Final Briefing:

Policy Solutions to the Commonwealth's Fentanyl Crisis

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Study purpose

Per House Joint Resolution No. 41 (2024):

- Study the causes of the rise in fentanyl prevalence and fentanyl overdoses
- Study the impact of the rise in fentanyl prevalence and fentanyl overdoses on Virginians and the health care system
- Study and provide insight into the fentanyl crisis within the context of other drug crises and addiction trends in recent history
- Establish and make policy recommendations to reduce the prevalence of fentanyl and reduce the number of fentanyl overdoses in the Commonwealth

Study approved by Commission for the 2025 workplan on December 17, 2024.

Major study questions

- What are the trends in fentanyl use, misuse, overdoses, and deaths in Virginia?
- What prevention, intervention, and treatment strategies are being implemented in Virginia?
- What gaps or unmet needs still exist in Virginia?

Findings in brief

- Illicit fentanyl is highly addictive, readily available, and deadly
- Impact of illicit fentanyl in Virginia has changed over time
- Virginia is successfully implementing evidence-based strategies to address illicit fentanyl use
- Virginia can take additional steps to enhance ongoing efforts
- Gaps exist in efforts to address illicit fentanyl use for certain high-need populations

Agenda

Illicit fentanyl use in Virginia

Virginia's response to the illicit fentanyl epidemic

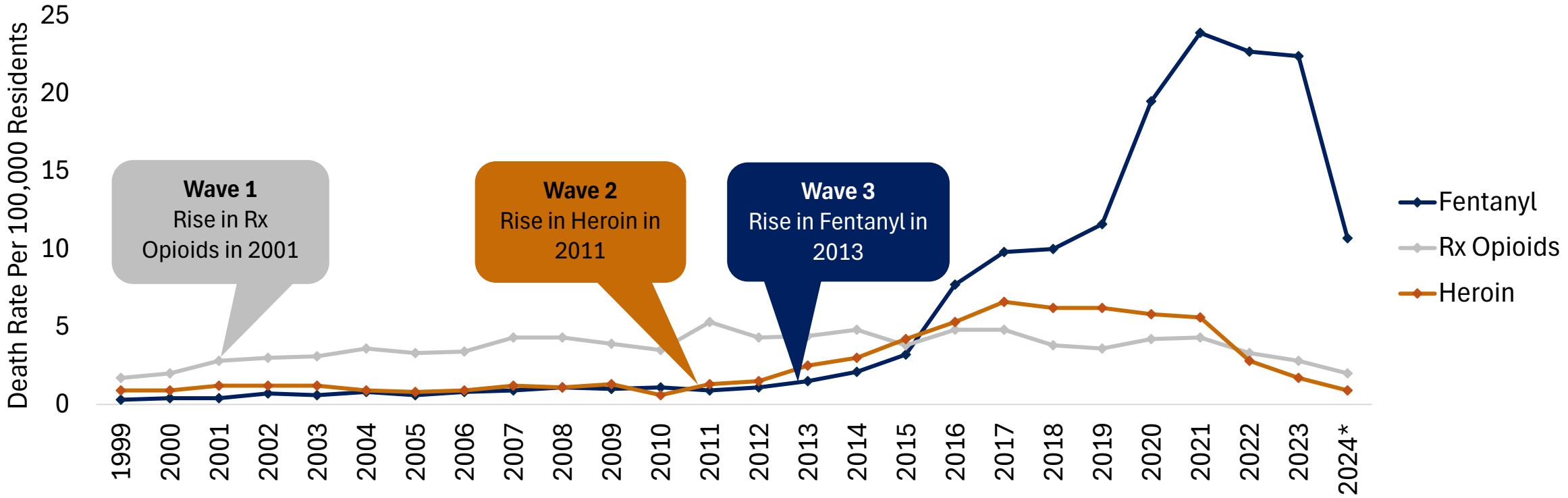
Enhancing ongoing efforts

Expanding access to services for high-need populations

Fentanyl is an efficient and effective analgesic and anesthetic

- Fentanyl travels through the blood to receptors in the brain and blocks pain messages from the body
- Pharmaceutical fentanyl effectively treats severe pain before or after surgery and for late-stage cancer patients
- Illicitly manufactured fentanyl is made in clandestine labs and distributed through illegal drug markets

