Bobby Jindal
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

May 30, 2011

The Honorable Bobby Jindal
Governor, State of Louisiana
P.O. Box 94004, Capitol Station
Baton Rouge, LA 70804-4004

The Honorable Joel T. Chaisson, II, President
Louisiana State Senate
P.O. Box 94183, Capitol Station
Baton Rouge, LA 70804-9183

The Honorable Jim Tucker, Speaker
Louisiana State House of Representatives
P.O. Box 94062, Capitol Station
Baton Rouge, LA 70804-9062

The Honorable Willie L. Mount, Chairwoman
Senate Health and Welfare Committee
Louisiana State Senate
P.O. Box 94183, Capitol Station
Baton Rouge, LA 70804-9183

The Honorable Kay Katz, Chairwoman
House Health and Welfare Committee
Louisiana State House of Representatives
P.O. Box 44486, Capitol Station
Baton Rouge, LA 70804-4486

Dear Governor Jindal, President Chaisson, Speaker Tucker, and Honorable Chairs:

In response to R.S. 46:2504, the Louisiana Department of Health and Hospitals (DHH) submits the enclosed report. R.S. 46:2504 requires the Louisiana Commission on Addictive Disorders, which is housed within the office for behavioral health within DHH, to report annually as to its activities for the previous year and recommendations for future programs. The statute requires the report be submitted to the governor and the House and Senate Committees on Health and Welfare. R.S. 24:772 also requires that the report be submitted to the President of the Senate and the Speaker of the House.

Pete Calamari, assistant secretary for the office of behavioral health, is available to discuss the enclosed report with you at your convenience. Please contact him at (225) 342-5236 with any questions or comments you may have.

Sincerely,

Bruce D. Greenstein
Secretary

Enclosures

Cc: The Honorable Members of the House Health and Welfare Committee
The Honorable Members of the Senate Health and Welfare Committee
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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.

2010

DEPARTMENT OF HEALTH
AND HOSPITALS
Behavioral Health

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 has been 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 2010 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.

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 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

I. About the Commission

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 – 2010

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

- The Commission met 12 times during the 2010 calendar year (once monthly). The majority of meetings were held at OBH Headquarters in Baton Rouge, with the exception of three meetings – March, July, and October – that were held in Lafayette, New Orleans, and again in Lafayette, respectively.

- Commission members participated in the Public Forums held by the Office for Addictive Disorders (prior to the merger) in 2010. These forums are held annually in locations around the state as a requirement of the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funding the Office heavily depends upon. 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. Select 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 two "at-large" members, leaving gaps in representation for FPHSA, Region VI, and Region VII. 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

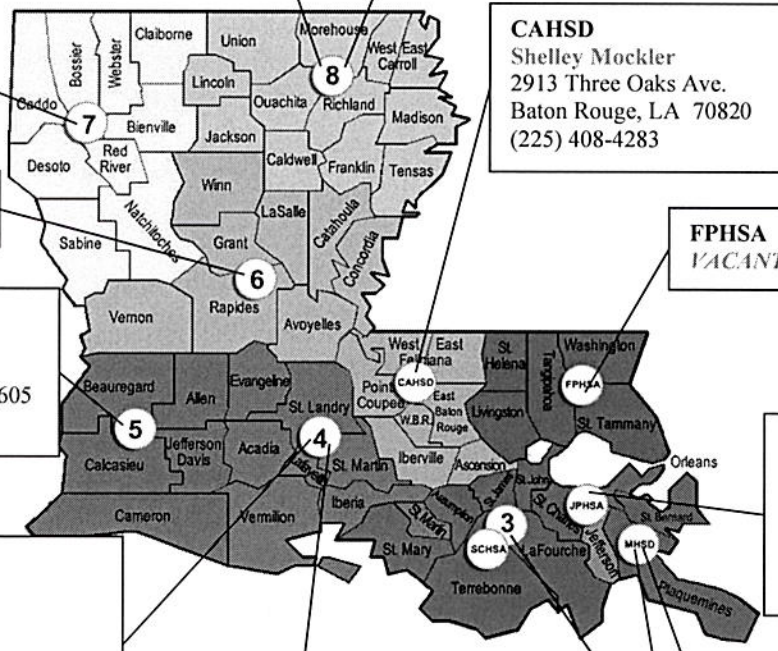
REGION VIII
Jon Lance Nickelson
1416 Spencer Avenue
Monroe, LA 71201
(318) 325-3251

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
George McHugh
(At-Large)
Vice Chair, Liaison
1061 Mimosa
St. Martinville, LA 70582
(337) 316-7194

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

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

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

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:

- The Drug Policy Board (*Freddie Landry*)
- The Prevention System Committee (*Freddie Landry*)
- The Association of Problem Gamblers (*Kathleen Leary*)
- Acadiana Area Human Services District Governance Board (*George McHugh*)

II. About the Office of Behavioral Health

Traditionally, mental health and addictive disorders have delivered services that treat addiction or mental illness as separate conditions. Mental health patients were referred to mental health services operated by or provided for by an organization that focused solely on the treatment of mental illness. The same was true of addictive disorders. Recently, the State of Louisiana joined a growing national trend to eliminate the segregation of services and provide integrated treatment for both conditions. Act 384 of the 2009 Regular Session of the Louisiana Legislature provided for the creation of an Office of Behavioral Health to develop and provide this integrated approach to treatment.[5]

As of July 1, 2010, this legislation took effect and the Office of Behavioral Health was created[5]. The current Office of Behavioral Health represents a merger of the state's former Offices of Mental Health and Addictive Disorders, an appropriate mixture of prevention and treatment services for mental health, addiction, and co-occurring disorders, and a progressively integrated approach to providing services that treat the whole individual[10]. The Office's vision and mission reflect this philosophy.

