SUBSTANCE ABUSE SERVICES COUNCIL

ANNUAL REPORT
2012-2013

to the Governor and

the

General Assembly

COMMONWEALTH OF VIRGINIA

January 10, 2014

COMMONWEALTH of VIRGINIA

William H. Williams, Jr.
Chair

Substance Abuse Services Council
P.O. Box 1797
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January 10, 2014

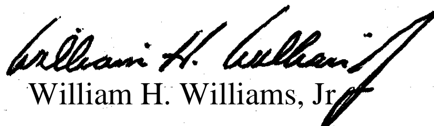
To: The Honorable Robert F. McDonnell
and

Members, Virginia General Assembly

In accordance with §2.2-2696 of the *Code of Virginia*, I am pleased to present the 2012-2013 Annual Report of the Substance Abuse Services Council. The *Code* charges the Council with recommending policies and goals relating to substance abuse and dependence and with coordinating efforts to control substance abuse. It also requires the council to make an annual report on its activities. The membership of the council includes representatives of state agencies, delegates, senators and representatives of provider and advocacy organizations appointed by the Governor.

On behalf of the council, I appreciate the opportunity to provide you with our annual report detailing the Council's study of several critical issues. We hope it will contribute to improving the lives of the many Virginians affected by substance use disorders.

Sincerely,


William H. Williams, Jr.

cc: The Honorable William A. Hazel, Jr., M.D.
The Honorable Bryan Rhode
The Honorable Javaid Siddiqi

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OF THE SUBSTANCE ABUSE SERVICES COUNCIL
TO THE GOVERNOR AND THE 2014 GENERAL ASSEMBLY
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Executive Summary

ANNUAL REPORT
OF THE SUBSTANCE ABUSE SERVICES COUNCIL
TO THE GOVERNOR AND THE GENERAL ASSEMBLY
2012-2013

Introduction

The Substance Abuse Services Council is established in the *Code of Virginia* [§2.2-2696] to advise the Governor, the General Assembly and the Board of the Department of Behavioral Health and Developmental Services (DBHDS) in matters pertaining to substance abuse. Its members are representatives of state agencies, senators, delegates and representatives of provider agencies and advocacy organizations who are appointed by the Governor. The *Code* requires DBHDS to provide staff and funding to support the operation of the council. The council met its requirement to meet four times each year. Notices of meetings, minutes and the membership are posted on the council's website at www.dbhds.virginia.gov.SASC/default.htm. The council did not file a report last year; therefore, this document summarizes the council's activities for 2012 and 2013.

Extent of the Substance Abuse Problem in Virginia

The extent of the substance abuse problem in Virginia has been documented by several sources. The National Household Survey on Drug Use and Health (NSDUH) indicates that, in the year prior to the surveys on which the estimates are based (2008-2010), 23.7 percent of Virginians age 12 and older participated in an episode of binge drinking, and that nearly 5 percent used pain relievers for a nonmedical use. More than 7 percent needed but did not receive treatment for alcohol use and 2.45 percent needed, but did not receive, treatment for illicit drug use. Data from the Virginia Department of Health's Office of the Chief Medical Examiner (OCME) indicate that the number of deaths caused by drugs increased 45.3 percent between 2003 and 2011, with 61.7 percent due to prescription drugs in 2011.

Enacted Legislation Related to Substance Abuse

Although many bills were introduced that related to substance abuse in the 2012 and 2013 sessions, the following enacted bills were the most relevant to the work of the council.

- House Bill 1291 (2012) transferred responsibility for the administration of the Governor's Office for Substance Abuse Prevention from the Secretary of Public Safety to the Department of Alcoholic Beverage Control, where it was renamed the Virginia Office for Substance Abuse Prevention .
- House Bill 507 (2012) addressed several issues related to prenatal exposure to illegal drugs or alcohol. It extends the time (from seven days to six weeks) that an infant can be determined to be substance exposed, increases the time that a child can be diagnosed with fetal alcohol spectrum disorder to anytime after birth, and allows a petition to be filed at anytime alleging child abuse or neglect related to substance-exposed infants.
- House Bill 1672 (2013) designates DBHDS, with support from the Virginia Department of Health (VDH) and the Department of Health Professions (DHP), as the lead agency with

responsibility for developing a pilot program to use naloxone to prevent opioid overdoses (via nasal administration). The statute allows prescribers to prescribe naloxone to lay rescuers for use with individuals not known to the prescriber. DBHDS must report on the results of the pilot to the General Assembly by December 1, 2014.

- The General Assembly approved an act that permits funding for the Virginia Foundation for Healthy Youth (VFHY) to be held in escrow, pending resolution of a dispute with tobacco manufacturers participating in the Master Settlement Agreement. This allows the foundation to retain about $500,000, with the rest of the funds (about $4 million) redirected to cancer research and the General Fund.
- House Bill 1941 expands the list of prohibited chemicals to address the surge in synthetic marijuana and "bath salts."
- The 2013 Appropriation Act permits localities to establish drug courts without the review of the General Assembly, as long as no state funds are requested, the application is approved by the Drug Treatment Court Advisory Committee, and the court meets certain other standards established in the language of the act.