Fentanyl represents the third wave of opioid overdose deaths in Virginia



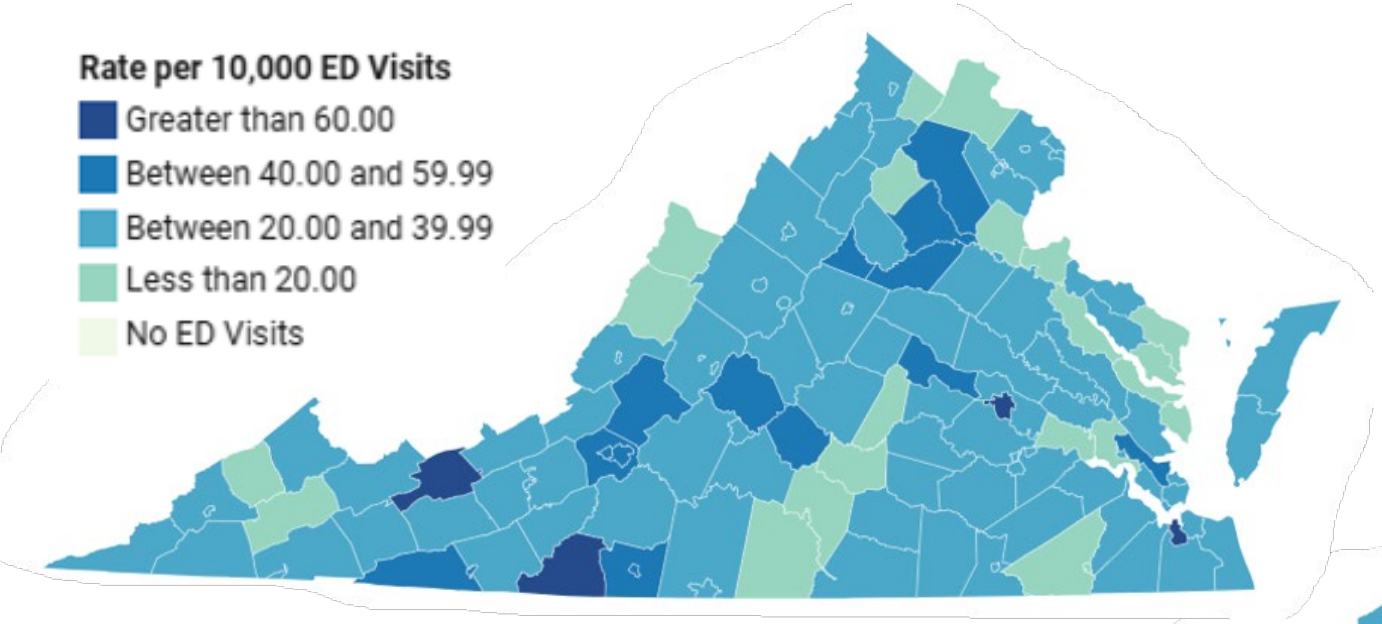
*2024 data are provisional until November 2025 and subject to change.
SOURCE: JCHC staff analysis of data from the Centers for Disease Control and Prevention, National Center for Health Statistics, 2025.

