A Needs Assessment and Program Intervention for Patients in Mental Health Crisis in Lieu of Admission to the Emergency Department of Rapides Regional Medical Center, Rapides Parish, Louisiana

Daphne R. Robinson, JD, MPH Candidate (May, 2016)
Emory University
Rollins School of Public Health
Atlanta, Georgia

Problem Statement

In 2013, the Louisiana State University Board of Supervisors approved a plan to close Huey P. Long Medical Center (HPLMC) in Rapides Parish, Louisiana, one of the ten public hospitals in Louisiana created to provide care to the indigent since 1936 (Becker's Hospital Review 2013). In 2012, Congress reduced Medicaid spending in Louisiana by $523 million dollars (Public Affairs Research Council, 2013). In response, the state of Louisiana chose to apply $329 million dollars in spending cuts to the Louisiana public hospital system forcing the closure of HPLMC in Rapides Parish, Louisiana, as a public hospital, and the creation of a public private partnership between the state of Louisiana and two private hospitals, Rapides Regional Medical Center (RRMC) and Christus St. Frances Cabrini Hospital (Cabrini), to provide a system of safety net services for the poor and uninsured (PAR, 2013). RRMC and Cabrini agreed to take on direct inpatient and emergency care loads from HPLMC (BHR, 2013).

Many individuals with mental illness or substance abuse disorders in the area served by HPLMC often sought non-emergency primary care services in the Emergency Department (ED) of HPLMC because they did not have private insurance or Medicaid and could not afford to pay for services (Hood, 2009). Serious mental illnesses include: major depression, schizophrenia, and bipolar disorder, and other mental disorders that cause serious impairment (Pearson, Janz, & Ali, 2013). Additionally, many individuals in the area served by HPLMC have co-occurring substance abuse disorders (Pearson et al., 2013).

After the closure of HPLMC and the reduction in community-based mental health services, hospital leadership at RRMC became concerned that the number of patients admitted via physician emergency certificate (PEC) in mental health crisis would increase, thereby reducing the quality of services provided to those patients and others in the ED. In Louisiana, any physician, psychiatric mental health nurse practitioner or psychologist may execute an emergency certificate, after an actual examination of a person alleged to be mentally ill or suffering from a substance abuse disorder. The person must be deemed in need of immediate care and treatment in a treatment facility, by an examining physician, psychiatric mental health nurse practitioner or psychologist, who determines the person to be dangerous to self or others or to be gravely disabled (La. R.S. 28:53, et seq). The certificate shall last for a period of seventy-two (72) hours (La. R.S. 28:53, et seq). After the emergency certificate is issued, the patient may be admitted and detained at a treatment facility for observation for a period not to exceed fifteen (15) days. The patient can be held for an additional fifteen-day period, only if a second emergency certificate is executed (La. R.S. 28:53, et. seq).

Ideally, if the patient is deemed to meet the criteria for a physician emergency certificate (PEC), as defined by the statute, the patient is held for seventy-two (72) hours in a hospital until the patient is stabilized or is discharged to an inpatient facility for further observation and treatment or referred to outpatient services. However, in reality, because of the lack of outpatient resources in central Louisiana and the statewide shortage of inpatient beds in Louisiana, many patients are discharged after the PEC period, only to return to the emergency department in mental health crisis (Hood, 2009).

Purpose

In 2013, mental health was identified as one of the top five health priorities in Rapides Parish, Louisiana, by focus groups because of the lack of mental healthcare providers in the area, the lack of inpatient mental health beds, the overutilization of ED services for patients in mental health crisis, and the lack of community-based services for mental and behavioral health disorders. Rapides Parish is designated as a Health Professional Shortage Area (HPSA) in mental health services and is characterized by high poverty and a large elderly population.

Many patients in mental or behavioral health crisis, particularly the indigent and the homeless, utilize area EDs because there are few, if any, available resources, to access treatment and medication in the community. To date, there has been very little information provided about this patient population or the factors that have contributed to the current state of mental health care in the community. The purpose of this study is conduct a community needs assessment of the mental and behavioral health care needs of Rapides Parish for patients in immediate mental health crisis and to examine the current practices in the community in order to recommend areas of improvement.

The objective of this CNA is to improve access to community-based mental health services for patients in mental health crisis, who otherwise would seek treatment in the ED of RRMC. Included in this study are also the findings of a community health needs assessment (CNA) done in by RRMC, in collaboration with the Rapides Foundation, detailing the overall community health of Rapides Parish, Louisiana. This assessment will evaluate the following:

- The demographics of the population in mental health crisis seeking services in the ED of RRMC
- The current state of mental health services in the area serviced by RRMC
- National best practice, community-based models for the treatment of individuals in mental or behavioral health crisis
- Recommendations for evidence-based models that can be replicated in the RRMC service area.

With this data, the community can, hopefully, map out a course of action to make positive and sustainable change in the provision of community-based services those in mental health crisis.

Mental Health in Louisiana

According to Mental Health of America (MHA), Louisiana is one of four states in the country with the highest prevalence of mental illness and the lowest rates of access to care (Nguyen & Counts, 2015). Over 19.28% of adults 18 and older in Louisiana or 649,000 people suffer from "any form of mental illness," compared to 18.19% nationally (Nguyen, et al, 2015). Over 285,000 people or 8.48% of adults in the state, compared to 8.46% nationally, are dependent on or abuse illicit drugs or alcohol (Nguyen, et al, 2015).

The highest percentages of uninsured adults with mental illness are in the Southern and Western states (Nguyen, etal, 2015). Louisiana ranks number 40 among the 50 states in the number of uninsured adults with any mental illness (Nguyen, et al, 2015). In addition to economic barriers to access, Louisianans are faced with barriers resulting from a lack of mental health providers as well. The state is ranked number 45 out of 50 for its lack of mental health provider workforce availability (Nguyen, et al, 2015). Nationally, in 2015, there was a ratio of 250 providers to every 1 person in the population (MHA, 2016). In Louisiana, however, the ratio was 859 citizens for every one mental health provider in the state (MHA, 2016). This means that there is almost four times less access for individuals in Louisiana who need mental health treatment, when compared to the national average (MHA, 2016). Consequently, people with chronic mental illness frequently are forced to seek non-emergency primary care services in emergency rooms throughout the state because they do not have private insurance or Medicaid coverage and cannot afford to pay for services (Hood, 2009).

Uncoordinated system of care

To add to the problems associated with accessing mental health treatment in Louisiana, the delivery of behavioral health services in the state is usually separate and uncoordinated from the broader health care delivery system (AHA, 2012). This fragmentation of care can often compromise the quality of care and clinical outcomes for patients with co-morbid behavioral and physical health conditions (AHA, 2012). Unlike the rest of the country in the last 50 years, which was moving towards a community-based model of rehabilitation and recovery in outpatient settings, Louisiana followed a much different path. Prior to Hurricane Katrina in 2005, the state did not close any of its long-term mental hospital facilities (Hood, 2009). Counter to the trend in other states, Louisiana actually expanded the number of state psychiatric institutions from five to six in the mid-1980's (Hood, 2009).

