# Louisiana Commission on Addictive Disorders

Bobby Jindal
GOVERNOR



May 14, 2013

The Honorable Bobby Jindal
Governor of Louisiana
Office of the Governor
Post Office Box 94004
Baton Rouge, Louisiana 70804

The Honorable John A. Alario
President
Louisiana State Senate
Post Office Box 94183, State Capitol
Baton Rouge, Louisiana 70804-9183

The Honorable David R. Heitmeier
Chairman
Senate Committee on Health and Welfare
Post Office Box 94183
Baton Rouge, Louisiana 70804

The Honorable Charles E. Kleckley
Louisiana Speaker of the House
Post Office Box 44281
Baton Rouge, Louisiana 70804

The Honorable Scott M. Simon
House Committee on Health and Welfare
Post Office Box 44281
Baton Rouge, Louisiana 70804

Kathy H. Kliebert, Interim Secretary
Department of Health and Hospitals
Post Office Box 629
Baton Rouge, Louisiana 70804

RE: 2012 ANNUAL REPORT – Louisiana Commission on Addictive Disorders

Dear Sirs and Madam:

The Louisiana Commission on Addictive Disorders is required by Act 899 of the 1984 Regular Session of the Legislature to provide an annual written report to the Governor, the chairpersons of the House and Senate Health and Welfare Committees, and the Secretary of the Department of Health and Hospitals.

Attached please find the 2012 Governor's Annual Report from the Louisiana Commission on Addictive Disorders.

If you would like further information, please contact me.

Sincerely,

Freddie G. Landry

Freddie G. Landry, Chair
Louisiana Commission on Addictive Disorders
(504) 236-0508

Attachment

c Rochelle Head-Dunham, M.D.
Medical Director and Chief of Adult Operations

P.O. Box 4049, Bin 18
Baton Rouge, Louisiana 70821

# Louisiana Commission on Addictive Disorders

## *Annual Report*

*A report on the activities of the Louisiana Commission on Addictive Disorders and related initiatives of the Office of Behavioral Health.*

**2012**

DEPARTMENT OF HEALTH
AND HOSPITALS
Behavioral Health

# I. About the Commission

## *A Message from the Chairperson*

*Dear Legislators and Stakeholders,*

The purpose of the Louisiana Commission on Addictive Disorders is to assess, evaluate, and recommend programs and/or services provided on a regional/district level; to represent the community needs related to addictive disorders legislatively; and to act as advocates for addictive disorders services and the clients who need them. Each year the Commission submits an Annual Report outlining the state of addictive disorders services and needs throughout the State of Louisiana. The ensuing report outlines the activities of the Commission along with valuable insights into how addictive disorders impacts many areas of government and the burden untreated addiction places on the state's budget.

During 2010, the Office for Addictive Disorders and the Office of Mental Health merged to create the Office of Behavioral Health within the Department of Health and Hospitals. The Commission's leadership continues to be active in this process, ensuring that the state's addiction treatment infrastructure remains viable and effective and the clients who need these services continue to receive the best treatment possible within the constraints of looming budget cuts.

The 2012 Annual Report delineates the many programs provided along the Office of Behavioral Health's continuum of care: from universal prevention efforts, to inpatient and outpatient treatment, to recovery support services. The addiction staff within the Office of Behavioral Health continues to work diligently to meet the needs of an ever-present waiting list for services, despite the challenges presented by a tough financial climate. With the creation of the Louisiana Behavioral Health Partnership and the contract with Magellan of Louisiana to serve as the State Management Organization, the Commission is thankful for the in-depth inclusion of addiction treatment through these Medicaid funded services.

One of the major challenges faced by the field of addictive disorders is the need for workforce development. Following Hurricane Katrina, many licensed and certified addiction professionals left the state and the workforce necessary for treating addiction in Louisiana was reduced substantially. The need to provide educational opportunities to train new and efficient addiction counselors is of paramount importance. Compounding this need is the prospect of expanding treatment opportunities and supports for those challenged by co-occurring addiction and mental health issues. It is critical – now, more than ever before – that local institutions of higher learning assist in building a qualified and competent workforce to meet these needs, through specialized recruitment and by offering the curricula necessary to prepare future clinicians to enter the field.

The Louisiana Commission on Addictive Disorders is committed to helping meet the challenges of the future and to serving as advocates for the recovery of those suffering from the ravages of addiction. If we can be of assistance in any way, please do not hesitate to call on us.

*Warmest regards,*

Freddie G. Landry, M.Ed., LPP
*Chair, Commission on Addictive Disorders*

## History and Role of the Commission

Act 899 of the 1984 Regular Session of the Louisiana Legislature created the Louisiana Commission on Addictive Disorders[5]. The same Act created the state agency known as the Office for Addictive Disorders[5]. During the 2009 Regular Session of the Louisiana Legislature, Act 384 merged the Office for Addictive Disorders with the Office of Mental Health to create a single Office of Behavioral Health (OBH)[5]. The new OBH is responsible for serving the needs of Louisiana citizens challenged by mental health issues, addictive disorders, and co-occurring disorders[5].

The statutory duties and responsibilities of the Commission are as follows:

1) To advise the Office of Behavioral Health "concerning the policy of the State with respect to addictive disorders;"[5]
2) To "recommend an annual State Plan…to the [Office of Behavioral Health]…setting forth proposed policy, program planning initiatives and goals relative to the prevention and treatment of addictive disorders;"[5]
3) To submit an annual report to the Governor, the Joint Health and Welfare Committee of the Louisiana Legislature, and the Secretary of the Department of Health and Hospitals as to the activities of the Commission and the Office of Behavioral Health for the previous calendar year, as well as recommendations concerning future program initiatives;[5] and
4) To "serve as liaison among all State and local government entities concerning addictive disorders"[5]

## Commission Activities – 2012

The Commission on Addictive Disorders is a viable, active committee, meeting regularly, with activities that have included assisting and supporting the Office of Behavioral Health with the following initiatives:

- The Commission met 11 times during the 2012 calendar year. The Commission met every month except for the month of September 2012. All of the meetings except one were held at OBH Headquarters in Baton Rouge. February 2012 meeting was held at the Florida Parish Human Service Authority (FPHSA) in Mandeville.
- Commission members participated in the Public Forums held by the Office of Behavioral Health in 2012. These forums are held annually in the regions/districts around the state as a requirement of the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funding. These Public Forums represent valuable opportunities to obtain input and feedback from consumers, stakeholders, and the public regarding prevention and treatment needs, as well as to demonstrate the accountability of the Office. Interested state legislators also participated in these forums.

## Representation

The Commission is comprised of thirteen individuals: the Assistant Secretary of the Office of Behavioral Health, who serves as the Commission's Executive Director in an *ex officio* capacity; ten regular members, who represent the regions and districts of the state; and two "at-large" members. All members are appointed by the Governor and confirmed by the Senate. Currently, the Commission only has eight regular members (not counting the Assistant Secretary) and one "at-large" member, leaving gaps in representation for FPHSA, Region VI, and Region VII. Assistance is requested from the Office of Boards and Commissions, Division of Administration, in filling the vacancies identified below as well as replacing those Commissioners who have been inactive. The Commission's membership is detailed on the map below.

**REGION VIII**
Damon Marsala
P.O. Box 104
Monroe, LA 71201
(318) 323-8871, Ext. 108

**REGION VIII**
Jon Lance Nickelson
1416 Spencer Avenue
Monroe, LA 71201
(318) 325-3251

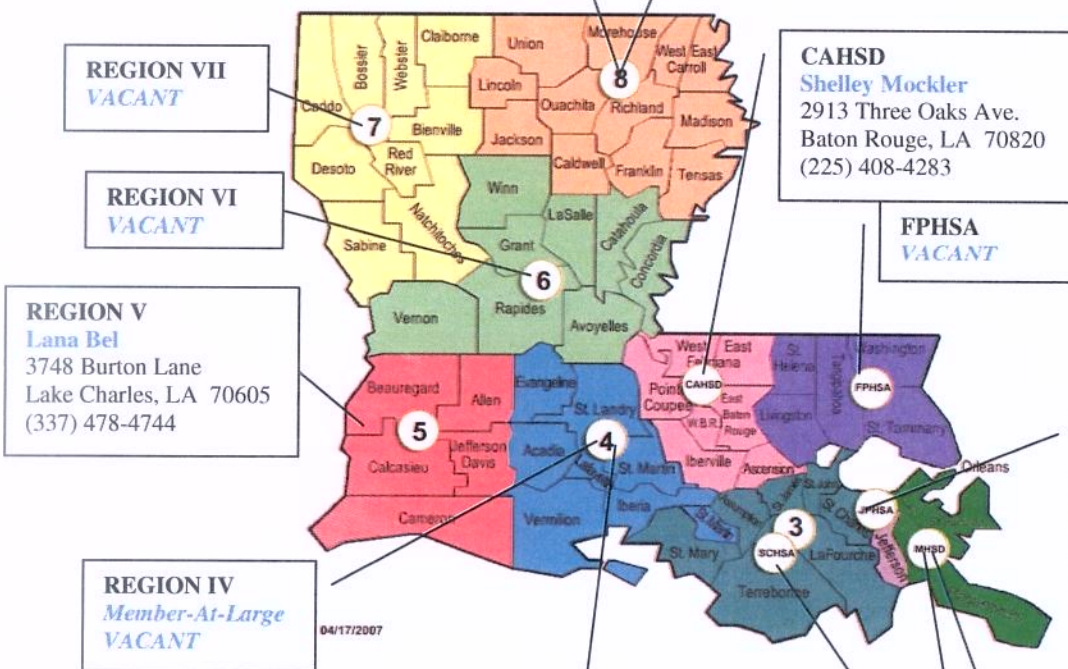
**REGION VII**
*VACANT*

**CAHSD**
Shelley Mockler
2913 Three Oaks Ave.
Baton Rouge, LA 70820
(225) 408-4283

**REGION VI**
*VACANT*

**FPHSA**
*VACANT*

**REGION V**
Lana Bel
3748 Burton Lane
Lake Charles, LA 70605
(337) 478-4744




**JPHSA**
Freddie Landry
*Chair*
3504 Taft Park
Metairie, LA 70002
(504) 454-3880

**REGION IV**
*Member-At-Large*
*VACANT*

**MHSD**
Thomas P. Lief
1521 Hillary St.
New Orleans, LA 70118
(504) 861-4756

**REGION IV**
Lloyd Hernandez
204 S. William Dr.
Lafayette, LA 70506
(337) 989-0278

**SCLHSA**
Kathleen Leary
212 Lake Crescent Circle
Houma, LA 70360
(985) 868-4826

**MHSD**
Anthony Wickramasekera
*Member-At-Large*
6609 Schouest Street
Metairie, LA 70003
(504) 887-0429

Members of the Commission also serve on other boards and committees, including:

- Behavioral Health Planning Advisory Council *(Freddie G. Landry, Kathleen Leary)*
- The Drug Policy Board (*Freddie G. Landry*)
- Prevention System's Committee of Drug Policy Board (Freddie Landry)
- Greater New Orleans Drug Demand Reduction Coalition *(Freddie G. Landry, Thomas P. Lief, Anthony Wickramasekera)*
- OBH Kitchen Cabinet *(Freddie G. Landry)*
- New Orleans Behavioral Health Coordination Committee *(Freddie G. Landry, Thomas P. Lief, Anthony Wickramasekera)*
- The Prevention System Committee (*Freddie G. Landry*)
- Board of Directors for the Louisiana Association on Compulsive Gambling (*Kathleen Leary)*
- Community Service Center Board of Directors (Thomas P. Lief)
- Jefferson Parish Community Health Care Center Board of Directors *(Freddie G. Landry)*
- Board of Directors for the Jefferson Performing Arts Society *(Freddie G. Landry)*

# II. The State of Addiction

## National Trends

During 2010, the Center for Behavioral Health Statistics and Quality (formerly the Office of Applied Studies) published several reports based on national data that indicate a number of specific areas of concern with regard to addiction's impact on society. One of these concerns was the impact of addiction on hospital emergency department services. A second major area of interest in the reports was trends related to underage drinking and drug use. Other studies point to the relationship between addiction, crime, and recidivism.

