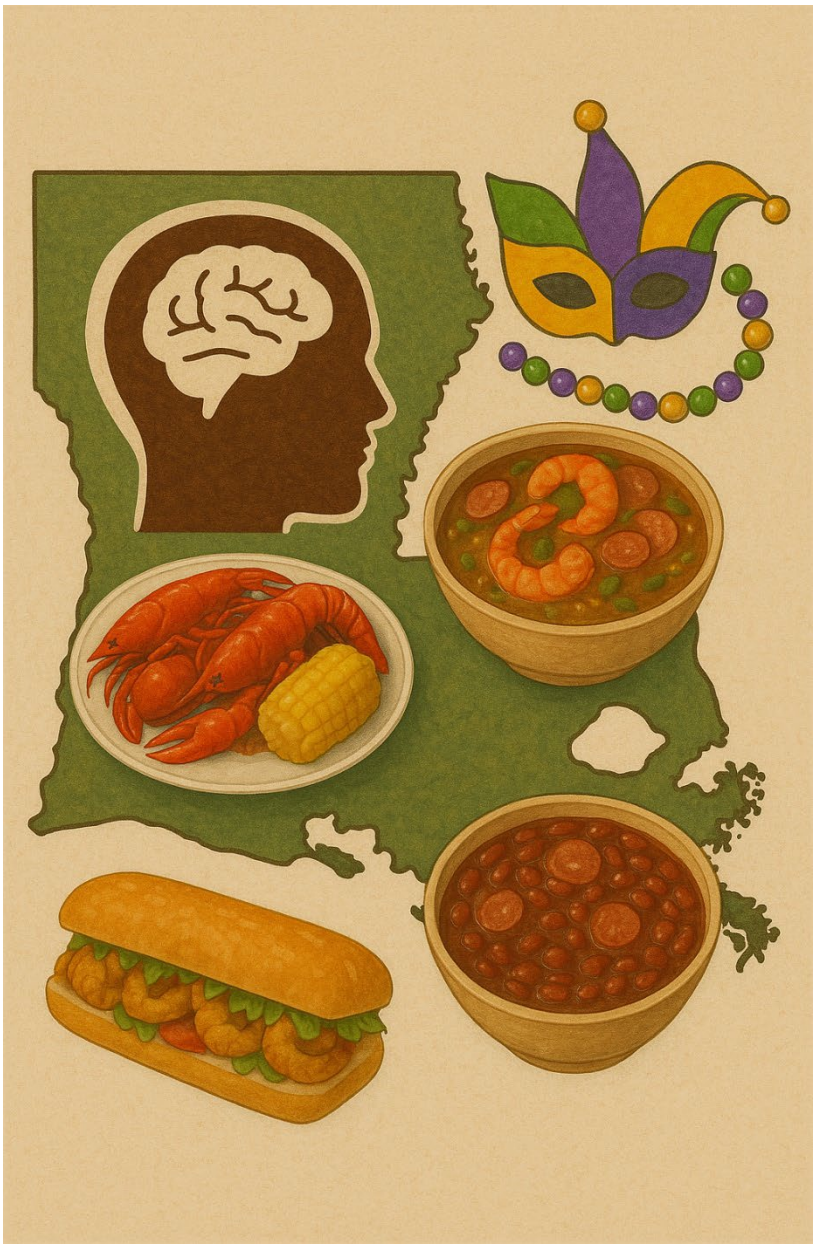

Center for Evidence to Practice

LSU Health NEW ORLEANS School of Public Health

Exploring Behavioral Health Services for Youth and Families in Louisiana: The 2024 Gaps and Needs Study

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INTRODUCTION

Gaps and needs assessments are used as evaluation tools to aid state behavioral health officials in identifying specific areas of strength and areas of inadequate behavioral service. This information can inform re-prioritizing and re-allocating resources effectively to address unmet needs within populations[5], including advancing evidence-based practices to best address prioritized needs.

A 2021 survey by the Louisiana Academy of Family Physicians reported that about 26% of Louisiana's mental health needs were being met, and funding for long-term prevention programs was limited.[4] To assess the strengths, gaps, and behavioral health needs of youth and families directly, the Louisiana State University's Center for Evidence to Practice (Center), in collaboration with the Louisiana Department of Health (LDH) - Office of Behavioral Health (OBH), conducted a survey to assess both workforce needs and gaps and the needs of those being served, with a primary focus on the population using Medicaid and access to evidence based practices.

METHODS

The Center conducted a three-pronged approach to assessing the gaps and needs in services for youth and their families in Louisiana. The first approach was to analyze the Medicaid claims from the most recent complete year (2023) which included information on diagnoses, services provided, and location of services throughout Louisiana. The next step was to complete a statewide Behavioral Health Gaps & Needs Survey of providers to understand their point-in-time perceptions on the state of the workforce. The survey aimed to identify gaps and needs in services, as well as strengths and challenges in the workforce. Finally, to better understand the findings generated by the survey, three focus groups of providers were gathered to explain what they believed the findings suggested.

Medicaid Data Analyses Methods

Medicaid data were gathered in aggregate form from January 2023 to June 2024 and transferred directly from Louisiana Medicaid to the Center using secure, encrypted sharing procedures. To present a full year of data, given a potential six-month Medicaid claims reporting, the current analysis included claims for visits from January 1, 2023 to December 31, 2023. The variables examined included age, diagnoses, zip code, and parish.

The analysis focused on claims for patients aged 0-18 identified as having had a primary or secondary mental health diagnosis during this study period, using the 2023 ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification).[10] Claims for patients aged 19 and above were excluded. Claims were grouped into respective diagnostic categories based on the first three digits of their ICD-10-CM codes according to primary diagnosis: adjustment disorders (F43), anxiety disorders (F41 and F42), bipolar affective disorders (F31), conduct disorders and mixed

disorders (F91 and F92), depression related disorders (F20, F32, F33, and F34), hyperkinetic disorders/Attention Deficit Hyperactivity Disorder (ADHD) (F90), other mental health and behavior disorders (Other FXX) and non-mental health and behavior disorders (Non FXX).

The following classification of the 10 Louisiana regions was used to group the parishes into regions, in keeping with LDH-OBH region designations:

- Region 1: Orleans, Plaquemines, St. Bernard
- Region 2: Ascension, East Baton Rouge, East Feliciana, Iberville, Point Coupee, West Baton Rouge, West Feliciana
- Region 3: Assumption, Lafourche, St Charles, St. James, St. John, St. Mary, Terrebonne
- Region 4: Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, Vermillion
- Region 5: Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis
- Region 6: Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, Winn
- Region 7: Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine, Webster
- Region 8: Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, West Carroll
- Region 9: Livingston, St. Helena, St. Tammany, Tangipahoa, Washington
- Region 10: Jefferson

Gaps & Needs Survey Methods

A survey was performed from August to September 2024 using the web-based platform REDCap. A total of 451 surveys were opened by behavioral health providers and agency representatives. Participants in the survey were recruited through emails from the Center's listserv (including but not limited to the Office of Behavioral Health and other associated Medicaid Managed Care Organizations (MCO)), providers listed on the Center's interactive provider map, and evidence-based practice training rosters of Louisiana providers. This was a convenience sample, and the opportunity to respond to the survey was not limited to only those on the Center's lists, as recipients (e.g., MCOs and providers) could forward the link to the survey.

The survey included multiple-choice and open-ended questions, covering demographic information, Medicaid MCO affiliation, and assessments of perceived workforce and care recipient gaps and needs. Additionally, the survey explored utilization of evidence-based practices (EBP) and other models of care. Branching logic within REDCap differentiated questions based on participant roles (direct provider or agency leadership representative); however, most questions were applicable to both groups. The Maslach Burnout Inventory-Human Services Survey (MBI-HSS) was included to measure emotional exhaustion, depersonalization, and personal accomplishment perceptions among behavioral health providers.[6]

Data analyses were conducted using Statistical Analysis System (SAS) software for quantitative data, with frequency statistics employed to summarize the results. For qualitative insights, open-ended questions assisted in exploring perceived barriers to EBP utilization with behavioral healthcare recipients as well as workforce needs. A thematic analysis approach was used to analyze, synthesize, and identify key patterns and themes from participant responses. This mixed-methods approach provided a more comprehensive understanding of the behavioral health gaps, strengths, needs, and challenges related to providing services for youth and families in Louisiana.

Focus Groups Methods

After survey findings were gathered, the preliminary results were reviewed and those requiring further exploration were identified. Three focus groups were gathered between December 2024 to January 2025. The groups included agency leadership and front-line staff (N=10). The focus groups were conducted as semi-structured group interviews. All groups were asked the following questions: "what has been the most challenging for you in considering, adopting, and maintain EBPs in your practice (based on similarities or differences from survey results, follow-up questions were asked);" "what kinds of support, resources, or training do you need to enhance services to children (based on similarities or differences from survey results, follow-up questions were asked);" and, "noting the top barriers providers and agency leaders stated from results of our Gaps and Needs survey, can you help us further understand what these might be in your experience?" The group responses were transcribed. Transcripts were then analyzed by ATLAS software, as well as two independent reviewers to arrive at themes and consensus on conclusions.

FINDINGS

Findings are presented in the same order as described in the methods. Claims data are provided, followed by survey results, and then concluding with focus group themes.

MEDICAID CLAIMS RESULTS

Findings from our Medicaid analysis showed more than half of youth (0-18) were diagnosed with hyperkinetic/ADHD disorders, most notably in Regions 5 and 10 of Louisiana.

The data analyzed included 1,336,089 claims. Each claim represents a billable service delivered through Medicaid to children aged 0-18 identified as having had a primary or secondary mental health diagnosis during this study period. While the data do not indicate the unique number of individuals with a particular diagnosis, they indicate the proportion of service delivery associated with the diagnosis. The prevalence of behavioral health claims (e.g., volume) related to 2023 Louisiana Medicaid billing requests for youth and the count of primary diagnoses grouped in behavioral health disorders diagnostic categories are presented in Table 1. Furthermore, the median, minimum, and maximum prevalence across parishes are also reported in Table 1.

Overall, hyperkinetic /ADHD disorders were the most prevalent diagnoses (56.1%) among all claims for patients aged 0-18. This diagnostic group was followed by conduct and mixed disorders (11.1%), depressive disorders (11.0%), adjustment disorders (10.4%). Parishes' individual prevalence is reported in Supplemental Table A.

Across all parishes, the median prevalence of hyperkinetic/ADHD disorders was 55.1%, ranging from 34.3% in Catahoula and East Feliciana to 79.1% in Cameron Parishes (Figure 1A, Supplement Table A). The median prevalence of adjustment disorders was 10.7%, ranging from 2.4% in Natchitoches to 29.0 % in St Helena Parishes (Figure 1B, Supplement Table A).

The median prevalence of conduct disorders and mixed disorders was 10.3%, ranging from 0.8% in Allen to 55.2% in East Carroll Parishes (Figure 2A, Supplement Table A). The median prevalence of depression disorders was 11.6%, ranging from 1.1% in Cameron to 23.6% in Catahoula Parishes (Figure 2B, Supplement Table A).

The region's summary data is detailed in Tables 2 and 3. Results across regions were very similar to overall state results and, as expected, within parishes' minimum and maximum. As in the state summary, hyperkinetic/ADHD disorders were the most prevalent claims across all ten Regions, ranging from 49.9% in Region 10 to 61.7% in Region 5.

Table 1: Prevalence and count of 2023 Medicaid claims for youth (ages 0-18) grouped in diagnostic category in Louisiana and median, min and max values across parishes (n=1,336,089).

Diagnostic Categories	State, % (n)	Parish, median (min – max)
Adjustment Disorder (F43)	10.4 (139,236)	10.7 (2.4 – 29.0)
Anxiety Disorder (F41 and F42)	5.4 (72,546)	5.8 (0.2 – 11.3)
Bipolar affective disorder (F31)	1.2 (15,390)	1.0 (0.1 – 4.7)
Conduct disorders and mixed disorders (F91 and F92)	11.1 (147,674)	10.3 (0.8 – 55.2)
Depression Disorder (F20, F32, F33, and F34)	11.0 (147,478)	11.6 (1.1 – 23.6)
Hyperkinetic disorders/ADHD (F90)	56.1 (749,729)	55.1 (34.3 – 79.1)
Other Mental health and Behavior disorders (Other FXX)	4.2 (55,672)	3.8 (0.7 – 19.8)
Non-Mental Health and Behavior disorders (Non FXX)	0.6 (8,364)	0.6 (0.1 – 5.0)

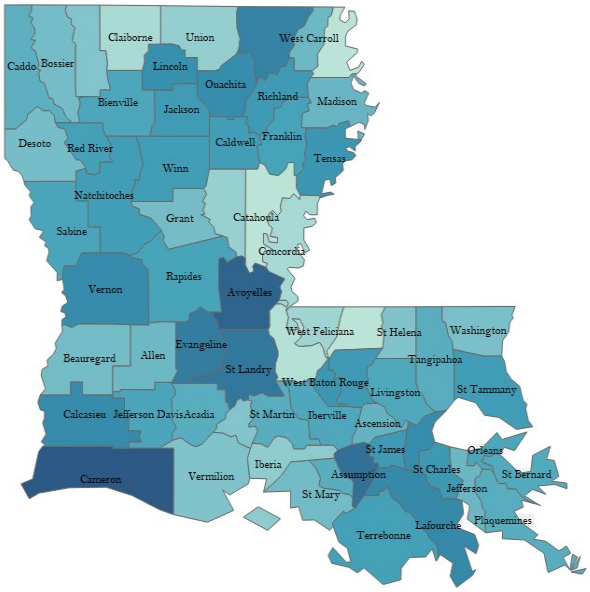
Table 2: Prevalence and count of 2023 Medicaid claims for youth (ages 0-18) grouped by diagnostic category presented within each region 1 to 5 (n=1,336,089).

	Region, % (n)				
Diagnostic Categories	**1**	**2**	**3**	**4**	**5**
Adjustment Disorder (F43)	10.8 (8,972)	9.2 (16,020)	11.2 (15,018)	12 (17,618)	14.1 (11,206)
Anxiety Disorder (F41 and F42)	4.8 (3,948)	5 (8,775)	6.8 (9,150)	6.2 (9,088)	5 (3,951)
Bipolar affective disorder (F31)	1.2 (987)	0.9 (1,636)	0.9 (1,175)	1.3 (1,904)	1.3 (1,049)
Conduct disorders and mixed disorders (F91 and F92)	11 (9,065)	11.9 (20,726)	6.9 (9,277)	11.7 (17,182)	4.7 (3,738)
Depression Disorder (F20, F32, F33, and F34)	11.9 (9,881)	10.7 (18,611)	9.2 (12,369)	10.9 (15,976)	8.2 (6,526)
Hyperkinetic disorders/ADHD (F90)	55.4 (45,787)	56.8 (98,925)	60.1 (80,665)	53.2 (78,206)	61.7 (48,942)
Other Mental health and Behavior disorders (Other FXX)	4.0 (3,339)	4.7 (8,154)	4.4 (5,889)	4.4 (6,430)	4.2 (3,352)
Non-Mental Health and Behavior disorders (Non FXX)	0.9 (728)	0.7 (1,218)	0.5 (672)	0.5 (715)	0.8 (610)
Total	6.2 (82,707)	13.0 (174,065)	10.1 (134,215)	11.0 (147,119)	6.0 (79,374)

Table 3: Prevalence and count of 2023 Medicaid claims for youth (ages 0-18) grouped by diagnostic category presented within each region 6 to 10 (n=1,336,089).

	Region, % (n)				
Diagnostic Categories	**6**	**7**	**8**	**9**	**10**
Adjustment Disorder (F43)	7.2 (8,043)	8.5 (13,984)	8.3 (18,542)	14.1 (19,838)	13 (9,995)
Anxiety Disorder (F41 and F42)	5.2 (5,873)	4.1 (6,681)	3.2 (7,172)	8.1 (11,412)	8.5 (6,496)
Bipolar affective disorder (F31)	0.7 (834)	2.3 (3,798)	0.7 (1,481)	1.2 (1,735)	1 (791)
Conduct disorders and mixed disorders (F91 and F92)	12.4 (13,925)	10.7 (17,645)	18.2 (40,818)	7 (9,907)	7 (5,391)
Depression Disorder (F20, F32, F33, and F34)	11.5 (12,938)	18.4 (30,248)	7.4 (16,627)	9.7 (13,640)	13.9 (10,662)
Hyperkinetic disorders/ADHD (F90)	57.7 (64,867)	51.7 (84,906)	58.7 (131,958)	54.9 (77,255)	49.9 (38,218)
Other Mental health and Behavior disorders (Other FXX)	4.3 (4,878)	3.7 (6,126)	3.1 (6,919)	4.4 (6,126)	5.8 (4,459)
Non-Mental Health and Behavior disorders (Non FXX)	0.9 (971)	0.6 (930)	0.5 (1,103)	0.6 (788)	0.8 (629)
Total	8.4 (112,329)	12.3 (164,318)	16.8 (224,620)	10.5 (140,701)	5.7 (76,641)

Figure 1: **Prevalences of Hyperkinetic/ADHD disorders (A) and Adjustment Disorders (B) Medicaid claims for youth (ages 0-18) within each Louisiana parish.**



A: Hyperkinetic/ADHD

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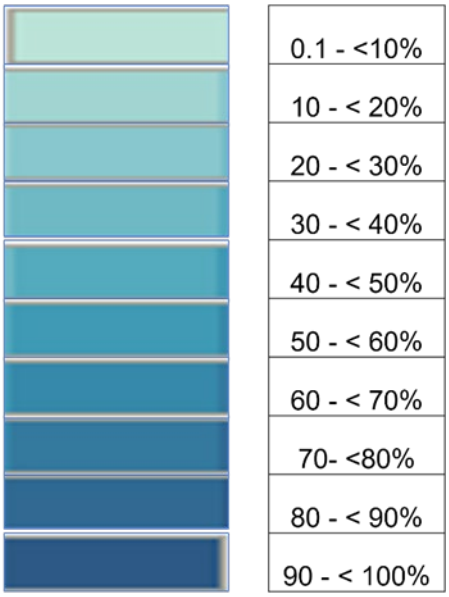
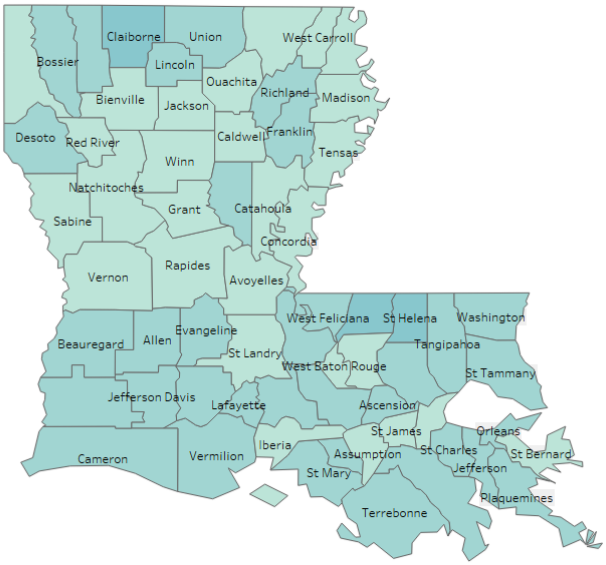
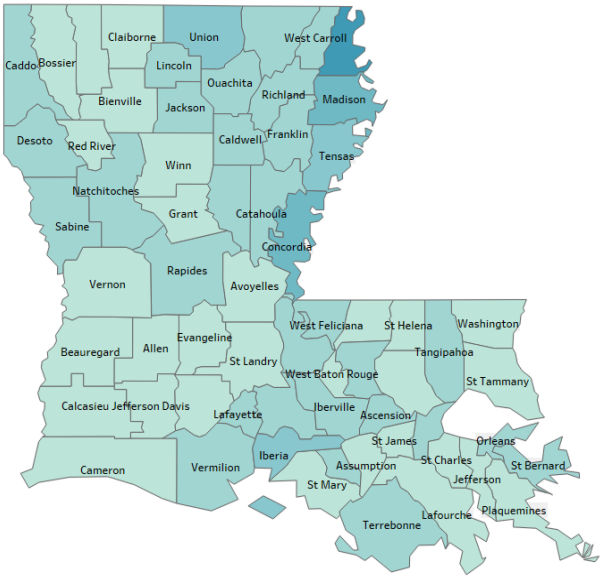




B: Adjustment disorders

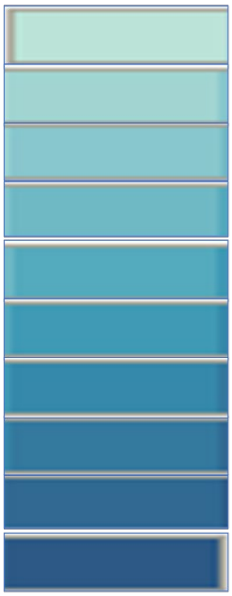
Figure 2: **Prevalences of Conduct and Mixed disorders (A) and Depression (B) Medicaid claims for youth (ages 0-18) within each Louisiana parish.**



A: Prevalence of Conduct and Mixed Disorders

B: Depression

KEY:



0.1 - <10%
10 - < 20%
20 - < 30%
30 - < 40%
40 - < 50%
50 - < 60%
60 - < 70%
70- <80%
80 - < 90%
90 - < 100%

SURVEY RESULTS

As this was a convenience sample and the survey link could be forwarded by recipients to colleagues, the total number of potential participants and a response rate could not be determined. According to the REDCap survey software, a total of 451 people opened the survey. Of those, 435 participants selected whether they were an individual provider or agency leader, and 16 did not respond to that initial question. Of the 435, 318 respondents completed or partially completed the remaining survey questions. These respondents (N=318) are described in the first section on demographics. The second section reports responses from agency level leadership regarding their perceptions of their agency's services and who they provide these services to. One hundred eleven agency leaders (n=111) responded to the survey of which 79 *completed* the survey in its entirety and 32 *partially completed* the survey. The third section illustrates the responses (n=207) from individual providers (some working for agencies and others working as solo practitioners or partners in smaller practices), of whom 189 providers *completed* the survey entirely and 18 *partially completed* the survey. These individual practitioners were also asked additional questions regarding burnout which are described at the end of the third section. Readers will note that individual item responses varied, thus the "n" for each survey question is presented with each figure and/or finding.

SECTION I- RESPONDENT DEMOGRAPHICS

Overall, the demographics show a representation of agencies and providers from across Louisiana, with respondents who were mostly female and serving a mix of urban and rural locations.

Demographics were gathered from both agency leaders and individual providers responding to the survey. Several demographic questions were posed as "select all that apply" options, and as stated above, not all questions were answered by all respondents. Thus, the number of respondents is offered for each item and the percentage of items selected may total more than 100%. Overall, the demographics show a representation of agencies and providers from across Louisiana. These respondents also offer a diverse demographic profile as described below.

