FY 2026-2027
Combined Behavioral Health Assessment and Plan

Community Mental Health Services
and Substance Use Prevention, Treatment and Recovery Services
Block Grants

Louisiana Department of Health

Office of Behavioral Health

September 1, 2025

LOUISIANA
DEPARTMENT OF HEALTH

Contents

Contents ... 1

State Information and Funding Agreements ... 3

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations ... 4

Prompt 1 ... 4

Prompt 2 ... 8

Prompt 3 ... 9

Step 2. Identify the unmet service needs and critical gaps within the current system ... 21

Prompt 1 ... 21

Prompt 2 ... 26

Prompt 3 ... 61

Planning Tables ... 68

Plan Table 1: Priority Area and Annual Performance Indicators ... 68

Plan Table 2. State Agency Budget for State Fiscal Years 2026-2027 ... 75

Plan Table 3. SUPTRS BG Persons in need/receipt of SUD Treatment ... 77

Plan Table 4. SUPTRS BG Planned Award Budget by Federal Fiscal Year ... 78

Plan Table 4. MHBG State Agency Planned Budget ... 79

Plan Table 5a. Primary Prevention Planned Expenditures ... 80

Plan Table 5b. SUPTRS BG Primary Prevention Planned Budget by IOM Category ... 83

Plan Table 5c. SUPTRS BG Planned Primary Prevention Priorities ... 84

Plan Table 6. Other Capacity Building/Systems Development ... 85

Environmental Factors ... 88

1. Access to Care, Integration, and Care Coordination- Required ... 88
2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) -10 percent set aside - Required MHBG ... 102
3. Person Centered Planning (PCP) –Required (MHBG) ... 109
4. Program Integrity – Required ... 113
5. Primary Prevention- Required (SUPTRS BG only) ... 114
6. Statutory Criterion for MHBG (Required MHBG) ... 127
7. Substance Use Disorder Treatment - Required SUPTRS BG ... 145
8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG ... 156

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG 159

10. Recovery – Required 172

11. Children and Adolescents M/SUD Services- Required for MHBG, Requested for SUPTRS BG . 177

12. Suicide Prevention……113

13. Support of State Partners - Required MHBG, SUPTRS BG……..190

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Prevention, Treatment and Recovery Services Block Grant Application- Required for MHBG..... 200

15. Public Comment on the State Plan- Required 204

Acronyms 205

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Signed Funding Agreements – Certifications and Assurances are submitted online.

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations

Prompt 1

Describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

Overview of the Louisiana Behavioral Health System

The Office of Behavioral Health (OBH) within the Louisiana Department of Health (LDH) manages and delivers the services and supports necessary to improve the quality of life for citizens with mental illness and substance use and related disorders. The agency acts as a monitor and subject matter consultant for Medicaid's Coordinated System of Care contract and the Healthy Louisiana plans, which manage specialized behavioral health services. OBH also delivers direct care through grants, state-owned hospitals, and monitoring of behavioral health community-based treatment programs through the human services districts and authorities, also known as local governing entities (LGEs). Services are provided for Medicaid and non-Medicaid eligible populations.

The mission of OBH is to work collaboratively with partners to develop and implement a comprehensive integrated system of behavioral health and healthcare, social supports, and prevention services that promote recovery and resilience for all citizens of Louisiana. OBH assures public behavioral health services are accessible, family-driven, have a positive impact, are culturally and clinically competent, and are delivered in partnership with all stakeholders. The goals of the Office of Behavioral Health are:

1. To serve children and adults with extensive behavioral health needs including mental health and/or substance use and related disorders by providing oversight and guidance of behavioral health services in the Medicaid Healthy Louisiana plans and Local Governing Entities (LGEs).
2. To assure that all Louisiana citizens with serious behavioral health challenges have access to needed forensic, residential, and other "safety net" services and promote use of contemporary, evidence-informed treatment, support, and prevention services, to include harm reduction models and approaches.
3. To support the refinement and enhancement of a comprehensive system and associated service array for children, youth and families that appropriately addresses their behavioral health needs that is based on contemporary, best practice principles of care.

The vision statement for OBH is: People can and do recover from mental illness and addictive disorders. Through the delivery of timely and person-centered, clinically effective behavioral health and healthcare and supports, citizens of Louisiana will experience positive behavioral health outcomes and contribute meaningfully to our State's growth and development.

OBH's Guiding Principles are as follows:

- This office aims to make a difference in the lives of adults and children in Louisiana.
- People who receive proper care and a supportive environment can recover from mental illness and addiction.

- OBH services respond to the needs of individuals, families and communities, including culturally and linguistically diverse services. The office respects the dignity of individuals, families, communities, and the workforce that serves them.
- Individuals, families and communities will be welcomed into the system of services and supports with a "no wrong door" approach.
- 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.
- OBH will utilize the unique skills of professionals with appropriate competencies, credentials and certifications.
- Mental illness and addiction are healthcare issues and must be seamlessly integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings.
- Many OBH service recipients suffer from both mental illness and addiction. As the office provides care, the staff must understand, identify and treat both illnesses as primary conditions. This 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.
- OBH will measure results to demonstrate both improved outcomes for the people served and fiscal responsibility to taxpayers.
- OBH will prioritize de-stigmatizing historical biases and prejudices against people with mental illness and substance use disorders, and those who provide services, through efforts to increase access to treatment. The office 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.

In State Fiscal Year (SFY) 2025, OBH was comprised of three distinct programs: Behavioral Health Administration and Community Oversight, Hospital Based Treatment, and Auxiliary. The SFY25 year-end budgets and notable budget items are shown, below:

Agency Programs	SFY25 Year-end Budget
BH Administration	$153,214,604
Hospital Based Treatment	$292,228,762
Auxiliary	$20,000
Total	**$445,463,366**

*Funding sources include State General funds, Interagency Transfers, Fees & Self-Generated revenue, Statutory Dedications and Federal funds

Notable Areas within SFY25 Budget[1]	SFY25 Year-end Budget
Social and Client Services Contracts	$64,588,899
Allocations to the LGEs	$58,997,539
Hospital Patient-related Budget	$281,630,534

[1]Some budget items within these areas are double-counted

OBH's priorities reflect the agency's mission and vision and carry the highest potential impact. These priorities are:

Access to Behavioral Health Services

OBH will lead efforts to increase access to behavioral health services by promoting early identification of behavioral health concerns, especially through leveraging integration to help physicians and behavioral health specialists collaborate to identify and treat behavioral health concerns (inclusive of trauma exposure) at the earliest opportunity. Strategies may include supporting primary care physicians through behavioral health consultation, as well as increasing access to high-quality evidence-based behavioral therapies for young children.

Additional strategies employed to address the increased volume on the behavioral health system with Medicaid Expansion will be the integration of Peer Support throughout the system of care. The use of trained, credentialed peers is a critical component to a recovery-oriented system of care and results in improvements in client engagement, treatment outcomes, and recovery. As an enhancement to traditional treatment services, peer support services allow for more effective and targeted interventions resulting in improved care and an increased capacity to serve a broader array of individuals.

To increase access to effective behavioral health supports and services, OBH will work with Medicaid, public and private universities and medical schools, providers, and Healthy Louisiana managed care partners to implement strategies to retain and increase the behavioral health workforce. Workforce development efforts will include training and support for providers of evidence-based therapies addressing issues emerging in early childhood, trauma exposure, and other psychiatric and Substance Related and Addictive Disorders service needs. OBH will lead efforts to provide training and support for providers of peer recovery supports, including mentoring and coaching opportunities.

Outcomes-Based Behavioral Healthcare

OBH will lead efforts to increase the use of outcomes measurement in the provision and decision-making around behavioral health services. Quality assessment and monitoring is necessary to ensure that these services are providing a good value to the state in terms of improving key outcomes and quality of life for Louisianans.

Substance Use Disorder System Enhancements

OBH recognizes the impact of Substance Related and Addictive Disorders on Louisiana's individuals, families, and communities, and strives to enhance policies, regulations and protocols to reduce the prevalence of SUDs. OBH will focus on several priority areas to achieve this goal. These include enhancement of Medications for Substance Use Disorder (MSUD) services, treatment capacity for pregnant women, reduction of prescription drug/opioid overdose-related deaths, increased use of early Screening, Brief Interventions and Referral to Treatment (SBIRT) including pregnant women, and development of residential treatment programs for pregnant women and children at risk of Neonatal Opioid Withdrawal Syndrome (NOWS).

Inpatient Psychiatric Hospital Needs

An ongoing priority of OBH will be to increase communication with the courts, the Department of Public Safety and Corrections (DPSC), and the Office of Juvenile Justice (OJJ) regarding available behavioral health

services. OBH will promote certification in Juvenile Competency Restoration to increase the number of providers across the state and continue oversight of the provision of competency restoration services.

OBH will increase collaboration with the DPSC to reduce recidivism and to monitor compliance of settlement agreement requirements. This includes determining if patients were evaluated in a timely manner, received twice weekly competency restoration sessions while in jail, and were placed within the established guidelines. Through collaboration with the staff at Eastern Louisiana Mental Health System (ELMHS), compliance with the settlement agreement rules will be maintained.

OBH is committed to providing access to treatment in the least restrictive and least costly setting possible for all clients, and optimizing clients to flow throughout the system, as each moves toward recovery in their own homes and communities, whenever possible. ELMHS and Central Louisiana State Hospital (CLSH) currently maintain 100% utilization of existing bed space; OBH will pursue strategic and financially feasible measures to provide necessary inpatient, jail-based, and community resources in order to accommodate the increasing forensic population. These measures may include partnerships with Cooperative Endeavor Agreement (CEA) hospitals to provide services to civil clients, and increasing resources in order to accommodate jail-based competency restoration in lieu of hospital restoration in the regional areas and parishes that have the highest number of referrals.

Pursuing a culture of wellness for Louisiana citizens

Integrated physical and behavioral healthcare is one strategy in moving toward comprehensive wellness. OBH identifies with the SAMHSA eight dimensions of wellness, described as emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual. OBH will lead efforts to address these elements in designing and implementing wellness activities. OBH partners with the Department Well Ahead initiative to ensure coordination with addressing health, mental health and addiction, and health disparities.

Children and Youth Services

Expansion of programs targeting youth and young adults

The Early Childhood Supports and Services (ECSS) program was implemented for approximately 10 years and eliminated in 2013. Act 167 of the 2022 Regular Legislative Session established in the state treasury the Early Childhood Supports and Services program fund, intended to fund the re-creation of this program. The provisions establishing the ECSS Program Fund shall terminate on December 31, 2026. Act 167 directs that monies in the fund shall be used by the Louisiana Department of Health to fund its Early Childhood Supports and Service Program.

Following an RFI process in 2022, in 2023 OBH proceeded with developing a Request for Proposals (RFP), to allow OBH to select an entity for statewide management of the program. The ECSS RFP was released on April, 26, 2024. The RFP review process is now complete and OBH has executed a contract with Magellan Complete Care of Louisiana, Inc. for statewide management of the ECSS program. OBH is working with Magellan Complete Care of Louisiana, Inc. towards the statewide rollout and management of ECSS sites across the state; Magellan Complete Care of Louisiana, Inc. released a Request for Applications (RFA) for regional sites in April 2025. They provided technical assistance and reviewed the proposals with the goal of selecting one provider agency for each of the 10 regions in Louisiana. Magellan Complete Care of Louisiana, Inc. is working on executing subcontracts with each of the selected provider

agencies to deliver a comprehensive ECSS program for children ages zero through five and their families. Once credentialed, contracted, and trained, the regional ECSS Sites will begin providing ECSS services to families in their assigned Human Service District region.

OBH has also supported the start-up of an early adopter site. Jefferson Parish Human Services Authority (JPHSA) has contracted with Tulane as the lead for a consortium of providers, to deliver an ECSS program in the Greater New Orleans area. They are serving children and families and are developing a network of community partners to connect families to needed community resources.

SAMHSA Clinical High-Risk for Psychosis (CHR-P) grant recipient

In 2024, SAMHSA awarded a grant to LDH/OBH in support of Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis (CHR-P). Tulane EPIC-NOLA has been named the CHR-P award sub-recipient. EPIC-CHRP will target those at clinical high risk (CHR) for psychosis by implementing a CHR team and a CHR community early detection campaign. The CHR cohort includes young people ages 10 through 25 years of age who exhibit noticeable changes in perception, thinking and functioning typically preceding the first episode of psychosis (FEP). The LaCHR-P contract has been submitted for processing and the grant Project Director has been hired.

Expansion of Crisis System to Youth

In 2023, the Louisiana Crisis Response System was expanded to serve youth and their families. With this expansion, the behavioral health peer program was also expanded to add a training curriculum for Recognized Family Peer Support Specialists (RFPSS). Louisiana partnered with national subject matter experts in the area of family and parent peer support specialists to include Family Peers as part of the youth crisis response teams to better serve the youth, their primary caregivers and families. At the close of SFY25, 22 RFPSS were trained in Louisiana.

Prompt 2

Describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services

The Louisiana Department of Health plays a vital role in providing essential resources, services, and supports to improve the well-being of individuals facing behavioral health challenges.

The Office of Behavioral Health (OBH), serving as both the Single State Agency (SSA) and the State Mental Health Authority (SMHA) within the Louisiana Department of Health (LDH), is the primary entity responsible for overseeing federal funding aimed at mental health and substance use prevention, treatment, and recovery.

Office of Behavioral Health (OBH) acts as monitors and subject matter consultants for the Children's Coordinated System of Care (CSoC) program and the Medicaid Healthy Louisiana Behavioral Health managed care plans, which manage behavioral health services. OBH also delivers direct care through hospitalization and oversees behavioral health community-based treatment programs through the human services districts and authorities, also known as local governing entities (LGEs). Services are available to everyone, including those who are insured, underinsured, and uninsured, as well as Medicaid and non-Medicaid eligible populations.

OBH's responsibilities include promoting effectiveness through planning, oversight, and accountability, reporting data, promoting and ensuring quality, encouraging coordination across state government, and working with the provider community.

OBH is committed to advancing recovery and improving the quality of life for all Louisianans affected by behavioral health challenges. In addition, OBH strives to steward the state's limited behavioral health resources with efficiency and effectiveness, ensuring the peace, health, safety, and overall well-being of the public through:

- Accountability of efficient and effective services through quality and performance measures, statewide standards for monitoring quality of service and performance, and reporting of quality of service and performance information.
- Creation and implementation of minimum service delivery standards.
- Coordination of integration of behavioral health and primary healthcare and continued collaboration with agency contract providers, advocacy groups, Local Governing Entities, regional support networks, and public and private agencies in order to reduce duplication in service delivery and promote complementary services among all entities that provide behavioral health services to adults and children throughout the state.
- Performance monitoring and evaluation regarding the effectiveness of services being provided and achievement of outcome measures.

Prompt 3

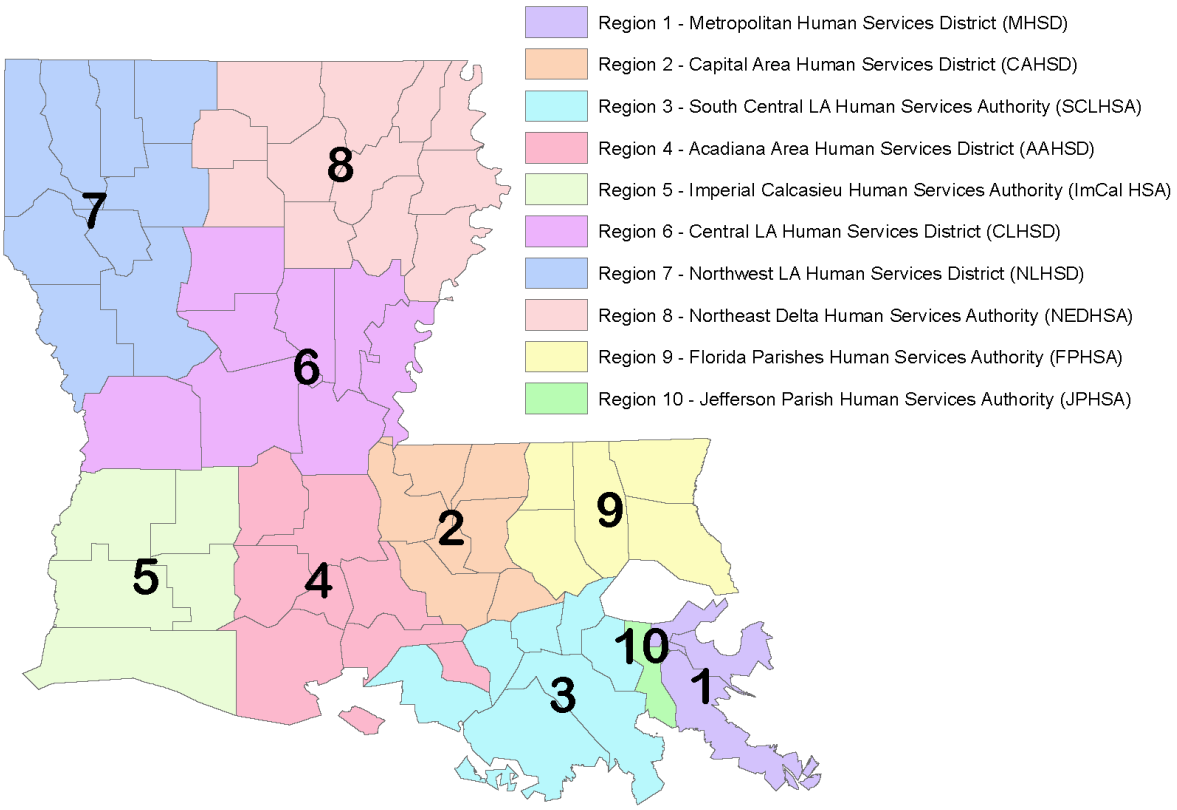
Describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

Local Governing Entities

The Local Governing Entities (LGEs), classified as a human services district or authority, have a contractual agreement with the Louisiana Department of Health (LDH). Considered the local umbrella agencies, the LGEs administer state-funded behavioral health and developmental disability services within an integrated system in their localities. Because the LGE model enhances local control and authority, there is more opportunity for greater accountability and responsiveness to the local communities. Each LGE is administered by an executive director who reports to a local governing board of directors of community and consumer volunteers. In 2017, ACT 73 of the Louisiana Legislature modernized the statutes governing the human service districts and authorities to revise board membership to include professionals and consumers in the fields of mental health, substance-related and addictive disorders, and developmental disabilities. Membership also includes representatives of professionals in finance, accounting, or auditing; judiciary and law enforcement, school-based healthcare or the coroner's office, depending on the region's needs. All LGEs remain part of the LDH departmental organizational structure, but not in a direct reporting line with OBH.

OBH's responsibilities include surveillance and monitoring of the statewide behavioral health system and the provision of technical assistance, training and resources that enable the LGEs to carry out service delivery within their catchment area. 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 statewide mechanisms for measuring these outcomes. 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). In addition, OBH continues to provide guidance to the LGEs to ensure federal Block Grant requirements are met. LGEs must maintain Regional Advisory Councils (RACs), officially linked to the State Behavioral Health Advisory Council, in order to qualify to receive Block Grant funding. To assist the reader in understanding the state behavioral health care system, a map is provided, which includes each LGE's service area.

Office of Behavioral Health - Local Governing Entities (LGE)



The following table lists the LGE clinics with capacity to provide mental health services, substance use and related disorders services, or both (MH = Mental Health; SUD = Substance Use Disorders; BH=Behavioral Health).

LGE	Clinic	Type	Address	City
MHSD	Algiers Behavioral Health Center	BH	3100 General DE Gaulle Drive	New Orleans
	Central City Behavioral Health Center	BH	2221 Phillip Street	New Orleans
	Chartres-Pontchartrain Behavioral Health Center	BH	719 Elysian Fields Avenue	New Orleans
	New Orleans East Behavioral Health Center	BH	5630 Read Boulevard, 2nd Floor	New Orleans
	St. Bernard Behavioral Health Center	BH	6624 St. Claude Avenue	Arabi
CAHSD	Baton Rouge Behavioral Health	BH	2751 Wooddale Blvd.	Baton Rouge
	Children's Behavioral Health	BH	422 Colonial Dr.	Baton Rouge
	Donaldsonville Mental Health	MH	901 Catalpa Street	Donaldsonville
	Ascension Behavioral Health	BH	1056 E. Worthey Street Suite B	Gonzales
	Iberville Behavioral Health	MH	24705 Plaza Drive	Plaquemine
	North Baton Rouge Behavioral Health	MH	7855 Howell Blvd. Suite 200	Baton Rouge
	Pointe Coupee Behavioral Health	MH	282-A Hospital Road	New Roads
	West Baton Rouge Behavioral Health	MH	685 Louisiana Avenue	Port Allen
	West Feliciana Behavioral Health	MH	5266 Commerce Street	St. Francisville
SCLHSA	Lafourche Behavioral Health Center	BH	157 Twin Oaks Drive	Raceland
	River Parishes Treatment Center	BH	1809 West Airline Highway	LaPlace
	River Parishes Assessment/Child & Adolescent Treatment Center	BH	421 Airline Highway, Suite L	LaPlace
	St. Mary Behavioral Health Center	BH	500 Roderick Street, Suite B	Morgan City
	Terrebonne Behavioral Health Center	BH	5599 Highway 311	Houma
AAHSD	Crowley Behavioral Health Clinic	BH	1822 West 2nd Street	Crowley
	Dr. Joseph Henry Tyler, Jr. Behavioral Health Clinic	BH	302 Dulles Drive	Lafayette
	New Iberia Behavioral Health Clinic	BH	611 West Admiral Doyle Drive	New Iberia
	Opelousas Behavioral Health Clinic	BH	220 South Market Street	Opelousas
	Ville Platte Behavioral Health Clinic	BH	312 Court Street	Ville Platte
IMCAL	Allen Parish Behavioral Health Clinic	BH	402 Industrial Drive	Oberlin
	Beauregard Behavioral Health Clinic	BH	106 Port Street	DeRidder
	Jefferson Davis Behavioral Health Clinic	BH	437 North Market Street	Jennings
	Lake Charles Behavioral Health Clinic	BH	4105 Kirkman Street	Lake Charles
	Sulphur Behavioral Health Clinic	BH	2651 E. Napoleon Street	Sulphur
CLHSD	Caring Choices Marksville	BH	694 Government Street	Marksville
	Caring Choices Alexandria	BH	5411 Coliseum Blvd.	Alexandria
	Caring Choices Jonesville	BH	308 Nasif Street	Jonesville
	Caring Choices Leesville	BH	105 Belview Road	Leesville
NLHSD	Minden Behavioral Health Clinic	BH	502 Nella Street Minden	Minden
	Natchitoches Behavioral Health Clinic	BH	210 Medical Drive	Natchitoches
	Shreveport Behavioral Health Clinic	BH	1310 North Hearne Avenue	Shreveport
	Many Behavioral Health Clinic	BH	265 Highland Drive	Many
NEDHSA	Bastrop Behavioral Health Clinic	BH	451 East Madison Ave	Bastrop
	Columbia Behavioral Health Clinic	BH	5159 Highway 4 East	Columbia
	Monroe Behavioral Health Clinic	BH	4800 South Grand Street	Monroe
	Ruston Behavioral Health Clinic	BH	602 East Georgia Avenue	Ruston
	Tallulah Mental Health Center	MH	1012 Johnson Street	Tallulah

LGE	Clinic	Type	Address	City
	Winnsboro Behavioral Health Clinic	BH	1301 B Landis Street	Winnsboro
FPHSA	Bogalusa Behavioral Health Clinic	BH	400 Georgia Avenue	Bogalusa
	Florida Parishes Human Services Authority Denham Springs	BH	1920 Florida Avenue SW	Denham Springs
	Mandeville Behavioral Health Clinic	BH	900 Wilkinson Street	Mandeville
	Rosenblum Behavioral Health Clinic	BH	835 Pride Drive, Ste. B	Hammond
	Slidell Behavioral Health Clinic	BH	2331 Carey Street	Slidell
JPHSA	JeffCare East Jefferson Health Center	BH/PC	3616 South I-10 Service Road West, Suite 100	Metairie
	JeffCare West Jefferson Health Center	BH/PC	5001 West Bank Expressway, Suite 100	Marrero

Managed Care for the Medicaid population

LDH has utilized the managed care model for delivery of Medicaid services since 2012, via contracts with managed care organizations (MCOs) to provide physical health and behavioral health services. While originally carved out, specialized behavioral health services have been integrated into the managed care health plans for almost 10 years. Children with extensive behavioral health needs who are either in or at risk of out-of-home placement and enrolled in the Coordinated System of Care (CSoC) program remain enrolled with a separate managed care entity. Covered services have expanded to include crisis services, peer support services, and additional Evidence-Based Practices.

OBH retains the responsibility of establishing guidelines associated with qualifications and requirements for providers rendering specialized behavioral health services, in collaboration with the Louisiana Department of Health, Health Standards Section (healthcare licensing agency) and Medicaid. The managed care entities monitor the specialized behavioral health provider network to assess compliance of these qualifications and requirements on an ongoing basis, which includes sampling provider records through desk and onsite reviews. Providers are required to complete the Medicaid screening and enrollment process, credential through the managed care entity, and undergo periodic re-credentialing in accordance with contractual requirements. Medicaid continues to move towards the use of a Credentialing Verification Organization (CVO) for enrollment and credentialing. Medicaid providers will credential through the CVO prior to engaging with the managed care entities for the purposes of credentialing and re-credentialing of all provider networks. The managed care entity provides initial and ongoing training to its providers about their infrastructure and operational requirements to assure readiness and success working within a managed care system.

Target Populations

Mental Health Clients: Adult

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

Age: 18 years of age or older.

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

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

1) Unemployed, 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 (e.g. must be reminded to take medicine, must have transportation arranged for him/her, needs assistance in household management tasks).
6) Exhibits social behavior which results in demand for intervention by the mental health and/or judicial/legal system.

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

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

Mental Health Clients: Child/Youth

A child or youth who has a serious emotional/behavioral disorder (SED) meets the following criteria for Age, Diagnosis, Disability, and Duration as agreed upon by all Louisiana children serving agencies.

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; thinking is frequently confused; behavior may be grossly inappropriate and bizarre; 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 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; 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) Substantial risk that the impairment or pattern or inappropriate behavior(s) will persist for an extended period
3) Pattern of inappropriate behaviors that are severe and of short duration

Substance Use and Related Disorder Clients: Adult and Adolescent

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

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

Serving Priority Populations

LGE operated and contracted programs are required to give priority admission and preference to treatment in the following order: pregnant injecting drug users, other pregnant substance users, other injecting drug users, and all others. They provide interim services to these priority populations within 48 hours, if comprehensive care cannot be made available upon initial contact with a waiting period of no longer than 120 days. Interim services are made available through individual sessions, phone contact, and referral or linkage to self-help groups and activities.

Pregnant Women and Women with Dependent Children (PWWDC)

OBH's Pregnant and Parenting Women (PPW) Program addresses the needs of women, including pregnant women and women with dependent children, through residential substance use disorder treatment services. The program provides services to women eighteen (18) years of age and older. Minor children up to age twelve (12) are allowed to accompany their mother/guardian to treatment, thus preserving the

family unity. Children up to 17 who reside offsite are eligible to receive therapeutic services at the residential facility. Women receive gender specific treatment which may include education on such topics as parenting, healing from trauma, spousal or partner abuse, overcoming depression and post-traumatic stress disorder, etc. Educational or employment assistance, in conjunction with transportation services as well as linkages to housing and other community resources are also provided. OBH uses a combination of Temporary Assistance for Needy Families (TANF) grant funds, received through a partnership with the Department of Children and Family Services (DCFS), and state general funds to support services for women and their children. Since 2021, OBH has been working to enhance the network of these PPW facilities using federal grants and state general funds, increasing the number of facilities from 2 to 6, with two additional facilities planning to open in the next year.

In addition, during the 2025 Legislative Session, the Louisiana State Legislature approved enhanced Medicaid reimbursement rates for these facilities, providing further incentive for more facilities to open.

Persons Who Inject Drugs (PWID)

In addition to priority treatment admission requirements, OBH targets PWID through the Louisiana State Opioid Response (LaSOR) grant's partnership with the Louisiana Department of Health, Office of Public Health, STI/HIV/Hepatitis Program (OPH SHHP). OPH-SHHP works with Syringe Service Programs (SSP) to provide care coordination, harm reduction services, and disseminate educational materials to individuals. LaSOR provides funding to embed Health Coordinators in SSPs to oversee HIV/Hepatitis C Virus (HCV) testing, linkages to care, and Overdose Education and Naloxone Distribution.

Persons in need of recovery support services for SUD (PRSUD)

Louisiana has long been a supporter of Oxford House. Oxford Houses are democratically run, self-supporting, drug free houses established for the purpose of providing a sober living environment for those seeking to live a sober, drug free life. OBH contracts with Oxford House to provide for two (2) outreach workers and one (1) re-entry worker to assist those leaving incarceration. The regional manager of Oxford House Louisiana is a credentialed Peer Support Specialist. Currently, there are 195 Oxford Houses within Louisiana with 1,456 beds.

Individuals with a co-occurring mental health and SUD

To ensure individuals with co-occurring metal health and SUD receive the specialized treatment they need, LGEs provide both mental health and SUD outpatient treatment services at their behavioral health clinics. For more intensive treatment, Louisiana licenses ASAM Level 3.7 (Medically Managed Residential Treatment) facilities. These are co-occurring disorder (COD) residential treatment facilities that provide 24 hour care including psychiatric and substance use assessments, diagnosis, treatment, habilitative and rehabilitation services to individuals with co-occurring psychiatric and substance disorders, whose disorders are of sufficient severity to require a residential level of care. They also feature professionally directed evaluation, observation and medical monitoring of substance use disorders and mental health treatment in a residential setting.

Persons with SUD at Risk for Tuberculosis (TB)

OBH ensures that all substance use disorder (SUD) treatment providers funded by Block Grant comply with federal requirements related to tuberculosis (TB) education, screening, referral, and treatment. The state has implemented a comprehensive compliance monitoring strategy that combines contractual

mandates, policy oversight, and onsite evaluation to ensure access to TB services for individuals receiving SUD care.

Persons with SUD at Risk for HIV (EIS/HIV)

All LGEs provide Early Intervention Services for HIV, including HIV testing, pre- and post-test counseling, and referral to treatment. In addition, OBH's HIV Coordinator participates on the Louisiana Governor's Commission on HIV and Hepatitis C Education, Prevention, and Treatment. This commission serves as an advisory body to the Governor, the Louisiana Department of Health, and the legislature on matters relating to Hepatitis C and HIV. The commission is also tasked with serving as a coordinating forum on matters relating to Hepatitis C and HIV between and among state agencies, local government, and nongovernmental groups

Individuals in Need of Primary Prevention Services

Prevention services are provided within each district and authority throughout the state to decrease and prevent substance use, misuse and abuse. Prevention resources are also available to address gambling. OBH services are family-focused, evidence-based, and outcome-driven. Prevention strategies are directed at individuals not identified to be in need of treatment and provide activities and services in a variety of school-based and community settings. These services target the general population as well as others that are at a higher risk for developing Substance Use and Gambling Disorders.

OBH utilizes a variety of strategies that target populations with different levels of risk and adheres to the Institute of Medicine (IOM) classifications of prevention. These classifications include universal, selective and indicated prevention. Universal prevention programming addresses the entire population (national, local community, school, and neighborhood) with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. Selective prevention programming targets subsets of the total population who are considered to be at risk for substance abuse by virtue of their membership in a particular population segment--for example, children of adult alcoholics, dropouts, or students who are failing academically. Finally, indicated prevention strategies are designed to prevent the onset of substance abuse in individuals who do not meet DSM-V criteria for dependence, but who are showing early danger signs, such as falling grades and consumption of alcohol, tobacco and marijuana that can lead to experimentation of more potent and harmful drugs.

OBH understands importance of comprehensive services and promotes the inclusion of the following strategies: Information Dissemination, Prevention Education, Alternative Activities, Problem Identification and Referral, Community-Based Processes and Environmental Strategies. Information Dissemination provides one-way communication from the source to the audience, with limited contact between the two. Examples include the following: Clearinghouse and other information resource centers, Media Campaigns, Brochures, Radio and Television Public Service Announcements, Speaking Engagements and Health Fairs. Prevention Education includes two-way communication based on an interaction between the educator and the participants. Examples include the following: Classroom and Small Group Sessions, Parenting and Family Management Classes, Education Programs for Youth Groups and Groups for Children of Substance Abusers. Environmental Strategies aim to enhance the ability of the community to more effectively provide substance abuse prevention services. Examples include the following: Technical assistance to communities to maximize local enforcement procedures governing the

availability and distribution of drugs, Review and modification of alcohol and tobacco advertising practices, Social norms strategies, and Media literacy.

Individuals in Need of Behavioral Health Crisis Services (BHCS)

LDH has developed a model for crisis response, called the Louisiana Crisis Response System (LA-CRS). Though initially focused on the adult Medicaid population, the goal is that these services will eventually be a resource for everyone in Louisiana, including the insured and uninsured, in every geographic location of the state. These services follow:

- Mobile Crisis Response (MCR) Services – a mobile crisis response service that is available as an initial intervention for individuals in a self-identified crisis. In SFY24, this service was expanded to serve child/youth and their families in addition to adults.
- Behavioral Health Crisis Care (BHCC) Clinics – a facility based service that operates twenty-four (24) hours a day, seven (7) days a week as a walk-in center providing short-term behavioral health crisis intervention for up to 23 hours, offering a community based voluntary home-like alternative to more restrictive settings
- Community Brief Crisis Support (CBCS) – a face-to-face intervention available to individuals for up to fifteen (15) days subsequent to receipt of MCR, BHCC, or CS. In SFY24, this service was expanded to serve child/youth and their families in addition to adults.
- Crisis Stabilization (CS) – a short-term bed-based crisis treatment and support services for members who have received a lower level of crisis services and are at risk of hospitalization or institutionalization. This service is currently available for children and we have expanded it for the adult population.

In late fiscal year 2025, LDH implemented the Louisiana Crisis Hub (LCH), a single, statewide, triage and dispatch line, capable of providing telephonic crisis de-escalation techniques to callers as well as connecting individuals to services through triage, referral, and dispatch to available services in the community appropriate to meet their crisis needs.

In order to support the implementation of the LA-CRS, LDH/OBH utilizes Mental Health Block Grant funds via its 5% set aside to support a contract with Louisiana State University Health Science Center (LSUHSC) School of Public Health, Center for Evidence to Practice. The purpose of this collaboration with LSUHSC is to recruit and support the ongoing development of a network of providers and stakeholder networks in communities where these services are housed. These supports are available throughout the state.

In addition to the LA-CRS, all behavioral health service (BHS) providers licensed under LAC 48:1.Chapter 56, including Local Governing Entities (LGEs), must provide core services including crisis mitigation. This critical service offers assistance to individuals during a crisis including 24-hour on call telephone assistance to prevent relapse or harm to self or others, to provide referral to other services, and to provide support during related crises. Referral to 911 or a hospital's emergency department alone does not constitute crisis mitigation services. All BHS providers develop a crisis mitigation plan with each individual receiving mental health and/or substance use services. Also, providers contracted with at least one managed care organization (MCO) to deliver Medicaid funded mental health and substance use services including Mental Health Rehabilitation (MHR), Assertive Community Treatment (ACT), Multi-Systemic Therapy

(MST) and other evidenced based and non-evidenced based interventions must conduct crisis planning and respond to individuals who report a crisis.

Adults with serious mental illness (SMI)

The Office of Behavioral Health (OBH) within the Louisiana Department of Health (LDH) manages and delivers the services and supports necessary to improve the quality of life for all citizens with mental illness and substance use disorders, to include youth and adults. OBH leads the state's effort to build and provide a comprehensive, integrated, person-centered system of prevention and treatment services that promote recovery and resilience for all citizens of Louisiana. OBH assures public behavioral health services are accessible, have a positive impact, are culturally and clinically competent, and are delivered in partnership with all stakeholders. Through this comprehensive system, adults with extensive behavioral health needs including mental health and/or substance use and related addictive disorders are served through the Medicaid Healthy Louisiana plans and Local Governing Entities (LGEs) with guidance from LDH/OBH. This comprehensive system of behavioral health care includes community-based services, crisis system of care, forensic services, and inpatient/residential psychiatric services.

In 2024, LDH/OBH was also awarded a SAMHSA CCBHC State Planning Grant. Furthermore, four (4) LGEs and two (2) Federally Qualified Healthcare Centers (FQHCs) were also awarded SAMHSA grants to establish CCBHCs in their local areas. These SAMHSA grants have provided additional critical supports to Louisiana to further develop the behavioral health system of care in Louisiana.

Children with serious emotional disturbance (SED) and their families

Through a contract partnership with LSUHSC, LDH/OBH developed and continues to support the Center for Evidence to Practice with the goal of expanding access to high quality, evidence-bad behavioral healthcare for youth with serious emotional disturbance who are receiving services through a Healthy Louisiana Medicaid MCO. The Center provides training and ongoing technical assistance on a menu of nationally-recognized EBPs that provide effective treatment of youth, and are designed to address behavioral health needs faced by many Louisiana children and families.

The Early Childhood Supports and Services (ECSS) program was implemented for approximately 10 years and eliminated in 2013. Act 167 of the 2022 Regular Legislative Session established in the state treasury the Early Childhood Supports and Services program fund, intended to fund the re-creation of this program. The provisions establishing the ECSS Program Fund shall terminate on December 31, 2026. Act 167 directs that monies in the fund shall be used by the Louisiana Department of Health to fund its Early Childhood Supports and Service Program. The ECSS RFP was released in April 2024 and resulted in LDH/OBH executing a contract with Magellan Complete Care of Louisiana, Inc. for statewide management of the ECSS program. Magellan Complete Care of Louisiana, Inc. released a Request for Applications (RFA) for regional sites in April 2025. In summer 2025, Magellan Complete Care of Louisiana, Inc. began actively working on executing subcontracts with each of the selected provider agencies to deliver a comprehensive ECSS program for children ages zero through five and their families. Once credentialed, contracted, and trained, the regional ECSS Sites will begin providing ECSS services to families in their assigned Human Service District region.

The Substance Abuse and Mental Health Services Administration (SAMHSA) awarded a grant to LDH/OBH in support of Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis (CHR-P) in 2024. Tulane EPIC-NOLA has been named the CHR-P award sub-recipient. EPIC-CHRP will target those at clinical high risk (CHR) for psychosis by implementing a CHR team and a CHR community early detection campaign. The CHR cohort includes young people ages 10 through 25 years of age who exhibit noticeable changes in perception, thinking and functioning typically preceding the first episode of psychosis (FEP). This program is in the early phases of implementation and scheduled to begin providing services in fall 2025.

Individuals who have an early serious mental illness (ESMI) [MHBG 10 percent set-aside]

Four LGEs - Jefferson Parish Human Services Authority (JPHSA), Capital Area Human Services District (CAHSD), Florida Parishes Human Services Authority (FPHSA), and South Central Louisiana Human Services Authority (SCLHSA) have continued their commitment to implementing First Episode Psychosis (FEP) programs utilizing Coordinated Specialty Care (CSC) models. Through a contract with Tulane University's Early Psychosis Intervention Clinic of New Orleans (EPIC NOLA) Program, Tulane's existing Coordinated Specialty Care (CSC) clinic serving individuals experiencing FEP has been able to expand their capacity and is working to establish spoke clinics in new regions of the state utilizing local partnerships and stakeholders. Through a contract with the Volunteers of America North Louisiana and assistance from LSU Health Shreveport, the EpiCenter opened in summer 2023, which is a FEP clinic serving the northwest Louisiana region. All FEP programs are actively recruiting and serving clients.

Individuals with SMI or SED in the rural and homeless populations

The Projects for Assistance in Transition from Homelessness (PATH) grant program is a formula grant through which states and territories provide Homeless and Outreach services. Specifically, these services are for individuals with serious mental illnesses and those with co-occurring substance use disorders who are homeless or at imminent risk of becoming homeless. PATH services include community-based outreach, mental health, substance use, case management and other support services, as well as a limited set of housing services within eight (8) LGEs that were identified as having the greatest need for additional resources for those who are unhoused and living with serious mental illness.

LDH/OBH has also designated a portion of the state's MHBG award to supporting SAMHSA's SSI/SSDI Outreach, Access and Recovery (SOAR) Program. SOAR incorporates essential components to assist adults to recover from homelessness. SOAR provides PATH case managers with tools necessary to expedite access to Social Security disability benefits that result in improved housing and treatment outcomes. OBH had contracted with Louisiana Housing Corporation (LHC) to implement a Statewide SOAR Initiative beginning in late 2023. With this contract ending in 2025, LDH/OBH is working with the LGEs to assume this role of hiring a regional SOAR Benefits Specialist for their respective catchment areas. This additional support assists with reducing institutionalization, increasing community supports, and support successful long-term recovery in the community.

The LDH/OBH utilizes MHBG funds to support transitional housing options for individuals with serious mental illness who require additional supports to live in the community. With MHBG funds, LDH/OBH funds the Wren Way Transitional Housing Program, which is a licensed adult residential care program that located in Houma. This two-year transitional housing program serves individuals who have serious and persistent mental illness (SPMI) and need additional staffing supports and life skills training to live safely

and independently in the community. Through a contract with Start Corporation, the Wren Way Transitional Housing Program supports 8 beds.

Through a contract with the National Alliance for Mental Illness of Louisiana (NAMI LA), LDH/OBH also supports the Housing Assistance Program (HAP). The Housing Assistance Program supports individuals who are diagnosed with serious mental illness (SMI), who are transitioning to the community from an institutional setting (i.e. inpatient mental health; nursing home; etc.), who are determined to need a community-based setting with additional supports before being able to successfully transition to independent living with the community, and do not receive SSI/SSDI. This program provides temporary rental assistance for a period of four to five months within a group home/transitional housing setting, case management supports, and assistance with applying for SSI/SSDI by utilizing the SOAR model.

Older adults with SMI

As behavioral health services are largely targeted to all adults, inclusive of older persons, LDH/OBH has no specific treatment programs for this population. Services typically provided to the general adult population with SMI include psychiatric evaluation, bio-psychosocial assessments, individual therapy, specialized group therapy and other evidence-based treatments based on unique individual needs. Behavioral health clinical and supportive services to individuals living with dementia and older populations have also been the topic of some trainings. Through the state's PASRR Program, trainings have been provided to the Louisiana Nursing Home Association (LNHA) members regarding PASRR and behavioral health issues with older populations. OBH staff also represents the State as a member of the National Association of State Mental Health Directors' (NASMHPD) Older Persons Division. The purpose of this group is to represent and advocate for state mental health agencies by informing them of emerging policy issues, research findings and best practices, and to provide consultation and collaboration on mental health issues pertaining to older persons.

Louisiana Peer Support Specialist Trainings

A Peer Support Specialist is a person in recovery from a behavioral health condition (mental health, substance use, or co-occurring) who provides mentoring, guidance, and support services and offers their skills to others who are experiencing behavioral health challenges and receiving behavioral health services. The Peer Support Specialist's role within the behavioral health system of care is to provide supportive services, working in conjunction with clinical treatment providers. While peer support services greatly enhance clinical services, they are not clinical in nature. Peer Support Specialists support individuals with behavioral health conditions in their recovery.

OBH is committed to promoting activities related to the utilization of Peer Support throughout its system of care. This has occurred through coordination with the MCOs, LGEs and the Medicaid provider network. During this reporting period, OBH continued to work in collaboration with The Extra Mile of Louisiana to provide additional Louisiana Core Peer Support Specialist Training opportunities. Over the past five years, the number of Peer Support Specialists trained each year has continued to grow. In 2023, LDH/OBH also implemented the Family Peer Training Program to support the expansion of the crisis system to serving youth and their families.

Step 2. Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps

Prompt 1

Describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

The Office of Behavioral Health (OBH) compiled a variety of national measures, statewide prevalence data, and survey indicators as part of a review of the state's behavioral health system. National sources contributing to this data include America's Health Rankings, KFF Health Factors, and the Annie E. Casey Kids Count. Data collection definitions, methodologies, and barriers are explained in the Quality and Data Collection Readiness section in *Prompt 2*.

Prevalence Estimates and Person Served

According to the U.S. Census Bureau (Annual Estimates of the Resident Population for Selected Age Groups by Sex for Louisiana: April 1, 2020 to July 1, 2024 and Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin: April 1, 2020 to July 1, 2024), there were estimated 4,588,071 individuals in Louisiana including 1,071,963 children/youth (ages 0-17) and 3,516,108 adults (ages 18+). These figures were disaggregated by Local Governing Entity (LGE) service areas to facilitate regional analysis of mental health needs.

Mental Health

The Office of Behavioral Health (OBH) conducted a comprehensive mental health needs assessment utilizing demographic and prevalence data to estimate the number of individuals affected by serious mental health conditions across the state.

Adults with Serious Mental Illness (SMI) and children/youth with Serious Emotional Disturbance (SED) are national designations that include only those individuals suffering from the most severe forms of mental illness or diagnosable behavioral, mental, or emotional condition/issue. OBH used SAMHSA's methodology and rates for calculating prevalence estimates. According to *URS Table 1: Number of Adults with Serious Mental Illness (SMI), age 18 and older, and Number of Children with a Serious Emotional Disturbance (SED), age 9 to 17, by State, 2023*, 5.4% of adults (ages 18+) are expected to have SMI and 7% of children and youth (ages 9- 17) are expected to have SED. The methodology used in calculating the number of children and youth does not include estimates for the population under 9 years of age; therefore, that segment of the population was excluded from reported SMI & SED estimates.

Please note that due to a change in the methodology that OBH uses for prevalence estimates, historical trend data is not shown at this time. Additionally, all prevalence figures should be interpreted as estimates, and caution is advised due to potential underreporting resulting from missing data in the SMI/SED variables.

OBH also compares the prevalence estimates and the number of persons served. The numbers do not reflect those served in private clinics and/or providers *not* receiving SAMHSA Block Grant money.

This needs assessment provides a foundational framework for planning and allocating resources to evidence-based mental health services across Louisiana's LGE regions.

Substance Use Disorders

In order to determine current estimates of the need for substance use disorder treatment, the prevalence of substance-related criminal activity, and the incidence of communicable diseases among Louisiana citizens, OBH collects and analyzes available national and state data sources. These data sources include but are not limited to: US Census Bureau, SAMHSA National Survey on Drug Use and Health (NSDUH), Louisiana State University, and Louisiana Department of Health. Distributions of the data collected by the Local Governing Entities (LGEs) through their electronic health records (EHRs) & Louisiana Addictive Disorders Data Systems (LADDS), and Inpatient Psychiatric Hospital's Patient Information Program (PIP), were also analyzed to estimate the percentage of people who received services and the percentage of people who are in need of treatment but not receiving services.

Estimates of the need for substance use disorder treatment, the prevalence of substance-related criminal activity, and the incidence of communicable diseases among Louisiana citizens within the LGE's service areas are detailed in the tables under *Prompt 2*. Caution should be used when utilizing these figures, as they are estimates.

There are also several limitations in the methodology used for the estimate calculations for the Treatment Needs Assessment Summary Matrix and Treatment Needs by Age, Sex, and Race/Ethnicity:

- The NSDUH data used in calculating the number of people that are in need of treatment services and that would seek treatment does *not* include estimates for the population under *12 years of age*; therefore, that segment of the population was excluded from the reported estimates.
- The NSDUH data estimates used for the calculations are representative of the state as a whole, and not necessarily specific to demographics of the parishes that comprise the LGE service areas.
- Counts for Depressive Disorder Diagnosis were from mental health diagnoses in each episode of care for each client from LGE Electronic Health Record (E HR) system, Inpatient Psychiatric Hospital's Patient Information Program (PIP) system and Group Homes from ELMHS. One client may have multiple episode of care, with multiple diagnoses. One episode of care may be counted more than one time in different diagnostic categories (not-unduplicated).
- Counts for Cannabis-related Disorder were from substance use disorder diagnoses in each episode of care for each client from LGE Electronic Health Record (E HR) system and Louisiana Addictive Disorders Data Systems (LADDS). One client may have multiple episode of care, with multiple diagnoses. One episode of care may be counted more than one time in different diagnostic categories (not-unduplicated).

OBH also provides a comparison of the number of admissions and persons served to the prevalence estimates determined in the Treatment Needs Assessment Summary Matrix. These numbers reflect an

unduplicated count within LGEs and do not count those served in private clinics and/or providers *not* receiving SAMHSA Block Grant money.

Additionally, in the 2022 Regular Legislative Session, House Concurrent Resolution (HCR) 45 was passed which tasked OBH with the completion of a comprehensive Substance Use Disorder (SUD) needs assessment of the state's capacity and needs for expansion of treatment programs, including the targeted populations of adolescents and women with children. OBH partnered with Tulane University to lead the research, data collection, and analysis of the assessment. Tulane used a variety of data sources, including Medicaid and Medicare claims data, National Plan and Provider Enumeration System (NPPES) National Provider Identification (NPI) Registry, and licensing data from the Health Standards Section (HSS) of the Louisiana Department of Health. In addition, Tulane developed a statewide Provider Survey to assess the range of available SUD services and programs, evaluate provider capacity, and gather insights on the perceived experiences and needs of individuals experiencing SUD from Louisiana practitioners. The final draft report is under review by the Secretary of the Louisiana Department of Health. Therefore, the state does not have a final publication of the assessment.

Primary Prevention

The State Epidemiology Workgroup (SEW), a subcommittee of the Louisiana Drug Policy Board (DPB), is tasked with identifying, collecting, analyzing and disseminating consumption and consequence data related to substance use and related mental, emotional and behavioral disorders that is available from state and national data sources, as well as prioritizing available data for substance use prevention needs. The SEW maintains an online data system, which includes consumption indicators and long- and short-term consequence indicators at the state and community level. The SEW makes recommendations regarding improvements in data collection, and continuously works to fill data gaps to improve the quality and integrity of the data at all levels, while supporting regional and community epidemiological efforts. The work of the SEW is guided by formalized bylaws and Cooperative Involvement Agreements that detail member roles and responsibilities. Membership is composed of data experts and epidemiologists from various state agencies.

OBH is a standing member of the SEW and provides prevention and treatment data for inclusion in the online data system and other SEW related reports. Through the DPB, the SEW has been successful in the creation and propagation of formal data sharing agreements among Louisiana's government agencies. The collaboration of DBP and SEW has reduced the burden on the SEW for data acquisition and allowed the SEW to focus more on providing analysis and guidance on the understanding and use of the data.

In addition, the SEW continues existing collaborations and institutes new collaborations needed to grow the state data system, disseminate data for decision-making, and monitor and evaluate the accuracy and timeliness of the data system.

In addition, the SEW continues existing collaborations and institutes new collaborations needed to grow the state data system, disseminate data for decision-making, and monitor and evaluate the accuracy and timeliness of the data system.

In an effort to better equip communities, prevention professionals, and decision-makers with up-to-date information on emerging drug trends, the State Epidemiological Workgroup (SEW), in collaboration with the Prevention Systems Committee, developed a series of four informational briefs. These briefs focus on

substances that are rapidly gaining prevalence in Louisiana and present serious public health concerns due to their accessibility, misuse potential, and lack of regulation or awareness.

The substances covered in the briefs include:

Hemp: Delta-8, Delta-9, and Delta-10 THC – psychoactive cannabinoids with varying potency and legality, often marketed as "legal alternatives" to marijuana.

Kratom: a plant-derived substance with opioid-like effects, available over the counter in many communities and often perceived as a natural remedy.

Tianeptine: sometimes referred to as "gas station heroin," this antidepressant is being misused for its euphoric and opioid-like effects.

Xylazine: a veterinary tranquilizer increasingly found in the illicit drug supply, frequently mixed with opioids, which contributes to severe health consequences and complicates overdose response.

These briefs were developed to support the primary prevention efforts across the state by providing accessible, evidence-informed summaries of each substance, including risks, patterns of use, challenges in detection or regulation, and implications for public health and prevention planning.