Major Presentations

Critical Issues Related to Tobacco Use in Virginia

The council heard several presentations concerning tobacco use and dependence, treatment resources, and monitoring of sales to minors. Staff from the Institute for Drug and Alcohol Studies at Virginia Commonwealth University presented research conducted on community services board staff attitudes about treating tobacco use among individuals in treatment for mental illness or substance use disorders. The study found that the more highly trained the behavioral health professional, the more likely he was to provide treatment for tobacco use to individuals already receiving services. Very few staff are providing services, however.

Staff from the Alliance for the Prevention and Treatment of Nicotine Addiction provided information about resources available to help individuals stop tobacco use. Demonstrated compliance with laws prohibiting sales of tobacco products to minors is a requirement of the federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG). The noncompliance rate for 2012 was about 13 percent, well within the allowed range of 20 percent. Failure to adequately demonstrate compliance could cost the state as much as $16 million. Staff from the Department of Alcoholic Beverage Control (ABC) and DBHDS discussed the two agencies' collaborative efforts to monitor retail sales of tobacco to minors, the penalties to the retail staff, and the potential costs to the state.

High Intensity Drug Trafficking Area (HIDTA) Program

HIDTA is a federal initiative that coordinates federal, state, and local efforts to reduce drug trafficking. Virginia has three designated HIDTA areas: northern Virginia (included in metropolitan Washington, D.C. HIDTA), metropolitan Richmond, and the far southwestern part of the state that is included in the Appalachian HIDTA. Staff who oversee the metropolitan Washington, D.C. and Richmond area HIDTAs provided information on the program's activities, which involves 18 agencies sharing information. The major focus is on trafficking heroin, cocaine (including "crack"), prescription narcotics, PCP, and marijuana. Outcome measures include the wholesale value of drugs seized, amount and number of cash seizures, numbers of

fugitives apprehended, and numbers of leads referred to other HIDTAs and other law enforcement agencies. Some of the intelligence strategies involve tracking gang members, learning the organizational networks of the gangs involved in drug trafficking, and tracking social networks of the gang members. The project also utilizes mapping technology. The information collected from many different sources by the participating law enforcement agencies is analyzed by a special unit of HIDTA that houses and shares the information. HIDTA also helps local law enforcement agencies coordinate logistics and targeted activities, such as surveillance and execution of search and seizure warrants with maximum public safety and security in mind.

In addition, these two HIDTA regions are unique in that they also fund treatment initiatives, both in the community and in jails and prisons, as well as drug courts. They also fund two prevention initiatives.

National Governors Association Policy Academy to Reduce Prescription Drug Abuse

In the fall of 2012, Virginia was competitively selected to participate, with seven other states, in the National Governors Association (NGA) Policy Academy to Reduce Prescription Drug Abuse. This was the first policy academy on this topic sponsored by the NGA. Led by the Director of the Department of Health Professions, Virginia's team included the Secretary of Health and Human Resources, the Secretary of Public Safety; the Superintendent of Virginia State Police, and the Commissioner of DBHDS. The team participated in two national meetings and hosted a statewide meeting where a draft plan was shared with the public. The plan was the result of intensive work by four subcommittees that included a variety of stakeholders from other state agencies, local agencies, industry professionals, community advocates, and legislators. The four subcommittees, which focused on specific strategies, were: Monitoring, Training and Education, Enforcement, and Drug Disposal. Although the framework of the NGA policy academy did not include a specific emphasis on improved access to addiction treatment services, the Virginia NGA policy team believed that this strategy is an important component in addressing abuse of prescription drugs, and included a recommendation that the issue be specifically addressed as an interagency initiative, to be led by DBHDS.

The Department of Corrections' Virginia Adult Re-Entry Initiative (VARI)

As a result of the creation of the Virginia Prisoner and Juvenile Offender Re-Entry Council, established under Executive Order 11, the Department of Corrections (DOC) has instituted a significant focus on programs within correctional institutions and during the transition period from institution to the community for offenders in its custody. Staff from DOC shared how the department had responded to this challenge through the Virginia Adult Re-Entry Initiative (VARI). Ninety percent of offenders in custody eventually return to the community and DOC releases 11,000 offenders each year. To reduce the recidivism rate, DOC is focusing its resources on providing services that corrections research has demonstrated can effectively assist the offender in learning how to successfully live in the community. As a result, DOC has moved from the sixth best to the second best recidivism rate in the nation. These programs include intensive cognitive behavioral therapies specifically designed for this correctional population, as well as a focus on intensive substance abuse treatment services, using therapeutic models based on research, as 70 percent of offenders have a need for substance abuse treatment.