Cost of mental health treatment

The most striking difference between Louisiana and most other states is the high level of spending for state mental hospitals that provide intermediate to long-term inpatient care (Hood, 2009). According to data provided by the National Association of State Mental Health Program Directors (NASMHPD), national spending on mental health services in 2006 included 28% for state mental hospitals and 70% for community-based services (Hood, 2009). However, in Louisiana, the spending distribution in 2006 was 56% for mental hospitals (which was second highest in the U.S.) and 30% for state community-based care (which was the worst in the U.S.) (Hood, 2009). At the time, per capita Louisiana spent $18.57 on community-based care, compared to $72.97 spent per capita nationally (Hood, 2009). Louisiana was also an outlier when it came to program costs and administration (Hood, 2009). The national average for administrative costs at the time was $2.14 per capita, but Louisiana ranked at four times the national average of $8.01 spending per capita (Hood, 2009).

In 2009, during another fiscal crisis, the Louisiana Department of Health and Hospitals moved to merge the Office of Addictive Disorders with the Office of Mental Health, creating the Office of Behavioral Health (OBH) (Hood, 2009). Later, in 2012, the state closed all but two of its mental hospitals. In 2014, the total budget for OBH was $272,888,963 and 54.9% of that amount was still allocated for the two mental health hospitals (Louisiana Office of Behavioral Health, 2015). This was an overall reduction of more than $27 million or 10% from the Office of Behavioral Health from the previous year (NAMI, 2014). Community based

services increased to 42.5% of the budget and administrative costs were in line with the national average at 2.5% (OBH, 2015). However, not only did the state reduce the number of inpatient beds by closing mental hospitals, there were only 65 state supported community-based clinics, of which only 39 provided integrated behavioral and mental health services for the entire state (OBH, 2015). Although the OBH budget remained unchanged in 2015, given the state's current fiscal crisis, (which is garnering national attention at this time), the budget for mental health is projected to be cut even further, thereby reducing funds for community-based outpatient services (NAMI, 2015).

When Community-Based Services Are Cut

Prior to Hurricane Katrina, Louisiana essentially had a "two tier" health system, in which the insured population (including those with Medicare and Medicaid) had access to a range of community hospitals and physicians, while the poor and uninsured were mostly cared for through the state-run safety net system of public hospitals (Rudowitz, Rowland, & Shartzer, 2006). There were ten hospitals across the state within the charity system, including Huey P. Long Medical Center in central Louisiana (PAR, 2013). Prior to 2013, the charity hospital system, which had existed in Louisiana since the 1700's, would treat anyone who resided in the state of Louisiana, regardless of ability to pay (PAR, 2013). The state public hospitals offered care for acute conditions, but provided fewer options for preventative care for the uninsured (PAR, 2013). Many uninsured in Louisiana lived far from a state public hospital because the hospitals were spread throughout the state (PAR, 2013). Consequently, this has led to an overutilization of expensive emergency care (PAR, 2013). The uninsured in the state with mental and behavioral health disorders often came to rely on being able to receive help in hospital EDs (PAR, 2013). Within the charity system of hospitals, Louisiana had historically high rates of ED visits, which is an indication of the limited access to primary care and preventive services in the state (Rudowitz, et al, 2006). In 2004, the year before Hurricane Katrina, the state ranked fourth in the nation for high ED use, with 548 visits per 1,000 people, compared to the national average of 383 visits (Rudowitz, et al, 2006).

In 2013, after a series of Medicaid cuts by the federal government, the state entered into a series of agreements with private partners to assume responsibility for operating five of the previously state-operated hospitals (PAR, 2013). However, four of the hospitals, which had previously provided a safety net for generations of citizens, would be closed.

Mental Health in Rapides Parish

Closing of Huey P. Long Medical Center

The Louisiana Legislature officially closed HPLMC, the charity hospital that served Rapides Parish, in May of 2014. However, emergency services were virtually non-existent at the hospital by the summer of 2013 (PAR, 2013). Once the hospital closed, the safety net that existed for these patients and those incarcerated in local jails and the state prisons, was gone. It was expected that many of these patients would be absorbed by RRMC and another local hospital, as a part of the agreement between the two hospitals and the state, to privatize the operations of HLPMC. In 2011, the last year that HLPMC was fully operational, HLPMC saw 37,758 patients in its ED alone (PAR, 2013). In a community with a health professional shortage in primary care and mental health services, the burden on local hospitals to absorb such a large number of patients in mental and behavioral crisis is certainly significant.

Demographics of the area

The geographic area of this CNA is Rapides Parish, Louisiana, which includes

Alexandria. The parish is located in the central region of the state and is often referred to as central Louisiana. The total population of Rapides Parish, Louisiana, in 2014 was 132,488. Of that total, 51.7% of the population was female and 48.3% was male. In 2014, white people made up 63.9% of the total population and African-Americans represented 32.0%. Only 2.8% of the total population was considered Hispanic or Latino (US Census Bureau, 2016). From 2009 to 2013, 19.9% of the total population lived below the poverty level[1] (US Census Bureau, 2016).

RRMC is a for-profit hospital in Alexandria, Louisiana, owned by Health Corporation of America (HCA). It is the largest hospital in the Rapides Healthcare System of Hospitals and attracts patients from a twelve-parish area with a total population of 431,416 (PRC, 2013). All twelve parishes within the healthcare system are medically underserved areas. Additionally, all twelve parishes, including Rapides, suffer because of an inadequate number of psychiatrists and treatment facilities available to address residents' behavioral health needs. There are a limited number of inpatient beds for mentally ill patients in the state, thus creating another reason for patients in the community to turn to hospital EDs when they are in crisis.

The Rapides Healthcare System conducted a Community Health Needs Assessment (CHNA) in 2013, as a follow up to similar studies conducted in the area in 2002, 2005, and 2010 to determine the health status, behaviors, and needs of residents in Rapides Parish. The CHNA included a survey instrument for the purposes of the study and included questions from the CDC Behavioral Risk Factor Surveillance System (BRFSS), other public health surveys, and certain customized questions created by the authors of the study (PRC, 2013). The sample design consisted of a random sample of 760 adults over the age of 18 and older in Rapides Parish. Additionally, the authors conducted focus groups of 43 key informants, which consisted of representatives from public health, physicians, other health professionals, social service providers, youth, and community leaders (PRC, 2013). At the conclusion of the key informant focus groups conducted in 2013, participants were asked to write down what they individually perceived as the top five health priorities for the community based on group discussions, as well as their own experiences and perceptions (PRC, 2013). It is interesting to note that mental health was identified by the key informants and the focus groups as one of the top four health priorities in Rapides Parish (PRC, 2013).