Multiple factors contribute to the change in illicit fentanyl use

- Education on risks of fentanyl and harm reduction strategies were initially limited
- COVID-19 exacerbated the growing epidemic through increased stressors and supply chain disruptions

Most of Virginia experienced high rates of ED visits for opioid overdoses

2021 ED Visit Rate for Opioid Overdose by Virginia Locality



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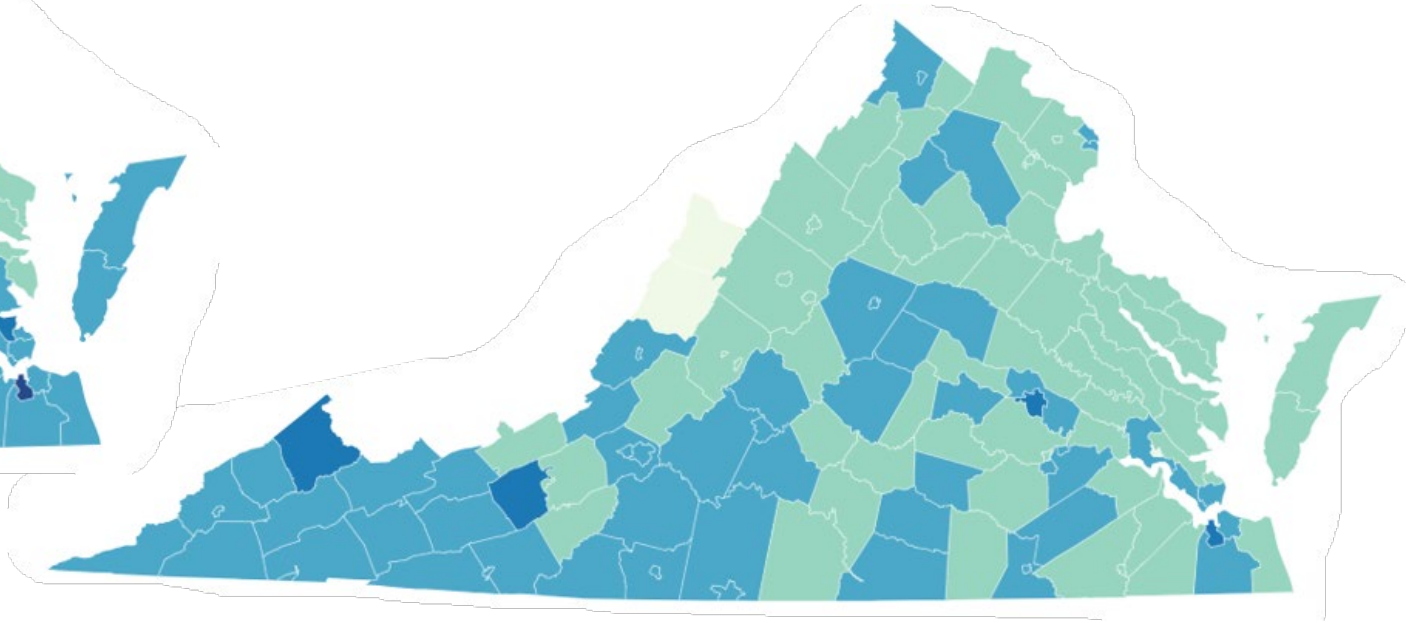
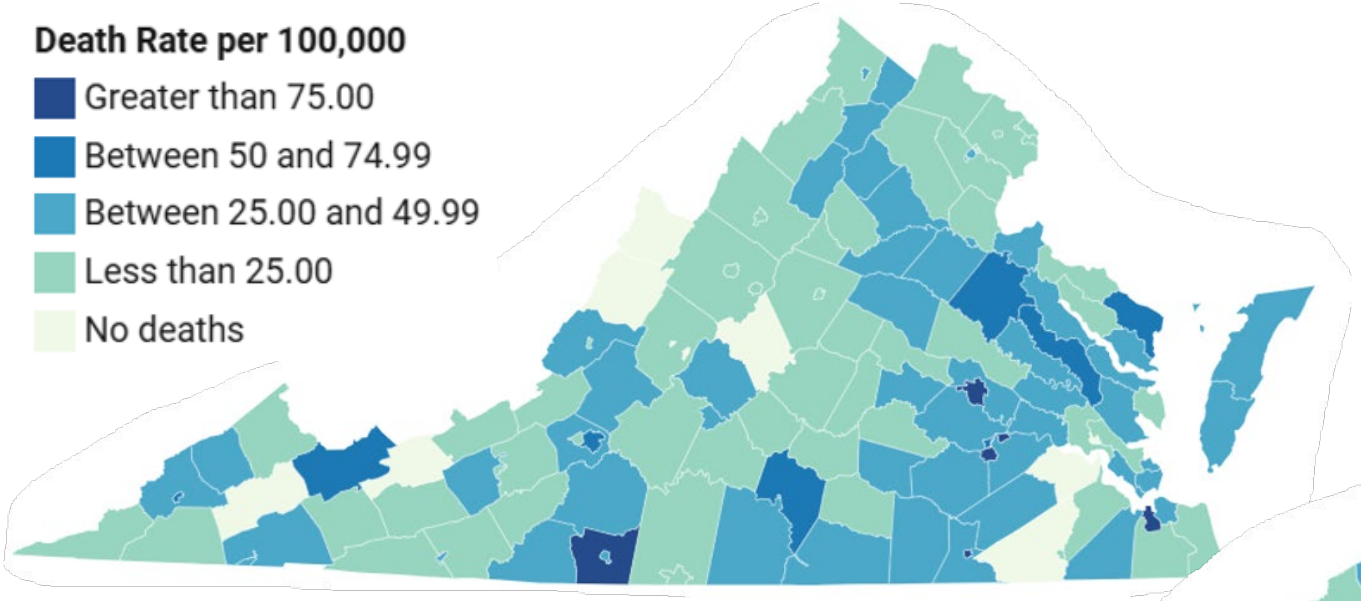