Prior to release, offenders are moved into correctional facilities closer to their home communities where they participate in these programs. Implementing these services has required extensive re-training of correctional staff, as well as the addition of new roles. Some of these new roles include: probation officers who specialize in serving as a liaison between the correctional institution and the community, forming partnerships with employers, helping to locate housing, and locating services that the offender will need once they return to the community. Implementing this program in a relatively short period of time presented a number of challenges to DOC, and the initiative remains somewhat hampered by the need for additional resources.

Patient Protection and Affordable Care Act (PPACA)

Staff from the State Associations of Addiction Services (SAAS) presented implications of the Patient Protection and Affordable Care Act (PPACA) for providers of substance abuse treatment. Virginia was one of six states competitively selected to receive technical assistance in this area from SAAS.

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OF THE SUBSTANCE ABUSE SERVICES COUNCIL
TO THE GOVERNOR AND THE 2014 GENERAL ASSEMBLY
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INTRODUCTION

The Substance Abuse Services Council is established in the *Code* of Virginia [§2.2-2696] to advise the Governor, the General Assembly and the Board of the Department of Behavioral Health and Developmental Services (DBHDS) on matters pertaining to substance abuse in the commonwealth. As required, the council met four times during 2012 (March 27, May 10, July 5 and August 30) and four times during 2013 (April 24, May 29, July 10 and September 4). All meetings were conducted in the metropolitan Richmond area. Meeting notices and approved minutes are posted on the council's website at www.dbhds.virginia.gov.SASC/default.htm.

No report was issued for 2012, therefore, the contents of this report cover the activities of the council in both 2012 and 2013. This document includes a very brief discussion of the epidemiology of substance abuse in the commonwealth. Also included is a brief discussion of legislative activities related to substance abuse. During this period, council members requested in-depth presentations on a number of critical topics related to providing services for people with substance use disorders. The council heard presentations on the following: critical issues related to tobacco use in Virginia, particularly among youth; the High Intensity Drug Trafficking Area (HIDTA) program, a federally-sponsored initiative to coordinate drug control efforts among multiple enforcement agencies; Virginia's participation in the National Governor's Association (NGA) Policy Academy to Reduce Prescription Drug Abuse; the Department of Corrections' Virginia (DOC) Adult Re-Entry Initiative; (VARI); and implementation of the Patient Protection and Affordable Care Act (PPACA) as it relates to prevention and treatment services for substance use disorders.

EXTENT OF THE SUBSTANCE ABUSE PROBLEM IN VIRGINIA

Numerous documents, both national and Virginia-specific, have enumerated and described the substance abuse issues in Virginia, both epidemiologically and from the perspective of impact on the commonwealth. Data from the National Survey on Drug Use and Health (NSDUH) covering 2008-2010, conducted by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), indicate that 1,889,941 (23.21%) Virginians age 12 and older have participated in an episode of binge drinking (consuming at least five drinks on one occasion), 376,648 (4.6%) used pain relievers for a nonmedical use, and 774,383 (9.46%) met clinical criteria for either dependence or abuse of illicit drugs or alcohol. Regarding unmet need for treatment, 542,533 (6.42%) Virginians age 12 years old or older needed, but did not receive, treatment for alcohol use, and 175,452 (2.18%) Virginians needed, but did not receive, treatment for illicit drug use in the past year.

The Virginia Department of Health's (VDH) Office of the Chief Medical Examiner's (OCME) Annual Report provides information about mortality related to substance use, including the misuse of prescription pain medication. The number of deaths caused by drugs increased 45.3%

between 2003 and 2011, from 563 in 2003 to 818 in 2011, with 61.7% due to prescription drugs in 2011. Overall, the rate of death from this cause (9.6 per 100,000) exceeds that from motor vehicle crashes (9.4 per 100,000). In some Virginia communities, mortality rates from deaths related to certain narcotic pain drugs exceed 40 per 100,000.

ENACTED LEGISLATION RELATED TO SUBSTANCE ABUSE

Each year council members are briefed on legislation related to substance abuse that is considered by the General Assembly. While many bills were introduced that related to substance abuse, the following were the most significant bills enacted during the 2012 and 2013 sessions of the General Assembly.

During the 2012 Session of the General Assembly, House Bill 1291 was enacted, transferring the responsibility for the administration of the Governor's Office for Substance Abuse Prevention (GOSAP) from the Secretary of Public Safety to the Virginia Department of Alcoholic Beverage Control (ABC) Board, where it was renamed the Virginia Office of Substance Abuse Prevention GOSAP had previously been named as an entity represented on the council, but its shift to ABC, an agency already represented on the council, removed the office from council membership.

House Bill 507 was also enacted, which provides additional time (from seven days to six weeks) for health care providers to identify that an infant is a substance exposed infant, and increases the period of time to identify that a child has fetal alcohol spectrum disorder to any time after birth. The bill also permits a petition to be filed at any time alleging suspected child abuse or neglect based on a finding that an infant is substance exposed.