***Emergency Department Services.*** Emergency department services are one of the most utilized and expensive categories of health care in the nation. In many cases, hospital emergency departments serve as a point of entry for people seeking substance abuse detoxification or treatment services due to the involvement of alcohol or illicit drugs in an accident, overdose, or suicide attempt[3]. According to the Drug Abuse Warning Network there were 5.1 million visits to emergency departments nation-wide in 2011 involving people seeking treatment services for drug misuse, abuse, adverse reaction, or accidental [3].

***Underage Drinking and Drug Use.*** During 2011, adolescents and young adults (20 or younger) visited the emergency departments at a rate of 134.6 per 100,000 population for alcohol (alcohol only). Of the 134.6 visits per 100,000 population, 81.3 visits per 100,000 population included alcohol and other drugs (21 and under). Additionally, 2011 showed that 458.3 per 100,000 population (all ages) emergency department visits involved misuse or abuse of pharmaceuticals. That accounts for a 114 percent increase from the year of 2004 when the rate was 214 per 100,000 population. The most common pharmaceutical drugs used by these patients were those used to treat anxiety or insomnia, followed by narcotic pain relievers and antidepressants. Emergency department visits involving synthetic cannabinoids rose from a rate under the reportable level in 2009, to 3.7 per 100,000 in 2010, to 9.2 visits per 100,000 population in 2011. Most alarming is that ages 18 to 20 visited the emergency department at a rate of 60.8 visits per 100,000 population involving synthetic cannabinoids followed by a 30.2 visits per 100,000 population for ages 12-17. The table below shows the distressing rates emergency department visits involving illicit drugs[3].

**Figure 2 Table. Rates of Emergency Department (ED) Visits Involving Illicit Drugs among Patients Aged 12 to 24 per 100,000 Population, by Age Group: 2011**

| Illicit Drugs | Persons Aged 12 to 17 | Persons Aged 18 to 20 | Persons Aged 21 to 24 |
|---|---|---|---|
| Marijuana* | 240.2 | 443.8 | 446.9 |
| Heroin** | 8.5 | 134.6 | 266.1 |
| Cocaine** | 23.5 | 112.5 | 214.4 |
| Illicit Stimulants** | 23.5 | 89.8 | 141.5 |
| Synthetic Cannabinoids** | 30.2 | 60.8 | 16.3 |

*** The differences between those aged 12 to 17 and the two older age groups were statistically significant at the .05 level.**
****All differences between age groups were statistically significant at the .05 level.**
**Source: 2011 SAMHSA Drug Abuse Warning Network (DAWN).**

***Crime and Recidivism.*** An expansive body of research documents the relationship between addiction and crime[1]. Many of those involved with the criminal justice system have known involvement with alcohol and drugs[1]. In addition, a large percentage of persons currently incarcerated or otherwise involved with the criminal justice system (including adolescents) have an addiction or history of addiction, a mental health issue, or both[10]. Many of these individuals do not receive effective treatment for their particular situation[1]. This has several negative effects on society and its financial stability: emergency room visits, property damages, and costs associated with prosecution and incarceration can all be attributed to a combination of substance abuse and criminal activity[1].

Taken together, the above consequences of untreated addiction (and others) exert a heavy financial toll on a state's budget[6]. Specific information on this topic is provided in the section titled "Impact on State Budget."

## Louisiana Trends

***People Served.*** According to data derived from the Louisiana Addictive Disorders Data System (LADDS), the Office of Behavioral Health provided treatment services to 21,925 people during Fiscal Year 2012[9]. Of these people served, 16,321 (74%) had only one treatment episode; the remaining 5,604 (26%) patients had two or more separate treatment episodes[9]. Of those admitted to treatment during FY 2012, approximately 34% were African American, 64% were Caucasian, and the remaining 2% were composed of Native Americans, Asians, and others[9]. The gender breakdown of people served reveals that 34% were female and 66% were male[9].

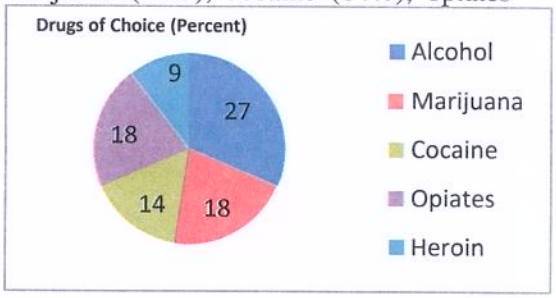
| **People Served (LADDS):** | | 21,925 |
|---|---|---|
| Ethnicity: | African American: | 34% |
| | Caucasian: | 64% |
| | Native American, Asian, Other: | 2% |
| Gender: | Male: | 66% |
| | Female: | 34% |
| **Source: LADDS** | | |

The Access To Recovery (ATR) project provided treatment services to 2,979 people during FY 2012. In addition to treatment services, the Office of Behavioral Health served 77,078 people with direct, individual-based prevention services and an additional 206,965 people with population-based prevention services during FY 2012. Together, the total number of people served by the Office of Behavioral Health during FY 2012 is 306,761 as demonstrated by the table below.

| Prevention | | Treatment | | Total |
|---|---|---|---|---|
| Enrollees | 77,078 | LADDS | 21,925 | |
| Participants | 206,965 | *ATR Merged | 2,979 | |
| *Prevention Subtotal:* | 284,043 | *Treatment Subtotal:* | 24,904 | 308,947 |

***ATR I and II have merged all services into one system as of August 8, 2011.**

***Drugs of Choice.*** According to the LADDS data described above, the drugs of choice in Louisiana for FY 2012 were (in order of frequency): alcohol (27%), marijuana (18%), cocaine (14%), opiates (18%), and heroin (9%) [9]. This trend is comparable to those represented by national data on the same topic.




Taken together, the frequency of alcohol and marijuana (commonly used in combination[3]) represent a majority of the drugs of choice. However, this evidence – in comparison with data from previous years – reveals that the non-medical use and abuse of opiates continues to rise, as does the use of heroin[3, 9]

***Treatment Outcomes.*** The Office of Behavioral Health collects, tracks, and analyzes data that describes the National Outcome Measures (NOMS) outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA). In addition, the ATR project collects data required by the Government Performance and Results Act (GPRA). Though the GPRA outcome measures are similar to the NOMS, a notable difference is the fact that ATR data reflects lower figures in the "stable living arrangements" category, since the GPRA definition of this outcome does not include dependent living situations, only those considered independent. The NOMS, listed in the table on the next page, include:

- Abstinence from drug and alcohol use;
- Gaining or maintaining either employment or education;
- Reduction in crime or criminal justice involvement;
- Stable living arrangements;
- Social connectedness;
- Access to services and capacity for providing services;
- Retention of patients in treatment;
- The patients' perception of care;
- The cost-effectiveness of care provided; and
- The use of evidence-based practices.

The table below describes what are considered to be critical or priority patient outcomes for the Office of Behavioral Health during SFY 2012.

**Note:** ATR I and II have merged all services into one system as of August 8, 2011. This project continues to be funded with State General Funds.

| Outcome Measure | | LADDS[1] | | | ATR Merged | | | National Outcome Measures (NOMS) |
|---|---|---|---|---|---|---|---|---|
| | | Admit | Discharge | +/- | Admit | Discharge | +/- | •Abstinence from Drug/Alcohol Use<br>•Employment/ Education<br>•Crime & Criminal Justice Involvement<br>•Stability in Housing<br>•Social Connectedness<br>•Access/Capacity<br>•Retention<br>•Perception of Care<br>•Cost Effectiveness<br>•Use of Evidence-Based Practices |
| Arrest Rate | | 10% | 3% | -7% | 7% | 2% | -5% | |
| Abstinence | | 22% | 82% | +60 | 28% | 87% | +59% | |
| Stable Living Arrangement[2] | | 92% | 94% | +2% | 49% | 71% | +22% | |
| Gained or Maintained Employment / Education | | 18% | 25% | +7% | 34% | 56% | +22% | |
| Average Length of Stay | Inpatient | 29 Days | | | 76 Days | | | |
| | Outpatient | 99 Days | | | | | | |

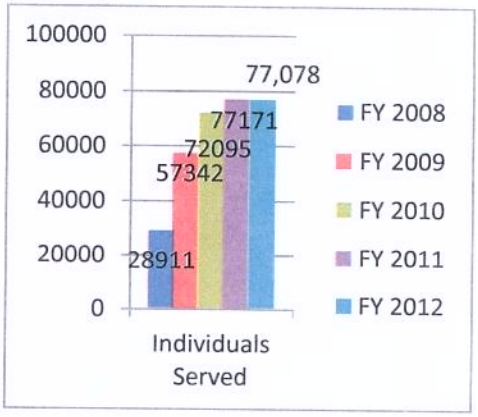
**Source: LADDS, ATR**

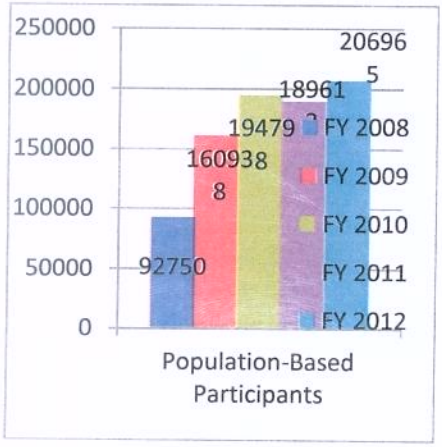
[1]Analyses do not include those who failed to come to treatment after admission or those who dropped out in the first week of treatment.
[2]ATR reflects lower figures in "Stable Living Arrangement" category due to difference between NOMS and GPRA definitions. GPRA (ATR) definition of Stable Living Arrangement does not include *dependent* living situations, only *independent*.

As indicated by this table, OBH saw improvement in each of these categories. The first category, which describes the arrest rate of patients seen during SFY 2012, shows a reduction in arrest rate from admission to discharge for each group of patients admitted to treatment (LADDS, ATR Merged). A significant improvement is also evident in each of these categories for promoting abstinence from drug and alcohol use. In addition, stable living arrangements and employment/education increased in each group of patients (please see footnote 2 regarding decrease in stable living arrangement in ATR).

***Adolescent Outcomes.*** In addition to the people served listed above, OBH provided services to 1,660 adolescent patients[9]. This population had a reduction in the arrest rate of 22% (28% at admission to 6% at discharge), a 57% increase in abstinence (28% at admission to 85% at discharge), and a 59% reduction in drug use (or maintained abstinence) from admission to discharge[9]. Of this treatment population, clinicians judged that 78% made some or significant progress[9].

