REPORT OF THE
JOINT SUBCOMMITTEE STUDYING

Mandated Substance Abuse Treatment Programs

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

Senate Document No. 28

COMMONWEALTH OF VIRGINIA
RICHMOND
1988

MEMBERS OF SUBCOMMITTEE

Benjamin J. Lambert, III, Chairman
Royston Jester, III, Vice-Chairman
Robert W. Ackerman
Dudley J. Emick, Jr.
Franklin P. Hall
Kevin G. Miller
A. Victor Thomas

STAFF

Legal and Research

E. Gayle Nowell, Research Associate
Susan C. Ward, Staff Attorney
Joyce Crone/Sherry M. Smith, Executive Secretaries

Administrative and Clerical

Office of the Clerk, Senate of Virginia

Report of the
Joint Subcommittee Studying
Mandated Substance Abuse Treatment Programs
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
January, 1988

To: Honorable Gerald L. Baliles, Governor of Virginia,
and
The General Assembly of Virginia

AUTHORITY FOR STUDY

The joint subcommittee was created pursuant to Senate Joint Resolution No. 171, agreed to by the 1987 Session of the General Assembly. The resolution directed the joint subcommittee to review legislatively mandated substance abuse programs, determine the need for coordination of rehabilitative and prevention services provided by various state agencies, determine the efficiency and effectiveness of the administration of substance abuse programs and services delivered by the community service boards, assess the delivery of substance abuse services in light of federal and state cutbacks, and recommend methods of maximizing the utilization of available funds and enhancing service delivery mechanisms (Appendix 1).

FINDINGS AND RECOMMENDATIONS OF THE JOINT SUBCOMMITTEE

- The joint subcommittee finds that the multitude and complexity of issues which have been identified during the course of the study make it difficult to envisage a simplistic solution which would be beneficial to the Commonwealth and to the consumers of substance abuse services. Consequently, the joint subcommittee recommends that the study be continued for an additional year in order to complete the review of programs and examine in depth several specific issues which demand further study, including the issue of insurance coverage and cost for such incurred by persons requiring treatment, examination of further amendment of the civil forfeiture statute for convicted drug dealers and trafficers and other law enforcement issues, alternative treatments for substance abusers, and review and make recommendations based on the interagency comprehensive plan developed by the Department (Appendix 2).

- The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to be required statutorily to report annually to the General Assembly on its activities in administering, planning and requesting substance abuse services (Appendix 3).

- That the DMHMRSAS shall be designated the lead agency, in cooperation with other affected state agencies, in the formulation of an Interagency Comprehensive Plan, reviewed by the Governor's Council on Alcohol and Drug Abuse Problems, which would describe current and projected state agency responsibilities, activities and resources. Recommendations offered by the Plan would be reviewed by the joint subcommittee.

- That the joint subcommittee endorses the development of a clinical research center through the joint effort of the DMHMRSAS and the Medical College of Virginia, Virginia Commonwealth University.

- That the joint subcommittee endorses the development by DMHMRSAS of a research coordinating council among existing public and private substance abuse programs throughout the Commonwealth to facilitate the implementation of research projects.

BACKGROUND

Definition

Substance abuse is the "continued use of alcohol and other mood-altering drugs, without medical reason, in the face of impairment that results in physical, mental, economic or social dysfunction. Substance abuse is characterized by two criteria in addition to dysfunction: (1) a pattern of use and (2) duration."[1]

Effects

The effects of substance abuse are multi-faceted. Obviously, substance abuse affects the user in terms of impact on health which ranges from various associated diseases to death from either accident, homocide or suicide. Even the process of ceasing to abuse substances, which results in withdrawal, can be life-treatening unless the abuser receives proper treatment.

Substance abuse affects not only the abuser but those around him or her as well. Economic security is threatened due to associated purchase, decreased productivity, and job loss. Family responsibility and relationships are also threatened. Family health is affected adversely not only from a psychological standpoint but from a physical aspect as well ranging from violent emotional outbursts to fetal alcohol syndrome, one of the three major causes of mental retardation. Heterosexual intravenous drug users are the second highest risk group for contracting AIDS (acquired immune deficiency syndrome). Rates of separation and divorce, spousal and child abuse are higher for families with a substance abuser.