During the 2013 session of the General Assembly, House Bill 1672 was enacted. This bill allows trained lay-rescuers to prevent overdose from opioids, such as heroin or prescription pain medication, by administering naloxone to individuals who are overdosing. The bill provides them with immunity from civil damages. The bill allows prescribers to write a prescription for a friend or family member of a person at risk for overdose (unknown to the prescriber) . It requires DBHDS to work with VDH, the Department of Health Professions (DHP), law enforcement agencies, addiction recovery support organizations, and other stakeholders to implement the legislation as a pilot program and to report on the pilot by December 1, 2014.

Also, the General Assembly approved redirecting funding for the Virginia Foundation for Healthy Youth (VFHY) to be held in an escrow account pending resolution of a dispute with tobacco manufacturers participating in the Master Settlement Agreement. The General Assembly's action will allow VFHY to retain about $500,000, with the other funding of about $4 million being redirected to cancer research and the state's General Fund.

The General Assembly also passed House Bill 1941, expanding the list of prohibited chemicals, to address the surge of synthetic cannabinoids, as well as the ever changing variety of chemicals used to manufacture "bath salts."

The Appropriation Act for FY 2013 and 2014 included language that allows localities to establish drug courts without legislative approval as long as all of the following conditions are

met: (1) no state funds are requested; (2) the application meets the standards of the Supreme Court of Virginia Drug Treatment Court Advisory Committee; (3) the offenders involved in the program have been assessed using a validated assessment tool; and (4) the court does not limit participation to first-time substance abuse offenders and does not exclude probation violators.

REPORT ON COUNCIL ACTIVITIES

The council heard presentations concerning a number of national and state initiatives related to substance abuse. The following provides highlights from these presentations.

Critical Issues Related to Tobacco Use in Virginia

Mr. Henry Harper, Director of Community Outreach and Development for VFHY, moderated a panel discussion on critical issues related to tobacco use in Virginia. Panel members included:

- J. Randy Koch, Ph.D., Executive Director, Institute for Drug and Alcohol Studies, Associate Professor, Epidemiology and Community Health, Virginia Commonwealth University
- Janis M. Dauer, M.S., CAC, Executive Director, Alliance for the Prevention and Treatment of Nicotine Addiction
- Joseph L. Cannon, Special Agent in Charge, Training and Support Services, ABC
- Marissa O. Harris, U.S. Food and Drug Administration (FDA) Tobacco Program Coordinator, ABC
- Sterling G. Deal, Ph.D., Manager, Evaluation and Data Support, Office of Substance Abuse Services, DBHDS

Dr. Koch presented the results of a research study he directed, "Behavioral Healthcare Staff Attitudes and Practices Regarding Consumer Tobacco Use." [1] The study focused on smoking and other types of tobacco use, and was based on findings from previous studies that indicate:

1) High prevalence of tobacco use among persons with mental health and substance use disorders;
2) Evidence that treating nicotine dependence does not negatively affect treatment of mental health and other substance use disorders and may, in fact, improve outcomes;
3) Little attention to tobacco use by providers and funders of behavioral healthcare services; and
4) Lost opportunity since behavioral healthcare clinicians have the foundational skills to screen, assess, and treat nicotine dependence.

The goal of this study was to assess the attitudes, practices and training needs of public behavioral healthcare staff regarding client tobacco use. The study collected information from practitioners working at community services boards (CSBs). The researchers reviewed the behavioral healthcare records of youth in treatment and then assessed adolescent tobacco

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[1] Koch, J. Randy, Virginia Commonwealth University Institute for Drug and Alcohol Studies; Breland, Alison; Irons, Jessica, Virginia Commonwealth University Institute for Drug and Alcohol Studies; Irons, Jessica, James Madison University; Munn, Meaghan, Virginia Commonwealth University. Acknowledgments to: Virginia Foundation for Healthy Youth; Virginia Partnership for Tobacco Cessation; Dauer, Janis M., Virginia Department of Behavioral Health and Developmental Services; Alliance for the Prevention and Treatment of Nicotine Addiction.

consumers who were receiving behavioral healthcare services. The study also collected information about behavioral healthcare staff attitudes and practices regarding client tobacco use. Staff from 38 of the 40 CSBs responded. A total of 5,709 invitations were extended to individual staff with 2,260 responding for a 39.6 % response rate.

The study found that:

- Staff who provided substance abuse treatment services were more likely to use tobacco cessation practices in their treatment than staff who provided mental health services.
- Licensed or certified staff were more likely to use tobacco cessation practices in their treatment than staff with less training.
- Of the types of positions held among those surveyed, division/program directors were more likely to use tobacco cessation practices than staff at lower levels in the organization.
- There was no measurable difference based on respondents' current tobacco use status or age group served.

Only a small percentage of staff surveyed report regularly providing any one of several tobacco cessation services, with the most common practice being to provide an initial screening of tobacco use. The study should a need to better disseminate information on effective strategies to address tobacco cessation. While nearly all of the respondents expressed confidence in their ability to screen for tobacco use, a relatively small percentage felt confident in their ability to provide counseling or medication information to their consumers.