When asked to describe their gender, race, ethnicity, and education, most self-identified as White (n=169/58%) or Black/African American (37%/ n=110), non-Hispanic (89%/ n=279), female (81%/ n=233) who have achieved a master's in counseling (29% n=81). Proportionately, this was mostly similar between agency leaders and individual providers (White 63% vs 58%, Black/African American 34% vs. 40%, non-Hispanic 96% vs 98%, female 70% vs. 86%, and master's degree in counseling 30% vs. 27% respectively).

When asked to describe the location of their agency and/or services, leaders (n=87 completed responses) described their agencies serving a variety of locations with 32% (n=28) providing services in urban areas primarily, 25% (n=21) of agencies served in predominantly rural areas, and 40% served both rural and urban areas (see Table 4). The top five parishes most often reported by leaders regarding their agency services were Orleans, Jefferson, Tangipahoa, Ouachita, and St. Tammany.

When asked the same question, individual providers described somewhat similar locations of services. Forty-seven percent (47%/ n=89) of individual providers stated they work in urban areas (urban only+ mostly urban) 23% (n= 45) of providers stated they work in rural areas (rural only+ mostly rural). See Table 3 below. A breakdown of parishes was also assessed with 61% (n= 116) of individual providers indicating practicing primarily in Orleans, Tangipahoa, and Jefferson; however, maps below show the density of providers reporting services in all parishes of Louisiana (Figures 3 and 4).

Table 4: Agency leader and provider demographics

Demographic	Agency Leadership % (n)	Providers % (n)	All
Race			
White/Caucasian	63 (50)	58 (119)	58 (169)
Black/African American	34 (27)	40 (83)	37(110)
American Indian/Alaskan Native	0 (0)	1 (3)	1 (3)
Asian	0 (0)	0 (0)	0 (0)
Native Hawaiian / Pacific Islander	0 (0)	0 (0)	0 (0)
Other	0 (0)	2 (4)	1 (4)
Decline to Answer	4 (3)	2 (4)	2(7)
Ethnicity			
Hispanic	4 (3)	2 (4)	2(7)
Non-Hispanic	96 (76)	98 (203)	89 (279)
Gender			
Female	70 (55)	86 (178)	233 (81)
Male	27 (21)	13 (27)	48 (17)
Nonbinary	0 (0)	1 (2)	0.7 (2)
Decline to Answer	4 (3)	0.5 (1)	4 (1)
Educational Background			
Doctorate Psychology	3 (2)	2 (4)	2 (6)
Doctorate Marriage and Family Therapy	3 (2)	0.5 (1)	1 (3)
Doctorate Counseling	3 (2)	0.5 (1)	1 (3)
MD	1 (1)	2 (5)	2 (6)
Master Counseling	30 (24)	27 (56)	29 (81)
Master Social Work	19 (15)	45 (93)	39 (108)
Master Business Admin	8 (6)	0 (0)	2 (6)
Master Psychology	6 (5)	3 (7)	4 (12)
Master Marriage & Family Therapy	1.3 (1)	1 (2)	1 (3)
Bachelor Psychology	1.3 (1)	0.5 (1)	0.8 (2)
High School or Equivalent (GED)	4 (3)	2 (5)	3 (8)
None of the above	4 (3)	0 (0)	1(3)

Other	18 (14)	11 (22)	13 (36)
Licenses Achieved			
LPC, LMHC, LCPC, LPCC, LCMHC, LMHP	55 (29)	35 (63)	35 (92)
LCSW	21 (11)	43 (76)	33 (87)
LMFT	13 (7)	4 (7)	5.4 (14)
Licensed Addiction Counselor	11 (6)	7 (13)	7 (9)
Licensed Psychologist	4 (2)	2 (3)	2 (5)
Other	17 (9)	20 (35)	17 (44)
Regions Served[1]			
Region 1	39 (9)	48 (10)	9 (87)
Region 2	43 (10)	43 (9)	9 (86)
Region 3	34 (8)	43 (9)	8 (77)
Region 4	55 (13)	65 (13)	13 (120)
Region 5	22 (5)	12 (2)	4 (34)
Region 6	23 (5)	29 (6)	6 (52)
Region 7	45 (11)	69 (14)	12 (114)
Region 8	121 (29)	107 (21)	25 (228)
Region 9	26 (6)	62 (12)	10 (88)
Region 10	15 (4)	20 (4)	4 (35)
Agency/Service Locations			
Urban Only or Mostly Urban	32 (28)	48 (91)	43 (119)
Rural Only or Mostly Rural	24 (21)	23 (43)	23 (64)
50% Urban & 50% Rural	44 (38)	29 (55)	34 (93)

[1]Providers and agencies can serve multiple regions.

LPC (Licensed Professional Counselor), LMHC (Licensed Mental Health Counselor), LCPC (Licensed Clinical Professional Counselor), LPCC (Licensed Professional Clinical Counselor), LCMHC (Licensed Clinical Mental Health Counselor), LMHP (Licensed Mental Health Professional)

Figure 3: Parishes reported served by <u>agency leadership</u> (n=111)

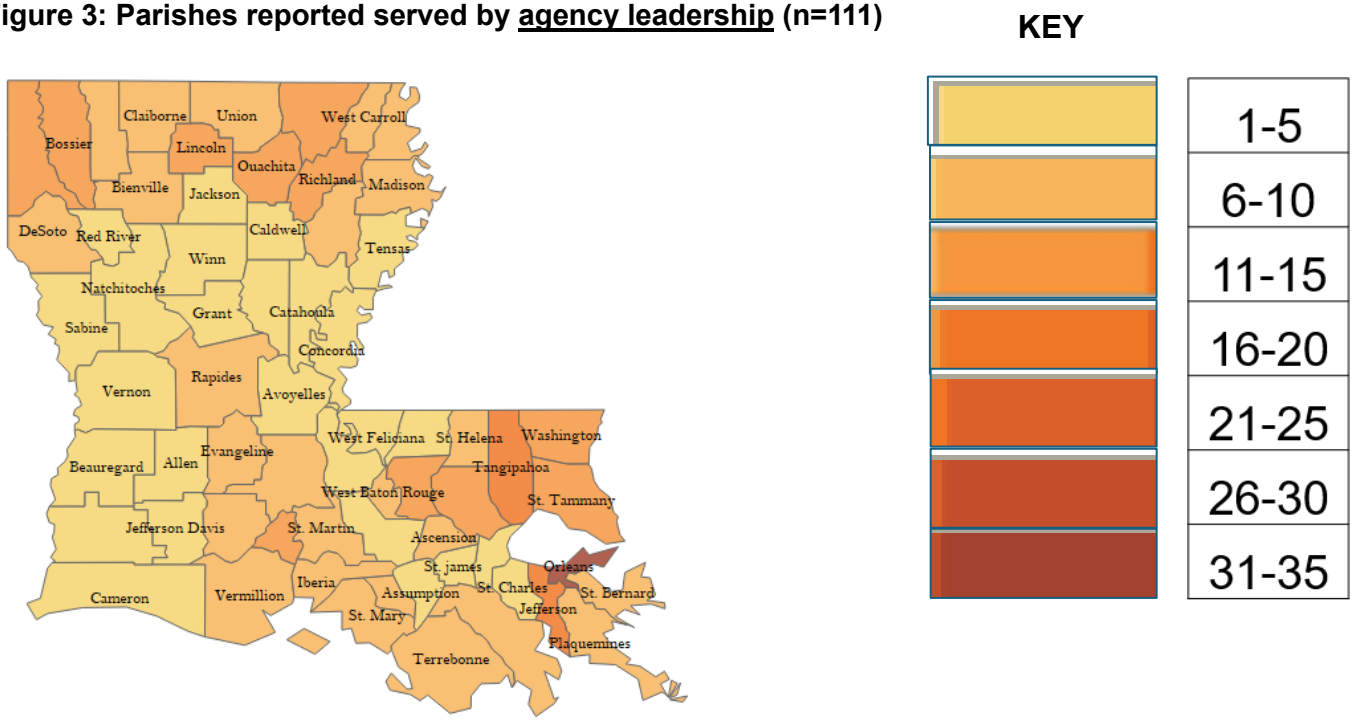
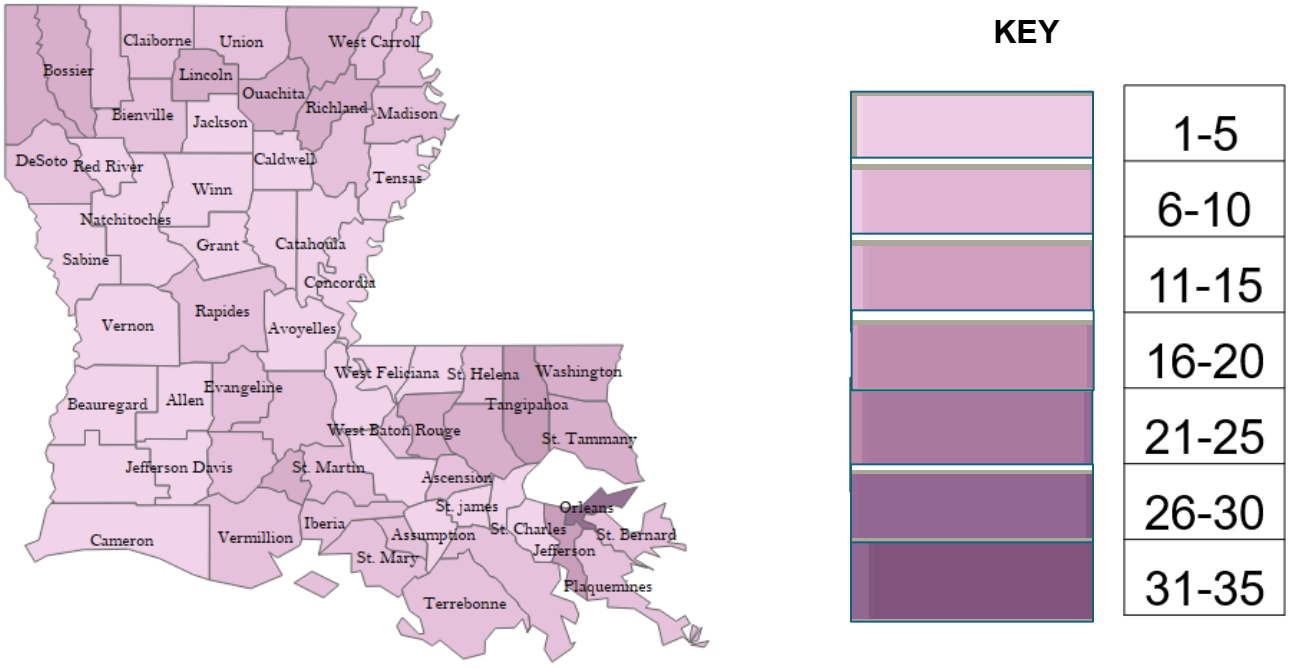


Figure 4: Parishes reported served by <u>individual providers</u> (n=116)

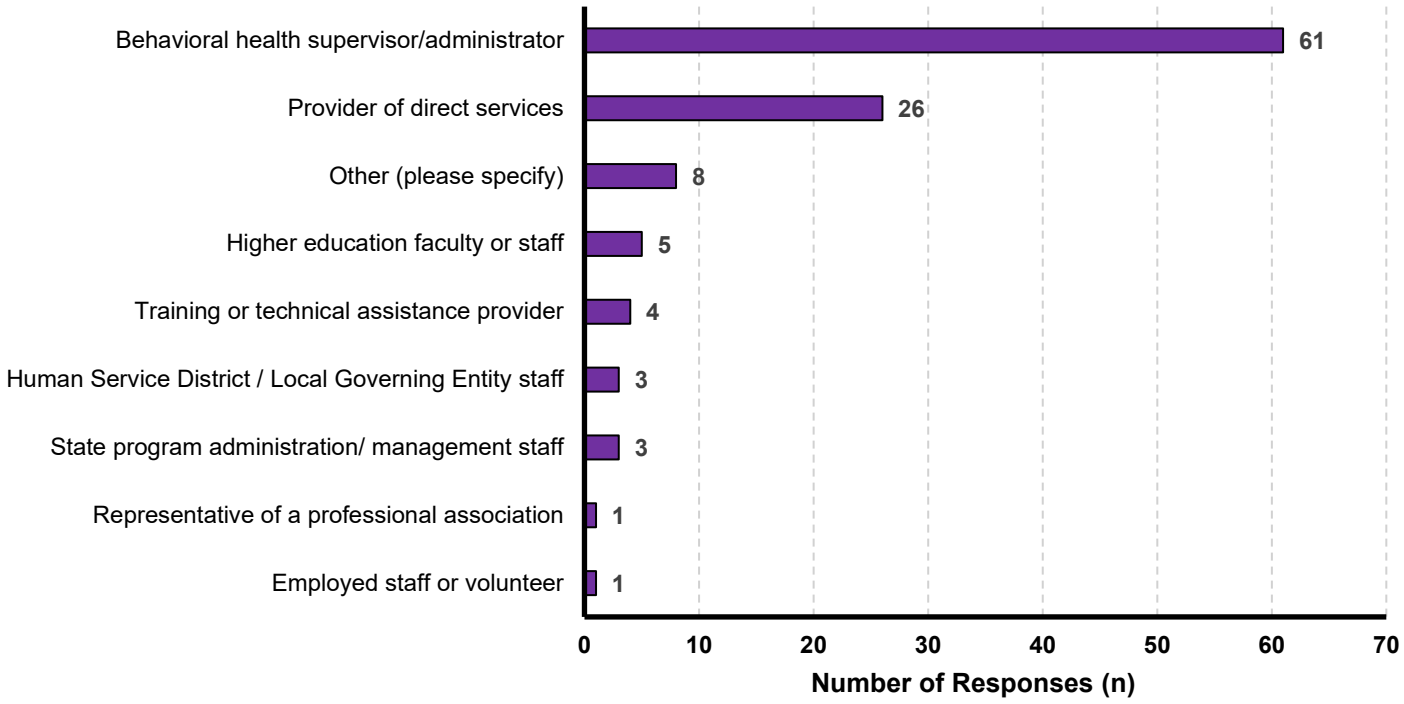


SECTION II- AGENCY LEADERSHIP RESPONSES

Agency leaders described maintaining Medicaid contracts and serving steady or growing referrals for populations that are primarily socioeconomically stressed with histories of trauma. Cognitive Behavioral Therapy was a common approach to treatment; however, "not using EBPs" was noted by 22% of the agencies. This suggests areas of potential growth, particularly as many agencies had more than twenty fulltime staff to perform this work and described opportunities to develop unlicensed providers and student interns. When asked if they could expand EBPs to address problems in their communities, they selected that they would target specific issues associated with anxiety, depression, and parenting challenges.

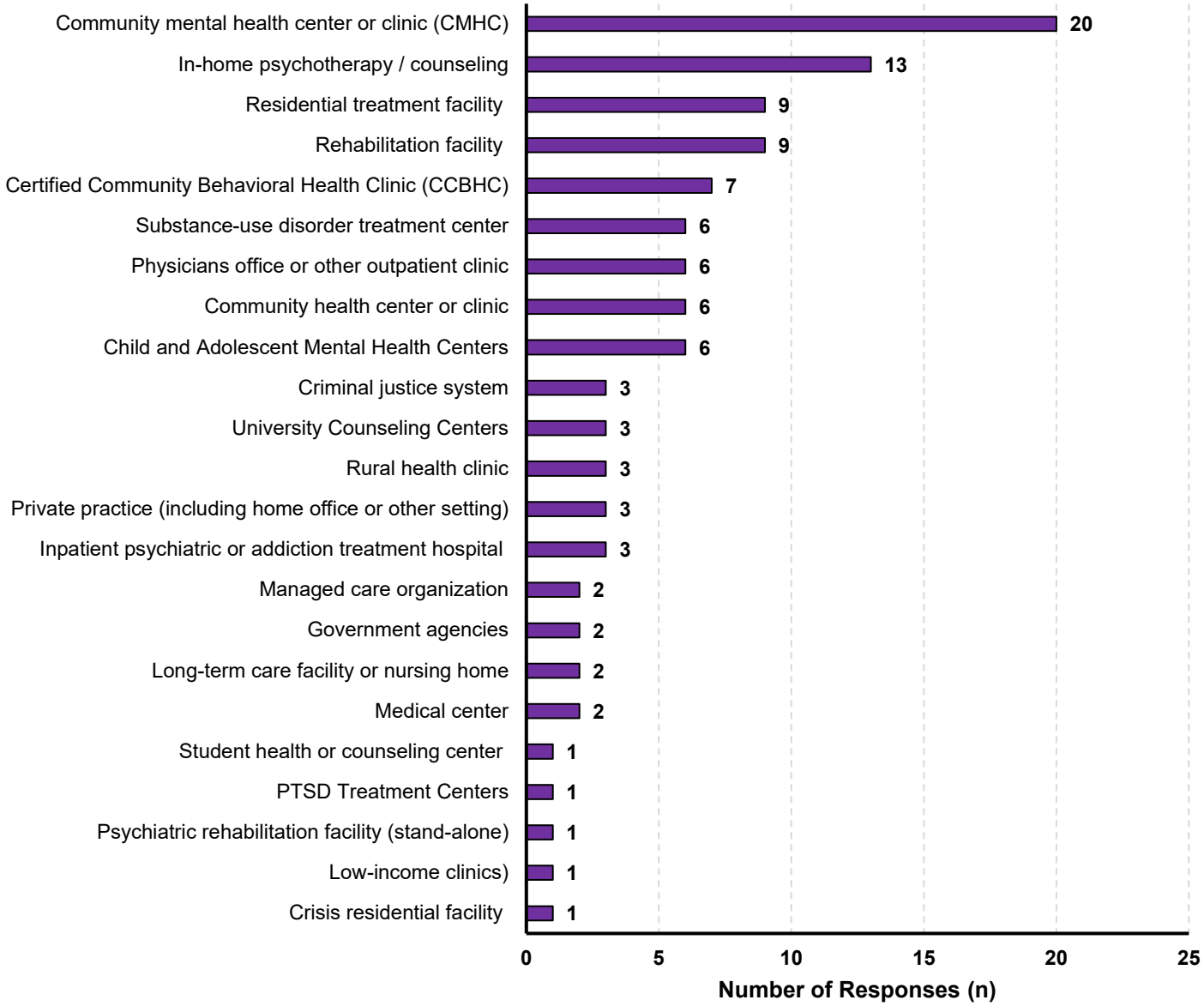
An objective in administering this survey involved ascertaining the perceptions of agency leaders about themselves, their agency, and the behavioral health services the agency provides, particularly related to youth and families. Agency leaders were asked to describe their role(s) in the behavioral healthcare system in a "select all the apply" response option. Over three quarters (77%/ n=61) described themselves as a behavioral health supervisor/administrator, and a third (33%/ n=26) also self-reported offering direct services. Figure 5 summarizes these findings.

Figure 5: Role in behavioral healthcare system (check all) (n= 79)



Types of Agencies – The survey asked agency leadership to describe the type of agency they were leading. This question was a "select all that apply" option. Just under one-quarter (23%/ n=20) reported they were a community mental health center/clinic, followed by those that said they provided in-home psychotherapy or counseling (15%/ n=13). See Figure 6 for details.

Figure 6: Types of agencies (check all) (n= 72)



Client Population- Agency leaders responded to questions regarding the age, race/ethnicity, and characteristics that describe the people they serve. Agencies reported the highest percentage of clients served were African American (23%/n= 81) or White (23%/ n=81) who varied widely in ages, with most clients served (53%/ n=262) between the ages of 12 and 49. The characteristics of these populations served were most frequently described as experiencing low SES (90%/ n=99), survivors of trauma (86%/ n=95), and/or being parents (81%/ n=89). Note- respondents checked all that apply to these questions. See Figures 7, 8, 9 for details.

