*LOUISIANA-YOUTH ENHANCED SERVICES (L*A-Y.E.S.)

CHILDREN'S MENTAL HEALTH ACTION PLAN 2010/2011

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This report was prepared with input from the LA-Y.E.S. Administration, Clinical and Evaluation Teams, from LA-Y.E.S. Consortia members, from families, and from community stakeholders. Opinions expressed may be his alone and not those of others and any errors are his and not those of the report's partners.

LA-Y.E.S.

ACTION ON CHILDREN'S MENTAL HEALTH: A CHILDREN'S MENTAL HEALTH ACTION PLAN 2009/2010

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LOUISIANA YOUTH ENHANCED SERVICES (LA-Y.E.S.)

A CHILDREN'S MENTAL HEALTH ACTION PLAN 2010/2011

INTRODUCTION

LOUISIANA YOUTH ENHANCED SERVICES (LA-Y.E.S.)

Action on implementing a Children's Mental Health Plan continues to remain an urgent matter for the in the LA-Y.E.S. service area. Five years after the disaster of Hurricane Katrina along the Gulf Coast and the collapse of the federal levees flooding the New Orleans area, progress is evident in the area's recovery though significant problems remain (Rowley, 2008). This plan describes characteristics of the area, examines structural features of the local service communities, reviews infrastructural barriers to care, makes recommendations for improvements, and focuses on actions needed to improve children's mental health. This action plan is a call for continuous quality improvement of the mental health system for our children. LA-Y.E.S. is a system of care established for children and youth with serious emotional and behavioral disorders funded through a Cooperative Agreement between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Louisiana Office of Mental Health. LA-Y.E.S. serves a five parish area including Orleans, Jefferson, Plaquemines, St. Bernard and St. Tammany Parishes.

The history of the development of mental health services for children has lead to the growing number of systems of care nationally which now encompass every state and includes many sub-areas (Pires, 2002). LA-Y.E.S. is a system of care which builds upon prior federal initiatives partnering with state and local public mental health programs for improving mental health services for children and youth. In 1983, the Child and Adolescent System Services Program (CASSP) was initiated to focus on services which address the mental health needs of all children. In the 1980's, Family Voices emerged with the growth and development of Federations of Families and Alliances of the Mentally Ill. In 1992, Congress funded "comprehensive community mental health services for children and their families" which presently has extended systems of care in all states. Foundations funded initiatives which demonstrated the importance of family supports in care and in promoting youth development. LA-Y.E.S. is a Louisiana cooperative agreement between the Center for Children's Mental Health Services of SAMHSA and local partners where the values and principles of systems of care are implemented.

LA-Y.E.S. has committed to developing a system of care for children and youth by implementing the values and principles of the systems of care as first articulated by Stroul and Friedman (1986):

Values

- Services are child centered and family focused, community-based, and culturally and linguistically competent.

Principles

- Access to comprehensive services; individualized services; least restrictive environments; family participants in all aspects of service planning; service systems integrated; all children have care management; children's problems are identified early; youth emerging

to adulthood transitioned into adult care; the rights of service recipients are protected; and services are non-discriminatory.

LA-Y.E.S. has joined with community partners to work with families and youth addressing children's mental health. Critical collaboration partners include mental health, juvenile justice, child welfare, education, health, and human services (social services) areas. Service integration may start in family courts, schools, or other community portals. Services are characterized by coordination, multi-disciplinary teams, comprehensive array of services, community-based, culturally and linguistically competent, evidence-based, and outcome oriented. This "wraparound" approach itself is an evidence-based model based on national evaluations funded to evaluate all federally funded systems of care.

The mental health system in the United States has been in disarray according to the President's New Freedom Commission on Mental Health released in 2003. Three main obstacles keeping Americans with mental illness from getting the care they need:

- The stigma associated with mental illness;
- The unfair treatment limitations and financial requirements placed on receiving care; and
- The fragmented mental health service delivery systems.

The New York Mental Health and Criminal Justice systems (2008) noted similar problems and offered analyses and recommendations:

- The system is fragmented, oversight is lacking, and poor accountability in mental health services for those involved with the criminal justice systems.
- Widespread inconsistencies in quality of care within the mental health treatment system.
- Limited coordination and shared information within and across systems.
- Insufficient training, supports and tools to engage families in services that need mental health treatments and are involved in the criminal justice system.

Like the national commission, this state commission as well articulated system-wide responses similar to those suggested by systems of care principles and values.

Mental health care in the region served by LA-Y.E.S. is not only characterized by these similar and oft-repeated obstacles, but also is coping with the aftermath from the largest disaster in our national history and with the current Gulf region disaster. The work of rebuilding a system of care for the children and families in our region continues. Building upon recommendations from the President's New Freedom Commission, and integrating principles supporting "transforming mental health care" (SAMHSA, 2005) is essential to overall health, care is consumer and family driven, where disparities in services are eliminated, where early interventions are the norm, where care is evidence-based, and where technology maximizes benefits.

Our vision is to rise above ongoing disaster experiences to put together a responsive community-based care delivery system, and to advocate for the resources necessary to end the suffering of children and their families exacerbated by systems challenges. While the local media decry the collapse of the mental heath care delivery system, we put forth a plan for children with a united stakeholder call for action. This vision is based on the best thinking on improving care, on the available evidence for what works, and on respect for families.

Reforms of our systems are supported by our federal partners through the development of a system of care in our region. This plan articulates immediate steps and long range views on the way to fulfilling this vision. It is shaped by the support we employ to this effort from wide corners of our communities, from a wide array of child-serving agencies and practitioners, and from a public that is suffering from a lack of basic mental health care in our communities. The

American Academy of Child and Adolescent Psychiatry (2007) has called for action to implement plans which reflect the values and principles of community systems of care. This children's mental health plan addresses these principles and practices.

This children's mental health service plan guiding LA-Y.E.S. in the next year examines demographic and epidemiological data in the service delivery area. Vulnerable populations are noted in this community-based care delivery collaborative effort. Community partners and families were involved in processes of gathering their ideas about the future directions of the systems of care development. Post-Katrina, a variety of professional, foundation-supported, and local initiatives have helped articulate the needs of children influencing the mental health of children in our area so deeply impacted by the hurricane and the flooding. This plan reflects a wide variety of input into our plan for addressing children's mental health and our recommendations for future directions.

PART I

CHILDREN/YOUTH AND THEIR FAMILIES IN THE LA-Y.E.S. SERVICE AREA

True compassion is more than flinging a coin to a beggar; it understands that an edifice which produces begging needs to be changed. Martin Luther King Jr.

PART I

CHILDREN/YOUTH AND THEIR FAMILIES IN THE LA-Y.E.S. SERVICE AREA

DEMOGRAPHIC CHARACTERISTICS and RELATED CHILD MENTAL HEALTH EPIDEMIOLOGIC DATA

The Greater New Orleans Community Data Center (June 30, 2010) reported that by mid-year 2008, the population of Orleans was estimated to be 80.0% of its 2005 pre-disaster level. Of the 73 Orleans neighborhoods, 66 have recovered more than half of their pre-disaster populations. Seven neighborhoods are less than half of their population (3 due to eliminating large public housing complexes). The current Gulf Coast disaster again threatens local economy and housing stability. By examining mail delivery, they estimated the populations of Orleans, St. Bernard, St. Tammany increased its population, and Jefferson and Plaquemines population declined (based on mail delivery household locations).

US Census Data/Data from the Community Data Center (2009)

Population Characteristics

	Orleans	Jefferson	St. Bernard	Plaquemines	St. Tammany
Population	311,853*	436,181	19,826	37,722	228,456
# children (0-24)	56,469	138,885	7,380	6,165	76,421
Child abuse (per 1,000)	3.42	1.58	6.99	.52	1.89
# Disabled	31,944	70,713	14,518	4,555	30,770
% adults employed	47.1%	43.3%	49.4%	38.5%	51.0%
Elderly Abuse (per 1,000)	.63	.67	.28	.52	.69
Reported serious mental health problem	16.3%	8.3%	18.6%	10.5%	9.9%
211 calls mental health—ind/family	19.6%	20.9%	23.3%	22.1%	14.6%
children (4-17) at poverty level	6.4%	4.8%	1%	7.1%	2.25

*US Census Bureau, Population Division, July 2008 (reported at www.gnocdc.org)

Families and children in Louisiana experience some of the highest concentrations of poverty in the nation (which dictates health outcomes) for 2007. The United States Census Bureau (November 14, 2008) estimate poverty in the area:

Poverty Rates in the LA-Y.E.S. Service Area

Parishes	% (All Ages) in Poverty	% Under 18 in Poverty
Orleans	22%	36%
Jefferson	15%	23%
Plaquemines	16%	22%
St. Bernard	19%	40%
St. Tammany	11%	15%

Describing the "population at a glance", the Greater New Orleans Data Center—GNOCDC (January 2009) reported that public school enrollment went from 185,387 to 141,072 (from 2005 to 2008) and college enrollment declined at 78% from 2005 levels. The Louisiana Office of Community Services reports addressing the financial needs of low income families in the state by providing financial assistance to 25,200 families in 2006 (steadily declining financial supports over the past decade) (Administration for Children and Families, 2009).

Human Development Indicators (2009).

Human Development Indicator	Orleans	Jefferson	Plaquemines/ St. Bernard	St. Tammany	USA Totals	African American
Human Development Index	3.85	4.37	3.46	4.59	5.08	2.32
Life Expectancy at Birth	73.25	75.65	72.8	76.8	78.3	72.2
Less than High School	19.3%	18.4%	25.1%	16.7%	15.5%	29.2%
At least High School	80.7%	81.6%	74.9%	83.3%	84.5%	70.8%
At least Bachelor's degree	27.9%	23.1%	10.1%	23.1%	27.5%	11.8%
Graduate Degree	11.4%	7.6%	2.8%	7.2%	10.1%	3.8%
Educational Attainment Score	4.67	4.16	2.52	4.24	1.22	2.42
School enrollment	89.8%	85.9%	83.2%	81.2%	86.8%	82.1%
Median earnings	$21,951	$26,790	$26,070	$29,219	$29,740	$17,010
Health Index	3.03	4.03	2.83	4.55	5.13	2.61
Education Index	5.34	4.53	3.22	4.17	5.10	3.02
Income Index	3.23	4.58	4.45	5.27	5.06	1.47

Human Development

Human development can be viewed as the process of achieving an optimum level of health and well-being. It includes physical, biological, mental, emotional, social, educational, economic, and cultural components. Only some of these are expressed in the Human Development Index, a composite scale that has three dimensions: life expectancy at birth, adult

literacy rate and mean years of schooling, and income as measured by real gross domestic product per capita. The Human Development Index is a composite scoring (1-5 being best) of all human development index scores.

Educational Attainment Score

The educational attainment score is a composite index of all education variables such as "the highest level of education completed in terms of the highest degree or the highest level of schooling completed."

Health Index

The Health Index scores are calculated using a combination of variables such as life expectancy at birth.

Education Index

The Educational Attainment Index and the Enrollment Index scores are combined to obtain the Education Index.

Income Index

The Income Index scores are calculated using a combination of collected income data.

Children's Defense Fund (November, 2008).

The Children Defense Fund summarizes some key demographic characteristics of children in *Louisiana*. They note:

- A child is born into poverty every 30 minutes
- A child is abused or neglected every 42 minutes
- A child dies before first birthday every 14 hours
- A child or teen is killed by gunfire every 4 days.

Louisiana ranks:

- 36 in states in per pupil expenditures
- 49th in infant mortality
- 50th in low birth weight babies.

Louisiana Poverty & Child Health

- Number of children in poverty (27%); number in extreme poverty (12%)
  - 46% of African American children in poverty
- Children without health insurance (13%)
- Children not immunized (23%)
- % of 3 years of age children in Head Start, Pre-K, or special education (21%)
- % of 4th graders reading below grade level (80%)
- % of 4th graders math below grade level (76%)
- % of 16-19 year olds not in school and not graduated (10%)
- Average freshman high school graduation rate (60%)

Immigrant Children and Families—American Immigration Law Forum

Immigrant data in the service area as reported by the American Immigration Law Forum (2006) and the Census Bureau Data (August 16, 2006) reports on changing characteristics:

- LA foreign born population (121,590) 2.8% of population (4.5% growth since 2000 census).
- Foreign born immigrants represent 9.3% of the states population (American Immigration Law Reform).

- The Census Bureau reports 8.4% of states population are foreign born (US Census Bureau, 2007).
- 19.4% of these arrived since 2000.
- 6% growth in foreign born in Louisiana from 2000 to 2005 (Fussell, 2007). Surveys of contract workers in the Metropolitan area in 2006 indicate 50% are Latino and 30% foreign born.
- The estimated percent of children attending public schools with limited English proficiency (Greater New Orleans Community Data Center, May 22, 2009) varies by local parishes: Jefferson (8.4%), Orleans (2.5%), Plaquemines (2.2%), St. Bernard (0.8%), and St. Tammany (1.4%).

Further information on immigrant children and their families are reported in later sections.

Snapshot Data from the Community Data Center

The Greater New Orleans Community Data Center illustrates the disparate disaster impact on the communities (March 2007).

Snapshot Data from the Community Data Center

Residential properties for sale (February) in Orleans Parish	4,971
Number of demolitions (February, 2007)	2,971
Cumulative residential permits (Orleans)	53,994
Number of new housing permits (Orleans)	725
Road Home applications/closings (3.12.2007)	115,185 applications/ 2,921 closings
Bus routes/buses in Orleans Parish	48% routes operating; 19% of buses operating
Public School Capacity (compared with 2005 and Spring 2008 data)	62% Orleans 95% Jefferson 33% St. Bernard 90% Plaquemines 100%+ St. Tammany
Percent of Child Care Reopening (Spring 2008)	52% Orleans 87% Jefferson 27% St. Bernard 79% Plaquemines 100% St. Tammany
Hospitals Open	13 Orleans (57% from 2005) 13 Jefferson (93%) 0 St. Bernard
% Libraries open (Orleans; Jefferson; Plaquemines; St. Bernard; St. Tammany) (2007)	62% Orleans; 69% Jefferson; 33% Plaquemines; 0% St. Bernard; 92% St. Tammany

Administration for Children & Families

The Administration for Children & Families (June 25, 2009) reported various family-related child variables impacting overall health outcomes in Louisiana in 2005:

Child Welfare Related Data

	LA (2005 data)	US* (2007 data)
Child maltreatment victims	12,366	905,000
Children in foster care	4,833	510,885
Children adopted	469	50,705
Children waiting for adoption	1,162 (1,079 in 2006)	139,064
Investigated child abuse reports	44,630	3,300,000
Child fatalities	37	1,530

*Data from the Child Welfare League of America (2009)

Child Welfare League of America

The Child Welfare League of America (2009) prepared a report on the Nation's Children where they summarized key data on children's wellbeing. The following summarizes some of the data they reported on:

- 1 in 5 youth have a diagnosable mental disorder
- 1 in 10 have a severe emotional or behavioral disorder
- 80% to 85% of youth have co-occurring substance abuse and mental disorders
- Suicide is the 3rd leading cause of death for youth ages 15-24
- Half of lifetime disorders occur by age 14; 75% by age 24
- Only 20% of youth with disorders receive care
- Approximately 75% of youth in foster care have disorders and warrant care
- 85% of youth in foster care have co-occurring disorders; 30% severe disorders
- 75% of the most vulnerable youth in foster care do not receive care for disorders
- Most of the youth receive Medicaid coverage (but care often not covered)
- About 12% receive care; yet they account for 40% of expenses (end-stage care)
- 9% of all youth have substance use disorders
- 10% of these youth receive care
- Up to 80% of youth in foster care have parents with substance use disorders
- 1,993 children were homicide victims in 2005 (rates are increasing)
- 92,854 youth were incarcerated in 2005
- Caseloads for care managers in child welfare average 26 cases (12 recommended)
- Care manager salaries are very low ($32,000; US average is $75,000)
- Turnover rates for child welfare workers is 19% annually
- The more time a worker has with families/child, the better the outcomes

Children in the child welfare system are the most disadvantaged youth in the nation, they have the highest rates of need for mental health interventions, and receive minimal care and there is little to no interactions between public child welfare and children's mental health providers.

The burden of chronic disease takes a heavy toll on families in Louisiana. The Centers for Disease Control and Prevention (May 24, 2009) report on the five leading causes of death in Louisiana compared with national data in 2005 (rates per 100,000 population):

Local and National Chronic Disease Burden

	Heart	Cancers	Stroke	Respiratory	Injuries
LA	256	209	57	45	69
US	211	184	47	43	39

The report also notes:

- In 2007, 23% of adults in Louisiana report being current smokers (20% nationally)
- Rates of obesity in Louisiana (65%) compared with 63% nationally
- Rates of insufficient physical activity in Louisiana (61%) compared to 51% nationally
- High blood pressure rates of 32% in Louisiana (28% nationally)
- No health coverage 38% in Louisiana (17% nationally)

HIV/AIDS Risk

The Louisiana HIV/AIDS Surveillance Program (2010) report that from 2009 data that there are 5 newly identified cases of HIV among 0-12 year olds (3 in Orleans Parish) and 284 cases among 13-24 year olds in Louisiana (34 in Orleans Parish). In Orleans Parish, there were 28 current cases of HIV/AIDS among 0-12 year olds and 41 cases among those 13-19 years of age. There were 73 cases of AIDS diagnoses (9% of all diagnosed cases) among the 13-24 age group. Orleans Parish reported 4,488 cases of HIV/AIDS, St. Bernard 111 cases, Plaquemines reported 31 cases, Jefferson 1,616 and St. Tammany 334 cases.

The Center for Disease Control and Prevention (2008) also report comparison data on infectious diseases in Louisiana compared with national data. They report that over 550,000 Americans have died from AIDS nationally. Louisiana ranks number 11 in the highest rates of infections. They also report that Louisiana ranks eighth in tuberculosis cases, first in cases of syphilis, and seventh in rates of Chlamydia (3.9 times greater for women).

National Center for Health Statistics

The National Center for Health Statistics (2009) report on data from 2006 comparing key health indicators from Louisiana and national comparison data:

Key Health Indicators

Health Indicators	LA	US
Low birth weight live births	8%	11%
Early prenatal care	84%	83%
Infant mortality (per 1,000 live births)	6.8	9.8
Reduced access in past year due to costs	5.5%	6.3%
Youth vaccinated	73%	65%
Per capita health care expenditures	$5,040	$5,283

National Survey of Children's Health (2007)

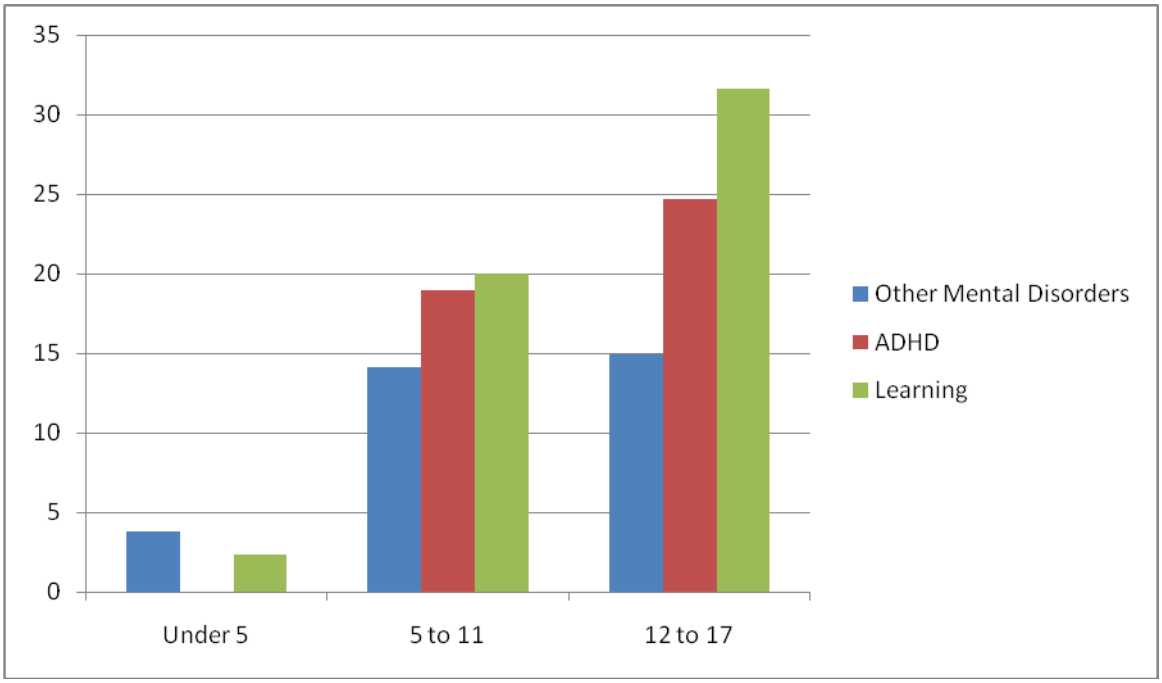
The Centers for Disease Control and Prevention (CDC) surveyed families nationwide to estimate health of children. The following data compares Louisiana survey data with national data on child health:

Key Health Indictors Reported by the CDC

Health Variables	Percentages	LA	US
Health Status	% children in excellent health	80%	84%
	% children with excellent oral health	79%	71%
	% children (0-5) requiring medical attention past year	10%	10%
	% children ever breastfed	56%	76%
	% with developmental problems	35%	26%
	% ages 6-17 missed 11 or more days school past year	7%	6%
Health Care	% children with health coverage	95%	91%
	% lacking health coverage	9%	15%
	% children having preventive health intervention past yr.	89%	89%
	% children having preventive dental care past year	77%	78%
	% children (2-17) screened for development problems	29%	19%
	% children w/problems requiring counseling	55%	60%
	% children with medical home	55%	58%
School/Activities	% (6-17) engaged in school	76%	81%
	% (6-17) repeated at least one grade	25%	11%
	% (6-17) participated in activities outside school	75%	81%
	% (6-17) watch more than 1 hour TV daily	61%	54%
Child's Family	% families that read to child (0-5) daily	42%	48%
	% families tell stories to child (0-5) daily	62%	59%
	% families attend church weekly	68%	54%
	% mothers in good physical/emotional health	61%	62%
	% fathers in good physical/emotional health	61%	63%
	% youth in homes where someone smokes	33%	26%
	% with emergency child care arrangement/past month	40%	31%
Neighborhood	% neighborhoods w/park, sidewalks, library, com. center	33%	48%
	% living in neighborhood with dilapidated housing	19%	17%
	% children living in neighborhoods which are supportive	83%	83%
	% children living in safe neighborhoods	83%	86%

National Center for Health Statistics, 2009

The National Center for Health Statistics (2009a) provides data on conditions associated with emotional, behavioral and developmental problems of children leading to activity limitations of the children. The national data shows learning disorders, attention deficit-hyperactivity disorders, and other disorders all plan key roles in youth nationally limiting their daily activities. As children progress into their teen years, the percentages of youth with the problems increase.



SAMHSA Childhood Mental Health Disorder Epidemiological Estimates

Childhood disorders nationally are estimated by SAMHSA based on a wide variety of these data sources and were reviewed by Surgeon General Satcher. These general population estimates are provided below. Below are estimates combining two SAMSHA supported sources on the epidemiology estimates of disorders for children (SAMHSA, March 25, 2007) and estimates on adolescents (Knopf, Park, & Mulye, 2008).

Childhood/Adolescent Epidemiological Estimates

Disorders	Child "n" per /100 estimates	Adolescent
Anxiety Disorders	13/100	5/100
Major Depressive Disorder	2/100	9/100
Bipolar Disorder	1/100	
Attention Deficit/Hyperactivity D	5/100	
Conduct Disorders		3.4/100
Learning Disorders	25/100	9.2/100
Eating Disorder anorexia/bulimia	4/100	4.5/100
Autism	12/100	
Psychotic Disorders	.5/100	
Substance Abuse Disorders		8.2/100
Suicide Attempts		8.4/100
All Disorders Combined	16/100	
(disorders among boys)	18/100	
(disorders among girls)	14/100	

TRAUMATIC EXPOSURE

Given the consequences to child bio-neurological, emotional and behavioral developments due to traumatic exposure, and the area influence of not only the catastrophic hurricane disaster and the current largely unexplored Gulf disaster, it is critical to this plan that traumatic exposure be given central focus. This focus would inevitably entail:

1. Children serving agencies develop, implement and evaluate "trauma informed policies, procedures and programs".
2. All children seen by child serving agencies (primary care, mental health, education, child care, community-based services, etc.) do screening for trauma exposure.
3. Evidence-based interventions for "traumatic stress" (child-focused cognitive behavioral therapy) be provided to all youth (at all levels of exposure).
4. Performance standards for trauma informed services be collaboratively established throughout child serving agencies and they be monitored for quality.
5. Provider capacity for delivering effective trauma and crisis services be enhanced.

Various Reports on Child Traumatic Stress in the LA-Y.E.S Service Area

Based on post-disaster epidemiologic research, we know that how children handle the stress post-disasters is based on how well their families cope with the impact (Silverman and LaGreca, 2002). As the area moves through the recovery and reconstruction phases and re-enters earlier phases in responses to the current Gulf crisis, some children experience symptoms related to Post Traumatic Stress Disorders (PTSD) and most have related traumatic stress symptoms. Most symptoms relate to behavioral and emotional symptoms such as hyper-arousal, mood disturbances, anxiety symptoms, intrusive thoughts, and distress (Silverman and LeGreca, 2006). Lister (2005) summarized the mental health consequences of disasters in a report to Congress.

