REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

Policy Solutions to the Commonwealth's Fentanyl Crisis (HJR 41, 2024)

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 6

COMMONWEALTH OF VIRGINIA
RICHMOND
2025

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Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care. For the purposes of this chapter, "health care" shall include behavioral health care.

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Policy Solutions to the Commonwealth's Fentanyl Crisis

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Policy Solutions to the Commonwealth's Fentanyl Crisis

POLICY OPTIONS IN BRIEF

Option: Designate VDH as the lead agency for comprehensive opioid response in the Commonwealth. (Option 1, page 24)

Option: Appropriate funds to optimally fund VDH's opioid antagonist distribution program. (Option 2, page 27)

Option: Direct VDH to develop a methodology for estimating future costs of the opioid antagonist distribution program. (Option 3, page 28)

Option: Remove requirement for VDH to purchase eight milligram naloxone nasal spray. (Option 4, page 29)

Option: Require health insurers to cover prescription and over-the-counter opioid antagonists at no cost to patients. (Option 5, page 30)

Option: Amend regulations to clarify initiation of medications for opioid use disorder when psychosocial counseling is refused or unavailable. (Option 6, page 33)

FINDINGS IN BRIEF

Illicit fentanyl is highly addictive, readily available, and deadly

Pharmaceutical fentanyl produces a more intense high, relative to other opioids, creating an increased potential for misuse and dependence. As prescription opioids became harder to obtain, illicit manufactured fentanyl increased in availability. Illicit fentanyl is manufactured in clandestine labs and distributed through illegal drug markets. It is a profitable narcotic as it is highly potent, cheaply made, and easily transported. Inconsistent manufacturing methods, however, result in various levels of fentanyl potency that are difficult to discern and therefore increase the risk of overdose death.

The impact of illicit fentanyl has changed over time in Virginia

Illicit fentanyl represents the third wave of opioid overdose deaths in Virginia, beginning in 2013 and rapidly increasing until 2021. In recent years, rates stabilized and then fell precipitously between 2023 and 2024. Multiple factors contribute to the change in illicit fentanyl deaths, including lack of education on the risks of fentanyl, limited availability of appropriate harm reduction strategies, and the COVID-19 pandemic. Data indicates that males, Black or African American individuals, and individuals between the ages of 35 and 44 experienced the highest rates of overdose deaths from fentanyl.

Virginia is successfully implementing evidence-based strategies to address illicit fentanyl use

Staff identified 53 state-funded or state-administered strategies across 18 agencies that address surveillance, prevention, intervention, treatment and recovery efforts. Stakeholders expressed concerns about the continuity of focus on preventing overdoses, the likelihood of sustained state funding, and the lack of information on the effectiveness of efforts that were rapidly implemented. Designating a lead agency in the Commonwealth for comprehensive opioid response may assist with sustainability.

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Option: Direct VDH and VADOC to develop guidelines for hiring peer recovery specialists with lived experience.
(Option 7, page 36)

Option: Appropriate $1.5M to establish three additional Project LINK programs at CSBs to treat pregnant women who use substances.
(Option 8, page 39)

Option: Direct VDH to develop and implement a plan to expand workforce incentive programs to medical staff in local and regional jails.
(Option 9, page 42)

Option: Appropriate funds to expand the Jail Mental Health Pilot Program to additional sites.
(Option 10, page 43)

Option: Sunset the model addiction recovery program and appropriate funds to expand the Virginia Opioid Use Reduction and Jail-Based Substance Use Disorder Treatment and Transition Program to additional sites.
(Option 11, page 45)

Virginia can take additional steps to enhance ongoing efforts

Virginia programs, legislation, and funding have increased the availability of opioid antagonists. VDH requires continued state funding to distribute naloxone for free or at cost to eligible organizations. Costs to patients for opioid antagonists are also a barrier. The state has made efforts to increase access to medications for opioid use disorder, but counseling co-requirements may prevent providers from initiating treatment. The expansion of peer recovery services is limited by misinformed hiring practices for positions that benefit from lived experience.

Gaps exist in efforts to address illicit fentanyl use for certain high-needs populations

Pregnant and parenting women who use fentanyl face unique barriers and need specialized supports. Funding to establish Project LINK sites could expand access to services for this population. The need for substance use services is significantly higher in incarcerated populations than in the general population. Recruiting and retaining health care staff to serve the incarcerated population is difficult, but workforce incentive programs may help. In addition, state investments in treatment and transition services for incarcerated individuals need additional flexibility to encourage expansion.

September 2025

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Policy Solutions to the Commonwealth's Fentanyl Crisis

In November of 2016, the Virginia State Health Commissioner declared the opioid addiction crisis a public health emergency, referencing an expected 25 percent increase in drug overdose deaths from the previous year and the identification of carfentanil, an extremely potent fentanyl analogue, for the first time in Virginia. The death rate from fentanyl in 2016 was 7.7 individuals per 100,000 population. In the wake of the emergency declaration, Virginia applied public health resources toward addressing the fentanyl crisis, but with the onset of the coronavirus (COVID-19) pandemic, most resources had to be redirected. Five years after the Commissioner's declaration, in 2021, the fentanyl overdose death rate peaked at 23.9 individuals per 100,000 population, three times the rate in 2016. In those five years, a total of 6,413 Virginians lost their lives to fentanyl.

Virginia has implemented multiple evidence-based strategies to prevent fentanyl overdose deaths and increase access to opioid use disorder treatment. Death rates from fentanyl overdoses have also decreased, with a 45 percent decline between 2023 and 2024[i]. However, fentanyl overdose death rates still far exceed death rates from most other types of illicit drugs and death rates from 2016, when the opioid epidemic was first declared a public health emergency. To better understand trends in overdoses and strategies to prevent them, the General Assembly passed House Joint Resolution 41 (2024) (APPENDIX 1), directing the Joint Commission on Health Care (JCHC) to:

- study the causes of the rise in fentanyl prevalence and fentanyl overdoses in the Commonwealth,
- study the impact of the rise in fentanyl prevalence and fentanyl overdoses in the Commonwealth on Virginians and the Commonwealth's health care system,
- study and provide insight into the fentanyl crisis within the context of other drug crises and addiction trends in recent history, and
- establish and make policy recommendations related to reducing the prevalence of fentanyl in the Commonwealth and reducing the number of fentanyl overdoses in the Commonwealth.

This study examines progress to date and remaining challenges nearly 10 years since Virginia declared the opioid addiction crisis as a public health emergency by (i) describing trends in fentanyl use, misuse, overdoses, and deaths in Virginia over time and by

[i] 2024 data on overdose deaths are provisional until November 2025. Data are as of August 2025.

populations most impacted; (ii) identifying evidence-based prevention, intervention, and treatment strategies to address fentanyl misuse and illicit use and which strategies are being implemented in Virginia; (iii) determining gaps or unmet needs in prevention, intervention, and treatment strategies in Virginia; and (iv) recommending policy options through which the state may reduce fentanyl misuse and illicit use in Virginia. JCHC staff maintained a central focus on the fentanyl epidemic throughout this study, as directed, but recognize that the challenges Virginia faces to addressing drug overdoses are not unique to a single substance. However, a comprehensive review of Virginia's substance use and mental health services was beyond the scope of this study.

Illicit fentanyl is highly addictive, readily available, and deadly

Pharmaceutical fentanyl is 100 times more potent than morphine and well suited to its use as a fast-acting analgesic and anesthetic for surgery and severe pain management. Fentanyl is also relatively easy and inexpensive to make, a benefit for its marketing as a therapeutic drug, but a weakness that contributed to illicit production. Illicit manufacturing can result in the development of fentanyl analogs – drugs with a slightly different chemical structure – that can be just as dangerous, or even more dangerous, than fentanyl itself. While this study refers to fentanyl in the singular form, JCHC staff acknowledge that the development and chemical composition of fentanyl-like drugs are constantly shifting, resulting in a multitude of closely related fentanyl analogs contributing to overdose deaths.

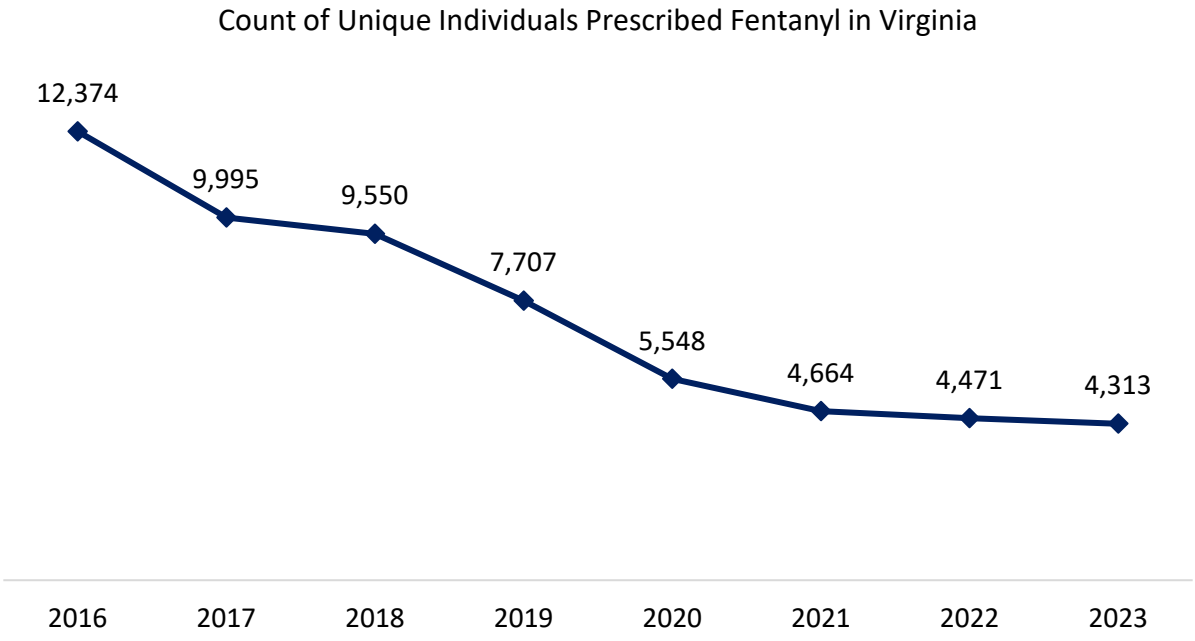
Pharmaceutical fentanyl is an efficient, effective analgesic and anesthetic

The history of fentanyl as a therapeutic drug begins in 1960, when Janssen Pharmaceutica created N-(1-phenethyl-4-piperidyl) propionanilide – shortened to fentanyl – by changing the properties of the organic compounds of the morphine molecule. Like other opioids, fentanyl travels through blood, attaches to receptors in the brain, and blocks pain messages from the body, blunting pain perception. Unlike its predecessors, fentanyl works faster and leaves the body more quickly, making it well suited for many human and veterinary applications. Pharmaceutical fentanyl can be formulated for various routes of administration depending on its intended use. Intravenous or intramuscular fentanyl is used in health care facilities before, during, or after surgery as an anesthetic or analgesic. Transdermal patches, lozenges, or intranasal spray can be prescribed for home use, typically for break through pain among cancer patients.

Scheduling of fentanyl. While pharmaceutical fentanyl is a Schedule II controlled substance under the federal Controlled Substances Act, since 2018 the federal DEA has implemented a temporary class-wide scheduling of illicitly manufactured fentanyl-related substances as Schedule I because of their high abuse potential and lack of accepted medical use. In 2025, with passage of the federal Halt All Lethal Trafficking of Fentanyl Act or the HALT Fentanyl Act, this temporary scheduling was made permanent.

Pharmaceutical fentanyl is classified by the Drug Enforcement Administration (DEA) as a Schedule II drug (SIDEBAR), reflecting its accepted medical use but also its high potential for misuse and dependence. Fentanyl produces a more intense high, relative to other opioids, and coupled with a shorter duration of action, can motivate individuals to repeatedly use fentanyl at higher doses as their bodies become more tolerant to the effects of the drug. High doses of fentanyl can cause respiratory distress and death. Continued use also leads to dependence or opioid use disorder. Growing concerns about misuse and increased risk of death from prescription opioids, including fentanyl, led to a focus on improving opioid prescribing practices and since 2016, the number of individuals prescribed pharmaceutical fentanyl has decreased 65 percent, from 12,374 individuals in 2016 to 4,313 individuals in 2023, the most current year of data available (FIGURE 1).

FIGURE 1. Number of individuals prescribed fentanyl decreased since 2016



SOURCE: JCHC staff analysis of pharmacy claims data from Virginia's All Payer Claims Data, 2025.

Illicitly manufactured fentanyl is made in clandestine labs and distributed through illegal drug markets

As prescription opioids became more difficult to obtain, illicitly manufactured fentanyl increased in availability to meet demand. The rise in fentanyl overdose deaths from 2013 through 2021 is attributed primarily to illicitly manufactured fentanyl. From an economic perspective, illicitly manufactured fentanyl is a profitable narcotic as it is highly potent, cheaply made, and easily transported. One kilogram of illicitly manufactured fentanyl costs

around $200 to produce compared to $6,000 to produce one kilogram of heroin. Lesser amounts of fentanyl are also necessary to elicit the same high as other street drugs. In some cases, fentanyl may be mixed with other drugs, making them more affordable for drug users while also leading to high profit margins for sellers. Fentanyl or its precursors can be easily concealed and transported in smaller packages that are more likely to escape detection.

The appealing economic benefits of illicit fentanyl result in clandestine, makeshift labs that use inconsistent manufacturing methods, resulting in various levels of potency that are nearly impossible for drug users to discern and increase the risk of overdose and death. Powdered fentanyl can be mixed in various concentrations within counterfeit pills purchased on the internet. Fentanyl can also be mixed with heroin, crack/cocaine, or other street drugs and smoked or injected, creating an extreme risk of unintentional fentanyl consumption. At an urban hospital emergency department (ED), one study of patients with a drug use history found a high rate of fentanyl exposure (81 percent) despite the majority of patients reporting preferential use of heroin. In a post-mortem study of overdose deaths, fentanyl was present in 69 percent of deaths in which cocaine was also detected and 77 percent of deaths in which methamphetamine was also detected.

Illicit manufacturing also results in the development of fentanyl analogs that have a slightly different chemical structure. Pharmaceutical carfentanil, for example, was initially developed to sedate very large animals and is 100 times more potent than fentanyl (FIGURE 2). By the late 2010s, illicitly manufactured carfentanil was blamed for rapidly increasing opioid overdose deaths in the United States.

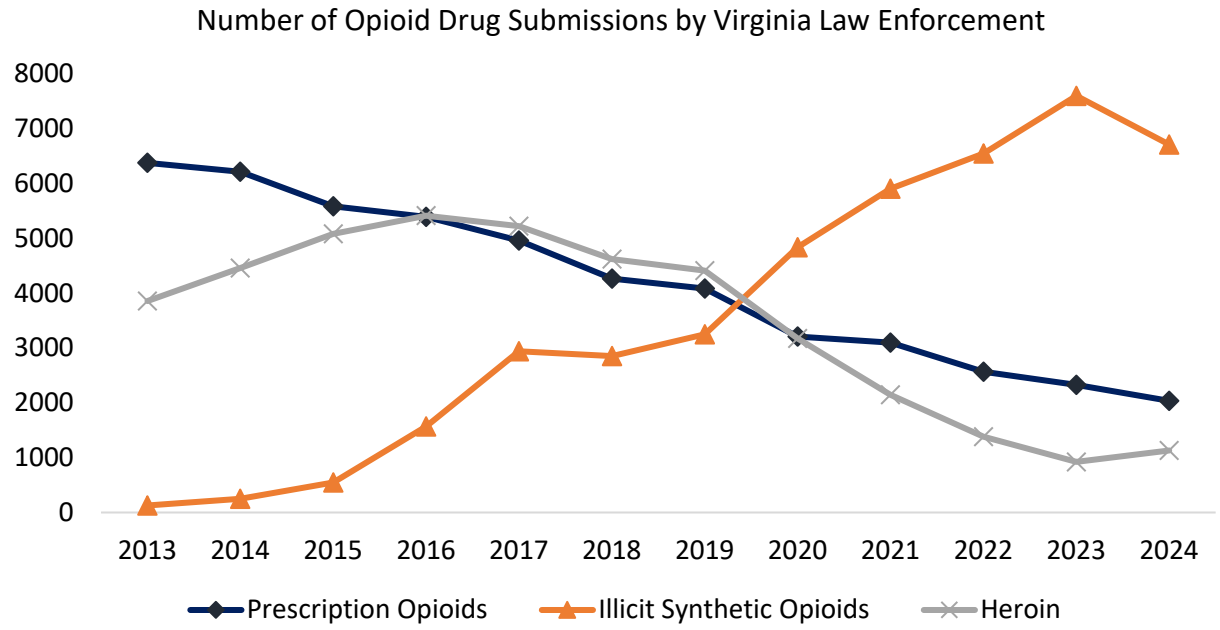
FIGURE 2. Carfentanil is 100 times more potent than fentanyl

SOURCE: National Institute of Drug Abuse, 2025.

Drugs seized by Virginia law enforcement agencies are submitted to the Virginia Department of Forensic Services (DFS) for confirmatory analysis and testing. In addition to supporting criminal proceedings, aggregate results can elucidate the types of drugs

circulating in Virginia communities and how the level of availability has changed over time. Illicit synthetic opioid submissions, including fentanyl, have increased steadily nearly every year in Virginia since 2013, with a decrease in submissions in 2024 (FIGURE 3). Of the illicit synthetic opioid submissions, 91 percent tested positive for fentanyl and eight percent tested positive for a fentanyl analogue. In contrast, prescription opioid submissions and heroin submissions decreased steadily over the same time period.

FIGURE 3. Illicit synthetic opioids submissions increased; prescription opioids and heroin decreased



SOURCE: JCHC staff analysis of Department of Forensic Science data, 2025.

Impact of illicit fentanyl in Virginia has changed over time

Virginia collects, monitors, and publishes comprehensive data on the opioid epidemic, permitting insight into important state-level trends as well as trends within geographic areas and key population groups.