State Epidemiology Workgroup	
Core Member Agencies	
Governor's Office of Drug Policy	LA Department of Health, Office of Public Health
Center for Analytics and Research in Transportation Safety at LSU	LA Department of Justice, Office of the Attorney General
Historically Black Colleges & Universities Rep	LA Department of Public Safety, Louisiana Highway Safety Commission
LA Center Addressing Substance Use in Collegiate Communities	LA Department of Public Safety, Louisiana State Police
Social Research and Evaluation Center (SREC) at LSU	LA Department of Revenue, Office of Alcohol and Tobacco Control
LA Department of Education	U.S. Drug Enforcement Administration
LA Department of Health, Office of Behavioral Health	University of Louisiana at Lafayette, Picard Center for Child Development
LSU Center for Analytics and Research in Transportation Safety (CARTS)	Member from American Indian Tribe
Office of Juvenile Justice	

Of-Counsel Member Agencies	
Capital Area Human Services District	Governor's Office of Elderly Affairs
Louisiana Commission on Law Enforcement	LA Department of Veterans Affairs
LA Department of Children & Family Services	Obrien House
I CARE/East Baton Rouge Schools	

Louisiana Caring Communities Youth Survey

The Louisiana Caring Communities Youth Survey (CCYS), a survey of 6th, 8th, 10th, and 12th grade students has been conducted since 1998. The survey is conducted every two years with the most recent survey conducted in the fall of 2023 into spring 2024. The results for the state of Louisiana are presented along with comparisons to 2020 and 2022 CCYS survey results, and the Monitoring the Future (MTF) survey results, as applicable. The MTF study is a long-term epidemiological study that surveys trends in drug and alcohol use among American adolescents.

The Louisiana CCYS was originally designed to assess students' involvement in a specific set of problem behaviors, as well as their exposure to a set of scientifically validated risk and protective factors identified in the Risk and Protective Factor Model of adolescent problem behaviors. These risk and protective factors have been shown to predict the likelihood of academic success, school dropout, substance use, violence, and delinquency among youth. As the substance use prevention field has evolved, the CCYS has been modified to measure additional substance use and other problem behavior variables to provide prevention professionals in Louisiana with important information for understanding their communities. Some examples of these additional variables include the percentage of youth who are in need for alcohol or drug treatment, measures of community norms around alcohol use, and bullying.

There is also data from the 2024 CCYS that provide the Gateway drug use profiles for alcohol, marijuana, prescription drugs, cigarettes, vaping and other tobacco products. Also included are the illicit drug use profiles for cocaine, methamphetamine, heroin, Inhalants, hallucinogens, steroids, and synthetics.

Core Alcohol and Drug Survey

The Core Alcohol and Drug Survey was developed to measure alcohol and other drug usage, attitudes, and perceptions among college students at two and four-year institutions. Development of this survey was funded by the U.S. Department of Education. The survey includes several types of items about drugs and alcohol. One type deals with the students' attitudes, perceptions, and opinions about alcohol and other drugs, and the other deals with the students' own use and consequences of use. There are also several items on students' demographic and background characteristics as well as perception of campus climate issues and policy.

There is data which provides details about Louisiana students' reported use of drugs. Unless otherwise indicated, percentages are based on the total number of students responding validly to a given item.

For comparison purposes some figures are included from a reference group of 66,199 students from 221 institutions who completed the Core Alcohol and Drug Survey Long Form in 2016 to 2018 National Data. More detailed analyses can be found by contacting the Core Institute.

Prompt 2

Describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served." The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

National Measures

The *America's Health Rankings® 2024 Annual Report* analyzed 88 health measures, 49 weighted and 39 unweighted, using the most recent data available as of October 31, 2024. Data sources varied by measure, and in some cases, multiple years were combined to ensure reliable state-level estimates.

Overall state rankings were derived from 49 weighted measures selected for their relevance to population health, availability of consistent state-level data, and potential for improvement. Each measure was standardized using z-scores, to reflect how far a state's value deviated from the national average. Summations were calculated by model category (e.g., Social and Economic Factors) and overall, providing comparative insights across states.

In terms of access to care, Louisiana has a moderate ranking of 26th for mental health providers, with 332.4 providers per 100,000 population, slightly below the national average of 344.9. However, behavioral health indicators reveal more concerning trends. The state ranks 47th for drug deaths, with a rate of 51.8 deaths per 100,000 population, far exceeding the national average of 32.4. Similarly, frequent mental distress affects 18.7% of adults, placing the state at 44th and well above the U.S. average of 15.4%. Excessive drinking is also slightly higher than the national average at 17.4%, ranking Louisiana as 31st. Behavioral risks remain high in other areas: high-risk HIV behaviors are reported by 7.3% of adults, placing the state at 48th, and smoking prevalence is 15.7%, ranking 45th and significantly above the national average of 12.1%.

Measures	Louisiana Rank	Louisiana Value	U.S. Value
Social Support and Engagement			
Adverse Childhood Experiences (% of children ages 0-17)	41	19.3%	14.5%
Access to Care			
Mental Health Providers (# per 100,000 population)	26	332.4	344.9
Behavioral Health			
Frequent Mental Distress (% of adults)	44	18.7%	15.4%
Drug Deaths (Deaths per 100,000 population)	47	51.8	32.4
Excessive Drinking (% of adults)	31	17.4%	16.7%
Behaviors			
High-Risk HIV Behaviors (% of adults)	48	7.3%	5.7%

Smoking (% of adults)	45	15.7%	12.1%

Data source: https://www.americashealthrankings.org/explore/states/LA

Per the KFF Health Facts (2023)[1], 18.7% of the adult population in Louisiana reported poor mental health 14+ days per month. This is higher than the United States' adult population, reported at 15.6%.

In the Annie E. Casey Foundation Kids Count Data Book (KIDS Count, 2025), Louisiana continued to rank near the bottom of the nation in terms of child health, education, family/community and economic well-being, ranking 49th overall in the nation. Louisiana ranked worse than the nation for the following indicators:

Indicators	Louisiana	United States
Economic Well-Being Indicators (Rank = 50th)		
• Children in poverty: 2023	25%	16%
• Children whose parents lack secure employment: 2023	32%	25%
• Teens (16-19 years) not in school and not working: 2023	9%	7%
Education Indicators (Rank = 35th)		
• Eighth graders not proficient in math: 2024	79%	73%
• High school students not graduating on time: 2021-2022	17%	13%
Health Indicators (Rank = 49th)		
• Low-birth weight babies: 2023	11.3%	8.6%
• Child and teen deaths per 100,000: 2023	48	29
• Children and teens (ages 10-17) overweight or obese: 2022-2023	36%	31%
Family and Community Indicators (Rank = 49th)		
• Children in single-parent families: 2023	45%	34%
• Children living in high-poverty areas: 2019-2023	20%	8%
• Teen births per 1,000: 2023	23	13

Data source: Indicator percentages from http://datacenter.kidscount.org/. Ranks from 2025 KIDS Count Data Book.

Prevalence Estimates and Person Served

According to the U.S. Census Bureau (Annual Estimates of the Resident Population for Selected Age Groups by Sex for Louisiana: April 1, 2020 to July 1, 2024 and Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin: April 1, 2020 to July 1, 2024), there were estimated *4,588,071* individuals in Louisiana including *1,071,963* children/youth (ages 0-17) and *3,516,108* adults (ages 18+).

2023 Louisiana Demographics Estimates				
Race	**Estimate**		**Age**	**Estimate**
American Indian/Alaska Native	42,364		0-17	1,071,963
Asian	91,119		18-24	418,662
Black/African American	1,493,586		25-44	1,212,611
Native Hawaiian/Other Pacific Islander	3,315		45-64	1,091,645
White	2,867,525		65 & Over	793,190

[1] https://www.kff.org/statedata/;

More than One Race Reported	90,162

Ethnicity	Estimate
Hispanic or Latino	341,767
Not Hispanic or Latino	4,246,304

Gender	Estimate
Female	2,344,866
Male	2,243,205

Population estimates for each LGE service area were used to determine prevalence estimates. These totals can be found in the following sections.

Mental Health

Estimates of the prevalence of mental illness for adults and children/youth within the state, categorized by LGE regions, are shown in the following tables. Caution should be used when utilizing these figures, as they are estimates.

SMI/SED Prevalence Estimates 2023 (URS Table 1: Number of adults with serious mental illness, age 18 and older, and Number of children with serious emotional disturbances, age 9 to 17, by state, 2023) listed SMI Prevalence= 5.4%; SED Prevalence= 7% for Louisiana.

Individuals with SMI/SED are considered to be the target population for MH block grant funded Evidence-based Practice (EBP) programs. These EBP programs are provided by the LGE regions and their contracted clinics.

2023 LOUISIANA SMI & SED PREVALENCE* ESTIMATES						
LGE	SED Child/Youth (9-17[£])		SMI Adult (18+)		Total SMI & SED	
	General Population (9-17)	Estimated Prevalence (7%* of 9-17 Years Population)	General Population (18+)	Estimated Prevalence (5.4%* of 18+ Population)	General Population (9 and Over)	Total Estimated Prevalence
MHSD & EPIC-NOLA Program✪	44,788	3,135	343,996	18,576	388,784	21,711
CAHSD	81,356	5,695	535,824	28,934	617,180	34,629
SCLHSA	46,604	3,262	287,484	15,524	334,088	18,786
AAHSD	75,945	5,316	448,114	24,198	524,059	29,514
IMCAL	37,872	2,651	225,842	12,195	263,714	14,847
NWLHSD & VOA-NLA Program[β]	35,246	2,467	218,546	11,801	253,792	14,269
NLHSD	62,626	4,384	391,402	21,136	454,028	25,520
NEDHSA	41,589	2,911	263,880	14,250	305,469	17,161
FPHSA	78,650	5,506	470,323	25,397	548,973	30,903
JPHSA	47,065	3,295	330,697	17,858	377,762	21,152
TOTAL	**551,741**	**38,622**	**3,516,108**	**189,870**	**4,067,849**	**228,492**

[£] census.gov (https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-detail.html): Annual Estimates of the Resident Population for Selected Age Groups by Sex: April 1, 2020 to July 1, 2024 (SC-EST2024-AGESEX).

The following tables show the total numbers of persons served receiving mental health services and the percentage of persons with SMI/SED. These numbers reflect an unduplicated count within LGEs. Please note that the overall count of SMI and SED population is under reported due to missing values in the special population SMI/SED variable.

Persons Receiving Mental Health Services						
LGE	FY 2023			FY 2024		
	YOUTH (9-17)	ADULT (18+)	TOTAL*	YOUTH (9-17)	ADULT (18+)	TOTAL*
MHSD & EPIC-NOLA Program✪	725	4,183	4,908	668	3,747	4,415
CAHSD	1,264	5,290	6,554	1,176	5,001	6,177
SCLHSA	1,561	7,861	9,422	1,461	7,367	8,828
AAHSD	659	4,608	5,267	466	3,470	3,936
IMCAL	735	3,110	3,845	716	3,021	3,737
CLHSD	336	2,608	2,944	255	2,275	2,530
NWLHSD & VOA-NLA Program[β]	234	1,375	1,609	215	1,209	1,424
NEDHSA	83	1,498	1,581	77	1,368	1,445
FPHSA	466	4,067	4,533	519	4,191	4,710
JPHSA	471	3,344	3,815	244	2,654	2,898
TOTAL	**6,534**	**37,944**	**44,478**	**5,797**	**34,303**	**40,100**

Data Source: LGE EHR data sent to OBH. Age at end of reporting time period. Unduplicated by client within LGE. EHR data for AAHSD available only from July 1, 2023 – December 29, 2023 of FY 2024.
✪ EPIC-NOLA (program through Sinfonia Family Services of Louisiana in conjunction with Tulane University). Serves Orleans, St. Bernard, Plaquemines Parishes. [β] Volunteers of America of North Louisiana (VOA-NLA): serves MH clients at nine parishes in northwestern part of the State. *Total count may include missing ages, resulting in counts greater than direct addition of child and adult counts.

While Louisiana's behavioral health system faces unmet needs and service gaps for individuals with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED), you will see Louisiana is making important progress in serving these individuals.

Key findings from the FY2024 tables below reflect:

- **Child/Youth with SED:** Out of 5,797 Child/Youth served in Community Settings for MH needs, 56% (n=3,268) were Child/Youth with SED.
- **Adult with SMI:** Out of 34,303 Adult served in Community Settings for MH needs, 42% (n=14,381) were Adult with SMI.

While the total number of children and youth (ages 9–17) served declined slightly from FY 2023 to FY 2024, the proportion of those identified with SED held firm at 56%. This consistency reflects a strong dedication to reaching youth with the greatest behavioral health needs, even as total service volumes shifted.

For adults (ages 18+), the data reveals that although the total number served decreased, the percentage of those identified with SMI rose from 40% to 42%. This shift signals that clinics are increasingly reaching those with the most acute needs.

The journey toward full access and equity in care remains ongoing, but the strides made in FY 2024 reflect a prioritization of those with the most serious needs.

Community Behavioral Health Clinics Child/Youth (Ages 9-17) with SED Served						
LGE	**FY 2023**			**FY 2024**		
	Child/Youth with SED	**Total Served**	**% SED**	**Child/Youth with SED**	**Total Served**	**% SED**
MHSD & EPIC-NOLA Program✪	300	725	41%	267	668	40%
CAHSD	998	1,264	79%	923	1,176	78%
SCLHSA	812	1,561	52%	814	1,461	56%
AAHSD	457	659	69%	334	466	72%
IMCAL	306	735	42%	263	716	37%
CLHSD	229	336	68%	170	255	67%
NWLHSD & VOA-NLA Program[β]	145	234	62%	87	215	40%
NEDHSA	22	83	27%	24	77	31%
FPHSA	227	466	49%	286	519	55%
JPHSA	157	471	33%	100	244	41%
TOTAL	**3,653**	**6,534**	**56%**	**3,268**	**5,797**	**56%**

Data Source: LGE EHR data sent to OBH. Age at end of reporting time period. Unduplicated by client within LGE. EHR data for AAHSD available only from July 1, 2023 – December 29, 2023 of FY 2024.

✪ EPIC-NOLA (program through Sinfonia Family Services of Louisiana in conjunction with Tulane University). Serves Orleans, St. Bernard, Plaquemines Parishes. β Volunteers of America of North Louisiana (VOA-NLA): serves MH clients at nine parishes in northwestern part of the State.

Community Behavioral Health Clinics						
Adults (Ages 18 and over) with SMI Served						
LGE	FY 2023			FY 2024		
	Adults with SMI	Total Served	% SMI	Adults with SMI	Total Served	% SMI
MHSD & EPIC-NOLA Program✪	2,227	4,183	53%	2,136	3,747	57%
CAHSD	3,179	5,290	60%	3,273	5,001	65%
SCLHSA	2,273	7,861	29%	2,452	7,367	33%
AAHSD	2,328	4,608	51%	1,706	3,470	49%
IMCAL	1,064	3,110	34%	765	3,021	25%
CLHSD	968	2,608	37%	880	2,275	39%
NWLHSD & VOA-NLA Program[β]	738	1,375	54%	464	1,209	38%
NEDHSA	431	1,498	29%	469	1,368	34%
FPHSA	1,112	4,067	27%	1,414	4,191	34%
JPHSA	702	3,344	21%	822	2,654	31%
TOTAL	**15,022**	**37,944**	**40%**	**14,381**	**34,303**	**42%**

Data Source: LGE EHR data sent to OBH. Age at end of reporting time period. Unduplicated by client within LGE. EHR data for AAHSD available only from July 1, 2023 – December 29, 2023 of FY 2024.
✪ EPIC-NOLA (program through Sinfonia Family Services of Louisiana in conjunction with Tulane University). Serves Orleans, St. Bernard, Plaquemines Parishes. β Volunteers of America of North Louisiana (VOA-NLA): serves MH clients at nine parishes in northwestern part of the State. SMI/SED based on most recent Special Population SMI/SED available from admission to end of reporting time period.

The next table compares the prevalence estimates and the number of persons served. OBH data reported 3,653 children and youth (ages 9-17) with SED were served at the end of FY 2023, revealing that 9.5 % of the estimated children with SED were being served in LGE clinics. OBH data also reported 15,022 adults with SMI were served at the end of FY 2023, revealing that 7.9 % of the estimated adults with SMI were being served in LGE clinics (percentages *not shown* in the table below). These numbers do not reflect those served in private clinics and/or providers *not* receiving SAMHSA Block Grant money.

Number of SMI/SED Persons Served Compared to Prevalence Estimates – FY 2023						
LGE	Child/Youth (Ages 9-17)		Adults (Ages 18 and over)		Total SMI/SED Served	Percentage of Prevalence Served
	Child/Youth with SED	Prevalence Estimate	Adults with SMI	Prevalence Estimate		
MHSD & EPIC-NOLA Program✪	300	3,135	2,227	18,576	2,527	12%
CAHSD	998	5,695	3,179	28,934	4,177	12%
SCLHSA	812	3,262	2,273	15,524	3,085	16%
AAHSD	457	5,316	2,328	24,198	2,785	9%
IMCAL	306	2,651	1,064	12,195	1,370	9%
CLHSD	229	2,467	968	11,801	1,197	8%
NWLHSD & VOA-NLA Program[β]	145	4,384	738	21,136	883	3%
NEDHSA	22	2,911	431	14,250	453	3%
FPHSA	227	5,506	1,112	25,397	1,339	4%
JPHSA	157	3,295	702	17,858	859	4%
TOTAL	**3,653**	**38,622**	**15,022**	**189,870**	**18,675**	**8 %**

Data Source: LGE EHR data sent to OBH. Age at end of reporting time period. Unduplicated by client within LGE. EHR data for AAHSD available only from July 1, 2023 – December 29, 2023 of FY 2024.
✪ EPIC-NOLA (program through Sinfonia Family Services of Louisiana in conjunction with Tulane University). Serves Orleans, St. Bernard, Plaquemines Parishes. β Volunteers of America of North Louisiana (VOA-NLA): serves MH clients at nine parishes in northwestern part of the State. SMI/SED based on most recent Special Population SMI/SED available from admission to end of reporting time period.

Substance Use Disorders

The Treatment Needs Assessment Summary Matrix for 2026–2027 presents a comprehensive overview of behavioral health and public health indicators across service regions in Louisiana. It details the demographic distribution, substance use trends, behavioral health challenges, and prevalence of communicable diseases among adult populations served by Local Governing Entities (LGEs).

The combined total population across all LGEs exceeds 4.5 million, with approximately 3.9 million individuals aged 12 and older, and over 2 million women in this age group. Treatment needs are assessed by region, revealing that an estimated 11,669 individuals are likely in need of services related to injection drug use, although only 595 are projected to seek treatment. Among women, roughly 436,623 are identified as needing treatment, though only 50,186 would seek treatment.

In terms of substance-related criminal activity, there are 7,445 arrests for driving while intoxicated (DWI) and just over 1,200 alcohol-related driving deaths statewide, with CAHSD and FPHSA reporting the highest counts. Behavioral health diagnoses show nearly 11,000 cases of depressive disorders and close to 3,700 instances of cannabis-related substance use disorders. Regions with the most mental health diagnoses include CAHSD, MHSD, and AAHSD.

Communicable disease data indicates that nearly 23,000 individuals across all LGEs are living with HIV, with MHSD and CAHSD reflecting the highest regional concentrations.

Overall, this matrix highlights noteworthy behavioral health challenges and regional disparities in treatment needs, behavioral health conditions, and disease prevalence.

Treatment Needs Assessment Summary Matrix

				TOTAL POPULATION		INJECTING DRUG USERS		WOMEN		PREVALENCE OF SUBSTANCE-RELATED CRIMINAL ACTIVITY		TOP BEHAVIORAL HEALTH DISEASE DIAGNOSES		INCIDENCE OF COMMUNICABLE DISEASE
LGE	**Population[1]**	**12+ Population[1]**	**Female 12+ Population[6]**	**Needing Treatment Services[2]**	**That would seek treatment[3]**	**Needing Treatment Services[4]**	**That would seek treatment[5]**	**Needing Treatment Services[7]**	**That would seek treatment[8]**	**Number of DWI Arrests[9] (Age>=21, BAC >=0.08)**	**Number of Alcohol-related Driving Deaths[10]**	**MENTAL HEALTH (Depressive Disorder)[11]**	**SUBSTANCE USE (Cannabis Related Disorder)[12]**	**# People Living with HIV[13]**
MHSD & EPIC-NOLA Program ✪	432,168	374,494	199,128	81,640	4,164	1,123	57	43,410	2,214	203	74	1,561	439	5,355
CAHSD	695,609	590,633	304,186	128,758	6,567	1,772	90	66,313	8,090	1,205	231	1971	1123	5,179
SCLHSA	375,916	319,325	162,782	69,613	3,550	958	49	35,486	4,329	988	122	1332	331	969
AAHSD	596,414	499,413	257,224	108,872	5,552	1,498	76	56,075	6,841	778	148	1,853	364	2,034
IMCAL	299,983	251,411	126,671	54,808	2,795	754	38	27,614	3,369	522	86	1110	290	1,069
CLHSD	287,772	242,386	119,704	52,840	2,695	727	37	26,095	3,184	495	82	835	333	1,077
NWLHSD & VOA-NLA Program[β]	511,250	433,454	225,515	94,493	4,819	1,300	66	49,162	5,998	903	139	407	291	2,187
NEDHSA	343,166	291,990	150,187	63,654	3,246	876	45	32,741	3,994	622	88	586	191	1,255
FPHSA	620,136	524,101	269,415	114,254	5,827	1,572	80	58,732	7,165	1,094	182	616	83	1,682
JPHSA	425,657	362,369	188,048	78,996	4,029	1,087	55	40,994	5,001	635	51	691	236	2,171
TOTAL	**4,588,071**	**3,889,576**	**2,002,860**	**847,928**	**43,244**	**11,669**	**595**	**436,623**	**50,186**	**7,445**	**1,203**	**10,962**	**3,681**	**22,978**

[1] The estimates for Population and 12+ Population by LGE service area were obtained from *U.S. Census Bureau* (https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-detail.html) *Annual County and Puerto Rico Municipio Resident Population Estimates by Selected Age Groups and Sex: April 1, 2020 to July 1, 2024 (CC-EST2024-AGESEX).*

[2] According to NSDUH (https://www.samhsa.gov/data/sites/default/files/reports/rpt56188/2023-nsduh-sae-state-tables_0/2023-nsduh-sae-state-tabs-louisiana.pdf) , **21.8%** of the population aged 12 or older needed substance use treatment in the past year. The 12+ population for each SPA was multiplied by **21.8%** to estimate the number of people *needing treatment* services. Source: **Table 48B:** *Substance Use Disorder, Substance Use Treatment, and Mental Health Measures: Among People Aged 12 or Older in Louisiana; by Age Group, Annual Average Percentages, 2022 and 2023.*

[3] According to NSDUH, **5.1%** of those who needed substance abuse treatment, *received* treatment in the past year. Source: **Table 48B**: *Substance Use Disorder, Substance Use Treatment, and Mental Health Measures: Among People Aged 12 or Older in Louisiana; by Age Group, Annual Average Percentages, 2022 and 2023.* This **5.1%** was used to estimate the Total Population *from those needing services*, that *Received/will Seek* Treatment by SPA.

[4] Information from a meta- analysis conducted by the CDC and published in 2014 was used to estimate Number of IDU's Needing Treatment Services by SPA. In Research Article: *Estimating the Number of Persons Who Inject Drugs in the United States by Meta-Analysis to Calculate National Rates of HIV and Hepatitis C Virus Infections* the combined estimated rate for injection drug use in the United Stated is .30% *(Table 3. Estimated proportion of persons who injected drugs (PWID) in the past year, by survey and combined by meta-analysis, United States.)* http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0097596 . The 12+ Population for each SPA was multiplied by .003 to estimate the number of IVDU's needing treatment services.

[5] The estimate of **5.1%** that was used to calculate the number of people that would need treatment in total population was also used to determine the *Number of IDU's that Would Seek Treatment*. The number of *IDUs* that will seek treatment was obtained by multiplying *those needing services* in each SPA category of IVDU by **5.1%**.

[6] An estimate for the Female 12+ Population by SPA was obtained from *U.S. Census Bureau* (https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-detail.html) *Annual County and Puerto Rico Municipio Resident Population Estimates by Selected Age Groups and Sex: April 1, 2020 to July 1, 2024 (CC-EST2024-AGESEX).*

[7] Information from the *2022 and 2023* National Survey on Drug Use and Health (NSDUH) was used to estimate the Total Number of Women Needing Treatment Services by SPA. The prevalence estimate of **21.8%** that used to calculate the number of total population needing treatment was also used to estimate the number of women (females 12+) in need of treatment. The number of women needing treatment services for each SPA was obtained by multiplying female 12+ population of each SPA category by **21.8%.**

[8] The estimate of **5.1%** that was used to calculate the number of people that would seek/received treatment was also used to determine the Number of Women that Received/will Seek Treatment. The number of women that will seek treatment was obtained by multiplying *from those needing services* in each SPA category of women by **5.1%**.

[9] The estimates for Number of DWI Arrests for 2023 were obtained from the Louisiana State University, Highway Safety Research Group's *2023 Number of Arrests and DWI by Parish Report* (Age>=21 BAC>=.08*)* at *https://carts.lsu.edu/datareports/report/dwi*.

[10] **Alcohol-Impaired Driving Deaths**: Data extracted from *https://www.countyhealthrankings.org/explore-health-rankings/louisiana/data-and-resources*.

[11] **Mental Health: Count of Depressive Disorder Diagnosis in Episode of Care in CY 2023.** Count of mental health diagnoses in each episode of care for each client from LGE Electronic Health Record (EHR) system, Inpatient Psychiatric Hospital's Patient Information Program (PIP) system and Group Homes from ELMHS. One client may have multiple episode of care, with multiple diagnoses. One episode of care may be counted more than one time in different diagnostic categories (not-unduplicated).

[12] **Substance Use Disorder: Count of Alcohol-related Disorder in Episode of Care in CY2023.** Count of substance use disorder diagnoses in each episode of care for each client from LGE Electronic Health Record (EHR) system and Louisiana Addictive Disorders Data Systems (LADDS). One client may have multiple episode of care, with multiple diagnoses. One episode of care may be counted more than one time in different diagnostic categories (not-unduplicated).

[13] **# People Living with HIV:** Data extracted from https://ldh.la.gov/assets/oph/HIVSTD/HIV_Syphilis_Quarterly_Reports/Fourth_Quarter_2023_HIV_Syphilis_Congenital_Syphilis_Report.pdf, as of December 31, 2023.

The following tables provide a comparison of the number of admissions and persons served to the prevalence estimates determined in the Treatment Needs Assessment Summary Matrix. These numbers reflect an unduplicated count within LGEs and do not count those served in private clinics and/or providers *not* receiving SAMHSA Block Grant money.

The data reflects that in FY 2023, Louisiana's Local Governing Entities (LGEs) served a fraction of individuals estimated to need substance use disorder (SUD) treatment, with only 2.0% of the general population, 1.7% of women aged 12 and older, and 13.2% of persons who inject drugs (PWID) receiving services. The total number of individuals needing treatment was 847,928, with 17,261 being served, and 13,610 were admitted. Among women, 436,623 were estimated to need treatment, while 7,400 were served. PWID had the highest treatment engagement relative to need, with 1,536 served out of 11,669 estimated, and notably higher service rates in regions like NEDHSA (37.1%) and CLHSD (24.3%). Demographically, the majority of those served were White (59.7%) and Black/African American (34.81%), with the predominant age group being 25–44 years old (53.25%). Males comprised 56.62% of the treated population, and 94.32% identified as not Hispanic or Latino.

Substance Use Disorder Treatment – FY 2023					
LGE	**Needing Treatment Services**	**That would seek treatment**	**Admissions**	**Total Served**	**Percent of Prevalence Served**
MHSD & EPIC-NOLA Program✪	81,640	4,164	571	789	1.0%
CAHSD	128,758	6,567	1,136	1,323	1.0%
SCLHSA	69,613	3,550	3,065	4,049	5.8%
AAHSD	108,872	5,552	2,003	2,645	2.4%
IMCAL	54,808	2,795	962	1,264	2.3%
CLHSD	52,840	2,695	1,292	1,521	2.9%
NWLHSD & VOA-NLA Program[β]	94,493	4,819	1,048	1,266	1.3%
NEDHSA	63,654	3,246	2,007	2,265	3.6%
FPHSA	114,254	5,827	1,143	1,491	1.3%
JPHSA	78,996	4,029	383	648	0.8%
TOTAL	**847,928**	**43,244**	**13,610**	**17,261**	**2.0%**

Data Source: Needing and Seeking Treatment: Table 48B: *Substance Use Disorder, Substance Use Treatment, and Mental Health Measures: Among People Aged 12 or Older in Louisiana; by Age Group, Annual Average Percentages, 2022 and 2023*). Admissions and Total Served: LADDS and LGE EHR data sent to OBH. EHR data for AAHSD available only from July 1, 2023 – December 29, 2023 of FY 2024.

Substance Use Disorder Treatment for Women (Female ages 12+) – FY 2023					
LGE	**Needing Treatment Services**	**That would seek treatment**	**Admissions**	**Total Served**	**Percent of Prevalence Served**
MHSD & EPIC-NOLA Program✪	43,410	2,214	242	321	0.7%
CAHSD	66,313	3,382	432	523	0.8%
SCLHSA	35,486	1,810	1,404	1,930	5.4%
AAHSD	56,075	2,860	956	1,341	2.4%
IMCAL	27,614	1,408	456	628	2.3%
CLHSD	26,095	1,331	460	551	2.1%
NWLHSD & VOA-NLA Program[β]	49,162	2,507	342	456	0.9%
NEDHSA	32,741	1,670	579	666	2.0%
FPHSA	58,732	2,995	528	707	1.2%
JPHSA	40,994	2,091	157	277	0.7%
TOTAL	**436,623**	**22,268**	**5,556**	**7,400**	**1.7%**

Data Source: Needing and Seeking Treatment: 2022 and 2023 NSDUH Survey (Table 48B). Admissions and Total Served: LADDS and LGE EHR data sent to OBH. Admissions and Total Served: LADDS and LGE EHR data sent to OBH. EHR data for AAHSD available only from July 1, 2023 – December 29, 2023 of FY 2024.

Persons Who Inject Drugs – FY 2023					
LGE	**Needing Treatment Services**	**That would seek treatment**	**Admissions**	**Total Served**	**Percent of Prevalence Served**
MHSD & EPIC-NOLA Program✪	1,123	57	56	81	7.2%
CAHSD	1,772	90	52	55	3.1%
SCLHSA	958	49	166	196	20.5%
AAHSD	1,498	76	209	231	15.4%
IMCAL	754	38	43	63	8.4%
CLHSD	727	37	164	177	24.3%
NWLHSD & VOA-NLA Program[β]	1,300	66	153	176	13.5%
NEDHSA	876	45	288	325	37.1%
FPHSA	1,572	80	195	206	13.1%
JPHSA	1,087	55	6	26	2.4%
TOTAL	**11,669**	**595**	**1,332**	**1,536**	**13.2%**

Data Source:

- Information from a meta- analysis conducted by the CDC and published in 2014 was used to estimate Number of IDU's Needing Treatment Services by SPA. In Research Article: *Estimating the Number of Persons Who Inject Drugs in the United States by Meta-Analysis to Calculate National Rates of HIV and Hepatitis C Virus Infections* the combined estimated rate for injection drug use in the United Stated is .30% *(Table 3. Estimated proportion of persons who injected drugs (PWID) in the past year, by survey and combined by meta-analysis, United States.)* http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0097596 . The 12+ Population for each SPA was multiplied by .003 to estimate the number of IVDU's needing treatment services.
- Seeking Treatment: *2022 and 2023 NSDUH Survey (Table 48 B; 5.1% of those needing treatment).*

- Admissions and Total Served: LADDS and LGE EHR data sent to OBH. EHR data for AAHSD available only from July 1, 2023 – December 29, 2023 of FY 2024

.

Demographics Profile of SUD Population Served – FY 2023				
Race/Ethnicity	**% Served**		**Age**	**% Served**
ALASKA NATIVE	0.03%		0 - 17	4.33%
AMERICAN INDIAN	0.80%		18 - 24	8.93%
ASIAN	0.23%		25 - 44	53.25%
BLACK/AFRICAN AMERICAN	34.81%		45 - 64	29.68%
MORE THAN ONE RACE REPORTED	0.72%		65 and over	3.80%
NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER	0.15%			
OTHER SINGLE RACE	1.37%			
UNKNOWN	2.20%			
WHITE	59.70%			
Hispanic or Latino	2.56%		**Gender**	**% Served**
Not Hispanic or Latino	94.32%		Male	56.62%
Unknown	3.12%		Female	43.38%

Data Source: LADDS and LGE EHR data sent to OBH. EHR data for AAHSD available only from July 1, 2023 – December 29, 2023 of FY 2024.

Below are preliminary findings of the Substance Use Disorder (SUD) needs assessment of the state's capacity and needs for expansion of treatment programs lead by Tulane University:

Substance Use Trends and Impact

- Drug overdose death rates in Louisiana increased 78.8% from 2019 to 2023, with 2,224 all drug-related deaths in 2023.
- Louisiana's all-drug overdose rate was 19 percentage points greater than the U.S. rate overall in 2023.
- Opioid-related overdoses made up the largest proportion (n=1,118, 50.2%) of all drug-related overdose deaths in 2023.
- Emergency department visits for drug poisoning increased by 1.77% from 2019 to 2023.

Current SUD Treatment Capacity

- 151,478 Medicaid and Medicare enrollees (5.93%) had an SUD diagnosis in 2023.
- The state has 382 substance use disorder treatment facilities: 299 outpatient-only (11 of which are Opioid Treatment Programs), 33 residential-only, and 50 offering both. Overall, 349 facilities offer outpatient treatment services, and 83 facilities offer licensed residential treatment services. This includes main or parent facilities and off-site facilities.
- Among providers surveyed, 79% identified fentanyl, 72% identified methamphetamine, and 57% identified alcohol as the most urgent substance use issue.

Treatment Access and Barriers

- Significant geographic disparities exist in provider distribution and client load across parishes.

- Regions 5 and 6 had the greatest average distance traveled for services (11.27 and 8.96 miles, respectively).
- 66% of providers reported transportation as a top challenge for clients.
- Other major barriers reported by providers include lack of transitional or recovery housing (54%), lack of health insurance coverage (50%), and stigma (50%).

Workforce and System Challenges

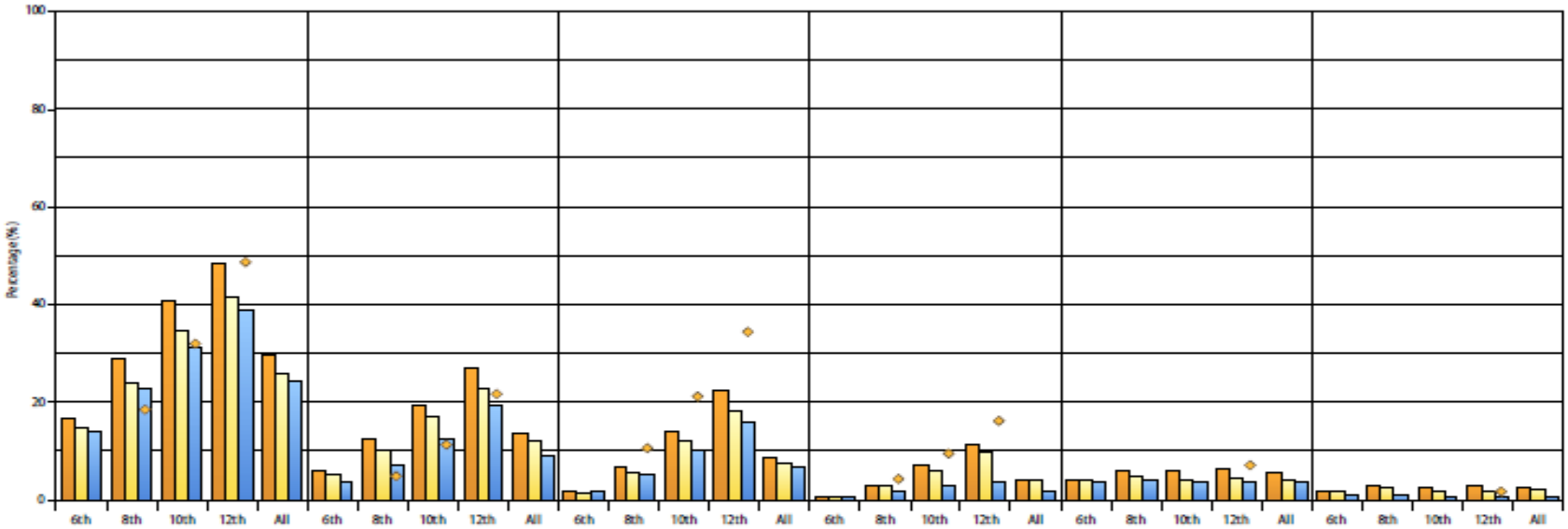
- 40% of providers identified recruiting and retaining SUD treatment staff as a top barrier to providing effective treatment.
- 38% of providers cited waitlists and wait times as significant obstacles to care delivery.
- 36% of providers reported difficulty maintaining knowledge of community resources.
- Only 14% of surveyed providers reported having co-located primary care providers within their facilities.

Primary Prevention

Below are tables from the 2024 CCYS that provide the Gateway drug use profiles for alcohol, marijuana, prescription drugs, cigarettes, vaping and other tobacco products. Also included are the illicit drug use profiles for cocaine, methamphetamine, heroin, Inhalants, hallucinogens, steroids, and synthetics.

The tables from the Louisiana 2024 Student Survey show a steady decline in alcohol, marijuana, and prescription drug use among students from grades 6 through 12 over the past four years. Lifetime and recent use of alcohol dropped most significantly in higher grades, with 12th-grade lifetime use falling from 61.4% in 2020 to 44.4% in 2024. Marijuana use also declined across all grades, especially among older students, while prescription drug use saw the sharpest reductions, particularly in younger grades like 6th and 8th. One small exception to the overall downward trend is the lifetime use of marijuana among 6th graders slightly increased from 1.4% in 2022 to 1.9% in 2024. Overall, the data suggests improving trends in youth substance use, with Louisiana students reporting lower usage rates than national averages.

Gateway drug use profile - Alcohol, marijuana, and prescription drugs
State of Louisiana 2024 Student Survey



Grade	Alcohol: Lifetime use State 2020	Alcohol: Lifetime use State 2022	Alcohol: Lifetime use State 2024	Alcohol: Past 30-day use* State 2020	Alcohol: Past 30-day use* State 2022	Alcohol: Past 30-day use* State 2024	Marijuana: Lifetime use State 2020	Marijuana: Lifetime use State 2022	Marijuana: Lifetime use State 2024	Marijuana: Past 30-day use* State 2020	Marijuana: Past 30-day use* State 2022	Marijuana: Past 30-day use* State 2024	Prescription drugs (all types combined)†: Lifetime State 2020	Lifetime State 2022	Lifetime State 2024	Past 30-days* State 2020	Past 30-days* State 2022	Past 30-days* State 2024
6th	16.5	14.7	14.0	5.8	5.1	3.6	1.5	1.4	1.9	0.6	0.6	0.5	4.1	3.9	3.8	1.9	1.9	0.8
8th	29.1	23.9	22.8	12.3	10.1	7.3	6.5	5.7	5.3	3.0	2.9	1.5	5.8	4.8	4.3	2.8	2.4	0.8
10th	40.9	34.6	31.3	19.3	17.1	12.4	14.2	12.0	10.2	6.9	6.1	2.9	5.9	4.1	3.4	2.5	1.8	0.6
12th	48.4	41.6	38.9	26.8	22.7	19.3	22.3	18.3	15.9	11.4	9.9	3.8	6.4	4.4	3.4	2.7	1.7	0.5
All	29.6	25.9	24.4	13.4	11.9	9.0	8.4	7.6	6.9	4.0	3.9	1.8	5.3	4.3	3.8	2.4	2.0	0.7

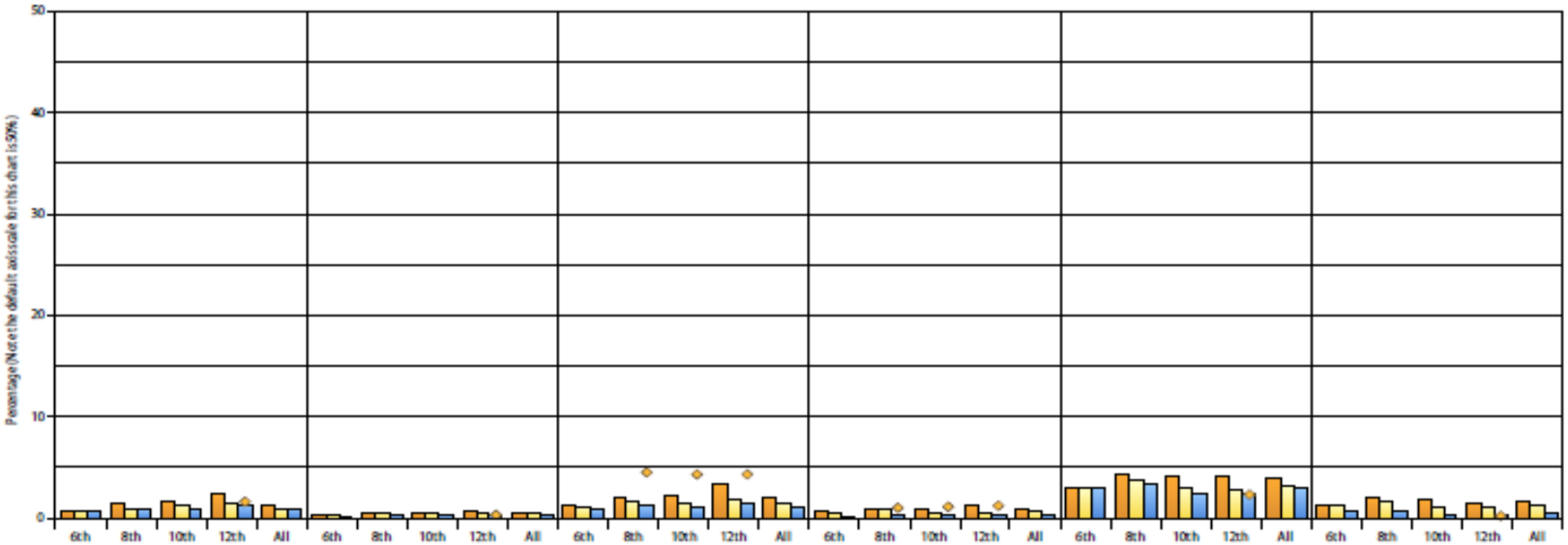
* Since not all students answer all questions, the percentage of students reporting use in the past 30 days may be greater than the percentage reporting lifetime use.

** National comparison data are available for 8th, 10th, and 12th grade only. Monitoring the Future does not survey 6th graders.

† "Prescription drug abuse" is a combined measure showing the total rate of abuse of any prescription stimulant, prescription sedative, prescription tranquilizer, or prescription narcotic drugs.

State 2020 | State 2022 | State 2024 | MTF**

Gateway drug use profile - Prescription drugs
State of Louisiana 2024 Student Survey



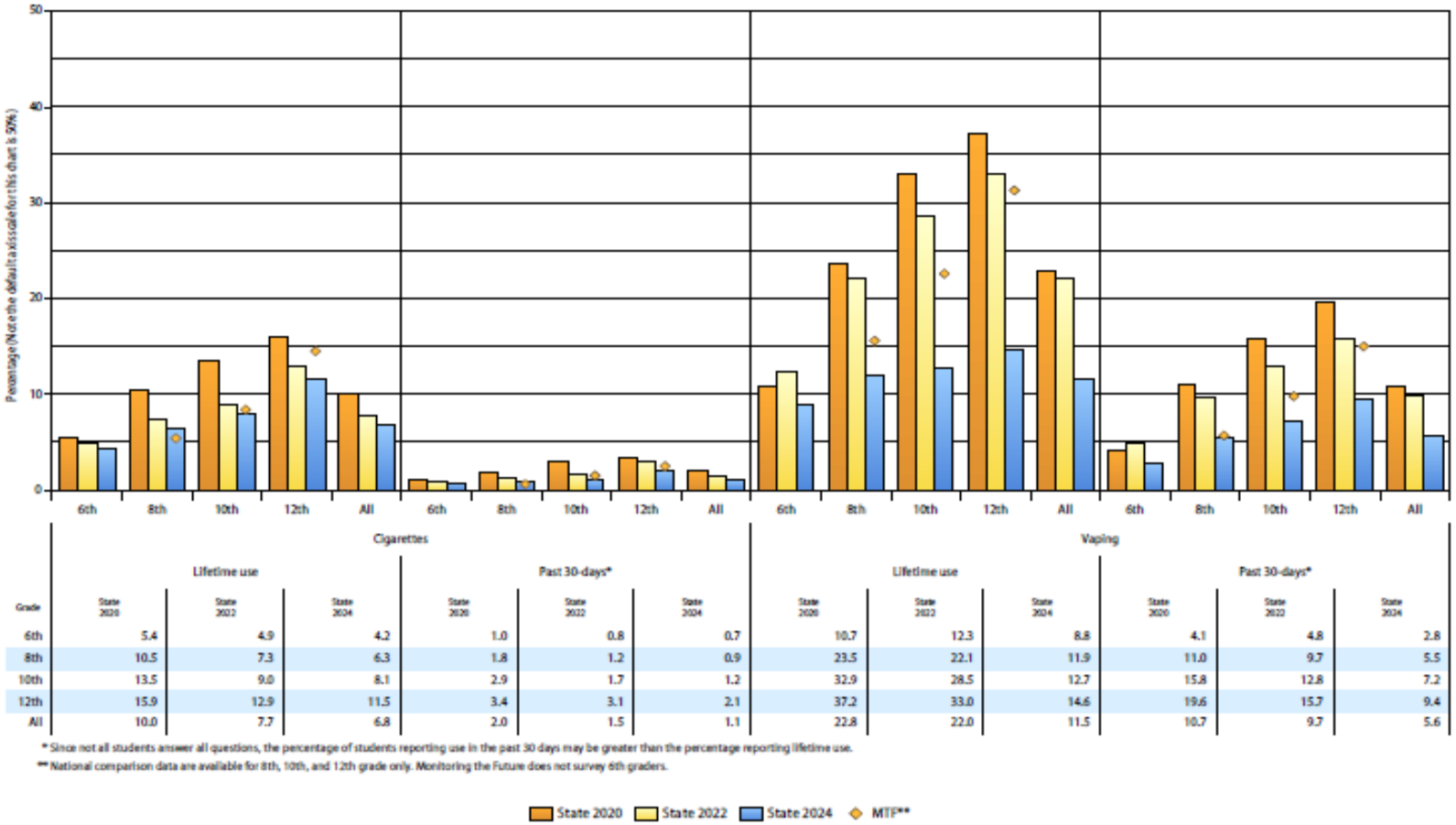
Grade	Prescription narcotic abuse						Prescription stimulant abuse						Prescription sedative abuse					
	Lifetime			Past 30-days*			Lifetime			Past 30-days*			Lifetime			Past 30-days*		
	State 2020	State 2022	State 2024	State 2020	State 2022	State 2024	State 2020	State 2022	State 2024	State 2020	State 2022	State 2024	State 2020	State 2022	State 2024	State 2020	State 2022	State 2024
6th	0.6	0.7	0.6	0.2	0.3	0.1	1.2	1.0	0.7	0.7	0.6	0.1	3.1	2.9	3.1	1.3	1.3	0.7
8th	1.4	0.9	0.8	0.5	0.4	0.2	2.0	1.6	1.2	0.8	0.9	0.2	4.4	3.7	3.4	2.0	1.6	0.7
10th	1.6	1.1	0.9	0.5	0.5	0.2	2.2	1.5	1.0	0.9	0.6	0.2	4.1	2.9	2.5	1.8	1.1	0.4
12th	2.4	1.5	1.2	0.7	0.5	0.2	3.2	1.8	1.5	1.1	0.6	0.2	4.0	2.8	2.3	1.4	1.1	0.3
All	1.3	1.0	0.9	0.4	0.4	0.2	1.9	1.4	1.1	0.8	0.7	0.2	3.8	3.1	2.9	1.6	1.3	0.6

* Since not all students answer all questions, the percentage of students reporting use in the past 30 days may be greater than the percentage reporting lifetime use.

** National comparison data are available for 8th, 10th, and 12th grade only. Monitoring the Future does not survey 6th graders.

State 2020 State 2022 State 2024 MTF**

Gateway drug use profile - Cigarettes and vaping products
State of Louisiana 2024 Student Survey

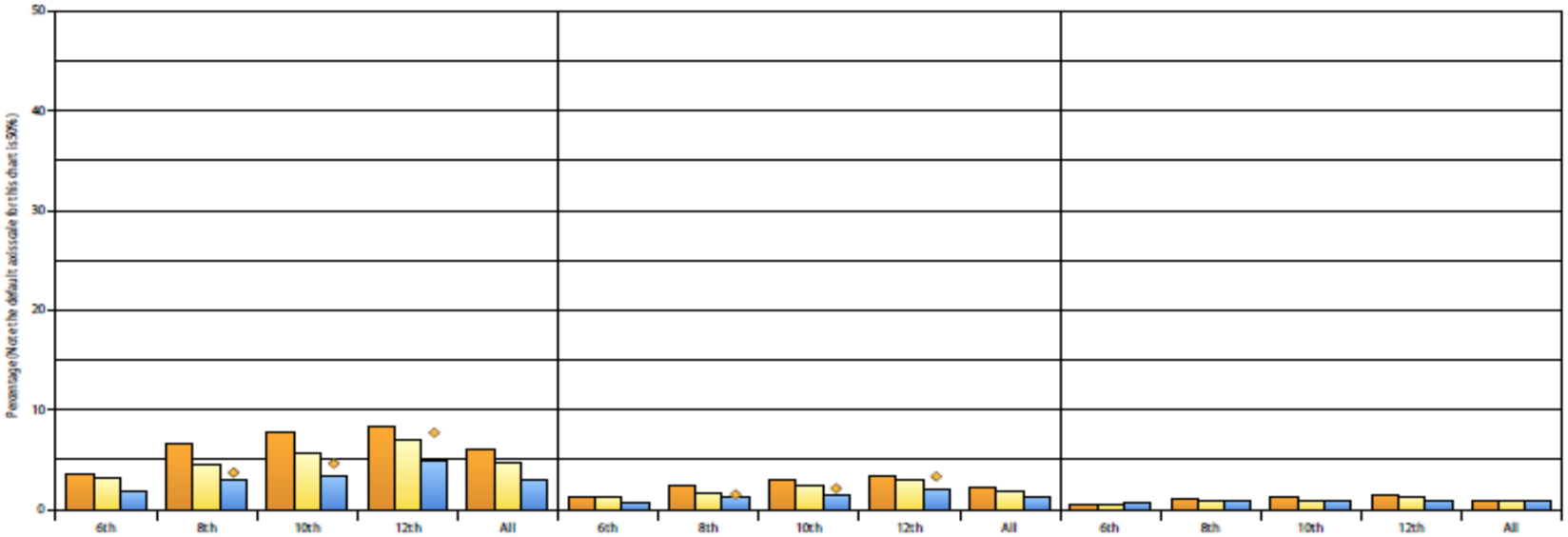


Grade	Cigarettes						Vaping					
	Lifetime use			Past 30-days*			Lifetime use			Past 30-days*		
	State 2020	State 2022	State 2024	State 2020	State 2022	State 2024	State 2020	State 2022	State 2024	State 2020	State 2022	State 2024
6th	5.4	4.9	4.2	1.0	0.8	0.7	10.7	12.3	8.8	4.1	4.8	2.8
8th	10.5	7.3	6.3	1.8	1.2	0.9	23.5	22.1	11.9	11.0	9.7	5.5
10th	13.5	9.0	8.1	2.9	1.7	1.2	32.9	28.5	12.7	15.8	12.8	7.2
12th	15.9	12.9	11.5	3.4	3.1	2.1	37.2	33.0	14.6	19.6	15.7	9.4
All	10.0	7.7	6.8	2.0	1.5	1.1	22.8	22.0	11.5	10.7	9.7	5.6

* Since not all students answer all questions, the percentage of students reporting use in the past 30 days may be greater than the percentage reporting lifetime use.

** National comparison data are available for 8th, 10th, and 12th grade only. Monitoring the Future does not survey 6th graders.

