

# Transforming the St. Tammany Behavioral Health System



2014

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## Executive Summary

The Louisiana Public Health Institute (LPHI) and the National Council for Behavioral Health (National Council) partnered with the St. Tammany Parish Government and the St. Tammany Behavioral Health Task Force (Task Force) over an 18-month period to increase access to high quality, coordinated, appropriate behavioral health (BH)<sup>1</sup> services within St. Tammany Parish. The primary purposes of this project were to determine the current state of BH needs and services, develop a plan to improve and sustain the BH service delivery system, and establish an ongoing online dashboard of up-to-date BH data to inform system decision makers.

The project team assessed the current state of the BH system by analyzing secondary data and conducting over 50 interviews of key providers and stakeholders. Stakeholders who were interviewed included clients, Florida Parishes Human Services Authority (FPHSA), private BH organizations, St. Tammany Community Health Center (STCHC), local hospital emergency departments (EDs), the St. Tammany Parish Public School System, social service organizations, the St. Tammany Parish Government, Magellan, the St. Tammany Parish Coroner's Office, the criminal justice system, and youth services. Major findings from the assessment of the current state of the BH system include:

- Long wait times to see BH providers greatly limit clients' access to timely services and sometimes leads to them ending up in the ED or jail
- The BH system over utilizes law enforcement, emergency certificates, EDs, and jail for individuals in BH crisis
- A lack of confidence in alternative services has led to few individuals in crisis being diverted from the ED and subsequent inpatient placement
- EDs see repeat frequent flyers in BH crisis
- There is a lack of coordination and information sharing between BH providers
- There are large gaps in data reporting and using data to monitor the BH system's effectiveness over time

This assessment was used to inform the five immediate and short-term recommendations in the table below. Task Force members have committed time and resources to accomplishing these recommendations and a number of milestones have already been achieved as a direct result of this project. FPHSA has reduced wait times for services from 60-90 days to three hours on the same day. In addition, STCHC has committed to a pilot to replace 70% of their traditional therapy services with brief interventions at one of their sites. Northlake Behavioral Health System has applied for credentialing and licensing to open a 16 bed crisis stabilization facility (CSF) on the campus of their existing hospital. The CSF plans to open in the first months of 2015 and will be staffed by a team of trained providers including peers, with medical staff available as needed, and will be followed by a substance abuse engagement center. Finally, in October, 2014, the Substance Abuse and Mental Health Services Administration (SAMHSA) provided free of charge a first round of Mental Health First Aid (MHFA) training to 28 St. Tammany community members.

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<sup>1</sup> Behavioral health in this report refers to both mental health and substance abuse.

<p><b>1. Enhance community-based behavioral health services</b></p> <ul style="list-style-type: none"> <li>• Florida Parishes Human Services Authority: on-site pharmacy</li> <li>• National Alliance on Mental Illness: reorient from service provider to advocacy organization</li> </ul> <p><i>Initiated or completed:</i></p> <ul style="list-style-type: none"> <li>• Florida Parishes Human Services Authority: transition to team-based care</li> <li>• Florida Parishes Human Services Authority: transition to same day/next day access</li> <li>• St. Tammany Community Health Center: transition to brief interventions model</li> </ul>
<p><b>2. Transform utilization of emergency services</b></p> <ul style="list-style-type: none"> <li>• Gain emergency department leadership commitment</li> <li>• Develop capacity for information sharing among emergency providers</li> <li>• Standardize suicide risk assessment protocol</li> </ul>
<p><b>3. Enhance crisis services continuum</b></p> <ul style="list-style-type: none"> <li>• Develop substance abuse engagement center</li> </ul> <p><i>Initiated:</i></p> <ul style="list-style-type: none"> <li>• Develop crisis stabilization facility (Northlake Behavioral Health System)</li> <li>• Transition Volunteers of America to mobile crisis services instead of traditional case management</li> </ul>
<p><b>4. Enhance education, advocacy, and training</b></p> <ul style="list-style-type: none"> <li>• Crisis Intervention Training</li> <li>• Additional Mental Health First Aid trainings</li> <li>• Additional trainings specifically for behavioral health staff</li> <li>• Additional trainings for all behavioral health/primary care/emergency department staff</li> </ul>
<p><b>5. Enhance social services</b></p> <ul style="list-style-type: none"> <li>• Assess and enhance transportation</li> <li>• Assess and enhance housing supports</li> </ul>

There has been an incredible amount of work done to improve the St. Tammany BH system over the last 18 months. St. Tammany Parish and the Task Force have been able to take advantage of national and local expertise to improve coordination, quality, and efficiency. *It is strongly recommended that the workgroup leaders be given dedicated time by their respective organizations to continue to champion the workgroups and lead the change efforts that are needed.* In order to sustain the momentum of the project to date, it is also essential to have a dedicated, paid leader to facilitate the Task Force, providing coordination between workgroups. While a large amount of work remains, this report will serve as a plan and guide of actionable next steps for St. Tammany Parish and the Task Force as they continue transforming their BH system. Given the existing resources in the community and the involvement of engaged stakeholders throughout the parish who serve as advocates of this work, St. Tammany will be able to improve the lives of residents for years to come.

## Introduction

In partnership with the St. Tammany Parish Government and the Task Force, LPHI and the National Council conducted a systems assessment of the BH service delivery system in St. Tammany Parish. The primary purposes of this project were to determine the current state of BH needs and services for residents in St. Tammany, develop a plan to improve and sustain the BH service delivery system, and establish an ongoing online dashboard of up-to-date BH data to inform system decision makers. This project will provide Parish President Pat Brister, her leadership team, and the Task Force members with the necessary information to maximize and leverage resources to increase residents' access to appropriate, high quality BH services within the community.

The demand for treatment of individuals<sup>2</sup> with mental illness and addictive disorders continues to increase as funding streams and services continue to dramatically decrease. The BH needs of low income residents of St. Tammany Parish have been historically served through a variety of federal and state resources. However, the cuts to Medicaid and the hiring freeze for state BH agencies further reduced these resources dramatically, leading to over-utilization of hospital EDs and long wait times for community-based services. Therefore, the St. Tammany Parish Government recognized an immediate responsibility and an urgent need to review, assess, and prioritize services. This includes the identification of funding sources and implementation of evidence-based and best practice approaches for improving the coordination, efficiency, and effectiveness of BH service delivery.

## St. Tammany Parish

Approximately 234,283 people live in St. Tammany Parish (American Community Survey (ACS), 2012). The table below compares St. Tammany Parish to the state of Louisiana on select demographics that impact health disparities.

**Table 1. Demographics (ACS, 2012)**

	<b>St. Tammany Parish</b>	<b>Louisiana</b>
<b>Total Population</b>	234,283	4,529,605
<b>Race</b>		
<i>White</i>	83.6%	63.1%
<i>Black</i>	11.5%	32%
<i>Asian</i>	1.4%	1.6%
<i>American Indian and Alaskan Native</i>	0.4%	0.6%
<i>Latino/Hispanic</i>	4.7%	4.3%
<b>Below Federal Poverty Level</b>	10.8%	18.7%
<b>Below High School/GED Education</b>	11.2%	17.8%
<b>Unemployment Rate</b>	7%	8.4%

While St. Tammany Parish is ahead of Louisiana in terms of risk factors such as poverty, education, and unemployment, there are still geographical discrepancies due to the diversity of urban and rural

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<sup>2</sup> This report will typically refer to individuals or clients, but these terms are interchangeable with patients and consumers.



communities across the parish. Please see Appendix A for maps that illustrate the dispersion of residents throughout St. Tammany Parish.

In 2012, St. Tammany Parish had a slightly lower rate of citizens with health insurance than the rest of the state. See Table 2 below for data prior to the Affordable Care Act. However, since Louisiana, like many of the other Southern states, is not implementing the Affordable Care Act Medicaid Expansion, many adults will fall into a coverage gap as the Medicaid eligibility levels for adults will remain low. It is estimated that 28% of Louisiana residents fall in that coverage gap, and therefore continue to be uninsured (Kaiser Family Foundation, 2014a).

**Table 2. Health Insurance Status (ACS, 2012)**

	<b>St. Tammany Parish</b>	<b>Louisiana</b>
<b>Total Uninsured</b>	14%	17%
<i>Under age 18</i>	4%	5%
<i>Age 18-64</i>	21%	25%
<i>Age 65+</i>	1%	0.7%
<b>Medicaid Insured</b>	17%	22%
<b>Medicare (age 65+) Insured</b>	95%	96%

Fortunately, the majority of St. Tammany Parish residents have a personal doctor or health care provider (80.7%), and have received a routine check-up within the past year (69.4%), according to the 2012 Behavior Risk Factor Surveillance Survey (BRFSS). On the other hand, a lower percentage of St. Tammany Parish residents had a routine check-up within the past year or the past two years than the state average. However, these data indicate there is a great opportunity for St. Tammany Parish to integrate BH services into existing primary care services where residents are already routinely going. See Table 3 below.

**Table 3. Access to Health Care (BRFSS, 2012)**

	<b>St. Tammany Parish</b>	<b>Louisiana</b>
<b>Has a personal doctor or someone they consider a health care provider</b>	80.7%	77%
<b>Unable to see a doctor when needed in past 12 months due to cost</b>	16.7%	18.7%
<b>Length of time since last routine check-up</b>		
<i>Within past year</i>	69.4%	72.4%
<i>Within past 2 years</i>	11.4%	12.4%
<i>Within past 5 years</i>	10.7%	5.8%
<i>5+ years</i>	8%	9.3%

Risk factor behaviors can have negative impacts on health outcomes, so it is important to understand which factors are at play and should be considered when people present for health services. See Table 4 below for select risk factor behaviors among St. Tammany Parish residents.

**Table 4. Risk Factor Behaviors (BRFSS, 2012)**

	<b>St. Tammany Parish</b>	<b>Louisiana</b>	<b>United States</b>
<b>Adults currently smoking</b>	22%	24.8%	19.6%
<b>Adults reporting binge drinking*</b>	17%	16.5%	16.9%
<b>Diabetes screening utilization rates</b>	64.1%	57.4	
<b>Adults age 20+ reporting no leisure time for physical activity</b>	23.4%	29.9	

\* defined as five or more drinks for men and four or more drinks for women in a single setting

Chronic health conditions impact overall health, and people with BH issues often have difficulty managing chronic health conditions. Additionally, people with serious mental illness may die up to 25 years earlier than the adult population, largely due to preventable conditions (Parks, Svendsen, Singer, & Foti, 2006). See Table 5 below.

**Table 5. Chronic Health Conditions (BRFSS, 2012)**

	<b>St. Tammany Parish</b>	<b>Louisiana</b>	<b>United States</b>
<b>Adult residents with BMI &gt;25</b>	67.2%	69.6%	63.4%
<b>Adults ever diagnosed with diabetes</b>	9.1%	13.9%	10.5%
<b>Adults ever told they have asthma</b>	8.4%	12.1%	13.3%
<b>Adults ever diagnosed with angina or coronary heart disease</b>	4.8%	4.9%	4.3%

Furthermore, Table 6 below illustrates the presence of depression and anxiety in St. Tammany Parish, as measured by the Patient Health Questionnaire-8 (PHQ-8) and the Generalized Anxiety Disorder 7-item Scale (GAD-7). Table 7 illustrates self-reported diagnosis rates for depressive disorders in St. Tammany Parish, the percentage of residents prescribed psychiatric medications in the past year, and the average number of days that residents reported their mental health was “not good.”

**Table 6. Mental and Behavioral Health (BRFSS, 2011)**

	<b>St. Tammany Parish</b>	<b>Louisiana</b>	<b>United States</b>
<b>Depression (PHQ-8)*</b>			
<b>No Depression</b>	76%	72%	
<b>Mild Depression</b>	16.5%	18%	
<b>Moderate Depression</b>	2%	6%	
<b>Moderately Severe Depression</b>	4%	3%	
<b>Severe Depression</b>	1.5%	1%	
<b>Anxiety Disorder (GAD-7)*</b>	15%		17%

\*PHQ-8 and GAD-7 not collected by BRFSS 2012

**Table 7. Mental and Behavioral Health (BRFSS, 2012)**

	<b>St. Tammany Parish</b>	<b>Louisiana</b>
<b>Ever had a depressive disorder (including depression, major depression, dysthymia, minor depression)</b>	17%	17%
<b>Currently taking medicine or receiving treatment from health professional for mental or emotional health condition</b>	14%	13%
<b>Average number of days within past 30 days that mental health was not good (including stress, depression, emotional problems)</b>	3.5 days	4.1 days

Additionally, St. Tammany Parish has one of the highest rates of suicide in the state of Louisiana, ranked number 18 out of 64 parishes (14.26/100,000 population) (Louisiana Office of Public Health, 2009-2011). According to the St. Tammany Coroner’s Office, 32 people completed suicide in 2013, down from 36 people in 2012 and 35 people in 2011. However, the number of suicides increased again in 2014, and 46 people completed suicide, which is 14 more than 2013. St. Tammany Parish has a 24 hour crisis hotline, where people can call for help. From January 1, 2014 through September 30, 2014, the United Way/VIA LINK 2-1-1 line received 1,103 mental health crisis/counseling calls and 66 calls related to substance abuse from St. Tammany Parish. Furthermore, local hospitals have reported high ED utilization by residents in crisis and in need of substance abuse treatment. According to interviews, the EDs often have the same handful of individuals presenting repeatedly for the same issue.

### Louisiana Involuntary Hospitalization Process

Louisiana is unique when it comes to how the state handles involuntary holds and commitments for individuals in psychiatric crisis. Each parish’s Coroner’s Office is responsible for issuing involuntary holds and commitments. Individuals are typically involuntarily held or committed to an inpatient setting for assessment and treatment in one of three ways. First, there is the Order of Protective Custody (OPC) where credible individuals, such as a family member or friend, can request that the Coroner’s Office or judge of a court of competent jurisdiction take someone into protective custody if they believe s/he is mentally ill or suffering from substance abuse and is in need of immediate treatment to protect himself/herself or others from physical harm. The individual would then be placed under an OPC and transported to a facility for immediate examination to determine whether s/he should be admitted by emergency certificate. Second, there is the Physician’s Emergency Certificate (PEC), which is issued by any physician, psychologist, or mental health nurse practitioner after a medical exam where the individual is found to be suffering from a mental illness or substance abuse disorder and is a danger to himself/herself or others. A PEC requires the individual to be detained for up to 72 hours until a second exam can be conducted by the Coroner or his/her designated representative. Third, the Coroner’s Office can place an individual under a Coroner’s Emergency Certificate (CEC) if they determine through an evaluation, usually as a result of a PEC, that the individual is in need of psychiatric treatment for mental illness or substance abuse issues. A CEC is in effect for up to 15 days, and can be renewed if further treatment is necessary beyond the initial 15 day period, or can be withdrawn when the individual is no longer showing any symptoms (Admission by emergency certificate; extension, 2011; St. Tammany

Parish Department of Cultural and Governmental Affairs, 2011). According to the St. Tammany Coroner's Office, between January 1, 2014 and November 31, 2014, there were a total of 225 OPCs, 4,923 PECs, and 3,418 CECs. As a comparison, in 2013, Jefferson Parish, which has a population almost double of St. Tammany, had 421 OPCs, 3,524 PECs, and 1,819 CECs while Lafourche Parish, which has less than half the population of St. Tammany, had 85 OPCs and over 600 PECs (Jefferson Parish Coroner's Office, 2014; Lafourche Parish Coroner's Office, 2014). This data indicates that St. Tammany Parish overuses these commitment processes and it is recommended that the Task Force focus on transforming the system in a way that will provide alternative service options that are community-based, whole-person centered, and readily accessible.

## Assessment Approach

In collaboration with the Task Force, LPHI and the National Council assessed the current state of the St. Tammany BH system by conducting interviews with over 50 key providers and stakeholders. These interviews were held over two full days in December 2013, and follow-up interviews were conducted from January to March 2014. Stakeholders who were interviewed included clients, FPHSA, private BH organizations, STCHC, local hospital EDs, the St. Tammany Parish Public School System, social service organizations, the St. Tammany Parish Government, Magellan, the St. Tammany Parish Coroner's Office, the criminal justice system, and youth services. A full list of organizations that were represented in the interviews is included in Appendix B.

The interview guide was developed based on Task Force input and previous assessment work done by LPHI. A protocol was developed for conducting the interviews, and community stakeholders were provided with an information sheet. Clients who were interviewed signed informed consent forms, and were provided with a \$25 gift card for their participation. All forms were approved by the Sterling Institutional Review Board prior to conducting the interviews. The first round of interviews were audio recorded and the audio files were saved on LPHI's secure server. Interview notes are kept in a locked file at LPHI. All audio recordings will be destroyed at the end of this project, and interview notes will be deleted two years after completion of the project. For the purposes of this report, no individual responses will be identified in order to protect the confidentiality of the participants.

