Annual Report of The Task Force on Substance Abuse Prevention

Submitted by the

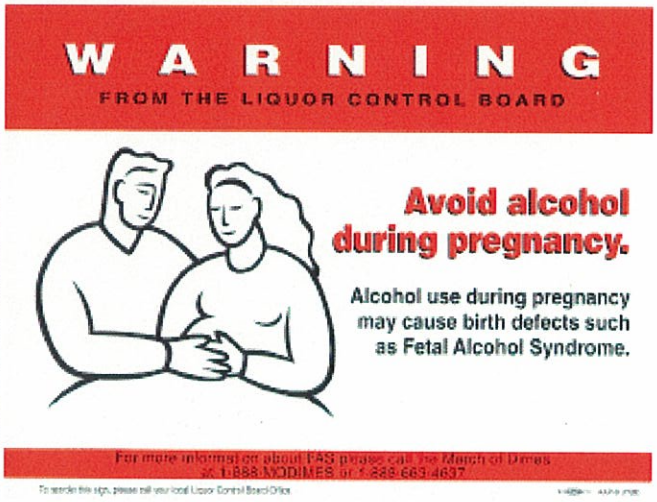
Task Force on Substance Abuse Prevention

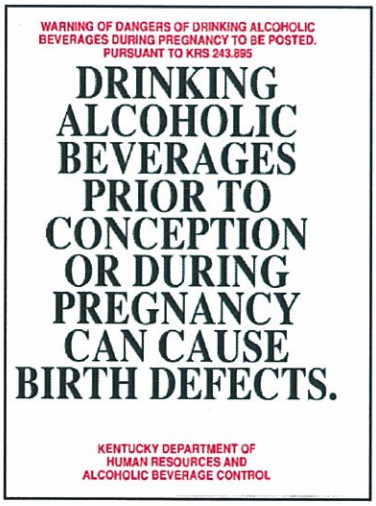
(legislated by Act 629 of the 86th General Assembly of the State of Arkansas)

October, 2010

Appendix 1

Fetal Alcohol Warning Sign Examples





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 2009 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; inconsistent laws regarding underage drinking; warnings to prevent fetal alcohol spectrum disorder; reporting of alcohol abuse among pregnant mothers; and maintenance of the 21 drinking age.

Task Force Recommendations for State Legislation

- **An increase in the wholesale excise tax on all alcoholic beverages sold in Arkansas designated specifically to fund substance abuse prevention, substance abuse treatment and law enforcement interdiction programs**
- **Maintain Support of Arkansas Tobacco Settlement Proceeds Act of 2000**
- **Recommended Legislation: Legislation to Expand Prescription Drug Monitoring Programs in Arkansas.**
- **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 law to require warnings to women regarding fetal alcohol spectrum disorder at the point of sale of alcohol in restaurants and bars**
- **A revision of Garrett's Law to include required physician reporting for alcohol use among pregnant mothers under 21**
- **A call to maintain the 21 drinking age in Arkansas, including on military bases**

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 programs.

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**
- **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 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 7.

Process Undertaken by the Task Force

The Task Force convened as a whole on several occasions, with subcommittee groups meeting more regularly. Several 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. The individuals who testified are listed below:

Regarding Current State Prevention Efforts:

- Teresa Belew, Media & Public Policy Liaison, MADD, Arkansas Office
- Jill Cox, Coordinator, SPF/SIG, Office of Alcohol & Drug Abuse Prevention, Department of Human Services

Regarding Underage DUI Laws

- Officer Rick Crisman, Fayetteville Police
- Fran Flener, Arkansas State Drug Director

Regarding Current State Efforts to Reduce Underage Access to Alcohol and Tobacco

- Michael Langley, Director, Arkansas Alcoholic Beverage Control Board
- Ann Hines, Executive Vice President, Arkansas Oil Marketers Association, Inc.
- J. R. Thomas, Director, Tobacco Control Board
- Polly Rand Martin, President, Arkansas Grocers & Retail Merchants Association
- Laurie Smalling, Senior Manager, Public Affairs & Government Relations, Wal-Mart Stores, Inc.