Figure 7: Client age group distribution (check all) (n=111)

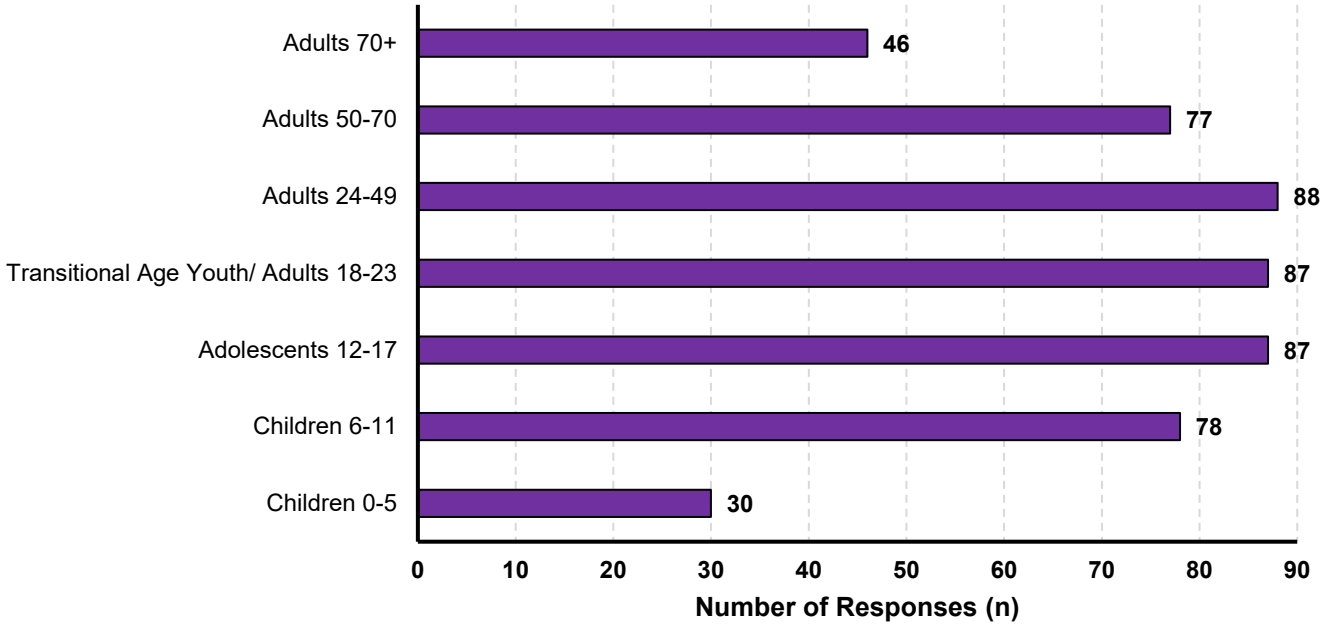


Figure 8: Client race and ethnicity (check all) (n=111)

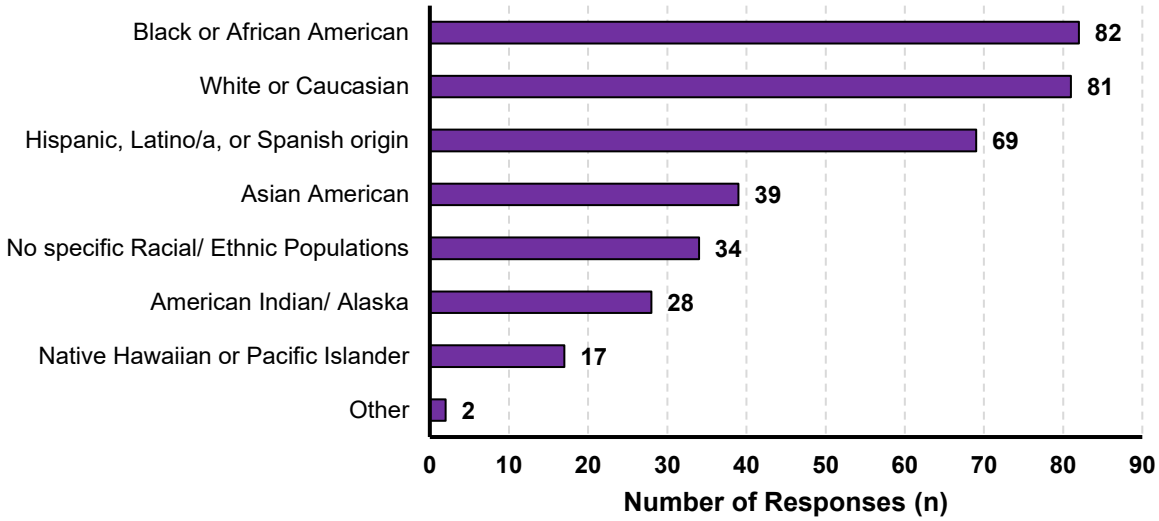
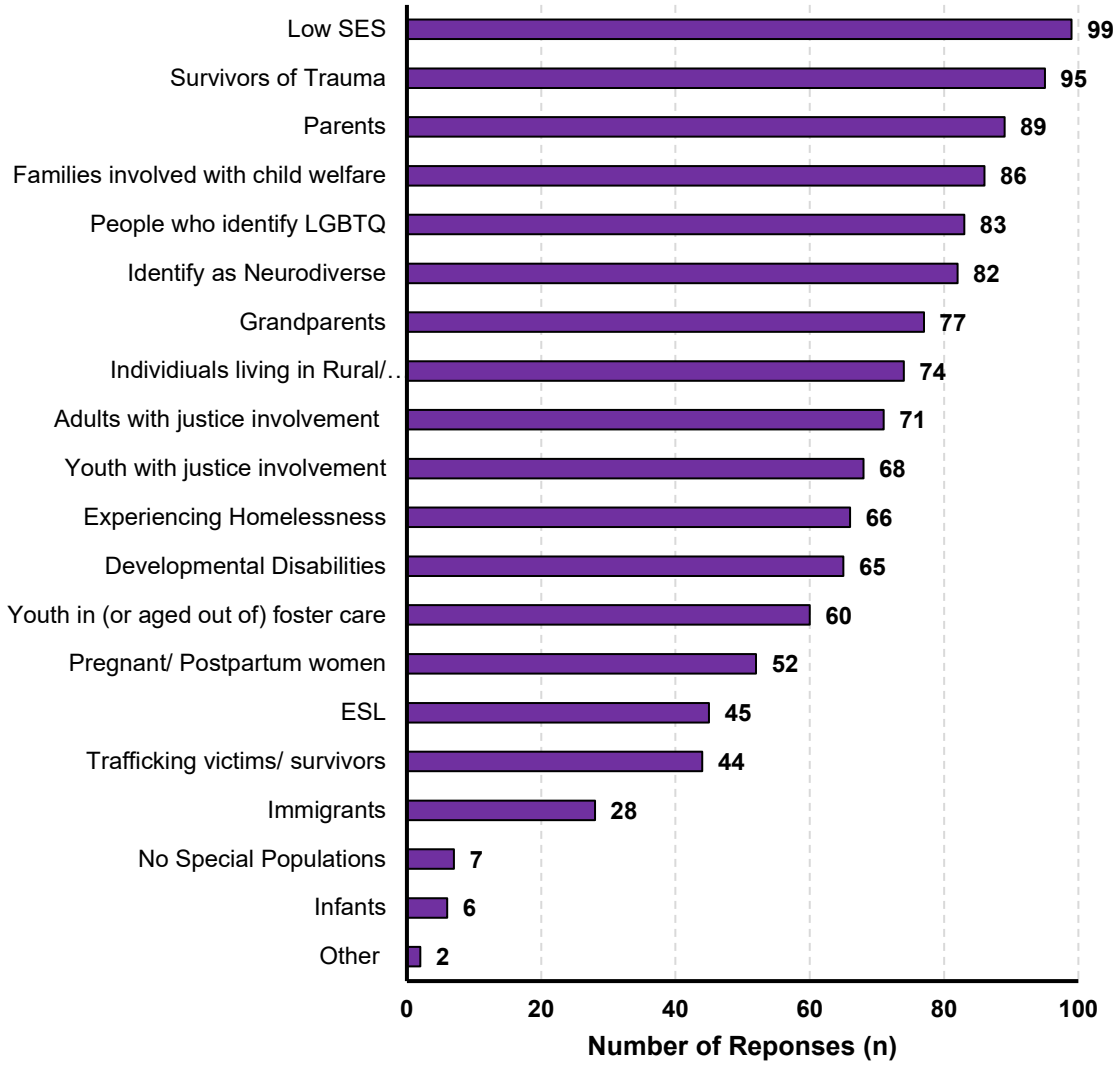


Figure 9: Client population characteristics (check all) (n=110)



Treatment focus- 110 agency leaders responded to the questions about treatment focus and approaches to providing these behavioral health services. Of those, almost half (48%/ n=53) stated that their organizations focused on treating mental health. They were then asked to "check all that apply" as to how they would categorize the treatment delivery methods employed by their agency in a "typical week". Individual therapy/counseling (71%/ n=78) and/or telehealth services (56%/ n=62) were most selected options. See Figures 10, 11 below.

Figure 10: Treatment focus described by agencies (n=110)

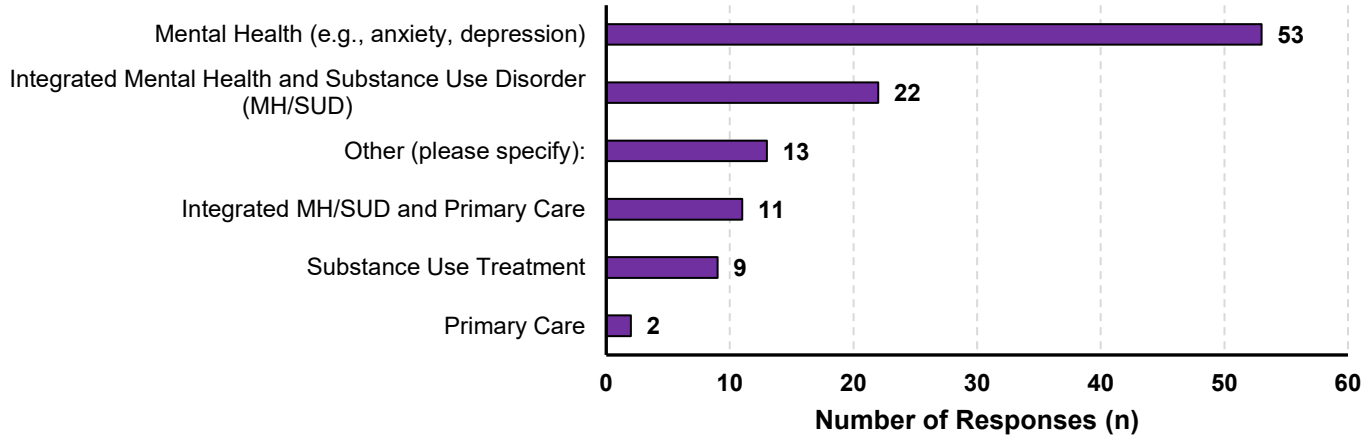
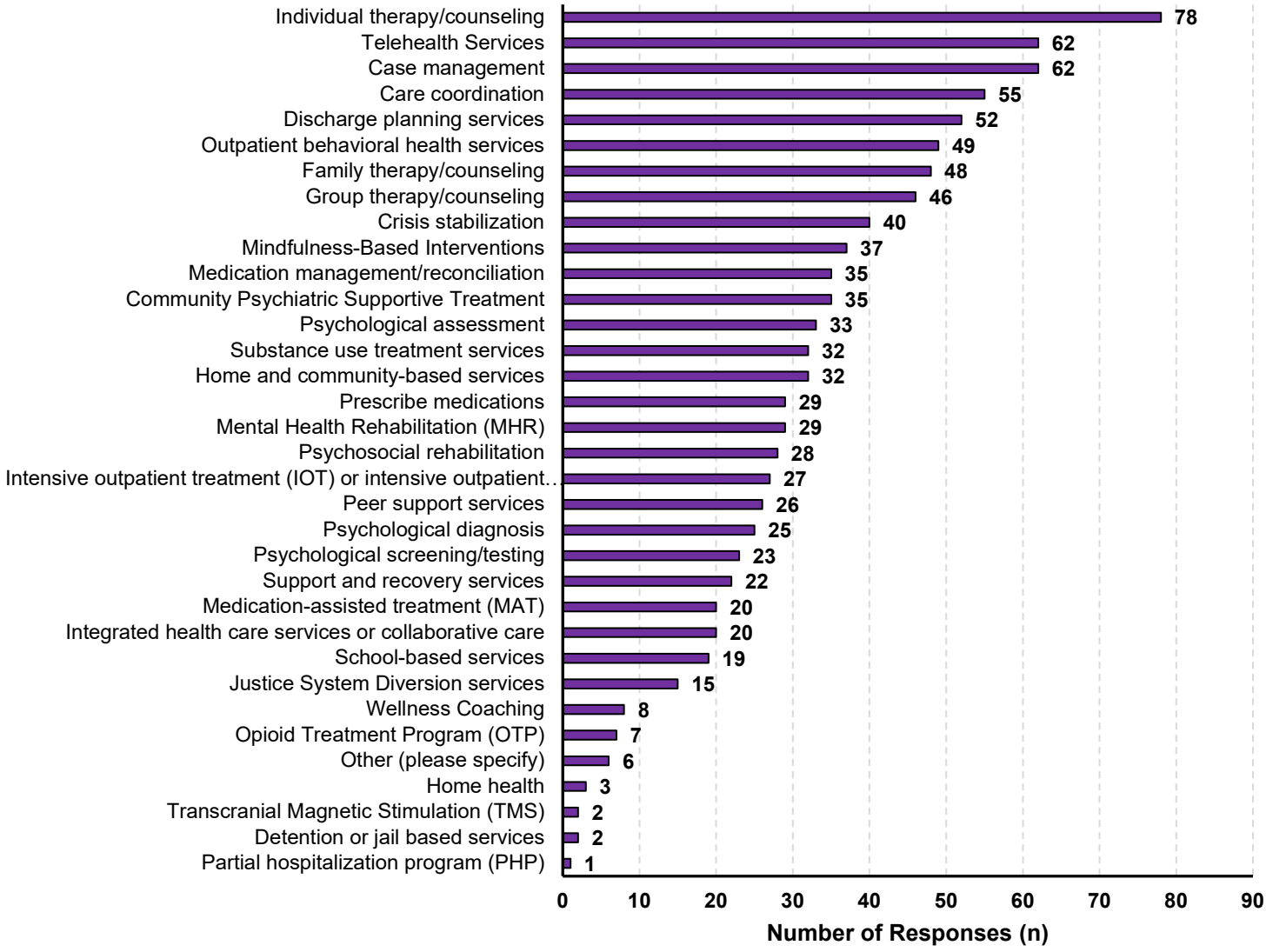
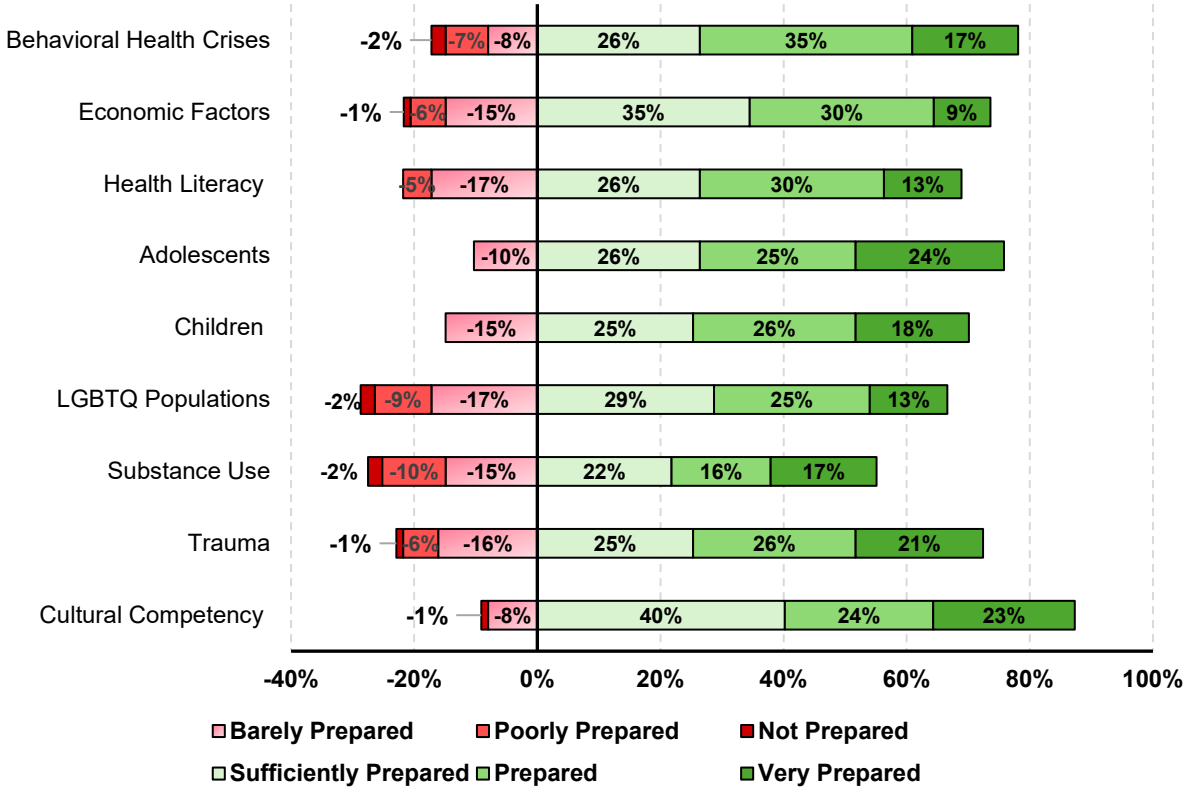


Figure 11: Approaches to treatment (n=110)



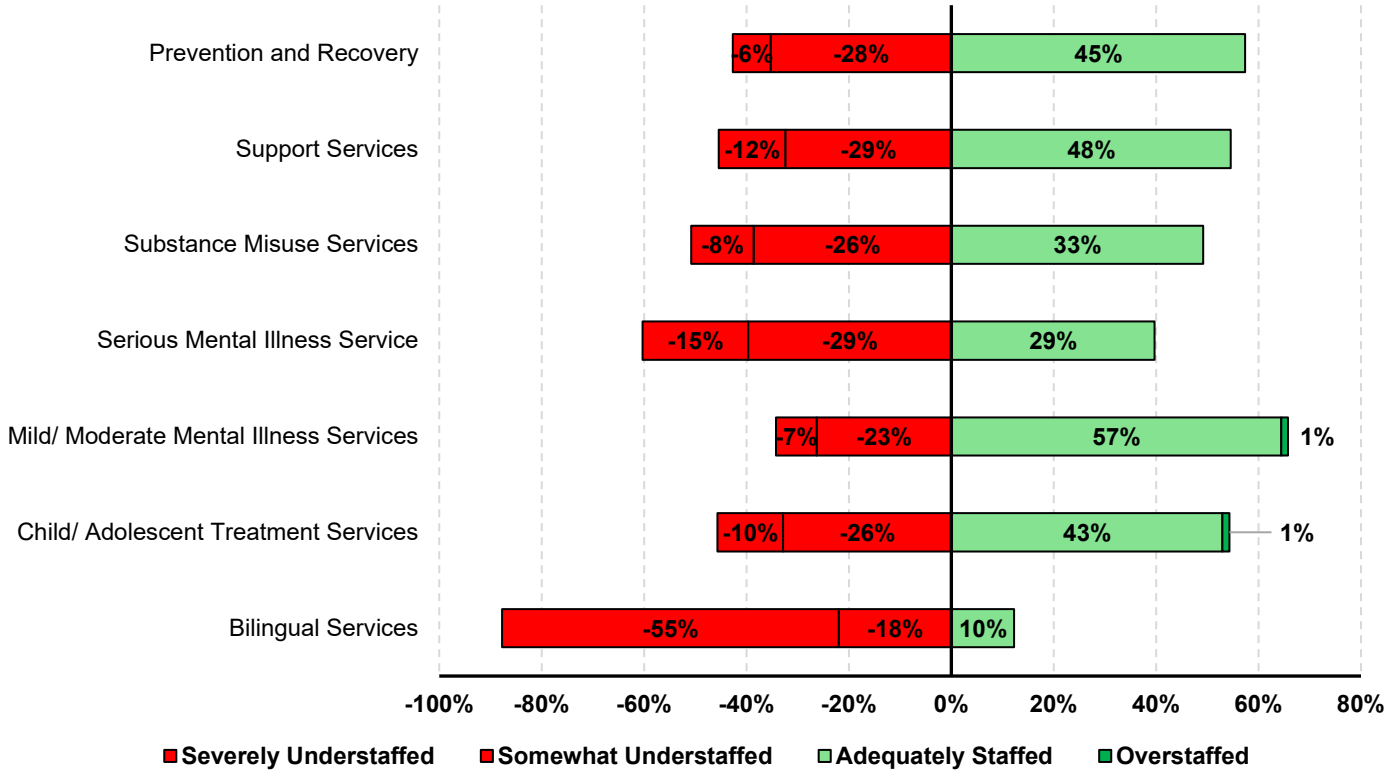
Agency leaders were asked to report on the degree of preparedness for specific service categories. Eighty-seven of the 111 agency leaders responded to this question. Of those, many reported being sufficiently to very prepared in most areas. The three areas that agencies reported being least prepared to address (noting variation agency to agency) were working with LGBTQ populations, populations contending with substance misuse, and trauma in populations. See Figure 12.

Figure 12: Perception of readiness in relation to behavioral health services (n= 87)



Agency leaders (n=87) described how they perceived their staffing appropriateness related to specific aspects of behavioral health service delivery. These respondents reported being adequately to overstaffed to provide services for mild/moderate mental illness issues (58%/ n=50) and support services (48%/ n=42). Agencies reported being most understaffed (severely to somewhat) in rendering bilingual services (74%/ n=64). (See Figure 13).

Figure 13: Staffing adequacy to parts of behavioral health delivery (n= 87)



EBP Utilization- The Center, in its partnership with OBH, focuses on the development of EBPs in the behavioral health workforce. When asked about the types of evidence-based and research-informed practices utilized by these agencies (select all that apply), agency leaders reported CBT (53%/ n=46), MI (39%/ n=34), TF-CBT (36%/ n=31), EMDR (33%/ n=29), and DBT (25%/n=22) the most. Not using EBPs was noted by 22% (n=19) of the agencies. This suggests areas of potential growth for agency level recruitment to provide EBPs. See Figure 14.

When asked to select the one EBP the agency utilizes most frequently (if they selected more than one), agencies reported CBT (30%/ n=26) (Figure 15).This coincided with agency leaders' responses that suggested, if they could expand EBPs to target specific issues for people in their agency's care, they would want to focus on depression (61%/ n= 53), anxiety (55%/ n= 48), and parenting challenges (49%/ n= 43) (Figure 18). When asked about ways agencies aim to ensure proper fidelity to an EBP model, they noted providing time off or funding for individual training/ education in EBP (49%/ n=43), offering specific supervisor and/or general guidance (49%/ n=43), and workshops or seminars (43%/ n= 37) as the top three approaches (Figure 16). Agency leaders also noted in order to stay up on specific EBP requirements, they primarily participate in trainings/ continuing education programs associated with each EBP (60%/ n= 52) (Figure 17).