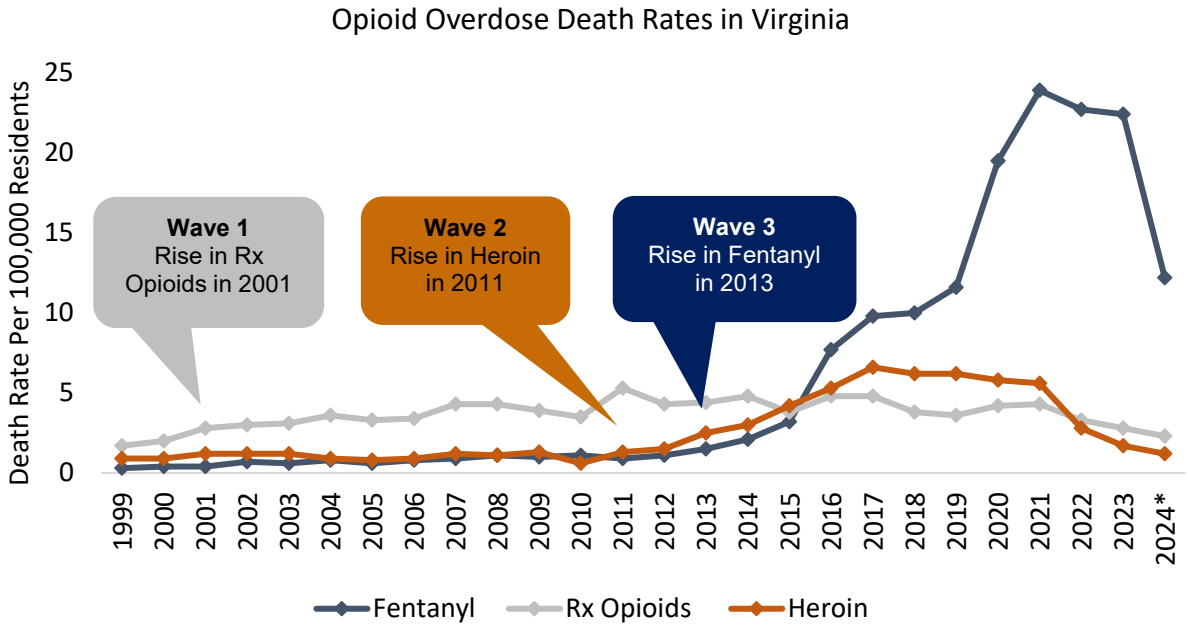
Fentanyl represents the third wave of opioid overdose deaths in Virginia

Most sources, including the Centers for Disease Control and Prevention, recognize three distinct waves of opioid overdose deaths in the United States. The first wave began in the early 2000's when overprescribing practices led to a rise in prescription opioid overdose deaths. As the risks of opioids became more well-known and states took action to limit access to the drugs, prescription opioids became harder for individuals to obtain and many individuals turned to heroin, giving rise to the second wave of overdose deaths beginning in

2011. The third wave of opioid overdose deaths began in 2013 with broader availability and use of illicitly manufactured fentanyl.

Consistent with national trends, Virgina also experienced three waves of opioid overdose deaths (FIGURE 4). Deaths from fentanyl overdoses in Virginia eclipsed deaths from prescription opioids in 2016 and continued to rapidly increase through 2021. An initial response to this rise, prior to the COVID-19 pandemic, created some stabilization in the death rates between 2017 and 2019; however, once the COVID-19 pandemic arrived in Virginia, the number of fentanyl overdose deaths increased sharply once again. In recent years, rates stabilized, then fell precipitously from 2023 to 2024.[ii]

FIGURE 4. Virginia's three waves of opioid overdose deaths

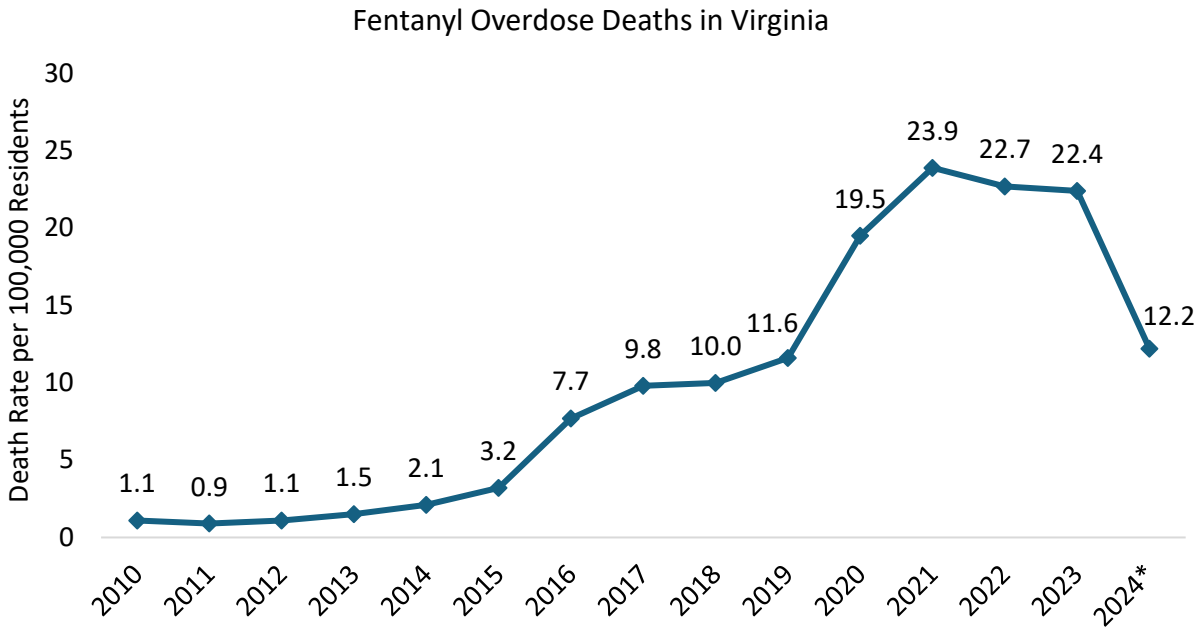


*2024 data are not final until November 2025 and subject to change.
SOURCE: JCHC staff analysis of Centers for Disease Control and Prevention, National Vital Statistics System, Mortality 1999-2020 and 2018-2024 on CDC WONDER Online Database.

At the highest point in 2021, 23.9 deaths per 100,000 residents in Virginia were due to a fentanyl overdose. The latest data from 2024, which are considered provisional until November 2025, indicate a decline to 12.2 out of every 100,000 Virginian residents dying of a fentanyl overdose (FIGURE 5).

[ii] 2024 data are provisional until November 2025. Data are as of August 2025.

FIGURE 5. Rates of fentanyl overdose deaths since 2010



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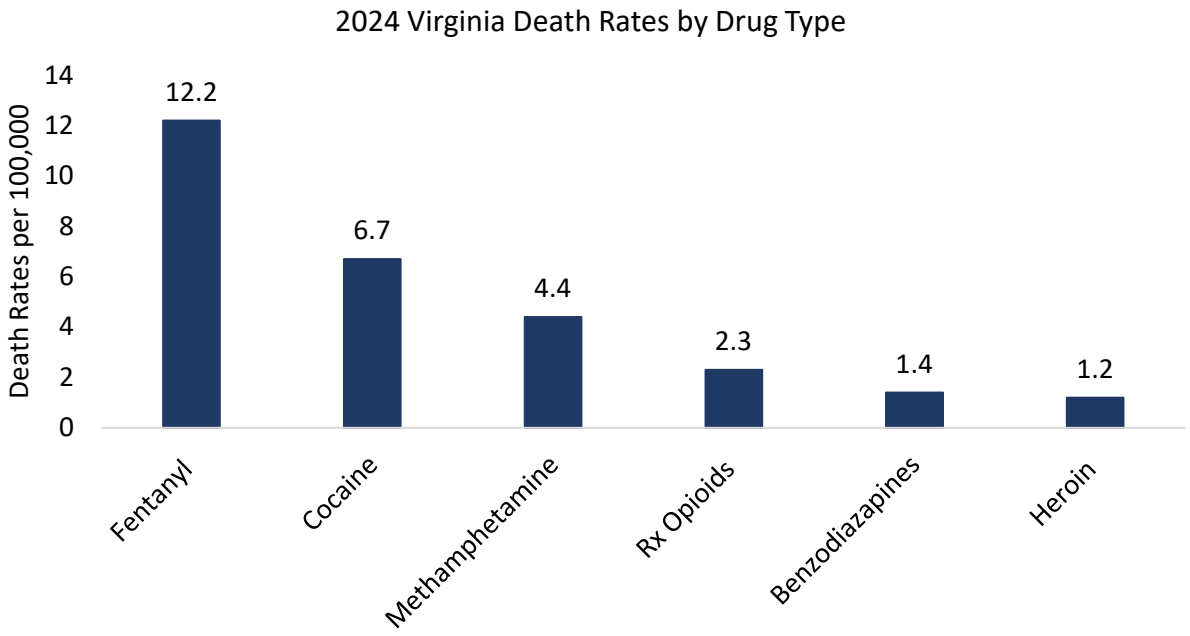
SOURCE: JCHC staff analysis of Centers for Disease Control and Prevention, National Vital Statistics System, Mortality 1999-2020 and 2018-2024 on CDC WONDER Online Database.

While rates of overdose deaths have returned to their pre-pandemic levels, they are still approximately 1.5 times higher than death rates when Virginia first declared the opioid epidemic a public health emergency in 2016. In addition, fentanyl overdose deaths in 2024 far exceed deaths from other drugs, including cocaine, methamphetamine, prescription opioids, benzodiazepines, or heroin (FIGURE 6).

FIGURE 6. Death rate from fentanyl is higher than most drugs



NOTE: 2024 data are not final until November 2025 and subject to change.
SOURCE: JCHC staff analysis of Centers for Disease Control and Prevention, National Vital Statistics System, Mortality 1999-2020 and 2018-2024 on CDC WONDER Online Database.

Multiple factors contribute to the change in illicit fentanyl use

Several factors contributing to fentanyl misuse and illicit use in the United States are not unique to fentanyl but shared among individuals and communities vulnerable to illicit drug use broadly. For example, communities that are socioeconomically disadvantaged, with higher rates of poverty and unemployment, may have fewer resources available to prevent drug use or treat substance use disorder. Drug availability in communities, drug exposure in families, genetics, and co-occurring mental health issues may also predispose individuals to drug use. No health insurance or inadequate coverage or access to health care and the stigma associated with seeking substance use treatment may also prevent individuals from accessing timely services. In addition to these general vulnerabilities, two factors specific to fentanyl explain its rapid rise and involvement in overdose deaths.

Education on risks of illicit fentanyl and harm reduction were initially limited

Even as national data showed a declining trend in the use of illicit drugs among youth, Virginia data points to a rise in teen overdose deaths 2018 through 2022. The early increase in teen overdose deaths, despite declining rates of drug use, is largely attributed to illicit fentanyl contaminating the supply of counterfeit pills made to resemble prescription medications. Epidemiological data suggest fentanyl-related exposures increased by 128

percent in youth aged 13 to 19 years between 2015 and 2021. During that time, youth were not receiving adequate education about the risks of fentanyl. In a 2022 survey, 27 percent of youth aged 13 to 18 had little to no knowledge of fentanyl, even as counterfeit pills laced with fentanyl were easily accessible on every major social media platform.

For individuals who use drugs, education about the pervasiveness and higher risk of overdose death from fentanyl use is not likely to change drug use behaviors in ways that would decrease fentanyl exposure. Many individuals' using fentanyl attribute overdoses or deaths to user inexperience and hold erroneous beliefs about how to prepare, detect, and use fentanyl to avoid overdose or death. Instead, harm reduction strategies specific to fentanyl, such as access to testing strips to detect the presence of drugs or the availability of medications to rapidly reverse opioid overdoses, are more effective. Both are well accepted evidence-based strategies, but they were not widely available to at-risk populations at the start of the fentanyl epidemic.

Impacts of the COVID-19 pandemic exacerbated the growing fentanyl crisis

The wide-ranging social and economic effects of the COVID-19 pandemic had a large impact on the increased use and mortality rate from illicitly manufactured fentanyl. This bears out in the data for fentanyl overdose deaths in 2020, which were significantly higher than the trends in overdose deaths from 2013 to 2019 would have predicted. For individuals who used drugs, increasing stress and anxiety coupled with the social isolation brought on by COVID-19 risk, stay-at-home orders, and subsequent job loss, led to increased frequency of use, as well as more frequent use while alone. Delays in non-emergency care impacted patients' access to medical care generally and treatment center closures affected access to treatment for opioid use disorders.

Lockdowns and stay-at-home orders that slowed or even temporarily stopped the flow of manufacturing and shipping during the COVID-19 pandemic also disrupted illicit drug supply chains. This impacted the costs and types of drugs available in communities. In one survey, more than half of respondents reported that the types of drugs they used changed during COVID-19 due to availability, and that the process of getting drugs had been more difficult during this time. Individuals reported an increasing cost and decreasing availability of heroin and methamphetamine, concerns about fentanyl contamination of methamphetamine, and an influx of less expensive fentanyl products as factors leading to more fentanyl exposure during the COVID-19 pandemic.

Impact of illicit fentanyl use varies across geographical regions and population groups

JCHC staff examined rates of ED visits for opioid overdose and fentanyl overdose death rates by locality, gender, race/ethnicity, and age to understand differences in the impacts of illicitly manufactured fentanyl throughout the state. While ED visits are an important

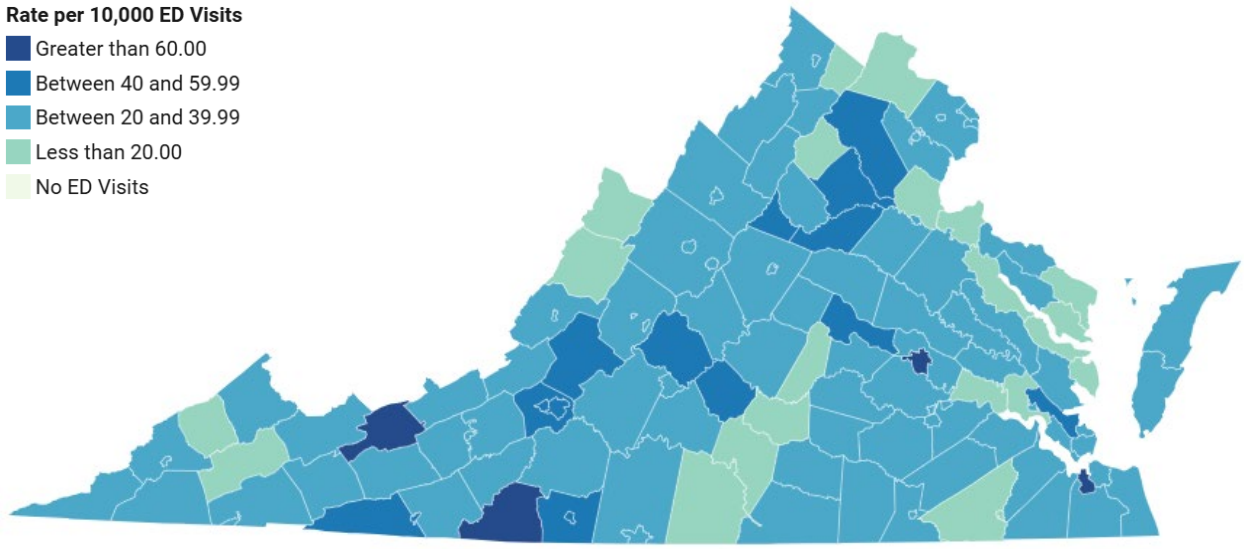
measure of opioid overdoses, rates of visits can be influenced by an individual's care-seeking behavior and ability to access emergency medical services.

Both rural and urban areas of the Commonwealth experienced high overdose rates

At the height of the fentanyl epidemic in 2021, all Virginia localities reported ED visits for an opioid overdose (FIGURE 7).[iii] Sixty-eight percent of localities (91 of 133) reported between 20 and 39 ED visits for an opioid overdose for every 10,000 total ED visits. Four localities – Bland County, Patrick County, Richmond City, and Portsmouth - reported greater than 60 ED visits per 10,000 total visits related to an opioid overdose.

FIGURE 7. Most of the state experienced high rates of ED visits for opioid overdoses

2021 ED Visit Rate for Opioid Overdose by Virginia Locality

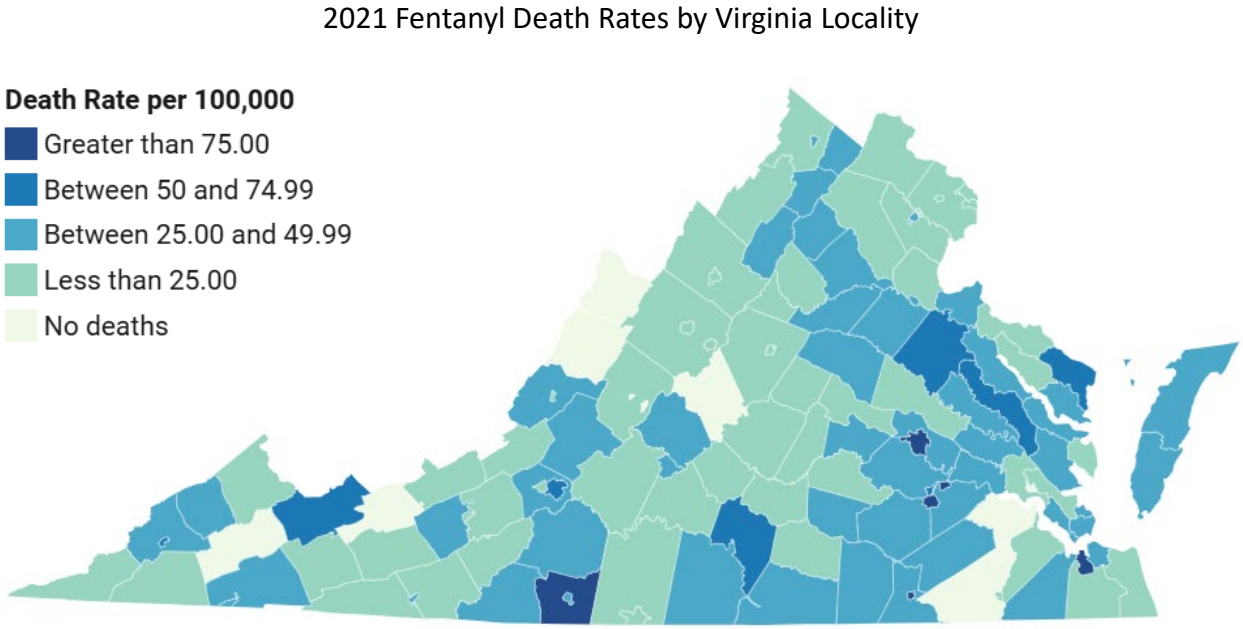


SOURCE: JCHC staff analysis of ED visit data from the Virginia Department of Health, 2025.