***Prevention Outcomes.*** Prevention reduces high-risk behaviors associated with alcohol, tobacco, and other drug use by providing evidence-based individual and population-based services and programs. The success of prevention programs is measured by examining the number of individuals enrolled in evidence-based programs, the number of participants positively impacted by one-time prevention services, and the perceived risk/harm of substance abuse as reported by individuals surveyed in schools and other community-based programs. During 2012, 77,078 individuals were enrolled in ongoing prevention programs and services, and 206,965 people were positively impacted by one-time population-based services. In total, 284,043 people were served in prevention programs and services during FY 2011. In addition, the perceived risk/harm of substance abuse increased during FY 2012, indicating that prevention efforts are having a positive impact on Louisiana youths' perception of the risks and harms associated with substance abuse.




Prevention services, in addition to the obvious benefits of delaying the age of initiation of substance use and reducing high-risk behaviors that lead to addictive disorders, are also very cost-effective. Since FY 2008, OBH Prevention has ***increased evidence-based prevention services by 163% without additional funding***. This increase has been the result of a cooperative partnership with the Department of Education, the mobilization of services, and the implementation of cost bands. Prevention services, due to their goals and outcomes, produce a very high return on investment, since they help prevent a younger and significant portion of the population from needing treatment.

## Surveys and Studies

***Caring Communities.*** *Youth Survey (CCYS).* OAD co-sponsored with the Louisiana Department of Education, the 2010 Caring Communities Youth Survey (CCYS). The CCYS has been conducted biennially since 1998 among students in grades 6, 8, 10, and 12. The 2010 survey was very successful, with a total of 113,414 participating students. Of all participants, data from 105,814 students were accepted for analysis. The students participating were from 709 schools in 67 LEAs in grades 6, 8, 10 and 12. 62 parishes participated. Results of the survey are outlined in State Regional and Parish reports. School level reports are available only to the superintendents of each parish. The State, Regional and Parish reports are posted on the OBH website for review and use by the general public as follows: http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1790. The CCYS was conducted at the end of 2012 with the results being available in mid-2013.

***Higher Education Core Survey.*** The Office for Addictive Disorders provided funding for a Core Survey conducted by Louisiana Institutions of Higher Education Coalition to Reduce Alcohol, Tobacco and Other Drugs (LaHEC) in Spring 2011. Thirty-five institutions of higher education participated in this

survey, which produced a sample size of almost 10,000 students. The State and Regional reports are posted at http://uiswcmsweb.prod.lsu.edu/edco/lacasu/CoreAlcoholandDrugSurvey/CoreData/item30083.html.

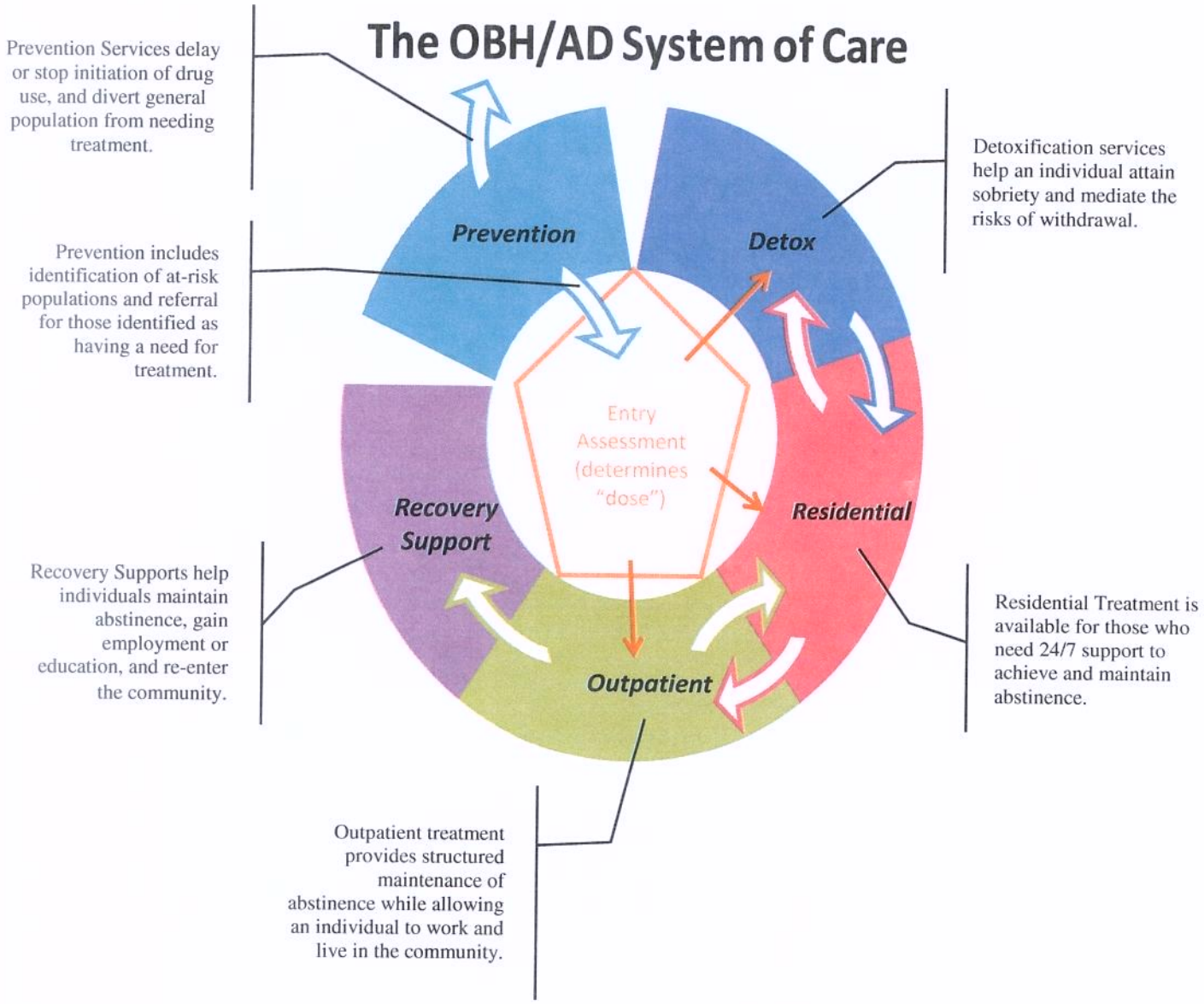
***Problem Gambling Study.*** The 2008 *Louisiana Study on Problem Gambling* measures four areas, divided by region: (1) problem and pathological gambling rates, (2) gaming establishments and video gambling devices per capita rates, (3) calls to the Louisiana Problem Gamblers Helpline, and (4) youth gambling data collected from the *Louisiana Caring Communities Youth Survey*.

The data revealed that 1.7 percent of gamblers in the state are problem gamblers (at-risk for addiction), and 1.4 percent are pathological gamblers (or compulsive gamblers). This represents an estimated 54,360 problem gamblers and 44,767 pathological gamblers statewide. Youth data indicates that almost 50 percent of Louisiana students (6th, 8th, 10th and 12th grades) have engaged in some form of gambling, most of them in the previous year. The numbers were highest in the New Orleans and Houma/Thibodaux areas. Calls to the toll-free problem gambling helpline increased from 2002 to 2007. In the 2006-2007 fiscal years, the Helpline received 53,127 calls. Of the intake calls received in 2007, females represented 53% of the callers and males represented 45%. Most callers identified themselves as either Caucasian (51%) or African American (37%). The study also revealed that the number of gambling sites in the state has decreased since 2002, from 2,890 locations to 2,372. However, the number of gambling devices has increased during this time from 37,864 machines in 2002 to 44,504 machines in 2008. The findings of this study remain consistent with current rates. Over the past few years, though the total number of calls has declined, the percentage of direct calls for assistance has been increasing. During Fiscal Year 2011-2012, the Helpline answered 27,291 calls. Of these, 1,485 (5.4%) were calls for direct assistance with a gambling problem.

# III. The OBH System of Care for Addiction

## How the Continuum Works

The OBH Continuum of Care is comprised of five basic segments, or categories of care: prevention, detoxification, residential treatment, outpatient treatment, and recovery support. These five categories represent a logical progression of services for the addiction population. American Society of Addiction Medicine (ASAM) Patient Placement Criteria is utilized in the determination of the appropriate level of care. Although prevention is not typically included in a continuum of care model, it is a vital first step in reducing the incidence and prevalence of addictive disorders, and is therefore included in this description of our service delivery system.




## Prevention Services

OBH prevention services are provided according to two basic categories: individual services, and population-based services. Individual services and programs are administered to enrollees, typically in an educational setting on an ongoing basis. Population-based services are provided to multiple people at once, typically in a one-time event setting such as a health fair. The primary goals of prevention are to delay or prevent initiation to substance abuse, reduce high-risk behaviors that lead to addictive disorders, and divert the state's younger population from entering the treatment system. However, prevention providers are also trained to identify individuals at risk for substance abuse and refer them to necessary services; following this, a determination is made as to whether or not additional services will be necessary to prevent the onset of substance abuse.

OBH Prevention has worked closely with the DOE to identify gaps in prevention services and has been successful in increasing services by utilizing DOE's infrastructure. By bringing prevention services into school classrooms, OBH Prevention has been able to decrease significantly the necessary personnel, operational, transportation, and capitol asset costs, making these resources available for direct services. It is important to note that increases in services were accomplished utilizing existing SAPT Block Grant funds: no additional monies were received.

***Strategic Prevention Framework State Incentive Grant.*** OBH and the Governor's Office of Safe and Drug Free Schools and Communities worked in partnership to apply for the grant. Louisiana was awarded $11.75 million to implement the SPF State Incentive Grant (SPF-SIG), "The Governor's Initiative to Build a Healthy Louisiana." The Strategic Prevention Framework (SPF) is a data-driven, outcome-based planning process intended to achieve sustainable reductions in the abuse of alcohol, tobacco, and other drugs among targeted populations through evidence-based prevention. The purpose of the SPF is to develop a system that coordinates planning, funding, and evaluation for substance abuse prevention. Through the work of the State Epidemiological Workgroup, twelve (12) parishes were identified as having the highest alcohol-related motor vehicle crashes and violent crime rates. These 12 parishes were offered funding to develop coalitions to address alcohol-related problems in their respective parish with the target population of 12-29 year olds. Of the original twelve (12), ten (10) parishes chose to participate. The 10 parishes are as follows: Cameron, Calcasieu, Jefferson Davis, Lafayette, Orleans, St. James, St. Mary, St. Landry, Tangipahoa, and West Baton Rouge. This grant expired on September 30, 2011. A goal of the SPF-SIG is to identify alternate sources of funding for prevention services and promote the sustainability of the system at the local/community level. SPF-SIG Project Staff did submit a proposal for a competitive grant to continue the work of the SPF-SIG, but were not selected for the grant award. Still, there is concern as to the continuation of the groundwork which has been established.

***State Prevention Enhancement Grant.*** In September 2011, OBH was awarded $600,000 to implement the State Prevention Enhancement (SPE) Grant. The SPE Grant is a one-year grant intended to strengthen and extend SAMHSA's national implementation of the Strategic Prevention Framework (SPF), in an effort to bring the SPF to scale and support communities of high need nationwide. The SPE Program is designed to support States and Tribes in enhancing their infrastructures to reduce the impact of substance abuse. Through stronger, more strategically aligned substance abuse infrastructures, SPE States and Tribes will be better positioned to apply the SPF process to implement data-driven, evidence-based prevention programs, policies and practices in their communities.

