Annual Report of The Task Force on Substance Abuse Prevention

Submitted by the

Task Force on Substance Abuse Prevention
(legislated by Act 629 of the 86th General Assembly of the State of Arkansas)

Executive Summary

Substance abuse is a key public health issue with severe consequences for affected individuals and society at large. When substance abuse is prevented, individuals, families, and communities reap the benefits in terms of quality of life and economic impact. Act 629 of 2007 was established to authorize formation of the Arkansas Legislative Task Force on Substance Abuse Prevention (referred to throughout this document as "The Task Force"). The Task Force examined the current picture of substance abuse in Arkansas and identified strategies to enhance statewide prevention efforts that will have a lasting impact on the health of Arkansans.

Due to examination of data from the 2011 Arkansas Prevention Needs Assessment Survey (APNA) and expert testimony, the Task Force continues to share the consensus that underage drinking should remain a major focus of Arkansas prevention efforts. Legislation proposed by the Task Force was passed by the Arkansas Legislature in 2009 and designed to address "root causes" of underage drinking identified by APNA data. Act 976 (AN ACT TO PROVIDE CRIMINAL LIABILITY FOR A SOCIAL HOST WHO KNOWINGLY SERVES ALCOHOL TO PERSONS UNDER THE AGE OF TWENTY-ONE; WHO KNOWINGLY ALLOWS MINORS TO CONSUME ALCOHOL ON HIS OR HER PROPERTY) and Act 352 (CONCERNING THE OFFENSE OF KNOWINGLY GIVING, PROCURING, OR FURNISHING ALCOHOL TO A MINOR) were passed to impact sites and sources of underage drinking.

The Task Force continues to support efforts to address the root causes of the underage drinking problem in Arkansas. However, after extensive discussion and professional testimony, the Task Force has identified other areas of recommendation to address preventive efforts to reduce the human and financial costs of substance abuse. These recommendations include: maintenance of the tobacco settlement fund chart plan, establishing state funding for prevention efforts; warnings to prevent fetal alcohol spectrum disorder; and maintenance of the 21 drinking age.

Task Force Recommendations for State Legislation

- **Oppose any legislation that would change the Arkansas Tobacco Settlement Proceeds Act of 2000.**
- **Support Legislation to require warnings to women regarding fetal alcohol spectrum disorder at the point of sale of alcohol in restaurants and bars (see examples in Appendix 1, page 18).**
- **Support Legislation to reinstate the authority of law enforcement to seize drivers licenses of all underage individuals charged with Minor in Possession for the purpose of administrative suspension.**
- **Oppose any legislation or regulation that would be contrary to federal law with regard to marijuana.**

The Task Force also recommends that the Arkansas Legislature utilize its influence to ensure that several programmatic recommendations are considered prevention priorities for Arkansas state agencies. These recommended practices include: a marketing effort to reduce underage drinking; promotion of the APNA survey; training to local coalitions; and support of drug take back program; and encouraging stakeholders to fully participate in the Arkansas Prescription Drug Monitoring Program as established by Act 304.

Task Force Recommendations to Support State Agency Programming Policy and/or Practices

- **Pursue resources to conduct an evidence-based social marketing campaign for underage drinking prevention.**
- **Acknowledge Arkansas school districts who participate in the Arkansas Prevention Needs Assessment Survey and actively encourage non- participants to participate.**
- **Provide grassroots training for local coalitions to implement city and county Social Host Ordinances to reduce underage drinking in private residences.**
- **Acknowledge and sustain prescription drug take-back programs by DEA, Arkansas law enforcement, and State Drug Director's Office.**
- **Encourage widespread participation in the prescription drug monitoring programs among stakeholders.**
- **Encourage Arkansans who are working in the prevention field to acquire certification from the Arkansas Prevention Certification Board.**

History and Purpose of Act 629 of 2007

Prevention of substance abuse is an effort, validated by research, capable of making a positive impact on the rising costs associated with substance abuse. Effective prevention efforts address various substances of abuse throughout the lifespan and are sustained at the community level. To date, Arkansas' substance abuse prevention programs and infrastructure have been primarily funded and directed by the federal government, leaving the state vulnerable to cuts in funding and jeopardizing opportunities for successful outcomes in prevention. In 2007, the 86th General Assembly of the State of Arkansas created Act 629. The Act provided legislative authority to form the Task Force on Substance Abuse Prevention*, whose duties include:

