LOUISIANA FY 2011
BLOCK GRANT PLAN

Part C
STATE PLAN
Section III

PERFORMANCE GOALS AND ACTION PLANS TO IMPROVE THE SERVICE SYSTEM

ADULT PLAN

EMERGENCY RESPONSE

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

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

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

Louisiana Spirit Hurricane Recovery Crisis Counseling Program

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

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

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

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

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

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

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

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

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

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

Louisiana Spirit Oil Spill Recovery Program

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

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

Workers reached out where fishermen, individuals, families and others affected by the oil spill were likely to be found. Geographically, this includes the southeast parishes of Jefferson, Lafourche, Orleans, Plaquemines, St. Bernard and Terrebonne. The sites where workers who were impacted were seen included: oil spill claims centers, oil spill recovery sites where workers congregated, animal recovery sites, emergency operations centers, resource distribution sites, businesses which

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

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

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

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

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

The BEST (formerly Access)

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

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

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

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

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

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

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

Crisis Counseling Assistance and Training Program (CCP) Grant:

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

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

AGE		
0 to 5 years:	6	0.2%
6 to 11 years:	87	3.4%
12 to 17 years:	78	3.0%
18 to 39 years:	1,447	56.5%
40 to 64 years:	776	30.3%
65+ years:	157	6.1%
Age unknown:	9	0.4%
RACE/ ETHNICITY		
Latino:	279	10.9%
Asian:	14	0.5%
Black:	1,346	52.6%

Pacific Islander:	2	0.1%
White:	498	19.5%

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

HEALTH, MENTAL HEALTH, MH REHABILITATION SERVICES & CASE MANAGEMENT

FY 2011 - ADULT PLAN

Individuals with Serious Mental Illnesses often have co-occurring chronic medical problems. Therefore, it is important to enhance a collaborative network of primary health care providers within the total system of care. The Office of Mental Health continues to develop holistic initiatives that offer comprehensive and blended services for vulnerable children and adults experiencing psychiatric and physical trauma, including those in acute crisis. In addition, Louisiana's extensive system of public general hospitals provides medical care for many of the state's indigent population, most of whom have historically had no primary care physician. Over the past few years, OMH's acute psychiatric inpatient services have been moved under the Louisiana Health Sciences Center-Health Care Services Division (LSUHSC-HCSD), and LSU Shreveport public general hospitals. It is believed that continuity of care is often better served under LSU and that those persons admitted with acute psychiatric problems might then receive the best *physical* assessment and treatment as well as care for their psychiatric problems. Adults who are clients of state operated mental health clinics or Medicaid funded Mental Health Rehabilitation (MHR) Services also benefit from a systematic health screening. Further, MHR providers who provide services to children, youth, and adults must assure through their assessment and service plan process that the whole health needs of their clients are being addressed in order to get authorization for the delivery of services through the Medicaid Behavioral Healthcare Unit. The OBH clinics work very closely with private health providers as well as those within the LSUHSC-HCSD.

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

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

Although the CMHC's operate with somewhat traditional hours, crisis services are provided on a 24-hour basis. These services are designed to provide a quick and appropriate response to individuals who are experiencing acute distress. Services include telephone counseling and referrals, face-to-face screening and assessment, community housing for stabilization, crisis respite in some areas, and access to inpatient care.

The Mental Health Rehabilitation (MHR) program continues to provide services in the community to adults with serious mental illness and to youth with emotional and behavioral disorders. As of July 1, 2009, the oversight and management of the MHR program was transferred to the Bureau of Health Services Financing (Medicaid) within DHH. All staff, equipment, materials, contracts, purchase orders, processes and personnel were transferred. Starting on that date, Medicaid began to provide all utilization management, prior authorization, training, monitoring, network, and member service activities.