LPHI also conducted an in-depth review of the literature of best practices around the nation to inform the recommendations for transforming the St. Tammany Parish BH system. The following list is a few relevant highlights of characteristics of successful BH systems. (See Appendix C for a list of references used in this literature review).

- A BH system needs to address BH issues in the community as a whole.
- A BH system should consider the area's cultural background and regional norms.
- Include peer specialists and engage clients and families.
- It is important that BH services educate clients' family members about mental illness and substance abuse conditions.
- Community-based programs may be able to more quickly and effectively address clients' needs than hospital-based resources.
- Programs should be continuously monitored using key performance indicators to assess progress and effectiveness.
- It is essential to have services in place along the entire continuum of care (from prevention to crisis stabilization to post-hospital recovery).
- BH systems should take advantage of existing services through repurposing and enhancing existing resources to minimize costs and maximize impact (i.e., train existing providers in new techniques instead of creating new providers).

At the end of the assessment period, an Interim Report with immediate and short term recommendations was completed and disseminated to Task Force members. This Interim Report informed the St. Tammany Parish Council on budget allocations for the next fiscal year, as well as

jumpstarted the implementation of select recommendations six months earlier than anticipated. All of the recommendations from the Interim Report are included in this report in greater detail. In the second half of this project, LPHI also developed an online data dashboard for use by the Task Force members to inform decision making and enable providers to monitor the state of the BH system over time. This dashboard is password protected and not available to the public at this time.

## State of Behavioral Health Services in St. Tammany Parish

This section of the report outlines the findings from the assessment process and documents the state of services and role of Task Force members as of May 2014, which is when the findings were shared with the Task Force and used to inform the development of recommendations for improvements and next steps. Recommendations were shared with the Task Force via an Interim Report in July 2014. Several recommendations have already been implemented, and will be discussed in a later section of this report.

### Summary of Findings

Many clients face severe challenges receiving timely services because of long wait times. Clients generally agreed that once enrolled in services and on the correct medication, service was adequate. However, according to one client, “when there are issues with the medication not working properly or you’re not feeling good with the medicine, that’s when [the wait times] are rough.” Another client expressed difficulties getting medication filled, even with an appointment, because “the doctors are so overloaded. I went almost a week without [the prescription].” If clients of community BH services have an issue with their medication between appointments, they often go to the ED and then have to be hospitalized because they cannot see their provider soon enough. They also may end up in jail due to erratic or threatening behavior as a result of a lapse in medication adherence (Cowell, Hinde, Broner, & Aldridge, 2013; Department of Mental Health Forensic Mental Health Services, 2009; Human Services Research Institute, 2015). This problem is exacerbated when individuals are released from jail or the hospital with only three to seven days of medication on hand, yet have to wait 30 days or more to see a dispensing provider.

The BH system over utilizes law enforcement, emergency certificates, the ED, and jails for individuals in crisis, and the PEC process almost always results in an inpatient stay. The EDs are overwhelmed with large numbers of individuals in crisis, most of whom are placed under PECs, and many are frequent flyers. While the mobile crisis team (MCT) professional often assesses the client and makes recommendations regarding an inpatient placement vs. an alternative outpatient referral, the hospital EDs make the final decision. A large number of interviewed providers have suggested that “this system has been this way forever.” Although some providers will release some individuals under OPCs to an outpatient setting, they very rarely divert individuals that are under PECs because of liability issues and community perceptions of public safety. Most providers see no alternatives to inpatient settings for individuals under PECs because there are not enough “good resources for outpatient care.” The recommendations in this report serve to fill that gap, and bring “good resources” to bear so providers can trust the outpatient BH system to more appropriately help individuals who do not need emergency or inpatient care.

Lastly, there is a huge gap when it comes to data reporting and using data to monitor the system’s effectiveness over time. There is also a lack of information sharing and coordination between providers regarding shared patients or the types of clients they serve. Many individual providers are not collecting sufficient data on the services they provide or clients they serve, which leads to challenges in advocating for increased or sustained funding, measuring impacts of system transformation efforts, and

demonstrating the added value of new services. LPHI developed a dashboard to add this capacity to the Task Force. The St. Tammany Parish Government is expected to take over administration of the dashboard management so the data can be used by the parish it serves.

## St. Tammany Parish Government

The St. Tammany Parish Government and Task Force are very engaged in improving the quality, delivery, and coordination of the parish's BH system. The St. Tammany Parish Government is responsible for allocating public health millage funds to community services, with a portion going towards BH services (roughly \$1,000,000 in 2014). While the millage has historically had a rather loose definition of public health, the Department of Health and Human Services (DHHS) has been eager to increase the proportion of funds that will be used to improve the BH of parish residents. The case for enhanced funding to BH services is based on the evidence in this report showing that a lack of funding for community BH results in inappropriately high use of police and emergency medical services (EMS), court, and inpatient hospitalization services, leading to higher expenditures and less effective care for residents than if they accessed non-emergency services appropriately.

In 2014, the public health millage funded the Volunteers of America (VOA) MCT (\$500,000), limited BH services for the uninsured at the St. Tammany Community Health Center (STCHC) (\$100,000), education and support through the National Alliance on Mental Illness (NAMI) (\$30,000), a Housing and Urban Development (HUD) match to operate transitional group housing for co-occurring homeless residents (\$80,000), a mental health case manager for the BH court (\$50,000), suicide prevention and education through St. Tammany Outreach for the Prevention of Suicide (STOPS) (\$15,000), and a crisis line, "The Phone," through Baton Rouge Crisis Intervention Center (BRCIC) (\$2,000). Additional information on select programs is included in the rest of this section.

Additionally, the St. Tammany Parish Coroner's Office is an engaged partner on the Task Force, and the newly elected Coroner has been greatly supportive and involved. The St. Tammany Parish Coroner's Office has committed \$250,000 to enhancing the crisis services continuum using their allocated funds within their budget (see the recommendations section below). The Coroner's Office also houses data regarding BH involuntary commitments through OPCs, PECs, and CECs, and is a key player in assisting the Task Force in monitoring the implementation of the transformed system components.



## Mobile Crisis Team and Emergency Department Utilization

The VOA MCT was created in 2011 with the intent to reduce ED usage among individuals in crisis. The MCT has four full-time counselors who each do case management and have one rotating day a week where they are on call for 24 hours. The MCT have three contracted counselors who work holidays and weekends for on-call crisis response only (i.e., no case management). During crises, responding police officers that suspect a BH issue call the MCT (these issues can be mental health and/or substance abuse related), and the MCT counselor meets the officer and individual at the ED. The vast majority of calls the MCT respond to are from police, while a small number come from the EDs, and very few come from community members. The MCT providers connect with the individual to ensure adequate follow-up once s/he is discharged from the ED or inpatient facility, if that is where s/he is transferred to from the ED. The most successful component of the MCT is its aftercare support provided to consumers post-release from the ED and/or inpatient setting. Many providers that were interviewed agreed that, while MCT's services do not necessarily divert people from the ED, the MCT's case management and follow-up services have filled a huge gap in the parish's BH system to serve residents, primarily those who are uninsured, and help them navigate the system and access services.



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Providers ... agreed that the MCT's case management and follow-up services have filled a huge gap...primarily for those who are uninsured.

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There were conflicting reports over how much impact the MCT has on its initial goal of diverting individuals from accessing the ED and subsequently ending up in inpatient settings. The majority of interviewees indicated that individuals in crisis will most likely be placed under a PEC whether the MCT shows up or not. This is because many ED providers are not comfortable treating individuals with BH issues. A concerning finding was that the St. Tammany ED staff that were interviewed said that the far majority of individuals under PECs will be sent to an inpatient setting even if the individual is willing to contract for safety and leave under the support of a family member. The reason is because of perceived liability issues; ED providers are not willing to release an individual to outpatient services for fear that the individual will harm himself/herself or others since they do not trust that there are reliable, accessible, and adequate outpatient services in the community. Therefore, the existing structure where the MCT responds to clients already in the ED means it misses out on the opportunity to intervene before those clients hit the ED door, when it is apparently too late to seek inpatient diversion opportunities.

In addition, individuals who report suicidal ideation and are intoxicated are often sent to an inpatient setting even though they are no longer suicidal after sobering up. As one ED provider stated, “Once police are called, they are bringing someone to the hospital, and the VOA ship has sailed a long time ago.” This process is not only an inefficient use of emergency and inpatient services and stressful to the individual, his/her family, and the ED staff, but it also places the ED/hospital at risk for a civil rights violation/lawsuit, given the impression of misuse of the PEC law. In fact, the existing PEC process works against reducing the St. Tammany suicide rate and could actually increase it. Take the example of a 50-plus year-old white male who decides to go to the emergency room to discuss disturbing thoughts he is having. If he mentions he has thought of suicide but states that he would never act on that thought, regardless, he will be placed under a PEC for three days and then admitted to an inpatient facility. This individual will have been involuntarily committed when he was just asking for help and now has a history of “mental illness” that will follow him for the rest of his life. How probable is it that this man will seek out help in the future if his suicidal thoughts return? Of all the findings in this report, the use of the ED and PEC are the most concerning from the standpoint of detriment to parish residents who struggle with BH conditions, and also the police, VOA, and ED staff who are working with suboptimal community resources to help this population.

Lastly, the panel of clients noted that the police department does not appear to differentiate between how they address a BH crisis and a criminal case, citing different anecdotes where the police were unprepared to deal with a BH crisis. For example, one client stated that “the police need to have help with that...I know they’re trained, but they need more training.” Recognizing this gap, the recommendations provided in this report include recommending that the ED and PEC baseline metrics be closely monitored to ensure all individuals struggling with BH conditions benefit from the system enhancements put in place by the Task Force, and specific opportunities for transforming the MCT and reframing how crisis services are approached in St. Tammany Parish are identified.

“The police need to have help with [behavioral health crises]...I know they’re trained, but they need more training.”

St. Tammany Parish resident, BH client

## Hospitals and Emergency Departments

Hospital EDs are currently overwhelmed each month with a large number of individuals who are experiencing a BH crisis. The number of PECs ranged from six to 72 per month, depending on the hospital. Since most of the EDs do not have psychiatric beds on their campuses (the only hospital with inpatient psychiatric beds is Lakeview Regional Medical Center and it is for ages 55 and older), they focus on finding inpatient placement to get these individuals out of their EDs. This task is typically challenging, and they often must make “deals” with inpatient providers to take uninsured individuals along with insured patients. Depending on hospital processes and whether the individual is difficult to place, very few individuals are placed in inpatient settings in less than 24 hours, while others sometimes stay in the ED for as long as two weeks until the hospital finds them an inpatient psychiatric bed. During this time, the individual may be chemically (i.e., sedated with pharmaceuticals) and/or mechanically restrained (e.g., physically restrained with handcuffs or leather restraints). Furthermore, many of these

inpatient placements are located outside of St. Tammany Parish, leading to further complications with costly transportation (i.e., an ambulance is required to transport) and the disruption of support systems. Generally most EDs have an easier time placing children and adolescents than adults due to the availability of Medicaid funding for pediatric care.

All of the EDs have different policies for how they screen, assess, and place individuals in outside facilities. Such policies and protocols include: having agreements with inpatient facilities and other organizations to do an on-site ED psychiatric assessment, using an outside agency to find placement (e.g., having a psychologist on retainer) and using a social worker or case manager to call around and find beds. The variance in policies and protocols between EDs results in various determinations for the most appropriate (i.e., least restrictive) placement for BH clients, meaning that a client's experience may vary drastically from one ED to the next, and even from one visit to the next. These inconsistencies impede tracking of BH ED clients and limit comparisons across hospitals, which results in a lack of care coordination for individuals who utilize multiple EDs and a number of challenges in assessing ED utilization for BH crises throughout the entire BH system.

Clients recognize the limitations of psychiatric care in the ED. One client said, "They do pretty well...They're not mean to you, but they put you in a room because that's all they know to do. That's it. They lock you up." In regards to the ED assessment of individuals in crisis another client stated, "I think they should have somebody that could judge a little better, what they're going to do." Furthermore, according to the provider and client interviews, not all individuals who present to the ED with a

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**"I think they should have somebody that could judge a little better, what they're going to do."**

St. Tammany Parish resident, BH client

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psychiatric complaint actually need an inpatient bed, but they are all sent to inpatient facilities due to a lack of alternative community-based resources. Hospitals are overwhelmed serving this population, but they are engaged in the BH system improvement process as they desperately want a solution to prevent individuals in crisis from clogging their EDs.

## Inpatient Capacity

Although hospital EDs report challenges finding placement for individuals in crisis, there seem to be inpatient facilities that have openings. Northlake Behavioral Health System accepts Medicaid as well as private insurance and maintains several safety net beds for uninsured individuals with acute needs. All patients must be medically cleared and detoxed before admission. Northlake Behavioral Health System is hoping to become a center that offers a continuum of services, and currently offers a long-term residential psychiatric treatment facility for adolescents. Northlake Behavioral Health System also has a dedicated discharge planner that works with the next level provider. Greenbrier Behavioral Health Hospital offers adult inpatient, intensive outpatient, and partial hospital services. While Greenbrier Behavioral Health Hospital does not receive safety net funding, it legally cannot deny indigent individuals. Greenbrier Behavioral Health Hospital sometimes offers medical detox services, and provides some onsite psychiatric crisis services. However, these services are not widely known in the community and are therefore often under-utilized. There exists significant opportunity to more

efficiently utilize beds at these inpatient facilities, as well as unused space at other hospital sites, as part of a transformed system of BH care in St. Tammany Parish.

### St. Tammany Outreach for the Prevention of Suicide

STOPS leads a number of programs around suicide prevention, education, intervention, and support. This year STOPS worked with the St. Tammany Parish Public School System to send information on suicide awareness and prevention to all students and their families. Within STOPS, Local Outreach to Survivors of Suicide (LOSS) offers immediate assistance to individuals who have recently lost someone to suicide, and the Survivors of Suicide support group serves friends and family members of suicide victims. From July of 2012 to June of 2013, STOPS trained approximately 200 people in suicide prevention and intervention, and their LOSS team contacted, counseled, and offered support to 95% of the families who lost loved ones to suicide.

### St. Tammany Community Health Center

The St. Tammany Parish public health millage provides limited funding for outpatient BH services at STCHC, which is a federally qualified health center (FQHC). FQHCs are community health centers that receive enhanced reimbursement from Medicaid to provide services to under- and uninsured residents. STCHC has two sites: one in Slidell that has been open since 2011 and a new site in Covington that opened in 2013. The Covington site offers BH services Monday to Friday and might add primary care in the future. The St. Tammany Parish Government rents the Slidell site space from Slidell Memorial Hospital and provides it free of cost to STCHC because of the parish's obligation to provide public health services. The Covington site hopes to increase the number of Medicaid clients, particularly children, so it can become self-sustainable within the next few years.

Currently, STCHC offers 50-minute traditional counseling services with social workers and medication management appointments with psychiatrists for both adults and pediatrics. When primary care providers identify the need for BH services, a referral is made to a behaviorist who provides traditional cognitive therapy. These BH providers see some clients who are unable to gain access to FPHSA (the state mandated provider of outpatient BH services in St. Tammany Parish) when they are "not sick enough" to meet FPHSA's criteria, or when the FPHSA wait list is too long. The wait times have steadily increased at the Slidell site, and STCHC estimated having 30-40% no show rates across its sites. While the psychiatrist does some consulting work with the primary care providers, the primary care and BH sides of the clinic are generally quite separated. However, the fact that both services exist within the same setting presents a unique opportunity for STCHC to transform to a more integrated system of care by making small operational changes at little or no cost to the center. These changes include the use of brief intervention and therapy approaches to reduce wait times and improved integration of the BH staff into the primary care team workflow.

## National Alliance on Mental Illness St. Tammany

NAMI has an extremely strong presence as a BH provider and advocacy leader in the parish. NAMI provides a number of services including: group homes on Northlake Behavioral Health System's campus, support groups, peer-to-peer support, family and community education, and advocacy. NAMI maintains a contract for a case manager that works with the BH court (see section on problem-solving courts below), and has disseminated a resource guide that many providers use to make referrals throughout the parish. NAMI also organized a modified Tennessee-model crisis intervention training (CIT) to police officers in 2013. While NAMI has expertise and offers evidence-based practices, it faces funding challenges as many of its programs are delivered at no cost to clients. NAMI is very highly regarded by both providers and clients alike, and it plays an important role in the parish by being a source of resources and support. Clients spoke very highly of the programs offered through NAMI, including the peer-to-peer group. One client reflected, "It does give you a sense of 'I'm not alone. I'm not doing this by myself.' I'm not destined to be this person with bi-polar disorder who's broken her entire life." NAMI also provides many volunteer opportunities for individuals with BH issues through its strong peer involvement services, which were commonly referred to as being very helpful for recovery. A common theme from clients was that volunteering helped them to "feel like they're doing something meaningful" and that they had something to keep their minds off of their illnesses. One client noted that her volunteer experience was "very healing."

