



California State Board of Pharmacy

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

COMMUNICATION AND PUBLIC EDUCATION COMMITTEE

Debbie Veale, R.Ph., Chair
Ramon Castellblanch, Ph.D., Vice Chair, Public Member
Lavanza Butler, Professional Member
Ricardo Sanchez, Public Member
Ryan Brooks, Public Member

1. Presentation by Department of Health Care Services Pharmacist James Gasper Promoting Naloxone and Buprenorphine Access and Subsequent Discussion

Attachment 1

The Legislature enacted, and the Governor signed, Assembly Bill (AB) 1535 (Chapter 326, Statutes of 2014), which allows pharmacists to furnish naloxone without a prescription under a protocol developed by the Medical Board and the Board of Pharmacy.

The board promulgated emergency regulations to establish a protocol for pharmacists furnishing naloxone hydrochloride. The emergency regulations were approved by the Office of Administrative Law and became effective 4/10/15. The board readopted the emergency regulations with an expiration date of 4/6/16 while the board sought to establish the regulations through the regulatory process which were noticed on 5/22/15 for a 45-day comment period and a subsequent 15-day comment period on 9/5/15. A copy of the current emergency regulation text and the proposed regulation text is included in **Attachment 1**.

At this meeting, James Gaspar, PharmD, BCPP, Psychiatric and Substance Use Disorder Pharmacist, Pharmacy Benefits Division, California Department of Health Care Services will provide a presentation briefly describing the current state of opioid addiction and opioid overdose deaths locally and nationally. Dr. Gaspar will discuss potential interventions that pharmacists can make today to improve access to treatment with buprenorphine and the opioid overdose antidote naloxone.

2. Discussion on Development of Regulations to Allow for the Waiver of Patient-Centered Label Requirements (Business and Professions Code Section 4076.5(d))

Attachment 2

The statutory requirements for patient-centered labels contain a provision that allows the board to provide a waiver from the requirements in certain circumstances.

Below are the provisions that provide the waiver from section 4076.5(d):

- (d) The board may exempt from the requirements of regulations promulgated pursuant to subdivision (a) prescriptions dispensed to a patient in a health facility, as defined in Section 1250 of the Health and Safety Code, if the prescriptions are administered by a licensed health care professional. Prescriptions dispensed to a patient in a health facility that will not be administered by a licensed health care professional or that are provided to the patient upon discharge from the facility shall be subject to the requirements of this section and the regulations promulgated pursuant to subdivision (a). Nothing in this subdivision shall alter or diminish existing statutory and regulatory informed consent, patients' rights, or pharmaceutical labeling and storage requirements, including, but not limited to, the requirements of Section 1418.9 of the Health and Safety Code or Section 72357, 72527, or 72528 of Title 22 of the California Code of Regulations.
- (e) (1) The board may exempt from the requirements of regulations promulgated pursuant to subdivision (a) a prescription dispensed to a patient if all of the following apply:
 - (A) The drugs are dispensed by a JCAHO-accredited home infusion or specialty pharmacy.
 - (B) The patient receives health-professional-directed education prior to the beginning of therapy by a nurse or pharmacist.
 - (C) The patient receives weekly or more frequent followup contacts by a nurse or pharmacist.
 - (D) Care is provided under a formal plan of care based upon a physician and surgeon's orders.
- (2) For purposes of paragraph (1), home infusion and specialty therapies include parenteral therapy or other forms of administration that require regular laboratory and patient monitoring.

The board has received requests from several entities over the years. At the October 2015 board meeting, the board approved the first waiver for Title 16 California Code of Regulations section 1707.5 regarding Patient-Centered Labels for Prescription Drug Containers as authorized by Business and Professions Code section 4076.5 to Coram CVS/Specialty Infusion Services. The approved waiver was for a two-year trial period with the condition that during the trial period, all consumer-based complaints are tracked by Coram CVS/Specialty Infusion Services and reported to the board.

In addition to granting this first waiver, the board directed staff to draft regulations so that future waivers for the labeling of TPN bags used by entities such as Coram CVS/Specialty Infusion Services would not be required. While the board is pursuing the regulation change to California Code of Regulation section 1707.5, the committee may consider and discuss delegating the authority to staff to review and approve these waivers, in accordance with Business and Professions Code section 4076.5 (d) and (e). Delegating waiver approval to staff would require ratification by the full board.

The board currently has a pending regulation to amend California Code of Regulation section 1707.5 to include “generic for” on labels that was noticed for 45-day comment period on October 23, 2015, and the comment period closed December 7, 2015. The board will need to pursue the waiver regulation once the “generic for” regulation is approved.

Provided in Attachment 2 are the existing regulation text for section 1707.5; the currently proposed regulation text for section 1707.5; and the draft language regarding waivers for consideration at this meeting.

3. Consideration of Request for Waiver of Requirements for Patient-Centered Labels as Provided in California Business and Professions Code Section 4076.5(d) from Access IV

Attachment 3

As previously discussed, the board approved the first waiver as provided in California Business and Professions Code Section 4076.5(d) to Coram CVS/Specialty Infusion Services. Since the October 2015 board meeting, the board has received an additional request for waiver from Access IV. Representatives from Access IV will be in attendance at the meeting to present to the committee their request for waiver.

The recommendation of the committee – whether to grant or deny the waiver request -- will be provided to the full board for ratification at the February 2016 Board Meeting. **Attachment 3** contains the presentation and request from Access IV.

4. Consideration of Issuing a Revised Patient Consultation Survey Questionnaire

At the July 2015 Board Meeting, the board reviewed the results of a short questionnaire made available to licensees via Survey Monkey regarding patient consultation. Over 1,000 individuals responded to this survey. During the discussion on the results of the survey, there were questions raised about the quality of the questions themselves. The board asked that this committee take a look at the questionnaire and see if it could be improved.

At the October 2015 Communication and Public Education Committee meeting, the committee put forth a recommendation to the board to bring before the full board for discussion the results from the current limited survey; discuss if the committee should prepare a broader survey; and request legal options available to invoke change.

At the October 2015 board meeting, President Gutierrez asked the committee to develop a broader survey. The request for legal options available to invoke change will

need to be addressed after the survey is developed, completed and findings determined.

During this portion of the meeting, the committee will have a chance to discuss consideration of issuing a revised patient consultation survey questionnaire.

5. Update on Information on the Board's Website Regarding the State's Emergency Contraception Protocol

Attachment 4

California currently has a protocol that allows pharmacists to provide emergency contraception to patients who request it. The protocol was developed by a group of sponsors for the enabling legislation, vetted and approved by both the board and the Medical Board. **Attachment 4** contains a copy of the protocol.

The board received a request from Professor Sally Rafie, PharmD, BCPS, from UCSD's School of Pharmacy to reevaluate the emergency contraception information provided on the board's website. Dr. Rafie joined the Communication and Public Education Committee by phone at the October 2015 committee meeting and provided information about components she believes would provide better information to pharmacists who provide emergency contraception and educational items for the public who may seek emergency contraception. Dr. Rafie also requested the board's assistance in sharing a new emergency contraception reference for pharmacists and patients. Dr. Rafie indicated that she is aware of confusion about the current regulations surrounding emergency contraception access.

The Communication and Public Education Committee requested Dr. Rafie to provide letters of endorsements from reproductive organizations supporting her position that posting such information on the board's website would assist in public education. Additionally, the committee asked Dr. Rafie to provide the educational materials without reference to brand names, so as not to confuse the posting on the board's website with an endorsement for a particular brand of contraception. Dr. Rafie will be joining the committee via telephone conference call.

Attachment 4 also contains the information Dr. Rafie submitted for the committee's review and consideration. Included is a letter of recommendation from Executive Director Kelly Cleland, MPA MPH of the American Society for Emergency Contraception (ASEC); President and CEO Jessica Arons of the Reproductive Health Technologies Project (RHTP); and Chair Brooke Griffin, PharmD, BCACP of the American College of Clinical Pharmacy Women's Health Practice & Research Network as well as updated educational material for the board's website without brand name identification.

6. Update on the Redesign of the Board's Website

Board Webmaster Victor Perez continues his work on redesigning the board's website to make it more user-friendly. A snapshot of the new design was provided at the July 2015 Board Meeting.

Mr. Perez is scheduled to meet with the Chair and Vice Chair of the Communication and Public Education Committee to receive feedback on the updated website design draft before and after this committee meeting. Mr. Perez anticipates rolling out the new design in February 2016.

7. Discussion on .Pharmacy Domain

Attachment 5

As discussed at prior meetings, the National Association of Boards of Pharmacy has established a .Pharmacy (pronounced as "dot pharmacy") top level domain (TLD) suffix system that will identify websites that comply with NABP's standards. This is like the "Good Housekeeping Seal" of approval. According to the NABP, of the 10,000 websites it has investigated, 97 percent do not conform to standard requirements for pharmacies.

One component of the .Pharmacy system is the offering to state boards of pharmacy the opportunity to establish .Pharmacy websites for their use. As previously reported, the California State Board of Pharmacy's .pharmacy website is www.CAboard.pharmacy, which currently links to our www.pharmacy.ca.gov website.

a. Options for the Board to Distribute Public Information Via the Board's Website

Board staff reached out to NABP for educational and informational resources about the .Pharmacy TLD to post on the board's website. Included in **Attachment 5** are educational and informational documents for the committee's consideration for posting to the board's website:

- NABP Recommended website text
- .Pharmacy Overview flyer -- English
- .Pharmacy Overview flyer -- Spanish
- Consumer flyer – English
- Consumer flyer -- Spanish
- Find a .pharmacy Website flyer
- Certification of translations

At this meeting, the committee will discuss the option of posting the NABP provided documents on the board's website to provide California consumers additional information about the .Pharmacy domain initiative.

b. Option of Sending a Letter of Support for .Pharmacy Domain

NABP has a support coalition of stakeholders who believe NABP to be the best equipped to establish the .Pharmacy TLD as a secure and trustworthy domain that indicates to consumers that medications they buy from .pharmacy websites are authentic and safe. Entities can offer support for the .pharmacy TLD by making financial contributions, providing letters of support as well as participation on the development committees.

At this meeting, the committee will discuss the option of developing and posting on the board's website a letter of support to NABP's .pharmacy TLD program. Board staff worked with NABP staff to develop draft language for consideration found in **Attachment 5**.

8. Final Report of the Prescription Drug Abuse Subcommittee

Over the last two years, the board convened a Prescription Drug Abuse Subcommittee to deal with issues relating to prescription drug abuse. Seven subcommittee meetings were held. Minutes of these subcommittee meetings can be found on the board's website.

Chairperson of the subcommittee, Ramón Castellblanch offered to write a final report summarizing the major work of this subcommittee and present it to the committee. The committee looks forward to Dr. Castellblanch's report.

9. Discussion Regarding Prescription Label Translations of Directions for Use

Attachment 6

Assembly Bill 1073 was approved by the Governor on October 11, 2015. The bill requires a pharmacist to use professional judgment to provide a patient with directions for use of a prescription, consistent with the prescriber's instructions. A copy of the chaptered bill is included in **Attachment 6**.

AB 1073 also requires a prescriber to provide translated directions for use, if requested, and authorizes the dispenser to use the translations made available on the board's website to comply with the requirement. Dispensers are not *required* to provide translated directions for use beyond what the board has made available. However, the bill does authorize a dispenser to provide his or her own translated directions for use to

comply with the requirement. Veterinarians are exempt from the requirement to provide translated directions for use. The provisions of the bill go into effect on January 1, 2016.

Also included in **Attachment 6** is information about Polyglot Systems' Meducation® software being integrated with Cerner® Retail Pharmacy management system as additional information about technology available for instructions on prescription labels.

At this meeting, the committee will have opportunity to discuss public education activities in relation to AB 1073.

10. Report on Development of FAQs Received From ask.inspector@dca.ca.gov

Attachment 7

Currently, the board has available to licensees the option to call and ask general questions to one of the board's pharmacist inspectors. This service is available Tuesdays and Thursdays from 8:00 am to 4:30 pm. In addition, licensees may submit an email request to a pharmacist inspector at ask.inspector@dca.ca.gov. Emails are responded to during business days. To ensure that all licensees receive the benefits of service, the board is developing an FAQ to be posted on the board's web site.

While the questions and answers are not intended, nor should they be construed, as legal advice, the answers are intended to provide guidance to the reader on relevant legal sections that should be considered when using professional judgment in determining the appropriate course of action. Should a licensee require legal advice or detailed research, the licensee is encouraged to contact an attorney or other source. Included in **Attachment 7** is a draft copy of the board's FAQ.

11. CURES 2.0 Update on Communication to Licensees

Attachment 8

The Department of Justice (DOJ) recently announced another milestone in its conversion to CURES 2.0. Specifically, the DOJ announced that beginning January 8, 2016, the upgraded prescription drug monitoring program will be available. As part of this transition, on or after January 8, 2016, all current registrants will be required to update their registration in the new 2.0 environment to ensure access to the system. This can be done electronically.

In its press release, the DOJ indicated that CURES 2.0 will be available to all registrants that use Microsoft Internet Explorer Version 11.0 or greater, Mozilla FireFox, Google Chrome, or Safari when accessing the system. Registrants that do not currently have access to one of those specified internet browsers will be able to continue to access the

prior version CURES until the legacy system's retirement, at that time the updated browser must be used. A copy of the DOJ press release may be found in **Attachment 8**.

All pharmacists are required to be registered to use CURES no later than July 1, 2016. On or after January 8, 2016, pharmacists can register using an automated system by visiting www.oag.ca.gov/cures and clicking on the Registration link and follow the instructions.

The board is working with the DOJ to develop "Frequently Asked Questions" to assist registrants with understanding CURES 2.0. The board will send out updates via its subscriber alert system as it learns additional information from the DOJ. Questions regarding these changes should be directed to cures@doj.ca.gov.

At this meeting, the committee will have the opportunity to discuss the board's communication to its licensees about this conversion to CURES 2.0.

12. Update on the Educational Information on Board's Website Regarding Opioids, Naloxone, Red Flags, Consumer Information, and Prescription Drug Abuse Prevention for 13/14/15 Year Olds, and UCSD/Consumer Reports

Attachment 9

In an effort to expand the board's consumer and licensee education and as a result of the Rx Drug Abuse Subcommittee and AB 1535, the board has significantly expanded educational and informational resources available on the board's website. The board has two distinct pages for the sole purpose of providing educational information on prescription drug abuse prevention - http://www.pharmacy.ca.gov/consumers/rx_abuse_prevention.shtml - and naloxone information - http://www.pharmacy.ca.gov/licensing/naloxone_info.shtml.

Included in **Attachment 9** are the educational brochures and pamphlets available on each web page. At this meeting, the committee will have the opportunity to discuss the option of expanding the information available on the board's website.

13. Update on *The Script* Newsletter

Board staff has written the Winter issue of *The Script* newsletter. The Winter issue is currently under legal review, and will be issued soon.

14. Update on Media Activity

The board's executive officer (unless otherwise noted) participated in the following media interviews and requests for information.

- **The Daily Beast**, October 6, 2015: M.L. Nestel, prescriptions with an alias
- **Enterprise Record**, October 8, 2015: Ryan Olson, cease and desist order
- **ProPublica**, October 16, 2015: Charlie Ornstein, Valeant
- **Reuters**, October 21, 2015: Deena Beasley, Philidor Rx Services
- **Wall Street Journal**, October 23, 2015: Jeanne Whalen, Philidor Rx Services and R&O Pharmacy
- **Bloomberg**, October 26, 2015: Robert Langreth, Philidor Rx Services
- **Bloomberg News**, October 29/30, 2015: Carolyn Chen, specialty pharmacies
- **California Health Line**, October 30/31, 2015: George Lauer, drug take back regulations
- **Thomson-Reuter's LA Bureau**, November 2, 2015: Tim Reid, Philidor/Valeant
- **ABC Channel 7, Albuquerque, NM**, November 3/4, 2015: Megan Cruz, Naloxone
- **San Diego Union Tribune**, November 20, 2015: Kristina Davis, drug diversion
- **Sacramento Bee**, November 20, 2015: Margie Lundstrom, disciplinary case
- **CBS 13 News**, November 23, 2015: Adrienne Moore, birth control and naloxone
- **New York Times**, November 25, 2015: Anna North, SB 493
- **LA Times**, December 1, 2015: Soumya Karlamangla, self-administered contraceptives provided by pharmacists
- **Medical Marketing & Media**, December 2/3, 2015: Jaimy Lee, disciplinary case
- **CBS News**, December 3, 2015: Chris Weicher, San Bernardino shooting incident
- **STAT**, December 4, 2015: David Armstrong, drug thefts from supply chain
- **Wall Street Journal**, December 4, 2015: Jeanne Whalen, San Bernardino shooting incident
- **Orange County Register**, December 4, 2015: Jenna Chandler, naloxone
- **Sacramento Bee**, December 8, 2015: Shawn Hubler, SB 493 implementation
- **Sacramento Bee**, December 9, 2015: Shawn Hubler, SB 493 implementation-continued
- **NBC Bay Area**, December 9, 2015: Kevin Nious, lost/stolen prescription drug information
- **NY Times**, December 10, 2015: Paula Span, patient-centered labels
- **Wall Street Journal**, December 15, 2015: Emily Rand, licensure status of an applicant
- **RV Traveler**, December 16, 2015: Russ Demaris, dispensing prescription written in a foreign country – spoke with Supervising Inspector Janice Dang

- **LA Magazine**, December 17, 2015: Jeff Gottlieb, disciplinary case – spoke with Assistant Executive Officer Anne Sodergren
- **KQED**, December 29, 2015: April Dembosky, CURES 2.0
- **CBS 13 News**, January 4, 2016: Adrienne Moore, hormonal contraception – including TV interview
- **CNN**, January 14, 2016: Heather Kelly, smart phone app for doctor consultation
- **Capitol Morning Report**, January 14, 2016: Lauralynne Powell, drug take back regulations

15. Update on Public Outreach Activities Conducted by the Board

A list of major public outreach activities provided by the board's staff is listed below:

- August 29: Supervising Inspector Janice Dang participated as a panel speaker at the Napa Pain Conference.
- September 11: Supervising Inspector Tony Ngondara provided information about being a pharmacist-in-charge and pharmacy operations for CPhA CE.
- September 12: Inspector Suzy Patell provided information about the board and staffed an information booth at the Indian Pharmacists Association annual meeting in Orange County.
- September 18: Supervising Inspector Christine Acosta presented to Tenet Healthcare on sterile compounding regulations and board expectations on sterile compounding regulations.
- September 30: Supervising Inspector Bill Young presented at Keck Graduate Institute.
- October 3: Executive Officer Virginia Herold presented at a joint board/DEA forum on prescription drug abuse and corresponding responsibility.
- October 13 & 14: Executive Officer Herold attended the NABP's Executive Officer Forum in Chicago, where she provided a presentation about the board's wholesaler and 3PL licensure programs.
- October 19: Executive Officer Herold provide information about implementation of SB 493 to the pharmacy department at UCSD's Hillcrest Hospital.
- October 24: Supervising Inspector Tony Ngondara provided information about prescription drug abuse at a seminar at Henry Mayo Hospital in Los Angeles.
- November 4: Inspector Manisha Shafir participated in a telephone conference presentation to the San Diego Pharmacist Association about Surviving as a Pharmacist-in-Charge.

- November 16-18: Executive Officer attended FDA's Interactive Forum on DSQA. She provide two presentations, one on outsourcing facilities and one on licensure components for wholesalers and third partly logistics providers.
- December 4: Executive Officer Herold provided a presentation on pending drug-take back regulations under development with the board to the CDPH state workgroup on opioid abuse.

16. Review and Discussion of News or Journal Articles

Attachment 10

Attachment 10 contains several items of potential issues of interest for this committee.

17. 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))*

Attachment 1

Current Emergency Regulation Text

CCR § 1746.3

**Protocol for Pharmacists
Furnishing Naloxone
Hydrochloride**

Title 16. Board of Pharmacy. Adopt §1746.3, which is new regulation text, as follows:

§1746.3 Protocol for Pharmacists Furnishing Naloxone Hydrochloride

(a) A pharmacist furnishing naloxone hydrochloride pursuant to Section 4052.01 of the Business and Professions Code shall follow the protocol specified in subdivision (b) of this section.

(b) Protocol for Pharmacists Furnishing Naloxone Hydrochloride

(1) Authority: Section 4052.01(a) of the California Business and Professions Code authorizes a pharmacist to furnish naloxone hydrochloride in accordance with a protocol approved by the California State Board of Pharmacy and the Medical Board of California. Use of the protocol in this section satisfies that requirement.

(2) Purpose: To provide access to naloxone hydrochloride via standardized procedures so that pharmacists may educate about and furnish naloxone hydrochloride to decrease harm from opioid¹ overdose.

(3) Procedure: When someone requests naloxone hydrochloride, or when a pharmacist in his or her professional judgment decides to advise of the availability and appropriateness of naloxone hydrochloride, the pharmacist shall complete the following steps:

(A) Screen for the following conditions:²

- (i.) Whether the potential recipient³ currently uses or has a history of using illicit or prescription opioids (If yes, skip question ii and continue with Procedure);
- (ii.) Whether the potential recipient is in contact with anyone who uses or has a history of using illicit or prescription opioids (If yes, continue with Procedure);
- (iii.) Whether the person to whom the naloxone hydrochloride would be administered has a known hypersensitivity to naloxone? (If yes, do not furnish).

(B) Provide training in opioid overdose prevention, recognition, response, and administration of the antidote naloxone.

(C) When naloxone hydrochloride is furnished:

- (i.) The pharmacist shall provide the recipient with appropriate counseling and information on the product furnished, including dosing, effectiveness, adverse effects, storage conditions, shelf-life, and safety. The recipient is not permitted to waive the required consultation.

¹ For purposes of this protocol, "opioid" is used generally to cover both naturally derived opiates and synthetic and semi-synthetic opioids.

² These screening questions shall be made available in alternate languages for patients whose primary language is not English.

³ For purposes of this protocol, "recipient" means the person to whom naloxone hydrochloride is furnished.

- (ii.) The pharmacist shall provide the recipient with any informational resources on hand and/or referrals to appropriate resources if the recipient indicates interest in addiction treatment, recovery services, or medication disposal resources at this time.
- (iii.) The pharmacist shall answer any questions the recipient may have regarding naloxone hydrochloride.

(4) Product Selection: Naloxone hydrochloride may be supplied as an intramuscular injection, intranasal spray, and auto-injector. Other FDA approved products may be used. Those administering naloxone should choose the route of administration based on the formulation available, how well they can administer it, the setting, and local context.

(5) Suggested Kit Labeling:

Intramuscular	Intranasal	Auto-Injector
<p>Naloxone 0.4mg/1ml single dose vial, # 2 vials SIG: Inject 1 ml intramuscularly upon signs of opioid overdose. Call 911. May repeat x 1.</p> <p>Syringe 3ml 25G X 1" # 2 SIG: Use as directed for naloxone administration.</p> <p>Kit should contain 2 vials and 2 syringes.</p>	<p>Naloxone needleless prefilled syringe (1mg/1ml concentration) 2ml, # 2 syringes SIG: Spray one-half (1ml) of the naloxone into each nostril upon signs of opioid overdose. Call 911. May repeat x 1.</p> <p>Mucosal Atomization Device (MAD) # 2 SIG: Use as directed for naloxone administration.</p> <p>Kit should contain 2 prefilled needleless syringes and 2 atomizers.</p>	<p>Naloxone 0.4 mg/0.4 ml #1 twin pack SIG: Use one auto-injector upon signs of opioid overdose. Call 911. May repeat x 1.</p> <p>Kit is commercially available as a twin pack with directions for administration included.</p>

Optional items for the kits include alcohol pads, rescue breathing masks, and rubber gloves.

Kit labels shall include an expiration date for the naloxone hydrochloride furnished. An example of appropriate labeling is available on the Board of Pharmacy website.

(6) Fact Sheet: The pharmacist shall provide the recipient a copy of the current naloxone fact sheet approved by the Board of Pharmacy. This fact sheet shall be

made available in alternate languages for patients whose primary language is not English.

(7) Notifications: If the recipient of the naloxone hydrochloride is also the person to whom the naloxone hydrochloride would be administered, then the naloxone recipient is considered a patient for purposes of this protocol and notification may be required under this section.

If the patient gives verbal or written consent, then the pharmacist shall notify the patient's primary care provider of any drug(s) and/or device(s) furnished, or enter the appropriate information in a patient record system shared with the primary care provider, as permitted by the patient and that primary care provider.

If the patient does not have a primary care provider, or chooses not to give notification consent, then the pharmacist shall provide a written record of the drug(s) and/or device(s) furnished and advise the patient to consult an appropriate health care provider of the patient's choice.

(8) Documentation: Each naloxone hydrochloride product furnished by a pharmacist pursuant to this protocol shall be documented in a medication record for the naloxone recipient, and securely stored within the originating pharmacy or health care facility for a period of at least three years from the date of dispense. The medication record shall be maintained in an automated data processing or manual record mode such that the required information under title 16, sections 1717 and 1707.1 of the California Code of Regulations is readily retrievable during the pharmacy or facility's normal operating hours.

(9) Training: Prior to furnishing naloxone hydrochloride, pharmacists who participate in this protocol must have successfully completed a minimum of one hour of an approved continuing education program specific to the use of naloxone hydrochloride, or an equivalent curriculum-based training program completed in a board recognized school of pharmacy.

(10) Privacy: All pharmacists furnishing naloxone hydrochloride in a pharmacy or health care facility shall operate under the pharmacy or facility's policies and procedures to ensure that recipient confidentiality and privacy are maintained.

Pending
Regulation Text
CCR § 1746.3
Protocol for Pharmacists
Furnishing Naloxone
Hydrochloride

Title 16. Board of Pharmacy
Modified Text

Changes made to the originally proposed language are shown by ~~strike-through~~ for deleted language and underline for added language.

Adopt §1746.3 of Article 5 of Division 7 of Title 16 of the California Code of Regulations to read as follows:

§1746.3 Protocol for Pharmacists Furnishing Naloxone Hydrochloride

A pharmacist furnishing naloxone hydrochloride pursuant to ~~S~~Section 4052.01 of the Business and Professions Code shall satisfy the requirements of this section.

(a) As used in this section:

- (1) "Opioid" means naturally derived opiates as well as synthetic and semi-synthetic opioids.
- (2) "Recipient" means the person to whom naloxone hydrochloride is furnished.

(b) Training. Prior to furnishing naloxone hydrochloride, pharmacists who use this protocol must have successfully completed a minimum of one hour of an approved continuing education program specific to the use of naloxone hydrochloride in all routes of administration recognized in subsection (c)(4) of this protocol, or an equivalent curriculum-based training program completed in a board recognized school of pharmacy.

(c) Protocol for Pharmacists Furnishing Naloxone Hydrochloride.

- ~~(4)~~ Before providing naloxone hydrochloride, the pharmacist shall:
 - ~~(A1)~~ Screen the potential recipient by asking the following questions:
 - ~~(A*i*)~~ Whether the potential recipient currently uses or has a history of using illicit or prescription opioids? (If the recipient answers yes, the pharmacist may skip screening question B.);
 - ~~(B*ii*)~~ Whether the potential recipient is in contact with anyone who uses or has a history of using illicit or prescription opioids. If the recipient answers yes, the pharmacist may continue.
 - ~~(C*iii*)~~ Whether the person to whom the naloxone hydrochloride would be administered has a known hypersensitivity to naloxone. If the recipient answers yes, the pharmacist may not provide the naloxone. If the recipient responds no, the pharmacist may continue.

The screening questions shall be made available ~~by the board~~ on the Board of Pharmacy's ~~its~~ website in alternate languages for ~~recipients and patients~~ whose primary language is not English.

- ~~(B2)~~ Provide the recipient training in opioid overdose prevention, recognition, response, and administration of the antidote naloxone.

(23) When naloxone hydrochloride is furnished:

- (A) The pharmacist shall provide the recipient with appropriate counseling and information on the product furnished, including dosing, effectiveness, adverse effects, storage conditions, shelf-life, and safety. The recipient is not permitted to waive the required consultation.
- (B) The pharmacist shall provide the recipient with any informational resources on hand and/or referrals to appropriate resources if the recipient indicates interest in addiction treatment, recovery services, or medication disposal resources at this time.
- (C) The pharmacist shall answer any questions the recipient may have regarding naloxone hydrochloride.

(34) Product Selection: ~~The pharmacist may supply naloxone hydrochloride as an intramuscular injection, intranasal spray, auto-injector, or any other FDA-approved products. A pharmacist shall provide advice to advise the recipient to on how to choose the route of administration of naloxone based on the formulation available, how well it can likely be administered, the setting, and local context. A pharmacist may supply naloxone hydrochloride as an intramuscular injection, intranasal spray, auto-injector or in another FDA-approved product form. A pharmacist may also recommend optional items when appropriate, including alcohol pads, rescue breathing masks, and rubber gloves.~~

(45) Product Labeling: A pharmacist shall label ~~each container~~ the naloxone hydrochloride consistent with law and regulations. Labels shall include an expiration date for the naloxone hydrochloride furnished. An example of appropriate labeling is available on the Board of Pharmacy's website.

(56) Fact Sheet: The pharmacist shall provide the recipient with a copy of the current naloxone fact sheet approved by the Board of Pharmacy. This fact sheet shall be made available on the Board of Pharmacy's website in alternate languages for patients whose primary language is not English ~~and made available on the board's website.~~

(67) Notifications: If the recipient of the naloxone hydrochloride is also the person to whom the naloxone hydrochloride would be administered, then the naloxone recipient is considered a patient for purposes of this protocol and notification may be required under this section.

If the patient gives verbal or written consent, then the pharmacist shall notify the patient's primary care provider of any drug(s) and/or device(s) furnished, or enter the appropriate information in a patient record system shared with the primary care provider, as permitted by the patient and that primary care provider.

If the patient does not have a primary care provider, or chooses not to give notification consent, then the pharmacist shall provide a written record of the drug(s) and/or device(s) furnished and advise the patient to consult an appropriate health care provider of the patient's choice.

(78) Documentation: Each naloxone hydrochloride product furnished by a pharmacist pursuant to this protocol shall be documented in a medication record for the naloxone recipient, and securely stored within the originating pharmacy or health care facility for a period of at least three years from the date of dispensing. The medication record shall be maintained in an automated data or manual record mode such that the required information under title 16, sections 1707.1 and 1717 of the California Code of Regulations is readily retrievable during the pharmacy or facility's normal operating hours.

(89) Privacy: All pharmacists furnishing naloxone hydrochloride in a pharmacy or health care facility shall operate under the pharmacy or facility's policies and procedures to ensure that recipient confidentiality and privacy are maintained.

~~Authority and Reference:~~ Section 4052.01, Business and Professions Code.
Reference: Section 4052.01, Business and Professions Code

Attachment 2

EXISTING: § 1707.5. Patient-Centered Labels for Prescription Drug Containers; Requirements.

(a) Labels on drug containers dispensed to patients in California shall conform to the following format:

(1) Each of the following items, and only these four items, shall be clustered into one area of the label that comprises at least 50 percent of the label. Each item shall be printed in at least a 12-point sans serif typeface, and listed in the following order:

(A) Name of the patient

(B) Name of the drug and strength of the drug. For the purposes of this section, “name of the drug” means either the manufacturer's trade name of the drug, or the generic name and the name of the manufacturer.