[iii] Opioid overdoses include prescription opioids and illicit opioids, like fentanyl. Some localities must be combined to calculate overdose visit counts and rates due to zip codes spanning multiple localities.

Only ten of Virginia's 133 localities did not report any overdose deaths from fentanyl in 2021 (FIGURE 8). Fourteen localities reported a rate of greater than 50 deaths per 100,000 residents, 51 localities reported a fentanyl overdose death rate between 25 and 49 deaths per 100,000 residents, and the remaining 58 localities reported a rate of less than 25 deaths per 100,000 residents.

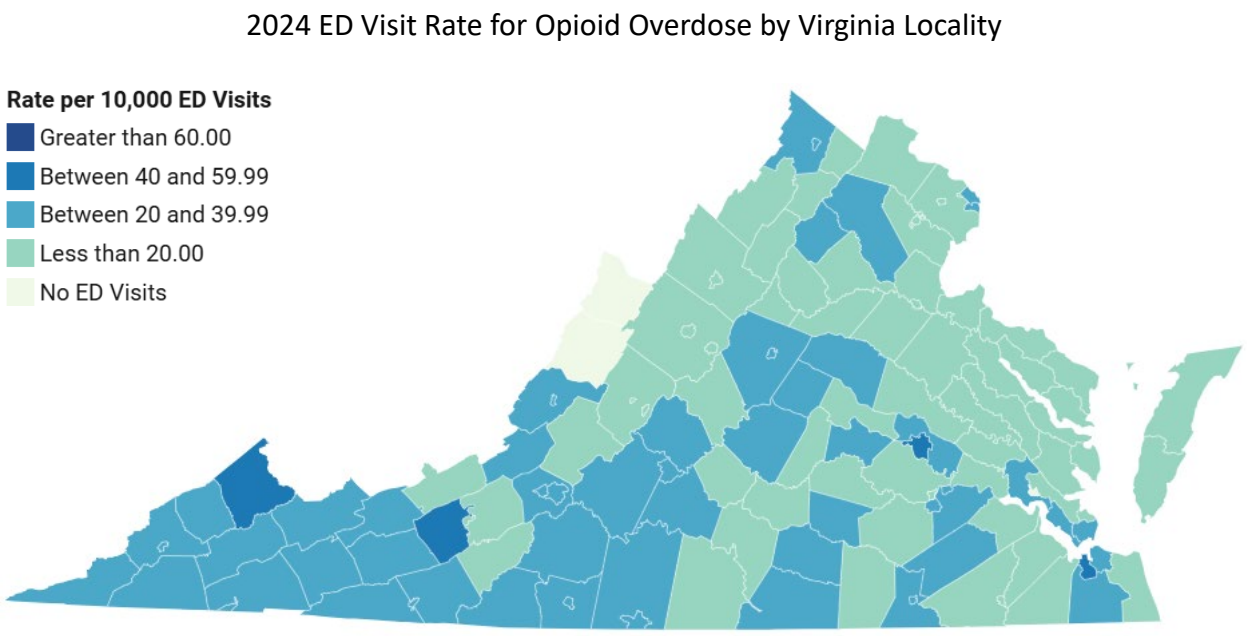
FIGURE 8. Urban and rural areas experienced high rates of overdose deaths



SOURCE: JCHC staff analysis of Centers for Disease Control and Prevention, National Vital Statistics System, Mortality 1999-2020 and 2018-2024 on CDC WONDER Online Database.

By 2024, 114 of 133 Virginia localities (86 percent) experienced a decline in the rate of ED visits for opioid overdoses between 2021 and 2024 (FIGURE 9). One locality did not report a change in rates between 2021 and 2024, and 18 counties reported an increase.

FIGURE 9. Rates of ED visits for opioid overdoses decreased across most counties by 2024

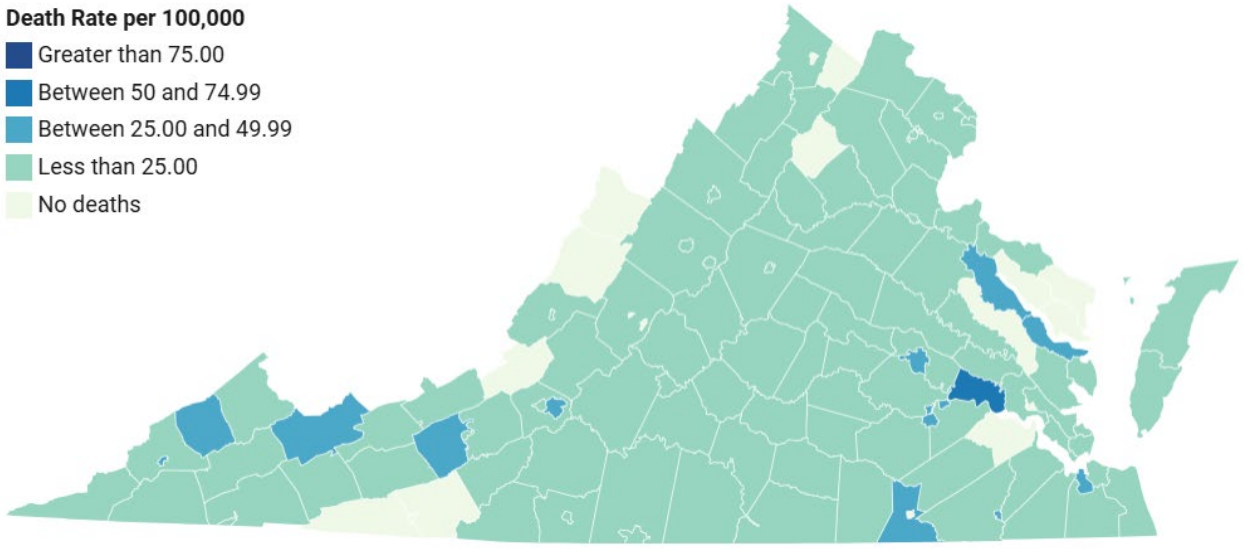


SOURCE: JCHC staff analysis of ED visit data from the Virginia Department of Health, 2025.

Similar to ED visits, 102 of 133 localities (77 percent) reported a decline in the rate of fentanyl overdose deaths, compared to 2021 (FIGURE 10).[iv] Twenty-one localities reported no change in overdose death rates, while ten localities experienced an increase in the rate of deaths from fentanyl between 2021 and 2024, opposite of state trends.

FIGURE 10. Rates of overdose deaths decreased across most counties by 2024

2024 Fentanyl Death Rates by Virginia Locality



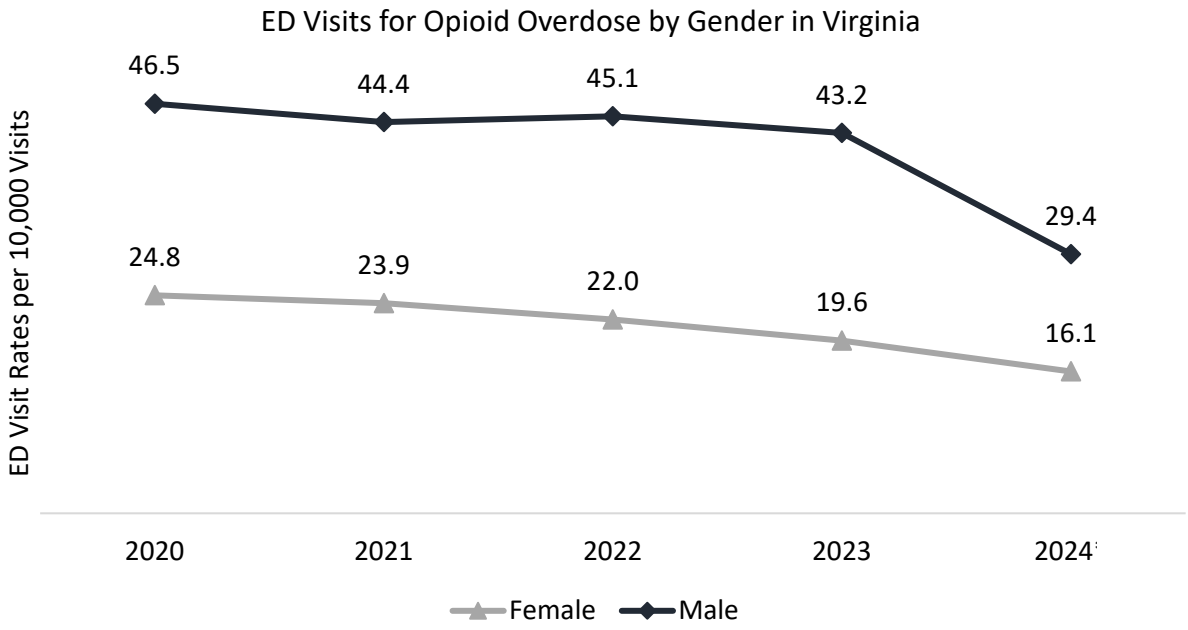
NOTE: 2024 data are not final until November 2025 and subject to change.
SOURCE: JCHC staff analysis of Centers for Disease Control and Prevention, National Vital Statistics System, Mortality 1999-2020 and 2018-2024 on CDC WONDER Online Database.

[iv] 2024 data on overdose deaths are provisional until November 2025. Data are as of August 2025.

Males are more likely to visit an emergency department for an overdose and to die from an overdose

Compared to females, males are more likely to experience an ED visit for opioid overdose (FIGURE 11). In 2024, 29.4 ED visits for an opioid overdose per 10,000 total ED visits were reported for males, while females experienced 16.1 ED visits for an opioid overdose per 10,000 total ED visits.

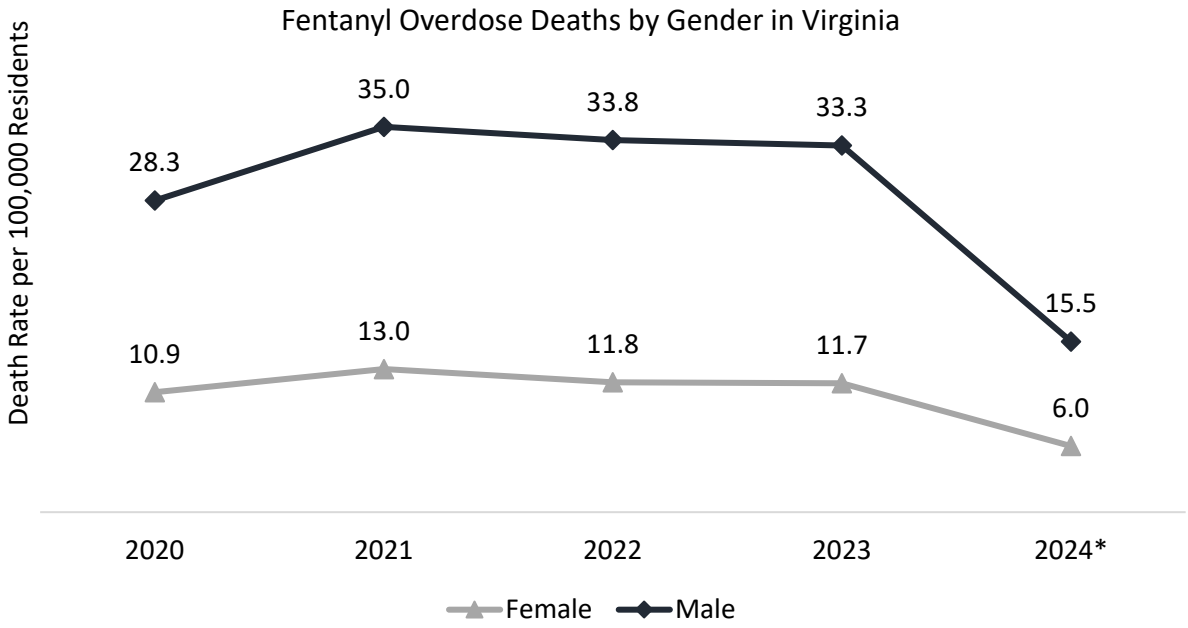
FIGURE 11. Males are more likely to have an ED visit for an opioid overdose



SOURCE: JCHC staff analysis of ED visit data from the Virginia Department of Health, 2025.

Death rates from fentanyl overdose disaggregated by demographic characteristics show similar patterns as ED visits rates for opioid overdoses. Males are more likely than females to die from a fentanyl overdose in Virginia (FIGURE 12). Since 2021, death rates for males and females have declined. In 2024, the fentanyl overdose rate for males was 15.5 per 100,000 deaths, while the fentanyl overdose rate for females was 6.0 per 100,000 deaths.

FIGURE 12. Males are more likely to die from a fentanyl overdose

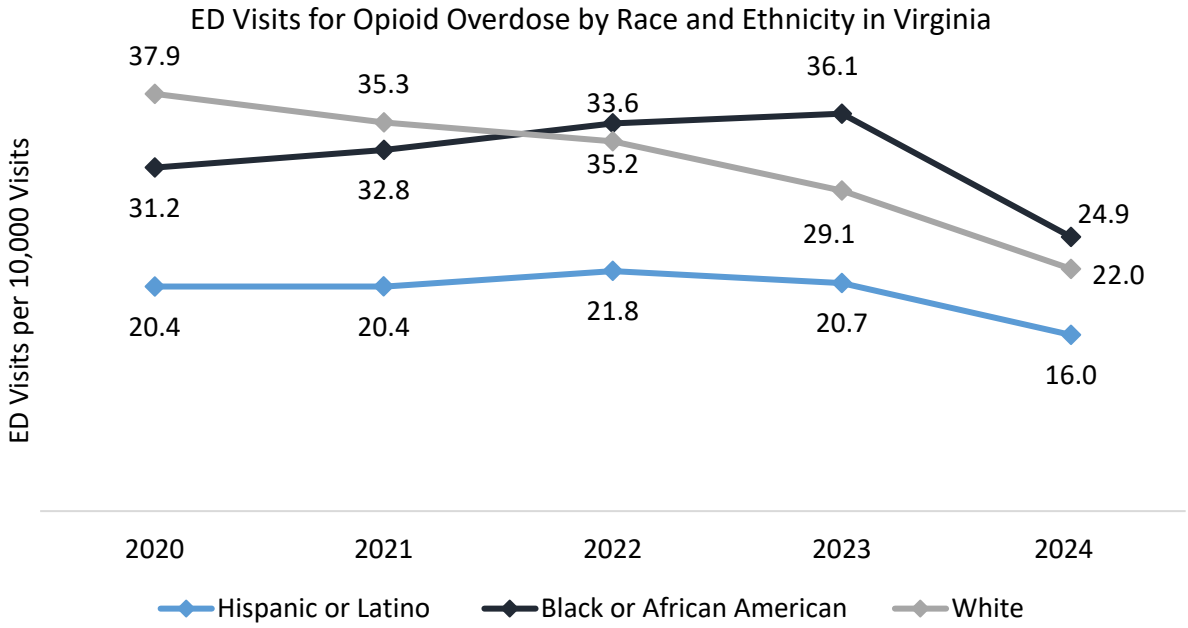


*2024 data are not final until November 2025 and subject to change.
SOURCE: JCHC staff analysis of Centers for Disease Control and Prevention, National Vital Statistics System, Mortality 1999-2020 and 2018-2024 on CDC WONDER Online Database.

Black or African American individuals experience higher rates of ED visits for opioid overdoses and deaths from fentanyl overdoses

Nation-wide data on ED visit rates and death rates are available for up to six different race categories and by Hispanic ethnicity. In Virginia, however, there are only sufficient data to calculate death rates for two races – white and Black or African American – and Hispanic ethnicity. While limited in scope, these data show important trends. In 2020 and 2021, white individuals had a higher rate of ED visits for opioid overdoses compared to Black or African American and Hispanic individuals. By 2022, Black or African American individuals experienced the highest rates of ED visits for opioid overdose and continue to do so through 2024 (FIGURE 13).

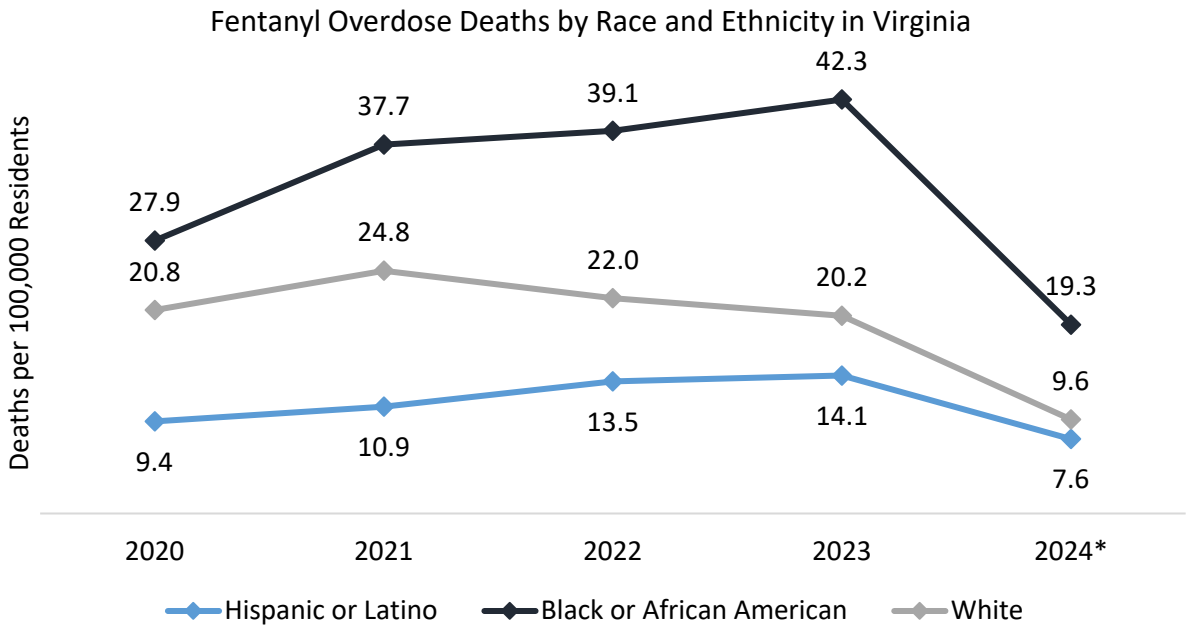
FIGURE 13. Rates of ED visits for an opioid overdose by race and ethnicity



SOURCE: JCHC staff analysis of ED visit data from the Virginia Department of Health, 2025.

