



Understanding the Landscape of Mental Health Care in New Orleans: *Availability, Accessibility, and Gaps*

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ABOUT THE INSTITUTE OF WOMEN & ETHNIC STUDIES IWES)

Founded in 1993, IWES is a national non-profit health organization that creates initiatives to heal communities, especially those facing adversity. Through community-driven research programs, training, advocacy, and partnerships, IWES helps to build emotional and physical well-being, resilience and capacity among women, their families and communities of color, especially those which are disadvantaged.

IWES uses a Social Ecological Model (SEM), which recognizes that individual behavior is shaped by the intersection of multiple influences occurring at the interpersonal, community and societal levels. Through this in-depth, multi-dimensional approach, IWES creates culturally proficient programs, activities and research to address and advocate for the emotional and physical well-being, resilience, and capacity of women of color, their families and communities to heal and create sustainable change. IWES works in the following areas: Resilience; Emotional/Physical Well-Being; Youth Development; and Sexual Health.

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EDITORIAL



Mental health is defined by the World Health Organization (WHO) as,

“

“A STATE OF WELL-BEING IN WHICH THE INDIVIDUAL REALIZES HER/HIS OWN ABILITIES, CAN COPE WITH THE NORMAL STRESSES OF LIFE, CAN WORK PRODUCTIVELY AND FRUITFULLY, AND IS ABLE TO MAKE A CONTRIBUTION TO HER/HIS COMMUNITY.”

”

In addition to individual genetics, temperament, exposures to adverse childhood experiences, and social and environmental factors contribute to mental distress and disorders. Indeed, communities have unique characteristics and systems that enable, constrain, and condition the mental well-being of people. Some of the known structural and environmental risk factors and negative determinants of mental health are disproportionate poverty, social and cultural oppression and discrimination, exclusion, neighborhood violence and crime, lack of transportation, and lack of leisure and green spaces.

This Situational Analysis is not intended to be a resource guide, but instead a snapshot of the key organizations and systems that contribute to the infrastructure of the current mental health system in New Orleans. It also does not examine the key social determinants of mental health defined by the WHO as the “various social, economic, and physical environments operating at different stages of life.” The World Health Organization Assessment Instrument for Mental Health Systems ([WHO-AIMS](#)) was used as a framework for this population systems approach to understand and evaluate: the barriers to accessing care and treatment for vulnerable populations; health and racial disparities and inequalities; strategies involved to educate the public and engage communities; policy development and advocacy; and, challenges faced in monitoring population health and addressing needs and service gaps. Captured through the lens of providers and healthcare system leaders, this report serves as a benchmark that can assist local and state government, health care providers, and public health practitioners promote and implement strategic initiatives for improving the well-being and quality of life for New Orleanians.

Thanks to the Baptist Community Ministries for their gracious support. And thank you to all those individuals who took the time to respond to our survey, and/or meet with us in person. There would have been no report without you! And because of your contribution,

a blueprint for a more vibrant, healthy, resilient, and happy New Orleans can now be imagined, planned, and implemented.

Such an outcome however will require applying a population systems approach to address the mental health of vulnerable populations: 1) Working upstream with early intervention/prevention/health promotion approaches at a systems level; 2) Assuring access to quality and culturally appropriate clinical services; 3) Working in non-clinical resilience-promoting settings in communities; and 4) Working to promote health literacy, activation, and empowerment strategies for those who do not traditionally engage in health-seeking behaviors. More simply put - promoting ongoing well-being for those who are well; screening and providing early intervention and secondary prevention for those who are at high risk; and, providing culturally-competent high-quality services for those who require clinical care.

It is my hope that the Louisiana Office of Public Health, working collaboratively with the Metropolitan Health Services District and the New Orleans Health Department will heed this call to action!

Sincerely,

Denese Shervington

Denese O Shervington MD, MPH
President / CEO Institute of Women and Ethnic Studies



BACKGROUND



From 1999 to 2003, Louisiana’s substance abuse and mental health programs came under public scrutiny. Program costs were spiraling out of control, yet access to quality services, particularly in-home and community-based services, was limited in many geographic areas; client advocates were asking for reform. In 2003, the Department of Health and Hospitals made the decision to terminate its Medicaid [substance use] program, due to concerns about fraud and abuse, and cover these services to children under the Office for Addictive Disorders (now part of the Office of Behavioral Health). DHH also began a complete overhaul of its mental health rehabilitation services, increasing program monitoring, requiring Mental Health Rehabilitation (MHR) provider agency accreditation, revamping service definitions and developing provider qualifications criteria. While progress was made from 2003-2005, the massive hurricanes, which struck Louisiana in 2005 and 2008, brought to light additional service gaps and system inadequacies.¹



Louisiana Department of Health and Hospitals
March 10, 2010

The Storm

On August 29, 2005, Hurricane Katrina struck the Gulf Coast. At the time, it was the deadliest hurricane in seven decades to hit the U.S., bringing severe winds and record rainfall into New Orleans for a 24-hour period (to be surpassed by Hurricane Maria in 2017, whose death toll rose to 4,645).² Two days of intense storm surges damaged the city’s pumping system, rendering the pumps incapable of draining the rising water as major floodwalls failed. As a result, 80% of the city was flooded, destroying homes, communities and the urban infrastructure. Water as high as five meters surged into some areas.² For weeks, the city was submerged under several feet of water that left New Orleans decimated by extensive structural damage, bringing services, rescue efforts, and emergency recovery to a standstill. More than 500,000 people were evacuated, and a minimum of 1800 people died in storm-related deaths.² In 2012, the National Weather Service estimated there was at least \$108 billion in property damage, making it the costliest natural disaster in U.S. history, only to be surpassed by Hurricane Harvey in 2017 which was estimated to inflict \$125 billion in damage.²

The devastation of Hurricane Katrina extended to what was already a struggling health care system. In the aftermath of the storm, there was little infrastructure to adequately respond to the escalating disaster-related mental health needs of the community. Pre-Katrina, in August of 2005, there were approximately 134 adult mental health hospital beds, 30 child and adolescent beds and 9 outpatient mental health clinics.³ Two years later, the prevalence of reported serious mental illness increased 13% in Orleans Parish, however, the number of beds decreased to only approximately 20 adult beds, 15 child and adolescent beds, plus limited alcohol and substance use services, and restricted outpatient mental health clinics.³ In addition, there were no emergency mental health or crisis services and many of the acutely mentally ill were housed in the parish jail.³ A 2007 Kaiser Family Foundation survey conducted around the second

anniversary of Katrina found that 43% of adults reported at least one health care access problem post-Katrina, and that the public mental health system only provided services for the serious and persistently mentally ill.⁴ In October 2007, the local newspaper described the public mental health agency as 'unfit', claiming that the city services for the mentally ill were in the hands of a district in crisis and unable to govern with oversight and accountability.⁵ In 2009, the mental health facility that served adolescents was closed and the services have not been replaced.

