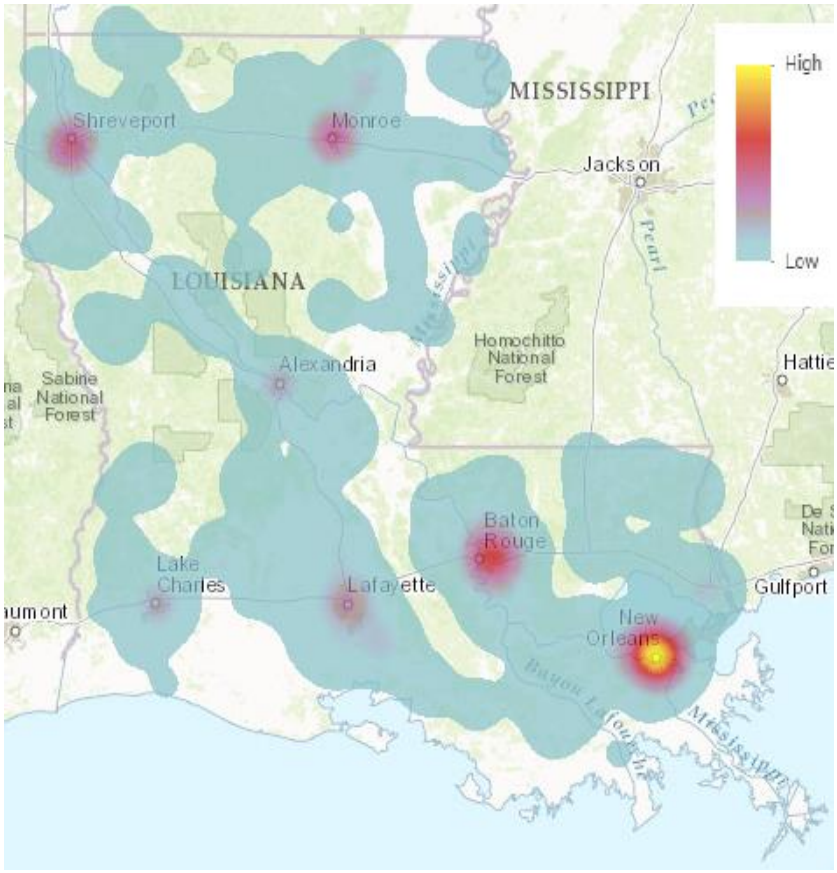

LOUISIANA BEHAVIORAL HEALTH PROVIDER SURVEY OF YOUTH RELATED SERVICES:

Results from the 2017 Self-Report Survey of Louisiana Medicaid and State Contracted Providers

Report by

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Funding provided by Louisiana Department of Health

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INTRODUCTION

Significant research advances have led to an improved understanding of effective treatments and interventions. This includes the development of demonstrated, effective interventions, commonly referred to as evidence-based practices (EBPs). In general, the term Evidence-Based Practices refers to clinical treatments, preventive programs, or service practices that have been carefully evaluated using rigorous research designs, and which have demonstrated effectiveness. The availability of EBPs represents a real opportunity for improving the behavioral health system's effectiveness, while simultaneously improving the lives of the youth and the communities in which they live.

In partnership with the Louisiana Department of Health- Office of Behavioral Health and the state's many service providers and stakeholders, the LSUHSC Institute for Public Health and Justice revised its behavioral health provider survey to focus on Medicaid and state contracted providers for children, adolescents, and their families. The goal of the survey was to provide an inventory of existing services and programs, the capacity of providers, and the perception of needs from the vantage point of practitioners. This information was used to identify gaps in services and provide critical understanding in order to develop a plan for the adoption and expansion of EBPs in our state. The information collected will help to guide future planning and decision making around evidence-based practices.

SURVEY METHODS

Behavioral healthcare provider practices were surveyed via a web-based instrument. The survey was delivered to targeted participants identified by OBH, Louisiana Medicaid Managed Care Organizations (MCOs), as well as DCFS and OJJ contracted providers. The instrument, the "Behavioral Health System Treatment Services Inventory", was developed by the Institute for Public Health and Justice at the Louisiana State University Health Sciences Center- School of Public Health. The survey is a web-based survey using REDCap. The survey is housed on LSUHSC servers in New Orleans, Louisiana.

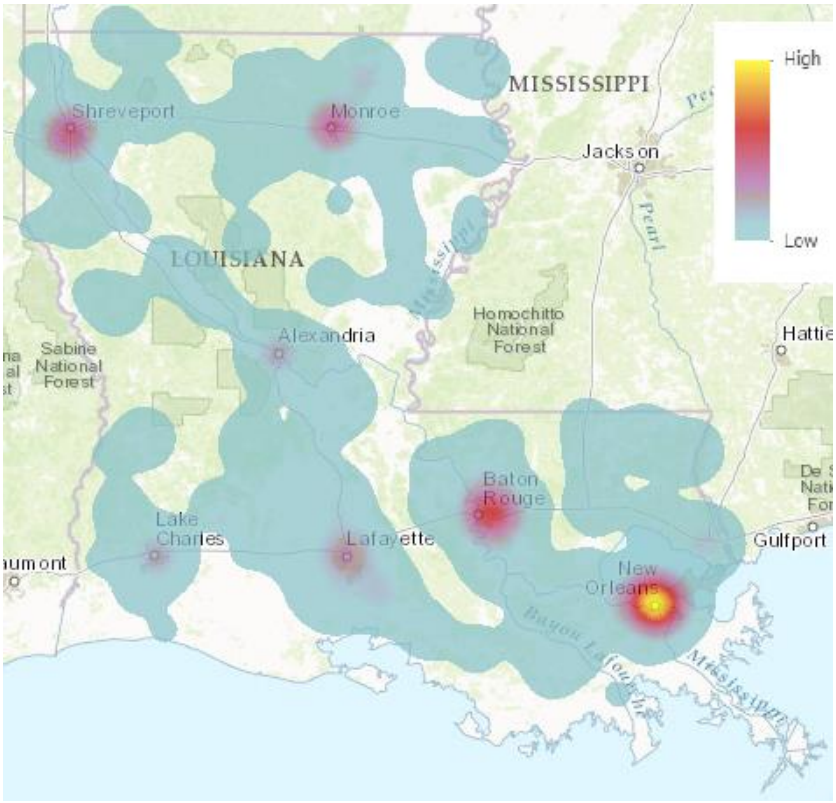
Activities for this regional administration of the survey began February 2017 and concluded in April 2017. Provider lists received from the Louisiana's five MCOs, OBH, and state contracted providers were merged to remove duplicate provider entries using unique NPI numbers. After cleaning, 890 unique providers with address, phone and/or fax numbers were identified. Faxes were sent to all providers to obtain email address for the survey. Those that did not respond to the fax received follow-up phone calls to request email addresses. Of the 890 unique providers…

- 518 provider email address were identified
- 118 providers provided information that they were not taking Medicaid, did not receive state contract money for services, and/or did not currently serve the child and adolescent population being targeted
- 27 providers refused to participate
- 69 providers had invalid phone or fax numbers (i.e., were not in service)
- 158 were unable to be reached using the above methods and multiple attempts

After combining lists, cleaning duplicate provider names, and removing providers that indicated they did not serve youth, **772 unique Medicaid providers were identified from the MCO lists**. These are providers believed to be serving Louisiana's youth. The heat map below (**see Graph A**)

shows the **highest concentration of those providers in New Orleans, Baton Rouge, and Shreveport**. There are also **rural areas of central and south Louisiana that have no reported service providers that reach an accessible fifty-mile radius**.

GRAPH A: Distribution of Medicaid Behavioral Health Service Providers Identified by Louisiana MCOs (n= 772)



In addition to the provider survey, the research team worked with de-identified Louisiana Medicaid claims data. Diagnosis categories for child and adolescent Medicaid claims were analyzed to provide an estimate of the prevalence of current behavioral health issues being seen by providers at the state, region, and parish level.

REPORT FORMAT

This report is organized to first describe Medicaid diagnosis prevalence followed by the findings of the provider survey. The provider survey findings are presented by identifying the question the providers were asked, followed by a graphical depiction of the findings and a written summary. This is done for each survey question and presented at the state level of findings in the body of this report. Regional findings are offered in the appendices.

STUDY FINDINGS

Medicaid Diagnosis Prevalence

Youth population and prevalence estimates of Medicaid served behavioral health disorders are described below in **Table 1**. Medicaid data were provided by the state for all diagnoses. Claims considered "paid" for all persons in the age range from 0 to18 were included. Denied claims and unpaid encounters were excluded. Disorders in the state data set represented primary diagnoses. Disorder counts for each parish were divided by the total number of children enrolled in Medicaid in order to determine prevalence percentages. Parish data have been combined into state Regions as follows:

Region 1: Jefferson, Orleans, Plaquemines, St. Bernard
Region 2: Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, West Feliciana
Region 3: Assumption, Lafourche, St. Charles, St. James, St. John, St. Mary, Terrebonne
Region 4: Acadia, Allen, Evangeline, Iberia, Jefferson Davis, Lafayette, St. Landry, St. Martin, Vermilion
Region 6: Avoyelles, Beauregard, Calcasieu, Cameron, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, Winn
Region 7: Bienville, Bossier, Caddo, Claiborne, De Soto, Natchitoches, Red River, Sabine, Webster
Region 8: Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, West Carroll\
Region 9: Livingston, Tangipahoa, St. Helena, St. Tammany

(Note: Region 5 was redistricted into 4 and 6 prior to this survey, thus there is not a Region 5.)

Table 1. Prevalence estimates for youth, served by Medicaid, with mental health diagnoses in 2016

Louisiana Region	Diagnostic Categories	Diagnosis Category Frequency	Child/Youth (Age 0-18) Population of Medicaid Enrollees*	Child/Youth (Age 0-18) Diagnosis Prevalence Estimate
Region 1	1 - Neurodevelopmental/ Developmental Disorders	20,734	136,323	15.21%
	2 - Schizophrenia/ Psychotic Disorders	573	136,323	0.42%
	3 - Bipolar Disorders	1,180	136,323	0.87%
	4- Depressive/Mood Disorders	5,297	136,323	3.89%
	5 - Anxiety Disorders	2,154	136,323	1.58%
	6 - Trauma/Stress-related Disorders	4,100	136,323	3.01%
	7 - Eating Disorders	80	136,323	0.06%
	8 - Disruptive/Impulse Control/ Conduct Disorders	4,336	136,323	3.18%
	9 - Substance-related/ Addictive Disorders	581	136,323	0.43%
Region 2	1 - Neurodevelopmental/ Developmental Disorders	19,148	95,278	20.10%
	2 - Schizophrenia/	472		0.50%

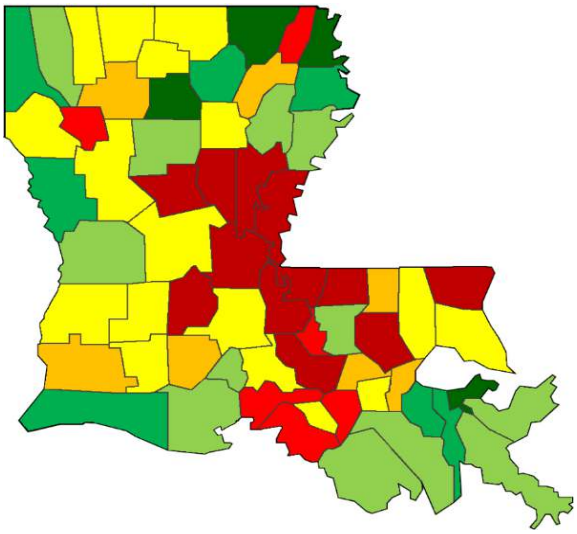
	Psychotic Disorders		95,278	
	3 - Bipolar Disorders	521	95,278	0.55%
	4 - Depressive/Mood Disorders	3,313	95,278	3.48%
	5 - Anxiety Disorders	1,444	95,278	1.52%
	6 - Trauma/Stress-related Disorders	2,728	95,278	2.86%
	7 - Eating Disorders	47	95,278	0.05%
	8 - Disruptive/Impulse Control/ Conduct Disorders	3,505	95,278	3.68%
	9 - Substance-related/ Addictive Disorders	454	95,278	0.48%
Region 3	1 - Neurodevelopmental/ Developmental Disorders	12,128	60,889	19.92%
	2 - Schizophrenia/ Psychotic Disorders	284	60,889	0.47%
	3 - Bipolar Disorders	592	60,889	0.97%
	4 - Depressive/Mood Disorders	3,100	60,889	5.09%
	5 - Anxiety Disorders	1,233	60,889	2.02%
	6 - Trauma/Stress-related Disorders	1,627	60,889	2.67%
	7 - Eating Disorders	34	60,889	0.06%
	8 - Disruptive/Impulse Control/ Conduct Disorders	1,897	60,889	3.12%
	9 - Substance-related/ Addictive Disorders	362	60,889	0.59%
Region 4	1 - Neurodevelopmental/ Developmental Disorders	22,532	109,180	20.64%
	2 - Schizophrenia/ Psychotic Disorders	493	109,180	0.45%
	3 - Bipolar Disorders	1,019	109,180	0.93%
	4 - Depressive/Mood Disorders	4,489	109,180	4.11%
	5 - Anxiety Disorders	2,206	109,180	2.02%
	6 - Trauma/Stress-related Disorders	2,430	109,180	2.23%
	7 - Eating Disorders	56	109,180	0.05%
	8 - Disruptive/Impulse Control/ Conduct Disorders	4,223	109,180	3.87%
	9 - Substance-related/ Addictive Disorders	582	109,180	0.53%
Region 6	1 - Neurodevelopmental/ Developmental Disorders	19,794	89,032	22.23%
	2 - Schizophrenia/ Psychotic Disorders	443	89,032	0.50%
	3 - Bipolar Disorders	960	89,032	1.08%
	4 - Depressive/Mood Disorders	3,692	89,032	4.15%
	5 - Anxiety Disorders	1,706	89,032	1.92%
	6 - Trauma/Stress-related Disorders	2,398	89,032	2.69%
	7 - Eating Disorders	62	89,032	0.07%
	8 - Disruptive/Impulse Control/ Conduct Disorders	3,650	89,032	4.10%
	9 - Substance-related/ Addictive Disorders	599	89,032	0.67%
Region 7	1 - Neurodevelopmental/ Developmental Disorders	15,487	86,418	17.92%
	2 - Schizophrenia/ Psychotic Disorders	480	86,418	0.56%

	3 - Bipolar Disorders	1,560	86,418	1.81%
	4 - Depressive/Mood Disorders	3,971	86,418	4.60%
	5 - Anxiety Disorders	956	86,418	1.92%
	6 - Trauma/Stress-related Disorders	2,886	86,418	3.34%
	7 - Eating Disorders	25	86,418	0.03%
	8 - Disruptive/Impulse Control/ Conduct Disorders	4,093	86,418	4.74%
	9 - Substance-related/ Addictive Disorders	291	86,418	0.34%
Region 8	1 - Neurodevelopmental/ Developmental Disorders	11,159	64,736	17.24%
	2 - Schizophrenia/ Psychotic Disorders	339	64,736	0.52%
	3 - Bipolar Disorders	495	64,736	0.76%
	4 - Depressive/Mood Disorders	2,598	64,736	4.01%
	5 - Anxiety Disorders	874	64,736	1.35%
	6 - Trauma/Stress-related Disorders	2,409	64,736	3.72%
	7 - Eating Disorders	38	64,736	0.06%
	8 - Disruptive/Impulse Control/ Conduct Disorders	3,864	64,736	5.97%
	9 - Substance-related/ Addictive Disorders	345	64,736	0.53%
Region 9	1 - Neurodevelopmental/ Developmental Disorders	18,062	81,052	22.24%
	2 - Schizophrenia/ Psychotic Disorders	384	81,052	0.47%
	3 - Bipolar Disorders	835	81,052	1.03%
	4 - Depressive/Mood Disorders	3,257	81,052	4.02%
	5 - Anxiety Disorders	1,888	81,052	2.33%
	6 - Trauma/Stress-related Disorders	3,067	81,052	3.78%
	7 - Eating Disorders	54	81,052	0.07%
	8 - Disruptive/Impulse Control/ Conduct Disorders	2724	81,052	3.36%
	9 - Substance-related/ Addictive Disorders	300	81,052	0.37%

*Annual Estimates of the Population for Parishes of Louisiana: Estimates Source: http://ldh.louisiana.gov/ Medicaid enrollment of children in December 2016

Each of the diagnostic categories were examined to yield a state median. The median was used to provide a visual of parishes falling above and below that point. Each of the maps below illustrate how parishes compare on specific diagnostic categories.

Neurodevelopmental/Developmental Disorders

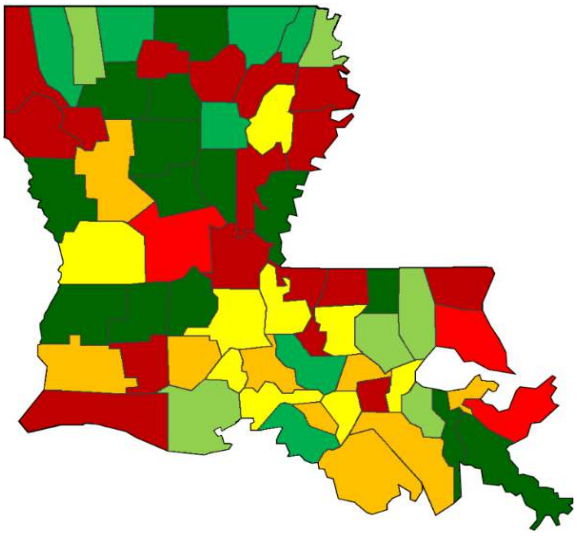


KEY:

- **X** ≤ 75%
- 75% < **X** ≤ 85%
- 85% < **X** ≤ 95%
- 95% < **X** ≤ 105%
- 105% < **X** ≤ 115%
- 115% < **X** ≤ 125%
- **X** > 125%

The Louisiana state median for diagnoses that were categorized as Neurodevelopment and/or Developmental Disorders is 20.02% for children in the state enrolled in Medicaid. The interquartile range (25^{th} – 75^{th} percentile) is 17.95% – 23.44%. These disorders are relatively evenly distributed throughout the state, as evidenced by the high prevalence of yellow, light green, and light orange in this map. Areas of higher concentration include the East-central Louisiana and parishes surrounding, but not including, Baton Rouge.

Schizophrenia/Psychotic Disorders

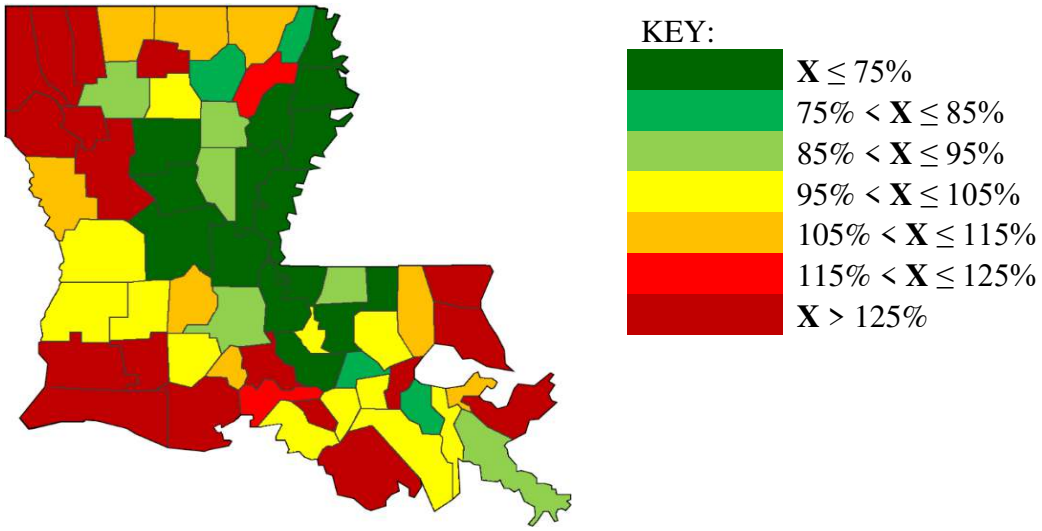


KEY:

- **X** ≤ 75%
- 75% < **X** ≤ 85%
- 85% < **X** ≤ 95%
- 95% < **X** ≤ 105%
- 105% < **X** ≤ 115%
- 115% < **X** ≤ 125%
- **X** > 125%

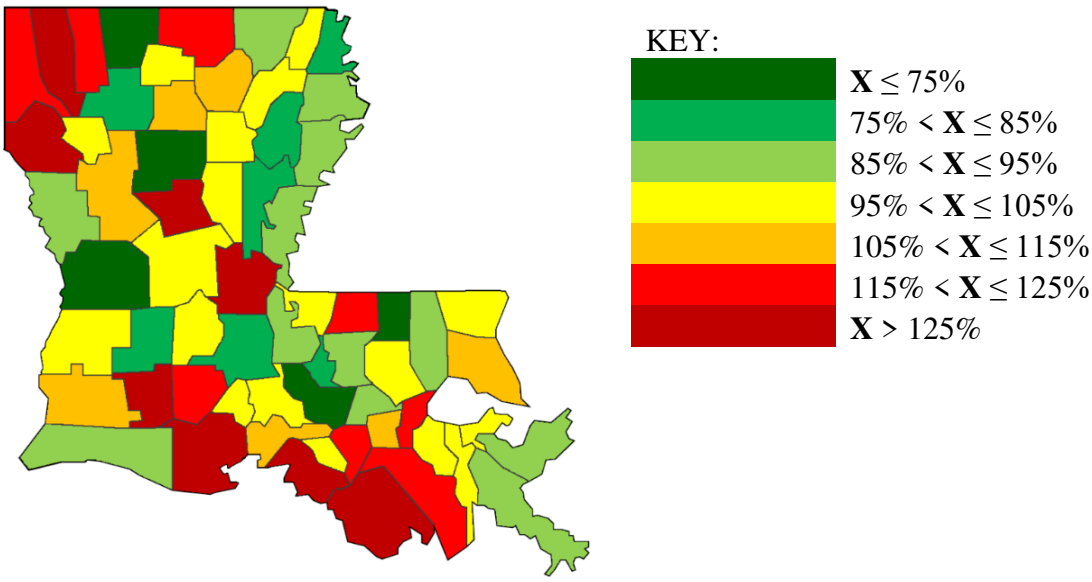
The Louisiana state median for diagnoses that were categorized as Schizophrenia and/or Psychotic Disorders is 0.46% for children in the state enrolled in Medicaid. The interquartile range (25^{th} – 75^{th} percentile) is 0.36% - 0.59%. Overall, there is a low prevalence of these disorders being claimed on Medicaid data; however, there is minimal regional clustering of these data. Higher rates are seen in Caddo, De Soto, Red River, Lincoln, Ouachita, Richland, Madison, Tensas, Catahoula, Avoyelles, Jefferson Davis, Cameron, West Feliciana, East Feliciana, West Baton Rouge Washington, and St. James parishes.

Bipolar Disorders



The Louisiana state median for diagnoses that were categorized as Bipolar Disorders is 0.81% for children in the state enrolled in Medicaid. The interquartile range (25^{th} – 75^{th} percentile) is 0.64% - 1.02%. In general, the prevalence of Bipolar Disorder diagnoses is lowest in areas with the highest rates of state Medicaid enrollment. The North-West, South-West, and far East corners of the state show the highest prevalence of children diagnosed with Bipolar Disorder and receiving Medicaid services.