For white individuals, the death rate from fentanyl overdoses has decreased the last four years, from a high of 24.8 per 100,000 residents in 2021 to 9.6 per 100,000 residents in 2024. In contrast, death rates for Black or African American individuals and Hispanic individuals increased through 2023 and declined starting in 2024 (FIGURE 14). In 2024, the death rate for Black or African American individuals was still twice the death rate of white individuals.

FIGURE 14. Black or African American individuals are more likely to die from a fentanyl overdose

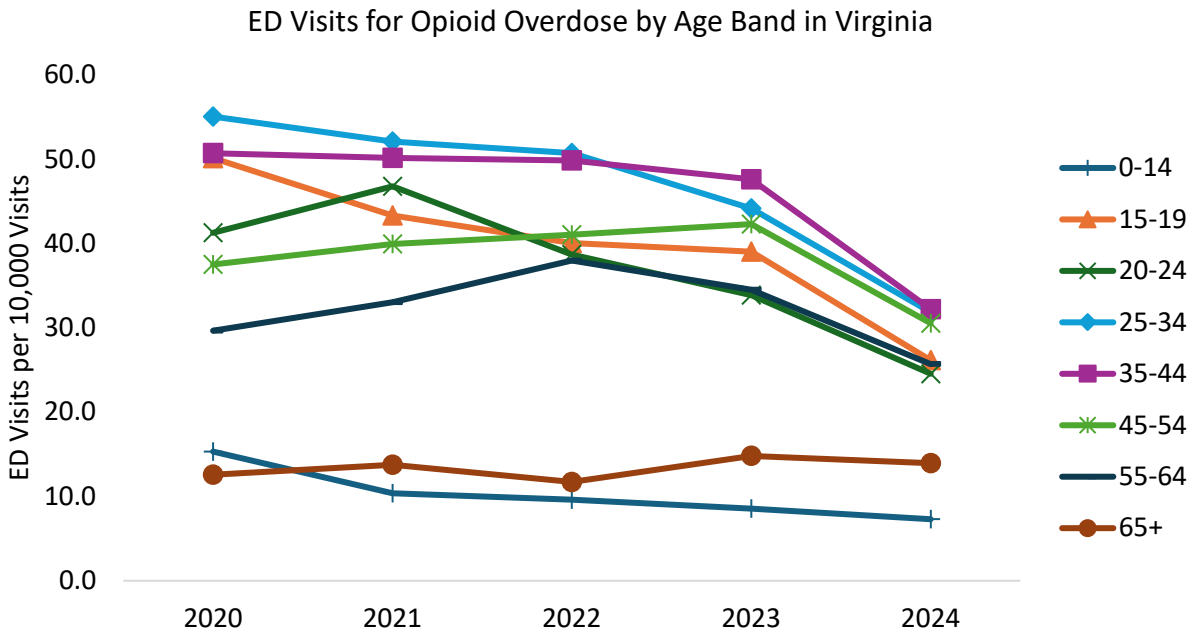


*2024 data are not final until November 2025 and subject to change.
SOURCE: JCHC staff analysis of Centers for Disease Control and Prevention, National Vital Statistics System, Mortality 1999-2020 and 2018-2024 on CDC WONDER Online Database.

Individuals aged 35 to 44 experience highest rates of ED visits for opioid overdose and fentanyl overdose deaths

In 2023 and 2024, individuals aged 25 through 54 were most likely to have an ED visit for an opioid overdose compared to other age groups (FIGURE 15). Rates of ED visits for individuals 65 and older were low but increasing, while rates of ED visits among 15- to 19-year-olds decreased by nearly half between 2020 and 2024, from 50.1 ED visits for an opioid overdose per 10,000 total visits in 2020 to 26.2 ED visits per 10,000 in 2024.

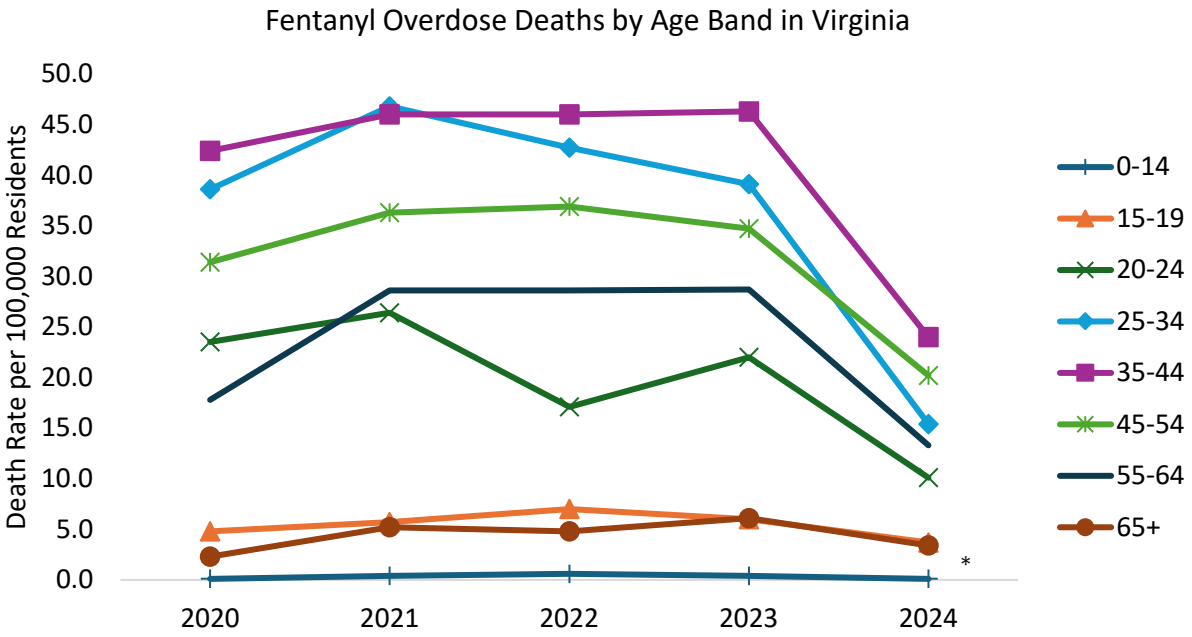
FIGURE 15. Individuals 25 to 44 experience high rates of ED visits for opioid overdoses



SOURCE: JCHC staff analysis of ED visit data from the Virginia Department of Health, 2025.

Fentanyl overdose deaths among individuals younger than 19 and older than 65 were relatively low compared to other age groups (FIGURE 16). In contrast, death rates among individuals 25 to 54 in Virginia were consistently high, with the highest death rates occurring among individuals aged 35 to 44. However, rates among this age group also decreased significantly in the past year from 46.3 per 100,000 residents in 2023 to 24.0 per 100,000 residents in 2024.

FIGURE 16. Individuals 35 to 44 experience high rates of fentanyl overdose deaths



*2024 data are not final until November 2025 and subject to change.
SOURCE: JCHC staff analysis of Centers for Disease Control and Prevention, National Vital Statistics System, Mortality 1999-2020 and 2018-2024 on CDC WONDER Online Database.

Virginia is successfully implementing evidence-based strategies to address illicit fentanyl use

The Commonwealth's approach to the illicit fentanyl epidemic, interrupted by the COVID-19 pandemic, reflects multiple lines of effort across many different entities. JCHC staff identified and reviewed 53 state-funded or state-administered strategy types across 18 agencies that address surveillance, prevention, intervention, and treatment efforts (see APPENDIX 2 - Table 2 for detailed methods).

Data collection to support decision making continues to expand

The ongoing collection, analysis, and reporting of public health surveillance data has been a critical component of the Commonwealth's response to fentanyl. The availability of data on overdose deaths, ED visits, and other negative health outcomes from illicit fentanyl use has both immediate and longer-term benefits. In the short term, data can be used to identify and rapidly respond to clusters of drug overdoses in communities where more resources may be needed. In the long term, data can inform decisions about how resources should be allocated and the impact of public health interventions. Public health data surveillance is primarily a function of the Virginia Department of Health (VDH). VDH makes information about drug overdoses and overdose deaths available through a dashboard on the agency's website. Stakeholders interviewed for this study described the data available from VDH as a "canary" to understand what might be happening. In addition to maintaining a state dashboard, VDH has leveraged federal funds from the Centers for Disease Control's Overdose Data to Action (OD2A) state grant to enhance state data collection, including supporting expedited drug testing protocols for DFS, and expanding reporting to federal data systems. These enhancements permit more efficient and effective use of comprehensive data to address pressing questions about the fentanyl epidemic.

In addition to agency reporting, the 2024 Appropriation Act provided $4 million across the state fiscal years (SFY) 2025 and 2026 from the Commonwealth Opioid Abatement and Remediation (COAR) Fund to Virginia Information Technologies Agency (VITA) to procure a cloud-based data analytics platform that collects, analyzes, interprets, and shares all opioid related data from relevant agencies across the Commonwealth, called Substance Use Disorder Abatement enterprise data platform. The platform is intended to create a "one-stop shop" for data related to the opioid epidemic, addressing ongoing data access barriers in Virginia as a result of having multiple and disparate data systems with limited data sharing ability. The platform will summarize public data sources across the Commonwealth to provide reports on substance use that meet information needs of anticipated end users, such as the General Assembly, state agencies, local government agencies, community organizations, and health care organizations. After completing the needs assessment in February 2024, VITA selected a vendor for platform development and is now working with the Opioid Abatement Authority (OAA), as the designated owner and business champion of the platform, to develop initial data reports by October 2025.

Educational efforts target youth to prevent unintentional fentanyl exposure

Virginia has implemented multiple statewide media campaigns - the Office of the Attorney General's participation in the federal *One Pill Can Kill* initiative, the First Lady of Virginia's *It Only Takes One* initiative, and the Virginia Foundation for Healthy Youth's (VFHY) *Deadly Dose* initiative - to raise awareness of the dangers of fentanyl among youth. Media campaigns have moderate but promising evidence for increasing knowledge and awareness of opioid-related harms. Social media ads from the VFHY campaign, for example, achieved

36.2 million impressions, reaching 92 percent of teens in Virginia at least once. Evaluation results indicate that 82 percent of teens surveyed about the campaign felt that they learned new information about fentanyl from the ads.

Students in Virginia public schools also receive education on the risks of fentanyl. The current Health Education *Standards of Learning* describes expectations for student learning and achievement in health education classes and includes objectives on substance use prevention globally and opioids specifically. In addition, the Virginia Department of Education's (VDOE) Opioid Abatement Education plan, which includes access to evidence-based opioid abuse prevention programming, is available to all students and school employees in public K-12 schools. Finally, House Bill 1473 from the 2024 General Assembly Session required VDOE to develop a fentanyl education and awareness informational one-sheet and distribute the document to all high school students within the first two weeks of the school year, annually.

Harm reduction strategies intend to prevent overdose and limit the risks of unsafe drug use

Harm reduction efforts in Virginia have focused primarily on expanding access to opioid antagonists like naloxone that can reverse the effects of an opioid overdose (SIDEBAR). Consistent with other states, Virginia has acted to reduce barriers to the prescribing, dispensing, possessing, and administering of opioid antagonists. In recent years, the Commonwealth has enacted laws or published regulations requiring or recommending the prescribing of an opioid antagonist to patients who are at risk of an overdose, granting civil immunity for prescribing, dispensing, and administering an opioid antagonist in good faith, permitting direct dispensing by pharmacies and non-patient specific dispensing models, and decriminalizing possession of opioid antagonists without a prescription (see APPENDIX 3 for a detailed summary of current state laws and regulations). The General Assembly has also appropriated funding to help individuals and organizations obtain opioid antagonists from VDH and tasked the Department of Behavioral Health and Developmental Services (DBHDS) with providing training on when and how to administer them.

Opioid antagonists. Opioid antagonists quickly reverse the effects of an opioid overdose by binding to opioid receptors and pushing away other opioids in the body. The most well-known opioid antagonist used for overdose reversal is a medication called naloxone. It is available as a generic or under brand names like Narcan and Kloxxado.

While access to opioid antagonists is a key component of harm reduction initiatives, comprehensive harm reduction programs provide additional services including education, peer support, referrals to treatment, testing for infectious disease, and linkages to medical care. Local health departments or other organizations that wish to offer comprehensive harm reduction programs in Virginia must obtain authorization to operate by the State Health Commissioner. Currently, comprehensive harm reduction is offered at 15 sites

throughout the Commonwealth. In 2024, comprehensive harm reduction sites served 5,801 clients of which 50 percent were newly enrolled individuals.

State-funded efforts address access to treatment services and medications for opioid use disorder

While a comprehensive review of state-administered substance use treatment services is outside the scope of this study, understanding state efforts to improve access to treatment services and access to medications for individuals with opioid use disorder is relevant.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs are a public health approach to the delivery of early intervention and treatment services for people with substance use disorders, as well as those at risk for developing these disorders.

SBIRT programs contain three core components: (i) screening individuals for risky substance use using standardized tools, (ii) having a brief, motivational conversation with the individual to entice positive changes in behavior; and (iii) referring the individual to treatment services if warranted. SBIRT programs are commonly implemented in EDs during "windows of opportunity," such as when individuals seek medical treatment following an opioid overdose. Individuals receiving SBIRT report decreased illicit opioid use in the seven days immediately following the intervention; however, combining the core components of SBIRT with the initiation of buprenorphine, a medication used to treat opioid use disorder, and intensive treatment support is more effective. Individuals who receive this enhanced version of SBIRT, often called bridge to treatment programs, are more likely to remain engaged in treatment than those that are referred without additional support.

EDs that implement bridge to treatment programs assess patients for opioid use disorder, use motivation interviewing techniques to elicit positive behavior changes, initiate treatment with buprenorphine, and use peer recovery specialists to connect patients to additional treatment services, including assisting the patient through intake procedures and making an initial appointment prior to discharge. ED bridge to treatment programs are designed to address a significant gap in the continuum of care for individuals who present to EDs with overdose emergencies and are interested in connecting to treatment services.

ED bridge to treatment programs have been shown to provide benefits that exceed the costs of the program. In addition, hospitals can bill Medicaid and Medicare for the core components of SBIRT and for peer recovery services and may be able to bill commercial insurers as well. However, hospitals and health systems may need incentives to implement programs and financial assistance to cover start-up costs, including training on new protocols, hiring additional staff, and building relationships with substance use treatment programs in their communities.

In Virginia, Roanoke-based Carilion Clinic has implemented an effective bridge to treatment model. Results of an initial assessment of the Carilion model, supported by VDH through

federal OD2A grant funds, found that 82 percent of ED patients referred to office-based opioid treatment through the program attended their first appointment. Carilion has partnered with VDH and the Department of Medical Assistance Services (DMAS) to support implementation of the model at other health systems. Using a $150,000 state grant through DMAS from OAA, Carilion Clinic has provided comprehensive technical assistance to six other health systems in Virginia (Augusta Health, Ballad Health, INOVA, Mary Washington, Sentara, and Valley Health) to implement bridge to treatment programs in their EDs. DMAS has applied for an additional $900,000 grant from OAA to incentivize three additional health systems to build similar bridge to treatment programs and to facilitate stronger connections to community-based treatment for individuals who are discharged from either the ED or the hospital.

Virginia has also taken steps to increase access to medications for opioid use disorder (MOUD). The U.S. Food and Drug Administration (FDA) has approved three medications for opioid use disorder – methadone, buprenorphine, and naltrexone. Each of these medications has different characteristics, but all can effectively treat opioid use disorder. Methadone is a full opioid agonist, suitable for severe opioid disorder, but has a higher risk of misuse and so is typically administered to individuals only in approved opioid treatment programs (OTPs). Buprenorphine is a partial opioid agonist, which carries a lower risk of overdose and is available in office-based settings. Naltrexone is available as an extended-release injectable but as an opioid antagonist requires complete detoxification of opioids before starting treatment.

Under the Affordable Care Act, most insurers are required to cover MOUD. State Medicaid programs are specifically mandated to provide coverage for MOUD through the federal SUPPORT for Patients and Communities Act. In addition, since 2017, DMAS has enhanced substance use treatment services for Medicaid members through a Section 1115 demonstration waiver, the Addiction and Recovery Treatment Services (ARTS) program. Among other successes, the ARTS program introduced a new care delivery model for treatment of opioid use disorder, the Preferred Office-Based Opioid Treatment provider, which integrates MOUD with co-located behavioral and physical health services. The redesigned delivery system doubled the number of Medicaid members who access MOUDs, among those diagnosed with an opioid use disorder.

