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BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

Prescription Medication Abuse Subcommittee

Ramon Castellblanch, PhD, Chair
Rosalyn Hackworth, Board Member
Darlene Fujimoto, PharmD
Gregory Murphy, Board Member

Materials for the August 26, 2014 Meeting

The Communication and Public Education's Prescription Medication Abuse Subcommittee was formed following the February 2013 Joint California Medical Board and Board of Pharmacy Appropriate Prescribing and Dispensing Forum. This subcommittee was formed to continue to explore ways to address the misuse and abuse of prescription medication, particularly of controlled substances. The Medical Board has formed its own subcommittee to work on similar issues.

1. Report on California Prescription Drug Abuse Work Group headed by the Director of the State Department of Public Health

   The Prescription Opioid Misuse and Overdose Work Group was formed by the Department of Public Health and is chaired by the director of Public Health. The workgroup is made up of representatives from various state agencies and meets monthly. The goal of the group is to unify a focused policy that can be articulated by the state agencies in efforts on opioid abuse education and prevention. The next meeting is on August 29.

2. Report on 50-States Meeting Addressing Opioid Abuse Recently Held in Washington D.C.

   Attachment 1

   The executive officers of the Medical Board and Board of Pharmacy recently attended a federal Department of Health and Human Services working meeting with state officials from across the country to share best practices and discuss how federal and state governments can work together to put a stop to the opioid abuse epidemic. A verbal report of this meeting was provided at the July board meeting.

   Attachment 1 contains informational materials distributed at the 50-States meeting and includes a commentary about the meeting written by the deputy director of the federalDepartment of Health and Human Services.

3. Report on CURES Data of Controlled Substances Dispensed in California and Controlled Substance Diversion for Fiscal Year 2013-14; and CURES Board Funds.

Attachment 2

Board staff compiled CURES data on products dispensed and the number of pills per California adult; controlled substance drug loss; top drugs lost or stolen; and board expenditures on the CURES system.

A copy of each of these reports is included in **Attachment 2**.

4. Discussion About Recommendations Developed by National Council for Prescription Drug Programs (NCPDP) for Improving Prescription Drug Monitoring Programs (PDMP)

Attachment 3

The National Council for Prescription Drug Programs formed a focus group whose goals and objectives were to identify the current and future issues and needs regarding the exchange of information for Prescription Drug Monitoring Programs (PDMP). The group identified the specific industry challenges and the goals of the PDMPs, providers, prescribers, and regulatory agencies. This allowed NCPDP to propose efficient solutions, which leverage existing standards and methodologies, and to develop applicable enhancements that could be standardized across the industry. The result of the focus group can be found in their white paper, which is provided as **Attachment 3**.

Nicole Russell, Government Affairs Specialist with NCPDP, will present the white paper by phone and discuss why the project was done, where it's going and who has adopted it.

5. Presentation of Red Flags Video Regarding Corresponding Responsibility Produced by the National Association of Boards of Pharmacy (NABP)

Attachment 4

The National Association of Boards of Pharmacy (NABP) produced a video on red flags that could indicate abuse of prescription medications. The group then filmed board of pharmacy executive officers introducing the video. The California version is now available on the board website at: https://www.youtube.com/watch?v=jdeQ0GeJjAM&feature=youtu.be.

Attachment 4 contains a press release announcement from NABP on the video.

6. Report on the Medical Board of California's Prescribing Task Force

   The Prescribing Task Force met in February and June 2014 to make revisions to the Medical Board's pain management guidelines. The guidelines are expected to be adopted by the Medical Board this fall.

7. Presentation by Angela Crispo, PharmD, Pharmacy Resident, PGY2 Psychiatric, University of California San Diego Health System, on Counseling Tips for Pharmacists on Opioid Prescriptions

   Dr. Crispo will present "Pharmacist Counseling Tips for Opioid Prescriptions." This presentation will contain information that pharmacists can utilize when counseling patients on new or changed opioid prescriptions. Topics will include common side effect profiles, side effect prevention methods and difficult conversation tips on tolerance and addiction.

8. Report on *Consumer Reports* Articles on the Dangers of Painkillers Presented by Doris Peter, PhD, Director of Consumer Reports Health Ratings Center

   Attachment 5

   Consumer Reports recently published a Special report on the dangers of painkillers. Doris Peter, PhD, Director of Consumer Reports Health Ratings Center, will present by phone information from their research.

   Articles published in *Consumer Reports* on prescription medications are included in **Attachment 5**.

9. Presentation on Opioid Addiction and Recovery and the Personal Experiences of Jason Smith

   Attachment 6

   Jason Smith is a writer, business owner and a pain medication addict, who is in recovery and has been sober for two years. Mr. Smith's use of opioids began after a car accident when he was prescribed pain medications. At some point, his use turned to abuse and Mr. Smith is able to chronicle his years of doctor and pharmacy shopping in order to get increasing amounts of opioids. He is also knowledgeable about opioid recovery and the ongoing support process.

   A series of three articles written by Mr. Smith about heroin abuse that begins with prescription pain medications is included in **Attachment 6.**

10. Report on Legislative Approval of Drug Overdose Prevention Bill (AB 1535, Bloom), Permitting Pharmacists to Furnish Naloxone

Attachment 7

Assembly Bill 1535, Assemblymember Richard Bloom's drug overdose prevention bill which was recently passed by the Legislature, would permit pharmacists to furnish the opiate overdose antidote naloxone, pursuant to procedures developed by the Board of Pharmacy and the Medical Board of California. The bill now heads to the Governor's desk for his signature.

Naloxone is used in cases of opioid overdose and acts as an antidote. It neutralizes the effects of opioids, allowing drug users to breathe during an overdose. Naloxone has been routinely used in emergency care and in anesthesiology for decades. It can be administered by injection or in a nasal form of the drug, known commonly by its trade name, Narcan. Now, the recent surge in opioid overdose deaths involving prescription painkillers has led policy makers, communities and public health agencies to expand the drug's availability to enable friends and loved ones to respond quickly in emergencies.

Attachment 7 includes a copy of the bill and an article on the California Legislature's passing of the bill. The board supported this bill. If the bill is enacted, the board will be required to develop a protocol with the Medical Board for Naloxone's distribution by pharmacists.

11. Report on Upcoming Joint DOJ and Board of Pharmacy CE Program in Santa Barbara

Attachment 8

A joint training for pharmacists by the California State Board of Pharmacy and the Los Angeles Field Division of the Drug Enforcement Administration will be held on September 3 and 4 in Santa Barbara on "What every pharmacist should know to prevent drug diversion."

Six units of CE will be provided to pharmacists and pharmacy technicians who attend. CURES registration will be available during this presentation.

Attachment 8 contains the agenda for the joint training program.

12. Report on the Next DEA Drug TakeBack on September 27, 2014

Since 2010, Drug Enforcement Administration's (DEA) National Prescription Drug Take-Back Day initiative has collected a total of 4.1 million pounds (2,123 tons) of unneeded medications, helping to prevent diversion, misuse, and abuse of the drugs. Held twice each year, once in spring and once in fall, the days offer safe and legal disposal of

prescription and over-the-counter medications, including prescription controlled substances.

DEA coordinates with local and regional law enforcement agencies across the country to set up disposal sites during each Take-Back Day. During the eighth, and latest, National Prescription Drug Take-Back Day on April 26, 2014, disposal sites collected the largest amount of unused drugs in take-back history. The DEA reported that more than 6,000 locations participated in the eighth Take-Back Day and 390 tons of unneeded medications were collected. The level of consumer participation in the event shows the continued need for a means of safe, legal disposal of unused medications.

The next Take-Back Day will be held on September 27, 2014. Participating locations will be posted on September 1 at http://www.deadiversion.usdoj.gov/drug_disposal/takeback/.

13. Review of Additions to the Board of Pharmacy Prescription Drug Abuse Prevention Website Page

Attachment 9

The Board of Pharmacy created a prescription drug abuse prevention page on the board website that contains free, downloadable information on prescription drug abuse for teens, college students, parents, educators and pharmacists. The page also includes helpful website links. The page can be found at http://www.pharmacy.ca.gov/consumers/rx_abuse_prevention.shtml.

The page was recently updated to include a number of recommendations that were made by Dr. Rabia Atayee and Dr. Nathan Painter from the University of California, San Diego School of Pharmacy, at the May subcommittee meeting held in San Diego.

Screenshots of the updated prescription drug abuse prevention page are included in **Attachment 9**.

14. Review and Discussion of Articles Documenting the Issues of Prescription Medication Abuse

Attachment 10

Attachment 10 includes articles on heroin use, abuse deterrents used in pain medications, chronic pain, opioid overdose, the psychology of addiction and elder use of pain medications. It also includes two state reports on the opioid epidemic and the White House National Drug Control Strategy report and SAMHSA's Opioid Overdose Toolkit and other related documents.

15. Public Outreach to Address Prescription Drug Abuse

- July 10: Executive Officer Virginia Herold and Public Information Officer Joyia Emard attended the California Prescription Drug Abuse Work Group meeting
- July 15: Board Inspector Brandon Mutrux, PharmD, spoke on prescription drug abuse and other pharmacy issues at a Senior Scam Stopper program held in Southern California
- August 21: Executive Officer Virginia Herold provided a presentation at the California Conference of Local Health Officers monthly meeting regarding the board's implementation of SB 493 and the state's immunization registry
- August 25: Executive Officer Virginia Herold provides a presentation about the board's activities regarding prescription drug abuse to the first meeting of the Dental Board of California's prescription drug abuse committee

16. Public Comment for Items Not on the Agenda, Matters for Future Meetings*
    **(Note: the committee may not discuss or take action on any matter raised during the public comment section that is not included on this agenda, except to decide to place the matter on the agenda of a future meeting. Government Code Sections 11125 and 11125.7(a))*

Adjournment **2 p.m.**

Attachment 1

CDC Vitalsi™

July 2014

Opioid Painkiller Prescribing

Where You Live Makes a Difference

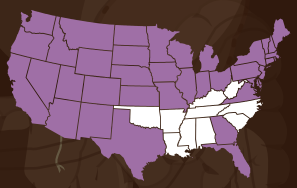
46

Each day, 46 people die from an overdose of prescription painkillers* in the US.

259 M

Health care providers wrote 259 million prescriptions for painkillers in 2012, enough for every American adult to have a bottle of pills.

10



10 of highest prescribing states for painkillers are in the South.

Health issues that cause people pain don't vary much from place to place—not enough to explain why, in 2012, health care providers in the highest-prescribing state wrote almost 3 times as many opioid painkiller prescriptions per person as those in the lowest prescribing state in the US. Or why there are twice as many painkiller prescriptions per person in the US as in Canada. Data suggest that where health care providers practice influences how they prescribe.

Higher prescribing of painkillers is associated with more overdose deaths. More can be done at every level to prevent overprescribing while ensuring patients' access to safe, effective pain treatment. Changes at the state level show particular promise.

States can

- ◇ Consider ways to increase use of prescription drug monitoring programs, which are state-run databases that track prescriptions for painkillers and can help find problems in overprescribing. Use of these programs is greater when they make data available in real-time, are universal (used by all prescribers for all controlled substances), and are actively managed (for example, send alerts to prescribers when problems are identified).
- ◇ Consider policy options (including laws and regulation) relating to pain clinics (facilities that specialize in pain treatment) to reduce prescribing practices that are risky to patients.

* "Prescription painkillers" refers to opioid or narcotic pain relievers, including drugs such as Vicodin (hydrocodone+acetaminophen), OxyContin (oxycodone), Opana (oxymorphone), and methadone.

→ See page 4

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www www.cdc.gov/vitalsigns/

National Center for Injury Prevention and Control
Division of Unintentional Injury Prevention

Problem

An increase in painkiller prescribing is a key driver of the increase in prescription overdoses.

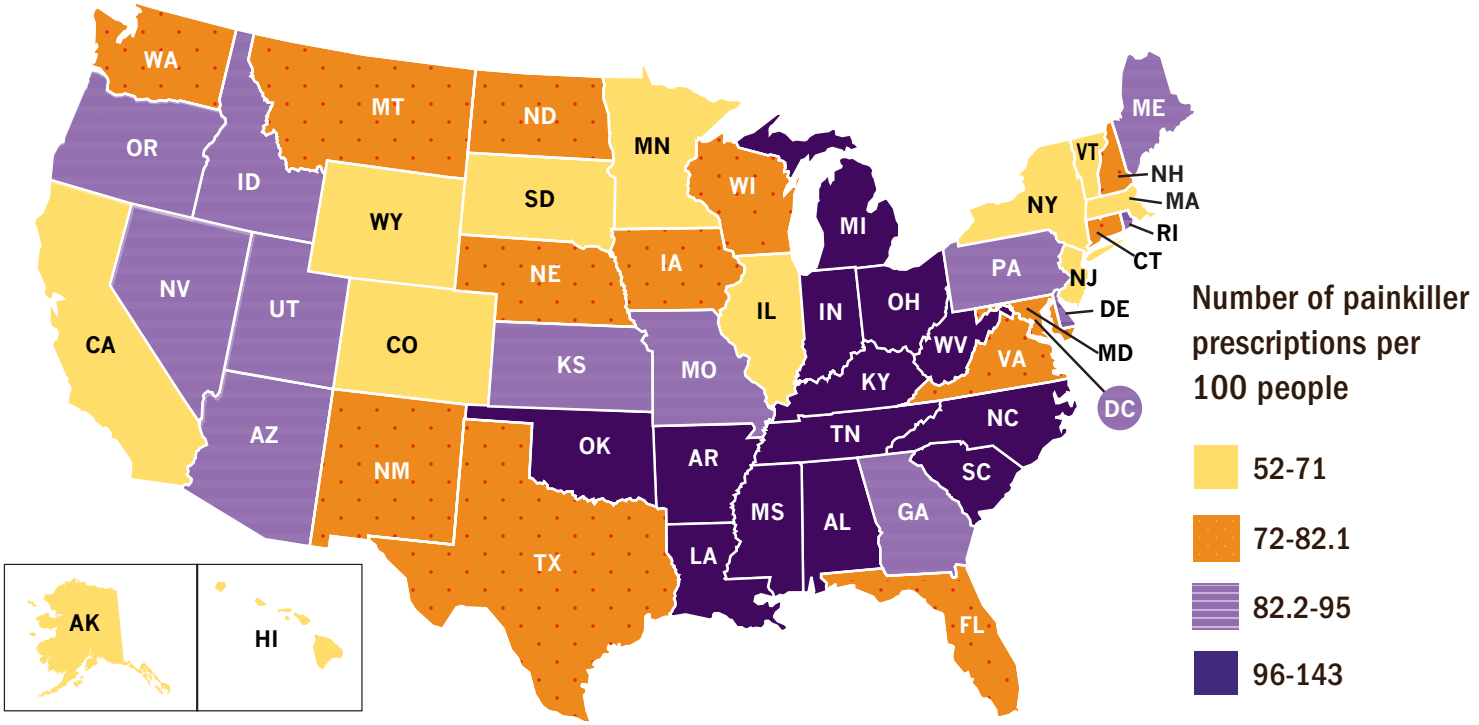
Health care providers in some states prescribed far more painkillers than those in other states in 2012.

- Southern states had the most prescriptions per person for painkillers, especially Alabama, Tennessee, and West Virginia.
- The Northeast, especially Maine and New Hampshire, had the most prescriptions per person for long-acting and high-dose painkillers.
- Nearly 22 times as many prescriptions were written for oxymorphone (a specific type of painkiller) in Tennessee as were written in Minnesota.

What might be causing this?

- Health care providers in different parts of the country don't agree on when to use prescription painkillers and how much to prescribe.
- Some of the increased demand for prescription painkillers is from people who use them nonmedically (using drugs without a prescription or just for the high they cause), sell them, or get them from multiple prescribers at the same time.
- Many states report problems with for-profit, high-volume pain clinics (so-called "pill mills") that prescribe large quantities of painkillers to people who don't need them medically.

Some states have more painkiller prescriptions per person than others.



SOURCE: IMS, National Prescription Audit (NPA™), 2012.

Health care providers in different states prescribe at different levels.

Number of painkiller prescriptions per 100 people

Lowest — Average — Highest

Lowest		Average		Highest
NJ 63	AZ 82	SC 102	MS 120	AL 143
NY 60	NE 79	NC 97	AR 116	WV 138
HI 52	WA 77	NV 94	MI 107	OK 128
MN 62	ND 75	DE 91	LA 118	TN 143
CA 57	TX 74	RI 90	IN 109	KY 128
	IA 73	PA 88		
	CT 72	DC 86		
	CO 71	ME 85		
	WY 70	OH 100		
	VT 67	MO 95		
	AK 65	KS 94		
	MT 82	GA 91		
	VA 78	OR 89		
	WI 76	UT 86		
	MD 74	ID 86		
	NM 74			
	FL 73			
	NH 72			
	MA 71			
	IL 68			
	SD 66			

State Abbreviation — GA 91 — Number of painkiller prescriptions per 100 people

SOURCE: IMS, National Prescription Audit (NPA™), 2012.

Making a Difference: State Successes

New York

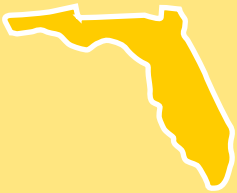
75%

2012 Action:

New York required prescribers to check the state's prescription drug monitoring program before prescribing painkillers.

2013 Result:

Saw a 75% **drop in patients** who were seeing **multiple prescribers** to obtain the same drugs, which would put them at higher risk of overdose.



Florida

50%

2010 Action:

Florida regulated pain clinics and stopped health care providers from dispensing prescription painkillers from their offices.

2012 Result:

Saw more than 50% **decrease in overdose deaths** from oxycodone.

Tennessee

36%

2012 Action:

Tennessee required prescribers to check the state's prescription drug monitoring program before prescribing painkillers.

2013 Result:

Saw a 36% **drop in patients** who were seeing **multiple prescribers** to obtain the same drugs, which would put them at higher risk of overdose.

SOURCES: NY, TN: PDMP Center of Excellence at Brandeis University, 2014. FL: Vital Signs Mortality and Morbidity Weekly Report, July 1, 2014.

What Can Be Done

The Federal government is

- ◇ Supporting states that want to develop programs and policies to prevent prescription painkiller overdose, while ensuring patients' access to safe, effective pain treatment.
- ◇ Improving patient safety by supplying health care providers with data, tools, and guidance for decision making based on proven practices.
- ◇ Increasing access to mental health and substance abuse treatment through the Affordable Care Act.

States can

- ◇ Consider ways to increase use of prescription drug monitoring programs, which are state-run databases that track prescriptions for painkillers and can help find problems in overprescribing. Use of these programs is greater when they make data available in real-time, are universal (used by all prescribers for all controlled substances), and are actively managed (for example, send alerts to prescribers when problems are identified).
- ◇ Consider policy options (including laws and regulation) relating to pain clinics to reduce prescribing practices that are risky to patients.
- ◇ Evaluate their own data and programs and consider ways to assess their Medicaid, workers' compensation programs, and state-run health plans to detect and address inappropriate prescribing of painkillers.
- ◇ Identify opportunities to increase access to substance abuse treatment and consider expanding first responder access to naloxone, a drug used when people overdose.

Health care providers can

- ◇ Use prescription drug monitoring programs to identify patients who might be misusing their prescription drugs, putting them at risk for overdose.
- ◇ Use effective treatments such as methadone or buprenorphine for patients with substance abuse problems.
- ◇ Discuss with patients the risks and benefits of pain treatment options, including ones that do not involve prescription painkillers.
- ◇ Follow best practices for responsible painkiller prescribing, including:
  - Screening for substance abuse and mental health problems.
  - Avoiding combinations of prescription painkillers and sedatives unless there is a specific medical indication.
  - Prescribing the lowest effective dose and only the quantity needed depending on the expected length of pain.

Everyone can

- ◇ Avoid taking prescription painkillers more often than prescribed.
- ◇ Dispose of medications properly, as soon as the course of treatment is done, and avoid keeping prescription painkillers or sedatives around "just in case."
- ◇ Help prevent misuse and abuse by not selling or sharing prescription drugs. Never use another person's prescription drugs.
- ◇ Get help for substance abuse problems 1-800-662-HELP. Call Poison Help 1-800-222-1222 if you have questions about medicines.

For more information, please contact

Telephone: 1-800-CDC-INFO (232-4636)

TTY: 1-888-232-6348

Web: www.cdc.gov

Centers for Disease Control and Prevention

1600 Clifton Road NE, Atlanta, GA 30333

Publication date: 7/1/2014

www www.cdc.gov/vitalsigns/opioid-prescribing

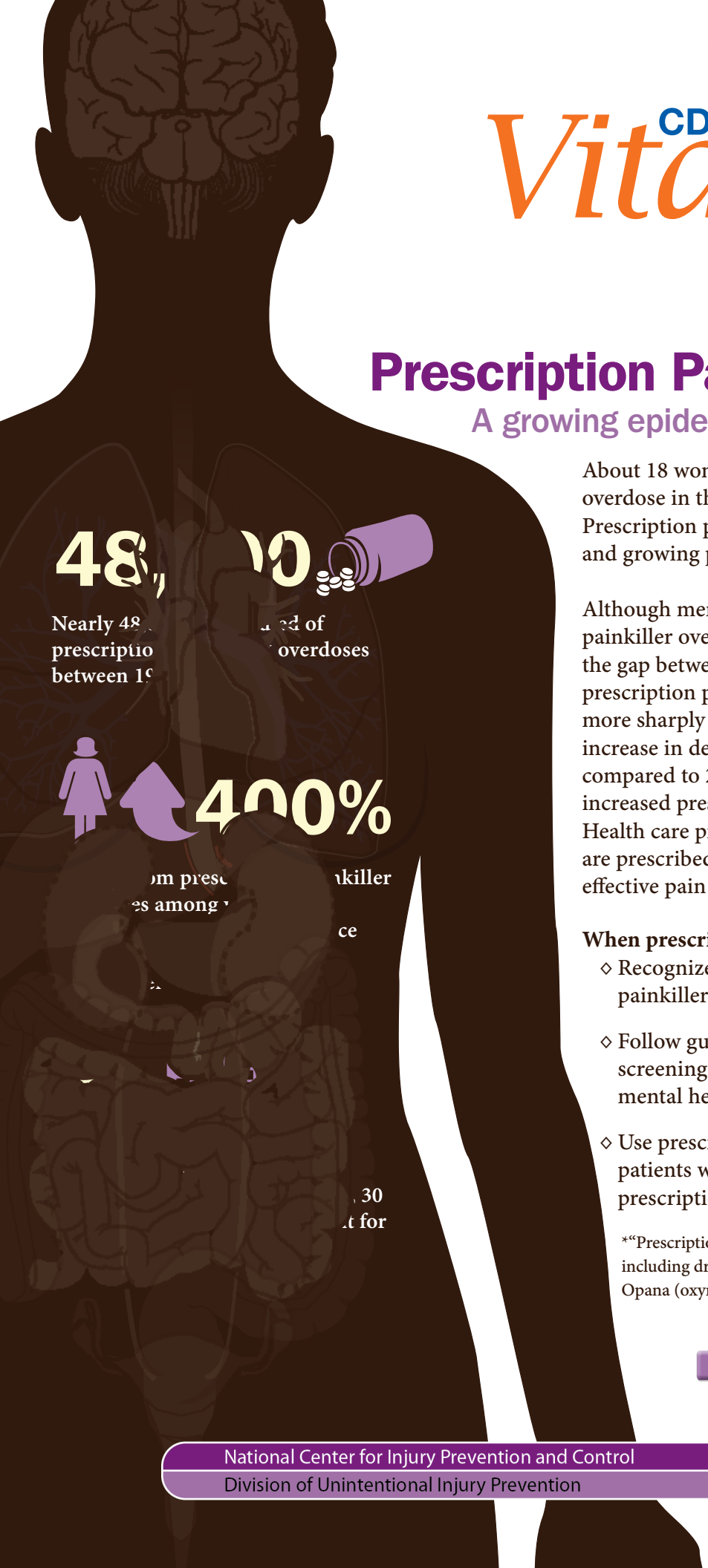
www www.cdc.gov/mmwr

CDC Vitalsi™

July 2013

Prescription Painkiller Overdoses

A growing epidemic, especially among women



About 18 women die every day of a prescription painkiller overdose in the US, more than 6,600 deaths in 2010. Prescription painkiller overdoses are an under-recognized and growing problem for women.

Although men are still more likely to die of prescription painkiller overdoses (more than 10,000 deaths in 2010), the gap between men and women is closing. Deaths from prescription painkiller overdose among women have risen more sharply than among men; since 1999 the percentage increase in deaths was more than 400% among women compared to 265% in men. This rise relates closely to increased prescribing of these drugs during the past decade. Health care providers can help improve the way painkillers are prescribed while making sure women have access to safe, effective pain treatment.

When prescribing painkillers, health care providers can

- Recognize that women are at risk of prescription painkiller overdose.
- Follow guidelines for responsible prescribing, including screening and monitoring for substance abuse and mental health problems.
- Use prescription drug monitoring programs to identify patients who may be improperly obtaining or using prescription painkillers and other drugs.

*"Prescription painkillers" refers to opioid or narcotic pain relievers, including drugs such as Vicodin (hydrocodone), OxyContin (oxycodone), Opana (oxymorphone), and methadone.

→ See page 4

Want to learn more? Visit

www http://www.cdc.gov/vitalsigns

National Center for Injury Prevention and Control
Division of Unintentional Injury Prevention

Problem

The prescription painkiller epidemic is killing more women than ever before.

Prescription painkiller overdoses are a serious and growing problem among women.

- More than 5 times as many women died from prescription painkiller overdoses in 2010 as in 1999.
- Women between the ages of 25 and 54 are more likely than other age groups to go to the emergency department from prescription painkiller misuse or abuse. Women ages 45 to 54 have the highest risk of dying from a prescription painkiller overdose.*
- Non-Hispanic white and American Indian or Alaska Native women have the highest risk of dying from a prescription painkiller overdose.
- Prescription painkillers are involved in 1 in 10 suicides among women.

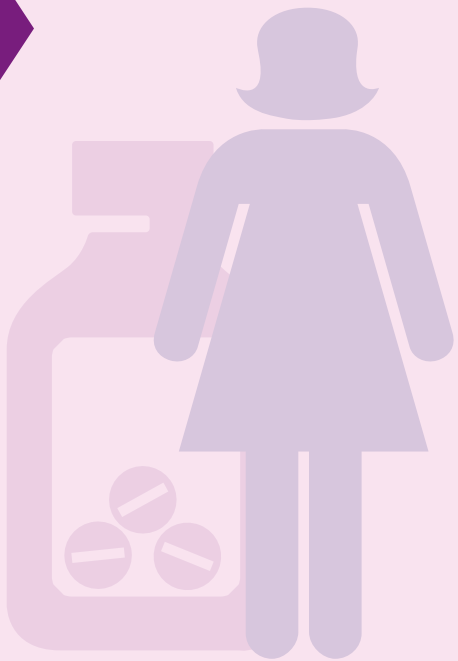
***Death data include unintentional, suicide, and other deaths. Emergency department visits only include suicide attempts if an illicit drug was involved in the attempt.**

The prescription painkiller problem affects women in different ways than men.

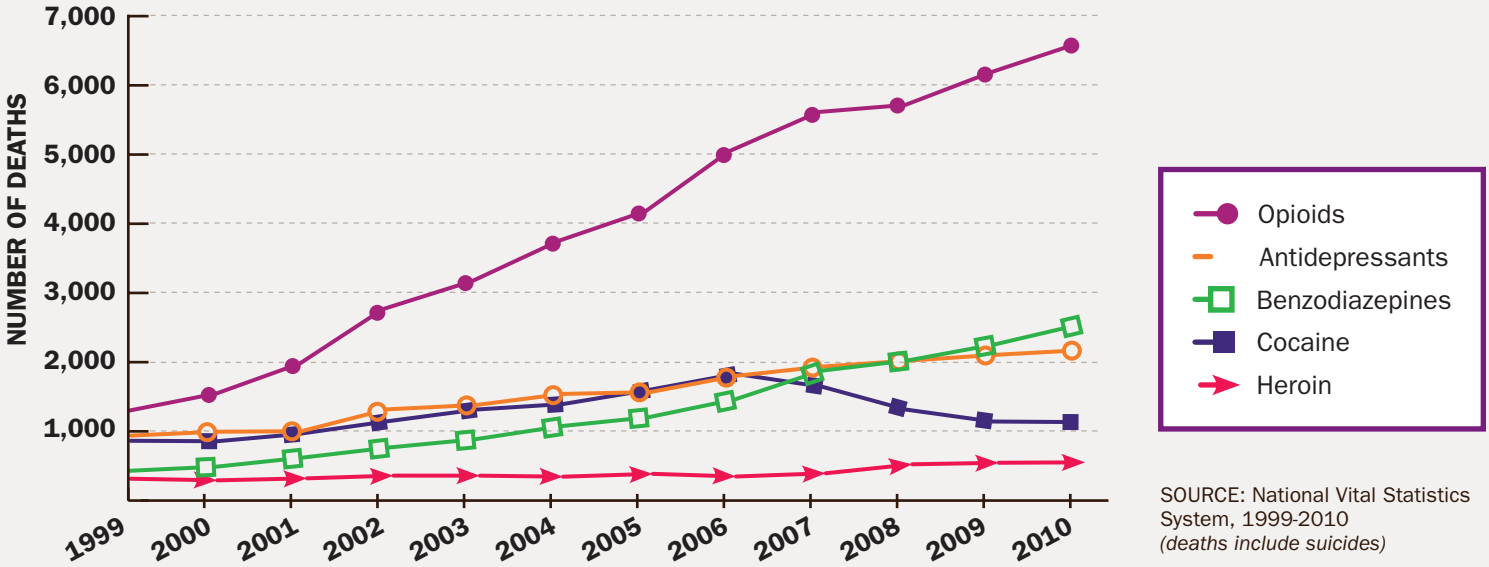
- Women are more likely to have chronic pain, be prescribed prescription painkillers, be given higher doses, and use them for longer time periods than men.
- Women may become dependent on prescription painkillers more quickly than men.
- Women may be more likely than men to engage in "doctor shopping" (obtaining prescriptions from multiple prescribers).
- Abuse of prescription painkillers by pregnant women can put an infant at risk. Cases of neonatal abstinence syndrome (NAS)—which is a group of problems that can occur in newborns exposed to prescription painkillers or other drugs while in the womb—grew by almost 300% in the US between 2000 and 2009.

Potential risks of combining medications

Medicines for treatment of pain and mental illness have benefits and risks. For women, 7 in 10 prescription drug deaths include painkillers. But other prescription drugs play a role in overdoses as well. Women are more likely than men to die of overdoses on medicines for mental health conditions, like antidepressants. Antidepressants and benzodiazepines (anti-anxiety or sleep drugs) send more women than men to emergency departments. Mental health drugs can be especially dangerous when mixed with prescription painkillers and/or alcohol. If you take mental health drugs and prescription painkillers, discuss the combination with your health care provider.



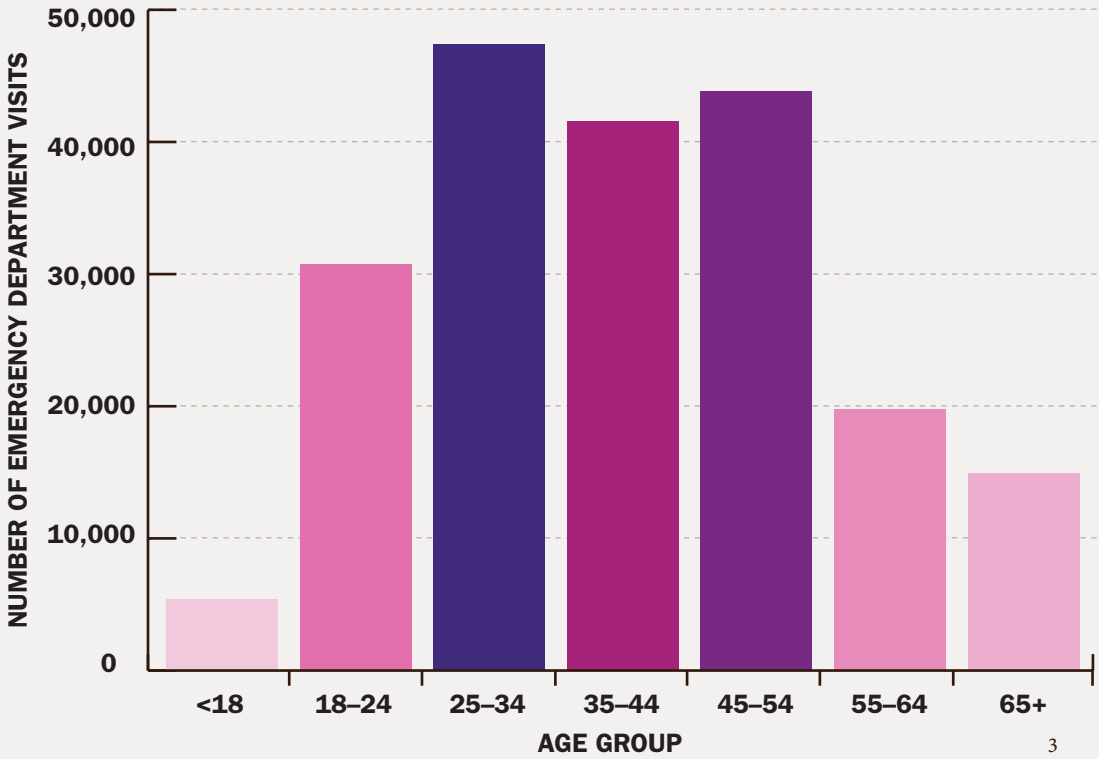
Prescription painkiller overdose deaths are a growing problem among women.



SOURCE: National Vital Statistics System, 1999-2010
(deaths include suicides)

Every 3 minutes, a woman goes to the emergency department for prescription painkiller misuse or abuse.

Women between the ages of 25 and 54 are most likely to go to the emergency department because of prescription painkiller misuse or abuse.



SOURCE: Drug Abuse Warning Network, 2010. (Suicide attempts are included for the cases (.03% of total) where opioids were combined with illicit drugs in the attempt.)

What Can Be Done

The US government is

- Tracking prescription drug overdose trends to better understand the epidemic.
- Educating health care providers and the public about prescription drug misuse, abuse, suicide, and overdose, and the risks for women.
- Developing and evaluating programs and policies that prevent and treat prescription drug abuse and overdose, while making sure patients have access to safe, effective pain treatment.
- Working to improve access to mental health and substance abuse treatment through implementation of the Affordable Care Act.

Health care providers can

- Recognize that women can be at risk of prescription drug overdose.
- Discuss pain treatment options, including ones that do not involve prescription drugs.
- Discuss the risks and benefits of taking prescription painkillers, especially during pregnancy. This includes when painkillers are taken for chronic conditions.
- Follow guidelines for responsible painkiller prescribing, including:
  - Screening and monitoring for substance abuse and mental health problems.
  - Prescribing only the quantity needed based on appropriate pain diagnosis.
  - Using patient-provider agreements combined with urine drug tests for people using prescription painkillers long term.
  - Teaching patients how to safely use, store, and dispose of drugs.
  - Avoiding combinations of prescription painkillers and benzodiazepines (such as Xanax and Valium) unless there is a specific medical indication.
- Talk with pregnant women who are dependent on prescription painkillers about treatment options, such as opioid agonist therapy.
- Use prescription drug monitoring programs (PDMPs)—electronic databases that track all controlled substance prescriptions in the state—to identify patients who may be improperly using prescription painkillers and other drugs.

States can

- Take steps to improve PDMPs, such as real time data reporting and access, integration with electronic health records, proactive unsolicited reporting, incentives for provider use, and interoperability with other states.
- Identify improper prescribing of painkillers and other prescription drugs by using PDMPs and other data.
- Increase access to substance abuse treatment, including getting immediate treatment help for pregnant women.
- Consider steps that can reduce barriers (such as lack of childcare) to substance abuse treatment for women.

Women can

- Discuss all medications they are taking (including over-the-counter) with their health care provider.
- Use prescription drugs only as directed by a health care provider, and store them in a secure place.
- Dispose of medications properly, as soon as the course of treatment is done. Do not keep prescription medications around "just in case." (See www.cdc.gov/HomeandRecreationalSafety/Poisoning/preventiontips.htm)
- Help prevent misuse and abuse by not selling or sharing prescription drugs. Never use another person's prescription drugs.
- Discuss pregnancy plans with their health care provider before taking prescription painkillers.
- Get help for substance abuse problems (1-800-662-HELP); call Poison Help (1-800-222-1222) for questions about medicines.

www http://www.cdc.gov/vitalsigns

www http://www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348
E-mail: cdcinfo@cdc.gov
Web: www.cdc.gov
Centers for Disease Control and Prevention
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Reversing the Prescription Drug Abuse Epidemic

By Bill Corr, Deputy Secretary, Department of Health and Human Services
Huffington Post

Posted: 08/04/2014 12:26 pm EDT Updated: 08/04/2014 2:59 pm EDT

Our nation is in the midst of an unprecedented epidemic of drug overdose deaths. Overdose deaths have increased five-fold since 1980. In 2009, prescription drug overdoses overtook every other cause of injury death in the United States, outnumbering fatalities from car crashes for the first time.

Prescription drugs, especially opioid pain relievers such as oxycodone, hydrocodone, and methadone, have largely driven this tragic increase. We're losing nearly 17,000 of our friends, family members, and neighbors each year. And with every death, the fabric of a home, a family, a community is torn.

This is a deeply troubling and challenging public health problem that is an enormous priority for our Department and President Obama. What gives us hope is the knowledge that we have the power to bring an end to this epidemic. These deaths are preventable.

While the problem is complex and multi-dimensional, we know that the over-prescription of opioid pain relievers is a driver of the problem. A recent CDC report showed that 259 million opioid prescriptions were written in 2012 alone. That's enough for every American adult to have a bottle. Multiple studies have shown that a small percentage of prescribers are responsible for prescribing the majority of opioids.

To effectively address this challenge, we need a strong, collaborative, and sustained response. That is why HHS recently hosted a working meeting with state officials from across the country to share best practices and discuss how federal and state governments can work together to put a stop to the epidemic. This meeting for the first time assembled governmental partners from across the country to share state successes and comprehensively focus on prescriber-targeted interventions.

Because states have the ability to regulate health care practices and monitor prescriptions, many of the critical policy levers exist at the state level. States are uniquely positioned to implement strategies that take into account the needs of patients at high risk of becoming addicted, while ensuring access to safe, effective pain treatment for those who need it. In addition, there are opportunities to provide prescribers with the knowledge and tools to help them improve clinical practice.

This meeting was an important step in expanding the reach of knowledge from those states that have already had success in areas such as provider oversight and collaboration, prescription drug monitoring programs, and prescribing guidelines and education.

Some states have already seen great success with provider oversight initiatives. For example, following legislative action taken in 2010, Florida saw oxycodone overdose deaths decline more than 50 percent in just two years as well as a 24 percent reduction in oxycodone prescribing.

Several other states shared their experiences with just how effective prescription drug monitoring initiatives can be, especially when systems are universal, updated in real-time, and integrated with health IT. We also heard about provider guidelines and education initiatives at the state level that are improving the way providers prescribe and monitor patient use of these drugs.

This meeting was an important step in building a long-term partnership with states to develop and implement policies and programs that can reduce prescription drug abuse. Together, we can achieve our shared goal of strengthening the public health of this nation by reversing this epidemic.

COMPILATION OF STATE PRESCRIPTION MONITORING PROGRAM MAPS

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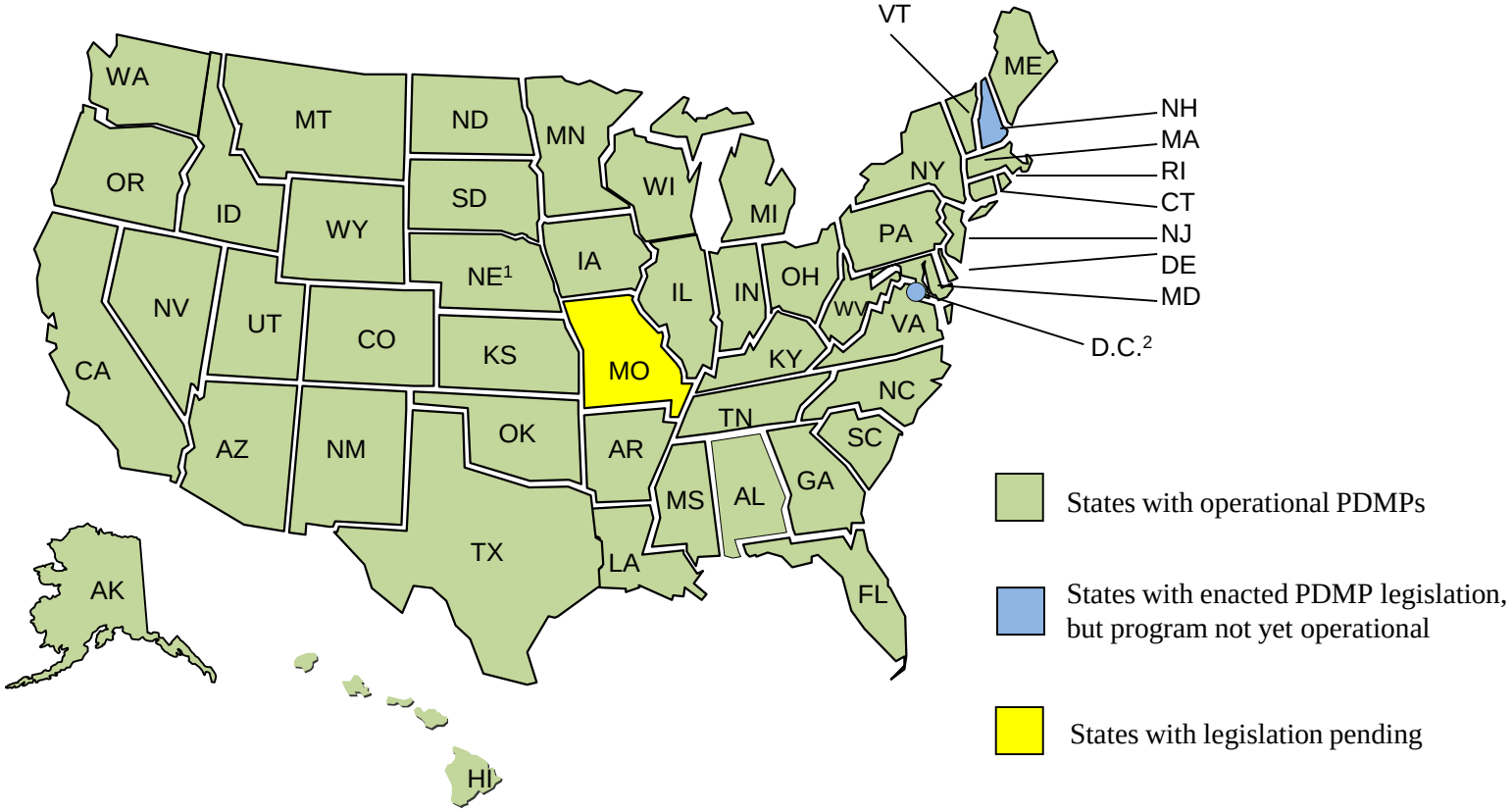
© 2014 Research is current as of December 2013. In order to ensure that the information contained herein is as current as possible, research is conducted using nationwide legal database software, individual state legislative websites., and direct communications with state PDMP representatives. Please contact Heather Gray at 703-836-6100, ext. 114 or hgray@namsdl.org with any additional updates or information that may be relevant to this document. Headquarters Office: THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS (NAMSDL). 215 Lincoln Ave. Suite 201, Santa Fe, NM 87501.

Status of State Prescription Drug Monitoring Programs (PDMPs)



[1] The operation of Nebraska's Prescription Monitoring Program is currently being facilitated through the state's Health Information Initiative. Participation by patients, physicians, and other health care providers is voluntary.
[2] The Mayor of D.C. has approved the legislation but it is pending a 30-day review process by Congress.

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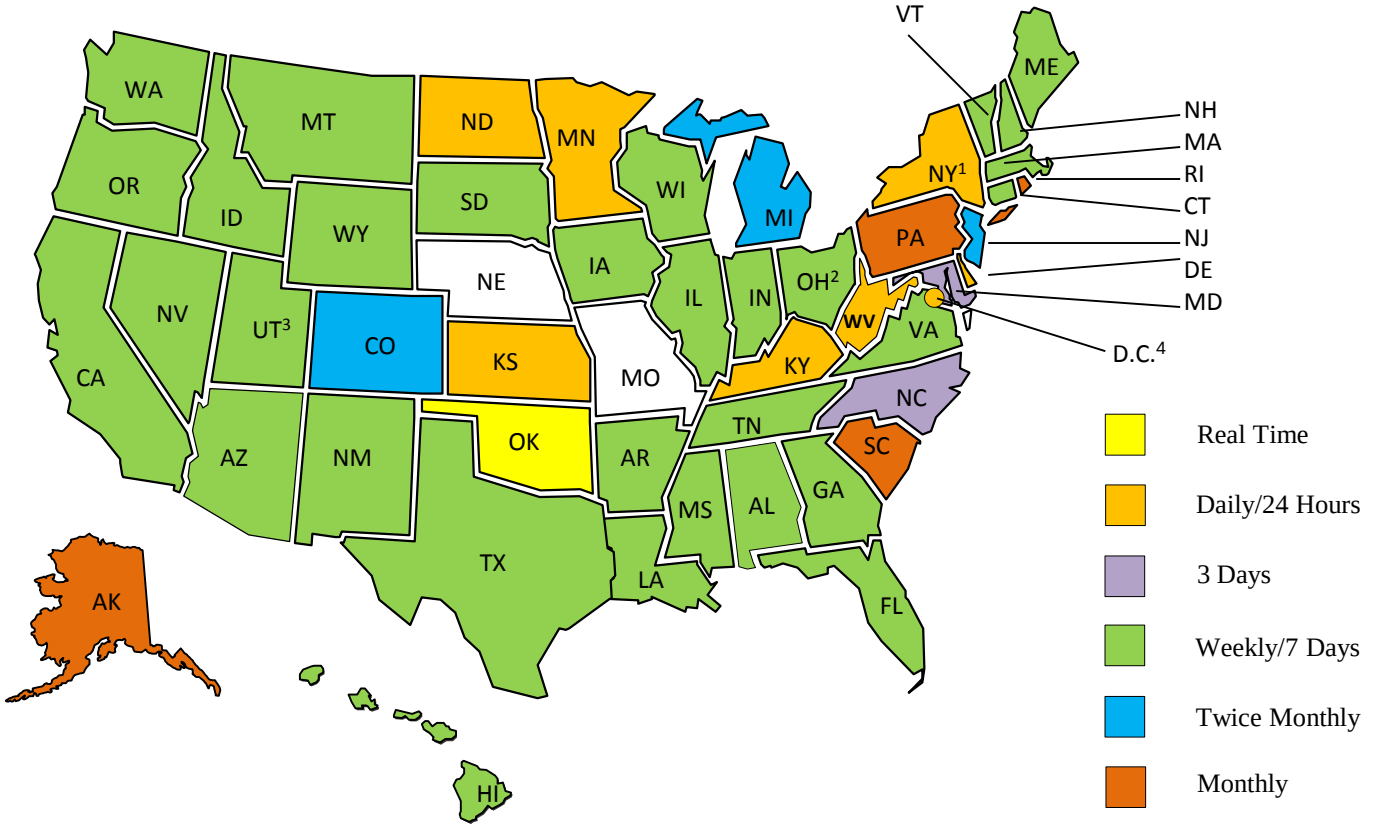
Data Collection Interval



[1] New York requires the submission of data in real time by statute, but that has been interpreted by regulation to mean no later than 24 hours after the substance is delivered. [2] Ohio requires submission of data from pharmacies weekly and from wholesalers monthly. [3] Utah requires submission weekly, but for those participating in the statewide pilot program, submission is required daily. [4] The Mayor of D.C. has approved the legislation Enacting a PMP, but it is pending a 30-day review by Congress.

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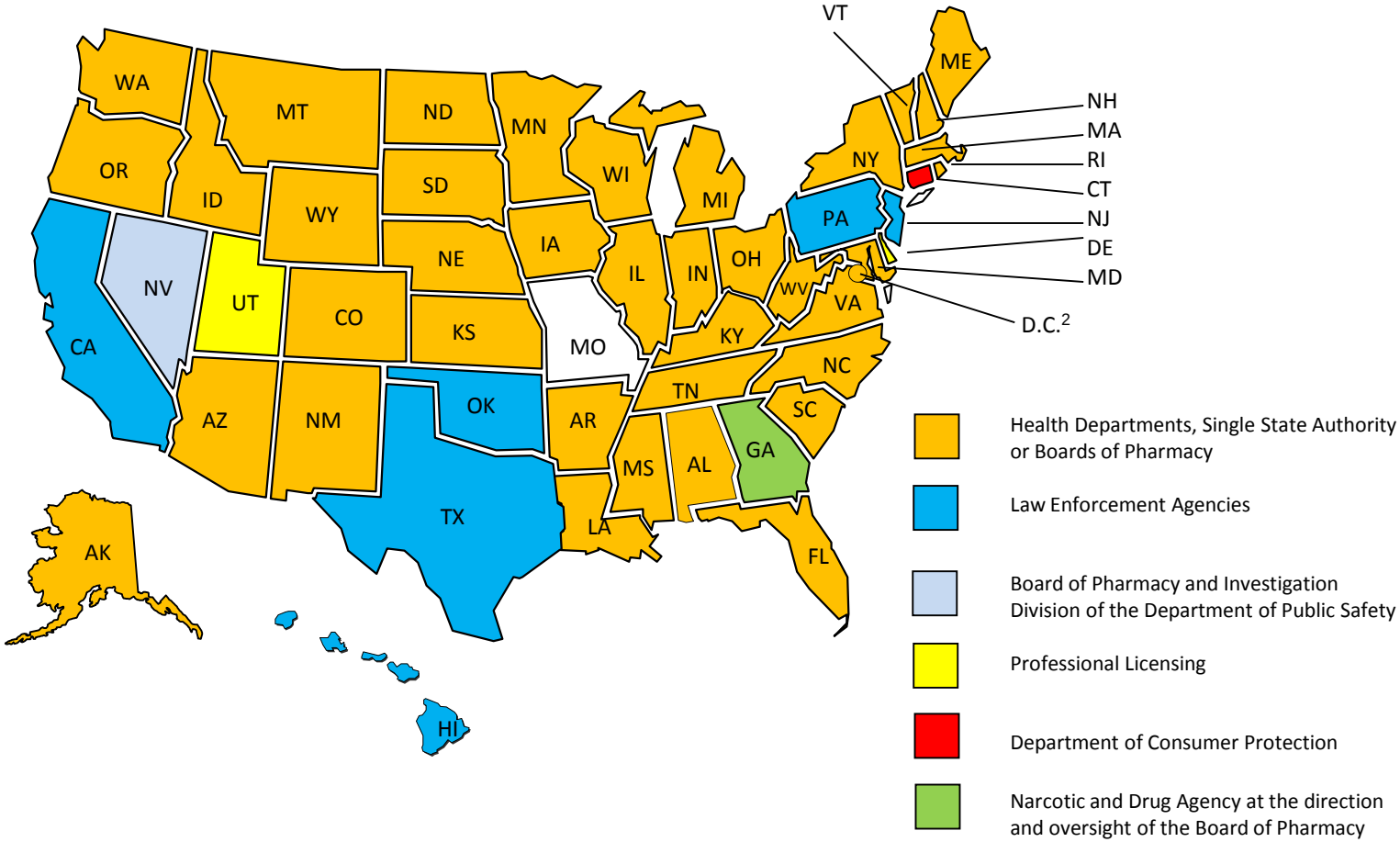
Breakdown of Housing Entities[1]



[1] This information is based on the agency the PMP statute or regulation indicates is required to establish the PMP.
[2] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

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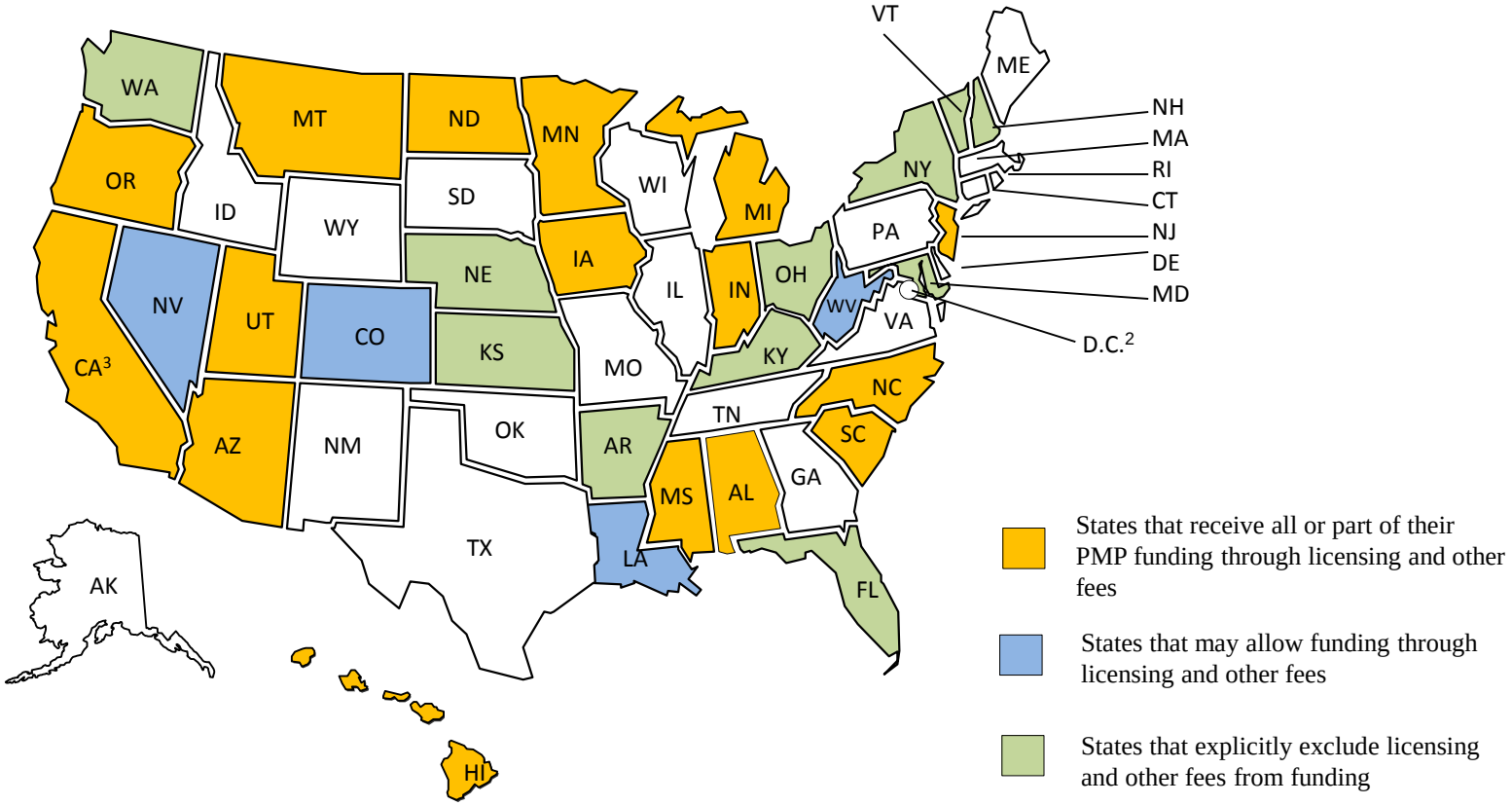
Funding Provisions of Prescription Monitoring Programs[1]



[1] This information is derived from the state PMP statutes and does not include any information that might be found in the state licensing statutes.
[2] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.
[3] California will begin collecting an annual fee from certain licensees beginning April 1, 2014.

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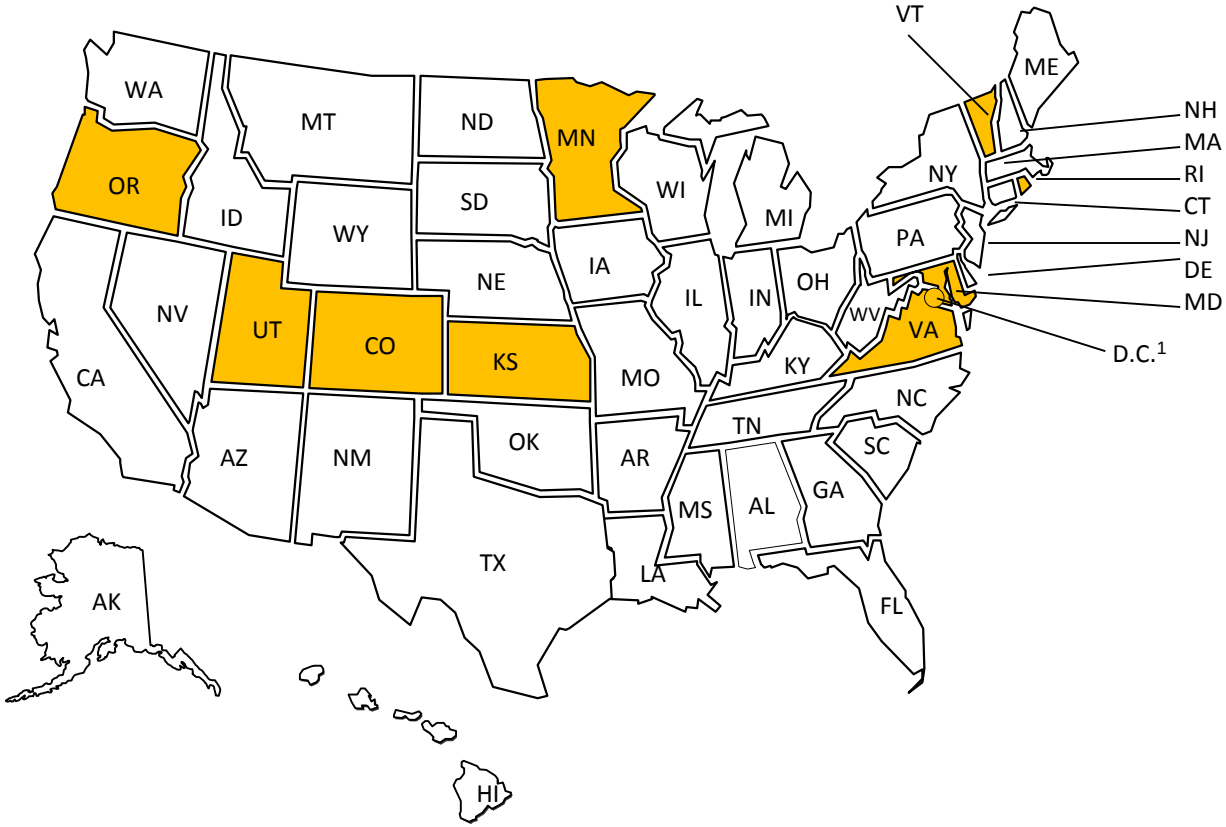
States that Require Prescribers and Dispensers to Notify Consumers That Their PMP Information May Be Accessed



[1] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

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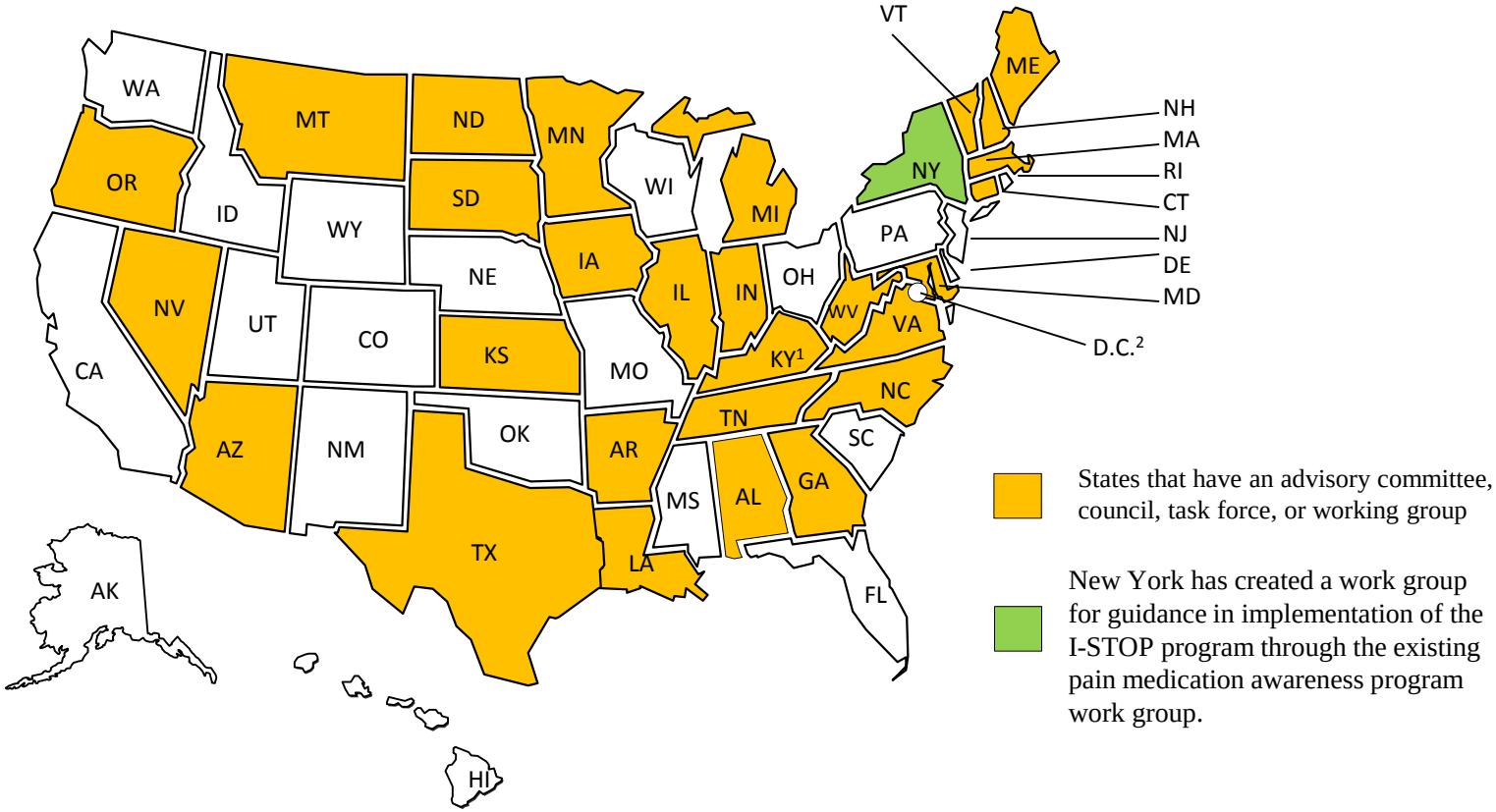
States That Mandate The Use of an Advisory Committee, Council, Task Force, or Working Group



[1] Kentucky has created an advisory council to recommend guidelines for use of the state PMP program by executive order of the Governor.

[2] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

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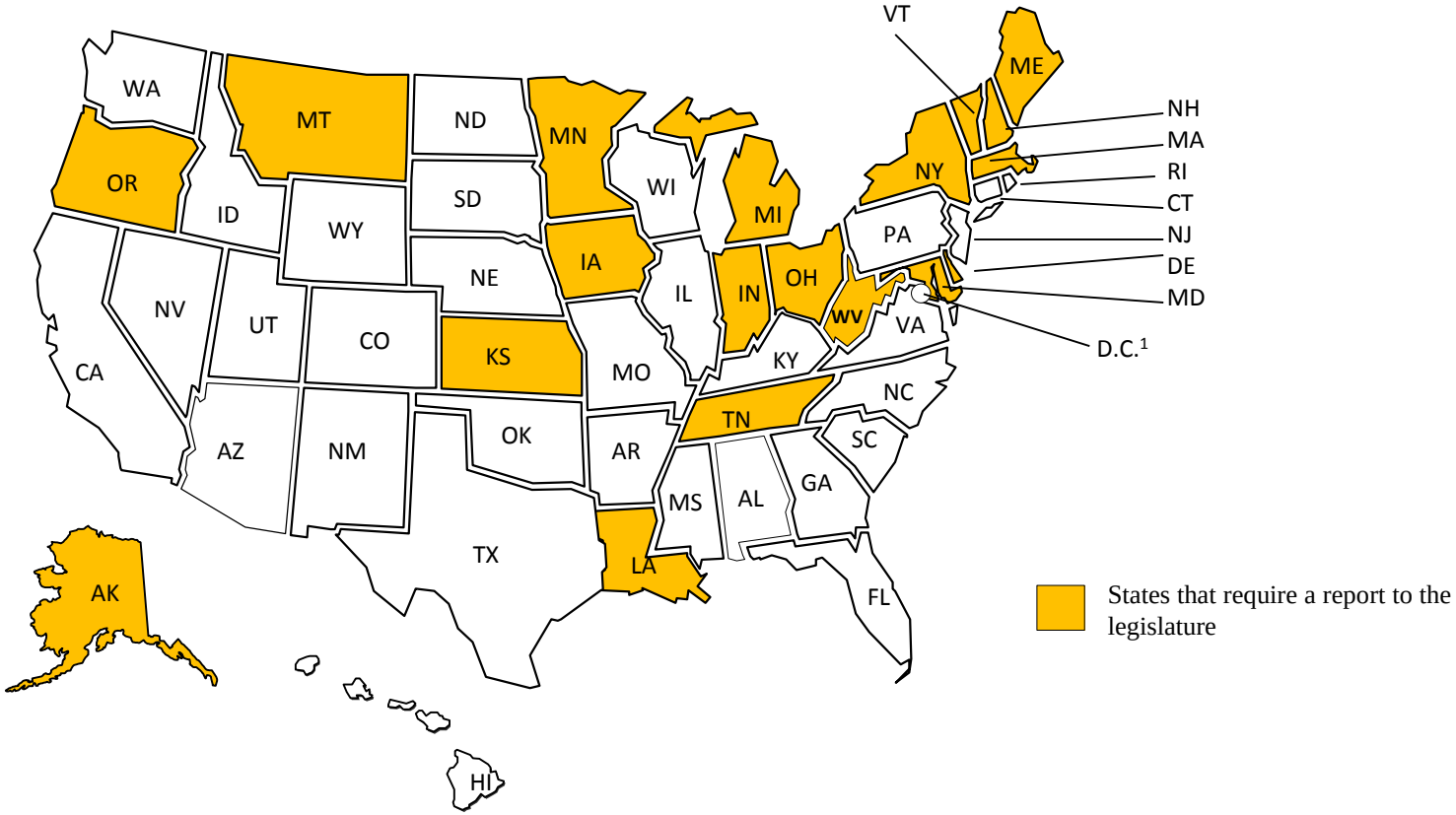
Evaluation of PMP – Report to Legislature



[1] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

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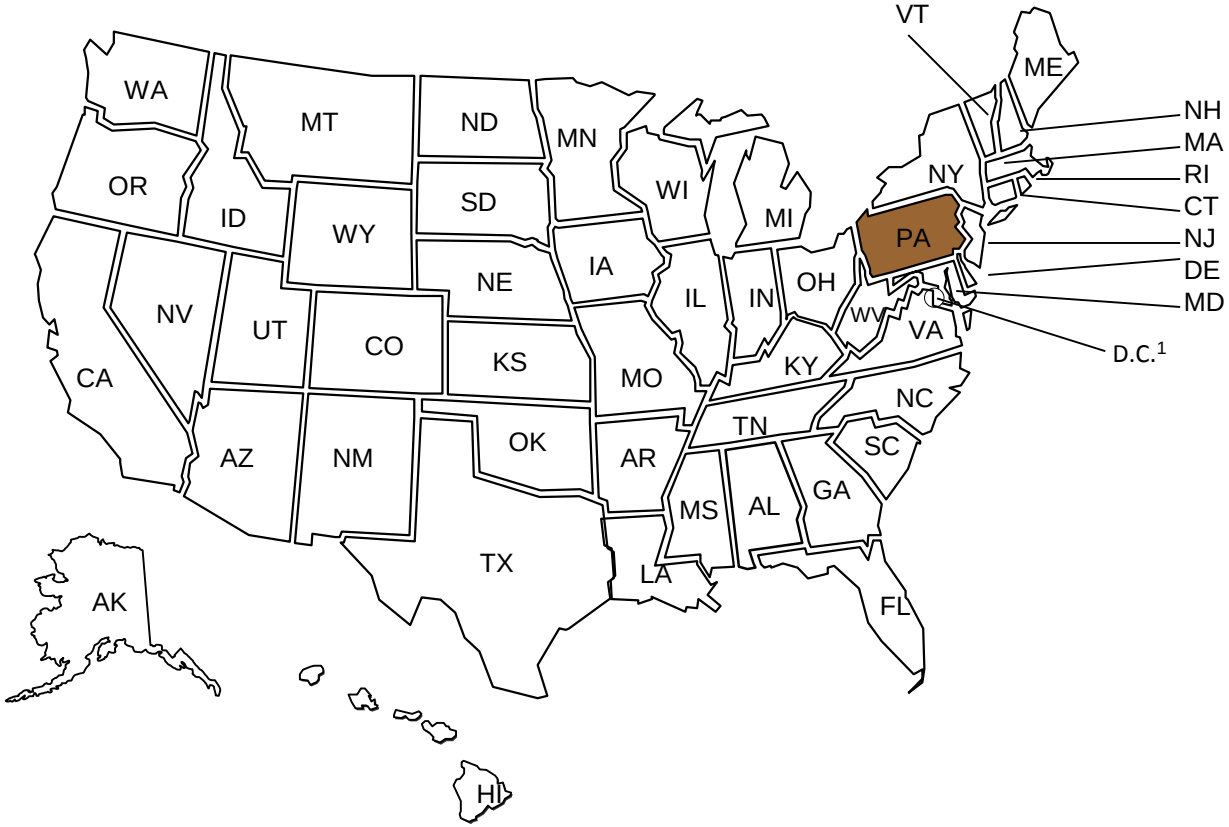
Prescription Drug Monitoring Programs
States With Authority to Monitor Schedule II Substances



[1] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

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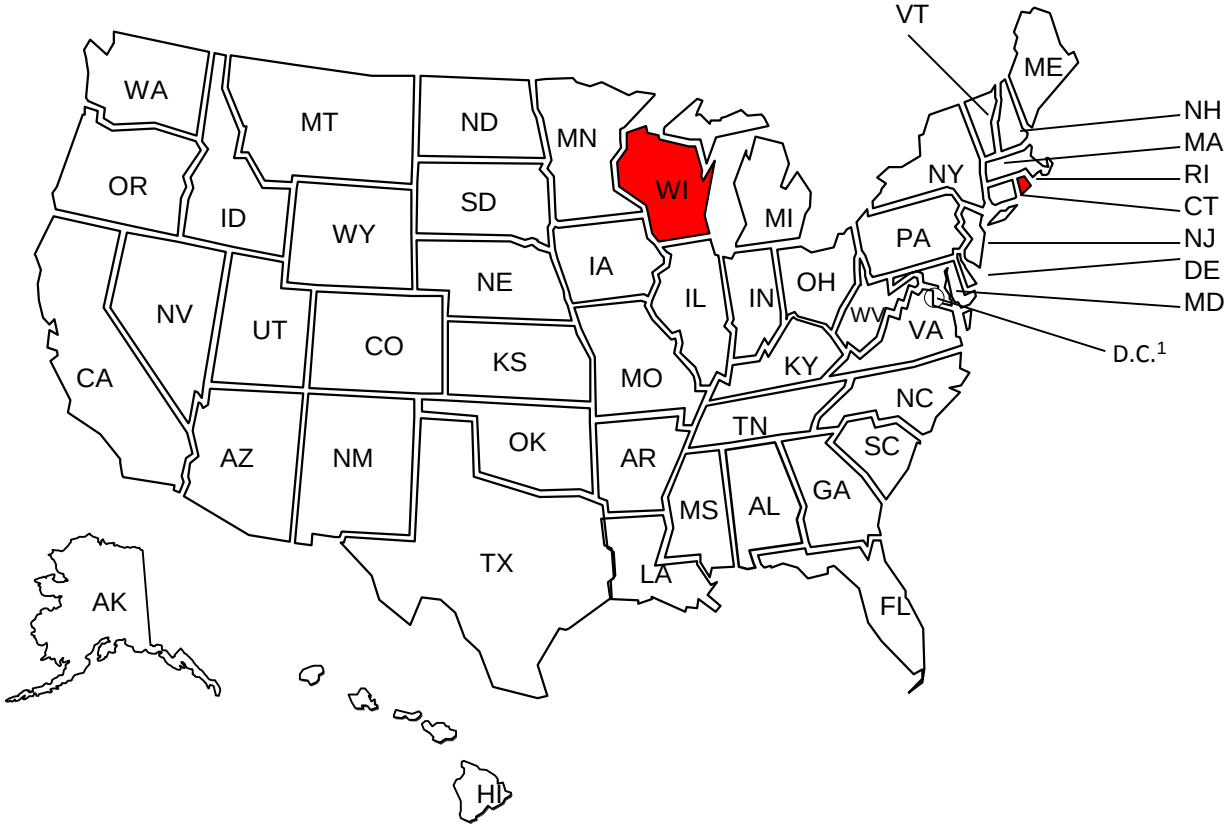
Prescription Drug Monitoring Programs
States With Authority to Monitor Schedule II & III Substances



[1] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

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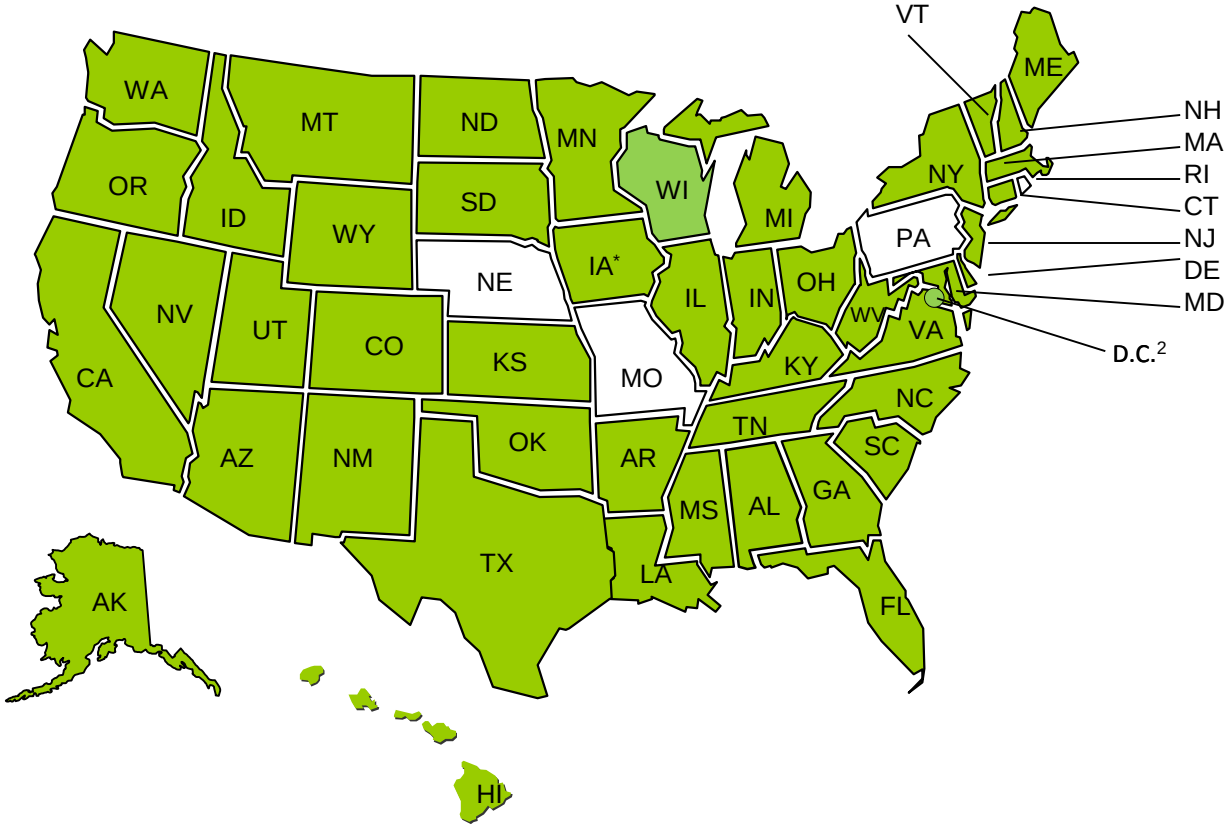
Prescription Drug Monitoring Programs
States With Authority to Monitor Schedule II, III and IV Substances



[1] Iowa's PDMP monitors Schedule III and IV substances that the advisory council and the Board of Pharmacy determine can be addictive or fatal if not taken under the proper care or direction of a prescribing practitioner.

[2] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

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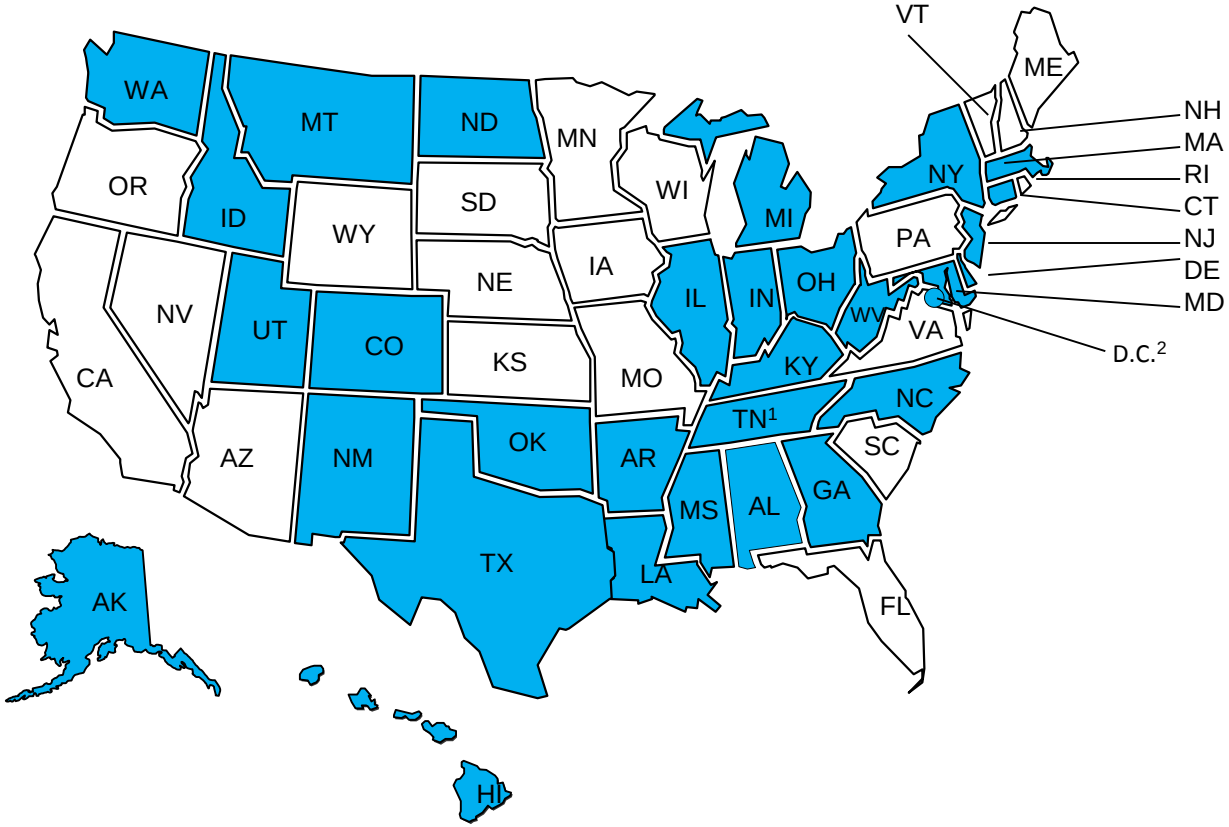
Prescription Drug Monitoring Programs
States With Authority to Monitor Schedule V Substances



[1] Tennessee's law authorizes the monitoring of Schedule V substances which have been identified by the controlled substances database advisory committee as demonstrating a potential for abuse.

[2] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

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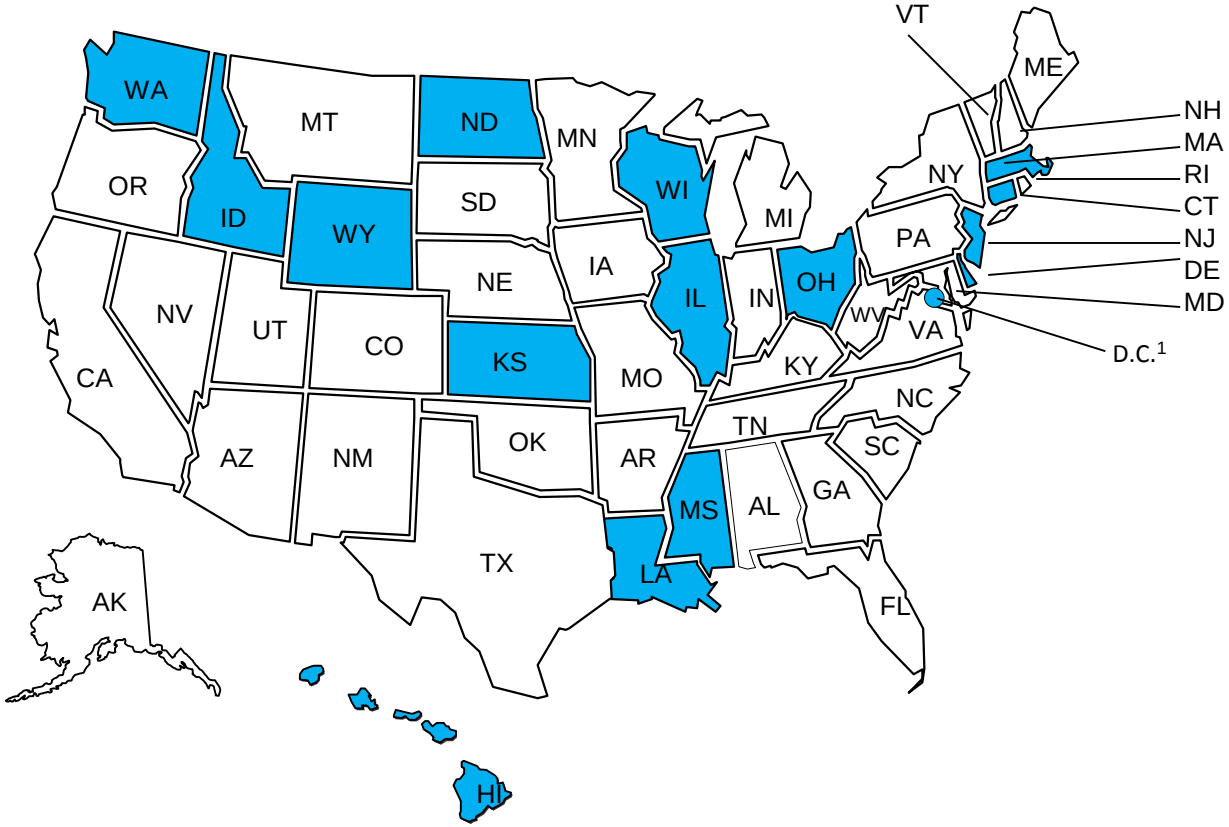
Prescription Drug Monitoring Programs
States With Authority to Monitor Non-controlled/Non-Scheduled Substances



[1] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

Please note that although a state may have statutory authority to monitor Non-controlled/Non-Scheduled substances, that state may not currently be monitoring prescriptions for such substances and may in fact require implementation of additional regulations before that monitoring can commence.

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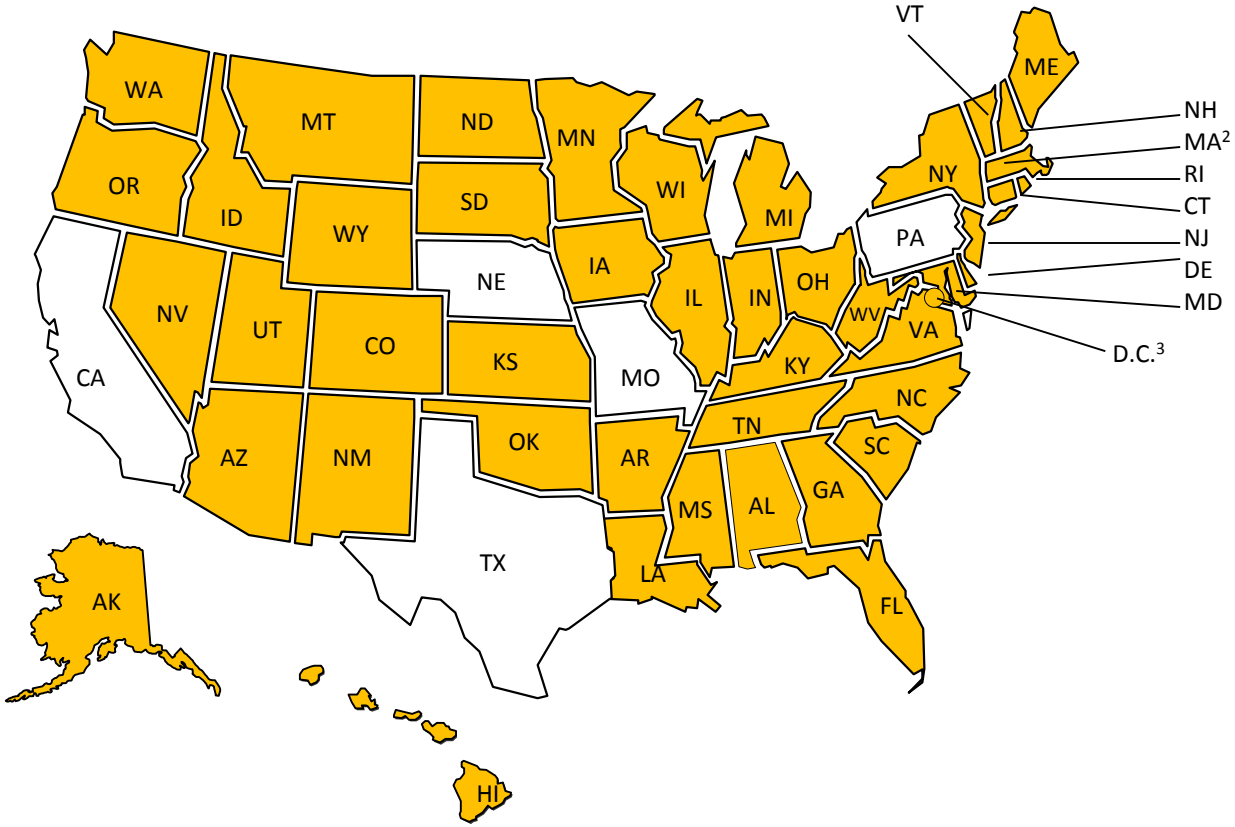
States with Statutory Authority to Require Nonresident Pharmacies to Report to State PMP[1]



[1] This map reflects those states with statutory authority to require nonresident pharmacies to report and does not reflect those states with such authority who are not actively collecting such data.

[2] Massachusetts requires nonresident pharmacies to report to the state PMP, but does not require them to register with or be licensed by the state.

[3] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

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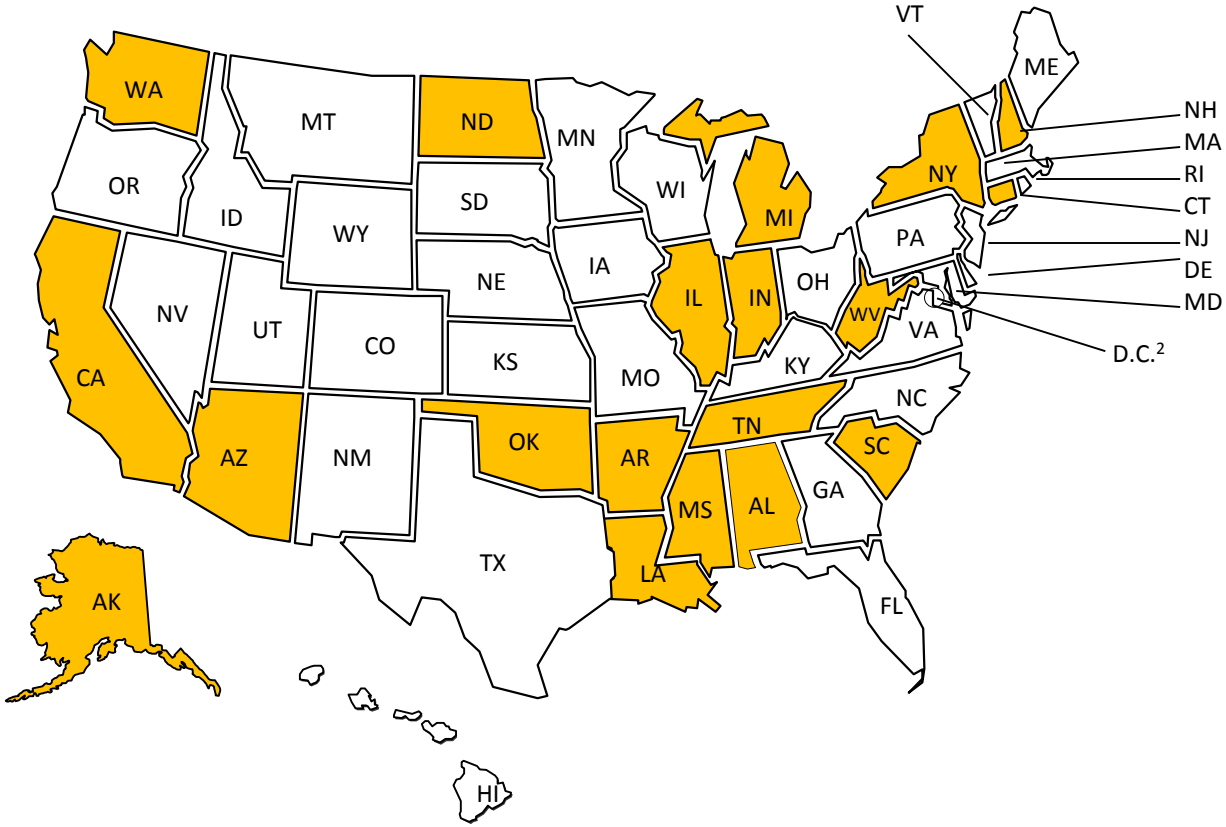
States with Statutory Authority to Require Veterinarians to Report to the State PMP[1]



[1] This map reflects those states with statutory authority to require veterinarians to report to the state PMP. It does not reflect those states that are actively collecting such data.

[2] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

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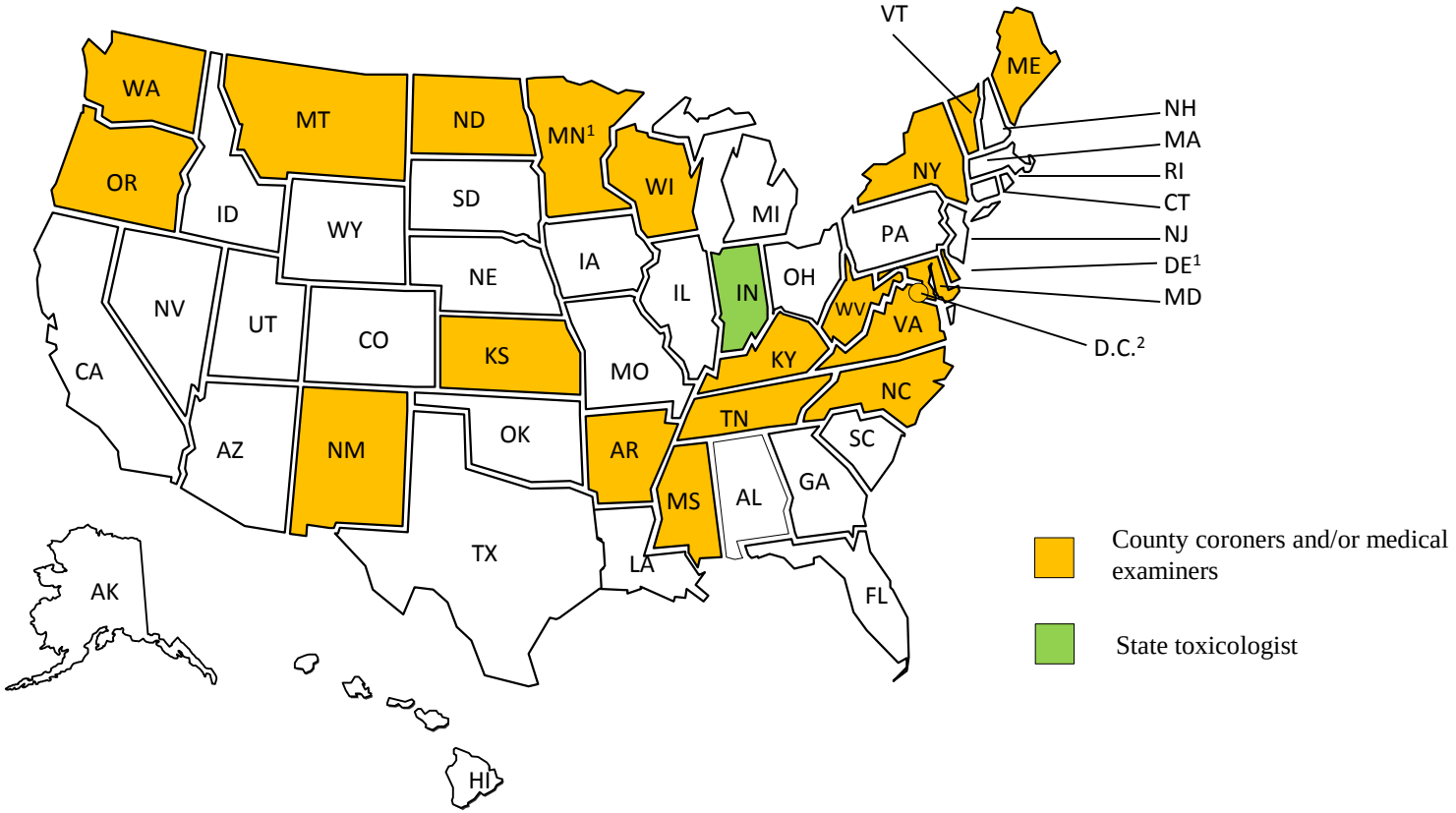
Types of Authorized Recipients - County Coroners, Medical Examiners, and/or State Toxicologists



[1] Minnesota has started a pilot program to allow access by county coroners and medical examiners. The Delaware provision goes into effect on March 1, 2014.

[2] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

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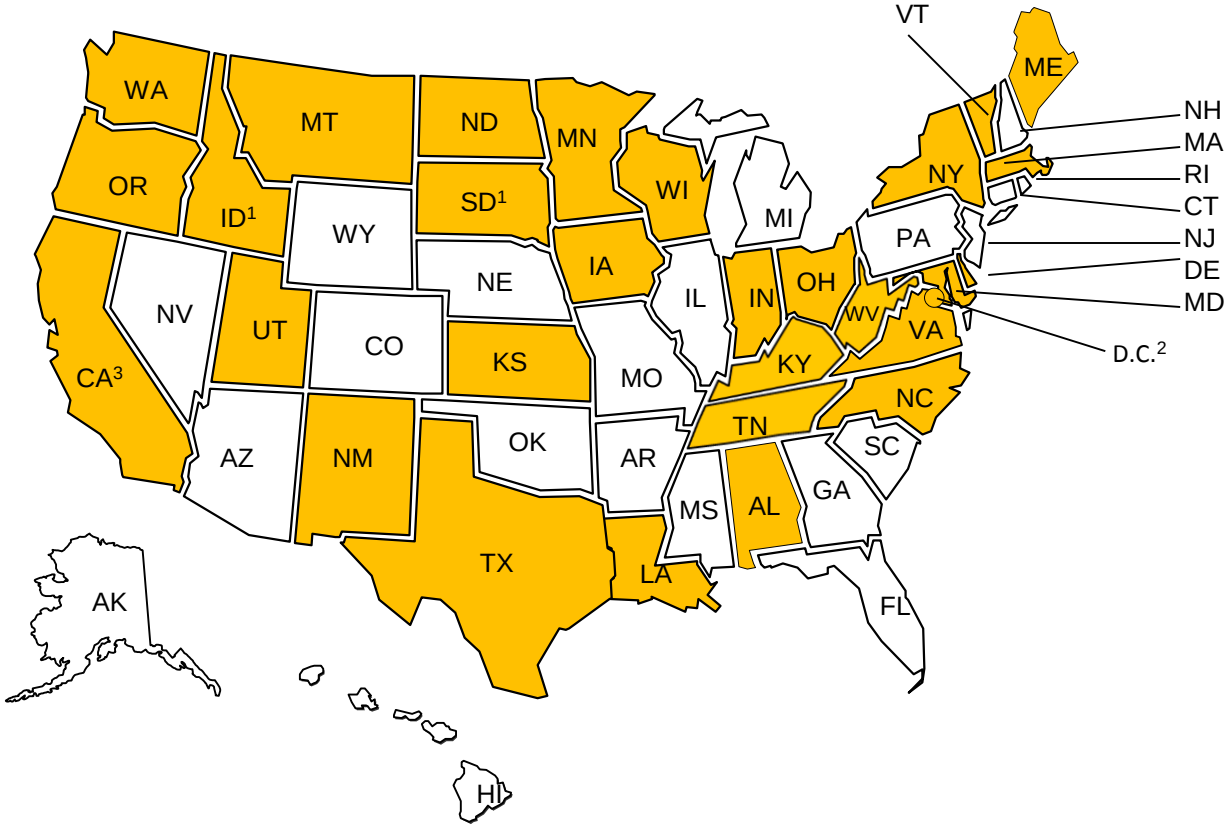
States that Allow Practitioners to Designate an Authorized Agent to Access the PMP Database



[1] Idaho and South Dakota only allow prescribers to designate an agent at this time.

[2] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

[3] The CA Department of Justice has been charged with the responsibility of identifying necessary procedures to enable practitioners and pharmacists to delegate their authority to access the PMP.