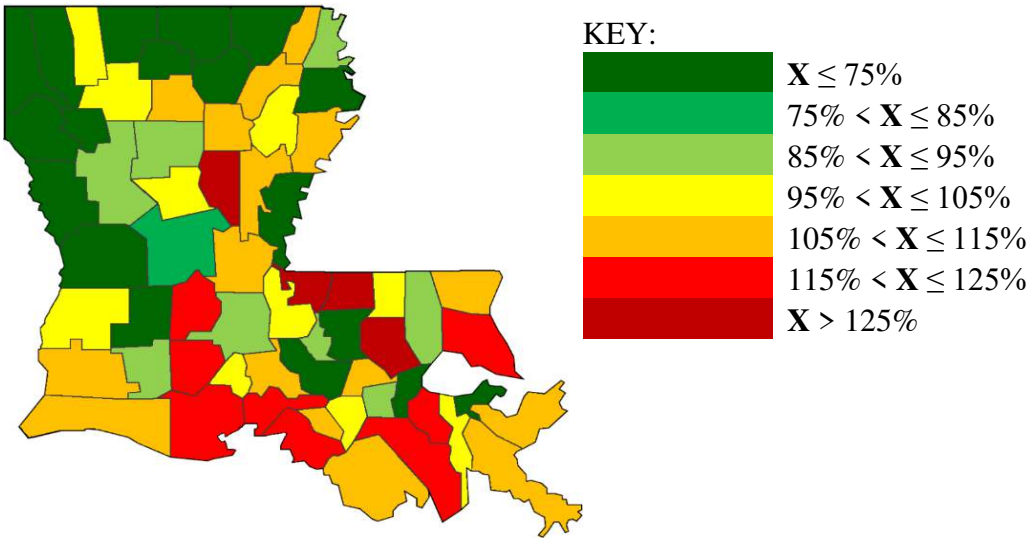
Depressive/Mood Disorders



The Louisiana state median for diagnoses categorized as Depressive and/or Mood Disorders is 3.98% for children in the state enrolled in Medicaid. The interquartile range (25^{th} – 75^{th} percentile) is 3.49% - 4.55%. The prevalence of these disorders is largely distributed at approximately at the

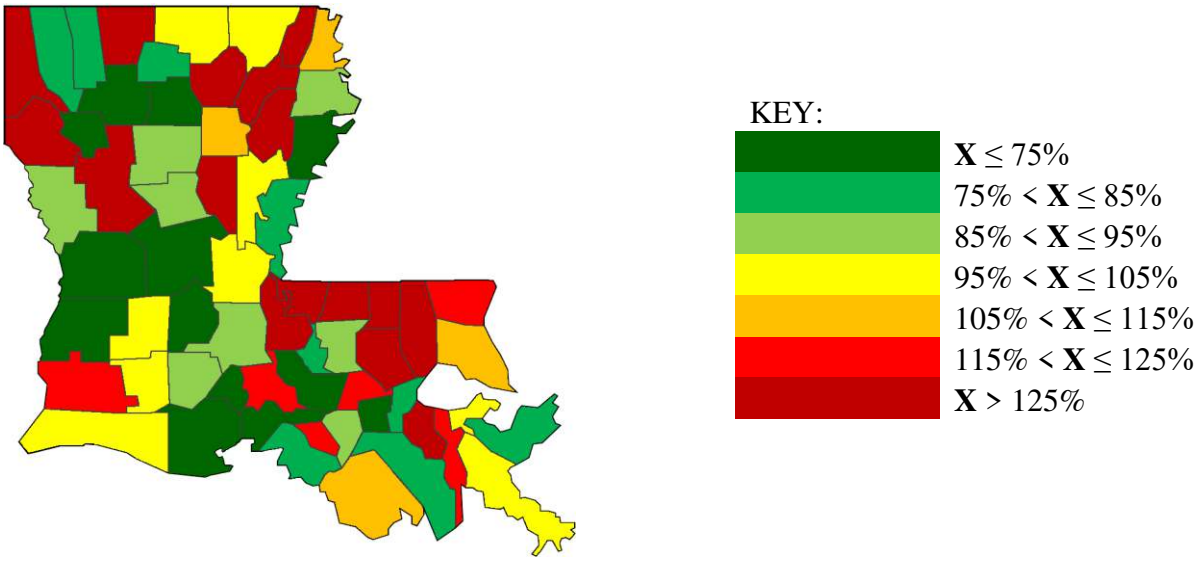
state median. The higher prevalence of Depressive and Mood Disorders is in Bossier, De Soto, Grant, Avoyelles, Jefferson Davis, Vermilion, St. Mary, and Terrebonne parishes.

Anxiety Disorders



The Louisiana state median for diagnoses categorized as Anxiety Disorders is 1.92% for children in the state enrolled in Medicaid. The interquartile range (25th – 75th percentile) is 1.38% - 2.16%. The prevalence ranges from lowest in the North-Northwest corner of the state to higher in the Southcentral-Southeast section of the state. A significant number of parishes are approximately equal to the state median, and more parishes are significantly lower than the overall state median than are higher (more parishes colored dark green than are colored dark red).

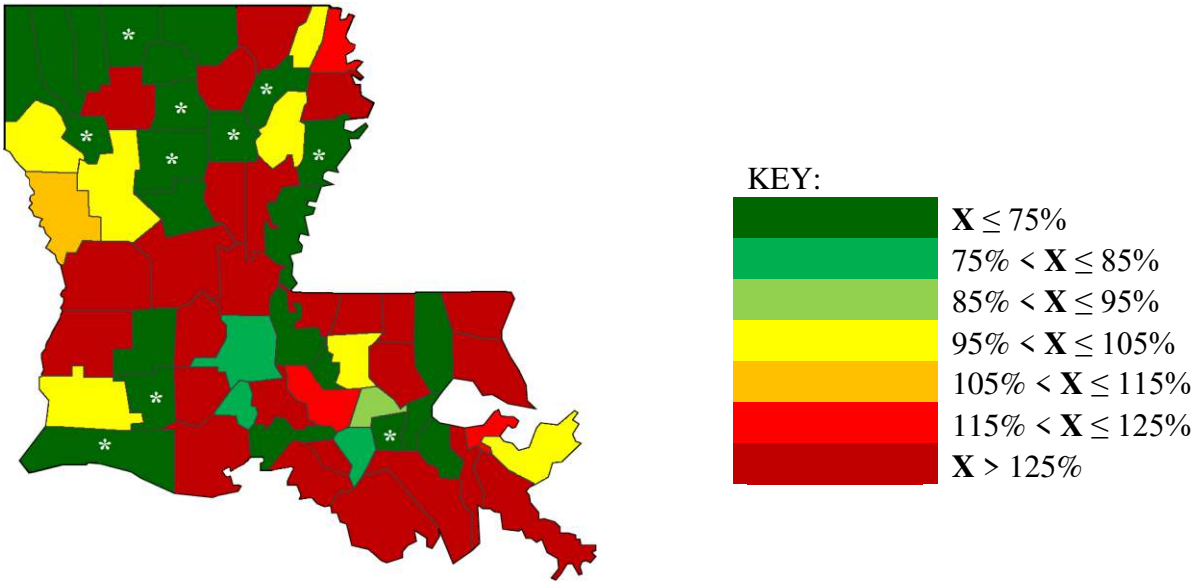
Trauma/Stress-related Disorders



The Louisiana state median for diagnoses categorized as Trauma and/or Stress-related Disorders is 2.82% for children in the state enrolled in Medicaid. The interquartile Range (25th – 75th percentile) is 2.21% - 3.54%. The prevalence is lowest in some of the most rural parts of the state

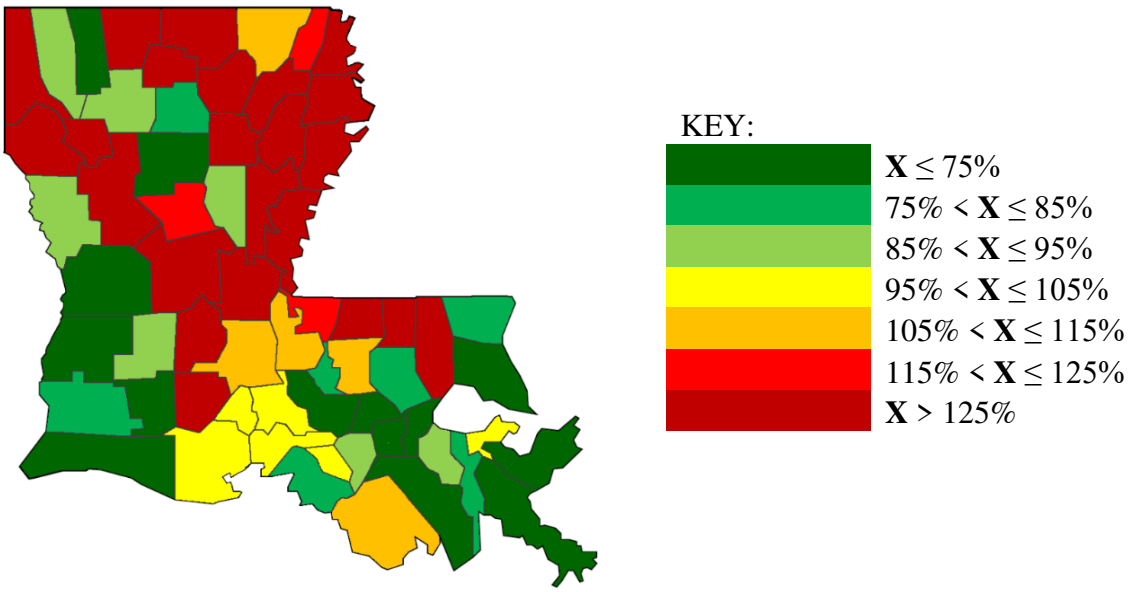
with higher prevalence in Caddo, De Soto, Claiborne, Ouachita, Richland, West Carroll, Franklin, La Salle, Pointe Coupee, West Feliciana, East Feliciana, St. Helena, Livingston, Tangipahoa, and St. Charles.

Eating Disorders



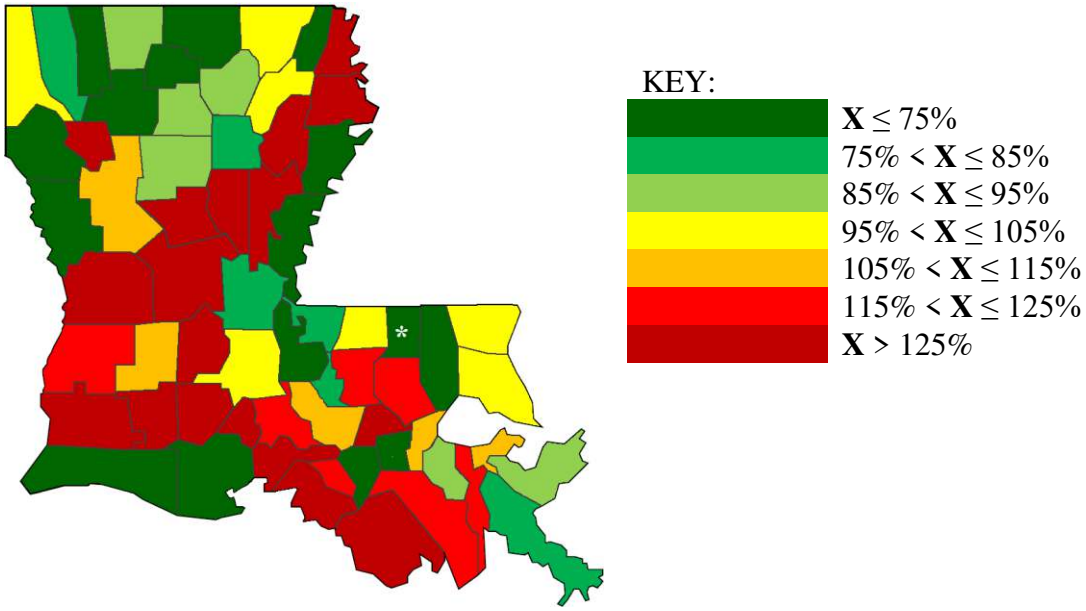
The Louisiana state median for Eating Disorders is 0.05% for children in the state enrolled in Medicaid. The interquartile range (25^{th} – 75^{th} percentile) is 0.03% - 0.07%. Thus, the prevalence is low throughout the state with some parishes reporting no youth with an Eating Disorder diagnosis being served by Medicaid. A white asterisk marks the ten parishes reporting a prevalence of zero.

Disruptive/Impulse Control/ Conduct Disorders



The Louisiana state median for diagnoses categorized as Disruptive, Impulse Control, and/or Conduct Disorders is 3.66% for children in the state enrolled in Medicaid. The interquartile range (25^{th} – 75^{th} percentile) is 2.99% - 5.15%. The prevalence is higher in areas with higher Medicaid enrollment. The central and eastern portions of the state show the highest prevalence.

Substance Use Disorders



The Louisiana state median for diagnoses categorized as Substance-related and/or Addictive Disorders is 0.38% for children in the state enrolled in Medicaid. The interquartile range (25^{th} – 75^{th} percentile) is 0.30% - 0.59%. One parish reported a prevalence of 0 (see asterisk), and the prevalence of youth being diagnosed with a substance use disorder throughout the state was low.

Provider Survey Findings

The survey was distributed to a range of stakeholders, identified as serving in some capacity a function of the wide range of services offered as part of the continuum of behavioral health services in Louisiana. With a **28.7% response rate** from those providers eligible (n=772) for the 2017 email survey, **222 Louisiana providers submitted information on 146 programs and services spanning each of Louisiana's 64 parishes**. Summaries of those providers' responses are included in this report.

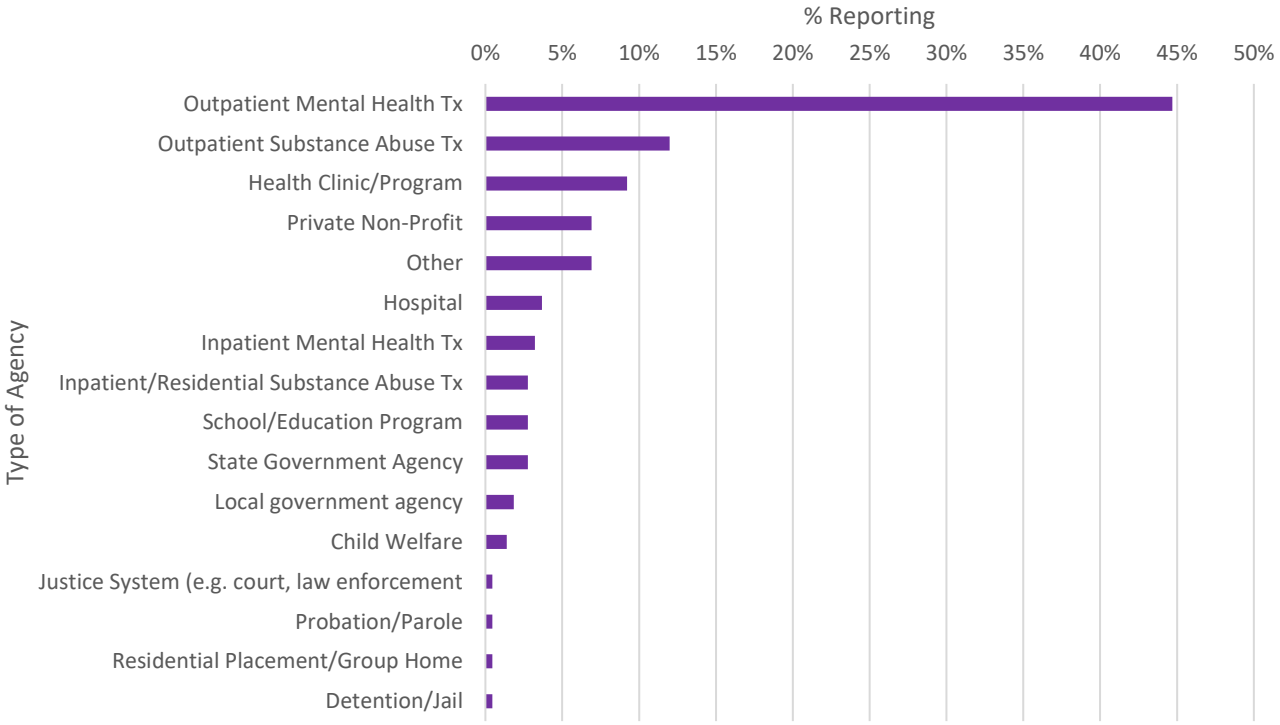
Note- Professional services and agency functions vary widely in the behavioral health system, so the survey was designed so not all respondents were required to answer every question in each section of the survey. Therefore, the following data are summarized at the individual survey item level. Response rates and percentages are based upon the number of providers answering a question applicable to their particular area of service.

Programs and Services

Types of Organizations

Providers were asked, "Which of the following best describes your agency, organization or group that implements behavioral health program(s)? (select all that apply)" (n=222)

Chart 1: Agencies,organizations,and groups responing to the survey on behavioral health program(s) in Louisiana



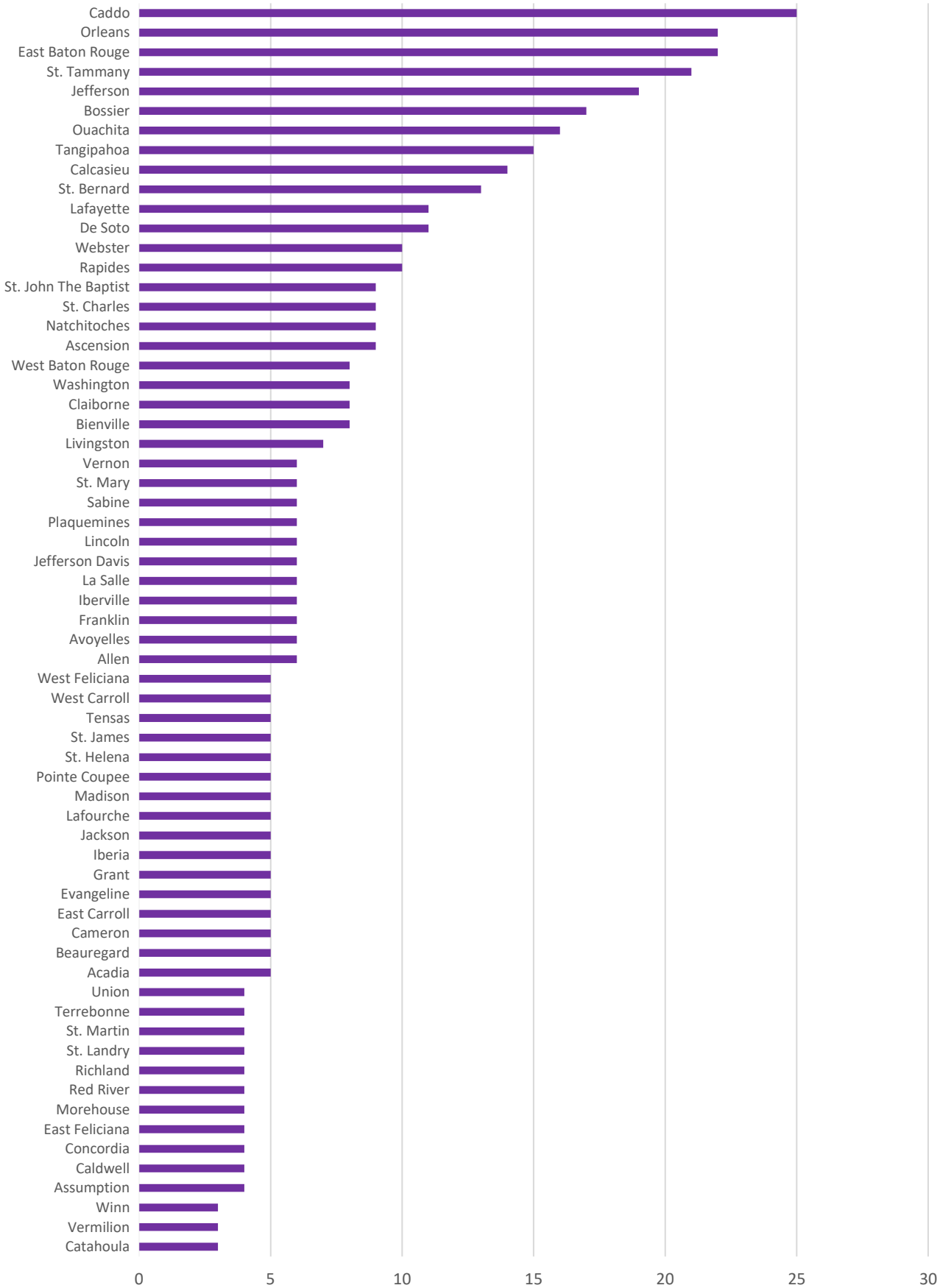
The **majority of programs described their agency** or organization that implements behavioral health services for Louisiana youth **as "outpatient mental health treatment," "outpatient substance abuse treatment," and/or a "health clinic/program**." (**See Chart 1**).

Parishes Served

Respondents were asked to self-report, "In which parish(es) is/are your programs offered? (select all that apply)" (n=222)

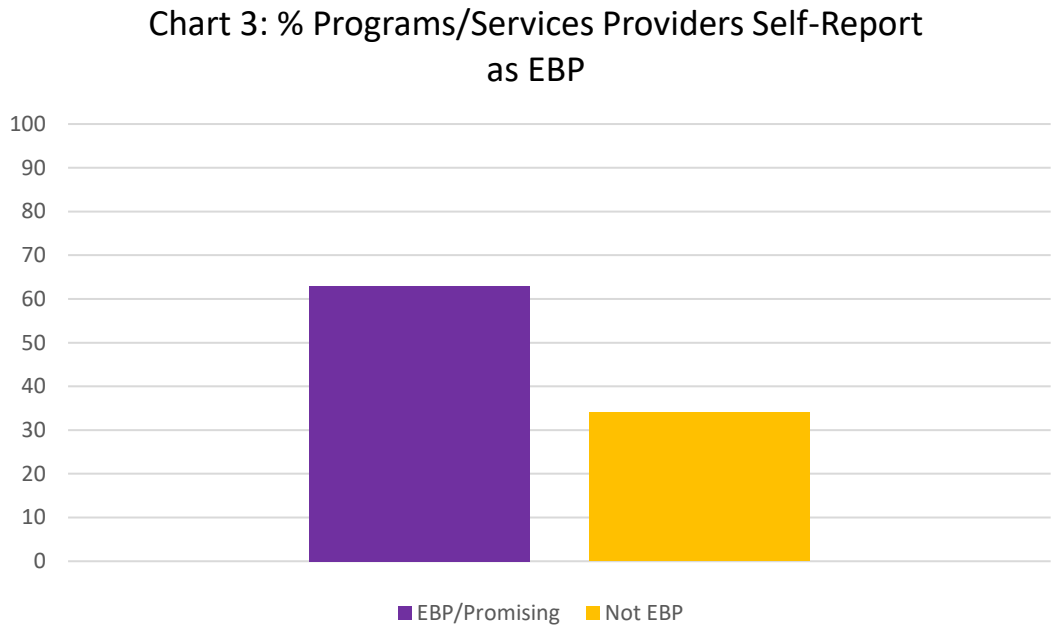
As illustrated in **Chart 2**, providers responding to this survey self-reported that their **services were most frequently offered in Caddo, Orleans, East Baton Rouge, St. Tammany, and Jefferson Parishes**. **Catahoula and Vermillion Parishes were reported least served** by the providers responding to this survey.