An assumption reflected in this plan is that we have a somewhat increased rate of PTSD but certainly all the children in our area are coping with increased measures of stress, with traumatic stress being widespread in our area. Some factors exacerbate coping with traumatic stress for children and youth, such as multiple traumatic exposure, persistent poverty, employment threats, dislocation, change in communities, families coping with stress, and female and minority status (Norris, 2005). Thus, given the population characteristics in our area, we estimate most children are coping with increased levels of traumatic stress.

Madrid and others (2006) summarize symptomology common to children and youth exposed to traumatic stress such as most youth in our service area. They summarize data from studies of terrorist attacks and natural disasters: children suffer from direct and indirect exposure; the more risk, the more symptoms; the more the family impact, the more childhood problems. Common manifestations include: increased regression; clinging; inattentiveness; aggression; bedwetting; somatic; irritability; social withdrawal; nightmares; and crying. More sever impacts are less frequent: depression; anxiety; adjustment; PTSD; interpersonal problems; and academic problems. The most vulnerable children are: homeless; in foster care; exposed to violence; are poor; and have special health needs. Moderators include: age; developmental level (older youth and girls are more at risk); and intellectual capacity.

Children and youth who experience trauma may express emotional and behavioral problems as a result of the trauma. It is not likely that most children who have been traumatized will develop post traumatic stress disorders. Copeland and others (2007) note two key points to remember:

- First traumatic experiences are common but do not usually cause post traumatic stress disorders.
- The risk of post traumatic stress symptoms increases with subsequent exposure to traumatic events.

A concern is that each community monitor heightened stress levels so that potential risk of suicide for vulnerable populations will be addressed. We are reminded of this in a recent mental health alert (Mental Health America Alert, February 5, 2007):

- Suicide rates nationally among youth increased in 2005 from a reported 7.3 per 100,000 to 8.2 (11% increase) for youth ages 10-19; for the younger of youth ages 10-14, it increased from 1.2 to 1.3/per 100,000 (8% increase)
- The 1999/2001 reported suicide rate in Louisiana for youth 12-17 was .04 per 100,000 and from 18-20 year olds it was 1.3 per 100,000. In our area, St. Tammany, St. Bernard, and Jefferson had slightly higher than state averages.

The stress children and families in our area experienced were captured in a report of surveys of dislocated families and those rebuilding in our areas. Golden (2006) reports on the "Katrina Impact":

- 39,000 children impacted in NO; 116,307 in area (5 or younger).
- 270,000 people were in shelters post-storm; 20,000 from NO.
- Most in shelters experienced direct trauma.
- 33% of adults in shelters reported Katrina-caused health or mental health problems.
- 40% of those in shelters were separated from family due to the disaster.
- 22% of adults reported being separated from children.
- Most traumatized children experience mental health problems.
- Parents' coping dictates the impact on children.
- Many of the children already have experiences with trauma; combined adding of traumatic experiences further fosters symptom expression and related suffering.
- Most of the youth impacted in need of help are not in services.

The unfolding Gulf disaster has yet to be determined emotional and behavior consequences.

The National Center for Disaster Preparedness (2007) reported to have surveyed Mississippi families displaced by Katrina and summarized their findings: (those who are poor experience greater impact of disaster—lack of resources for managing finances and for personal circumstances; more than half of children reported mental health problems; 62% of parents reported mental health problems—reported on standard measures; 35% reported new problems with hypertension; 44% of children lacked health coverage; 29% of children were missing large number of school days). The most vulnerable are at the end of the funding pipeline and receive the least direct benefits.

Abramson and Garfield (2006) also surveyed displaced families in the Gulf Coast post-disaster. They summarized their survey findings indicating high levels of risk for children and families including those in our service area:

- Children suffer high rates of chronic health conditions and poor access to care (34% have one diagnosed medical condition; ½ lost their medical home; 14% were not receiving needed medications; 11% of parents report poor health; 61% said health problems were more severe).
- Mental health is a significant problem (half of the parents report their child as having emotional or behavioral problems; parents scored very low on standard mental health measures).

- The safety net has major gaps (1/5 of children were not in school regularly; 44% of caregivers lacked health coverage)
- Displaced families lost stability, income, and security (a reported 3.5 moves on average in past year; employed caregiver went from 67% to 45%; less than ½ report feeling "safe"; 72% reported financial needs w/no solutions.

Forums were held that were sponsored by the Center for the Advancement of Children's Mental Health (2006)—Columbia University School of Public Health with support from Latham & Watkins Law Firm in June and August of 2006 in New Orleans. This collaborative group of children's experts described their group as a KIDS (Kids in Disaster Situations) Alliance. The forum was composed of key leaders in children's well-being and this group identified key problems facing children in our service area: widespread emotional problems of children (mood disorders; anxiety disorders); and increased suicide risk among adults.

Substance abuse problems may spike shortly after disasters, but tend to level off within a year. However, youth risk for substance abuse is well documented as a planning need for the wellbeing of youth. The substance abuse prevention plan for Louisiana (State of Louisiana, July 13, 2006) highlights some of the reason for inclusion of this problem in a comprehensive plan for youth mental health:

- 27% of LA students report drinking alcohol by the 6th grade; 55% of 8th graders report having drunk alcohol in the prior 30 days.
- 30% of all 12th graders report binge drinking.
- Between 1990/2002, fatal alcohol crashes in LA were the highest in the nation.
- 26.2% of youth report using tobacco.
- Death rates from drug overdoses in Louisiana was the highest in the nation from 1999-2001.
- 30% of all property crimes are attributed to drug use.
- Orleans Parish has higher than the state average for alcohol and drug use.
- There are data gaps (and suspected service gaps) due to post-Katrina conditions in affected parishes.
- Recovery plan recommended by the group for the affected areas: protect affected areas from financial implications; develop communication plans; maintain and secure data; do on-going needs assessments; modify scope of services in contracts; fast-track contract changes; and link to statewide disaster planning.

It is difficult to quickly assess the rates of disorders for children and youth following a disaster but estimates range from 20% to 68% of children experience emotional and behavioral problems secondary to disaster trauma (Bendsen, Blair, Holandez, Lutwick, Parkes, Sagness et al., 2007).

The Kaiser Family Foundation (May 12, 2007) reported on survey data of 1,504 people returned to Orleans, Jefferson, Plaquemines and St. Bernard parishes. They reported baseline data which they plan to resurvey people over time to examine changes in attitudes of people living in the area. They reported key opinion indicators:

- 50% reported their finances suffered; 13% reported being denied legitimate claims on insurance coverage.
- 17% reported lost jobs or underemployment.
- 37% reported major life disruptions (17% reported being forced to move; 14% reported having lost a close friend due to the storm).

- 36% reported health access barriers (22% report deteriorated health; 18% reported harder to access regular sources of care).
- 23% reported psychological stress (17% reported temper problems; 14% reported marital problems due to storm; 10% reported alcohol problems after the storm.
- 34% (drop from 65% before the storm) reported being satisfied with their quality of life (25% in Orleans Parish).
- 16% report mental health problems; 4% report their child has mental health problems.
- 75% reported feeling they increased ability to cope after the storm.

The Kaiser Survey (2007) data suggest needs are substantial, especially in New Orleans:

- 77% report they or their children are experiencing critical challenges in key areas of life.
- 52% of those in Orleans Parish reported multiple challenges in key areas of life (compared to 41% in Jefferson Parish).
- 43% reported chronic health or disability issues.
- 27% reported they lost access to their health care delivery system.
- 42% of those who rely on public transportation reported health care access burdens.
- 32% reported having a child with serious health and disability problems post storm.
- 27% reported serious employment related problems.

The Kaiser Survey (2007) also noted that African Americans stand out disproportionately impacted by the disaster and aggrieved by the rebuilding process:

- 59% reported their lives as disrupted (compared to 29% of Whites).
- 58% reported living in flooded areas with more than 2 feet of water (compared to 34% of Whites).
- 47% reported financial declines (compared with 32% of Whites).
- 56% reported housing costs have gone up substantially (compared with 42% of Whites).
- 72% reported health care access problems (compared with 32% of Whites).
- 50% reported relying on emergency room care (compared with 15% of Whites).
- 26% reported difficulties traveling for care (compared with 5% of Whites).
- 55% believe they are given worse opportunities for rebuilding than Whites (compared with 19% of Whites reported believing African Americans receive better opportunities).
- 26% of African Americans report declined mental health while 18% of Whites did so.

The survey was post-disaster and no comparative data prior to the disaster is available. The survey makes a strong statement from the voices of those returned to the area that the hurricane and flood disaster has pervasively impacted the quality of life of people living here, and secondly, the survey confirms immense and immediate needs.

<u>Kessler and others Study on Post-Disaster Mental Health in the Gulf Coast (2008)</u>

A representative sample of 815 pre-disaster and 1 year following the disaster they were followed up in interviews using several standardized measures of mental health risk. The following summarizes some of their findings:

- Contrary to other findings on post-disaster mental health, prevalence increased significantly for PTSD (14.9%/20.9%), serious mental illness (10.9%/14.0%), suicidal ideation (2.8%/6.4) and suicidal attempts (1.0%/2.5%).
- Unresolved hurricane-related stresses accounted for the time differences—SMI (89.2%), PTSD (31.9%) and suicidality (61.6%) (in the New Orleans area).
- Outcomes were only weakly related to socio-demographic characteristics.

Two years Post-Katrina, surveys again revealed the estimated prevalence of serious emotional disturbance in the Metropolitan area. McLaughlin, Fairbank, Gruber, Jones, Lakoma, Pfefferbaum, Sampson and Kessler (2009) estimates are:

Epidemiological Estimates of Disorders by Trauma Analysts

Serious Emotional Disturbance	Metro Area %	Surrounding Area %	Total %
High—Serious Emotional Disturbance	8.5%	9.8%	9.3%
Not high—but Serious Emotional Disturbance	3.7%	6.5%	5.5%
Total with Serious Emotional Disturbance	12.2%	16.3%	14.9%

The study estimated the risk of high exposure to hurricane related stress, and found that high exposure to hurricane distress, a history of mental illness, and low income strongly related to high levels of emotional disturbance.

In summary, the service area has been significantly impacted by Post-Katrina influences, and planning for the well-being of children and youth occurs in this context. This context drives the need for planning and care coordination.

PART II

VULNERABLE AND AT RISK YOUTH AND THEIR FAMILIES

Of the three million seriously emotionally disturbed children in this country, two-thirds are not getting the services that they need. Countless others get inappropriate care. These children are 'unclaimed' by the agencies with responsibility to serve them.
Knitzer (1982).

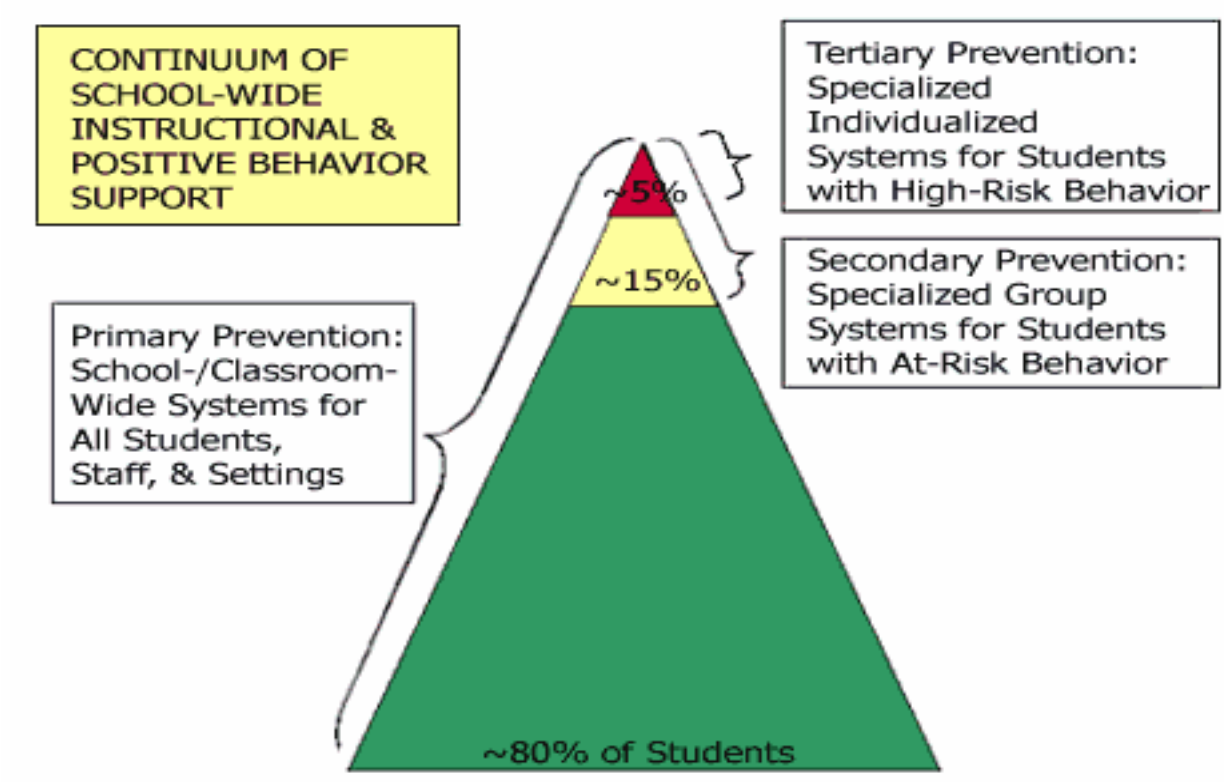
The test of our progress is not whether we add more to the abundance of those who have much; it is that we provide enough for those who have too little.
Franklin D. Roosevelt

PART II

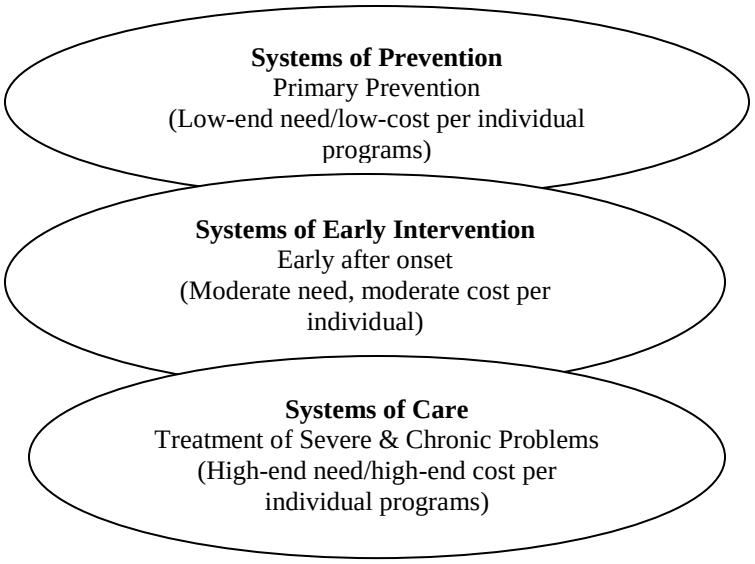
VULNERABLE AND AT RISK YOUTH AND THEIR FAMILIES

Planning for the mental health and well-being of children and youth includes all children. Post-Katrina and with the unfolding Gulf disaster, all local and displaced children and youth have exposure vulnerabilities. Some children and youth are more at risk given a range of social and structural vulnerabilities. For example, we know that unemployment is related to poor health outcomes. In this section, we briefly summarize some of these vulnerabilities. Public social responsibilities require those most vulnerable to be at the core of planning for public health and social services. When public services are in jeopardy whether from fragmentation, retrenchment, and/or capacity problems, the most vulnerable are most harmed by systems failures. Their vulnerabilities get transformed from health and mental health related problems to other related social problems such as school failure, juvenile delinquency or interpersonal instabilities. Interventions known to be successful range from prevention, early intervention, community-based care, or for a very few, to institutional care.

Approximately 20% of young people experience mental health problems during the course of a year, yet 75% to 80% of these do not receive appropriate interventions (U.S. Department of Health and Human Services, 1999).



The Adelman and Taylor model (2000) describes the public health model of intervention focus: primary prevention, early intervention, and systems interventions for children with the most serious needs. These systems collaborate to form an integrated continuum of services that go beyond *traditional* mental health services to promote healthy behavior, reinforce protective factors and reduce the risks that may ultimately result in more serious mental health problems for children and youth. This is an example of a system of care. Below illustrates interconnected systems as conceptualized by Adelman & Taylor (2000) and represents pooling of resources between schools and communities.



Weissberg and Greenberg (1998) further suggest the addition of universal health promotion strategies to expand the prevention, early intervention and treatment continuum and emphasize a "permeable" separation between indicated prevention strategies and promote a focus on evidence based practices as a unifying construct throughout the entire spectrum. The framework is built on the premises that strengths reside in youth, families, communities and culture and that this should drive service continuum development. As such, these premises are consistent with those of systems of care. These are compared with the Interconnected Systems approach in Table 2 below.

Planning for services requires a consideration of all levels of interventions. The following table by Weissberg and Greenberg (1998) demonstrates a model for this spectrum when talking about plans for children's mental health services. The model uses schools as an example.

School Based Model of a System of Care

Interconnected Systems	Continuum of Service Strategies	Approach	Examples
Systems of Prevention	Health Promotion & Positive Development	Target an entire population with the goal of enhancing strengths so as to reduce the risk of later problem outcomes and/or to increase the prospects of positive development	Prenatal care K-12 drug education School-wide character education Positive Behavior Supports Program Recreation
	Universal Prevention	Designed to address risk factors in the entire population of youth - for example, all youngsters in a classroom, all in a school or all in multiple schools - without attempting to discern which youths are at elevated risk	EPSDT Positive Behavior Supports Good Behavior Game
Systems of Early Intervention	Selective Prevention & Intervention	Target groups of youth identified because they share a significant risk factor and mount interventions designed to counter that risk.	LA – 4 ECSS (Early Childhood Supports & Services) PATHS (Promoting Alternative Thinking Strategies)
	Indicated Prevention	Aimed at youth who have significant symptoms of a disorder but who do not currently meet diagnostic criteria for the disorder.	Drug prevention curricula Anger management
Systems of Care	Treatment	Target those who have high symptom levels or diagnosable disorders at the current time.	ECSS Infant Mental Health Cognitive Behavior Therapy Psychopharmacology

YOUTH RISK BEHAVIORS

The Centers for Disease Control and Prevention (2010) reported state survey data on youth risk behaviors in the *Morbidity and Mortality Weekly Report*—June 4, 2010. The following tables summarize data from Louisiana youth (n = 1,035) with information on national averages (n = 16,410). Local survey data from the New Orleans area is not available. The data shows vulnerable youth engage in behaviors that place them at risk for leading causes of morbidity and mortality. The risk does not vary greatly from place to place.

Self-Reported Youth Risks

Variable	Louisiana	National
Rarely or never wore seatbelt	12.8%	11.4%
Rarely or never wore a bicycle helmet	92.9%	84.0%
Rode in care with driver drinking alcohol	35.9%	25.6%
Drove while drinking alcohol	13.9%	8.9%
Carried a weapon	19.6%	18.2%
Carried a weapon on school property	5.8%	5.4%
Engaged in a physical fight	36.1%	29.8%
Injured while in a physical fight	5.8%	3.8%
Physical fight on school property	13.7%	10.6%
Were bullied	15.9%	19.9%
Experienced dating violence/forced to have sex	17.8%	11.1%
Forced to have sexual intercourse	na	8.8%
Didn't go to school because felt unsafe	9.1%	5.7%
Felt sad or hopeless	31.2%	27.0%
Seriously considered suicide	14.4%	11.6%
Made a plan to commit suicide	11.6%	11.4%
Attempted suicide	7.9%	7.9%
Seen by Dr. for suicide attempt	4.9%	2.8%
Had sex before age 13	na	5.7%
Currently sexually active	33.6%	35.4%
Have had more than 4 sexual partners	na	14.5%
Condom use	na	60.5%
Birth control use	na	21.2%
Drank alcohol or used drugs time of last intercourse	na	21.3%
Taught about HIV infection and AIDS in school	76.2%	85.7%
Physically active for 60 minutes more than 5 times a week	36.8%	44.0%
Obese or over weight	18.0%	14.6%
Have asthma	10.9%	10.9%

The added burdens experiences by gay, lesbian and bisexual youth contributes to the considerably higher estimated rates of substance abuse by gay, lesbian and bisexual youth. A recent study reports a 20% (in the past 30 days) use of illegal drugs for 12-17 year olds (Padilla, Crisp, and Rew, 2010). SAMHSA recently reported in a news release (2010, June 23) that only 6% of substance abuse treatment programs have specialized programs treating gay, lesbian and bisexual youth. Those that treat co-occurring mental health challenges and those in the private sector compared with government run programs tended to offer slightly more services to these children. In an "assets based approach" to working with glbtq youth in systems of care services, Gamache and Lazear (2009) outline some of the unique issues (15% of new HIV infections are among 13-24 year olds; 11% to 35% of all runaway and homeless youth are glbtq; a meta-analysis of 18 studies show glbtq youth have elevated risks for substance abuse; one-third of youth "coming out" attempt suicide). This system of care approach notes that supports predict positive youth outcomes. Ryan, Heubner, Diaz and Sanchez (2009) provide sound research

demonstrating that family rejection predicts negative health and mental health outcomes, and culturally competent intervention models that stress family engagement are effective in improving health and mental health outcomes.

Substance Use Risks

Variable	Louisiana	National
Ever smoked	54.8%	48.8%
Currently smoke	17.6%	18.2%
Smoke frequent cigarette use	6.2%	7.4%
Tried to quit cigarette use	58.7%	53.2%
Buy own cigarettes	22.7%	14.5%
Ever drank alcohol	73.5%	70.3%
Currently drink alcohol	47.5%	39.3%
Binge drink	24.6%	24.0%
Ever marijuana use	32.8%	36.5%
Current use of marijuana	16.3%	20.3%
Ever use of cocaine	7.9%	6.3%
Current use of cocaine	4.0%	2.8%
Ever use of inhalants	12.4%	11.6%
Ever use ecstasy	9.5%	6.8%
Ever use of ecstasy	6.4%	3.0
Current use of methamphetamines	7.9%	3.9%
Current use of steroids without prescription	7.2%	3.6%
Ever inject illegal drug	5.4%	2.5%

National survey data on the risk behaviors of youth significantly impact health outcomes. The National Alliance to Advance Adolescent Health (Fox, McManus and Arnold, 2010) reports from two large-scale surveys various risk factors:

Adolescent Risks

Risk Indicator	Boys	Girls	African American	White	Latino/ Latina	TOTAL
Intercourse before age 13	10.4%	4.6%	16.2%	4.9%	8.5%	7.5%
Days since last unprotected sex	15.5	19.4	19.7	16.8	19.2	17.5
Persistent sadness	21.6%	35.9%	29.6%	26.3%	36.5%	28.7%
Suicidal thoughts or plans	21.6%	13.6%	16.1%	16.9%	19.5%	17.6%
Abnormal weight loss behavior	10.9%	21.3%	14.1%	15.4%	19.1%	16.0%
No exercise in past week	12.9%	20.3%	20.8%	15.5%	16.0%	16.6%
Current frequent smoker	8.9%	7.5%	4.4%	10.3%	4.8%	8.2%
Problem alcohol behavior	31.2%	26.1%	16.8%	31.7%	30.2%	28.7%
Used marijuana in past month	22.9%	17.3%	21.9%	20.1%	19.2%	20.1%
Used other drug (ever)	20.4%	20.1%	12.2%	21.4%	19.4%	19.8%
2 or more fights past year	28.5%	14.9%	30.2%	17.8%	26.6%	21.8%
Carried a weapon	28.8%	7.9%	18.2%	18.4%	18.9%	18.5%

The study reports that over half of students are engaged in more than one risk behavior. The study authors (2010) recommend that that since the majority of youth are engaged in multiple risk behaviors, that interventions should be comprehensive, include a wide array of risk behavior interventions, and should be individualized to address diversity. Mental and physical health interventions should not be seen as a duality but integrated in approaches. Mental Health approaches address health risks as should health services address mental health in a comprehensive and holistic approach (Fox, McManus and Arnold, 2010).

School-Based Health Centers in Metropolitan New Orleans

The School-Based Health Centers surveyed students in Orleans Parish to know more about the health needs of the student population. They surveyed youth who received services through the clinics (n = 980) and other students (n = 944) for a total of 1,924 students surveyed (Louisiana Public Health Institute, 2010). The respondents were female (60%), African American (90%), and eligible for reduced fee lunches (66%). The students were asked about various health problems they experience:

- 22% reported they did not have a medical home
- 34% reported being over weight or obese
- 3.5% diagnosed with diabetes
- 12% high blood pressure
- 30% depression
- 11% reported suicidal ideation
- 57% reported being sexually active
- 23% had been tested for HIV and 26% for other sexually transmitted diseases
- 34% reported being in a physical fight in the past year

The evaluation of the school-based health centers (Louisiana Public Health Institute, 2010) concluded that the centers are an effective method of providing preventive and primary care services to an underserved and needy population and good, cost-effective public policy.