***Synar Compliance.*** OAD has funded a community contractor since 1997 in each of the state's ten regions. Each provides retailer education to 400 tobacco merchants regarding the sale of tobacco products to minors through unconsummated compliance checks. . In addition, OAD continues its partnership with the Office of Alcohol and Tobacco Control (OATC) by contracting with OATC to conduct 2,400 random unannounced tobacco compliance checks. This contract ensures that tobacco compliance checks are being conducted statewide on an on-going basis allowing the state to remain in compliance with The Synar Amendment to the Public Health Service Act (PL 102-321).

The Synar Amendment requires that states must implement annual random, unannounced compliance inspections to determine their buy rates of tobacco products sold to youth under the age of 18. If that state's buy rate exceeds 20%, OAD would lose 40% of its Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds, which are used to provide treatment and prevention services. In SFY 2012, the non-compliance rate in Louisiana was 4.1%. This rate is one of the lowest in the nation.

The model that Louisiana has utilized is considered as a model program by the Center for Substance Abuse Prevention as it pairs community mobilization and enforcement efforts.

## Treatment Services

The state of Louisiana, Office of Behavioral Health, offers the American Society of Addiction Medicine (ASAM) continuum of care through state operated and contracted providers throughout the state.

American Society of Addiction Medicine (ASAM) Levels of Care

**Five Levels of Care Assessed Over Six Dimensions**

| | |
|---|---|
| Level 0.5 | Early Intervention |
| Level I | Outpatient Services |
| Level II | Intensive outpatient/partial hospitalization services |
| Level III | Residential/Inpatient services |
| Level IV | Medically managed intensive inpatient services |

1. Acute intoxication and/or withdrawal
2. Biomedical conditions and complications
3. Emotional, behavioral, or cognitive conditions and complications
4. Readiness to change
5. Relapse, continued use, or continued problem potential
6. Recovery environment

Through this strength-based multidimensional assessment the ASAM Patient Placement Criteria addresses the patient's needs, obstacles and liabilities, as well as the patient's strengths, assets, resources and support structures.

The State of Louisiana provides for several detoxification programs throughout the State. Three different levels of intensity are available for those seeking detoxification services.

## Detoxification Programs

***Level II-D Ambulatory detoxification with extended on-site monitoring.*** This level of care is an organized outpatient service, which may be delivered in an office setting, health care or addiction treatment facility by trained clinicians, who provide medically supervised evaluation, detoxification and referral services. The care is delivered in an office/health care setting or Behavioral Health treatment facility. Provides care to patients whose withdrawal signs and symptoms are of moderate intensity but are sufficiently stable enough physically and mentally to permit participation in outpatient treatment. Ambulatory detoxification is provided in conjunction with intensive outpatient treatment services (Level II.1).

***Level III.2D Clinically Managed Residential Detoxification.*** Residential programs provided in an organized, residential, non-medical setting delivered by an appropriately trained staff that provides safe, 24-hour medication monitoring, observation and support in a supervised environment for a person served, to achieve initial recovery from the effects of alcohol and/or other drugs. Provides care to patients whose withdrawal signs and symptoms are non-severe but require 24-hour inpatient care to address biomedical and recovery environment conditions/complications.

***Level III.7D Medically Monitored Residential Detoxification–Adult.*** Medically monitored residential detoxification is an organized service delivered by medical and nursing professionals, which provide for 24-hour medically supervised evaluation under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care.

| *Programs* | *Number of Programs* | *Number of Beds* |
|---|---|---|
| Clinically Managed Residential Detoxification | 3 | 28 |
| Medically Monitored Residential Detoxification | 5 | 46 |

## Residential Programs

The Office of Behavioral Health (OBH) funds residential programs in every Region/LGE of the state. OBH also funds one residential program for compulsive gambling treatment that provides services for the entire state. Following the completion of primary inpatient treatment, residential programs provide community-based care and treatment. Individuals are provided with transitional arrangements, support, counseling, room and board, social and recreational activities, and vocational opportunities in a moderately structured, substance-free environment. Community based residential treatment focus on re-socialization and encourages individuals to resume independent living and functioning in the community.

The residential level of care provides services for those individuals who need relatively intense treatment in a structured environment. There are four subcategories of intensity within this level of care:, clinically managed low-intensity (Level III.1), clinically managed medium-intensity (Level III.3), clinically managed high-intensity (Level III.5) and medically-monitored intensive residential (Level III.7) . Services provided in these levels of care are dependent on the severity of the individual's disorder, and are available twenty-four hours a day, seven days a week.

***Level III.1 Clinically Managed Low-Intensity Residential Treatment – Adult.*** Residential programs offer at least five hours per week of a combination of low-intensity clinical and recovery-focused services. Treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual into the worlds of work, education and family life. Services provided may include individual, group and family therapy, medication management and medication education. Mutual/self-help meetings usually are available on site. Does not include sober houses, boarding houses or group homes where treatment services are not provided.

***Level III.3 Clinically Managed Medium Intensity Residential Treatment – Adult.*** Residential programs offer at least 20 hours per week of a combination of medium-intensity clinical and recovery-focused services. Frequently referred to as extended or long-term care, Level III.3 programs provide a structured recovery environment in combination with medium-intensity clinical services to support recovery from substance-related disorders.

***Level III.5 Clinically Managed High Intensity Residential Treatment – Adult.*** This level of care is designed to treat persons who have significant social and psychological problems. Programs are characterized by their reliance on the treatment community as a therapeutic agent. Treatment goals are to promote abstinence from substance use and antisocial behavior and to effect a global change in participants' lifestyles, attitudes and values. Individuals typically have multiple deficits, which may

include substance-related disorders, criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values. Example: therapeutic community or residential treatment center.

***Level III.7 Medically Monitored Intensive Residential Treatment – Adult.*** This COD residential treatment facility provides 24 hours of structured treatment activities per week including, but not limited to, psychiatric and substance use assessments, diagnosis treatment, habilitative and rehabilitation services to individuals with co-occurring psychiatric and substance disorders (ICOPSD), whose disorders are of sufficient severity to require a residential level of care. It also provides a planned regiment of 24-hour professionally directed evaluation, observation and medical monitoring of addiction and mental health treatment in a residential setting. They feature permanent facilities, including residential beds, and function under a defined set of policies, procedures and clinical protocols. Appropriate for patients whose subacute biomedical and emotional, behavior or cognitive problems are so severe that they require co-occurring capable or enhanced residential treatment, but who do not need the full resources of an acute care general hospital. In addition to meeting integrated service criteria, COD treatment providers must have experience and preferably licensure and/or certification in both addictive disorders and mental health.

| *Programs* | *Number of Programs* | *Number of Beds* |
|---|---|---|
| Adult | 25 | 600 |
| Adolescent | 3 | 48 |
| Women and Dependent Children | 2 | 88 |

Beginning March 1, 2012, these programs are now under the Louisiana Behavioral Health Partnership and will provide services through Magellan Health of Louisiana.

## Compulsive and Problem Gambling Programs

The Office of Behavioral Health contracts with providers to offer compulsive and problem gambling prevention and treatment services to Louisiana citizens. The goal of this program is to raise public awareness of, prevent, and treat problem gambling. The OBH Problem Gambling Services program provides for a 24/7 helpline, a variety of awareness and prevention services, and a full array of treatment services statewide. During FY 2011, a total of 787 people were served by this program. Of those individuals, more than 80% successfully completed the program. Outpatient compulsive gambling treatment services consistently receive very positive feedback. During Fiscal Year 2012, a total of 533 people received direct gambling treatment services by this program. Of those individuals, more than 60% reported successfully decreasing their frequency of gambling. These services consistently receive very positive feedback.

Services are delivered by local behavioral health clinics or through contracts with local social service agencies and/or behavioral health professionals. These services are provided free of charge to Louisiana citizens, utilizing funds from the Compulsive and Problem Gaming Fund. The total amount of funding provided by the Compulsive and Problem Gaming Fund is $2.5 million, which covers the entire cost associated with the program. According to the National Council of Problem Gambling, the national social costs of problem gambling in 2010 totaled $7 billion. Research suggests, however, that for every $1 invested in problem gambling services, a savings in social costs of $2 is realized.

## Outpatient Programs

***Level I: Outpatient.*** Outpatient services are professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized non-residential treatment setting. Outpatient services are organized activities which may be delivered in any appropriate community setting that meets State licensure. These services include, but are not limited to, individual, group, family counseling and psycho-education on recovery and wellness. These programs offer comprehensive, coordinated and defined services that may vary in level of intensity but are fewer than nine contact hours or less per week.

***Level II.1: Intensive Outpatient Treatment.*** Intensive outpatient treatment is professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized non-residential treatment setting. Intensive outpatient services are organized activities which may be delivered in any appropriate community setting that meets State licensure. These services include, but are not limited to individual, group, family counseling and psycho-education on recovery, as well as monitoring of drug use, medication management, medical and psychiatric examinations, crisis intervention coverage and orientation to community-based support groups. Intensive outpatient program services should include evidence-informed practices, such as cognitive behavioral therapy (CBT), motivational interviewing and multidimensional family therapy. These programs offer comprehensive, coordinated and defined services that may vary in level of intensity but must be a minimum of nine contact hours per week for adults, age 21 years and older, (six hours per week for adolescents, age 0 – 21years) at a minimum of three (3) days per week. This level consists of a scheduled series of face-to-face sessions appropriate to the individual's plan of care.

## Access To Recovery (ATR) Programs

ATR I and II have merged all services into one system as of August 8, 2011. This project continues to be funded with State General Funds.

The Office of Behavioral Health continues to operate the Access to Recovery initiatives, which began in 2004 and 2007, respectively, as federal grants from the Substance Abuse Mental Health Services Administration (SAMHSA). These initiatives continue to be funded using State General Funds due to the success of the project and have been merged into one system.

The enrollment of faith-based and community based providers, ensuring freedom of choice for clients, and providing recovery support services have been key components of the success of this project. A listing of clinical treatment and recovery support services available through the ATR program is provided below:

- Clinical Treatment Services:
  - Outpatient
  - Intensive Outpatient
  - Long-Term Residential Treatment
  - Short-Term Inpatient Treatment
  - Detoxification Services

The Louisiana Behavioral Health Partnership (LBHP) was implemented on March 1, 2012. Effective March 1st many services currently provided or managed by OBH have now been authorized and

administered by Magellan Health Services of Louisiana. ATR providers were advised to continue to operate "as is" for the immediate future. OBH will begin discussions with providers regarding how LBHP may impact ATR. Providers were told to begin preparation for the LBHP implementation by enrolling with Magellan as providers for the clinical treatment services they are licensed to provide. The provider enrollment process requires being certified by OBH and credentialed by Magellan to become an approved provider agency for the LBHP.

All ATR providers have completed the certification process with OBH and most have been credentialed with Magellan. Providers that are fully credentialed are able to accept Medicaid eligible clients for treatment and be reimbursed by Magellan.

### Recovery Support Programs

Recovery Support Services (RSS) are ancillary services that help an individual achieve and maintain recovery from substance abuse. These services may include transportation to and from outpatient services, job skills training, and education. Typically, a variety of recovery supports is helpful in achieving sustained recovery. Many recovery support services are provided through the voucher-based Access To Recovery (ATR) program.

A listing of recovery support services available through the ATR program is provided below:

- Recovery Support Services:
  - Transportation
  - Housing
  - Childcare
  - Life Skills
  - Anger Management
  - Job Readiness
  - Spiritual Support Groups/Pastoral Counseling

## IV. Partnerships

**The Louisiana Behavioral Health Partnership (LBHP)** is the partnership between the Louisiana Department of Health and Hospitals - Office of Behavioral Health, the Department of Child and Family Services, the Office of Juvenile Justice, the Department of Education and Magellan Health Services, Inc.