Policy and Legislation

In 2010, the Louisiana Department of Health merged the Office of Addictive Disorders and the Office of Mental Health to create the Office of Behavioral Health (OBH) "in order to streamline services and better address the needs of people with co-occurring mental illness and addictive disorders."⁶ Through the human services districts and authorities, OBH "oversees behavioral health community-based treatment programs and monitors the Medicaid Healthy Louisiana managed care plans," also known as managed care organizations (MCOs).⁶ MCOs manage behavioral health services for both traditional and expanded Medicaid populations.⁶

In 2016, Louisiana enacted Medicaid expansion. Since then, over 473,900 Louisianians have signed up for coverage.⁷ This reduced the uninsured rate from 10.3% in 2016 to 8.4% in 2017, which is due almost entirely to the Medicaid expansion.⁷ As the majority of those with mental illness are Medicaid-eligible individuals (majority of mental health services are paid through Medicaid), this significantly impacted the mentally ill population's access to care.⁸ After Medicaid expansion, the 1915b/c waiver program was revised to allow for intensive community-based services, comparable to an institutional level of care for people who require long-term services and supports, to also be covered.⁹ These began to form as mental health rehabilitation (MHR) centers. MHRs can only deliver services through MCOs as all specialized behavioral health benefits are under mandatory managed care waivers. MCOs are responsible for establishing their own authorization criteria for MHRs and this is not governed by the state.⁹ In light of this new policy, MHRs are becoming increasingly popular and now make-up the largest portion of Medicaid reimbursements, greater than any other facility type. The benefits of MHRs are that they allow individuals to seek treatment in a community-based setting, rather than in an institutional setting and can provide a wide variety of services that are covered by Medicaid. However, the quality of care being provided at these facilities is still up for debate. As each MHR is individually owned and operated and not required by law to follow the same policies as institutions in regard to delivering mental health care, providers argue that there are some drawbacks to this health care delivery model. Some providers complained that the reimbursement rates for rehabilitation services such as Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) are extremely low. As a result, they are unable to hire or retain licensed, competent providers. This is not surprising seeing as the quality of care through Medicaid coverage has been consistently cited as being below standard.^{8,10}

AS OF 2018, THERE ARE OVER 634,000 LOUISIANIANS—17.3% OF THE POPULATION—SUFFERING FROM A MENTAL HEALTH ILLNESS.



ONLY 38.2% OF ADULTS WITH MENTAL ILLNESS IN LOUISIANA RECEIVE ANY FORM OF TREATMENT FROM EITHER THE PUBLIC SYSTEM OR PRIVATE PROVIDERS.

Present Day

As of 2018, there are over 634,000 Louisianians—17.3% of the population—suffering from a mental health illness.¹¹ A mental illness is defined as having a “diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder.” This includes persons who have mild, moderate, or serious mental illness.¹¹ Only 38.2% of adults with mental illness in Louisiana receive any form of treatment from either the public system or private providers.¹² The remaining 61.8% receive no mental health treatment,¹² leaving the state of Louisiana ranked 45 out of the 50 states and Washington D.C., for providing access to mental health services.¹¹ Thus, with the increase in access to care, the high prevalence of mental illness, and the lack of care being provided to Louisianians, it is important to evaluate the health care system, specifically for mental health services due to increased need.

Functions of a Mental Health System

According to the World Health Organization, a “mental health system” is defined as “all the activities whose primary purpose is to promote, restore or maintain mental health.”¹³ There is a global consensus that effective mental health systems perform the essential functions listed on the following page.¹³

EFFECTIVE MENTAL HEALTH SYSTEMS

1.

Ensure access to hospital and integrative community services for treatment of mental health conditions

2.

Ensure access to essential psychotropic medications

3.

Address health disparities and racial/inequities

4.

Educate the public

5.

Involve communities, families, and consumers

6.

Respond to changes in population health and needs through policy and program development

7.

Develop and sustain an effective workforce

8.

Link with other sectors

9.

Continuously monitor community mental health status - epidemiology, needs and gaps in services

10.

Support relevant research



In an effort to identify systems- and community-level mental health service gaps as well as assess the capacity of the existing mental health services to respond to community need, in 2018, IWES conducted a situational analysis of the mental health landscape in New Orleans. New Orleans is the largest city in Louisiana with five large hospital systems that serve the Greater New Orleans region. The city also includes two medical schools, eight private colleges and universities, three public universities, and two seminaries each providing a variety of health care services and research and training to local hospital systems and communities. This array of resources provides a strong foundation for the in-depth assessment to follow.

The overarching goal of the situational analysis was to assess how [in its present state] New Orleans' mental health system measures up to the essential functions of an effective mental health system, which can serve as a basis for monitoring changes to the availability, accessibility, and quality of mental health services. By collecting this data, the community's mental health needs, existing mental health resources, service and resource gaps, and access barriers within the community are better understood. Further, this report will outline the methodology of this investigation, summarize the findings and discuss the effectiveness of New Orleans' mental health system in performing the 10 essential functions declared by the WHO. With this information, IWES aims to support advocacy efforts for a more responsive public mental health system.

ADAPTATION OF WHO-AIMS

The first step in this study was to adapt the World Health Organization's Assessment Instrument for Mental Health Systems ([WHO-AIMS](#)) as a framework for collecting essential, comprehensive information on existing policies, facilities and organizations, and resources focused on mental health in New Orleans. This instrument includes six domains: (1) Policy and Legislative framework, (2) Mental Health Services, (3) Mental Health in Primary Care, (4) Human Resources, (5) Public Education and Link with Other Sectors, and (6) Monitoring and Research.¹³ Each domain contains multiple measures from which the most applicable to the context in New Orleans were selected. The selection of measures was an iterative consensus-building process designed to ensure that the resulting adapted instrument would be appropriately pared down to capture city-level system components and encompass both provider and user/consumer interactions with and navigation within the mental health system. In addition to adapting the WHO-AIMS, a comprehensive literature review of the structure, organization, and functions of mental health systems was conducted. Expert feedback was solicited from key stakeholders knowledgeable about the various components of the New Orleans public mental health system.

Next, an extensive environmental scan of mental health service providers was conducted in 2018, resulting in the identification of 62 providers^a (see Table 1). This process included

online internet research, published directories and resource guides of mental health services in the city, and stakeholders' input of known providers to generate a comprehensive list of providers. From the general list, a "priority list" of the largest (in terms of people served) and/or most commonly- and frequently-used mental health providers was created. Organizations on the priority list were contacted first for in-person interviews and smaller organizations were sent electronic-based web surveys to be conducted remotely. Providers were then categorized by type of services provided and the resources accessible to the public. In the face of the growing epidemic of opioids and other drugs, substance use treatment centers were included in the analysis, as the correlation between mental health and substance use is an essential consideration for discerning provider- and system-level capacity to meet the needs of people that are among New Orleans' most vulnerable citizens.

After the close of the survey, an additional 22 providers were identified that were not originally identified in the initial environmental scan that was conducted. These 22 were identified as MHRs. Table 1 lists these facilities. Reasons for not capturing these providers initially may be attributed to the lack of knowledge of these facilities' existence by research staff and stakeholders, as many have only been open for a short time.

^aIn the event that a providing organization had multiple site locations, the organization was only counted once in the situational analysis. These providers are listed in Table 1.

Survey Instrument Development

After all providers were identified, the adapted WHO-AIMS instrument was used to develop six unique surveys specific to each type of mental health facility in New Orleans. The classification of facility types [and resulting surveys] are as follows:^b

- 1) Community residential facilities
- 2) Mental hospitals
- 3) Inpatient psychiatric unit/facilities
- 4) Mental health [and substance use] outpatient facilities
- 5) Mental health [and substance use] day treatment facilities
- 6) User/consumer and family associations

Upon deeper analysis, and per the WHO-AIMS definition of mental hospitals as “long-term stand-alone mental health facilities,” the Greater New Orleans area (particularly Orleans Parish and surrounding parishes) does not have “mental hospitals.” The nearest mental hospital is located in Jackson, Louisiana—115 miles outside of New Orleans. For that reason, mental hospitals were not included in the situational analysis, and only five facility-specific surveys were administered. Mental health services provided by large, multi-faceted hospitals were included and classified as inpatient and/or outpatient as appropriate. Surveys were comprised of questions derived directly from each of the measures in the adapted WHO-AIMS instrument and were used to organize the collection of specific structural and functional aspects of each facility type.

Through this scan, providers were categorized by facility type, and an inventory of the services offered, staffing of service providers, and clients served were documented. In addition to collecting information about structural and functional aspects of each facility type, each survey was designed to collect information about referrals to the facility, staffing, characteristics of the patient population served, aspects of the patient experience (e.g. wait times, duration of stay, etc.), as well as data collection and reporting done by the facility to governmental authorities. It is important to note that most providers and their services were easily categorized, although the classification of and collecting complete information from larger, multi-faceted facilities posed some challenges. Table 1 lists each organization by facility type.



^bRefer to Glossary section for definition of each facility type.