Chart 2: Survey Respondents Serve What Parish(es)



Evidence-based and Promising Practices

Survey participants were asked if their identified program(s) or service(s) was/were grounded in research. Specifically, given definitions supplied in the survey**, respondents were questioned, "Is the intervention/service model considered to be an evidence-based practice or a promising practice?" (n=146)



**An EBP is a program or practice that has had multiple site, randomized, controlled trials demonstrating that the program or practice is effective for specific populations. A promising practice is one that has some independent evaluation, and published research, demonstrating effectiveness, but does not meet the higher empirical standard of an EBP.

Based on this studies sample of 146 programs and services described by providers, **just under two-thirds (63%) were self-reported as either evidence-based or promising and that there exists external, nationally published research supporting usage**. **Chart 3** illustrates the division of those self-reporting their service as evidence-based or promising and just over one-third (34%) describing themselves as neither.

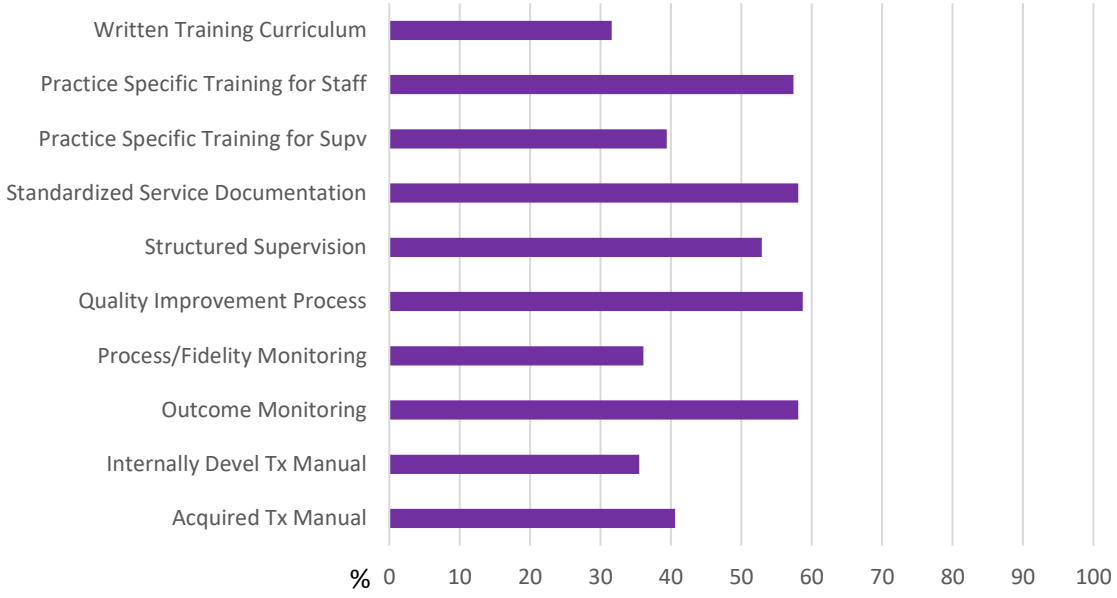
Qualities of Programs and Services

As a secondary measure, the survey asks a series of questions about certain components of programs and services common in evidence-based or promising behavioral health practices that have been disseminated nationally. This offers a confirmation of the likelihood of an accurate self-report of evidence-based or promising. Specifically, respondents were asked, "Does the intervention/service/practice being described include any of the following?" (select all that apply). The answer options were:

- Externally acquired treatment manual (i.e., replication of an existing model)
- Internally developed treatment manual
- Outcome monitoring
- Process monitoring method and/or fidelity tracking procedures

- Quality improvement process
- Routine structured supervision
- Standardized service delivery documentation procedures
- Specific training for practice supervisors
- Structured staff training on specific service/intervention methods
- Written/Standardized training curriculum

Chart 4: % Providers Self-Reporting Quality Components

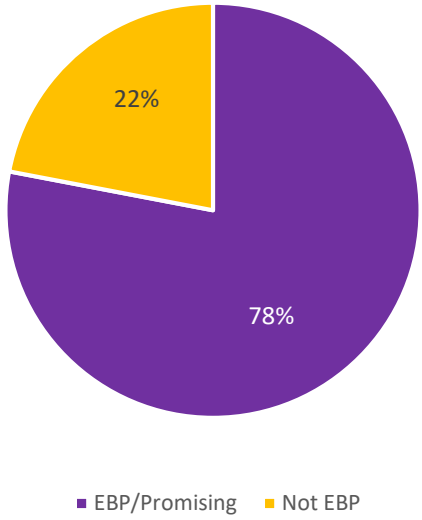


Just **under 60% of providers described practices utilizing key components such as practice specific training for staff; standardized documentation of services; structured supervision, and outcome monitoring**. These all give support for the 63% self-reporting to use and evidence-based or promising practice. However, **the proportion of providers reporting using an externally acquired treatment manual; a standardized training curriculum; or, fidelity monitoring processes suggests that the number self-reporting to be an evidence-based or promising practice may be inflated**. (See **Chart 4.**)

Clinicians Trained and Delivering Services

Survey respondents were asked to report the number of staff delivering the services they were describing. Specifically, the survey asked, "What are the number of staff trained to deliver the interventions/services?" (n=122)

Chart 5: % of Clinical Staff Using EBPs or Promising Practices



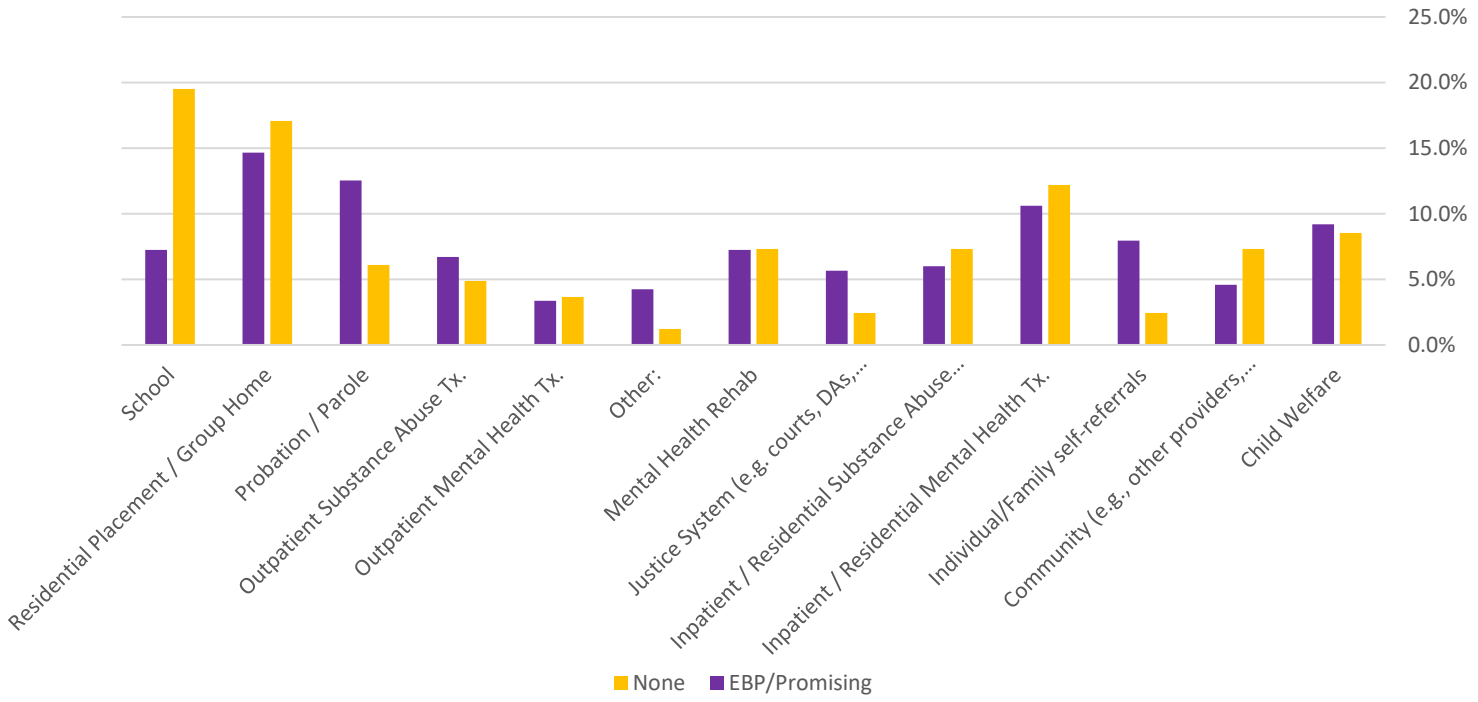
Of the 1326 staff who were described as trained to provide the 146 services reported, **78% staff were described to be delivering an evidence-based, research-driven or promising practice**. See **Chart 5,** illustrating that **just over 1 in 5 staff may be delivering a service other than an EBP or promising practice**. Organizations ranged in size from one to one-hundred providers delivering these self-reported services. The average team size was 11 providers (median 5). Required education and/or training credentials of the providers delivering services was reported as follows (providers could select all that applied):

Bachelor's Degree: 39%
Master's Degree: 88%
PhD/MD/Other Doctoral Degree: 24%
Specialty License: 41%
Certificate: 9%
No Degree or Specialty Required: 7%

Referral Sources

The survey asked providers to describe, "From what source do these services/interventions get their referrals? (select all that apply)" (n=146). The highest proportion of referrals reported by providers were from schools, individuals/families, and inpatient/residential mental health treatment centers. When divided by whether the receiving service was an evidence-based/promising practice or not, **school referrals were the least likely to receive an evidence-based or promising practice. Families and justice system referrals were reported to have the greatest likelihood of being referred to an evidence-based or promising practice**. (See **Chart 6**.)

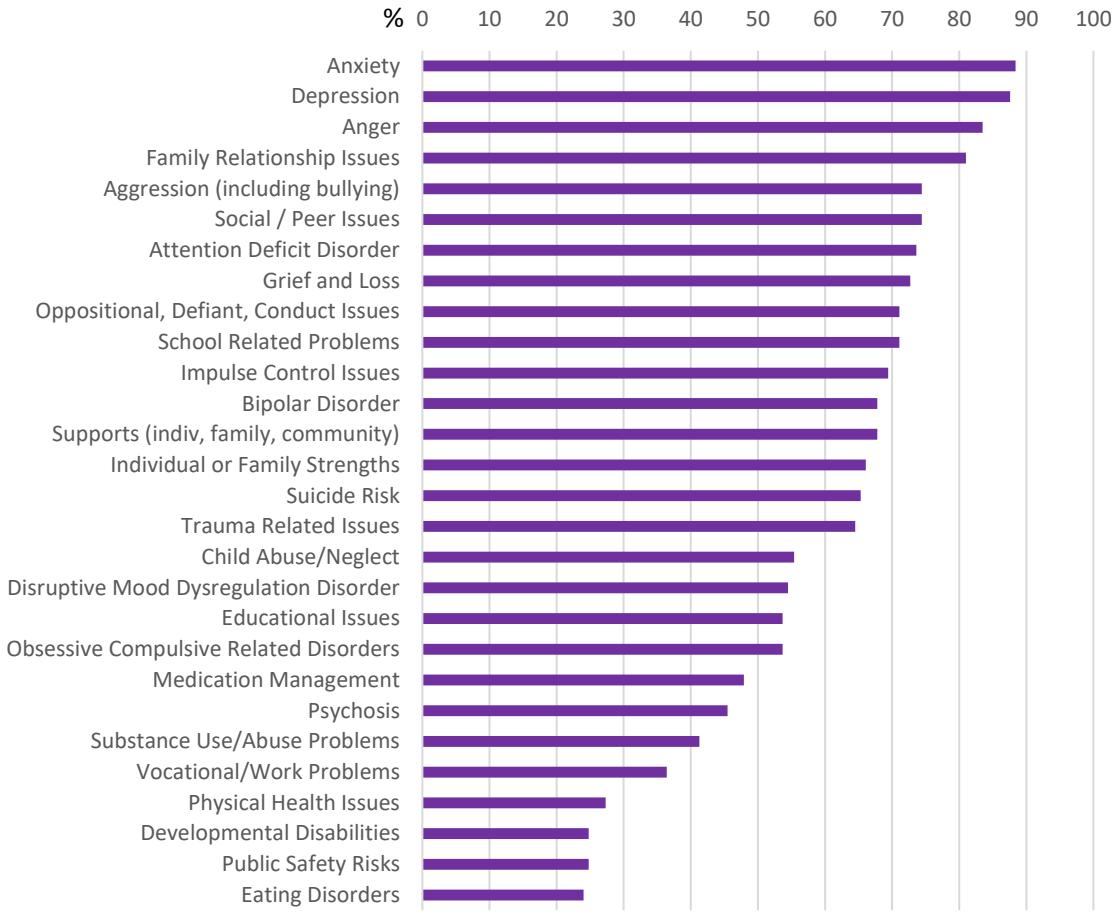
Chart 6: Sources of Referrals



Interventions Targets / Populations of Focus

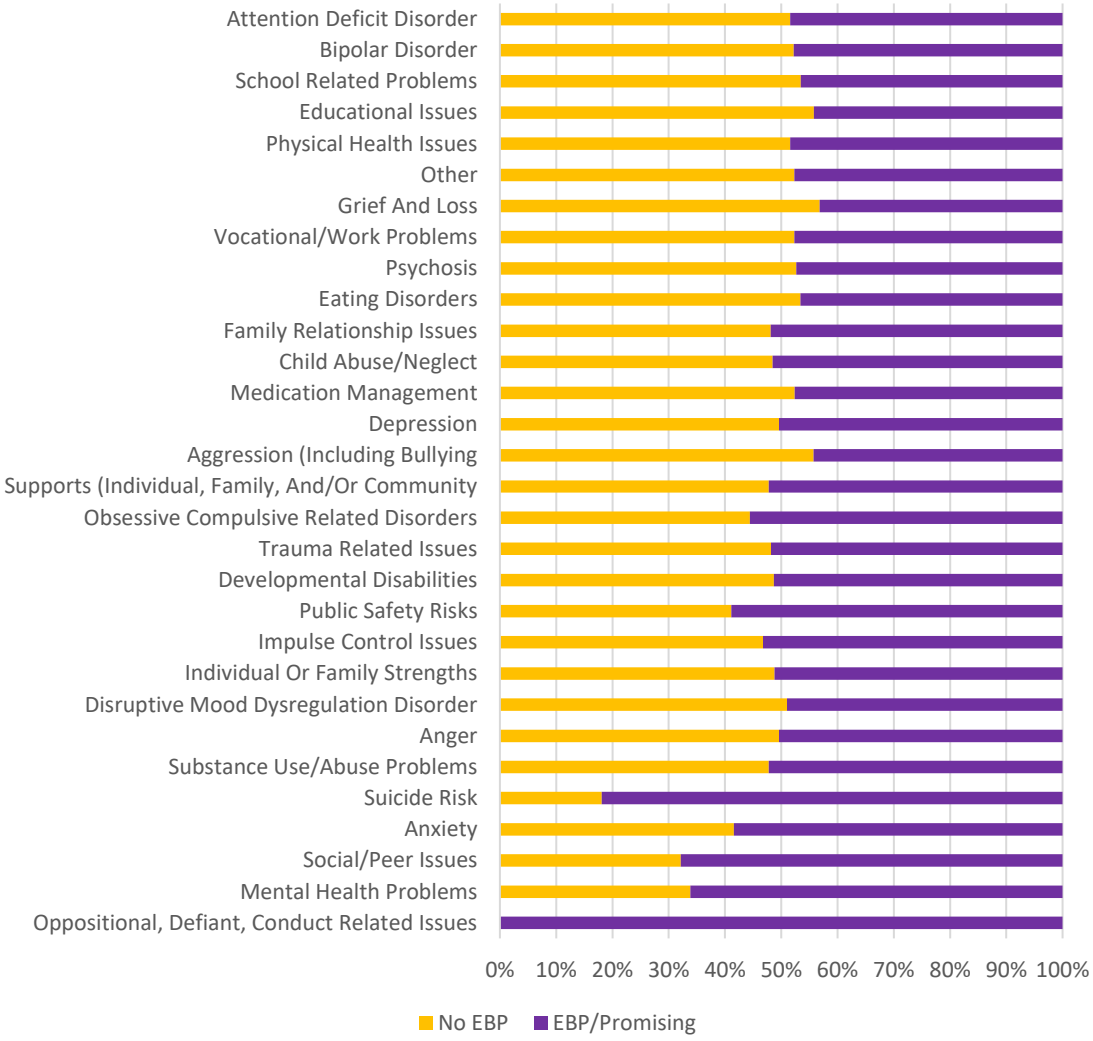
Providers were asked to describe the population their interventions serve. The first of several survey items was, "Describe what behavioral health related issues the service / intervention targets (check all that apply)." (n=146) As described in **Chart 7**, **anxiety, depression, anger, and family relationship issues were the most commonly targeted issues of providers' interventions**. Eating disorders, public safety risk, and developmental disabilities were the least targeted by the sample.

Chart 7: % of Providers Self-Reporting Targeting Behavioral Health Related Issues



Further analysis of those same data against providers self-reporting as an evidence-based or promising practice vs. those not describing themselves as evidence-based was completed. Chart 8 suggests that there was **about a 50% chance of most issues being targeted by interventions describing themselves as an evidence-based or promising practice**. The exceptions were conduct related issues, social/peer issues, and suicide risk, where programs were more frequently self-reported as an evidence-based or promising practice. (See **Chart 8**)

Chart 8: Liklihood of a Behavioral Health Issue Targeted by an Evidence-based or Promising Practice



Another survey question asked about the age of the population the programs/services were addressing. The survey asked providers to, "Describe the age range of those served (check all that apply)." (n=146) As described in **Chart 9**, **providers were most likely to serve youth, and young adults 11 to 24**. They were **least likely to report serving the 0 to 5 population**.

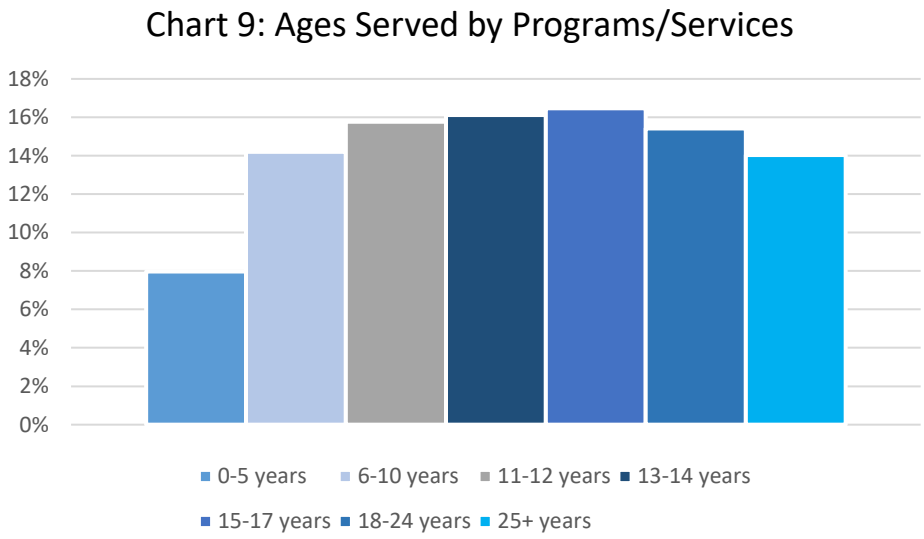
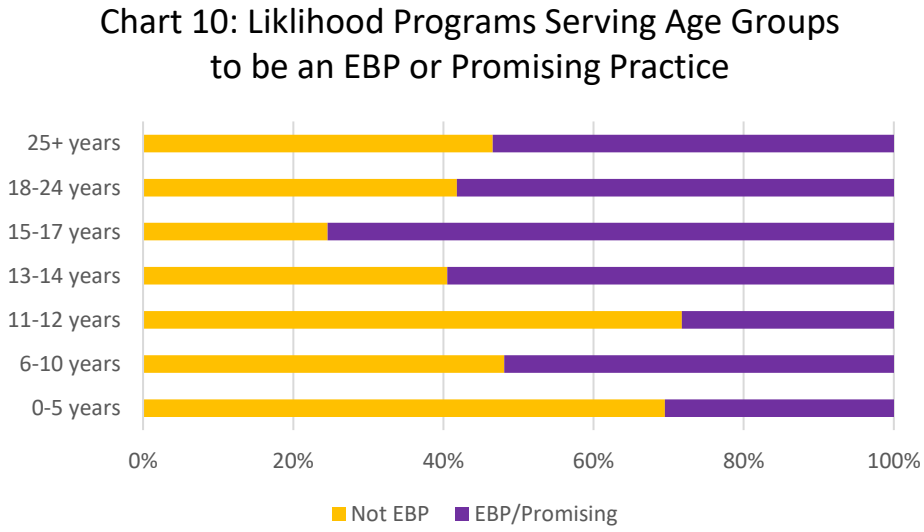
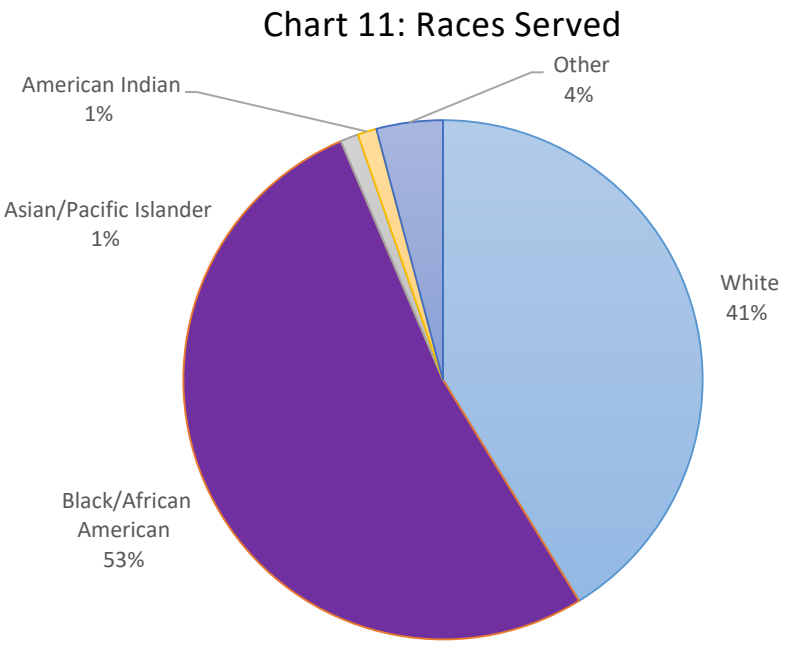


Chart 10 describes the **likelihood of the program or service being an evidence-based or promising practice is highest for youth ages 15 to 17** and **least likely for those 0 to 5**.

