COLUMBIA CLIMATE SCHOOL
NATIONAL CENTER FOR DISASTER PREPAREDNESS

PART 3: FINDINGS AND RECOMMENDATIONS

Baton Rouge Mental Health Resource Mapping

2024

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Research Team: Jonathan Sury (Principal Investigator), Sean Hansen, Qëndresa Krasniqi, Antonia Samur, Brittany Markarian (Graduate Research Assistant), Thalia Balkaran, Jeff Schlegelmilch

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Cover Image: Flooding and devastation in Baton Rouge, Louisiana, on Aug. 15, 2016. Melissa Leake via Flickr

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NATIONAL CENTER FOR DISASTER PREPAREDNESS

475 Riverside Drive, Suite 820
New York, NY 10115-0095
ncdp@columbia.edu | https://ncdp.columbia.edu

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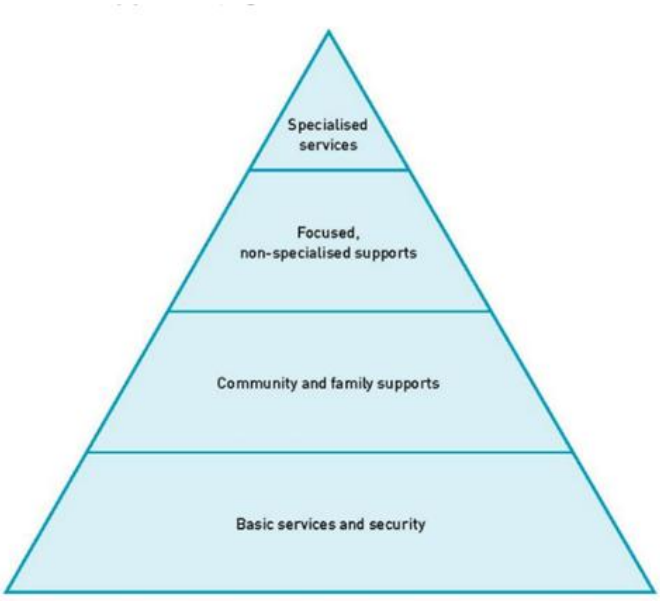
Study Background

The resilience of a community to the disruption of a disaster depends substantially on its systems of support, among them inherent pre-disaster processes in management and governance, as well as resource availability and local context (Abramson, Culp, Sury, & Johnson, 2011). In general, these systems of support may include resources provided by formal governmental agencies, intergovernmental entities, non-profit or non-governmental organizations, and grassroots efforts such as mutual aid working groups or other community-led activities. After a disaster in a domestic setting, a community often receives mental health and psychosocial support resources, which may include individual therapy, group discussions, or morale-focused services to help address basic needs such as shelter, food, and safety. These are provided by local and regional actors but may be supplemented with a surge of external response actors who help fill a short-term need. These may have different levels and depths of training and may utilize different therapeutic approaches (Young, Ruzek, Wong, Salzer, & Naturale, 2006).

Mental health and psychosocial support services are essential not just in the immediate aftermath of an event but perhaps even more so in the recovery phase 6 to 24 months after. This second wave of need manifests as household resources diminish and stressors such as incomplete repairs to the home weigh on individuals, which was clearly seen after Superstorm Sandy in 2012 (Abramson et al., 2015). It is at this early-to-mid-disaster recovery phase that the externally provided responsive resources are no longer available, and local actors who were present before the event are left to shoulder additional responsibility in addition to their normal "blue sky" time services. The local workforce were themselves likely directly affected by the event and may have their own personal and household recovery to manage. This paucity of capacity places an undue burden on Mental Health & Psychosocial Support (MHPSS) providers and can limit the accessibility and visibility of services to community members.

Figure 1: The Mental Health and Psychosocial Support Intervention Pyramid (IASC MHPSS Reference Group, 2007)



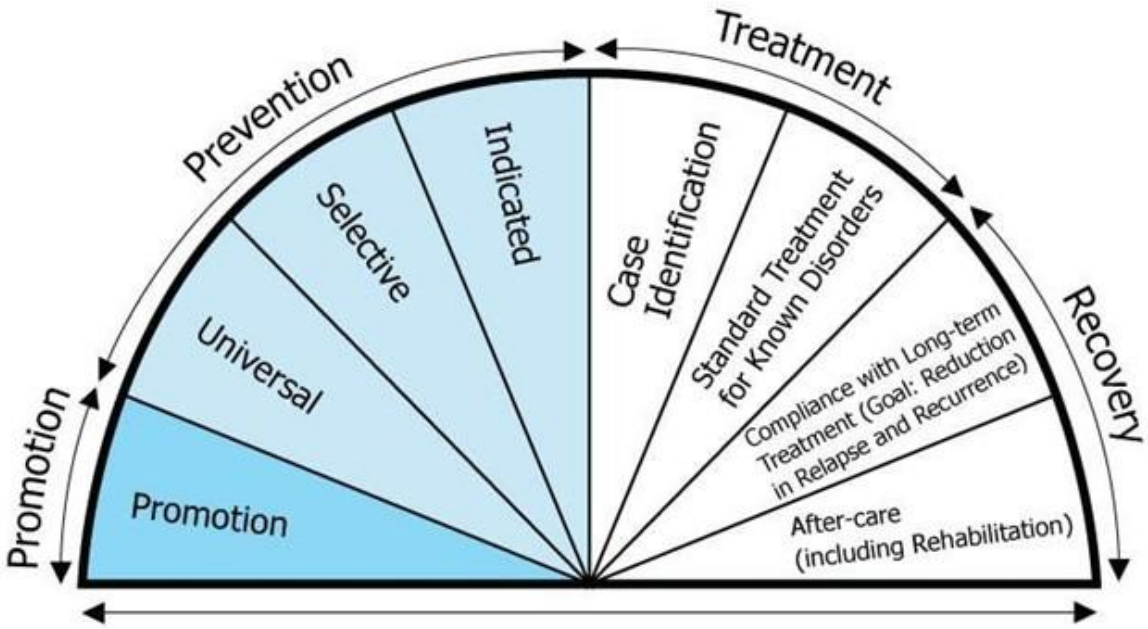
In general, an overemphasis is placed on individual-level interventions to support post-disaster mental health. However, service interventions focused only on individuals do not necessarily lead to population-level impact (Keyes, 2013). Figure 1, The Mental Health and Psychosocial Support Intervention Pyramid (IASC MHPSS Reference Group, 2007) from the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings helps to visualize and explain that the smallest proportion of the population requires specialized services for those who have severely diminished ability to function, whereas the base of the pyramid is built upon basic human needs followed by community support mechanisms (IASC MHPSS Reference Group, 2007). The emphasis on individual services is incongruent with mental health provider availability, capacity, and funding. The rest of the pyramid is composed of non-specialized mental health and psychosocial support services that may be administered by non-clinical individuals.

These services may include group discussions, support groups, and activities such as mental health first aid or basic resilience-building programs.

Even in non-emergent contexts, a regular service gap exists, preventing communities' ability to meet treatment needs due to a lack of trained professionals in relation to the total burden of mental illness (Tol, 2015). Furthermore, these services may be ill-timed and ineffectual at the population level to address the appearance of mental health distress six or more months after a disaster event. Additionally, in "blue sky" times, the capacity of mental health service providers, due to either demand or lack of personnel, is overextended. Tol makes the case that, rather than treatment-focused interventions, resources should be mobilized largely around mental health promotion and prevention (Figure 2: SAMHSA Continuum of Care wheel. (Begun, 2019).

Approaching mental health with a public health lens through the social determinants of health framework allows for the application of the socio-ecological model of health and its extension to mental health (Tol, 2015). An influential 2007 review made the case for "no health without mental health" and demonstrated the connection between the global burden of disease due to neuropsychiatric disorders, which manifests through diminished ability to seek medical help, and poverty and its social determinants (Prince et al., 2007). Tol states that "mental health is shaped by the context in which people live" and that, as such, any mental health intervention should be tailored to the local context and specifically the "risk, protective, and promotive" factors (Tol, 2015). The latter varies for each level of a socio-ecological model. Any attempt to assess interventions should explore their relationship across and within the model.

Figure 2: SAMHSA Continuum of Care Wheel (Begun, 2019)



A central tenet of any socio-ecological model is that there is a *bi-directional relationship* between levels. Improved outcomes from one level may improve the outcomes from another. Therefore, an alternative approach to mental health programming is to focus on community strengths to improve the overall psychosocial support mechanisms throughout community actors and to do so proactively and *preemptively* outside of a disaster

context during "blue sky" times, specifically within the disaster and emergency planning preparedness and mitigation phases. These approaches can be more sustainable, focused on addressing root causes or social determinants, and are able to affect a greater number of community members by bolstering system-wide resilience. This approach is, in effect, what Miller and Rasco (2004) describe as the "ecological paradigm of community psychology," which extends these relationships directly to community members for their inclusion in ecological interventions that are culturally and contextually appropriate. This method aims to apply an assets-based ecological approach to assessing ongoing community mental health assets, and those that are perceived to be needed but may or may not exist in sufficient supply, to build community resilience for future disruptive events regardless of scale or scope. The concepts of mental health and resilience are closely connected: The baseline health of each affects how a person may recover from and adapt to new conditions with any kind of changing circumstances, whether the loss of a job, the loss of a family member, a major disaster, the slow grind of climate change, or social unrest. We can, therefore, posit that the baseline mental health of a community may predict its ability to withstand stress.

Study Context

Baton Rouge, Louisiana, in addition to serving as a major relocation region for Hurricane Katrina survivors, has experienced its own repeated exposure to hurricanes, major floods, and toxic environmental contaminants. It is a socioeconomically diverse community with clusters of high social vulnerability as characterized by CDC's Social Vulnerability Index (SVI) (See Figures 13 to 16 in Community Profile), specifically seen in predominantly Black neighborhoods. The community has noted recent upticks in gun violence and suicide and is lagging behind the state in many health and educational outcomes for children. In theory, these are driven or perpetuated by underlying social, political, and structural forces that can be presented as social and structural determinants of health. These determinants are not fatalistic but are incredibly influential in the direction of health outcomes. Archibald and Dobson-Sydnor (2015) point out that addressing them leads to reduced inequity (the latter being "an unjust and an undesirable set of conditions" deepened by discrimination, cultural barriers, and poor access to care).

As part of understanding context, it is important to note that some mental health risk factors are race-specific and not always predictable. The "minority mental health status dilemma" is based on data that suggest the mental health of Blacks is often better than that of Whites. Accounting for stressors such as discrimination as structurally driven socioeconomic status, the mental health of Blacks would be even higher (Archibald & Dobson-Sydnor, 2015). To create the possibility of equity in mental health, a "promotive" is preferable to a "treatment-based" approach (Keyes, 2013). The dual-continua, or two-continua, model of health and mental health (see Appendix 5: Dual-Continua Model of Mental Health) states that designing interventions to address only mental illness does not necessarily result in good mental well-being and vice versa. To achieve "flourishing" mental health, a community must have both treatment and well-being-focused interventions (Keyes, 2013). This approach is relevant for the project and its community assessment to ensure that the assets that are evaluated are not solely focused on individual treatment interventions but also on activities that are multi-sectoral and focused on multiple levels.