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

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

Beginning June 2010, the MHR program began statewide implementation of its new Provider Performance Indicator reviews. The Clinical Documentation/Utilization Management Monitoring module (covering screening, initial assessments, reassessments, initial and ongoing treatment planning, crisis planning, discharge planning and service delivery domains) and its Covered Services Module (monitoring Assessment and Service Planning, Community Support, Counseling, Individual, Group and Family Interventions, as well as Psychosocial Skills Training and Parent/Family Interventions) were implemented. Results will be used for Provider Report Cards, as well as referrals for possible Notices of deficiencies, provider training and education referrals, and as focused monitoring tools for complaints, grievances, etc. In addition, enhancements to the Behavioral Health Section's website included more service and referral information for

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

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

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

Number Receiving Mental Health Rehabilitation Services

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

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

Mental Health Rehabilitation Providers

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

EMPLOYMENT SERVICES
FY 2011 - ADULT PLAN

The Office of Behavioral Health (OBH) recognizes that work is a major component in the recovery process and supports consumers who have work as a goal. OBH had utilized Employment Specialist training and other related employment training available through The University of North Texas & the Federal Region VI Community Rehabilitation Continuing Education Program to build a cadre of trained Employment Coordinators in each Region. At this time however, most Regional Employment Coordinators have additional duties and on average devote less than 25% of their time to employment issues. Additionally, there has been turnover in staff, leaving individuals functioning in this capacity without formal training. Both of these issues have served to hamper efforts to increase employment initiatives. Though several regions have expressed an interest in hiring full time employment coordinators and have been working towards doing so, not many have been able to make this a reality to date.

To expand employment of persons with severe mental illness, OBH has promoted a strategy to actively seek and access opportunities external to OBH at the state and federal level to fund the further development of such services which expand employment opportunities. Such external opportunities may include, but are not limited to monies available for employment, employment

services related to housing support, vocational rehabilitation services, and related employment services. Such funds are available through the Social Security Administration, HUD, Workforce Commission (formerly Department of Labor), the Rehabilitation Services Administration, and other Federal and state programs. The passage of the Federal Ticket to Work Program and the Work Incentives Improvement Act of 1999 make a large pool of federal dollars available for development of these employment related services.

OBH also has active linkages to, and representatives serving on the advisory body of, the Louisiana Medicaid Infrastructure Grant (which facilitated the organization of the Medicaid Purchase Plan). Additionally, staff coordinates with other programs, and program offices, such as the Disability Navigator initiative through the Louisiana Workforce Commission (formerly Department of Labor), the Work Incentive Planning and Assistance (WIPA) program through both the Advocacy Center and Louisiana State University, Louisiana Rehabilitation Services, and other employment related work groups such as the WORK PAY$ committee. This committee is comprised of community partners and is intended to further the employment of individuals with disabilities in the state of Louisiana. OBH is also working as a collaborative partner on both a state and regional level in the development and implementation of job fairs for individuals with disabilities throughout the state. This will be the 7th year of the job fairs, which have traditionally been held in October for National Disability Employment Awareness Month.

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

Louisiana Work Incentive Planning and Assistance (LAWIPA)

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

OBH has participated in the development and implementation of Supported Self-Employment (Micro enterprise) pilots in different regions of the state, and in the previous development and establishment of intensive employment placement and support pilots (Employment Recovery Teams) in two regions. OBH has also supported the continued implementation of an employment

program through the Jefferson Parish Human Services Authority's community mental health clinic. The program continues with great success as the JPHSA staff collaborates with LRS, DOL and the Career Solution Centers, as well as actively works with their clinician pushing employment as a path to recovery.

Joint OBH-LRS efforts are aimed at offering consumers intensive individualized supports in order to assist them in seeking, finding, obtaining, and keeping employment in community based competitive jobs and/ or self-employment. A joint LRS-OBH agreement spells out each party's areas of responsibility and supports regular collaboration between the agencies. OBH has conducted Employment Needs Assessments with collaborative participation by LRS in each Area, and engages in routine joint regional meetings to: assess each Area's current employment initiatives; determine needs for enhancement/creation of new employment programs/opportunities for consumers; share information on current and planned OBH employment projects; develop/enhance cooperation with LRS and private employment providers; develop a database of employment related resources for each Region/Area.

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

Act 378 funds for adults are limited to those who have been hospitalized for at least 18 months and are ready for discharge. These funds can be used in any manner to assist the individual in remaining in the community. Should they need any type of job training or assistance in obtaining a job, or a job coach, these funds can cover those costs.