Housing in the Metropolitan Area

The Greater New Orleans Community Data Center (2009) provides data summaries on housing trends in the New Orleans area. Housing is a key support areas all children need to grow and develop in a safe and nurturing environment. The following is some of the data trends reported by the GNOCDC:

- From 2007 to 2008, home sales volumes were down markedly (28%) as were home values
- New home construction was down 10%
- 90.5% of Road Home applicants have received grants (averaging $62,748)
- Rents increased in the metropolitan area 52% from 2005 to 2008 (highest in Orleans Parish)
- 14,422 families continue to receive disaster assistance for housing (compared to 31,000 nationally) in March 2009

The GNOCDC (June 23, 2009) released a report on housing affordability in the New Orleans Metropolitan Area which also included data on housing and housing support-related infrastructural issues in the area. Housing costs rose sharply in the area after the 2005 disaster. This is especially true for rentals. Rent averages increased from on average of $676 in 2004 to $856 in 2007. It was highest in Orleans Parish (average $892) compared with nationally ($789).

- This report prepared a data chart showing housing in general being less affordable in the area than nationally. The following table shows the percentage of households paying more than 30% of their annual income on housing costs:

Home Ownership/Rentals

Parish/Area	All Households	Homeowners	Renters
Orleans	47%	36%	60%
Jefferson	33%	24%	51%
St. Tammany	30%	24%	61%
NO metro area	35%	26%	54%
US	36%	31%	49%

The lack of affordable housing produces duress for some families. The National Center for Family Homelessness ranked states at highest risk for child homelessness—Louisiana ranked #46 out of 50 states (Tilove, March 10, 2009). They reported Louisiana having 204,053 people in crisis (2006 data)—85,702 under 6 years of age, 87,699 from k-8, and 30,652 in 9-12. The article reports poverty driving the homeless rate. The report the Louisiana condition is deteriorating over the past decade and not just related to post-disaster and re-occurring disaster circumstances. The report states that even minor events can send families into catastrophic conditions. "The ripple effect of homelessness is profound, according to the study, affecting every aspect of a child's life, including: higher incidences of asthma, dental problems, and emotional difficulties, including an increased likelihood of witnessing traumatic stress and violence." (Tilove, March 10, 2009).

It is estimated in 2007 (Homeless Management Information System Data as reported in OMH, 2009, p. 130) that approximately 2, 2219 homeless persons lived in Region I (Orleans Metropolitan Area) and 480 in Jefferson Parish. As noted earlier, approximately 11-35% of homeless and runaway youth are sexual minority youth.

Schools in the Metropolitan Area

The GNOCDC (2009) cites a variety of data on the infrastructure supporting youth in the metropolitan area. Regarding schools, they report:

- 14 schools opened from the Fall of 2007 to 2008 in the area (12 public schools, 2 private)
- 69% of Orleans Parish schools have re-opened as of the Fall of 2008,with more than half being charter schools (comprising 56% of Orleans Parish public school students)
- There are 88 public schools in Orleans Parish,
- Each parish in the area has one less public library as of the beginning of the 2009 year
- The jurisdiction of Orleans Parish public schools as of February 2009 included:
    - Recovery Schools 33
    - Recovery Schools—charter 27
    - Algiers Charter 9
    - Orleans Parish Public Schools 5
    - Orleans Public—charters 10
    - Independent charters 2
    - Other (Youth Studies; Alternative (2)

- The GNOCDC website (www.gnocdc.org) reports maps which show the location by neighborhood of the schools open as well as characteristics of students per school (enrollment size, grade levels, free/reduced cost lunches, and students with limited English proficiency). The following table summarizes some of this data:

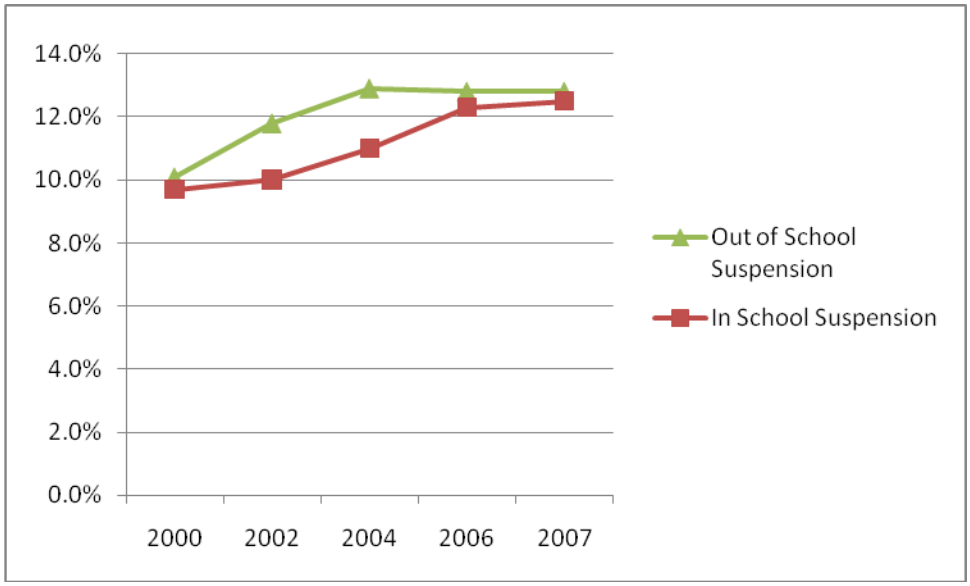
School Risks

Parish	Public School Enrollment	Number of Schools	Free/Reduced lunch participants	At Risk (special ed; poverty)	% with limited English Proficiency
Jefferson	45,076	90	76.5%	76.5%	8.0%
Orleans	38,051	92	82.6%	82.6%	2.4%
Plaquemines	4,698	8	57.4%	57.4%	2.3%
St. Bernard	5,298	8	74.1%	74.1%	.05%
St. Tammany	36,753	56	44.8%	44.8%	1.4%

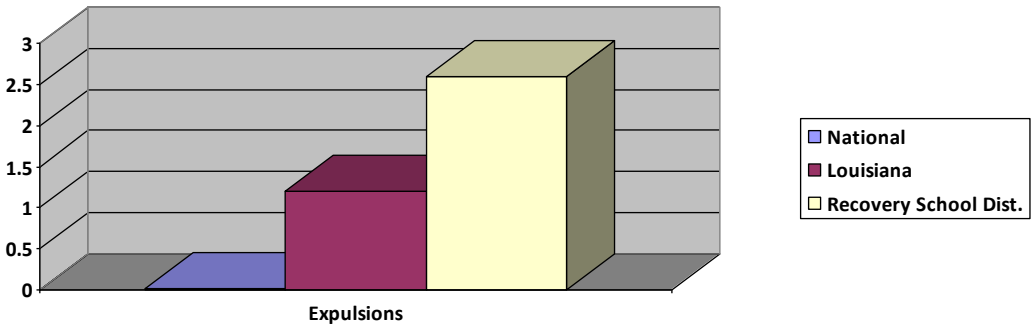
Few youth in the metropolitan area receive afterschool supports. The Greater New Orleans Afterschool Partnership (2009) summarizes data on afterschool programs in the area. They report that approximately 25% of youth receive afterschool supports and those youth in the most damaged post-disaster and newly threatened neighborhoods are least likely to access to afterschool care. The neighborhoods with the highest crime rates have the least access to afterschool supports. They also report few high school students have access to these supports. Locally some of the key funders include Baptist Community Ministries (2 programs); United Way (8 programs), the City of New Orleans (8 programs), and the Greater New Orleans Foundation (8 program funding areas). This list (see www.gnoafterschool.org) describes a variety of ways funders try and address this widely needed yet under-developed area of services for at risk youth. The website provides an interactive site where nearly 30 programs are described. This includes a rare program for at risk lesbian, gay, bisexual and transgender youth—a group most providers shun. The innovative website provides important program information to help families make decisions about securing access to help.

Concerns have been expressed with the high rates of school disciplinary actions in Orleans Parish (Sullivan and Morgan, 2010). They cite the Louisiana State Constitution saying that the "goal of public education system is to provide learning environments and experiences, at all stages of human development, that are humane, just, and designed to promote excellence in order that every individual may be afforded an equal opportunity to develop his (sic) full potential." The numbers of disciplinary actions directly speak to this opportunity (lost). Louisiana suspended 86,000 students and expelled over 7,000 students in 2007-08. Sullivan and Morgan provide tables illustrative of the problems they address:

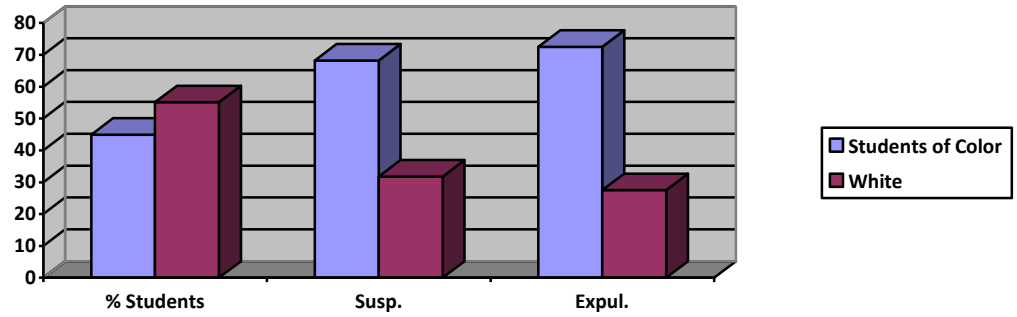
The Percentage of Suspensions are Rising



The Rate of Expulsions is Dramatically Higher in Louisiana and the RSD than Nationally



The Rates of Suspensions for Students of Color is Dramatically Higher than for Whites



In the Sullivan and Morgan report (2010) prepared for the Families and Friends of Louisiana's Incarcerated Children and the National Economic and Social Rights Initiative, it is noted that various mental health related interventions are demonstrated to be effective at reducing violence,

conflict, improving learning, and helping students develop good social relationships by engaging families and schools in solutions. These approaches provide solutions to underlying causes and meet students needs rather than setting in motion interventions with known to have bad outcomes.

Child Care Centers

The GNOCDC (2009) cites a variety of data on the child care centers also supporting youth in the metropolitan area. Regarding child care centers, they report:

- The metropolitan area has less child care centers in December 2008 than were available in 2005
- Orleans—45% less; St. Bernard, 50% less; Plaquemines 29% less, Jefferson 17% less

HEALTH/MENTAL HEALTH RISKS

Health Centers

Information on the health care delivery infrastructure is reported by the Louisiana Public Health Institute on its website (www.lphi.org). LPHI (2009) reports:

- hospitals in the metropolitan area:
  - Orleans Parish (MCL/NO; Tulane; Oshsner Baptist; Touro; Children's)
  - Jefferson Ochsner (Kenner; Jefferson; Metairie; Gretna); West Jefferson; Tulane-Lakeside
- School Health Clinics
  - School Based (Riverdale; Bonnabel; Butler; McMain; O. Perry Walker; Charter Science & Math; Chalmette High)
  - School-Linked (Douglass; Martin Behrman; Murray Henderson; Craig Elementary)
  - Five in Planning (Ehret; Sarah T. Reed; Cohen Senior High; Warren Easton; L. B. Landry)
- Path Community Health Care Facilities
  - Common Ground; Daughters of Charity; EXCELth (3); Jefferson Community Centers (2); MCLA/NO (2); New Orleans Health Department (3); St. Charles; St. Thomas; Covenant House; Tulane Drop In Center; LSU Adolescent Health (2)
  - Other community facilities in planning phases

Commission to Build a Healthier America

The Robert Woods Johnson Foundation (2008a) report on the percentage of children in Louisiana with at risk health outcomes:

Health Risk Outcomes

	LA
Number of youth under age 17	1,172,477
% with less than optimal health care	18%
% with poor health	19%
LA rank (compared to national data) in differences in poor health between higher and lower income youth	46

Every Child Matters

There are many indicators of child risk which influence the mental health of children and youth. This children's plan is based on an agreement that focuses on improving mental health and has to include the overall well-being of children and youth. The Every Child Matters Educational Fund (2008) recommends 10 key indicators be used to determine the relative well-being of children. This Children's Plan (2008/2009) recognizes that these indicators are the benchmarks for improvement required for the mental health of children and youth in our area. This is the "dashboard" needing implementation to improve child well-being and children's mental health.

Every Child Matters Child Well-Being Indicators

Indicator	LA Rates	% Higher Compared with Best State	LA Ranking
Infant Deaths per 1,000	10.5	133%	50th
Deaths per 100,000 (aged 1-14)	34	209%	47th
Deaths per 100,000 (aged 15-19)	96	140%	45th
Births to Mothers aged 15-19 per 1,000	56	211%	44th
% Births to Women Receiving Late/No Prenatal Care	2.9	92%	16th
% of Children in Poverty	28%	180%	49th
% of Uninsured Children	15.9%	278%	44th
Incarceration rate per 100,000 juveniles	386.8	434%	45th
Child Abuse Fatalities per 100,000	1.8	408%	28th
Per Capita Child Welfare Expenditures	$47.88	26%	39th
Louisiana Overall Ranking Among All States			*50th*

These social indicators are the best predictors of health outcomes. The Robert Wood Johnson Foundation (2008) reported on some of these basic connections. They reported for example that a mother who had less than a high school education had a higher infant mortality rate (8.1) than a mother with a college degree (4.2). Men with a college degree lived longer (54.7 years) compared to men without a high school degree (47.9 years). Women with a college degree lived 58.5 years compared to women without a high school degree (53.4 years). Men with higher incomes (400% above the poverty level) lived longer (53.5 years) compared to people at less than the poverty level (45.5 years) and women with higher incomes lived longer (58.2 years) compared with men (51.5 years) on average. People with higher incomes had fewer poor health outcomes (6.6%) compared with people below poverty with poor health outcomes (30.9%). People with less than a high school education had poor health outcomes (25.7%) compared with people with a college education with poor health outcomes (5.2%). Parents with greater incomes (400% above the poverty level) had fewer children with poor health outcomes (0.6%) compared with families below poverty levels with children with poor health outcomes (4.3%). Parents without a high school degree had more children with poor health outcomes (4.7%) compared with parents with a college degree (0.7%). Parents with lower incomes (below poverty) had more children with chronic health conditions (32.2%) compared with parents with higher incomes (9.4%). Even when controlling for poverty, African Americans have poorer health outcomes (e.g., below poverty rates for African Americans is 30.9% compared with Whites at 11.4%). Latino rates were close to those with African Americans when controlling for

income. Income is related to health outcomes regardless of incomes, but more pronounced for African Americans and Latinos. This Robert Wood Johnson report (2008) clearly shows the connection between health outcomes and social indicators. Thus, the vulnerabilities to Louisiana post-disaster persist to be greatest in the nation, with the greatest risk for Louisiana children. Poverty and geography predict bad health and mental health outcomes. We are required to look at the social indicators when we plan for children's mental health.

One of the most critical pieces of information to guide us in thinking about vulnerable and at risk youth is to remember from the epidemiological data (comprehensively described in research summaries from Fran Norris) is that we need to make sure parents are doing well because the better parents cope with disasters, the better children cope. Gurwitch and Silovsky (2005) developed guidelines for parents and teachers on what to expect after trauma. These are available for printing and sharing with families, teachers, and other helpers. They address possible reactions to trauma for elementary, middle school, and high school youth.

Kids Count

The Annie E. Casey Foundation's "Kids Count—2008 data" (2010) report summarizes how Louisiana youth are particularly vulnerable relative to national data on nearly all youth. Louisiana continues to rank 49 of 50 states on key children's outcomes. The measure of successful health care systems is on achieving improved health outcomes in these data areas.

Kids Count Data on Structural Risk (2010)

Child Characteristic	Orl	Jeff	Plaquem	St. Bernard	St. Tammany	LA	US
Children in Poverty	36%	21%	20%	16%	14%	25%	18%
Ch/Extreme Poverty	22%	Na	na	na	na	11%	8%
Population by poverty	23%	13%	15%	20%	10%	18%	13%
Single Parent by poverty						45%	32%

Kids Count Data Report (2010)

Child Characteristic	LA	US
Teens HS Dropout	11%	7%
HoH HS Dropout	18%	16%
HoH with BA Degree	20%	27%
Youth enrolled in Collage	38%	45%
Child w/out computer in home	44%	31%
Child w/out Internet access in home	53%	41%
Scored below Math level (4^{th} grade)	27%	19%
Scored below Reading level (4^{th} grade)	48%	34%
Scored below Science level (4^{th} grade)	43%	34%
Living w/unemployed parent(s)	43%	33%
Unemployed Teens	67%	64%
% births to females < 20 years of age	15%	10%
Births to unmarried mothers	49%	36%
Low birth weight babies	11%	8%
2 year olds immunized	76%	83%
Grandparents raising grandchildren	8%	5%

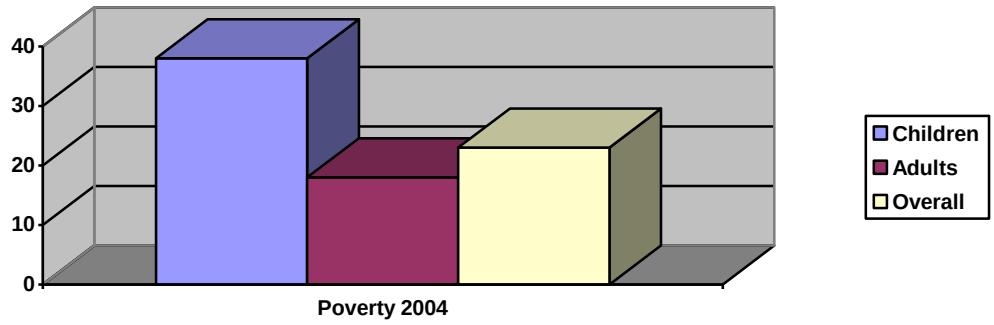
Child poverty rates have ranged from 15% to 23% nationally for the past four decades (Ratcliffe and McKernan, 2010). By examining the incidence and duration of poverty, consequences become more evident. Some consequences of poverty they note are:

- 10% of children are persistently poor, spending at least half of their childhoods in extreme poverty.
- African American children are 2 times more likely to experience poverty, and 7 times more likely to be persistently poor.
- Children tend to cycle in and out of poverty.
- 69% of African American children who are poor at birth go on to spend at least half of their childhood in poverty.
- These children have worse health, mental health, and social (e.g., education, employment, marital, cradle to prison) outcomes.

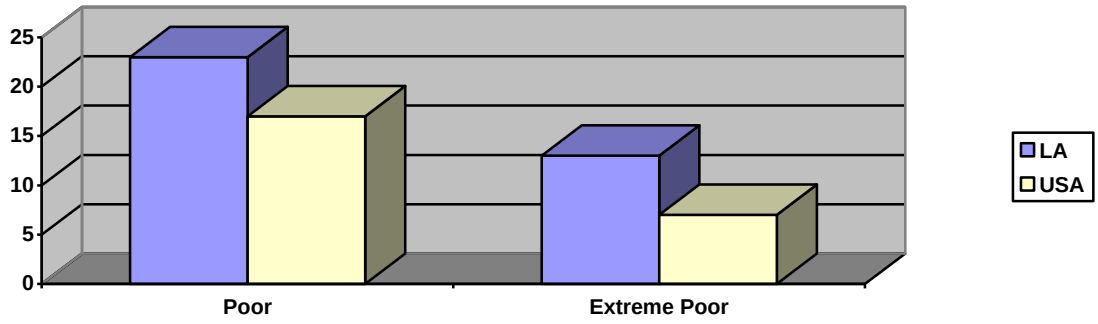
It is for this reason that poverty and its eradication is at the core of health care reform.

The National Center for Children in Poverty (2007) also describes some of the dimensions of youth vulnerability as illustrated in the next few tables. The first table shows the overall poverty rates in Louisiana. This data is prior to the disaster. These data figures on poverty illustrate the extent of vulnerabilities prior to the added burdens brought on by the disaster.

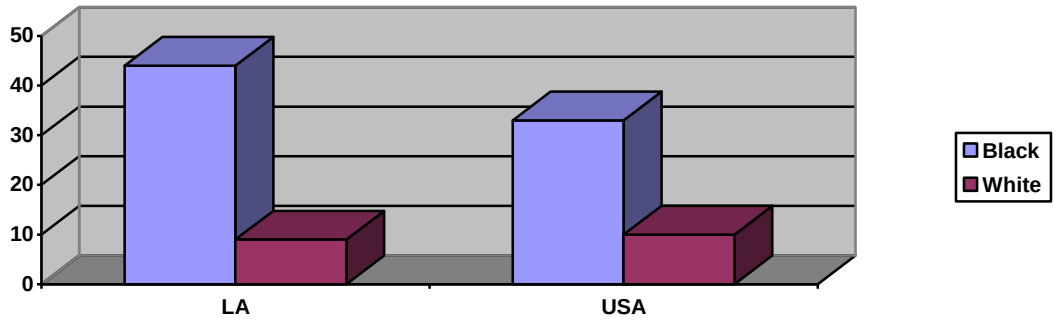
Overall poverty percentage rates for 2004



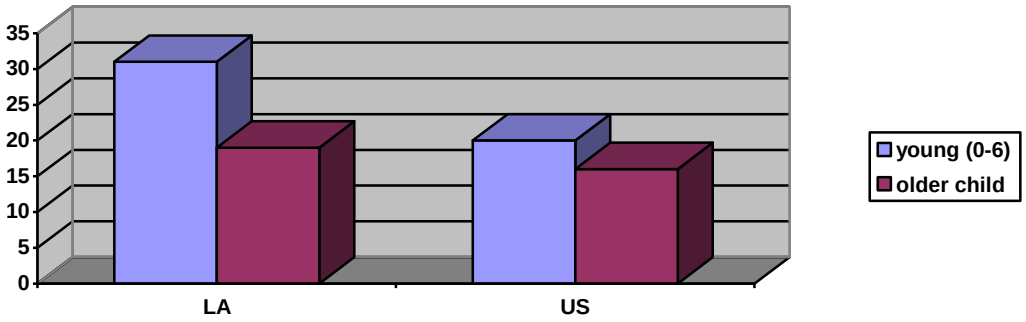
Louisiana has among the highest percentage rates of extreme poverty in the nation



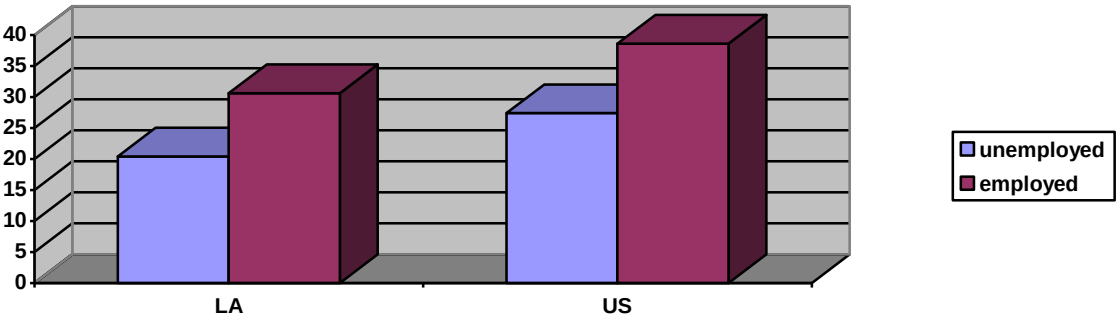
Child poverty percentage rates in LA and USA by race



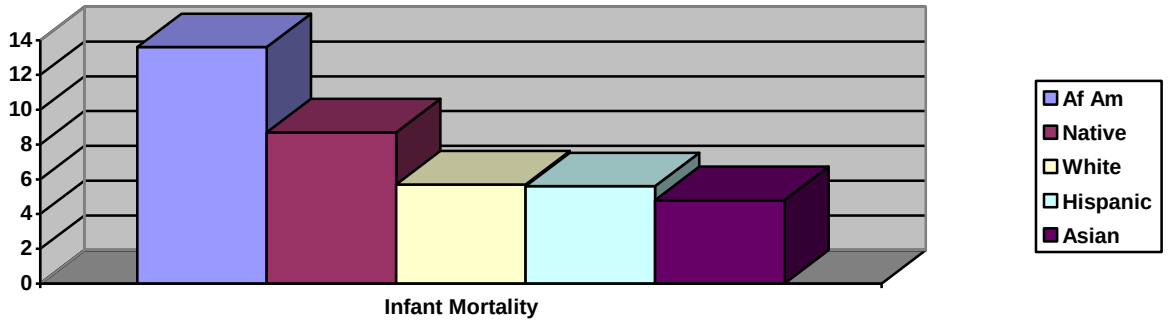
Percentage of younger children in LA and US that live in poverty