Gateway drug use profile - Other tobacco products
State of Louisiana 2024 Student Survey



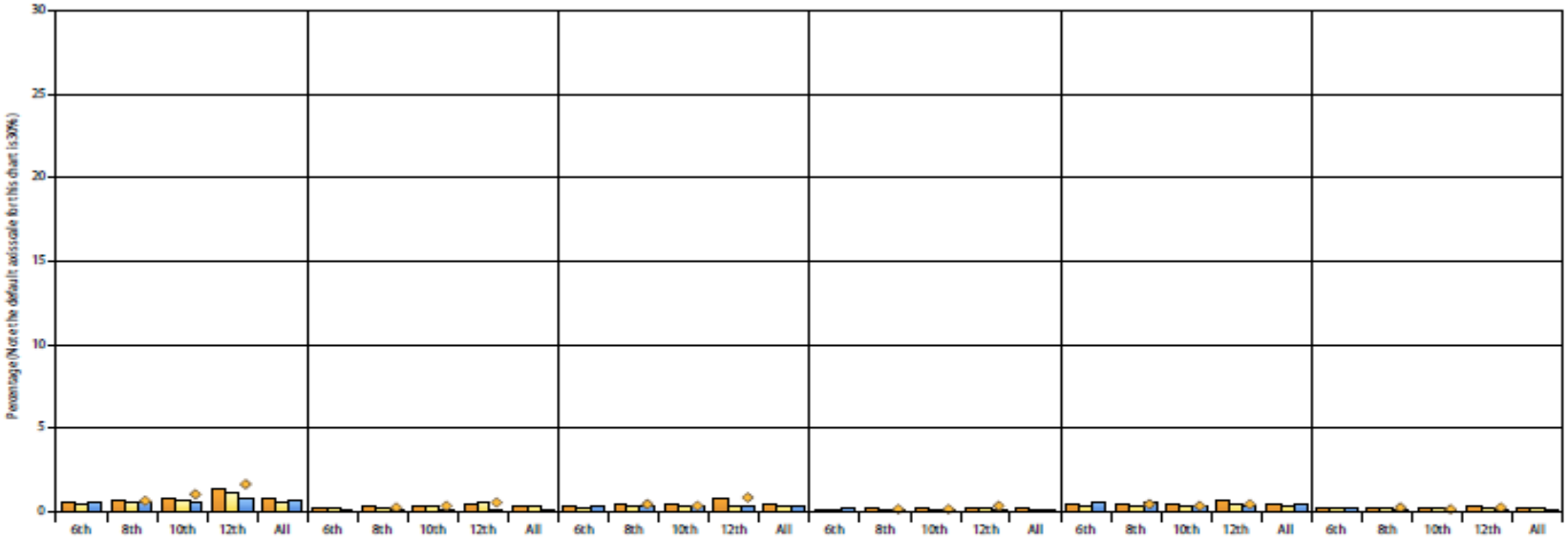
Grade	Chewing tobacco: Lifetime use State 2020	Lifetime use State 2022	Lifetime use State 2024	Past 30-days* State 2020	Past 30-days* State 2022	Past 30-days* State 2024	Hookah or waterpipe: Past 30-day use* State 2020	Past 30-day use* State 2022	Past 30-day use* State 2024
6th	3.5	3.1	1.8	1.3	1.2	0.7	0.5	0.6	0.7
8th	6.6	4.5	2.9	2.3	1.6	1.1	1.0	0.9	0.8
10th	7.6	5.6	3.3	3.1	2.4	1.3	1.2	1.0	0.8
12th	8.2	7.1	4.9	3.2	3.1	2.0	1.5	1.3	1.0
All	6.0	4.7	2.9	2.2	1.9	1.2	0.9	0.9	0.8

* Since not all students answer all questions, the percentage of students reporting use in the past 30 days may be greater than the percentage reporting lifetime use.

** National comparison data are available for 8th, 10th, and 12th grade only. Monitoring the Future does not survey 6th graders.

State 2020 | State 2022 | State 2024 | MTF**

Other illicit drug use profile - Cocaine, methamphetamine, heroin
State of Louisiana 2024 Student Survey



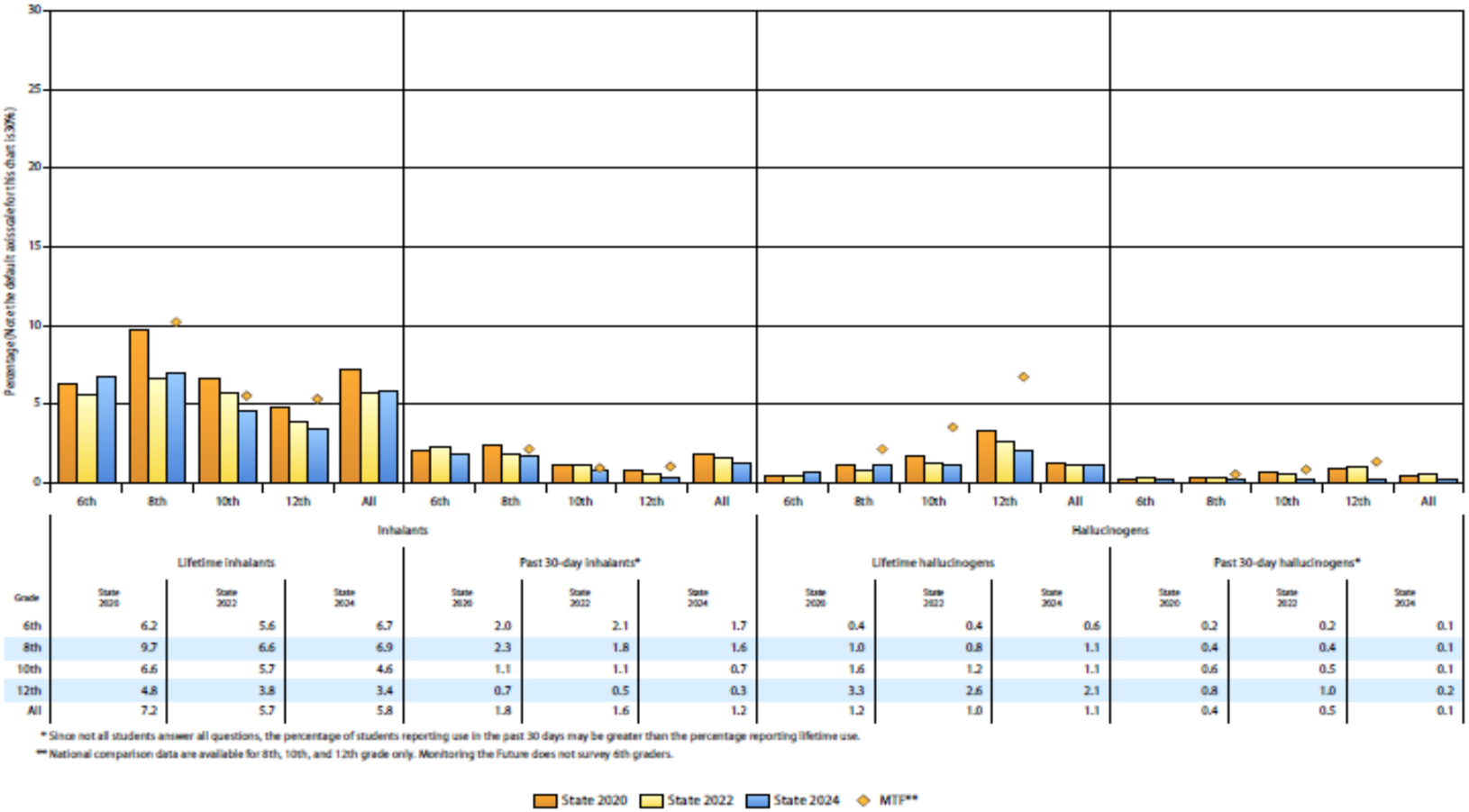
Grade	Cocaine						Methamphetamine						Heroin					
	Lifetime cocaine			Past 30-day cocaine*			Lifetime methamphetamines			Past 30-day methamphetamines*			Lifetime heroin			Past 30-day heroin*		
	State 2020	State 2022	State 2024	State 2020	State 2022	State 2024	State 2020	State 2022	State 2024	State 2020	State 2022	State 2024	State 2020	State 2022	State 2024	State 2020	State 2022	State 2024
6th	0.5	0.4	0.6	0.2	0.2	0.1	0.3	0.2	0.4	0.1	0.0	0.1	0.4	0.4	0.5	0.2	0.2	0.1
8th	0.6	0.5	0.6	0.2	0.2	0.1	0.3	0.3	0.3	0.1	0.1	0.1	0.4	0.4	0.4	0.1	0.1	0.1
10th	0.7	0.6	0.6	0.3	0.3	0.1	0.4	0.3	0.3	0.1	0.1	0.0	0.4	0.3	0.4	0.2	0.1	0.1
12th	1.3	1.0	0.7	0.4	0.5	0.1	0.7	0.3	0.3	0.2	0.2	0.0	0.6	0.4	0.4	0.3	0.1	0.0
All	0.7	0.6	0.6	0.2	0.3	0.1	0.4	0.2	0.3	0.1	0.1	0.1	0.4	0.4	0.4	0.2	0.2	0.1

* Since not all students answer all questions, the percentage of students reporting use in the past 30 days may be greater than the percentage reporting lifetime use.

** National comparison data are available for 8th, 10th, and 12th grade only. Monitoring the Future does not survey 6th graders.

State 2020 State 2022 State 2024 MTF**

Other illicit drug use profile - Inhalants, hallucinogens, steroids, synthetics
State of Louisiana 2024 Student Survey



Grade	Inhalants: Lifetime inhalants State 2020	Lifetime inhalants State 2022	Lifetime inhalants State 2024	Past 30-day inhalants* State 2020	Past 30-day inhalants* State 2022	Past 30-day inhalants* State 2024	Hallucinogens: Lifetime hallucinogens State 2020	Lifetime hallucinogens State 2022	Lifetime hallucinogens State 2024	Past 30-day hallucinogens* State 2020	Past 30-day hallucinogens* State 2022	Past 30-day hallucinogens* State 2024
6th	6.2	5.6	6.7	2.0	2.1	1.7	0.4	0.4	0.6	0.2	0.2	0.1
8th	9.7	6.6	6.9	2.3	1.8	1.6	1.0	0.8	1.1	0.4	0.4	0.1
10th	6.6	5.7	4.6	1.1	1.1	0.7	1.6	1.2	1.1	0.6	0.5	0.1
12th	4.8	3.8	3.4	0.7	0.5	0.3	3.3	2.6	2.1	0.8	1.0	0.2
All	7.2	5.7	5.8	1.8	1.6	1.2	1.2	1.0	1.1	0.4	0.5	0.1

* Since not all students answer all questions, the percentage of students reporting use in the past 30 days may be greater than the percentage reporting lifetime use.

** National comparison data are available for 8th, 10th, and 12th grade only. Monitoring the Future does not survey 6th graders.

The Core Alcohol and Drug Survey Table 2 below reflects substantial proportions of students report having used alcohol, tobacco, and marijuana in response to the question, "At what age did you first use _ _?" whereas comparatively few report having used each of the other substances. This question examines "lifetime prevalence" as opposed to annual prevalence and 30-day prevalence.

Table 2 describes lifetime prevalence, annual prevalence, 30-day prevalence, and high frequency use (3 times a week or more). Overall, the college group shows higher frequent use of tobacco and marijuana, and slightly elevated use of certain prescription and designer drugs compared to the national reference. Alcohol remains the most commonly used substance, though with less frequent consumption among college students.

Table 2 - Substance Use

	Lifetime Prevalence		Annual Prevalence		30-Day Prevalence		3X/Week or more	
Substance	Coll.	Ref.	Coll.	Ref.	Coll.	Ref.	Coll.	Ref.
Tobacco	37.3	33.3	26.5	24.6	19.8	14.9	15.1	6.6
Alcohol	78.5	83.1	72.9	80.3	53.6	67.2	11.3	18.1
Marijuana	47.0	47.5	33.0	36.9	20.4	21.3	11.7	8.4
Cocaine	6.9	8.3	3.3	5.8	1.0	2.4	0.2	0.2
Amphetamines	9.2	7.9	4.0	4.6	2.4	2.4	1.7	1.1
Sedatives	6.5	5.1	2.2	2.7	0.9	1.3	0.5	0.3
Hallucinogens	10.0	7.8	4.7	5.0	1.4	1.3	0.1	0.1
Opiates	2.8	2.0	1.1	1.0	0.7	0.6	0.2	0.2
Inhalants	2.5	1.9	1.1	0.8	0.5	0.5	0.1	0.1
Designer drugs	7.0	6.6	2.1	3.5	0.6	0.9	0.1	0.2
Steroids	1.7	1.0	0.8	0.5	0.6	0.4	0.1	0.2
Other drugs	2.7	2.8	1.1	1.3	0.4	0.6	0.1	0.1

Coll. = Multiple Selection
Ref. = Reference group of 66,199 college student

Quality and Data Collection Readiness

The Office of Behavioral Health (OBH) continues to make great strides in upgrading information technology and data systems to address the growing and changing business intelligence needs of the agency as the behavioral health service delivery system adjusts to significant transformations.

As of December 1, 2015, specialized behavioral health services were integrated into the physical health services of the five Healthy Louisiana plans (previously called Bayou Health plans). Magellan, which used to be the Statewide Management Organization (SMO) for specialized behavioral health services for Louisiana until November 31, 2015, is currently responsible for Medicaid specialized behavioral health services for the Coordinated System of Care (CSoC) population (children and youth between 5-20 years).

The OBH Business Intelligence (BI) Section, including the OBH Analytics team, is responsible for information management and data standards development, decision support and performance improvement initiatives, and computer/network technical support and assistance. The BI Section strives to transform data into actionable information for purposes of behavioral health service planning, quality improvement, and performance accountability. Information, training, and technical assistance is regularly provided to LGEs, clinics, facilities, the state office, and private provider staff/personnel on how to access and utilize program data.

Louisiana has improved statewide client-level data collection from the LGEs and their contracted providers. Currently, all ten LGEs, and two mental health providers (EPIC-NOLA and VOA-NLA) are providing client-level data through their contracted Electronic Health Record (EHR) vendors. The OBH Analytics team generates two *Pre-Integration Data Validation Report* each month for each LGE (20 reports per month), analyzing the bi-monthly client-level data files submitted by the LGEs. These reports, which are regularly shared with the LGEs, list the gaps and barriers in the client-level data files. Barriers to data collection and reporting include, but are not limited to, access to data collection systems, costs to providers, training individuals on data collection methods, needed EHR modifications and data collection modifications per the Client-level Data Manual (CLDM), and time required to implement those changes. The OBH Analytics team conducts data calls with the LGEs and their E HR vendors to provide technical assistance for improving data quality.

The OBH Analytics team regularly uploads MH and SUD client-level admission and discharge records as Substance Abuse-Treatment Episode Data Set (SA-TEDS) and Mental Health (MH) TEDS. Other recurring federal (SAMHSA) reports include annual Substance Abuse Block Grant (SUPTRS BG) and Mental Health Block Grant (MHBG) report, MH Universal Reporting System (URS) tables, and bi-annual Combined SUPTRS BG/MHBG Behavioral Health Assessment and Plan.

Electronic Health Record Systems for Collection of Statewide MH and SUD Data

Since December 1, 2015, Magellan's proprietary Electronic Heath Record (EHR), Clinical Advisor (CA) is decommissioned and replaced by LGE-contracted EHR vendors. LGE contracted providers are encouraged to explore options for submitting their clinical data (MH and/or SUD) through the EHRs procured by their LGE. At this time, all the LGEs have contracted with EHR vendors (i.e., ICANotes, CareLogic-Qualifacts, Next Gen, E-Clinical Works, and Remarkable Health).

In addition to EHRs, another legacy system called the *Louisiana Addictive Disorders Data System (LADDS)* is available for SUD/addictive disorders providers. However, LAADS is an antiquated system and the State is in the process of gradually transitioning from LADDS since late 2023. LGEs have been notified to enter their SUD treatment records into their E-HR system. MH Client-level data from the state-funded inpatient psychiatric hospitals are also collected through Patient Information Portal (PIP).

OBH Data Warehouse/Business Intelligence System

Client-level data collected through EHRs, LADDS, and PIP systems from LGE operated/contracted community mental health and substance use disorder service providers, and state-funded inpatient psychiatric hospitals, are stored in a standardized format (.csv files) into one integrated database/data system. OBH maintains this comprehensive data warehouse/business intelligence system to provide access to and use of integrated statewide data and performance measures to managers and staff. The

data warehouse is the main source of data for the MH and SUD-TEDS submission, Uniform Reporting System (URS), federal Block Grant, National Outcomes Measures (NOMS) and all other statewide reporting.

OBH Analytics has also rolled out a new website called LGE Corner/OBH Analytics Library (https://ldh.la.gov/page/2605) to provide a repository for the most up-to-date documentation on state and federal reporting requirements. This site is expected to provide a "one-stop" resource for LGEs and OBH staff seeking information on policies, manuals, and reporting.

Prevention Management Information System

The state collects process data through OBH's online Prevention Management Information System (PMIS). PMIS is the primary reporting system for the SAPT Block Grant for prevention services. Prevention staff and contract providers input information about direct and indirect individual and population-based services into PMIS. PMIS is available to all on a daily basis and real-time rollup reports are compiled for the state, regional, and provider level. These reports allow OBH Central Office staff to support the field by assessing the state's current capacity and determining whether performance targets have been achieved. This provides a mechanism for staff to develop, intervene and implement corrective action in a timely manner.

Specific data elements collected by PMIS include demographic data (e.g. age, race, and ethnicity) and program deliverables (e.g., target population and number served), as well as services provided within the six Center for Substance Abuse Prevention (CSAP) prevention strategies. A PMIS Process Evaluation Report is generated each quarter by OBH central office detailing services and deliverables information for each region, provider, and program. This report is followed by a quarterly site visit by a state office Prevention staff member to provide technical assistance during the service delivery period. Resources are monitored and reallocated during the year as needed.

Data Definitions and Methodology

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

Estimation Methodology:

- Mental Health – OBH uses prevalence rates for SMI (5.4%) and SED (7%) from SAMHSA's Uniform Reporting System (URS) *Table 1: Number of Adults with Serious Mental Illness (SMI), age 18 and older, and Number of Children with a Serious Emotional Disturbance (SED), age 9 to 17, by State, 2023*. Each prevalence rate was applied to 2023 Louisiana population to estimate the prevalence of targeted persons to be served.
- Substance Use Disorders – According to SAMHSA National Survey on Drug Use and Health (NSDUH) data in 2023 (https://www.samhsa.gov/data/sites/default/files/reports/rpt56188/2023-nsduh-sae-state-tables_0/2023-nsduh-sae-state-tabs-louisiana.pdf), the need for substance use treatment in the past year among people aged 12 or older was 21.8% among the total population. This national percentage was applied to the 2023 Louisiana population to estimate the number of Louisiana citizens needing treatment. NSDUH also reported that 5.1% received specialty substance use

treatment in the past year among people aged 12 or older who needed substance use treatment in the Past Year. This percentage was applied to the number of Louisiana citizens needing treatment, providing the estimated number of Louisiana citizens seeking treatment.

- Population Estimate: State of Louisiana is divided in ten Local Governing Entities (LGEs/Regions), each comprising of several parishes (counties). Parish-level population count, categorized by gender and select age groups are necessary to estimate population for each LGE/Region. In https://www.census.gov/en.html web portal, no parish/county-level table is available for population in 9-17 years, or 12+ age group (https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-detail.html). Moreover, SAMHSA URS Table 1 provides State SED estimate for 9-17 years. Considering these facts and limitations, all parish/county-level population estimates were calculated internally for age group 9-17 years, 12+ and 18+ categories, from *Annual County and Puerto Rico Municipio Resident Population Estimates by Single Year of Age and Sex: April 1, 2020 to July 1, 2024 (CC-EST2024-SYASEX*) table.

Admissions: Number of clients entering treatment during the time period.

Discharges: Number of clients that have completed treatment during the time period.

Persons Receiving Services: The number of clients who received at least one treatment service during the time period.

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.

Assessment of Strengths and Needs

OBH facilitated several opportunities to engage community, providers, and other stakeholders on best practices in the behavioral health system. This included Advisory Council quarterly meetings, ongoing dialogues with mental health and SUD treatment providers, associations, and with LGEs. OBH also participates in South Southwest Addiction/Prevention Technology Transfer Center forums to stay abreast of evidence and promising practices. OBH compiled these items as strengths and needs during the planning process.

Strengths

Grants:

- The Louisiana Partnerships for Success III (LaPFS III) proposes to address the significant challenges many Louisianans ages 12-25 face regarding substance misuse within racially, culturally, and economically diverse populations. The LaPFS III Grant will target five underserved communities across the State in three Regions (AAHSD, SCLHSA, FPHSA) that present higher rates of use when compared to the state in underage drinking and polysubstance use. Louisiana will establish a state/community prevention collaborative to implement the Strategic Prevention Framework (SPF) at the State and community levels which will allow stakeholders to assess problems, plan and implement strategies, and evaluate solutions to address alcohol, tobacco, and other drugs (ATODs), and polysubstance use while promoting mental health services and resources. The State will utilize the SPF to make informed data-driven decisions to implement, effective prevention strategies, thus leading to observable and tangible changes within the select Parishes over time.
- Zero Suicide Grant – The Louisiana Department of Health/Office of Behavioral Health (OBH) was awarded the five-year Zero Suicide Grant from SAMHSA in July 2020 to implement the Louisiana Zero Suicide Initiative, aimed at reducing suicide deaths and attempts among adults aged 25 and older. A no-cost extension was approved through August 2026, ensuring the continuation of project activities and achievement of key deliverables. The evidence-based Zero Suicide Framework, which includes seven essential elements, guides this initiative: leadership commitment, workforce training, risk identification, patient engagement, evidence-based treatment, care transitions, and continuous quality improvement. OBH has collaborated with four local governing entities (FPHSA, SCLHSA, AAHSD, NEDHSA), two state psychiatric hospitals (ELMHS and CLSH), and additional community organizations to implement and embed the Zero Suicide model within their behavioral health systems.

  Throughout the grant period, OBH has provided robust technical assistance and capacity-building opportunities including a Zero Suicide Workshop, a two-day Academy, and a nine-part Community of Practice series in collaboration with the Educational Development Center (EDC), the Zero Suicide Institute (ZSI), and the Louisiana Center for Prevention Resources (LCPR). These activities have supported implementation planning, identification of system gaps, and the development of suicide care protocols. To date, 3,861 staff members across the provider sites have been trained in a variety of suicide prevention and intervention approaches such as ASIST, QPR, SafeTALK, and cognitive behavioral strategies occurred on June 13th and 14th, 2023. There were 12 teams that participated.

- 988 Implementation Grant – This technical assistance grant supports the transition from the previous National Suicide Prevention Lifeline number to the new 3-digit 988 number which was launched in July 2022. The grant promotes a shift from a law enforcement and justice system response to one of immediately connecting to care for individuals in suicidal, mental health and substance use crises. The grant provides technical assistance for the implementation of 988.
    - *The 988 Cooperative Agreement Grant*- The purpose of these cooperative agreements is to improve state and territory response to 988 contacts (including calls, chats, and texts) originating in the state/territory by: (1) recruiting, hiring and training behavioral health workforce to staff local 988/Lifeline centers to respond, intervene, and provide follow-up to individuals experiencing a behavioral health crisis; (2) engaging Lifeline crisis centers to unify 988 response across states/territories; and (3) expanding the crisis center staffing and response structure needed for the successful implementation of 988.
    - *The 988 Supplemental Grant***-** The supplemental grant works to improve coordination with 911 Public Safety Answering Points (PSAPS) and Marketing and Communications efforts. This grant also supports hiring and workforce development to the local crisis call centers.
- Promoting Integration of Primary Behavioral Healthcare (PIPBHC) to promote the integration of primary and behavioral health care services to improve the overall wellness and physical health status of adults with mental illness or a substance use disorder who have co-occurring physical health conditions or chronic diseases. PIPBHC I provided services from 2018-2023, with OBH submitting a no cost extension to extend the grant period from Sept. 30, 2023 to March 30, 2024. OBH submitted an application in 2023 PIPBHC II, which currently is ending year 2 of the grant cycle.
- The Louisiana State Opioid Response (LaSOR) program aims to address the opioid crisis by increasing access to medications- for opioid use disorder (MOUD) using the three FDA-approved medications for the treatment of OUD and through the provision of prevention, treatment, and recovery activities for OUD. In addition, the LaSOR program supports evidence-based prevention, treatment, and recovery support services to address stimulant use and misuse, including cocaine and methamphetamine. The LaSOR 3.0 grant no cost extension ends Sept. 29, 2025. The current LaSOR 4.0 grant ends Sept. 29, 2027.

Cross Sector Collaborative Opportunities:

- Heroin and Opioid Prevention and Education (HOPE) Council- Thirteen (13) agency heads, with LDH as the Chair, addresses prevention and education of heroin and opioids.
- The Governor's DWI Taskforce, a sub-committee under the Louisiana Drug Policy Board was reestablished through Executive Order in March 2018. The purpose of the Task Force is to address the high incidence of driving while intoxicated or under the influence of drugs; address data collection and analysis on DWI conviction rates; address the prevalence of drivers refusing to submit to tests as directed by law enforcement and strategies to reduce such incidences; and identify and implement effective DWI countermeasures.
- Project AWARE- In partnership with the Louisiana Department of Education, a comprehensive Louisiana School Mental Health Support Program has been established to increase awareness of mental health issues among school-aged youth, to provide specialized training to school

personnel on how to detect and respond to mental health issues, and to connect students struggling with behavioral or mental health issues and their families to the appropriate services.

- OBH collaborates with Local Governing Entities (LGEs), the Department of Public Safety and Corrections (DPSC), and the Orleans Day Reporting Center to provide a comprehensive array of services to justice-involved individuals with opioid use disorder (OUD), including peer support services, outpatient treatment services, and other recovery support services. This collaboration is instrumental in engaging and retaining justice-involved individuals with OUD in treatment and recovery services, increasing the use of diversion and/or alternatives to incarceration, and reducing the incidence of overdose deaths.
- Louisiana Center for Prevention Resources (LCPR) established at Southern University and A&M College and the Office of Behavioral Health (OBH) developed a partnership aimed at improving implementation and delivery of effective substance use prevention interventions. This Center also offers training and technical assistance services to the Substance Use Prevention Workforce. This partnership provides specific courses and trainings necessary to become a certified/licensed prevention professionals, at no cost to participants. Additional trainings are available to youth, communities, professionals, and others in the prevention community, to increase capacity, skills and expertise to ensure and/or enhance delivery of effective substance use prevention interventions, trainings and other prevention activities. In addition to the above initiative, OBH partnered to:
    - Support mental health training needs specifically related to suicide prevention. Trainings under this partnership enables participants to assist someone in a crisis mode by being trained to recognize the warning signs of suicide ideation. These trainings will provide the skills needed to individuals for outreach and initial support to someone who may be in crisis or developing a mental health or substance use problem.
    - Developed a Statewide Media Alcohol Awareness Campaign. The purpose of this campaign is to increase awareness of alcohol use and misuse and the associated consequences. This campaign will be used to address risk factors and educate community members on the increase in substance use. In addition LCPR will provide trainings and awareness campaigns for Service Members, Veterans and their Families (SMVF) with targeted messages that focus on behavioral health prevention and trainings related to substance use.
- OBH collaborates with the Office of Public Health (OPH) to enhance services provided by Syringe Service Programs (SSPs). This collaboration supports the distribution of harm reduction materials and a health coordinator to connect individuals with treatment and other community resources and supports, along with linkages to care.
- <u>Louisiana Office of the Governor</u>

  OBH contracts with the Louisiana Office of the Governor to collaborate and continue to build the State's capacity for data driven, evidence-based prevention services to reduce the risk factors for substance use and related mental, emotional and behavioral disorders. The contract between OBH and the Louisiana Office of the Governor allows for sustainment of the state infrastructure that has played a vital role to addressing substance misuse. This partnership supports the salary and related benefit of the Director of Drug Policy and the Prevention Systems Coordinator who oversee and facilitate three advisory boards to include the Drug Policy Board (DPB), Prevention Systems Committee (PSC) and the State Epidemiology Workgroup (SEW). The identified boards provide and promote pivotal partnerships across different state and community sectors. In

addition, this contract ensures implementation and fulfillment of the requirements of the Louisiana Partnership for Success III (LaPFS III) Grant.

- Louisiana Alcohol and Tobacco Control

  OBH has a long-standing partnership with the Louisiana Office of Tobacco Control (ATC) in an effort to address youth access to tobacco and alcohol, which remain a nationwide problem. The contract with ATC allows OBH to meet the requirements of the Synar Amendment. The Synar Amendment to the Public Health Service Act (PL 102-321) requires that states must reduce the access of tobacco products to minors. The Louisiana Office of Alcohol and Tobacco Control is the regulatory agency for both alcohol and tobacco as stipulated in Louisiana State Law. As such, OBH has contracted with ATC to conduct random, unannounced compliance checks of both over-the-counter and vending machine outlets for tobacco products. In addition, as funding is available, OBH has contracted with ATC to conduct random, unannounced compliance checks of both on-premise and off-premise outlets for alcohol products statewide.

- University of Louisiana at Lafayette (ULL)

  Office of Behavioral Health (OBH) and the University of Louisiana at Lafayette (ULL) partners to administer the Caring Communities Youth Survey (CCYS) and serve as the State's Evaluator to provide data to support evidence-based programming. CCYS is a bi-annual survey completed by 6th, 8th, 10th and 12th grade students enrolled in public and private schools throughout the state. The survey is funded by the Louisiana Office of Behavioral Health (OBH) and has been administered statewide since 2002. The CCYS taps into several behavioral health indicators for school-age children, including Risk and Protective factors, substance use/abuse, mental health and antisocial behaviors. Schools and districts use the CCYS reports to apply for grants or funding that address areas of need illuminated by survey outcome measures. Since 2002 the Picard Center has been tasked with coordinating, monitoring, and providing technical assistance for survey administration.

  This partnership aims to identify high-risk behaviors among middle and high school students, including risk factors associated with alcohol, tobacco, and other drug use. Additionally, it supports the Office of Alcohol and Tobacco Control (ATC) by providing representative samples of compliance checks under the SYNAR Amendment. The ultimate goal is to operate a seamless system of care that integrates prevention and intervention strategies based on evidence and data.

- Louisiana Board of Regents

  The Louisiana Board of Regents (BORs) implements strategies, trainings and helps to raise awareness in an effort to reduce identified negative consequences of substance misuse. BORs works directly with the Louisiana Department of Health (LDH), Office of Behavioral Health (OBH) and other statewide entities to improve implementation and delivery of effective substance misuse prevention interventions within institutions of higher education.

  OBH partners with the Louisiana Board of Regents to collect and assess data on populations enrolled in institutions of higher education related to substance use disorders and other behavioral health issues. BOR conducts the CORE Alcohol and Drug Survey in odd years to Postsecondary Education Institutions (PEI). BORs also host the Louisiana Higher Education Coalition (LaHEC) annual summit, Regional Trainings based on the outcomes of the CORE Alcohol and Drug Survey, webinars related to outstanding trends amongst the higher education population. In addition, BOR monitors implementation of evidence-based curriculums, such as

Alcohol Edu. BORs also provides support to Collegiate Recovery Communities through technical assistance and naloxone education and distribution.

New Initiatives:

- Louisiana Crisis Response System- Funding was approved during the 2021 state legislative session for the implementation of three (3) new Medicaid-funded crisis services to be implemented statewide for individuals 21 years and older via the Louisiana Crisis Response System (LA-CRS). Implementation was phased in by service beginning in January, 2022 including the following:
    - Mobile Crisis Response (MCR), a community-based, mobile crisis response service.
    - Community Brief Crisis Support (CBCS), an ongoing crisis intervention response rendered for up to fifteen (15) days for those in need.
    - Behavioral Health Crisis Care (BHCC) clinics, a time-limited and facility based walk in clinic for individuals in crisis.

  Funding was approved during the 2022 state legislative session for the implementation of a fourth new Medicaid-funded crisis service to be implemented for individuals 21 years and older via the LA-CRS.
    - Crisis Stabilization (CS), short-term bed-based crisis treatment and support services for members who have received a lower level of crisis services and are at risk of hospitalization or institutionalization.

  Funding was approved during the 2023 state legislative session to expand the LA-CRS to include the availability of MCR and CBCS services to children, 20 years and younger, and their families; implementation of these services began in June 2024.
- The Louisiana Crisis Hub was formally implemented effective May 1, 2025. The last overarching service associated with the Louisiana Crisis Response System, the LCH is a statewide triage and dispatch resource for individuals in crisis throughout the state. The LCH has air traffic control capacity and, through their collaborations with the LA-CRS providers, is able to provide real time data and dash boarding.
- Behavioral Health Personal Care (BH-PCS)- In order to address a need developed through OBH's My Choice Louisiana transition coordination initiative, in-home Personal Care Assistant (PCA) services for those program participants who do not meet eligibility for existing home and community based service (HCBS) programs were developed and implemented.
- SSI/SSDI Outreach, Access and Recovery (SOAR)- is a SAMHSA initiative that provides technical assistance and a training program that identifies and removes barriers faced by persons who are homeless, at risk of becoming homeless, and who have difficulties accessing benefits. A contract with Louisiana Housing Corporation was established to employ this initiative within each Region (9) of the State. The goal is to assist individuals not connected to a program that provides assistance with applying for SSI/SSDI benefits and obtaining documents (birth certificates, Identifications and Social Security cards) required to receive other mainstream benefits they may be entitled to.
- Collegiate Recovery Programs (CRP) – OBH is partnering with the Board of Regents (BoRs) to expand the Collegiate Recovery Program statewide. The expansion will support the development of three additional CRPs. CRPs will provide a safe environment for students on college campuses to help deter and support them from returning to drugs and alcohol. The CRPs will build student

achievement by offering specialized and strategic supportive services to help students achieve growth and success with their recovery and academic journeys. The students identified as being in recovery will have a facility designed with them in mind and staff will be onsite to assist as needed. The facility and staff will provide support and resources that play a critical role in relapse prevention. The CRPs have the potential to directly impact student success, engagement, resiliency, and retention.

- Campus Peers in Higher Education Settings – In 2023, OBH established contract partnerships with three (3) NAMI affiliates throughout the state to support students with behavioral health and/or emotional challenges on campus. Through this partnership, trained Campus Peers will be available to a maximum of 12 universities throughout the state. Trained Campus Peers will provide support, guidance and referrals to students who are experiencing behavioral health and/or emotional challenges as they transition to this next phase in their early adulthood. This initiative ended in June 2025 with the termination of federal funds. OBH and contract partners continue to be available to support students on higher education campuses with other available resources.
- Early Childhood Supports and Services (ECSS)- The ECSS program was implemented for approximately 10 years and eliminated in 2013. Act 167 of the 2022 Regular Legislative Session established in the state treasury the Early Childhood Supports and Services program fund, intended to fund the re-creation of this program. The provisions establishing the ECSS Program Fund shall terminate on December 31, 2026. Act 167 directs that monies in the fund shall be used by the Louisiana Department of Health to fund its Early Childhood Supports and Service Program. Following an RFI process in 2022, in 2023 OBH proceeded with developing a Request for Proposals (RFP), to allow OBH to select an entity for statewide management of the program. The ECSS RFP was released on April, 26, 2024. The RFP review process is now complete and OBH has executed a contract with Magellan Complete Care of Louisiana, Inc. for statewide management of the ECSS program. OBH is working with Magellan Complete Care of Louisiana, Inc. towards the statewide rollout and management of ECSS sites across the state; Magellan Complete Care of Louisiana, Inc. released a Request for Applications (RFA) for regional sites in April 2025. They provided technical assistance and reviewed the proposals with the goal of selecting one provider agency for each of the 10 regions in Louisiana. Magellan Complete Care of Louisiana, Inc. is working on executing subcontracts with each of the selected provider agencies to deliver a comprehensive ECSS program for children ages zero through five and their families. Once credentialed, contracted, and trained, the regional ECSS Sites will begin providing ECSS services to families in their assigned Human Service District region.

  OBH has also supported the start-up of an early adopter site. Jefferson Parish Human Services Authority (JPHSA) has contracted with Tulane as the lead for a consortium of providers, to deliver an ECSS program in the Greater New Orleans area. They are serving children and families and are developing a network of community partners to connect families to needed community resources.
- SAMHSA Clinical High-Risk for Psychosis (CHR-P) grant recipient- In 2024, SAMHSA awarded a grant to LDH/OBH in support of Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis (CHR-P). Tulane EPIC-NOLA has been named the CHR-P award sub-recipient. EPIC-CHRP will target those at clinical high risk (CHR) for psychosis by implementing a CHR team and a CHR community early detection campaign. The CHR cohort

includes young people ages 10 through 25 years of age who exhibit noticeable changes in perception, thinking and functioning typically preceding the first episode of psychosis (FEP). The LaCHR-P contract has been submitted for processing and the grant Project Director has been hired.

Data:

- Louisiana has a statewide prevention system, as well as an institutionalized state epidemiology workgroup (SEW). Originally linked to specific grant funds, the SEW is currently a permanent sub-committee of the Governor's Drug Policy Board, regardless of funding. Many states are not as fortunate and do not have continuity of activities or membership.
- Louisiana Opioid Data & Surveillance System (LODSS) - collects information from LDH and external organizations to analyze health data related to opioid use disorder. LODSS disseminates results through facts sheets, publications, training and educational materials, to include online data access to public and private providers and the community.
- The Core Alcohol and Drug Survey has been administered since 2007. The survey was developed to measure alcohol and other drug usage, attitudes, and perceptions among college students at two and four-year institutions. The survey includes several types of items about drugs and alcohol. One component deals with student attitudes, perceptions, and opinions about alcohol and other drugs, and the other deals with students own use and consequences of use.
- The Louisiana Caring Communities Youth Survey (CCYS) is designed to assess student involvement in a specific set of problem behaviors, as well as their exposure to a set of scientifically validated risk and protective factors. These risk and protective factors have been shown to indicate the likelihood of academic success, school dropout, substance use, violence, and delinquency among youth. The survey, which has been implemented since 1998, is administered every two years to Louisiana students in grades 6, 8, 10, and 12. Reports are compiled and generated for the state, regional, school-level (only available to the Department of Education), and parish level.
- The University of Louisiana at Lafayette, Picard Center will conduct a study to determine the prevalence of problem and pathological gambling behaviors, attitudes about gambling, knowledge of gambling interventions and resources for those who need assistance, and gambling infrastructure throughout the state. This study will allow OBH to obtain current rates, assess the distribution of problem gambling across the state, and conduct a trend analysis of gambling rates over time.
- Tulane University Department of Psychiatry and Behavioral Health conducted a needs assessment to analyze the current capacity and unmet needs of substance use disorder (SUD) treatment in the state of Louisiana for adults, adolescents, and youth. The needs assessment consisted of a review of existing epidemiological data, interviews with key stakeholders, and surveys of individuals with knowledge of and interest in opioid-related issues and SUD. Through this assessment, Tulane has identified gaps in service delivery for SUD treatment, proposed means to provide access to a full continuum of SUD services across the state, and delineated a strategy for enhancing SUD provider treatment capacity statewide.
- Louisiana State University Social Research & Evaluation Center (LSUSREC) provides data collection and performance measurement for multiple programs within OBH, including data storage, cleaning and organization, analysis, and reporting. LSUSREC serves as the subject matter data

experts for several OBH federal grants, including offering stakeholder trainings and learning communities to heighten awareness about federal reporting regulations for the Government Performance Results Act (GPRA).

Ongoing:

- Louisiana has statewide coverage through the Compulsive and Problem Gaming Fund that provides free gambling treatment to Louisiana residents. Louisiana offers outpatient and residential treatment for individuals with gambling disorder. All residents that seek treatment for behavioral health issues within the OBH provider network are screened for problem gambling. Those individuals that screen positive for problem gambling are offered an opportunity to meet with a Certified Compulsive Gambling Counselor (CCGC). The Compulsive and Problem Gaming Fund also provides funding for the Louisiana Problem Gambling Helpline, which is used to assist individuals, whether it be someone with a gambling problem, or others seeking help for someone with a gambling problem. The Louisiana Problem Gambling Helpline links individuals to the appropriate gambling treatment services throughout the state. In addition, the Compulsive and Problem Gaming Fund supports training for Gambling Treatment Coordinators statewide so they can receive the latest standards and best practices to treat a gambling disorder.
- The Tobacco Tax Health Care Fund provides tobacco cessation treatment to Louisiana residents, free of charge. This includes access to nicotine replacement therapy (NRT) including nicotine patches, lozenges and gum. All those that seek treatment for any behavioral health condition are screened for tobacco usage. Those that screen positive are offered the opportunity to participate in Tobacco Cessation Treatment. The Tobacco Tax Health Care fund also supports Tobacco Quitline Services, by providing telephone and web-based tobacco cessation coaching to individuals who are considering quitting tobacco products.
- The C'est Bon program is a peer-to-peer process of surveying recipients of state funded behavioral health services regarding satisfaction with services provided. Utilizing a consumer satisfaction team model for consumer-to-consumer monitoring and evaluation, the C'est Bon process relies on consumers as the core of this initiative. By having direct involvement in monitoring and evaluating the services they receive, consumers and family members will have a greater voice and a more meaningful role in influencing the design and quality of public behavioral health services. Once the data from the surveys is analyzed, a report is prepared and posted in the clinics for service recipients to view the program's performance. This supports total transparency in consumer satisfaction surveys and ongoing improvements. In SFY25, all ten LGEs were surveyed by the C'est Bon Team and nearly 600 surveys with service recipients were completed.
- Peer support services allow for more effective and targeted interventions resulting in improved care and an increased capacity of the system to serve a broader array of individuals. In March 2021, the initial phase of Medicaid reimbursement for Peer Support Services was implemented, with LGEs being the first provider type allowed to bill Medicaid for these services. As the initial phase of implementation has been closely monitored, OBH has worked with Medicaid and other stakeholders to plan future phases of implementation for Peer Services within SFY24. In SFY24, LDH/OBH expanded Medicaid reimbursement for Peer Support Services to the Permanent Supportive Housing (PSH) providers throughout the state. This expansion would continue to support some of the most vulnerable populations needing behavioral health services and the DOJ Agreement target population.

During SFY21, OBH also obtained approval to hire nine (9) additional Peer Support Specialists [called Peer In Reach Specialists (PIRS)] to support the My Choice LA (MCL) initiative to provide additional supports to individuals with serious mental illness (SMI) who are transitioning from a nursing facility or diversion from nursing facility placements. Through these efforts, PIRS meet with individuals affiliated with the MCL program, inquiring about their interest in moving into the community, linking them to a transition coordinator, and supporting the transition process. These activities remain ongoing and will continue.

In SFY25, the Louisiana Peer Training program continued to grow through the addition of the Family Peer Training and increased training participants. Please see totals below of training participants who have successfully completely each Peer Training:

- Recognized Peer Support Specialists (RPSS) – 170 Trained
- Recognized Family Peer Support Specialists (RFPSS) – 22 Trained
- Peer Supervisors – 29 Trained

- Single Preferred Drug List (PDL) - Opioid antagonist and partial agonist medications are now available without prior authorization to all Medicaid recipients and providers.
- Open access - When the state moved to Managed Care and with Medicaid expansion, the provider network expanded and gave clients more options and therefore, less waiting for services.
- Increased professional and workforce development trainings.
- Increased access to MOUD – All residential providers enrolled in the Medicaid managed care program are required to provide MOUD onsite or facilitate access to MOUD offsite which includes coordinating with the member's health plan for referring to available MOUD provider and arranging Medicaid non-emergency medical transportation if other transportation is not available for the patient.
- Methadone coverage – LDH allows Medicaid coverage of Methadone treatment for Medicaid enrollees ages 18 and older diagnosed with opioid use disorder.
- Supported Employment - In an effort to enhance integrated day activities and improve employment outcomes for individuals with behavioral health conditions, OBH developed a Medicaid-reimbursable supported employment service, Individual Placement and Support (IPS), which is an evidence-based supported employment model designed for individuals with serious mental illness. In 2022, IPS became Medicaid reimbursable for the My Choice Louisiana target population. IPS supported employment helps people living with behavioral health conditions work at regular jobs of their choosing. To support OBH's ongoing efforts to grow the IPS model statewide, OBH participates in the IPS Learning Community with dozens of other states that have implemented this evidence-based model. In 2022, OBH also applied for and was selected as an Advancing State Policy Integration for Recovery and Employment (ASPIRE) grant participant to be provided with technical assistance from national experts to support further growth of the IPS model in Louisiana. While the ASPIRE technical assistance grant ended in 2024, OBH has continued efforts to grow the IPS program and collaborate with IPS Learning Community to provide ongoing training and technical assistance to the Louisiana IPS providers. In 2023, Louisiana also expanded the IPS program to include all Assertive Community Treatment (ACT) Teams throughout the state. All 44 ACT Teams in Louisiana were provided with training to become IPS certified and integrate IPS as the supported employment model within ACT services in Louisiana. An enhanced Medicaid

reimbursement rate for ACT Teams was also approved to support the provision of IPS as an evidence based model for supported employment.

- Created opportunities and collaborations between Emergency Departments (ED) and the LGEs across the state, to place Peer Support Specialists within EDs. This model assists in the identification, engagement and referral to treatment for persons that experienced an overdose.
- Harm Reduction Portal - OBH partnered with the Office of Public Health to develop a new Harm Reduction Hub and Spoke Model. With this model, the state created a centralized distribution site (Hub), which performs as an electronic mechanism (website portal) to request naloxone and other harm reduction products, report data, and obtain education and training. Currently, 67 organizations across the state are registered as local distribution sites (Spokes). Spokes request harm reduction products, including naloxone, safe storage and disposal products, fentanyl testing strips (FTS), nalox-boxes, harm reduction vending machines, and more, to distribute these essential items to identified areas in need. All requesting organizations are required to complete training as part of the agreement to distribute naloxone on behalf of the project. This Hub and Spoke Model is instrumental in maximizing naloxone distribution and other harm reduction/prevention materials within Louisiana per the state's naloxone saturation plan.
- Expansion of Residential Programs for Women, Pregnant Women and Women with Children -OBH continues to enhance the network of residential SUD treatment programs for women, pregnant women and women with dependent children, through the opening of three new facilities, bringing the total number of facilities to six. Two additional facilities are slated to open in 2025. These efforts will help to increase access to residential treatment services for this vulnerable population.

Needs

- Accessible housing for individuals with behavioral health diagnoses.
- Integrated services for patients with intellectual disabilities, mental health issues and substance use disorders, particularly at residential levels of care (inpatient settings, PRTFs, and therapeutic group home settings).
- Data system updates to enhance data collection capacity.
- Expansion of transitional facilities from inpatient to community with a particular focus on housing resources. As individuals with SMI transition from institutional settings to the community, many require added supports and services to be successful in the community. In addition to needing housing supports, many individuals do not have social or family supports to navigate the systems to obtain primary and/or behavioral healthcare, mainstream benefits, job skills or other necessary services and supports. Addressing these areas can decrease re-institutionalization amongst those needing behavioral health services.
- While crisis services for individuals on Medicaid have been funded and implemented, robust crisis systems are most impactful when they serve the population as a whole. As such, there is the need to ensure expansion of service providers throughout the state while also expanding eligibility to other populations including those without Medicaid on an ongoing basis beyond initial support provided during program implementation.

- Enhanced integration initiatives are needed, as studies show coordinating and integrating primary and behavioral healthcare can improve quality and length of life, especially for individuals suffering from an SMI or SUD.
- Expansion of providers to offer Medication for Opioid Use Disorder (MOUD).
- Engagement and expansion of the behavioral health workforce.
- Increased transportation opportunities for those without access to public transportation.
- Naloxone distribution within Emergency Departments, to include peer navigators.
- Expansion of psychiatric Residential Treatment Facility (PRTF).
- Funding to support new and existing Collegiate Recovery Programs across Louisiana.

Prompt 3

Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

OBH will align with traditional and non-traditional partners to enhance outreach and awareness of behavioral health resources available and enhance or expand service delivery options. Together with these partners, OBH has developed a strategic plan to address the identified gaps and unmet service needs. OBH will also provide technical assistance and training to close programmatic and service delivery gaps.

Substance Use Disorders Services

Substance Use Disorder services are provided statewide by each regional human service district/authority, or through the Healthy Louisiana plans for the Medicaid population. OBH partners with local human services districts and authorities to provide treatment for people suffering from drugs, alcohol or gambling, as well as support for their families and friends.

Treatment Program

According to federal regulations, persons identified as indigent or Medicaid eligible are considered priority populations. Priority admission is given to the following populations: pregnant women who inject drugs, other pregnant women who use substances, and others who inject drugs. For these groups, OBH aims to provide substance use services with no or a minimal waiting period. If care is not available to this priority population within 48 hours, interim treatment services are provided, as appropriate.

Below is a listing of levels of care or programs offered for Substance Use Disorders:

Outpatient Care (non-intensive and intensive)

Outpatient services are community based and offers either non-intensive or intensive based levels of services. Non-intensive programs provide professionally-directed screening, assessment, diagnosis,

treatment/counseling, supportive services, and aftercare or rehabilitation services. These services are provided in a community setting and are less than nine hours per week. The client receives treatment services with or without medication, when indicated. In intensive programs, services provided to a client last three or more hours per day for three or more days per week, with a minimum of nine treatment hours per week provided.

Residential Care

These services provide nonemergency residential treatment 24 hours a day, seven days a week and include a planned, professionally-implemented regimen for people suffering from substance use disorders. Individuals at this level of care typically are unable to reach or maintain recovery goals on an outpatient basis and need structure and support in their living situation to be able to get better. Individuals at this level may have multiple deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values. Medical and psychiatric care are provided as warranted. The services range in intensity and the level of services received is based on the level needed; the state uses the American Society of Addiction Medicine (ASAM) classification level.

Residential Care (co-occurring disorder- mental health and substance use)

These services provide residential care 24 hours a day, seven days a week and structured treatment activities including, but not limited to, psychiatric and substance use assessments, diagnosis, treatment, habilitation and rehabilitation services to individuals with co-occurring psychiatric and substance use disorders, whose disorders are of sufficient severity to require a residential level of care.

Residential Care for Pregnant Women and Women with Dependent Children

These programs provide residential treatment services to women and their dependent children up to age 12. Services include assessment, individual, group and family counseling, trauma informed services, drug education, relapse prevention, case coordination and collateral consultations, as well as a continuum of evidenced-based curriculum designed to help get families back to their best individual level of functioning.

Withdrawal management (detox)

These services are available as medically-monitored inpatient withdrawal management (medically supported) or clinically managed residential withdrawal management (social detox) levels of care. Medically-monitored services provide immediate, acute care to substance users at moderate to severe health risk, either because of a co-occurring medical condition or because of a severe medical condition resulting from substance use. Clinically-managed detox services treat clients who need immediate care to treat substance use disorders but do not have any urgent health problems.

Medications for Opioid Use Disorder (MOUD) Treatment Services

These services are offered in community based/office based opioid treatment or Opioid Treatment Program (methadone only) settings for those struggling with opioid use disorder (either alone or combined with use of other substances). These programs offer detoxification, stabilization and/or maintenance via FDA approved medications

Recovery Homes/Oxford Houses Inc.

Oxford House is a self-run, self-supported recovery house program for individuals recovering from substance use disorders. Oxford Houses assure an alcohol- and drug-free living environment. Oxford

House describes a democratically-run, self-supporting and drug-free home environment. The number of residents in a house may range from six to 11; there are houses for men, houses for women, and houses that accept women with children. This community-based approach represents a remarkably effective and low-cost method of preventing relapse. For a list of Oxford Home vacancies, visit https://www.oxfordvacancies.com.

Primary Prevention

OBH partners with local human services districts and authorities to provide prevention services throughout the state to decrease and prevent substance use disorders (including but not limited to opioids and stimulants). OBH Prevention Services provides family-focused, evidence-based, outcome-driven and cost-effective services.

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

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

Although it is important to recognize that not all use is necessarily problematic, for some, experimental use will inevitably escalate to regular or heavy use.

Mental Health Services

To address the unmet needs, the state has developed an implementation strategy utilizing Mental Health Block Grant (MHBG) resources. MHBG is used to support the public sector mental health programs and services, community-based programs, and community awareness and education. The largest portion of the MHBG is allocated to the ten local governing entities (LGEs), which are the state's regional human service authorities that manage the provision of behavioral health and intellectual/developmental disability (IDD) programs and services. The LGEs are responsible for providing mental health services to the indigent population in their catchment areas, to include the uninsured and under-insured. OBH also utilizes MHBG to support various statewide housing resources that target individuals living with serious mental illness who are homeless or at risk of becoming homeless. MHBG funds are also utilized by OBH to support partnerships with various non-profit community-based organizations that provide statewide community awareness, information, and trainings to behavioral health partners and stakeholders.