Table 1: 2018 Mental Health Providers in the city of New Orleans by Facility Type (N=62)

Community-based Psychiatric Inpatient Unit

1. Beacon Behavioral Health (Jefferson Parish)
2. Children’s Hospital
3. Community Cae Hospital
4. Ochsner Medical Center: Acute Psychiatry Services (Jefferson Parish)
5. River Oaks Hospital (Jefferson Parish)
6. UMC Behavioral Health
7. Veterans Affairs (VA) Medical Center

Community Residential

1. Belle Reve
2. Bridge/Grace House
3. Covenant House New Orleans
4. Living Witness Church of God in Christ, Inc. - Nehemiah Restoration Program
5. Odyssey House
6. Project Lazarus
7. Qualis Care
8. Townsend
9. Two Dreams
10. Unity of Greater New Orleans

Mental Health Day Treatment

1. Daughters of Charity
 - a. Carrollton Center
 - b. New Orleans East Center
 - c. Gentilly Center
 - d. St. Cecilia Center
 - e. Metairie Center
2. Divine Intervention Rehab, LLC
3. Excelth Family Health Center
4. Luke’s House

Mental Health Outpatient

1. Access Health Louisiana
 - a. South Broad Community Health Center
 - b. Ruth E. Fertel
 - c. Primary Care at Pythian
2. Behavioral Health Group
3. Center for Hope, Children and Family Services*
4. Children’s Bureau*
5. Clarke Community Services, LLC
6. Community Care Solutions*

7. Counseling Solutions Organization: Catholic Charities Archdiocese of New Orleans
8. Crescent Care
9. Destined for a Change, Inc.
10. Ekems HealthCare
11. Enhanced Destiny Services
12. Essential Care Services*
13. Family Preservation Services
14. Family Services GNO
15. Grace Behavioral Health Center, LLC
16. Grace Outreach Center*
17. Greenpath*
18. Integrated Behavioral Health
19. Integrated Family Services*
20. Key Behavior Essentials, LLC
21. LSU: Behavioral Science Center
 - a. LSUHSC Orleans Parish Permanency Infant and Preschool Placement Program
22. Mercy Family Center
23. Metropolitan Human Services District (MHSD)
 - a. Algiers Behavioral Health Center
 - b. Central City Behavioral Health and Access Center
 - c. New Orleans East Behavioral Health Center
 - d. Chartres-Pontchartrain Behavioral Health Center
 - e. St. Bernard Behavioral Health Center
24. Milestones Mental Health Agency
25. New Orleans Center for Mind/Body Health
26. New Orleans East LA (NOELA) Community Health Center
27. Obyke Health Care Services, LLC*
28. Plaquemines Community C.A.R.E. Center (MHSD contractor)
29. Positive Living Treatment Center*
30. Resources for Human Development
31. Seaside Behavioral Center
32. St. Thomas Community Health Center
33. The Guidance Center - St. Claude
34. Tulane: Behavioral Health Clinic
 - a. Tulane: Children’s Behavioral Health Clinic (Metairie)**

User/Consumer Associations (including Family Associations)

1. Alcoholics Anonymous
2. Bethel Colony South Transformation Ministry
3. Cocaine Anonymous
4. Council on Alcohol and Drugs Abuse
5. NAMI New Orleans
6. Narcotics Anonymous
7. True Love Movement

Additional Facilities/Providers Identified Post-Survey Completion***

1. Absolute Health Inc.*
2. Accountable Behavioral Services, LLC*
3. Alpha Behavioral Health Services*
4. Bridges to Hope, LLC*
5. Cenikor Foundation*
6. Choices Behavioral Health*
7. Crescent Community Outreach*
8. Delta Mental Health*
9. Genesis Housing, Counseling & Outreach Services, Inc.*
10. Imagine Recovery*
11. In This Together*
12. Inspiring Hope*
13. Louisiana Health Partners*
14. New Beginnings Behavioral Health Center*
15. Next Step Health Services*
16. Responsibility House*
17. Restoring Hope Behavioral Health Services*
18. Serenity Outreach Center, LLC*
19. Sinfonia Family Service*
20. Suncreat Behavioral Health Services*
21. The Creed Group of Louisiana, LLC*
22. The Gift, LLC*

Note: In the event that a providing organization had multiple site locations, the organization was only counted once in the situational analysis.

*Indicates Mental Health Rehabilitation (MHR) Centers.

**Update: Tulane's children services are in the process of merging with Children's Hospital;

***These facilities were identified after the survey completion date and thus were not contacted to complete a survey.

FINDINGS

“

ONLY 12 FACILITIES (42.8%) STATED THEY SERVED CHILDREN AND ADOLESCENTS, MAKING UP 18% (9,197 PATIENTS) OF THOSE TREATED IN THE PAST 12 MONTHS.

”

The environmental scan resulted in the identification of 62 providers (Table 1). Of those, 28 survey responses were received: 8 (28.5%) electronic survey responses via email, 3 (10.7%) telephone interviews, and 17 (60.7%) in-person interviews were conducted. Fifteen (53.6%) were mental health outpatient facilities, 7 (25%) were community residential facilities, 3 (10.7%) were mental health day treatment facilities, and 3 (10.7%) were psychiatric inpatient units. Although 7 out of 62 providers were identified as user/consumer associations, responses were not received from these facilities.

Table 2 provides descriptive statistics. Across all 28 facilities in the sample of respondents, 50,583 patients were treated in the past 12 months. Only 12 facilities (42.8%) stated they served children and adolescents, making up 18% (9,197 patients) of those treated in the past 12 months. The interviews revealed that in most cases, when children were admitted through the emergency department for mental health reasons, they were “stabilized and then transferred to a facility that serves children.”

Mental Health Outpatient

The majority of providers surveyed were mental health outpatient facilities (n=15, 53.6%). Mental health outpatient facilities are defined as facilities that provide outpatient services for patients with mental disorders and can commonly be seen in general hospitals.¹³ Four of the 14 outpatient facilities were integrated within a hospital. Additionally, 26.7% (n=4) were government-administered and 26.7% (n=4) were for-profit entities, while the remainder were non-profit (n=7, 46.8%).

Across the 15 outpatient facilities, 30,734 patients were seen, of which 8,790 (28.6%) were under the age of 17. The average duration on the waitlist for an initial non-emergency psychiatric appointment was 14 days and the average duration spent in an initial appointment with a psychiatrist was 46.5 minutes. A majority (87%) of mental health outpatient facilities stated that their patients received at least one of more psycho-social interventions^c during their visit. Lastly, 60% of facilities stated their patient population is comprised of at least 51% of racial and ethnic minorities, while 21.4% said at least 80% of their patient population comprised of racial and ethnic minorities.

Community Residential

Community residential facilities made up 25% of the respondent sample (n=7), with 6 (85.7%) of these facilities being non-governmental organizations (NGO) or non-profit organizations. Community residential facilities are non-hospital, community-based facilities that provide overnight residence for people with mental disorders and/or substance use disorder.¹³ Typically these facilities serve persons with relatively stable mental disorders not requiring intensive medical interventions.¹³

Consequently, 5 (71.4%) facilities reported that “the majority of people receiving services had a diagnosable mental/substance use/co-occurring disorder”; one facility reported that the majority of people receiving services did not have a diagnosable disorder; and for one facility, this was unknown. Less than two percent of patients served—201 of the 15,188 patients seen by community residential providers in our sample—were under the age of 17. Moreover, three residential facilities reported their average length of stay (LOS) for patients, which was an average of 176.7 days (min. 45 days, max, 365 days). Three community residential facilities did not report average LOS and one facility reported that patients never transition out as they provide permanent housing. One facility reported average length of time in an initial appointment with a psychiatrist was 45 minutes. For others, length of time in an initial appointment with a psychiatrist was either unknown or not relevant because there was no psychiatrist on staff; the majority only had social workers or counselors on staff.

^c **Psychosocial intervention:** An intervention using primarily psychological or social methods for the treatment and/or rehabilitation of a mental disorder or substantial reduction of psychosocial distress. See Glossary for examples.