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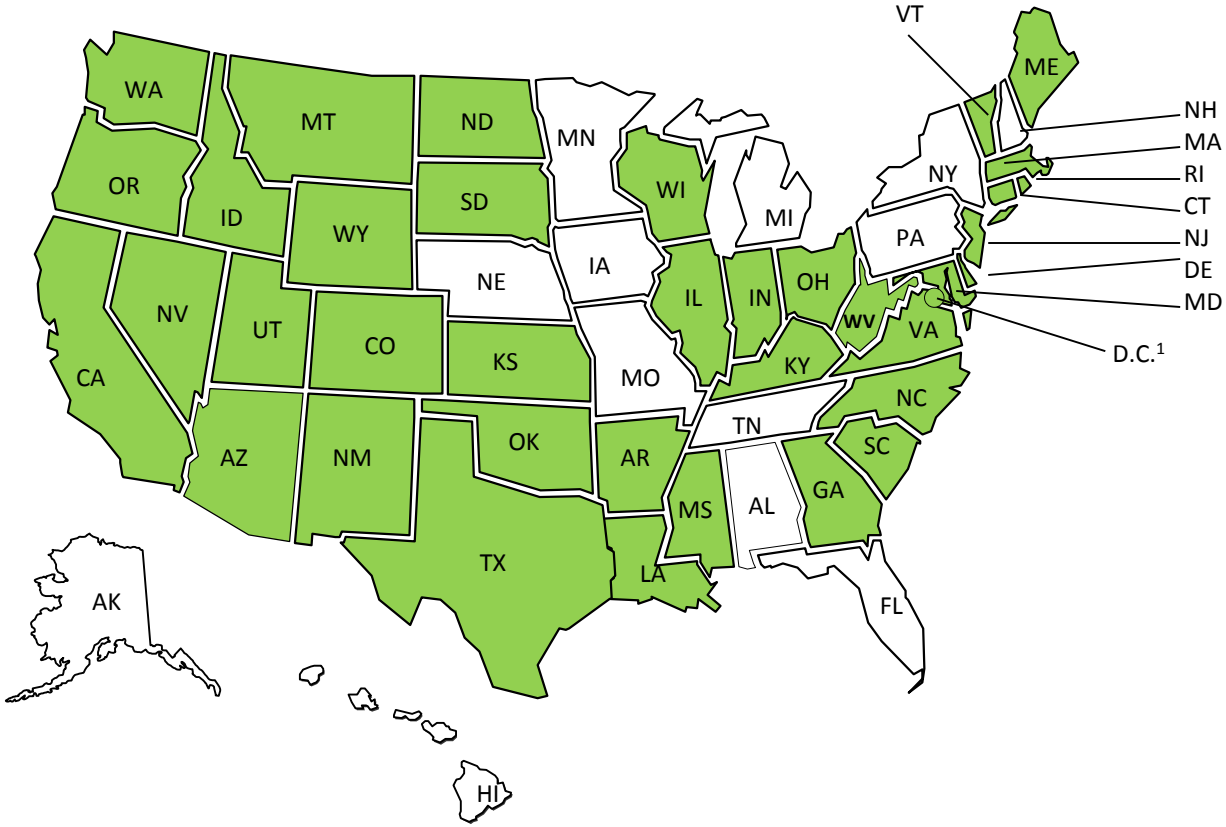
Types of Authorized Recipients - De-identified Data



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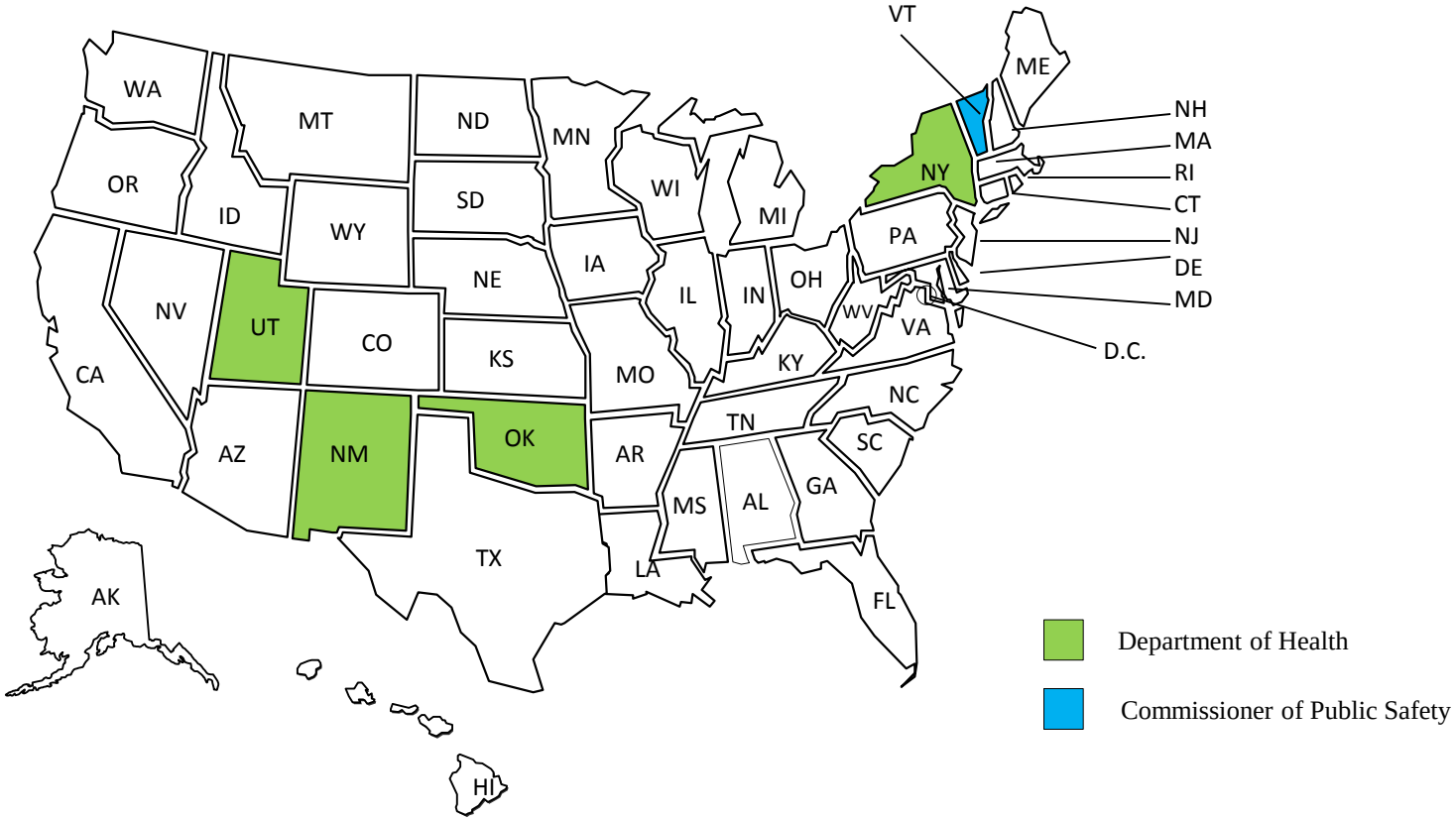
Types of Authorized Recipients – Department of Health or Commissioner of Public Safety



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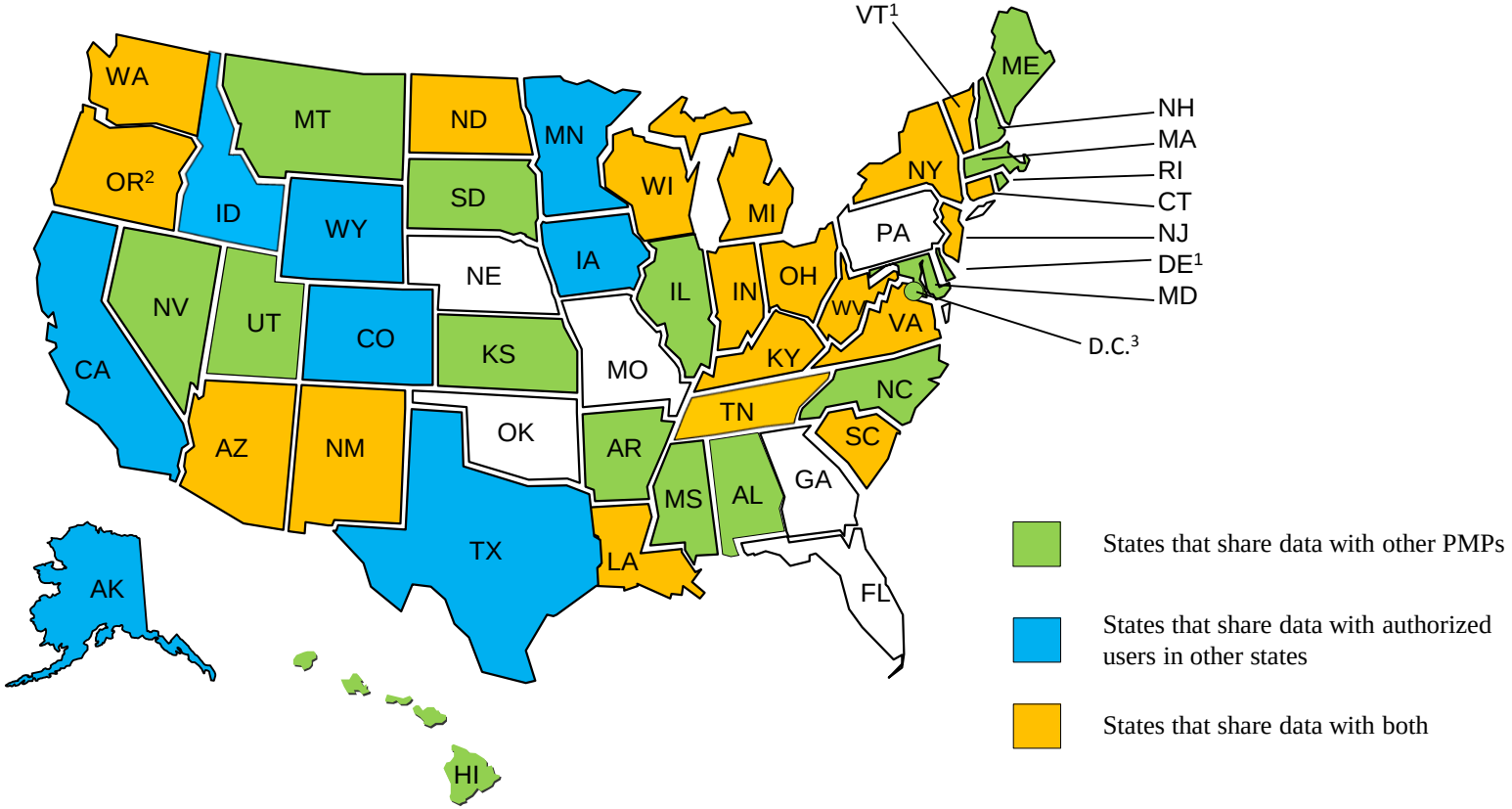
Interstate Sharing of Prescription Monitoring Program Data Pursuant to Statute, Regulation, and/or Statutory Interpretation



[1] The Delaware provision goes into effect on March 1, 2014.
[2] Oregon will only allow direct access to the PMP to practitioners in CA, ID, and WA.
[3] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

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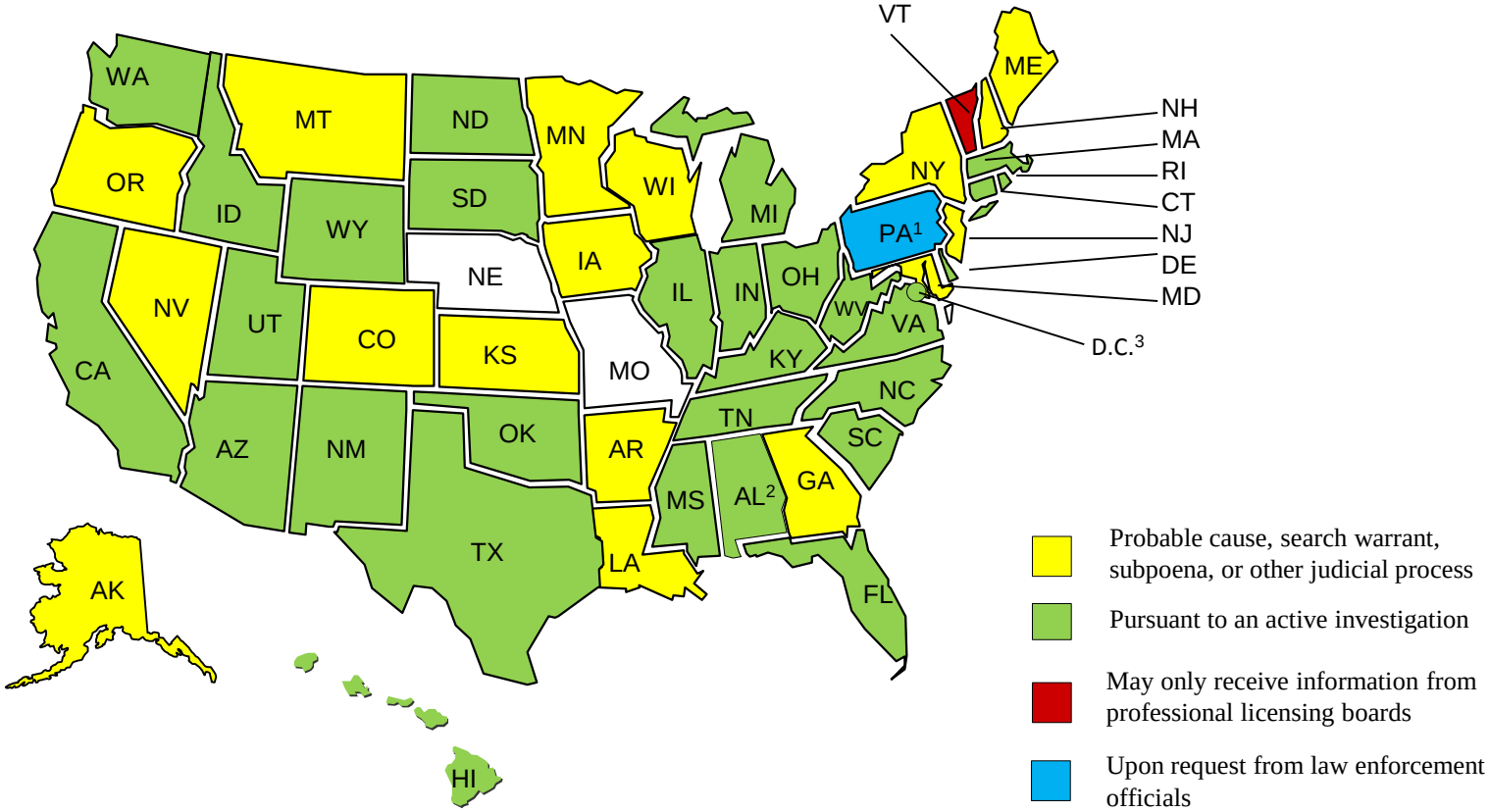
Types of Authorized Recipients – Law Enforcement Officials



[1] Law enforcement requests must be approved by the Office of the Attorney General. Law enforcement officials do not have direct access.
[2] Law enforcement officers must make a declaration that probable cause exists, but there is no judicial process involved.
[3] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

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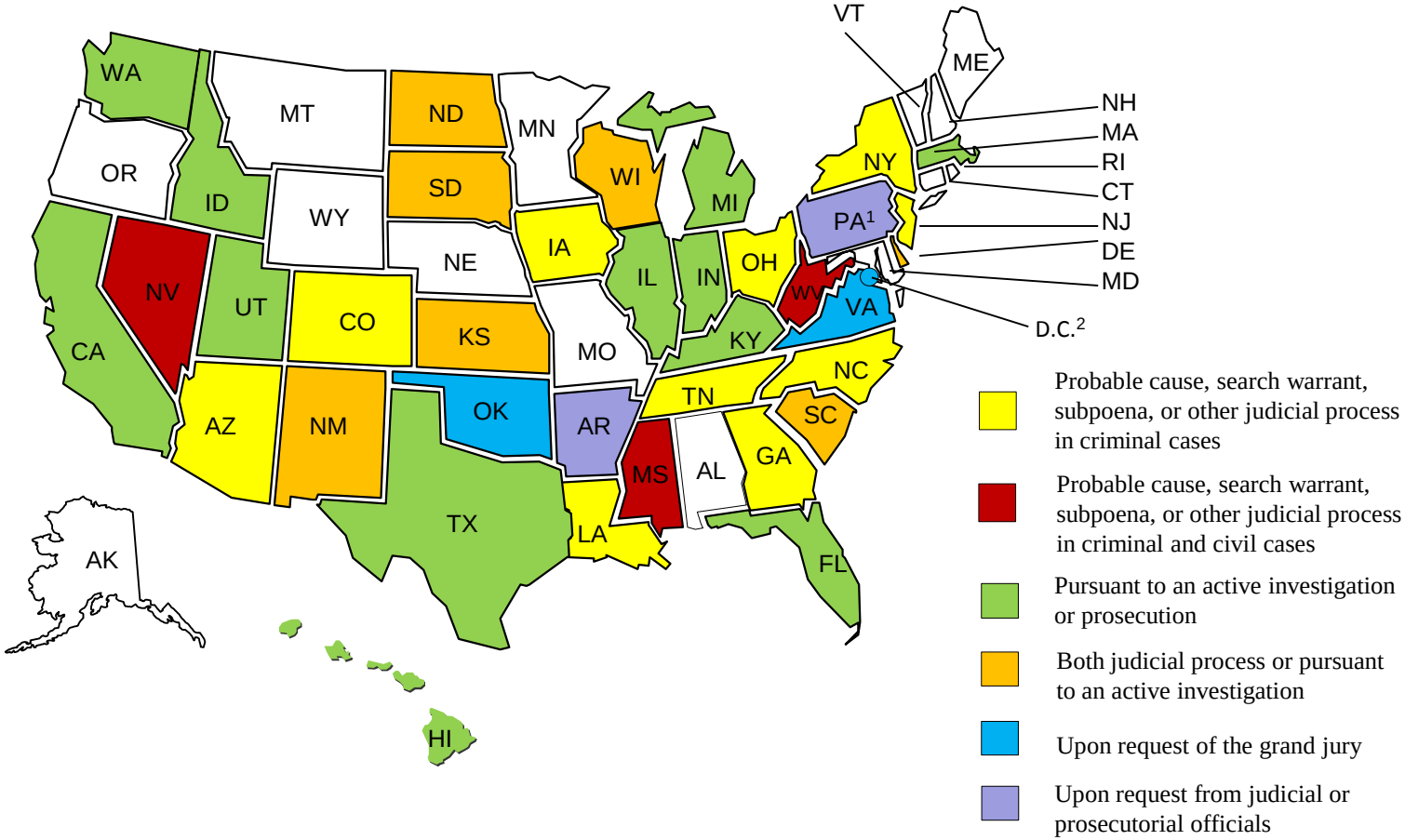
Types of Authorized Recipients – Judicial and Prosecutorial Officials



[1] The Pennsylvania provision pertains only to cases involving criminal investigations into violations of state or federal drug laws, health care fraud, or insurance fraud statutes.

[2] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

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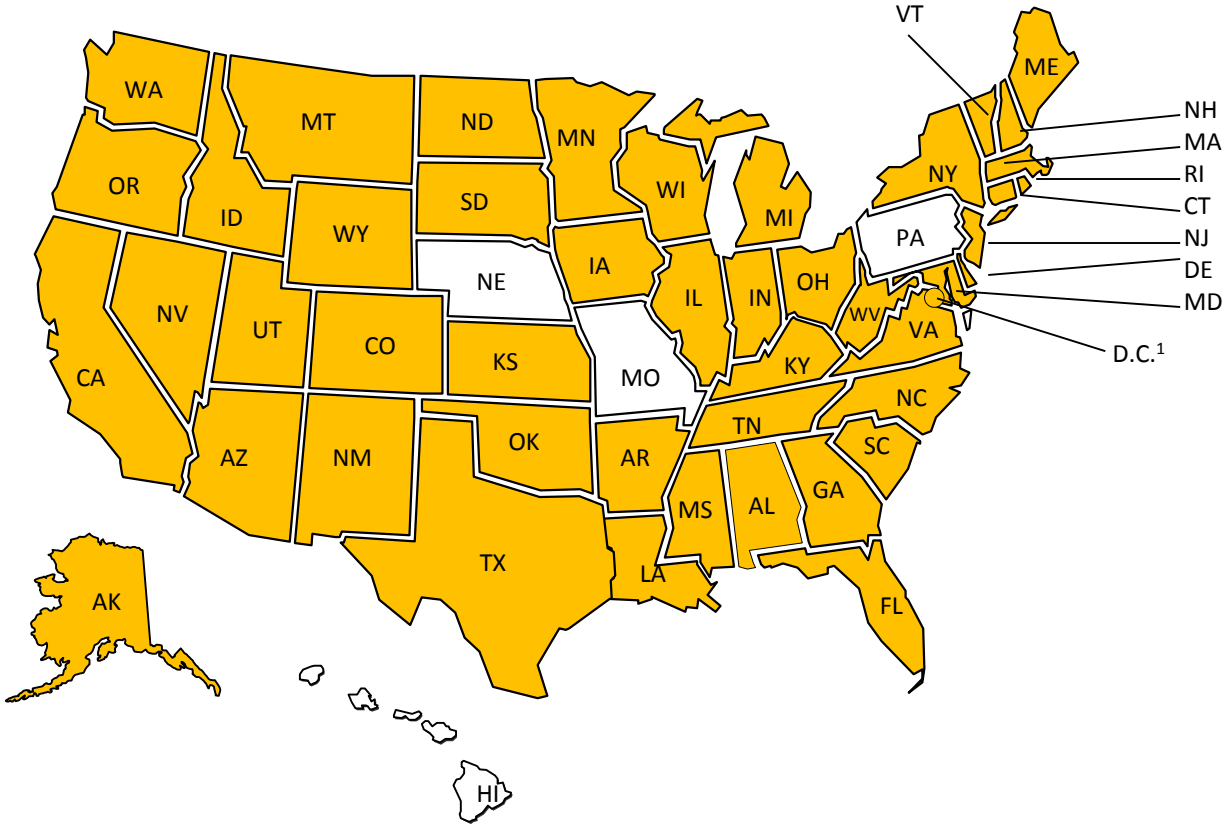
Types of Authorized Recipients - Licensing/Regulatory Boards



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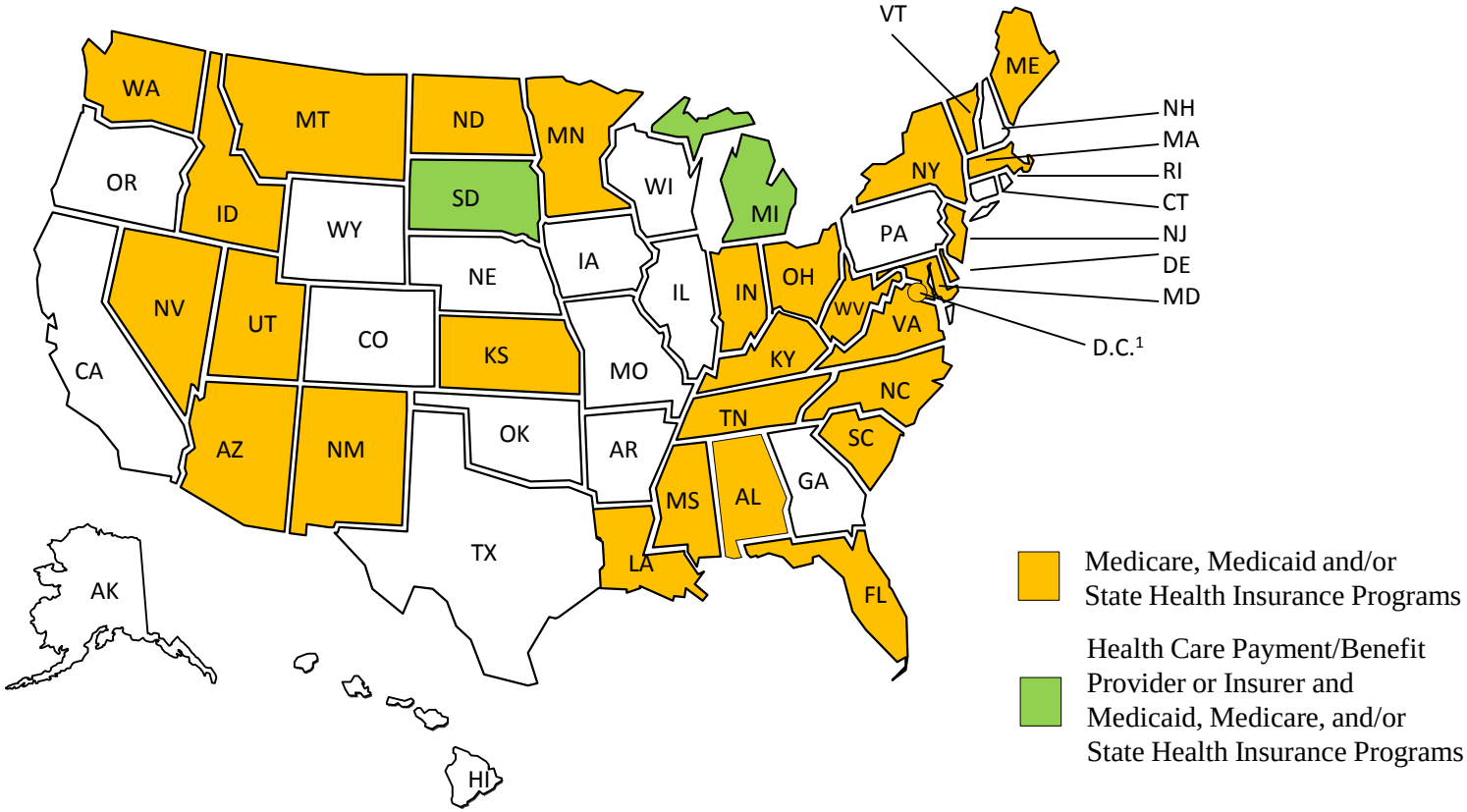
Types of Authorized Recipients – Medicare, Medicaid and/or State Health Insurance Programs or Health Care Payment/Benefit Provider or Insurer



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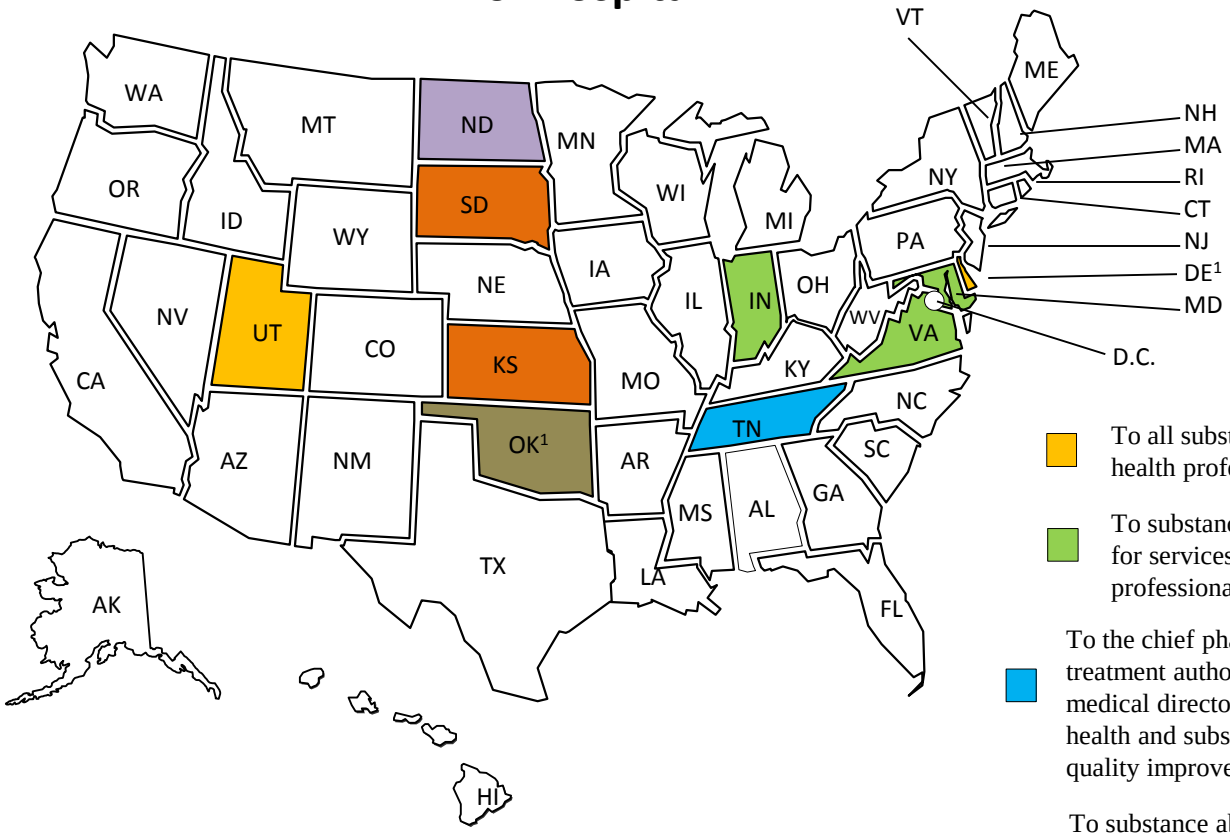
Types of Authorized Recipients - Mental Health/Substance Abuse Professionals, Peer Review Committees or Quality Improvement Committee of Hospital



To all substance abuse or mental health professionals

To substance abuse professionals for services to licensed health care professionals

To the chief pharmacist, the state opioid treatment authority or its designee, and the medical director of the department of mental health and substance abuse services and the quality improvement committee of hospital

To substance abuse and mental health professionals licensed in ND and in a state licensed program and peer review committees

To peer review committees only

To the Department of Mental Health and Substance Abuse Services

[1] The Delaware provision goes into effect on March 1, 2014.

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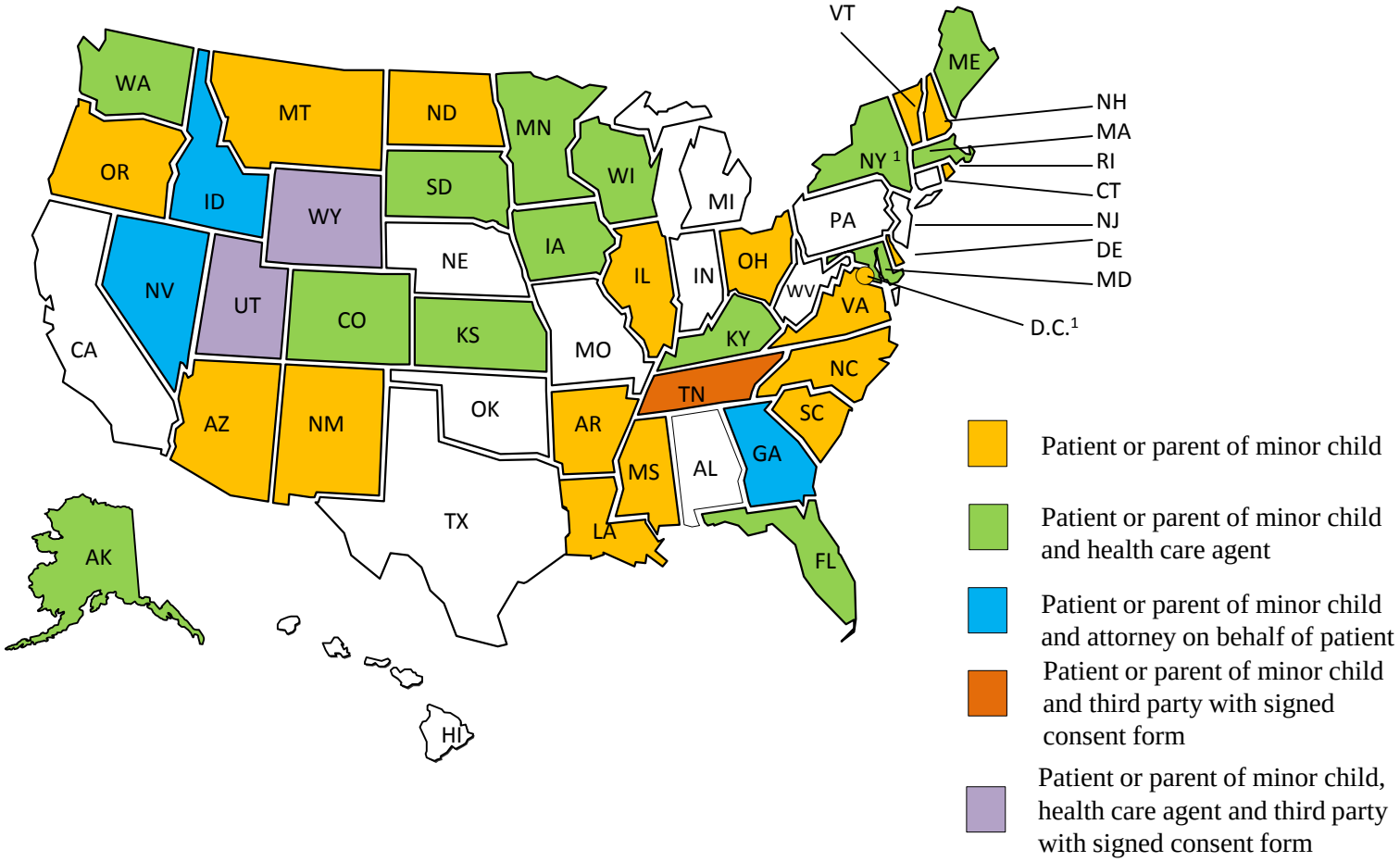
Types of Authorized Recipients – Patient, Parent or Guardian of Minor Child, Health Care Agent or Attorney on Behalf of Patient



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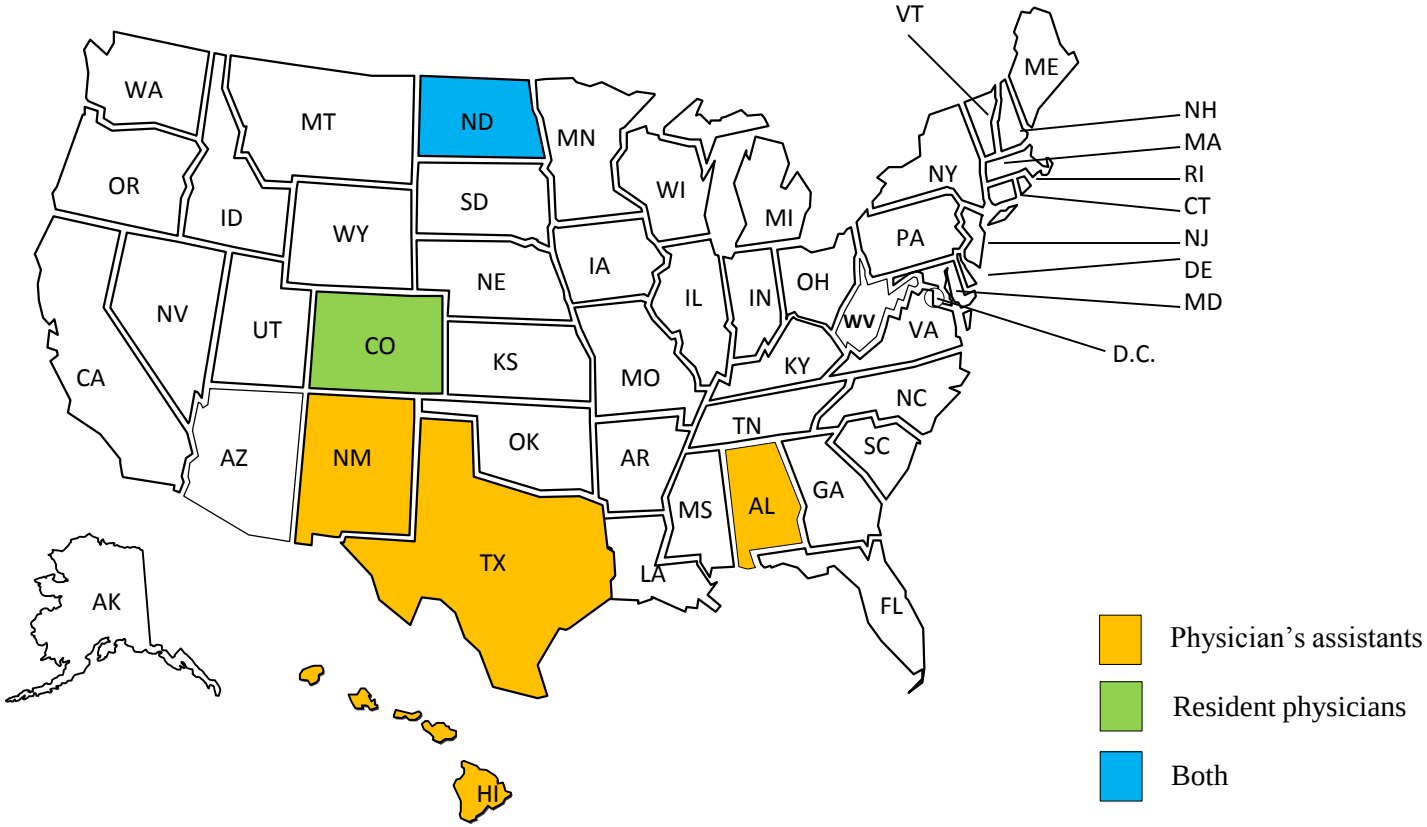
Types of Authorized Recipients – Physician's Assistants and Resident Physicians



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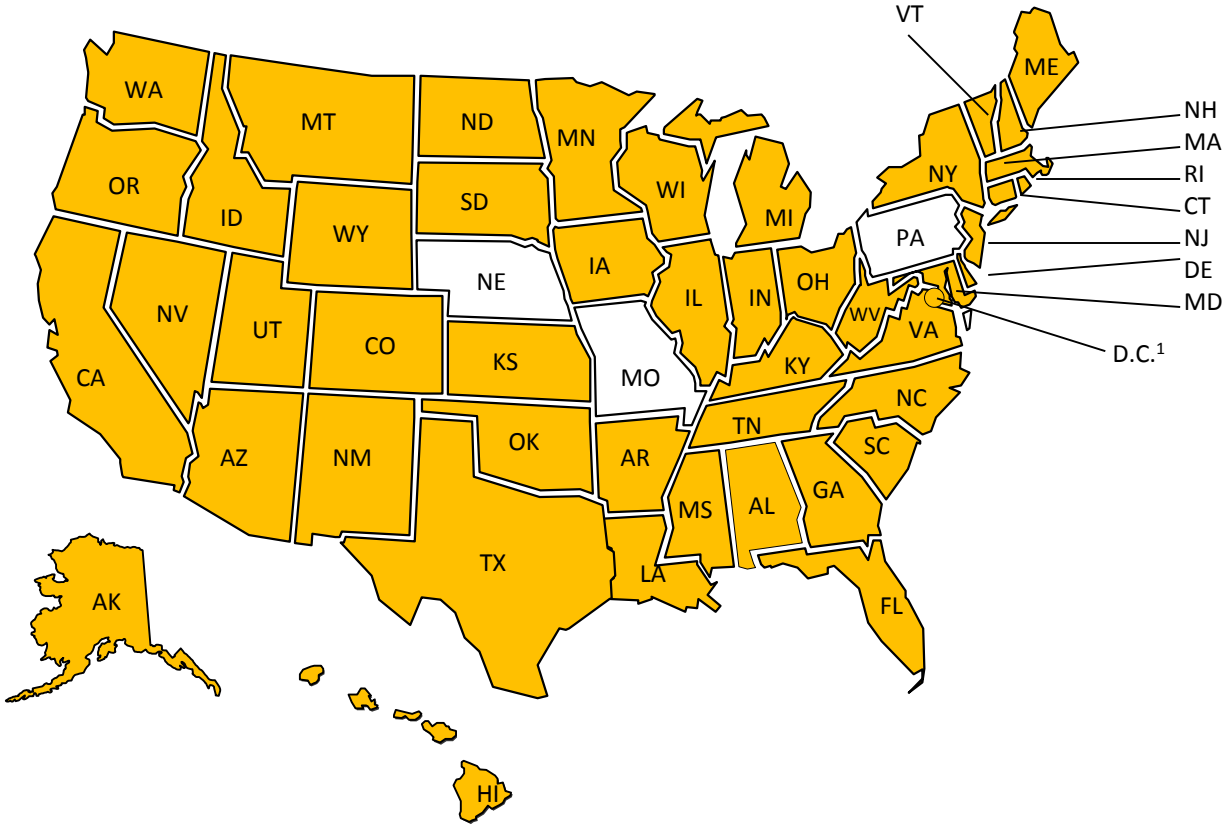
Types of Authorized Recipients - Prescribers and Dispensers



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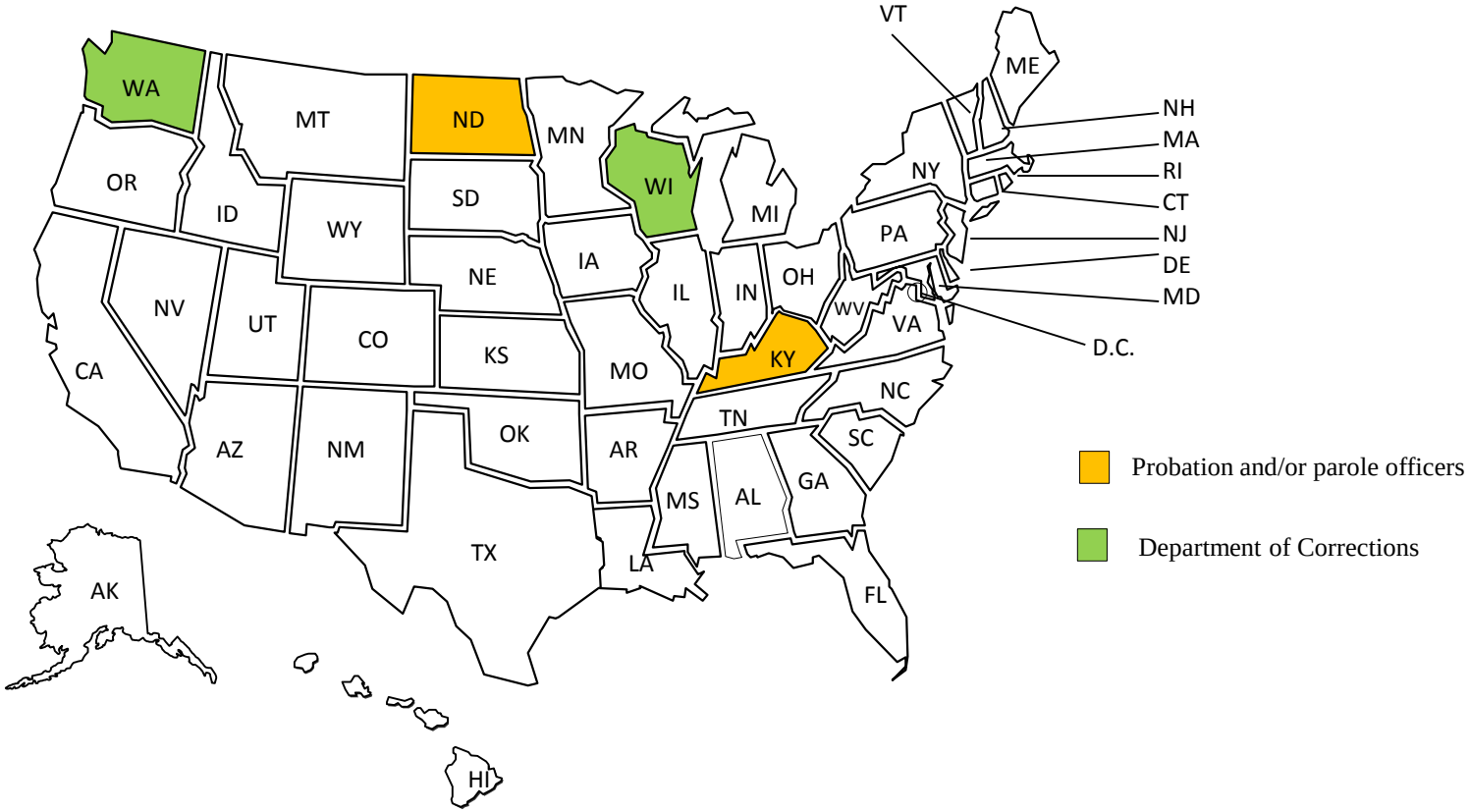
Types of Authorized Recipients – Probation/Parole Officers or the Department of Corrections



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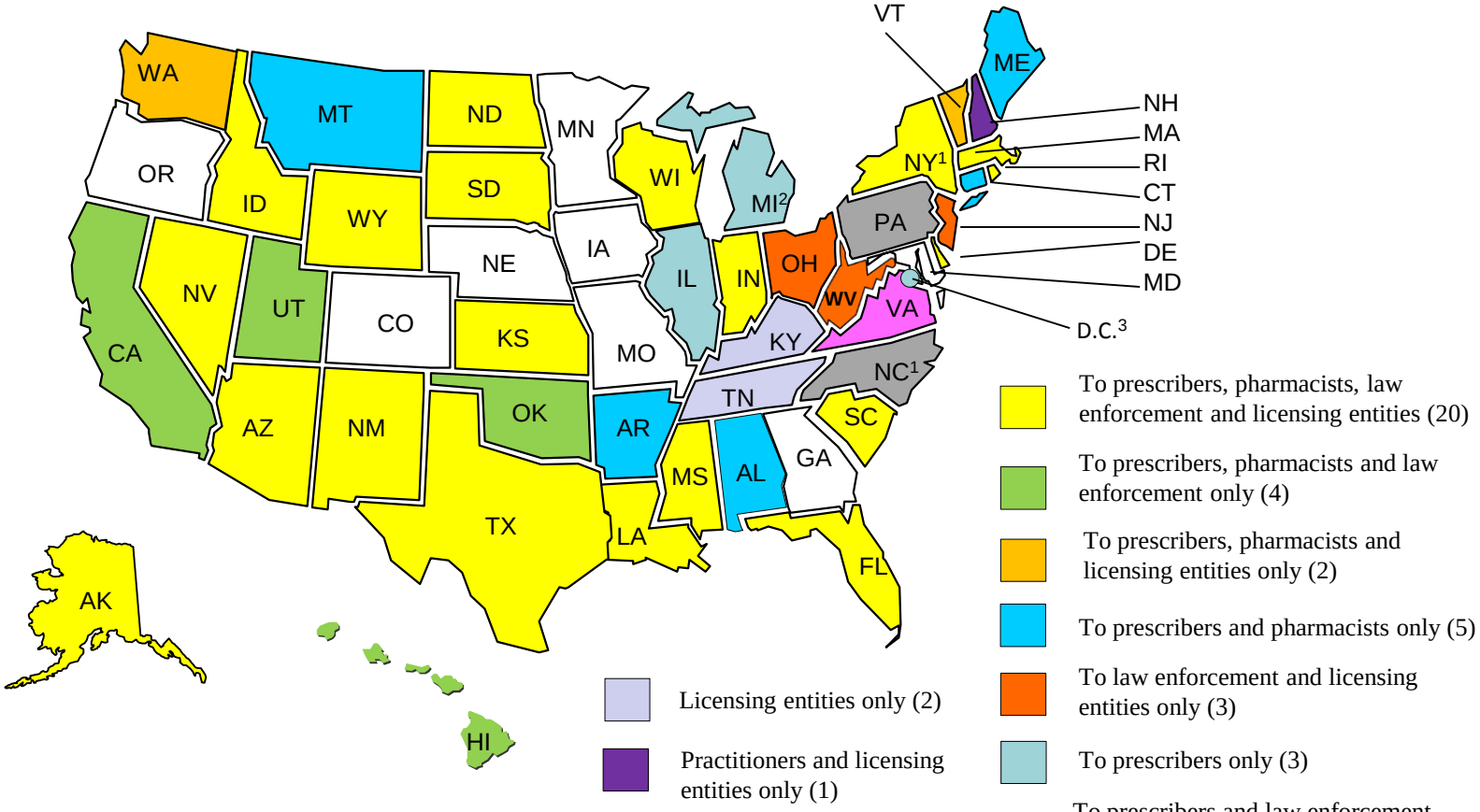
Unsolicited PMP Reports/Info to Prescribers, Pharmacists, Law Enforcement and Licensing Entities



[1] North Carolina provides unsolicited reports to the Attorney General who has the discretion to forward the information to law enforcement.

[2] Michigan send alerts to physicians when a patient surpasses the threshold but does not send the actual report.

[3] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

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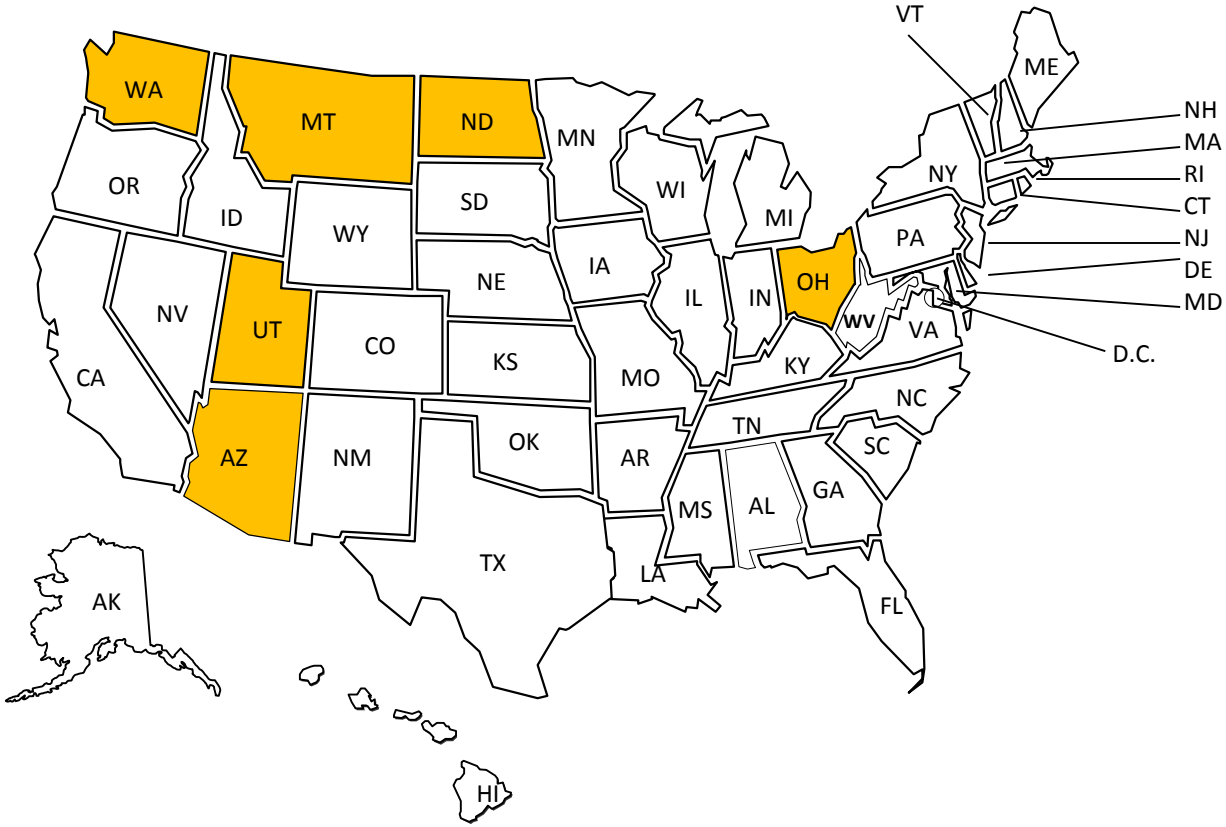
Types of Authorized Recipients - Worker's Compensation Specialists



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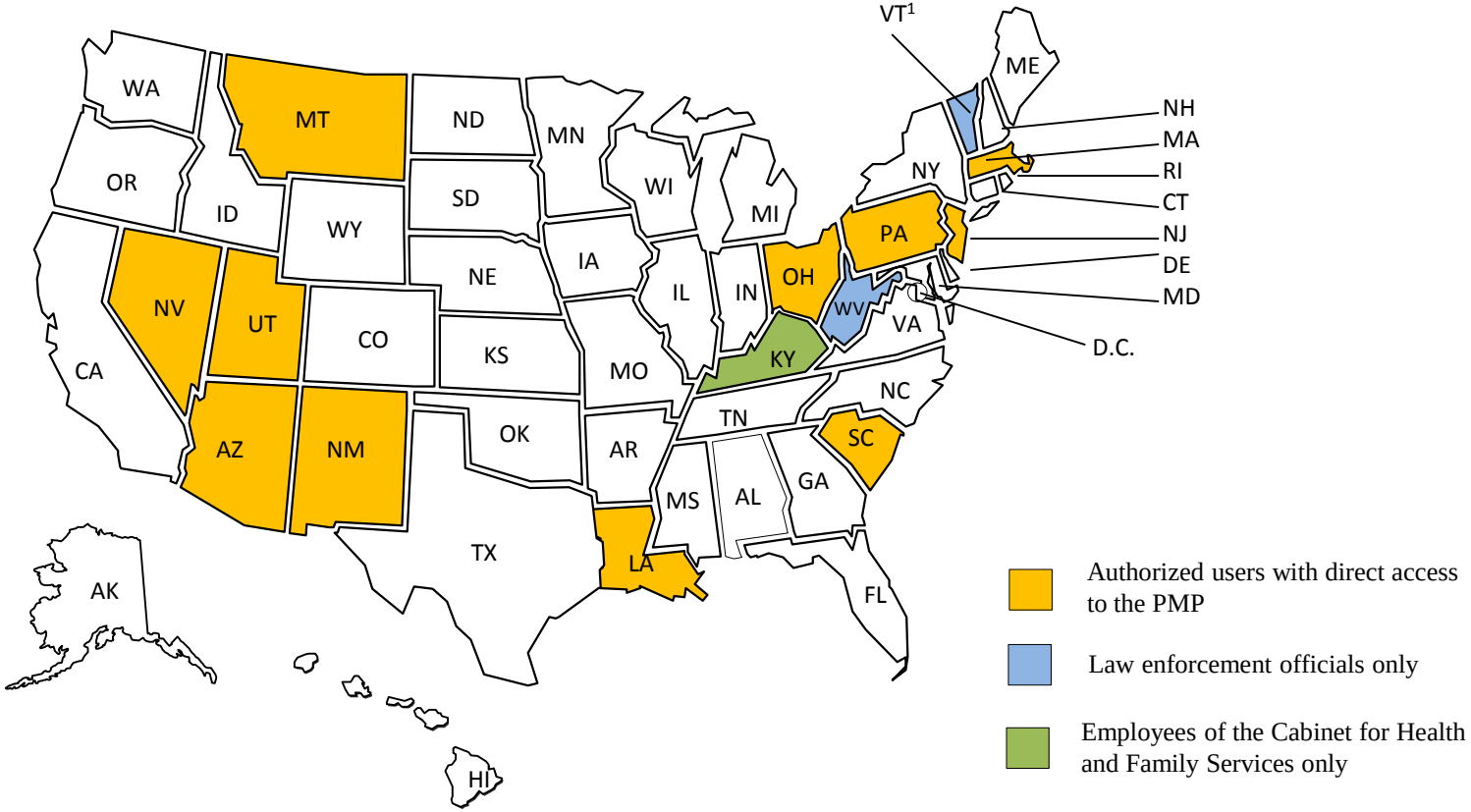
States that Require Authorized Users to Undergo Training for Use of PMP



[1] Law enforcement officials in Vermont do not have access to the PMP, but must undergo training before being allowed access to PMP data provided to them by licensing boards.

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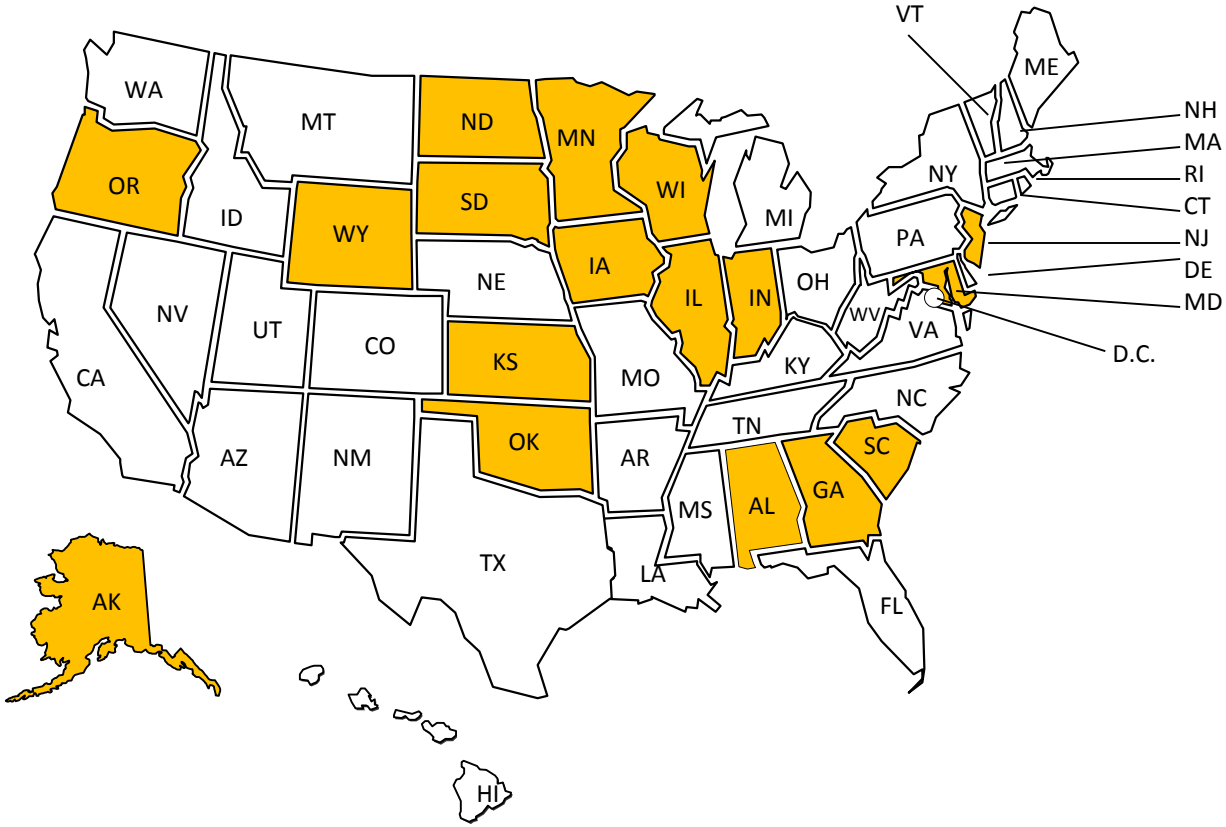
State PMP Laws that Explicitly Do Not Require Prescribers or Dispensers to Access PMP Information



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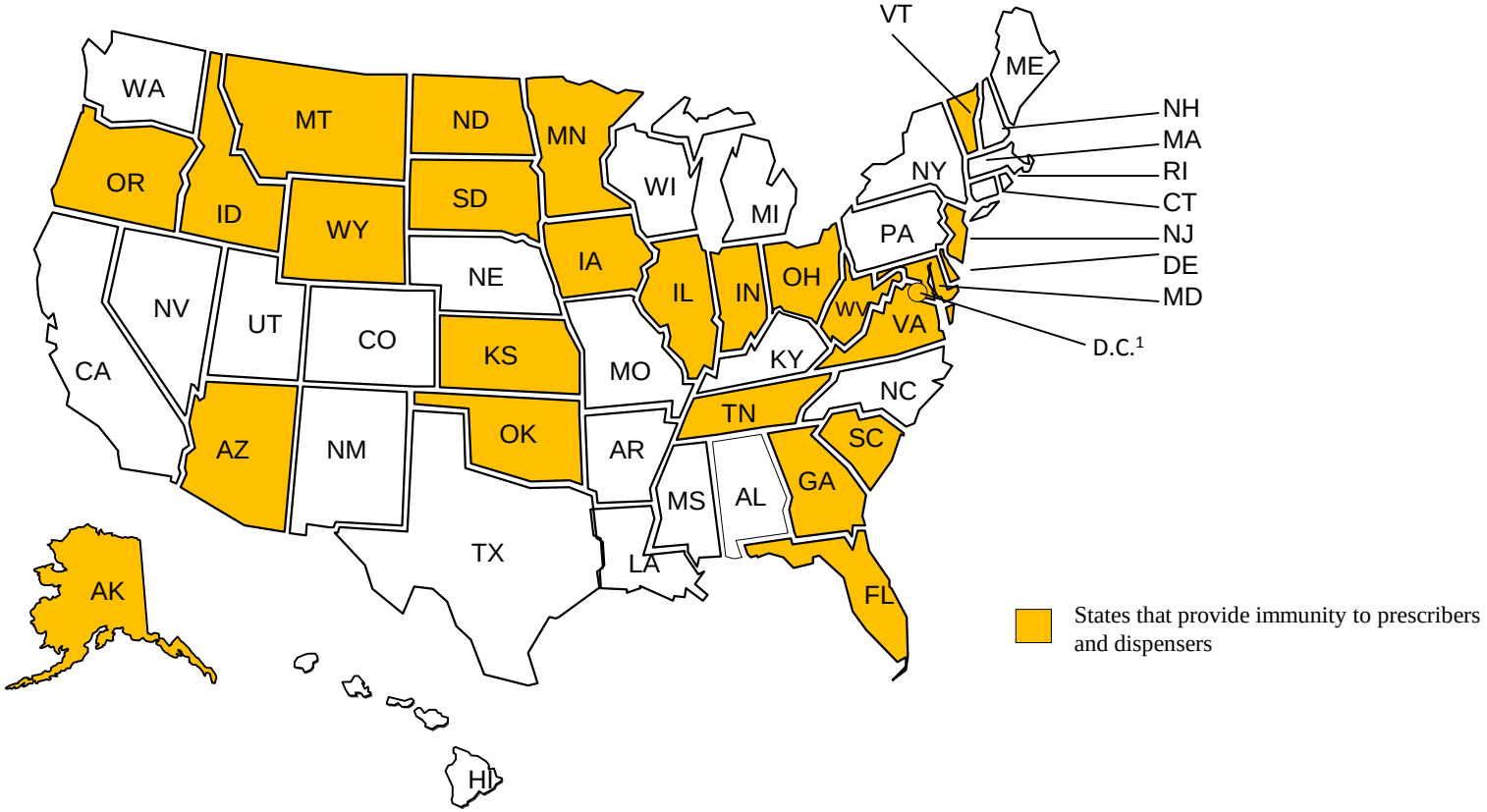
States that Specifically Provide Immunity to Prescribers and Dispensers



[1] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

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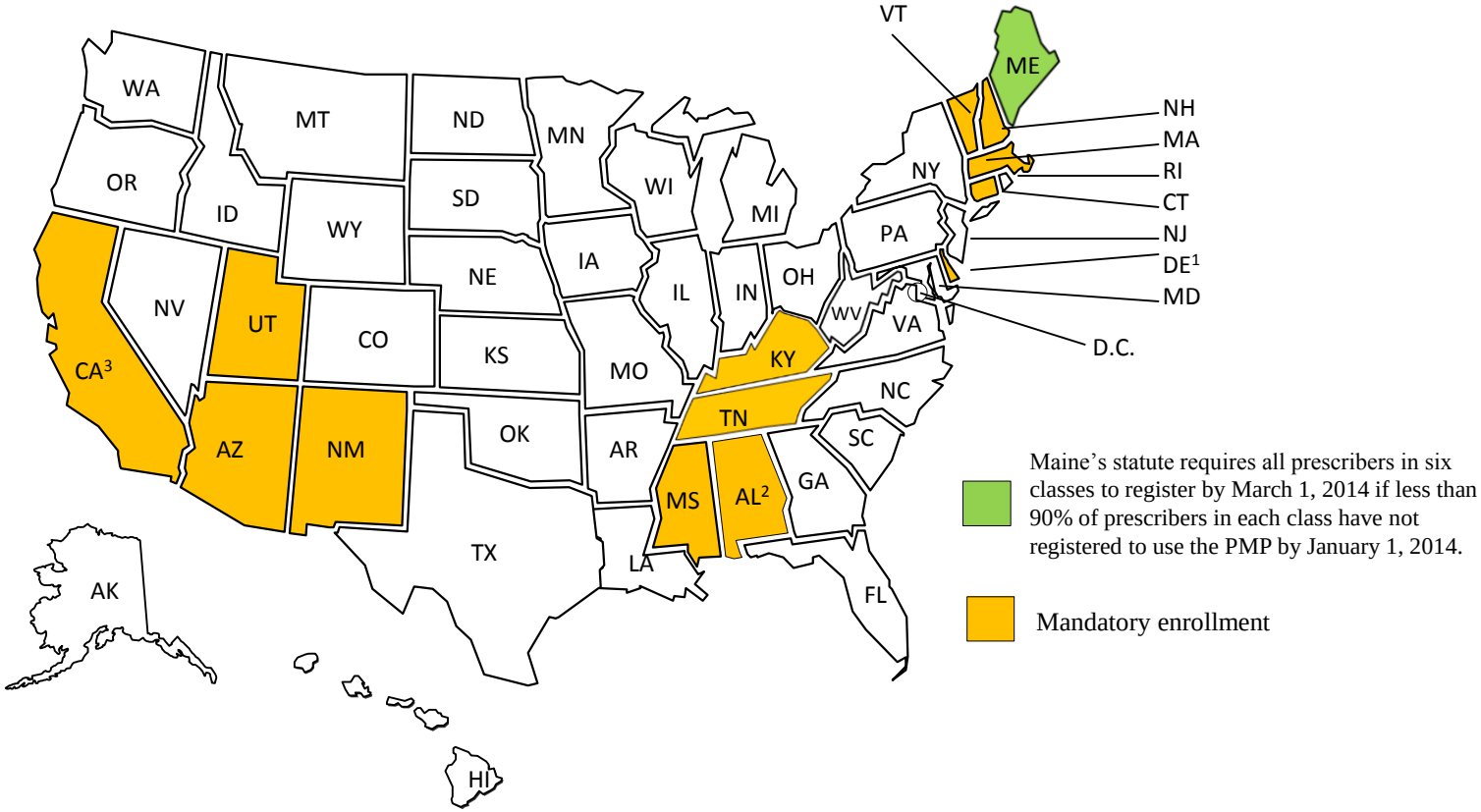
States that Require All Licensed Prescribers and/or Dispensers to Register with PMP Database*



* Many states require that persons requesting access to the state PMP database first register as an authorized user. This map and the memorandum located on the NAMSDL website are concerned with only those states that require all practitioners licensed in the state to also register to use the PMP database.

[1] The Delaware provision goes into effect on March 1, 2014, but all dispensers and prescribers must be registered with the program by January 1, 2014.

[2] Alabama only requires physicians with or seeking a pain management registration to be registered with the PMP.

[3] California requires all practitioners and pharmacists to register before January 1, 2016.

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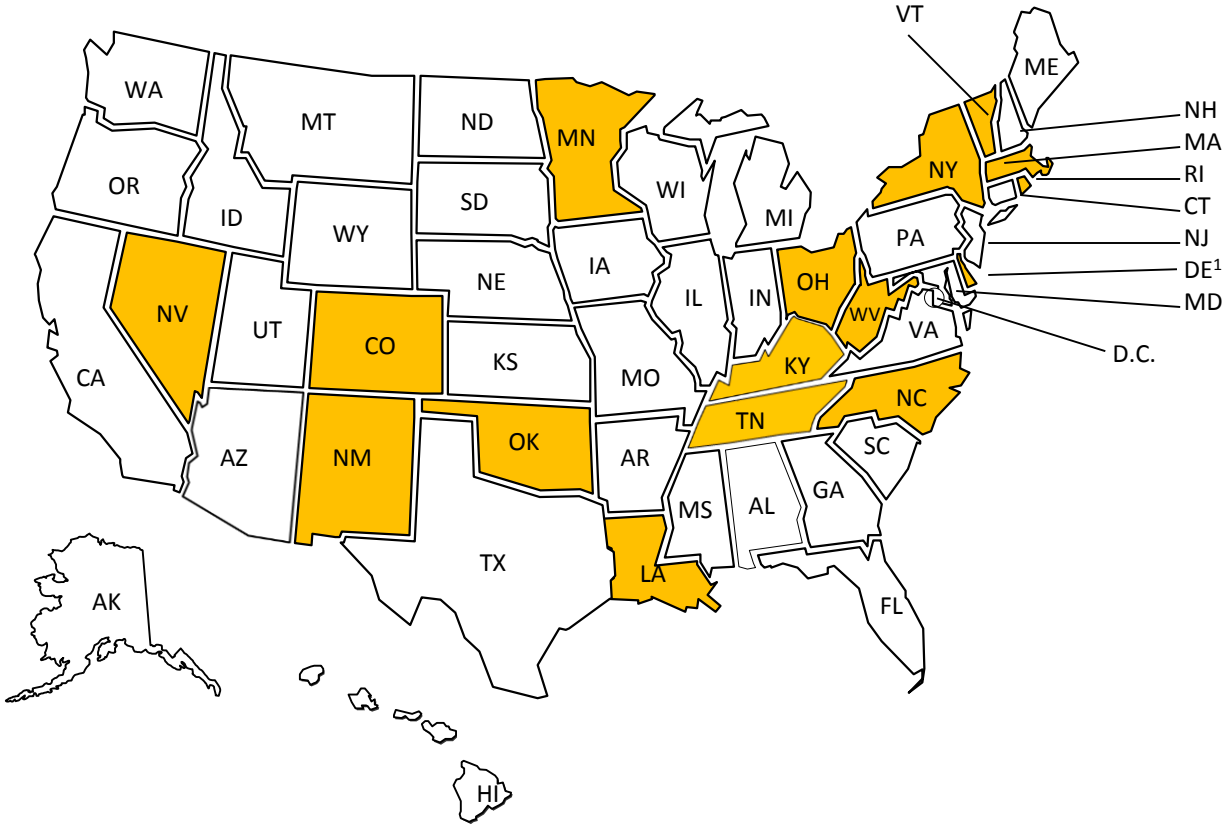
States that Require Prescribers and/or Dispensers to Access PMP Information in Certain Circumstances*



* Please see the accompanying memorandum for specifics as to the circumstances under which a prescriber and/or dispenser is obligated to access the PMP database in each state.

[1] The Delaware requirement that dispensers check the database goes into effect on March 1, 2014.

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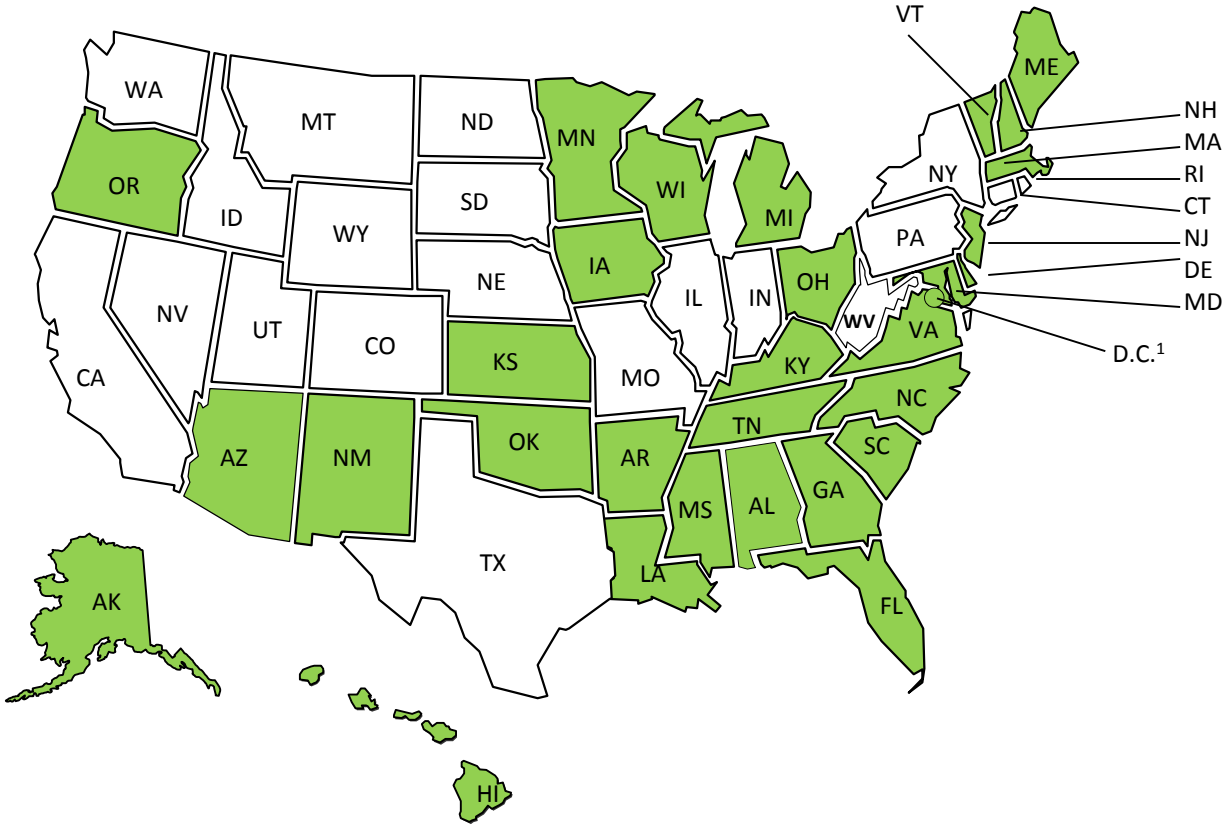
Data Confidentiality – Not Subject to Public or Open Records Laws



[1] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

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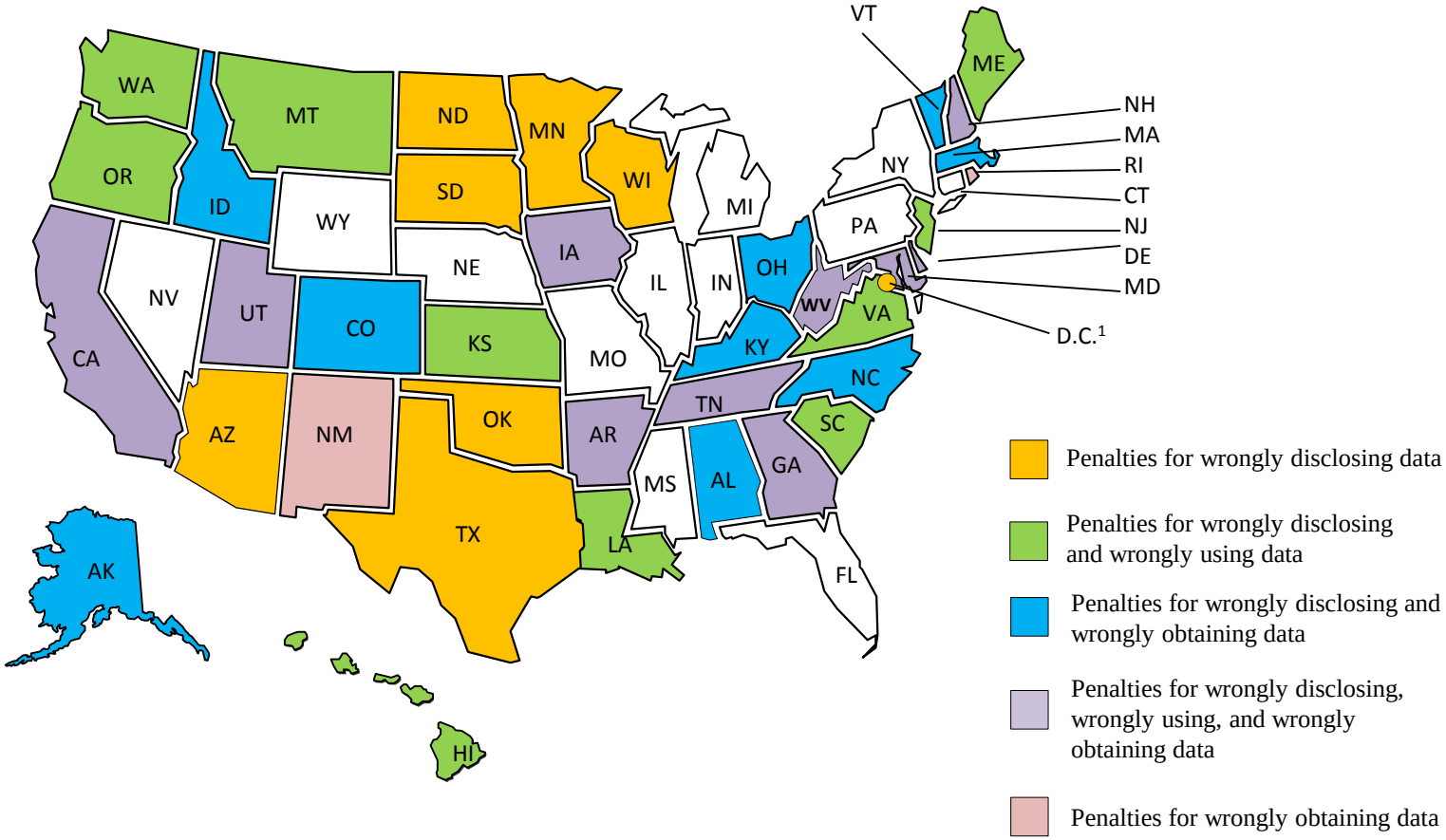
Data Confidentiality – Penalties for Wrongly Disclosing, Using or Obtaining Data



[1] The Mayor of D.C. has approved the legislation enacting a PMP, but it is pending a 30-day review by Congress.

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Attachment 2

California State Board of Pharmacy

CURES prescription drug monitoring program

Data from 7/1/2013 to 6/30/2014

Products Dispensed FY 2013/14	Number of Prescriptions Filled	Total Quantity Dispensed	Average Quantity of Pills Per Prescription	Pills Per California ADULT age 18+ **prescription
Oxycodone & Combinations	3,170,474	278,252,758	87.7	9.5
Hydrocodone & Combinations	15,384,374	1,008,859,313	65.6	35
Alprazolam & Combinations	3,683,580	205,865,005	55.9	7
Codeine & Hydrocodone Cough Syrups and Combinations *	680,139mL	136,830,801mL	201.18mL	4.7mL
Phentermine	780,504	37,136,265	47.6	1.3

* The majority of these cough syrups are Schedule V and are not required to be reported to CURES; however, many pharmacies know the potential for abuse so they do report them to CURES. Data for this category is therefore, incomplete.

** Based on 2013 US Census Data from the Anne E Casey Foundation website on 7/9/2014 for Californians over 18 years of age – 29,157,644.

California State Board of Pharmacy
Data Captured from Controlled Substance Drug Loss Reports

Year	2009	2010	2011	2012	2013	2014 1/1/14-6/30/14
Number of Reports	614	749	536	639	1224	678
Loss Type	**Total Count Reported**					
Armed Robbery			70,786	35,773	106,787	80,464
Customer Theft			9,550	4,598	5,684	13,175
Employee Pilferage			252,225	452,877	372,926	125,305
Lost in Transit			13,239	412,168	*1,657,875	22,310
Night Break In			505,016	80,971	689,925	154,156
Other			121,635	532,441	518,432	94,267
Totals			972,450	1,518,828	3,351,628	489,677

* High transit losses.

DEA 106 Reports by License Category

Category	**2011**	**2012**	**2013**	**2014***
Pharmacy	376	460	943	551
Hospital	115	104	230	97
Wholesaler	33	35	58	35
Out of State Distributor	1	6	8	4
Correctional Facility	10	5	2	5
Clinic	1	2	0	0
Non Resident Pharmacy	0	1	0	0
Drug Room	0	0	1	0
Other	0	0	2	1
Total	536	613	1244	693

* Data thru 7/8/2014

0767- Board of Pharmacy
Controlled Substance Utilization Review and Evaluation System (CURES) Budget Information 8.21.14

CURES EXPENDITURES	FY 2013-14	FY 2014-15*
CURES Existing Contract	$ 84,333	$ 92,000
CURES 2.0 Upgrade Contract*	$ 221,000	$ 203,000
Total Expenditures	$ 305,333	$ 295,000

*CURES 2.0 Budget Act Appropriation for $424,000 to be expended or encumbered until June 30, 2015. The amount identified in FY 2014-15 is a carryover of funds that was unspent in FY 2013-14.

CURES FEES	FY 2013-14	FY 2014-15*
CURES Contribution $6 (Annual Renewals)	$ 22,064	$ 51,462
CURES Contribution $12 (Biennial Renewals)	$ 37,404	$ 246,384
Total Revenue	$ 59,468	$ 297,846

*Projected

Due to a trailer bill to the 2013/14 California State Budget, the board is funding for two years (2013/14 and 2014/15) an additional $215,000 (in addition to ongoing annual funding of $92,000 that we have been providing for approximately 10 years) that will be used to replace the aging CURES computer and replace it with a more robust system, capable of providing better access to the state's prescribers and dispensers who are checking the controlled substances dispensed to specific patients as part of the prescription drug monitoring program (PDMP). The dispenser boards are also contributing sizeable amounts to secure a new computer system.

Attachment 3

NCPDP Recommendations for Improving Prescription Drug Monitoring Programs (PDMP)

VERSION 1.Ø

This paper offers guidance to the pharmacy industry

March 2Ø13

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NCPDP Recommendations for Improving Prescription Drug Monitoring Programs (PDMP)

Version 1.Ø

NCPDP recognizes the confidentiality of certain information exchanged electronically through the use of its standards. Users should be familiar with the federal, state, and local laws, regulations and codes requiring confidentiality of this information and should utilize the standards accordingly.

NOTICE: In addition, this NCPDP Standard contains certain data fields and elements that may be completed by users with the proprietary information of third parties. The use and distribution of third parties' proprietary information without such third parties' consent, or the execution of a license or other agreement with such third party, could subject the user to numerous legal claims. **All users are encouraged to contact such third parties to determine whether such information is proprietary and if necessary, to consult with legal counsel to make arrangements for the use and distribution of such proprietary information**.

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1. PURPOSE AND SCOPE

A focus group on Prescription Drug Monitoring Programs (PDMPs) was held in Baltimore, MD on October 18, 2012, facilitated by the National Council for Prescription Drug Programs. Goals and Objectives of the focus group were to identify the current and future issues and needs regarding the exchange of information for PDMPs. Identifying the specific industry challenges and the goals of the PDMPs, providers, prescribers, and regulatory agencies, will allow NCPDP to propose efficient solutions leveraging existing standards and methodologies as well as develop applicable enhancements that would be standardized across the industry.

The focus group included attendees from pharmacies, Pharmacy Benefit Managers (PBMs), intermediaries, prescriber vendors, ePrescribing vendors, software vendors, drug compendia, consultants, state agencies, Federal Drug Administration (FDA), Drug Enforcement Administration (DEA), United States Department of Health and Human Services (HHS), the MITRE group, and NCPDP.

At the request of the PDMP focus group, during the November 2012 NCPDP Maintenance and Control Work Group meeting, the PDMP Task Group was formed, with the initial task of developing this White Paper to: (1) examine the problems; (2) identify future needs; and (3) recommend solutions for PDMP reporting as well as the role of NCPDP. The goals are (1) to complete the white paper and send it to the Office of the National Coordinator (ONC) by March 2013 to coincide with the MITRE contract timeline, and (2) make the white paper available to the industry.

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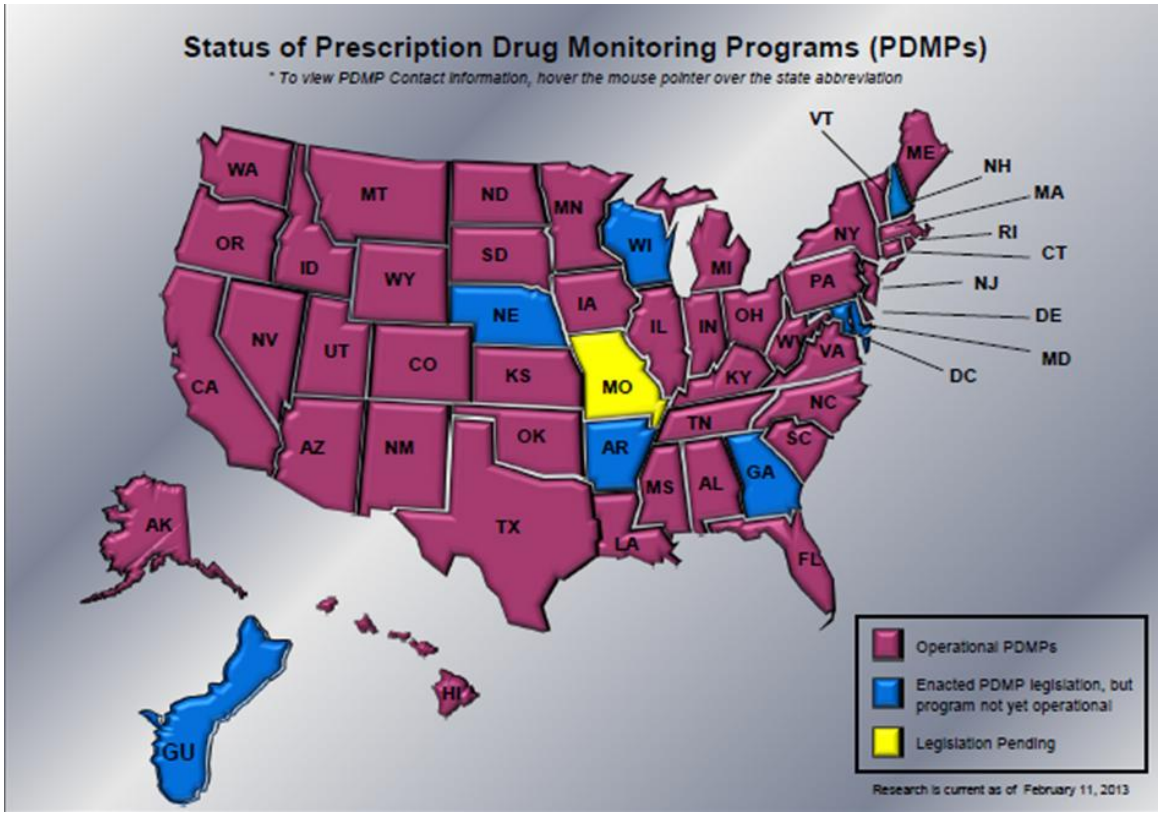
2. BACKGROUND

A PDMP is an electronic database that collects designated data on controlled substances dispensed or prescribed within a given state. The data collected usually includes the names and/or demographic information for the patient, prescriber, and dispenser; the name and dosage of the drug; the quantity supplied; the number of authorized refills; and the method of payment.

As of February 2013, 49 states, the District of Columbia, and one U.S. Territory have enacted legislation that establishes a PDMP. Of those, 43 states have operational PDMPs while 6 other states, the District of Columbia, and Guam have PDMPs that are not yet operational. Illustration 1 below displays the status of the PDMPs across the United States. [1]

Illustration 1
Status of Prescription Drug Monitoring Programs



PDMPs are established and managed at the state level and can vary considerably from state-to-state. Some areas of variation include:

[1] PDMP Training & Technical Assistance Center, Brandeis University. Available at http://www.pdmpassist.org/pdf/pmpprogramstatus2013.pdf

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- **Organizational structure.** Each state determines which agency houses the PDMP and how it is operated.

- **Substances monitored**. PDMPs monitor controlled substance prescriptions and other drugs with potential for abuse. This varies by state.

- **Level of access.** Some PDMPs allow law enforcement to access the database directly; others require law enforcement to obtain a court order or subpoena to access data; and some allow indirect access via a report in response to a request from law enforcement as a part of an active investigation.

- **Solicited and Unsolicited Reporting.** In some states, the PDMP is "reactive" meaning that only solicited reports are generated in response to a query by authorized users such as prescribers, dispensers and other groups with the appropriate authority. PDMPs of other states, in addition to providing solicited reports, are "proactive", generating unsolicited reports when there is reason to suspect that violations on the part of the patients or users have occurred.[2]

- **Purpose and Usage.** The purpose is dependent on user intent and varies by user. Users may be law enforcement, regulatory agencies, state payer programs, researchers and providers.

- **Timeliness of data.** Timeliness of PDMP reporting varies by state—anywhere from monthly to real-time.

- **Interoperability.** State PDMPs vary widely whether information contained in the database is shared with other states. While some states do not have measures in place allowing interstate sharing of information, others have specific practices for sharing. An effort is ongoing to facilitate information sharing using prescription monitoring information exchange (PMIX) architecture. The infrastructure of the PMIX program is based on the National Information Exchange Model (NIEM), which is a data sharing partnership among all levels of government as well as the private sector.[3] The PMIX Architecture utilizes "end-to-end encryption" so that no protected health information can be stored at the hub. The encrypted data leaves the sending state PDMP system and cannot be decrypted until it reaches the receiving state PDMP system.

- **Reporting Formats.** State PDMPs are currently using different versions of the American Society for Automation in Pharmacy (ASAP) data transmission formats.

- **Multiple Work Groups.** The Office of the National Coordinator for Health Information Technology (ONC) has various work groups determining best practices for standardizing the use of PDMP programs.[4]

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[2] Simeone R, Holland L. Simeone Associates, Inc. (2006, September 1). An evaluation of prescription drug monitoring programs. Retrieved September 7, 2009, from National Alliance for Model State Drug Laws Official Site website: http://www.simeoneassociates.com/simeone3.pdf

[3] Alliance of States with Prescription Monitoring Programs, *Prescription Monitoring Information Exchange (PMIX),* is available at http://pmpalliance.org/

[4] United States Department of Health and Human Services (HHS), *More doctors adopting EHRs to improve patient care and safety,* available at http://www.hhs.gov/news/press/2012pres/12/20121212b.html

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3. GLOSSARY

ASAP

American Society for Automation in Pharmacy (ASAP) has various versions of different layouts for PDMP reporting.

Authorized Healthcare Professionals

Healthcare professionals involved in patient treatment who may or may not have prescribing or dispensing authority, need access to PDMP data, and have the ability to appoint delegates. These licensed healthcare professionals could include practitioners who work in fields such as medication therapy management, disease management, behavioral health that involves utilization management review and case management, and practitioners such as substance abuse clinicians and psychologists.

Clinical Data

Concepts or terms applying to the clinical delivery of care.

Clinical Decisions

Judgmental process clinicians use to make logical, rational decisions to decide whether an action is right or wrong. *Clinical Decision Support (CDS) is defined as "providing clinicians or patients with clinical knowledge and patient-related information, intelligently filtered or presented at appropriate times, to enhance patient care."*[5]

DEA Number

A number assigned to a health care provider by the U.S. Drug Enforcement Administration (DEA) allowing them to write prescriptions for controlled substances. Legally, the DEA number is solely to be used for tracking controlled substances. It is used by the industry, however, as a general "prescriber number" that is a unique identifier for anyone who can prescribe medication.

Dispenser

Pharmacy or physician authorized to dispense controlled substances

FTP

File Transfer Protocol; commonly used protocol for exchanging files over any network.

Manual Claim Form

Various forms used by the provider of service to submit a claim to the patient's payer or insurer or the state.

NABP

National Association of Boards of Pharmacy

NCPDP

National Council for Prescription Drug Programs

NDC

National Drug Code describes specific drugs by drug manufacturer and package size.

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[5] *Informatics and Clinical Decision Support,* Kathryn A. Walker, PharmD, BCPS Faculty and Disclosures CE Released: 03/07/2008; Valid for credit through 03/07/2009 accessed February 1 4, 2013 *http://www.medscape.org/viewarticle/571099*

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NPI

National Provider Identifier is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services.

ONC

Office of the National Coordinator for Health Information Technology

PDMP

A PDMP is a ***statewide*** electronic database which collects designated data on substances dispensed in the state. The PDMP is housed by a specified statewide regulatory, administrative or law enforcement agency. The housing agency distributes data from the database to individuals who are authorized under state law to receive the information for purposes of their profession.[6]

Prescriber

A practitioner authorized by state and federal agencies to prescribe controlled substances.

SCRIPT Standard

The NCPDP SCRIPT Standard is used for transmitting prescription information electronically between prescribers, providers, and other entities. The standard addresses the electronic transmission of new prescriptions, changes of prescriptions, prescription refill requests, prescription fill status notifications, cancellation notifications, relaying of medication history, transactions for long-term care, and other transaction functions. The SCRIPT Standard is named in the Medicare Modernization Act.

SFTP

Secure File Transfer Protocol (also referred to as SSH File Transfer Protocol); provides file transfer and manipulation functionality over any reliable data stream.

SSL

Secure Sockets Layer; cryptographic protocol that provides secure communications for data transfers.

Telecommunication Standard

The NCPDP Telecommunication Standard is used for the electronic submission of eligibility verification, claim and service billing, predetermination of benefits, prior authorization, information reporting, and controlled substance (general and regulated) transaction exchanges. The Telecommunication Standard is named in HIPAA and the Medicare Modernization Act.

[6] Source, U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control accessed February 27, 2013 website: *http://www.deadiversion.usdoj.gov/faq/rx_monitor.htm*. Accredited to the National Alliance for Model State Drug Laws (NAMSDL) website: *http://www.namsdl.org/home.htm*

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4. THE PROBLEM

According to the Office of National Drug Control Policy, prescription drug abuse is the nation's fastest-growing drug problem, and prescription drug overdose deaths have been classified as epidemic by the Centers for Disease Control and Prevention. An integrated workflow solution to provide a streamlined, standard communication process would enhance the ability of the health care provider to address the epidemic and mitigate patient care risks. The current prescription monitoring communication process is outside the workflow process and systemically burdensome. It does not effectively provide information in a timely manner or evaluations across all state lines and across all pharmacies.

From a pharmacist's and prescriber's perspective, workflow integration and the adoption of national standards is critical to allow the provider to identify potential drug abuse, diversion, and evaluate patient safety risk and to make appropriate clinical decisions before a prescription is written or dispensed.

In addition to a pharmacist's and prescriber's perspective, there are other entities that impact prescription drug monitoring programs, such as emergency departments, pain clinics, dispensing physicians, and ambulatory surgery centers. These entities may provide information for PDMP reporting and may need access to reporting information.

4.1 PHARMACY PERSPECTIVE

From a pharmacy perspective, today's processes for using PMDPs for preventing prescription abuse and evaluating patient safety risk are not adequate. Barriers include:

- Lack of real-time interoperable databases among all the states.
- Lack of a nationally adopted ANSI or other accredited standard for real-time reporting to state PDMP databases.
- Lack of a standard set of data elements and values to make interoperability possible.
- Lack of real-time response for validating accurate data.
- Lack of a real-time response in order to make clinical decisions before the prescription is dispensed. The current process is manual and outside of the pharmacy workflow.

4.1.1 EVALUATION OF PRESCRIPTION DATA

- No standard measurement for evaluating clinical risk among patient and pharmacy history and doctor prescribing data submission and verification.
- Response to data submissions and queries is untimely. As a result, the process of storing the data is inefficient, whereby clinical decisions could be at risk.
- Lack of validation of accurate prescription data elements required for PDMP at the time the prescription is dispensed.
- PDMP alerts are not available within the pharmacy dispensing workflow.

4.1.2 REPORTING/DATA SUBMISSION

- Pharmacy has varying requirements by state for submitting PDMP data. The result is supporting multiple transaction layouts that increase administrative costs,
- If the data submitted is inaccurate or incomplete (i.e. missing patient zip code), the notification and update process is inconsistent amongst the different programs.
- Frequency of data submission varies from state to state:
  - Near real-time-1 state
  - Daily-2 states
  - Weekly-22 states
  - Bi-weekly-11 states
  - Monthly-6 states

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  - Every 6 weeks-1 state
- Data and format requirements vary from state to state. Most states require data formatted in various versions of the American Society for Automation in Pharmacy Standards (ASAP).
- Pharmacy compliance monitoring varies by state.
- Data is not normalized (i.e. address/city/state, one vs. 1)
- Data is delivered using many automated and manual methods (such as):
  - Secure FTP over SSH
  - Encrypted File with OpenPGP via FTP
  - SSL Website
  - Physical Media (Tape, Diskette, CD, DVD)
  - Universal Claim Form submission

4.1.3 ACCESSIBILITY

- Internal security firewalls can prevent access to databases.
- Gaining access to state PDMPs varies widely from state to state.
- Access is unavailable to those participating in the dispensing and clinical processes.
- Pharmacy does not have access to PDMP data within their workflow and must interrupt workflow to access an external database.
- Lack of access to PDMP data across state lines impacts the pharmacy's ability to make accurate clinical decisions.
- Pharmacists providing patient care (clinical services such as Drug Utilization Review and Medication Therapy Management) should have access to PDMP data prior to comprehensive medication reviews.

4.1.4 DATA INTEGRITY

- Gaps in data (e.g. not all Indian Health Services, state specific programs, and other providers and locations that are administering and dispensing medications are included.)
- Missing, incomplete and/or invalid data due to lag in reporting and validation leads to incomplete records.

4.2 PRESCRIBER PERSPECTIVE

From a prescriber perspective, the current process for preventing prescription drug abuse is not adequate for addressing the need for improving patient safety. The ePrescribing process is a method to help data verification reporting accessibility but prescription drug monitoring information needs to fit into the prescriber's ePrescribing workflow. Barriers include:

4.2.1 DATA VERIFICATION

- Access to the PDMP data is a manual process and does not fit into the prescriber's workflow.
- Data varies by state, and is inconsistently organized and/or presented.
- Clinical decisions are not integrated into the prescribing process.
- Individual state record look-up often times-out after several seconds.

4.2.2 REPORTING

- Lack of completeness and filtering of data
- Data duplication
- Lack of timeliness in reporting the data makes it difficult for prescribers to make clinical decisions.

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- Data and Format requirements vary by state making it difficult for prescriber vendors consuming the data.

4.2.3 ACCESSIBILITY

- Medication history is not shared real-time on a national level.
- Prescribers are notified of doctor shopping issues outside of their workflow, i.e. email.
- State specific regulations, i.e. California not allowing prescriber access to medication history.

4.2.4 DATA INTEGRITY

- Gaps in data (e.g. not all Indian Health Services, state specific programs, and other providers and locations that are administering and dispensing medications are included.)
- Missing, incomplete and/or invalid data due to lag in reporting and validation leads to incomplete records.

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5. IMPROVEMENT RECOMMENDATIONS

By leveraging existing industry standards and processes, several recognized problems are resolved.

5.1 STANDARDIZATION

- Require a minimum set of data elements to be submitted by dispensers systems to the PDMP to be adopted by all states.
- Require one standard transaction format for reporting PDMP, one standard transaction for inquiry and one standard transaction for response.
- Enable accurate reporting of prescriber NPI and DEA numbers.
- Require accurate reporting of all reportable ingredients including compound ingredients.
- Create and adopt a nationally recognized clinical risk score to assist prescribers and dispensers with clinical decisions.

5.2 REAL-TIME REPORTING

- Provide timely access to data as appropriate to all impacted parties for real-time decision making.
- Reduce reporting delays by allowing PDMP type rejections to be corrected at point of adjudication.
- Improve patient quality of care with clinical decision alerts presented at the time of prescription writing or dispensing.
- Enable the exchange of information across states to create a comprehensive picture of prescribing and dispensing patterns.
- Report Date Filled or Date of Service rather than Date Sold (Date delivered or shipped.)
- Eliminate the need for zero reports (no schedules filled).

5.3 CENTRAL DATA REPOSITORY

- Provide PDMPs with more comprehensive multi-state access to data.
- Provide PDMPs with more accurate, timely and consistent data.
- Provide prescribers and pharmacies centralized access to accurate and up-to-date data for clinical and other decision making reasons.
- Provide clinical data to pharmacies and prescribers that are integrated within their workflow.
- Provide data analytics that are more consistent and inclusive.

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6. PROPOSED SOLUTIONS

The task group recommends the following solutions to allow authorized healthcare providers, including prescribers and pharmacists, to make more informed clinical decisions prior to writing and dispensing medications, in an effort to reduce patient prescription drug overdosing and abuse.

1. Adopt a minimum data set and standard transaction format across all states for submission of prescription data to PDMPs.
2. Adopt a minimum data set and standard transaction format across all states for submission of dispensing data to PDMPs.
3. Leverage the NCPDP SCRIPT Standard, including the Medication History transaction, to query PDMP data in real-time within the prescriber's work flow to enable appropriate clinical decisions before the medication is prescribed.
4. Leverage the NCPDP SCRIPT Standard, including the Medication History transaction, to query PDMP data in real-time within the pharmacy's work flow to enable appropriate clinical decisions before the medication is prescribed.
5. Leverage the NCPDP Telecommunication Standard to support real-time reporting within the pharmacy's workflow to PDMP state repositories.
6. Leverage the NCPDP Telecommunication Standard to support clinical alerts to the pharmacy prior to dispensing.
7. Leverage the NCPDP SCRIPT Standard RxFill transaction to report to the prescriber and/or PDMP the date the medication was delivered or shipped to the patient.
8. Enable a nationally recognized process to exchange data between PDMP databases.