Figure 14: EBPs sustained by agencies (check all) (n=87)

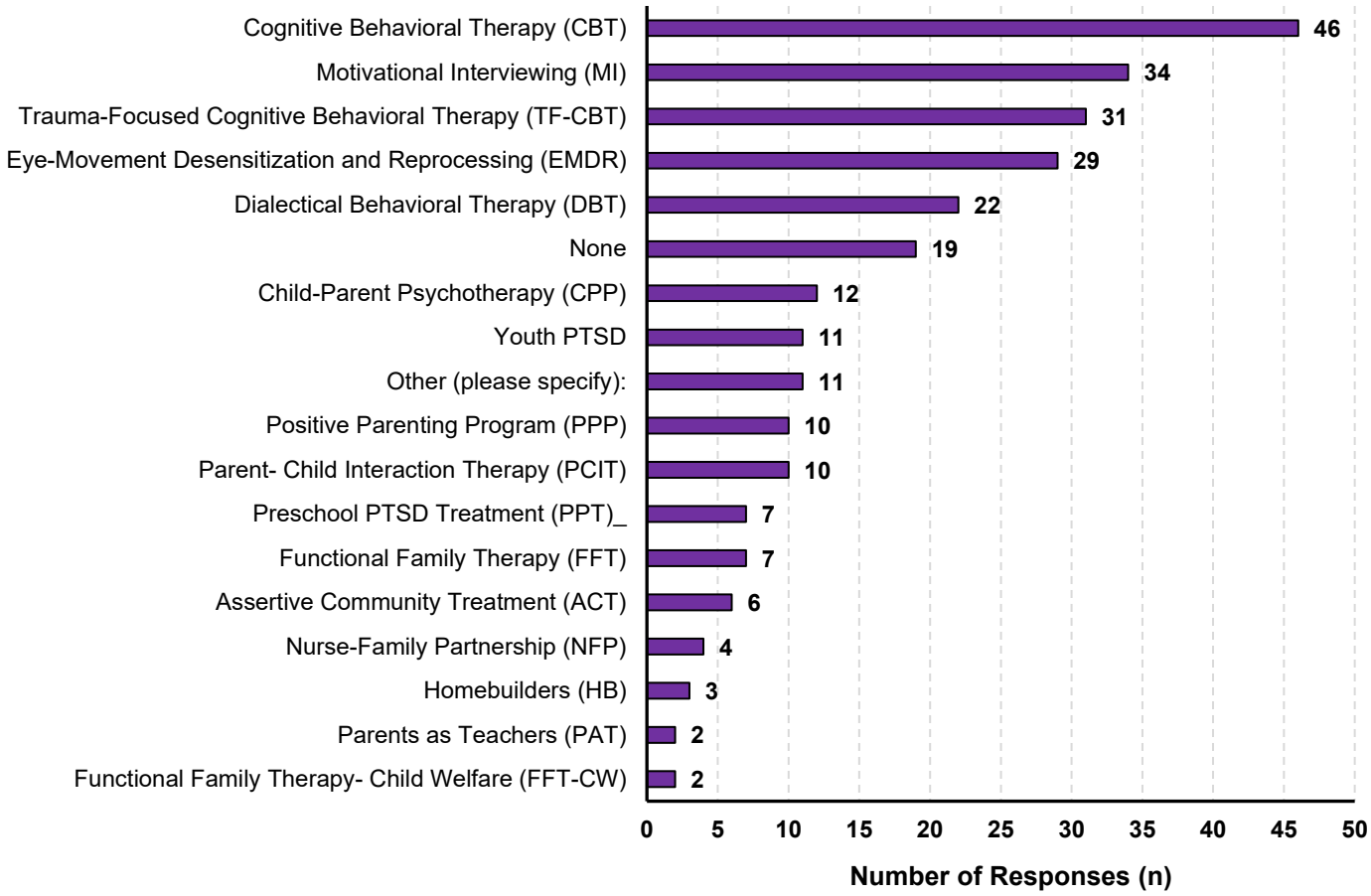


Figure 15: Most used EBP if selected more than one (n=69)

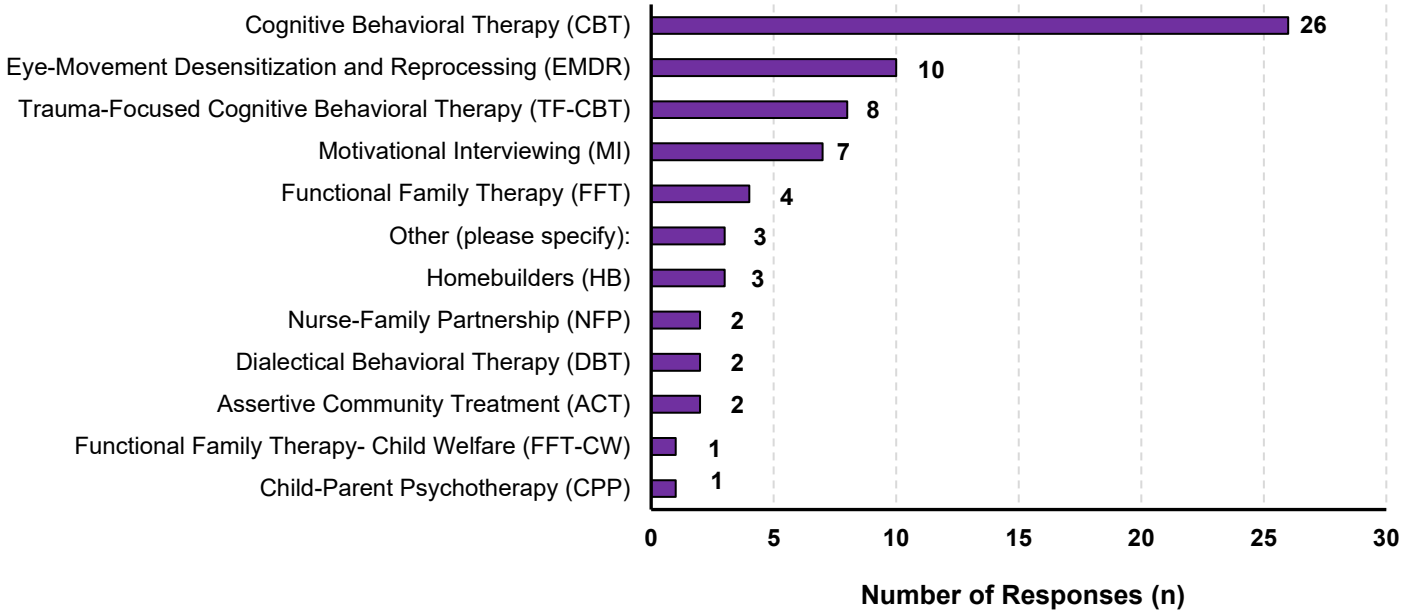


Figure 16: Tools implemented to increase quality and fidelity to an EBP model (n=87)

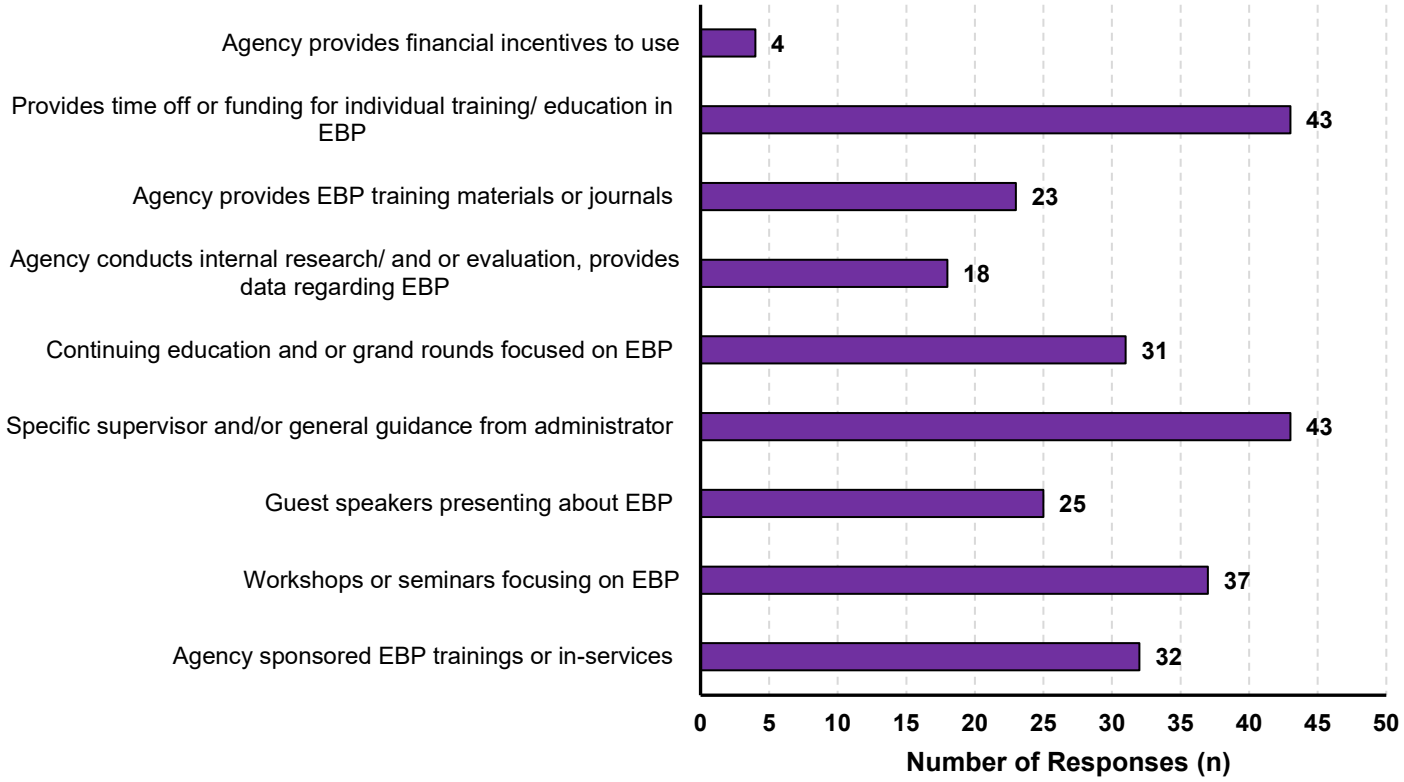


Figure 17: Participation in quality/ improvement professional development activities (n= 87)

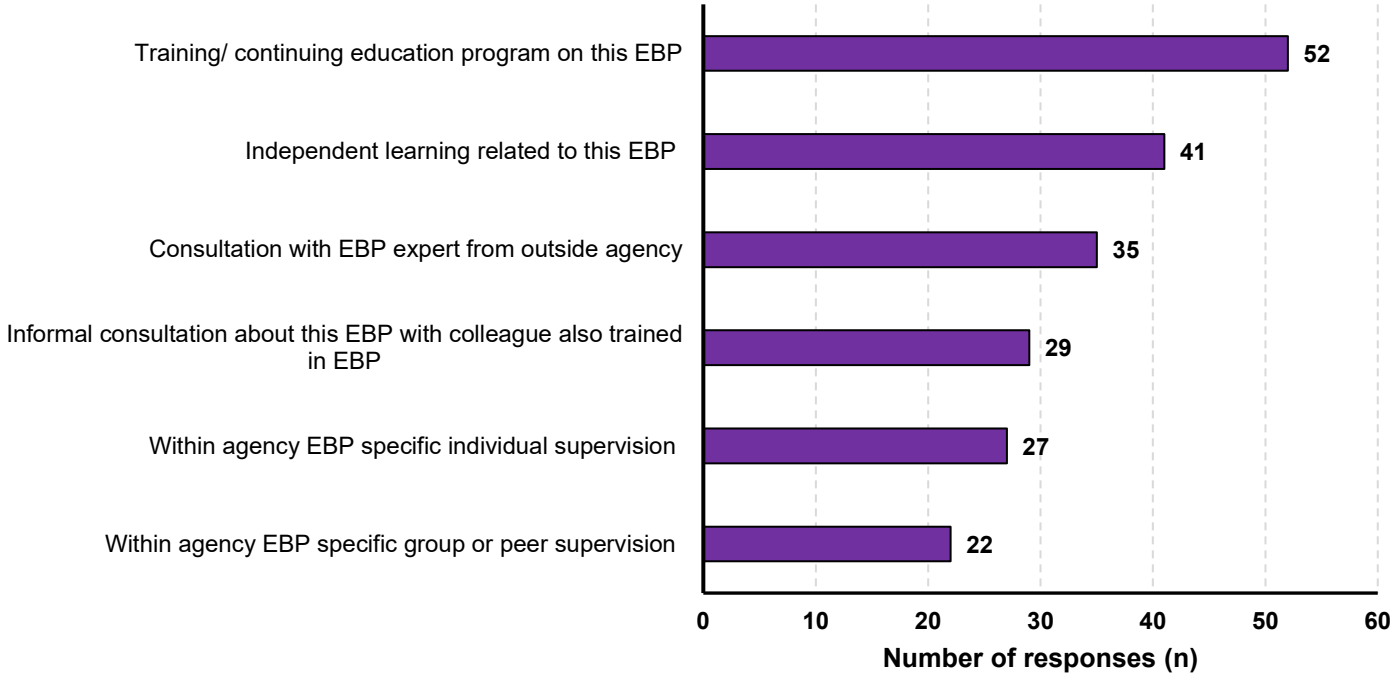
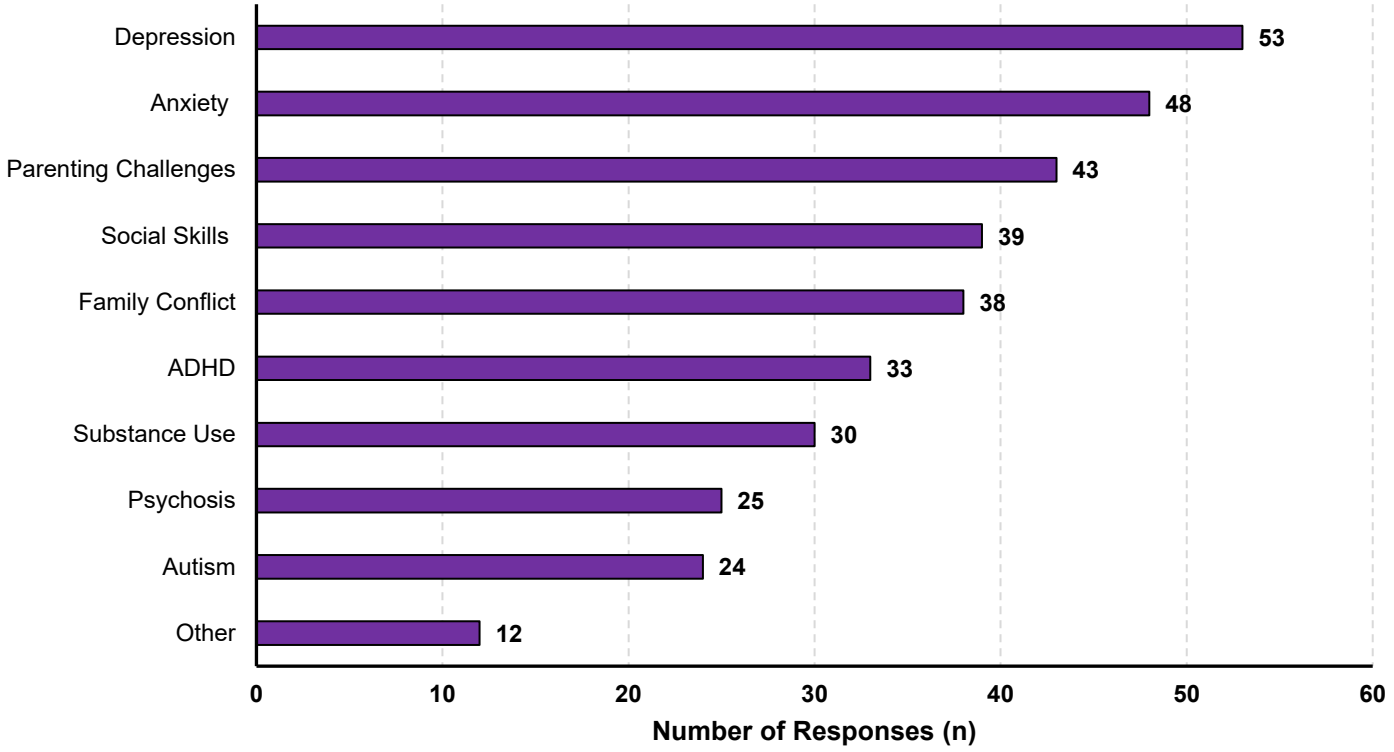


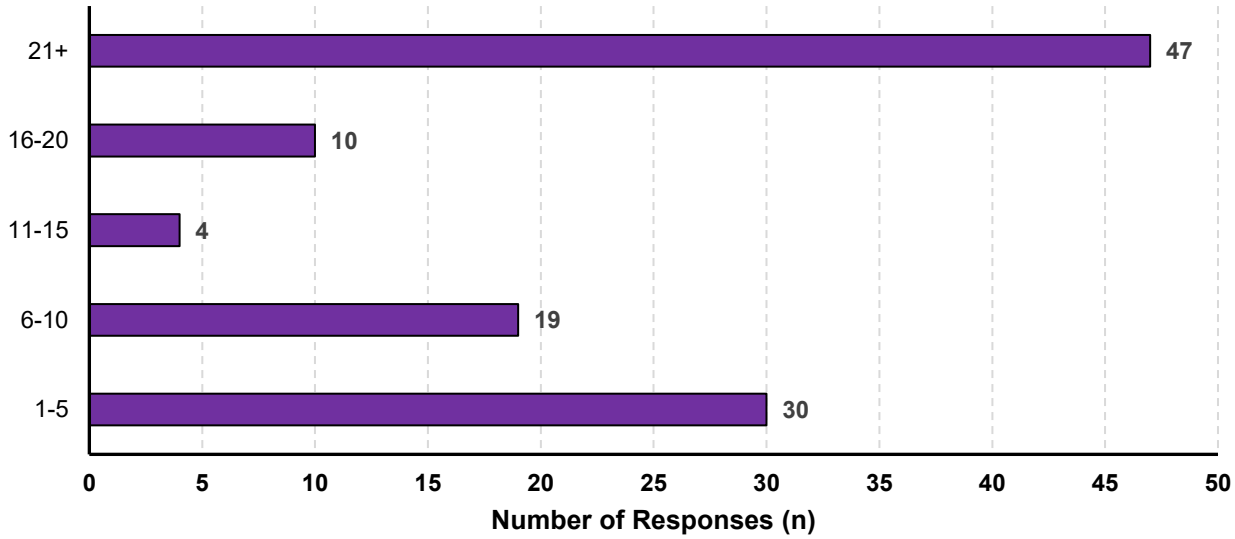
Figure 18: Problems and treatments EBPs should help with (check all) (n=87)



Challenges Implementing EBPs- Agencies were asked about challenges in adopting EBPs. This was an open text answer question. The top three challenges agency leaders reported can be summarized as follows: First, there were difficulties in sustaining the costs of implementation and obtaining funding to secure staff retention, supervision, and consultation. Secondly, they voiced difficulty in having enough staff, the right staff, or staff willing to be trained and pursue EBP certifications. Additionally, having access to affordable training, finding certified providers, and/or accessing the right EBPs for specific populations were additional sources of strain.

Number of Sites and Staffing - Agencies were asked about the number of full-time employees, number of behavioral health providers employed, the number of agency locations, and the number of internship placements provided. Over half (52%/ n=57) of agencies stated they employed less than twenty full-time equivalent employees, but 43% (n=47) of the agencies reported employing more than 21 people (with "21+" being the maximum option offered). On average, in an open text question, agencies reported having fifteen behavioral health care providers (either part-time or full-time). In another open text option response, these leaders described their agencies operating in a range from 1 to 18 locations, but half (50%/ n=40) reported 1 location. See Figure 19 for details.

Figure 19: Number of full-time employees employed at agency (n=110)



Of eighty-seven agencies being described by their leadership, over half (57%/ n=50) reported providing supervision towards licensure (note: the majority of EBPs require a license to provide services). When asked how many people were being supervised for licensure per year, one in four (25%/ n=12) of the responding agencies reported having two supervisees preparing for licensure. See Figures 20 and 21.

Figure 20: Percentage of agencies providing supervision towards licensure (n=87)

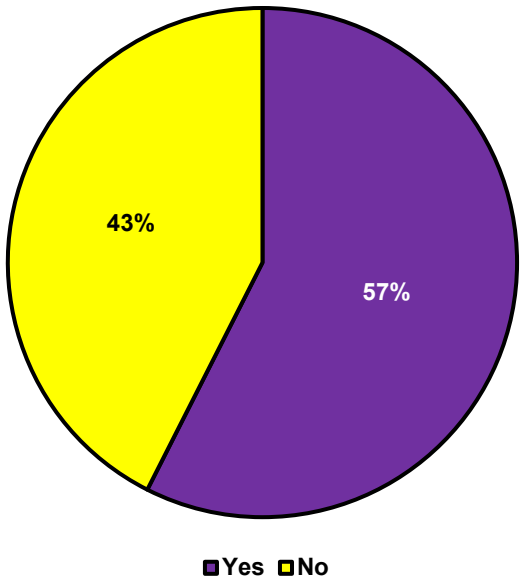
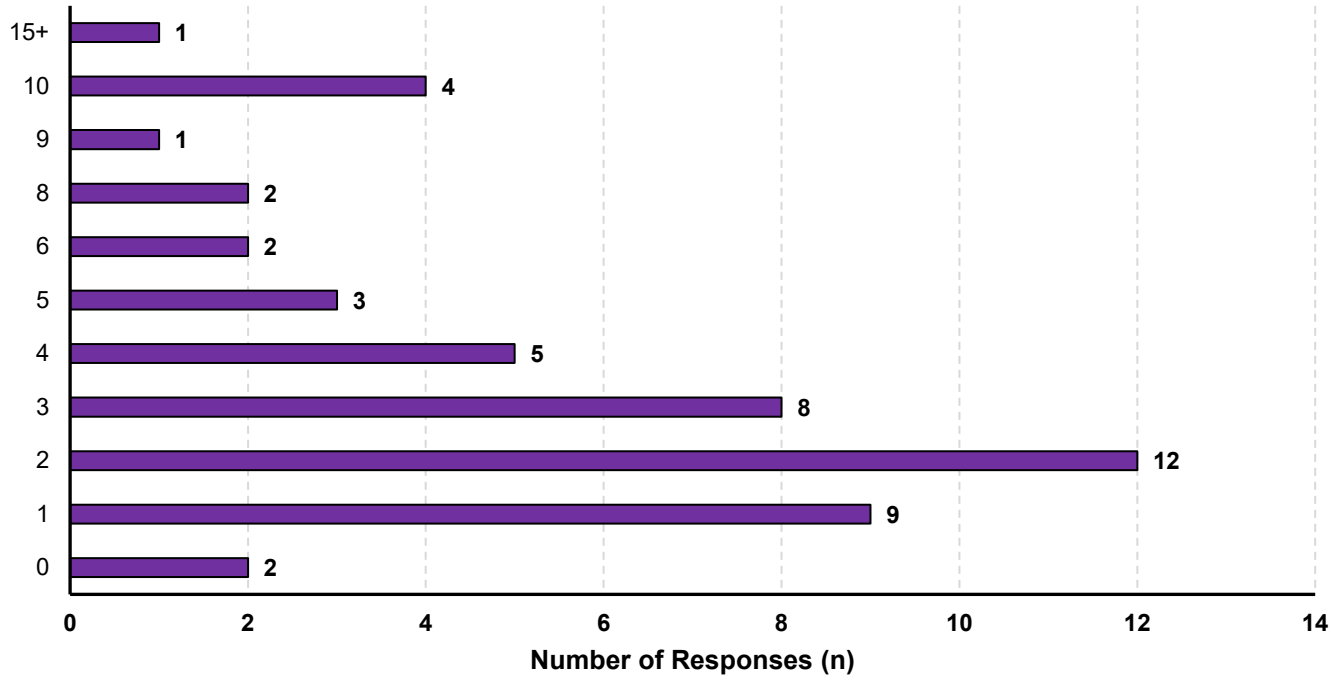


Figure 21: Number of Supervisees for Licensure (n= 49)



Going a step further back in the career path for behavioral health providers, agency leaders were asked if they afford graduate students internship placement opportunities. 73% (n=80) indicated supporting

student internships. 20% provide at least five internships per year. Fifty-seven agencies (29%/n=23) reported providing payment for student internship opportunities. Regardless of pay, internships expose students to clinical practice, training, and supervision. See Figures 22 & 23.