- The LBHP offers expanded services and care for:
  - Eligible adults with a serious mental illness or addiction.
  - Children with a serious emotional disorder or emotional behavioral disorder.
  - Coordinated care, including wraparound services for children and youth with significant behavioral problems.
- Through Magellan Health Services, consumers will be provided 24-hour access to care for themselves and their families, seven days a week.

- Magellan will work closely with behavioral health care providers to ensure consumers are more involved in decisions about their own care.

To be eligible for referrals and reimbursement for covered services rendered to eligible members, each provider must sign a Magellan provider participation contract agreeing to comply with Magellan's policies, procedures, and guidelines.

Providers are contracted as individual practitioners, groups or organizations:

- **Individual Practitioners:** To be a network provider, individual providers must be both *credentialed* and *contracted* by Magellan. Individuals must be enrolled in Medicaid.
- **Group Providers:** Magellan *contracts* directly with the group entity. The group must be contracted with Magellan AND the practitioners within the group must be individually credentialed by Magellan in order to be referral eligible.
- **Organizations:** To be a network provider, organizations must hold an active license through DHH and be credentialed by Magellan. Organizations must also be enrolled in Medicaid. Practitioners within an organization are not individually credentialed, only the organization itself.

As of January 31, 2013, the total number of individuals that have been served by the LBHP is 116,846; 49,911 children, 58,704 adults and 8,231 others. These numbers can be broken down into type of illness (mental health, substance abuse, or co-occurring) as follows:

**Overall Persons Served**

| Overall Person's Served by LBHP (3/1/12-1/31/13) | | | | |
|---|---|---|---|---|
| **Count of Persons** | **Children** | **Adults** | **Other** | **Total** |
| Mental Health | 47,167 | 47,961 | 5,487 | 100,615 |
| Substance Abuse | 1,297 | 8,279 | 2,095 | 11,671 |
| Co-occurring | 71 | 1,538 | 546 | 2,155 |
| Missing | 1,376 | 926 | 103 | 2,405 |
| Total | 49,911 | 58,704 | 8,231 | 116,846 |

**Note: Counts are claims-based service utilization values and represent all persons served by the LBHP (including persons served by the Office of Behavioral Health). Other- represents members for whom services were authorized but no claims were submitted (non-Medicaid OBH members).**

Under the Louisiana Behavioral Health Partnership, addiction services include an array of individual-centered outpatient, intensive outpatient and residential services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance abuse symptoms and behaviors.

Services for adolescents must be:

1. Separate from adult services,
2. Developmentally appropriate,
3. Involve the family or caregiver, and
4. Coordinated with other systems (such as child welfare, juvenile justice and the schools).

These services are designed to help individuals achieve changes in their substance abuse behaviors. Services should address an individual's major lifestyle, attitudinal and behavioral problems that have the potential to be barriers to the goals of treatment. Outpatient services may be indicated as an initial modality of service for an individual whose severity of illness warrants this level of treatment or when an individual's progress warrants a less intensive modality of service than they are currently receiving. Intensive outpatient treatment is provided any time during the day or week and provides essential skill restoration and counseling services for individuals needing more intensive treatment. Outpatient, intensive outpatient and residential services are delivered on an individual or group basis in a wide variety of settings, including treatment in residential settings of 16 beds or less, designed to help individuals achieve changes in their substance abuse behaviors.

These rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid-eligible individuals with significant functional impairments resulting from an identified addiction diagnosis. Services are subject to prior approval, must be medically necessary and must be recommended by a LMHP or physician who is acting within the scope of his/her professional licensed and applicable State law to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level according to an individualized treatment plan.

Services are provided by licensed and unlicensed professional staff who meets the provider qualifications listed in the LBHP Service Definitions Manual. Anyone who is unlicensed providing addiction services must be registered with the Addictive Disorders Regulatory Authority and demonstrate competency as defined by the Department of Health and Hospitals, state law (ACT 803 of the Regular Legislative Session 2004) and regulations. State regulations require supervision of unlicensed professionals by a Qualified Professional Supervisor (QPS).

The Office of Behavioral Health maintains a dynamic, responsive, and comprehensive system of care for those challenged by mental health and addiction issues. With regard to addiction, that system encompasses a "continuum of care" that begins with prevention and ends with recovery supports for sustained abstinence and re-entry into the community.

## Strategic Partnerships

***Counselor Education, Licensing & Certification Boards.*** The Commission maintains a collaborative partnership with both the Louisiana Association of Substance Abuse Counselors & Trainers, Inc. (LASACT), Certification Examining Board (CEB), and the Addictive Disorders Regulatory Authority (ADRA) in the interest of providing a more unified voice in the advocacy for addiction treatment. ADRA's mission is to ensure that the highest quality continuum of care is provided to citizens of Louisiana through the credentialing and regulation of addiction professionals; high standards of education are set by ADRA and required of professionals in the field of addiction treatment and prevention. In addition, LASACT is an Approved Educational Provider (AEP) through ADRA which provides workshops throughout the state year-round on topics such as substance abuse prevention and counseling, compulsive gambling counseling, professional ethics, and clinical supervision. They also sponsor an annual conference which provides continuing education opportunities by presenting in-state experts and nationally and internationally-renowned speakers. A thorough application and testing process are implemented by ADRA and LASACT to ensure only the most qualified specialists in the field of addictions bare ADRA credentials.

***Judicial Drug Courts (JDC).*** The Drug Court program was transferred to the Supreme Court in 2001. The Office of Behavioral Health continues to collaborate with and support the efforts of drug court programs across the state. However, in Region 8, the behavioral health clinic in the 37th Judicial Drug Court (Caldwell Parish), has a contract to provide services for drug court clients.

***Department of Children~~en~~ and Family Services (DCFS).*** The Office for Behavioral Health continued a contract with the Department of Children and Family Services (DCFS), to address issues among Temporary Assistance for Needy Families (TANF) women and their dependent children. The services in this program provide addictive disorder treatment for women, including screening, assessment and referral services for women involved with the Child Welfare Section (CWS) and Economic Stability and Self Sufficiency (ES&SS) sections of DCFS, gender specific Intensive Outpatient Treatment services, and residential services for women and their dependent children. All individuals involved in this programming are referred by DCFS staff. This initiative is not funded with Block Grant monies. However, this program greatly impacts OBH's ability to provide services to pregnant women and women with dependent children. Despite mid-year reductions in SFY 2013, OBH maintained the women and dependent children's residential treatment program. This program supports 88 beds for seven (7) residential facilities for women, pregnant women, and women with dependent children through TANF funding. Six (6) of these facilities housed children on-site with their mothers and provided a drug free environment, thus preserving family unity and providing therapeutic services for the entire family. However, the screening, assessment and referral programs at child welfare sites and Families in Need of Temporary Assistance (FITAP) sites, located in each of the ten Regions/LGEs throughout the state were abolished during SFY 2013. This service was absorbed by the DCFS site program staff through re-implementation of screening the TANF population by utilization of the DAST 20 instrument. In addition, two (2) TANF women's gender specific intensive outpatient treatment programs were abolished due to this reduction. This program will be absorbed by the Office of Behavioral Health. OBH continued collaborations with DCFS on the above-listed programs through continued monitoring and implementation of best practices for continued quality outcomes. This process includes quarterly on-site monitoring of all programs, teleconferences with staff, and monthly review of invoices and outcomes which is submitted along with an on-line report. Further, OBH and DCFS staff participates in quarterly teleconferences to address obstacles and barriers to implementation, while developing and/or revising protocols as indicated.

***Department of Education (DOE).*** The Office for Addictive Disorders has partnered with the Department of Education (DOE), since 1998, to conduct the bi-annual Louisiana Caring Communities Youth Survey (CCYS). The CCYS is the primary youth needs assessment tool for state, regional, and community prevention planning. In addition, OAD and DOE have partnered to share resources to include funding, staffing and infrastructure to provide school-based prevention programs. This partnership has reduced OAD's infrastructure cost and allowed resources to be moved to direct services.

# V. Emergency Preparedness

The State of Louisiana is vulnerable to a variety of hazards that threaten its citizens, communities, businesses, economy, and environment. It is the responsibility of the Office of Behavioral Health (OBH) to develop and maintain readiness for behavioral health emergency response operations as part of the Department of Health and Hospitals Emergency Support Function (ESF-8) for Public Health and Medical Services within the State of Louisiana Emergency Operations Plan (EOP). In the provision of its mission and essential functions, OBH emergency plans are developed to ensure critical supports and services continue in an all-hazards environment. The following is a general overview of emergency preparedness operations for the Office of Behavioral Health.

- OBH is also the designated lead agency for the development and administration of FEMA and SAMHSA funded emergency crisis counseling programs following a Presidential Declaration of a Major Disaster Incident.
- OBH regional facilities and clinics are responsible for maintaining current emergency response plans which integrate response capacity with other state agencies and local emergency operations.
- In the event of a declared emergency or disaster, the OBH provides support to the Office of Public Health for the department's ESF-8 responsibilities following the National Incident Management Structure (NIMS).
- OBH responsibilities include provision of staff assistance to the Office of Public Health at the designated Medical Special Needs Shelters and to designate behavioral health staff (inclusive of the Office for Citizens with Developmental Disabilities) to staff EOC operations, bus triage, strike teams and other staging areas as assigned.
- Continuity of regular operations as needed for those individuals who are in need of immediate access to outpatient treatment and/or 24 hour care. Each OBH regional office or Local Governmental Entity (LGE) maintains regional protocols for access to emergency psychiatric services, including hospitalization during the preparation, response and recovery phases of the disaster incident.
- OBH is also responsible for the health and safety of patients and staff at the psychiatric and detox facilities, all of which are required to have an emergency response plan. These plans address actions for sheltering-in-place and evacuation of staff and psych patients to other host (destination) facilities.
    - During a declared disaster incident OBH makes available excess bed capacity for the temporary sheltering of patients and staff from other public and quasi-public psychiatric facilities within the state (signed Memorandums of Understanding (MOU) required).
    - OBH also serves as the lead state agency for the development, design and implementation of a brief stay medically supported special needs shelter for psychiatric patients through a cooperative endeavor or established contingency contract for emergency psychiatric beds and staff.
    - Stress management for first responders

## Disaster Readiness/Event Response for FY 12/13

***Readiness Activities.*** OBH conducted either directly or indirectly, four tabletops (behavioral health inpatient facilities, regions and central office) between April 2012 and August 2012. Behavioral Health first responders participated in the Bus Triage tabletop exercise in August 2012 and designated behavioral health staff participated in two functional exercises conducted by the Emergency Operations Center. Additional trainings included: two Psychological First Aid (PFA) trainings were held in Alexandria and Baton Rouge; one Skills for Psychological Recovery (SPR) training held in Slidell; and two suicide prevention trainings (ASIST) in Orleans and Houma for Isaac related responders and available regional staff in January. Disaster readiness briefings were also conducted with headquarters and behavioral health first responders. Stress management training and services were provided to Departments of Culture and Tourism, Children and Family Services, Emergency Medical Services, and the local governing entities in Jefferson, South Central, Metropolitan and Florida Parishes post Hurricane Isaac. In June 2012, OBH conducted a two-day training in New Orleans entitled, "Collaborative Efforts toward Understanding Disasters and Future Preparedness in the Gulf Coast: Knowledge Dissemination, Planning, and Readiness".

***Hurricane Isaac Response.*** In August 2012, OBH provided immediate support to survivors impacted by Hurricane Isaac using existing behavioral health resources. Members of the behavioral health first responder team and the local governing entities (LGEs) in the impacted regions were deployed to assist with the evacuation and sheltering of individuals pre- and post-landfall. OBH coordinated the provision of crisis support and psychological first aid for survivors evacuated to medical special needs shelters (MSNS) and critical transportation needs shelters (CTNS) across the state. Stress management and first responder teams were activated to deploy as needed to local and state emergency operations centers, parish pick-up and bus triage sites. In addition to sheltering-in-place patients and staff, the three inpatient psychiatric hospitals in the state also repositioned staff and resources to accommodate a surge of psychiatric patients from private hospitals and emergency departments who had evacuated from flooded areas. The total number sheltered in the state inpatient psychiatric hospitals was 835 patients and 435 staff. Behavioral health teams were deployed statewide to address behavioral health needs of more than 6,353 individuals evacuated to medical special needs and general shelters. The state also provided 24/7 phone support access to assist individuals in need of services and support throughout the duration of the storm.

***Louisiana Spirit Project***. The OBH and the LGEs identified 14 of the 24 parishes that were in need of services to respond to Hurricane-Isaac related need beyond what the system and existing resources could provide. OBH applied for and was awarded grant funds for Immediate Services Program (ISP) for the period from September 14, 2012 through February 24, 2013. OBH submitted a grant application for the second phase of the crisis counseling program (CCP) and was awarded funds for continued services under the Regular Services Program (RSP) covering the period from February 25, 2013 through November 24, 2013. It is anticipated that this grant project will serve approximately 49,986 survivors who would potentially benefit from CCP primary services. Currently, crisis services are being delivered in all 14 impacted parishes via the LGE structures of Metropolitan Human Services District, Florida Parishes Human Services Authority, Jefferson Parish Human Services Authority, and South Central Human Services Authority. OBH is providing ongoing oversight, monitoring, training and technical assistance to support the nine teams deployed by the LGEs.

The CCP data from the ISP reflect reports from CCP provider leadership and staff regarding the disaster experiences of persons in need of CCP services and served during the ISP. The most common risk factors reported by survivors seen during individual crisis counseling sessions include damaged homes, financial loss, displacement from home for at least one week, being forced to evacuate quickly with little time to prepare, suffering the loss of a vehicle or other personal property, and experiencing past trauma. At least one in five survivors (20% or more) experienced fatigue or exhaustion, feeling irritable or angry, feeling anxious or fearful, having feelings of despair or hopelessness, and feeling sad or tearful as a result of Hurricane Isaac. Other common reactions include being agitated/jittery/shaky and having difficulty making decisions.

As expected, a number of people (approximately one in four) seen during individual counseling sessions experienced past trauma, making them more vulnerable following Hurricane Isaac. The program served children of various ages and elderly survivors. Among survivors 65 years of age and older, the most common adverse reactions to the disaster include emotional reactions, such as feeling sad or tearful, despair, anxious or fearful, and irritable or angry. Other common reactions include feeling fatigued or exhausted; being agitated/jittery/shaky; and having difficulty concentrating, making decisions, and remembering things. For children and youth, emotional reactions were also most common, including feeling anxious or fearful (23% to 33% of each age group under 18), sad or tearful (15% to 23%), despair (15% to 21%), and irritable or angry (13% to 22%). Adolescents (ages 12 to 17) had a higher prevalence of physical reactions than other children, with 21% of adolescents reporting sleep difficulties and 15% reporting fatigue since the disaster.

The prevalence of risk factors and adverse reactions is in line with that which was expected given the nature of Hurricane Isaac and the damage it left in its wake. Survivors suffered in a number of ways, including damaged homes, financial loss, displacement from their home for at least one week, being forced to evacuate quickly with little time to prepare, suffering the loss of a vehicle or other personal property, and experiencing past trauma that left them more vulnerable to adverse reactions following Hurricane Isaac. As expected, adverse emotional reactions are problematic for survivors; particularly feelings of fatigue, irritability, anxiety and fear, despair and hopelessness for the potential to recover, and feeling sad or tearful. This high prevalence of adverse emotional reactions led to approximately one half of all survivors seen during individual counseling sessions being referred for additional CCP services. Survivors also report difficulty making decisions, or determining how to best proceed in their recovery process. This makes support from the CCP important, as staff can help survivors prioritize their needs and develop the best course of action to move forward in their recovery from Hurricane Isaac.

The State issued a press release announcing the availability of crisis counseling services through the Louisiana Spirit Program in the 14 targeted parishes. PSAs were developed and distributed in each area with details regarding 24/7 provider contact information, available services, and the toll free State crisis line for access to services and referrals. Teams distributed packets of educational materials related to the services offered by the Louisiana Spirit program, information about self-care, how to recognize signs of stress, local resources to address physical and behavioral health needs, and state and national helplines for disaster related emotional support. The State's website was also updated to include contact information for individuals in need of crisis counseling services available through the Louisiana Spirit Program.

# VI. Major Challenges and Triumphs of 2012

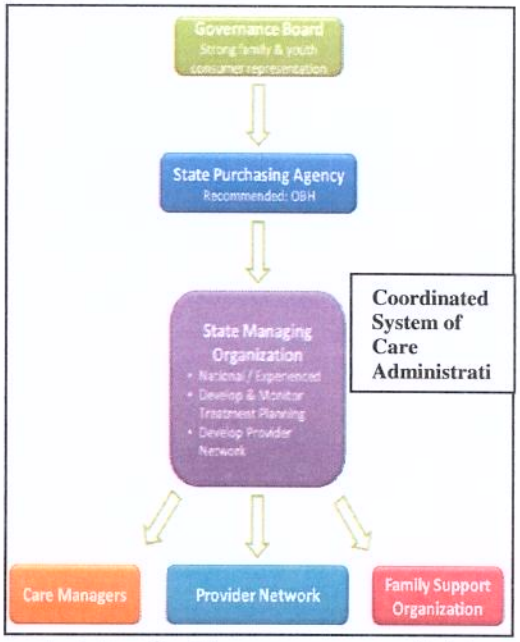
The Office of Behavioral Health faced a number of difficult challenges during **2012**, but also realized some significant triumphs. Some of those issues or situations constantly challenge the Office since they arise from growth, change, and progress. Others presented new obstacles that stretched the resources of the agency or offered opportunities for expansion and efficiency. Regardless of its origin or nature, each of the following situations is a measure of and tribute to the strength, resolve, and continuing dedication of "those we serve, and those who serve them.

## Behavioral Health Merger

***Re-organization.*** When the merger of the Office of Mental Health and the Office for Addictive Disorders took effect on July 1, 2010, the agency's administration – following the recommendations made in the OBH Implementation Advisory Committee's (IAC) Report – evaluated the appropriateness of its organization structure. Per the recommendations outlined in the IAC report, the administration began the process of re-organizing the Office into a more suitable and effective structure. This re-organization was driven by five key considerations:

1) The needs of consumers versus available resources;
2) Improving efficiency while maintaining effectiveness;
3) The role of the Office of Behavioral Health (OBH) in monitoring and supporting the functions of the Local Governing Entities (LGE);
4) The implications of the OBH merger and a more unified service delivery system; and
5) The role of OBH in a Coordinated System of Care.

***Regional Integration.*** Prior to the regional integration, OBH directly operated behavioral services in five (5) regions of the state, with mental health and addictive disorders regional administrative offices and clinics being located in each region. 2011 the integration of these regional offices and clinics was completed without a reduction in service delivery. The integration included combining prevention, access to services, treatment, and community supports that allow individuals to function successfully in the community. Integration processes included:




1) The clarification and establishment of performance standards and outcome measures;
2) The expansion of a single point of entry process;
3) Establishing, through DHH rule-making, revised behavioral health licensing standards; and
4) Aligning business operations and workforce development strategies in a manner consistent with maximizing funding resources available at the local, state, and federal level.

***Transitioning to Fill New Roles.*** During the 2006 legislative session, the Department of Health and Hospitals put forward legislation that would convert all remaining Regions to Human Services Districts (Act 90). The transition process began immediately and continues through the present. The legislation outlines that there is to be a Human Services Interagency Council (HSIC) that will be comprised of the Assistant Secretary from each office, the Executive Directors of the Human Services Districts, and the Deputy Secretary of the Department of Health and Hospitals. The HSIC met several times with the goal of formulating a framework document that outlines the expectations of existing and new Districts. The framework document was promulgated and follows Act 337, which outlines the roles and responsibilities of the Districts and DHH.

Shifting away from the role of direct service delivery, the Office of Behavioral Health investigated the reorganization of its central office. This effort will be finalized during early 2011. The result of the investigation led administration to organize the agency in a manner reflective of its responsibilities. The agency's new organizational structure includes a System of Care Division that includes all personnel involved in the delivery and monitoring of services; a Development Division that includes policy and planning, workforce development, business intelligence, emergency preparedness, and quality management; and an Administration Division that includes executive management and fiscal operations.

The Coordinated System of Care, a new initiative in the State of Louisiana, represents a cooperative partnership across four state agencies: the Department of Health and Hospitals, the Department of Education, the Department of Children and Family Services, and the Office of Juvenile Justice. This new service delivery system is intended to provide more efficient and effective services for those treatment populations who typically receive services from more than one segment of the state system. Specifically, this initiative began as a way to provide "wrap-around" services for youth who are identified as being at-risk for institutionalization or are currently in an institution. As the system was developed, opportunities were discovered to extend services to adults as well as adolescents. The implementation of this new cooperative service delivery system is projected to save Louisiana approximately $59M.

The Coordinated System of Care model has four basic levels of administration. The top level is a Governance Board that has strong family and youth consumer representation, making the system consumer-driven. The second tier of administration is a State Purchasing Agency. Under the State Purchasing Agency is a State Managing Organization responsible for overseeing the fourth tier (care managers, the provider network, and a family support organization).

As the State Purchasing Agency in this Coordinated System of Care, the Office of Behavioral Health will bear responsibility for coordinating with the other agencies involved, the Governance Board, and the State Managing Organization to develop policy; determining performance-based funding options; and monitoring services for fiscal and quality management.

## Maximizing Available Resources

During 2009, the State of Louisiana announced that it was facing serious budget shortfalls and would need to identify efficiencies within state government. Combined with large cuts at the federal level, the puzzle of continuing funding for prevention and treatment of addictive disorders in Louisiana grew into a large endeavor. The primary challenge for the Office of Behavioral Health lies in identifying and implementing even more evidence-based practices and efficiencies to improve the quantity and quality of services while simultaneously streamlining its administrative functions and service delivery system.

***Update on Louisiana Behavioral Health Partnership (LBHP) and the Statewide Management Organization (SMO).*** On March 1, 2012, the Office of Behavioral Health (OBH) implemented the LBHP. The LPHP is the managed care system for both Medicaid and non-Medicaid eligible adults and children who require specialized behavioral health services. The LBHP is managed by Magellan Health Services of Louisiana, the company selected through a Request for Proposals (RFP) process. The LBHP includes collaboration between various community-based stakeholders and state agencies, including OBH, Medicaid, the Office of Juvenile Justice (OJJ), the Department of Children and Family Services (DCFS), and the Department of Education (DOE).

The LBHP is designed to serve the needs of individuals who comprise one of the following populations of focus:

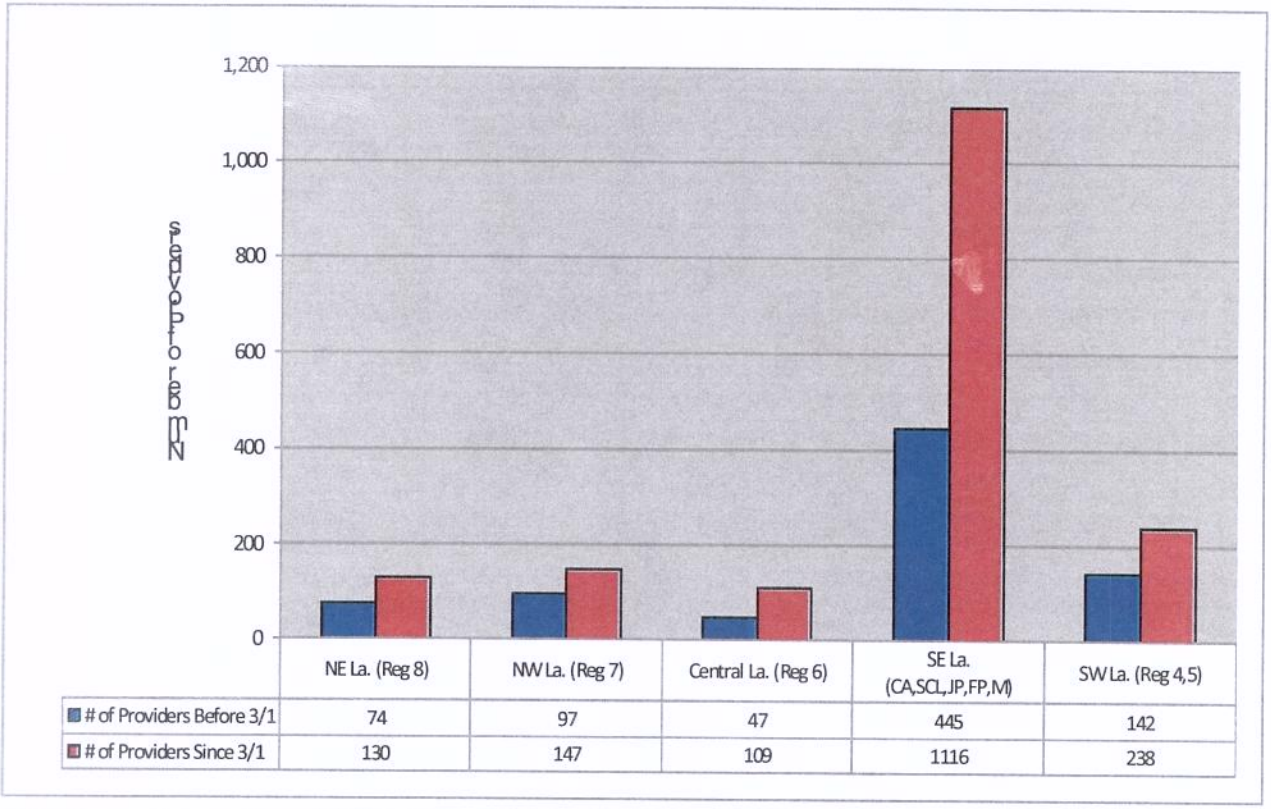
- Children with extensive behavioral health needs either in or at-risk of out of home placement;
- Medicaid-eligible children with medically necessary behavioral health needs;
- Adults with severe mental illness and/or addictive disorders who are Medicaid eligible; and
- Non-Medicaid children and adults who have severe mental illness and/or addictive disorders

The Office of Behavioral Health oversees the Behavioral Health Statewide Management Organization (SMO), Magellan Health Services of Louisiana. Magellan manages behavioral health services for both Medicaid and non-Medicaid eligible populations including those Medicaid eligible children who will need coordination of services provided by the multiple partner agencies of the LBHP.

There are 1.2 million people eligible for services under the LBHP. As Magellan members, these individuals have 24-hour/7-day a week telephonic access to professional clinicians. Magellan helps members identify services and assists them in accessing network providers.

Year one objectives were: Contracting with and credential a stable, comprehensive statewide network; implementing an efficient claims system that pays providers accurately and on time; beginning to build out the crisis system and expand the network to include alternatives to inpatient care; developing consensus, establish baseline measures and begin provider profiling.

***Greater Access.*** Under the new managed care system the number of providers, as well as the levels of care and provider types, has increased significantly. The LBHP provider network now includes a wider array of community-based, residential and inpatient treatment options to increase choice and benefits to members. The chart on the right shows the before implementation (blue bars) and after implementation (red bars) numbers of providers by general geographic region of the state (Northeast LA, Northwest LA, Central LA, Southeast LA, and Southwest LA). In all areas of the state the number of providers has increased. In addition, the graphic below compares the Adult Bed capacity before and after implementation of the LBHP. This bed capacity includes all public and private institutions currently enrolled in the LBHP. The change represents an 86% increase in adult bed capacity and was due to contracts with free standing psychiatric units.




*Data Source: 1. Annual Report\POST_LA Medicaid - Par 761 by Region WORK 3 v02 values shared*

Services for children, youth and families have been enhanced as evidenced by:

- Increased access to a more comprehensive array of both services and providers. New provider and service types previously unavailable may now be accessed with the goal of supporting youth and families in communities. Access to care has been simplified, anyone seeking behavioral health treatment – a parent, school staff member, pediatrician, child-serving state agency personnel – can call one number 24/7 and assure a child's behavioral health issues are appropriately assessed and proper services are put in place.
- The first two licensed Psychiatric Residential Treatment Facilities (PRTF) (108 beds) are now in place with dialogues continuing with several hospitals about expansion of their service array to include PRTFs.
- The state has licensed eight Therapeutic Group Home beds. A therapeutic group home is a community-based 24-hour living setting that provides care under the supervision of a psychiatrist or psychologist. There are ongoing conversations to encourage programs to obtain licensure for this service.
- There are currently 248 Therapeutic Foster Care beds. Therapeutic Foster Care are foster families who have received specialized training to more effectively provide care for children who have emotional/behavioral problems or serious medical conditions.
- There are currently 230 non-medical group home beds which serve as a safe placement option for children/youth where services from community-based providers can be offered

- Two hundred fifty one (251) provider locations have been contracted for Crisis Intervention services
- One hundred eighty three (183) new Other Masters Level Professional Therapists have entered the provider network since 3/1`

As part of the Coordinated System of Care (CSoC), there are five new specialized services that are available to enrolled children and their families. These include two types of peer support, Parent Support and Training and Youth Support and Training which are skill development services offered by parents, family members and young people who have faced and successfully managed their own behavioral health challenges. In addition, families can access Short Term Respite Care designed to help meet the needs of the caregiver and the child by offering a break to reduce stressful situations in the home. Independent Living and Skills Building is available to teach older youth important life skills for the transition to adulthood. Crisis Stabilization is offered as an alternative to hospitalization and provides intensive out of home services and resources for the youth and his or her family on a short-term basis, thereby reducing the need for longer term more costly out of home placements.

With the centralized access and authorization offered under the Partnership, OBH is poised to more actively monitor service utilization and outcomes. Data from the SMO is routinely reviewed through an established quality monitoring process that allows OBH to engage in continuous quality improvement activities that position us to adapt our approaches and assure our ability to best meet the needs of the children and youth population.

## Quality Management Oversight and Monitoring

***Performance Guarantees.*** Updates are sent monthly indicating the status of ten performance indicators. There are an additional three indicators that are submitted on an annual basis only. Reports detailing out these indicators are also submitted. The figure below gives the performance guarantee measures through 2012.

**MAGELLAN LA CMC PERFORMANCE GUARANTEES**

| PERFORMANCE MEASURE | 1Q 2012* | 2Q 2012 | 3Q 2012 | 4Q 2012 | Milestone Met?/Goal |
|---|---|---|---|---|---|
| Financial Payment Accuracy | 100.00% | 99.28% | 99.67% | 99.53% | Yes/97% |
| Claims Procedural Accuracy | 100.00% | 99.31% | 99.40% | 99.25% | Yes/98% |
| Turn-around Time (TAT) 30 Days | 95.00% | 99.93% | 99.95% | 99.88% | Yes/95% |
| Turn-around Time (TAT) 45 Days | 99.00% | 100.00% | 99.99% | 99.96% | Yes/99% |
| Call Abandonment Rate Member Services | 1.62% | 0.56% | 1.36% | 2.04% | Yes/<5% |
| Average Speed of Answer Member Services | 11 | 3 | 6.7 | 11 | Yes/30 seconds |
| Ambulatory Follow-up 7 days | 32.6% | 31.7% | 28.4% | 29.33% | Baseline TBD ** |
| Ambulatory Follow-up 30 days | 54.9% | 54.7% | 40.2% | 42.67% | Baseline TBD ** |
| Readmission Rate to Inpatient | 19.0% | 17.3% | 12.5% | 14.33% | Baseline TBD ** |
| Adult high Service users enrolled in ACT or PSR | TBD | TBD | 10.5% | 13.27% | Baseline TBD ** |
| Annual Member Satisfaction | TBD | TBD | TBD | TBD | Baseline TBD ** |
| Annual Provider Satisfaction | TBD | TBD | TBD | 74.40% | Baseline TBD ** |
| Completion of Annual Plan Milestones | TBD | TBD | TBD | TBD | Baseline TBD ** |

* First Quarter based on March data only

** Baseline TBD: Establish baseline for year 1 and reset measure as a % change from year 1

*Data Source: Executive IMT Folder\Reports-Data\Magellan-OBH Report Packages\2013.01 Report - Performance Guarantees Report*

***Quality Assurance, Performance Improvement Projects, and Utilization Control.*** The Office of Behavioral Health (OBH) and Louisiana Medicaid have taken great strides to ensure that the Louisiana Behavioral Health Partnership and its associated Medicaid Waiver Authorities promote and protect the well-being of residents while containing costs and expanding access to services. Managed Care Organizations and Prepaid Inpatient Health Plans must have an ongoing quality assessment and performance improvement program for the services it furnished to its enrollees (per 42 CFR 438.20(a). In order to ensure compliance with these federal regulations, the Intradepartmental Monitoring Team receives the following reports from Magellan Health Services:

**CSoC Reporting Package:**

- Member attributes (e.g., level of care, demographic information)
- Louisiana Adverse Incident and Quality of Care reports
- Therapeutic foster home availability
- Non-medical group home availability

**Clinical Reporting:**

- Ambulatory follow up within 7 and 30 days of discharge from 24-hour facility
- Readmission rates
- High service utilizers enrolled in Assertive Community Treatment

**Other Reports:**

- Claims administration
- Telephone responsiveness
- Annual member satisfaction
- Account management
- Grievance and Appeals
- Network Services Reporting

**OBH State-funded Services Reporting:**

- Number of youth receiving services
- Number of active youth receiving services in prior 180 days
- Number of youth receiving services within prior 90 days
- Average number of outpatient services per unique youth
- Total number of youth in inpatient and/or Psychiatric Residential Treatment Facility (PRTF) level of care in a month
- Average length of stay (ALOS) inpatient
- Number of physician emergency certificates and coroner's emergency certificates (PEC/CEC) per month
- Total number of diagnostic or assessment services rendered to youth per month
- Average number of assessment services per youth served per month
- Total number of crisis services rendered to youth per month
- Total number of prescriber services rendered to youth per month
- Average number of prescriber services per youth
- Total and average number of CPST and PSR services rendered to youth
- Average and total number of CSoC services rendered to youth
- Total projected cost per youth per month

Claims data and Clinical Advisor Metrics are reported by Magellan to OBH on a regular basis, and include detailed data on the number of recipients with services, billable progress notes, claims entered, claims paid, each reported on a weekly and cumulative basis. Such reports are broken out by Medicaid claims paid, by provider type, by local governmental entities (LGE), Regions, etc.

By design, Magellan sends these reports to the OBH Contract Monitor, who then redistributes them to OBH Monitoring Team Leads, who review these, and prepare to represent concerns for any required corrective action to OBH Leadership and/or the Executive, Youth or Adult Interdepartmental Monitoring Teams (IMT's), which meet at least monthly. OBH IMT's are now in the process of developing comprehensive report listing, matrices and standard report requirements for all Performance Measures related to the 1915(b) and 1915(c) waivers, as well as the 1915(i) State Plan Amendment, including related reporting on the Quality Management Strategy, which includes additional Medicaid and CSOC-related Performance Measures and Performance Improvement Projects. State Standards, baselines, methods of review, and performance thresholds are being developed for each of these items.

**Key areas to address in the second year of implementation:**

- Refinement of the data systems used by Magellan to improve billing, claims and clinical outcomes data collection and tracking, in addition to federal block grant data reporting requirements;
- Enhancement and standardization of data collection efforts across all of Magellan systems;
- Compare baseline data collected on key performance measures in year one to identify areas needing improvement;
- Reducing the processing time of non-clean claims; A non-clean claim is a claim that has some type of defect, impropriety or special circumstance, including incomplete documentation that delays timely payment.
- Completion of two external reviews of the SMO.
- Fully leverage management of Permanent Supportive Housing to help members reach Recovery goals
- Fully implement early childhood programs
- Expand crisis network
- Expand children's network (PRTF; therapeutic group homes)
- Outreach to non-traditional referral sources, such as primary care provider community and law enforcement
- Improve coordination of care between BAYOU Health plans, behavioral health providers, and primary care
- Seek certification of electronic health record
- Drive change in discharge planning
- Drive change in crisis response away from emergency departments and physician emergency certificates to better use of community programs

The LBHP is committed to examining all of the strengths and needs of this complex re-design for behavioral health treatment. Key data is being collected and analyzed in order to correct issues, where necessary. The ultimate and most critical goal is to improve the lives of children, youth and adults who experience behavioral health challenges.

***Structure and Location.*** One opportunity to answer this specific challenge presented itself through the merger of mental health and addictive disorders at both a central office and regional level. The central office began efforts in 2010 to identify and re-organize key personnel into a more suitable and efficient structure. The regional offices for OBH followed the same process, with the added task of determining opportunities for co-location of services. Essentially, this means that where two separate facilities – one

for mental health services, and one for addictive disorders – were in relatively close proximity to one another, they could merge into a single facility (as described above) that would offer both types of services.

## Other OBH Initiatives

***Performance Improvement Initiatives.*** In most recent years, the Office of Behavioral Health has worked with the Network for the Improvement of Addiction Treatment (NIATX) to improve the quality of patient care by addressing patient initiation, engagement, and retention in treatment. Implementation of this model has continued as the Office of Behavioral Health transitions into a managed care system. Regional Administrators and Local Governing Entities (LGE) were provided with technical assistance to guide planning and implementation of their recent NIATX projects. Each Region/LGE was asked to develop rapid change cycles that would target business practices to support transformation of their organizational structures that would increase efficiencies, enhance quality of care and transition from the traditional cost reimbursement approach to a fee for service method. Providers are currently collecting and analyzing pre and post test data to determine which strategies or business practices should be abandoned, adopted or adapted. The outcomes of these projects can be used by other agencies in the state system to improve the use of financial resources and the quality of patient care.

***Workforce Development Initiatives.*** The implementation of the Louisiana Behavioral Health Partnership this past year has brought with it, new challenges for assuring the competency of the behavioral health workforce. While maintaining focus on required ORM, Supervisory, CPTP, and other trainings, the Office of Behavioral Health workforce unit was also tasked with the responsibility of developing and implementing a certification process for all behavioral health providers statewide under the LBHP. Certification standards were developed, a process implemented and this unit, consisting of three staff, certified over 1,000 providers in approximately 3 months. The workforce development unit continues to work with providers to assure compliance with standards, address issues of compliance, and refine the standards and process to ensure that we not only have certified providers, but we have verified compliance via attestations, site visits, documentation audits, etc. We are working closely with the Statewide Management Organization to assure that there is consistency between our certification records and the credentialing and contracting records issued to providers, essentially closing the documentation loop to assure enrollment of qualified providers. As we conclude the first year of implementation for the LBHP, the OBH Workforce development unit will begin to focus on re-certification and the addition of site visits, documentation audits, and assisting the SMO in the provider network assessment and expansion efforts.

The Office of Behavioral Health continues to offer the Learning Management System method of training delivery for courses related to treatment for all OBH staff. This platform documented over 20,000 hrs of training last year at a very reasonable cost. This method of training minimizes lost time due to pre-scheduled trainings, travel, and allows users to increase their productivity in providing services. The Office also continues to make use of electronic seminars called "webinars," where personnel can attend a "live" training directly from their computer terminal. Thus eliminating the need for travel while providing a high degree of interactivity and presenter functionality (such as the ability to build and present a customized slideshow while speaking to and interacting with the participants). In addition, webinars can be recorded for later viewing by those whose daily work schedules prevent them from attending at a set time.

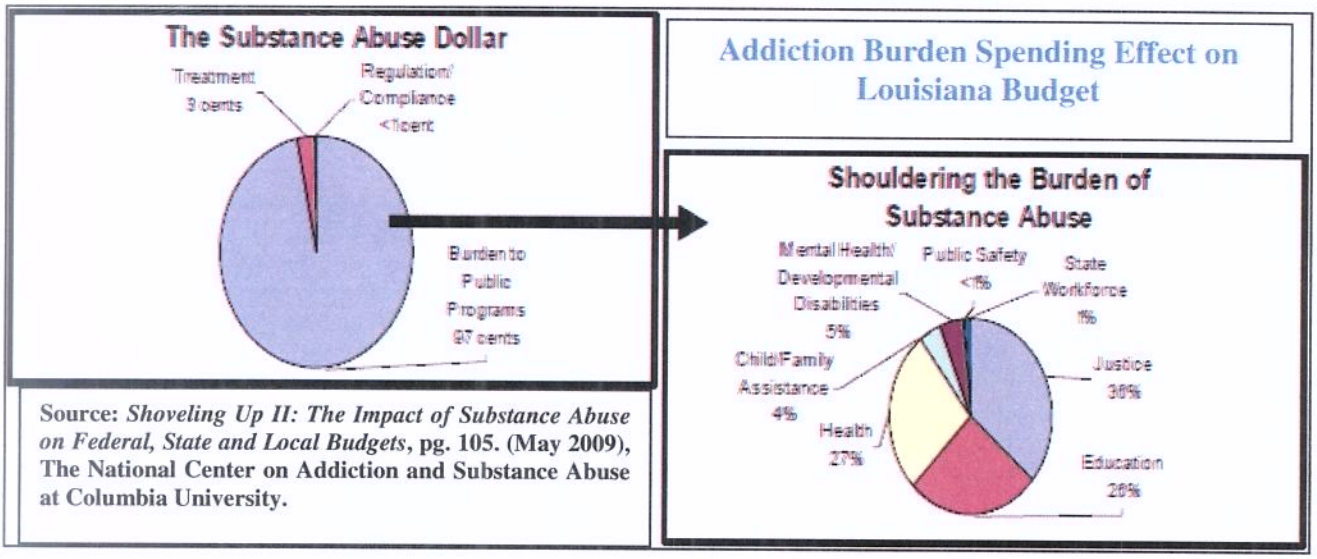
"Live" training will continue as an important method of delivering content to staff with a renewed focus on how decisions are made and what resources should be allocated to this intensive level of staff development. We can expand the "reach" of our live training by using video conferencing equipment, more interactive learning and overcoming limitations of physical space for training.

It is still the case that traditional means of training staff (such as face-to-face training sessions) are less cost-effective and newer technologies and practices allow for more efficient, more effective means of achieving OBH training goals. OBH continues to investigate how best to assure transfer of learning, when utilizing the technology of online training.

## Preservation of Critical Infrastructure

***Prevention Services.*** As the only "front line" for deterring the onset of substance abuse, reducing high-risk behaviors that lead to addictive disorders, and diverting the state's youth population from entering the treatment system, prevention services are a significant and critical portion of the Office of Behavioral Health's service delivery infrastructure. Since Substance Abuse Prevention and Treatment (SAPT) Block Grant monies (20%) are the sole source of funding for all prevention services, any reduction in this funding stream is likely to impact negatively the prevention service delivery capabilities of OBH, thereby creating a services gap where at-risk youth may not be identified. Such a gap would limit the ability of the office to identify and mitigate high-risk behaviors and increase the youth population's initiation to drug and alcohol use, creating a larger burden on the state's treatment system. It is recommended that careful consideration be given to the preservation of funding for prevention services and the critical infrastructure they represent.

***Treatment Services.*** Untreated addiction affects every area of the State of Louisiana's budget[6]. The state pays for the consequences of untreated addictive disorders in increased rates of high school dropouts, incarceration, child welfare costs, highway fatalities, and lost workforce productivity[6]. An economic study on addiction titled *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets* states that on average, "States pay over 11 times the total amount spent on prevention, treatment and research coping with the burden of substance abuse and addiction in the health care system"[6]. The same 2009 study, conducted by the National Center on Addiction and Substance Abuse (NCASA) at Columbia University, indicates that as the state invests in addiction treatment programs, society profits from reductions in future criminal justice, medical, and health care expenses[6]. Also, "burden spending" in other areas of state and local government is drastically reduced by funding effective prevention and treatment programs[6].




**Source:** ***Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets*****, pg. 105. (May 2009), The National Center on Addiction and Substance Abuse at Columbia University.**

According to SAMHSA Administrator Pamela S. Hyde, J.D., "Behavioral health services are critical to health systems and community strategies that improve health status and they lower costs for individuals, families, businesses, and governments. The value of behavioral health services is well documented. Studies have shown that every dollar invested in evidence-based treatments yields $2.00 to $10.00 in savings in health costs, criminal & juvenile justice costs, educational costs, and lost productivity. **Yet, too many people don't get needed help for substance abuse or mental health problems and health care costs continue to skyrocket"[11].**

Louisiana generally has a higher concentration of population in need of addiction treatment than the national average[4]. In addition, Louisiana has one of the highest incarceration rates in the nation[4]. Given these initial conditions, it is reasonable to assume that investments in the prevention and treatment of substance use disorders for Louisiana residents would produce a return greater than the national average.

The Office of Behavioral Health and the Commission on Addictive Disorders continue to believe in the validity of, and will make all efforts to move toward, the integration of addiction treatment into a primary care/public health model. Leveraging Department of Education partnerships and the existing Public Health Unit infrastructure to increase OBH's preventive impact is a current initiative of the Office.

The Office of Behavioral Health continues to seek and develop additional sources of funding in the interests of expanding the state's service capacity for addiction treatment and ensuring the delivery of quality care to citizens in a timely and effective manner. Addiction is a health care issue, and systems that acknowledge and treat it as such tend to realize significant benefits, as noted above.

# VII. References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