Society as a whole can be directly affected by substance abusers and each citizen can be a victim. Thirty-seven percent of all accident victims have been using alcohol or other drugs, with deaths from alcohol-related traffic accidents making up twenty-four percent of total crashes; thirty-seven percent of all suicides and fifty-four percent of all homocides are substance abuse related; and, in 1985, thirty-eight percent of all arrests were related to substance abuse.[2]

History

Substance abuse is not new--non-medical substance abuse is thousands of years old. Colonial Virginia had an average per capita annual consumption of absolute alcohol (pure alcohol undiluted by fillers or mixers) estimated at six to seven gallons due to beliefs in alcohol as being soothing or medicinal as well as being a popular substitute for water. Current consumption is less than 2.5 gallons per capita. In 1762, Virginia imposed a penalty on land owners that did not grow marijuana, used primarily for rope manufacturing, but whose leaves were used medicinally and abused by the very rich and poor alike. In the 19th and early 20th centuries, "Mother Bailey's Quieting Syrup" and "Mrs. Winslow's Soothing Syrup" contained narcotics and were common panaceas for all ills. Cocaine was not removed from Coca-Cola until 1906 and narcotics were not considered controlled substances until 1914.[3]

Substance abuse is costly. Between 1981 and 1984, an annual average of 1,956 Virginians died as a direct or indirect result of substance abuse. The total cost is staggering as shown below:

Total Estimated Costs to Virginia
for Substance Abuse Problems, 1983[4]

All Treatment and Support	$ 417,924,000
Mortality	510,796,000
Reduced Productivity and Lost Employment	2,596,844,000
Other Related Costs	850,136,000
	$4,375,700,000

Organization

Public substance abuse programs are provided by community services boards by contract or directly. These boards (CSB's) are local governmental agencies responsible for mental health, mental retardation and substance abuse services and are composed of individuals appointed by the local governing board. They provide a multitude of services, including fiscal and programmatic accountability for public funds. State and federal funds are augmented by local funds and client and third-party fee payment for a substance abuse budget of $29.5 million in 1986. Direct treatment services are provided to approximately 50,000 clients annually but three times that number of persons have been identified as being in need of treatment.

Activities of CSB's fall into three categories for substance abuse services (SAS):

- prevention to eliminate or decrease the incidence of problematic behavior or illness includes education, training in resistance skills, and promotion of life skills;

- intervention is the identification and referral of substance abusers; and

- treatment which begins with a comprehensive assessment and diagnostic evaluation and culminates in a treatment plan based on individual situation and needs. Treatment is a continuation of services including detoxification for withdrawal, hospitalization, transitional living arrangements, counseling, self-help groups, employment services, recreation, and education.

The community-based system of services through community services boards began in 1968 and have grown to a total of forty boards. Enabling legislation, found in § 37.1-197 of Chapter 10 of Title 37.1 of the Code, outlines the powers and responsibilities of CSB's:

- Evaluate all services and facilities available in the community;
- Submit a program to the local governing board;
- Execute programs approved and for which monies have been appropriated;
- Enter into contracts for the provision of services;
- Make rules or regulations concerning the operation of services;
- Appoint a director, outline his duties and set compensation;
- Set a fee schedule and reimbursement schedule;
- Accept or refuse gifts, donations, etc.
- Seek and accept federal grants;
- Disburse funds;
- Apply for and accept loans; and
- Develop annual written agreements with other local agencies for what specific services will be provided to clients.

The funding allocation system of the department provides each community services board a target additional funding level. Each community services board then proposes uses for these new resources based on the results of local planning and needs assessments and departmental reviews. These proposals are submitted to the department as potential comprehensive plan input. The department provides specific guidance to each community services board in terms of priority populations and services. Each community services board submission is reviewed by departmental staff in conjunction with community services board staff; after mutual agreement on content it is added to the comprehensive plan.

After finalization of appropriations to the department, each community services board is notified of the pending award. Program applications and performance contracts are submitted by each community services board for departmental program and fiscal review. The program application (a budget or grant request) is submitted each year to obtain state and federal block grant funds. The application consists of a series of detailed line item revenue and expenditure budgets for programs or agencies the community services board proposes to support. The performance contract is a key element of the funding process. The department is moving toward replacing the program application with the performance contract as the sole funding and accountability document. Currently, eight (8) community services boards submit only the performance contract in a pilot of this change.

The performance contract stipulates the scope of services, numbers to be served, units of service delivered, costs, and revenues for directly operated and contractual programs. Additionally, the performance contract

contains general conditions that are based in the Code of Virginia and State Board policy. Each community services board may have other conditions attached that are based on previous reviews by departmental staff. Performance reports are submitted to the department on a quarterly basis, and report the units of services provided and the number of clients served. The fourth quarter report presents information on the actual units of service delivered, numbers of clients served, admissions, discharges, personnel and operating expenditures, and revenues received. This report also contains information on age, race, sex, and level of disability of clients served.

The Department of Mental Health, Mental Retardation and Substance Abuse Services has as its requirements under Title 37.1, Chapter 11, Code of Virginia the responsibility to:

- Recommend to the Governor and General Assembly legislations necessary to implement programs, services, and facilities and rehabilitation of substance abusers;

- Encourage and assist community services boards in the formation of locally based substance abuse prevention, education, crisis intervention, treatment, and rehabilitation programs;

- Provide for the treatment and rehabilitation of persons addicted to or involved in substance abuse;

- Contract to and/or establish hospital and clinic facilities necessary to care properly for persons involved in substance abuse;

- Provide technical assistance and consultation services to state and local agencies in planning, developing and implementing services for alcoholics and intoxicated persons;

- Prepare, publish, and disseminate educational material dealing with the nature and effects of alcohol;

- Organize and foster training programs for all persons engaged in treatment of alcoholics and intoxicated persons;

- Assist in the development of, and cooperate with, alcohol education and treatment programs for employees of state and local governments and businesses and industries in the Commonwealth;

- Utilize the support and assistance of interested persons, including recovered alcoholics, to encourage alcoholics voluntarily to undergo treatment;

- Establish standards for treatment facilities, inspections, and a listing of facilities.

The department has only situationally reviewed and commented on other state agency substance abuse services plans, grant applications on state and local levels, and requests for general fund appropriations. Also, the departments comprehensive plan does not present all substance abuse

services and ancillary services across all state agencies. The department has not been able to institute a formalized process to accomplish these tasks, given the scope of departmental activities and current staffing with respect to prevention and treatment service delivery through the community services board system.

In addition to the DMHMRSAS, a number of other agencies provide services to substance abusers:

- Department of Motor Vehicles: prevention services focused on drinking and driving, both through direct activities and by funding projects conducted by other state agencies.

- Department of Education: school-based prevention programming and the development (in conjunction with other state agencies) of a statewide plan to augment the prevention, education, and early intervention efforts of local school districts.

- Virginia State Police and the Department of Education: The Drug Abuse Resistance Education (DARE) project, which teaches fifth and sixth graders how to resist negative peer influences toward substance use.

- Attorney General of Virginia: a statewide initiative, the Commonwealth Alliance for Drug Rehabilitation and Education (CADRE), that involves the departments of Social Services, Education and Mental Health and Mental Retardation in enhancing local prevention, treatment, and law enforcement activities in the area of substance abuse.

- Department of Health: small grants for health promotion activities that include substance abuse prevention and a health congress that included substance abuse as a key issue.

- Department of Alcoholic Beverage Control: distribution of materials on the dangers of excessive and inappropriate alcohol use, including a focus on Fetal Alcohol Syndrome, and promotion of prevention activities on college and university campuses.

- Council of Higher Education: collaboration with the departments of Education, Alcoholic Beverage Control, Motor Vehicles, and Mental Health and Mental Retardation to enhance substance abuse education, prevention, and intervention services on campus.

- Department of Criminal Justice Services: funds for various state and local prevention efforts, like the DARE project, in addition to supporting public inebriate shelters.

Public groups such as the Governor's Council on Alcohol and Drug Abuse Problems, the Virginia Federation of Parents, PTA's and others have organized to address local substance abuse problems.[5]

The present Office of Substance Abuse Services, located in DMHMRSAS, was created in 1976 by HB 872 which abolished the Division of Drug Abuse

Control, the Bureau of Drug Rehabilitation and the Bureau of Alcohol Studies and Rehabilitation. The intent was to consolidate substance abuse programs in order to promote cost effective coordination of drug and alcohol abuse programming at the state level. This originally was set up in three sections: the community services section to facilitate the establishment of quality services; the technical assistance section for specific technical and administrative support services such as training and funding procedures; and, the program development section, responsible for methodologies of treatment, data collection and identification by target populations.