Figure 22: Agencies that provide paid internships (n=80)

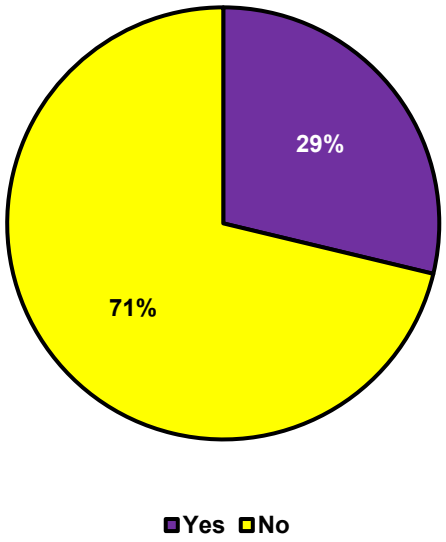
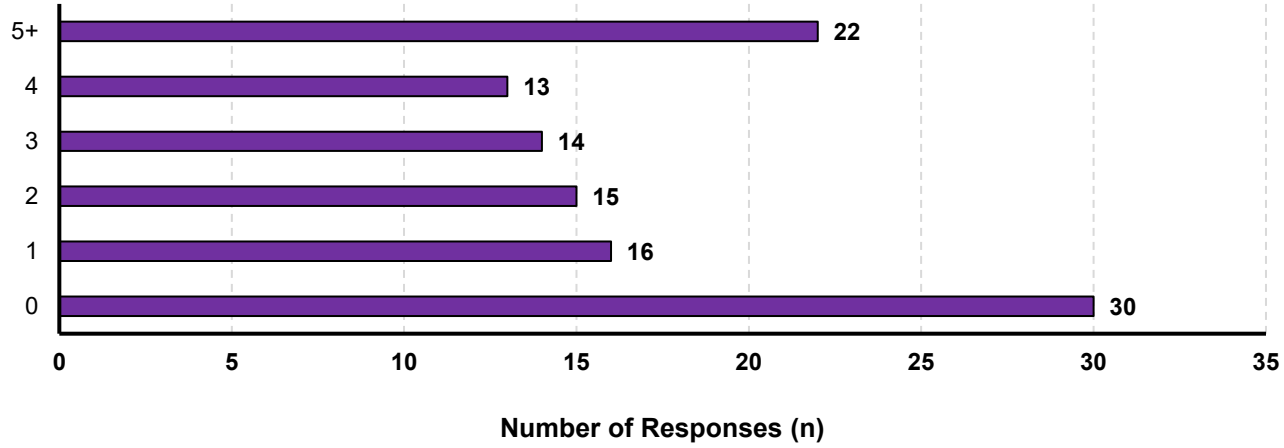
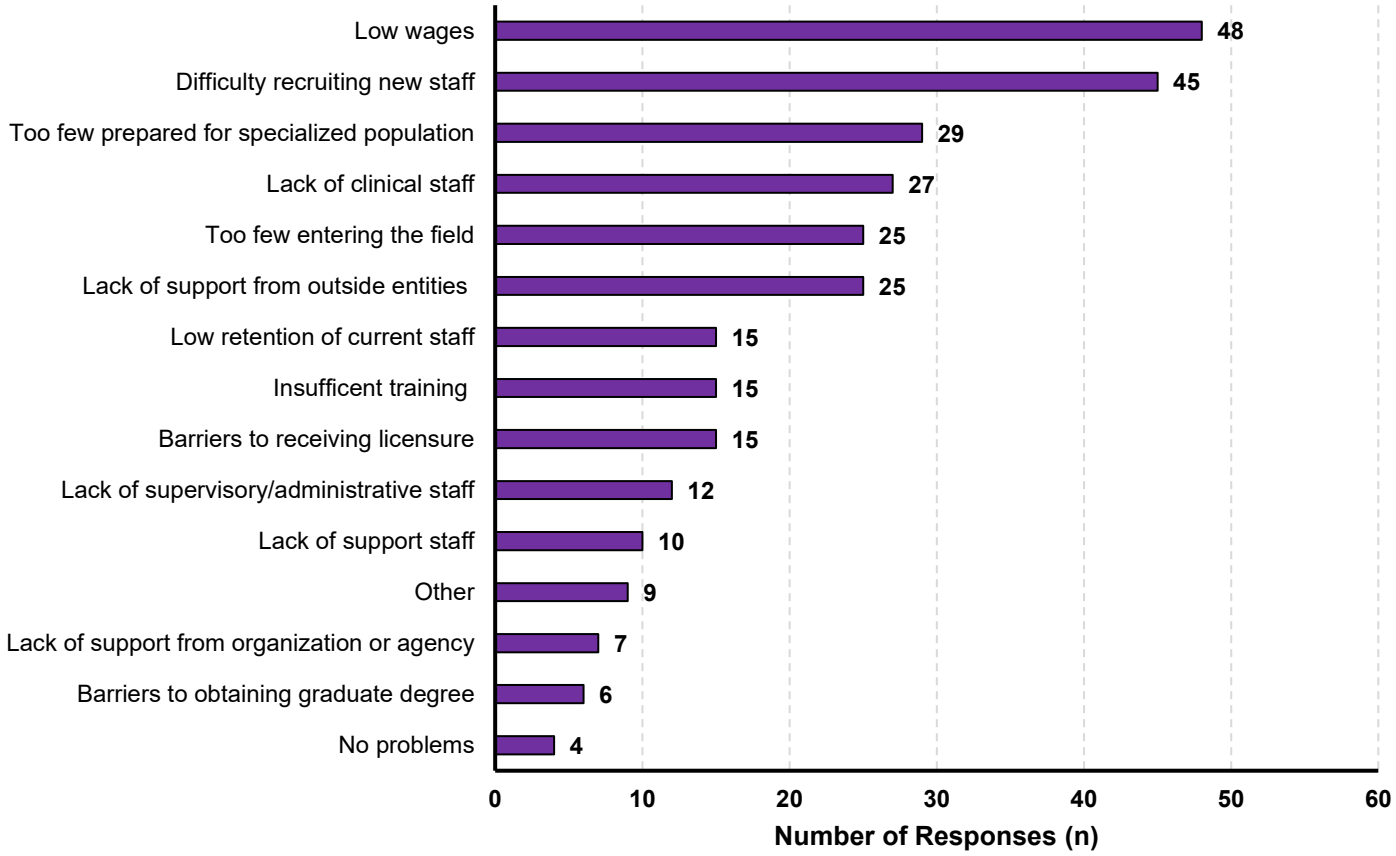


Figure 23: Number of college/ graduate student internship placements (n=110)



Workforce Barriers and Behavioral Health Resources- Agency leaders were asked about the most prominent / most pressing workforce problem for their agency. Low wages (55%/ n=48), staff recruitment (52%/ n=45), and too few prepared for specialized populations (33%/ n=29) were the top three responses based on a "select all that apply" question. See Figure 24.

Figure 24: Current workforce barriers (check all) (n= 87)



Over a third (37%/ n=41) of agency leaders reported that their agencies are seeing more clients as compared to previous years, including some having more referrals than they are able to serve. Just over a third (38%/ n=42) of agencies reported that the number of clients seen remains the same as compared to previous years. Of the clients seen, over a third of the agencies (36%/ n=40) reported seeing more than 100 people in their services in an average week. See Figures 25 and 26.

Figure 25: Changes in the number of clients/ patients in the past year (n=110)

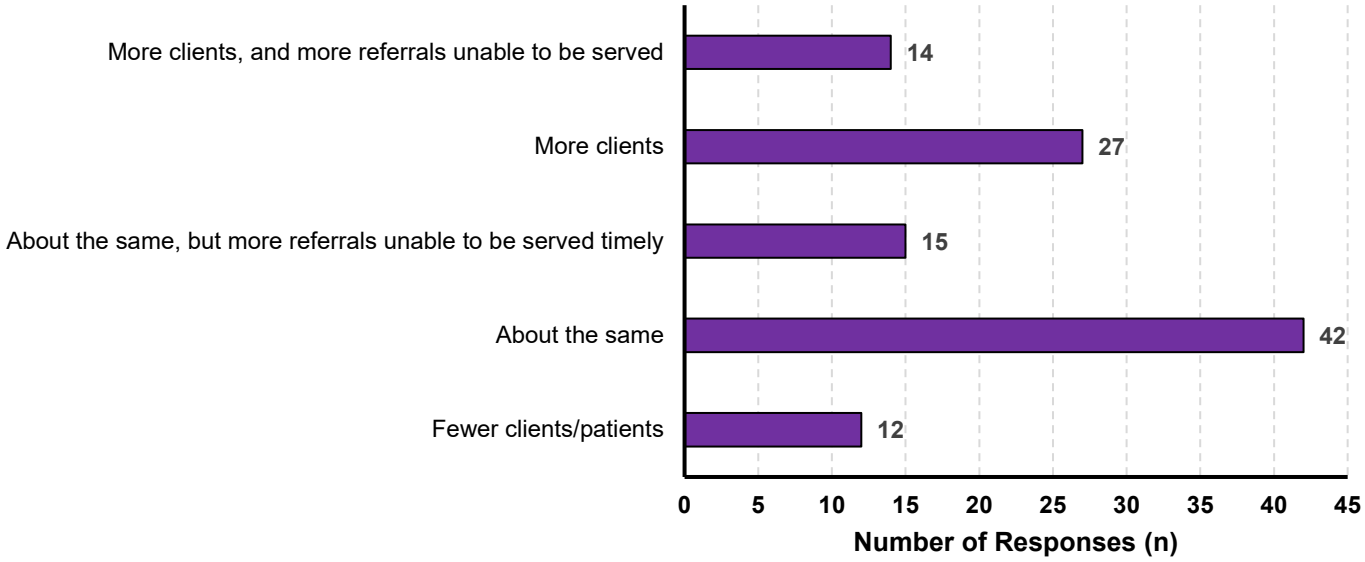
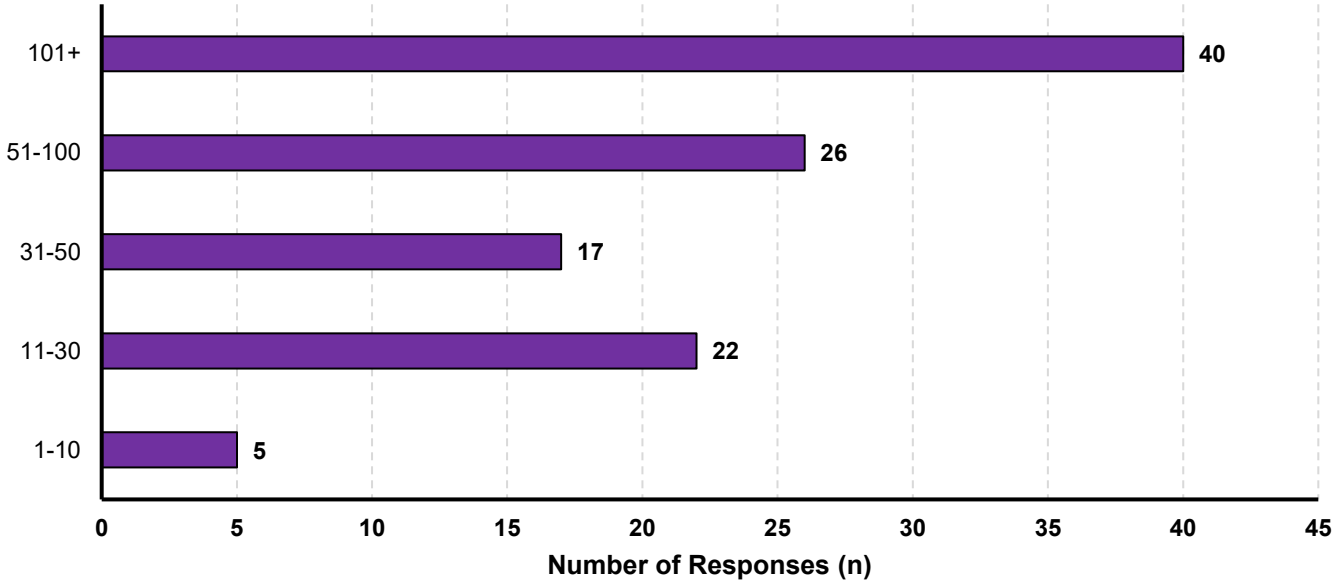
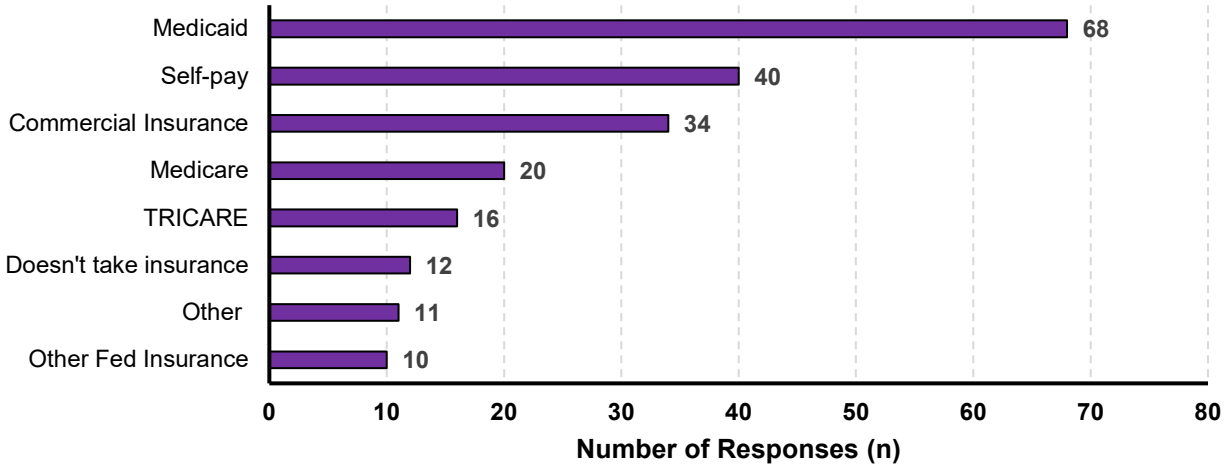


Figure 26: Number of clients seen in an average week (n=110)



Funding/ Payment- Eighty-seven of the one-hundred eleven agency leaders responded to questions about the types of payments and insurance accepted to serve clients. Most (78%/ n=68) accepted Medicaid (note- the focus of the Center's initiatives is Medicaid, so this is likely a skewed response), but there was also a myriad of other funding sources, responding agencies noted reliance on. See Figure 27. This question was framed as "select all that apply".

Figure 27: Types of payment/ insurance accepted (check all) (n= 87)



75% (n=65) of agencies reported contracting with Medicaid organizations, and those contracts appear evenly spread across the seven Louisiana MCOs (this was also structured as a "select all that apply question). Only 3% (n=3) reported ending Medicaid MCO contracts in the past year. The reasons for ending MCO contracts were described as late or inconsistent payments, administrative burdens, and changes in MCO requirements. See Figures 28, 29, 30.

Figure 28: Continuous contracts with Louisiana MCOs (n= 87)

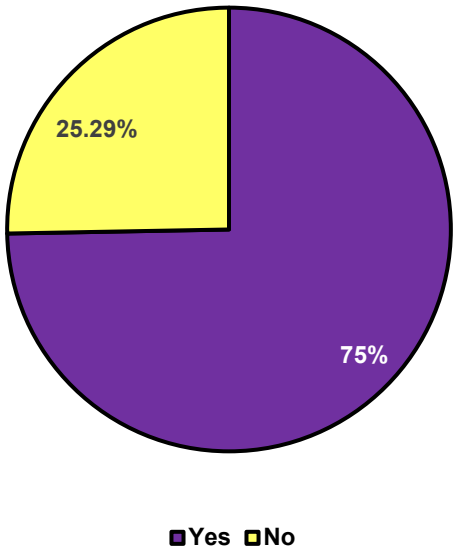


Figure 29: MCOs contracted (check all) (n= 65)

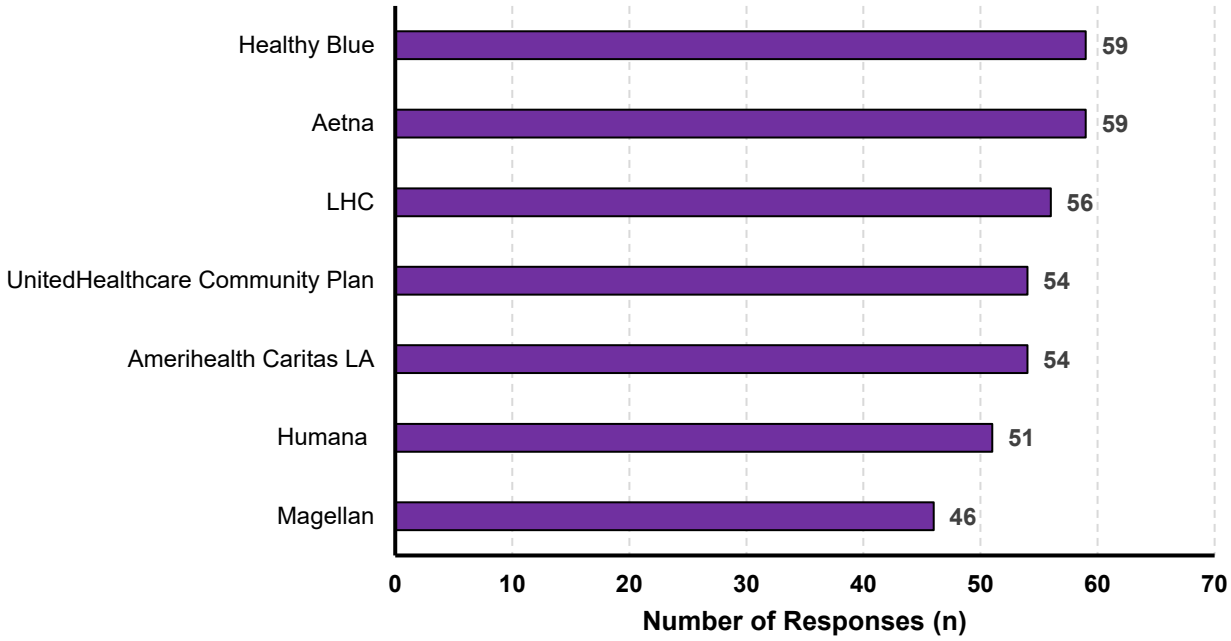
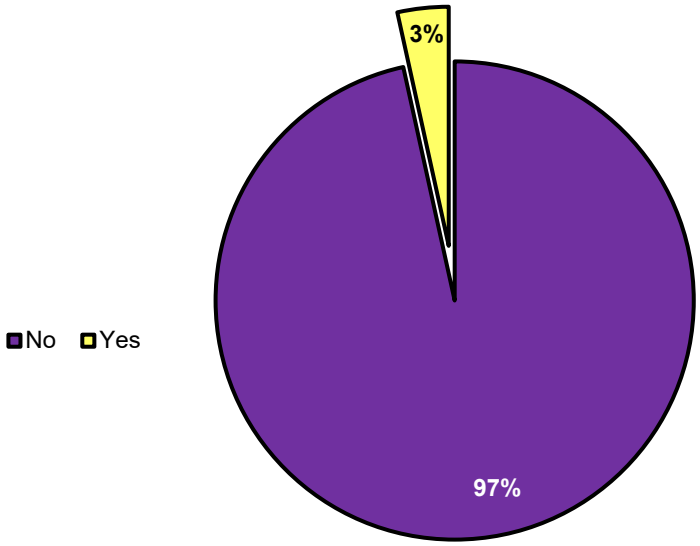


Figure 30: Terminated Medicaid MCO contract within the past year (n= 87)



SECTION III- INDIVIDUAL PROVIDER RESPONSES

This section describes the perceptions of 207 individual providers who responded to the survey. For the most part perceptions appear consistent with agency leadership responses. There are occasional differences that are highlighted.

Over half of providers reported working for an agency/organization and over a third stated they were self-employed. When asked about the people providers serve, providers stated that these youth and adults (including parents) are characterized as socioeconomically stressed and having histories of trauma. Providers stated these populations were typically served with individual and/or family therapy, often delivered via telehealth. Referrals usually come from self-referrals, community providers, and schools. Cognitive Behavioral Therapy was indicted as the most used EBP, and 6% reported not using an EBP. Anxiety, depression, and parenting challenges were the issues most often treated using EBPs. The top barrier to providing adequate treatment was funding and payment followed by lack of clinicians to adequately serve the population. However, most of these same providers reported plans to remain in the workforce, and many indicated low levels of burnout and high levels of a sense of personal accomplishment.

Employment- When asked about their current employment in a "select all that apply" response option, the vast majority of respondents (93%/ n=175) stated they have served as a behavioral health provider. Almost a quarter of these (27%) reported having been behavioral health supervisors and/or administrators (Figure 31). The majority of providers (93%/ n=175) stated that they are currently providing behavioral health services (Figure 32).

When asked about the type of location of their practice, just over half (53%/ n=101) of the providers reported employment with an organization followed by over a third selecting being self-employed (38%/ n=72) (Figure 33). Private practice (42%/ n=61) was selected most frequently to describe the setting of their practice. This was followed by community health centers or clinics (15%/ n=22), and in-home psychotherapy/ counseling (13%/ n=19). This question was posed as a "select all that apply" (Figure 34).

