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Testimony for:

"Post-Catastrophe Crisis: Addressing the Dramatic Need and Scant Availability of Mental Health Care in the Gulf Coast"

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Introduction:

Madam Chairman and members of the Committee, thank you for the opportunity to testify on the current status of the need for, and availability of, mental health care in the Gulf Coast, specifically, Louisiana's greater Baton Rouge area. I am Dr. Jan Kasofsky, Executive Director of Capital Area Human Services District (CAHSD), the publicly funded mental health authority in the Baton Rouge region. Today I will share our progress in serving the community, highlight the shortage of psychiatrists, and present other factors currently impacting the local mental and physical health care and the disaster delivery system. I will close my testimony by describing the continuing and most pressing needs in the greater Baton Rouge area's system of care.

In the years since Hurricane Katrina, much has been accomplished locally through collaboration, innovation and increased funding to serve the large number of evacuees who have traveled through and relocated to the Baton Rouge community. Of the initial surge of 350,000 evacuees, estimates remain at between 30,000-40,000 who have chosen to stay. It must be acknowledged that this population of individuals may or may not be the comprised of the individuals due to the continuous migration, into and out of this community. Many individuals are seeking to return to the state from afar and use this community as a nearby re-entry point. Many continue to live in transitional housing and the number of homeless continues to expand. There is no question that the rate of disabilities and homelessness in this population, particularly mental illness, is much higher than in the typical population. This is reflected by the sustained 65% increase

post-Katrina in the use of our clinics and outreach personnel. The ongoing mental health crisis in this region speaks to sheer numbers and levels of acuity. While we have "front loaded" our clinics and outreach services for rapid and easy access to our consumers, many in need are then lost due to the lengthy waits for follow up care.

Overall State of Mental Health Infrastructure:

In Louisiana, prior to Katrina, the reliance on facilities for acute care beds, the use of emergency rooms as the main point of entry to access care, the lack of electronic information technology, and the low level of integrated care across disciplines and between community-based clinics and acute units, led to a system equipped to serve those with only the most severe mental illness, and ensured a high level of recidivism among the mentally ill. In reality, the most devastating blow dealt by Katrina against the mental health system was the decimation of the facilities in the greater New Orleans area and the diaspora it created for the mental health practitioners. This occurred due to the fact that geographically, New Orleans served vast numbers of patients from across the state. With the demise of the facilities and the evacuation of physicians, many of whom have now left the state, the loss of this centralized system of care in New Orleans continues to greatly impact the Baton Rouge area's ability to meet local demands.

<u>Local Emergency Departments</u>

In the ongoing aftermath of the hurricanes, there has been a steady, and now permanent increase of 30% in the number of adults presenting to emergency departments in psychiatric crisis in the Capital Area, causing emergency departments to be placed on "divert" more often. The relocation of evacuees, the loss of housing, inpatient psychiatric beds and health care infrastructure, including the loss of emergency departments in the

Orleans area, have greatly increased the population and acuity of those suffering with mental illness, substance abuse, and homelessness. In late August 2006, CAHSD formed a collaborative of service providers including emergency room physicians and administrators, "First Responders" (law enforcement, EMS), coroners, and other health professionals from the seven parish area, to study service delivery model options. Everyone agreed that when people with behavioral health problems rely on a general emergency department to provide their care, they enter into an ongoing cycle of recidivism because they cannot get the ongoing care they need in that setting. CAHSD was able to fund clinic-based service expansion due to an increased appropriation to help prevent crises, yet the missing continuum for those in crises needed further development. The large numbers of people using the emergency departments were a clear result of a larger and more acute population trying to access acute care beds through the emergency departments, due to both increased trauma and the loss of public and private beds from the greater New Orleans area and an overwhelmed local public out-patient clinic system. Many private psychiatric beds will not reopen in the affected areas and half are gone forever, while the public beds continue gradually to be re-established.