Table 2: Descriptive Characteristics of Survey Responses by Facility Type

	Total		Community Residential		Inpatient Psychiatric Unit		Mental Health/ Substance Use Day Treatment		Mental Health/ Substance Use Outpatient	
	N	%	N	%	N	%	N	%	N	%
N (%)*	28	100	7	25	3	10.7	3	10.7	15	53.6
<u>Org type</u>										
<i>NGO/Non-profit</i>	17	60.7	6	85.7	1	33.3	3	100	7	46.8
<i>Government-Administered</i>	5	17.9	0	0	1	33.3	0	0	4	26.6
<i>Private/For-Profit</i>	6	21.4	1	14.3	1	33.3	0	0	4	26.6
Serve children (yes/no)	12	42.8	1	14.3	0	0	2	66.6	9	60
# of Patients treated	50583		15188		4661		UN		30734	
# of Children treated	9197	18.1	201	1.3	0	0	206		8790	28.6
# of Beds	783		663		120		0		0	
<u># of Staff</u>										
<i>Psychiatrists</i>	106		7		28		4		67	
<i>Psychologists</i>	75		2		46		1		26	
<i>Nurses</i>	216		26		113		9		68	
<i>Social workers</i>	162		27		19		11		106	
<i>Occupational therapists</i>	7		0		6		0		1	
<i>Other MDs</i>	60		4		0		22		34	
<i>Other MH staff</i>	159		25		1		18		115	

*Row Percentage; UN - Unknown; NA - Not Applicable

Mental Health Day Treatment

A mental health day treatment facility is one that typically provides care for service users during the day (lasting half or one full 8-hour work day) and the primary mode of treatment delivery is group-based rather than delivering services to individuals one at a time.¹³ Three of the 28 survey respondents (10.7%) represented mental health day treatment facilities all of which were non-profit organizations. Two of these facilities stated their patient population was comprised of at least 80% racial/ethnic minorities, while one reported that racial/ethnic minorities comprised between 50-79% of their patient population. Only one facility reported average duration on their waitlist as 45 days; the other facilities were unsure. All day treatment facilities, however, reported that on average, patients spent one hour in an initial appointment with a psychiatrist. These facilities did not report number of patients treated nor did they report whether individuals receiving services had diagnosable mental or substance use co-occurring disorders.

Psychiatric Inpatient Unit

A psychiatric unit is one that provides inpatient care for the management of mental disorders within a community-based facility.¹³ These units are usually located within general hospitals, as they provide care to users with acute problems, and the period of stay is usually short (weeks to months).¹³ There were three respondents from community-based psychiatric inpatient facilities, one of which was a non-profit organization and two were for-profit or government-administered entities. During the initial environmental scan, known major inpatient facilities in Jefferson Parish were included, with the understanding that Orleans Parish residents receive services in these facilities. Of those facilities, only one Jefferson Parish facility submitted a survey response. The other two inpatient units included in this analysis are in Orleans Parish. The small number of respondents for the psychiatric inpatient unit facility type accurately reflects that few of these facilities exist in the city as only 3 (4.8%) of the 62 providers identified were psychiatric inpatient units. All psychiatric inpatient facilities reported that “all or almost all” of their patients receive one or more psycho-social interventions. One facility reported their average waitlist duration was 17.5 days, and the other two reported having no waitlists for inpatient services, with the caveat that if beds are full, patients are referred to another facility. Number of beds within these facilities ranged from 14 beds to 60 beds, with the maximum LOS ranging from 9 days to 15 days. Each facility’s maximum LOS was also their average LOS reported, as patients tend to stay the entire amount of days allotted, with a few cases of patients staying longer in severe circumstances.

Service User/Consumer Associations

User/Consumer associations (including family associations) are entities that extend membership to patients who are mental health users/consumers as well as to the families they support.¹³ These organizations not only provide supportive mental health and substance use services, but they also engage user/consumer and families to participate in providing actual services to other users, such as training and education programs (e.g. Alcoholics Anonymous, “AA”). As reported above, responses were not received from these organizations, however a list of identified user/consumer organizations is listed in Table 2.

DISCUSSION

The goal of this analysis was to evaluate the effectiveness of New Orleans' mental health system in performing the 10 essential functions declared by the WHO. Through survey data collection, anecdotal information received from interviews, and online research, substantial information was captured to adequately assess whether these functions are being met.

1. Ensure access to hospital and integrative community services for treatment of mental health conditions

This domain function was heavily observed and discussed with survey respondents when describing their effectiveness in ensuring access to care for mental health conditions. Multiple issues were highlighted by these analyses. The first issue identified was the absence of a mental hospital or any facility that provides long-term intensive mental health services in the Greater New Orleans area. There is an urgent need for long-term mental health services as a recent report found that the largest institution currently housing the mentally ill is the jail.¹⁴ As was stated

by a provider, "here in New Orleans, sadly the jail is the largest mental health provider in the city."

————— “ —————
HERE IN NEW
ORLEANS, SADLY
THE JAIL IS THE
MENTAL HEALTH
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CITY.

Further, at long-term intensive treatment facilities, which are all outside of the Greater New Orleans area, long waitlists hinder patients from being admitted into these institutions in a timely manner, if at all.^{14,15} A recent report by the Times-Picayune found that most patients who are admitted to long-term intensive institutions come through the criminal justice system.^{14,15} This observation concurs with findings from this analysis as one provider stated, "It's actually faster to be admitted into a long-term facility if you go through criminal courts, than being on a waitlist." Hence, providers expressed a need for partial hospitalization programs for intermediate stay for patients on waiting lists prior to being admitted into a mental hospital or community-based facility.

Mental hospitals are not the only facilities with long waitlists. When comparing private versus government organizations, a substantial difference was found in the average duration on a waiting list for an initial non-emergency psychiatric outpatient appointment. For private entities the average waitlist was 20 days, while government organizations had an average of 6 days on waitlist. Hence, the need and demand for services, as many facilities consistently remain at capacity and unable to see new patients.

Another issue arose when speaking with providers regarding the high rate of emergency room (ER) admissions and readmissions, as those who get discharged from the ER or inpatient departments end back up in the ER shortly thereafter due to not receiving proper intensive treatment in the facilities to which they were referred. As one provider said, "Patients end up in the ER and then discharged and then back here... it's a cycle." Moreover, respondents from community-based residential facilities that serve homeless adults or adults with substance use disorders, revealed they have people who initially present symptoms or issues that meet the criteria of admission to that facility (i.e. alcohol or drug addiction). However, once admitted,

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IT'S ACTUALLY FASTER TO BE ADMITTED INTO A LONG-TERM FACILITY IF YOU GO THROUGH CRIMINAL COURTS, THAN BEING ON A WAITLIST.

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facilities realize these individuals have mental health needs and do not need services to treat a drug or alcohol addiction. As one provider said, "We have people who actually do not have substance use problems, they have mental health problems, but they come here just to have a place to stay." The absence of residential services solely for mental health patients is widely apparent in the city and patients are desperate for residential support. As one provider informed us, "Payers will pay for outpatient substance use services but not mental health, and people [patients] know these services get covered so they lie to get treatment."

Long waitlists and a lack of facilities are not the only barrier for patients, as cost is a major factor that providers emphasized attributes to low utilization of services. A recent media campaign by the Times-Picayune, reported similar results through anecdotal evidence with patients who are navigating the mental health system.¹⁴⁻¹⁶ For example, a father and caregiver of a 24 year-old with severe and persistent mental illness, stated his son was number 51 on the waitlist to get into a long term treatment facility outside of the city and even then, if he did make it to the top of the waitlist, Medicaid refused to cover an ambulance ride to the facility.^{14,16} Medicaid is the single largest payer of mental health services in the U.S., however, due to the low reimbursement rate, there is a struggle to get doctors and other providers to accept Medicaid patients. For those providers that do accept Medicaid, it is difficult to expand their capacity due to financial constraints.