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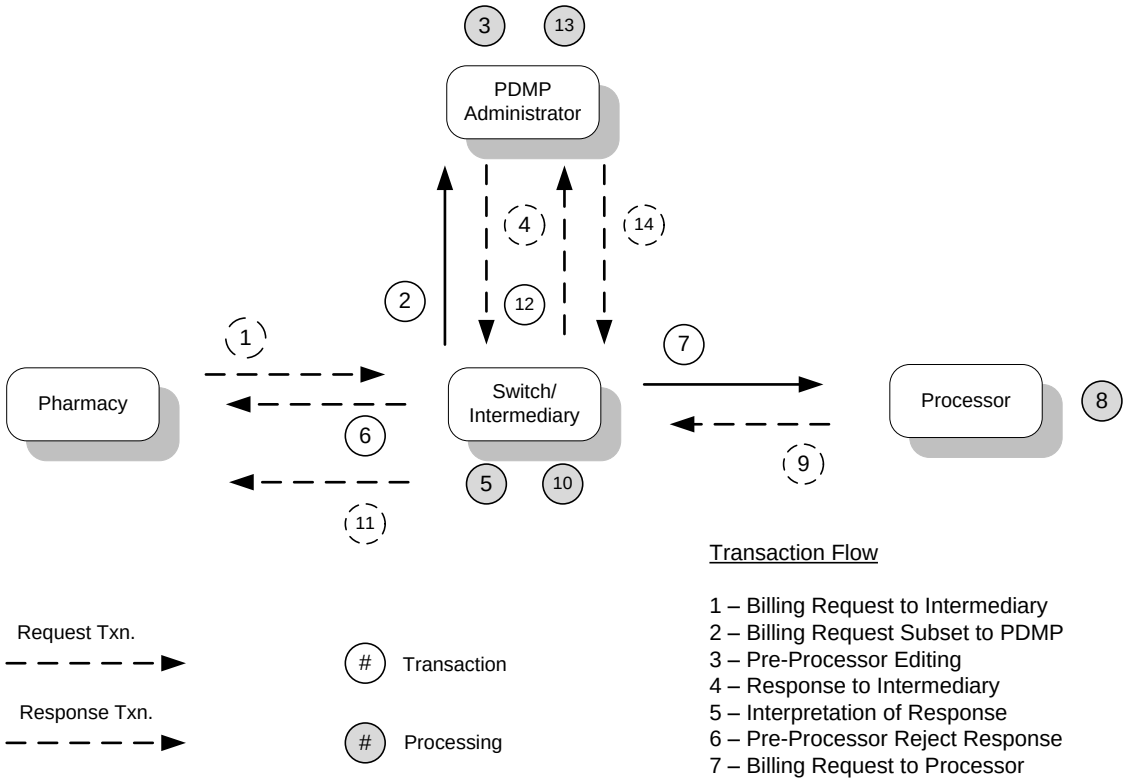
7. FLOW CHARTS

Transaction Flow Sequence
(Pharmacy)



Transaction Flow

1 – Billing Request to Intermediary
2 – Billing Request Subset to PDMP
3 – Pre-Processor Editing
4 – Response to Intermediary
5 – Interpretation of Response
6 – Pre-Processor Reject Response
7 – Billing Request to Processor
8 – Adjudication of Request
9 – Response to Intermediary
10 – Interpretation of Response
11 – Response to Pharmacy
12 – Data Delivery Request to PDMP
13 – Accept Response
14 – Data Delivery Acknowledgement

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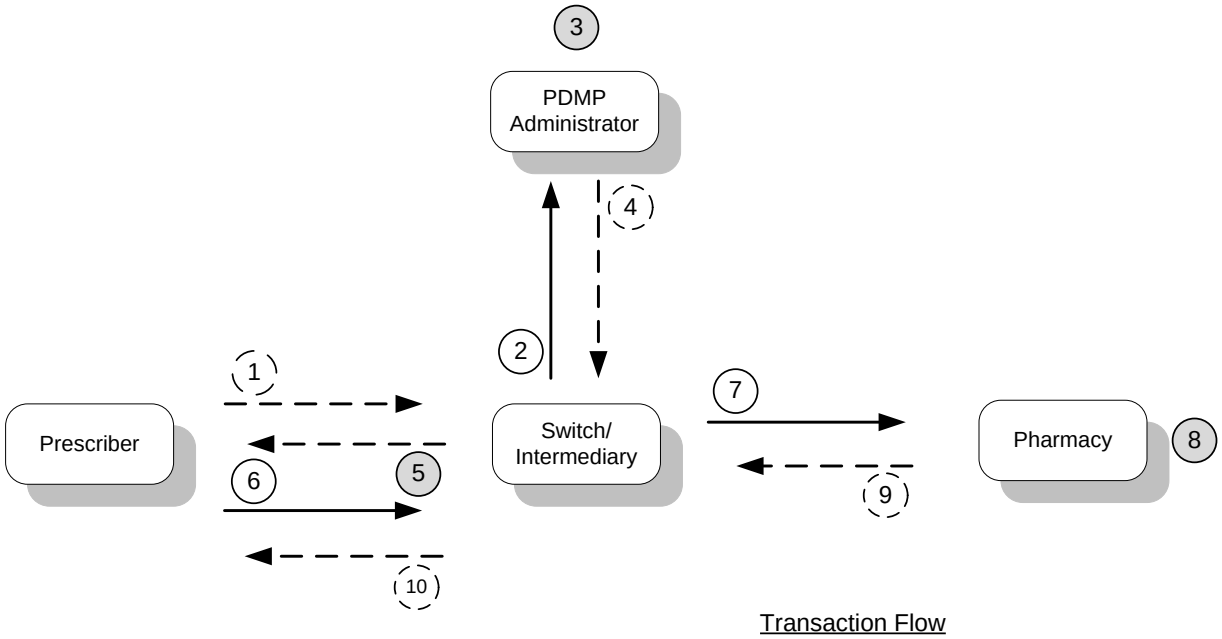
Transaction Flow Sequence
(Prescriber)



Request Txn.

Response Txn.

Transaction

Processing

Transaction Flow

1 – Medication History to Intermediary
2 – Medication History to PDMP
3 – Medication History Processing
4 – Response to Intermediary
5 – Response to prescriber
6 – eRx to Switch/Intermediary
7 – eRx to Pharmacy
8 – eRx Receipt
9 – Acknowledgement to Intermediary
10 – Acknowledgement to Prescriber

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8. APPENDIX A. HISTORY OF CHANGES

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9. APPENDIX B. LIST OF PARTICIPANTS

Alan Gardner	RxResults. LLC
Alex Adams	NACDS
Amy Bricker	Express Scripts
Andrew Helm	Target Corporation
Anne Kling	MITRE
Barbara Carter	State of Minnesota
Basil Panagoulopoulos	CVS Caremark
Becki Poston	Florida Department of Health
Brian Wehneman	Humana
Carol Pamer	FDA
Carolyn Ha	National Community Pharmacists Association
Charles Boothe	DrFirst
Charlie Oltman	Target Corporation-Task Group Leader
Chris Baumgartner	Washington Department of Health
Christian Tadrus	Sam's Health Mart
Dale Slavin	FDA
Darren Townzen	Wal-Mart
Dave Hopkins	State of Kentucky
Debbie Simmons	Elsevier/Gold Standard
Debra Green	Express Scripts
Dennis Wiesner	HEB
Don Vogt	State of Oklahoma
Douglas Hillblom	Optum
George Chapman	Wal-Mart
George Tomson	Walgreens
Grant Carrow	PDMP Center of Excellence
James Potts	ScriptSave
James Sullivan	Rite Aid
Jay Rombro	Omnicare
Jeffrey Hammer	MITRE
Jeffrey McMonigal	Surescripts
Jennifer Frazier	Health and Human Services
Jinhee Lee	Health and Human Services
Joe Casar	State of Kentucky
John DeSoto	Creative Information Technology Inc.
Karen Guinan	Wegmans
Ken Whittemore	Surescripts
Kerri Paulson	Emdeon
Kim Nolen	Pfizer
Kittye Krempin	NCPDP Staff
Lawson, Bryan	McKesson
Lynne Gilbertson	NCPDP Staff
Michael Palladini	PDMI
Michael Wissel	State of Michigan
Mike Menkhaus	Kroger
Patsy McElroy	NCPDP Staff
Peter Kaufman	DrFirst
Kittye Krempin	NCPDP Staff
Lawson, Bryan	McKesson
Roger Pinsonneault	RelayHealth
Ron Fitzwater	MoRx

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Scott Clark	Humana
Scott Robertson	Kaiser Permanente
Sharon Gruttadauria	CVS
Shawn Ohri	ScriptSave
Shelly Spiro	Pharmacy e-HIT Collaborative
Stephen Mullenix	NCPDP Staff
Tina Janacek	Surescripts
Tom Beard	Health Information Designs
Tom Bizzaro	First DataBank
Vidura Stich	Kaiser Permanente
Wendy Faldet	HEB

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Attachment 4

New Educational Video for Pharmacists Addresses Prescription Drug Abuse

May 21, 2014 1:00 PM Topics: Diversion and Prescription drug abuse

National Association of Boards of Pharmacy and Anti-Diversion Industry Working Group Educate on "Red Flags" that May Be Difficult to Detect

The National Association of Boards of Pharmacy® (NABP®) and the Anti-Diversion Industry Working Group (ADIWG), a consortium of pharmaceutical manufacturers and distributors, has released an educational video for pharmacists to help them identify the warning signs of prescription drug abuse and diversion when dispensing controlled substance prescriptions. The video, entitled, "Red Flags," was released at the NABP 110th Annual Meeting.

Americans abuse prescription drugs more than cocaine, heroin, and hallucinogens combined, according to the Substance Abuse and Mental Health Services Administration. "Red Flags" encourages pharmacists to help combat this national problem by exercising their professional judgment to ensure the prescriptions they dispense were written for a legitimate medical purpose, and to act upon any unusual behavior they observe.

"Prescription drug abuse is a complex issue and, as one of the last lines of defense, pharmacists have a corresponding responsibility to recognize common red flags and establish a prescription's validity to curb this abuse," said NABP President Joseph L. Adams, RPh. "We appreciate the support of the ADIWG in providing pharmacists with this important informational video to help prevent the misuse and diversion of opioids and other prescription drugs."

Drug Enforcement Administration (DEA) and various state pharmacy boards have described red flags as circumstances surrounding the presentation of a controlled substance prescription that should raise reasonable suspicion about the validity of that prescription. The video highlights a number of these potential warning signs, some of which are not easy to spot, by weaving personal narratives with interactions between pharmacists and customers.

"Red Flags" is sponsored by six ADIWG member companies – the group's founder, Mallinckrodt Pharmaceuticals, along with members, Cardinal Health, McKesson Corporation, AmerisourceBergen, Actavis and Endo-Qualitest Pharmaceuticals – as part of the group's commitment to reduce prescription drug diversion and abuse. This is the first educational tool produced by the ADIWG as it continues its collaborative effort to help combat America's fastest growing drug problem.

"The abuse of prescription pain medicine is a serious and complex problem that requires strong partnerships, broad collaboration, and innovative approaches to combat it, said Donald Lohman, Mallinckrodt Pharmaceuticals. "This video is exactly the kind of project we envisioned when Mallinckrodt convened the ADIWG last August. As an essential partner in tackling prescription

drug abuse and addiction, pharmacists were a natural target for the ADIWG to reach with this initiative."

"Prescription drug abuse knows no boundaries, adversely affecting every race, gender and age group," said Robert Giacalone, Cardinal Health, "The ADIWG is proud to collaborate with the NABP to bring attention to this growing problem and enlist the nation's pharmacists in our determination to address this abuse."

The video is available in the Pharmacists section of NABP's prescription drug safety website.

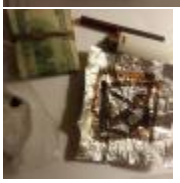
Attachment 5

Consumer Reports materials can be found by contacting *Consumer Reports* at www.consumerreports.org

Attachment 6

Heroin in the Foothills - Part 1

‘It’s everywhere: Auburn, Colfax, Loomis ...'
By: Jason Smith, for the Auburn Journal
-A +A



About the series

‘Heroin in the Foothills’ is a project conceived, researched and written by Auburn freelance writer Jason Smith, with assistance from Auburn Journal reporter Andrew Westrope. It’s the product of more than six weeks of research and interviews, motivated solely by Smith’s desire to raise awareness of a scourge plaguing our communities. The story will run in the Journal in three parts:

- **Part 1, Thursday: A look at the dealers, the users and the many victims of heroin addiction, and how its insidious spread got started.**
- Part 2, Friday: Though heroin is the ultimate uncontrolled street drug, its popularity has roots in one of America’s most popular pharmaceutical products.
- Part 3, Sunday: Its toll is severe, but opiate addiction isn’t necessarily a death sentence. Awareness and resolve – by all concerned – is a big part of the solution.

I didn’t even know this neighborhood existed in Auburn, and I’m from here. Million-dollar homes nestle up beside multimillion-dollar homes, each offering the same stunning view, from similarly stunning decks, of the American River Confluence. From where I sit, with the rest of Auburn beneath us, it’s easy to get lost in thought. For a brief moment, I forget the real reason I’m here.

The gram of heroin in my hand snaps me back to reality with a force that I wasn't expecting.

"If you buy in bulk, it's cheaper," my host states flatly, eyes darting around as if he's half-expecting a SWAT team to be trailing me. "$800 an ounce if you know who to call." He smirks. "I know who to call."

After a brief lesson in weights, measures and the almighty dollar, it's time to get down to business. My host – we'll call him Kevin – knows that to grant interviews in his line of work is not only dangerous but potentially deadly. In this particular business, talking too much is a failing business model; his reluctance is understandable. Then, without notice, he breaks character, saying what would be perhaps the truest and most real thing I'd hear throughout my month of research for this article:

"This drug is the devil," he states matter-of-factly. "If me talking to you helps stop what is happening in Auburn right now, then I'll do it. Because it's getting bad."

***

As is the case with most addicts, Kevin's descent into the drug world began innocently enough.

"It started with pills," he explains, a little something to change the way he felt, be it at a party to have fun or alone to relax. "Vicodin, Norco, Percocet -- they were everywhere." Climbing that narcotic ladder one rung at a time – Roxies, Opana, Fentanyl– eventually brought him to OxyContin.

"OxyContin was like the initiation for a heroin addict," he says. The actual addiction to OxyContin came on slowly: Once a week, then every few days. Every other day, then only at night. Only to wake up. Suddenly, the line between wanting the drug and needing the drug became blurred. Using throughout the day was now the only way to keep from getting sick, and it was then that he learned you could take a razor blade to the pill and snort the drug. Or better yet, smoke it.

"In 2006, you could get one 80-milligram pill for $5," he says, almost longingly. "By 2012, it cost $80 for the same pill." Using that much Oxy was not economically feasible, meaning heroin was suddenly a viable alternative. It was the same high, but much more affordable.

If switching from OxyContin to heroin was a financial decision, becoming a dealer was a business decision.

Inserting himself between the supply coming up from Sacramento and the increasing demand amongst the 18- to 30-year-old crowd in Auburn, he has been able to finance his own daily use without going broke, something at which very few addicts are ever successful.

"The heroin only touches about four people's hands between the cartel and me," he says. If one believes the rule of supply and demand, based on the price alone, demand in the Auburn area

began to skyrocket. “I’d go down to San Diego, and they’d be talking about some place up north called Auburn where you could go to make quick money. It was crazy. It happened so fast.”

Auburn’s increase in heroin use since 2006 would mirror what was happening throughout the rest of the country. The Centers for Disease Control and Prevention found that from 2007 to 2011, heroin use more than doubled. A study by the Journal of the American Medical Association, led by Washington University psychiatrist Thomas Cicero, found that 75 percent of those who began using heroin in the 2000s started by abusing prescription drugs. Of those, 94 percent reported to have switched because the prescription drugs got both more expensive and harder to find.

This coincided with the Drug Enforcement Agency’s pressuring of doctors to use more discretion in prescribing narcotics.

In 2010, Purdue Pharmaceuticals, the maker of OxyContin, changed the makeup of the drug so it would be nearly impossible to snort, smoke, or inject via syringe.

“That changed the whole game, right there, when they changed the OxyContins,” explains Kevin, the dealer. “Nothing was the same after that.”

An enormous void in the narcotic supply was created at the exact moment the demand was at an all-time high – a void that heroin was more than able to fill.

Heroin use by young white people in suburban areas became more prevalent, for the first time in American history, than heroin use in inner cities.

And those suburbs are demographically no different from those in the Sierra foothills.

***

Kristen Netto, 27 of Placerville, had no idea she was about to live this statistic firsthand when, just to be safe, she tagged along with her husband to his doctor’s appointment after he hurt his back at work. He’d struggled with addiction in the past, and she wanted to be sure his doctor knew this. They described to the doctor her husband’s past struggles, and how they wished to avoid any sort of narcotic medication. To their shock, the doctor wrote a prescription for Norco, a powerful semi-synthetic opioid derived from codeine.

“It’s not a problem if he really needs them,” the doctor said. “It’s only addictive if you take them without pain.”

She tried hiding his pills and dispensing them per the instructions on the bottle, continually counting how many were left, but something was always off. While his behavior became more erratic, she tried her best to convince herself that he hadn’t progressed from using the Norco to something far more sinister.

She wanted to believe him. She really did. His mood swings, the constantly fatigue, the progressive disregard for personal hygiene, his apathy toward the condition of the house, her discovery of disassembled Q-tips in the bathroom, his strange habit of always carrying around a lighter despite not smoking cigarettes – she tried her best to pretend none of this had anything to do with drugs. She even bought his excuse that his random drug test from work that came up positive for heroin was some sort of misunderstanding.

Then came Jan. 16, 2014.

The Placer County Sheriff's Office called, asking her to come pick up her car and toddler son. When she arrived on scene, an officer looked her in the eyes and asked, "Do you have any idea what your husband's been doing?"

Not knowing the answer would have been bad enough. Knowing the answer was far worse.

The officer pulled out the syringe, spoon, lighter and small amount of black-tar heroin that had been found in the car. Her husband had already been taken to jail. The baby sat, still screaming, in his car seat.

The disintegration of Kristen's marriage -- and thus, her life -- due to heroin addiction took just six months from beginning to end. It squashed the argument that drug abuse is a "victimless" crime.

"I must have called 20 different rehabs to get him into, and each said the same thing: 'Your husband's story of back injury to pills to heroin is what we're hearing every day,'" she says.

It was even less comforting to know she wasn't alone in what she was going through.

"The amount of people using heroin in Placerville is just crazy," she says. "Even the deputy that day told me that it's getting out of control."

***

Control is something "Michael," a 19-year-old from Auburn, thought he could maintain when it came to drug use. A promising young basketball player for both E.V. Cain and Placer High, he began using Norcos in 10th grade for the typical aches and pains that come with being an athlete.

"They made me feel comfortable," he explains, "and they came from a doctor, so I figured they were all right."

By 11th grade, "kids you would never expect to do drugs were taking pills," he says, still sounding surprised. "They were everywhere." While parents who failed to secure their medications were unwittingly supplying high school campuses with a healthy amount of narcotics, Michael was progressing in his addiction.

The leap from smoking OxyContin to smoking heroin was a short, much more affordable one. The first time he smoked heroin before a high school basketball game, he'd never felt so alive.

"I played great. No anxieties, no pain," he says. "I loved it."

Before long, using before a game went from a luxury to a necessity.

"I couldn't play without it," he says, shaking his head. "I needed it. I was hooked." Finding the drug was easy.

"Auburn is bad right now," he says. "And it's not like it's just my group of friends. Rich, poor, white, black -- it doesn't matter. It's everywhere: Auburn, Colfax, Loomis, Roseville. …" His voice trails off.

Being in the drug game has granted him backstage access to its inner workings. He explains how gangs from Modesto are coming up to Auburn and fronting entire ounces of heroin to dealers, with little doubt that it will sell quickly.

"Auburn has a reputation of being a bunch of little spoiled white kids with money," he says, half smiling. "If you can come up with $40 a day, you can maintain (your habit) and your parents will never know."

***

Twenty-eight days clean, with our interview wrapping up, Michael sits in reflection.

"You know," he says, "there's a sick part of me that worries that my helping you with this article will make it harder to find if I go back out." He pauses. "But this drug is the devil. It's evil."

That's the second time I've heard that said about this drug, and it's starting to weigh on me. Having recently finished an interview for this story in Roseville, I head up the hill toward Auburn, my mind racing. I think back to what the drug dealer, Kevin, said at the end of our interview.

I'd asked him what he thought Auburn would look like in 10 years if we don't do something about this now. He sat, thinking for a second, and then laughed, not out of humor but rather of incredulity.

"A black hole," he said, bluntly, eyebrows raised as if that's the first time he's realized his role in all of this.

As I pass the "Welcome to Auburn" billboard, my stereo chooses "The End" by the Doors.

"Lost in a Roman wilderness of pain/and all the children are insane/this is the end."

Part of me can't help but wonder if Jim Morrison is right.

An entire generation is being destroyed from the inside out. I feel angry. I feel confused. More than anything, I want to know how this has happened.

***

In Part 2: Heroin is the ultimate uncontrolled street drug, but its popularity has roots in one of America's most popular pharmaceutical products.

Heroin in the Foothills - Part 2

http://www.auburnjournal.com/article/7/18/14/heroin-foothills

Drug created for pain relief instead leads to ruin
By: Jason Smith, for the Auburn Journal

About the series

'Heroin in the Foothills' is a project conceived, researched and written by Auburn freelance writer Jason Smith, with assistance from Auburn Journal reporter Andrew Westrope. It's the product of more than six weeks of research and interviews, motivated solely by Smith's desire to raise awareness of a scourge plaguing our communities. The story will run in the Journal in three parts:

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- Part 3, Sunday: Its toll is severe, but opiate addiction isn't necessarily a death sentence. Awareness and resolve – by all concerned – is a big part of the solution.

Felix Hoffman knew he was onto something. With the 20th century right around the corner, he spent his nights in his laboratory in Elberfeld, Germany, adding various compounds to morphine in an attempt to dampen its strength. Morphine was decimating a generation of soldiers who had been treated with the drug for war injuries, only to find it nearly impossible to quit once started. Felix's boss at Bayer Pharmaceutical, maker of Bayer aspirin, was pushing him hard to come up with something, and what he stumbled upon would have a profound effect upon the next two centuries. What he found was considered a miracle drug.

Felix wasn't the first to discover the drug, but Bayer Pharmaceutical was first to market it. In 1898, Bayer sold the drug over the counter as a miraculous cough suppressant and pain reliever that was a completely non-addictive morphine substitute.

Bayer took the unusual steps of marketing it in German, English, Italian, French and Russian, making the miracle drug one of the first globally marketed medicines in history.

Finally, Bayer promised, a pain reliever that was non habit-forming and safe.

Bayer named it heroin.

More than a century after its mass introduction by Bayer, heroin remains a societal infection that not only refuses to heal, but insists upon inching its way toward epidemic proportions.

Doubled in 10 years

Placer County sheriff's Deputy Zach Poiesz, a 16-year veteran who spent the past seven years on the Narcotics Task Force, has had a front-row seat for the drug's evolution over the past decade.

"In Auburn, right now, I could go out tonight and find heroin and paraphernalia," he says. "It's that easy."

Over the past decade, heroin use has doubled, demonstrating the unusual ability to affect every ethnic group and every economic class. It is truly a nondiscriminatory drug.

"When I first started working narcotics, heroin was rare to come across," explains Poiesz. "Everything changed when Purdue (Pharmaceutical) changed the binder of the OxyContin."

In order to understand heroin's dramatic resurgence, it is first necessary to understand the OxyContin abuse that preceded it. Approved by the US Food and Drug Administration in 1995, OxyContin was designed as a high-dose capsule with timerelease coating, meaning it would need to be taken only once or twice daily for pain management, compared to traditional oxycodone, which is taken every 4-6 hours.

It was soon discovered that if the dissolvable coating were removed from the tablet, the entire dose could be felt at once. It could be smoked. It could be snorted. It could be dissolved in water and shot up intravenously.

When abused, it was essentially heroin in pill form.

From 1996-2000, Purdue Pharmaceutical, the maker of OxyContin, more than doubled its number of pharmaceutical sales representatives, while using sophisticated data collection that tracked which doctors across the country wrote the highest number of narcotics prescriptions. Purdue then targeted those doctors with a barrage of sales reps – sales reps who received bonuses according to how often those particular doctors prescribed OxyContin.

These were the same market representatives upon whom many doctors relied for education about the dangers of the drug.

With this marketing strategy, OxyContin sales mushroomed from $48 million in 1996 to $1.1 billion in 2000.

Like Bayer a century earlier, Purdue downplayed the danger of the drug, reporting that fewer than 1 percent of OxyContin users became addicted – an absurdly optimistic number in hindsight, and even more absurd when compared to national studies at the time. These studies showed an addiction rate of up to 50 percent among people using opiates for long-term care.

In 2007, Purdue Pharmaceutical, along with three executives, pleaded guilty to deliberately downplaying the risk of OxyContin addiction and abuse.

Purdue was fined $634 million.

Its sales that year exceeded $1.5 billion.

New formula, new problem

It was during this time, according to Deputy Poiesz, that OxyContin began showing up on the streets in abundance.

“The demographic was 16to 24-year-olds,” says Poiesz, “and we were finding a large majority of them to be under the influence of prescription narcotics. These pills were prescribed so loosely for so long, and parents weren’t locking up the medications. They were everywhere.”

Demand for OxyContin was so high that the street value, according to Poiesz, ranged from $80-$120 for a single 80-milligram pill.

Abuse was so rampant that Purdue Pharmaceutical was pressured to do something about it. In 2010 it responded by introducing a tamper-resistant coating for the tablet, making it nearly impossible to smoke, snort or inject.

In 2012, the New England Journal of Medicine documented an immediate decline in OxyContin abuse as a result of the formula change — and a dramatic increase in heroin use.

Abusers of OxyContin were effectively faced with a decision: switch to heroin, use other opiates or get clean.

The decision, it turns out, was a generational one. According to Danita Sands, executive director and co-founder of Pathways Recovery in Placer County, two groups of addicts are currently seeking help, divided by both age and drug of choice.

The first group is made up of 18- to 30-year-old local heroin addicts who were in their teens and early 20s when the Oxy-Contin epidemic reached its peak. Heroin, for many of them, was an easy transition from OxyContin. It was the same high, but much cheaper.

“Prior to 2010, most of the young people we had coming here to detox were for OxyContin,” says Sands. “Now, it’s primarily heroin.” The second group is made up of the 30-and-over crowd. This group, according to Sands, is made up of soccer moms, executives, business owners – people who wouldn’t traditionally fit the stereotype of a “drug addict.” Rather than heroin, this group has moved onto other prescription opiates, avoiding heroin due to the stigma their generation associates with the drug.

“With the older clients, we see a lot of addiction to Vicodin, Norco, Percocet, Opana – lowerstrength medications than Oxy-Contin but just as powerful when taken in excess,” Sands states.

In Sands’ experience at Pathways Recovery, compared to the over-30 crowd, heroin doesn’t seem to carry the same stigma of being a “junkie” drug for the younger generation. Instead of OxyContin being brought down to the level of heroin, heroin has instead, for those under 30, been elevated to the level of OxyContin.

And that demand for heroin in the foothills is one that cartels from Mexico have been happy to fill.

“This is a new issue for affluent communities,” Sands explains, “where you have parents who are wealthy enough to not notice when money goes missing.”

Affluent communities like Folsom, where police have recently declared heroin the No. 1 drug problem.

Affluent communities like Roseville, where a heroin ring was recently broken up and whose court documents show heroin presence in Loomis, Auburn, Lincoln and Rocklin.

Dr. Andrew Kolodny, chief medical officer at the Phoenix House Rehabilitation Clinic, calls the heroin resurgence “the worst epidemic this country has ever faced.” In 2011, the federal Centers for Disease Control and Prevention declared opiate addiction an epidemic.

Thor Cain, an Auburn paramedic and EMT, says that drug-seeking 911 “emergency” calls from people who demand opiate medications “have gone from maybe three or four a month to at least one per day.”

And a 2014 survey of every pharmacy in Auburn found that hydrocodone, a powerful synthetic opiate, was the most-prescribed medication.

Opiate addiction is here. Heroin addiction is here. At this point, that is indisputable.

In 2010, the CDC reported that "enough [opioid painkillers] were sold to medicate every American adult with a typical dose of 5 milligrams of hydrocodone every four hours for one month."

With only 5 percent of the world's population, the U.S. consumes 80 percent of its opiate supply.

Charmaine Moller, an Auburn pharmacist for the past 10 years, has seen the dramatic increase in opiates in Auburn firsthand.

"These doctors aren't treating the problem. They're treating the symptom and handing out these medications," she explains. "Not all doctors. But it only takes a few who hand out pills like candy, and pretty soon people are hooked."

Deputy Poiesz offers a more complete picture: "The pill user of yesterday is the syringe user of today. That whole demographic that we used to bust with prescription drugs a few years ago, now have track marks on their arms from needles," he says. "And they all started by saying they'd never switch to heroin. But at some point, it became inevitable."

'Facing an uphill battle'

As for Auburn's future, Poiesz pauses and lets the question settle. "I wish I could say there's a positive light at the end of the tunnel, but it's hard to say," he says, his voice drifting off.

"We're definitely facing an uphill battle."

In December 2012, the year after the CDC declared an opiate epidemic in America, a company in California submitted its application to the FDA's Anesthesia, Analgesia and Addiction Products section.

The application was to market Zohydro, a new, high-dose, long-acting pain medication. The drug was submitted in capsule form, with no effort made to make it tamper-resistant.

In a familiar tone, the makers of the drug extolled the benefit of the powerful narcotic, explaining how the drug needed to be taken only once or twice a day, compared with the every 4-6 hours of existing hydrocodone tablets.

At the public hearing, parents and families whose lives were destroyed by addiction that began with prescription drug abuse lined up to speak, practically begging the panel to reject the drug's application.

The FDA's scientific advisory committee, made up of doctors and researchers responsible for safety recommendations, which the FDA almost always follows, voted 11-2 to reject the drug.

In October 2013, the FDA approved the high-dose, nontamper-proof version of Zohydro.

"The benefits," the FDA declared in a statement, "outweigh its risks."

Heroin in the Foothills - Part 3

Back from addiction: A terrifying, beautiful trek

By: Jason Smith / For the Auburn Journal

http://www.auburnjournal.com/article/7/19/14/heroin-foothills-part-3

It really is a shame that the last image I have of my Uncle Mark is him lying on the floor, dying, with my left hand behind his head and my right hand under his chin, trying to somehow breathe my life into him. A syringe lay at his right, a burnt spoon on the table, empty Saran Wrap and a lighter on the floor. Just chaos. Uncle Mark was a gracious man, and part of me feels like he deserved a better final mental snapshot than that. I was 13.

Uncle Mark was 39, and he knew he had a problem. He had used heroin since he was 15, so that was undeniable.
But admitting he had a problem was something he refused to do.

Knowing something comes from one's head. Admitting it comes from one's heart. And he'd lost touch with his heart well before he lay dying in my arms.

Heroin eats away at your soul, at that intrinsic little voice that tells us right from wrong, good from bad, love from hate. It numbs everything in its path; the soul is just an innocent bystander.

It takes everything you love, everything you care about, all of your dreams, your aspirations, your friends, your family, everything — and pushes it to the side in favor of finding ways and means to get more heroin.

And until an addict finally succumbs to reality and admits he or she has a problem, there can be no solution. Sure, it can be forced. But more often than not, for addicts' families, it's nothing but a lesson in redundancy and heartbreak. It's feeling stupid for actually believing they'd get it this time around. It's wondering what they did wrong and how they could've stopped such a beautiful person from taking such an ugly path through life.

For the addict in denial, it's promises — lots and lots of empty promises. Nothing kills the soul more than failing, once again, like they said you would. Nothing annihilates your self-esteem more than using against your own will, possessed by an obsession to outrun a detox in $20 increments.

Not a dead-end road

After the admission, solutions are plentiful. Help is out there.

Auburn, Grass Valley, Placerville, Rocklin and Roseville all have inpatient and outpatient rehabilitation services. County funding is available. There are 12-step meetings for both drugs and alcohol at nearly every hour of the day. Transitional living facilities are available for social reintegration.

The help is out there. But before we can receive it, we must first, as a community, admit that we have a problem.
There's no magic pill we can take to defeat addiction. And let's face it — America being America, if there were a magic pill, we'd chop it up and snort it or find a way to smoke it on foil.

I spent about six weeks conducting interviews and research for this series. I wish I could say that the subjects were difficult to find — that there was only one drug dealer in town, that there was only one heroin addict in town, that there was only one person whose husband chose drugs over his own family. But the truth is that I was granted only so much space in this newspaper, and it wasn't nearly enough.

There's the story of a mother and father who dearly miss their daughter who went from being a straight-A college student holding down two jobs to living in a car in the course of 10 months because of her heroin addiction. A handful of ER nurses told me that their jobs are being constantly interrupted by waves of addicts trying to score narcotics.

The stories were plentiful, and they came from your friends and neighbors right here in Auburn.

If nothing else comes from this series, I hope a dialogue emerges. All of us have either a family member or friend who is battling addiction of one kind or another, and to convince ourselves that because we live in a tight-knit, upper-middle-class community we are immune to stereotypically "inner-city problems" is not only foolish; it's dangerous.
To put it more plainly: It's denial.

Addiction doesn't care how old you are, what color you are, what you do for a living, what kind of car you drive, what tax bracket you're in, how much you love your husband or wife, how much you love your kids.
And it certainly doesn't care that you live in Auburn.

No place to hide

The isolation of living in the foothills didn't protect Kristin Netto (Thursday, Part 1) from having her life torn apart by her husband's drug addiction. Her little boy is now 3 years old, and when he asks for his father, her only response is, "Daddy's still sick," she explains. "What else do you tell a 3-year-old?"

She has since filed for legal separation, receiving full custody of not only her biological son, but also her soon-to-be ex-husband's two sons from a previous relationship. As of the writing of this article, he's still disappeared into his addiction.

The drug dealer (Part 1), "Kevin," is trying to stay clean. "When I'm clean, I don't sell," he says. "I don't need to." At the writing of this article, he was two days clean. That may not sound like much, but believe me, two days clean for a drug addict is two consecutive 24-hour miracles.

As for "Michael" (Part 1), after completing the Community Recovery Resources program in Grass Valley, he has been clean for 42 days. He's just 19 years old, and the temptation of old friends carries with it the temptation of old habits. To say he has an uphill battle in front of him would be an understatement, but to say it's an impossible task would be to sell short the human spirit. Millions of others have done it, and it's up to him to decide whether he is finished.
I wish both "Kevin" and "Michael" nothing but the best.

As for me, my clean date is irrelevant, but let's just say I know what the road ahead of them looks like. I've been there. I am there. It's difficult and it's trying and it's frustrating and it's probably the most beautiful, rewarding journey of self-discovery one could ever embark upon.

You'd think that holding my uncle while he took his last breath would've scared me away from ever touching drugs.

You'd be wrong.

It doesn't work that way. It'd be nice if it did, because then we could show kids "Scared Straight" videos, show them an egg frying in a pan and tell them that "this is your brain on drugs," come up with catch slogans like "Just say no!," and we'd never have to worry about them trying drugs.

How has that worked out so far?

No, my path to hell went the prescription drug route after having a back surgery, and when I went in, I went in deep. I almost didn't make it out. In fact, for all intents and purposes I shouldn't have, at least according to the ER doctors. But I did, and now I feel that I have an obligation to make the most of this second chance by doing what I can to give back.

Don't get me wrong; it's hard work. For me it requires a healthy dose of 12-step meetings, lots of sponsoring, going into rehabs to speak, letting people know there's a better life awaiting them should they choose to live it.

Addiction does not have to be a dead end. There is a way out. You just have to be ready to find it.

If you had just met me on the street, you'd probably never know that I was a recovering addict.

You'd never know that I've seen hell up close and personal, all over the world, in multiple languages, in a variety of cultures, and I didn't know whether I had what it took to make it back.

You'd never know unless I was willing to talk about it.

Editor's note: "Kevin" and "Michael" are the only pseudonyms used in this series; everyone else spoke on the record and for attribution.

Attachment 7

ASSEMBLY BILL **No. 1535**

Introduced by Assembly Member Bloom
(Coauthor: Senator Pavley)

January 21, 2014

An act to add Section 4052.01 to the Business and Professions Code, relating to pharmacists.

LEGISLATIVE COUNSEL'S DIGEST

AB 1535, Bloom. Pharmacists: naloxone hydrochloride.

Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy. Existing law, generally, authorizes a pharmacist to dispense or furnish drugs only pursuant to a valid prescription. Existing law authorizes a pharmacist to furnish emergency contraceptives and hormonal contraceptives pursuant to standardized procedures or protocols developed and approved by both the board and the Medical Board of California, as specified, or developed by the pharmacist and an authorized prescriber. Existing law also authorizes a pharmacist to furnish nicotine replacement products pursuant to standardized procedures or protocols developed and approved by both the board and the Medical Board of California, as specified. Existing law authorizes a licensed health care provider who is permitted to prescribe an opioid antagonist and is acting with reasonable care to prescribe and dispense or distribute an opioid antagonist for the treatment of an opioid overdose to a person at risk of an opioid-related overdose or a family member, friend, or other person in a position to assist a person at risk of an opioid-related overdose.

This bill would authorize a pharmacist to furnish naloxone hydrochloride in accordance with standardized procedures or protocols developed and approved by both the board and the Medical Board of California, in consultation with specified entities. The bill would require the board and the Medical Board of California, in developing those procedures and protocols, to include procedures requiring the pharmacist to provide a consultation to ensure the education of the person to whom the drug is furnished, as specified, and notification of the patient’s primary care provider of drugs or devices furnished to the patient, as specified. The bill would prohibit a pharmacist furnishing naloxone hydrochloride pursuant to its provisions from permitting the person to whom the drug is furnished to waive the consultation described above. The bill would require a pharmacist to complete a training program on the use of opioid antagonists prior to performing this procedure. The bill would require each board to enforce these provisions with respect to its respective licensees.

This bill would authorize the California State Board of Pharmacy to adopt emergency regulations to establish the standardized procedures or protocols that would remain in effect until the earlier of 180 days following their effective date or the effective date of regulations adopted as described above.

DIGEST KEY

Vote: MAJORITY Appropriation: NO Fiscal Committee: YES Local Program: NO

BILL TEXT

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1.

Section 4052.01 is added to the Business and Professions Code, to read:

4052.01.

(a) Notwithstanding any other provision of law, a pharmacist may furnish naloxone hydrochloride in accordance with standardized procedures or protocols developed and approved by both the board and the Medical Board of California, in consultation with the California Society of Addiction Medicine, the California Pharmacists Association, and other appropriate entities. In developing those standardized procedures or protocols, the board and the Medical Board of California shall include the following:

(1) Procedures to ensure education of the person to whom the drug is furnished, including, but not limited to, opioid overdose prevention, recognition, and response, safe administration of naloxone hydrochloride, potential side effects or adverse events, and the imperative to seek emergency medical care for the patient.

(2) Procedures to ensure the education of the person to whom the drug is furnished regarding the availability of drug treatment programs.

(3) Procedures for the notification of the patient's primary care provider with patient consent of any drugs or devices furnished to the patient, or entry of appropriate information in a patient record system shared with the primary care provider, as permitted by that primary care provider, and with patient consent.

(b) A pharmacist furnishing naloxone hydrochloride pursuant to this section shall not permit the person to whom the drug is furnished to waive the consultation required by the board and the Medical Board of California.

(c) Prior to performing a procedure authorized under this section, a pharmacist shall complete a training program on the use of opioid antagonists that consists of at least one hour of approved continuing education on the use of naloxone hydrochloride.

(d) The board and the Medical Board of California are each authorized to ensure compliance with this section. Each board is specifically charged with enforcing this section with respect to its respective licensees. This section does not expand the authority of a pharmacist to prescribe any prescription medication.

(e) The board may adopt emergency regulations to establish the standardized procedures or protocols. The adoption of regulations pursuant to this subdivision shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The emergency regulations authorized by this subdivision are exempt from review by the Office of Administrative Law. The emergency regulations authorized by this subdivision shall be submitted to the Office of Administrative Law for filing with the Secretary of State and shall remain in effect until the earlier of 180 days following their effective date or the effective date of regulations adopted pursuant to subdivision (a).

California Poised to Lead the Nation in Innovative Overdose Prevention Effort

http://www.drugpolicy.org/news/2014/08/california-poised-lead-nation-innovative-overdose-prevention-effort

Strong Bipartisan Support Delivers California's 'Pharmacy Naloxone' Bill to Governors Desk

SACRAMENTO, CA — Yesterday (Aug. 14), the California legislature passed Assemblymember Richard Bloom's important drug overdose prevention bill (AB 1535), which would permit pharmacists to furnish the opiate overdose antidote naloxone, pursuant to procedures developed by the Board of Pharmacy and the Medical Board of California. The bill now heads to the Governor's desk for his signature.

"The bipartisan support of the Legislature is gratifying and will directly help many California families," said Assemblymember Bloom (D-Santa Monica). "As the bill heads to the Governor's desk, I am committed to continuing our efforts to stop the epidemic of overdose deaths."

While California was an early leader in drafting legislation permitting sales of naloxone without a prescription, the movement to expand access to the overdose antidote can be seen in other states including Washington, Rhode Island and New Mexico, where naloxone is becoming increasingly accessible to patients without prescription and via collaborative practice agreements between pharmacists and physicians. New York and Vermont recently passed similar legislation.

In addition to expanding access to naloxone, California also has a '911 Good Samaritan' law, which encourages people to call for emergency assistance at the scene of an overdose without fearing arrest or prosecution for minor drug law violations.

"This bill reaching the Governor is a triumph for all Californians who love someone at risk of an overdose," said Meghan Ralston, Harm Reduction Manager of bill co-sponsor the Drug Policy Alliance. "California has thousands of pharmacies, and lives can be lost in the minutes waiting for a police officer or ambulance to arrive with naloxone to reverse an overdose. This would make it easier for caregivers and family members to keep naloxone on hand for use in those critical moments."

Naloxone is a safe, generic, non-narcotic drug, approved by the FDA in 1971. It has been used in ambulances and emergency rooms for decades. In recent years, it has become more widely available, largely in response to the growing opiate overdose crisis across the US. It can be administered as a nasal spray via an atomizer or as an intramuscular injection. It works within minutes to reverse the effects of opiate drugs such as heroin and oxycodone, but has no effect if administered to someone not overdosing on an opiate.

"It's a model that can be followed by other states," said Ralston. "This approach reduces some of the traditional constraints that make it time-consuming or difficult to implement pharmacy sales of naloxone directly to the consumer. It represents a quantum leap in overdose prevention in California."

The bill remained unopposed throughout its movement through the Legislature and benefited from unanimous, bipartisan support in committee hearings.

AB 1535 is supported by a long list of public health organizations, drug treatment providers and advocacy groups including: California Pharmacists Association (co-sponsor); Drug Policy Alliance (co-sponsor); California Narcotic Officers' Association; Medical Board of California; California Hospital Association; California Society of Addiction Medicine; A New PATH; Addiction Research and Treatment; Amity Foundation; Bay Area Addiction Recovery Treatment; Behind the Orange Curtain; Broadway Treatment Center; Broken No More; California Association of Alcohol and Drug Program Executives, Inc.; California Mental Health Directors Association; California Opioid Maintenance Providers; California Retailers Association; California United for a Responsible Budget; Center for Living and Learning ; County Alcohol and Drug Program Administrators Association of California; CRI-HELP, Inc.; Drug and Alcohol Addiction Awareness and Prevention Program; Families ACT!; Fred Brown Recovery Services; Gateways Hospital and Mental Health Center; Grief Recovery After a Substance Passing; Health Officers Association of California; Health Right 360; Hillview Mental Health Center; Homeless Health Care Los Angeles; Hope of the Valley Rescue Mission; In Depth; Legal Services for Prisoners with Children; Los Angeles Centers for Alcohol and Drug Abuse; Los Angeles Community Action Network; Los Angeles County HIV Drug & Alcohol Task Force; Mary Magdalene Project; National Federation of Independent Business; Not One More; Paramedics Plus; Paving the Way Foundation; Phoenix House of Los Angeles; Primary Purpose Sober Living Homes; Safer Alternatives thru Networking & Education; San Fernando Recovery Center; SHIELDS For Families; Soberspace; Solace.

News

Belinostat approved for use in treating rare lymphoma

FDA on July 3 announced it approved the marketing of belinostat, or Beleodaq, for the treatment of relapsed or refractory peripheral T-cell lymphoma (PTCL).

Richard Pazdur, head of FDA's Office of Hematology and Oncology Products, said the drug is the third one that the agency has approved since 2009 for the treatment of PTCL.

The labeling for belinostat, a histone deacetylase inhibitor, recommends a dosage of 1000 mg per square meter of body surface area once daily on days 1–5 of a 21-day treatment cycle. In patients homozygous for the *UGT1A1*28* allele, a variant of the uridine glucuronosyltransferase 1A1 gene, the starting dose should be 750 mg per square meter. Doses should be given by i.v. infusion over 30 minutes. This infusion time may be extended to 45 minutes if infusion-site pain or other symptoms attributable to the infusion occur.

Thrombocytopenia or neutropenia during a treatment cycle may necessitate a 25% decrease in each dose during the next cycle, depending on the patient's platelet or absolute neutrophil count. If nausea, vomiting, and diarrhea occur for more than seven days despite supportive management, the labeling recommends decreasing each dose in the next treatment cycle by 25%. Two such reductions necessitate discontinuation of belinostat therapy.

Treatment cycles can be repeated until the disease progresses or unacceptable toxicity occurs, the labeling states.

During an open-label, single-group, nonrandomized international trial of belinostat in 129 patients with relapsed or refractory PTCL, the most common adverse reactions were nausea, fatigue, fever, anemia, and vomiting. The labeling reports that each of these reactions occurred in at least 29% of the patients.

In 26% of the patients in the trial, PTCL tumors shrank or disappeared, the labeling reports. This response typically started to occur in the first six weeks of treatment.

Beleodaq will be available in single-use vials containing 500 mg of lyophilized belinostat. The vials should be stored at 20–25 °C. The drug is reconstituted in a vial by adding 9 mL of sterile water for injection and then swirling the contents; this 50-mg/mL solution may be stored for up to 12 hours at 15–25 °C.

To prepare an infusion of belinostat for administration, the labeling says to transfer the required dose to a bag containing 250 mL of 0.9% sodium chloride injection. This infusion bag may be stored for up to 36 hours, which includes the 30 or 45 minutes for drug administration, at 15–25 °C. The infusion set should have a 0.22-µm inline filter.

The labeling states that belinostat is a cytotoxic drug and requires proper handling and disposal. Belinostat is also genotoxic; women should avoid pregnancy while receiving the drug.

Beleodaq will be marketed by Spectrum Pharmaceuticals Inc.

The company said the new product would be available to patients in July.

—*Cheryl A. Thompson*

DOI 10.2146/news140056

New drugs and dosage forms

Methotrexate injection (Rasuvo, Medac): The folate analog metabolic inhibitor, in a formulation intended for once-weekly subcutaneous injection, is indicated as a second-line therapy for the management of patients with severe active rheumatoid arthritis or polyarticular juvenile arthritis. The product is also indicated for the symptomatic control of severe recalcitrant, disabling psoriasis in adults not adequately responsive to other forms of therapy.

Tavaborole topical solution (Kerydin, Anacor Pharmaceuticals): The oxaborole antifungal agent is indicated for the topical treatment of onychomycosis of the toenails caused by *Trichophyton rubrum* or *T. mentagrophytes*.

Rhode Island's opioid epidemic response features collaborative practice model

The response to Rhode Island's crisis of opioid-related overdose deaths includes a collaborative practice model through which a single physician authorizes the dispensing of naloxone kits at multiple pharmacies to anyone who may encounter an overdose victim.

The program began in 2012 as a pilot project at four Walgreens pharmacies before expanding last year to all 26 Walgreens pharmacies in the state, said University of Rhode Island Clinical Associate Professor of Pharmacy Jeffrey Bratberg.

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Jeffrey Bratberg

Now, anyone can walk into any of the chain's pharmacies in the state and leave with a naloxone kit and training in its use without first obtaining a prescription for the drug.

Bratberg helped present the idea for the collaborative practice model to the state board of pharmacy and has been raising awareness among healthcare providers about the importance of making naloxone widely available to prevent overdose deaths.

"It's my new passion," said Bratberg, an infectious diseases specialist who is also active in public health issues.

In all, Bratberg said, 79 Walgreens pharmacists in Rhode Island have completed an online training module for naloxone dispensing and signed the collaborative practice agreement overseen by Miriam Hospital physician Josiah Rich.

Rich is also codirector of the Center for Prisoner Health and Human Rights, based at the hospital.

The online training module was developed by a student at the University of Rhode Island College of Pharmacy. Bratberg said the training module is freely available for viewing or can be completed for continuing education credits through the university for a small fee.

"It's been used worldwide—there's people in Australia who've done it," he said. "Last spring, I got calls from Utah, and Maryland, and Virginia, and lots of other states that are very interested, and I just direct them to the program."

Bratberg said some states may not be able to craft collaborative practice agreements that allow a single physician to authorize dozens of pharmacists at multiple sites to dispense naloxone.

"In other states, the prescriber needs to have a relationship with the patient," he noted. But he said nothing should prevent a prescriber from recognizing patients in the practice who are at risk for opioid addiction and ensuring that they have access to naloxone.

Bratberg urged pharmacists to learn about naloxone as a remedy for opioid overdose because the country is flooded with opioids, and patients are dying as a predictable result of exposure to these highly addictive drugs.

And he noted that pharmacists are the last check in an opioid-prescribing process "that gets people dependent and leads to addiction."

The numbers. Centers for Disease Control and Prevention (CDC) Director Thomas Frieden said on July 1 that 259 million prescriptions for opioid drugs were dispensed at pharmacies during 2012.

"That's enough for every American adult to have their own bottle of pills," Frieden said.

Rhode Island ranks in the middle nationally for opioid prescribing, with about 90 prescriptions filled per 100 population in 2012, according to CDC.

CDC in 2011 declared that opioid overdosage deaths were at an epidemic level nationwide. According to the agency, about 110 Americans died of a drug overdose every day during 2011, and prescription opioids were a factor in nearly 17,000 overdose deaths that year.

Rhode Island's health department in March announced that 50 opioid-related deaths had been reported in the state since the start of the year. The department enacted emergency regulations at that time and called expanded access to naloxone an "immediately necessary priority to save lives."

Bratberg said overdose deaths nowadays aren't limited to stereotypical i.v. drug users—anyone may succumb to addiction.

He said that during a presentation he gave to about 100 pharmacists in Connecticut, half of the participants raised their hands when he asked if they knew someone who suffered or died from opioid overdose.

"That was shocking to me, even knowing the exposure and knowing what's happening," Bratberg said.

Enter naloxone. Naloxone hydrochloride, an opiate antagonist that rapidly reverses the effects of opioids on the respiratory and central nervous systems, was approved by FDA in 1971. The drug is indicated for intravenous, intramuscular, or subcutaneous injection but has also been widely administered intranasally using a syringe and atomizer.

FDA in April approved Evzio, a naloxone autoinjector device marketed by Richmond, Virginia–based Kaleo Inc. that delivers an intramuscular or subcutaneous dose of the drug.

According to CDC, naloxone distribution through community-based opioid prevention programs resulted in the reversal of 10,171 overdoses from 1996 through 2010.

Under its March emergency regulations, Rhode Island allowed prescribers "to issue a non-patient-specific order to numerous organizations, such as police departments," to increase the availability of naloxone at the scene of an overdose—a model similar to that used at Walgreens.

State police officers in Rhode Island now carry a naloxone kit, assembled by the state's disaster medical assistance team, in their cruisers and have been trained in intranasal administration of the drug. The police department in May announced that a trooper had administered an intranasal dose of the drug to an overdose victim during a traffic stop and saved the person's life.

In Massachusetts, which declared an opioid-related public health emergency in March, all first responders are authorized to carry naloxone, and pharmacies may use a standing order, signed by a collaborating state-licensed physician, to dispense "naloxone rescue kits" to the general public.

New York Attorney General Eric Schneiderman in April announced the launch of a program to expand the availability of naloxone to law enforcement agencies in the state. And New York City on July 1 graduated the first class of police officers to be trained in the use of naloxone, according to the police department.

U.S. Attorney General Eric Holder has urged law enforcement agencies to train their personnel in naloxone administration and to equip them with the drug. A total of 19 states had passed some sort of naloxone access law as of April 2014, according to the White House Office of National Drug Control Policy.

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Bratberg said law enforcement and public health efforts to increase access to naloxone are part of the broader goal of making the antidote a routine part of opioid prescribing and use.

"The ultimate goal is to have the public, everyone, asking [for naloxone]; for the prescriber to say, 'Do you want naloxone with that?' and write a prescription; and the pharmacist to say, 'Do you want naloxone with that?' and either initiate a prescription or ask the prescriber for one; or have the patient say, 'I'm really worried about how many opioids my family member is on—I'd like to have naloxone in my house and be trained on it,'" Bratberg said.

"You never know when you're going to truly save a life," he said.

—Kate Traynor

DOI 10.2146/news140057

Appointments

Joseph T. DiPiro, Pharm.D., has been appointed Dean, Professor, and Archie O. McCalley Chair, Virginia Commonwealth University School of Pharmacy, Richmond; previously he was the executive dean and a professor at the South Carolina College of Pharmacy, with campuses at the University of South Carolina in Columbia and the Medical University of South Carolina in Charleston.

Steven J. Martin, Pharm.D., has been appointed Dean, Ohio Northern University Raabe College of Pharmacy, Ada; previously he was a professor at the University of Toledo College of Pharmacy and Pharmaceutical Sciences and chairman of its department of pharmacy practice.

Recent appointments to the Pharmacy Quality Alliance's work groups included **Krista Capehart, Pharm.D.; Starlin Haydon-Greatting, M.S., B.S.Pharm., FAPhA, FASCP;** and **Maria Osborne, Pharm.D., BCACP.** Capehart, director of the Wigner Institute for Advanced Pharmacy Practice, Education, and Research at West Virginia University in Morgantown, serves on the Adherence Workgroup. Haydon-Greatting, clinical pharmacist consultant at SHG Clinical Consulting in Springfield, Illinois, also serves on the Adherence Workgroup. Osborne, a clinical pharmacist in UPMC St. Margaret family practice offices in the Pittsburgh area, serves on the Medication Use Safety Workgroup.

Discussion continues on content, format of consumer drug leaflets

FDA has made some progress toward improving consumer information leaflets for prescription drugs, officials said during a July 1 policy forum held at the Brookings Institution in Washington, D.C.

The leaflets, also known as patient medication information (PMI), are drug information documents that are commonly stapled to the bag in which patients pick up their prescription medications from a pharmacy.

PMI documents are generally created from content developed by ASHP and other providers of drug information. Pharmacies select the specific content to include in PMI documents and the format in which the printed documents appear.

Bryon Pearsall, director of FDA's Division of Medical Policy Programs, said the agency's "current thinking" about PMI is that it should consist of one-page documents produced by drug manufacturers and "based on content, format, and testing standards established in regulation."

Pearsall, a pharmacist, said FDA is looking at several methods to ensure that PMI meets agency standards. He said one possibility is to base PMI on FDA-approved prescribing information and to have the agency review and approve the PMI content.

He said FDA envisions that PMI will be centrally housed and available in an electronic form "that will provide open online access to patients, healthcare providers, and pharmacies."

Long time coming. FDA in 1980 finalized regulations requiring that manufacturers prepare FDA-approved PMI for distribution with certain prescription drugs. The agency revoked the regulations two years later after receiving assurance from manufacturers, healthcare professional organizations, and other stakeholders that a voluntary system would better result in PMI documents that are helpful to patients.

Studies since then have shown that the documents have failed to meet that goal. Although most patients receive some sort of PMI with their filled prescriptions, only about 60% of the documents in 2008 met FDA's predetermined criteria for usefulness, according to a report commissioned by the agency.

The July 1 forum was the latest in a series of PMI stakeholder meetings convened since 2010 through a cooperative agreement between FDA and the Brookings Institution.

Kevin Nicholson, vice president of public policy and regulatory affairs at the National Association of Chain Drug Stores, acknowledged that the problems with PMI have persisted for years.

Today, he said, "patients receive several different types of information developed by different sources that may be duplicative, incomplete, and difficult to read and understand."

Mark McClellan, director of the Health Care Innovation and Value Initiative at Brookings, said the stakeholders' meetings over the years have led to a "general agreement" that PMI needs to be standardized, easy for patients to navigate, and available in print and electronic forms.

"We need to make sure that patients have access to accurate, clear, and actionable information about their medication. This kind of information needs to be presented in a consistent and easily understood format," McClellan said.

Options. Julie Aker, president of Concentrics Research, a consulting firm for the drug industry, said the format of a PMI leaflet "strongly influences" whether a patient will read the document.

Aker presented findings of a study comparing PMI in the current leaflet format, PMI organized in a grid containing icons and major headings, and PMI in so-called bubble format with content organized into six different categories and presented as "chunks."

Continued on page 1334

Attachment 8

Joint Training by the California State Board of Pharmacy and the Los Angeles Field Division of the Drug Enforcement Administration

What every pharmacist should know to prevent drug diversion

September 3, 2014
September 4, 2014
CenCal Health
4050 Calle Real
Santa Barbara, CA 93110

Pharmacists and pharmacy technicians will be awarded 6 hours CE credit for attending the full session on either September 3, 2014 or September 4, 2014. Space is limited pre-registration is strongly encouraged. Registration instructions are available online at http://www.pharmacy.ca.gov/meetings/registration.shtml. If you have questions please contact Laura Hendricks at laura.hendricks@dca.ca.gov or (916) 574-7918.

Pharmacists who wish to register with CURES may do so at this meeting by following the CURES Registration Information sheet that follows as the last page of this agenda.

Pharmacy Diversion Awareness Conference

AGENDA

Space is Limited, Registration Strongly Encouraged

Location: CenCal Health
4050 Calle Real
Santa Barbara, CA 93110

Co-sponsored by the DEA and California State Board of Pharmacy

California State Board of Pharmacy

September 3, 2014 and September 4, 2014

9: 00 a.m. - 9:15 a.m.	Welcome/Orientation California Board of Pharmacy Executive Officer Virginia Herold DEA Diversion Program Manager Mike Lewis
9:15 a.m. - 10:15 a.m.	Drug Trafficking / Trends in Los Angeles DEA Diversion Program Manager Mike Lewis
10:15 a.m. - 10:30 a.m.	Break
10:30 a.m. - 11:30 a.m.	Pharmaceutical Supply Chain Thefts -- Reporting and Prevention, and Pharmacist's Corresponding Responsibility California Board of Pharmacy Executive Officer Virginia Herold
11:30 p.m. - 12:30 p.m.	Lunch
12:30 p.m. - 1:00 p.m.	Controlled Substances Utilization Review and Evaluation System – CURES Records, Inquiries and Reports DOJ Administrator Mike Small
1:00 p.m. - 1:45 p.m.	Los Angeles Field Division Tactical Diversion Squad Local Investigations DEA Group Supervisor Derrick Jones
1:45 p.m. - 2:00 p.m.	Break
2:00 p.m. - 3:00 p.m.	Board Actions Against Internet Prescribing, Gray Market Sales California Board of Pharmacy Executive Officer Virginia Herold
3:00 p.m. - 4:00 p.m.	Pseudoephedrine Sales and Reporting DEA Diversion Program Manager Mike Lewis
4:00 p.m.	Adjournment

Pharmacists will be awarded 6 hours CE credit for attending

Meeting location provided by CenCal Health

Sign Up for CURES

NOTE: Registration must be done in person.

The California State Board of Pharmacy wants to help pharmacists register for access to CURES and has created a procedure for registration.

CURES is California's prescription drug monitoring program for controlled substances and is operated under the California Department of Justice. Effective January 1, 2016, all California licensed pharmacists must be registered to access CURES (as required by Section 209 of the California Business and Professions Code).

To aid pharmacists and the California Department of Justice in meeting this deadline, the board is offering to assist in the registration of pharmacists. The information below advises pharmacists on how to register in CURES in order to access patient activity reports.

BEFORE THE MEETING

Before coming to the board meeting, you must start the process by going to oag.ca.gov/cures-pdmp.

Select "pharmacist," then:

1. **Complete** the online application form
2. **Print** the completed form, then sign and date it
3. **Attach** a copy of:
    - Your CA pharmacist license
    - DEA controlled substances registration (if you possess one)
    - Driver's license or other photo government identification

AT THE MEETING – APPLICANT MUST BE PRESENT TO PROCESS

YOU must bring the **completed** packet in person to the meeting.

A confirmation will be emailed to you by the Department of Justice once your registration is processed.

Attachment 9

Prescription Drug Abuse Prevention

PRESCRIPTION DRUG ABUSE PREVENTION PUBLIC SERVICE ANNOUNCEMENT

- 60-second video
- 30-second video
- Medical Board Prescription Drug Abuse PSA Video

MATERIALS

Teens

- TEEN Poster *PDF*
- TEENS Drug abuse prevention *PDF*
- TEENS RX abuse prevention *PDF*

College Students

- COLLEGE RX abuse *PDF*
- COLLEGE STUDENTS Nonmedical use of prescription drugs *PDF*

Parents

- PARENT Talk Kit *PDF*
- PARENTING Practices to reduce child drug or alcohol problems *PDF*
- PARENTS Talking to your kids *PDF*
- PARENTS Abuse of prescription and OTC drugs is dangerous *PDF*
- PARENTS How teens abuse medicine *PDF*
- PARENT GUIDE Family drug and alcohol testing *PDF*
- PARENTS Synthetic Bath Salts K2 Spice *PDF*
- PARENTS Drug Chart *PDF*
- PARENTS Fact Sheet Preventing Teen Abuse of Prescription Drugs *PDF*
- PARENTS Overdose Prevention Toolkit *PDF*
- PARENTS Internet Pharmacies *PDF*

Teachers

- TEACHERS RX abuse education *PDF*

CONTACT US
1625 N Market Blvd, N219
Sacramento, CA 95834
Phone (916) 574-7900
Fax (916) 574-8618

Pharmacists

- Corresponding Responsibility Brochure *PDF*
- PHARMACISTS CDC - Prescription Painkiller Overdoses Policy Impact Brief *PDF*
- PHARMACISTS 2014 White House National Drug Strategy *PDF*
- Red Flags Video

Treatment

- TREATMENT How to Find Help For Your Child *PDF*

WEBSITES

Teens

NIDA For Teens – the science behind drug abuse
http://teens.drugabuse.gov/
The National Institute on Drug Abuse (NIDA), a component of the National Institutes of Health (NIH), created this website to educate adolescents, ages 1
addresses appropriate questions and timely concerns.

Above The Influence
www.abovetheinfluence.com
This campaign is inspired by what teens say about their lives and how they deal with the influences that shape their decisions about not using drugs or a

Just Think Twice
http://www.justthinktwice.com/
Website for teens

Drugs: What you should know
http://kidshealth.org/teen/drug_alcohol/drugs/know_about_drugs.html
Also available in Spanish. TeensHealth is part of the KidsHealth family of websites. These sites, run by the nonprofit Nemours Center for Children's Heal

Parents

Saving Lives and Protecting People: Preventing Prescription Painkiller Overdoses
http://www.cdc.gov/injury/about/focus-rx.html
Centers For Disease Control

The Partnership at Drugfree.org
http://www.drugfree.org/
Working toward a vision where all young people will be able to live their lives free of drug or alcohol abuse.

Get Smart About Drugs
http://www.getsmartaboutdrugs.com/
DEA sponsored website to educate parents

Teens and Parents

AwareRx Get informed. Prescription drug safety.
http://www.awarerx.org/
National Association of Boards of Pharmacy offers authoritative resources about medication safety, prescription drug abuse, medication disposal, and sa

Wake up now. "In Your Face" Information
http://www.wakeupnow.org/
Educational campaign established by The Pain Truth, a Florida 501(c)(3), to combat the increase in prescription drug abuse among teenagers.

Educators

Free information kit for educators
http://www.drugfreeworld.org/freeinfo.html
The Foundation for a Drug-Free World is a nonprofit public benefit corporation that empowers youth and adults with factual information about drugs so tl

Free prescription drug abuse education materials for middle school and high school students
http://www.neahin.org/rxforunderstanding/
National Education Association Health Information Network. Shipping costs apply.

Free School Tool Kit for middle and high school students
http://www.nasn.org/

Pharmacists

White House Office of National Drug Control Policy
http://www.whitehouse.gov/ondcp/prescription-drug-abuse
Overview of the prescription drug abuse problem by the White House.

National Institute on Drug Abuse
http://www.drugabuse.gov/drugs-abuse/prescription-drugs-cold-medicines

Prescription Medication Overdose
http://www.cdc.gov/homeandrecreationalsafety/rxbrief/
Centers For Disease Control and Prevention policies overview

Treatment

Seeking Drug Abuse Treatment: Know What To Ask
http://www.drugabuse.gov/publications/seeking-drug-abuse-treatment-know-what-to-ask/introduction
The National Institute on Drug Abuse (NIDA)

Time to get help: Support for parents of a child struggling with drugs and alcohol
http://www.drugfree.org/
By bringing together renowned scientists, parent experts and communications professionals, The Partnership at Drugfree.org translates the science of teen drug use and addictior teens and young adults.

Treatment facilities
http://www.dhcs.ca.gov/provgovpart/Pages/SUD-Directories.aspx
California Department of Healthcare Services

This web site contains PDF documents that require the most current version of Adobe Reader to view. To

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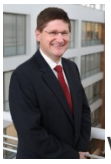
Attachment 10

A reminder of the promise and limitations of abuse-deterrent properties

Posted on **July 24, 2014** by **FDA Voice**

By: Douglas C. Throckmorton

The ongoing growing amount of drug abuse in our nation, particularly with prescription pain relievers known as opioids, has prompted a lot of talk about the potential of opioids with “abuse-deterrent” properties to help combat this public health problem. But care must be taken in putting too much promise into abuse-deterrent technology at this time because the science is still relatively new and evolving.

 While the FDA strongly supports the development of products with effective abuse-deterrent properties and believes they can make a real difference, abuse-deterrent properties do not make an opioid impossible to abuse, and do not prevent overdose and death – they only makes certain kinds of abuse more difficult or less rewarding.

Current abuse-deterrent technologies tend to focus on making the drug either harder to crush, which makes them harder to snort or inject; harder to extract, which means the opioid cannot be easily separated from the other ingredients in the drug for purposes of abuse; more difficult to abuse orally, which is the most common form of opioid abuse; or less attractive for abuse (e.g., the drug may contain an ingredient that counteracts the action of the opioid, making the drug less “likeable” or even unpleasant).

This week, FDA approved a new prescription opioid tablet called Targiniq ER, which contains a combination of the opioid pain medicine oxycodone and a drug called naloxone, an opioid antagonist. Naloxone can block the euphoric effects of opioid medicines and is

used most often to treat an overdose. The science behind this particular abuse-deterrent formulation works like this: If the Targiniq ER tablet is taken as directed (i.e., swallowed according to its approved use), the naloxone will not interfere with the oxycodone. If, however, the tablets are crushed into a powder and snorted or injected, the naloxone inside the tablet will be absorbed and block the desired effect from the oxycodone.

Targiniq ER joins OxyContin (oxycodone) as the second drug FDA has approved with labeling describing the product's abuse-deterrent properties consistent with FDA's 2013 draft guidance for industry *Abuse-Deterrent Opioids –Evaluation and Labeling* which states that for claims to be made, they must be based on robust, compelling, and accurate data and analysis, and the description of the abuse-deterrent properties or potential to reduce abuse must be clearly and fairly communicated.

OxyContin gets its abuse-deterrent properties differently than Targiniq, by including ingredients that make the tablet hard to crush or dissolve. Efforts to pulverize the tablets into a powder result in a chemical reaction that makes the crushed tablet into a gooey gel that makes it more difficult to be inhaled or injected the way drug abusers would like. While Targiniq and OxyContin use different abuse-deterrent technologies, they serve the same purpose: they are expected to help deter the often lethal practice of snorting or injecting prescription drugs.

In the context of this important and evolving area of science, FDA is very encouraged to see another drug with proven abuse-deterrent properties come to the market. We do need to remember that "abuse-deterrent" is not the same as "abuse-proof" and even abuse-deterrent formulations can be abused and people who take them can overdose and die. For example, someone who wants to "get high" from prescription opioids can still swallow more than the prescribed amount, and this simple but common form of abuse can result in overdose and death.

Currently available products with abuse-deterrent properties are an important step in the right direction, but there is much more work to be done. The technologies involved in abuse deterrence and methods for evaluating whether those technologies actually deter abuse are rapidly evolving. To address this rapid change, FDA is working with many drug makers to advance the science of abuse deterrence and to help them navigate the regulatory path to market as quickly as possible. While FDA strongly supports a transition to opioids with abuse-deterrent properties, we do not believe it is feasible or in the interest of public health at this time to require all opioid products to have such properties.

To help support the safe use of all opioid products, FDA is working in many other ways to help prescribers and patients make the best possible choices about how to use these powerful drugs. Our goal is to find the balance between appropriate access to opioids for patients with pain and the need to reduce the tragedies of their abuse and misuse.

Douglas Throckmorton, M.D., is Deputy Center Director for Regulatory Programs in FDA's Center for Drug Evaluation and Research

Who's Got A Heroin Addiction? White, Older, Non-Urbanites Who Are Practiced Users Of Prescription Opioids

Medical Daily
By **Susan Scutti** | May 28, 2014 04:00 PM EDT

Heroin is now a mainstream drug occurring in more suburban and rural areas among white males... and females. Photo courtesy of **Shutterstock**.

For years, heroin carried the stigma of being a lethal street drug abused mostly by an inner city crowd of poor minorities with an added dash of artist-hipsters thrown in for good measure; the musicians Miles Davis and Chet Baker as well as beat writer William S. Burroughs were all well-known junkies. Yet anecdotal evidence over the past few years suggests the highly addictive drug has undergone a sea change and now sports an entirely new reputation. Based on a retrospective analysis of the past 50 years, Dr. Theodore J. Cicero and his research team found the face of heroin has indeed changed, at least among those seeking treatment for their addiction. The current population of users surveyed in his new study included more whites than in previous generations, with a majority of users (75 percent) coming to heroin after first using prescription opioids.

"Our data just serves as a warning that heroin has become a mainstream drug ... occurring in more suburban and rural areas among white males *and* females," Cicero told *Medical Daily*.

Then and Now

The **Foundation for a Drug-Free World** counts 9.2 million people worldwide as users of heroin, a drug known for its treacherous withdrawal symptoms. Estimates range from 153,000 to 900,000 current heroin users within the U.S. For the current study, the researchers analyzed data from an ongoing nationwide survey of heroin users who had entered substance abuse treatment programs and agreed to anonymously answer questions as part of the Researched Abuse, Diversion and Addiction-Related Surveillance (**RADARS**) System. Of the 9,346 opioid-dependent patients, all over the age of 18, who agreed to complete the survey, 2797 reported heroin as their primary drug of abuse (the drug used most frequently in the past month). In addition to the surveys, collected between 2010 and 2013, the researchers conducted interviews with a subset of 54 patients.

Cicero's motivation to perform a retrospective analysis was simple. "We had been monitoring opiate abuse for the past 15 years or so, we noticed that a sharp increase in the number of people who said they'd taken heroin in the last 30 days," Cicero told *Medical Daily*. He and his team had become aware of media reports as well as anecdotal evidence of a changing demographic of users so they set to work in an attempt to better understand the problem.

Crunching the numbers, they soon discovered about 83 percent of respondents who began using heroin in the 1960s were young men at an average age of 16.5 years old. Among these old-time users, the first opioid of abuse was heroin for roughly 80 percent. By comparison, more recent heroin users are older (an average age of about 23), non-city dwellers (75 percent), and their first opioids are prescription drugs (75 percent). Prior to the 1980s, whites and nonwhites were equally represented among first-time users, but nearly 90 percent of users who began on heroin in the years since 2003 are white.

"Heroin is attractive now because it is accessible and cheap," Cicero explained. People are becoming addicted to pharmaceutical opioids, whether sold on the street or through some valid prescription. Then, when they run out of money to buy these expensive drugs, they often turn to cheaper heroin, which has lost its stigma and is increasingly available. "All the data suggests the number (of opioid addiction) is increasing, but none of us have a fix on what that number may be." Seemingly, then, more heroin users are in the making.

"They find it more acceptable and that's a very scary development," Cicero said. One reason for his fears being a greater degree of uncertainty with heroin. "People are leaving the safety of prescription drug ... and taking some powder form of heroin for which they have no idea how pure it is or how adulterated it is," Cicero commented. "It could be five percent or 10 percent purity. It makes a huge difference when injecting it." Compared to prescription drug abusers, heroin users are at greater risk of overdose, plus all the dangers surrounding injection: infections, needle sharing leading to HIV and hepatitis C, and a range of other medical complications.

"This is a very ominous development that people need to be aware of," Cicero concluded.

Source: Cicero TJ, Ellis MS, Surratt HL, Kurtz SP. The changing face of heroin use in the United States: a retrospective analysis of the past 50 years. *JAMA Psychiatry*. 2014.

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Down The Rabbit Hole: A Chronic Pain Sufferer Navigates The Maze Of Opioid Use

A woman living with chronic pain tries to manage her condition while maneuvering through the maze of opioid medications.

BY JANICE LYNCH SCHUSTER

I have never been one to visit my primary care physician regularly. For many years I kept healthy, with periodic visits to local urgent care facilities for my minor health care woes. By fifty, though, I had accumulated my share of problems and had found my way to specialists who could help me along: an orthopedist for my arthritic knees; an ear, nose, and throat doctor for my poor hearing; and a dermatologist for occasional instances of squamous cell cancer. Even so, I considered myself to be among the mostly well.

But in the winter of 2013 I began to experience a terrible and persistent pain in my tongue. It alternately throbbed and burned, and it often hurt to eat or speak. The flesh looked red and irritated, and no amount of Orajel or Sensodyne relieved it. I paid a rare visit to my doctor, who suggested I see my dentist, who, in turn, referred me to an oral surgeon. He thought the problem was a result of my being "tongue-tied," a typically harmless condition in which the little piece of tissue under the tongue, called the frenulum, is too short, limiting the tongue's range of motion. It seems I have always had this, but had never noticed because it hadn't affected my ability to eat or speak. Now things had changed. The doctor recommended I undergo a frenectomy, a procedure to remove the frenulum and relieve tension on the tongue.

"Just a snip," he promised.

It sounded trivial, and I was eager to be done with it. Although I make a living writing about health care, I didn't even bother to Google the procedure. It never occurred to me that "a snip" might entail some risks. I trusted the oral surgeon. His medical and dental degrees gave me confidence in his skills and knowledge.

And so in March 2013, a day before I was due to travel to Chicago for a weeklong business conference, I went in for the frenectomy. I sat back in the dental chair and, as I have always done, closed my eyes lest I catch sight of what I imagined must be an exceedingly long novocaine needle.

My calming thoughts ended abruptly with the first novocaine shot, dead center in the floor of my mouth. I nearly fainted with pain. By the second shot, I was in tears, grasping the surgical aide's hand in distress.

The procedure began and although my mouth was numb, the slicing sounds of the cut made me anxious. It felt as if the oral surgeon was, in fact, slicing my entire tongue away. When I thought the ordeal was surely over, it proved to be only halfway there, as he still had to sew up the wound—a task that required several stitches to the underside of the tongue itself. The oral surgeon and I were both surprised at how painful the process had been for me. Even when he was done, I continued to cry.

He prescribed routine follow-up care:

Illustration by Brett Ryder

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salt water rinses and an antibiotic. And Percocet, a fairly common painkiller, for when the numbness wore off.

Down The Rabbit Hole

I had optimistically expected to be back to normal in time for my flight to Chicago the next morning. But that evening, when the novocaine wore off, the intense pain returned. I took the Percocet. When that didn't help, I added aspirin and then dutifully swished with warm salt water, all to no avail. I called the oral surgeon to explain that my mouth was killing me. He prescribed Norco, a slightly stronger medication than Percocet, and I picked it up from the pharmacy. Norco was a bad match. It left me itching from head to toe. On my way to the airport the next day, I stopped at the CVS to get yet another prescription painkiller, but this one made me vomit. I boarded my flight anyway, certain that I'd feel better at any moment.

But over the next few days, the pain worsened. It was a combination of sensations, alternating between the feeling that I had scalded my tongue, bitten down on it hard, or pierced it with something sharp. No matter what I did, it hurt. In the ensuing days, my oral surgeon called in a variety of medications, none of which helped. I managed to get through my talk at the conference by sucking on ice chips.

Later the following week, still in terrible pain, I went back to the oral surgeon, whose colleague suspected that an undissolved stitch was triggering my pain, and removed it. That didn't help, either.

The Root Of The Problem: Nerve Damage

Though I did not know it then, my misery had just begun. In the ensuing months I would become one of the estimated 100 million American adults who live with chronic pain. In my case, the pain was eventually characterized as neuropathy: pain caused by nerve damage. Although the course of neuropathic pain varies by source and mechanism, and treatments range from sophisticated surgical interventions to massage, the outcome is often the same: The chronic pain itself becomes an affliction to be treated, in addition to whatever

injury or condition caused it in the first place.

Invisible pain is hard for others to understand. If I'd broken my leg, for instance, I could have propped up my foot or limped around on crutches. Neuropathic pain is far less evident. As far as oral pain goes, there is little to be done. And little, really, can be done, to let others know you suffer from mouth pain. Yet such pain is constant: You cannot simply put your tongue up or not use it for a while.

Severe chronic pain can make life itself a test of endurance and will. People who suffer from chronic pain—and who turn to physicians to heal it—often discover that some clinicians view us with skepticism or disbelief. At times we are reduced to begging for help. Even then, many of us are dismissed as drug-seeking addicts.

For several weeks after my return from Chicago, I was in nearly daily contact with the oral surgeon, who said again and again that he had not heard of a patient experiencing such pain as a consequence of a lingual frenectomy. And yet when I began to Google relevant terms—tongue damage, tongue pain, frenectomy, and so on—I found repeated references to the kinds of damage that can occur. Eventually, I joined a closed group on Facebook, where I met a few hundred other people who were suffering from mouth pain, triggered for the most part by routine oral surgeries.

I had now entered the maze of pain management, where getting effective medication that I could tolerate, and an adequate supply, itself became a constant struggle.

At one point, when my oral surgeon was away for a week, his assistant refused to call in a refill of pain medication. This was in 2013, before newer regulations were enacted that would have prohibited such a prescription from being called in. According to the surgeon's electronic records, I already had been prescribed a veritable pharmacy of pain meds and had received more than 100 pills over the course of the month. The electronic record did not include my bad reactions to several of these, nor that I could not take them as prescribed.

The surgeon's assistant finally agreed to order a refill once I had returned any unused medications to the office or to the pharmacy. Unfortunately, it turned out that the office could not accept my unused pills, nor could CVS, which had no collection mechanism in place. The pharmacist did, finally, call the doctor to verify that I had at least tried to return the pills. Finally, the new prescription was filled.

More than a month after my surgery, the pain had become even worse. Some days I could hardly get out of bed; I was so incapacitated by pain and its companion, despair. The oral surgeon called on his colleagues and, eventually, I wound up at the University of Maryland School of Dentistry, seen by an oral surgeon who specializes in oral and maxillofacial surgery.

He injected two points in my jaw with novocaine. The relentless pain subsided almost immediately—an indication that, in fact, the pain was originating somewhere in the tongue itself, and not in my brain.

The surgeon told me he suspected that an errant stitch had wrapped around a nerve in my tongue. Although exploratory surgery was possible, he said, it was unwise, as the nerves were so small and the process so likely to cause more damage. Left on their own, he continued, the nerves might heal in twelve or eighteen months. He suggested I find a neurologist to explore appropriate treatments.

Eventually, I found one who could actually see me, but I was dismayed when she handed me a few samples of antidepressants and antiseizure drugs, both indicated for the treatment of neuropathic pain but both likely to cause troublesome side effects. It was up to me to

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Policy Checklist

The issue: Chronic pain and its management are a major public health problem, exacting an enormous physical, emotional, and financial toll on patients. Complicating the matter is the widespread opioid abuse epidemic, which challenges law enforcement and threatens patient access. Policies that alleviate the stigma on patients with chronic pain, and strategies for understanding the mechanisms of pain and how to manage it, are essential.

Resources:

American Academy of Pain Management, http://www.aapainmanage.org/

American Society of Anesthesiologists, https://www.asahq.org/

Pain and Policy Studies Group, http://www.painpolicy.wisc.edu/

Related reading:

Federation of State Medical Boards. "Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain." Washington (DC): Federation of State Medical Boards; 2013 Jul [cited 2014 20 May]. Available from: http://www.painpolicy.wisc.edu/sites/www.painpolicy.wisc.edu/files/FSMB_pain_policy_july2013.pdf

Imhof S, Kaskie B. "How Can We Make the Pain Go Away? Public Policies to Manage Pain at the End of Life." Gerontologist. 2008;48(4):423–31.

Institute of Medicine. Relieving Pain in America: *A Blueprint for Transforming Prevention, Care, Education, and Research*. Washington (DC): National Academies Press, 2011.

McNicol ED, Midbari A, Eisenberg E. "Opioids for Neuropathic Pain." Cochrane Database Syst Rev. 2013 Aug 29;8:CD006146.

Noble M, Treadwell JR, Tregear SJ, Coates VH, Wiffen PJ, Akafomo C, et al. "Long-Term Opioid Management for Chronic Noncancer Pain." Cochrane Database Syst Rev. 2010 Jan 20;(1):CD006605.

select which I'd prefer—a choice that worried me, since neither seemed a good solution. I saw another neurologist, who suggested a trial of Cymbalta, an antidepressant that might lift my mood and relieve my pain. It could take six weeks to kick in.

And so, week after week, I continued to see my own oral surgeon, who would dutifully examine my tongue and lament my ongoing need for painkillers. I had told him about my lifelong problems with depression and my ongoing treatment for it, and he was concerned that I might be predisposed to addiction. I assured him that the opioids had no salutary effect on me—I certainly didn't feel euphoric, as some apparently do—other than to take the edge off the pain long enough for me to get through each day.

Risks And Benefits Of Opioids

Like most US clinicians, my oral surgeon and other health care providers have reason to be concerned about the safety of long-term use of opioid analgesics, such as Percocet and OxyContin. First touted as a godsend for the management of severe and chronic pain when the Food and Drug Administration (FDA) approved it in 1995, OxyContin has since become a widely abused medication. Contrary to claims by leading advocates for better pain management, OxyContin can, in fact, lead to addiction. It undoubtedly leads to physical dependence, and those who take it routinely cannot simply quit.

In the mid-1990s Russell Portenoy emerged as a champion of opioids for use in managing moderate-to-severe pain for a range of medical conditions. Until then, they had been used almost exclusively for advanced cancer. Portenoy pointed to research that, he claimed, indicated that patients would not abuse opioids but would limit their use to managing pain. Today's opioid epidemic tells a different story.

Since the introduction of these drugs, there is no denying that millions of suffering Americans now have more effective options for pain management. But the cost of this improvement has been the emergence of a widespread public health crisis of addiction and fatal overdoses. Figures from the Centers for Disease Control and Prevention (CDC) indicate that in 2010 some twelve million Americans were using prescription painkillers without a prescription. The CDC reported that in 2008 painkillers played a role in as many as 15,000 overdose deaths—more than heroin and cocaine combined. In addition, as regulations have been tightened to control OxyContin and other prescription painkillers, more and more people have resorted to heroin and other illicit drugs.

In the fall of 2013 the FDA took back-to-back actions that reflect our confused national response to opioids. On October 24, 2013, the director of the FDA's Center for Drug Evaluation and Research announced that the agency would recommend tightening regulations that govern how hydrocodone is prescribed, making it harder for people to acquire it. The very next day the FDA approved a new extended-release opioid, Zohydro ER—despite recommendations by its own technical advisory committee that the drug presented such significant risk of abuse that it should not be approved.

In the realm of chronic pain, such competing and conflicting aims are the norm. Pain patients like me often feel trapped between the clinical need to treat and manage pain and the social imperative to restrict access to such drugs and promote public safety.

Widespread access to opioids for every single ache and pain is clearly not the answer. In a 2011 report the Institute of Medicine (IOM) calls pain management a "national challenge" that will require "cultural transformation" in terms of researching pain to understand its scope, particularly in terms of its underdiagnosis and undertreatment. Among the IOM's recommendations are that providers and patients alike receive more education on the ways in which biology and psychosocial factors affect the experience of pain. For me, understanding and accepting those factors has not done much to alleviate the day-to-day experience of pain.

The IOM also recommends that providers "tailor care to each person's experience" and promote self-management of pain, which could include strategies such as keeping a pain journal; monitoring pain triggers; and learning coping

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strategies, such as meditation and yoga. Experts also recommend that primary care doctors coordinate care and treatment with pain specialists. When my primary care doctor dismissed my symptoms, I wound up trying to organize and coordinate my care as I journeyed among my oral surgeon, neurologists, pain experts, primary care, and psychiatry. It was more complicated than I could manage. During a two-week period last summer, I wound up in the emergency department four or five times because of adverse reactions to several medications.

One of these visits occurred early in the course of my ordeal, after I had a severe reaction to Cymbalta. I had not been warned that it could make me photo sensitive, and, as a fair-skinned person, I was at even greater risk for this. When I erupted in giant welts, I called my dermatologist, perplexed by what was happening. As I sat in her examining room, I fainted, and she called 911.

It was terrifying to leave the dermatologist's office on a gurney. I remember the cool rain that fell and how the EMTs shielded my face from it. I remember their urgency and their calm as they got an IV going and tried to get my vital signs back to normal.

At the hospital, the ED doctor stood near my head, patting my arm as he looked at my chart, then saying, "I see that you are in chronic pain."

"I am," I said, crying.

"And are you depressed?" he asked. "Because I have never met a pain patient who was not."

Pain sufferers like me swim against two tides: the pain itself and the experience of seeking treatment for the pain.

To be sure, the complex interplay of mind and body affects how one experiences pain, as well as how it is treated. No doubt, clinical depression simply makes one feel worse and makes it even more difficult to try alternative and complementary pain treatments. In my case, I had little energy for anything.

Waiting For Better Days

I have since explored alternative therapies: herbal remedies, guided meditation, journaling, exercise. These lift my spirits but do not reduce the near-constant presence of pain.

There is still a chance that my pain will vanish—for instance, if the nerves do heal in the next few months. If they don't, then I have a lifetime ahead of me to adjust to this situation.

I do my best not to let pain run my life. Some days are better than others. I try to keep a sense of humor. Some days, though, are hard to endure, and I chide myself to be grateful that I am still standing.

Had I spent a moment or two researching the risks of the frenectomy, would I have avoided this experience? Perhaps. But now I have few choices but to live through it.

I am weary of this experience. When I am not overwhelmed by pain, or depressed by it, I am furious at the attitudes I encounter, especially among physicians and pharmacists. It has been stigmatizing and humiliating. The cost to my productivity has been steep, and the toll on my family has been high. I have spent countless hours in doctor's offices, and even more hours in bed. Some people find meaning in suffering, but I find none.

I read science news closely, hoping that some new non-narcotic pain treatment will yield better and more effective treatments that do not include the risk of abuse and addiction. In the meantime, though, pain sufferers like me swim against two tides: the pain itself and the experience of seeking treatment for the pain. Pain represents a complex nexus of mind and matter. Surely, for all our yearning to understand both, we can find better ways to ease the suffering and devise treatments and strategies that do more good than harm and that do not shame and stigmatize those who suffer. ■

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Heroin major focus of new WH drug strategy

http://thehill.com/regulation/administration/211728-white-house-unveils-new-drug-policy

By **Benjamin Goad** - 07/09/14 02:06 PM EDT

The White House on Wednesday rolled out a 2014 drug control strategy that targets the growing scourges of heroin and prescription drug abuse, while placing a premium on treatment programs over incarceration for offenders.

A the same time, the Obama administration remains firm in its view that marijuana is illegal in the eyes of the federal government, despite **President Obama's view** that pot is no more dangerous than alcohol.

The administration's stance on marijuana, now legal for recreational purposes in Colorado and Washington, is just one of a litany of thorny issues detailed in **the 102-page document.**

"Among those challenges are the declining perceptions of harm — and associated increases in use — of marijuana among young people," according to the Office of National Drug Control Policy (ONDCP) report, which contends those challenges "gained prominence" with the developments in Colorado and Washington.

Last August, the Justice Department laid out eight priorities that would guide the enforcement of federal laws, while allowing legal pot use to continue in those states. But the administration remains steadfast in its position that using marijuana remains a crime at the federal level.

The firm policy is out of touch with the growing number of Americans who support the drug's legalization, said Mason Tvert, spokesman for the Marijuana Policy Project.

"The drug czar's office is still tone deaf when it comes to marijuana policy," he said. "It appears to be addicted to marijuana prohibition."

The White House plan is far more concerned with the abuse of opioids, both in the form of heroin and prescription drugs like oxycodone, methadone and hydrocodone. In 2010 alone, some 16,600 Americans died in overdoses involving those drugs.

While heroin use remains relatively low, officials have seen a "troubling increase" in the drug's prevalence, with many abusers graduating from prescription pills to the needle.

The 2014 policy sets our a multipronged plan to address the rise in opioid abuse through a public education campaign and redoubled enforcement efforts — both domestically and in partnerships with authorities in Mexico — to crack down the illegal drug trade.

Also in the administration's crosshairs is the proliferation of synthetic drugs, such as "K2" and "Spice," which are often marketed as an alternative to marijuana but can be far more dangerous, federal officials say.

The White House has increasingly promoted treatment and alternative sentencing instead of jail time for people arrested for garden-variety drug use.

That strategy, defended in the 2014 plan, is embodied by the Justice Department's Smart on Crime Initiative. Through the program, the administration has dialed back charging policies for low-level nonviolent offenders, among other steps to promote sentencing reform and combat demographic disparities in the criminal justice system.

Acting Drug czar Michael Botticelli said Wednesday that the policy, "rejects the notion that we can arrest and incarcerate our

way out of the nation's drug problem."

"Instead, it builds on decades of research demonstrating that while law enforcement should always remain a vital piece to protecting public safety, addiction is a brain disorder — one that can be prevented and treated, and from which people recover," Botticelli said.

Read more: http://thehill.com/regulation/administration/211728-white-house-unveils-new-drug-policy#ixzz3714OlHan
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HEALTHCARE COST AND UTILIZATION PROJECT

Agency for Healthcare Research and Quality

STATISTICAL BRIEF #177

August 2014

Hospital Inpatient Utilization Related to Opioid Overuse Among Adults, 1993–2012

Pamela L Owens, Ph.D., Marguerite L. Barrett, M.S., Audrey J. Weiss, Ph.D., Raynard E. Washington, Ph.D., and Richard Kronick, Ph.D.

Highlights

- The rate of hospital stays involving opioid overuse among adults increased more than 150 percent between 1993 and 2012. By 2012, there were 709,500 total opioid-related hospital stays representing a rate of 295.6 stays per 100,000 population.
- In 1993, the national rate of hospital stays involving opioid overuse among adults was 116.7 per 100,000 population, with the highest rates in select subgroups: men (144.0 per 100,000 population), people aged 25–44 years (188.6 per 100,000 population), and people living in the Northeast (264.0 per 100,000 population).
- By 2012, hospital stays involving opioid overuse had increased by approximately 150 percent, with the largest rates of increase among subgroups with relatively lower rates in 1993 (women, people aged 85 years and older, and people living in the Midwest).
- In 2012, rates for various age groups were much more similar, the Northeast was no longer a notable outlier, and rates for men and women were nearly equal.
- Medicaid had the largest proportion of stays involving opioid overuse (43 percent) in 1993, but Medicare had the largest annual increase over time. By 2012, Medicaid and Medicare each were billed about one-third of all opioid-related stays.

Introduction

Opioids, or pain medications, are commonly used to manage pain associated with injury, illness, or following surgery. Opioids include both prescription pain medications, such as morphine, codeine, fentanyl, oxycodone, and hydrocodone, as well as illegal drugs such as heroin.[1] A variety of negative side effects can occur from opioid use, including vomiting, severe allergic reactions, and overdose.[2] In 2010, opioids, predominantly prescription medications, were estimated to be nonmedically used by more than 12 million people,[3] resulted in 425,000 emergency department visits,[4] and were related to approximately 17,000 deaths.[5,6]

Opioid overdose can occur for a variety of reasons, including accidental and deliberate misuse of a prescription (e.g., taking more doses than prescribed), taking medication prescribed for someone else, and combining opioids with other substances such as alcohol.[7] The U.S. Department of Health and Human Services has recognized opioid misuse and abuse as a significant public health issue.[8,9,10]

[1] Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA Opioid Overdose Prevention Toolkit. HHS Publication No. (SMA) 13-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.
[2] Ibid.
[3] SAMHSA. Results from the 2010 National Survey on Drug Use and Health: volume 1: summary of national findings. Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies; 2011. http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm#2.16. Accessed July 11, 2014.
[4] SAMHSA. The DAWN Report: Highlights of the 2011 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits. February 22, 2013. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. http://www.samhsa.gov/data/2k13/DAWN127/sr127-DAWN-highlights.pdf. Accessed July 15, 2014.
[5] Jones CM, Mack KA, Paulozzi LJ. Pharmaceutical overdose deaths, United States, 2010. Journal of the American Medical Association. 2013;309(7):657–9.
[6] Centers for Disease Control and Prevention (CDC). National Center for Injury Prevention and Control. CDC Vital Signs Fact Sheet: Opioid Painkiller Prescribing: Where you Live Makes a Difference. July 2014. http://www.cdc.gov/vitalsigns/pdf/2014-07-vitalsigns.pdf. Accessed June 30, 2014.
[7] SAMHSA. SAMHSA Opioid Overuse Prevention Toolkit. 2013.
[8] Food and Drug Administration. FDA's Efforts to Address the Misuse and Abuse of Opioids. Last updated April 9, 2014. http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm337852.htm. Accessed May 27, 2014.

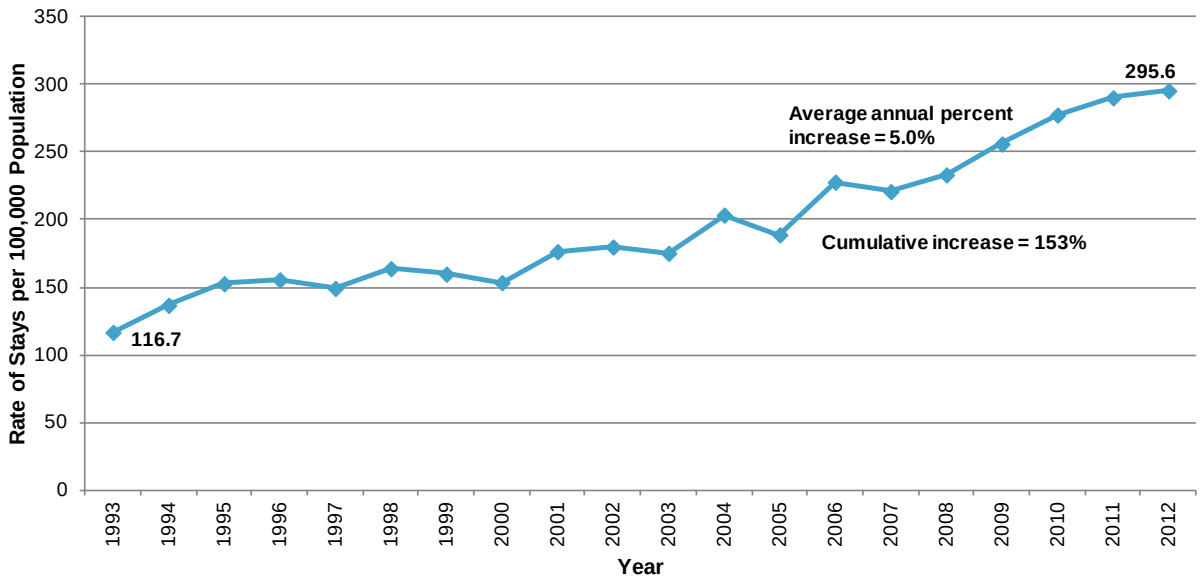
This HCUP Statistical Brief presents data on adult inpatient hospitalizations involving overuse of opioids, including opioid dependence, abuse, poisoning, and adverse effects. Hospitalizations that involved illegal drug use were excluded from this analysis. Trends in hospital inpatient stays related to opioid overuse among adults are presented along with characteristics of these types of stays. Differences between group rate estimates noted in the text are statistically significant at the 0.05 level or better and differ by at least 10 percent.

Findings

Trends in inpatient hospitalizations involving opioid overuse, 1993–2012

The trend in the rate of hospital inpatient stays involving opioid overuse from 1993 to 2012 is presented in Figure 1. The rate is calculated per 100,000 population aged 18 years and older.

Figure 1. Rate of hospital inpatient stays related to opioid overuse* among adults, 1993–2012



* Opioid overuse was identified using all-listed diagnoses.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Inpatient Sample (NIS), 1993–2012.

- **The rate of adult hospital inpatient stays related to opioid overuse increased, on average, by 5 percent annually.**

  The rate of inpatient stays that included a diagnosis of opioid overuse among adults aged 18 years and older increased more than 150 percent between 1993 and 2012, from 116.7 to 295.6 stays per 100,000 population. This represents an average increase of 5.0 percent per year. The percentage of stays with opioid overuse that were admitted from the ED increased from 43 percent in 1993 to 64 percent in 2005 and remained relatively constant from 2005–2012 (data not shown).

[9] SAMHSA. SAMHSA Opioid Overuse Prevention Toolkit. 2013.

[10] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Policy Impact: Prescription Painkiller Overdoses. November 2011. http://www.cdc.gov/HomeandRecreationalSafety/pdf/PolicyImpact-PrescriptionPainkillerOD.pdf. Accessed June 26, 2014.

Characteristics of inpatient hospitalizations involving opioid overuse, 1993–2012

Table 1 presents the number of hospital inpatient stays involving opioid overuse among adults in 2012 by patient sex, patient age, and hospital region. The rate of stays per 100,000 population is provided for 1993, 2000, 2006, and 2012. The average annual percentage change from 1993 to 2012 also is provided. Figures 2, 3, and 4 present the rate of hospital inpatient stays for opioid overuse by patient sex (Figure 2), adult age group (Figure 3), and hospital region (Figure 4) in 1993 and 2012.