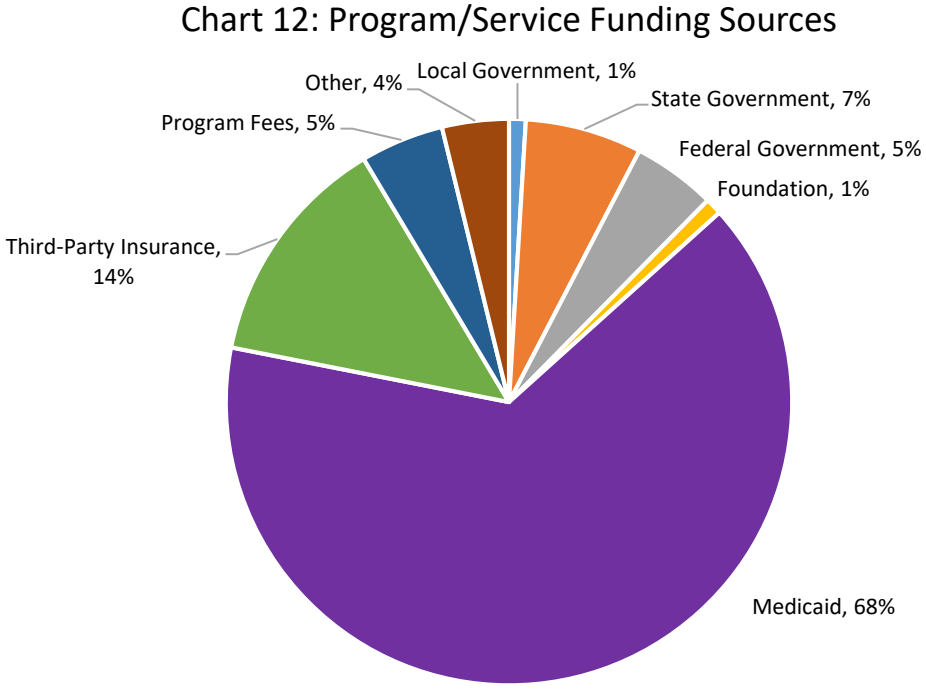


The Survey also asked about gender served by programs and services. That was about evenly split. Programs and **services self-reported serving about 54% female and 46% male populations**. Races served were **predominantly Black/African-American and White/Caucasian**. **Chart 11** below gives a breakdown of the races providers described being served by their programs and services. In terms of ethnicity, 7% of providers reported serving Hispanic clients.



Program Funding

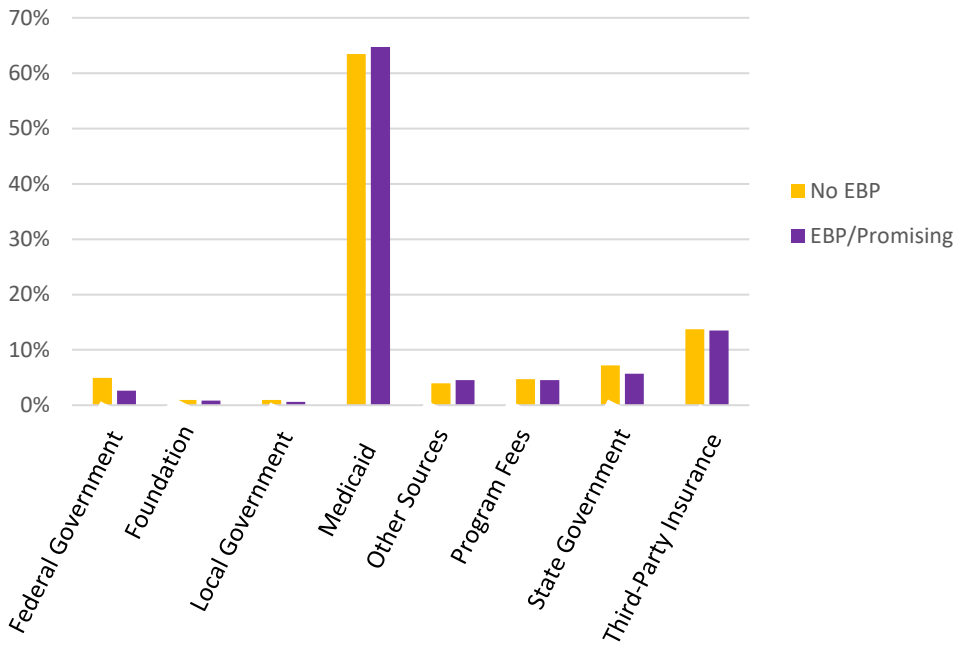
Survey respondents were asked to describe the funding sources for their programs and services. **Chart 12** shows **the majority of programs rely on Medicaid (68%) funding**. Other, lesser, funding sources included third-party insurance (14%) and state government contracts (7%).



The **estimated average annual agency budget** self-reported to provide the services and interventions described **was $377,559**.

The **likelihood of the service or intervention being and evidence-based or promising practices did not appear to be impacted by the funding source**. (See **Chart 13**.)

Chart 13: Liklihood of EBP/Promising Practice by Funding Sources



Qualitative Findings

Providers were asked to give their perceptions in three areas. These included behavioral health priorities, policy issues, and service gaps.

The first question was to rank order/prioritize needs they perceive in services given a list of ten behavioral health areas/issues. They could also write in "other" suggestions. With sixty-six providers responding to this survey question, **the following are the highest perceived needs in order from highest to lowest**.

1. **Psychiatric services** (including medication management)
2. **Trauma response and recovery**
3. **Services for youth with intellectual, developmental disabilities**
4. **Mental health wellness** programming
5. (tie) **Family Focused behavioral health services** & **Child abuse / neglect services**
6. **Crisis interventions** (including suicidal behaviors)

Respondents were then asked, "How could **state policies change to better enable your organization to serve Louisiana's children and adolescents**?" (n=65) These open-ended responses were coded and categorized. The **top three response** areas were as follows:

- 37% **Funding**
- 31% **Better coordination of services needed**
- 13% **Improve family involvement**

Finally, the survey asked providers, "If you could implement any behavioral health service to address what you perceive as the top need in your community, what would it be?" (n=66) These open-ended responses were coded and categorized. The **top three needs providers recommended to improve the behavioral health system in their community were**:

- 21% **Improve family (primarily parental) involvement**
- 14% **Increase community- and school-based services**
- 12% **Substance abuse prevention and treatment**

CONCLUSIONS

This survey of the child and adolescent behavioral health service providers of Louisiana was both successful and challenging. The largest challenges were acquiring and cleaning provider lists in order to establish an efficient way to contact providers (i.e., via email). Based on the final list of providers, it is apparent that several areas of Louisiana may be woefully underserved, particularly rural areas. There are areas of central and south Louisiana that appear to have no reported service providers within an accessible fifty-mile radius (see Graph A). For those areas with services, 29% of the identified child and adolescent providers successfully responded to the survey. Several lessons were learned, conclusions drawn, and recommendations made for future behavioral health practices. These are summarized below.

Available Medicaid mental health diagnosis data for youth served in Louisiana in 2016 was coupled with regional U.S. census data to provide a view of the mental health burden throughout the state. For instance, according to the DSM-5, the prevalence of Neurodevelopmental/ Developmental Disorders nationally, including ADHD, Autism Spectrum Disorder, and others, is between 1% and 15% (ADHD and Learning Disabilities being the most prevalent). Louisiana Medicaid diagnosis data reflects a higher prevalence for this category of diagnoses, ranging from 15.21 to 22.24% regionally (see Table 1). Similarly, Louisiana's prevalence rates for Disruptive/ Impulse Control/ Conduct Disorders are consistently higher (3.12% - 5.97%) as compared to U.S. population prevalence (1.2% - 4.0%). Other diagnosis categories had prevalence rates similar to U.S. population estimates, with the exception of Substance-related/Addictive Disorders.

Louisiana's rates (0.34% - 0.67%) were considerably lower than national population rates (3.6% - 4.6%). This may suggest a lack of behavioral health preventive response to Substance Use Disorders in youth given that the rates of substance use reported by schools and the juvenile justice system are considerably higher. According to the Louisiana Communities that Care Survey, by 12th grade, 1% to 15% of students are reporting illicit drug use (most commonly marijuana, sedatives, and narcotics) within the last 30-days. Furthermore, the Louisiana's Office of Juvenile Justice consistently reports a significant risk of substance abuse for almost 50% of their youth receiving services (identified objectively by the SAVRY).

Providers responding to this survey were primarily from outpatient mental health and outpatient substance abuse treatment centers throughout Louisiana (see Charts 1 & 2). Almost two-thirds of providers self-reported using an evidence-based or promising practice with external, nationally published research supporting utilization (see Chart 3). However, this is likely to be an inflated self-assessment as many of the programs (ranging from 41% to 68% depending on item) failed to describe using key components of research driven practices (see Chart 4). This may suggest quality improvement areas for Louisiana's behavioral health service providers. Areas of improvement that could be targeted include training, supervision, documentation, fidelity monitoring, outcome monitoring, and using or developing treatment manuals.

Looking at the workforce delivering services, almost a quarter could be targeted to change their service provisions to those that are more research driven (see Chart 5). Given that the vast majority of the staff are reported to possess Master's degrees, and most frequently report working in teams of five providers, several child and adolescent EBPs could be implemented. These EBPs could target the areas with the least likelihood of a referral receiving an EBP, such as school referrals (see Chart 6). Also, given the high prevalence of substance abuse reported among Louisiana youth, the low clinical identification of related diagnoses, and the small number of providers indicating they are providing substance abuse treatment, this could be an area for workforce capacity development. Finally, providers were also least likely to report serving youth ages 0 to 5 with quality behavioral health services (see Charts 9 & 10), thus developing the workforce to address parents' needs, and these young children's needs, could address a gap in Louisiana services.

Given both the quantitative and qualitative responses to the survey, providers appear to be heavily reliant on Medicaid funding (see Chart 12 and Appendices I-VIII). Some regions are reporting relying on Medicaid for as much as 87% of their behavioral health service funding. These programs were equally as likely to self-reported as an evidence-based or promising practice as they were to be neither (see Chart 13). This offers a targeted group of providers that may have the capacity to further develop EBPs as well as a group that may benefit from assistance developing the business practices necessary to sustain EBPs under Medicaid funding. Several key informant discussions with providers also suggests that further development is needed to merge EBP and Medicaid business models. Many EBPs are short-term, intense interventions, while traditional Medicaid approaches rely on frequent, long-term contact with the populations served. Finding ways to incentivize the use of EBPs without needing to transition to longer term Medicaid supported care may be key to improving the likelihood of positive outcomes for many populations while also lowering overall system cost.

Appendix – I
Region One Specific Findings

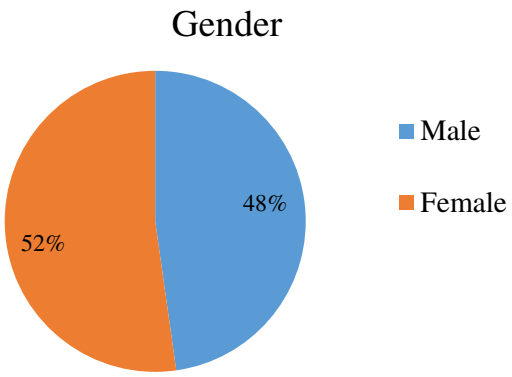
In partnership with the Louisiana Department of Health- Office of Behavioral Health, the LSUHSC Institute for Public Health and Justice administered a survey to Medicaid and state contracted providers for children, adolescents, and their families. The goal of the survey was to provide an inventory of existing services and programs, the capacity of providers, and the perception of needs from the vantage point of practitioners. This appendix details several Region 1 specific findings from the larger statewide study. These are self-report findings from the region sample.

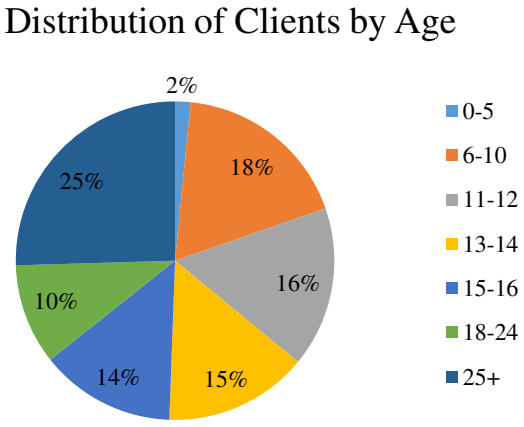
Parishes Included (n=70 services/interventions—note: providers could serve more than one parish):

- Jefferson
- Orleans
- Plaquemines
- St. Bernard

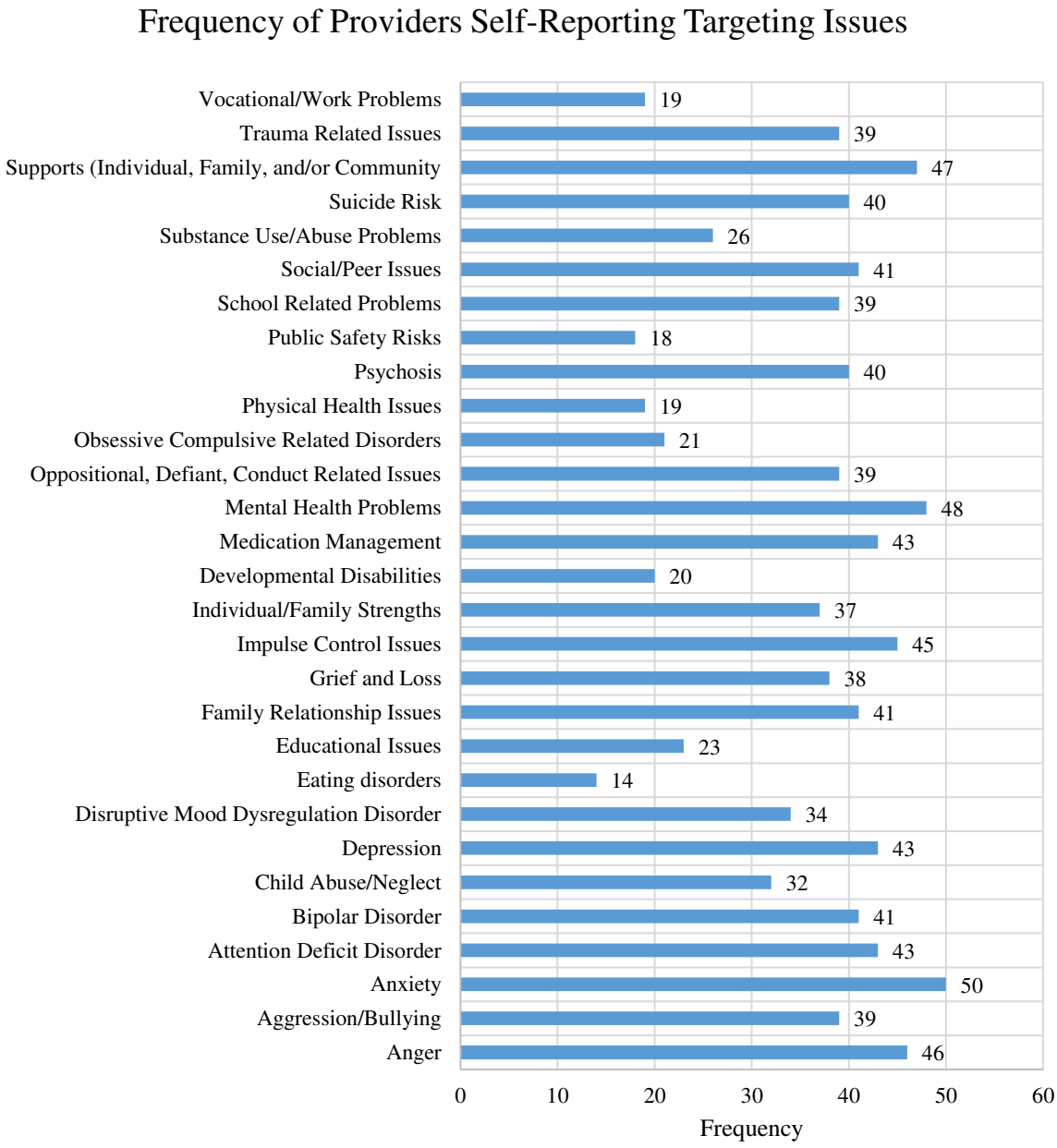
Demographics for Child/Youth Population Served

Racial/Ethnic Distributions	(%)
Hispanic	5.5
Non-Hispanic	94.5
White	27.5
Black/African-American	63.7
Asian/Pacific Islander	2.2
American Indian	1.8
Other	4.8





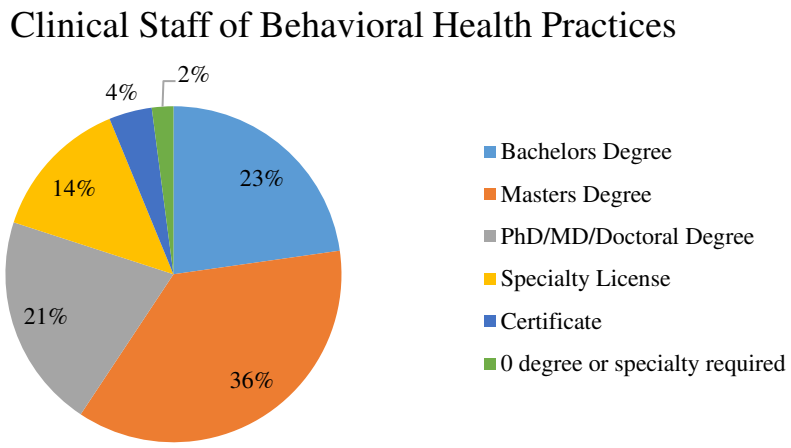
Programs and Services



Languages in which Services are offered other than English:

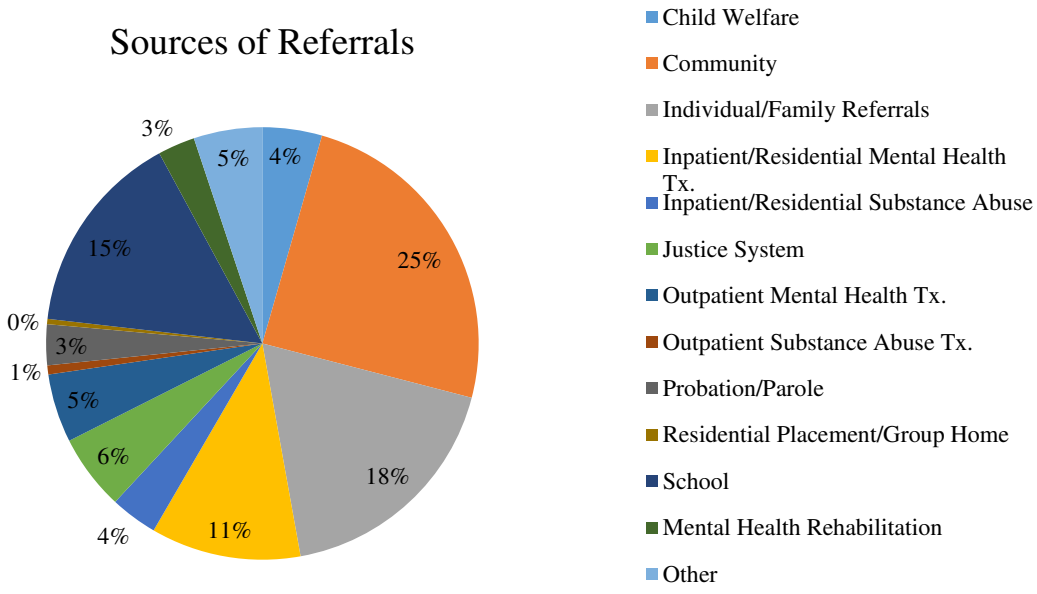
- American Sign Language
- Spanish

Credentials of staff providing services:

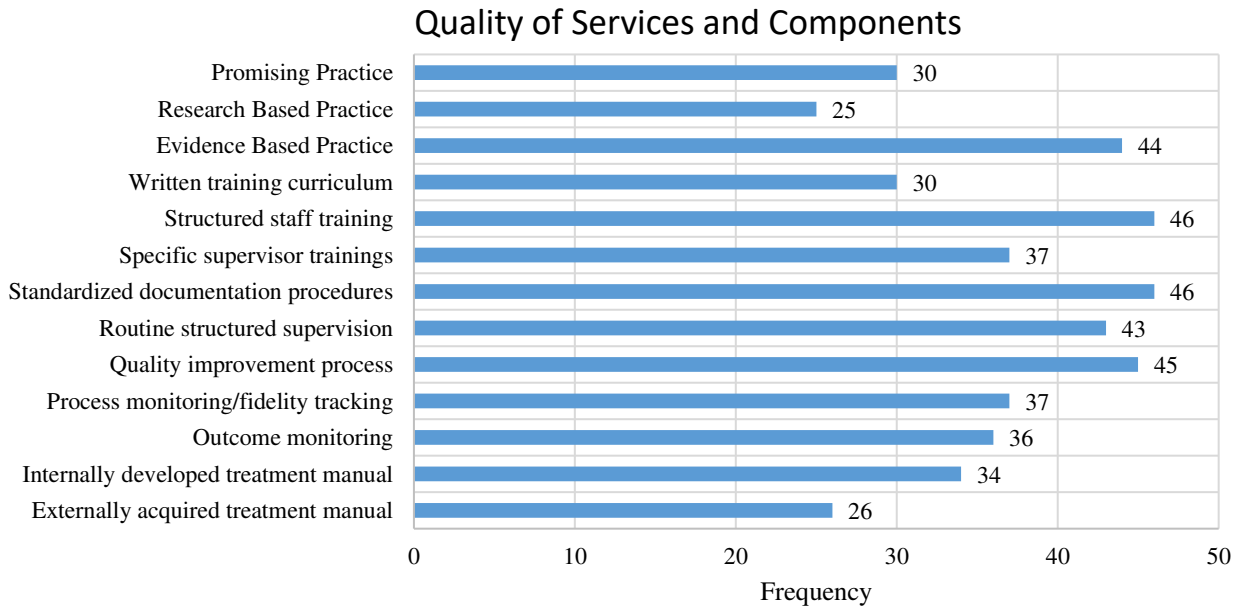


The respondents to the survey described a total of 856 trained staff/practitioners.

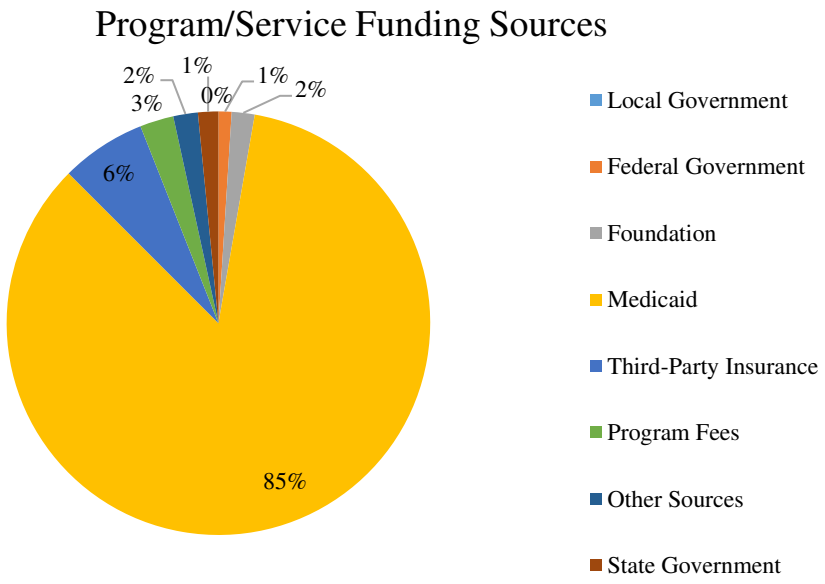
Referral Sources



Self-Report of Evidence-based, Promising Practices and Quality Components



Funding



Appendix – II
Region Two Specific Findings

In partnership with the Louisiana Department of Health- Office of Behavioral Health, the LSUHSC Institute for Public Health and Justice administered a survey to Medicaid and state contracted providers for children, adolescents, and their families. The goal of the survey was to provide an inventory of existing services and programs, the capacity of providers, and the perception of needs from the vantage point of practitioners. This appendix details several Region 2 specific findings from the larger statewide study. These are self-report findings from the region sample.