"It does give you a sense of 'I'm not alone. I'm not doing this by myself.'"

St. Tammany Parish resident, BH client

## Florida Parishes Human Services Authority

FPHSA is a human services district (also known as a Local Governing Entity (LGE)) created by state statute to provide community BH care to residents regardless of their ability to pay. As a safety net organization, FPHSA serves Medicaid, under-, and uninsured populations in a five-parish region, and has two locations in St. Tammany Parish—Mandeville and Slidell. These community mental health centers provide traditional office-based 50-minute counseling, group counseling, crisis evaluation, psychiatric, psychological, and psychosocial evaluation, medication management, addiction services, permanent supportive housing, and residential services. At the time of the assessment in May 2014, FPHSA had 40 open hiring positions that were unfilled due to the state hiring freeze. Partially as a result of being understaffed as well as other inefficiencies in scheduling, care team composition, and service delivery models, FPHSA was facing wait times of up to 60-90 days from when clients called to seek services until they were seen by a provider. FPHSA's policy stated that if clients in crisis walked into a FPHSA site during open office hours, they would be seen immediately by a licensed social worker and evaluated by a psychiatrist if it was determined that they needed to be hospitalized. However, this immediate access policy only applied to those in crisis and did not address the preventive and stabilization needs of the vast majority of clients.

In addition to the long wait times to access services, FPHSA also faced a 50% no-show rate for first appointments and a 20% no-show rate for psychiatric evaluations at their Lurline Smith Mental Health

Center in Mandeville. Recognizing this challenge, along with the fact that FPHSA continued providing traditional models of service to all clients (e.g., 50-minute therapy sessions), the recommendations provided in this report aim at reducing inefficiencies by restructuring how services are scheduled and delivered, all of which can be accomplished at no financial cost to FPHSA.

It is worth noting and applauding in this report that the wait time for addiction services at FPHSA were much shorter—only one to two days, on average. FPHSA’s addictions team and services will complement the work that is recommended to improve access for their mental health services.

## Problem-Solving Courts

There are several problem-solving courts under the 22<sup>nd</sup> Judicial District Court in St. Tammany that work with individuals with BH conditions. These courts include: adult drug court, re-entry court, Driving under the Influence (DUI) court, and BH court. Many of the providers and clients who were interviewed identified the problem-solving courts as an example of what the current system is doing well. One client noted, “They are here to help you. Each and every one of them, at some point, has done that for me completely.” Clients who qualify participate in intensive case management in which they are matched with appropriate services and have weekly calls and groups. Clients of problem-solving courts all appreciated and respected their case manager and fellow group members. As one client said, “I know I can pick up the phone and call up anybody in there at any time, and they would drop what they’re doing.” Although BH court clients are supposed to have expedited access to BH services like those at FPHSA’s Lurline Smith Mental Health Center in Mandeville, they often encounter long wait times. Many of the BH and drug court clients reported how helpful the structure of the program was for them, with a few of them mentioning that they voluntarily signed up for more probation so that they could officially graduate from the BH court program. Several shared how they have gotten their families back and their lives under greater control since starting the program. For example, drug court participants have a 5.4% recidivism rate after two years, compared with a 36% recidivism rate for offenders on felony probation without drug court or treatment, and a 31% recidivism rate for offenders who are incarcerated. A few

clients suggested expanding BH and drug courts to include more levels and adding a similar program for youth as well. With the success of these intensive case management programs, St. Tammany should look at ways to replicate these services for residents before they enter the criminal justice system.

After two years, drug court participants have a **5.4%** recidivism rate vs. **36%** for offenders on felony probation *without* drug court or treatment, and **31%** for offenders who are incarcerated.

## Leveraging Opportunities with Magellan

At the time of this report, Magellan is the Louisiana statewide BH care managed care provider. Magellan is trying to build reimbursable services to develop a sustainable crisis continuum and is open to conversation about innovative programming. Magellan is currently focusing on getting individuals

into community-based outpatient care rather than inpatient care, and is interested in helping communities make this transition. To this end, Magellan started a “rate setting committee” to work with providers on rate changes based on quality improvement criteria such as their ability to reduce readmissions and create bridge appointments for clients who are transitioning in between providers. Magellan’s performance planning for 2014 was around improving discharge planning along the continuum of care. Magellan is currently doing case management with agencies to build community relationships, and it has considered funding the training of providers on newer models. Magellan also expressed that it would pay to support enhanced transition planning. Transition planning is a component of effective care coordination and involves medication reconciliation and the timely sharing of treatment records between providers who are transitioning care. Importantly, the client and their supports must also understand any changes made to their treatment plan including medication changes. Lastly, Magellan is accepting applications for Home Based Community Services (HBCS), under which Northlake Behavioral Health System is proposing to open a new CSF on their existing campus.

As of November, 2014, it was announced that Magellan will not continue as the managed care organization for BH services in Louisiana beyond December 1, 2015. The state of Louisiana has decided to carve-in BH services within five Medicaid insurance plans, known as Bayou Health plans, next year. In the interim, St. Tammany is working diligently to get a CSF up and running during the first few months of 2015, while Magellan is still the managing party. For more information on the CSF, see the recommendations section below.

### Crisis Phone Lines

The United Way/VIA LINK 2-1-1 service is a 24-hour phone line that is staffed by individuals with Bachelors of Social Work (BSWs) and Masters of Social Work (MSWs) who are trained to respond to individuals in crisis. While the 2-1-1 line serves 10 parishes, 25% of their calls are from St. Tammany Parish. The 2-1-1 counselors directly transfer individuals to providers when possible, and also make follow-up calls. They often make referrals to STCHC and Catholic Charities (a local social service organization). From January 1, 2014 through September 30, 2014, the United Way/VIA LINK 2-1-1 line received 2,321 calls from residents of St. Tammany Parish, 1,103 of which were classified as mental health-related and 66 as substance abuse-related.

“The Phone” is a second crisis phone line that was created in November 2013 and it has a local 985 area code number. It is run by the Baton Rouge Crisis Intervention Center and is an alternative option to the United Way/ VIA LINK 211 line. It is available 24 hours a day and is staffed by trained counselors who offer counseling and emotional support. Between January and December 2014, 47 calls from St. Tammany were reported to “The Phone.” There has been ongoing discussion of how to promote and raise awareness about this service within St. Tammany Parish.

### St. Tammany Parish Public School System

The St. Tammany Parish Public School System has had mental health providers (MHPs) consisting of counselors and social workers in public schools since 1994, and is currently providing services in 55 schools and two alternative programs. The MHPs’ main focus is alleviating students’ barriers to

education posed by BH conditions to ensure success in school. All of the MHPs have ancillary certificates through the Louisiana Department of Education and all have master degrees in counseling or social work. The school system participates in the Louisiana Behavioral Health Partnership to determine reimbursement of school-based BH services to children with or suspected of having disabilities.

Services provided at the schools include individual supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis. The school system incorporates districtwide Positive Behavior Intervention and Supports which include mentoring, bullying prevention, social skills groups, coping skills groups, emotional regulation groups, and restorative practices. MHPs and teachers partner to provide suicide prevention through the health and PE curriculum to junior high and high school students. MHPs also provide case management services to locate necessary resources and collaborate with other agencies to support and coordinate care; one example is using the NAMI resource list to make outside referrals. Students are self-referred or referred by parent calls, Individualized Education Plans (IEP) for special education, teachers, and the principal. The school nurses do not regularly do BH screenings, and schools do not have school-based health centers on campus. Most students who receive services see the MHPs on a routine basis and the schools ensure that there are adequate services available at all times.

The school system formed a committee in 2013 to address suicide prevention. STOPS has done some Applied Suicide Intervention Skills Training (ASSIST) training with teachers, and suicide prevention training has also been provided to staff through The Jason Foundation curriculum, safeTALK, and Safe Schools. In addition, BH education and awareness information and resources were sent to all students' families at the beginning of the school year and are also available on the school system website. In an effort to receive the most up to date, evidence-based information, the school system received the school suicide prevention specialist accreditation through the American Association of Suicidology.

Many BH clients that were interviewed recognized that a BH issue affects not only the individual but the entire family, and expressed concerns for their children. Clients agreed that the counseling provided through schools has been helpful, but they perceived that BH currently is not a priority concern in schools, and that awareness among the greater public is lacking. There was widespread agreement on the need for early intervention programs and education for all students. In reference to BH education being provided in schools, one BH consumer stated, "It may be something you don't talk about, but we educate on everything else!" The school system is continuing to collaborate with outside agencies to increase their understanding of what the school system can do, and how to collaborate on providing services to students in the community.

### Private Providers and Other Agencies

Throughout the interviews, various private providers were mentioned as collaborative partners serving the Medicaid and safety-net population in St. Tammany Parish.



## Trinity Community Support Services

Trinity Community Support Services provides Community Psychiatric Supportive Treatment (CPST) services to both adults and children. Clients receive individualized plans for their BH and physical health needs. Clients can be self-referred or are often referred from schools, doctor's offices, Youth Services Bureau, Department of Children and Family Services, or Magellan. Trinity's treatment support team is comprised of a social worker, clinical supervisor, and a part-time psychiatrist. Staff is on call 24 hours per day. If a client presents as psychotic or suicidal, they try to get him/ her to talk to the nurse practitioner or doctor, and may help facilitate the PEC process by going with him/her to the ED when necessary. Trinity Community Support Services accepts Medicaid and Magellan and operates on a sliding scale for the uninsured. Staff conduct at least 51% of their meetings out in the community, and provide CPST for trauma, abuse, loss, grief, and family issues, as well as psychosocial rehabilitation. New clients typically wait between two and a half to six weeks to get in for CPST services because their psychiatric and Medicaid assessments have to first be approved by Magellan. As an alternative, new clients do not have to wait to receive pass-through services. Pass-through services are only offered in the office and include 24 therapy visits and 12 medicine management visits per year. After an intensive program, those on Medicaid go on a step-down program with medication management every other week.

Trinity has good relationships with other services, such as VOA, pharmacies, and FPHSA. Trinity hopes to expand to have more groups and parent-family interventions, but are facing challenges as its providers receive low reimbursement rates for their counseling services. However, Trinity Community Support Services can act as a model for other BH providers that want to start offering CPST services to their clients.

## Youth Services Bureau

Youth Service Bureau (YSB) is a local social service agency that started in 1981 and provides services to at-risk youth and their families. Their programs include Court Appointed Special Advocates, Truancy Assessment and Service Center, Families in Need of Services, Crossroads delinquency intervention, and Options addiction treatment program. The programs address truancy, juvenile delinquency prevention and intervention, and substance abuse. Many of the YSB clients are referred from schools and YSB refers their clients to a number of BH providers in the parish. The client panel seemed to be well aware of YSB, but agreed that the services, although helpful, were not sufficient.

## Family Preservation Services—Assertive Community Treatment

Recently, Family Preservation Services began operating an Assertive Community Treatment (ACT) team to provide services to St. Tammany Parish residents. The ACT team is an evidence-based, high intensity, community-based team approach to serving clients with severe and persistent mental illness (SPMI) (Bond, Drake, Mueser, & Latimer, 2001). At the time of this report, the ACT team had available openings for Medicaid-eligible adults in St. Tammany Parish.

## Other Community Supports

Other agencies, support resources, and private providers who were mentioned in interviews were Abundant Health, Acer, AL-ANON, Beacon Behavioral Hospital, Catholic Charities, St. Vincent de Paul, Center for Hope Children and Family Services, Community Resource and Referral Centers, Magnolia Behavioral Health Care, Mercy Family Center, Red River Treatment Center, River Oaks Hospital, Southeast Community Health System, Therapeutic Partners, Townsend, and Truth 180. Clients mentioned many of these private providers as being of high quality and very helpful. However, the services were often too expensive and not covered by Medicaid. On occasion, those with private insurance were able to access services for a short period of time for themselves or their children. Clients saw the expensive private centers as being the only alternative to Lurline Smith Mental Health Center for issues such as drug abuse or BH care for minors.

## Opportunities

Based on these report findings, the team identified several opportunities for transforming the St. Tammany BH system into one that is high quality, coordinated, and accessible to all residents of St. Tammany Parish. During a Visioning Session in May 2014, the Task Force convened to establish a shared vision for moving forward and consensus on prioritized issues. During this meeting, the Task Force committed to participating in three workgroups to address the identified issues: emergency services, crisis continuum, and education, training, and advocacy. Each of these workgroups plays an integral part in moving this work forward.

### Summary of Opportunities

It is recommended that St. Tammany move to a recovery oriented system of care (ROSC) approach, which requires a flexible, collaborative continuum of services. There will need to be substantial investment in community oriented systems of care including crisis residential services, supportive housing, supported employment, group counseling services, and specific psycho-social rehabilitation services such as clubhouses and community centers. An ideal continuum of services was used to model a “future state” system of care for St. Tammany Parish, which the Task Force will use as a guide during their system transformation over the coming years.

### Recovery Oriented System of Care

St. Tammany’s BH efforts have historically largely focused on suicide prevention and crisis intervention. There is growing agreement that the parish’s scope of focus needs to be broadened to include the entire continuum of BH services. As one client pointed out, “There’s no togetherness in all of this.” Rather than just honing in on crisis interventions, it is essential to address the lack of access to preventive and less intensive BH services in the parish.

Over the past decade the approach to treating individuals with SPMI has dramatically changed, moving medication and individual therapy to a ROSC approach (Sheedy & Whitter, 2009). A traditional outpatient approach to treatment has been found to be less effective with individuals who are struggling with basic elements of daily living such as housing, employment, food, and clothing. Much more effective is a ROSC that provides for basic needs first and, when individuals are ready, works on problems that are best solved through talk therapy.

In this model, recovery does not mean cured. SAMHSA defines recovery as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2011). It assumes that addiction and mental health disorders are long-term, chronic illnesses that will require care over a lifetime in the same way that diabetes and heart disease require life-long care. This definition does not mean the individual cannot achieve a full life in recovery, but it does require that a continuum of care be available where the client can step up their care if symptoms are present and step down their care when symptoms are controlled. Clients in St. Tammany Parish recognize the need for a continuum of care, and one shared that there are too many

individuals that “can’t get the right level of help, or adequate help.” Another stated, “Some people will be leading to recovery and it may be too soon for them to start the [group] class...it will start them on this roller coaster-type thing that they may end up in the hospital.” A ROSC requires a flexible, collaborative continuum of services in the community. Further principles of recovery include:

- There are many pathways to recovery.
- Recovery is self-directed and empowering.
- Recovery involves a personal recognition of the need for change and transformation.
- Recovery is holistic.
- Recovery has cultural dimensions.
- Recovery exists on a continuum of improved health and wellness.
- Recovery emerges from hope and gratitude.
- Recovery involves a process of healing and self-redefinition.
- Recovery involves addressing discrimination and transcending shame and stigma.
- Recovery is supported by peers and allies.
- Recovery involves (re)joining and (re)building a life in the community.
- Recovery is a reality (Sheedy & Whitter, 2009).

Developing a ROSC for individuals with addictive and/or mental health disorders requires a substantial investment in community oriented systems of care including crisis residential services, supportive housing, supported employment, group counseling services, and specific psycho-social rehabilitation services such as clubhouses and community centers. It reduces the reliance on costly inpatient care, ED utilization, and traditional outpatient counseling. These services are focused on:

- Being person-centered;
- Including family and other natural supports;
- Being individualized and including comprehensive services across the lifespan;
- Systems anchored in the community;
- Continuity of care;
- Partnership-consultant relationships;
- Being strength-based;
- Being culturally responsive;
- Being responsive to personal belief systems;
- Peer recovery support services;
- Voices and experiences of recovering individuals and their families;
- Integration of physical, mental health, and substance abuse disorder services;
- System-wide education and training to extinguish stigma;
- Ongoing monitoring and outreach;
- Targeting Quality Outcomes, Innovation, Cost Effectiveness, and Customer Satisfaction;
- Research-based/evidence-based services; and
- Being adequately and flexibly financed.

See Figure 1 below for the framework for developing a ROSC. This framework is used to guide and inform all of the recommendations in this report. How St. Tammany Parish can move to this model and specific implications for existing services are discussed in the recommendations section of this report below.