The genesis of this research study, sparked by an observation by a local philanthropic organization, is rooted in the assumption that continued investment in "reactive" mental health services will not lead to lasting and sustainable improvements in community-wide mental health and resilience. After the 2016 floods in Baton Rouge, one study, which examined Medicaid claims data, found significant increases in treatment sought for

substance abuse by men (66%) and depression symptoms for women (44%) (Phillippi et al., 2019). Even more important to note is that support-seeking lasted for ten months post-flood, at the end of the study period. We could reasonably conclude that these services were needed even beyond this period. The study also noted that outpatient services increased by 69%. Increases in service utilization stress existing systems and continue to point those in need to clinically focused services, which may be unavailable or hard to acquire. Furthermore, the repeated reactive actions only address short-term symptomatology rather than aiming to ameliorate the social determinants of health and mental health or resilience building efforts. It is therefore posited that community-based mental health services should be adjusted and improved upon to address root causes of mental health disparities and focus on bolstering the psychological resilience of the whole community, through both clinical and non-clinical services, such as community-led psychosocial support programs.

In an effort to gain a deeper understanding of the current state of mental health services in East Baton Rouge Parish, an assets-based service map has been designed to identify key community strengths that may be built upon. Synthesizing a robust mapping of mental health service assets requires developing an awareness of organizations and key stakeholders, as well as an understanding of the capabilities and capacities of their respective services. To accomplish this goal, the National Center for Disaster Preparedness (NCDP) at Columbia University's Columbia Climate School implemented a multifaceted asset- and resource-mapping project that leveraged publicly available information, administered an organizational assessment, and conducted key informant interviews with mental health and psychosocial support practitioners to collectively provide a rich understanding of the existing resources and capacities in the Baton Rouge area, with children identified as a special area of focus within the broader system(s) and stakeholders.

This study has several aims:

Characterize the state of mental health and psychosocial support services in East Baton Rouge Parish,

Develop a deep understanding of forces that impact community mental health, and

Identify mental health and psychosocial support service strengths and areas for improvement.

To accomplish these aims, the NCDP research team utilized a qualitative research approach using a triangulation of desk reviews, key informant interviews, and an organizational survey.

Study Objectives

- Develop a Community Profile of demographics, key industries, historical events, health disparities, and other relevant contexts.
- Conduct contextual analysis utilizing a search of peer-reviewed and gray literature, triangulated with interview and discussion findings.
- Develop an analysis of community mental health and psychosocial support resources.
- Conduct in-depth interviews with key informants.
- Draft recommendations and key findings.

Methods

Study Design

Desk Review and Contextual Analysis

A comprehensive desk review of mental health and psychosocial support resources available in the Baton Rouge area was conducted to identify local initiatives and key stakeholders and to populate a sampling frame of organizations and individuals to recruit into the study. The desk review examined publicly available data sources: organizational (governmental and non-governmental) websites, referral lists from public service agencies, and provider licensing information (via the Louisiana Department of Health directory). These sources served as a baseline to understand the current landscape of mental health services and supported outreach for more in-depth data collection.

In addition to the desk review, a contextual analysis of East Baton Rouge Parish was conducted. This analysis was composed of two parts: 1) a Community Profile and 2) a Contextual Analysis. The Community Profile generated a report of sociodemographic, health, infrastructure, and prior disaster data. These data are intended to provide information for the research team to understand the research setting and to inform the additional contextual analysis. The Contextual Analysis provided a peer-reviewed literature–based background on the contextual factors that may influence various aspects of community mental health and resilience. Topics covered include historical factors, contributions, and pathways for intergenerational trauma, prior disaster experience, drivers of social and economic disadvantage, and issues relating to social, environmental, and intergenerational justice and trauma. This review aimed to include community strengths and assets and did not use a deficiency-centric approach. Literature was sought out that characterized community functioning and aspects of positive mental health in the community. To ensure the inclusion of enough locally relevant information, we also reviewed gray literature, including local press releases and news stories, legal documents, and organizational website content and blogs, all of which assisted in characterizing aspects of community mental health and resilience.

Organizational Survey

NCDP distributed an organizational-level mental health and psychosocial support provider survey to facilitate stakeholder and resource mapping. Questions in the survey were structured around the capacity to provide mental health and psychosocial support services, identification of organizational contacts, regular and surge capacity capabilities, types of services offered, populations served, types of therapeutic interventions provided, capacity to train others, and organizational mission. NCDP invited organizations it had identified through the Desk Review and key informant interviews to participate. The content of the survey was catered to direct service providers and non-service providers.

Key Informant Interviews

The Children's Health Fund and the Irene W. and C.B. Pennington Foundation provided a seed list of potential study participants who could speak about community mental health needs from their perspective, the availability of capabilities, and their associated capacities to meet those needs. The list was expanded after an extensive search for relevant organizations, drawing upon local and state databases. NCDP carried out all study recruitment activities. Initially, NCDP aimed to host sector-specific focus groups to gain further insights. These groups were to include government agencies, community-based organizations, mental health service providers, and community representatives, the last of which would help to triangulate desk review, interview, and focus group findings. However, due to a lack of response to recruitment efforts and the complexity of scheduling focus groups with respondents, a study design shift was made to use in-depth key informant interviews as the primary source of data. These interviews were carried out with a mix of organization types who work within the mental health and psychosocial support spaces, specifically in East Baton Rouge Parish.

The interviews were conducted utilizing a semi-structured interview guide (see Appendix 2: Key Informant Interview Guide), and led by the NCDP research team, recorded, and transcribed for thematic analysis. The interview guide was designed around the socio-ecological framework of mental health and well-being (see Appendix 1: The Mental Health Well-being and Socio-Ecological Model). The resulting qualitative data were analyzed both deductively and inductively for common themes, specific resource identification, and community protective factors, as well as barriers to overall community mental health and resilience.

All research methods and materials were approved by the Columbia University Institutional Review Board with Protocol # IRB-AAAU0805. Approval documents are available on request.

Community Profile

See the Part 1 for the Community Profile, consisting of demographics, health data, and other relevant characteristics of East Baton Rouge Parish.

Contextual Analysis

See Part 2 for the contextual analysis, which draws attention to various contextual factors that are related to mental health in the community and thereby influence and inform the respondents' perspective and experience as well as the interpretation by the research team. Additionally, the contextual analysis is useful to understand the forces that influence the mental health of Baton Rouge Parish residents by examining socioeconomic, sociopolitical, sociocultural, structural, and systemic factors.

Results

Key Informant Interviews

The sampling frame included a total of 83 organizations of 11 types: Art therapy and Counseling, Case Management/Community or Faith-based, Community Non-Profit, Funding/Philanthropic, Governmental, Hospitals/residential, MCO Managed Care Organizations, Nonprofit, School-Based Outpatient Behavioral Health, and University. Outreach was made via email and phone recruitment, and at least three attempts were made to contact all individuals for whom we had contact information.

A total of 28 in-depth interviews (32 hours of interviews) were completed with key informants representing 25 different agencies, departments, or organizations (n=28). The respondents represented private mental health service providers, government, quasi-governmental organizations, community-based organizations, and philanthropic groups. The audio recordings were transcribed, edited for accuracy, and qualitatively coded in NVivo using inductive and deductive coding approaches. To develop the codebook, a Consensual Qualitative Research approach was used.

For a list of all organizations included in outreach for study participation and those that participated, see Appendix 7: Organizational Table at the end of this report. The table also indicates if a key informant mentioned the organization as having an important role in community mental health.

Organizational Survey

The web-based organizational assessment was created and distributed to 43 organizations identified within East Baton Rouge Parish. Each organization was provided a personal link to the assessment and had the option to revisit the unfinished survey if it required more than one sitting or include the contributions of more than one staff member. The organizational assessment included a mix of 82 categorical and open-ended questions. These were separated into six thematic sections: organizational demographics (demo), services (serv), COVID-19 (COVID), networks/coalitions (netw), disaster/recovery plans (prep), and community resilience (res). Question blocks were adjusted for direct service providers.

To help increase completion rates, upon the conclusion of a key informant interview, respondents were alerted of the survey and asked to complete it or forward it to a responsible individual in their organization. At least three rounds of emails and three rounds of phone calls were made to boost completion rates. The final study sample consisted of 14 organizations (n=14), with a 32.6% competition rate.

Topline results are available for review in a separate document; however, due to the low response rate, a representative analysis is not possible.

Key Informant Interview Key Findings

Assets

In line with the study design, all respondents were asked to discuss various aspects of their specific domain and community mental health and well-being in general, in terms of assets. Assets were described as currently existing strengths in the form of tangible and intangible items, among them champions of mental health, organizations that hold significant power in this space, community spaces, and key service providers. The purpose of this line of questioning was to highlight which strengths and assets can be built upon and strengthened, and where critically important interventions and resources already exist. Overall, many respondents had a difficult time naming assets but were much more comfortable discussing barriers and gaps, which was expected as barriers are often easier to identify than assets. The following paragraphs will thematically summarize assets and relevant stakeholders, actors, and resources.

Knowledge and Information Assets

Knowledge and information assets are those that help people in need to locate mental health services or that serve a role as a central repository for individuals to locate their own providers. An asset mentioned across multiple interviews is Louisiana 2-1-1, run by United Way (https://www.louisiana211.org/). 2-1-1 maintains a database of service providers for mental health and other wraparound services and provides callers with information to pursue their own outreach to services. A benefit of this platform is that it is a centrally managed database and actively maintained. Respondents' criticisms of this service included that it requires information seekers to know of its existence and the type of resources it offers and that it places the onus on the individual to take the next step, regardless of which barriers may exist (e.g., financial, transportation, schedule). However, it is a fairly unanimously identified asset.

In July 2022, a new phone number was released for the National Suicide Prevention Lifeline run by SAHMSA. The new number, 9-8-8, was launched through the Louisiana Department of Health (https://ldh.la.gov/news/LA988), which will be managing contracts with service providers who will run the 988 Suicide and Crisis Lifeline. By dialing 988, callers in the state of Louisiana who may be experiencing a mental health crisis, suicidal thoughts, or substance abuse issues can access counselors who are trained to help individuals in crisis. This resource was seen as a promising improvement to the existing system, with an easy-to-remember number and the ability to assist in times of crisis. This asset is not a therapeutic approach to community mental health but provides a time-sensitive intervention that is distinct from a call to 911.

Baton Rouge Mayor Sharon Weston Broome, through the Mayor's Healthy City Initiative, launched HealthyBR, a collective impact approach to community health with several focal areas, one of which is behavioral health. In addition to a Behavioral Health Task Force, the initiative created a comprehensive Resource Database (https://healthybr.com/resource) with a specific subsection for inpatient, outpatient, substance abuse, residential, and other services (including housing, peer support, trauma, and informed services). The directory provides a filtering function, a map, and a listing of location and contact data points. This resource was created to provide a centrally located and hyperlocal directory of services for Baton Rouge residents. While this resource did receive some praise from survey respondents, it also received some criticism for several reasons:

1. The potential duplication of services with 2-1-1
2. The significant initiative required by the information seeker to locate the database
3. The individual's need to reach out to the identified provider

What is not immediately apparent is that the architect of the database had a future goal for this platform to serve as the basis for an online referral network. It is unclear if this intention still exists or how often the database is updated. A similar database exists through the Louisiana Department of Health, but its navigation is less user-friendly, and the information is often outdated. The Resource Database is connected to a larger initiative. which gives it a greater degree of relevance and potential for utility.