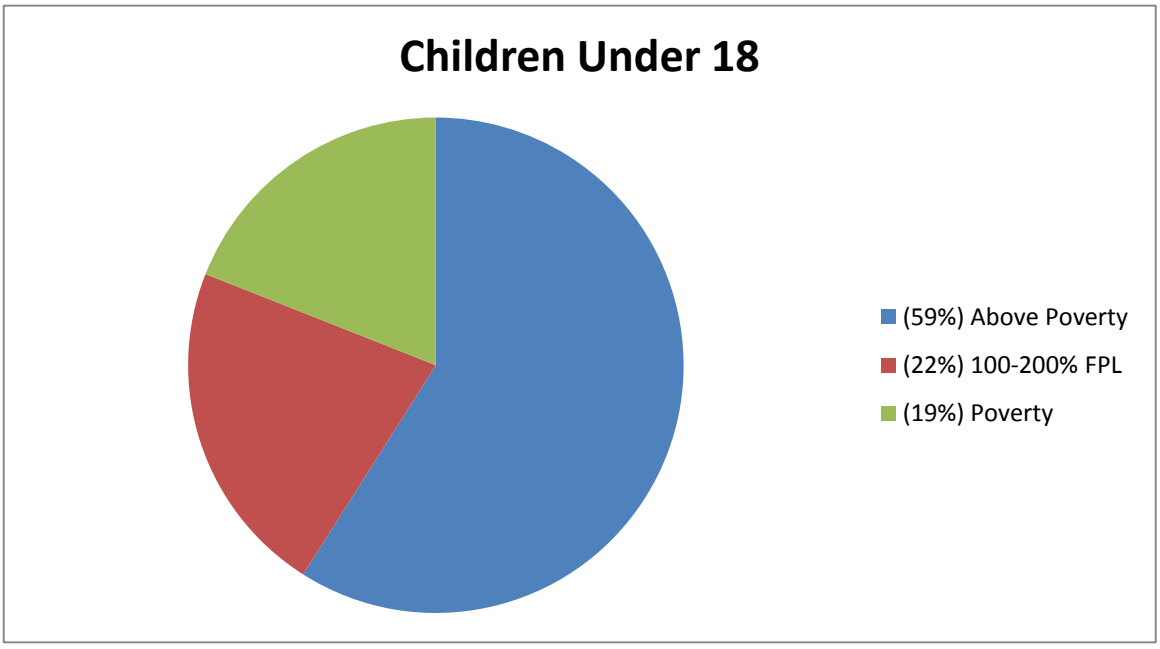
Percent of families that experience high percentage rates of unemployment/underemployment



Incidence of infant mortality in Louisiana (Rates per 100,000)

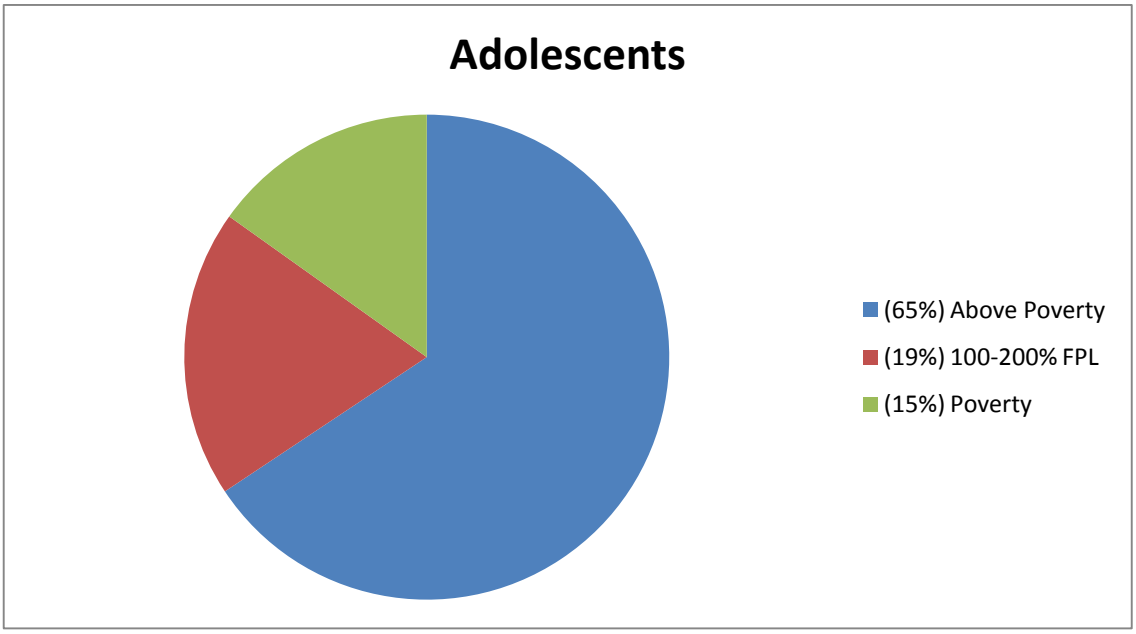


The National Center for Children in Poverty examines poverty conditions for children (2009a) and for adolescents (2009b). For 2009, they reported 19% of children and 15% of adolescents live in poverty; 22% of children and 19% of adolescents live in low income families (100% to 200% of the federal poverty line), and 59% of children (65% of adolescents) live above the low income. The federal poverty level for the average income level for a family of three is $18,310.



- 8% of low income children have at least one parent working full time
- 73% of low income children do not have an employed parent
- 24% of low income children live with a parents with < a high school education
- 67% of all children with a single parent have low income families
- The burden of poverty is disproportionately impacting minority youth
    - 57% of Native American children live in low income families
    - 62% of Latino and Latina children live in low income families
    - 61% of African American children live in low income families
    - 31% of Asian American children live in low income families

    - 27% of White children live in low income families
- 60% of immigrant children live in low income families
- 51% of children in urban areas live in low income families
- 47% of children in rural areas live in low income families



- 55% of low income adolescents have at least one parent working full time
- 21% of low income adolescents do not have an employed parent
- 25% of low income adolescents live with a parents with < a high school education
- The burden of poverty is disproportionately impacting minority youth
    - 52% of Native American adolescents live in low income families
    - 56% of Latino and Latina adolescents live in low income families
    - 55% of African American adolescents live in low income families
    - 33% of Asian American adolescents live in low income families
    - 23% of White adolescents live in low income families
- 55% of immigrant children live in low income families
- 46% of adolescents in urban areas live in low income families
- 41% of adolescents in rural areas live in low income families

Health Disparities: Kaiser Family Foundation

Health disparities indicate further risks for vulnerable youth and their families. The Kaiser Family Foundation (2009) reports some recent data on infant mortality, diabetes mortality, and AIDS cases (per 100,000). They also report percentages of those in poverty, those receiving Medicaid, and those uninsured.

Incidence per 100,000 of Selected Health Variables and Percentages of Risk by Race (2007)

Health Variable	LA: White	LA: Black	LA: Latino	LA: All		US: White	US: Black	US: Latino	US: All
Infant Mortality	.071	.139	.056	.010		.057	.136	.056	.069
Diabetes Mortality	29.7	65.4	NSD	38.5		22.5	47.0	NSD	24.6
AIDS Case Rate	6.7	60.0	20.4	21.2		7.2	68.6	23.3	14.0
% in poverty	14.8	39.7	Na	23.1		11.6	33.0	29.0	17.3
% with Medicaid	9.8	27.4	Na	16.0		9.3	26.2	21.6	13.5
% Uninsured	16.3	27.0	Na	20.2		13.2	20.9	34.3	17.9

In the United States, adolescent AIDS cases reflect this disparity:

- African American adolescents—60.3% of Dx cases
- White—6.4%
- Latino—20.8%
- Other—12.2%

Zuckerman and Coughlin (2006) also report "long before the onslaught of Hurricane Katrina or the chaos of evacuation, New Orleans' social structure was failing". They summarized low health outcomes in the region. According also to the United Health Foundation (2004), Louisiana ranked lowest overall in the country for health outcomes. Zuckerman and Coughlin report Louisiana ranks one of the five worst states for infant mortality, cancer deaths, prevalence of smoking, and premature death. It is in this context of health care that children's mental health care must be examined. They also note that families in Louisiana are more likely to require hospitalization and to need crisis health care. Those without insurance coverage (the highest rates in the nation) were most likely to receive care in public facilities. They report that low income children in Louisiana have lower private health coverage (26.1% compared to nationally 30.7%) and more Medicaid/LA-CHIP (51.3% compared to 44.3% nationally). Zuckerman and Coughlin recommended both short term recommendations to manage the crisis and longer term solutions to focus on infrastructure reforms.

International Medical Corp

The International Medical Corp surveyed families displaced by the 2005 disaster. Many of those families were in temporary housing in congregate FEMA housing travel trailers when interviewed in 2006. The International Medical Corp (2006) reported serious mental health problems among the residents:

- 49% did not personally feel safe
- 45% did not feel it safe for their children
- Reported triple the national rate for domestic violence
- Reported rapes that were 53 time higher than Louisiana average rates
- Reported major depression at 50%--seven times the national rate.
- Reported suicidal feelings (at 15 time higher than national rates)
- 75% reported the need for personal counseling.

These survey data on an at risk population of displaced families indicate high rates of ongoing traumatic experiences of displaced families.

Children with Special Health Care Needs (Child Health Insurance Research Initiative) (2009)

The Child Health Insurance Initiative (2009) surveyed families to explore health care needs of youth. They found:

- Mental disorders were second only to asthma in problems parents reported
- More than 1/3 of youth had reportable disorders (38%), yet only ¼ of these considered care
- Families routinely underestimated the need for or effectiveness of care
- African American families were twice as likely to under-estimate need, though prevalence was similar to those of white youth
- This study showed a critical need for screening and training. (Families often confused normal adolescent behaviors as related to disorders, and under-estimated symptoms related to disorders.)

LSU Health Sciences Center Survey 2006

In a non-random survey of school children in the LA-Y.E.S. service area, the survey reported 41% of fourth through twelfth graders met cutoff scores for a need for mental health services (depression, stress, anger; concentration, worry). Of these, 13% reported requesting mental health services, and 5% reported having received any type of counseling intervention.

The survey conducted by Kessler, Galea, Gruber, Sampson, Ursano, and Wessely (2008) of the Harvard Medical School which was a random sample of adults in the area reported 6% of adults having severe mental illness symptoms in 2005 to 14% in 2006 post Katrina.

Immigrant Children

The "Kids Count—2007" report (Casey Foundation, 2008) provides data on immigrant children in Louisiana relative to those in the United States.

Immigrant Children Characteristics	**LA Children**	**US Children**
Foreign Born	1%	4%
Living with Secure Parental Employment	32%	29%
Difficulty Speaking English	12%	20%
Living with Married Families	82%	77%
Living in the US for the Past three Years	3%	3%
From Latin America	42%	62%

Approximately 12,000 Vietnamese Americans lived in the New Orleans area before Katrina comprising 22% of all foreign-born immigrants (VanLandingham, Norris, Vu, and Fu, 2007). These authors in a small convenience sample of Vietnamese Americans both before and after Katrina report on a negative impact of Katrina. They note statistically significant declines in health—increased limitations due to physical health, increases in bodily pain, role limitations due to emotional problems, less vitality and energy, greater fatigue, and generally poorer health perceptions. As parental measures of health problems increase, so do those of children.

Runaway/Homeless Sexual Minority Youth

A recent report by Ray (2007) on homeless youth also identifies vulnerable youth. Ray uses different research with larger estimates that range from 575,000 to 1.6 million homeless youth (using a very broad definition of homeless or at risk of homeless) at any time in the US. It is estimated that 20 to 40% of homeless youth are lesbian, gay or transgendered (LGT) (ranges

from 115,000 to 640,000 youth). Approximately 26% of them were kicked out of homes due to "coming out" issues and 33% experienced violent assaults when coming out. Approximately 10% to 20% of homeless youth self-identify as having substance abuse problems, and being LGT confound problems in securing shelter and treatment. More than 50% report engaging in "survival sex" (exchange sex for money for survival needs). LGT youth are seven times more likely to be victimized by crimes than other homeless youth and if incarcerated, are estimated to be over-represented among youth sexually assaulted by other youth and staff in institutional settings. Ray (2007) estimates one in five transgendered youth are at risk for homelessness.

Kaiser State Health Facts

There is an increased risk for HIV infection among youth due to traumatic stress: increased risk-taking behaviors; developmental threats; disproportionate impact on already vulnerable populations; and the combinational effects of high rates of other risks for youth in Louisiana. The Kaiser State Health Facts (2007) describes this risk:

- LA AIDS Cases: White 27.7%; Black 59.7%; others 2.4%
- LA is 15th in the number of pediatric AIDS cases (131).
- The LA rate for AIDS cases is 21.2/100,000 with a national rate of 14.2/100,000).
- LA is rated #4 for Teen Deaths (accidents, homicides, suicides): 97/100,000 with a national rate of 66/100,000).
- LA is rated #7 for Child Deaths (28/100,000 with national rate of 21/100,000).
- LA is rated #2 for Infant Mortality (10.3/100,000 with a national rate of 7/100,000).
- LA has the second-lowest rate of children (ages 1-17) who received help for emotional, developmental, or behavioral problems in the nation (44% compared to 59% nationally).
- LA has the 7th highest teen birth rate (56.2/100,000 compared nationally at 41.1/100,000).

National Adolescent Health Information Center Fact Sheet

Data from the National Adolescent Health Information Center (2007 Fact Sheet)

- (2004 data): Leading Causes of Death Nationally for ages 10-24 reports:
- Motor vehicle 31.3%; homicide 14.2%, suicide 12.3%, unintentional injuries 14.2%; all other 28.1%.
- Homicide rates for males per 100,000 (white—3.4; Hispanic 20.1; Black 53.8).

Good planning for all youth in need of support from their families and communities is particularly responsive to the needs of the most vulnerable youth.

National Survey on Drug Use and Health

The *National Survey on Drug Use and Health Report* (Office of Applied Studies, 2009) reports on the risks adolescents face with substance use. Decisions youth make on alcohol, tobacco and other drugs have short and long term consequences on their health and development. From surveys of adolescents nationally, they note that:

- 40.0% of adolescents perceive great risk in binge drinking and heavy marijuana smoking
- Females are more likely than males to perceive the risk
- 69% of adolescents perceive the risk of smoking more than one or more packs of cigarettes a day.

Waiting lists for treatments for children (and adults) remain considerable in the service area (Louisiana Commission on Addictive Disorders Annual Report, 2009). According to the

Louisiana Caring Communities Youth Survey (Louisiana Department of Education, 2009), which surveyed 50,166 Louisiana youth grades 6, 8, 10 and 12, the following lifetime use and past 30 day use of substances were reported by age groups:

Substance Use Survey of Risks by Younger and Older Adolescents

Use	Substance	6th grade	8th grade	10th grade	12th grade
Lifetime	Alcohol	25.7%	49.4%	67.6%	73.9%
Past 30 days	Alcohol	9.5%	23.9%	37.8%	46.9%
Lifetime	Binge Drinking	5.4%	12.9%	20.5%	26.9%
Lifetime	Cigarettes	12.6%	27.7%	38.4%	44.3%
Past 30 days	Cigarettes	3.0%	9.0%	15.3%	20.7%
Lifetime	Marijuana	2.0%	9.6%	20.2%	27.5%
Past 30 days	Marijuana	0.8%	4.2%	8.9%	11.2%

The lifetime and recent use for African American students is less for alcohol, binge drinking, and cigarette use and more for marijuana use (Louisiana Department of Education, 2009).

Approximately 1% of the 6th graders reported needing alcohol treatment (10% of 12th graders reported this need). Of the 12th graders, 17.2% reported drinking and driving within the past 30 days, and 32.3% reported riding with a drinking driver in the past 30 days (Louisiana Department of Education, 2009). These rates were slightly lower for African American students.

Among the 12th graders, a profile of high risk emerged: 38.5% of the youth reported a perceived availability of drugs in their neighborhood (36.2% of African American youth, 32.3% the perceived availability of handguns available in their neighborhood (36.2% African American youth), 41.9% youth reported their parents attitudes favored drug use (27.9% African American youth), 31.0% reported their friends use drugs (21.1% African American youth), 32.3% reported depressive symptoms (29.3% African American youth), 10.2% reported suicidal ideation (10.0% African American youth), 7.0% reported experiencing bullying 6.6% African American youth), 14.2% reported hitting or striking a peer (19.6% of African American youth), and 21.8% reported not feeling safe at school (28.1%). Though African American youth substance use is somewhat less than statewide averages, risk factors in other areas are increased.

PART III

THE SAFETY NET FOR YOUTH

We made progress (in mental health services)…but clearly we have much to do and we have much further to go.
David Satcher, Former Surgeon General

While mental disorders may touch all Americans, either directly or indirectly, all do not have equal access to treatment and services. The revolution in science that has led to effective treatments for mental illnesses needs to benefit every American of every race, ethnicity and culture.
David Satcher

Promoting mental health for all Americans will require scientific know-how but, even more importantly, a societal resolve that we will make the needed investment. The investment does not call for massive budgets; rather, it calls for the willingness of each of us to educate ourselves and others about mental health and mental illness, and thus to confront the attitudes, fears, and misunderstandings that remain as barriers before us.
David Satcher

PART III

THE SAFETY NET FOR YOUTH

The field of children's mental health has been revolutionized by the ground-breaking work of recently deceased Jane Knitzer in her work *Unclaimed Children: The Failure of Public Responsibility to Children in Need of Mental Health Services* (1982). This report spurred widespread improvement in service delivery for the most needy of children across the nation. The national development of concepts and implementation "systems of care models" characterize how services have been re-conceptualized based on this seminal work (Stroul, 1996).

To update Knitzer's work and policy recommendations, Cooper, Aratani, Knitzer, Douglas-Hall, Masi, Banghart and Dababnah (2008) did an exhaustive review of existing state efforts in children's mental health and provided a new set of recommendations. They surveyed:

- 53 mental health state and tribal authorities
- 19 mental health advocacy organizations
- 700 respondents in a local study (California)
- 100 key informants from a statewide system study (Michigan)
- 80 children's mental health and cultural and linguistic competency directors.

From this project, progress is reported as well as the future challenges in establishing the children's mental health safety net. The following is a list of some of their key findings:

- Children with complex needs that cut across traditional serviced silos (e.g., co-occurring disorders) pose the most challenges and state lack the scope to address these complex needs (22% of states report they do not serve children with complex needs well).
- Balancing complex needs in a public health framework is difficult for states to implement and advocates don't always see it happening.
- Most states have developed systems of care for these children but at varying levels of success in implementation (60% of states report statewide efforts at systems establishment) but they respond vary differently to the needs of the children and families.
- States have made progress in promoting evidence-based practices but only 12 states mandate its use, families are generally not engaged in this arena, and outcome-based services are not common.
- States report progress in being family and youth responsive in services but in 15 states the advocates were not aware of any progress.
- States (27) implement strategies and policies to support cultural competency.
- States have mixed records of capacity (infrastructural and information technology) to deliver outcome based services (19 states describe their systems as "rudimentary").
- States lack accountability and transparency to report children's spending across systems (only 11 states reported funding mental health conditions across systems). Children's mental health needs are readily apparent in child welfare, juvenile justice and education systems for example, but interventions cross-systems are rare.
- States recognize the need to use federal and state opportunities for funding, but most report barriers preventing use of such dollars through Medicaid to support effective interventions across systems.

- Related to Medicaid spending, most states report fiscal constraints in using dollars for treating children's mental health problems with Medicaid dollars, and they also report the simultaneous lack of provider capacity to deliver evidence-based treatments. Only 16 states report substantive cross system collaboration occurring, 16 states provide reimbursement, barriers to care related to diagnosing issues, and only 10 states provide non-medical office services which advocates and families call for in this arena. They note that 23 states report policies disallowing Medicaid expenditures for diagnosed mental disorders for youth in juvenile justice settings.
- States report limited capacity to have and use data-driven outcome information on which to plan and implement services.
- States report fiscal barriers to increasing services.

The areas most states would like to see reforms are better partnerships with the federal government for doing prevention and early intervention, workforce training, and also for internal statewide systems reforms to get around barriers to systems development.

Based on the "Unclaimed Children Revisited" research (Cooper and others, 2010) make a series of recommendations. These recommendations are woven into the recommendations of this report (See section V of this report).

Louisiana Office of Behavioral Health (formerly Office of Mental Health)

The safety net provided for youth influence how youth manage their problems. This section briefly describes some aspects of the safety net for youth in the LA-Y.E.S. service area. The Louisiana Office of Mental Health (OMH) developed the Louisiana Community Mental Health Services Block Grant (2007) which provides a component of safety net guiding the emotional and behavioral well-being of youth in the LA-Y.E.S. service area. Some key descriptive features in the report indicate risks and vulnerabilities as well as structural supports:

- In 2005/2006, OMH reported providing services to 4,886 children through Medicaid funding. OMH reports of the 946,926 youth, (.5% of the states children between 0-17). OMH estimates 9% of the state's children have a serious emotional disturbance. Thus, they estimate 4.17% of the states youth with serious emotional disturbance receive any kind of services they provide.
- As of June 2006 (Post-Katrina), most parishes reported a serious lack of providers. For example, the MHSD reported having 10 FTE psychiatrists available, no child psychiatrists. JPHSA reported having 9 psychiatrists, 2 child psychiatrists. Other parishes in the service area report having none. (Anecdotally, other programs report difficulty in recruiting related mental health providers for staff or contract services and those that have these providers report high turnover among its vulnerable professional staff).
- "In Louisiana, only 7-14% of children with mental health disorders are receiving services and only 13% of the Office of Mental Health's budget is spent on children's services."

A report called "A Roadmap for Change" prepared for the Department of Health and Hospitals provides other data on the mental health safety net in Louisiana:

- Youth (and adults) with mental illness are drastically unemployed and underemployed in Louisiana.
- Mental health services for youth (and adults) and their families are woefully inadequate for those coming through the criminal justice and family court systems.

- Louisiana has an inadequate financing structure to ensure access to appropriate mental health care.
- Louisiana currently makes very limited use of evidence-based and best practices.
- Louisiana lacks alternatives to traditional crisis services thus creating an even greater shortage of the state's acute, inpatient bed capacity.
- Louisiana is 38th in the nation in terms of suicides.
- The capacity of the mental health programs are challenged in meeting the needs of its diverse populations.
- Louisiana is facing a serious shortage of professionals trained in delivery of evidence-based or best practices.
- Louisiana lacks a system for assessing behavioral health needs at the community level.
- Mental illness and substance abuse problems contribute to a serious homelessness problems in Louisiana.

Various OMH programs provide services to children and their families

- Louisiana Spirit (crisis and follow up services for traumatic stress).
- Early Childhood Supports and Services (promotes a positive learning environment for learning, growth, and relationship building. It provides screening, counseling, violence-prevention, care management, behavioral modification, parent support, and emergency interventions).
- Louisiana Youth Enhanced Services (see introduction).
- Juvenile Justice Reform (HRC 0005 and HB 1372) commits the Office of Mental Health to work with incarcerated youth as "restoration service providers".

The Community Mental Health Services Block Grant (Office of Mental Health, 2007) funds various programs for youth: school based mental health; crisis response services; in-home crisis; crisis hot line; suicide prevention; crisis/respite; crisis housing; counseling; case management; family preservation; assertive community treatment; juvenile diversion; after school/mentoring; wraparound; transportation; and multi-systemic therapy. These services are often provided through the human service districts and generally not available statewide (often only in few select parishes).

The *Louisiana FY2010 Block Grant Plan: Children/Youth Families* (2010) reflects services post-disaster that have been built into the service array (2008 data). Louisiana Spirit as a program greatly increased mental health services to children and their families with traumatic exposure. The following table from the "Plan" summarizes some of this increased service reach:

Children Served

10/1/08 to 5/31/09	Individual (ICCs)	Group Sessions	Group Participants	% of those in need served
0 to 5	134	21	324	
6 to 11	192	126	961	
12 to 17	569	120	967	
Totals	895	267	2,252	4.3%

Service Program Funding

Mental Health Rehab Services	Numbers Children Seen
Children: Medicaid Funded	5,205
Rehab Agencies Statewide	68
Seen at the MHSD (Metro Orleans)	63 youth served

Children Served by Parish

Unduplicated Count Children by Parish	Numbers Served in 2008
Orleans, Plaquemines and St. Bernard	784
Jefferson	2,496
Statewide: Inpatient	6,220
Statewide: Outpatient	

Louisiana Office of Public Health

The Louisiana Office of Public Health (2008) reports parish health profiles which reflect the health infrastructure in Louisiana parishes compared with others. The last data reported is for 2005. Further data is collected every two years nationally, though Louisiana did not participate in 2007 in the data collection.

Severe Mental Illness by Parish

Severe Mental Illness	Orleans	Jefferson	St. Bernard	Plaquemines	St. Tammany	Louisiana
Children	11,647	10,373	1,526	703	4,896	109,782*
Adults	9,237	8,845	1,307	492	3,559	84,479
Suicide Attempts	576	692	85	433	168	5,845

*Number of estimated adults with diagnosable mental illness in LA is estimated to be 650,000 and the number of children 245,000

The Louisiana Office of Behavioral Health (Block Grant Plan, 2010) estimates the number of seriously mentally ill children to be 5,775 in Orleans, 503 in Plaquemines, 685 in St. Bernard, and 9,311 in Jefferson Parish.