Barriers to providing tobacco cessation were lack of education and training. Funding did not appear to be a barrier.

The panel followed up with a discussion of resources, policies and practices. Janis M. Dauer shared that Medicaid reimbursement is available to support tobacco cessation, including coverage for medication. VDH also sponsors a “quit-line” that is available by phone.

Marisa O. Harris provided an overview of the Center for Tobacco Products and the Family Smoking Prevention and Tobacco Control Act, which grants the FDA the authority to regulate tobacco products.

Joseph L. Cannon gave an overview of ABC’s history of enforcing laws related to retail sales of tobacco, which began in 1997 when the General Assembly designated ABC as the agency that would enforce underage tobacco laws. In 1998, the ABC started working with the FDA.

Dr. Sterling G. Deal explained how the state’s activities related to enforcing law that prohibits the sale of tobacco to minors began with the federal Synar Amendment to the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) Reauthorization Act, which authorizes the Substance Abuse Prevention and Treatment Block Grant that provides over $40 million to support community-based prevention and treatment efforts in Virginia. The amendment requires states to have laws prohibiting the sale of tobacco products to minors and to conduct compliance checks of a scientific sample of retail outlets to assure that no more than 20 percent sell tobacco to minors. Failure to comply can result in a loss of up to 40 percent of the federal award (about

$16 million). Virginia's noncompliance rate for 2012 was about 13 percent, well below the allowed rate of 20 percent.

High Intensity Drug Trafficking Area (HIDTA) Program

Thomas Carr, the Executive Director of the Washington/ Baltimore HIDTA, and other members of the HIDTA Executive Team presented information to the council about some of the federally coordinated efforts occurring in Virginia.

HIDTA is a federally-sponsored initiative that coordinates enforcement resources related to illegal drug use in specially designated areas. HIDTA's function is to enhance and coordinate drug control efforts among federal, state, local, and tribal law enforcement agencies. The mission of HIDTA is to disrupt the market for illegal drugs in the United States by assisting the entities participating in the HIDTA program in dismantling and disrupting drug trafficking organizations, especially those with operations that affect the United States. HIDTA works to facilitate cooperation, enhance intelligence capacity, share information and intelligence, and maximize resources by coordinating strategies among law enforcement agencies in the designated HIDTA areas. Virginia participates in three designated HIDTA programs: metropolitan Washington, D.C., metropolitan Richmond, and Appalachia. The team that presented to the council works with the first two programs. The current primary drug threats are heroin, crack, cocaine, prescription narcotics, PCP, and marijuana.

HIDTA has eight law enforcement initiatives operating in Virginia. Six of the co-located initiatives are in Annandale and two are in Richmond. Performance measure initiatives include: wholesale value of drugs removed from the marketplace, amount and value of cash seizures, number of fugitives apprehended, and number of leads referred to other HIDTAs and other agencies.

The council learned details of two other critical aspects of HIDTA's operations. First, intelligence gathering that includes the organizational structure of drug trafficking organizations, gang intelligence system, and social network research on these organizations. The Investigative Support Center has five focus units: case support, investigative intelligence, watch, gang, and crime mapping. There are currently 18 agencies sharing data. The Investigative Support Center assists law enforcement agencies in analyzing the data and developing reports to support the work of the various agencies. Second, information technology including data hosting and sharing by HIDTA helps local law enforcement coordinate logistics and targeted activities such as surveillance, buy/bust activities, and the execution of search and seizure warrants while maintaining maximum public safety.

HIDTA is also sponsoring four community-based treatment initiatives, two jail/prison-based programs, four drug courts, and two prevention initiatives.

National Governors Association Policy Academy to Reduce Prescription Drug Abuse

Ralph Orr, the Director of the Prescription Monitoring Program at the DHP, provided a presentation on the state's participation in the National Governors Association's first policy

conference on reducing prescription drug abuse. Led by the Director of the Department of Health Professions, Virginia was selected with seven other states in a competitive process to form a team that would address several aspects of this problem. Virginia's team included the Secretary of Health and Human Resources, the Secretary of Public Safety, the Virginia State Police Superintendent, and the Commissioner of DBHDS. The team was assisted by other state agency staff, members of the General Assembly, and representatives of the public. Virginia's team attended the first of two national meetings hosted by the NGA in Montgomery Alabama, where experts provided information and the teams focused on identifying goals, objectives and strategies.

The major goal of Virginia's plan is to promote the appropriate use of controlled substances for legitimate medical purposes and reduce/prevent the misuse, abuse, and diversion of these substances. Based on this input, Virginia's team formed four workgroups that focused on four major strategies: Monitoring, Training and Education, Enforcement, and Disposal. In March, the team hosted a public meeting, facilitated by staff from NGA, and each workgroup shared its plan and received public input. The workgroups took this information and integrated it into their final strategies. The team attended the second national meeting in Denver, Colorado, where each participating state presented its plan and received comments and questions from other states. In May, the final plan was presented to the Governor for consideration.