Louisiana State University, located in Baton Rouge, offers many types of assets to the community, including educational capital, legitimacy, sports and athletics, a library program with community outreach, and various mental health and social work training programs. The university is considered an important pipeline for trained professionals if, and only if, these graduates remain in the greater Baton Rouge Area.

Prosocial Spaces

The high-density nature and convening power of the **faith-based community** (i.e., houses of worship and congregations) were highlighted as a high-opportunity space for the responsible integration of psychosocial support. These are not places for direct service provision but can be used to address stigmas around mental health, particularly in the Black community, promote health-seeking actions, raise awareness of service availability, address trauma in the community, and provide some early intervention training for leadership (such as trauma-informed principles), with the intention of referral to a regular provider or support network.

Baton Rouge Parks and Recreation, known as BREC (BR+REC), was consistently mentioned as an important prosocial space for the community. Interview participants did not mention a direct connection to any kind of service by BREC, though the park system was consistently mentioned. Similarly, the East Baton Rouge Public Library was mentioned as a key asset and a highly utilized local resource. In general, local libraries and community centers were considered potential places to educate the community about mental health and possibly even service delivery, and can be beneficial due to their location within unique communities rather than only in more central locations, such as downtown.

Service Delivery Infrastructure and Programming

Several key programs and organizations were mentioned across multiple interviews, which highlighted them as central to mental health in the community. The first is Capital Area Human Services District (CAHS), which serves seven surrounding parishes but has its headquarters in Baton Rouge. Several of its locations offer a variety of services, including addiction recovery and outpatient child and adult behavioral health. CAHS is unique in its organizational structure in that it is not a government agency but rather a quasi-governmental agency, operating as the Local Governing Entity (LGE) for the Louisiana Department of Health's Office of Behavioral Health in Region 2, which includes East Baton Rouge Parish. Its reimbursement sources include Medicaid, Medicare, private insurance, fee-for-service cash (including sliding scale payment options), and state funds. The organization has 258 full-time employees, of whom 48 are direct service providers. Across the organization, 80 employees hold master's degrees and 15 have earned doctorates. The organization is described by many respondents as the go-to location for services for uninsured or low-income residents. Specifically, CAHS accepts Medicaid insurance, which sets them apart from many mental health service providers in the area who choose not to due to the minimal reimbursement and potential for more complex cases. Interestingly, because they are a quasi-governmental organization, they are often in competition for funding with other service providers who may be private or not-for-profit. It was discussed that this funding schema often results in tension between service providers and an environment where collaboration across organizations is minimal, resulting in siloed and poorly coordinated care networks. In other words, each entity

is concerned with its own bottom line. Despite its size and multiple locations, some respondents pointed out that many members of the community may not fully understand or be aware of the types of services available through CAHS and felt this could be remedied through better advertising and awareness-building. It was also brought up that due to its size, some potential users are not keen to pursue services due to long waits for appointments. Regardless, CAHS is a major player with a well-established reputation in the community.

The Louisiana Spirit Crisis Counseling Program led by the Louisiana Department of Health's Office of Behavioral Health, is a federally funded direct outreach program that utilizes door-to-door peer counseling in disaster-affected areas. After a state-requested presidential disaster declaration, funds are released by FEMA and through their Crisis Counseling Assistance and Training Program (CCP), jointly administered through SAMHSA. Funds are released to the Local Governing Entity (LGE), which must partner with the state to implement the program. The program typically operates for a short period of time, with the first funding period being 60 days; upon approval, a second funding period can last up to a total of 9 months. However, during COVID-19, the Louisiana Spirit program was in operation for over two years, partly due to seven declared disasters after the onset of the pandemic. The last time the program had run for such an extended period was in the two years after Hurricane Katrina. One of the stated challenges of this program is its limited duration. This creates staffing challenges for the retention of skilled and trained peer support team members, who are contract-based due to the ebb and flow of event-driven funding. Added to this, there are limits to the number of workers who can be hired, dictated by a FEMA formula that may be affected by the total number of declared disasters nationwide. The program uses what would be considered psychosocial support services based on the following key principles: Strengths Based, Diagnosis-Free, Outreach-Oriented, Culturally Sensitive, Flexible, Capacity Building, Practical More than Psychological, One Identity. The services offered range from individual and group counseling to referrals and public education. Some survey respondents' criticisms of the program included its limited duration (as some mental health needs may not manifest during this period), its timing (as some households may be more focused on immediate "mucking and gutting"), and its operation period, which begins only after a disaster. Despite these limitations, it is still an effective strategy to address immediate needs and connect households to services to initiate the recovery process.

As an overall category, schools were considered an important asset in the community. Specifically, these were mentioned as an intervention point to increase awareness and education about mental health, serve as a location for direct services, and ultimately normalize mental health, reducing its stigma. However, the coverage and penetration of mental health services in the school system seem limited. Our Lady of the Lake's Healthcare Centers in Schools program provides on-site comprehensive care to children in 7 different locations. These services, however, are not affiliated with the school itself: The program rents spaces at a very low cost. This is an excellent model of care and could be expanded with financial support.

Perhaps the most novel program and entity with a high level of approval across multiple respondents is the Bridge Center for Hope. This crisis stabilization center fills a service gap in the community for individuals who are in a mental health or substance abuse crisis but may not require long-term inpatient care and who may not get the proper suite of services in an emergency department. The Bridge Center for Hope is unique in that it is funded through a tax that was passed in the local government. This project was initiated and supported through the Baton Rouge Area Foundation after it became clear that there was a need to decriminalize mental illness in the community. The Center also creates a positive link with law enforcement, who are able to drop off individuals in crisis through a back entrance with a "no questions asked" policy, thereby redirecting people from the criminal justice system who need acute mental health assistance.

Governance and Policy

Baton Rouge **Mayor-President Sharon Weston Broome** has been a strong advocate and ally for behavioral health initiatives in the community. One signature initiative is the HealthyBR campaign, a collaborative approach that unites dozens of community health partners and places a strong emphasis on mental health, well-being, and health equity. Mayor Broome has also sought to address the crisis of mental illness in East Baton Rouge Parish prison, which ultimately contributed to the financing and establishment of the Bridge Center for Hope. The structure of the Mayor's Healthy City Initiative has provided a central hub focused on cross-cutting initiatives addressing key issues ranging from blight reduction to community health.

Through the Bright Initiative, passed in 2022 by the Louisiana House of Representatives, **HR 173** created the Student Behavior, Mental Health, and Discipline Task Force ("House Resolution 173," 2022). This committee has several objectives and will be submitting a report in January of 2023 with the findings from their efforts. The chosen facilitator of this initiative was the Louisiana Center for Health Equity, to which the NCDP was unable to speak, despite several attempts. The outcomes of this task force may be of particular relevance to any school-based programming. Recommendations have been presented to the legislature as of January 11, 2023; however, at the time that this report was written, a formal report was not publicly accessible (Skinner, 2023). See recommendation 6 for more information.

The Louisiana **Medicaid expansion** in 2016 by Governor Jon Bel Edwards increased access to medical services and resulted in an additional 732,000 persons being covered under Health Louisiana across the state. This expansion has increased access to mental health providers for many. While the expansion of Medicaid has, in theory, created an opening for low-income families to receive care, a burden placed on providers is limiting the supply-side regardless of demand. The demonstrated relationship to mental health was a significant increase in mental health claims in the ten months following the 2016 Baton Rouge floods (Phillippi et al., 2019). Some providers with whom we spoke emphasized that a substantial number of mental health providers do not accept Medicaid because of the difficulty and hassle of reimbursement rates.

See **Bridge Center for Hope tax** in the Contextual Analysis for more information.

Philanthropic Influence

Several key philanthropic organizations have demonstrated variable interest and engagement in the mental health space. These actors include the Baton Rouge Area Foundation (BRAF), Huey and Angela Wilson Foundation, Irene W. and C.B. Pennington Foundation, Blue Cross Blue Shield Foundation, and United Way. All of these entities are interested in mental health and see value in investing in it. Some funders are moving toward a collective impact model but, overall, little long-term investment has been made in mental health programming with the exception of the Bridge Center for Hope. The funding potential for long-term community investment lies not only in direct mental health services but the empowerment of community-based organizations engaged in psychosocial support programs and ultimately ameliorating the root causes of poor mental health.

Psychosocial Support & Resilience Leadership

The Baton Rouge community has a collection of highly motivated, well-trained, and visionary leaders. Several entities that do not provide clinical services but fall within the **psychosocial support** arena—and that should be considered exemplary—include OneRouge, Front Yard Bikes, Sexual Trauma Awareness & Response (STAR), Humanities Amped, Youth Oasis, and the Center for Mind-Body Medicine. In addition, these organizations' officials, several other individuals emerged as key leaders, including Toni Bankston, Dr. Jeremy Blunt, and Tonja Myles.

Generational Shift

Several respondents shared optimism about younger generations within the general and provider communities who have a **positive view of mental health**. They felt that these young people are catalyzing a shift in reducing stigma among their generation. Similarly, when discussing provider pipelines, some positivity was shared in that young Black therapists were able to reach their community more effectively even if they were limited in number. Older generations were still seen as an impediment to increasing the acceptance of seeking mental health services; however, respondents shared their optimism about the faith-based community's ability to reach this population if trained appropriately and provided with the right referral tools and resources.

COVID-19

The COVID-19 pandemic may have a silver lining for mental health despite its overall toll. As one respondent commented, "if COVID has taught us anything [it] is that all of us have challenges and mental health is key." As a result of the pandemic, many providers were thrust into the provision of **telehealth services**. This was seen as a shift in a direction to allow for a greater reach of services and for continuity of services, which might previously have been affected by the transportation barrier (see next section). Some providers have retained this form of service, some use it almost exclusively, and some retain the option to use it when they need to. Some providers were happy to return to in-person services, given the nuance of body language that they need to see to be able to properly assess and treat their clients. Enhancing service providers' capability to reach their clients remotely proved to be a valuable tool during the pandemic. With the right training, technologies, and shift of culture away from "the way we have always done thing," it holds great future potential. Additionally, some interviewees noted that the shift to telehealth allowed some community members to participate in mental health services without the stigma that can be associated with being seen at a provider's office. Stigma is further discussed below in the barriers section.

Barriers

Respondents were often fluent in discussing barriers, gaps, and challenges in mental health service delivery, systemic issues, and fundamental causes of health and mental health disparities. Barriers were often spoken of as systemic challenges rooted in inequitable community resources, with a highly spatial and racial divide. The next few paragraphs will thematically summarize barriers to mental health, along with relevant stakeholders, themes, and history.

Infrastructure Gaps

Unanimously, respondents identified the lack of adequate public **transportation** and reliable Medicaid-funded ride services as a major barrier to the community's access and utilization of mental health outpatient services of any type. The resounding concern was extended to highlight the concentration of resource deprivation in several urban ZIP codes (70802, 70805) and diametrically the rural areas of the Parish. As one respondent explained, "If you start talking about crime and poverty, you always hear these numbers 70805 and 70802. Those are the two ZIP codes that seem to be the center of poverty, crime, and other social ills in the area." Interviewees noted that while bus routes existed, patients who solely relied on metro bus transportation could sacrifice an entire day waiting for bus schedules to align with their needs.