Using a benchmark data that included the previous surveys conducted in 2002, 2005, and 2010, regional risk factors, statewide risk factor data, nationwide risk factor data, and objectives from Healthy People 2020, the following significant findings were made regarding mental health in Rapides Parish:

- An increase in the number of suicides
- An increase in the number of individuals without health insurance
- An increase in the number of drug induced deaths
- An increase in the percentage of individuals who view their mental health as fair or poor
- An increase in the percentage of individuals with symptoms of depression lasting for two or more years
- An increase in the percentage of those with chronic depression who were seeking help.

[1] For the purposes of this CNA, the poverty threshold for a family of four is $23,550 annual household income or lower (PRC, 2013).

During the focus groups, respondents expressed concerns that many in the community, who suffer from mental illness, also have co-occurring substance abuse issues and self-medicate with drugs or alcohol (PRC, 2013). Overall, the community suffers due to an inadequate number of psychiatrists and treatment facilities available to address residents' behavioral health needs (PRC, 2013). There are only a limited number of inpatient beds for mentally ill patients, so physicians must PEC mentally ill patients in order to obtain inpatient services. This results in people waiting in the emergency room for days (PRC, 2012). Respondents during the focus groups were very vocal and felt very strongly that the ED was not an appropriate place for mentally ill patients. Many voiced concerns that the ED did not provide appropriate treatment for the patient and if a patient did not have health insurance, it would be impossible to locate an inpatient bed (PRC, 2013). Outpatient mental health clinics are scattered throughout central Louisiana, but continuity of care suffers, because of staff turnover (PRC, 2013). There are not enough services to treat mental and behavioral health disorders in the community, so very ill patients return to the community without acquiring the necessary treatment (PRC, 2013). For those residents who can access mental and behavioral health services, the wait times before appointments exceed several weeks. The current waiting periods may cause patients to go without timely care, which increases the likelihood of needing hospitalization (PRC, 2013). The aforementioned problems in accessing mental and behavioral health care in Rapides Parish contribute to the use of the ED for patients in mental health crisis, although it is the least appropriate place for treatment of these conditions.

Literature Review

The review of literature for this CNA includes extensive searches in databases such PubMed, Lexis/Nexis Academic, Emory University's EJournals and Ebooks. These resources were used to search for peer reviewed journals and books, scholarly articles, and grey literature (to include government publications, reports, statistical publications, and policy documents) to provide background and insight into the prevalence of mental illness in the United States and the state of Louisiana, the extent of the use of EDs to treat mental illness, the effectiveness of such treatments, and the kinds of community-level, evidence-based models that are being utilized across the country to treat patients in mental health crisis outside of the ED.

Data Collection and Results

This assessment utilizes a mixed-methods research approach, in which both quantitative and qualitative data were collected.

1. Quantitative Data

The law of Louisiana provides that any physician, psychiatric mental health nurse practitioner or psychologist may execute an emergency certificate, after examining a patient alleged to be mentally ill or suffering from a substance disorder (La. R.S. 28:53, et seq). In order to issue the emergency certificate, the provider must determine that the patient is a danger to self or others or is considered gravely disabled (La. R.S. 28:53, et. seq). The certificate lasts for a period of 72 hours and it is during this time that the patient is stabilized by the staff of the ED and an inpatient bed is located for the patient, if necessary, or the person is discharged to out-patient services or the patient is simply discharged to their home (La. R.S. 28:53, et seq).

The ED does not maintain a computerized database of patient records for this population, but does maintain a paper record that includes the mandatory Form OBH1. The Form OBH1 is a two-part,

carbonless copy document sold to hospitals by the Office of Behavioral Health for a cost of $6.55 per pack of 50 that states the reasons for certifying the patient and is signed by the physician. The carbon copy is maintained in the file and the original returned to the OBH. The documents related to the admission of the patient via PEC are separately maintained in a paper file by RRMC and are not part of any other Electronic Health Record (EHR) maintained by the hospital on the patient. Consequently, much of what is known about PEC patients is anecdotal, thus it is difficult to evaluate patterns or trends. This is the first time that patient data has been collected and analyzed on this specific population.

The quantitative data includes the collection of secondary data from 197 records of patients admitted to the RRMC ED via PEC from March 2014 to October 2014. From those records, the following information was collected:

- Unique Identifier Number (UIN)
- Date of Birth (DOB),
- Age,
- Gender,
- Race,
- Street Address,
- Parish, City, State, Zip Code,
- Admission Date
- Examination Date,
- ED Physician,
- Primary Care Physician (PCP),
- Insurance,
- Marital Status,
- Street Address,
- Reason for Visit,
- Diagnosis,
- PEC Reason,
- Alcohol Use,
- Drug use,
- History of Mental Illness,
- Suicidal,
- Homicidal,
- Violent, and
- Mental Condition.

Parameters for whether the patient was admitted to a long-term care facility (Admitted) and the facility the patient was admitted to (Facility) were also collected for 108 of the patient records.[2] The data collected was then input into a Microsoft Excel Spreadsheet, and later uploaded into **Epi Info7**, a public domain, statistical software for epidemiology developed by CDC in Atlanta, Georgia. After data was entered into the database, Epi Info7 was used to statistically analyze patterns and frequencies of the subject population. Secondary research from existing population-based databases, such as the American Community Survey and the U.S. Census Bureau, was used for comparison to benchmark data at the state and national levels.

2. Qualitative Data

Qualitative data collected includes primary research gathered through several key stakeholder and key informant interviews using an open-ended, semi-structured set of interview questions. To this end, interviews were conducted with a Registered Nurse and the Director of the ED at RRMC, a Registered Nurse and ED Case Manager at RRMC, and the Director of Programs and Communications at the Rapides Foundation via Zoom, a videoconferencing software. The interviews were recorded via Zoom and transcribed using T5 Transcription software and analyzed and coded using Atlas.ti software. Specifically, the qualitative data collection addressed issues regarding the current state of community-based mental health services in the area serviced by RRMC. The interview discussions explored participants' perceptions of the state of mental health

[2] Although the ED staff works very hard to get patients into a long-term care facility after the expiration of the 72 hour hold, the name of the facility was not routinely documented, and thus was not included in the first 87 records.

services in Rapides Parish and central Louisiana, where patients go in the community to access mental health services, the barriers in the community accessing community services, and the populations affected by those barriers.

The collected qualitative information was coded using ATLAS.ti, qualitative data analysis software, and then analyzed thematically for main categories and sub-topics. Key themes emerged from each of the interviews. In the qualitative findings, the term 'participant' is used to refer to the individuals that were interviewed.