Regarding Arkansas Prescription Drug Take-Back Efforts

- Steve Varady, Policy Coordinator, Office of the State Drug Director

Regarding Fetal Alcohol Spectrum Disorder and Prevention Efforts

- Carol Rangel, Project Director, FASD, Division of Children & Family Services, Department of Human Services

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 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 will cease in 2011. Many other needs were identified that formed the basis for the following recommendations:

Task Force Recommendations for State Legislation

- **An increase in the wholesale excise tax on all alcoholic beverages sold in Arkansas designated specifically to fund substance abuse prevention, substance abuse treatment and law enforcement interdiction programs** - The wholesale excise tax on most alcoholic beverages sold in Arkansas has not been significantly increased since 1947. Seventy percent (70%) of Arkansans surveyed report that they support an increase in alcohol tax if the funds are dedicated to prevention and treatment.
- **Maintain Support of 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.
- **Recommended Legislation: Legislation to Expand Prescription Drug Monitoring Programs in Arkansas.** Unfortunately, Arkansas is among the nation's leaders in prescription drug abuse, particularly by its young people. Preventing and addressing prescription drug abuse in Arkansas requires coordinated and comprehensive efforts consisting of both public education *and* regulatory measures. The establishment of an Arkansas Prescription Drug Monitoring Program would enhance not only the prevention of abuse of pharmaceuticals, but also help identify and treat addicted persons.
- **Reinstate the authority of law enforcement to seize driver's licenses of all underage individuals charged with Minor in Possession for the purpose of immediate 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.
- **A law 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.

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Task Force Recommendations for State Legislation – Continued…

- **A revision of Garrett's Law to include required physician reporting for alcohol use among pregnant mothers under 21** – The current law does not require assessment of alcohol use of pregnant mothers.
- **A call to maintain the 21 drinking age in Arkansas, including on military bases** – Since 1988, the 21 minimum drinking age law has saved about 900 lives per year as estimated by the National Highway Traffic Safety Administration (NHTSA). Arkansas should not support any effort to reduce underage drinking restrictions that could lead to higher rates of alcohol-related accidents, injuries, and deaths among underage drinking drivers

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.

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

- **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 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. Certification as a Prevention Specialist or a Prevention Consultant assures professional competency and enhances credibility through a process that proves knowledge and skills.

Members of the Arkansas Legislative Task Force on Substance Abuse Prevention

Legislative Members	Appointed by:
Senator Bill Pritchard (Chair)	Senator Bob Johnson, President Pro Tempore of the Senate
Sen. Ruth Whitaker	Senator Bob Johnson, President Pro Tempore of the Senate
Rep. Gene Shelby	Representative Robbie Wills, Speaker of the House
Rep. Tracy Pennartz	Representative Robbie Wills, Speaker of the House
Non-Legislative Members	**Agency/Position Authorized by Act 629**
Teresa Belew	Mothers Against Drunk Driving (MADD), Arkansas Representative
Willa Black Sanders	UAMS College of Public Health
Fran Flener	State Drug Director
Jill Cox	Office of Alcohol and Drug Abuse Prevention
Joy Laney	Arkansas Department of Health, Hometown Health Improvement Office
Terrence Love	Arkansas Prevention Network (APNet)
Michelle Moore-Rather	University of Arkansas at Little Rock Mid South Prevention Institute
Stacie Morris	AR Collegiate Drug Education Committee
Ann Patterson	Arkansas Head Start Collaboration Office
Lisa Ray	University of Central Arkansas, College of Health and Behavioral Sciences
Laurie Reh	Arkansas Prevention Network (APNet)
Susan Rumph	Arkansas Prevention Certification Board
Otistene Smith	Arkansas Department of Education - Safe and Drug-Free Schools Program (state level)
Cindy Stokes	Prevention Resource Centers
Max Snowden	Arkansas Commission on Child Abuse, Rape, and Domestic Violence
Sanford Tollette	Office of Alcohol and Drug Abuse Prevention (prevention provider)
Wanda Williams	Arkansas Department of Education, Safe and Drug-Free Schools Program (LEA)

Task Force Recommendations for State Legislation

An increase in the wholesale excise tax on all alcoholic beverages sold in Arkansas designated specifically to fund substance abuse prevention, substance abuse treatment and law enforcement interdiction programs.