Another issue identified when speaking with providers was the frustration with the lack of comprehensive services for adults and children. There is no continuum of coordinated care when navigating the mental health system. Providers have expressed the importance of the role that

care coordination can play when implemented in a health care system. Care coordination is defined as the “deliberate organization of patient care activities between two or more participants (including the patient), often managed by the exchange of information”.¹⁷ Care coordination enables individual providers, provider groups, and hospitals to communicate and share information in an effort to provide high quality care that is easily transferable across all continuums of care—allowing for each patient to be properly diagnosed, treated, monitored, and referred based on their individual health care needs. Effective care coordination in a mental health system has the ability to reduce hospital admissions and readmissions, decrease emergency department visits, and improve care transitions.^{18,19} Providers suggest having peer navigators and care coordinators to facilitate these “warm handoffs” and monitor a patient’s transitions within the mental health system can drastically improve the delivery of care for each individual.

“ [YOU] CAN’T HAVE HOSPITALS THAT DON’T ACCEPT MEDICAID WHEN 60% OF YOUR COMMUNITY RELIES ON MEDICAID. ”

Resource coordination was another glaring gap mentioned by providers that is needed to improve the mental health system. Resources being provided to patients should mirror the make-up of the community, both economically and culturally. For example, the cost of services should be within affordability range to the population being served, and facilities should strategically be placed in geographic areas where need and demand is high. Resource coordination has the potential to reduce access and cost barriers for individuals seeking care. As was stated by a leader of the public mental health system, “[you] can’t have hospitals that don’t accept Medicaid when 60% of your community relies on Medicaid.” Furthermore, providers revealed that many components of the mental health system are siloed both within organizations at the department level and across facilities at the city level, adding another layer of difficulty for addressing care coordination. As one health care system leader followed in response, “...if one [component] is lacking, all components cannot function in the most effective way.”

To address this lack of coordination within the mental health system, Metropolitan Human Services District (MHSD) has created a plan to: (1) develop a comprehensive behavioral and mental health system that promotes partnerships across providers and institutions; (2) establish strong relationships with communities to inform them of MHSD services and resources; and, (3) encourage individuals to seek treatment. As the largest system for behavioral health in the city of New Orleans, MHSD is constantly working on ways to market their services to low-income underserved communities, who tend to stigmatize seeking mental health services.

2) Ensure access to essential psychotropic medications

Similar to accessing care, cost is also a barrier for accessing essential psychotropic medications. Newer medications are available to patients and tend to be covered by most insurance payers, however many have preferred lists that will only cover the full costs of those drugs that are prioritized. Additionally, the copay cost on these medications may be too high for patients to afford.

3) Address health disparities and racial/ethnic inequities

The New Orleans metro area has a population of 1,275,762 with the non-white population making up 69% (n = 880,276) of this population: Non-Hispanic black - 765,457 (60%), Non-Hispanic white - 395,486 (31%), Hispanic 76,547 (6%), and Asian - 38,272 (3%).^{20,21} In assessing the racial and ethnic demographic make-up within the mental health system, all facility types reported that the majority of their patient populations were non-white, matching the racial/ethnic demographics in the city as the majority of New Orleanians are people of color. However, the racial and ethnic disparities in disease prevalence within these populations are very present, which may speak to the difference in quality of care being delivered to populations based on race, income, and place of residence.

For example, the last report by the New Orleans Health Department on health disparities, published in June of 2013, used survey data conducted by the Kaiser Family Foundation and found that “African Americans in Orleans Parish were significantly more likely than whites to have any chronic condition.”²² Specifically pertaining to mental illness, Blacks had a 17% prevalence rate of any serious mental illness such as depression, compared to a 15% disease prevalence amongst whites.²² This likely reflects the overall lack of resource coordination and service availability in all areas, and specifically in those predominantly Black communities (i.e. New Orleans East). The report did not provide data on Latino and Asian populations because of their small population size, making the data “statistically unreliable.”²² Future research should attempt to investigate the health disparities amongst Latino and Asian populations and provide an evaluation on current health disparities and the impact of insurance coverage on these disparities, following Medicaid expansion.

Moreover, a 2012 study published by the Joint Center for Political and Economic Studies’ Place Matters project examined the impact of place on health in Orleans Parish between 2001 and 2007 and found there was a significant 25.5 year difference between ZIP codes in New Orleans with the highest and lowest life expectancies.²³ The lowest zip code, 70112, had a life expectancy of 54.5 years and 36% of their population were below 150% of the Federal Poverty Level (FPL).

The highest zip code, 70124, had a life expectancy of 80 years and only 6% of the population was below 150% of the FPL.²³ When examining race, whites were found to have a life expectancy of 76.2 years while Blacks had a life expectancy of 67.4 years, resulting in a statistically significant difference of 8.8 years.²³ In addition to race, income, and place of residence, disparities within mental health are also reinforced by stigma. Further, as there are linguistic barriers that can contribute to health disparities providers identified a need for Spanish and Vietnamese speaking counselors and mental health workers as the non-English speaking populations of predominantly Latin and Asian populations in New Orleans are steadily increasing each year. As of 2017, the Hispanic population has increased by 3% (from 3% in 2000 to 6% in 2017) and the Asian population has increased by 1% (from 2% in 2000 to 3% in 2017).²¹ Recognizing this population growth, 12 providers reported that they employ specific linguistic services for non-English speaking patients, such as scheduling bilingual staff during appointments or using interpreter services.

To address these disparities, the New Orleans Health Department developed a Community Health Improvement Plan (CHIP) to address five health priority areas: Access to Physical and Behavioral Health, Social Determinants of Health, Violence Prevention, Healthy Lifestyles, and Family Health.²⁴ The most recent version of this plan was updated in May of 2015 and includes goals and objectives to be met by the city to ensure progress in addressing disparities and health outcomes. An update on the current status of these objectives are unavailable.

4) Educate the public

In regard to public education and awareness campaigns on mental health, New Orleans does not provide adequate resources and education opportunities for the public to engage and learn. Health literacy and education is a major barrier to accessing care for this population and providers struggle to provide support for engaging and educating patients on their mental health needs. From a policy perspective, substance use disorders have been recognized as a medical need, however other mental health disorders have not. Providers concur that the opioid crisis has opened the door to conversations as the city has done well at establishing and promoting the importance of education and treatment for opioid addiction, however, this same effort needs to be seen for mental health treatment and services. In the last five years, a number of underserved and underrepresented populations (e.g. children, women, trauma survivors, ethnic groups and the homeless) have been targets of mental health campaigning. The success of these campaigns has not been measured and based on health outcomes, recent news stories, and community insight, these campaigns do not capture large audiences nor bring awareness to the importance of seeking mental health services.

A majority of community-based organizations surveyed receive funding through government support and grants; these funds are for direct services. As one provider emphasized, "Grants and government only give money for specific services and those services most of the time barely generate any revenue. The margin of profitability is small." With already limited funding for health care services and staffing, mass education and promotion campaigns are not often

seen as an immediate priority for community-based organizations. As multiple providers commented, “The core capacity needed to grow is limited because we don’t have the funds.” And another, “...can’t hire as many people as we’d like, thus we can’t expand services. We would love to hire a grant writer or a marketing manager but can’t afford it.”

When asked whether they provided school-based programs or activities to promote mental health, 14 (50%) survey respondents reported “no”; 12 (42.9%) reported “yes”; and 2 (7.1%) either reported not knowing or did not answer. This coincides with previous findings described above, as most facilities do not serve children and therefore see no need to implement school-based programs. Nonetheless, results showed that 81 of 94 schools within the Orleans Parish School Board (OPSB) public school system had either a part-time or full-time licensed social worker and/or licensed counselor. However, this number does not consider the number of hours and days worked at each school. Future research will continue to explore these specifics.

“ GRANTS AND GOVERNMENT ONLY GIVE MONEY FOR SPECIFIC SERVICES AND THOSE SERVICES MOST OF THE TIME BARELY GENERATE ANY REVENUE. THE MARGIN OF PROFITABILITY IS SMALL.