MISSION	VISION
The mission of the Office of Behavioral Health is to promote recovery and resiliency through services and supports in the community that are preventive, accessible, comprehensive, and dynamic.[10]	*The Office of Behavioral Health ensures care and support that improves quality of life for those who are impacted by behavioral health challenges.*[10]

In addition, the Office of Behavioral Health uses the following twelve Guiding Principles to guide its decision-making, policy, and operations.

GUIDING PRINCIPLES[10]

1) We can and will make a difference in the lives of children and adults in the state of Louisiana.

2) People recover from both mental illness and addiction when given the proper care and a supportive environment.

3) The services of the system will respond to the needs of individuals, families and communities, including culturally and linguistically diverse services.

4) Individuals, families and communities will be welcomed into the system of services and supports with a "no wrong door" approach.

5) We respect the dignity of individuals, families, communities and the workforce that serves them.

6) Through a cooperative spirit of partnerships and collaborations, the needs of individuals, families and communities will be met by a workforce that is ethical, competent and committed to the welfare of the people it serves.

7) We will utilize the unique skills of professionals with appropriate competencies, credentials and certifications.

8) Mental illness and addiction are health care issues and must be seamlessly integrated into a comprehensive physical and behavioral health care system that includes primary care settings.

9) Many people we serve suffer from both mental illness and addiction. As we provide care, we must understand, identify and treat both illnesses as primary conditions.

10) The system of care will be easily accessible and comprehensive and will fully integrate a continuum of prevention and treatment services to all age groups. It will be designed to be evidence-based, responsive to changing needs, and built on a foundation of continuous quality improvement.

11) We will measure our results to demonstrate both improved outcomes for the people we serve and fiscal responsibility to our funders.

12) We will prioritize de-stigmatizing historical biases and prejudices against those with mental illness and substance use disorders, and those who provide services, through efforts to increase access to treatment. We will do this by reducing financial barriers, addressing provider bias, integrating care and increasing the willingness and ability of individuals to seek and receive treatment.

III. 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, approximately 177,879 visits to emergency departments nation-wide in 2008 involved people seeking detoxification or substance abuse treatment services[3].

Underage Drinking and Drug Use. During 2008, adolescents and young adults (ages 12 to 20) made an estimated 188,981 alcohol-related visits to emergency departments[7]. The use of illicit drugs was identified in more than two thirds of those visits, and more than half involved the use or abuse of pharmaceutical drugs[7]. Of those visits, the illicit drug most used in combination with alcohol was marijuana; the next most common was cocaine[7]. The most common pharmaceutical drugs used in combination with alcohol by these patients were those used to treat anxiety or insomnia, followed by narcotic pain relievers and antidepressants or antipsychotics[7]. Alcohol took an especially heavy toll on the adolescent and young adult population during the holidays. During July of 2008, there were an average of 502 emergency department visits per day involving underage drinking[8]; however, during the 3-day Fourth of July weekend, that number increased 87% to an average of 938 per day[8]. An alarming point to note is that of all these patients age 12-20, nearly two thirds did not seek or were not referred to follow-up care or services[7].

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."

Trends in Louisiana

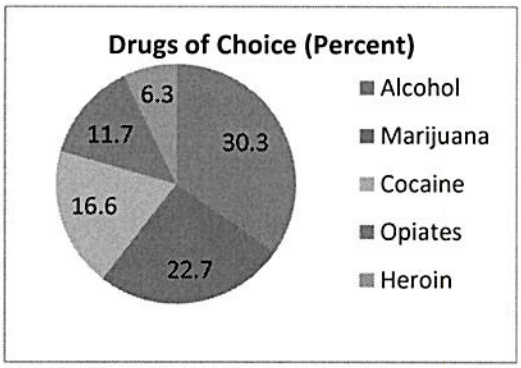
People Served. According to data derived from the Louisiana Addictive Disorders Data System (LADDS), the Office of Behavioral Health provided treatment services to 48,898 people during Fiscal Year 2010[9]. Of these people served, 33,915 (69.4%) had only one treatment episode; the remaining 14,983 (30.6%) patients had two or more separate treatment episodes[9]. Of those admitted to treatment during FY 2010, approximately 37% were African American, 60% were Caucasian, and the remaining 3% were composed of Native Americans, Asians, and others[9]. The gender breakdown of people served reveals that 32% were female and 68% were male[9].

People Served (LADDS):		48,898
Ethnicity:	African American:	37%
	Caucasian:	60%
	Native American, Asian, Other:	3%
Gender:	Male:	68%
	Female:	32%
		Source: LADDS

The Access To Recovery (ATR-I) project provided treatment services to 3,080 people during FY 2010. The ATR-II project provided treatment services to 3,453 people during the same reporting period. In addition to treatment services, the Office of Behavioral Health served 72,095 people with direct, individual-based prevention services and an additional 194,798 people with population-based prevention services during FY 2010. Taken together, the total number of people served by the Office of Behavioral Health during FY 2010 is 322,324,a s demonstrated by the table below.