- **70% of Arkansans surveyed report that they support an increase in alcohol tax if the funds are dedicated to prevention and treatment.**
- **The wholesale excise tax on most alcoholic beverages sold in Arkansas has not been significantly increased since 1947.**
- **Alcoholic beverages reported sold in Arkansas by the industry have consistently increased annually.**
- **The Arkansas Department of Corrections reports that more than 80% of incarcerated individuals in custody report a personal history that includes the use and abuse of alcohol and/or illicit substances.**
- **Because of the economic cost to all Arkansans, the industry should pay a fair share to offset the financial costs of prevention, treatment and law enforcement interdiction.**

Increasing Alcohol Taxes Saves Lives, Reduces Crime

Doubling taxes on alcohol products could lead to substantial reductions in alcohol-related deaths, STD rates, and crime, **Health.com** reported Sept. 24. Health policy researchers at the University of Florida in Gainesville analyzed data from 50 studies examining the relationship between alcohol taxes, mortality, and risky behaviors. (The studies took place between 1955 and 2004, and most were conducted in the U.S.) Statistical estimates based on the findings showed **a 50 percent alcohol tax increase could effectively reduce alcohol-related mortality by 35 percent, automobile fatalities by 11 percent, STD rates by 6 percent, violence by 2 percent, and crime by 1.4 percent.**[1] The only measure in which higher taxes did not significantly reduce alcohol-related harms was for suicide.

"What is surprising is the consistency of the effect across a broad range of health outcomes that kind of don't have anything to do with each other," said Alexander C. Wagenaar, Ph.D., professor of epidemiology and health outcomes at the University of Floriday and lead author of the research. One of the included studies took place in Alaska, which instituted tax increases on alcohol in 1983 and 2002. **Both tax increases corresponded with a drop in alcohol-related deaths in the state, including a 29 percent drop after the 1983 increase.**

Although the increases would be small in terms of dollars, Wagenaar continued, they might be enough to reduce intake among heavy drinkers on tight budgets, college students, and social drinkers. "Studies show that all these groups respond to price," he said. The study was published online in the **American Journal of Public Health** on Sept. 23, 2010.

1. Wagenaar, A.C. & Toomey, T.L. (2002). Effects of Minimum Drinking Age Laws: Review and Analyses of the Literature from 1960 to 2000. Journal of Studies on Alcohol. Supplement 14, 206-221.

Maintain Support of 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 prevention funds exist (other than $2,500 per year for problem gambling prevention and a one-time $1500 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 Office of Alcohol and Drug Abuse Prevention (OADAP).**

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

Recommended Legislation: Legislation to Expand Prescription Drug Monitoring Programs in Arkansas.

Unfortunately, Arkansas is among the nation's leaders in prescription drug abuse, particularly by its young people. In one past report, **Arkansas led the nation in youth abuse of pain medications.**[1] In another, Arkansas's teens are reported to abuse sedatives at three times the national rate.[2] Preventing and addressing prescription drug abuse in Arkansas requires coordinated and comprehensive efforts consisting of both public education *and* regulatory measures. The establishment of an Arkansas Prescription Drug Monitoring Program would enhance not only the prevention of abuse of pharmaceuticals, but also help identify and treat addicted persons. As it is today, **Arkansas remains one of only seven states without a legislatively authorized or deployed Prescription Drug Monitoring Program.**

Prescription Drug Monitoring Programs (PMPs) are electronic databases which gather information on medications prescribed and dispensed within a state, and provide extremely valuable tools to prevent misuse, abuse and diversion of prescription drugs at multiple points. Depending on the design and operation of the program, opportunities would become available to prescribing health care professionals, dispensing pharmacists, or investigating law enforcement officials. For example, a physician, upon learning through a query of the PMP database that her patient had inappropriately received multiple prescriptions for a commonly abused drug, could elect not to write an additional prescription for the same drug. The physician could then provide a referral for treatment if necessary. Likewise, a pharmacist presented with this situation could elect not to dispense the drug once it has been prescribed.

