocacy & Education	The Extra Mile/Consumer Training	\$ 1,500	
Consumer Liaisons			
Consumer Monitoring and Evaluation			
Consumer Support Services	JPHSA Employee/Social Inclusion Counselor	\$ 37,505	
	The Extra Mile/Consumer Initiative-Peer Mentors	\$ 10,150	
Crisis Response Services			
Mental Health Treatment Services			
Planning Operations and System Development			
Residential / Housing			
Respite			
Staff Development			
Transportation	The Extra Mile/Training, Mobility Training	\$ 2,200	
Other Contracted Services (Specify)			
TOTAL Adult Services		\$ 73,855	
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>			

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name **Jefferson Parish Human Services Authority** **Child/Youth Services**
 Address 5001 West Bank Expressway
Marrero, LA 70072

Contact Person Angela Henry Date Reviewed _____
 Phone (504) 838-5700 & 838-5002 by RAC: _____

Email ahenry@jphsa.org Date Prepared _____

CHILD/YOUTH SERVICES	BLOCK GRANT INTENDED USE PLAN	FY 2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#
Advisory Council Support	The Extra Mile/Advisory Council Children Activities	\$ 2,500	
Assertive Community Treatment (ACT)			
Consumer Advocacy & Education	The Extra Mile/Consumer Training	\$ 1,500	
Consumer Liaisons			
Consumer Monitoring and Evaluation			
Crisis Response Services			
Family Support Services	Community Support Program – Wrap Around Services	\$ 38,935	
Planning Operations and System Development			
Residential / Housing			
Respite			
School-based Mental Health Services	JPHSA Employee/School Based Clinic	\$ 30,920	
Staff Development			
Transportation			
Other Contracted Services (Specify)			
TOTAL Child/Youth Services		\$ 73,855	
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>			

Department of Health & Hospitals

Office of Behavioral Health

Region/ District Name	Central Office - Statewide Services	Adult Services
Address	628 N. 4th Street, 4th Floor, P. O. Box 4049 Baton Rouge, LA 70821-4049	
Contact Person	Ann Darling, LCSW	Date Reviewed
Phone	225-342-8678	by RAC:
Email	Ann.Darling@la.gov	Date Prepared: 7/15/10

ADULT SERVICES	BLOCK GRANT INTENDED USE PLAN	FY 2011	CFMS#
Service Category	Provider Name/ Service Type	Amount	
Adult Employment	Adult Employment Training (Darling)	\$10,000	
Advisory Council Support			
Assertive Community Tx(ACT)			
Consumer Advocacy & Education	JPHSA - supported employment pilot (in yr 3)	\$40,000	
Consumer Liaisons			
Consumer Monitoring and Evaluation	C'est Bon Salaries/Interviewers	\$63,484	
Consumer Support Services	NAMI - Family-To-Family	\$120,000	
	NAMI - Olmstead (Darling/Mack)	\$50,000	
	Meaningful Minds (Mitchell)	\$32,000	
	MHA of GBR - Bridges (Darling)	\$90,000	
	Extra Mile-Region 4 - Peer Support (Mitchell)	\$150,000	
Crisis Response Services			
Mental Health Tx Services			
Planning Operations and System Development	Credential Verification/ Camille Elsbury (Comaty)	\$22,480	
	Salaries	\$63,566	
	Conference/Travel/Printing; NARO Travel - \$2,500; Block Grant Travel - \$4,000; C'est Bon Travel - \$66,500; Printing \$1,500	\$74,500	
Residential / Housing			
Respite			
Staff Development	Staff Development - Conference	\$80,971	
	Training & Technical Assistance - EBP	\$85,000	
Transportation			
Other Contracted Services (Specify)	MHAL-MH Reform Coalition/ Adult (Mitchell)	\$30,000	
	NAMI LA - MH Planning Council (Castille)	\$55,805	
	David Lloyd (was Nat'l Council) (Speier)	\$10,150	
	NAMI - Program Manager (Hensarling/Butler)	\$4,000	
	Forensic Aftercare*	\$ 300,810	
	Tulane Univ/ Sex Offender Eval & Tx*	\$ 85,955	
TOTAL Adult Services		\$1,368,721	
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>			

* transferred contract from Area B

State of Louisiana Fiscal Year 2010-2011
 Department of Health & Hospitals
 Office of Behavioral Health

Region/ District Name	Central Office - Statewide Services	Child/ Youth Services
Address	628 N 4th Street, 4th Floor, PO Box 4049 Baton Rouge, LA 70821-4049	
Contact Person	Gilda Armstrong-Butler	Date Reviewed
Phone	225-342-2540	by RAC:
Email	gilda.armstrong-butler@LA.GOV	Date Prepared 07/22/10

CHILD/YOUTH SERVICES	BLOCK GRANT INTENDED USE PLAN	FY 2009-2010	
Service Category	Provider Name/ Service Type	Amount	CFMS#
Advisory Council Support			
Assertive Community Treatment (ACT)			
Consumer Advocacy & Education	LA Federation of Families/Mentoring (Armstrong-Butler)	\$57,240	
	MHAL-Behavioral Health Coalition/Child (Armstrong-Butler)	\$54,160	
Consumer Liaisons	Family Support Liaison	\$36,275	
Consumer Monitoring and Evaluation	MHAL-LaFete (Comaty)	\$63,302	
Crisis Response Services			
Family Support Services	LA Federation of Families/FIEP (Armstrong-Butler)	\$71,936	
	Salaries	\$52,000	
Planning Operations and System Development	Camille Elsbury-Credential Verification (Comaty)	\$22,480	
	Salaries	\$63,566	HR
	Conference Travel/Printing; NARO Travel - 2,500; Block Grant Travel - \$4,000; Printing - 1,500	\$8,000	P.O.
Residential / Housing			
Respite			
School-based Mental Health Services			
Staff Development	Staff Development & Technical Assistance (Armstrong-Butler)	\$50,000	Travel/PO
	C/Y Training & Technical Assistance in EBPs (Armstrong-Butler)	\$84,000	
Transportation			
Other Contracted Services (Specify)	NAMI LA - MH Planning Council (Castille)	\$55,806	
	David Lloyd (Speier)	\$12,444	
	NAMI Program Manager (Armstrong-Butler)	\$4,000	
	Juvenile Competency Evaluation- Vyas, Vosburg & Stanley (Henig)	\$21,000	
TOTAL Child/Youth Services		\$656,209	
<u>ADD lines as necessary, but DO NOT add or change Service Categories</u>			