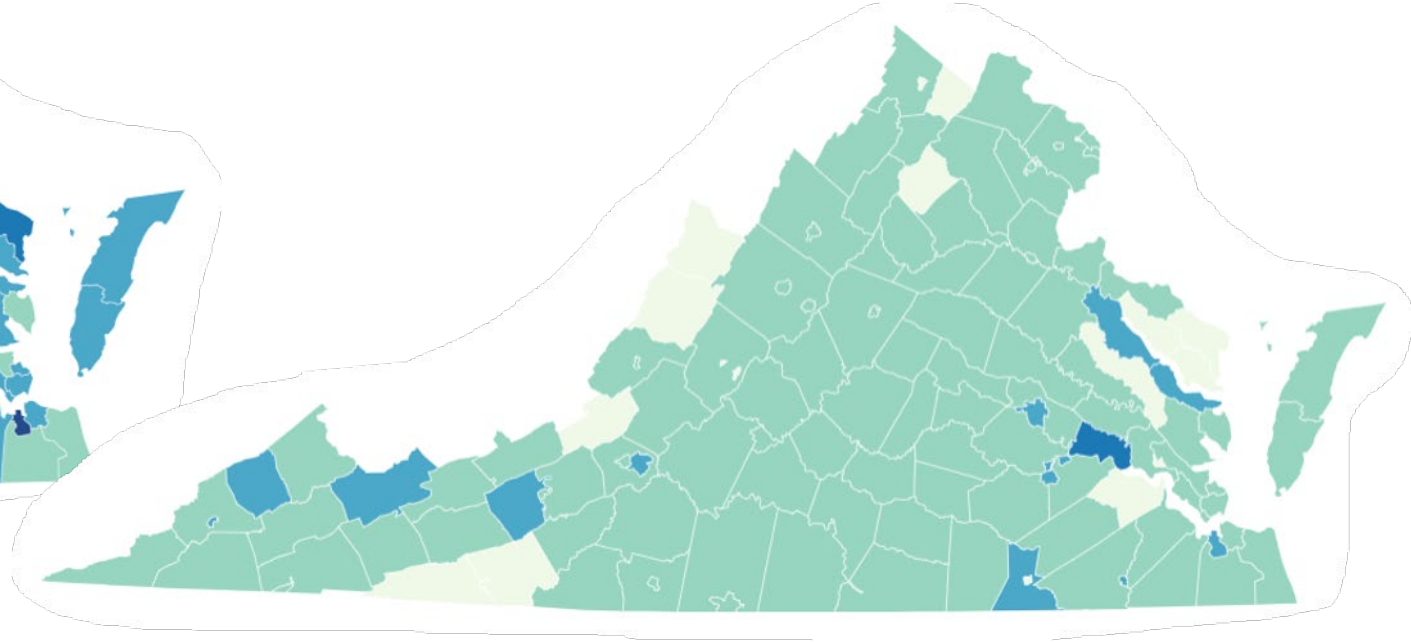
ED = emergency department
SOURCE: JCHC staff analysis of ED visit data from the Virginia Department of Health, 2025.

