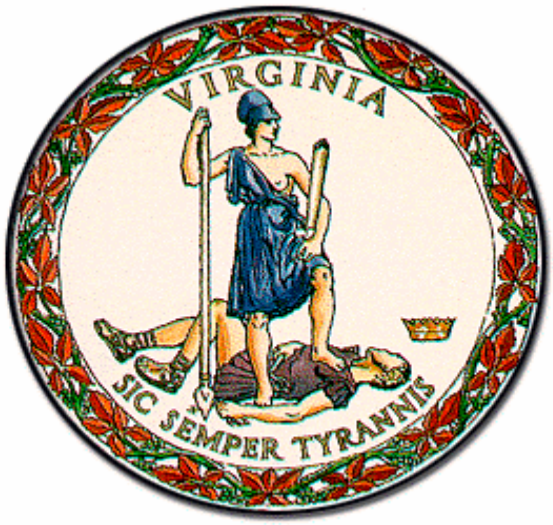
SUBSTANCE ABUSE SERVICES COUNCIL

ANNUAL REPORT
2015

to the Governor and

the

General Assembly



COMMONWEALTH OF VIRGINIA

October 1, 2015

COMMONWEALTH of VIRGINIA

William H. Williams, Jr.
Chair

Substance Abuse Services Council
P.O. Box 1797
Richmond, Virginia 23218-1797

October 1, 2015

To: The Honorable Terence R. McAuliffe
and
Members, Virginia General Assembly

In accordance with §2.2-2696 of the *Code of Virginia*, I am pleased to present the 2015 Annual Report of the Substance Abuse Services Council. The *Code* charges the council with recommending policies and goals relating to substance abuse and dependence and with coordinating efforts to control substance abuse. It also requires the council to make an annual report on its activities. The membership of the council includes representatives of state agencies, delegates, senators and representatives of provider and advocacy organizations appointed by the Governor.

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

Sincerely,

William H. Williams, Jr.

cc: The Honorable William A. Hazel, Jr., M.D., Secretary of Health and Human Resources
The Honorable Anne Holton, Secretary of Education
The Honorable Brian Moran, Secretary of Public Safety and Homeland Security
Jack Barber, M.D., Interim Commissioner, Department of Behavioral Health and Developmental Services
Paula Mitchell, Chair, State Board of Behavioral Health and Developmental Services

ANNUAL REPORT
OF THE SUBSTANCE ABUSE SERVICES COUNCIL
TO THE GOVERNOR AND THE GENERAL ASSEMBLY
2015

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ANNUAL REPORT
OF THE SUBSTANCE ABUSE SERVICES COUNCIL
TO THE GOVERNOR AND THE GENERAL ASSEMBLY
2015

INTRODUCTION

The Substance Abuse Services Council is established in the *Code of Virginia* [§2.2-2696] to advise the Governor, the General Assembly and the State Board of Behavioral Health and Developmental Services on matters pertaining to substance abuse in the Commonwealth. As required, the council met four times during 2015 (March 10, May 13, June 24 and August 5). All meetings were conducted in the metropolitan Richmond area. Meeting notices and approved minutes are posted on the council's web page at http://www.dbhds.virginia.gov/about-dbhds/boards-and-councils/substance-abuse-services-council.

The contents of this report cover the activities of the council in 2015. This document includes a very brief discussion of the epidemiology of substance abuse in the Commonwealth. During this period, council members heard presentations on critical topics related to providing services for people with substance use disorders.

EXTENT OF THE SUBSTANCE ABUSE PROBLEM IN VIRGINIA

Numerous documents, both national and Virginia-specific, have enumerated and described substance abuse issues and their impact in Virginia. Data from the National Survey on Drug Use and Health, covering 2012-13, indicate that 1,827,620 Virginians (21.95%) age 12 and older have participated in an episode of binge drinking (consuming at least five drinks on one occasion). Data also show that 381,344 Virginians (4.58%) used pain relievers for a nonmedical use, and 650,283 (7.81%) met clinical criteria for either dependence or abuse of illicit drugs or alcohol. Regarding unmet need for treatment, 512,067 Virginians (6.15%) age 12 years old or older needed, but did not receive, treatment for alcohol use in the past year. Also, 184,011 Virginians (2.21%) needed, but did not receive, treatment for illicit drug use in the past year.

The Virginia Department of Health's (VDH) Office of the Chief Medical Examiner's Annual Report provides information about mortality related to substance use, including the misuse of prescription pain medication. The number of deaths caused by drugs increased 53.3% between 2003 and 2013 (from 595 in 2003 to 912 in 2013). In 2013, 51.0% of these deaths were due to prescription drugs, while illegal (street) drug poisoning accounted for 26.8% of deaths, which represents a significant increase from 2012 (when they accounted for 19.4% of deaths). Heroin deaths alone more than doubled between 2011 and 2013, from 87 to 174, respectively.

LEGISLATION RELATED TO SUBSTANCE ABUSE

Each year, council members are briefed on legislation related to substance abuse that is considered by the General Assembly. Members reviewed a summary of 2015 legislation tracked by the Department of Behavioral Health and Developmental Services (DBHDS), Office of Substance Abuse Services, as well as a comprehensive summary of additional legislation most relevant to the work of the council. Members were briefed on the following legislation:

House Bill 1445 (identical to Senate Bill 1235) *Cannabidiol oil and THC-A oil; recommendation and dispensing. Possession or distribution of marijuana for medical purposes; epilepsy.* Provides an affirmative defense in a prosecution for the possession of marijuana if the marijuana is in the form of cannabidiol oil or THC-A oil possessed pursuant to a valid written certification issued by a practitioner of medicine or osteopathy licensed by the Board of Medicine for purposes of treating or alleviating a patient's symptoms of intractable epilepsy. The bill provides that a practitioner shall not be prosecuted for distribution of marijuana under the circumstances outlined in the bill.

House Bill 1458 *Naloxone or other opioid antagonist; pharmacist may dispense in cases of opiate overdose,* was enacted. This legislation: (1) expanded the naloxone pilot enacted in the 2013 Session to permit lay people statewide to use naloxone to reverse opioid overdoses; (2) expanded access to naloxone by permitting pharmacists utilizing a specific protocol for a standing order to dispense naloxone; (3) permits law enforcement officers and firefighters who have been trained to carry and use naloxone; and (4) extends civil immunity to individuals using naloxone to reverse opioid overdose.

Senate Bill 1186 (identical to House Bill 1833) *Naloxone; administration by law enforcement officers,* which also passed.

Senate Bill 892 (identical to House Bill 1500) *Overdoses; establishes an affirmative defense to prosecution of an individual, etc., safe reporting,* which establishes an affirmative defense if a person reports an overdose, remains on the scene, and cooperates with police. The bill also passed.

REPORT ON COUNCIL ACTIVITIES

During 2015, the Substance Abuse Services Council continued its study of issues related to marijuana. Members heard presentations on the impact of legalization in Colorado, the prevalence of adolescent use of marijuana, including its impact on the adolescent brain, and the experience, perspectives and recommendations of members of Virginia’s law enforcement community. The following summarizes these presentations.

The Real Impacts of Marijuana: What Virginia Can Learn from Colorado

Brittany Sandidge, Director of Development, Prevention Council of Roanoke County, and Regina Whitsett, Executive Director, Substance Abuse Free Environment (SAFE), Inc., reported on their travel to Colorado to participate in a conference of police chiefs representing 39 states and three countries discussing marijuana's impact on their communities. The Community Coalition of Virginia (CCoVA), a state level group of coalitions that educates and supports prevention programs across the Commonwealth, supported travel for Ms. Sandidge and Ms. Whitsett.