At the same time PMPs offer a promising environmental prevention strategy in deterring inappropriate drug-seeking behavior and inappropriate prescribing, they also impact the supply. In 2009, Arkansas ranked #5 in prescription drugs filled per capita.[3] **PMPs reduce the per capita supply, particularly for often abused prescription pain relievers and stimulants,** which then can lead to a decrease of abuse.[4] Because most young people buy, steal, or are freely given prescription drugs from relatives or friends and also report that obtaining prescription drugs directly from their parents' medicine cabinets is "easy", **reducing the per capita supply of prescription drugs holds promise in reducing youth misuse and abuse.**

A workgroup has been convened by Arkansas State Drug Director Fran Flener to explore and develop a program tailored to meet our state's unique PMP needs. The workgroup has been charged with designing an Arkansas program which maximizes the benefits of PMPs, ensures that patients who legitimately need prescription drugs encounter no barriers to receiving them, and safeguards private patient health information. Additionally, the workgroup will explore and identify potential funding sources.

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[1] Teens and Prescription Drugs. Office of National Drug Control Policy, 2007.
[2] Adolescent Prescription Drug Misuse in Arkansas. Arkansas Department of Human Services, Division of Behavioral Health Services, Office of Alcohol and Drug Abuse Prevention, 2008.
[3] **http://www.statehealthfacts.org/comparetable.jsp?ind=267&cat=5&sub=66&yr=92&typ=1&sort=a**, Kaiser Foundation, 2009
[4] Simeone, Ronald, and Lynn Holland. An Evaluation of Prescription Monitoring Programs. Simeone Associates, Inc., 2004.

Recommended Legislation: Reinstate the authority of law enforcement to seize drivers licenses of all underage individuals charged with Minor in Possession for the purpose of immediate 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.

Recommended Legislation: A law to require public warning signs regarding Fetal Alcohol Spectrum Disorders (FASD) at the point of sale of alcohol in stores, restaurants, and bars.

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

Recommended Legislation: A revision of Garrett's Law to include required physician testing and reporting for alcohol among pregnant mothers under 21 years of age.

In 2005, a bill was passed by the Arkansas Legislature that requires physicians to report instances where a pregnant woman giving birth to a child with health problems is suspected of abusing illegal substances.

The first reporting period for **Garrett's Law** was April 1, 2005 – March 31, 2006. During this period, 363 cases of women giving birth with drugs in their bodies were reported to the Arkansas State Police, Crimes Against Children Division. This represents approximately 10 per 1,000 births during the reporting period. Of the 8 reported children who died shortly after birth or were stillborn, only two had illegal substances in their systems. Seventy-seven children had various health problems, ranging from minor ailments to life-threatening medical conditions. Some of these problems could not be linked to the mother's substance abuse. Over two-thirds of the reported newborns (235) were born without apparent health problems.

The Garrett's Law database is unique in two ways. It is one of the few data sets available that looks at substance abuse among pregnant women, and it records multiple substances found during a reported incidence.

Underage drinking is illegal. Approximately **4% of Arkansas women under age 20 report drinking 1 to 2 drinks per week during the last three months of their most recent pregnancy.** [1]

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. **There is no known safe level of alcohol that a woman can drink during pregnancy.** Prevalence studies 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. FASD is the leading known cause of mental retardation and FASD is 100% preventable.

Amending Garrett's Law to include required physician testing and reporting for alcohol among pregnant women under 21 will:

1. Provide valuable prevalence data regarding fetal exposure to alcohol.
2. Provide opportunities for early diagnosis and intervention for Fetal Alcohol Spectrum Disorders.
3. Provide opportunities for intervention with alcohol-abusing mothers.
4. Serve as a deterrent to women who may drink during pregnancy.

[1] Centers for Disease Control, Pregnancy Risk Assessment Monitoring System (PRAMS) http://www.cdc.gov/PRAMS/index.htm

Recommended Action: Maintain the 21 drinking age in Arkansas, including on Arkansas military bases.

The passage of Minimum Legal Drinking Age 21 (MLDA 21) laws has been one of the most successful traffic safety countermeasures implemented over the past 30 years. The National Highway Traffic Safety Administration (NHTSA) estimates that **900 lives are saved every year due to these laws, with a total of more than 25,000 lives since 1975.**[1] (Arnold, 1985; Kindelberger, 2005; NCSA, 2005; Womble, 1989)

Several studies in the 1970s demonstrated that motor vehicle crashes increased significantly among teens when the MLDA was lowered (Cucchiaro et al, 1974; Douglas et al, 1974; Wagenaar, 1983, 1993; Whitehead, 1977; Whitehead et al, 1975; Williams et al, 1974, as cited by the AMA.) Consequently, the U.S. Congress passed the National Minimum Drinking Age Act and President Reagan signed the bill into law in 1984.

Since 1988, the MLDA has been 21 in all 50 States and the District of Columbia (DC). Between 1982 and 1998, the population-adjusted involvement rate of drinking drivers aged 20 and younger in fatal crashes decreased 59 percent. MLDA-21 laws have been shown to be associated with this decline. (Hedlund, Ulmer, and Preusser, 2001)

Rep. Jack Kingston, R-Ga., introduced legislation recently which would allow service members as young as 18 to enjoy alcoholic drinks at restaurants or clubs on any stateside military base.

According to CADCA, (Community Anti-Drug Coalitions of America), during 2002, 20.2 percent of junior enlisted personnel reported serious alcohol-related consequences, 27.2 percent reported lost productivity, and 22.6 percent reported symptoms of dependence. More than half of all active duty military personnel report binge drinking in the past month, and young adult service members exposed to combat are at significantly greater risk of binge drinking than older service members. (Jacobson, Ryan, Hooper, Smith, et al.).

Lowering the drinking age on military bases would also exacerbate problems associated with underage drinking that are already occurring. **http://www.cadca.org/resources/detail/cadca-opposes-legislation-allow-underage-drinking-military-installations**

The prevention field has made major strides in reducing underage drinking in recent years. This national legislation severely undermines the efforts of the many community anti-drug coalitions throughout the country and in Arkansas.

[1]Minimum Legal Drinking Age Policy, James C. Fell, M.S., Pacific Institute for Research and Evaluation (PIRE) http://knol.google.com/k/saprp-knowledgeassets/minimum-legal-drinking-age-policy/13kykpwd3qs47/5#

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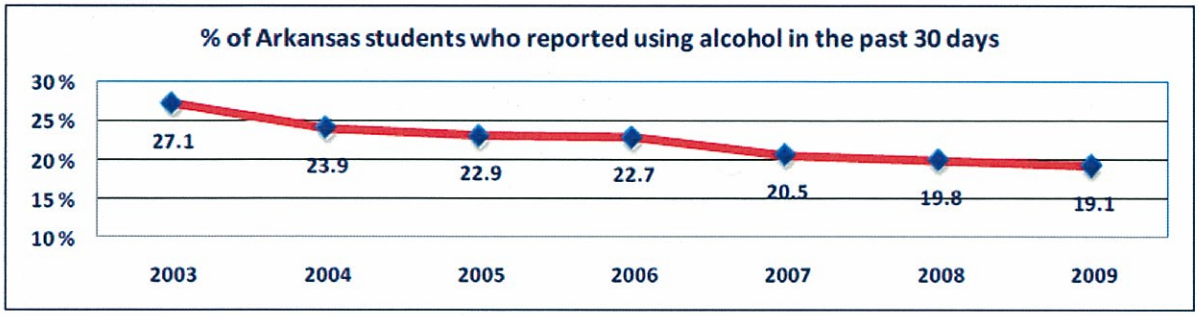
Jacobson IG, Ryan MAK, Hooper TI, Smith TC, et al. Alcohol use and alcohol-related problems before and after military combat deployment. JAMA 2008;300:663–675.

J.H. Hedlund, R.G. Ulmer, D.F. Preusser. **Determine Why There Are Fewer Young Alcohol-Impaired Drivers**. Washington D.C.: U.S. Department of Transportation, 2001 [Report Number DOT HS 809 348].

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.

Arkansas has had some preliminary success reducing underage drinking as a result of a Strategic Prevention Framework State Incentive Grant (SPF SIG). Unfortunately, the SPF SIG program was a onetime federal grant and it will cease on June 30, 2011.



Source: The Arkansas SPF SIG: Reducing Underage Drinking. Arkansas DHS

As evidenced by the progress of the 17 Arkansas counties currently funded through the (SPF SIG) program to prevent underage drinking, **social marketing** campaigns that compliment other evidence based strategies appear to lower student drinking rates.

Examples of current county-based **social marketing** campaigns in the SPF SIG program include: *"Underage, Under the Influence, Under Arrest,"* which is a message to youth and *"Don't provide,"* which is a message to parents. The SPF SIG program 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, 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 2009, 97,387 students were surveyed, which resulted in a total of 88,912 Arkansas students, in 224 of 246 **(91%)** of Arkansas public school districts and three charter 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 Office of Alcohol and Drug Abuse Prevention (ADAP), 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 2009 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.

Recommended Action: 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. Lawrence and Franklin County coalitions are also currently considering ordinances to address local issues with regard to social hosting.

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.

Arkansas has the worst teen prescription pain reliever abuse problem in the entire United States. (SAMHSA, 2007, as reported in ONDCP's Teens and Prescription Drugs, Feb. 2007)

- By the time Arkansas high school students have reached their senior year, 22% have abused prescription drugs. (Arkansas Prevention Needs Assessment [APNA], 2008)
- Close to 10% of Arkansas high school seniors reported non-medical use of prescription drugs in the past thirty days. (APNA, 2008)
- The rate of past 30-day sedative use among Arkansas seniors is roughly three times the national rate. (DHS, Adolescent Prescription Drug Misuse in Arkansas, June 2009)
- Arkansas has consistently ranked among the ten states with the highest rate of non-medical use of pain relievers by 12 to 20 year-old individuals since state estimates of this measure first began in 2002. (SAMHSA, Office of Applied Studies, Short Report on Substance Abuse and Mental Health Issues - Arkansas, December, 2008).

Seven of the 10 drugs most abused by high school seniors are prescription or over-the-counter drugs acquired primarily from teens' friends or relatives. (NIDA, Monitoring the Future, 2009)

On **Saturday, September 25**, from **10 a.m. to 2 p.m.,** Arkansans participated in a nationwide prescription drug "take-back" event. **Over 190 collection sites were scheduled and a total of 5,407 pounds of prescription and over-the counter drugs were collected and destroyed. The estimated collected pill count ranged between 7 and 9 million pills.**

One out of every 20 take-back sites in the U.S. registered with the National Drug Enforcement Agency was located in Arkansas. Arkansas had two times the average number of take-back sites and three times the average number of law enforcement agency involvement than other states. Federal, state, or local law enforcement officers worked at each site to ensure that all pills were collected and destroyed in a safe, legal and environmentally friendly manner.

Only one other state in the United States had more registered sites for the National Drug Take Back Event than Arkansas. Collaboration between law enforcement, state offices, local community coalitions, pharmacies, and numerous other agencies made this event a tremendous success.

The Task Force recognizes this extremely successful effort to reduce the amount of prescription and over-the-counter drugs available for misuse and abuse and recommends that the State sustain future drug take back efforts with resources, training, and other support. Further, the Task Force recommends that the State formally recognize those who contributed to the successful drug take-back effort on September 25th, 2010.

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 44 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, ADAP-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, 92 individuals are certified by the APCB and approximately 100 are in the process of certification. **Of the 75 counties in Arkansas, there are 41 counties without anyone certified in prevention.** Each school district would benefit from having a certified individual to implement prevention programs.

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 substance abuse 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.