Opioid settlement funds provide opioid abatement and remediation opportunities to localities and state agencies

Virginia's OAA is an independent state agency established by the General Assembly in 2021 to oversee the distribution of a portion of Virginia's total settlement funds from litigation against manufacturers, distributors, and pharmacies that were alleged to have contributed to the opioid epidemic. OAA distributes these funds through direct, individual distributions to cities and counties, and through cooperative partnership grants to cities, counties, and state agencies. Since its inception, OAA has issued nearly $99 million in settlement funds to

localities and state agencies to support opioid abatement and remediation efforts, with an additional $14 million proposed for the 2025-2026 performance period. Local government and state agency stakeholders interviewed for this study expressed appreciation and excitement for the additional efforts they can support in their communities with the influx of settlement funds. A smaller portion of settlement funds are held within the COAR Fund, managed by the Virginia Department of Treasury. These funds can be appropriated through the state budgeting process, either through the Governor's introduced budget or through General Assembly member amendments. The use of settlement funds is restricted by court orders and state statutes only to fund efforts designed to treat, prevent, or reduce opioid use disorder or the misuse of opioids through evidence-based or evidence-informed methods, programs, or strategies.

Virginia must pivot from an emergent response to a sustainable effort

While Virginia is implementing multiple evidence-based efforts and has seen a significant decline in opioid overdose deaths in recent years, stakeholders expressed concerns about the continuity of state funding and focus on preventing overdoses given the impending change in elected state leadership. The fate of initiatives directed through Governor Youngkin's Executive Order 26, *Crushing the Fentanyl Epidemic,* for example, are uncertain given the end of his term in January 2026. Upcoming administration changes may also impact the priorities of state agency staff who have developed informal collaborative partnerships to complete work across similar initiatives, absent formal direction.

Stakeholders also point out that the enthusiasm to address the fentanyl epidemic in Virginia has resulted in many different efforts, with different perspectives on how to proceed, and no meaningful coordination or strategic planning efforts. The lack of a formalized inter-agency structure to direct work is an additional concern for sustainability when the federal funding landscape is uncertain and there is a lack of information on the effectiveness of efforts that were implemented rapidly. To maintain progress in addressing the fentanyl epidemic, Virginia must move from an emergent response to a sustainable effort and address persistent challenges among high-need populations.

➔ **Option 1:** The JCHC could submit legislation to amend the *Code of Virginia* to designate the Virginia Department of Health as the lead agency for comprehensive opioid response in the Commonwealth and to direct relevant state agencies to work with the Virginia Department of Health to create, implement, and monitor a statewide strategic plan for opioid response.

This policy option could also include a budget amendment providing funds to VDH to initiate state planning responsibilities with a comprehensive needs assessment and program evaluation of existing efforts. Planning responsibilities could include coordination of efforts, identifying and addressing gaps in existing services, and monitoring of outcomes to guide future activities and funding decisions. This policy option recognizes that the

ongoing responsibility for state planning should rest with staff in an executive branch agency so that it is minimally affected by changes in elected administration. As such, VDH is the appropriate agency to lead this work given their ability to collect, produce, and use data to describe the opioid epidemic, as well as the agency's full public health mission.

Legislation for this policy option could be written in such a way that a connection to relevant administration secretaries, including the Secretary of Health and Human Resources, the Secretary of Education, and the Secretary of Public Safety and Homeland Security, is maintained through reporting requirements or a governance structure. In addition, the state plan could be used as a platform to recommend future investments in the state's response to fentanyl using state general funds, COAR funds, or the pursuit of federal grant funds, if available.

Virginia can take additional steps to enhance ongoing efforts to address the fentanyl epidemic

Following Virginia's rapid deployment of strategies to address the fentanyl epidemic, a thorough review of implementation challenges must be performed to understand barriers to sustainable progress. For example, while Virginia programs, legislation, and funding have increased the availability of opioid antagonists, costs to patients are still a barrier for access. Similarly, the state has made efforts to increase access to medications for opioid use disorder, but counseling co-requirements may prevent prescribers from initiating treatment. Finally, the expansion of peer recovery services is limited by misinformed hiring practices for positions that benefit from lived experience.

VDH and DBHDS split responsibility for the Commonwealth's Overdose Education and Naloxone Distribution program

Overdose Education and Naloxone Distribution (OEND) programs pair training on the appropriate response to an opioid overdose with distribution of naloxone or other opioid antagonists to individuals who complete the program. These programs target individuals who use drugs, caregivers, first responders, and the lay public, can be implemented in a variety of settings, and are cost-effective. OEND programs produce long-term knowledge improvement regarding opioid overdoses, improve participants' attitudes toward opioid antagonists, provide sufficient training for participants to safely and effectively manage overdoses, and reduce overdose mortality. Overdose death rates are significantly reduced in communities with OEND programs, even with low-level implementation, compared to communities without these programs. OEND programs are also successful in high-risk populations, such as individuals being released from prison, where studies show a decrease in opioid-related deaths four weeks following prison release.

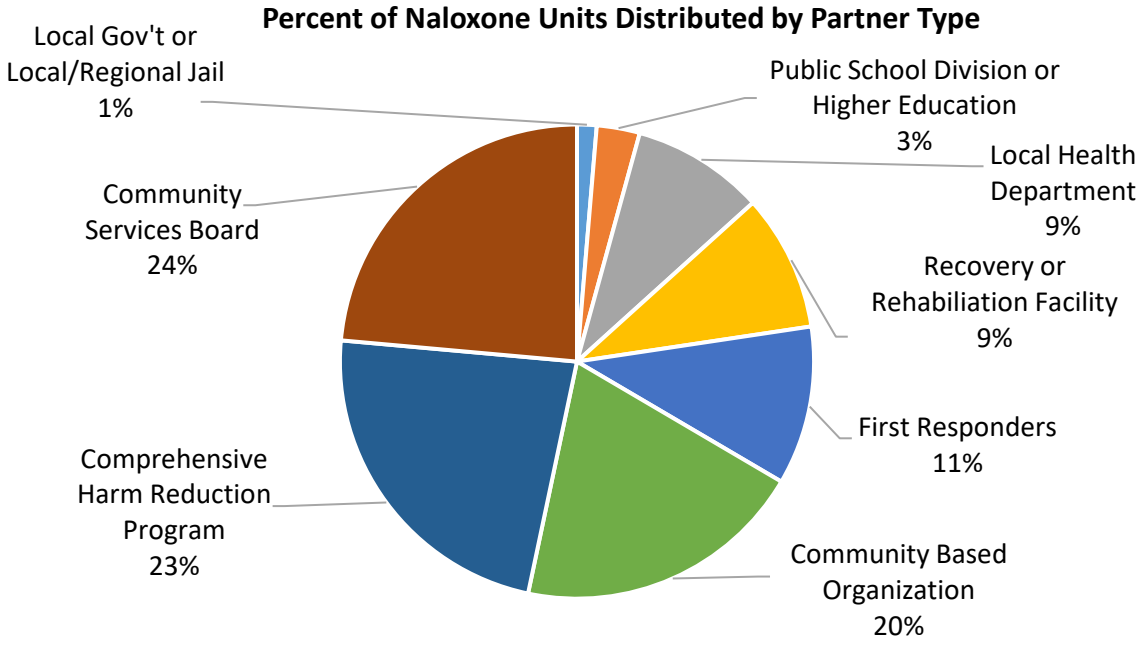
DBHDS coordinates the training component of Virginia's OEND program. DBHDS' REVIVE! training provides information on opioids, risk factors of opioid overdoses, and how to

respond to an opioid overdose emergency with the administration of opioid antagonists. DBHDS provides REVIVE! training for the lay public and first responders. DBHDS also offers a train-the-trainer option for individuals representing organizations that provide services to individuals at risk of opioid overdose who, upon completion of such training, may deliver REVIVE! training and dispense opioid antagonists to others. For first responders, REVIVE! training is conducted by the Virginia Association of Chiefs of Police and also includes information on interacting with individuals who may have a substance use disorder and preventing provider burnout. Prior to the COVID-19 pandemic, Virginia Commonwealth University evaluated REVIVE! training, concluding that localities with higher numbers of REVIVE! trainees reported a steeper reduction in opioid overdose deaths than localities with fewer REVIVE! trainees.

VDH procures and distributes opioid antagonists to individuals who have completed REVIVE! training or the organizations they represent through its High Impact and Extended Access Naloxone Distribution programs. The High Impact program provides naloxone and other opioid antagonists for free to high-risk individuals (including people who use drugs or those who work directly with people who use drugs) and high-impact organizations, such as comprehensive harm reduction sites, Community Services Boards (CSBs)[v], law enforcement and emergency services agencies, and K-12 public schools, among others. The Extended Access program provides opioid antagonists at cost to eligible organizations, including institutions of higher education, city and county governments, and state agencies. In SFY25, VDH distributed 158,700 naloxone units, nearly two-thirds of which were distributed to authorized comprehensive harm reduction sites, community services boards, and community-based organizations working directly with people who use drugs (FIGURE 17).

[v] For the purposes of this report, references to community services boards include behavioral health authorities, unless otherwise noted.

FIGURE 17. VDH distributed 158,700 naloxone kits in state Fiscal Year 2025



SOURCE: JCHC staff analysis of data from the Virginia Department of Health, 2025.

VDH should be optimally funded to maintain the naloxone distribution program

The General Assembly appropriates funds to support VDH's naloxone distribution programs each year in the annual Appropriation Act. In SFY 2025, VDH received approximately $8.4 million to procure and distribute opioid antagonists to qualifying organizations, up from $3.9 million the year prior. Of this amount, $5.5 million is from the COAR Fund, $1.6 million is from Virginia's State Opioid Response Grant from the Substance Abuse and Mental Health Services Agency (SAMHSA), and $1.3 million is from the state general fund.

Saturating high-risk communities with opioid antagonists like naloxone is an effective method of preventing death from fentanyl overdoses. To do this, VDH's naloxone distribution program must be optimally funded to continue outreach and relationship building with high impact community partners, replenish used stock, replace expiring stock, and monitor trends in overdoses to flex resources for rapid distribution as needed.

➔ **Option 2:** The JCHC could introduce a budget amendment appropriating funding each state fiscal year to VDH from the Commonwealth's Opioid Abatement and Remediation Fund or state general funds to maintain the Commonwealth's opioid antagonist distribution program.

Program cost estimates beyond the current state budget were not available from VDH at the time of this report but are anticipated prior to the 2026 General Assembly Session. In SFY24, VDH estimated the cost of program operations, including procuring opioid

antagonist kits, staff, and administrative costs, at approximately $10 million. Beginning July 2025, VDH is required to submit quarterly reports to the General Assembly on the quantity, formulation, and dosage of opioid antagonist kits distributed. While these reports will improve understanding of program spending, they will not estimate future costs. Accurate, timely program cost estimates that take into account the changing landscape of the opioid epidemic are needed for policy makers and appropriators to ensure the program continues to be funded at a sufficient level. Future cost estimates should consider VDH's naloxone distribution goals, community needs, local resources, and the costs of opioid antagonist products.

➔ **Option 3:** The JCHC could introduce a budget amendment directing VDH to develop a methodology to estimate annual naloxone distribution program costs that is based on available data and takes into account distribution goals, community needs, local resources, and the costs of products, and to report annually on estimated annual naloxone distribution program costs for the next fiscal year using such methodology to the JCHC and the Chairs of the House Appropriations Committee and Senate Finance and Appropriations Committee by December 1 each year.

Naloxone distribution program funding should be flexible to account for changing community needs

Item 275.L of the 2025 Appropriation Act requires VDH to use $1 million of the $5,519,945 appropriated each fiscal year from COAR Fund for the naloxone distribution program to purchase and distribute eight-milligram naloxone nasal spray. This specific formulation of naloxone nasal spray, which is produced by a single manufacturer, was once thought to be a better option for stronger opioids like illicitly manufactured fentanyl. More recently, scientific literature does not consistently support any additional medical benefit of eight-milligram naloxone spray compared to the standard four-milligram naloxone spray. Rather, evidence indicates that most overdoses can be managed through four-milligram naloxone spray, with appropriate intervals between each dose and airway management. In addition, eight-milligram naloxone spray carries a higher risk of causing severe withdrawal symptoms than the four-milligram spray, which can accelerate relapse and close the window on an individual's interest in pursuing treatment.

VDH staff indicate that a minority of community partners prefer the eight-milligram spray and do occasionally request this formulation but that a $1 million set aside is in excess of the funding needed to support those requests. In addition, restricting funding for the purchase of the eight-milligram formulation reduces the resources available for the purchase of other formulations preferred by community partners. Without this restriction in funding, VDH could provide increased access to opioid antagonists for additional community partners, further reducing opioid overdose deaths in the Commonwealth.

Removal of language requiring VDH to set aside funds for the purchase of the eight-milligram formulation would not prohibit VDH from procuring and distributing eight-

milligram spray for high-impact community organizations that prefer it. Instead, it would effectively allow the $1 million allocated each year to the exclusive purchase of eight-milligram spray to be used more flexibly for community needs.

➔ **Option 4:** The JCHC could submit a language-only budget amendment removing the requirement that VDH dedicate $1 million of its naloxone distribution program budget to the purchase and distribution of eight-milligram naloxone nasal spray.

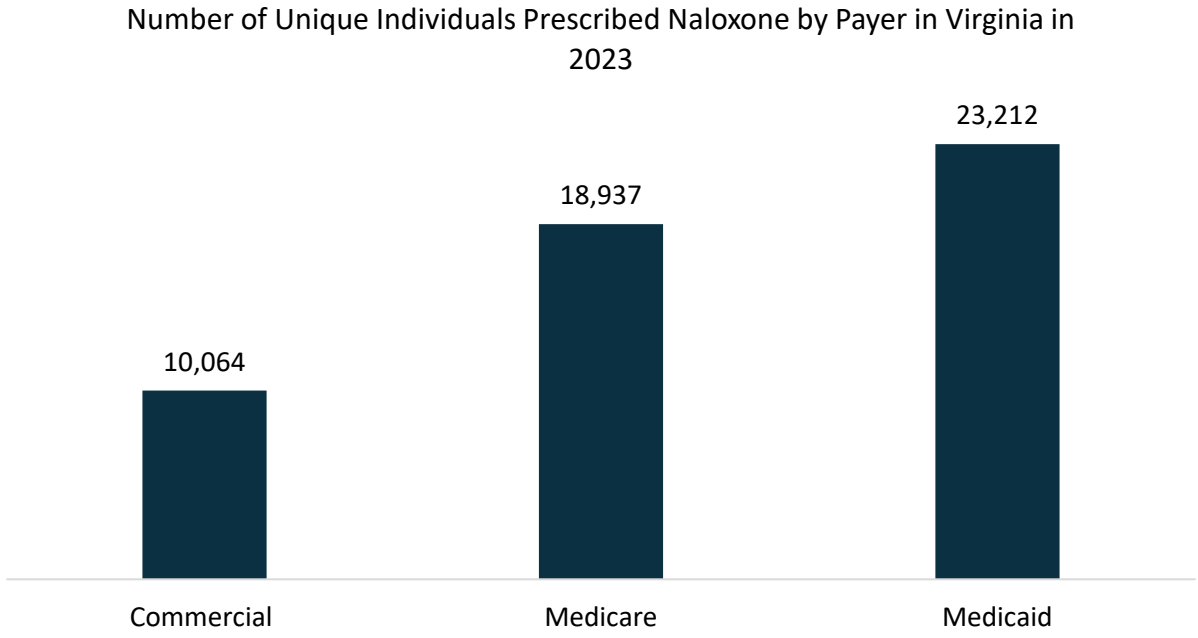
Opioid antagonists can be prescribed or dispensed directly from pharmacies, but costs to patients may create barriers to access

In addition to the OEND program, Virginia has opened multiple pathways for individuals to obtain opioid antagonists through the health care system. Providers can write a prescription for an opioid antagonist and are required to do so upon initiation of opioid treatment per *18VAC90-40-160* when certain risk factors are present, including previous overdoses or substance misuse. Pharmacists and ED personnel may dispense opioid antagonists to an individual in the absence of a prescription from a health care provider pursuant to a standing order from the Commissioner of Health (SIDEBAR). While each of these pathways improves access to opioid antagonists, health insurers may implement cost-sharing requirements or other service limitations, such as prior authorization, that create barriers to access. In addition, stakeholders report that the availability of over-the-counter naloxone may also lead to less coverage by health insurers for prescription opioid antagonists, further reducing access.

Dispensing naloxone in the ED. Dispending naloxone prior to discharge for patients who present to the ED for a suspected overdose can be particularly effective at preventing subsequent overdoses. Dispensing directly from the ED can also overcome barriers to patients who report not being willing to fill prescriptions for naloxone on their own. However, ED providers report concerns about the costs to patients as a significant barrier to dispensing naloxone through the ED.

Virginia's Medicaid program covers the cost of opioid antagonists dispensed pursuant to a prescription or by a pharmacist pursuant to a standing order in the absence of a prescription, as well as over-the-counter naloxone, at no cost to patients. In 2023, Virginia's Medicaid program provided the highest number of naloxone kits to its beneficiaries compared to Medicare and commercial insurers (FIGURE 18). Commercial insurers in Virginia are not required to provide coverage of opioid antagonists but may do so on a voluntary basis. Information from the Virginia Association of Health Plans indicates that most private health plans offer coverage of prescription opioid antagonists as an employer option, with varying copayments or cost-sharing requirements. Few health plans provide coverage of over-the-counter naloxone, however, as the need for manual claim submissions can create significant administrative burdens.

FIGURE 18. Medicaid was the largest prescriber of naloxone in 2023



NOTE: Data includes claims for the following coverage types: 100% Medicare, 100% Medicaid, and roughly 40-65% of commercially insured plans (including 100% fully insured plans).
SOURCE: JCHC staff analysis of prescription claim data from the All Payers Claim Database, 2025.

Requiring health insurance providers to cover naloxone or other opioid antagonists without cost sharing could eliminate barriers to accessing opioid antagonists, as individuals with insurance coverage would be able to obtain opioid antagonists from at least one source without additional costs.

➔ **Option 5:** The JCHC could amend the *Code of Virginia* to require health insurers to (i) include at least one opioid antagonist nasal spray on its formulary; (ii) prohibit prior authorization or any other requirements other than those imposed by state and federal law for these drugs; (iii) provide coverage for any FDA-approved over-the-counter naloxone or similarly effective opioid antagonist; and (iv) not impose any copayment or other out-of-pocket expense for these drugs.

As of April 2023, seven states (Arkansas, Colorado, Illinois, Missouri, New Jersey, Rhode Island) have laws requiring health insurers to provide coverage of opioid antagonists or a similarly effective opioid antagonist. Five additional states (Connecticut, Delaware, Maryland, Minnesota, and New York) have laws removing barriers to coverage of opioid antagonists, including prohibiting prior authorization. A policy option of this nature will likely require review by Virginia's Health Insurance Reform Commission (HIRC).

Medication-assisted treatment is effective for opioid use disorder

Opioid use disorder is defined as a problematic pattern of opioid use that causes significant impairment or distress. Clinical criteria for a diagnosis of opioid use disorder include unsuccessful efforts to control opioid use and failure to fill major obligations at work, school or home, among others. Opioid use disorder is treatable with medication-assisted treatment (MAT) which includes both medications for opioid use disorder and psychosocial counseling. Given the harms of untreated opioid use disorder, including overdose or death, many states – Virginia included – have taken steps to reduce barriers to accessing evidence-based MAT.

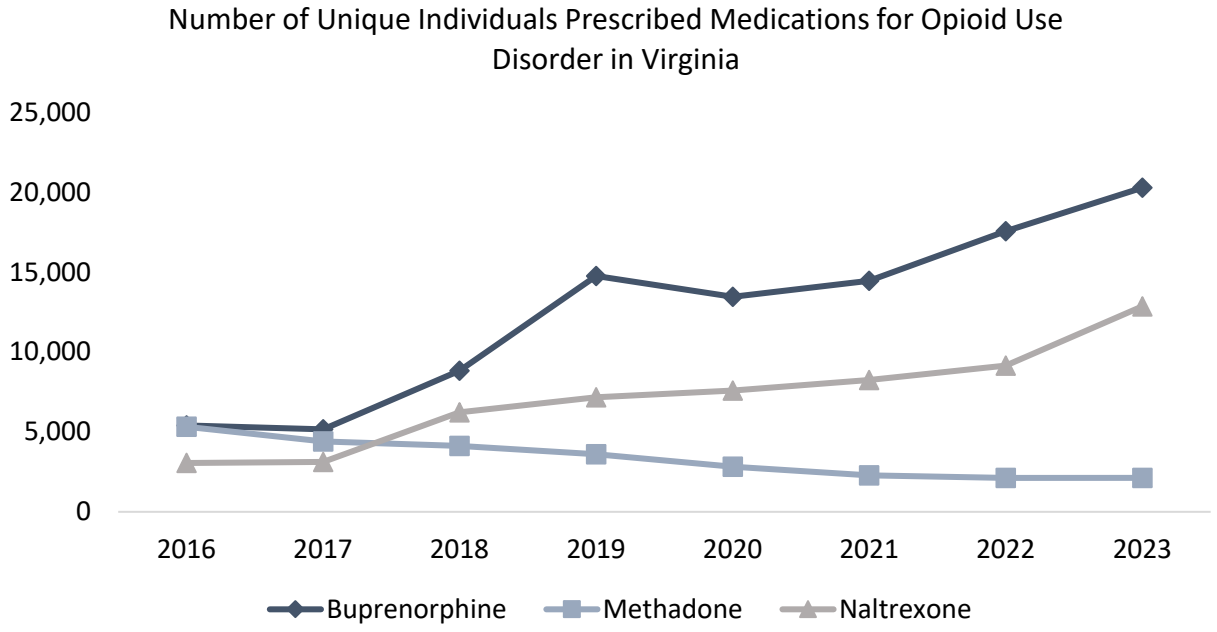
Clinical practice guidelines recommend that all FDA-approved medications should be available to all patients

The American Society of Addiction Medicine's (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder, last published in 2020, recommends that the three FDA-approved medications for opioid use disorder – methadone, buprenorphine, and naltrexone - should be available to all patients. Requirements for prescribing these medications are governed by state and federal laws and vary by medication type (SIDEBAR). Methadone treatment providers must be located at OTPs licensed by DBHDS and certified by SAMHSA. Providers are no longer required to seek waivers from the DEA to prescribe buprenorphine, but they must still be licensed in Virginia and have DEA registration for Schedule III drugs. Naltrexone can be prescribed by any health care provider with prescriptive authority. ASAM's Guideline promotes shared decision-making among clinicians, patients, and families when planning an appropriate course of treatment.

Methadone access through mobile units. In 2021, the DEA lifted restrictions on OTPs deploying mobile units to dispense medications for opioid use disorder, including methadone. Since then, DBHDS adjusted the OTP licensure process to allow programs to add mobile units, and the Board of Pharmacy designated a pathway through which OTPs can waive certain regulatory requirements under a special-use pharmacy permit. In April 2025, the Board of Pharmacy approved the first OTP mobile unit in Virginia, operated by the Hampton-Newport News Community Services Board.

In Virginia, the number of individuals with a prescription for any of the three approved medications has increased by 156 percent in the last eight years, from 13,790 individuals in 2016 to 35,276 individuals in 2023. The number of individuals prescribed buprenorphine and naltrexone have increased over time, while individuals prescribed methadone have decreased (FIGURE 19). This is likely due to methadone's higher risk of overdose and limited availability.

FIGURE 19. Buprenorphine is prescribed more than naltrexone or methadone



NOTE: Data includes claims for the following coverage types: 100% Medicare, 100% Medicaid, and roughly 40-65% of commercially insured plans (including 100% fully insured plans).
SOURCE: JCHC staff analysis of prescription claim data from the All Payers Claim Database, 2025.

Patients should be offered or referred to counseling based on their individual needs

In addition to medication, the ASAM National Practice Guideline recommends patients' psychosocial needs be assessed and patients be offered or referred to psychosocial counseling based on their individual needs and treatment preferences. Psychosocial counseling most often includes structured, professionally administered interventions or nonprofessional interventions such as self-help groups. Psychosocial counseling in combination with pharmacotherapy improves clinical outcomes; however, evidence is lacking on specific types of psychosocial counseling that are most effective.

In Virginia, regulations pertaining to the prescribing of buprenorphine for opioid use disorder found under *18VAC85-21-130*, state "practitioners engaged in medication-assisted treatment shall either provide counseling in their practice or refer the patient to a mental health service provider … [and] shall document provision of counseling or referral in the medical record." Providers interviewed for this study indicate that some of their peers interpret this language as requiring patients to engage in counseling to receive medications for opioid use disorder. This creates an unintended barrier to accessing medications. Per the ASAM Guideline, a patient's decision to decline psychosocial counseling or the absence

of available psychosocial counseling should not preclude or delay pharmacological treatment of opioid use disorder.

As of September 2024, Virginia is one of thirteen states or territories that have laws co-requiring counseling with medications for opioid use disorder. Recent reviews of the evidence on counseling co-requirements recommend against this practice as it has shown little-to-no effect on OUD treatment engagement or retention, OUD remission, or opioid overdose mortality. In Virginia, this language may also be misinterpreted as a barrier to medication access.

➔ **Option 6:** The JCHC could submit legislation directing the Boards of Dentistry and Medicine to amend regulations regarding office-based buprenorphine treatment to require providers to offer counseling or referral to counseling but clarify that patients' participation in counseling is not required for office-based buprenorphine treatment.

The purpose of this amendment is to clarify for providers that medications for opioid use disorder should still be made available to patients, with appropriate management, even if the patient refuses psychosocial counseling or psychosocial counseling is not available at the time of prescribing. This amendment is not intended to deemphasize the importance of counseling and should not remove the requirement for providers who prescribe medications for opioid use disorder to assess patients' psychosocial needs and have counseling available in their office or refer the patient to community providers, as needed.

Peer support during recovery is an evidence-based extension of treatment services

Recovery is a process through which individuals with substance use disorder overcome their illness and regain health and social functioning. Peer support, in the context of substance use, refers to non-clinical support provided to individuals in recovery by others who have lived experience with a mental health or substance use disorder and are also in recovery. Peer support significantly improves outcomes for individuals in substance use recovery, with research consistently showing positive impacts on engagement in treatment, reduced relapse rates, improved relationships with providers, and greater treatment satisfaction.

Peer support can be provided by people with diverse backgrounds, training, and skill sets. Virginia recognizes four levels of peer support (FIGURE 20). Employers may choose the qualifications, certification, or registration of peer supporters they hire. Certification or registration is not required for employment in Virginia; however, Medicaid will only reimburse for services provided by Registered Peer Recovery Specialists.

FIGURE 20. Four levels of peer support in Virginia

Natural Peer Support

- Referred to as Peer Supporter, Recovery Coach, or Peer Specialist
- May or may not be a trained role

Peer Recovery Specialist

- Completion of 72-hour Peer Recovery Specialist Training, provided by the Virginia Department of Behavioral Health and Developmental Services (DBHDS)

Certified Peer Recovery Specialist

- Completion of DBHDS Peer Recovery Specialist Training
- 500 hours of relevant work experience (volunteer or paid)
- 25 hours on-the-job supervision of relevant work experience
- Certified by the Virginia Certification Board, the National Association of Alcohol and Drug Addicition Counselors, or an acceptable alternative

Registered Peer Recovery Specialist

- Must meet requirements of a Certified Peer Recovery Specialist
- Registered with Virginia Board of Counseling
- Eligible for Medicaid billing of services by a qualified Medicaid provider

SOURCE: Virginia Department of Behavioral Health and Developmental Services, 2025.

Agencies report inconsistencies during the hiring process when considering past criminal history of peer recovery specialists

Peer Recovery Specialists, like other mental health professionals, work directly with vulnerable populations and therefore face additional scrutiny during the hiring process to ensure they can practice with reasonable skill and safety to their clients. Given their lived experience, some peer recovery specialists experience barriers to employment due to their past criminal history. Recently introduced federal legislation, if passed, would instruct the federal Department of Health and Human Services and Department of Justice to conduct a study to research other states' screening processes for prospective peer support specialists that may pose undue barriers to their certification, and provide evidence-based recommendations for overcoming those barriers.

In Virginia, the Board of Counseling is responsible for credentialing individuals as Registered Peer Recovery Specialists. The Board has issued guidance on the impact of criminal convictions on the licensure, certification, or registration process, stating that "each applicant is considered on an individual basis [and] there are NO criminal convictions or impairments that are an absolute bar to licensure, certification or registration by the

Board of Counseling." Rather, decisions regarding the impact of prior criminal convictions are addressed on a case-by-case basis. For some individuals, prior criminal convictions will not be a bar to registration as a Registered Peer Recovery Specialist while for others prior criminal convictions could result in a denial of registration.

During the 2024 General Assembly Session, legislation carried by Senator Pillion (Senate Bill 626) and Delegate Price (House Bill 1269) amended several sections of the *Code of Virginia* to permit DBHDS, private providers licensed by DBHDS, and CSBs to hire peer recovery specialists convicted of certain offenses for employment at adult substance abuse or mental health treatment programs, provided that such convictions occurred more than four years prior to the application date for employment. Prior to this change, applicants were required to undergo a background check and those who had been convicted of barrier crimes specified in §§ 37.2-314, 37.2-416.1, and 37.2-506.1 of the *Code of Virginia*, including misdemeanor assault and battery or crimes involving controlled substances, could not be employed unless one of a few very narrow exceptions applied. As a result, many peer recovery specialists with lived experience were barred from employment at DBHDS, private providers licensed by DBHDS, and CSBs.

VDH hires peers for employment in comprehensive harm reduction programs at local health departments, and the Virginia Department of Corrections (VADOC) hires peers for employment in transition programs (SIDEBAR). Unlike DBHDS, VDH and VADOC are not subject to agency specific requirements to conduct background checks for individuals employed to provide mental health or substance abuse treatment services. However, because peer recovery specialists employed by VDH and VADOC interact with vulnerable populations, the positions they are hired to fill are often classified as "sensitive" and subject to the statewide background check requirement mandated by § 2.2-1201.1 of the *Code of Virginia*. The provisions of § 2.2-1201.1 do not explicitly prohibit state agencies from hiring individuals convicted of specified barrier crimes; instead, each state agency required to comply with the statewide policy must establish internal hiring processes that dictate how the results of background checks are addressed. Both VDH and VADOC stakeholders report that internal processes adopted by those agencies to satisfy the requirements of § 2.2-1201.1 have prevented the hiring of qualified applicants as peer recovery specialists. Even Registered Peer Recovery Specialists, who are certified and have been reviewed by the Virginia Board of Counseling, are not able to pass the scrutiny of agency hiring officials who may not be familiar with the necessity of lived experience for these roles. As such, agencies must either provide additional documentation or request additional references from applicants, extending the hiring process, or potentially hire individuals who may not be as qualified to fill these roles.

Peer Recovery Specialist Services. VADOC recognized the value of peer recovery specialists to support inmates through recovery and as a means of employment. Inmates free from substance misuse for 12 months can join the Peer Recovery Specialist Training program where they are provided training, staff supervision and coaching in exchange for supporting substance use services in correctional facilities for at least 12 months.

➔ **Option 7:** The JCHC could submit Section 1 bills directing the Virginia Department of Health and the Virginia Department of Corrections to develop agency guidelines for hiring peer recovery specialists with previous criminal convictions for compensated employment. These guidelines could include provisions clarifying the requirements for employment in specific programs and positions operated by the agencies and include, at a minimum, language providing for employment of such individuals that is consistent with the provisions of § 37.2-314 of the *Code of Virginia* granting exceptions to the list of barrier crimes for individuals hired for compensated employment at an adult mental health or substance abuse treatment program.

This option requires VDH and VADOC to further specify the criteria against which individuals with previous criminal convictions may be considered for employment as peer recovery specialists in the specific programs. It also requires the agencies to afford peer recovery specialists considered for employment similar opportunities for employment as peer recovery specialists employed through DBHDS substance use disorder programs. The process should specifically remove any undue barriers to employment for these positions.

Gaps exist in efforts to address illicit fentanyl use for certain high-needs populations in Virginia

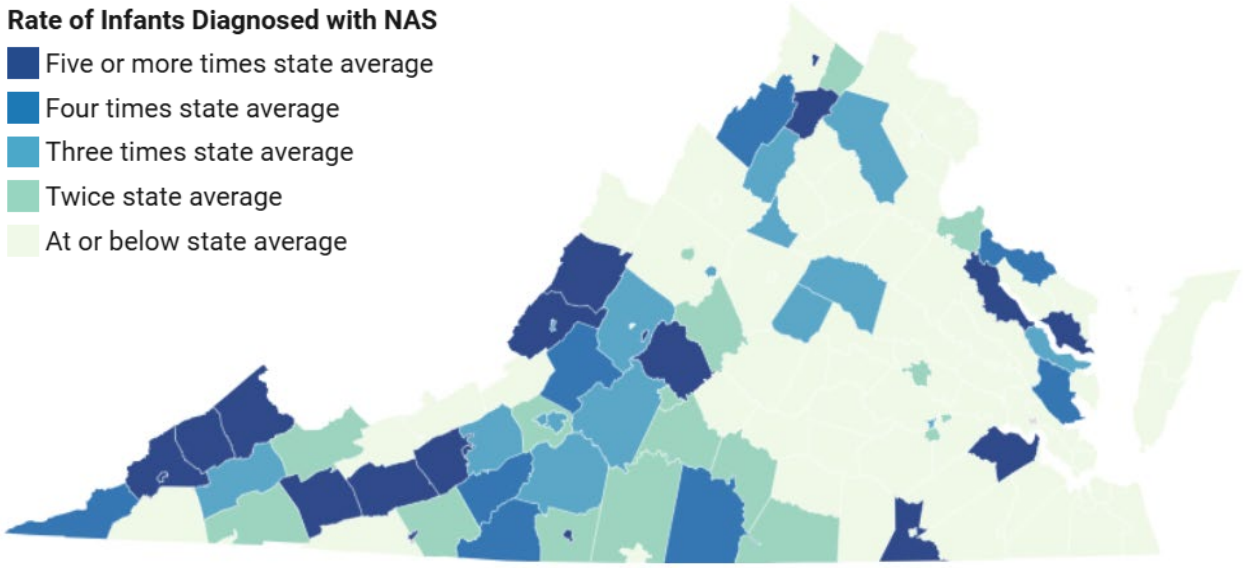
The policy options presented thus far are intended to address barriers to prevention, intervention and treatment services for all Virginians who experience negative outcomes from illicit fentanyl use. Certain populations, however, face unique barriers and need specialized supports to address their fentanyl use. Pregnant and parenting women and individuals who are incarcerated are differentially impacted by the fentanyl epidemic and require additional focus to overcome challenges in accessing care.

Pregnant and parenting women who use fentanyl remain in need of specialized services to address barriers to care

Data provided by Virginia's Maternal Mortality Review Team indicate 80 percent of accidental deaths of women who are pregnant or within one year of pregnancy were from overdoses. Pregnant and postpartum women who misuse substances are at high risk for poor maternal outcomes, including preterm labor and complications related to delivery. Infants exposed to opioids before birth also face negative outcomes, including a higher risk of being born preterm, having a low birth weight, and experiencing the effects of neonatal abstinence syndrome (NAS), a group of conditions that occur when newborns withdraw from substances they were exposed to before birth. In Virginia, rates of NAS have declined by 35 percent in the last five years from 7.1 infants diagnosed per 1,000 hospital births in 2019 to 4.6 infants diagnosed per 1,000 hospital births in 2023. However, rates of neonatal abstinence syndrome remain significantly higher than the state average in certain areas of the Commonwealth (FIGURE 21). For example, in seven counties in southwest Virginia, rates of neonatal abstinence syndrome are between seven and ten times the state average.

FIGURE 21. Twenty localities exceed five times the state average rate of neonatal abstinence syndrome

Rates of Infants Diagnosed with Neonatal Abstinence Syndrome by County in 2023



SOURCE: JCHC analysis of data from the Virginia Department of Health, 2025.

During pregnancy, women are often motivated to change risky behaviors. However, pregnant and parenting women face multiple barriers to accessing care including gendered responsibilities, lack of access to childcare or transportation, and perception of stigmatization for their substance use by providers, friends, and family. Family-based substance use treatment options are incredibly limited in Virginia, with only four residential facilities available to pregnant women and women with children, leaving those who need intensive services very few options for treatment.