While the final plan had not been released by the Governor's Office at the time of this document's publication, some highlights of the plan can be shared. The Monitoring workgroup made recommendations which include: using health information technology to improve identification of misuse of prescription drugs either by the patient or due to poor prescribing practices, integrating prescriber registration for the Prescription Monitoring Program with license renewal for eligible health professionals to encourage broader use of the program, developing data sets that could be used to share information more efficiently, and developing more training about using the Prescription Monitoring Program.

The Training and Education workgroup recommended establishing a web-based resource center where a variety of types of information could reside, improving training for health professionals about pain management and addiction, continuing education for prescribers about addiction and pain management, disseminating tools to help prescribers identify patients who may either potentially or already have a problem with prescription pain medication, developing more community resources to engage the community in addressing the issue of abuse of prescription pain medication, providing information about best practices for prescribing and dispensing prescription pain medication, and developing urine drug screening guidelines for prescribers.

The Enforcement workgroup recommended expanding access to the information that is collected by the Prescription Monitoring Program concerning prescribing and dispensing, allowing drug courts to have access to information collected by the Prescription Monitoring Program, allowing reports to third parties with the patient's authorization, extending the statute of limitations to allow for more time to investigate crimes related to falsifying patient records, and code amendments to permit improved communication between wholesale pharmacy distributors and state agencies charged with oversight of pharmacy operations, currently vested with the Board of Pharmacy and the Virginia State Police.

The Drug Disposal workgroup recommended increasing the number of drug “take-back” events, providing continuous access to safe and legal drug disposal through strategically placed drug collection boxes, and developing programs to allow individuals to mail in unwanted controlled medications. Additionally, the team recommended that the Governor identify a task force chaired by the secretaries of Public Safety and Health and Human Resources that would oversee implementation of the strategies and identify gaps in the treatment system, an area which did not receive very much attention in the NGA framework. The Virginia NGA policy team believed that establishing a task force to focus on the issue of abuse of prescription pain medication is an important component in addressing abuse of prescription drugs, and included a recommendation that the issue of gaps in the treatment system be specifically addressed as an interagency initiative, to be led by DBHDS.

The Department of Corrections' Virginia Adult Re-Entry Initiative (VARI)

Jean Mottley, Ph.D., Administrator of Programs and Case Management Services, and C. Dudley Bush, III, M.S., Administrator for Cognitive and Re-Entry Services, presented on the DOC's VARI plan. Their presentation reflected the evolving changes taking place within DOC that are focused on enhancing public safety by providing effective programs, reentry services, and supervision. Effective re-entry policies improve public safety, reduce victimization, improve outcomes for offenders returning to their communities, and favorably impact recidivism. Dr. Mottley described the steps that preceded the creation of VARI, discussed the VARI plan, described the challenges in implementing the model, and described the Cognitive Community Re-Entry Model in detail. She pointed out the importance of reentry efforts and noted how the mission and goals of VARI are consistent with DOC's overall mission.

VARI was created in 2010 when Governor McDonnell signed Executive Order Number 11 establishing the Virginia Prisoner and Juvenile Offender Re-Entry Council and tasked the members with developing collaborative re-entry strategies. The mission of VARI is to promote public safety and reduce crime by preparing offenders for success through a continuum of services and supervision, in collaboration with state and local partners, from the time of the offender's entry into prison all the way through his or her transition and integration in the community. This initiative is a four-year strategic plan.

Prior to the creation of VARI in 2010, some efforts were already underway at DOC, including a risk/needs assessment instrument, evidence-based practice pilot sites, a new offender management system, and the Cognitive Community model. The National Institute of Corrections' Transition from Prison to Community (TPC) model served as a model for the VARI plan. The re-entry effort is important because 90 percent of the offenders in Virginia will return to their homes and the DOC releases over 11,000 offenders a year. Effective re-entry policies can improve public safety, reduce victimization, improve outcomes for offenders returning to their communities, and favorably impact recidivism. In 2010, Virginia was tied for the sixth best recidivism rate. Virginia is now second best in the nation with a 23.4 percent recidivism rate, with only Oklahoma having a lower rate. Dr. Mottley emphasized that the re-entry process starts the day the offender comes into contact with the DOC.

An integral focus of DOC's efforts is use of Intensive Re-Entry Programs. Within these programs, DOC employs a treatment model called the Cognitive Community. The Cognitive Community includes the full integration of cognitive programming within an intensive residential setting similar to a Therapeutic Community model. In the Cognitive Community model, the primary goal is to change the negative patterns of thinking, feeling, and behaving that predispose crime, drug use, and other antisocial behaviors. Programming provided within the Cognitive Community model includes two evidence-based practices appropriate for the population and the incarcerated setting: Thinking for a Change and the Matrix Model. Thinking for a Change is one of the most widely used cognitive behavioral programs in correctional settings and the Matrix Model is an intensive substance abuse treatment program supported through a Residential Substance Abuse Treatment grant from the U.S. Bureau of Justice Assistance.