Figure 31: Currently or previously held positions in behavioral health (check all) (n= 189)

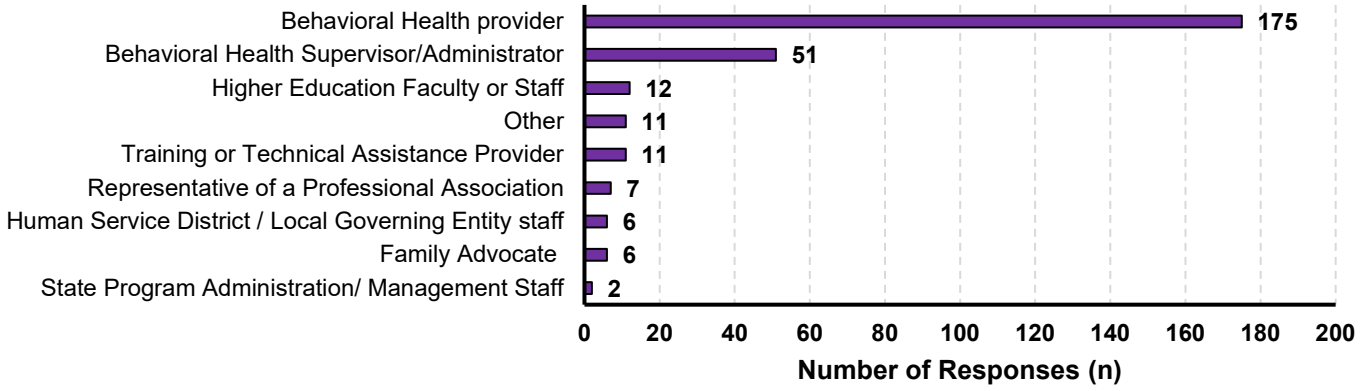


Figure 32: Currently providing health treatment services to clients (n= 207)

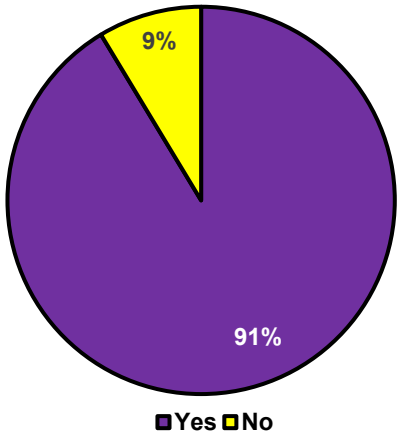


Figure 33: Primary practice location employment status (n= 189)

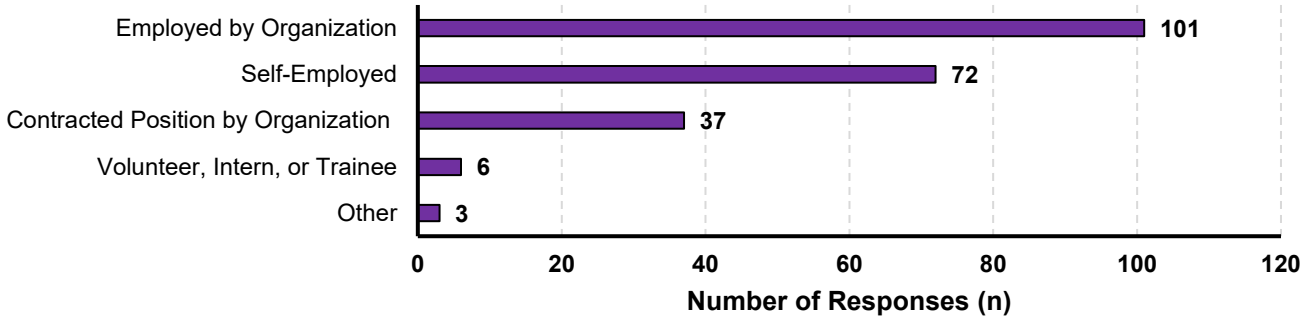
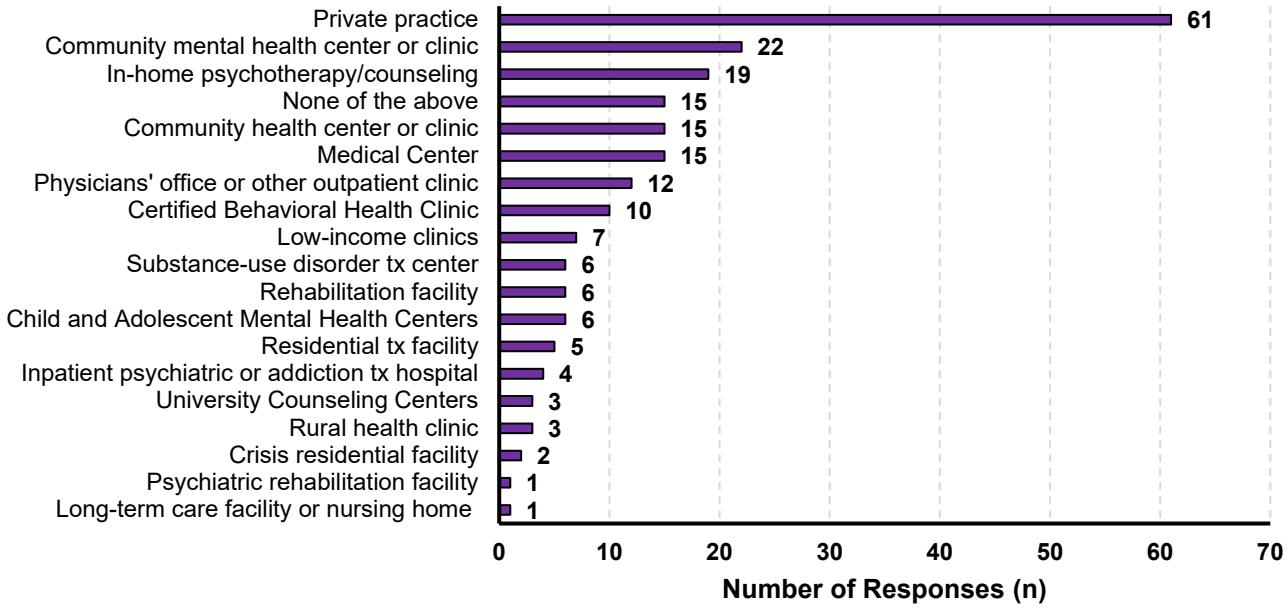


Figure 34: Type of work setting (check all) (n= 146)



Client Demographics- The survey inquired about demographics of the clients served by providers. These were "select all that apply" options, where providers reported that their clients were a mix of adults (ages 24-49), transitional adults (ages 18-23), and adolescents (ages 12-17). The majority of whom were African American and Caucasian. Please see Figures 35 and 36 below.

Figure 35: Ages Served (check all) (n= 189)

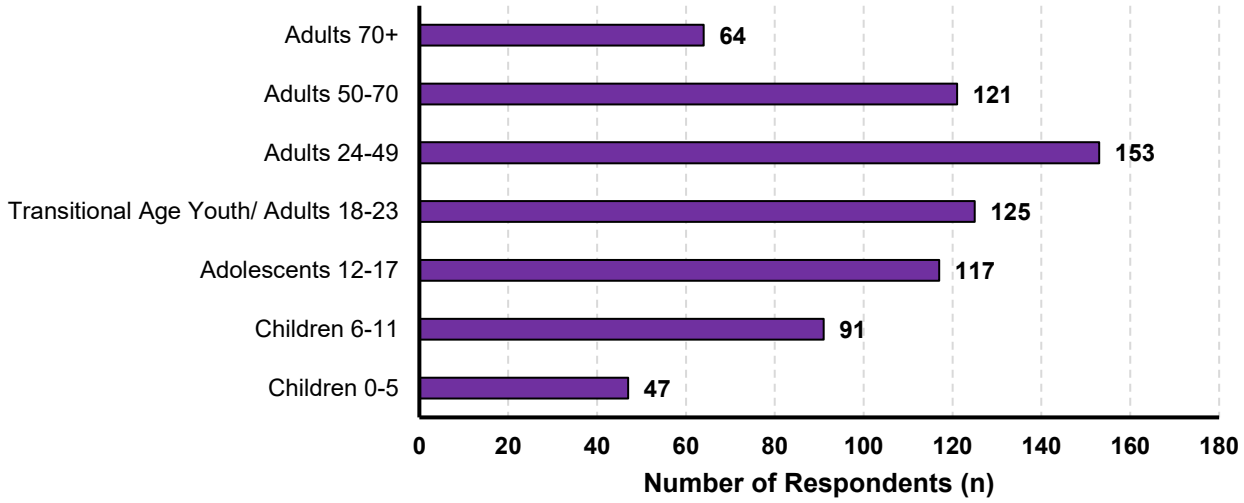
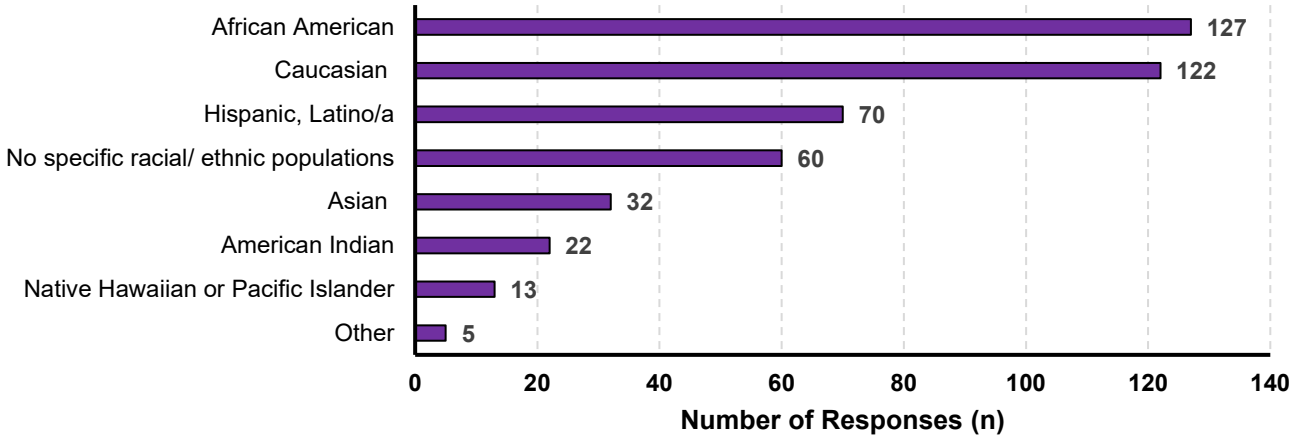
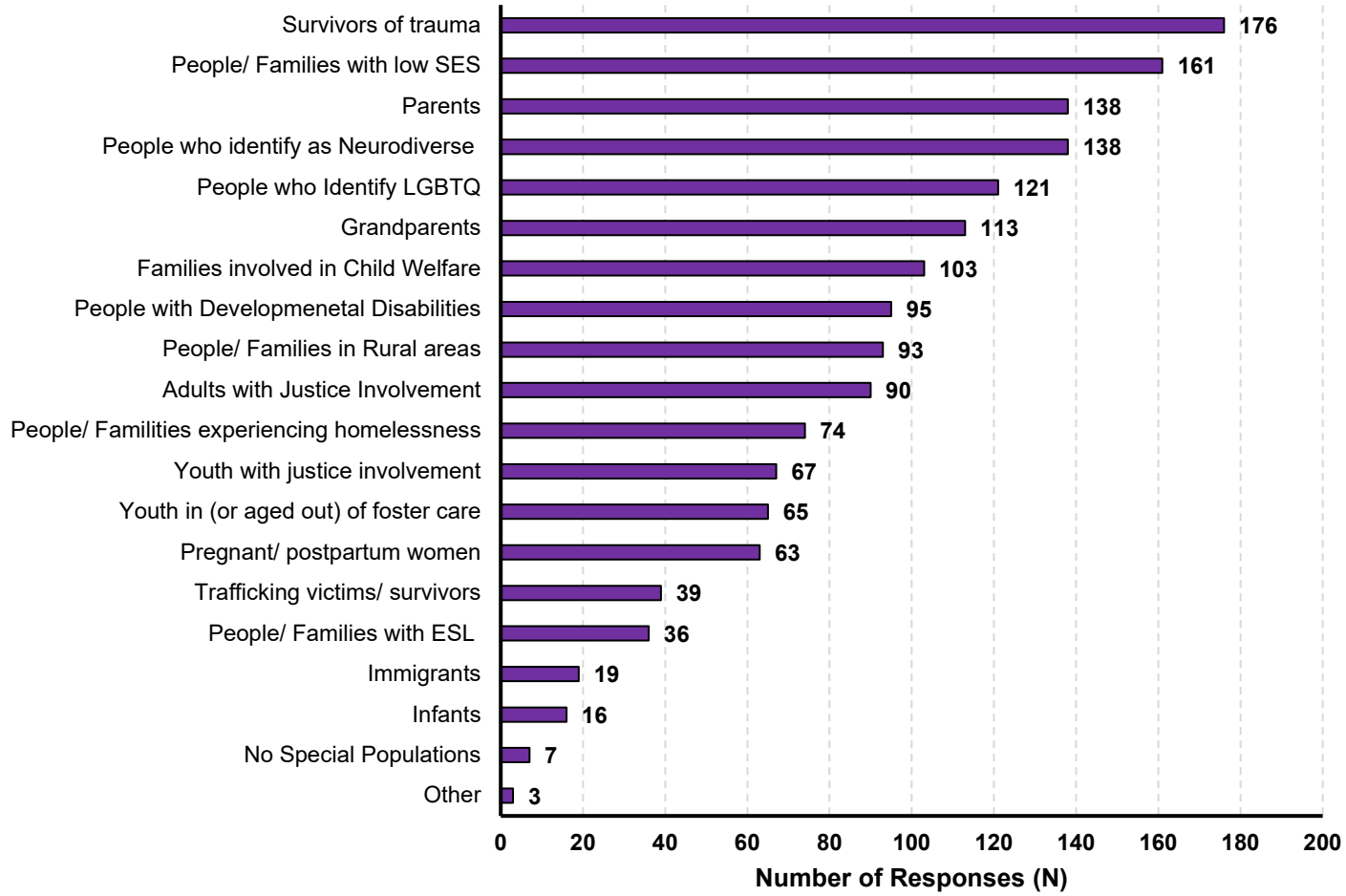


Figure 36: Client race/ ethnicity (check all) (n= 189)



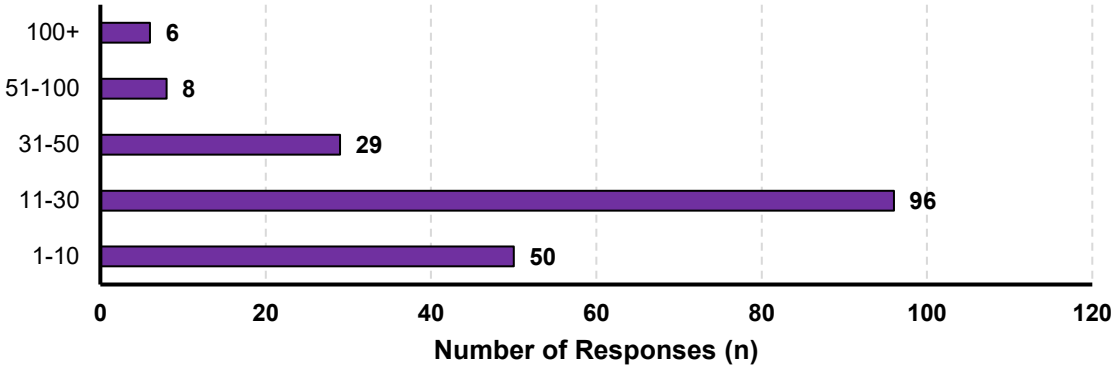
When asked about the characteristics of the populations they treat, providers shared similar responses to that of agency leaders. This included serving survivors of trauma (93%/ n=176), people/families with low SES (85%/ n=161), and parents (73%/ n=138) (Figure 37). What appears different from the agency leaders is the percentages of people/ families with low SES higher in comparison to that seen in providers (90% vs. 85%) and survivors of trauma populations (86% vs.93%) described as being served.

Figure 37: Special populations seen in a week (n= 189)



More than half (51%/ n=96) of providers reported seeing an average of 11 to 30 clients per week (Figure 38).

Figure 38: Average client caseload per week (n= 189)



Services Offered and Referrals- Individual providers reported, in a select all that apply option, that the three most utilized approaches to seeing clients in an average week were individual therapy/ counseling (82%/ n=120), telehealth services (58%/ n=84), and family therapy/ counseling (37%/ n=54) (Figure 39). In regard to the types of referral sources for these services, individual/ family self-referral (73%/ n=100), community psychiatric treatment (64%/ n=93), and schools (53%/ n=77) were the most common sources (Figure 40).

Figure 39: Categories of behavioral health services provided weekly (check all) (n=146)

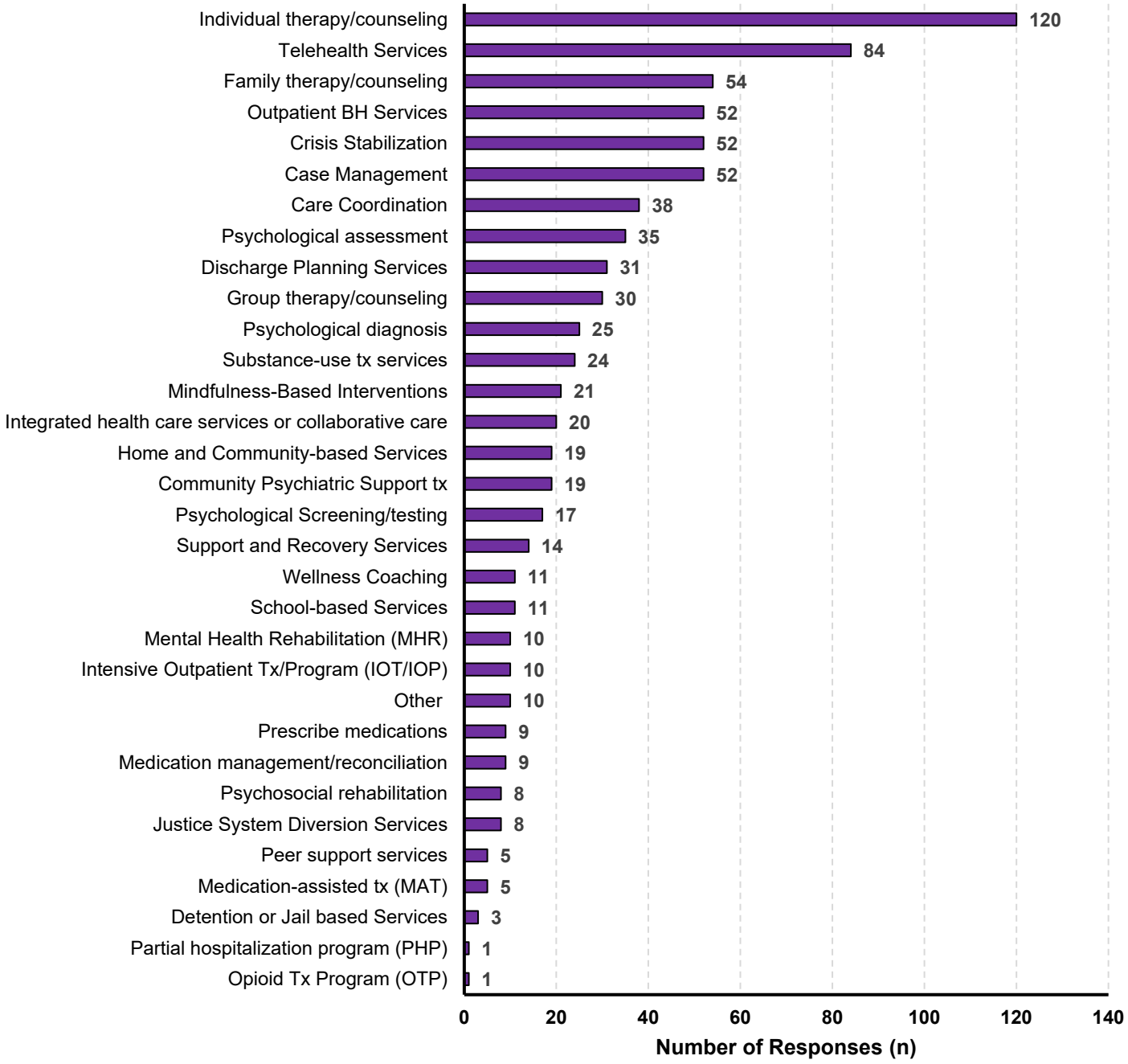
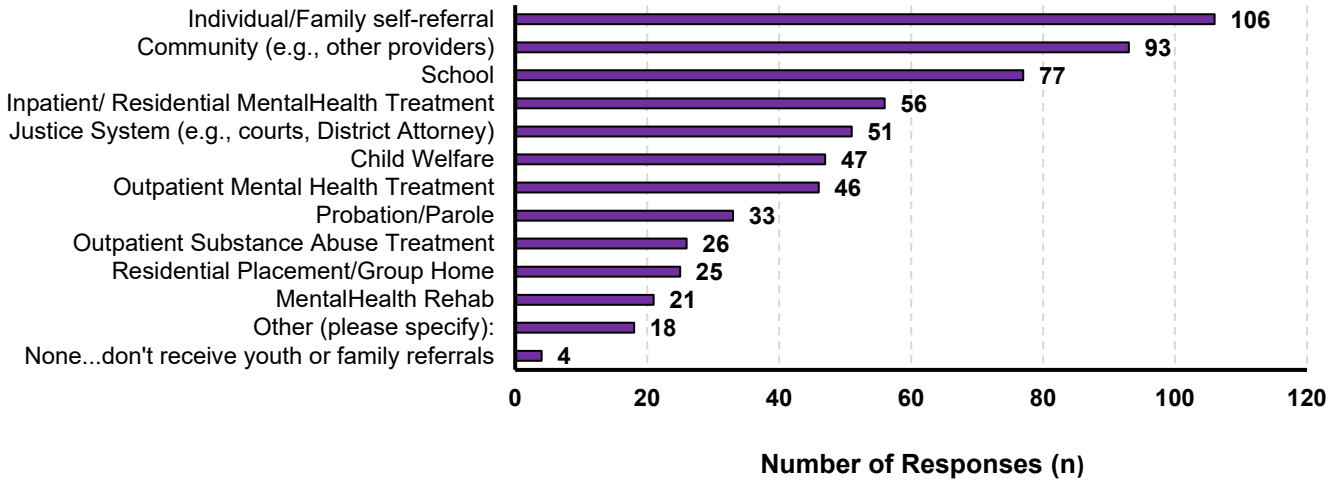


Figure 40: Referral sources for provider services (check all) (n= 146)



EBP Utilization- Behavioral Health providers were asked about types of evidence-based practices offered, activities related to the adoption and use of EBPs, the methods used to implement EBPs, and types of mental health conditions commonly treated with EBPs. (Note: these were all "select all that apply" questions). Providers stated that CBT (76%/ n=111), MI (53%/ n=77), and TF-CBT (45%/ n=65) were the more commonly used EBPs. 10% (n= 70) of providers report that as CBT (Figures 41 and 42).