5) Involve communities, families, and consumers

Results from this analysis show providers are actively trying to find ways to involve and engage communities, families and consumers. In one effort to increase engagement, MHSD created a new position within their leadership, “Advocacy Director,” who will oversee peer workers and develop programs to bring awareness to MHSD services. Moreover, in addition to educating the public through trainings and marketing campaign strategies to target communities, 64.29% of facilities reported having ongoing collaborations with user/consumer associations and community-based organizations. These collaborations varied across topics, target populations, and types of programs offered such as community building activities, health fairs, focus groups, informal trainings, informative wellness classes and health advocacy workshops. The National Alliance on Mental Illness (NAMI) New Orleans was consistently mentioned as a primary user/consumer association that has formal or informal partnerships with mental health providers. NAMI is a family-based grassroots support and advocacy organization that provides behavioral health services for adults living with mental illness in the Greater New Orleans area.²⁵ However, even with the effort and resources NAMI provides, more engagement is needed with communities, families, and consumers.

6) Respond to changes in population health and needs through policy and program development

At the city and state level, there are changes being made to enhance and embed population health, as a key component of healthcare, however there is minimal effort being expended for mental health. There are a few responses being made to address changes in population health for mental health and substance use at the organization level, however many tend to be independent efforts, siloed from one another. The following are four such examples:

a. A new initiative by University Medical Center (UMC), a level one trauma center and academic research hospital in New Orleans, embedded behavioral health services inside the Trauma Surgery service to properly capture and identify patients with mental distress and substance use disorders. This was due in part to the steady increase in violence in New Orleans, as the city “had the highest per capita homicide rate in the United States of 46.9 deaths per capita from 2010 to 2015.”²⁶ Subsequently, Conrad et al., 2013, found that traumatically injured patients have complex comorbidities of post-traumatic stress disorder (PTSD) (52%), depression (44%), alcohol abuse (20%) and potential for violence (48%) or re-victimization (60%).²⁷ Being the only level one trauma center in the region, covering Jefferson, Orleans, Plaquemines, and St. Bernard parishes, and one of two facilities that has a psychiatric inpatient unit, there was a need to implement both behavioral health services in the trauma center, and a hospital-based behavioral health outpatient clinic specializing in the treatment of psychological sequelae following traumatic injury, or for short, a “trauma recovery clinic.” The goal of this program is to reduce recurring victimization by identifying these patients upon arrival and providing proactive screening and assessments of depression, acute stress disorder, substance use disorder, and violence potential. Once screened, patients are then provided with needed resources such as psychiatry consultation and/or social services. Patients can then follow up in the outpatient Trauma Recovery Clinic that opened in 2017. In 2018, there were 2,837 trauma activations due to motor vehicular crashes, and assaults due to gun shot wounds, fighting, stabbing, etc.

b. In response to the needs of Veterans and their families, the Veterans Affairs (VA) Medical Center reopened its doors in November 2016.³⁰ In the aftermath of Hurricane Katrina, the VA Medical Center was devastated and Veterans and their families had limited access to services in the city. Today, the Southeast Louisiana Veterans Health Care System, which includes the VA Medical Center, provides quality care to Veterans throughout 23 parishes in southeast Louisiana, as “90% of Veteran patients live within 30 minutes of primary care and mental health services.”³¹ There is a 60-bed inpatient unit plus mental health clinics that include specialized mental health programs such as PTSD, homeless services, substance use treatment, compensated work therapy program, and home-based management of chronic mental illnesses (Mental Health Intensive Case Management).³¹ The home-based management provides “doctor-directed, nurse-provided care to Veteran patients in their homes, shortening hospital stays, and increasing patient comfort.”³¹

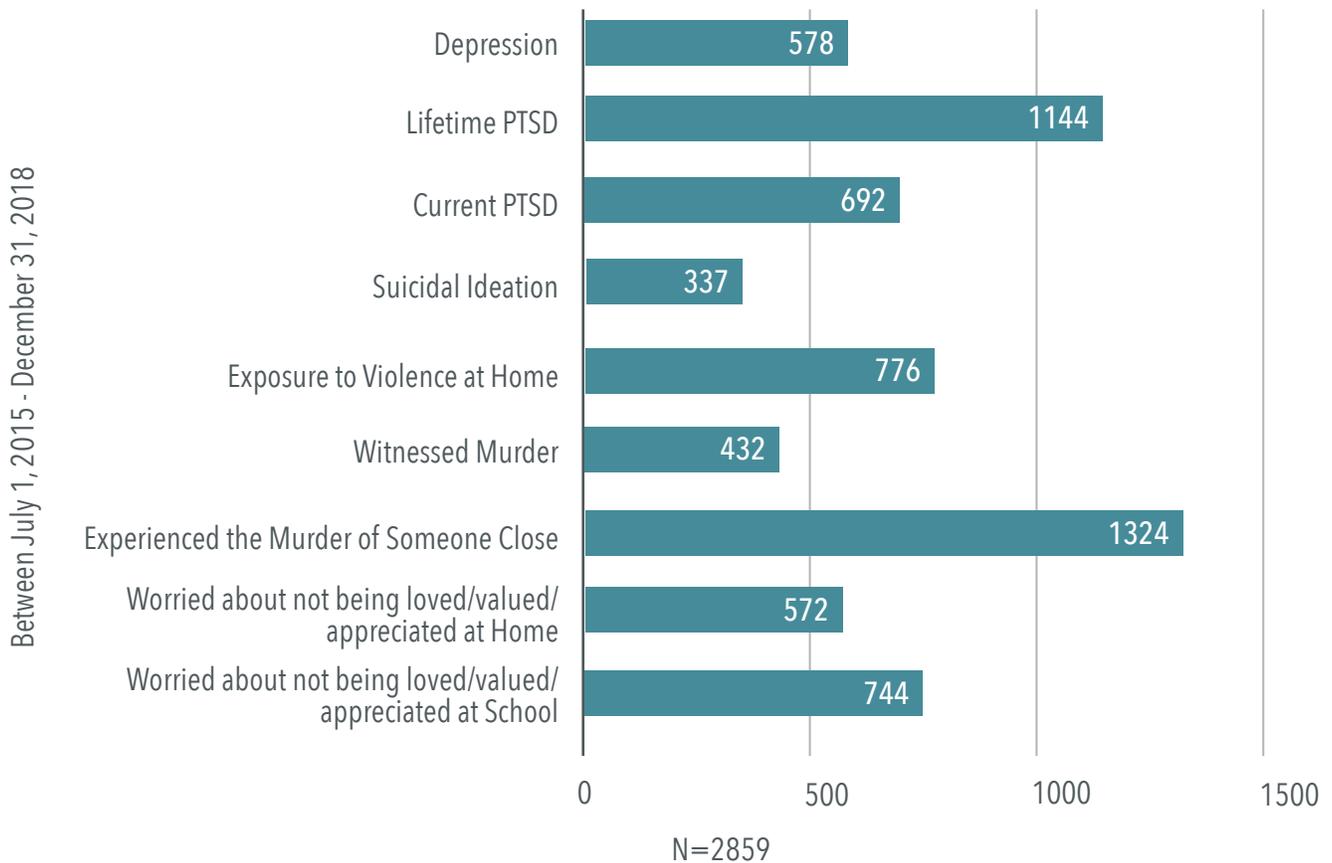
c. To address the increase in need for services for children, in an effort to offer a more comprehensive and coordinated range of services to patients, facilities have begun developing cross system partnerships (i.e. public and private hospital partnerships). For example, with a new partnership between Children’s Hospital (the only free-standing hospital in the state that solely focuses on children) and Tulane University School of Medicine, their goal is to increase access to “high-quality pediatric health care and enhance pediatric educational and training opportunities for medical students and medical residents in Louisiana.”²⁸ As there is already an existing partnership between LSU Department of Pediatrics and Children’s Hospital, this new partnership with Tulane will strengthen the delivery of mental health services for children and join the shared mission to become the “region’s leader in pediatric clinical care, education and focused research by the year 2030.”²⁹

d. Due to the lack of a coordinated public mental health system response to providing culturally responsive trauma-based mental health services for vulnerable populations in the post-disaster (Katrina) environment, IWES created a division of post-disaster emotional resiliency in 2006. The public mental health system continued to prioritize services for only the serious and persistently mentally ill population, in spite of the need to address and include post-disaster trauma-based disorders as a new priority population. Hence, IWES began collecting data on trauma-based conditions among youth, which, from 2012 to present, has shown a persistent elevation in symptoms of post-traumatic stress disorder, depression and suicidal ideation (Table 3). In response, and utilizing the Social Ecological Model as the underlying theory of change, IWES has: provided psychoeducation and clinical school-based services at the individual and group level; hosted ‘Red Tent’ wellness community events where community members can access complementary healing activities and psychosocial support; provided professional development on common mental health disorders in youth and compassionate responses for school personnel and youth-serving organizations; and conducted a public will campaign entitled In That Number (#sadnotbad) to increase public will to support all youth having access to mental health and restorative services, versus being referred into the juvenile justice system when they are behaviorally dysregulated due to their untreated trauma.



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IDEATION (TABLE 3)**

Table 3: Emotional Wellness Screener



*Note: This emotional wellness screener screens for signs and symptoms of PTSD and Depression utilizing the PCL-5 and DSM-5.³⁹

At the state level, Medicaid expansion is the largest and most significant policy to date that has had direct impact on access to care for mental health services. Although expansion increased access to care by expanding the income threshold, allowing persons previously uninsured to now be insured and able to access services, the reimbursement rates for Medicaid are still major barriers to access.⁹ Providers expressed frustration with the lack of services covered through Medicaid and the low reimbursement rates received for services that are covered through Medicaid, as one provider stated, “if they [Medicaid reimbursements] were adequate, everyone would instantly take these patients.” Additionally, even within private and commercial insurance, payers do not reimburse enough. At a more granular level, in an effort to offset issues of capacity in clinic and the inability to treat the community as swiftly as preferred, 50% of respondent mental health outpatient facilities have implemented mobile health clinics to provide mental health services directly in the neighborhoods they serve.

Overall, there is an absence of a system of coordinated statewide policy and program development for responses in changes for population mental health needs. The Office of Public Health focuses on a variety of public health issues such as environmental health, emergency preparedness, and preventative health.³² However, mental and behavioral health is not a primary focus. Provider respondents insist mental and behavioral health in this city should be viewed as a public health issue, as opioid addiction, diabetes, and hemophilia have, in order to shift the public health agenda in such a way that it incorporates policy and funding for population

level needs assessments. This would allow the city and state to capture population level data on mental health conditions, service utilization, and need for services which could then inform policy and program development on a large scale. Finally, a common theme that needs to be addressed is the lack of a single point of entry where patients can be treated, obtain a proper health assessment and care plan, and receive adequate referrals with efficient monitoring and follow-up protocols.

7) Develop and sustain an effective workforce

There appears to be a consensus amongst our survey respondents and prior research regarding the lack of psychiatrists in the city.¹⁵ Although community residential facilities provided a vast number of mental health services to a large proportion of individuals, the majority only had social workers and nurses, and very few had medical doctors on staff. A similar pattern was seen in mental health day treatment centers, as all were non-profit, and reported difficulties competing with larger for-profit organizations for medical doctors and nurses, as larger for-profit entities can afford to offer higher salaries that non-profits cannot. Budget considerations make cost a major barrier in terms of hiring physicians, providing high quality services, and expanding their capacity to see new patients. Providers from the smaller community-based organizations revealed they have limited ability to grow their programs in both services offered and hiring new staff as budget cuts remain constant and funding opportunities remain scarce. One provider stated, “there is only enough money for current staff support and not enough money to expand staff and services, additionally at least 10% of claims are denied by Medicaid.” Due to this, providers are having to use overhead funds to pay out of pocket to cover the costs of services for their patients that would normally be covered by insurance. For larger teaching hospitals, workforce development is not as difficult. As residents train and work at these facilities, it is inherently easier for these organizations to develop and sustain an effective workforce.

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...THERE IS ONLY ENOUGH MONEY FOR CURRENT STAFF SUPPORT AND NOT ENOUGH MONEY TO EXPAND STAFF AND SERVICES, ADDITIONALLY AT LEAST 10% OF CLAIMS ARE DENIED BY MEDICAID.

Regarding the workplace environment and employee engagement, some organizations expressed satisfaction with current leadership and staff within their organizations and shared recommendations for reducing burnout and attrition in an effort to minimize turnover and sustain an effective workforce. Beginning with leadership and their ability to create a positive workplace environment where employees feel empowered to do their best work, providers explained how casual engagement and quality time between leadership and front-line staff in the office can promote collaboration and innovation.

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8) Link with other sectors

The analysis revealed that a majority of facilities link with other sectors across a wide variety of agencies and program areas such as HIV/AIDS, child and adolescent health, substance use, education, employment, housing, criminal justice, reproductive health and primary care in the form of formal collaborative training programs. However, they miss opportunities to collaborate on joint community program initiatives where they can share costs and resources amongst one another to provide community-based services and resources that are innovative and responsive to current community health needs and gaps in services, aside from just training programs for employees.

Within the healthcare sector, there are a variety of collaborations, however, these tend to be informal linkages rather than formalized partnerships. As one provider stated, “[relationships with outside organizations] kind of starts from the departmental level rather than the hospital/organization level.” For example, there are many informal linkages and connections that are established through the LSU Department of Psychiatry, as LSU residents rotate between UMC, Ochsner, and Children’s Hospital. UMC and Children’s Hospital also have an ongoing relationship in an effort to direct children to proper services. Additionally, to address the lack of care coordination, UMC, MHSD, and NAMI have partnered together to provide a continuum of care for patients after hospital discharge. Patient navigators link patients to MHSD outpatient clinics after they are discharged from UMC where they are then assigned to peer supports from NAMI who continue to support them as they go through treatment.

9) Continuously monitor community mental health status - epidemiology, needs and gaps in services

As mentioned previously, there is a lack of city and state response to change in population health needs through policy and program development. This is a result of the lack of evaluation and assessment on the state of mental health in the city. Without a proper evaluation, there cannot be a thorough and coordinated response. There is not a continuous process for monitoring the mental health status of communities. As one provider mentioned, “We need more of that, we currently don’t know this, and people want to know.” Since the enactment of the Patient Protection and Affordable Care Act, community health needs assessments (CHNAs) are required to be conducted every three years for tax-exempt hospitals and health systems, as imposed by the IRS.³³ For all CHNAs, hospitals and community-based facilities must “adopt an implementation strategy to meet the community health needs identified through the assessment, and report how it is addressing the needs identified in the CHNA and describe needs that are not being addressed, with justification.”³³ CHNAs have been completed for Ochsner Health System, Tulane Medical Center, LCMC Health which includes UMC, Children’s Hospital, and New Orleans East Hospital among many others in the surrounding Louisiana parishes.³⁴⁻³⁸ All

assessments are publicly available and provided by hospitals and community-based organization to assess community health needs.

Based on the most recent CHNAs by hospitals, all identified the same three priority areas to be addressed: (1) behavioral health (mental health and substance use), (2) health literacy, and (3) access to care.³⁴⁻³⁸ Each hospital prioritized these areas differently based on their “study area” or zip codes for which their services cover. In one example, as part of UMC’s response to addressing these priority areas, UMC has recently opened an Intensive Outpatient Program (IOP) for addiction services staffed by LSU; an outpatient psychiatry clinic will open in the spring of 2019 which will also be staffed by LSU.

These extensive assessments are critical for the advancement of our mental health system. However, an integrated approach is needed that would combine all assessments and create a formal monitoring process at the city and state level that incorporates needs and recommendations from all hospitals and community-based organizations. This undertaking should be led by a governing office which has the proper platform to report population level findings epidemiology, needs and gaps in services. This comprehensive city and statewide assessment would have the potential to push the public health agenda for the benefit of those with mental health and substance use needs, a high need vulnerable population that has been consistently identified as a priority area by all large hospitals in the region.

10) Support relevant research

New Orleans’ mental health system as a whole has not produced a substantial amount of relevant research on mental health. Fourteen (50%) respondents said they had mental health professionals on staff who had participated in mental health research as an investigator or co-investigator in the last five years, while 12 (42.8%) reported “no” and 2 (7.2%) did not know. Of the 14 facilities that reported conducting research, all covered at least one of the seven research topics measured by the WHO-AIMS instrument: (1) epidemiological studies in community and clinical samples; (2) non-epidemiological clinical/questionnaires assessments of mental disorders; (3) services research; (4) biology and genetics; (5) policy, programs, financing and economics; (6) psychosocial and psychotherapeutic interventions; and (7) pharmacological, surgical and electroconvulsive interventions.¹³ The majority of research being conducted in the Greater New Orleans area is through university teaching hospitals, such as UMC, Tulane, and LSU. These leading research institutions assess data collected by both their own institutions and outside organizations who share their data. For community-based organizations, research is not a high priority, although wanted and needed, lack of funding limits these organizations’ ability to analyze and evaluate data from their programs and patient outcomes.





CONCLUSION

These findings form the basis of advocacy efforts to improve the New Orleans public mental health system in order for it to be more responsive to the needs of the population. As further research continues, priorities can be determined for increasing New Orleans' mental health capacity to link adults and children to mental health services and address identified service gaps. This report reveals that there is a need to strengthen the care coordination and continuum of care for patients so that they are able to receive quality services at an affordable cost.

Although this Situational Analysis does not fully capture the entire state of New Orleans' mental health system, it does put into context the current major landscape of mental health and substance use care. In the very near future, a community needs assessment will be conducted by IWES to capture the perspective of the New Orleans mental health system from the lens of users, consumers, and families. Through this assessment, service utilization, gaps, and barriers to care will be identified and compared with results from this analysis to produce a comprehensive assessment of the mental health system through the lens of providers and the communities they serve.

GLOSSARY

Community-based facility: A mental health facility outside of a *mental hospital*.^d

Community-based psychiatric inpatient unit: A psychiatric unit that provides inpatient care for the management of mental disorders within a *community-based facility*. These units are usually located within general hospital, they provide care to users with acute problems, the period of stay is usually short (weeks to months).^e

Community Psychiatric Support and Treatment (CPST): Non-clinical individualized goal-directed rehabilitative services with skills building and linkage to resources and medical supports to reduce disability.^f

Community residential facility: A non-hospital, community-based mental health facility that provides overnight residence for people with mental disorders. Usually these Facilities serve users with relatively stable mental disorders not requiring intensive medical interventions.^g

Continuum of Care: A concept involving a system that guides and tracks patients over time through a comprehensive array of health services spanning all levels and intensity of care.^h

Mental Health: The World Health Organization defines mental health as a state of wellbeing in which the individual realizes her/his own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her/his community. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.ⁱ

Mental health day treatment facility: A facility that typically provides care for *users* during the day. The facilities are generally: (1) available to groups of *users* at the same time (rather than delivering services to individuals one at a time), (2) expect *users* to stay at the facilities beyond the periods during which they have face-to-face contact with staff (i.e. the service is not simply based on users coming for appointments with staff and then leaving immediately after the appointment) and (3) involve attendances that last half or one full day.^j

Mental health outpatient facility: A facility that focuses on the management of mental disorders and the clinical and social problems related to it on an outpatient basis.^k

^d. WHO-Aims 2.2, 2005, (p11)

^e. WHO-Aims 2.2, 2005, (p11)

^f. Louisiana Department of Health and Hospitals. [Louisiana Behavioral Health Partnership Service Definitions 2012](#), (Assessed 17 July 2019)

^g. WHO-Aims 2.2, 2005, (p11)

^h. Evashwick, C. (1989). Creating the continuum of care. *Health Matrix*, 7(1), 30-39.

ⁱ. World Health Organization 2017. [Mental Health](#) (1 June 2019)

^j. WHO-Aims 2.2, 2005, (p12)

^k. WHO-Aims 2.2, 2005, (p12)

Mental health rehabilitation center: Agencies that provide outpatient mental health services and counseling in the community, in client homes, and schools for those seeking help for emotional or behavioral problems. Often referred to as MHRs.^l

Mental hospital: A specialized hospital-based facility that provides inpatient care and long-stay residential services for people with mental disorders. Usually these facilities are independent and stand-alone, although they may have some links with the rest of the healthcare system. The level of specialization varies considerably: in some cases, only long-stay custodial services are offered, in others specialized and short-term services are also available (rehabilitation services, specialist units for children and elderly, etc.).^m

Intensive outpatient program (IOP): An intensive outpatient program (IOP) is similar to an outpatient program but differs in that the duration of treatment is longer.^m

Other residential facility: A residential facility that houses people with mental disorders but does not meet the definition for *community residential facility* or any other mental health facility defined for this instrument (*community-based psychiatric inpatient unit, community residential facility, mental hospital*).ⁿ

Psychosocial intervention: An intervention using primarily psychological or social methods for the treatment and/or rehabilitation of a mental disorder or substantial reduction of psychosocial distress.

Includes: psychotherapy; counseling; activities with families; psycho-educational treatments; the provision of social support; rehabilitation activities (e.g. leisure and socializing activities, interpersonal and social skills training, occupational activities, vocational training, sheltered employment activities).

Excludes: intake interviews; assessment; follow-up psychopharmacology appointments as psychosocial interventions.^o

Psychotropic medication: Type of drug used to treat clinical psychiatric symptoms or mental disorders.^p

Psychosocial Rehabilitation (PSR): Services designed to assist an individual with compensating for or eliminating functional deficits and interpersonal and/or environmental

^l WHO-Aims 2.2, 2005, (p12)

^m WHO-Aims 2.2, 2005, (p12)

ⁿ WHO-Aims 2.2, 2005, (p13)

^o WHO-Aims 2.2, 2005, (p14)

^p National Institute of Mental Health. [Mental health medications](#). NIH publication no. 12–3929. 2010

barriers associated with their mental illness. The intent of PSR is to restore the fullest possible integration of the individual as an active and productive member of his or her family, community and/or culture with the least amount of ongoing professional intervention.^q

Single Point of Entry: A local or regional access point where persons receive information, assessment of needs, care planning, referrals to health and social services and, in some systems, authorization of services for home care, community-based care or residential care facilities.^r

Substance use Disorder: A maladaptive pattern of substance use leading to clinically significant impairment or distress. Classified as a mental health disorder under the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).^s

Transitional Care services: A broad range of services and environments designed to promote the safe and timely passage of patients between levels of health care and across care settings.^t

User/Consumer/Patient: A person receiving mental health care. These terms are used in different places and by different groups of practitioners and people with mental disorders and are used synonymously in WHO-AIMS.^u

User/Consumer associations (including family associations): Are those entities that include membership to the patients who are mental health users/consumers and families they support. These organizations not only provide mental health and substance use services, but they also engage user/consumer and families to participate in providing actual services to other users, such as training and education programs (i.e. Alcoholics Anonymous, AA).^v

^q Louisiana Department of Health and Hospitals. [Louisiana Behavioral Health Partnership Service Definitions](#). 2012 (Assessed 17 July 2019)

^r WHO-Aims 2.2, 2005, (p14)

^s Center for Substance Abuse Treatment. *Managing Chronic Pain in Adults with or in Recovery From Substance Use Disorders*. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2012. (Treatment Improvement Protocol (TIP) Series, No. 54.) Exhibit 2-6, DSM-IV-TR Criteria for Substance Abuse and Substance Dependence.

^t Naylor, M., & Keating, S. A. (2008). Transitional care. *The American journal of nursing*, 108(9 Suppl), 58–63. doi:10.1097/01.NAJ.0000336420.34946.3a

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