- Evaluate the current substance abuse prevention service delivery system and its capacity to respond to current and projected prevention needs across the full life spectrum, from the prenatal state and early childhood development through adolescence and until the conclusion of adult life;
- Assess the degree of community awareness across the state of the value of effective evidence-based substance abuse prevention;
- Assess financial resources available to invest in substance abuse prevention programs and to identify all available revenue streams, including underutilized revenue and revenue not currently documented as prevention spending;
- Identify all active substance abuse prevention programs in each county throughout the state and determine the specific areas of the state where prevention programs are inadequate or absent; and
- Make recommendations designed to improve and increase sustainable substance abuse prevention services throughout the state, including identifying methods to enhance the development and support of effective community-based programs.

*Task Force members are listed on page 8.

Process Undertaken by the Task Force

The Task Force convened as a whole on several occasions, with subcommittee groups meeting more regularly. Individuals testified before the committee regarding various prevention efforts throughout the state. Individuals testified in order to share information to the Task Force so it could complete its duties as defined by Arkansas Act 629.

Progress reports have been shared at scheduled meetings of the full Task Force, with appropriate discussion ensuing. Representatives of the Bureau of Legislative Research have regularly participated in Task Force meetings and provided support as necessary. Presentations, subsequent discussions, and supplemental materials have been compiled and analyzed to arrive at the findings and recommendations presented below.

Findings

Regular, repeated survey information confirms that prevention works. The data depict behaviors, attitudes and perceptions relating to substance abuse and indicate where there has been progress in reducing and preventing use. The most compelling benefit of effective substance abuse prevention is saved lives, including lives that have barely begun, to the lives of our older generations and all those in between. Additionally, it is estimated that benefits of a universal prevention program could save from $2.40 to $10.00 for every $1.00 spent (Substance Abuse and Mental Health Services Administration, and National Institute on Drug Abuse).

Sustainability of efforts is also a key to success. An assessment of financial resources confirmed that four state agencies make funds available to support community-based substance abuse prevention efforts. These delivery systems operate with no state general revenue. Thus, the state's ability to maintain the existing level of substance abuse prevention services or to meet projected future needs lies in the hands of the federal government.

Just as there are multiple factors that place individuals at risk for substance abuse, multiple prevention strategies are needed to produce results. These strategies include evidence-based programs and broader "environmental" strategies which alter the environment in such a way as to deter use. During testimony by state experts, it was discovered that while successful grassroots prevention efforts are ongoing in many Arkansas counties, federal funding for current underage drinking prevention ceased in 2011. Many other needs were identified that formed the basis for the following recommendations:

Task Force Recommendations for State Legislation

- **Oppose any legislation that would change the Arkansas Tobacco Settlement Proceeds Act of 2000-** Arkansans overwhelmingly voted to dedicate 100% of the state's Master Settlement Agreement dollars to improving health through funding seven specific programs. The Act's stated focus on health should remain as approved by the citizens of Arkansas and the Act and its related funding should be sustained, intact, in order to follow the will of the people and maintain the trust and will of voters.

- **Support Legislation to require public warning signs regarding fetal alcohol spectrum disorders (FASD) at the point of sale of alcohol in stores, restaurants and bars.** - Currently Arkansas does not require FASD warning signs to be posted. Alcohol use during pregnancy causes more damage to the developing fetus than use of any other substance including marijuana, heroin, and cocaine (Institute of Medicine, 1996). FASD is the leading known cause of mental retardation. There is no cure for FASD--the effects are irreversible and last a lifetime. FASD is 100% preventable. Estimated lifetime costs are from 3 to 5 million dollars per child permanently disabled by prenatal alcohol exposure (see examples in Appendix 1, page 18).

- **Support Legislation to reinstate the authority of law enforcement to seize driver's licenses of all underage individuals charged with Minor in Possession for the purpose of administrative suspension -** A change in Arkansas Juvenile Code during the 2009 legislative session restricted the authority of an officer to begin immediate administrative suspension proceedings when a juvenile is charged with Minor in Possession. This undermines the original Minor in Possession legislation enacted in previous legislation as well as the proven effectiveness of administrative suspension.