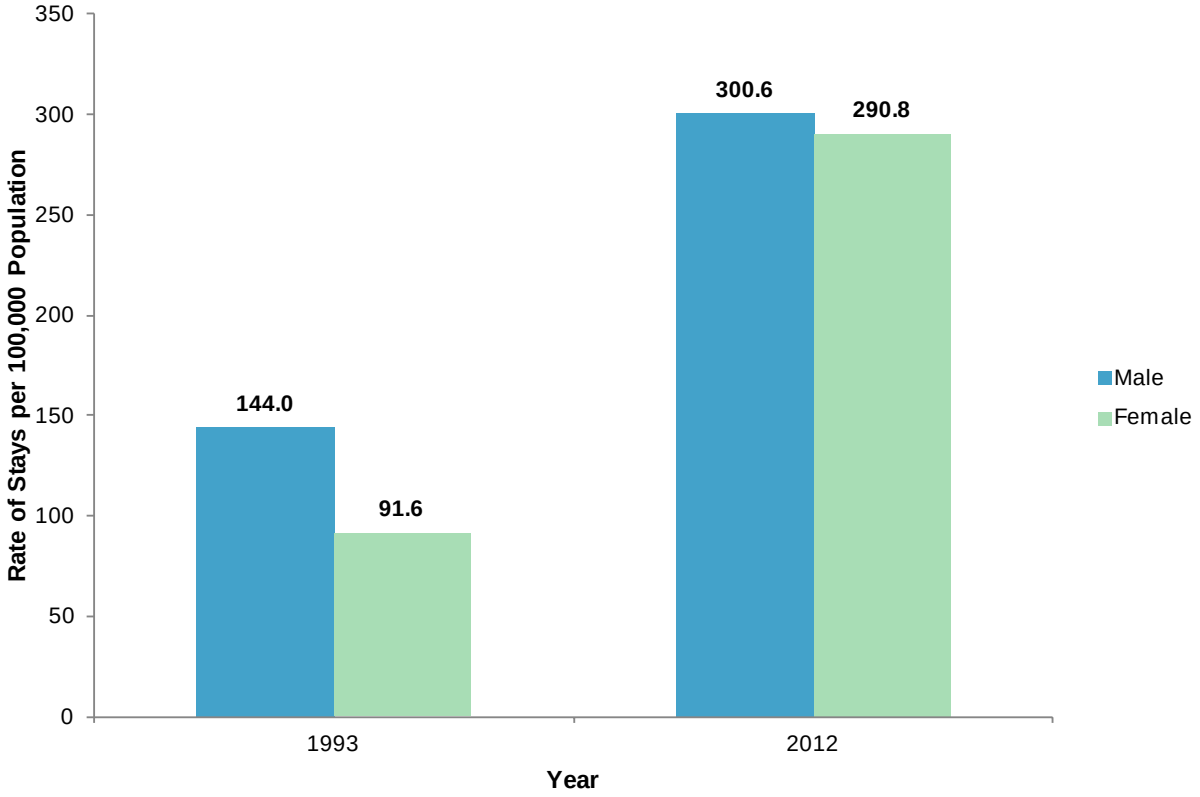
Table 1. Rate and change over time of hospital inpatient stays related to opioid overuse* among adults, 1993–2012

Characteristic	Number of inpatient stays, 2012	Rate of inpatient stays per 100,000 population				Average annual percentage change in rate of stays 1993–2012 (all years)
		1993	2000	2006	2012	
All U.S. adult stays	709,500	116.7	153.5	227.9	295.6	5.0
Patient sex						
Male	350,900	144.0	175.6	251.5	300.6	4.0
Female	358,600	91.6	132.8	205.6	290.8	6.3
Patient age						
18–24 years	69,500	70.7	86.0	133.2	221.8	6.2
25–44 years	258,300	188.6	205.7	272.7	312.3	2.7
45–64 years	280,000	66.6	150.9	255.5	338.1	8.9
65–84 years	86,000	46.0	81.9	144.1	230.8	8.9
85+ years	15,800	51.1	101.1	175.7	265.3	9.1
Hospital region						
Northeast	168,900	264.0	276.4	432.9	392.7	2.1
Midwest	163,700	61.3	168.0	209.9	320.8	9.1
South	223,100	94.0	98.5	169.6	254.0	5.4
West	153,900	79.1	120.1	170.6	281.9	6.9

* Opioid overuse was identified using all-listed diagnoses.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Inpatient Sample (NIS), 1993, 2000, 2006, and 2012

Figure 2. Rate of hospital inpatient stays related to opioid overuse* by patient sex, 1993 and 2012



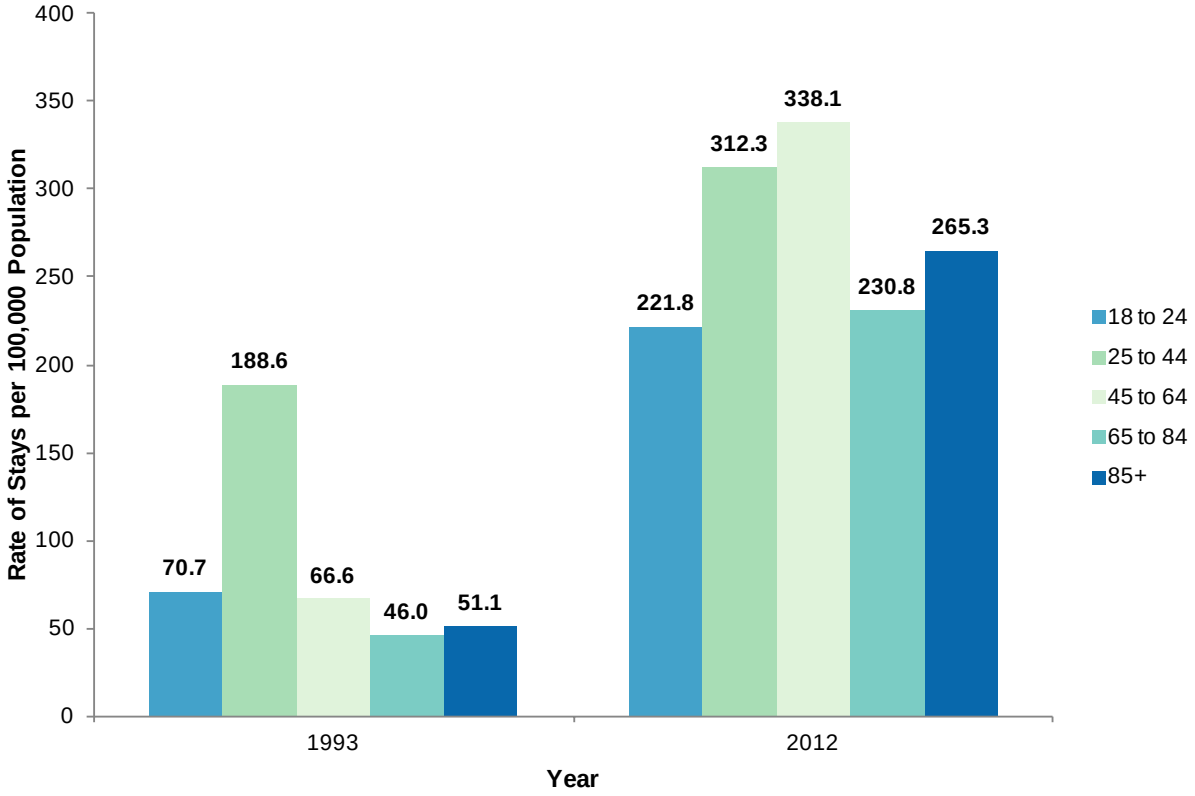
* Opioid overuse was identified using all-listed diagnoses.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Inpatient Sample (NIS), 1993 and 2012

- **In 1993, males had a higher rate of inpatient stays involving opioid overuse than females, but this difference in rates decreased over time.**

  In 1993, males had a higher rate of inpatient stays related to opioid overuse than did females (144.0 versus 91.6 stays per 100,000 population). However, the annual increase in inpatient stays related to opioid overuse was greater for females than males between 1993 and 2012 (6.3 versus 4.0 percent). By 2012, males and females had similar rates of inpatient stays involving opioid overuse (300.6 versus 290.8 stays per 100,000 population).

Figure 3. Rate of hospital inpatient stays related to opioid overuse* by adult age group, 1993 and 2012



* Opioid overuse was identified using all-listed diagnoses.

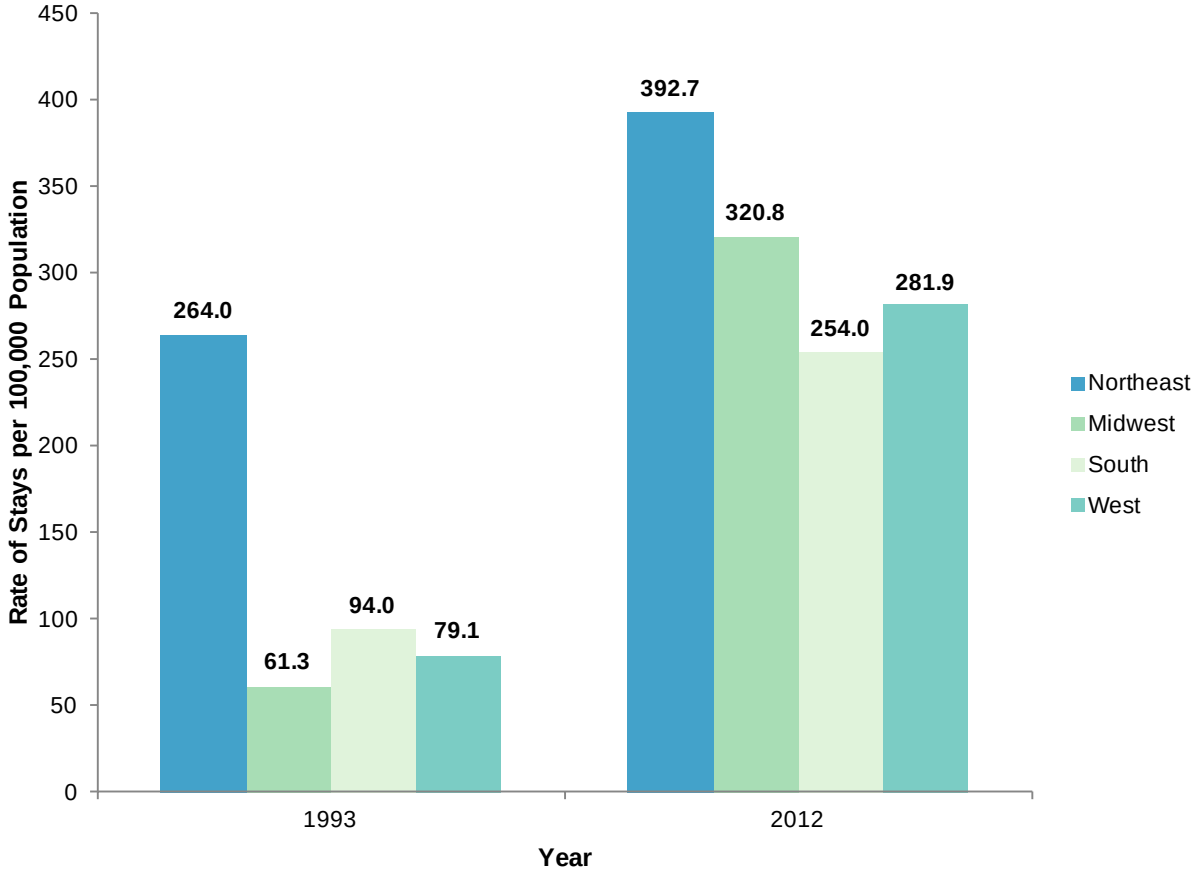
Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Inpatient Sample (NIS), 1993 and 2012

- **In 1993, the highest rate of opioid overuse was for patients aged 25–44 years; however, between 1993 and 2012, opioid overuse increased more for other age groups. The average annual increase was highest for adults aged 45 years and older.**

  In 1993, adults aged 25–44 years had the highest rate of hospital inpatient stays involving opioid overuse (188.6 stays per 100,000 population) compared with the other adult age groups. However, between 1993 and 2012, the average annual increase in the rate of hospital stays involving opioid overuse was lowest among adults aged 25–44 years (2.7 percent) and highest for adults aged 45 years and older (8.9 to 9.1 percent average annual percent change). By 2012, the rate of inpatient stays involving opioid overuse was similar among adults aged 25–44 years and 45–64 years, with over 300 stays per 100,000 population.

  From 1993 to 2012, the rate of hospital stays involving opioid overuse among adults aged 25–44 years increased by 1.7 times, while the rate increased more than 3-fold for adults aged 18–24 years and more than 5-fold for each of the three oldest age groups (45–64, 65–84, and 85+ years).

Figure 4. Rate of hospital inpatient stays related to opioid overuse* among adults by hospital region, 1993 and 2012



* Opioid overuse was identified using all-listed diagnoses.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Inpatient Sample (NIS), 1993 and 2012

- **In 1993, the Northeast had a rate of hospital stays for opioid overuse that was approximately 3–4 times higher than the other regions; however, by 2012 the differences diminished.**

  In 1993, the Northeast had the highest rate of adult hospital inpatient stays involving opioid overuse (264.0 stays per 100,000 population) compared with the other regions. However, between 1993 and 2012, differences between regions decreased. The Midwest had the largest average annual increase in the rate of hospital stays involving opioid overuse (9.1 percent) compared with the other regions. By 2012, the rate of inpatient stays involving opioid overuse had increased by 5.2 times in the Midwest, 3.6 times in the West, 2.7 times in the South, and 1.5 times in the Northeast. The rate of hospital stays for opioid overuse in the Northeast remained 1.4 to 1.5 times higher than rates in the West and South.

Inpatient hospitalizations involving opioid overuse by payer, 1993–2012
Table 2 presents the number of hospital inpatient stays involving opioid overuse by expected primary payer in 1993, 2000, 2006, and 2012. The average annual percentage change from 1993 to 2012 also is provided. Figure 5 presents the distribution of adult opioid-related and nonopioid-related hospital stays by payer in 1993 and 2012.

Unlike the previous table and figures, the values presented here for payer are based on the number of inpatient stays and not population rates. Population denominator data for payer-specific rates are difficult because HCUP discharges are categorized by the primary expected payer for the hospital service at the time of discharge, while population surveys capture the health insurance coverage over a specific time period such as the year.[11]

Table 2. Number and change over time of hospital inpatient stays related to opioid overuse* among adults by payer, 1993–2012

Characteristic	Number of inpatient stays				Average annual percentage change in number of stays 1993–2012 (all years)
	1993	2000	2006	2012	
Payer					
Medicare	30,900	59,500	116,800	211,200	10.6
Medicaid	95,600	130,700	181,800	226,600	4.6
Private insurance	41,500	72,900	104,100	154,400	7.2
Uninsured	43,800	44,900	86,500	82,100	3.4
Other	9,900	12,700	22,100	33,700	6.6

* Opioid overuse was identified using all-listed diagnoses.

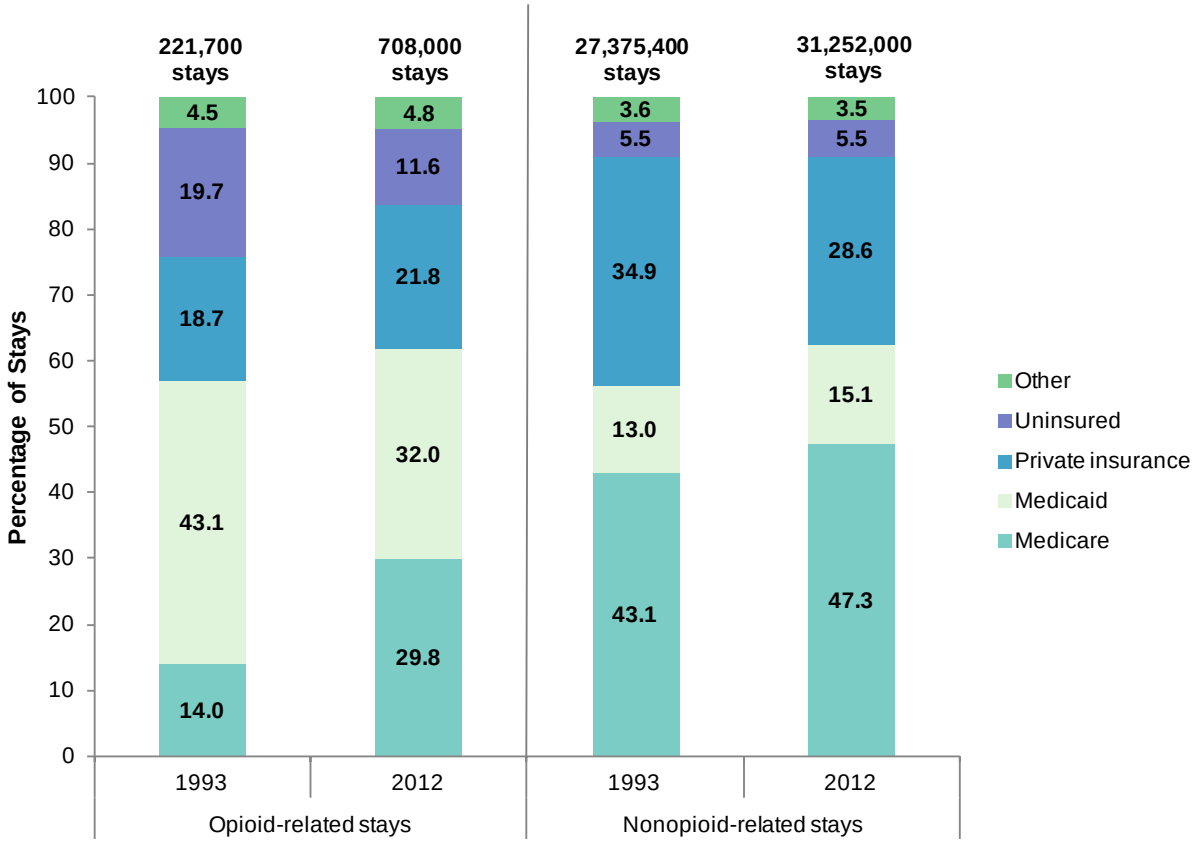
Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Inpatient Sample (NIS), 1993, 2000, and 2006, and 2012

- **In 1993, Medicaid was billed for more than twice as many stays involving opioid overuse as any other payer, but by 2012 these differences were diminished with the largest increase seen for patients covered by Medicare.**

  In 1993, Medicaid was billed for nearly 100,000 hospital stays involving opioid overuse—three times higher than the number of stays billed to Medicare and over twice as many stays as were billed to private insurance or to uninsured patients. However, Medicare had the most rapid growth in the number of hospital stays between 1993 and 2012, at 10.6 percent average annual growth, compared with the other payers, which had between 3.4 and 7.2 percent average annual increase.

[11] For more information on the differences between population estimates by insurance and HCUP discharge counts by expected payer, please refer to Appendix B of the HCUP Methods Series #2013-01 Population Denominator Data for use with HCUP Databases (Updated with 2012 Population data). http://www.hcup-us.ahrq.gov/reports/methods/methods.jsp. Accessed July 11, 2014.

Figure 5. Distribution of opioid-related* and nonopioid-related hospital inpatient stays among adults by payer, 1993 and 2012



* Opioid overuse was identified using all-listed diagnoses. The total number of stays in this figure is slightly below the count of all adult stays, because some discharge records are missing payer information.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Inpatient Sample (NIS), 1993 and 2012

- **The proportion of inpatient stays for opioid overuse billed to Medicaid decreased over time, while the proportion billed to Medicare more than doubled.**

  In 1993, Medicaid was the primary expected payer for the largest proportion (43.1 percent) of all adult hospital inpatient stays involving opioid overuse. By 2012, Medicaid and Medicare each constituted about one-third of opioid-related stays. For Medicare, the proportion of opioid-related stays more than doubled from 1993 to 2012 (from 14.0 to 29.8 percent), while the proportion of nonopioid-related stays increased by less than 10 percent (from 43.1 to 47.3 percent). For Medicaid, the proportion of opioid-related stays decreased by 26 percent (from 43.1 to 32.0 percent), while the proportion of nonopioid-related stays increased by 16 percent (from 13.0 to 15.1 percent).

  From 1993 to 2012, the proportion of opioid-related stays covered by private insurance increased from 18.7 to 21.8 percent, while the proportion of nonopioid-related stays decreased from 34.9 to 28.6 percent. The uninsured population constituted 19.7 percent of opioid-related stays in 1993 and 11.6 percent of opioid-related stays in 2012, but the uninsured population represented only 5.5 percent of all nonopioid-related stays in each year.

Data Source

The estimates in this Statistical Brief are based upon data from the Healthcare Cost and Utilization Project (HCUP) 1993–2012 Nationwide Inpatient Sample (NIS). The 2012 Nationwide Inpatient Sample is a preliminary analysis file derived from the HCUP State Inpatient Databases (SID) that was designed to provide national estimates using weighted records from a sample of hospitals from 44 States using the same methodology employed for the 1993–2011 Nationwide Inpatient Sample. It should be noted that the 2012 Nationwide Inpatient Sample (NIS), which uses a sampling approach based on hospitals, is a separate file from the 2012 National Inpatient Sample (NIS), which uses a sampling approach based on discharges. This analysis was limited to adult discharges aged 18 years and older. Supplemental sources included population denominator data for use with HCUP databases.[12]

Definitions

Diagnoses and ICD-9-CM

The *principal diagnosis* is that condition established after study to be chiefly responsible for the patient's admission to the hospital. *Secondary diagnoses* are concomitant conditions that coexist at the time of admission or develop during the stay. *All-listed diagnoses* include the principal diagnosis plus these additional secondary conditions. ICD-9-CM is the International Classification of Diseases, Ninth Revision, Clinical Modification, which assigns numeric codes to diagnoses. There are approximately 14,000 ICD-9-CM diagnosis codes.

The average number of secondary diagnoses reported on the hospital discharge record has increased over time, as illustrated in Table 3.

Table 3. Average number of secondary diagnosis codes on hospital discharge records, 1993–2012

Year	Average number of secondary diagnoses per hospital discharge record		Year	Average number of secondary diagnoses per hospital discharge record
1993	2.86		2003	4.45
1994	3.14		2004	4.70
1995	3.33		2005	4.98
1996	3.50		2006	5.35
1997	3.59		2007	5.75
1998	3.68		2008	6.34
1999	3.70		2009	6.71
2000	3.77		2010	7.10
2001	3.98		2011	7.76
2002	4.24		2012	7.93

[12] Barrett M, Lopez-Gonzalez L, Coffey R, Levit K. Population Denominator Data for use with the HCUP Databases (Updated with 2012 Population data). HCUP Methods Series Report #2013-01. Online. March 8, 2013. U.S. Agency for Healthcare Research and Quality. http://www.hcup-us.ahrq.gov/reports/methods/2013_01.pdf. Accessed December 13, 2013.

Case definition
Opioid overuse was identified using the ICD-9-CM diagnosis codes listed in Table 4, based on all-listed diagnoses on the hospital discharge record.

Table 4. ICD-9-CM diagnosis codes defining opioid overuse (inclusion criteria)

ICD-9-CM diagnosis code	Description
304.00	OPIOID DEPENDENCE-UNSPECIFIED
304.01	OPIOID DEPENDENCE-CONTINUOUS
304.02	OPIOID DEPENDENCE-EPISODIC
304.03	OPIOID DEPENDENCE, IN REMISSION
304.70	OPIOID OTHER DEP-UNSPECIFIED
304.71	OPIOID OTHER DEP-CONTINUOUS
304.72	OPIOID OTHER DEP-EPISODIC
304.73	OPIOID OTHER DEP-IN REMISSION
305.50	OPIOID ABUSE-UNSPECIFIED
305.51	OPIOID ABUSE-CONTINUOUS
305.52	OPIOID ABUSE-EPISODIC
305.53	OPIOID ABUSE-IN REMISSION
965.00	OPIUM POISONING
965.09	POISONING BY OTHER OPIATES AND RELATED NARCOTICS
E850.2	ACCIDENTAL POISONING BY OTHER OPIATES AND RELATED NARCOTICS
E935.2	OTHER OPIATES AND RELATED NARCOTICS CAUSING ADVERSE EFFECTS IN THERAPEUTIC USE

Hospital stays that included illegal drug use, as defined using the ICD-9-CM diagnosis codes in Table 5 and identified using all-listed diagnoses, were excluded.

Table 5. ICD-9-CM diagnosis codes defining illegal drug use (exclusion criteria)

ICD-9-CM diagnosis code	Description
965.01	HEROIN POISONING
969.6	PSYCHODYSLEPTIC POISONING
E850.0	ACCIDENTAL POISONING BY HEROIN
E854.1	ACCIDENTAL POISONING BY HALLUCINOGENS
E935.0	ADVERSE EFFECTS OF HEROIN
E939.6	ADVERSE EFFECTS OF HALLUCINOGENS

Average annual percentage change
Average annual percentage change is calculated using the following formula:

$$\text{Average annual percentage change} = \left[\left(\frac{\text{End value}}{\text{Beginning value}}\right)^{\frac{1}{\text{change in years}}} - 1\right] \times 100$$

Types of hospitals included in HCUP
HCUP is based on data from community hospitals, which are defined as short-term, non-Federal, general, and other hospitals, excluding hospital units of other institutions (e.g., prisons). HCUP data include obstetrics and gynecology, otolaryngology, orthopedic, cancer, pediatric, public, and academic medical hospitals. Excluded are long-term care, rehabilitation, psychiatric, and alcoholism and chemical dependency hospitals. However, if a patient received long-term care, rehabilitation, or treatment for psychiatric or chemical dependency conditions in a community hospital, the discharge record for that stay will be included in the Nationwide Inpatient Sample (NIS).

Unit of analysis
The unit of analysis is the hospital discharge (i.e., the hospital stay), not a person or patient. This means that a person who is admitted to the hospital multiple times in one year will be counted each time as a separate "discharge" from the hospital.

Payer
Payer is the expected primary payer for the hospital stay. To make coding uniform across all HCUP data sources, payer combines detailed categories into general groups:

- Medicare: includes patients covered by fee-for-service and managed care Medicare
- Medicaid: includes patients covered by fee-for-service and managed care Medicaid
- Private Insurance: includes Blue Cross, commercial carriers, and private health maintenance organizations (HMOs) and preferred provider organizations (PPOs)
- Uninsured: includes an insurance status of "self-pay" and "no charge"
- Other: includes Worker's Compensation, TRICARE/CHAMPUS, CHAMPVA, Title V, and other government programs.

Hospital stays billed to the State Children's Health Insurance Program (SCHIP) may be classified as Medicaid, Private Insurance, or Other, depending on the structure of the State program. Because most State data do not identify SCHIP patients specifically, it is not possible to present this information separately.

When more than one payer is listed for a hospital discharge, the first-listed payer is used.

Region
Region is one of the four regions defined by the U.S. Census Bureau:

- Northeast: Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, and Pennsylvania
- Midwest: Ohio, Indiana, Illinois, Michigan, Wisconsin, Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, and Kansas
- South: Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida, Kentucky, Tennessee, Alabama, Mississippi, Arkansas, Louisiana, Oklahoma, and Texas
- West: Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada, Washington, Oregon, California, Alaska, and Hawaii

About HCUP

The Healthcare Cost and Utilization Project (HCUP, pronounced "H-Cup") is a family of health care databases and related software tools and products developed through a Federal-State-Industry partnership and sponsored by the Agency for Healthcare Research and Quality (AHRQ). HCUP databases bring together the data collection efforts of State data organizations, hospital associations, private data organizations, and the Federal government to create a national information resource of encounter-level health care data (HCUP Partners). HCUP includes the largest collection of longitudinal hospital care data in the United States, with all-payer, encounter-level information beginning in 1988. These databases enable research on a broad range of health policy issues, including cost and quality of health services, medical practice patterns, access to health care programs, and outcomes of treatments at the national, State, and local market levels.

HCUP would not be possible without the contributions of the following data collection Partners from across the United States:

Alaska State Hospital and Nursing Home Association
Arizona Department of Health Services
Arkansas Department of Health
California Office of Statewide Health Planning and Development
Colorado Hospital Association
Connecticut Hospital Association

Florida Agency for Health Care Administration
Georgia Hospital Association
Hawaii Health Information Corporation
Illinois Department of Public Health
Indiana Hospital Association
Iowa Hospital Association
Kansas Hospital Association
Kentucky Cabinet for Health and Family Services
Louisiana Department of Health and Hospitals
Maine Health Data Organization
Maryland Health Services Cost Review Commission
Massachusetts Center for Health Information and Analysis
Michigan Health & Hospital Association
Minnesota Hospital Association
Mississippi Department of Health
Missouri Hospital Industry Data Institute
Montana MHA - An Association of Montana Health Care Providers
Nebraska Hospital Association
Nevada Department of Health and Human Services
New Hampshire Department of Health & Human Services
New Jersey Department of Health
New Mexico Department of Health
New York State Department of Health
North Carolina Department of Health and Human Services
North Dakota (data provided by the Minnesota Hospital Association)
Ohio Hospital Association
Oklahoma State Department of Health
Oregon Association of Hospitals and Health Systems
Oregon Health Policy and Research
Pennsylvania Health Care Cost Containment Council
Rhode Island Department of Health
South Carolina Revenue and Fiscal Affairs Office
South Dakota Association of Healthcare Organizations
Tennessee Hospital Association
Texas Department of State Health Services
Utah Department of Health
Vermont Association of Hospitals and Health Systems
Virginia Health Information
Washington State Department of Health
West Virginia Health Care Authority
Wisconsin Department of Health Services
Wyoming Hospital Association

About Statistical Briefs

HCUP Statistical Briefs are descriptive summary reports presenting statistics on hospital inpatient and emergency department use and costs, quality of care, access to care, medical conditions, procedures, patient populations, and other topics. The reports use HCUP administrative health care data.

About the NIS

The HCUP National (Nationwide) Inpatient Sample (NIS) is a national (nationwide) database of hospital inpatient stays. The NIS is nationally representative of all community hospitals (i.e., short-term, non-Federal, nonrehabilitation hospitals). The NIS is a sample of hospitals and includes all patients from each hospital, regardless of payer. It is drawn from a sampling frame that contains hospitals comprising more than 95 percent of all discharges in the United States. The vast size of the NIS allows the study of topics at the national and regional levels for specific subgroups of patients. In addition, NIS data are standardized across years to facilitate ease of use.

About the SID

The HCUP State Inpatient Databases (SID) are hospital inpatient databases from data organizations participating in HCUP. The SID contain the universe of the inpatient discharge abstracts in the participating HCUP States, translated into a uniform format to facilitate multistate comparisons and analyses. Together, the SID encompass more than 95 percent of all U.S. community hospital discharges in 2009. The SID can be used to investigate questions unique to one State, to compare data from two or more States, to conduct market-area variation analyses, and to identify State-specific trends in inpatient care utilization, access, charges, and outcomes.

About HCUPnet

HCUPnet is an online query system that offers instant access to the largest set of all-payer health care databases that are publicly available. HCUPnet has an easy step-by-step query system that creates tables and graphs of national and regional statistics as well as data trends for community hospitals in the United States. HCUPnet generates statistics using data from HCUP's Nationwide Inpatient Sample (NIS), the Kids' Inpatient Database (KID), the Nationwide Emergency Department Sample (NEDS), the State Inpatient Databases (SID), and the State Emergency Department Databases (SEDD).

For More Information

For more information about HCUP, visit http://www.hcup-us.ahrq.gov/.

For additional HCUP statistics, visit HCUPnet, our interactive query system, at http://hcupnet.ahrq.gov/.

For information on other hospitalizations in the United States, refer to the following HCUP Statistical Briefs located at http://www.hcup-us.ahrq.gov/reports/statbriefs/statbriefs.jsp:

- Statistical Brief #166, Overview of Hospital Stays in the United States, 2011
- Statistical Brief #168, Costs for Hospital Stays in the United States, 2011
- Statistical Brief #162, Most Frequent Conditions in U.S. Hospitals, 2011
- Statistical Brief #165, Most Frequent Procedures Performed in U.S. Hospitals, 2011

For a detailed description of HCUP, more information on the design of the Nationwide Inpatient Sample (NIS), and methods to calculate estimates, please refer to the following publications:

Introduction to the HCUP Nationwide Inpatient Sample, 2009. Online. May 2011. U.S. Agency for Healthcare Research and Quality. http://hcup-us.ahrq.gov/db/nation/nis/NIS_2009_INTRODUCTION.pdf. Accessed December 13, 2013.

Introduction to the HCUP State Inpatient Databases. Online. August 2013. U.S. Agency for Healthcare Research and Quality. http://hcup-us.ahrq.gov/db/state/siddist/Introduction_to_SID.pdf. Accessed December 13, 2013.

Houchens R, Elixhauser A. Final Report on Calculating Nationwide Inpatient Sample (NIS) Variances, 2001. HCUP Methods Series Report #2003-2. Online. June 2005 (revised June 6, 2005). U.S. Agency for Healthcare Research and Quality. http://www.hcup-us.ahrq.gov/reports/CalculatingNISVariances200106092005.pdf. Accessed December 13, 2013.

Houchens RL, Elixhauser A. Using the HCUP Nationwide Inpatient Sample to Estimate Trends. (Updated for 1988–2004). HCUP Methods Series Report #2006–05. Online. August 18, 2006. U.S. Agency for Healthcare Research and Quality. http://www.hcup-us.ahrq.gov/reports/methods/2006_05_NISTrendsReport_1988-2004.pdf. Accessed December 13, 2013.

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AHRQ welcomes questions and comments from readers of this publication who are interested in obtaining more information about access, cost, use, financing, and quality of health care in the United States. We also invite you to tell us how you are using this Statistical Brief and other HCUP data and tools, and to share suggestions on how HCUP products might be enhanced to further meet your needs. Please e-mail us at hcup@ahrq.gov or send a letter to the address below:

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Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, MD 20850

COUNTY OF MARIN

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Promoting and protecting health, well-being, self-sufficiency, and safety of all in Marin County.

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

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PUBLIC HEALTH ADVISORY

July 10, 2014

New Community-wide Standards for Prescribing Opioid Pain Medications

There were 49 drug overdose deaths in Marin County in 2012, according to recently released California Vital Statistics data. This was the highest ever number of drug overdoses for Marin, and was more than four times the number of motor vehicle accident deaths in that year.

The number of prescriptions written for narcotics in Marin County more than doubled between 2004 and 2013. This mirrors national trends in prescribing patterns and correlates to increased drug overdoses and addiction services admissions.

To help address this emerging public health problem, Marin County Emergency Departments have adopted community-wide standards for prescribing opioid pain medicines. These are available below. The standards, collaboratively developed by all of Marin County's Emergency Departments, the Department of Health and Human Services, and Emergency Medical Services, are designed to balance the commitment to safe pain control with measures to limit the harm of prescription drug misuse. Because the majority of pain killer prescriptions are written in Primary Care settings, a similar set of standards will be developed in collaboration with Primary Care providers.

With a common understanding of what can be expected in opioid prescribing as a community, patients and providers can better coordinate care to ensure safe and effective pain management.

SAFE PAIN MEDICINE PRESCRIBING IN EMERGENCY DEPARTMENTS

- We care about you. We are committed to treating you safely.
- Pain relief treatment can be complicated. Mistakes or abuse of pain medicine can cause serious health problems and even death.
- Our emergency department is committed to providing safe pain relief options. Many types of pain can be safely and effectively managed without prescription medications.

For your SAFETY, we follow these rules when treating your pain:

1. We look for and treat emergencies. We use our best judgment when treating pain. These recommendations follow legal and ethical advice.
2. You should have only one provider and one pharmacy helping you with chronic pain. We do not usually prescribe pain medication if you already receive pain medicine from another health care provider.
3. If prescription pain medication is needed, we generally only give you a small amount.
4. We do not refill lost or stolen prescriptions. If your prescription is stolen, please contact the police.
5. We do not prescribe long-acting pain medicines: OxyContin, MSContin, Fentanyl (Duragesic), Methadone, Opana ER, Exalgo and others.
6. We do not provide missing doses of Subutex, Suboxone, or Methadone.
7. We do not usually give shots for flare-ups of chronic pain. Medicines taken by mouth may be offered instead.
8. Health care laws, including HIPAA, allow us to ask for your medical records. These laws allow us to share information with other health care providers who are treating you.
9. We may ask you to show a photo ID when you receive a prescription for pain medicines.
10. We use the California Prescription Drug Monitoring Program, called CURES. This statewide computer system tracks narcotic and other controlled substance prescriptions.

If you need help with substance abuse or addiction, call

(415) 755-2345

for confidential referral and treatment.

These standards were developed by Marin County Department of Health and Human Services, Marin County Emergency Medical Services and all Marin County hospital Emergency Departments.

Rx SAFE MARIN
MARIN COUNTY PRESCRIPTION DRUG MISUSE AND ABUSE INITIATIVE

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

COUNTY OF MARIN

If you are a person with a disability and require this document in an alternate format (example: Braille, Large Print, Audiotape, CD-ROM), you may request an alternate format by calling: (415) 473-4167(Voice)/(415) 473-3232 (TTY) or by e-mail at: cmai@marincounty.org

Massachusetts Department of Public Health

Findings of the Opioid Task Force and Department of Public Health Recommendations on Priorities for Investments in Prevention, Intervention, Treatment and Recovery

June 10, 2014

Executive Summary

In response to the growing opioid addiction epidemic in Massachusetts, and across the nation, Governor Patrick declared a public health emergency on March 27, 2014. The Governor directed the Department of Public Health (DPH) to take several actions to combat overdoses, stop the opioid epidemic from getting worse, help those already addicted to recover, and map a long-term solution to ending widespread opioid abuse in the Commonwealth. Per the Governor's directive, DPH utilized the Executive Committee of the Interagency Council on Substance Abuse and Prevention to create the Opioid Task Force (Task Force). This Task Force was charged with providing recommendations to strengthen the Commonwealth's opioid abuse prevention and treatment systems to reduce overdose events, prevent opioid misuse and addiction, increase the numbers of persons seeking treatment, and support persons recovering from addiction in our communities.

This report summarizes the findings of the Task Force and provides recommendations for strengthening our Commonwealth's ability to respond to the opioid crisis with a focus on prevention, intervention, treatment and recovery. These recommendations include, but are not limited to, the expansion of treatment beds; the formation of a centralized navigation system for patients, families, and first responders to locate treatment services; a public-facing dashboard that would help facilitate consumer choice of services; additional opioid prevention coalitions for support and education; more stringent safeguards for those opioids which are most frequently abused and misused; a meeting of New England governors to develop a regional response to the opioid epidemic; and the expansion of the use of injectable naltrexone for persons re-entering the community from correctional facilities.

Since the convening of this Task Force, the Massachusetts Legislature has also taken actions to address the opioid epidemic in Massachusetts. The recommendations included in this report complement the Legislature's proposals, and DPH looks forward to continuing to work closely with the Legislature on the important issue of opioid misuse, abuse and overdose.

Despite having one of the strongest treatment systems in the country as measured by the robust continuum of care offered and the presence of dedicated addiction treatment providers, there are still opportunities for improvement. DPH believes that with the policy recommendations made here, particularly with an emphasis on safe opioid prescribing, the Department will be able to help those struggling with addiction, their loved ones and communities.

Introduction

Massachusetts is experiencing an opioid addiction epidemic. From 2000 to 2012 the number of unintentional fatal opioid overdoses in Massachusetts increased by 90 percent.[1] In 2012, 668 Massachusetts residents died from unintentional opioid overdoses, a 10 percent increase over the previous year.[2] The Massachusetts State Police reported that in jurisdictions in which they respond to homicides at least 140 people died of suspected heroin overdoses between November 2013 and March 2014. Various communities in the Commonwealth have reported previously unseen spikes in both fatal and non-fatal opioid overdose in recent months. The Department of Public Health (DPH) Bureau of Substance Abuse Services (BSAS) data shows that in FY13 nearly half of all persons receiving treatment in the publicly funded system reported opioids as their primary or secondary drug of choice. In addition, approximately 40 percent of persons served in FY13 in the BSAS system were between the ages of 13 and 29.

Massachusetts is not alone in struggling with the devastating consequences of opioid misuse, abuse and addiction. In 2013, the U.S. Department of Health and Human Services deemed prescription-opioid overdose deaths an epidemic.[3] In the United States, deaths from

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[1] Fatal Opioid-related Overdoses Among MA Residents, 2000-2013. Massachusetts Department of Public Health, March 2013. Available at: http://www.mass.gov/eohhs/docs/dph/substance-abuse/opioid/fatal-opioid-overdoses-2000-2013.docx. Accessed on June 5, 2014.

[2] Fatal Opioid-related Overdoses Among MA Residents, 2000-2013. Massachusetts Department of Public Health, March 2013. Available at: http://www.mass.gov/eohhs/docs/dph/substance-abuse/opioid/fatal-opioid-overdoses-2000-2013.docx. Accessed on June 5, 2014.

[3] Addressing prescription drug abuse in the United States: current activities and future opportunities. U. S. Department of Health and Human Services, 2013. Available at: http://www.cdc.gov/homeandrecreationalsafety/overdose/hhs_rx_abuse.html. Accessed on: June 9, 2014.

prescription opioid overdose quadrupled between 1999 and 2010.[4] People who are abusing opioids are also at high risk for, among other things, liver disease, Hepatitis C, and HIV infection.[5] Opioid addicted individuals live approximately 15 years less than people who do not have the disease.[6] Opioid addiction is a chronic disease, which like other chronic illnesses, cannot be cured but can be effectively treated and managed.[7]

On March 27, 2014, in response to the crisis of opioid abuse in the Commonwealth and after meeting individuals and families impacted by it, Governor Patrick declared a public health emergency and, among other actions, committed an additional $20 million in state funding to increase treatment and recovery services and directed the Commissioner of the Department of Public Health to establish an Opioid Task Force (Task Force) within the Interagency Council on Substance Abuse and Prevention (Council). The Task Force was charged with providing recommendations to reduce overdose events, prevent opioid misuse and addiction, increase the numbers of persons seeking addiction treatment, support persons recovering from addiction in our communities, and map a long term solution to address opioid abuse in the Commonwealth.

This report contains a description of the Task Force's methodology, an overview of substance abuse services offered by the Commonwealth, findings from the Task Force's deliberations, and actions recommended by DPH in response to the Task Force's work and findings.

Task Force Methodology

In addition to the Executive Committee of the Council, the membership of the Task Force included those struggling with addiction and their families, providers, insurers, first responders, public safety officials, local

[4] Jones CM, Mack KA, Paulozzi LJ. Pharmaceutical overdose deaths, United States, 2010. JAMA 2013; 209:657-659.
[5] Moore K and Dusheiko G. Opiate Abuse and Viral Replication in Hepatitis C. American Journal of Pathology November 2005;167(5):1189-1191.
[6] Smyth B, Fan J, Hser Y, Life Expectancy and Productivity Loss Among Narcotics Addicts Thirty-Three Years After Index Treatment. Journal of Addictive Diseases 2006; 25(4): 37-47.
[7] Kritz S, Chu M, John-Hull C, Madray C, Louie B, and Brown LS Jr., Opioid dependence as a chronic disease: the interrelationships between length of stay, methadone dose and age on treatment outcome at an urban opioid treatment program. J Addiction Dis. 2009, 28(1):53-6.

government representatives, the judiciary and legislators. A complete list of participants can be found in Appendix III. The mission of the Task Force was to develop recommendations to improve on the Commonwealth's current efforts to (1) prevent opioid abuse, addiction and overdose; (2) educate the public about opioid addiction and treatment options; (3) facilitate access to treatment though improved care coordination; (4) expand the current treatment system; (5) ensure access to the full continuum of treatment services by all insurers; (6) divert non-violent criminal offenders with substance use disorders to appropriate treatment; (7) assist persons with addictive disorders re-entering the community from correctional facilities to maintain opioid abstinence; and (8) expand community based recovery supports.

Given the urgency of the opioid epidemic and taking into consideration the 60-day time frame in which to consider and develop recommendations, the Task Force formed focus groups (Appendix V) to maximize stakeholder input and to allow for a comprehensive overview of the current system. A total of 19 focus groups and/or interviews were held with stakeholders from across the Commonwealth, including persons who were actively using opioids, persons in recovery, parents, prevention coalitions, law enforcement, members of the judiciary, state agency representatives, schools and colleges, behavioral health providers, pharmacists, hospitals, emergency room physicians, physicians specializing in addiction medicine, first responders and insurers. As previously noted, approximately 40 percent of persons served in FY13 in the BSAS system were between the ages of 13 and 29, so particular attention was given to this age group when discussing priorities.

The Task Force met as a committee of the whole three times. During the first meeting, the Task Force members discussed the opioid problem and its charge, agreed upon the focus group approach, and brainstormed potential investments. During the second meeting, members reviewed and commented on early findings and proposed recommendations from the initial focus groups, which can be found in Appendix IV. During the final meeting, the Task Force members reviewed a series of focus group recommendations and provided feedback to DPH on those

recommendations. Finally, DPH reviewed and prioritized those recommendations based on their ability to have a positive impact on the public health emergency in the short and long term.

Overview of Massachusetts Substance Abuse Services

Massachusetts has one of the strongest substance abuse treatment systems in the country.[8] The Bureau of Substance Abuse Services (BSAS) is the single state authority on substance abuse and provides a robust system that provides services across the full continuum of care. The BSAS is charged with licensing addiction treatment programs as defined in 105 CMR 164.012, licensing addiction counselors as defined in 105 CMR 168.000, and funding a continuum of prevention, intervention, treatment and recovery support services. The BSAS also sets policy in this area and serves as the payer of last resort for persons seeking treatment services who are either uninsured or underinsured. The types of services are summarized below.

Prevention

The BSAS prevention efforts include funding community based primary prevention campaigns across the state aimed at preventing the misuse and abuse of, and addiction to, alcohol and other drugs. Other BSAS prevention efforts include the development of print materials and media campaigns to educate various stakeholders about the consequences of underage drinking and the misuse of alcohol and other drugs, the dissemination of evidence based prevention practices and the expansion of education about addictive disorders in various training programs for health professionals, including physicians and allied health professionals.

[8] See, for example, treatment rates as documented in the National Survey of Substance Abuse Treatment Services (N-SSATS), 2011. Population: U.S. Census Bureau, Population Estimates, State population dataset - SCPRC-EST2009-18+POP-RES. From: The Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Available at: http://www.samhsa.gov/data/DASIS/2k11nssats/NSSATS2011Tbl6.33.htm. Accessed on: June 5, 2014.

Intervention

The BSAS intervention efforts include providing funding to groups that support and advocate for individuals and families dealing with addictive disorders such as the Massachusetts Organization for Addiction Recovery (MOAR) and Learn to Cope. The Massachusetts Overdose Education and Naloxone Distribution program is a model for the nation in terms of how to widely distribute naloxone (sometimes referred to as Narcan), a lifesaving medication that can reverse opioid overdose, to persons likely to witness an opioid overdose.

Treatment

The BSAS provides a full continuum of licensed treatment services in inpatient, residential and outpatient treatment settings. In FY13 there were approximately 40,000 enrollments to the BSAS-funded acute treatment services (ATS) or detoxification programs. The primary purpose of these programs is to medically treat withdrawal symptoms in persons dependent upon opioids, alcohol or other drugs. Specialized services are available to those under 18 through Youth Stabilization Programs. Detoxification services are paid for by commercial insurers, MassHealth and other public payers, and the BSAS. Typically, individuals remain in detox programs for 4-6 days. Best practice dictates that persons in these programs should continue in “step-down” treatment services in order to maximize their potential for continued abstinence from drugs of abuse. Focus groups that included active consumers, consumers in recovery and family members all emphasized this point.

There are a number of step-down services available, including Clinical Stabilization Service (CSS) programs which provide a range of services, including nursing, intensive education and counseling on the nature of addiction and its consequences, relapse prevention and aftercare planning for individuals beginning to engage in recovery. The usual length of inpatient stay in a CSS program is 10-14 days. These programs are paid for by MassHealth, the BSAS and some commercial insurers. Transitional Support Service (TSS) programs are another example of a short term

residential “step-down” service. The expected length of stay in these programs is up to 30 days. TSS services provide intensive care management services to prepare individuals for long-term residential rehabilitation or a return to the community. TSS services are solely funded with the BSAS dollars.

Residential rehabilitation treatment programs feature a planned program of substance abuse treatment within a 24-hour residential setting located in the community. These residential treatment programs serve individuals in the early stages of addiction recovery, where safe and stable living environments are essential to recovery. Residential rehabilitation facilities primarily serve adults, but there are some facilities that focus on youth or families. Individuals and families typically receive treatment in residential settings for 6-12 months while youth programs are generally 3 months in duration. Like TSS, residential rehabilitation is only funded by the BSAS.

Outpatient substance abuse treatment is also available across the state. Paid for to varying extents by commercial insurers, MassHealth and other public payers, and the BSAS, services may include individual, group and family counseling, intensive day treatment and educational services. A subset of outpatient programs focus on providing services to individuals dually diagnosed with substance abuse and mental health conditions, persons who have been convicted of driving under the influence of substances and/or adolescents.

Many opioid addicted people utilize outpatient medication assisted treatment (MAT) services. Opioid Treatment Programs (OTP) provide methadone dosing services in combination with an array of other services including counseling, drug screening and case management services. Buprenorphine, sometimes known as suboxone, is another example of MAT. Buprenorphine is available to patients in physician offices. This arrangement is called Office Based Opioid Treatment (OBOT). In order to prescribe buprenorphine, a physician must obtain a waiver from the Drug Enforcement Agency. Physicians are limited to providing OBOT to 30 individuals in the first year of receiving a waiver and up to 100 individuals thereafter. In 2012, injectable naltrexone, known as Vivitrol, was approved

for the treatment of opioid dependence. This medication can be prescribed by any qualified health professional, including mid-level practitioners, and is given in the form of an injection on a monthly basis in the prescriber's office. All of these medications are FDA approved for the treatment of opioid dependence and are shown to be effective in the scientific literature. Methadone treatment is primarily paid for by MassHealth and the BSAS, while buprenorphine and injectable naltrexone are paid for by MassHealth and the majority of commercial insurers.

Some persons suffering from opioid addiction do not see a need for treatment. When these persons pose a danger to themselves or others by virtue of their addictive behaviors, they may be involuntarily committed to treatment. Under Massachusetts General Law Chapter 123, Section 35 (Section 35), "any police officer, physician, spouse, blood relative, guardian or court official" can petition the court to commit a "person who he has reason to believe is an alcoholic or substance abuser" if that abuse "substantially injures his health or substantially interferes with his social or economic functioning, or… he has lost the power of self-control over the use of such controlled substances." After reviewing the evidence to determine if the person is an immediate risk to himself or others, a judge may commit a person to treatment for up to 90 days. There are specific treatment programs that focus on serving individuals who are committed to treatment through Section 35.

Recovery is an ongoing process. Today, the BSAS funds 7 Recovery Support Centers (RSC) across the state staffed primarily by peer members in recovery. RSCs offer a drug-free environment and a variety of activities including classes, leisure activities and support group meetings. The BSAS also supports Recovery High Schools which provide a structured school environment for high-school aged youth in recovery to maintain their recovery and complete their education. Case management services are provided to youth and adults in their homes to support their continued abstinence from substances in the community.

Task Force Findings with DPH Recommended Actions

Below are the findings of the Task Force and DPH recommended actions in the areas of prevention, intervention, treatment, and recovery. The list of recommended investments in order of priority can also be found in Appendix I and additional policy and regulatory recommendations in Appendix II.

When considering infrastructure investments, especially the addition of inpatient and residential treatment services, the current proposed expansion in the number of treatment beds was taken into account. For example, the Governor's FY15 budget already includes the addition of a new detoxification and clinical stabilization service and both the House and the Senate supported the addition of these 64 beds in their respective budget proposals. Furthermore, as of April 2014, DPH completed an expansion of 80 transitional support services beds and 200 long term residential beds for single adults. Additionally, the Governor's FY15 budget includes the addition of long term residential services under the trial court expansion budget, another initiative supported by the legislature. The Governor's current budget also calls for the expansion of 8 specialty courts to divert non-violent offenders.

PREVENTION

Finding: There is a need for increased education for youth and families about the dangers of drug use.

Task Force members emphasized the importance of ongoing education for children and parents about the dangers of drug use, the appropriate use of prescription pain medications and their potential addictive qualities. Focus groups also discussed the potential of leveraging community coalitions.

Prevention programs designed and tested to reduce risk and increase awareness can help people of various ages develop and apply the skills necessary to stop problem behaviors before, and after, they begin. Research has demonstrated that research-based drug abuse prevention programs are cost-effective. Each dollar invested in prevention saves up to

7 dollars in areas such as substance abuse treatment and criminal justice system costs, not to mention their wider impact on the trajectory of young lives and their families.[9]

Recommended Actions

- The Governor should convene a meeting of New England governors to discuss a collective response to the opioid epidemic impacting the region;

- Develop a statewide evidence-based public service campaign on the prevention of addictive disorders targeted at youth and parents;

- Add up to five new Opioid Overdose Prevention Coalitions in high need areas.

Finding: There is a need for increased education for prescribers to ensure safe and effective pain management

The diagnosis and treatment of pain is integral to the practice of medicine, and inappropriate treatment of pain, including both over-treatment and under-treatment, is an important problem. Providers must balance the legitimate needs of patients with pain against the dangers to the public of opioids circulating through communities. Prescribers reported that they would like enhanced education about the potential addictiveness of prescription pain medications, how to identify at risk individuals, how to identify potential opioid abuse, and how to effectively taper people off of prescription pain medications without leading to addiction.

Recommended Action

- Practitioners are already required by medical boards to complete training on pain management to renew their licenses. This training could be further enhanced, particularly around safe prescribing

[9] National Institute on Drug Abuse. Topics in Brief: Drug Abuse Prevention. Revised March 2007. Available at: http://www.drugabuse.gov/publications/topics-in-brief/drug-abuse-prevention. Accessed on: June 5, 2014.

practices and managing of medications to decrease the risk of addiction.

INTERVENTION

Finding: Opportunities exist to improve safe prescribing and dispensing of controlled substances.

Deaths from prescription opioid overdoses quadrupled from 1999 to 2010 and far exceed the combined toll of cocaine and heroin overdoses.[10] At the same time, prescription opioid pain medications serve an important and legitimate role in the treatment of pain. Safe prescribing and dispensing practices are needed to decrease the risk of misuse and abuse while allowing for the legitimate use of these important medications. Focus groups discussed the role of pharmacists in providing education to consumers at the time of dispensing, as well as potentially engaging with prescribers. Focus groups also discussed the utility and limitations of the Prescription Monitoring Program, and its role in preventing prescription drug misuse and abuse.

Recommended Actions

- Review and develop regulations to promote the safe prescribing and dispensing of controlled substances, including the funding of necessary infrastructure to support these activities;
- For those opioids which are most frequently abused and misused, DPH recommends that the DPH Drug Control Program propose regulations mandating all prescribers to utilize the PMP each time they issue a prescription for Schedule II or III drugs that have been determined by DPH to be commonly misused or abused and designated as a drug that needs additional safeguards;

[10] Jones CM, Mack KA, Paulozzi LJ. Pharmaceutical overdose deaths, United States, 2010. JAMA 2013;309:657-659.

- Task the various boards of registration, within and beyond DPH, with consideration of regulations to minimize diversion and misuse while ensuring safe prescribing and patient access to medication;

- Consider additional safe prescribing recommendations to be issued by the Joint Policy Working Group.

TREATMENT

Finding: There is a need for centralized treatment resources.

Task Force members discussed the challenges to accessing services in a timely manner, noting the importance of getting treatment within the window of opportunity when an individual is ready to accept it. Well-accepted models recognize that treatment needs to be matched to the patient's acceptance of it for the treatment to be most successful. Across the focus groups, there was not a clear understanding of how to access the treatment network in Massachusetts. Focus group participants described the burden of having to call multiple programs on an ongoing basis to find available services.

Recommended Actions

- Develop a central navigation system for adult services that can be accessed through an 800 number. The system would maintain a real time inventory of available substance abuse services across the continuum of care. Central navigation could be utilized to identify appropriate resources by consumers and their families, first responders, schools, and providers. When contacted, intake staff would work, if appropriate, with the caller to place the person needing services into the best available setting;

- Establish pilot regional walk-in centers that could coordinate with central navigation as needed. These centers could provide assessment, liaison with central intake to place the person in the best

treatment setting, daily clinically run group sessions, and emergency one-on-one counseling;

- Develop and implement a public facing dashboard to facilitate consumer choice by providing quality assessments and other information about treatment options.

Finding: Individuals and families report challenges in accessing services beyond simply knowing where they are.

Treatment is necessary to provide patients relief from physical withdrawal symptoms and to place patients on the road to recovery. Task Force members heard from several individuals struggling with addiction and their families who described difficulty in accessing treatment services. BSAS notes that approximately 40 percent of persons served in FY13 in the BSAS system were between the ages of 13 and 29, making this an important population to consider. In addition, 20 percent of 16 to 24 year olds served in the BSAS system in FY13 had children under six, highlighting the need for services for families with children.

<u>Recommended Actions</u>

- Add treatment programs with an emphasis on:
    - Community-based treatment programs for youth and young adults to provide home-based counseling services;
    - Residential treatment programs for populations in need, including adolescents and transitional age youth, families, single adults with children, Hispanics, and residents in currently geographically underserved areas such as Franklin County; and
    - Clinical Stabilization Services program for step down services.
- Add funding to allow community health centers to increase capacity to provide medication assisted treatment including injectable naltrexone to people in the community.

Finding: Providers and consumers express concerns about barriers to access

Even when treatment is available, individuals and families may still have trouble accessing that treatment. For example, providers and consumers that participated in our focus group expressed the belief that insurers are too restrictive in authorizing certain care. Other issues that potentially affect access include housing issues and physician reluctance to receive authority to prescribe buprenorphine due to real and/or perceived burdensome regulatory requirements. Stigma is also an important barrier to treatment. All of these factors can prevent individuals from obtaining the treatment they need as the first step to recovery.

Recommended Actions

- DPH and the Division of Insurance, in consultation with the Health Policy Commission, should conduct a comprehensive review of medical necessity criteria and utilization review guidelines for opioid abuse and addiction treatment developed by carriers and consult with clinical experts to develop minimum criteria for opioid abuse and addiction treatment services that will be considered medically necessary for all plans;
- The Interagency Council on Substance Abuse and Prevention should expand its review of substance abuse issues to review interagency regulatory and operational barriers to treatment, such as loss of foster care placement, long wait periods for insurance coverage, lack of drug-free shelters, and physician reluctance to receive authority to prescribe buprenorphine due to real and/or perceived burdensome regulatory requirements.

Finding: Correctional facilities are an important site of care for opioid addiction.

Task Force members noted the impact of opioid addiction on incarcerated individuals. Jails and prisons offer treatment for addiction on a voluntary

basis; however, in some facilities, individuals receive incentives to participate in treatment programs. Whether or not individuals have received treatment for their substance use while incarcerated, it is important to provide individuals support once they complete their sentences. Otherwise, without that support, they may relapse, and this relapse could cause them to engage in behaviors that potentially result in re-incarceration.

Recommended Actions

- Enhance the DOC's and Sheriff Offices' continuum of care by increasing the availability of treatment for offenders at designated DOC facilities. Specifically, DOC recommends implementing a basic substance abuse education/motivation enhancement program targeting offenders with substance abuse issues, and a graduate maintenance and aftercare program for offenders who have completed the residential substance abuse treatment program. Currently, the DOC provides substance abuse treatment for inmates who are nearing release, as research has indicated that offenders receive the maximum benefits of treatment prior to release when they are focused on reentering the community;

- Support the expansion of the use of injectable naltrexone for persons re-entering the community from correctional facilities by providing funding for supportive case management services to ensure participants comply with their post-release treatment plan and assist them in navigating access to other critical services.

RECOVERY

Finding: There is a need for peer support in the recovery process.

Research has shown that recovery is facilitated by social support. Peer recovery support services are designed and delivered by people who have experienced both substance use disorder and recovery. These services help people become and stay engaged in the recovery process and reduce

the likelihood of relapse. Because they are designed and delivered by peers who have been successful in the recovery process, they embody a powerful message of hope, as well as a wealth of experiential knowledge. The services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery. Focus group participants emphasized that opioid addiction is a chronic disease and recovery is an ongoing process that requires ongoing supports. In addition, they emphasized the need to provide support services not just during normal business hours but on nights and weekends to provide safe, drug-free activities to support the recovery process.

Recommended Actions

- Develop a peer to peer support network by encouraging the hiring of recovering peers to speak with at-risk youth and other special high risk populations, participate in a speakers bureau, and meet with individuals at critical transition points such as in emergency rooms, time of arrest or when returning to the community.

Finding: There is a need for expanded recovery services across the state.

There are currently 7 Recovery Support Centers across the Commonwealth that operate 12 hours per day. People in recovery highlighted the value of these services and their desire to have increased access to them. Both the focus groups and Task Force recognized that there is a need for expanded recovery support services focused on creating healthy communities that assist individuals maintain abstinence from drugs and alcohol after formal treatment has completed.

Recommended Actions

- Augment the capacity of Recovery Support Centers by expanding the hours of currently existing centers to include nights and weekends and by adding new Recovery Support Centers;

- Add a Recovery High School in Worcester area;
- Add Learn to Cope chapters across the Commonwealth;
- DPH also recommends developing and implementing a voluntary accreditation program for Alcohol Drug-Free Living housing, also known as sober homes. These homes can provide affordable housing and are an important part of the continuum of recovery support in the community.

Conclusion

These recommendations are important steps towards addressing the Commonwealth's public health emergency. DPH appreciates the leadership of Governor Patrick and the commitment and hard work of Task Force members who contributed their time, ideas, and expertise to help the Commonwealth address the opioid epidemic.

Since the convening of the Task Force, the Massachusetts Legislature has taken steps to address the opioid epidemic in Massachusetts. The recommendations included in this report complement the Legislature's proposals and DPH looks forward to continuing to work closely with the Legislature on the important issue of opioid misuse, abuse, and overdose.

Despite having one of the strongest treatment systems in the country as measured by the robust continuum of care offered and the presence of dedicated addiction treatment providers, we still have opportunities for improvement. DPH believes that with Governor Patrick's leadership and the policy recommendations made here, particularly with an emphasis on safe opioid prescribing, we will be able to help those struggling with addiction, their loved ones and impacted communities.

Appendix I: DPH Recommended Investments in Priority Order

Recommendation	Funding Estimate	Annualized	Pending Legislative Action
Develop a central navigation system that could be accessed through an 800 number. The system would build upon existing information lines, other central navigation systems and be used by consumers, families, first responders, health care professionals and behavioral health providers to access information about treatment options including current availability.	$1,450,000	Yes	Proposed Senate budget includes language and funding for a central navigation system
Pilot regional centers that provide assessment, drop-in counseling and referral to treatment on demand leveraging existing treatment organizations.	$1,800,000	Yes	Senate budget proposes $10M Trust Fund to expand services.
Develop Prescription Monitoring Program infrastructure to support safe opioid prescribing practices and new regulations related to the Public Health Emergency and accelerated enrollment of prescribers.	$1,500,000	Yes	SB2142 provides DPH additional authorities to require PMP registration and consultations, as well as places limitations on the prescribing physician. In the budget, House and Senate proposed $3.7M for roll-out of full, mandatory use of the PMP by prescribers.
DPH and the DOI, in consultation with the Health Policy Commission to conduct a comprehensive review of medical necessity criteria and utilization review guidelines for opiate abuse and addiction treatment developed by carriers pursuant to sections 12 and 16 of chapter 1760. The agencies to consult with clinical experts to develop minimum criteria for opiate abuse and addiction treatment services that will be considered medically necessary for all plans.	$250,000	No	SB2142 directs the Center for Health Information and Analysis (CHIA) to review accessibility of substance abuse treatment and the adequacy of coverage; while the Health Policy Commission is to determine standards for evidence-based substance abuse treatment and to create a certification process for providers.
Enhance the DOC's continuum of care by increasing the availability of treatment for offenders at designated DOC facilities.	$2,000,000	Yes	

Recommendation	Funding Estimate	Annualized	Pending Legislative Action
Support the expansion of the use of injectable naltrexone for persons re-entering the community from correctional facilities.	$1,000,000	Yes	
Add funding to allow community health centers to increase capacity to provide medication assisted treatment including injectable naltrexone to people in the community.	$300,000	Yes	
Develop a statewide evidence-based public service campaign on the prevention of addictive disorders targeted at youth and parents.	$1,000,000	No	SB2142 requires distribution of educational information on family support services to families, upon admission to the program. The Senate final budget proposes funding for a public education campaign.
Develop/implement voluntary accreditation for Alcohol and Drug-Free living homes.	$500,000	Yes, for at least 3 years	Senate and House proposed budgets include language and funding for voluntary accreditation for Alcohol and Drug-Free living homes.
Add five community based treatment programs for youth and young adults to provide home based counseling services using both evidence based treatment models.	$1,000,000	Yes	As noted above, the Senate budget proposes a $10M trust fund to expand services.
Add two adolescent residential treatment programs for 13-17 year olds.	$855,125	Yes	As noted above, the Senate budget proposes a $10M trust fund to expand services.
Add one residential treatment programs for 16-21 year olds.	$660,985	Yes	As noted above, the Senate budget proposes a $10M trust fund to expand services.
Add one residential treatment program for 18-25 year olds.	$660,985	Yes	As noted above, the Senate budget proposes a $10M trust fund to expand services.
Add one family residential treatment program.	$820,000	Yes	As noted above, the Senate budget proposes a $10M trust fund to expand services.
Add two adult residential treatment programs prioritizing Hispanics and single adults with children.	$1,100,000	Yes	As noted above, the Senate budget proposes a $10M trust fund to expand services.
Add one detoxification program in Franklin County.	$550,000	Yes	As noted above, the Senate budget proposes a $10M trust fund to expand services.
Add one Clinical Stabilization Services Program.	$350,000	Yes	As noted above, the Senate budget proposes a $10M trust fund to expand services.
Add five Opioid Overdose Prevention Coalitions in high need areas.	$500,000	Yes	As noted above, the Senate budget proposes a $10M trust fund to expand services.

Recommendation	Funding Estimate	Annualized	Pending Legislative Action
Develop peer to peer support networks to meet with persons at critical transition points, such as in emergency rooms, at times of arrest, at times of program transition.	$500,000	Yes	As noted above, the Senate budget proposes a $10M trust fund to expand services.
Expand the hours of currently existing Recovery Support Centers to cover nights and weekends.	$350,000	Yes	As noted above, the Senate budget proposes a $10M trust fund to expand services.
Add three new Recovery Support Centers.	$1,050,000	Yes	As noted above, the Senate budget proposes a $10M trust fund to expand services.
Add another Recovery High School in the Worcester area.	$500,000	Yes	As noted above, the Senate budget proposes a $10M trust fund to expand services.
Add Learn to Cope Chapters across the state by adding program staff.	$300,000	Yes	As noted above, the Senate budget proposes a $10M trust fund to expand services.
Add a public facing dashboard to facilitate consumer choice and transparency, includes development of IT and data structures.	$1,000,000	No	Senate budget recommends a public facing dashboard.
TOTAL	$19,997,095		

Appendix II: Additional DPH Recommendations

DPH Policy and Regulatory Recommendations
DPH Drug Control Program will be proposing regulatory amendments to the PMP requiring all prescribers to utilize the PMP each time they issue a prescription for a Schedule II or III drug which has been determined by the Department to be commonly misused or abused and which has been designated as a drug that needs additional safeguards.
DPH suggests that the various boards of registration, within and beyond DPH, be tasked with consideration of regulations to minimize diversion and misuse while ensuring safe prescribing and patient access to medication
DPH recommends consideration of additional safe prescribing recommendations to be issued by the Joint Policy Working Group.

Appendix III: Task Force Members

Member	Affiliation
Dr. Thomas Amoroso	Medical Director, Tufts Health Plan
Cheryl Bartlett	Commissioner, Department of Public Health
Kim Bishop-Stevens	Coordinator, Substance Abuse Services, Department of Children and Families
Dr. Troy Brennan	Medical Director, CVS
Andrea Cabral	Secretary, Executive Office of Public Safety
Paula Carey	Chief Justice of the Trial Court
Paul Doherty	Parent, Learn to Cope
Ed Dolan	Commissioner of Probation
Chuck Farris	President and CEO, Spectrum Health Services
Peter Forbes	Commissioner, Department of Youth Services
Marcia Fowler	Commissioner, Department of Mental Health
Maryann Frangules	Executive Director, MA Coalition for Addiction Services
Dr. Barbara Herbert	Medical Director, St. Elizabeth's Comprehensive Addiction Program, Steward Health Care System
Tom Hoye	Mayor, Taunton
Hilary Jacobs	Director, Bureau of Substance Abuse Services, DPH
Paul Jeffrey	Pharmacy Director, MassHealth
Theodore Joubert	Chief, Fire Chiefs Association
Katie Joyce	Vice President for Policy and Domestic & International Government, Mass Life Sciences
Paul Kusiak	Parent
William Luzier	Executive Director, Interagency Council on Substance Abuse Services and Prevention
John McGahan	President, Gavin Foundation
Richard McKeon	Major, Division of Investigative Services
Rosemary Minehan	Judge, Plymouth District Court
Christopher Mitchell	Director of Program Services, DOC
Joseph Murphy	Commissioner, Massachusetts Division of Insurance

Member	Affiliation
Coleman Nee	Secretary, Department of Veterans' Services
Heidi Nelson	CEO, Duffy Health Center
Lora Pellegrini	President & CEO, Massachusetts Association of Health Plans
Dr. Debra Pinals	Assistant Commissioner, Forensic Mental Health Services, Department of Mental Health
John Polanowicz	Secretary, Executive Office of Health and Human Services
Domenic Sarno	Mayor, Springfield
David Seltz	Executive Director, Health Policy Commission
Luis Spencer	Commissioner, Department of Corrections
Martin Walsh	Mayor, Boston
Steven Walsh	Executive Director, Massachusetts Council of Community Hospitals
Steven Tolman	President, AFL-CIO

Appendix IV: Focus Group Feedback

Proposed Priorities and Funding Recommendations

(from Focus Groups with Task Force feedback included)

May 21, 2014

Focus Group Recommendations	Funding Estimate
DATA	
Develop and implement a public facing dashboard to facilitate consumer choice and improved performance management.	$1,000,000 Includes development of IT infrastructure
Increase capacity to allow for ongoing data analytics of service delivery system, including the supply and demand for services, program effectiveness, utilization patterns, provider service profiles, including results of injectable naltrexone (vivitrol) services	
POLICY/REGULATORY ACTION	
Develop and implement an accreditation program for Alcohol Drug-free Living housing, also known as sober homes. In developing program, be cognizant of sober homes as an important piece of the affordable housing.	$500,000

Focus Group Recommendations	Funding Estimate
Recommend initiatives to enhance the capabilities of clinicians to identify and treat patients with substance abuse issues or who are at risk for developing substance abuse issues. Such initiatives could include: • Enhancing the content of required CME course to include more on opiate addiction, including paths to addiction involving prescription drugs, and best practices on prescribing buprenorphine • Requiring all providers to complete the training by a specified date, and not wait until the time of license renewal. • Require Massachusetts medical schools and residency programs, nursing schools, and physician assistant training programs to increase training of physicians on pain management, including non-pharmaceutical management of pain, the use of pain medication and addiction medicine, training in SBIRT, screening pregnant women, safely weaning patients from pain medication, how to provide patient education and reduction in stigma Following training, provide support to providers of addiction services that are targeted at removing barriers to patient's receiving needed care.	Some funds may be needed to provide post training support
Review and develop regulations to promote the safe prescribing and dispensing of controlled substances.	N/A
Develop DOI and DPH regulations that require insurers to increase the medical management of opiate prescriptions by insurers (quantity limits, prior authorization, etc.), create physician prescription profiles, and use profiling information in making re-credentialing decisions.	N/A
Direct MassHealth and DPH to develop a pilot payment reform initiative based on an episodes of care model	$100,000 to develop the pilot (additional money needed to fund the pilot)

Focus Group Recommendations	Funding Estimate
DPH and the DOI, in consultation with the Health Policy Commission to conduct a comprehensive review of medical necessity criteria and utilization review guidelines for opiate abuse and addiction treatment developed by carriers pursuant to sections 12 and 16 of chapter 1760. The agencies to consult with clinical experts to develop minimum criteria for opiate abuse and addiction treatment services that will be considered medically necessary for all plans. DPH and DOI, in consultation with public and private payers to address barriers to accessing medication-assisted treatment.	$250,000
Provide PMP data downloads to insurers to enable them to obtain a complete prescribing profile of patients and physicians. Provide access to PMP data by health plan physicians and pharmacists to enable insurers to review patient-specific prescription histories.	$200,000
Hold a series of facilitated stakeholder forums to review and discuss evidence based research regarding most effective treatment approaches. Aim to develop a shared understanding of best treatment and care management practices and how persons seeking care can have that care covered by a combination of insurance and BSAS-funded services. Participants would include providers, insurers, state officials, first responders, consumers and family members. The sessions would be professional facilitated to assure that all parties are heard and the consensus goals are achieved.	$10,000 per session (recommend up to 10 sessions)
Develop statewide strategy for safely disposing of needles by providing locked needle disposal boxes in public areas throughout the state	N/A
Consider adoption of the Model Drug Dealer Act which allows family members to bring a civil lawsuit against a dealer if he/she sells drugs that lead to a fatal overdose.	N/A

Focus Group Recommendations	Funding Estimate
Charge Interagency Task Force on Substance Abuse and Prevention to review interagency regulatory and operational barriers to treatment. Examples of potential areas of review include: • Loss of foster care placement for a child who seeks residential treatment; • Long wait periods for insurance coverage; • Lack of drug-free shelters; • Physician reluctance to receive authority to prescribe buprenorphine due to real and/or perceived burdensome regulatory requirements.	N/A
PREVENTION	
Develop a sustained, state-wide, evidence-based public service campaign to educate youth and parents about dangers of addiction. In addition, the campaign may provide information on Massachusetts' Good Samaritan Law. Involve public figures who are role models for youth.	$1,000,000
Develop peer-to-peer support network by hiring recovering peers to: • Speak with at-risk youth and other special high risk populations • Participate in a speakers' bureau • Meet with individuals at critical transition points, such as in emergency rooms, at time of arrest, or when returning to the community	$400,000
Add five new Opioid Prevention coalitions in high need cities.	$100,000 per coalition
INTERVENTION	

Focus Group Recommendations	Funding Estimate
Develop a central navigation system for adult services that can be accessed through an 800 number. The system would maintain a real time inventory of available substance abuse services across the continuum of care. Central navigation could be utilized to identify appropriate resources by consumers and their families, first responders, schools, and providers. When contacted, intake staff would work, if appropriate, with the caller to place the person needing services in the best available setting. In addition, intake staff could direct uninsured individuals to assistance in applying for MassHealth benefits. The central navigation system should include resources available from both public and private payers and should be designed to gain efficiencies by building on existing resource programs.	$1,450,000
Pilot regional walk in centers that provide: • Assessment • Liaison with central intake to place person in best treatment setting • Daily open clinically run group sessions • Emergency 1 on 1 counseling The walk in centers would also coordinate with Central Navigation as needed. Where possible, leverage existing organizations to pilot walk-in center model.	$600,000 per site cost
Establish a state-wide, community-based care management service that supports consumers and families receiving services: • At times of transitions of care from one type of service provide to another (e.g., initial entry into the system, from detox to CSS, to TSS to residential programs, from jails/prisons to community) • When the person is living and receiving services in the community Care management services would be provided by both clinical care managers and peer navigators, working collaboratively on shared caseloads. The Care Management program should be designed to gain efficiencies by building on existing programs offered by other state agencies and insurers.	$10,000,000 (estimated based on cost of providing to Section 35 clients - $1M for 5,000 clients; assuming would interact with 50,000 clients)

Focus Group Recommendations	Funding Estimate
To increase early identification, develop and implement a widespread education and training program to allow nurses and other professionals to identify high risk individuals at as many interaction points as possible (e.g., schools, courts, MH clinics, CBHI providers). The training should include both information on how to identify potential opioid abuse and information on where and how to refer individuals and their families for assistance and/or treatment services.	$25,000 per regional training
Work with colleges to develop capacity to identify and treat at risk college students	$150,000
Share funding with cities and towns on a regional basis to fund at least one substance abuse counselor in each District Attorney's office to work with courts, first responders, and community and school organizations.	$40,000 per site
Expand the number of Drug Courts throughout the Commonwealth	$350,000 per court
Provide education, training and resource materials to First Responders to allow for them to provide hands on assistance in directing individuals to treatment, as appropriate.	TBD
TREATMENT	
Fund injectable naltrexone (Vivitrol), which reduces opioid cravings, for incarcerated people (in prisons and jails) who are returning citizens and work with public and private payers to reduce barriers to benefit coverage for medication-assisted treatments. Provide transition of care services to assure that returning citizens are linked up to appropriate services and MassHealth care management support services to assure on-going treatment and patient engagement.	$147,000 per site
Establish Opiate Treatment Programs in Correctional Facilities (e.g., jails and prisons)	$75,000 per site

Focus Group Recommendations	Funding Estimate
Enhance the DOC's continuum of care and improve post release linkages to community based services through the implementation of the following initiatives: • Improve the identification of offenders with substance abuse issues by adding a substance abuse specific assessment instrument at the Department's reception centers • Increase the availability of treatment for offenders with substance abuse issues by adding basic substance abuse education and motivational enhancement programs at designated DOC institutions. • Enhance the residential substance abuse treatment program by adding a graduate maintenance, aftercare and post release mentoring component • Increase salaries of substance abuse treatment staff to maximize the recruitment and retention of the most competent staff	$2,000,000
Selectively add residential beds for particularly vulnerable populations who are underserved, including women, single parents with children and Hispanics, and 18-25 year olds.	$504,000 per contract for adults $735,000 per contract for transitional age youth and young adults
Work with MassHealth and commercial insurers to increase capacity for outpatient services including, for example: • Intensive Outpatient Programs • Group visits at walk-in centers • Family-based programs • Youth programs, which will allow for diversion from DYS	N/A
Add medication-assisted treatment service sites, including expanding treatment at CHCs, to the extent possible under the law.	$100,000 per OBOT or injectable naltrexone; $300,000 per Methadone site
Add one detoxification program in Franklin County	$550,000
Add one CSS program, location to be determined	$350,000

Focus Group Recommendations	Funding Estimate
Provide technical assistance to pharmacies to encourage them to stock and dispense Naloxone Provide technical assistance and training to assure availability of Naloxone through first responders. Provide funding to assist first responders in replacing Naloxone supply.	N/A (TBD)
RECOVERY SUPPORTS	
Expand the number of recovery support centers (RSC) and expand access to RSC on nights and weekends.	$350,00 per new site (assuming expanded hours) $50,000 for current sites to expand hours
Provide drug free housing and programing 24/7	TBD
Add an additional recovery high school in Worcester County.	$500,000 per high school
Add support groups, such as Learn to Cope, in areas of state with need and no existing program.	$300,000

Appendix V- Focus Group Meetings

Focus Groups	
Organization	**Meeting Dates**
Active Consumers	May 14 (10:00AM) at Project AHOPE
Consumers in Recovery	April 17 (11:00AM) MOAR meeting (Lawrence) May 7 (10:00AM) at StepRox (Roxbury)
Family Members (Learn to Cope)	May 8 (7:00PM), Quincy
Health Insurers	April 23 (10:00AM) Attended meeting at MAHP April 25 (1:00PM) Attended BCBSMA meeting
Colleges	April 24 (1:00PM) Conducted call with Diane Fedorchak from UMASS Amherst
Mass Medical Society/Addictive Physicians	May 12 (6:00PM) at MMS offices in Waltham
ER doctors	April 24 (10:00AM) Call held with ER doctors from Sturdy Hospital
MA Hospital Association	April 30 Call held with MHA staff
Pharmacists	April 23 (1:00PM) Meeting held
BH providers	April 28 (12:30PM) Meeting held at Framingham Public Library
Judiciary	April 28 (10:00AM) Phone meeting held with Judges Carey and Minehan
Law Enforcement – Police/Fire	April 25 (10:00AM) Meeting held with firefighters in North Attleboro. May 12 Meeting held with police chiefs in Norwood
Interagency Workgroup on Youth (Jen Tracey)	May 14 (1:00PM)
Prevention Coalitions	May 12
Full Interagency Council	April 16 (9:45AM)
BSAS Consumer Advisory Council	April 16 (5:30PM)

Opioid Maintenance Therapy: Questions and Controversies

http://www.huffingtonpost.com/tessie-castillo/opioid-maintenance-therap_b_5604200.html

Opioid maintenance therapy, or using a legal opiate to reduce a person's urge to take illicit drugs, has long generated controversy. Scientific evidence supports it as a practical, cost-effective strategy that prevents death and illness generated by street drug use and allows people who suffer from addiction to resume "mainstream" lives. But opponents argue that it simply replaces one addiction for another. So what's the real story?

Currently there are two kinds of opioid maintenance drugs, methadone and buprenorphine (often packaged under the brand names, Suboxone or Subutex. In addition to buprenorphine, Suboxone contains an added ingredient, naloxone, which is meant to deter abuse by sending users into withdrawal if they inject the drug). Methadone was first approved for use in substitution therapy under the Nixon administration, but due to concerns about its misuse, it continues to be highly regulated. To receive methadone, most people have to go to a clinic to receive a daily dose in liquid form, which they drink under the watchful eye of a nurse. Numerous barriers prevent people from seeking or maintaining methadone treatment, including lack of transportation, the inconvenience of daily visits to the clinic, and cost (no insurance company except Medicaid will cover the treatment.)

"I have to drive 45 minutes to a clinic in another city to get my methadone," says Chad of Durham, North Carolina. "Altogether, it's about three hours out of my morning, every morning, for years. Most people just can't do that."

Like many others, Chad takes methadone to reduce his craving for heroin. Although heroin and methadone are both opiate drugs with abuse potential, heroin provides users with a quick, potent high followed by a crash, while methadone is slow onset and long-acting. Ideally, methadone therapy allows opiate-dependent people to take just enough of the drug to avoid withdrawal symptoms and reduce the urge to take illicit opiates so that they may focus their energies on other pursuits.

Buprenorphine (bupe), also an opiate maintenance drug, was licensed for use in the U.S. in 2002 to circumvent the regulatory barriers around methadone access. Unlike methadone, bupe is not dispensed in regulated clinics, but prescribed by licensed physicians as a sublingual tablet or dissolvable film. Insurance companies usually pick up the cost, but many place limits on coverage - to the ire of medical providers.

"It's crazy for insurance companies to make up artificial limits," says Dr. Sharon Stancliff, MD, a buprenorphine provider and also the former Medical Director for a methadone clinic in New York City. "We don't place limits on blood pressure medication or diabetic insulin." She points out that in addition to helping reduce a person's craving for illegal drugs, opioid replacement therapy is shown to reduce the incidence of HIV transmission, drug overdose, and other morbidity and mortality related to illegal opioids.

Dr. Logan Graddy, MD, who runs an opioid maintenance clinic in Durham, North Carolina, agrees that artificial limits on treatment presents a serious impediment to recovery. "I recommend at least one year [on bupe] to my patients, but warn them that some might need it the rest of their lives. Many patients stay on the therapy at low doses because they feel that coming off completely can put them at risk for relapse."

Even though leading health organizations, including SAMSHA, WHO and UNODC promote opioid maintenance as a cost-effective tool to prevent HIV transmission and save lives from overdose and other drug-related activity, these programs continue to face criticism from traditional recovery groups, medical providers, and even users themselves.

"People taking methadone feel stigmatized," says Dr. Stancliff. "There is a pervasive idea that abstinence is the only answer to addiction even though we know it doesn't always work."

Medical providers who prescribe methadone and bupe often face stigma as well, but that doesn't stop providers like Dr. Stancliff and Dr. Graddy, who advocate for opioid replacement therapy because they have seen real results with their patients.

"A motivated patient on replacement therapy can make astounding changes in a year," Dr. Graddy says. "Many change careers, go back to school, and turn their lives around to where they might have been before they started taking drugs. I've seen miracles happen."

Psychology of addiction in the family

By Clay Neely

http://www.times-herald.com/local/20140810-SUN_Drug-Addiction-Part-3

When addiction comes home to roost, parents inevitably find themselves asking the same question – how did this happen?

When addiction comes home to roost, parents inevitably find themselves asking the same question – how did this happen?

Because the psychology behind drug addiction is complex, there are no simple answers. From those who have lost the fight against peer pressure to those who are self-medicating an underlying problem, teens travel different routes that lead to the same destination.

Natasha Ryles has spent countless hours talking to teenagers who are undergoing drug rehabilitation at Willowbrooke at Tanner, a facility in Carroll County. As the director of nursing, she acknowledged teenagers today are not far removed from those in the past.

"When we talk about the growing number of teenagers using hard drugs, it all comes back to that initial willingness to take an unknown substance from a stranger or so-called friend," Ryles said. "Smoke this, drink this – they don't ask questions. They just want to fit in."

In Ryles' adolescent unit, she has spent time talking to many teenage patients who were given something and didn't bother to ask what it was. When asked why they would ingest a substance from someone they barely know, their response was, "I thought it would be fun."

"These kids simply aren't aware of the end result – they just do not possess that awareness at this point in their lives," Ryles said. "It's always 'this can't happen to me,' because at that age, they feel superhuman. When that feeling is combined with a need for acceptance, it can be very rough."

Ryles also agrees that the rise of heroin abuse in suburban communities is a byproduct of the efforts by authorities to crack down on prescription pills. While law enforcement, emergency rooms and doctors are cracking down on the problem of prescription drug abuse, the availability, price and supply of heroin is the most common substitute.

“When you’re taking unknown substances from people you barely know, you also have no idea how much you’ve taken,” Ryles said. “If you’re overdosing, the people who have given you the drugs certainly don’t want to be involved – so they leave.”

For many rehabilitation specialists, the story is a familiar one. A teenager may start with alcohol and marijuana, but soon their entire social world becomes oriented toward drug use.

“It comes back to tell me who your friends are and I’ll tell you who you are,” she said. “If you see the progression of addiction, you will see their social group change. When they get to be 18 and have autonomy and independence, if they don’t break away from their social group, it’s almost impossible to break that cycle of addiction.”

Unfortunately, many parents’ understanding of how rehabilitation works is flawed, according to Wayne Senfeld, administrator at Willowbrooke. From his observations, many parents of addicts are just as ignorant of the disease as their children.

“Parents need to go into this process knowing that they could be facing a lifelong struggle,” Senfeld said. “It’s a naivety to believe that once their child goes into a hospital, they will be ‘fixed.’ Unfortunately, we’re not going to fix them the first time, and we might not fix them the 15th time. In fact, they don’t get fixed – it’s learning to live and manage their addiction on a daily basis.”

With the recently passed state Amnesty Bill along with the availability of Narcan, the drug used to counter the effects of opioid overdose, Senfeld feels that bringing awareness to both parents and the general public is the best weapon in the ongoing process of facing down the reality of drug abuse in the community.

But if parents aren’t listening to the dialogue, it’s a campaign falling on deaf ears.

“Parents are very naive about their child’s drug abuse. They ignore the gravity of what they’re both up against,” Senfeld said. “Kids will tell their parents that it’s their first time. But the reality is, kids get caught doing drugs the same way we get caught speeding on the highway. It’s never the first time.”

And because of the parents’ willingness to believe, the child is often given the benefit of the doubt – thus prolonging treatment and exacerbating the problem. But for the parents who accept the problem head-on, Senfeld believes the road to recovery will be a far more fluid and successful one.

“The longer you deny the problem, the worse it gets,” he said. “This problem doesn’t fix itself. Parents need to have their [Narcan] kit and be ready.”

The good news for both parents and teens is that help does exist in their community. For those who are willing to accept the reality of addiction and are prepared to rebuild their lives, the future can be a promising one.

SAMHSA

Opioid Overdose TOOLKIT

Facts for Community Members

Five Essential Steps for First Reponders

Information for Prescribers

Safety Advice for Patients & Family Members

Recovering from Opioid Overdose

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SCOPE OF THE PROBLEM

Opiate overdose continues to be a major public health problem in the United States. It has contributed significantly to accidental deaths among those who use, misuse or abuse illicit and prescription opioids. In fact, U.S. overdose deaths involving prescription opioid analgesics increased to about 17,000 deaths a year in 2010 [1, 2], almost double the number in 2001 [1]. This increase coincided with a nearly fourfold increase in the use of prescribed opioids for the treatment of pain [3].

WHAT ARE OPIOIDS? Opioids include illegal drugs such as heroin, as well as prescription medications used to treat pain such as morphine, codeine, methadone, oxycodone (Oxycontin, Percodan, Percocet), hydrocodone (Vicodin, Lortab, Norco), fentanyl (Duragesic, Fentora), hydromorphone (Dilaudid, Exalgo), and buprenorphine (Subutex, Suboxone).

Opioids work by binding to specific receptors in the brain, spinal cord and gastrointestinal tract. In doing so, they minimize the body's perception of pain. However, stimulating the opioid receptors or "reward centers" in the brain also can trigger other systems of the body, such as those responsible for regulating mood, breathing and blood pressure.

HOW DOES OVERDOSE OCCUR? A variety of effects can occur after a person takes opioids, ranging from pleasure to nausea, vomiting, severe allergic reactions (anaphylaxis) and overdose, in which breathing and heartbeat slow or even stop.

Opioid overdose can occur when a patient deliberately misuses a prescription opioid or an illicit drug such as heroin. It also can occur when a patient takes an opioid as directed, but the prescriber miscalculated the opioid dose or an error was made by the dispensing pharmacist or the patient misunderstood the directions for use.

Also at risk is the person who takes opioid medications prescribed for someone else, as is the individual who combines opioids — prescribed or illicit — with alcohol, certain other medications, and even some over-the-counter products that depress breathing, heart rate, and other functions of the central nervous system [4].

WHO IS AT RISK? Anyone who uses opioids for long-term management of chronic cancer or non-cancer pain is at risk for opioid overdose, as are persons who use heroin [5]. Others at risk include persons who are:

- Receiving rotating opioid medication regimens (and thus are at risk for incomplete cross-tolerance).
- Discharged from emergency medical care following opioid intoxication or poisoning.
- At high risk for overdose because of a legitimate medical need for analgesia, coupled with a suspected or confirmed history of substance abuse, dependence, or non-medical use of prescription or illicit opioids.
- Completing mandatory opioid detoxification or abstinent for a period of time (and presumably with reduced opioid tolerance and high risk of relapse to opioid use).
- Recently released from incarceration and a past user or abuser of opioids (and presumably with reduced opioid tolerance and high risk of relapse to opioid use).

Tolerance develops when someone uses an opioid drug regularly, so that their body becomes accustomed to the drug and needs a larger or more frequent dose to continue to experience the same effect.

Loss of tolerance occurs when someone stops taking an opioid after long-term use. When someone loses tolerance and then takes the opioid drug again, they can experience serious adverse effects, including overdose, even if they take an amount that caused them no problem in the past.

STRATEGIES TO PREVENT OVERDOSE DEATHS

STRATEGY 1: Encourage providers, persons at high risk, family members and others to learn how to prevent and manage opioid overdose. Providers should be encouraged to keep their knowledge current about evidence-based practices for the use of opioid analgesics to manage pain, as well as specific steps to prevent and manage opioid overdose.

Federally funded Continuing Medical Education courses are available to providers at no charge at http://www.OpioidPrescribing.com (six courses funded by the Substance Abuse and Mental Health Services Administration) and on MedScape (two courses funded by the National Institute on Drug Abuse).

Helpful information for laypersons on how to prevent and manage overdose is available from Project Lazarus at http://projectlazarus.org/ or from the Massachusetts Health Promotion Clearinghouse at http://www.maclearinghouse.org.

Encourage providers and others to learn about preventing and managing opioid overdose.

STRATEGY 2: Ensure access to treatment for individuals who are misusing or addicted to opioids or who have other substance use disorders. Effective treatment of substance use disorders can reduce the risk of overdose and help overdose survivors attain a healthier life. Medication-assisted treatment, as well as counseling and other supportive services, can be obtained at SAMHSA-certified and DEA-registered opioid treatment programs (OTPs), as well as from physicians who are trained to provide care in office-based settings with medications such as buprenorphine and naltrexone.

Information on treatment services available in or near your community can be obtained from your state health department, state alcohol and drug agency, or from the federal Substance Abuse and Mental Health Services Administration (see page 7).

Ensure access to treatment for individuals who are misusing or addicted to opioids or who have other substance use disorders.

STRATEGY 3: Ensure ready access to naloxone. Opioid overdose-related deaths can be prevented when naloxone is administered in a timely manner. As a narcotic antagonist, naloxone displaces opiates from receptor sites in the brain and reverses respiratory depression that usually is the cause of overdose deaths [5]. *During the period of time when an overdose can become fatal, respiratory depression can be reversed by giving the individual naloxone* [4].

On the other hand, naloxone is *not* effective in treating overdoses of benzodiazepines (such as Valium, Xanax, or Klonopin), barbiturates (Seconal or Fiorinal), clonidine, Elavil, GHB, or ketamine. It also is not effective in overdoses with stimulants, such as cocaine and amphetamines (including methamphetamine and Ecstasy). However, if opioids are taken in combination with other sedatives or stimulants, naloxone may be helpful.

Naloxone injection has been approved by FDA and used for more than 40 years by emergency medical services (EMS) personnel to reverse opioid overdose and resuscitate persons who otherwise might have died in the absence of treatment [6].

Naloxone has no psychoactive effects and does not present any potential for abuse [1, 4]. Injectable naloxone is relatively inexpensive. It typically is supplied as a kit with two syringes, at a cost of about $6 per dose and $15 per kit [7].

For these reasons, it is important to determine whether local EMS personnel or other first responders have been trained to care for overdose, and whether they are allowed to stock naloxone in their drug kits. In some jurisdictions, the law protects responders from civil liability and criminal prosecution for administering naloxone. So-called "Good Samaritan" laws are in effect in 10 states and the District of Columbia, and are being considered by legislatures in at least a half-dozen other states [8]. Such laws provide protection against prosecution for both the overdose victim and those who respond to overdose. To find states that have adopted relevant laws, visit the CDC's website at: http://www.cdc.gov/HomeandRecreational Safety/Poisoning/laws/immunity.html.

Encourage the public to call 911.

STRATEGY 4: Encourage the public to call 911. An individual who is experiencing opioid overdose needs immediate medical attention. An essential first step is to get help from someone with medical expertise as quickly as possible [9, 10]. Therefore, members of the public should be encouraged to call 911. All they have to say is, "Someone is not breathing" and give a clear address and location.

Encourage prescribers to use state Prescription Drug Monitoring Programs.

STRATEGY 5: Encourage prescribers to use state Prescription Drug Monitoring Programs (PDMPs). State Prescription Drug Monitoring Programs (PDMPs) have emerged as a key strategy for addressing the misuse and abuse of prescription opioids and thus preventing opioid overdoses and deaths. Specifically, prescribers can check their state's PDMP database to determine whether a patient is filling the prescriptions provided and/or obtaining prescriptions for the same or similar drug from multiple physicians.

While a majority of states now have operational PDMPs, the programs differ from state to state in terms of the exact information collected, how soon that information is available to physicians, and who may access the data. Therefore, information about the program in a particular state is best obtained directly from the state PDMP or from the board of medicine or pharmacy.

RESOURCES FOR COMMUNITIES

Resources that may be useful to local communities and organizations are found at the following websites:

Substance Abuse and Mental Health Services Administration (SAMHSA)
National Treatment Referral Helpline
1-800-662-HELP (4357) or 1-800-487-4889
(TDD — for hearing impaired)

National Substance Abuse Treatment Facility Locator:
http://www.findtreatment.samhsa.gov/TreatmentLocator to search by state, city, county, and zip code

Buprenorphine Physician & Treatment Program Locator:
http://www.buprenorphine.samhsa.gov/bwns_locator

State Substance Abuse Agencies:
http://findtreatment.samhsa.gov/TreatmentLocator/faces/abuseAgencies.jspx

Center for Behavioral Health Statistics and Quality (CBHSQ):
http://www.samhsa.gov/data/

SAMHSA Publications: http://www.store.samhsa.gov
1-877-SAMHSA (1-877-726-4727)

Centers for Disease Control and Prevention (CDC)
http://www.cdc.gov/Features/VitalSigns/PainkillerOverdoses
http://www.cdc.gov/HomeandRecreationSafety/Poisoning

White House Office of National Drug Control Policy (ONDCP)
State and Local Information: http://www.whitehouse.gov/ondcp/state-map

Association of State and Territorial Health Officials (ASTHO)
Prescription Drug Overdose: State Health Agencies Respond (2008):
http://www.astho.org

National Association of State Alcohol and Drug Abuse Directors (NASADAD)
State Issue Brief on Methadone Overdose Deaths:
http://www.nasadad.org/nasadad-reports

National Association of State EMS Officials (NASEMSO)
National Emergency Medical Services Education Standards:
http://www.nasemso.org

American Association for the Treatment of Opioid Dependence (AATOD)
Prevalence of Prescription Opioid Abuse: http://www.aatod.org/

Resources that may be useful to local communities and organizations...

FIVE ESSENTIAL STEPS FOR FIRST RESPONDERS

Overdose is common among persons who use illicit opioids such as heroin and among those who misuse medications prescribed for pain, such as oxycodone, hydrocodone, and morphine. The incidence of opioid overdose is rising nationwide. For example, between 2001 and 2010, the number of poisoning deaths in the United States nearly doubled, largely because of overdoses involving prescription opioid analgesics [1]. This increase coincided with a nearly fourfold increase in the use of prescribed opioids for the treatment of pain [3].

To address the problem, emergency medical personnel, health care professionals, and patients increasingly are being trained in the use of the opioid antagonist naloxone hydrochloride (naloxone or Narcan), which is the treatment of choice to reverse the potentially fatal respiratory depression caused by opioid overdose. (Note that naloxone has no effect on non-opioid overdoses, such as those involving cocaine, benzodiazepines, or alcohol [11].)

Based on current scientific evidence and extensive experience, the steps outlined below are recommended to reduce the number of deaths resulting from opioid overdoses [2, 4, 7, 12-14].

STEP 1: CALL FOR HELP (DIAL 911)

AN OPIOID OVERDOSE NEEDS IMMEDIATE MEDICAL ATTENTION. An essential step is to get someone with medical expertise to see the patient as soon as possible, so if no EMS or other trained personnel are on the scene, dial 911 immediately. All you have to say is: "Someone is not breathing." Be sure to give a clear address and/or description of your location.

STEP 2: CHECK FOR SIGNS OF OPIOID OVERDOSE

Signs of **OVERDOSE**, which often results in death if not treated, include [11]:

- Face is extremely pale and/or clammy to the touch
- Body is limp
- Fingernails or lips have a blue or purple cast
- The patient is vomiting or making gurgling noises
- He or she cannot be awakened from sleep or is unable to speak
- Breathing is very slow or stopped
- Heartbeat is very slow or stopped.

Signs of **OVERMEDICATION**, which may progress to overdose, include [11]:

- Unusual sleepiness or drowsiness
- Mental confusion, slurred speech, intoxicated behavior
- Slow or shallow breathing
- Pinpoint pupils
- Slow heartbeat, low blood pressure
- Difficulty waking the person from sleep.

Because opioids depress respiratory function and breathing, one telltale sign of a person in a critical medical state is the "death rattle." If a person emits a "death rattle" — an exhaled breath with a very distinct, labored sound coming from the throat — emergency resuscitation will be necessary immediately, as it almost always is a sign that the individual is near death [13].

STEP 3: SUPPORT THE PERSON'S BREATHING

Ideally, individuals who are experiencing opioid overdose should be ventilated with 100% oxygen before naloxone is administered so as to reduce the risk of acute lung injury [2, 4]. In situations where 100% oxygen is not available, rescue breathing can be very effective in supporting respiration [2]. Rescue breathing involves the following steps:

- Be sure the person's airway is clear (check that nothing inside the person's mouth or throat is blocking the airway).
- Place one hand on the person's chin, tilt the head back and pinch the nose closed.
- Place your mouth over the person's mouth to make a seal and give 2 slow breaths.
- The person's chest should rise (but not the stomach).
- Follow up with one breath every 5 seconds.

STEP 4: ADMINISTER NALOXONE

Naloxone (Narcan) should be administered to any person who shows signs of opioid overdose, or when overdose is suspected [4]. Naloxone injection is approved by the FDA and has been used for decades by emergency medical services (EMS) personnel to reverse opioid overdose and resuscitate individuals who have overdosed on opioids.

Naloxone can be given by intramuscular or intravenous injection every 2 to 3 minutes [4, 13-14]. The most rapid onset of action is achieved by intravenous administration, which is recommended in emergency situations [13]. The dose should be titrated to the smallest effective dose that maintains spontaneous normal respiratory drive.

Opioid-naive patients may be given starting doses of up to 2 mg without concern for triggering withdrawal symptoms [2, 4, 7, 14].

The intramuscular route of administration may be more suitable for patients with a history of opioid dependence because it provides a slower onset of action and a prolonged duration of effect, which may minimize rapid onset of withdrawal symptoms [2, 4, 7].

DURATION OF EFFECT. The duration of effect of naloxone is 30 to 90 minutes, and patients should be observed after this time frame for the return of overdose symptoms [4, 13-14]. The goal of naloxone therapy should be to restore adequate spontaneous breathing, but not necessarily complete arousal [4].

More than one dose of naloxone may be needed to revive someone who is overdosing. Patients who have taken longer-acting opioids may require further intravenous bolus doses or an infusion of naloxone [4].

Comfort the person being treated, as withdrawal triggered by naloxone can feel unpleasant. As a result, some persons become agitated or combative when this happens and need help to remain calm.

SAFETY OF NALOXONE. The safety profile of naloxone is remarkably high, especially when used in low doses and titrated to effect [2, 4, 13, 17]. When given to individuals who are not opioid-intoxicated or opioid-dependent, naloxone produces no clinical effects, even at high doses. Moreover, while rapid opioid withdrawal in tolerant patients may be unpleasant, it is not life-threatening.

Naloxone can safely be used to manage opioid overdose in pregnant women. The lowest dose to maintain spontaneous respiratory drive should be used to avoid triggering acute opioid withdrawal, which may cause fetal distress [4].

STEP 5: MONITOR THE PERSON'S RESPONSE

All patients should be monitored for recurrence of signs and symptoms of opioid toxicity for at least 4 hours from the last dose of naloxone or discontinuation of the naloxone infusion. Patients who have overdosed on long-acting opioids should have more prolonged monitoring [2, 4, 7].

Most patients respond by returning to spontaneous breathing, with minimal withdrawal symptoms [4]. The response generally occurs within 3 to 5 minutes of naloxone administration. (Rescue breathing should continue while waiting for the naloxone to take effect. [2, 4, 7])

Naloxone will continue to work for 30 to 90 minutes, but after that time, overdose symptoms may return [13, 14]. Therefore, it is essential to get the person to an emergency department or other source of medical care as quickly as possible, even if he or she revives after the initial dose of naloxone and seems to feel better.

SIGNS OF OPIOID WITHDRAWAL. The signs and symptoms of opioid withdrawal in an individual who is physically dependent on opioids may include, but are not limited to, the following: body aches, diarrhea, tachycardia, fever, runny nose, sneezing, piloerection, sweating, yawning, nausea or vomiting, nervousness, restlessness or irritability, shivering or trembling, abdominal cramps, weakness, and increased blood pressure. In the neonate, opioid withdrawal may also include convulsions, excessive crying, and hyperactive reflexes [13].

NALOXONE-RESISTANT PATIENTS. If a patient does not respond to naloxone, an alternative explanation for the clinical symptoms should be considered. The most likely explanation is that the person is not overdosing on an opioid but rather some other substance or may even be experiencing a non-overdose medical emergency. A possible explanation to consider is that the individual has overdosed on buprenorphine, a long-acting opioid partial agonist. Because buprenorphine has a higher affinity for the opioid receptors than do other opioids, naloxone may not be effective at reversing the effects of buprenorphine-induced opioid overdose [14].

In all cases, support of ventilation, oxygenation, and blood pressure should be sufficient to prevent the complications of opioid overdose and should be given priority if the response to naloxone is not prompt.

SUMMARY:

Do's and Don'ts in Responding to Opioid Overdose

- **DO** support the person's breathing by administering oxygen or performing rescue breathing.
- **DO** administer naloxone.
- **DO** put the person in the "recovery position" on the side, if he or she is breathing independently.
- **DO** stay with the person and keep him/her warm.
- **DON'T** slap or try to forcefully stimulate the person — it will only cause further injury. If you are unable to wake the person by shouting, rubbing your knuckles on the sternum (center of the chest or rib cage), or light pinching, he or she may be unconscious.
- **DON'T** put the person into a cold bath or shower. This increases the risk of falling, drowning or going into shock.
- **DON'T** inject the person with any substance (salt water, milk, "speed," heroin, etc.). The only safe and appropriate treatment is naloxone.
- **DON'T** try to make the person vomit drugs that he or she may have swallowed. Choking or inhaling vomit into the lungs can cause a fatal injury.

NOTE: All naloxone products have an expiration date, so it is important to check the expiration date and obtain replacement naloxone as needed.

INFORMATION FOR PRESCRIBERS

Opioid overdose is a major public health problem, accounting for almost 17,000 deaths a year in the United States [15]. Overdose involves both males and females of all ages, ethnicities, and demographic and economic characteristics, and involves both illicit opioids such as heroin and, increasingly, prescription opioid analgesics such as oxycodone, hydrocodone, fentanyl and methadone [3].

Physicians and other health care providers can make a major contribution toward reducing the toll of opioid overdose through the care they take in prescribing opioid analgesics and monitoring patients' response, as well as throiugh their acuity in identifying and effectively addressing opioid overdose. Federally funded CME courses are available at no charge at http://www.OpioidPrescribing.com (six courses funded by the Substance Abuse and Mental Health Services Administration) and on MedScape (two courses funded by the National Institute on Drug Abuse).

OPIOID OVERDOSE

The risk of opioid overdose can be minimized through adherence to the following clinical practices, which are supported by a considerable body of evidence [2, 7, 16-17].

ASSESS THE PATIENT. Obtaining a history of the patient's past use of drugs (either illicit drugs or prescribed medications with abuse potential) is an essential first step in appropriate prescribing. Such a history should include very specific questions. For example:

- "In the past 6 months, have you taken any medications to help you calm down, keep from getting nervous or upset, raise your spirits, make you feel better, and the like?"
- "Have you been taking any medications to help you sleep? Have you been using alcohol for this purpose?"
- "Have you ever taken a medication to help you with a drug or alcohol problem?"
- "Have you ever taken a medication for a nervous stomach?"
- "Have you taken a medication to give you more energy or to cut down on your appetite?"

The patient history also should include questions about use of alcohol and over-the-counter (OTC) preparations. For example, the ingredients in many common cold preparations include alcohol and other central nervous system (CNS) depressants, so these products should not be used in combination with opioid analgesics.

Positive answers to any of these questions warrant further investigation.

TAKE SPECIAL PRECAUTIONS WITH NEW PATIENTS. Many experts recommend that additional precautions be taken in prescribing for new patients [7, 17]. These might involve the following:

1. **Assessment:** In addition to the patient history and examination, the physician should determine who has been caring for the patient in the past, what medications have been prescribed and for what indications, and what substances (including alcohol, illicit drugs and OTC products) the patient has reported using. Medical records should be obtained (with the patient's consent) directly from past caregivers.
2. **Emergencies:** In emergency situations, the physician should prescribe the smallest possible quantity (typically not exceeding 3 days' supply) and arrange for a return visit the next day. The patient's identity should be verified by asking for proper identification.
3. **Non-emergencies:** In non-emergency situations, only enough of an opioid analgesic should be prescribed to meet the patient's needs until the next appointment. The patient should be directed to return to the office for additional prescriptions, as telephone orders do not allow the physician to reassess the patient's continued need for the medication.

STATE PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs) have emerged as a key strategy for addressing the misuse and abuse of prescription opioids and thus preventing opioid overdoses and deaths. Specifically, prescribers can check their state's PDMP database to determine whether a patient is filling the prescriptions provided and/or obtaining prescriptions for the same or similar drugs from multiple physicians.

While many states now have operational PDMPs, the programs differ from state to state in terms of the exact information collected, how soon that information is available to physicians, and who may access the data. Therefore, information about the program in a particular state is best obtained directly from the PDMP or from the state board of medicine or pharmacy.

SELECT AN APPROPRIATE MEDICATION. Rational drug therapy demands that the efficacy and safety of all potentially useful medications be reviewed for their relevance to the patient's disease or disorder [2, 17].

When an appropriate medication has been selected, the *dose*, *schedule*, and *formulation* should be determined. These choices often are just as important in optimizing pharmacotherapy as the choice of medication itself. Decisions involve (1) dose (based not only on age and weight of the patient, but also on severity of the disorder, possible loading-dose requirement, and the presence of potentially interacting drugs); (2) timing of administration (such as a bedtime dose to minimize problems associated with sedative or respiratory depressant effects); (3) route of administration (chosen to improve compliance/adherence as well as to attain peak drug concentrations rapidly); and (4) formulation (e.g., selecting a patch in preference to a tablet, or an extended-release product rather than an immediate-release formulation).

Even when sound medical indications have been established, physicians typically consider three additional factors before deciding to prescribe an opioid analgesic [2, 17]:

1. The **severity of symptoms**, in terms of the patient's ability to accommodate them. Relief of symptoms is a legitimate goal of medical practice, but using opioid analgesics requires caution.
2. The patient's **reliability in taking medications**, noted through observation and careful history-taking. The physician should assess a patient's history of and risk factors for drug abuse before prescribing any psychoactive drug and weigh the benefits against the risks. The likely development of physical dependence in patients on long-term opioid therapy should be monitored through periodic check-ups.
3. The **dependence-producing potential of the medication**. The physician should consider whether a product with less potential for abuse, or even a non-drug therapy, would provide equivalent benefits. Patients should be warned about possible adverse effects caused by interactions between opioids and other medications or substances, including alcohol.

At the time a drug is prescribed, patients should be informed that it is illegal to sell, give away, or otherwise share their medication with others, including family members. The patient's obligation extends to keeping the medication in a locked cabinet or otherwise restricting access to it and to safely disposing of any unused supply (visit http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm101653.htm for advice from the FDA on how to safely dispose of unused medications).

EDUCATE THE PATIENT AND OBTAIN INFORMED CONSENT. Obtaining informed consent involves informing the patient about the risks and benefits of the proposed therapy and of the ethical and legal obligations such therapy imposes on both physician and patient [17]. Such informed consent can serve multiple purposes: (1) it provides the patient with information about the risks and benefits of opioid therapy; (2) it fosters adherence to the treatment plan; (3) it limits the potential for inadvertent drug misuse; and (4) it improves the efficacy of the treatment program.

Patient education and informed consent should specifically address the potential for physical dependence and cognitive impairment as side effects of

opioid analgesics. Other issues that should be addressed in the informed consent or treatment agreement include the following [17]:

- The agreement instructs the patient to stop taking all other pain medications, unless explicitly told to continue by the physician. Such a statement reinforces the need to adhere to a single treatment regimen.
- The patient agrees to obtain the prescribed medication from only one physician and, if possible, from one designated pharmacy.
- The patient agrees to take the medication only as prescribed (for some patients, it may be possible to offer latitude to adjust the dose as symptoms dictate).
- The agreement makes it clear that the patient is responsible for safeguarding the written prescription and the supply of medications, and arranging refills during regular office hours. This responsibility includes planning ahead so as not to run out of medication during weekends or vacation.
- The agreement specifies the consequences for failing to adhere to the treatment plan, which may include discontinuation of opioid therapy if the patient's actions compromise his or her safety.

Both patient and physician should sign the informed consent agreement, and a copy should be placed in the patient's medical record. It also is helpful to give the patient a copy of the agreement to carry with him or her, to document the source and reason for any controlled drugs in his or her possession. Some physicians provide a laminated card that identifies the individual as a patient of their practice. This is helpful to other physicians who may see the patient and in the event the patient is seen in an emergency department.

EXECUTE THE PRESCRIPTION ORDER. Careful execution of the prescription order can prevent manipulation by the patient or others intent on obtaining opioids for non-medical purposes. For example, federal law requires that prescription orders for controlled substances be signed and dated on the day they are issued. Also under federal law, every prescription order must include at least the following information:

Name and address of the patient
Name, address and DEA registration number of the physician
Signature of the physician
Name and quantity of the drug prescribed
Directions for use
Refill information
Effective date if other than the date on which the prescription was written.

Many states impose additional requirements, which the physician can determine by consulting the state medical licensing board. In addition, there are special federal requirements for drugs in different schedules of the federal Controlled Substances Act (CSA), particularly those in Schedule II, where many opioid analgesics are classified.

Blank prescription pads — as well as information such as the names of physicians who recently retired, left the state, or died — all can be used to forge prescriptions. Therefore, it is a sound practice to store blank prescriptions in a secure place rather than leaving them in examining rooms.

NOTE: The physician should immediately report the theft or loss of prescription blanks to the nearest field office of the federal Drug Enforcement Administration and to the state board of medicine or pharmacy.

MONITOR THE PATIENT'S RESPONSE TO TREATMENT. Proper prescription practices do not end when the patient receives a prescription. Plans to monitor for drug efficacy and safety, compliance, and potential development of tolerance must be documented and clearly communicated to the patient [2].

Subjective symptoms are important in monitoring, as are objective clinical signs (such as body weight, pulse rate, temperature, blood pressure, and levels of drug metabolites in the bloodstream). These can serve as early signs of therapeutic failure or unacceptable adverse drug reactions that require modification of the treatment plan.

Asking the patient to keep a log of signs and symptoms gives him or her a sense of participation in the treatment

program and facilitates the physician's review of therapeutic progress and adverse events.

Simply recognizing the potential for non-adherence, especially during prolonged treatment, is a significant step toward improving medication use [18]. Steps such as simplifying the drug regimen and offering patient education also improve adherence, as do phone calls to patients, home visits by nursing personnel, convenient packaging of medication, and periodic urine testing for the prescribed opioid as well as any other respiratory depressant.

Finally, the physician should convey to the patient through attitude and manner that any medication, no matter how helpful, is only part of an overall treatment plan.

When the physician is concerned about the behavior or clinical progress (or the lack thereof) of a patient being treated with an opioid analgesic, it usually is advisable to seek a consultation with an expert in the disorder for which the patient is being treated *and* an expert in addiction. Physicians place themselves at risk if they continue to prescribe opioids in the absence of such consultxations [17].

CONSIDER PRESCRIBING NALOXONE ALONG WITH THE PATIENT'S INITIAL OPIOID PRESCRIPTION. With proper education, patients on long-term opioid therapy and others at risk for overdose may benefit from having a naloxone kit to use in the event of overdose [4].

Patients who are candidates for such kits include those who are:

- Taking high doses of opioids for long-term management of chronic malignant or non-malignant pain.
- Receiving rotating opioid medication regimens (and thus are at risk for incomplete cross-tolerance).
- Discharged from emergency medical care following opioid intoxication or poisoning.
- At high risk for overdose because of a legitimate medical need for analgesia, coupled with a suspected or confirmed history of substance abuse, dependence, or non-medical use of prescription or illicit opioids.
- Completing mandatory opioid detoxification or abstinence programs.
- Recently released from incarceration and a past user or abuser of opioids (and presumably with reduced opioid tolerance and high risk of relapse to opioid use).

It also may be advisable to suggest that the at-risk patient create an "overdose plan" to share with friends, partners and/or caregivers. Such a plan would contain information on the signs of overdose and how to administer naloxone or otherwise provide emergency care (as by calling 911).

DECIDE WHETHER AND WHEN TO END OPIOID THERAPY. Certain situations may warrant immediate cessation of prescribing. These generally occur when out-of-control behaviors indicate that continued prescribing is unsafe or causing harm to the patient [2]. Examples include altering or selling prescriptions, accidental or intentional overdose, multiple episodes of running out early (due to excessive use), doctor shopping, or engaging in threatening behavior.

When such events arise, it is important to separate the patient as a person from the behaviors caused by the disease of addiction, as by demonstrating a positive regard for the person but no tolerance for the aberrant behaviors.

In such a situation, the essential steps are to (1) stop prescribing, (2) tell the patient that continued prescribing is not clinically supportable (and thus not possible), (3) urge the patient to accept a referral for assessment by an addiction specialist, (4) educate the patient about signs and symptoms of spontaneous withdrawal and urge the patient to go to the emergency department if withdrawal symptoms occur, and (5) assure the patient that he or she will continue to receive care for the presenting symptoms or condition [17].

Identification of a patient who is abusing a prescribed opioid presents a major therapeutic opportunity. The physician should have a plan for managing such a patient, typically involving work with the patient and the patient's family, referral to an addiction expert for assessment and placement in a formal addiction treatment program, long-term participation in a 12-Step mutual help program such as Narcotics Anonymous, and follow-up of any associated medical or psychiatric comorbidities [2].

In all cases, patients should be given the benefit of the physician's concern and attention. It is important to remember that even drug-seeking patients often have very real medical problems that demand and deserve the same high-quality medical care offered to any patient [2, 17].

TREATING OPIOID OVERDOSE

In the time it takes for an overdose to become fatal, it is possible to reverse the respiratory depression and other effects of opioids through respiratory support and administration of the opioid antagonist naloxone (Narcan) [13]. Naloxone is approved by the FDA and has been used for decades to reverse overdose and resuscitate individuals who have overdosed on opioids.

The safety profile of naloxone is remarkably high, especially when used in low doses and titrated to effect [4, 13]. If given to individuals who are not opioid-intoxicated or opioid-dependent, naloxone produces no clinical effects, even at high doses. Moreover, while rapid opioid withdrawal in tolerant patients may be unpleasant, it is not typically life-threatening.

Naloxone should be part of an overall approach to opioid overdose that incorporates the following steps.

RECOGNIZE THE SIGNS OF OVERDOSE. An opioid overdose requires rapid diagnosis. The most common signs of overdose include [2]:

- Pale and clammy face
- Limp body
- Fingernails or lips turning blue/purple
- Vomiting or gurgling noises
- Cannot be awakened from sleep or is unable to speak
- Very little or no breathing
- Very slow or no heartbeat

Signs of **OVERMEDICATION**, which may progress to overdose, include [2]:

- Unusual sleepiness or drowsiness
- Mental confusion, slurred speech, intoxicated behavior
- Slow or shallow breathing
- Pinpoint pupils
- Slow heartbeat, low blood pressure
- Difficulty waking the individual from sleep

Because opioids depress respiratory function and breathing, one telltale sign of an individual in a critical medical state is the "death rattle." Often mistaken for snoring, the "death rattle" is an exhaled breath with a very distinct, labored sound coming from the throat. It indicates that emergency resuscitation is needed immediately [4].

SUPPORT RESPIRATION. Supporting respiration is the single most important intervention for opioid overdose and may be life-saving on its own. Ideally, individuals who are experiencing opioid overdose should be ventilated with 100% oxygen before naloxone is administered to reduce the risk of acute lung injury [2, 4]. In situations where 100% oxygen is not available, rescue breathing can be very effective in supporting respiration [4]. Rescue breathing involves the following steps:

- Verify that the airway is clear.
- With one hand on the patient's chin, tilt the head back and pinch the nose closed.
- Place your mouth over the patient's mouth to make a seal and give 2 slow breaths (the patient's chest should rise, but not the stomach).
- Follow up with one breath every 5 seconds.

ADMINISTER NALOXONE. Naloxone (Narcan) should be given to any patient who presents with signs of opioid overdose, or when overdose is suspected [4]. Naloxone can be given by intramuscular or intravenous injection every 2 to 3 minutes [4, 13-14].

The most rapid onset of action is achieved by intravenous administration, which is recommended in emergency situations [13]. Intravenous administration generally is used with patients who have no history of opioid dependence. Opioid-naive patients may be given starting doses of up to 2 mg without concern for triggering withdrawal symptoms [4].

The intramuscular route of administration may be more suitable for patients with a history of opioid dependence because it provides a slower onset of action and a prolonged duration of effect, which may minimize rapid onset of withdrawal symptoms [4].

Pregnant patients. Naloxone can be used safely to manage opioid overdose in pregnant women. The lowest dose to maintain spontaneous respiratory drive should be used to avoid triggering acute opioid withdrawal, which may cause fetal distress [4].

MONITOR THE PATIENT'S RESPONSE. Patients should be monitored for re-emergence of signs and symptoms of opioid toxicity for at least 4 hours following the last dose of naloxone (however, patients who have overdosed on long-acting opioids require more prolonged monitoring) [4].

Most patients respond to naloxone by returning to spontaneous breathing, with mild withdrawal symptoms [4]. The response generally occurs within 3 to 5 minutes of naloxone administration. (Rescue breathing should continue while waiting for the naloxone to take effect.)

The duration of effect of naloxone is 30 to 90 minutes. Patients should be observed after that time for re-emergence of overdose symptoms. The goal of naloxone therapy should be restoration of adequate spontaneous breathing, but not necessarily complete arousal [4, 13-14].

More than one dose of naloxone may be required to revive the patient. Those who have taken longer-acting opioids may require further intravenous bolus doses or an infusion of naloxone [4]. Therefore, it is essential to get the person to an emergency department or other source of acute care as quickly as possible, even if he or she revives after the initial dose of naloxone and seems to feel better.

SIGNS OF OPIOID WITHDRAWAL: Withdrawal triggered by naloxone can feel unpleasant. As a result, some persons become agitated or combative when this happens and need help to remain calm.

The signs and symptoms of opioid withdrawal in an individual who is physically dependent on opioids may include (but are not limited to) the following: body aches, diarrhea, tachycardia, fever, runny nose, sneezing, piloerection, sweating, yawning, nausea or vomiting, nervousness, restlessness or irritability, shivering or trembling, abdominal cramps, weakness, and increased blood pressure [13]. Withdrawal syndromes may be precipitated by as little as 0.05 to 0.2 mg intravenous naloxone in a patient taking 24 mg per day of methadone.

In neonates, opioid withdrawal also may produce convulsions, excessive crying, and hyperactive reflexes [13].

NALOXONE-RESISTANT PATIENTS: If a patient does not respond to naloxone, an alternative explanation for the clinical symptoms should be considered. The most likely explanation is that the person is not overdosing on an opioid but rather some other substance or may even be experiencing a non-overdose medical emergency. A possible explanation to consider is that the individual has overdosed on buprenorphine, a long-acting opioid partial agonist. Because buprenorphine has a higher affinity for the opioid receptors than do other opioids, naloxone may not be effective at reversing the effects of buprenorphine-induced opioid overdose [4].

In all cases, support of ventilation, oxygenation, and blood pressure should be sufficient to prevent the complications of opioid overdose and should be given the highest priority if the patient's response to naloxone is not prompt.

NOTE: All naloxone products have an expiration date. It is important to check the expiration date and obtain replacement naloxone as needed.

LEGAL AND LIABILITY CONSIDERATIONS

Health care professionals who are concerned about legal risks associated with prescribing naloxone may be reassured by the fact that prescribing naloxone to manage opioid overdose is consistent with the drug's FDA-approved indication, resulting in no increased liability so long as the prescriber adheres to general rules of professional conduct. State laws and regulations generally prohibit physicians from prescribing a drug such as naloxone to a third party, such as a caregiver. (Illinois, Massachusetts, New York, and Washington State are the exceptions to this general principle.) More information on state policies is available at http://www.prescribetoprevent.org/ or from individual state medical boards.

CLAIMS CODING AND BILLING

Most private health insurance plans, Medicare, and Medicaid cover naloxone for the treatment of opioid overdose, but policies vary by state. The cost of take-home naloxone should not be a prohibitive factor. Not all community pharmacies stock naloxone routinely but can always order it. If you are caring for a large population of patients who are likely to benefit from naloxone, you may wish to notify the pharmacy when you implement naloxone prescribing as a routine practice.

The codes for Screening, Brief Intervention, and Referral to Treatment (SBIRT) can be used to bill time for counseling a patient about how to recognize overdose and how to administer naloxone. Billing codes for SBIRT are as follows:

Commercial Insurance: CPT 99408 (15 to 30 minutes)

Medicare: G0396 (15 to 30 minutes)

Medicaid: H0050 (per 15 minutes)

RESOURCES FOR PRESCRIBERS

Additional information on prescribing opioids for chronic pain is available at the following websites:

http://www.opioidprescribing.com. Sponsored by the Boston University School of Medicine, with support from SAMHSA, this site presents course modules on various aspects of prescribing opioids for chronic pain. To view the list of courses and to register, go to http://www.opioidprescribing.com/overview. CME credits are available at no charge.

http://www.pcss-o.org or http://www.pcssb.org. Sponsored by the American Academy of Addiction Psychiatry in collaboration with other specialty societies and with support from SAMHSA, the Prescriber's Clinical Support System offers multiple resources related to opioid prescribing and the diagnosis and management of opioid use disorders.

http://www.medscape.com. Two course modules sponsored by the National Institute on Drug Abuse and posted on MedScape can be accessed at http://www.medscape.org/viewarticle/770687 and http://www.medscape.org/viewarticle/770440. CME credits are available.

WHAT ARE OPIOIDS?

Opioids include illicit drugs such as heroin and prescription medications used to treat pain such as morphine, codeine, methadone, oxycodone (Oxycontin, Percodan, Percocet), hydrocodone (Vicodin, Lortab, Norco), fentanyl (Duragesic, Fentora), hydromorphone (Dilaudid, Exalgo), and buprenorphine (Suboxone).

Opioids work by binding to specific receptors in the brain, spinal cord and gastrointestinal tract. In doing so, they minimize the body's perception of pain. However, stimulating the opioid receptors or "reward centers" in the brain also can trigger other systems of the body, such as those responsible for regulating mood, breathing, and blood pressure.

A variety of effects can occur after a person takes opioids, ranging from pleasure to nausea, vomiting, severe allergic reactions (anaphylaxis) to overdose, in which breathing and heartbeat slow or even stop.

Opioid overdose can occur when a patient misunderstands the directions for use, accidentally takes an extra dose, or deliberately misuses a prescription opioid or an illicit drug such as heroin. Also at risk is the person who takes opioid medications prescribed for someone else, as is the individual who combines opioids — prescribed or illicit — with alcohol, certain other medications, and even some over-the-counter products that depress breathing, heart rate, and other functions of the central nervous system [4].

PREVENTING OVERDOSE

If you are concerned about your own use of opioids, don't wait! Talk with the health care professional/s who prescribed the medications for you. If you are concerned about a family member or friend, urge him or her to do so as well.

Effective treatment of opioid use disorders can reduce the risk of overdose and help a person who is misusing or addicted to opioid medications attain a healthier life. An evidence-based practice for treating opioid addiction is the use of FDA-approved medications, along with counseling and other supportive services. These services are available at SAMHSA-certified and DEA-registered opioid treatment programs (OTPs) [19-20]. In addition, physicians who are trained to provide treatment for opioid addiction in office-based and other settings with medications such as buprenorphine/naloxone and naltrexone may be available in your community [21].

IF YOU SUSPECT AN OVERDOSE

An opioid overdose requires immediate medical attention. An essential first step is to get help from someone with medical expertise as soon as possible.

Call 911 immediately if you or someone you know exhibits any of the symptoms listed below. All you have to say: "Someone is unresponsive and not breathing." Give a clear address and/or description of your location.

Signs of **OVERDOSE**, which is a life-threatening emergency, include:

- Face is extremely pale and/or clammy to the touch
- Body is limp
- Fingernails or lips have a blue or purple cast
- The patient is vomiting or making gurgling noises
- He or she cannot be awakened from sleep or is unable to speak
- Breathing is very slow or stopped
- Heartbeat is very slow or stopped.

Signs of **OVERMEDICATION**, which may progress to overdose, include:

- Unusual sleepiness or drowsiness
- Mental confusion, slurred speech, intoxicated behavior
- Slow or shallow breathing
- Pinpoint pupils
- Slow heartbeat, low blood pressure
- Difficulty waking the person from sleep.

WHAT IS NALOXONE?

Naloxone (Narcan) is an antidote to opioid overdose. It is an opioid antagonist that is used to reverse the effects of opioids. Naloxone works by blocking opiate receptor sites. It is not effective in treating overdoses of benzodiazepines (such as Valium, Xanax, or Klonopin), barbiturates (Seconal or Fiorinal), clonidine, Elavil, GHB, or ketamine. It also is not effective in treating overdoses of stimulants such as cocaine and amphetamines (including methamphetamine and Ecstasy). However, if opioids are taken in combination with other sedatives or stimulants, naloxone may be helpful.

IMPORTANT SAFETY INFORMATION. Naloxone may cause dizziness, drowsiness, or fainting. These effects may be worse if it is taken with alcohol or certain medicines. Use naloxone with caution. Do not drive or perform other possibly unsafe tasks until you know how you react to it.

If you experience a return of symptoms (such as drowsiness or difficulty breathing), ***get help immediately***.

REPORT ANY SIDE EFFECTS

Get emergency medical help if you have any signs of an allergic reaction after taking naloxone, such as hives, difficulty breathing, or swelling of your face, lips, tongue, or throat.

Call your doctor or 911 at once if you have a serious side effect such as:

- Chest pain, or fast or irregular heartbeats;
- Dry cough, wheezing, or feeling short of breath;
- Sweating, severe nausea, or vomiting;
- Severe headache, agitation, anxiety, confusion, or ringing in your ears;
- Seizures (convulsions);
- Feeling that you might pass out; or
- Slow heart rate, weak pulse, fainting, or slowed breathing.

If you are being treated for dependence on opioid drugs (either an illicit drug like heroin or a medication prescribed for pain), you may experience the following symptoms of opioid withdrawal after taking naloxone:

- Feeling nervous, restless, or irritable;
- Body aches;
- Dizziness or weakness;
- Diarrhea, stomach pain, or mild nausea;
- Fever, chills, or goosebumps; or
- Sneezing or runny nose in the absence of a cold.

This is not a complete list of side effects, and others may occur. Talk to your doctor about side effects and how to deal with them.

STORE NALOXONE IN A SAFE PLACE

Naloxone is usually handled and stored by a health care provider. If you are using naloxone at home, store it in a locked cabinet or other space that is out of the reach of children or pets.

SUMMARY: HOW TO AVOID OPIOID OVERDOSE

1. Take medicine only if it has been prescribed to you by your doctor.
2. Do not take more medicine or take it more often than instructed.
3. Call a doctor if your pain gets worse.
4. Never mix pain medicines with alcohol, sleeping pills, or any illicit substance.
5. Store your medicine in a safe place where children or pets cannot reach it.
6. Learn the signs of overdose and how to use naloxone to keep it from becoming fatal.
7. Teach your family and friends how to respond to an overdose.
8. Dispose of unused medication properly.

READ MORE AT http://www.drugs.com/cdi/naloxone.html.

RESOURCES FOR OVERDOSE SURVIVORS AND FAMILY MEMBERS

Survivors of opioid overdose have experienced a life-changing and traumatic event. They have had to deal with the emotional consequences of overdosing, which can involve embarrassment, guilt, anger, and gratitude, all accompanied by the discomfort of opioid withdrawal. Most need the support of family and friends to take the next steps toward recovery.

While many factors can contribute to opioid overdose, it is almost always an accident. Moreover, the underlying problem that led to opioid use — most often pain or substance use disorder — still exists and continues to require attention [2].

Moreover, the individual who has experienced an overdose is not the only one who has endured a traumatic event. Family members often feel judged or inadequate because they could not prevent the overdose. It is important for families to work together to help the overdose survivor obtain the help that he or she needs.

FINDING A NETWORK OF SUPPORT

As with any disease, it is not a sign of weakness to admit that a person or a family cannot deal with the trauma of overdose without help. It takes real courage to reach out to others for support and to connect with members of the community to get help. Health care providers, including those who specialize in treating substance use disorders, can provide structured, therapeutic support and feedback.

If the survivor's underlying problem is pain, referral to a pain specialist may be in order. If it is addiction, the patient should be referred to an addiction specialist for assessment and treatment, either by a physician specializing in the treatment of opioid addiction, in a residential treatment program, or in a federally certified Opioid Treatment Program (OTP). In each case, counseling can help the individual manage his or her problems in a healthier way. Choosing the path to recovery can be a dynamic and challenging process, but there are ways to help.

In addition to receiving support from family and friends, overdose survivors can access a variety of community-based organizations and institutions, such as:

- Health care and behavioral health providers
- Peer-to-peer recovery support groups such as Narcotics Anonymous
- Faith-based organizations
- Educational institutions
- Neighborhood groups
- Government agencies
- Family and community support programs.

RESOURCES

Information on opioid overdose and helpful advice for overdose survivors and their families can be found at the following websites:

Substance Abuse and Mental Health Services Administration (SAMHSA)

- National Treatment Referral Helpline 1-800-662-HELP (4357) or 1-800-487-4889 (TDD — for hearing impaired)
- National Substance Abuse Treatment Facility Locator: http://www.findtreatment.samhsa.gov/TreatmentLocator to search by state, city, county, and zip code
- Buprenorphine Physician & Treatment Program Locator: http://www.buprenorphine.samhsa.gov/bwns_locator
- State Substance Abuse Agencies: http://findtreatment.samhsa.gov/TreatmentLocator/faces/abuse-Agencies.jspx

Centers for Disease Control and Prevention (CDC): http://www.cdc.gov/Features/VitalSigns/PainkillerOverdoses

National Institutes of Health (NIH), National Center for Biotechnical Information: http://www.ncbi.nlm.nih.gov

The Partnership at Drug-Free.org: http://www.drugfree.org/uncategorized/opioid-overdose-antidote

Project Lazarus: http://projectlazarus.org

Harm Reduction Coalition: http://harmreduction.org

Overdose Prevention Alliance: http://overdosepreventionalliance.org

Toward the Heart: http://towardtheheart.com/naloxone

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19. National Treatment Referral Helpline 1-800-662-HELP (4357) or 1-800-487-4889 (TDD for hearing impaired)

20. National Substance Abuse Treatment Facility Locator: http://www.findtreatment.samhsa.gov/TreatmentLocator to search by state, city, county, and zip code

21. Buprenorphine Physician & Treatment Program Locator: http://www.buprenorphine.samhsa.gov/ bwns_locator

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Seniors' use of potent meds via Medicare staggering

Peter Eisler, USA TODAY 7:15 p.m. EDT June 10, 2014

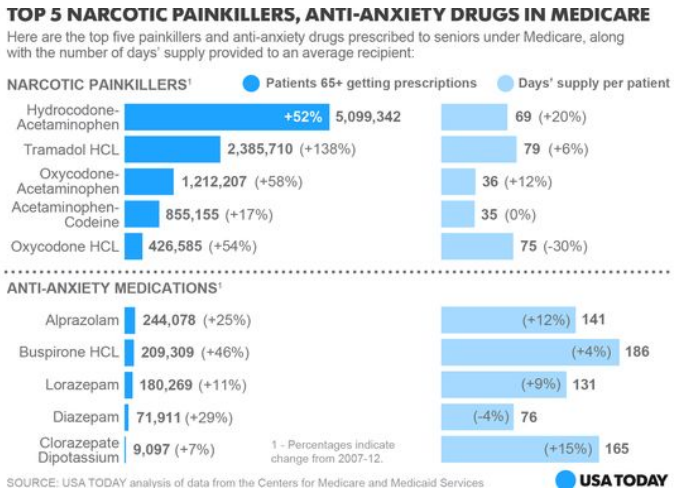
Michael Von Korff, investigator at the Seattle-based Group Health Research Institute, says seniors on powerful drugs risk injuries from falls, impaired breathing and cognitive problems.

WASHINGTON – The number of senior citizens getting narcotic painkillers and anti-anxiety medications under Medicare's prescription drug program is climbing sharply, and those older patients are being put on the drugs for longer periods of time, a USA TODAY examination of federal data shows.

From 2007-2012, the number of patients 65 and older getting Medicare prescriptions for powerful opioid pain medications rose more than 30% to upward of 8.5 million beneficiaries, the data show. Use of some of the most commonly abused painkillers, such as hydrocodone and oxycodone, climbed more than 50%. And the supply of each narcotic provided to the average recipient grew about 15% to about three months.

The figures suggest that one in five of the nation's 43 million seniors get Medicare prescriptions to take pills like Vicodin or Percocet for their aches and pains, often on a long-term basis.

Meanwhile, the number of seniors getting Medicare prescriptions for anti-anxiety medications, such as alprazolam (also sold as Xanax), busipirone and lorazepam (also sold as Ativan), rose about 25% to more than 700,000. By 2012, the average patient got about five months' worth – about 10% more than in 2007. The data for anti-anxiety medications are less comprehensive than for narcotics because one of the most popular classes of anti-anxiety drugs, benzodiazepines, got very limited coverage until last year under the Medicare drug benefit, known as Part D.



While often helpful on a short-term basis, many narcotic painkillers and anti-anxiety medicines carry considerable risks of abuse and dependence if their use is not closely supervised over longer periods. They also can contribute to confusion and physical injuries. As a result, public health officials have been urging prescribers to be far more judicious in determining which patients should be put on the drugs.

The increased prescribing to seniors "is something we really need to be concerned about," says Michael Von Korff, an investigator for the Group Health Research Institute in Seattle.

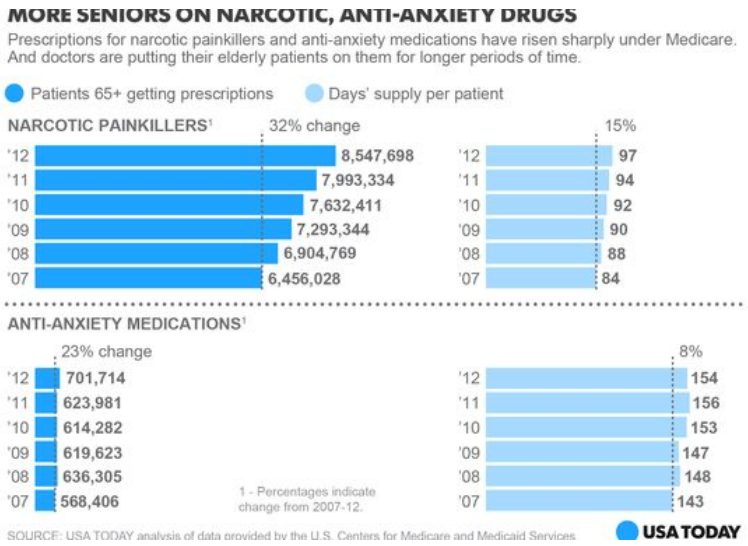
Von Korff says seniors on the drugs risk injuries from falls, impaired breathing and cognitive problems, and those risks often are magnified when the medications are used in combination. What's more, he says, "misuse and abuse of these medicines is not uncommon among the elderly. They do get into trouble with these drugs."

In a story last month, USA TODAY found that the number of seniors misusing painkillers and anti-anxiety drugs climbed substantially over the past decade. In 2012, an estimated 336,000 seniors had misused or become dependent on prescription pain relievers, according to data from the Substance Abuse and Mental Health Services Administration.

The rise in such prescriptions reflects "old teaching" that led many physicians to over-prescribe the drugs, especially for long-term treatment, says Jane Ballantyne, anesthesiologist and pain medicine expert at the University of Washington Medical Center. The newer consensus is that the drugs' use should be much more limited, particularly in patients with a history of substance abuse or among groups, such as seniors, who are more vulnerable to side effects, she adds. "But it takes a lot of time and effort to turn the old teaching around."

By drug type, the data show:

- Hydrocodone-acetaminophen, also sold as Lortab, Norco and Vicodin, has consistently been the most prescribed opioid painkiller for seniors under Medicare's drug program. It was prescribed to more than 5 million patients in 2012, up 52% from 2007, and the average patient got more than two months' worth – 20% more than 2007.
- Among other popular painkillers, the use of oxycodone–acetaminophen, also sold as Percocet, grew 58% to 1.2 million patients.The average patient got about a month's worth –12% more than 2007. Use of Tramadol grew the most. It was prescribed to 2.4 million patients in 2012, up nearly 140% since 2007.
- Despite limited coverage, the benzodiazepine Alprazolam still was the most prescribed anti-anxiety medication. There was a 25% rise in recipients from 2007-2012 to 244,000. The average patient got about four months' worth.
- The number of patients getting buspirone, another anti-anxiety drug, grew 46%, to 209,000. The average patient got nearly six months' worth. There also was an 11% increase in patients getting Lorazepam to 162,000. The average supply was four months.



"The big surprise for me is the amount of time that people are being left on these drugs – it's really concerning," says Linda Simoni-Wastila, a professor at the University of Maryland School of Pharmacy.

Simoni-Wastila notes that many anti-anxiety medications should not be taken for months at a time. And the same is true for painkillers, she adds. "Most folks don't need to be on long-term opioids; there are a lot of risks associated with that."

Officials from the Centers for Medicare & Medicaid Services (CMS) declined requests for an interview. In a statement, CMS said: "Medicare takes instances of prescription drug misuse very seriously and recently put in place aggressive new rules that take further steps to prevent drug abuse and overutilization."

Prescription for Success:

Statewide Strategies to Prevent and Treat the Prescription Drug Abuse Epidemic in Tennessee

TDMHSAS
Tennessee Department of Mental Health and Substance Abuse Services

A report produced by the Tennessee Department of Mental Health and Substance Abuse Services, in conjunction with:

Tennessee Department of Health

Lift them up! DCS

TennCare

Tennessee Bureau of Investigation

Department of Safety & Homeland Security

TDOC

U.S. Department of Justice Drug Enforcement Administration

Summer 2014

BILL HASLAM
GOVERNOR
STATE OF TENNESSEE

Fellow Tennesseans:

Prescription drug abuse is a serious problem in our state that is devastating to families and our communities. That is why I am pleased agencies across state government have come together to produce Prescription For Success: Statewide Strategies to Prevent and Treat the Prescription Drug Abuse Epidemic in Tennessee, a comprehensive, multi-faceted plan to combat the prescription drug abuse problem in our state.

The plan has three major components: a description of the extent of the prescription drug problem in Tennessee, information about how the problem is currently being addressed, and a plan for the future that includes specific, measurable goals that will allow us to determine if the lives of individuals and families in Tennessee have been improved as a result of these efforts. A menu of policy options is provided for the state's leaders to consider as we work to make progress toward these goals.

Combatting prescription drug abuse is aligned with my priorities as Governor. Tennesseans that are drug- free make better and more productive employees, family members and community members. In addition, stemming this epidemic will save our state millions of dollars in incarceration and treatment costs.

This plan requires many state agencies to work together, but there are also ways that individuals and communities can be part of solving this problem. I hope that we all can be part of reducing prescription drug misuse and abuse in our state and that you will find ways to connect with these efforts.

Sincerely,

Bill Haslam

Governor Bill Haslam

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FORWARD & ACKNOWLEDGEMENTS

Prescription drug abuse is a pervasive, multi-dimensional epidemic that is impacting Tennessee families and communities and requires a coordinated and collaborative response.

Prescription for Success: Statewide Strategies to Prevent and Treat the Prescription Drug Abuse Epidemic in Tennessee is a strategic plan developed by the Tennessee Department of Mental Health and Substance Abuse Services in collaboration with sister agencies impacted by the prescription drug epidemic. The Tennessee Department of Mental Health and Substance Abuse Services would like to acknowledge the contributions of the following partners: Departments of Health, Children's Services, Safety and Homeland Security, and Correction, Bureau of TennCare, the Tennessee Bureau of Investigation, and the Tennessee Branch of the United States Drug Enforcement Agency. Special thanks are extended to the commissioners of each of the partner agencies as well as those people who were interviewed and provided expertise and resources:

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Prescription For Success is comprehensive and multi-year in scope and nature. However, this plan does not obligate the Administration or the General Assembly to any additional funding requests to fulfill this plan's purpose. Funding requests related to the initiatives in this document will be determined through the normal General Assembly budgeting process.

EXECUTIVE SUMMARY

The Prescription Drug Epidemic in Tennessee:

Prescription drug abuse is a pervasive, multi-dimensional issue impacting Tennessee individuals, families, and communities. Of the **4,850,000 adults** in Tennessee, it is estimated that **221,000 (or 4.56%) have used pain relievers, also known as prescription opioids, in the past year for non-medical purposes**. Of those adults, it is estimated that **69,100 are addicted to prescription opioids and require treatment for prescription opioid abuse**. The other **151,900 are using prescription opioids in ways that could be harmful and may benefit from early intervention strategies**[1]. The remaining 4,629,000 adults in the population would benefit from broad-based prevention strategies that target the entire population.

The abuse of prescription drugs, specifically opioids, is an epidemic in Tennessee, with disastrous and severe consequences to Tennesseans of every age including: overdose deaths, emergency department visits, hospital costs, newborns with Neonatal Abstinence Syndrome, children in state custody, and people incarcerated for drug-related crimes.

Current Efforts to Combat the Prescription Drug Epidemic:

The Tennessee Department of Mental Health and Substance Abuse Services is designated as the Single State Authority for issues regarding mental health and substance abuse services, and has responsibility for setting a direction and leading coordinated efforts to address the prescription drug epidemic in Tennessee. Across the state, there are a number of current efforts already in place to combat the prescription drug epidemic. Along with the Tennessee Department of Mental Health and Substance Abuse Services, the departments of Health, Safety and Homeland Security, Correction, and Children's Services, and the Bureau of TennCare are engaged in combatting the epidemic, along with the Tennessee Bureau of Investigation and the U.S. Drug Enforcement Administration. The current strategies include work through community level organizations to prevent access to prescription drugs through prescription drug disposal opportunities as well as legislative efforts to improve the utility of the Controlled Substance Monitoring Database by requiring prescribers to report and view the database on a regular basis. In addition, efforts are being made to treat individuals who are addicted to prescription opioids and provide recovery opportunities after they complete treatment.

A Plan for the Future:

The response to prevent and treat prescription drug abuse demands comprehensive and coordinated solutions involving many different state departments. Strategies have been developed to meet the following outcomes:

1) Decrease the number of Tennesseans that abuse controlled substances.
2) Decrease the number of Tennesseans who overdose on controlled substances.
3) Decrease the amount of controlled substances dispensed in Tennessee.
4) Increase access to drug disposal outlets in Tennessee.
5) Increase access and quality of early intervention, treatment and recovery services.
6) Expand collaborations and coordination among state agencies.
7) Expand collaboration and coordination with other states.

***Please note: All references to the term "prescription drugs" are referring to controlled or scheduled prescription drugs.**

SUMMARY OF THE PRESCRIPTION DRUG EPIDEMIC IN TENNESSEE

Who Abuses Prescription Drugs?

- In 2012, prescription opioids became the primary substance of abuse for people in Department of Mental Health and Substance Abuse Services-funded treatment, overtaking alcohol for the first time.
- Almost 5% of Tennesseans have used pain relievers in the past year for non-medical purposes.
- Young adults (18-25-year-olds) in Tennessee are using prescription opioids at a 30% higher rate than the national average.

Access to Prescription Drugs

- **High Number of Prescriptions Dispensed**
  - There were 25% more controlled substances dispensed in Tennessee in 2012 than in 2010.
- **Doctor Shopping**
  - In March 2013, 2,010 people received prescriptions for opioids or benzodiazepines from four or more prescribers.
- **Prescribing Practices**
  - As of August 1, 2013, 25 physicians had been prosecuted for overprescribing during 2013.
- **Sources of Prescription Drugs**
  - More than 70% of people who use prescription drugs for non-medical reasons got them from a friend or relative.

Consequences of Prescription Drug Abuse

- **Healthcare Costs**
  - The number of emergency department visits for prescription drug poisoning has increased by approximately 40% from 2005 to 2010.
- **Overdose Deaths**
  - There has been a 220% increase in the number of drug overdose deaths from 1999 to 2012 (342 in 1999 to 1,094 in 2012).
- **Criminal Justice System Involvement**
  - Drug-related crimes against property, people and society have increased by 33% from 2005 to 2012.
- **Lost Productivity**
  - The cost of lost productivity due to prescription drug abuse in Tennessee was $142.9 million in 2008. This number adjusted for 2013 inflation is $155.2 million.
- **Children in State Custody**
  - About 50% of the youth taken into Department of Children's Services custody resulted from parental drug use.
- **Neonatal Abstinence Syndrome**
  - Over the past decade, we have seen a nearly ten-fold rise in the incidence of babies born with Neonatal Abstinence Syndrome in Tennessee.
- **Treatment Costs**
  - It is estimated that the cost of providing state-funded treatment services to individuals that abuse prescription drugs and live below the poverty level would cost $27,933,600.

SUMMARY OF CURRENT EFFORTS TO COMBAT THE PRESCRIPTION DRUG EPIDEMIC IN TENNESSEE

Prevention

Collaborative Efforts
- Governor's Public Safety Subcabinet Strategies
- Neonatal Abstinence Syndrome Subcabinet Workgroup
- Substance Abuse Data Taskforce

Mental Health and Substance Abuse Services
- Community Prevention Coalitions
- Prescription Drug Disposal
  - Take-backs
  - Permanent Drop Boxes
- Information Dissemination
  - "Take Only As Directed" Media Campaign
- Strategic Prevention Framework State Prevention Enhancement Grant

Health
- Controlled Substance Monitoring Database Pain Clinic Oversight
- Drug Overdose Reporting
- Development of Guidelines for Prescribing Narcotics
- Top 50 Prescribers

Safety and Homeland Security
- Governor's Public Safety Subcabinet Strategies

Drug Enforcement Administration
- National Prescription Drug Take-Back Day

Bureau of TennCare
- Formulary Regulations
- Pharmacy Lock-In Program
- Prescriber Identification

Early Intervention

Mental Health and Substance Abuse Services
- Screening, Brief Intervention, Referral to Treatment

Health
- Screening, Brief Intervention, Referral to Treatment

Enforcement

Safety and Homeland Security
- Law Enforcement Access to Controlled Substances
- State Trooper Training

Bureau of Investigation
- Drug Investigation
- Medicaid Fraud Control
- Forensic Services
- Methamphetamine and Pharmaceutical Task Force

Drug Enforcement Administration
- Drug Enforcement Administration Requirements
- Diversion Investigations

Treatment

Mental Health and Substance Abuse Services
- Full Continuum of treatment services provided to indigent people
- Neonatal Abstinence Syndrome Funded Treatment
- Recovery (Drug) Courts
- Residential Recovery Court
- Community Treatment Collaborative
- Community Housing with Intensive Outpatient Services
- Medication Assisted Therapies

Health
- Impaired Healthcare Professionals Program

Safety and Homeland Security
- Governor's Public Safety Subcabinet Strategies

Correction
- Substance Abuse Therapeutic Community
- Substance Abuse Group Therapy
- Technical Violators Diversion Program
- Community Treatment Collaborative
- Co-occurring Treatment
- Residential Recovery Court

Children's Services
- Treatment Services for youth and young adults in Custodial Care
- Treatment for babies born addicted to substances

Bureau of TennCare
- Contracts with Managed Care Organizations to provide a comprehensive continuum of substance abuse services

Recovery

Mental Health and Substance Abuse Services
- Recovery Support Services
- Low Cost/High Impact Alternatives
  - Oxford House Program
  - Lifeline
  - Community Housing with Intensive Outpatient Services

SECTION 1

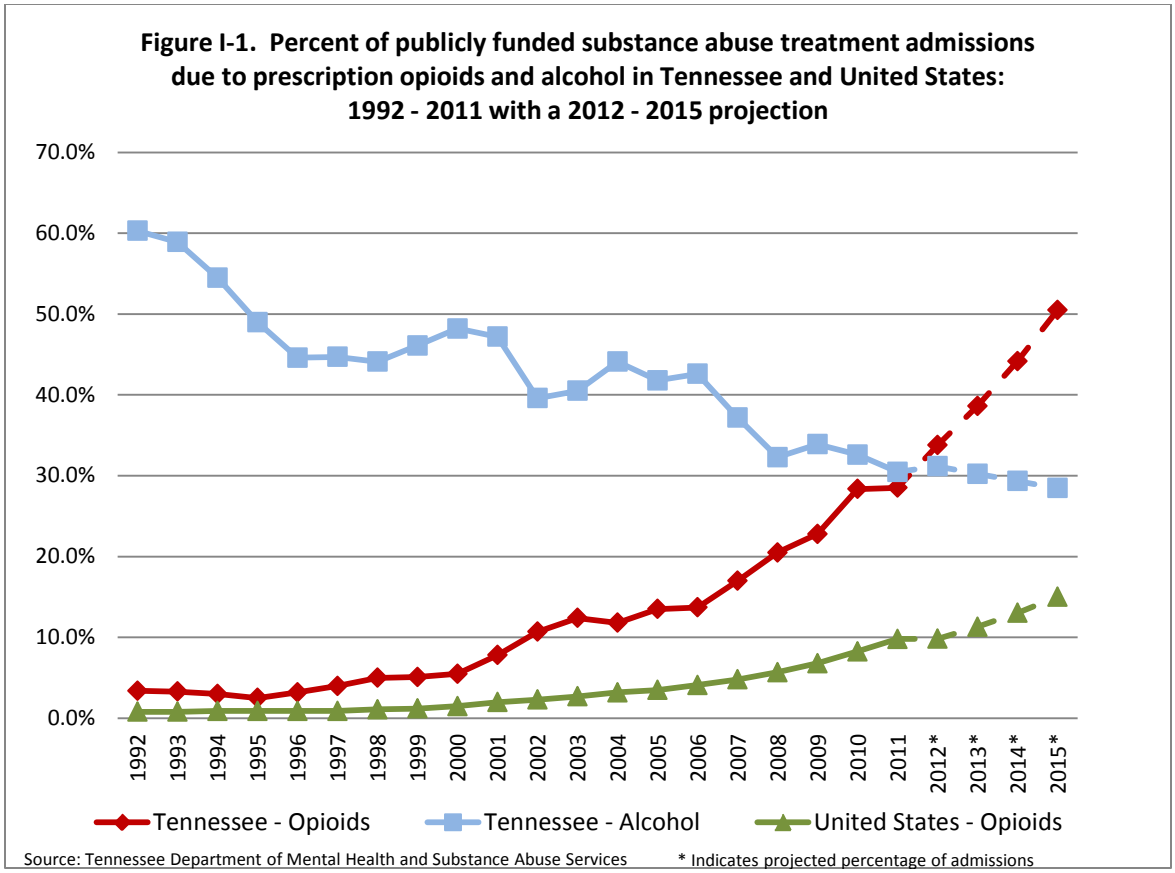
Overview of the Prescription Drug Epidemic in Tennessee

OVERVIEW OF THE PRESCRIPTION DRUG EPIDEMIC IN TENNESSEE

The abuse of prescription opioids has been identified as one of the most serious and costly issues facing Tennesseans and other Americans today. Prescription drug abuse pervades every segment of Tennessee families and communities. Tennessee currently has many efforts to combat prescription drug abuse. However, before identifying current efforts to prevent and treat prescription drug abuse, it is useful to understand the nature and extent of the prescription drug epidemic in Tennessee.

Who Abuses Prescription Drugs?

Over the past ten years, there has been a drastic shift in the primary substance of abuse for Tennesseans receiving publicly funded treatment services. For many years, alcohol was the primary substance of abuse and the state's prevention and treatment efforts focused on that population. However, in 2012, prescription opioids surpassed alcohol as the primary substance of abuse for people whose treatment was funded through the Tennessee Department of Mental Health and Substance Abuse Services.[2]

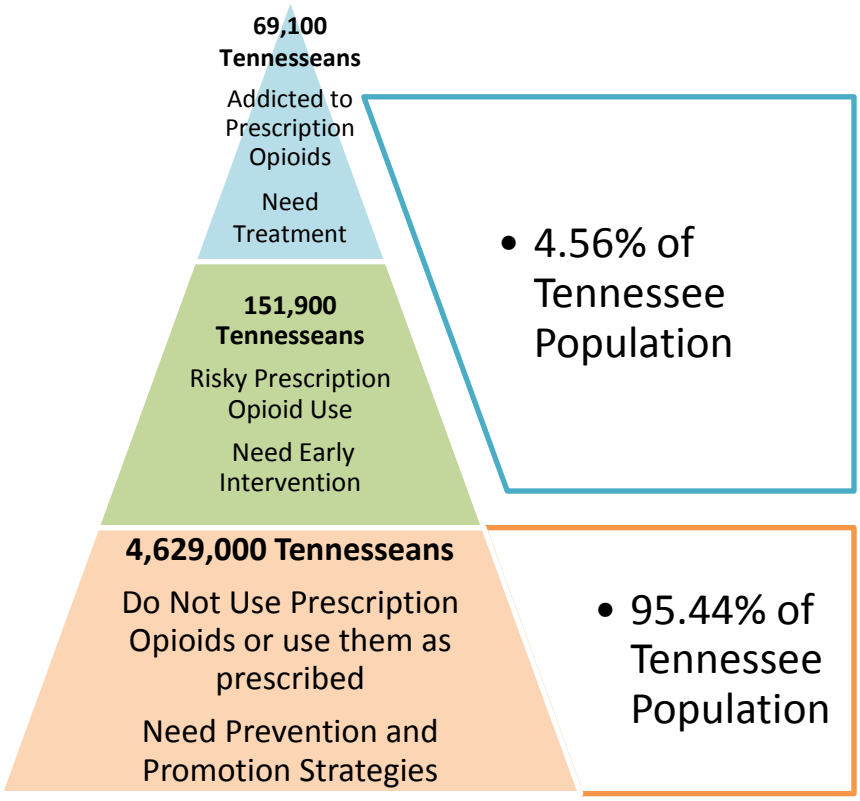


According to 2010 data comparing people in state-funded treatment programs across the United States, **Tennesseans were more than three times more likely to identify prescription opioids as their primary substance of abuse than the national average.**[3] Additionally, the rise in

prescription opioid abuse was indicated through a survey of the 12 state-licensed methadone clinics, who served 9,221 individuals in 2012. These clinics were originally designed to treat people with heroin addiction. **However, a 2011 survey of individuals receiving services at the private, for-profit clinics found that 78% of people receiving methadone services were addicted to prescription drugs, another 17% were addicted to both prescription drugs and heroin, and only 4% reported using heroin alone[4].**

An additional area where the rise of prescription drug use is apparent is in the individuals who receive Tennessee Department of Mental Health and Substance Abuse Services-funded treatment as a result of being charged with driving under the influence. **Among this population, there has been an almost 40% increase in prescription opioids as the primary drug of choice in the past two years (from 9.3% to 12.5%)[5].**

A survey of Tennesseans also reveals the increased use of prescription opioids in the state. Of the 4.85 million adults in Tennessee, it is estimated that 4.56% (221,000) have used pain relievers in the past year for non-medical purposes. Of those adults, it is estimated that 69,100 are addicted to prescription opioids and require treatment for prescription opioid abuse. The other 151,900 are using prescription opioids in ways that could be harmful and may benefit from early intervention strategies[6].



Even more alarming is the use rate of prescription opioids among young adults (18-25-year- olds) in Tennessee, which was 30% higher than the national average in 2011[7]. Also concerning, the survey also found that almost 7% of Tennessee's 12-17-year-old population have used prescription drugs for non-medical reasons[8].

Demographic trends for individuals receiving Tennessee Department of Mental Health and Substance Abuse Services-funded opioid treatment (when compared to others using illicit drugs) show that **people addicted to opioids are more likely to be married, employed, and have greater than 12 years of education[9].** Additionally, since 2001, there has been a steady rise in the number of women abusing prescription opioids in treatment services funded by the Tennessee Department of Mental Health and Substance Abuse Services and **a rise in the number of pregnant women receiving treatment services.** From 2001 to 2010, there was approximately a 1,000%

increase in the number of pregnant women receiving state-funded treatment services who reported prescription opioids as a substance of abuse, from 5% (5 pregnant women out of 96) to 54% (82 pregnant women out of 152).[10]

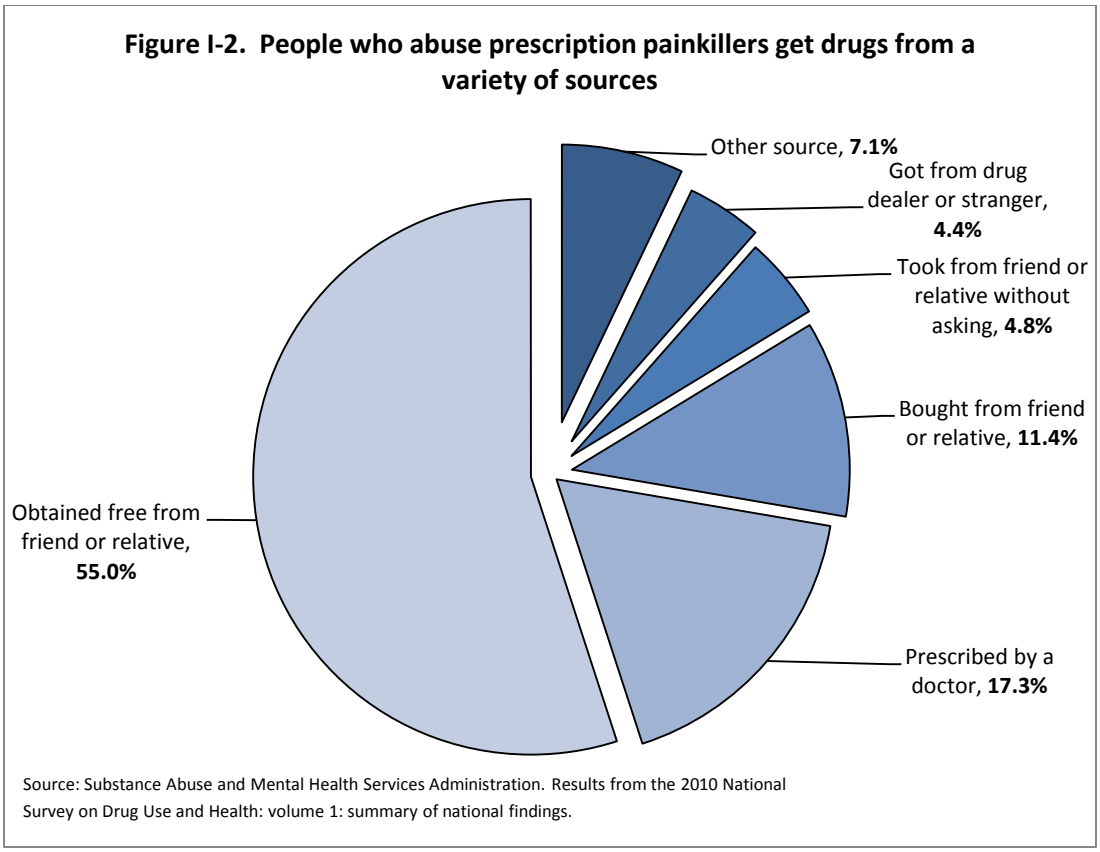
National data indicates that the following groups are at especially high risk for prescription drug abuse:

- Men ages 25 to 54 have the highest numbers of prescription drug overdoses and are about twice more likely to die from an overdose than women.[11]
- In the United States, about 18 women die each day from prescription painkiller overdoses. For every one woman who dies, 30 more visit an emergency department for painkiller misuse or abuse.
- While rates are high in both urban and rural communities, people in rural counties are about twice as likely to overdose on prescription drugs as people in big cities.
- Nearly one in 12 high school seniors reported nonmedical use of Vicodin and one in 20 reported nonmedical use of OxyContin.
- One in eight active duty military personnel is a current user of illicit drugs or is misusing prescription drugs.

Access to Prescription Drugs

In Tennessee, prescription drugs with addictive qualities are easily accessible. One source of prescription drugs is a legitimate prescription from a doctor. While many of these prescriptions may be legitimate, there is evidence that some individuals are "doctor shopping" in order to obtain more prescription drugs. There is also evidence that doctors are overprescribing prescription opioids and benzodiazepines (a class of psychoactive drugs used to treat anxiety, insomnia, and a range of other conditions). The high number of prescription drugs available is contributing to the problem as many people are obtaining prescription drugs from their own medicine cabinet or from a friend or relative.

Research indicates the high availability of prescription drugs in Tennessee is contributing to the addiction problem across the state. According to the 2010 National Survey on Drug Use and Health, 70% of people who abused or misused prescription drugs got them from a friend or relative, either for free, by purchasing them, or by stealing them[12]. As shown in Figure I-2, people who abuse prescription drugs also obtain them from other sources including "pill mills," or illegitimate pain clinics; prescription fraud; pharmacy theft; illegal online pharmacies; and "doctor shopping". Some individuals who use prescription drugs for non-medical reasons believe these substances are safer than illicit drugs because they are prescribed by a physician and dispensed by a pharmacist.



High Number of Prescriptions Dispensed

Most non-medical use of prescription drugs originates from a legitimate prescription. Tennessee is prescribing prescription opioids at an alarmingly high rate. Data from the Drug Enforcement Administration showed that in 2010, Tennessee tied for second, along with Nevada, for the amount of opioid pain relievers in morphine equivalents sold per 10,000 people (11.8 kilograms). Only Florida had a higher rate of opioid pain relievers sold than either Tennessee or Nevada[13].

Tennessee has a Controlled Substance Monitoring Database, which reveals the extent of the prescription drug problem in Tennessee; in 2010, evidence showed there were enough prescriptions dispensed to represent:

- 51 pills of hydrocodone for EVERY Tennessean above the age of 12;
- 22 pills of Xanax for EVERY Tennessean above the age of 12;
- 21 pills of oxycodone for EVERY Tennessean above the age of 12[14].

This demonstrates the high number of controlled substances readily available in Tennessee and the upward trend in prescribing and dispensing of these drugs. As shown in Figure I-3, in 2012, there were 18,258,566 prescriptions reported to the Controlled Substance Monitoring Database. This represents a 25% increase in the number of prescriptions dispensed from 2010 through 2012[15]. (Please note: this data was collected before changes in reporting took place as a result of the Prescription Safety Act of 2012.)

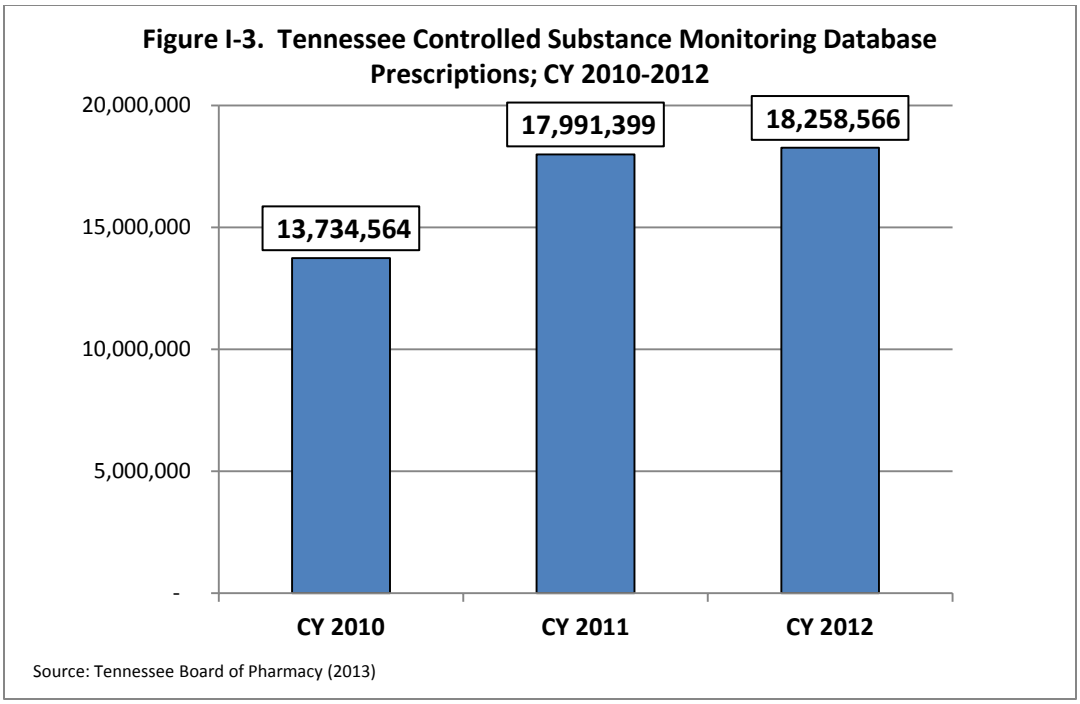
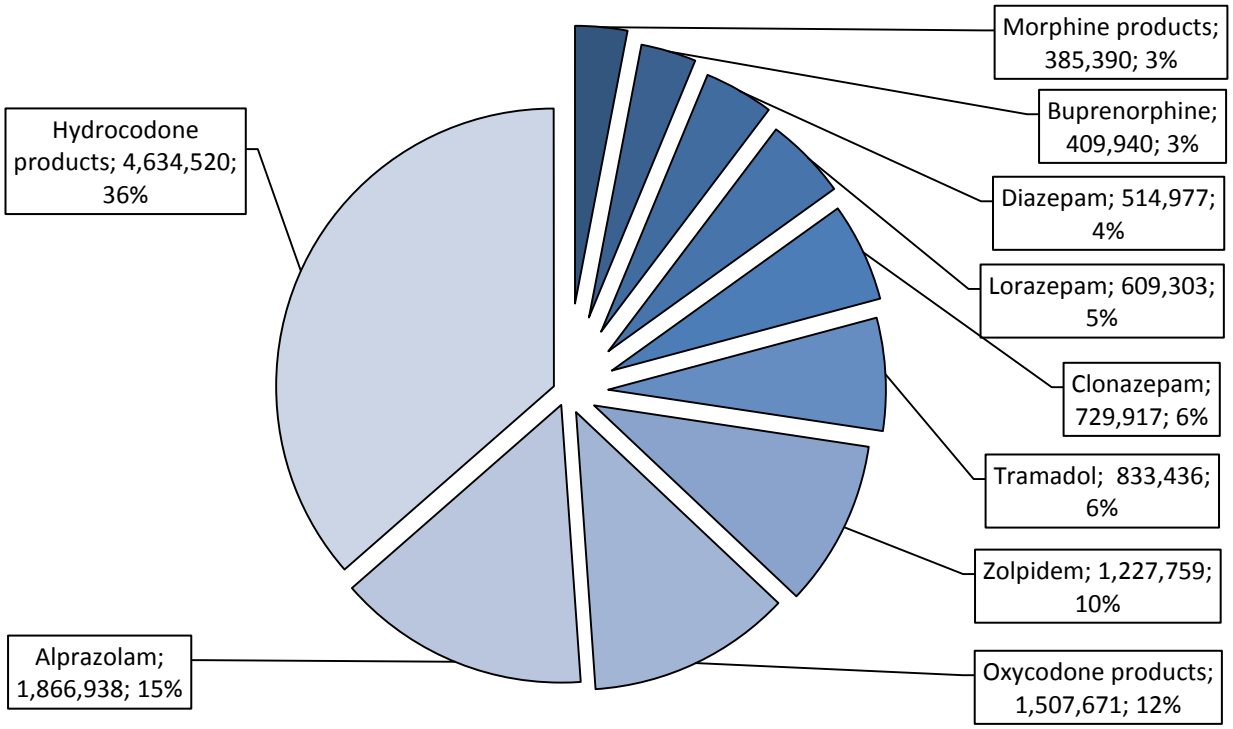


Figure I-4 lists the top 10 prescriptions reported to the Controlled Substance Monitoring Database in 2012. The top 10 controlled substance prescriptions filled in 2012 account for 69.5% of all controlled substance prescriptions filled, or approximately 12.7 million prescriptions. Of the top 10 prescriptions reported, five (hydrocodone, oxycodone, tramadol, buprenorphine, and morphine) are opioids and represent 42% of all the controlled substances reported to the Controlled Substance Monitoring Database in 2012[16].

Figure I-4. Top 10 Drug Types Reported to CSMD in Tennessee; 2012

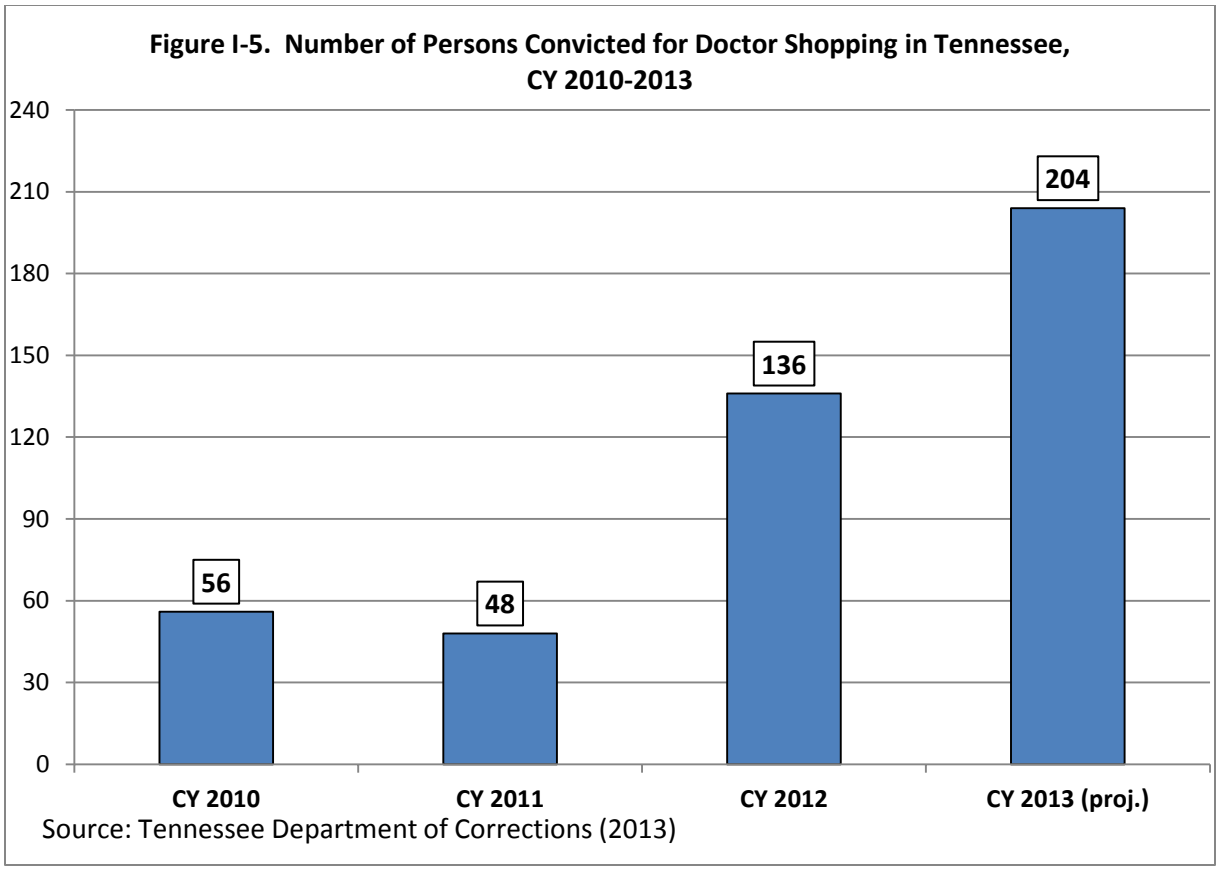


Source: Tennessee Department of Health, Controlled Substance Monitoring Database (2013)

"Doctor Shopping"

One specific area of concern is "doctor shopping," or the practice of a patient requesting care from multiple physicians simultaneously. This usually stems from a patient's addiction to, or reliance on, certain prescription drugs or other medical treatment. Usually a patient will be treated by his or her regular physician and prescribed a drug that is necessary for the legitimate treatment of his or her current medical condition. Some patients will then actively seek out other physicians to obtain more of the same medication, often by faking or exaggerating the extent of their true condition, in order to feed their addiction to that drug.

Recent data demonstrates that doctor shopping is an area of concern in Tennessee. In March 2013, 2,010 people received prescriptions for opioids or benzodiazepines from four or more prescribers. Additionally, data from the Department of Correction indicates that people are being convicted for doctor shopping. From January to September of 2013, 153 individuals were convicted of doctor shopping, which surpasses the 2012 total of 136 individuals convicted. As utilization of the Controlled Substance Monitoring Database has increased, the number of people doctor shopping has decreased.

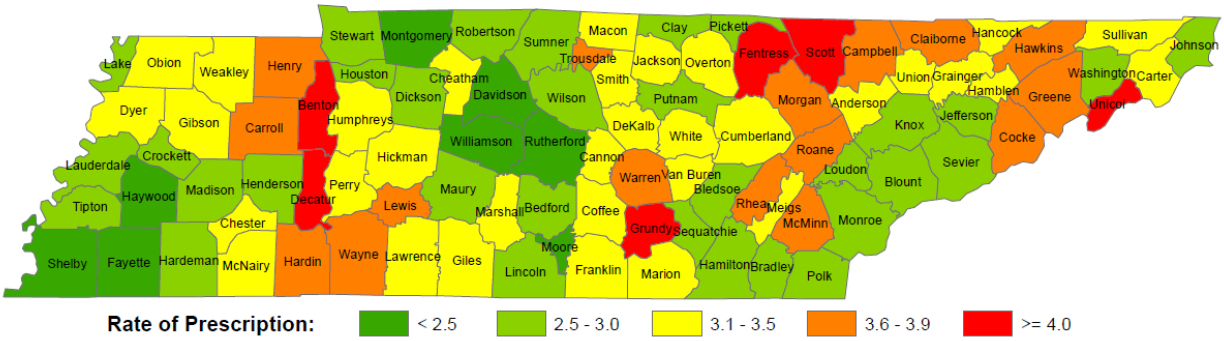


Prescribing Practices

There has been a longstanding belief that prescribing opioids is the best way to treat chronic pain. In fact, the Tennessee Intractable Pain Treatment Act enacted in 2001 gives patients with chronic pain a Bill of Rights, which guarantees access to long-term opioids as a first-line treatment for chronic pain. The perceived underprescribing or prescribing opioids less frequently than appropriate by Tennessee physicians in 2001 has now been replaced by overprescribing or prescribing opioids excessively or unnecessarily[17]. While opioids should no longer be considered first-line treatment of chronic pain, they do continue to be prescribed at very high rates in Tennessee[18]. As of August 1, 2013, 25 physicians had been prosecuted for overprescribing during 2013[19].

Additionally, Map I-1 indicates the rate of controlled substances dispensed across Tennessee counties adjusted by population. As the map shows, Unicoi, Scott, Fentress, Grundy, Decatur, and Benton Counties all dispense more than four prescriptions for opioids or benzodiazepines per resident. Henry, Carroll, Harden, Wayne, Lewis, Trousdale, Warren, Rhea, McMinn, Roane, Morgan, Campbell, Claiborne, Hawkins, Greene, and Cocke counties had a rate of 3.6- 3.9 prescriptions dispensed per capita[20].

Map I-1. Rate of Prescriptions Dispensed (per capita) in Tennessee Among Tennessee Residents Reported to CSMD, 2012



Source: Tennessee Department of Health

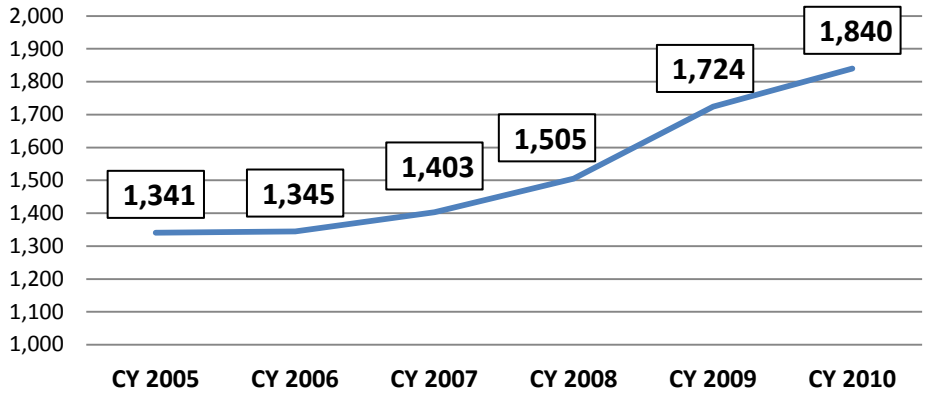
Consequences of Prescription Drug Abuse

The misuse and abuse of prescription opioids is a major threat to the health and well-being of Tennesseans. The prescription opioid epidemic is damaging to the state and its residents in multiple ways. Tennesseans are losing their lives or having their lives severely disrupted as a result of their abuse. The state is also losing the economic benefits associated with a healthy workforce as productivity is lost and taxpayer dollars are expended to pay for expensive hospital visits, incarceration, and custody of children.

Healthcare Costs

As Figure I-6 indicates, the number of emergency department visits for prescription drug poisoning has increased by approximately 40% from 2005 to 2010[21].

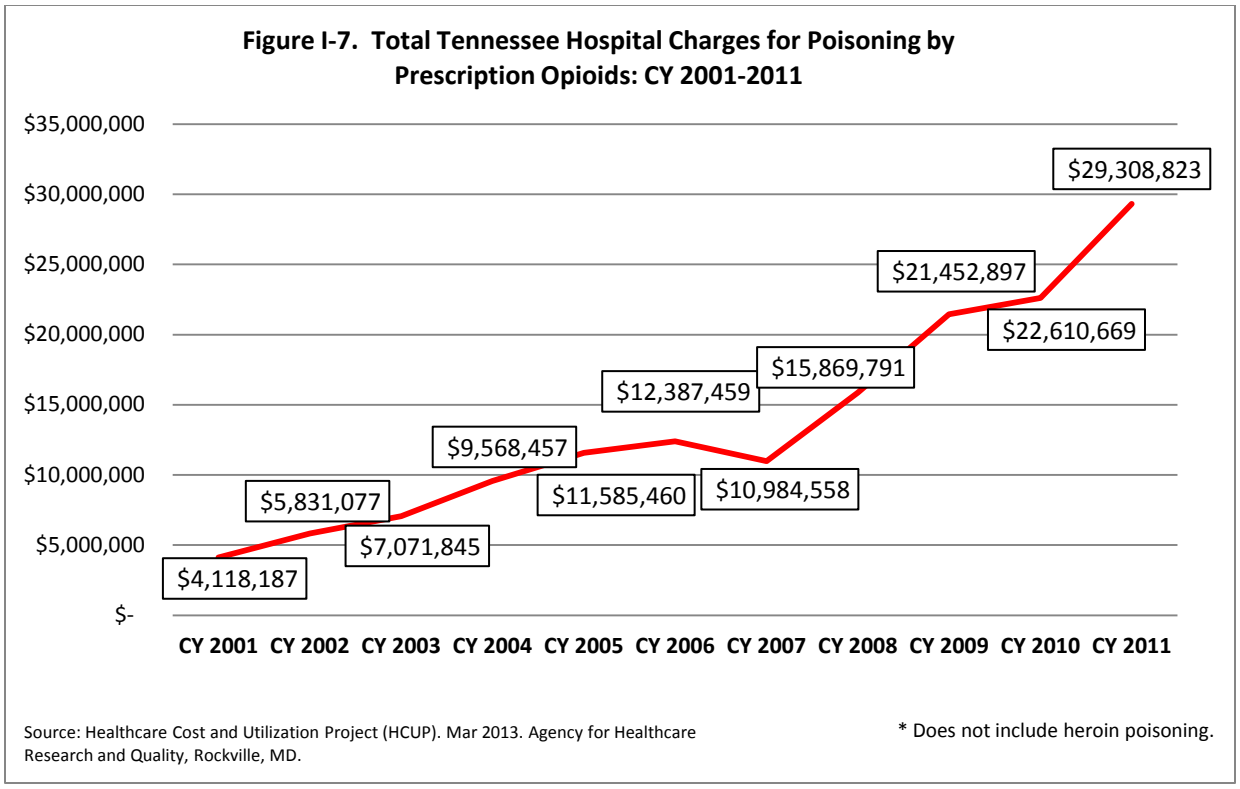
Figure I-6. Tennessee emergency department visits for poisoning by prescription opioids and related narcotics*: 2005-2010



Source: HCUP Home. Healthcare Cost and Utilization Project (HCUP). May 2013. Agency for Healthcare Research and Quality, Rockville, MD.

* Does not include heroin poisoning.

The Healthcare Cost and Utilization Project shows that the total Tennessee hospital charges for prescription opioid poisonings has risen exponentially over the past 10 years. As seen in Figure I-7, **in 2001, the cost was $4,118,187 and increased by 600% to $29,308,823 in 2011[22].**

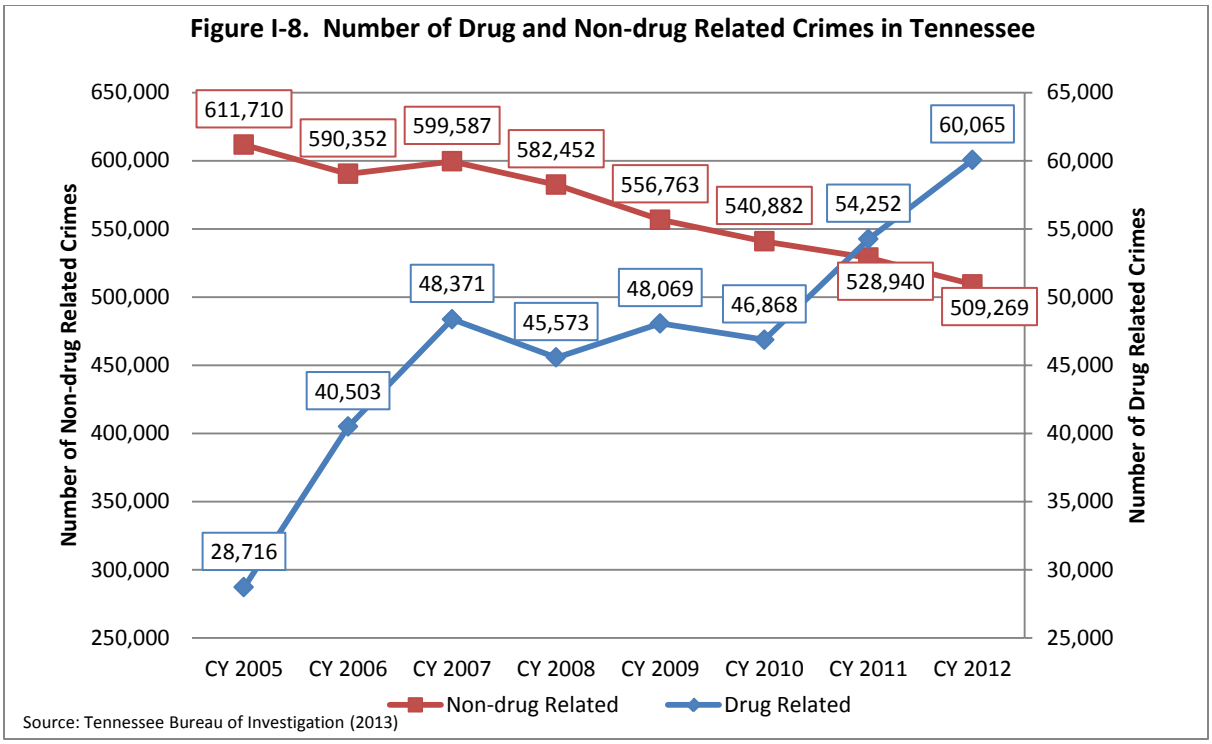


Overdose Deaths

Sadly, drug-related overdoses have also dramatically increased in Tennessee. From 1999 to 2010, the number of people dying from drug-related overdoses increased at a greater rate in Tennessee than in the United States. While there has been an increase of 127% nationwide, (16,849 deaths in 1999 to 38,329 in 2010), in Tennessee[23] there has been a 210% increase, (342 in 1999 to 1,059 in 2010), in the number of drug overdose deaths[24]. In 2012, there were 1,094 drug related overdose deaths in Tennessee.

Criminal Justice System Involvement

Individuals that are using prescription opioids are also committing crimes. As Figure I-8 indicates, drug-related crimes against property, people and society have increased by 33% from 2005 to 2012[25]. During the same period, non-drug-related crimes decreased. In 2008, the cost of apprehending, prosecuting, and incarcerating people involved with drug-related crimes in Tennessee was $356.5 million; adjusted for inflation in 2013, this cost is $387.3 million[26].



Lost Productivity

Even if individuals are not incarcerated as a result of their prescription drug abuse, their abuse still results in substantial costs related to absenteeism and lost productivity. In 2008, the cost of lost productivity due to drug abuse in Tennessee was $142.9 million; this number adjusted for 2013 inflation is $155.2 million[27].

Children in State Custody

Prescription opioid abuse is also resulting in children being removed from homes and entering state custody. About 50% of the youth taken into Department of Children's Services custody resulted from parental drug use. It is projected that during 2013 there will be 1,534 substance abuse related custodies[28].

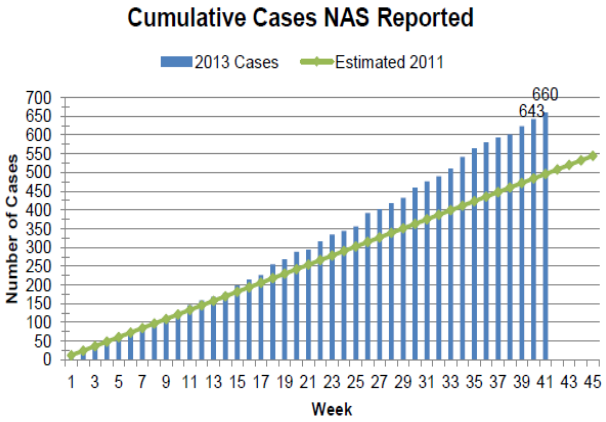
Additionally, incidents of child abuse resulting from drug exposure are one of the primary reasons that children were referred to the Department of Children's Services over the last four years. Using data from the first six months of 2013, it is projected that 22,714 incidents of child abuse will be reported as a result of drug exposure[29].

Neonatal Abstinence Syndrome

Another consequence of the prescription drug epidemic that has been quite apparent in our state over the past several years is Neonatal Abstinence Syndrome. Neonatal Abstinence Syndrome is a condition in which a newborn has withdrawal symptoms after being exposed to certain substances in utero. Many times, the newborn is exposed when the mother uses substances such as medications or illicit drugs during pregnancy and after the baby is born, the baby goes through withdrawal. Figure I-9 represents a week by week report of the babies born in Tennessee who are reported as having Neonatal Abstinence Syndrome.

Over the past decade, we have seen a nearly ten-fold rise in the incidence of babies born with Neonatal Abstinence Syndrome in Tennessee[30]. Infants with Neonatal Abstinence Syndrome stay in the hospital longer than other babies and they may have serious medical and social problems. The average cost to stabilize a newborn with Neonatal Abstinence Syndrome is $62,973, while the cost of birthing newborns who are not suffering withdrawals is only $7,258[31]. As identified in Figure I-9, Neonatal Abstinence Syndrome cases have risen exponentially since the beginning of 2013[32]. (This number may be inflated due to the fact that Neonatal Abstinence Syndrome was not a reportable condition until January 1, 2013.) From January through October 13, 2013, 660 newborns were born with Neonatal Abstinence Syndrome in Tennessee, which has cost the state $41,562,180. **The average cost for 660 newborns without Neonatal Abstinence Syndrome would be $4,790,280 a difference of $36,771,900.** Using TennCare eligibility records, it was determined that 179 of the 736 infants diagnosed with Neonatal Abstinence Syndrome in 2012 (24.3%) were placed in Department of Children's Services custody within one year of their birth, a nine percent increase from 2011. Among all TennCare infants born in 2012, 1.6% were placed in Department of Children's Services custody within one year of birth. Infants born with Neonatal Abstinence Syndrome are 14.8 times more likely to be in Department of Children's Services custody during their first year of life as compared with other TennCare infants[33].

Figure I-9. Cumulative Cases NAS



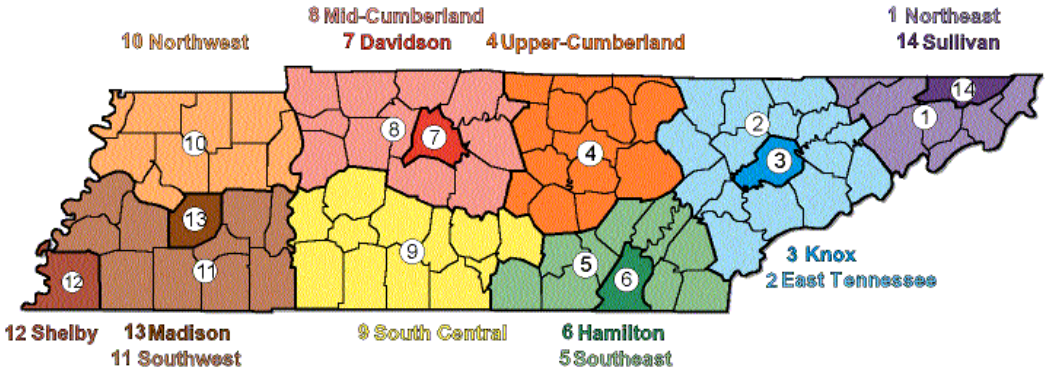
Source: Tennessee Department of Health Neonatal Abstinence Syndrome Summary, Week 31

Table I-1. Drug Dependent Newborns (Neonatal Abstinence Syndrome) Surveillance Summary 2013

TDOH Planning Region #	TDOH Region of Maternal Residence	Number of Babies Born with NAS After 41 Weeks	Rate of Babies Born with NAS Per Week	52 Week Projection of Babies Born with NAS	Number of Live Births (2011)	Rate of Babies Born with NAS per 1,000 Live Births
1	North East	100	2.44	127	3,431	36.97
14	Sullivan	67	1.63	85	1,511	56.24
2	East	181	4.41	230	7,969	28.81
3	Knox	71	1.73	90	5,143	17.51
4	Upper Cumberland	85	2.07	108	3,868	27.87
5	South East	10	0.24	13	3,507	3.62
6	Hamilton	11	0.27	14	4,047	3.45
7	Davidson	33	0.80	42	9,888	4.23
8	Mid-Cumberland	46	1.12	58	14,412	4.05
9	South Central	22	0.54	28	4,311	6.47
10 and 11	West	19	0.46	24	6,111	3.94
12	Shelby	14	0.34	18	13,993	1.27
13	Jackson/Madison	1	0.02	1	1,271	1.00
	Total	660	16.10	837	79,462	10.53

Source: Tennessee Department of Health (2013)

Map I-2. Tennessee Department of Health Regions



As Table I-1 shows, Neonatal Abstinence Syndrome is most prevalent in East Tennessee. 76% of babies born with Neonatal Abstinence Syndrome come from Department of Health Regions 1, 14, 2, 3, and 4, which comprise only 28% of all live births in Tennessee. The Department of Health's Eastern regions have the highest percentage of cases in 2013, totaling 64% of all cases in the state, with the East Region (Region 2) having the highest at 26.3%. A map of the Department of Health's regions is depicted in Map I-2, and this map corresponds to the graph.

Treatment Costs

An additional consequence of the prescription drug epidemic in our state is the increased need for treatment. Tennessee is already spending a significant amount of funding to treat people with prescription opioid abuse. In Fiscal Year 2013, 5,854 people addicted to opioids were served by the Department of Mental Health and Substance Abuse Services at a cost of $16,280,429[34].

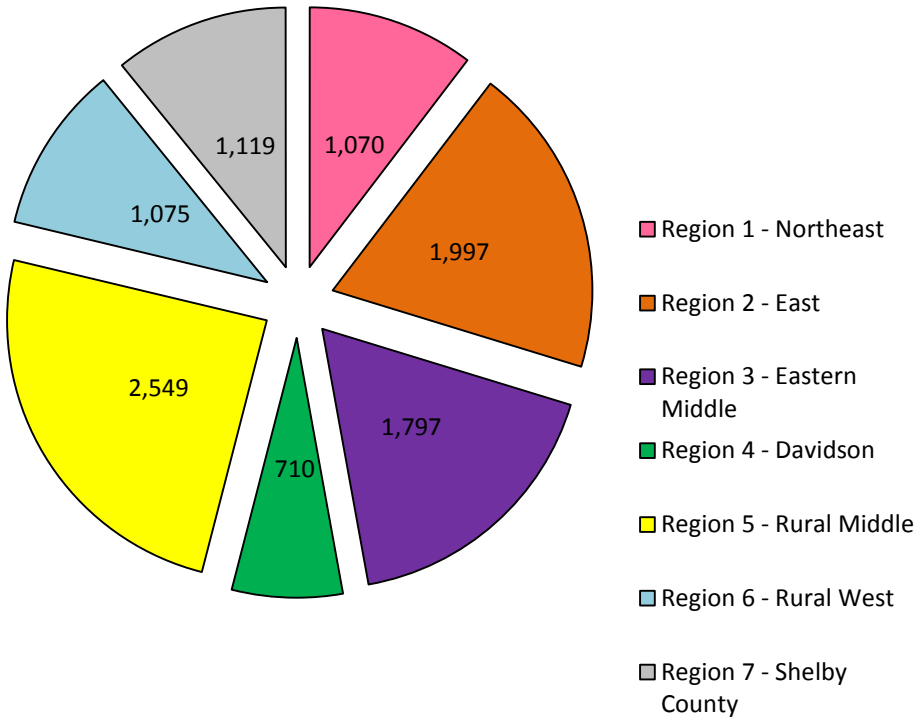
There is significant unmet opioid treatment need in our state. It is estimated that 10,300 Tennesseans live at or below the poverty level and would like to access state-funded treatment services.

While some people are receiving treatment, there is significant unmet need in our state. It is estimated that 221,000 adults in Tennessee (or 4.56%) have used pain relievers in the past year for non-medical purposes. Of those adults, it is estimated that 69,100 are addicted to prescription opioids and require treatment for prescription opioid abuse[35]. Of the **69,100 adults that require treatment services,** it is estimated 10,300 (or 14.6%) live at or below the poverty level and would be in need of and desire state-funded treatment services[36]. The average cost of care in 2012 for an individual receiving treatment services from the Tennessee Department of Mental Health and Substance Abuse Services is $2,848. Thus, it is estimated that the cost of providing treatment services to these individuals would total $29,334,400.

- Department of Mental Health and Substance Abuse Services Expenditures for treating people with prescription opioid abuse in Fiscal Year 2013: **$16,280,429**
- Unmet Need Amount for individuals with prescription opioid abuse below poverty level: **$29,334,400**
- Total Cost for Department of Mental Health and Substance Abuse Services to meet the needs of people with prescription opioid addiction in Tennessee: **$45,614,829**

As Figure I-10 indicates, the highest need for treatment is in Northeast, East, Eastern Middle, and Rural Middle Tennessee. Although, as a percent of the total population, there are large numbers of people across the state that need treatment services.

Figure I-10. Estimated Number of Tennesseans in Poverty with an Opioid Diagnosis in Need of Treatment



Source: Tennessee Department of Mental Health and Substance Abuse Services (2013)

The Department of Mental Health and Substance Abuse Services has divided the state into seven different regions for planning purposes. A map of the Department of Mental Health and Substance Abuse Services regions is depicted in Map I-3, and this map corresponds to Figure I-10.

Map I-3 Planning and Policy Regions

Source: Tennessee Department of Mental Health and Substance Abuse Services

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SECTION 2

Current Efforts to Combat the Prescription Drug Epidemic in Tennessee

CURRENT EFFORTS TO COMBAT THE PRESCRIPTION DRUG EPIDEMIC IN TENNESSEE

A variety of state agencies are engaged in efforts to combat the prescription drug epidemic in Tennessee. This section of the report will focus on the current efforts to address the problem. These strategies are comprehensive and include prevention, early intervention, enforcement, treatment, and recovery. This section will begin with a brief overview of each of these important strategies and then give information from state departments about their current efforts in these areas.

Overarching Framework

The overarching framework for services provided to combat prescription drug abuse in Tennessee is the Institute of Medicine's Continuum of Care. The Institute of Medicine's framework provides a classification system that recognizes the importance of the whole spectrum of interventions for behavioral health disorders, from prevention through treatment to recovery support. Research has shown us that it is important to implement the right strategy at the right time and that a variety of strategies must be used to adequately address the prescription drug problem in Tennessee.

Definition and Description of Prevention

Prevention strategies are delivered prior to the onset of a disorder, and are intended to prevent or reduce the risk of developing a behavioral health problem, such as prescription opioid abuse. While prevention strategies are difficult in the short term to quantify, there is good evidence that over time, prevention can have a powerful effect as evidenced by successful efforts related to reducing tobacco use and increasing seat belt use.

Definition and Description of Early Intervention

Early intervention primarily focuses on high-risk users who do not meet the criteria for a substance use disorder, but are using in ways that may be causing them problems in their physical health or in their activities of daily life. Early intervention models bridge prevention and treatment and seek to interrupt abusive behavior before addiction develops.

Definition and Description of Enforcement

Enforcement activities focus on ensuring that laws meant to keep the public safe are followed. Enforcement activities related to prescription opioids include ensuring that individuals are not "doctor shopping" and that doctors are not prescribing illegally.

Definition and Description of Treatment

Treatment interventions are designed for individuals that meet the criteria for abuse or dependence. These interventions are designed to treat existing disorders in a therapeutic way while developing foundational skills that will allow an individual to deal with the many issues surrounding addiction. Treatment interventions include a variety of services including assessment, detoxification, residential services, and outpatient services.

Definition and Description of Recovery

The Substance Abuse and Mental Health Services Administration defines recovery as, "A process of change through which individuals improve their health and wellness, live a self-directed life, and

strive to reach their full potential."[37] Recovery is a lifelong process and while relapse often occurs, it is not considered the end of someone's recovery journey; instead, it is part of the journey and an opportunity for growth and learning.

Recovery services help service recipients live a full and productive life and may result in the reduction or complete remission of problems, or abstinence from addictive behaviors. Recovery services include housing, employment assistance, and self-help groups like Alcoholics Anonymous and Narcotics Anonymous.

CURRENT STRATEGIES: COLLABORATIVE EFFORTS

The prescription drug epidemic is a multi-dimensional problem that must be addressed in a collaborative and coordinated fashion. Many state departments have recognized the need for coordination and are actively working together to address the problem systemically. The efforts described below involve multiple state departments and include the following initiatives: The Governor's Public Safety Subcabinet, the Neonatal Abstinence Syndrome Workgroup, the Substance Abuse Data Taskforce, and the Morgan County Residential Recovery Court.

Governor's Public Safety Subcabinet

The Governor's Public Safety Subcabinet was created in 2012 with the following goals:

- To develop and implement a measurable public safety action plan designed to have a significant impact on crime in Tennessee; and
- To help create a climate in communities across the state that fosters the creation of more and better jobs[38].

The Public Safety Subcabinet is coordinated by the Department of Safety and Homeland Security and is made up of commissioners and directors from the departments of Mental Health and Substance Abuse Services; Health; Children's Services; Correction; Board of Parole; Finance & Administration, Office of Criminal Justice; Transportation, Governor's Highway Safety Office; Commerce & Insurance, Law Enforcement and Training Academy; and Military, as well as the Tennessee Bureau of Investigation.

The subcabinet workgroup identified three major challenges that significantly impact crime in our communities:

- Drug abuse and trafficking
- Violent crime
- Repeat offenders

For the purpose of this report, we will focus specifically on the action items that are pertinent to preventing, treating and regulating prescription drug abuse. Those 19 pertinent action steps are outlined in Table II-1 below:

Table II-1. Action Steps

Action Step #	Action Step
1	Require prompt reporting of controlled substance prescriptions to the CSMD.
2	Create tougher restrictions on over-prescribing pain clinics.
3	Develop a regional approach with surrounding states, including the sharing of timely database information
4	Increase use of the CSMD by prescribers and dispensers.
5	Strengthen penalties for doctor shopping.
6	Teach health professional students and assure continuing education for prescribers and dispensers about prescription drug abuse, the CSMD, and the laws in TN that govern prescribers and dispensers.
7	Develop and implement a statewide prescription drug take-back initiative that is accessible to all Tennesseans.
8	Implement more effective regulation and monitoring of Opioid Treatment Programs.
9	Increase public awareness about prescription drug abuse through an on-going communications campaign.
10	Increase and improve data sharing among state agencies about prescription drug use and abuse, including use of similar formats, language, and geographic breakdowns in data collection.

11	Assist health care organizations and providers in developing expertise and standard protocols in the prevention and treatment of drug abuse.
12	Expand law enforcement access to the CSMD.
13	Require uniform drug overdose reporting by all county medical examiners.
19	Expand access to recovery (drug) courts across Tennessee, with emphasis on treating serious methamphetamine and/ or prescription drug addictions.
20	Focus more of the state recovery (drug) court funding for courts serving defendants who would otherwise be incarcerated at the state's expense.
21	Establish regional residential drug court facilities.
22	Establish a uniform, effective, and comprehensive evaluation process on the performance of recovery (drug) courts.
23	Provide 40-hour courses on drug interdiction to all road state troopers.
24	Develop a new database under which officers can submit real time information on traffic stops involving suspicious levels of prescription drugs and query the database for prior suspicious stops involving the same suspects.

To implement the Public Safety Action Plan, strong partnerships with key stakeholders are required. A variety of state departments are responsible for implementing various action steps related to the goal of "tackle(ing) aggressively the growing problem of prescription drug abuse." In order to produce successful outcomes for each of the action steps, it will take a coordinated and comprehensive effort of diverse stakeholders.

Neonatal Abstinence Syndrome Subcabinet Workgroup

A collection of state leaders known as the Neonatal Abstinence Syndrome Subcabinet Workgroup is working collaboratively to reduce the number of babies born dependent on drugs, bring attention to the growing problem in Tennessee, and provide more information to physicians and the general public. The workgroup is composed of commissioners or their designees from the departments of Health, Mental Health and Substance Abuse Services, Children's Services, Human Services, and the Bureau of TennCare.

The workgroup petitioned, and the U.S. Food and Drug Administration approved, the adoption of a new "Black Box Warning" that would appear in medication reference material used by clinicians and would alert them to have heightened awareness of the possibility of unintended harm to a newborn from the mother's use of narcotics. The request to the U.S. Food and Drug Administration follows earlier action by the Department of Health to make Neonatal Abstinence Syndrome a reportable condition effective Jan. 1, 2013, and collect Neonatal Abstinence Syndrome specific data, a move that is allowing health officials to identify cases more quickly and accurately as part of an expanded effort to reduce Neonatal Abstinence Syndrome births statewide.

The Department of Health has created a multi-institutional, multi-disciplinary research consortium dedicated to better understanding prevention and treatment of Neonatal Abstinence Syndrome. A one-day meeting was held in Knoxville and focused on identifying key evaluation questions and identifying the infrastructure needed to answer the identified questions.

Uniform Data Collection and Sharing

Several departments are working collaboratively to increase and improve data sharing for prescription drug abuse. The goals of the group include using similar formats, language, and geographic breakdowns in data collection. The agencies involved in the Substance Abuse Data Taskforce include the departments of Children's Services, Correction, Finance and Administration, Health, Mental Health and Substance Abuse Services, Safety and Homeland Security, and

Transportation, along with the Administrative Office of the Courts, the Bureau of TennCare, the Tennessee Bureau of Investigation, the Tennessee Methamphetamine and Pharmaceutical Task Force, the Tennessee Board of Pharmacy, the Tennessee Board of Parole, and the Tennessee National Guard.

This work is needed in order to provide an increased understanding of the extent of the problem, identify patterns of misuse and abuse of the drugs involved, and better target limited resources by focusing on what has proven to be effective.

The tasks of the Substance Abuse Data Taskforce are:

- ✓ Evaluate legal barriers to releasing data from the Controlled Substance Monitoring Database to state agencies and propose any necessary legislation to overcome those barriers;
- ✓ Research National Institutes of Health and Centers for Disease Control and Prevention standard reporting on prescription drug abuse and over-prescribing;
- ✓ Identify and clarify potential language issues;
- ✓ Identify units of data collection and barriers to use (HIPAA, small numbers, etc.);
- ✓ Design geographic information system applications for displaying critical data;
- ✓ Improve reporting to include geographic analysis;
- ✓ Identify a list of metrics using a multi-departmental web-based Delphi technique;
- ✓ Communicate common definitions; and
- ✓ Widely disseminate data to all entities that are seeking it.

On April 10, 2013, the Taskforce met to standardize reporting categories for prescription drugs. A draft document to improve standard reporting of drugs statewide has been developed.

Looking Toward the Future

- The Substance Abuse Data Taskforce should continue to meet regularly in order to improve data and share findings as it relates to prescription drugs.

Residential Recovery Court

The Morgan County Recovery Court is a collaborative effort between the Department of Mental Health and Substance Abuse Services and the Department of Correction, and is the first statewide Residential Recovery Court in the nation. The Recovery Court is a nine- month residential program with an additional nine months of aftercare in the community following release. The Morgan County Recovery Court has a 100-bed capacity and began enrolling felony offenders on August 1, 2013. Six Judicial Districts (9, 13, 15, 21, 23, and 26) will ultimately feed into the Morgan County Recovery Court. The Recovery Court will cost an average of $35 per person per day compared to $67 per day in prison.[39]

The Department of Mental Health and Substance Abuse Services has implemented a new Recovery Court data system, which became fully operational on July 1, 2013. Client-level data collected in the new problem-solving court module includes: participant demographic information; substances of abuse by method and age of first use; treatment level of care and progress; weekly progress summary sheet; criminal history; and military/veteran status. Descriptive statistics about Tennessee Recovery Courts were compiled in October 2013. These statistics will help better quantify the outcomes and

help promote or build successful strategies.

Looking Toward the Future

- Create up to three additional Residential Recovery Courts.
    - The Department of Mental Health and Substance Abuse Services is currently in discussions with the Department of Correction about expanding Residential Recovery Courts to additional people. The next Statewide Residential Recovery Court is under consideration for Middle Tennessee. Currently the Davidson County Residential Drug Court houses 40 females and 60 males. Current planning provides for an additional 60 female beds and 90 male beds for a total of 250 beds that will be open to people from across the state. Additional Residential Recovery Courts are being considered in West Tennessee and Shelby County, subject to availability of funding. The new Middle Tennessee Residential Recovery Court is projected to be operational in fiscal year 2015.

CURRENT STRATEGIES: TENNESSEE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

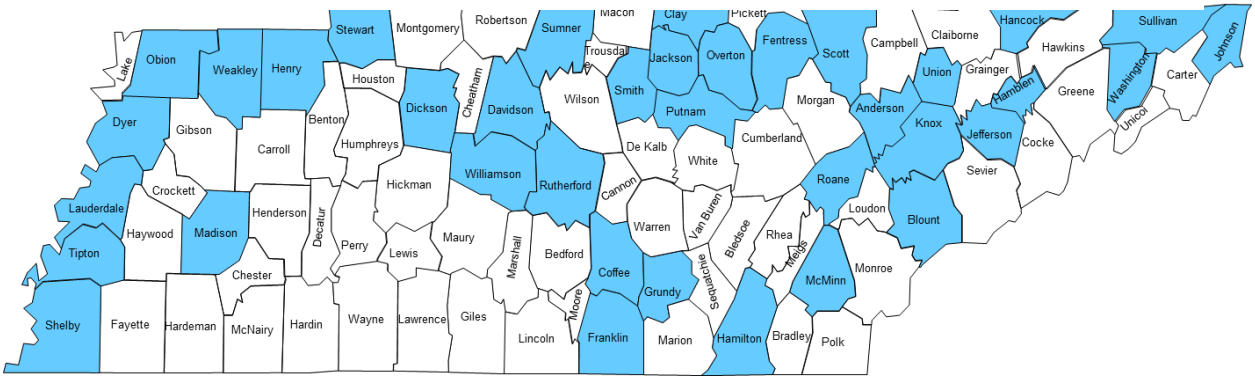
The Tennessee Department of Mental Health and Substance Abuse Services has a continuum of strategies in place to address the prescription drug epidemic. Those strategies begin with prevention and community-level work and extend all the way to recovery services. These strategies are essential to addressing the prescription drug problem in Tennessee and are described below.

Community Prevention Coalitions

One of the primary strategies utilized by the Department of Mental Health and Substance Abuse Services is supporting the work of Community Prevention Coalitions. Community Prevention Coalitions focus on "environmental" prevention strategies rather than programmatic, one-on-one work. Environmental prevention strategies, such as public awareness campaigns, public policy development, and work with law enforcement, tend to create an environment in which people are less likely to misuse or abuse substances. Sectors represented in Community Prevention Coalitions include law enforcement, youth, parents, businesses, media, schools, youth-serving organizations, faith-based communities, civic and volunteer groups, health care professionals, state, local or tribal agencies, and other organizations involved in reducing substance abuse in the community.

Currently the Department of Mental Health and Substance Abuse Services funds 37 Community Prevention Coalitions. The locations of these coalitions are identified in Map II-1 below.

Map II-1. Tennessee Community Prevention Coalitions



Community prevention coalitions funded by the Department of Mental Health and Substance Abuse Services.

Source: Tennessee Department of Mental Health and Substance Abuse Services

One area where the coalitions' focus their efforts is on non-medical use of prescription drugs. The Department of Mental Health and Substance Abuse Services believes that local communities are better able to understand and address their own issues with prescription drugs and empowers them to do so by providing financial support and technical assistance for the development and implementation of strategic plans.

The community coalition process is outlined below:

1) Conduct a Community-Level Needs Assessment
2) Plan strategically about the best way to address the needs and gaps identified during the assessment process by identifying and selecting evidence-based interventions
3) Implement the Strategic Plan
    - Strategic Plan activities that are implemented usually include the following types of strategies (Adapted from Community Anti-Drug Coalition of America's Seven Strategies to Effect Community Change):
        - Modify/change community policies to promote positive behaviors and discourage negative behaviors.
        - Provide information that increases understanding of negative consequences of substance use and abuse and positive impacts of substance abuse prevention efforts.
        - Enhance prevention skills among coalition members and staff, community members, service providers, law enforcement, educators, and youth.
        - Provide support to individuals or organizations to take action.
        - Increase barriers to substance misuse and abuse and reduce access to substances.
        - Increase incentives for behaviors that should be encouraged and increase penalties for behaviors that should be discouraged.
        - Change physical design of space or change the environment to encourage or discourage targeted behaviors.

The 37 community coalitions funded by the Department of Mental Health and Substance Abuse Services have been actively engaged in efforts to combat the prescription drug epidemic in Tennessee. Table II-2 is a sample of some of the notable Prescription Drug Policy Work they have done:

Table II-2. Notable Policy Work Examples

•**Sumner County** established a practice between Walgreens and the sheriff's office to conduct take-backs at five easily accessible retail locations.
•**Madison County** worked with law enforcement to ensure a full investigation is completed for all drug thefts and reported into a computer-based system.
•**Franklin County** helped establish a policy that school nurses must use drug disposal sites for destroying unused student medications. Additionally, they worked to establish a policy that all new school system employees be drug tested upon hire.
•**Putnam County** organized a medical professionals' workgroup for responsible prescribing practices and enlisted concerned doctors to help reduce overprescribing. Additionally, they established a local standard of care in prescribing for long-term chronic pain through a voluntary survey. Putnam County also educated community groups and policymakers concerning the need for a policy requiring emergency departments to check the prescription database in cases of accidental overdose and report overdoses to the prescribing doctor and Board of Medical Examiners.
•**Knox County** worked with local government to establish a zoning ordinance to regulate pain clinics.
•**Coffee County** worked with local law enforcement departments to approve policy changes allowing for permanent take-back boxes as well as procedures for collecting and sharing data concerning the controlled substances.
•**Roane County** worked with the city of Kingston to establish an ordinance that restricts business licenses issued for pain clinics within their city limits.

Looking Toward the Future

- Currently only 37 of Tennessee's 95 counties have state-funded coalitions. These 37 coalitions are working diligently to tackle the prescription drug problem in their communities. However,

in order to fully maximize the community coalition model, funding should be increased to expand the capacity of current coalitions and fund additional community coalitions.

- Support the Coalition for Healthy and Safe Campus Communities.
    - The Coalition for Healthy and Safe Campus Communities, an organization that works with college campuses across the state on prevention efforts, has proven to be an effective mechanism for sharing information and changing behaviors on college campuses in Tennessee. It is recommended that the funding for the Coalition for Health and Safe Campus Communities be expanded to further their prevention efforts around prescription drugs on college campuses.

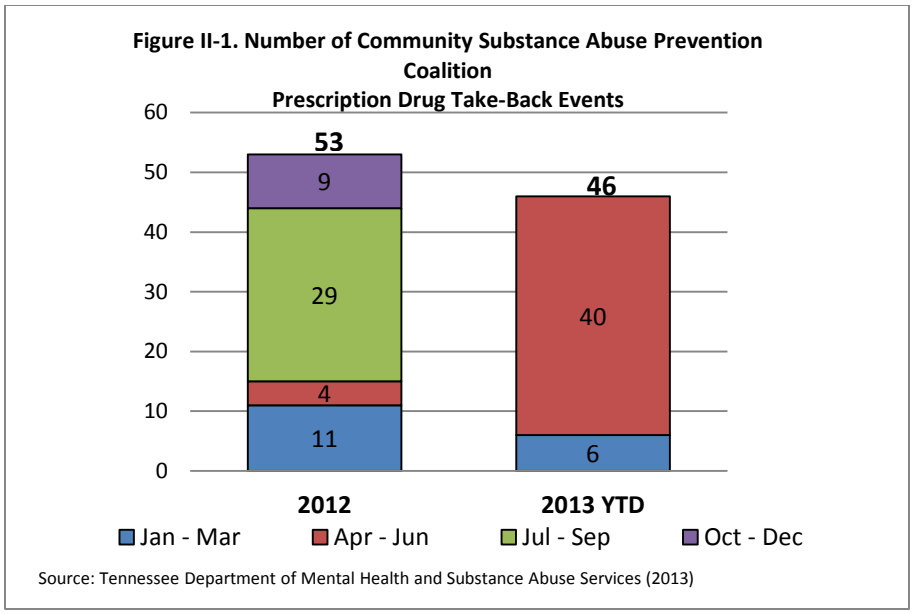
Prescription Drug Disposal (Take-backs and Permanent Prescription Drop Boxes)

An additional prevention initiative that the Department of Mental Health and Substance Abuse Services is actively working toward in collaboration with the Community Prevention Coalitions is disposal of prescription drugs. Access to prescription drugs is one factor leading to the prescription drug epidemic. One way to control access to prescription drugs is by developing mechanisms for safe, convenient, and responsible means of disposal. Drug disposal must have law enforcement cooperation as access to prescription drugs must be carefully controlled. The Department of Mental Health and Substance Abuse Services has been actively engaged in two types of disposal activities: Take-Back Events and Permanent Prescription Drop Boxes.

Take-Back Events

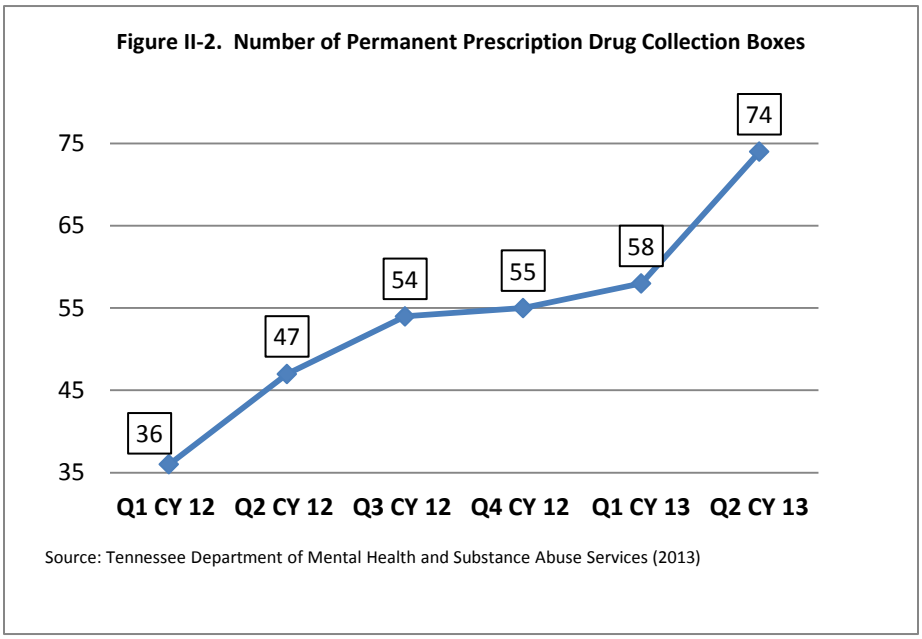
Take-Back Events are one-day events where the public is encouraged to discard their unused, unwanted, and expired prescription medications from around their homes. These events also raise awareness of the prescription drug epidemic and inform the public about why disposing of prescription drugs is critical.

Community Prevention Coalitions work with local stakeholders, law enforcement, and the Drug Enforcement Administration's Nashville District Office to coordinate local take-back events and hosted 46 events from January through June of 2013. The number of take-back events for 2012 and 2013 is shown in Figure II-1. Three Tennessee college campuses (Bethel University, the University of Tennessee at Chattanooga, and Middle Tennessee State University) also engage in regular Take-Back events.



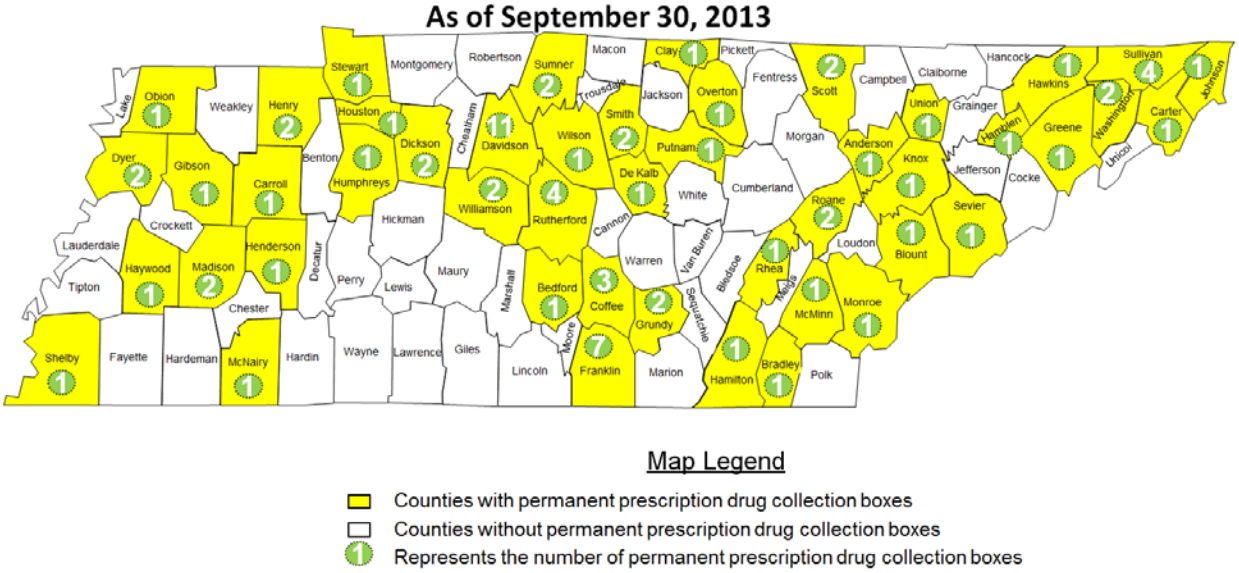
Permanent Prescription Drug Collection Boxes

Permanent Prescription Drug Collection Boxes are disposal sites located within law enforcement offices where prescription drugs can be dropped off by the general public at any time. Since the beginning of 2012, the number of permanent prescription drug collection boxes, shown in Figure II-2, has more than doubled from 36 boxes to 74 boxes. This achievement would not have been possible without the Department of Environment and Conservation, the Department of Health, and the Department of Mental Health and Substance Abuse Services working together to ensure the availability of safe places for prescription drug disposal.



Map II-2 below shows the locations of permanent prescription drug collection boxes across the state.

Map II-2 Locations and Number of Permanent Prescription Drug Collection Boxes; As of September 30, 2013



Map Legend

- Counties with permanent prescription drug collection boxes
- Counties without permanent prescription drug collection boxes
- Represents the number of permanent prescription drug collection boxes

Looking Toward the Future

- Establish additional permanent prescription drug collection boxes.
    - 50 of Tennessee's 95 counties do not have a permanent prescription drug collection box. The short-term goal is to establish at least one permanent prescription drug collection box in the top 20 opioid-prescribing counties by the end of 2014. A more long-range goal is to establish permanent prescription drug collection boxes in every county in Tennessee.

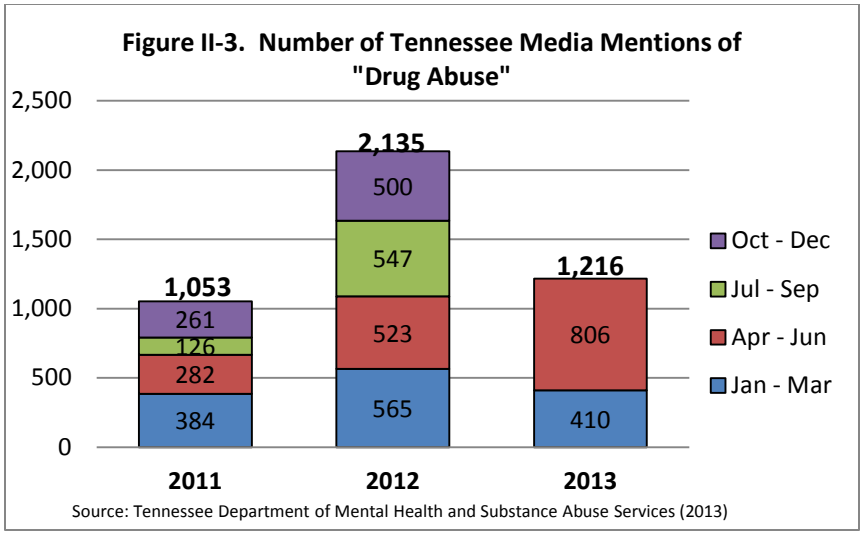
- Develop guidelines for the destruction of pharmaceuticals received from local Take-Back events and permanent prescription drug collection boxes.
    - Currently, the Drug Enforcement Agency, local community coalitions, and law enforcement work together to ensure proper disposal of prescription drugs. However, one barrier to widespread participation in Take-Back efforts is clarity regarding how prescription drugs, once collected, may be disposed. It is recommended that clear guidelines for the collection and disposal of prescription drugs be outlined and disseminated statewide. Additionally, the Department of Environment and Conservation's policy on destroying pharmaceuticals received from Take-Back events and permanent prescription drug collection boxes should be revised to allow drugs collected to be destroyed in the same manner as confiscated contraband.

- An additional goal for the future is to work with community coalitions to establish local incineration sites for the destruction of unused prescription medications.
    - One barrier to installing permanent prescription drug collection boxes has been the lack of a method for destroying prescription drugs once they are collected. The

establishment of conveniently located incineration sites should increase the likelihood of local law enforcement being willing to place a permanent prescription drop box in their precinct.

Information Dissemination

One important mechanism for the prevention of prescription drug misuse and abuse is sharing information and increasing the public's knowledge about the dangers associated with prescription drugs. A common misperception exists that prescription drugs are safer than illegal drugs, and less likely to lead to abuse, because they are prescribed by a health care provider. The Department of Mental Health and Substance Abuse Services has been working hard to change this misperception and increase public knowledge and awareness regarding the important issue of prescription drug abuse. As shown in Figure II-3, from January to June 2013, there have been 1,216 mentions of "drug abuse" by the media, which is on target to exceed the number from 2012. In 2012, there were 2,135 mentions of "drug abuse" which doubled the amount from 2011.



In order to further increase knowledge about the prescription drug epidemic, the Department of Mental Health and Substance Abuse Services is implementing a media campaign, "Take Only As Directed." The goals of the campaign are to educate and inform Tennessee's citizens about the prescription drug epidemic; the importance of taking prescription drugs as prescribed; and how to recognize the need for treatment. "Take Only As Directed" began in September 2013 and targets audiences in East and Middle Tennessee with radio and television advertisements. Additional messages will be delivered through decals and ceiling hangers displayed in pharmacies, as well as informational tags that will be attached to prescription bags with the message "This May Be Hard To Swallow." In addition, brochures will be available directing people to the "Take Only As Directed" website located at TakeOnlyAsDirected.com. **It is estimated that the "Take Only As Directed" message will reach 4 million people.**

Looking Toward the Future

- Continue and expand the "Take Only As Directed" statewide prescription drug media campaign.
    - The Department of Mental Health and Substance Abuse Services has limited funding

for the "Take Only As Directed" effort. This effort could have a greater impact if it was expanded. The initial media campaign was based in Middle and East Tennessee, but in recognition that the problem is spreading to West Tennessee, the campaign should also be expanded to West Tennessee.

- Support the Tennessee Congressional Delegation in promoting a policy that restricts direct-to-consumer marketing of prescription drugs on television, radio and other social media sites.
    - The U.S. Food and Drug Administration oversees the approval and marketing of prescription drugs including direct-to-consumer advertising of prescription drugs. The United States is one of the few places in the world that allows direct-to-consumer advertising. The only other developed nation that allows direct-to-consumer advertising is New Zealand[40]. No federal law has ever banned direct-to-consumer advertising. Until the mid-1980s, drug companies gave information about prescription drugs only to doctors and pharmacists. When these professionals thought it appropriate, they gave that information to their patients. However, during the 1980s, some drug companies started to give the general public more direct access to this information through direct-to-consumer advertisements. It is recommended that federal law be changed to restrict the direct-to-consumer marketing of prescription opioids.

Strategic Prevention Framework State Prevention Enhancement Grant

In 2011, Tennessee received the Strategic Prevention Framework State Prevention Enhancement Grant, which brought together high-level representatives from the Department of Mental Health and Substance Abuse Services; Tennessee Department Of Health; Tennessee Department of Children's Services; Department of Education; Governor's Highway Safety Office; Tennessee Primary Care Association; and Tennessee Alcoholic Beverage Commission. Representatives of these "Policy Consortium" members expressed a common vision for strengthening the infrastructure of prevention services in Tennessee including establishment of a coordinated and data-driven service delivery system, shared data, enhanced capacity to measure process and outcomes, and better use of limited resources.

The State Prevention Enhancement Grant culminated in a collaborative strategic five-year prevention plan that will be updated annually as the Consortium develops understanding of prevention needs and strategies to address those needs. One of Tennessee's five foremost goals is to prevent or reduce consequences of prescription drug misuse and abuse. Some of the strategies the Consortium is implementing include:

- Screening for prescription drug abuse at public health sites;
- Signing Memorandums of Understanding with Consortium partner agencies to provide funding and coordinate implementation of the plan; and
- Developing a website (www.tnprevent.org) and distributing the statewide "Take Only As Directed" media campaign.

Looking Toward the Future

- Continue the Strategic Prevention Enhancement Policy Consortium.
    - The Strategic Prevention Enhancement Policy Consortium has successfully

developed a five-year plan and has made great strides in interdepartmental efforts. It is recommended that this work be continued and expanded in order to best reach all Tennesseans.

Screening, Brief Intervention and Referral to Treatment

An important component of stopping the prescription drug epidemic is early recognition and early intervention when problems associated with misuse of prescription drugs arise. One significant effort the Department of Mental Health and Substance Abuse Services has been engaged in since 2011 that has the potential to greatly impact the prescription drug epidemic is the five-year Screening, Brief Intervention and Referral to Treatment (SBIRT) grant, which provides SBIRT services and disseminates information about SBIRT as a best practice. SBIRT is an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. The goal of SBIRT is to have sites of care, such as physicians' offices and outpatient hospitals, trauma centers, hospital emergency departments, ambulatory medical practices, and school clinics, screen patients who are at-risk for substance use, and if appropriate, provide them with brief intervention services or referral to appropriate treatment. By screening people in these settings it is possible to identify people who have had substance use related illness or injury that could provide a motivation for behavior change.

The following entities are currently part of the SBIRT grant project:

- East Tennessee State University Family Medicine Associates of Johnson City
- East Tennessee State University Family Medicine Clinic of Bristol
- East Tennessee State University Family Medicine Clinic of Kingsport
- The Clinic at Nashville General
- United Neighborhood Health Services, Madison Family Clinic
- The Tennessee National Guard

Looking Toward the Future

- Expand SBIRT into Department of Health primary care sites state-wide.
  - SBIRT is a proven prevention and early intervention model. The Department of Health reaches a large percentage of Tennessee's population through the primary care clinics it operates throughout Tennessee. It is recommended that SBIRT be adopted as the standard of care in each of these clinics.

- Expand the use of SBIRT in Tennessee.
  - The SBIRT model allows individuals to be identified in their health homes and receive an appropriate level of intervention targeted to their specific needs. The SBIRT service is billable through insurance. It is recommended that additional primary care sites begin using SBIRT as the standard of care.

Treatment Services

The Department of Mental Health and Substance Abuse Services contracts with a variety of non-profit and faith-based organizations to provide a continuum of treatment services to indigent people that are unable to pay for services on their own. **Services include: outpatient, intensive**

outpatient, partial hospitalization, residential treatment, halfway house, social detoxification, medically monitored detoxification, medically monitored crisis detoxification, and medically managed detoxification to individuals who meet the criteria for indigence and are in need of substance abuse services. Special priority is given to the following populations who meet the criteria outlined in the Substance Abuse Prevention and Treatment Block Grant administered by the Substance Abuse and Mental Health Services Administration: pregnant women with intravenous drug use, pregnant women abusing other drugs, and individuals with intravenous drug use. Additionally, those enrolled into the Medically Monitored Crisis Detoxification services are also included as a priority population.

In Fiscal Year 2012-2013, 5,854 people received opioid treatment through substance abuse providers funded by the Department of Mental Health and Substance Abuse Services. The Department of Mental Health and Substance Abuse Services uses the American Society of Addiction Medicine Patient Placement Criteria, an evidence-based assessment tool, to determine exactly which level of services an individual requires, at the beginning of their services and periodically throughout so that they will be given the most appropriate levels of care. Generally, as an individual progresses in their treatment experience, lesser levels of care are required and this assists the individual in moving effectively back into the community to live a life of recovery. On occasion, an individual needs a greater level of care and can be moved to that level based on the American Society of Addiction Medicine Patient Placement Criteria assessment.

The Department recognizes that many of the individuals served may have co-occurring mental health and substance use disorders as well as trauma issues. The Department contractually requires agencies to provide high quality services for individuals with co-occurring substance use and mental health disorders. The Department also contractually requires that trauma be assessed and treated if need is indicated. Training and technical assistance specific to co-occurring disorders and trauma are provided to all substance abuse agencies.

Looking Toward the Future

- Provide additional state funding for evidence-based treatment services for people with prescription opioid dependency who are indigent and unable to pay for services on their own.
    - The Substance Abuse Prevention and Treatment Block Grant funds treatment services for indigent people. The funding is not sufficient to address Tennessee's prescription drug epidemic. It is recommended that additional funding be allocated to fund treatment services for indigent people.

- Provide specialized training to treatment providers on best practices for serving people with opioid addiction.
    - People with opioid addiction have unique needs. It is recommended that the treatment workforce be trained on how to best serve this population.

- Increase the availability of and refine training for time-limited substance abuse case management services.
    - Substance abuse case management is a unique time-limited service that helps individuals gain access to resources that will help them overcome obstacles around

employment, housing, and education, become productive citizens, and live in recovery from their addiction. A training curriculum should be developed that focuses on the unique aspects of providing substance abuse case management. All agencies that are contracted to provide substance abuse treatment services should receive training on the curriculum.

Medication Assisted Therapies

Medication Assisted Therapy is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Research shows that when treating substance-use disorders, a combination of medication and behavioral therapies is most successful. Medication assisted treatment is clinically driven with a focus on individualized patient care.[41] Effective April 1, 2008, the Division of Substance Abuse Services assumed responsibility for oversight of Tennessee's Opioid Treatment Programs (also known as "medication assisted treatment programs"). The State Opioid Treatment Authority within the Department of Mental Health and Substance Abuse Services is responsible for program oversight and clinical assistance. Specifically, the State Opioid Treatment Authority is responsible for providing administrative, medical, and pharmaceutical oversight to certified opioid treatment programs, including, but not limited to planning, developing, educating, and implementing policies and procedures to ensure that opioid addiction treatment is provided at an optimal level. Tennessee has twelve for-profit methadone clinics.

The Department of Mental Health and Substance Abuse Services recognizes that there is a place for buprenorphrine (i.e. suboxone, subutex, etc.), an additional medication used in the treatment of prescription drug disorders, in the continuum of treatment modalities. However, the Department is concerned about the oversight and/or regulations governing buprenorphrine. The Department has noted problems with the efficacy in outcomes for buprenorphrine treatment and the lack of a person-centered treatment plan that includes other essential treatment strategies including clinical therapy.

Neonatal Abstinence Syndrome Funded Treatment

The Department is promoting an innovative approach to treating women whose infants are born with Neonatal Abstinence Syndrome. A pilot project has been developed with the Department of Mental Health and Substance Abuse Services, Helen Ross McNabb Center, and East Tennessee Children's Hospital that will result in detoxification and intensive outpatient treatment services being delivered at the East Tennessee Children's Hospital. It is expected that 25 mothers and their infants will be treated as a result of this innovative new program during Fiscal Year 2013.

Looking Toward the Future

- Provide additional specialized treatment options for mothers with opioid addiction whose babies have been born with Neonatal Abstinence Syndrome or who are at risk of losing their children.
    - Women with children need specialized treatment services tailored to meeting their needs as well as the needs of their children. These services include a full continuum of treatment services as well as other wraparound services to assist mothers in caring for their children. These services include safe drug-free housing and aftercare services to ensure recovery is maintained and support is offered when required. While some services are being offered to meet the needs of this specialized

population, there is still considerable unmet need.

- Develop best practices for opioid detoxification of pregnant women.
    - Current guidelines from the American Congress of Obstetricians and Gynecologists do not recommend detoxification during pregnancy. However, many women in Tennessee have been safely detoxified during pregnancy without harm to them or their baby. A workgroup should be formed to explore the efficacy of opioid detoxification of pregnant women. The workgroup should be composed of (at minimum) individuals from the following entities: the Department of Mental Health and Substance Abuse Services, the Department of Health, the Tennessee Medical Association, the Tennessee Nurses Association, the Tennessee Chapter of the American Academy of Pediatrics, the Tennessee Chapter of the American Congress of Obstetricians and Gynecologists, the Board of Medical Examiners, and the Board of Osteopathic Examination.

Recovery (Drug) Courts

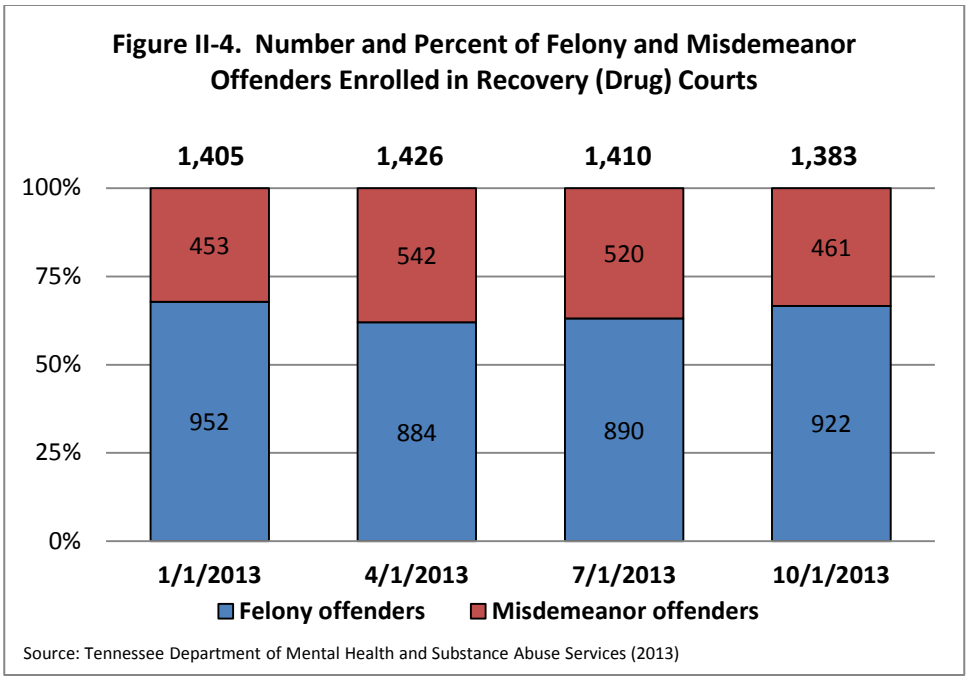
Many people are incarcerated as a result of their addiction to drugs. Thus, it is important to provide mechanisms for non-violent individuals that have been charged with drug-related crimes to receive treatment. Recovery (Drug) Courts are a mechanism for providing treatment as well as accountability for crimes that were committed. In Tennessee, eligible drug-addicted people may be sent to Recovery Court in lieu of traditional justice system case processing. Recovery Courts keep individuals in treatment long enough for it to work, while supervising them closely. For a minimum term of one year, participants are:

- Assisted in finding intensive treatment and other services they require to get and stay clean and sober;
- Held accountable by the Recovery Court judge for meeting their obligations to the court, society, themselves and their families;
- Regularly and randomly tested for drug use;
- Required to appear in court frequently so that the judge may review their progress; and
- Rewarded for doing well or sanctioned when they do not live up to their obligations.

Tennessee has 44 existing Recovery Courts that work with people engaged in the criminal justice system. Beginning July 1, 2013, the Recovery Courts have broadened their mission to include other high-need populations including consumers of mental health services and veterans. The courts are now known as Recovery Courts. This move eliminates duplication of efforts and allow for better coordination of care, as many individuals with a substance use disorder also have co-occurring mental health needs and are veterans. The Department of Mental Health and Substance Abuse Services will assist each of the existing drug courts as they move toward a Recovery Court model.

As depicted in Figure II-4, on July 1, 2013 there were 890 felony offenders enrolled in Recovery (Drug) Courts and 520 misdemeanor offenders, for a total of 1,410. In 2013, there have been a consistent number of offenders enrolled in Recovery Courts, with substantially more felony offenders than misdemeanor offenders. The General Assembly placed funding in its 2013-2014 budget to develop 10 new Recovery Courts. Tennessee is fortunate to have many judges already involved in Recovery Courts and is looking forward to working with many more in the future, as they

are essential to the success of Recovery Courts.



Looking Toward the Future

- Develop additional Recovery Courts throughout the state.
    - In Tennessee, 44 Recovery Courts are currently funded. These courts should be further expanded to ensure that they are available to those that most need them. It is recommended that funding for additional courts be allocated.

Community Treatment Collaborative Program

The Community Treatment Collaborative Program is funded through an interagency agreement between the Department of Correction and the Department of Mental Health and Substance Abuse Services. The Community Treatment Collaborative is a coordinated effort to divert at-risk probation and parole technical violators with substance abuse and co-occurring disorders from returning to state prison. This program requires a collaborative treatment approach which engages service recipients, providers, Department of Correction staff, and other community supports. The Community Treatment Collaborative program provides a full continuum of care including detoxification, residential rehabilitation, halfway house, and outpatient services.

Recovery Support Services

It is generally understood by science and experience that the longer an individual is engaged in substance abuse services, the more likely it is that a better outcome will be achieved and the individual will live a life of recovery that is free from alcohol and/or drugs. Recovery Support Services are key to continued engagement and thus improve an individual's chance of positive continued outcomes. Recovery Support Services build on successful 12-step program models as well as the concept of peers helping peers.

Current Recovery Support Services include the following: recovery support services assessment, case management, drug testing, recovery skills, relapse prevention, spiritual/ pastoral support, transitional housing, and transportation. These services may take place concurrently with clinical treatment, but generally occur following the treatment episode.

Looking Toward the Future

- Study efficacy and feasibility of Recovery Schools and Collegiate Recovery Communities.
    - Recovery Schools and Collegiate Recovery Communities support adolescents and young adults in pursuing their education while in a safe, supportive, and recovery-oriented environment. Data shows that the 12-17-year-old and 18-25-year-old population are most at risk for abusing prescription opioids in Tennessee. It is important that these populations have increased access to recovery support as they pursue their education in either high school or post- secondary school. Recovery Schools and Collegiate Recovery Communities are designed specifically for students recovering from substance abuse or dependency where students can surround themselves with other individuals that are also on the recovery journey.

Low Cost/High Impact Alternatives

State agencies must always balance the competing needs of high quality and cost effectiveness. The three programs, Oxford House, Community Housing with Intensive Outpatient Services, and Lifeline, strike the perfect balance of low cost and high impact. These programs often utilize volunteers and other natural supports in the community to maximize impact and minimize cost.

Oxford House Program

The Oxford House Program is a conglomeration of democratically run, self-supporting, drug- free homes. Oxford House, Inc., is a publicly supported, non-profit 501(c)(3) corporation and is the umbrella organization which provides the network connecting all Oxford Houses and allocates resources to duplicate the Oxford House concept. It has operated for 37 years and is the only recovery home organization that is national in scope, provides an ongoing evaluation and has a track record of proven and effective results. Beginning July 1, 2013, the Department of Mental Health and Substance Abuse Services contracted with Oxford House, Inc., to provide two outreach workers to begin six to 10 new Oxford Houses annually in Tennessee. As of October 15, 2013, there were 12 established Oxford Houses in Tennessee.

Community Housing with Intensive Outpatient Services

Appropriate community housing that is recovery-based as well as Intensive Outpatient Treatment is a good alternative to more expensive residential treatment services for many people. Recovery housing locations are not licensed treatment facilities, but offer a safe, sober, supportive environment for individuals in early recovery to bridge the gap between treatment services and full community integration. The average cost per day of recovery housing with Intensive Outpatient Treatment is $80/day compared to $140/day for residential treatment[42].

Lifeline

The Lifeline Project has three key goals:

1) Reduce stigma;
2) Increase community understanding and support of policies that provide access to treatment and recovery services; and
3) Encourage the establishment of additional 12-step meetings, such as Narcotics Anonymous and other recovery support services, across the state.

Project approaches include encouraging the establishment of evidence-based addiction and recovery programs (including 12-step programs) as well as educational presentations for civic groups, faith-based organizations, and community leaders to increase understanding of the disease of addiction and support for recovery strategies.

Looking Toward the Future

- Provide additional low cost/high impact services such as Oxford Houses, Community Housing with Intensive Outpatient Services, Lifeline, 12-step meetings, and faith-based initiatives.
    - Recovery services are essential to individuals who have completed treatment and are living a substance-free lifestyle. Recovery services offer opportunities to interact with others who are on a similar recovery journey and experiencing the same struggles as they navigate a life free of substances. Many recovery services can be provided for little to no cost. However, some initiatives do require funding for startup or staff time to recruit additional sites in high-need locations. The Tennessee General Assembly allocated one-time funding in the amount of $550,000 in 2013 for the Lifeline program, an initiative to increase the number of recovery support services in Tennessee. It is recommended that this funding become recurring.

CURRENT STRATEGIES: TENNESSEE DEPARTMENT OF HEALTH

The Tennessee Department of Health plays a key role in combatting the prescription drug epidemic in Tennessee through oversight of the Controlled Substance Monitoring Database and Pain Clinics, as well as working through the Health Related Licensing Boards to promote a uniform protocol for prescribing guidelines for opioids and benzodiazepines.

Controlled Substance Monitoring Database

The Controlled Substance Monitoring Database was legislatively mandated in 2002 and administratively attached to the Board of Pharmacy. The purpose of the database is to collect data about the controlled substances being dispensed in Tennessee in order to identify unusual prescribing and/or dispensing practices, taking into account the particular specialty, circumstances, and patient-type or location of the prescriber or dispenser[43]. It was also created to inform prescribers and dispensers of the controlled substance prescriptions their patients were receiving from other prescribers.

The Tennessee Prescription Safety Act of 2012 contained key provisions that will increase the timeliness and accuracy of information reported into the Controlled Substance Monitoring Database by decreasing the amount of time that dispensers have to report into the Database. Currently, the Department of Health is working to inform people in the medical profession who will be affected by the new law about its provisions and how it will affect their work. The Department of Health has conducted seven regional continuing education conferences across the state. Additionally, the Board of Medical Examiners now requires all 22,000 licensed physicians to complete a one-hour continuing education program on controlled substances and the new law now requires prescribers to attain two hours. Continuing medical education checks have found a 90% compliance with the current requirement. The Department of Health is currently studying recommendations for adoption of similar standards by other professional boards.

Another important mechanism for sharing information with medical professionals is by educating people pursing undergraduate and graduate degrees in the health professions. The Department of Health, in cooperation with related professional societies and associations, is developing a teaching tool to be used in higher education settings. The teaching tool will include the following information:

- A description of the Prescription Drug Safety Act of 2012;
- How the Prescription Drug Safety Act of 2012 is applicable to their profession; and
- The nature of the prescription drug problem in Tennessee.

The Department of Health is working to ensure that the information in the Controlled Substance Monitoring Database can be used to make informed decisions when prescribing prescription opioids. One important new development is a notification system that sends clinicians an alert when their patients have met certain risk thresholds. These thresholds have been developed through analysis of prescription data in the Controlled Substance Monitoring Database and can be utilized to identify patients at potential risk for adverse events. The three areas of risk are: number of prescribers, number of dispensers, and morphine milligram equivalent (MME) dose. In 2014, these notifications will be present upon login to the Controlled Substance Monitoring Database and are presented to the Controlled Substance Monitoring Database user from high to low priority.

High Pharmacy Utilization

- Red – 4 pharmacies in 60 days
- Yellow – 3 pharmacies in 60 days

High Prescriber Utilization

- Red – 4 prescribers in 60 days
- Yellow – 3 prescribers in 60 days

High Morphine Equivalent Dose

- Red – 120 MME per day
- Yellow – 90 MME per day

When selecting a notification, the patient's Controlled Substance Monitoring Database report will be generated and sent to the clinician for evaluation. A reminder email will be sent if the clinician does not view the patient report. Studies have shown that this type of notification is an effective tool in identifying potential doctor shoppers and providing an opportunity for an intervention.

An additional way that the Department of Health has begun to use the Controlled Substance Monitoring Database to inform prescribers about their prescribing habits is by sending letters to the top 50 prescribers of controlled substances and requesting an explanation justifying the amounts.

The Department of Health is also working to improve information sharing across state lines. Tennessee borders eight states and crossing over state lines to obtain controlled substances is fairly easy. Without information from other states' prescription drug monitoring programs it will be impossible to get a full picture of the types of drugs that individuals are being prescribed. The Department of Health is working with other states' prescription drug monitoring programs and has met with the states that are in close proximity to Tennessee (Kentucky, West Virginia, Ohio, Alabama, Virginia, North Carolina, South Carolina, Indiana, and Florida) to create a prescription drug alliance to share prescriber and dispenser information from each state's Prescription Drug Monitoring Program. Exchanges have been established with South Carolina, Virginia, and Michigan. Pilot testing is under way with Kentucky.

Looking Toward the Future

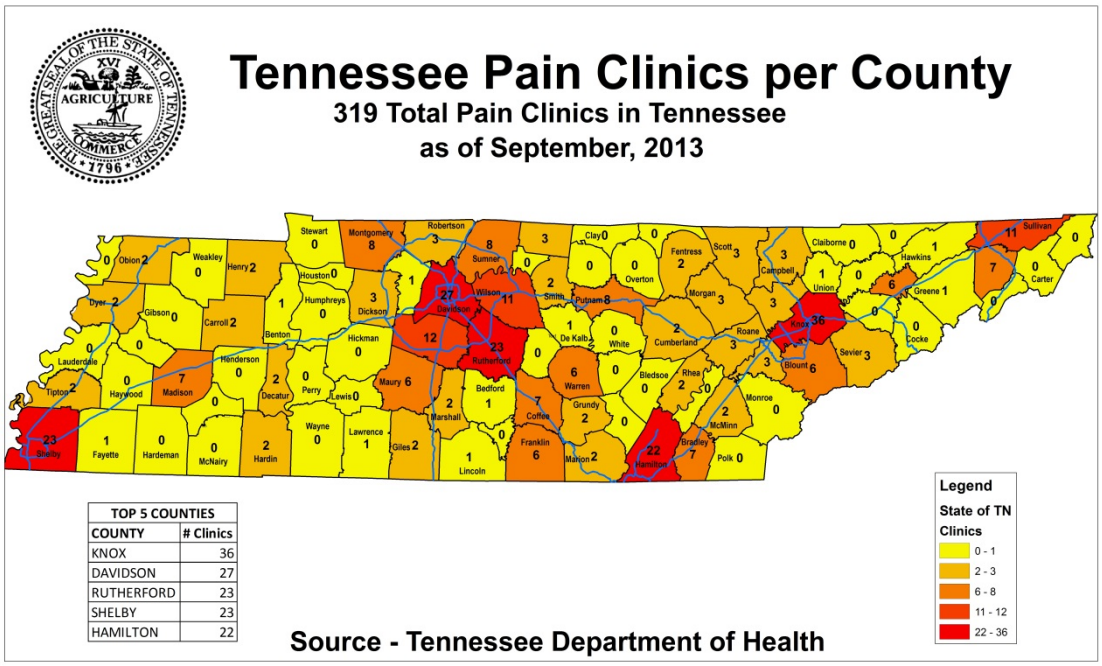
- There are still some desired changes that would further improve the utility of the Controlled Substance Monitoring Database and assist in curtailing the prescription drug problem including:
    - Continue to make technological improvements to enhance the ability to report data in more real-time and with easier user access.
    - Provide de-identified aggregate data obtained from the database for purposes of education and outreach both to healthcare practitioners and the public.
- Develop memorandums of understanding between other states that guide information sharing practices for information gained through prescription drug monitoring programs.

Pain Clinic Oversight

The Department of Health is responsible for oversight of pain clinics and is working to take a more

proactive oversight role by querying data from the Controlled Substance Monitoring Database to determine unusual activity and by regularly conducting inspections. The Database information is being used to identify prescribing patterns for individual prescribers and dispensers as well as pain clinics. In addition, the Department of Health is enhancing the enforcement activities in the Office of Investigations and legal office to conduct inspections of pain clinics, bring violations to conclusion, and turn matters over for possible prosecution where warranted.

Map II-3. Tennessee Pain Clinics per County



Looking Toward the Future

- Revise Pain Clinic Rules to better address the prescription drug problem in Tennessee.
    - Pain clinic rules can be further enhanced to ensure they have language that discourages illegal practices and increased standards for medical directors with the goal of improving quality. When designing, the new rules, the National Alliance for Model State Drug Laws' overview on "State Regulations of Pain Clinics" should be referenced.

Drug Overdose Reporting

Another important tactic in understanding and combatting the prescription drug problem in Tennessee is to have more information about people who have died from drug overdoses. One way that this can be accomplished is by obtaining consistent information from medical examiners across the state about the drug overdose deaths that occur in their area. National guidelines recommend that autopsy, investigation, and toxicology should be completed to accurately diagnose drug overdose deaths. Baseline data of the total number of autopsy-confirmed drug overdose deaths for each county was obtained**. The 2011 data shows that only 62% of overdose deaths were autopsied[44].** Reports of Investigation submitted to the Office of the Chief Medical Examiner indicate some counties certify deaths as drug overdose based on circumstantial information without

doing the needed autopsy and appropriate laboratory studies. Thus, it is important that additional work be done to ensure that overdose deaths are being autopsied. The Department of Health drafted rules in December 2012 to address the Public Chapter requirement to improve uniform investigation of deaths. As of July 2013, 16 counties submit reports of investigation to the Office of the Chief Medical Examiner.

Looking Toward the Future

- Improve the uniformity and reliability of drug overdose reporting by all county medical examiners.
    - The Department of Health is planning to improve the uniformity and reliability of drug overdose reporting by all county medical examiners by reviewing the current state laws for needed modifications for the 2015 General Assembly.

- Implement a new case management system for medical examiners.
    - The Department of Health has identified a potential statewide medical examiner's case management system and is working to estimate costs and details of a licensing agreement.

Development of Guidelines for Prescribing Narcotics

The Department of Health has a workgroup whose purpose is to identify chronic pain management guidelines. Workgroup participants represent private providers as well as the departments of Health, Mental Health and Substance Abuse Services, and Commerce and Insurance, and the Bureau of TennCare. Guidelines are intended to assist prescribers on appropriate prescribing patterns for individuals needing opioid pain relievers, including management of acute pain, having a long-term plan, understanding opioid's morphine equivalent, and what is the best and highest use. The guidelines should also improve the dialogue between the medical community and law enforcement.

A Frequently Asked Questions document was prepared and distributed in December 2012 to 30,000 prescribers and dispensers regarding the new requirements for the Controlled Substance Monitoring Database. The document included statements of intent to develop statewide protocols. In the spring of 2013, the Department of Health held a series of five regional provider symposia with prescribers, dispensers, regulators, and communities to consensually develop and encourage adoption of standards and assure integration of prevention strategies. A rough draft of the guidelines should be completed by December 1, 2013. The final step will be preparation of a strategic plan for the whole effort that will include cost projections.

Looking Toward the Future

- Design a smartphone application that will provide prescribers automatic updates on milligram/morphine equivalents and other technological enhancements.
    - It is important that prescribers have the most up-to-date information about medications they are prescribing. Using the latest technology including smart phone applications will ensure that prescribers are using the latest information when making medication decisions.

- Review and revise the Tennessee Intractable Pain Treatment Act and the Tennessee Code related to pain management clinics in order to address current opioid prescribing practices.[45]

- The Tennessee Intractable Pain Treatment Act was enacted in 2001 to give patients with chronic pain a Bill of Rights which guarantee access to long-term opioids as a first-line treatment for chronic pain. The subsequent illegal misuse, abuse or diversion of opioids formulated for chronic pain was not anticipated when this act was codified.
- The perceived under-prescribing of opioids by Tennessee physicians in 2001 has now been replaced by overprescribing. Unless the patient has a serious illness, opioids are no longer conventionally considered first-line treatment of chronic pain as guaranteed by the Tennessee Pain Patient's Bill of Rights (Tenn. Code Ann. § 63-6-1104).
- With this in mind, it is recommended that the Tennessee Intractable Pain Treatment Act (Tenn. Code Ann. § 63-6-1101) and the Tennessee Code related to Pain management clinics (Tenn. Code Ann. § 63-1-301) be reviewed and legislative revision or repeal be considered as necessary to reduce the pressure on health care providers to prescribe opioids over other options for chronic pain management. Legislation should not discourage the use of opioids as first choice when indicated for treatment of acute severe pain or persistent pain due to active cancer or other advanced illnesses.

- Complete the development of guidelines for prescribing opioids and encourage adoption.

- Licensing bodies should continue to review their own policies and procedures around unsafe opioid prescribing practices and enact new rules that allow better self- regulation of licensees including tougher and more timely consequences for physicians who over-prescribe.

- Develop additional specific guidelines for prescribing narcotics for Acute Care Facilities (Urgent Care and Emergency Departments).
  - Acute Care Facilities are unique environments where the treatment of pain is frequently indicated without the benefit of an established patient/doctor relationship. It is also often conducted in an environment of limited resources including prescriber time and diagnostic information. Therefore, it is important to establish general guidelines that can help urgent care and emergency departments reduce inappropriate prescribing of opioid pain medication while preserving their vital role of treating patients with emergent medical conditions.

Impaired Healthcare Professionals Program

The Tennessee Professional Assistance Program is a program administered by the Tennessee Nurses Foundation and funded by the Department of Health, Division of Health Related Boards. It assists in the rehabilitation of impaired healthcare professionals by providing consultation, referral, and monitoring services to facilitate a safe return to practice. It is a voluntary program that aids healthcare professionals who are struggling with physical, psychological or chemical impairment impacting their professional practice by providing an avenue for early identification, treatment, monitoring and advocacy. A healthcare provider, who cooperates fully with recommended evaluation/treatment and complies with requirements of the program, may be allowed to continue practicing if they engage in sound recovery techniques.

CURRENT STRATEGIES: TENNESSEE DEPARTMENT OF SAFETY AND HOMELAND SECURITY

The Tennessee Department of Safety and Homeland Security is also an active partner in stopping the prescription drug epidemic in Tennessee. This Department has taken an active role by leading the Governor's Public Safety Subcabinet and working to educate state troopers about intercepting and confiscating illicit drugs.

Doctor Shopping

During the first six months of 2013, the Department of Safety and Homeland Security saw an increase in people being convicted of doctor shopping, with 67 individuals being found guilty. If the rate of people being convicted for doctor shopping continues for the remainder of 2013, it is expected that 204 people will be convicted, a significant increase from the 2012 number of 96 individuals convicted[46]. As utilization of the Controlled Substance Monitoring Database has increased, the number of people doctor shopping has decreased.

Law Enforcement Access to Controlled Substance Monitoring Database

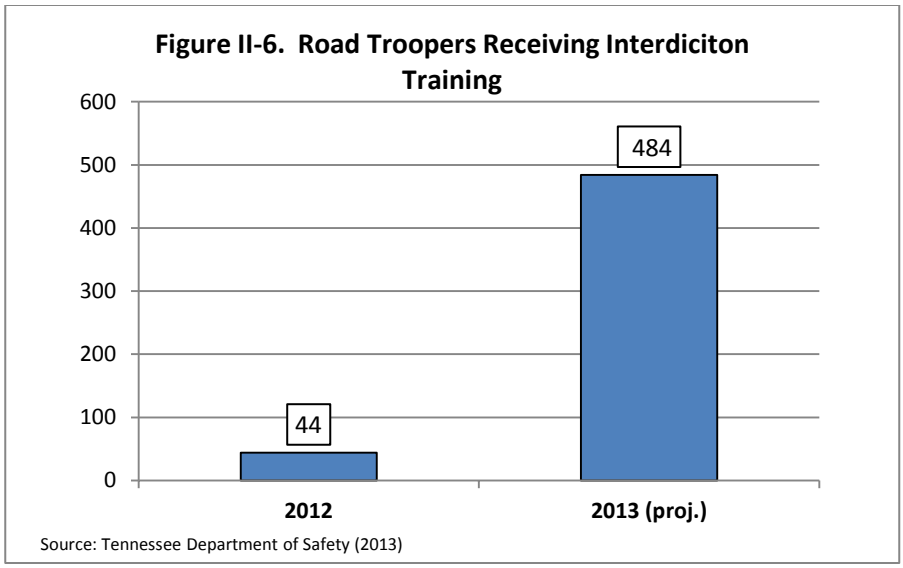
The passage of the Prescription Safety Act of 2012 expanded law enforcement access and utilization of the Controlled Substance Monitoring Database when specific criteria are met (i.e., it is part of an ongoing investigation). The Department of Health is in the process of developing rules to clearly describe the procedures by which law enforcement may access the Controlled Substance Monitoring Database. There were 2,565 queries submitted by law enforcement for Controlled Substance Monitoring Database data in 2012, and the projection for 2013 is 2,180[47].

Enhanced Database

The Department of Safety and Homeland Security is utilizing the Tennessee Fusion Center's "pharmaceutical diversion suspicious activity reporting database" to check for prior suspicious stops involving suspects and to enter new information into the database as a result of stops involving suspicious levels of prescription drugs. The Fusion Center is an ideal location for the "pharmaceutical diversion suspicious activity reporting database" as it was developed to enhance information sharing between federal, state and local law enforcement agencies. The collaborative effort of the partnered agencies provide resources, expertise, and information to the center with the goal of maximizing the ability to detect, prevent, apprehend and respond to criminal activity. There were 11 entries made into the "pharmaceutical diversion suspicious activity reporting database" by troopers in 2012, and 23 entries through June 30, 2013[48].

State Trooper Training

The Department of Safety and Homeland Security plans to conduct a 40-hour drug interdiction training course two times this year for approximately 50 state troopers. Interdiction refers to the interception and confiscation of illegal drugs. During the first half of 2013, 186 troopers and 56 Tennessee Highway Patrol Cadets received 24 hours of interdiction training.



The Department of Safety and Homeland Security is working to meet its goal that all road troopers will receive 24 hours of interdiction training during 2013. An additional 16 hours of interdiction training is still planned for in-services scheduled for 2014 giving troopers a total of 40 hours of drug interdiction training. For the first six months of 2013, 242 road troopers have received interdiction training compared to 44 in 2012.

CURRENT STRATEGIES: TENNESSEE BUREAU OF INVESTIGATION

The Tennessee Bureau of Investigation is responsible for providing specialized law enforcement services to state and local law enforcement agencies. The Tennessee Bureau of Investigation provides drug diversion investigators, who pursue those who fraudulently overprescribe and doctor shop.

Drug Investigation Division

The Drug Investigation Division is responsible for investigating and assisting in the prosecution of crimes involving controlled substances, narcotics, and illegal drugs. These investigations can, and often do, involve the illegal diversion of prescription drugs. Agents assigned to the Drug Investigation Division are stationed throughout the state.

Medicaid Fraud Control Unit

The responsibilities of the Medicaid Fraud Control Unit are "to investigate and refer for prosecution violations of all applicable laws pertaining to provider or vendor fraud and abuse in the administration of the Medicaid program, the provision of goods or services or the activities of providers of goods or services under the state Medicaid plan; Medicaid fraud; and abuse or neglect in health care facilities receiving payments under the state Medicaid plan such as board and care facilities as allowed by federal law" (Tenn. Code Ann. § 71-5-2508). These provider fraud investigations include cases on over-prescribers, as well as abuse occurring in health care facilities, which sometimes involve theft or diversion of patient medications. The Medicaid Fraud Control Unit is a 75% federally funded law enforcement entity located within the Criminal Investigation Division of the Tennessee Bureau of Investigation. It is one of 50 federally certified units across the country.

Forensic Services Division

The Tennessee Bureau of Investigation Forensic Services Division is comprised of a central laboratory in Nashville and two regional laboratories in Memphis and Knoxville. Within each laboratory is a Toxicology and Forensic Chemistry Unit that each provides testing of submitted samples for the presence of alcohol and/or drugs. The statewide increase in synthetic drug demand and distribution has created the need for the Forensic Chemistry Unit to expand testing, provide training and guidance for submitting agencies and prosecutors, and consult with legislators concerning trends in synthetic drug case work. Alcohol is by far the most prevalent sample encountered in toxicology cases, followed by marijuana. Prescription drugs are the next most common group of drugs found, and these are found in many disturbing combinations. Frequently encountered prescription drugs are alprazolam, hydrocodone, diazepam, carisoprodol, clonazepam, and many others.

Tennessee Methamphetamine and Pharmaceutical Task Force

The mission of the Tennessee Methamphetamine and Pharmaceutical Task Force is to enforce the controlled substance laws of Tennessee and the United States and to bring to the criminal justice system those individuals and organizations involved in the clandestine manufacture and trafficking of methamphetamine and the abuse and diversion of other controlled substances, particularly opioids and benzodiazepines. The Task Force has broadened its mission to focus on prescription drugs using the framework established through work around methamphetamines. The Task Force is made up of a diverse range of community and statewide stakeholders, including the Department of Mental Health and Substance Abuse Services and the Department of Health. The Task Force focuses on areas of the state where there is increased activity related to opioids and benzodiazepines.

CURRENT STRATEGIES: U.S. DRUG ENFORCEMENT ADMINISTRATION

The U.S. Department of Justice Drug Enforcement Administration is a key partner in solving the prescription drug epidemic that exists in Tennessee. All prescribers and dispensers must register with the Drug Enforcement Administration. Additionally, the Drug Enforcement Administration pursues criminal activity as it relates to prescribing and dispensing pharmaceuticals. The Drug Enforcement Administration has also been very involved with Drug Take-Back Days.

Drug Enforcement Administration Registration

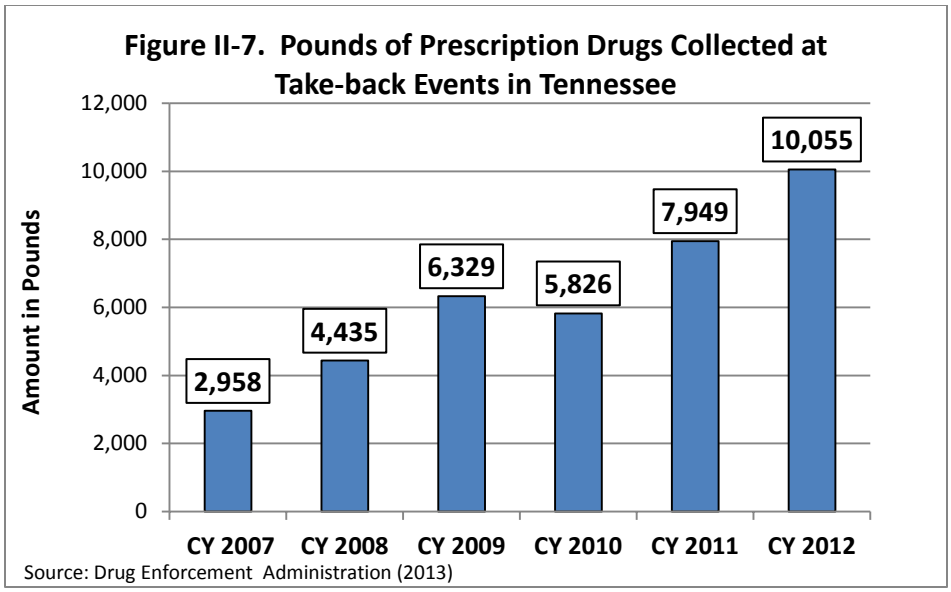
Under federal law, all businesses that import, export, manufacture, or distribute controlled substances; all health professionals licensed to dispense, administer, or prescribe them; and all pharmacies authorized to fill prescriptions must register with the Drug Enforcement Administration. Registrants must comply with regulatory requirements relating to drug security and record keeping. There are currently 31,700 Type A registrants in Tennessee (individuals who can prescribe) and 313 Type B registrants (manufacturers, distributers, and narcotic treatment programs)[49].

Diversion Investigations

One of the main responsibilities of the Drug Enforcement Administration is to conduct diversion investigations. These investigations involve, but are not limited to, physicians who sell prescriptions to drug dealers or abusers; pharmacists who falsify records and subsequently sell the drugs; employees who steal from inventory and falsify orders to cover illicit sales; prescription forgers; and individuals who commit armed robbery of pharmacies and drug distributors. Diversion investigations almost always are conducted in collaboration with state and local partners.

National Prescription Drug Take-Back Day

The Drug Enforcement Administration coordinates the National Prescription Drug Take-Back Day, which aims to provide a safe, convenient, and responsible means of disposing of prescription drugs while also educating the general public about the potential for abuse of medications. Figure II-7 shows that over the last few years, the amount of pills collected at Take-Back Days in Tennessee has increased. **In 2012, 10,055 pounds of pills were collected.** The Drug Enforcement Administration also processes requests for local law enforcement to house permanent drop-boxes and will take custody of drugs received from local take-back events and permanent prescription drop-boxes if requested.



Looking Toward the Future

- Provide training on the new Drug Enforcement Administration's regulations.
  - The Drug Enforcement Administration is expected to release new regulations on prescription drug disposal. When these regulations are released, it will be important to train local law enforcement and pharmacies on the new rules.

CURRENT STRATEGIES: TENNESSEE DEPARTMENT OF CORRECTION

High numbers of individuals are being incarcerated as a result of drug use. The Tennessee Department of Correction ensures that incarcerated individuals who are in need of treatment services receive those services while incarcerated.

Treatment Services

The Department of Correction uses a highly structured program model as the primary treatment format, including a robust risk/needs assessment, and a blend of both cognitive restructuring and behavior modification treatment approaches. This structured program model has proven to be a cost-effective treatment option for offenders housed within a correctional setting. This structured program model is based on the "criminogenic need principle" that enables program participants to acquire a wide range of specific and individual skills to achieve long-term sobriety and promote pro-social behavior changes. Offenders typically participate in substance abuse treatment programs near the end of the term because the Department of Correction wants to provide this service as close to the offender's release date as possible so that the skills will easily be transferred to the home environments[50].

Currently, the Department of Correction offers the following substance abuse and behavioral treatment options[51]:

Substance Abuse Therapeutic Community

Available at 13 Department of Correction facilities, this is a high-intensity, modified therapeutic community program with over 1,400 beds available. The duration is 9-12 months based both on the completion of standardized tasks as well as observable behavioral change.

Substance Abuse Group Therapy

Available at seven Department of Correction facilities, this is a medium-intensity program. Run in a full-time setting, the duration is 3-4 months; run in a part-time setting, the duration is 4-6 months.

Technical Violators Diversion Program

Located at the Turney Center Industrial Complex Annex and available only through a Parole Board recommendation, this is an intensive six-month program for offenders who violated the terms of their parole. It is run in a therapeutic community setting in conjunction with the substance abuse therapeutic community at the same location and there are 75 beds available.

Co-Occurring Treatment

The 48-bed treatment unit is located at Bledsoe County Correctional Complex. This intensive 12-month program offers inmates the opportunity to recover from addiction while learning how to manage their mental health disorder.

Volunteer Involvement

The Department of Correction also provides opportunities for volunteer groups to come into their facilities to provide recovery support services. Volunteer groups provide 12-step meetings, sponsorship, and faith-based recovery groups including Celebrate Recovery. The Department of

Correction also provides individuals who are paroled with relapse prevention groups as well as supporting ongoing participation in local 12-step meetings, Celebrate Recovery and other faith-based recovery groups.

The average cost for a day in prison is $67 throughout the Department of Correction system. For an offender to receive substance abuse treatment services, it costs approximately $2.40 per offender per day in addition to the cost to provide food, shelter, and clothing. The average length of the substance abuse treatment programs is nine months. For an offender to participate in a substance abuse treatment program within a Department of Correction prison, it costs approximately $648 per person[52].

Looking Toward the Future

- Create up to three additional Residential Recovery Courts.
    - The Department of Mental Health and Substance Abuse Services is currently in discussions with the Department of Correction about expanding Residential Recovery Courts to additional people. The next Statewide Residential Recovery Court is under consideration for Middle Tennessee. Currently the Davidson County Residential Drug Court houses 40 females and 60 males. Current planning provides for an additional 60 female beds and 90 male beds for a total of 250 beds that will be open to people from across the state. Additional Residential Recovery Courts are being considered in West Tennessee and Shelby County, subject to availability of funding.

CURRENT STRATEGIES: TENNESSEE DEPARTMENT OF CHILDREN'S SERVICES

The Tennessee Department of Children's Services seeks to preserve and re-unify families whenever possible when confronted with addiction. The Department of Children's Services addresses the prescription drug epidemic by providing treatment services to people in custody, coordinating treatment for babies born addicted to substance, and supporting and referring parents for treatment services.

Treatment Services for Youth and Young Adults in Custodial Care

All children in state custody regardless of age are assessed for medical and mental health needs, including drug use and addiction through regular and periodic screenings which include Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and the Child and Adolescent Needs Assessment (CANS). Appropriate in-patient, residential and/or outpatient services are provided through TennCare-funded service providers.

Treatment Coordination for Babies Born Addicted to Substances

When a baby is born addicted or has been exposed to drugs prior to birth and is brought into Department of Children's Services custody, services are coordinated with the local medical provider/hospital. In most cases, the child will be assessed and treatment provided through one of the five Centers of Excellence hospitals in Tennessee. Centers of Excellence hospitals provide consultation for children who are in Department of Children's Services custody who have complex medical, behavioral, psychological, and psychiatric problems.

Supports and Referrals for Parents in Custodial and Non-Custodial Cases and Children in Non-Custodial Cases

Department of Children's Services has a Crisis Management Team that assists parents of non-custodial children who have significant alcohol and drug problems with locating appropriate services to prevent the child from coming into custody due to the alcohol and/or drug addiction. In addition, when a child enters custody due to the parent/caregiver's drug addiction, case managers offer support and referral services to the parents/caregivers to assist them with finding appropriate inpatient or outpatient services. Case managers will work with parents/caregivers on issues such as child care and transportation to facilitate the parent's/caregiver's participation in treatment.

Looking Toward the Future

- Develop strategies and resources to assist Department of Children's Services caseworkers in making referrals for treatment for parents at risk of substance abuse in non-custodial and custodial cases and train Department of Children's Services caseworkers on effective practices to support recovery.

CURRENT STRATEGIES: TENNCARE

The Bureau of TennCare provides for the health and wellness needs of many Tennesseans, including substance abuse treatment services, when it is medically necessary. In addition to treatment services, TennCare addresses the prescription drug epidemic through formulary regulations as well as pharmacy lock-in programs.

Covered Treatment Services

TennCare contracts with three Managed Care Organizations to provide a comprehensive continuum of substance abuse services, including medication-assisted treatment. Covered services for TennCare beneficiaries include outpatient treatment and detoxification (including intensive outpatient), inpatient treatment and detoxification, and residential treatment and detoxification. Buprenorphine containing products may be approved for the treatment of prescription opioid addiction. Currently, two of the three Managed Care Organizations utilize the American Society of Addiction Medicine Patient Placement Criteria, while the other Managed Care Organization uses the Milliman Criteria to determine the necessary level of treatment services.

Formulary Regulations

The TennCare Formulary specifies particular medications that are approved to be prescribed for TennCare enrollees and has regulations in place to prevent doctor shopping and abusing prescriptions. The regulations include:

- ~ 5 prescription limit per month on prescription drugs and refills;
- ~ Policy for tamper-resistant prescriptions;
- ~ Coverage of buprenorphine containing products are subject to strict limitations regarding prior authorization and maximum daily dosages.

Pharmacy "Lock-In" Program

TennCare maintains a pharmacy "lock-in" program designed to address member abuse, overutilization, and quality-of-care concerns for TennCare enrollees. TennCare possess the authority to restrict or lock-in TennCare enrollees to a specified and limited number of pharmacy providers if it's determined that the enrollee has abused the TennCare Pharmacy Program. If a patient gets "locked-in" and attempts to fill a prescription from an unauthorized pharmacy, the patient will receive a reject notice. Specific patients may also be subject to prior authorization requirements for all controlled substances. There were 511 beneficiaries locked-in in 2012, and 185 were locked-in from January to May 2013.

TennCare's Pharmacy "Lock-In Program" is designed to address member abuse, over-utilization and quality of care concerns for TennCare enrollees. There were 511 beneficiaries locked-in in 2012.

Prescriber Identification

TennCare has developed a unique and innovative algorithm to help identify providers who are potentially prescribing opioids in a way that is very

inconsistent with their peers. Instead of simple volume-based analytics, the algorithm scores prescribers based on a composite index of many factors including short- versus long-acting opioids, pure opioids versus combination products, more likely to be abused versus less likely to be abused (i.e. C-II vs. C-III), and a number of targeted medications that are widely used by prescription drug abusers. Providers at the top of this list are manually evaluated by the pharmacy staff for appropriate prescribing habits. There are a number of interventions that may be employed depending on the result of the manual investigation ranging from targeted education to the complete blocking of prescriptions by the TennCare Drug Utilization Review Board and referral to the appropriate health-related board.

CURRENT STRATEGIES: LEGISLATION

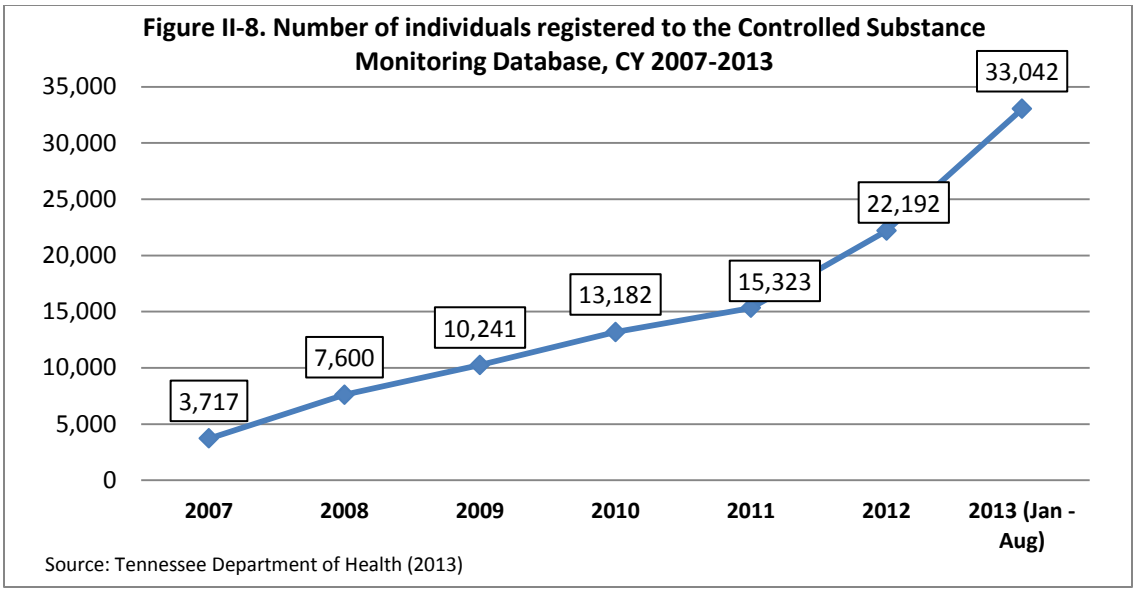
While state departments have made significant strides in addressing the prescription drug abuse problem, there have also been important legislative efforts that have been essential to proactively addressing the prescription drug epidemic.

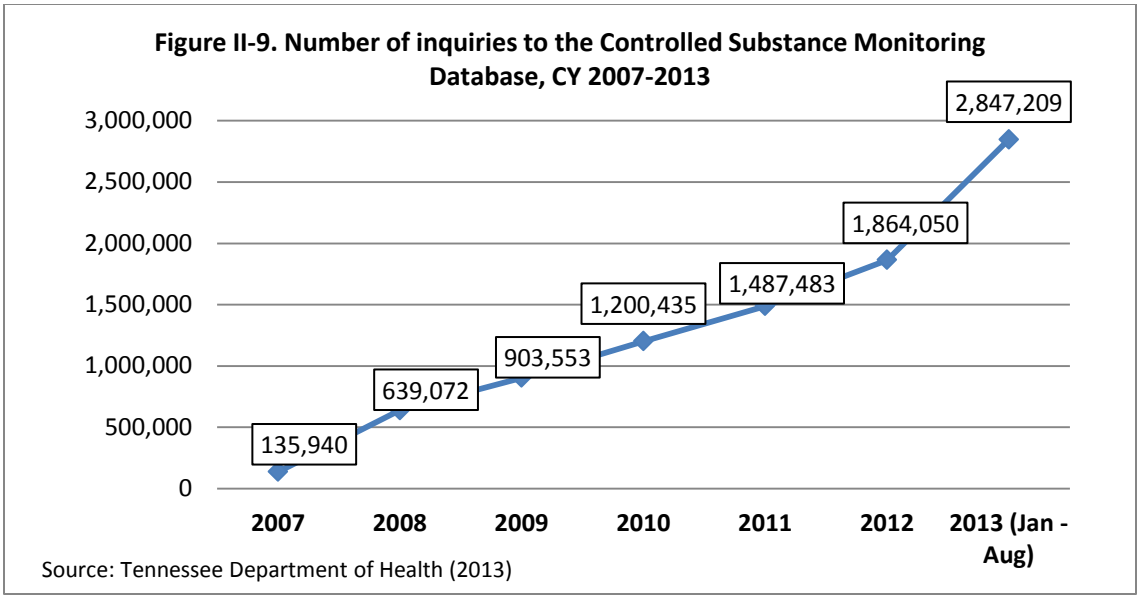
Tennessee Prescription Safety Act of 2012

In May 2012, Public Chapter 880 also known as the "Tennessee Prescription Safety Act of 2012" amended several requirements of the original legislation governing the Controlled Substance Monitoring Database[53]. The Tennessee Prescription Safety Act of 2012 had several key provisions that will assist in the effort to control Tennessee's prescription opioid epidemic.

- All prescribers and dispensers of controlled substances must register in the Controlled Substance Monitoring Database. Newly licensed prescribers and dispensers of controlled substances must register within 30 days of licensure. Any licensee working in Tennessee for 15 days per year must meet the registration requirement.
- All prescribers must check the Controlled Substance Monitoring Database prior to prescribing opioids or benzodiazepines for a patient at the beginning of a new episode of treatment and at least every 12 months during that episode of treatment.
- A practitioner may designate agents or healthcare practitioner extenders to access the database on their behalf. Healthcare practitioner extenders register for separate password access after designation and approval from their supervising practitioner.
- Also of importance is the ability to connect with other states and share patient records with other providers who are also treating the patient.
- As of January 1, 2013, dispensers are required to report to the Controlled Substance Monitoring Database every seven days all controlled substance prescriptions dispensed as well as the source of payment.
- The database capacity was increased in anticipation of more activity from practitioners.

The Prescription Safety Act of 2012 was a huge step forward in controlling access to prescription opioids. Figures II-8 and II-9 demonstrate that the provisions of the new law have resulted in a marked increase in the number of prescribers and dispensers registered in the database, as well as the number of times the database has been queried. Preliminary information shows that the requirements to regularly check the database have increased information about patients' use of controlled substances and is in turn changing prescriber behavior.





The ADDISON Sharp Act

The ADDISON (Abolish Drug Distribution Igniting Support Of New Beginnings) Sharp Act was passed in 2013. The Act is named after Addison Sharp, a resident of Knoxville, whose young life was tragically cut short in 2012 by an overdose of prescription medication[54]. After his death, his family worked with legislators, law enforcement, and medical professionals to attempt to decrease the number of lives being taken by this growing epidemic. The Act enhances and tightens the regulations on prescribers and pain management clinics already being addressed through the Action Steps of the Governor's Public Safety Forum. Provisions of the bill include:

- Direct the Commissioner of Health to develop guidelines for prescribing the most commonly abused prescription medications and provide this information to the various licensing boards who oversee prescribers;

- Require two hours of training for medical professionals every two years on these guidelines and other pertinent requirements such as medicine addiction and risk management;
- Limit the dispensing of opioids and benzodiazepines to 30 days (the prescription may still be issued for 90 days, but this will limit it to a 30-day supply at a time);
- Require reporting to the Controlled Substance Monitoring Database by all prescribers who dispense at their offices;
- Clarify the definition of manufacturer and wholesaler of drugs and require the reporting of the drug distribution;
- Strengthen the definition of pain management clinics by closing a loophole in the law that has allowed some operators to avoid registration;
- Require a patient of pain management clinics to have a current and valid government-issued identification or health insurance card for monitoring purposes;
- Limit the medical director at pain management clinics to four clinics total;
- Limit money order payments as a method to reimburse pain management clinics for services to put an end to cash business; and
- Enhance the fine for violations on unregistered clinics to (between $1,000 and $5,000 per day) to substantially impact those who choose to operate illegally.

Safe Harbor Act

Senate Bill 459/House Bill 277, also known as the Safe Harbor Act of 2013, is a significant piece of legislation that affects children and families. The Safe Harbor Act of 2013 establishes pregnant women as priority users of available treatment from publicly-funded drug addiction treatment providers. The bill also requires the Department of Mental Health and Substance Abuse Services to ensure that family-oriented drug abuse and drug dependence treatment is available, as appropriations allow. Additionally, the bill prohibits certain treatment centers from refusing treatment solely because a woman is pregnant. Furthermore, the bill requires attending obstetrical providers to encourage pregnant women, who are using prescription drugs in a way that may place the fetus in jeopardy, to seek drug addiction or drug dependence treatment and prohibits the Department of Children's Services from petitioning for the newborn's protection solely because of the mother's use of prescription drugs for non-medical purposes during the term of her pregnancy, if the mother initiates drug abuse or drug dependence treatment prior to her next regularly scheduled prenatal visit after her obstetrical provider has encouraged her to seek treatment (approximately the twentieth week of pregnancy) and the mother maintains compliance with both drug abuse or drug dependence treatment as well as prenatal care throughout the remaining term of her pregnancy. This legislation addresses the need for treatment services in this specific situation and should lead to Tennesseans regaining control of their lives, forging healthy relationships within their families, and securing addiction free futures.

Looking Toward the Future

- Improve the utility of the Controlled Substance Monitoring Database.
    - Significant progress has been made in enhancing the regulations for timely reporting in the Controlled Substance Monitoring Database. However, the functionality of the database can be greatly improved if the law is changed to require reporting occur at the time prescriptions are dispensed instead of waiting up to seven days as the

current law allows. Additionally, changes should be made to give hospital quality improvement committees limited access to the Controlled Substance Monitoring Database. However, access to the Controlled Substance Monitoring Database must be balanced with the Health Insurance Portability and Accountability Act and privacy concerns.

- Enact a Good Samaritan Law.
    - Good Samaritan Laws provide a degree of immunity from criminal charges or mitigation of sentencing for an individual seeking help for themselves or others experiencing an overdose. Good Samaritan Laws are designed to encourage people to help those in danger of an overdose. 17 other states have enacted a Good Samaritan Law and it is recommended that the legislature consider enacting this type law.

SECTION 3

A PLAN FOR THE FUTURE

A PLAN FOR THE FUTURE

This plan takes a proactive and comprehensive approach in tackling the prescription drug epidemic in Tennessee. This approach includes strategies that reach all segments of the population with the appropriate amount of intervention, whether that I through prevention, treatment, or recovery services. Most of the general public will be best served by prevention strategies that aim to reduce the risk of becoming addicted to prescription drugs. Some people who are at increased risk will benefit from early intervention efforts that include screening and brief interventions. People who need treatment will benefit from access to effective treatment options and recovery supports after they complete treatment. The recommendations included below address each of these important intervention phases.

Vision of this Plan

To reduce the misuse and abuse of prescription drugs so Tennesseans can live happy, healthy, and fulfilling lives of recovery.

Mission of this Plan

To partner with state and local entities to provide a continuum of services/strategies to educate, prevent, intervene early, and provide access to treatment and recovery supports for all Tennesseans.

Goals of this Plan

1) Decrease the number of Tennesseans that abuse controlled substances.
2) Decrease the number of Tennesseans who overdose on controlled substances.
3) Decrease the amount of controlled substances dispensed in Tennessee.
4) Increase access to drug disposal outlets in Tennessee.
5) Increase access and quality of early intervention, treatment and recovery services.
6) Expand collaborations and coordination among state agencies.
7) Expand collaboration and coordination with other states.

Goal 1: Decrease the number of Tennesseans that abuse controlled substances.

Measure of Success

By 2018:

- 20% decrease in people using prescription opioids.

Recommendation	Description
Support community coalitions as the vehicle through which communities will successfully prevent and reduce prescription drug diversion, abuse, and overdose deaths.	Only 37 of Tennessee's 95 counties currently have state-funded coalitions. These 37 coalitions are working diligently to tackle the prescription drug problem in their communities. However, in order to fully maximize the community coalition model, funding should be increased to expand the capacity of current coalitions and fund additional community coalitions.

Responsible for Implementation

Department of Mental Health and Substance Abuse Services

Regulatory or Legislative Action Required

Legislation Required	Regulation Required	Additional Funding Required
		✓

Recommendation	Description
Continue and expand the "Take Only As Directed" statewide prescription drug media campaign.	The Department of Mental Health and Substance Abuse Services has limited funding for the "Take Only As Directed" effort. This effort could have a greater impact if it was expanded. The initial media campaign was based in Middle and East Tennessee, but in recognition that the problem is spreading to West Tennessee, the campaign should be expanded to West Tennessee.

Responsible for Implementation

Department of Mental Health and Substance Abuse Services

Regulatory or Legislative Action Required

Legislation Required	Regulation Required	Additional Funding Required
		✓

Recommendation	Description
Support the Tennessee Congressional Delegation in promoting a policy that restricts direct-to-consumer marketing of prescription drugs on television, radio, and social media sites.	The U.S. Food and Drug Administration oversees the approval and marketing of prescription drugs, including direct-to-consumer advertising of prescription drugs. The United States is one of the few places in the world that allows direct-to-consumer advertising. The only other developed nation that allows direct-to-consumer advertising is New Zealand. No federal law has ever banned direct-to-consumer advertising. Until the 1980s, drug companies gave information about prescription drugs only to doctors and pharmacists. When these professionals thought it appropriate, they gave that information to their patients. However, during the 1980s, some drug companies started to give the general public more direct access to advertising material through direct-to-consumer advertisements. It is recommended that federal law be changed to restrict the direct-to-consumer marketing of prescription opioids.

Responsible for Implementation
Lead Agency: Tennessee Congressional Delegation

Regulatory or Legislative Action Required

Legislation Required	Regulation Required	Additional Funding Required
✓		

Recommendation	Description
Support the Coalition for Healthy and Safe Campus Communities.	The Coalition for Healthy and Safe Campus Communities, an organization that works with college campuses across the state on prevention efforts, has proven to be an effective mechanism for sharing information and changing behaviors on college campuses in Tennessee. It is recommended that the Coalition for Healthy and Safe Campus Communities be given funding to expand their prevention efforts around prescription drugs on college campuses.

Responsible for Implementation
Department of Mental Health and Substance Abuse Services

Regulatory or Legislative Action Required

Legislation Required	Regulation Required	Additional Funding Required
		✓

Goal 2: Decrease the number of Tennesseans who overdose on controlled substances.

Measure of Success

By 2018:

- Reduce by 20% the number of Tennesseans who die by prescription drug overdose.

Recommendation	Description
Improve the uniformity and reliability of drug overdose reporting by all county medical examiners.	The Department of Health is planning to improve the uniformity and reliability of drug overdose reporting by all county medical examiners by reviewing the current state laws for needed modifications for the 2015 General Assembly.
Responsible for Implementation Department of Health	**Regulatory or Legislative Action Required**

Legislation Required	Regulation Required	Additional Funding Required
✓		

Recommendation	Description
Implement new case management system for medical examiners.	The Department of Health has identified a potential statewide medical examiner's case management system and is working to estimate costs and details of a licensing agreement.
Responsible for Implementation Department of Health	**Regulatory or Legislative Action Required**

Legislation Required	Regulation Required	Additional Funding Required
		✓

Recommendation	Description
Enact a Good Samaritan Law.	Good Samaritan Laws provide a degree of immunity from criminal charges or mitigation of sentencing for an individual seeking help for themselves or others experiencing an overdose. Good Samaritan Laws are designed to encourage people to help those in danger of an overdose. 17 other states have enacted a Good Samaritan Law and it is recommended that the legislature consider enacting this type law.
Responsible for Implementation Tennessee General Assembly	**Regulatory or Legislative Action Required**

Legislation Required	Regulation Required	Additional Funding Required
✓		

Goal 3: Decrease the amount of controlled substances dispensed in Tennessee.

Measure of Success

By 2018:

- 15% decrease in amount of prescription dispensed in Tennessee.

Recommendation	Description
Complete the development of guidelines for prescribing opioids and encourage adoption.	Standard guidelines around prescribing opioids would assist prescribers in making informed choices when prescribing pain medications for patients. The planned guidelines will focus on: what to do before initiating chronic opioid therapy; when to initiate opioid therapy; referral to treatment for abusers; and follow-up of therapy. A rough draft of the guidelines is planned for completion by December 1, 2013.
Responsible for Implementation Lead Agency: Department of Health Supporting Agencies: Professional Licensing Boards including Medical Examiners, Nursing and Physician Assistants	**Regulatory or Legislative Action Required** None

Recommendation	Description
Licensing bodies should continue to review their own policies and procedures around unsafe opioid prescribing practices and enact new rules that allow better self-regulation of licensees including tougher and timelier consequences for physicians who overprescribe.	Through their licensing authority, professional bodies can continue to exercise initiative in stopping illicit access to prescription drugs, for example, by revoking licenses of physicians acting outside the limits of accepted medical practice or adopting regulations and policies that require increased disclosure and transparency standards. Licensing bodies should continue to review their own policies and procedures around unsafe opioid prescribing practices and enact new rules that allow better self- regulation of those that are licensed including tougher and timelier consequences for physicians who overprescribe.
Responsible for Implementation Professional Licensing Boards including Medical Examiners, Nursing, and Physician Assistants	**Regulatory or Legislative Action Required** Legislation Required: ✓ Regulation Required: ✓ Additional Funding Required: ✓

Recommendation	Description
Improve the utility of the Controlled Substance Monitoring Database.	Significant progress has been made in enhancing the regulations for timely reporting in the Controlled Substance Monitoring Database. There are still some desired changes that would further improve the utility of the Controlled Substance Monitoring Database and assist in curtailing the prescription drug problem including: • Continue to make technological improvements to enhance the ability to report data in more real-time and with easier user access. • Provide de-identified aggregate data obtained from the database for purposes of education and outreach both to healthcare practitioners and the public. However, access to the Controlled Substance Monitoring Database must be balanced with the Health Insurance Portability and Accountability Act and privacy concerns.
Responsible for Implementation Lead Agency: Department of Health Supporting Agencies: Departments of Mental Health and Substance Abuse Services, Safety and Homeland Security	**Regulatory or Legislative Action Required** Legislation Required: ✗ Regulation Required: ✓ Additional Funding Required: ✗

Recommendation	Description
Review and revise the Tennessee Intractable Pain Treatment Act and the Tennessee Code related to pain management clinics in order to address current opioid prescribing practices.[55]	The Tennessee Intractable Pain Treatment Act was enacted in 2001 to give patients with chronic pain a Bill of Rights which guarantee access to long-term opioids as a first-line treatment for chronic pain. The subsequent illegal misuse, abuse or diversion of opioids formulated for chronic pain was not anticipated when this act was codified. o The perceived under-prescribing of opioids by Tennessee physicians in 2001 has now been replaced by overprescribing. Unless the patient has a serious illness, opioids are no longer conventionally considered first-line treatment of chronic pain as guaranteed by the Tennessee_Pain Patient's Bill of Rights (TCA 63-6-1104). o With this in mind, it is recommended that the Tennessee Intractable Pain Treatment Act (Tenn. Code Ann. § 63-6-1101) and the Tennessee Code related to Pain management clinics (Tenn. Code Ann. § 63-1-301) be reviewed and legislative revision or repeal be considered as necessary to reduce the pressure on health care providers to prescribe opioids over other options for chronic pain management. Legislation should not discourage the use of opioids as first choice when indicated for treatment of acute severe pain or persistent pain due to active cancer or other advanced illnesses.
Responsible for Implementation Lead Agency: Department of Mental Health and Substance Abuse Services Supporting Agency: Department of Health	**Regulatory or Legislative Action Required**

Legislation Required	Regulation Required	Additional Funding Required
✓		

Recommendation	Description
Revise pain clinic rules to better address the prescription drug problem in Tennessee.	Pain clinic rules can be further enhanced to ensure they have language that discourages illegal practices and increased standards for medical directors with the goal of improving quality. When designing, the new rules, the National Alliance for Model State Drug Laws' overview on "State Regulations of Pain Clinics" should be referenced.
Responsible for Implementation Lead Agency: Department of Health Supporting Agencies: Departments of Mental Health and Substance Abuse Services, Safety and Homeland Security	**Regulatory or Legislative Action Required** Legislation Required: ✗ Regulation Required: ✓ Additional Funding Required: ✗

Recommendation	Description
Develop additional specific guidelines for prescribing narcotics for Acute Care Facilities (Urgent Care and Emergency Departments).	Acute Care Facilities are unique environments where the treatment of pain is frequently indicated without the benefit of an established patient/doctor relationship. It is also often conducted in an environment of limited resources including prescriber time and diagnostic information. Therefore, it is important to establish general guidelines that can help urgent care and emergency departments reduce inappropriate prescribing of opioid pain medication while preserving their vital role of treating patients with emergent medical conditions.
Responsible for Implementation Lead Agency: Department of Health Supporting Agencies: Professional Licensing Boards including Medical Examiners, Nursing and Physician Assistants	**Regulatory or Legislative Action Required** None.

Recommendation	Description
Design a smartphone application that will provide prescribers automatic updates on milligram/morphine equivalents and other technological enhancements.	It is important that prescribers have the most up-to-date information about the medications they are prescribing. Using the latest technology including smartphone applications will ensure that prescribers are using the latest information when making medication decisions.
Responsible for Implementation Department of Health	**Regulatory or Legislative Action Required**

Legislation Required	Regulation Required	Additional Funding Required
		✓

Goal 4: Increase access to drug disposal outlets in Tennessee.

Measure of Success

By 2018:

- Every county in Tennessee has easily accessible drug disposal options available.

Recommendation

Develop guidelines for the destruction of pharmaceuticals received from local Take-Back events and permanent prescription drug collection boxes.

Description

Currently, the Drug Enforcement Administration, local community coalitions, and law enforcement work together to ensure proper disposal of prescription drugs. However, one barrier to widespread participation in take-back efforts is clarity regarding how prescription drugs, once collected, may be disposed. It is recommended that clear guidelines for the collection and disposal of prescription drugs be outlined and disseminated statewide. Additionally, the Department of Environment and Conservation's policy on destroying pharmaceuticals received from Take-Back events and permanent prescription drug collection boxes should be revised to allow drugs collected to be destroyed in the same manner as confiscated contraband.

Responsible for Implementation

Lead Agency: Department of Environment and Conservation

Supporting Agencies: Drug Enforcement Administration, Department of Mental Health and Substance Abuse Services

Regulatory or Legislative Action Required

Legislation Required	Regulation Required	Additional Funding Required
	✓	

Recommendation

Establish additional permanent prescription drug collection boxes

Description

50 of Tennessee's 95 counties do not have a permanent prescription drug collection box.

- The short-term goal is to establish at least one permanent prescription drug collection box in the top 20 opioid prescribing counties by the end of 2014.
- A more long-range goal is to establish permanent prescription drug collection boxes in every county in Tennessee.

Responsible for Implementation

Lead Agency: Department of Mental Health and Substance Abuse Services

Supporting Agencies: Department of Environment and Conservation, local law enforcement

Regulatory or Legislative Action Required

Legislation Required	Regulation Required	Additional Funding Required
		✓

Recommendation	Description
Establish local incineration sites for the destruction of unused prescription medications.	One barrier to installing permanent prescription drop boxes has been the lack of a method for destroying prescription drugs once they are collected. The establishment of conveniently located incineration sites should increase the likelihood of local law enforcement being willing to place a permanent prescription drug collection box in their precinct.
Responsible for Implementation Lead Agency: Department of Mental Health and Substance Abuse Services Supporting Agency: Department of Environment and Conservation	**Regulatory or Legislative Action Required** Legislation Required: ✗ Regulation Required: ✓ Additional Funding Required: ✗

Recommendation	Description
Provide training on the new Drug Enforcement Administration's regulations.	The Drug Enforcement Administration is expected to release new regulations on prescription drug disposal. When these regulations are released, it will be important to train local law enforcement and pharmacies on the new rules.
Responsible for Implementation Lead Agency: Drug Enforcement Administration Supporting Agency: Department of Mental Health and Substance Abuse Services	**Regulatory or Legislative Action Required** None

Goal 5: Increase access to and quality of early intervention, treatment and recovery services.

Measure of Success

By 2018:

- 20% increase in the number of people receiving early intervention, treatment or recovery services in Tennessee.
- Increase the number of individuals who successfully complete treatment by 20%
- Increase the number of individuals that are employed after treatment by 30%
- Increase the number of people with stable housing after treatment by 20%

Recommendation	Description
Provide additional state funding for evidence-based treatment services for people with prescription opioid dependency who are indigent and unable to pay for services on their own.	The Substance Abuse Prevention and Treatment Block Grant funds treatment services for indigent people. The funding is not sufficient to address Tennessee's prescription drug epidemic. It is recommended that additional funding be allocated to fund treatment services for indigent people.

Responsible for Implementation

Department of Mental Health and Substance Abuse Services

Regulatory or Legislative Action Required

Legislation Required	Regulation Required	Additional Funding Required
		✓

Recommendation	Description
Expand Screening Brief Intervention Referral to Treatment (SBIRT) into Tennessee Department of Health primary care sites statewide.	SBIRT is a proven prevention and early intervention model. The Department of Health reaches a large percentage of Tennessee's population through the primary care clinics it operates throughout Tennessee. It is recommended that SBIRT be adopted as the standard of care in each of these clinics.

Responsible for Implementation

Lead Agency: Department of Health

Supporting Agency: Department of Mental Health and Substance Abuse Services

Regulatory or Legislative Action Required

None

Recommendation	Description
Expand the use of SBIRT in Tennessee.	The SBIRT model allows individuals to be identified in their health homes and receive an appropriate level of intervention targeted to their specific needs. The SBIRT service is billable through insurance. It is recommended that additional primary care sites begin using SBIRT as the standard of care.
Responsible for Implementation Department of Mental Health and Substance Abuse Services	**Regulatory or Legislative Action Required** None

Recommendation	Description
Provide additional specialized treatment options for mothers with opioid addiction whose babies have been born with Neonatal Abstinence Syndrome or who are at risk of losing their children.	Women with children need specialized treatment services tailored to meeting their needs as well as the needs of their children. These services include a full continuum of treatment services as well as other wraparound services to assist mothers in caring for their children. These services include safe drug-free housing and aftercare services to ensure recovery is maintained and support is offered when required. While some services are being offered to meet the needs of this specialized population, there is still considerable unmet need.
Responsible for Implementation Lead Agency: Department of Mental Health and Substance Abuse Services Supporting Agency: Department of Children's Services	**Regulatory or Legislative Action Required** Legislation Required: ✗ Regulation Required: ✗ Additional Funding Required: ✓

Recommendation	Description
Study efficacy and feasibility of Recovery Schools and Collegiate Recovery Communities.	Recovery Schools and Collegiate Recovery Communities support adolescents and young adults in pursuing their education while in a safe, supportive and recovery-oriented environment. Data shows that the 12-17-year-old and 18-25-year-old populations are most at risk for abusing prescription opioids in Tennessee. It is important that these populations have increased access to recovery support as they pursue their education in either high school or post-secondary school. Recovery schools and Collegiate Recovery Communities are designed specifically for students recovering from substance abuse or dependency where students can surround themselves with other individuals that are also on the recovery journey.
Responsible for Implementation	**Regulatory or Legislative Action Required**
Department of Mental Health and Substance Abuse Services	None

Recommendation	Description
Provide additional low budget/high impact services such as Oxford Houses, Lifeline, 12-Step Meetings, and Faith-Based initiatives.	Recovery services are essential to individuals who have completed treatment and are living a substance free lifestyle. Recovery services offer opportunities to interact with others who are on a similar recovery journey and experiencing the same struggles as they navigate a life free of substances. Many recovery services can be provided for little to no cost. However, some initiatives do require funding for startup or staff time to recruit additional sites in high need locations. The Tennessee General Assembly allocated one time funding in the amount of $550,000 in 2013 for the Lifeline program, an initiative to increase the number of recovery support services in Tennessee. It is recommended that this funding become recurring.
Responsible for Implementation	**Regulatory or Legislative Action Required**
Department of Mental Health and Substance Abuse Services	Legislation Required: ; Regulation Required: ; Additional Funding Required: ✓

Recommendation	Description
Develop additional Recovery Courts throughout the state.	Recovery courts are specialized courts or court calendars that incorporate intensive judicial supervision, treatment services, sanctions, and incentives to address the needs of people with substance abuse, veterans or people with mental health issues who are nonviolent offenders. In Tennessee, 44 Recovery Courts are currently funded. These courts should be further expanded to ensure that they are available to those that most need them. It is recommended that funding for additional courts be allocated.
Responsible for Implementation Department of Mental Health and Substance Abuse Services	**Regulatory or Legislative Action Required** Legislation Required: ✓ Regulation Required: ✓ Additional Funding Required: ✓

Recommendation	Description
Create up to three additional Residential Recovery Courts.	The Department of Mental Health and Substance Abuse Services is currently in discussions with the Department of Correction about expanding Residential Recovery Courts to additional people. The next Statewide Residential Recovery Court is under consideration for Middle Tennessee. Currently the Davidson County Residential Drug Court houses 40 females and 60 males. Current planning provides for an additional 60 female beds and 90 male beds for a total of 250 beds that will be open to people from across the state. Additional Residential Recovery Courts are being considered in West Tennessee and Shelby County, subject to availability of funding.
Responsible for Implementation Lead Agency: Department of Mental Health Services and Substance Abuse Services Supporting Agency: Department of Correction	**Regulatory or Legislative Action Required** Legislation Required: ✓ Regulation Required: ✓ Additional Funding Required: ✓

Recommendation	Description
Develop best practices for opioid detoxification of pregnant women.	Current guidelines from the American Congress of Obstetricians and Gynecologists do not recommend detoxification during pregnancy. However, many women in Tennessee have been safely detoxified during pregnancy without harm to them or their baby. A workgroup should be formed to explore the efficacy of opioid detoxification of pregnant women.
Responsible for Implementation	**Regulatory or Legislative Action Required**
Lead Agency: Department of Mental Health and Substance Abuse Services Supporting Agencies: Tennessee Medical Association, Tennessee Nurses Association, Tennessee Chapter of the American Academy of Pediatrics, Tennessee Chapter of the American Congress of Obstetricians and Gynecologists, Board of Medical Examiners, Board of Osteopathic Examination, Department of Health	None

Recommendation	Description
Provide specialized training to treatment providers on best practices for serving people with opioid addiction.	People with opioid addictions have unique needs. It is recommended that the treatment workforce be trained on how to best serve this population.
Responsible for Implementation	**Regulatory or Legislative Action Required**
Department of Mental Health and Substance Abuse Services	None

Recommendation	Description
Increase the availability of and refine training for time-limited substance abuse case management services.	Substance abuse case management is a unique time-limited service that helps individuals gain access to resources that will help them overcome obstacles around employment, housing, and education, become productive citizens, and live in recovery from their addiction. A training curriculum should be developed that focuses on the unique aspects of providing substance abuse case management and provided to all agencies that are contracted to provide substance abuse treatment services.
Responsible for Implementation Lead Agency: Department of Mental Health and Substance Abuse Services	**Regulatory or Legislative Action Required** Legislation Required: Regulation Required: Additional Funding Required: ✓

Goal 6: Expand collaborations and coordination among state agencies.
Measure of Success
By 2018:

- Increase by 20% the number of cross-departmental initiatives implemented.

Recommendation	Description
Continue the Strategic Prevention Enhancement Policy Consortium.	The Strategic Prevention Enhancement Policy Consortium has successfully developed a five-year plan and has made great strides in interdepartmental efforts. This work should be continued and expanded in order to best reach all Tennesseans.
Responsible for Implementation	**Regulatory or Legislative Action Required**
Lead Agency: Department of Mental Health and Substance Abuse Services Supporting Agencies: Departments of Children's Services, Education, and Health and Bureau of Alcoholic Beverage Commission	None

Recommendation	Description
Continue the Substance Abuse Data Taskforce.	Several departments are working collaboratively to increase and improve data sharing for prescription drug abuse. It is important that this task force continue to meet to provide increased understanding of the extent of the prescription drug problem, to identify patterns of misuse and abuse of the drugs involved, and better target limited resources.
Responsible for Implementation	**Regulatory or Legislative Action Required**
Lead Agency: Department of Mental Health and Substance Abuse Services Supporting Agencies: Departments of Children's Services, Correction, Finance and Administration, Health, Safety and Homeland Security, and Transportation, Administrative Office of the Courts, Bureau of TennCare, Tennessee Bureau of Investigation, Tennessee Methamphetamine and Pharmaceutical Task Force, Tennessee Board of Pharmacy, and Tennessee Board of Parole.	None

Recommendation	Description
Develop strategies and resources to assist Department of Children's Services caseworkers in making referrals for treatment for parents at risk of substance abuse in non-custodial and custodial cases and train Department of Children's Services caseworkers on effective practices to support recovery.	More than 2,000 children were taken into Department of Children's Services custody in 2012 as a result of parental substance abuse. Caseworkers in Department of Children's Services are often the front line individuals dealing with families. It is important that these caseworkers receive updated information about treatment services that are available in their region as well as training about addiction and recovery. This knowledge will help them design appropriate resources and services that could best benefit the family. It is recommended that Department of Children's Services caseworkers receive training annually about addiction and recovery. The Department of Mental Health and Substance Abuse Services would design and implement the training. It is also recommended that referral information be made readily available to Department of Children's Services.
Responsible for Implementation	**Regulatory or Legislative Action Required**
Lead Agency: Department of Children's Services Supporting Agency: Department of Mental Health and Substance Abuse Services	None

Goal 7: Expand collaboration and coordination with other states.

Measure of Success

By 2018:

- 5 memorandums of understanding with other states developed.

Recommendation

Develop memorandums of understanding between other states that guide information sharing practices for information gained through Prescription Drug Monitoring Programs.

Description

It is important to be aware of prescriptions that patients receive in our state, but also across state lines. At this point, information sharing is very difficult and could be improved by developing formalized mechanisms to share information.

Responsible for Implementation

Department of Health

Regulatory or Legislative Action Required

Legislation Required	Regulation Required	Additional Funding Required
✓		

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NATIONAL DRUG CONTROL STRATEGY

2014

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To the Congress of the United States

I am pleased to transmit the 2014 *National Drug Control Strategy*, a 21st century approach to drug policy that is built on decades of research demonstrating that addiction is a disease of the brain—one that can be prevented, treated, and from which people can recover. The pages that follow lay out an evidence-based plan for real drug policy reform, spanning the spectrum of effective prevention, early intervention, treatment, recovery support, criminal justice, law enforcement, and international cooperation.

Illicit drug use and its consequences challenge our shared dream of building for our children a country that is healthier, safer, and more prosperous. Illicit drug use is associated with addiction, disease, and lower academic performance among our young people. It contributes to crime, injury, and serious dangers on the Nation's roadways. And drug use and its consequences jeopardize the progress we have made in strengthening our economy—contributing to unemployment, impeding re-employment, and costing our economy billions of dollars in lost productivity.

These facts, combined with the latest research about addiction as a disease of the brain, helped shape the approach laid out in my Administration's first *National Drug Control Strategy*—and they continue to guide our efforts to reform drug policy in a way that is more efficient, effective, and equitable. Through the Affordable Care Act, millions of Americans will be able to obtain health insurance, including coverage for substance use disorder treatment services. We have worked to reform our criminal justice system, addressing unfair sentencing disparities, providing alternatives to incarceration for nonviolent substance-involved offenders, and improving prevention and re-entry programs to protect public safety and improve outcomes for people returning to communities from prisons and jails. And we have built stronger partnerships with our international allies, working with them in a global effort against drug trafficking and transnational organized crime, while also assisting them in their efforts to address substance use disorders and related public health problems.

This progress gives us good reason to move forward with confidence. However, we cannot effectively build on this progress without collaboration across all sectors of our society. I look forward to joining with community coalitions, faith-based groups, tribal communities, health care providers, law enforcement agencies, state and local governments, and our international partners to continue this important work in 2014. And I thank the Congress for its continued support of our efforts to build a healthier, safer, and more prosperous country.

President Barack Obama
The White House

Preface from Acting Director Botticelli

Like previous editions of the *National Drug Control Strategy,* the plan put forth here is the result not just of a comprehensive and far-reaching consultation process but also of countless meetings over the past year with Federal, state, local, and tribal officials, nongovernmental organizations, Members of Congress, international partners, and private citizens. In this regard, the *Strategy* continues to follow through on the President's original commitment to develop a drug policy that is as open and inclusive as possible. This approach has also led to some of the most innovative and reform-oriented elements of the *National Drug Control Strategy.*

For example, last year's *Strategy* included numerous new elements that reflected our interaction with a wide range of stakeholders. Increased dialogue with leaders in Puerto Rico led to a wider recognition of the Commonwealth's challenges related to drug use, trafficking, and the consequences for public health and public safety. As a result, the *Strategy* included an enhanced focus on issues affecting the island, which guided our efforts throughout 2013. Likewise, the Administration's work to prevent and address prescription drug abuse led to a greater emphasis in the 2013 *Strategy* on two critical issues: evidence-based overdose prevention/intervention and maternal addiction/neonatal abstinence syndrome.

These new components are carried through to the 2014 *Strategy*, and we have also made a number of new enhancements based on our work throughout 2013. For example, in July, Administration officials traveled to Montana and North Dakota to meet with Federal, state, local, and tribal officials and discuss some of the increasing public health and safety challenges faced in the booming towns of the oil-producing Bakken Region. As a result, the 2014 *Strategy* includes a new action item focusing on providing support to areas with emerging drug-related problems but limited law enforcement resources. In addition, we have added two new action items addressing the threat of new synthetic drugs, such as "K-2," "Spice," and "bath salts," which have been emerging in communities across the country. And to reflect the efforts of the Administration to employ new law enforcement tools and authorities in cooperation with our international partners, we have added an action item focusing on the implementation of the President's *Strategy to Combat Transnational Organized Crime.*

While we continue to pursue the goals for 2015 set by the President's inaugural *National Drug Control Strategy,* this process of consultation and enhancement will serve to significantly strengthen our efforts. I look forward to working with the Congress and the American people throughout 2014 to implement the *Strategy* and continue this dynamic, reform-oriented approach to drug policy.

Michael P. Botticelli
Acting Director of National Drug Control Policy

Introduction

Throughout 2013, the Administration continued to play a leading role in advancing drug policy reform, beginning with the release of the 2013 *National Drug Control Strategy,* which called for an approach rooted in scientific research on addiction, evidence-based prevention programs, increased access to treatment, a historic emphasis on recovery, and criminal justice reform. In May, the Office of National Drug Control Policy (ONDCP) hosted actor Matthew Perry at the White House to discuss alternatives to incarceration and criminal justice reform. Mr. Perry currently serves as a celebrity ambassador for drug courts, which divert approximately 120,000 nonviolent substance-involved offenders each year to treatment instead of prison. There is a large base of research supporting the effectiveness of drug courts, and Mr. Perry has been instrumental in getting the word out about this important criminal justice and public health program. In June, ONDCP participated in a White House event focusing on 12 "Champions of Change" who have dedicated themselves to helping children of incarcerated parents and their caregivers. This event was linked to the work of the Federal Interagency Reentry Council, which is committed to identifying and eliminating legal obstacles faced by people reentering society after incarceration.

In August, Attorney General Eric Holder announced new changes to the Department of Justice's (DOJ) charging policies regarding mandatory minimum sentences for certain nonviolent, low-level drug offenses. The policy changes are part of DOJ's "Smart on Crime" initiative, a comprehensive review of the criminal justice system aimed at ensuring Federal laws are enforced more fairly, Federal resources are used more efficiently, and focus is placed on top law enforcement priorities. These changes ensure that the most severe mandatory minimum penalties are reserved for serious, high-level, or violent drug traffickers. And, where appropriate, Federal law enforcement encourages alternatives to incarceration such as drug courts, specialty courts, or other diversion programs for non-violent offenses. Also in August, the Administration observed International Overdose Awareness Day with the release of the Department of Health and Human Services (HHS) Opioid Overdose Toolkit. The Toolkit provides information on overdose prevention, treatment, and recovery for first responders, prescribers, and patients. It also promotes the use of naloxone, a life-saving overdose reversal prescription drug that should be in the patrol cars of every law enforcement professional across the Nation for use as appropriate.

In November, another critical component of drug policy reform was introduced when the Administration issued the final rule implementing the Mental Health Parity and Addiction Equity Act of 2008. The rule makes it easier for Americans to get the care they need by prohibiting certain discriminatory practices that limit insurance coverage for behavioral health treatment and services. The "parity rule" ends discrimination against those who suffer from substance use and mental health disorders, significantly expands access to treatment services, and improves the ability of health care providers to identify symptoms and provide treatment before a chronic condition develops. The Affordable Care Act now requires Qualified Health Plans offered through the Health Insurance Marketplaces in every state to include coverage for mental health and substance use disorders as one of the 10 categories of Essential Health Benefits, and the coverage must comply with these Federal parity requirements.

The Administration capped this important year with the first-ever Drug Policy Reform Conference at the White House in December. The conference gathered more than 100 leaders from the prevention, treatment, early intervention, and criminal justice reform communities to discuss innovative, evidence-based approaches to reducing drug use and its consequences. The conference included addresses from senior Administration officials and panel discussions focusing on public health approaches to drug policy, the transition from "tough on crime" to "smart on crime" policies, and efforts to lift the stigma faced by those struggling with substance use disorders and those who are in recovery.

The Importance of Language: Reducing the Stigma Surrounding Substance Use Disorders

Substance use disorders are medical conditions, and reducing the stigma surrounding these medical conditions is a particularly important component of drug policy reform—one in which every American can play a part. As we have worked to help guide the millions of Americans who suffer from substance use disorders into recovery and support the millions more who are already in long-term recovery, we have learned that how we describe or refer to substance use disorders can have an important effect on outcomes. Research demonstrates that the use of stigmatizing words like "addict" can discourage individuals from seeking help.[1] Additionally, using such terms reinforces the idea that someone with a substance use disorder is exhibiting a willful choice rather than suffering from a recognized medical condition.[2] Researchers also note that identifying an individual with a substance use disorder as a "substance abuser" evokes less sympathy than if the individual is described as having a disease.[3] Avoiding these terms—and thereby reducing the stigma faced by those with substance use disorders—can play an important role in encouraging these individuals to seek help at an earlier stage in the disease.

While we have made significant progress in advancing evidence-based drug policy reform, serious challenges still remain. Among those challenges are the declining perceptions of harm—and associated increases in use—of marijuana among young people. These challenges have gained prominence with the passage of state ballot initiatives in 2012 legalizing marijuana in the states of Colorado and Washington. In August DOJ released guidance reiterating that marijuana remains illegal under Federal law and that Federal law enforcement activities in these two states would continue to be guided by eight priorities focused on protecting public health and safety. ONDCP is working with DOJ and other Federal partners to monitor the implementation of these state laws and the public health and safety consequences related to these eight priorities. ONDCP is also working with its Federal partners and stakeholders throughout the country to address other remaining challenges like the problem of opioid use disorders—including both prescription opioids and heroin—and the dynamic problem of new synthetic drugs.

Responding to the Opioid Abuse Epidemic: Heroin and Prescription Drugs

In 2010, opioid pain relievers like oxycodone, hydrocodone, and methadone were involved in more than 16,600 overdose deaths—approximately 45 Americans every day.[i] This startling figure is approximately 4 times greater than the number of deaths just a decade earlier in 2000.[ii] And with reports of increasing heroin use in many American communities, the potential transition from prescription opioid abuse to heroin and injection drug use has become an increasing concern.

Although rates of heroin use remain low compared to rates of use for other drugs, there has been a troubling increase in the number of people using heroin—from 373,000 past year users in 2007 to 669,000 in 2012. A recent report from the Substance Abuse and Mental Health Services Administration (SAMHSA) found that four out of five recent heroin initiates (79.5 percent) had previously used prescription pain relievers non-medically.

These findings underscore the need for a comprehensive approach to address opioid abuse, focusing on both heroin and prescription drug abuse. The Administration is working to increase the use of FDA-approved medications to treat opioid use disorders, to include providing treatment within the criminal justice system. ONDCP is working with the Office of National AIDS Policy, Federal partners, and state and local governments to develop a collaborative approach to address substance use disorders as well as the public health consequences resulting from increased use of syringes. The Administration has increased its focus on overdose prevention and intervention, to include

- educating the public about overdose risks and interventions (such as through the HHS Opioid Overdose Prevention Toolkit);
- increasing access to naloxone, an emergency overdose reversal medication; and
- working with states to promote Good Samaritan laws and other measures that can help save lives.

The Administration is also working with law enforcement partners across the country and around the world to disrupt and dismantle criminal organizations involved in the trafficking of heroin. Mexico remains the primary source of heroin to U.S. markets, and U.S. and Mexican agencies continue to build on their strong law enforcement partnership to target transnational criminal organizations involved in heroin trafficking.

Through all of these efforts, the Administration is working to improve data collection on heroin use, production, trafficking, and street-level sales. This effort to improve our understanding of the heroin problem and its relationship with prescription drug abuse was significantly advanced during the "Summit on Heroin and Prescription Drugs," hosted by ONDCP at the White House in June 2014. During the Summit, public health specialists, law enforcement professionals, drug policy experts, community organizations, and Federal, state, and local government officials gathered to discuss the epidemic of opioid abuse in the United States. The discussions at the Summit will inform the Administration's continuing efforts to address this urgent public health and safety issue throughout 2014.

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i Jones, C.M., Mack, K.A., & Paulozzi, L.J. (2013). Pharmaceutical overdose deaths, United States, 2010. Journal of the American Medical Association, 309(7), 657-9.

ii Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 2000-2010 on CDC WONDER Online Database. Extracted February 2013.

The *Strategy* that follows addresses these challenges and others through a modern, evidence-based approach encompassing prevention, early intervention, treatment, recovery support, criminal justice reform, effective law enforcement, and international cooperation. The overall framework, goals, and agency responsibilities established in the President's first *Strategy* remain in effect, even as we remain ready to adapt our approach based on new developments and emerging trends. With a significant record of accomplishment, an ongoing agenda for reform, and strong partnerships throughout the Government, across the country, and around the world, we will continue our progress toward the President's goals for 2015.

National Drug Control Strategy **Goals to Be Attained by 2015**

Goal 1: Curtail illicit drug consumption in America

- 1a. Decrease the 30-day prevalence of drug use among 12- to 17-year-olds by 15 percent
- 1b. Decrease the lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15 percent
- 1c. Decrease the 30-day prevalence of drug use among young adults aged 18–25 by 10 percent
- 1d. Reduce the number of chronic drug users by 15 percent

Goal 2: Improve the public health and public safety of the American people by reducing the consequences of drug abuse

- 2a. Reduce drug-induced deaths by 15 percent
- 2b. Reduce drug-related morbidity by 15 percent
- 2c. Reduce the prevalence of drugged driving by 10 percent

Data Sources: SAMHSA's National Survey on Drug Use and Health (NSDUH) (1a, 1c); Monitoring the Future (1b); What Americans Spend on Illegal Drugs (1d); Centers for Disease Control and Prevention (CDC) National Vital Statistics System (2a); Substance Abuse and Mental Health Services Administration's (SAMHSA) Drug Abuse Warning Network (DAWN) drug-related emergency room visits, and CDC data on HIV infections attributable to drug use (2b); NSDUH and National Highway Traffic Safety Administration (NHTSA) roadside survey (2c)

Advocate for Action: Edward H. Jurith

This year, we remember and celebrate the contributions of our colleague Edward Jurith, who passed away in 2013. During his distinguished career at ONDCP, Ed was appointed twice to serve as Acting Director—first by President Clinton in 2001, then by President Obama in 2009. Since 1994, he also served as ONDCP's General Counsel, Senior Counsel, and Associate Director for Legislative Affairs. Ed also served as the United States Representative and Working Committee Chair for the Education Committee for the World Anti-Doping Agency, an international independent agency composed of sport and government leaders that focuses on promoting science and research-based guidance to establish a doping-free sporting environment. Ed's reputation as a leader in drug policy crossed international borders. In 1997, he served as an Atlantic Fellow in Public Policy at the University of Manchester in the United Kingdom, where he researched and lectured on drug policy issues. As part of the Atlantic Fellowship, Ed assisted the UK Anti-Drugs Coordinator in developing the Blair Government's strategy for reducing substance use. He lectured widely on drug policy at U.S. and British universities and authored numerous publications on substance use disorders and drug policy. Outside of his official duties, Ed also served on the Advisory Committee of the American Bar Association Standing Committee on Substance Abuse, as well as the District of Columbia Bar Lawyer Assistance Program, a program providing assistance to law students, lawyers, and judges with substance use and/or mental health disorders. Ed will be remembered fondly by the many colleagues and friends whose lives he touched during his exemplary public service career.

Chapter 1. Strengthen Efforts to Prevent Drug Use in Our Communities

One of the Administration's primary drug policy goals is preventing drug use before it begins. The consequences of drug use affect every sector of society and hamper the ability of both young people and adults to reach their full potential. Prevention is a cost-effective and common-sense way to avoid the consequences of drug use among youth.[4]

Substance use prevention efforts can be effective when approaches are comprehensive,[5] address risk and protective factors,[6] and focus on a community's unique challenges.[7] It is also important that prevention efforts focus on parental awareness and involvement,[8] strengthen social norms against drug use,[9,10] and limit access to illicit substances.[11] Research has shown that every dollar invested in school-based substance use prevention programs has the potential to save up to $18 in costs related to substance use disorders.[12]

This research into the effectiveness of prevention has become even more relevant in light of recent trends in youth drug use. Long term data from the Monitoring the Future study—which surveys 8th, 10th, and 12th graders on their behaviors and attitudes—demonstrate that when the perceptions of harm related to drug use decrease, rates of drug use are more likely to subsequently increase.[13] Over the past 5 years, perception of harm regarding marijuana use among 12th graders has decreased,[14] signaling potential continued increases in marijuana use.

Improving youth educational achievement is vital to America's success in the global economy of the 21st century, but substance use can serve as a major obstacle to such achievement. Youth who use drugs are often at risk for poor academic performance, truancy, delinquency, and other problems. Studies have shown that among youth who earn mostly Ds and Fs in school, 66 percent had used marijuana, a higher percentage than other risk behaviors studied.[15] Heavy cannabis use during the teen years has also been found to result in an average 8 point drop in IQ between childhood and adulthood; by comparison, those who never used marijuana showed no decline in IQ.[16]

Despite these challenges, it is possible to make a positive impact on youth, their families, and communities. A range of Federal efforts have helped make certain that communities, schools, parents, and health professionals have the information they need to implement evidence-based prevention programs and policies. For example, the U.S. Department of Agriculture (USDA) 4-H program has established a peer mentoring program, and the Department of Education is providing professional development and technical assistance through the 21st Century Community Learning Centers program, which enables communities to establish or expand centers that provide additional student learning opportunities, such as before- and after-school programs and summer school programs, and provide related services to students' families. ONDCP's Drug-Free Communities (DFC) Support Program provides funding to over 600 community coalitions organized to prevent youth substance use.

Strengthening efforts to prevent drug use in our communities requires a strategic plan to carry out comprehensive policies, programs, and practices. Partnerships have been developed with Federal, state,

and local agencies, school health officials, criminal justice agencies, and community-based organizations that are interested in changing the landscape regarding drug use among youth. Federal agencies, tribal nations, states, and local coalitions have worked together to ensure the latest and most accurate information is available for communities to execute their own plans of action. This *Strategy* continues to be a blueprint to inform this process, and progress made throughout 2013 is detailed below.

1. A National Prevention System Must be Grounded at the Community Level

A. Collaborate with States to Support Communities

The President's Proclamation for National Substance Abuse Prevention Month, issued in October 2013, called upon all Americans to promote comprehensive substance abuse prevention efforts within their communities. The Administration works with states and communities to promote the critical role of prevention partnerships. Through support from the Substance Abuse and Mental Health Services Administration (SAMHSA), states utilize the Substance Abuse Prevention and Treatment Block Grant Prevention Set-Aside to implement substance abuse prevention activities in communities across the Nation. In 2013, a total of 49 technical assistance visits in 27 states were completed. Under the Partnership for Success II program, 15 new grants were awarded to states to address priority areas, including underage drinking and prescription drug abuse among high-risk populations. SAMHSA's Center for Substance Abuse Prevention (CSAP) provided support to states through the State Epidemiological Outcomes Workgroups, which are funded at $150,000 per year for states and a range of $75,000 to $100,000 for jurisdictions and tribal entities. These grants help communities develop secure data collection systems to expand prevention capacity, adopt data-driven strategies, and promote evidence-based and outcome-based approaches. The Guide to Community Preventive Services serves as a comprehensive resource to support communities in implementing evidence-based prevention strategies targeting such substance use issues as underage alcohol and tobacco use.

The Administration has worked with national organizations such as the America's Promise Alliance and state-affiliated professional membership groups to advance the message that we must make substance abuse prevention a priority.[17] These groups have helped promote youth prevention messaging through their Federal, state, and local affiliations. The National Education Association Representative Assembly passed a resolution to disseminate prescription drug abuse information among its membership and developed resource materials for educators to reach their youth in schools.

Comprehensive Prevention Efforts in Yukon, Oklahoma

The community of Yukon, Oklahoma is taking a comprehensive and collaborative approach to substance abuse prevention, and survey results show that the approach has been effective.[18] Working out of the Red Rock Behavioral Health Services Agency, and funded by the Oklahoma Department of Mental Health and Substance Abuse Services, the Region Prevention Coordinator has been an active member of the Yu-Can coalition for over 5 years. This is the first coalition in this community that has brought together a broad group of youth-led stakeholders. Its priorities include: implementation of Project Alert, an evidence-based substance abuse prevention curriculum; alcohol compliance checks to reduce alcohol sales to minors; alcohol restrictions at community events; and AlcoholEdu (an Internet-based education tool provided to every high school). To help build capacity for the community and to ensure sustainability, the Yu-Can Coalition receives support from the Oklahoma State Office of Substance Abuse Services, the Yukon Public Schools, a DFC grant, and the area Office of the School Superintendent. The Coalition works with local law enforcement, alcohol retailers, businesses, parents, school groups, and other stakeholders to create sustainable and effective community partnerships.

B. Spread Prevention to the Workplace

The workplace is a prime location to educate employees about making informed decisions about the health and well-being of themselves and their families. The Division of Workplace Programs at SAMHSA disseminates information on building safer, healthier, and more productive workplaces through health risk assessments, brief screenings, early identification, and referral to treatment services. The Division of Workplace Programs also has oversight for drug testing of 400,000 Federal employees in security and safety sensitive positions, including employees regulated by the Nuclear Regulatory Commission. SAMHSA and the U.S. Food and Drug Administration's (FDA) Office of Women's Health launched National Wellness Week in September 2013 to focus on the eight dimensions of wellness and their integration into a person's home and work life. SAMHSA also manages the Preventing Prescription Drug Abuse in the Workplace program to provide technical assistance to Federal and state partners. The Department of Transportation (DOT) regulates a strong industry-based drug and alcohol testing program that conducted approximately 6.1 million drug screenings in 2013. The testing program protects public health and safety by ensuring that safety-sensitive transportation employees in the aviation, trucking, railroad, mass transit, pipeline, and other transportation industries are screened for substance abuse issues and receive help if needed.

2. Prevention Efforts Must Encompass the Range of Settings in Which Young People Grow Up

A. Strengthen the Drug-Free Communities Support Program

Coalitions across the country mobilize to address the drug trends unique to their communities. Through the DFC Support Program, community-based coalitions have mobilized more than 9,000 community volunteers across the country. DFC-funded coalitions are required to work with various sectors of

a community to identify local drug problems and implement comprehensive strategies to create community-level change. According to the DFC Support Program's national cross-site evaluation, communities with DFC-funded coalitions have experienced consistently lower rates of past 30-day teen substance use as compared to communities without DFC-funded coalitions. For FY 2013, ONDCP announced $19.8 million in new DFC grants to 147 communities and 19 new DFC mentoring grants across the country. The awards are in addition to the existing $59.4 million in DFC continuation grants simultaneously released to 473 currently funded DFC coalitions and 4 DFC mentoring coalitions. The DFC Support Program collaborates with SAMHSA/CSAP to provide grants of up to $625,000 over 5 years to coalitions, with technical assistance provided through the Community Anti-Drug Coalitions of America (CADCA). CADCA's National Coalition Institute also provides technical assistance to states for coalition development, reaching 1,153 participants.

B. Leverage and Evolve the Above the Influence Brand to Support Teen Prevention Efforts

The Above the Influence (ATI) campaign is dedicated to demonstrating the power of young people living "above the influence" of drugs and alcohol. The second annual National ATI Day was held on October 17, 2013 as part of National Substance Abuse Prevention Month. On that day, teens and community organizations across the country participated in various youth-focused events and activities. Campaign partners and young people in four featured markets—California, New York, Florida, and Washington, D.C.—were visited by the ATI team for a special "cross-country" event. Through social media, the teens interacted with participants at the other event sites. Nearly 1,000 teens participated directly in local ATI Day events. Social networks (Facebook, Tumblr, Twitter, and Instagram) further extended participation across the country. Thousands of teen-generated messages on these networks reached an audience exceeding 700,000.

ATI has achieved a greater than 80 percent awareness level among teens. The campaign continues to have a strong presence in the Facebook community, surpassing 1.8 million "likes" and making it one of the largest national teen-targeted Facebook presences among Federal Government or nonprofit youth organizations. Additionally, three independent peer-reviewed studies have confirmed that ATI is effective, relevant to youth, and instrumental to drug prevention efforts in communities across the country.[19,20,21] ONDCP is transitioning the ATI brand to The Partnership for Drug-Free Kids to help ensure its continuation.

C. Support Mentoring Initiatives, Especially Among At-Risk Youth

Mentoring young people who are at risk helps reduce drug use among this vulnerable group. Young people who participate in structured activities and identify with mentors who are a consistent presence in their lives have better outcomes for success. The National Guard Youth ChalleNGe Program is a community-based program that leads, trains, and mentors at-risk youth so that they may become productive citizens. Currently, there are 33 ChalleNGe programs in 27 states and the Commonwealth of Puerto Rico. The Department of Justice advances tribal mentoring initiatives by providing grants to federally recognized tribes to develop and implement culturally sensitive programs in the five following categories: prevention services to impact risk factors for delinquency, interventions for court-involved

youth, improvements to the juvenile justice system, alcohol and substance abuse prevention programs, and mental health program services.

The USDA 4-H program prepares young people to be leaders in their communities and take an active role in improving the lives of fellow young people. ONDCP partnered with USDA 4-H to host a webinar that provided 60 USDA staff members tools to implement ATI activities and to encourage their youth partners to participate in the campaign.

The Department of Education's You for Youth (Y4Y) portal provides online professional development and technical assistance resources, such as substance abuse prevention strategies, for professionals working with students through the 21st Century Community Learning Centers program.

Advocate for Action: Judge Arthur L. Burnett, Sr.

Retired Judge Arthur L. Burnett, Sr. is being honored as an Advocate for Action for his role in founding the National African American Drug Policy Coalition (NAADPC) program for youth drug prevention. Judge Burnett designed and implemented a program through which African American professionals visit schools and talk to young people about the harmful effects of drug use on individual health and academic success. Under his leadership, the NAADPC works 7 days a week to prevent youth drug and alcohol use across the country. NAADPC provides tutors, counselors, and mentors from a coalition of African American professionals numbering over one million. Judge Burnett personally appears in schools across the country to provide inspirational talks about avoiding youth alcohol and drug use. His talks emphasize the value of good citizenship and the potential for individuals from humble backgrounds to be a part of the American dream. In the course of his work, Judge Burnett also provides expert advice on drug and juvenile delinquency judicial issues to Members of Congress.

D. Mobilize Parents To Educate Youth to Reject Drug Use

Parents need to be equipped with information and skills to communicate effectively with their youth. National Substance Abuse Prevention Month, declared by the President in October 2013, included activities with a focus on parents. Parent resource materials are available to ensure that parents receive the support and tools they need to engage their youth. ONDCP works with the National Institute on Drug Abuse (NIDA) to get parents to participate in their research-based prevention tools—including the Family Check-Up, which focuses on parenting skills and interactive scenarios. NIDA's updated web page for parents and educators provides resources for caregivers and teachers. In 2013 CADCA hosted online chats and provided state-level trainings to 385 attendees in 7 states. SAMHSA released its *Talk. They Hear You.* campaign especially for parents of youth aged 9-15 to provide messages for parent-youth conversations. In 2013, the campaign's public service announcements (PSAs) were seen 809 million times via earned media through national television networks, PSA placements, and other placements, including malls and airports.

3. Develop and Disseminate Information on Youth Drug, Alcohol, and Tobacco Use

A. Support Substance Abuse Prevention on College Campuses

The Department of Education supports the National Center on Safe Supportive Learning Environments (NCSSLE), which provides technical assistance, training, and resources on substance abuse prevention to institutions of higher education to benefit college and university students. SAMHSA has launched technology-based products to prevent high risk drinking among college students. The Federal Government, through its Interagency Coordinating Council on Preventing Underage Drinking, collaborates with colleges and universities and provides training and technical assistance. Comprehensive resources developed with input from 15 Federal agencies are maintained on a web portal that includes materials to support prevention efforts.

B. Expand Research on Understudied Substances and other Drug-related Issues

The ONDCP Prevention Interagency Work Group has focused on working with Federal partners to develop an agenda to address research gaps, such as newly emerging drugs of abuse. NIDA's prevention research program focuses on risks for drug use and other problem behaviors that may occur throughout a child's development. Leading researchers have formulated a prevention cooperative that will publish outcomes from prevention research conferences as well as action items for continued dialogue and collaboration between researchers and practitioners.

C. Prepare a Report on the Health Risks of Youth Substance Use

It is important to keep information current and disseminate information to address behavioral risk factors that increase the incidence of drug use. In 2012, HHS released *Preventing Tobacco use Among Youth and Young Adults: A Report of the Surgeon General*. The HHS Interagency Workgroup on Adolescent Health has disseminated materials to its partners to include drug use information and best practices. The National Prevention Council identified four strategic directions designed to improve overall health and wellness and includes preventing drug use and excessive alcohol use among its targeted priorities. The Centers for Disease Control and Prevention (CDC) document *Work in Adolescent Health: Selected Tools for Moving Research into Practice* provides a snapshot of adolescent health tools that include HIV/AIDS prevention, a particularly important issue given that rates of infectious diseases such as HIV, viral hepatitis, sexually transmitted diseases, and tuberculosis are substantially higher among persons who use drugs illicitly than among persons who do not use drugs illicitly.[22]

4. Criminal Justice Agencies and Prevention Organizations Must Collaborate

A. Enable Law Enforcement Officers to Participate in Community Prevention Programs in Schools, Community Coalitions, Civic Organizations, and Faith-Based Organizations

Participation by law enforcement professionals in prevention activities in schools, community settings, and organizations that involve youth is an effective way to support prevention efforts. Twenty of the 28 High Intensity Drug Trafficking Areas (HIDTAs) are engaged in activities that connect law enforcement with community-based prevention efforts through mentoring, role modeling, and life skills education. The Houston HIDTA has increased its coalition efforts and includes over 15 new partners.

The Drug Enforcement Administration (DEA) is committed to partnering with community prevention programs, providing education materials and trainings to targeted law enforcement groups and continuing its annual Red Ribbon Week prevention events.

The Federal Bureau of Investigation's (FBI) Community Outreach Program (COP) seeks to enhance public trust and confidence in the FBI in order to enlist the cooperation and support of the community in preventing crime. The COP also provides information to the public in support of crime prevention efforts and opens new lines of communication to help make the FBI more responsive to community concerns. In these ways, the COP plays an increasingly broader role in improving the FBI's understanding of the communities it serves.

The National Association of School Resource Officers is refining its curriculum training to ensure officers in school settings are getting the most updated information on best practices in substance use prevention. At its annual conference, over 800 participants identified preventing youth substance use as a priority.

Houston HIDTA Prevention Efforts

Newly established in mid-2013, the Houston HIDTA Drug Prevention and Awareness Initiative (DPAI) was designed to present a concerted and collaborative drug prevention and awareness effort for the Houston community. DPAI involves a partnership with the DEA Demand Reduction Unit and the Houston mayor's office Crackdown Coalition, merging behavioral health professionals, law enforcement officials, and professionals in prevention and treatment. This coalition has broad representation and works together to increase awareness of drug trafficking and community drug use trends. The Houston HIDTA co-sponsored the 2013 Coalition's 4th Annual Community Drug Awareness Day at Rice University, with an audience of approximately 240 people. The event received positive reviews from the community and afforded the Houston HIDTA the opportunity to be involved in prevention work. Plans are underway to provide forums on specific college campuses to engage at least 1,000 students in 2014. The Houston HIDTA has also partnered with the Success Through Addiction Recovery (STAR) program, which bridges the gap between criminal justice and therapeutic approaches for defendants with drug dependencies.

B. Strengthen Prevention Efforts along the Southwest Border

The *National Southwest Border Counternarcotics Strategy* includes a focus on supporting communities in the Southwest border region. The *Strategy* emphasizes elevating support for coalitions to enhance their prevention efforts with existing community-based organizations and agencies. Relationships are being developed among HIDTA grantee sites, local DFCs, and community-based non-profit groups to ensure collaboration to address regional issues. The National Prevention Network Conference, held in Oklahoma City in August of 2013 with nearly 700 attendees, provided information and opportunities for further dialogue with local coalitions in the southwest region. Work with the U.S.-Mexico Border Commission has expanded to include dissemination of prevention information to its member organizations and has reached 42 key drug demand reduction professionals in the region.

Chapter 2. Seek Early Intervention Opportunities in Health Care

A systematic approach within health care systems for the early identification of substance use disorders among patients is critical to reducing drug use and its consequences. As research findings emerge and are translated into practice, the benefits of investing in early intervention for substance use disorders are becoming ever more apparent. Research suggests that investing in early intervention services can contribute to a reduction in health care costs and help ensure the improved health and well-being of patients.[23] Health care reform under the Affordable Care Act extends access to and parity for substance use and mental health disorder services for an estimated 62 million Americans.[24]

Early intervention helps individuals recognize when they are at risk of substance use disorders and need help to identify and change high-risk behaviors into healthy patterns. Health care providers use approaches such as Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify individuals with problematic substance use behaviors before they progress to substance use disorders. SBIRT can be implemented in primary care settings and hospitals, allowing quick responses to substance use disorders and providing care for more people.

Research indicates that the younger a person begins using alcohol or drugs, the more likely that individual is to develop a substance use disorder later in life.[25,26] According to the 2013 Monitoring the Future study, by the time students reach the 12th grade, 50 percent of these youth had used illicit drugs in their lifetime, with over 45 percent having used marijuana.[27] Given these findings, the Administration is giving special attention to substance use disorders among adolescents and young adults. Using SBIRT, health care providers can identify and intervene early with adolescents and young adults who engage in high-risk behaviors (See Figure 1).

Figure 1. Brief Interventions Reduce Adolescent Substance Use[28]

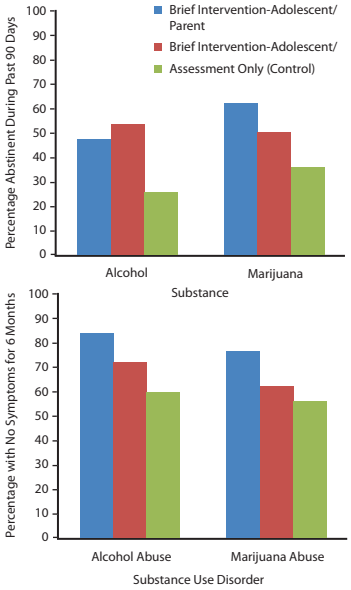
Brief Interventions Reduce Adolescent Substance Abuse

NIDA research on brief interventions show that two hour-long sessions a week apart reduce symptoms of substance abuse or dependence.

Drug- and alcohol-involved middle and high school students markedly reduced their substance use following two 60-minute sessions that combined motivational interviewing (MI) and cognitive behavioral therapy.

The students also reported significantly fewer substance-related symptoms of substance use disorders during the 6 months after the intervention compared with the 6 months before it.

Adding a separate 1-hour MI-based session with a parent or primary caregiver enhanced the beneficial effects.



Winters, K.C., Fahnhorst, T., Botzet, A., Lee, S. & Lalona, B. (2012) Brief intervention for drug-abusing adolescents in a school setting: Outcomes and mediating factors. *Journal of Substance Abuse Treatment 42(3):* 279–288.

Substance use behaviors initiated early in life are often carried into older adulthood. For example, the rate of current illicit drug use among adults aged 50 to 64 has increased significantly from 2002 to 2012. This trend represents the aging of the "baby boomer" generation, which has consistently exhibited higher levels of illicit drug use than older age groups.[29] This underscores the importance of prevention and intervention early in life, while also highlighting an additional population for which screening and brief intervention services can still be useful.

1. Catching Substance Use Disorders Early Saves Lives and Money

A. Expand and Evaluate Screening for Substance Use in All Health Care Settings

In 2013, SAMHSA funded SBIRT grants to Vermont, Ohio, South Carolina, New Mexico, and New York. An Addiction Technology Transfer Center (ATTC) for SBIRT was established to provide resources to SAMHSA grantees and health care entities. The ATTC conducted an SBIRT webinar series; developed an electronic SBIRT newsletter; provided SBIRT resources, training products, and information; and maintained two learning communities.

Throughout 2013, the Health Resources and Services Administration (HRSA) partnered with SAMHSA through the SAMHSA/HRSA Center for Integrated Health Solutions to provide SBIRT technical assistance to HRSA-funded health centers. A series of webinars were conducted using model SBIRT programs for adolescents, employee assistance programs, criminal justice professionals, and the military. A Technical

Assistance Protocol released in 2013 on SBIRT from a state's administrative and organizational perspective was posted on the SAMHSA/HRSA Center for Integrated Health Solutions website.

B. Increase Adoption and Use of SBIRT Codes

SBIRT billing codes can be used to reimburse health care providers for SBIRT services. Medicaid, Medicare, and commercial insurers have these codes for provider reimbursement. In 2013, SAMHSA conducted webinar trainings and provided technical assistance for SBIRT grantees to integrate the codes for billing and reimbursement for SBIRT services into their systems. These webinars use model SBIRT health care programs that successfully integrate methods for generating revenue for services. Conducting these webinars helps address provider challenges, such as unfamiliarity with the codes in billing departments and the need to initiate new processes for billing submission. SBIRT specifications must be made a part of the newly developed electronic medical records (EMR) billing system. In 2014, SAMHSA will conduct additional webinars on the effective use of SBIRT codes.

C. Enhance Health Care Providers' Skills in Screening and Brief Intervention

With SBIRT, substance abuse screening is incorporated into mainstream health care settings, such as college health clinics, hospitals, trauma centers, and dental clinics, as well as tribal and military health care settings. Practitioners screen patients to assess substance use, then, based on the screening results, provide the appropriate intervention. In 2013, 17 SBIRT medical residency grantees trained 6,600 physicians. Of these grantees, 14 programs trained 11,800 other health professionals. Also in 2013, 16 state SBIRT programs trained clinical staff and other health care professionals.

Throughout 2013, SAMHSA offered webinars or online courses using the medical residency program curriculum. To demonstrate SBIRT in action, best practice examples were used in these trainings and disseminated to medical and behavioral health practitioners. In addition, a webinar series was conducted on lessons learned from successful former and current SBIRT grantees. SAMHSA developed an SBIRT Medical Residency Training Implementation Guide for dissemination to current and future grantees. The SBIRT Technical Assistance Publication was released, providing information and guidance for the implementation of SBIRT in diverse health care settings.

D. Identify and Make Available Additional Training in Evidence-based Practices for Substance Use Disorder Assessment and Care to Health Care Professionals Providing Care to Military Health System Beneficiaries

In 2013, the Department of Defense (DoD) instituted a web-based training program called *Do No Harm*. The training includes scenario-based clinical vignettes for military treatment personnel on prescription drug misuse. In 2014, performance metrics will be developed to evaluate the program.

Throughout 2013, DoD focused its efforts to improve access to behavioral health in primary care. DoD has assigned 470 behavioral health professionals to primary care clinics to increase access to behavioral health screening and intervention in less stigmatizing environments. Through the Patient Centered Medical Home, DoD will provide consultation on mental health and substance use issues to staff members in primary care. Next year, DoD plans to incorporate SBIRT training for Army primary care providers.

Advocate for Action: Dr. Joan Standora

For 40 years, Joan Standora, Ph.D. has worked tirelessly to improve clinical, administrative, and educational practices in the substance use disorder field. Early in her career, Dr. Standora developed an expressive therapy program in a methadone-maintenance residential program and received a NIDA grant for a program serving mothers with substance use disorders and their children. In 1998, she became the first clinical director of New York City's Manhattan Treatment Court. Dr. Standora established protocols and policies, supervised staff, and conducted outreach to providers for the drug court participants. Dr. Standora was instrumental in establishing the New York City Regional Drug Court/Treatment Consortium. Dr. Standora then became the Executive Clinical Director at a Bronx-based treatment program, instituting staff trainings focusing on substance use disorders among clients from low-income minority communities plagued by poor health care and unemployment. In 2000, Dr. Standora developed and implemented a substance abuse counselor education program at the City University of New York's Kingsborough Community College. The program became a degree program in 2003, approved by both New York State's Education Department and the Office of Alcoholism and Substance Abuse Services (OASAS). In 2010, Dr. Standora received a grant from the Department of Labor (DOL) through OASAS to retrain 25 unemployed workers as substance abuse counselors as part of the American Recovery and Reinvestment Act of 2009. In 2013, Dr. Standora received a grant to enroll persons over the age of 50 as a community college workforce education project for professionals in the substance use disorder field. She currently directs the degree program in chemical dependency counseling at the City University of New York.

Chapter 3. Integrate Treatment for Substance Use Disorders into Health Care and Expand Support for Recovery

Recovering from a substance use disorder is often a long process, one that may require help from health care professionals such as doctors, physician assistants, nurses, counselors, social workers, recovery peer support counselors, and other specialists. Across the Nation, teams of health care professionals and recovery support service providers work with patients to reduce the prevalence of substance use disorders by providing treatment and recovery support. This effort includes the use of innovative technologies to help individuals access substance use disorder services. These technologies range from electronic health records to mobile health applications to telehealth technologies. They support health care reform by delivering evidence-based care, coordinating care, engaging the patient in shared decision making, and monitoring progress and outcomes. As substance use disorder services can be received in many locations, efforts should be made to support interoperable technologies that provide seamless care provision across all settings of care and types of provider.

In addition to encouraging health care professionals to use innovative technologies to help patients with substance use disorders, the Administration encourages the use of the FDA's approved medications to treat opioid use disorders: methadone, naltrexone (Vivitrol - a once-monthly extended-release injectable formulation), and buprenorphine. Under a health care provider's care, medication is often an essential element of opioid use disorder treatment. According to NIDA, "medication assisted treatment of opioid addiction increases patient retention and decreases drug use, infectious disease transmission, and criminal activity."[30] Used properly, the medication does not continue an addiction nor create a new one. Rather, it can stabilize individuals, permitting them to pursue and sustain recovery.[31] The Administration continues to underscore the importance of educating practitioners across all medical fields about medications for the treatment of opioid use disorders.

Another area of importance is providing effective care for persons living with substance use disorders and infectious diseases such as HIV and viral hepatitis. Increased prevention efforts must be focused and brought to scale for populations at highest risk. Science-based interventions are vital, to include testing and treatment, prevention education, comprehensive substance use disorder treatment, and new prevention technologies such as pre-exposure prophylaxis. To better facilitate access to appropriate care for HIV, viral hepatitis, and substance use disorders, support is needed for screening in general health care and specialty treatment settings. The 2012 Summary Guidance from CDC and HHS describes the rationale for and importance of integrated prevention services for infectious diseases among persons who use drugs illicitly and provides information on effective models and evaluation of integrated services.[32]

Stigma, rooted in the misperception that a substance use disorder is a personal moral failing rather than a brain disease, is a major obstacle to drug policy reform. The Administration is committed to addressing laws, policies, and practices that often prevent people in recovery from accessing housing, education, and employment. The Administration is also committed to ensuring that substance use disorders are

recognized as chronic conditions that often require ongoing support after treatment. Nowhere is this of greater importance than among adolescents and young adults who are in or seeking recovery. In the coming year, the Administration will continue to work to support promising approaches to expand access to housing and employment among recovering persons with felony convictions.

Community-based recovery support service providers are an indispensable part of the substance use disorder services infrastructure. These providers help people sustain recovery by providing a stable and welcoming peer recovery community through which recovery coaching, training, employment, housing, and other services are provided. The Administration celebrates and champions recovery throughout the year and gives it special recognition every September when the White House issues a Presidential Proclamation for National Alcohol and Drug Addiction Recovery Month. In 2013, the Administration actively used social media as part of these efforts. In addition to hosting Twitter chats, ONDCP established the Americans in Recovery Facebook page, providing a place for people in recovery to share their stories and learn about relevant Federal policies and programs.

1. Addiction Treatment Must Be an Integrated, Accessible Part of Mainstream Health Care

A. Expand Addiction Specialty Services in Health Centers

The Affordable Care Act will increase the availability of treatment for people with substance use disorders. With an increased demand for substance use disorder treatment will come a need for an increase in the skilled health care workforce. To begin to address this demand, the SAMHSA-HRSA Center for Integrated Health Solutions organized a year-long learning network in three states, involving two health centers from each state, to establish medication-assisted treatment services within health centers. In addition, the SAMHSA-HRSA Center for Integrated Health Solutions created an online course for substance use disorder treatment providers specific to the experience and skills needed to succeed in a primary care environment.

B. Increase Addiction Treatment Services within the Indian Health Service

In 2013, the Indian Health Service's (IHS) Tele-Behavioral Health Center of Excellence, along with the SAMHSA-HRSA Center for Integrated Health Solutions, conducted webinar training on substance use disorders for more than 2,400 service providers in the IHS, as well as tribal and urban Indian health care providers. In addition, the IHS Scholarship Program provided funding for 17 behavioral health scholars in clinical psychology, social work, and substance abuse counseling.

C. Expand the Innovations of the Department of Veterans Affairs Substance Use Disorder Treatment Approach to Other Federal Health Care Systems

The Veterans Health Administration is America's largest integrated health care system, serving 8.7 million veterans a year at more than 1,700 sites of care.[33] The Department of Veterans Affairs' (VA) commitment to expand access to behavioral health care is an important component of its work with veterans and their family members. To assist veterans who experience posttraumatic stress disorder (PTSD), depression, substance use disorders, suicidality, chronic pain, insomnia, and nicotine dependence, the VA provides

evidence-based psychotherapies and psychopharmacology interventions specified in clinical practice guidelines for mental health and substance use disorders. To ensure these services are known to veterans and their families, the VA developed and implemented Make the Connection. *Make the Connection* is a public awareness and outreach campaign connecting veterans and their friends and family members with information, resources, and solutions related to issues affecting their health, well-being, and relationships. The initiative aims to:

1. Reduce the stigma many veterans and their families associate with seeking mental health support;
2. Highlight the particular strengths of veterans who have sought support and are living a richer life today as a result: resilience, courage, perseverance, leadership, and mission focus; and
3. Feature more than 300 veterans and their family members who have contributed personal, candid testimonials about seeking treatment for challenges ranging from physical injury, flashbacks, traumatic brain injury, posttraumatic stress disorder, and depression.

ONDCP continues to work with the VA to ensure continuing education for health care practitioners on proper prescribing and disposal of prescription drugs, with a focus on opioid analgesics. More information can be found under "Policy Focus: Preventing and Addressing Prescription Drug Abuse."

D. Enhance Public and Private Insurance Coverage of Addiction Treatment

In 2013, SAMHSA conducted a state-by-state analysis to determine state readiness and progress related to health care reform. Analysis results were used to identify technical assistance and other resources that state behavioral health agencies needed to fully implement the Affordable Care Act requirements. Subsequently, SAMHSA convened the 10th State Systems Development Program Conference titled "Mental Health and Substance Abuse Prevention and Treatment Block Grants: Cornerstones of Behavioral Health Services," which provided information to state mental health and substance abuse treatment authorities about enhanced coverage of substance use disorder treatment under the Affordable Care Act.

E. Inform Public Health Systems on Implementation of Needle Exchange Programs

Addressing the connection between substance use disorders and infectious diseases such as HIV and viral hepatitis remains a priority for both ONDCP and the Office of National AIDS Policy. The reported increase in injection drug use among young people in some parts of the country—particularly in rural and suburban settings—means that state and local governments need to develop a collaborative approach to address substance use disorders as well as the public health issues that result from increased use of syringes. The Administration is committed to informing public health systems on the implementation of needle exchange programs that protect the public, reduce infections, and encourage involvement in substance use disorder treatment. Although the Consolidated Appropriations Act of 2012 reinstated a ban on most Federal funding for syringe services programs, 30 states, the District of Columbia, the Commonwealth of Puerto Rico, and several Indian Nations currently have their own sterile syringe exchange programs.[34]

2. Patients with Substance Use Disorders and Their Families Must Receive High-Quality Care

A. Support the Development of New Medications for Addiction

Progress continues to be made in leveraging public-private partnerships to help bring substance use disorder medications to market. Over the past year, NIDA has established formal collaborations with several pharmaceutical companies. Accumulated knowledge and recent discoveries have revealed numerous potential new approaches to medications development. To achieve the goal of accelerating medications development, NIDA is focusing on the scientific opportunities in genetics research, high-resolution mapping of targeted brain areas, the development of vaccines against substance use disorders (see text box), and combination medications similar to promising strategies used for treating other diseases such as cancer and HIV/AIDS.

Building an Anti-Drug Vaccine

Vaccines have a unique role to play in a comprehensive strategy to help people overcome substance use disorders. A successful vaccine will make it easier for individuals with substance use disorders to establish and maintain abstinence. It will reduce the chances that isolated lapses into drug use escalate into protracted relapses. Ideally, a single dose will remain effective for months or longer, eliminating the potential for missed doses and consequent gaps in protection that sometimes occur with shorter-acting agents.

Anti-drug vaccines take advantage of a tissue filter that surrounds the blood vessels in the brain. The filter, called the blood-brain barrier, protects the brain from exposure to many potentially harmful substances circulating in the blood. The barrier normally does not block out drug molecules, which easily pass through it despite being harmful.

If an individual has been vaccinated, the antibodies produced by the vaccine bind to the drug molecules in the bloodstream. The compound drug-antibody molecules are too big to go through the blood brain barrier. The drug cannot enter the brain and cannot produce psychoactive effects or lead to the development of a substance use disorder. An anti-drug vaccine will be clinically useful if the antibody response it induces is sufficiently strong and long-lasting.

A video from NIDA on anti-drug vaccines can be viewed here

B. Integrate and Coordinate Substance Use Disorder Services under the Affordable Care Act (3.2.B.)

Health homes were established under the Affordable Care Act to coordinate care for people with Medicaid who have chronic conditions such as mental health disorders, substance use disorders, asthma, diabetes, heart disease, and obesity. Health home providers integrate and coordinate all primary, acute, behavioral health, and long-term services, as well as support services to treat the whole person. Ensuring implementation of the health home program involves effective integration of the treatment of substance use disorders into primary care, and SAMHSA and CMS have developed a state consultation plan for states submitting proposals for State Plan Amendments to create health home programs. As of December 31, 2013, 14 states had approved State Plan Amendments that include plans for screening of substance abuse and referral to treatment. An additional 15 states are developing a health home proposal.

C. Promulgate the National Quality Forum Standards for Addiction Treatment

Mental health and substance use disorder clinical quality measures support health care quality, promoting effective, safe, efficient, patient-centered, equitable, and timely care. In 2013, ONDCP, HHS, and other Federal partners recommended behavioral health related clinical quality measures to be included in the Centers for Medicare and Medicaid Services (CMS) Medicare and Medicaid EHR Incentive Program, also known as the "Meaningful Use Program." The Meaningful Use Program provides Federal incentives to help health care providers adopt electronic health records. These measures are to be endorsed by the Office of the National Coordinator for Health Information Technology and CMS.

Also in 2013, ONDCP, SAMHSA, and NIDA facilitated the development of the Composite Measure for Substance Use Screening for inclusion in the CMS Electronic Health Records Meaningful Use Incentive Program. This measure includes screening and brief counseling for the use of tobacco, alcohol, illicit drugs, and misuse of prescription drugs.

D. Equip Health Care Providers and First Responders To Recognize and Manage Overdoses

Naloxone is a lifesaving overdose-reversal medication. First responders and community-based programs can use naloxone to save the lives of those overdosing from heroin or prescription medicines made with opioids. In 2013, SAMHSA launched an Opioid Overdose Toolkit. For further information about this toolkit, see "Policy Focus: Preventing and Addressing Prescription Drug Abuse."

E. Integrate Substance Use Treatment and HIV Prevention and Care, Including in the Criminal Justice System

Approximately half of all teens who enter the juvenile justice system need treatment for substance use disorders.[35] The remaining half would benefit from a drug abuse prevention intervention. To address this situation, in 2013, NIDA launched Juvenile Justice Translational Research on Interventions for Adolescents in the Legal System (JJ-TRIALS). As part of this JJ-TRIALS cooperative, seven research centers will work together to determine how juvenile justice programs can effectively adopt science-based prevention and treatment services for drug abuse and HIV. Awardees will develop and execute collaborative multisite studies across a variety of juvenile justice settings, including juvenile probation and drug courts. This initiative is particularly important given the connection between illicit drug use and infectious diseases such as HIV, viral hepatitis, sexually transmitted diseases, and tuberculosis.[36]

3. Celebrate and Support Recovery from Addiction

A. Review Laws and Regulations that Impede Recovery from Addiction

In 2013, ONDCP and the Department of Education developed and released a document clarifying restrictions on eligibility for Federal student aid related to convictions for the possession or sale of illegal drugs. Titled FAFSA Facts, the document explains how drug-related convictions affect student loan eligibility; clarifies the period of time a person is considered to be receiving Federal student aid; and details steps people can take to regain eligibility for Federal student aid. ONDCP and the Department of Housing and Urban Development (HUD) completed a document profiling promising practices among Public Housing Authorities that provide housing and support to people returning to the community

from incarceration—many are in recovery from substance use disorders. For further discussion about housing for reentering offenders, see Chapter 4.

B. Foster the Expansion of Community-Based Recovery Support Programs, Including Recovery Schools, Peer-led Programs, Mutual Aid Groups, and Recovery Community Organizations

Under its new Peer-to-Peer Targeted Capacity Expansion grant program, SAMHSA has awarded grants to 15 recovery community organizations (RCOs) and five facilitating organizations that serve as fiduciary agents for emerging RCOs. An RCO is a community-based, non-profit organization led by members of the recovery community. These organizations serve the community by providing a range of peer-led services, such as peer recovery coaching, employment and housing support, training, ongoing access to a community of recovering peers, and advocacy. By funding established and emerging RCOs, the grants expand and enhance access to a wide array of community-based peer recovery support services. Many of these services were initially developed under the Recovery Community Services Program, which also funded RCOs.

In 2013, the ONDCP Recovery-Oriented Systems of Care Learning Community for states, tribes, and local governments continued its operations with teams from 14 jurisdictions. Additionally, SAMHSA conducted an online policy academy for states interested in implementing the Recovery-Oriented Systems of Care framework. The Administration continues to highlight the needs of adolescents and young adults in recovery, including recovery high schools and collegiate recovery programs.

Advocate for Action: Scott Strode

Scott Strode has dedicated his life to helping individuals with substance use disorders find and maintain their recovery through sport, a dedication that has earned the attention of national media organizations such as CNN, which honored him as a CNN Hero. Scott founded Phoenix Multisport in 2007 to foster a safe, supportive, physically active community for individuals recovering from alcohol and substance abuse and for those who choose to live a sober life. Through pursuits such as climbing, hiking, running, strength training, yoga, road/mountain biking, CrossFit, and other activities, Phoenix seeks to help its members develop and maintain the emotional strength they need to stay sober. All activities are free. The only requirement is that individuals have at least 48 hours of continued sobriety to participate. They also must adhere to Phoenix Multisport's code of conduct, which says that anything that is not nurturing is not welcome. Since 2007, over 11,000 individuals have attended Phoenix Multisport events in Colorado, where they find a safe, sober community of friends to help support them in their recovery. Scott is devoted to changing how the world views those with substance use disorders. By living sober and rising from the ashes of one's substance use disorder, Scott believes that one's life has new meaning and should be celebrated. Scott and the staff at Phoenix Multisport welcome newly-recovering individuals to join them for a free activity or workout. It is Scott's hope that Phoenix Multisport will expand to other areas of the country to reach even more of those in need.

Chapter 4: Break the Cycle of Drug Use, Crime, Delinquency, and Incarceration

At the end of 2012, nearly 7 million adults were involved in the criminal justice system—either on probation, parole, or incarcerated in jail or prison.[37] The United States has the largest per capita prison population in the world,[38] a costly statistic in terms of both money and societal impact. In too many cases, individuals with substance use disorders are sent to jail or prison when drug treatment—or alternatives such as drug courts—can achieve better outcomes at reduced costs. The long-lasting and far reaching consequences of criminal justice involvement are an impediment to employment, housing, and education, all necessary for a strong recovery and successful reentry into the community.

Since the release of the President's first *Strategy*, the Administration has emphasized the importance of a full range of interventions for individuals with substance use disorders at every stage of the criminal justice system. States are currently implementing such approaches and programs as pre-trial diversion, the use of risk assessment tools, drug courts, enhanced probation and parole protocols, the expansion of treatment (including medication-assisted treatment), and reentry support. At the Federal level, DOJ's Smart on Crime Initiative pursues such reform efforts as modifications to charging policies for low-level nonviolent offenders, sentencing reform, and addressing persistent demographic disparities.

If incarceration is necessary, appropriate treatment and other supportive services should be provided to help incarcerated individuals fully recover from their substance use disorder and maintain their recovery after their sentence is complete. A study conducted in the California Department of Corrections and Rehabilitation found that inmates who participated in an in-prison treatment program and completed an aftercare program had the lowest 3-year recidivism rates—31.3 percent—when compared to those who did not receive treatment and only received some aftercare (78.8 percent).[39]

Like all diseases, substance use disorders should be treated with every evidence-based, medically appropriate tool available, including the use of medications for the treatment of opioid disorders. Several jurisdictions have encountered success with the use of medication-assisted treatment for justice-involved individuals. For example, methadone has long been used to maintain abstinence from heroin while people are incarcerated, but newer medications like buprenorphine and Vivitrol have also shown promise in controlling opioid use disorders. When combined with behavioral therapy, connecting offenders with a maintenance program after their release can help them sustain recovery.

The Administration has made significant strides in assisting formerly incarcerated individuals successfully transition back into their communities. The Federal Interagency Reentry Council,[40] consisting of 20 Federal partners, continues to identify and reduce barriers to employment, education, and housing, helping justice-involved individuals who have served their sentences. Across the country, state and local authorities are also taking action to help formerly incarcerated individuals reenter the community, with some jurisdictions instituting "ban the box" initiatives that ask employers to remove questions about prior criminal convictions from initial employment applications.

The Administration, with the help of experts, practitioners, researchers, policymakers, and private citizens, is poised to effect systemic change. Implementing evidence-based interventions for individuals within the criminal justice system; saving the most resource-intensive programs for those with the most need and the highest risk of recidivism; and providing opportunities for gainful employment, housing, and education are all part of the Administration's reform efforts. Many of these efforts have already met with great success, and the items below outline the actions the Administration will continue to take to break the cycle of drug use, crime, delinquency, and incarceration.

1. Provide Communities with the Capacity to Prevent Drug-Related Crime

A. Organize Communitywide Efforts to Reduce Open-Air Drug Markets and Gang Activity via Drug Market Intervention Approaches

The Drug Market Intervention (DMI) model has proven effective in shutting down open-air drug markets through community-based solutions and direct engagement with the community. The Bureau of Justice Assistance (BJA) is working with RAND to evaluate the success of the DMI training and technical assistance initiative. Previously, BJA funded technical assistance to several cities, including Roanoke, VA, which has reported great success in the implementation of DMI. Since the beginning of their DMI efforts, the Roanoke Police Department reports a 71 percent reduction in crime, as well as an interest from businesses to develop in the area.

B. Engage Faith-Based and Neighborhood Community Organizations to Prevent Drug-Related Crime

The National Youth Violence Prevention Forum is a White House-led initiative commissioned by the President in 2010, linking cities and Federal agencies to implement strategies and programs to prevent youth and gang violence in the United States. The 10 cities of the Forum[41] sent leaders and youth to Washington, D.C. in September 2013 to share their work and exchange ideas at the Summit on Preventing Youth Violence. The 2013 Summit focused on the issue of sustaining and growing the cities' efforts beyond the availability of Federal funds.

C. Support Innovative Criminal Justice Research Programs

In 2011, BJA funded the Honest Opportunity Probation with Enforcement Demonstration Field Experiment (HOPE DFE) in four jurisdictions.[42] This program is modeled on Hawaii's successful probation program that combines drug testing with swift, certain sanctions to reduce probation violations. In 2013, the HOPE Training and Technical Assistance team hosted a peer-to-peer training session for the judges, probation administrators, and project coordinators involved in the HOPE DFE to assist them in more closely approximating the successful model used in Hawaii. BJA anticipates that the four pilot sites will expand to serve more probationers prior to the conclusion of the program. The BJA training and technical assistance team is also developing materials to assist in other jurisdictions that might be interested in implementing a "swift and certain" model; these documents are expected to be released in 2016. The National Institute of Justice (NIJ) is conducting an evaluation to determine the effectiveness of the HOPE model at the four sites. The final evaluation results are expected in summer 2016.

2. Develop Infrastructure to Promote Alternatives to Incarceration When Appropriate

A. Enhance and Promote Diversion Strategies

BJA is working with the Center for Court Innovation to develop the Misdemeanor Evidence-Based Assessment project, a screening tool for offenders in New York that can be used at the earliest possible moment in the processing of a court case. Before arraignment, the tool will be administered to provide information on key needs to both attorneys and the judge. Ultimately, the project will supply an evidence-based assessment tool that can be administered by case managers, pre-trial services staff, or prosecutors and will allow individuals to be matched with appropriate interventions. The tool will be created and ready for validation beginning in early 2015, with initial results available in mid-2015.

B. Support Drug Courts and Other Problem-Solving Courts

The Administration supports the use of drug courts and other problem-solving courts—including family dependency courts, tribal healing to wellness courts, and veterans treatment courts—to meet the unique needs of offenders with substance use disorders. BJA has received feedback from its drug court grantees regarding the need for additional training and technical assistance to educate practitioners on evidence-based services. As a result of this feedback, BJA has convened a new grantee orientation call to better acquaint grantees with available trainings and services.

ONDCP issued a training and technical assistance grant to the National Association of Drug Court Professionals (NADCP) to provide, among other things, training to drug court practitioners on emerging issues at national conferences. Specifically, NADCP has provided training sessions on integrating these issues into drug court practice, including medication-assisted treatment for individuals with opioid use disorders, recovery support systems, addressing the problem of synthetic drugs, and interventions for pregnant and postpartum women. ONDCP also worked with NIDA to provide training on the use of medication-assisted treatment in justice settings to criminal justice practitioners in the American Correctional Association.

Jurisdictions across the country are exploring opportunities to develop community courts, which focus on improving the quality of life for the localities in which they sit. The courts rely on community-based public/private partnerships to deliver wrap-around services to clients while also protecting the safety of the community. In 2012, BJA and the Center for Court Innovation named three regional mentor community courts, including the South Dallas Community Court.[43] Since the inception of this project, the Dallas program has hosted more than a dozen teams from cities across the United States and from other countries; Dallas is assisting in the planning stages for community courts in Houston, Atlanta, Detroit, and Canada.

C. Support Systemic Change in Evidence-Based Sentencing through Training and Outreach

To improve the criminal justice system at all levels, change agents must be identified and informed of new evidence, perspectives, and innovations. In partnership with NADCP and Treatment Alternatives

for Safe Communities (TASC), ONDCP is funding training sessions to help law enforcement officers and executives understand the science of addiction and how this understanding could inform practices and policies. In 2013, TASC convened a task force of law enforcement professionals and police organizations to develop training materials. The task force comprised representatives from the Police Executive Research Forum, the International Association of Chiefs of Police, and Major Cities Chiefs; experts from the criminal justice and law enforcement fields; and senior and mid-level managers from police departments in Chicago, IL, Philadelphia, PA, Montgomery County, MD, the Cherokee Nation, Austin, TX, Overland Park, KS, and Hennepin County, MN. In spring 2014, TASC convened a roundtable of police chiefs, sheriffs, and national law enforcement organizations to discuss the science of addiction, training for officers, and law enforcement's role in criminal justice reform. Curricula developed through these two meetings will be piloted over the course of 2014.

Advocates for Action: Melody Heaps and Pamela Rodriguez

Melody Heaps and Pamela Rodriguez are partners and leaders in advancing system-wide justice interventions for people with substance use disorders. For more than 30 years, they have shared a collective commitment to collaborative solutions that improve both public health and public safety.

Melody founded TASC in Chicago in 1976 as a nonprofit agency focused on alternatives to incarceration. She would go on to lead TASC to become a nationally recognized organization before she retired from her role as president and CEO in 2009. She remains president emeritus of TASC and is an advisor to TASC's Center for Health and Justice, which offers public policy and consulting services nationally and internationally.

Melody began her career during the civil rights movement and served on Martin Luther King, Jr.'s staff during the Chicago campaign. From these roots grew a lifelong professional commitment to addressing the complex and interrelated issues of drugs, poverty, and crime. Under her leadership, TASC matured from a small pilot project in Cook County, Illinois to a statewide organization providing direct services for 25,000 individuals annually.

Pamela Rodriguez has served as TASC's president and CEO since 2009, having previously directed every aspect of the agency's operations. Under her leadership, TASC has continued to grow and thrive, including an expanded focus on diversion programs early in the justice continuum to reduce recidivism and the collateral consequences of justice involvement.

An expert in connecting research to clinical practice, Pam was appointed in 2007 to serve as a practitioner model of the Federal Coordinating Council on Juvenile Justice and Delinquency Prevention. She is active in numerous bodies to increase alternatives to incarceration, improve juvenile justice, and decrease the disproportionate incarceration of people of color.

Together, Melody and Pam have played significant roles at local, state, and national levels in the development and expansion of community-based diversion programs and treatment alternatives to incarceration to create healthier and safer communities.

D. Foster Equitable Drug Sentencing

In 2013, DOJ announced the Smart on Crime initiative to ensure that law enforcement resources are best prioritized to protect public safety. In a memorandum to United States Attorneys (USAs) issued in August 2013, the Attorney General reaffirmed that, when making charging decisions, prosecutors "must take into account numerous factors, such as a defendant's conduct and criminal history and the circumstances relating to the commission of the offense…and Federal resources and priorities." Pursuant to this policy, USAs should "decline to pursue charges triggering a mandatory minimum sentence" in certain circumstances. This guidance may prove to lessen "unduly harsh sentences and perceived or actual disparities" in the justice system.[44]

E. Promote Best Practices as Alternatives to Incarceration

To study the impact of legislation promoting alternatives to incarceration for nonviolent drug offenders, the National Institute of Justice funded a policy analysis of the 2009 New York state drug law reform legislation that removed previously mandated prison sentences and created treatment diversion alternatives. The Vera Institute of Justice examined the impact of this legislation on felony drug cases based on arrest charges in New York City and found an increase in judicial diversion and a decrease in criminal sentences to incarceration, as well as fewer rearrests on both misdemeanor and felony charges. However, implementation varied widely across counties. Furthermore, savings to law enforcement, corrections, and victims resulting from decreased recidivism were outweighed by an increase in treatment costs related to increased use of residential over outpatient services.[45]

ONDCP is working through a grant to NADCP to collaborate with national criminal justice leaders and experts on alternatives to incarceration. The project will yield a repository of evidence-based practices that practitioners can use to choose the best intervention for each offender. The model takes into account each offender's risk of violating the terms of their supervision or dropping out of treatment and their need for treatment services. In 2014, NADCP will develop and pilot training sessions both to trainers, who can in turn train others, and to end-users.

F. Improve Intervention and Treatment Services for Female Offenders in the Juvenile and Criminal Justice Systems

The National Institute of Corrections (NIC) is working with Federal and non-governmental partners to improve programmatic responses to the needs of female offenders. For example, the Center for Gender and Justice has developed the "Gender Responsive Policy and Practices Assessment," an evidence-based, gender-informed tool for correctional agencies to assess their current practices for women and assist in planning for future improvements to policy, practice, and programming; development of budget requests; and strategic planning. The tool has been piloted in a jail, a prison, and two community corrections agencies, and will be available online by the end of the fiscal year.

NIC has also revised "Women Offenders: Developing an Agency-Wide Approach," a curriculum for correctional administrators to assist them in adapting their programs to improve outcomes for female offenders. The curriculum, which consists of in-person classroom training, webinars, and follow-up coaching provided by experts in the field, was piloted with 24 correctional administrators in August 2013 and will be offered again in 2014.

G. Examine Interventions and Treatment Services for Veterans within the Criminal Justice System

The VA has built the Veteran Reentry Search Service (VRSS), a Web-based system that will allow prison, jail, and court staff to quickly and accurately identify veterans among their inmate or defendant populations. VRSS will also prompt VA field staff to conduct outreach to the identified veterans to help connect them to benefits.

VA produced a brief outreach video titled *Suits* that encourages incarcerated veterans to use their time wisely by taking an active role in the reentry planning process and informs them how to contact a VA outreach specialist for help. The video, directed by an Operation Iraqi Freedom veteran, has been distributed to all state and Federal prisons, as well as more than 500 local jails.

H. Connect Incarcerated Veterans with Critical Substance Abuse and Reentry Services

The VA has reached more than 100,000 justice-involved veterans through direct outreach in prisons, jails, and criminal courts—including through the estimated 168 veterans treatment courts—to connect them with needed mental health, substance abuse, and other clinical services.[46]

Veterans, particularly those who are homeless, at risk of becoming homeless, or have prior criminal justice system involvement, have a significant and often unmet need for legal services. Although VA cannot provide legal services directly, local legal service providers have been given space in VA medical centers so that they can work with veterans where they receive health care. In some cases, assistance with prior criminal activity is available.

I. Address the Issue of Drug Use and Drug-Related Crime for American Indian/Alaskan Natives

In June 2013, President Obama signed an Executive Order creating the White House Council on Native American Affairs. The Executive Order called on all Federal agencies with equities in Indian Country to work together and with tribal nations. Among the priorities identified by tribal leadership and the White House are, "supporting greater access to and control over…health care" and, "improv[ing] the effectiveness and efficiency of tribal justice systems."[47] Improving health and justice in Indian Country requires an emphasis on reducing drug use and its consequences, and the Administration is working to ensure resources and technical assistance are available to tribes seeking help on their lands and among their people.

Further, SAMHSA's Office of Indian Alcohol and Substance Abuse is working with tribes to develop "Tribal Action Plans," strategic documents that identify ways to prevent and treat substance use as part of a comprehensive approach to public health.

3. Use Community Corrections Programs to Monitor and Support Drug-Involved Offenders

A. Support Drug Testing with Certain and Swift Sanctions in Probation and Parole Systems

Drug testing with swift and certain sanctions, such as short periods of incarceration, has shown promise as a way to reduce probation and parole violations, and the Administration supports further research into its potential for broader applicability. Currently, NIJ is conducting two field studies. The first field experiment is a drug testing and graduated sanctions program, assessing the implementation process of such a program in a large urban probation department. The Decide Your Time (DYT) Program is an intensive supervision protocol

developed by the Delaware Department of Corrections for new probationers and parolees who test positive for drugs.48 The field experiment randomly assigned 400 offenders who tested positive at intake to the DYT protocol and compared recidivism outcomes for 200 participants to those for 200 offenders in the default standard probation. The final evaluation results are expected in 2014.

The second project, based at Pepperdine University, investigates long-term recidivism and relapse outcomes for the 2007-2009 cohorts of the Hawaii HOPE program. Researchers are using administrative court and probation records to determine recidivism outcomes and testing oral fluid and hair for a sample of those probationers to examine drug use in the context of how fidelity to the program model may affect these outcomes.

B. Consider Mechanisms for Assessing and Intensifying Community Corrections

The Department of Justice is working on community corrections improvement through its "Smart Supervision" initiative. BJA provided funding for jurisdictions to implement risk/needs assessments in probation departments aimed at matching individuals with the appropriate level of supervision—making more cost-effective decisions while preserving public safety. BJA will issue additional awards in 2014 and will expand the project to include parole. The project also has a research aspect, analyzing the type of offense and offender as well as the assessments of relative risk of re-offense and need for social services and supports.

C. Align the Criminal Justice and Public Health Systems to Intervene with Heavy Users

SAMHSA is providing funding to improve treatment interventions in problem-solving courts, expanding the number of courts and improving the effectiveness of existing courts. In 2013, SAMHSA issued 42 drug court awards: 10 Joint Adult Drug Court Grants with BJA; 29 Adult, Juvenile, and Family Drug Court Grants; and three Early Diversion Grants.

The new "Early Diversion" grants were a joint solicitation between SAMHSA's Center for Substance Abuse Treatment and its Center for Mental Health Services, focusing on diverting people with severe behavioral health issues away from the criminal justice system and toward community-based service alternatives by developing effective partnerships among law enforcement, behavioral health care providers, and service providers. One of the grantees, the Knoxville Early Diversion Program, is developing a specialized

diversion team. The team, comprising police liaisons and case managers, will work with police officers to identify individuals in need of behavioral health services and connect them with community resources instead of arresting them.

D. Tackling Co-Occurring Disorders Using a Community-Based Response

Substance use and mental health disorders often co-occur, and in many instances require treatment for both disorders. In the general population, adults with a serious mental illness were more likely to experience dependence on or abuse of drugs or alcohol in the past year than those without any mental illness.[49] For offenders with a diagnosable substance use disorder, early intervention can make the difference between recurring criminal behavior and sustained recovery and mental well-being. SAMHSA requires grantees to ensure that community-based programs in its portfolio include effective screening for co-occurring disorders and appropriate treatment approaches. In 2013, SAMHSA's grantees screened more than 20,000 clients for co-occurring mental health and substance use disorders.[50]

E. Improve and Advance Substance Abuse Treatment in Prisons

The Federal Bureau of Prisons (BOP) is expanding access to evidence-based treatment for substance use disorders. In 2013, BOP implemented 18 new Residential Drug Abuse Treatment programs to reach more than 1,500 additional inmates, including two newly available Spanish-language treatment programs in Texas and Florida.

BOP has completed its portion of a demonstration project regarding the use of medication-assisted treatment in a community corrections environment. The project established a network of stakeholders that brought together community corrections, treatment agency staff, and other essential persons to better serve Federal offenders participating in Transitional Drug Abuse Treatment. The study demonstrated the benefits of establishing a network, and through this project, the Bureau determined medication-assisted treatment could be a viable treatment option for Federal offenders in a community corrections environment. BOP is now reviewing the possibility of conducting a trial study in which inmates would receive medication-assisted treatment for substance use disorders during the final weeks of their incarceration and then continue the medication-assisted treatment in the Residential Reentry Center. Based upon the outcome of the trial study, the Bureau will determine if a broader implementation of medication-assisted treatment should be pursued.

At the state level, BJA funds the Residential Substance Abuse Treatment program (RSAT) to help states create treatment programs for people in their custody that approximate residential treatment available in the community. Several grantees have used these funds to adopt and advance evidence-based treatment within their facilities. In Barnstable County, Massachusetts, the Sheriff, with support from community health officials, has started using Vivitrol—a medication for the treatment of opioid use disorders—to assist individuals in their return to their communities. The medication is only one aspect of their treatment: it helps prevent relapse while the individual with the substance use disorder works to make lasting behavioral changes. For each person in the RSAT program, there is a thorough risk and needs assessment to assist in planning for reentry. The Sheriff has already reported some success in this program, which started in 2012: of the 37 inmates treated, 59 percent remain in recovery and 2 people have stopped using Vivitrol to maintain their recovery.

In a further step to expand access to treatment for those in the criminal justice system, in March 2014 the Attorney General announced a new component of the Department of Justice's Smart on Crime initiative, through which the Bureau of Prisons (BOP) will impose new requirements on Federal halfway houses that help inmates transition back into society. Under the proposed new requirements, these halfway houses will have to provide a specialized form of treatment to prisoners, including those with mental health and substance use disorders.[51]

4. Create Supportive Communities to Sustain Recovery for the Reentry Population

A. Expand Reentry Support and Services through the Second Chance Act and Other Federal Grants

The Federal Interagency Reentry Council is helping reentering offenders compete for appropriate work opportunities. In the past year, the Office of Personnel Management, DOL, and the Equal Employment Opportunity Commission have issued guidance and best practices on the appropriate use of criminal histories in hiring procedures.[52,53,54]

B. Develop Ex-Offender Adult Reentry Programs

Several Federal programs are working to provide appropriate supportive services for individuals returning to their communities after a period of incarceration. For example, SAMHSA has funded 13 Offender Reentry Programs, which allow grantees to develop multidisciplinary approaches to planning, developing, and providing transitional services. These services include connecting ex-offenders with community-based substance abuse treatment and related reentry services before their release from jail or prison. In Chattanooga, TN, the program begins with reentry planning while offenders are still incarcerated to help them quickly adjust to daily life post-release. The Transitioning to Recovery program provides screening, assessments, and planning for offenders with substance use disorders and helps them stay engaged in treatment and recovery support services post-release through the use of intensive clinical case management.

C. Facilitate Access to Housing for Reentering Offenders

Access to safe, stable, affordable housing can be among the most significant barriers for individuals wishing to reenter their communities. An evaluation of Second Chance Act grantees, released in August 2013, noted housing instability as one of the foremost challenges for clients receiving reentry services. The Administration for Children and Families (ACF) has funded grants aimed at helping reentering fathers improve the quality and stability of family relationships by improving overall stability, such as housing and employment assistance. ACF is working with the Urban Institute on the Ex-Prisoner Reentry Strategies Study to evaluate the pilot grants and provide future guidance for other programs that improve chances of successful reentry for fathers and improved family relationships.

HUD is working with ONDCP to identify local public housing authorities who have implemented successful models for helping reentering offenders find safe and stable housing. More information about this project can be found in Chapter 3.

D. Provide Work-Related Training and Assistance to Reentering Offenders

DOL issues several grants that help prepare youth and adult ex-offenders for the workforce and remove barriers to employment. These include grants on Training to Work, Strategies Targeting Characteristics Common to Female Ex-Offenders, and Face Forward. As of mid-2013, the 1-year recidivism rate for adults involved in DOL-funded reentry programs was 13 percent.[55]

In 2013, DOL awarded two new grants to New York and Massachusetts to improve employment outcomes for formerly incarcerated individuals. The New York State Pay for Success Project: Employment to Break the Cycle of Recidivism will serve 1,000 individuals who are recently released from prison and have high employment needs with life skills assistance, transitional jobs, job placement, and post-placement support. The Massachusetts Juvenile Employment and Recidivism Initiative will reach more than 500 young men aging out of the juvenile justice system. These young men will have access to education and pre-vocational training as part of the grant program's long-term engagement in supportive services.

E. Encourage States Receiving Federal Funds for Corrections Programs to Provide Assistance to the Bureau of Justice Statistics in Conducting Annual Recidivism Studies

The Bureau of Justice Statistics (BJS) is working with data from state and Federal criminal history repositories to determine national estimates of recidivism. BJS has spent several years developing a software system that requests, captures, and processes large samples of rap sheets into research databases. The first product of this new technology is a report published in April 2014 describing the recidivism patterns of persons released from state prisons in 30 states in 2005.[56] Currently, BJS is working to develop statistically sound comparisons with its prior recidivism study of prisoners released in 1994, taking into account compositional differences in the demographic and criminal history attributes of the 1994 and 2005 release cohorts and changes in the nature and quality of information captured on rap sheets.

5. Improve Treatment for Youth Involved with the Juvenile Justice System

A. Develop and Disseminate More Effective Models of Addressing Substance Abuse and Mental Health Problems among Youth in the Juvenile Justice System

The Office of Juvenile Justice and Delinquency Prevention has issued several grants to expand interventions for justice-involved young people, including two training and technical assistance grants for juvenile substance abuse and family drug courts and program grants to seven family drug courts across the Nation. Family drug courts focus on treating substance use disorders among parents involved in the criminal justice system so they may be reunited with their children and provide safe, healthy home environments. For example, the Idaho Family Drug Court Enhancement Project will use the grant to expand the capacity of the drug courts from 40 to 60 participants per year, increase the percentage of children reunited with their parents, and provide comprehensive services to improve retention in the drug court program and success in recovery. Substance abuse and mental health assessments, improved case management, and recovery coaching services are among the wraparound supports the courts will provide.

In 2014, OJJDP will fund the implementation of the Reclaiming Futures model in up to three new sites. This model calls for a multi-disciplinary approach to working with juveniles in the justice system and integrates evidence-based treatment approaches that are appropriate to the adolescent populations served.

Chapter 5. Disrupt Domestic Drug Trafficking and Production

Drug trafficking organizations and the criminal activity associated with them can be found in every part of the United States. Whether they are operating watercraft along the California coast, using illicit crossborder tunnels along the Southwest border, or even using public lands for drug cultivation, these organizations unlawfully smuggle and distribute both illegal and diverted legal drugs in our communities. Trafficking and use of illicit drugs continue to constitute dynamic and challenging threats to the United States. Drug use not only poses risks to public health, but also is linked to violence and, in some cases, the financing of terrorism. Methamphetamine availability is on the increase because of sustained production in Mexico and ongoing small-scale domestic production. Additionally, marijuana availability appears to be growing because of sustained high levels of production in Mexico along with domestic cultivation.

Federal, state, local, and tribal law enforcement agencies play an integral role in the Administration's balanced approach to reducing drug use and its consequences. Maximizing Federal support for interagency law enforcement drug task forces is critical to leveraging limited resources. Law enforcement agencies and the intelligence community have strengthened cooperative efforts to address challenges related to information sharing and exchanging intelligence. Sharing information ensures law enforcement agencies are working together on targeted threats and taking full advantage of available resources. New and continued information sharing initiatives have led to substantial improvements in the combined intelligence capabilities of law enforcement.

Continued focus on security along the Mexican and Canadian borders also plays a significant role in reducing drug trafficking, use, and its consequences. Although still a serious concern, since 2008, crime in each of the four Southwest border states (California, Arizona, New Mexico, and Texas) has decreased significantly.[57] Transnational criminal organizations operating on both sides of the U.S.-Canada border also exploit the international boundary to smuggle proceeds from illegal drugs sold in the United States and Canada and to transport drugs such as marijuana, MDMA (ecstasy), methamphetamine, and cocaine between the two countries. Meanwhile, illicit proceeds cross the border in both directions, along with members of gangs and other organized crime groups, traffickers, facilitators, and couriers.

The Administration recognizes that communities across the country face distinct drug-related challenges. The abuse of non-controlled synthetic designer drugs such as synthetic cannabinoids, commonly referred to as "K2" and "Spice," and synthetic cathinones, commonly referred to as "bath salts," rapidly increased during the past several years, with serious public health and safety consequences. The Nation's law enforcement community must continue to focus on existing threats and collect information and data to address emerging threats. New economic developments in areas with limited resources like those occurring in the Bakken oilfields of Montana and North Dakota are resulting in an increase in drug-related criminal activity that requires a multi-agency approach.

It remains important that Federal, state, local, and tribal law enforcement agencies work together with prevention and treatment specialists to provide a balanced, holistic approach to reducing drug use and its consequences.

Working with Puerto Rico to Address Drug-Related Challenges

South American transnational criminal organizations are increasingly trafficking larger and more numerous drug shipments through the Caribbean region. As a result, drug trafficking remains a significant threat to Puerto Rico and the U.S. Virgin Islands (USVI). An increase in violent crime has contributed to social problems in Puerto Rico and the USVI. Continuing the work started by the Puerto Rico Interagency Public Safety Working Group (added to the President's Task Force on Puerto Rico's Status) in 2012, ONDCP is working with the Puerto Rico/USVI HIDTA and in close cooperation with DOJ, the Department of Homeland Security (DHS), and other Federal and local partners to confront the ongoing threat to public safety.

Federal, commonwealth, and local law enforcement agencies in Puerto Rico continue to conduct operations derived from real time intelligence. The Caribbean Corridor Strike Force (CCSF) is a Federal multi-agency strike force involving the United States Attorney's Office for the District of Puerto Rico, DEA, the Federal Bureau of Investigation (FBI), U.S. Immigration and Customs Enforcement (ICE)/Homeland Security Investigations (HSI), Coast Guard Investigative Service, U.S. Customs and Border Protection (CBP), and the Puerto Rico Police Department. The CCSF, which seeks to disrupt maritime drug trafficking in the Caribbean, relies on tactical assets from local law enforcement agencies, CBP, the United States Coast Guard (USCG), the DoD Joint Interagency Task Force (JIATF) South, and the naval forces of partner nations. Since its inception in 2005, CCSF operations have resulted in the seizure of 42,902 kilograms of cocaine, 1,655 kilograms of marijuana, 241 kilograms of heroin, and $15,296,554 in cash. CCSF activities have also resulted in the arrest of 293 individuals.[58]

The Illegal Firearms and Violent Crime Reduction Initiative, which involves the Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF), DEA, FBI, U.S. Attorney's Office, ICE/HSI, United States Postal Inspection Service, and the Puerto Rico Department of Justice, has been in effect since November 2011 in five judicial regions in Puerto Rico. The main objective of the initiative is to halt the use of illegal firearms by immediately detaining persons prohibited from possessing them (including convicted felons). To date, the initiative has resulted in 896 arrests and the seizure of 739 firearms and more than 20,000 rounds of ammunition. Notably, more than a third of those arrested had prior convictions.

1. Federal Enforcement Initiatives Must be Coordinated with State, Local, and Tribal Partners

A. Maximize Federal Support for Drug Law Enforcement Task Forces

Federal funding for drug law enforcement task forces enables state and local law enforcement agencies to participate in joint investigations, promotes local and regional coordination, and helps minimize duplication of effort. In 2012, HIDTA-funded initiatives disrupted or dismantled 3,030 drug trafficking organizations, removing significant quantities of drugs from the market and seizing over $819.0 million in cash and $1.1 billion in non-cash assets from drug traffickers ($1.9 billion total).[59] State and local

law enforcement agencies are active participants in Organized Crime Drug Enforcement Task Forces (OCDETF) Strike Forces. As of November 15, 2013, state and local law enforcement agencies were participating in 4,643 out of 5,098 OCDETF investigations (91.1 percent).[60]

At the Nation's borders, the Border Enforcement Security Task Forces (BESTs) have expanded to a total of 35 locations in 16 states and in Puerto Rico. From their inception in 2005 through August 2013, BEST units had collectively initiated more than 10,654 cases that resulted in the seizure of over $130 million in cash, 110,711 pounds of cocaine, 1.03 million pounds of marijuana, and 15,062 weapons.[61]

Currently there are 163 FBI-led Violent Gang Safe Streets Task Forces (VGSSTF), which are vehicles to join Federal, state, and local law enforcement agencies to effectively combat violent crime. The VGSSTF concept expands cooperation and communication among Federal, state, and local law enforcement agencies, increasing productivity and avoiding duplication of investigative effort. In Fiscal Year 2013, VGSSTF funded initiatives disrupted or dismantled over 2,300 violent gangs, the majority of which were involved in some form of criminal drug activity.

B. Improve Intelligence Exchange and Information Sharing

Systematic collection, analysis, and secure dissemination of accurate and timely intelligence are critical to thwarting the activities of criminal organizations. The HIDTA Investigative Support Centers and Domestic Highway Enforcement (DHE) program have used the DHS Homeland Security Information Network (HSIN) to share intelligence products and requests for information with their partners, including state and major urban area fusion centers (fusion centers), Regional Information Sharing System centers, the El Paso Intelligence Center (EPIC), and the OCDETF Fusion Center (OFC). In FY 2013 the OFC generated 4,079 unique actionable intelligence products that were disseminated to 15,890 investigators in the field. These actionable intelligence products provided analysis on 17,129 targets. This number represents a 21 percent increase over FY 2012.

As recommended in an April 2013 Government Accountability Office report, the HIDTAs are working to ensure that there is interoperability among the three deconfliction systems currently being used: the Secure Automated Fast Event Tracking Network (SAFETNET); RISS Officer Safety Event Deconfliction System (RISSafe); and Case Explorer (CE). The HIDTAs have worked with officials from DHS, DOJ, the office of the Program Manager for the Information Sharing Environment, and the Office of the Director of National Intelligence to integrate the three deconfliction systems.

Along the Nation's highways, the HIDTA DHE program integrates intelligence from border/source enforcement efforts and transit/destination investigation activity. Increased awareness from the HIDTA DHE program resulted in the submission of 6,533 incidents reported as traffic stops to EPIC's National Seizure System (NSS) in Calendar Year 2013, which resulted in 8,660 seizures reported to the NSS.

C. Ensure State and Local Law Enforcement Access to Federal Information on Mexico-Based Traffickers

Current intelligence on Mexico-based traffickers must be readily available to state, local, and tribal law enforcement. State, local, and tribal law enforcement agencies are many times the first to encounter suspects associated with Mexico-based traffickers. The EPIC Strategic Analysis Section provides all-source

strategic intelligence, including the Gatekeeper Project[62] assessments, in support of Federal, state, local, and tribal law enforcement activities along the U.S.-Mexico border.

The Financial Crimes Enforcement Network (FinCEN) provides 140 state and local law enforcement agencies with direct access to financial data through its Internet portal and directly supports state and local investigative efforts through its participation in the Southwest Border Anti-Money Laundering Alliance, with which it shares finished intelligence products. FinCEN recently changed its organizational structure to more effectively map, target, and disrupt the financial networks of drug trafficking organizations, support Federal, state, and local law enforcement actions, and more strategically apply its own enforcement and regulatory authorities. FinCEN and the Treasury Department continue to partner with other governments to target illicit financial networks, transnational criminal organizations, drug trafficking organizations, and other criminal actors.

D. Promote Law Enforcement Collaboration along Drug Trafficking Corridors via "Gateway/Destination" Initiatives

Law enforcement information sharing is essential to reducing the drug-related violence that often occurs along drug, money, and weapon trafficking corridors. Increased technology integration at more border ports of entry has forced smugglers to seek other alternatives to smuggle illicit drugs, such as illicit cross-border tunnels, ultra-light aircraft, and the use of panga boats along the California coast. Transnational criminal organizations use these vessels primarily to smuggle marijuana around the land border through the waters off the Southern California coast (from San Diego to as far north as Monterey County).

DEA continues to provide access to the De-Confliction & Information Coordination Endeavor (DICE), a web-based software tool for use by HIDTAs and other state, local, tribal, and Federal law enforcement agencies that provides the ability to de-conflict information such as phone numbers, Push-to-Talk IDs, email addresses, license plates, and other types of data. Through DICE, state and local law enforcement receive notifications involving overlaps of data among investigations. DICE is sponsored by over 102 DEA field division, district, and resident offices, and at the most recent count, DICE has over 17,600 active users (33 percent are state, local, or tribal and 67 percent are Federal law enforcement).

E. Assist Tribal Authorities to Combat Trafficking on Tribal Lands

Seven HIDTA programs collaborate on enforcement operations and training with tribal nations. In Arizona, for example, the HIDTA has provided training and equipment to tribal law enforcement while also coordinating a task force interdiction effort with state, local, and tribal agencies. In the summer of 2013, the Native American Targeted Investigation of Violent Enterprises (NATIVE) Task Force was created as a new HIDTA Initiative for the Arizona HIDTA. NATIVE is a cooperative Federal and tribal task force targeting smuggling operations throughout the Tohono O'odham Nation. NATIVE includes law enforcement personnel from the Tohono O'odham Police Department, ICE/HSI Shadow Wolves, and the Bureau of Indian Affairs Drug Enforcement Division.

In 2013, the FBI conducted a Violent Crime Threat Assessment on the Navajo Nation (AZ) and subsequently held meetings to discuss the scope of the threat and available resources. Additionally, in January 2013 the FBI and DOJ Office of Legal Education sponsored a Criminal Enterprise training course at the National Advocacy Center with approximately 53 attendees, most of whom were tribal police officers.

F. Ensure Comprehensive Review of Domestic Drug Threat

ONDCP's Office of Intelligence will collaborate with its intelligence community colleagues in DHS, DOJ, the Office of the Director of National Intelligence, and other relevant agencies to ensure that national policy makers are provided with the best possible domestic all-source counterdrug intelligence analysis. In support of this endeavor, DEA completed and distributed the *National Drug Threat Assessment* in June 2013. ONDCP's Office of Intelligence will continue to collaborate with DEA and other applicable intelligence community, law enforcement, and domestic health agencies on successive iterations of the *National Drug Threat Assessment,* while also continuing to further develop and refine the requirements for domestic, strategic, all-source drug intelligence analysis and improving the quality, scope, sophistication, and usefulness of products presented to policy makers.

2. U.S. Borders Must be Secured

A. Implement the *National Southwest Border Counternarcotics Strategy*

The Southwest border is a major arrival zone for illicit drugs, weapons, and money, and the implementation of the *National Southwest Border Counternarcotics Strategy* is critical to addressing these threats. DHS has increased the funding it provides to state and local law enforcement to address border-related crime through the Operation STONEGARDEN[63] grant program. In 2013, $55 million in Federal funds was awarded to states bordering Mexico, Canada, (including Alaska), and states and territories with international water borders. Based on risk, cross-border traffic, and border-related threat intelligence, 80 percent of Operation STONEGARDEN awards between 2011 and 2013 went to Southwest border states. The Southwest Border HIDTA consists of five Regional HIDTAs in Texas, New Mexico, Arizona, and California and has continued to effectively facilitate programs that provide a forum for interagency cooperation at the state, local, tribal, and Federal level.

B. Implement National Plan for Outbound Interdiction of Currency and Weapons

The enormous amount of money generated by drug sales in the United States and its outward flow fuels the operations of violent drug trafficking organizations. In FY 2013, OCDETF Program Co-located Strike Forces expanded the participation of state and Federal agencies in several key locations, enhancing their ability to address the outbound flow of currency and weapons. The San Diego OCDETF Strike Force added the ICE/HSI Marine Task Force, as well as a multi-agency Anti-Money Laundering Group. The Arizona OCDETF Strike Force completed its expansion to Tucson and added a full FBI enforcement group. The New Mexico office of the El Paso Strike Force also secured FBI participation in FY 2013. The Houston/South Texas OCDETF Strike Force expanded to add an additional office in San Antonio.

In addition, DEA expanded the National License Plate Reader Initiative. The National License Plate Reader Initiative is a complex camera and alerting system strategically located along the Southwest border that DEA uses to monitor and interdict roadway conveyances suspected of transporting bulk cash and other contraband.

ATF has increased its capability to identify, disrupt, and dismantle organized efforts to traffic firearms from the United States to Mexico. In September of 2010, Mexico's Attorney General signed a Memorandum of

Understanding to trace seized firearms through the Spanish version of ATF's successful eTrace program. As of December 31, 2012, approximately 350 Mexican law enforcement personnel had received training and access to Spanish eTrace, and several additional training sessions were presented in 2013-2014.

C. Coordinate Efforts to Secure the Northern Border Against Drug-Related Threats

In January 2012, following an extensive consultation process, the Administration released the first *National Northern Border Counternarcotics Strategy*, a framework for ongoing efforts to reduce the drug threats on both sides of the U.S.-Canada border. The *Strategy* builds upon the understanding of shared responsibility articulated in *Beyond the Border: A Joint Vision for Perimeter Security and Economic Competitiveness*. The *Strategy* also recognizes the reality that transnational criminal organizations operating on both sides of the U.S.-Canada border exploit the international boundary to smuggle proceeds from illegal drugs sold in the United States and Canada and to transport drugs such as marijuana, MDMA (ecstasy), methamphetamine, and cocaine between the two countries. To increase each country's individual security and economic prosperity, the United States and Canada must appropriately plan, train, and act together to address threats at the earliest point possible and work toward optimizing joint border management goals.

Currently, ONDCP, in consultation with interagency partners, Canadian counterparts, and other stakeholders, is drafting an update to the *Strategy*, to be released in 2014. As in the previous *Strategy*, numerous departments and agencies will be charged with implementing the more than 40 specific action items. A report on the progress of implementing the action items and identified performance measures will also be released in 2014.

D. Deny Use of Ports of Entry and Routes of Ingress and Egress Between the Ports

Air and maritime ports represent a unique challenge with regard to drug-related threats. In FY 2013, DOJ and DHS continued to engage in operations that coordinated U.S. Federal, state, local, and tribal law enforcement agencies with international (Government of Mexico) forces to disrupt and dismantle transnational criminal organizations. Some of the operations are year-round efforts employing a whole-of-government approach. Also in 2013, all required bi-national documents were completed under the U.S.-Canada Integrated Cross-border Maritime Law Enforcement Operations "ShipRider" agreement, and regular activities began in USCG Districts 1, 9, and 13. This agreement reduces the ability of drug traffickers to use the international border to evade pursuit.

Efforts will continue to promote collaboration and increase effectiveness by co-locating coordination centers and local fusion centers with OCDETF Southwest Border Strike Forces and BESTs. DHS has 14 of its 35 BESTs located on the Southwest border. These teams include participation from ICE/HSI, CBP, DEA, ATF, the U.S. Attorney's Office, the USCG, state and local law enforcement agencies, and, in some locations, Mexican law enforcement liaisons.

E. Disrupt Surveillance Operations of Drug Trafficking Organizations

Along the Southwest border, drug trafficking organizations employ large numbers of strategically placed spotters who closely observe the enforcement activities of CBP officers and agents, canines, and

inspection technology. In turn, these spotters provide guidance to traffickers entering the United States. Traffickers also use advanced technology to intercept law enforcement communications.

Law enforcement agencies employ countermeasures to target the tactics and methods of transnational criminal organizations and to locate and apprehend spotters as they conspire to traffic and smuggle drugs, money, weapons, and humans. While the details of such countermeasures are understandably sensitive, they may include frequent and random personnel rotations, as well as employment of counter-surveillance techniques and activities designed to locate, identify, apprehend, and prosecute spotters.

The FBI created the National Border Corruption Task Forces (BCTFs) in cooperation with the DOJ Public Integrity Section, CBP-Internal Affairs, and Transportation Security Administration (TSA) Office of Inspection. The mission of the BCTFs is to enhance communication, coordination, and cooperation among Federal, state, and local government agencies representing the law enforcement, intelligence, and homeland security communities to more effectively combat corruption at our Nation's borders and ports of entry. There are 23 local BCTFs within 15 FBI field offices. This includes 15 BCTFs operating on the Southwest border and three BCTFs on the Northern border. Currently, there are 91 FBI agents and 103 task force officers from various agencies assigned to the BCTFs. The mission of the BCTFs is to enhance communication, coordination, and cooperation among Federal, state, local, and tribal government agencies representing the law enforcement, intelligence, and homeland security communities to more effectively combat corruption at our Nation's borders and ports of entry. In Fiscal Year 2013, these task forces were responsible for 47 arrests, 41 indictments, and 40 convictions.

3. Focus National Efforts on Specific Drug Problems

A. Counter Domestic Methamphetamine Production

The Administration remains committed to reducing the production, trafficking, and use of methamphetamine. In 2012, more than 8,300 methamphetamine laboratories were seized nationwide. The number of laboratories seized was more than double that in 2007, although seizures remained low in states such as Oregon and Mississippi, where pseudoephedrine is available only by prescription. Nationwide, the laboratories seized during the last few years are smaller and produce significantly smaller quantities; however, the danger posed by these small toxic labs and the drugs they produce remains significant.

We have seen progress in decreasing the prevalence of methamphetamine use in the United States: according to NSDUH, the number of past month methamphetamine users has declined 40 percent since 2006. However, availability indicators reflect that the supply of Mexican methamphetamine is increasing in the United States. Price and purity data and increased methamphetamine seizures across the Southwest border indicate rising domestic availability, most of which is the result of high levels of methamphetamine production in Mexico. Seizures of Mexican methamphetamine coming across the Southwest border have increased over sixfold between 2008 (2,282.6 kilograms) and 2013 (14,400 kilograms).

To address these threats, the HIDTA program's National Methamphetamine and Pharmaceuticals Initiative (NMPI) provides assistance through coordination, information sharing, and training for prosecutors, investigators, intelligence analysts, and chemists to: enhance the identification of criminal targets;

increase the number of chemical/pharmaceutical drug related investigations and prosecutions; and curtail foreign chemical and precursor sources that are used by domestic illicit drug manufacturers.

B. Identify Interior Corridors of Drug Movement and Deny Traffickers Use of America's Highways

Drug traffickers use our Nation's roads and highways to move large amounts of drugs, currency, weapons, and other illicit contraband. The HIDTA DHE program has funded specialized equipment, training, intelligence-sharing activities, and operational capabilities to address this threat. The DHE strategy is based on collaborative, intelligence-led policing to enhance law enforcement efforts on interstate highways specifically identified as drug trafficking corridors. In FY 2012, DHE task forces removed $432.4 million worth of drugs and disrupted or dismantled 32 drug trafficking organizations. Drug-related cash seizures totaled $58.6 million and other drug-related assets seized were valued at $3.2 million.

To enhance DHE enforcement effectiveness, EPIC System Portal (ESP) account holders are able to access HSIN via the ESP. The website allows DHE informational reports and current trends associated with drug trafficking to be accessed by law enforcement officers across the Nation. DHE Coordinators also host 100 Information Sharing Corridor Web meetings per year. Information collected during the corridor meetings is posted live to DHE HSIN. There are more than 500 vetted users from Federal, state, and local law enforcement agencies, with 3,000 searchable corridor drug trafficking documents posted.

C. Address Marijuana Cultivation and its Threat to Public Safety and the Environment

Disrupting the cultivation of marijuana on the Nation's public lands and its attendant public safety and environmental dangers is a priority for the Administration's enforcement of the Controlled Substances Act.[64] Federal enforcement efforts also prioritize the prevention of violence and the use of firearms in the cultivation and distribution of marijuana. Grow sites—even those on public lands—often are protected by booby traps and armed guards. DEA reports that in 2012 more than 10,000 weapons were seized from marijuana cultivation sites, more than double the number seized in 2011.[65]

The cultivation of marijuana frequently entails the diversion of water resources, the clearing of native brush, and the use of banned pesticides. During the 2013 eradication season, the California Campaign Against Marijuana Planting (CAMP) reported that eradication teams seized 44.3 miles of water line and dismantled 89 dams or illegal reservoirs that had been constructed to irrigate marijuana gardens. Of the 284 grow sites and nearly 1 million marijuana plants seized by CAMP teams in 2013, 114 grow sites and more than half a million plants were on public lands. Eradication efforts on public lands are assisted by the National Guard Counterdrug Program, which provides helicopter flight hours, analyst support, and program management.

The HIDTA program seeks to address the issue of marijuana cultivation on public lands through the National Marijuana Initiative (NMI), a law enforcement support initiative that seeks to detect, deter, and disrupt domestic marijuana cultivation and trafficking by coordinating investigations and interdiction operations. The NMI's efforts are coordinated with the Public Lands Drug Control Committee (PLDCC), a Federal interagency group that aligns policies and coordinates programs to support marijuana eradication operations, investigations, and related intelligence and information sharing.

Marijuana Cultivation: A Threat to Wildlife

Illicit marijuana cultivation threatens the wildlife inhabiting National Forests and other public lands. Information compiled by CAMP shows that in the 2013 eradication season, law enforcement officers seized 6.8 metric tons of fertilizer, 307 pounds of common pesticides, and 3.1 gallons of extremely hazardous restricted poisons from grow sites. These materials indiscriminately kill wildlife, leach into the soil, and ultimately contaminate the water table, potentially causing irreparable damage.[66] In July 2013, researchers with the University of California-Davis and the Hoopa Valley Tribe found evidence that marijuana cultivators were deliberately poisoning wildlife on public lands.[67] At a marijuana cultivation site, law enforcement officers discovered poisoned hot dogs hung from fishing hooks. Approximately 10 meters away, law enforcement found a dead adult male fisher, a rare forest carnivore declared a candidate species for listing under the Endangered Species Act. A full necropsy conducted by a board-certified veterinary pathologist revealed that the animal died from acute carbamate insecticide (methomyl) poisoning associated with contaminated bait.

Previously, researchers had documented the presence of poisonous chemicals and toxicants at marijuana cultivation sites inhabited by fishers; however, the July incident was the first confirmed intentional poisoning of a fisher with an insecticide associated with a marijuana cultivation site. Researchers will continue to study the effects of marijuana cultivation on fishers. Additional research, funded primarily by the U.S. Fish and Wildlife Service, is planned to determine whether rat poisons used around marijuana grow sites are responsible for the deaths of rare spotted owls.

D. Target Indoor Marijuana Production

Pressure from marijuana eradication efforts has caused many cultivators to abandon large outdoor cannabis plots in favor of indoor cultivation that is easier to conceal. In 2012, researchers documented public health risks associated with indoor marijuana grow operations, including elevated mold spore levels high enough to require respiratory protection for investigators entering the site. Researchers also found pesticides and fertilizers within the reach of children residing in the homes where the grow sites were operating. The detection of these indoor grows has proven challenging for law enforcement. In 2013, DEA and partner agencies seized more than 2,754 indoor grow operations, with 361,727 plants eradicated.[68]

E. Partner with Local Law Enforcement Agencies to Combat Street, Prison, and Motorcycle Drug Gangs

The California Gang Intelligence Initiative (CGII) is a joint intelligence collection and analysis task force consisting of the FBI Safe Streets Gang Unit, BOP, California Department of Corrections and Rehabilitation (CDCR), and the National Gang Intelligence Center (NGIC) to identify, analyze, and disseminate intelligence within the CDCR and BOP relevant to California prison gang leadership, members, associates, and facilitators that enable gangs and gang activity to extend beyond the prison setting and into the community. CGII continues to serve as a resource for law enforcement agencies across the Nation for alternative avenues of case support, intelligence collection, and potential source recruitment. Currently, CGII is composed of 23 FBI personnel, one BOP Special Agent, and 20 CDCR personnel.

The FBI, through personnel assigned to NGIC, ensures gang intelligence products are released to Federal, state, local, and tribal law enforcement through Law Enforcement Online (LEO) and NGIC Online. FBI works closely with the National Alliance of Gang Investigators Association (NAGIA), which represents over 20,000 gang investigators across the country. Requests for information on gangs are disseminated to the NAGIA membership and are addressed through Requests for Information submitted to the FBI's Safe Streets Gang Task Forces, as well as to the other government agencies represented at NGIC.

The FBI works with local and international law enforcement partners to address the growing population of individuals joining or associated with Outlaw Motorcycle Gangs (OMGs), organizations whose members use their motorcycle clubs as conduits for criminal enterprises. OMGs are using their members to sell and traffic in heroin, cocaine, large quantities of marijuana, and methamphetamine. The oil-producing Bakken region has experienced a large influx of OMGs attempting to establish "ownership" of the territory, facilitating the illegal drug trade and prostitution. The FBI, working in concert with its local and international partners, is continuing to aggressively investigate the activities of these groups.

F. Disrupt Illicit Financial Networks by Exploiting Cash Seizures

The National Bulk Cash Smuggling Center (BCSC) provides its Federal, state, and local law enforcement partners with real-time intelligence, investigative support, and expertise in addressing the illicit transportation and smuggling of bulk cash. Since its inception in 2009, the BCSC has initiated more than 700 criminal investigations for referral and has played an active role in more than 550 criminal arrests and currency seizures totaling $206.6 million.

DEA works to identify co-conspirators, shell corporations, and assets used by drug trafficking organizations around the world, and evidence and intelligence gleaned from its investigations often provide critical information on terrorist financing. Towards the end of FY 2013, EPIC consolidated three units involved in financial intelligence into the Financial Intelligence Unit to better focus on supporting the financial aspects of investigations in response to customer requests. EPIC's Bulk Currency Team, within the Financial Intelligence Unit, conducts research on bulk currency seizures, providing intelligence information to law enforcement agencies for tactical and operational support. As of August 31, 2013, DEA had successfully denied drug traffickers $2.1 billion in illicit revenue. From FY 2005 through August 31, 2013, DEA had denied over $24 billion in revenue to drug traffickers.

In 2013, DEA conducted 5 financial investigation training seminars for 87 Federal, state, and local law enforcement officials. In addition, OCDETF conducted 9 financial training seminars in FY 2013 for 595 attendees.

The OFC Pro-Active Asset Targeting Team was established in September 2010 and identifies criminal case connections through review and analysis of FinCEN's suspicious activity reports. As of September 2013, the OFC Proactive Asset Targeting Team identified 13,206 bank accounts, 4,139 vehicles, and 5,820 businesses with suspicious activity and seized assets totaling more than $56 million.

Through direct support to law enforcement conducting drug investigations, the National Guard Counter Threat Finance (CTF) Program supported over 566 money laundering investigations. Subjects of investigation included outlaw motorcycle gangs on the Northern border, transnational criminal organizations on the Southwest border, and financial institutions and front companies with links to

terrorist financing, precursor chemical diversion, drug trafficking, and money laundering. Within this target set, National Guard CTF Analysts identified over 1373 targets and 639 money laundering methods previously unknown to law enforcement.

G. Interdict Drug Trafficking through Mail and Parcel Services

CBP, TSA, and the United States Postal Service are working with the Universal Postal Union and others in the international postal community to enhance the screening of international mail prior to its conveyance to the United States. The parties are developing the foundations for providing advance electronic data on international mail packages to allow CBP and TSA to perform risk-based targeting prior to foreign departure and entry into the domestic mail supply chain. This strategy will enhance CBP's ability to identify, interdict, and disrupt the movement of illicit drugs and stem the persistent threat posed by the smuggling of counterfeit pharmaceuticals and "gray market" goods. This approach is also linked to the *Long Term Strategy for the Screening of International Mail* and the *Global Supply Chain Strategy*.

The Laboratories and Scientific Services Directorate (LSSD) is the scientific arm of CBP. Over 15 years ago, LSSD implemented Operation Safeguard to prevent counterfeit and illicit pharmaceuticals from entering the United States. Operation Safeguard now includes participation from numerous other agencies, including the U.S. Postal Inspection Service, ICE/HSI, and the FDA. While each agency has its own compliance and enforcement objectives for Operation Safeguard, the collective efforts are coordinated by LSSD to maximize efficiency and effectiveness. Operation Safeguard activities are conducted monthly at International Mail Facilities and Express Consignment Centers throughout the United States. Each onsite examination period lasts several days and entails the inspection of hundreds of parcels containing pharmaceuticals and designer drugs. In Fiscal Year 2013, parcels containing over 2,000 different pharmaceutical products were processed and analyzed.

H. Establish Interagency Task Force on Drug Endangered Children

Over a decade ago, the Drug Endangered Children (DEC) movement was founded to address the growing phenomenon of children living in environments made unsafe and unhealthy by drug activity. Some actions had been taken at the state level, but prior to the establishment of the Federal Interagency DEC Task Force, a cohesive and coordinated Federal response was lacking. Initiated as part of the 2010 *National Drug Control Strategy,* the DEC Task Force gathered and produced educational resources (model protocols, programming, promising practices, and downloadable checklists) to aid law enforcement, child welfare workers, health and education professionals, and children's advocates nationwide. In addition, the DEC Task Force expanded the definition of drug endangered children to include children living in an environment where drugs, including pharmaceuticals, are illegally used, possessed, trafficked, diverted, and/or manufactured. In 2012, the DHS Federal Law Enforcement Training Center (FLETC) assembled experts from the National DEC Training and Advocacy Center, the National Alliance for Drug Endangered Children, criminal justice professionals, and FLETC staff to begin development of two courses on drug endangered children for Federal, state, local, tribal, and international law enforcement agencies. Both training programs were developed in 2013 and approved as Center Advanced Programs. The Introduction to Drug Endangered Children Training Program was piloted in August 2013. The Drug Endangered Children Investigations Training Program was approved but has not yet

been piloted. DEA continues to raise awareness and provide training on DEC issues for domestic and international law enforcement professionals, educators, social service professionals, first responders, and community leaders.

Advocate for Action: Judge Robert Russell

In January 2008, Judge Robert Russell created and began presiding over the first Veterans Treatment Court in the United States. The Veterans Treatment Court is a hybrid Drug Court/Mental Health Court model for justice-involved veterans that features regular court appearances (a bi-weekly minimum in the early phases of the program), mandatory attendance at treatment sessions, and frequent and random testing for substance use (drug and/or alcohol). The Veterans Treatment Court acts as a "one-stop shop" at the courthouse, with a team of Federal, state, and local veterans agencies and organizations working together to link veterans with the programs, benefits, and services they have earned. For his dedication and perseverance in helping this country's veterans, the Vietnam Veterans of America has awarded Judge Russell with the Vietnam Veterans of America Achievement Medal and the Veterans of Foreign Wars of the United States has awarded Judge Russell with the James E. Van Zandt Citizenship Award.

Judge Russell has been a pioneer in the drug treatment court movement and remains a strong leader to this day. In December 1995, Judge Russell created the Buffalo Drug Treatment Court and continues to serve as the Presiding Judge. In addition, in December 2002, he established and began serving over Buffalo's Mental Health Treatment Court.

Judge Russell is the Past Chairman of the Board of Directors of NADCP and the Past President of the New York State Association of Drug Treatment Court Professionals, Inc. He also serves on the National Advisory Board of the Judges' Criminal Justice and Mental Health Leadership Initiative. He is the recipient of several Awards of Merit from the American Bar Association, New York State Bar Association, and the Erie County Bar Association.

I. Respond to the Emerging Threat of Synthetic Drugs

Communities across the United States are facing new challenges related to the threat of synthetic drugs, an umbrella term that includes synthetic cannabinoids ("herbal incense"), synthetic cathinones ("bath salts"), and synthetic hallucinogens like the "2-C" and "NBOMe" series compounds. In 2013, poison control centers logged more than 2,600 exposures[69] to synthetic cannabinoids[70] and nearly 1,000 exposures to synthetic cathinones. While the Administration and state drug control agencies have moved quickly to control many of these substances, producers and traffickers have proven adept at altering the chemical composition of the drugs to exploit gaps in controls. Policy makers and legislators at both the national and state levels must remain vigilant to ensure this threat is contained.

J. Coordinate the Interagency Response to Emerging Drug Related Criminal Activity in Locations with Limited Law Enforcement Resources

The development of the Bakken oil fields of northeastern Montana, northwestern North Dakota, and southern Saskatchewan has caused a sharp spike in both population and income levels. Between 2005 and 2012, the population in the Williston Basin region—driven by the addition of more than 20,000 jobs—grew an estimated 17 percent. This influx of highly paid oil field workers into an area with limited opportunities for spending their income has created a market for drugs and contributed to an overall increase in crime. The FBI Uniform Crime Report shows that crimes in the Williston Basin region increased 32 percent from 2005 through 2011, and violent crimes (which include murder, aggravated assault, forcible rape, and robbery) increased 121 percent. These dramatic increases have overwhelmed state, local, and tribal law enforcement agencies working with limited resources.[71]

In response to this burgeoning threat, FBI and other Federal agencies have partnered with state, local, and tribal law enforcement agencies to conduct task force operations in the Bakken region. Collaborative efforts among Federal, state, local, and tribal partners in June 2013 resulted in the arrest of 22 people and, in October 2013, a coordinated effort led to 4 arrests in North Dakota and 12 in Montana. In both efforts, the charges predominantly were related to drugs, specifically heroin and methamphetamine, which have become increasingly available in the Bakken region. The National Guard assists these efforts by providing intelligence support, including collection, analysis, and dissemination of intelligence data submitted by Federal, state, and local agencies.

In December 2013, ONDCP and the White House Domestic Policy Council (DPC) convened an interagency meeting to explore a comprehensive Federal response to deal with the complex justice, public health, and social issues that have arisen in the area. Moving forward, the Administration will continue to work on law enforcement, quality of life, women's safety, and tribal issues.

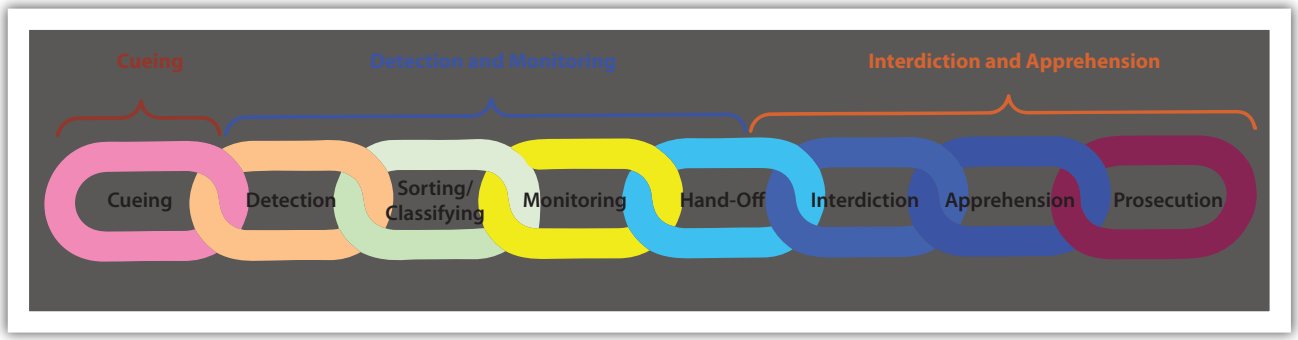
Chapter 6: Strengthen International Partnerships and Reduce the Availability of Foreign-Produced Drugs in the United States

The United States is engaged internationally in bilateral and regional partnerships that are critical aspects of our efforts to reduce drug use and its consequences. Central to these partnerships is a balanced and effective strategy that assists our international partners to reduce the supply of drugs and the demand for those drugs in their communities. Supply reduction enables governments to more effectively address the entire range of negative consequences associated with drug use. The impact of supply reduction policy can be seen most clearly through the dramatic reduction in cocaine supply and demand over the last decade.

Activities far from our shores, such as interdiction on the high seas or cooperating with foreign governments around the world, are too often seen as part of a distant struggle. In reality these efforts have a direct impact within the United States. Available information indicates that cocaine consumed in the United States is almost exclusively derived from Colombian-sourced cultivation and production. Since 2006, cocaine production in Colombia has been reduced, while large multi-ton seizures have been made within South America and the transit zone. The combined effect of eradication, alternative development, law enforcement, and maritime interdiction efforts has contributed to a sharp reduction in cocaine availability in U.S. communities. There also have been significant reductions in cocaine use, treatment admissions, emergency room visits, and overdose deaths. A balanced approach to both demand and supply reduction is essential; and while we have made significant progress in the area of cocaine, recent increases in domestic heroin and methamphetamine use necessitate continued attention and collaboration.

Interdiction operations in the transit zone have been essential to supply reduction efforts. Interdiction can be understood by examining the interdiction continuum (Figure 2). The interdiction continuum reduces the availability of illicit drugs in our communities while providing valuable intelligence that contributes to drug seizures, arrests, prosecutions, and the ultimate disruption and dismantling of international drug trafficking organizations. A successful interdiction continuum, involving cooperation across the interagency, is self-sustaining. Seizures produce new intelligence and advance investigations into major transnational criminal networks. These activities lead to more actionable intelligence on future events, producing follow-on seizures and contributing to a cycle of success.

Figure 2. The Interdiction Continuum



The U.S. cocaine market has been dramatically transformed, but the threat still remains. Prioritization of resources—affecting our assistance to foreign partners and our interdiction efforts in the transit zone—complicate our efforts to sustain the momentum of the last decade in driving down cocaine supply, consumption, and consequences. Additionally, increases in heroin and methamphetamine trafficking remind us of the threats posed by other drugs. The Administration will examine options to address these challenges in the coming year.

U.S. international initiatives also include expanding global prevention and treatment initiatives through collaboration with partner nations and multilateral organizations. By establishing international partnerships on demand reduction, evidence-based practices will become the standard for global prevention, treatment, and recovery programs. This international collaboration will serve to reduce both the supply and demand for drugs within the global community.

There is more work to be done to consolidate previous efforts. The United States and its partners need to make more efficient use of resources by coordinating activities to disrupt the operations of criminal networks, best accomplished by employing all relevant agencies and their respective legal authorities and operational capabilities.

1. Collaborate with International Partners to Disrupt the Drug Trade

A. Conduct Joint Counterdrug Operations with International Partners

Collaboration with partner nations remains a cornerstone of the *Strategy*. Such collaboration is often reflected in counterdrug operations, such as the DEA-led Operation All Inclusive, the ninth iteration of which took place in 2013. Sixty-seven land, air, maritime, financial, and chemical operations were conducted from intelligence generated by Operation All Inclusive; these operations resulted in the arrest of 1,097 individuals, including two Consolidated Priority Organization Targets (CPOTs), and the seizure of 80 metric tons of cocaine, 1,562 kilograms of methamphetamine, 200 kilograms of heroin, 122 metric tons of precursor chemicals, $19 million in U.S. currency, and 1,163 weapons. In 2013 USCG aircrews from the Helicopter Interdiction Tactical Squadron (HITRON) conducted cross-deck operations with Airborne Use of Force (AUF) capable helicopters on Dutch and British naval vessels, and a USCG Law Enforcement Detachment completed a proof of concept deployment in which Dutch small boats were

authorized to conduct surface use-of-force operations, providing additional capability in the Eastern Caribbean. Additionally, in 2013 Operation MARTILLO, a 14-nation combined operation to deny use of Central America as a trafficking corridor, resulted in the disruption of the trafficking of more than 132 metric tons of cocaine, 41 thousand pounds of marijuana, $3.5 million in bulk cash, 315 arrests, and the seizure of 107 vessels, vehicles, and aircraft. The pressures put upon trafficking organizations by Operation MARTILLO resulted in a 38 percent decrease in illicit air trafficking activity and decreases of 29 percent and 57 percent of the illicit maritime activities in the Western Caribbean and Eastern Pacific littoral routes, respectively.

Advocate for Action: Commander Harry Schmidt

CDR Harry Schmidt is being recognized as an Advocate for Action for his tireless work to strengthen international partnerships against transnational organized crime and illicit trafficking. CDR Schmidt led the expansion of the Multilateral Maritime Counterdrug Summit from eight to 17 partner nations in the Western Hemisphere transit zone, sharing operational and legal expertise to improve transnational cooperation and coordination in the apprehension and prosecution of major drug smugglers. The program has been so successful that the Department of State asked CDR Schmidt to replicate the Summit as part of the Caribbean Basin Security Initiative; the first meeting was held in March 2014. CDR Schmidt also initiated and developed the concept for *Coast Guard Support to Interdiction and Prosecution*, an initiative through which three-person USCG teams will be embedded within select U.S. embassies in the Western Hemisphere transit zone. These teams will assist regional partners in case documentation, evidence handling, and prosecution of maritime drug smuggling cases. Through these and other ongoing efforts, CDR Schmidt is helping to strengthen international partnerships to reduce drug production, trafficking, use, and their consequences.

B. Work with Partner Nations and OAS/CICAD to Strengthen Counterdrug Institutions in the Western Hemisphere

The United States delegation to the Organization of American States Inter-American Drug Abuse Control Commission (OAS/CICAD) continued to share U.S. drug policy research and best practices with Western Hemisphere partners in 2013. The U.S. Government continued to work within the OAS/CICAD Intergovernmental Working Group to update and enhance the Multilateral Evaluation Mechanism (MEM). The MEM evaluates implementation of drug control efforts by CICAD member states and provides recommendations for improvement. DEA and USCG also participated in CICAD Expert Working Groups on anti-money laundering, chemicals and pharmaceuticals, and maritime interdiction, all of which produce guides and model regulations and legislation for use by OAS countries. The United States will work to promote the priorities developed by the Brazilian Chair of the OAS/CICAD Demand Reduction Experts Group, focusing on training health care system professionals on Screening and Brief Intervention strategies and enhancing the treatment/rehabilitation skills of addiction counselors.

C. Work with Partners in Europe, Africa, and Asia to Disrupt Drug Flows in the Trans-Atlantic and Trans-Pacific Regions

The Departments of State, Homeland Security, Justice, and Defense continued to coordinate interagency efforts to promote bilateral and regional cooperation against drug trafficking and transnational organized crime in Europe, Africa, and Asia in 2013. Efforts to promote coordination among donor nations regarding drug trafficking and transnational crime in West Africa were the focus of a U.S.-hosted January 2013 G8 Roma-Lyon Group meeting. The United States coordinates an array of drug issues through semi-annual drug policy discussions in Brussels with the European Commission and member state representatives. The USCG is a member of both the 20-member North Atlantic Coast Guard Forum and the six-member North Pacific Coast Guard Forum, two distinct international organizations that promote multilateral cooperation among member coast guards. In 2013, JIATF West, DEA, and INL continued to partner through the Narcotics Enforcement Training Team (NETT), which focuses on the development of partner nation counterdrug investigative units that operate with U.S. law enforcement. Current efforts are concentrating on assisting Thailand in building the capability to conduct comprehensive investigations against transnational criminal organizations.

Another initiative that promotes bilateral and regional cooperation against drug trafficking and transnational organized crime is the DEA-sponsored International Drug Enforcement Conference (IDEC), a global forum that provides an opportunity for senior drug law enforcement officials to meet, deliberate, and determine the most effective strategies to disrupt and dismantle drug trafficking organizations. The strategies behind many past and future operations are discussed in regional, multilateral, and bilateral meetings that are at the core of IDEC's activities.

D. Coordinate with Global Partners to Prevent Synthetic Drug Production and Precursor Chemical Diversion

The United States continued its efforts to limit the availability of methamphetamine precursor chemicals in 2013. Methamphetamine manufacturers, operating primarily in Mexico, continued to gain access to sufficient amounts of chemical precursors to produce and transship large amounts of high purity, high potency methamphetamine. Data from the Southwest border show an increase of over 500 percent in methamphetamine seizures from 2008 to 2013.[72] Ready availability at declining price per pure gram could elevate the risk for increased methamphetamine use in the United States. Within the Western Hemisphere, DEA and the State Department are working with Mexico and Central American nations to identify, seize, and destroy chemical precursors and to equip Central American partners with the appropriate legal frameworks to effectively tackle the challenge. In 2013, JIATF West continued its valuable work identifying global methamphetamine precursor diversion networks. China and India remain the primary sources for precursor chemicals used by both Asian and Latin American methamphetamine producers. JIATF West's efforts include conducting network analysis in support of law enforcement efforts, increasing analytical capacity, and enhancing partnerships within the Asia-Pacific region.

E. Address International Production and Trafficking of New Synthetic Drugs

During the past 5 years new synthetic drugs, also referred to as new psychoactive substances (NPS), have posed an increasing public health threat to the United States. These substances, including synthetic cannabinoids ("Spice,""K2") and synthetic cathinones ("bath salts"), pose a severe risk to those that consume them. Although DEA, through emergency scheduling, and the Congress, via statutory changes, have banned many of these substances, new variants are continually manufactured and distributed, posing a serious challenge to Federal, state, and local authorities seeking to protect public health and safety. DEA has been working closely with bilateral and multilateral partners to increase controls on synthetic drugs. China, a source for most of these new substances, controlled 11 of these substances on January 1, 2014. The Administration will continue to work to ensure an effective global response to this rising concern.

F. Expand Global Prevention and Treatment Initiatives Bilaterally and Through Cooperation with the United Nations, the Organization of American States, the Colombo Plan, and Other Multilateral Organizations

Under the leadership of the Department of State, U.S. international demand reduction initiatives continue to mature. In 2013, 29 new anti-drug community coalitions were established throughout the world (Bolivia, Brazil, Cape Verde, Colombia, Costa Rica, Ghana, Kenya, Philippines, Senegal, Tajikistan, and Iraq). ONDCP is working with international organizations to expand the development of prevention, treatment, and recovery services in areas that have not had access to demand reduction resources. These initiatives to build demand reduction capacity work in concert with broader efforts to promote law and order and strengthen governance structures. In 2014, ONDCP will work to share U.S. experiences in recovery support and overdose prevention and will emphasize the value of collaboration among public health and law enforcement agencies.

G. Expand Internationally a Comprehensive Package of Health Interventions for Injection Drug Users

The President's Emergency Plan for AIDS Relief (PEPFAR) partners with a number of countries and multilateral organizations to provide needed health and drug treatment services for injection drug users. Countries that receive PEPFAR funds provide an array of interventions, such as community-based outreach, counseling and testing, medication-assisted treatment, antiretroviral therapy, and prevention, diagnosis, and management of viral hepatitis and tuberculosis. These evidence-based interventions, along with supportive national laws, policies, and regulations, have been identified by the World Health Organization, UN Office on Drugs and Crime, and UNAIDS as essential interventions for the treatment of opioid use disorders and the prevention of HIV and other blood-borne diseases. In 2013 efforts to maintain or expand medication-assisted treatment continued in Tanzania, Kenya, Vietnam, Ukraine, and Cambodia.

H. Support the *Strategy to Combat Transnational Organized Crime*

Illicit narcotics provide a means for transnational criminal organizations to obtain wealth, power, and influence, resulting in the destabilization and corruption of vulnerable nations, communities, and institutions. In 2011, the President released the *Strategy to Combat Transnational Organized Crime,* a

commitment to build, balance, and integrate U.S. efforts against the expanding national security threat posed by transnational organized crime (TOC). The *Strategy* lays out 56 action items that support five overarching policy objectives:

- Protecting Americans from the negative effects of TOC;
- Helping partner countries strengthen governance and transparency, break the corruptive power of TOC, and sever state-crime alliances;
- Breaking the economic power of transnational criminal networks while protecting strategic markets and the U.S. financial system;
- Defeating TOC networks that pose the greatest threat to national security; and
- Building international, multilateral, and public-private partnerships to defeat TOC.

Overseeing the implementation of this interagency effort is the National Security Council/ONDCP co-chaired Interagency Policy Committee on Illicit Drugs and Transnational Criminal Threats. Under this implementation framework, a number of actions have been taken that advance the goals of both the *Strategy to Combat Transnational Organized Crime* and the *National Drug Control Strategy,* to include a new sanctions program to block the property of and prohibit transactions with significant transnational criminal networks, a new rewards program for information that leads to the arrest and conviction of key transnational criminals, and the formation of an Interagency Threat Mitigation Working Group that has identified those TOC networks that present a sufficiently high national security threat.

2. Support the Drug Control Efforts of Major Drug Source and Transit Countries

Supporting Drug Control in Key Regions of the World

The *National Drug Control Strategy* remains focused on helping partner nations improve citizen security through programs that strengthen democratic institutions and help reduce drug production, trafficking, and use. Within drug source and transit countries, the center of gravity of past strategies focused on providing specific assistance to disrupt the infrastructure, cultivation, and production efforts of drug trafficking organizations and to break up trafficking routes and networks. While this remains important, the U.S. Government must continue to enter into strong and collaborative partnerships with affected nations to expand our common security goals and create safe communities. We must go beyond traditional relationships and assist friendly nations, where needed, to modernize their security forces, reform their justice systems, support human rights training, and provide alternative development assistance in a safe environment, while at the same time continuing to address the threat posed by the supply side of the illicit trafficking market. This approach aims to build permanent partner nation capacity to provide under governed areas with modern and capable law enforcement and security forces and to provide justice sector reforms to address rising domestic crime, gang activity, and money laundering. In a time of declining resources, it is more important than ever that plans, programs, and activities be coordinated. This is a global undertaking, but particular efforts will be made, under the Department of State's coordination, to ensure integration, coordination, and the achievement of measurable outcomes in Afghanistan and through the Caribbean Basin Security Initiative (CBSI), the Central America Regional Security Initiative (CARSI), the Merida Initiative, the Colombia Strategic Development Initiative, and the West Africa Cooperative Security Initiative (WACSI).

A. Strengthen Strategic Partnerships with Mexico

U.S.-Mexico bilateral cooperation remains strong and focuses on common goals identified and supported through the Merida Initiative and other bilateral efforts. In 2013, the Department of State continued its existing programs, including training of Mexican state and municipal law enforcement professionals. The Department of State's Bureau of International Narcotics and Law Enforcement Affairs (INL) trained nearly 3,500 state and municipal police officers during 2013. INL also provided training, technical assistance, and equipment to the Mexican states of Chihuahua and Sonora to establish joint agency information-sharing task forces, which have already provided key assistance in the arrest of suspects in several cases. INL continues to work with Mexican states to address common needs and promote collaboration among intra-state law enforcement forces. The North American Maritime Security Initiative (NAMSI), a partnership among the United States, Canada, and Mexico, continues to foster cooperation on maritime law enforcement and prosecutions.

The Information Analysis Center (IAC) is responsible for ensuring close coordination of resources between the Government of Mexico (GOM) and the United States in cross border operations along the shared border with Mexico. At the IAC, CBP Office of Air and Marine (OAM), through air surveillance data sharing, enhances partner nation capability and provides the Government of Mexico a means to organically resolve suspect air targets in Northern Mexico; in turn, OAM is capable of fusing radar data from both Mexican and select U.S. sites along the Southwest border. CBP's Air and Marine Operations Center located on March Air Reserve Base provides direct intercept support to the Government of Mexico through the detection, tracking, and sharing of information on suspect radar tracks both within Mexican airspace and approaching Mexico's southern sovereign airspace.

B. Build the Afghan Licit Economy

Illicit drug cultivation, production, trafficking, and consumption flourish in Afghanistan, particularly in parts of the south and southwest where instability is high and state institutions are weak or nonexistent. The Afghan drug trade saps the capacity of the Afghan people and undermines governance and democratic institutions. The United States Government estimates that poppy cultivation increased by 10 percent to 198,000 ha in 2013. Total eradication carried out in 2013 was 7,348 hectares (ha), a decline compared to the 9,672 ha eradicated in 2012, but still well above the 2010 level of 2,316 ha and the 2011 level of 3,810 ha.

The U.S. Government's and Afghan Government's counternarcotics strategies call for a multifaceted, long-term approach, well-integrated into broader efforts to build good governance and a licit economy. In 2014, the United States will continue to support Afghanistan's capacity to interdict illicit trafficking within its borders (including through support to the Afghan Special Mission Wing) and bring those traffickers to justice within the Afghan criminal justice system. The United States will also seek collaboration with international partners; support eradication, alternative livelihoods, counternarcotics public information, and demand reduction; and work to disrupt, degrade, and diminish drug trafficking and drug-financed threats in Afghanistan and the region.

In FY 2013, U.S. Government alternative development programs in Afghanistan continued to focus on licit income generation and job creation by improving commercial agriculture, specifically in poppy

production-prone areas. In FY 2013, 8,446 ha of licit alternative crops supported by U.S. Government programs were under cultivation in Afghanistan—significantly exceeding the target of 3,285 ha, with 156,209 households benefiting from agriculture and alternative livelihood interventions. This represented a 172 percent increase over the target number of households (57,231), due to better than average precipitation, improved farming techniques, and expansion of extension services. The number of new direct jobs (measured as full-time equivalent) created by U.S. Government-sponsored alternative development programs totaled 4,565, exceeding the target of 3,500.

C. Build the Law Enforcement and Criminal Justice Capacities of Source Countries in the Western Hemisphere to Sustain Progress Against Illicit Drug Production and Trafficking

U.S. diplomatic, law enforcement, and security efforts seek to reduce the threat of drugs and organized crime in the hemisphere through interagency counternarcotics assistance and rule of law programs. Multilateral efforts supported by DEA, CBP, State, USAID, and other agencies will assist source and transit countries to promote regional coordination, modernize and enhance the capabilities of their security forces, and reform justice systems to more effectively prosecute criminals. In 2013, the USCG and Department of State co-hosted two Maritime Multilateral Counterdrug Summits with Western Hemisphere partners to exchange best practices on regional interoperability, interdiction operations, and legal issues. The Department of State's assistance to Panama in introducing the Computer Statistics (COMPSTAT) model of modern policing—also implemented in Costa Rica—is an example of the cooperative efforts that can improve technology and management techniques to proactively track crime, develop preventative techniques, and promote community policing. Alternatives to incarceration and increased access to treatment and recovery support also hold the potential to reduce recidivism rates and optimize the use of limited resources.

D. Continue Implementation of the Caribbean Basin Security Initiative

The focus of CBSI is to develop and maintain the capability and capacity of our Caribbean partners to significantly reduce illicit trafficking, increase public safety and security, and promote social justice, enabling them to exercise their sovereign rights and responsibilities. This initiative takes on renewed emphasis given a small but observable uptick in illicit trafficking through the region. During 2013, the USCG, U.S. Southern Command, and the Department of State collaborated to expand the Technical Assistance Field Team (TAFT) to support CBSI. TAFT's mission is to professionalize and improve the operational readiness of 13 Caribbean maritime forces through technical assistance visits.

Beyond CBSI, JIATF South and U.S. Southern Command are assisting the Caribbean Community (CARICOM) with the development and integration of the first-ever *CARICOM Counter Illicit Trafficking Strategy*, which will, when implemented, provide the framework for collaborative multilateral law enforcement responses to regional trafficking threats that will enable direct coordination between JIATF South and the operations centers of the many CARICOM countries.

E. Promote Alternative Livelihoods for Coca and Opium Farmers

In 2013, USAID continued to lead U.S. Government efforts in support of alternative development projects in Colombia and Peru. In Colombia in 2012, USAID's alternative development activities helped contribute to the reduction of the number of hectares cultivated with coca to 78,000 ha. USAID leveraged approximately $15 million in public and private sector funds—by helping achieve approval of nearly 70 project proposals to the Ministry of Agriculture for grants to farmer associations to adapt their production technology to market demand, including for health and organic certifications. In addition, USAID initiated 110 rapid response infrastructure projects (schools, health clinics, sports facilities, tertiary roads) with a total value of $48 million.

In Peru, the regional leader in potential pure cocaine production (305 metric tons in 2013,) the partnership between the U.S. Government and the Humala administration has resulted in a proactive and ambitious strategy that seeks to find alternatives to the drug trade. Peru eradicated a record 23,785 coca ha in 2013. Working hand-in-hand with INL and the Government of Peru, USAID has responded with a comprehensive set of alternative development interventions, including entering the Monzón valley for the first time. USAID helped strengthen the capacity of the Peruvian counternarcotics agency and, working together in collaboration, reached a total of 14,778 farmers with technical assistance and collectively maintained a total of 35,317 ha of licit crops, of which 5,467 were newly planted. Licit sales from USAID-assisted farmers in cacao, oil palm, and coffee production totaled $31.9 million at farm-gate prices and generated 14,574 full-time equivalent jobs, 18 percent of which are held by women.

F. Support the Central America Regional Security Initiative

Through CARSI, the United States works with partner nations to strengthen institutions to counter the effects of organized crime, uphold the rule of law, and protect human rights. Institution building is coupled with prevention programs that dissuade at-risk youth from turning to crime and gangs, and community policing programs engage local communities on citizen security issues. Programs cater to each nation's capabilities and include: model police precincts; youth outreach and vocational training centers; crime prevention in vulnerable communities; training of specialized investigative units; public-private partnerships focused on crime prevention; capacity building for judicial actors; assistance for police academy reform; operations support; and border security capability development. In 2013, CARSI leveraged regional expertise and experience by incorporating regional actors as well as multinational organizations.

Through the U.S.-Colombia Action Plan on Regional Security Cooperation, the United States and Colombia have formalized support to targeted third countries. In 2013, this security assistance included 39 capacity-building activities in four Central American countries focused on multiple areas, such as asset forfeiture, investigations, polygraphs, and interdiction. In 2014, the United States and Colombia will increase security assistance to 152 capacity-building activities in six countries in Central America and the Caribbean. In 2014, these initiatives will expand to include officials from the Dominican Republic and Costa Rica.

G. Leverage Capacities of Partner Nations and International Organizations to Help Coordinate Programs in the Western Hemisphere

In April 2013, representatives from the nations of the Central American Integration System (SICA) gathered in Washington, D.C. for the North America-SICA Security Dialogue in an effort to coordinate international support for Central America. Colombia and Mexico in particular have shown significant leadership and commitment in this area. With support from the Department of State, SICA organized a technical-level workshop to address threats related to precursor chemicals, held in Guatemala City in September 2013. ONDCP met regularly with ambassadors from SICA countries to discuss counternarcotics issues, including the development of a precursor chemical control plan, the United States narcotics certification/majors list process, and demand reduction programs in the United States. The focus in 2014 will be to promote efforts by Mexico and Colombia to share lessons learned and best practices with regional partners.

H. Consolidate the Gains Made in Colombia

The United States made substantial progress in its counternarcotics and security partnership with Colombia during 2013 through the nationalization of aviation programs, expansion of international security cooperation, and reductions in the cultivation of coca. Colombia's coca cultivation fell to 78,000 ha in 2012—a 53 percent decline since 2007. Colombia's production potential also decreased from 190 to 175 metric tons during 2012. The Department of State and DoD will work with Colombian partners to support increased eradication and to develop alternative eradication methods to address the changing patterns of cultivation.

3. Attack Key Vulnerabilities of Transnational Criminal Organizations

A. Improve Our Knowledge of the Vulnerabilities of Transnational Criminal Organizations

Information on the organization and operations of transnational criminal groups is the cornerstone of efficient, targeted efforts to disrupt and dismantle those organizations that pose the greatest threat to the United States and its partners. Information sharing among the intelligence, law enforcement, and defense communities continues to pay dividends in identifying threats and areas in which organizations might be targeted most effectively, sustaining the cycle of success. In FY 2013 the Administration continued to identify the issues of drugs and transnational organized crime as national intelligence priorities; conducted major studies on the transportation and illicit finance operations of illicit trafficking groups; and continued bilateral cooperation with key partner nations, including Mexico and Colombia. The U.S. Government in 2014 will continue to refine its intelligence collection and analysis on the operations and hierarchy of key transnational criminal organizations.

B. Disrupt Illicit Drug Trafficking in the Transit Zone

Targeting bulk shipments of illegal drugs before they reach U.S. borders has the greatest effect on reducing their flow toward the United States, relieves pressure on partner nations, and reduces illicit revenue streams that fund transnational criminal organizations. During FY 2013, 184 metric tons of cocaine were seized or disrupted in the transit zone out of a total documented flow of 646 metric tons, as recorded in

the Consolidated Counterdrug Database (CCDB).[73] This represents a 28.5 percent removal rate, which, while below the annual target for 2013 (36 percent), is consistent with the historical average of 25 percent over the past decade and well above the removal rate in 2012 (23.8 percent). The availability of U.S. interdiction assets remains a persistent concern. As depicted in Figure 2, reduced numbers of interdiction assets in the transit zone can have a negative effect on the entire interdiction continuum. The interagency community will examine options to counter the continuing drug trafficking threat in the transit zone.

C. Target the Illicit Finances of Drug Trafficking Organizations

U.S. agencies aggressively targeted the illicit financial activities of drug trafficking and transnational criminal organizations in FY 2013. The Office of Foreign Assets Control designated numerous additional entities linked to Mexico's Sinaloa Cartel and to Zetas leader Miguel Angel Trevino Morales under the Foreign Narcotics Kingpin Act, freezing their assets and financial transactions under U.S. jurisdiction. OFAC also successfully accomplished derivative designations on persons and entities linked to the Yakuza families of Japan and the South-Asian crime syndicate known as "D-Company," headed by Indian national Dawood Ibrahim. The multiagency Financial Crimes Task Force's investigations of illicit money service businesses led to multiple indictments and convictions for money laundering. The DEA, ICE/HSI National Bulk Cash Smuggling Center, and Treasury's FinCEN continued to work with state and local law enforcement entities along the Southwest border to improve information sharing at all levels and to enhance state and local authorities' ability to identify illicit financial activities.

D. Target Cartel Leadership

U.S. Federal agencies and partner nations continue to identify and exploit the vulnerabilities of criminal organizations responsible for drug trafficking and money laundering. Years of bilateral cooperation between the United States and Mexico has bolstered Mexico's capacity for arresting cartel leadership. Notably, Mexican authorities arrested the previously mentioned Zeta organization leader Miguel Angel Trevino Morales in July 2013, the leader of the rival Gulf Cartel Mario Ramirez Trevino the following month, and in February 2014, Mexican authorities captured Joaquin "Chapo" Guzman Loera, the leader of the infamous Sinaloa Cartel. Bilateral cooperation with Colombia led to the extradition of kingpin Daniel "El Loco" Barrera to the United States in July to face trafficking and money laundering charges. Over the next year, OCDETF member agencies will continue to share information, identify CPOTs, and work cooperatively to disrupt and dismantle them.

Chapter 7. Improve Information Systems for Analysis, Assessment, and Local Management

Federal drug control programs and policies must be based upon sound evidence. The credibility of that evidence rests upon the quality of the methods with which the data are compiled and analyzed. Formulation of the *National Drug Control Strategy* relies upon scientifically rigorous studies published in peer-reviewed journals and government reports; rigor and transparency are essential to establishing credibility. Data collected and analyzed with such methods are routinely used in the formulation and evaluation of drug control programs and policies.

For example, in recent years the United States has experienced the emergence and spread of non-controlled synthetic drugs, in particular synthetic cannabinoids and cathinones. Synthetic cannabinoids, colloquially but incorrectly referred to as synthetic marijuana, are chemical compounds laced on plant materials and then smoked. They affect the same brain receptors as marijuana and are said by some users to provide similar effects. However, many users experience effects that include anxiety, confusion, paranoia, dysphoria, intense hallucinations, panic attacks, and aggressive behavior—often with life-threatening consequences. Synthetic cathinones, commonly referred to as "bath salts," are man-made drugs designed to have stimulant effects similar to amphetamines, cocaine, methamphetamine, and MDMA. These synthetic designer drugs are typically labelled as "not for human consumption" in an attempt to avoid law enforcement.

The use of these substances for their psychoactive effect first arose in Europe during the past decade. Media reports and domestic law enforcement seizures were the first indication of their spread to the United States. Shortly thereafter, some U.S. data systems began to track their use and consequences. In 2011, researchers for the Monitoring the Future study began to ask high school seniors whether they had used synthetic cannabinoids in the past year. Surprisingly, 11.4 percent of them responded in the affirmative, making it the second most used illicit drug behind marijuana. This estimate was unchanged in 2012, but declined to 7.9 percnet in 2013—similar to the rate of past year use of amphetamines (8.7%). The use of synthetic cathinones among seniors was much lower—1.4 percent in 2012, the first year they were included in the survey, and unchanged in 2013.[74]

The American Association of Poison Control Centers in 2010 began tracking calls to regional centers related to synthetic drugs. That year there were 2,906 calls concerning synthetic cannabinoids; in 2011, the calls more than doubled to 6,968. By 2013, such calls had fallen to 2,643.[75] A similar pattern was observed for bath salts: there were 306 calls in 2010, rising dramatically to 6,137 in 2011, and dropping nearly as dramatically to 995 in 2013.[76]

Users of synthetic cannabinoids have suffered serious health problems that have sent them to the emergency department (ED). The Drug Abuse Warning Network began reporting such cases in 2010, with 11,406 such visits. These visits more than doubled in 2011 with 28,531 synthetic cannabinoid-related ED visits.[77]

As a result of the emergence of these dangerous synthetic substances, Congress enacted the Synthetic Drug Abuse Prevention Act of 2012, as part of the 2012 FDA Safety and Innovation Act. The Act permanently places 26 different synthetic cannabinoids, cathinones, and phenethylamines into Schedule I of the Controlled Substances Act. In 2011, DEA exercised its emergency scheduling authority to control five of these synthetic cannabinoids and three synthetic cathinones.[78] By 2012, all of these substances were permanently designated as Schedule I substances.[79] At least 41 states and Puerto Rico have taken action to control one or more synthetic cannabinoids.[80] Prior to 2010, synthetic cannabinoids were not controlled by any state, nor were they controlled at the Federal level. In addition, at least 43 states and Puerto Rico have taken action to control one or more synthetic cathinones.[81]

As policies and programs are implemented to further address synthetic drugs, the Administration will continue to support research to evaluate their effects and assess the threat. This research is being conducted using rigorous methods and the highest professional standards. Results will be disseminated via peer-reviewed journal articles and government reports.

Much of the evidence base used by policymakers to assess the effectiveness of drug policies and programs is derived from several key Federal data systems, including the following:

- National Survey on Drug Use and Health (NSDUH),
- Drug Abuse Warning Network (DAWN)
- Treatment Episode Data Set (TEDS),
- Monitoring the Future (MTF) study,
- System to Retrieve Information on Drug Evidence (STRIDE),
- National Seizure System (NSS),
- Consolidated Counterdrug Database (CCDB),
- Arrestee Drug Abuse Monitoring II (ADAM) program, and the
- National Vital Statistics System (NVSS).

The status of the Administration's efforts to achieve the *Strategy*'s goals and evaluate programs is assessed with the data from these systems and many more. These data systems—while observing appropriate privacy policies and protections—also provide the information that populates the *National Drug Control Strategy: Data Supplement*, a compendium of the leading indicators of drug use, drug supply, and related consequences. At a time of limited resources, the role of this information in informing Federal drug policy and ensuring its efficiency and efficacy is increasingly important.

These data systems are not static; they require continual review and updating to ensure their methods incorporate the latest scientific advancements in survey design and data collection. The following paragraphs provide an update on progress that has been made over the past year in ensuring that these data systems continue to provide accurate and timely data on drug use and its consequences.

1. Existing Federal Data Systems Need to Be Sustained and Enhanced

A. Enhance the Drug Abuse Warning Network Emergency Department Data System

In 2011, SAMHSA began the process of replacing the Drug Abuse Warning Network with the SAMHSA Emergency Department Surveillance System (SEDSS). DAWN data collection was discontinued at the end of 2011 (however, analytical reports continue to be published). At the same time, planning for SEDSS commenced as a joint undertaking between SAMHSA and the CDC's National Center for Health Statistics. Under SEDSS, data on drug involvement in ED visits would continue to be collected. NCHS's existing National Hospital Care Survey is being modified to enable collection of these data. This solution is not without trade-offs While the costs of obtaining the data will be constrained, the data on drug-involvement in ED visits will not be as detailed under the new system as it was under DAWN due to sample constraints. However, the new system will provide data on such visits not previously available, including patient disposition following the ED visit. Funding issues have delayed the expansion of data collection for the SEDSS until 2014. In 2013, with the benefit of additional funding, the ED recruitment process and data collection instrument were pilot tested.

B. Better Assess Price and Purity of Illicit Drugs on the Street

Drug prices are also of great interest to communities, as they provide a snapshot of what drugs are available and how easy they are to obtain. Currently, DEA tracks the price of drugs as part of ongoing casework (STRIDE) or through a few recurring drug purchase programs. From these DEA data, national trends for drug prices and purities are developed for the four major drugs (cocaine, heroin, marijuana, and methamphetamine) in various market levels and are published annually in the *National Drug Control Strategy: Data Supplement*.

An analysis was recently conducted comparing forensic laboratory price trends with law enforcement surveys to determine correlation. These data will be published in the next ONDCP report on illicit drug price and purity. The results indicate there is a mixed level of correlation between price trends and law enforcement survey results, pointing to the necessity of conducting drug purchase programs to obtain accurate price trends.

DEA pursued several possibilities for improved assessment of street drug prices and purities. DEA contacted counterparts at state/local forensic labs seeking specimens for subsequent analysis. However, unlike DEA, the state/local labs do not retain drug samples; specimens are returned to the acquiring law enforcement agencies, which will not release them for various reasons, ranging from legal restrictions to the desire to maintain all evidence until adjudication. A limited set of state and local forensic laboratories do conduct purity analyses on their submitted drug specimens. DEA's National Forensic Laboratory Information System has recorded purity information from these labs. ONDCP and DEA are collaborating to determine the most feasible mechanism for exploiting these data for monitoring trends and comparing geographic fluctuations.

C. Strengthen Drug Information Systems Focused on Arrestees and Incarcerated Individuals

Although national surveys provide invaluable data on overall drug use prevalence, there is special value in studying drug use among the criminal justice population. The ADAM program estimates the prevalence of drug use and related information among booked arrestees in selected U.S. counties and is the only Federal drug survey to include a biologic indicator (urine sample) of recent drug use. The National Institute of Justice conducted ADAM from 2000 through 2003; ONDCP has conducted it (as ADAM II) since 2007; however, due to budget constraints, 2013 was the last year for which ADAM data would be collected. In 2013, ONDCP published the findings from the 2012 ADAM and conducted data collection for 2013. The final annual report is scheduled for publication in 2014.[82]

In 2013, ONDCP implemented a pilot program, the Community Drug Early Warning System (CDEWS), to reassess urine samples collected from individuals under the supervision of the criminal justice system (e.g., drug courts, parolees, and probationers) in the Washington, D.C. and Richmond, Virginia areas. The reassessment tested for drugs that were not originally tested for by the various criminal justice programs. Results suggest that significant proportions of individuals tested positive for synthetic cannabinoids.[83] ONDCP is funding a second round of CDEWS, with results to be published in 2014.

2. New Data Systems and Analytical Methods to Address Gaps Should Be Developed and Implemented.

A. Transition Drug Seizure Tracking to the National Seizure System

Tabulation of drug seizures is the foundation for reporting statistics on the trends, activities, and patterns related to drug supply reduction policy. EPIC has completed its integration of historical seizure data from the Federal-wide Drug Seizure System with the latest NSS data. Federal agencies are collaborating on improving the consolidation and de-duplication of drug seizure data electronically to provide more accurate and timely tabulations. A template for a strategic drug seizure report with standardized, defined fields will be available by late spring 2014. Each agency's seizure data will be mapped into the NSS for use in strategic reports. The strategic reports will provide decision makers with statistics on temporal and geographic trends in drug seizures.

B. Enhance the Various Data that Inform Our Common Understanding of Global Illicit Drug Markets

Federal agencies continue to refine and enhance the *Interagency Assessment of Cocaine Movement* (IACM)—an annual assessment of the global flow of cocaine—bringing additional Federal and international partners into the analytic process. Incorporating additional information from agencies ranging from CBP to the Australian Federal Police provides additional insight into the global market for cocaine. The IACM relies on U.S. Government estimates of illicit drug production and on the CCDB, which also continues to improve its collection of data on illicit heroin and other opioid movements and the trafficking of precursor chemicals for illicit drugs. Agencies will continue efforts to improve the efficiency and comprehensive nature of CCDB's data collection. At a time of limited resources, the role of the CCDB and other data systems in providing understanding of illicit drug supply trends is increasingly

important. Other critical data systems include: the DEA's scientific studies of illicit crop yield and illicit drug lab efficiency, known as Operation Breakthrough; the Cocaine Signature Program; Heroin Signature Program; Methamphetamine Profiling Program; and Heroin Domestic Monitor Program. Evaluating the origin and purity of illicit drugs and the price information in STRIDE also remains essential. Several of these data systems are currently operating under severe budget constraints. These key data sets need to be maintained in order to enable critical research, assessment, and evaluation to continue.

C. In Coordination with Our International Partners, Improve Capacity for More Accurately, Rapidly, and Transparently Estimating the Cultivation and Yield of Marijuana, Opium, and Coca in the World

U.S. Government analysts continue to collaborate with UNODC on improving estimate methodology, sharing best practices, and evaluating potentially useful new techniques. DEA made progress in its studies to inform U.S. Government estimates of illicit drug crop cultivation and production, with analyses in Colombia and Peru. Funding for annual U.S. Government estimates of illicit cultivation of coca, marijuana, and poppy, and production of cocaine and heroin, should be supported to maintain these critical estimates of potential illicit drug production. Continued work with partners around the world, including in Mexico, on yield studies should be supported with adequate funding to further enhance estimates of illicit drug yields and properly inform actions in the *Strategy*.

Operation Breakthrough

Through Operation Breakthrough, DEA supports the *Strategy* by examining illicit drug cultivation and drug production in major source regions. These scientific studies have provided U.S. policy makers and international partners with unique scientific data and strategic analysis on the nature and magnitude of the evolving threats posed by illicit crop cultivation and drug production. For example, coca yield studies in Colombia have documented the success of the Colombian Government's coca eradication operations in reducing coca yields in major coca growing areas. DEA scientific studies specifically provide four of the five data sets (crop yield, alkaloid content, base lab efficiency, and hydrochloride lab efficiency) required for the U.S. Government to produce science-based cocaine and heroin production estimates.

B. Measures of Drug Use and Related Problems Must Be Useful at the State and Community Level

A. Develop a Community Early Warning and Monitoring System that Tracks Substance Use and Problem Indicators at the Local Level

Progress in reducing the Nation's drug problem is made at the local level through the efforts of community coalitions, treatment providers, recovery support services providers, law enforcement, and others. SAMHSA, with the assistance of its Federal partners, is developing a system of local drug indicators In FY 2013, SAMHSA signed an agreement with the US Department of Agriculture's National Institute of Food and Agriculture (USDA/NIFA) to engage their community extension network in identifying

community measures, community behavioral health surveillance programs, and strategies currently used by communities to track and monitor substance abuse at the community level. USDA/NIFA has awarded a 1-year grant to Michigan State University to promote this work. Expected deliverables in 2014 will identify data opportunities, develop new data collection strategies, and develop learning tools to teach communities about behavioral health surveillance and monitoring.

Advocate for Action: Dr. Kenneth Silverman

Dr. Kenneth Silverman is a researcher and Professor of Psychiatry and Behavioral Sciences at Johns Hopkins University's School of Medicine and is also Director of the Bayview Medical Center's Center for Learning and Health. Dr. Silverman's research concerns the Therapeutic Workplace, an employment-based intervention for behavioral change. Through the Therapeutic Workplace, unemployed adults living in poverty earn the opportunity to work and earn wages by meeting treatment goals. Goals may include abstinence verified through drug monitoring, as well as adherence to Vivitrol (injectable naltrexone), a medication to prevent narcotic relapse. Pay is contingent on attendance, work speed, and accuracy. Workplace participants are trained in data entry skills using a web-based computerized program that automates teaching and accelerates learning. Enrollees also learn professional demeanor. While Dr. Silverman's approach is similar to other employee drug testing programs, patient recovery is the priority. If drug use occurs, every effort is made to keep the bond between employee and employer intact, so work can resume once abstinence is reestablished. Studies show incentives are among the most effective tools for initiating and sustaining abstinence, but they can be costly. Using wages from employment to pay for incentive interventions is a unique solution for treating people with chronic substance use disorders who may be at risk for relapse even after years of abstinence. In clinical trials, patients with long histories of unemployment and severe substance use disorders, including intravenous heroin and cocaine use, have been able to achieve long-term recovery through the Therapeutic Workplace.

Policy Focus: Reducing Drugged Driving

Alcohol-impaired driving has been a focus of road safety for decades, and rates of drunk driving on the roads have declined due to improved laws, enforcement, and sustained public awareness campaigns that have changed the social norm around drunk driving.[84] However, drugs other than alcohol—illicit as well as prescribed and over-the-counter—can affect driving performance with the potential to alter behavior. In the 2010 *National Drug Control Strategy,* the President set a goal of reducing drugged driving in America by 10 percent by 2015. The Administration continues to collaborate with state and local governments, nongovernmental organizations, and Federal partners to raise awareness of the dangers of drugged driving and meet the President's goal.

Results of the latest National Highway Traffic Safety Administration (NHTSA) National Roadside Survey are expected in late 2014 and will provide a benchmark regarding how successful efforts have been to meet the goal stated in the 2010 *National Drug Control Strategy.* However, early results from other sources are promising. In 2012, according to NSDUH, 10.3 million persons (3.9 percent) aged 12 or older reported driving under the influence of illicit drugs during the past year. The 2012 rate was lower than the 2002 rate (4.7 percent), but it was higher than the 2011 rate (3.7 percent).[85]

The Administration has focused on four key areas to reduce drugged driving: increasing public awareness; enhancing legal reforms to get drugged drivers off the road; advancing technology for drug tests and data collection; and increasing law enforcement's ability to identify drugged drivers. These efforts remain the Administration's focus for the upcoming year

Collaboration among Federal partners is essential to meeting the President's goal. ONDCP works closely with DOT (specifically with NHTSA), the National Transportation Safety Board, and HHS to partner on key projects and research opportunities. Support of research to improve drug testing and to evaluate the prevalence of drugged driving on the Nation's roads is a priority of the Administration. ONDCP is also working with its international partners in the European Union, Australia, and other countries to exchange best practices and the latest research related to drugged driving. In 2012, the European Union completed the most comprehensive analysis of drugged driving ever conducted, *Driving Under the Influence of Drugs, Alcohol and Medicines in Europe*, known as the DRUID Project.

Ensuring that young drivers drive safely is of particular concern to the Administration. *Monitoring the Future*, an annual survey of high school seniors, provides data from 2001 through 2012 on the driving and substance use habits of high school seniors. Consistent with national trends in marijuana use, the number of teens driving after using marijuana has increased in recent years, and the number of teens driving after using other illicit substances has not changed. Students in 2012 indicated that they were more likely to drive after using marijuana than after drinking (11.0 percent vs. 8.7 percent).[86] ONDCP has developed relationships with youth-serving organizations including RADD: The Entertainment Industry's Voice for Road Safety, Students Against Destructive Decisions, and National Organizations for Youth Safety to ensure that young people are aware of the dangers of driving after using marijuana and other drugs.

Preventing Drugged Driving Must Become a National Priority on Par with Preventing Drunk Driving

Encourage States to Adopt *Per Se* Drug Impairment Laws

The Administration continues to encourage states to enact drug *per se*—analogous to "zero tolerance"—laws to reduce the prevalence of drug-impaired drivers on the road. This standard, which has been adopted in 17 states and has been applied to commercial drivers for decades, increases the ability to prosecute drivers using drugs other than alcohol without specifying a bodily fluid concentration.[87] The Governors Highway Safety Association has joined ONDCP in supporting the elevation of drugged driving as a national priority and supports *per se* standards in the states. In 2013, NHTSA also sought interest from the states in pursuing pilot test implementation of administrative license revocation in cases of drugged driving, which would require that law enforcement have the ability to screen suspected drug impaired drivers for drug use. To this end, NHTSA initiated a field examination of oral fluid drug screening devices to look at their accuracy and reliability.

Advocate for Action: Steve Talpins

Stephen K. Talpins, an attorney with Rumberger, Kirk & Caldwell, is Vice President of the Institute for Behavior and Health (IBH), a non-profit organization devoted to identifying and promoting new strategies to reduce illegal drug use and its consequences. IBH was founded and is led by Dr. Robert L. DuPont, the first Director of NIDA and the second White House drug policy advisor.

Mr. Talpins is an innovator and recognized authority on the full range of drugged driving issues. For more than 20 years he has worked collaboratively with public, private, and non-profit stakeholders on drugged driving. In 1994, Mr. Talpins argued and won a precedent-setting Frye hearing on the admissibility of Drug Recognition Expert (DRE) testimony and evidence, including the horizontal gaze nystagmus test. Since that time, Stephen has consulted with prosecutors around the country on issues involving the DRE protocol and field sobriety tests. In 2010-2011, Mr. Talpins drafted a model *per se* drugged driving law for IBH. The model law was designed to be adapted to the needs of any state and provided the basis for a bill filed in the Florida legislature. In 2012, following a conversation with NHTSA, Mr. Talpins identified ways to incorporate drugged driving into the established Administrative License Review (ALR) system. Mr. Talpins drafted a model provision that was presented to the Board of Directors of the Governors Highway Safety Administration. The model ALR drug law was well-received and, in August 2013, the Governors Highway Safety Administration adopted a resolution encouraging states to study the efficacy of an ALR system for drugged drivers. Steve's legal work and advocacy have served as important contributions to the national effort to prevent drugged driving and its public health and safety consequences.

Collect Further Data on Drugged Driving

Collecting data on the prevalence and effects of drugged driving is crucial to establishing strong policy. In 2013, NHTSA implemented data collection for the National Roadside Survey, a voluntary and anonymous survey that collected data, including oral fluid and a blood sample, from drivers to determine the prevalence of driving after consuming alcohol or an illicit drug or medication with the ability to impair. Results of this survey are expected in late 2014. The Crash Risk Study, conducted in Virginia Beach, Virginia, assessed the relative risk of becoming involved in a crash after consuming drugs. Results from the study are expected in 2014. ONDCP has partnered with NHTSA and NIDA to support driver simulator research to examine driving impairment as a result of marijuana and combined marijuana and alcohol use and correlate it with the results of oral fluid testing to identify behavioral indicators of impairment. Results from this research are expected by the end of 2014.

Enhance Prevention of Drugged Driving by Educating Communities and Professionals

President Obama declared December 2013 *National Impaired Driving Prevention Month* for the fourth consecutive year, showing a continued dedication to reduce deaths on our Nation's roads. ONDCP has worked with national organizations including RADD: The Entertainment Industry's Voice for Road Safety, the Governors Highway Safety Association, National Organizations for Youth Safety, and Students Against Destructive Decisions to raise awareness of drugged driving. The Drugged Driving Toolkit, created as part of the ATI campaign, was shared with hundreds of parents and community leaders, and more than 300 youth participated in drugged driving prevention workshops conducted by ONDCP. In November 2013, the National Transportation Safety Board declared that impaired driving, to include both drug and alcohol influenced operation of a motor vehicle, would serve as one of their 10 "Most Wanted" policy priorities for the year.

Provide Increased Training to Law Enforcement on Identifying Drugged Drivers

NHTSA, in partnership with ONDCP, developed an online Advanced Roadside Impaired Driving Enforcement program (ARIDE) that launched in August 2013. The online ARIDE training is a vital tool that can help law enforcement officers recognize the signs that a driver may be impaired by drugs, alcohol, or both. Online ARIDE is available for free to all police departments and can be completed at an officer's convenience. There is no travel expense involved in completing this training, and the online ARIDE module provides an officer up to 60 days to complete the course. More than 550 learners enrolled in the Online ARIDE training during the first month of availability.

Develop Standard Screening Methodologies for Drug-Testing Labs to Use in Detecting the Presence of Drugs

SAMHSA is expected to propose oral fluid testing guidelines in 2014. ONDCP began supporting the development of guidelines on toxicology laboratory standards for detecting drugs and their metabolites in oral fluids in 2011 and expects further developments in oral fluid screening technology to make feasible on site drug screening by law enforcement. Once guidelines are adopted, these guidelines may also be adopted for use in the DOT-regulated program. In addition to roadside testing, oral fluids testing will enhance how drug testing is carried out in the workplace.

Policy Focus: Preventing and Addressing Prescription Drug Abuse

Reducing and preventing the abuse of prescription medications remains a core priority for the Administration. As communities across the Nation know far too well, the diversion and misuse of prescription drugs, particularly opioid analgesics, have taken a significant toll on public health and safety in the United States. Over the past decade, there have been increases in rates of diagnosable abuse or dependence,[88] substance abuse treatment admissions,[89] and emergency department visits[90] involving prescription medications.

In 2010, more than 38,300 Americans died from drug overdose, with prescription drugs involved in the majority of those deaths.[91] Opioid pain relievers like oxycodone, hydrocodone, and methadone were involved in more than 16,600 of these deaths—approximately 45 Americans every day.[92] This startling figure is approximately 4 times greater than the number of deaths just a decade earlier in 2000.[93] The scope and urgency of this problem has reached such a level that the CDC labeled prescription drug overdose an epidemic, bringing the severity of this problem to the forefront.[94]

In April 2011, the Administration released a comprehensive *Prescription Drug Abuse Prevention Plan* that created a national framework for reducing prescription drug diversion and abuse. The *Plan* focuses on improving education for patients and health care providers, supporting the expansion of state-based prescription drug monitoring programs (PDMPs), developing more convenient and environmentally responsible disposal methods to remove unused medications from the home, and reducing the prevalence of pill mills and diversion through targeted enforcement efforts. There are signs that national efforts to address this problem are working. The latest national survey data indicate that while the 2012 rate of past month non-medical use of prescription drugs among young adults (18 to 25 years old) was 5.3 percent, up from 5.0 percent in 2011, these rates are still lower than those from 2003-2007.[95] State efforts also may be having an impact. For example, in 2011, Florida enacted legislation to shutter rogue pain clinics. Overdose deaths in the state involving prescription drugs declined 10 percent from 2011 to 2012.[96] In another example of progress, Tennessee, which requires prescriber usage of PDMPs, has reported declines in the number of patients using multiple prescribers from 2012 through 2013.[97]

The Administration's *Plan* calls for reducing drug-induced deaths by 15 percent from 2010 to 2015 and extending this 15 percent goal to include unintentional overdose deaths related to opioids. Given the urgency of drug overdose in the United States, the Administration is focusing its efforts on not only preventing the diversion and abuse of prescription drugs but also reducing the number of Americans dying every day from overdose nationwide.

While focused on reducing overdose deaths, the Federal Government also continues to address other aspects of this problem, including prescription drug abuse among expectant mothers and the potential consequences to their children (neonatal abstinence syndrome), as well as the potential transition from prescription opioid abuse to heroin and injection drug use, particularly among young adults. These issues, together with ongoing efforts to reduce rates of misuse more broadly, require coordinated action from public health and safety leaders at the Federal, state, local, and tribal levels.

The Administration has made considerable progress in all four areas of the *Plan*, including expanding available continuing education for health care providers, improving the operations and functionality of prescription monitoring across the country, safely removing millions of pounds of expired and unwanted medications from circulation, and targeting Federal law enforcement efforts to meet state and local needs.

Pillar 1: Education

Educate Health Care Providers about Opioid Painkiller Prescribing

As many health care practitioners know, managing a patient's pain is a crucial and often difficult task. Despite the importance of this area of clinical practice, research indicates that students in medical school receive on average only 11 hours of training on pain education, and most schools do not offer specific training on opioids, substance use disorders, or clinical decision making.[98] A 2011 Government Accountability Office report on education related to the abuse of prescription pain relievers found that "most prescribers receive little training on the importance of appropriate prescribing and dispensing of prescription pain relievers, on how to recognize substance abuse in their patients, or on treating pain."[99]

For these reasons, the Administration's Plan includes a core action to require practitioners (such as physicians, dentists, and others authorized to prescribe) who request DEA registration to prescribe controlled substances to be trained on responsible opioid prescribing practices as a precondition of registration. Several states, including Iowa,[100] Kentucky,[101] Massachusetts,[102] Ohio,[103] Tennessee,[104] and Utah,[105] have passed mandatory prescriber education legislation, and the Administration strongly encourages other states to explore this option. At the Federal level, HHS is implementing education requirements for HHS agency health care personnel, including professionals serving tribal communities through the IHS, and those working with underserved populations through HRSA. Similar efforts are underway at BOP, and education efforts are underway at DoD and the VA.

The Administration also supports other education efforts, including free and low-cost options to provide online and field-based training for prescribers and dispensers of these medications. ONDCP worked with NIDA to develop two free online training tools on safe prescribing for pain and managing pain patients who abuse prescription opioids. These courses, eligible for continuing medical education and continuing education (CME/CE) credit, provide health care professionals with critical skills to manage high-risk patients and more safely prescribe in their day-to-day practice. Since their launch in October 2012, thousands of doctors, nurses, and pharmacists have completed these training modules.

Moreover, the FDA now requires manufacturers of extended-release and long-acting opioid pain relievers to make available free or low-cost continuing education to prescribers under the *Risk Evaluation and Mitigation Strategy* for extended-release and long-acting (ER/LA) opioid analgesic drugs. Eligible curricula have been developed by experts from the Boston University School of Medicine, the American Academy of Family Physicians, and the Henry Ford Health System, among many others.[106] Approximately 60 CME/CE-eligible courses were launched in 2013 and early 2014, offering practitioners a broad array of online and in-person education options.[107]

The Administration is also committed to improving medication safety by better informing prescribers and patients about opioid risks and prescribing practices. SAMHSA published a guide for clinicians entitled *Managing Chronic Pain in Adults with or in Recovery from Substance Use Disorders*. The guide provides practitioners with guidelines on assessing chronic pain patients as well as effectively educating and managing the risk of substance use disorders among patients treated with opioids.[108]

In addition, in September 2013, ONDCP joined the FDA to announce significant new measures to enhance the safe and appropriate use of ER/LA opioids.[109] FDA required class-wide labeling changes for these medications, including modifications to the products' indication, limitations of use, and warnings, as well as post-market research requirements. The new language states that ER/LA opioids are indicated only for management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. The changes also include a new boxed warning that chronic maternal use during pregnancy can result in opioid withdrawal symptoms for newborns. FDA also announced that certain ER/LA opioid application holders must conduct postmarketing studies and clinical trials to assess the serious risks of misuse, abuse, addiction, overdose, and death associated with the long-term use of these drugs. And in April 2013, FDA approved updated labeling for reformulated OxyContin that describes the medication's abuse-deterrent properties, which the FDA expects will deter abuse by non-oral routes of administration.[110] Finally, in December 2013, after an extensive review of scientific literature, hundreds of public comments, and several public meetings, FDA completed and HHS transmitted to DEA a recommendation to reschedule hydrocodone combination products into Schedule II of the Controlled Substances Act. Schedule II drugs are subject to more stringent requirements regarding storage, record keeping, and prescribing than Schedule III drugs, and, should DEA reschedule hydrocodone combination products, these requirements may help reduce diversion and abuse. By exercising its legal and regulatory authorities to take these actions, FDA is helping safeguard access to pain relievers while reducing the risks of abuse, misuse, and overdose.

The Administration is also working to educate the general public. The DFC Support Program enables approximately 670 community coalitions to work with local youth, parent, business, religious, civic, and other groups to help prevent youth substance use. These coalitions implement an array of prevention strategies and programs in their communities to help reduce prescription drug abuse, including prescription drug take back events to enable communities to safely dispose of unused and unwanted medications.[111] In another example, the United States Attorneys' Offices have joined with community leaders to educate young people on the dangers of prescription drugs through local and national initiatives.[112]

Advocate for Action: Dr. Stephen Loyd

Dr. Stephen Loyd is making a difference in the national effort to prevent and address prescription drug abuse through prescriber education. Dr. Loyd is an Internal Medicine physician and medical educator in Tennessee with expertise in proper prescribing of controlled substances and substance use disorders. He is in recovery from his own prescription opioid and benzodiazepine disorder and now regularly lectures and educates health care professionals, law enforcement, policymakers, and others on the potential dangers of prescription narcotics. He is the Associate Chief of Staff of Education at the Mountain Home VA Medical Center, has considerable expertise in neonatal addiction issues/neonatal abstinence syndrome (NAS), and is a vocal advocate for public health and public safety cooperation. In a November 2012 article about him, Dr. Loyd discussed the challenges related to addressing substance use disorders: "Will addiction ever go away? No way. There'll always be something. The key is to treat the underlying problems. We're not going to get a handle on this until we get a multi-pronged approach and erase the stigma associated with addictive disease."[113]

Pillar 2: Monitoring

Expand Prescription Drug Monitoring Programs and Promote Links among State Systems and to Electronic Health Records

The careful monitoring of prescription medications and safe prescribing practices—while also ensuring appropriate privacy protections—can be of great benefit to patients, health care providers, public health professionals, and law enforcement agencies. The second pillar of the Administration's *Plan* focuses on strengthening PDMPs, secure state-administered databases that monitor the prescribing and dispensing of controlled substances. The records contained in PDMPs can assist prescribers and pharmacists in identifying patients who are at risk for substance use disorders, overdose, or other significant health consequences of misusing prescription medications. State regulatory and law enforcement agencies may also use this information to identify and prevent unsafe prescribing, doctor-shopping (seeing multiple doctors to obtain prescriptions), and other methods of illegally diverting controlled substances. In 2006, only 20 states had PDMPs. Today, 49 have laws authorizing PDMPs, and 48 states have operational programs.

Building upon this progress, the Administration is working with state governments and private sector technology experts to make PDMPs more user-friendly so prescribers can access them quickly and easily. As of April 2014, 24 operational PDMPs can share data with other states' systems,[114] and many PDMP administrators are working to better integrate these systems into other health IT programs. To further these efforts, the Office of the National Coordinator for Health Information Technology and SAMHSA funded nine pilot studies, completed in 2012 and 2013, that improved integration of PDMPs into provider workflow and other health records systems. For example, the Indiana Network for Patient Care leveraged its secure hospital network to offer information from the state PDMP along with a "narcotic score" alert (using a formula to determine high risk based on the number of prescriptions) to emergency

department doctors as part of their normal view of a patient's record. In Kansas, a secure e-mail protocol sent a PDMP report to a patient's electronic health record when a certain threshold was met, such as when the patient sought to fill five prescriptions from five providers during 1 calendar quarter. These examples, along with the other pilots, are driving innovation that will better enable health care providers to protect the safety of their patients.

To further encourage the development of innovative health IT integration with PDMPs, SAMHSA awarded nine 2-year grants in FY 2011. CDC is conducting an evaluation of this initiative, and in 2013 SAMHSA awarded additional grants.[115] Ongoing support from BJA through the Harold Rogers PDMP Program is facilitating ongoing efforts to enhance interoperability among state systems.

Prescription monitoring systems must continue to mature, and the Administration continues to focus on expanding interstate data sharing, streamlining PDMP operations, ensuring that data from prescribers in Federal agencies are shared with state PDMPs, and working with state leaders to effectively fund these programs over the long term. In February 2013, VA issued an Interim Final Rule authorizing VA physicians to access state PDMPs in accordance with state laws and to develop mechanisms to begin sharing VA prescribing data with state PDMPs. The Interim Final Rule became final on March 14, 2014. IHS clinics are now sharing data with state PDMPs in many states, and IHS is in the process of negotiating data-sharing agreements with more states. With funding from CDC and FDA, the Center for Excellence in PDMPs at Brandeis University has developed the Prescription Behavior Surveillance System, which collects de-identified PMDP data from participating states. The data is being used in a novel way to track trends in the prescribing of controlled substances and indicators of their misuse. This information is used to evaluate the impact of various interventions related to prescribing at the state level.

Pillar 3: Disposal

Increase Prescription Return/Take-Back and Disposal Programs

Nearly 70 percent of people misusing prescription pain relievers report getting them from a friend or relative the last time they misused these drugs.[116] This is how many new non-medical users of prescription medication initially obtain these drugs. Medication disposal programs allow individuals to dispose of unneeded or expired medications in a safe, timely, and environmentally responsible manner and can help prevent potential diversion and abuse.

DEA has partnered with thousands of state and local law enforcement agencies and community coalitions, as well as other Federal agencies, to hold eight National Take-Back Days. Through these events, DEA has collected and safely disposed of more than 3.4 million pounds (1,733 tons) of unneeded or expired medications.[117]

As directed under the Secure and Responsible Drug Disposal Act of 2010, DEA issued a Notice of Proposed Rulemaking (NPRM) in December 2012 that would expand the options available for consumers to safely dispose of unused medications. The NPRM outlined options that included allowing authorized manufacturers, distributors, reverse distributors, and retail pharmacies to voluntarily administer mail-back programs and maintain collection receptacles. The DEA is currently reviewing public comments and developing the final rule. In preparation for the completion of the rulemaking process, the

Administration is working with state, local, and tribal stakeholders to identify ways to establish long-term, sustainable disposal programs in their communities.

Pillar 4: Enforcement

Assist States to Address Diversion and Pill Mills

Federal law enforcement is partnering with state and local agencies across the country to reduce the number of pill mills and prosecute those responsible for improper or illegal prescribing practices. The Administration is helping improve state and local law enforcement leaders' investigative skills and knowledge around prescription drug cases. The National Methamphetamine and Pharmaceuticals Initiative (NMPI), funded through ONDCP's HIDTA program, is providing critical training on pharmaceutical crime investigations to law enforcement agencies across the country. Since 2009, NMPI has provided training in pharmaceutical crime investigations and prosecutions to over 26,000 law enforcement and criminal justice professionals. These efforts continue to disseminate critical knowledge to enforcement and prosecution professionals.

In addition, the National Institute of Justice awarded three new grants in FY 2012 to promote research on illegal prescription drug market interventions. These research grants are helping Federal, state, and local law enforcement identify high-risk prescribing practices by using PDMP data and identifying best practices and tactics to shut down sources of diversion.

Drive Illegal Internet Pharmacies Out of Business

The Administration has taken steps to reduce the role of illegal Internet pharmacies in diversion of opioid pharmaceuticals. The Ryan Haight Online Pharmacy Consumer Protection Act requires all Internet pharmacies dispensing controlled substances to obtain a special DEA registration and report monthly to DEA. The Act also requires Internet pharmacies to disclose detailed information on their home page and to not provide pharmaceuticals to individuals who have not had at least one face-to-face evaluation by a prescribing medical practitioner, subject to limited exceptions for telemedicine practice. The Act allows the DEA to better monitor unlawful Internet pharmacy operations, and reduces the number of Internet pharmacies distributing controlled substances illegally.

Crack Down on Rogue Pain Clinics that Do Not Follow Appropriate Prescription Practices

Pain clinics operating outside accepted medical practice and legal boundaries continue to contribute to the prescription drug abuse problem. Federal law enforcement is working closely with state and local enforcement and regulatory bodies to address this problem. As of February 2014, DEA had 66 operational Tactical Diversion Squads that investigate suspected violations of Federal and state laws governing the diversion of controlled substances. These unique groups combine the skill sets of Federal agents, diversion investigators, and a variety of state and local law enforcement agencies. These squads investigate, disrupt, and dismantle organizations engaged in the illegal diversion of prescription drugs, including "pill mills," prescription forgery rings, and practitioners or pharmacists who divert pharmaceuticals.

With the expansion of Tactical Diversion Squads across the country, the number of diversion-related criminal and administrative cases has increased significantly. Between FY 2008 and FY 2013, these Tactical

Diversion Squads have also increased the number of diversion-related Priority Target Organization investigations by approximately 45 percent (from approximately 294 to 426). Priority Target Organization investigations focus on those criminal organizations or groups that significantly affect particular areas of the country.

Overdose Prevention and Intervention

Overdoses persist as a major cause of preventable death in the United States, and the 2010 *National Drug Control Strategy* established a goal of reducing drug-induced deaths by 15 percent by 2015. The Administration is committed to reducing overdose deaths nationwide and is focusing on several key areas, including educating the public about overdose risks and interventions; increasing access to naloxone, an emergency overdose reversal medication; and working with states to promote Good Samaritan laws and other measures that can help save lives.

With the recent rise in overdose deaths across the country,[118] it is increasingly important to prevent overdoses and make antidotes available. In August 2013, ONDCP and SAMHSA released the *Opioid Overdose Prevention Toolkit,* which provides communities and local governments with information that can help prevent opioid-related overdoses and deaths.[119] This comprehensive document addresses issues for first responders, treatment providers, and those recovering from opioid overdose.

SAMHSA's Opioid Overdose Toolkit

The Administration is committed to reducing overdose deaths by 15 percent by 2015. In support of this goal, SAMHSA released the *Opioid Overdose Toolkit* in August 2013. This toolkit provides communities and local governments with material to develop policies and practices to help prevent opioid-related overdoses and deaths. It contains sections dedicated to addressing issues for first responders, treatment providers, and those recovering from opioid overdose. This kit will enable state and community leaders to implement effective overdose prevention initiatives, saving lives and connecting people to the treatment they need.

In addition, working closely with ONDCP, the American Society of Anesthesiologists has created an informational card on recognizing and responding to an opioid overdose.[120] The ASA's "Opioid Overdose Resuscitation" card lists symptoms to look for when an opioid overdose is suspected and details step-by-step instructions for assisting a person suspected of an overdose prior to the arrival of emergency medical personnel. The Administration is working with the American Society of Anesthesiologists and other key stakeholders to provide this card to those who may encounter and can intervene with victims of opioid overdoses.

The Administration continues to promote the use of naloxone, the emergency opioid overdose reversal medication, among those likely to encounter overdose victims.[121] Profiled in the 2013 *National Drug Control Strategy,* the Police Department in Quincy, Massachusetts, has partnered with the Commonwealth's health department to train and equip police officers to resuscitate overdose victims

using naloxone. Since October 2010, officers in Quincy have administered naloxone in more than 170 overdose events, almost all of them resulting in successful overdose reversals.[122] The Lorain Police Department in Ohio, working with county public health and substance abuse leaders, started a similar pilot program in October 2013. Lorain officers, equipped with and trained in the use of naloxone, have already reversed overdoses in their community. ONDCP is working with health officials in these states and other experts to provide technical assistance and best practices information to health and law enforcement officials in other states.

In addition, the Administration is working with health care leaders to identify and promote other promising naloxone distribution models. For example, a joint program with the University of Rhode Island's College of Pharmacy, the Rhode Island Pharmacy Foundation, the state Board of Pharmacy, and Walgreens, has created a continuing education program and collaborative practice agreement that allows pharmacists to initiate naloxone therapy for patients who may be at risk for an opioid overdose.[123]A Department of Defense-led program, Operation Opioid Safe at Fort Bragg, North Carolina, educates patients about the risks and abuse issues surrounding long-term use of prescription opioids and distributes naloxone to high-risk patients.[124] These programs represent leading community-driven efforts that the Administration is exploring as models for the Nation.

Naloxone is an extremely valuable tool, but it is only one element in the broad range of overdose prevention efforts. The Administration is committed to removing legal impediments that can mean the difference between life and death. The odds of surviving an overdose, much like the odds of surviving a heart attack, depend on how quickly the victim receives treatment. At least 14 states have passed Good Samaritan laws, which protect victims and witnesses who seek medical aid for an individual who is overdosing.[125] As these laws are implemented, the Administration will carefully monitor their effect on public health and safety.

Neonatal Abstinence Syndrome

The Administration continues to focus on vulnerable populations affected by prescription drug abuse, including pregnant women and their newborns. Research suggests that over the last decade the prevalence of pregnant women using prescription drugs may have increased.[126,127] Over the same period of time the number of infants displaying symptoms of drug withdrawal after birth, known as neonatal abstinence syndrome (NAS), increased approximately threefold nationwide.[128] Newborns with NAS have more complicated and longer initial hospitalizations than other newborns. In 2012, the Administration held a symposium of key stakeholders and researchers aimed at improving outcomes for opioid dependent women and their newborns. From this symposium, partnerships developed around the country focused on this emerging issue, including partnerships with the National Governor's Association and the Association of State and Territorial Health Officials. In 2013, ONDCP worked with the Vermont Oxford Network to improve care for mothers and infants affected by opioid dependence. The network's multidisciplinary effort involves teams from 205 hospitals from 42 states, Canada, Ireland, and the United Kingdom. This ambitious project aims to improve every aspect of care delivered to families, from standardizing newborn treatment to engaging community partners at the local level. The Administration will continue to engage key stakeholders to improve public health systems and outcomes for pregnant women and infants affected by prescription drug abuse.

Conclusion

The year 2013 was an important time for drug policy reform in America—a year that saw significant changes that promise to make our public health and safety policies more effective and more equitable. Important progress was made in providing support to those in need, particularly individuals with substance use disorders who are involved with the criminal justice system—as well as their families. Increased focus was placed on overdose prevention and intervention, with local governments taking important steps to save lives and the Federal Government providing resources such as the Opioid Overdose Toolkit to support their efforts. The implementation of the Affordable Care Act provided millions of Americans with the opportunity to obtain health insurance, and the implementation of the Mental Health Parity and Addiction Equity Act helped to ensure those individuals could obtain mental health and substance use disorder treatment services "at parity" with treatment for other kinds of health disorders.

This progress significantly advances the long-term plan to reduce drug use and its consequences originally set forth in the 2010 *National Drug Control Strategy*. The Administration has sustained its commitment to an evidence-based continuum of prevention, early intervention, treatment, and recovery support services. We have worked to promote substance use disorder services within correctional facilities, through alternative sentencing programs, and in community corrections and reentry systems. We have maintained our support for effective multi-agency law enforcement initiatives to protect our communities from drugs and associated violence. And working with our global partners, we have promoted evidence-based public health approaches, cooperated to reduce drug production and trafficking, and brought some of the most dangerous transnational organized crime leaders to justice.

Yet we must continue to challenge ourselves to do better. We must be mindful of how we discuss issues related to substance use disorders, making sure that we do not stigmatize those with the disease of addiction, yet also ensuring that our young people get the right information about the risks of drug use. And we must seek to avoid over-simplified debates between the idea of a "war on drugs" and the notion of legalization as a panacea. In reality, drug use and its consequences are complex phenomena requiring an array of evidence-based policy responses. The Administration remains committed to charting this "third way" toward a healthier, safer, and more prosperous America.

List of Abbreviations

ACF	Administration for Children and Families (U.S. Department of Health and Human Services)
ADAM	Arrestee Drug Abuse Monitoring
AIDS	Acquired Immunodeficiency Syndrome
ALR	Administrative License Review
ARIDE	Advanced Roadside Impaired Driving Enforcement
ATF	Bureau of Alcohol, Tobacco, Firearms, and Explosives
ATI	Above the Influence
ATR	Access to Recovery
ATTC	Addiction Technology Transfer Center
BCTF	Border Corruption Task Force
BEST	Border Enforcement Security Task Force
BJA	Bureau of Justice Assistance
BOP	Federal Bureau of Prisons
CADCA	Community Anti-Drug Coalitions of America
CAMP	California Campaign Against Marijuana Planting
CARSI	Central America Regional Security Initiative
CBP	U.S. Customs and Border Protection
CBSI	Caribbean Basin Security Initiative
CCDB	Consolidated Counterdrug Data Base
CCSF	Caribbean Corridor Strike Force
CDC	Centers for Disease Control and Prevention
CDCR	California Department of Corrections and Rehabilitation
CDEWS	Community Drug Early Warning System
CGII	California Gang Intelligence Initiative
CME	Continuing Medical Education
CMS	Centers for Medicare & Medicaid Services
CNWG	Counternarcotics Working Group

CPOT	Consolidated Priority Organizational Target
CSAP	Center for Substance Abuse Prevention
CTF	Counter Threat Finance
DAWN	Drug Abuse Warning Network
DEA	Drug Enforcement Administration
DEC	Drug Endangered Children
DFC	Drug Free Communities
DFE	Demonstration Field Experiment
DHS	U.S. Department of Homeland Security
DICE	DEA Internet Connectivity Endeavor
DMI	Drug Market Intervention
DoD	U.S. Department of Defense
DOJ	U.S. Department of Justice
DOT	U.S. Department of Transportation
DPAI	Drug Prevention and Awareness Initiative (Houston HIDTA)
DRE	Drug Recognition Expert
EPIC	El Paso Intelligence Center
ER	Emergency Room
ER/LA	Extended-Release/Long-Acting
ESP	EPIC System Portal
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FinCEN	Financial Crimes Enforcement Network (U.S. Department of the Treasury)
HHS	U.S. Department of Health and Human Services
HIDTA	High Intensity Drug Trafficking Area
HIV	Human Immunodeficiency Virus
HOPE	Hawaii's Opportunity Probation with Enforcement or Honest Opportunity Probation with Enforcement
HRSA	Health Resources and Services Administration (U.S. Department of Health and Human Services)
HSI	Homeland Security Investigations

HSIN	Homeland Security Information Network
HUD	U.S. Department of Housing and Urban Development
IBH	Institute for Behavior and Health
ICE	U.S. Immigration and Customs Enforcement
IHS	Indian Health Service
INL	Bureau of International Narcotics and Law Enforcement Affairs
ISC	Investigative Support Center
JIATF	Joint Interagency Task Force
JJ-TRIALS	Juvenile Justice Translational Research on Interventions for Adolescents in the Legal System
LEO	Law Enforcement Online
LSS	Laboratories and Scientific Services
MSB	Money Services Business
NADCP	National Association of Drug Court Professionals
NAGIA	National Alliance of Gang Investigators Associations
NAS	Neonatal Abstinence Syndrome
NATIVE	Native American Targeted Investigation of Violent Enterprises
NFLIS	National Forensic Laboratory Information System
NGIC	National Gang Intelligence Center
NHTSA	National Highway Traffic Safety Administration
NIC	National Institute of Corrections
NIDA	National Institute on Drug Abuse
NIFA	National Institute of Food and Agriculture (U.S. Department of Agriculture)
NIJ	National Institute of Justice
NMPI	National Methamphetamine and Pharmaceuticals Initiative
NPRM	Notice of Proposed Rulemaking
NREPP	National Registry of Effective Prevention Programs and Practices
NSDUH	National Survey on Drug Use and Health
NSS	National Seizure System
NVSS	National Vital Statistics System
OAS/CICAD	Organization of American States/Inter-American Drug Abuse Control Commission

OASAS	Office of Alcoholism and Substance Abuse Services (New York State)
OCDETF	Organized Crime Drug Enforcement Task Forces
OFC	OCDETF Fusion Center
ONDCP	Office of National Drug Control Policy
PDMP	Prescription Drug Monitoring Program
PEPFAR	President's Emergency Plan for AIDS Relief
PSA	Public Service Announcement
RCO	Recovery Community Organization
RSAT	Residential Substance Abuse Treatment
SADD	Students Against Destructive Decisions
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SEDSS	SAMHSA Emergency Department Surveillance System
STAR	Success Through Addiction Recovery
TAFT	Technical Assistance Field Team
TASC	Treatment Alternatives for Safe Communities
TEDS	Treatment Episode Data Set
TOC	Transnational Organized Crime
TSA	Transportation Security Administration
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
USA	U.S. Attorney
USAID	United States Agency for International Development
USCG	U.S. Coast Guard
USDA	U.S. Department of Agriculture
USVI	United States Virgin Islands
VA	U.S. Department of Veterans Affairs
VRSS	Veteran Reentry Search Service
Y4Y	You for Youth

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