Key Indicators on Health in Louisiana

Indicator	Orleans	Jefferson	St. Bern	Plaquem.	St. Tam	LA	USA
% in poverty	27.9%	13.7%	13.1%	18.0%	9.7%	19.6%	12.4%
Children in Poverty	40.5%	20.3%	17.1%	20.9%	12.3%	26.6%	16.6%
Adults unemployed	9.5%	5.6%	5.8%	6.7%	3.8%	7.3%	5.8%
School Attendance	91.6%	93.1%	93.4%	95.5%	94.0%	93.5%	
School Dropout	11.0%	8.3%	5.2%	4.6%	4.2%	7.0%	
Infant Mortality	13.0	7.7	10.6	7.8	6.9	10.2	7.0
Prenatal Care	78.5%	84.7%	89.7%	82.8%	88.9%	83.8%	83.7%
Adequate Prenatal	74.7%	78.0%	79.9%	81.3%	85.4%	78.9%	76.2%
Low Birth Weight	13.3%	9.4%	9.5%	8.3%	7.9%	10.5%	7.7%
Birth to Teens	-	13.3%	12.7%	14.4%	9.9%	15.5%	10.6%
Child Immunization	-	-	-	-	-	69.8%	78.5%
Syphilis*	-	-	-	-	-	4.1	2.5
Chlamydia	959.4	324.9	193.4	276.6	208.6	469.8	304.3
Gonorrhea	591.9	163.3	96.7	82.2	55.9	265.6	116.2
TB	14.1	5.4	2.9	11	3.6	5.8	5.1
Heart***	237.7	246.5	283.1	204.3	189.5	248.4	241.7
Cancer***	232.0	214.7	242.7	186.1	184.9	209.7	193.7
Cerebrovascular Disease***	69.4	57.0	43.4	-	46.9	57.4	56.4
Accident***	28.5	46.3	67.4	-	45.9	46.7	37.0
Diabetes***	61.5	51.3	49.4	-	31.6	39.5	25.4
Respiratory***	34.4	40.4	41.9	-	40.2	37.8	43.3
Child Abuse	12.0	6.2	26.9	1.9	7.7	10.9	12.4
Motor Vehicle Deaths	2.1	2.0	3.1	2.7	2.4	2.1	1.5

*rates per 100,000
**from LA Office of Public Health (2008)
***death rates

Other Sources of Health Vulnerability Reporting

The Agency for Healthcare Research and Quality (2009a) reports on a wide range of health care quality variables which describe the context of risk. Variables related to youth health outcomes are reported below. The data available in this report format is from national data—state and local is not reported. Although the prevalence of mental disorders is similar for racial and ethnic minorities and whites, minorities have less access and less likely to receive needed care (AHRQ, 2009a). People with lower incomes and lower education are least likely to receive care.

Quality Indicators

Variable	Achieved %
Received prenatal care in the first trimester	83.9%
Children 19-35 months received all recommended vaccines	80.6%
Children 3-6 who had vision checked by a health provider	60.2%
Children 6-17 who received advice on exercise by provider	35.8%
Children 6-17 who received advice on nutrition by provider	62.0%
Suicide deaths per 100,000 (ages 0-17)	13.2
Received needed treatment for substance abuse (ages 12-17)	20.3%
Received minimally adequate Tx for mental disorders (adult)	29.4%
Emergency visits when left before being able to be seen (ages 0-17)	2.2%
Caregiver reported poor communication with provider (children seen)	5.5%
Percentage of core measures of health (35) not showing improvement for African Americans compared to Whites	77%

The Agency for Healthcare Research and Quality (2009b) examined treatment for depression and found 69.4% of adults with depression received treatment in the past 12 months, though African Americans and Latinos/Latinas were statistically significantly less likely to receive treatment. Their research indicates that 30% of adults who received care received minimally adequate treatment—about 23% for African Americans. Minorities and those with less education received less adequate treatment—though their was no statistically significant difference for those with low incomes. Data on youth was not presented in this report.

The Urban Institute provides an ongoing assessment of Post-Katrina social conditions. Zedlewski (2006) assesses the key issue of the local safety net. This report notes the most vulnerable: the elderly; people with physical and mental disabilities; and single parents out of the labor market. Rebuilding provides an opportunity to strengthen the safety net.

One way of tracking the strength of the social safety net for children and youth is to track children's spending in the federal budget. A recent analysis in "Kids' Share" (Carasso, Steuerle, Reynolds, 2007) in an Urban Institute report indicate:

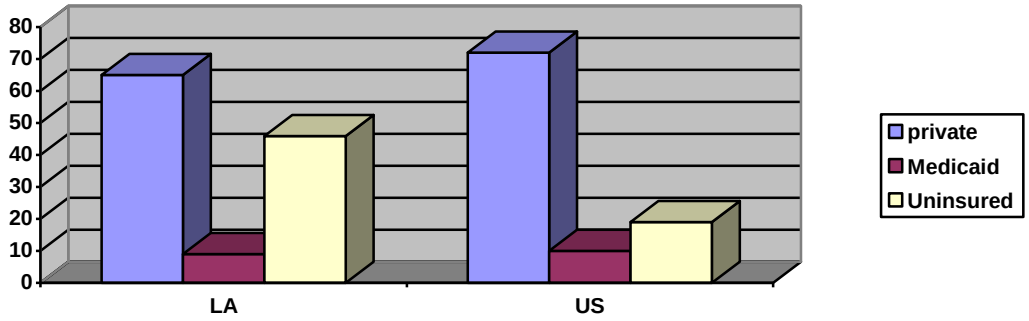
- From 1960 to 2006, children's spending rose only from 1.9% to 2.6% of the federal budget; other entitlements rose from 2.0% to 7.6%; as a percent of federal domestic spending, children's spending declined from 20.1% to 15.4%.
- Federal spending tends to target the very poor (increased from 11% to 61% of children's spending) with steep phase outs; less middle-class support; tax programs decreased (from 68% to 7%).

The Children's Health Campaign (2006) notes gaps in the safety net around coverage for basic health care (which reflects mental health coverage):

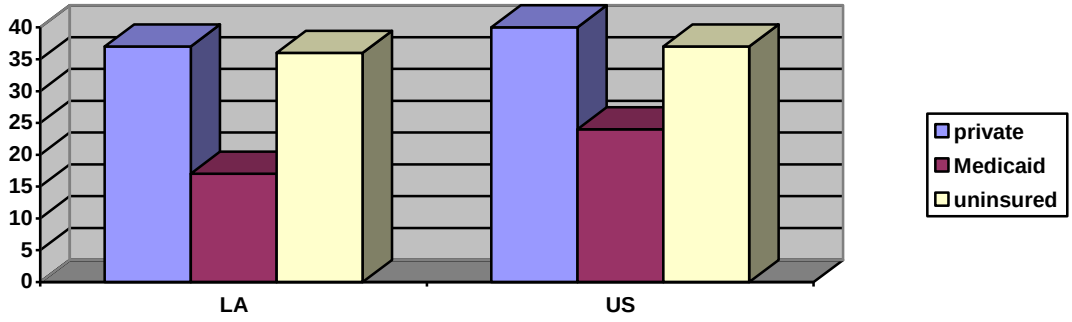
- There are 1,200,000 children under 19 years of age in LA; 135,000 are estimated to have no health coverage;
- 11% of Louisiana children have no coverage (78% of low income children have no private coverage)
- 79% of them have working parent(s)
- 9% of children under age 6 are uninsured (risking a healthy start on life)

The Kaiser Family Foundation (2007) reports on the safety net for women who provide the care for most vulnerable children in Women's Health Policy Facts. This data is illustrated in the following charts:

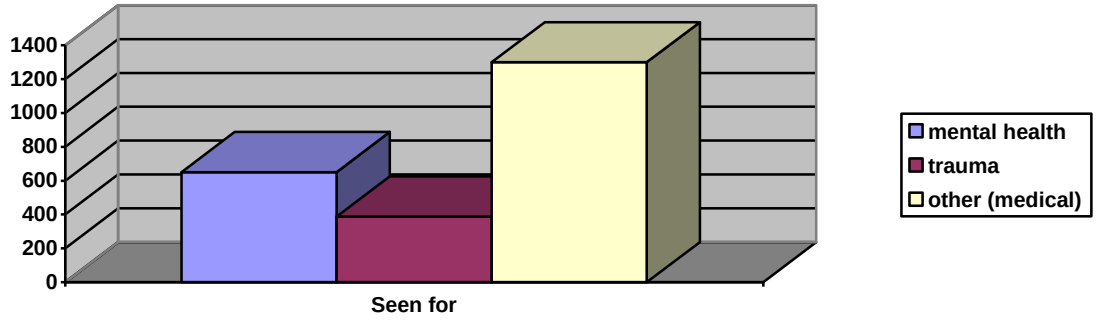
Percentage of health insurance coverage for women



Percentage of health insurance coverage for low income women

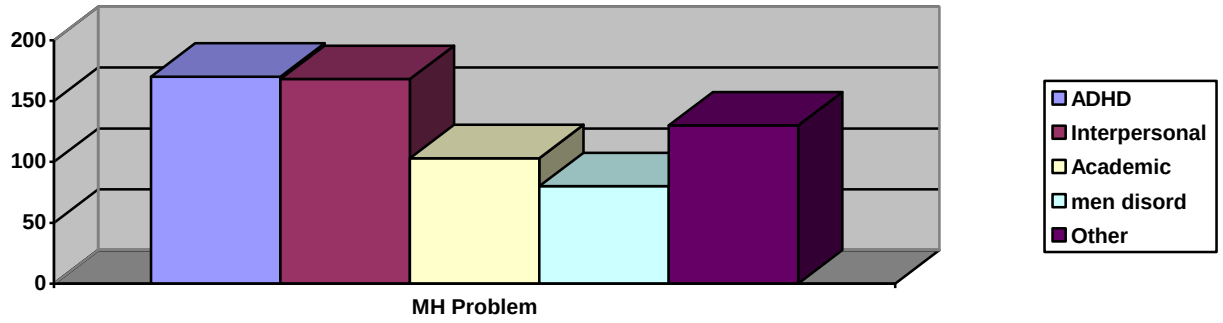


Jefferson Parish School Based Health Clinics: Numbers seen in clinics—Bunche Site



One key way children's mental health needs are directed through community-based provider networks is through the school-based clinics. A report form one of these clinics gives a snapshot of the mental health of youth in our service delivery area. The Jefferson Parish School Based Health Clinics (2007) report "Mental Health Related Visits—Bunche Site".

Number of mental health related problems reported at the School Based Clinic



The safety net provides supports for vulnerable youth yet gaps exist in care availability and access. The mental health safety net includes a variety of providers financed through multiple funding mechanisms. A broad overview of the mental health safety net (Bendsen, Blair, Holandez, Lutwick, Parkes, Sagness and others, 2007) describes some of the essential components of these inter-related care sources. The following table summarizes their descriptive list. It is not meant to include all possible services—just some key noted ones.

How the Local Parishes are Ranked in Health Infrastructural and Health Outcome Variables

The Robert Wood Johnson Foundation (2010) reports data that reflects Parish-level data on health infrastructural and health outcome variables. This data describes health characteristics of the context of mental health care for youth in the area.

Rating Health Infrastructure Outcomes by Parish

Rank	Health Variable	Parish
59	Overall Health Outcomes (combined mortality & morbidity)	**Orleans**
16	Overall Health Outcomes (combined mortality & morbidity)	Jefferson
62	Overall Health Outcomes (combined mortality & morbidity)	St. Bernard
13	Overall Health Outcomes (combined mortality & morbidity)	Plaquemines
62	Mortality rates (length of life; premature death; loss of life before 75)	**Orleans**
21	Mortality rates	Jefferson
60	Mortality rates	St. Bernard
10	Mortality rates	Plaquemines
47	Morbidity rates (reported poor health; days of poor health; poor mental health; low birth weight)	**Orleans**
14	Morbidity rates	Jefferson
59	Morbidity rates	St. Bernard
20	Morbidity rates	Plaquemines
11	Healthy Behaviors (smoking; nutrition; exercise; alcohol use; risky sex behavior)	**Orleans**
6	Healthy Behaviors	Jefferson
43	Healthy Behaviors	St. Bernard
16	Healthy Behaviors	Plaquemines
63	Social & Economic Risk (education; employment; income; family support; community safety)	**Orleans**
18	Social & Economic Risk	Jefferson
54	Social & Economic Risk	St. Bernard
17	Social & Economic Risk	Plaquemines

The Health Rankings below compare Orleans Parish health variables with statewide health variables (Robert Wood Johnson Foundation, 2010):

Orleans and Statewide Ratings of Health Outcomes

Health Variable	Orleans Parish	Louisiana Statewide
Premature death	14,216	10,807 (per 100,000)
Reported poor health	17%	19%
# days poor health	3.5	3.6
Poor mental health days	3.3	3.0
Low birth weight	13.4%	10.8%
Adult smoking	22%	23%
Adult obesity	28%	31%
Binge drinking	17%	14%
Vehicle crash death rate	12	23
Chlamydia rate	934	452
Teen birth rate	59	56
Uninsured	20%	21%
Primary care provider	278	119
Preventable hospital stays	113	83
Diabetic screening	72%	75%
Hospice use	31%	31%
High school graduation	13%	60%
College degree	29%	20%
Unemployment	6%	5%
Children in Poverty	36%	27%
Income inequality	54	48
Inadequate social support	26%	23%
Single parent households	12%	12%
Homicide rate	49	13
Access to healthy food	22%	38%
Liquor store density	0.8	0.4

National Alliance on Mental Illness (NAMI)

The National Alliance on Mental Illness (2009) issued a report card grading the states on healthcare provided for adults with serious mental illness. They reported a state by state review of mental health and rated Louisiana very poorly (a grade of "D").

Mental Health Rates

Categories	Detailed Scores	Grades
Health promotion and measurement	Use of evidence-based practices; emergency room wait times; quantity of psych beds available	D
Financing & Core Treatment/Recovery Services	Medicaid reimbursements for care; effective services	D
Consumer & Family Empowerment	Families provided essential information; consumer-run programs; family education & supports	D
Community Integration and Social Inclusion	Collaboration among state agencies	D
Innovations	Capital Area Human Service District; Road Home funding for care; co-occurring training	D
Urgent Needs	Crisis and community-based care; financing under Medicaid; workforce shortages	D

NAMI gave six states a B, eighteen states a C, twenty-one a D, and six an F.

Children's' Mental Health Related Services Infrastructure (January 2007)

New Orleans Adolescent Hospital	Two walk in clinics in New Orleans; one planned for Plaquemines Parish; NOAH's Arc Mobile Medical Unit
Nurse Family Partnership	Prenatal and early childhood home visits for some low income women
Early Childhood Supports and Services (ECSS)	Infant mental health providing screening, evaluation, referral and treatment
Louisiana Spirit	Crisis counseling; CBITS in schools
LSU Health Sciences Centers	Outpatient clinics; traumatic stress screening
Metropolitan Human Services District	Outpatient clinics
Tulane University	Outpatient clinic; mobile medical units
Non-Profit Providers (Catholic Charities; Jewish Family Services; Celebration Church Counseling; Counseling Services of New Orleans; McFarland Institute; Mercy Family Center; Chambers Counseling Center; Trinity Counseling; Children's Bureau; Common Ground; Family Services)	Various counseling approaches and models;
School Based Clinics	(5 clinics planned in Orleans; 4 in other areas)
Project Fleur-de-Lis (Mercy Family Center; Catholic Charities; Daughters of Charity)	Counseling in Catholic Schools and some Charter Schools
VIA Link	211 system
Louisiana Public Health Institute	Coordination activities; workforce development School based health centers
Southern University at New Orleans/Louisiana Youth Enhanced Services (LA-Y.E.S.)	Workforce development (post-masters certificate in treating child traumatic stress)
LA Health Care Redesign	Governor's Task Force—mental health access

In a 2010 study follow up to mental health care satisfaction, the Commonwealth Fund (2010) reported:

- 20% of clinic patients reported being told by medical providers that they have mental health challenges
- 50% reported a need for mental health services
- 78% followed up when recommended for services.

This data speaks to the need to coordinate services linking primary care with mental health care to tap into the great need and the barriers to services.

United Way of Greater New Orleans

The United Way of Greater New Orleans funds a variety of service areas that support mental health. Post Katrina, a re-examination of priority areas shifts support areas, but the following table provides some examples of these related supports. This work is being challenged again by the current disaster in United Way's service area which overlaps that of LA-Y.E.S. These supportive programs promote family well-being and reduced stress on vulnerable families as well as promote access to care.

United Way Supported Community-Based Support Agencies

Service Area	Program Examples
Child Care	Faith-based organizations; community centers
Housing/Shelter	Battered women's programs; emergency shelter; rental assistance
Health	Disorders (e.g., AIDS; hearing impaired; substance abuse)
Mental Health	Prevention; counseling; evidence-based models of care; crisis services; care management; special populations
Community Development	Neighborhood building; data infrastructure
Youth Development	Advocacy; emergency assistance; mentoring; support for at risk youth; prevention

Families and children do better when their comprehensive needs are adequately addressed. This improves a wide range of psychosocial features in the lives of the families as well as supports broad public improvement. Funding of comprehensive care for addressing the youths with mental health problems is demonstrated to be effective through evaluation of programs across the country (SAMHSA, 2007). In an evaluation of systems of care services which provide wraparound services to families who have a child with emotional and behavioral problems, positive findings are numerous:

- Reduced costs due to fewer days in inpatient care.
- Decreased utilization of inpatient care.
- Reduced arrests result in per-child cost savings.
- Mental health improvements sustained.
- Suicide-related behavioral were significantly reduced.
- School attendance improved.
- School achievement improved.
- Significant reduction in placements in juvenile justice.

This national data provides a reason to understand why the safety net needs to be rebuilt as an urgent priority to the devastated areas of the region.

United Health Foundation Determinants of Health Outcomes State Ranking

The United Health Foundation (2007) ranks states in health outcomes. Louisiana moved up from the 50th in ranking (worst health outcomes) to 49th from 2006 to 2007. It shows strengths in areas of access to prenatal care, low rates of binge drinking at 13 years of age, and few reported days of poor physical and mental health. Its key challenges include low immunization coverage, high infant mortality, high premature death, high rates of uninsured, high percentage of children in poverty, high rates of preventable hospitalizations, and high cancer rates. The United Health Foundation (2007) rankings show improvements in the health infrastructure but also noted severe challenges. The following table reflects this ranking in Louisiana.

Ranking of Health Outcome Quality in Louisiana and US

Determinants	Variables	Value	LA Rank	US Values
Personal Behaviors	Smoking	23.4%	43	20.1%
	Binge drinking	13.1%	11	15.3%
	Obesity	27.1%	38	25.1%
	HS graduation	69.4%	39	74.3%
Community Involvement	Violent crime (per 100,000)	698	46	474
	Occupational Fatalities (per 100,000)	8.4	41	5.3
	Infectious Disease (per 100,000)	28.3	45	22.5
	Children in Poverty	23.8%	48	17.4
Public & Health Policies	Lack insurance	21.9%	48	15.8%
	Per capita public health spending	$121	33	$162
	Immunizations	72.3%	49	80.6%
Clinical Care	Prenatal Care	82.8%	6	75.4%
	Primary Care Physicians (n per 100,000)	113.5	26	119.9
	Preventable Hospitalization	119.9	48	78.4
All Determinants Combined			50	
	Poor Mental Health Days (previous 30)	3.2	18	3.4
	Poor Physical Health Days (previous 30)	3.3	17	3.6
	Infant Mortality	9.9	49	6.8
	Cardio Deaths (per 100,000)	349.6	42	317.5
	Cancer Deaths (per 100,000)	221.9	48	201.1
	Premature Death (Years Lost)	10,802	49	7,411
Overall Rank			49	

Louisiana Health Care Quality Compared to All States (Agency for Health Care Quality)

The Agency for Health Care Quality (2009) provides a snapshot view of benchmarks in health care quality comparing states with all states. The following table shows how AHCQ rated

Louisiana on what they consider key benchmarks. Very weak means nearly all other states have better averages and weak means most states have better averages.

Performance Measures of Health Quality for Louisiana

Performance Measures	LA Performance	Showed Improvement from Last Year
Overall Health Quality	Very Weak	Same
Preventive Measures	Weak	Improved
Acute Care	Weak	Decreased
Chronic Care	Very Weak	Decreased
Hospital Care	Very Weak	Same
Ambulatory Care	Weak	Improved
Nursing Home	Weak	Decreased
Home Health Care	Very Weak	Improved
Cancer Care	Very Weak	Decreased
Diabetes Care	Weak	Improved
Heart Disease Care	Very Weak	Decreased
Maternal and Child Health Care	Weak	Improved
Respiratory Disease Care	Weak	Improved

(No change was reported from the 2008 data to the current data).

The Commonwealth Fund

The Commonwealth Fund uses various key indicators to assess the ranking of states in Children's Health Outcomes based on various health infrastructure variables (McCarthy, How, and Schoen, 2009). The report uses data from 2007-2008 for this report. This report shows the infrastructure for health of Louisiana's children is near the worst in the nation. Louisiana ranked 49 of the 50 states for having the least favorable infrastructure for children's health care. This is a decline from the 48th rank in the last report (2004-2005). Though we tend to spend at rates that exceed national averages, we tend to have the poorest outcomes. The following table summarizes some of the domains considered in the report with an emphasis on those more directly addressing children's health outcomes.

Ranking of Louisiana Child Health Infrastructure (Commonwealth Fund)

Domain	Area	LA Ranking	LA Average	US Average
Access		37		
	Children insured	41	95.3%	91.4%
	Non-elderly adults insured	49	73.8%	82.2%
	At risk adults, visited Dr. past 2 years	6	88.7%	87.0%
	Adults, without a time that could not visit Dr. due to costs	48	82.5%	87.5%
Prevention & Treatment		45		
	Childhood immunizations	40	77.7%	80.1%
	Child-Medical/Dental Prevention Visit Past Year	33	68.6%	71.0%
	Child-received needed Emotional/behavioral care	40	55.3%	63.0%
	Children with Medical Home	43	55.3%	60.7%
Avoidable Hospital Use & Cost		51		
	For pediatric asthma	Na	6.291	253.5
	Hospital readmissions within 30 days	51	21.3%	17.5%
	Home health w/hospital admission	51	43.3%	28.7%
Healthy Lives		46		
	Mortality amenable to healthcare, deaths per 100,000	49	137.2	95.6
	Infant Mortality per 100,000	49	9.8	6.8
	Child obesity (10 to 17 years)	45	35.9	30.6
Overall		49		

Poverty is also impacted by the exposure of businesses to the Katrina-related disaster (LA Recovery Corporation, 2007):

- One year after the storm: the state of Louisiana experienced a 2.3% decline in businesses (business failures).
- One year after the storm in the five parishes in Southeast LA, there was a 25.6% business failure rate.
- One year after the storm, there has been a 13.3% decline statewide of prior businesses in operation; (Orleans experienced a 26.7% decline; St. Bernard a 53.9% decline; and St. Tammany experienced a 2.6% increase in business operations).

Risks to vulnerable children are impacted by the opportunity structures in the communities in which they and their families live. Not only youth are at risk, but disparities in risk threaten some youth more than others. The National Institute for Health Care Management Research and Education Foundation (February 2007) provides an example of this disparate risk:

- Disparities are found by race and ethnicity as well as socioeconomic status (SES); SES does not account for all the differences.
- Among poor children, 3 times more self-report "poor health" compared with all children; poor children are reported to have half as many doctor visits as do all children. Racial and ethnic minority youth groups are also reported to have half as many doctor visits than compared with all other children).

  Homeless youth are also at risk. Homelessness among children and youth at a national level indicates this is a vulnerable population needing to be considered in care planning. The federal Housing and Urban Development reports annually on homelessness.

The latest report on homelessness (HUD, 2007) indicates:

- HUD estimates in its 2006 annual report on homelessness that on any given day, 335,000 people are homeless. Nearly ¼ of all sheltered homeless people are 17 years of age or younger.

ACCESS TO CARE BARRIERS

A variety of access barriers exist for the youth and their families. This report summarizes a few examples of these barriers, some of which are related to relatively recent conditions and as well are related to structural characteristics of the communities in which families and youth live.

Robert Wood Johnson Foundation Access to Care State Report

The Robert Wood Johnson Foundation (December 2007) reported on what they considered key variables on access to health care by state. The following table reports on these key variables indicating Louisiana access relative to United States averages.

Key Access Variables (most recent data—2005/2006)	LA	US
Health Insurance Coverage and Income		
% of people with health coverage	83.1%	84.9%
Employer offered health coverage	52.5%	56.3%
% employees enrolled by employer offered coverage	73.6%	76.6%
% premiums contributed by employees enrolled in employer	20.4%	18.1%
% adults spending 20% or more on out of pocket medical expenses	10.5%	8.0%
Medicaid enrollment as a % of population	59.5%	46.5%
% of population at or above 200% federal poverty level	60.9%	68.7%
System-Wide Health Care Resources		
Physicians per 100,000 population	309	321
Hospital beds per 1,000 population	3.4	2.7
% population with a personal doctor or health care provider	76.8%	80.0%
% who can get medical care when needed	82.3%	86.7%
Safety-Net Resources		
PHC clinics per 100,000 under 200% federal poverty level	2.9	6.2
% hospitals publicly owned by state	39.8%	22.5%
Patients served by federal health centers	7.7%	16.0%

National data shows adolescents face problems in access to mental health and specialty care. NAHIC (2008) reports:

- 36.2% of all adolescents did not get needed mental health care
- 17.0% reported problems getting needed specialty care.