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

Employment Programs Serving SMI by Region – FY 2010

year ending 6/30/2010

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

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

	Age 18-20		Age 21-64		Age 65+		TOTAL		
	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	TOTAL
Employed: Competitively Employed Full or Part-time (includes Supported Employment)	188	146	4,710	2,945	128	55	5,026	3,146	8,172
Unemployed	230	230	3,901	3,490	51	40	4,182	3,760	7,942
Not in Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc)	568	596	14,318	9,548	914	353	15,800	10,497	26,297
Employment Status Not Available	203	219	4,135	2,671	122	36	4,460	2,926	7,386
TOTAL	1,189	1,191	27,064	18,654	1,215	484	29,468	20,329	49,797

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

HOUSING SERVICES
FY 2011 - ADULT PLAN

OMH has recently been combined with the Office for Addictive Disorders to form the new Office of Behavioral Health in an effort to utilize strengths and services of each to effectively address the needs of mental health and addictive disorders jointly. As new methodologies and strategies are used to redesign the mental health system of care to engage mental health and other co-occurring disorders with a Housing First model, it is important to realize that appropriate support services are essential to this transition. The overall framework of the Housing First Model is that housing is a necessity and the primary need is to obtain housing first without any pre-conditions to services. The impact for prevention of the causes that created homelessness should be addressed with a client-centered approach to sustain homeless and at-risk homeless populations from repeating cycles of homelessness. Moreover, housing is a basic right, and should not be denied to anyone, even if they are abusing substances or refusing mental health treatment services. Housing First is endorsed by The United States Department of Housing and Urban Development and considered to be an evidence-based practice and a solution to addressing the chronically homeless.

The Olmstead Decision of 1999 is a critical legal victory and supports the right of institutional mental health consumers and other disability populations to have access to housing and support services that is necessary to sustain community treatment and services after reaching treatment objectives. Unjustified institutionalization violates the ADA and to that end creates a pathway to therapeutic residential housing. With employment services described elsewhere, the MHR, Intensive Case Management, ACT and FACT programs are very involved in assisting consumers and families with opportunities to secure and maintain adequate housing. Furthermore, in keeping with the use of best practices and consumer and family choice OBH has a strong commitment to keeping families together and to increasing the stock of permanent supportive housing; and consequently has previously withstood pressure to fund large residential treatment centers. Instead, effort and dollars have been put into Family Support Services, housing with individualized in-home supports, and other community based services throughout the state. The consumer care resources provide highly individualized services that assist families in their housing needs. OBH, in partnership with other offices in DHH, disability advocates, and advocates for people who are homeless, has actively pursued the inclusion of people with disabilities in all post-disaster development of affordable housing. These efforts resulted in a Permanent Supportive Housing (PSH) Initiative which successfully gained a set aside of 5% of all units developed through a combination of disaster-related housing development programs (including Low Income Housing Tax Credits) targeted to low income people with disabilities. Congress approved funding for 3,000 rental vouchers to go to participants in the PSH program, furthering the goal of serving 3,000 people and their families. Because people with mental illness are present to a high degree in all of the targeted subpopulations of this initiative, it is likely that they will benefit significantly. This initiative also targets the aging population so those persons with mental illness who are in that subpopulation will have targeted housing.

In 2008, a plan was developed by the Department of Health and Hospitals to provide immediate assistance to the mental health delivery system in New Orleans that had continued to struggle post-Hurricane Katrina. One of the items in the plan was a rental assistance program that funded 300 housing subsidies for individuals; some of whom are homeless with serious mental illness and co-occurring disorders. Of particular note has been the OMH pursuit of State General Funds for housing and support services. OMH was successful in obtaining initial funding sufficient to develop housing support services for 600 adults with mental illness (60 for each of the 10 planning

regions) and 24 hour residential care beds to serve 100 people (10 for each of the 10 planning regions) in 2006. This program was successfully continued through FY 2008-09. The program participants were successfully transitioned to the federally funded PSH that had been previously advocated for in the United States Congress. The Department of Housing and Urban Development administers the PSH housing program with a subsidy administrator.