Urban and rural areas experienced high rates of fentanyl overdose deaths

2021 Fentanyl Death Rates by Virginia Locality



2024* Fentanyl Death Rates by Virginia Locality



*2024 data are provisional 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.

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Virginia is implementing evidence-based strategies to address fentanyl

- Staff identified 53 state-funded or state-administered strategies across 18 agencies:
  - Data collection and reporting to support decision making
  - Educational efforts targeting youth
  - Harm reduction strategies
  - Access to treatment, including medications for opioid use disorder
  - Distribution of opioid settlement funds to localities and state agencies

Virginia must pivot to a sustainable effort

Stakeholders expressed concerns about:

- Continuity of focus on preventing overdoses and of state funding
- Limited coordination, strategic planning, or formalized inter-agency structure
- Lack of information on effectiveness of efforts that were rapidly implemented

Policy Option 1

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

Implementation Considerations

- State planning responsibilities include coordination of effort, identifying gaps, and monitoring outcomes
- Policy option could include a budget amendment for VDH to begin state planning process with a comprehensive needs assessment and evaluation of existing efforts

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Virginia can take additional steps to enhance ongoing efforts

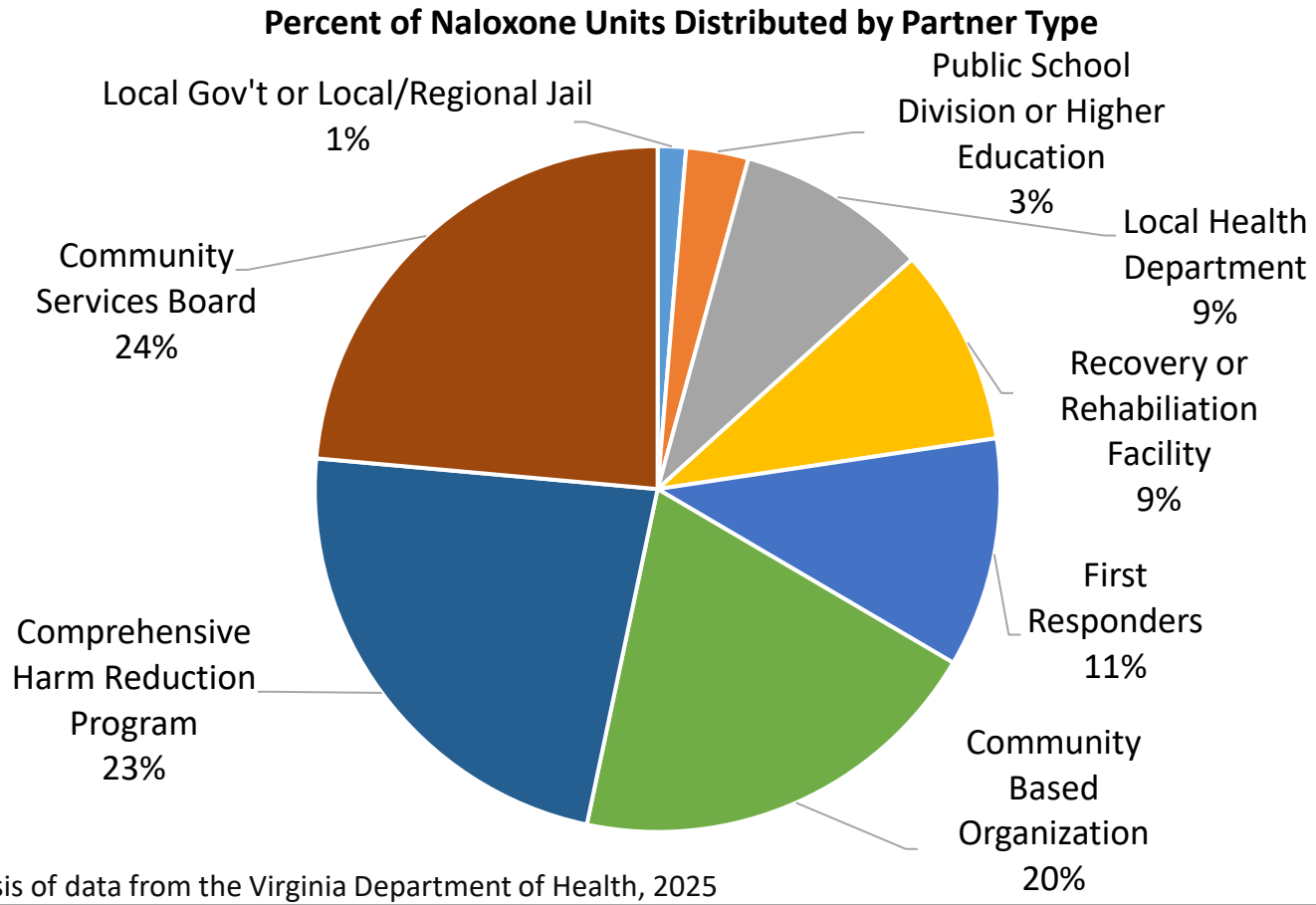
- Availability and costs of opioid antagonists
- Counseling co-requirements for initiation of medication for opioid use disorder
- Hiring practices for peer recovery specialists

DBHDS, VDH responsible for overdose education and naloxone distribution

- DBHDS coordinates REVIVE! training for first responders, the public, and train-the-trainer programs
- VDH procures and distributes opioid antagonists to individuals and organizations who have completed REVIVE! training for free or at cost

DBHDS = Department of Behavioral Health and Developmental Services

VDH distributed 158,700 naloxone kits in Fiscal Year 2025



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

VDH should be optimally funded to maintain naloxone distribution program

- In FY25, VDH received $8.5M for naloxone distribution:
  - $5.6M from COAR fund
  - $1.6M from SAMHSA grant
  - $1.3M from state general fund
- Most recent estimates place program operations costs at $10M per fiscal year for staff, administrative costs, and procurement of naloxone kits

COAR = Commonwealth Opioid Abatement and Remediation Fund; SAMHSA = Substance Abuse and Mental Health Services Administration

Policy Option 2

The JCHC could introduce a budget amendment appropriating funding each 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.

Policy Option 3

The JCHC could introduce a budget amendment directing VDH to develop a methodology to estimate annual naloxone distribution program costs based on available data and to report annually on such estimates to the JCHC and the Chairs of HAC and SFAC by December 1 each year.

HAC = House Appropriations Committee; SFAC = Senate Finance and Appropriations Committee

Implementation considerations

- VDH is required to submit quarterly reports on quantity, formulation, and dosage of naloxone kits distributed
- To inform future funding, VDH could produce timely estimates of program costs that consider the changing landscape of the opioid epidemic

Program funding should be flexible to account for changing community needs

- Budget language requires VDH to use $1M in appropriated funds to purchase and distribute 8mg naloxone nasal spray
  - Scientific evidence does not show additional benefit compared to 4mg dose
  - Higher doses can precipitate withdrawal symptoms
- VDH staff indicate that $1M set aside is more funding than needed to fulfill community requests for 8mg spray

Policy 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 8mg naloxone nasal spray.