A recent article by the Times Picayune (Maggi and Moran, April 23, 2007) reports on the "mental health crisis" in the unavailability of psychiatric beds (all persons) in the Metropolitan area (Orleans, Jefferson, and St. Bernard Parishes). Data includes both adults and youth. They provide the following data:

Times Picayune Review of Hospital Beds

Parish	Psychiatric Beds	Before Katrina	Post-Katrina
Orleans	Bywater Hospital	20	0
	Charity Hospital	100	0
	Community Care Hospital	38	24
	DePaul-Tulane	52	0
	Kindred Acute Care	25	0
	Lakeland Medical Center	11	0
	Methodist Hospital	14	0
	New Orleans Adolescent Hospital	30	35*
	Psychiatric Pavilion of New Orleans	24	24
	Touro Infirmary	48	0
	Veteran's Affairs	25	0
	Orleans Parish Subtotal	**387**	**83**
Jefferson	Advanced Care	12	12
	Behavioral Health of Kenner	NA	8
	East Jefferson Hospital	33	34
	Generations	20	0
	Ochsner	16	12
	River Oaks	52	49
	West Jefferson Medical Center	16	16
	Jefferson Parish Subtotal	**149**	**131**
St. Bernard	Chalmette Medical Center	16	0

*New Orleans Adolescent Hospital has the only designated beds for youth prior to Katrina. Post-Katrina, these beds are for both children and adults.

As a result of the catastrophic loss of beds (more than 300) in Orleans and St. Bernard Parishes, the Times Picayune (Maggi and Moran, April 23, 2007) reported the state of mental health in the area as in crisis. They ran the headline for their featured article as "Mental Patients Have No Where to Go". Law enforcement are reported to have to bring in psychiatric patients for evaluations and wait with them because existing facilities (those that currently take crisis cases) do not have the capacity to handle crisis cases and so police are required to stay with patients during the entire process. This is generating a crisis in law enforcement time and resources. Many facilities are on a list to accept crisis patients, but police are focusing on sites where they do not have to spend exorbitant time, and thus are basically declining to bring in persons in mental health crisis. Patients are reported to sometimes spend days in the emergency room because of a lack of beds for them. Hospitals are reporting crises because they are not able to handle medical crisis because their emergency rooms are filled with psychiatric patients with

no place to go. Without treatment, many end up in jail. The criminal justice system says they are "paying for the breakdown in the mental health system". Presumably the detention facilities are picking up the cases. Prior to Katrina, police averaged 330 crisis calls per month for persons with mental health problems—Post Katrina the rate is 207calls per month. Orleans Parish Prison reserves 60 beds for "psychiatric" prisoners. The Orleans Parish Prison spends 20% of their pharmaceutical budget on psychotropic medications. Because of the collapse of the public out patient care in the area, the pressure on in-patient care is intense and crippling. The newspaper article quoted the Medical Director of the Office of Mental Health as saying "The thing about hospital beds is you only need them when your outpatient services have failed. We do not have the services to prevent hospital visits".

A General Accounting Office (GAO, 2006) report (Post-Katrina) summarizes some of the access issues:

- 80% decline in hospital beds post-Katrina; close of Charity/LSUHSC; of the 160 clinics operating before/19 remain operating post at 50% capacity; loss of 6,000 health professionals; 100 community health centers harmed—7 destroyed.

A Times Picayune Report (March 13, 2007) provides information on mental health care:

- 211 beds for men; 24 for women; 25 coming on line soon
- Times-Picayune Report March 12, 2007, p. A-5: 18 community-based health care clinics in operation in the greater New Orleans area (both public and private).
- The Greater New Orleans Community Data Center reported 11 hospitals open in the Greater New Orleans area as of March 30, 2007 (MCL/NO; Tulane; Ochsner Baptist; Touro; Children's; West Jefferson; Ochsner West Bank; Ochsner; East Jefferson; Tulane/Lakeside; and Ochsner Kenner).

The Center for the Advancement of Children's Mental Health (Mailman School of Public Health—Columbia University, 2007) also report consensus statements based on community forum information:

- There is a lack of centralized information on mental health needs or resources.
- There is a lack of communication and coordination between providers and community.
- There is a lack of treatment capacity (resources; human resources).

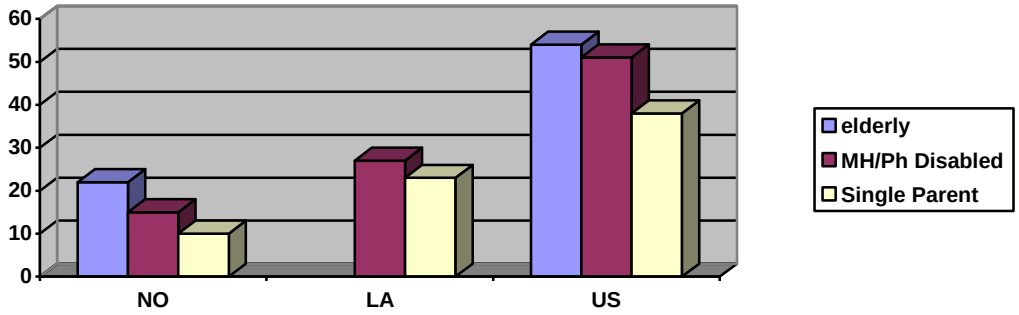
The Medical Center of Louisiana has opened a variety of community health centers intended to help improve health by increasing access to quality health services and preventive services. The centers are located at:

- Murray Henderson Elementary School
- Martin Behrman Elementary School
- Fredrick Douglas Senior High School
- Jackson Barracks
- New Orleans East Community Clinic
- HIV Outpatient Program
- Medicine Clinic Appointment Desk

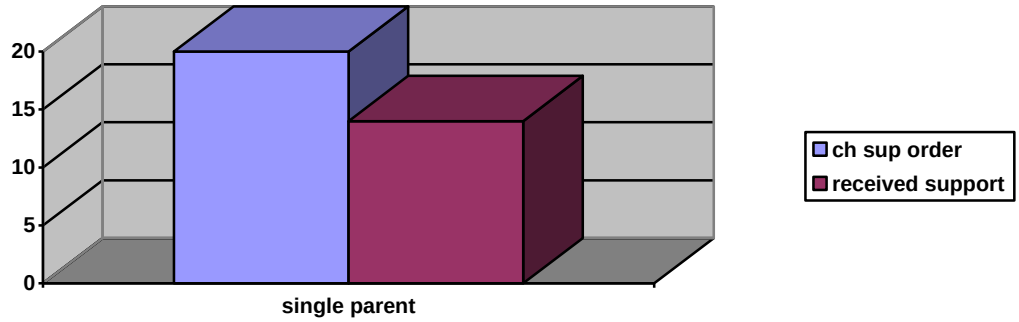
The Urban League (Zedlewski, 2007) reports poverty level percentage among vulnerable populations; (about 10% of population in NO w/disabilities; about 32,000 pre-Katrina); LA spends less than other states on its safety net (ranked 48 of 51). (E.g., LA does not supplement SSI payments for those with disabilities; does not have general assistance program for disabled). Though high rates of poverty, less than 3% in New Orleans receive public assistance; and 11% food stamps (7% nationally). The report indicates 20% of the children in New Orleans

experience ongoing hunger (2007). Nearly 50% of poor families paid own rent for housing (compared to 34% of poor in Baton Rouge); rent equaled 40% of income—16% in region.

Percentage of poverty of at risk groups (elderly; disabled; single parents) in LA

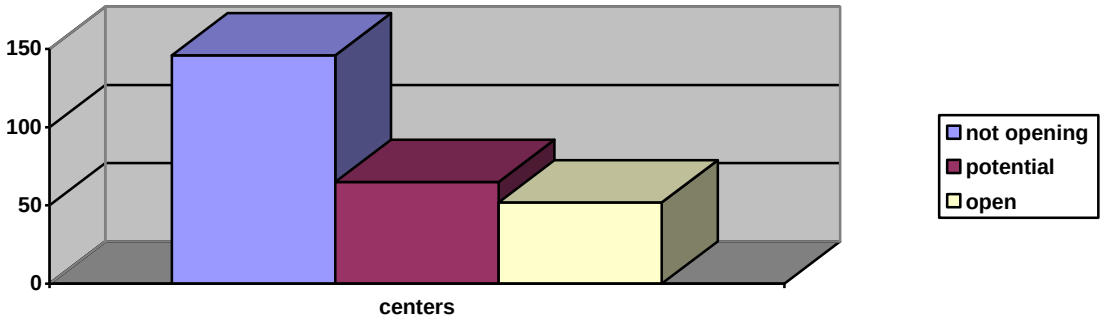


Percentage of families receiving child support in LA

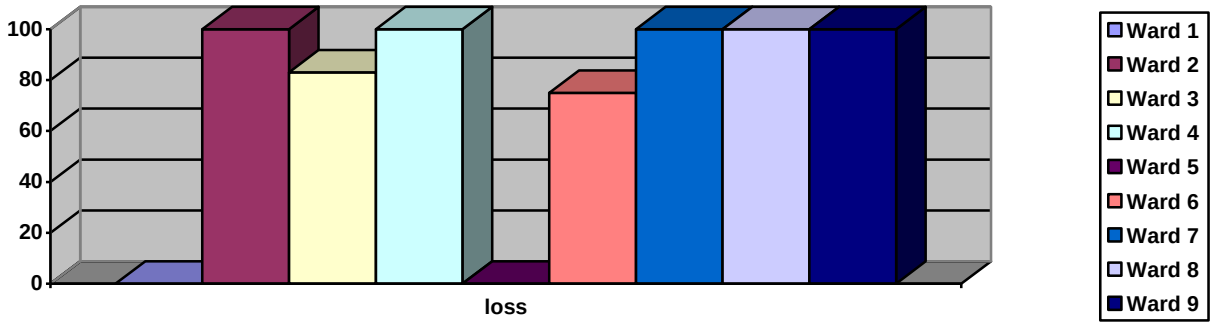


In an examination of child care needs Post-Katrina, Shores and others (2006) reported no child care "plan" exists (as of June 2006) for children in the New Orleans Metropolitan area. The June 2006 survey showed: 56% of prior centers were not re-opening; 25% were possibly reopening but not open; and 20% were open. This is an 80% loss of slots—closures and loss of spots are far outpacing the returned population. Their analysis indicated that 54% of neighborhoods have lost "all" slots. The following charts illustrate the loss.

Number of child care centers



Number of child care center loss Post-Katrina



The Greater New Orleans Community Data Center (February 26, 2007) also reports on the loss of child care facilities in Orleans Parish.

Child Care Centers in Orleans Parish

Child Care Facilities in Orleans Parish	Numbers
Open pre-Katrina	273
Re-opened	80 (29%)
Closed	193 (71%)
New Facilities	4

Access to child care in the metropolitan area is greatly limited.

The Greater New Orleans Community Data Center also reports on the limits on school space in Orleans parish as of January, 2007: Status of Public Schools in Orleans Parish. This data is indicated on the following table.

School Resources

School	Numbers
Recovery School District	19
Orleans Parish School Board	5
Algiers Charter School Board	8
Independent Charters	23
Total Schools	55
Number closed	77

The Times Picayune (April 30, 2007) provided a summary comparing school districts in Orleans and their special education populations.

Times Picayune Review of Special Education in Orleans Parish

	East Bank Independent Charters	New Orleans Public Schools	Algiers Charter Schools	Recovery School District
% of schools serving students w/mental disabilities	59.1%	100%	100%	100%
% of schools serving students w/emotional disturbances	59.1%	80%	100%	94.1%
% of schools serving students w/multiple disabilities	0%	20%	37.5%	23.5%
% of schools serving students with autism	22.7%	80%	75%	52.9%
Special Education total	465	207	326	610
Total Enrollment	9,753	2,825	4,664	8,381
% of student population in special education	4.7%	7.3%	7%	7%
% of all students served by the system	38.1%	11%	18.2%	32.7%
% of all special ed. students served by the system	29%	12.9%	20.9%	39.1%
% of schools with special ed. populations above 5%	50%	100%	87.5%	88%

Critics of this approach are concerned that the East Bank Independent Charter Schools are under-serving students with disabilities and mental health problems which not only limit access to families but limits choice.

Another key access point into care for low income families (generally excluding families of the working poor) is through Medicaid spending. The following tables provide a brief look at some aspects of access to care through Medicaid in the LA-Y.E.S. service area. The data from these tables are for the area just prior to the disaster (Medicaid Annual Report, 2004/05.

Medicaid enrollment as % of population in LA-Y.E.S. service area

Enrollment in Parish	Medicaid (% of all children)	La-CHIP (number enrolled)
Jefferson	22	14,380
Orleans	33	15,821
Plaquemines	22	901
St. Bernard	22	2,132
St. Tammany	16	6,030

State Medicaid Enrollment by Age and Payments

Children (0 – 20)	Percent
Enrollment (statewide total of who enrolled)	65%
Payment	24%

Some of the most vulnerable youth with serious emotional and behavioral disorders access care through the juvenile justice system. Data on the population of youth committed to the juvenile justice system at the end of 2006 were provided by the Office of Youth Development (2007).

The rates of mental health expenditures for community-based programs nationally is increasing—w as 16% in 1997; 20% in 2002, and 21% in 2004 (Cooper, 2008). It remains true that while 20% of children need mental health services, fewer than 20% of the children in need receive services (Cooper, 2008). States spend approximately 14% of funds on inpatient care, 3% on 24 hour care out of hospitals, and 83% on outpatient care. Louisiana spends more on in-patient care. Average in patient care is about $38,000 per child nationally, and $10,033 for outpatient care. Nationally, state general funds for mental health services have been declining (60% of all funds in 1997 to 42% in 2004) and Medicaid expenditures rose from 38% to 41% by 2004. Cooper's analyses of state spending came to various conclusions: Medicaid expenditures have expanded the role of states in children's mental health; the funding is "haphazard" and fragmented over-relying on residential care and underfunding community-based care and building the capacity for community-based care; the fiscal policy supports ineffective care and does not secure good outcomes; spending supports a lack of accountability; spending is not guided by national policy directives or guides building on evidence-based services.

Juvenile Justice Data

Parish	Secure Custody	Non-Secure Custody	Parole	Probation	Total
Jefferson	49	31	18	102	200
Orleans	28	6	29	163	226
Plaquemines	2	2	0	8	12
St. Bernard	2	0	1	2	5
St. Tammany	18	14	1	189	222
State Total	450	663	182	3407	4702

The population in secure facilities in 2007 was 77.9% African American, 20.4% Caucasian, and 1.7% other. The population was 93.7% male. They were incarcerated for: violent crimes (41.4%), drugs (11.2%), property crimes (30.2%), and other (17.3%). The most likely age was between 16-17 years old.

In March of 2007, the Office of Youth Development (2007) reports a variety of placements for youth to address a range of needs.

OYD Placements for Youth

Office of Youth Development Program (Statewide Data)	# of Youth	Yearly Average
Community Diversion	104	55.2
Day Treatment	370	293.9
OYD Foster Care	16	14.2
Group Home	190	198.8
Independent Living Halfway Home	12	13.5
Intense In Home	58	59.0
Private Psychiatric Facility	8	7.5
Residential	167	209.7
State Hospital	10	9.9
Substance Abuse	49	38.6
Total (including all in custody)	4755	4710.9

The following data summarizes some of the data related to access to care for these vulnerable youth.

The Coalition for Juvenile Justice (2000) reported some general data which provides a context for this access to care issue.

- 50 to 75% of incarcerated youth have diagnosable mental disorders.
- 1 in 3 in need of mental health care receives it.
- 36% of care givers say youth is incarcerated to get mental health care.
- Care reduces recidivism by 80%.
- 75% of incarcerated youth in juvenile facilities are without care resources.
- 67% of all incarceration costs go for care of mental health problems of the youth.
- African American youth are less likely to receive care and are frequently not diagnosed and misdiagnosed.
- 75% of girls incarcerated have been sexually abused (NB: from a presentation at Southern University at New Orleans sponsored by SAMHSA Dr. Linda Tempton reported that girls have higher rates of disorders than boys and receive less treatment).
- More than ½ of girls incarcerated have attempted suicide.

In a related report called "And Justice for Some: A Report on African Americans and Juvenile Justice", the National Council on Crime and Delinquency (2006) report on disparities in access for African American youth. They note that African Americans youth are:

- 16% of population.
- 28% of juvenile arrests.
- 30% of referrals to juvenile court.
- 37% of detainees.

- 34% of youth formally processed through juvenile court.
- 30% of adjudicated youth.
- 35% of youth formally waived to criminal court.
- 38% of youth in residential treatment.
- 58% of youth admitted to state adult prison.

The reform movement for juvenile justice provides an excellent opportunity for those involved in youth services to address the integration of mental health and youth development into service delivery for all youth, and especially supporting the most vulnerable youth such as those whose portal of entry into care may be the juvenile justice system.

Many vulnerable youth enter care through the child welfare system. This system was gravely impacted by the disaster. In 2005, the Office of Community Services (2007) reported that 7,145 children were in foster care in Louisiana. They reported 656 of these youth were provided services in institutional settings (residential facilities, psychiatric hospitals, or medical facilities). An estimated 2,300 foster children (already traumatized) were displaced by Katrina in Louisiana. These children need to be integrated into the service plan for the LA-Y.E.S. area.

Children and youth transitioning out of the child welfare system are important considerations in service planning and largely not integrated into care planning in the area. A key element of services is transitional services for youth with serious emotional and behavioral health problems. Davis, Geller, and Hunt (2006) outline some of this populations needs.

- (Getting GED; entering post-secondary education; employment help; preparing for independent living; help with adult relations; obtaining age-appropriate mental health services; transition planning).
- Reviewed both adult and children's services: fewer than 4 states provided any of these services. When available, access covered less than 8% with adult services and 22% of youth services.

This very vulnerable population is not addressed well nationally nor integrated into the service delivery system locally.

In a summary report estimating the numbers of at risk youth using just a three part estimate, the National Center for Disaster Preparedness (2007B) used the following table to demonstrate risk.

Estimates of Childhood Risk in Louisiana

Children at Risk	Percentage of Children
Educational Risk (scale of 0-10, had more than 3 point drop in grades)	25.4%
Health Access Risk (lost either medical home or medical insurance)	25.3%
Mental Health Risk (child had clinical diagnoses)	37.1%
Proportion with Any of these Risks	55.4%
% among households with incomes of < $10,000 annually	52.1%
% among households with incomes of > $35,000 annually	34.6%

The American Association for Retired Person's Public Policy Institute (2008) estimates that most long term care for people at risk is provided by non-paid caregiving. This is so at all ages and for all disabilities. This data is not broken down by age categories, but is inclusive of caregivers caring for youth with disabilities. They estimate great benefits in all states, including

Louisiana for this caregiving. Their estimate for Louisiana is that we save $4.4 billion by caregiver contributions (three times more than spent by Medicaid). Thus, the Children's Plan does focus on the context of care needed for children with serious emotional and behavioral problems.

The Louisiana Office of Mental Health (Children's Services)

The Louisiana Office of Mental Health (OMH) has overall responsibility for the provision of public mental health services for children statewide. In 2009 OMH appointed a Children's Services lead person (Gilda Armstrong-Butler, Child/Youth Best Practices) who also is the Principal Investigator for LA-Y.E.S.

The OMH (2009) Block Grant Application describes the statewide plan for children's mental health. The set aside for children for fiscal year 2008 was $16,043,045. The plan notes that the state is required to provide integrated services statewide for children with serious emotional disturbances. LA-Y.E.S. (an OMH program) provides such services in the metropolitan area—funded by federal funds for the provision of systems of care services.

The OMH plan (2009, p. 49) describes efforts to build on "systems of care" principles to improve the array of community-based services. Region 1 has six operational clinic community sites (in Orleans, St. Bernard) and also covering the LA-Y.E.S. area are Region II's clinics in Jefferson Parish.

The state mental health plan operates in an environment of considerable change in state services—the OMH plan (2009, p. 59) describes a variety of legislation impacting public health care and mental health service delivery in the state (including such areas as juvenile competency, appropriations, crisis services, telemedicine, trauma, forensics, mental health access, contracting, service integration, electronic medical records, crisis stabilization, and care access). The mental health plan very directly speaks to transforming children's services—such as implementing evidence-based interventions; suicide prevention (LA ranks #38 in suicide rates), cultural competence, workforce development, and directly speaks to children's services. The report documents that 7-14% of youth in the state have disorders, and only 13% of them receive interventions (OMH, 2009, p. 64). The plan notes few receive evidence-based interventions (plans to supply MST for example addresses this concern) as well as improving access (opening local clinic services to children are other possible solutions being developed). The plan identifies over-arching goals (p. 66) of increasing access to evidence-based care, access to crisis services, developing effective recovery-oriented services, provide comprehensive care, provide individualized services, and provide leadership in service delivery. These goals support systems of care development. The Child & Youth plan (p. 70) covers such areas as community-supports for services, consumer empowerment, service monitoring, comprehensive services, support services, crisis services (CART program) and workforce development as examples of connecting the plan with national guides.

LA-Y.E.S. is a vehicle for the implementation of the children's services goals expressed in the plan (OMH, 2009, p. 80). With extensive experience in working with trauma (post-disaster), workforce development has (through for example LA Spirit credentialing of professionals), the plan recognizes the need for integrating trauma-informed systems into service delivery (though it does not use this systems model terminology). LA-Y.E.S. serves approximately 45% of youth with trauma exposure and this would be increased if service integration with juvenile justice and child welfare further expands. Expansion of the continuum

of care is critical to this further integration of state services to the most at risk youth. (See surveys of the continuum of care later in this report).

Services in the region have had extra-ordinary services injected into the service delivery continuum because of post-disaster events. The crisis over the murder of a police officer by a person with serious mental illness brought renewed focus (and additional service support) to the area in 2006/2007 as well as the extensive crisis services by statewide LA Spirit temporary post-disaster programs. The Road Home Programs devoted resources to improve housing access for at risk populations. Co-occurring services received federal supports as well as focus on comprehensive care for early intervention for infants/early interventions.

Infrastructural Challenges, Local Action

The infrastructure for delivery of health care faces many challenges. This action plan operates in the context of a complex and large system of health care concerns. By most outside observations of quality and performance, much is needed to improve Louisiana's ranking as a dangerous and hostile place to raise children. Children's mental health is largely not a priority, not is it given the focus required to improve the climate for child and adolescent mental health.

In this past year, many changes have occurred in this context. The Metropolitan Human Services District is regrouping with the establishment of new priorities and vastly different policies and procedures. Efforts to especially implement Child and Adolescent Crisis Services are receiving attention. However, the needs are so great, and the infrastructure so badly challenged, that a concerted community based effort with widespread participation of key stakeholders is required to improve the system. This LA-Y.E.S. action plan endeavors to join in this ongoing challenge. The struggle for justice in health and mental health care requires planning and advocacy merged with commitment to service planning and implementation (Mancoske and Bowers-Stephens, 2009).

It is unimaginable that an area so badly harmed by the 2005 disaster would again today face an environmental disaster of unparalleled harm to the local economy, culture and well-being of children and families in the region. This review of risk does not adequately speak to the resiliencies manifested by those enduring ongoing impact. Though the outcomes of this are untold, the infrastructural barriers to children's well-being are replete with data telling us of children's well-being laden with risk and overall poor outcomes.

PART IV

REPORT RECOMMENDATION SUMMARIES

The federal government should pass legislation and design incentives to move the children's mental health system towards a universal public health model that begins with cross-system commitment to mental health promotion, prevention and comprehensive treatment.
Cooper and others, 2010.

PART IV

REPORT RECOMMENDATION SUMMARIES

This report provides a guide for ongoing examination of the systems development and reconstruction of the service delivery network for LA-Y.E.S. and the families and youth in the service parishes (Orleans, Jefferson, St. Bernard, Plaquemines, and St. Tammany). These recommendations come from a variety of community development, reconstruction and planning efforts over the past year three years in our service delivery area. These plans come from local professionals, families, and advocates who have brought resources and key informants together to address the needs of children and youth in our area. This has been supported by various outside sources, including reports from foundations, professional groups, and public policy advocates. This set of recommendations have been reviewed locally and involved professionals in the public and private sectors in a process of identifying elements of plans that would help families and youth regain lives in new and changed environments. Through a process of involving local stakeholders (families as well as providers and advocates as well as public service agencies), this list of recommendations are included into the conversation about a plan for children's mental health in the LA-Y.E.S. service area.

The following section summarizes recommendations from a variety of sources all thought to be important to this discussion of the development of a plan for improving children's mental health services in the LA-Y.E.S. service area. These areas are bulleted to provide the range and depth of the recommendations and yet to provide a concise overview of them. In earlier sections of this report, some of the data supporting their recommendations are provided. References to these reports are provided at the end of this report. The recommendations are not listed in order of priority.

SUMMARIES OF RECOMMENDATIONS

A. Recommendations on Vulnerable Youth and Improving the Safety Net

Center for Mental Health Services

Five years after Katrina, the area is still "rebuilding" and the crisis toll remains both incompletely addressed and lingering despite efforts to put the crisis behind us. The new crisis from the oil spill in the Gulf further exacerbates recovery and rebuilding efforts. Its impact is too new to adequately address. However, it is necessary to summarize why "crises has a profound impact on serious mental health and emotional problems" (Center for Mental Health Services, 2009):

- From a third to one half of homeless people have severe mental health challenges (SMIs).
- About 7% of all police encounters are with persons with SMIs.
- Those incarcerated are 4 times more likely to have SMIs.
- 6% of all emergency visits are by persons living with SMIs.
- 79% of emergency rooms report having people with SMIs waiting more than 8 hours at a time for care.
- 10% of psychiatric hospital discharges will be readmitted in 30 days; 20% in 180 days.