In the period 1979 to 1985, the Department reorganized with a reduction in staff for SAS occurring and community services made a priority. Many of the specialized functions such as training, fiscal, personnel were transferred to and applied generally to all disabilities but simply not counted specifically as SAS staff. Since the consolidation of all state agencies responsible for substance abuse programs which, altogether, numbered forty, there has been a decrease to seven staff positions.

Through the department and the localities financial support and numbers served have been doubled for substance abuse treatment and prevention. But, there are over 600,000 persons in Virginia identified as needing treatment and less than eight percent are being served.

The current Office of Substance Abuse Services, which focuses primarily on treatment services, has as its primary duties:

- monitoring of programs through certification, ongoing licensure, and community services board evaluation

- program technical assistance on planning, implementation and maintenance

- state-to-state social services block grant program management (residential services for alcoholics)

- facilitate "state-of-the-art" activities with various organizations including the Virginia Association of Drug and Alcohol Programs and the Virginia Association of Alcohol and Drug Abuse Counselors

- review of CSB input to the departmental comprehensive annual plan

- provide ongoing technical assistance on special programming:

  - employment services for substance abusers
  - services for the substance abusing mentally ill
  - drug services for the pregnant addict and as AIDS prevention
  - specialized services for women
  - specialized services for youth
  - detoxification services
  - methadone programming

The Office of Prevention, Promotion, and Library Services is an additional office within the department that has three major functions related to substance abuse, prevention, employee assistance, and information.

ISSUES RAISED BY PUBLIC COMMENTS

During the course of this study, many issues were raised by a multitude of varied interests. Representatives of groups from parents, private and public service providers, and interested individuals as well as state government provided input for the committee to enable them to receive an accurate overview of the system and various perceptions of problems within. All testimony presented orally or offered in writing was reviewed and the major issues raised and comments or suggestions offered were extracted for the summary. The summary consists entirely of this material without comment by the subcommittee or its staff. Major issues which were addressed include:

- Resources - Service capability is not seen to meet service need and although the number of clients receiving treatment has risen to 50,000, there are an estimated 600,000 Virginians identified as having a substance abuse problem. Unfortunately, all those identified as substance abusers are not actively seeking treatment, but the demand still far exceeds the supply. The Department is currently requesting an additional $18 million for substance abuse services but, although this will help to meet some of the current need, it will not do it all. On the national level, the cost of substance abuse is estimated to be $176 billion while the cost of mental illness is $73 billion. The question was raised concerning the relative proportion of money being spent for mental health and mental retardation in the Commonwealth as opposed to substance abuse services which receives only about five percent of the total budget (Appendix 4). The Department did point out that substance abuse services was equally aligned organizationally with other services in the department and that the division between mental health and substance abuse services is not easily defined. SAS clients receive treatment from various state facilities operated by the DMHMRSAS and approximately forty percent of these clients are "dual- diagnosed," that is, have a diagnosis of mental illness but also have a substance abuse problem as a secondary, contributing illness.

- Organization - The site of the current Office of Substance Abuse Services poses a possible problem. Although comments were generally favorable as to the quality and expertise of the current staff, seven positions was seen to be insufficient to adequately do the job that needs to be done. The office is currently adding or requesting several additional positions but the DMHMRSAS qualified the small staff by explaining that many support services previously done as an internal function, such as personnel and training, are now done on an agency-wide basis. The services are still being provided but not counted as staff particularly for the Office of Substance Abuse Services. Also, treatment services receive priority when the decision as to how dollars are to be spent are made.

A larger organizational issue was raised with the recommendation that the Office of Substance Abuse Services be made a free-standing agency accountable directly to the Governor. A number of states employ this form of organization.

• Interagency Cooperation - There are approximately fifteen state agencies which do some type of substance abuse service ranging from prevention and education to intensive medical treatment. There is no comprehensive state plan by which the activities of these agencies are described, information shared, and collaboration arranged. The Department of MHMRSAS has been designated by § 37.1-205 of the Code as the "sole state agency for the planning, coordination and evaluation of the state comprehensive plan or plans for substance abuse." This involves the statutory power "to formulate, in cooperation with federal, state, local and private agencies, a comprehensive state plan or plans for substance abuse, consistent with federal guidelines and regulations, for the long-range development of adequate and coordinated programs, services and facilities for research, prevention and control of substance abuse and for treatment and rehabilitation of substance abusers through the utilization of federal, state, local and private resources; to review such plan or plans annually and to make such revisions as may be necessary or desirable." This involvement must include collaborative action and the implementation of projects under the coordination of a state agency with the professional expertise to insure that the Commonwealth's approach is collaborative, coordinated and comprehensive. A comprehensive interagency substance abuse services plan, developed by the DMHMRSAS and reviewed by the Governor and the Governor's Council on Alcohol and Drug Abuse Problems, would make:

- A statement of the basic philosophy guiding substance abuse policy and services development in Virginia.

- A presentation of indicators, measures and data that describes the nature, scope and degree of the substance abuse problem in Virginia.

- A description, by state agency, of current state and local substance abuse service activities and resources.

- A description of interagency collaboration to implement and maintain a comprehensive continuum of substance abuse services.

- A presentation of strategies, action steps and resource requirements for future substance abuse service.

- Individual state agency policy statements which denotes the agency's response to substance abuse among its clientele, and the agency's intent to work within the Governor's comprehensive substance abuse services plan in the provision of either direct or ancillary services to substance abusers or those at risk.

- A description of respective state agency roles and responsibilities in implementation of the plan, supported by inclusion of interagency agreement.

• Research - Despite current advances in the field of substance abuse treatment, there is much to be learned about the identification of clients and matching him with the specific type of treatment which will benefit him most. There is also great need for training programs for professionals in the medical field to enable them to recognize symptoms of substance abuse and react appropriately. Funding by the DMHMRSAS is currently being provided to the Division of Substance Abuse Medicine at the Medical College of Virginia in support of treatment for the very complex substance abuse client, and the Division has gained a national reputation for the training of physicians and other health care providers in substance abuse services. Research into proper identification and application of treatment modes have been recognized as a vital component for providing adequate services. Federal funds are available to research units but require an established "track record." In order to do this, the DMHMRSAS is requesting an item in the biennium budget for such research to enable the Division to be in a position in two years to successfully compete for federal support.

• Community Services Boards - The basic structure of using community-based facilities was questioned by some but was generally found to be the most desirable method of delivering services. Persons who live and work within the communities are perceived to be inherently better able to identify problems and deal with clients in a way most beneficial to individual needs. Criticism of the system do not necessarily imply an abandonment but merely suggest that there is room for vast improvement. Critics suggest that: there is a lack of consistent and constant coordination between boards; critical stages of planning, such as needs assessment, service demands, funding, and setting of priorities are seen to be closed to the private provider who contracts to provide the services; the average citizen, appointed to serve on CSB's, does not always have the full background required to understand the various facets of the substance abuse problem; numerous for-profit organizations do not bid to provide services due to low levels of state reimbursement; CSB's are too independent and this causes a breakdown in consistent services; service capability does not meet service need; previous administrations closed down 240 substance abuse beds in state institutions with no community replacement; treatment centers are pitted against each other to compete for a decreasing number of real dollars; CSB's can provide a good mechanism for interagency cooperation but the coordinating mandate must be clearly spelled out by statute; and methods of treatment, although recognized as effective, can be rejected by individual CSB's.

• Insurance - Insurance coverage for substance abuse services is declining while the problem is growing, and many consumers soon find themselves "psychiatrically indigent". Presently eleven percent of total in-patient dollars is spent on in-patient substance abuse treatment while less tha one-half of one percent is spent on out-patient. Insurance providers are now placing many limitations on hours and types of services provided and there seems to be a lack of understanding, in deference to the "bottom line", that a variety of services is needed. Many substance abusers are admitted for other

secondary health problems because insurance companies are disallowing coverage for psychiatric treatment as "not medically necessary" and therefore the core problem is never addressed. Although drugs and alcohol in the workplace are of increasing concern to business, funding in the state has remained constant. Many businesses have reduced treatment benefits to cut costs or contracted with service providers who discourage access to such. This increases the number of persons seeking treatment through the CSB's and public programs. And out-patient treatment is not always the answer either, especially for highly susceptible adolescents, but residential care, even when available, is not always covered by insurance. There is also a lack of after-care program and halfway houses as well as residential treatment. Typical 28-30 day in-patient hospital confinement can free a kid from drugs initially, but most adolescents stay chemically free for only six weeks after discharge. There was some concern that substance abuse clients were not getting the same treatment in terms of long-term care such as that received by the mentally retarded. Representatives of insurance providers have expressed an interest in working with the subcommittee to investigate this issue in depth and reach a workable solution.