Figure 1. Recovery Oriented System of Care Continuum

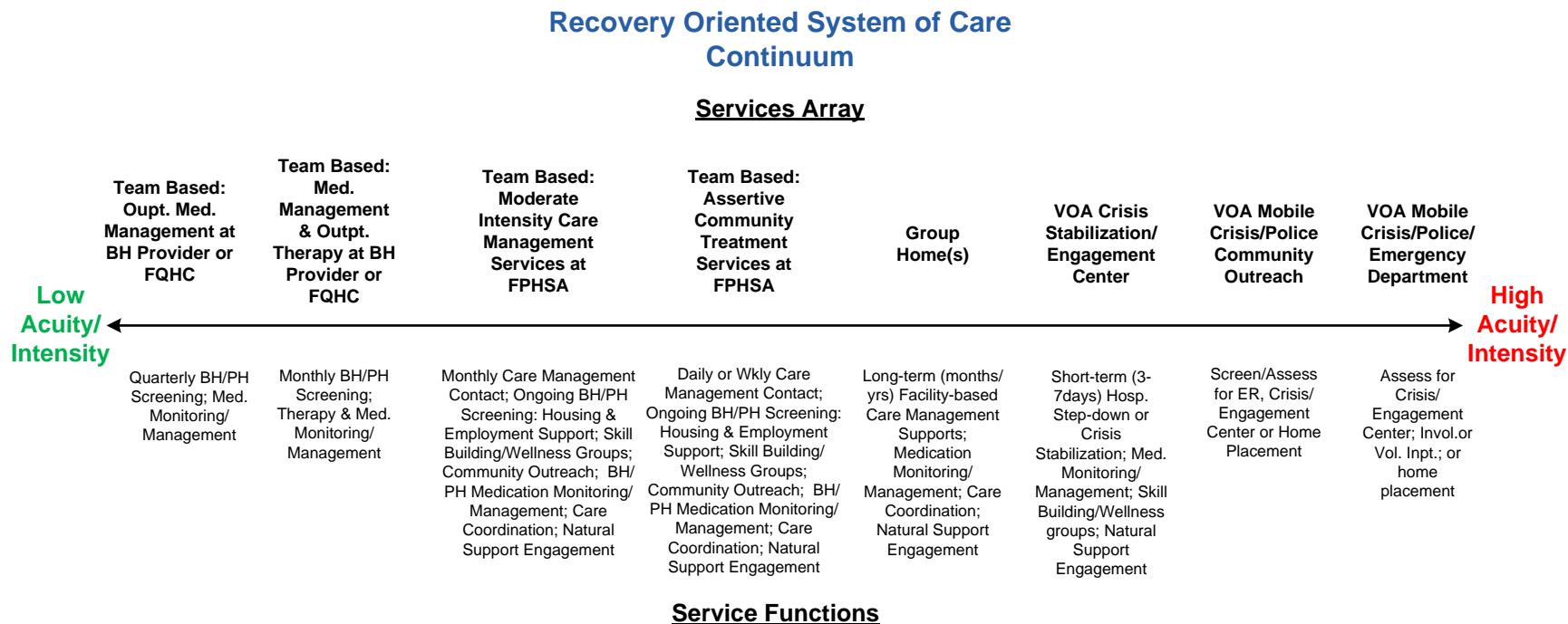
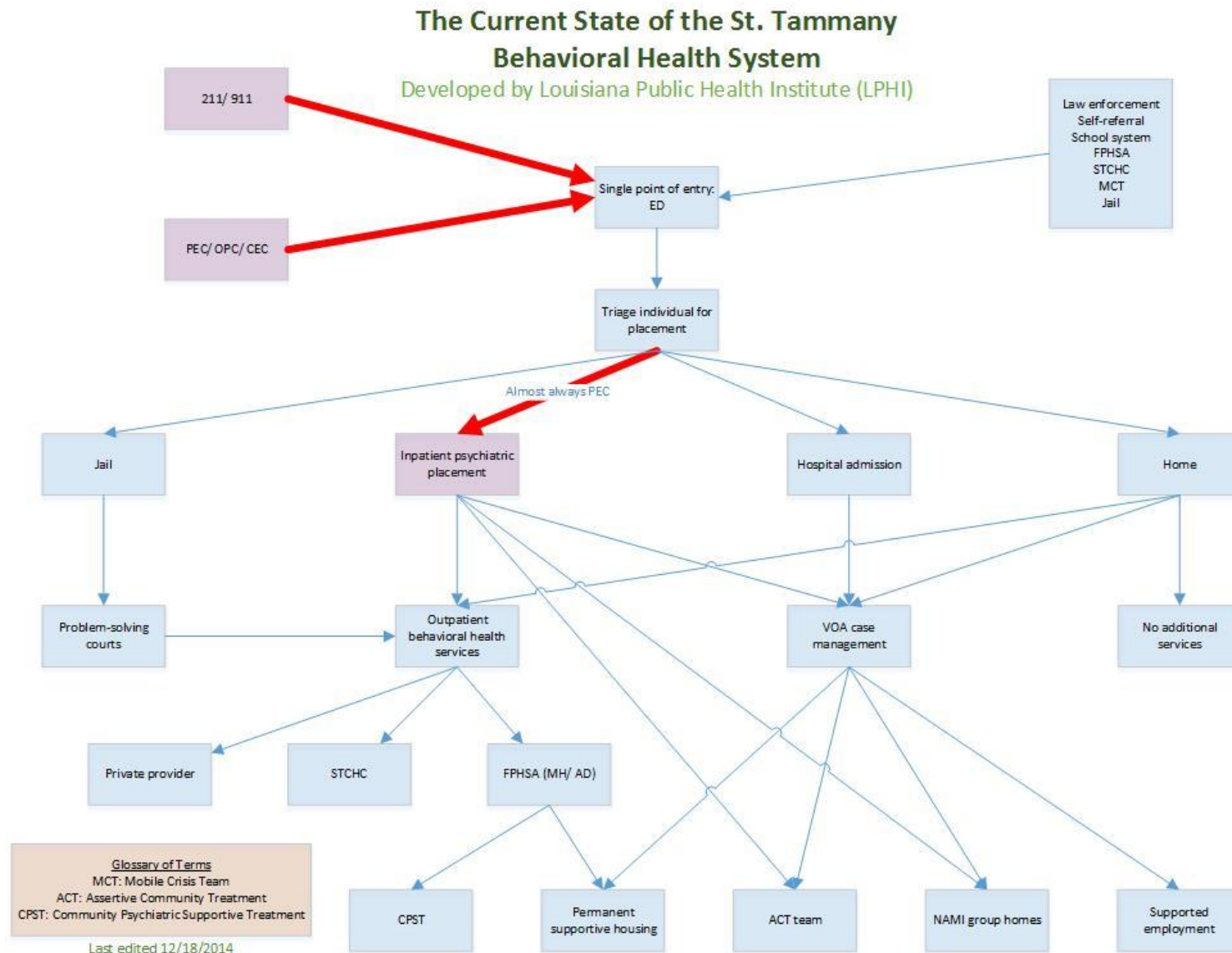


Figure 1 above details a proposed continuum of services from low acuity to high acuity services. This “ideal” continuum was used to model a “future state” system of care for St. Tammany Parish, which the Task Force will use as a guide during their system transformation over the coming years. The crisis continuum workgroup provided input on the development of the “future state” system to ensure alignment with the Task Force’s overall vision. In order to understand what steps are needed and which new services need to be developed in order to get to this future state, the current system was also mapped with clearly defined gaps, bottlenecks, and barriers. Both the current state and future state diagrams can be found below in Figures 2 and 3, respectively.

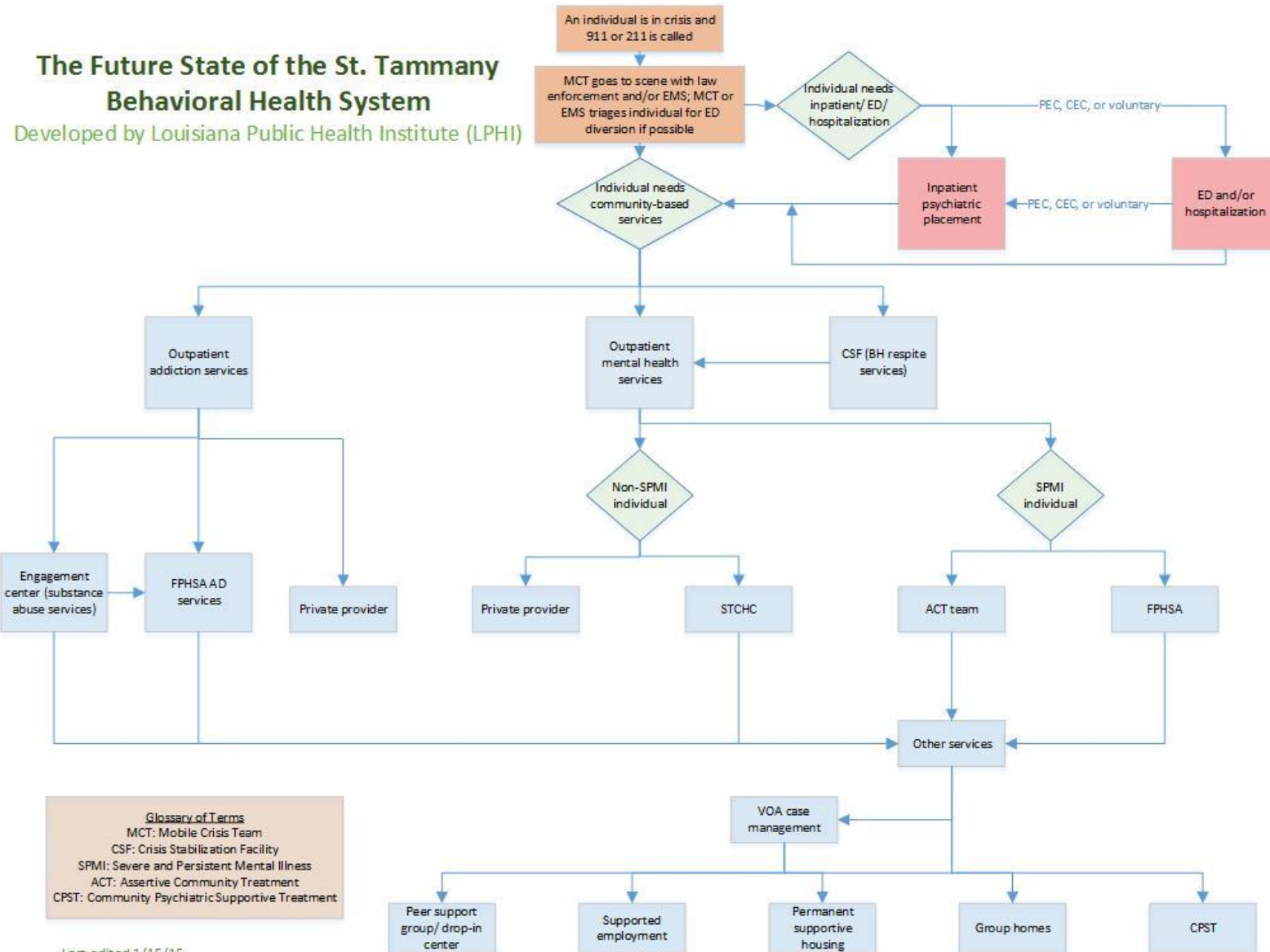
Figure 2. Current State of the St. Tammany Behavioral Health System





The current system diagram in Figure 2 above illustrates the over-reliance on PECs, CECs, OPCS, and the ED for individuals in crisis. As seen in the diagram above, the ED acts as the single point of entry. The purple boxes and red arrows indicate pathways that are currently the most common for individuals in crisis and are areas that need improvement, many of which are addressed by the recommendations within this report. Most individuals in crisis come to the ED through 911 and/or PECs, CECs, and OPCs. While the MCT's aim was to increase diversion from the ED, the MCT typically meets the individual at the ED rather than at the scene, and they are rarely able to divert the individual to their home or an outpatient setting rather than an inpatient placement. Individuals in the ED are almost always placed under PECs and sent to an inpatient psychiatric placement. While VOA case management helps connect clients with a variety of services, it is not really a preventative service as it is mostly only available for clients that recently experienced a crisis. In the current system there is a lack of coordination and information sharing between providers regarding the types of clients that should be receiving the different levels of services. There is also a distinct percentage of clients that are not linked with services or that face extremely long wait times to get into services following crises.

Figure 3. Future State of the St. Tammany Behavioral Health System



The future state diagram in Figure 3 above is a working document that provides the Task Force and workgroups a vision of the ideal system that they are working towards. It lays out the exact interplays between partners and creates a sense of collaboration, responsibility, accountability, and mutual understanding of how each piece fits together to hold the system together and prevent clients from going back into crisis. It is easy to see how if one element falls through, then the rest of the system may collapse as well. This diagram has been created in collaboration with the crisis continuum workgroup, and the workgroup members will continue revising it as they change and create services, processes and protocols, and linkages between services.

The diagram and arrows do not represent a linear process, but rather shows the flow of services for individuals in crisis in which individuals can receive multiple services depending on their needs. While the current BH system relies on the ED as the single point of entry for individuals in crisis, the future system has a number of community-based alternatives and a triaging system to divert individuals from the ED into outpatient addiction and/or mental health services if possible. When individuals are in crisis, the MCT will go to the scene with law enforcement and/or EMS, and the MCT or EMS will triage the individuals depending on which services are the most appropriate for them. While the current system overly relies on PECs, CECs, and OPCs, in the future system, individuals will only be placed under PECs and CECs when it is absolutely necessary that they go to an inpatient setting or ED. Individuals will flow to different outpatient mental health services based on whether they have SPMI or not, and outpatient providers will coordinate and share information to ensure clients are seeing the appropriate level of provider. The new system also includes an engagement center and a CSF, both of which are included as recommendations in this report. The other services listed at the bottom of the diagram including VOA case management will provide a strong foundation of community-based services to prevent clients from going into crisis. All individuals, including those who have not experienced a crisis, will be linked into these other services.

The next section will present the recommendations as they were shared with the Task Force in July 2014, with updates noted as appropriate on recommendations that have been adopted so far at the time of this report (January 2015).

## Recommendations

Communities often have the misperception that bringing in new providers is the best solution to improving their BH system. Creating new providers increases the administrative costs of the system and decreases resources for care. A better approach is to work collaboratively with existing providers and improve their service delivery through concrete outcomes and performance-based contract monitoring. If providers are not successful at what they do, it is important to either help them get better or not renew a contract. Allowing poor performance of any provider lessens the quality of care and wastes precious funding.

To enhance the collaboration between providers and establish responsible parties for implementing the recommendations from this report, the three workgroups that formed as a result of the Visioning Session have been tasked with following through on the recommendations provided below. It is recommended that the workgroup leaders be given dedicated time by their respective organizations to champion the workgroups and lead the change efforts that are needed. It is also essential to have a dedicated, paid leader to facilitate the Task Force, providing coordination between workgroups. These recommendations are built on the foundation of developing a ROSC in St. Tammany Parish that capitalizes on the existing, talented providers within the community.

### Summary of Recommendations

The following five recommendations provide a framework for St. Tammany Parish and the Task Force to transform their BH system and improve coordination, quality, and efficiency.

- Enhance existing community behavioral health services.
- Transform Utilization of Emergency Services
- Enhance the Crisis Services Continuum
- Enhance Advocacy, Education, and Training Opportunities
- Enhance Social Services

### Recommendation #1: Enhance Existing Community Behavioral Health Services

St. Tammany Parish has multiple community BH safety net service providers who deliver excellent care once clients are enrolled in services. The problem is getting clients in the door in a timely manner. The following strategies are recommended to restructure how services are delivered, without adding new providers or significant financial cost to the providers.

#### Florida Parishes Human Services Authority: Transition to Team-Based Care

Multidisciplinary team-based approaches are an effective method for improving the provision and coordination of care (Smith, Allwright, & O'Dowd, 2007). A team-based approach has also been linked to reduced staff burnout (Ibid). Team-based care is called for in the Affordable Care Act and is an evidence-based service for BH care in the U.S. (Hunter, 2013). The team-based approach will enhance

the FPHSA staff's capacity to engage and serve clients in the community and coordinate with social service and health care providers. Additionally, this approach should create staffing efficiencies allowing for more ready access to medication services, as well as individual and group therapy and wellness and psychoeducation services. The National Council could work alongside FPHSA as it makes the transition to team-based care to include primary care integration as part of the team. Integrated care has long been the standard of care for individuals with SPMI to address the early loss of life and to provide quality care (Sabourin & Reynolds 2008).

*Status Update:* Under the leadership of their Executive Director and a new Medical Director, FPHSA is already in the process of redistributing their caseloads from individual providers to teams. FPHSA received two days of on-site consultation from the National Council to design and implement team-based care protocols, and reports from FPHSA staff indicate they are eager to begin restructuring their programs to accommodate a team-based approach.