- **Oppose any state legislation or regulation that would be contrary to federal law with regard to marijuana. -** Marijuana is classified as a Schedule I controlled substance under the Controlled Substances Act (CSA). As a Schedule I drug, marijuana is classified under the following criteria: (A.) The drug has a high potential for abuse. (B.) The drug has no currently accepted medical use in treatment in the United States and (C.) There is a lack of accepted safety for use of the drug under medical supervision. The United States Department of Justice guidance explicitly states that marijuana remains illegal under Federal law.

The State Legislative Task Force recognizes that the legislature cannot conduct prevention programming. However, the Task Force does recommend that legislators work with the appropriate state agencies to ensure that departmental policies, practices, and actions enhance and improve upon current prevention efforts. The following are recommended areas that should receive effort, resources, and leadership among state agencies who conduct and/or support substance abuse prevention efforts:

Task Force Recommendations for State Agency Programming Policy and/or Practices

- **Pursue resources to conduct an evidence-based social marketing campaign for underage drinking prevention -** There is currently no coordinated, unified effort from state officials that would direct an evidence-based, statewide campaign to influence data- based root causes of underage drinking. Other states such as Utah have seen state-level reductions in underage drinking as a result of coordinated media, social media, and earned media efforts specific to underage drinking. Collaboration with Utah and other states showing success with these efforts, combined with efforts to secure funding for media is recommended.
- **Acknowledge Arkansas school districts who participate in the Arkansas Prevention Needs Assessment Survey and actively encourage non-participants to participate -** Systematic collection of data from Arkansas school systems is critical to planning, implementation, and evaluation of statewide, county-level, and district level prevention efforts. While **over 90%** of Arkansas public schools currently participate in the APNA survey, any recognition that can be given to maintain and increase participation would help ensure this successful effort.
- **Provide grassroots training for local coalitions to implement city and county Social Host Ordinances to reduce underage drinking in private residences -** Local communities have expressed a need for training on how to enact city and county ordinances to address individuals' continued propensity to provide sites for underage drinking. State resources could be used to increase positive policy changes at the local level to reduce underage drinking.
- **Acknowledge and sustain prescription drug take-back programs By DEA, Arkansas law enforcement, and State Drug Director's Office -** Arkansas prescription drug abuse (especially among teens) is among the worst in the nation. Several recent efforts to reduce access have been undertaken across the state. The Task Force would like to see these efforts recognized, supported and sustained by all pertinent state agencies. Continuation of this successful effort will raise awareness of prescription drug abuse and reduce access to these drugs.
- **Encourage widespread participation in the prescription drug monitoring programs among stakeholders** - In 2009, Act 304 to establish a prescription drug monitoring program in Arkansas was established. The Prescription Drug Monitoring Act's purpose is to protect the state health system and the citizens of Arkansas. State resources should be devoted to encouraging all pertinent stakeholders to fully utilize the program so that a reduction in prescription drug abuse, diversion, misuse, and illegal trade can be effectively reduced.
- **Encourage Arkansans who are working in the prevention field to acquire certification from the Arkansas Prevention Certification Board. –** The Arkansas Prevention Certification Board (APCB) is organized to increase the recognition of prevention as a profession and increase the skills and competencies of people providing prevention services in Arkansas, by offering voluntary certification as a Prevention Specialist or Consultant using a set of recognized national standards.

Members of the Arkansas Legislative Task Force On Substance Abuse Prevention

Legislative Members	Appointed by:
Senator Mike Fletcher	Senator Paul Bookout, President Pro Tempore of the Senate
Senator David Burnett	Senator Paul Bookout, President Pro Tempore of the Senate
Representative Tracy Pennartz	Representative Robert Moore, Speaker of the House
Representative Jeremy Gillam	Representative Robert Moore, Speaker of the House
Non-Legislative Members	**Agency/Position Authorized by Act 629**
Teresa Belew	Mothers Against Drunk Driving (MADD), Arkansas Volunteer
Willa Black-Sanders	Office of Alcohol and Drug Abuse Prevention
Fran Flener	State Drug Director
Hank Wilkins V	Prevention Resource Centers
Ann Brown	Office of Alcohol and Drug Abuse Prevention
Joy Laney	Arkansas Department of Health, Hometown Health Improvement Office
Terrence Love	Arkansas Prevention Network (APNet)
Michelle Anderson	AR Collegiate Drug Education Committee
Jackie Dedman	Arkansas Head Start Collaboration Office
Lisa Ray	University of Central Arkansas, College of Health and Behavioral Sciences
Jessica Hestand	Arkansas Prevention Network (APNet)
Susan Rumph	Arkansas Prevention Certification Board
Otistene Smith	Arkansas Department of Education - Safe and Drug-Free Schools Program (state level)
Max Snowden	Arkansas Commission on Child Abuse, Rape, and Domestic Violence
Fred Harvey	Office of Alcohol and Drug Abuse Prevention (prevention provider)
Wanda Williams	Arkansas Department of Education, Safe and Drug-Free Schools Program (LEA)
Michelle Moore-Rather	University of Arkansas at Little Rock Mid South Prevention Institute