Societal Barriers: Stigma

At a societal level, the **stigma of mental health–seeking behavior** raised a paramount concern across all interviews. We functionally defined stigma as a "social process that is characterized by labelling, stereotyping, and separation leading to status loss and discrimination, which may impact mental health–seeking behaviors." Stigma associated with mental health services was strongly associated with the Black community, where, culturally and generationally, the act of seeking mental health services is seen as taboo and specifically, a sign of weakness. Stigma, particularly within communities of color, was mentioned by a key informant: "It's a generational stigma, just kind of passed down from generation to generation, you know? 'Figure it out on your own.' 'You'll be okay.' 'Man up.' 'Cry in the shower' type of deal. You know, just push it away and deal with it later or don't deal with it at all." Several interviewees also underscored that the legacy of racism and discrimination toward Black communities has led to mistrust of medical professionals. This, alongside the harmful stigma of mental health care in the Black community, has made it difficult for providers to access this population, particularly the older generations.

Financial Barriers

Financial barriers can be characterized from two different viewpoints: provider-side and seeker-side. On the **seeker side**, financial barriers were cited consistently across all interviews as a major factor in preventing community members from seeking mental health care. Patient responsibility is significant for some mental health service seekers, even before they need to seek care. The lack of provider parity and participation in sliding-scale reimbursement schemes or acceptance of non-commercial insurance contributes to this barrier. The cost is additive to the service seeker in that they are often burdened with the time and energy cost of identifying a provider that can meet their financial requirements, and, adding an additional layer, the time they must wait to see providers that are already at or above capacity. For some, this is further compounded by the time spent on public transportation or using a dial-a-ride-type service, which can lead to a loss of wages for hourly workers.

On the **provider side**, poor Medicaid reimbursement rates have pushed many providers to only accept commercial insurance or private-pay clients. In Louisiana, after the closing of mental health hospitals during the Jindal administration, there was a boom of new private providers, particularly for inpatient services. Many of these have extensive wait times for beds or do not have the ability to take lower-reimbursed patients. This boom has created a competitive market among both inpatient and outpatient providers, which has contributed to the favoring of cash pay or commercial reimbursement.

Knowledge and Information Barriers

Respondents felt that even though many **resources** were available in the parish, they were being underutilized. Even though entities such as Capital Area Human Services are centrally located, many people do not have any idea what kind of services are offered in each location. The where, how, and when to get assistance questions are currently not easily accessible to the entire community. Furthermore, many practitioners are not sure where to send their clients for additional help or are held back because they are aware of wait times or other systemic dysfunctions in the mental health continuum of care.

Systemic Barriers

Many **social and structural determinants of health** were discussed by respondents. These systemic factors, rooted in hundreds of years of discrimination, marginalization, and racism, are all forms of structural violence and have created an environment where mental health does not come first. The linkages between substance use, housing and homelessness, inequitable city planning, the criminal justice system, extractive industries (e.g., plantations), disaster exposure, and now climate change have all had negative impacts on mental health. And there is no health without mental health. Some respondents felt that it is hard to prioritize mental health when giant root causes run through the community, and putting food on the table or finding a job, for example, come before taking the time to find a therapist. In Baton Rouge, much of this came to a head in 2016, when major floods, the shooting of Alton Sterling, and the subsequent retaliation against police led to a new spotlight on these disparities.

The **health care delivery system** has also taken a hit, starting with the **closure of key hospitals** and mental health facilities during the Jindal administration. The service gap, particularly for the indigent, has never been filled. Concern was expressed by several respondents that the mental health continuum of care (the criminal justice system, hospitals, medical providers, therapists, inpatient and outpatient facilities, homeless shelters, foster care, schools, law enforcement) is not in fact a continuum but rather separate siloed entities with little to no information-sharing or coordination. In particular, the connection between criminal justice and mental illness has been highlighted in the parish, with no adequate solution to the criminalization of mental illness since the closure of key state-funded hospitals. The recently opened Bridge Center for Hope has helped provide critical relief to stabilize persons with mental illness and could serve as a crucial long-term solution to the lack of mental health hospitals. However, some providers made it known that they were unaware of or unfamiliar with how the Bridge Center operated. This **uncoordinated continuum of care** and **poor continuity** result in more extreme cases of mental illness and subsequent crises that could be avoided.

Another systemic issue identified is a **poor provider pipeline** of licensed mental health providers. Several reasons were cited for this bottleneck, including new licensing restrictions and the reimbursement policies related to them, brain drain, and the fact that turnover is so high because the work is so hard and the parity of pay does not match.

An additional issue that was mentioned frequently in interviews is the growing movement of **breakaway communities** or secessions from East Baton Rouge Parish. New districts such as Zachary, Central, and Baker have all seceded from the parish to establish independent school districts and local governments. This trend has caused significant controversy and reignited a debate around segregation, because the new school districts are generally more White and affluent than the surrounding areas. The breakaway communities present significant challenges for East Baton Rouge Parish, which, in addition to community unity, stands to lose a significant tax base through these secessions. Another community, St. George, is seeking to incorporate as its own city and school district, although at this writing local courts have ruled against this. Breakaway communities redirect community resources to higher-SES families and can lead to a decreased tax base for Baton Rouge City and East Baton Rouge Parish. Policies and Governance.

With a few exceptions, most respondents could not point to a single piece of local, state, or federal policy that they felt improved or directly addressed mental health and resilience in the community. Some exceptions do exist, among them **Medicaid expansion**, the **tax to fund the Bridge Center for Hope**, the federally funded Louisiana Sprit program via FEMA and a presidentially declared disaster, and the use of CARES Act funding during the pandemic for Mayoral Initiatives such as **Safe, Hopeful, and Health**. Only one respondent was aware of legislative bill **H.R.173**, and then only because they had helped to write it. There is a need for better policy guidance to link federal, state, and local initiatives to identify policy levers for systemic long-term change and investment in mental health.

Discussion and Recommendations

"And at the end of the day, crisis—crisis does not discriminate. But unfortunately, some of the resources and the spaces that people need to enter in does. And so I think that we have to do a better job of. Again, I go back to leveraging the playing field and making sure that people know what the resources are, and even before they get there. Because at the end of the day, if I send someone to somewhere and they're in a crisis and I'm expecting them to jump through 15 hoops to get the help that they need, then they just got traumatized all over again." ~ Key Informant

1. Identify or create transportation solutions to increase service accessibility.

Lack of transportation was cited as a major barrier to community mental health. Even though some free options exist, such as Medicaid-funded transportation, these services are slow, unpredictable, and often leave the client waiting on either side of the trip for extended periods. When time and resources are limited, the costs may outweigh the perceived benefits for the individual. Investment by an individual in pursuing mental health services is a long-term and ongoing commitment, and the pathways to care must be consistent and flexible in availability. Solutions must be free or low-cost to the service recipient and must be efficient.

Alternatively, or additionally, investments could be made to expand the reach of service providers. If service recipients cannot be easily transported to their provider, then the services could be brought to them. This might be accomplished in two ways. The first is the dispatch of mobile mental health units directly into high-need areas. Another is to establish community mental health centers or community-based mental health service/resource hubs that can fill service area gaps. These centers can provide psychosocial support as well as clinical services and may also serve as case managers. It is noted that these are the types of services provided by Capital Area Human Services; however, their penetration into higher-need areas and rural locations is low. One caution with the mobile unit approach is that it must be done in a way that simultaneously addresses stigma. There is potential for reduced privacy if individuals are seen seeking assistance when a stigma is already associated with it in certain communities.

"When we talk about food access and we talk about transportation and mobility, transportation is not just getting from one place to the next. Mobility is about being able to reach your destination without having to—without being put into danger, without being additionally traumatized. And I use that word not loosely, but it is absolutely traumatizing to be up at five in the morning waiting on a bus that may or may not come in the dark when they're by yourself, especially if you're a woman or somebody who's very young in a neighborhood that may have issues with crime. These are all things that create more and more stressors and undue burden and harm to folks who are already under a lot of unnecessary stress." ~ Key Informant

2. Reduce stigma and normalize mental health across the community.

Reducing stigma around mental health as a concept and health-seeking behaviors may improve overall community mental health and resilience. By increasing acceptance, it is possible to create a culture shift that encourages people to seek assistance earlier, which is in line with promotive and prevention approaches on the mental health continuum (Figure 2 SAMHSA Continuum of Care wheel). (Begun, 2019). This can ultimately reduce the system's impact on clinical services provided.

Stigma reduction efforts should be catered to two primary communities: the Black community and the older generation. These two communities were consistently identified as having the greatest need for stigma reduction. Potential partners for reducing stigma include the faith-based community and religious congregations, which function as critical social institutions in the parish, and schools, which can provide an early intervention point for normalizing the discussion about and participation in mental health services. Religious congregations and faith leaders, in particular, can serve as crucial conduits for shifting the narrative around mental health and mental illness.

> *"I think the very well-known skepticism about getting mental health care, like going to therapy and those kinds of things… is certainly something that's that this idea of, like, 'We don't do that here,' you know, 'That's weakness.' 'That's not who we are. That's not what we do' is definitely a part of the identity that many people have."* ~ Key Informant

3. Create a community-wide Mental Health Communications Strategy to effectively coordinate and promote existing services and resources.

While resource directories are helpful to some people, they do not adequately represent the breadth of services provided across the community, nor are they able to cater to various communities within the community. Themes discussed across several interviews include the siloed nature of service providers, the lack of a collective strategy, the competitive nature of funding, stigma, and a sheer lack of basic community awareness and education about mental health, how to access help, and what kind of help to access. To address these information and knowledge gaps, a Community-wide Mental Health Communication Strategy could be developed that leverages a collective impact model across all actors within the mental health provider community. The Mayor's HealthyBR campaign represents a model that can be built upon, in particular the triannual Community Health Needs Assessment (CHNA) and Community Health Implementation Plan (CHIP) – assessments that are conducted jointly by hospitals and medical centers in the parish to identify crucial needs, shortcomings, and goals. Potential partners for such a communications strategy could include the Mental Health Association, NAMI Baton Rouge, and the Behavioral Health Task Force (which is a part of the Mayor's HealthyBR initiative).

> *"And at the end of the day, crisis, crisis does not discriminate. But unfortunately, some of the resources and the spaces that people need to enter in does. And so I think that we have to do a better job of. Again, I go back to leveraging the playing field and making sure that people know what the resources are and even before they get there. Because at the end of the day, if I send someone to somewhere and they're in a crisis and I'm expecting them to jump through 15 hoops to get the help that they need, then they just got traumatized all over again."* ~ Key Informant

4. Provide long-term investments in community-led coalition-building for mental health and psychosocial support programs.

Several multi-sector coalitions exist, such as the Behavioral Health Task Force run by the Mayor's HealthyBR Initiative. However, there are several challenges with these types of coalitions:

1. The community is not invited to participate
2. The participating stakeholder organizations are not involved in setting the agenda or direction of the coalition, and
3. They are voluntary, and therefore, there is no "skin in the game."