Figure 41: Evidence- based practices provided (check all) (n= 146)

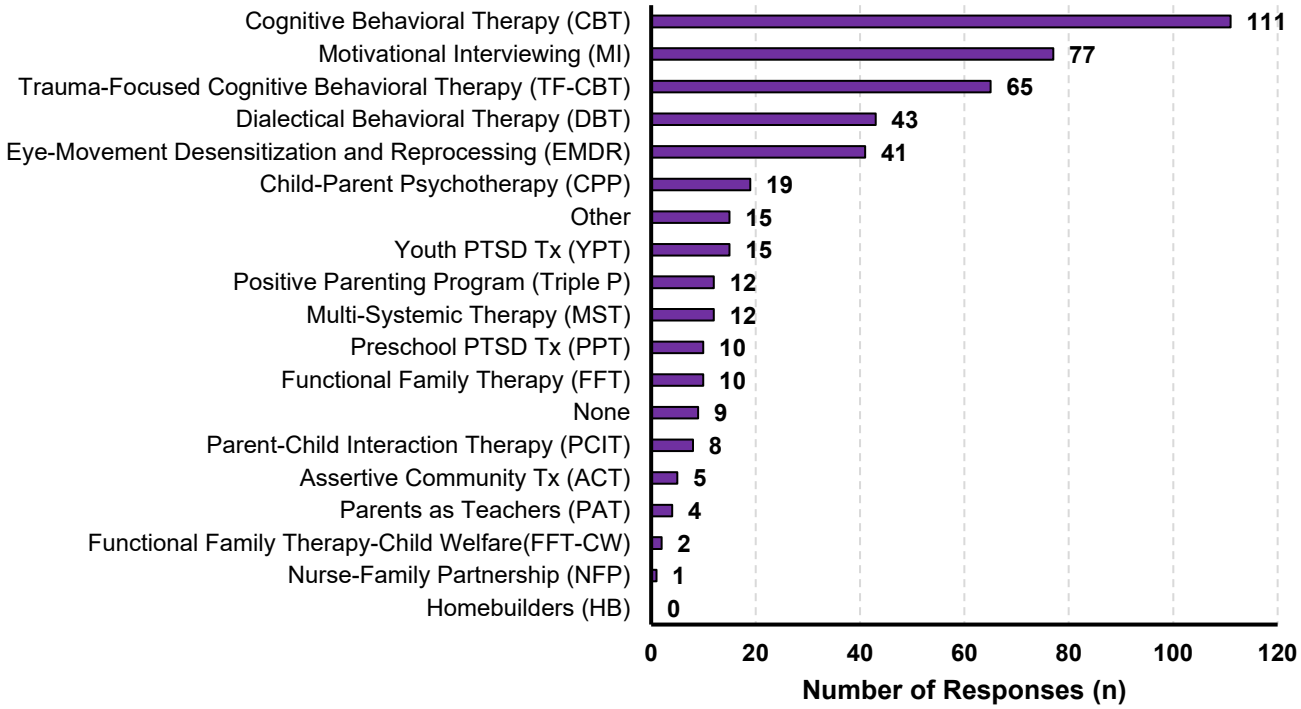
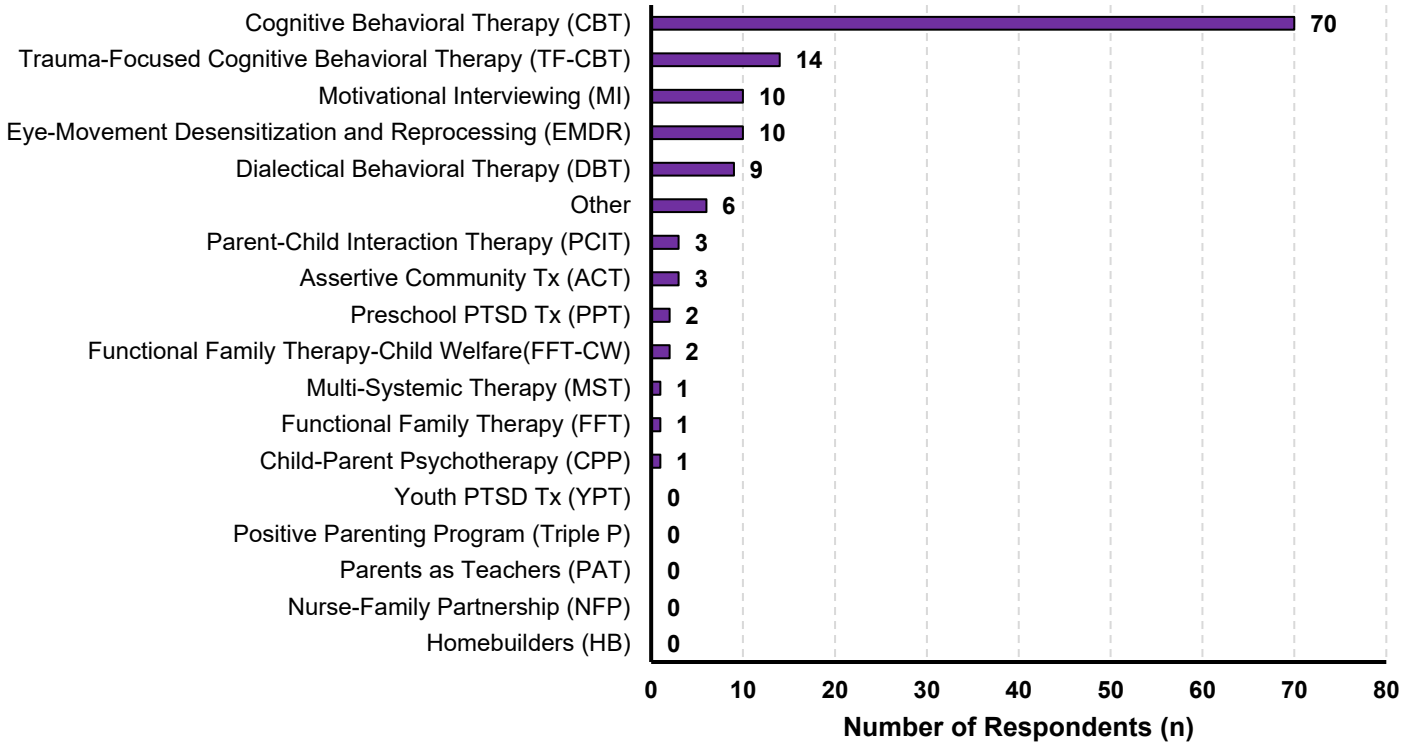
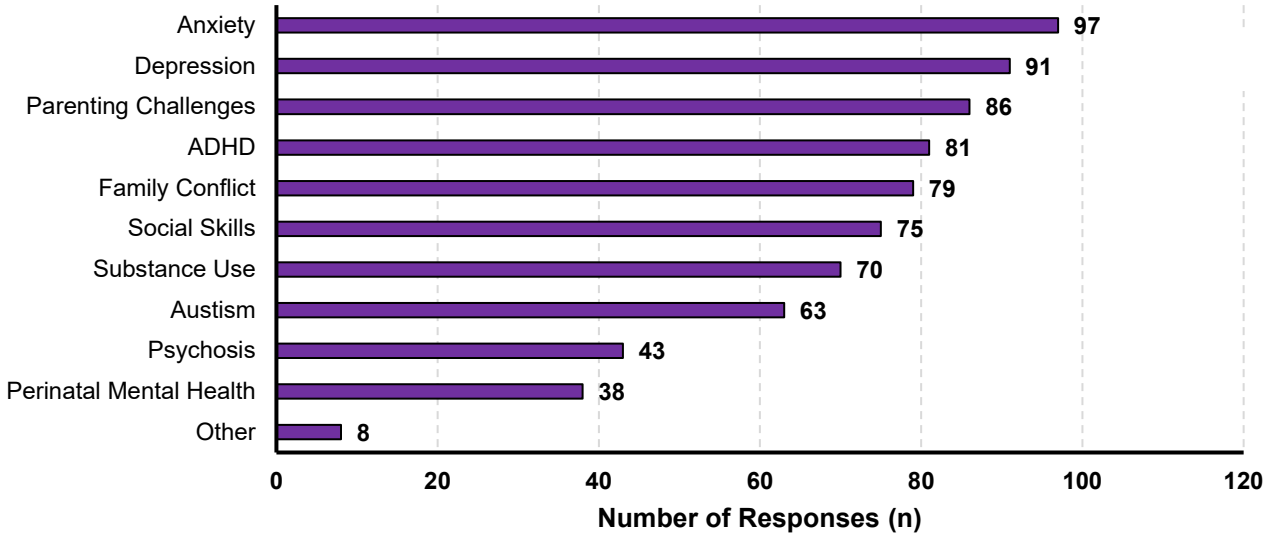


Figure 42: Most frequently used EBP (check all) (n= 132)



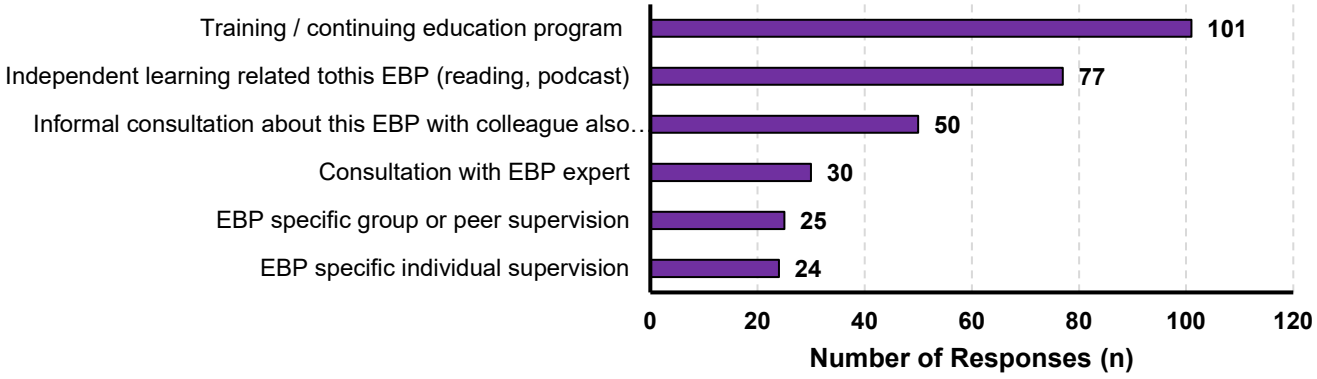
When asked the types of issues or conditions providers used these EBPs to treat, anxiety, depression, and parenting challenges were most commonly selected (posed as a select all that apply question) (Figure 43).

Figure 43: Issues and conditions providers commonly use EBPs to treat (check all) (N= 146)



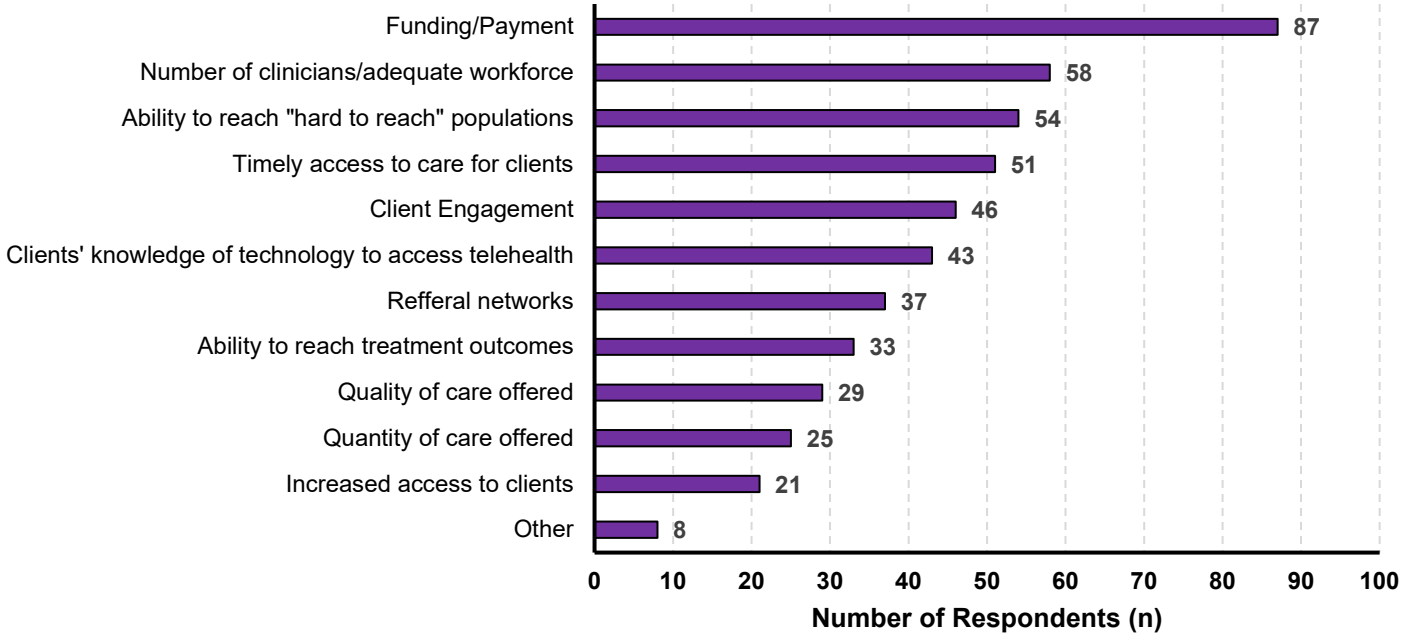
When asked about tools useful for learning and adopting EBPs, providers stated that training/ continuing education (n=101/ 71%) programs and independent learning related to specific EBPs were the most used methods. EBP specific individual supervision (n= 24/ 17%) and group or peer supervision were the least selected as methods for implementation. This was a "select all that apply" question (Figure 44).

Figure 44: EBP training and implementation activities (check all) (n= 143)



Barriers- Almost two-thirds (60%/ n=87) of providers stated that funding/payment was a challenge to providing adequate behavioral health treatment. Over one-third (40%/ n= 58) stated that there were not enough clinicians to adequately support the demand for care. 37%(n=54) reported difficulty in providing services for "hard to reach" populations. Note this question was also structured as a "select all that apply" format (Figure 45).

Figure 45: Barriers in providing behavioral health treatment (check all) (n= 145)



Funding Sources for Services - The majority of individual providers reported accepting Medicaid (75%/ n= 110), followed by self-pay (66%/ n=97), and commercial insurance (64%/ n=93) to fund their services (Figure 46). Providers who reported accepting Medicaid indicated that they contracted with MCOs fairly evenly across all seven organizations, with Magellan and Humana the least indicated (Figure 47). It should be noted that Magellan is a more specialized MCO for a distinctly smaller portion of the Medicaid population and the Humana is the newest of the MCOs. These two questions were "select all that apply". Similar to agency leadership responses (noted above), 60% (n= 88) stated that they still contracted with MCOs, with only 2% (n=3) reporting ending Medicaid MCO contracts in the past year. Reasons offered as to why contracts were ended included inadequate reimbursements, late payments, and administrative burdens. See Figures 48 and 49 for details.

Figure 46: Types of payments/ insurance accepted (check all) (n= 146)

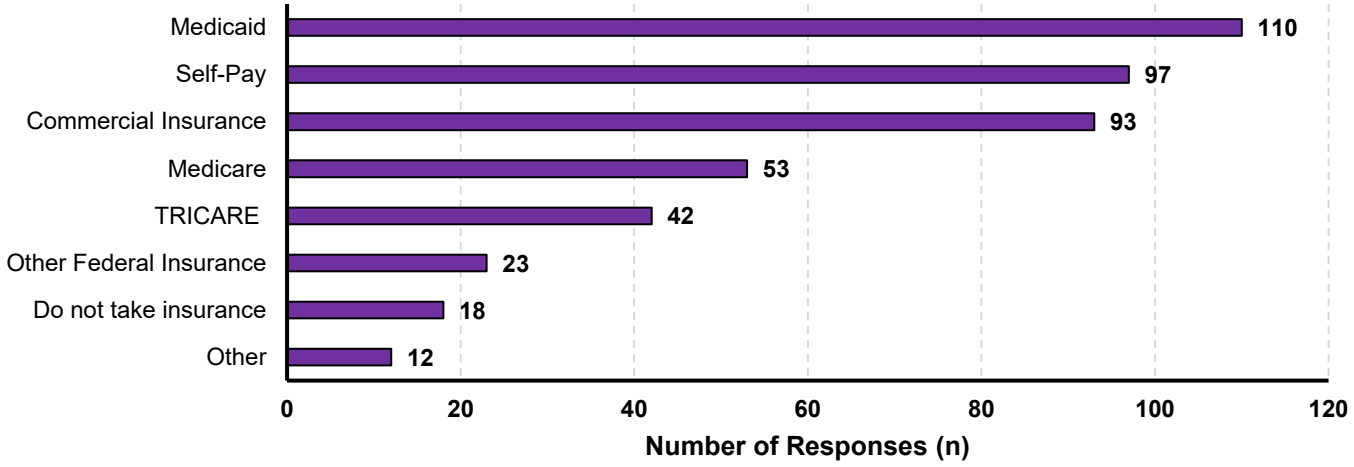


Figure 47: Medicaid Managed Care Organization contracts (check all) (n=88)

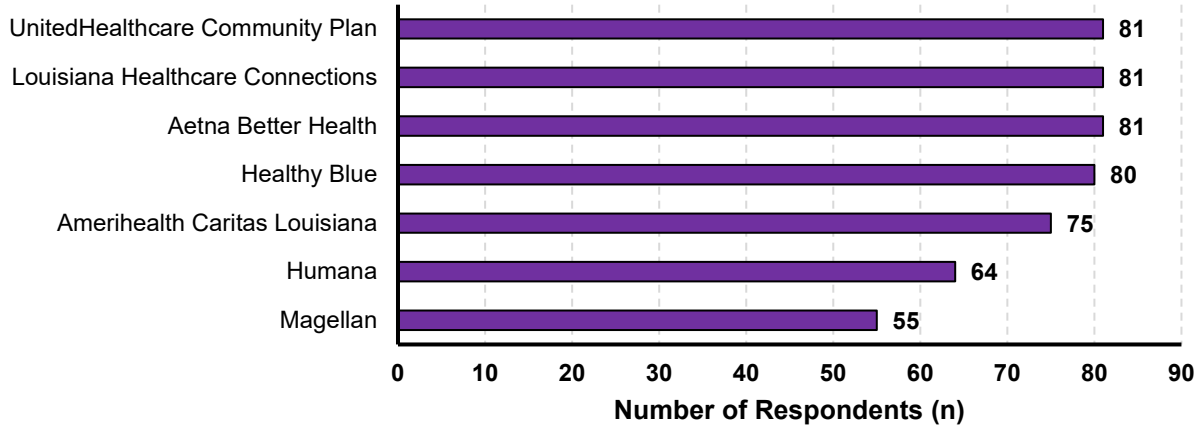


Figure 48: Current contracts with Medicaid Managed Care Organizations (n= 146)

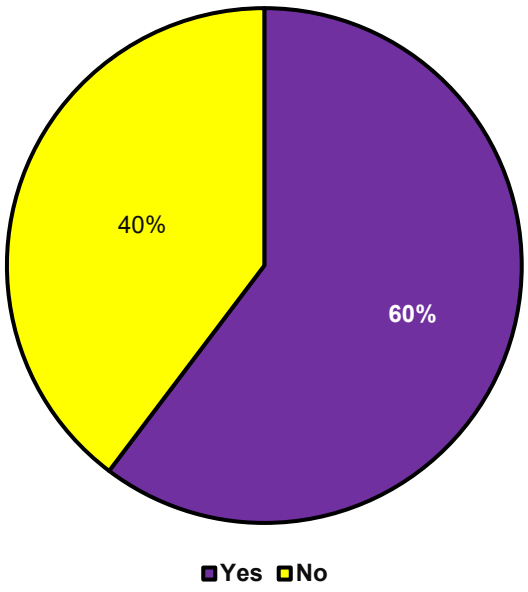
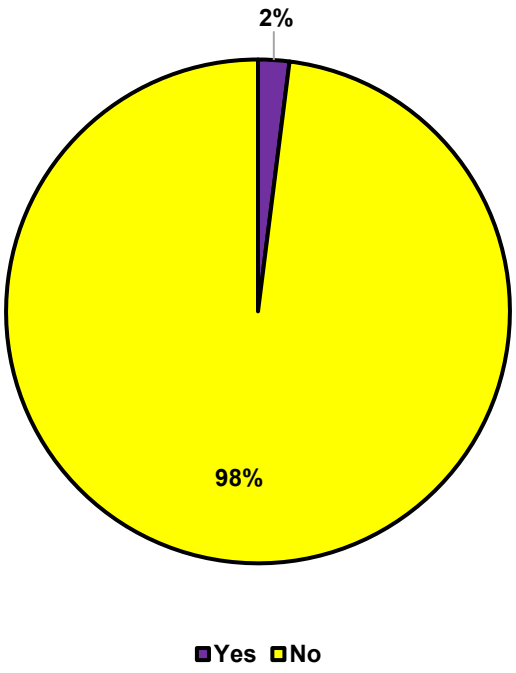
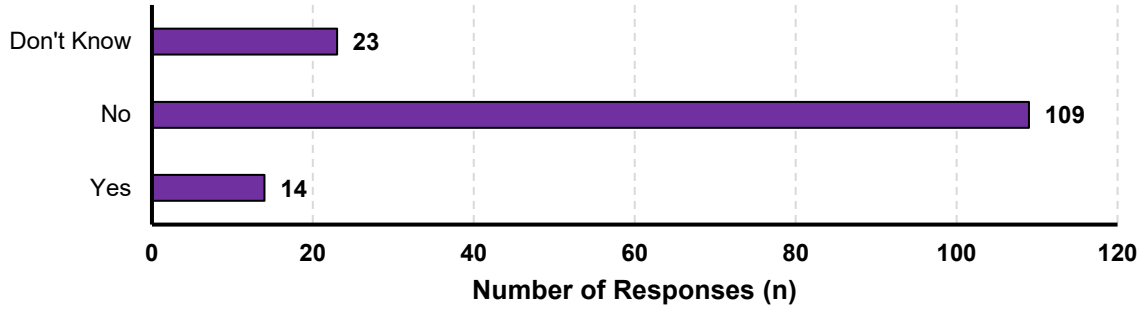


Figure 49: MCO contracts terminated in the last year (n= 146)



Workforce Stability- The success of behavioral health in Louisiana is contingent upon the availability of well-trained mental health providers. When asked whether these Louisiana providers anticipated leaving their current position in the next year, 75% (n=109) indicated they did not expect to do depart their position (Figure 50).

Figure 50: Anticipated career departure in the next year (n= 146)



PROVIDER BURNOUT

The findings of the Maslach Burnout Inventory- Human Services Survey (MBI-HSS), which was included as subsection of the individual provider questions, measures burnout across three subscales- emotional exhaustion, depersonalization, and personal accomplishment. A provider is classified as having burnout if he or she scores high in emotional exhaustion and depersonalization or high emotional exhaustion and low personal accomplishment.

Over half (55%) of the providers surveyed reported low levels of emotional exhaustion, and even more (79%) reported low perceived depersonalization. Additionally, over half (57%) reported a sense of high personal accomplishment (Figure 51).

Levels of Emotional Exhaustion, Depersonalization and Personal Accomplishment by providers' gender, education, treatment focus, and average weekly caseload did show mover variation and are illustrated in Figures 52, 53 and 54, respectively.