ESMI/FEP Services

The 10% set-aside for Early Serious Mental Illness (ESMI)/First Episode Psychosis (FEP) is used to support the development and expansion of Coordinated Specialty Care (CSC) programs in various areas of the state, as well as a public health model to inform communities on ESMI and FEP, as well as the benefits to early diagnosis and treatment.

Crisis Services

The 5% set-aside for Crisis Services helps fund Louisiana's statewide comprehensive crisis system of care. This is called the Louisiana Crisis Response System (LA-CRS). In order to support the implementation of the LA-CRS, LDH/OBH is utilizing Mental Health Block Grant funds to provide a contract with Louisiana State University Health Science Center (LSUHSC) School of Public Health, Center for Evidence to Practice with the main goal being to recruit and develop a network of providers that provide crisis services ultimately in a stable, sustainable, all-encompassing system. It will conduct activities critical to implementation of a crisis system including the following activities, which will have a positive impact on all crisis providers, which render services to both the insured and uninsured populations.

Additionally, in the 988 Suicide and Crisis Lifeline network, we have 2 certified Lifeline crisis call centers in Louisiana. With these two centers we have statewide primary and back-up coverage to ensure a high in-state answer rate and to provide referrals to local resources. Trained crisis counselors at these centers respond to calls twenty-four (24) hours per day, seven (7) days per week (24/7) providing telephonic access for crisis intervention, suicide prevention, and information and referral services for Louisiana residents. They also respond to texts and chats from 7pm until 7am 7 days a week. These crisis call centers are available to everyone in Louisiana regardless of insurance status.

Block Grant Priorities

Based on the information in Steps 1 and 2, the Office of Behavioral Health has identified the following priorities for the FY 26-27 Combined Behavioral Health Block Grant Plan:

1. Access to behavioral health services
2. Substance Use Disorder system enhancements
3. Pursuing a culture of wellness and prevention for Louisiana citizens

The following summarizes OBH's Block Grant priorities and the metrics we will use to evaluate progress toward achieving them. Further details for each priority are outlined in the planning tables.

Priority 1: Access to behavioral health services

Louisiana is taking coordinated steps to transform its behavioral health landscape, with a clear focus on early identification, integrated care, and crisis response. Through Priority Area 1, Access to Behavioral Health Services, the state is leading efforts to ensure that individuals across vulnerable populations receive timely, high-quality behavioral health support.

This priority centers on a strong dedication to identifying behavioral health concerns early, with a particular focus on trauma-related issues in Louisiana. Louisiana aims to foster collaboration between

physicians and behavioral health specialists, leveraging integrated care models and crisis response systems to intervene at the earliest possible moment.

The initiative is designed to serve a wide array of populations, including:

- Individuals with Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), and Early Serious Mental Illness (ESMI)
- Pregnant and parenting women with dependent children (PWWDC), persons with HIV or TB, and those with substance use disorders (SUT, SUP, SUR)
- People who inject drugs (PWID) and those needing behavioral health crisis services (BHCS)

To achieve its goal, Louisiana is implementing a multi-pronged strategy:

1. Expand Access to Evidence-Based Therapies for Young Children
   - Increase the number of Medicaid-certified therapists trained in recognized evidence-based practices (EBPs)
   - Partner with the Center for Evidence to Practice to coordinate training and certification
2. Strengthen Peer Support Services
   - Integrate peer support throughout the system of care
   - Expand peer support as a Medicaid-reimbursable service
   - Maintain and grow the number of Recognized Peer Support Specialists (RPSS)
3. Grow and Retain the Behavioral Health Workforce
   - Offer professional development opportunities including trainings, workshops, and continuing education
   - Track and increase participation in workforce development initiatives
4. Implement Crisis Services
   - Continue to implement and expand operations associated with the Louisiana Crisis Response System including Mobile Crisis Response teams, Community Brief Crisis Support programs, Behavioral Health Crisis Care centers, and Crisis Stabilization services
   - Build provider capacity through community coalitions and partnerships

Priority 2: Substance Use Disorder system enhancements

Louisiana is taking action to strengthen its substance use disorder (SUD) system, with a focus on expanding access, improving quality, and tailoring services to meet the needs of its most vulnerable populations. Through Priority Area 2, the state is advancing a comprehensive strategy to address the opioid crisis and broader substance use challenges by enhancing treatment infrastructure, workforce capacity, and early intervention efforts. This initiative reflects Louisiana's commitment to building a responsive and evidence-based behavioral health system that supports individuals at every stage of recovery.

The goal is to increase access to quality SUD services, particularly for populations affected by substance use, including:

- Pregnant and parenting women with dependent children (PWWDC),
- People who inject drugs (PWID), and
- Individuals impacted by HIV and tuberculosis (EIS/HIV, TB).

The state's objective is to improve the quality and expand the availability of SUD care, ensuring that services are not only accessible but also tailored to the complex needs of these groups. To achieve this, Louisiana is implementing a versatile approach that includes:

1. Expand Access to Medications for Opioid Use Disorder (MOUD)
    - Enhance MOUD services to ensure timely and effective treatment for individuals with opioid use disorder (OUD)
    - Track the number of individuals receiving MOUD, with annual targets to maintain or increase service reach
2. Strengthen Treatment Services for Pregnant and Parenting Women (PPW)
    - Expand treatment capacity for pregnant women, including residential programs for those at risk of Neonatal Opiate Withdrawal Syndrome (NOWS)
    - Develop specialized residential treatment programs designed for pregnant women and their children
    - Evaluate the number of licensed facilities offering residential treatment for PPW
3. Increase Use of Screening and Early Intervention Tools
    - Promote Screening, Brief Intervention, and Referral to Treatment (SBIRT), especially among pregnant women
    - Integrate SBIRT into routine care to identify behavioral health concerns early
4. Build and Equip the OUD Workforce
    - Offer statewide training programs through the Louisiana State Opioid Response (LaSOR)
    - Monitor and grow participation among providers and community members to strengthen capacity to address OUD

Priority 3: Pursuing a culture of wellness and prevention for Louisiana citizens

Louisiana is advancing a proactive vision for behavioral health by prioritizing prevention, wellness, and early intervention. Through Priority Area 3, the state is working to delay the onset and progression of behavioral health disorders by equipping individuals and communities with the knowledge, tools, and support they need to thrive.

A central focus of this priority is executing statewide prevention efforts that promote overall wellness and reduce risk factors for behavioral health conditions. Louisiana is investing in evidence-based programs and public awareness initiatives that empower citizens, especially youth, to make informed, healthy choices.

This initiative is designed to serve a broad spectrum of vulnerable groups, including:

- Adults with Serious Mental Illness (SMI), Children with Serious Emotional Disturbance (SED), and Individuals with Early Serious Mental Illness (ESMI) including psychosis
- People in need of Behavioral Health Crisis Services (BHCS)
- Pregnant women and women with dependent children (PWWDC)
- Persons with HIV or tuberculosis (EIS/HIV, TB)
- People who inject drugs (PWID)
- Persons in need of primary substance use disorder prevention (PP)

To accomplish its prevention and wellness goals, Louisiana is implementing three key strategies:

1. Expand School-Based Prevention Programs
    - Deliver evidence-based prevention curricula in partnership with the Louisiana Department of Education
    - Reach students across the state with non-duplicated, high-impact programming
2. Enhance Suicide Prevention Education
    - Provide suicide prevention and awareness trainings to schools, communities, and professionals
3. Promote Use of the 988 Crisis Helpline
    - Increase public awareness of the 988 helpline through outreach and education
    - Encourage help-seeking behavior by normalizing access to crisis support

Further details of implementation can be found throughout the Combined MHBG/SUPTRS BG Application, Behavioral Health Assessment and Plan, particularly in Strengths section of Strengths and Needs and the following Environmental Factors: MH Criterion, Primary Prevention, SUD Treatment, Recovery, Crisis Services, and Support of State Partners.

Planning Tables

Plan Table 1: Priority Area and Annual Performance Indicators

States are required to complete a separate table for each state priority area to be included in the MHBG and SUPTRS BG. Please include the following information:

1. Priority area (based on an unmet service need or critical gap).
2. Priority type (SUP– substance use primary prevention, SUT– substance use disorder treatment, SUR – substance use disorder recovery support, MHS– mental health service, ESMI – early serious mental illness, or BHCS – behavioral health crisis services.)
3. Targeted/required populations – indicate the population from the following:
    a) SMI–Adults with SMI
    b) SED–Children with an SED
    c) ESMI—Individuals with ESMI including psychosis
    d) BHCS- Individuals in need of behavioral health crisis services,
    e) PWWDC- Pregnant women and women with dependent children who are receiving SUD treatment services,
    f) PP—Persons in need of primary substance use disorder prevention
    g) PWID—Persons who inject drugs, formerly known as intravenous drug users (IVDUs)
    h) EIS (Early Intervention Services)/HIV–Persons with or at risk of HIV/AIDS, who are receiving SUD treatment services
    i) TB–Persons with or at risk of tuberculosis who are receiving SUD treatment services
    j) Other: Specify
4. Goal of the priority area. Goal is a broad statement of general intention. Therefore, provide a general description of what the state hopes to accomplish.
5. Objective: Objective should be a concrete, precise, and measurable statement.
6. Strategies to attain the objective. Indicate state program strategies or means to reach the stated goal.
7. Annual Performance Indicators to measure success on a yearly basis. Each indicator must reflect progress on a measure that is impacted by the block grant. For each performance indicator, specify the following components:
    a) Baseline measurement from where the state assesses progress;
    b) First-year target/outcome measurement (Progress to the end of SFY 2024;
    c) Second-year target/outcome measurement (Final to the end of SFY 2025;
    d) Data source;
    e) Description of data; and
    f) Data issues/caveats that affect outcome measures.

Priority Area 1	**Access to Behavioral Health Services**
Priority Type	SUT, SUP, SUR, MHS, ESMI, BHCS
Population(s)	SMI, SED, ESMI, BHCS, PWWDC, PP, PWID, EIS/HIV, TB

Goal of the Priority Area	Lead efforts to increase access to behavioral health services by promoting early identification of behavioral health concerns, especially through leveraging integration and crisis response to help physicians and behavioral health specialists collaborate to identify and treat behavioral health concerns (inclusive of trauma exposure) at the earliest opportunity.
Objective	Increase access to behavioral health services, including mobile and center-based crisis services.
Strategies to attain the objective	1. Increase access to high-quality evidence-based behavioral therapies for young children 2. Integrate Peer Support throughout the system of care 3. Expand and enhance Peer Support Services, to include the addition of Peer Support Services as a Medicaid Reimbursable Service 4. Retain and increase the behavioral health workforce 5. Develop and implement Medicaid-funded Mobile Crisis services (including Mobile Crisis Team services and Community Brief Crisis Support services, 24 hour crisis walk in centers and crisis stabilization providers).
Indicator #1	Access to high-quality evidence-based behavioral therapies for young children
Baseline Measurement	Number of therapists serving Medicaid youth who are trained and certified in each OBH/Medicaid-recognized EBP model in SFY 20
First Year Target/Outcome Measurement	Maintain or increase number of therapists serving Medicaid youth who are trained and certified in each OBH/Medicaid-recognized EBP model for SFY 26
Second Year Target/Outcome Measurement	Maintain or increase number of therapists serving Medicaid youth who are trained and certified in each OBH/Medicaid-recognized EBP model in SFY 27
Data Source	Provider data: Center for Evidence to Practice reporting and MCO data on credentialed providers in MCO provider networks.
Description of Data	Center for Evidence to Practice (OBH/Medicaid funding, housed at LSU) is in place to coordinate and sponsor trainings for providers in EBPs. We will report the number of therapists serving Medicaid youth who are trained and certified in each OBH/Medicaid-recognized EBP model.
Data Issues/Caveats	
Indicator #2	Access to Qualified Peer Support Specialists
Baseline Measurement	Number of peers trained and recognized for SFY 24
First Year Target/Outcome Measurement	Maintain or increase the total number of peers trained and recognized for SFY 26
Second Year Target/Outcome Measurement	Maintain or increase the total number of peers trained and recognized for SFY 27
Data Source	Training Records and Annual Recognition Renewal Records

Description of Data	Number of Peers successfully completing training and maintaining their status as a Recognized Peer Support Specialist (RPSS).
Data Issues/Caveats	
Indicator #3	Behavioral Health Workforce Development
Baseline Measurement	Number of behavioral health professional development opportunities held in SFY 23
First Year Target/Outcome Measurement	Maintain or increase the number of behavioral health professional development opportunities held in SFY 26
Second Year Target/Outcome Measurement	Maintain or increase the number of behavioral health professional development opportunities held in SFY 27
Data Source	Behavioral health professional development opportunities available through sponsored, funded or hosted opportunities by LDH, inclusive of LDH contractors such as the Medicaid Managed Care entities. (MCO, OBH, LaSOR data)
Description of Data	Professional development opportunities used to educate and instruct the behavioral health workforce to assist them in acquiring, developing and enhancing their knowledge and skill on topics relevant to the behavioral health profession. Behavioral health professional development opportunities include but are not limited to provider trainings, continuing education, seminars, workshops and conferences. The number of behavioral health professional development trainings will be tracked.
Data Issues/Caveats	The number of behavioral health professional development opportunities include peer support, suicide prevention and SUD training counts that may also be reflected in other indicators throughout the priority table. Therefore, there may be duplication in these counts.
Indicator #4	Behavioral Health Crisis Providers
Baseline Measurement	Number of behavioral health crisis providers for adults and youth (i.e., MCR, CBCS, BHCC and CS providers) enrolled in SFY 22
First Year Target/Outcome Measurement	Sustain or increase the number of behavioral health crisis providers for adults and youth enrolled in SFY 24
Second Year Target/Outcome Measurement	Sustain or increase the number of behavioral health crisis providers adults and youth enrolled in SFY 25
Data Source	Medicaid Data Warehouse; Managed Care Organization (MCO) Provider Enrollment data

Description of Data	The number of behavioral health crisis providers enrolled in the Medicaid program to deliver crisis services for adults and youth. These crisis services include Mobile Crisis Response (MCR), Community Brief Crisis Support (CBCS), Behavioral Health Crisis Centers (BHCC), and Crisis Stabilization (CS).
Data Issues/Caveats	Provider development and implementation is driven by community coalitions and partnerships. During this time, OBH facilitated multiple meetings (local and statewide) to garner community interest and worked with its partners through LSU-HSC to develop a guide for providers to develop community coalitions. Expectations related to coalition development were conveyed in meetings with providers.

Priority Area 2	**Substance Use Disorder System Enhancements**
Priority Type	SUT, SUP, SUR
Population(s)	PWWDC, PWID, EIS/HIV, TB
Goal of the Priority Area	Increase access to quality SUD services
Objective	To improve quality and expand access to SUD care
Strategies to attain the objective	Enhance Medication for Opioid Use Disorders (MOUD) services, treatment capacity for pregnant women, increased use of early Screening, Brief Interventions and Referral to Treatment (SBIRT), including pregnant women, and development of residential treatment programs for pregnant women and children at risk of Neonatal Opiate Withdrawal Syndrome (NOWs)
Indicator #1	Medication for Opioid Use Disorder (MOUD)
Baseline Measurement	The number of individuals with OUD receiving MOUD in SFY 25
First Year Target/Outcome Measurement	Maintain or increase the number of individuals with OUD receiving MOUD in SFY 26
Second Year Target/Outcome Measurement	Maintain or increase the number of individuals with OUD receiving MOUD in SFY 27
Data Source	Medicaid Claims
Description of Data	The number of individuals with OUD receiving MOUD
Data Issues/Caveats	
Indicator #2	Opioid Use Disorder (OUD) Workforce Development
Baseline Measurement	Number of individuals that attend trainings related to opioid use disorder for FFY 24

First Year Target/Outcome Measurement	Maintain or increase the number of individuals trained on OUD for FFY 26
Second Year Target/Outcome Measurement	Maintain or increase the number of individuals trained on OUD for FFY 27
Data Source	LaSOR Data Hub
Description of Data	The Louisiana State Opioid Response (LaSOR) Program provides trainings statewide to the behavioral health workforce and community at large to assist them in acquiring, developing and enhancing their knowledge, skills, and attitudes on topics related to opioid use disorder (OUD) prevention, treatment, harm reduction, and recovery support services. OUD training opportunities include but are not limited to provider trainings, continuing education, seminars, workshops and conferences. The number of individuals trained is tracked through the LaSOR Data Hub.
Data Issues/Caveats	Funding for these trainings is provided by LaSOR, which is dependent on federal allocations. Outcomes are based on the federal fiscal year. Participation in these trainings is voluntary.
Indicator #3	Pregnant and Parenting Women (PPW)
Baseline Measurement	Number of residential treatment programs for pregnant and parenting women (PPW) for SFY24
First Year Target/Outcome Measurement	Maintain or increase the number of PPW facilities SFY26
Second Year Target/Outcome Measurement	Maintain or increase the number of PPW facilities SFY27
Data Source	Licensing data from Health Standards
Description of Data	Number of substance use disorder (SUD) facilities licensed to provide residential treatment services specific to the needs of pregnant and parenting women.
Data Issues/Caveats	

Priority Area 3	**Pursuing a culture of prevention and wellness for Louisiana citizens**
Priority Type	SUP, MHS, BHCS, ESMI
Population(s)	SMI, SED, ESMI, BHCS, PWWDC, PP, PWID, EIS/HIV, TB
Goal of the Priority Area	Ensure that effective and efficient prevention services are provided statewide to promote overall wellness and to delay the initiation and progression of behavioral health disorders by increasing knowledge, awareness, and healthy behaviors
Objective	OBH will continue to provide evidence-based prevention programs in school based settings and suicide prevention awareness trainings.

Strategies to attain the objective	1. Implement evidence-based prevention programs in school-based settings through a partnership with the Department of Education 2. Continue to provide Suicide Prevention education and awareness activities 3. Continue to provide training, education and awareness of the new 988 Helpline.
Indicator #1	Primary Prevention Evidence Based Practices
Baseline Measurement	Number of individuals receiving EBPs for Primary Prevention in SFY 25
First Year Target/Outcome Measurement	Maintain or increase the number of individuals receiving EBPs for Primary Prevention in SFY 26
Second Year Target/Outcome Measurement	Maintain or increase the number of individuals receiving EBPs for Primary Prevention in SFY 27
Data Source	Prevention Management Information System (PMIS)
Description of Data	The numbers are reflective of our school based curricula. The numbers reported are non-duplicated and represent the total number of students who have been enrolled in an evidence-based prevention program funded by the SUPTRS Block Grant.
Data Issues/Caveats	The Prevention Management Information System (PMIS) will continue to capture the number of individuals receiving EBPs. Implementation of EBPs is contingent on 20% Prevention Set Aside from the SUPTRS Block Grant.
Indicator #2	Suicide Prevention and Awareness Trainings
Baseline Measurement	Number of suicide prevention and awareness trainings in SFY 25
First Year Target/Outcome Measurement	Maintain or increase the number of suicide prevention and awareness trainings in SFY 26
Second Year Target/Outcome Measurement	Maintain or increase the number of suicide prevention and awareness trainings in SFY 27
Data Source	Suicide Prevention and Awareness Training Tracking Form
Description of Data	Number of suicide prevention and awareness trainings
Data Issues/Caveats	It is a voluntary reporting system for all non-OBH employees.
Indicator #3	Number of calls to 988 originating in Louisiana
Baseline Measurement	Baseline is 36,774 988 calls which is the average number of calls over two calendar years (2023 and 2024).
First Year Target/Outcome Measurement	Increase the number of Louisiana callers using the three-digit 988 helpline number by 2% each year.

Second Year Target/Outcome Measurement	Maintain or increase the number of Louisiana callers using the three digit 988 helpline number by 2% each year.
Data Source	Data will be provided by Vibrant Emotional Health.
Description of Data	Number of calls originating in Louisiana.
Data Issues/Caveats	Increasing the number of calls will be contingent on resources allocated towards marketing efforts.

*Suicide prevention and awareness trainings are funded by MHBG dollars.

Plan Table 2. State Agency Budget for State Fiscal Years 2026-2027

Activity	A. SUPTRS BG	B. MHBG	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	J. BSCA Funds[a]
1. Substance Use Disorder Prevention[a] and Treatment	$ 30,215,387		$ 449,306,576	$ 37,725,526	$ 49,073,764		$1,359,864	
a. Pregnant Women and Women with Dependent Children (PWWDC)[b]	$ 9,478,423						$1,359,864	
b. All other	$ 20,736,964		$ 449,306,576	$ 37,725,526	$49,073,764			
2. Recovery Support Services[c]	$ 545,122			$ 699,446				
3. Primary Prevention[d]	$ 10,250,630			$ 2,500,000				
4. Early Intervention Services for HIV[e]	$ 2,562,658							
5.Tuberculosis								
6. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total MHBG award)[b]		$ 2,467,525						$500,000
7.State Hospital			$ 280,538,168		$ 221,676,124		$14,601,620	
8.Other Psychiatric Inpatient Care			$ 535,052,954		$ 163,572,696			
9.Other 24 Hr Care (Residential Care			$ 5,039,418	$	$ 25,935,076			
10. Ambulatory/Community Non-24 Hour Care		$15,770,589	$811,610,388	$12,534,860	$183,201,935		$ 19,248,192	
11. Crisis Services (5 % set-aside)[c]		$ 1,233,762	$ 7,347,490					$1,506,264
12. Other Capacity Building/Systems Development[f]	$ 5,116,696	$3,969,609		$ 1,851,112				
10. Administration[g]	$ 2,562,658	$1,233,762		$2,515,858				
12. Total	**$ 51,253,150**	**$ 24,675,248**	**$2,088,894,994**	**$ 57,826,802**	**$ 643,459,595**	**$**	**$ 35,209,676**	**$2,006,264**

Plan Table 2 for SUPTRS BG:

[a] Prevention other than primary prevention.

[b] Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women's Maintenance of Effort (MOE) over the two-year planning period.

[c] This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only plan RSS for those in need of RSS from substance use disorder.

[d] Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

[e] The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[f] Other Capacity Building/Systems development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**

[g] Per **45 CFR § 96.135** Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

Plan Table 2 for MHBG:

[a]The expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

[b]Row 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c]Row 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d]Per statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

Plan Table 3. SUPTRS BG Persons in need/receipt of SUD Treatment

	Aggregate Number Estimated in Need	Aggregate Number in Treatment
Pregnant Women	44,765	116
Women with Dependent Children	N/A	1,589
Individuals with a co-occurring M/SUD	305,000	10,070
Persons who inject drugs	11,669	1,211
Persons experiencing homelessness	3,169	1,351

- Aggregate Number Estimated ***in Need***: most of the estimated counts are based on *2023 LA NSDUH Table (except Person who inject drugs)*. Count for *Person who inject drugs* was calculated by methodology used in Step 2 Needs Assessment.
- Aggregate Number Estimated ***in Treatment***: All Measures from Louisiana OBH Data Warehouse (submitted to TEDS) for FY 2023.

Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is unable to estimate the need or number in treatment, please provide an explanation for why these estimates could not be drawn.

	Aggregate Number Estimated in Need (A)	**Aggregate Number in Treatment** (B)
Pregnant Women	https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/state-releases/2022-2023 *2023 LA NSDUH Table 8.27B:* Percentage of Pregnant in past month illicit drug use (4.9%) among 913,568 Female aged 15-44 in Louisiana in 2023.	LA TEDS
Women with Dependent Children	N/A (No survey question re: Women with Dependent Children was included in 2022-2023 LA NSDUH Survey, or listed in other federal/state data tables/reports).	LA TEDS
Individuals with a co-occurring M/SUD	https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/state-releases/2022-2023 *2023 LA NSDUH Table 47B (*Annual average number in 18+ Age group)	LA TEDS
Persons who inject drugs	Calculated by methodology used in Step 2 Needs Assessment	LA TEDS
Persons experiencing homelessness	https://files.hudexchange.info/reports/published/CoC_PopSub_State_LA_2023.pdf	LA TEDS

Plan Table 4. SUPTRS BG Planned Award Budget by Federal Fiscal Year

Budget Category	FFY 2026 SUPTRS Block Grant Award	FFY 2027 SUPTRS Block Grant Award
1. Substance Use Prevention[a] and Treatment	$ 15,107,694	$
2.Recovery Support Services[b]	$ 272,561	
2. Primary Substance Use Prevention[c]	$ 5,125,315	$
3. Early Intervention Services for HIV[d]	$ 1,281,329	$
4. Tuberculosis Services	$	$
5. Other Capacity Building/Systems Development[e]	$ 2,558,348	$
6. Administration[f]	$ 1,281,328	
7. Total	**$ 25,626,575**	**$**

a Prevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

bThis expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

cThis row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

dThe most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

eOther Capacity Building/System Development include those activities relating to substance use per 45 CFR §96.122 (f)(1)(v). The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

fPer 45 CFR §96.135 Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

Plan Table 4. MHBG State Agency Planned Budget

MHBG- Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	
1b. Crisis Services for Adults	$1,211,176
1c. CSC/ESMI program for Adults	$2,134,065
1d. Other outpatient/ambulatory services for Adults	$11,480,908
1e. *Other Direct Services for Adults	$1,639,671
2. Subtotal of Services for Adults	$16,465,820
3. Services for Children	
3a. EBPs for Children	
3b. Crisis Services for Children	$22,587
3c. CSC/ESMI program for Children	$333,460
3d. Other outpatient/ambulatory services for Children	$2,628,476
3e. *Other Direct Services for Children	$21,534
4. Subtotal of Services for Children	$3,006,057
5. Other Capacity Building/Systems Development[a]	$3,969,609
6. Administrative Costs[b]	$1,233,762
7. *Any Other Cost	
8. Total MHBG Allocation[c]	**$24,675,248**

[a] This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6
[b] Administrative Costs should not exceed 5 percent of total MHBG allocation
[c] The total budget should be equal to your MHBG allocation for the next two years.

Please provide brief explanation for services with an asterisk* below:

1e: Includes three positions: a Behavioral Health Services Coordinator, Social Worker, and an APRN Prescriber; costs for a Mental Health Court and the 2025 Behavioral Health Symposium.

3e: Behavioral Health Services Coordinator

Plan Table 5a. Primary Prevention Planned Expenditures

The state's primary prevention program must include, but is not limited to, the six primary prevention strategies defined below. On Table 5a below, Louisiana lists the FFY 2022 and FFY 2023 SUPTRS BG planned expenditures for each of the six primary prevention strategies plus Synar. Expenditures within each of the six strategies should be directly associated with the cost of completing the activity or task; for example, information dissemination should include the cost of developing pamphlets, the time of participating staff or the cost of public service announcements, etc. If the state plans to use strategies not covered by these six categories, they will be reported under "Other" in Table 5a.

In most cases, the total amounts should equal the amount reported on plan Table 4, row 2, Primary Prevention. The one exception is if the state chooses to use a portion of the primary prevention set-aside to fund Non-Direct Services/System Development activities. Planned expenditures for Non-Direct Services/System Development activities should not be included in Table 5a.

If the state chooses to report activities utilizing the Institute of Medicine (IOM) Model of Universal, Selective, and Indicated; complete Form 5b. If Form 5b is completed, the state must also complete Section 1926 –Tobacco on Form 5a.

Information Dissemination– This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two.

Education - This strategy builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental abilities. There is more interaction between facilitators and participants than in the information strategy.

Alternatives - This strategy provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with healthy activities and to discourage the use of alcohol and drugs through these activities.

Problem Identification and Referral - This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.

Community-based Process - This strategy provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning.

Environmental - This strategy establishes or changes written and unwritten community standards, codes, and attitudes; thereby, influencing alcohol and other drug use by the general population.

Other - The six primary prevention strategies have been designed to encompass nearly all of the prevention activities. However, in the unusual case an activity does not fit one of the six strategies, it may be classified in the "Other" category.

Section 1926 – Tobacco - Costs Associated with the Synar Program. Per January 19, 1996, 45 CFR Part 96 Tobacco Regulation for Substance Use Prevention, Treatment and Recovery Services Block Grants; Final Rule (45 CFR § 96.130), states may not use the Block Grant to fund the enforcement of their statute, except that they may expend funds from their primary prevention set aside of their Block Grant allotment under 45 CFR § 96.124(b)(1) for carrying out the administrative aspects of the requirements such as the development of the sample design and the conducting of the inspections.

In addition, prevention strategies may be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by the population targeted. Definitions for these categories appear below:

Universal: Activities targeted to the public or a whole population group that has not been identified based on individual risk.

Selective: Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

Indicated: Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not meeting diagnostic levels (Adapted from The Institute of Medicine).

States that are able to report on both the strategy type and the population served (universal, selective, or indicated) should do so. If planned expenditure information is only available by strategy type, then the state should report planned expenditures in the row titled Unspecified (for example, Information Dissemination, Unspecified).

Strategy	IOM Target	FFY 2026 SUPTRS Block Grant Award	FFY 2027 SUPTRS Block Grant Award
1. Information	Universal	$ 512,532	$
	Selective	$	$
	Indicated	$	$
	Unspecified		
2. Education	Universal	$ 2,339,989	$
	Selective	$ 135,810	$
	Indicated	$ 12,125	$
	Unspecified		
3. Alternatives	Universal	$ 512,532	$
	Selective	$	$
	Indicated	$	$
	Unspecified		
4. Problem Identification	Universal	$ 512,532	$
	Selective	$	$
	Indicated	$	$
	Unspecified		
5. Community-Based	Universal	$ 600,000	$
	Selective	$	$
	Indicated	$	$
	Unspecified		
6. Environmental	Universal	$ 102,464	$
	Selective	$	$
	Indicated	$	$
	Unspecified		
7. Section 1926-Tobacco	Universal	$ 397,331	$
	Selective	$	$
	Indicated	$	$
	Unspecified	$	$
8. Other	Universal	$	$
	Selected	$	$
	Indicated	$	$
	Unspecified	$	$
9. Total Prevention		$ **5,125,315**	$
Total SUPTRS BG Award		$ 25,626,575	$
Planned Primary		20.00%	0.00%

* The Primary Prevention planned expenditures amount on Table 5a does not match the Table 4 amount because the state uses a portion of the primary prevention set-aside to fund Non-Direct Services/System Development activities. Therefore, planned expenditures for Other Capacity Building/Systems Development are not included on Table 5a figures.

Plan Table 5b. SUPTRS BG Primary Prevention Planned Budget by IOM Category

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Activity	FFY 2026 SUPTRS Block Grant Award	FFY 2027 SUPTRS Block Grant Award
Universal Direct	$ 2,339,989	$
Universal Indirect	$ 2,637,391	$
Selective	$ 135,810	$
Indicated	$ 12,125	$
Column Total	$ 5,125,315*	$
Total SUPTRS BG Award	$25,626,575	$
Planned Primary Prevention Percentage*	20.00 %	%

*Does not reflect Non-Direct Services/System Development activities

Plan Table 5c. SUPTRS BG Planned Primary Prevention Priorities

The following tables identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 SUPTRS BG award.

	SUPTRS BG
Alcohol	☒
Tobacco	☒
Cannabis/Cannabinoids	☒
Prescription Medications	☒
Cocaine	☒
Heroin	☒
Inhalants	☒
Methamphetamine	☒
Fentanyl or Other Synthetic Opioids	☒
Other	☐

Targeted Populations*	
	SUPTRS BG
Students in College	☒
Military Families	☒
American Indians/Alaska Natives	☒
African American	☒
Hispanic	☒
Persons Experiencing Homelessness	☐
Native Hawaiian/Other Pacific Islanders	☒
Asian	☒
Rural	☒

*Louisiana serves all populations in Table 5C through its primary prevention programs and services. While all populations identified in Table 5C are reached, these populations are not intentionally targeted as primary prevention services are implemented universally. Demographic data is collected on all individuals served.

Plan Table 6. Other Capacity Building/Systems Development

Expenditures for these activities may be direct expenditures (involving the time of state or sub-state personnel, or other state or sub-state resources) or be through funding mechanisms with independent organizations. Expenditures may come from the administrative funds and/or program funds (but may not include the HIV set-aside funds). These include state, regional, and local personnel salaries prorated for time spent and operating costs such as travel, printing, advertising, and conducting meetings related to the categories below.

Non-direct services/system development activities *exclude* expenditures through funding mechanisms for providing treatment or mental health "direct service" and primary prevention efforts themselves. Instead, these expenditures provide support to those activities.

The following categories are used to describe the types of expenditures supported with Block Grant funds, and if the preponderance of the activity fits within a category.

Information systems – This includes collecting and analyzing treatment data as well as prevention data under the SUPTRS BG in order to monitor performance and outcomes. Costs for EHRs and other health information technology also fall under this category.

Infrastructure Support – This includes activities that provide the infrastructure to support services but for which there are no individual services delivered. Examples include the development and maintenance of a crisis-response capacity, including hotlines, mobile crisis teams, web-based check-in groups (for medication, treatment, and re-entry follow-up), drop-in centers, and respite services.

Partnerships, community outreach, and needs assessment – This includes state, regional, and local personnel salaries prorated for time and materials to support planning meetings, information collection, analysis, and travel. It also includes the support for partnerships across state and local agencies, and tribal governments. Community/network development activities, such as marketing, communication, and public education, and including the planning and coordination of services, fall into this category, as do needs-assessment projects to identify the scope and magnitude of the problem, resources available, gaps in services, and strategies to close those gaps.

Planning Council Activities – This includes those supports for the performance of a Mental Health Planning Council under the MHBG, a combined Behavioral Health Planning Council, or (OPTIONAL) Advisory Council for the SUPTRS BG.

Quality assurance and improvement – This includes activities to improve the overall quality of services, including those activities to assure conformity to acceptable professional standards, adaptation and review of implementation of evidence-based practices, identification of areas of technical assistance related to quality outcomes, including feedback. Administrative agency contracts to monitor service-provider quality fall into this category, as do independent peer- review activities.

Research and evaluation – This includes performance measurement, evaluation, and research, such as services research and demonstration projects to test feasibility and effectiveness of a new approach as well as the dissemination of such information.

Training and education – This includes skill development and continuing education for personnel employed in local programs as well as partnering agencies, as long as the training relates to either substance use disorder service delivery (prevention, treatment and recovery) for SUPTRS BG and services

to adults with SMI or children with SED for MHBG. Typical costs include course fees, tuition, and expense reimbursements to employees, trainer(s) and support staff salaries, and certification expenditures.

MHBG Plan Table 6 addresses MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a **24-month period**. Please document the planned uses of BSCA funds in the footnotes section.

SUPTRS BG Plan Table 6 Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a **single Federal Fiscal Year (FFY)**, specified in the table below.

The planned expenditures indicate Other Capacity Building/Systems Development for the FFY 2026 and 2027 Block Grant award.

Activity	MHBG	SUPTRS BG Treatment	SUPTRS BG Recovery Support	SUPTRS BG Prevention*
1. Information Systems	$643,163			
a. SSA		$16,363		$15,000
b. Subrecipient		$515,876		
2. Infrastructure Support	$291,348			
a. SSA				
b. Subrecipient		$28,533		
3. Partnerships, community outreach, needs assessment	$660,000			
a. SSA		$10,000		$513,430
b. Subrecipient		$5,000		$641,835
4. Planning Council activities	$325,000			
a. SSA				
b. Subrecipient		$2,500		
5. Quality assurance and improvement	$829,654			
a. SSA				
b. Subrecipient		$348,475		
6. Research and evaluation				
a. SSA		$98,000		
b. Subrecipient				$11,000
7. Training and education	$1,220,444			
a. SSA		$40,000		$205,836
b. Subrecipient		$30,500		$76,000

Total	**$ 3,969,609**	**$1,095,247**	**$**	**$1,463,101**

* $ of the total SUPTRS BG Primary Prevention funds are planned to be used for Non-direct Prevention and are not included in the amounts listed in Tables 5a and 5b.

* The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

* The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states]. (Not included on this table, as no BSCA funds will be used for *Other Capacity Building/Systems Development*.)

Environmental Factors

1. Access to Care, Integration, and Care Coordination- Required

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral health needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: The Essential Aspects of Parity: A Training Tool for Policymakers; Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions. Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in an efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness, who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness (SMI)
b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)
c) Pregnant women with substance use disorders
d) Women with substance use disorders who have dependent children
e) Persons who inject drugs
f) Persons with substance use disorders who have, or are at risk for, HIV or TB
g) Persons with substance use disorders in the justice system
h) Persons using substances who are at risk for overdose or suicide
i) Other adults with substance use disorders
j) Children and youth with serious emotional disturbances (SED) or substance use disorders
k) Children and youth with SED and a co-occurring I/DD
l) Individuals with co-occurring mental and substance use disorders

OBH serves as subject matter experts for all specialized behavioral health services in the Medicaid program. OBH works closely with the state Medicaid agency for monitoring of the managed care organizations (MCOs), including provider network requirements and standards for access to care.

The MCOs are engaged in activities to develop the network of substance use providers and Psychiatric Residential Treatment Facilities (PRTFs) independently and collaboratively by conducting exhaustive searches for providers to enhance the network; comparison of competitors' networks, especially those with other lines of business; and reaching out to current providers and hospitals within the state to identify existing providers willing to expand services, levels of care or open new locations. Discussions are initiated with out-of-state providers in which MCOs enter into single case agreements, when there are no available providers to discuss opportunities in Louisiana to increase access or expand opportunities in Louisiana to increase access. Discussions focus on barriers to providing care, current levels of care provided, expanding levels of care/populations served, and opportunities to open new locations. The MCOs often offer enhanced rates to expand current services and foundational payments to open new locations.

One MCO continues to promote the use of the Providers Clinical Support System (PCSS) free online training that trains health professionals to provide MAT to patients with OUD in primary care, psychiatric care, substance use disorder treatment, and pain management settings. In addition, they are actively coordinating not only with behavioral health prescribers for MAT services, but also Primary Care Physicians (PCPs) to expand this service.

Four new crisis services for adults were added to the Medicaid array of covered services in 2022. Mobile Crisis Response (MCR), Community Brief Crisis Support (CBCS), Behavioral Health Crisis Care (BHCC), and Crisis Stabilization are available regionally through a network of providers partnering with the MCOs and OBH. In early 2024, MCR and BHCC moved to 24/7 availability for adults. In the summer of 2024, a network of providers offering MCR and CBCS 24/7 to youth was also implemented. The system matured further in May 2025 with the implementation of the Louisiana Crisis Hub, a 24/7 call center and website serving as the primary access point for Louisiana's crisis services.

Other recent changes to improve access to Medicaid services include expanding the provider agency types eligible to provide peer support services and expanding practitioner types eligible to provide for mental

health therapeutic services. To align with recently updated federal standards, OBH also coordinated with LDH's Health Standards Section and Medicaid to amend the provisions governing opioid treatment programs in order to remove outdated eligibility criteria, expand the types of practitioners eligible to provide services, adjust the provisions related to take-home doses of medication, and include provisions for mobile dosing units.

OBH also works closely with the local human service districts or authorities, or local governing entities (LGEs). The ten LGEs have local accountability and management of behavioral health, intellectual disability, and developmental disability services, as well as any public health or other services contracted to the district or authority by the department. LGEs ensure that behavioral health services are available statewide, regardless of insurance status or payor source. LGE legislative mandates include, but are not limited to, the following:

- Perform the functions which provide community-based services and continuity of care for the prevention, detection, treatment, rehabilitation, and follow-up care of mental and emotional illness;
- Perform community-based functions for the care, diagnosis, training, treatment, and education related to substance-related and addictive disorders, including but not limited to alcohol, drug abuse, or gambling;
- Perform community-based functions which provide services and continuity of care for education, prevention, detection, treatment, rehabilitation, and follow-up care relating to personal health, as determined to be feasible by the department; and
- Provide state-funded services to meet the needs of the individuals in their statutory governance area.

OBH received a Certified Community Behavioral Health Clinic (CCBHC) state planning grant to develop and implement a state-specific certification program for CCBHCs, establish Prospective Payment Systems (PPS) for Medicaid reimbursable behavioral health services, and prepare an application to participate in a four-year CCBHC Demonstration program. CCBHCs ensure access to integrated, evidence-based substance use disorder and mental health services, including 24/7 crisis response and medication-assisted treatment (MAT), and ensure that no individuals are denied access to services due to an inability to pay.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

The Louisiana Department of Insurance (LDI) performs state regulatory and oversight functions with respect to MHPAEA, and will refer matters to CMS for possible enforcement. LDH performs regulatory and oversight functions for the Medicaid program and services only. Information on Medicaid compliance can be found at https://ldh.la.gov/page/2809.

LDH's comprehensive parity analysis on the Medicaid program was completed and published in 2017, and most recently updated in 2021. LDH reviewed the MH/SUD and M/S benefits provided through both its FFS and managed care coverage systems to ensure the full scope of services available to all individuals enrolled in Medicaid complies with parity. As described in the analysis report, "[i]f MH/SUD services for beneficiaries are provided through a combination of MCOs, PIHPs and the state, the state has the responsibility of undertaking the parity analysis within the plans and across delivery systems. While the

managed care plans were required to provide information about limitations imposed by the health plan for each benefit package and classification as well as complete surveys designed to elicit assurances to ensure parity and compliance with applicable requirements, because of the multiple delivery systems, LDH is ultimately responsible for performing the parity analysis.

OBH is lead on the parity compliance activities for LDH and the Medicaid program. OBH implemented various monitoring procedures to ensure ongoing compliance with parity, including that non-quantitative treatment limitations (NQTLs), such as prior authorization, network admission standards or documentation requirements, for MH/SUD benefits are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the classification.

3. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

OBH was created by Act 384 of the 2009 Legislative Session, which directed the consolidation of the offices of addictive disorders and mental health into the Office of Behavioral Health effective July 1, 2010, in order to streamline services and better address the needs of the people with co-occurring mental illness and addictive and substance use disorders. LDH's work in implementing Act 384 was guided by stakeholders and leaders in the behavioral health field from across Louisiana who sat on the department's Office of Behavioral Health Implementation Advisory Committee.

Currently, OBH has an integrated organizational chart and does not distinguish between addictive and substance use disorder and mental health staff, resources, or state general fund mechanisms. LGEs as Medicaid and non-Medicaid providers provide services in an integrated manner for both mental health and addictive and substance use disorders, as do the Medicaid managed care organizations. Licensing standards and operations of mental health and substance use providers are integrated under one integrated behavioral health services provider license.

a. Please describe how this system differs for youth and adults

The CSoC program offers specialized services and support through Wraparound to children ages 5 through 20, who are referred to and/or enrolled in the CSoC Program. In addition to the full array of Medicaid benefits, waiver services for CSoC youth currently include Youth Support and Training (YST), Parent Support and Training (PST), Short-term Respite (STR), and Independent Living/Skills Building (ILSB). The CSoC Contractor is responsible for the coordination and continuity of care of healthcare services for all CSoC members and for ensuring that each member has an ongoing source of care appropriate to the youth's needs.

OBH supports provider trainings to increase workforce capacity to deliver Evidence-Based Practices specific to both youth and adults. SUD provider licensure is based on nationally-recognized evidence-based practice standards and requirements and distinguishes services for youth and adults. OBH is currently updating these practice standards for adults based on *The ASAM Criteria* Fourth Edition.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

Through the LGEs and Medicaid specialized behavioral health services, integrated treatment for co-occurring behavioral health disorders are available statewide. The LGEs serve as the state's regional entities to provide comprehensive community based mental health and substance use disorder services to adults and youth in their respective catchment areas. Each LGE utilizes a program and/or service model that best meets the needs of their local communities; therefore, the service model and/or program utilized varies throughout the state. Within each LGE, a multidisciplinary approach is utilized with various staff trained and/or credentialed in the treatment of both mental health and substance use disorders to support integrated care and increased access for service recipients. Various programs and services offered through the state's Medicaid specialized behavioral health services also support integrated care. Examples of these programs include Assertive Community Treatment (ACT) Teams statewide and other community based treatment programs that address both substance use and mental health conditions.

c. How many IT-COD teams do you have? Please explain.

The state does not specifically have any IT-COD teams. The state's behavioral health services system is identified through ten separate LGEs – each of which provides services to parishes (counties) within their specific catchment area. Each LGE utilizes an integrated care approach to offer comprehensive and effective to treating individuals with co-occurring disorders. In addition, there are 44 ACT Teams throughout the state.

d. Do you monitor fidelity for IT-COD? Please explain.

The SMHA does not monitor fidelity for IT-COD treatment. As indicated above, the treatment programs and services utilized by each LGE varies based on the needs of the local communities. As each LGE does not utilize the same EBP, fidelity monitoring is not conducted. The state does monitor each LGE annually to ensure compliance with contract and block grant intended use plans deliverables. For ACT Teams, fidelity monitoring is conducted through the Medicaid MCOs, who contract with a subject matter expert in this area (Case Western Reserve University).

e. Do you have a statewide COD coordinator?

LDH/OBH does not have an individual who serves statewide as a COD Coordinator; however, the oversight and coordination of all behavioral health programs falls within one division of LDH/OBH. The Behavioral Health Community and Clinical Programs Division collectively provides oversight to community based prevention and treatment programs for mental health, substance use, and co-occurring disorders programs and services.

4. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers
b) Efforts to improve behavioral health care provided by primary care providers
c) Efforts to integrate primary care into behavioral health settings
d) How the state provides integrated treatment for individuals with co-occurring disorders

LDH integrated behavioral health care into the existing physical health Medicaid managed care program in 2015. All Louisiana Medicaid members now receive their behavioral health services through integrated

managed care with a managed care organization (MCO). The MCOs are required to establish and maintain interdepartmental structures and processes to support the operation and management of the Medicaid program and services in a manner that fosters integration of physical and behavioral health service provisions.

The MCOs are required to have established policies to facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs. Principles that guide care integration are as follows:

- Mental illness and addiction are healthcare issues and must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings;
- Many people suffer from both mental illness and addiction. As care is provided, both illnesses must be understood, identified, and treated as primary conditions;
- The system of care will be accessible and comprehensive, and will fully integrate an array of prevention and treatment services for all age groups. It will be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement; and
- It is important that relevant clinical information is accessible to both the primary care and behavioral health providers consistent with federal and state laws and other applicable standards of medical record confidentiality and the protection of patient privacy.

Based on this, the MCOs must provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity of care. These procedures must address members with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services.

MCOs are required to develop and implement specific strategies to promote the integration of physical and behavioral health service delivery and care integration activities and establish policies and procedures to facilitate integration. Specifically, the MCOs:

- Support PCPs who screen enrollees for behavioral health issues and treat mild to moderate cases, including educating and training practices on how to treat common behavioral health conditions and providing clinical consultations and guidance for issues that do not require specialty referrals;
- Encourage and support providers to co-locate primary care and behavioral health services, whether the co-located service is in a primary care or behavioral health setting;
- Provide incentives to clinics to employ Licensed Mental Health Professionals (LMHP) in primary care settings to monitor the behavioral health of patients and to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients;
- Allow providers to bill for both primary care and behavioral health services on the same day;
- Develop, in coordination with LDH and other MCOs, a system to provide psychiatric prescribing support to primary care providers. Such support may be provided through consultation with psychiatrists regarding psychiatric prescribing practices;
- Endorse real time consultation of primary care providers with behavioral health professionals or psychiatrists for behavioral health issues or consultations on medications;
- Distribute Release of Information forms as per 42 C.F.R. § 431.306, and provide training to providers on its use;

- Share necessary and integrated data with its network providers to promote clinical integration of physical and behavioral health; and
- Offer provider trainings on integrated care, including, but not limited to, appropriate utilization of basic behavioral health screens in the primary care setting and basic physical health screenings in the behavioral health setting.

MCOs are required to integrate physical and behavioral health services through:

- Enhanced detection and treatment of behavioral health disorders in primary care settings;
- Coordination of care for enrollees with both medical and behavioral health disorders, including promotion of care transition between inpatient services and outpatient care for enrollees with co-existing medical-behavioral health disorders;
- Assisting enrollees without a diagnosed behavioral health disorder, who would benefit from psychosocial guidance in adapting to a newly diagnosed chronic medical disorder;
- Utilization of approved communication and consultation by PCPs with behavioral health providers of co-enrolled enrollees with co-existing medical and behavioral health disorders requiring co-management;
- Have enhanced rates or incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients;
- Have enhanced rates or incentives for integrated care by providers;
- Distributing Release of Information forms as per 42 C.F.R. § 431.306, and provide training to MCO providers on its use;
- Educating MCO enrollees and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate;
- Identifying those who use emergency department (ED) services to assist in scheduling follow-up care with PCP and/or appropriate contracted behavioral health specialists;
- Ensuring continuity and coordination of care for enrollees who have been screened positive or determined as having need of specialized medical health services or who may require inpatient/outpatient medical health services. These activities must include referral and follow-up for enrollee(s) requiring behavioral health services;
- Documenting authorized referrals in the MCO's clinical management system;
- Providing or arranging for training of MCO providers and Care Managers on identification and screening of behavioral health conditions and referral procedures;
- Conducting Case management rounds at least monthly with the Behavioral Health Case management team; and
- Participating in regular collaborative meetings at least yearly or as needed, with LDH representatives for the purpose of coordination and communication.

MCOs provide guidelines, education and training, and consultation to PCPs to support the provision of basic behavioral health services in the primary care setting.

MCOs are required to ensure network providers utilize behavioral health screening tools and protocols consistent with industry standards. The MCO shall work to increase screening in primary care using validated screening instruments for developmental, behavioral, and social-emotional delays, as well as screening for child maltreatment risk factors, trauma, adverse childhood experiences (ACEs), and

substance use. The MCO may provide technical assistance to providers, incentives, or other means to increase screening for behavioral health needs in primary care.

MCOs work to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen positive for developmental, behavioral, and social delays, as well as child maltreatment risk factors, trauma, adverse childhood experiences (ACEs), and substance use. The MCO shall work to increase the percentage of children with positive screens who 1) receive a warm handoff to and/or are referred for more specialized assessment(s) or treatment, and 2) receive specialized assessment or treatment.

MCOs work with LDH to conduct annual assessments of practice integration using the publicly available Integrated Practice Assessment Tool (IPAT) on a statistically valid sampling of providers to include, but not be limited to, behavioral health providers and primary care providers: internists, family practitioners, pediatrics, OB-GYNs, and any other providers that are likely to interface with behavioral health populations. The MCO-led workgroup identify opportunities to coordinate this effort across MCOs to ensure comparability of results across MCOs and minimize burden on providers. The results of the initial survey must be reported to LDH annually.

The MCO must use an integration assessment tool to self-assess annually. Those results are reported annually to LDH. The assessment should be inclusive of, but not limited to, such factors as:

- Assessing enrollee and provider experiences around integrated care annually and make improvements as appropriate.
- Identifying opportunities to strengthen or complement the IPAT by identifying barriers and opportunities in the following functional areas:
    - Knowledge, attitudes and cross-training needs (e.g., assessing provider knowledge of best practices to address non-complicated behavioral health conditions in primary care);
    - Human resource needs (e.g., access to behavioral health providers at primary care clinics and medical providers at mental health clinics);
    - Access to services (e.g., laboratories for behavioral health practices);
    - Existing processes for integration (e.g., joint rounds on complex medical-behavioral cases, joint treatment team meetings, and established procedures for consultations);
    - Existing tools for integration (e.g., brief screening tools, electronic health records);
    - How contractors will use data from the IPAT assessment in their annual report;
        - Number and type of trainings on integration offered by the MCO;
        - The number of forums held with outcomes;
        - What outreach was done to promote integration, especially on the physical health side;
        - How many “hot spot” sources of high emergency department (ED) referrals and/or inpatient psychiatric hospitalization have been identified;
        - Has the identification of these “hotspots” led to pre-emptive coordination;
        - What incentives are being offered to improve integration of providers and are the incentives effective;
        - The status of real time consultation of primary care providers with behavioral health professionals or psychiatrists for behavioral health issues or consultations on medications;
        - The status of a single or integrated clinical documentation system;

- The status of unified systems across behavioral and physical health management; and
- How is the MCO addressing integration at the MCO level to include specific actions taken and the timeline to assess integration at this level.

In support of integrated care through Federally Qualified Health Center (FQHC) providers in the Medicaid program, LDH created an alternative payment methodology for behavioral health services provided in FQHCs. This allowed a change in the payment for services provided by physicians with a psychiatric specialty, nurse practitioners or clinical nurse specialists with a psychiatric specialty, licensed clinical social workers, or clinical psychologists within an FQHC setting. The alternative payment methodology allows access to behavioral health services on the same day that patients access primary care within FQHCs to the benefit of patients.

The Promoting Integration of Primary and Behavioral Health Care (PIPBHC) Program is to promote the integration of primary and behavioral health care services to improve the overall wellness and physical health status of adults with mental illness who have co-occurring physical health conditions or chronic diseases and individuals with a substance use disorder (SUD). PIPBHC I provided services from 2018-2023, with the Office of Behavioral Health (OBH) submitting a no cost extension to extend the grant period from Sept. 30, 2023 to March 30, 2024. OBH submitted an application in 2023 for PIPBHC II, which currently is ending year 2 of the grant cycle. OBH has contracted with four federally qualified health centers (FQHCs) for PIPBHC II, geographically dispersed throughout the state of Louisiana, to provide integrated primary and behavioral health services. All providers are located in Health Resources and Services Administration (HRSA) designated health professional shortage areas. Through this grant, these centers offer coordinated care that combines primary medical services with mental health and substance use disorder treatment. Key offerings include comprehensive screening and assessment, collaborative care planning, outpatient counseling, medication-assisted treatment (MAT), health education, and recovery support services such as peer support and care coordination. In addition, these FQHCs provide a range of supportive services like pharmacy access, transportation assistance, translation, and community outreach, ensuring care is accessible and culturally appropriate for underserved populations. The aim is to deliver holistic, person-centered care that addresses both physical and behavioral health needs, ultimately improving health outcomes for vulnerable communities across Louisiana.

FQHC	Examples of Services Provided Under PIPBHC
EXCELth	Integrated primary care, mental health, substance use disorder screening and treatment, health education, care coordination
CrescentCare	Comprehensive mental health and substance use services, integrated primary care, CCBHC model services, outreach and prevention
Morehouse Community Medical Center / CommuniHealth Services	Medical, dental, behavioral health, pharmacy, substance abuse counseling, transportation, translation, specialty care, health education, outreach
Open Health	Integrated primary and behavioral health care, screening, treatment, recovery supports (based on PIPBHC model and typical FQHC offerings)

5. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness (SMI)
b) Adults with substance use disorders
c) Adults with SMI and I/DD
d) Children and youth with serious emotional disturbances (SED) or substance use disorders
e) Children and youth with SED and I/DD

The MCOs are required to implement a tiered Case Management program that provides for differing levels of Case Management based on an individual enrollee's needs. This includes three (3) levels of Case Management and Transitional Case Management for individuals as they move between care settings.

- Intensive Case Management for High Risk Enrollees (High) (Tier 3)

  Enrollees engaged in intensive Case Management are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH. A POC shall be completed in person within thirty (30) Calendar Days of the Case Management assessment being completed and shall include assessment of the home environment and priority SDOH. Case Management meetings shall occur at least monthly, in person, in the Enrollee's preferred setting, or more as required within the Enrollee's POC, or as needed to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i), with monthly updates to the POC and formal in person re-assessment quarterly. Case Management may integrate community health worker support. Attestations of monthly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 3 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs.

- Case Management (Medium) (Tier 2)

  Enrollees engaged in the medium level of Case Management are typically of rising risk and need focused attention to support their clinical care needs and to address SDOH. A POC shall be completed in person within thirty (30) Calendar Days of Case Management assessment being completed and include assessment of the home environment and priority SDOH. Case Management meetings shall occur at least monthly, with quarterly updates to the POC, or as needed to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i), and formal in-person re-assessment quarterly. Case Management may integrate community health worker support. Attestations of quarterly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 2 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the

Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs.

- Case Management (Low) (Tier 1)

  Enrollees engaged in this level of Case Management are of the lowest level of risk within the Case Management program and typically require support in care coordination and in addressing SDOH. A POC shall be completed in person within ninety (90) Calendar Days of the Case Management assessment being completed and include assessment of the home environment and priority SDOH. Case Management meetings shall occur at least quarterly, or more as required within the Enrollee's POC, or as needed to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i), with annual updates to the POC and formal in-person re-assessment annually. Attestations of annual updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed.

- Transitional Case Management

  The MCO are required to implement procedures to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i). The Contractor shall provide Transitional Case Management for Enrollees not already enrolled in Case Management Tiers 1, 2, or 3 to support transitions between institutional and community care settings, including, but not limited to, transitions to/from inpatient hospitals, nursing facilities (not including members of the DOJ Agreement Target Population), psychiatric residential treatment facilities (PRTFs), therapeutic group homes (TGHs), ICF/IIDs, residential substance use disorder treatment settings, and incarceration and transitions to permanent supportive housing.

  Transitional Case Management includes:

  - Development of a transition POC in coordination with the care setting, the Enrollee, and other key members of an Enrollee's multi-disciplinary team prior to the transition which is provided in writing to the Enrollee upon discharge, includes post discharge care appointments and linkages as appropriate, medication reconciliation, patient education and self-management strategies, and addresses Prior Authorization needs. The Enrollee shall be provided the case manager's name and contact information prior to discharge.
  - For Enrollees preparing for discharge from a PRTF, TGH, or ICF/IID, aftercare services shall be in place thirty (30) Calendar Days prior to discharge.
  - Ensuring that the setting from which the Enrollee is transitioning is sharing information with the Enrollee's PCP and behavioral health providers regarding the treatment received and contact information.
  - Follow up with Enrollees within seven (7) Calendar Days following discharge/transition to ensure that services are being provided as detailed within the Enrollee's transition POC. The POC shall identify circumstances in which the follow-up includes a face-to-face visit.
  - Additional follow-up as detailed in the discharge plan.
  - Coordination across the multi-disciplinary team involved in Transitional Case Management for Enrollees.

- For Enrollees identified as homeless at the time of care transition, the care management team shall include a housing specialist on the multi-disciplinary care team. Housing specialists shall also be used to ensure Enrollees transitioning from facility to community are connected to appropriate housing resources, including, but not limited to, referral of Potential Enrollees to Contractor's Permanent Supportive Housing liaison for application to the Louisiana Permanent Supportive Housing program.

The MCOs are required to develop a comprehensive individualized, person-centered Plan of Care (POC) for all enrollees who are found eligible for Case Management. When an enrollee receives services from the MCO only for specialized behavioral health services, the POC shall focus on coordination and integration, as appropriate. Development of the POC shall be a person-centered process led by the enrollee and their case manager with significant input from members of the enrollee's interdisciplinary care team. When an enrollee receives specialized behavioral health services and has treatment plans developed through their behavioral health providers, the MCO shall work with the enrollee's behavioral health providers in order to incorporate the treatment plans into the enrollee's overall POC and to support the enrollee and the provider in their efforts to implement the treatment plan. The POC shall be based on the principles of self-determination and recovery, and shall include all medically necessary services identified by the enrollee's providers as well as the care coordination and other supports to be provided by the MCO.

MCOs identify a multi-disciplinary care team to serve each enrollee based on individual need for all enrollees in Case Management Tiers 2 and 3 and Transitional Case Management. MCOs assign lead case managers based on an enrollee's priority care needs, as identified through the POC. Where behavioral health is an enrollee's primary health issue, the case manager shall be a behavioral health case manager. If the enrollee is under the age of six (6), the lead case manager shall have expertise in early childhood mental health or access to a consultant with expertise in infant and early childhood mental health.

OBH and the MCOs have also developed a specialized community Case Management program consistent with a Department of Justice (DOJ) Agreement for the target population transitioning or diverted from nursing facility level of care using subcontracted community case managers, who meet the qualifications established by OBH. The MCO makes referrals to a community Case Management agency within one (1) business day of receipt of a referral from LDH. The MCO maintains ultimate responsibility for ensuring the Case Management needs of the target population are met by community case managers and community case managers satisfactorily completing required activities.

MCOs must also have policies and procedures to support the development of a workforce and provide services to the dually diagnosed, individuals with a co-occurring developmental disability and mental health diagnosis. These policies and procedures must include: a plan for how to improve and increase services available for individuals with behavioral health and developmental disabilities, including autism spectrum disorders; an annual assessment of the number of providers serving Enrollees with behavioral health and developmental disabilities and of whether the needs of this population are being met; a database of trainers, consultants, and contractors that specialize in working with enrollees with dual diagnosis of behavioral health and developmental disabilities; training plans and curricula that address dual diagnosis, which shall be offered to behavioral health Network Providers, who are interested in certification and required for unlicensed staff working with this population; and incentives for providers to achieve certification.

The CSoC Contractor is responsible for creating a framework for delivery of services, staff development, and policies and procedures for providing effective care for members with co- occurring behavioral health and developmental disabilities. This population should have the same reasonable access to behavioral health services as someone without a co-occurring behavioral health and developmental disability. If a CSoC member qualifies for services through the Office of Citizens with Developmental Disabilities (OCDD), the Contractor shall coordinate with OCDD concerning the care of the member. A Statement of Approval for services from OCDD shall not preclude services from the Contractor. The CSoC Contractor is responsible for coordinating with OCDD for the behavioral health needs of the I/DD co-occurring population.

At the local level, the LGEs are responsible for community-based programs and functions relating to the care, diagnosis, training, treatment, case management, and education of persons with intellectual disabilities, persons with developmental disabilities, and persons with autism.

6. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

OBH was created by Act 384 of the 2009 Legislative Session which directed the consolidation of the offices of addictive disorders and mental health into the Office of Behavioral Health effective July 1, 2010, in order to streamline services and better address the needs of the people with co-occurring mental illness and addictive and substance use disorders. LDH's work in implementing Act 384 was guided by stakeholders and leaders in the behavioral health field from across Louisiana who sat on the department's Office of Behavioral Health Implementation Advisory Committee.

Currently, OBH has an integrated organizational chart and does not distinguish between addictive and substance use disorder and mental health staff, resources, or state general fund mechanisms. LGEs as Medicaid and non-Medicaid providers provide services in an integrated manner for both mental health and addictive and substance use disorders, as do the Medicaid managed care organizations. Licensing standards and operations of mental health and substance use providers are integrated under one integrated behavioral health services provider license.

7. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD), including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

The Office for Citizens with Developmental Disabilities (OCDD) serves as the Single Point of Entry (SPOE) into the developmental disabilities services system and oversees public and private residential services and other services for people with developmental disabilities. OCDD conducts an assessment of people who request services to determine the person's eligibility for system entry. Eligibility is based on the definition of developmental disability contained in Louisiana statute, and the LGEs serve as the points of entry for individuals to receive services. While the screening, assessment, and diagnosis/service

authorization for behavioral health vs I/DD will occur with different staff within each LGE, this system supports integrated services and supports through one state entity at the community level.

As stated above, the managed care entities have contract requirements regarding the provision of integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD). Through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit in Medicaid, youth under age 21 can receive comprehensive and preventive healthcare services. Medicaid also provides coverage for Applied Behavior Analysis and access to mental health services through a robust provider network.

Many schools across Louisiana also offer health services that are eligible for reimbursement under Medicaid, including nursing services, therapy services (speech therapy, OT and PT), behavioral health services, ABA therapy, special transportation, and personal care services. The Louisiana Department of Education has developed a Louisiana School Based Medicaid Program (SBMP) Resource Library to help local education agencies implement a health services program that is eligible for funding through Medicaid.

8. Please indicate areas of technical assistance needed related to this section:

N/A

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) -10 percent set aside - Required MHBG

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among individuals and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations [Note: MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with SMI or SED]. The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by the Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals experiencing first episode of psychosis (FEP). RAISE was a set of federal government-sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have b shown to improve symptoms, reduce relapse, and lead to better outcomes.

States shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals experiencing early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount, the state receives under this section for a fiscal year as required, a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/ EBPs for SMI/FEP	Number of Programs
NAVIGATE	3
YALE-STEP	1
PIER	1 (Initially trained in August, 2023)

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 26 and FY 27 (only include MHBG funds).

FY 2026	FY 2027
$1,233,762	$1,233,762

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

Currently, insurances including Medicaid are billed first for ESMI/FEP services provided to individuals such as psychotherapy or medication management. Other services such as peer support, which are not covered by insurance including Medicaid, are then paid for by MHBG funding.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

Several Local Governing Entities (LGEs) provide ESMI/FEP services using Coordinated Specialty Care models:

- Capital Area Human Services District (CASHD) provides coordinated specialty care for individuals experiencing ESMI/FEP in Region 2 of Louisiana. CASHD provides medication management, community-based therapeutic intervention, peer support services, family therapy, case management, and a supportive, team approach to care from a dedicated team of licensed professionals in both the home and community setting.
- Florida Parishes Human Services Authority (FPHSA) also provides coordinated specialty care for individuals experiencing ESMI/FEP, out of three clinic locations and the home and community setting, in Region 6 of Louisiana. FPHSA provides medication management with a physician, nurse practitioner, or medical psychologist, psychotherapy, family education and support, employment and education services, and peer support services with a supportive, team approach to care.
- South Central Human Services Authority (SCLHSA) also provides coordinated specialty care for individuals experiencing ESMI/FEP in Region 3 of Louisiana. Similar to the program mentioned above, SCLHSA through a team approach provides medication management, psychotherapy, family education and support, employment and education

services, and peer support services by licensed professionals. For FFY24, they began a partnership with Tulane University in New Orleans Department of Psychiatry Early Psychosis Intervention Clinic (EPIC-NOLA) to enhance their services to individuals experiencing ESMI/FEP.

- Metropolitan Human Services (MHSD) also provides coordinated specialty care to individuals experiencing ESMI/FEP. This program mainly focus on youth in region 1 of Louisiana. MHSD provides medication management, therapeutic intervention, peer support services, family therapy, case management, and a supportive, team approach to care from a dedicated team of licensed professionals in both the home and community setting. For FFY24, they began a partnership with the EPIC NOLA clinic to provide joint services to individuals experiencing ESMI/FEP.
- Jefferson Parish Human Services Authority (JPHSA) provides coordinated specialty care services following the NAVIGATE Model. This program focuses on Jefferson Parish. JPHSA provides medication management, community-based therapeutic intervention, peer support services, family therapy, case management, and a supportive, team approach to care from a dedicated team of licensed professionals in both the home and community setting. During FFY25, they are establishing a partnership with EPIC NOLA clinic to provide joint services to individuals experiencing ESMI/FEP.

LDH-OBH supports a certified Peer Support Specialist at the following LGEs, which use the public health model: Imperial Calcasieu Human Services Authority (Region 5 of Louisiana), Northwest Louisiana Human Services District (Region 7), and Central Louisiana Human Services District (Region 6).

Through a contract with Tulane University, LDH-OBH supports EPIC-NOLA in its efforts to continue to expand its own clinic for both youth and adults in New Orleans and to expand FEP services to areas of Louisiana with the greatest need that do not currently have FEP treatment programs. The EPIC-NOLA program provides an evidence-based, recovery oriented, and person centered CSC model of FEP care that includes a comprehensive package of services including: family education, social skills training, individual cognitive behavioral therapy, social cognitive based psychotherapy, and personalized pharmacologic management by using a team approach of staff working within their respective roles to provide collaborative services to program participants. Through this contract, OBH also supports the statewide media campaign Clear Answers to Louisiana's Mental Health (CALM) as a hub for psychosis awareness and treatment resources to provide active outreach and engagement strategies into FEP programs. EPIC NOLA is funded by MHBG.

LDH-OBH assists the Volunteers of America – North Louisiana through BSCA funding for the EpiCenter for youth and adults with ESMI/FEP in Region 7. This program represents a partnership between VOA of North Louisiana and LSU Health Sciences of Shreveport. This program was implemented in the summer of 2023. The EpiCenter clinic provides Coordinated Specialty Care (CSC) services for first-episode psychosis that include psychotherapy, psychiatric medication management/primary care, case management, supported employment and education, peer services, and individual, group, and family education. The multi-disciplinary team works with patients and their families in order to determine goals and navigate the path towards long lasting recovery and wellness.

5. Does the state monitor fidelity of the chosen EBP(s)?

☒ Yes ☐ No

Due to staff resignations (April 2022 and February 2023), current program staff needed to be trained to conduct fidelity monitoring. This occurred in March 2023 when Dr. Donald Addington provided a statewide training, including training OBH staff. OBH is planning to continue fidelity monitoring in the coming fiscal years.

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?

☒ Yes ☐ No

Efforts were made in the initial years of program implementation to increase awareness of the needs of individuals experiencing first episodes of psychosis and the benefit of early identification and treatment in order to reduce the duration of untreated psychosis.

For the first phase of implementation, Louisiana enlisted Rutgers University for training and consultation. Through an initial needs assessment of each LGE, conducted by Rutgers University staff, the state was better able to identify each LGEs readiness to implement an FEP program and training needs. Subsequent to the completion of the needs assessment, a training series was developed and implemented through which participants were provided information about FEP, tenants of the RAISE model were explored, and best practices regarding the provision of services were reviewed. The trainings included a series of two face-to-face trainings, each held in three areas of the state, and a series of webinars. , Beginning August 2, 2023, the Volunteers of America – North Louisiana's EpiCenter staff was trained in the coordinated specialty care model of the PIER Institute.

Beginning June 10, 2025, LDH/OBH sponsored a two-day virtual workshop entitled; Cognitive Behavioral Therapy for Psychosis: Introductory Training for Mental Health Care Providers. This workshop oriented mental health care providers to the most recent literature on cognitive behavioral approaches to treating individuals with psychotic symptoms, introduced a recovery-oriented model for treating psychosis and providing CBT-p informed concepts and strategies for this population.

Providers continued actively engaging in trainings presented by Stanford University in 2024 and 2025 that included:

a. Working with Psychosis: Visions and Presences – January 19, 2024
b. Cognitive Therapy for Command Hallucinations, February 16, 2024
c. Treating persecutory delusions: an introduction to the Feeling Safe Program - March 15, 2024
d. Integrating Cultural Considerations in CBTp — Racial Threat and Paranoia – April 19, 2024
e. Social Recovery Therapy (SRT) for People Who Have Experienced Psychosis – May 20, 2024
f. Comprehend, Cope, and Connect. Getting to the simple heart of the complex problem and enabling
g. Psychological working across a team – June 21, 2024

h. Bent Not Broken: Navigating Queer & Trans Mental Health – July 19, 2024
i. Ebb and Flow: A cognitive interpersonal approach to staying well after psychosis – August 16, 2024

j. Hallucinations, Dreams & Visions: Indigenous perspectives – September 6, 2024
k. Working with cognitive difficulties and negative symptoms in psychosis – October 18, 2024
l. Trauma and Psychosis – November 15, 2024
m. Learning from the Hearing Voices Movement: Mutual Aid outside the Medical Model – December 13, 2024
n. The Psychology of Conspiracy Theories vs Delusions: Bridging the gap in clinical practice – January 17, 2025
o. Liberation-Based CBT to Address Race-Based Stress and Intersectional Oppression – February 21, 2025
p. Optimizing Outcomes and Maintaining Safety: learning from experts by experience and busting myths, misunderstandings, and misapplication of CBT- p – March 21, 2025
q. Metacognitive Reflection and Insight Therapy (MERIT): A recovery-oriented psychotherapy framework for working with individuals experiencing psychosis – April 18, 2025
r. Narrative Enhancement and Cognitive Therapy for Self-Stigma among People Diagnosed with Serious Mental Illness – May 16, 2025
s. Working with visual and multi-modal hallucinations in psychosis – June 20, 2025
t. Collaborative Practices: "Dialogues Between and Through Us" Peer Support, Lived Experience and Social Network Approaches as Anti-Oppression Practice – July 18, 2025
u. Increasing Flourishing and Happiness: A Practical and Experiential Introduction to Integrating Positive Psychology into CBT- p – August 15, 2025
v. Working with Depersonalization and Derealization – September 19, 2025
w. Queer Affirming Psychosis Care – October 17, 2025
x. DBT skills for psychosis – November 21, 2025
y. Transformative Mutual Aid for Clinicians: Supporting Recovery in Psychosis Care – December 19, 2025

Our focus for the upcoming year is to continue offering FEP contractors essentials of care for supporting individuals with Serious Mental Illness with Clinical High Risk and First Episode Psychosis Fidelity/Fidelity Scale training by Dr. Addington, M.B.B.S., Clinical Professor, Department of Psychiatry, University of Calgary, NAVIGATE training and additional CBT-p specific trainings and consultations.

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

The goal of Louisiana ESMI/FEP programs is to reduce the duration of untreated psychosis and to increase the likelihood of recovery by introducing these individuals into treatment within the first few years of their illness. Through partnerships with agencies throughout the state including Tulane University and the Volunteers of America – North Louisiana, LDH-OBH is working towards enhancing and expanding FEP Programs and services available statewide to serve this highly vulnerable population with the CSC evidence based model to improve access to care and the prognosis for individuals living with serious mental illness. Several locations have added staff members including a primary care physician at EPIC NOLA to increase access to services.

LDH-OBH also supports the statewide media campaign CALM for psychosis awareness and treatment resources to provide active outreach and engagement strategies into FEP programs. Several agencies are increasing outreach and educational events to increase knowledge of psychosis and other serious mental

illnesses and decrease myths and stigma regarding psychosis and other serious mental illnesses. This improves awareness and access to treatment.

8. Please describe the planned activities in FFY 2026 and FFY 2027 for your state's ESMI/FEP programs.

Ongoing activities related to Louisiana's First Episode Psychosis initiative include the following:

- Peer Support – Continued support of PSS in each of LGEs that are implementing the public health model
- Outreach – Providers will continue to development and distribute outreach materials for individuals experiencing FEP and their families. Materials will be in line with that which is available through NAVIGATE, OnTrackNY, PIER, and other established evidence-based FEP programs.
- CSC Program Implementation and Support – Continued support of the CSC programs implemented in JPHSA, CAHSD, FPHSA, SCLHSA and MHSD. These programs, except for SCLHSA and MHSD, began identifying and serving individuals experiencing FEP in SFY17, subsequent to the 2-day NAVIGATE training held June 23 and 24, 2016. Also in SFY17, OBH began contracting with Tulane University's EPIC NOLA program to provide monthly case consultation to these LGEs regarding psychotherapeutic approaches and best prescriber practices. This contract partnership has continued since SFY17. After trainings conducted in June 2019 to promote and encourage other LGEs to begin their own FEP programs, both SCLHSA and MHSD opted to expand or develop new CSC clinics. SCLHSA obtained training through a contract with the EPIC NOLA program on the YALE STEP program and MHSD obtained NAVIGATE training within the year. MHSD, SCLHSA and JPHSA are contracting with EPIC NOLA to enhance their FEP services.
- Ongoing Technical Assistance – Through contracts with consultants, providing on-going technical assistance to LGEs throughout the state, supporting them as they implement their selected FEP model:
    - LGEs adopting the Public Health Model will be provided with ongoing assistance to each of the LGEs implementing this model to better help them develop programming which will meet their individualized needs through consultation calls with EPIC NOLA regarding the role of the peer support staff within Coordinated Specialty Care.

In 2023, SAMHSA awarded a grant to LDH/OBH in support of Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis (CHR-P). Tulane EPIC-NOLA has been named the CHR-P award sub-recipient. EPIC-CHRP will target those at clinical high risk (CHR) for psychosis by implementing a CHR team and a CHR community early detection campaign. The CHR cohort includes young people ages 10 through 25 years of age who exhibit noticeable changes in perception, thinking and functioning typically preceding the FEP. The LaCHR-P contract hasbeen submitted for processing and the Project Director has been hired.

OBH continues to provide trainings and workshops for continuing education through the Stanford Master Clinician Series. OBH is planning to contract with OnTrackNY and/or NAVIGATEto provide future trainings and consultations in the spring of 2026 with the interested FEP providers regarding their specific roles within Coordinated Specialty Care Clinic. These include consultations with prescribers, primary clinicians, the outreach and recruitment staff, the supported employment and education staff, the peer support specialist, and a specific consultation for Program Directors on the implementation of a First Episode Psychosis Coordinated Specialty Care Clinic.

- OBH Central Office First Episode Psychosis Coordinator continues using the First Episode Psychosis-Fidelity Scale when conducting ongoing monitoring of First Episode Psychosis Clinics who receive MHBG funding .
  The state continues to collaborate with Volunteers of America – North Louisiana in Shreveport, EpiCenter, to serve youth and adults who are experiencing symptoms of psychosis.

9. Please list the diagnostic categories identified for your state's ESMI programs

- NAVIGATE and OnTrackNY: 15 – 40 y.o. (+/- with approval of treatment team); 1 year or less of treatment; 12 months or less of taking anti-psychotic medications and/or 2 year or less of psychotic symptoms.
- EPIC-NOLA (modeled off of the YALE-STEP program): 12 – 35 y.o. (+/- with approval of treatment team); Experiencing psychosis for less than 2 years, have received a diagnosis of schizophrenia or other psychotic disorder, have recently been hospitalized for psychosis, are willing to be evaluated and treated by healthcare professionals.
- EpiCenter (to begin using the PIER model): No age requirement; Experiencing psychosis for less than 3 years, have received a diagnosis of schizophrenia or other psychotic disorder, and are willing to be evaluated and treated by healthcare professionals.

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

The estimated incidence of individuals with a first episode psychosis in Louisiana is 4,598 persons per year for the 18-25 age group.

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

LDH-OBH is working to actively engage those with FEP who use the public mental health system by a statewide outreach campaign, CALM. CALM not only brings awareness to what psychosis is, it seeks to actively engage those with mental illness into treatment and decrease stigma associated with psychosis and mental illness. CALM and several of the LGEs host and participate in community events to bring awareness to psychosis and promote access to treatment.

Through partnerships with various agencies throughout the state, LDH/OBH is working towards enhancing and expanding FEP Programs and services available statewide to serve this highly vulnerable population with the coordinated specialty care, evidence based model to improve access to care and the prognosis for individuals living with serious mental illness.

LDH-OBH continues to work with the LGEs' public mental health system to have five coordinated specialty care clinics throughout the state as well as three additional LGEs who provide the public health model for ESMI/FEP.

12. Please indicate area of technical assistance needed related to this section.

As Louisiana continues to grow ESMI/FEP programs throughout the state, technical assistance in regards to the sustainability of programming would be beneficial, especially in regards to the engagement of Managed Care Organizations and reimbursement of services through Medicaid. In addition, more technical assistance to help OBH encourage and support more Local Governing Entities to develop their

Early Serious Mental Illness programs in order to expand Coordinated Specialty Care Models throughout the state.

3. Person Centered Planning (PCP) –Required (MHBG), Requested for SUPTRS BG

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from https://acl.gov/news-and-events/announcements/person-centered-practices-resources

1. Does your state have policies related to person centered planning?

☒ Yes ☐ No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

N/A, the state has policies related to person centered planning.

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhance communication.

The State requires contracted managed care organizations (MCOs) to:

- Initiate welcome calls to all new members to provide a brief explanation of the program, discuss availability of oral and written translation services, and determine if the member has any special health care needs; Provide members with a member handbook, which includes information on topics such as member rights and responsibilities, freedom of choice, disenrollment rights, procedures for obtaining benefits, policies on advance directives and grievance and appeal procedures; and
- Develop and maintain a member-focused webpage, which includes general program information, contact information, member handbook, and provider directory, and is interactive and accessible

using mobile devices, and has the capability for bidirectional communications, i.e. members can submit questions and comments to the MCO and receive responses.

Person Centered Planning is also an integral component of discharge planning activities associated with a Nursing Facility discharge initiative currently underway in Louisiana. The discharge initiative was developed as a result of an Agreement Louisiana has with the Department of Justice related to individuals with serious mental illness in Nursing Homes, and is called My Choice Louisiana (MCL). Several aspects of the Agreement reiterate the need to utilize person centered planning processes in the development of service/treatment plans and transition activities as individuals move from nursing facilities into the community. To complement these activities, national consultants developed a Person Centered Planning training during SFY 21, which the Managed Care Organizations are offering to their provider networks. These trainings are ongoing.

4. Describe the person-centered planning process in your state.

Managed Care Organizations

In Louisiana, individuals enrolled in Medicaid receive mental health and substance use disorder services through state contracted managed care plans. The LDH contracts define person centered planning as the following:

A care planning process driven by the enrollee that identifies supports and services that are necessary to meet the enrollee's needs in the most integrated setting. The enrollee directs the process to the maximum extent possible and is provided sufficient information and support to make informed choices and decisions. The process is timely and occurs at times and locations convenient to the enrollee, reflects the cultural and linguistic considerations of the enrollee, provides information in plain language and in a manner that is accessible to enrollees, and includes strategies for resolving conflict or disagreement that arises in the planning process.

The MCOs are required through contract to offer case management and individual care planning for special populations including but not limited to individuals transitioning from nursing homes and members diagnosed with a SED, SMI or substance use disorder

The managed care contract requires the development of a person-centered assessment and plan of care led by the enrollee's case manager with significant input from the enrollee as well as members of the enrollee's interdisciplinary care team. The plan of care shall be based on the principles of self-determination and recovery, and shall include all medically necessary services identified by the enrollee's providers as well as the care coordination and other supports to be provided by the Contractor. The plan of care shall be reviewed and revised upon reassessment of functional need.

Behavioral Health Providers

Person centered planning is required for Medicaid funded services delivered by a wide range of providers statewide. Services include community based mental health services including mental health rehabilitation, evidenced based interventions for youth and adults including Multi-Systemic Therapy, Functional Family Therapy, Homebuilders, and Assertive Community Treatment. Person centered planning is also required in the delivery of substance use outpatient treatment and residential treatment. Louisiana Medicaid has a specialized program, the Coordinated System of Care for youth in or at risk of out of home placement. A critical component of this program is the person centered planning process. This process is guided by System of Care values (family driven, youth guided, culturally and linguistically competent, home and community based, strength-based, individualized, integrated across systems,

connected to natural helping networks, data and outcome driven, and unconditional care). The treatment planning team known as the Child and Family Team is facilitated by a Wraparound Facilitator This is an effective planning process with its primary goal of individual, family, and provider involvement in the treatment planning process.

All behavioral health service (BHS) providers licensed under LAC 48:1.Chapter 56, including Local Governing Entities, must develop treatment plans that meet the following guidelines.

A. A BHS provider shall deliver all services according to a written plan that:
    1. is age and culturally appropriate for the population served;
    2. demonstrates effective communication and coordination;
    3. provides utilization of services at the appropriate level of care;
    4. is an environment that promotes positive well-being and preserves the client's human dignity;
    5. utilizes evidence-based counseling techniques and practices.
B. The provider shall make available a variety of services, including group and/or individual treatment
    1. the strategies and activities to be used to help the client achieve the goals;
    2. information specifically related to the mental, physical, and social needs of the client;
    3. the identification of staff assigned to carry out the treatment.
C. The BHS provider shall ensure that the treatment plan is in writing and is:
    1. developed in collaboration with the client and when appropriate, the client's family and is signed by the client or the client's family, when appropriate;
    2. reviewed and revised as required by this Chapter or more frequently as indicated by the client's needs;
    3. consistently implemented by all staff members;
    4. signed by the Licensed Mental Health Professional or physician responsible for developing the treatment plan;
    5. is in language easily understandable to the client and to the client's family, when applicable.

Nursing Facility Discharge Initiative

Transition Coordinators located throughout the state work with individuals with serious mental illness transitioning from Nursing Facilities utilizing a process, which is driven by the individual that identifies supports and services, which are necessary to meet the individual's needs in the most integrated setting. The individual directs the process to the maximum extent possible and is provided sufficient information and support to make informed choices and decisions. The process is timely and occurs at times and locations convenient to the individual; reflects the cultural and linguistic considerations of the individual; provides information in plain language and in a manner that is accessible to individuals within the Target Population; and includes strategies for resolving conflict or disagreement that arises in the planning process. In order to ensure this occurs, all evaluation tools have been developed in a manner intended to facilitate and support the person centered planning process. Additionally, principles of person centered planning have been integrated in staff training.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as A Practical Guide to Psychiatric Advance Directives)?

Louisiana's Mental Health Law encourages the voluntary treatment of mental illness and substance use and requires medically appropriate treatment in the least restrictive setting possible. Individuals, may not be forced to receive treatment or be confined in a hospital unless certain legal criteria are met.

Louisiana law recognizes two types of advance directives: 1) A living will (also known as a declaration); and 2) A health care power of attorney. Advanced Directives for Behavioral Health Treatment are outlined in Louisiana law, R.S. 28:221-237 (Act 755 of 2001). This outlines that a person may use an advance directive to provide authorization for mental health treatment or to appoint a representative to make mental health treatment decisions when the person is incapable. An advanced directive template has been developed and is available online. Information about advanced directives is made available through the MCO and advocacy organizations.

Additionally, a number programs have been developed with the goal of supporting individuals in their recovery/wellness journey. These include:

1. Behavioral Health Forums which are facilitated throughout the state and provide an overview off the service system but also of available to individuals in an effort to help them understand legal commitments and their rights as service recipients.
2. Peer to Peer groups implemented throughout the state, entitled Target Health. This program is led by trained peers who facilitate a 10 week training program which focuses on the development and implementation of a wellness plan. Sessions are comprised of the following topics:
    a. Coping with Traumatic Events
    b. Recognizing and Managing Anxiety
    c. Understanding Self
    d. Developing Healthy Relationships
    e. Social Media
    f. Practicing Self-Care
    g. Recognizing and Managing Depression
    h. Suicide Awareness
    i. Understanding Substance Abuse

As stated in the Louisiana Medicaid Behavioral Health Services Provider Manual, ACT Teams are expected to have a tracking system for services and time rendered for or on behalf of any member, as well as a treatment plan that must consist of various components, to include a crisis/relapse prevention plan, including an advance directive. LDH/OBH contract partner, NAMI Louisiana (NAMI LA), also provides education and resources on psychiatric advance directives (https://namilouisiana.org/resources/advanced-directive-for-mental-health-treatment/).

6. Please indicate areas of technical assistance needed related to this section.

N/A

4. Program Integrity – Required

There is a strong emphasis on ensuring that Block Grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's program integrity efforts are to promote the proper expenditure of Block Grant funds, improve Block Grant program compliance nationally, and demonstrate the effective use of Block Grant funds

While some states have indicated an interest in using Block Grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in 42 U.S.C. § 300x–5 and 42 U.S.C § 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), there are periodic site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. Guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. Please respond to the following:

1) Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?

☒ Yes ☐ No

2) Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

☒ Yes ☐ No

3) Does the state have any activities related to this section that you would like to highlight?

N/A

Please indicate areas of technical assistance needed related to this section.

N/A

5. Primary Prevention- Required for SUPTRS BG

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies. The strategies are directed at individuals not identified to be in need of treatment programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The Levels of Risk are defined as Universal (general population), Selective (higher risk of engaging in an activity) and Indicated (history of substance use and/or risky behaviors). A comprehensive program will be comprised of a variety of strategies that address risk at all levels. The program must include, but is not limited to, the following strategies:

1. **Information dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem identification and referral** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based processes** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

6. **Environmental strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following questions:

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)?

   a) ☒ Yes ☐ No

   Note: The state's group is identified as the State Epidemiology Workgroup (SEW)

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply):

   a) ☒ Data on consequences of substance-using behaviors
   b) ☒ Substance-using behaviors
   c) ☒ Intervening variables (including risk and protective factors)
   d) ☐ Other (please list :)

3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply):

   a) ☒ Children (under age 12)
   b) ☒ Youth (ages 12-17)
   c) ☒ Young adults/college age (ages 18-26)
   d) ☒ Adults (ages 27-54)
   e) ☒ Older adults (age 55 and above)
   f) ☒ Rural communities
   g) ☐ Other (please list :)

4. Does your state use data from the following sources in its primary prevention needs assessment? (check all that apply):

   a) ☒ Archival indicators (Please list :)

   - Alcohol Epidemiologic Data System (AEDS)
   - Fatality Analysis Reporting System (FARS)
   - National Vital Statistics System (NVSS)
   - Uniform Crime Reporting Program (UCR)
   - United States Census Bureau Population Projections
   - Louisiana Caring Communities Youth Survey
   - CORE Alcohol and Drug Survey

- Crash Report Data. Louisiana Highway Safety Commission (LHSC)/Highway Safety Research Group (HSRG)
- Hepatitis Data, Louisiana Office of Public Health (OPH)
- HIV/AIDS Data, Louisiana Office of Public Health (OPH)
- Mortality Data, Louisiana Office of Public Health (OPH)
- Student Information System (Disciplinary Action Data Related to Substance Use), Louisiana Department of Education
- Substance Use Treatment Admissions, Office of Behavioral Health (OBH)

b) ☒ National Survey on Drug Use and Health (NSDUH)
c) ☒ Behavioral Risk Factor Surveillance System (BRFSS)
d) ☒ Youth Risk Behavior Surveillance System (YRBS)
e) ☒ Monitoring the Future
f) ☐ Communities that Care
g) ☒ State-developed survey instrument (Louisiana Caring Communities Youth Survey)
h) ☒ Other (please list :)

The State Epidemiology Workgroup (SEW) maintains an online data system, which includes consumption indicators and long- and short-term consequence indicators at the state and community level. The online data system can be accessed at http://www.bach-harrison.com/lasocialindicators/.

Other National Data Sources:

- Alcohol Epidemiologic Data System (AEDS)
- Fatality Analysis Reporting System (FARS)
- National Vital Statistics System (NVSS)
- Uniform Crime Reporting Program (UCR)
- United States Census Bureau Population Projections

Louisiana Specific Data Sources:

- Louisiana Caring Communities Youth Survey
- CORE Alcohol and Drug Survey
- Crash Report Data. Louisiana Highway Safety Commission (LHSC)/Highway Safety Research Group (HSRG)
- Hepatitis Data, Louisiana Office of Public Health (OPH)
- HIV/AIDS Data, Louisiana Office of Public Health (OPH)
- Mortality Data, Louisiana Office of Public Health (OPH)
- Student Information System (Disciplinary Action Data Related to Substance Use), Louisiana Department of Education
- Substance Use Treatment Admissions, OBH

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds?

a) ☒ Yes ☐ No

i) If yes, (if yes, please explain)

The criteria utilized by OBH Prevention Services uses for establishing primary prevention priorities require the use of state epidemiological data to support the decision to fund a given strategy. Only programs that are evidenced-based/evidence-informed and on a federally recognized register, or have been presented in a peer-reviewed journal with good results, are considered. For instance, LifeSkills Training, Second Step, and Kids Don't Gamble…Wanna Bet? account for 67.5 % of all enrollees in SFY 2022. The proven outcomes for these programs are centered around alcohol, tobacco, family relationships, drugs, social functioning, crime and violence. The primary data sources include: 2020 and 2022 Caring Communities Youth Survey (CCYS), the 2019 and 2021 CORE Alcohol and Drug Survey, which are both funded by OBH, and the State Epidemiology Workgroup (SEW) online data system.

Historically, OBH has maximized the positive impact on citizens by funding primarily universal programs based on needs (indicated by data) and partnering with the Department of Education to deliver these services using a cost-effective school-based model. OBH headquarters and Local Governing Entity staff reviews epidemiological data annually to ensure that the risk factors are identified and the appropriate strategy is implemented to effectively address the issues. In years that new data are available, training and technical assistance is provided to ensure accurate interpretation of the new data.

ii) If no, please explain how SUPTRS BG funds are allocated:

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce?

a) ☒ Yes (if yes, please describe)

b) ☐ No

Louisiana does have a statewide licensing/certification program for the substance use prevention workforce. The Addictive Disorder Regulatory Authority (ADRA) is the state licensing and credentialing board for addiction counselors and prevention professionals. A prevention professional must first register as a Prevention Specialist in Training (PSIT). Based on education and experience, a prevention professional may become a Licensed Prevention Professional (LPP), a Certified Prevention Professional (CPP), and a Registered Prevention Professional (RPP).

Eligibility Requirements for LPP

1) At least 21 years of age and holds a Master's or Doctoral degree from an accredited institution of higher education
2) A legal resident of the United States
3) In not in violation of any ethical standard subscribed to by the ADRA
4) Has not been a substance user or compulsive gambler for at least two years prior to the date of the application
5) Has not been convicted of a felony; however the ADRA has the discretion to waive this requirement upon review of the circumstance
6) Has successfully completed 100 total clock hours of education approved by the ADRA. 50 hours of the 100 hours must be specific to substance use training, with 6 hours in professional ethics, 30 hours from National Prevention Training with the remaining 14 hours being related. All hours are subject to approval by the ADRA

7) Has successfully completed 2000 hours (1 full-time year) of supervised work experience engaged in providing prevention services. Of the 2000 hours, a 120 hour practicum in the 5 domains must be obtained with at least 10 hours in each domain. The experience must be supervised by a qualified professional
8) Has completed and received approval for testing based on submission of the application prescribed by the ADRA to include a case study
9) Demonstrates competence in addiction counseling by passing the written examination prescribed by the ADRA

Eligibility Requirements for CPP

1) At least 21 years of age and holds a Bachelor's degree from an accredited institution of higher education
2) A legal resident of the United States
3) In not in violation of any ethical standard subscribed to by the ADRA
4) Has not been a substance user or compulsive gambler for at least two years prior to the date of the application
5) Has not been convicted of a felony; however the ADRA has the discretion to waive this requirement upon review of the circumstance
6) Has successfully completed 100 total clock hours of education approved by the ADRA. 50 hours of the 100 hours must be specific to substance use training, with 6 hours in professional ethics, 30 hours from National Prevention Training with the remaining 14 hours being related. All hours are subject to approval by the ADRA
7) Has successfully completed 4000 hours (2 full-time years) of supervised work experience engaged in providing prevention services. Of the 4000 hours, a 120 hour practicum in the 5 domains must be obtained with at least 10 hours in each domain. The experience must be supervised by a qualified professional
8) Has completed and received approval for testing based on submission of the application prescribed by the ADRA to include a case study
9) Demonstrates competence in addiction counseling by passing the written examination prescribed by the ADRA

Eligibility Requirements for RPP

1) At least 21 years of age and hold a High School Diploma or a high school diploma equivalent (GED).
2) A legal resident of the United States
3) In not in violation of any ethical standard subscribed to by the ADRA
4) Has not been a substance user or compulsive gambler for at least two years prior to the date of the application.
5) Has not been convicted of a felony; however the ADRA has the discretion to waive this requirement upon review of the circumstance
6) Has successfully completed 100 total clock hours of education approved by the ADRA. 50 hours of the 100 hours must be specific to substance use training, with 6 hours in professional ethics,

30 hours from National Prevention Training with the remaining 14 hours being related. All hours are subject to approval by the ADRA

7) Has successfully completed 6000 hours (3 full-time years) of supervised work experience engaged in providing prevention services. Of the 2000 hours, a 120 hour practicum in the 5 domains must be obtained with at least 10 hours in each domain. The experience must be supervised by a qualified professional
8) Has completed and received approval for testing based on submission of the application prescribed by the ADRA to include a case study
9) Demonstrates competence in addiction counseling by passing the written examination prescribed by the ADRA

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?

a) ☒ Yes (if yes, please describe mechanism used)
b) ☐ No

OBH builds the capacity of its prevention system, including the capacity of its prevention workforce through continuous training and other capacity building efforts. Louisiana's prevention system is comprised of ten (10) Local Governing Entities (LGEs). OBH maintains a functional relationship with both LGEs and Prevention Coordinators (PCs) through regularly scheduled monthly conference calls and Learning Communities. The prevention team also conducts quarterly site visits. Local Prevention Coordinators are responsible for community mobilization activities, oversight of prevention contract providers, and serve as liaisons to state and local stakeholders. Local PCs are provided technical assistance and resources via OBH's State Prevention Staff and participate in trainings to ensure appropriate delivery of prevention services throughout the State. OBH fully understands the importance of collaborating, braiding resources, and networking to either maintain its existing prevention system or to enhance the system. As prevention broadens its scope to include health promotion and the prevention of mental, emotional and behavioral disorders as well as suicide prevention, trainings are being offered to PCs, providers, and other partners to build prevention workforce capacity.

In addition, OBH Prevention Services contracts with the Louisiana Center for Prevention Resources (LCPR) at Southern University Baton Rouge (within the Nelson Mandela College of Government and Social Sciences in the Psychology Department) to provide training and technical assistance services to the Substance Use Prevention Workforce. LCPR helps to increase capacity, skills and expertise to ensure and/or enhance delivery of effective substance abuse prevention interventions, trainings and other prevention activities. The services are available to youth, communities, professionals, and others in the prevention community. LCPR works directly with the LDH/OBH Prevention Services and other statewide entities aimed at improving implementation and delivery of effective substance abuse prevention interventions. LCPR provides prevention skills trainings and technical assistance based on prevention science; use evidence-based and promising practices; and leverage the expertise and resources available through new and existing alliances. It will offer courses and trainings required for prevention certification and/or licensure. The LCPR serves as a repository for prevention resources.

More specifically, LCPR offers the educational requirements needed for Prevention Specialists in-training as well as continuing education requirements needed for Prevention Specialists to renew their credentials.

Most of these courses and trainings will be offered online and available free of charge to your prevention coordinators and vendors (providers) on a first-come, first served basis.

Additionally, the LCPR offers specialty trainings related to the "latest trends" that provide knowledge and skills to enhance the capabilities of persons in the prevention field. Below is a list of trainings from SFY 2022 that have been sponsored by the LCPR include

- Preventing Marijuana Use & Misuse
- Cultural Competency in Substance Abuse Prevention
- Prevention Ethics Seminar
- Suicide Prevention Facilitation Skills and Training and Prevention
- Mental Health First Aid
- Question Persuade and Refer(QPR)
- Substance Abuse Prevention Skills Training (SAPST)
- LivingWorks – Star Program
- Focus Group Training
- MindWise

OBH also works closely with the South-Southwest Prevention Technology Transfer Center (PTTC) Network to improve implementation and delivery of effective substance use prevention interventions, and provide training and technical assistance services to the substance use prevention field. The PTTC has provided intensive technical assistance and learning resources to prevention professionals in Louisiana.

In addition, as part of the Partnerships for Success Grant, there are on-going Learning Communities provided. These Learning Communities are open to PFS sub-grantees, Prevention Coordinators, and other community partners. The Learning Communities provide information on the SPF Model, current trends, and other substance related topics. The Learning Communities are carried out both virtually and in-person.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?

a) ☒ Yes (if yes, please describe mechanism used)

b) ☐ No

The state has adopted the Strategic Prevention Framework (SPF) as the Planning Model for all Prevention services. Much time has been devoted to training and technical assistance around the first and second steps of the SPF, Assessment and Capacity. Specific information is provided on assessing data, readiness and resources. Webinars and in-person trainings are held each year with LGE Staff on specific topics with special attention devoted to assessment and capacity. The training begins with a review of the Strategic Prevention Framework. The assessment section of the training includes: an assessment of data from community profiles, review of community resource scans and a power point describing the Tri-Ethnic community readiness model. The capacity section of the training includes an overview and review of action planning templates for developing coalition membership action plans, data enhancement action plans and community readiness action plans. The community readiness assessment is a comprehensive process that includes interview questions, review of information across dimensions, scoring, and developing strategies based upon the final readiness score.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?
    a) ☒ Yes (If yes, please attach the plan in BGAS)
    b) ☐ No

The *2022-2026 Louisiana Substance Use Prevention Strategic Plan* is the third iteration of a statewide strategic plan focused on preventing substance use in Louisiana. As with the two previous five-year plans, this document serves as the roadmap for realizing the vision of Louisiana's substance use prevention system stakeholders. The plan begins with a pictorial and narrative description of Louisiana's statewide prevention infrastructure. Next, we define the foundational elements of Louisiana's prevention system and explain how the adoption and integration of these elements have provided a legacy for the everlasting support and growth of the system. The plan provides an analysis of data and identifies the priority substance use problems to be addressed. Finally, we outline a set of topic-specific goals and objectives that the members of the prevention system are committed to accomplishing in its effort to making measurable improvements in the health and welfare of Louisiana's citizens.
The *2022-2026 Louisiana Substance Use Prevention Strategic Plan* is a fluid document and adjustments will be made as needed throughout the five-year implementation process to respond to emerging priorities or redirect resources as achievements are realized.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?
    a) ☒ Yes ☐ No
    ☐ Not applicable (no prevention strategic plan)

3. Does your state's prevention strategic plan include the following components? (check all that apply):
    a) ☒ Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
    b) ☒ Timelines
    c) ☒ Roles and responsibilities
    d) ☒ Process indicators

e) ☒ Outcome indicators

f) ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds?

a) ☒ Yes ☐ No

The Louisiana Behavioral Health Advisory Council (LBHAC) provides guidance for the Block Grant Application/State Behavioral Health Plan and monitors, reviews, and evaluates the allocation and adequacy of behavioral health services within the state. Regional Advisory Councils (RACs) are similar in purpose to the LBHAC, 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.

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds?

a) ☒ Yes ☐ No – Not a formal Evidence-Based Workgroup

b) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

Although not a formal "Evidence-Based Workgroup", Louisiana has an infrastructure in place to identify and support Local Governing Entities with identifying risk and protective factors and matching these factors with appropriate evidence-based and or evidence-informed strategies.

OBH Prevention Services over the past four years has moved from a pattern of historical funding of prevention services to a data-driven planning process. Annually, the 10 LGEs review their funding of prevention services to determine the need. As previously mentioned in Question #5, the mechanisms by which SUPTRS BG primary prevention funding decisions are made include needs assessments using the Louisiana Caring Communities Youth Survey, the Higher Education Core Survey reports, and State Epidemiological Workgroup report. These data resources are reviewed and provide a data focused mechanism to determine community level needs. The needs assessments are updated every two years.

Based upon the LGEs findings, strategic plans are developed. To support the LGEs, OBH provides resources to fund evidence-based programs, strategies, and other substance use prevention initiatives. Over the last several years, LGEs have submitted annual Strategic Plans to document proposed services. Thereafter, LGEs contract with local partners to develop formalized contracts that clearly state deliverables and expectations. The contracts are developed based upon deliverables found within the Strategic Plan. Implementation of deliverables and process data are tracked through data collected in the State's web-based data management system, the Prevention Management Information System (PMIS). A PMIS report is generated each quarter by the state Prevention Services detailing services and deliverables information for each region, provider, and program. This report is followed by a quarterly site visit by a state office prevention staff member to provide technical assistance during the service delivery period.

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

a) ☐ SSA staff directly implements primary prevention programs and strategies.

b) ☒ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).

c) ☒ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.

d) ☒ The SSA funds regional entities that provide training and technical assistance.

e) ☒ The SSA funds regional entities to provide prevention services.

f) ☒ The SSA funds county, city, or tribal governments to provide prevention services.

g) ☒ The SSA funds community coalitions to provide prevention services.

h) ☐ The SSA funds individual programs that are not part of a larger community effort.

i) ☒ The SSA directly funds other state agency prevention programs.

j) ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

All OBH contract providers provide information specific to their program and alcohol, tobacco, and other drugs (ATOD) to the communities in which they reside. OBH also maintains at least one Regional Alcohol and Drug Awareness Resource (RADAR) Associate Network in each LGE. OBH, through its Prevention Management Information System (PMIS), confirms this information dissemination. Examples include dissemination of ATOD literature, audiovisual materials, curriculum materials, printed material, resource directory, and telephone information. They also conducted health fairs, health promotion events, media campaigns, public service announcements, and speaking engagements.

b) Education:

OBH contract providers provide on-going prevention education from evidence-based curriculums to enrollees in their respective program(s). OBH confirms through its Prevention Management Information System (PMIS) the number of evidence-based programs provided to enrollees. The following table lists the 23 Evidence-Based Educational Programs that were funded during SFY 2022 designated by Universal, Selective, or Indicated.

Universal Program(s)		Selective Program(s)
Life Skills Training	Generation Rx Elementary	Parenting Wisely
Kids Don’t Gamble Wanna Bet?	Lion’s Quest	Strengthening Families
Second Step	Too Good for Violence	Selective Program(s) Total: 2
Too Good for Drugs	Catch My Breath	
Project Northland	Generation Rx Teen	Indicated Program(s)

Coping Skills	Curriculum-Based Support Group Program	Children's Program Kit
Protecting You - Protecting Me	Stacked Deck	Indicated Program(s) Total: 1
Al's Pals	Positive Action	
Project Toward No Tobacco Use	Keeping It Real	
Generation Rx College	Project Alert	
Universal Program(s) Total: 20		

c) Alternatives:

Prevention contractors have the option of providing alternative strategies through in-kind contributions to their respective target population(s) as may be appropriate. Provider staff provides alcohol, tobacco and other drug-free events; community drop-in center activities; community services; and youth and adult leadership functions.

d) Problem identification and referral

OBH continues to provide problem identification and referral services statewide. Contract providers are responsible for ensuring access to community resources by referring participants and/or their families for services not provided by the contractor. Providers referred customers to services that included DUI/DWI/MIP services, as well as student and employee assistance programs. Providers delivered these services on an individual basis and in venues such as adult education classes, suicide prevention workshops*, and teen job fairs.

*Suicide prevention workshops are funded by the Mental Health Block Grant and are made available to prevention and treatment staff, providers, and community partners

e) Community-Based Processes:

OBH continues to develop a comprehensive, research-based approach to prevention services. In an effort to mobilize communities, OBH staff and contractors participate in the implementation of the Strategic Prevention Framework. The Framework includes the following steps: 1) needs, readiness, and resource assessment; 2) building capacity; 3) selecting appropriate programs, policies and practices; 4) implementing selected programs, policies and practices; and 5) evaluating outcomes. Agency and provider staff participated in accessing services and funding, assessing community needs, community volunteer services, community needs assessment, community team activities, contract monitoring, formal community teams, professional development, strategic prevention planning, technical assistance, and training.

f) Environmental:

OBH funds a Synar Contractor in each region of the state in an effort to maintain no more than a 10 percent sale rate of tobacco products to minors. OBH staff and contractors identify and collaborate with other agencies and organizations (e.g. the Coalition for Tobacco-Free Living, Students Against Destructive Decisions, the American Lung Association, Highway Safety Coalitions, etc.) that are engaged in environmental strategies that address substance use disorders and related behaviors.

Provider and agency staff participated in alcohol use restrictions in public places, changing environmental laws, social norms campaigns, social marketing campaigns, compliance checks of alcohol and tobacco retailers, environmental consultation to communities, establishing ATOD-free policies, prevention of

underage alcoholic beverage sales, public policy efforts, checking age identification for alcohol and tobacco purchase, minimum age of seller requirements, developing policies concerning cigarette vending machines, and alcohol restrictions at community events.

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means?

a) ☒ Yes (if so, please describe:)
b) ☐ No

Mobilizing the existing infrastructure via partnership growth and expansion of the SPF planning process is the focus of change. Mobilizing the state and community partners around the SPF training will increase community awareness and support around the consequences of substance use and addiction. OBH has learned that in order to effectively reach the citizens of the state, it cannot operate in isolation. For this reason. OBH has cultivated true partnerships with agencies whose focus aligns with the primary mission of prevention; to reduce substance use and addiction and related consequences. These partnerships allow us to avoid duplication of services and maximize existing resources. This change in the service-delivery model was possible through a partnership with the Louisiana Department of Education, which allowed OBH to move from funding infrastructure, and use these monies to provide increased service delivery to our citizens.

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

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?

a) ☐ Yes (If yes, please attach the plan in BGAS)
b) ☒ No

Though not a formal Evaluation plan, OBH has procedures in place to annually track process and outcomes annually of SUPTRS BG-funded programs through the state's Prevention Management Information System.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

a) ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
b) ☐ Includes evaluation information from sub-recipients

c) ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
d) ☐ Establishes a process for providing timely evaluation information to stakeholders
e) ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
f) ☐ Other (please describe:)
g) ☒ Not applicable/no prevention evaluation plan

The state collects process data through OBH's online Prevention Management Information System (PMIS). PMIS Process evaluation is conducted at the state, regional, and provider level. Prevention staff and contract providers input information about direct and indirect individual and population-based services into PMIS. PMIS is available to all on a daily basis and real-time rollup reports are compiled for the state, regional, or provider level. Specific data elements collected by PMIS include demographic data (age, race, and ethnicity) as well as tracking of specific services to include number served, target population, as well as services provided within the six CSAP prevention strategies.

Real time reports allow OBH Central Office staff to support the field by assessing the State's current capacity and determining whether performance targets have been achieved. This provides a mechanism for staff to develop, intervene and implement corrective action in a timely manner.

In addition to tracking process data, OBH is committed to a statewide system to evaluate outcomes. Each contract provider is required to obtain an external evaluator. Each provider administers the pre- and post-test that was developed and validated by each evidence-based program's developer. Since SFY 2011, a state evaluator compiles regional and state outcome reports based upon each evidence-based program funded by OBH Prevention services. In addition to the developer's pre- and post-test, Government Performance and Results Act (GPRA) supplemental questions are asked of youth age 12 and older.

State and Regional staff review these reports to determine fidelity improvement needs by content area of each program. It also helps strengthen our monitoring process of the evaluation cycle. Quarterly reviews of process and monitoring data ensures a stronger outcome evaluation system.

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

a) ☒ Numbers served
b) ☒ Implementation fidelity
c) ☐ Participant satisfaction
d) ☒ Number of evidence based programs/practices/policies implemented
e) ☒ Attendance
f) ☒ Demographic information
g) ☐ Other (please describe:)

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

a) ☒ 30-day use of alcohol, tobacco, prescription drugs, etc…
b) ☒ Heavy alcohol use
c) ☒ Binge alcohol use

d) ☒ Perception of harm

e) ☒ Disapproval of use

f) ☒ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

g) ☐ Other (please describe:)

6. Statutory Criterion for MHBG- Required for MHBG

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Louisiana began its efforts to establish and implement an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders, in 2012 with the implementation of the Louisiana Behavioral Health Partnership (LBHP). The implementation of the LBHP was the beginning of Louisiana's efforts to right-size inpatient services and increase the utilization of community-based services through managed care.

In 2015, the Louisiana Department of Health (LDH) integrated all behavioral health care services into its existing physical health Medicaid managed care system. On December 1, 2015, behavioral health services were integrated with primary health care services under Louisiana Medicaid's managed care system, Healthy Louisiana.

Through a number of quality improvement measures, LDH/OBH partners with the six (6) Medicaid MCOs to strive to ensure implementation of an array of specialized behavioral health services to meet the needs of Louisiana citizens. This includes ensuring an adequate number, type, and geographic distribution of behavioral health providers in addition to ensuring the quality provision of services in congruence with state and national standards of operations. The MCOs are also tasked with quality and utilization reviews, to ensure individuals are receiving services in the least restrictive setting to meet their needs.

In 2014, the United States Department of Justice (DOJ) initiated an investigation of the State of Louisiana's mental health service system to assess compliance with Title II of the ADA. Following this investigation, in 2016, DOJ concluded that Louisiana unnecessarily relies on nursing facilities (NFs) to serve people with serious mental illness instead of serving them in the most integrated setting appropriate to their needs as required by the ADA. On June 6, 2018, the State of Louisiana and the Louisiana Department of Health announced an agreement with the U.S. Department of Justice to help ensure that people with serious mental illnesses have the opportunity to live in a community setting. With the DOJ Agreement, LDH welcomed the opportunity to enhance and strengthen programs to serve individuals in the least restrictive setting. In 2018, LDH established the My Choice Louisiana Program in response to the DOJ Agreement. LDH named the program "My Choice Louisiana" to reflect two of the key principles discussed in the

Agreement: self-determination and choice. Through My Choice Louisiana, the State provides transition planning and support, as well as screening and evaluations to all Medicaid eligible individuals with serious mental illness who are currently in a nursing facility. The State also looks to improve on diverting individuals with serious mental illness to appropriate community-based services in lieu of nursing facility placement.

OBH works with both Central Louisiana State Hospital and East Louisiana State Hospital to help facilitate and coordinate the discharge of patients located in the civil intermediate care units. This collaborative process mirrors the State's previous discharge efforts during the Mental Health Redesign and Hospital Discharge Initiative. This discharge initiative has the objective of working with hospital discharge teams to find secure and effective placement settings (such as Permanent Supportive Housing units, group homes, or family homes) that will provide the level of care necessary to help the patient obtain optimal success. OBH staff meets with hospital staff to discuss cases at length, offer guidance, and work as a mediator between the hospital and behavioral health and housing entities. This process, which was established March 1, 2013, and continues to evolve, is in line with OBH's goal of emphasizing community-based treatment.

Additionally, OBH has implemented an acute care Continued Stay Review (CSR) process for contracted partners providing indigent care. The CSR process was put in place in order to appropriately ration disproportionate shares funding to these psychiatric acute care facilities. When this care extends beyond what is deemed as the typical acute care stay (due to a number of issues), disproportionate shares funding is used to cover the remainder of the stay. The OBH CSR unit helps to manage this support to assure that funds are appropriately spent and care is medically necessary.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a) Physical health
☒ Yes ☐ No

b) Mental Health
☒ Yes ☐ No

c) Rehabilitation services
☒ Yes ☐ No

d) Employment services
☒ Yes ☐ No

e) Housing services
☒ Yes ☐ No

f) Educational services
☐ Yes ☒ No

g) Substance misuse prevention and SUD treatment services
☒ Yes ☐ No

h) Medical and dental services
☒ Yes ☐ No

i) Support services
☒ Yes ☐ No

j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)
☐ Yes ☒ No

k) Services for persons with co-occurring M/SUDs
☒ Yes ☐ No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Programs and services will vary across the state. For Physical Health and Medical and Dental services, a number of the LGEs have established Federally Qualified Health Centers (FQHC) to provide comprehensive integrated primary and behavioral healthcare services to individuals. Some programs offer supports to individuals for educational services, but not actual Educational Services.

In addition to some LGEs establishing FQHCs, four (4) LGEs have also established Certified Community Behavioral Health Clinics (CCBHCs) via SAMHSA demonstration grants. As the SMHA, LDH/OBH was also awarded a SAMHSA CCBHC Planning Grant in 2024 to support the state's efforts. With the support of this SAMHSA Planning Grant, LDH/OBH has established several workgroups and contract partnerships to establish the CCBHC model for Louisiana within the coming year to apply for as a CMS Demonstration State for the CCBHC model in 2026. The CCBHC model has further supported LDH/OBH goal of further integrating primary and behavioral healthcare and ongoing growth of a comprehensive behavioral health service delivery structure throughout the state.

3. Describe your state's case management services

Case management services are available via various programs within the Louisiana behavioral healthcare system. Within the managed care model for integrated primary and behavioral healthcare services, it is a requirement of the contract that services provided by MCOs includes Case Management services. The MCOs are required to maintain an adequate number of case management staff necessary to support members in need of specialized behavioral health services. These staff persons shall be certified in treatment planning through the completion of specialized training in the Treatment Planning Philosophy. For the population receiving specialized behavioral health services, the MCO shall have integrated care management centers/case management staff that physically co-locate with care management staff. The MCO shall employ care managers to coordinate follow-up to specialty behavioral health providers and follow-up with patients to improve overall health care.

Within the integrated primary and behavioral health care managed care model for Medicaid services, the Special Health Care Needs (SHCN) population is also required to be offered Tiered Case Management based on need; this includes:

- Intensive Case Management for High Risk Enrollees (High) (Tier 3)
- Case Management (Medium) (Tier 2)
- Case Management (Low) (Tier 1)

The following additional case management programs are also offered:

- Transitional Case Management
- Case Management for Individuals in DOJ Agreement Target Population

The Special Health Care Needs population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches. For the behavioral health population, individuals with special health care needs include any MCO enrollee who:

- have complex needs such as multiple chronic conditions, co-morbidities, and co-existing functional impairments;
- are at high risk for admission/readmission to a hospital within the next six (6) months;
- are at high risk of institutionalization;
- have been diagnosed with a Serious Emotional Disturbance, a Severe and Persistent Mental Illness, or a Substance Use Disorder, or otherwise have significant behavioral health needs, including those Enrollees presenting to the hospital or emergency department with a suicide attempt or non-fatal opioid, stimulants, and sedative/hypnotic drug overdose reason;
- are homeless as defined in Section 330(h)(5)(A) of the Public Health Service Act and codified by the US Department of Health and Human Services in 42 U.S.C. §254(b);
- are women with high-risk pregnancies (i.e., pregnancies that have one or more risk factors) or who have had an adverse pregnancy outcome during the pregnancy, including preterm birth of less than thirty-seven (37) weeks;
- have been recently incarcerated and are transitioning out of custody;
- are at high risk of inpatient admission or emergency department visits, including certain Enrollees transitioning care across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting;
- are members of the DOJ Agreement Target Population;
- are enrolled under the Act 421 Children's Medicaid Option; or
- receives care from other State agency programs, including, but not limited to, programs through OJJ, DCFS, or OPH.

The MCO shall identify members with special health care needs and assess those members within the specified timelines. The assessment must be done by appropriate behavioral or primary healthcare professionals. Assessments that determine a course of treatment or regular care monitoring as appropriate shall result in a referral for case management.

Assertive Community Treatment (ACT) is available in throughout the state. This medical, comprehensive case management and psychosocial intervention program is provided on the basis of the following principles:

- The service is available 24 hours a day, seven days a week.
- An individualized service plan and supports are developed.
- At least 90% of services are delivered as community-based outreach services.
- An array of services are provided based on individual patient medical need.
- The service is consumer-directed.
- The service is recovery-oriented.

In 2022, LDH implemented Community Case Management for individuals who were transitioned or diverted from NFs. Community Case Managers (CCMs) are responsible for engaging individuals who are diverted from NFs through the Preadmission Screening and Resident Review (PASRR) Level II process, assessing their needs, developing a community plan, referring individuals to needed services, and tracking individuals for one year post transition. CCMs are to coordinate services including services in the DOJ

Agreement and medical and long-term services and supports to address the individual's healthcare and activities of daily living needs. LDH tracks and reports the number of individuals who were diverted and engaged in Community Case Management, as well as what services are utilized by these individuals.

4. Describe activities intended to reduce hospitalizations and hospital stays.

A major goal of the efforts to integrate behavioral and primary health care services into Louisiana Medicaid's managed care model, Healthy Louisiana, is to improve care coordination for their enrollees, provide more opportunities for seamless and real-time case management of health services, and better transition and use of all resources provided by Louisiana's healthcare system. Through better coordination of services, the integrated model enhances the consumer experience, increases access to a more complete and effective array of behavioral health services and supports, improves quality of care and outcomes, and reduces repeat emergency room visits, hospitalizations, out-of-home placements, and other institutionalizations. The managed care model consist of more than 1,800 behavioral health providers statewide.

Competency Restoration/Jail-Based Services are designed for pretrial detainees, who have been identified or adjudicated as incompetent and ordered to be hospitalized or to receive jail-based (community) treatment. District Forensic Coordinators (DFC), working with contract Psychiatrists and Psychologists, go to the jails and perform mental status assessments to determine the timeframe for admission to the hospital which may be 30 days, 10 days or 2 days depending on severity of symptoms. Other individuals may be deemed appropriate for 90-day jail-based competency restoration which allows them to bypass hospitalization, thus diverting the need for lengthy inpatient stays.

The community-based Child and Adolescent Response Team (CART) program and other community-based supports and services continue to provide a route to assist in the reduction of inpatient hospitalizations and diversion from out-of-home placements. Assertive Community Treatment (ACT) services, an evidence-based medical, comprehensive case management and psychosocial intervention program, is also available in all areas of the state, which contributes to the reduction of inpatient hospitalizations and offers intensive supports to allow individuals to remain in the community.

As reported in previous applications, the Louisiana Department of Health (LDH)/Office of Behavioral Health (OBH) has actively worked towards expanding and restructuring the Medicaid service delivery system related to crisis services. LDH/OBH recognizes that a robust crisis system of care encompasses more than just crisis treatment such as psychiatric hospitalizations. A robust crisis system includes a focus on prevention, early and acute intervention, crisis recovery, and reintegration. Louisiana recognizes it had an underdeveloped crisis system. In an effort to restructure the system, OBH envisioned and planned an expansion of the service array to address the entire crisis continuum and to emphasize community-based provision of crisis services and supports. In this model, crisis prevention and early intervention were emphasized in an effort to stave off higher levels of intervention, while care coordination following the crisis events was strengthened as individuals reintegrate into lower levels of care. Ongoing implementation of services across this continuum allow for the provision of individualized interventions intended to maximize voluntary utilization while keeping individuals out of higher levels of care and in the community.

In 2022, LDH implemented the Louisiana Crisis Response System (LA-CRS), a modern, innovative and coordinated approach to crisis services that builds upon the unique and varied strengths, resources and

needs of Louisiana's local communities. LDH launched the expansion of services to Louisiana Medicaid adults experiencing a mental health crisis with the phased implementation of a comprehensive crisis system of care, a critical goal identified in LDH's Fiscal Year 2022 Business Plan. These services are directly correlated to LDH's DOJ Agreement and are critical to LDH's compliance with the Agreement. The services implemented include Mobile Crisis Response, Community Brief Crisis Support, Behavioral Health Crisis Care, and Crisis Stabilization.

Individuals experiencing a psychiatric crisis can access these services until the crisis is resolved and/or the person returns to existing services or is linked to other behavioral health supports as needed. OBH is working to expand services to every region during a phased-in rollout, and expanded access to Mobile Crisis Response and Community Brief Crisis Support services to youth and their families experiencing mental health crises in fiscal year 2024.

Additionally, in fiscal year 2025, LDH implemented the Louisiana Crisis Hub (LCH), a single, statewide, triage and dispatch line, capable of providing telephonic crisis de-escalation techniques to callers as well as connecting individuals to services through triage, referral, and dispatch to available services in the community appropriate to meet their crisis needs. The LCH serves as an access point to LA-CRS and will play a critical role in tracking demand for and facilitating access to crisis services throughout the state. Through these efforts, the Crisis Hub tracks data to measure demand and utilization of crisis services throughout the state.

5. Please indicate areas of technical assistance needed related to this section.

As implementation of the Crisis Response System continues to progress and expand, technical assistance in areas related to expansion may be needed, especially related to integration of these systems into the fabric of local communities through the development of partnerships.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health or other federal/state data that describes the populations of focus

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system. MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Statewide Prevalence (column B) was determined from the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus. Statewide Incidence (column C) indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system, determined by the method described under Incidence of SMI and SED section below.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED (FY 2023)		
Target Population (A)	**Statewide prevalence (B)**	**Statewide incidence (C)**
Adults with SMI	189,870	8,463
Children with SED	38,622	2,186

2. Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence**.**

Prevalence of SMI and SED

Statewide prevalence of adults (age 18 and over) with SMI, and children with SED (ages 9 to 17), are calculated by obtaining the annual estimates from U.S. Census Bureau (*Annual Estimates of the Resident Population for Selected Age Groups by Sex for Louisiana: April 1, 2020 to July 1, 2024*), and then multiplying the estimated population by the SMI/SED prevalence rate obtained from 2023 URS table #1 [Number of adults with serious mental illness, age 18 and older (**5.4%**), and Number of children with serious emotional disturbances, age 9 to 17 (**7%**), by state, 2023].

Incidence of SMI and SED

Statewide incidence of adults (age 18 and over) with SMI and children with SED (ages 9 to 17) are calculated in three steps. First, the number of persons (with SMI and SED) served in FY 2023 are calculated following Louisiana Office of Behavioral Health methodology (column A). These numbers are also reported in the Uniform Reporting System (URS) tables, and include both continuing and new clients. Secondly, numbers are determined for all SMI and SED clients who started receiving services *before* FY 2023 (continuing clients, column B). Lastly, the continuing SMI and SED clients are subtracted from persons served during FY 2023 to obtain the number of *new* clients during FY2023 (incidence, column C).

SMI/SED	Person Served in FY 2023 (A)	SMI and SED Clients Who Started Receiving Services before FY 2023 (Continuing Clients) (B)	Incidence (New SMI and SED Clients) Who Received Services during FY2023 (C=A-B)
Adults with SMI	15,022	6,559	8,463
Child/Youth with SED	3,653	1,467	2,186

3. Please indicate areas of technical assistance needs related to this section.

There are currently no technical assistance needs related to this section.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs.

1. Does your state integrate the following services into a comprehensive system of care?

   a) Social Services

   ☒ Yes ☐ No

b) Educational services, including services provided under IDEA
☒ Yes ☐ No

c) Juvenile justice services
☒ Yes ☐ No

d) Substance misuse prevention and SUD treatment services
☒ Yes ☐ No

e) Health and mental health services
☒ Yes ☐ No

f) Establishes defined geographic area for the provision of the services of such systems
☒ Yes ☐ No

2. Please indicate areas of technical assistance needs related to this section.

As the state continues to develop youth crisis services, the CCBHC model, and Early Childhood Supports & Services (ECSS) program, technical assistance in the expansion of these statewide programs that provide direct services to youth and their families may be needed.

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

Provides outreach to and services for individuals who experience homelessness; community- based services to individuals in rural areas; and community-based services to older adults.

a) Describe your state's tailored services to rural population with SMI/SED. See the federal **Rural Behavioral Health** page for program resources.

Community- Based Services to Individuals in Rural Areas

Although OBH has implemented many effective programs in rural areas, residents of rural areas continue to face barriers to service, especially transportation. Transportation in the rural areas of the state continues to be 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 also to employment and educational opportunities. Some of the LGEs have chosen to utilize their block grant funds for transportation contracts, whereas the LGEs are contracting with private transportation companies to provide transportation to clinic appointments when necessary. The ongoing expansion of behavioral health programs and providers and the recruitment of transportation providers in rural areas are ongoing goals. In many cases, community-based services, such as Assertive Community Treatment (ACT), have been made available to serve some of these populations. The ability of the six (6) Healthy Louisiana Managed Care Organizations (MCOs) to use mapping technology to monitor services and service providers throughout the State continues to help shape the network of providers and services by identifying gaps in services and locating where additional providers may be needed. One outcome of the transfer of the management of behavioral health services to the MCOs continues to be the development of a more robust provider network, even in the more rural areas of the state. Overall, the expanded option of telehealth services during the COVID pandemic has been helpful with increasing access to services. Many providers have expressed increase in participation rates and decrease in “no show” rates for scheduled appointments. While telehealth has been an added benefit to access to care for the rural areas, there continues to be an infrastructure challenge in some rural areas of Louisiana with limited internet availability.

b) Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources

Community- Based Services to Homeless Population

The Projects for Assistance in Transition from Homelessness (PATH) program is a formula grant through which states and territories provide Homeless and Outreach services. Specifically, these services are for individuals with serious mental illnesses and those with co-occurring substance use disorders who are homeless or at imminent risk of becoming homeless. PATH services include community-based outreach, mental health, substance use, case management and other support services, as well as a limited set of housing services. States are encouraged to develop a uniform permanent supportive housing resources policy framework, priority population targeting criteria and defined pathways for entry into housing. This approach coupled with street outreach and case management should result in strong linkages and referrals to permanent supportive housing for persons with serious mental illnesses and co-occurring substance use disorders that are homeless or at imminent risk of becoming homeless.

In an effort to carry out this grant, the LGEs identify the appropriate social service contractor or service delivery method to allocate PATH funds. LGE staff monitors the provision of these services for programmatic issues, outcomes, chart documentation and data reporting. The chart below provides information on Louisiana PATH providers.

Louisiana PATH Providers	LGE
Unity of Greater New Orleans	MHSD
Start Corporation	CAHSD
Start Corporation	SCLHSA
Volunteers of America South Central LA - Lafayette	AAHSD
Volunteers of America South Central LA - Alexandria	CLHSD
HOPE Connection	NLHSD
Easter Seals	NEDHSA
JPHSA	JPHSA

In addition, OBH has two contracts using Mental Health Block Grant funding to provide housing supports and services to homeless individuals with serious mental illness. These contracts are with Start Corporation (Start Corp) to fund nine (9) beds with a transitional housing/adult residential care program for individuals with serious and persistent mental illness (PSMI) who are homeless or at risk of homelessness and the Housing Assistance Program contract with National Alliance for the Mentally Ill of Louisiana (NAMI Louisiana).

The contract with Start Corp, which began in 2018, funds the Wren Way Transitional Housing program. This program allows a length of stay for up to two years for individuals with a primary diagnosis of serious and persistent mental illness (SPMI). The contract for the Wren Way program was previously with NAMI St. Tammany. As evidenced by the historical data with this program, the majority of residents have co-occurring disorders, to include substance use disorders, chronic medical conditions, and/or intellectual developmental disabilities (IDD).

This Wren Way Transitional Housing program allows individuals, who otherwise may be subject to further institutionalization or homelessness, to live in a less restrictive community-based environment while

preparing them to move in the direction of recovery and independence. Start Corp provides qualified trained staff to ensure supervision and provision of services to the residents ranging from assistance with ADLS, Life Skills, Job Readiness and Case Management needs. Start Corp also partners with other community based healthcare providers to ensure the residents behavioral and primary healthcare needs are met. Start Corp coordinates linkage to providers for treatment of primary healthcare, behavioral healthcare, and IDD services through either their own agencies, which includes ACT Teams and FQHCs, or any other appropriate provider agency the resident chooses.

The purpose of the contract with NAMI LA is to provide housing assistance for adults with serious mental illness or co-occurring serious mental illness and substance use disorders. The target population consists of individuals transitioning from institutional care, substandard community housing, or homelessness to approved transitional housing. Individuals discharging from intermediate care facilities often do not have stable housing or support systems that they can return to in the community. Moreover, residing in the institutional care facilities for extended timeframes has resulted in a lack of sufficient household furnishing and basic necessities for community living. In addition, some individuals with mental health disorders residing in substandard housing will require assistance to transition into independent housing.

This contract supports the compliance with the Supreme Court Olmstead Decision, ensuring that individuals with serious mental illness or co-occurring disorders have access to alternative housing options in the least restrictive setting while being informed about available wraparound community services. The contract provides an opportunity for stable housing and allows the individuals to participate in treatment and recovery.

The intent is to be consistent with the Supreme Court Olmstead Decision to provide alternative housing options in least restrictive settings and to inform institutional mental health and substance use individuals with treatment options that provide wraparound services in the community. The contract provides an opportunity for stable housing and allows the individuals to participate in treatment and recovery.

Successful transition includes stability and income. The SSI/SSDI Outreach, Access and Recovery (SOAR) model increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults and children who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or a co-occurring substance use disorder. To increase probability of successful transition, Mental Health Block Grant funds are also intended to be used to fund a SOAR Benefit Specialist position to assist participants in NAMI Louisiana housing assistance program. In 2023, LDH/OBH began a contract partnership with Louisiana Housing Corporation (LHC) to hire and train a SOAR Benefits Specialist in the ten LDH/OBH regions. In the coming year, the plan is to transition this program to the LGEs or another identified contract partner. The ten regional SOAR Benefits Specialist positions will assist targeted individuals with serious mental illness with their applications for SSI/SSDI and other mainstream resources. This additional support will also assist with reducing institutionalization, increasing community supports, and support successful long-term recovery in the community.

In 2020, OBH also began to have representation on the Louisiana Statewide Independent Living Council (SILC) to provide behavioral health information and support to the Council and individuals it represents from throughout the state. The Louisiana Statewide Independent Living Council (SILC) was established by the Rehabilitation Act of 1973 to support the efforts of our citizens with disabilities to live independently in the community of their choice. SILC works to maximize the leadership, empowerment, independence

and productivity of individuals with disabilities, facilitating integration and full inclusion into the mainstream of American society.

In 2019, LDH Leadership began to serve on the Task Force on Human Degradation & Exploitation of Vulnerable Individuals in Community-Based Settings, which was established through legislation to address the needs for appropriate community-based settings for individuals with SMI and IDD. In addition to LDH Leadership, OBH staff also serves as a support to this Task Force, whose goal is to ensure safe community-based and group home settings for individuals with disabilities.

c) Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources.

Community-based Services to Older Adults

As behavioral health services are largely targeted to all adults, inclusive of older persons, the Office of Behavioral Health (OBH) has no specific treatment programs for this population. Services typically provided to the general adult population with SMI include psychiatric evaluation, bio-psychosocial assessments, individual therapy, specialized group therapy and other evidence-based treatments based on unique individual needs.

CMHC ADULT MENTAL HEALTH CASELOAD SIZE ON LAST DAY OF FY2023 & FY2024

	FY22-23			FY23-24		
	Age 18-64	Age 65+	TOTAL Age 18+	Age 18-64	Age 65+	TOTAL Age 18+
LGE						
01- MHSD & EPIC-NOLA Program✪	3,179	319	3,498	2,670	316	2,986
02-CAHSD	3,627	482	4,109	3,372	509	3,881
03-SCLHSA	6,217	611	6,828	5,698	653	6,351
04-AAHSD	3,262	369	3,631			
05-IMCAL	2,593	176	2,769	2,388	208	2,596
06-CLHSD	1,962	244	2,206	1,601	231	1,832
07- NWLHSD & VOA-NLA Program✪	927	78	1,005	866	88	954
08-NEDHSA	883	103	986	841	110	951
09-FPHSA	3,063	357	3,420	2,749	325	3,074
10-JPHSA	1,875	202	2,077	1,242	131	1,373
TOTAL	27,588	2,941	30,529	21,427	2,571	23,998

The majority of mental health conditions upon admission to community-based services for Louisiana's senior population are Depressive Disorders followed closely by Psychotic Disorders. The following table represents the distribution of primary admitting diagnoses for seniors.

Current primary diagnosis is most recent available primary diagnosis from admission to end of the time period

Current Primary Diagnosis	Count and Percentage of Services Received, for Mental Health & Co-Occurring Clients, Age 65 and Over, by Local Governing Entities (LGEs), Fiscal Year 2024																				TOTAL	
	01-MHSD & EPIC NOLA		02-CAHSD		03-SCLHSA		04-AAHSD		05-IMCAL		06-CLHSD		07-NLHSD &VOA-NLA		08-NEDHSA		09-FPHSA		10-JPHSA			
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
ANXIETY DISORDERS	46	2.7%	237	5.1%	29	0.9%	39	3.6%	83	7.9%	72	5.3%	18	2.6%	50	2.7%	39	1.9%	50	5.5%	663	3.6%
ATTENTION DEFICIT	.	.	.	.	9	0.3%	2	0.2%	17	1.6%	.	.	.	.	.	.	.	.	.	.	28	0.2%
BIPOLAR AND RELATED DISORDERS	138	8.1%	529	11.4%	145	4.4%	183	16.7%	103	9.8%	115	8.5%	67	9.7%	169	9.1%	55	2.7%	12	1.3%	1516	8.1%
DEPRESSIVE DISORDERS	255	15.0 %	918	19.9%	281	8.4%	371	33.9%	212	20.2 %	269	19.9%	126	18.2%	597	32.2%	200	9.8%	203	22.2%	3432	18.4%
DISRUPTIVE, IMPULSE, & CONDUCT DISORDERS	1	0.1%	17	0.4%	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	18	0.1%
ILLNESS, UNSPECIFIED	.	.	.	.	10	0.3%	.	.	.	.	.	.	.	.	75	4.0%	.	.	.	.	85	0.5%
INTELLECTUAL DISABILITY	1	0.1%	22	0.5%	.	.	8	0.7%	4	0.4%	4	0.3%	7	1.0%	.	.	.	.	1	0.1%	47	0.3%
OTHER/UNSPECIFIED MENTAL DISORDERS	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	1	0.1%	1	0.0%
PERSONALITY DISORDERS	.	.	.	.	.	.	.	.	3	0.3%	.	.	.	.	.	.	3	0.1%	.	.	6	0.0%
PSYCHOTIC DISORDERS	587	34.5 %	1715	37.1%	344	10.3%	209	19.1%	147	14.0 %	214	15.8%	71	10.3%	335	18.0%	173	8.5%	29	3.2%	3824	20.5%
SUBSTANCE RELATED AND ADDICTIVE DISORDER	24	1.4%	201	4.3%	27	0.8%	13	1.2%	18	1.7%	22	1.6%	.	.	10	0.5%	36	1.8%	84	9.2%	435	2.3%
TRAUMA & STRESSOR RELATED DISORDERS	6	0.4%	58	1.3%	23	0.7%	14	1.3%	22	2.1%	3	0.2%	.	.	32	1.7%	2	0.1%	43	4.7%	203	1.1%
Z CODES	.	.	30	0.6%	84	2.5%	.	.	13	1.2%	7	0.5%	.	.	25	1.3%	110	5.4%	.	.	269	1.4%
Missing	641	37.7 %	895	19.4%	238 0	71.4%	254	23.2%	428	40.8 %	649	47.9%	403	58.2%	563	30.3%	1413	69.6%	492	53.8%	8118	43.5%
TOTAL	**1699**	**100.0 %**	**4622**	**100.0%**	**333 2**	**100.0 %**	**1093**	**100.0%**	**1050**	**100.0 %**	**1355**	**100.0%**	**692**	**100.0%**	**1856**	**100.0%**	**2031**	**100.0%**	**915**	**100.0 %**	**18645**	**100.0%**

Data Source: LGE EHR data sent to OBH. Age at end of reporting time period. Unduplicated by client within LGE. EHR data for AAHSD available only from July 1, 2023 – December 29, 2023 of FY 2024.
[α] EPIC-NOLA (program through Sinfonia Family Services of Louisiana in conjunction with Tulane University). Serves Orleans, St. Bernard, Plaquemines Parishes. [β] Volunteers of America of North Louisiana (VOA-NLA): serves MH clients at nine parishes in northwestern part of the State. SMI/SED based on most recent Special Population SMI/SED available from admission to end of reporting time period.

OBH works collaboratively with Medicaid, the Office of Aging and Adult Services (OAAS), and the Office for Citizens with Developmental Disabilities (OCDD) in identifying and monitoring individuals with behavioral health disorders who are nursing facility (NF) applicants and may require specialized treatment beyond those traditionally offered in a nursing home setting. The collaboration is part of the federally mandated Pre-Admission Screening and Resident Review (PASRR) process created in 1987 through the Omnibus Budget Reconciliation Act and a required part of the Medicaid State Plan. PASRR has three main goals: to ensure that individuals are evaluated for evidence of possible mental illness, to see that they are appropriately placed in the least restrictive setting possible, and to recommend needed services wherever they are placed. Presently, OBH incorporates the use of web-based record filing and faxing to accommodate the transmission, receipt and storage of information obtained from hospitals and nursing facilities throughout the state. Additionally, in FY25, OBH has collaborated with OAAS, the PASRR Level I authority, on the integration of a I.5 process through Maximus which allows for a clinical screen of individuals to more precisely determine whether or not the individual is in need of a Level II evaluation.

OBH has integrated the PASRR evaluation process into the contracts with the six (6) Managed Care Organizations. The MCOS have Licensed Mental Health Practitioners (LMHPs) conduct face-to-face evaluations on individuals who are seeking nursing facility placement. The evaluations are completed in compliance with federal PASRR standards and include topics covering the individual's behavioral health history, their physical/medical history, social history, trauma history, living situation, learning/working and functional status including mental status and risk assessment. The evaluations are completed prior to admission to nursing homes as well as when there is a significant change in status (resident review) or an extension to the existing authorization is being made (extension request). Expert psychiatric consultation is also used for cases involving complex clinical behavioral health and medical presentations, when nursing facility placement is not the least restrictive environment for the individual, and/or to verify the presence of Alzheimer's or a dementia-related condition. Recommendations for nursing home placement and behavioral health treatment are made based on a comprehensive review of clinical information.

The table below represents the number of individuals evaluated by OBH for nursing home during FY25:

Evaluations for Nursing Home by OBH	**FY 2025**
PASRR Process Referrals (excluded deaths)	12091
Types of Referrals	
• Referrals for admission to nursing facilities (preadmission)	3897
• Referrals for resident reviews performed while in the nursing facility after a significant change in status (resident review)	2781
• Referrals for Extension Requests through the Continued Stay Request process for individuals already admitted to a nursing facility (continued stay review)	5413
Decisions	
• Approved for Nursing Facility Placement	7089
• Denied Nursing Facility Placement	286
• Decided not to go to Nursing Facility and withdrew request	936

• Determination by OBH Level II Authority was not required. Final determination made by the PASRR Level I Authority, Office of Aging and Adult Services (OAAS).	3569
• OCDD in charge of determination	211
Number of Level II Evaluations (MCO and Merakey)	**6615**
• Aetna (MCO)	999
• AmeriHealth Caritas of Louisiana (MCO)	907
• Healthy Blue (MCO)	1057
• Humana (MCO)	832
• Louisiana Healthcare Connections (MCO)	1150
• Merakey	530
• United Healthcare (MCO)	1137
Number of Evaluations by OBH Psychiatrist	**445**

The status of individuals recommended for specialized behavioral health care is tracked and monitored to ensure the delivery of services. Services are provided by an array of mental health care providers managed by the six (6) Healthy Louisiana Managed Care Organizations (MCOs). Individuals may receive services from a psychiatrist, a licensed mental health professional, Assertive Community Treatment team, mental health rehabilitation provider, and providers of addiction services while in the nursing facilities. Of course, they may also utilize inpatient psychiatric treatment as needed.

On June 6, 2018, the Louisiana Department of Health entered into an agreement with the Department of Justice in response to their determination, subsequent to an investigation, that Louisiana has inappropriately institutionalized individuals with serious mental illness in Nursing Facilities throughout the state. OBH has been heavily involved in the implementation of activities developed as a response to the Agreement. These activities include:

- Improvements to the PASRR Level II process as it relates to length and frequency of authorization as well as requirements related to the accurate identification of those individuals who have Alzheimers or other dementia-related conditions. As of June 6, 2018, the effective date of the Agreement with DOJ, PASRR Level II staff has modified processes and all authorizations made by this office are temporary not to exceed 90 – 100 days for initial admits and 365 days for extension requests.
- Development of a statewide cadre of Transition Coordinators who are able to connect with individuals with SMI residing in NF, helping to transition them back into the community in collaboration with Managed Care Organizations, behavioral health service providers, and Office of Aging and Adult Services (OAAS) staff/service providers. OBH has hired ten (10) regional Transition Coordinators with experience in behavioral health programs and services to assist individuals with SMI transitioning from a nursing facility to the community, as well as to assist with diverting individuals with SMI from nursing facility placements when a less restrictive setting in the community would be the most appropriate placement. This program is called My Choice Louisiana (MCL).

- This program has expanded in scope and in addition to transition coordinators working throughout the state, Peer Support Specialists (called Peer In-Reach Specialists) have also been integrated into the transition teams to assist in the transition process.
- Evaluation and expansion (as needed) of the behavioral health service system ensuring individuals are able to transition into the community and/or divert from Nursing Facility placement.

Through this DOJ initiative and others, OBH has continued to work on several multi-agency projects over the past year to enhance the identification of individuals in nursing homes with a mental illness and ensure they have appropriate services. These initiatives include:

- Identification of individuals in nursing facilities that no longer meet Level of Care (LOC)
- Increased collaborations between OBH and the LDH Health Standards Section (HSS) as well as collaborations between LDH and the Louisiana Hospital Association (LHA) and the Louisiana Nursing Home Association (LNHA)
- Site visits to nursing facilities that have large populations with behavioral health issues
- Continued consultation between OBH and HSS as behavioral health issues arise
- Collaborations to include PASRR in state nursing facility licensing standards
- Improvements to the PASRR tracking systems
- Internal quality improvement processes for the PASRR and MCL programs
- Development of a dementia protocol within the PASRR program
- Integration of a PASRR I.5 process through OAAS and their contractor, Maximus
- OBH offers continuous technical assistance and trainings. Trainings offered by OBH include:
  - Training to state surveyors regarding PASRR
  - Trainings to Nursing Facilities (NF)
  - LDH Collaborative Discharge Planning Trainings to NF
  - OBH trainings to LNHA members regarding PASRR and behavioral health issues in older adults
  - LDH trainings to the LHA about PASRR and MCL
  - Trainings to Managed Care Organizations (MCOs)
  - Trainings to the Behavioral Health provider network
  - Trainings to NF referral sources
  - Training to OBH/OAAS/OCDD PASRR staff
  - Trainings to the Office of Aging and Adult Services' (OAAS) staff regarding suicide awareness and behavioral health services provided to older adults
  - Quality audits of PASRR requests and implementation of Grand Rounds with the MCOs and Level II evaluators to develop congruence amongst partners related to recommendations for placement and services.

OBH also partners with other agencies on activities and best practices for this population. These activities include Money Follows the Person (MFP), which is a federal initiative to transition people with Medicaid from nursing facilities back into the community with necessary supports and other activities identified through OAAS, Adult Protective Services, OCDD, Health Standards, as well as private hospitals and providers. OBH staff also represents the State as a member of the National Association of State Mental Health Directors' (NASMHPD) Older Persons Division. The purpose of this group is to represent and advocate for state mental health agencies by informing them of emerging policy issues, research findings

and best practices, and to provide consultation and collaboration on mental health issues pertaining to older persons.

d. Please indicate any other areas of technical assistance needed related to this section.

N/a

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

a) Describe your state's management systems.

The Louisiana Medicaid and Coordinated System of Care (CSoC) MCOs have continued to offer statewide training to behavioral health providers on various topics, such as: utilization management, eligibility, website resources and tools, authorization process, billable services, levels of care, care coordination, treatment planning, peer support, effective practices in ADHD treatment, crisis management planning, crisis interventions, and coordination of care with primary care physicians. Due to the COVID-19 Pandemic, training programs made the transition from in-person to virtual in 2020. The MCOs have continued to provide web-based training opportunities to providers and partners.

The Coordinated System of Care (CSoC) team has been responsible for ensuring that all wraparound agencies and family support organization staff have the necessary training to successfully implement wraparound in their regions. In addition, the CSoC team at OBH and representatives from the CSoC MCO (Magellan) are responsible for providing additional training and support.

OBH continues to make use of a web-based learning management systems (i.e. Louisiana Employee Online Training) to provide training at the state, LGE, parish, and community level. OBH also provides "live" training events as topics, presenters, and identified needs are made known. Participants for most of the "live" trainings are selected by LGE leadership, and participants must possess the leadership and communication skills required to transfer information and provide trainings to colleagues and other providers within their respective LGE. Transfer of learning remains a key objective for all training provided, whether online or "live" and supervisory follow up is encouraged as a basic requirement for all training offered.

OBH continues to sponsor, co-sponsor, or support with in-kind resources trainings and conferences within the state, such as the annual National Association of Social Workers Louisiana Chapter (NASW-LA) conference and the Louisiana Association of Substance Use Counselors and Trainers (LASACT) annual conference, by presenting specified material during workshops as requested. Throughout the pandemic with virtual events and as events transitioned back to in-person or hybrid models, OBH has continued to provide supportive resources to both of these large statewide conferences. OBH intends to continue to support these efforts for the upcoming fiscal years.

In September 2024 OBH also sponsored a statewide Behavioral Health Symposium with a theme of "Together We Will: Erase the Stigma, Build Resistance, and Embrace Authenticity." The 2024 BH Symposium addressed mental health and substance use disorders treatment and prevention topics that provided guidance on skills, services and programs to overcome the impacts of mental illness, substance

use, opioid use, and other co-occurring disorders to support individuals, families and communities through recovery. The three-day behavioral Health Symposium was co-sponsored by the Medicaid MCOs, Acadiana Area Human Services District (AAHSD), and Foundation for Wellness. Over 500 individuals registered and participated in the 2024 Behavioral Health Symposium. The Behavioral Health Symposium provided training on behavioral health in Louisiana across the lifespan. Topics of the Symposium included mental health, substance use, and prevention services, as well as a pre-conference day that included day-long presentations on Louisiana's Response to the Opioid Crisis. Keynote speakers and topics from the 2024 Behavioral Health Symposium included the following:

- Louisiana State Surgeon General, Dr. Ralph Abraham
- Thomas Farley, A Story of Addiction, Love and Forgiveness
- Dr. Don Stader, Maternal Addiction & Overdose Crisis
- Carlton Hall, Prioritizing Prevention to Address the Fierce Urgencies of Now
- Kristie Brooks, SAMHSA Programs and Outcomes in Louisiana
- Dr. Kenneth Minkoff, Integrated Services for People with Co-Occurring Disorders

Partners invited to participate in the 2024 Behavioral Symposium included service providers throughout the private and public behavioral health and primary health systems, preventionists, peer support specialists, other state agencies, as well as service recipients, their families and advocates.

Please see list below of training topics included in the 2024 Behavioral Health Symposium:

- Opioid Epidemic
- From Informed to Trauma Practicing CareEthics for Behavioral Health Specialists
- Grief and Loss
- Peer Support Services
- Serving Homeless Population with Behavioral Health Disorders
- Medication Assisted Treatment
- Suicide Prevention

During the upcoming fiscal years, OBH intends to continue to utilize block grant funds and LaSOR funds to support ongoing community education and training on various behavioral health topics. Throughout the coming fiscal year, OBH is planning to continue the virtual series of webinars. These webinars will be expansions of topics addressed during the 2024 Behavioral Health Symposium. Topics to be addressed will include those that partners have continued to express an interest and need for additional training as communities, families and individuals.

b) Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach

for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access the federal resource guide Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.

Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

As indicated in the previous Criterion, the expanded option of telehealth services during the COVID pandemic has been helpful with increasing access to services. Many providers have expressed increase in participation rates and decrease in "no show" rates for scheduled appointments. Feedback from providers have indicated that telehealth has expanded options to provide services and a combined model of both in-person and telehealth visits has proven to be the most effective. In 2023, LDH issued informational bulletins announcing the telehealth option for behavioral health services would be extended beyond the public health emergency (PHE).

While telehealth has been an added benefit to access to care for the rural areas, there continues to be an infrastructure challenge in some rural areas of Louisiana with limited internet availability. Based on current research studies, Louisiana currently ranks 46th among states in *BroadbandNow's* annual rankings of internet coverage, speed and availability. In 2019, Louisiana's Broadband for Everyone in Louisiana (BEL) Commission with diverse representation of stakeholders was established with a goal to improve both the adoption and availability of broadband service for Louisiana residents by providing universal access to broadband service with minimum committed speed of 25 Megabits per second (Mbps) download and 3 Mbps upload, scalable to up to 100 Mbps download and 100 Mbps upload, for all Louisianans by 2029.

c) Please indicate areas of technical assistance needed related to this section.

At this time, there are no areas of technical assistance identified within this section.

7. Substance Use Disorder Treatment - Required for SUPTRS BG

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs.

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services:
   i) Screening
      ☒ Yes ☐ No
   ii) Education
      ☒ Yes ☐ No
   iii) Brief intervention
      ☒ Yes ☐ No
   iv) Assessment
      ☒ Yes ☐ No
   v) Withdrawal Management (inpatient/social)
      ☒ Yes ☐ No
   vi) Outpatient
      ☒ Yes ☐ No
   vii) Intensive outpatient
      ☒ Yes ☐ No
   viii) Inpatient/residential
      ☒ Yes ☐ No
   ix) Aftercare/Continuing Care
      ☒ Yes ☐ No
   x) Recovery Services
      ☒ Yes ☐ No

b) Services for special populations:
   i) Prioritized services for veterans?
      ☐ Yes ☒ No
   ii) Adolescents?
      ☒ Yes ☐ No
   iii) Older adults?
      ☐ Yes ☒ No

Criterion 2: Improving Access and Addressing Primary Prevention – see Section 8

Criterion 3: Pregnant Women and Women with Dependent Children (PWWDC)

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability?
   a) ☒ Yes ☐ No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?
   a) ☒ Yes ☐ No

3. Does your state have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?
   a) ☒ Yes ☐ No

4. Does your state have an arrangement for ensuring the provision of required supportive services?
   a) ☒ Yes ☐ No

5. Has your state identified a need for any of the following:
   a) Open assessment and intake scheduling
      ☐ Yes ☒ No
   b) Establishment of an electronic system to identify available treatment slots
      ☒ Yes ☐ No
   c) Expanded community network for supportive services and healthcare
      ☒ Yes ☐ No
   d) Inclusion of recovery support services
      ☐ Yes ☒ No
   e) Health navigators to assist clients with community linkages
      ☒ Yes ☐ No
   f) Expanded capability for family services, relationship restoration, custody issue
      ☒ Yes ☐ No
   g) Providing employment assistance
      ☒ Yes ☐ No
   h) Providing transportation to and from services
      ☒ Yes ☐ No
   i) Educational assistance
      ☒ Yes ☐ No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

OBH/LGE Accountability Plan Monitoring Procedures include

1. Method for monitoring shall include on-site visits as well as electronic desk-top monitoring.
2. Data types under review may include, but are not limited to assessments, chart audits, policies and procedures, and interviews (staff, clients, secret shoppers, etc.).
3. The OBH shall conduct 1 on-site visit and 1 virtual review to each LGE managed program location each year.
4. The LGE shall conduct two on-site visits to each contracted program location each year.
5. The OBH standardized tool with outcome scores shall be utilized by OBH and LGEs for all programs.
6. OBH shall email the initial report and corrective action form to the contractor within thirty (30) business days of each monitoring visit.
7. LGE shall email the initial report and corrective action form to the contractor within the LGE's established timelines and processes.

8. For OBH conducted reviews, the LGE may seek clarification, dispute any elements of the initial report and/or submit corrective action within thirty (30) business days of receipt of the initial report. The responses to the report shall be sent to the OBH staff who conducted the review.
9. For LGE conducted reviews, the contractor may seek clarification, dispute any elements of the report, and/or submit corrective action within thirty (30) business days of receipt of the initial report. The responses to the report shall be sent to the OBH staff who conducted the review.
10. For LGE conducted reviews, OBH shall respond to the LGE program within thirty (30) business days to any LGE responses added to the initial report.
11. LGE will respond to the contractor within the LGE's established timelines and processes to the initial report.
12. OBH shall issue the final report to the LGE program within 30 days of receipt of the LGE response.
13. The LGE shall require the contractor to submit a corrective action plan to address any deficiencies identified within the LGE's established timelines and procedures.
14. The LGE will email the final monitoring tool and corrective action plan to OBH for review within thirty (30) business days for LGE operated programs and within forty-five (45) business days for contractors following receipt of the final monitoring report.
15. For any program with a score of less than 70%, the OBH/LGE shall offer technical assistance and may conduct a follow-up visit or remote follow-up review.

Criterion 4, 5 and 6: Persons Who Inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the

   a) 90 percent capacity reporting requirement
   ☒ Yes ☐ No
   b) 14-120 day performance requirement with provision of interim services
   ☒ Yes ☐ No
   c) Outreach activities
   ☒ Yes ☐ No
   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation
   ☒ Yes ☐ No

2. Has your state identified a need for the following:

   a) Electronic system with alert when 90 percent capacity is reached
   ☒ Yes ☐ No
   b) Automatic reminder system associated with 14-120 day performance requirement
   ☒ Yes ☐ No
   c) Use of peer recovery supports to maintain contact and support
   ☒ Yes ☐ No
   d) Service expansion to specific populations (military families, veterans, adolescents, older adults)

   ☒ Yes ☐ No

3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Current agency policy states that all funded programs give priority admission and preference to treatment in the following order: pregnant injecting drug users, other pregnant substance users, other injecting drug users, and all others. Priority admissions monitoring practices are reviewed during the mandated independent peer review process and during the Annual Accountability Plan (AP) on-site visits. This has helped to confirm that priority admissions are handled in a timely manner and according to Block Grant mandates.

LGE operated and contracted programs are required to provide interim services to these priority populations within 48 hours, if comprehensive care cannot be made available upon initial contact with a waiting period of no longer than 120 days. Interim services are made available through individual sessions, phone contact, and referral or linkage to self-help groups and activities. Documentation of interim services and waiting period are discussed during annual peer reviews and AP visits within each LGE.

All Block Grant requirements related to the OBH system of care are communicated through contractual agreements, with language that addresses the details related to termination of the agreement due to lack of compliance.

OBH/LGE Accountability Plan Monitoring Procedures

1. Method for monitoring shall include on-site visits as well as electronic desk-top monitoring.
2. Data types under review may include, but are not limited to assessments, chart audits, policies and procedures, and interviews (staff, clients, secret shoppers, etc.).
3. The OBH shall conduct 1 on-site visit and 1 virtual review to each LGE managed program location each year.
4. The LGE shall conduct two on-site visits to each contracted program location each year.
5. The OBH standardized tool with outcome scores shall be utilized by OBH and LGEs for all programs.
6. OBH shall email the initial report and corrective action form to the contractor within thirty (30) business days of each monitoring visit.
7. LGE shall email the initial report and corrective action form to the contractor within the LGE's established timelines and processes.
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9. For LGE conducted reviews, the contractor may seek clarification, dispute any elements of the report, and/or submit corrective action within thirty (30) business days of receipt of the initial report. The responses to the report shall be sent to the OBH staff who conducted the review.
10. For LGE conducted reviews, OBH shall respond to the LGE program within thirty (30) business days to any LGE responses added to the initial report.
11. LGE will respond to the contractor within the LGE's established timelines and processes to the initial report.
12. OBH shall issue the final report to the LGE program within 30 days of receipt of the LGE response.

13. The LGE shall require the contractor to submit a corrective action plan to address any deficiencies identified within the LGE's established timelines and procedures.
14. The LGE will email the final monitoring tool and corrective action plan to OBH for review within thirty (30) business days for LGE operated programs and within forty-five (45) business days for contractors following receipt of the final monitoring report.
15. For any program with a score of less than 70%, the OBH/LGE shall offer technical assistance and may conduct a follow-up visit or remote follow-up review.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?

   a) ☒ Yes ☐ No

2. Has your state identified a need for the following:

   a) Business agreement/MOU with primary healthcare providers?
      ☐ Yes ☒ No
   b) Cooperative agreement/MOU with public health entity for testing and treatment?
      ☐ Yes ☒ No
   c) Established co-located SUD professionals within FQHCs?
      ☒ Yes ☐ No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   OBH ensures that all substance use disorder (SUD) treatment providers funded by Block Grant comply with federal requirements related to tuberculosis (TB) education, screening, referral, and treatment. The state has implemented a comprehensive compliance monitoring strategy that combines contractual mandates, policy oversight, and onsite evaluation to ensure access to TB services for individuals receiving SUD care.

OBH/LGE Accountability Plan Monitoring Procedures

1. Method for monitoring shall include on-site visits as well as electronic desk-top monitoring.
2. Data types under review may include, but are not limited to assessments, chart audits, policies and procedures, and interviews (staff, clients, secret shoppers, etc.).
3. The OBH shall conduct 1 on-site visit and 1 virtual review to each LGE managed program location each year.
4. The LGE shall conduct two on-site visits to each contracted program location each year.
5. The OBH standardized tool with outcome scores shall be utilized by OBH and LGEs for all programs.
6. OBH shall email the initial report and corrective action form to the contractor within thirty (30) business days of each monitoring visit.

7. LGE shall email the initial report and corrective action form to the contractor within the LGE's established timelines and processes.
8. For OBH conducted reviews, the LGE may seek clarification, dispute any elements of the initial report and/or submit corrective action within thirty (30) business days of receipt of the initial report. The responses to the report shall be sent to the OBH staff who conducted the review.
9. For LGE conducted reviews, the contractor may seek clarification, dispute any elements of the report, and/or submit corrective action within thirty (30) business days of receipt of the initial report. The responses to the report shall be sent to the OBH staff who conducted the review.
10. For LGE conducted reviews, OBH shall respond to the LGE program within thirty (30) business days to any LGE responses added to the initial report.
11. LGE will respond to the contractor within the LGE's established timelines and processes to the initial report.
12. OBH shall issue the final report to the LGE program within 30 days of receipt of the LGE response.
13. The LGE shall require the contractor to submit a corrective action plan to address any deficiencies identified within the LGE's established timelines and procedures.
14. The LGE will email the final monitoring tool and corrective action plan to OBH for review within thirty (30) business days for LGE operated programs and within forty-five (45) business days for contractors following receipt of the final monitoring report.
15. For any program with a score of less than 70%, the OBH/LGE shall offer technical assistance and may conduct a follow-up visit or remote follow-up review.

Early Intervention Services for HIV (For "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery?

   ☒ Yes ☐ No

2. Has your state identified a need for the following:

   a) Establishment of EIS-HIV service hubs in rural areas
      ☒ Yes ☐ No
   b) Establishment or expansion of tele-health and social media support services
      ☐ Yes ☒ No
   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS
      ☐ Yes ☒ No

Hypodermic Needle Prohibition

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances (42 U.S.C.§ 300x-31(a)(1)F)?
   ☒ Yes ☐ No

Criterion 8, 9 and 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independent Peer Review

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention, and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement?
   ☒ Yes ☐ No
2. Has your state identified a need for the following:
   a) Workforce development efforts to expand service access?
      ☒ Yes ☐ No
   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services?
      ☐ Yes ☒ No
   c) Establish a peer recovery support network to assist in filling the gaps?
      ☐ Yes ☒ No
   d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, persons experiencing homelessness)?
      ☒ Yes ☐ No
   e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations?
      ☒ Yes ☐ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered care?
   ☒ Yes ☐ No
2. Has your state identified a need for the following:
   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services
      ☐ Yes ☒ No
   b) Establish a program to provide trauma-informed care
      ☐ Yes ☒ No
   c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education.
      ☒ Yes ☐ No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)
   ☒ Yes ☐ No

2. Does your state provide any of the following:

   a) Notice to Program Beneficiaries?
      ☒ Yes ☐ No
   b) An organized referral system to identify alternative providers?
      ☐ Yes ☒ No
   c) A system to maintain a list of referrals made by religious organizations?
      ☐ Yes ☒ No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs
   ☒ Yes ☐ No
2. Has your state identified a need for any of the following:

   a) Review and update of screening and assessment instruments?
      ☐ Yes ☒ No
   b) Review of current levels of care to determine changes or additions?
      ☒ Yes ☐ No
   c) Identify workforce needs to expand service capabilities?
      ☒ Yes ☐ No

Patient Records

1. Does your state have an agreement to ensure the protection of client records
   ☒ Yes ☐ No
2. Has your state identified a need for any of the following:

   a) Training staff and community partners on confidentiality requirements?
      ☒ Yes ☐ No
   b) Training on responding to requests asking for acknowledgement of the presence of clients?
      ☐ Yes ☒ No
   c) Updating written procedures which regulate and control access to records?
      ☒ Yes ☐ No
   d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure?
      ☒ Yes ☐ No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?

   a) ☒ Yes ☐ No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.
   - Nine of the ten Sub-recipients/LGEs will participate in IPR during FFY26-27.

3. Has your state identified a need for any of the following

   a) Development of a quality improvement plan?
      ☐ Yes ☒ No
   b) Establishment of policies and procedures related to independent peer review?
      ☐ Yes ☒ No
   c) Develop long-term planning for service revision and expansion to meet the needs of specific populations?
      ☐ Yes ☒ No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for Block Grant funds?

   a) ☒ Yes ☐ No
   b) If Yes, please identify the accreditation organization(s)
      i) ☒ Commission on the Accreditation of Rehabilitation Facilities
      ii) ☒ The Joint Commission
      iii) ☐ Other (please specify)

Criterion 7 and 11: Group Homes for Persons In Recovery and Professional Development

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?
   ☐ Yes ☒ No
2. Has your state identified a need for any of the following:

   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service?
      ☐ Yes ☒ No
   b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing?
      ☐ Yes ☒ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

   a) Recent trends in substance use disorders in the state?

☒ Yes ☐ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services?
☒ Yes ☐ No

c) Performance-based accountability?
☒ Yes ☐ No

d) Data collection and reporting requirements?
☒ Yes ☐ No

If the answer is No to any of the above, please explain the reason: N/a

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs?
☐ Yes ☒ No

b) Addition of training sessions designed to increase employee understanding of recovery support services?
☐ Yes ☒ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services?
☒ Yes ☐ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort?
☐ Yes ☒ No

3. Has your state utilized the Regional Prevention, Treatment, and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC
☒ Yes ☐ No

b) Mental Health TTC
☒ Yes ☐ No

c) Addiction TTC
☒ Yes ☐ No

d) State Opioid Response
☒ Yes ☐ No

e) Strategic Prevention Technical Assistance (SPTAC)
☒ Yes ☐ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections ***42 U.S.C.§ 300x-22(b)***,***300x-23***,***300x-24***, *and* ***300x-28*** *(****42 U.S.C.§ 300x-32(e)****).*

1. Is your state considering requesting a waiver of any requirements related to:

   a) Allocations Regarding Women (300x-22(b))
   ☐ Yes ☒ No

2. Is your state considering requesting a waiver of any requirements related to:
   a) Intravenous substance use (300x-23)
   ☐ Yes ☒ No

3. Is your state considering requesting a waiver of any requirements regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

   a) Tuberculosis
   ☐ Yes ☒ No
   b) Early Intervention Services Regarding HIV
   ☐ Yes ☒ No

4. Is your state considering requesting a waiver of any requirements regarding Additional Agreements (300x-28)

   a) Improvement of Process for Appropriate Referrals for Treatment
   ☐ Yes ☒ No
   b) Professional Development
   ☐ Yes ☒ No
   c) Coordination of Various Activities and Services
   ☐ Yes ☒ No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

https://ldh.la.gov/assets/medicaid/hss/docs/BHS/BHSP_06.25.2025.pdf

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to

assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

1. Briefly describe the SMHA 's data collection and reporting system and what level of data are reported currently (e.g., at the client, program, provider, and/or other levels).

The State of Louisiana (SMHA) uses ***Mental Health Treatment Episode Data Set (MH-TEDS)*** system to collect demographic, clinical and National Outcome Measures (NOMS) data ***for clients*** receiving mental health and support services from programs funded or provided by the SMHA within a state-defined 12-month reporting period. The system is designed to collect information on treatment events, such as Admissions (includes transfer), Discharges (includes updates), at a particular service type/setting (referred to as a ***treatment episode***) within the client's treatment continuum during the reporting period. Both ***individual client*** and ***treatment episode*** can serve as units of analysis.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

Louisiana's current data collection and reporting system is designed for collection and reporting of *Client-level Treatment Data* through Treatment Episode Data System (*TEDS*) for SAMHSA's MHBG and SAPT Block Grant reporting. It is *not* a part of any other larger data system.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

Since the system SMHA uses for URS and MH-TEDS reporting includes individual PHI fields (First/Last Names, DOB, SSN), then we are able to link to other state agencies/entities data that also includes the same PHI fields.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

For URS and MD-TEDS reporting, the SMHA uses client level treatment episode data from LGEs for EBPs including ESMI; and the SMHA uses Medicaid claim/encounter records for BHCS outcome data.

5. Briefly describe the limitations of the SMHA 's existing data system.

State of Louisiana (SMHA) collects Client-level Episode of Care data from Ten Regional Health Partners (Local Governing Entities; LGEs). SMHA relies on those LGE records for URS and MD-TEDS reporting, and sometimes we see significant data quality and non-submission issues related to changes to the LGE's E-HR systems and changes to their staffing.

6. What strategies are being employed by the SMHA to enhance data quality?

Louisiana reports Admission and Discharge files for MH-TEDS, and SA-TEDS, per SAMHSA reporting requirements mentioned in TEDS Data Submission System (DSS) guide and URS Reporting Instructions.

Strategies to enhance data quality:

- Pre-Integration (into the OBH LGE data warehouse) Data Reports: data validation reports are generated twice a month to monitor data quality of E HR files, submitted by Regional Health Partners (Local Governing Entities; LGEs). These reports are shared with the LGEs, listing areas that need improvement.
- Post-Integration Data Reports: Validation checks to review integration process. Following integration to OBH LGE data warehouse, data is reviewed for missing data fields and completeness of data fields. For URS data and TEDS reporting, the data is also reviewed to meet the applicable relational edit checks for interdependent data fields.
- Ongoing technical assistance: provided through data quality reports, zoom meetings, tele conferences and email correspondence to regional health partners that changed their EHR vendors.
- Quarterly on-site visits: Conducted to monitor data collection and reporting activities of the LGEs and MH and/or SUD facilities. Monitoring team ask the LGE to develop and submit a Corrective Action Plan to OBH HQ if data is not submitted from the providers.
- MH-TEDS Update/Correction: Monthly/Quarterly submission of TEDS data files help the state to prepare working data set to generate recurring and ad-hoc state-level reports, and Federal (MHBG, URS, SAPT) BG reports.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

There are a few well-known barriers at the LGEs' end (staffing, change to a new E-HR vendor/system, data quality issues etc.), and the State provides necessary technical assistance to resolve these barriers.

8. Please indicate areas of technical assistance needs related to this section.

Currently no TA is needed related to this section.

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> …….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.
>
> CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:
>
> Crisis call centers
>
> 24/7 mobile crisis services
>
> Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.
>
> STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.

A crisis response system has the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include Crisis Services: Meeting Needs, Saving Lives, which consists of the National Guidelines for Behavioral Health Coordinated System of Crisis Care as well as an Advisory: Peer Support Services in Crisis Care There is also the National Guidelines for Child and Youth Behavioral Health Crisis Care which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (P.L. 116-172) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

Historically, Louisiana had in many ways an underdeveloped crisis system. While there had been requirements for behavioral health treatment providers to render core services including crisis mitigation, such as crisis planning and response, and there were a couple of limited areas of the state that had developed mobile crisis response and/or walk-in centers, there was not a cohesive crisis response system

operating throughout the state. However, a number of activities have been undertaken within Louisiana to develop a statewide comprehensive crisis system of care. This is called the Louisiana Crisis Response System (LA-CRS).

In addition to the LA-CRS, all behavioral health service (BHS) providers licensed under LAC 48:1.Chapter 56, including Local Governing Entities (LGEs), must provide core services including crisis mitigation. This critical service offers assistance to individuals during a crisis including 24-hour on call telephone assistance to prevent relapse or harm to self or others, to provide referral to other services, and to provide support during related crises. Referral to 911 or a hospital's emergency department alone does not constitute crisis mitigation services. All BHS providers develop a crisis mitigation plan with each individual receiving mental health and/or substance use services. Also, providers contracted with at least one managed care organization (MCO) to deliver Medicaid funded mental health and substance use services including Mental Health Rehabilitation (MHR), Assertive Community Treatment (ACT), Multi-Systemic Therapy (MST) and other evidenced based and non-evidenced based interventions must conduct crisis planning and respond to individuals who report a crisis. For providers licensed under LAC 48:1, Chapter 56 the crisis plan and crisis mitigation plan may be the same document.

Expanding Access to Crisis Services

LDH has developed a statewide model for crisis response that maintains regional and geographic relevance and builds upon the unique and varied strengths, resources, and needs of Louisiana's individual communities. To achieve this vision, LDH, sought feedback from individuals, advocates, service providers, and MCOs via a Request for Information (RFI) to develop key components of this modern, innovative and coordinated crisis system for adults which operates in congruence with the following:

- Values and incorporates "lived experience" in designing a crisis system and in crisis service delivery;
- Encompasses a continuum of services that includes crisis prevention, acute intervention and post-crisis recovery services and supports;
- Is built on principles of recovery and resiliency, delivering services that are individualized and person-centered;
- Provides interventions to divert individuals from institutional levels of care including inpatient placements, emergency departments utilization, nursing facilities and other out of home settings;
- Provides timely access to a range of acute crisis responses, including locally available home and community-based services and mobile crisis response;
- Provides stabilizing interventions and supports that allow individuals to recover as quickly as possible;
- Delivers resolution-focused interventions and assists individuals in problem-solving and in developing strategies to prevent future crises and enhance their ability to recognize and deal with situations that may otherwise result in crises;
- Supports individuals to increase or improve their network of community and natural supports, as well as their use of these supports for crisis prevention;
- Continuously improves its processes to assure seamless and efficient care;
- Collaborates and innovates with partner systems including healthcare systems, judicial systems, law enforcement, child protective services, educational systems, homeless coalitions, as well as any other system that touches individuals who may experience a behavioral health crisis; and

- Collaborates with the individual's existing behavioral health service providers, or links individuals to new behavioral health service providers for longer-term treatment when appropriate and desired by the recipient.

Initially developed as a service system for adults 21 and older, in FY24, Mobile Crisis Response (MCR) and Community Brief Crisis Support (CBCS) was expanded to children, youth, and their families.

In order to support the implementation of the LA-CRS, LDH/OBH is utilizing Mental Health Block Grant funds to support a contract with Louisiana State University Health Science Center (LSUHSC) School of Public Health, Center for Evidence to Practice with the main goal being to recruit and develop a network of providers that provide crisis services ultimately in a stable, sustainable, all-encompassing system. It will conduct activities critical to implementation of a crisis system including the following activities, which will have a positive impact on all crisis providers, which render services to both the insured and uninsured populations:

- Collaborate with communities throughout Louisiana, developing a readiness process and measures for communities that demonstrate awareness, resources, key partners and benchmarks for progress, with technical assistance (TA) being provided to aid in the transition to and implementation of this new crisis service system.
- Develop a training curriculum inclusive of a process for ongoing coaching for the crisis response workforce; this process includes developing a model of implementation to include an online learning platform and a cadre of trainers, which will be critical to the sustainability of this project.
- Identify workforce and implement training curriculum and ongoing coaching to ensure appropriate execution of services.
- Conduct ongoing data collection required to inform LDH/OBH of the quality of the process, sustainability and outcomes associated with these efforts.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

a) The ***Exploration*** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.

b) The ***Installation*** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.

c) ***Initial Implementation*** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA guidelines.

d) ***Full Implementation*** stage: occurs once staffing is complete, services are provided, and funding streams are in place.

e) ***Program Sustainability*** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.

Check one box for each row indicating state's stage of implementation:

	Exploration Planning	Installation	Early implementation Less than 25% of people in state	Middle Implementation About 50% of people in state	Majority Implementation At least 75% of people in state	Program Sustainment
Someone to talk to						X
Someone to respond					X	
Place to go				X		

3. Briefly explain your stages of implementation selections here.

1. Someone to talk to: Call Center Capacity

a. Number of locally based crisis call Centers in state

i. In the 988 Suicide and Crisis Lifeline network – We have 2 certified Lifeline crisis call centers in Louisiana. With these two centers we have statewide primary and back-up coverage to ensure a high in-state answer rate and to provide referrals to local resources. Trained crisis counselors at these centers respond to calls twenty-four (24) hours per day, seven (7) days per week (24/7) providing telephonic access for crisis intervention, suicide prevention, and information and referral services for Louisiana residents. They also respond to texts and chats from 7pm until 7am 7 days a week. These crisis call centers are available to everyone in Louisiana regardless of insurance status. Primary coverage areas for each center are listed below:

1. VIA LINK has offices in Jefferson and St. Tammany Parishes. VIA LINK provides primary coverage for the following area codes/parishes:

   - 225 area code: Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, St. James, West Baton Rouge, West Feliciana
   - 504 area code: Jefferson, Orleans, Plaquemines, St. Bernard
   - 985 area code: Assumption, Lafourche, St. Charles, St. John the Baptist, St. Tammany, Tangipahoa, Terrebonne, Washington

   Additionally, it provides backup coverage to LACG.

2. Louisiana Association on Compulsive Gambling (LACG) has an office in Bossier Parish. LACG provides primary coverage for the following area codes/parishes:
   - 318 area code: Avoyelles, Bienville, Bossier, Caddo, Caldwell, Catahoula, Claiborne, Concordia, DeSoto, East Carroll, Franklin, Grant, Jackson, LaSalle, Lincoln, Madison, Morehouse, Natchitoches, Ouachita, Rapides, Red River, Richland, Sabine, Tensas, Union, Webster, West Carroll, and Winn

- 337 area code: Acadia, Allen, Beauregard, Calcasieu, Cameron, Evangeline, Iberia, Jefferson Davis, Lafayette, St. Landry, St. Martin, St. Mary, Vermilion, Vernon

Additionally, it provides backup coverage to VIA LINK.

ii. Not in the suicide lifeline network

Several local areas around the state have crisis call numbers initiated through non-profit organizations or regional human service districts providing behavioral health services. These lines are available to everyone regardless of insurance type, including the indigent populations. In addition, the Medicaid managed care organizations also have crisis call numbers available to their members.

b. Number of Crisis Call Centers with follow up Protocols in place - 2 (VIA LINK and LACG)

c. Total number of calls statewide and by local crisis call center-

During SFY 2025, there were 42,533 calls routed to call Lifeline call centers in Louisiana. 37,746 or 88.7% were answered in-state. The table below shows the number of calls routed and answered by month. This is a 40.5% increase over SFY 22 which was the year 988 was implemented.

	Metrics		
Month	**Number of Calls Routed**	**Number of Calls Answered In-State**	**In-State Answer Rate**
July 2024	3,880	3,501	90.2%
August 2024	3,628	3,255	89.7%
September 2024	3,516	3,114	88.6%
October 2024	3,458	3,078	89.0%
November 2024	3,438	3,048	88.7%
December 2024	3,598	3,190	88.7%
January 2025	3,295	2,877	87.3%
February 2025	3,242	2,873	88.6%
March 2025	3,434	3,023	88.0%
April 2025	3,481	3,109	89.3%
May 2025	3,612	3,149	87.2%
June 2025	3,951	3,529	89.3%

d. Percent of 911 calls that are identified as MH related –

Each 911 system maintains their own data and there is no centralized data repository. Therefore, the ability to analyze data for the state is limited. There is a database code for suicide related calls utilized statewide. However, there are no codes for other behavioral health emergencies at this time. The Caddo Parish 911 system recently developed a behavioral health code for call takers and dispatchers to use when

making their notes. The Ouachita Parish representative expressed interest in utilizing the coding as well. The code will be useful for future data analysis. The following preliminary suicide related data was shared:

- The Calcasieu Parish PSAP took 1,240 suicide related (includes suicide in progress and callers considering suicide) calls in 2020 which was about 0.6% of the overall call volume. Extrapolating that percentage to the statewide call volume indicates that 911 PSAPs across the state receive about 24,000 suicide related calls annually.
- 131 of 105,000 (0.1%) 911 calls were suicide related in Ouachita Parish.
- In SFY 2025, 474 calls were referred/ transferred/ breached to 911 from 988.

2. Someone to respond: mobile behavioral health crisis capacity

a. Number of crisis mobile responder teams that are independent of first responder structures (police, paramedic, fire) – Through the LA-CRS, Louisiana has implemented adult mobile crisis response teams operating in four (4) of the ten (10) geographically distinct multi-parish catchment areas, with three (3) more programs in the midst of implementation of this service. Additionally, child/youth mobile crisis response teams have been implemented in eight (8) of the ten (10) geographically distinct multi-parish catchment areas.

b. Number of crisis mobile responder teams that are integrated with first responder structures (police, paramedic, fire) -The mobile crisis response teams cited above have the ability to operate in collaboration when needed with first responder structures. However, ongoing collaboration in this space is beneficial in order to ensure programs are operating in congruence with best practices related to co-response models.

c. Number of mobile responders that employ peers – Peer support is a critical component of the Mobile Crisis Response model developed in Louisiana. As such, the mobile crisis response teams cited above have peers working within their programs.

d. Number of police responses to mental health crises – Unknown; this information is not tracked by LDH and is unavailable for reporting here.

3. Place to Go: Available resources in the state

a. Number of Emergency Departments- 107 emergency departments across the state

b. Number of Emergency Departments that operate a specialized behavior health component. – A number of independent hospitals may have behavioral health teams that can assess individuals who present with behavioral health conditions. The frequency and location with which this occurs is not currently tracked by LDH and is unavailable for reporting here.

c. Number of Crisis Receiving and Stabilization Centers (short term, 23 hr units that can diagnose and stabilize individuals in crisis) – Through the LA-CRS, Louisiana has implemented Behavioral Health Crisis Care (BHCC) Centers in two (2) out of the ten (10) geographically distinct multi-parish catchment areas, with three (3) more programs in the midst of implementing this service.

d. Number of hours of overtime by law enforcement related to accompaniment of persons with MH conditions in ED or other settings. This information is not tracked by LDH and is unavailable for reporting here.

e. Number of persons boarded in ED (In ED longer than 24 hours and waiting for psychiatric admission.) This information is not tracked by LDH and is currently unavailable for reporting here.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

The Louisiana Department of Health (LDH) is committed to ensuring that individuals in crisis and their families experience treatment and support that is compassionate, effective and resolution-focused, and delivered by a crisis system that is coordinated, responsive and efficient. By addressing the needs of all populations, including Louisiana's most vulnerable citizens (e.g. children and youth in crisis and their families, and individuals with co-occurring conditions), LDH believes improvements to its crisis system of care will maximize the use of voluntary treatment and reduce the need for law enforcement involvement. In addition, it will allow people to remain in their communities and reduce the need for restrictive levels of care including nursing homes, residential care centers, out of home placements, jails, intermediate care facilities for individuals with intellectual / developmental disabilities, and hospitals.

The LDH has focused the last 36 months on building a comprehensive crisis system of care for adults. In particular improved services to include a mobile crisis response capacity and crisis intervention services for the Medicaid population, and crisis telephone lines, which will benefit everyone in Louisiana regardless of insurance type/status. Implementation of these services are consistent with the principles outlined above. In order to achieve these goals LDH has developed the following services and supports for Medicaid-eligible adults. Though initially focused on the Medicaid population, it is the goal that these services will eventually be a resource for everyone in Louisiana, including the insured and uninsured:

- Mobile Crisis Response (MCR) Services – a mobile crisis response service that is available as an initial intervention for individuals in a self-identified crisis. The service is available twenty-four (24) hours a day, seven (7) days a week and includes maximum one (1) hour urban and two (2) hour rural face-to-face/onsite response times. In SFY24, this service was expanded to serve child/youth and their families in addition to adults.

- Behavioral Health Crisis Care (BHCC) Clinics – a facility based service that operates twenty-four (24) hours a day, seven (7) days a week as a walk-in center providing short-term behavioral health crisis intervention for up to 23 hours, offering a community based voluntary home-like alternative to more restrictive settings

- Community Brief Crisis Support (CBCS) – a face-to-face intervention available to individuals subsequent to receipt of MCI, BHUC, or CS. This ongoing crisis intervention response is intended to be rendered for up to fifteen (15) days and are designed to provide relief, resolution and intervention through maintaining the member at home/community, de-escalating behavioral

health needs, referring for treatment needs, and coordinating with local providers. In SFY24, this service was expanded to serve child/youth and their families in addition to adults.

- Crisis Stabilization (CS) - a short-term bed-based crisis treatment and support services for members who have received a lower level of crisis services and are at risk of hospitalization or institutionalization, including nursing home placement.
    - This service is currently available for children and we have expanded it for the adult population.
- Louisiana Crisis Hub (LCH) - in late fiscal year 2025, LDH implemented the Louisiana Crisis Hub (LCH), a single, statewide, triage and dispatch line, capable of providing telephonic crisis de-escalation techniques to callers as well as connecting individuals to services through triage, referral, and dispatch to available services in the community appropriate to meet their crisis needs. The LCH serves as an access point to LA-CRS and will play a critical role in tracking demand for and facilitating access to crisis services throughout the state. Through these efforts, the Crisis Hub tracks data to measure demand and utilization of crisis services throughout the state.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state

i. In the 988 Suicide and Crisis lifeline network: 2

ii. Not in the suicide lifeline network: The number and location of other lifeline networks are not currently tracked by LDH and is unavailable for reporting here.

b. Number of Crisis Call Centers with follow up protocols in place

i. In the 988 Suicide and Crisis lifeline network: : 2. Both VIA LINK and LACG have follow up protocols.

ii. Not in the suicide lifeline network: The number and location of other lifeline networks are not currently tracked by LDH and is unavailable for reporting here.

c. Estimated percent of 911 calls that are coded out as BH related:

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the total number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): Louisiana has implemented adult mobile crisis response teams operating in four (4) of the ten (10) geographically distinct multi-parish catchment areas, with three (3) more programs in the midst of implementation of this service. Additionally, child/youth mobile crisis response teams have been implemented in eight (8) of the ten (10) geographically distinct multi-parish catchment areas.

b. Integrated with public safety first responder structures (police, paramedic, fire): n/a

c. Number that utilizes peer recovery services as a core component of the model: The use of Peers is a critical component of Louisiana's MCR service. As such, all service areas referenced above include this level of support.

Safe place to be

a. Number of Emergency Departments: 107

b. Number of Emergency Departments that operate a specialized behavioral health component: A number of independent hospitals may have behavioral health teams that can assess individuals who present with behavioral health conditions. The frequency and location with which this occurs is not currently tracked by LDH and is unavailable for reporting here.

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): Louisiana has implemented Behavioral Health Crisis Care (BHCC) Centers in two (2) out of the ten (10) geographically distinct multi-parish catchment areas, with three (3) more programs in the midst of implementing this service.

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

LDH/OBH is utilizing Mental Health Block Grant funds to support a contract with Louisiana State University Health Science Center (LSUHSC) School of Public Health, Center for Evidence to Practice to conduct activities critical to the ongoing implementation of a crisis system of care. This includes the following activities:

- Collaborate with communities throughout Louisiana, implementing a readiness process and measures for communities that demonstrate awareness, resources, key partners and benchmarks for progress, with technical assistance (TA) being provided to aid in the ongoing implementation of this new crisis service system.
- Develop, implement, and update as needed a training curriculum inclusive of a process for ongoing coaching for the crisis response workforce; this process includes developing a model of implementation to include an online learning platform and a cadre of trainers, which will be critical to the sustainability of this project.
- Identify crisis workforce and implement training curriculum and ongoing coaching to ensure appropriate execution of services within this crisis system.
- Conduct ongoing data collection required to inform LDH/OBH of the quality of the process, sustainability and outcomes associated with these efforts related to the crisis system of care.

This project will run multiple fiscal years and will ultimately affect the larger crisis system in Louisiana including those that serve the uninsured populations. Additionally, the project is being expanded to

include the future provision of services (MCR and CBCS) to children and their families. The amount allocated for SFY26 is $859,987.

The block grant also supports Louisiana's two 988 Suicide and Crisis Lifeline call centers. With these two call centers we have statewide primary and back-up coverage to ensure a high in-state answer rate and to provide referrals to local resources. Trained 988 helpline specialists at these call centers respond to calls twenty-four (24) hours per day, seven (7) days per week (24/7) providing telephonic access for crisis intervention, suicide prevention, and information and referral services for Louisiana residents. They also respond to texts and chats from 7pm until 7am 7 days a week. These crisis call centers are available to everyone in Louisiana regardless of insurance status. Primary coverage areas for each center are listed below:

VIA LINK has offices in Jefferson and St. Tammany Parishes. VIA LINK provides primary coverage for the following area codes/parishes:

- 225 area code: Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, St. James, West Baton Rouge, West Feliciana
- 504 area code: Jefferson, Orleans, Plaquemines, St. Bernard
- 985 area code: Assumption, Lafourche, St. Charles, St. John the Baptist, St. Tammany, Tangipahoa, Terrebonne, Washington
  Provides backup coverage to LACG

Louisiana Association on Compulsive Gambling (LACG) has an office in Bossier Parish. LACG provides primary coverage for the following area codes/parishes:

- 318 area code: Avoyelles, Bienville, Bossier, Caddo, Caldwell, Catahoula, Claiborne, Concordia, DeSoto, East Carroll, Franklin, Grant, Jackson, LaSalle, Lincoln, Madison, Morehouse, Natchitoches, Ouachita, Rapides, Red River, Richland, Sabine, Tensas, Union, Webster, West Carroll, and Winn
- 337 area code: Acadia, Allen, Beauregard, Calcasieu, Cameron, Evangeline, Iberia, Jefferson Davis, Lafayette, St. Landry, St. Martin, St. Mary, Vermilion, Vernon
  Provides backup coverage to VIA LINK

Staff coverage of a call center varies throughout a 24-hour day, by day of the week, time of the day, weekend, holiday, and other factors based on call volume. The scheduled supervisor monitors incoming calls and is able to add specialists as needed to manage call volume. Louisiana began responding to chats and texts in December 2022 between 7pm and 1am daily. On July 1, 2025, chat and text was expanded from the hours of 7pm – 1am daily to 7pm - 7am daily. Both call centers offer 24/7, free and confidential support for people in distress, delivering prevention and crisis resources for individuals throughout Louisiana. This type of access is the first level of supportive intervention for individuals in crisis, helping to stabilize the individual so that services that are more intensive are only utilized when necessary.

The Office of Behavioral Health (OBH) was awarded a SAMHSA Certified Community Behavioral Health Center (CCBHC) Planning grant on 12-31-24 for a one year period. Expectations for the planning year include; developing a steering committee, developing state specific certification requirements, assuring that CCBHCs have meaningful input from diverse populations, establishing capacity to provide behavioral health services that meet certification criteria, developing data collection and reporting capacity, and submitting a proposal to participate in the CCBHC Demonstration Program. Currently the scope of services

work group is developing the scope of services criteria for Louisiana. The proposed crisis services for CCBHCs include; emergency crisis intervention services through a 24 hour crisis line, mobile crisis response, adult crisis walk-in services and youth crisis walk-in services. The CCBHC may provide these services directly if they are a State sanctioned crisis provider or may enter into a Designated Collaborating Organization (DCO) Agreement with a State sanctioned crisis provider to render these services on their behalf.

7. Please indicate areas of technical assistance needs related to this section.

As implementation of the Crisis Response System continues to progress and expand along with integration of the Louisiana Crisis Hub (LCH), technical assistance in areas related to expansion may be needed, especially related to integration of these systems into the fabric of local communities through the development of partnerships.

As part of the CCBHC planning grant, OBH entered into a contract with the National Council for Wellbeing to provide Louisiana specific Technical Assistance to help prepare the State to participate in the SAMHSA CCBHC Demonstration Program. Several of the technical Assistance sessions have involved presentations from other States on how they have integrated crisis services into the CCBHC certification criteria. Also, the fifteen States that have SAMHSA CCBHC Planning Grants are provided technical assistance from the National Council for Wellbeing and the Centers for Medicaid Services twice a month. Several sessions have focused on the integration of crisis services into CCBHCs as well as prospective payment system (PPS) options that provide enhanced payments for CCBHCs to provide crisis services. At this time, OBH is not in need of additional technical assistance regarding the integration of crisis services into the CCBHC criteria, however, we have several avenues available to request technical assistance in this area if needed in the future.

10. Recovery – Required

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, there are 10 identified guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see Working Definition of Recovery.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the Recovery Support Services Table.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing, and monitoring the state behavioral health treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?
   ☒ Yes ☐ No
   b) Required peer accreditation or certification?
   ☒ Yes ☐ No
   c) Use Block Grant funds for recovery support services?
   ☒ Yes ☐ No
   d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health system?
   ☒ Yes ☐ No

2. Does the state measure the impact of your consumer and recovery community outreach activity?

   ☐ Yes ☒ No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Louisiana has adopted the definition of recovery as stated by SAMHSA. The definition states: “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” The recovery principles are simply to allow those with behavioral health challenges to guide their own recovery. These principles were developed by key stakeholders, especially those in recovery. The state has had peers working within leadership positions in the Office of Behavioral Health since 2004. This has expanded through the Managed Care Organizations (MCOs) through Healthy Louisiana. OBH utilizes the C’est Bon program for continuous quality improvement of both services and facilities, as well as to provide accountability to the public. The C’est Bon program, which is Cajun French for “That’s Good,” uses a consumer satisfaction team- model for consumer-to-consumer monitoring and evaluation. The consumer-to-consumer interviews foster more open and honest feedback from the consumers and assures that the consumer respondents fully understand the purpose and use of the survey. Because the C’est Bon program process relies on consumers as the core of this initiative by having direct involvement in monitoring and evaluating the services they receive, consumers and family members have a greater voice and a more meaningful role in influencing the design and quality of public behavioral health services. Consumer satisfaction teams also offer opportunities for fostering consumer empowerment, leadership development and paid employment experiences. Peer Support services are offered by all ten (10) LGEs and all State run psychiatric hospitals as well as being imbedded into Assertive

Community Treatment (ACT) and Permanent Supported Housing (PSH). Peer Support Specialists (PSS) are assisting consumers with services such as:

a) Integrated Health Care – OBH recognizes that the best possible outcomes are achieved when the care of the whole consumer is effectively managed. By integrating primary care and behavioral health, providers are able to look at the whole person, identifying behavioral health issues that need treatment and helping to prevent problems before they occur. Behavioral health services include treatment and prevention for both mental health and substance use disorders. PSS are assisting consumers with navigating the integrated health care system.
b) Employment – PSS are assisting consumers with job readiness and in searching for employment. PSS are conducting groups within the LGEs to assist consumers to develop WRAP plans to help them to maintain wellness so that they can become and remain employable. PSS are also assisting consumers with resume building and skills building including the development of computer skills and job search skills. Peers are also included with the Individual Placement and Support (IPS) evidence base program (EBP) of supported employment that was implemented in Louisiana in 2022 as they may function as the Employment Specialist in this EBP approach.
c) Target Health - OBH collaborated with the Mental Health Association for Greater Baton Rouge (MHAGBR) to develop a new Peer Support program entitled Target Health. Target Health is a holistic program, based off of the Whole Health Action Management (WHAM) model which will train Peer Support Specialists to assist those they serve to develop and maintain whole health goals.
d) PSS are working within treatment teams to assist with identifying goals, treatment planning, life skills coaching, resource referral, conducting recovery groups, and assisting with discharge planning.
e) In Louisiana, PSS work in a variety of capacities throughout the behavioral health service system. While PSS provide vital roles in peer to peer programs which are not funded by Medicaid, there are several rehabilitation services outlined within the Behavioral Health Manual in which PSS are identified as a qualified provider type. These services include:
    1) Community Psychiatric Support and Treatment
    2) Psychosocial Rehabilitation
    3) Crisis Intervention
    4) Assertive Community Treatment
    5) Permanent Supported Housing
    6) Addiction Services
    7) Individual Placement and Support (IPS) Supported Employment

The Coordinated System of Care (CSoC) is a joint effort of OBH, Medicaid, the Office of Juvenile Justice (OJJ), the Department of Children and Family Services (DCFS), and the Louisiana Department of Education (LDOE). The CSoC is conceptualized upon the national standards of the system of care and is expanding practices that support family involvement as a core component. Through the CSoC, children who are at-risk for out-of-home placement are able to access wraparound services through a Wraparound Agency (WAA) that coordinates comprehensive children's behavioral health services and supports, inclusive of wraparound facilitation/child and family teams (CFTs). Children and youth enrolled in CSoC are eligible for all Medicaid behavioral health services, including four (4) services not available to other members. These specialized services are independent living/skills building, youth support and training, parent support and

training, and respite. A commendable innovation within the Louisiana CSoC model is the partnership with the Family Support Organization (FSO), which provides the services and support of youth and family mentors within the child and family teams through youth support and training and parent support and training.

In 2024, Louisiana also implemented a Recognized Family Peer Support Specialists (RFPSS) to support youth with SED and their primary caregivers with navigating the behavioral health services system. The RFPSS training curriculum for Louisiana was developed through consultation with national subject matter experts in the area of Family Peer Supports. Louisiana's expansion of the crisis system to include youth and their families in 2024 prompted the development of Family Peer Support Services to ensure proper supports to youth and their families experiencing behavioral health crises. Since implementing the Family Peer Training Program in 2024, 22 Family Peers have successfully completed the training.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state i.e., RCOs, RCCs, peer-run organizations.

The Office of Behavioral Health (OBH) subscribes to SAMHSA' definition of "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

OBH encourages and promotes the use of peers within all treatment programs statewide. OBH provides peer support training and recognition for individuals wanting to be a Peer Support Specialist and conducts multiple Peer Support Specialist Supervisor trainings a year in order to help develop and sustain a peer support workforce.

Louisiana has long been a supporter of Oxford House. Oxford Houses are democratically run, self-supporting, drug free houses established for the purpose of providing a sober living environment for those seeking to live a sober, drug free life. OBH contracts with Oxford House to provide for two (2) outreach workers and one (1) re-entry worker to assist those leaving incarceration. The regional manager of Oxford House Louisiana is a credentialed Peer Support Specialist. Currently, there are 195 Oxford Houses within Louisiana with 1,456 beds.

The Pregnant and Parenting Women (PPW) residential substance use treatment program addresses the needs of women, including pregnant women and women with dependent children, with a substance use disorder. The program provides substance use treatment services to women eighteen (18) years of age and older. Minor children up to age twelve (12) are allowed to accompany their mother/guardian to treatment, thus preserving the family unity. Children up to 17 who reside offsite are eligible to receive therapeutic services at the residential facility. Women receive gender specific treatment which may include education on such topics as parenting, healing from trauma, spousal or partner abuse, overcoming depression and post-traumatic stress disorder, etc. Educational or employment assistance, in conjunction with transportation services, as well as linkages to housing and other community resources, are also provided. There are currently 6 programs statewide in the following Local Governing Entity catchment areas: Reality House -- Capital Area Human Service District (CAHSD) - 30 licensed beds (26 beds funded by OBH), Claire House—Southcentral Louisiana Human Services Authority (SCLHSA) - 36 licensed beds (21 beds funded by OBH), Meredith's Place – Acadiana Area Human Services District (AAHSD) - 17 licensed beds (16 beds funded by OBH, Restore Recovery Center—Central Louisiana Human Services District (CLHSD)-16 licensed beds (14 beds funded by OBH), The Family Renewal Program—Northwest Louisiana

Human Services District (NLHSD)—7 licensed beds (all funded by OBH), and The Ness Center—Florida Parishes Human Services Authority---30 licensed beds (10 beds funded by OBH).

5. Does the state have any activities that it would like to highlight?

The momentum in Louisiana in support of the enhancement and expansion of Peer Services has continued to be on a remarkable trajectory. In 2021, the initial phase of Medicaid reimbursement for Peer Support Services was implemented in Louisiana with the LGEs being the first provide type allowed to bill Medicaid for the service. During the 2022 Regular Legislative Session, legislation (HB 334) was submitted that would allow for exceptions for limited criminal offenses for Peer Support Specialists employed in behavioral health settings. Peer Support Specialists are non-licensed persons. This legislation was passed by the Louisiana Legislature with full support from the House, Senate and Governor's Office to become Act 151. Governor John Bel Edwards signed Act 151, which became effective on August 1, 2022.

LaSOR – On September 30th 2018, Louisiana was awarded the first Louisiana State Opioid Response (LaSOR) grant to target and reduce opioid usage across the state. OBH is now in the no cost extension period of LaSOR 3.0, which ends September 29, 2025, and the first year of LaSOR 4.0, which ends September 29. 2027. The grant is being used to enhance existing statewide prevention, treatment and recovery services that are available to individuals who have or are at risk for opioid use disorder and other concurrent substance use disorders (SUD). Services provided also support the continuum of care for individuals with stimulant use and misuse disorders (SUM), including cocaine and methamphetamine. The grant is able to provide guidance and technical assistance to treatment providers in an effort to facilitate data entry compliance. The grant also helped expand financial eligibility criteria to include patients with a higher income due in part to Medicaid Expansion which approved coverage for Methadone treatment. Through LaSOR, OBH has partnered with the Office of Public Health (OPH) to develop a centralized harm reduction hub to be utilized by providers throughout the state. Providers can register as a distribution site through this hub to get harm reduction materials, including fentanyl testing strips and naloxone, to distribute to the public. With the advent of LaSOR 4.0, OBH plans to expand the services provided at Federally Qualified Health Centers (FQHC) to include the provision of medications for opioid use disorder (MOUD) and peer recovery support services.

6. Please indicate areas of technical assistance needed related to this section.

In 2024, OBH completed a contract with a national subject matter expert (SME) to facilitate a statewide research study on the development of a Peer credential/certification and oversight entity. Upon conclusion of the research study, which includes several focus groups with Peer Stakeholders from throughout the state, the SME presented an executive report and recommendations for a statewide certification/credential and oversight entity that aligns with SAMHSA's National Model Standards for Peer Support Certification and best meets the needs of the state's Peer Workforce. LDH/OBH anticipates next steps to be implemented within the coming years to support a strategic expansion of the Peer Profession through a formal certification/credentialing process. With this growth for the Peer Profession, technical assistance, guidance and support may be helpful with supporting these goals.

11. Children and Adolescents M/SUD Services- Required for MHBG, Requested for SUPTRS BG

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using substances before the age of 18, one in four will develop an addiction compared to one in 25 who started using substances after age 21.

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance use, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance use screening, treatment and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to financing, workforce development, and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence- based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.

According to data from the 2017 Report to Congress on systems of care, services:

- Reach many children and youth typically underserved by the mental health system;
- Improve emotional and behavioral outcomes for children and youth;
- Enhance family outcomes, such as decreased caregiver stress;
- Decrease suicidal ideation and gestures;
- Expand the availability of effective supports and services; and
- Save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

Please respond to the following:

1. Does the state utilize a system of care approach to support:

   a) The recovery of children and youth with SED?
   ☒ Yes ☐ No
   b) The resilience of children and youth with SED?
   ☒ Yes ☐ No
   c) The recovery of children and youth with SUD?
   ☒ Yes ☐ No
   d) The resilience of children and youth with SUD?
   ☒ Yes ☐ No

2. Does the state have an established collaboration plan to work with other child- and youth- serving agencies in the state to address M/SUD needs:

   a) Child welfare?
   ☒ Yes ☐ No
   b) Health care?
   ☒ Yes ☐ No
   c) Juvenile justice?
   ☒ Yes ☐ No
   d) Education?
   ☒ Yes ☐ No

3. Does the state monitor its progress and effectiveness around:
   a) Service utilization?
      ☒ Yes ☐ No
   b) Costs?
      ☒ Yes ☐ No
   c) Outcomes for children and youth services?
      ☒ Yes ☐ No
4. Does the state provide training in evidence-based:
   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?
      ☒ Yes ☐ No
   b) Mental health treatment and recovery services for children/adolescents and their families?
      ☒ Yes ☐ No
5. Does the state have plans for transitioning children and youth receiving services:
   a) to the adult M/SUD system?
      ☒ Yes ☐ No
   b) for youth in foster care?
      ☒ Yes ☐ No
   c) Is the child serving system connected with the Early Serious Mental Illness (ESMI) services?
      ☒ Yes ☐ No
   e) Is the state providing trauma informed care?
      ☒ Yes ☐ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

SFY 2025 was the thirteenth year of the implementation of CSoC which began in 2012 as the result of a Centers for Medicare and Medicaid Services (CMS) waiver. As of June 30, 2025, 2,682 children and youth were enrolled in CSoC (including presumptively eligible and enrolled). The maximum enrollment is 2,900 children and youth at any given time. Over the past thirteen years, more than 29,700 children have been served in CSoC since implementation in March 2012.

CSoC serves children and youth aged 5 through 20, statewide, who have significant behavioral health challenges or co-occurring disorders and are in or at imminent risk of out-of-home placement. Children and youth with complex behavioral health challenges and their families benefit from a coordinated approach to care. New behavioral health services that were previously not part of the service array in Louisiana are now available as part of the Medicaid State Plan Amendments and Waivers that support CSoC. These new services include an organized planning process for young people with significant emotional and behavioral challenges, called Wraparound, which helps to ensure that individual and family needs are identified and addressed with an array of specialized services and natural supports. These efforts are proven to result in a reduced need for more costly out-of-home placement options. Families and young people also benefit from other specialized services which include: Parent Support and Training, Youth Support and Training, Independent Living/Skills Building and Short-term Respite.

7. Does the state have any activities related to this section that you would like to highlight?

As of July 4, 2025 CSoC has served over 29,733 youth and children, with current enrollment of 2,688 children/youth (including presumptively eligible and enrolled). Current enrollment ranges from 153 to 502 per region as follows: Greater New Orleans (428), Baton Rouge (332) Covington (243), Thibodaux (314), Lafayette (331), Lake Charles (153), Alexandria (190), Shreveport (195), and Monroe (502).

The CSoC team is composed of a CSoC Director with a PhD in Counseling Psychology and three additional team members with extensive backgrounds in wraparound, policy, administrative and other macro level state government work. The team provides guidance, support, and technical assistance to the Wraparound Agencies (WAAs) and Family Support Organization (FSO) in each region. The CSoC team is also responsible for the oversight and monitoring of quality measures and waiver performance measures.

Quarterly meetings of the CSoC Governance Board were held to review progress, provide guidance, and establish policy as needed. Governor Jeff Landry continued the CSoC Governance Board with signing of Executive Order JML 24-117 on July 29, 2024.

Wraparound Agencies (WAAs) in each region ensured that youth with complex needs benefited from a coordinated care planning process that produced a single plan of care that was created with the youth, their family, natural supports and all agencies and providers involved with the youth and family.

The Louisiana Model for Coaching and Training was implemented on April 1, 2025. Previously, the state operated under two separate models. All wraparound agencies are now operating under the new model. The CSoC Team has continued to support the on-going skill development of the WAA supervisors/coaches and facilitators. The goal of this support is to assure these WAA staff have the knowledge, skills and experience needed to deliver high fidelity wraparound to the children, youth and families of Louisiana.

CSoC connects youth and family members to behavioral health services in their homes and communities that offer low-cost alternatives to prevent institutional care:

- 100% of CSoC children are enrolled with a Wraparound agency providing intensive care coordination through a single plan of care.
- 87% of members reported they are receiving waiver services in the type, amount, duration, and frequency specified on their Plan of Care.
- 94% of youth and families are connected with natural and informal community supports to strengthen community ties.

Over the average length of enrollment (12 months), CSoC children demonstrated significant improvements in overall functioning.

- 52% of the children discharged demonstrated improvements in clinical functioning.
- 46% of the children discharged showed improved school functioning.
- 90% of youth and families reported positive overall satisfaction with CSoC.
- 96% of youth and families reported that CSoC providers respect their family's cultural and language needs.
- 92% of guardians reported a positive experience when working with Magellan

One of the primary goals of CSoC is to maintain children and youth safely in their homes and communities.

- Only 7% of the children enrolled in CSoC spent any days in an inpatient hospital setting.

- 94% of youth discharged to home and community-based settings.

8. Please indicate areas of technical assistance needed related to this section.

N/A

12. Suicide Prevention- Required for MHBG, Requested for SUPTRS BG

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.
Please respond to the following:

1. Have you updated your state's suicide prevention plan since the FY2024-2025 Plan was submitted?

☐ Yes ☒ No

The State Suicide Prevention Plan is updated every five years. It was last updated in 2021.

2. Describe activities intended to reduce incidents of suicide in your state.

OBH is legislatively mandated to be on the State level Child Death Review Panel (CDR) coordinated by the Office of Public Health; the State Suicide Prevention Coordinator provides information and technical assistance on youth suicide prevention, youth suicide prevention resources and best practices are shared with panel members for further dissemination through their member networks.

The Office of Public Health is working with OBH to examine suicide attempt and death data in more detail and to create a web-based platform to share data on suicide deaths in the Louisiana on the OPH website. Easily accessible data on suicide prevention and attempts will help guide statewide decisions about how to comprehensively address suicide prevention across the lifespan. OPH has created some suicide fatality data maps on their Nonfatal Suicide Data Dashboard: https://partnersforfamilyhealth.org/injury-dashboards/ OBH also collaborates with OPH to pilot their Suicide Community Alert System (SCAN). For ages 10-19, OPH is sending out the OPH SCAN when there is an uptick in suicide related Emergency Department visits. At this time, participation by emergency departments in syndromic surveillance includes 89% of facilities and accounts for 96% of visits statewide. This includes visits related to suicidal ideation and suicide attempt. In 2024, there were 33,059 emergency department visits related to suicidal ideation and attempt. The SCAN alerts indicate the parishes of the upticks which will provide an opportunity for targeted action strategies to be implemented.

OBH's State Suicide Prevention Coordinator has been coordinating and collaborating with multiple entities around suicide prevention. These include but aren't limited to: the Office of Public Health, the American

Foundation for Suicide Prevention-LA Chapter (AFSP-LA), Louisiana Mental Health Association (LAMHA), , Governor's Challenge for Suicide Prevention and Service Member, Veterans and their Families (SMVF) Collaborative, suicide prevention specialists with the Veterans Administration in the Alexandria/Lafayette area, suicide prevention specialists with the LA Army National Guard, St. Tammany Outreach for the Prevention of Suicide, SaveCenla, Jacob Crouch Foundation, and some of the LGEs and two state psychiatric hospitals. In October 2022, the Office of Public Health established a Suicide Prevention Partner workgroup group that is working towards developing a guide for regions that would like to develop a suicide prevention coalition. The Suicide Prevention Partner group is working to establish a community of practice (or shared statewide network of local and regional groups) to share resources, collaborate, and understand what services and resources are available regionally and statewide. One outcome from the Statewide Suicide Prevention Collaborative is the development of regional coalitions. As of July 2025, three regional coalitions have formed (Acadiana region, Northshore, and Greater New Orleans area). These coalitions have identified coalition facilitators/leads, reviewed regional and local data, and have begun to identify gaps and priorities. The coalitions are supported by the Statewide Collaborative.

A case management intervention model was developed for individuals at risk for suicide. OBH partnered with the Louisiana Mental Health Association (LAMHA) to provide case management for individuals who have attempted suicide or experienced a suicide crisis. Individuals are at an increased risk of suicide after discharge from emergency departments and inpatient psychiatric facilities. The program offers rapid follow-up of adults who have attempted suicide or experienced a suicidal crisis after discharge from emergency departments and inpatient psychiatric facilities. Follow-up and care transition protocols were developed to ensure safety, especially among high risk adults. Enhanced services are also being provided to domestic violence survivors to reduce the risk of suicide such as case management, support groups and psychoeducation. Relationships have been established with shelters and other domestic violence coalitions and resources to address trauma of domestic violence survivors. The following services were also provided for domestic violence survivors that are at risk for suicide: screening for suicide risk, ongoing assessment, safety planning and means restriction, discharge planning, transition care, and warm hand off(s) to treatment or community organizations.

In addition to case management intervention, suicide prevention, intervention, and postvention trainings have been provided statewide to community members, health and behavioral health providers, first responders/law enforcement, Peer Support Specialists, and service member veterans and their families (SMVF) to increase awareness of suicide and help individuals recognize when someone is struggling with their mental health.

988 Implementation

OBH was awarded the Cooperative Agreements for States to Improve Local 988 Capacity from SAMHSA. The grant started in September 2023 and is planned to extend to September 2026. The purpose of this grant is to improve states and territories response to 988 contacts (including calls, chats, and texts) originating in the state. States are expected to use resources to: (1) enhance recruitment, hiring, and training of the 988 workforce to meet at minimum 90% state or territory calls, chats, and texts demand; (2) implement additional technology and security measures to fully support 988 infrastructure and effective coordination across the crisis continuum; (3) improve 988 support and service for high-risk and underserved populations; (4) develop and implement comprehensive quality assurance plans, to include identification and review of critical incidents; and (5) develop and implement comprehensive 988 communication plans to align with SAMHSA's 988 partner toolkit.

- Based on Vibrant's Broad Metrics report, in 2022 there were 2,252 call routed. In June 2025 there were 3,952 call routed resulting in a 57% increase in calls.. The in-state answer rate rose from 64% in June 2022 to a monthly average of 89.3% in SFY 2025.
- In December 2022, OBH launched text and chat for those who prefer not to call. Based on the Vibrant Broad Metrics report, Louisiana has responded to an average of 388 texts and 193 chats per month in SFY 2025. Chat and text is answered in Louisiana between the hours of 7:00pm and 7:00am (Text and Chats are routed to the National Backup Centers outside of those hours).
- In May 2023, as part of the 988 awareness campaign LDH launched an online 988 Dashboard providing transparency on key metrics of crisis call data from Louisiana's two 988 crisis centers. The dashboard, which will be updated monthly, contains metrics on accessibility, referral source, reason for the call, and some outcomes. The 988 Dashboard can be reached at ldh.la.gov/988

OBH is working with the crisis contact centers to collect and report Infrastructure, Prevention, and Promotion (IPP) measures (workforce trained, partnership/collaborations, screening, referral, access).

Service Members, Veterans and Their Families Collaborative

OBH collaborates with the Louisiana suicide prevention coordinators for the Army National Guard, Army Reserve, Marine Reserve and Veteran's Administration in various ways. This includes sharing information about suicide resources outside of the military system, assistance with locating suicide intervention trainers when the military trainers are unavailable, providing information on state behavioral health resources that will benefit, and obtaining information on military resources available to service members, veterans, and their families (SMVF) to share with community behavioral health resources.

OBH continues to work with the SMVF Collaborative, whose membership includes representatives from LGEs, veterans, family members and other community organizations with the common interest of providing behavioral health services to this disparate population. The SMVF collaborative is identifying resources for SMVF related to housing, transportation, employment, behavioral health, college/universities, benefits and families. OBH has a part-time staff person who works as a liaison between OBH and existing veteran and service member organizations, as well as provides support to the SMVF Collaborative. This ensures OBH has a linkage to veterans to serve this important population.

In the implementation of the Zero Suicide Framework, the Zero Suicide providers are collaborating with their nearest VA facility to provide information and enhance their awareness of the availability of the Zero Suicide Initiative for the referral of veterans, especially those who are not eligible for VA services. The LGEs and hospitals will continue to enhance the knowledge of the VA facility staff and the suicide prevention coordinators who follow up on the Lifeline calls on suicide awareness, intervention and treatment by inviting them to attend staff trainings held as part of the Zero Suicide grant. In addition, LGEs and hospitals with ASIST and safeTALK trainers will continue to offer these trainings to local VA facility staff.

Black Youth Suicide Policy Academy

In June 2023, the Center of Mental Health Services (CMHS)/SAMHSA invited the OBH Suicide Prevention Coordinator and OBH Suicide Prevention Specialist to attend a Black Youth Suicide (BYS) Prevention Policy Academy held July 17-19 in Baltimore, MD. OBH was tasked with establishing an implementation team to help create an action plan to address Black youth suicide, which is a growing problem in the U.S. The goal of the CMHS Black Youth Suicide Prevention Initiative is to reduce the suicidal thoughts, attempts, and deaths of Black youth and young adults between the ages of 5-24. OBH joined multiple state teams at the BYS Policy Academy to work with a subject matter expert to develop a plan to reduce black youth suicide and attempts in Louisiana. The plan consists of three goals:

1.) Build a community network centering Black youth populations.

2.) Increase awareness of wellness for Black youth through the development of a student-led awareness campaign.

3.) Analyze suicidal behaviors and deaths among Black youth.

OBH continues to meet quarterly with the implementation team to track the goals' progress. Additionally, OBH and the implementation team attend monthly learning collaborative meetings with SAMHSA and a subject matter expert to assess progress of goals, address challenges and strategize effective ways to advance this initiative.

Louisiana Youth Suicide Prevention Initiative (LYSPI)

In November 2024, The Louisiana Department of Health (LDH)/Office of Behavioral Health (OBH) was awarded the 2025 Transformation Transfer Initiative (TTI) to implement the strategic action plan developed at the Black Youth Suicide Policy Academy entitled the Louisiana Youth Suicide Prevention Initiative (LYSPI). The award period is from December 2024 to August 2025. LYSPI is a comprehensive initiative aimed at reducing suicidal behaviors and deaths among youth populations in Louisiana, specifically among high school students.

Through this initiative, OBH seeks to achieve the following goals:

- Increase suicide prevention efforts for youth populations with higher rates of suicide in Louisiana.
- Build a community network of Suicide Prevention Champions centering youth populations in Louisiana.
- Analyze suicidal behaviors and deaths among youth ages 10-24 in Louisiana.

To achieve these goals, The Louisiana Department of Health/Office of Behavioral Health will contract with Peer Initiatives- Leaders of Tomorrow, a local nonprofit organization, to achieve the following objectives:

- Expand student peer support and suicide prevention programs in up to 10 Louisiana high schools.
- Provide suicide prevention training to up to 50 school faculty members and up to 1,000 students across 10 high schools, equipping them with the skills needed to identify and respond to mental health crises.

- Support the identification and training of up to 10 Suicide Prevention Champions from various community organizations (college students, faith-based, sports recreational, individuals with lived experience, etc.).
- Collect and analyze data to inform the creation of awareness materials, including an infographic, community training, and other ongoing efforts to reduce youth suicide rates in the state.
- Increase awareness and access to 988 within youth populations in Louisiana.
- Distribute suicide prevention and 988 awareness and educational materials to Louisiana High Schools.

Ultimately, the project's goal is to foster a more inclusive and supportive environment for Louisiana youth by addressing mental health, emotional well-being, and suicide prevention through targeted, data-driven interventions. The initiative is expected to begin in one geographical area based on need and willingness to participate, with a focus on building capacity in schools and communities where students live and visit. Student leaders will be trained as part of a peer support program to integrate them into the broader community network of Suicide Prevention Champions who are suicide-informed and committed to promoting mental health. Through partnerships, the project will develop an infographic to raise awareness, with the ultimate goal of creating a toolkit that schools can adopt to support long-term sustainability and normalize conversations about suicide and mental health.

House Concurrent Resolution 86 Task Force (2024)

More recently OBH was tasked with staffing House Concurrent Resolution 86 (HCR 86) and the State Suicide Prevention Coordinator has been identified as a designee for this taskforce. HRC 86 calls for a task force to study suicide among African Americans in Louisiana.

During the 2024 Legislative Session, House Concurrent Resolution 86 Task Force (HCR 86)[2] was proposed.[3] The purpose of HCR 86 is to continue the Task Force on African American Suicide Rates to study death by suicide statistics for African Americans in Louisiana and to propose any recommendations regarding suicide prevention. HCR 86 requires each designating authority to submit the name of its designee for the task force to the Louisiana Department of Health no later than July 15, 2024 and the chairman of the task force to reconvene the task force no later than August 1, 2024. The designated members of the task force remain the same as listed above. The task force is to report its findings to the legislature no later than February 1, 2026. OBH has been tasked with staffing the task force and will continue efforts to support the chair of the task force and ensure its success. Meetings have not yet convened for HCR 86 Task Force.

3. Have you incorporated any strategies supportive of Zero Suicide?

☒ Yes ☐ No

OBH provides leadership to decrease suicide deaths and suicide attempts of adults ages 25 or older within behavioral healthcare systems through the following milestones:

[2] https://legis.la.gov/legis/ViewDocument.aspx?d=1380758
[3] https://legis.la.gov/legis/ViewDocument.aspx?d=1380758

- OBH has continued to collaborate with four designated LGEs and two state psychiatric hospitals to implement a Zero Suicide framework into their behavioral healthcare systems. The Zero Suicide framework is a way to improve suicide care within health and behavioral health systems through the following seven components: leadership development, healthcare workforce training, identification of suicide risk factors, patient engagement, and access to treatment, health system transition, and health system quality improvement.

- In collaboration with Louisiana Center for Prevention Resources (LCPR) and the Educational Development Center (EDC)/Zero Suicide Institute (ZSI), OBH held the Zero Suicide Workshop on June 6 and June 7, 2022, for behavioral health providers participating in the Zero Suicide Grant, including representatives from the four LGEs and two state psychiatric hospitals. Thirty-nine participants engaged in presentations and discussions that offered resources for beginning implementation and ways to overcome barriers. Additionally, attendees learned how to incorporate best practices into their organizations and processes to improve care and safety for individuals at risk. Following the workshop, OBH requested that the implementation teams complete an Organizational Self Study designed to assess the components of the comprehensive Zero Suicide approaches currently in place and the degree to which the components are embedded within key clinical areas. The Organizational Self-Study also helps to assess organizational and clinical area-specific strengths and opportunities for development across each component.

- OBH provided a two-day Zero Suicide Academy in collaboration with LCPR which Zero Suicide provider organizations were required to attend. Twelve teams attended the Zero Suicide Academy, including FPHSA, SCLHSA, AAHSD, NEDHSA, ELMHS and CLSH. The other teams included local behavioral health organizations: the Bridge Center for Hope, a local crisis stabilization center; and Southern University and A&M College, a local HBCU. Participants learned about the Zero Suicide framework and its seven elements, began strategic implementation planning, and prepared for commonly faced challenges. Each Zero Suicide provider is developing and implementing policies and procedures to ensure all clients are screened at intake for suicide risk. Clients identified to be at risk for suicide are engaged in the development of a suicide care management plan and are treated using evidence-based approaches that target suicidal thoughts and behaviors directly and support successful care transitions. This coordinated, comprehensive approach to suicide prevention and intervention will help to raise awareness of suicide, establish referral processes, and improve care and outcomes for individuals who are at risk for suicide.

- OBH continues to participate in the Veteran Affairs (VA)/ SAMHSA Governor's Challenge to prevent suicide among service members, veterans and their families (SMVF). SAMHSA's SMVF Technical Assistance (TA) Center works with states and communities to strengthen their behavioral health systems servicing SMVF. The TA Center has been working with the Louisiana Governor's Challenge team to provide support through the provision of technical assistance and the promotion of ongoing interagency collaboration. This is a key accomplishment as the SMVF population is a target population in the Zero Suicide grant. An "Ask the Question" campaign is in development through the work of the Governor's Challenge to identify the SMVF population that may be in need of resources and services. A resource card with a QR code will be available to the Zero Suicide Provider sites and mobile crisis teams.

- OBH continued collaborating with the Education Development Center (EDC) and the Louisiana Center for Prevention Resources (LCPR) to plan and implement the ongoing Community of Practice (CoP) calls. OBH's Suicide Prevention team, in partnership with LCPR, hosted a Zero Suicide Community of Practice series consisting of nine learning sessions. The CoP is designed to offer ongoing support and guidance to organizations integrating the Zero Suicide framework into their behavioral health systems. In collaboration with EDC and LCPR, OBH's Suicide Prevention team hosted the final session of the CoP series on June 24, 2025, to further support the work of Zero Suicide implementation teams.
- The six behavioral health systems have made significant progress with increasing the amount of staff members trained in suicide prevention. As of 2025, 3,861 suicide prevention staff trainings have been completed.

4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments? If yes, please describe how barriers are eliminated.

☒ Yes ☐ No

The COVID-19 Emergency Response for Suicide Prevention (COVID-19 ERSP) Grant was awarded to the Louisiana Department of Health, Office of Behavioral Health (OBH), with a project period from July 1, 2020 through May 31, 2022. The grant targeted individuals aged 25 and older who were at increased risk for suicide, including those who had recently attempted suicide, experienced a suicide crisis, were discharged from psychiatric care, or who struggled with chronic suicidal ideation.

The initiative focused on implementing suicide prevention and intervention strategies through a case management model that employed Peer Support Specialists (PSS) as case managers under the supervision of Licensed Mental Health Professionals (LMHPs). Case management services included:

- Comprehensive screening and assessment
- Safety planning and means restriction
- Discharge and transition planning
- Warm hand-offs to treatment providers and community resources
- Information sharing and caring contacts

The program raised awareness of suicide risk, strengthened referral pathways, and improved access to coordinated care during the height of the COVID-19 pandemic—and beyond. The use of Peer Support Specialists, an evidence-based practice, helped participants improve engagement with services, quality of life, and overall self-management. Additionally, Peer Support staff addressed social determinants of health to enhance long-term health outcomes. Peer Support is an evidenced-based practice for individuals with mental health conditions or challenges.

This program also delivered statewide suicide prevention, intervention, and postvention training, increasing awareness of warning signs and connecting individuals in crisis to appropriate care. The COVID-19 Emergency Response to Suicide Prevention Grant ended May 31, 2022.

To build on the success of the ERSP initiative, LDH-OBH approved a three-year contract with the Louisiana Mental Health Association (LAMHA) covering the project period from July 1, 2023 through June 30, 2025.

This contract sustained and expanded the work under the Fisher Project, broadening eligibility to include individuals ages 18 and older who are at risk for suicide. The project continues to use a peer-led case management model and supports OBH's broader goal of strengthening Louisiana's crisis response infrastructure and promoting person-centered, community-based care in the least restrictive settings.

- The Fisher Project team enrolled 71 clients and completed 1117 assessments. The leading social determinants of health are lack of housing, lack of employment/finances, and trauma/violence/relationship issues. Leading barriers to success include relationship issues, missed appointments, non-compliance, lack of family support and lack of point of contact with inpatient providers. The PSS team members are continuing their efforts to reduce the identified social determinants of health and are enabling clients to obtain the tools they need to overcome the barriers. The team provided comprehensive case management services which included referrals to mental health professionals, housing assistance, transportation resources, resources for basic needs assistance and additional community based resources. The Fisher Project Peer Support Specialists (PSS) team completed 562 caring contacts maintaining consistent engagement and support for clients throughout the contract period.

- The Fisher Project has continued its strategic outreach and engagement efforts, forming partnerships with key stakeholders and community champions, including:

    - Xavier University
    - CareSouth
    - Longleaf Hospital
    - 988 Crisis Centers
    - Louisiana Service Members Veterans and Family Coalition
- Key Outcomes Achieved:

    - Reduced suicide incidence rates among the enrolled population
    - Expanded outreach and improved care coordination across emergency departments, inpatient/outpatient psychiatric providers, LGEs, 988 Crisis Centers and academic institutions.
    - Rapid follow-up care provided to individuals post-crisis or hospital discharge.
    - Strengthened interagency collaboration streamlining care and support for clients.

The program raised awareness of suicide risk, strengthened referral pathways, and improved access to coordinated care during the height of the 2020 pandemic and beyond. The use of Peer Support Specialists, an evidence-based practice, helped participants improve engagement with services, quality of life, and overall self-management. Additionally, Peer Support staff addressed social determinants of health to enhance long-term health outcomes.

During the 4th quarter of FY25 the following adverse events occurred:

- Two hospitalizations: one due to suicidal ideation, one following a suicide attempt.

- Additionally, there was a death by suicide of student who had been referred to the Fisher Project but had not yet enrolled at the time of the incident.

While the fourth quarter noted several achievements in outreach, client engagement, and care coordination, the reported suicide related incidents underscore the continued urgency and importance of timely intervention. The Fisher Project team is committed to addressing needs and improving clients by meeting them were they are and improving outcomes for individuals at risk. Most notably there were no deaths by suicide among the clients enrolled with the Fisher Project.

Due to the continued success of the Fisher Project, LDH-OBH is applying for a second three-year contract with LAMHA, extending the project through June 30, 2028. This renewed commitment ensures the continuity of vital peer support case management services for individuals experiencing suicidal ideation or recovering from a suicide crisis.

The Fisher Project has been instrumental in helping participants overcome significant barriers that contribute to suicidal ideation and poor mental health outcomes. Many individuals served by the program face challenges such as unstable housing, lack of financial resources, limited access to transportation, food insecurity, and social isolation. Through the support of Peer Support Specialists, clients receive individualized assistance to navigate these barriers—whether through referrals to housing programs, support with applying for benefits, access to food and basic needs, or connection to community resources. By addressing these social determinants of health, the Fisher Project not only stabilizes individuals in crisis but also promotes long-term recovery and improved quality of life. This holistic approach ensures that clients are supported beyond their immediate mental health needs, creating a foundation for sustainable wellness and safety.

The extended contract will allow for further expansion of outreach, deeper integration with local behavioral health providers, and the continued enhancement of crisis response systems throughout the state.

5. Have you begun any targeted or statewide initiatives since the FFY 2024 - FFY 2025 plan was submitted?

☒ Yes ☐ No

If so, please describe the population of focus?

Louisiana 988 College and University Initiative

The Louisiana Department of Health (LDH)/Office of Behavioral Health (OBH) launched the *988 Louisiana College and University Initiative* to address rising suicide rates among youth and young adults. The initiative develops effective, collaborative marketing strategies to increase awareness of the 988 Suicide & Crisis Lifeline across Louisiana's colleges and universities. Partnerships with Southern University and A&M College and Grambling State University play a vital role in shaping the campaign's messaging, outreach strategies, and campus engagement including the development of a toolkit. As part of the initiative, student ambassadors will be added to actively promote 988 among their peers, helping to build trust and expand awareness. The goal is to raise awareness of 988 and increase access to 988 as a vital suicide prevention and mental health tool. Student ambassadors will also be utilized during events to engage faculty, staff, and community members, within the colleges/universities to increase 988 awareness and access.

Louisiana Youth Suicide Prevention Initiative (LYSPI)

Since the submission of the FFY24–FFY25 plan, the Louisiana Department of Health/Office of Behavioral Health (LDH/OBH) has launched a targeted initiative known as the Louisiana Youth Suicide Prevention Initiative (LYSPI). Funded through the 2025 Transformation Transfer Initiative (TTI) beginning in December 2024, LYSPI is a comprehensive effort designed to reduce suicidal behaviors and deaths among youth, particularly high school students across Louisiana. This initiative builds on strategic goals developed during the Black Youth Suicide Policy Academy and targets populations with historically higher rates of suicide.

Through a partnership with Peer Initiatives–Leaders of Tomorrow, the initiative is currently expanding student peer support and suicide prevention programming in up to 10 Louisiana high schools. Efforts include training up to 1,000 students and 50 school faculty members, increasing awareness of 988, and identifying and equipping Suicide Prevention Champions from diverse community sectors. The project also includes robust data collection and analysis to inform culturally responsive materials, such as infographics and training tools. LYSPI focuses on one geographical area to start, with plans to scale, ensuring a data-driven, community-centered approach to youth suicide prevention and mental wellness.

6. Please indicate areas of technical assistance needed related to this section

N/A

13. Support of State Partners - Required

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medical Authority (SMA) agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities are working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster

care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;

- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities

are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?

   ☒ Yes ☐ No

2. Has your state identified the need to develop new partnerships that you did not have in place?

   ☒ Yes ☐ No

   If yes, with whom?

   1. Emergency Room Departments to incorporate Peer Support Specialist as vital roles to assist with identification and referral resources for person's with SUD/OUD to treatment and to connect individuals experiencing behavioral health crises to Louisiana Crisis Response Services (LA-CRS)
   2. Peer Association Boards, Councils or Advocacy groups
   3. Louisiana Crisis Response Services (LA-CRS), Louisiana Crisis Hub, 988, and local stakeholders including police, hospital systems and EMS, ensuring individuals experiencing a behavioral health crisis receive the following services necessary to meet their needs:
      a. Mobile Crisis Response (MCR)Teams and Community Brief Crisis Support (CBCS) providers for adults and youth
      b. Behavioral Health Crisis Centers (BHCC) and Crisis Stabilization (CS) units for adults
   4. Early Childhood Support & Services providers - Request for Proposals (RFP) to identify a statewide management entity
   5. Federally Qualified Health Centers to provide SUD and Medication for Opioid Use Disorders (MOUD)
   6. Native American Tribes, particularly those that are state-recognized
   7. Office Based Opioid Treatment (OBOT) providers
   8. Louisiana Housing Corporation - SSI/SSDI Outreach, Access, and Recovery (SOAR) Regional Benefits Specialists statewide

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

Through the Louisiana Department of Health (LDH), the Office of Behavioral Health (OBH) implements treatment, prevention and recovery support services statewide for individuals with or at risk for Substance Use Disorders, other related addictions, and mental health diagnoses. In order to accomplish this task several key partners were identified to enhance and expand capacity of treatment providers to provide a

full array of comprehensive services, including: screening, assessment, orientation, urine drug screens, methadone management and other forms of Medicated for Opioid Use Disorder (MOUD), counseling (individual, group, and/or family), case coordination, home and community based mental health treatment programs, such as Assertive Community Treatment (ACT) and Mental Health Rehab (MHR) services, and coordinated specialty care (CSC) programs for the ESMI/FEP population of focus, including planning for Certified Community Behavioral Health Clinics (CCBHC) etc. OBH uses a multi-faceted, collaborative approach. Below is a brief description of the partners and their roles.

Opioid Treatment Programs (OTP)

OTPs provide direct substance use services by combining use of (MOUD), specializing in Methadone Maintenance, to include counseling and behavioral therapies for treatment. OTPs offer medically necessary treatments and services that target persons severely affected by opioid use disorder (OUD).

Louisiana State University Social Research & Evaluation Center (LSUSREC)

LSUSREC provides data collection and performance measurement for multiple programs within OBH, including data storage, cleaning and organization, analysis, and reporting. LSUSREC serves as the subject matter data experts for several OBH federal grants, including offering stakeholder trainings and learning communities to heighten awareness about federal reporting regulations for the Government Performance Results Act (GPRA). This partnership has led to the LaSOR program consistently exceeding the GPRA follow-up target rate, as well as the rates of the other grantees.

Additionally, LSUHSC partners with OBH in support of the development and training of a network of crisis providers operating within the LA-CRS which includes mobile crisis response (MCR) for adults and youth, community brief crisis support (CBCS) for adults and youth, behavioral health crisis care (BHCC) centers for adults, and crisis stabilization (CS) beds for adults. This support occurs through community and provider readiness activities, community coalition building, as well as the implementation of a robust training curriculum.

Louisiana Primary Care Association (LPCA)

OBH is partnering with LPCA to serve as the administrative service organization to expand the number of Office based Opioid Treatment Providers (OBOTs) throughout the state. LPCA is focusing its efforts on Federally Qualified Health Centers (FQHC) for an integrated approach to OUD treatment, providing both primary care and behavioral health services at one location. In addition, LPCA will provide staff for Spoke Care Teams (SCT), which consist of one Licensed Mental Health Professional (LMHP) and one Peer Support Specialist per LDH region (9 total). These teams provide assistance to the OBOT provider to offer services, such as screening, brief intervention and referral to treatment (SBIRT), assessments, case coordination, recovery support services, and assistance with data collection requirements.

LPCA will also provide the implementation of Project ECHO (Extension for Community Healthcare Outcomes), which uses video-conferencing technology to establish a virtual “knowledge network” between a team of inter-disciplinary specialists and OBOT providers for training and mentoring.

Tulane University

Tulane University provides Academic Detailing, which uses specially trained clinical educators who meet one-on-one with physicians, nurse practitioners, and physician assistants (at their practice locations), to discuss best practices and to improve their service range in MOUD Tulane is currently focusing its academic detailing efforts on prisons, jails, detention centers, and courts to address the gap in care in the

criminal justice system for incarcerated individuals with opioid use disorder (OUD). Tulane is also identified as the evaluator for the state's current SUD 1115 Waiver.

Department of Public Safety and Corrections (DPSC) MOUD

OBH partners with the Department of Public Safety and Corrections (DPSC) to provide MOUD services in six prisons (2 women's facilities, 2 men's facilities, and 2 facilities for both men and women) throughout the state. Offenders with a diagnosis of OUD are selected 9 months to 1 year prior to their earliest release date. Treatment is individualized and may include MOUD, if indicated, in addition to Cognitive-Behavioral Therapy. Currently, the primary medication used in these settings is Naltrexone. Other FDA approved meds are not allowable at this time. However, the state is working with DPSC to help provide knowledge on evidence based practices to this vulnerable population.

- Day Reporting Center - Through an interagency agreement with DPSC, OBH also supports a Day Reporting Center in New Orleans, La., which promotes strategies for appropriate diversion and alternatives to incarceration. This program offers individuals with OUD who are on probation with screening, treatment and recovery support services at the center and implement transition services for those individuals reentering the community, including efforts to transition individuals in residential substance use treatment or MOUD services as needed.

Oxford Recovery Housing

Oxford Inc. provides safe recovery housing to persons in recovery and guides administrative oversight of the network. Oxford Outreach Liaisons are hired to create new homes and monitor operations of the existing network of 195 Oxford Houses. The state plans to expand homes statewide by adding 16 additional homes during this block grant period (18-homes in FY26/8-homes in FY27). Oxford Inc. provides ongoing technical assistance and trainings to new and existing homes, while also troubleshooting any incidence that may occur within any homes statewide. This program offer opportunities for staff and residents to participate in the Annual Oxford World and State Conference, to stay abreast of cutting edge models of practices for treatment and recovery. OBH also provides monitoring and oversight of Oxford Inc., to bridge gaps and improve collaboration with the DPSC Re-Entry Program, to ensure offenders being released are connected to vital substance use and mental health services in their respective communities.

Southern University Center for Prevention Resources,

Louisiana Center for Prevention Resources (LCPR), established at Southern University and A&M College, and the Office of Behavioral Health (OBH) developed a partnership aimed at improving implementation and delivery of effective substance use prevention interventions. This Center also offers training and technical assistance services to the Substance Use Prevention Workforce. This partnership provides specific courses and trainings necessary to become a certified/licensed prevention professionals, at no cost to participants. Additional trainings are available to youth, communities, professionals, and others in the prevention community, to increase capacity, skills and expertise to ensure and/or enhance delivery of effective substance use prevention interventions, trainings and other prevention activities. In addition to the above initiative, OBH partnered to:

- Support mental health training needs specifically related to suicide prevention. Trainings under this partnership enables participants to assist someone in a crisis mode by being trained to recognize the warning signs of suicide ideation. These trainings will provide the skills needed to

individuals for outreach and initial support to someone who may be in crisis or developing a mental health or substance use problem.

- Develop a Statewide Media Alcohol Awareness Campaign. The purpose of this campaign is to increase awareness of alcohol use and misuse and the associated consequences. This campaign will be used to address risk factors and educate community members on the increase in substance use. In addition LCPR will provide trainings and awareness campaigns for Service Members, Veterans and their Families (SMVF) with targeted messages that focus on behavioral health prevention and trainings related to substance use.

Louisiana Board of Regents

The Louisiana Board of Regents (BORs) implements strategies, trainings and helps to raise awareness in an effort to reduce identified negative consequences of substance misuse. BORs works directly with the Louisiana Department of Health (LDH), Office of Behavioral Health (OBH) and other statewide entities to improve implementation and delivery of effective substance misuse prevention interventions.

OBH partners with the Louisiana Board of Regents to collect and assess data on populations enrolled in institutions of higher education related to substance use disorders and other behavioral health issues. BOR conducts the CORE Alcohol and Drug Survey in odd years to Postsecondary Education Institutions (PEI). BORs also host the Louisiana Higher Education Coalition (LaHEC) annual summit, Regional Trainings based on the outcomes of the CORE Alcohol and Drug Survey, webinars related to outstanding trends amongst the higher education population. In addition, BOR monitors implementation of evidence-based curriculums, such as Alcohol Edu. BORs also provides support to Collegiate Recovery Communities through technical assistance and naloxone education and distribution.

University of Louisiana at Lafayette (ULL)

Office of Behavioral Health (OBH) and the University of Louisiana at Lafayette (ULL) partners to administer the Caring Communities Youth Survey (CCYS) and serve as the State's Evaluator to provide data to support evidence-based programming. CCYS is a bi-annual survey completed by 6th, 8th, 10th and 12th grade students enrolled in public and private schools throughout the state. The survey is funded by the Louisiana Office of Behavioral Health (OBH) and has been administered statewide since 2002. The CCYS taps into several behavioral health indicators for school-age children, including Risk and Protective factors, substance use/abuse, mental health and antisocial behaviors. Schools and districts use the CCYS reports to apply for grants or funding that address areas of need illuminated by survey outcome measures. Since 2002 the Picard Center has been tasked with coordinating, monitoring, and providing technical assistance for survey administration.

This partnership aims to identify high-risk behaviors among middle and high school students, including risk factors associated with alcohol, tobacco, and other drug use. Additionally, it supports the Office of Alcohol and Tobacco Control (ATC) by providing representative samples of compliance checks under the SYNAR Amendment. The ultimate goal is to operate a seamless system of care that integrates prevention and intervention strategies based on evidence and data.

Louisiana Office of the Governor

OBH contracts with the Louisiana Office of the Governor to collaborate and continue to build the State's capacity for data driven, evidence-based prevention services to reduce the risk factors for substance use and related mental, emotional and behavioral disorders. The contract between OBH and the Louisiana

Office of the Governor allows for sustainment of the state infrastructure that has played a vital role to addressing substance misuse. This partnership supports the salary and related benefit of the Director of Drug Policy and the Prevention Systems Coordinator who oversee and facilitate three advisory boards to include the Drug Policy Board (DPB), Prevention Systems Committee (PSC) and the State Epidemiology Workgroup (SEW). The identified boards provide and promote pivotal partnerships across different state and community sectors. In addition, this contract ensures implementation and fulfillment of the requirements of the Louisiana Partnership for Success III (LaPFS III) Grant.

Louisiana Office of Alcohol Tobacco Control

OBH has a long-standing partnership with the Louisiana Office of Tobacco Control (ATC) in an effort to address youth access to tobacco and alcohol, which remain a nationwide problem. The contract with ATC allows OBH to meet the requirements of the Synar Amendment. The Synar Amendment to the Public Health Service Act (PL 102-321) requires that states must reduce the access of tobacco products to minors. The Louisiana Office of Alcohol and Tobacco Control is the regulatory agency for both alcohol and tobacco as stipulated in Louisiana State Law. As such, OBH has contracted with ATC to conduct random, unannounced compliance checks of both over-the-counter and vending machine outlets for tobacco products. In addition, as funding is available, OBH has contracted with ATC to conduct random, unannounced compliance checks of both on-premise and off-premise outlets for alcohol products statewide.

Emergency Preparedness

SMHA/SSA actively partner with the various agencies within the Louisiana Department of Health, regional and local partner agencies to collaborate in emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response, recovery) including appropriate engagement of volunteers with expertise and interest in behavioral health.

Early Serious Mental Illness (ESMI) / First Episode Psychosis (FEP)

- *Tulane University School of Psychiatry – Early Psychosis Intervention Clinic of New Orleans (EPIC NOLA)*

Through a contract with Tulane University's EPIC NOLA Program, Tulane's existing Coordinated Specialty Care clinic serving individuals experiencing FEP has been able to expand their capacity. Technical Assistance is ongoing amongst the FEP programs, with a consultation contract with the medical director of Tulane's EPIC NOLA Program. The purpose of this is to improve LGEs capacity to serve individual experiencing psychosis with the intention of shortening durations of untreated psychosis

Tulane University continues to offer consultation to any existing ESMI/FEP clinics that are operating in other parts of the state as needed. Tulane University Department of Psychiatry provides monthly consultation to the various LGEs operating FEP programs in the northern region of the state.

- *Early Psychosis Intervention Center (EpiCenter)*

Through a new contract with the Volunteers of America (VOA) – North Louisiana, OBH supports the Early Psychosis Intervention Center in Shreveport. The EpiCenter provides CSC to both youth and adults using a CSC model to provide a comprehensive package of services including: family education, cognitive behavioral therapy for psychosis, supported employment and education services, and personalized

pharmacologic management. Staff members use a team approach to provide collaborative services to program participants. This program represents a partnership between VOA of North Louisiana and LSU Health Sciences of Shreveport. This program implemented in 2023.

Initiatives to Serve the Homeless Population with SMI

- *PATH*

With the Projects for Assistance in Transition from Homelessness (PATH) grant, outreach services to homeless individuals with SMI are provided by various partners. Specifically, these services are for individuals with serious mental illnesses and those with co-occurring substance use disorders who are homeless or at imminent risk of becoming homeless. PATH grant funding supports community-based outreach, mental health, substance use, case management and other support services, as well as a limited set of housing services.

LGE	PATH PROVIDER(S)
MHSD	Unity of Greater New Orleans
CAHSD	Start Corporation
SCLHSA	SCLHSA Start Corp
AAHSD	Volunteers of America – Lafayette
CLHSD	Volunteers of America – Alexandria
NLHSD	Hope for the Homeless
NDHSA	Easterseals LA
JPHSA	Responsibility House

- *NAMI Louisiana*

The Office of Behavioral Health partners with the National Alliance on Mental Illness Louisiana Chapter (NAMI LA) through a contract to support the housing assistance program, which is funded with MHBG funds. Through this contract, eligible individuals with serious mental illness who are homeless/at-risk of homelessness and are exiting an institution, such as a hospital, correctional facility, and/or nursing home, are allowed a specified amount to help with the transition from an institution to the community. This assistance may be temporary rental assistance for an apartment or chosen group home, as well as for incidentals needed to support a successful transition to the community.

- *START Corporation Transitional Homes*

The Office of Behavioral Health has partnered with START Corporation to support the transitional housing assistance previously on the campus of Northlake Behavioral Health System. The transitional housing program was relocated to Houma, LA to a newly constructed facility in 2020. The transitional housing program serves individuals with serious and persistent mental illness (SPMI) who are homeless and need assistance with daily living skills. Start Corporation has a long history of partnering with OBH to serve the most vulnerable populations of those with SPMI who are experiencing lack of stable housing.

- *Louisiana Housing Corporation*

In 2023, the Office of Behavioral Health began a partnership with Louisiana Housing Corporation (LHC) to implement a Statewide SSI/SSDI Outreach, Access and Recovery (SOAR) Program. SOAR incorporates

essential components to assist adults to recover from homelessness. LHC contracted with each Continuum of Care (CoC) to create nine (9) regional SOAR Specialist positions to assist targeted individuals with serious mental illness with their applications for SSI/SSDI and other mainstream resources. This additional support would also assist with reducing institutionalization, increasing community supports, and support successful long-term recovery in the community. This partnership with LHC ended in June 2025 and is in process of transitioning to a partnership with the state's human services districts.

Mental Health Advocacy and Education

- *Mental Health Association of Greater Baton Rouge (MHAGBR) / Louisiana Affiliate of Mental Health America*

In 2019, MHAGBR was elected by Mental Health America National Office as the Louisiana Affiliate of their organization. In 2019, MHAGBR also began a partnership with OBH, which is an expansion of the already existing partnership, to provide statewide educational forums to families and communities on how to access resources and help when a loved one or member of their community is challenged by mental illness. These forums, Mental Health 911, will occur throughout the state during the coming year. As part of this collaboration effort, MHAGBR also organizes the annual Behavioral Health Day at the State Capitol building.

- *NAMI St. Tammany*

NAMI St. Tammany continues to partner with OBH to provide education and advocacy services to local communities, to include law enforcement agencies and specialty behavioral health courts. This education and advocacy has included training local law enforcement on Crisis Intervention Training (CIT), Mental Health First Aid (MHFA), and the development of an app that includes quick references to resources.

- *NAMI Louisiana*

NAMI Louisiana continues to partner with LDH/OBH to provide advocacy, education and support the Louisiana Behavioral Health Advisory Council (LBHAC). NAMI LA provides statewide training on mental illness and how to work with the legislature to support services and programs for those with mental illness.

- *Louisiana State University School of Social Work*

OBH negotiated a contract with the Louisiana State University School of Social Work to initiate a *Better Futures* Program in summer of 2023. This program helps youth in foster care and with serious mental health challenges, prepare for postsecondary education. The program will help support young people in exploring their postsecondary interests and opportunities, and in preparing them to participate in postsecondary education, including college and vocational training programs. The purpose of *Better Futures* is to support young people in exploring their postsecondary interests and opportunities, and in preparing them to participate in postsecondary education, including college and vocational training programs. The purpose of *Better Futures* is to support young people in exploring their postsecondary interests and opportunities, and in preparing them to participate in postsecondary education, including college and vocational training programs.

Peer Support Services

- *The Extra Mile, Region IV, Inc.*

The Extra Mile, Region IV, Inc. continues to partner with OBH to provide an LDH-OBH approved Peer Education Training course for individuals with behavioral health challenges, who are successfully in recovery to become employed as a Certified Peer Support Specialist. In 2023-24, the contract with The Extra Mile includes the development and implementation of a Family Peer Training Program to support the expansion of Louisiana Crisis Response System to serving youth and their families.

- *NAMI St. Tammany*

NAMI St. Tammany has continued to partner with OBH to provide Peer Support Specialists in one of the mental health hospitals. In support of the evidence based practices of utilizing peers to support the treatment and recovery process, NAMI St. Tammany has provided two Peers to work in the Northlake Behavioral Health Hospital and continues to support this service through a contract with OBH.

- *Louisiana Mental Health Association (LA Affiliate of Mental Health America)*

In 2018, OBH collaborated with the Louisiana Mental Health Association (LAMHA) to develop a new Peer Support program entitled Target Health. Target Health is a holistic program, based off of the Whole Health Action Management (WHAM) model which will train Peer Support Specialists to assist those they serve to develop and maintain whole health goals. In 2022, LAMHA expanded the Target Health program with the development and implementation of a curriculum focusing on youth.

- *Campus Peers in Higher Education Settings*

In 2023, OBH established contract partnerships with three (3) NAMI affiliates throughout the state to support students with behavioral health and/or emotional challenges on campus. Through this partnership, trained Campus Peers will be available to a maximum of 12 universities throughout the state. Trained Campus Peers will provide support, guidance and referrals to students who are experiencing behavioral health and/or emotional challenges as they transition to this next phase in their early adulthood. This initiative ended in June 2025.

NAMI AFFILIATE	TARGETED UNIVERSITIES
NAMI Acadiana **Marietta Puckett, Executive Director** nami@namiacadiana.org	• University of Louisiana Lafayette (NAMI ON Campus) • McNeese – Lake Charles • LSU – Alexandria • LSU – Eunice
NAMI LA **LaShonda G. Williams, J.D., Executive Director** lderouen@namilouisiana.org www.namilouisiana.org	• Louisiana State University Baton Rouge (NAMI ON Campus) • Southeast Louisiana – Hammond • Tulane – New Orleans (NAMI ON Campus) • Nicholls State University – Thibodeaux • Southern University HBCU – Baton Rouge
NAMI Ruston **Jerrilene Washington, Ph.D., Executive Dir.** washington.jerrilene1922@gmail.com	• Northwestern State University - Natchitoches (MOU signed) • Grambling State University HBCU – Grambling (MOU signed) • Louisiana State University LSU-S – Shreveport (MOU signed)

Early Childhood Supports and Services (ECSS)

The ECSS program was implemented for approximately 10 years and eliminated in 2013. Act 167 of the 2022 Regular Legislative Session established in the state treasury the Early Childhood Supports and Services program fund, intended to fund the re-creation of this program. The provisions establishing the ECSS Program Fund shall terminate on December 31, 2026. Act 167 directs that monies in the fund shall be used by the Louisiana Department of Health to fund its Early Childhood Supports and Service Program.

Following an RFI process in 2022, in 2023 OBH proceeded with developing a Request for Proposals (RFP), to allow OBH to select an entity for statewide management of the program. The ECSS RFP was released on April, 26, 2024. The RFP review process is now complete and OBH has executed a contract with Magellan Complete Care of Louisiana, Inc. for statewide management of the ECSS program. OBH is working with Magellan Complete Care of Louisiana, Inc. towards the statewide rollout and management of ECSS sites across the state; Magellan Complete Care of Louisiana, Inc. released a Request for Applications (RFA) for regional sites in April 2025. They provided technical assistance and reviewed the proposals with the goal of selecting one provider agency for each of the 10 regions in Louisiana. Magellan Complete Care of Louisiana, Inc. is working on executing subcontracts with each of the selected provider agencies to deliver a comprehensive ECSS program for children ages zero through five and their families. Once credentialed, contracted, and trained, the regional ECSS Sites will begin providing ECSS services to families in their assigned Human Service District region.

OBH has also supported the start-up of an early adopter site. Jefferson Parish Human Services Authority (JPHSA) has contracted with Tulane as the lead for a consortium of providers, to deliver an ECSS program in the Greater New Orleans area. They are serving children and families and are developing a network of community partners to connect families to needed community resources.

4. Please indicate areas of technical assistance needed related to this section.

N/A

14. State Planning/Advisory Council and Input on the MHBG/ SUPTRS BG Application- Required for MHBG

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in **42 U.S.C. §300x-3** for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the

Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from Council Chair, etc.)

The Louisiana Behavioral Health Advisory Council is instrumental in assisting in the development of priorities and direction for the Block Grant. Input is solicited from consumers, family members, providers, advocates, and state employees who are all members of the Council. Each year, an Intended Use Plan (IUP) that allocates Block Grant funds for the following state fiscal year is prepared by OBH Central Office and each Local Governing Entity (LGE), in partnership with their local Regional Advisory Council (RAC). This is an opportunity for each LGE and the corresponding RAC to decide upon how Block Grant funds should be allocated in their community. The IUPs are discussed during a RAC meeting attended by RAC members and the LGE Executive Director, or appointed personnel. Once input has been received from the RAC, the IUPs are then submitted to OBH Central Office for review by OBH executive management. The Central Office and LGE IUPs are then submitted to the Louisiana Behavioral Health Advisory Council's Committee on Programs and Services for review. The committee then reports findings from the review process to all members of the Advisory Council.

Discussions about the Block Grant are a part of all quarterly Council meetings, with an overview and updates about the current status, issues, etc. occurring during each meeting. The Assistant Secretary of the Office of Behavioral Health as well as representatives from the executive management team attend all quarterly meetings of the LBHAC. At the local level, local executive directors and/or administrators attend all RAC meetings. Their presence at these meetings provides ample opportunity for open dialogue between the administration and the LBHAC members. It is during this time that information is shared, questions are asked and answered, and recommendations and suggestions are made.

The Block Grant application is posted on the LBHAC webpage on the Office of Behavioral Health website prior to its submission. Council members are provided with a direct link to review the application and encouraged to email with questions and/or comments. Additionally, a review of the application is provided via a webinar.

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

   State Plan ☐ Yes ☒ No

   State Report ☐ Yes ☒ No

3. What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment, and recovery services?

All quarterly meetings include presentations from the Office of Behavioral Health prevention and substance use treatment specialists. These presentations include new initiatives, programs, and data sharing. Council members have opportunities to ask questions and provide comments at all meetings.

4. Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

   ☒ Yes ☐ No

5. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

   ☒ Yes ☐ No

6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

In addition to providing guidance for the Block Grant Application/State Behavioral Health Plan, the LBHAC also monitors, reviews, and evaluates the allocation and adequacy of behavioral health services within the state. The LBHAC serves as an advocate for adults with serious mental illness, children with serious emotional disturbance, other individuals with mental illness or emotional problems, and persons with substance use and addictive disorders. This includes continued efforts toward public education, education of its members, and endeavors to reduce the stigma of mental illness and addictive disorders throughout the state. Council members are given opportunity to review the block grant application and implementation reports online and make comments prior to their submission.

Currently, the LBHAC includes seats for 40 members consisting of consumers of both mental health and addiction services, family members of adults with serious mental illness and substance use disorders, family members of children with emotional/behavioral disorders and substance use disorders, behavioral health advocates, representatives from regional advisory councils (RACs), and state agency employees. Additionally, the council has representatives of special populations, namely the following: representatives of the behavioral health needs of the elderly, members of a federally recognized tribe, the homeless, transitional youth, veterans, and the LGBTQI population.

The Council has been designed to have geographical representation of the ten local governing entities in the state, and includes members from diverse backgrounds and ethnicities. A representative from each RAC serves on the LBHAC. Improved communication has been a continuing initiative, and each RAC representative reports on regional activities at quarterly LBHAC meetings.

Strategic planning was conducted in 2017-18 and the following Mission, Vision, and Value statements were adopted and continue to represent the focus of the LBHAC:

Mission Statement

The mission of the Louisiana Behavioral Health Advisory Council is to review and monitor the Behavioral Health system, advise and make recommendations, and serve as advocates for persons with Behavioral Health issues in the state of Louisiana.

Vision Statement

Through advocacy we see Louisiana filled with informed, healthy individuals who have the opportunity to live, work, and play in the community of their choice.

Value Statement

In pursuit of our mission, we believe the following value statements are essential and timeless:

- We trust our colleagues as valuable members of the team and pledge to treat one another with loyalty, respect, and dignity.
- We recognize the value of lived experience and the development of partnerships.
- We believe in prevention and early intervention.
- We promote an atmosphere that is respectful of recovery and wellness and strive for a behavioral healthcare system that is responsive and accountable to the individual's strengths and needs.
- We believe in data driven decisions based on quality measures.

7. Please indicate areas of technical assistance needed related to this section.

None at this time.

Please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.

Behavioral Health Advisory Council Composition by Member Type

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery* (including adults with SMI who are receiving or have received, mental health services)	7	
Family Members of Individuals in Recovery * (to include family members of adults with SMI, not parents of children with SED)	4	
Parents of children with SED	3	
Vacancies (individual & family members)	2	
Total Individuals in Recovery, Family Members, and Parents of Children with SED	**16**	**40%**
State Employees	15	
Providers	3	
Vacancies (state employees / providers)	0	
TOTAL State Employees & Providers	**18**	**45%**

Persons in recovery from or providing treatment for or advocating for SUD services	0	
Federally Recognized Tribe Representatives	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Advocates/ Representatives who are not state employees	4	
Other vacancies (who are not individuals in recovery/ family members or stat employees/providers)	2	
Total Non-required but encouraged members	**6**	**15%**
Total Membership	**40**	

*States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

15. Public Comment on the State Plan- Required

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the federal government.

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

   a) Public meetings or hearings?

   ☒ Yes ☐ No

   b) Posting of the plan on the web for public comment?

   ☒ Yes ☐ No

   If yes, provide URL: https://ldh.la.gov/office-of-behavioral-health

   c) Other (e.g. public service announcements, print media)

   ☐ Yes ☒ No

   d) Please indicate areas of technical assistance needs related to this section.
   None at this time.

Acronyms

ADRA	Addictive Disorders Regulatory Authority
AEDS	Alcohol Epidemiological Data System
AOD	Alcohol & Other Drugs
AR	Alcohol Related
ARMVC	Alcohol Related Motor Vehicle Crash
ASAM	American Society of Addiction Medicine
ASIST	Applied Suicide Intervention Skills Training
ATC	Alcohol and Tobacco Control
ATLAS	Addiction Treatment Locator, Assessment, and Standards Platform (by Shatterproof)
BHCC	Behavioral Health Crisis Care
BH-PCS	Behavioral Health Personal Care Services
BRFSS	Behavioral Risk Factor Surveillance System
CADCA	Community Anti-Drug Coalitions of America
CBCS	Community Brief Crisis Support
CCYS	Caring Communities Youth Survey
CDC	Center for Disease Control and Prevention
CCN	Coordinated Care Network
CEU	Continuing Education Units
CHR-P	Clinical High Risk for Psychosis
CIA	Cooperative Involvement Agreement
CLHS	Central Louisiana State Hospital
CSAP	Center for Substance Abuse Prevention
CS	Crisis Stabilization
CSoC	Coordinated Systems of Care
CVO	Credentialing Verification Organization
DCFS	Department of Children and Families
DFC	Drug Free Communities
DPB	Drug Policy Board
DPSC/ DOC	Department of Public Safety and Corrections
EBP	Evidence Based Practices
EBS	Evidence-Based Strategies
ECHO	(Project) Extension for Community Healthcare Outcomes
ECSS	Early Childhood Supports and Services
ED	Emergency Department
ELMHS	Eastern Louisiana Mental Health System
ER	Emergency Room
ESMI	Early Serious Mental Illness
FARS	Fatality Analysis Reporting System
FFY	Federal Fiscal Year
FQHC	Federally Qualified Health Clinics
HARM	Hepatitis, Addiction, and stigma Reduction in Medicine

HCR	House Concurrent Resolution
HCV	Hepatitis C Virus
HEDIS	Healthcare Effectiveness Data Information Set
HSRG	Highway Safety Research Group
IPS	Individualized Placement and Support
LaBOR	Louisiana Board of Regents
LaHEC	Louisiana Higher Education Coalition
LaPFS	Louisiana Partnerships for Success
LaSOR	Louisiana State Opioid Response
LBHP	Louisiana Behavioral Health Partnership
LCSW	Licensed Clinical Social Worker
LDCFS	Louisiana Department of Children & Family Services
LDOE	Louisiana Department of Education
LDH	Louisiana Department of Health
LEEDS	Louisiana Early Event Detection System
LGBTQ	Lesbian, Gay, Bi-sexual, Transgender and Questioning
LGE	Local Governing Entity
LHSC	Louisiana Highway Safety Commission
LODSS	Louisiana Opioid Data & Surveillance System
LSP	Louisiana State Police
LSU	Louisiana State University
LSUHSC	Louisiana State University Health Science Center
LYSPI	Louisiana Youth Suicide Prevention Initiative
MAT-PDOA	Medication Assisted Treatment-Prescription Drug and Opioid Addiction
MCO	Managed Care Organization
MCL	My Choice Louisiana
MCR	Mobile Crisis Response
MHBG	Mental Health Block Grant (Also referred to as Community Mental Health Services Block Grant)
MOU	Memorandum of Understanding
MOUD	Medications for Opioid Use Disorder
M/SUD	Mental Health/Substance Use Disorder
MTF	Monitoring the Future Survey
NREPP	National Registry of Evidence-based Programs and Practices
NSDUH	National Survey on Drug Use and Health
NVSS	National Vital Statistics System
OAD	Office of Addictive Disorders
OBH	Office of Behavioral Health
OJJ	Office of Juvenile Justice
OMB	Office of Management and Budget
OMV	Office of Motor Vehicle
OPH	Office of Public Health
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PASRR	Pre-Admission Screening Resident Review
PIRS	Peer In-Reach Specialist

PMP	Prescription Monitoring Program
PMIS	Prevention Management Information System
PMS	Prevention Management System
PRAMS	Pregnancy Risk Assessment Monitoring System
PRTF	Psychiatric Residential Treatment Facility
PSC	Prevention Systems Committee
PSS	Peer Support Specialist
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPST	Substance Abuse Prevention Specialist Training
SAPT	Substance Abuse Prevention and Treatment
SBIRT	Screening, Brief Intervention and Referral to Treatment
SEW	State Epidemiology Workgroup
SHHP	STD/HIV/HEP Program
SIG	State Incentive Grant
SOW	Statement of Work
SPF	Strategic Prevention Framework
SPF-RX	Strategic Prevention Framework for Prescription Drugs
SPF-SIG	Strategic Prevention Framework State Incentive Grant
SPE	Strategic Prevention Enhancement
SSA	Single State Authority
SSP	Syringe Service Provider
STARS	State Technical Assistance and Resource Staff
SUD	Substance Used Disorder
SUPTRS BG	Substance Use Prevention, Treatment, and Recovery Services Block Grant, formerly the Substance Abuse Block Grant (SAPT BG)
SUN	Substance Use Navigator
SWCAPT	Southwest Center for the Application of Prevention Technologies
TA	Technical Assistance
TGF	Therapeutic Group Home
UCR	Uniform Crime Reporting Program
YRBS	Youth Risk Behavior Survey

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