Models of community participatory program development can be leveraged to address the first two concerns. The third issue is tied to the fact that it takes dedicated human power to lead and drive these efforts. Therefore, the long-term non-voluntary engagement of the mental health community requires financial support to fund individual champions and organizers as well as organizational representatives who participate. Community convening and relationship-building is a full-time job, and funding to support dedicated staff to focus on these tasks could be powerful. These actions should include a participatory process to develop a community-driven strategy independent of funder management. Future efforts do not need to be novel (i.e., development of a new coalition may not be necessary) but can and should build on existing coalitions, organizations, or other structures. Funders should similarly adjust grant processes and other funding mechanisms to reduce competition while simultaneously increasing participation, such as awarding multi-year collaborative grants that incentivize partnerships and cover partial salary for participation.

> *"We need a collective impact strategy. We need to set some priorities, and then we need a lot of facilitation, a lot of training, a lot of ongoing learning. Because if we don't pour into the people who provide those resources and supports, then we're not going to be able to get different outcomes. And I think oftentimes we've done coalitions, coalitional things in the past, is, like, 'Here's just a bunch of little separate islands.' ... You know, like, I'm exhausted because of the need for the facilitation that I see the need for, but I don't have the time to provide that facilitation for my community. You know what I'm saying? And I know there are people who can do it, but, like, we haven't called them in and honored that kind of work that has to happen to really bring people together, to talk, to understand, to share, to develop a shared strategy with collective investment so that we can align our own resources."*
>
> ~ Key Informant

5. Foster the development of a trauma-informed community to build resilience.

Survey respondents described Baton Rouge as an area that has experienced a series of trauma-related events, particularly since 2016. One respondent discussed the incidence of trauma, including "the fear of civil unrest … the poverty that's found in certain ZIP codes …in 2016 we had the Alton Sterling shooting, the police ambush, the 'Great Flood.'" These events were described by many respondents as pivotal, both in a positive and a negative light. Conversations around trauma rose up around these events and helped spur new action. The momentum and resources must continue. The concept of a trauma-informed community has been gaining momentum across the US, particularly in response to addressing violence in schools and the adult health indicator of Adverse Childhood Experiences (ACEs).

Childhood trauma can be a predictor of adult health outcomes later in life. A shift in approach from "What's wrong with you?" to "What happened to you?" has been lauded as a sensitive and restorative approach to acknowledging the familial and societal trauma experienced across a community. Several key community actors, such as Humanities Amped, the Center for Mind-Body Medicine, and STAR all encourage and utilize trauma-informed and/or restorative approaches such as healing circles in their programming. Extending these efforts in a structured implementation to build a trauma-informed community can build resilience to shifts in the balance from normalcy, whether a disaster, civil unrest, or daily challenges. Along the same lines, this approach may create a cultural shift away from the "bootstrap" form of resilience to building tools and capacity to be more resilient as individuals and collectively across the community.

> *"I know ACEs resonates in general with people. It just has that effect. But in Baton Rouge, it is really resonated, I think, because we are a community that's no stranger to trauma. And so the things that they hear in the workshops resonate and it makes it make sense to people. Well, you can see the light bulbs going off when they realize in that moment something that I used to think we took for granted that everybody knows they don't: that if something happens to a child in their childhood, it leads to everything bad in adulthood — you know, social problems, mental health problems, physical problems. But people have really [seen] a lot of light bulbs going off in our community. And what's really cool is we actually have the prevention piece in our community, we're seeing it not only at the average person level, but we're seeing teachers really latch on to this."* ~ Key Informant

6. Support sustainable school-based mental health programming to increase access points for children and youth.

School programming like that provided by Humanities Amped and Our Lady of the Lake requires financial support and buy-in from school leadership. Many respondents shared a belief that children and youth are an under-reached population for mental health services. The politics of the school system, disparities between public and charter schools, and the "new segregation" of schools have made it challenging to create uniform and equitable access to mental health education and school-based services. Additional support and expansion of existing school-based interventions should be explored. Findings from the output of the H.R. 173 Student Behavior, Mental Health, and Discipline Task Force are expected, but have not been released at the time of this report. The task force's findings were presented on January 11, 2023, in a hearing of the Louisiana legislature (Skinner, 2023). Initial recommendations included nine actions that would require legislative action, including permitting mental or behavioral health as an excused absence for school students; requiring mental health instruction for students; organizing all school-based health centers under the purview of the LDH's Office of Public Health; conducting a review of corporal punishment, willful disobedience, and zero tolerance policies by the Louisiana Department of Education; and establishing a state-wide definition of "willful disobedience" and clearly defined roles for support

professionals in school. An additional 16 recommendations that would not require legislative action included adding quiet spaces in schools, providing mental health screenings during school health screenings, creating a centralized repository of mental health providers and organizations, maximizing school-based Medicaid services, and making additional school staff training measures (Skinner, 2023). This output may inform school-based interventions.

> *"We found out that 40% of all the children who came in for really serious cases of child abuse never came back. And that's when we launched a school-based program because we realized we had to go to the schools and find them. And most of the time, when we'd call the parents, we would hear about transportation issues. Basically, poverty kind of based reasons for not coming in. Parents working two jobs, not being able to get the kids there. So access is a huge barrier, I would say, still. Not everybody innovates. It says, 'Well, if they're not coming to me, I'm gonna go find them.' Not everybody does that, but ... that's actually what it takes right now in Baton Rouge to make sure a kid gets the help they need. Outreach has to be a big part of your budget."* ~ Key Informant

7. Educate and engage the faith-based community to reduce stigma.

Churches were discussed by key informants as a pro-social space that brings together people in every location of the parish. They are also seen as having incredible influence on their congregations and therefore have the ability to promote the reduction of stigma of mental health, particularly on the older generation. Dr. Jeremy Blunt is especially equipped as a pastor and service provider to deliver trainings and education to church leadership. A strategic engagement of the faith-based community is a powerful lever to promote community mental health and well-being.

> *"Churches are another huge area that I've thought we need to focus on in two ways: helping African American churches realize that mental health is real and getting counseling therapy is not outside of faith. Right. Those two things can coexist together. And then if we can get them to be on board with that, then offering resources at the church. Because if you offer resources at a community church, people automatically feel like there's a check, it's approved, I should do it, it's there, and it's accessible. It's somewhere I'm going to be, somewhere that I trust."* ~ Key Informant

8. Identify leverage points for payer equity to reduce provider competition and increase client access.

The disparity in insurance company reimbursement is driving providers to more profitable reimbursement sources. While the expansion of Medicaid has, in theory, created an avenue for increased client base, this is still not enough to make it desirable for them to accept Medicaid clients. The creation of a fund to incentivize providers to accept Medicaid patients or identifying other sources of gap-fill reimbursement could be explored. Larger efforts to change reimbursement rates or create equity across various payers may also be useful. Federally Qualified Health Centers (FQHC) do exist and can provide free care to anyone; however, one key informant noted that not all FQHCs provide all types of mental health services.

> *"Louisiana in the last few years has become a Medicaid expansion state, meaning that we'd like to think that there is more access to health care and especially mental health care than there ever was before. But you don't necessarily see a whole lot more providers accepting Medicaid. There are some. But, the Medicaid reimbursement rates have not necessarily changed. And so you don't hear about a lot of private providers working in that field."* ~ Key Informant

9. Integrate mental health as a component of any type of community program to recognize and address the interconnectedness of mental health throughout the social ecology of the community.

Prioritize the inclusion of mental health and resilience at the community level in any programming that addresses structural or social determinants of health, including housing, economic security, food security, and the legal system. And the reciprocal should be observed in mental health programming. The complex interconnection of various components of the community system is inextricably linked. Appendix 3: Whole-city socio-ecological model for public mental health provides a useful diagram for visualizing what a city-wide approach to mental health may look like, specifically in that everything is connected. Programs should not operate in silos but must be thoughtfully connected and integrated across community actors and stakeholders. Following the socio-ecological model concept, Appendix 4: Community Intervention Processes by Socio-ecological model levels provides examples of interventions to improve mental health within the framework.

> *"So this region, like much of Louisiana, has a lot of poverty. It has a lot of crime. Has a lot of those social determinants of health issues, high rates of cancer, high rates of diabetes and heart disease, and all of the social ills are present here. And more than many places in the country, maybe, maybe not more than other places in Louisiana. But Baton Rouge is known as, for example, it's got one of the highest rates of violent crime. Sometimes you see a top 10. Sometimes you see the top 20. But it's a metropolitan area. It's quite—there's quite a dichotomy between the haves and the have-nots, because it's also a wonderful place to live. It's got state government, it's got LSUs, it's got Southern University. It's got all these wonderful things about it. And yet you cross the track, you cross over the highway, and the standard of living just plummets. So, when you start talking about mental health, mental health issues have to be correlated with all of those things, right? You know, there's got to be a correlation between mental health issues and stress and all of those other social issues."* ~ Key Informant

10. Strengthen the mental health continuum of care and service pathways to improve the continuity of care.

A systems analysis in the continuum of care and service pathways for mental health and psychosocial support may be useful in understanding the disconnects and, ultimately, levers that may help build a more cohesive system. This type of effort would require the convening power of someone like Mayor Sharon Weston Broome. This particular analysis did not gather enough information to determine whether this type of effort has been made in the past or is currently underway. This continuum is not mutually exclusive from primary care and other healthcare services, such as hospitals and primary care providers, can provide referrals, address mental health crises, and also provide screening and basic education on the link between physical and mental health.

> *"I saw how that and mental health intersected with emergency rooms having to—I'm not saying that they shouldn't have, but emergency rooms had to take on a burden of addressing mental health problems that they never saw before. And that trickles down, then it trickles over into how it affects first responders, police, EMS, all of that. It affects what's going on in the private clinics and the mental health centers around the city. You know, it starts this—there's this triggering of services that have to come to bear when somebody shows up at the most intensive level of care, the emergency room."*
> ~ Key Informant

11. Build a diverse provider pipeline to address current and future needs.

The idea of going to a "therapist that looks like you" was a theme heard across several respondents. One key informant who declared that mental health is not treated the same as physical health in the United States expressed the need for more training, particularly within the Black community. There is "urgency felt by universities and training institutions to train more nurses and but not necessarily the same urgency around training more licensed counselors or social workers or psychologist or psychologist … I think we definitely need more, and particularly in our city where it's primarily it's a majority Black city and Baton Rouge … we need a lot more Black leadership around mental health work and a lot more training there. You know, a lot of spaces. Like, we need to be able to pour into Black practitioners who can then hold these spaces." The idea of training professionals locally, providing them with incentives to stay local, and building a diverse and inclusive community of providers is a pipe dream for some, but it cannot be impossible. Creative thinking around programming and licensing requirements may be required. Partnerships with LSU have occurred in the past, but it appears some relationships with the university may have fizzled out or transitioned. Scholarships and related incentives should be offered, particularly to communities of color within the parish, to study and pursue the field of mental health. A unique program mentioned by one key informant was a JumpStart initiative promoted by the Baton Rouge Chamber of Commerce to create a pipeline for Mental Health Technician Certification. Mental health technicians must work with a licensed provider, but may provide similar services. This may be a program to explore in more detail.