Discussion

1. Quantitative Data

After conducting a retrospective cohort study of the records of patients, who presented to RRMC ED in mental and/or behavioral health crisis from March 2014 to October 2014, the data was analyzed and the following findings were made:

The patient population was evenly divided between female (51%) and male (49%). Over 50% of the patients were single or divorced. The racial makeup of the target population was Black (39%) and White (61%). These numbers approximately reflect both the gender and racial makeup of Rapides Parish. The largest percentage of the target population was domiciled in Rapides Parish (73%) and Grant Parish (10%), Louisiana. Patients primarily reside in the two largest cities in Rapides Parish, Alexandria (36%) and Pineville (21%).

Forty-eight (48%) percent of the population analyzed had private insurance. Surprisingly, only 28% of the patient population was uninsured. Sixteen (16%) percent of the patient population had Medicare and 5% had Medicaid. Three (3%) percent of the patient population had VA benefits.

The median age of the patient population was 31. The oldest patient admitted was 75 and the youngest was 7. The mean age of the patient population at the time of admission to the ED was 23. One of the most significant findings of the study was that the majority of the patient population studied did not have a primary care physician. Sixty-four (64%) percent of the target population reported not having a primary care physician. Eighty-eight (88%) percent of the target population had a history of mental illness. A majority of the target population (81%) presented to the ED with some type of suicidal ideation.

Seventy-eight (78%) percent of female patients and eighty-seven (87%) percent of male patients were suicidal. Eight-seven (87%) of black patients within the target were suicidal, compared to seventy-four (74%) of white patients within the target population. Of the target population, only fifteen (15%) percent were deemed homicidal at the time of admission to the ED. Twenty-three (23%) percent of the target population were determined to be violent at the time of admission.

Over sixty (60%) of the entire target population admitted to or tested positive for drug use. Of those that admitted to using drugs at the time of admission or tested positive for drugs at the time of admission, forty-four (44%) percent were women and fifty-six (56%) percent were men. Of those that admitted to drug use at the time of admission or tested positive for drugs at the time admission, forty-three (43%) percent were black and fifty-seven (57%) percent were white. Regarding alcohol use, only twenty-five (25%) percent of the target population admitted to or tested positive for alcohol use at the time of admission.

There are approximately twenty (20) different physicians on duty during the time period in question. Of those twenty (20)

physicians, four (4) physicians admitted forty-eight (48%) percent, or a majority, of the total target population.

Almost all of the patients that presented to the ED with mental or behavioral health problems were actually admitted via physician emergency certificate (93%). The primary reasons given by ED physicians for issuing the emergency certificate were that the patient was a danger to self (49%), a danger to others (32%), or gravely disabled (9%).

From March 2014 to October 2014, only 14 people visited the ED twice, 1 visited the ED 3 times, and 1 patient visited the ED 6 times. All of the visits were to address mental and behavioral health issues.

The data defeated several assumptions that hospital staff had about the target population. First, contrary to popular belief, a majority of the patients were insured. Moreover, a majority of those insured were covered by private insurance. However, even patients with health insurance did not have primary care physicians, which may explain why these patients' mental and/or behavioral health issues have gone untreated.

Next, a significant portion of the target population have co-occurring substance abuse concerns, as evidenced by the number of patients, who admitted to or were determined to have used alcohol or drugs. Thus, outpatient providers must be prepared to address co-occurring substance abuse problems.

Third, the racial demographics of the target population roughly reflect the racial makeup of Rapides Parish. The majority of the patients resides in Rapides Parish and lives in the two largest cities in the parish, Alexandria and Pineville. This is significant because it indicates where outpatient services should be located in the community.

Finally, only 108 of the 197 patient records were analyzed to determine which in-patient facilities accepted the most patients from the ED. However, of that number, the data shows that the psychiatric unit at Christus St. Francis Cabrini Hospital and Longleaf Behavioral Health Center are the facilities that accepted the most patients from the ED at RRMC. This information helps the hospital staff to determine which in-patient facilities have the best track record of accepting this patient population.

3. Key Informants

Key informant interviews were conducted with three individuals in Rapides Parish who are very familiar with the target population and the community-based resources available to address their mental and behavioral health needs. Those interviewed include: Shawn Moreau, a Registered Nurse and the Director of the ED at RRMC, Lynne Bordelon, a Registered Nurse and ED Case Manager at RRMC, and Annette Beuchler MBA, FACHE, the Director of Programs and Communications at the Rapides Foundation. These individuals were chosen because of their familiarity with patient population and their familiarity with the landscape of mental health services in Rapides Parish.

4. Interview Themes

The interview discussions explored the informants' perceptions about the care of patients in mental health crisis in Rapides Parish, Louisiana. The themes that emerged included the following:

- The state that patients are in when they arrive in the ED,
- The lack of community services for indigent and Medicaid patients,
- Whether the closing of HPLMC increased the number of patients in mental health crisis seeking care at RRMC, and

- The barriers to accessing community-based, mental health services in Rapides Parish.

The informants agreed that many patients who arrive in the ED suffering from mental and/behavioral health issues are either brought in by families, the police, or come in voluntarily. Upon presenting to the ED, many of these patients are depressed, suicidal, psychotic, and many are also suffering from co-occurring substance abuse disorders. Many of these patients come to the RRMC ED because they are indigent and homeless and have no other place to go to get their medications. At least one informant acknowledged that some patients may be insured, but are unable to access mental health treatment through a primary care physician in the community because of the shortage of primary care physicians or the primary care physician's unwillingness to treat mental health disorders.

All of the participants overwhelmingly agreed that although there are a few community-based services for those in mental health crisis in Rapides, they are very limited, particularly for the indigent and those that receive Medicaid. At this time, there is only 1 community-based provider in Rapides Parish that accepts indigent and Medicaid patients, if openings are available. The only other publicly funded option for outpatient and inpatient mental health services in Rapides Parish was Central State Hospital, a state owned and operated mental health facility. Unfortunately, that facility is now closed.

According to the participants, the greatest improvement that could be made to improve the care of the target population is to provide follow-up care through community-based, mental and behavioral health services for homeless, indigent, and Medicaid patients. If these services were provided, it is believed that the number of patients that utilize the ED for mental and behavioral health treatment would diminish significantly. Another suggestion for care of those patients that present to the ED in mental or behavioral health crisis includes the creation of a crisis intervention center or crisis intervention mobile team.