Prevention		**Treatment**		**Total**
Enrollees	72,095	LADDS	48,898	
Participants	194,798	ATR I & II	6,533	
Prevention Subtotal:	**266,893**	*Treatment Subtotal:*	**55,431**	**322,324**

Drugs of Choice. According to the LADDS data described above, the drugs of choice in Louisiana for FY 2010 were (in order of frequency): alcohol (30.3%), marijuana (22.7%), cocaine (16.6%), opiates (11.7%), and heroin (6.3%)[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 FY 2010.

Outcome Measure		**LADDS[1]**			**ATR-I**			**ATR-II**			**National Outcome Measures (NOMS)**
		A	**D**	**+/-**	**A**	**D**	**+/-**	**A**	**D**	**+/-**	•Abstinence from Drug/Alcohol Use •Employment/ Education •Crime & Criminal Justice Involvement •Stability in Housing •Social Connectedness •Access/Capacity •Retention •Perception of Care •Cost Effectiveness •Use of Evidence-Based Practices
Arrest Rate		9.7%	3.5%	-6.2%	10%	2%	-8%	9%	3%	-6%	
Abstinence		9.5%	70%	+60.5 %	29%	87%	+58%	31%	83%	+52%	
Stable Living Arrangement[2]		92.9%	93.9%	+1%	67%	63%	-4%	77%	83%	+6%	
Gained or Maintained Employment / Education		28.1%	30.4%	+2.3%	33%	55%	+22%	38%	53%	+15%	
Average Length of Stay	**Inpatient**	28 Days			135 Days			N/A			
	Outpatient	90 Days						128 Days			

Source: LADDS, ATR

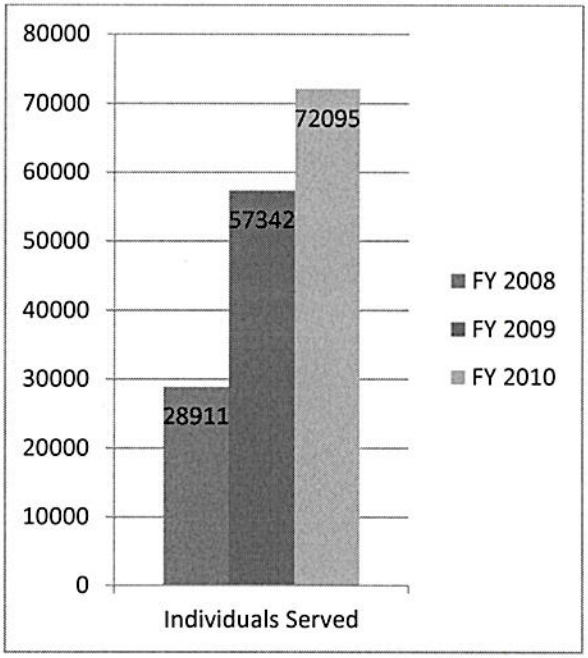
[1]Analyses do not include those who failed to come to treatment after admission or those who dropped out in the first week of treatment.

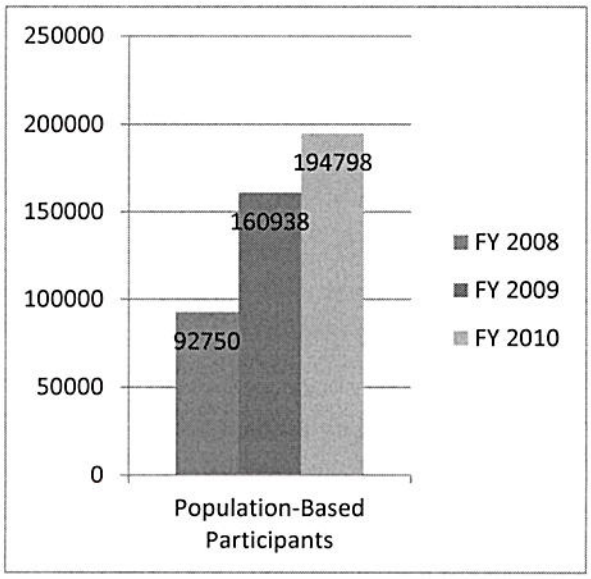
[2]ATR reflects lower figures in "Stable Living Arrangement" category due to difference between NOMS and GPRA definitions. GPRA (ATR) definition of Stable Living Arrangement does not include *dependent* living situations, only *independent*.

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 FY 2010, shows a reduction in arrest rate from admission to discharge for each group of patients admitted to treatment (LADDS, ATR-I, and ATR-II). 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-I). The clinical judgment of this outcomes data indicates that 78% of the people served during FY 2010 made some or significant improvement[9].

Adolescent Outcomes. In addition to the people served listed above, OBH provided services to 2,484 adolescent patients[9]. This population had a reduction in the arrest rate of 15% (20% at admission to 5% at discharge), a 50% increase in abstinence (22% at admission to 72% at discharge), and a 79% reduction in drug use (or maintained abstinence) from admission to discharge[9]. Of this treatment population, clinicians judged that 72% made some or significant progress[9].

Prevention Initiatives. 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 FY 2010, 72,095 individuals were enrolled in ongoing prevention programs and services, and 194,798 people were positively impacted by one-time population-based services. In total, 266,893 people were served in prevention programs and services during FY 2010. In addition, the perceived risk/harm of substance abuse increased during FY 2010, indicating that prevention efforts are having a positive impact on Louisiana youths' perception of the risks and harms associated with substance abuse.