Homelessness

The impact of homelessness cannot be overstated. Figures post-Katrina show an increase of 15%, and rising in the Baton Rouge area. Many were homeless in New Orleans before Katrina and were evacuated to this area, and while the homeless population here continues to grow due to the loss of housing in the New Orleans area and increased rent, the population of disabled continues to grow in the Baton Rouge area. Last year in a point in time survey of local homeless people, 1100 persons responded and

stated their reasons for homelessness: 34% due to addictions, 25% due to mental illness, 23% due to Katrina, and their stated disabilities: 38% addiction and 42% mental illness. While these figures are consistent with other locales, 37% noted that they did not reside in this part of the state prior to Katrina. Based on these figures it is clear that many were mentally ill or suffering from addictions before they evacuated, but it is unclear as to the number previously in treatment. Advertising our clinic locations, expanding hours, and providing access to all, prevented many more from ending up on the street, being ejected from their shelters and becoming incarcerated.

Prevalence of Mental Illness:

Prior to and immediately following the flooding in New Orleans, CAHSD began assisting evacuees by deploying integrated teams of behavioral health and primary care providers to assist the 350,000 people spread out over 67 shelters, hotels and then later into the transitional housing sites. Assisted by the Louisiana Spirit Teams we located and performed primary and secondary level screens on over 7,000 people. Our goal was to rapidly locate and deploy teams to provide appropriate, accessible, and timely services to maintain mental health stability, prevent on-set of serious mental illness, and provide treatment and referrals for ongoing care to people in crisis. Our teams dispensed medications to many, supplied from our own pharmacy and the good will of regional pharmaceutical company representatives. These psychiatric medications were not made available in the special needs shelters, aside from our own supply, and I am told, are not part of the Federal Government's formulary. Initially we opened our clinics and admissions criteria to serve everyone and saw a large influx of people both from the public and private system in New Orleans. On a transient basis, evacuated physicians

joined our team along with private sector psychiatrists. Most patients needed access to their ongoing medication regiment. Most of the "new" patients were struggling with anxiety which we have now added to our permanent admission criteria. New patients were required to be seen more frequently and needed to receive higher dosages of their medications than within the non-evacuee population. Our ongoing patients, who prior to the storm waited one month between appointments, were forced to wait three months, and many dropped out of treatment.

By six months post-disaster, our adult mental health clinics saw a 70% increase in new admissions. Today we have a 65% increase compared to pre-Katrina. Currently, comparing pre- and post-Katrina statistics, our mental health clinics, excluding our mobile treatment teams' volumes, have an increase in unduplicated clients annually of 1,277 (27%), and an increase in new admissions annually of 707 (64.5%). The clinic closest to the transitional housing sites (Renaissance Village and the Airport FEMA sites, as well as the commercial sites) had been our second busiest clinic but now has caseloads equivalent to our largest clinic, with an annual increase in admissions of 326 (124.4%). Patients in the trailers were identified by our mobile and ACT teams, and ongoing transportation to our clinic is provided by this agency. During FY'07, there was an annual increase of 47 Physician Emergency Certificates (PEC) (121%) within our own clinics. All of these patients require hospitalization. The level of acuity in our clinics continues to increase and our latest statistics show the increase in PECs is now approaching 30 per month. Numbers in all local community hospital emergency departments total over 700 per month inclusive of all types of legal holds.

We recently set up a phone screening system to augment the agency's Access Service which we initiated soon after the storm. We receive over 8,000 calls monthly, with more than 865 being referred to a social worker, over 500 undergoing a screen by a social worker, and the majority of these people are deemed to qualify for our services.