> *"So, I think we're working into an area where our professional population is phasing out because they're getting older, and you don't have that middle ground where people are. You have some younger folks that are now getting into it because it's such a need. But you have to have so much behind it to even practice in the state. So there is a section of individuals that at some point, you're not going to have enough, kind of like nurses, you know, you don't — you're not going to have enough. … Because if you start looking at all of these people who are pushing out mental health services and all these other things, they're always saying, 'Oh, you need a licensed clinical social worker. You need a licensed professional counselor.' Well, that takes time. … And then not only does it take time, it takes experience."* ~ Key Informant

12. Invest now in building mental health service capacity and peer support mechanisms to meet people where they are.

Identify systems and structures that can be built upon, enhanced, and expanded to proactively address mental health needs in the community. For example, programs such as Louisiana Spirit have a cadre of trained peer support specialists who could be doing what they do after a disaster on a day-to-day basis: building relationships, educating, and building referral pathways. There are many experts in the community with keen insight and lived experience who have progressive ideas but just need time and funding to build the change their community needs.

> *"There's a big trend of peer support and para-professional health. So, we have people that really do want to do that work, and not just because it's a job, but because they've had trauma in their life and they want to help another person. So if you have a lot of high-ACEs scores, the downside is you've got high-ACEs scores. But the positive end is that it's going to bring forth more people who really want to help other people because they've been impacted. And we definitely have a strong community of that happening here in Baton Rouge."* ~ Key Informant

13. Proactively link emergency management and disaster risk reduction principles and fields of practice with mental health and psychosocial support to mitigate poor disaster outcomes.

As the threats from climate change continue to rise alongside disaster risk, there is an opportunity to recognize the linkage between mental health and psychosocial support services and disaster risk reduction/emergency management principles and response systems. Connecting concepts and objectives from each can help reduce the mental health impact of a disaster while also increasing resilience to future disruptions from disasters and emergencies. Appendix 6: Linking Disaster Risk Reduction (DRR) and Mental Health and Psychosocial Support Principles provides a clear visualization of the overlap between the two fields.

> *"So, climate change and mental health. Let me just start simply with good mental health. A satisfactory mental health is a feeling of safety. That's where we start. And I feel that based on our experiences here, we see the coast changing. People have fears about—in some areas of Louisiana, are some areas of Louisiana even going to be livable ten years from now? So, there is an underlying sense of disruption of safety that occurs when climate change is in the fore, forethought, forethought of people's minds… And sometimes it actually is a disruption of their safety. So, if they lose their home to flooding repeatedly, they have to move away, you know? So it's actually a practical disruption of their lives. That leads, of course, to poor mental health outcomes… But I think that the flood—I think things changed here with the floods of 2016, because they were historical. They never happened before. People flooded areas that weren't in the flood zone. And the vulnerability that it brings up, I still see and hear mental health being impacted from those floods in 2016, not because they didn't put their house back together, but because it really awoke in people a new sense of vulnerability that they didn't have before."*
>
> ~ Key Informant

14. Build financial and conceptual support, psychosocial support programs to support the mental health of those without a clinically diagnosed mental illness.

Many of the barriers discussed in this report are large, but when examining the breadth and range of mental health, the majority of people who may be struggling with mental health do not necessarily have a mental illness. In Appendix 5: Dual-Continua Model of Mental Health, we see that it is possible to have a mental illness and flourish, and it is also possible to have poor mental health and languish, but one requires clinical treatment and the other does not. This distinction is paramount to seeing both the value of clinical intervention and the value of psychosocial support services, which do not need to be implemented by trained clinicians. These types of interventions or programs run by organizations such as OneRouge, LSU Libraries, and Front Yard Bikes, or by peer-support specialists and groups like NA and AA, can be incredibly influential. Similarly, investing in training for ACEs and building a trauma-informed community can have a ripple effect through all levels of the socio-ecological model of mental health and well-being (see Appendix 1: The Mental Health Well-being and Socio-Ecological Model). Further exploration of this concept should be undertaken.

> *"I think a support system in general, whatever that might look like for somebody, as long as it's a positive support system and it's not necessarily going the opposite direction of, you know, dependent support, where you're depending on alcohol, you're depending on drugs, like not that sort of thing, obviously. But anything that brings health to your mental—you know, a healthiness to your mental state of mind."* ~ Key Informant

15. Explore the development of or pursue certification for Certified Community Mental Health Centers to provide comprehensive hyperlocal mental health services.

In 2022, the *New York Times* Editorial Board reminded readers of a somewhat forgotten vision of John F. Kennedy to have Community Mental Health Centers across the U.S. to deliver community education, provide inpatient and outpatient care, and provide emergency or partial hospitalization for acute mental illness (The Editorial Board, 2022). The Community Mental Health Act of 1963 aimed to provide three-year grants to states from the federal government to build 1,500 Community Mental Health Centers (Blake Erickson, 2021). Unfortunately, only half of these centers were built, and, through repeals by subsequent presidents, including Ronald Reagan, JFK's vision was never fulfilled. There is, however, a growing and renewed interest in this point of care concept of Certified Community Behavioral Health Clinics (CCBHCs) (https://www.samhsa.gov/certified-community-behavioral-health-clinics). In 2022, with support from the Biden administration, an enhanced set of grants from HHS/SAMHSA to fund either the Planning, Development, and Implementation (PDI) or Improvement and Advancement (IA) of these CCBHCs was made available (HHS, 2022). This hyperlocal concept of comprehensive free mental health services could be explored to build upon existing services in Baton Rouge and may fill gaps in the neighborhoods that need services the most.

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The content of this document, including all data and hyperlinks, is current up to April 2025. Hyperlinks will not be maintained after publication, but are available in full length for the reader's reference.

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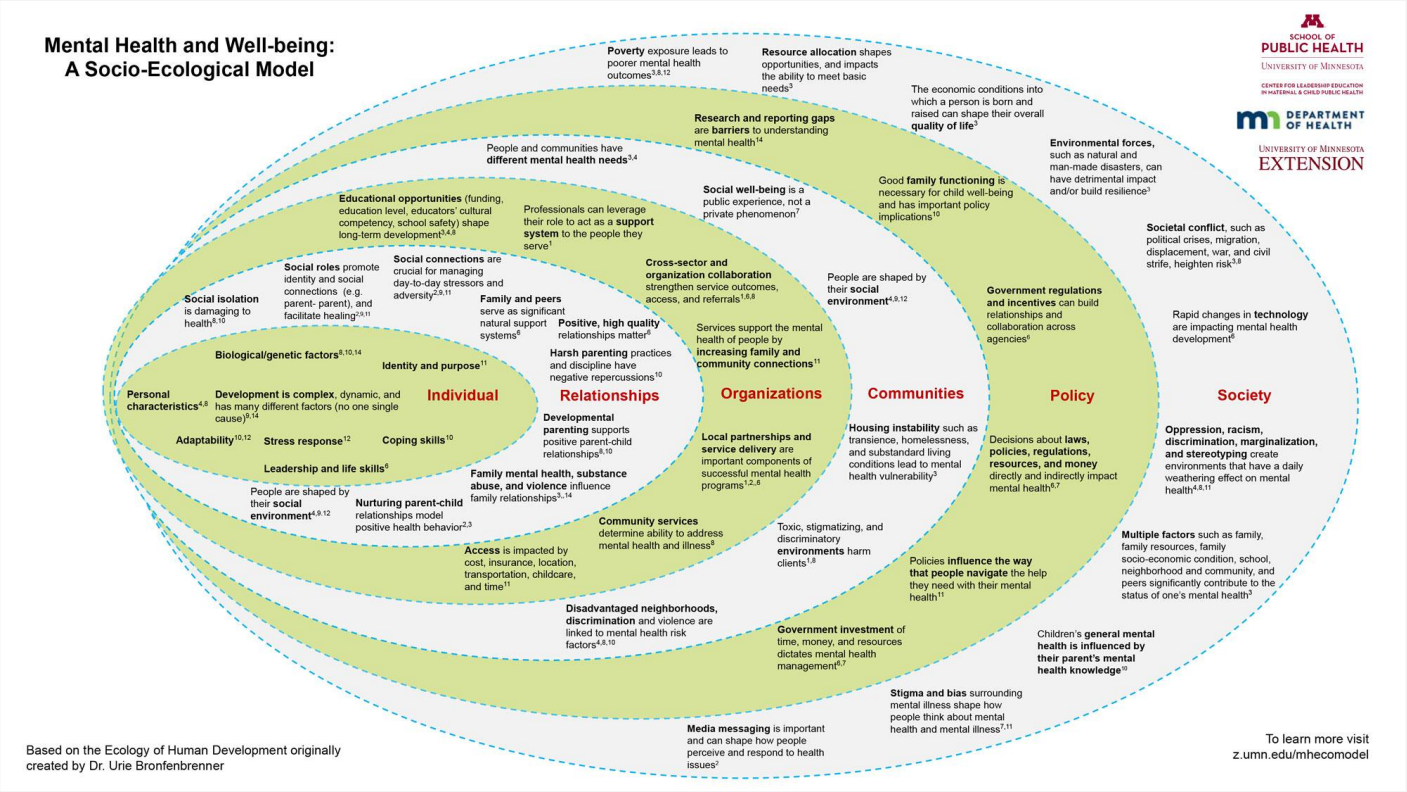
Appendix 1: The Mental Health Well-being and Socio-Ecological Model

Figure 3: Mental Health and Well-being Socio-Ecological Model.