The state has continued to pursue housing resources through the HUD funding streams such as the Continuum of Care for the Homeless program and the Section 811 and Section 8 programs over the past ten years. In addition, OBH is developing partnerships with Rural Development housing programs and state Housing Authorities. The American Reinvestment and Recovery ACT of 2009 is a welcome housing resource to stimulate and provide bridge subsidy funds for some of our most vulnerable homeless and/or disability populations. Specifically the Homeless Prevention and Rapid Re-Housing (HPRP) program has the potential provide widespread relief. Louisiana received over $26,000,000 in HPRP funding with DCFC Administering $13.5 million and the other funds going to direct allocation to existing community providers. Our goal is to collaborate across departmental agencies and to utilize all available housing funding resources to develop or partner with housing providers to develop a sufficient housing stock of affordable housing. While shifts in HUD policy have created barriers to persons with mental illness qualifying for housing resources through the Continuum of Care, and the Section 811 and Section 8 programs have been severely reduced, the HUD programs continue to be a focus of development activities. OMH Regional Housing Coordinators are active participants in the regional housing/homeless coalitions. In some cases these coordinators are in leadership positions in their local coalitions. Service providers have pursued Section 811 applications and sought to develop fruitful relationships with local housing authorities 202 Elderly Housing programs and The Louisiana Housing Finance Agency to pursue disability required rental units set-asides. It is essential and critical that housing development continue with particular emphasize on strategies to coordinate tax credits, rental vouchers (Section 8 and Shelter + Care) and affordable financing. The Weatherization Programs and Rental Rehabilitation administered through our local Community Developments needs continual funding and efficient access to assistance. Federal applications for housing and support services submitted by mental health providers have increased over the years as agencies search for avenues to develop housing and support services for the mental health consumers they serve.

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

Housing Assistance Programs by Region/ Local Governing Entity (LGE) FY 2010

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

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

The annual reports from Louisiana Projects to Assist in Transition from Homelessness (PATH) providers show that 4,385 homeless persons with mental illness were served in the fiscal year 2009 with Federal and matching PATH funds and other sources of funding. Annual data reported by PATH providers for the number of individuals enrolled in PATH in 2009 was 1,315 (unduplicated count). This is less than the number identified through the shelter system with one possible explanation being that PATH is not a statewide program. UNITY of Greater New Orleans, a non-profit organization for the homeless, estimates that there are approximately 12,000 homeless persons on any given day in the Greater New Orleans area alone who are in need of housing and supportive services, and approximately 40% or 4,800 have a mental illness.

This is in stark contrast to the most recent Point in Time (PIT) survey (2007), in which the total number of literally homeless persons in all of Louisiana was 5,994. Literally homeless persons are those who live in emergency shelters or transitional housing for some period of time, or who sleep in places not meant for human habitation (streets, parks, abandoned buildings, etc.) and may use shelters on an intermittent basis. The PIT survey was a statewide count of homeless persons done during the 24-hour period between noon, January 30th and noon, January 31st.

UNITY states their estimation was based upon a multi- factorial analysis including the PIT results, outreach statistics, and agency-reported requests for services as well as the demand for services identified by the homeless population. It should be noted that the Point in Time survey is limited in its population coverage; for instance, unsheltered persons are difficult to identify and count, not all identified persons are willing to release information, and/or persons are undocumented because they do not seek services from a participating provider during the survey period. Therefore, by a conservative estimate, on any given day, there may be as many as twice the *reported* count of homeless adults and children living in Louisiana.

The face of homelessness changed in the New Orleans area due to the aftermath of Hurricanes Katrina and Rita in 2005, and Gustav and Ike in 2008. Many individuals and families experienced homelessness for the first time. It was, ironically not the last time for many of these individuals, since their housing assistance came to an end again with the closing of FEMA programs in 2009. It is difficult to estimate the number of people who continue to be affected by the hurricanes, because many of them have been in and out of different housing situations since the hurricanes occurred. The metropolitan areas around New Orleans continue to report severe problems, as do other areas affected by the hurricanes.

Individuals with financial concerns, including many people with disabilities, are having an increasingly difficult time in retaining their housing and are at risk for homelessness. Those already homeless are facing significant barriers to obtaining housing they can afford. According to the National Low Income Housing Coalition, in Louisiana the Fair Market Rent for a two bedroom apartment is $788 per month. In order to afford this level of rent and utilities without paying more than 30% of income on housing, a full time work wage of $15.00 per hour is required.

In a defined time period following the 2005 hurricanes, the average SSI payment increased 16.4% from $579 to $674 per month. During that same time period, the federal minimum wage level increased 27.2% from $5.15 to $6.55. In contrast, the fair market rent for a 1-bedroom apartment, including utilities, in the Greater New Orleans area increased 52.4% from $578 to $881. As a result, many consumers were unable to maintain independent housing. Many of them lived with family members or friends, often in overcrowded environments. Some of them ended up in homeless shelters or on the streets because they were unable to stay permanently with family or friends.

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

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

EDUCATIONAL SERVICES
FY 2011 - ADULT PLAN

Louisiana OBH Supported Education is a program based on a 1997 OMH/Louisiana State University (LSU) joint research project concerning theories and models of Supported Education nationwide, and development of a '*Louisiana Model*' for Supported Education based on that research. The Louisiana Office of Mental Health initially funded the LSU Supported Education Program for students with serious mental illness (SMI). In keeping with Goal #1 of the *President's New Freedom Commission Report*, stating that Americans understand that mental health is essential to overall health, supported education became a part of the disability program at LSU forcing recognition that mental health is as important as physical health to the well-being of college students. LSU became one of the first four year universities in the nation to have a supported education program in place and operational, with initiation of the program in 1997. Upon LSU's agreement to continue the program, OMH then moved the funding to the University of Louisiana at Lafayette (ULL). The ULL program became operational in the Fall Semester of 2000, with the

University being fully able to sustain it internally as of 2006. Both LSU and ULL initially received funding with OMH Block Grant monies to establish a Supported Education Advisor position within each university's existing services for students with disabilities. The Supported Education Advisor only serves those students identifying themselves as persons with Serious Mental Illness (SMI) emphasizing that mental health care is consumer and family driven.

The OBH sponsored supported education programs provide both individual and group support to students with serious mental illness pursuing post-secondary education. Students also receive assistance with needed accommodations under ADA, as well as disability management counseling and information/referral to on and off campus agencies. The Supported Education Advisor serves as a case manager for students with SMI; is a liaison to the student's primary therapist; and serves as an on-campus advocate. The focus is on attempting to minimize the impact of a student's psychiatric illness by determining what accommodations are needed in order for the student to successfully handle both academics and adaptation to the social milieu of the university. The long-term goal of the program is to see the student with SMI successfully complete a university education and enter the world of work in a career field of the student's choice. The program targets students with SMI of all ages, both those who are older and are (re) entering a secondary educational setting after years of mental health treatment, as well as those who are younger and may be experiencing psychiatric symptomatology for the first time. Thus the goal of the program is achieved through both funneling individuals back into the educational system as well as maintaining them there as they cope with the onset of their mental illness. These goals fall in line with the *President's New Freedom Commission* for Mental Health through its call for quality community based services, improved transition services and promotion of innovative and effective services such as supported education which are specifically targeted towards individuals with SMI.

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

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

SERVICES FOR PERSONS WITH CO-OCCURRING DISORDERS (SUBSTANCE ABUSE/ MENTAL HEALTH) AND OTHER SUBSTANCE ABUSE SERVICES

FY 2011 - ADULT PLAN

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

Outpatient Outpatient treatment services are defined as either:

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

Outpatient Treatment (Non-Intensive)

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

Intensive Outpatient Treatment/Day Treatment

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

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

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

Detoxification There are two types of detoxification offered:

Medical detoxification

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

Social Detoxification

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

Community-Based Services

Halfway House Services

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

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

Three-Quarter Way House Services

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

Therapeutic Community (TC)

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

Recovery Homes

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

Gambling Services

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

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

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

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

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

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

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

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

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

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

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

The following is a list of relevant updates to COSIG:

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

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

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

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

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

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

MEDICAL & DENTAL HEALTH SERVICES
FY 2011 - ADULT PLAN

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

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

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

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

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

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

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

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

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

SUPPORT SERVICES
FY 2011 - ADULT PLAN

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

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

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

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

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

Consumer Resource Centers FY 2010

Region/ LGE	# of Consumer Resource Centers	Block Grant Funds	Total Funding Includes SGF& other sources	FY 08-09 #served unduplicated
MHSD	1 Center	0	$66,394	756
CAHSD	1 Center	$27,700	$130,000	81
III	2 Centers	$70,836	$292,974	250
IV	2 Centers	$47,550	$97,550	188
V	2 Centers	$29,700	$35,690	189
VI	3 Centers	$32,646	$123,555	535
VII	1 Center	0	$249,984	88
VIII	3 Centers	$$61,160	$187,051	438
FPHSA	1Center	0	$200,000	38
JPHSA	1 Center	0	$28,356	84
Totals:	**17 Programs**	**$208432**	**$1,411,554**	**2647**

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

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

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

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

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

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

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

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

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

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

Utilization of state hospital beds dropped significantly with the introduction of community-based Mental Health Rehabilitation (MHR) services and the development of brief stay psychiatric acute units within general public hospitals. Moreover, Louisiana and OMH have a network of services that

provide alternatives to hospitalization for consumers and families in Louisiana through a broad array of community support services and consumer-run alternatives. Housing, employment, educational, rehabilitation, and support services programs, which take into account a recovery-based philosophy of care, all contribute to reductions in hospitalization.

As an adjunct to current services, Mental Health Emergency Room Extension (M-HERE) Units have been established in most Regions/ LGEs. M-HEREs provide a specifically designated program within hospital emergency departments to triage for behavioral health conditions. The services include medical clearance, behavioral health assessment and evaluation, and crisis treatment of a person in crisis to determine the level of service/resource need. The M-HERE provides the opportunity for rapid stabilization in a safe, quiet environment, increasing the person's ability to recognize and deal with the situations that may have initiated the crisis while working to increase and improve the network of community and natural supports. All patients receive a medical screening exam and appropriate medical evaluation.

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

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

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

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

MHSD: University Hospital
CAHSD: Earl K Long Hospital (recently opened)
Region 3: Chabert Hospital
Region 4: University Medical Center
Region 5: Memorial Hospital (This service is not funded for FY 2010)
Region 6: Huey P. Long Hospital –contract ended– never opened and never staffed.
Region 7: none
Region 8: none
FPHSA: none
JPHSA: West Jefferson Hospital (pending)

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

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

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

The American Reinvestment and Recovery Act of 2009 includes about $13.61 billion for projects and programs that are currently being administered by the Dapartment of Housing and Urban Development. The primary focus of the Act was to stimulate the ecomony by providing a boost in these difficult times and to create jobs, restore economic growth and strengthen America's Middle class. The stimulation of the economy is designed to modernize the nation's infrasture, jump start America's energy independence, expand high quality educational opportunies, improve access to affordable health care and protect those in greatest need. The lack of affordable housing with appropriate support and the ability to provide basic necessities are changing the faces of homelessness. The job crisis and lack of sufficient income denies many individuals and families the opportunity to participate in the free market society without supports to bridge the gaps to obtaining and maintaining housing and financial resources to prevent homelessness. The new faces of the homeless are a direct result of the struggling economy created by the housing crisis, record breaking unemployment and inflation that makes housing impossible to afford without subsidized assistance and services. In the past few years, Louisiana has advocated successfully with the United States Congress to provide 3000 units of Permanent Supported Housing (PSH) to address the housing demand for affordable housing with support services in response to hurricanes Katrina and Rita. The units are designed to assist some of our most vulnerable homeless and disability populations. In addition, PATH (Project in Assistance to the Transition from Homelessness) expanded services to 8 of the 10 geographical regions/LGEs demonstrating efforts to provide homeless outreach and housing assistance to mental health individuals with other co-occurring disorders. The Olmstead decision of 1999 recently made a ten year anniversary and has been a driving force along with other budget restraints in our decision to change the state's mental health intermediate hospital system of care as OBH embraces a community model of care using best practice like Housing First and Therapeutic Residential Housing. The Olmstead program has been particularly affected in assisting persons with mental illness transition into the community with appropriate supports to sustain housing and services in the community.

There is no doubt that hurricanes continue to have a tremendous impact on housing and homelessness in the state however, it is not the only factor. The economy is critical to restoring jobs and housing stability. This is particularly significant since the areas of the state that were the most directly hit by the storms of 2005 and 2008 were the areas that have traditionally had the greatest population, and therefore the highest rates of homelessness, as well as the highest numbers of people with mental illness. State housing recovery efforts for affordable housing continue amidst a multiplicity of barriers including changes in development costs at all levels and local resistance to affordable housing development.