Community Services Boards provide pregnant women priority access to treatment or referral and case management

Plans of Safe Care. States are required to adopt policies requiring the development of Plans of Safe Care to receive grant allocations under the federal Child Abuse and Prevention Treatment Act (CAPTA). A Plan of Safe Care is designed to ensure the safety and well-being of an infant with prenatal substance exposure by addressing the health and substance use disorder treatment needs of both the infant and the affected family or caregiver. Health care, treatment and service providers involved in caring for women who use(d) substances during pregnancy are expected to develop and help implement Plans of Safe Care.

Virginia is served by 40 CSBs located throughout the state. These local government agencies provide services for individuals with substance use disorders, mental health conditions, or intellectual disabilities. Pregnant women impacted by substance use are a priority population for CSBs and are provided services within 48 hours. The CSB can help develop and implement the Plan of Safe Care for each family (SIDEBAR), provide or coordinate the provision of women-led treatment, and provide case management before, during, and after hospital discharge. These same services are available whether women voluntarily seek assistance or are referred by a health care provider or Child Protective Services for having a substance-exposed infant.

Project LINK program provides additional wraparound supports for pregnant women seeking services at their local CSB

The Project LINK program is a DBHDS initiative that provides specialized services to pregnant and parenting women at participating CSBs. Services offered through Project LINK programs are supplemental to standard services offered to women at the CSBs. The Project LINK program focuses on reducing barriers to services by providing the entire family unit intensive case management services, home visiting services, prenatal care, parenting education classes, linkages to transportation and child care services to facilitate treatment attendance, and referrals for developmental screenings and interventions for infants and children, as appropriate. The Project LINK program is offered at 14 of Virginia's 40 CSBs. In SFY25, Project LINK programs served 1,395 clients, an average of about 100 clients per Project LINK location.

An external evaluation of the Project LINK program shows promising results. Individuals participating in Project LINK reported significantly less alcohol and drug use in the past 30 days at a six-month follow-up. Notably, reports of illegal drug use in the past 30 days dropped by 54 percent at follow-up and participants reported no use of most prescription and illicit opioids. In addition, 55 percent of participants were successfully discharged from the treatment program. Compared to non-completers, individuals who completed the program attended significantly more counseling sessions, case coordination visits, transportation services, support groups, and relapse prevention groups.

Funding to establish additional Project LINK sites could expand access to substance use services for pregnant and parenting women

Funding for Project LINK programs comes from a variety of sources. Every CSB operating a Project LINK site receives $100,000 in sustainment funds through the federal Substance Use Prevention, Treatment, and Recovery Services (SUPTR) Block Grant. Funding from the federal block grant has not changed since the program was established in 1992. CSBs also bill Medicaid for services provided to covered individuals (in SFY25, 89 percent of Project LINK recipients were Medicaid beneficiaries). The remaining balance of Project LINK program costs is covered by funding provided to the CSB by participating local governments.

While funds provided through the SUPTR Block Grant, reimbursements from Medicaid, and local funds cover the cost of sustaining Project LINK services, CSBs rely on DBHDS for start-up funding to establish such programs. DBHDS provides initial funding to add Project LINK sites at CSBs that wish to offer the services until state or federal funds become available. Since 1992, the number of Project LINK sites has increased from five initial sites to 14 statewide in 2025. The last four sites that established a Project LINK program were established with funding from the American Rescue Plan Act of 2021. With no other federal funding opportunities available, providing additional general funds to DBHDS to cover the cost of establishing Project LINK sites at additional CSBs in the Commonwealth would expand access to substance use services for pregnant and parenting women. DBHDS indicates a need for additional Project LINK sites and CSB interest, particularly in Southwest Virginia where there is a higher need for services and fewer available treatment options.

➔ **Option 8:** The JCHC could submit a budget amendment to provide $1.5 million to DBHDS to establish additional Project LINK programs at CSBs in areas with limited treatment options for pregnant women, based on criteria established by DBHDS.

This policy option would provide startup funding of $500,000 each to three CSBs that do not have Project LINK programs. Based on information provided by DBHDS, this amount would be sufficient to cover the upfront costs of hiring staff and the time needed to provide staff training in evidence-based practices and develop partnerships with community services. As with other Project LINK programs, funding for sustainment of effort would be drawn from the federal block grant, Medicaid and insurance billing, and other local CSB funds. Because this policy option builds upon existing infrastructure and existing models of service delivery, it would require no additional investment in DBHDS central office.

Startup funding for new Project LINK sites could be awarded through a competitive grant program where applicants are required to demonstrate locality interest and buy-in to increase the likelihood of long-term sustainability. Priority could be given to applicants in areas with higher rates of neonatal abstinence syndrome or high rates of mothers diagnosed with opioid use disorder to target funds to communities with the greatest need

for services. While DBHDS should determine final criteria for awards, based on currently available data for these measures of need, the Middle-Peninsula Northern Neck CSB (10 localities), Northwestern CSB (six localities), and Piedmont CSB (four localities) could be prioritized for funding.

Incarceration is an opportunity to break the cycle of drug use among a high-need population

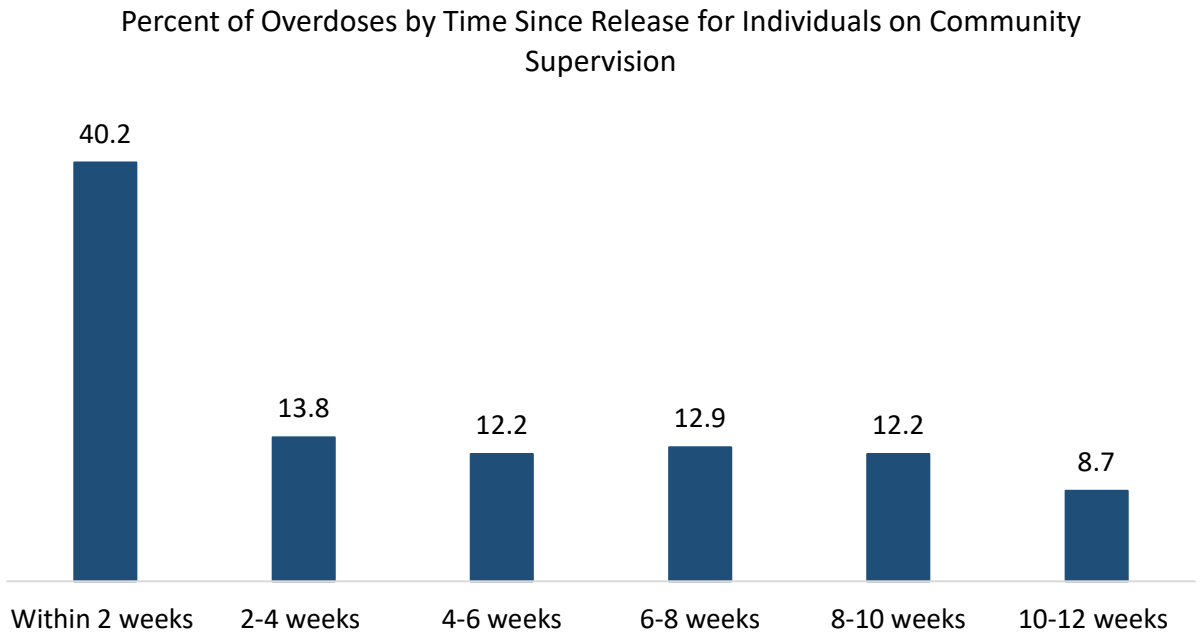
Justice-involved individuals are more likely to experience substance use disorders than the general population and are at significant risk of overdose following release. Incarcerated individuals have varying access to medical professionals, particularly in smaller settings, and all settings have difficulty retaining medical and behavioral health staff. Local and regional jails are particularly burdened by staff shortages and high costs of medication and treatment services. Local and regional jails that provide treatment services for individuals with behavioral health disorders, including substance use, face additional unique challenges created by short stays of incarcerated individuals.

The need for substance use services is significantly higher in incarcerated populations than in the general population

The National Institute of Drug Abuse estimates that 65 percent of the incarcerated population has an active substance use disorder. Virginia estimates are similar. In Calendar Year 2023, 67 percent of all inmates housed in a VADOC facility screened positive for the need for substance use treatment. Female inmates were more likely to need treatment compared to males, with 72 percent of women and 67 percent of men screening positive for substance use treatment services.

In addition, among individuals who overdose following incarceration, the risk of drug-related death is significantly elevated in the first four weeks following release. This is primarily due to the disruption of social services, the re-introduction of problematic behaviors or peer networks, and lowered drug tolerance due to incarceration. VADOC's study of individual supervisees who experienced an overdose on community supervision between 2016 and 2023 also confirms this. Among the overdoses that occurred within twelve weeks following release, 40 percent occurred in the first two weeks, and an additional 14 percent occurred within the first two to four weeks (FIGURE 22).

FIGURE 22. Overdoses occurring in the first twelve weeks from incarceration release



SOURCE: JCHC staff analysis of data from the Virginia Department of Corrections, 2025.

Finding qualified and committed health care staff to serve the incarcerated population is difficult, particularly in rural areas

Incarcerated individuals have varying access to medical and behavioral health professionals, particularly in smaller settings like local and regional jails. Local and regional jails have smaller recruiting pools for open positions, face competition with other employers in the region that may offer better pay and benefits, and have challenging work environments with ongoing staffing shortages and short stays by incarcerated individuals.

In 2020, the Board of Local and Regional Jails adopted 15 minimum standards for mental and behavioral health services in jails (APPENDIX 4). In 2021, the Department of Criminal Justice Services (DCJS) studied the costs of implementing those standards, reporting that staff costs represent the main driver of implementation costs. To meet the standards, DCJS concluded that staffing levels for mental and behavioral health services in each jail should reasonably include:

- 24/7 coverage, either onsite or on-call, by a registered nurse;
- On-call and regularly scheduled services from a psychiatric provider;
- A qualified mental health professional to provide regularly scheduled group and individual therapy services; and

- Behavioral health case management services, to include discharge planning, provided by a minimum of one full-time equivalent case manager per jail and one additional full-time equivalent case manager per 160 inmates.

Since SFY22, the Compensation Board has received nearly $10 million each fiscal year to staff local and regional jails to the minimum standard for behavioral health case managers and medical treatment positions, but challenges remain in recruiting and retaining a high-quality workforce. In 2024, the Compensation Board reported that 54 percent of inmates referred to clinical services were released before services could be provided and an additional 20 percent did not receive services due to insufficient mental health staff.

Workforce incentive programs, such as those that offer scholarships or student loan forgiveness in return for a period of employment, can encourage individuals to enter and remain in specific professions with high demand. Expanding access to workforce incentive programs for health care providers, including substance use service providers working at local and regional jails, could help alleviate workforce challenges and improve access to needed services. While Virginia offers workforce incentive programs through VDH in multiple professional areas, medical and behavioral health employees of local and regional jails are only eligible for one state and one federal program. The federal Substance Use Disorder Treatment and Recovery Loan Repayment Program (STAR LRP) provides up to $250,000 in educational loan repayment in exchange for six years of full-time employment in an eligible profession in an eligible locality. Substance use services providers working in local and regional jails in qualifying professions are eligible to participate. Approximately 100 awards are distributed nationally each year resulting in very few providers receiving incentives offered through this program in each state. The state-funded Virginia Behavioral Health Loan Repayment Program provides student loan repayment for qualified professionals working in mental health professional shortage areas. Tier 3 recipients can receive up to 25 percent of their total student loan debt, not to exceed $10,000 per year, for up to three years. Local and regional jail employees currently qualify for this program because all local and regional jails are located in mental health professional shortage areas. During the most recent funding cycle, 43 providers were awarded funds through the program; none were employed in local or regional jails.

➔ **Option 9:** The JCHC could submit a Section 1 bill or language-only budget amendment directing the Virginia Department of Health to work with relevant stakeholders to develop and implement a plan to expand workforce incentive programs to health care workers in local and regional jails.

The policy option grants flexibility to VDH to work within their regulatory authority and existing staffing and programmatic budget, in addition to working with relevant stakeholders at local and regional jails, to determine the most efficient and effective means for prioritizing and expanding existing health care workforce incentive programs to reach medical and behavioral health personnel working in local and regional jails. VDH could develop a marketing strategy specific to local and regional jail employees and their

respective Human Resource departments to create awareness of existing programs, modify existing incentive programs to prioritize employees of local and regional jails, or create a new incentive program, depending on budgetary constraints and expressed needs. For example, the long-term care incentive program for Licensed Practical Nurses and Registered Nurses could be a model for a program specific to regional and local jails. The program is currently funded at $64,000 per year, but only three providers were awarded funds ($2,000 per year) in the last funding cycle. This incentive program could be adapted to target hard-to-staff institutionalized settings, including local and regional jails.

State investments in treatment and transition services among incarcerated populations have increased but lack of flexibility limits expansion

Virginia has invested and continues to invest funds to improve treatment and transition services in local and regional jails, in recognition of the high incidence of mental illness and substance use disorders among inmates in these settings. However, the lack of flexibility in the selection of grantees and the limited availability of funds has prevented capacity building or expansion of services in other localities.

The 2016 Appropriation Act established the Jail Mental Health Pilot Program (JMHPP), a grant program to provide a continuum of behavioral health services to inmates incarcerated in local or regional jails and upon release to the community. Grants are made for a period of twelve months, and grant funds are used to help jails identify individuals with mental health needs or co-occurring substance use disorders, produce treatment plans tailored to their needs, and provide services in accordance with the treatment plan during incarceration and after release from jail. DCJS submits annual evaluation reports on the pilot to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees that document measurable improvement in inmate well-being and the availability of services provided to individuals.

Beginning in 2017, the General Assembly appropriated $2.5 million each fiscal year to DCJS for JMHPP to support programs in six local and regional jails; the appropriation decreased to $2 million each fiscal year in SFY25. Language included in the 2019 Appropriation Act, which remains in the budget at this time, states, "the number of pilot sites shall not be expanded beyond those participating in the pilot program the first year." As a result, the same five sites that were initially selected for funding continue to participate in the JMHPP, as one site ceased operations in SFY24. While the remaining pilot sites continue to show positive outcomes from the funding, additional local and regional jails could also benefit from an opportunity to learn from the original grantees and apply for funds offered through the JMHPP to establish more treatment and transition programs throughout the Commonwealth.

➔ **Option 10:** The JCHC could submit a budget amendment to (i) expand funding for the Jail Mental Health Pilot Program, (ii) permit the Department of Criminal Justice Services, in consultation with the Virginia Department of Behavioral Health and Developmental

Services, to develop criteria to select additional grantees for the program, and (iii) establish guidance on the duration of grants awarded through the program to ensure additional grantees have the opportunity to compete for program funds in the future.

Grants provided through the JMHPP could be time limited and awarded based on criteria developed by DJCS and DBHDS that consider the applicant's need and available resources. Selection criteria could also include evidence of stakeholder support and engagement and a plan for progress toward sustainability upon expiration of grant funds. DCJS could prioritize current grantees in the first year to allow current grant recipients the opportunity to transition to sustainability.

Virginia has also invested $153,600 in general funds each fiscal year since 2017 for local and regional jails to develop a model addiction recovery program that may be administered by sheriffs, deputy sheriffs, jail officers, administrators, or superintendents. Inmate participation in the model addiction recovery program must be voluntary, and the program may address aspects of the recovery process, including medical and clinical recovery, peer-to-peer support, availability of mental health resources, family dynamics, and aftercare aspects of the recovery process. Language included in the 2018 Appropriation Act, which remains in the budget at this time, requires DCJS to fund the same four grantees that were initially selected to receive funding. Currently, each of the four grantees receives $38,400. While the amount of funds received per grantee is small, stakeholders believe the money is meaningful to those grantees as they can provide additional services to inmates at their locations.

More recently, the Virginia General Assembly established the Virginia Opioid Use Reduction and Jail-Based Substance Use Disorder Treatment and Transition (JSUT) Program, receiving a one-time appropriation of $2 million from the COAR fund in SFY24. The funds are intended to expand access to substance use disorder treatment and transitional services for individuals incarcerated in local and regional jails in Virginia based upon DCJS-established guidelines, developed in consultation with the Virginia Sheriff's Association and the Virginia Association of Regional Jails. Funded programs may include medication assisted treatment therapies, addiction recovery and other substance use disorder services, reentry and transitional support, or a combination of these services. Beginning in SFY25, fifteen local and regional jails were awarded three-year grants, obligating all funds for this program with no additional appropriations expected.

The model addiction recovery programs and JSUT programs share a similar intent, to expand access to substance use treatment and recovery services in local and regional jails. Both programs also experience funding challenges. While the model addiction recovery program has sustained funding, it can only serve the same four grantees. In contrast, JSUT is funded through a one-time appropriation from COAR but provides more flexibility in site selection. Combining the state resources invested in these programs and adopting flexibility in the selection of grantees could bolster treatment and transition services in additional local and regional jails throughout the Commonwealth.

➔ **Option 11**: The JCHC could submit legislation to amend the *Code of Virginia* § 9.1-102 to sunset the model addiction recovery program. In addition, the JCHC could submit a budget amendment to (i) move funds from the model addiction recovery program to the JSUT Fund, (ii) appropriate funds for an additional cohort of three-year JSUT program grantees, and (iii) direct DCJS to provide technical assistance to current grantees of the model addiction recovery program, as needed, to support their applications for the additional cohort of JSUT program grantees.

Appendix 1: Study Mandate

2024 SESSION

ENROLLED

HOUSE JOINT RESOLUTION NO. 41

Directing the Joint Commission on Health Care to study policy solutions to the Commonwealth's fentanyl crisis. Report.

Agreed to by the House of Delegates, February 12, 2024
Agreed to by the Senate, March 5, 2024

WHEREAS, in 2022 there were 2,490 drug overdose deaths among Virginians; and

WHEREAS, nearly eight out of 10 drug overdose deaths in Virginia in 2022 were caused by fentanyl, fentanyl analogs, and tramadol; and

WHEREAS, there were 22,398 drug overdose emergency department visits among Virginians in 2022, a five percent increase from 2021; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care be directed to study policy solutions to the Commonwealth's fentanyl crisis.