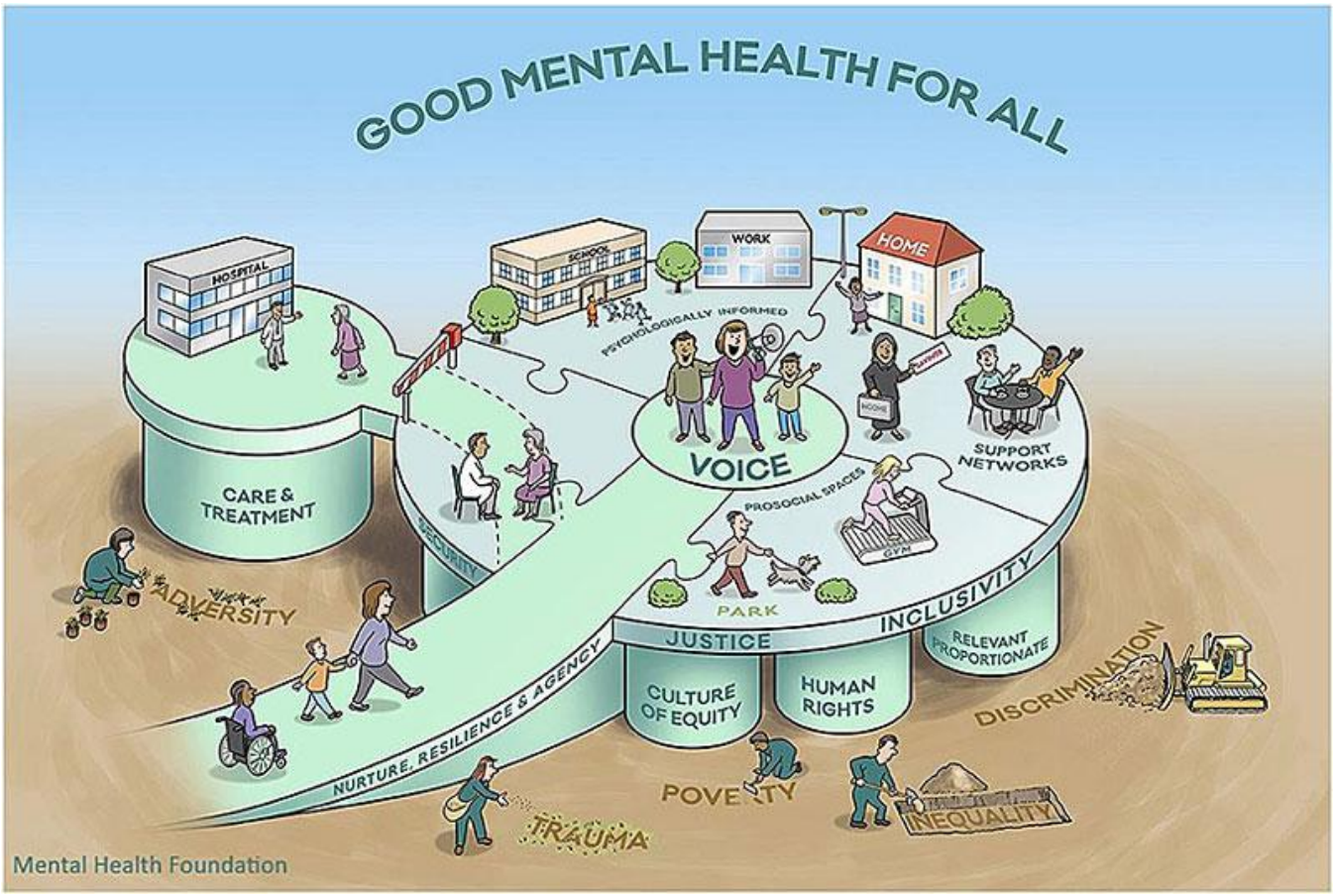
Source: University of Minnesota, 2021

Appendix 2: Key Informant Interview Guide

1. How would you define the following terms in your community:
    - Mental health
    - Psychosocial support
    - Resilience?
2. How does regional history affect mental health and resilience in your community? How does that history affect individuals and the community?
3. Describe how community resilience is fostered across the Baton Rouge Area. Please list and describe any specific programs that promote this outcome. What about mental health?
4. Describe the greatest assets to enhancing community mental health and well-being.
5. Describe the greatest barriers to enhancing community mental health and well-being.
6. Describe any current mental health programming that supports:
    - Individuals
    - Households and families, peers, or social connections
7. Who are the champions of mental health in the East Baton Rouge Parish? Are they individuals or organizations?
8. Describe any community-wide multi-sectoral approaches to mental health.
9. What community strengths does your sector or industry foster? If so, which ones and how? Which do you think supports mental health and well-being across the community?
10. List and describe any cross-sector or community partnerships that you are aware of that work to address community mental health and psychosocial support.
11. What resources or information might community-based organizations, government agencies, and health professionals need to better position themselves for long-term impact in the community, with specific respect to mental health and community resilience?
12. Who are the greatest community allies?
13. What are and with whom are the greatest sticking points in realizing the mission and vision of those working to improve mental health and psychosocial support systems?
14. What are the most helpful policy-related activities (which may also include advocacy or specific legislation) that have helped promote long-term mental health? What means did that occur (e.g., increased funding, staff support, access to other resources)?
15. What resources does the community need to be better prepared to meet the mental health and psychosocial support needs of your community before a disaster?

Appendix 3: Whole-City Socio-Ecological Model for Public Health

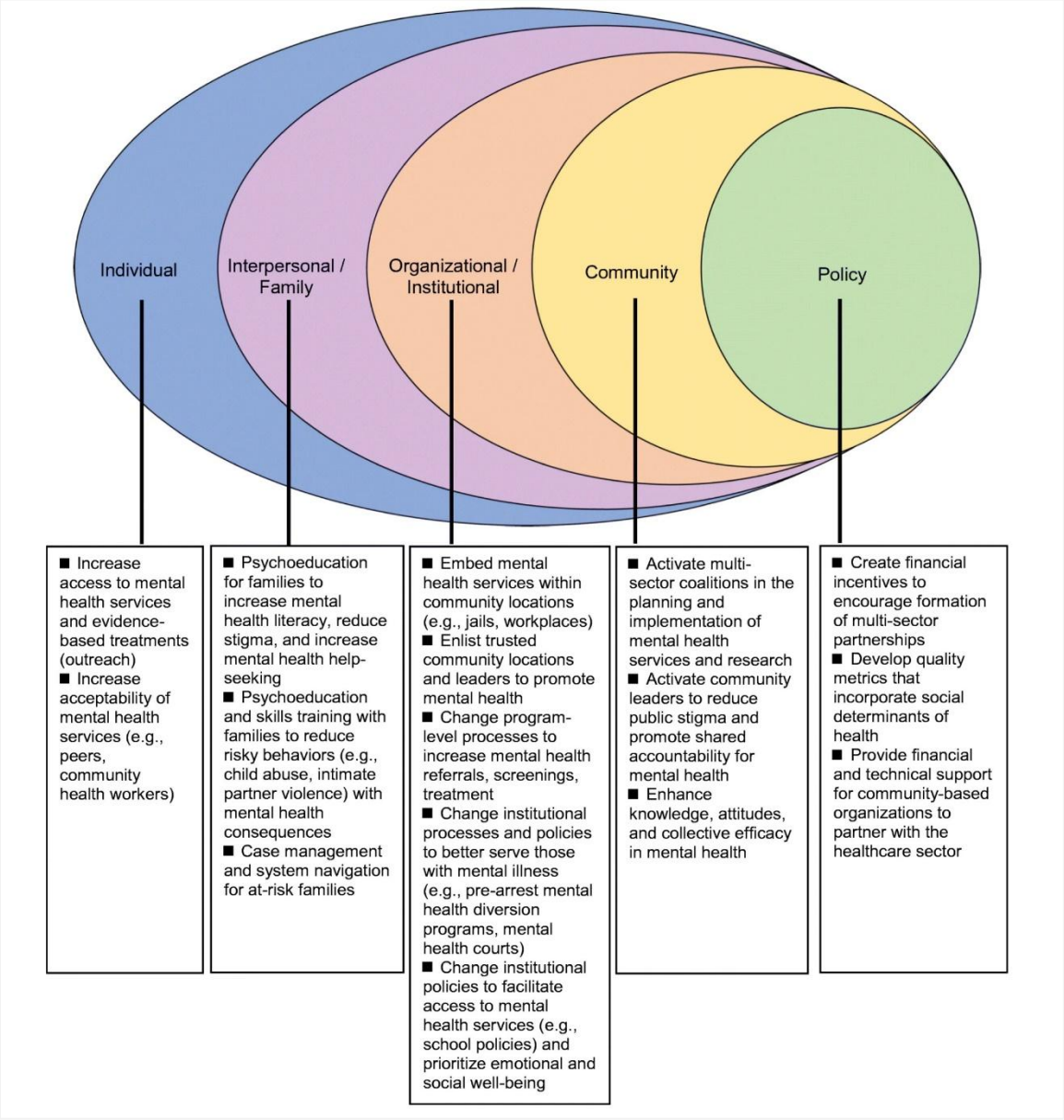
Figure 4: Whole-City Socio-Ecological Model for Public Mental Health



Source: Kousoulis & Goldie, 2021

Appendix 4: Community Intervention Processes by Socio-Ecological Model Levels

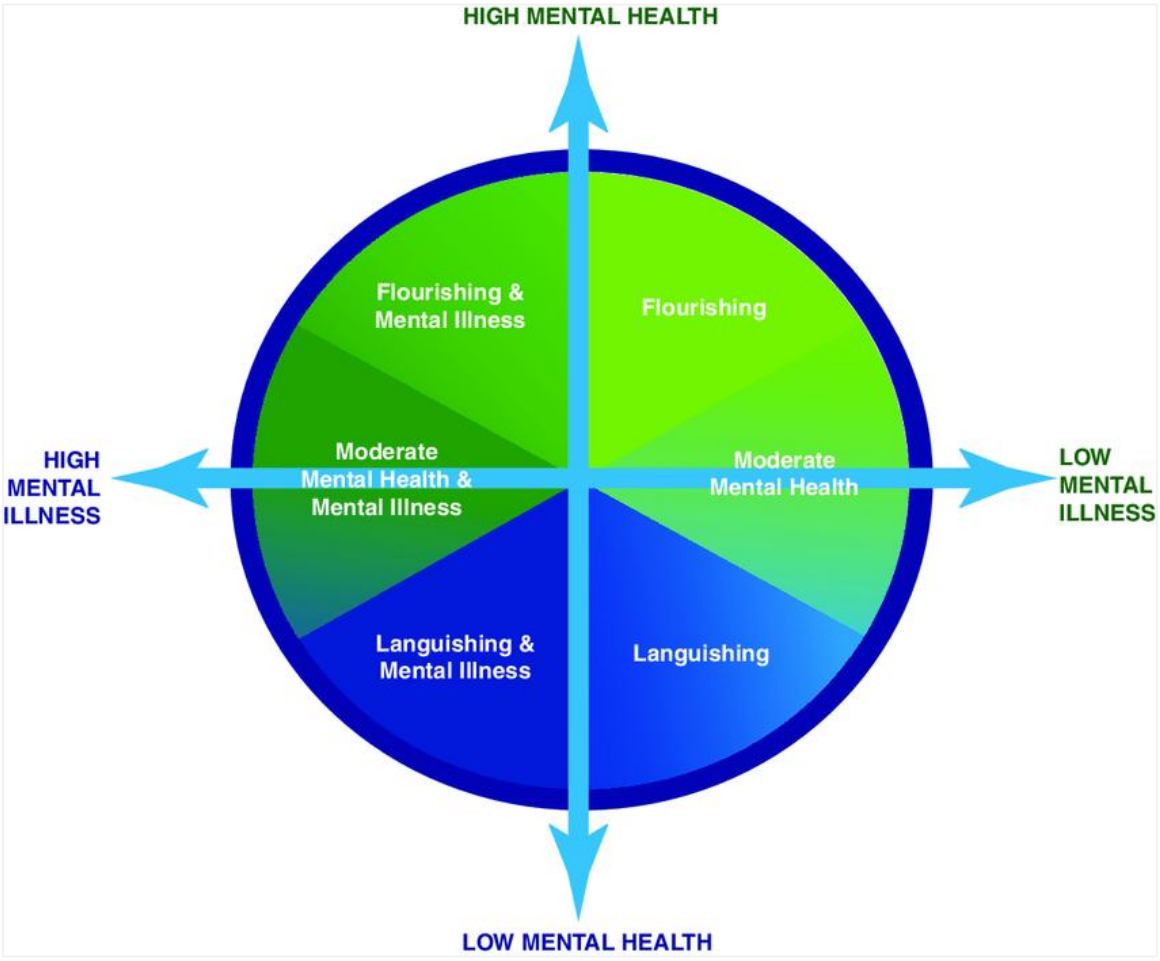
Figure 5: Community Intervention Processes to Promote Mental Health Mapped to the Socio-Ecological Model