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

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

Experience suggests that persons with mental illness are underserved in the general shelter population and, therefore, there may be significant numbers of *unsheltered* homeless who have a mental illness. It is also likely that there are a number of persons *sheltered* who are undisclosed as having a mental illness and, therefore, their mental illness is undetected and not included in the count. In addition, prevalence of substance abuse among adults with serious mental illness is between 50-70%. Taking those factors into consideration, some sources use the higher percentage of 30% in calculating homelessness for persons with mental illness. This would yield an estimate of the number of persons with mental illness, inclusive of those with co-occurring addictive disorders, who are homeless is approximately 9,634 persons, or 30% of the total 32,112 homeless served by the shelters who reported for the 2008 survey.

The Shelter Survey is broken down by sub-population in the Table below. This sub-population breakdown relates to the primary reason a person is homeless, although it is recognized that homelessness is multifactorial, and some individuals may fall into more than one category.

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

Projects to Assist in Transition from Homelessness (PATH)

The Projects to Assist in Transition from Homelessness (PATH) program of CMHS is targeted specifically towards those homeless persons with severe mental illness and/or severe mental illness with a co-occurring disorder. Louisiana's PATH program provides a significant amount of *outreach* activity as well as other support services. The annual reports from Louisiana PATH providers for 2008 showed that 4,385 homeless persons with mental illness were served.

One of the greatest needs in Louisiana is the creation of housing that is affordable to persons living on an income level that is comparable to that of SSI recipients. That is, housing that is aimed at those individuals at and below 20% of Median Income. Supportive services necessary to assist an individual in remaining housed are also crucial. Efforts to increase available and appropriate housing for persons with mental illness through training and recruitment of housing providers and developers and development and access to support services continues to be a priority.

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

outreach and/or shelter and housing services to the homeless, as well as substance abuse and mental health services. Services targeted to the elderly, children, youth and their families who are homeless have been generally limited in the past, however, there have been strides to identify and improve a number of service gaps for children and youth who are homeless across the state.

For the federal PATH funding, Louisiana relies on in-kind and contractual contributions as its federal match. For FY 10 the match amount is $499,083.00. Virtually all of the PATH service providers are part of the local Continuum of Care systems for the homeless. As a part of the planning process, these coalitions participate and facilitate public hearings to request comment on the current use of funding to put an end to homelessness, and provide opportunities for public comment.

Louisiana Road Home Recovery Plan

The Louisiana Road Home Recovery Plan, an initiative of the Louisiana Recovery Authority (LRA) has included the rebuilding of affordable housing in the areas most impacted by Hurricanes Katrina, Rita, Gustav and Ike. This is being accomplished through a system of funding incentives that encourage the creation of mixed income housing developments. This plan targets not only the metropolitan areas impacted by the hurricanes but also several of the rural parishes that were more impacted by hurricane Rita. Included in this plan is the use of Permanent Supportive Housing as a model for housing and supports for people with special needs, such as people with disabilities, older people with support needs, families with children/youth who have disabilities and youth aging out of foster care. It is a model that provides for housing that is fully integrated into the community. The model does this through setting aside a percentage of housing units within each housing development built to be used for persons in special population categories, and includes support services that are delivered in the individual's (or family's) home. Adults with SMI and families of children with emotional/behavioral disorders, and the frail elderly are included within the identified special needs population targeted for the supportive housing set aside units. The services to be delivered to persons/families in the target population will be those services likely to help them maintain housing stability.

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

Homeless Coalition

There are multiple providers of homeless programs in each area of the state. Each Region / LGE has a Homeless Coalition, an organization that addresses systems issues and coordinates services for the homeless. The Regional Homeless Coalitions incorporate a complete continuum of care for homeless clients from outreach services to placement in permanent housing. Both private and public agencies are members of these organizations. The programs provide outreach and/or shelter and housing services to the homeless, as well as substance abuse and mental health services. Services targeted to children, youth and their families who are homeless have been generally limited

in the past, however, there have been strides to identify and improve a number of service gaps for children and youth who are homeless across the state.

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

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

NOTES:
***HMIS: Homeless Management Information System Data**
****The extremely large jump in homelessness is due to the removal of FEMA housing supports**

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

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

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

Although OBH has placed many effective programs in rural areas, barriers, especially transportation, continue to restrict the access of consumers to these rural mental health programs. Transportation in the rural areas of the state has long been problematic, not only for OBH consumers, but for the general public living in many of these areas. The lack of transportation resources not only limits access to mental health services, but to employment and educational opportunities. The resulting increased social isolation of many OBH clients with serious mental illness who live in these areas is a primary problem and focus of attention for OBH. Efforts to expand the number of both mental health programs and recruiting of transportation providers in rural areas are an ongoing goal.