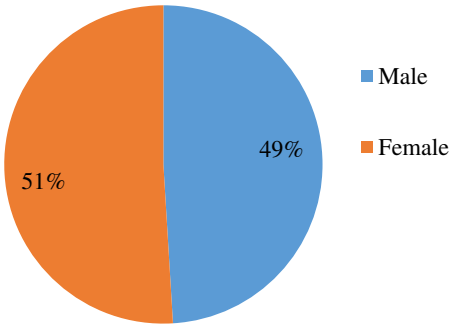
Parishes Included (n=83 services/interventions—note: providers could serve more than one parish):

- Ascension
- East Baton Rouge
- East Feliciana
- Iberville
- Pointe Coupee
- West Baton Rouge
- West Feliciana

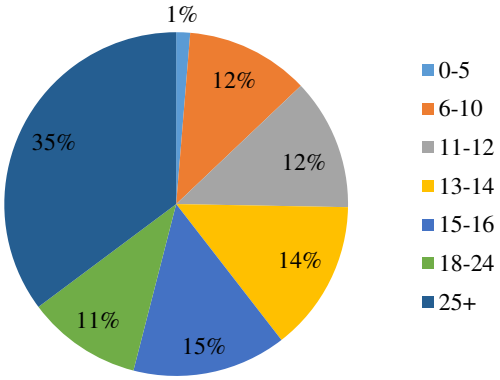
Demographics for Child/Youth Population Served

Racial/Ethnic Distributions	(%)
Hispanic	7.5
Non-Hispanic	92.5
White	30.8
Black/African-American	54.3
Asian/Pacific Islander	3.3
American Indian	3.1
Other	8.7

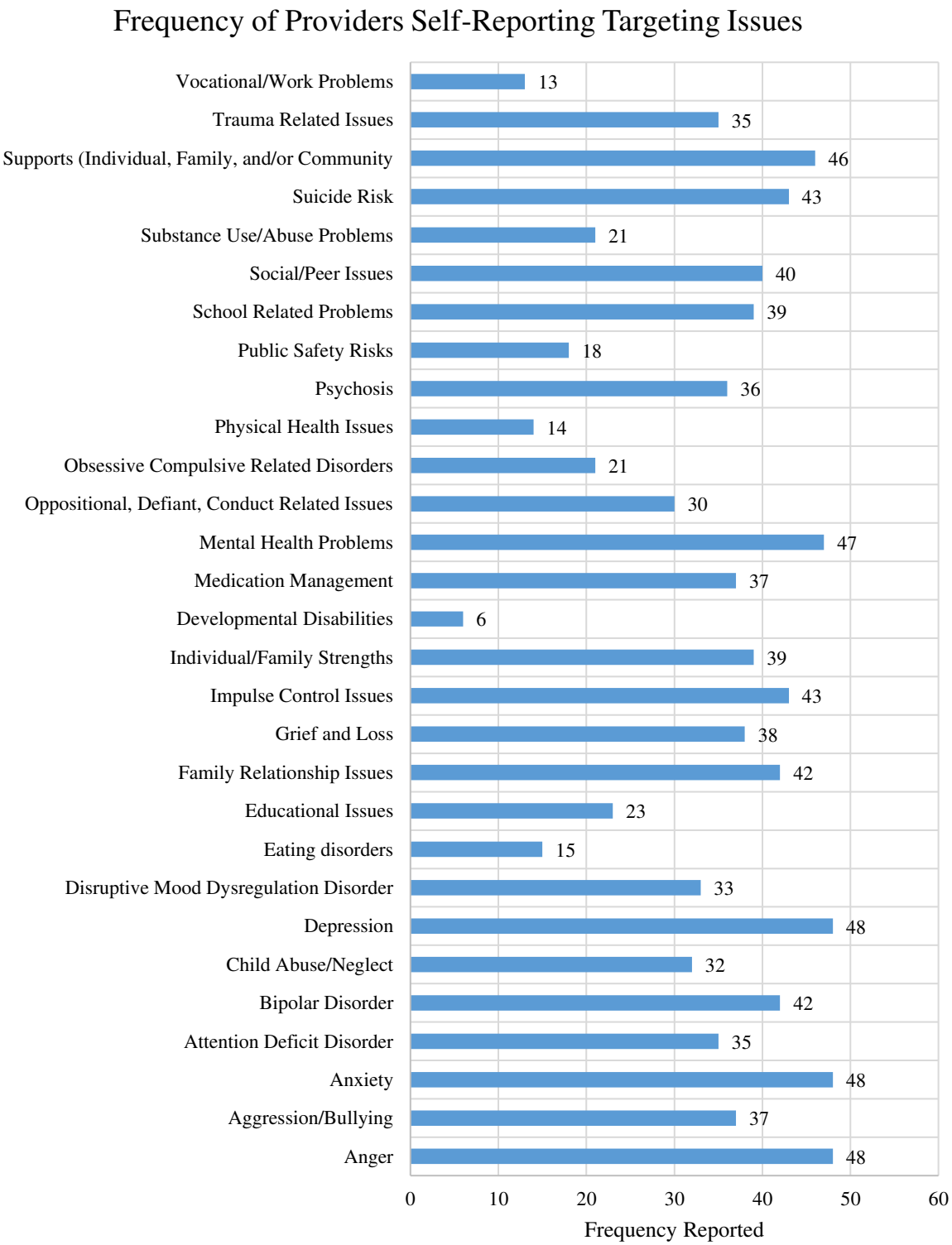
Gender



Distribution of Clients by Age



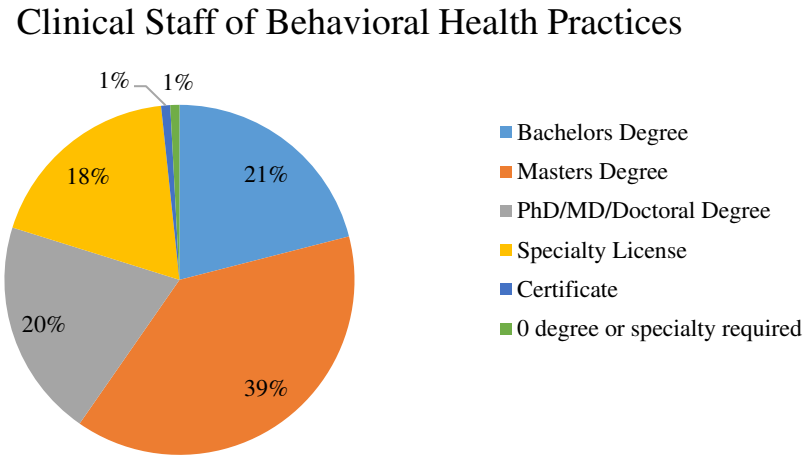
Programs and Services



Languages in which Services are offered other than English:

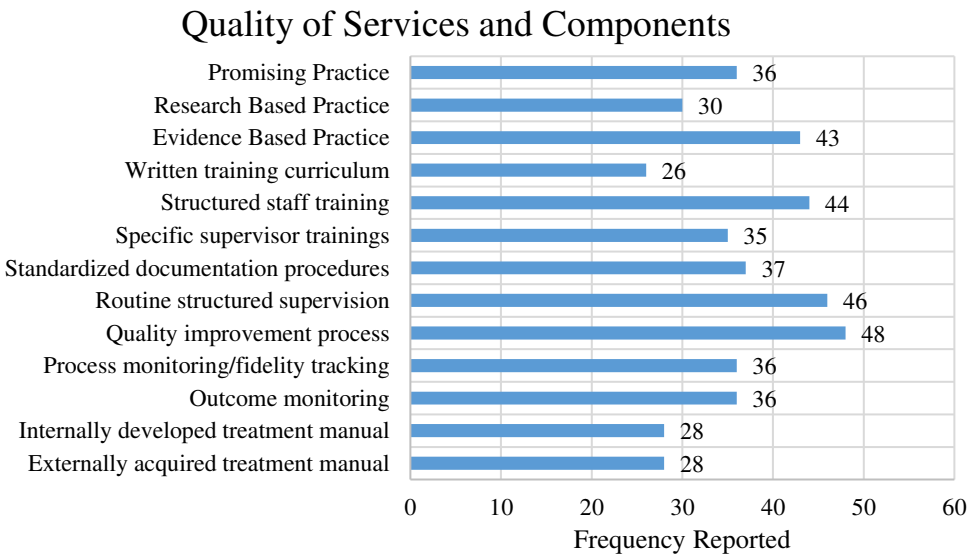
- American Sign Language
- Spanish

Credentials of staff providing services:

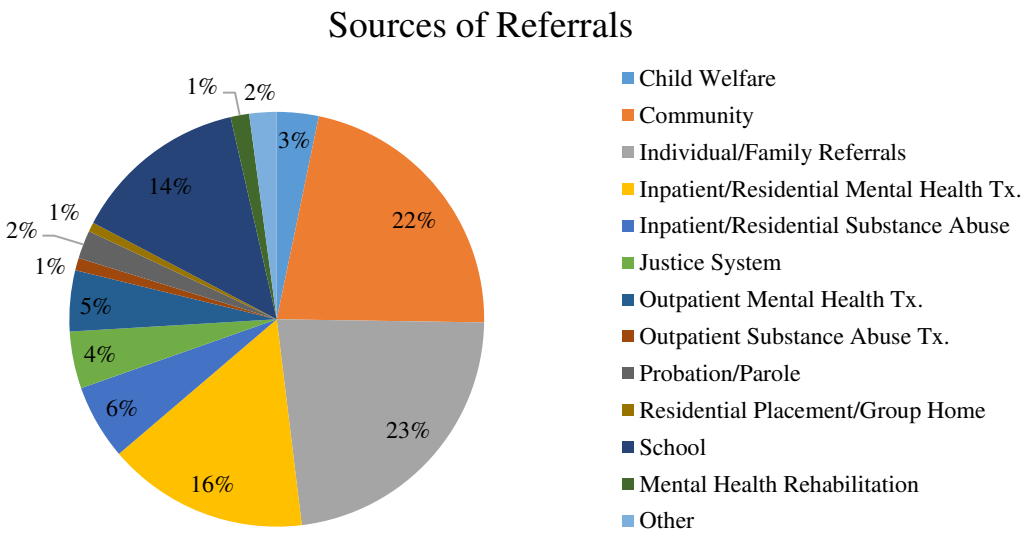


The respondents to the survey described a total of 472 trained staff/practitioners.

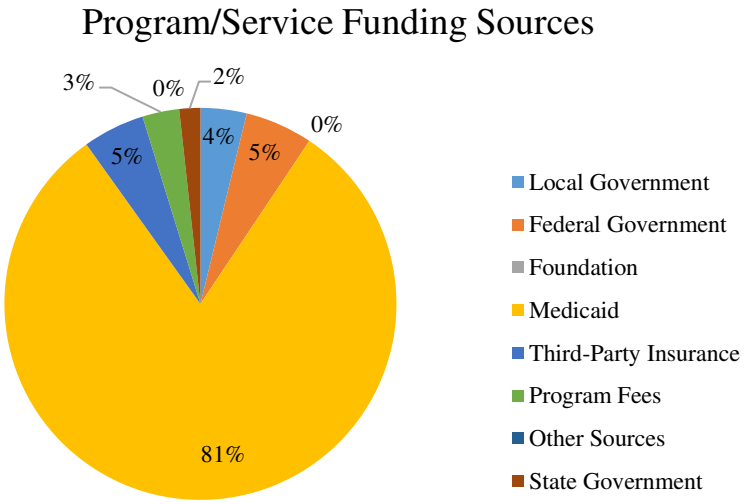
Self-Report of Evidence-based, Promising Practices and Quality Components



Referral Sources



Funding:



Appendix – III
Region Three Specific Findings

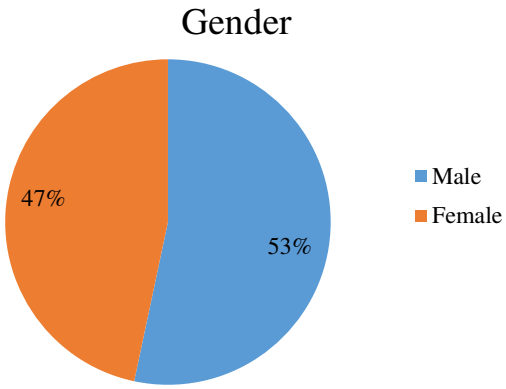
In partnership with the Louisiana Department of Health- Office of Behavioral Health, the LSUHSC Institute for Public Health and Justice administered a survey to Medicaid and state contracted providers for children, adolescents, and their families. The goal of the survey was to provide an inventory of existing services and programs, the capacity of providers, and the perception of needs from the vantage point of practitioners. This appendix details several Region 3 specific findings from the larger statewide study. These are self-report findings from the region sample.

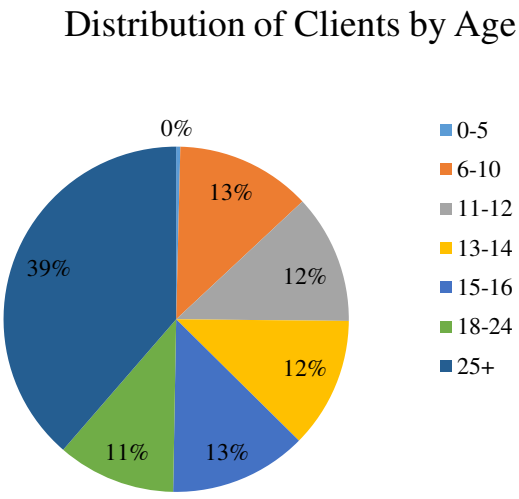
Parishes Included (n=53 services/interventions—note: providers could serve more than one parish):

- Assumption
- La Fourche
- St. Charles
- St. James
- St. John the Baptist
- St. Mary
- Terrebonne

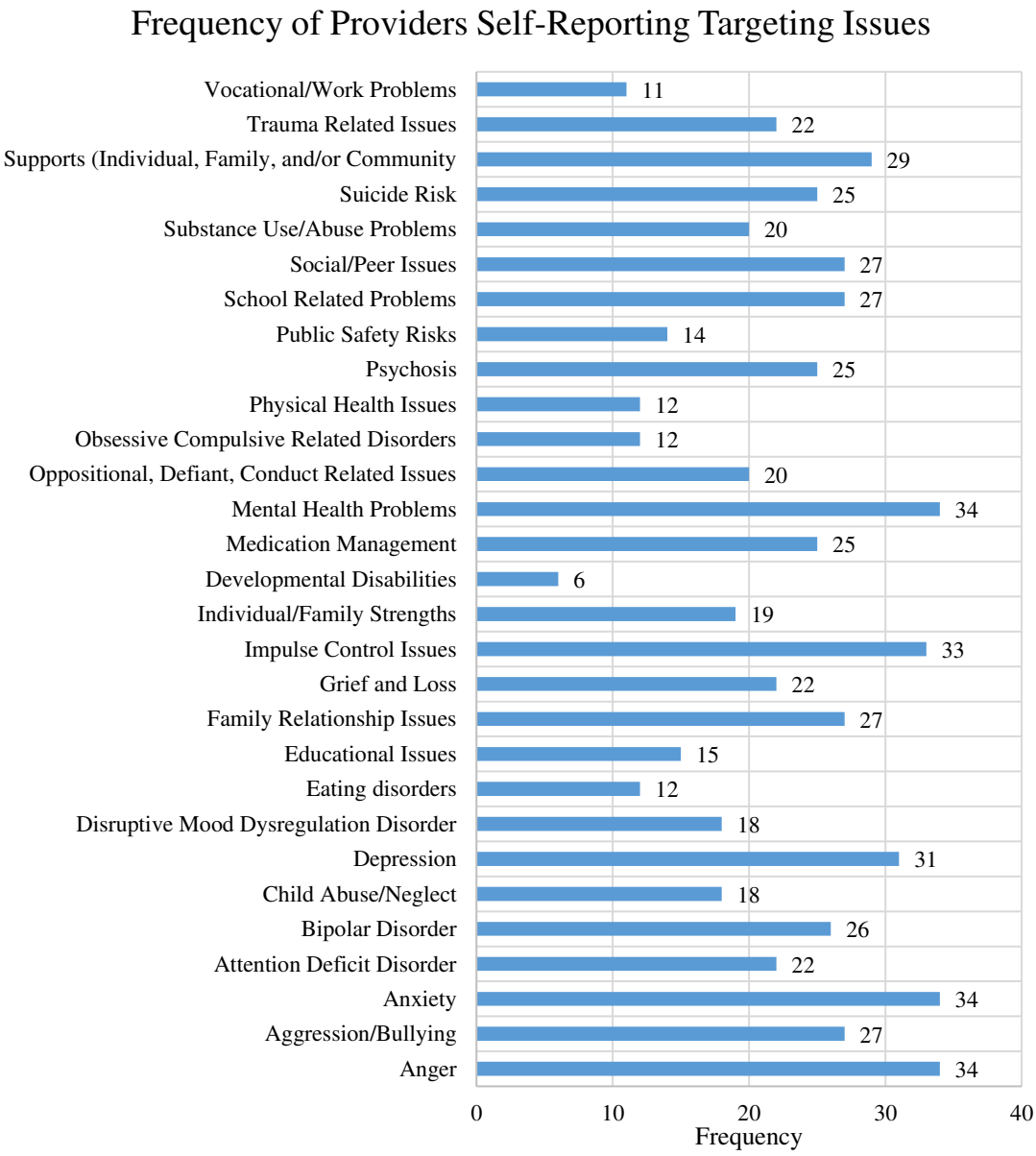
Demographics for Child/Youth Population Served

Racial/Ethnic Distributions	(%)
Hispanic	4.9
Non-Hispanic	95.1
White	33.2
Black/African-American	51.3
Asian/Pacific Islander	4.1
American Indian	4.0
Other	7.3





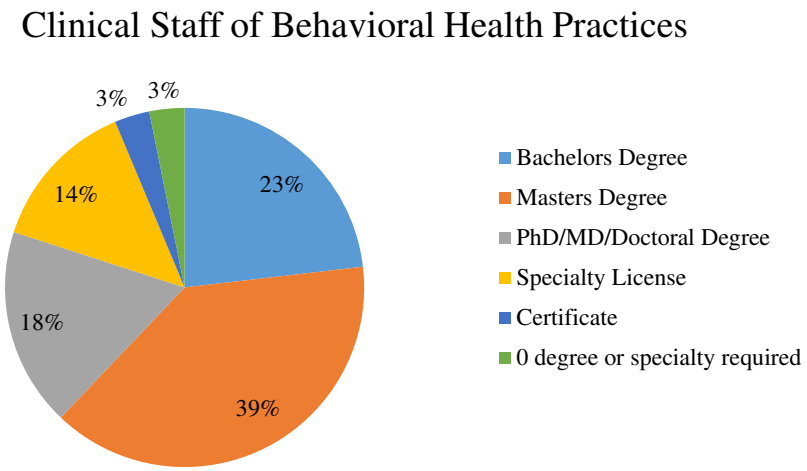
Programs and Services



Languages in which Services are offered other than English:

- American Sign Language
- Spanish

Credentials of staff providing services:



The respondents to the survey described a total of 435 trained staff/practitioners.

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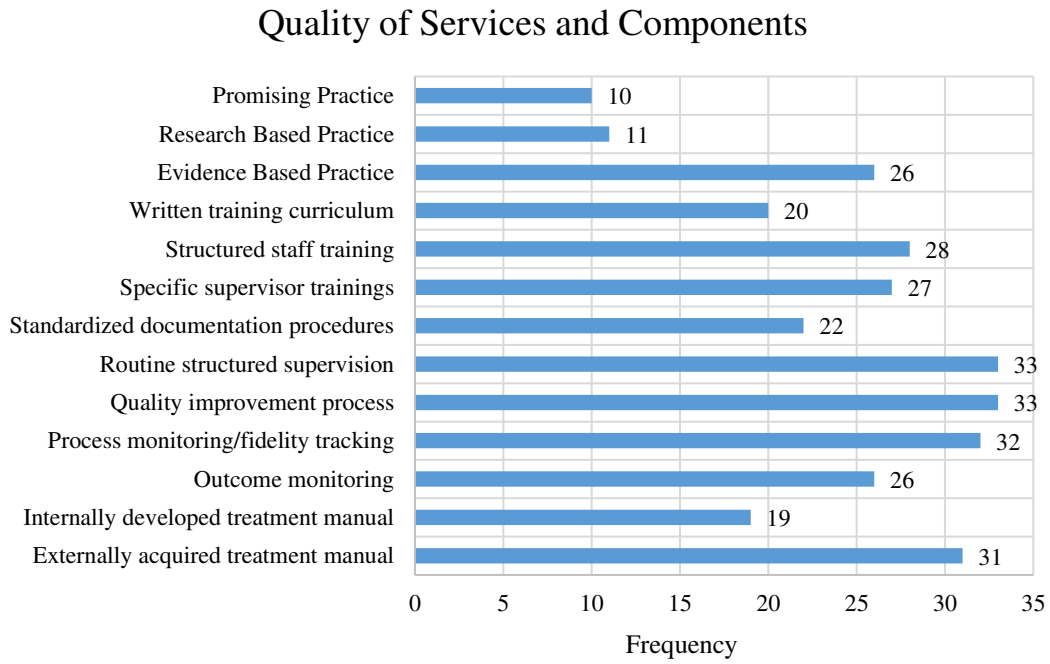
Self-Report of Evidence-based, Promising Practices and Quality Components



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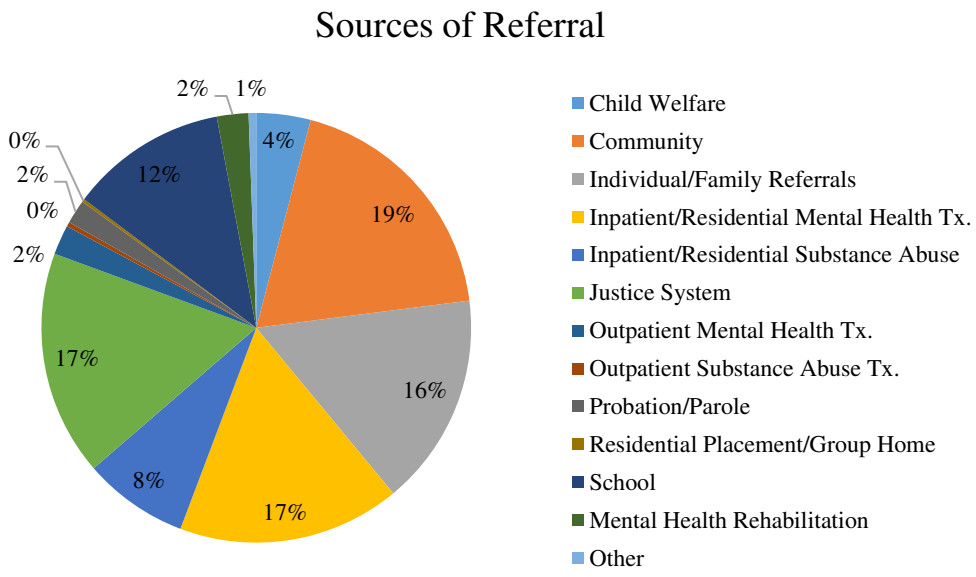
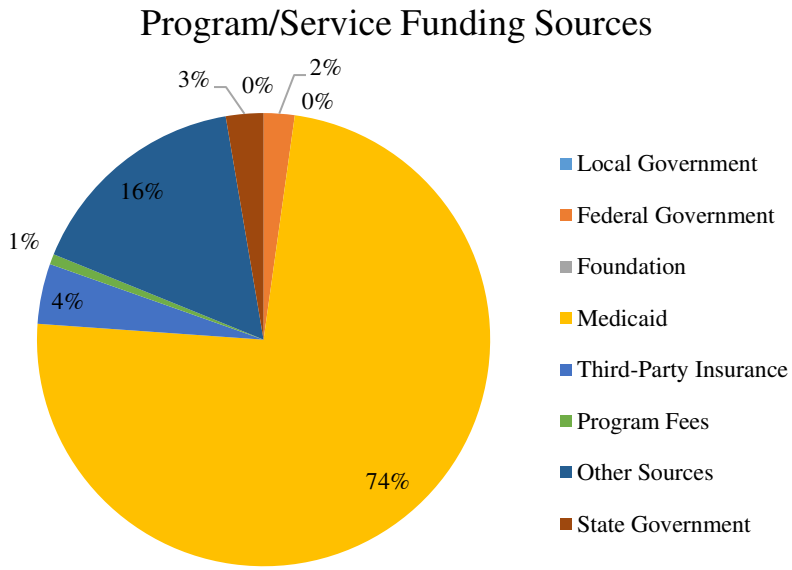


Funding



Appendix – IV
Region Four Specific Findings

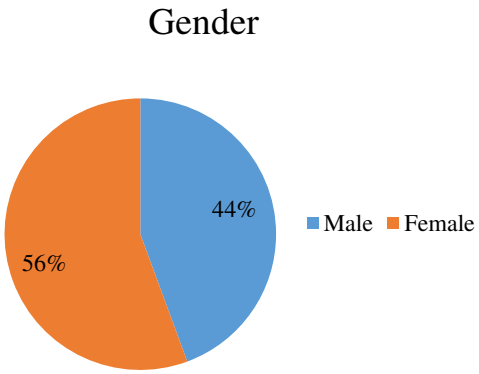
In partnership with the Louisiana Department of Health- Office of Behavioral Health, the LSUHSC Institute for Public Health and Justice administered a survey to Medicaid and state contracted providers for children, adolescents, and their families. The goal of the survey was to provide an inventory of existing services and programs, the capacity of providers, and the perception of needs from the vantage point of practitioners. This appendix details several Region 4 specific findings from the larger statewide study. These are self-report findings from the region sample.