Source: Castillo et al., 2019

Appendix 5: Dual-Continua Model of Mental Health

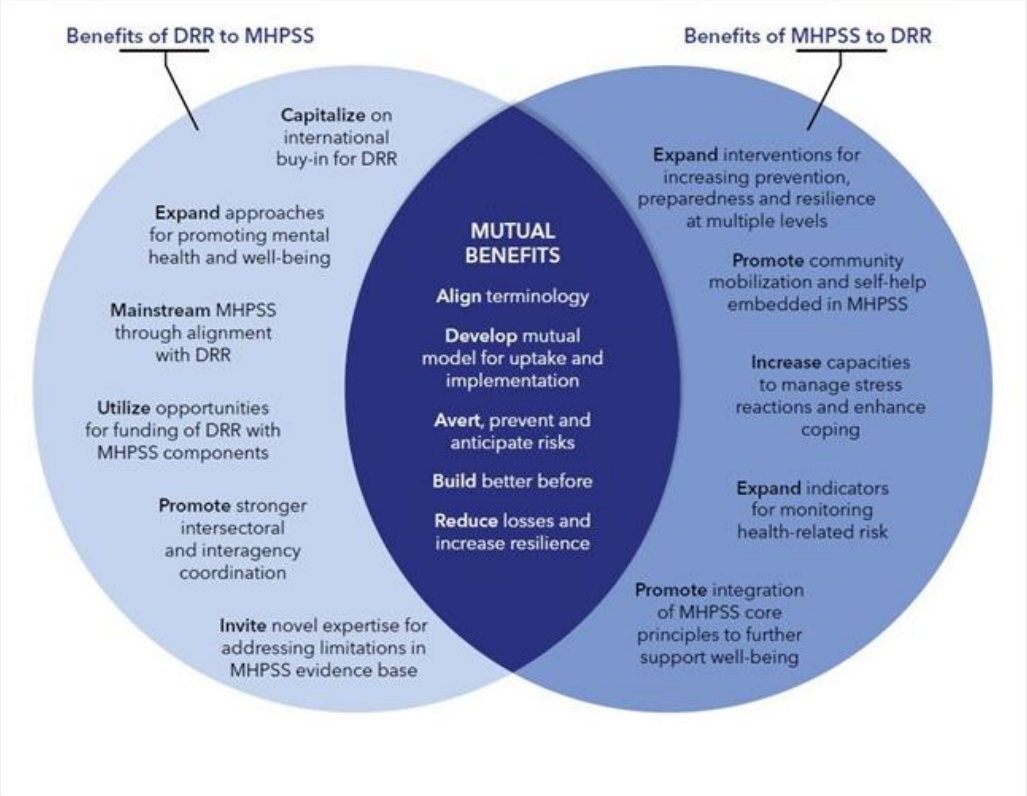
Figure 6: Dual-Continua Model of Mental Health



Source: Keyes, 2013

Appendix 6: Linking Disaster Risk Reduction (DRR), Mental Health, and Psychosocial Support Principles

Figure 7: Linking Disaster Risk Reduction (DRR) and Mental Health and Psychosocial Support Principles



Source: IASC Reference Group on Mental Health and Psychosocial Support, 2021

Appendix 7: Organizational Table

The organizations listed below encompassed the breadth of outreach for participation in this study as well as those mentioned after the initial outreach during the data collection phase. The table the general type of service area they operate within and whether or not key informants mentioned the organization as an asset to the community when asked to name any community champion or ally organizations. The interviewed column "N/A" value represents any organization that was not in the sampling frame but came up during interviews. A "Yes" response in the mentioned in interview column represents an organization that was referenced in an interview as being relevant to the study topic. A total of 110 organizations are listed below, of which 83 were invited to participate in some part of the study.

Table: List of Baton Rouge Organizations

Name of Organization	Org Type/Service Area	Mentioned in the Interview
Accurate Care, LLC	Outpatient Behavioral Health	
Acer LLC-Baton Rouge	Outpatient Behavioral Health	
All Out Community Care Services	Outpatient Behavioral Health	
Allstar Community Care, LLC	Outpatient Behavioral Health	
Always Hope LLC	Outpatient Behavioral Health	
AmeriHealth Caritas	MCO Managed Care Organizations	
Anchor Community Services	Outpatient Behavioral Health	
Apollo Behavioral Health Hospital, LLC	Hospital/Residential/Inpatient, Outpatient Behavioral Health	
Array of Hope Outreach Center, LLC	Outpatient Behavioral Health	
Baton Rouge Area Foundation	Funding/Philanthropic	Yes
Baton Rouge Area Youth Network	Non-profit	Yes
Baton Rouge Behavioral Hospital Treatment Center	Hospital/Residential/Inpatient, Outpatient Behavioral Health	
Baton Rouge Children's Advocacy Center (BRCAC)	Outpatient Behavioral Health	Yes
Baton Rouge Comprehensive Treatment Center	Outpatient Behavioral Health	
Baton Rouge Crisis Intervention Center (BRCIC)	Outpatient Behavioral Health	Yes
Baton Rouge District Attorney	Governmental	Yes
Baton Rouge General Medical Center; *Baton Rouge Recovery Health, LLC; *Behavioral Wellness Center	Hospital/Residential/Inpatient, Outpatient Behavioral Health	
Baton Rouge Health District	Governmental	
Baton Rouge Parks and Rec (BREC)	Governmental	Yes
Baton Rouge Police Department	Governmental	Yes
Baton Rouge Youth Coalition (HealthyBR)	CBO/Non-profit	Yes
Beacon Behavioral Health	Outpatient Behavioral Health	
Behavioral Health Task Force (HealthyBR)	Governmental/Non-profit	Yes
Behavioral Services of Louisiana	Outpatient Behavioral Health	
BHI Counseling (Black Family Initiative)	Outpatient Behavioral Health	

Name of Organization	Org Type/Service Area	Mentioned in the Interview
Blue Cross and Blue Shield of Louisiana Foundation	Funding/Philanthropic	Yes
Bridge Center for Hope	Hospital/Residential/Inpatient, Outpatient Behavioral Health	Yes
Capital Area Human Services, Baton Rouge Behavioral Health	(Quasi)Governmental	Yes
Capital Area United Way	Community Non-profit/CBO/Philanthropic	Yes
Catholic Charities Diocese of Baton Rouge	Faith-based non-profit	Yes
The Center for Mind Body Medicine	School-Based	Yes
Cognitive Development Center of Baton Rouge, LLC	Outpatient Behavioral Health	
Community Counseling Agency, LLC	Outpatient Behavioral Health	
Crescent Health	Outpatient Behavioral Health	
D & D Community Care, LLC	Outpatient Behavioral Health	
East Baton Rouge Parish Coroner's Office	Governmental	
East Baton Rouge Schools	School-Based	
The Emerge Center	Non-profit	Yes
Family Focus	Outpatient Behavioral Health	
Family Services of Greater Baton Rouge	Outpatient Behavioral Health	Yes
Forum 225	Professional	Yes
Front Yard Bikes	Community Non-profit/CBO	Yes
Gardere Initiative	Non-profit	Yes
Genesis Behavioral Health	Outpatient Behavioral Health, Hospital/Residential/Inpatient	
Grief Recovery Center	Outpatient Behavioral Health	Yes
The Grove Recovery Center	Hospital/Residential/Inpatient, Outpatient Behavioral Health	
Healthcare Centers in Schools	School-Based	
HealthyBR	Governmental	Yes
Heritage Ranch	Hospital/Residential/Inpatient	
Holistic Behavioral Health Services	Outpatient Behavioral Health	
The Hospice of Baton Rouge	Hospital/Residential/Inpatient	
Humana	Funding/Philanthropic	
Humanities Amped	School-Based	Yes
ICARE of East Baton Rouge Parish School System	School-Based	Yes
Independent Practitioner(s)	Outpatient	
Integrated Wellness Clinic (also Woodlake Addiction Recovery)	Outpatient Behavioral Health	
Jefferson Oaks Behavioral Health, Inc.	Outpatient Behavioral Health	
LDH Child Services	Governmental	

Name of Organization	Org Type/Service Area	Mentioned in the Interview
LDH Emergency Preparedness	Governmental	
LDH Office of Behavioral Health	Governmental	Yes
LDH Office of Public Heath	Governmental	Yes
Legacy Behavioral Health	Outpatient Behavioral Health	
Louisiana Behavioral Health Advisory Council	Governmental	
Louisiana Center for Health Equity	Non-profit/CBO	
Louisiana Department of Health (LDH)	Governmental	Yes
Louisiana Mental Health Advocacy Service	Governmental	Yes
Louisiana Mental Health Association	Outpatient Behavioral Health	Yes
LSU History Department	University	
LSU School of Social Work	School-Based	Yes
Mayor's Healthy Cities Initiative	Governmental/Non-profit	Yes
MetroHealth	Outpatient Behavioral Health	Yes
Metromorphosis	Case Management/Community or Faith-based	Yes
NAMI	Non-profit	Yes
National Alliance on Mental Health	Non-profit/CBO	Yes
Neighborhood Arts Program @ LSU Museum of Art	Art therapy and Counseling	
Oceans Behavioral Hospital of Baton Rouge	Hospital/Residential/Inpatient	
Ochsner Baton Rouge	Hospital/Residential/Inpatient	
One Rouge / The Walls Project	Community Non-profit/CBO	Yes
Our Lady of the Lake Children's Health Project	Hospital/Residential/Inpatient	
Our Lady of the Lake Psychiatry Residency Program	Outpatient Behavioral Health	Yes
Pennington Biomedical Research Center (Athletes and Mental Health)	Private	
Pennington Foundation	Philanthropic	Yes
Mary Bird Perkins Cancer Center Healing Arts Program	Art Therapy and Counseling	
PREACH	Faith-based Non-profit	Yes
ReCast Baton Rouge	Non-profit/CBO	Yes
Red Cross	Non-profit	Yes
The Red Shoes (Center for Personal and Spiritual Growth)	CBO/Non-profit	Yes
Regions Behavioral Hospital	Hospital/Residential/Inpatient	
RKM Primary Care	Outpatient Behavioral Health, School-Based	
Safe Hopeful Healthy Neighborhoods	Governmental	Yes
St. Christopher's Addiction Wellness Center Treatment Center	Outpatient Behavioral Health, Hospital/Residential/Inpatient	
Salvation Army	Non-profit	Yes

Name of Organization	Org Type/Service Area	Mentioned in the Interview
Seaside Health System	Hospital/Residential/Inpatient, Outpatient Behavioral Health	
Sexual Trauma Awareness and Response (STAR) Treatment Center	Outpatient Behavioral Health	Yes
Stitches 4 Life	Non-profit/CBO	
TAG (Trauma and Grief) Center - (Houston)	Outpatient Behavioral Health	
Thrive Academy	School-Based	
Together Baton Rouge	CBO/Non-profit	Yes
211 - United Way of Louisiana	Non-profit	Yes
232 HELP	Non-profit	Yes
Volunteers of America	Non-profit	Yes
When You're Ready	Non-profit	Yes
Huey and Angelina Wilson Foundation	Funding/Philanthropic	
Woodlake Addiction Recovery Center	Outpatient Behavioral Health	
YMCA/YWCA	Non-profit/CBO	Yes
Yoga & Expressive Art-making - Relaxation, Recharge	Art Therapy and Counseling	Yes
Yoga Noir Project	CBO/Wellness	Yes
You Are Not Alone	CBO/Non-profit	Yes
Youth Oasis	Case Management/Community or Faith-based	Yes

COLUMBIA CLIMATE SCHOOL
NATIONAL CENTER FOR DISASTER PREPAREDNESS

475 Riverside Drive, Suite 820
New York, NY 10115-0095
ncdp@columbia.edu | https://ncdp.columbia.edu