RURAL TRANSPORTATION PROGRAMS FOR SMI / EBD 2009-2010

Region/ LGE	Type of Programs	# of Rural Programs
MHSD	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	4
CAHSD	Medicaid Transportation, City/Parish Transportation; Local Providers	29
III	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	9
IV	Medicaid Transportation, City/Parish Transportation, Local Providers	9
V	Medicaid Transportation; City/Parish Transportation; Local Providers, Other	15
VI	Medicaid Transportation, City/Parish Transportation,, Local Providers, Others	13
VII	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	23
VIII	Medicaid Transportation, City/Parish Transportation, Local Providers	6
FPHSA	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	28
JPHSA	Medicaid Transportation	6
TOTAL		**142**

RURAL MENTAL HEALTH PROGRAMS FOR SMI / EBD 2009-2010

Region/ LGE	Name/Type of Programs	# of Adult Rural Programs	# of C/Y Rural Programs
MHSD	CMHC, Satellite Clinics, ACT teams, Drop-In Centers, Other	8	1
CAHSD	Satellite Clinics	10	6
III	CMHC, Satellite Clinics, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	15	7
IV	CMHC, Satellite Clinics, Outreach Sites, ACT Teams, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	21	6
V	Satellite Clinics, Outreach Sites, Mobile Outreach, Drop-in Centers, MHR Agencies, Support Groups, Other	20	11
VI	CMHC, Satellite Clinics, Outreach Sites, Mobile Outreach, Drop-In Centers, MHR, Support Groups, Other	24	11
VII	CMHC, Satellite Clinics, ACT teams, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	8	5
VIII	CMHC, Satellite Clinics, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	25	22
FPHSA	CMHC, Outreach Sites, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	27	12
JPHSA	Outreach Sites	0	1

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

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

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

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

emergency that happens outside normal work hours. The system is also used for training and other administrative purposes. Forensic patients at ELMHS are being linked with Tulane University psychiatrists in New Orleans through telemedicine. Telemedicine has resulted in more efficient communication between various sites across the state.

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

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

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

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

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

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

Activities have been provided for the elderly through services offered by OBH through the Louisiana Spirit (LA Spirit) Hurricane Recovery Crisis Counseling Program. The LA Spirit

program began providing services immediately after the hurricanes of 2005 and continued to provide expanded crisis services and education for survivors of Hurricane Gustav during the last fiscal year. Louisiana Spirit services included the provision of crisis counseling and resource referral services to priority populations, including older adults. Given that the elderly are considered one of the priority populations in the State, a special emphasis was placed on reaching out to this population. LA Spirit counselors worked with entities as varied as local Councils on Aging, Senior Living and Assisted Living sites, Senior Centers, Nursing Homes, and Transitional Living Sites where many individuals lived after being evacuated after the storms. LA Spirit functioned effectively as a bridge between the elderly and the communities in which they are currently residing.

As discussed in the Housing Services Section of Criterion 1 and previously in this Criterion (see Outreach to Homeless), there are several initiatives to assist the elderly with housing. OBH, in partnership with other offices in DHH, disability advocates, and advocates for people who are homeless, has actively pursued the inclusion of people with disabilities in the development of affordable housing. These efforts resulted in a Permanent Supportive Housing (PSH) Initiative which successfully gained a set aside of 5% of all units developed with Low Income Housing Tax Credits to go to low income people with special needs, including the elderly population. Because people with mental illness are present to a high degree in all of the targeted subpopulations of this initiative, it is likely that they will benefit significantly. This initiative also targets the aging population so those persons with mental illness who are in that subpopulation will have targeted housing, emphasizing that disparities in mental health services be eliminated.

Some clinics have benefits specialists who work with all populations, but particularly the elderly to ensure that they receive individualized case management. Some clinics have assigned a registered nurse to deliver specialized health needs to the elderly population, and other regions provide enhanced nursing services for this population. In some regions, there are interagency support groups for Alzheimer's disease.

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

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