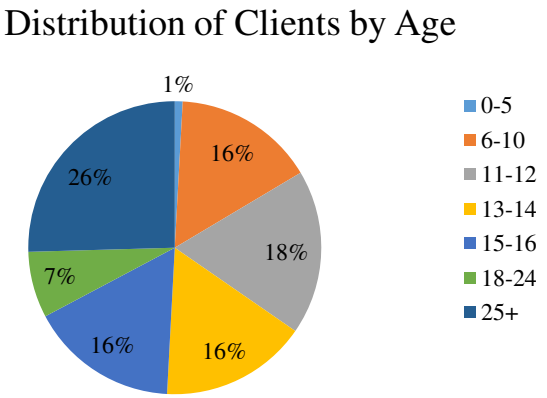
Parishes Included (n=56 services/interventions—note: providers could serve more than one parish):

- Acadia
- Allen
- Evangeline
- Iberia
- Jefferson Davis
- Lafayette
- St. Landry
- St. Martin
- Vermilion

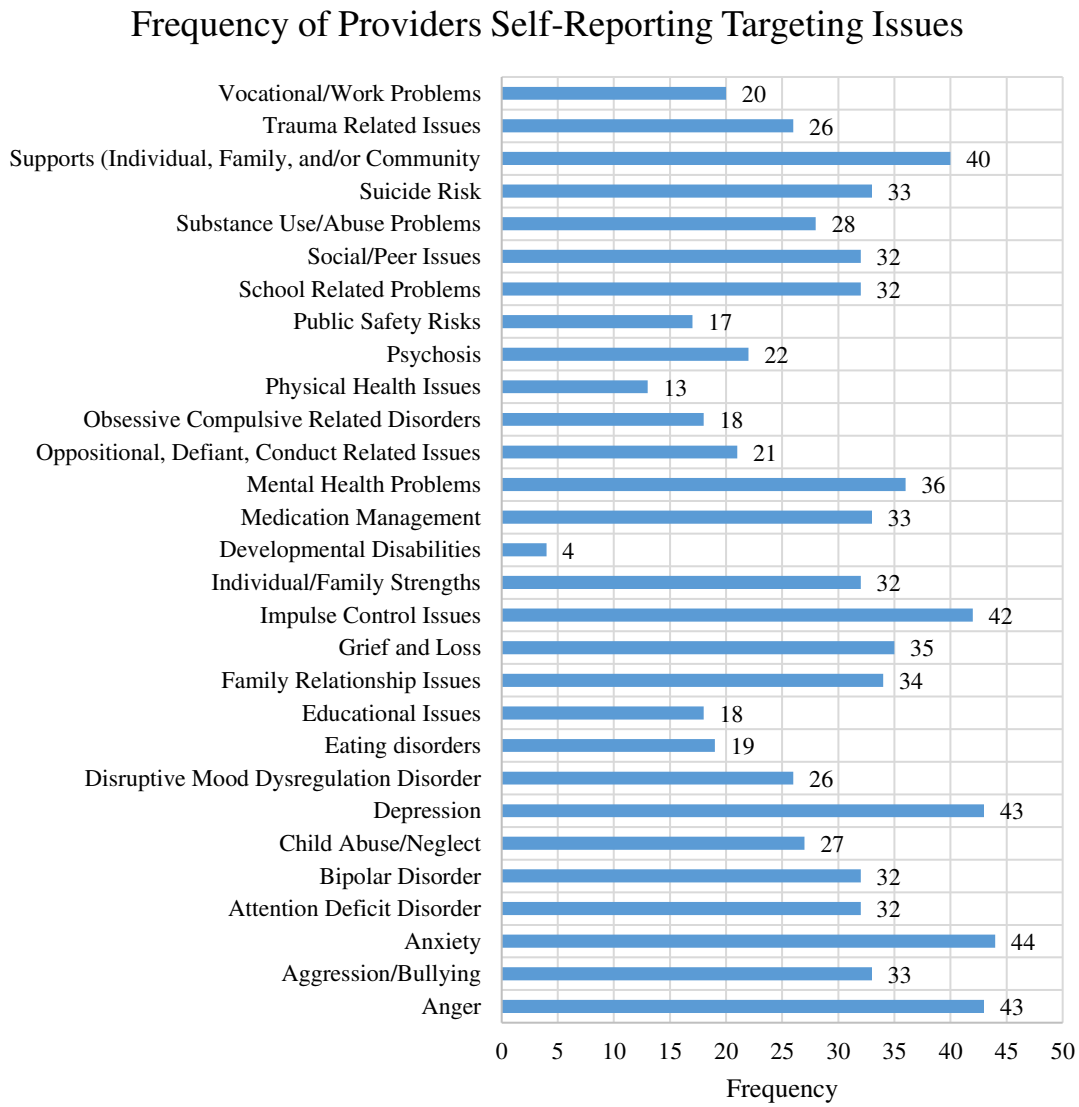
Demographics for Child/Youth Population Served

Racial/Ethnic Distributions	(%)
Hispanic	6.8
Non-Hispanic	91.3
White	40.8
Black/African-American	44.6
Asian/Pacific Islander	4.4
American Indian	4.7
Other	5.0





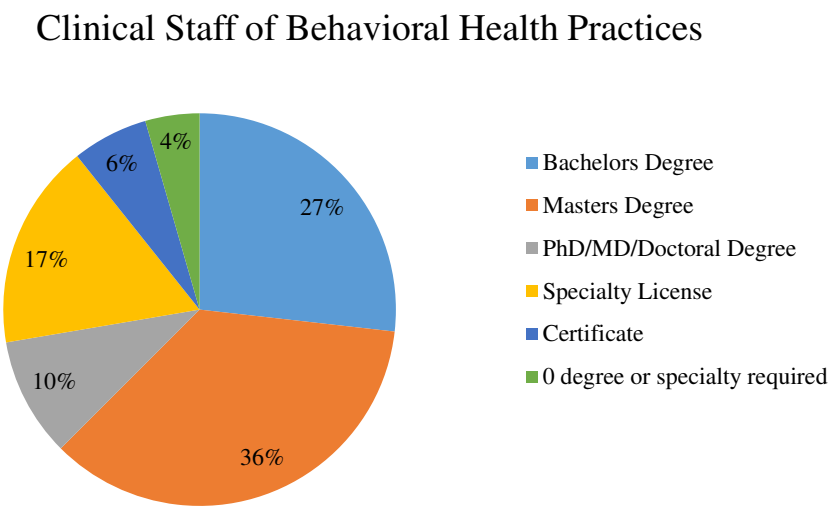
Programs and Services



Languages in which Services are offered other than English:

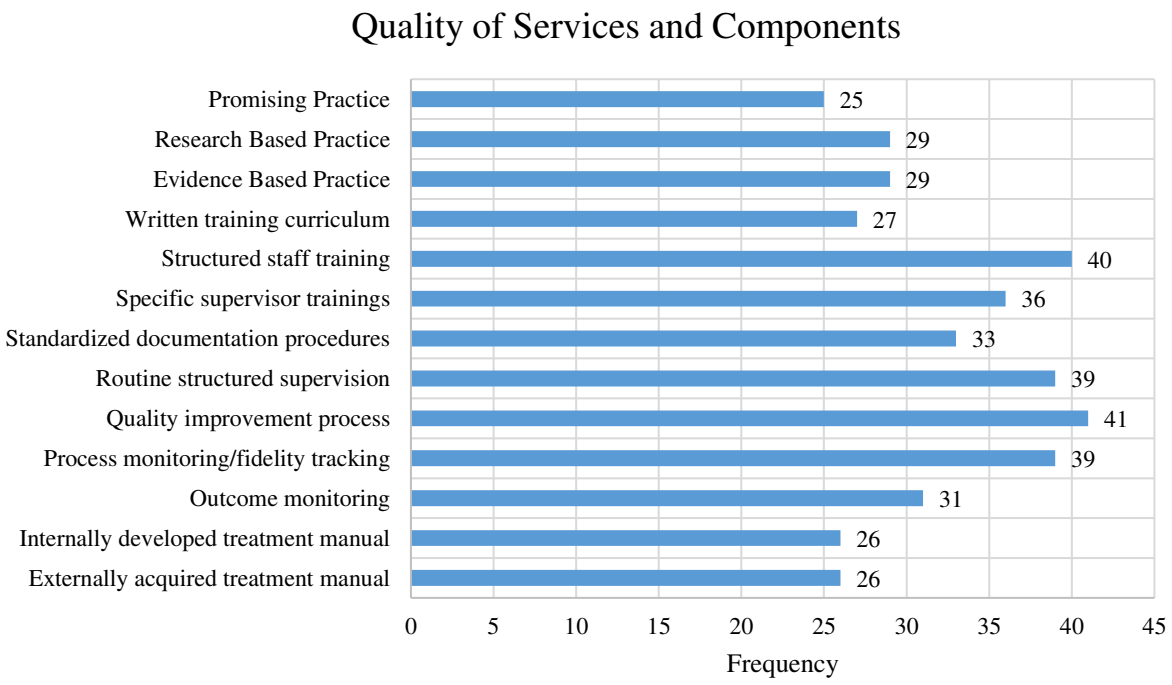
- Chinese
- Spanish

Credentials of staff providing services:

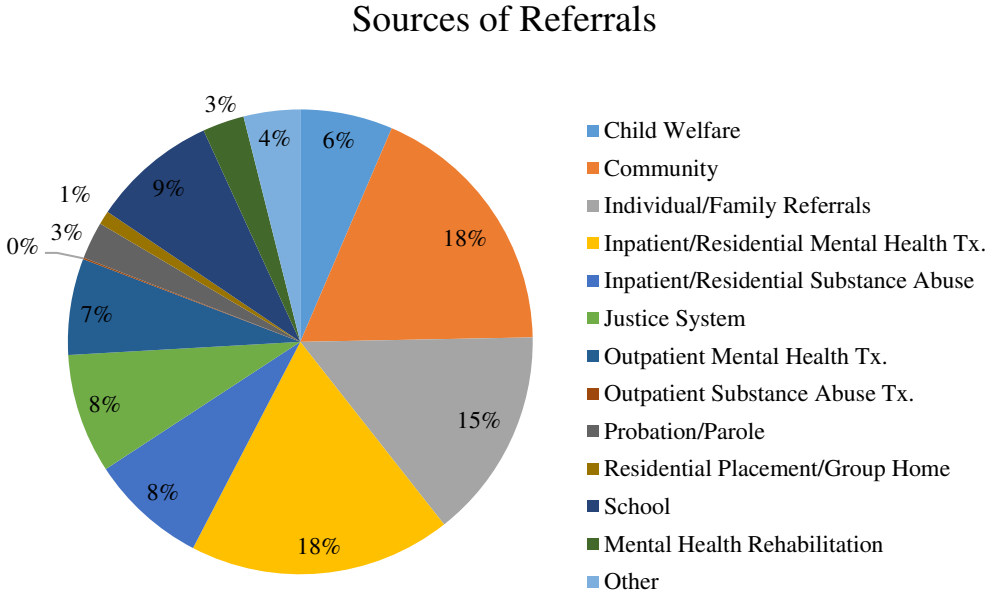


The respondents to the survey described a total of 649 trained staff/practitioners.

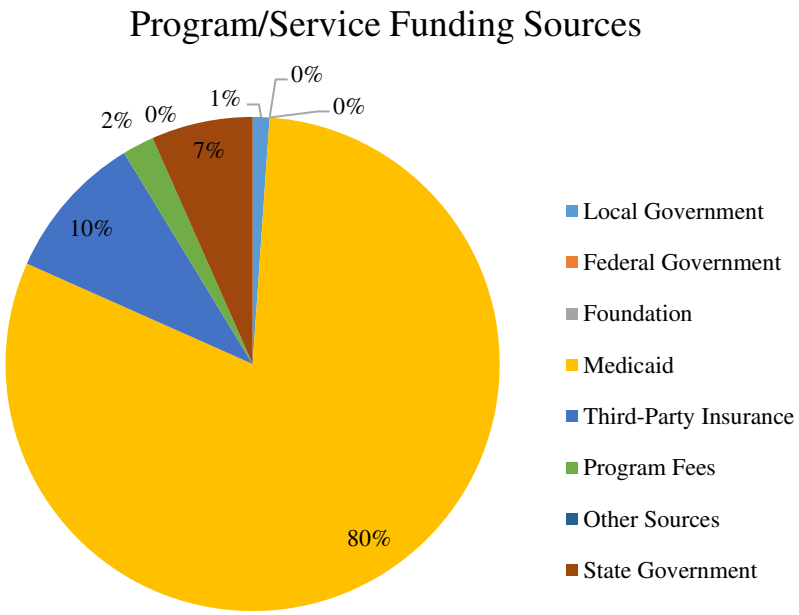
Self-Report of Evidence-based, Promising Practices and Quality Components



Referral Sources



Funding



Appendix – V
Region Six Specific Findings

In partnership with the Louisiana Department of Health- Office of Behavioral Health, the LSUHSC Institute for Public Health and Justice administered a survey to Medicaid and state contracted providers for children, adolescents, and their families. The goal of the survey was to provide an inventory of existing services and programs, the capacity of providers, and the perception of needs from the vantage point of practitioners. This appendix details several Region 6 specific findings from the larger statewide study. These are self-report findings from the region sample.

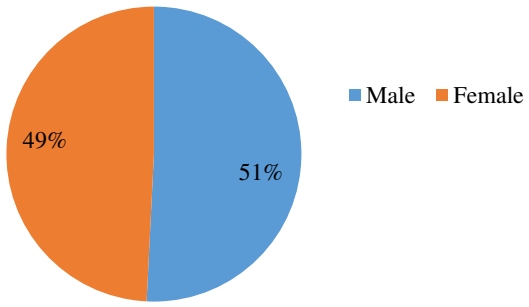
Parishes Included (n=70 services/interventions—note: providers could serve more than one parish):

- Avoyelles
- Beauregard
- Calcasieu
- Cameron
- Catahoula
- Concordia
- Grant
- La Salle
- Rapides
- Vernon
- Winn

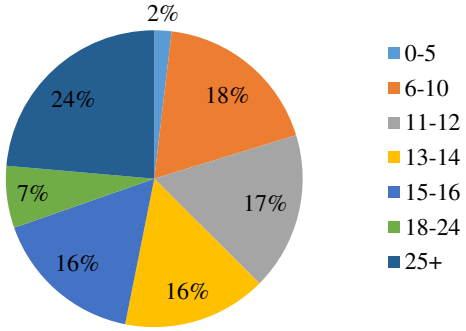
Demographics for Child/Youth Population Served

Racial/Ethnic Distributions	(%)
Hispanic	7.8
Non-Hispanic	92.2
White	42.7
Black/African-American	42.7
Asian/Pacific Islander	4.2
American Indian	4.6
Other	5.2

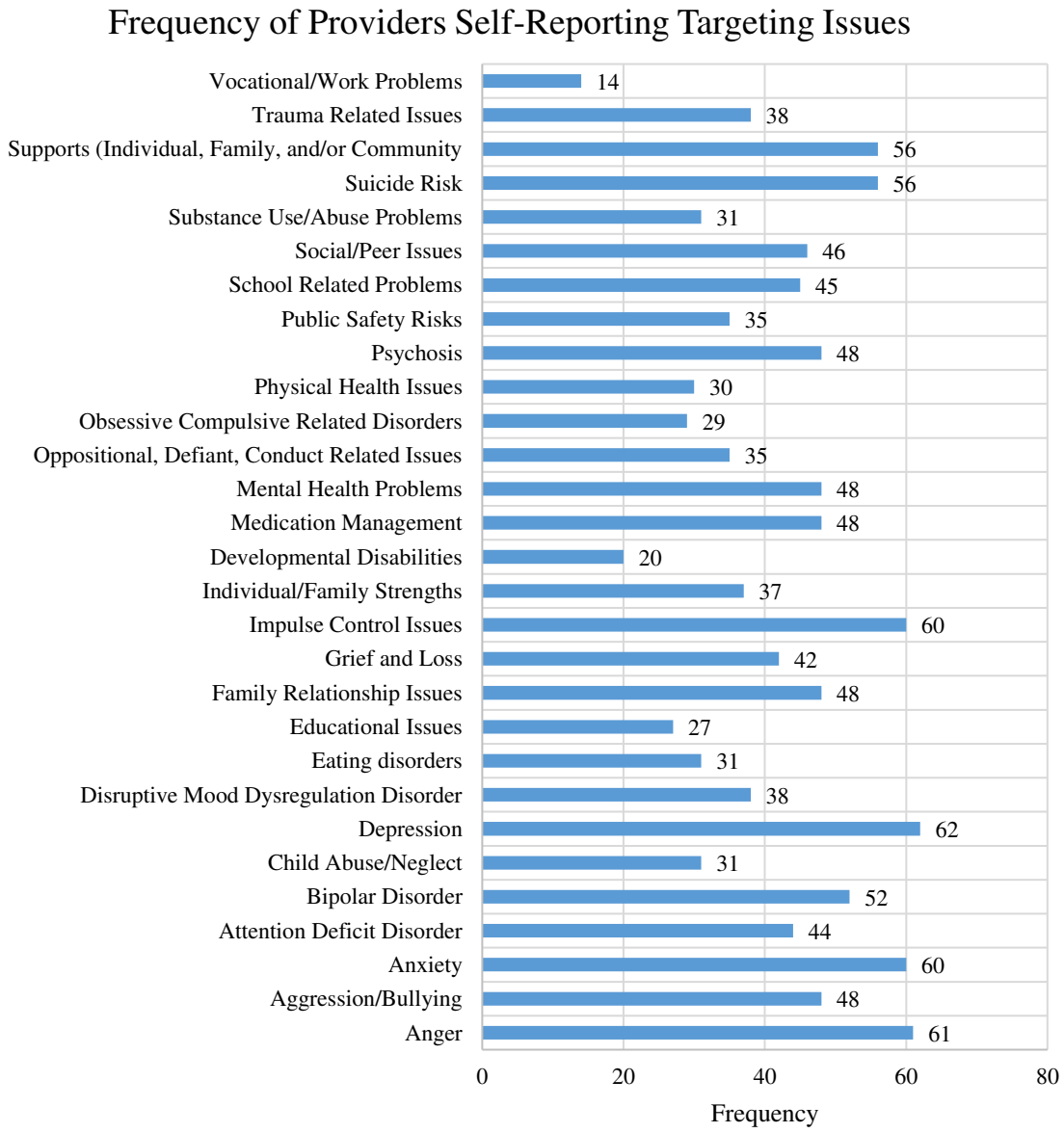
Gender



Distribution of Clients by Age



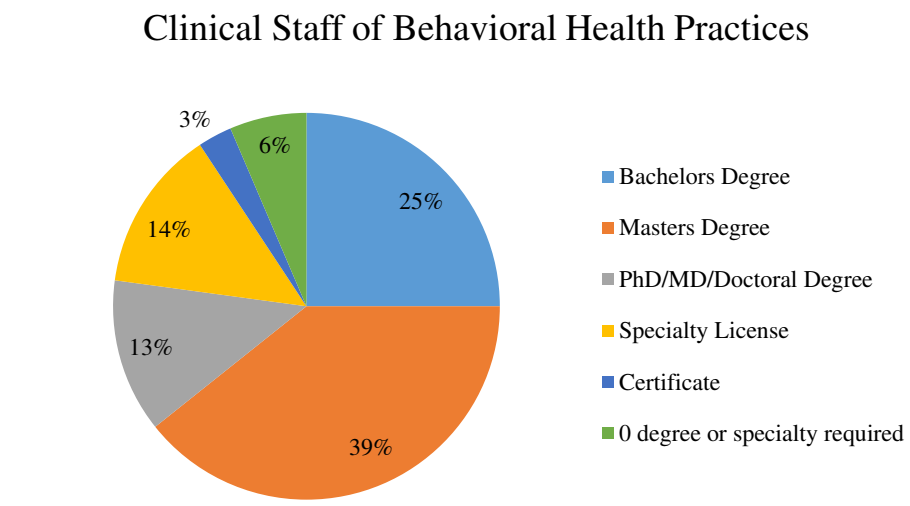
Programs and Services



Languages in which Services are offered other than English:

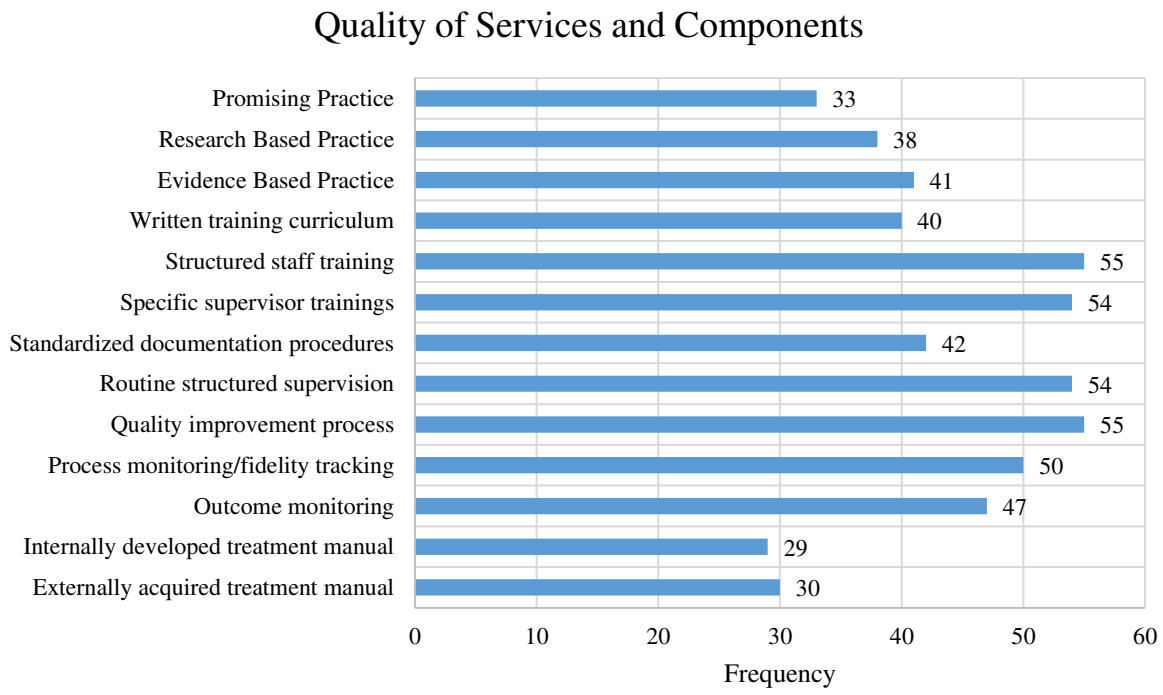
- Spanish

Credentials of staff providing services:



The respondents to the survey described a total of 1010 trained staff/practitioners.