Overall we are seeing the same types of diagnoses as before Katrina, but some new patients are now also struggling with depression. Many of the patients with pre-existing mental illness now have PTSD symptoms co-existing, as do many of the new patients experiencing depression. There is little pure PTSD because extended grief reactions are now being expressed as depression. One could describe clinically what has been seen as a cycle comprised of the following three phases: 1. evacuees wanting medications to remain stable (some brought in by family members for this), who comprised the clinic walk-in patients immediately post- Katrina, and include those newly coming into the region, 2. patients discharged from hospitals after four months and beyond, and post-Katrina patients who were hospitalized secondary to stress-related decompensation, but more so, because they did not receive their medications fast enough following evacuation, and 3. people returning to Louisiana from out of state trying to get home and are now new to our mental health services, perhaps starting at step number one.

Our services to children and adolescents had also increased sharply, but are now dropping. These services are provided in a more decentralized system than our adults with delivery in our main clinics, satellite clinics in schools, Federally Qualified Health Centers (FQHCs), primary care/rural clinics, public health units, Offices for Community Services (OCS), and through three types of mobile teams. Numbers seen annually have now stabilized at a 12% increase attributed to the evacuee population. Most of the

children and adolescents are diagnosed with ADHD and anxiety disorder. Some are diagnosed with PTSD, but less severe than in the adult clients. Many patients also had behavioral problems prior to the evacuation and the storm exacerbated their symptoms.

Impact on Medical Personnel and Staffing Level:

Recruitment and retention of psychiatrists is at a critical stage within the local mental health system. While we have established new and faster processes to access services at our clinics, we continue to lose clients following their initial appointments due to the wait times between services. Physicians are increasingly uncomfortable with initiating treatment and assuming responsibility for a patient's care while facing limitations in how soon the patient can return for follow up. This time ranges from one month to three months. Wait times for new appointments with physicians at our adult clinics are up to 12 weeks, and for the child/adolescent clinics 10 weeks. Although we have funded positions, they go unfilled even with offering competitive salaries, using national recruitment agencies, and attempting to use locum tenens to fill in. It is essential that the recruitment incentives for physicians, both psychiatrists and medical specialists and nurses, in the Greater New Orleans area be available to the greater Baton Rouge area to enable the system to serve the evacuees who continue to live here and to use this as a stopping point for preparing to return home. The population here is comprised of the very people who left during the floods. They are the New Orleanians in need of mental and physical health care. It is nearly impossible to recruit the staff needed, when all incentives are geared only to rebuilding efforts without consideration of impacted areas that are treating the populations that remain. Even efforts to recruit the USPHS providers look only to provide placement in New Orleans. It is very clear that our continuing

efforts will never allow us to get ahead of the cycling of the chronically mentally ill through crisis and hospitalization if we cannot provide adequate access to psychiatrists.

Accessibility of Medical Care:

Primary Care to the Evacuee Population

Almost as soon as the flooding began in New Orleans, local providers received e-mails and calls to convene in Baton Rouge at CAHSD to discuss evacuee needs and plan a response. This collaborative, comprised of approximately 70 agencies and providers met on a daily basis for months, then monthly, and was terminated last Spring. Providers were both private and public sector, and behavioral health and physical health providers, including local clinics, FQHCs, Office of Public Health staff, and evacuee providers. It was determined from the inception that deployment teams would be multi-disciplinary and would screen and treat both medical and behavioral health needs. It was also decided that as much as possible, people who could access permanent facilities would be directed to do so to speed their access to care, take pressure off of the mobile teams, avoid redundancy/multiple calls on the same individuals, and ensure a higher level of care by attaching patients to ongoing care from a permanent provider, facility and medical records. From the beginning we prioritized the use of permanent, pre-existing providers and facilities. Aside from using these teams to go to the shelters which operated for the first three months post-disaster, this collaborative also established medical and behavioral health hubs at the congregate housing sites with mobile units whenever possible. Unfortunately, our many requests for tents and modular facilities on the premises were ignored and many providers saw patients in open spaces, without privacy or shelter from the weather, or in cars. The community providers feel as a whole we were able to

accomplish the goal of primary care access during the height of the evacuation, and through the many months that followed by utilizing our hub model of localized authority in the congregate setting with mobile clinics. Since our initial goal was to make evacuees aware mobile services were temporary, and they were provided clear termination dates to transition services to permanent sites, we are seeing high rates of utilization among the local FQHCs and the hospital clinics across the region. It was crucial to identify, communicate, educate and increase awareness of all community resources so that residents were appropriately linked long before termination of mobile units. A contract was placed by CAHSD to provide transportation from Renaissance Village to CAHSD's clinics, local FQHCs and the Public Health Clinics, and it continues to be utilized. Most recent utilization rate is about 100 per month with 75% utilization for access to primary care clinics.