- 90% of inpatient psychiatric hospital stays involve people with traumatic exposure.
- 75% of juvenile incarcerations involve trauma exposure.
- 20% of juvenile incarcerations involve youth with SMIs.
- Mothers with SMIs are 4 times more likely to lose custody of their children.
- People with SMIs die on average 25 years younger than others.

As a result, the CMHS consensus panel makes the following recommendations:

- Access to support services be timely
- Services provided in the least restrictive environments
- Peer supports are available
- Adequate time is spent with the individual in crisis
- Plans are strengths based
- Emergency interventions consider the context of the individual's overall plan for services
- Crisis services are provided by those with appropriate training and competencies to evaluate and effectively intervene
- Individuals with a self-defined crisis not be turned away from services
- Interveners have a comprehensive understanding of the crisis
- Helping the individual regain a sense of control is an essential priority
- Services are congruent with the persons culture, gender, sexual orientation, health literacy and communication of needs of the individual serviced
- Rights are respected
- Services are trauma-informed
- Reoccurring crisis signal problems in assessment and care planning, and
- Meaningful measures are taken to reduce the likelihood of future emergencies.

The recommendations have a particular focus on infrastructure such as addressing provider capacities; philosophies of recovery; access to critical information; flexibility of resources; partnerships with clients; supportive organizational climates; coordinated systems of care; and establishment of rigorous performance standards.

Center for Disaster Preparedness—NCDP, (2006)

- Economic development programs should emphasize job retraining, skill building, and home ownership.
- Need community-based care managers to impact new neighborhoods, new schools.
- Need mechanisms developed supporting "community engagement".
- Maximize Medicaid/LA-CHIP enrollment.
- Assure ongoing supports for mental health engagement.

Gurwitch and Silovsky, University of Oklahoma Health Sciences Center, 2005

- Recommended guidelines for assessing the impact of the trauma on youth in elementary, middle school, and high school
- Specific recommendations to parents: be a role model (since how parents cope dictates how youth cope); take care of oneself (diet, rest, exercise); give oneself time to relax; put off making major decisions as possible; focus on an optimistic outlook; and ask for help.

Goldman (2006)

- Given the widespread and deep impact, the response needs to be commensurate (e.g., support Head Start and Early Head Start programs—demonstrated effective; multiple RTC studies support effectiveness).
- Programs need to be as comprehensive and community based as is the impact of the disaster.
- Need to focus on high quality (training—educators, mental health, caregivers of trauma informed practices; evidence-based care).
- Best responses: engage parents in interventions.

Zedlewski (2006)

- (Short-term safety net solutions). Food Stamp Program was one of the first responders: enrolled 900,000/$400 million in benefits after storm (reduced reapplication hurdles; feds paid administrative costs; $12 million for food banks). Need to assure easier access is maintained as programs stabilize.
- TANF benefits after storm exempted from the "clock". Benefit levels too low to help get families on their feet ($200 average per month for family of 3). Levels of payment exacerbate problems rather than solve them.
- Housing: need to address housing need for all poor families wishing to return…no comprehensive plan is in place.
- (Long range safety net solutions). Need to develop permanent plan to reduce poverty among the vulnerable (including families with a child with mental health problems). Goals: increase employment; increase savings rates; reduce single-parent head of households; reduce poverty rate). Strategies: basic skills training; GED completion rates; pregnancy prevention; supportive housing for at risk families.
- Need to provide support services to achieve goals: child care; transportation to facilitate employment/education.
- Develop programs integrating care for at risk youth that bridge gaps between education institutions and at risk populations.
- Include supports with housing for vulnerable families.

Madrid and others (2006) describe lessons learned from early child mental health responses

- Promote family resilience (emphasis on empowerment; reunify families; focus on strengths; assist with re-integration; deal with coping and losses; comprehensive needs assessments; emphasize dignity of each family; identify special needs families and youth).
- Identify the most vulnerable (poverty; race; lesbian/gay/transgendered; underserved; hire minority providers; focus on cultural and linguistic competence.
- Help families resettle (link to health, mental health, and social supports—wraparound services; community-based); link to health care.
- Mental health is key to resettlement (see NCDP guidelines above).
- Connect those trained in trauma care with families; develop resource connections; implement human resource development activities.

Zuckerman and Coughlin, (2006)

- Short run needs: provide focus on potential environmental toxins; provided concerted attention to mental health trauma (post traumatic stress disorders; depression, and other psychological distress problems; make sure mental health services are available to the poor and uninsured.
- Long range needs: expand public health insurance coverage for all people, including children through LA-CHIP; explore options in balancing public coverage with public health care; coordinate services (especially for youth) between public health, social services, and education developing an integrated system of care.

National Institute for Health Care Management (February, 2007) makes these recommendations to reduce health disparities among children impacted locally

- Develop strategies to expand coverage; expand culturally and linguistically competent care; reach out to immigrants;
- Successful health plan features: collect data on quality by at risk groups; provide provider training; focus treatments on disparities; develop "community-based approaches to delivery" (neighborhood; target populations; supports; stigma reduction; targeted education)
- Key points: collect adequate data; train providers; plan for cultural competencies; develop public awareness; partner with community-based groups; focus on disparities: quality and cost.

Knitzer & Lefkowitz (2006)

Ten strategies for helping the most vulnerable youth

- Expand access to all low income families to child development and family support programs.
- Provide evidence-based interventions in community-based programs.
- Embed intensive interventions into service programs.
- Organize service delivery by level of family risk.
- Provide basic supports along with intensive services.
- Develop partnerships (early intervention/child welfare).
- Screen for and address maternal depression and other risks in health care settings.
- Implement parenting curriculum and informal supports for higher-risk families.
- Build community-based services.
- Include vulnerable families in all advocacy strategies.

National Child Trauma Network (2004)

Recommendations for improving access:

- Many who get care have long histories of trauma: do early case finding and secure treatments.
- Engage in stigma reduction activities (public information).
- Integrate services into where children live—community-based services; school-based; community mental health clinics; hospitals; crime scenes; disaster shelters; and in home services.
- Focus on under-served (immigrants; rural; disabled; ethnic minorities).

- Make sure they receive effective interventions (few recommended: TFCBT; PCIP; CBITS) agency change is required: not services as usual.
- Monitor standards of care.
- Make sure affected areas have "trauma systems" work being done: focus on trauma at homes, in families, in communities—not mental health offices.
- Develop collaborations and advocacy groups to focus on trauma informed services.
- Do training and education for providers (at all levels): on evidence-based practices; adaptation of new treatments; provide on-going consultation; reach rural settings and minority populations (Cultural and Linguistic Competence); and runaway/homeless youth.
- Disseminate knowledge/resource information (public information); community partners sharing.

National Council on Community Behavioral Healthcare (2007) report: Discharged from hospitals, transitions home/Into the Community: Recommendations for continuity of care

- Collaboration between institutions and community based providers.
- Develop quality assurance benchmarks for related collaborators.
- Connect families to care management.
- Connect community providers before youth leaving institutions.
- Educate/empower families on personal care.
- Develop a focus on prevention of further institutionalized care.
- Share data between agencies on care outcomes in usable and timely ways.
- Involve families and their advocates at all levels of care.

Ray (2007). Recommendations for Lesbian/Gay/Transgendered Homeless Youth

- Commitments and monitoring of faith based service providers to assure non-discrimination (staff; other youth).
- Model programs for homeless youth identified and need to be replicated (NYC; Waltham, MA; Detroit; Ann Arbor; Denver).
- Federal policy (reauthorization of the RHY Act; health coverage; estimate prevalence; broad enough definition to include homeless situations common to runaway homeless youth).
- State policy (develop inclusive housing streams; provide dedicated space; do outreach to adoptive and foster homes; not criminalizing risk behaviors but provide effective interventions; expand health coverage).
- Local policy recommendations: (require non-discrimination by providers; develop and enforce cultural and linguistic competence standards; conduct cultural and linguistic competence training).

Shores and others (2006) Recommendations

- Help families in their communities (open centers near to schools that reopen).
- Target vulnerable families (open centers in areas with low income working families); subsidize low income families w/vouchers; support centers with successful learning programs (Head Start).

- NB: authors recommend this most highly: Build on program strengths (large scale; high impact; comprehensive; quality; responsive to families); (prioritize Head Start; Early Head Start); those already open; those close to open schools.
- Provide technical assistance to open sites; NB: provide needed mental health services at sites.
- Develop policies supporting "public/private" partnerships: incentives for businesses; set up opportunities for joint meetings; develop objectives for partnerships; sustainability of partnerships.

Coalition for Juvenile Justice (2000) General Recommendations

- Effective programs for incarcerated juveniles (more highly structured; focus on skills; focus on behaviors; culturally competent; families involved; community-based rather than institution-based; wrap-around services; youth-focused; strong after-care services).

Strategic Plan for Substance Abuse Prevention, Governor's Initiative (2006)

- Overall Goals
    - Profile population needs; resources; and readiness to address problems and service gaps (short-term and long objectives identified).
    - Mobilize and build capacity.
    - Develop a comprehensive strategic plan.
    - Monitor; process, evaluate effectiveness; sustain effective programs; improve or replace those that fail.
- Cross-Cutting Issues:
    - Sustainability: service integration required; support for action plans promoting objectives; develop community-support.
    - Cultural and Linguistic Competence: need for system wide plan; promotion of respect for diversity; services reflect populations served; assess disparities; build coalitions with diverse partners; develop state plan; review processes supporting competencies; evaluate outcomes.
    - Underage Drinking: absorbing more of state budget (review and analysis of problem); include college/age youth; partner with academic institutions.
    - Katrina/Rita Service Interruptions: clarify partnerships; points of contact; capture what is being done; have trained responders; do on-going post-trauma training; document disaster responses; assess human and financial capacity issues; ignore regional boundaries during duress of recovery.

Unclaimed Children Revisited (Cooper and others, 2010)

- A public health approach (prevention, early intervention) and systems of care approach should be codified into laws at federal, state and local levels.
- Children with serious mental health problems should be a priority in services to children.
- Comprehensive children's plans should have the authority to create empirically-supported evidence-based treatments into plans and access Medicaid for payments.
- Empirically supported family based treatments and supports should be at the center of state financing of care for children's mental health.
- Disparities across diverse groups of children's services should be addressed in an outcome-based approach.

- Poor infrastructure and information technology needs should be addressed.
- A financial strategy that supports a public health approach in funding care should be developed.
- Services should be outcome-focused.
- States should be encouraged to develop strategic plans to address these recommendations.

B. Recommendations on Human Resources

LaGreca and others (2006) (EBPs in treating childhood trauma)

- Make sure providers are trained in evidence-based practices (EBPs) and that trauma informed assessments and EBPs are provided.
- Trauma-focused CBT w/exposure techniques is recommended for not only PTSD but for youth with a wide variety of symptoms that are traumatic stress related (psychoeducation; exposure; cognitive restructuring).

National Center for Quality and Accountability. (Extracted from Matrix of Evidence-Based Practice Models)

- There are a wide variety of model programs but a key to quality is maintaining fidelity to the models and replications in different settings

The following table provides a brief descriptive overview of research supported models studied and reported on as those with an evidence-base.

Listing of recommended evidence-based models

Focus	Setting	Problem	Program Models Recommended
Prevention	School	Aggression; disruptive; SEDs; substance abuse; emotions; risk behaviors; suicide	16 programs sited
Prevention/Interventions	School	Violence; aggression	2 programs sited
	Across settings	Mood, conduct, aggression,	21 programs sited
Treatment Models	Clinic	Anxiety; mood; conduct; suicide	23 programs sited
	School	Mood; conduct	7 programs sited
	Across settings	Mood; conduct; aggression; anxiety; suicide; substance abuse	17 programs sited
Crisis Interventions	Across settings	Crises	8 programs

These program models are identified and recommended for implementation for those developing a plan for delivery of evidence-based models. The models are described in this report and fidelity to the models is part of the purpose of identifying the models for local applications.

LA-Y.E.S. Review of Cases and Need for Particular Models of Evidence-Based Interventions

In a review of the types of cases served by care managers in LA-Y.E.S. and a source of nine key reports on the use of Evidence-Based Interventions with Children and Youth, LA-Y.E.S. found the model with the most widespread applicability is primarily Cognitive Behavioral Therapy. This is the most widespread EBPP model applied to the most commonly seen problems (locally and nationally). It was recommended (see table below showing how many receiving services matched with the most highly recommended intervention models.

Based on current child and youth diagnostic problems, and the literature recommendations, we establish the highest level of priority for selection of Evidence-Based Interventions that are needed in our service area. Cognitive Behavioral Therapy needs to be our focus for service delivery and human resource development.

LA-Y.E.S. Diagnoses Linked With Recommended Models

PSYCHOTHERAPEUTIC INTERVENTION MODELS WITH LEVEL ONE/HIGH LEVELS OF EVIDENCE	Primary Dx*	Total % of LA-YES Need
Cognitive Behavioral Therapy (CBT; TFCBT; Exposure)	5, 5, 7, 18, 11, 1, 1	48%
Behavioral (behavior modification; contingency management)	20, 1, 1, 18, 1, 1	42%
Parent Management Training (parent training; video)	20, 18	38%
Psychopharmacology	20, 5, 11, 1	37%
Parent-Child Interpersonal Psychotherapy	18, 11	29%
Brief Strategic Family Therapy	18, 1, 1	20%
Functional Family Therapy	18, 1, 1	20%
Therapeutic Foster Care		1%
Multi-Systemic Therapy	18, 1	19%
Assertive Training	18	18%
Problem-Solving Therapy	18	18%
Rational Emotive Therapy	18	18%
Family Education	1	1%
Family Support	1	1%

*This is the number of different diagnoses where the model is highly supported and the percentage of LA-YES clients with this diagnosis indicating this model. These are in addition to our wraparound/comprehensive care management.

LA-Y.E.S. Summary

- CBT has the most numbers of LA-YES clients with this need and for the most different diagnosis.
- CBT appears to have the least cost involved for monitoring fidelity (can be monitored internally). It has the most trained providers (per the credential list).
- CBT has the most of LA-YES clients indicating this need. Therefore, we should perhaps move more toward developing our base of services with a focus on CBT.
- We may wish to consider focus of our purchase of services from the credential base to those that deliver CBT and stop providing non-evidence-based interventions.

- We may wish to improve our tracking and reporting of EBPPs. If the diagnosis is of a specific disorder, and the family chooses psychotherapeutic interventions, then we should make sure the ISP includes these services and that the care manager reports the services in the monthly reporting system (whether purchased by LA-YES or by community partners).
- All ISPs should review for the need for effective psychotherapeutic interventions and families informed of this benefit. Where we do not have the resources for provision, or unavailable from community partners, we should develop a plan for securing for this need in partnership with the Federation of Families for Children's Mental Health and the Mental Health Association.

The majority of LA-Y.E.S. children and youth served have traumatic experiences. These are compounded by the ongoing experiences along with the post-disaster experiences. One specialized form of evidence-based intervention is trauma-focused cognitive behavioral therapy, also highly recommended for implementation locally by all the sources addressed above.

As a cooperative project, Southern University at New Orleans School of Social Work partnered with LA-Y.E.S. to develop a post-masters certificate program in treating childhood traumatic stress. It has successfully trained 6 of its own staff and approximately 50 community partners. Those trained include providers serving youth in child welfare, public education, criminal justice, mental health, and non-profit providers. This program brings together providers from child welfare, juvenile justice, LA-Y.E.S., mental health, and community-based care providers to examine evidence-based and culturally competent models of care delivery for youth experiencing traumatic stress and to work on systems of care improvements. The program reviews the evidence-base, and some of this information is briefly summarized below:

<u>Treatment Guidelines (SUNO/LA-Y.E.S. Certificate Program Review, 2006/08)</u>

- NIMH Consensus Panel (2002)
  - Caution using "crisis debriefing" model; provide supportive counseling; triage more vulnerable youth; provide community-based services.
- APA Guidelines for Treating Acute Stress Disorder/Post Traumatic Stress Disorder (PTSD).
  - Community-based; interdisciplinary treatments;
  - Psychopharmacology; trauma focused cognitive behavioral therapy (TFCBT).
- Nathan & Gorman (Guide to EBPs: PTSD)
  - Psychopharmacology
  - Psychotherapies: TFCBT; (also forms of CBT: exposure; psycho-education; eye movement—EMDR); psychodynamic.
- Child Trauma Academy
  - 4 most supported models: CBT; psycho-ed; parent-child interpersonal psychotherapy--PCIP; psychopharmacology.
- National PTSD Center
  - High Evidence: none.
  - Medium Evidence: CBT (TFCBT).
  - Low Evidence: debriefing (cautions); EMDR. Psychopharmacology.
- American Psychological Association
  - CBT/w/ exposure; pharmacotherapy; EMDR (limited support); brief family therapy.

- Rand Corporation Studies
    - TFCBT in schools (several models of cognitive behavioral intervention treatment services—CBITS).
- Maine Department of Mental Health/Department of Social Services studies:
    - Doing uniform trauma informed assessments across all state agencies—link to EBPs for trauma interventions.
    - Most youth in the child welfare, juvenile justice, and mental health system exposed to traumatic stress and interventions should flow from this (using EBPs).
- Office of Victims of Crime
    - TFCBT; PCIP; CBT.
- Issues Integral to Child Trauma/TFCBT Model for Practice
    - Community violence (exposure); family driven care; CA/N; sexual abuse; adolescent HIV and risk behaviors/trauma influences; family violence; disaster mental health (Parent Child Interpersonal Psychotherapy—PCIP); Immigrant families/trauma—TFCBT; Cultural and Linguistic Competence; Family Supports (public policy in disasters); Psychopharmacology; Mental health/trauma policy; Fires/death; Cultural and Linguistic Competence with African Americans; Disasters (9-11); vicarious traumatization.
    - Other considerations: family focus; ethics; Cultural and Linguistic Competence; spirituality; and substance abuse.

C. Recommendations for a Comprehensive Array of Services

The Woodrow Wilson School of Public and International Affairs (Bendsen, Blair, Holandez, Lutwick, Parkes, Sagness, and others, January 2007) reviewed Post-Katrina mental health services for children and adults in the Orleans metropolitan area. They examined barriers to care, service provision, funding, and made recommendations to improve the overall system. They addressed five goal areas with specific recommendations with each area.

- Accessibility and affordability;
- Effective and evidence-based treatments;
- Adequate workforce and coordination;
- Sustained financing; and
- Suitable policy environment.

As a result of these goal areas, the group developed several specific recommendations to support these goals. The following table summarizes their recommendations.

Policy Recommendations

Area of Recommendation	Policy Recommendations
Workforce Development	▪ Relocation assistance; training programs; loan repayments; incentives for Spanish speaking providers ▪ Support Academic Partnerships: support helping professional training programs; support psychiatric residency programs; support training in evidence-based interventions
Integration of Mental Health w/Primary Care	Screening at primary care sites; develop shared medical record technology (mental health/primary care); redesign clinic flow to accommodate primary care/mental health care; cross-provider training and coordination activities
Information Systems	Need for improved information sharing (providers; consumers; policy makers) on service design, outcomes, costs; capacity/needs of families different than those of providers for basic information. Focus on three areas: on-line sharing data; print materials; outreach.
Transportation	Need for planning activities as well as service funding

The American Academy of Child and Adolescent Psychiatry (2007) developed recommendations for the establishment of principles and practices to guide the development of community systems of care. Their thirteen recommendations are:

- Assessments and intervention approaches for children and youth are guided by the ecology of their families involving comprehensive information from their formal and informal support networks.
- Providers are partners with families coming from a strengths-based approach.
- Mental health services are integrated with other services provided to families (including juvenile justice, child welfare, and other supportive networks).
- Services are culturally competent respecting diversity and focused on the most vulnerable and at risk children and youth.
- Services are individualized for the child and family and envelope the family in wraparound services.
- Services are based on the evidence-based practices.
- Providers (e.g., psychiatrists) play a variety of roles in teams.
- Psychopharmacology is integrated into care plans where indicated.
- Providers assume advocacy roles on behalf of children and families served.
- Providers and families share accountability for services and accountability is built into service delivery.
- Services are provided in least-restrictive environments, access potential is maximized, and level or intensity of services is based on informed and shared decisions.
- Transitions between systems should be addressed in care delivery.
- Prevention strategies are incorporated into care delivery.

This community system of care approach supports the development of a comprehensive array

of services. The Cooperative Agreement between SAMHSA and LA-Y.E.S. outlines the basic structures of this array of services.

SAMHSA (Systems of Care Cooperative Agreement with LA-Y.E.S.—2005-2009)

REQUIRED CMH SERVICES	OPTIONAL CMH SERVICES
Diagnosis and evaluation (assessment)	Screening for Eligibility
Care Management	Training (EBPs; ISPs; intensive services; Cultural and Linguistic Competence)
Outpatient (community-based care)	Recreation
Emergency services (24/7)	Individualized Tx
Intensive Home-Based Care (imminent risk)	
Intensive Day Treatment	
Respite Care	
Therapeutic Foster Care	
Therapeutic Group Home Care	
Transitional Services	

Local Key Informant and Caregiver Surveys on Service Access and Availability

The following table is derived from community input from key informants estimating the availability and access to both mandated and optional services essential to the LA-Y.E.S. system of care offered in each of the parishes. This data was collected at various community forums and at the monthly LA-Y.E.S. Consortia Meetings. The forms were also distributed to various community partners via email. This reflects the Post-Katrina fact of service paucity and dire need for children in our service area. The respondents were family members (16%), providers (43%), related children's service workers (26%), child advocates (21%), and others (8%).

2009 Key Informant Surveys of Service Availability and Access

REQUIRED CMH SERVICES	Orleans (n = 44)	Jefferson (n = 35)	Plaquemines (n = 23)	St. Bernard (n = 32)	St. Tam (n = 17)
Diagnosis and Evaluation	2.2*	1.9	1.8	0.9	1.6
Care Management	1.5	2.1	1.5	1.0	1.3
Outpatient (community-based)	1.4	2.1	0.7	0.3	1.0
Emergency services (24/7)	1.2	2.0	0.8	0.5	1.8
Intensive Home-Based Care	0.7	1.8	0.4	0.8	1.2
Intensive Day Treatment	0.8	0.8	0.4	0.2	1.0
Respite Care	0.8	1.7	0.6	0.3	1.0
Therapeutic Foster Care	1.2	1.5	1.4	0.6	1.1
Therapeutic Group Home Care	1.0	1.8	0.7	0.6	1.0
Transitional Services	1.1	1.3	0.7	0.3	1.0
OPTIONAL CMH SERVICES					
Screening for Eligibility	1.5	1.8	1.3	1.0	1.5
Training (EBPs; ISPs; intensive services; Cultural and Linguistic Competence)	1.0	1.6	1.3	0.5	1.3
Recreation	1.3	1.5	1.4	1.1	1.8
Individualized Tx	1.6	1.7	1.7	0.7	1.0

0 = services not available; 1 = services exist but very limited/restricted; 2 = exist but limited;
3 = exist widely with no substantive access barriers or Don't Know (not calculated in above averages)

Note on Methodology: this is not a random survey but a purposive sample of people thought to have some knowledge about child mental health service delivery in the parishes. Participants were asked to only speak to those they knew about and in the parishes they know about. We have approximately 90 respondents who are primarily LA-Y.E.S. consortia members including family members, community advocates, local providers, and a few LA-Y.E.S. staff. This is not meant to be a definitive summary of existing services but a reflection of key informants on what is available for families locally. The standard limitations from such an approach on reliability and validity are noted in this caution.

Key informants basically describe a dearth of services available to families with a child with emotional and behavioral disorders in their parish. The services most likely to be available in each of the parishes are help in getting a diagnosis/evaluation of the child and having the child screened for services—but the actual services needed are from very limited with multiple access restrictions. This is as much so for what SAMHSA calls required services for a rudimentary system of care as well as for optional services. This is so in each parish, though this is more pronounced in the more rural Parishes of St. Bernard and Plaquemines.

Family members were informally surveyed asking their general opinions on the availability and access to services for their child or adolescent who has some emotional or behavioral problems. This informal survey was asked of families (caregivers) in services with LA-Y.E.S. and of caregivers attending family organizational meetings. Approximately 7 families

shared ideas with us. The following table briefly summarizes some of the caregiver opinions shared. (Note, this is presented to engage in conversation about the needs of families and youth and not intended to be viewed as a scientific study of caregiver opinions).