### Florida Parishes Human Services Authority: Transition to Same Day/Next Day Access

Efficiencies created by a team-based approach will help lessen the burden brought about by understaffing but may not be able to meet the entire need. FPHSA has expressed interest in implementing evidence-based short-term behavioral interventions and same day/next day services as a way to alleviate their long wait times and high appointment no-show rates.

The standard of care for accessing BH services has moved to same day/next day access to mental health and addiction outpatient services (LLOYD, 2010). Same day/next day access means that clients or family members who call to initiate care are encouraged to come into the clinic that same day or, at worst, the next day. Clients come in without an appointment and are seen within 30 minutes to begin the initial intake and assessment process. This ensures that all clients leave their first appointment with answers to their questions and a plan to address their presenting problem or concern. The first response to this concept is often that it is impossible to do without any new resources. However, across the country this model of care is implemented each and every day in mental health and addiction programs within existing funds. During the transition to same day/ next day access, current scheduled intakes processes are dismantled, with support from supervisors and administration. This approach increases client engagement because clients receive initial care when they need it, not just when the provider is available. It also increases productivity by decreasing no-shows and leads to greater community and client satisfaction with care.

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FPHSA has reduced wait times from **60-90 days** to  
**3 hours** on the same day.

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*Status Update:* FPHSA staff participated in a three-part training (two separate on-site consultation visits and bi-weekly coaching phone calls with the National Council and LPHI) on same day/next day access and the use of a team-based model of care to support same day/next day access in St. Tammany Parish. The FPHSA leadership was convinced that same day/next day access was possible after two days of detailed discussion, and on May 15, 2014 the concept was reviewed with all FPHSA staff in a series of small group meetings. FPHSA also discussed this movement to same day/next day access with the community at the Task Force meeting and received positive input at that time. FPHSA implemented the same day/next day access model at their Lurline Smith Mental Health Center and Northlake Addictive Disorders Clinic on November 3, 2014 and has since reduced wait times for services from 60-90 days to 3 hours on the same day.

### Florida Parishes Human Services Authority: Incorporate On-Site Pharmacy for Some Locations

Pharmacy companies across the country are integrating into BH clinics due to the large volume of high-cost medications that BH clients are prescribed. When invited, pharmacy providers will often pay for renovation to the building as well as rent. Any accreditations or licenses are paid for by the pharmacy. This model provides a convenient solution to medication reconciliation and adherence issues, as the pharmacy provides itemized pill boxes and/or “bubble packs” for clients. The on-site location is convenient for the clients and the community at large. On-site pharmacies can also track the prescribing practices of physicians, including filling and refilling prescriptions, and provide consultation to the BH team. This model can help reduce the overuse of multiple unnecessary medications, and support compliance with appropriate medication regimens.

Pharmacy services would be a self-funding and potentially revenue-generating opportunity for FPHSA. At least two national pharmacy companies would be available to bid on a pharmacy at Lurline Smith Mental Health Center and/or other FPHSA sites. The National Council could facilitate a meeting with these companies. The advantage here is that these companies can assist with Patient Assistance Program medications and help support the 340B drug pricing program so STCHC and FPHSA have greater access to low-cost medications for their shared clients.

### St. Tammany Community Health Center: Transition a Portion of the Behavioral Health Services to Evidence-Based Brief Interventions

The counseling services at STCHC could be expanded if the service delivery model was revised to include evidence-based, short-term, solution-focused therapy, provided alongside the primary care services (Robinson & Reiter, 2007). Currently the program operates as a BH program only, providing traditional 50-minute sessions. A combination of traditional sessions and the increased availability of brief solution-focused interventions during the primary care appointment could increase the number of individuals seen for BH from eight, one-hour appointments to at least 12 half-hour appointments and two one-hour appointments. This model extends the services without additional funding for the uninsured.

Additionally, FQHCs can bill Medicaid and Medicare at enhanced rates for BH services compared to non-FQHC providers and it is recommended that STCHC maximize third party payments and document those third party collections to St. Tammany Parish in monthly reports. The funding STCHC receives from the St. Tammany Parish public health millage should be used for uninsured individuals only, and should be requested monthly through a fee for service reimbursement model, rather than receiving a lump sum each year. In the fee for service model STCHC would identify the number of counseling and brief intervention sessions provided to indigent clients each month, and St. Tammany Parish would reimburse the center at an agreed upon rate per session. This model should increase productivity and expand capacity for BH services at STCHC without requiring additional financial investment from St. Tammany Parish.

*Status Update:* STCHC received on-site consultation with the National Council to engage leadership and train providers (Licensed Clinical Social Workers) on moving towards using brief interventions in clinical practice. The training was well received, and the FQHC operator (Access Health Louisiana) committed to piloting the roll out in one of their sites by replacing 70% of their traditional therapy services with brief interventions.

### National Alliance on Mental Illness: Reorient from Service Provider to Advocacy Organization

It is clear from the stakeholder interviews that NAMI is providing a considerable amount of high quality education, advocacy, and clinical services provision. Across the U.S., NAMI does not traditionally provide clinical services; its mission is education and advocacy. It is recommended that NAMI be allowed to focus on education and advocacy and turn clinical services provision over to the BH provider community. Given the great need and the high quality of the NAMI clinical services, it is recommended that these services only transition if other providers are able to provide a commensurate level of service capacity and quality.

### Recommendation #2: Transform Utilization of Emergency Services

The issue of ED overuse for psychiatric crises is not unique to St. Tammany Parish. What is unique is that all hospital EDs are members of the Task Force, which presents the opportunity to transform how emergency services are utilized throughout the parish as a whole, rather than the responsibility falling on each ED independently. The emergency services workgroup is responsible for considering these recommendations and taking the next steps towards implementation.

### Gain Emergency Department Leadership Commitment to Improve the Emergency Services System Design

As discussed previously, the St. Tammany BH system currently greatly relies on crisis staff, police, hospital EDs, and PECs as the primary means of addressing BH crises. It is essential that the emergency services system is able to respond to and refer individuals in mental health or substance abuse crises to the appropriate level of care, especially to determine when individuals are facing an actual emergency

vs. when they would be better served by community providers. The Task Force needs to gain commitment from the leadership of the emergency services in the parish (hospital CEOs, police, EMS, etc.) to collaborate and allocate staff resources to improving the design of the emergency services system.

### Develop Capacity for Sharing Real-Time Information among Emergency Providers

As with many communities, different hospital EDs in St. Tammany Parish often share clients, yet there is no system in place to communicate among the various providers. There is also no established protocol for communicating about appropriate referrals and placements, whether that is between police and/or EMS responding at the scene who need to locate appropriate emergency services (e.g., availability of psychiatric capacity at the closest hospital) or EDs who need to locate appropriate inpatient facilities to which they can discharge individuals in need of such placements. It is highly recommended that the hospital ED leads meet and create a workflow that maps the current process for responding to BH crises. They can then begin to identify gaps in the current flow and brainstorm how processes can be improved. It is also recommended that the emergency providers investigate the possibility of creating business associate agreements so that providers can share information regarding their shared clients. These agreements can be designed to assure all Health Insurance Portability and Accountability Act (HIPAA) and other privacy concerns are protected.

### Assess Technology Needs for Clinicians to Work Collaboratively

A variety of technology solutions are required to enhance the efficiency and effectiveness of BH service provision in St. Tammany Parish. FPHSA is in the process of upgrading their electronic medical record (EMR). In order for staff to work effectively and efficiently in the community they will need hardware with connectivity to the EMR. Additionally, FPHSA and other community-based providers need access to health information exchanges and managed care portals. Finally, telemedicine is a billable and effective solution to a scarcity of prescribing professionals. All of these needs require a thorough assessment of the current technology and technology gaps.

Completing a full technology assessment and strategic plan for BH providers would cost approximately \$100,000. This process could include working with a national firm (for example, Afia). The firm would meet with providers, identify core technology needs of the system, choose and implement an EMR and mobile technology (e.g. phone, tablet, kiosk, and health monitoring devices for clients), and develop a full strategic plan for moving the system to 100% computerization of documents and billing. The cost would be less if the providers do not need to choose a new EMR.

### Standardize Screening and Referral Process between Emergency Providers

ED and inpatient diversion are critical to any BH continuum of care (People, Inc. & OptumHealth, 2011). While St. Tammany Parish has incredible support from hospitals, good community care needs to focus on diversion activities that support recovery. At the core of this overuse of ED and inpatient hospitalization in St. Tammany Parish seems to rest a heightened level of discomfort with suicidal



ideation that surpasses most communities. While a completed suicide is devastating for a family and a client, it cannot paralyze and prevent a community from engaging in evidence-based community care.

Findings from the interviews indicate that there is a lack of distinction between when an individual seeks care voluntarily at an ED and when an individual truly needs involuntary commitment. It was also found that all EDs have different protocols for assessing suicide risk. With that variance in protocol, one commonality between all EDs is that it appears that any use of the word “suicide” or indication of harm to self results in a PEC and most likely a subsequent inpatient admission. However, suicidal thought is often temporary and a solution to an individual’s problem can often be addressed in a much less restrictive setting. In order to accurately assess suicide ideation, the individual should be assessed with an evidence-based tool to determine the true risk of completing suicide, and can then be consented into signing a contract to call for help if the feeling returns.

The suicide risk protocol should be designed in collaboration with providers, EDs, VOA, etc. The protocol should uniformly determine the individual’s level of risk regardless of at which hospital s/he is assessed, and should lead to hospitalization for only those at the highest risk of completing suicide. The tool is often administered by a social worker in the hospital ED and in consultation with a psychiatrist (via phone or tele-psychiatry) (Suicide Prevention Resource Center, 2012). The Columbia-Suicide Severity Rating Scale is one example of a tool that can be used (2009). While the tool itself does not have to be the same across the EDs, the protocol and threshold for referral to various levels of care should be consistent. All providers involved in suicide risk assessment (e.g., MCT, EMS, ED providers, etc.) should be trained on protocol and appropriate follow-up.

The adoption of an evidence-based screening tool would require only the investment of time for key staff to review and choose a tool. The cost in this recommendation would be in the universal training on the tool across the community. It is recommended that training be provided for each hospital (five half days), the police departments (one half day) and key provider agencies (one half day). After the initial trainings are complete, ongoing training should be built into new staff orientation and/or a half day of training every six months for all new staff. Following adoption of the tool, a more long-term recommendation would be to have monthly meetings with key staff from the hospital EDs to see if the proposed crisis strategies are impacting ED utilization. The dashboard is an available tool that can be utilized by the emergency services workgroup to monitor the ED utilization over time.

### Recommendation # 3: Enhance the Crisis Services Continuum

St. Tammany Parish does not currently have adequate alternatives to ED use or hospitalization for residents in crisis. By enhancing the crisis services continuum and bringing new services to St. Tammany Parish, residents will be provided with options for care depending on acuity and can be served in the most appropriate, least restrictive setting (SAMHSA, 2014).

#### Develop a Crisis Stabilization Facility for Emergency Department Diversion

While the MCT is having a positive effect on the quality of life of many residents in St. Tammany Parish, its current model is an expensive and time consuming way of diverting individuals from the ED. For a

portion of what is currently invested in the team, an 8-10 bed CSF could be developed and the MCT could operate out of it (Fenton, Hoch, Herrell, Mosher, & Dixon, 2002; People, Inc. & OptumHealth, 2011). The existing MCT could cover the facility and staffing. The MCT could also continue providing mobile crisis response services under a different payment model and the mobile worker could be dispatched from the CSF to respond on-scene with police officers in an effort to divert an individual from being automatically taken to the ED.

It is important to emphasize that a CSF is not a medical facility. It does not require on-site medical staff. A CSF specializes in helping clients stabilize post-hospitalization and in preventing hospitalization. Often run by peers, this crisis stabilization model has the individual staying at the CSF for three to five days, resolving the immediate crisis, getting linked with outpatient BH services (e.g., FPHSA's Lurline Smith Mental Health Center), and returning home. An example is the "Living Room" model (Keilman, 2011; Ashcraft, 2006). Another similar model, yet more medically focused than what is recommended for St. Tammany due to lower costs as a non-medical facility, is New Hope NOLA, which operates in New Orleans (Resources for Human Development, 2014).

Creating this model of care in St. Tammany Parish will require collaboration between the St. Tammany Parish Government, the St. Tammany Parish Coroner's Office, hospital EDs, VOA, FPHSA, Magellan, and the State of Louisiana. This program is most consistent with a specialized group home service and could fall under that set of licensing rules and regulations. Because it is "non-medical" it would not fall under the current rules and regulations that programs such as New Hope in New Orleans are currently required to follow, resulting in considerable cost savings. Since the program will be providing crisis stabilization as an alternative to ED and/or inpatient services, the staff will need training above and beyond traditional group home staff training including suicide risk evaluation, de-escalation of psychiatric crises training, short-term solution-focused counseling techniques, and crisis intervention technologies.

Funding for this service would typically be based on a daily rate charged to insurance companies (Medicaid and private insurers). Funding for the uninsured would need to come from St. Tammany Parish and it is recommended that some of the funding be redirected from the existing crisis team to this community facility. The average cost of a CSF is about \$175/day per bed (or whatever amount is negotiated by Northlake Behavioral Health System), which is a quarter of the cost of an average hospitalization (\$700-900/day) and less than 15% of the cost of a visit to the ED (\$1,200-\$1,500/day). A six bed facility would cost around \$350,000 and an eight bed facility would average around \$467,200.

*Status Update:* Northlake Behavioral Health System has applied for credentialing and licensing to open a 16 bed CSF on the campus of their existing hospital. The CSF will have eight beds for males, eight beds for females, and will be credentialed as a billable service under Magellan's HBCS. The CSF will be staffed by a team of trained providers including peers, with medical staff available as needed. As of the writing of this report, funding for the uninsured was still being investigated. The CSF plans to open in the first months of 2015.

## Develop an Engagement Center for Individuals with Addictive Disorders

Based on the 12 step model of recovery and the ROSC approach, an engagement center is a safe place for police, EMS, and other agencies to take inebriated individuals to sober up for a 23-hour period. Once sober, the individuals are offered treatment and, if they are willing to go, treatment on demand is provided. If they are not willing to go to treatment, they are invited back to the engagement center if they later find themselves intoxicated and need to sober up. A facility like this one is run with great support from the 12 step community. It is not unusual for individuals with addictions to become suicidal when intoxicated, but to not be suicidal after detoxification. The CSF and engagement center can be co-located and co-staffed. VOA could staff and operate out of the facility. Northlake Behavioral Health System has expressed interest in developing an engagement center on their campus, in addition to the CSF.

Designed specifically for individuals with an addictive disorder, this service would reduce the need for ED visits and/or provide a diversion from ED and jail for individuals experiencing suicidal ideation as a result of intoxication. Individuals that are medically cleared can go to the engagement center to sober up and prepare for a return to their home (more information on innovative ways to do medical clearance is included in the transitioning VOA to mobile crisis services recommendation below). Clients generally spend fewer than 23 hours in engagement centers, and once they are below the legal blood alcohol level they are met by a “sponsor” or “coach” who supports them in deciding whether to seek treatment and/or return home and in how to access a 12 step group or similar addiction treatment services in the community.

The average cost for an engagement center for individuals with addictive disorders is about \$175/day per bed, on average, which is a quarter of the cost of an average hospitalization (\$700-900/day) and less than 15% the cost of a visit to the ED (\$1,200-\$1,500/ day). A six bed facility would cost around \$350,000 and an eight bed facility would average around \$467,200. Paired with the training on who is eligible and safe to divert from the ED, this facility could drastically improve outcomes and reduce the costs of addiction on the community safety net. If the facility is recovery oriented and staffed by clients in recovery, those costs can be reduced even further.

*Status Update:* The St. Tammany Parish Coroner’s Office has committed \$250,000 to enhancing the crisis services continuum using their allocated funds within their budget. The proposed use of these funds must be approved by the St. Tammany Parish Council, which is still pending.

## Transition Volunteers of America to Provide Mobile Crisis Services over Traditional Case Management

Currently, the VOA MCT is providing a much needed case management service for St. Tammany Parish residents. However, typically this case management service should be provided by the safety net providers, such as FPHSA. The team realizes that VOA is currently filling a system need; this gap should be filled by other providers as a result of this transformation process. Therefore, it is recommended that VOA transitions its team to do solely mobile crisis services once case management responsibilities

are assumed by the appropriate parties (e.g., FPHSA, ACT Team, etc.). A typical MCT would respond to crisis calls in the community alongside law enforcement officers and EMS, arriving on the scene before an individual is transported to the ED or jail. The MCT would assess the individual, engage in crisis de-escalation techniques, and work alongside law enforcement and EMS to establish a plan of care with ED or jail as the last resort. Since many inpatient units currently require medical clearance, leading to many individuals being taken to the ED, it is recommended that a new program begin where EMS medically clears on site and then brings individuals to the CSF. The ED representatives are open to piloting this model. The MCT will also need to coordinate with Northlake Behavioral Health System regarding intake into and discharge from the new CSF. The MCT can only transition out of traditional case management once the community-based services are accessible and trusted to provide the care needed to keep individuals out of further crisis. Through FPHSA's transformation to same day/next day access, these services should now be available.