Specialty Care

When there is a protracted period of time to serve an evacuee population it is not feasible to only address primary care needs. Many evacuees suffered from chronic diseases requiring attention by specialists, and many needed access for cancer treatments and other life sustaining therapies initiated before the floods, but there was not and still is not, access to specialists due to the huge numbers seeking to access the few pre-existing specialists in the community. Wait times to access the public specialty clinics such as cardiology, GI, orthopedics, endocrinology, ENT, pulmonary, and rheumatology run from 10 weeks to 20 weeks. No new patients are currently being accepted for neurology. There remains a great need for additional specialists to expand capacity at the public specialty clinics.

Primary Care to the Chronically Mentally Ill

Within all of its mental health clinics, CAHSD is presently implementing a medical care "screening tool" and policy requiring clients to be assessed by the nursing staff for their present engagement in ongoing care with a primary care provider. The policy requires that all new clients and ongoing clients are "screened" annually and a referral to their assigned Community Care physician is made, if they are Medicaid eligible, or a referral is made to a proximate primary care clinic with a flexible, non-fee, or sliding fee scale. The CAHSD nursing staff will ensure that the clients sign a release of information to the provider and follow-up to determine the appointment was kept.

For efficiency and access, CAHSD has made a concerted effort to place mental health satellite sites within public health units (PHU) and Federally Qualified Health Centers (FQHC). These unique settings provide easier primary care access to the chronically mentally ill based on the physical location of the clinic by reducing the stigma to accessing services and allowing for integration of physical and behavioral healthcare. All clinics provide assessments for emotional/behavioral/addictive disorders. Currently, CAHSD is co-located in 10 FQHCs and Public Health Units combined, and in two hospital-based clinics. We have taken steps to allow for a two-way information flow so that the medical and behavioral health information can be used by both provider agencies to support overall health and stability and assist in avoiding crisis and reliance on the emergency department.

Steps that CAHSD Has Taken to Remedy the Loss of Infrastructure

In 2006, Social Services Block Grant funds were provided to CAHSD to expand clinic capacity, create new, and expand existing mobile treatment teams, further decentralize our clinic based services to primary care settings (FQHCs and public health units) and schools, for the creation of new positions (social workers, physicians, social services counselors, pharmacy tech, LPNs, RNs, case managers and clerical to support adult MH clinical services expansion, mobile, crisis and satellite treatment teams) and for new contracted services. Although it was difficult to find and hire staff fast enough to make total use of all of the allocated dollars, CAHSD surpassed most areas of the state due to having created a community-wide service plan through the community collaborative, months before the funds were received. The agency having been established as a Title 38 Agency under the procurement code, can contract directly from its office, enabling it to cut down on bureaucracy and time loss. It is also not constrained by the legislative limit on staff positions through a Table of Organization, and so was able to rapidly hire needed staff. The 2008 budget was minimally reduced from the prior year as it was clear to the legislature and the Division of Administration that the newly created and expanded services and contracts were needed and being utilized based on the performance indicators collected and documenting the large and permanent increase in patients new to the area and utilizing the services. The following are <u>selected</u> new services developed and implemented post-Katrina to assist in improved stability of the mentally ill in this community:

Behavioral Health Crisis Avoidance and Continuum of Care

Nine critical components to a behavioral health crisis continuum of care were defined by the collaborative. Many of the components have already been funded and implemented; others still need funding. Several are being funded by CAHSD's ongoing operational budget, and some through a redesign of pre-existing services. These components include:

- Standardized screening and assessment tools & training,
- Access Service: Immediate clinic access,
- Interagency Services Coordination,
- Crisis Intervention Team: Specially trained law enforcement officers,
- Mobile & Assertive Community Treatment Team,
- Crisis Intervention Unit: A specialized Emergency Department (ED),
- Medical Case Management,
- Coordinated Referral to Treatment & Public Awareness, and
- Housing.

See below for further descriptions of a few of these components.

Access Service

This service targets individuals who present with symptoms of serious mental illness, (i.e., major depression, post-traumatic stress, anxiety disorders, mood disorders, schizophrenia) and/or alcoholism/addictions. This service front loads the system by allowing for rapid screening, assessment and treatment. However, due to the large numbers of people who contact CAHSD with all levels of need, it also serves as an important community service to the broader public by reducing waiting times for

screening, evaluation and referral for behavioral health services, and identifying and stabilizing people in crisis who would otherwise be directed to the emergency departments.

The following services are provided by the Access Service: phone and face to face screening for behavioral health problems including mental health; addictions and psychiatric evaluations; coordination of admissions to the CAHSD mental health or addictive disorders centers and/or referral to the appropriate community service. Clinic based psychiatric interventions are provided for those new clients seeking or requiring services, such as arranging hospitalization, detoxification services and placing clients on medications. The Access Service was effective in reducing the number of evacuees from the congregate sites who presented with behavioral health emergencies in the emergency department as well as in providing immediate appointments for patients who were referred from the emergency department to the CAHSD outpatient mental health centers. Within the CAHSD system, the Access Service acts as a referral point for all of the District's mental health, addiction and developmental disability services to the indigent and low income consumers residing in the greater Baton Rouge area.

Children's Services Outreach

The CAHSD intensified outreach efforts for children in the following ways: fast tracked treatment services at its two primary care clinics and in satellite facilities, at its expanded school-based sites (27), added access and social workers at some public health units and at federally qualified health clinics, created Children's Behavioral Health Disaster Mobile Teams serving the transitional living sites, and expanded major collaborative endeavors with other area agencies and organizations. One important new

service at the CAHSD is the child and adolescent behavioral health Children's Mobile Disaster Teams. Escalating stress from displacement issues and/or anxiety of coming storms, and other survivor issues have created the critical need for the new mobile behavioral health service teams. The CAHSD, using block grant funding, mobilized two teams conducting daily "rounds" in various temporary housing communities. The teams' schedules are designed to respond to referrals from area providers and from the CAHSD adult mobile team or by self referral. The Child and Adolescent Response Team, (CART) responds to crises that may include, but not be limited to, suicidal or homicidal thoughts, and out of control or threatening behavior to others or self. The specially trained behavioral health providers deliver the following services: assessment, stabilization, and respite care for up to seven days or until the crisis is resolved.

The CAHSD school-based behavioral health services, working with its collaborators, addressed the needs of more than 10,000 children and adolescents. Last year there were approximately 5000 evacuee students in the school systems supported by the agency, but that number now dropped to approximately 150 who continue to be enrolled in the Capitol region school districts. (Many no longer list New Orleans as their residence.) In addition, the CAHSD's Children's Services also collaborates with the new LSU Health Sciences Center Children's Mobile Medical Teams in North Baton Rouge. They are also working with children in the adjoining Baker School System.

Care for People with Mental Health Needs Not Meeting State's Criteria

It has long been well understood that within this community, there has been a dearth of referral sources for people not meeting the state's strict criteria for mental health services. This gap is being felt more intensely now due to the numbers of people

new to this area who had mental health needs prior to relocating, and those who have suffered through loss and trauma due to the storms Currently CAHSD is establishing contracts with local FQHCs to hire social workers to provide interventions to all clinic adults who currently need services but do not meet the state funded service's criteria for the seriously and chronically mentally ill. These social workers will be fully trained on when and how to make referrals to CAHSD services if the acuity warrants a higher level of care.

Crisis Intervention Unit (CIU) Product or Service

The collaborative developed a CIU for the Baton Rouge area to serve those individuals suffering from serious mental illness who present either to a District Community Mental Health Center, Addictive Disorders Clinic or are otherwise identified (by law enforcement, coroner, etc.) as experiencing an emergency behavioral health condition or crisis situation (e.g. the individual's need may be such that they require treatment to reduce the likelihood of death, harm to self or others, serious injury or deterioration of physical condition or a major setback in their condition or illness). Services will be provided to individuals who are in psychiatric crisis whose needs cannot be accommodated safely in less restrictive settings, and to stabilize the client and re-integrate him or her back into the community quickly. Services will include administering medication, counseling, referrals and linkage to ongoing services (inpatient/outpatient) and transportation of client and/or family members. They will also include redirection of adults presenting in psychiatric crisis into appropriate and safe services at the appropriate and least intensive level within a Comprehensive Behavioral Health Crisis Continuum of Care, thereby relieving the pressures on existing emergency

departments of both public and private hospitals in the seven parishes of the Capital District. This modular unit has not yet been established due to not having received the promised funding into the agency's budget.

Housing

Often homeless people with behavioral health concerns present at emergency departments if they are not aware of more appropriate means for accessing housing options. The impact of homelessness has had a significant impact on the Capitol region. In 2005 the survey and the application of HUD's formula for calculating the annual rate of homelessness indicated an estimated number of 890 homeless persons. The 2007 survey yielded a count of 1042, or an increase of 15%. In addition, 876 FEMA trailers are still occupied, though many are scheduled for de-commissioning in the near future. Additional families are still receiving rental subsidies for market housing. Given the income levels of these clients, many will enter the homeless population once subsidies end.

The CAHSD is newly contracting with the local Capital Area Homeless Alliance (CAAH) for housing and treatment for individuals with addictive disorders and/or those who have received a dual diagnosis of an addictive disorder and mental illness. This program serves 40 individuals annually and provides placement for up to three months per client, although a client's stay can be extended if circumstances warrant. Services include: case management, life skills, drug screens, treatment planning, individual, group and family counseling, co-occurring disorders treatment, transportation, education, and job training/services.

Within the region, an additional 50-75 transitional housing beds are under construction, and permanent supportive housing has increased from 302 beds in 2005 to 333 beds in 2007, with an additional 162 units currently under construction or in the development phase.

Recommendations of Ways to Improve Current Systems to Increase Availability and Access to Mental Health Services in the Wake of the Disaster

Emergency Preparedness Efforts

The Agency has placed emergency preparedness and response in the forefront and serves as the convener for behavioral health services in the Capitol region. The CAHSD has pledged leadership and collaboration by working with the Regional Incident Command Center team and utilizing the principles and practices of the National Incident Management System (NIMS), which assures safety and efficiency in response. As the lead agency for behavioral health locally, the CAHSD staff is planning and working with the Department of Health and Hospitals, Red Cross, Louisiana Capitol Area Volunteer Organizations Active in Disasters, and the seven parish Offices of Homeland Security and Emergency Preparedness. The CAHSD will provide staff for 12 hour shifts, 24 hours per day, 7 days per week at the Medical Special Needs Shelter on the LSU campus. The CAHSD will deploy pre-credentialed volunteers into the field as general shelters are opened. During emergency operations, the CAHSD will deploy multi-disciplinary teams to general sites determined to have need.

CAHSD acts as the crucial local convening agency and location, leads the network of providers, oversees the use of one brief screening/triage tool and one chart or EMR. It ensures that deployment utilizes multiple service delivery strategies/maintains

flexibility and targets services to special populations. This collaborative locally develops the intermediate and long term plans for implementation, and that an exit plan to normalize service access is developed at the onset of deployment. CAHSD also ensures that the public is communicated with as quickly as possible with reassuring statements, clear directions, and information on where help is available.

Louisiana Spirit Teams and the Stafford Act Inflexibility:

Capital Area Human Services District (CAHSD) began assisting non-medically needy evacuees across the community two days following the flooding of New Orleans by deploying teams of behavioral health and primary care providers, assisted by the intelligence on evacuee location gained by the Spirit teams. Demographics of inhabitants at particular sites were unknown for periods of time which impeded the deployment of needed services. I strongly recommend that these teams take deployment direction from the local mental health authority or lead, consistent with NIMS to ensure efficiency and effectiveness. Without the intelligence provided by the Spirit teams, more devastation would have occurred. However, after our teams benefited from being given client specific information, we were informed that this was not permitted and it was not until the lawyers intervened to note that since the teams received direction from CAHSD, the clients were actually ours, and so sharing of information was permitted. The Spirit teams must be able to make the referral, and not just give out contact information to people experiencing trauma and in need of an immediate intervention to ensure service access. There was no transportation available for many to come to the clinic to receive this emergency care.

Federal Formulary Needs to be Amended:

CAHSD's pharmacy served as the delivery and distribution point for our own and the large quantity of behavioral health medications and supplies donated by the pharmaceutical companies for evacuees in the region. Access to these medicines is crucial to maintaining stability and managing behaviors that will not be tolerated within the shelters. These medicines must become a part of the federal formulary, in the same way pharmaceuticals are provided for medical conditions. The formulary must also address the needs of people on methadone and pain management medications.

Addressing Facilities for Providers at Federally Provided Congregate Settings:

The lack of building space provided at the congregate settings forced limitations on the ability for the providers to deliver care because of confidentiality, personal privacy and the climate. Space was requested multiple times but was provided more than a year later. A building from which to deliver care on the premises is a requirement.

Transportation for Evacuees to Provider Facilities Needed:

The proximity of many of the non-commercial congregate sites to nearby permanent service delivery facilities is essential. However, the lack of transportation to those sites forced the dependency onto mobile delivery systems which was inefficient and fraught with complications such as placement/availability of medical records, transportation of the teams and their coordination at the sites. FEMA needs to establish the transportation to nearby services sites as a priority.

Most Pressing Needs in the Greater Baton Rouge Area's System of Care:

Recruitment of Psychiatrists

It is essential that the recruitment incentives for physicians in the Greater New Orleans area be available to the greater Baton Rouge area to enable the system to serve the evacuees who continue to live here and to use this as a stopping point for preparing to return home. Establishing the CIU and any other efforts for increasing capacity and decentralization are dependent on successful recruitment efforts.

Integration of Evacuees into the Community

There must be acknowledgement of the levels of ongoing need by the evacuees for housing, employment and transportation for self efficacy and integration within the community. Accessible, affordable housing and transportation must be a priority to the evacuee population, especially those with disabilities.

Expansion of Local Specialty Care Clinics

Access to specialists through the public specialty clinics is nearly unavailable with waiting times ranging from 10 to 20 weeks, and some clinics are not accepting new clients. It must be noted that a sub-population of evacuees will always need immediate and ongoing access to specialty care. Any long term relocation must make arrangements for capacity expansion to life sustaining care. Recruitment of medical specialists for life sustaining treatment is essential.

Conclusion

I want to thank this subcommittee for its attention to our needs in the greater Baton Rouge area and for the financial assistance provided the state over the past 1.5 years. I hope you can appreciate the level of commitment to immediate relief and long term

recovery that has been made by this community in terms of its dedication, innovation, restructuring and redesign of its services to meet and anticipate the needs of our new community members. Still, we have ongoing needs, especially for psychiatrists. Filling these existing positions is the true key for addressing capacity and the ongoing care and prevention of crises. Accessible and affordable housing is crucial to the stability and recovery of our new community members. I greatly appreciate the opportunity to testify today as well as your ongoing commitment to the greater Baton Rouge area's recovery.