Task Force Recommendations for State Legislation

Oppose any legislation that would change the Arkansas Tobacco Settlement Proceeds Act of 2000

In October 1998, major U.S. tobacco companies settled a pending lawsuit with 4 states—Minnesota, Florida, Mississippi, and Texas—after public disclosure that these companies intentionally targeted youth in marketing and knowingly withheld information on the addictive nature of nicotine. Immediately thereafter, the remaining 46 states were offered a legal option to join the national Master Settlement Agreement (MSA). In November 1999, Arkansas's Attorney General, Winston Bryant, agreed on behalf of the state to accept approximately $62 million per year in exchange for an agreement that Arkansas would not sue the tobacco companies for negative health impact or past health care costs caused by tobacco use.

The Coalition for a Healthier Arkansas Today (CHART) coalition, led by the Governor, successfully mounted an Initiated Act campaign that was passed by 65% of Arkansas voters on November 7, 2000. The Initiated Act created seven funded programs: The Tobacco Prevention and Cessation Program, the Fay. W. Boozman College of Public Health, the Arkansas Aging Initiative, the Delta Arkansas Health Education Center, the Minority Health Initiative, the Arkansas Biosciences Institute, and the Medicaid Expansion Program.

The Tobacco Prevention and Cessation Program (TPCP) administered through the AR Department of Health works to lower tobacco use in Arkansas through the implementation of programs educating Arkansans on tobacco dangers and encouraging them to quit. **Teen tobacco use rates in smoking have gone from a high of 43.2% in 1997 to a low of 20.7% in 2007.** [1]

No other dedicated state substance abuse prevention funds exist (other than $2,500 per year for problem gambling prevention and a one-time $1500 2008 General Improvement Fund effort to reduce prescription drug abuse) for the prevention of alcohol, tobacco, drugs, or other addictive behaviors. **The only dedicated funds for alcohol, tobacco, and other drug (ATOD) prevention are federal block grant monies managed by the Department of Behavioral Health Services.**

Tobacco Settlement funds utilized from the CHART master plan and made available through efficiently managed grants, are a significant resource for local community coalitions who strive to create conditions where tobacco (and other drug use) are less likely to occur. Successful efforts to influence policy, such as the 2006 Clean Indoor Act are a direct result of local, grassroots coalition prevention efforts. Other funded efforts include the Fay W. Boozman College of Public Health, University of Arkansas for Medical Sciences (UAMS) with over 200 graduates who currently work in a public health related field.

Recent efforts have been made to utilize portions of the Master Tobacco Settlement proceeds dedicated to primary prevention for treatment and/or other non prevention activities.

[1] Arkansas Department of Health; Arkansas Tobacco Settlement Commission

Support legislation to require public warning signs regarding Fetal Alcohol Spectrum Disorders (FASD) at the point of sale of alcohol in stores, restaurants, and bars (see examples in Appendix 1, page 18).

Alcohol use during pregnancy causes more damage to the developing fetus than use of any other substance including marijuana, heroin, and cocaine (Institute of Medicine, 1996). Use of alcohol during pregnancy can damage the brain of the developing fetus as well as affect the heart, kidneys, and other organs. Fetal alcohol spectrum disorders (FASD) is an umbrella term describing the range of effects that can occur in an individual who was prenatally exposed to alcohol.

FASD is the leading known cause of mental retardation. **There is no cure for FASD** - the effects are irreversible and last a lifetime. **FASD is 100% preventable.** While some exposed babies will have mental retardation, others will have cognitive and psychological problems which result in difficulties with learning and behavior problems. (www.nofas.org)

Estimated lifetime costs can be up to 5 million dollars per child permanently disabled by prenatal alcohol exposure. There is no known safe level of alcohol that a woman can drink during pregnancy. A 12 ounce can of beer has the same amount of alcohol as a 4 ounce glass of wine or a 1 ounce shot of straight liquor. When a woman plans to become pregnant, it is best that she abstain from drinking alcohol before and during her pregnancy. Women who do not plan to get pregnant should abstain as soon as pregnancy is suspected.

At least 22 states/jurisdictions require that mandatory signs (see appendix 2) warning about the possible dangers of consumption of alcohol during pregnancy be posted on premises where alcoholic beverages are served/sold and/or in the health care settings where pregnant women receive treatment. This includes licensees that sell alcohol for on-premise consumption and those providing sale of alcohol for off-premise consumption and/or offering tasting rooms. These states include Alaska, Arizona, California, Delaware, Georgia, Illinois, Kentucky, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, Nevada, North Carolina, Oregon, South Dakota, Tennessee, Washington, West Virginia, and the District of Columbia.[1]

Prevalence studies[2] indicate that for every 1000 births in Arkansas, two babies are born with Fetal Alcohol Syndrome and an additional eight are born with some level of FASD. **There are a projected 27,770 Arkansans - 8,330 children (18 and under) and 19,438 adults (over 18)--living with some level of FASD.** The majority of these are undiagnosed. FASD individuals are disproportionally prevalent in cases of mental retardation, congenital heart defects, epilepsy, speech and language disorders, sensorineural hearing loss, cerebral palsy, autism, attention deficit-hyperactivity disorders, mental illness, and foster care. **Calculated special education and juvenile justice costs alone for FASD (children 5-18) in Arkansas total $13,994,400 annually.**

[1]Report on State Approaches to FASD, National Organization on Fetal Alcohol Syndrome (NOFAS)
[2]Dr. Larry Burd, Director of the North Dakota Fetal Alcohol Syndrome Center and Professor of Pediatrics at the University of North Dakota School of Medicine and Health Sciences

Support legislation to reinstate the authority of law enforcement to seize drivers licenses of all underage individuals charged with Minor in Possession for the purpose of administrative suspension

A change in Arkansas Juvenile Code (Act 956 of the 2009 Regular Session) restricted the authority of an officer to begin immediate administrative suspension proceedings when a juvenile is charged with Minor in Possession. This undermines the original Minor in Possession legislation enacted in previous legislation as well as the proven effectiveness of administrative suspension.

The negative outcome of this change means that (practically speaking); an officer may come into contact with both a 17-year-old (a juvenile) and an 18-year-old and there be two entirely different outcomes as a result of their same illegal conduct. The 18 year old subject's license is subject to immediate seizure and administrative action while the 17 year old subject's (a juvenile) license suspension is delayed until such time as an appearance before a juvenile officer occurs.

Since the administrative sanctions of drivers licenses fall under the office of Driver Control, this authority needs to be placed back under that office's regulation and the authority of law enforcement officers to seize licenses of all charged underage (minors) immediately needs to be reinstated. To do otherwise sends a mixed message to teens; and may subject younger teens to having to "take the fall" for older teens (because younger teens will not immediately lose their drivers' license.

Referenced section of Act 956:

SECTION 2. Arkansas Code § 5-65-402(a) (1), concerning the age of a person required to surrender of a license or permit to an arresting officer, is amended to read as follows:
(a)(1)(A) At the time of arrest for violating § 3-3-203(a), § 5-27-503(a)(3), § 5-65-103, § 5-65-205, § 5-65-303, § 5-65-310, § 27-23-114(a)(1), § 27-23-114(a)(2), or § 27-23-114(a)(5), the arrested person shall immediately surrender his or her license, permit, or other evidence of driving privilege to the arresting law enforcement officer.
(B) The arresting law enforcement officer shall seize the license, permit, or other evidence of driving privilege surrendered by the arrested person or found on the arrested person during a search.
(C)(i) If a juvenile, as defined in § 9-27-301 et seq., is arrested for violating § 3-3-203(a) or § 5-27-503(a)(3), the arresting officer shall issue the juvenile a citation to appear for a juvenile intake with a juvenile intake officer.
(ii) The arresting officer shall forward a copy of the citation and the license, permit, or other evidence of the driving privilege to the juvenile office before the scheduled juvenile intake.