Furthermore, the St. Tammany Parish public health millage currently supports the VOA MCT and case management services with \$500,000 a year. It is recommended that St. Tammany Parish begin collecting data on the clients served by VOA in order to establish which ones should be covered under Medicaid or other payers, and which ones are indigent. Collecting diversion data will also provide the parish with valuable data on cost savings. Additionally, transitioning to a fee for service model with agreed upon rates for MCT response and case management visits would provide further transparency and accountability for VOA and St. Tammany Parish.

*Status Update:* St. Tammany Parish included new reporting requirements in the 2015 contract with VOA that will be monitored over the next year and will help inform future contracting and funding going forward.

#### Recommendation #4: Enhance Advocacy, Education, and Training Opportunities

The proposed BH system transformation will require the Task Force to organize a multi-year training process. These trainings can begin in St. Tammany almost immediately, and a plan should be developed for ongoing community member education and workforce development training. The following trainings are recommended for the community:

##### Crisis Intervention Training for Law Enforcement (the Memphis, Tennessee Model)

It is recommended that St. Tammany Parish send a team of law enforcement officers from the Sheriff's Office and City Police Departments to be trained in CIT from the Memphis, Tennessee police department that originated the concept. Building on the work started by NAMI, CIT is unparalleled in its effectiveness because the trainers are officers. This means that St. Tammany officers will learn from other officers who understand the challenges and intricacies of their work. The CIT needs to then be embedded at all levels of staffing hierarchy, including a new recruit orientation, and all officers need to have refresher training to achieve ultimate effectiveness.

Initial cost estimates for providing a five-day CIT program for law enforcement with fidelity to the model would cost approximately \$450/officer, for up to 30 officers per training. An initial training for 30 officers would cost \$13,500 plus expenses for space, food, and travel expenses for any outside law enforcement trainers. Lake Charles, Louisiana has a team of CIT officers who may be able to travel to St. Tammany to conduct this training.

### Mental Health First Aid

MHFA is an internationally recognized program that provides a solid base of knowledge for all community members to understand and recognize symptoms of mental illness as well as how to help individuals who display symptoms of mental illness. The training is provided to community members through faith-based organizations, schools, hospitals, chambers of commerce, and other organizations to provide a basic level of mental health literacy in the community. It is recommended that St. Tammany Parish offer MHFA trainings twice a year, as well as have up to four people trained to be MHFA trainers. See Appendix C for full details on MHFA trainings.

The cost to provide MHFA training to community members is estimated to be \$170 per person, for up to 30 people per training for a total cost of approximately \$5,100 plus expenses. This training is typically for one full day. A training of trainers for the St. Tammany Parish would cost approximately \$30,000 plus expenses. This five day long training is a “Train the Trainer” model and can accommodate up to 30 people. Individuals that complete the training are certified MHFA Trainers and can provided additional shorter trainings for agencies and the community. Each of these trained trainers are then required to provide three trainings a year to keep their certification up to date. This arrangement would provide a long-term, sustainable model for the community for a one-time investment of funds.

*Status Update:* SAMHSA provided the first round of MHFA training to community members in St. Tammany free of charge in October, 2014. Twenty-eight residents were trained and the training was well received. NAMI hosted the training and will coordinate bringing future MHFA trainings to St. Tammany.

### Additional Trainings for Behavioral Health Staff

The National Council can assist with these trainings as necessary and/or provide referrals to groups that provide the trainings in local communities. Complete descriptions of the two trainings mentioned below are included in Appendix D.

1. Case Management to Care Management training for case managers on the “whole health approach” to services and how to provide those services in a community-based setting. Case to Care Management training for up to 50 participants per day, if provided by the National Council, would cost \$3,500/day plus expenses. The total cost would be determined by the total number of staff to be trained from across the continuum.

2. Whole Health Action Management Training for peer staff and their supervisors to train clients on how to set and achieve health goals. It is a five-day training and costs \$10,000 plus expenses for the week. The training can accommodate up to 30 participants.

#### Additional Trainings for Behavioral Health/Primary Care/Emergency Department Staff

These trainings are specific to St. Tammany Parish and would be developed by the National Council in association with key national experts.

1. Evidence-based suicide risk assessment protocol training for use in all EDs across the parish, public safety systems, and BH providers. One such tool is the Columbia-Suicide Severity Rating Scale (2009).
2. Training on distinguishing between BH crises that require hospitalization and those that do not. This one-day training for ED staff would cost approximately \$5,000 plus expenses.
3. Training on community alternatives and diversion to inpatient psychiatric hospitalization. This one-day training for the community on alternatives and diversion would cost \$1,875 plus expenses.

#### Recommendation #5: Enhance Social Services

Social services are an integral part of any BH system. Basic needs such as safe and affordable housing and reliable transportation must be addressed in a ROSC. The need for crisis services is directly proportional to the capacity and effectiveness of the existing continuum of evidence-based outpatient services. Not traditional outpatient services such as counseling, but outpatient services such as case management, supported employment, crisis residential services, supported living, and group home services (Parks, Swinfard, & Stuve, 2010). When there is an inadequate amount of these services, visits to EDs exceed expectations, inpatient admissions are used in lieu of outpatient services, and even suicide rates can increase. Communities can then fall into a trap thinking that they need more “crisis services” and counseling, when in fact they need prevention, community-based psycho-social, and longer term interventions. For example, sometimes enhanced transportation services to get individuals to existing services can go a long way to addressing the problem. The need for enhanced transportation and housing supports emerged as the top social service gaps in St. Tammany Parish.

#### Assess and Enhance Transportation Services

The need for transportation to and from appointments was identified by multiple individuals during the stakeholder interviews. Lack of transportation has been found to be a significant barrier to maintaining health and therefore cannot be ignored when working with a client from a “whole person-centered approach” (National Research Council, 1993; Surface Transportation Policy Partnership). One method of ensuring clients receive services is by providing more team-based community outreach where certain BH staff can meet the individual in their home. However, attending office appointments will still be necessary. Providing access to reliable transportation would ensure individuals can make it to see their providers when they need to. Some examples of potential transportation solutions include volunteer

driver programs, client-run van services, contracts with local taxi services to provide reduced rate contracts in exchange for guaranteed ridership, and use of Medicaid-eligible reimbursements (National Volunteer Transportation Center, 2014; SAMHSA, 2004). It is recommended that the Task Force research these potential options to determine which ones would have the most impact in their community.




### Assess and Enhance Housing Supports

Currently, a limited number of FPHSA clients receive residential supports, and the public health millage supports limited housing opportunities in partnership with NAMI and HUD. Developing team-based community outreach approach to staffing will help to address this need (e.g., assisting with communication with the client's landlord, finding home goods, assessing living conditions, or arranging utilities). However, additional supports are needed to ensure clients are able to remain living in their community in the least restrictive environment possible. It is recommended that the Task Force work collaboratively with FPHSA, NAMI, the ACT team, and other social service organizations in St. Tammany Parish to identify all available housing supports and to create a work plan for filling in the gaps that are identified.

## Summary and Next Steps

In summary, the St. Tammany BH system is in a great place to begin making some immediate, influential changes at little to no cost. St. Tammany Parish and the Task Force have had a unique opportunity over the past few months to take advantage of national and local expertise to transform their system and improve coordination, quality, and efficiency. This opportunity exists due to the commitment and dedication of the providers and clients who are engaged in the process. While this plan is a starting place, the next few years will be instrumental in poising the St. Tammany BH system as a leader in the BH field.

**Table 8. Status of Recommendations**

Recommendation	Status	
<b>1. Enhance community-based behavioral health services</b>		
Florida Parishes Human Services Authority: transition to team-based care	Process initiated	
Florida Parishes Human Services Authority: transition to same day/next day access	Implemented as of 11/3/14	
Florida Parishes Human Services Authority: on-site pharmacy	Next steps	
St. Tammany Community Health Center: brief interventions	Technical assistance received; process initiated	
National Alliance on Mental Illness: reorient from service provider to advocacy organization (once other providers are able to provide a commensurate level of service capacity and quality)	Next steps	
<b>2. Transform utilization of emergency services</b>		
Gain emergency department leadership commitment	Next steps	
Develop capacity for information sharing among emergency providers	Next steps	
Standardize suicide risk assessment protocol	In process	



3. Enhance crisis services continuum		
Develop crisis stabilization facility	Facility location and operator established; awaiting state licensing; opening during first quarter of 2015	✓
Develop engagement center	In process	
Transition Volunteers of America to mobile crisis services instead of traditional case management	Technical assistance received; in process	✓
4. Enhance education, advocacy, and training		
Crisis Intervention Training	Next steps	
Mental Health First Aid	One already provided 10/28/14; more to come	✓
Additional trainings specifically for behavioral health staff	Next steps	
Additional trainings for all behavioral health/primary care/emergency department staff	Next steps	
5. Enhance social services		
Assess and enhance transportation	Next steps	
Assess and enhance housing supports	Next steps	

Given the existing resources in the community and the involvement of stakeholders throughout the parish who advocate for good stewardship of funds, St. Tammany will be able to improve the lives of residents for years to come.

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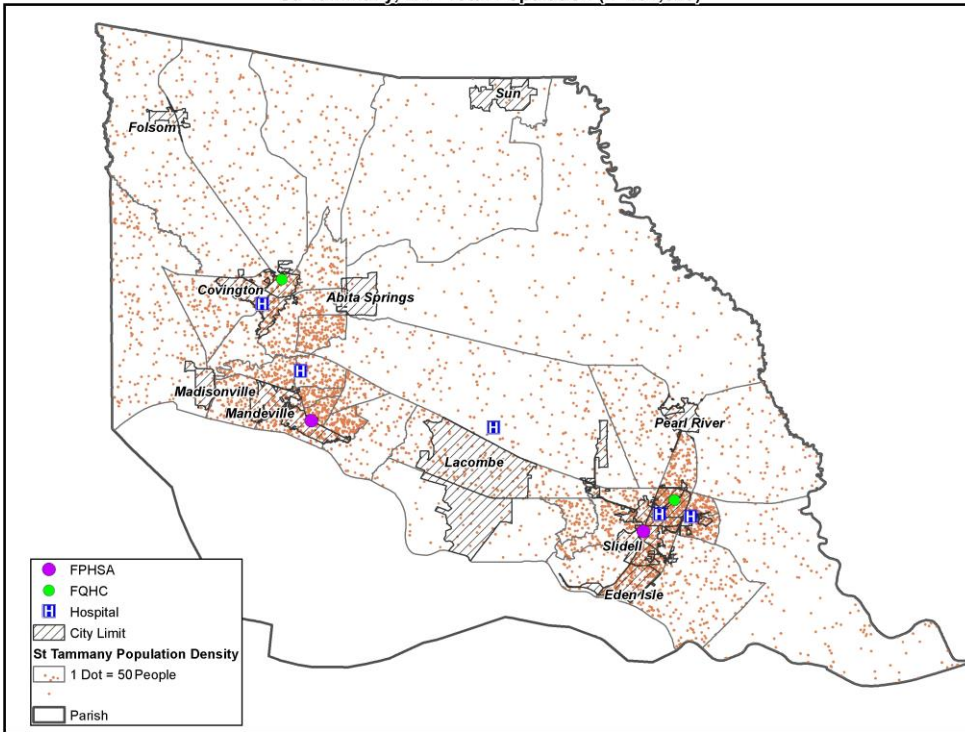
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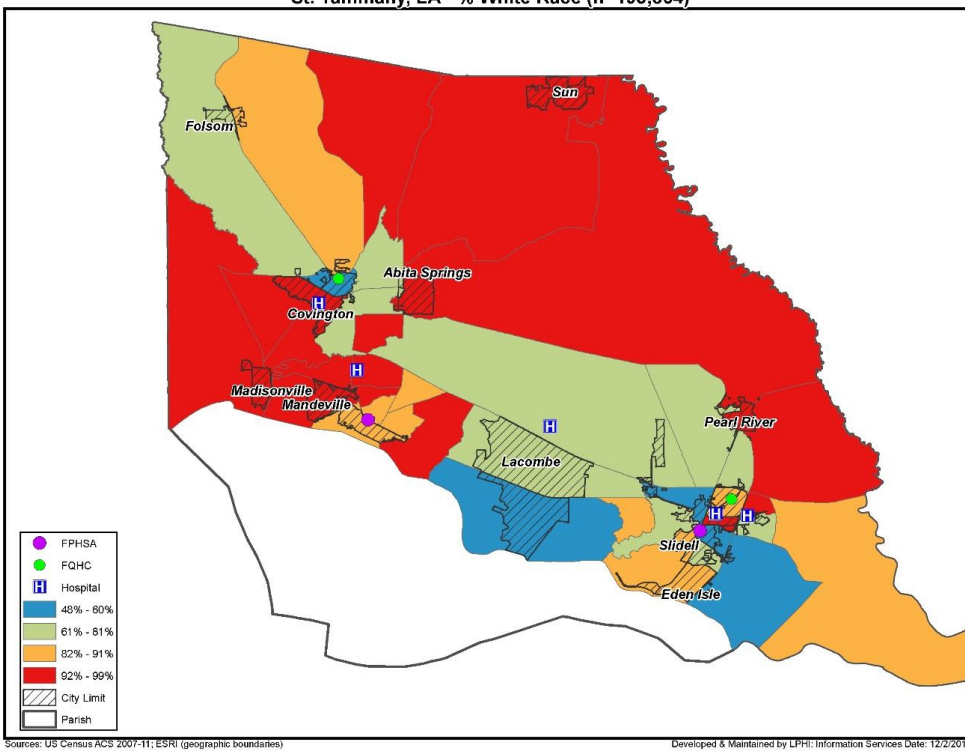
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# Appendix A: Maps

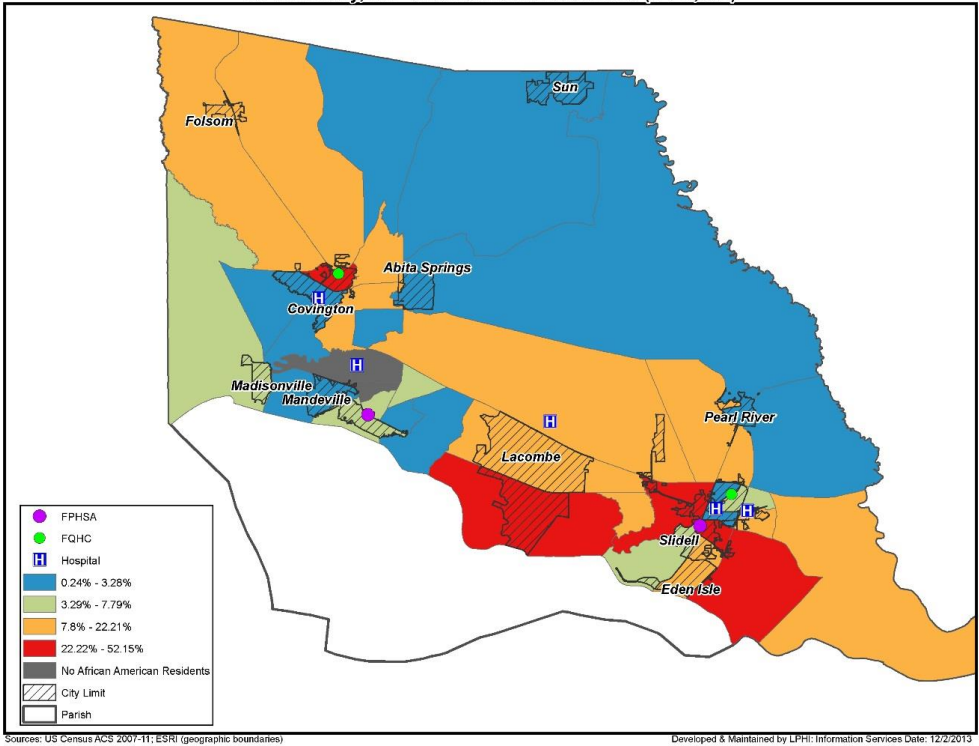
St. Tammany, LA - Total Population (n=231,629)