One key informant explained that sometimes she is not sure if there is truly a lack of services in the area or if there is simply not a good system in place to assist people in finding the care or services that they need, especially for mental health treatment. The provision of mental and behavioral health services in the state is seen as disjointed and limited by the lack of funding provided by the state. State legislation mandates that the administration of the Louisiana behavioral healthcare system, including community and residential services, should be operated by independent health care districts or authorities (also referred to as local governing entities or LGEs) (La. R.S. 28:22, et seq). However, these entities are poorly funded and offer little, if any, support to the individuals in the community that need them the most. For example, the legislature passed legislation in 2008 to create crisis identification and stabilization services, which would include a coordinated system of entry into the crisis system rather than use of ED services (La. R.S. 28:22, et seq). Although this was viewed as an excellent initiative by at least one key informant, the legislation has not been implemented by the Central Louisiana Human Services District, the local governing healthcare entity that includes Rapides Parish, because of a lack of funding from the state (Torbett, 2014). All of the stakeholders agree that there are many people of good will in Rapides Parish, who recognize the lack of community services for those with mental and behavioral health issues, but admit that without funding it is impossible to achieve progress.

Transportation was also identified as another barrier to access in Rapides Parish. Although the Rapides Foundation has provided funding to Federally Qualified Health Centers (FQHCs) to integrate behavioral health into the primary care setting in Winn and Grant Parishes, both parishes are over 50 miles away from Rapides in rural central Louisiana, creating an access problem for many who do not have transportation to reach these communities.

Another barrier to accessing community-based services is the unwillingness of many primary care physicians in the area to assess and treat mental health conditions. Increased educational opportunities are needed for primary care physicians, who still may not feel comfortable diagnosing a patient with depression or anxiety and providing medication management for these patients.

Limitations

There were some limitations related to the research methods that should be acknowledged. First, regarding the quantitative data analysis, the sample size is relatively small and the patient data is only captured for an eight-month window of time. Of course, as with quantitative data collections, there is missing or incomplete data. Patient data for this population is recorded using a paper and pencil method at the time of admission to the ED. Additionally, there are multiple individuals collecting and inputting data, which may result in missing or incomplete data.

Next, secondary data based on self-reports (e.g., 2012 and 2013 Community Health Needs Assessments for Rapides Parish) should be interpreted with particular caution. In some instances, respondents may over or underreport behaviors and illnesses based on fear of social stigma or misunderstanding the question asked. Respondents may be prone to recall bias. Additionally, public health surveillance data has its limitations regarding how the data was collected and reported, who is included in the public health datasets, and whether sample sizes for specific populations are large enough for analysis.

Finally, although the interviews conducted for this study provide valuable insights, the results are not statistically representative due to the small sample size. The individuals interviewed have a significant interest in mental and behavioral issues in central Louisiana. Because of this, it is possible that the responses received only provide one perspective on the issues discussed.

Assertive Community Treatment (ACT) Model

Results

There are a number of existing, evidence-based programs that could be implemented in Rapides Parish, Louisiana to assist patients when they are in mental health crisis.

1. Assertive Community Training

The first program is the Assertive Community Treatment (ACT) model. ACT is a comprehensive community-based model for delivering treatment support, and rehabilitation services to individuals with severe mental illness (Phillips, et al, 2008). ACT is appropriate for individuals who experience the most intractable symptoms of severe mental illness and the greatest level of functional impairment (Phillips, et al, 2008). Those with severe mental illness are often heavy users of the ED and inpatient psychiatric services and they frequently have the poorest quality of life (Phillips, et al, 2008). The program can also be enhanced and adapted to meet the needs of the Rapides Parish community (Phillips, et al, 2008).

Research has shown that ACT is effective in reducing hospitalizations and is

no more expensive than other types of traditional community-based care. Additionally, the rate of patient satisfaction is higher for patients and their families (Phillips, et al, 2008).

2. Crisis Intervention Team (CIT) Model

Very often, the people who come in contact with individuals in mental health crisis are members of law enforcement. Unfortunately, in Rapides Parish and in other parts of the country, a significant number of instances of police involvement with individuals in mental health crisis have resulted in injury or even death. The three largest law enforcement agencies in Rapides Parish have had several, well reported cases of police encounters with individuals in mental health crisis, particularly since the closing of HPLMC.

One program touted by SAMSHA and NAMI as a successful collaboration between law enforcement and the mental health community in responding to individuals in the community in mental health crisis is the Crisis Intervention Team (CIT) model (SAMSHA, 2009). This intervention is considered a best practice model for the diversion of those offenders that are mentally ill out of the criminal justice system (NMHA, 2003). CIT is an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships.

The use of CIT in Rapides Parish could result in the de-escalation of situations that are life-threatening for officers and the individuals involved. Moreover, the partnerships developed between law enforcement officers and mental health professionals in the community may provide officers with treatment options for these individuals other than the ED or jail.

3. Integration of Behavioral Health into Primary Care

As demonstrated by the quantitative data analysis of patients admitted via PEC to the RRMC ED, a majority of the patients had private insurance, but did not have a primary care physician. Studies show that for most patients with behavioral health issues, the primary care setting would be the best point of care because most mental health care is provided in the primary care setting (Crowley & Kirschner, 2015). A 2000 survey determined that 32% of undiagnosed, asymptomatic adults would likely turn to their primary care physician to help with mental health issues; only 4% would approach a mental health professional (Crowley & Kirschner, 2015). Employers and public and private health insurance payers should work to encourage insureds to have a patient centered medical home (PCMH) by offering incentives for routine screening by crediting premiums and deductibles. These organizations should also work to remove payment barriers that impede the integration of primary and behavioral health care into one setting (Crowley & Kirschner, 2015).

Additionally, physicians also cite educational needs and a lack of training as obstacles to integrated care. The Integrated Behavioral Health Project under the California Mental Health Services Authority identified training gaps that need to be addressed to facilitate integration (Crowley & Kirschner, 2015). The top 3 training needs cited by physicians were "better understanding of the impact of physical disorders on mental health, addressing behavioral health components of physical disorders, and understanding and addressing the psychiatric effects of medications for physical conditions (Crowley & Kirschner, 2015). Cross discipline training is needed to prepare behavioral health workers and primary care physicians to effectively integrate their respective specialties into the primary care setting (Crowley & Kirschner, 2015). Primary care physicians in Rapides need to be trained to screen, manage, and

treat common behavioral health conditions before they rise to a level that requires crisis intervention.

4. Peer Support Services

Another intervention that may be effective in addressing the shortage of mental health professionals in Rapides Parish and central Louisiana is peer support services. MHA has taken the position that peer support is an essential element of successful communities that effectively address mental and behavioral issues (MHA, 2016) SAMSHA has identified peer support services as a vital component in recovery (MHA, 2016). Peer-run services are based on the principle that individuals who have shared similar experiences can help themselves and each other (MHA, 2016). Such programs provide an opportunity for communities of consumers who have significantly recovered from their illnesses to help others direct their own recoveries by teaching one another the skills necessary to lead meaningful lives in the community (MHA, 2016). Peer support programs have demonstrated effective outcomes such as reduced isolation and increased empathic responses.