Ms. Sandidge reported that the first constitutional amendment for medical marijuana was adopted in Colorado in 2000. In 2009-10, regulations were developed around medical dispensaries and the medical marijuana caregiver model. Amendment 64, which legalized recreational marijuana in Colorado, passed in 2010. In 2013, the Colorado Department of Revenue created a structure to oversee retailing of recreational marijuana, and, in 2014, the commercialization of marijuana began in Colorado. She noted that Denver has 50% of the retail recreational and medical marijuana licenses in Colorado. She provided information on the typical marijuana card holder: 94% register for severe pain; 2% for seizure; 1% for glaucoma and treatment for HIV/AIDS symptoms. The average card holder in Colorado is a white male, about 30 years old, living in suburbia. As of December 2014, there were 115,000 medical marijuana cardholders in Colorado. Those names are held by the Department of Health, whereas licensing regulation and control for compliance purposes are managed by the Department of Revenue in its Marijuana Enforcement Division. Law enforcement does not have access to the patient registry because of HIPAA regulations. She noted that the average past month use of marijuana by college age (18 to 25 years old) individuals has increased to almost 30% since legalization, from 22.36% in 2008 to 29.05% in 2013 (National Survey on Drug Use and Health, 2006-2013). Also, the rate of use in Colorado among adults (26+) in 2013 was 10.13%, almost double the national rate of 5.45%

Ms. Whitsett provided information on the "home grow" and the "caregiver" models, which are unregulated in Colorado. The home grow legislation allows a person to grow six plants without registration. These individuals are not licensed or regulated; anyone can grow six plants in their home. In the caregiver model, an individual can have up to six patients and grow six plants per patient (i.e., 36 plants). She indicated that home grown marijuana is diverted to the black market to be sold out of state. She provided data on butane hash oil and extraction explosions, caused by individuals blowing up their homes in trying to extract the THC out of the marijuana plant, which have increased since 2013. As of January 2015, metro Denver has more marijuana dispensaries than Starbucks and McDonalds combined.

Ms. Whitsett provided data on the total revenue from marijuana taxes for calendar year 2014. The anticipated drop in medical sales and rise in recreational sales did not occur because medical sales are taxed at 18% whereas recreational sales are taxed at 28-32%. The economic incentive for most residents who buy marijuana is to use a medical marijuana card and pay the lower tax. Marijuana in edible forms accounts for 50% of the recreational sales in Colorado. There are over 400 different edibles on the market, and 4.1 million pieces were sold last year. Until last September, there was no maximum dosage or way of verifying what a dose was in packaged products. Currently, there is limited regulation for recreational purchases but restrictions are

voluntary for medical edibles.

Based on the lessons learned from research, from the experience in Colorado, and from an awareness of the current climate and laws within the Commonwealth, Ms. Whitsett and Ms. Sandidge recommended:

- Avoid altering marijuana-related laws, as it is still a Schedule I Drug;
- Utilize the FDA process to validate all medical treatments;
- Avoid home grow and caregiver models;
- Plan regulation and tracking mechanisms (patient registry with law enforcement access);
- Create clear state *and* local governance;
- Establish case law (minimize conflicts between code changes, new laws, and federal regulations);
- Collect and manage baseline and impact data; and
- Follow the advice of Colorado officials - *WAIT AND WATCH.*

Marijuana and Adolescents: A Companionship Headed for Destruction

Malcolm V. King, MS, CSAS, Adolescent Substance Abuse Treatment Coordinator, Office of Child and Family Services, DBHDS, reported on general effects of natural and synthetic marijuana use, the prevalence of adolescent use, and the impact on the adolescent brain. Documentation related to adolescent marijuana use in 2014 was provided through statistics from a long-term study of American adolescents, college students, and adult high school graduates through age 55.

Marijuana continues to be the most widely used and abused illicit drug by adolescents. It is estimated that 46% of high school students will have experimented with the drug at least once in their lifetime. Based on information gathered in the 2014 *Monitoring the Future Study,* a biennial study of high school students conducted by the University of Michigan, marijuana use in the 8th, 10th and 12th grades dropped in 2013 and continued to decline into 2014. The perceived risk of harm was low but it has been rising in 12th graders. The *Monitoring the Future Study* reports that:

- Half of 12th graders have used marijuana in their lifetime;
- One percent of the 8th graders surveyed use marijuana daily;
- Public perception of harmlessness decreases the stigma of use;
- Use is more frequent in high-school students than cigarette smoking; and
- Availability of over-the-counter synthetic marijuana creates a false sense of safety.

While marijuana is still the most popular drug, the method of use has changed in recent years. The drug continues to be smoked as “joints” and “blunts,” but a rapidly increasing way of using is the practice of “dabbing.” Butane hash oil (BHO), a medicinal marijuana product, is extracted from the plant and concentrated into oil that is smoked. To manufacture BHO, users typically take a tube, fill it with marijuana and then fill the tube with butane. The butane strips the (THC) from the plant and the butane boils off at room temperature. After the butane boils off, a sticky yellow residue, BHO, is left behind. This is the substance that is smoked. This method is popular because the heavily concentrated vapor that is inhaled produces a very strong “high.” Synthetic

marijuana is the second most popular method of use. It is classified as a "designer" drug, and the ability to purchase the ingredients over-the-counter creates a false sense of safety. It is marketed as K-2 or Spice and has street names such as Skunk, Moon Rock, Genie, and Black Mamba. It is a drug in which herbs, incense or other leafy materials are sprayed with liquid chemicals to mimic the effect of THC.

All of these forms of marijuana are very dangerous because of the effects on the developing adolescent brain. Any form of drug use has a profound effect on brain chemistry, but adolescent brains are especially vulnerable to the negative short- and long-term impact of marijuana use. The adolescent brain is immature. Normal brain development is not complete until age 25, and marijuana use significantly slows down the maturation process. Using the drug in any form may alter judgment, problem-solving, and emotional reactions. Regular use in the early teen years lowers IQ into adulthood. It impairs critical thinking and memory function even if users stopped smoking marijuana in adulthood. Marijuana use in young adults provides an introduction into the drug culture, which can lead to lifetime addiction. Research suggests that there is an association between adolescent marijuana use and developing psychosis or schizophrenia later in life.

According to the 2014 *Monitoring the Future* report, legalization of recreational marijuana, with extensive advertising and marketing, could result in greatly increased use by adolescents. Careful monitoring is needed on the effects on youth behaviors and attitudes of the introduction of medical use and the legalization of recreational use by adults.

Marijuana in the Commonwealth: Experience, Perspectives and Recommendations from Members of Virginia's Law Enforcement Community

Captain Paul Cleveland, Fairfax County Police, Organized Crime and Narcotics Commander, stated that the nationwide perception of marijuana has changed drastically. In the past, police went out, conducted undercover "buys," and used Special Weapons and Tactics (SWAT) teams for enforcement. Since some states have legalized marijuana, response has become more ambiguous. In Fairfax, there is a changing perception of how the SWAT team should be used. Previously, its use was based on the Supreme Court decision that if the police have a drug search warrant, they can use a SWAT team to execute the search warrant. Today, every search warrant that is written has to be scrutinized to decide if it is appropriate to use a SWAT team. Marijuana is a game changer and a money maker, leading to violent confrontations associated with dealing it. In Fairfax there are indoor grows that produce hundreds of thousands of plants. With the sale of those plants, there is a greater chance for robbery, home invasion, and violent armed encounters. In states that have legalized it, assaults, crimes against persons, and robberies have dramatically increased.

Detective Joseph Partin, Chesterfield County Police Department, noted recent trends related to marijuana in his jurisdiction since it was legalized in other states. He reported some of the problems with using and with distribution, and presented statistics from 2010-2015 on the number of arrests for distribution. He stated that the number of marijuana grow operations has significantly decreased due to the increase of marijuana being imported from states where it is legal. It is extremely hard to find low grade marijuana anymore and the only strand presently available is high grade marijuana. He reported six homicides in his area that were directly related

to the distribution of marijuana. Three were of someone purchasing one ounce of marijuana.

Many people are affected by crime where marijuana is involved, and many arrests are associated with parcel interdictions. Since there is a lot of money to be made selling high grade marijuana, most dealers are having the product shipped in. There is a large amount of cash involved in dealing with marijuana, increasing risk of robbery**.** Detective Partin stated that there is a lot of violence associated with selling marijuana and that the greatest risks with legalization will come from robberies, burglaries and violent crimes. He believes that states that have legalized marijuana will also see an increase in robberies at legal dispensaries, putting citizens at risk of violence.

Lieutenant Kevin M. Hood and **Trooper Aubrey B. (Byron) Treakle, Virginia State Police, Counter-Terrorism and Criminal Interdiction Public Transportation Team**, provided an overview of how their team operates within the Virginia State Police. The team is primarily responsible for the day-to-day operations of intercepting and interdicting parcels. Lt. Hood and Trooper Treakle stated a lot of marijuana is being grown in Virginia, particularly in the western part of the state, and a substantial amount of marijuana is currently being shipped into the Commonwealth through various modes such as parcels and freight. In 2014, the team seized 377 pounds of marijuana with a street value of over $1 million. In the first five months of 2015, the team has seized about 1,100 pounds of marijuana with a street value of over $500,000. Most of the shipments are coming from California; there have also been parcels from Colorado, Washington State and Arizona. Drug trafficking organizations are integrating the shipment of marijuana into complex schemes incorporating legitimate businesses. Marijuana is being comingled with other illicit materials such as cocaine and prescription medication, and also food products.

Marijuana generates a substantial amount of money for individuals and criminal organizations. Lt. Hood stated that THC oil extractions are hitting the market; this trend is growing very quickly because the oil is very profitable. Some of the dangers of extracting THC are that the oil has very high levels of THC (30-80% compared to 7%, which is the "dirt" marijuana, and 35% with hydroponic marijuana). Significant amounts of marijuana are being shipped into Virginia. For instance, in June, the team worked with the U.S. Drug Enforcement Administration, Immigration and Customs Enforcement and postal inspectors in Henrico County. On two nights in the Richmond Metro area, there were seizures of 15 parcels containing marijuana, including 129 pounds of marijuana with a street value over $700,000, 15 fluid ounces of THC oil with a street value of $1,500, and $25,000 in cash. All of the parcels came from California or Arizona. Lt. Hood emphasized three key messages: the increased volume of marijuana, the complexity of shipping operations, and the money that is being made.

Sergeant Keith Winingear, Vice and Narcotics, Norfolk Police Department, reported a significant increase in marijuana seizures in the Hampton Roads area. In one instance, dealers were bringing in 2,700 pounds of marijuana every two weeks; their records showed $2-$3 million in sales per month. He also reported that dealers use private carriers, such as FedEx and UPS, to transport marijuana. He stated that grow operations in the Hampton Roads area have been reduced because it is much simpler to have it shipped in. He believes that private carriers and the U.S. Postal Service have unknowingly become the largest carriers of narcotics in the

United States. In Norfolk, about 409 pounds of marijuana were seized through interdiction in the first six months of 2015. There has also been an increase in the amount of edibles being shipped into this area. Hampton Roads has seen an increase in seizures of marijuana from Atlanta, Colorado, Oregon, and Washington State. Hampton Roads is also seeing more deliveries of "medical" marijuana.

Now that marijuana is decriminalized in Colorado, the new trend is to get the strongest or highest THC content possible. THC content has increased from 1-4% purity to 13% normal with an upper limit seen at 37% purity. People are not accustomed to smoking something so strong, which greatly increases health risk. In Colorado, there have been many calls to poison control centers because people think that they are dying from such strong content. Sergeant Winingear described butane extractions and showed pictures the extraction devices. The extraction process essentially creates a pipe bomb. Butane Hash Oil (BHO) is 70-90% pure THC. Butane is highly explosive; it takes just a spark to create an explosion. This process is becoming an issue around local college campuses.

In Colorado several other issues have also plagued the state since decriminalization. A black market still exists in Colorado, making up about 40% of sales. Because money from the sales cannot be put into a federally insured bank, the marijuana industry is considering starting its own banking industry. Colorado is also having issues in schools. Students have little concern about marijuana, and school resource officers report seeing use at a higher rate than ever. Reports to poison control have increased for youth due to consuming edible marijuana. In Colorado, prior to legalization of marijuana, there were 106,000 medical marijuana licenses in 2012. There are now 115,000 licenses; of those, 94% are issued for severe pain, which cannot be objectively verified.

Ms. Dana G. Schrad, Executive Director, Virginia Association of Chiefs of Police, discussed marijuana in the context of drug policy in the Commonwealth. In the mid-1990s, Virginia received funding for substance abuse treatment and prevention. Since then, policy issues surrounding addiction have become more complicated due to a shift in what is perceived as "normal." This is particularly true concerning the use of marijuana. The presentations by law enforcement provide a view of narcotics trafficking that the public does not see on a day-to-day basis. The perception that "everybody's doing it" and myths around decriminalizing or legalizing marijuana can lead to bad policy decisions. Decriminalizing and legalizing marijuana will not get rid of the black market; in many instances, it enhances it. Also, taxing marijuana is not an appropriate revenue source since legalizing it would have an adverse effect on public safety. Ms. Schrad believes that marijuana is a gateway drug for youth. It changes their value system and may introduce them to the criminal community and a violent drug culture.

In working with the International Association of Chiefs of Police on policy development, Virginia officials looked at Colorado statistics. Colorado fatalities involving drivers testing positive for marijuana have increased 114% between 2006 and 2011. Youth admissions into Emergency Rooms for marijuana-related incidents also increased. The Department of Health and Human Services in Colorado reported that youth age 12-17 is the leading age group represented in drug-involved Emergency Room admissions. Officials have also documented major increases in exports of marijuana from Colorado to other states. In states that have decriminalized or legalized marijuana, there are too many gray areas creating other kinds of problems (e.g.,

economic problems, finding enough treatment and education services, and problems with bordering states).

CONCLUSION AND RECOMMENDATIONS

Over the last two years, council members deliberated on critical issues related to marijuana. In particular, they analyzed the potential impacts on the Commonwealth if marijuana were legalized in Virginia. Members considered multiple viewpoints presented by experts in science, medicine, law, public health, and publicly-funded treatment programs, community stakeholders and members of advocacy groups.

Experts in law enforcement expressed grave concern about the adverse impact legalization would have on their operations and on public safety. Council members concluded that an increase in the availability and acceptability of marijuana, even if limited to medicinal purposes, will lead to increased rates of use, especially among youth. Misuse and addiction in local communities will require additional state resources to address public health and safety concerns and to provide prevention and treatment services. The council formulated the following recommendations based on expert input, evidence-based research, experience of other states such as Colorado, and from an awareness of the current climate and laws within the Commonwealth.

The primary recommendation of the Substance Abuse Services Council is that Virginia should not decriminalize or legalize marijuana at this time. The council also recommends that there not be any general exception for use of marijuana for medical purposes. The council believes that legislative approval for any additional medical use of marijuana or any of its derivatives should be approved by the United States Food and Drug Administration (FDA) through its assessment processes before legislative action. Any narrow exception to this, such as approval for cannabinoid oils for a small number of people with intractable seizure disorder as occurred during the 2015 Session, should be considered only if no relevant FDA trials are being conducted and there is compelling evidence of need and benefits with limited risks or negative effects.

The council further recommends that the Governor and General Assembly initiate the following action steps:

- *Request a study by the Joint Legislative Audit and Review Commission (JLARC) on the impact of legalization, decriminalization, and medical use of marijuana*. By researching current effects of legalization in Colorado, other states, and the District of Columbia, a JLARC study could identify how new marijuana legislation might impact the Commonwealth across various sectors (e.g., the economy, workforce, education, wellness, child safety, traffic safety, law enforcement, the courts, prevention efforts and access to treatment). Recognizing the need for Virginia to be prepared should marijuana legalization occur at the federal or state level, the council also recommends that the JLARC study address potential topics such as; 1) conflicts between Code changes, new laws, and federal regulations; 2) creating a tracking mechanism, such as a patient/user registry with law enforcement access; and 3) lessons learned from the Colorado experience with practices such as home grows and caregiver models. For consistency, it will be critical to develop clear state and local governance to close loopholes, correct

misinterpretations, and avoid unintended consequences, such as black and gray markets, that could conflict with state regulations.

- *Implement a program for research and data collection.* Continued research and systematic data collection are critical for developing effective prevention strategies and appropriate treatment services. It is essential to collect and analyze baseline and impact data. The council recommends conducting extensive research and evaluating the results before making any changes to current marijuana laws. The council recommends studying data from the High Intensity Drug Trafficking Area (HIDTA) program (an enforcement program run by the U.S. Office of National Drug Control Policy), CCoVA, and SAFE, and other similar organizations in the Commonwealth. In addition, council recommends encouraging state institutions to conduct valid and reliable scientific research studies of marijuana's impacts on physical and mental health across the life span.

- *Encourage collaboration among concerned stakeholders.* Council recommends a multi-agency, collaborative approach to long-range planning to prepare for potential legalization in the future in the Commonwealth, as well as planning and response to the impact on the Commonwealth from changing marijuana legislation in other states. The council recommends convening a core group of leaders with decision-making power from relevant agencies (DBHDS, VDH, Department of Education, Department of Alcoholic Beverage Control, etc.), as well as representatives from law enforcement and advocacy groups, to develop a coordinated strategic approach to potential legalization of marijuana in the Commonwealth. The State Health and Human Resources cross-agency data efforts offer an opportunity to collect, share and evaluate research.

Although the council appreciates advice from Colorado officials to *"WAIT AND WATCH,"* the council chooses to be proactive and, therefore, recommends that Virginia *"WAIT AND WORK."*

APPENDICES

§ 2.2-2696. Substance Abuse Services Council

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

B. The Council shall consist of 30 members. Four members of the House of Delegates shall be appointed by the Speaker of the House of Delegates, in accordance with the principles of proportional representation contained in the Rules of the House of Delegates, and two 222members of the Senate shall be appointed by the Senate Committee on Rules. The Governor shall appoint one member representing the Virginia Sheriffs' Association, one member representing the Virginia Drug Courts Association, one member representing the

Substance Abuse Certification Alliance of Virginia, two members representing the Virginia Association of Community Services Boards, and two members representing statewide consumer and advocacy organizations. The Council shall also include the Commissioner of Behavioral Health and Developmental Services; the Commissioner of Health; the Commissioner of the Department of Motor Vehicles; the Superintendent of Public Instruction; the Directors of the Departments of Juvenile Justice, Corrections, Criminal Justice Services, Medical Assistance Services, and Social Services; the Chief Operating Officer of the Department of Alcoholic Beverage Control; the Executive Director of the Governor's Office for Substance Abuse Prevention or his designee; the Executive Director of the Virginia Foundation for Healthy Youth or his designee; the Executive Director of the Commission on the Virginia Alcohol Safety Action Program or his designee; and the chairs or their designees of the Virginia Association of Drug and Alcohol Programs, the Virginia Association of Alcoholism and Drug Abuse Counselors, and the Substance Abuse Council and the Prevention Task Force of the Virginia Association of Community Services Boards.

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

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

E. Members of the Council shall receive no compensation for their services but shall be reimbursed for all reasonable and necessary expenses incurred in the performance of their duties as provided in §§ 2.2-2813 and 2.2-2825. Funding for the cost of expenses shall be provided by the Department of Behavioral Health and Developmental Services.

F. The duties of the Council shall be:

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

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

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

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

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

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

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

SUBSTANCE ABUSE SERVICES COUNCIL
2015 MEMBERSHIP ROSTER

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