(C) The directions for the use of the drug.

(D) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.

(2) For added emphasis, the label shall also highlight in bold typeface or color, or use blank space to set off the items listed in subdivision (a)(1).

(3) The remaining required elements for the label specified in section 4076 of the Business and Professions Code, as well as any other items of information appearing on the label or the container, shall be printed so as not to interfere with the legibility or emphasis of the primary elements specified in paragraph (1) of subdivision (a). These additional elements may appear in any style, font, and size typeface.

(4) When applicable, directions for use shall use one of the following phrases:

(A) Take 1 [insert appropriate dosage form] at bedtime

(B) Take 2 [insert appropriate dosage form] at bedtime

(C) Take 3 [insert appropriate dosage form] at bedtime

(D) Take 1 [insert appropriate dosage form] in the morning

(E) Take 2 [insert appropriate dosage form] in the morning

(F) Take 3 [insert appropriate dosage form] in the morning

(G) Take 1 [insert appropriate dosage form] in the morning, and Take 1 [insert appropriate dosage form] at bedtime

(H) Take 2 [insert appropriate dosage form] in the morning, and Take 2 [insert appropriate dosage form] at bedtime

(I) Take 3 [insert appropriate dosage form] in the morning, and Take 3 [insert appropriate dosage form] at bedtime

(J) Take 1 [insert appropriate dosage form] in the morning, 1 [insert appropriate dosage form] at noon, and 1 [insert appropriate dosage form] in the evening

(K) Take 2 [insert appropriate dosage form] in the morning, 2 [insert appropriate dosage form] at noon, and 2 [insert appropriate dosage form] in the evening

(L) Take 3 [insert appropriate dosage form] in the morning, 3 [insert appropriate dosage form] at noon, and 3 [insert appropriate dosage form] in the evening

(M) Take 1 [insert appropriate dosage form] in the morning, 1 [insert appropriate dosage form] at noon, 1 [insert appropriate dosage form] in the evening, and 1 [insert appropriate dosage form] at bedtime

(N) Take 2 [insert appropriate dosage form] in the morning, 2 [insert appropriate dosage form] at noon, 2 [insert appropriate dosage form] in the evening, and 2 [insert appropriate dosage form] at bedtime

(O) Take 3 [insert appropriate dosage form] in the morning, 3 [insert appropriate dosage form] at noon, 3 [insert appropriate dosage form] in the evening, and 3 [insert appropriate dosage form] at bedtime

(P) If you have pain, take ___ [insert appropriate dosage form] at a time. Wait at least ___ hours before taking again. Do not take more than ___ [appropriate dosage form] in one day

(b) By October 2011, and updated as necessary, the board shall publish on its Web site translation of the directions for use listed in subdivision (a)(4) into at least five languages other than English, to facilitate the use thereof by California pharmacies.

(c) The board shall collect and publish on its Web site examples of labels conforming to these requirements, to aid pharmacies in label design and compliance.

(d) The pharmacy shall have policies and procedures in place to help patients with limited or no English proficiency understand the information on the label as specified in subdivision (a) in the patient's language. The pharmacy's policies and procedures shall be specified in writing and shall include, at minimum, the selected means to identify the patient's language and to provide interpretive services in the patient's language. The pharmacy shall, at minimum, provide interpretive services in the patient's language, if interpretive services in such language are available, during all hours that the pharmacy is open, either in person by pharmacy staff or by use of a third-party interpretive service available by telephone at or adjacent to the pharmacy counter.

(e) The board shall re-evaluate the requirements of this section by December 2013 to ensure optimal conformance with Business and Professions Code section 4076.5.

(f) As used in this section, "appropriate dosage form" includes pill, caplet, capsule or tablet.

Note: Authority cited: Sections 4005 and 4076.5, Business and Professions Code. Reference: Sections 4005, 4076 and 4076.5, Business and Professions Code.

PROPOSED REGULATIONS: § 1707.5. Patient-Centered Labels for Prescription Drug Containers; Requirements.

To Amend Section 1707.5 of Article 2 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

§ 1707.5. Patient-Centered Labels for Prescription Drug Containers; Requirements.

(a) Labels on drug containers dispensed to patients in California shall conform to the following format:

(1) Each of the following items, and only these four items, shall be clustered into one area of the label that comprises at least 50 percent of the label. Each item shall be printed in at least a 12-point sans serif typeface, and listed in the following order:

(A) Name of the patient

(B) Name of the drug and strength of the drug. For the purposes of this section, “name of the drug” means either the manufacturer's trade name of the drug, or the generic name and the statement “generic for _____” where the brand name is inserted into the parentheses. If it has been at least five years since the expiration of the brand name’s patent or, if in the professional judgment of the pharmacist, the brand name is no longer widely used, the label may list only the generic name of the drug and outside of the patient centered area, the name of the manufacturer.

(C) The directions for the use of the drug.

(D) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.

(2) For added emphasis, the label shall also highlight in bold typeface or color, or use blank space to set off the items listed in subdivision (a)(1).

(3) The remaining required elements for the label specified in section 4076 of the Business and Professions Code, as well as any other items of information appearing on the label or the container, shall be printed so as not to interfere with the legibility or emphasis of the primary elements specified in paragraph (1) of subdivision (a). These additional elements may appear in any style, font, and size typeface.

(4) When applicable, directions for use shall use one of the following phrases:

(A) Take 1 [insert appropriate dosage form] at bedtime

(B) Take 2 [insert appropriate dosage form] at bedtime

(C) Take 3 [insert appropriate dosage form] at bedtime

- (D) Take 1 [insert appropriate dosage form] in the morning
- (E) Take 2 [insert appropriate dosage form] in the morning
- (F) Take 3 [insert appropriate dosage form] in the morning
- (G) Take 1 [insert appropriate dosage form] in the morning, and Take 1 [insert appropriate dosage form] at bedtime
- (H) Take 2 [insert appropriate dosage form] in the morning, and Take 2 [insert appropriate dosage form] at bedtime
- (I) Take 3 [insert appropriate dosage form] in the morning, and Take 3 [insert appropriate dosage form] at bedtime
- (J) Take 1 [insert appropriate dosage form] in the morning, 1 [insert appropriate dosage form] at noon, and 1 [insert appropriate dosage form] in the evening
- (K) Take 2 [insert appropriate dosage form] in the morning, 2 [insert appropriate dosage form] at noon, and 2 [insert appropriate dosage form] in the evening
- (L) Take 3 [insert appropriate dosage form] in the morning, 3 [insert appropriate dosage form] at noon, and 3 [insert appropriate dosage form] in the evening
- (M) Take 1 [insert appropriate dosage form] in the morning, 1 [insert appropriate dosage form] at noon, 1 [insert appropriate dosage form] in the evening, and 1 [insert appropriate dosage form] at bedtime
- (N) Take 2 [insert appropriate dosage form] in the morning, 2 [insert appropriate dosage form] at noon, 2 [insert appropriate dosage form] in the evening, and 2 [insert appropriate dosage form] at bedtime
- (O) Take 3 [insert appropriate dosage form] in the morning, 3 [insert appropriate dosage form] at noon, 3 [insert appropriate dosage form] in the evening, and 3 [insert appropriate dosage form] at bedtime
- (P) If you have pain, take ___ [insert appropriate dosage form] at a time. Wait at least ___ hours before taking again. Do not take more than ___ [appropriate dosage form] in one day

(b) By October 2011, and updated as necessary, the board shall publish on its Web site translation of the directions for use listed in subdivision (a)(4) into at least five languages other than English, to facilitate the use thereof by California pharmacies.

(c) The board shall collect and publish on its Web site examples of labels conforming to these requirements, to aid pharmacies in label design and compliance.

(d) The pharmacy shall have policies and procedures in place to help patients with limited or no English proficiency understand the information on the label as specified in subdivision (a) in the patient's language. The pharmacy's policies and procedures shall be specified in writing and shall include, at minimum, the selected means to identify the patient's language and to provide interpretive services and

translation services in the patient's language. The pharmacy shall, at minimum, provide interpretive services in the patient's language, if interpretive services in such language are available, during all hours that the pharmacy is open, either in person by pharmacy staff or by use of a third-party interpretive service available by telephone at or adjacent to the pharmacy counter.

(e) The board shall re-evaluate the requirements of this section by December 2013 to ensure optimal conformance with Business and Professions Code section 4076.5.

(f) (e) As used in this section, "appropriate dosage form" includes pill, caplet, capsule or tablet.

Note: Authority cited: Sections 4005 and 4076.5, Business and Professions Code. Reference: Sections 4005, 4076 and 4076.5, Business and Professions Code.

DRAFT RECOMMENDATION TO INCLUDE WAIVER: § 1707.5. Patient-Centered Labels for Prescription Drug Containers; Requirements.

(a) Labels on drug containers dispensed to patients in California shall conform to the following format:

(1) Each of the following items, and only these four items, shall be clustered into one area of the label that comprises at least 50 percent of the label. Each item shall be printed in at least a 12-point sans serif typeface, and listed in the following order:

(A) Name of the patient

(B) Name of the drug and strength of the drug. For the purposes of this section, “name of the drug” means either the manufacturer's trade name of the drug, or the generic name and the name of the manufacturer.

(C) The directions for the use of the drug.

(D) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.

(2) For added emphasis, the label shall also highlight in bold typeface or color, or use blank space to set off the items listed in subdivision (a)(1).

(3) The remaining required elements for the label specified in section 4076 of the Business and Professions Code, as well as any other items of information appearing on the label or the container, shall be printed so as not to interfere with the legibility or emphasis of the primary elements specified in paragraph (1) of subdivision (a). These additional elements may appear in any style, font, and size typeface.

(4) When applicable, directions for use shall use one of the following phrases:

(A) Take 1 [insert appropriate dosage form] at bedtime

(B) Take 2 [insert appropriate dosage form] at bedtime

(C) Take 3 [insert appropriate dosage form] at bedtime

(D) Take 1 [insert appropriate dosage form] in the morning

(E) Take 2 [insert appropriate dosage form] in the morning

(F) Take 3 [insert appropriate dosage form] in the morning

(G) Take 1 [insert appropriate dosage form] in the morning, and Take 1 [insert appropriate dosage form] at bedtime

(H) Take 2 [insert appropriate dosage form] in the morning, and Take 2 [insert appropriate dosage form] at bedtime

(I) Take 3 [insert appropriate dosage form] in the morning, and Take 3 [insert appropriate dosage form] at bedtime

(J) Take 1 [insert appropriate dosage form] in the morning, 1 [insert appropriate dosage form] at noon, and 1 [insert appropriate dosage form] in the evening

(K) Take 2 [insert appropriate dosage form] in the morning, 2 [insert appropriate dosage form] at noon, and 2 [insert appropriate dosage form] in the evening

(L) Take 3 [insert appropriate dosage form] in the morning, 3 [insert appropriate dosage form] at noon, and 3 [insert appropriate dosage form] in the evening

(M) Take 1 [insert appropriate dosage form] in the morning, 1 [insert appropriate dosage form] at noon, 1 [insert appropriate dosage form] in the evening, and 1 [insert appropriate dosage form] at bedtime

(N) Take 2 [insert appropriate dosage form] in the morning, 2 [insert appropriate dosage form] at noon, 2 [insert appropriate dosage form] in the evening, and 2 [insert appropriate dosage form] at bedtime

(O) Take 3 [insert appropriate dosage form] in the morning, 3 [insert appropriate dosage form] at noon, 3 [insert appropriate dosage form] in the evening, and 3 [insert appropriate dosage form] at bedtime

(P) If you have pain, take __ [insert appropriate dosage form] at a time. Wait at least __ hours before taking again. Do not take more than __ [appropriate dosage form] in one day

(b) By October 2011, and updated as necessary, the board shall publish on its Web site translation of the directions for use listed in subdivision (a)(4) into at least five languages other than English, to facilitate the use thereof by California pharmacies.

(c) The board shall collect and publish on its Web site examples of labels conforming to these requirements, to aid pharmacies in label design and compliance.

(d) The pharmacy shall have policies and procedures in place to help patients with limited or no English proficiency understand the information on the label as specified in subdivision (a) in the patient's language. The pharmacy's policies and procedures shall be specified in writing and shall include, at minimum, the selected means to identify the patient's language and to provide interpretive services in the patient's language. The pharmacy shall, at minimum, provide interpretive services in the patient's language, if interpretive services in such language are available, during all hours that the pharmacy is open, either in person by pharmacy staff or by use of a third-party interpretive service available by telephone at or adjacent to the pharmacy counter.

(e) The board shall re-evaluate the requirements of this section by December 2013 to ensure optimal conformance with Business and Professions Code section 4076.5.

(f) As used in this section, "appropriate dosage form" includes pill, caplet, capsule or tablet.

(g) (1) The board may exempt from the requirements of this section pursuant to subdivision (a) a prescription dispensed to a patient if all of the following apply:

(A) The drugs are dispensed by home infusion or specialty pharmacy accredited by The Joint Commission.

(B) The patient receives health-professional-directed education prior to the beginning of therapy by a nurse or pharmacist.

(C) The patient receives weekly or more frequent follow up contacts by a nurse or pharmacist.

(D) Care is provided under a formal plan of care based upon a physician and surgeon's orders.

(2) For purposes of paragraph (1), home infusion and specialty therapies include parenteral therapy or other forms of administration that require regular laboratory and patient monitoring.

Note: Authority cited: Sections 4005 and 4076.5, Business and Professions Code. Reference: Sections 4005, 4076 and 4076.5, Business and Professions Code.

Attachment 3

January 15, 2016

Virginia Herold
Executive Officer
California State Board of Pharmacy
1625 North Market Blvd, Suite N219
Sacramento, CA 95834

Subject: Request for Exemption – Patient Centered Labels (1707.5)

The California offices of Access IV are requesting an exemption to the Patient Centered labeling requirements as outlined in section Article 4, Section 4076.5. In that section the rules spell out the requirements that must be met in order to have the Board consider such exemption. Access IV meets all of these requirements, which are addressed as follows:

Joint Commission Accreditation:

Access IV is a provider of home infusion services and is accredited for these services by The Joint Commission. The four pharmacies listed below are accredited under AxelaCare Holdings, Inc., organizational ID 473713. Attached as **Exhibit A** are the current accreditation certificates for the four sites, as well as a screen print of the Joint Commission's Quality Check web site showing their accreditation status. The complete results of the accreditation survey that was conducted in April of 2015 can be provided if requested.

Patient Education:

As an integral part of Access IV's services, all patients are provided written and hands-on education as part of their start of care. Nurses provide the on-site care, while the office-based pharmacists provide education and support telephonically. Written education materials are provided as part of this start of care and include a welcome packet, administration directions, drug information, etc. Due to the nature of the compounded sterile products dispensed, patients receive weekly deliveries and all patients are contacted prior to delivery to review and assess adherence, compliance, tolerance to the medication(s), medication and supply usage, etc. If laboratory monitoring has been ordered by the prescriber, labs are reviewed and the prescriber contacted if necessary as part of the weekly medication review. **Exhibit B** will be available at the meeting, including samples of the education materials, including the patient handbook, drug information, and administration instructions.

Care Plan:

All patients have a care plan prepared at the start of care based on the prescriber's orders, as well as an assessment of the patient, their home environment, etc. The plan of care is updated as necessary. **Exhibit C** includes copies of templates utilized for the initial Pharmacist Assessment/Care Plan, 24-72 hour Pharmacist Follow-up Assessment, Additional Care Plan Assessment, and Refill Assessment.

Access IV has implemented a patient-centered label, but is seeking an exemption due to limitations in the pharmacy dispensing system. Examples are attached as **Exhibit D**. Specifically, due to limitations in the label width and number of characters that can fit in the direction field, the system is cutting off words, etc. when printing, although all information looks correct on the computer screen.

This in turn has increased the time required for the pharmacists to process a prescription due to having to print a label, review for missing words, adjust the text in the direction field, reprint, etc. It also increases the opportunity to have product labeled with incomplete directions. Also the larger font (12 pt, BOLD) is resulting in a label that looks busy, is sometimes hard to follow, etc. The original label uses a smaller font size similar to the branch's address.

The exemption requirements addressed above are followed by all the Access IV branches listed below, including following a common core set of policies and procedures for the company, provision of initial and ongoing education, care plan development and review and patient monitoring based on the prescribers' orders and/or prescriptions. Patients are contacted weekly and as stated above, that contact includes a review of compliance, adherence and tolerance to the drug(s).

The four Access IV sites requesting this exemption are:

Access IV

4610 Northgate Blvd, Suite 130
Sacramento, CA 95834
License Nbr: 53890
Sterile Cmpd: 99867
PIC: Lynn Day (44383)

Access IV

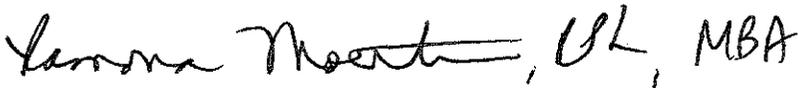
455 Reservation Road, Suite G
Marina, CA 93933
License Nbr: 53892
Sterile Cmpd: 99868
PIC: Jonathan Vessey (53348)

InfuSource, LLC dba Access IV
170 Professional Center Drive,
Suite C
Rohnert Part, CA 94928
License Nbr: 53893
Sterile Cmpd: 99866
PIC: Maria Ledezma (43965)

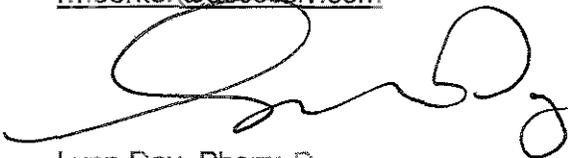
ARC Infusion, LLC dba Access
IV
12604 Hiddencreek Way, Suite
C
Cerritos, CA 90703
License Nbr: 53891
Sterile Cmpd: 100742
PIC: Wawan Natapraya (46801)

Thank you for considering this request and the opportunity to present it to the Board of Pharmacy Communication and Public Education Committee. Should any additional information be needed or requested, please feel free to contact me at the phone number or email address below.

Respectfully,



Ramona Moenter, R.Ph., MBA
General Manager
(916) 648-0124
rmoenter@accessiv.com



Lynn Day, Pharm.D.
Pharmacist-in-charge
(916) 648-0124
lday@accessiv.com

EXHIBIT A

Access I.V.

Cerritos, CA

has been Accredited by



The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the
Home Care Accreditation Program

April 18, 2015

Accreditation is customarily valid for up to 36 months.

Rebecca J. Patchin, MD
Chair, Board of Commissioners

ID #473713

Print/Reprint Date: 08/03/2015

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.



Access IV, LLC

Marina, CA

has been Accredited by



The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the
Home Care Accreditation Program

April 18, 2015

Accreditation is customarily valid for up to 36 months.

Rebecca J. Patchin, MD
Chair, Board of Commissioners

ID #473713
Print/Reprint Date: 08/03/2015

Mark R. Chassin, MD, FACP, MPP, MPH
President

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Access I.V.
Rohnert Park, CA

has been Accredited by



The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the
Home Care Accreditation Program

April 18, 2015

Accreditation is customarily valid for up to 36 months.

Rebecca J. Patchin, MD
Chair, Board of Commissioners

ID #473713

Print/Reprint Date: 08/03/2015

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Access IV, LLC

Sacramento, CA

has been Accredited by



The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the
Home Care Accreditation Program

April 18, 2015

Accreditation is customarily valid for up to 36 months.

Rebecca J. Patchin, MD
Chair, Board of Commissioners

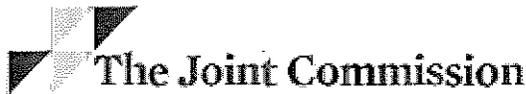
ID #473713

Print/Reprint Date: 08/03/2015

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The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.





Accreditation Quality Report

- > Summary of Accreditation Quality Information
- > Accredited Programs
- > Accreditation National Patient Safety Goals
- > Sites and Services
- > Accreditation History
- > Download Accreditation PDF Report
- > Accreditation Quality Report User Guide

Quality Report

Summary of Accreditation Quality Information



AxelaCare Holdings, Inc.
 DBA: AxelaCare Health Solutions
 Org ID: 473713
 15529 College Blvd.
 Lenexa, KS 66219
 (913)747-3700
axelacare.com

Accreditation Programs	Accreditation Decision	Effective Date	Last Full Survey Date	Last On-Site Survey Date
Home Care	Accredited	4/18/2015	4/17/2015	10/16/2015

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Symbol Key

- The organization has met the National Patient Safety Goal.
- The organization has not met the National Patient Safety Goal.
- The goal is not applicable for this organization.

National Patient Safety Goals and National Quality Improvement Goals

Compared to other Joint Commission Accredited Organizations

Home Care	2015 National Patient Safety Goals	See Detail	Nationwide	Statewide
				*

* State results are not calculated for the National Patient Safety Goals.

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Sites and Services

*** Primary Location**

An organization may provide services not listed here. For more information refer to the [Quality Report User Guide](#).

Locations of Care

→ Access IV, LLC
 455 Reservation Road, Suite G
 Marina, CA 93933

Available Services

Services:

- Durable Medical Equipment
- Enteral Equipment and/or Supplies
- Enteral Nutrients
- External Infusion Pumps and/or Supplies
- Parenteral Equipment and/or Supplies
- Parenteral Nutrients
- Pharmacy, Clinical Consulting Services
- Pharmacy/Dispensary, General Services
- Supplies

→ Access IV, LLC
 4610 Northgate Blvd, Suite 130
 Sacramento, CA 95834

Services:

- Durable Medical Equipment
- Enteral Equipment and/or Supplies
- Enteral Nutrients
- External Infusion Pumps and/or Supplies
- Parenteral Equipment and/or
- Parenteral Nutrients
- Pharmacy, Clinical Consulting Services
- Pharmacy/Dispensary, General Services
- Supplies

ARC Infusion, LLC
DBA: Access I.V.
12604 Hiddencreek Way, Suite
C
Cerritos, CA 90703

Services:

- Durable Medical Equipment
- External Infusion Pumps and/or Supplies
- Pharmacy, Clinical Consulting Services
- Pharmacy/Dispensary, General Services

AxelaCare Health Solutions, LLC
450 East 96th Street
Indianapolis, IN 46240

Services:

- Home Health, Non-Hospice Services
- Skilled Nursing Services

AxelaCare Health Solutions,
LLC *
15529 College Blvd.
Lenexa, KS 66219

AxelaCare Health Solutions, LLC
15529 College Rd.
Lenexa, KS 66219

Services:

- Durable Medical Equipment
- External Infusion Pumps and/or Supplies
- Home Health, Non-Hospice Services
- Parenteral Equipment and/or Supplies
- Parenteral Nutrients
- Pharmacy, Clinical Consulting Services
- Pharmacy/Dispensary, General Services
- Skilled Nursing Services
- Supplies

AxelaCare Health Solutions, LLC
4H Raymond Dr.
Havertown, PA 19083

Services:

- Durable Medical Equipment
- External Infusion Pumps and/or Supplies
- Parenteral Equipment and/or Supplies
- Parenteral Nutrients
- Pharmacy/Dispensary, General Services
- Supplies

AxelaCare Health Solutions, LLC
4514 Cole Ave., Ste 600
Dallas, TX 75205

Services:

- Home Health, Non-Hospice Services
- Skilled Nursing Services

AxelaCare Health Solutions, LLC
One Westbrook Corporate
Center; Suite 300
Westchester, IL 60154

Services:

- Home Health, Non-Hospice Services
- Skilled Nursing Services

AxelaCare Health Solutions, LLC
1529 Ambassador Caffery Pkwy
Lafayette, LA 70506

Services:

- Durable Medical Equipment
- External Infusion Pumps and/or Supplies
- Pharmacy, Clinical Consulting Services
- Pharmacy/Dispensary, General Services

Guardian Health Systems, LP
DBA: AxelaCare
7512 North Broadway, Suite
308
Oklahoma City, OK 73116

Services:

- Durable Medical Equipment
- Enteral Equipment and/or Supplies
- Enteral Nutrients
- External Infusion Pumps and/or Supplies
- Parenteral Equipment and/or Supplies
- Parenteral Nutrients
- Pharmacy, Clinical Consulting Services
- Pharmacy/Dispensary, General Services
- Supplies

Home Care IV of Bend, LLC
DBA: AxelaCare
2065 NE Williamson Court
Bend, OR 97701

Services:

- Durable Medical Equipment
- Enteral Equipment and/or Supplies
- Parenteral Equipment and/or Supplies
- Pharmacy, Clinical Consulting

QualityReport

- Enteral Nutrients
- External Infusion Pumps and/or Supplies
- Home Health, Non-Hospice Services

- Pharmacy/Dispensary, General Services
- Skilled Nursing Services
- Supplies

Home Infusion With Heart, LLC
DBA: AxelaCare
7602 Park Drive, Suite C
Omaha, NE 68127

Services:

- Durable Medical Equipment
- External Infusion Pumps and/or Supplies
- Parenteral Equipment and/or Supplies
- Parenteral Nutrients

- Pharmacy, Clinical Consulting Services
- Pharmacy/Dispensary, General Services
- Supplies

InfuSource, LLC
DBA: Access I.V.
170 Professional Center Drive,
Suite C
Rohnert Park, CA 94928

Services:

- Durable Medical Equipment
- Enteral Equipment and/or Supplies
- Enteral Nutrients
- External Infusion Pumps and/or Supplies
- Parenteral Equipment and/or Supplies

- Parenteral Nutrients
- Pharmacy, Clinical Consulting Services
- Pharmacy/Dispensary, General Services
- Supplies

Serquinox LLC
DBA: Axelacare
1934 Old Gallows Road
Vienna, VA 22182

Services:

- Home Health, Non-Hospice Services
- Skilled Nursing Services

Serquinox LLC
DBA: AxelaCare
9204 Berger Road, Suite A
Columbia, MD 21046

Services:

- Durable Medical Equipment
- Enteral Equipment and/or Supplies
- Enteral Nutrients
- External Infusion Pumps and/or Supplies
- Home Health, Non-Hospice Services
- Parenteral Equipment and/or Supplies

- Parenteral Nutrients
- Pharmacy, Clinical Consulting Services
- Pharmacy/Dispensary, General Services
- Skilled Nursing Services
- Supplies

Sirona Infusion, LLC
460 S. Benson Lane, Suite 11-12
Chandler, AZ 85224

Services:

- Durable Medical Equipment
- Enteral Equipment and/or Supplies
- Enteral Nutrients
- External Infusion Pumps and/or Supplies
- Home Health, Non-Hospice Services
- Parenteral Equipment and/or Supplies

- Parenteral Nutrients
- Pharmacy, Clinical Consulting Services
- Pharmacy/Dispensary, General Services
- Skilled Nursing Services
- Supplies

Sirona Infusion, LLC
DBA: AxelaCare
12503 E. Euclid Drive, Unit 80
Centennial, CO 80111

Services:

- Durable Medical Equipment
- Enteral Equipment and/or Supplies
- Enteral Nutrients
- External Infusion Pumps and/or Supplies
- Home Health, Non-Hospice Services

- Parenteral Equipment and/or Supplies
- Pharmacy, Clinical Consulting Services
- Pharmacy/Dispensary, General Services
- Skilled Nursing Services
- Supplies

Sirona Infusion, LLC
DBA: AxelaCare
2420 Comanche NE, Suite A5
Albuquerque, NM 87107

Services:

- Durable Medical Equipment
- Enteral Equipment and/or Supplies

- Parenteral Nutrients
- Pharmacy, Clinical Consulting Services

QualityReport

- Enteral Nutrients
- External Infusion Pumps and/or Supplies
- Home Health, Non-Hospice Services
- Parenteral Equipment and/or Supplies
- Pharmacy/Dispensary, General Services
- Skilled Nursing Services
- Supplies

Summit Home Infusion, LLC
3135 New Germany Road, Suite 38
Ebensburg, PA 15931

Services:

- Durable Medical Equipment
- Enteral Nutrients
- External Infusion Pumps and/or Supplies
- Parenteral Equipment and/or Supplies
- Parenteral Nutrients
- Pharmacy, Clinical Consulting Services
- Pharmacy/Dispensary, General Services
- Supplies

- Top -

The Joint Commission obtains information about accredited/certified organizations not only through direct observations by its employees [...Read more.](#)

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EXHIBIT B

(Available at meeting)

EXHIBIT C

RPh Initial Assessment / Care Plan* For TEST TEST

Date of Birth 08/19/1953

Visit Info

Clinician Lynn Day	Visit Date / Time 01/15/2016 02:53:41 PM
Visit Location	Visit Type

Vital Info

Last / First TEST, TEST	Drug Allergies Penicillins
Address 14 Lookout Ct	Other Allergies
City / State / Zip Sacramento, CA 95831	Diabetic
Diet	Code Status
Home Phone 916-424-0444	Language English
Work Phone Cell	Diagnosis 3 -
Diagnosis 1 Cellulitis of face L03.211	Diagnosis 4 -
Diagnosis 2 -	

Access / Vital Signs

Access Type	Date	Placed By
BP	HR	RR
		TEMP
		WT (lbs.)

Clinician Lynn Day

Visit Date / Time 01/15/2016 02:53:41

Question

Answer

Subjective / Objective

- 1 Patient age
- 2 Patient sex
- 3 Height
- 4 Patient weight (pounds)
- 5 Is the Weight
- 6 PMH/PSH Summary
- 7 Smoking history:
- 8 Alcohol usage:
- 9 Recreational drug usage:
- 10 Social Issues noted
- 11 Therapy diagnosis reviewed:
- 12 Is this a first dose of medication?
- 13 Therapy Ordered

RPh Initial Assessment / Care Plan* For TEST TEST

Clinician Lynn Day

Date of Birth 08/19/1953

Visit Date / Time 01/15/2016 02:53:41

Question

Answer

(Drug, Dose, Frequency, length of infusion)

14 Type of Administration / Device

15 Expected length of Therapy

16 Type of IV Access

17 If other, please list

18 Number of lumens

19 Agency or RN contacted?

Assessment

20 Orders signed and complete

21 Are the medication orders appropriate for:

22 Follow up required?

23 If yes, explain

Plan

24 Obtain medication profile & assess for potential drug interactions & therapeutic duplications

25 Monitoring Plan

26 Labwork orders / changes

27 Other

28 Frequency of labwork:

29 Pharmacist Assessment comments

RPh 24-72 hr Follow Up Assessment* For TEST TEST

Clinician Lynn Day

Visit Date / Time 01/15/2016 02:54:36

Question

Answer

Subjective / Objective

- 1 Verification of Patient Identity
- 2 If not the patient - enter name and relationship to patient
- 3 Patient or caregiver can confirm contact information for pharmacy and nursing:
- 4 Patient / caregiver to confirm the following are available in home:
[NO to any item - please address in planning section]
- 5 Current Infusion Orders

Assessment

- 6 Any problems with the infusion of medication we are providing?
- 7 Medication related side effects
- 8 Any problems with infusion supplies and / or equipment
- 9 If answered "YES" to any of the above questions, explain:
- 10 Allergies confirmed with patient, updated in profile, noting type or severity of reaction if relayed:
- 11 Social history and PMH reviewed and updated; as needed
- 12 Pain at present
- 13 Current pain level (0=none, 10=worst)
- 14 Pain comments

Nutritional Risk Screening

- 15 Is this patient full service {AxelaCare nursing and pharmacy}?
- 16 Diet:
- 17 Is education / reinforcement required:

RPh 24-72 hr Follow Up Assessment* For TEST TEST

# Question	Answer
18 Height	
19 Current weight	
20 Usual weight (prior to illness)	
21 Weight loss of greater than 10% over 3 months?	
22 Chronic disease state?	
23 Illness or condition exists that caused decreased PO intake for greater than 5 days?	
24 Does the patient have any of the following nutritional risk factors:	
25 Nutritional Risk	
26 Nutritional Comments	

Medications

- 27 Medication profile reconciliation performed (open med profile tab & enter / update information)
- 28 Drug Utilization Review performed
- 29 Medication counseling / education offered by the pharmacist to the patient regarding current medication(s) & OTC(s)
- 30 Medication Profile Comments

Plan

- 31 Review with patient / caregiver(s) plan for therapy; monitoring, goals and expectations:
- 32 Pharmacist Assessment comments
- 33 Next RN visit is scheduled for? // :: AM
- 34 Next physician or clinic appointment // :: AM
- 35 Scheduled delivery date: // :: AM

RPh Additional Care Plan Assessment* For TEST TEST

Clinician Lynn Day

Visit Date / Time 01/15/2016 02:55:07

Question

Answer

Subjective / Objective

- 1 Is additional assessment related a new diagnosis (medication) added for ongoing patient? {e.g. PN patient needing ABX}
- 2 If yes, please document the additional diagnosis:
- 3 Is this additional assessment from a change of one medication to a new medication for the same diagnosis
- 4 If yes, please document the medication to be stopped with reason for change. (e.g.: ceftriaxone 2gm ivp q24 stopped due to elevated ALT at 565)
- 5 Therapy Ordered
(Drug, Dose, Frequency, length of infusion)
- 6 Expected length of Therapy
- 7 Is this a first dose of medication?
- 8 Name & phone of Monitoring Physician
- 9 Agency or RN contacted?