Figure 51. Maslach Burnout Inventory- Human Services Survey of Emotional Exhaustion, Depersonalization, and Personal Accomplishment

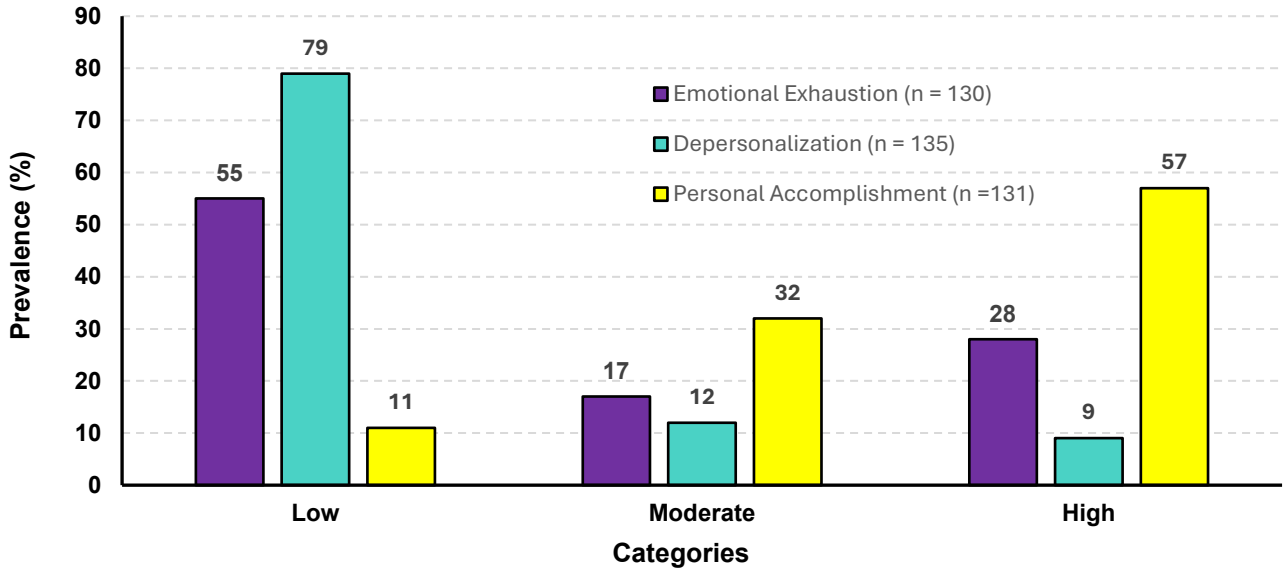


Figure 52. Emotional Exhaustion per the Maslach Burnout Inventory- Human Services Survey by providers' gender, education, treatment focus and average weekly caseload (n =130)

(Note: Subgroups with count less than five are not reported)

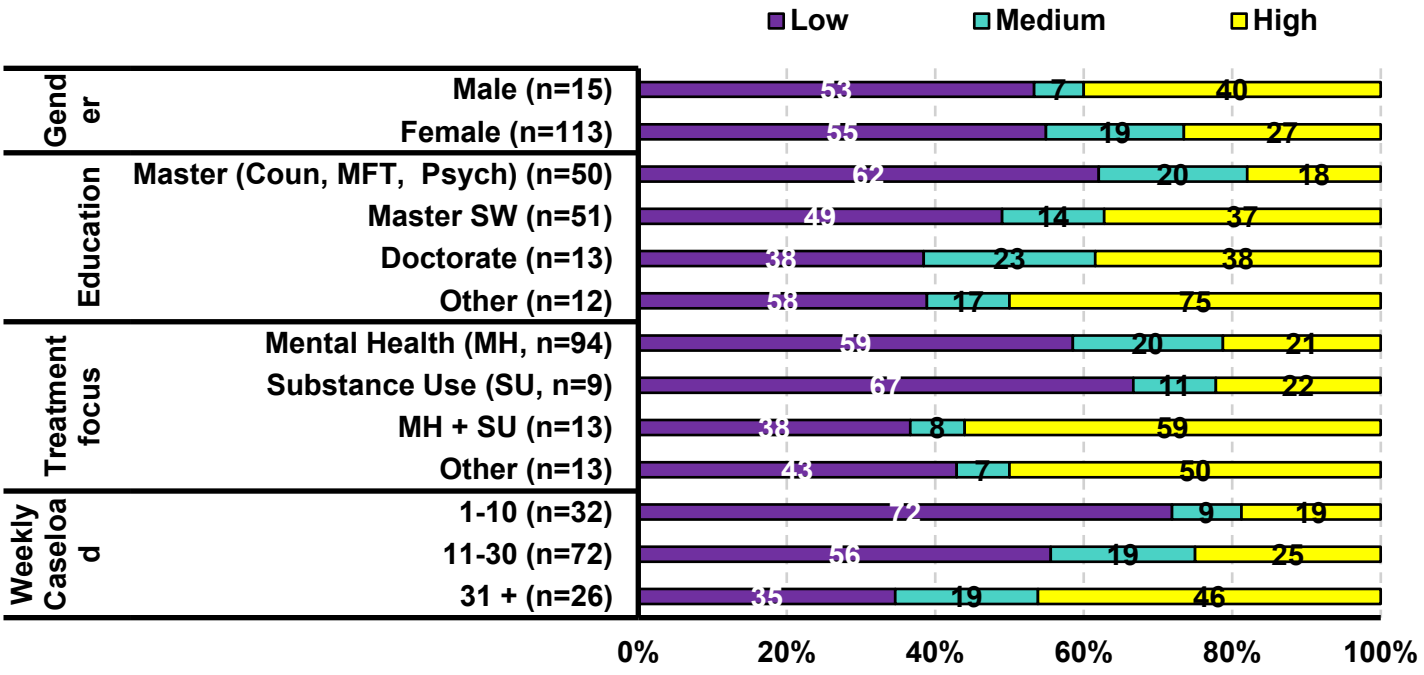


Figure 53. Depersonalization per the Maslach Burnout Inventory- Human Services Survey by providers' gender, education, treatment focus and average weekly caseload (n=135)

(Note: Subgroups with count less than five are not reported)

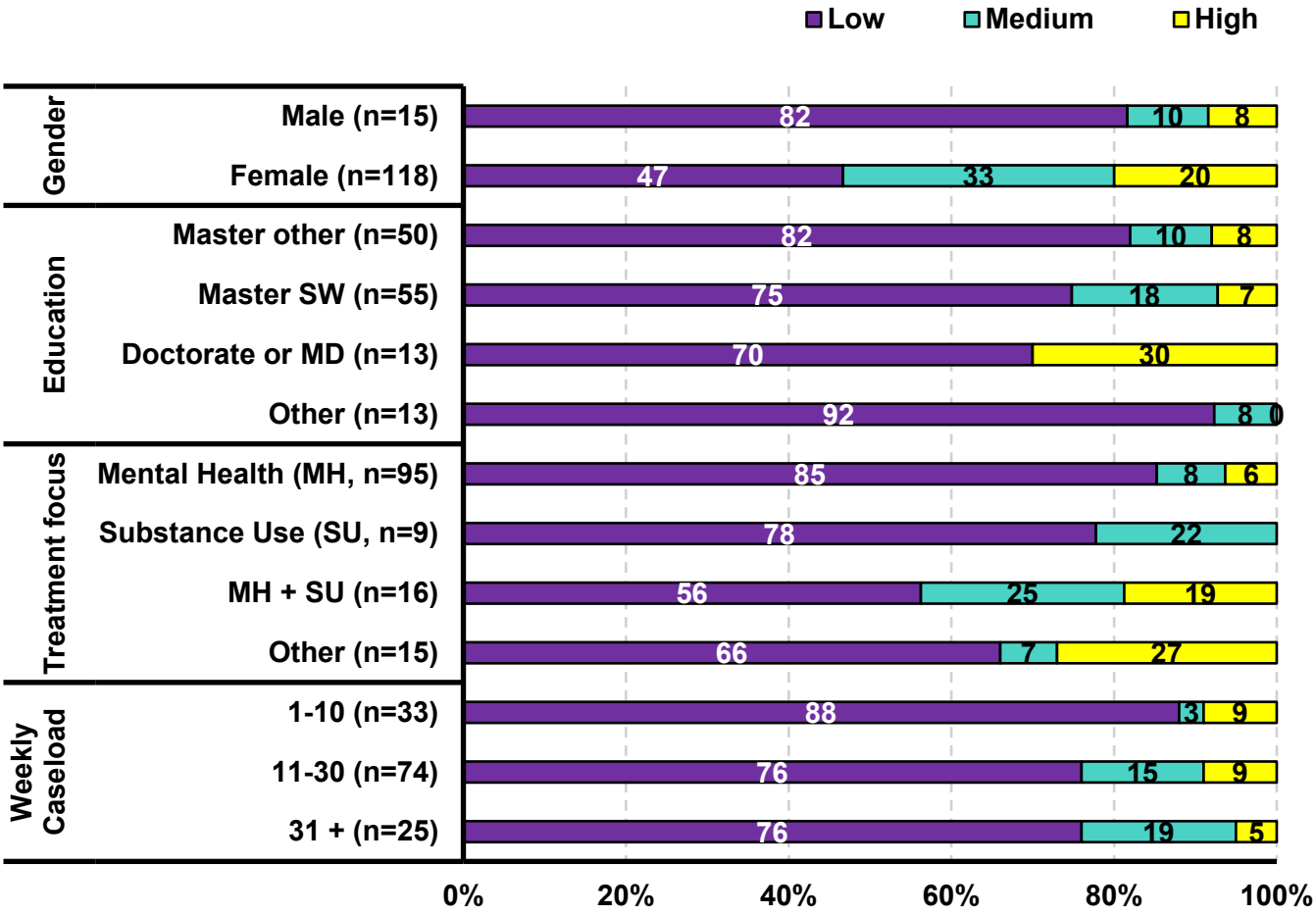
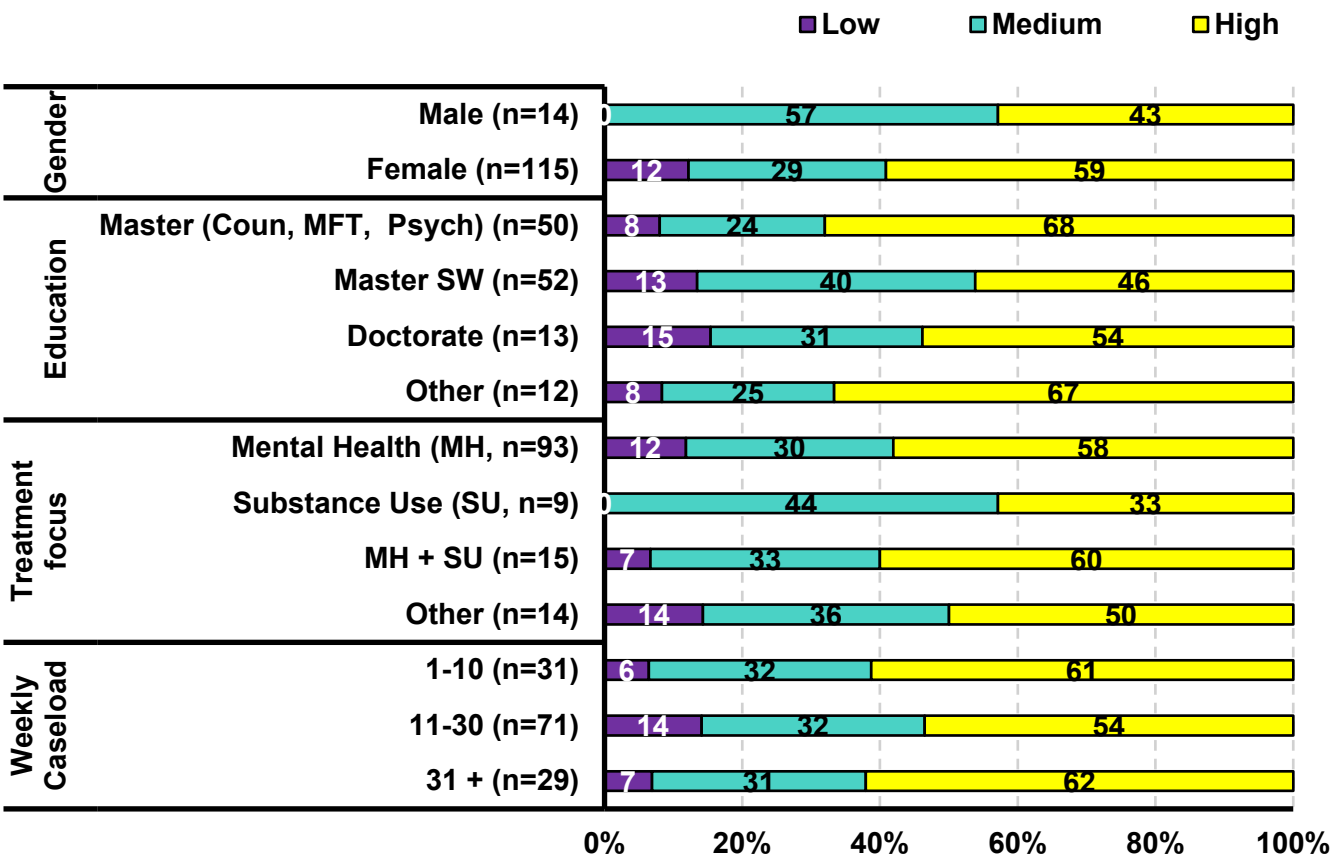


Figure 54. Personal Accomplishment per the Maslach Burnout Inventory- Human Services Survey by providers' gender, education, treatment focus and average weekly caseload (n = 131)

(Note: Subgroups with count less than five are not reported)



FOCUS GROUP FINDINGS

Focus group findings suggests groups perceive a strong desire for continued system improvement and workforce development to continue to expand EBPs. Those interviewed stated that workforce turnover remains a problem to meet the demand for services, particularly in rural areas. Solutions offered by participants included increasing partnerships with universities around internships and recruitment of bilingual mental health professionals. Focus group members also suggested EBPs remain underutilized and need improved referral processes. According to these groups, challenges persist in maintaining supervisors and funding for EBPs they see as effective, such as trauma focused EBPs, PCIT, and CBT which they believe are warranted to meet the needs of our Louisiana populations.

Participants in the focus groups offered that overall, the behavioral health landscape in Louisiana is marked by a strong desire for systemic improvement, from workforce development and compensation to the expansion of evidence-based practices and service availability. According to them, addressing these challenges requires coordinated efforts from both the public and private sectors, with a focus on sustainability, accessibility, and cultural competence.

Accessing Services

According to focus group participants, the demand for children's behavioral health services in Louisiana is characterized by the need for improved referral processes, targeted interventions, and better engagement strategies. Recommendations from participants included enhancing the accuracy of referrals and ensuring alignment with EBPs to match specific populations' needs. Interviewees also emphasized the importance of streamlining the intake and assessment process. They also reported a need for additional resources for school social workers. Furthermore, participants reported that workforce turnover remains a significant challenge, often hindering continuity of care and follow-through with treatment plans. Addressing these issues, particularly by focusing on specialized interventions such as play therapy, which is of interest to new graduates, was voiced as a priority.

Workforce Challenges

Focus group participants described the behavioral health workforce in Louisiana facing multiple pressing issues. These included the shortage of qualified professionals, particularly in rural areas, the need for more trauma-informed care, and limited access to child psychologists and medication management services. Recommendations for addressing these workforce issues include improving training opportunities, offering better compensation, supporting work-life balance, and reducing caseloads. Interviewees suggest that partnerships with schools and offering internships could help create a pipeline for new professionals entering the workforce to learn and practice skills. Increasing workforce diversity and promoting family support were also key considerations offered. In terms of priorities perceived in staffing the workforce, participants stated that there is a strong need for psychiatrists, quality prescribers, peer support roles, and professionals trained in trauma-informed care.

Evidence-Based Practices (EBPs)

The sustainability of current EBPs is a concern across many of the focus group participants. While there is broad recognition of the effectiveness of EBPs, the challenges of funding, billing, and ensuring adequate supervision were identified as significant barriers. Recommendations for improving sustainability include offering specialized reimbursement rates, increasing investment in training, and creating in-house training programs within organizations. There is also a call for flexibility in adapting EBPs to meet the specific needs of local populations and for ensuring that EBP implementation aligns with Medicaid and billing requirements. Trauma-informed practices and models for crisis team training were highlighted as key areas of interest, with programs like Parent-Child Interaction Therapy (PCIT) receiving particular recognition by some participants for its effectiveness in involving parents and families.

Group Therapy

Group therapy, though reported as a significant service (41.8% of survey respondents reported using it), is not commonly recommended for youth due to the nature of peer influence, which can deter from therapist recommendations and skill building attempts. When asked to give their thoughts about such high utilization of group therapy, focus group participants suggested that this percentage may reflect the desire for group therapy in certain contexts (like Intensive Outpatient Programs) rather than widespread availability. Some also felt this might be referring to parenting skills groups vs. youth groups, but none of the respondents reported a high use of groups for therapy. Some interviewees also suggested logistical barriers to offering group therapy, which might limit the accessibility of this service if offered.

Systemic Challenges and Future Directions

Focus group participants offered a broad recognition that structural challenges, such as the complexities of Medicaid billing and authorization processes, need to be addressed to improve the accessibility and efficiency of behavioral health services. They shared that more targeted efforts are needed to diversify the mental health workforce, particularly by focusing on increasing the representation of African American counselors and enhancing incentives for providers in rural and underserved areas. According to this group of interviewees, telehealth is also viewed as a promising avenue for expanding access, particularly among clinicians who prefer remote work.

CONCLUSIONS & RECOMMENDATIONS

Findings from these gaps and needs analyses provide insights into the current state of behavioral health among Louisiana's agencies and providers. While addressing these conditions is vital, workforce shortages, wages, and recruitment challenges are barriers to providers and agencies for delivering care. Despite the known effectiveness of EBPs, noted by the rapid expansion of practices such as TF-CBT and EMDR, funding, training, and sustainability for EBP services remain critical focus areas. Re-prioritizing and re-allocating resources effectively to address needs will be the next step.

Recommendations:

1) Further explore the more than 1 in 5 agencies reporting not using EBPs to look at ways to expand reach to serve their populations.
2) Strategize ways to more effectively engage behavioral health career paths from students to provisionally licensed to licensed professionals in order to recruit, train, and retain these individuals.
3) Examine EBPs that can either be expanded or added to best address key issues that appear in this study related to ADHD, substance use, trauma, anxiety, depression, and parenting issues, including improving referral pathways to best practices.
4) Discuss adult focused EBPs that can best serve transitional aged youth, parents, and adults, while continuing the focus on expanding access to EBPs for families of young children.
5) Continue to promote mainstream and creative approaches to incentivize EBP adoption and sustained implementation, including expanding EBP specific consultation and supervision/support which appears to be underutilized.

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Supplement Table A: Prevalence of 2023 Medicaid Claims for Youth (ages 0-18) grouped by diagnosis and Parish of Associated Claim

Parish	AdjD	AnxD	BaD	CDMD	DepD	Hyp/ADHD	Other MH	Non MHBD
Acadia	14.6	6.2	1.2	8.8	12.1	53.2	3.3	0.5
Allen	17.4	8.3	3.1	0.8	14.7	49.5	3.3	2.8
Ascension	10.1	9.2	1	11	11.8	51.3	4.7	0.9
Assumption	5.5	4.5	0.7	3.6	10.1	71.9	3.2	0.6
Avoyelles	3.1	3.7	0.3	6.4	6.1	75.5	3.8	1.1
Beauregard	11.5	9.1	2.1	5.8	18.4	48	4.3	0.9
Bienville	9	4.1	1.1	6.9	18.9	55.4	4.5	0.1
Bossier	10.9	4.8	2.7	8.3	21.2	48	3.7	0.3
Caddo	7.6	3.4	2.6	11.3	18.6	52.6	3.4	0.6
Calcasieu	14.2	4.3	1.2	5	6.6	63.8	4.2	0.7
Caldwell	9.6	6.5	1.4	13.5	7.9	58	3	0.2
Cameron	16.7	1.9	.	1.3	1.1	79.1	.	.
Catahoula	9.5	3.9	0.1	14.3	23.6	34.3	13.9	0.4
Claiborne	22.1	9.1	0.1	8.2	14.9	37.6	7.8	0.3
Concordia	8	3	0.8	34.2	12.7	38.1	3	0.2
Desoto	11.7	6.6	1.3	10.3	16.5	47.8	5.7	0.1
East Baton Rouge	8.1	4	1	11.9	11	59.2	4.2	0.6
East Carroll	3.7	2.6	0.1	55.2	3.1	34.4	0.7	0.2
East Feliciana	22.5	6.4	0.5	8.6	7	34.3	19.8	1
Evangeline	11	3	0.7	7.2	8	67.9	2	0.2
Franklin	11.3	1.9	0.2	19.9	5.9	56.6	3.7	0.6
Grant	8.7	8.3	1	8.7	15.7	48	8.4	1.2
Iberia	9	8.4	1.1	21	13.3	42.7	4	0.5
Iberville	11.6	5	0.3	18	6.7	55.2	2.2	1
Jackson	8.6	4.2	2	11	13.7	58.9	1.3	0.2
Jefferson	13	8.5	1	7	13.9	49.9	5.8	0.8
Jefferson Davis	13.8	6.8	1.6	2.7	14.1	55.8	4.9	0.2
LaSalle	10.4	7.9	2.5	14.7	19.4	41.1	3.4	0.6
Lafayette	13.4	7.2	1.6	13.4	12.6	45.4	6	0.5
Lafourche	10.7	6.2	0.8	3	8.7	64.4	5.8	0.4
Lincoln	10.7	3.8	0.8	10.2	8.4	62	3.8	0.3
Livingston	15.5	7.4	1.3	5.6	10.2	55	4.5	0.5
Madison	5.6	1	0.2	36.9	3.7	50.4	1.9	0.3
Morehouse	4.6	3.4	1.1	10.4	10.7	66.1	2	1.6
Natchitoches	2.4	3.6	1.9	15.9	11.8	58.1	4.2	2.1
Orleans	11.2	4.2	1.3	10.9	12.1	55.6	3.9	0.8
Ouachita	8	3.3	0.6	14.2	6.9	63	3.7	0.4
Plaquemines	14.2	6.6	0.8	7.4	11.3	53.3	5.1	1.2
Pointe Coupee	18.6	7.8	1	15.5	12.3	35.9	8.2	0.6
Rapides	8.1	5	0.7	12.6	11.6	56.2	4.8	0.9
Red River	3.1	3.6	2.2	9	21.7	57	3.1	0.5
Richland	10.7	4.6	0.6	15.5	6	59.2	2.3	1.2
Sabine	4.3	3.8	0.5	11.7	19.8	55.9	3.8	0.4
St Bernard	7.9	7.5	0.9	12.2	11.3	54.3	4.5	1.4

St Charles	12.5	7.9	1.4	3.1	8.9	59.6	5.5	1
St Helena	29	4.4	0.3	5.8	6.5	45.5	3.5	5
St James	8.6	7.4	0.3	8.4	11.6	59.1	4.2	0.4
St John	6.6	4.7	1.1	10.1	9.4	63.1	4.3	0.5
St Landry	8.9	4.1	1	6.5	6.8	69.6	2.6	0.5
St Martin	15.5	5	1	12	8	53.3	4.6	0.4
St Mary	15.7	11.3	1.3	6.1	11	48.4	5.6	0.6
St Tammany	11.2	10.6	1.8	2.7	10.5	58.2	4.4	0.5
Tangipahoa	15.7	6.1	0.6	12.3	7.9	53.3	3.5	0.5
Tensas	5.7	0.2	0.1	20.8	11.7	60.2	1	0.2
Terrebonne	13	6.7	0.7	10.5	8.4	57.3	3.1	0.4
Union	15	3.3	0.6	20.2	15.4	41.8	3	0.7
Vermilion	12.3	7.8	2.2	10.7	15	45.7	5.9	0.3
Vernon	6.4	7	1	7.2	13.3	63.4	1.2	0.6
Washington	13.5	7.9	1.5	10	12.3	46.9	7.3	0.6
Webster	19.2	6.2	2.3	7.6	16.2	45.4	2.6	0.6
West Baton Rouge	9.5	6.3	1.4	7.4	8.2	60.1	6.1	1
West Carroll	7.4	8.5	4.7	16.8	8.6	49.6	3.6	0.7
West Feliciana	11.6	5.5	0.4	19.5	17	39.5	2.3	4.3
Winn	8.8	10.9	0.4	5.8	12.1	58.3	2.5	1.3

AdjD = Adjustment Disorder (F43), AnxD = Anxiety Disorder (F41 and F42), BaD = Bipolar affective disorder (F31), CDMD = Conduct disorders and mixed disorders (F91 and F92), DepD = Depression Disorder (F20, F32, F33, and F34), Hyp/ADHD= Hyperkinetic/ADHD disorders, Other MH = Other Mental health and Behavior disorders (Other FXX), and Non MHBD = Non-Mental Health and Behavior disorders (Non FXX).