2008 Qualitative Caregiver Survey on Children's Mental Health Services (n = 33 respondents)

Service Needs /Opinions*	Statements of Caregivers (numbers indicate caregivers reported same items as did others)
Services most needed by child?	• A service plan most directly focused on individual child needs • Summer camp; physical therapy; get counseling promised to family; mentoring (3) • Look at needs of all my children—not just one; evaluation only looks at one child also—but both need help • Interventions for specific behavioral and emotional problem • More counseling help (3) • Need behavioral therapy for child; anger management (5) • Help dealing with school system problems • More visits by youth coordinator; mentoring (3) • More information on medications; more intensive counseling • Need help for caregiver (2) • Really benefits from care management; likes care manager • Satisfied with services; child doing better (2) • Would like multiple family sessions • Would like mom only or dad only sessions • More community activities for youth (2) • Needs a youth support group • Need tutoring or school supplies (3)
Services needed by child but not available?	• Counseling; summer camp; physical therapy (2) • Transportation (8) • Follow up on help with child's problems • Help with problems dealing with schools • School liaison; help with youth transitioning into adulthood • Mentors (2) • Financial help to pay for needed services (8) • More therapies • Services just not available • Help with other problems (housing; work) • More activities needed for youth (5)
What is keeping you from getting services your child needs:	• Transportation (6) • Service not available (6) • Outside problems such as housing, work, etc. ( ) • Child care problems (4) • Other: knowing what help is out there; help is delayed when you need it;

	problems with school; child won't participate; can't find psychiatrist • Lack of finances (2) • Son needs a male role model
Ideas for improving service delivery	• Services get approved in a more timely manner; payment for supports like tutoring kept up—late payments—afraid services will be cut off • Have more available therapies (3) • Evaluate services and act on what you are told • Get follow through on help for my child • Help deal with schools (2) • Help motivating youth to get help • More activities (6) • Help finding money to pay for care needed (2) • Needs a youth mentoring camp; mentors (2) • Care manager is good but doesn't get the things son needs • Overall, things are OK now (7) • No complaints about services; "loves LA-YES) (4) • Likes care manager ( ) • Need to know more about available help

*Note on methodology. This informal survey was conducted by the Family Coordinator and Youth Coordinator asking all families who have an active care management case opened to participate in the survey. The survey was hand delivered to families and help in filling it out was offered if requested. This is not intended to reflect the opinions of all families in services (not a representative sample) but to describe the opinions of those who responded.

Based on the key informant surveys, it is evident that the mental health service infrastructure is in crisis, is extremely limited, and is costing the community by impacting overuse of juvenile justice, child welfare, hospital services is the most restrictive environments rather than in the least restrictive environments provided by community-based care. This crisis costs money by requiring services in more costly institutional structures, and costs increased burden on families and the community. This may well be the highest priority for community redevelopment reflected in this children's mental health plan.

Recommendations from the Center for Children's Mental Health at Columbia University School of Public Health (2006) based on several community forums in the Gulf Coast affected disaster areas:

- Technological Recommendations
    - Web-based common site for common access and sharing of trauma informed data; develop web-based disaster response software; shared data bases; updating resource directories (ongoing); on-line discussion groups (advocates; provides; families); portal to share EBPs (best practices); common site on EBPs for specific problems.
    - Support the 211 call centers.
- Education Recommendations
- Need for concerted efforts at training of care providers:

    - Parent empowerment; provider training (in what works—evidence-based practices); clinician support (assistance for vicarious trauma); training in psychoparmacotherapies.
    - Develop "empowerment materials" that educate parents on various psychological issues related to their children's mental health; informational tools for providers; resources for pediatricians.
- Human Resource Recommendations
    - Recruitment and hiring of new professionals (w/orientations; training); secure trained volunteers; support peer to peer and parent/family mentoring programs; tap into student volunteer resources.
- Financial Recommendations
    - Shared fund development; grant writing; partnerships; maximize donor impact.
- Recommended manuals on delivering services which are evidence-based and trauma specific (crisis follow ups; depression; anxiety; conduct; and parent empowerment).

<u>Voices of Youth in New Orleans on Recovery (Center for Empowered Decision Making, 2006)</u>

- Five Public Policy Themes Emerged from the Youth Forum (13 youth from ages 8-16 from diverse racial/ethnic backgrounds)
    - Safety: need for more police protection; worry about strangers in neighborhoods; concerned about drugs in neighborhoods; worried about future storms.
    - Experienced schools elsewhere: want more and better teachers; schools in disrepair; want a learning environment which supports them and their growth.
    - Places to play/do things; want organized activities; want streets cleaned so they can use them; need playgrounds.
    - Want trash removed; want the city to look clean like places they lived following the storm; feel city attracts others but isn't clean like others.
    - Want the City to be prepared in case of another storm in the future; want plans to think about everyone who is in need; want families to be better informed on what to do.
    - Meetings with service providers supported the themes & priorities expressed by the youth.

The following table summarizes some of the opinions expressed by the youth.

Voices of Youth Recommendations

Steering Committee	
	Identify leadership regarding accountability/implementation
	Examine history of services—leverage successes
	Focus on synergies: collaborate with people working together
	Reconvene relevant partners in children's mental health of those doing wraparound
	Develop service resource guides and online resources
	Develop a system to share information with the public
Steering/Subcommittee Leaders	
	Employ a consensus model balanced with accountability
	Prioritize children's needs and capacities
	Identify existing resources/establish new focuses
	Strengthen children's coalitions/collaborative
	Create of comprehensive children's plan which includes physical, mental, social, and spiritual health
	Establish a vision statement
	Continue to develop collaborative partnerships
	Reconvene strategic dialogue and action agenda setting
	Provide organized opportunities to promote networking
	Continually examine community needs directly coming from the communities
	Better coordinate the funding streams coming into community
	Use PSA's to inform communities
Play/Things to Do	
	Explore city progress on inclusive recreational and extracurricular activities for youth
	Show children's video to City Council
Improved Schools	
	Work with neighborhood planning groups on schools
	Support better teacher training
Plan/Prepare/Protect	
	Track housing initiatives and share information
	Continue ongoing examination of evacuation plans
Family Services	
	Establish comprehensive health/mental health services in schools
	Revitalize strategic planning and coordinate body for social services (including wraparound)
	Work directly with youth via schools
	Work with children not living with parents
	Increase cultural and linguistic competency (training)
	Help grandparents raising grandchildren
	Establish more parenting classes/better approaches
Safer, Cleaner City	
	Identify youth leaders to work on these issues

Center for Children's Mental Health's Legislative Recommendations (2006)

- Expand Medicaid coverage.
- Cautions: cost sharing; increased premiums; benefit levels (results: avoid utilization; difficulty w/prescriptions; maintaining coverage).
- Watch prevention packages from the EPSDT services (comprehensive developmental histories; comprehensive physical exams; immunizations; lab tests; screenings (lead; vision; hearing; dental); and health education.
- Enabling services vital: transportation.
- Medicaid waivers are jeopardized by funding streams/reimbursement requirements. Eligibility requirements for evacuees need reconsiderations. Studies by the NCTSN estimates 100,000 children will experience PTSD—while no system is in place to provide coverage, service, training, and infrastructure.
- Existing funding structures (CDC; SAMHSA; Preventive Health and Human Services Bock Grant) needs to prioritize impacted area.
- NB: 10 point emergency plan:
    - Recognize the urgency (hold hearings).
    - Medicaid waiver process does not adequately provide flexibility state(s) need.
    - Address the designated Health Profession Shortage Area.
    - Deploy the USPHS (under the direction of the Surgeon General) to the area until shortages addressed (817 physicians needed) (2,000/1 ration needed).
    - Expand capacity of the community health care system.
    - Support advances in health technology (uniform records; statewide registries; tele-med).
    - Enhance transportation capacity of provider base (to area already in crisis for lack of transpiration to the medically needy.
    - Avoid restrictions on post-disaster mental health services; expand capacity for comprehensive mental health services; expand Medicaid coverage of mental health.
    - Expand school-based mental health coverage (already established and expanded need is extensive); have centers become referral sites.
    - A massive over-sight system control is needed: a Marshall Plan for Mental Health in the area.

Huffman and others (2004): Use of Outcome Data in Children's Mental Health

- For improving utilization of effective interventions for children and youth in mental health services, some findings may influence approaches to improvements: providers generally view outcome data collection positively (psychiatrists somewhat less than other provides); those with more positive views expressed less burden by implementing them; those with more positive views were supported in these views by the organizational climate.

As noted above, the Center for Mental Health Services evaluations (SAMHSA, 2007) documents wide success of providing comprehensive services to families with vulnerable and at risk youth with mental health challenges. In summarizing this research, the National Center for Children and Poverty (2006) recommend the following based on this broad national evaluation data:

- Improve mental health access consultation with a specific focus on young children.

- Coordinate services and hold youth serving agencies accountable.
- Provide mental health services and supports that meet developmental needs of children.
- Apply consistent use of effective treatments and supports.
- Engage families and youth in their own treatment planning and implementation.
- Provide culturally and linguistically competent services.
- Implant concrete strategies to prevent and identify mental health problems and intervene early.

This action plan has sought the advice following the disaster to how best to address the children's mental health issues locally. We have summarized the various reports above. As a matter of process, we then took summaries of these ideas to various community forums and public meetings to seek input into how the use these ideas and to best develop an action plan. The following is a briefer overview of the action plan which reflects the priorities and focus which flowed from this process.

Recommendations--Municipal Government and Oversight of Children's Mental Health Services

Dr. Bowers-Stephens prepared a Briefing Paper for the Special Committee on Mental Health for the New Orleans City Council (2008). This briefing paper reviewed how six different areas structured Government involvement and oversight for children's mental health services. The following will briefly summarize these six and then make a suggested recommendation for New Orleans government and oversight based on a blending of these six areas.

- Philadelphia: Mayor's Blue Ribbon Commission on Children's Behavioral Health
- New Jersey: Community Mental Health Service Requirements
- Milwaukee: County Board of Supervisors Committee on Health and Human Needs
- Little Rock: Commission on Children, Youth and Families
- Illinois: Community Mental Health Act
- Juvenile Justice Reform Act in Louisiana

The following will describe each of these legislated bodies:

- Philadelphia: encourages active participation of key stakeholders to make recommendations on improving children's behavioral health. The purpose of the Commission is to 1) act as a champion for children by focusing on priority issues; 2) provide leadership on issues affecting children and strategies to improve their well-being using data and proven effective interventions, and 3) engage high-level stakeholders with citizens in this endeavor. The commission meets quarterly to assess needs and recommend solutions. The Commission produces an annual "children's report card" on the state of the city's children and the status of finances against these needs. An additional focus is on children in "out of school time", academic success, engaging older youth, and reducing violence.
- New Jersey: requires each county to develop a Mental Health Board. The Board (7-12 members) selected by County Commissioners includes: 2 consumers, health commissioner, school board member, lay persons, PTA, professional associations, advocates, and others deemed necessary. The Board should reflect the different areas as well as other areas of diversity and should not include anyone receiving funding for children's mental health related services. The roles and responsibilities include the operation of Board functioning; meet 8 times a year in open meetings; develop policies and procedures; (planning process; implementation and monitoring of plan; assess needs;

action plans for accomplishing recommendations; educating the community on needs; and secure space to conduct such business).

- Milwaukee: The Committee reviews policies and procedures of the agency; monitors implementation of programs; reviews and recommends budgets for the agency; supports the development of community-based services, and supports service improvements.
- Little Rock: the Commission acts to advise and promote comprehensive and holistic ways to help families with at risk children. The Commission meets monthly to educate and advise the Board of Supervisors on children and their families' needs, plan for services, develop information and resources, promote best practices, collaborate cross systems, complement the work of other intersecting committees and commissions of the city, report annually on the status of children and youth, and secure the assistance of professionals in planning and providing services to children and youth and their families.
- Illinois County Mental Health Boards: can levy taxes to support mental health services to adults and children; develop a children's mental health plan; creates partnerships to monitor services; advise on legislation, and link school board polices with mental health policies.
- Louisiana Juvenile Justice Reform Act: created an advisory board to advise on the reform of the juvenile justice system. The Act separated the Office of Youth Development from that of the Department of Corrections, closed problematic institutions, and established youth planning Boards.

There is a direct trend in local municipalities taking more active roles in oversight and planning of service delivery for children's mental health. In some cases, state legislatures required the interventions, and in others, they were motivated by internal needs for oversight and planning. Dr. Bowers-Stephens presented this report to help demonstrate the rationale for New Orleans City Council involvement.

<u>The National Alliance on Mental Illness</u>

NAMI (2009) recommended 10 "pillars of high quality state l health care" for services:

1. Provide comprehensive and effective services (services should be evidence-based)
2. Integrate multiple systems
3. Provide adequate funding of care (the role of Medicaid and block grant)
4. Focus on wellness and recovery
5. Create safe and respectful treatment environments
6. Provide accessible services (community-based care)
7. Establish cultural competence
8. Build consumer-centered and consumer (family) driven systems
9. Field an adequate and qualified mental health workforce
10. Ensure transparency and public accountability

NAMI recommends:

- Increase funding for care
- Improve data collection, outcome measurement and accountability
- Integrate mental health and physical health care
- Promote recovery and respect
- Increase services to those most at risk

These standards build on the same principles that guide children's systems of care.

Children's Defense Fund (2009)

Immediately after the disaster, the Children's Defense Fund (CDF, 2006) developed a series of community group activities to identify and prioritize needs to help "rebuild the village" post-disaster. They initially developed leadership to address the emergency health and mental health needs of children and their families; addressed crisis in local education; addressed access to care barriers; support for families; cultivate community leadership; engage community partners; focus on children within their cultural contexts; and secure resources. The CDF's follow up "Call to Action" (CDF, 2007) build upon the 2006 recommendations and focused on updated recommendations: emergency services; educational supports; health and mental health access and coverage; family engagement; community leadership engagement with vulnerable families; public awareness; faith and justice connections; early childhood development supports; and political organizing.

A few years after the storm, working in partnership with community leaders, families and children, the CDF (2009) developed a variety of further recommendations that reflected their experiences in working after the disaster. Their recommendations for rebuilding the village included:

- Adopting the *UN Guiding Principles on Internal Displacement* (acknowledging the displacement; the role of governments; and targeting comprehensive needs).
- Safeguard against displaced people becoming homeless or jobless (comprehensive array of services to address unmet need; prioritizing for the most vulnerable; engage displaced people in the recovery processes).
- Address the learning and growing needs of displaced children (coordination of services between fragmented agencies; prioritize rebuilding educational environments).
- Address health and wellness (access; coordination; culturally relevant mental health).
- Dismantle the "cradle to prison" pipeline (effectiveness accountability of education; appropriate education standards; community-based care rather than incarcerations).

PART V

PRIORITIES AND CONSENSUS STATEMENTS

We envision a future when everyone wit a mental illness will recover, a future when mental illnesses can be prevented and cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports—essentials for living, working, and participating fully in the community.
President's New Freedom Commission, 2003.

PART V

PRIORITIES AND CONSENSUS STATEMENTS

THE LA-Y.E.S. CHILDREN'S MENTAL HEALTH PLAN

Recovery in our service delivery area is moving forward and this plan is intended to supplement and be an integral part of the more broadly defined recovery efforts. This is a community wide engagement—not in any way limited to mental health. In the context of recovery, mental health is a core component. It is our concern that it is not given appropriate attention or focus by either the broader recovery efforts or the more general health and mental health processes planning for improvement in service delivery. This plan is based on the data informing our system of care development, the input from families and youth in the process, the shared ideas from providers and the consortia stakeholders, and from recommendations from the LA-Y.E.S. Administrative Services Organization. After receiving considerable input into the planning process and in collaboration with families, youth and other key stakeholders, LA-Y.E.S. prioritizes and recommends the following key priorities for 2010/2011.

Lessons learned from service planning and implementation post-disaster have taught us that the most vulnerable youth remain the most at risk, that the public mental health system becomes more critical for those with considerable barriers to care, and that participatory planning offers hope in planning for systems change and improvements (Mancoske and Ford, 2009). This plan integrates the interests of the most in need with the change context of care system planning.

PRINICPLE RECOMMENDATION

- Incorporation of the children's mental health components into all aspects of the broader recovery plan. This should address access to care (affordability; trained providers; expand capacity; crisis care; effective services; transportation). Access needs to be addressed for mild/moderate (e.g., depression; anxiety disorders; PTSD) to severe (major depression; severe anxiety; severe PTSD; schizophrenia; and bipolar). The service delivery system is grossly deficient to address the need.
- The following is a summary list of the key recommendations provided by multiple stakeholders that are integrated into our plan of action for 2010/2011.

SUMMARY:

1. RECOMMENDATIONS : VULNERABLE YOUTH/SAFETY NET

- Develop strategies for systematic engagement of families and youth in service planning, implementation, and evaluation.
- Develop strategies and resources to expand the basic mental health infrastructure including SAMHSA "required services" for successful systems of care within the service area.

- Develop strategies and resources to expand mental health support services such as SAMHSA "optional services" for successful systems of care to the most at risk and vulnerable youth in the service area.
- Collaborate with Medicaid and LaCHIP to enroll all eligible children in the service area.
- Collaborate with Medicaid for a waiver and with other key child service stakeholders to enroll all children with serious emotional and behavioral disorders.
- Expand access to and resources for integration of family supports into service plans, such as transportation and child care.
- Provide supports help parents because how well they cope dictates how well their children cope.
- Expand the focus on cultural and linguistic competence standards promoted through training, establishment of benchmarks, ongoing monitoring, and regular outcome reporting and integrate the standards into policy and programs.
- Focus services on youth with serious emotional and behavioral problems who have the greatest vulnerabilities and traumatic stress.
- Incorporate trauma informed assessments across service provider agencies for youth services in the area.
- Document service outcomes for all youth and their families engaged in the service delivery network.
- Provide adequate evidence-based mental health services in schools.
- Develop strategies to train child serving professionals to work with youth with mental health problems.
- Provide training to stakeholders in the system of care philosophy and practices.
- Provide wraparound services to families to help navigate systems of care.
- Expand community-based services.

SUMMARY:

2. RECOMMENDATIONS: HUMAN RESOURCE ISSUES

- Engage families, youth, and key stakeholders (child welfare; juvenile justice; mental health; education) in collaborative efforts with providers at systems reform.
- Focus on high quality training for service providers in key service delivery areas: evidence-based practice; best practices; cultural and linguistic competency; family/youth engagement; and vicarious traumatization.
- Collaborate to develop trauma informed care across youth services (juvenile justice; child welfare; mental health; and counseling services.
- Engage in stigma reduction, especially among diverse at risk populations.
- Train providers and develop resources to support the evidence-based approach of "wraparound" comprehensive services across systems in the service delivery area.
- Develop data bases for sharing information integrating services and supporting family involvement in care planning, implementation, and evaluation.
- Establish collaborative agreements between community-based recreation and growth development programs for the youth served in the area.
- Develop resources and provide training and support for increasing the capacity and effectiveness of professional mental health service providers.

- Develop stakeholder input in the evaluation and cost-effectiveness assessments of service delivery across systems of care.
- Collaborate with academic and other training programs to support the systems goals and training activities required to inform systems improvement.
- Establish a consensus panel (e.g., the Hawaii "blue book" model) comprised of families, youth, providers, and academics to plan for the selection, development and monitoring of the delivery of evidence-based practices.
- Provide incentives or activities to increase the array of services of community providers.
- Support integration of mental health services with primary care (e.g., screenings; shared medical records; redesign of clinic flows).
- Develop sharing data mechanisms (focus on consumers; providers): services; operations; linguistic diversity; capacity; costs; outcomes.
- Coordinate care using multiple approaches (e.g., on line; printed materials; outreach).

SUMMARY:

3. RECOMMENDATIONS: LEGISLATIVE SUPPORT FOR SERVICES

- Expand Medicaid coverage to broaden service penetration for youth with serious emotional and behavioral disorders (including wraparound and other evidence-based interventions).
- Local parish level governments establish Boards for oversight and planning for children's mental health services.
- Provide for trauma informed review for all served by public agencies (child welfare; juvenile justice; education; mental health) and implement evidence-based interventions.
- Expand enabling resources to engage families in service delivery (transportation; child care).
- Expand Medicaid waivers to include care management and wraparound services for children and youth with emotional or behavioral problems and also for those exposed to traumatic stress.
- Address service provider shortage of trained and qualified mental health and care management providers in the disaster exposed areas (e.g., relocation assistance; supported training; loan repayments; incentives for bilingual staff).
- Expand and supplement service capacity for the numbers of children served in community based programs through public and private providers.
- Support building capacity for communication and data transfer technology in communities serving at risk and vulnerable youth.
- Expand accountability for program collaboration and service integration between agencies in service delivery areas.
- Expand and develop training and supports for children's service providers.
- Secure funds which allow access to care through provision of support services such as transportation (planning and services), child care, and recreational activities.
- Develop Program/Provider partnerships with Academic Programs (invest in training programs for professional training—e.g., social work, psychology, psychiatry); develop training partnerships.

- Provide crisis services (acute care beds; crisis teams—e.g., Memphis Crisis Intervention Teams model; Child and Adolescent Response Teams) and community-based services to prevent more restrictive and costly residential care.
- Support mental health services in the schools throughout the five parish area.
- Legislate support for crisis respite to support least restrictive services for youth.

EXAMPLES OF RECENT ACCOMPLISHMENTS

- Successful collaboration with the juvenile justice system and the child welfare system.
- The project has become a major provider of trainings in the community on System of Care principles. The project on an ongoing basis provides training to community stakeholders.
- The project has been able to utilize local media personnel to discuss the issues surrounding Children's Mental Health.
- Trainer of mental health providers in best practices related to Child Traumatic Stress.
- Increased family participation in the governance of the LA-Y.E.S Project.
- Development of the Consortium and Parish level councils to support the Consortium as outlined in the system of care legislation in Louisiana.
- LA-Y.E.S continues to actively identify service providers and non-traditional services in the community. LA-Y.E.S identified two additional psychiatrists to provide services for our families.
- LA-Y.E.S. conducts the Family Involvement Enhancement Project in conjunction with the Louisiana Children's Museum and the Louisiana Federation of Families for Children's Mental Health. The Project provides advocacy training for families and skills-building exercises for youth with mental health challenges.
- LA-Y.E.S. partnered with Southern University at New Orleans School of Social Work to provide certification for about 100 post-master's level child serving professionals in culturally competent, family focused systems of care principles using "evidence-based treatments" for children and their families.
- LA-Y.E.S. implemented the Kinship Care Support Groups which provide support for youth being raised by someone other than their biological families.
- All goal areas are targets for increased implementation, and the plans presented above reflect the implementation strategies that will be used to increase the Project's overall effectiveness in meeting its goals and objectives to transform the way in which children's mental health services are provided in the five target parishes.
- Our primary focus in the upcoming year will be on sustainability with significant effort going toward successful implementation of a permanent governance structure and the implementation of a Children's Mental Health Relief Fund to support services and supports for youth and their families with mental health needs.
- Families and youth receiving care management services in the system of care services from LA-YES report general areas of improvement:
- Examples of areas of improvements:
    - School examples (baseline to follow-up scores)
        - School attendance
        - Grades

        - Less disciplinary actions
        - Special education
    - Clinical score examples of areas of improvement
        - Overall competencies (functioning, etc.)
        - Less internalizing problems (mood, etc.)
        - Less externalizing problems (behavior, etc.)
        - Less overall problems
        - Less overall impairment
        - More areas of strengths
        - Less caregiver strain
        - More active family life
        - High satisfaction (services; cultural competency)

FOCUS FOR STRATEGIC PLANNING 20010/2011

Priorities for 2010/2011

- **Development of the LA-Y.E.S. Consortium and Care Managed (Wraparound) Services in the Community-Based Service System**
- **Development of Community Participatory Research to Guide the Development and to Promote Quality Improvements of the System of Care**
- **Both of the above be Integrated with the LA-Y.E.S Administrative Services Organization (501C).**

These ideas in this report were shared in community forums and in discussions with the LA-Y.E.S. consortia. The following are basic suggestions for LA-Y.E.S. and its partners to focus on in the upcoming year. These were based on group discussions in the three areas in which other recommendations were centered.

1. Improving the safety net for vulnerable populations (Examples of strategies):
    a. Integrate comprehensive health and mental health interventions because of the effectiveness of both at impacting the other
    b. Focus on increasing caregiver involvement such as increasing capacity for parenting and increasing knowledge and skills for "how to do things" needed by their child.
    c. Improve social marketing of programs, effective services and service outcomes. Connect interventions with families where help is needed (e.g., at schools, pediatrician offices, with juvenile justice and child welfare sites, and at mental health offices).
    d. Help caregivers know about resources so they can make more informed decisions and choices (e.g., secure resources like transportation, recreational activities, and child care while they seek help; get more widely distributed and accurate resource guides to care givers and their care managers). Focus is on getting families connected to resources. Secure funding for required and optional type services needed in each parish.
2. Human Resources Development (Examples of strategies):

a. Continue to assess ongoing training needs of staff and key stakeholders and do an ongoing assessment of changing training needs. Provide training in evidence-based policies and program interventions that are culturally competent.
b. Identify places where services integration has broken down and create change. For example, each parish should have an active and fully functioning ISC process for service integration to occur. Develop strategies to remedy problems.
c. Train care providers in methods and techniques that are effective and evidence-based. Monitor quality.

3. Legislative Agenda for further development of the service array (Examples of strategies)
    a. Find ways of supporting service integration (examples like having a "medical home; one-stop shopping; shared data bases). Find stable funding for wraparound services. Develop strategies for funding community-based wraparound care.
    b. Focus on community-based services (at schools or where services most likely are connected or involve with caregivers and youth).
    c. Secure funding for support the range of needs of families and connect families to services array. Connect families earlier rather than waiting for crises or late-stage multi-agency involvement.

Never discount that a small group of concerned citizens can change the world. Indeed, it is the only thing that ever has.
Margaret Mead

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