In conducting its study, the Joint Commission on Health Care shall (i) study the causes of the rise in fentanyl prevalence and fentanyl overdoses in the Commonwealth, (ii) study the impact of the rise in fentanyl prevalence and fentanyl overdoses in the Commonwealth on Virginians and the Commonwealth's health care system, (iii) study and provide insight into the fentanyl crisis within the context of other drug crises and addiction trends in recent history, and (iv) establish and make policy recommendations related to reducing the prevalence of fentanyl in the Commonwealth and reducing the number of fentanyl overdoses in the Commonwealth.

All agencies of the Commonwealth shall provide assistance to the Joint Commission on Health Care for this study, upon request.

The Joint Commission on Health Care shall complete its meetings by November 30, 2025, and the chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the next Regular Session of the General Assembly for each year. Each executive summary shall state whether the Joint Commission on Health Care intends to submit to the General Assembly and the Governor a report of its findings and recommendations for publication as a House or Senate document. The executive summaries and reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

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Appendix 2: Methods and data sources

JCHC staff used multiple data sources and methods to inform this study, including a literature review, document review, administrative data analysis, and a comprehensive review of state strategies that included interviews with stakeholders of each strategy. Detailed methods for each source are documented below.

Literature Review

JCHC staff conducted a review of the available scientific literature on the effectiveness of prevention, intervention, treatment, and recovery strategies to address fentanyl misuse and illicit use. Findings from this review were used to create an evidence-based framework through which Virginia's strategies could be compared. JCHC staff conducted a literature review in two databases – PubMed and PsycINFO - using the following search phrase:

fentanyl OR opioid OR opiate [Title]

AND

misuse OR illicit OR abuse OR addict OR disorder [Title/Abstract]*

AND

prevent OR interven* OR treat* OR reduc* [Title/Abstract]*

PubMed is a database of biomedical and life sciences literature, while PsycINFO is a database of literature in psychology and related fields. JCHC staff limited the search to publication years 2010 through 2025 and included documents written in English and for which the full text was available. Given the large amount of literature available on this topic, JCHC staff further limited the inclusion criteria to systematic literature reviews or meta-analyses, resulting in 155 total studies (133 from PubMed and 22 from PsycINFO). Following title and abstract review, staff retained 29 studies for further review.

Staff developed additional search terms to pull systematic reviews on specific strategies that did not appear in the first set of articles identified. Specifically, the search terms "fentanyl test strip," "naloxone distribution," "fentanyl AND harm reduction," and "fentanyl AND enforcement" resulted in the identification of an additional 89 articles. Following title and abstract review, 30 of the additional 89 articles were included in the full review, bringing the total number of articles reviewed for prevention and intervention strategies to 59.

Document Review

JCHC staff conducted a document review to identify the factors that contribute to fentanyl's rapid spread and increasing mortality, as well as how fentanyl misuse and illicit use has changed over time, geographically, and within specific subpopulations. The document review was conducted in Google Scholar using a series of search terms related to fentanyl

misuse and illicit use. Google Scholar provides access to peer-reviewed online academic journals and books, conference papers, theses and dissertations, preprints, abstracts, technical reports, and other scholarly literature. Limiting the search to publication years 2010 through 2025 and including only documents written in English for which the full text was available, staff identified 218 documents for review. Following title and abstract review, staff retained 27 documents for full text review.

In addition, staff reviewed citations for the 27 documents to identify other relevant information. Staff also reviewed documents available on websites of organizations that commonly publish vetted information on fentanyl misuse and illicit use, including the White House Office of National Drug Control Policy, operating divisions of Health and Human Services (e.g., the Centers for Disease Control and Prevention, the National Institutes of Health), and federal agencies such as the Drug Enforcement Agency and the Department of Labor. State agency websites for the Virginia Department of Health, the Department of Social Services, the Department of Medical Assistance Services, and the Department of Behavioral Health and Development Services were also reviewed. This search resulted in an additional 12 documents for review.

Data Analysis

JCHC staff analyzed data from multiple sources to understand trends in fentanyl misuse, illicit use, overdoses, and deaths in Virginia (TABLE 1). Findings from this analysis place Virginia's fentanyl crisis into context and illuminate how rates of adverse outcomes from fentanyl misuse or illicit use vary geographically and by select demographic characteristics.

TABLE 1. Data sources

Metrics	Data Sources
Illicit fentanyl use	U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2024). National Survey on Drug Use and Health. Centers for Disease Control and Prevention. Youth Risk Behavior Survey Data Summary & Trends Report: 2021. U.S. Department of Health and Human Services; 2023. Virginia Department of Forensic Science Seized Drug Dashboard.
Overdose deaths	Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999-2020 and 2018-2025 on CDC WONDER Online Database, released in 2024. Virginia Department of Health Drug Overdose Deaths Dashboard.

TABLE 1, continued.

Metrics	Data Sources
Non-fatal overdoses	Centers for Disease Control and Prevention. Drug Overdose Surveillance and Epidemiology (DOSE) System: Nonfatal Overdose Syndromic Surveillance Data. Atlanta, GA: US Department of Health and Human Services; 2025. Virginia Department of Health Drug Overdose Emergency Department Visits Dashboard.
Pharmacy claims	Virginia All Payer Claims Database, provided by Virginia Health Information.

Strategy Identification

JCHC staff conducted a review of state laws and regulations, documents, websites, and reports to identify state-funded or state-administered strategies to address fentanyl misuse and illicit use in Virginia. JCHC staff define state-administered or state-funded strategies as any intentional effort to address fentanyl misuse or illicit use that is funded by the state or administered using state resources. Strategies include laws, programs, policies, initiatives, or task forces, and can include efforts funded through multiple sources, such as state general funds, special funds, federal dollars appropriated or granted to state agencies, or opioid settlement funds issued to states.

JCHC staff developed a list of key words to search the following sources for strategies to address fentanyl misuse and illicit use:

- 2024 and 2025 Appropriation Acts, *Code of Virginia*, and *Virginia Administrative Code*
- Enacted legislation
- Reports to the General Assembly
- Governor's Executive Orders
- State agency and commission websites and reports
- Grants.gov, for federal grants administered in Virginia
- National Conference of State Legislatures website

The key word search identified 151 strategies implemented by 40 state agencies or organizations. For each, the strategy name, goal, and authority (e.g., state law or regulation) were documented in an Excel sheet. JCHC staff then reviewed information available on each strategy to determine its focus area (education, prevention, intervention, treatment,

recovery, enforcement, oversight, or study), the drug type targeted (any drug, opioids broadly, fentanyl specifically, or prescription drugs), and the target population (general population, youth, justice-involved individuals, or other).

Given the resources available for this study, JCHC staff then developed and applied inclusion and exclusion criteria to each strategy to concentrate study efforts on strategies specifically targeting opioids or fentanyl and strategies focused on prevention, intervention, treatment, or recovery consistent with a public health approach. Strategies were identified for further review if they met the following criteria:

- Addressed opioid or fentanyl misuse or illicit use; and
- Received state funding (in part or whole) or administered by a state entity; and
- Met the definition of a prevention, intervention, or treatment strategy, as defined by this study:
    - Prevention strategies – strategies to prevent opioid misuse and illicit use, including public messaging campaigns and education
    - Intervention strategies – strategies to limit the risks and harms associated with unsafe drug use, including access to naloxone, Good Samaritan laws, and syringe service programs
    - Treatment strategies – strategies to treat individuals with opioid use disorder, including increasing access to medication-assisted treatment (MAT)
    - Recovery strategies – strategies to support individuals recovering from opioid use disorder

Strategies were excluded from further review if they met the following criteria:

- Lacked focus on opioid or fentanyl misuse or illicit use;
- Primarily focused on enforcement efforts, oversight or administration of programs and initiatives, or data reporting/surveillance/study efforts;
- Not currently being implemented in Virginia; or
- Insufficient information is available to determine program status or outcomes.

Following application of the inclusion and exclusion criteria, 60 programs were removed from consideration, retaining 91 programs for further analysis. These were then grouped into 53 strategy types (TABLE 2).

TABLE 2. Virginia is addressing the fentanyl epidemic through 53 strategy types

Agency	Strategy
Department of Behavioral Health and Developmental Services	Injectable drug treatment for individuals on specialty dockets Project LINK REVIVE! Training State Opioid Response Grant activities Substance use treatment and recovery services through Community Service Boards Services in juvenile detention centers Youth Opioid Response Initiative
Department of Corrections	Fentanyl Response Program Medication Assisted Treatment for community supervision population Medication Assisted Treatment for incarcerated population Medication Assisted Treatment Re-Entry Initiative Naloxone Education/Take Home Program Peer Recovery Specialist Initiative Residential Illicit Drug Use Program
Department of Criminal Justice Services	Addiction Recovery Grant Program Pre-Release and Post-Incarceration Services Programs Residential Substance Abuse Treatment for Prisoners Grant Fund Training for School Security Officers and School Resource Officers Virginia Opioid Use Reduction and Jail-Based Substance Use Disorder Treatment and Transition Grant Program Virginia Youth Violence & Substance Use Prevention and Intervention Grant Program Virginia's Framework for Addiction Analysis and Community Transformation (FAACT) Program
Department of Education	Naloxone distribution in schools Recovery high schools School-based overdose response Substance use prevention education
Department of General Services	State contracting vehicle for naloxone
Department of Health	Comprehensive harm reduction Enhanced overdose data collection Fentanyl wastewater testing Intercept mapping Local and regional overdose fatality reviews Naloxone distribution Public Health and Safety Teams Requirements for hospitals to screen urine Risk mitigation guidelines for extended release long-acting opioids Quality improvement for bridge to treatment programs

TABLE 2, continued.

Agency	Strategy
Department of Juvenile Justice	Fentanyl risk education
Department of Medical Assistance Services	Addiction and Rehabilitation Treatment Services (ARTS) Technical assistance for bridge to treatment programs Treatment for Family Access to Medical Insurance Security (FAMIS) MOMS enrollees
Department of Social Services	Family-based Substance Use Treatment Kinship Navigator Program
Department of Veterans Services	Suicide Prevention and Opioid Addiction Services Program
Office of the Attorney General	One Pill Can Kill media campaign
Opioid Abatement Authority	Grants to localities Grants to state agencies Operation STOP locality grants
State Council of Higher Education for Virginia	Opioid antagonist training for Resident Assistants
Supreme Court of Virginia	Specialty dockets
Virginia Association of Chiefs of Police	First responder naloxone program
Virginia Foundation for Healthy Youth/First Lady of Virginia	It Only Takes One media campaign
Virginia IT Agency	Substance Use Disorder Abatement data platform
Virginia Neonatal Perinatal Collaborative	Training for providers

JCHC staff assigned a level of review for each strategy type. For 14 strategies that focused on substance use but were not specifically implemented for the current fentanyl crisis, staff documented implementation based on existing reports. For 39 strategies focused on addressing the needs of the current opioid and fentanyl crisis, strategies were assessed for effectiveness based on available data, reports, and interviews with stakeholders.

Appendix 3: Virginia's naloxone access laws and regulations

State laws and regulations that expand access to naloxone or other opioid antagonists for overdose reversal generally fall into nine categories.[i] Virginia has laws or regulations that address eight of the nine categories (TABLE 3).

TABLE 3. Virginia's naloxone access laws and regulations

Category	Virginia Authority
Policies targeting prescriber/prescription	
Prescriber immunity. Prescribers are granted criminal or civil immunity for dispensing or distributing naloxone to a lay person.	No specific statute providing immunity; however, *Code of Virginia* § 8.01-581.7 provides that health care providers may only be liable for damages in a civil suit if the evidence supports a conclusion that the health care provider failed to comply with the appropriate standard of care AND that failure is a proximate cause of the alleged damages.
Third party prescribing. Naloxone/opioid reversal agent prescriptions can be written for third parties.	None
Prescribing requirements. Recommends or requires prescribing of naloxone/opioid reversal agent to patients at risk of an overdose.	*18VAC85-21-40.* (Board of Medicine) Treatment of acute pain and subacute pain with opioids *18VAC85-21-70.* (Board of Medicine) Treatment of chronic pain with opioids *18VAC90-40-160.* (Board of Nursing – Advanced Practice Registered Nurses) Treatment of acute pain with opioids *18VAC90-40-190.* (Board of Nursing – Advanced Practice Registered Nurses) Treatment of chronic pain with opioids *18VAC90-70-150.* (Board of Nursing – Certified Nurse Midwives) Treatment of acute pain with opioids *18VAC90-70-180.* (Board of Nursing – Certified Nurse Midwives) Treatment of chronic pain with opioids *18VAC60-21-103.* (Dentistry) Treatment of acute pain with opioids *18VAC105-20-48.* (Optometry) Prescribing an opioid for acute pain

[i] Smart R, Pardo B, Davis CS. Systematic review of the emerging literature on the effectiveness of naloxone access laws in the United States. Addiction. 2021 Jan;116(1):6-17. doi: 10.1111/add.15163. Epub 2020 Jul 8. PMID: 32533570; PMCID: PMC8051142.

TABLE 3, continued.

Category	Virginia Authority
Policies targeting dispenser/distribution	
Dispenser immunity/pharmacy distribution. Dispensers (pharmacists) are granted criminal or civil immunity for dispensing or distributing naloxone to laypersons.	*Code of Virginia* § 8.01-225(A)(20) provides any person who, in good faith, prescribes, dispenses, or administers naloxone pursuant to subsection Y or Z of §54.1-3408 civil immunity for ordinary negligence in acts or omissions resulting from such prescribing, dispensing, or administering.
Non-patient specific dispensing models/standing orders. Naloxone can be dispensed or distributed without patient-specific prescriptions such as via standing order.	*Code of Virginia* § 54.1-3303.1(A)(1) permits a pharmacist to initiate treatment with, dispense, or administer naloxone or other opioid antagonist to persons 18 years of age or older with whom the pharmacist has a bona fide pharmacist-patient relationship, in accordance with a statewide protocol developed by the Board of Pharmacy together with the Board of Medicine and the Department of Health. *Code of Virginia* § 54.1-3408(Y) allows a pharmacist, health care provider providing services in a hospital emergency department, or emergency medical services personnel to dispense naloxone pursuant to an oral, written, or standing order issued by a prescriber or a standing order issued by the Commissioner or his designee authorizing such dispensing in the absence of an oral or written order for a specific patient issued by a prescriber and in accordance with protocols developed by the Board of Pharmacy together with the Board of Medicine and the Department of Health.
Lay dispensing. Laypersons may dispense naloxone.	*Code of Virginia* § 54.1-3408(Y) also allows the multiple individuals to dispense naloxone or other opioid antagonist used for overdose reversal pursuant to an oral, written, or standing order issued by a prescriber or a standing order issued by the Commissioner of Health or his designee, and in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and Virginia Department of Health. *Code of Virginia* § 54.1-3408(Z) allows any person acting on behalf of an organization that provides services to individuals at risk of experiencing an overdose or training in the administration of naloxone for overdose reversal to dispense naloxone pursuant to a standing order issued by a prescriber (which can include the Commissioner of Health) and in accordance with protocols developed by the Board of Pharmacy together with the Board of Medicine and the Department of Health.

TABLE 3, continued.

Category	Virginia Authority
Policies targeting individuals obtaining or using naloxone	
Protections for lay persons administering. Laypersons are immune from criminal or civil liability when administering naloxone.	*Code of Virginia* § 8.01-225(A)(21) provides any person who in good faith administers naloxone or other opioid antagonist used for overdose reversal to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose in accordance with the provisions of subsection AA of *Code of Virginia* § 54.1-3408 immunity from civil damages for any personal injury that results from any act or omission in the administration of naloxone or other opioid antagonist use for overdose reversal, unless such act or omission was the result of gross negligence or willful or wanton misconduct.
Decriminalizing possession without a prescription. Removes criminal penalties for possession of naloxone without prescription.	*Code of Virginia* § 18.2-250 makes it a crime to "knowingly or intentionally to possess a controlled substance unless the substance was obtained directly from, or pursuant to a, a valid prescription or order of a practitioner while acting in the course of his professional practice, or except as otherwise authorized in the Drug Control Act (§ 54.1-3400 et seq.)." However, because naloxone is not a scheduled drug, the prohibition of § 18.2-250 does not apply.

Appendix 4: Minimum behavioral health standards for jails

TABLE 4. Minimum standards for mental and behavioral health services in Virginia jails

Standard	Description
Access to Care	Inmates have access to care to meet their mental health needs.
Policies & Procedures	The facility has a manual or compilation of policies and defined procedures regarding mental health care services which may be part of a larger health care manual.
Communication of Inmates' Needs	Communication occurs between the facility administration and behavioral healthcare professionals regarding inmates' significant behavioral healthcare needs that must be considered in classification decisions in order to preserve the health and safety of that inmate, other inmates, or safety of the institution/staff.
Mental Health Training for Correctional Officers	A training program established or approved by the responsible health authority in cooperation with the facility administration guides the mental health related training of all correctional officers who work with inmates.
Medication Services	Medication needs are reviewed as part of the intake/screening process. Jail has policies and procedures to guide the timeliness of responding to the medication needs of inmates.
Mental Health Screening	Mental health screening is performed on all inmates on arrival at the intake facility to ensure that emergent and urgent mental health needs are met.
Mental Health Assessment	All inmates receive mental health screening; inmates with positive screens receive a mental health assessment.
Emergency Services	The facility provides 24-hour emergency mental health services.
Restrictive Housing	When an inmate is held in restrictive housing, staff monitor his or her mental health.
Continuity and Coordination of Health Care During Incarceration	All aspects of mental health care are coordinated and monitored from admission to discharge.
Discharge Planning	Discharge planning is provided for inmates with mental health needs.
Primary Mental Health Services	Mental health services are available for all inmates who suffer from serious mental illness.
Suicide Prevention Program	The facility identifies suicidal inmates and intervenes appropriately.
Identification and Treatment of Substance Use Disorders	Inmates are screened for the existence of substance use disorders.

TABLE 4, continued.

Standard	Description
Management of Intoxication, Withdrawal, and Overdose	Protocols exist for managing and responding to inmates under the influence of alcohol or other drugs and those undergoing withdrawal from alcohol, sedatives, or opioids.

SOURCE: RD137 – Minimum Standards for Behavioral Health Services in Local Correctional Facilities (HB 1942). (Appendix A)

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