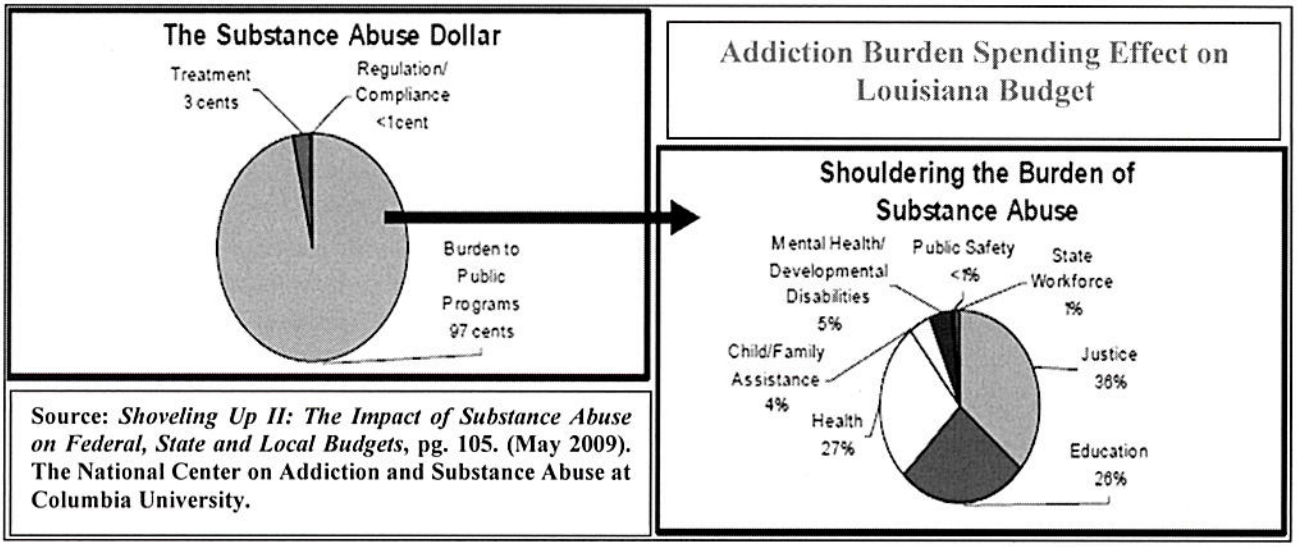




Prevention services, in addition to the obvious benefits of delaying the age of initiation of substance use and reducing high-risk behaviors that lead to addictive disorders, are also very cost-effective. Since FY 2007, OBH Prevention has ***increased evidence-based prevention services by 593% without 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.

Impact on State Budget

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.

Surveys and Studies

Caring Communities Youth Survey (CCYS). OAD co-sponsored with the Louisiana Department of Education, the 2008 Caring Communities Youth Survey (CCYS). The CCYS has been conducted bi-annually since 1998 among students in grades 6, 8, 10, and 12. This survey was conducted again during 2010, and the results will be available in May 2011.

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 2009. Thirty-three institutions participated in the survey; 26 of 31 institutions of higher education participated in the Core Alcohol and Drug Survey; five did not participate for various reasons. Seven technical schools also took part in the survey this year. The LaHEC mission is to foster safe and healthy campus communities by reducing problems associated with collegiate alcohol, tobacco, and other drug use through collaboration among institutions of higher education and key state and community stakeholders.

Problem Gambling Study. The *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 year, 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.

Future Needs. The need for business intelligence relative to the population served by the Office of Behavioral Health, as well as relevant trends in addiction and co-occurring disorders, dictates that further surveys and studies are required to provide the most effective and cost-efficient services possible. To that end, the Commission recommends the development and implementation of a more regular survey or information-gathering means focused on the critical areas of business intelligence necessary to providing these services in a more responsive and efficient manner.

IV. The OBH System of Care for Addiction

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.

How the Continuum Works

The OBH Continuum of Care is comprised of five basic segments, or categories or care: prevention, detoxification, inpatient 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. 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. Combined, these two categories of services positively impacted 266,893 people in Louisiana during state fiscal year 2010.

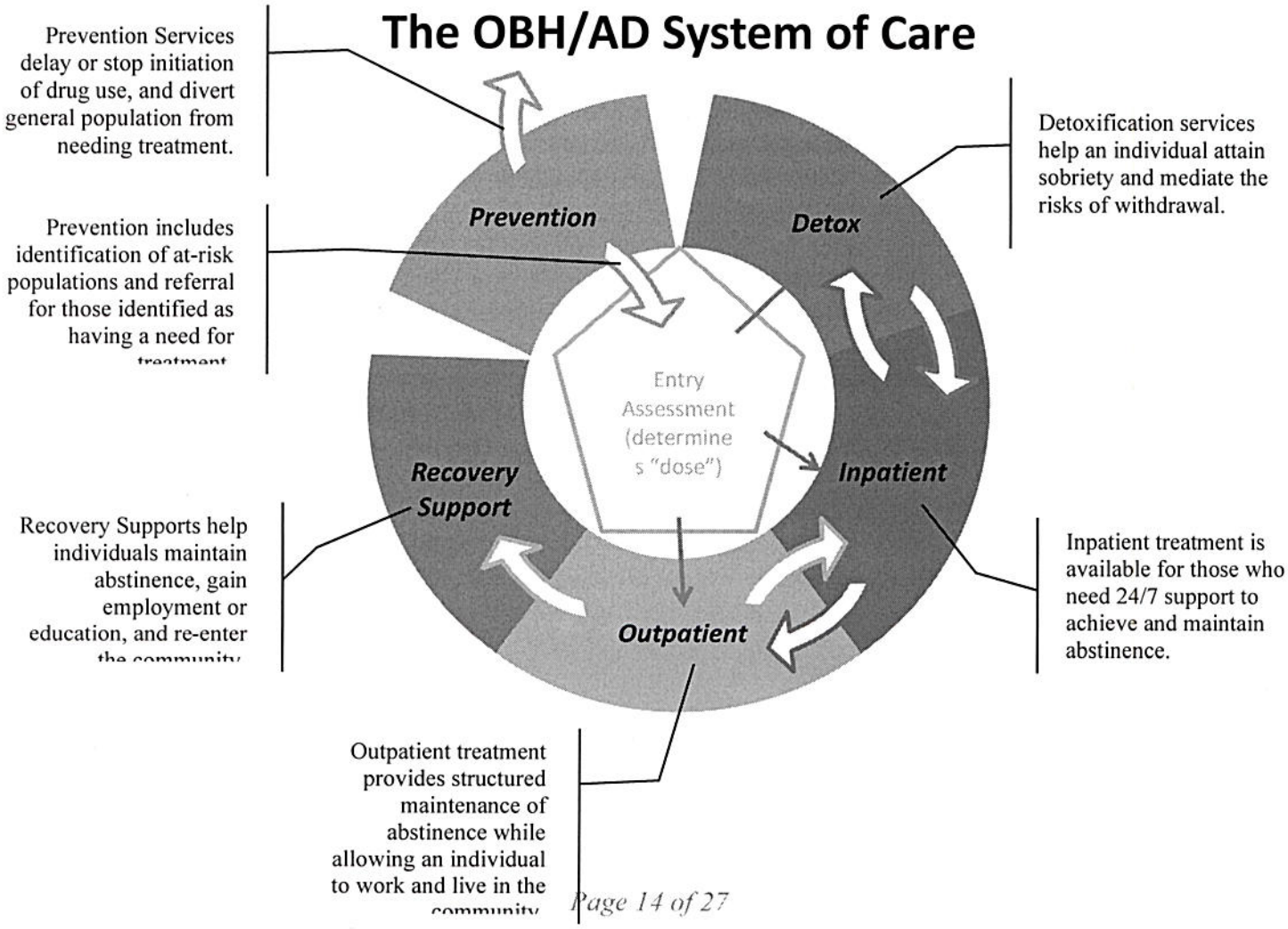
Detoxification. Detoxification services are provided to those seeking substance abuse treatment that are at risk for experiencing withdrawal symptoms. There are three types of detoxification services offered by OBH, according to the specific needs of patients. Social detox includes twenty-four hour monitoring, and is available for those who need detox services but have no health risks associated with withdrawal. Medically supported detox is available for those who may require nursing and other medical services as part of their detoxification process. Medically managed detox is appropriate for those patients who require medication management as part of their detox and may need nursing and medical services. Once the period of detoxification is complete (in the case of medically-managed detox, this typically refers to when the patient has been stabilized after serious withdrawal symptoms cease), the patient is de-escalated to the next lowest "dose" of treatment appropriate to their situation.

Inpatient Treatment. Inpatient treatment is appropriate for many individuals who would benefit from a stable, supervised, and controlled setting. A variety of support services are offered during inpatient treatment, including individual and group therapies, counseling, education, life skills education, and job skills training. Once clinical staff determines that patients would benefit more from a less restrictive

setting, they may be stepped down to outpatient treatment options per their specific needs. The option to return to detoxification services is available for those who experience a serious relapse.

Outpatient Treatment. Outpatient treatment comes in two "doses": intensive, and regular. Intensive outpatient treatment (IOP) requires a slightly more rigorous, 9 hours or more, weekly contact schedule of attendance and counseling, and is generally reserved for those patients that would benefit from a greater level of support. Standard outpatient treatment requires less than 9 hours of weekly contact for a less intense attendance and counseling schedule. Each outpatient treatment schedule is determined according to the specific needs and situation of the individual. The option to return to inpatient treatment (and even detoxification) is available for those patients that experience a serious relapse.

Recovery Support. 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.



Prevention

During SFY 2010, OBH Prevention provided ongoing evidence-based prevention programming to 72,095 enrollees, a significant increase over previous years. Increases in service delivery since SFY 2007 are due to a cooperative partnership with the Department of Education (DOE) and its local education authorities, the mobilization of prevention services, implementation of cost bands for universal, selective and indicated programs, and fee for service contracts. 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. In addition to the 72,095 enrollees mentioned earlier, population-based prevention services positively impacted the lives of 194,798 people in Louisiana. The total number of people served by OBH Prevention in FY 2010, including both individual and population-based services, was 266,893.

Strategic Prevention Framework State Incentive Grant. OAD 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 expires on September 30, 2010. 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.

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 2010, the non-compliance rate was 4.3%. 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.

Detoxification Programs

The State of Louisiana provides for several detoxification programs statewide through contracted providers. Three different levels of intensity are available for those seeking detoxification services:

1) Social Detoxification, for those who require 24/7 monitoring and supervision but who are not at risk for serious withdrawal effects that may adversely affect their health;
2) Medically-Monitored/Supported Detoxification, for those who may need nursing or other 24-hour free-standing residential facility based medical services in addition to the above; and
3) Medically-Managed Detoxification, for those whose detoxification process may be dangerous to their health and may require medication management, close monitoring, nursing, and other 24-hour hospital based medical services.

Inpatient Addiction Treatment

The Office of Behavioral Health contracts with providers to offer Medically Monitored treatment options for those seeking treatment who may benefit from a residential environment. Currently, OBH provides for the following number of residential/inpatient treatment programs:

- 19 residential adult programs
- 4 residential adolescent programs
- 7 specialized residential programs for women & dependent children

During 2010, OBH began efforts to privatize its remaining state-operated inpatient facilities. As of the date of this report, all inpatient treatment facilities and programs are operated under contract.

Compulsive and Problem Gambling. 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 2010, a total of 703 people were served by this program. Of those 703 individuals, more than 80% successfully completed the program. On the most recent client satisfaction surveys, the program's outpatient compulsive gambling treatment services received 100% 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 $2.5M, which covers all of the costs associate

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 Addiction Treatment

Behavioral Health Clinics. The Office of Behavioral Health, in keeping with the integration of central office functions related to addictive disorders and mental health, has begun the process of co-locating addictive disorders and mental health clinics to form behavioral health clinics. These clinics provide a wide variety of outpatient services for those impacted by behavioral health challenges. Each of these co-locations was carefully considered.

Access To Recovery II (ATR-II). Admissions for the SAMHSA $13.4 M Access to Recovery II (LA-ATR II) grant began in January 2008. Substance abuse treatment and recovery support services were provided to adults and adolescent substance abusers involved with the criminal and juvenile justice system and methamphetamine using clients. This grant provided the opportunity to partner with the Department of Corrections and the Office of Juvenile Justice. The LA-ATR II project served 8,156 clients through a network of 100 service providers, including faith-based, community-based, private and public sector organizations. The LA-ATR II federal grant ended as scheduled on September 29, 2010.

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 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 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 regional facilities and clinics shall develop and keep current an emergency response plan which provides for an integrated response capacity with other state agencies and the local emergency operations plan;
- 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 staff responsibilities include providing assistance and staffing to the Office of Public Health at the designated Medical Special Needs Shelters and serve as part of a cadre of Behavioral Health Staff which will include the Office for Citizens with Developmental Disabilities;
- In addition to special needs shelter staffing; continuity of regular operations is expected as this resource will be needed to refer 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) shall maintain 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 shall include actions for sheltering-in-place and evacuation of staff and patients to other host (destination) facilities.
    - During a declared disaster incident OBH will make 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 shall also serve 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.
- 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.

Disaster Event Response for 2010. There were three specific areas of focused response activities for 2010. The first activity was that of providing support and assistance with the DHH H1N1 Swine Flu Pandemic response activities. OBH supported this response by providing prophylactics in 24-hour psychiatric facilities and clinics and PPE materials such as facial masks, hand sanitizing solutions, informational brochures, and orientation with headquarters, field offices, and behavioral health consumers.

The second event supported by OBH Emergency Response was that of the Gulf Oil Spill event of April 20th, 2010. In the aftermath of this event, the Office of Behavioral Health (OBH) was charged to manage the overall behavioral health recovery process of the oil spill disaster and coordinate recovery activities in partnership with other state and local levels of government. These recovery services addressed both mental health and substance abuse considerations for oil spill disaster victims and response workers. Core concepts of service delivery to those impacted were to engage, empower, and promote efforts towards recovery. Utilizing the Louisiana Spirit Coastal Recovery Counseling Program (CRCP), OBH was able to provide behavioral health intervention that included face-to-face, outreach, and education for those individuals, families, communities and businesses affected by the Deepwater Horizon oil spill.

This "on-the-ground" service delivery approach allowed team members access into the sites where residents were impacted and included oil spill claims centers, oil spill recovery sites where workers congregated, animal recovery sites, emergency operations centers, resource distribution sites, businesses which had lost revenue because of the spill, and various community events where residents were likely to be present. As with previously implemented Louisiana Spirit programs, this project was executed in cooperation with existing resources, including: the Louisiana State University Health Sciences Center; the Local Governing Entities (LGEs, i.e.: the Human Services Districts/Authorities); the Catholic Charities Archdiocese of New Orleans; the Department of Children and Family Services; the Governor's Office of Homeland Security Emergency Preparedness; local government officials such as parish presidents and police juries; and local non-governmental entities such as non-profit and faith based organizations.

Funding provided to the State of Louisiana by British Petroleum has allowed for the delivery of continued crisis support, treatment, and services to those residents, families, workers, businesses and communities impacted by the Gulf Coast Oil Spill event through August 2011.

Other activities of emergency response for 2010 included support and assistance with state ESF-8 response to tropical storms Danielle and Bonnie as they threatened the Louisiana coastline. OBH supported the storm response by readying staff for deployment and standing up EOC operations including deployment of crisis support staff to assist with persons who may be experiencing emotional issues related to previous hurricanes and the recent oil spill event.

Hurricane Recovery. Recovery efforts continued during 2010 to repair the damage caused by 2005 Hurricanes Katrina and Rita. Additionally, Hurricanes Gustav and Ike disrupted the service delivery system for prevention and treatment services statewide in 2008. The infrastructure that was in place to provide behavioral health prevention and treatment services has not yet been fully restored, though progress has been made.

Strategic Partnerships

Louisiana Integrated Treatment Services (LITS). The Office of Mental Health and OAD continue to collaborate on the Louisiana Integrated Treatment Services (LITS) initiative, which was originally funded by the Co-Occurring State Incentive Grant (COSIG) through the Substance Abuse and Mental Health Services Administration. The goal of the LITS initiative is to develop and sustain a treatment delivery system within the state of Louisiana in which all publicly-funded mental health and substance abuse programs are Co-Occurring Diagnosis Capable (CODC). At the conclusion of the COSIG Project in 2008, an integrated network was created between state and local mental health and addictive disorders personnel in the areas of Workforce Development/Training, Clinical Protocol Development, Program Evaluation, Information Management, and Funding.

Counselor Education, Licensing & Certification. 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. 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.

Drug Courts. The Drug Court program was transferred to the Supreme Court in 2001. The Office for Addictive Disorders continues to collaborate with the Drug Court, and is the treatment provider for many of the courts.

Children and Families. The Office for Addictive Disorders continued a Memorandum of Understanding (MOU) with the Department of Social Services, Office of Family Support, to address issues among Temporary Assistance for Needy Families (TANF) residential women with dependent children. This initiative is not funded with Block Grant monies. However, this program greatly impacts OAD's ability to provide services to pregnant females and women with dependent children. OAD was successful in obtaining renewed TANF funding in 2009.

OAD continued collaborations with DSS/OCS and developed a 2007-2008 MOU to provide screening, assessment and referral to treatment. Funding was allocated to provide acute care inpatient beds and long term residential treatment beds for women with dependent children who are involved with the child welfare system. Additionally, the new initiative provides gender specific intensive outpatient treatment. OAD and OCS participate in quarterly team meetings to address obstacles and barriers to implementation, while developing and/or revising protocols as indicated.

Department of Education. 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.

Future Considerations

As the Office of Behavioral Health transitions out of the role of direct service delivery and moves toward the implementation of a managed care environment, it becomes increasingly important to ensure that services are delivered in an efficient and cost-effective manner. The Office – in partnership with other state agencies – is currently in the process of developing a Coordinated System of Care for this purpose. As the State Purchasing Agency for the Coordinated System of Care, one key consideration will be the role of OBH in the preservation of services, professional competency, and provider accountability.

V. Major Challenges and Triumphs of 2010

The Office of Behavioral Health faced a number of difficult challenges during 2010, 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 OBH in monitoring and supporting the functions of the LGEs;
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. OBH directly operates behavioral services in five regions of the state, with mental health and addictive disorders regional administrative offices and clinics located in each region. A priority during 2010 (and continuing into 2011) is the integration of these regional offices and clinics without a reduction in service delivery. Aspects of this integration include combining prevention, access to services, treatment, and community supports that allow individuals to function successfully in the community. The next steps in this integration process include:

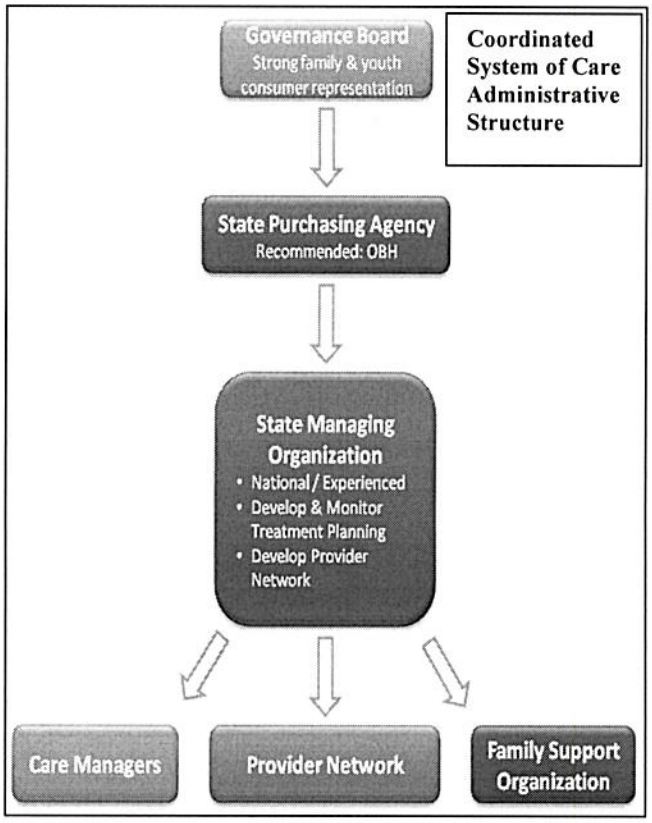
1) The clarification and establishment of performance standards and outcome measures;
2) The expansion of a single point of entry process;
3) Establishing, through DHH rule-making, revised behavioral health licensing standards; and
4) Aligning business operations and workforce development strategies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

The transition to integrated regional service delivery is expected to be complete during 2011.

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.

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.

Waiting Lists. The waiting list for 24-hour care (detox, inpatient/residential, and halfway houses) and access to outpatient treatment services remains constant. Progress has been made in the past two years: the average daily waiting list for people waiting to access 24-hour care decreased from an average of 1,450 people per day in 2008 to 1,307 people per day in 2009 and 1,239 in 2010. The waiting lists provides an indicator to determine if OAD's residential treatment service capacity needs to be expanded to meet the needs of Louisiana citizens. In seeking a solution to this problem, the Office for Addictive Disorders chose to expand the capacity of its community-based outpatient services and to continue statewide utilization of American Society of Addiction Medicine (ASAM) patient placement criteria. Use of ASAM criteria supports patient placement in the most appropriate level of care, avoiding unnecessary use of more expensive levels of care.

Privatization of Addictive Disorders Services. The Office for Addictive Disorders as part of the Department of Health and Hospitals' plan for efficiencies and budget reductions made the decision to privatize the remaining six (6) State operated inpatient /residential programs. RFPs were issued in October 2010 and all programs were awarded to private providers. Implementation of privatized services began with one program on January 27, 2011 and all programs have implemented privatized services with the last program going online March 14, 2010. See table below:

State Facility	Private Organization Operator	Privatized Services Began
Briscoe	Cenikor Foundation, Inc.	February 2, 2011
SOAR	B and B of Marion, LLC	January 27, 2011
Pines	Center Point, Inc	February 13, 2011
Red River Adult Inpatient /Medically Supported Detoxification	Pathways Community Behavioral Healthcare	February 1, 2011
Red River Co-Occurring Unit	Pathways Community Behavioral Healthcare	February 23, 2011
Springs of Recovery Adolescent Inpatient	Pathways Community Behavioral Healthcare	March 14, 2011

Performance Improvement Initiatives. The Office of Behavioral Health is working with the Network for the Improvement of Addiction Treatment (NIATX) and the Treatment Research Institute (TRI) to address performance-based budgeting. This initiative is designed to improve the quality of patient care by addressing patient initiation, engagement, and retention in treatment. The majority of this project is complete, though performance improvement initiatives are ongoing at the clinic level. 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 Office of Behavioral Health is currently engaged in an ongoing series of initiatives to improve the professional development of its workforce. Many traditional means of training staff (such as face-to-face training sessions) are no longer cost-effective: they require expenditures for personnel travel reimbursement, costs associated with a venue, and contracting with material experts. Newer technologies and practices allow for more efficient, more effective means of achieving OBH training goals. In the interest of maintaining a knowledgeable, skilled, and vital workforce, OBH is in the process of investigating and implementing the new training modes that accomplish professional educational goals, but do not require as much financial burden.

One such mode is to offer online training courses that are self-administered through a Learning Management System (LMS). The LMS content provider for OBH is Essential Learning, an organization that provides health care-related information and content competency courses through a web-based portal. The courses offered to students range in content from software skills (such as Microsoft Word and Excel) to specific addictive disorders and mental health education. Essential Learning also offers OBH the opportunity to build its own courses and upload them for its entire workforce. OBH employees statewide (both clinical and non-clinical) have unrestricted access to the entire library of Essential Learning courses, including content relative to their educational and professional level or certification/licensure. Many of these classes are approved by the Addictive Disorders Regulatory Authority (ADRA) and other bodies, and count toward the continuing education requirements of clinical staff (CEUs).

Another mode of workforce development currently being investigated by OBH is the use of electronic seminars called "webinars," where personnel can attend a "live" training directly from their computer terminal. This eliminates 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.

A third method of training staff involves an integrated system of video conferencing equipment. Also, conferences may take place through a network of linked webcams. These modes of workforce development are still being investigated.

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.

Models for Change

Access to Recovery I & II. The Office of Behavioral Health continues to operate the Access to Recovery (ATR-I) initiative, which began in 2004 as a federal grant from the Substance Abuse Mental Health Services Administration (SAMHSA). When the initial ATR-I federal grant ended in 2007, the Louisiana State Legislature and Office of the Governor opted to continue funding the ATR-I prototype using State General Funds, due to the success of the project. During FY 2010, ATR-I served 3,080 individuals with state appropriated funding.

During the implementation of the ATR-I initiative, OAD recruited a total of 202 service providers for treatment and recovery support services. Of this total, 52% were community- and faith-based providers; 139 were new service providers. The recruitment of faith-based providers was a key component of this grant to ensure freedom of choice for clients. Another unique feature of the grant was the ability to provide recovery support services such as job readiness skills, safe housing, childcare and transportation. Louisiana was required to serve a minimum of 8,928 clients. From March 1, 2005 through August 2, 2008, OAD served more than 24,000 individuals: ***200% of the target required by the federal government.***

In 2007, OAD was awarded an Access to Recovery II (ATR-II) federal grant through SAMHSA. The ATR-II initiative is a $13.4 million three-year federal grant that targets adult and adolescent methamphetamine using individuals, and individuals involved with the criminal/juvenile justice systems who also have a problem with alcohol or drug use. In 2009, the LA-ATR II project also began to partner with the Louisiana National Guard to serve those deployed to combat in Iraq and Afghanistan. During FY 2010, the ATR-II federal grant initiative served 3,453 individuals. The ATR-II federal grant initiative ended in September of 2010, resulting in a loss of resources and capacity to serve more than 2,200 clients annually.

Both the ATR-I and ATR-II initiatives provide freedom of choice for clients in selecting service providers for clinical treatment and recovery support services through a web-based electronic voucher system. At the close of the 2010 fiscal year, the ATR-II initiative had served more than 3,400 individuals. The ATR-II federal grant initiative ended in September 2010. The loss of federal grant funding presented a challenge to maintenance of the services offered through Access To Recovery providers. $1.37M in State General Fund dollars was set aside for SFY 2011 to help preserve ATR-II services. The $1.37M allocated allowed the program to serve 760 clients for four (4) months. During 2009, SAMHSA announced the request for grant applications for the Access To Recovery III grant, which focuses on serving military personnel. Despite submitting an application for this grant program and a proven record of accomplishment, the Office of Behavioral Health was not selected to participate in the ATR-III project.

Pay for Performance Model. During 2009, the proposal for a new process of funding determination for state government programs was introduced. The Office of Behavioral Health continues to participate in budget exercises that help determine the best course of action with regard to streamlining and funding allocation. Under this new funding process, known as "outcome-based budgeting," programmatic funding decisions are based on demonstrative data that reflect efficient and effective performance practices and outcomes. This system ensures that quality services are provided and that taxpayer monies are spent wisely.

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