Oppose any state legislation or regulation that would be contrary to federal law with regard to marijuana

Federal laws against the use, cultivation, and transportation of marijuana should be maintained and enforced and no state legislation should be supported that would undermine the Federal Controlled Substance Act.

Marijuana is classified as a Schedule I controlled substance under the Controlled Substances Act (CSA). As a Schedule I drug, marijuana is classified under the following criteria: (A.) The drug has a high potential for abuse. (B.) The drug has no currently accepted medical use in treatment in the United States and (C.) There is a lack of accepted safety for use of the drug under medical supervision. The United States Department of Justice guidance explicitly states that marijuana remains illegal under Federal law.

According to the National Institutes of Drug Abuse, drug addiction is a pediatric/adolescent onset disease. Prevention of first use is critical. According to the Arkansas Prevention Needs Assessment Survey of 90,468 Arkansas students, the age of first use in 2011 among marijuana users was 13.7 years.

A recent study specific to medical marijuana diversion by Salmonsen, Sakai, Thurstone, Corley and Hopfer found that as many as 3 out of 4 teens that are referred to substance abuse treatment are referred for marijuana use; and that diversion of prescription marijuana did occur in Colorado where legislation contrary to federal law was passed. The study found that as many as **74% of teens referred for substance abuse treatment in Colorado reported using marijuana that was diverted (prescribed for others).** "Teens that had used diverted marijuana had started using marijuana at a younger age, used it frequently, and had more conduct disorder symptoms that teens in the group who did not use diverted marijuana.[1]

Treatment rates for marijuana addiction have risen dramatically in recent years. The National Center on Addiction and Substance Abuse at Columbia University found that **clinical diagnoses rates for marijuana abuse and/or dependence for minors has increased by 492.1% (four-hundred, ninety-two percent) between 1992 (when marijuana use was at its lowest point) and 2006.** During that same time period, there was a 57.3% DECREASE in rates of clinical diagnoses for all other substances combined, including alcohol, illicit, controlled prescription and over the counter drugs and inhalants.

Those states which have implemented "medical" marijuana ballot initiatives have some of the highest addiction rates in the country. According to the State Estimates of Substance Use from the 2006 – 2007 National Surveys on Drug Use and Health, released by the Substance Abuse Mental Health Services Association in May of 2009, seven of the 14 states that have legalized or decriminalized marijuana use, the perception of harm associated with smoking marijuana once a month has declined among those 12 and older and among those aged 18-25.

Responsible Arkansas drug policy must focus on effective research based efforts to both prevent and treat drug use. **Any legislation seeking to decriminalize and/or legalize marijuana will reduce the perception of harm associated with its use. This will increase the number of Arkansans who try marijuana and enable existing addictive behaviors to continue.**

1.Salomonsen-Sautel S, Sakai JT, Thurstone C, Corley R, Hopfer C. Medical marijuana use among adolescents in substance abuse treatment. J Am Acad Child Adolescent Psychiatry. 2012 Jul; 51(7):694-702.

Task Force Recommendations for State Agency Programming Policy and/or Practices

Recommended Action: Pursue resources to conduct an evidence-based social marketing campaign for underage drinking prevention

Examples of past county-based **social marketing** campaigns include: ***"Parents Who Host, Lose the Most", "Underage, Under the Influence, Under Arrest,"*** which is a message to youth and *"Don't provide,"* which is a message to parents. Arkansas was unable to finance a statewide **social marketing** campaign due to funding restrictions. However, the state has learned some important findings that can be applied to future efforts, should opportunities present themselves.

Social marketing interventions can be effective in improving diet, increasing exercise, and tackling the misuse of substances like alcohol, tobacco, and illicit drugs.[1] This type of campaign is known to be successful because specific behavior change, its reach, and dosage can be all is measured.

A comprehensive **social marketing** campaign is intended to include a website with information for parents and youth. Radio, TV, and print ads are also important components. Youth spend an average of 72 hours a week using electronic media such as TV, internet, movies and music. The use of all of these media sources is essential to reaching this target audience.