Assessment

- 10 Orders obtained & complete as required by state regulations
(including RX for Heparin, Saline; Ancillaries and / or Anaphylaxis kit as applicable)
- 11 Prescription medication is appropriate for:
- 12 Desired outcome for the treating diagnosis

Plan

- 13 Medication change
- 14 Drug Utilization Review performed
- 15 Labwork orders / changes
- 16 Monitoring Plan
- 17 Other patient specific monitoring parameters

Pharmacy Refill Assessment* For TEST TEST

Clinician Lynn Day

Visit Date / Time 01/15/2016 02:55:40

Question

Answer

Subjective / Objective

- 1 Date patient called: // : : AM
- 2 Name of person initiating this form:
- 3 Verification of patient identity:
[choose two]
- 4 If not the patient - enter name and relationship
to patient
- 5 Any changes to insurance?
- 6 New insurance information:
- 7 Therapy Type
- 8 Current Infusion Orders
- 9 Since our last call; are you feeling?
- 10 What is the patients current weight?
(review / update in med info tab)
- 11 Are you having an side effects such as:
- 12 Any problems with the infusion of medication
we are providing?
- 13 Any missed doses?
- 14 Any problems with IV site?
- 15 If answered "YES" to any of the above
questions, explain:
- 16 Have you been to the doctors office recently?
- 17 If yes, did the physician change any of your
medications?

Plan

- 18 Has the Pharmacy Inventory Note been
completed for this dispense? (NOTE:
Mandatory for all Medicare patients)
- 19 Scheduled delivery date: // : : AM
- 20 Delivery should last through: // : : AM
- 21 Next physician or clinic appointment // : : AM
- 22 Next nursing visit? // : : AM

Pharmacy Refill Assessment* For TEST TEST

Question

Answer

Assessment

- 23 Were issues relayed by the patient requiring clinician follow up?
- 24 Clinician intervention comments:
[patient and/or prescriber]
- 25 Were there medication profile changes made?
- 26 Medication profile comments:
- 27 Pharmacy Labwork Review
- 28 Labwork Review Comments

- 29 Patient information assessed by this clinical pharmacist and appropriate to continue current orders as noted in EMR
- 30 Pharmacist Assessment comments

EXHIBIT D

Access I.V.
4610 Northgate Boulevard Ste 130
Sacramento, CA 95834-1154

Rx# 01100377 Date Filled: 11/11/15

TPN 3 in 1 3250 ml (Mon-Fri) # 5

Directions:

ON MON-FRI. Add MVI to bag & mix well. Infuse one bag over 16hrs via CADD pump. Pump prog: Tot Res Vol = 3350ml, Tot Vol Inf = 3250ml, Taper 0, Taper down = 2hrs. Warm bag to room temp prior to use. Compounded by Access.

up

Exp: 11/20/15 RPH:LD Storage: Keep Refrigerated

exp 11/08/2016

CAUTION: Federal law prohibits transfer of this drug to any person other than the patient for whom prescribed

Access I.V.
4610 Northgate Boulevard Ste 130
Sacramento, CA 95834-1154

Rx# 01100371 Date Filled: 11/11/15

TPN 3:1 2500 ml MWF # 3

Directions:

Infuse 2400ml TPN IV daily over 12 hour via CADD Pump prog: Res Vol:2550 ml Inf Vol:2500ml Period: 12 Hr Taper Up/Down 1 Hr up and 1Hr Allow to warm to room temperature prior to Add 10ml Infuvite just prior to use DAILY.

down

Exp: 11/20/15 RPH:AB Storage: Keep Refrigerated

CAUTION: Federal law prohibits transfer of this drug to any person other than the patient for whom prescribed

Access I.V.
4610 Northgate Boulevard Ste 130
Sacramento, CA 95834-1154

Rx# 01100377 Date Filled: 11/11/15

CEFTAZIDIME 5 GM/ NS 230ML # 6

Directions:

Infuse contents of one Eclipse over 22 hours once as directed. Begin infusion at same time each day. Remove from refrigerator 2-3 hours prior to Do Not Heat.

daily

Fixed this in system (modified label) but was on screen as this label reads.

Exp: 11/25/15 RPH:RM Storage: Keep Refrigerated

BOT 11/20/15

CAUTION: Federal law prohibits transfer of this drug to any person other than the patient for whom prescribed

Access I.V.
4610 Northgate Boulevard
Sacramento, CA 95834-1154
916-648-0124 DEA#: FA3534004

Rx #: 0110037844 11/20/15 Qty: 1

Anaphylaxis Kit 1 EA

Manuf: Misc (2 caps)

Directions:
Mild reaction give diphenhydramine 50mg Slow
infusion. If needed, give 2 additional (50mg) For
moderate reaction, give 50mg diphenhydramine
and STOP inf. For severe breathing problem, give
50mg IV diphenhydramine, EpiPen, Saline, call 911

Storage:
Discard After: 12/20/15 RPh: AB

CAUTION: Federal law prohibits transfer of this drug to any person other than the patient for whom prescribed

Access I.V.
4610 Northgate Boulevard
Sacramento, CA 95834-1154
916-648-0124 DEA#: FA3534004

Rx #: 0110037154 09/22/15 Qty: 4

HIZENTRA 10GM SUB Q WEEKLY

Manuf: CSL

Directions:
Withdraw a total of 10 gm (50 ml) into 60 ml syringe
infuse subcutaneously once weekly via Freedom 60
pump. Dose will infuse over approximately 65
using F-900 tubing and 3 sites
dose = 10gm per week.

Storage: Room Temperature
Discard After: 08/27/16 RPh: LD

Access I.V.
4610 Northgate Boulevard
Sacramento, CA 95834-1154 916-648-0124

Access I.V.
4610 Northgate Boulevard
Sacramento, CA 95834-1154 916-648-0124

RX# 0110035040 Date Filled: 10/27/2014

DiphenhydrAMINE Capsule # 2

Storage:

Warning: FOR ORAL USE ONLY

Take 1-2 capsules (25-50 mg) by mouth prior to IVIG infusion as needed

Manuf: MAJOR PHARMACEUTICALS

Refills: 12 RPh: LD Exp Date: 10/27/2015

CAUTION: Federal law prohibits transfer of this drug person other than the patient for whom

RX# 0110035041 Date Filled: 10/27/2014

Acetaminophen Oral Tablet 325 # 8

Storage: Room Temperature

Warning: FOR ORAL USE ONLY

Take 1-2 tablets (325-650 mg) by mouth prior to IVIG infusion as needed

Manuf: MAJOR PHARMACEUTICALS

Refills: 12 RPh: LD Exp Date: 10/27/2015

CAUTION: Federal law prohibits transfer of this drug person other than the patient for whom

Access I.V.
4610 Northgate Boulevard
Sacramento, CA 95834-1154
916-648-0124 DEA#: FA3534004

[REDACTED]
Rx #: 0110037155 08/28/15 Qty: 1

Anaphylaxis kit

Directions:

Manuf: DEY LABS

Slow infusion, IS

Mild reaction, give diphenhydramine 50mg (2 caps) needed give additional 50mg. Moderate reaction, give diphenhydramine 50mg & stop infusion. For severe reaction with breathing problem, give diphenhydramine 50mg IM, EpiPen, and call 911

Storage: Room Temperature

Discard After: 08/27/16 RPh: LD

CAUTION: Federal law prohibits transfer of this drug to any person other than the patient for whom prescribed

Access I.V.
4610 Northgate Boulevard
Sacramento, CA 95834-1154 916-648-0124

[REDACTED]
RX# 0110034805 Date Filled: 10/15/2014

Isosource HN Liquid # 180

Storage:

Warning: FOR ENTERAL USE ONLY

Start bolus feed using 1/2 can 6x daily.

Increase by 1/2 can per feeding as *operated*

Manuf: NESTLE HEALTHCARE NUTRITION

Refills: 3 RPh: LD/m Exp Date: 09/02/2015

CAUTION: Federal law prohibits transfer of this drug person other than the patient for whom

November 23, 2015

Virginia Herold
Executive Officer
California Board of Pharmacy
1625 North Market Blvd, Suite N219
Sacramento, CA 85634

Subject: Request for Exemption – Patient Centered Labels (1707.5)

Access IV is requesting an exemption to the Patient Centered labeling requirements as outlined in section Article 4, Section 4076.5. In that section the rules spell out those requirements that can be met to have the board consider such exemption.

Access IV is a provider of home infusion services and is accredited by The Joint Commission. The four pharmacies listed below are accredited under AxelaCare Holdings, Inc., organizational ID 473713. Results of the accreditation survey that was conducted in April of 2015 can be provided if requested.

As part of Access IV's services provided, all patients are provided education as part of their start of care. Nurses provide on site care, while the office based pharmacists provide education and support telephonically. Written education materials are provided as part of this start of care and include a welcome packet, administration directions, drug information, etc. Due to the nature of the compounded sterile products dispensed, patients receive weekly deliveries and all patients are contacted prior to a delivery to review and assess adherence, compliance, tolerance to the medication(s), medication and supply usage, etc. If laboratory monitoring has been ordered by the prescriber, labs are reviewed and the prescriber contacted as part of the medication review.

All patients have a care plan prepared at the start of care based on the prescriber's orders, and an assessment of the patient, their home environment, etc. The plan of care is updated as necessary.

Access IV has implemented a patient centered label but is seeking an exemption due to limitations in the pharmacy dispensing system. An example is found to the right, and several others are separately attached. Specifically, due to the limitations of the label width and number of characters that can fit in the direction field, the system is cutting off words, etc. when printing, although all information looks correct on the screen. This in turn has increased the time required for the pharmacists to process a prescription due to having to print a label, review for missing words, adjust the text in the direction field, reprint, etc.

Access IV,
4610 Northgate Boulevard
Sacramento, CA 95834-1154
916-648-0124 DEAR: FA3534004

EXP: [REDACTED] 11/20/15 Exp: [REDACTED]

TYGACIL 50MG / 100ML NS MB+ Manufacturer: WYETH

Directions: **Infuse the contents of 1 bag (TYGACIL 50MG) intravenously every 24 hours over 30-60 minutes via dial-a-flow tubing. **after admixture stable for 18 hour at room and 2 days at refrigeration*** Cmpd by**

Storage: Room Temperature RPh: AB/ks

Discard After: 12/08/15

CAUTION: Federal law prohibits transfer of this drug to any person other than the patient for whom prescribed

Experience. The Difference.

It also increases the opportunity to have product labeled with incomplete directions. Also the larger font (12 pt, BOLD) is resulting in a label that looks busy, sometimes hard to follow, etc. The original label uses a smaller font size similar to the branch's address.

All the Access IV branches listed below follow a common core set of policies and procedures for the company, provide initial and ongoing education, care plan development and review and patient monitoring based on the prescribers' orders and/or prescriptions. Patients are contacted weekly and as stated above, that contact includes a review of compliance, adherence and tolerance to the drug(s).

The four sites requesting this exemption include:

Access IV
4610 Northgate Blvd, Suite 130
Sacramento, CA 95834
License Nbr: 53890
Sterile Cmpd: 99867
PIC: Lynn Day (44383)

Access IV
455 Reservation Road, Suite G
Marina, CA 93933
License Nbr: 53892
Sterile Cmpd: 99868
PIC: Jonathan Vessey (53348)

InfuSource, LLC dba Access IV
170 Professional Center Drive, Suite C
Rohnert Part, CA 94928
License Nbr: 53893
Sterile Cmpd: 99866
PIC: Maria Ledezma (43965)

ARC Infusion, LLC dba Access IV
12604 Hiddencreek Way, Suite C
Cerritos, CA 90703
License Nbr: 53891
Sterile Cmpd: 100742
PIC: Wawan Natapraya (46801)

Thank you for considering this request and we look forward to having further discussions with the Board. Should any additional information be needed or requested, please contact myself at the phone number or email address below.

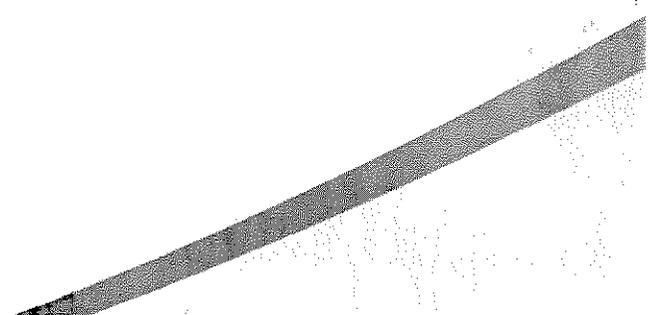
Respectfully,

Ramona Moenter, RPh, MBA

Ramona Moenter, R.Ph., MBA
General Manager
(831) 384-8080
rmoenter@accessiv.com



Lynn Day, PharmD
Pharmacist-in-Charge
(831) 384-8080
lday@accessiv.com



Access I.V.
4610 Northgate Boulevard
Sacramento, CA 95834-1154
916-648-0124 DEA#: FA3534004

Rx #: 0110037844

11/20/15

Qty: 1

Anaphylaxis Kit 1 EA

Directions:

Manuf: **Misc**

Mild reaction give diphenhydramine 50mg, slow
infusion. If needed, give 2 additional 50mg. For
moderate reaction, give 50mg diphenhydramine
and STOP inf. For severe breathing problem, give
50mg IV diphenhydramine, EpiPen, Saline, call

Storage:

911

Discard After: 12/20/15

RPh: AB

CAUTION: Federal law prohibits transfer of this drug to any person other than the patient for whom prescribed

Access I.V.
4610 Northgate Boulevard Ste 130
Sacramento, CA 95834-1154

Rx# 01100377 Date Filled: 11/11/15

TPN 3 in 1 3250 ml (Mon-Fri) #5

Directions:

ON MON-FRI. Add MVI to bag & mix well. Infuse one bag over 16hrs via CADD pump. Pump prog: Tot Res Vol = 3350ml, Tot Vol Inf = 3250ml, Taper 0, Taper down = 2hrs. Warm bag to room temp prior to use. Compounded by Access.

up

Exp: 11/20/15 RPH:LD Storage: Keep Refrigerated

exp 11/08/2016

CAUTION: Federal law prohibits transfer of this drug to any person other than the patient for whom prescribed

Access I.V.
4610 Northgate Boulevard Ste 130
Sacramento, CA 95834-1154

Rx# 01100371 Date Filled: 11/11/15

TPN 3:1 2500 ml MWF #3

Directions:

Infuse 2400ml TPN IV daily over 12 hour via CADD Pump prog: Res Vol:2550 ml Inf Vol:2500ml Period: 12 Hr Taper Up/Down 1 Hr up and 1Hr Allow to warm to room temperature prior to Add 10ml Infuvite just prior to use DAILY.

down

Exp: 11/20/15 RPH:AB Storage: Keep Refrigerated

CAUTION: Federal law prohibits transfer of this drug to any person other than the patient for whom prescribed

Access I.V.
4610 Northgate Boulevard Ste 130
Sacramento, CA 95834-1154

Rx# 01100377 Date Filled: 11/11/15

CEFTAZIDIME 5 GM/ NS 230ML #6

Directions:

Infuse contents of one Eclipse over 22 hours once as directed. Begin infusion at same time each day. Remove from refrigerator 2-3 hours prior to Do Not Heat.

daily

Fixed this in system (modified label) but was on screen as this label reads.

Exp: 11/25/15 RPH:RM Storage: Keep Refrigerated

EOT 11/20/15

CAUTION: Federal law prohibits transfer of this drug to any person other than the patient for whom prescribed

Attachment 4

CA State Board of Pharmacy Regulations:

- (a) A pharmacist furnishing emergency contraception pursuant to Section 4052.3(a)(2) of the Business and Professions Code shall follow the protocol specified in subdivision (b) of this section.
- (b) Protocol for Pharmacists Furnishing Emergency Contraception (EC).
 - (1) Authority: Section 4052.3(a)(2) of the California Business and Professions Code authorizes a pharmacist to furnish emergency contraception pursuant to a protocol approved by the California State Board of Pharmacy and the Medical Board of California. Use of the protocol specified in this section satisfies that requirement.
 - (2) Purpose: To provide timely access to emergency contraceptive medication and ensure that the patient receives adequate information to successfully complete therapy.
 - (3) Procedure: When a patient requests emergency contraception, the pharmacist will ask and communicate the following:

Are you allergic to any medications?

Timing is an essential element of the product's effectiveness. EC should be taken as soon as possible after unprotected intercourse. Treatment may be initiated up to five days (120 hours) after unprotected intercourse.

EC use will not interfere with an established or implanted pregnancy.

If more than 72 hours have elapsed since unprotected intercourse, the use of ella™ (ulipristal) may be more effective than levonorgestrel. For other options for EC, consult with your health care provider.

Please follow up with your health care provider after the use of EC.

- (4) The pharmacist shall provide a fact sheet and review any questions the patient may have regarding EC. In addition, the pharmacist shall collect the information required for a patient medication record required by Section 1707.1 of Title 16 of the California Code of Regulations. Fact Sheet: The pharmacist will provide the patient with a copy of the current EC fact sheet approved by the Board of Pharmacy as required by Business and Professions Code Section 4052.3(e).
- (5) Referrals and Supplies: If emergency contraception services are not immediately available at the pharmacy or the pharmacist declines to furnish pursuant to conscience clause, the pharmacist will refer the patient to another emergency contraception provider. The pharmacist shall comply with all state mandatory reporting laws, including sexual abuse laws.
- (6) The pharmacist may provide up to 12 non-spermicidal condoms to each Medi-Cal and Family PACT client who obtains emergency contraception.
- (7) Advanced provision: The pharmacist may dispense emergency contraception medication for a patient in advance of the need for emergency contraception.
- (8) EC Product Selection: The pharmacist will provide emergency contraception medication from the list of products specified in this protocol. This list must be kept current and maintained in the pharmacy. Along with emergency contraception products, the list will include adjunctive medications indicated for nausea and vomiting associated with taking EC containing estrogen. Patients will be provided information concerning dosing and potential adverse effects.
- (9) Documentation: Each prescription authorized by a pharmacist will be documented in a patient medication record as required by law.
- (10) Training: Prior to furnishing emergency contraception, pharmacists who participate in this protocol must have completed a minimum of one hour of continuing education specific to emergency contraception.

(11) Medications Used for Emergency Contraception

Dedicated Approved Products for Emergency Contraception

Ethinyl Estradiol Brand Dose

<i>per dose (mcg) One Tablet Regimens Plan B™ One-Step</i>	1 tablet	0	1.5mg levonorgestrel
ella™	1 tablet	0	30mg ulipristal
Levonorgestrel	1 tablet	0	1.5mg levonorgestrel

Two Tablet Regimens

Next Choice™	2 tablets at once (1.5mg total dose) or 1 tablet (0.75mg) followed by 1 tablet (0.75mg) 12 hours later	0	Each tablet is 0.75 mg levonorgestrel
Levonorgestrel	2 tablets at once (1.5mg total dose) or 1 tablet (0.75mg) followed by 1 tablet (0.75mg) 12 hours later	0	Each tablet is 0.75 mg levonorgestrel

Oral Contraceptive Pills

<i>Brand</i>	<i>Tablets per Dose (two doses 12 hours apart*)</i>	<i>Ethinyl Estradiol per dose (mcg)</i>	<i>Levonorgestrel per dose (mg)*</i>
Alesse	5 pink tablets	100	0.50
Aviane	5 orange tablets	100	0.50
Levlen	4 light-orange tablets	120	0.60
Levlite	5 pink tablets	100	0.50
Levora	4 white tablets	120	0.60
Lo/Ovral	4 white tablets	120	0.50
Low-Ogestrel	4 white tablets	120	0.60
Nordette	4 light-orange tablets	120	0.60
Ogestrel	2 white tablets	100	0.50
Ovral	2 white tablets	100	0.50
Tri-Levlen	4 yellow tablets	100	0.50
Triphasil	4 yellow tablets	120	0.50
Trivora	4 pink tablets	120	0.50
Ovrette	20 yellow tablets	0	0.75

*The progestin in Ovral, Lo/Ovral, and Ovrette is norgestrel, which contains two isomers, only one of which (levonorgestrel) is bioactive; the amount of norgestrel in each dose is twice the amount of levonorgestrel.

In addition to the products specified in this paragraph, generic equivalent products may be furnished. Estrogen containing regimens are not preferred and should be used only when the other options are not available.

(12) Anti-nausea Treatment Options for use with Emergency Contraception

<i>Non-Prescription Drugs</i>	<i>Dose</i>	<i>Timing of Administration</i>
Meclizine hydrochloride (Dramamine II, Bonine)	One or two 25 mg tablets	1 hour before first EC dose; Repeat if needed in 24 hours
Diphenhydramine hydrochloride (Benadryl)	One or two 25 mg tablets or capsules	1 hour before first EC dose; repeat as needed every 4-6 hours
Dimenhydrinate (Dramamine)	One or two 50 mg tablets or 4-8 teaspoons liquid	30 minutes to 1 hour before first EC dose; repeat as needed every 4-6 hours
Cyclizine hydrochloride (Marezine)	One 50 mg tablet	30 minutes before first EC dose; repeat as needed every 4-6 hours

Note: Authority cited: Section 4005, Business and Professions Code. Reference: Sections 4052 and 4052.3, Business and Professions Code.



January 6, 2016

To: State Boards of Pharmacy
Pharmacy Professional Associations
Pharmacy Corporations

Re: Emergency Contraception Guide for Pharmacies

As advocates for direct pharmacy access and over the counter access to emergency contraception (EC), the undersigned organizations encourage state boards of pharmacy, professional pharmacy associations, and pharmacy corporations to facilitate access by disseminating resources to pharmacists, pharmacy staff, and the public. States with pharmacist EC protocols in place have an additional opportunity to ensure timely access to this medication.

In the past several years, there have been numerous new EC products and changes in regulations, such as restricting access based on age or checking identification. As a result, pharmacies are often unable to keep up with the latest products and changes. This has led to misinformation to the public and refusals by community pharmacies, most commonly related to presumed age or gender restrictions.

Some key findings from recent studies of pharmacy access to EC:

- EC is available in 80% of pharmacies [Wilkinson et al. 2012; Samson et al. 2013; Rafie et al. 2013].
- Pharmacy staff members regularly give misinformation about age restrictions for EC to consumers (43%) and physicians (39%) alike [Wilkinson et al. 2012]. Callers are often put on hold or passed between multiple pharmacy staff members to get answers to their questions about EC [Wilkinson et al. 2012; Nelson et al. 2009].
- Young men are denied EC at pharmacies that require the presence of a female or her identification card [Bell et al. 2015; Wilkinson et al. 2014].

To address the knowledge and awareness deficits among pharmacists, pharmacy staff, and consumers alike, we encourage boards of pharmacy, professional pharmacy associations, and pharmacy corporations to make accurate information available to public consumers, as well as their licensees, members, and employees. Suggested resources include a pharmacy guide to the various EC products, EC locator tools, and patient education materials and websites.

A concise and comprehensive guide on EC product availability and access has been developed to serve as an easy reference to stay current on access issues and available products. This guide is intended for use as a reference for pharmacists, as well as pharmacy or store management and staff.

The guide is updated as needed and can be found on the American Society for Emergency Contraception (ASEC) website:

http://americansocietyforec.org/uploads/3/2/7/0/3270267/pharmacy_ec_access_overview.pdf.

The guide is also available in Spanish:

http://americansocietyforec.org/uploads/3/2/7/0/3270267/pharmacy_ec_access_overview_spanish.pdf

This guide was developed by ASEC in collaboration with the American College of Clinical Pharmacy Women's Health Practice and Research Network and the Reproductive Health Technologies Project. Organizations are welcome to adapt this guide to meet their needs.

Pharmacies are encouraged to stock EC products and make them available on the over-the-counter shelves as well, in order to minimize barriers to access. Pharmacists can help provide evidence-based counseling on medications, in addition to referrals for more effective methods of contraception and sexually transmitted infection screening/treatment. Please refer to specific state laws regarding refusals for personal objections.

Sincerely,



Kelly Cleland, MPA MPH
Executive Director
American Society for Emergency Contraception



Jessica Arons
President & CEO
Reproductive Health Technologies Project



Brooke Griffin, PharmD, BCACP
Chair
American College of Clinical Pharmacy Women's Health Practice & Research Network

EMERGENCY CONTRACEPTION: A GUIDE FOR PHARMACIES AND RETAILERS (JUNE 2015)

What is emergency contraception (also known as “the morning-after pill”)?

- Emergency contraception (EC) prevents pregnancy; EC will not disrupt an existing pregnancy.
- EC pills that contain the progestin hormone, levonorgestrel (LNG), are sold under several names. Most levonorgestrel EC products are available over-the-counter (OTC) without age restrictions. (See reverse side for specific medication details.)
- EC pills that contain ulipristal acetate are available and are prescription only.
- All EC works best when taken as soon as possible after unprotected sex but may be effective up to 5 days after.
- EC is safe for women of all ages to use.

What are the restrictions for purchasing EC over-the-counter? Do customers need to show ID?

- For the one-pill LNG EC products containing one 1.5 mg levonorgestrel pill (brand and generics), there are NO age or point-of-sale restrictions. Previously, OTC purchases were subject to age restrictions, but these have been removed by the U.S. Food and Drug Administration (FDA) and most brands have updated their labels to reflect the new regulations.
 - Any woman or man of any age can purchase these EC products without needing to show ID.
 - There is no limit on the number of packages that a person can purchase.
 - Although some of the generic one-pill product labels state that the product is intended for women aged 17 and older, this is not a restriction on sale (no ID required); it is guidance for the consumer only.
- For the two-pill LNG EC products containing two 0.75 mg levonorgestrel pills, there are still age restrictions and these must be kept behind the pharmacy counter. A pharmacy staff member must check ID to ensure the person purchasing the product is age 17 or older, but a pharmacist consultation is not required.

Can men purchase LNG EC?

- Yes, men can purchase over-the-counter LNG EC. There are no sex/gender restrictions on the sale of any over-the-counter products. However, prescriptions for EC can only be issued to the patient who will be taking it.

Where can EC be found within pharmacies and stores?

- Pharmacies and retailers can sell one-pill LNG EC products directly from store shelves as long as the products have updated OTC packaging.
 - Most retailers stock it in the family planning aisle so it can be found easily.
 - There is no need for these EC products to be kept behind the pharmacy counter.
- Two-pill LNG EC products must still be stocked behind the pharmacy counter. The customer can purchase the product without a prescription if they are at least 17 years old. Patients aged 16 or younger will need a prescription. Some states may have protocols that allow the pharmacist to provide a prescription directly to patients.
 - You may consider removing these products from your stock unless they are cheaper than the one-pill products. The one-pill product is easier for patients to take and there's no chance of not taking the second pill at the right time.
- Ulipristal acetate is available by prescription only so it must be kept behind the pharmacy counter. Some states may have protocols that allow the pharmacist to provide a prescription directly to patients.

Why is it important to stock one-pill LNG EC on the shelf?

- EC is a woman's last chance to prevent an unintended pregnancy after birth control failure, sexual assault, or unprotected sex.
- EC works best when it's taken as soon as possible. Convenient and timely access is critically important.
- Keeping EC behind the counter is an unnecessary and harmful barrier; FDA has approved these EC products to be sold on store shelves without any restrictions.
- Customers may feel embarrassed about purchasing EC; placing it directly on the shelf without locked security boxes protects people's privacy and confidentiality.
- Pharmacies and stores have an important role to play in helping women prevent unintended pregnancy by maintaining a stock of easily accessible EC on the shelf at all times.

What can I do if my store doesn't stock one-pill LNG EC on the shelf?

- If you are the person who makes stocking decisions, you can make space for EC in the family planning aisle.
- If your store doesn't sell EC on the shelf, it may be because the regulations around EC have changed frequently in the past few years, and it can be confusing. Share these guidelines with your management and encourage them to stock EC on the shelf.
- If you cannot fulfill a customer's request for EC, please refer them to Not-2-Late's EC locator: www.not-2-late.com.

FDA-APPROVED EMERGENCY CONTRACEPTIVE PILLS AS OF JUNE 2015

Under current regulations, the medications listed below should be made available in the following ways:

MEDICATION	INFORMATION
<p>Brand and Generic <u>One-Pill</u> Levonorgestrel EC Products</p>	<ul style="list-style-type: none"> • May be stocked on OTC shelves in stores. • Label may indicate that the product is intended for use by women ages 17 and older, but ID check is <u>not</u> required. • Take as soon as possible; may be effective up to 5 days after unprotected sex. • 1 tablet (1.5 mg levonorgestrel)
<p>Generic <u>Two-Pill</u> Levonorgestrel EC Product</p>	<ul style="list-style-type: none"> • <u>Must</u> be stocked behind the pharmacy counter. • Prescription required for those 16 years and younger. Available for purchase over-the-counter for those 17 and older. • Only EC product that is currently "dual labeled" for prescription and OTC usage. • Take both pills together as soon as possible; may be effective up to 5 days after unprotected sex. • 2 tablets (each 0.75 mg levonorgestrel)
<p>Ulipristal acetate</p>	<ul style="list-style-type: none"> • <u>Must</u> be stocked in the pharmacy as a prescription-only drug. • Available for purchase by prescription at the pharmacy and online. • Only EC product labeled for prescription use only. • Take as soon as possible; effective up to 5 days after unprotected sex. • 1 tablet (30 mg ulipristal acetate)

If you have questions or want to share comments about how EC is sold at your store, contact us:
asec@americansocietyforec.org.

Learn more about EC at www.not-2-late.com and www.rhtp.org.

Pharmacy Access to Emergency Contraception in California: Opportunities for Enhancing Pharmacist and Public Education

Situation:

Many opportunities related to availability of emergency contraception (EC) and misinformation given to consumers and prescribers identified anecdotally and by research studies. Selected key findings:

- EC is available in 80% of pharmacies [Wilkinson et al. 2012; Samson et al. 2013; Rafie et al. 2013].
- Pharmacy staff members regularly give misinformation about age restrictions for EC to consumers (43%) and physicians (39%) alike [Wilkinson et al. 2012]. Callers are often put on hold or passed between multiple pharmacy staff members to get answers to their questions about EC [Wilkinson et al. 2012; Nelson et al. 2009].
- Young men are denied EC at pharmacies that require the presence of a female or her identification card [Bell et al. 2015; Wilkinson et al. 2014].
- Use of EC among sexually active teens has increased from 15% in 2006-2010 to 22% in 2011-2013 ($p < 0.05$) [NCHS Data Brief #209].

Background:

California has a protocol for pharmacists to provide direct pharmacy access to emergency contraception. The protocol was recently expanded to include all emergency contraceptive pills, including the newest ulipristal acetate (Ella).

Assessment:

Pharmacists may believe there's no need for pharmacy access to EC now that there are over-the-counter products available. However, pharmacy access is critical for insurance coverage and to ensure patients receive the most effective method. All prescribed contraceptives are covered without patient cost sharing by plans compliant with the Affordable Care Act requirements. The over-the-counter EC products range from ~\$40-\$55. Further, many consumers are facing barriers to the over-the-counter product such as age, ID, and gender requirements [see Situation section above]. All the over-the-counter EC products contain levonorgestrel. Pharmacists may determine that ulipristal acetate (Ella) is more effective for a particular patient based on how many hours since unprotected intercourse or her body weight [Cleland et al. 2014]. Pharmacy access remains critical for some women who need to access this product.

Many pharmacists may be unaware that ulipristal acetate (Ella) was added to the California protocol. Prescriber awareness and prescribing of ulipristal acetate (Ella) remains low as well at 52% and 14% respectively [Batur et al. 2015].

Pharmacy Access to Emergency Contraception in California: Opportunities for Enhancing Pharmacist and Public Education

Recommendations:

Pharmacist Education:

- Include an article in the next issue of The Script newsletter regarding this pharmacist authority and recent updates to the protocol.
- Add the following resources on the Board website where the protocol is posted:
 - EC guide for pharmacies and retailers (by the American Society of Emergency Contraception, Reproductive Health Technologies Project, and the American College of Clinical Pharmacy Women's Health Practice and Research Network) on the Board website with the protocol: http://americansocietyforec.org/uploads/3/2/7/0/3270267/pharmacy_ec_access_overview.pdf
 - Locator tools that pharmacists can list their pharmacies in:
 - Princeton's Not2Late EC locator: <http://ec.princeton.edu/providers.html>
 - Bedsider EC locator: http://bedsider.org/clinic_submissions/new?has_ec=true
 - Patient education materials that can be printed or ordered: <http://providers.bedsider.org/order-materials/> and <http://www.reproductiveaccess.org/resources/>

Public/Consumer Education:

- There is currently nothing on the Board website aimed at the public related to EC and pharmacy access to EC. Under the Consumers tab on the Board website, create space for information on EC. Include the following resources:
 - Not2Late & Bedsider EC locator tools: <http://not-2-late.com> and http://bedsider.org/where_to_get_it
 - Bedsider website for information about all EC methods: http://bedsider.org/methods/emergency_contraception
 - Bedsider patient education (single page): http://www.contraceptionjournal.org/cms/attachment/2020606468/2040327265/gr1_lrg.jpg or Reproductive Health Access Project patient education (single page): <http://www.reproductiveaccess.org/wp-content/uploads/2014/12/emergency-contraception.pdf>

Attachment 5

Board of Pharmacy Content

Protecting Patients Online From Rogue Online Pharmacies

At [name] Board of Pharmacy, we are concerned about the safety of [state name] patients who purchase medication online. NABP has reviewed more than 11,000 Internet drug outlets selling prescription medications and found that only 4% operate legally and ethically. This means that the drugs you order from websites pretending to be legitimate pharmacies could contain such ingredients as glue, chalk, and rat poison, or not contain enough medicine. And 16% of the rogue sites reviewed do not protect your personal information, leaving you exposed to identity theft and fraud. Finally, without a doctor's prescription or a pharmacist to answer your questions, you also increase your risk misdiagnosing an illness, or experiencing serious adverse reactions to your medication.

Can anyone stay safe in the face of these numbers? Yes – by buying medicines only from online pharmacies that use the .pharmacy domain. These pharmacies have been vetted thoroughly and found to be compliant with [state name] and federal laws as well as pharmacy practice standards.

A list of .pharmacy websites is available at <http://www.safe.pharmacy/buying-safely/find-a-pharmacy-website>.

In addition, tips on spotting a rogue online pharmacy can be found in the Buying Safely section of this site. Knowing the characteristics of rogue sites, such as not requiring a prescription or not providing a phone number or street address, will help protect you from receiving counterfeit, contaminated, or otherwise unsafe products.

[name] Board of Pharmacy has allied itself with the .pharmacy program because it continues [state name]'s long-standing commitment to protecting your health and safety through regulating the profession you've come to rely upon as an integral part of your personal health care goals.

The mission of [name] Board of Pharmacy is as follows:
[mission statement]

Visit the full board website to contact us and for other important pharmacy information.



Committed to Safe Online Pharmacy Around the World

.Pharmacy is a Top-Level Domain (TLD) like “.com” or “.net.” Uniquely, .pharmacy is a TLD dedicated to patient safety. The National Association of Boards of Pharmacy® (NABP®) is the administrative and responsible organization overseeing .pharmacy. .pharmacy will be managed by an international coalition of stakeholders who are members of the community supporting .pharmacy, including the International Pharmaceutical Federation (FIP).

The Goal

The goal of .pharmacy is for patients to easily identify legitimately operating websites authorized to provide services in their country, and to know that the medications, information, and services they obtain from those sites are authentic and safe.

The Global Need

Millions of patients worldwide are getting healthcare information and products via the Internet. At any one time there are approximately 35,000 - 50,000 active online drug sellers, but the vast majority of these sites – roughly 96% -- do not comply with applicable laws.

Online sales of unregulated and counterfeit drugs are a significant global problem. According to the World Health Organization (WHO) over 50% of the drugs purchased over the Internet from illegal sites that conceal their physical address are selling unsafe medications (spurious, substandard, falsely labeled, falsified, or counterfeit).

Currently there is no easy way for patients to know that what they get online is legitimate and safe. .Pharmacy fills this gap as there is no possible way to fake legitimacy as the seal of quality is the web address itself.

The Patient Safety Benefits

.Pharmacy gives patients an easy way to access safe medicines and information provided legally via the Internet. Patients seeking safe online medications and health information should “shop to the right of the dot” – *Be safe. Choose smart. Shop .pharmacy*

About NABP

NABP is a not-for-profit, international, impartial professional organization that supports its member boards of pharmacy in protecting the public health. Boards of pharmacy regulate and license pharmacists and pharmacies.

For more information on applying for a .pharmacy domain name, go to www.safe.pharmacy or contact NABP directly at +1-847-391-4406.





***Comprometidos con las farmacias seguras
en línea en todo el mundo.***

.pharmacy es un dominio de primer nivel (TLD, por sus siglas en inglés) como “.com” o “.net.” De manera exclusiva, .pharmacy es un TLD dedicado a la seguridad del paciente. La Asociación Nacional de Juntas de Farmacia (National Association of Boards of Pharmacy®, NABP®) es la organización administrativa y responsable de supervisar .pharmacy. .pharmacy será gestionado por una coalición internacional de partes interesadas integrantes de la comunidad que respalda a .pharmacy, incluyendo la Federación Farmacéutica Internacional (FIP, por sus siglas en inglés).

Objetivo

El objetivo de .pharmacy es que los pacientes identifiquen de forma sencilla y legítima los sitios web autorizados a proporcionar servicios en su país y sepan que los medicamentos, la información y los servicios que obtengan en esos sitios son auténticos y seguros.

Necesidad global

Millones de pacientes en todo el mundo están obteniendo información sobre atención médica y productos a través de Internet. En cualquier momento dado hay, aproximadamente, entre 35 000 y 50 000 vendedores de fármacos en línea activos, pero la amplia mayoría de estos sitios (más o menos el 96 %) no cumple con las leyes aplicables.

Las ventas en línea de fármacos no regulados y adulterados son un problema global grave. Según la Organización Mundial de la Salud (OMS), más del 50 % de los fármacos que se compran por Internet en sitios ilegales que ocultan su dirección real son medicamentos no seguros (espurios, por debajo de los estándares exigidos, con etiquetas falsas, falsificados o adulterados).

Actualmente no existe una forma sencilla para que los pacientes sepan si lo que están obteniendo en línea es legítimo y seguro. .pharmacy resuelve esta carencia, ya que no hay forma posible de fingir legitimidad dado que el sello de calidad es la dirección web misma.

Beneficios de seguridad para el paciente

.pharmacy ofrece a los pacientes una manera sencilla de acceder a medicamentos seguros e información ofrecidos de manera legal a través de Internet. Los pacientes que buscan medicamentos e información médica seguros en línea deben comprar según lo que aparece a la derecha del punto. Condúzcase con seguridad. Elija con inteligencia. Compre en .pharmacy



Acerca de la NABP

La NABP es una organización profesional internacional, imparcial y sin fines de lucro que respalda a las juntas farmacéuticas que la integran en la protección de la salud pública. Las juntas farmacéuticas regulan y licencian a farmacéuticos y farmacias.

Para obtener más información o solicitar un dominio .pharmacy, entre en www.safe.pharmacy o comuníquese directamente con la NABP al +1-847-391-4406.





Committed to Safe Online Pharmacy Around the World

As the official registry operator for the .pharmacy Top-Level Domain (TLD), the National Association of Boards of Pharmacy® (NABP®) is accepting applications from those pharmacies and pharmacy-related businesses that wish to register a .pharmacy domain. Prior to registering a .pharmacy domain, registrants will be vetted by NABP to ensure that only legitimate Internet pharmacies and related entities are able to use the .pharmacy domain suffix. NABP has implemented this application process to provide consumers around the world with an easy way to identify safe online pharmacies and resources.

Internet Fuels Global Public Health Threat

- Illegal prescription drug sales and counterfeit medicines threaten patient safety worldwide.
- Diseases are needlessly left untreated.
- Illness and death due to products containing toxic substances.
- Prescription drug abuse on the rise.
- More than 11,000 Internet sites reviewed, NABP found that 96% appear to be operating in conflict with pharmacy laws and practice standards.

.Pharmacy TLD Promotes Patient Safety

Because the means to easily recognize safe online pharmacies is important for consumers worldwide, NABP only makes the domain available to legitimate online pharmacies and related entities.

- Patient safety is the central goal of the .pharmacy initiative.
- NABP ensures that only legitimate website operators that adhere to pharmacy laws in the jurisdictions in which they are based and to which they sell medicine can register domain names in .pharmacy.
- Consumers worldwide can be sure the medications they buy online are authentic and safe.

Global Community Supports Initiative

In developing its .pharmacy proposal, NABP partnered with international regulators, pharmacy organizations, and law enforcement agencies that share the Association's concern about illegal online drug sellers distributing products that endanger patient health. NABP will continue to work cooperatively with regulators and stakeholders worldwide to maintain universal Internet pharmacy standards.

Stakeholders that support NABP's application include many groups in the global pharmacy community. Among the coalition of stakeholders behind this initiative are the Alliance for Safe Online Pharmacies, Eli Lilly and Company, European Alliance for Access to Safe Medicines, Gilead Sciences, Inc, International Pharmaceutical Federation, INTERPOL, Janssen Pharmaceuticals, Inc, LegitScript, Merck/MSD, National Association of Pharmacy Regulatory Authorities, Pfizer Inc, and the state boards of pharmacy.

More information is available at www.safe.pharmacy.



National Association of Boards of Pharmacy
1600 Feehanville Drive • Mount Prospect, IL 60056
(P) 847/391-4406 • (F) 847/391-4502 • www.nabp.net



Comprometidos con las farmacias seguras en línea en todo el mundo.

En su calidad de operador oficial de registro para el dominio de primer nivel (TLD) .pharmacy, la Asociación Nacional de Juntas de Farmacia (National Association of Boards of Pharmacy®, NABP®) está aceptando solicitudes de aquellas farmacias y negocios farmacéuticos que deseen registrar un dominio .pharmacy. Antes de registrar un dominio .pharmacy, la NABP examinará a los registrantes para asegurarse de que solo farmacias legítimas por Internet y entidades relacionadas puedan usar el sufijo de dominio .pharmacy. La NABP ha implementado este proceso de solicitud para proporcionar a los consumidores de todo el mundo una forma sencilla de identificar las farmacias y recursos en línea seguros.

Internet impulsa una amenaza global para la salud pública

- Las ventas ilegales de fármacos recetados y medicamentos adulterados amenazan la seguridad del paciente en todo el mundo.
- Las enfermedades quedan sin tratar, innecesariamente.
- Ocurren enfermedades y muertes debido a productos que contienen sustancias tóxicas.
- El abuso de medicamentos recetados están aumentando.
- Se revisaron casi 11 000 sitios de Internet; la NABP descubrió que el 96 % parecen estar operando de manera contraria a las leyes farmacéuticas y los estándares de práctica.

El TLD .pharmacy promueve la seguridad del paciente

Como los medios para reconocer fácilmente las farmacias en línea seguras son importantes para los consumidores de todo el mundo, la NABP pondrá el nuevo dominio solo a disposición de farmacias en línea legítimas y entidades relacionadas ubicadas tanto en Estados Unidos como en otros países.

- La seguridad del paciente es el objetivo principal de la iniciativa .pharmacy.
- La NABP se asegurará de que solo puedan registrar nombres de dominio en .pharmacy aquellos operadores de sitios web legítimos que cumplan con las leyes farmacéuticas en las jurisdicciones donde se encuentren y donde vendan medicamentos.
- Los consumidores de todo el mundo podrán estar seguros de que los medicamentos que compren en línea sean auténticos y seguros.

Iniciativa de apoyo de la comunidad global

Al desarrollar su propuesta .pharmacy, la NABP se asoció con reguladores internacionales, organizaciones farmacéuticas y agencias de cumplimiento de la ley que comparten la preocupación de la



Asociación respecto a los vendedores de fármacos ilegales en línea que distribuyen productos que ponen en riesgo la salud del paciente. La NABP trabajará en colaboración con reguladores y partes interesadas en todo el mundo para mantener los estándares internacionales de farmacias por Internet.

Las partes interesadas que respaldan la solicitud de la NABP incluyen a muchos grupos de la comunidad farmacéutica internacional. Entre la coalición de partes interesadas detrás de esta iniciativa se encuentran la Alianza para farmacias seguras en línea (Alliance for Safe Online Pharmacies), Eli Lilly and Company, la Alianza europea de acceso a medicamentos seguros (European Alliance for Access to Safe Medicines), Gilead Sciences, Inc, la Federación Farmacéutica Internacional (International Pharmaceutical Federation), INTERPOL, Janssen Pharmaceuticals, Inc, LegitScript, Merck/MSD, la Asociación Nacional de Autoridades Reguladoras Farmacéuticas (National Association of Pharmacy Regulatory Authorities), Pfizer Inc. y las juntas farmacéuticas estatales.

Hay más información en www.safe.pharmacy.



Become Part of the Growing .Pharmacy Domain!

The .pharmacy Top-Level Domain helps patients quickly and easily identify that you have a safe and legitimate pharmacy. Join these pharmacies and pharmacy-related entities – become a leader in the pharmacy community!

Boards of Pharmacy

- azboard.pharmacy (Arizona)
- arboard.pharmacy (Arkansas)
- caboard.pharmacy (California)
- cphmboard.pharmacy (Manitoba)
- dcboard.pharmacy (District of Columbia)
- guboard.pharmacy (Guam)
- iaboard.pharmacy (Iowa)
- idboard.pharmacy (Idaho)
- ilboard.pharmacy (Illinois)
- laboard.pharmacy (Louisiana)
- mnboard.pharmacy (Minnesota)
- nvboard.pharmacy (Nevada)
- nhboard.pharmacy (New Hampshire)
- njboard.pharmacy (New Jersey)
- nmboard.pharmacy (New Mexico)
- ncboard.pharmacy (North Carolina)
- nodak.pharmacy (North Dakota)
- nsboard.pharmacy (Nova Scotia)
- orboard.pharmacy (Oregon)
- txboard.pharmacy (Texas)
- vtboard.pharmacy (Vermont)
- wacommission.pharmacy (Washington)

Pharmacy Information Sites

- awarerx.pharmacy
- goodrx.pharmacy
- legitscript.pharmacy

Pharmacy Organizations

- fip.pharmacy
- congress.pharmacy (FIP)

Pharmacies

- 340b.pharmacy (Accredo)
- accredo.pharmacy
- alpha1.pharmacy (Accredo)
- assistedliving.pharmacy (OnePoint Patient Care)
- avella.pharmacy (Apothecary Shop Holdings)
- bioplus.pharmacy
- bioplusspecialty.pharmacy
- bleedingdisorders.pharmacy (Accredo)
- caremark.pharmacy (CVS)
- cvs.pharmacy
- cvscaremark.pharmacy
- cysticfibrosis.pharmacy (Accredo)
- drugmart.pharmacy (Pace Pharmacy & Drug Mart)
- drugsourceinc.pharmacy
- empower.pharmacy
- fertilitypharmacy.pharmacy (Dobbs Ferry)
- freedom.pharmacy (Freedom Fertility Pharmacy)
- freedomfertility.pharmacy
- futrell.pharmacy
- growthhormone.pharmacy (Accredo)
- hae.pharmacy (Accredo)
- healthwarehouse.pharmacy
- hemophilia.pharmacy (Accredo)
- hepc.pharmacy (Accredo)
- hometown.pharmacy
- hometownlongtermcare.pharmacy
- hometownspecialty.pharmacy
- hospice.pharmacy (OnePoint Patient Care)

To learn more about applying and registering for a .pharmacy domain, visit www.safe.pharmacy.



Pharmacies continued

- immunedisorders.pharmacy (Accredo)
- infusion.pharmacy (Accredo)
- ipf.pharmacy (Accredo)
- longsdugs.pharmacy
- longs.pharmacy (Long's Drugs)
- longsrx.pharmacy
- medlife.pharmacy
- mingocare.pharmacy
- netscripx.pharmacy (HealthWarehouse.com)
- onepoint.pharmacy (OnePoint Patient Care)
- palliativecare.pharmacy (OnePoint Patient Care)
- palliative.pharmacy (OnePoint Patient Care)
- pillpack.pharmacy
- pns.pharmacy (Pharmacy Network Services)
- procompounding.pharmacy (Clinical Management Concepts)
- ridgeway.pharmacy (Ridgeway Mail Order)
- riteaid.pharmacy
- rxoutreach.pharmacy
- specialty.pharmacy (Accredo)
- sullivans.pharmacy
- target.pharmacy
- triadisotopes.pharmacy

Veterinary Pharmacies

- 1800petmeds.pharmacy
- buprenorphine.pharmacy (Diamondback Drugs)
- cat.pharmacy (Heartland Vet)
- dog.pharmacy (Heartland Vet)
- diamondbackdrugs.pharmacy
- kvsupply.pharmacy
- leedstone.pharmacy
- petmart.pharmacy
- petmeds.pharmacy
- valleyvet.pharmacy
- vetrxdirect.pharmacy (VetCara, LLC)



ATA Membership ID: 249794

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Certificate of Translation

From: English
Into: Spanish
Reference number: 147961-EB5159B1
Documents:

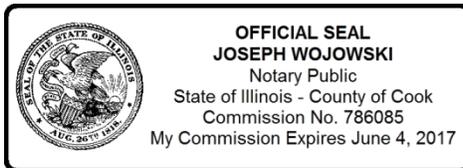
- .Pharmacy Program Overview.docx
- Company Benefits Flyer - .pharmacy.docx
- Consumer Information Flyer - .pharmacy.docx
- Frequently Asked Questions - .pharmacy.docx

We, Foreign Credits, Inc., hereby affirm that the enclosed translation corresponding to the above reference number is, to the best of our knowledge, an accurate and complete rendering of the original text prepared by a qualified translator conversant in both languages.

Garrett Conway, Project Coordinator
Foreign Credits, Inc.

9/21/15
Date

State of Illinois, County of Cook
Subscribed and sworn before me
On September 21, 2015
Notary Public:

Joseph Wojowski, Notary Public

Draft Letter of Support for NABP's .Pharmacy Top-Level Domain (TLD) Initiative

To the National Association of Boards of Pharmacy (NABP):

On behalf of the California State Board of Pharmacy, I write to express the board's endorsement and support for NABP's .pharmacy Top-Level Domain (TLD) initiative. The board believes the .pharmacy TLD, as operated by NABP, fully represents the board's vision of healthy Californians through safe, quality pharmacists care.

The California State Board of Pharmacy is responsible for actively licensing and regulating the businesses and individuals involved in the distribution and dispensing of medications, from the time the product leaves the site of manufacture until it reaches the consumer. The board licenses over 139,000 licensees in 23 licensing categories including but not limited to pharmacists, pharmacy technicians, pharmacies, wholesale distributors, and other drug distribution outlets in California and those entities that ship pharmaceuticals into California.

The Internet has become an invaluable resource for communication, education, and commerce. At the same time, however, it is too often used by cybercriminals to defraud consumers. Such threats make it difficult for consumers to utilize this resource safely. The board believes that the .pharmacy TLD, as operated by NABP, will help to ensure public health and safety.

For this reason, the board fully supports NABP in its role as registry operator for the .pharmacy TLD. NABP has a respected history of promoting safe access to medicine online and developing uniform standards to protect public health in the United States. The board is confident that NABP is currently operating and will continue to operate the .pharmacy TLD in a safe and effective manner.

Please accept this letter of endorsement and support for NABP's .Pharmacy TLD Program. The California State Board of Pharmacy applauds this initiative and its mission to protect the public health.

Attachment 6

Assembly Bill No. 1073

CHAPTER 784

An act to amend Sections 4076 and 4199 of, and to add Section 4076.6 to, the Business and Professions Code, relating to pharmacy.

[Approved by Governor October 11, 2015. Filed with Secretary of State October 11, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1073, Ting. Pharmacy: prescription drug labels.

The Pharmacy Law provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy. That law requires a pharmacist to dispense a prescription in a container that, among other things, is correctly labeled with the directions for use of the drug, and requires the board to promulgate regulations that require, on or before January 1, 2011, a standardized, patient-centered, prescription drug label on all prescription medicine dispensed to patients in California. Existing regulations of the board implement that requirement, establishing standardized directions for use to be used when applicable, and requiring that the board publish on its Internet Web site translation of those directions for use into at least 5 languages other than English. A violation of that law is a crime.

This bill would require a pharmacist to use professional judgment to provide a patient with directions for use of a prescription that enhance the patient's understanding of those directions, consistent with the prescriber's instructions. The bill would also require a dispenser, excluding a veterinarian, upon the request of a patient or patient's representative, to provide translated directions for use as prescribed. The bill would authorize a dispenser to use translations made available by the board pursuant to those existing regulations. The bill would make a dispenser responsible for the accuracy of English-language directions for use provided to the patient. By imposing new requirements on dispensers, the violation of which would be a crime, this bill would impose a state-mandated local program.

The Pharmacy Law also provides for the licensure and regulation of veterinary food-animal drug retailers by the board. That law subjects to specific prescription drug labeling requirements any veterinary food-animal drug dispensed pursuant to a prescription from a licensed veterinarian for food-producing animals from a veterinary food-animal drug retailer pursuant to that law.

This bill would also subject any veterinary food-animal drug so dispensed to the above drug labeling requirements relating to standardized directions for use.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 4076 of the Business and Professions Code is amended to read:

4076. (a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

(1) Except when the prescriber or the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

(2) The directions for the use of the drug.

(3) The name of the patient or patients.

(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(5) The date of issue.

(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.

(7) The strength of the drug or drugs dispensed.

(8) The quantity of the drug or drugs dispensed.

(9) The expiration date of the effectiveness of the drug dispensed.

(10) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.

(11) (A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules, except as follows:

(i) Prescriptions dispensed by a veterinarian.

(ii) An exemption from the requirements of this paragraph shall be granted to a new drug for the first 120 days that the drug is on the market and for the 90 days during which the national reference file has no description on file.

(iii) Dispensed medications for which no physical description exists in any commercially available database.

(B) This paragraph applies to outpatient pharmacies only.

(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container.

(D) This paragraph shall not become operative if the board, prior to January 1, 2006, adopts regulations that mandate the same labeling requirements set forth in this paragraph.

(b) If a pharmacist dispenses a prescribed drug by means of a unit dose medication system, as defined by administrative regulation, for a patient in a skilled nursing, intermediate care, or other health care facility, the requirements of this section will be satisfied if the unit dose medication system contains the aforementioned information or the information is otherwise readily available at the time of drug administration.

(c) If a pharmacist dispenses a dangerous drug or device in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include on individual unit dose containers for a specific patient, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(d) If a pharmacist dispenses a prescription drug for use in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include the information required in paragraph (11) of subdivision (a) when the prescription drug is administered to a patient by a person licensed under the Medical Practice Act (Chapter 5 (commencing with Section 2000)), the Nursing Practice Act (Chapter 6 (commencing with Section 2700)), or the Vocational Nursing Practice Act (Chapter 6.5 (commencing with Section 2840)), who is acting within his or her scope of practice.

(e) A pharmacist shall use professional judgment to provide a patient with directions for use that enhance the patient's understanding of those directions, consistent with the prescriber's instructions.

SEC. 2. Section 4076.6 is added to the Business and Professions Code, to read:

4076.6. (a) Upon the request of a patient or patient's representative, a dispenser shall provide translated directions for use, which shall be printed on the prescription container, label, or on a supplemental document. If translated directions for use appear on a prescription container or label, the English-language version of the directions for use shall also appear on the container or label, whenever possible, and may appear on other areas of the label outside the patient-centered area. When it is not possible for the English-language directions for use to appear on the container or label, it shall be provided on a supplemental document.

(b) A dispenser may use translations made available by the board pursuant to subdivision (b) of Section 1707.5 of Title 16 of the California Code of Regulations to comply with this section.

(c) A dispenser shall not be required to provide translated directions for use beyond the languages that the board has made available or beyond the directions that the board has made available in translated form.

(d) A dispenser may provide his or her own translated directions for use to comply with the requirements of this section, and nothing in this section shall be construed to prohibit a dispenser from providing translated directions for use in languages beyond those that the board has made available or beyond the directions that the board has made available in translated form.

(e) A dispenser shall be responsible for the accuracy of the English-language directions for use provided to the patient. This section shall not affect a dispenser's existing responsibility to correctly label a prescription pursuant to Section 4076.

(f) For purposes of this section, a dispenser does not include a veterinarian.

SEC. 3. Section 4199 of the Business and Professions Code is amended to read:

4199. (a) Any veterinary food-animal drug dispensed pursuant to a prescription from a licensed veterinarian for food producing animals from a veterinary food-animal drug retailer pursuant to this chapter is subject to the labeling requirements of Sections 4076, 4076.6, and 4077.

(b) All prescriptions filled by a veterinary food-animal drug retailer shall be kept on file and maintained for at least three years in accordance with Section 4333.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

From: Polyglot Systems, Inc. [mailto:friends@pgsi.com]
Sent: Thursday, January 07, 2016 8:36 AM
To: Herold, Virginia@DCA
Subject: Meducation® Integrated with Cerner® Retail Pharmacy



Meducation® to Provide “Universal Medication Schedule” Instructions on Prescription Labels with Cerner

Morrisville, NC - January 7, 2016 - Polyglot Systems' [Meducation](#)® software is now integrated with *Cerner® Retail Pharmacy* management system. For almost three decades, *Cerner Retail Pharmacy* has distinguished itself as the one-stop software technology provider for retail pharmacies. Now, those pharmacies can access Meducation to provide intuitive, simplified, multilingual [pill bottle-labeling](#) and medication instructions that incorporate the [“Universal Medication Schedule”](#).

Meducation creates medication instructions at 5-8th grade reading level, in any of 21 languages, with larger font sizes, pictograms and access to supplemental videos, to make it easier for patients to understand how to take their medications. Meducation is accessed from within the *Cerner Retail Pharmacy* system, so there is no interruption to pharmacist workflow. This complements Cerner's innovative SMART® on FHIR EMR integration, which enables healthcare providers to access the Meducation software from within their existing hospital workflow.

The patient's specific dose and schedule are shown on [prescription labels](#) using the “Universal Medication Schedule” (UMS). The [UMS](#), which has been described by both the National Council of Prescription Drug Programs and the Institute of Medicine, is being widely adopted across the country as a best practice. It clearly conveys both the amount and time of each dose. Meducation further enhances the UMS by providing intuitive pictograms of the time of day and amount of medicine to be taken. Only Cerner pharmacies are uniquely able to provide their customers with Meducation's UMS-formatted instructions on prescription labels.

Meducation bridges the communication barriers between the healthcare system and patients, enabling hospitals and

pharmacies to take critical steps towards improving the overall quality of patient care. "To improve medication adherence, we must provide medication instructions that all patients can understand," said Polyglot COO Lori McLean. "Since more than 90 million Americans have low health literacy or limited English proficiency, this means offering instructions in multiple languages and simplified, easy-to-understand formats." Improving patient understanding and medication adherence leads to improved overall patient health outcomes, reduced healthcare costs and increased patient satisfaction.

###

About Polyglot Systems

[Polyglot Systems](#)' award-winning Meducation software was developed under a grant from the National Institutes of Health to address the communication barriers between healthcare providers and their patients. By improving patient understanding, medication adherence and overall patient health are improved, reducing healthcare costs and increasing patient satisfaction. Polyglot's products have been licensed to hospitals, health systems, clinics and pharmacies.

For more information: Polyglot Systems Inc., Morrisville NC, 919-653-4380, info@pgsi.com

This message was sent to Virginia.Herold@dca.ca.gov from:

Polyglot Systems, Inc. | friends@pgsi.com | Polyglot Systems, Inc. | 2000 Aerial Center Parkway |
Morrisville, NC 27560

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Email Marketing by



Attachment 7

Ask.Inspector Frequently Asked Questions

As part of its licensee education, the board restored a service whereby a board inspector and board staff are available to respond to verbal and written inquiries from the public and board licensees. To ensure that all licensees receive the benefits of service, the board has developed an FAQ.

It is important to note that the below questions and answers are not intended, nor should they be construed as legal advice. The answers provided below are intended to provide guidance to the reader on relevant legal sections that should be considered when using professional judgement in determining the appropriate course of action. Should you require legal advice or detailed research, you will need to contact an attorney or another source.

Question: What is the maximum number of days allowed for a supply of controlled substance prescription?

Answer: Health and Safety Code Section 11200 provides restrictions on dispensing or refilling controlled substances. Specifically this section prohibits and individuals from dispensing or refilling a controlled substance prescription more than six months after after the date prescribed. The section also provides that no prescription for a schedule III or IV substance may be refilled more than five times and in an amount, for all refills of that prescription, taken together, exceeding a 120-day supply. This section also establishes the prohibition to refill a prescription for a schedule II substance.

A pharmacist must also exercise professional judgement as well as corresponding responsibility when filling a prescription for a controlled substance.

Question: What must be included on a controlled substance prescription security form for it to be valid?

Answer: Health and Safety Code Section 11162.1 provides the requirement for a controlled substance prescription security form.

Question: Can a pharmacist refuse to fill a controlled substance prescription if the pre-printed form has been altered or shows signs of potential tampering?

Answer: California Code of Regulations Section 1761 specifies in part that a pharmacist shall not compound or dispense any prescription which contains any significant error, omission, irregularity, uncertainty, ambiguity or alteration. Upon receipt of any such prescription, the pharmacist must contact the prescriber to obtain the information needed to validate the prescription.

Question: Does a pharmacist have to perform a final verification by physically inspecting the patient's medication if it was filed by a pharmacy technician or an intern?

Answer: There are a few sections of law that address this question as the answer varies based on various factors. Relevant legal references include:

1. Section 1726 of the California Code of Regulations states a pharmacist supervising an intern pharmacist be responsible for all professional activities performed by the intern under his or her supervision, including the correct dispensing of a prescription.
2. Section 1793.7 of the California Code of Regulations states any function performed by a pharmacy technician in connection with the dispensing of a prescription, including repackaging from bulk, must be verified and documented in writing by a pharmacist.

If have a question that is not included above, you can access this service using one of the following routes:

- Email: ask.inspector@dca.ca.gov – if sending an email, include your name, organization, contact phone number and best time to contact you.
- Fax: (916) 574-8618
- Phone: (916) 574-7900 (Tuesday and Thursday from 8:00 a.m. to 4:30 p.m.)

Attachment 8

State of California Department of Justice

OFFICE of the ATTORNEY GENERAL
KAMALA D. HARRIS

Attorney General Kamala D. Harris Launches New Prescription Drug Monitoring Program, CURES 2.0

Tuesday, December 22, 2015

Contact: (415) 703-5837, agpressooffice@doj.ca.gov

SACRAMENTO – Attorney General Kamala D. Harris and the California Department of Consumer Affairs today announced the universal launch of the new Controlled Substance Utilization Review and Evaluation System (“CURES 2.0”), a state-of-the-art overhaul of California’s prescription drug monitoring program that will allow health providers and pharmacists to more effectively flag at-risk patients and curb prescription drug abuse.

“This innovative prescription drug database ensures that California continues to lead the fight against our country’s prescription drug abuse epidemic,” said Attorney General Harris. “Through the use of new technology, CURES 2.0 will save lives and improve public health while also providing a vastly improved user experience for healthcare professionals, regulatory boards, and law enforcement.”

Starting January 8, 2016, current CURES users logging in with up-to-date and secure web browsers will be automatically redirected to the new 2.0 system. In anticipation of the launch, Attorney General Harris also sent a letter to members of the medical community urging them to only use secure software to access confidential and sensitive patient information.

“CURES 2.0 will give California’s healthcare professionals who prescribe and dispense potent prescription drugs a powerful tool to better access and utilize patient information to help them identify individuals who are abusing these drugs,” said Awet Kidane, Director of the California Department of Consumer Affairs. “It is a direct result of the hard work and collaboration between the Department of Justice, the Department of Consumer Affairs, and the regulatory boards funding this project.”

The online CURES database enables healthcare providers to review a patient’s medication history before prescribing new drugs, storing prescription records for all controlled substances classified as Schedule II, III, and IV. Over 5.5 million such requests have been processed so far in 2015 alone.

In addition to providing users with faster and more reliable access to patient activity reports, the upgraded 2.0 system features cutting-edge analytics for flagging at-risk patients, allowing medical professionals to prescribe wisely and helping to prevent abuse or diversion of controlled medications such as opioids.

“CURES 2.0 is without a doubt the most effective tool for doctors and pharmacists to help curb prescription drug abuse. Many lives will be saved in California,” said Bob Pack, a patient safety advocate.

By law, all health practitioners licensed to prescribe or dispense scheduled medications are required to sign up for CURES by July 1, 2016. The launch of the new 2.0 system will also include the release of a new streamlined registration process, which will allow users to apply for access and verify their credentials entirely online using secure web browsers.

CURES 2.0 was implemented through Senate Bill 809, legislation authored by former California State Senator Mark DeSaulnier and sponsored by Attorney General Harris in 2013.

"The U.S. claims less than 5% of the world's population, but consumes roughly 80% of the world's opioid supply. Each day, 44 people in the U.S. die from an overdose of prescription painkillers. By launching CURES 2.0 and requiring all prescribers and pharmacists to enroll, California will be on the cutting edge of addressing this crisis. I am proud to have authored this law in the memory of the countless sons and daughters who were lost to this epidemic. I thank Attorney General Harris and Governor Brown for their years of work to ensure the modernization of CURES is a success," said Congressman Mark DeSaulnier (CA-11).

To learn more about CURES 2.0, visit <https://oag.ca.gov/ures-pdmp>.

###

Attachment	Size
 CURES Universal Launch and Streamlined Registration - 12-21-15.pdf	136.37 KB
 AG Letter to CA Healthcare Professionals - 12-21-15.pdf	649.41 KB

CURES 2.0



STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

CONTACT:
cures@doj.ca.gov
(916) 227-3843

December 21, 2015

RE: CURES 2.0 Universal Launch and Streamlined Registration

The Department of Justice (DOJ) and the Department of Consumer Affairs (DCA) are pleased to announce substantial milestones in the enhancement of the state's Controlled Substance Utilization Review and Evaluation System (CURES).

Beginning January 8, 2016, the upgraded prescription drug monitoring program – commonly referred to as “**CURES 2.0**” – will be released to all users in compliance with the system's minimum security requirements.¹ This upgraded database offers a significantly improved user experience and features a number of added functionalities, including the ability to delegate report queries and new practitioner-identified patient alerts.

Also beginning January 8, 2016, a streamlined registration process will be implemented for new users. This fully-automated process will enable licensed health care prescribers and pharmacists to request access to CURES and validate their credentials entirely online using a secure web browser.

All health care practitioners authorized to prescribe or dispense Schedule II-IV controlled substances must be registered to use CURES no later than July 1, 2016.² To register using the automated system, simply visit oag.ca.gov/cures and follow the instructions. Registrants will need their state license information and prescribers must provide federal DEA license information to register.

Learn more: oag.ca.gov/cures/faqs

¹ CURES 2.0 users will be required to use Microsoft Internet Explorer Version 11.0 or greater, Mozilla FireFox, Google Chrome, or Safari when accessing the system. Users attempting to access the new CURES 2.0 database with noncompliant web browsers will be redirected to the previous 1.0 system.

² Pursuant to Health & Safety Code Section 11165.1 as amended by AB 679 (2015)



STATE OF CALIFORNIA
OFFICE OF THE ATTORNEY GENERAL
KAMALA D. HARRIS
ATTORNEY GENERAL

December 21, 2015

RE: Patient Privacy and Online Security Standards

Dear California Healthcare Professionals:

The right to privacy is embedded in the California Constitution.¹ In 2012, I created a Privacy Enforcement and Protection Unit within the California Department of Justice to ensure that our state and federal privacy laws are adequately enforced. Since then, my office has released a number of publications aiming to educate businesses, organizations and consumers about ways to mitigate and protect themselves from the devastating effects of data breaches.

My office and our state legislature have long recognized the importance of maintaining the confidentiality of individuals' medical information. The exceedingly sensitive nature of health records and treatment histories demand a high level of privacy and security that must be maintained throughout the course of patient care and beyond.^{2,3} While the advent of new technologies has dramatically improved the quality and efficiency of modern healthcare, California's providers must take extra care to safeguard their patients' information as they continue to lead the way in medical innovation.

Today, many digital health practice tools are available simply through access to the Internet. When taking advantage of online resources and web-based databases, healthcare professionals must vigilantly protect against hackers by adhering closely to the latest security standards. One of the most basic best practices for medical professionals when using technology is to ensure that web browsers used to engage with sensitive information are updated regularly.⁴ Older versions of software frequently contain vulnerabilities to cyber intrusion that must be regularly patched by developers to prevent the exposure of personal information. Most browser developers provide these patches automatically; however, when healthcare practitioners and pharmacists interact with patient records using older versions of Internet Explorer, such browsers must be manually upgraded to newer versions.

¹ Cal. Const., art. I, § 1

² Department of Health and Human Services, 45 CFR parts 160, 162, and 164 of the Health Insurance Reform Security Standards, Final Rule

³ 45 C.F.R. § 164.308

⁴ *Protect Your Computer from Viruses, Hackers, & Spies*, Consumer Information Sheet 12, CA Dept. of Justice

As of January 12, 2016, Microsoft will no longer be providing technical support and security updates for older versions of Internet Explorer (IE).⁵ This means that in addition to lacking many of the security features and functionalities of the newer software, these outdated browsers will be left susceptible to data breaches targeting unpatched software liabilities. Since announcing this timeline in August 2014, Microsoft has been actively working with current users of older IE products to migrate over to their latest supported version of IE, which has enhanced backwards compatibility to accommodate business users. More information and resources are available on Microsoft's website.⁶

It has come to my office's attention that as Microsoft's support lifecycle end date draws near, many medical professionals and healthcare networks have yet to make necessary upgrades to their web browsers. In doing so, they may be jeopardizing the privacy of their patients' sensitive personal data. As the state's chief law enforcement officer, this is deeply concerning to me, and I urge the medical community to take the issue of privacy seriously. In light of this, earlier this year I directed my CJIS Division to impose minimum browser security standards as a condition of access to the state's new CURES 2.0 prescription drug database to make sure the system's personally identifying patient records remain accessible only to authorized users and are not left exposed by unaddressed browser vulnerabilities.

Thank you for the critical services you provide to Californians and for taking the necessary steps to ensure that your patients' privacy remains protected. If you need any assistance or guidance in this regard, please do not hesitate to reach out to my office. Please feel free to contact Deputy Attorney General Robert Sumner at Robert.Sumner@doj.ca.gov if you have any questions or need further information.

Sincerely,



KAMALA D. HARRIS
Attorney General

⁵ <https://support.microsoft.com/en-us/lifecycle#gp/Microsoft-Internet-Explorer>

⁶ <https://www.microsoft.com/en-us/WindowsForBusiness/End-of-IE-support>

Attachment 9

DEPARTMENT OF CONSUMER AFFAIRS
BOARD OF PHARMACY

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](#)

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](#)
- [Presentation by the US DEA on Issues and Trends Involving Controlled Substances and Prescription Drug Abuse](#)

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 11 through 15, and their parents and teachers on the science behind drug abuse. NIDA enlisted the help of teens in developing the site to ensure that the content 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 alcohol. The goal is to help teens stand up to negative pressures or influences.

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 Health Media, provide accurate, up-to-date health information that's free of "doctor speak."

Parents

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.awarerox.org/>

National Association of Boards of Pharmacy offers authoritative resources about medication safety, prescription drug abuse, medication disposal, and safely buying medications on the Internet.

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 they can make informed decisions and live drug-free.

Free prescription drug abuse education materials for middle school and high school students

<http://neahealthyfutures.org/wp-content/uploads/2015/04/rx-for-understanding-grades-5-to-8.pdf>

<http://neahealthyfutures.org/wp-content/uploads/2015/04/rx-for-understanding-grades-9-to-12.pdf>

National Education Association Health Information Network. Shipping costs apply.

Free School Tool Kit for middle and high school students

<http://www.nasn.org/>

National Association of School Nurses

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/>

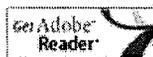
By bringing together renowned scientists, parent experts and communications professionals, The Partnership at Drugfree.org translates the science of teen drug use and addiction for families. At drugfree.org, you can find information, tools and opportunities to help prevent and get help for drug and alcohol abuse by 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 download click on the icon below.



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Not Worth The Risk
X even if it's legal

YOU'RE IN CONTROL



Taken a prescription medication when you **had a headache?**

Taken a prescription pill to help you **study for an exam?**

If so, you've **abused** prescription drugs.

Risky. Illegal. Potentially harmful. Can lead to addiction. Or worse.
YOU are in control of **YOUR** life and **YOUR** medications.

If you, or a friend, need help – ask for it. You are not alone.

RECOGNIZE *the risks.* **RESPECT** *medicine.* Take **RESPONSIBILITY.**

Learn more about prescription drug abuse at <http://www.samhsa.gov>. To find treatment visit <http://www.samhsa.gov/treatment> or call **1-800-662-HELP** for 24/7, free and confidential help and information.



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov



A group of four diverse teenagers (two boys and two girls) are standing against a brick wall. From left to right: a blonde girl with a backpack and folders, a boy in a blue t-shirt and cap with a messenger bag, a girl in a blue top and white pants with a purple folder, and a boy in a striped shirt with a messenger bag. They are all smiling and looking towards the camera.

Drug Prevention 4teens

A Drug Abuse Prevention Guide For Teens

Drug Prevention **4**Teens

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Substance Abuse Guide For Teens

Learning for Life has partnered with the Drug Enforcement Administration (DEA), the federal agency best known for dismantling international and domestic drug trafficking organizations. DEA is also a leader in the prevention community and works with schools, parents, communities, and the public to provide accurate information on the harm drugs cause. Learning for Life groups, posts, and participants embrace these efforts in our communities and, with DEA Special Agents across the nation, hope to have an impact on teen drug use in our country.

Learning for Life and the Drug Enforcement Administration consider young people to be a valuable resource in preventing substance abuse. Whether you make a personal decision not to use drugs, help educate your peers about the dangers of drugs, or inform members of the community about the damages caused by drug use and trafficking, you are making a difference in combating this problem.

Jointly, we are pleased to present this program guide to supplement Learning for Life programs.





Part One: Today's Drug Problem

Extent of Problem

Drug use in the United States is a serious problem, but much progress has been made through effective drug prevention and enforcement programs during the past decade. Teen drug use decreases when young people perceive that drug

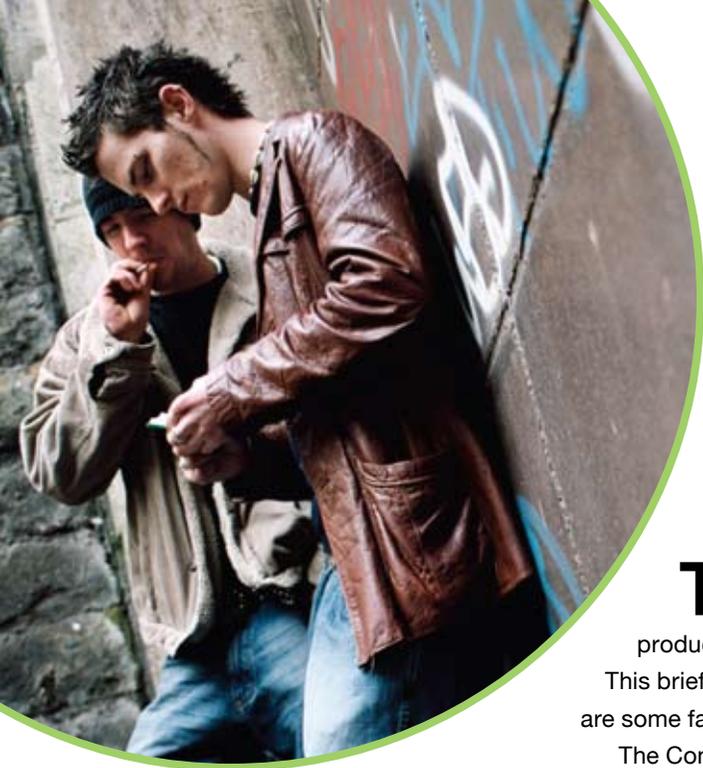
use is risky, and good drug prevention programs help teens understand how and why drugs are harmful.

Most kids don't take drugs. According to a recent government survey drug use rates have decreased since 2001. Kids are rejecting

marijuana, LSD, steroids, ecstasy, methamphetamine, alcohol and tobacco. They are also telling researchers that they know more about the dangers of drugs—and that helps them say no to drugs.

You can find detailed information on drug use in America from the following sources:

Monitoring the Future www.monitoringthefuture.org • National Survey on Drug Use and Health <http://oas.samhsa.gov>
• Substance Abuse and Mental Health Services Administration www.samhsa.gov • National Institute on Drug Abuse www.drugabuse.gov • Office of National Drug Control Policy www.whitehousedrugpolicy.gov • Drug Enforcement Administration www.dea.gov • www.justthinktwice.com



Drugs of Abuse

There are many illegal substances abused today. There are other substances, such as over-the-counter medications, household products, and legitimate pharmaceuticals (medicines) that are also abused. This brief guide provides information on the most commonly abused drugs. Here are some facts which will help you understand the facts about illegal drugs.

The Controlled Substances Act (CSA) categorizes drugs into five categories (Schedules I-V) according to their medical use, potential for abuse, and safety. The most addictive drugs, and drugs which have no medical use, are in Schedule I.

Federal penalties for manufacturing and/or distributing illegal drugs are based on the danger each drug poses to individuals and to the public.

There are several classes of drugs; each class has different properties and effects on the user.

Narcotics: Narcotics (such as heroin, morphine, OxyContin, etc.) are used to dull the senses and reduce pain. Narcotics can be made from opium (from the opium poppy) or created in a laboratory (synthetic and semi-synthetic narcotics).

Stimulants: Stimulants reverse the effects of fatigue on the body and brain.

Sometimes they are referred to as “uppers.” Cocaine, amphetamines, methamphetamine and Ritalin™ are stimulant drugs. Cocaine is derived from the coca plant grown in South America. Nicotine (found in tobacco) is also a stimulant.

Depressants: Substances included in this category are tranquilizers, sedatives, hypnotics, anti-anxiety medications and alcohol.

Cannabis: Marijuana and hashish are substances referred to as cannabis and THC (delta-9-tetrahydrocannabinol) is the ingredient in cannabis which makes the user feel “high.”

Hallucinogens: These substances alter the perceptions and moods of users. LSD, Ecstasy, PCP and Ketamine are made in laboratories, some of which are clandestine; non-manufactured hallucinogens include peyote and mescaline.

Inhalants: Many common items such as glue, lighter fluid, paint products, cleaning fluids, gasoline, and propellants in aerosol cans contain chemicals that produce intoxicating effects similar to alcohol. Inhalant abuse is the deliberate inhaling or sniffing of these products to get high.

Steroids: Anabolic steroids are defined as any drug or hormonal substance that is chemically and pharmacologically related to testosterone and promotes muscle growth. Some steroids are used for legitimate medical reasons, but many are illegally manufactured and distributed.

Drug

Effects:Cannabis

Effects: Euphoria, relaxed inhibitions, increased appetite, disorientation, impaired motor skills and concentration. • **Overdose Effects:** Fatigue, paranoia, and possible psychosis. • **CSA Schedule:** Schedule I: Marijuana has no medical use. Schedule II: Marinol™ is a synthetic form of THC which can be prescribed for patients with particular medical conditions. • **Street Names:** Pot, Grass, Sinsemilla, Blunts, Mota, Yerba, Grifa, Aunt Mary, Boom, Chronic (marijuana alone or marijuana with crack), Dope Ganja, Gang-



Specific Drugs

Cannabis

Cannabis Sativa L.

Marijuana is grown in the United States, Mexico, Canada, South America, Asia, and other parts of the world. It can be cultivated outdoors and in indoor settings. Marijuana is usually smoked and the effects are felt within minutes. Depending on the dosage and other variables, users can feel relaxed and have altered senses of smell, sight, taste and hearing, distorted senses of time, shifting sensory imagery, rapidly fluctuating emotions, fragmentary thoughts, impaired memory and dulling of attention.

THC (delta-9-tetrahydrocannabinol) is the psychoactive ingredient found in the marijuana plant. In the 1970's, the average THC content of illicit marijuana was less than one percent. Today most commercial grade marijuana from Mexico/Colombia and domestic outdoor cultivated marijuana has an average THC content of 4 to 6 percent, although some samples have tested as high as 25 percent THC.

High doses of marijuana can result in hallucinations. Marijuana smokers experience the same health problems as tobacco smokers: bronchitis, emphysema, and bronchial asthma. Extended use is associated with anti-motivational syndrome, lung damage, and risk to reproductive systems.

Hashish and Hashish Oil (smoked, ingested)

Hashish consists of the THC-rich resinous material of the cannabis plant which is collected, dried, and then compressed into a variety of forms, such as balls, cakes, or cookie-like sheets. Pieces are then broken off, placed in pipes, and smoked. The Middle East, North Africa, Pakistan, and

Afghanistan are the main sources of hashish.

Hash oil is produced by extracting the cannabinoids from plant material with a solvent. The color and odor of the resulting extract will vary, depending on the type of solvent used. Current samples of hash oil, a viscous liquid ranging from amber to dark brown in color, average about 15 percent THC.

Heroin

Heroin is a narcotic which can be injected, smoked or snorted. It comes from the opium poppy grown in Southeast Asia (Thailand, Laos and Myanmar—Burma); Southwest Asia (Afghanistan and Pakistan), Mexico and Colombia. It comes in several forms, the main ones being “black tar” from Mexico (found primarily in the western United States) and white heroin from Colombia (primarily sold on the East Coast).

In the past, heroin was mainly injected. Because of the high purity of the Colombian heroin, many users now snort or smoke heroin. All of the methods of use can lead to addiction, and the use of intravenous needles can result in the transmission of HIV.

Cocaine

Cocaine is a powerful stimulant derived from coca leaves grown in Bolivia, Peru and Colombia. The most common method of use is snorting the cocaine powder (Cocaine Hcl). Its crack form is smoked (freebased). Cocaine is usually distributed as white powder, often diluted (“cut”) with a variety of sub-



Drug Effects: Heroin

Effects: Euphoria, drowsiness, respiratory depression, constricted pupils, and nausea.

• **Overdose Effects:** Slow and shallow breathing, clammy skin, convulsions, coma, and possible

death. • **CSA Schedule:** Heroin has no legitimate medical use: Schedule I. • **Street Names:** Horse, Smack, Black Tar, Chiva, and Negra (black tar).



Drug Effects: Cocaine

Effects: Increased alertness, excitation, euphoria (sometimes followed by a “crash”), increased

pulse rate and blood pressure, insomnia and loss of appetite. • **Overdose Effects:**

Agitation, increased body temperature, hallucinations, convulsions, possible death. • **CSA Schedule:** Approved for use as an anesthetic for ear, eye and throat surgeries: Schedule II. • **Street Names:** Coke, Flake, Snow, Crack, Coca, and Blanca.



Drug Effects:

Methamphetamine

Effects: Increased alertness, excitation, euphoria, increased pulse rate and blood pressure, insomnia and loss of appetite.

• Overdose Effects: Agitation, increased body temperature, hallucinations, convulsions, possible death.

• CSA Schedule: Methamphetamine hydrochloride is prescribed for appetite suppression: Schedule II. **• Street Names:** Crank, Ice, Crystal, Krystal, Meth, Speed, and Tina.

stances, the most common being sugars and local anesthetics. This is done to stretch the amount of the product and increase profits for dealers.

Crack is sold in small, inexpensive doses that are smoked. Its effects are felt immediately and are very intense and short-lived. The intensity of the psychological effects of cocaine depends on the dose and rate of entry to the brain. Cocaine reaches the brain through the snorting method in three to five minutes. Intravenous injection of cocaine produces a rush in 15-30 seconds, and smoking produces an almost immediate intense experience. These intense effects can be followed by a “crash.”

The cocaine manufacturing process takes place in remote jungle labs where the raw product undergoes a series of chemical transformations.

Methamphetamine

Methamphetamine is a stimulant which is generally produced in large laboratories in Mexico, the United States and Asia, or in “small toxic labs” in the United States. It can be injected or smoked. “Ice” is the crystallized form of methamphetamine and it is generally smoked. In all its forms, methamphetamine is highly addictive and toxic.

The onset of meth effects is about the same as cocaine, but they last longer. Meth remains in the central nervous system longer than cocaine, and chronic abuse produces a psychosis that resembles schizophrenia. Other signs of meth use include paranoia, picking at the skin, preoccupation with

one’s thoughts, and auditory and visual hallucinations. These effects can last for months and even years after using methamphetamine, and violent and erratic behavior is often seen among chronic users.

Prescription Drugs

Pain Killers

Vicodin™ is hydrocodone mixed with acetaminophen. Hydrocodone is a semi-synthetic opioid similar in effects to morphine. Hydrocodone products, when abused, can lead to dependence, tolerance, and addiction. Vicodin™ is one of the most frequently prescribed medications for pain. Other products include Vicoprophen™, Tussionex™, and Lortab™.

Oxycodone is used as an analgesic and is formulated into numerous pharmaceuticals including OxyContin™ (a controlled-release product) and with aspirin (Percodan™) or with acetaminophen (Percoset™). These drugs are prescribed for pain relief. They all require a doctor’s prescription and are prescribed for moderate to severe pain.

Fentanyl is extensively used for anesthesia and analgesia. Duragesic™ is a fentanyl transdermal (through the skin) patch used in chronic pain management, and Actiq™ is a solid formulation of fentanyl citrate on a stick that dissolves slowly in the mouth for absorption through mucous membranes.

Illicit use of pharmaceutical fentanyl first appeared in the mid-1970’s in the medical community. To date, over 12 different analogues of fentanyl have been produced clandestinely and identified in the U.S. drug traffic.

The biological effects are indistinguishable from those of heroin, with the exception that the fentanyl may be hundreds of times more potent. Fentanyl is most commonly used by intravenous administration, but like heroin, it may



Drug Effects:

Pain Killers

Effects: Euphoria, drowsiness, respiratory depression, constricted pupils, and nausea.

• Overdose Effects: Slow and shallow breathing, clammy skin, convulsions, coma, and possible death. **• CSA**

Schedule: Pure hydrocodone and oxycodone are in Schedule II. Hydrocodone products fall into schedules III and V.

also be smoked or snorted.

Ultram™ (tramadol hydrochloride) and Ultracet™ (tramadol with acetaminophen) are prescription medications indicated for the management of moderate to moderately severe pain.

Depressants

Xanax™ (alprazolam) is from the benzodiazepine family of depressants. It is used to treat anxiety and panic disorders.

Valium™ (diazepam) is also from the benzodiazepine family of depressants. It is usually used to treat anxiety, alcohol withdrawal, muscle spasms, and seizures. Valium™ is among the most widely prescribed medications in the United States. Concurrent use of alcohol or other depressants with Valium™ can be life-threatening.

Alprazolam and diazepam are the two most frequently encountered benzodiazepines on the illicit market. Abuse is frequently associated with adolescents and young adults who take the drug to get high. Abuse of benzodiazepines is particularly high among heroin and cocaine abusers.

Stimulants

Methylphenidate (Ritalin™, Concerta™) is a stimulant which is prescribed for attention deficit/hyperactivity disorder. It has a high potential for abuse and produces many of the same effects as cocaine and amphetamines. Binge use, psychotic episodes, cardiovascular complications, and severe psychological addiction have all been associated with methylphenidate abuse. According to the National Institute on Drug Abuse, methylphenidate is a valuable medicine for adults as well as children with attention deficit and hyperactivity disorder. Research shows that individuals with ADHD do not become addicted

to stimulant medications when taken in the form and dosage prescribed by doctors. In fact, it has been reported that stimulant therapy in childhood is associated with a reduction in the risk for subsequent drug and alcohol use disorders.

Adderall™ is an amphetamine which is used to treat attention deficit hyperactivity disorder (ADHD) in children 6 years of age and older and in adults.

GHB

There are three kinds of GHB abusers: those who take the drug to get high, those who use it in bodybuilding, and those who commit sexual assault after drugging their victims. GHB is also frequently used in combination with MDMA (Ecstasy) to counter overstimulation. It is frequently taken with alcohol and is often found at bars, parties, nightclubs, raves and gyms.

GHB is often called the “date-rape” drug. Because of its effect on memory, GHB may cause users to forget details surrounding a sexual assault. GHB is quickly eliminated from the body, and it is sometimes hard to confirm its presence during rape investigations.

Ecstasy (MDMA)

Ecstasy is a synthetic drug that produces both stimulation and hallucinatory effects and is associated with increased energy, sensual arousal



Drug Effects:

Depressants

Effects: Xanax™ and Valium™ misuse is associated with amnesia, hostility, irritability, and vivid or disturbing dreams, as well as tolerance and physical dependence.

• **Overdose Effects:** Concurrent use of alcohol or other depressants with Valium™ or Xanax™ can be life-threatening. • **CSA**

Schedule: Xanax™ and Valium™ are in Schedule IV.



Drug Effects:

Stimulants

Effects: Misuse of Ritalin™ and Adderall™ may cause short, intense periods of high energy.

• **Overdose Effects:** High doses of Ritalin™ or Adderall™ can produce agitation, tremors, euphoria, palpitations, and high blood pressure. Psychotic episodes, paranoid delusions, hallucinations, and bizarre behavior have been associated with stimulant abuse.

• **CSA Schedule:** Ritalin™ and Adderall™ are in Schedule II.



Drug Effects: GHB

Effects: Slurred speech, disorientation, drunken behavior without the odor of alcohol, impaired memory of events, and interaction with alcohol.

• **Overdose Effects:** Shallow respiration, clammy skin, dilated pupils, weak and rapid pulse, coma and possible death.

• **CSA Schedule:** GHB in its illegal form is schedule I; a prescription drug, Xyrem™, formulated from components of GHB, is Schedule III. • **Street Names:**

GHB, Georgia Home Boy, Grievous Bodily Harm, Liquid Ecstasy, Liquid X, Sodium Oxybate, and Xyrem™.

Drug

Effects: Ecstasy

Effects: Heightened senses, teeth grinding and dehydration. • **Overdose Effects:** Increased body temperature, electrolyte imbalance, cardiac arrest, possible death. • **CSA Schedule:** Schedule I. • **Street Names:** Ecstasy, XTC, Adam, Love Drug, Eve, Hug, and Beans.



and enhanced tactile sensations. The effects of MDMA are felt within 30-45 minutes, peaking at 60-90 minutes, and lasting 4-6 hours.

It produces nerve cell damage that can result in psychiatric disturbances, muscle tension, tremors, blurred vision, and increased body temperature which can result in organ failure and death. The majority of MDMA is produced in laboratories in Europe and then smuggled into the United States. MDMA is usually distributed in tablet form and many of these tablets are imprinted with pop culture designs or commercial logos.

Drug

Effects: LSD

Effects: Illusions and hallucinations, altered perception of time and distance, impaired judgment leading to possible personal injury. • **CSA Schedule:** No recognized medical use: Schedule I. • **Street Names:** Acid, Microdot, Sunshine, and Boomers.



LSD

For years, LSD has been produced in laboratories in the United States. It is generally sold in the form of impregnated paper typically imprinted with colorful graphic designs. It has also been found in tablets (microdots), thin squares of gelatin (window panes), in sugar cubes, and (rarely) in liquid form.

During the first hour after ingestion, users may experience visual changes with extreme changes in mood. While hallucinating, the user may suffer impaired depth and time perception accompanied by distorted perception of the shape and size of objects, movements, colors, sound, touch and the user's own body image.

Drug Effects:

PCP

Effects: Illusions and hallucinations, altered perceptions of space and time. • **Overdose Effects:** Suicidal and hostile behavior, coma, convulsions, and possible death from respiratory arrest. • **CSA Schedule:** Was used in 1950's as intravenous anesthetic and discontinued for human use in 1965: Schedule I. • **Street Names:** PCP, Angel Dust, Killer Weed, and Supergrass.



The ability to make sound judgments and see common dangers is impaired, making the user susceptible to personal injury. It is possible for users to suffer acute anxiety and depression after an LSD "trip" and flashbacks have been reported days, even months, after taking the last dose.

PCP

PCP is generally produced in clandestine laboratories in the United States. It was originally used as a veterinary anesthetic and is illegally produced for human consumption in powder, capsule and liquid form, and is frequently sprinkled on parsley, mint, oregano or marijuana and smoked.

PCP use often causes a user to feel detached from his surroundings. Numbness, slurred speech, and loss of coordination can be accompanied by a sense of strength and invulnerability. Auditory hallucinations and severe mood disorders can occur. In some users, acute anxiety, paranoia, hostility, and psychosis can occur.

Ketamine

Ketamine is a fast-acting anesthetic and can be used on both humans and animals.

As a drug of abuse, it can be taken orally, snorted, or injected, and can be sprinkled on marijuana or tobacco and smoked. If used intravenously, effects can be felt immediately, and if snorted or taken orally, effects are evident in 10-15 minutes.

Ketamine can act as a depressant or a psychedelic and low doses can produce vertigo, slurred speech, slow reaction time and euphoria. In higher doses, Ketamine produces amnesia and coma.



Anabolic Steroids

Anabolic steroids are synthetically produced variants of the naturally occurring male hormone testosterone. The two main effects of these drugs are androgenic (developing male characteristics) and anabolic (building muscles).

The three main patterns of abuse include: cycling (alternating periods of use); stacking (using two or more at the same time); and pyramiding (progressively increasing and then decreasing doses and types of steroids).

Besides the short-term effects on both men and women, long-term use can lead to adverse cardiovascular effects, liver dysfunction, liver tumors, liver cancer, and cancer of the prostate in men. Among the most prevalent side-effects of steroids is the development of female characteristics in males (developing breasts) and the masculinization of women.

Inhalants

Inhalants are a diverse group of substances that are sniffed, snorted, huffed, or placed in bags and inhaled to produce intoxication. Common household products such as aerosol propellants, glue, lighter fluid, cleaning fluids, and paint are the most abused inhalants. Inhalant users experience headache, nausea, slurred speech and loss of motor coordination. They sniff or “huff” ordinary household products like

nail polish remover, cleaning fluid, gasoline, and spray paint.

Over The Counter (OTCs)

DXM (dextromethorphan) is a cough suppressant available in a variety of over-the-counter cough and cold medications. DXM is abused because, when taken in doses that dramatically exceed those recommended by physicians and pharmacists, it produces hallucinations and a sense of dissociation. As an over-the-counter medication, DXM is available in various forms including liquids, lozenges, tablets, capsules, and gel caps.

Individuals who abuse DXM consume much higher doses (typically more than 360 milligrams), which produce hallucinations and dissociative effects similar to those experienced with PCP (phencyclidine) or ketamine. While under the influence of the drug,



Drug Effects: Ketamine

Effects: Illusions and hallucinations, altered perceptions of space and time.
Overdose Effects: Unable to direct movement, feel pain, or remember. **CSA Schedule:** Used as veterinary anesthetic: Schedule III. **Street Names:** Special K.



Drug Effects: Anabolic Steroids

Effects: Virilization, edema, testicular atrophy, gynecomastia, acne, aggressive behavior, and mood changes.
CSA Schedule: Anabolic steroids are used medically to treat hormonal imbalances and other medical conditions.

Street Names: Depo Testosterone, Juice,



Drug Effects: Inhalants

Effects: Flushing, hypotension, and headache.
Overdose Effect: Can include damage to the heart, liver, kidneys, lungs, and brain; death can occur from a single use or after prolonged use. **CSA Schedule:** Inhalants are not scheduled under CSA.
Street Names: Poppers, Rush, Snappers, Whippets, Kick, Bang and Amys.



Drug Effects:
Over the
Counter Drugs
(OTCs)

Effects: Dissociation and hallucinations. • **Overdose Effects:** Loss of consciousness, seizures, brain damage, death. • **CSA Schedule:** OTCs are not scheduled under the CSA. • **Street Names:** Dex, DM, Drex, Robo, Rojo, Skittles, Triple C, and Velvet.

which can last for as long as 6 hours, DXM abusers risk injuring themselves and others because of the drug's effects on visual perception and cognitive processes.

In addition, individuals who ingest high doses of DXM risk hyperthermia (exceptionally high fever), particularly if they use the drug in a hot environ-

ment or while physically exerting themselves—such as at a rave or dance club. Other risks associated with DXM abuse include nausea, abdominal pain, vomiting, irregular heartbeat, high blood pressure, headache, numbness of fingers and toes, loss of consciousness, seizures, brain damage, and death. Over-the-counter medications containing DXM frequently contain other ingredients that can cause additional health problems.

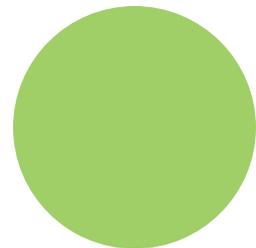


Costs to Society

The consequences of drug use are not limited to the individuals who take drugs. Even non-users are at risk; drug use costs our society over \$180 billion a year. Drug production harms the global environment; methamphetamine production uses toxic chemicals which seep into the ground and contaminate water sources. The Amazon region is being depleted by coca production. Drugged drivers injure and kill innocent people every year. Terrorist activities are connected to drugs; many organizations raise money for their violent attacks through drug production and trafficking. Children are adversely affected by drugs their parents use or manufacture in their homes.

Did you know that:

- According to government surveys which ask young people about their drug use patterns, about 600,000 high school seniors drive after smoking marijuana. More than 38,000 seniors told surveyors that they had been involved in accidents while driving under the influence of marijuana. Other surveys conducted by MADD (Mothers Against Drunk Driving) and the Liberty Mutual Insurance Company revealed that many teenagers (41 percent) were not concerned about driving after taking drugs. Medical data indicates a connection between drugged driving and accidents. A study of patients in a shock-trauma unit who had been in collisions revealed that 15 percent of those who had been driving a car or motorcycle had been smoking marijuana and another 17 percent had both THC and alcohol in their blood.
- From the clear-cutting of rain forests in Central and South America for the planting of coca fields, to the destruction of national forests in the United States for the growing of marijuana, to the dumping of hazardous waste byproducts into the water table after the manufacture of methamphetamine, illegal drugs have a far-reaching impact on the environment. These activities have consequences for the health of the groundwater, streams, rivers, wildlife, pets and the people living in those areas. Illegal drug production contributes to deforestation, reduced biodiversity, increased erosion, air pollution and global climate change.
- Drug exposed children cost society millions of dollars. The total lifetime costs associated with caring for babies who were exposed to drugs or alcohol range from \$750,000 to \$1.4 million. These figures take into account the hospital and medical costs for drug exposed babies, housing costs, and other care costs. The long-term health damage to meth-exposed children has not yet been calculated.
- Drug money helps to support terrorists operating in countries around the world.



Activity:

What costs are you and your family paying for others' drug use? What evidence have you seen that drugs damage our society and other societies around the world?





Why Do Young People Use Drugs?

When asked, young people offer a number of reasons for using drugs; most often they cite a desire to change the way they feel, or to “get high.”

Other reasons include:

- Escape school and family pressures
- Low self-esteem
- To be accepted by their peers
- To feel adult-like or sophisticated
- Curiosity
- Perception of low risk associated with drugs
- Availability of drugs

Prevention experts have identified “risk factors” and “protective factors” to help determine how drug abuse begins and how it progresses. Risk factors can increase a person’s chances for drug abuse, and protective factors can reduce the risks. It’s important to remember that not everyone at risk for drug abuse actually becomes a drug user.

Here are some early signs of risk that may predict later drug use:

- Association with drug abusing peers
- A lack of attachment and nurturing by parents or caregivers
- Ineffective parenting
- A caregiver who abuses drugs
- Aggressive behavior
- Lack of self-control
- Poor classroom behavior or social skills
- Academic failure

Young people are most vulnerable to drug use during times of transition; for instance, when teens make the switch from elementary to middle school or when they enter high school, new social and emotional challenges affect them on many levels.

Scientists have also studied the adolescent brain, and have determined that the teen brain is not fully formed until young adulthood. Using drugs during the time that the brain is developing increases the potential for drug addiction. According to the 2003 National Survey on Drug Use and Health, adults who had first used substances at a younger age were more likely to be classified with dependence or abuse than adults who initiated use at a later age. This pattern of higher rates of dependence or abuse among persons starting their use of marijuana at younger ages was observed among all demographic subgroups analyzed.

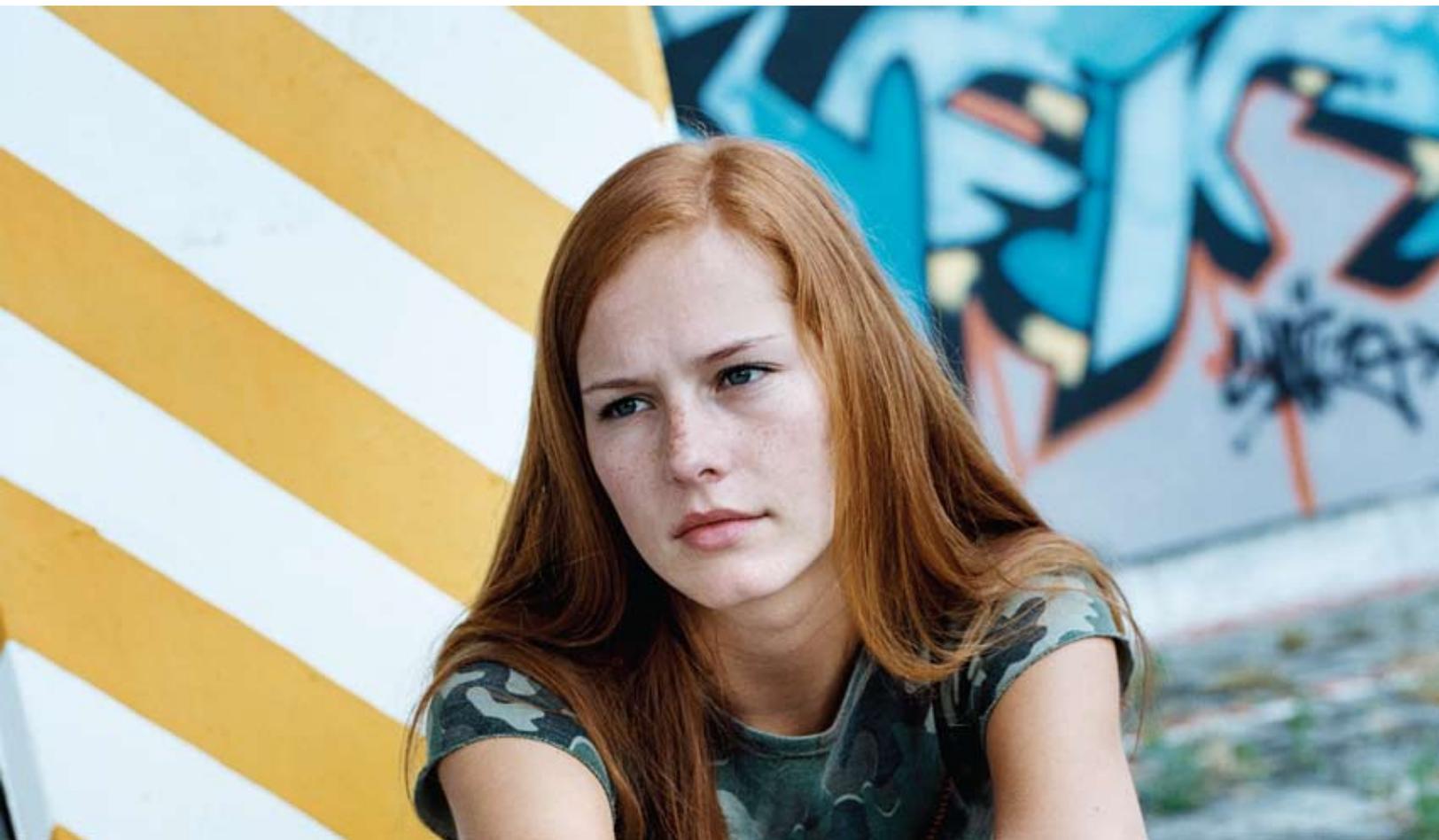
Experts agree that association with drug abusing peers is often the most immediate risk for exposing adolescents to drug abuse and delinquent behavior.

What other factors contribute to drug abuse among youth?

- We are a pill-taking society. Many of us believe there's a pill for anything and everything that ails us; for improving our appearance; for better performance and mood. There are thousands of good medications which are safe and effective, and new drugs come on the market often. We are bombarded with advertisements about the benefits of these drugs. But don't be fooled: legal prescription drugs are not something to play around with. Neither are some over-the-counter medications, like cough syrup. Just because a doctor prescribed them to a relative or a friend doesn't make them safe for you. Just
- because something comes from a drug store doesn't make it safe to abuse.
- Our society frequently portrays drug-taking in a positive light, and there is not enough realistic depiction of the consequences of drug use.
- Leading figures in sports, entertainment and public life openly discuss their drug use, sending a message that taking drugs is "normal" behavior.

Activity:

What are some of the most obvious signs of drug addiction? Are there other signs that may not be obvious to family and friends? What are the physical manifestations of drug addiction? What has technology taught us about the impact of drugs on the brain? You may want to ask your friends and classmates to discuss these questions. What other causes can they suggest for the problem?





Attitudes About Drugs

Adult Behavior and Attitudes May Contribute to the Problem

Many adults are uninformed—or in denial—about drug use, and their attitudes contribute to or enable young people to engage in drug-using behavior. According to the Partnership for a Drug Free America, many parents need to get better educated about the drug situation.

- Today's parents see less risk in drugs like marijuana, cocaine and even inhalants, when compared to parents just a few years ago.
- The number of parents who report never talking with their child about drugs has doubled in the past six years, from 6 percent in 1998 to 12 percent in 2004.
- Just 51 percent of today's parents said they would be upset if their child experimented with marijuana.
- While parents believe it's important to discuss drugs with their children, fewer than one in three teens (roughly 30 percent) say they've learned a lot about the risks of drugs at home.
- Just one in five parents (21 percent) believes their teenager has friends who use marijuana, yet 62 percent of teens report having friends who use the drug.
- Fewer than one in five parents (18 percent) believe their teen has smoked marijuana, yet many more (39 percent) already are experimenting with the drug.

Activity

What can adults do to educate themselves about drugs? How should adults discuss drugs with their children? How can children talk to their parents about drugs?

Denial Can Make the Problem Worse

Some parents may be afraid to confront the realities of drug use, so they may deny the truth, even to themselves. You may have heard some adults say: "My kid doesn't use drugs." "It's not a problem for our family." "I used drugs and survived." "Drug use is a normal part of growing up." "We'll never solve the drug problem." "Alcohol is more dangerous than marijuana."

Community Indifference Allows the Drug Problem to Escalate

In some communities, drug abuse goes hand-in-hand with community apathy. If drug dealing and use are allowed to flourish within a community, there is little chance that progress can or will be made.

Sociologists who have studied the phenomenon of urban crime understand the links between community neglect and escalating crime rates. James Q. Wilson, a noted sociologist, put forth the "broken window theory" which claims that little things—like a single broken window—convey a message to criminals that it is okay to break other windows, leading to a succession of actions which further degrade a community. Problems accumulate when the broken window is not fixed quickly. When communities recognize problems quickly, and take positive steps to ad-



dress these problems, criminal activity like drug trafficking has less chance to damage that community.

Many communities have opted to develop and implement comprehensive strategies to address issues related to crime and drug abuse. One critical

element in successful strategies is the inclusion of all sectors of a community: law enforcement, businesses, educators, elected officials, the clergy, community leaders, medical and treatment professionals, etc.

For examples of how communities successfully addressed problems and reduced drug trafficking and abuse visit the following web sites: www.fightingback.org and www.cadca.org.

Activity:

How has your community dealt with the problems of crime and drugs? If you were mayor for a day, what strategies would you employ to address the drug problem?



“... addiction is a chronic, relapsing disease characterized by compulsive drug-seeking and abuse and by long-lasting chemical changes in the brain.”

What Is Addiction?

According to the experts at the National Institute on Drug Abuse (NIDA), addiction is a chronic, relapsing disease characterized by compulsive drug seeking and abuse, and by long-lasting chemical changes in the brain. Some drugs are more addictive than others; however, depending on an individual user’s propensity for addiction, someone can become addicted to drugs very quickly.

Experts say that there are several ways to determine if you have a drug problem. A user should ask questions about drinking or drug use and assess how he/she feels when using. “Am I losing control of my life? Am I giving up things I used to love because of drugs? Have family and friends become less important?”

Obtain more information on drug addiction from the National Institute on Drug Abuse (NIDA) at www.nida.gov. Information on the signs of drug addiction is also available at www.checkyourself.com.

Drug Treatment

NIDA scientists tell us that “There is no cure for drug addiction, but it is a treatable disease; drug addicts can recover. Drug addiction therapy is a program of behavior change or modification that slowly retrains the brain. Like people with diabetes or heart disease, people in treatment for drug addiction learn behavioral changes and often take medications as part of their treatment regimen.”

Did you know that over 60 percent of the young people currently in treatment are there for dependence on marijuana? When using illegal drugs, or abusing other substances such as inhalants, prescription drugs, or over the counter medications, there is a tremendous potential for addiction, and treatment may be the only option.

Drug treatment is available to those who need help, including in-patient and out-patient centers, therapeutic communities and 12-step programs. In addition to medical treatment programs, some are faith-based. Additionally, community programs such as Drug Courts give non-violent drug users in the criminal justice system opportunities for treatment—with conditions—instead of jail time. For more information on drug treatment, go to the Center for Substance Abuse Treatment (CSAT) at www.samhsa/csaf.gov. Drug Court information is available at www.nadcp.org. There are also many stories on the internet about teens seeking drug treatment. For information on how to help someone who needs treatment, go to the National Youth Anti-Drug Media Campaign at www.mediacampaign.org.

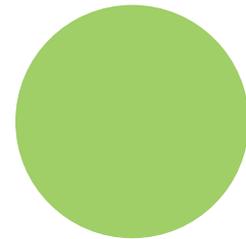
Activity:

What strategies do treatment programs employ to help users remain drug free? What are the different outcomes that can be expected from the various forms of drug treatment? How can you help a friend or family member who is abusing drugs get into drug treatment?

What About Drug Legalization?

Some people are of the opinion that drug use is a personal choice and that the U.S. Government should legalize drug use. They support their claims with opinions that marijuana is a medicine and is not harmful, that legalization will remove the violence and profit from the drug trade, and that adults will be able to take drugs safely and responsibly. The vast majority of Americans do not want drugs legalized. They believe legalization will lead to further disintegration of families, increase health and social costs, and jeopardize the safety of innocent people. Given the enormous toll that legal substances such as tobacco and alcohol have taken on our society, why would we want to compound our problems by adding legal drugs to the mix? Marijuana is not harmless, nor is it a medicine. Many studies have been conducted to determine whether or not marijuana should be approved as a medicine. There are many rigorous and complex elements to the U.S. government's approval of any drug that is used as medicine in this country. If scientists conclude that marijuana should someday be considered a medicine, these same rigorous steps would need to be followed before doctors are permitted to prescribe it to patients.

Furthermore, there are no smoked medicines. Have you ever heard of anyone who smoked medicine? After all we know about the dangers of cigarette smoking, why would the scientific community approve smoked marijuana? Those who smoke marijuana regularly may have many of the same respiratory problems that tobacco smokers do, such as daily cough and phlegm production, more frequent acute chest illnesses, a heightened risk of lung infections, and a greater tendency toward obstructed airways. Marijuana has the potential to promote cancer of the lungs and other parts of the respiratory tract because marijuana smoke contains 50 percent to 70 percent more carcinogenic hydrocarbons than does tobacco smoke. *Source: National Institute on Drug Abuse, Research Report Series - Marijuana, October 2001.*



Activity:
Imagine a scenario where drugs were legal in your community. What would be affected by the increased drug use that occurred? How would the impact of this policy affect young people? What would the consequences of increased availability and use be on non-users? How would this compare to the problems caused by alcohol?



Part Two: Drug Prevention and Awareness

Drug prevention is a critical component in our nation's effort to reduce drug use, particularly among young people. When it is part of a comprehensive strategy which includes law enforcement and drug treatment, prevention is a very powerful tool to reduce drug use. Over the decades, various types of drug prevention approaches have been implemented to help people reject drugs and choose healthy alternatives. Over the years, many lessons have been learned in the prevention

field, and evaluating whether prevention programs actually work has been critical to their success. While drug prevention efforts continually evolve based on actual situations and needs, there are some guiding principles which are basic to successful drug prevention efforts.

The ultimate aim of drug prevention programs is to change behaviors which encourage drug abuse and to reinforce positive behaviors which lead to the rejection of drugs.

Principles of Prevention

Know What The Problem Is and Who You Are Trying To Reach

Address Appropriate Risk and Protective Factors for Substance Abuse in a Defined Population

- **Define a population.** A population can be defined by age, gender, race, geography (neighborhood, town, or region), and institution (school or workplace).
- **Assess levels of risk, protection, and substance abuse for that population.** The risk factors increase the risk of substance abuse, and protective factors inhibit the risk of substance abuse in the presence of risk. Risk and protective factors can be grouped in domains for research purposes (genetic, biological, social, psychological, contextual, economic, and cultural) and characterized as to their relevance to individuals, the family, peers, school, workplace, and community.
- **Focus on all levels of risk, with special attention to those exposed to high risk and low protection.** Prevention programs and policies should focus on all levels of risk, but special attention must be given to the most important risk factors, protective factors, psychoactive substances, individuals, and groups exposed to high risk and low protection in a defined population. Population assessment can help sharpen the focus of prevention.

Find Out What Works—and Use It

Use Approaches that Have Been Shown to be Effective

- **Reduce the availability of illicit drugs, and of alcohol and tobacco for the under-aged.** Community-wide laws, policies, and programs can reduce the availability and marketing of illicit drugs. They can also reduce the availability and appeal of alcohol and tobacco to the underaged.
- **Strengthen anti-drug-use attitudes and norms.** Strengthen environmental support for anti-drug-use attitudes by sharing accurate information about substance abuse, encouraging drug-free activities, and enforcing laws, and policies related to illicit substances.
- **Strengthen life skills and drug refusal techniques.** Teach life skills and drug refusal skills using interactive techniques that focus on critical thinking, communication, and social competency.
- **Reduce risk and enhance protection in families.** Families strengthen these skills by setting rules, clarifying expectations, monitoring behavior, communicating regularly, providing social support, and modeling positive behaviors.
- **Strengthen social bonding.** Strengthen social bonding and caring relationships with people holding strong standards against substance abuse in families, schools, peer groups, mentoring programs, religious and spiritual contexts, and structured recreational activities.



Activity:

Define “critical thinking” and “social competency” and put them into the drug abuse prevention context.

- **Ensure that interventions are appropriate for the populations being addressed.** Make sure that prevention interventions, including programs and policies, are acceptable to and appropriate for the needs and motivations of the populations and cultures being addressed.

abuse, including homes, social services, schools, peer groups, workplaces, recreational settings, religious and spiritual settings, and communities.

Stay On Top of Your Program Manage Programs Effectively

- **Ensure consistency and coverage of programs and policies.** Implementation of prevention programs, policies, and messages for different parts of the community should be consistent, compatible, and appropriate.
- **Train staff and volunteers.** To ensure that prevention programs and messages are continually delivered as intended, training should be provided regularly to staff and volunteers.
- **Monitor and evaluate programs.** To verify that goals and objectives are being achieved, program monitoring and evaluation should be a regular part of program implementation. When goals are not reached, adjustments should be made to increase effectiveness.
Source: ONDCP.

Successful drug prevention programs depend on the contributions and expertise of many segments of our society: for example, the media, educators, parents, peers, the clergy, law enforcement, the medical community and community leaders. The success of prevention efforts increases when various segments collaborate and provide clear anti-drug messages to targeted populations.

Understand When And Where Drug Use Begins Intervene Early

- **Intervene early and at developmental stages and life transitions that predict later substance abuse.** Such developmental stages and life transitions can involve biological, psychological, or social circumstances that can increase the risk of substance abuse. Whether the stages or transitions are expected (such as puberty, adolescence, or graduation from school) or unexpected (such as the sudden death of a loved one), they should be addressed by preventive interventions as soon as possible—even before each stage or transition, whenever feasible.
 - **Reinforce interventions over time.** Repeated exposure to scientifically accurate and age-appropriate anti-drug-use messages and other interventions can ensure that skills, norms, expectations, and behaviors learned earlier are reinforced over time.
- **Intervene in appropriate settings and domains.** Intervene in settings and domains that most affect risk and protection for substance

Activity:

Think of three age appropriate programs and activities for elementary students. How about for teens?

Successful drug prevention programs depend on the contributions and expertise of many segments of our society: for example, the media, educators, parents, peers, the clergy, law enforcement, the medical community and community leaders.

Drug Prevention Programs

Drug prevention programs are designed and implemented on many levels. The federal government has instituted a number of national drug prevention programs which reach targeted populations through public service announcements, grant programs, educational programs and the sharing of expertise. State and local governments also have a significant number of prevention programs which are tailored to address particular problems and needs. Law enforcement and the military have brought drug prevention expertise into classrooms and communities; businesses have also contributed significantly to drug prevention through sponsored programs, drug-free policies and corporate support for community initiatives. Other segments of society, including faith-based institutions, civic organizations and private foundations are also active forces in drug prevention.



Prevention Resources

Below is a partial list of drug prevention agencies and programs. There are many other outstanding efforts which are ongoing across the nation; it is impossible to include them all. Some programs are aimed at particular populations or specific drugs. Within a given agency, there may be many prevention programs which are aimed at different audiences.

Federal Drug Prevention Agencies and Programs:

Office of National Drug Control Policy (ONDCP):

This office reports to the President of the United States. ONDCP administers the Youth Anti-Drug Media Campaign.

www.mediacampaign.org

www.whitehousedrugpolicy.gov

Substance Abuse and Mental Health Services Administration (SAMHSA):

This organization is responsible for overseeing and administering mental health, drug prevention and drug treatment programs around the nation. The Center for Substance Abuse Prevention (CSAP) and the Center for Substance

Abuse Treatment (CSAT) are part of SAMHSA.

www.samhsa.gov

www.samhsa/csap.gov

www.samhsa/csat.gov

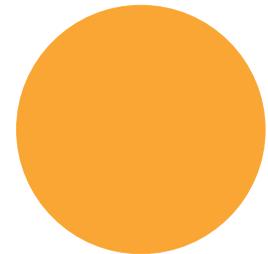
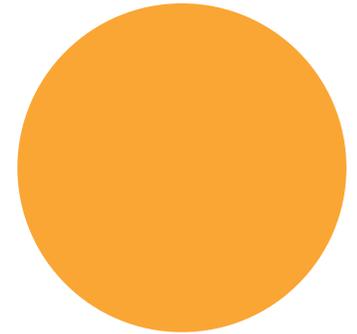
U.S. Department of Education (DOE):

DOE has many anti-drug programs.

www.ed.gov

Drug Enforcement Administration (DEA):

In addition to dismantling the major drug trafficking organizations, DEA is committed to reducing the demand for drugs in America. DEA's Demand Reduction Program is carried out by





Special Agents across the United States who work in communities to share expertise and information on drug trends, emerging problems and the dangers of drugs.

www.dea.gov

www.justthinktwice.com

www.GetSmartAboutDrugs.com

National Institute on Drug Abuse (NIDA):

NIDA conducts and disseminates the results of research about the effects of drugs on the body and the brain. NIDA is an excellent source of information on drug addiction.

www.nida.gov

National Guard:

The National Guard provides drug education to communities in all 50 states.

www.ngb.army.mil

Weed and Seed:

Operation Weed and Seed is a strategy to prevent and reduce violent crime, drug abuse, and gang activity in targeted high-crime neighborhood. Law

enforcement agencies and prosecutors cooperate in “weeding out” criminals and “seeding” to bring in human services, prevention intervention, treatment, and neighborhood revitalization.

877-727-9919

www.ojp.usdoj.gov/ccdo/ws/welcome.html

Other Anti-Drug Organizations:

National Association of State Alcohol and Drug Abuse Directors (NASADAD)

www.nasadad.org

Community Anti-Drug Coalitions Of America (CADCA)

<http://cadca.org>

National Crime Prevention Council (NCPC)

www.ncpc.org

National Families in Action (NFIA)

www.nationalfamilies.org

You can obtain free anti-drug information from:

National Clearinghouse for Alcohol and Drug Information (NCADI)

www.health.org

The National Center on Addiction and Substance Abuse at Columbia University (CASA)

www.casacolumbia.org

Elks Drug Awareness Program

www.elks.org/drugs/default.cfm

Partnership for a Drug-Free America (PDFA)

www.drugfree.org

Scott Newman Center

www.scottnewmancenter.org

American Council for Drug Education (ACDE)

www.acde.org

Drug Strategies

www.drugstrategies.org

Youth Anti-Drug Organizations:

Learning For Life

www.learning-for-life.org

PRIDE Youth Programs

www.prideyouthprograms.org

Drug Abuse Resistance Education (DARE America) (DARE)

www.dare.com

Students Against Destructive Decisions (SADD)

www.sadd.org

Teens In Prevention

www.deatip.net

Law Enforcement Exploring

www.learning-for-life.org/exploring/lawenforcement/

Youth Crime Watch of America

www.ycua.org





Part Three: What You Can Do

How Teens Can Assist With Drug Awareness Programs

There are many avenues for teens to work in drug prevention. You can work with established programs, create your own anti-drug programs, or work individually as role models or mentors. Working within the community, schools, faith organizations, or in conjunction with businesses, young people can make a tremendous difference in reducing the demand for drugs.

Working With Schools:

Young people who are aware of the risks and consequences of drug use can make sound life decisions. Prevention programs help to improve skills to resist drugs, strengthen personal commitments against drug use, and increase social competency (communications, peer relationships, self efficacy, and assertiveness), in conjunction with

reinforcement of attitudes against drug use. Good prevention programs include interactive methods, such as peer discussion groups, rather than just lecture methods alone.

You can play an important role in drug awareness and prevention by informing the public about the perils of substance abuse. A prerequisite for youth involvement in this area would be a comprehensive training program covering the identification, use, misuse, and effects of drugs. Teens should also be familiar with the dangers and effects of alcohol and tobacco abuse. A vital component of this training would be public speaking skills and methods of presenting substance abuse information to various types of audiences.

Early Elementary School

Prevention programs for youth in this age category should be based on the concept that only sick people need drugs. Children should be taught that while drugs can be beneficial

if medically prescribed and used, all drugs are dangerous if they are misused. Acquaint this age group with the techniques used to lure young people into experimenting with drugs. Because students in this age bracket are more responsive to visual than audio stimulus, audiovisual aids should be an integral part of any such presentation.

Middle School

Use a factual approach with junior high school students. They should be told about the legal, physiological, and psychological consequences of substance abuse. The adverse results of alcohol, tobacco, and marijuana use should receive considerable attention at this level. The importance of positive decision making as it relates to the sometimes negative effect of peer pressure should be examined and discussed. Peer pressure can be used to support either type of decision. Role-playing scenarios would be helpful in reinforcing this information.

High School

Research shows that teens rely on peers for accurate information on all important issues, including drugs. You have lots to say, and are both questioning and skeptical. So, it's important to tell the real truth, without exaggerating, because if teens sense that one bit of information is untruthful or exaggerated, you will tend not to believe any of it. Be prepared to be challenged and ready to back up your information with good sources. Don't forget to respect differing opinions, cultures, and experience levels. It would also be a good idea to get pointers from a trusted teacher or counselor about persuasive ways to deliver information to your peers.

Adults

School organizations, community service groups, etc

There are many avenues for teens to engage adults in drug prevention efforts, and it's important for young people to know what perspectives and attitudes adults have about drugs. Many parents don't know the extent of the drug problem facing teens, and may not be familiar with current drugs of abuse. Some parents are also skeptical about how successful communities and families can be in reducing drug use. You can provide insight and information to adults in many sectors of your communities.

In dealing with adults, be straightforward about the realities you are facing in school, with peers, on weekends and in our culture. They need to know these things. Share your ideas on what they can do to help teens be drug free. For example, members of the business community can join with you to tighten up restrictions on cigarette and alcohol sales to minors. Civic leaders can help make communities and living areas safer for kids and teens. Adults can help get the word out to the media, political leaders and others about your needs and prevention plans.

Encourage adults to read as much as they can about drug use trends, and familiarize themselves with information about what teens are up against. They can be real allies in your efforts to reduce drug use in your schools and communities.

Key elements in the success of any prevention program are training and preparation. Teens can be of vital assistance to our communities and fellow citizens in combating substance abuse.



Drug Prevention Projects

Red Ribbon Week

Red Ribbon Week is an important tradition for the drug prevention community, and especially for the DEA. The event that has become a national symbol of drug prevention began as a grassroots tribute to a fallen DEA hero, Special Agent Enrique Camarena. The National Red Ribbon Campaign was sparked by the murder of DEA Special Agent Camarena by drug traffickers. In March of 1985, Camarena's Congressman, Duncan Hunter, and high school friend Henry Lozano, launched Camarena Clubs in Imperial Valley, California, Camarena's home. Hundreds of club members pledged to lead drug-free lives to honor the sacrifices made by Camarena and others on behalf of all Americans. From these clubs emerged the Red Ribbon Week Campaign.

Today, Red Ribbon Week is nationally recognized and celebrated, helping to preserve Special Agent Camarena's memory and further the cause for which he gave his life. The Red Ribbon Campaign is a symbol of support for DEA's and America's efforts to reduce demand for drugs through prevention and education programs. By wearing a red ribbon during the last week in October, Americans demonstrate their ardent opposition to drugs, and pledge to live drug free lives.

Ideas For Other Substance Abuse Prevention Projects

Forums or discussions:

Hold assemblies that help your peers think about, understand, and make constructive contributions to problems that affect their lives.

Subject ideas include: drunk or drugged driving, underage use, drug testing in the schools, impact of drug use on individual and society.

Fairs and displays:

Hold a drug abuse prevention fair in the school parking lot or hallway. Design educational displays for malls, school, hospitals, businesses, and community centers to get more people outside your school or program involved in drug prevention projects.

Pamphlets:

Design and distribute pamphlets on different substance abuse prevention topics. If inhalant abuse or marijuana is the problem in your community, research the issue and make that the subject of your publication. You may find assistance from the Elks Club, a local printer, or other community group in printing your pamphlet.

Videos:

Write, tape and edit a script for a video as part of an education program. You might find assistance at a local public interest television station,

Red Ribbon Week Activities:

- A "wear red" day or week
- Poster Contest
- Door Decoration Contest
- Essay/ Letter Writing Contest
- A "plant red tulips" day
- Drug-Free pledge banner
- Anti-drug/ anti-alcohol pledge

Projects for Businesses:

- Employees wear Red Ribbons
- Display Red Ribbon posters
- Support local schools' Red Ribbon activities

Community and Religious Group Projects:

- Host Red Ribbon speakers
- Pass out Red Ribbon handouts at events
- Support local schools' Red Ribbon activities
- Include Red Ribbon information in group publications

and they might even broadcast your efforts.

Performances:

Write and perform skits and shows for other students, younger children, the neighborhood, or community dealing with some aspect of drug abuse.

Writing, music, or art contests:

Organize these for your school or your whole community to have fun, educate, and build interest. You might have an essay, song, or poster contest. You could print the essays in the school newspaper or literary magazine, have a talent show with the songs or skits, and display the posters in the hallways or other venue. Sponsor positive graffiti contests.

Media campaign:

You could produce public service announcements (PSAs) for radio or television and urge your local stations to carry them. You could write letters to the editor of your local newspaper. You could write an article for your school newspaper on drug abuse.

Puppet show:

You could write your own script, design your own puppets, and give performances for younger children after school.

Drug-free events:

You could sponsor a drug-free day at school, or organize a drug and alcohol-free prom or dance, or perhaps a 5K run.

Conferences:

You could organize a conference on drug-free youth and give presentations on various drugs and how to say no and live a drug-free life as well as teaching leadership skills.

Peer counseling:

Get training to be peer counselors to help other young people with problems.

Tutoring, mentoring:

Set up a student teaching service to help educate your peers or younger children about substance abuse. Being a big brother or big sister for younger children can make a big impact on their lives.



Community clean-up:

Drugs are less likely to flourish in areas that are clean. With appropriate adult supervision clean up trashy, run-down, or overgrown public areas. Spruce up schools, neighborhood parks, and the yards of those unable to do the work. Wipe out or paint over graffiti.

Summer programs:

Plan and staff recreation programs for young children; build playgrounds, help provide outings for disadvantaged children.

Real Life Examples

Learning for Life (LFL)

Learning for Life is a youth-serving organization which aims to help youth meet the challenge of growing up by teaching character and good decision-making skills and then linking those skills to the real world.

As part of the Elementary Learning for Life program, LFL has developed a set of lesson plans for kindergarten through grade six. Each set of plans contains age appropriate and grade specific lessons and activity sheets. For more information call your local Learning for Life office, or visit www.learningforlife.org.

Inspiration from South Carolina Teens

In the Jesse Jackson Housing Project in Greenville, South Carolina, a group of teens decided they would like to make a difference, and they wanted to focus on drug prevention in their community. You have probably heard about McGruff the Crime Dog and The National Crime Prevention Council (NCPC). With the help of this national crime prevention organization and some local pharmacists, these teens researched drugs and their interactions to put together a presentation for parents and grandparents on ways to help keep their kids drug free. They started small by visiting local churches and speaking to the seniors. Within a year, though, they were out there in their community and in the schools doing drug prevention. You can learn a lot about how teens can contribute to community efforts at www.ncpc.org.

Teens In Prevention

Teens in Prevention (TiP) is a youth-driven network sponsored by the Drug Enforcement Administration which aims to empower America's youth to become part of the solution to their drug problem and provide a community solution to a community problem. Every

Real Life Example Highlight

Learning for Life

Meet Reginald "Renell" McCullough, former National Youth Representative for Law Enforcement Exploring, a program of Learning for Life. Renell is a former member of Post 219 sponsored by the Franklin, TN, Police Department. He volunteered hundreds of hours to work events with his post and with the Police Department. He has taken part in a number of leadership trainings and experiences, including a four-month program called Youth Leadership Franklin. In May 2008 Renell graduated from the University of Tennessee in Knoxville and is preparing for a career in public service. He believes that knowing that you have made a difference in somebody's life is the greatest feeling in the world.



October, teens from El Paso, Texas; Las Cruces, New Mexico; and Ciudad Juarez, Mexico meet at the International Bridge of the Americas and exchange red ribbons as part of the Annual Bi-National Red Ribbon Rally. The ribbon exchange is followed by a parade and entertainment as well as exhibits where anti-drug material is distributed.

The TiP chapter at LaCueva High School in New Mexico set up a booth for Homecoming and had “drunk goggles” that students could put on. The students could throw a cream pie at a teacher if they answered a drug question correctly, but they had to put on the goggles before they took the shot. The goggles showed what 1.0, 1.5, and 2.0 blood alcohol look like. These same students went to the Zia Native American Pueblo and presented a drug-free program to the students at the Zia Elementary School.

PRIDE Youth Programs

America’s PRIDE is a drug and violence prevention program for youth

in high school. PRIDE team members reach out to their peers and community with an assertive, drug-free message. They also organize drug-free, fun activities.

A PRIDE team from Newaygo County, Michigan, performs at Champion Cheerleading, a summer camp. The PRIDE team goes to the camp for four days during the months of July and August every year to do an hour-long presentation of high energy drug prevention and awareness to the cheerleaders attending the camp. The object is for the cheerleaders to go back to their schools in the fall and spread the enthusiasm of drug free youth and the PRIDE organization.



Oregon Teens Create Anti-Meth Ads

Students at Newberg High School in Oregon created two anti-meth public service announcements (PSAs) as part of the Oregon Partnership’s Yamhill County’s Meth Awareness Project (MAP). The 30 second ads point out

Real Life Example Highlight

D.A.R.E

Many people know DARE as an elementary school program where police officers teach children about drugs. Did you know that DARE also has a Youth Advisory Board made up of high school representatives from each state? Their role is to provide feedback to the DARE organization and assist DARE programs in the local schools. Working with DARE is a good way to gain leadership experience and help the community at the same time.

Meet Haida Boyd from South Dakota. She has just finished her 2-year term as her state’s representative. Among the projects she helped establish was an after-school program in Aberdeen, South Dakota, a community without a DARE program. She worked with the school superintendent and the police department on projects for several schools in that community. Her first project, called PEER PLUS, was a program focused on homework help and outdoor recreation. She says she has learned a lot from the experience and has pledged to never drink alcohol or abuse drugs. “Seeing other teens around me doing drugs only makes me stronger,” she said. “To me, life is priceless and drugs always come with a consequence. Learn more at: www.dare.com.





the dangers of methamphetamine to other teens. The PSAs were created in conjunction with the Northwest Film Center. They are currently being broadcast by several television stations at a time when methamphetamine use by teens in Oregon is a growing problem. See their PSAs at: www.methawarenessproject.org.

Resources

There are lots of resources to help put a program together, including publications, audiovisual material, financial support, and local experts. Speakers are available, often free of charge. Contact local police departments, the Chamber of Commerce, hospitals, parent groups, and other local groups to obtain speakers for your events.

On the federal level, the Drug Enforcement Administration (DEA) and the National Clearinghouse on Alcohol and Drug Information (NCADI) have limited quantities of free publications.

Each state has a drug and alcohol abuse prevention division. These offices are responsible for putting together a prevention plan for the state each year, and they are aware of resources located around the state. You can obtain the

address and telephone number of your state office by contacting your state government, the Center for Substance Abuse Prevention, or the National Association of State Alcohol and Drug Abuse Directors (NASADAD).

Films, videos, PSAs and news clips can help make your programs interesting. Your local library may have some for loan, or check with your state prevention coordinator for other possibilities. The National Clearinghouse for Alcohol and Drug Information (NCADI) has audiovisual materials available for a very minimal cost. Videos are also available from many commercial firms. There are also a number of web sites which host satellite broadcasts on topics of interest.

Training Resources

It's important to be up to date on drug trends and anti-drug programs. Get some training from local contacts and programs to help you in these areas. Some potential trainers for you and your groups include:

- Your police department's narcotics or community relations unit;
- The local DEA office has personnel in each Field Division around the country;
- The National Guard in each state has a Drug Demand Reduction Administrator;

Activity:

Are you aware of other organizations which have sponsored events or activities? Talk to people involved in those efforts to learn what worked. Can you join forces with existing programs to accomplish more?

- Substance Abuse Counselors at drug rehabilitation centers;
- Your local pharmacist or doctor;
- Local teachers and college professors.

Planning And Implementing A Successful Drug Prevention Program

Successful prevention programs do not need to be elaborate—sometimes the most successful programs are simple. But planning and carrying out a good program requires some thought, planning and oversight. Here are some things to help with a successful program.

- **Decide what type of effort you want to undertake.** Do you want to influence peers? Help children stay away from drugs? Improve your community? Get the attention of adults and organizations?
- **Identify an advisor/sponsor for your program.** This person can be an adult involved in drug prevention, a teacher, coach, guidance counselor, clergy member, etc. It could be another teen who is already involved in a program or a business person or civic leader who is interested in drug prevention.
- **Form a team of interested people and pick a team leader.** If you choose to work by yourself, identify who is there to help you if you need assistance.
- **Do research on the drug problem in your area.** Find out as much as you can about the problem and community resources to address the problem.
- **Have a plan.** Identify your objectives and set realistic goals. Remember that small steps sometimes lead to great successes.
- **Establish a timetable for your**

activities. Adjust the timetable if necessary.

- **Get training from experts in the areas you will need help with.**
- **Keep notes on the progress of your project.** Record information on obstacles you faced during your project, and how you overcame them.
- **Keep track of any funding you have received and spent.**
- **Report back to advisors/sponsors on the progress you have made, and what you have accomplished.**

Financial Resources

Implementing a community drug awareness program need not involve large sums of money. The important thing to remember is that there are organizations willing and able to help young people make a difference in fighting drugs. Potential sources of support may include service or civic clubs, neighborhood watch groups, local corporations, etc. The Elks are one service group which has selected drug abuse prevention as a major project. In addition, groups can earn money by holding events such as dances, bowling, car washes, bake sales, etc.

Activity:

Do some research in your own community. Your local library or mental health or drug treatment center should have lots of information that you can use in your program. There are many experts in your community who may be willing to assist your group. These include the police, doctors, pharmacists, psychologists, and others.

Sample Drug Abuse Prevention Program Planning Worksheet

Group/Project Name: _____
Advisor/Sponsor: _____

Program Purpose:

Nature of Drug Problem: _____

Selected Target: _____

Brief Statement of Program: _____

Program Resources:

Group Resources: _____

Community Resources Available: _____

Materials Needed: _____

Budget:

Expenses:

Income Sources:

Goals: These are the goals and objectives the group hopes to accomplish in the next year.

30-Day Objectives: _____

60-Day Objectives: _____

90-Day Objectives: _____

6-Month Objectives: _____

1-Year Objectives: _____

Drug Prevention **4**Teens

2008 United States Department of Justice
Drug Enforcement Administration
Demand Reduction Programs
www.dea.gov
www.justthinktwice.com
www.GetSmartAboutDrugs.com
www.learning-for-life.org
Item No. 99-349



REMEMBER THAT:

- Prescription drug abuse refers to many things. It could mean using a medication not prescribed for you, using a medication in a manner other than prescribed (such as using more than the amount prescribed) or using a medication for the experience or feeling the drug can cause.
- If abused, some medications can slow breathing, cause irregular heartbeats, be addictive, and even kill you.
- Prescription medicines are usually safe when used correctly under a doctor's supervision. But using prescription drugs that aren't intended for you, or mixing them with any amount of alcohol or illicit drugs, can result in serious health conditions – some of which are fatal.
- If you have a friend who has had severe mood changes, is hanging out with a different crowd, or has less interest in school and hobbies, he or she may be exhibiting signs of prescription drug abuse. But help is available and recovery is possible.

Please remember that prescription medicines, when used correctly and under a doctor's supervision, are usually safe and effective.

SMA-12-4677B2

RESOURCES

Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Helpline:
800-662-HELP (800-662-4357)
(Toll-Free) (English and Spanish)
800-487-4889 (TDD) (Toll-Free)

Substance Abuse and Mental Health Treatment Locator:
<http://www.samhsa.gov/treatment>

SAMHSA's website:
<http://www.samhsa.gov>

SAMHSA's Center for Substance Abuse Treatment's (CSAT's) **Recovery Month** website:
<http://www.recoverymonth.gov>

To order SAMHSA publications:
<http://store.samhsa.gov>

National Institute on Drug Abuse (NIDA) for Teens:
301-443-1124
<http://www.teens.drugabuse.gov>

FDA Safe Disposal of Unused Medication:
<http://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187.htm>

National Council on Patient Information and Education (NCPPIE):
301-340-3940
<http://www.talkaboutrx.org>



The statistics in this brochure are from the Partnership at Drugfree.org's 2010 Partnership Attitude Tracking Study: Teens and Parents.

This brochure was prepared under contract number HHSS2832007000081/HHSS28300002T (Reference Number 270-08-0209) through the Office of Consumer Affairs in the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS).

PRESCRIPTION DRUGS

They can help but also hurt

Not Worth The Risk
X eve | it's legal



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

ABUSING PRESCRIPTION DRUGS – NO BIG DEAL...

WRONG!

Prescription drug abuse means using a medication in a different way than how it should be used, including using greater amounts than prescribed. Even if a medicine is specifically prescribed for you, if you don't follow the instructions for using it safely, it may have the potential to be misused. But taking medicine that wasn't prescribed for you at all is abuse. **It's no different than abusing alcohol or illicit drugs.**

Many teens believe that prescription drugs are safer than alcohol or illicit drugs, and that abusing them isn't risky – **but it is, and it is also illegal.**

WHAT COULD POSSIBLY HAPPEN TO ME IF I ABUSE PRESCRIPTION DRUGS?

The truth is:

- Abusing certain painkillers is similar to **abusing heroin** because their ingredients affect the brain in the same way.
- Sleeping pills can slow your breathing and your heart, which **can be fatal**—especially if combined with certain prescription pain medicines, alcohol, or over-the-counter cold remedies.
- Abusing medicines intended to treat ADHD can cause irregular heartbeats or deadly seizures. Mixing them with cold medicines could make these **dangerous effects** worse.

MYTHS AND FACTS

You are smart enough to avoid abusing prescription drugs. But chances are you may have a friend who may not be. Nearly 1 and 4 teens (23 percent) report taking a prescription drug not prescribed to them by a doctor at least once in their lives.

Many teens are unaware of the dangerous risks of prescription drug abuse. Below are some common misconceptions and the facts about prescription drugs:

- **MYTH:** Prescription painkillers, even if they are not prescribed by a doctor, are not addictive.

FACT: Prescription painkillers act on the same site in the brain as heroin and can be addictive.

- **MYTH:** There is nothing wrong with using prescription drugs without a doctor's consent.

FACT: Taking prescription medicine that your doctor didn't prescribe and doesn't know about can be harmful, especially if it shouldn't be mixed with other drugs prescribed for you.

- **MYTH:** If a prescription drug is legal and widely available, it must be safe.

FACT: Prescription drugs are safest when used correctly under a doctor's supervision. But taking prescription drugs that aren't intended for you and/or mixing them with alcohol or illicit drugs can result in potentially deadly consequences.

HOW DO I KNOW IF ONE OF MY FRIENDS (OR I) HAVE A PROBLEM?

Prescription drugs are intended to make people who have a condition or illness better. When people use them for anything other than their recommended purposes, they are at risk for serious health consequences. Here are some things to look for if you suspect your friends are abusing prescription drugs:

- Are they hanging out with new friends or withdrawing from your group of friends entirely?
- Do these friends hold parties where everyone contributes medicines that are taken, often with alcohol or other illegal substances?
- Is there a notable change in their personality? Perhaps starting arguments?
- Do they seem drowsier on some days and have a lot more energy on others?
- Are they less interested in hobbies or school activities that they had been involved with?

Because these signs could signal other problems, be sure to get help right away.

WHAT IF I NEED HELP?

If you notice a friend who needs help for abusing prescription drugs—or if you feel your own misuse has spiraled out of control—there are ways to get help. Talk to a parent, teacher, guidance counselor, or other trusted adult. There also are additional helpful resources on the back of this brochure. The sooner you acknowledge the problem, the better the chances are of overcoming an addiction—and ultimately saving a life.

HOW CAN I COPE BETTER WITH STRESS AND PEER PRESSURE?

Peer pressure is real, but don't give in to the temptation to fit in. Your true friends will respect your decisions.

- If you're feeling stressed or pressure about class deadlines, ask your professors how you can better manage your time, or find ways to relax, such as exercising or spending time with friends.
- Discuss your prescriptions with your doctor or pharmacist, and learn how to properly use them. Commonly abused medicines include pain relievers, stimulants, sedatives, and tranquilizers.
- If someone offers you a stimulant or another drug to stay up all night cramming for a big exam, remember, not only is this dangerous, but people who are well-rested perform better on tests.
- Turn to your family and friends for support during this exciting, yet challenging, time in your life.
- Look at the big picture – keep your goals and the “finish line” in mind when making decisions – on campus and off.

Please remember that prescription medicines, when used correctly and under a doctor's supervision, are usually safe and effective.

SMA12-4676B1

RESOURCES

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800-662-HELP (800-662-4357)
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<http://www.samhsa.gov>

SAMHSA's **Recovery Month** website:
<http://www.recoverymonth.gov>

To order SAMHSA publications:
<http://store.samhsa.gov>

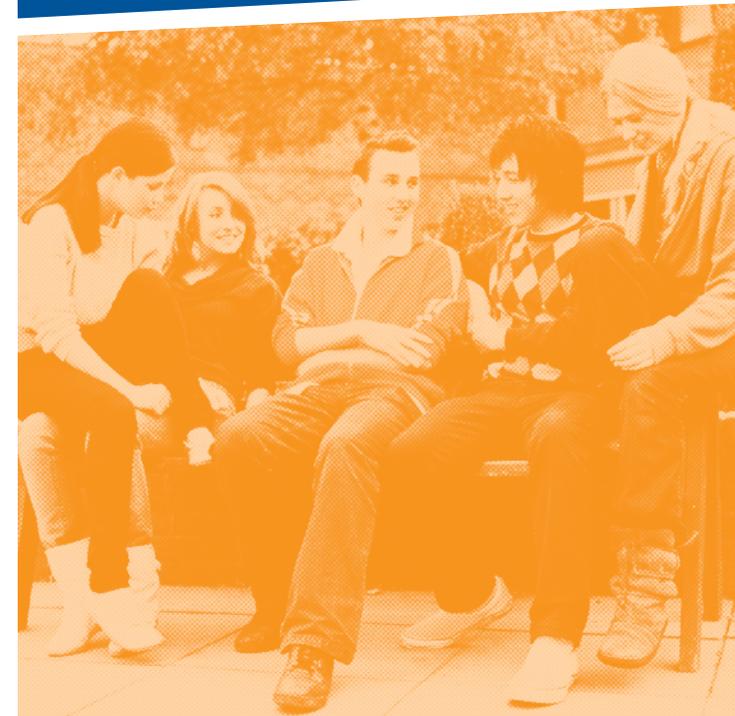
National Institute on Drug Abuse (NIDA):
301-443-1124
<http://www.drugabuse.gov>

FDA Safe Disposal of Unused Medication:
<http://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187.htm>

National Council on Patient Information and Education (NCPIE):
301-340-3940
<http://www.talkaboutrx.org>



Not Worth The Risk
X eve i it's legal



YOU'RE IN
CONTROL
Using Prescription Medicine Responsibly

The statistics in this brochure are from SAMHSA's 2010 National Survey on Drug Use and Health, SAMHSA's Drug Abuse Warning Network, 2009; National Estimates of Drug-Related Emergency Department Visits, and "Drug exposure opportunities and use patterns among college students: Results of a longitudinal prospective cohort study" (Arria et. al., 2008).

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

I DON'T THINK I'M ABUSING PRESCRIPTION DRUGS...AM I?

Have you ever used a friend's prescription painkiller to get rid of a headache? Taken a prescription stimulant to help you focus better the night before an exam? Or experimented with a prescription medicine to get high? If so, you've misused or abused prescription drugs.

Although most college students do use prescription drugs properly, nearly 30 percent of people aged 18 to 25 (28.7 percent) report using prescription-type psychotherapeutics drugs nonmedically at least once in their lives. The issue is real. By your sophomore year in college, about half of your classmates will have been offered the opportunity to abuse a prescription drug.

IS IT RISKY?

Yes. Combining any medicines (including prescription and/or over-the-counter medicines) together with alcohol or illicit drugs can be deadly.

Remember:

- You can become addicted if you abuse prescription drugs.
- It's illegal to give someone your prescription medicine or to take a prescription medicine that is not prescribed for you.
- Prescription drugs are not safer to use than illicit drugs. All prescription drugs have risks, but can be safe and effective when used as prescribed by a doctor just for you.
- Some painkillers contain ingredients very similar to heroin – and are just as dangerous as heroin.

WHAT COULD REALLY HAPPEN?

- You could be putting your friends at risk if you share your medicines.
- You could have a seizure or end up in the hospital with serious health problems such as respiratory failure – in 2009, more than 1 million visits to the emergency room involved the nonmedical use of prescription drugs.
- You could face criminal prosecution for possessing prescription drugs without a prescription. Illegal distribution of prescription drugs is a Federal drug violation, punishable by up to five years in Federal prison. The consequences are more severe if the illegal distribution leads to injury or death.
- Your actions now may affect your future, especially when you're trying to complete college and find a job.

Speak with your doctor or other healthcare professional about the medicines you are taking. The risks and dangers tied to abusing prescription drugs are real.

AREN'T DRUGS JUST A WAY TO DEAL WITH COLLEGE LIFE?

Exams, classes, extracurricular activities, communal living situations, new environments – college is stressful! College-aged people have among the highest rates of prescription drug abuse. But prescription drugs should not be used to relieve stress, or taken because of peer pressure.

YOU are in control of YOUR life and YOUR medications. If you find yourself, or friends, in a situation of abusing prescription drugs, speak with a counselor, trusted teacher, or resident assistant on campus – they are there to help. You and your friends can take steps to avoid the dangers associated with the abuse of prescription drugs.

HOW DO I KEEP PEOPLE AWAY FROM MY MEDICINES?

The potential for temptation may be in your dorm, sorority or fraternity house, or other communal living situation. People around you may be interested in taking your prescriptions, especially if they are left visible (sitting on your desk or dresser, for example). More than half of people age 12 and older who abuse prescription drugs get them from a friend or relative for free.

It may seem easy for fellow students to gain access to your prescription drugs, but you can play it safe:

- Properly store your medications in a secure place, like a lock box or in the back of your closet, where they are not easy for others to find.
- Keep track of your medicine – know how many pills you have at any given time.
- If a friend or teammate is injured, instead of “sharing” your pain reliever, make sure your friend sees a medical professional for care. It is illegal to share your prescription medicines.
- Your medicines are your business. There's no reason to tell your friends about the medicines you take.
- Do not purchase or use controlled prescription drugs obtained from illegal websites.

RECOGNIZE *the risks.*
RESPECT *medicine.*
Take RESPONSIBILITY.

Nonmedical Use of Prescription Stimulants

What college administrators, parents, and students need to know

What is nonmedical use of prescription stimulants?

- › Prescription stimulants, such as Ritalin[®] or Adderall[®], are sometimes used by students who do not have a prescription or used in ways that are inconsistent with the prescribing physician's instructions (e.g., extremely high doses, snorting, injecting). This is called nonmedical use.¹ Typically the reason students have for using prescription stimulants nonmedically is that they think it will help them do better on a test or study more effectively.
- › Prescription stimulants are most commonly prescribed to students for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) and have been shown to be effective for the management of this condition. *This fact sheet on nonmedical use does not address issues related to ADHD treatment and the proper medical use of these medications.*

How many students are using prescription stimulants nonmedically?

› Adolescents

In 2011, less than one in ten adolescents reported using Ritalin[®] or Adderall[®] nonmedically during the past year (see Table 1). The percentage of adolescents who use these medications nonmedically has stayed relatively stable during the past few years.

	8 th graders	10 th graders	12 th graders
Ritalin [®]	1.3%	2.6%	2.6%
Adderall [®]	1.7%	4.6%	6.5%

› College Students

The nonmedical use of prescription stimulants is more common among college students than high school students. Studies have found that 4.1% to 10.8% of college students reported using prescription stimulants nonmedically during the past year.³⁻⁷ Table 2 shows findings from the College Life Study.^{8,9}

	Freshmen	Sophomores	Juniors	Seniors	Cumulative ^a
Offered	36.0%	38.5%	41.1%	32.0%	61.8%
Used	13.3%	17.9%	20.1%	16.1%	31.0%

^aCumulative refers to being offered or used at any time during college.

Where do students obtain the prescription stimulants they use nonmedically?

Many studies have shown that most students who nonmedically use prescription stimulants obtain the drugs from a friend who has a prescription.¹⁰⁻¹² These friends often give away their pills for free.^{10,13}

› Prescriptions

One study found that 5.3% of college students were currently prescribed ADHD medications.¹⁴

› Diversion

Diversion includes the illicit sharing, selling, and trading of prescription medications. In one study, 61.7% of college students diagnosed with ADHD reported diverting their prescription stimulants.¹⁴ Risk factors for diversion are childhood conduct problems¹⁴ and cannabis use disorder.¹⁰

Perceived availability

Table 3. Adolescents' reported ease of obtaining Adderall® or Ritalin® for nonmedical use (percent reporting "fairly easy" or "very easy"). ²		
8 th graders	10 th graders	12 th graders
15.0%	28.5%	47.0%

What characteristics or behaviors are associated with nonmedical use of prescription stimulants?

› Excessive drinking and other drug use^{3,10,15,16}

› Lower GPA^{3,4,10}

› Low perceived harmfulness of using prescription stimulants nonmedically¹⁷

› Attention difficulties¹⁸

› Psychiatric distress or depressed mood¹⁹

› Skipping classes

In one study, nonmedical users of prescription stimulants skipped 16.1% of their classes while non-users skipped 9.4% of their classes.⁴

› Affiliation with a Greek (fraternity/sorority) organization.^{3,11}

One study showed that the association between nonmedical use and Greek involvement became non-significant once statistical adjustment was made for drinking and other drug use.¹⁰

MYTHS AND REALITIES

MYTH	Everyone is doing it.
REALITY	Use is not the norm. In 2011, less than one in ten adolescents used prescription stimulants nonmedically. ²
MYTH	These drugs are safe.
REALITY	Taking prescription stimulants without a physician’s supervision carries health risks to the nonmedical user because of the possibility of unknown interactions with other drugs, risk for dependence, and adverse health consequences. Specifically, taking high doses of prescription stimulants may result in dangerously high body temperatures, irregular heartbeat, seizures, or heart attack. Nonmedical use also carries risk for the person diverting the medication; trading, sharing, or selling medication might mean the diverter is skipping doses and not treating their disorder appropriately. The diversion of prescription stimulants also carries legal risks for the diverter.
MYTH	These drugs are perceived to be safer than illicit drugs by individuals who nonmedically use them.
REALITY	In one study, more college students perceived a “great risk” from occasional nonmedical prescription stimulant use than from occasional marijuana use. ¹⁷
MYTH	Most students who use prescription stimulants nonmedically do well academically.
REALITY	Nonmedical use is concentrated among students who have lower GPAs. ^{3,7,20,21} Moreover, nonmedical users often have a history of heavy drinking and other drug involvement, especially with marijuana. ^{3,10,15,16} If other drug use is an underlying factor in poor academic performance, then nonmedical use of prescription stimulants might be seen as a compensatory behavior for not having studied or gone to class. There is evidence to suggest that prescription stimulants are used as an attempt to meet academic demands in the context of an active social lifestyle, which often includes drinking, illicit drug use, and little time for studying. Yet there is no evidence that this compensatory strategy is effective.
MYTH	By using prescription stimulants nonmedically, students can improve their cognitive performance and gain a competitive edge.
REALITY	Experimental research has shown mixed findings on the performance effect of prescription stimulants among study volunteers with no attention difficulties. There is much uncertainty about their effectiveness due to dosage issues, individual differences, expectancy of the effect, and type of task. Thus, it is unlikely that these drugs can improve academic performance in the long run.

Prepared by the Center on Young Adult Health and Development | University of Maryland School of Public Health
For more information, email Amelia Arria, Ph.D., Director at aarria@umd.edu or visit www.cyahd.umd.edu

IMPLICATIONS AND PRACTICE SUGGESTIONS

College administrators, health care providers, parents, and students all have the responsibility to actively discourage nonmedical use of prescription stimulants, as well as all other forms of drug use, because of the possible adverse impact that drug use has on health, safety, and well-being.

College Administrators

- › Colleges should consider providing a comprehensive support structure that integrates academic advising with assessment of substance use and mental health problems. One recommendation might be to flag students who exhibit a precipitous drop in their academic performance (e.g., from a 3.8 GPA to a 3.2 in one semester) and investigate what factors might be responsible.
- › Early intervention strategies should be put into place to assist students who are struggling academically. These strategies should include screening for substance use and an individualized plan to address it.
- › Most campus health centers are underfunded and need more resources and tools to address substance use, mental health problems, and adjustment issues among college students.

Health Care Providers

- › Physicians who prescribe stimulants should: a) be mindful of the prevalence of diversion, b) give their patients explicit instructions regarding the ways in which these medications should—and should not—be used, c) provide clear instructions to their patients regarding sharing and selling of medications, and d) include specific instructions on how to dispose of any unneeded medication.
- › Health care providers are encouraged to drug test and monitor students with a history of substance abuse to insure that they remain drug-free.

Parents

- › Parents should not condone or facilitate the nonmedical use of these drugs but rather view this practice as a red flag for substance use. Some parents might be tempted to turn a blind eye toward sharing of prescriptions among friends simply because they believe it might help their college-aged child get better grades. However, the link between the use of multiple drugs and nonmedical use of prescription drugs is strong. When parents suspect their child might be nonmedically using prescription stimulants, they should seek out a comprehensive evaluation for that child in order to determine the presence and severity of substance use and/or other mental health problems, including ADHD, anxiety, and/or depression.
- › The pressures of college, both academically and socially, are real. Parents can be part of a supportive network that contributes to the success of a student in appropriate, safe, and healthy ways. This might involve encouraging healthy habits like getting enough sleep, eating well, exercising, and practicing effective time management.

Students

- › Students must understand that there are few shortcuts to success. The way to good grades and a successful career is through hard work and constructive activities such as working part-time, taking an extra class, or participating in extracurricular activities. Not getting enough sleep, skipping class, and partying through college while taking prescription stimulants nonmedically to study and cram will be counterproductive in the long run.

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PARENT TALK KIT

Tips for Talking and What to Say to Prevent Drug and Alcohol Abuse



THE PARTNERSHIP[®]
AT DRUGFREE.ORG

PARENT TALK KIT

Tips for Talking and What to Say to Prevent Drug and Alcohol Abuse

Table of Contents

How to Say It

Conversations are one of the most powerful tools parents can use to connect with — and protect — their kids. But when tackling some of life's tougher topics, especially those about drugs and alcohol, just figuring out what to say can be a challenge. These age-by-age scripts will help you get conversations going with your child whether he or she is in preschool, grade school, middle school, high school or post-high-school/college.

Page 3

What to Say: Teen Abuse of Prescription Drugs and Over-The-Counter Cough Medicine Scenarios

In addition to talking with your child about the dangers of street drugs and alcohol, it's essential that you also address the abuse of prescription (Rx) drugs and over-the-counter (OTC) cough medicine. The following scripts will help you address various scenarios and explain to your teen the risks of abusing Rx drugs and OTC cough medicine — and the severity of taking someone else's medicine.

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Answering the Question: "Did You Do Drugs?"

The issue isn't about your past. It's about your children's future. What's important now is that your kids understand that you don't want them to use drugs or alcohol.

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Five Teachable Moments

Having trouble talking to your teen about the risks of drugs and alcohol? Here are five everyday examples of easy ways to bring up the topic.

Page 10

How To Teach Kids To Turn Down Drugs

There's no way you can shield your kids from finding out that street drugs, alcohol and tobacco exist — but you can help your child reject offers to try them.

Page 11

Friends, Family and Beyond: How Other Adults Can Help

Even if you're not a parent, you can play a significant role in a child's life. Grandparents, aunts, uncles, older siblings, cousins, mentors, teachers and coaches can all help guide a child toward healthy choices at every stage of life.

Page 11

How to Say It

Open, honest conversations are some of the most powerful tools parents can use to connect with — and protect — their kids. But when tackling some of life's tougher topics, especially those about drugs and alcohol, just figuring out what to say can be a challenge. The following scripts will help you start the conversation with your child — and keep it going throughout his or her life.

PRESCHOOL

Scenario: Giving your child a daily vitamin.

What to Say: Vitamins help your body grow. You need to take them every day so that you'll grow up big and strong like Mommy and Daddy — but you should only take what I give you. Too many vitamins can hurt your body and make you sick.

Scenario: Your kids are curious about prescription medicine bottles around the house.

What to Say: You should only take prescription medicine that has your name on it or that your doctor has chosen just for you. If you take prescription medicine that belongs to somebody else, it could be dangerous and make you sick.

Scenario: Your child sees an adult smoking and, since you've talked about the dangers of smoking, is confused. (Parenting expert Jen Singer says the same script applies to grade-schoolers.)

What to Say: Grownups can make their own decisions and sometimes those decisions aren't the best for their bodies. Sometimes, when someone starts smoking, his or her body feels like it has to have cigarettes — even though it's not healthy. And that makes it harder for him or her to quit.

GRADE SCHOOL

Scenario: Your child tells you he was offered prescription medicine by a classmate— but said no.

What to Say: After praising your child for making a good choice and telling you about it, let him know that in the future, he can always blame you to get out of a bad situation. Say, "If you're ever offered

drugs — or someone else's medicine — at school, tell that person, "My mother would kill me if I took that and then she wouldn't let me play baseball." And then you'll want to follow up with the other parent and/or school.

Scenario: Your grade-schooler comes home reeking of cigarette smoke.



What to Say: I know you're curious and you wanted to see what smoking was like, but as you can see, it's pretty disgusting and it probably made you cough and gag a lot. It's important for you to know that smoking cigarettes is very unhealthy for your body. I love you and am concerned about your well-being and health and I don't want you smoking. Let's talk about why you decided to smoke. If there are any related issues — or anything on your mind, let's talk about it. I'm here to listen and help you.

Scenario: Your child has expressed curiosity about the pills she sees you take every day — and the other bottles in the medicine cabinet.

What to Say: Just because it's in a family's medicine cabinet doesn't mean that it is safe for you to take. Even if your friends say it's okay, say, "No, my parents won't let me take something that doesn't have my name on the bottle." (Keep in mind that the medicine cabinet isn't the safest place to keep your medicine. Learn the best ways to safeguard medicine: <http://medicineabuseproject.org/pages/monitor-secure-dispose-of-your-medicine-a-how-to-guide>).

Scenario: One in 7 teens in America has tried huffing — inhaling the fumes from everyday items like nail polish remover, hair spray and cooking spray. Talk to your child about the dangers of the products under the kitchen sink — it's important to reiterate the warning.

What to Say: I know it's been a while since I talked to you about the dangers of cleaning products and that they should only be used for cleaning. But I've heard that some kids are using them to get high. I just want to let you know that even if your friends say, "Hey, we can get this stuff at the supermarket so it's totally okay to sniff it," it's not. Inhaling fumes from cleaners or products like cooking spray and nail polish remover is as dangerous as abusing medicine and street drugs, like marijuana. Now, situation if that happens. What do you think you should say? Remember, you can always blame me and say, "My mom's expecting me to be home now, gotta go!" or "My mom would kill me if I tried that!" or simply, "No thanks, I'm not interested."

MIDDLE SCHOOL

Scenario: Your child is just starting middle school and you know that eventually, he will be offered drugs and alcohol.

What to Say: There are a lot of changes ahead of you in middle school. I know we talked about drinking and drugs when you were younger, but now is when there's probably going to be an issue. I'm guessing you'll at least hear about kids who are experimenting or find yourself some place where kids are doing stuff that is risky. I just want you to remember that I'm here for you and the best thing you can do is just talk to me about the things you hear or see. Don't think there's anything I can't handle or that you can't talk about with me, okay?

Scenario: You find out that kids are selling prescription medicine at your child's school. Your child hasn't mentioned it and you want to start a conversation about it.

What to Say: Hey, you probably know that parents talk to each other and find things out about what's going on at school... I heard there are kids selling pills — prescription medicine that either they are taking or someone in their family takes. Have you

heard about kids doing this?

Scenario: Your child's favorite celebrity — the one he or she really looks up to — has been named in a drug scandal.

What to Say: I think it must be really difficult to live a celebrity life and stay away from drugs and alcohol. They're probably under a lot of pressure — always being in the public eye, being watched and having to do well — and, unfortunately, some make the wrong choices and turn to drugs and alcohol. But a lot of famous people manage to stay clean — like [name others who don't do drugs] — and hopefully this incident is going to help [name of celebrity] straighten out his or her life. Of course, people make mistakes — the real measure of a person is how accountable he is when he messes up. The thing is, when a person uses drugs and alcohol — especially a young person because he's still growing — it changes how his brain works and makes him do really stupid things. Most people who use drugs and alcohol need a lot of help to get better. I hope [name] has a good doctor and friends and family members to help him/her.

HIGH SCHOOL

Scenario: Your teen is starting high school — and you want to remind him that he doesn't have to give in to peer pressure to drink or use drugs.

What to Say: You must be so excited about starting high school. It's going to be a ton of fun, and we want you to have a great time. But we also know there's going to be some pressure to start drinking, abusing medicine, smoking pot or taking other drugs. A lot of people feel like this is just what high-school kids do. But, it's not what you have to do. Not all high school kids drink or use drugs! Many don't, which means it won't make you weird to choose not to drink or use drugs, either.

You can still have a lot of fun if you don't drink or use drugs. It is important to seek out these other kids who are making good choices, and be brave about trying new activities or making new friends. You'll have a lot of decisions to make about what you want to do in high school and you might even make some mistakes. Just know that you can talk to us about anything, anytime — even if you DO

make a mistake or feel stuck in a situation that you need help to get out of. We won't freak out. We'll figure out a way to help you. We want you to count on us to help you make smart decisions and stay safe, okay?

Scenario: Every time you ask your teen how his day was, you get a mumbled “Whatever, it was okay” in return.



What to Say: Skip asking general questions like, “How’s school?” or questions that only need a... yes/no answer. Instead, ask more specific questions on topics that interest both you and your teen (“Tell me about the pep rally yesterday.” “What are the cliques like in your school?” “Fill me in on your Chemistry lab test.”) You can also use humor and even some gentle sarcasm, to get yes/no answer. Instead, ask more specific questions on topics that interest both you and your teen (“Tell me about the pep rally yesterday.” “What are the cliques like in your school?” “Fill me in on your Chemistry lab test.”)

You can also use humor and even some gentle sarcasm, to get the conversation flowing by making your child laugh and start opening up a bit. To show your teen that you want to know what it’s like in his or high school, try this with an exaggerated playful and light tone, “If I call the principal and ask for a behind-the-scenes pass, I can tag-along with you to class and know what a day-in-your-life is really like.” or “I hope MTV does a reality-show on your high school so I could see what it’s really like for you every day.” It can also be helpful to share a brief anecdote revealing something about your

day to model opening up, and let your teen experience how it feels good to connect, suggests Bonni Hopkins, PhD., Director of Research & Evaluation at The Partnership at Drugfree.org.

Scenario: Your high schooler comes home smelling of alcohol or cigarette smoke for the first time.

What to Say: “The response should be measured, quiet and serious — not yelling, shouting or overly emotional,” says parenting expert and author Marybeth Hicks. “Your child should realize that this isn’t just a frustrating moment like when he doesn’t do a chore you asked for; it’s very big, very important and very serious.”

Say, “I’m really upset that you’re smoking/drinking. I need to get a handle on how often this has been happening and what your experiences have been so far. I get that you’re worried about being in trouble, but the worst part of that moment is over — I know that you’re experimenting. I love you and care about you. Your health and well-being are very important to me. Let’s talk about this. I need you to be honest with me. So for starters, tell me about what happened tonight...”

Scenario: Your teen has started to hang out with kids you don’t know — and dropped his old friends.

What to Say: It seems like you are hanging with a different crowd than you have in the past. Is something up with your usual friends? Is there a problem with [old friends’ names] or are you just branching out and meeting some new kids? Tell me about your new friends. What are they like? What do they like to do? What do you like about them?

YOUNG ADULTS (18-25)

Scenario: Your adult child is moving to her own apartment or into a college dorm.

What to Say: I know you’re off to start your own life, but please know that I’m always here for you. I respect that you’re old enough to make your own choices, but if you ever want another perspective on things, please reach out to me. I’ll try my hardest to help you out without judging you for your decisions. Sound good?

Amelia Arria, PhD, senior research scientist at the Treatment Research Institute, also suggests saying, “There are certain things that you can count on in life and one of the things you’re going to be able to count on is me. As your parent, I am always here for you. Remember, I am your support. I’m the one who can guide you.”

Scenario: After watching a movie portraying drug use together, you want to gauge your adult child’s opinion on drugs.

What to Say: I know you’re going to think that I’m overprotective or meddling, but that movie really disturbed me and I just have to ask: Is there a lot of drug use at your college/in your new town? Do the new friends that you’ve made dabble in drugs at all? How do you feel about it?

*Script coaching was provided by parenting experts Jen Singer, author of *You’re a Good Mom (and Your Kids Aren’t So Bad Either)*, Marybeth Hicks, author of *Bringing Up Geeks: How to Protect Your Kid’s Childhood in a Grow-Up-Too-Fast World* and Amelia Arria, Ph.D., senior research scientist, Treatment Research Institute.*

What to Say: Teen Abuse of Prescription Drugs and Over-The-Counter Cough Medicine Scenarios

In addition to talking with your child about the dangers of street drugs and alcohol, it’s essential that you also address the abuse of prescription (Rx) and over-the-counter (OTC) cough drugs. The following scripts will help you address various scenarios and explain to your teen the risks of abusing Rx drugs and OTC cough medicine — and the severity of taking someone else’s medicine.

1. Abusing Rx Stimulants for Better Grades

The Situation: Your daughter returns home from her first semester of college and confesses that she used a prescription stimulant typically used to treat ADHD. She says she bought it from a friend to focus and power through long nights of stressful studying. After you express concern about her abusing prescription medicine, she retorts that the stimulant’s effectiveness is unquestionable, since she got all A’s this semester, and says, “Everybody

uses stimulants to study!”

What to Say: Acknowledge that you are proud of her outstanding grades, but assure her that you believe it was her hard work and intelligence that earned them – not her use of stimulants. In fact, using a drug to enhance the performance of any kid (whether it’s illegal steroids in sports or a prescription medicine for school) is cheating and research has shown it is actually tied to lower grades. Be sure to let her know that you understand how stressful and time-consuming it can be to go to school while trying to balance a social life, jobs, internships, etc., but stress that you are more concerned over her physical and mental well-being than her grades.

Inform her that stimulants are intended for those with medical conditions like attention deficit hyperactivity disorder (ADHD), and it can be dangerous to her because she took them without a doctor’s prescription. Just because she thinks other students are using stimulants does not mean that it is acceptable or safe for her. Side effects of abusing stimulants include vomiting, tremors, increased heart and respiratory rates and cardiovascular collapse. Brainstorm coping, relaxation and time-management skills she could try to help next semester.

2. OTC Cough Medicine Binge

The Situation: While putting away your son’s laundry, you notice five bottles of over-the-counter cough medicine in his dresser. When you confront him, he admits that he drinks cough syrup in excess to get high alone in his room. He tells you that he has friends buy the bottles for him on different days of the week so that he can bypass pharmaceutical regulations. While you cannot fathom why he abuses over-the-counter cough medicine of all things, he explains that it is not only cheap, but also gives an “indescribable” high and places him in a new world where “everything is altered.”

What to Say: Try to acknowledge and appreciate his honesty before losing your cool. Ask questions and try to understand why your son wants to get high; perhaps the reason isn’t as nonchalant as he makes it sound. After hearing him out, explain that just because an cough medicine is sold

over-the-counter does not mean it's safe to consume in excess — abuse of over-the-counter cough medicine can be just as dangerous as abusing prescription medicine and street drugs.

Abusing over-the-counter cough medicine can cause dizziness, double or blurred vision, slurred speech, abdominal pain, nausea and vomiting, rapid heartbeat, drowsiness, and even a coma or death when consumed.

Please seek professional help for your son. You can call our [Parents Toll-Free Helpline](http://www.drugfree.org/timetogetherhelp) 1-855-DRUG-FREE (1-855-378-4373) to speak to a parent specialist and visit www.drugfree.org/timetogetherhelp for more information and support.

[Learn more about teen over-the-counter cough medicine abuse >](http://www.drugfree.org/timetogetherhelp) (<http://medicineabuseproject.org/pages/getting-high-on-prescription-and-over-the-counter-cough-medicine-is-dangero>)

3. Painkillers After Sports Injury

The Situation: A few weeks ago, your son suffered a painful sports injury. The doctor prescribed painkillers to ease his agony, but you notice your son's supply of prescription medicine dwindling way too quickly. When you ask him why he has so little medicine left, he says that he's been taking more than prescribed because the pain is unbearable.

What to Say: Be sure to listen and understand the extent of your son's pain before diving into the issue of prescription medicine abuse. It is often the case that the abuse of painkillers by athletes starts off innocently — they genuinely do try to tame the pain. Emphasize the point that prescription painkillers can be dangerous due their highly-addictive nature and that he needs to closely follow the doctor's specific instructions about his dosage.

You should then tell him that taking more than prescribed is dangerous because not only can he become addicted, but he can face short-term effects like vomiting and respiratory depression or long-term effects like building up a tolerance where the medicine doesn't help anymore — which can lead many abusers to overdose. Tell him that you will schedule another appointment with his doctor to be sure his pain is addressed right away.

Also, be aware that there is also a chance that your son might be sharing his medicine with his friends.

That's why it is important to manage the supply of these types of medications and be aware of the risk of abuse by your teen or others. Be sure to [monitor and safeguard your son's prescription medicine](#) and [get him the help he needs](#).

4. Being Challenged on Your Own Rx Use

The Situation: You discover that your daughter has been taking a depressant not prescribed to her. When you ask her about it she says it's because she works herself into a breathtaking frenzy whenever she is stressed and it helps her relax. She says she is getting the pills from the family medicine cabinet. When you ask her why she took pills without a prescription, she calls you a hypocrite because you occasionally take a pill or two from an old prescription to “calm your nerves.”

What to Say: Whenever a child confronts her parent about his/her own drug or prescription medicine use, the conversation can quickly grow awkward and tense, with the parent stammering, making excuses or getting defensive. While you don't have to tell your child every detail, be open with her. Admit that you have misused prescription medicine, that it was wrong and you regret it. And let her know that you don't want her making the same mistakes. It's important to emphasize that this is about her, not about you.

Try to understand why she felt she needed the prescription medicine and how you can help her manage her stress in a healthier way. [Examples: exercise, relaxation techniques, breaking a large task into smaller, more attainable tasks, taking breaks from stressful situations, listening to music or reaching out to a friend.]

If she pushes the hypocrisy point, cite a bit of science. Scientists believe that it takes about 25 years for the brain to fully develop. Explain that her brain is vulnerable to unhealthy influences like the abuse of Rx drug and OTC cough medicine, street drugs and alcohol. If your daughter is feeling anxious and overly stressed, a consultation with a child and adolescent psychiatrist or qualified mental health professional may be helpful. There are

many techniques such as relaxation and cognitive-behavioral skills training that have been proven to help people feel better.

5. Illegal vs. Legal Drugs

The Situation: You hear rumors from another mom that there was drug use at a recent high-school party your son attended. When you confront your son, he tells you that other kids were taking “hard-core” drugs like cocaine and heroin and he “only” took someone else’s prescription medicine. He doesn’t believe that prescription medicine and illegal street drugs have the same level of danger.

What to Say: Begin the conversation by letting your son know that you appreciate his honesty and you’re glad that he feels he can talk to you. Be sure your son understands that simply because prescription medicine is legal it does not mean it is always safe — and that prescription medicine is only legal for the person for whom it’s prescribed. Abuse of prescription and over-the-counter cough medicines can be just as addictive and dangerous (even fatal) as the abuse of illegal street drugs. In fact, some of those “hardcore,” illegal street drugs are made of the same stuff as prescription medicine. For instance, heroin and oxycodone are both opioids derived from a common root: poppy. While kids might think that taking a prescription painkiller gives the full-on euphoria of heroin without the risks, the truth is if misused or abused, prescription painkillers are very dangerous. Also, if you take someone else’s prescription you may not know what the pill really is or what the strength is. A large, single dose of oxycodone can result in potentially fatal respiratory depression.

6. The Internet and Snooping

The Situation: You look at the Internet history on your family computer and notice that someone searched for information on prescription medicine and where to buy it. You suspect your daughter conducted the search. When you mention your discovery, she adamantly denies that it was her, calling you “paranoid” and “intrusive.”

What to Say: Both when you initiate the conversation and respond to her defensiveness, be sure not

If you do buy medicine online, be sure it’s through safe, legitimate and law-abiding online pharmacies.

- Criminals are selling unsafe medicines on the internet. At any one time there are roughly 40,000 active rogue websites pushing counterfeit or otherwise illegitimate medicines to U.S. consumers, often without requiring a doctor’s evaluation in accordance with U.S. state and federal laws.

- Illegal online medicines can put your health at risk. Medicines from illegal online drug sellers are often not what patients expect. Such products have been found to contain anything from powdered concrete to antifreeze. Many people have suffered harm or died from the effects of medicines bought from illegitimate online drug sellers.

- Be smart. Avoid websites that allow you to buy a prescription medicine without a prescription, send you unsolicited emails offering cheap medicines, offer “too good to be true” discounts and offer to ship prescription medicines worldwide.

For more information, visit The Alliance for Safe Online Pharmacies (ASOP) at <http://safeonlineRx.com>.

to sound harsh or accusatory, but rather make it clear that you are coming from a place of genuine concern. Let her know that you weren’t out to get her when browsing your computer’s Internet history.

Rather than freaking out over your discovery, ask her if anything is bothering her and provide specific examples of questionable behavior that led you to your concerns and suspicions. State any signs of use you’ve noticed such as a sudden change in mood, her not spending as much time with friends or any other **warning signs** (<http://timetoact.drug-free.org/think-look-for-signs.html>). Ask her if she has used anything and, if so, what she has used. By providing these concrete instances, you dismiss her accusation of “paranoia” and begin to show her that you have reasons to be worried. However, be aware that her defensiveness and counter-complaining may be red flags of her guilt.

Regardless of her feelings, you have the right to monitor her behavior and activity as her parent. You may also want to point out the danger of buying medicine online without a prescription — since there are roughly 40,000 illegal websites pushing counterfeit medicines (often with bogus ingredients that can put one’s health at risk — see box). However, emphasize that it is never okay to take any kind of Rx medicine without a prescription from a doctor — whether it came from a local pharmacy or the Internet. Purchasing illegal prescription medicine from the Internet simply adds to an already dangerous health risk. Calmly explain that you are not trying to “ruin her life,” but it is your house and your computer, and underscore that your love her and that her health and well-being is your utmost responsibility.

7. When Friends Change

The Situation: You notice your son is home more often than usual and you inquire whether everything is okay with friends at school. He tells you that some of his friends have started taking their parents’ prescription medicine and that he did not want to take any, so his friends have become distant. You can tell how upset he is and you’re worried that his loneliness and peer pressure may cause him to cave in.

What to Say: First, let your son know how proud you are of his decision not to accept the prescription medicine. Shower him with praise! Then discuss the problems he is having with his friends and why he feels isolated.

While you don’t want to dismiss his friends as no-good misfits, let him know that sometimes people change and make poor decisions, but that doesn’t mean you have to follow down their path. Emphasize that if someone is truly your friend, he or she will not pressure you into taking drugs or condemn you for not taking drugs. Real friends respect your decisions. However, as a parent you still may not want your son immersed in a crowd of kids who abuse drugs — including prescription medicine.

Use our [idea-generator](http://teenbrain.drugfree.org/tools/channelit/ideagenerator.pdf) (<http://teenbrain.drugfree.org/tools/channelit/ideagenerator.pdf>) to help your son brainstorm activities that might interest

and clubs at school where he can meet other kids with similar interests. If he has a greater pool of kids with whom he can spend time, he is less likely to get caught up in risky behavior.

Acknowledge that making the right decision can sometimes be especially hard in the short-term because the positive impact doesn’t come until later, emphasizes Bonni Hopkins, PhD, Director of Evaluation & Research at The Partnership at Drugfree.org and a mom of three. She suggests inviting some of his other friends or acquaintances over to your home to actively support new relationships and celebrate his healthy choices with an immediate reward. Most of all, use this “found time” together for any shared activities you both enjoy and might have been putting off, and further strengthen your connection with your child.

Answering the Question: “Did You Do Drugs?”

For many parents, a child’s “Did you ever use drugs?” question is a tough one to answer. Unless the answer is no, most parents stutter and stammer through a response and leave their kids feeling like they haven’t learned anything — or, even worse, that their parents are hypocrites. Yes, it’s difficult to know what to say. You want your kids to follow your rules and you don’t want them to hold your history up as an example to follow — or as a tool to use against you. But the conversation doesn’t have to be awkward, and you can use it to your advantage by turning it into a teachable moment.

Some parents who’ve used drugs in the past choose to lie about it — but they risk losing their credibility if their kids ever discover the truth. Many experts recommend that you give an honest answer — but you don’t have to tell your kids every detail. As with conversations about sex, some details should remain private. Avoid giving your child more information than she asked for. And ask her a lot of questions to make sure you understand exactly why she’s asking about your drug history. Limit your response to that exchange of information.

The discussion provides a great opportunity to speak openly about what tempted you to do

drugs, why drugs are dangerous, and why you want your kids to avoid making the same mistakes you made. The following are good examples of the tone you can take and wording you can use:

“I took drugs because some of my friends used them, and I thought I needed to do the same in order to fit in. In those days, people didn’t know as much as they do now about all the bad things that can happen when you take drugs.”

“Everyone makes mistakes and trying drugs was one of my biggest mistakes ever. I’ll do anything to help you avoid making the same stupid decision that I made when I was your age.”

“I started drinking when I was young and, as you can see, it’s been a battle ever since. Because of my drinking, I missed a big part of growing up, and every day I have to fight with myself so it doesn’t make me miss out on even more — my job, my relationships, and most importantly, my time with you. I love you too much to watch you make the same mistakes I’ve made.”

Five Teachable Moments

Having trouble talking to your teen about the risks of drugs and alcohol? Here are five everyday examples of easy ways to bring up the topic.

1. Fictional Character

You just took your teen to a PG-13 movie in which one of the main characters drinks and smokes excessively. It’s a good thing you insisted on tagging along, because now you have the opportunity to discuss the film — especially that lead character’s addiction — with your teen. Did your son think the main character’s drug use was cool or did he recognize that she had a problem?

2. Movie Star

Your daughter reads every magazine she’s in, owns all her movies, and has her posters taped to her wall. So what happens when her magical movie star goes to rehab for the third time? When that famous face graces the cover of *Us Weekly*, ask your daughter why she thinks [actor or actress’ name] it may be this week is such a cool person. If your daughter only cares about her expensive clothes and good looks, remind her that her role

model should also be someone who drinks responsibly and either doesn’t do drugs or has taken the initiative to get help for her drug problem.

3. Professional Athlete

For as long as you can remember, you’ve taught your daughter that “cheaters never win.” Unfortunately, this holds true when her favorite athlete is in the news for taking drugs. Ask your daughter how she feels about professional athletes using illegal substances of any kind and point out how much it can hurt a person’s career and reputation — especially when they get caught.

4. Classmate

You don’t need a movie star to get the conversation going with your teen. Two kids in your son’s school each received a DUI over the weekend — and they had other friends in their car when it happened. A lot can come out of this conversation — why drunk driving is so dangerous, the consequences of getting caught and why you never want your son to get into a car with a friend who’s been using drugs or alcohol — no matter what.

5. Relative

Substance abuse issues can often hit close to home, and it’s important that we’re open and honest with our kids when it happens. If you can, tell them all the details about your relative who is struggling and how it impacts everyone in the family. Explain why there’s a problem and how you, as a family, are going to do what you can to support one another through this tough time. If your teen isn’t asking a ton of questions, that’s okay — he might be feeling uncomfortable about the topic. It might help to emphasize that while addiction can wreak havoc on a person’s life, it is always possible for him or her to make a recovery with the support of friends and family. (For stories of people in recovery, visit www.drugfree.org/youarenotalone.)

Please note that if there is a history of drug or alcohol dependence or addiction in your family, you should let your child know since he or she is at a higher risk for developing a drug or alcohol problem. There’s no reason to be embarrassed or shy about discussing your own addiction problems with your kids. Discuss it in the same way you would if you had a disease like diabetes.

How To Teach Kids to Turn Down Drugs

There's no way you can shield your kids from finding out that street drugs, alcohol, tobacco and prescription drugs and over-the-counter cough medicine abuse exist — but you can help your child reject offers to try them.

Before you work with your child on this issue, there's one thing you need to know: kids don't usually get drugs from strangers. They get drugs from their friends. And that's the toughest issue of all: teaching your kids that it's okay to say no to their friends — the people they look to for validation, recognition and fun. Strongly encourage your child to avoid friendships with kids who use drugs and alcohol.

A great way to help kids prepare for drug-related situations is by acting out — also known as role playing — scenarios with them. It's important to practice these scenarios with your kids before these situations really happen.

Remember, teens rarely verbally pressure or chastise each other into drinking or doing drugs. Rather, the offer is usually casual. "Peer pressure" is more internal than you probably think. For example, your child sees other teens that she wants to be friends with enjoying a drink, smoke pot or abuse a prescription medicine to get high and she feels like she wants to be part of it too. Or, she may be afraid that the other teens will think she is less cool if she doesn't join them. Try to include this dynamic when you act out scenarios with your teens.

Use the following two scenarios as a starting point, but create new ones based on your child's life and family:

Scenario #1

Your son goes to a party at his friend's house and someone has brought a bottle of vodka or some beer. Some of the older high school guys are drinking and ask him, "You want some?" Take the role of the older teens or of your son's friends who casually offer beer or vodka to your son.

Help your child develop firm, but friendly responses. Reassure him that his friends will respect his decision not to get involved. Remind him that people are pretty focused on themselves, which

leaves much less brain space for them to be concerned with what others do.

Scenario #2

Your daughter is at her friend's house with a few close pals and one of them pulls out a joint. Take the role of her friend offering it to the group.

Help your child develop firm, but friendly responses. Reassure her that her friends will respect her decision not to get involved. