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1. The General Assembly should allocate state funds to support substance abuse prevention programming in all areas of the Commonwealth.

Funds allocated for substance abuse prevention services should be allocated in equal amounts to Virginia's 40 community services boards to support provision of evidence-based programming either directly by the CSB or pursuant to a contract between the CSB and a service provider. Funds should be used to determine local prevention program needs, identify specific evidence-based prevention programs to meet those needs, implement the programs selected, and collect and evaluate outcome data for each program to determine program effectiveness.

Amount: \$2.4 million (This amount was requested by Delegate Morgan and Senators Hanger, Blevins, and Whipple in 2008 but ultimately not included in the 2008-2010 Biennial Budget).

2. The General Assembly should allocate state general funds for substance abuse prevention and early intervention services in schools, to replace Safe and Drug Free School funds that were discontinued in 2010.

The Drug-Free Schools and Communities program was first established by the Anti-Drug Act of 1986, for the purpose of support state and local programs intended to prevention the use of alcohol, tobacco, and drugs by elementary and secondary school students. The program was subsequently revised in 1994. Additional changes were made in 2001 when the program was reauthorized as part of the No Child Left Behind Act. At this time, the program, enacted as the Safe and Drug-Free Schools and Communities Act (SDFSCA), was amended to include programs intended to prevention violence in schools as well as the use of alcohol, tobacco and drugs by students.

The SDFSCA program provides funding for states and localities to support violence and substance use prevention through grants to state education agencies. State education agencies coordinate distribution of funds to local education agencies. In Virginia, SDFSCA funds are received by the Department of Education and distributed to local school divisions. In 2002, Virginia received \$8.9 million through the SDFSCA program. Between 2002 and 2009, SDFSC program funds declined steadily, so that in 2009 Virginia's allocation was \$5.4 million. Twenty percent of funds the allocated to Virginia through the SDFSCA program were distributed to the Governor's Office for the Governor's Office of Substance Abuse Prevention. The remaining 80 percent were distributed to the Department of Education for violence and substance abuse prevention activities. In 2009, funding for SDFSCA programs was eliminated from the federal budget complete, so that SDFSC funds ended at the beginning of FY2010.

In 2009, the federal Substance Abuse and Mental Health Administration (SAMHSA) estimated that between 2003 and 2006 approximately 25,000 Virginia youth needed but did not receive drug treatment, and another 29,000 needed but did not receive alcohol treatment. In 2008, local school divisions identified Student Assistance Programming implementation training as their #1 need. In response, the Board of Education included Student Assistance Programming as a strategy to combat violence and increase safety in schools in its 2007-2012 comprehensive plan. In 2009, Virginia's Office of Comprehensive Services identified intensive substance abuse services as the #2 gap in the Commonwealth's behavioral health service system, and substance abuse prevention services as the #14 gap in the Commonwealth's behavioral health service system. The loss of SDFSCA funding is anticipated to exacerbate these gaps, reducing the availability of funding and access to services.

Amount: \$4.3 million (this amount would equal the amount received by the Department of Education through the SDFSCA program in 2009, the last year in which funds were provided).

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- 3. The General Assembly should enact legislation requiring Virginia school divisions to participate in statewide random sample youth survey to collect local, regional, and statewide data on substance use and abuse to guide the planning and implementation of substance abuse treatment and prevention services.**

Currently, the Virginia Department of Health conducts a Virginia Youth Survey with the support of the Department of Education. The survey, an anonymous, self-administered questionnaire, is designed to gather information about health risk behaviors among Virginia youth. Participation was optional for school districts. The 2009 Survey was completed by 755 students in 24 public high schools. The school response rate was 65%, the student response rate was 73%, and the overall response rate was 47%. In a news letter published in the months following the 2009 survey, the Virginia Department of Health noted that "due to the low overall response rate, the results [were] representative of only those students who completed the questionnaire and cannot be generalized to the entire population." As a result, the information obtained through this survey is insufficient to support effective statewide substance abuse treatment and prevention planning. School districts should be required to develop and administer the survey in collaboration with the Department of Behavioral Health and Developmental Services and community services boards to ensure collection of sufficient community risk and protective factor data and youth health risk behavior data to guide more accurate development of treatment and prevention programs, while still protecting student's privacy.

- 4. The General Assembly should enact legislation requiring all prescribers to request and review information about a patient from Prescription Monitoring Program prior to prescribing a Schedule IV controlled substance.**

This recommendation could be expanded to include Schedule II and Schedule III prescriptions. HB 1167 (2010)(Phillips) required prescribers to request and review information about patients when a Schedule II, III, or IV drug is first prescribed and then at least annual for so long as the prescriber continues to prescribe the drug; this bill was continued to 2011 in the House Health, Welfare, and Institutions Committee.

- 5. The General Assembly should enact legislation requiring all pharmacies operating in the Commonwealth to provide access to the Prescription Monitoring Program for at least one designated user per shift at each location.**

At the September meeting of the SJR 73 Joint Subcommittee Studying Strategies and Models for Prevention and Treatment of Substance Abuse, the joint subcommittee received information indicating that certain large pharmacy chains did not provide access to the Prescription Monitoring Program, preventing pharmacists from utilizing the PMP to request and review information about patients for whom they filled prescriptions. The joint subcommittee also received information indicating that requiring access to the system in each pharmacy for at least one person per shift would enable pharmacists to request and review such information, and could result in reduced rates of prescription drug abuse and associated harms and costs.

- 6. The General Assembly should require all prescribers of controlled substances licensed by the Commonwealth to receive 1 hour of continuing education in the area of substance abuse, addiction, pain management, and prevention practices each year.**

In 2009, the SJR 73 Joint Subcommittee Studying Strategies and Models for Prevention and Treatment of Substance Abuse heard testimony from stakeholders regarding the importance of ensuring that prescribers and pharmacists received education about substance abuse, addiction, pain management, and

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prevention practices. In November of 2009, the SJR 73 work group recommended that legislation be enacted to require mandatory continuing medical education on this topic for prescribers and pharmacists. HB 1169 (Phillips), introduced during the 2010 Session, would have required the Board of Dentistry, Board of Medicine, and Board of Optometry to require continuing education on the topics of substance abuse, addiction, and related pain management and prescribing practices for practitioners licensed by the Board who are authorized to prescribe controlled substances. This bill was left in the House Health, Welfare, and Institutions Committee.

7. The General Assembly should provide funding to support development and implementation of educational programs on the topic of substance abuse, addiction, and prevention training to all pharmacy schools in the Commonwealth.

At the September 2010 meeting of the SJR 73 Joint Subcommittee Studying Strategies and Models for Prevention and Treatment of Substance Abuse, the joint subcommittee received information about a training program for pharmacists that has been implemented at the Appalachian School of Pharmacy. This program, which includes both classroom-based education and hands on training through internships, has successfully trained pharmacists to identify and address substance abuse among clients.

Currently, four universities in Virginia offer pharmacy programs: University of Appalachia, Hampton University, Shenandoah University, and Virginia Commonwealth University. Dr. Melton, of the Appalachian School of Pharmacy, estimates the cost of that schools program to be \$39,300 per year.

Amount: \$ 160,000 to support development and implementation or continuation of substance abuse prevention programs provide education and training about substance abuse for pharmacy students at all four pharmacy schools in the Commonwealth.

8. The General Assembly should enact legislation directing the Department of Alcoholic Beverage Control to requiring point-of-sale messaging regarding the risks of consuming alcohol while pregnant to be displayed in all outlets selling alcoholic beverages.

9. The General Assembly should provide funding to support a provision of a full range of publicly funded substance abuse services, including prevention, early intervention, treatment, and recovery support services for adults and youth.

The SJR 73 Joint Subcommittee Studying Strategies and Models for Prevention and Treatment of Substance Abuse has heard testimony stating that an effective substance abuse treatment system should include a full array of services, including prevention, screening and assessment, early intervention, crisis intervention, outpatient, intensive outpatient, detoxification, residential inpatient, and recovery support services that are available to adolescents, adults, pregnant and parenting women, and elderly persons for whom such services are determined to be appropriate. In 2006, the Office of the Inspector General for Behavioral Health and Developmental Services concluded that "the range, variety, and capacity of substance abuse services are not adequate to meet the needs of consumers in the majority of Virginia communities." In that report, the Office of the Inspector General identified a number of service gaps. The Office of the Inspector General also reported that the availability of many services had actually decreased between 2000 and 2006, and that the average wait time for substance abuse services was 25.4 days, with wait times ranging from six days to 65 days for individual community services boards.

One area of particular concern is services for adolescents. According to 2007 report prepared by SAMHSA using data collected by the National Survey of Drug Use and Health, 26,000 Virginians between the ages of 12 and 17 needed but did not receive treatment for illicit drug use, and another 29,000 needed but did not receive treatment for alcohol use. Limited resources, local priorities, and competing agendas at the

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state and local level have resulted in a fragmented and imbalanced system of care for adolescents in the Commonwealth. Currently, there is insufficient capacity across all modalities of services for adolescents. Impediments to developing and delivering comprehensive, integrated services include: separate and un-accessed funding streams for adolescent substance abuse services; failure to identify youth in need of services; lack of a clear service model for adolescents; lack of a standardized service delivery methodology for adolescent services; and lack of a trained work force. The federal Substance Abuse Treatment and Prevention Block Grant, which provides a significant portion of funding for state substance abuse services, does not include required set-asides for adolescent services, and at this time no state funds are allocated specifically for adolescent services. Additional funding for adolescent services is needed to maintain existing services, and to enable providers to develop and provide a full range of services to meet the unique needs of adolescents with substance use disorders. Specific needs include: funding for community services boards to operate adolescent specific intensive outpatient programs; funding to increase the availability of residential treatment for adolescents throughout the state (currently Fairfax CSB is the only CSB offering residential treatment options for adolescents, and these services are only available for males); and emphasis on ongoing workforce development initiatives to build capacity to treat adolescents with substance use disorders.

A second area of particular concern is services for pregnant and parenting women, particularly residential services for pregnant and parenting women and medication-assisted treatment services for pregnant and parenting women. Medical best practices recommend that opiate dependent pregnant women be maintained on methadone throughout their pregnancy for the health of the child. Although Medicaid will fund these services, Virginia's methadone programs have failed to seek Medicaid reimbursement. This has been especially problematic for pregnant women, who must either self-pay or seek funding through community services boards, which are frequently unable to pay the costs of this type of treatment.

At this time, the Department of Behavioral Health and Developmental Services is focused on expanding and improving public substance abuse prevention, treatment and recovery support services in the Commonwealth as part of its Creating Opportunities initiative.

In the future, the General Assembly should continue to take steps to fund the development and provision of a full range of substance abuse prevention, treatment, and recovery support services, including services for adolescents, adults, pregnant and parenting women, and the elderly in the Commonwealth, including supporting the work of the Department of Behavioral Health and Developmental Services related to its Creating Opportunities initiative.

- 10. The General Assembly should enact legislation authorizing the establishment of adult drug courts in Dickenson, Buchanan, and Russell Counties and the Thirtieth Judicial Circuit, and family drug courts in Goochland and Montgomery Counties during the 2011 Session.**
- 11. In the future, the General Assembly should grant permission for and authorize establishment of all drug courts that have been recommended for approval by the state drug treatment court advisory committee and for which legislation has been introduced.**
- 12. The General Assembly should continue to provide funding to those drug courts that currently receive state general funds in an amount consistent with allocations authorized in the 2008/2009 Biennial Budget.**

In order to ensure that those drug courts that currently receive state funds are able to continue to meet current service levels, the Commonwealth should, at minimum, continue existing funding levels and not reduce state funding for currently funded drug courts. In 2010, the 10 state supported adult drug courts and 4 state supported juvenile drug courts in Virginia received \$2.9 million.

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- 13. The General Assembly should remove language providing that "no state funds used to support the operation of drug court programs shall be provided to programs that serve first-time substance abuse offenders only or do not include probation violators" (Item 39) from the 2010-2012 Appropriation Act.**

Currently, the appropriation act provides that no drug court programs receiving state funding should provide services for first time substance abuse offenders only, and do not include probation violators. This language restricts the scope of drug court programs, and prevents drug courts from serving some individuals for whom drug courts may be appropriate and beneficial.

- 14. The General Assembly should provide funding to support drug courts that do not currently receive funding from the Commonwealth or the federal government.**

If funding is not available in the 2010/2011 Biennial Budget, the General Assembly should consider allocating funding to support drug courts that do not currently receive state funds in the next or future biennia as funds are available.

- 15. The Joint Subcommittee should allocate funding to support the development and implementation of a Recovery-Oriented System of Care (ROSC) in the Commonwealth, which should include the Department of Behavioral Health and Developmental Services, Department of Social Services, Department of Education, Department of Corrections. and other public and private stakeholders.**

Recovery-oriented systems of care for individuals with substance use disorders are premised on the idea that recovery from alcohol and drug abuse and addiction is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life. Recovery-oriented systems of care are systems of services for persons with substance use disorders that are person-centered; inclusive of family and other allies; individualized and comprehensive, including a full array of services across the lifespan; anchored in the community; oriented around a continuum of care; focused on partnership-consultant relations; strength-based; culturally responsive; responsive to personal belief systems; committed to peer - recovery support services and inclusion of voices and experiences of recovering individuals and their families; integrated; research based; outcomes driven; and built on system-wide education and training, ongoing monitoring, and outreach. Recovery-oriented systems of care embrace both professionally directed and peer-based services focused on pre-recovery identification and engagement, recovery initialization and stabilization, long-term recovery maintenance, and quality of life enhancements for individuals and families, including primary medical and psychiatric care, addiction treatment, peer-based recovery support services and recovery coaches, and other ancillary services like case management, transportation, day care, housing, financial counseling, educational services, vocational services, and legal counseling. Post-treatment monitoring and support including saturated support during the first 90 days and "recovery check-ups" thereafter help individuals maintain recovery.

More than half of people who complete specialized addiction treatment in the U.S. resume use within one year of finishing treatment and 50% of people who complete substance abuse treatment will reenter treatment within two years. People relapse after treatment for many reasons, but research shows that the effects of treatment diminish over time, and stability of recovery is not reached for four or five years. Research also shows that post-treatment monitoring and support can improve outcomes for adults and adolescents, the length of service contact is the single best indicator of post-treatment addiction recovery, and that recovery-oriented systems of care can provide the support and assistance necessary to address many problems that lead people to relapse.

Currently, the Department of Behavioral Health and Developmental Services is evaluating options for increasing availability of recovery services and expanding the role of recovery oriented systems of care in

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the Commonwealth as part of its Creating Opportunities initiative. The work group recommends that the Joint Subcommittee support the work of the Department in this area. The work group also recommends:

- **The General Assembly should allocate funds to support development and expansion of recovery support services as part of an effort to establish recovery-oriented systems of care in the Commonwealth.** Funding should be allocated to and administered by the Department of Behavioral Health and Developmental Services in cooperation with an Autonomous Recovery Organization Advisory Council. The Department, together with the Advisory Council, should assess needs related to recovery support services in the Commonwealth with input from recovery support services organizations, issue Requests for Proposals, and provide grants to recovery support organizations to develop new services or expand existing services. Grants should include data collection and outcome reporting requirements. The primary goal of the Department and Advisory Council should be to support autonomous recovery organizations to fill gaps in the current system of treatment services, including providing reimbursement to autonomous recovery organizations for recovery services.
- **The General Assembly should consider providing funding to establish an Office of Recovery Services in the Department of Behavioral Health and Developmental Services to coordinate development of a recovery-oriented system of care in the Commonwealth.**

16. Medication-assisted treatment services should be available to all persons for whom they are clinically appropriate, and should always be provided in conjunction with necessary wrap-around and support services.

The General Assembly should take steps to ensure that medication-assisted treatment services and associated wrap-around services are available throughout the Commonwealth, including providing funding for services offered through community services boards. Funding for medication-assisted treatment services should include funding for purchase of medications as well as funding necessary to ensure access to necessary medical and nonmedical staff and to provide necessary wrap-around and support services for persons receiving medication-assisted treatment services.

- **The General Assembly should establish a pool of funds to support development of new medication-assisted therapy services offered by community services boards, and expansion of existing medication-assisted therapy services currently offered by community services boards.** Pool funds would be administered by the Department of Behavioral Health and Developmental Services. Community services boards wishing to establish new medication-assisted treatment services (including necessary wrap-around and support services) or expand existing services could apply for and receive funds. The General Assembly may want to consider requirements for outcome and other data reporting by community services boards receiving pool funds, to allow for improved planning and implementation of substance abuse treatment services generally and medication-assisted treatment services specifically.
- **The General Assembly should establish a pool of funds to support the provision of medication-assisted treatment services for persons reentering society from jails and prisons.** Pool funds would be administered by the Department of Behavioral Health and Developmental Services and allocated to community services boards wishing to develop new medication-assisted treatment services (and necessary wrap-around and support services) for persons reentering society from jails and prisons or to expand existing services. Recent research indicates that the provision of medication-assisted treatment services for persons reentering society from jails and prisons, where clinically appropriate, can reduce rates of resumed drug use and reincarceration. At least one community services board in the Commonwealth currently provides this service.

17. The General Assembly should take steps to increase public awareness of the dangers posed by alcoholic energy drinks, and to reduce the negative impacts of overconsumption of these drinks.

Alcoholic energy drinks are beverages that combine alcohol with caffeine and other stimulants (guarana, ginseng and others). Alcoholic energy drinks are classified and regulated as malt beverages, but generally contain substantially higher amounts of alcohol than beer (up to 12%). Many of these beverages also contain distilled spirits. Alcoholic energy drinks are sold premixed, or are created by mixing alcohol with packaged energy drinks (e.g. Red Bull and vodka). Combinations of alcohol and energy drinks are sold as mixed drinks in many bars and restaurants. Premixed alcoholic energy drinks are sold in the same places in which beer may be sold, and are often sold in large containers, ranging from 16 to 23.5 ounces, some containing the alcohol content of five or more servings of beer per container. Advertising of alcoholic energy drinks appears to target young people.

The effects of alcoholic energy drinks differ from those of alcohol alone. Stimulants contained in alcoholic energy drinks counteract the depressive effects of alcohol, reducing the subjective perception of the symptoms of alcohol intoxication and masking the effects of alcohol. As a result, individuals who consume these beverages do not feel the effects of intoxication or perceive that they are intoxicated, despite the fact that they are actually intoxicated. Studies of the effects of alcoholic energy drinks indicate that people who consume these beverages are more likely to engage in risky behavior. One study of consumption among college students found that students who drank alcoholic energy drinks were twice as likely to binge drink, more than twice as likely to be injured accidentally, and more than twice as likely to require medical treatment as students who drank other types of alcohol. The study also found that female students who consumed alcoholic energy drinks were nearly twice as likely as others to be sexually assaulted or taken advantage of, and that male students who drank alcoholic energy drinks were more than twice as likely to sexually assault or take advantage of someone. Another study of bar patrons in a college community in Florida found that patrons who consumed alcohol mixed with energy drinks were three times more likely to leave the bar highly intoxicated and four times more likely to drive after drinking compared with other patrons who consumed alcohol but did not consume alcohol mixed with energy drinks.

Recently, national news outlets have featured a number of stories about severe negative consequences of consumption of alcoholic energy drinks by college students, including an incident that occurred at Central Washington University in late October that resulted in nine students being rushed to the emergency room after what emergency responders initially thought was a mass drug overdose. Since that time, Michigan and Washington State have banned alcoholic energy drinks. Several other states are considering similar action.

To address the problems caused by alcoholic energy drinks, the work group recommends:

- The General Assembly should ban alcoholic energy drinks in the Commonwealth.
- If the General Assembly chooses not to ban alcoholic energy drinks in Virginia, the General Assembly should:
 1. Provide funding to the Governor's Office of Substance Abuse Prevention to conduct a public awareness campaign about alcoholic energy drinks, their effects, and the associated dangers.
 2. Provide additional funding to the Department of Alcoholic Beverage Control to conduct compliance checks on sales of alcoholic energy drinks.
 3. Consider re-classifying alcoholic energy drinks in a manner that would provide for sale of these beverages through package stores only.

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4. Increase the tax on alcoholic energy drinks to reduce consumption; funds received as a result of this tax should be allocated to substance abuse prevention and treatment services.
 5. Require warning labels on premixed alcoholic energy drinks sold in the Commonwealth (California considered legislation (AB 1598) that would have required labeling, but the bill failed to report from committee).
 6. Prohibit the mixing of alcohol and energy drinks in restaurants and other establishments that serve alcohol.
- 18. The Joint Subcommittee should draft a letter to Virginia's Congressional Delegation advising them of significant statutory, regulatory, and policy changes occurring at the federal level which can be expected to impact funding for substance abuse prevention and treatment services provided through the federal Substance Abuse Prevention and Treatment Block Grant, and advising them of the importance of maintaining funding for substance abuse prevention and treatment through the SAPT Block Grant, including dedicated funding for prevention services.**
- 19. The Joint Subcommittee should advise the members of Virginia's Congressional Delegation of the need to increase funding for substance abuse prevention, treatment, and recovery services provided through the Substance Abuse Prevention and Treatment Block Grant.**
- 20. The Joint Subcommittee should advise the members of Virginia's Congressional Delegation of the need to establish minimum funding levels to support the provision of recovery support services, that such funding should be included in the Substance Abuse Prevention and Treatment Block Grant, and that the Substance Abuse Prevention and Treatment Block Grant should include a requirement that such funding be used to provide recovery support services.**
- 21. The Joint Subcommittee should advise the members of Virginia's Congressional Delegation of the need to ensure that funding allocated to the state for substance abuse treatment services also includes funding for non-medically necessary support services.**
- Non-medically necessary support services include transportation, child care, housing support and other services that allow clients to access and utilize treatment or recovery support services effectively. The availability of this type of service can have significant impact on reducing or eliminating substance abuse.
- 22. The Joint Subcommittee should recommend that any study of the proposal to privatize the sale of liquor in the Commonwealth should include a focus on the public health impacts of privatization of liquor sales, and the impact that a loss of funding for substance abuse treatment services resulting from privatization of liquor sales might have on the Commonwealth.**
- 23. The Joint Subcommittee should pursue options for continuing its work after 2010.**

The SJR 73 Work Group recommends that the Joint Subcommittee should pursue options for continuing its work after 2010, including:

- Legislation establishing an independent legislative commission charged with ongoing study of substance abuse services in the Commonwealth and development of recommendations to reduce the fiscal and human costs of substance abuse to the Commonwealth.

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- Legislation amending the enabling legislation of the Joint Commission on Health Care to include a focus on substance abuse services.
- A resolution continuing the Joint Subcommittee for one additional year.

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