Mr. Bush reviewed the origins of the Cognitive Community model, its primary goals and philosophy, and essential elements of the model. The core of this approach is that the offender community itself is the agent of change. He described how the model is implemented and how re-entry is managed in different security levels.

The first Cognitive Community was created at the Southampton Women's Pre-Release Center in 2004. The recommitment rate of completers versus inmates who received no treatment increased over a three year period, demonstrating the efficacy of the model. Six months later, the model was introduced as a six-month intensive re-entry program at Powhatan Correctional Center, a male facility. Based on the successes of the male and female model Cognitive Community Program outcomes, the DOC and the Governor elected to expand the re-entry model to all offenders releasing from the medium security facilities who were within 12months of release. Eleven sites were originally selected across Virginia as Intensive Re-entry Programs. Within the last 12-14 months of incarceration, an offender will be moved to one of the 11 reentry sites as close as possible to his or her home.

A few of the challenges to implementation of the Cognitive Community model included short timeframes for implementation, constant staff turnover, maintaining faithfulness to the model, and staff burnout. Some lessons learned included the importance of establishing a theoretical framework that is evidence-based, the need to establish pilot programs, the value of consolidating multiple programs at different sites into a single, streamlined program, the need to anticipate aggressive timelines when developing implementation plans, and the importance of being inclusive.

To specifically address substance abuse among inmates, the Matrix Model, an evidence-based substance abuse treatment practice, is available for offenders in the Intensive Reentry sites whose background demonstrate significant substance abuse as measured by COMPAS, a risk needs instrument used in correctional settings. Offenders who score within the medium range for substance abuse are offered the opportunity to participate in the Matrix program, which is facilitated by fourteen substance abuse counselors. The DOC has taken an innovative approach by providing training to correctional officers so that they can become treatment officers. In addition to performing security duties, the officers lead treatment groups and are fully involved in the unit. Additionally, to help with the re-entry transition once the inmate is ready to go home,

Senior Re-Entry Probation Officers act as liaisons between the institution and the communities. Partnerships are created with the community by bringing in employers, holding job fairs, hosting community speakers, providing resources, and supporting family reunification events and reentry training events for faith-based organizations.

In summary, Dr. Mottley noted that DOC continues to face a number of issues related to providing substance abuse services, specifically:

- Limited resources for clinical supervision to ensure program fidelity, provide technical assistance, and enhance outcomes.
- Limited staff resources for programming, as well as assessment and data collection activities.
- Limited availability of evidence-based treatment services in Community Corrections for offenders with substance abuse problems.
- Limited special resources for offenders with co-occurring mental disorders.
- Limited evaluation resources.
- Sometimes a lack of optimal programming space in prisons.

Council members discussed these challenges, recognizing that an increase in resources would increase the number of offenders who could be provided with treatment, as well as enhance the quality of the programs to provide better outcomes.

Patient Protection and Affordable Care Act (PPACA)

To become better informed about upcoming changes in health care policies, particularly concerning coverage of treatment for substance use disorders, the council invited Mr. Enzo Pastore, the Director of Health Policy of the State Associations of Addiction Services (SAAS), to discuss the impact of the PPACA on the substance abuse treatment system and community prevention services. SAAS membership consists of 43 state associations across the country, representing over 7,000 providers of addiction and behavioral health services. SAAS functions as an information broker and an advocate to link state association members with reliable information on national policy. The mission of SAAS is to ensure available and accessible behavioral health and substance abuse treatment, to offer prevention programs, and to provide related educational services.

SAAS developed an initiative, "Moving the Field Forward," to help providers of substance abuse treatment services prepare for implementation of PPACA. Six states, including Virginia, were selected from among a competitive field to receive targeted, intensive technical assistance, guidance, and resources. The goals of the project are to help the selected states by:

- Ensuring that addiction and behavioral health services receive attention and focus regarding implementation of PPACA;
- Providing training, technical assistance, guidance, and resources for advocacy, outreach, education, and tools to monitor legislation and regulations;
- Identifying potential partners in primary care to facilitate integration with behavioral health as an aspect of healthcare reform implementation;

- Developing policy recommendations to ensure that current and future regulations support the intent of PPCACA - to make health care accessible to everyone who needs it;
- Developing a state-specific advocacy tool kit; and
- Partnering with other provider organizations offering substance abuse services in the states.

Implementation of the PPACA would have the following results:
- More people would have insurance coverage;
- Medicaid would play larger role in treatment for mental illness and substance use disorders;
- Primary care and coordination with specialty care would be a major focus; and
- Treatment would focus on community-based services, away from institutional care.