Self-Report of Evidence-based, Promising Practices and Quality Components



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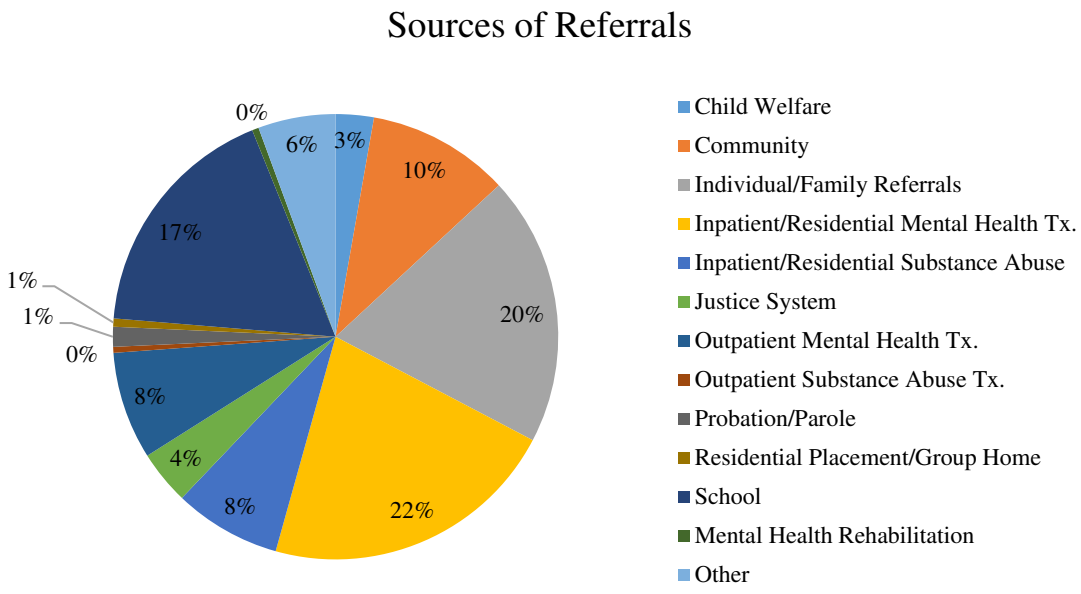
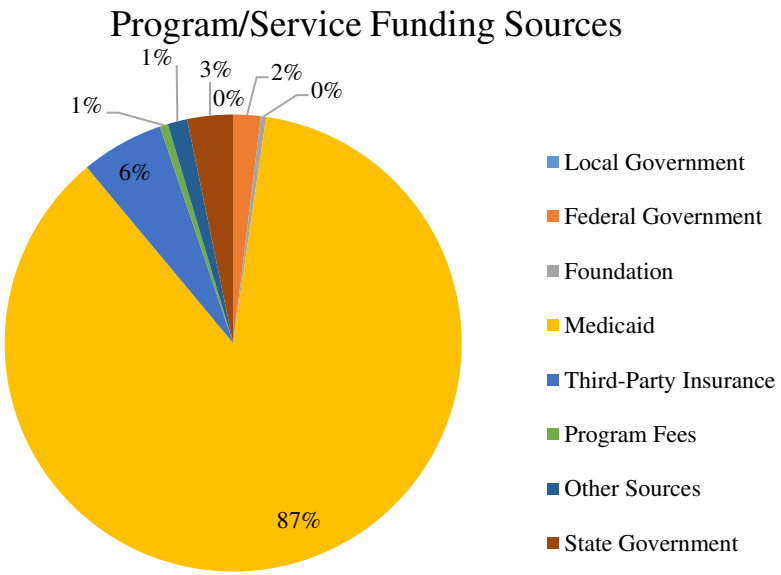


Funding



Appendix – VI
Region Seven Specific Findings

In partnership with the Louisiana Department of Health- Office of Behavioral Health, the LSUHSC Institute for Public Health and Justice administered a survey to Medicaid and state contracted providers for children, adolescents, and their families. The goal of the survey was to provide an inventory of existing services and programs, the capacity of providers, and the perception of needs from the vantage point of practitioners. This appendix details several Region 7 specific findings from the larger statewide study. These are self-report findings from the region sample.

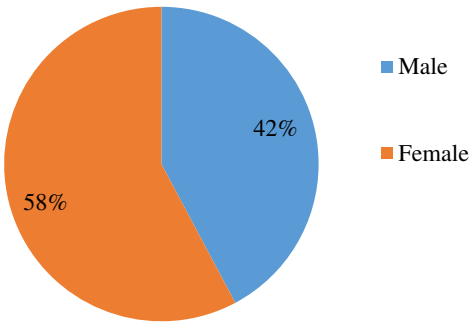
Parishes Included (n=112 services/interventions—note: providers could serve more than one parish):

- Bienville
- Bossier
- Caddo
- Claiborne
- De Soto
- Natchitoches
- Red River
- Sabine
- Webster

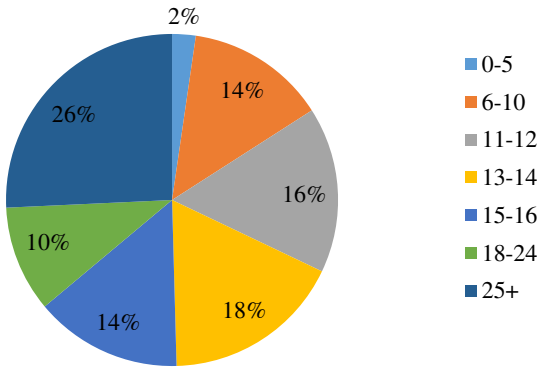
Demographics for Child/Youth Population Served

Racial/Ethnic Distributions	(%)
Hispanic	6.4
Non-Hispanic	93.6
White	38.9
Black/African-American	49.6
Asian/Pacific Islander	2.7
American Indian	3.1
Other	5.2

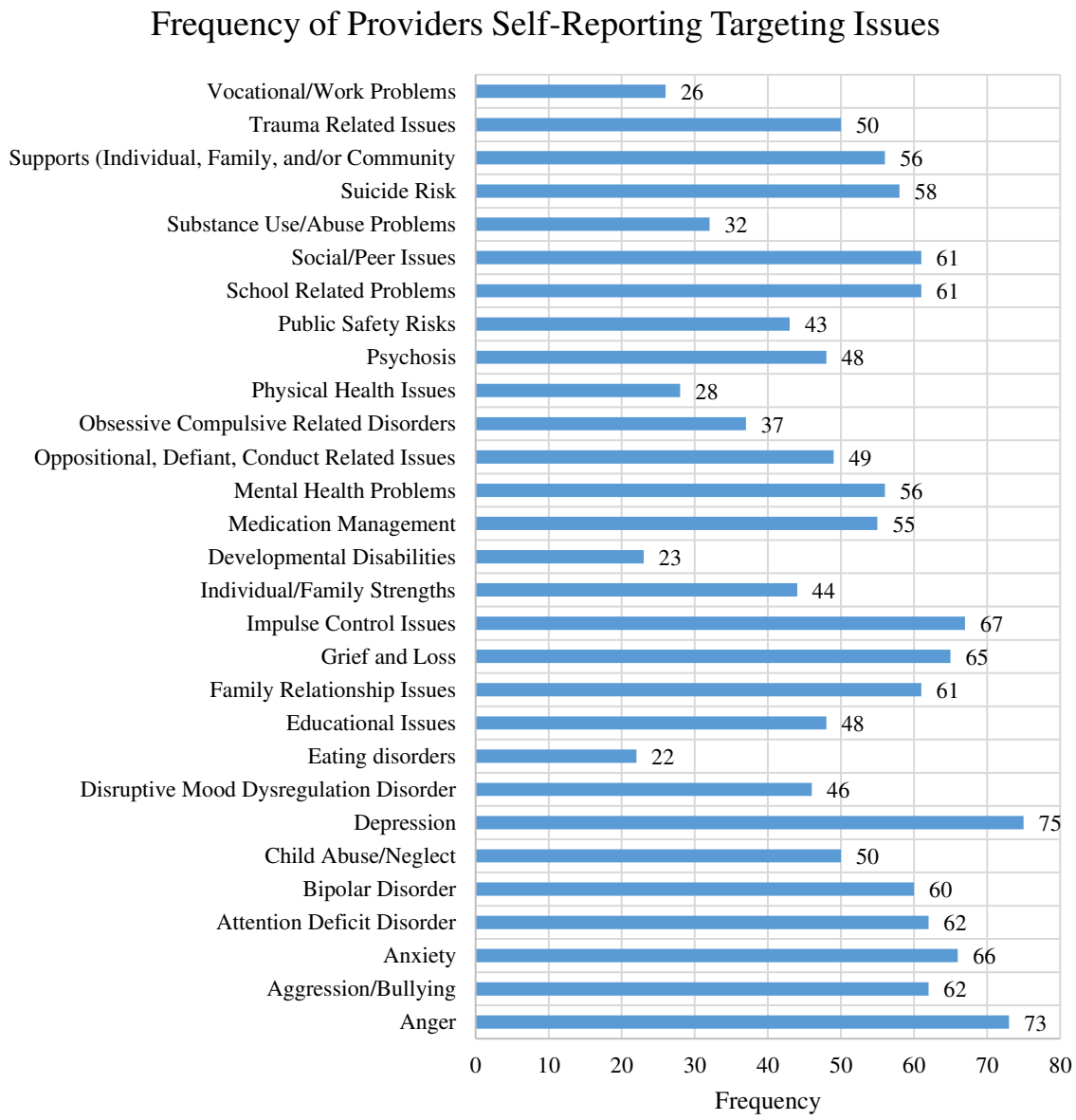
Gender



Distribution of Clients by Age



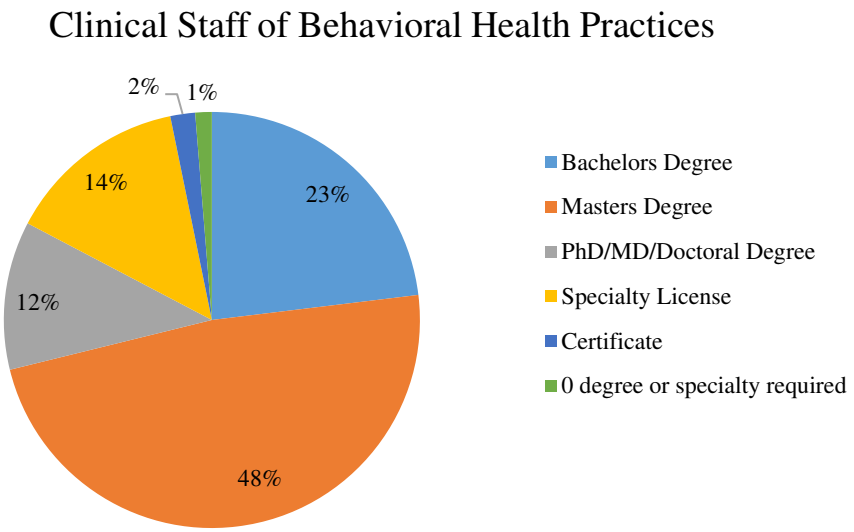
Programs and Services



Languages in which Services are offered other than English:

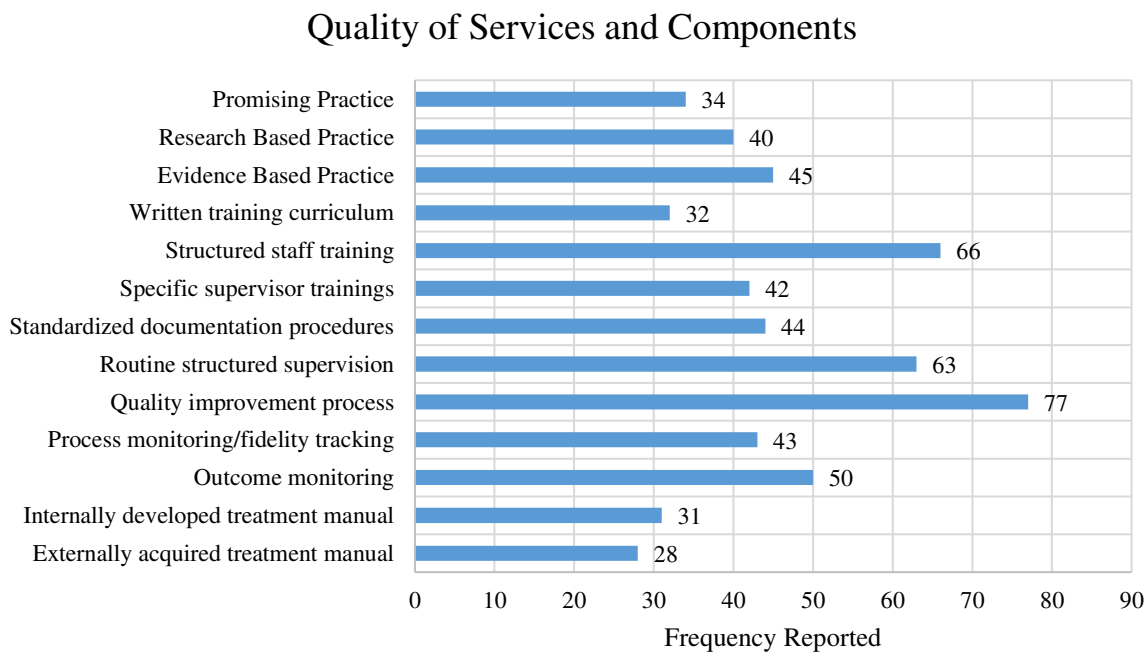
- Spanish

Credentials of staff providing services:



The respondents to the survey described a total of 1505 trained staff/practitioners.

Self-Report of Evidence-based, Promising Practices and Quality Components



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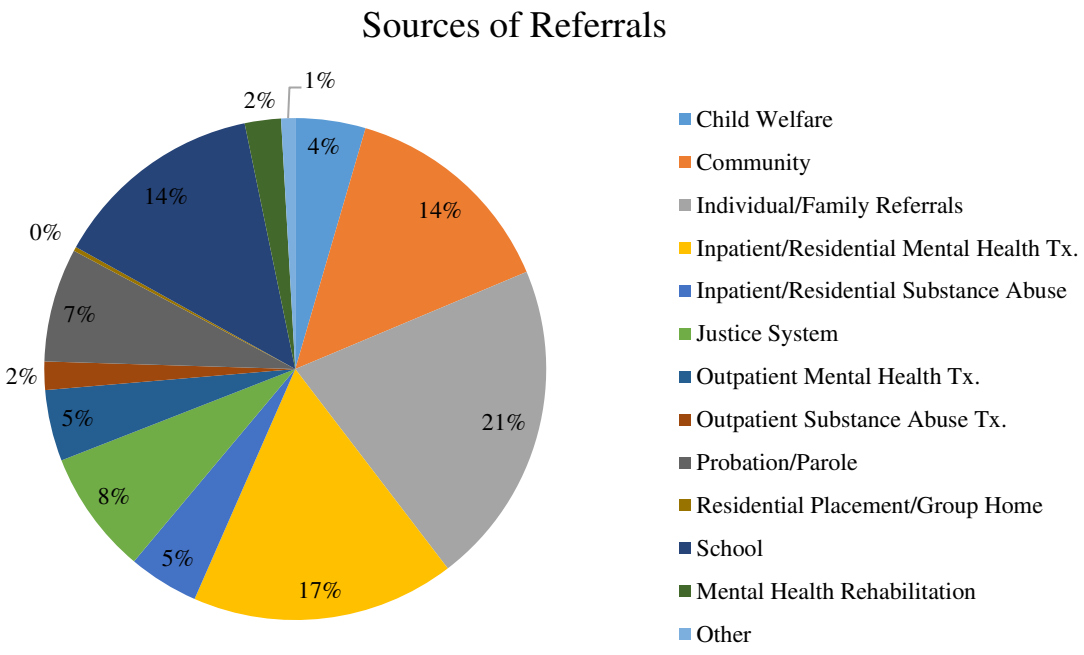
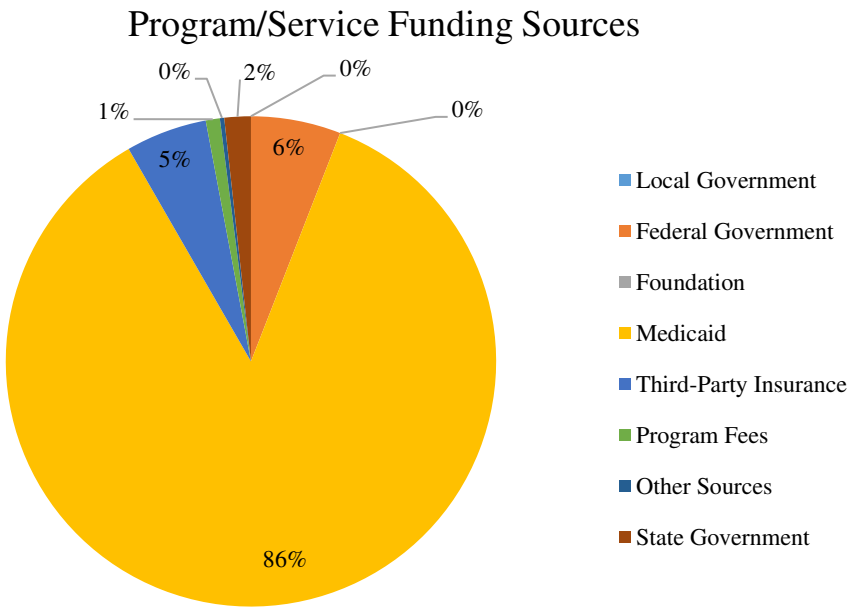


Funding



Appendix – VII
Region Eight Specific Findings

In partnership with the Louisiana Department of Health- Office of Behavioral Health, the LSUHSC Institute for Public Health and Justice administered a survey to Medicaid and state contracted providers for children, adolescents, and their families. The goal of the survey was to provide an inventory of existing services and programs, the capacity of providers, and the perception of needs from the vantage point of practitioners. This appendix details several Region 8 specific findings from the larger statewide study. These are self-report findings from the region sample.

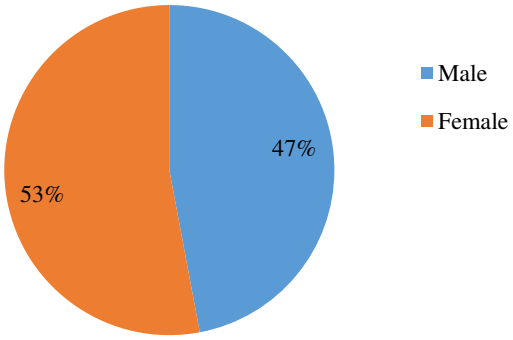
Parishes Included (n=85 services/interventions—note: providers could serve more than one parish):

- Caldwell
- East Carroll
- Franklin
- Jackson
- Lincoln
- Madison
- Morehouse
- Ouachita
- Richland
- Tensas
- Union
- West Carroll

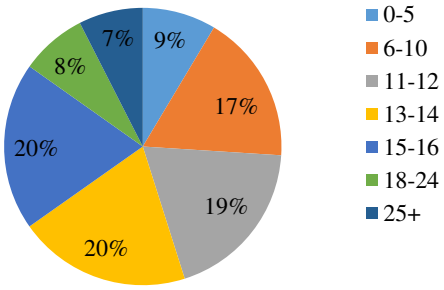
Demographics of Child/Youth Population Served

Racial/Ethnic Distributions	(%)
Hispanic	15.8
Non-Hispanic	84.2
White	35.6
Black/African-American	47.2
Asian/Pacific Islander	5.0
American Indian	4.8
Other	7.8

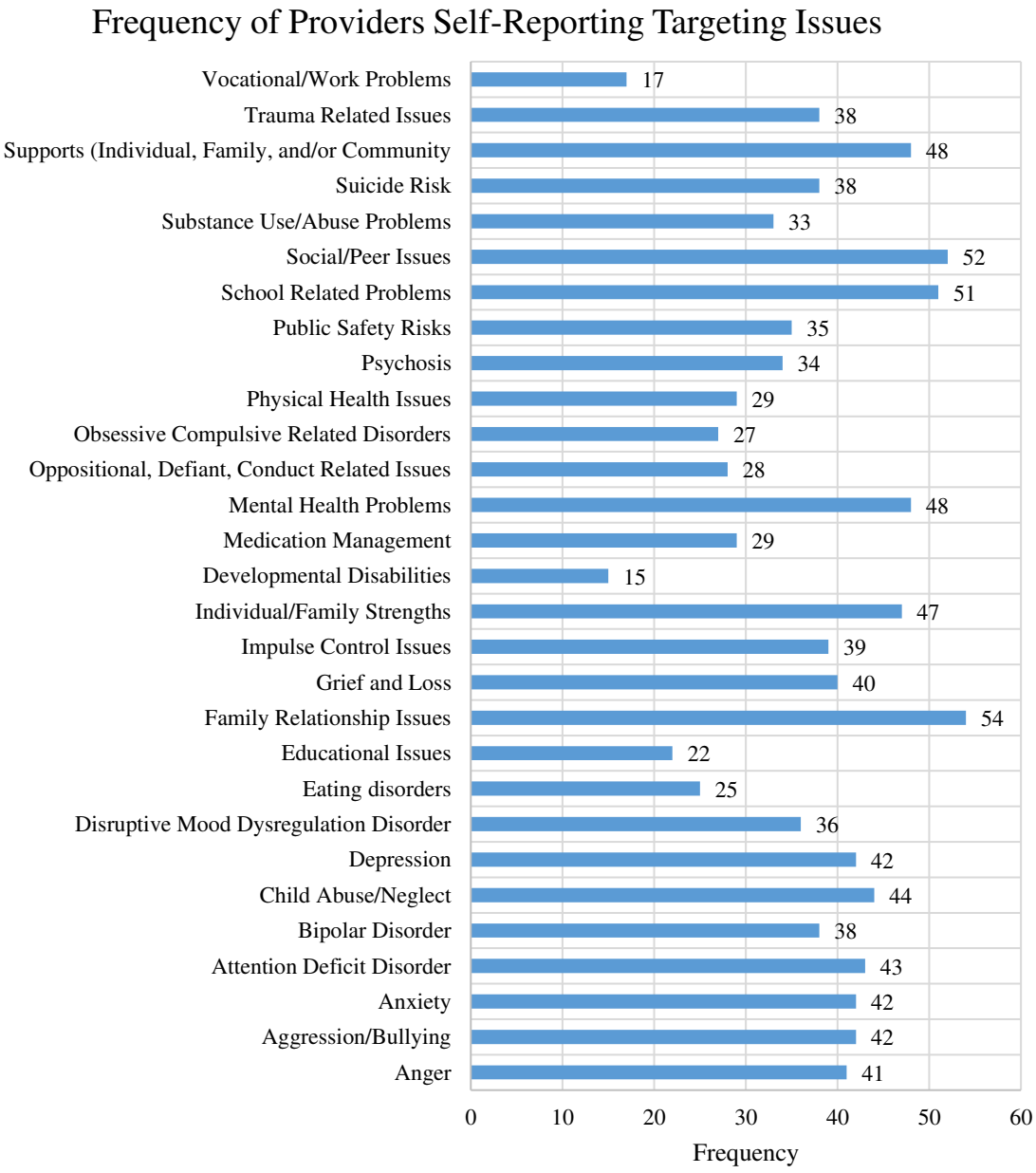
Gender



Distribution of Clients by Age



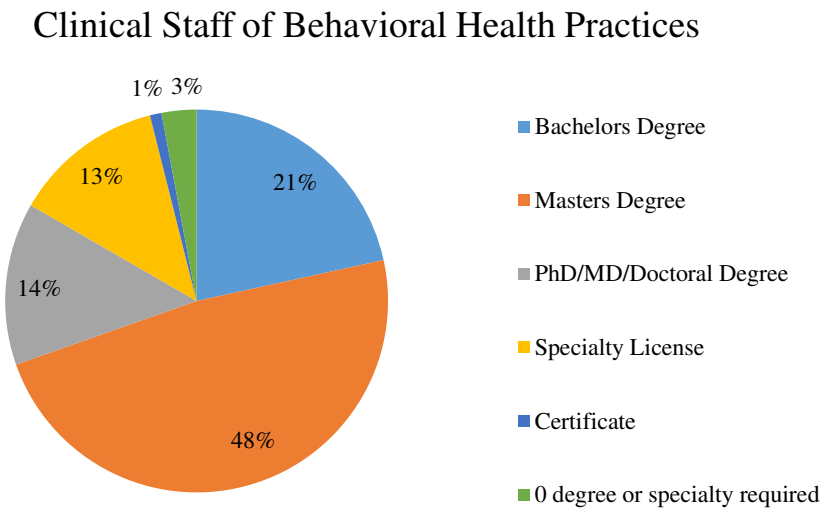
Programs and Services



Languages in which Services are offered other than English:

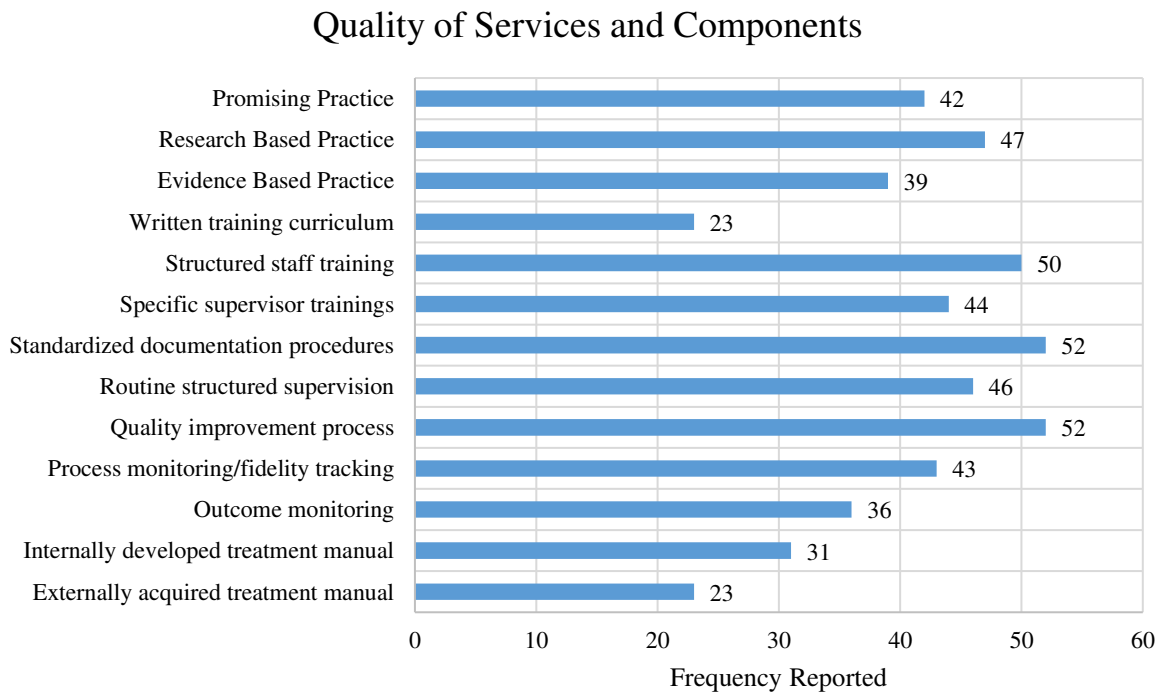
- Spanish

Credentials of staff providing services:



The respondents to the survey described a total of 729 trained staff/practitioners.

Self-Report of Evidence-based, Promising Practices and Quality Components



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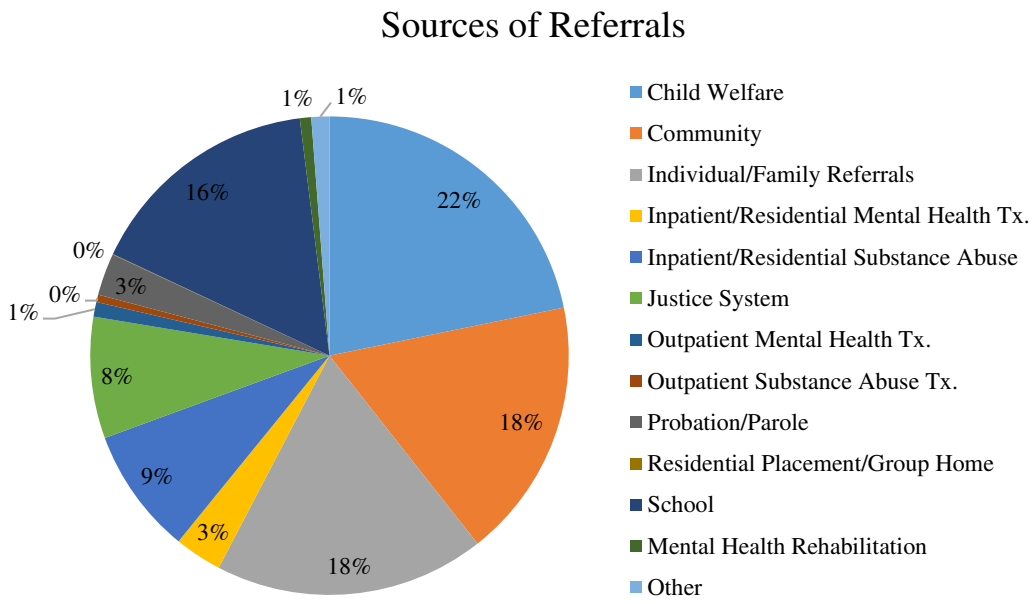
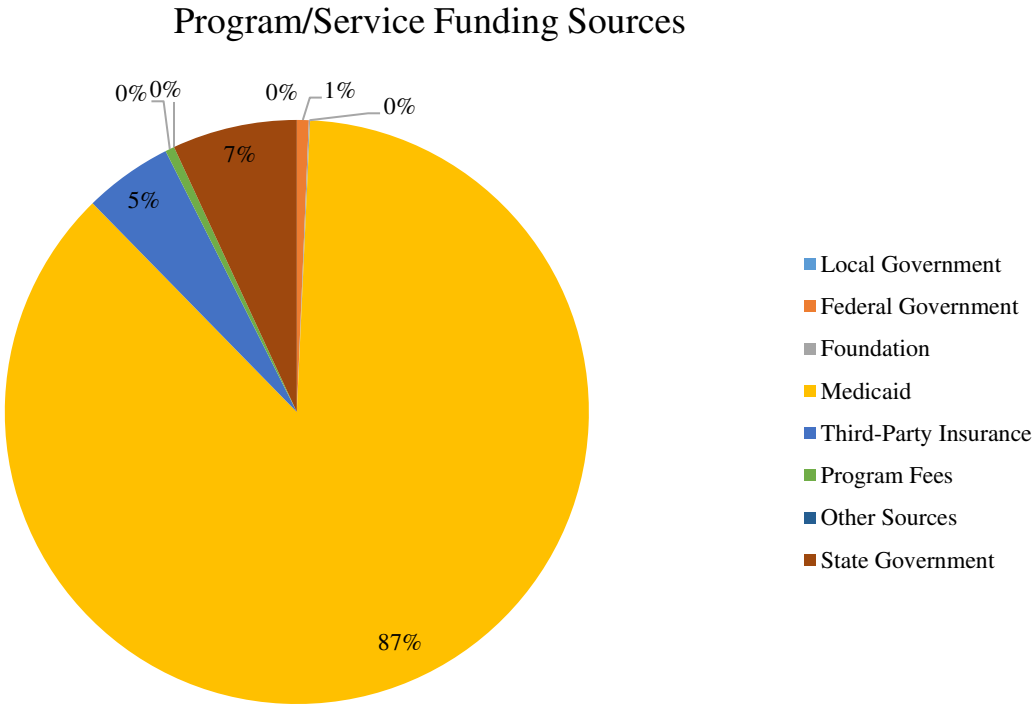


Funding



Appendix – VII
Region Nine Specific Findings

In partnership with the Louisiana Department of Health- Office of Behavioral Health, the LSUHSC Institute for Public Health and Justice administered a survey to Medicaid and state contracted providers for children, adolescents, and their families. The goal of the survey was to provide an inventory of existing services and programs, the capacity of providers, and the perception of needs from the vantage point of practitioners. This appendix details several Region 9 specific findings from the larger statewide study. These are self-report findings from the region sample.

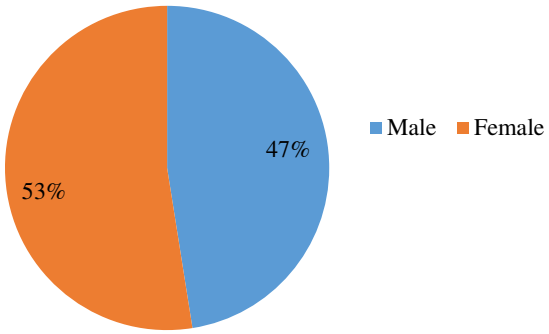
Parishes Included (n=64 services/interventions—note: providers could serve more than one parish):

- Livingston
- St. Helena
- St. Tammany
- Tangipahoa
- Washington

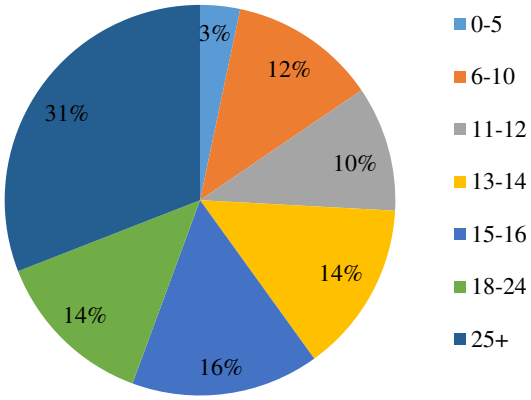
Demographics for Child/Youth Population Served

Racial/Ethnic Distributions	(%)
Hispanic	6.9
Non-Hispanic	93.1
White	41.4
Black/African-American	48.0
Asian/Pacific Islander	2.6
American Indian	3.0
Other	5.0

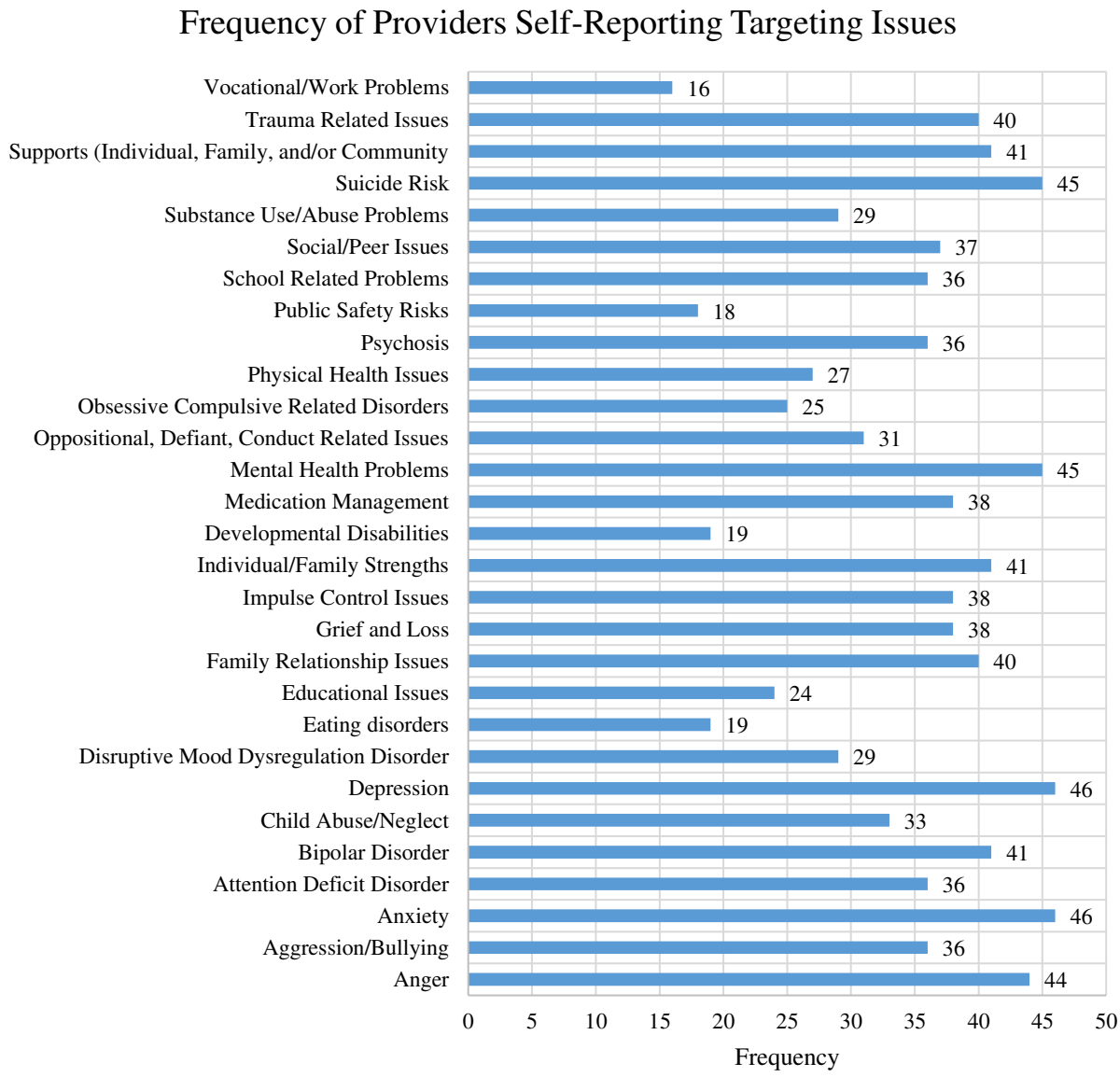
Gender



Distribution of Clients by Age



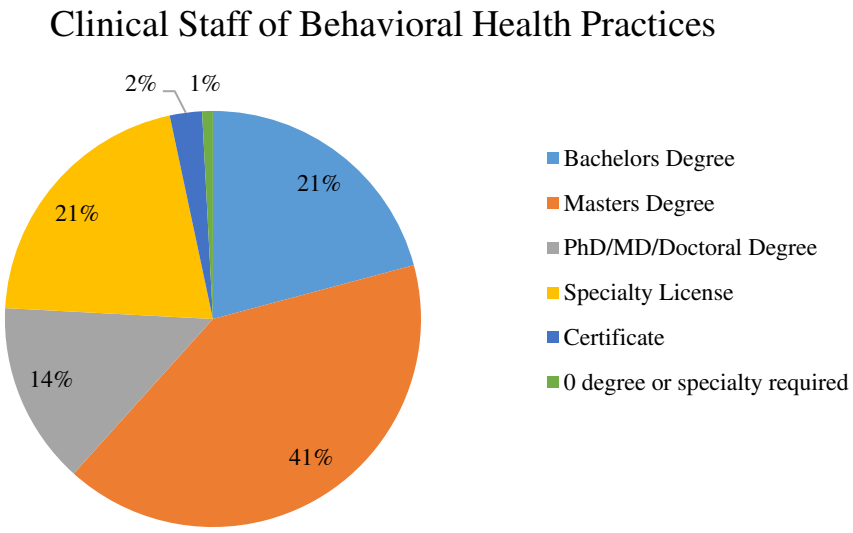
Programs and Services



Languages in which Services are offered other than English:

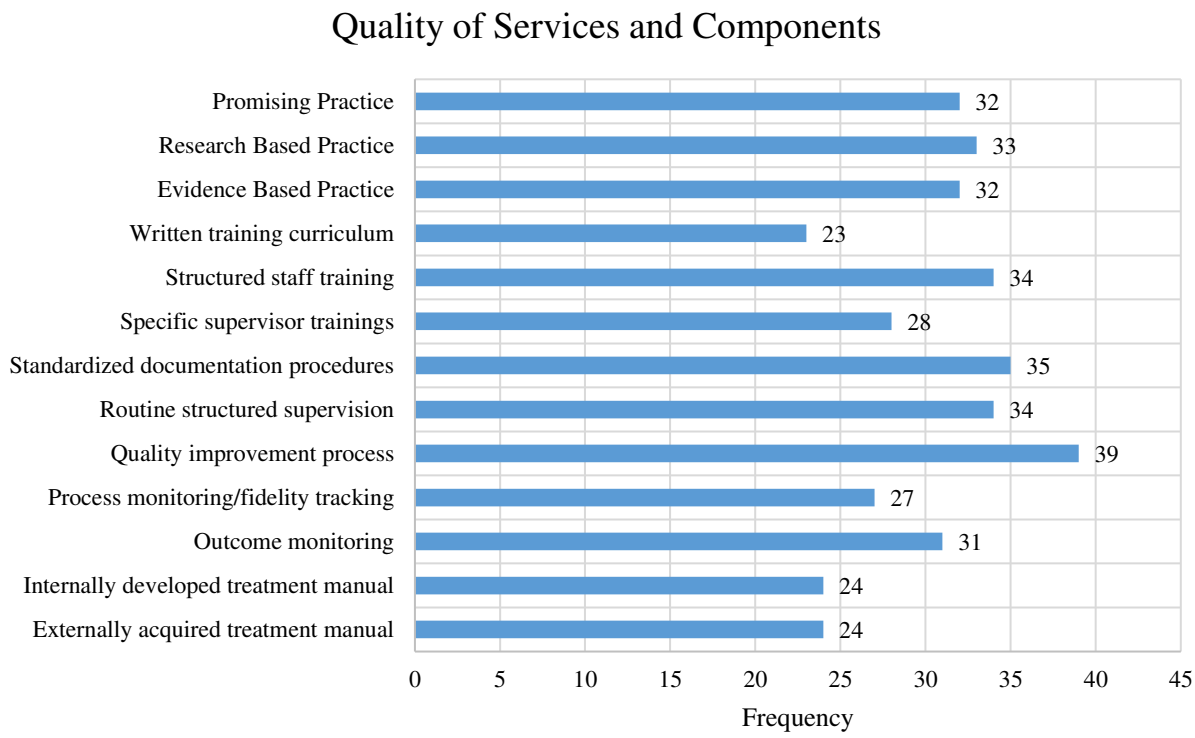
- Spanish

Credentials of staff providing services:



The respondents to the survey described a total of 865 trained staff/practitioners.

Self-Report of Evidence-based, Promising Practices and Quality Components



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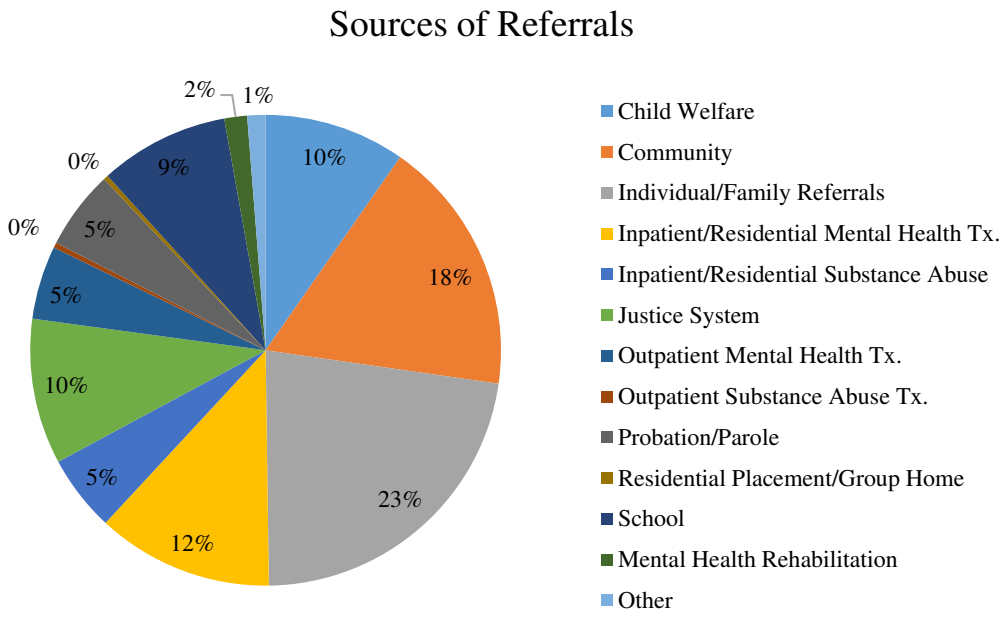

Funding