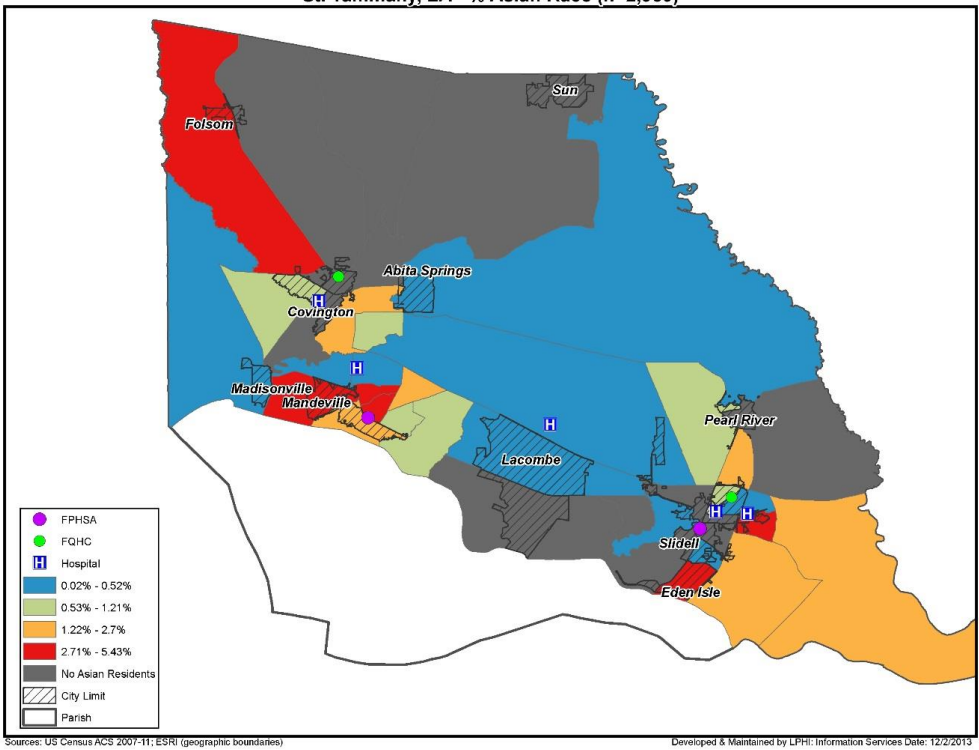
St. Tammany, LA - % White Race (n=193,864)



St. Tammany, LA - % African American Race (n=26,393)

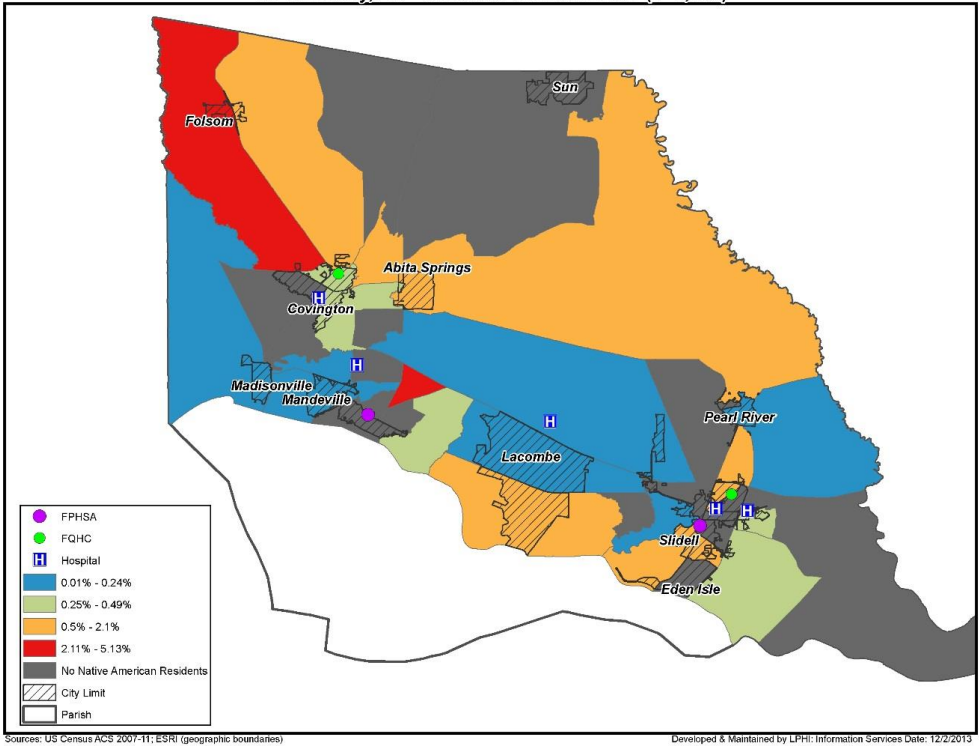


St. Tammany, LA - % Asian Race (n=2,959)

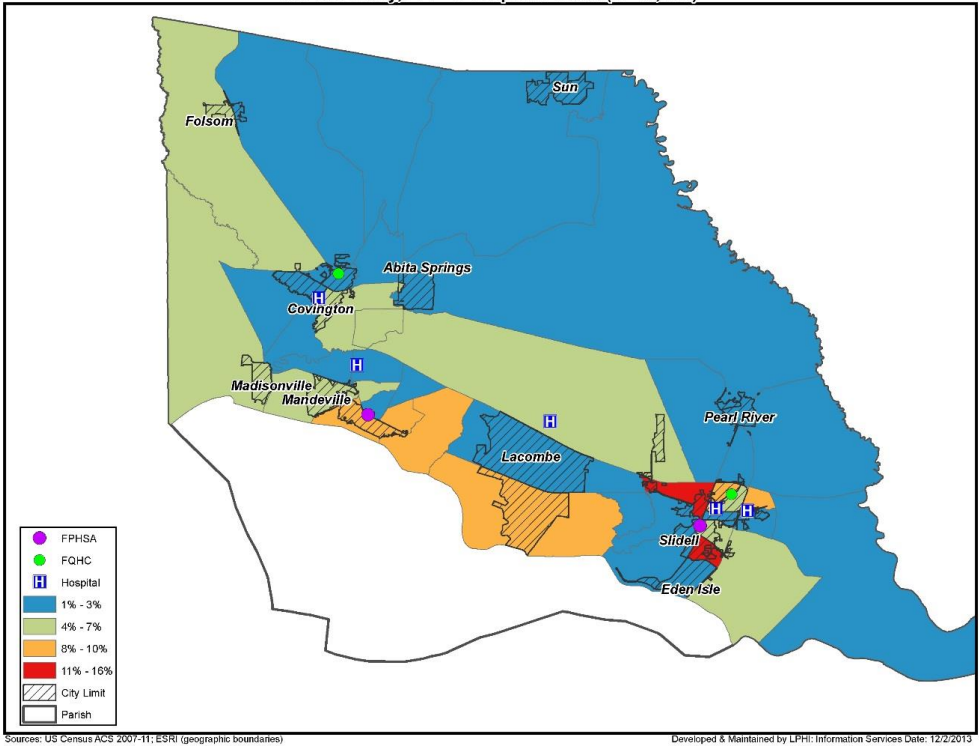




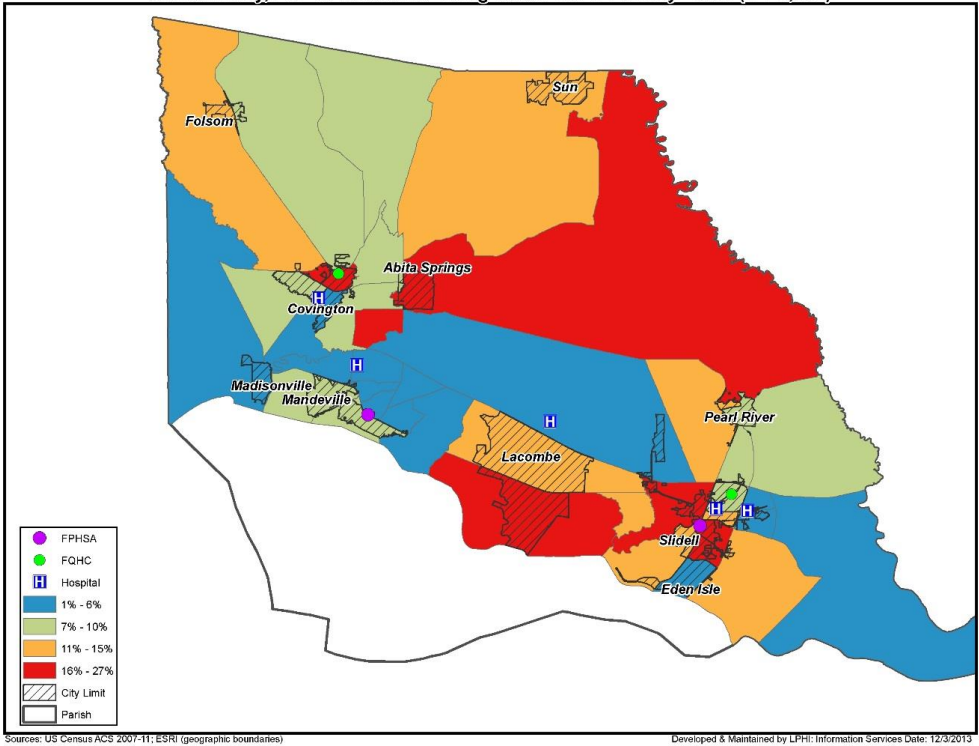
St. Tammany, LA - % Native American Race (n=1,068)



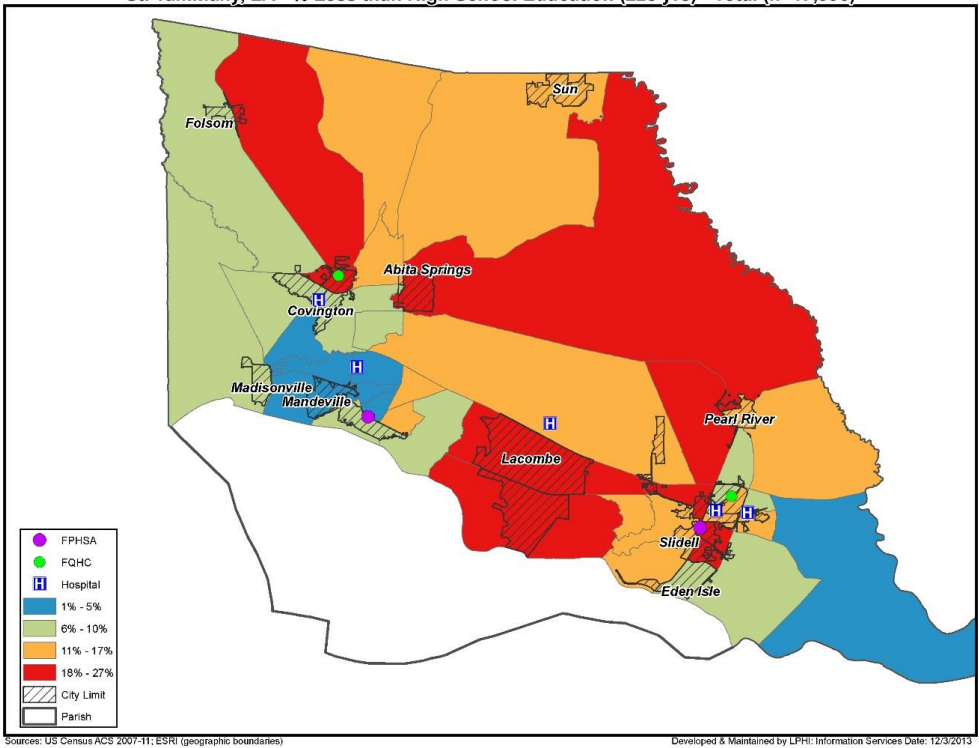
St. Tammany, LA - % Hispanic Race (n=10,542)



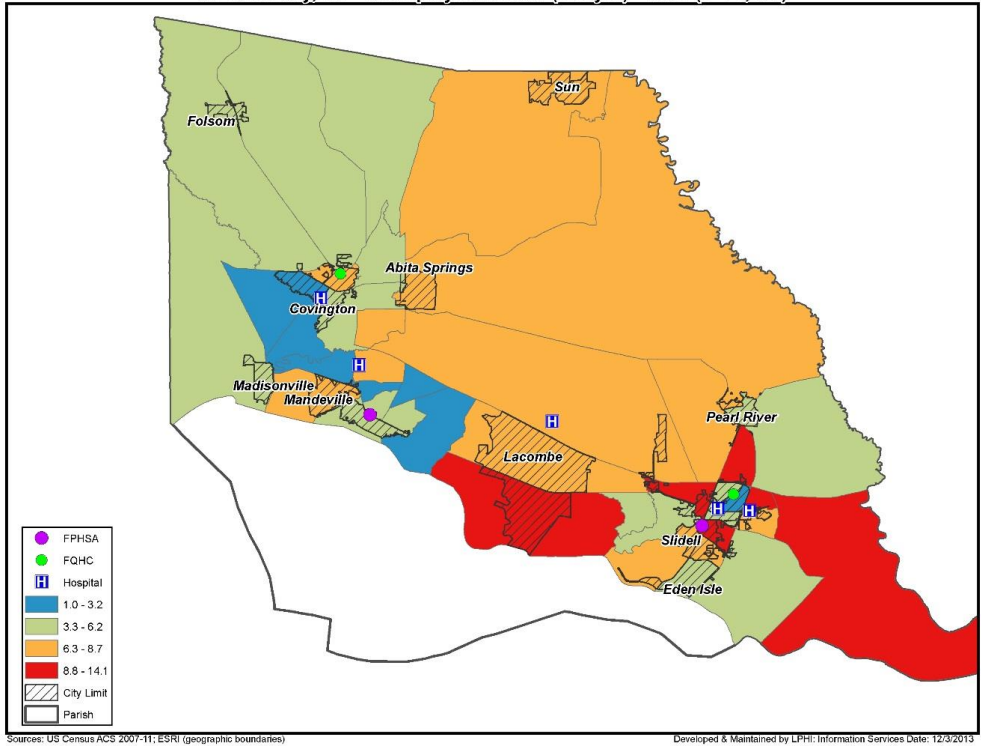
St. Tammany, LA - % Residents Living Below 100% Poverty- Total (n=23,202)



St. Tammany, LA - % Less than High School Education (≥25 yrs) - Total (n=17,996)



St. Tammany, LA - Unemployment Rate (≥16 yrs) - Total (n=74,208)



## Appendix B: Organizations That Were Interviewed

The following organizations were represented in interviews that were conducted in December, 2013-March, 2014.

- 22<sup>nd</sup> Judicial District Court
- Department of Health and Human Services
- Florida Parishes Human Services Authority
- Greenbrier Behavioral Health Hospital
- Homeless Coalition
- Lakeview Regional Medical Center Emergency Department
- Louisiana Heart Hospital Emergency Department
- Magellan
- National Alliance on Mental Illness
- NAMI Clients
- Northlake Behavioral Health System
- North Oaks Medical Center Emergency Department
- Ochsner Medical Center- North Shore Emergency Department
- Slidell Memorial Hospital Emergency Department
- St. Tammany Community Health Center/Access Health Louisiana
- St. Tammany Coroner's Office
- St. Tammany Parish Council
- St. Tammany Parish Hospital Emergency Department
- St. Tammany Parish Jail
- St. Tammany Parish Public School System
- St. Tammany Parish Sheriff's Office
- St. Tammany Outreach for the Prevention of Suicide
- Trinity Community Support Services
- Veterans Affairs
- VIA LINK/ 2-1-1
- Volunteers of America
- Youth Service Bureau

## Appendix C: List of References Used in Literature Review

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## Appendix D: List of Available Trainings



### Mental Health First Aid USA

Mental Health First Aid is a public education program that introduces participants to risk factors and warning signs of mental illnesses, builds understanding of their impact, and overviews common supports. This 8-hour course uses role-playing and simulations to demonstrate how to offer initial help in a mental health crisis and connect persons to the appropriate professional, peer, social, and self-help care. The program also teaches the common risk factors and warning signs of specific types of illnesses, like anxiety, depression, substance use, bipolar disorder, eating disorders, and schizophrenia.

Mental Health First Aid is included on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP).

#### COURSE DETAILS

Mental Health First Aid teaches participants a five-step action plan, ALGEE, to support someone developing signs and symptoms of a mental illness or in an emotional crisis:

- Assess for risk of suicide or harm
- Listen nonjudgmentally
- Give reassurance and information
- Encourage appropriate professional help
- Encourage self-help and other support strategies

Like CPR, Mental Health First Aid prepares participants to interact with a person in crisis and connect the person with help. First Aiders do not take on the role of professionals — they do not diagnose or provide any counseling or therapy. Instead, the program offers concrete tools and answers key questions, like “what do I do?” and “where can someone find help?” Certified Mental Health First Aid instructors provide a list of community healthcare providers and national resources, support groups, and online tools for mental health and addiction treatment and support. All trainees receive a program manual to compliment the course material.

#### PROGRAM GROWTH

Mental Health First Aid was introduced in the U.S. in 2008 and, to date, more than 175,000 people from all 50 states, the District of Columbia, and Puerto Rico have taken the course. The course is offered to a variety of audiences, including hospital staff, employers and business leaders, faith communities, and law enforcement. In 2012, a Spanish adaptation of the course was released.

In 2012, Youth Mental Health First Aid was introduced to prepare trainees to help youth ages 12-18 that may be developing or experiencing a mental health challenge. The youth course is most appropriate for adults who regularly interact with youth, such as teachers or coaches, but may also be appropriate for youth who are 16 years and older.

To find a course or contact an instructor in your area, visit [www.MentalHealthFirstAid.org](http://www.MentalHealthFirstAid.org).

*Mental Health First Aid USA is coordinated by the National Council for Behavioral Health, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health.*

## Mental Health First Aid for Public Safety

*Mental Health First Aid USA is an 8-hour course that teaches a 5-step action plan encompassing the skills, resources, and knowledge to help an individual in crisis connect with appropriate professional, peer, and self-help care. Participants learn the unique risk factors and warning signs of mental health problems, builds understanding of the importance of early intervention, and, most importantly, teaches individuals how to help someone in crisis or experiencing a mental health challenge.*

### ABOUT THE PROGRAM

The course is taught to police, first responders, corrections officers, and other public safety audiences around the country. Mental Health First Aid for Public Safety provides officers with more response options to help them deescalate incidents and better understand mental illnesses so they can respond to mental health related calls appropriately without compromising safety. Approximately 20,000 public safety professionals have taken the course, including at police academies in Philadelphia, DC, Seattle, and numerous smaller and rural departments.

"Public Safety Officers, regardless of rank or position, may find themselves confronted with a mental health crisis. My Mental Health First Aid training helped me save a life, and regular incidents serve as reminders of how public safety officers fall back on their training in times of crisis."

- Captain Joseph Coffey,  
Rhode Island Municipal Police Academy



"What struck me most about Mental Health First Aid is the interest it generates among people who don't have a direct connection to the mental health field. This is a program that can move us beyond usual constituencies to truly build a healthy community."

-David Johnson, CEO, Bert Nash Center, Lawrence, Kansas

### WHO CAN BE A MENTAL HEALTH FIRST AIDER?

- Law enforcement
  - Corrections officers
  - Other first responders
  - 911 Dispatch Staff
  - Human resources professionals
  - Business leaders
  - Nurses and other primary care workers
  - School and college workers
  - Faith community leaders
  - Caring citizens
- Defusing crises
  - Promoting mental health literacy
  - Combating stigma of mental illness
  - Enabling early intervention through recognition of signs and symptoms
  - Connecting people to care

To see who is already providing the course in your community, visit [www.MentalHealthFirstAid.org](http://www.MentalHealthFirstAid.org).



## Youth Mental Health First Aid

Youth Mental Health First Aid USA is an 8 hour public education program which introduces participants to the unique risk factors and warning signs of mental health problems in adolescents, builds understanding of the importance of early intervention, and teaches individuals how to help an adolescent in crisis or experiencing a mental health challenge. Mental Health First Aid uses role-playing and simulations to demonstrate how to assess a mental health crisis; select interventions and provide initial help; and connect young people to professional, peer, social, and self-help care.

### WHAT WILL PARTICIPANTS LEARN?

The course teaches participants the risk factors and warning signs of a variety of mental health challenges common among adolescents, including anxiety, depression, psychosis, eating disorders, AD/HD, disruptive behavior disorders, and substance use disorder. Participants **do not** learn to diagnose, nor how to provide any therapy or counseling – rather, participants learn to support a youth developing signs and symptoms of a mental illness or in an emotional crisis by applying a core five-step action plan:

- Assess for risk of suicide or harm
- Listen nonjudgmentally
- Give reassurance and information
- Encourage appropriate professional help
- Encourage self-help and other support strategies



The Youth Mental Health First Aid USA curriculum is primarily focused on information participants can use to help adolescents and transition-age youth, ages 12-18.

### WHO SHOULD TAKE THE COURSE?

The course is designed for adults who regularly interact with adolescents (teachers, school staff, coaches, youth group leaders, parents, etc.), but is being tested for appropriateness within older adolescent groups (18 and older) so as to encourage youth peer to peer interaction. In January 2013, President Obama recommended training for teachers in Mental Health First Aid. Since 2008, the core Mental Health First Aid course has been successfully offered to more than 175,000 people across the USA, including hospital staff, employers and business leaders, faith communities, law enforcement, and the general public.

### WHO CREATED THE COURSE?

Mental Health First Aid USA is coordinated by the National Council for Behavioral Health, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health. Mental Health First Aid USA worked with experts at the National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development to develop the youth program.

### WHERE CAN I LEARN MORE?

To learn more about the Mental Health First Aid USA, or to find a course or contact an instructor in your area, visit [www.MentalHealthFirstAid.org](http://www.MentalHealthFirstAid.org).

# CASE TO CARE

## MANAGEMENT TRAINING

[www.TheNationalCouncil.org](http://www.TheNationalCouncil.org)

### RECOMMENDED FOR:

Case managers, organizational leaders, supervisors, and other direct care staff in community behavioral health organizations.

### TRAINING TOPICS:

The National Council for Behavioral Health's Case to Care Management Training is an in-person, 1-day group training that equips case managers with the expanded skills they need to help the people they serve navigate the new healthcare marketplace and manage their whole health needs. Training topics include:

- Major changes in healthcare delivery — health homes, chronic care models, etc.
- Healthcare system navigation support for people in need of services.
- Physical health challenges of people with mental health and addiction disorders.
- Key issues and interventions for diabetes and heart disease.
- Skills to support health behavior change.
- Rapid cycle change principles for health behavior change, goal planning, and documentation.
- Self-assessment of individual practice.

### THE NEED:

The changing healthcare marketplace requires case managers to act as health navigators, support health behavior change, and understand the intersection of common health problems with behavioral health needs and quality of life. Upgrading case managers' skills gives behavioral health organizations a competitive edge in promoting services across the healthcare system.

### TAKEAWAYS:

Those who complete Case to Care Management Training are able to:

- Identify current healthcare trends impacting their role.
- Understand the difference between physical health and behavioral health culture.
- Describe strategies to build strong partnerships with primary care providers.
- List strategies to help prepare people for primary care appointments and to increase self-management.
- Apply basic chronic care principles to managing heart disease and diabetes.
- Identify and apply strategies to help people change their health behavior.
- Commit to two immediate changes they will make in their practice.

### LOGISTICS:

- Cost:** *\$4,000 (National Council members)  
\$4,500 (Not yet a member)  
Trainer travel expenses are additional and billed at cost.*
- Duration:** *1-day, in-person training (9 am - 4 pm)*
- Class size:** *Up to 60 participants.*



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### Ask Us About Other National Council Trainings

*Case to Care Management Training  
Community Health Worker Training  
Mental Health First Aid Instructor Training  
(Adult and Youth)*

*Middle Management Academy  
Trauma-Informed Care Training  
Online Library and Learning Management System  
WMAA*

# WHAM

## Whole Health Action Management

[www.TheNationalCouncil.org](http://www.TheNationalCouncil.org)

### RECOMMENDED FOR:

Peer workforce in behavioral health organizations.



### THE NEED:

As the call for patient-centered care resounds across healthcare, behavioral health has a competitive advantage with experience in person-centered planning and engaging persons receiving care in a collaborative decision-making process with their providers. The peer workforce has the potential to move community behavioral health organizations to success in new integrated models like health homes.

### HOW IT WORKS:

The National Council for Behavioral Health's WHAM — Whole Health Action Management — is an in-person, 2-day group training that equips peers to help the people they serve set and achieve whole health goals to improve chronic health and behavioral health conditions. Based on a curriculum from the SAMHSA-HRSA Center for Integrated Health Solutions, the WHAM trains peers in person-centered planning and to facilitate 8-week support groups.

### TAKEAWAYS:

After WHAM training, peers will be able to:

- Identify strengths and supports in 10 science-based whole health and resiliency factors.
- Write a whole health goal with weekly action plans.
- Facilitate 8-week WHAM peer support groups to change health behaviors.
- Use tools for shared decision making.

### LOGISTICS:

- Cost:** *\$11,000 (National Council members)  
\$12,500 (Not yet a member)  
Discounted when multiple trainings are booked.  
Trainer travel expenses are additional and billed at cost.*
- Duration:** *2 days (9 am – 4 pm) in person*
- Class size:** *Up to 30 participants*

### WHAT YOUR COLLEAGUES ARE SAYING:

*"WHAM training encouraged me to gain faith and confidence that I can regain my health...This training provided me with an opportunity to think about what can be done to help improve the health of peers who are in a similar situation."*

*Kyung Hwa Chang, Peer Leader, Asian Community Mental Health Services, Seattle, WA*



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*Care to Care Management Training*

*Community Health Worker Training*

*Mental Health First Aid Instructor Training (Adult and Youth)*

*Middle Management Academy*

*Trauma-informed Care Training*

*Online Library and Learning Management System  
WHAM*

## Appendix D: Addendum to the LPHI St. Tammany Behavioral Health Services Report for the St. Tammany Department of Health and Human Services

*Note: The following addendum was used in July of 2014 to inform the St. Tammany Parish budget. The numbers included in this addendum might not completely align with what is included in this final report as many of the recommendations have since evolved.*

The St. Tammany Parish has been a leader in supporting improvement in the mental health and addiction services for some time. In reviewing the financial support the Parish has made available to behavioral health partners in addressing issues related to suicidal ideation, individuals who have problems with alcohol and other drugs and need safety and support and individuals at temporary risk from symptoms of mental illness the Parish has invested heavily in programs that are achieving good results for small number of people, based on the investment of resources. To expand the impact of the St. Tammany Parish investment the National Council has three over-arching recommendations for St. Tammany Parish Human Services Department. These recommendations are to

- (1) Move funding provided to some health care and behavioral health services to fee for service contracts rather than grant based funding; and
- (2) Use St. Tammany government funds for services for the insured only, while working with the providers to enhance their third party billing collections and capabilities
- (3) Expand funding from the millage to support transformation of the behavioral health system through implementation of evidenced interventions

### **Recommendation #1: Move funding to fee for service model**

The National Council is recommending that two of the contracts that St. Tammany Parish currently has move to fee for service models, which means the Parish would pay the contractor monthly for actual units of service provided vs. giving a block of money for those services. The two contract this recommended for are the Volunteers of America Crisis Response Team and their Case Management Services and the FQHC counseling contract.

The FQHC contract would remain at the same amount of funding as this year, however, the FQHC would provide the Parish with monthly bills identifying the number of counseling sessions provided to uninsured individuals. The Parish would then pay the FQHC a set rate for each service provided. Total funding would be capped at the existing \$130,000. The FQHC will bill Medicaid, Medicare and private insurance for counseling provided to individuals with those resources. The FQHC will provide St. Tammany Parish with a report on the total number of third party payments they receive for counseling as well. The suggested rate for these services is the FQHCs existing prospective payment rate they receive from the State of Louisiana.

Should the FQHC need more money for services, i.e. they provide enough counseling sessions to use all of the funds allocated, the Parish can then consider adding more funding to the contract. This method provides an objective way to determine funding levels by incentivizing the provider to provide services while ensuring the funder of service level provided.

For Volunteers of America, it is recommended that the existing funding be halved and the program move to the model described above. St. Tammany Parish would pay VOA for each crisis event they go out to and then reimburse them for each case management session they provide at a later time for that individual. Given the relative small numbers of people served in this project, funding for Crisis Outreach would be capped at \$250,000/year. Setting the actual rates per services unit would take some work with VOA, however, an estimate of costs could be \$500/outreach and \$65/hour for case management services.

**Recommendation #2: St. Tammany Parish provided funding for the uninsured only**

Most of the behavioral health services that St. Tammany Parish is provided for behavioral services are generally billable should the recipients have a third party payer. The Parish should designate their funding for indigent consumers. This could be paired with helping provider’s bill third parties successfully. This strategy will expand the existing funding St. Tammany Parish is providing now, while expanding services at the same time.

**Recommendation #3: Expand funding for behavioral health services from the existing millage for evidence based behavioral health services**

The following chart identifies the recommendations made in the full Behavioral Health Task Force Report and associates projected costs and potential funders for these services. It is recommended that the Parish invest some one-time funding in training to enhance the existing and future behavioral health system. It is also recommended that the Parish and/or the Coroner’s Office assist with starting desperately needed, evidence based mental health and addiction crisis services. Please note that the costs are distributed across funders including foundations, the State of Louisiana/Magellan, SAMHSA and third party reimbursement sources.

The following chart summarizes the detailed recommendations from the report and estimates potential costs for each recommendation.

Recommendation	Estimated Cost	Potential Funder(s)	% Contribution	Comments
1. Recovery Oriented System of Care	\$0			This is a philosophical recommendation that lays the ground work for the other recommendation.
<b>Recommendation #2: Enhance existing BH Services within St. Tammany Parish</b>				
2.1 Team Based Care At FPHSA	TBD (see report for formula)	Medicaid, Medicare and Third Party Insurance  State Funds, St. Tammany Parish Funds for the Uninsured	% of people in service with these insurances	B. Funding from the state does not cover all services for insured. St. Tammany Parish could provide fee for service reimbursement to increase access to services for uninsured

2.1 Onsite Pharmacy at FPHSA	\$0	Self-funded	\$0	National pharmacy companies create the pharmacy at no cost to FPHSA
2.2 Same Day/Next Day Access to FPHSA	TBD	Insurances, state funds	X% X%	FPHSA calculating costs currently
2.3 FQHC Counseling Services – Move to different type of funding system and adjust model to an evidence based process	TBD  \$130,000	Insurance  St. Tammany	Insurance will pay for services at the FQHC  For Uninsured only	FQHC expansion funds will come from billing insurances. FQHC should share FQHC Third Party Billing payment summary to the Parish  Transition the St. Tammany Parish funding to fee for service and have FQHC send in number of sessions provided to UNINSURED ONLY and pay a rate per service provided
2.4 Reorient NAMI to Advocacy Organization	\$0			Philosophical recommendation: Transition group homes services to a provider that specializes in residential
<b>Recommendation #3: Reduce the reliance on crisis staff and police outreach, hospital emergency rooms and the PEC process as the primary means of addressing the perceived increase in behavioral health needs</b>				
3.1 Adoption of an evidence based suicide risk tool	\$10,000	Foundation	Training for use of tool	Includes \$8,427 for training and \$1,573 for consultation in selection of the tool
3.2 8 Bed Crisis Residential Facility	\$500,000	St. Tammany Parish and Insurance	\$250,000 from Insurance Carriers \$250,000 diverted from existing crisis team to this facility	Recommendation here is to reduce the funding for the existing crisis intervention team by \$250,000 and allocate those funds to the facility and have the crisis team operate out of that facility
3.3 Engagement Center for persons with addictive disorders	\$350,000	St. Tammany Parish Coroner		While working on making this facility billable for insurance it will need initial full funding from the Parish
<b>Recommendation #4: Provide Training and Education on Recovery Oriented System of Care Services</b>				

4.1 Mental Health First Aid – Train the Trainer	\$35,000	Foundation	One –time expense	Train the trainer so that St. Tammany can education all the community of addressing the common needs of persons with mental health problems
4.2 Mental Health First Aid Training for the Community	\$0	SAMHSA	One- time expense	SAMHSA has agreed to provide the first MHFA training for the community for free
4.3 Crisis Intervention Training for the Police (with fidelity)	\$20,000	Coroner	One -time expense	Fidelity based training with police officers from Lake Charles providing the training. Funding includes trainers (\$13,500), space and food
4.5 Alternatives to hospitalization Training	\$10,000	Foundation	One-time expense	\$6,875 for trainers + expenses
4.6 Short Term Solution Focused Therapy Training for FQHC Staff	\$7,000	Foundation	One-time expense	\$5,625 for trainers + expenses
4.7 Case to Care Management Training for all providers staff	\$20,000	St. Tammany Parish	One-time expense	Five days of training for up to fifty people each day
4.8 Whole Health Action Management Training for Consumer	\$10,000	St. Tammany Parish	One-time expense	\$10,000 for training 30 consumers in WHAM
<b>Recommendation #5: Enhance collaboration between entities</b>				
5.1 Continue the Behavioral health Task and Create Subcommittees	\$20,000	St. Tammany Parish	Ongoing Expense	Facilitation expense and reimbursement for subcommittee chairs
5.2 Technology Assessment	\$100,000	St. Tammany Parish and/or Foundation	One-time expense	Extensive cost savings could be found if the Parish enhanced the technology capacity of the BH system to communicate electronically. This assessment would provide a 5 year strategy plan for

				computerizing St. Tammany Health Services
Recommendation #6: Enhance current social services – Cost need to be determined for these services after further assessment and evaluation				