The identification of service needs, delivery of behavioral health services, drivers of access, provider issues, integration, and next steps in health care reform were also addressed. There was discussion about the impact of health care reform on adults ages 18-64 who have serious mental illness, serious psychological distress, or substance use disorders. These diagnoses comprise about 6 percent of the current Medicaid population. The association estimates that by 2014, if the state were to expand Medicaid, this percentage could increase to 20.8 percent. In the health insurance exchange, the association projects the proportion to reach 23.0 percent for Virginia.

Essential health benefits (EHBs) are a core component of PPACA. Each state would design its own benefits within the required ten categories of benefits. Nationally, these ten categories, which include mental health and substance abuse treatment services, would pay for treatment for 25 million Americans with untreated mental health, substance abuse, and co-occurring disorders. These EHBs would need to be consistent with the Mental Health Parity and Addiction Equity Act. States would make decisions on co-pays and limitations, if any, on services.

APPENDICES

§ 2.2-2696. Substance Abuse Services Council.

A. The Substance Abuse Services Council (the Council) is established as an advisory council, within the meaning of § 2.2-2100, in the executive branch of state government. The purpose of the Council is to advise and make recommendations to the Governor, the General Assembly, and the State Board of Behavioral Health and Developmental Services on broad policies and goals and on the coordination of the Commonwealth's public and private efforts to control substance abuse, as defined in § 37.2-100.

B. The Council shall consist of 30 members. Four members of the House of Delegates shall be appointed by the Speaker of the House of Delegates, in accordance with the principles of proportional representation contained in the Rules of the House of Delegates, and two members of the Senate shall be appointed by the Senate Committee on Rules. The Governor shall appoint one member representing the Virginia Sheriffs' Association, one member representing the Virginia Drug Courts Association, one member representing the Substance Abuse Certification Alliance of Virginia, two members representing the Virginia Association of Community Services Boards, and two members representing statewide consumer and advocacy organizations. The Council shall also include the Commissioner of Behavioral Health and Developmental Services; the Commissioner of Health; the Commissioner of the Department of Motor Vehicles; the Superintendent of Public Instruction; the Directors of the Departments of Juvenile Justice, Corrections, Criminal Justice Services, Medical Assistance Services, and Social Services; the Chief Operating Officer of the Department of Alcoholic Beverage Control; the Executive Director of the Governor's Office for Substance Abuse Prevention or his designee; the Executive Director of the Virginia Foundation for Healthy Youth or his designee; the Executive Director of the Commission on the Virginia Alcohol Safety Action Program or his designee; and the chairs or their designees of the Virginia Association of Drug and Alcohol Programs, the Virginia Association of Alcoholism and Drug Abuse Counselors, and the Substance Abuse Council and the Prevention Task Force of the Virginia Association of Community Services Boards.

C. Appointments of legislative members and heads of agencies or representatives of organizations shall be for terms consistent with their terms of office. Beginning July 1, 2011, the Governor's appointments of the seven nonlegislative citizen members shall be staggered as follows: two members for a term of one year, three members for a term of two years, and two members for a term of three years. Thereafter, appointments of nonlegislative members shall be for terms of three years, except an appointment to fill a vacancy, which shall be for the unexpired term. The Governor shall appoint a chairman from among the members for a two-year term. No member shall be eligible to serve more than two consecutive terms as chairman.

No person shall be eligible to serve more than two successive terms, provided that a person appointed to fill a vacancy may serve two full successive terms.

D. The Council shall meet at least four times annually and more often if deemed necessary or advisable by the chairman.

E. Members of the Council shall receive no compensation for their services but shall be reimbursed for all reasonable and necessary expenses incurred in the performance of their duties

as provided in §§ 2.2-2813 and 2.2-2825. Funding for the cost of expenses shall be provided by the Department of Behavioral Health and Developmental Services.

F. The duties of the Council shall be:

1. To recommend policies and goals to the Governor, the General Assembly, and the State Board of Behavioral Health and Developmental Services;

2. To coordinate agency programs and activities, to prevent duplication of functions, and to combine all agency plans into a comprehensive interagency state plan for substance abuse services;

3. To review and comment on annual state agency budget requests regarding substance abuse and on all applications for state or federal funds or services to be used in substance abuse programs;

4. To define responsibilities among state agencies for various programs for persons with substance abuse and to encourage cooperation among agencies; and

5. To make investigations, issue annual reports to the Governor and the General Assembly, and make recommendations relevant to substance abuse upon the request of the Governor.

G. Staff assistance shall be provided to the Council by the Office of Substance Abuse Services of the Department of Behavioral Health and Developmental Services.

(1976, c. 767, § 37.1-207; 1977, c. 18; 1978, c. 171; 1979, c. 678; 1980, c. 582; 1984, c. 589; 1990, cc. 1, 288, 317; 1998, c. 724; 1999, c. 614; 2005, cc. 713, 716; 2009, cc. 424, 554, 813, 840; 2011, cc. 691, 714.)

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