Implementation considerations

- Option would not prohibit the purchase and distribution of 8mg spray in response to community requests
- Allows $1M in program funding to be used more flexibly to purchase opioid antagonist products

Opioid antagonists are widely available, but costs may be a barrier for some

- Patients can obtain opioid antagonists through multiple pathways
- Cost-sharing requirements or other service limitations may create financial barriers
  - Medicaid covers prescribed and over-the-counter naloxone, at no cost to patients
  - Coverage is an employer option for most commercial plans, with varying cost-sharing requirements

Policy Option 5

The JCHC could amend the *Code of Virginia* to require health insurers to:

- include at least one opioid antagonist nasal spray on its formulary
- prohibit prior authorization or any other requirements other than those imposed by state and federal law for these drugs
- provide coverage for any FDA-approved over-the-counter opioid antagonist
- not impose any copayment or other out-of-pocket expense for these drugs

Implementation considerations

- As of 2023:
  - Seven states require health insurers to provide coverage of opioid antagonists at no cost
  - Five states have other laws removing barriers to coverage, such as prior authorization
- Policy option would likely require review by Virginia Health Insurance Reform Commission

Medication-assisted treatment is effective for opioid use disorder

- Opioid use disorder is treatable with medication-assisted treatment:
  - Medications for opioid use disorder
  - Psychosocial counseling
- Patients' decision to decline psychosocial counseling or absence of available counseling should not delay use of medications

Providers perceive Virginia's co-counseling requirement as a barrier

- *18VAC85-21-130* states "practitioners engaged in medication-assisted treatment shall either provide counseling in their practice or refer the patient to a mental health service provider …"
- Providers can interpret language as requiring patients to engage in counseling to receive medications for opioid use disorder
- Co-counseling requirements are no longer recommended as they have limited impact on treatment engagement or retention

Policy Option 6

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

Implementation considerations

- Option clarifies that medications for opioid use disorder should be made available to patients regardless of engagement in psychosocial counseling, consistent with national practice guidelines
- Amendment should retain requirements for assessment of psychosocial needs and availability of counseling in office-based settings

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

- Peer support is provided by individuals who have lived experience and are also in recovery
- Peer support positively impacts engagement in treatment, relapse rates, provider relationships, and treatment satisfaction
- DBHDS recognizes four levels of peer support

Hiring inconsistencies bar employment of peer recovery specialists

- Peer recovery specialists may be barred from employment given past criminal convictions
- Virginia has reduced employment barriers in some contexts
  - Board of Counseling issued guidance on impact of criminal convictions
  - SB626/HB1269 (2024) permits DBHDS to hire peer recovery specialists convicted of certain offenses

Peers still face barriers to employment at VDH and VADOC

- Peer recovery specialists positions at VDH and VADOC are classified as “sensitive” and therefore subject to statewide background check requirement
- Internal hiring processes dictate how the results of background checks are addressed and may not account for lived experience required by these roles

VADOC = Virginia Department of Corrections

Policy Option 7

The JCHC could submit Section 1 bills directing VDH and VADOC to develop agency guidelines for hiring peer recovery specialists with previous criminal convictions for compensated employment.

Implementation considerations

- Guidelines could clarify requirements for employment in specific programs and positions operated by the agencies
- At a minimum, guidelines could afford similar opportunities for employment at VDH and VADOC as peer recovery specialists employed through DBHDS

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Gaps exist in efforts for pregnant and parenting women

- In Virginia, 80% of accidental deaths among women who are pregnant or within one year of pregnancy are from overdoses
- Infants with mothers who use substances are at higher risk of being born preterm, having a low birth weight, and experiencing the effects of neonatal abstinence syndrome (NAS)

Project LINK provides specialized services, but start-up funding limits expansion

- Project LINK programs, available at 14 of 40 CSBs, reduces barriers to care for pregnant women
  - Intensive case management for the family unit
  - Home visiting services
  - Transportation and childcare to support treatment attendance
- Sustainment funds are available, but start-up funds have been historically provided by DBHDS based on availability

CSB = Community Services Boards, including Behavioral Health Authorities

Policy Option 8

The JCHC could submit a budget amendment for $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.

Implementation considerations

- Option provides one-time start up funding
  - $500K per site for three sites
  - Covers costs of hiring and training staff, and developing community partnerships for supplemental services
- Could be awarded through a competitive grant program using needs-based criteria

Treatment needs are higher in justice-involved populations

- 67% of inmates in a Virginia correctional facility screen positive for needing substance use treatment
- Risk of drug-related death is significantly elevated following release from incarceration
  - In Virginia, 54% of overdoses among community supervisees occurred within 4 weeks following release
  - Primarily due to disrupted social supports, re-introduction to problematic behaviors, and lowered drug tolerance

Virginia has invested in jail medical staff but gaps persist

- Development of minimum standards for mental and behavioral health services in jails in 2020
- $10M each FY since 2022 for behavioral health case managers and medical treatment positions
- Majority of inmates are still not receiving services
  - 54% of inmates referred to clinical services were released before services could be provided
  - 20% did not receive services due to insufficient mental health staff

Workforce incentive programs could alleviate staffing challenges

- Programs offer student loan forgiveness in exchange for a period of employment in high-demand positions
- Medical and behavioral health staff at local and regional jails are eligible for one federal and one state program
  - Federal Substance Use Disorder Treatment and Recovery Loan Repayment Program
  - Virginia's Behavioral Health Loan Repayment Program

Policy Option 9

The JCHC could submit a Section 1 bill or language-only budget amendment directing VDH 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.

Implementation considerations

Provides VDH flexibility to determine the most efficient and effective means to extend health care workforce incentive programs to personnel working in local or regional jails

Virginia invests in treatment and transition services in local and regional jails

- $2M per year: Jail Mental Health Pilot Program (JMHPP) provides a continuum of behavioral health services to inmates with mental health or co-occurring substance use needs
- $154K per year: Model addiction recovery program addresses aspects of recovery, including peer support and aftercare
- $2M in FY24: Virginia Opioid Use Reduction and Jail-Based Substance Use Disorder Treatment and Transition (JSUT) Program expands access to treatment and transitional services

DCJS lacks flexibility and funding to expand programs

- Budget language for JMHPP prohibits expansion beyond the five sites selected in FY17 that are still operational
- Budget language for model addiction recovery programs prohibits expansion beyond the four sites selected in FY18
- JSUT funds 15 sites for three years through a one-time appropriation from the COAR fund

DCJS = Department of Criminal Justice Services

Policy Option 10

The JCHC could submit a budget amendment to:

- Expand funding for the Jail Mental Health Pilot Program
- Permit DCJS, in consultation with DBHDS, to develop criteria to select additional grantees
- Establish time limits for the duration of grants awarded to ensure additional grantees have the opportunity to compete for funds in the future

Policy Option 11

The JCHC could submit legislation and a budget amendment to:

- Sunset the model addiction recovery program
- Move funds from the model addiction recovery program to the JSUT Fund
- Appropriate funds for an additional cohort of three-year JSUT program grantees
- Direct DCJS to provide technical assistance to current grantees of the model addiction recovery program

Opportunity for public comment

- Submit written public comments by close of business on Friday, October 3rd

  Email: jchcpubliccomments@jchc.virginia.gov

  Mail: 411 E. Franklin Street, Suite 505

  Richmond, VA 23219

NOTE: All public comments are subject to FOIA and must be released upon request.

Questions/Discussion