[1] The effectiveness of social marketing interventions for health improvement: What's the evidence? Public Health, Volume 120, Issue 12, Pages 1133-1139 (December 2006) http://www.publichealthjrnl.com

Recommended Action: Acknowledge Arkansas school districts who participate in the Arkansas Prevention Needs Assessment Survey and actively encourage non-participants to participate

The Arkansas Prevention Needs Assessment Survey (APNA) is a vital tool for prevention planning and evaluation in Arkansas. The APNA http://www.arkansas.pridesurveys.com/ , conducted annually since 2002, is administered to Arkansas' youth in grades 6, 8, 10, and 12. The APNA has provided Arkansas policy makers and prevention workers with one of the primary tools for understanding Arkansas' prevention needs in the area of alcohol, tobacco, and other drugs, antisocial behavior and delinquency; school dropout and violence.

In November 2010, 100,371 students were surveyed, which resulted in a total of 90,468 Arkansas students in 221 of 239 (93%) Arkansas public school districts providing valid survey data. **This is the largest number of students ever participating in the APNA.**

The APNA survey measures the current student use of alcohol, tobacco, and other drugs (ATOD). The substances include: 1) alcohol, 2) cigarettes, 3) smokeless tobacco, 4) marijuana, 5) hallucinogens, 6) cocaine, 7) inhalants, 8) stimulants, 9) sedatives, 10) methamphetamines, 11) ecstasy, and 12) heroin.

Students' use of these drugs is compared with national data, as well as between different Arkansas regions. The APNA also measures student involvement in a broad range of antisocial behaviors including assault and gang involvement. Finally, the APNA measures the prevalence of 19 risk and 13 protective factors in students' lives. Risk and protective factors are characteristics of the school, community, and family environments, as well as characteristics of students and their peer groups, that predict the future likelihood of drug use, delinquency, school dropout, teen pregnancy, and violent behavior among youth.

The Division of Behavioral Health, Arkansas Department of Human Services, the sponsor of this survey, is grateful for the cooperation and support of Arkansas' students, school administrators, and teachers, in making this survey a success.

The 2010 APNA Survey was conducted with federal funds from the Substance Abuse Prevention and Treatment Block Grant, Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services.

<u>Recommended Action</u>: Provide grassroots training for local coalitions to implement city and county Social Host Ordinances to reduce underage drinking in private residences

In 2008, the Arkansas Legislature passed Act 976 to provide criminal liability for a social host who knowingly serves alcohol to persons under the age of twenty-one and/or who knowingly allows minors to consume alcohol on his or her property.

Act 976 was created to address one of the root causes of underage drinking identified by the Arkansas Prevention Needs Assessment Survey (APNA), namely that youth report private residences as the primary site for underage drinking behavior.

This act has been used to provide a deterrent to those who would host underage drinking parties, especially in those communities where the act has been publicized by local coalitions and utilized by law enforcement and judicial systems.

One provision of Act 976 was to allow for townships, cities, and counties to establish by ordinance regulations more stringent than the provisions of the act. For example, various communities may identify ordinances to address local concerns more specifically than the state law.

Cities have expressed a desire to create more stringent local ordinances: Waldron, Wynne, Cherry Valley, and Parkin have successfully implemented social host ordinances to meet local needs. Counties have also passed ordinances. They include: Perry County, Cross County, and Van Buren County.

One issue that was identified by the Task Force was a need for local community coalitions to receive specialized training with regard to policy development, policy change, and policy implementation.

If local communities decide to pursue local ordinances more restrictive than the state law, resources should be made available by state agencies to assist them.

Recommended Action: Acknowledge and sustain prescription drug take-back programs by DEA, Arkansas law enforcement, and State Drug Director's Office

As part of the 2010 National Drug Control Strategy, the Office of National Drug Control Policy called for an increase of prescription drug return and disposal programs as a means to curbing prescription drug abuse and preserving the benefits of pharmaceuticals.

Recognizing that utilization of prescription drug take-back events for unneeded and/or expired medications in Arkansas household permanently removes a potential source of diversion of pharmaceuticals, particularly by children and teens, a coalition working on statewide prescription abuse issues and led by the Office of the Drug Director, the Attorney General's Office, the U.S. Attorney's Office and the U.S. Drug Enforcement Administration and consisting of law enforcement, federal and state agencies, businesses, and prevention professionals, regularly plan, organize, and execute Arkansas's participation in the U.S. Drug Enforcement Administration's national effort to hold prescription drug take-back programs.

Typically, two statewide take back events are provided per year, and to date, five total events have occurred. **Collectively, over 23½ tons of unneeded and/or expired medications have been returned to law enforcement for destruction, thereby ensuring that they would never be diverted or abused.** A weight to pill conversion tool provided by the Arkansas State Crime Laboratory indicates that close to **66 million individual pills are estimated to have been collected**.

An analysis of DEA-provided data by the Office of the Drug Director determined that Arkansas had the fourth-highest per capita weight of returned medications in the United States. 748 sites in total have been offered through the five events, and each site has afforded law enforcement the opportunity to provide individuals returning medications with extremely valuable information concerning the prevention of prescription abuse.

The success of Arkansas's participation has been possible due to the very effective collaboration of the aforementioned multitude of groups. In order to ensure the continued success of future take-back programs, a continuing high level of participation, collaboration, and support is necessary, and it is recommended that partnering state agencies continue their involved to the fullest extent. Development of additional corporate sponsorships on a state and local level, the addition of new collaborating agencies and organizations, and the employment of existing partner entities' time, talent, and resources will enable future take-back programs to continue to be delivered at minimal costs.

Recommended Action: Encourage Arkansans who are working in the prevention field to acquire certification from the Arkansas Prevention Certification Board.

Arkansas recognizes the concept that prevention of alcohol and other drug use, misuse, abuse and prevention of other harmful behaviors is a specialty field requiring service delivery by a competent and professional individual.

The Arkansas Prevention Certification Board (APCB) is organized to increase the recognition of prevention as a profession and increase the skills and competencies of people providing prevention services in Arkansas, by offering voluntary certification as a Prevention Specialist or Consultant using a set of recognized national standards.

Certification as a Prevention Specialist or a Prevention Consultant assures professional competency, enhances credibility through a process that proves knowledge and skill, and provides reciprocity in 14 countries and 47 states through the International Certification and Reciprocity Consortium **(**IC&RC**)**.

The APCB helps maintain and ensure competency for participants working in prevention. Program participants are able to develop and enhance their skills to become a more effective prevention professional. To become certified, candidates must complete 100 (Specialist) or 150 (Consultant) education/training hours, 120 hour supervised practicum, 2,000 (Specialist) or 6,000 (Consultant) work hours in prevention, and pass the IC&RC certified prevention specialist exam.

The population APCB serves includes certified prevention professionals, DBHS-funded prevention programs, individuals who work with families, schools, communities, faith-based, law enforcement, those in the health service fields, and others who provide prevention programming.

Currently, 89 individuals are certified by the APCB and approximately 75 are in the process of certification. Anyone receiving funding to do prevention work should be prevention certified. Each school district would benefit from having a certified individual to implement prevention programs and policies.

Two of the duties of the Task Force on Prevention support this recommendation. One is to evaluate the current substance abuse prevention service delivery system and its capacity to respond to current and projected prevention needs across the full-life spectrum. Another is to make recommendations designed to improve and increase sustainable prevention services throughout the state. Increasing the number of certified prevention professionals better ensures that Arkansas' prevention service delivery system capacity is enhanced and sustained.

<u>Recommended Action</u>: Encourage widespread participation in the prescription drug monitoring program among stakeholders.

In 2009, Act 304 to establish a prescription drug monitoring program in Arkansas was established. The Prescription Drug Monitoring Act's purpose is to protect the state health system and the citizens of Arkansas by: (1) Enhancing patient care by providing prescription monitoring information that will ensure legitimate use of controlled substances in health care, including palliative care, research, and other medical pharmacological uses; (2) Helping curtail the misuse and abuse of controlled substances; (3) Assisting in combating illegal trade in and diversion of controlled substances; and (4) Enabling access to prescription information by practitioners, law enforcement agents, and other authorized individuals and agencies and to make prescription information available to practitioners, law enforcement agents, and other authorized individuals and agencies in other states.

The prescription drug monitoring program is designed to collect, manage, analyze, and provide information regarding Schedule II, III, IV, and V controlled substances as provided under the Uniform Controlled Substance Act and the Food and Drug Cosmetic Act.

<u>Appropriate state agencies should seek and provide resources to ensure that this program becomes a model prescription drug monitoring program. State resources should be devoted to encouraging all pertinent stakeholders to fully utilize the program so that a reduction in prescription drug abuse, diversion, misuse, and illegal trade will be realized.</u>

Pertinent state agencies and professional associations should work together to evaluate the success of Act 304 and recommend any additional legislative changes to improve upon the existing prescription drug monitoring program.

Appendix 1

Fetal Alcohol Warning Sign Examples