- Procurement - Local providers see the bid process for the provision of human services, not capital projects, to be self-defeating and not in the best interests of the client. It was requested that the subcommittee consider recommending that the provision of human services be exempted from the Procurement Act.

- Public Perception - Public demand and support for many programs is hinged on their beliefs about the cause and the needs. Unfortunately, many individuals still perceive drug and alcohol addiction to be a "disease of choice" and controllable only by human desire rather than a disease as others. There are no public rallies or outcry for substance abusers because it is a hidden disease and it has never been a popular issue. Education could go a long way in remedying this situation.

- Life skills training was suggested as a practical prevention/ treatment service. Most job or skills training is directed at older individuals and many federal training programs have been cut. Education as to how to deal with basic functions in life such as job training, getting a job, work ethic, etc., might do much to prevent substance abuse problems. Many substance abusers, unlike other clients under the DMHMRSAS do have job skills, but unemloyment due to substance abuse problems creates a virtual unbroken circle of problems. A number of studies support the value of vocational rehabilitation as a means of gaining employment and continued obstinence among substance abusers. The DMHMRSAS has initiated a small pilot program to involve a vocational rehabilitation counselor in the treatment process, but lack of resources has hampered the project. The Department has added an addendum to their budget request for the 1988-90 biennium of $480,000 for each year in order to develop a team approach with DRS to enhance employment for people with substance abuse problems who are enrolled in treatment programs.

• Law Enforcement Issues - Various issues from education to referral of youth who are identified or have contact with the law because of substance abuse to the state policy of confiscation of assets and how they might be used to work against drug pushers and trafficers were discussed by the subcommittee who agreed in principal that further investigation would be necessary.

• Counselor Certification - Alcoholism and drug abuse counselors are certified under the direction of the Department of Health Regulatory Boards. It has been recommended by the state's substance abuse professional organizations that (i) standards need to be developed to meet recognized national consortium standards; (ii) additional representation of certified substance abuse counselors on the Board of Professional Counselors is needed; and (iii) there is a need to promulgate new regulations for counselor certification in a timely manner.

• State Employee Assistance Services (SEAS) - Established in 1978, SEAS was a pilot program to demonstrate the extent and costs of alcohol and drug problems among the 80,000 employees of the Commonwealth, and to initiate a program to reduce such costs. The model used was the successful private sector employee assistance program (EAP) which had proven cost effective when fully implemented. SEAS initially employed one counselor and a secretary; from its beginning SEAS was used at an increasing rate, with alcohol problems being 40% of the problems presented. The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), after initial SEAS start-up, transferred control of the program to the Department of Personnel and Training (DPT). Since 1979, several requests by the Department and a resolution from the State MHMRSAS Board have been presented to DPT and the Governor's Office urging expansion of SEAS to all areas of Virginia. SEAS remains a "pilot program" with the original staff plus one part-time counselor. Two surveys ('79 and '86) by independent consultants urged expansion of SEAS to all employees, based on the State's need to save money and improve managerial efficiency and also in response to many agency heads asking for SEAS in their area. SEAS receives over 60 referrals per month and cannot adequately provide needed services. Supervisors from outside Richmond complain of lack of service; some bring employees to the office for assistance. Overloaded staff cannot provide the thorough assessment of problems or the ongoing follow-up after treatment that is necessary for lasting recovery. Over 3,000 cases of alcohol/drug problems are on record, the "tip of the iceberg" according to SEAS staff. Drug use is increasing; younger workers come to the State with more problems; and family, emotional, legal issues impair workers. Early intervention, referral and case management must be initiated in order to contain employee costs.

• Dedicated Tax on Alcohol - A "dedicated" tax on alcohol has been discussed for approximately twelve years. Funds currently from ABC profits to the localities are not a direct appropriation but are transfers of funds to reimburse the state general fund for alcohol-related treatment expenses and does not affect the amount of funds appropriated to the DMHMRSAS. Twenty-nine other states have some form

of dedicated funding, seventeen have dedicated taxes, eleven have fines and nine have fees. The advantages of a dedicated tax on alcohol are increased and secure funding which is symbolically linked while the disadvantages include unstable funding levels and the danger that other funding sources will be cut thereby keeping spending levels constant.

Tax would be based on absolute alcohol and a $0.50 dedicated tax per gallon of absolute alcohol would result in average price increases of 1 1/4¢ for a six pack of beer to 5 2/10¢ per quart of spirits and yield approximately $5 million per year. This would be an augmentation only to current service support.

PLAN FOR COMPLETION OF STUDY

Anticipating approval of the resolution which would extend this study an additional year, the joint subcommittee will continue to review organizational as well as treatment issues which have been identified during the past year. This will provide adequate time to examine some of the more complex issues, such as insurance coverage, in a more complete and thorough manner and to hopefully be able to address some of the problem areas in a more substantive fashion. The complexity of the issues and the need to provide adequate treatment services to the citizens of the Commonwealth deserved additional time and critique.

Respectfully submitted,

Benjamin J. Lambert, III, Chairman
Royston Jester, III, Vice-Chairman
Robert W. Ackerman
Dudley J. Emick, Jr.
Franklin P. Hall
Kevin G. Miller
A. Victor Thomas

Bibliography

Thacker, Wayne and Seward, Hope, "Substance Abuse in Virginia: Problems, Prevention and Treatment", Newsletter, Institute of Government, University of Virginia, Vol. 63, No. 10, June, 1987.

"Background Paper: The Department of Mental Health, Mental Retardation and Substance Abuse Services", presentation to the Joint Subcommittee Studying Mandated Substance Abuse Programs (SJR 171, 1987).

SENATE JOINT RESOLUTION NO. 171

Directing a joint subcommittee study of mandated substance abuse, treatment, and prevention programs.

Agreed to by the Senate, February 27, 1987
Agreed to by the House of Delegates, February 25, 1987

WHEREAS, alcohol and drug abuse have been cited as pervasive social problems in the nation and in the Commonwealth, seeping into every area of society; and

WHEREAS, in 1985, it was estimated that seventy-two percent of high school seniors in Virginia use alcohol, five and one-half percent use alcohol on a daily basis, and five percent use marijuana on a daily basis; and

WHEREAS, alcohol is the most widely used and abused drug in the nation and is a factor in at least ten percent of all deaths in the country; and

WHEREAS, alcohol abuse costs the nation an estimated $116 billion annually; and

WHEREAS, it is estimated that drug abuse costs the country nearly $100 billion annually in lost productivity and health expenses; and

WHEREAS, the invasion of cocaine and crack is contributing to an increase in the number of substance abusers in all age groups; and

WHEREAS, throughout the Commonwealth, the lure of financial gain and the growing social acceptability of the use of these substances ensnare more and more persons, result in devastated lives and destroyed relationships, and endanger the public safety; and

WHEREAS, in 1976, the Virginia General Assembly mandated that "the Department of Mental Health and Mental Retardation shall be responsible for the administration, planning and regulation of substance abuse services in the Commonwealth," and shall effectuate a comprehensive state plan regarding substance abuse, and provide certain substance abuse treatment, rehabilitation and prevention programs; and

WHEREAS, the General Assembly mandated an annual legislative review of the extent to which these duties have been performed for the purpose of aiding the Legislature in its oversight responsibilities; and

WHEREAS, such annual legislative reviews have not been undertaken, and recent federal and state allocations for the development of treatment and rehabilitative programs have suffered fiscal cutbacks, limiting the number of clients that can be served; and

WHEREAS, a thorough review of these programs and services in light of the growing number of substance abusers and increasing fiscal constraints would facilitate the planning and funding of appropriate and cost-effective programs; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Senate Committees on Education and Health, on Rehabilitation and Social Services, and on Finance, and the House Committees on Health, Welfare and Institutions and on Appropriations are directed to establish a joint subcommittee to study the implementation of legislative mandates concerning substance abuse, treatment and prevention programs.

The joint subcommittee shall be composed of seven members, one member each of the Senate Committees on Education and Health, on Rehabilitation and Social Services and on Finance to be appointed by the Senate Committee on Privileges and Elections; and two members each of the House Committees on Health, Welfare and Institutions and on Appropriations to be appointed by the Speaker of the House.

The joint subcommittee shall review the legislatively mandated substance abuse programs and services, determine the need for the coordination of rehabilitative and prevention services provided by various state agencies, determine the efficiency and effectiveness of the administration of substance abuse programs and services delivered by the community services boards, assess the delivery of substance abuse services in light of federal and state cutbacks, and recommend methods of maximizing the utilization of available funds and enhancing service delivery mechanisms.

The agencies of the Commonwealth shall provide assistance upon request. The joint subcommittee shall complete its study in time to submit its findings and recommendations to the Governor and to the 1988 Session of the General Assembly.

The indirect costs of this study are estimated to be $13,045; the direct costs of this study shall not exceed $6,300.

LD4013128

SENATE JOINT RESOLUTION NO. 65

Offered January 26, 1988

Continuing the Joint Subcommittee Studying Mandated Substance Abuse Treatment and Prevention Programs.

Patron -Lambert, Miller, K. G. and Emick; Delegates: Thomas, Ackerman and Hall

Referred to the Committee on Rules

WHEREAS, Senate Joint Resolution No. 171, agreed to by the 1987 Session of the General Assembly, created the Joint Subcommittee Studying Mandated Substance Abuse Treatment and Prevention Programs to study, among other issues, the implementation of legislative mandates concerning such programs and to review current administrative coordination of such programs and the efficiency and effectiveness of such; and

WHEREAS, the Joint Subcommittee has determined that further discussion and attention are needed in this area given the multitude and complexity of the issues involved; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Subcommittee Studying Mandated Substance Abuse Treatment and Prevention Programs be continued. The membership of the Subcommittee shall continue to serve, and any vacancies which occur shall be filled in the manner of the original appointments.

In addition to other considerations, the Joint Subcommittee shall consider, with the cooperation of other state agencies, providers and consumers, insurance coverage for substance abuse clients in the Commonwealth, given the increasing numbers of persons requiring such treatment and the cost of providing such coverage, and possible alternative treatments which have been developed for substance abusers.

Contingent on the implementation of a comprehensive interagency substance abuse plan currently being developed by the Department, the joint subcommittee shall also review the findings of such plan and make appropriate recommendations based on its findings.

The Joint Subcommittee shall complete its work and report its recommendations to the 1989 Session of the General Assembly.

The indirect costs of this study are estimated to be $13,045; the direct costs of this study shall not exceed $6300.

Official Use By Clerks	
Agreed to By The Senate	**Agreed to By The House of Delegates**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
Clerk of the Senate	Clerk of the House of Delegates

1988 SESSION

LD0218128

SENATE BILL NO. 277

Offered January 26, 1988

A BILL to amend the Code of Virginia by adding a section numbered 37.1-205.1, relating to substance abuse services.

Patrons–Lambert and Miller, K. G.; Delegates: Thomas, Ackerman and Hall

---

Referred to the Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 37.1-205.1 as follows:

§ 37.1-205.1. Department to report to General Assembly.–The Department shall report annually to the General Assembly on its activities in administering, planning and regulating substance abuse services and shall specifically state the extent to which the Department's duties as specified in this chapter have been performed.

Official Use By Clerks	
Passed By The Senate	**Passed By The House of Delegates**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
_____	_____
Clerk of the Senate	Clerk of the House of Delegates

Source: Department of Mental Health, Mental Retardation and Substance Abuse Services, FY88 (1 July, 1987 - 30 June, 1988) Working Budget, as of 31 July, 1987.

Mental Health Facilities	$168,800,000
Mental Retardation Facilities	133,200,000
Total For All Facilities	$302,014,680
Total For All Community Services	94,220,951
Central Office	20,106,301
TOTAL DEPARTMENT BUDGET FY88	$416,141,932

Community Services State Controlled Appropriations:

Total For All Community Services	$ 94,220,951
Administration	4,749,066
Mental Health	43,471,336
Mental Retardation	23,605,854
Substance Abuse	22,436,224

Percentage of Community Services State Controlled Appropriations:

Total For All Community Services ---------- 100%

Administration ---------- 5%

Mental Health ---------- 46%

Mental Retardation ---------- 25%

Substance Abuse ---------- 24%

The Department's 88-90 budget request for additional community substance abuse service development and expansion:

Community Services	$ 18,000,000
Southwest Virginia Services*	1,400,000
Employment Services	480,000
TOTAL	$ 19,880,000

*In support of community services required as Southwestern State Hospital evolves into an Institute; includes $306,000 for a specialized acute stabilization and diagnostic unit at Catawba Hospital.