Medicaid is increasingly being viewed as a mechanism to fund peer support specialists along with clinical services for the more traditionally underserved. In order to receive reimbursement and to insure quality care for peer services, there may be a certification process (MHA, 2016). The state of Georgia became one of the first states to pioneer the use of certified peer specialists in order to provide services to persons with serious and persistent disorders and made these services eligible for Medicaid services (Sabin & Daniels, 2003). Training and support for individuals who meet the criteria for peer specialists could be one way to address the health care provider shortage in Rapides Parish and an opportunity for individuals in mental health crisis to find someone to help them maneuver through the complex mental health process.

5. Supportive Housing Services for the Homeless Population

All three of the key informants acknowledged that there is a growing homeless population in Rapides Parish and that many of the individuals who find themselves in the ED of RRMC in mental health crisis are homeless. The Central Louisiana Homeless Coalition is non-profit coalition of volunteers, who wanted to streamline the homelessness services in Central Louisiana and seek federal funding for homelessness programs (CLHC, 2016). Founded in 1999, the Coalition's membership has evolved to include over 30 members including nonprofit service providers, local law enforcement agencies, faith-based organizations, and individuals who share the mission of ending homelessness in Central Louisiana (CLHC, 2016). According to the organization's website, although Rapides Parish may not have dozens of people lining the major roadways of the area, there is a homeless population estimated to be about 40 unsheltered, chronically homeless people in Rapides Parish. Many of these individuals live in abandoned buildings and abandoned houses (CLHC, 2016). In addition, there are many families in the area, who are considered the "hidden homeless" (CLHC, 2016). Many of these people live in cars or move from one friend or family member's home every few days. In fact, the Rapides Parish School Board has identified over 300 homeless children and families each school year. Additionally, shelters across the region, serve over 400 people annually and there are over 100 people in shelters throughout the central Louisiana on any given night (CLHC, 2016).

Supportive housing has been endorsed by the federal government, including the Department of Housing and Urban Development, the Surgeon General, the Department of Health and Human Services,

and the National Council on Disability (Bazelon Center, 2009). Three basic principles guide supportive housing. First, supportive housing gives participants immediate, permanent housing in their own apartments or homes (Bazelon Center, 2009). Second, individuals in supportive housing have access to a comprehensive array of services and supports, such as access to ACT teams that are interdisciplinary and mobile and can provide mental health and substance abuse treatment so that the individual is able to live successfully in the community (Bazelon Center, 2009). Third, supportive housing allows an individual to focus on housing first and then recovery (Bazelon Center, 2009). Third, supportive housing allows full integration of the mentally ill into the community through possibilities for employment and education. People recovering from mental illness cannot be expected to succeed without a safe, secure home (Bazelon Center, 2009). Moreover, most the cost of supportive housing can be funded through existing programs, including Medicaid, federal housing, and rental assistance programs (Culhane, Metraux, & Hadley, 2001).

6. Expansion of Medicaid ACA Coverage

Louisiana became the 31st state in the United States to expand Medicaid after the swearing-in of Governor John Bel Edwards in January of 2016 (Litten, 2016). With his executive order expanding Medicaid coverage, Governor Bel Edwards made Louisiana the first state in the Deep South to accept Medicaid funding to care for those caught in the gap of coverage (Litten, 2016). Beginning July 1, 2016, when Medicaid expansion is expected to take effect, Louisiana will be closely watched and evaluated because the state has some of the poorest health outcomes in the country, particularly for those suffering from mental illness.

In 2014, an estimated 1.9 million low-income, uninsured people with a substance use disorder or a mental illness lived in states that had not yet expanded Medicaid under the ACA (Rief, et al, 2016). In addition, people with behavioral health needs (28%) make up a substantial share of all low-income uninsured individuals in these states (Rief, et al, 2016). It is estimated that the percentage of uninsured adults in Louisiana aged 18-64 who had any mental illness or substance use disorder in the past year during the period of 2010-2014 was 28.8% (Rief, et al, 2016).

7. Creation of Advocacy Group

The primary goal of public health is the protection and promotion of the public's health. Typically, research, surveillance, policies, and programs in public health are focused on the patterns and factors associated with understanding and improving the health of target populations. These factors go beyond health care to include social, economic, political, and physical environmental conditions which affect people's health (Kieffer & Reischmann, 2004). Historically, many public health interventions required little inherent necessity for community building and capacity, such as the development of water and sanitation or addressing outbreaks of immunization-preventable diseases (Kieffer & Reischmann, 2004). Mass media and the formal public health system were sufficient to address these health problems. However, many of today's problems, particularly those causing large health disparities in marginalized communities, have complex causation and require similarly complex and long-term interventions (Kieffer & Reischmann, 2004).

The lack of an advocacy organization to organize and mobilize the community around the creation and expansion of community-based resources for individuals in mental and behavioral health crisis in Rapides Parish is one of the most critical

missing pieces. To address this public health problem, many of the community health interventions discussed must include a strategy that also focuses on building a coalition of public health practitioners, community leaders, mental health advocates, and volunteers.

Improving public health often involves policy changes that are the result of complex advocacy efforts (Tabak, Eyler, Dodson, & Brownson, 2014). However, as public health practitioners, little emphasis is placed on the critical role of advocacy in translating research and evidence into policy, practice, and change in public opinion (Chapman, 2001). Everyone involved in public health, social services and direct health care in central Louisiana understands the problem, but little has been done to mobilize the community-at-large to create change.

Conclusion

In Rapides Parish, the approach to crisis services must be forward-looking rather than merely reactive, with success seen as the ability of the population served to return to a stable life in the community. Rather than simply trying to increase the number of beds available for an individual in mental health crisis, the goal must be preventative care and a reduction in the number of crises that occur among people with mental illnesses, and thus a reduction in the need for emergency services.

References

1. AAEP, (2016a). Journal of the American Association for Emergency Psychiatry. Retrieved March 15, 2016, from http://emergencypsychiatry.org/index.html

2. AAEP. (2016b). Journal of the American Association for Emergency Psychiatry, Retrieved March 15, 2016, from http://emergencypsychiatry.org/index.html

3. Agency for Healthcare Research and Quality, (2014). *Project Title : Management Strategies to Reduce Psychiatric Readmissions.* Retrieved March 15, 2016, from http://www.ahrq.gov

4. American Hospital Association, (January, 2012). Bringing Behavioral Health into the Care Continuum. *Trendwatch*, Retrieved from http://www.aha.org/research/policy/2012.shtml

5 Baillargeon, J., Thomas, C. R., Williams, B., Begley, C. E., Sharma, S., Pollock, B. H., Raimer, B. (2008). Medical emergency department utilization patterns among uninsured patients with psychiatric disorders. *Psychiatric Services*, *59*(7), 808–811.

6. Bazelon Center for Mental Health Law. (2007). *Increased Emergency Room Use by People with Mental Illnesses Contributes to Crowding and Delays*. Retrieved from http://www.bazelon.org/LinkClick.aspx?filetickет=Epvwc7WBOHg=&tabid=386

7. Bazelon Center Center for Mental Health Law. (2009). *Supportive Housting Fact Sheet.* Retrieved March 15, 2016 from http://bazelon.org.

8. Centers for Disease Control and Prevention. (2013). *Community Needs Assessment* (CDC, Atlanta, Georgia).

9. Centers for Disease Control and Prevention. (2013). Emergency Department Visits by Patients with Mental Health Disorders — North Carolina, 2008–2010. *Morbidity and Mortality Weekly Report (MMWR)*, *62*(23), 469–472.

10. Centers for Disease Control and Prevention. (n.d). Social Determinants of Health. Retrieved March 15, 2016, from http://www.cdc.gov/socialdeterminants/

11. Chapman, S. (2001). Advocacy in public health: roles and challenges. *International Journal of Epidemiology*, *30*, 1226–1232.

12. Central Louisiana Homeless Coalition. (n.d.). About: Central Louisiana Homeless Coalition, Inc. Retrieved March 27, 2016, from http://www.cenlahomeless.org/about-clhc

13. Cochran, M., Pillsbury, S., Saunders, M., & Dailey, J. (2007). Crisis Intervention Team: The Core Elements. *Communities*, (901), 1–20.

14. Coffman, J., & Beer, T. (2015). The Advocacy Strategy Framework: A tool for articulating an advocacy theory of change, (March) 1-14.

15. Canadian Public Health Association. (2016). *Leadership in Public Health Advocacy.* Retrieved from http://www.cpha.ca/uploads/progs/_/sopha/advocacy-booklet-colour-en-final.pdf

16. Creswell, J. (2013). E.R. Costs for Mentally Ill Soar, and Hospitals See Better Way. *New York Times*. Retrieved from http://www.nytimes.com/2013/12/26/health/er-costs-for-mentally-ill-soar-and-hospitals-seek-better-way.html?_r=0

17. Crowley, R., & Kirschner, N. (2015). The integration of care for mental health, substance abuse, and other behavioral health conditions into primary care: Executive summary of an American college of physicians position paper. *Annals of Internal Medicine*, *163*(4), 298–299.

18. Culhane, D. P., Metraux, S., & Hadley, T. (2001). *The New York / New York Agreement Cost Study : The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals*. Retrieved from http://shnny.org/uploads/NY-NY_Agreement_Cost_Study_2001.pdf

19. Department of Health & Human Services. (2013). HRSA Data Warehouse. Retrieved March 10, 2016, from http://datawarehouse.hrsa.gov/tools/analyzers/HpsaFindResults.aspx

20. FHI 360. (2010a). *Engaging Innovative Advocates as Public Health Champions*. Retrieved from http://www.fhi360.org/sites/default/files/media/documents/engaging-innovative-advocates-as-public-health-champions.pdf

21. Golden L., & Vail R. (2014). The Implications of the Affordable Care Act for Mental Health Care. *Generations*, *38*(3), 96–103. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=cin20&AN=2012833780&site=ehost-live

22. Gomm, M., Lincoln, P., Pikora, T., & Giles-Corti, B. (2006). Planning and implementing a community-based public health advocacy campaign: A transport case study from Australia. *Health Promotion International*, *21*(4), 284–292.

23. Goodell, S. (2014). Health policy brief: Mental health parity. *Health Affairs*. Retrieved from http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=112

24. Gregory, M. (2015, February 20). As services are cut, police deal more with mentally ill. *The Town Talk*. Alexandria, Louisiana. Retrieved from http://www.thetowntalk.com/story/news/local/2015/02/20/services-cut-police-deal-mentally/23771945/

25. Health Management Associates. (2011). Impact of Proposed Budget Cuts to Community- Based Mental Health Services. *Texas Conference of Urban Counties*, 1–14. Retrieved from http://www.txcouncil.com/userfiles/file/Impact%20of%20Budget%20Cuts%20to%20Community-based%20Mental%20Health%20Services%20Final%203%209%2011.pdf

26. Hood, D. (2009). *Public Mental Health Care System*. *Public Affairs Research Council of Louisiana*. Retrieved from http://www.parlouisiana.com/s3web/1002087/docs/Publications/MentalHealth_Dec2009.pdf

27. Health Resources and Services Administration. (2016a). Medically Underserved Areas Criteria. Retrieved March 30, 2016, from http://www.hrsa.gov/shortage/mua/index.html

28. Health Resources and Services Administration. (2016c). Primary Medical Care HPSA Designation Criteria. Retrieved March 29,

2016, from http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/primarycarehpsacriteria.html

29. Johnson, K. (2014, May 12). Part III: The Cost of Not Caring: Mental Illness Cases Swamp Criminal Justice System. *USA Today*. Retrieved from http://www.usatoday.com/topic/4138a246-2c2a-45a4-a36a-9aacb070fe2d/mental-illness/

30. Kieffer, E. C., & Reischmann, J. (2004). Contributions of Community Building to Achieving Improved Public Health Outcomes: Final Report, (August) 1-33.

31. Litten, K. (2016a, January 12). John Bel Edwards signs Medicaid expansion to make 300,000 eligible for federal program. *The Times-Picayune*. Retrieved from http://theadvocate.com/news/14552428-123/gov-john-bel-edwards-issues-executive-order-to-expand-medicaid

32. Litten, K. (2016b, January 12). John Bel Edwards signs Medicaid expansion to make 300,000 eligible for federal program. *The Times-Picayune*, 0–2. Retrieved from http://theadvocate.com/news/14552428-123/gov-john-bel-edwards-issues-executive-order-to-expand-medicaid

33. Louisiana Office of Behavioral Health. (2015). *FY 2016 Combined Behavioral Health Assessment and Plan*. Baton Rouge, Louisiana. Retrieved from http://new.dhh.louisiana.gov/assets/docs/BehavioralHealth/publications/LA2016-17_COMBINED-BG-ASSESSMENTandPLAN_08042015.pdf

34. Mental Health of America. (2016). *Prevention and Early Intervention B4Stage4: The State of Mental Health in America 2016*. Retrieved from http://www.mentalhealthamerica.net/b4stage4

35. Mental Health of America. (n.d.). Position Statement 37: Peer Support Services, 4–7. Retrieved March 16, 2016 from http://www.mentalhealthamerica.net/positions/peer-services

36. National Alliance on Mental Illiness. (2011). *State Mental Health Cuts : A National Crisis*. Retrieved from http://www2.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=126233

37. National Alliance o Mental Illness. (2013). *Medicaid Expansion and Mental Health*. Retrieved from http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Public_Policy/Issue_Spotlights/Health_Care_Reform/ACA-FactSheet3-Medicaid.pdf

38. National Alliance on Mental Illness. (2015). *State Mental Health Legislation 2015*. Retrieved from http://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/State-Mental-Health-Legislation-2015/NAMI-StateMentalHealthLegislation2015.pdf

39. National Alliance on Mental Illness of Greater Houston. (n.d.). NAMI Greater Houston: History. Retrieved March 28, 2016, from http://namigreaterhouston.org/about-nami-greater-houston/history/

40. National Alliance on Mental Illness. (2014). State Mental Health Legislation: 2014 Trends , Themes & Effective Practices, (December), 1–47. Retrieved from http://www2.nami.org/Template.cfm?Section=Policy_Reports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=172851

42. National Mental Health Association. (2003). MHA Position Statement 52: In Support of Maximum Diversion of Persons with Serious Mental Illness from the Criminal Justice System. Retrieved from http://www.mentalhealthamerica.net/positions/diversion

43. Nguyen, T., & Counts, N. (2015). *Parity or Disparity : The State of Mental Health in America*. Retrieved from http://www.mentalhealthamerica.net/sites/default/files/Parity%20or%20Disparity%202015%20Report.pdf

44. National Institutes of Health. (2013a). *Alcohol related emergency department visits and hospitalizations and their co-occurring drug-related mental health, and injury conditions in the united states*. *U.S. alcohol epidemiologic data reference manual* (Vol. 9). Retrieved from http://pubs.niaaa.nih.gov/publications/NEDS&NIS-DRM9/NEDS&NIS-DRM9.pdf

45. NIH. (2013b). *Alcohol related emergency department visits and hospitalizations and their co-occurring drug-related mental health, and injury conditions in the united states*. *U.S. alcohol epidemiologic data reference manual* (Vol. 9).

46. Office of Disease Prevention and Health Promotion (ODPHP). (2016). Leading Health Indicators: Mental Health. Retrieved from https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Mental-Health

47. Perumal, S. (1999). *Organizing a Community Health Advocacy Coalition*. Retrieved from http://www.cwru.edu/med/epidbio/mphp439/Community_Health_Coalition.htm

48. Phillips, Susan, et al. (2008). The Evidence: Assertive Community Treatment. *Psychiatric Services*, *52*(6), 771–779.

49. Professional Research Consultants. (2013). *2013 PRC Rapides Parish, Louisiana* (Vol. 2316). Retrieved from http://www.healthcouncil.org/documents/2013_prc_miami_dade_county_chna_report_reduced.pdf

50. Professional Research Consultants. (2012a). *2012 PRC Community Health Needs Assessment Report-Rapides Parish, Louisiana.* (Vol. 2316).

51. Professional Research Consultants, (2012b). 2012 PRC Community Health Needs Assessment Report. *2316*(800).

52. Public Affairs Research Council of Louisiana. (2013). *A New Safety Net: The Risk and Reward of Privatizing Louisiana's Charity Hospital System*. 1-27. Retrieved from http://www.parlouisiana.org/s3web/1002087/docs/parhospital2013.pdf

53. Rhodes, K. V. (2008). Mood disorders in the emergency department: the challenge of linking patients to appropriate services. *General Hospital Psychiatry*, *30*(1), 1–3.

54. Rief, I., Dey, B., Rosenoff, E., Aspe, K., Ali, M., Lynch, S. (2016) *Benefits of Medicaid Expansion for Behavioral Health*. Retrieved from https://aspe.hhs.gov/pdf-report/benefits-medicaid-expansion-behavioral-health

55. Rosenfield, S. (1991). Homelessness and Rehospitalization: The Importance of Housing for the Chronically Mentally Ill. *Journal of Community Psychology*, *19*(1), 60–69.

56. Rudowitz, R., Rowland, D., & Shartzer, A. (2006). Health care in New Orleans before and after Hurricane Katrina: The storm of 2005 exposed problems that had existed for years and made solutions more complex and difficult to obtain. *Health Affairs*, *25*(5).

57. Sabin, J., & Daniels, N. (2003). Managed care: Strengthening the consumer voice in managed care: VII. The Georgia peer specialist program. *Psychiatric Services (Washington, D.C.)*, *54*(4), 497–8.

58. Substance Abuse and Mental Health Services Administration. (2009). Practice Guidelines: Core Elements in Responding To Mental Health Crises, 1–14. Retrieved from http://store.samhsa.gov/shin/content/SMA09-4427/SMA09-4427.pdf

59. SAMSHA. (2011). Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States, (July), 1–23. Retrieved from www.samhsa.gov

60. Substance Abuse and Mental Health Services Administration (2013). The Primary Care Extension Program: A Catalyst for Change, 173–178. Retrieved from http://www.annfammed.org/content/11/2/173.full

61. Substance Abuse and Mental Health Services

Administration SAMSHA. (2013). Community Conversations about Mental Health: Information Brief Series. (July)*1-27*. Retrieved from http://www.mentalhealth.gov/talk/community-conversation/information_brief_english_07-22-13.pdf

62. Substance Abuse and Mental Health Services Administration (n.d.). Definitions: Mental and Substance Use Disorders. Retrieved March 2, 2016, from http://www.samhsa.gov/disorders#co-occurring

63. Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion*. (10)*282-298*. http://doi.org/10.4278/0890-1171-10.4.282

64. Tabak, R, Eyler, A. A., Dodson, E. A., & Brownson, R. C. (2014). Accessing evidence to inform public health policy: A study to enhance advocacy. *Public Health*, *129*(6), 698–704. http://doi.org/10.1016/j.puhe.2015.02.016

65. The Kaiser Family Foundation. (2013). The Impact of the Coverage Gap in States not Expanding Medicaid by Race and Ethnicity. (January 2014), 1–10. Retrieved from http://kff.org/disparities-policy/issue-brief/the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid-by-race-and-ethnicity/

66. Torbett, M. (2014, August 11). Report: Central Louisiana needs improved mental health. *The Town Talk*. Alexandria. Retrieved from http://www.thetowntalk.com/story/news/local/2014/08/09/report-central-la-needs-improved-access-mental-health/13843757/

67. US Census Bureau. (n.d.). State and County Quick Facts. Retrieved March 15, 2016, from http://quickfacts.census.gov/qfd/states/22/22079.html

68. World Health Organization. (2015). *Optimal Mix of Services for Mental Health*. *The WHO Mind Project: Mental Improvement for Nations Development* (Vol. 1). Geneva, Switzerland. Retrieved from http://www.who.int/mental_health/policy/services/4_organisation services_WEB_07.pdf?ua=1

69. World Health Organization. (2012). *Risks to mental health: An overview of vulnerabilities and risk factors: Background paper by WHO Secretariat for the development of a comprehensive mental health action*. Retrieved from http://www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf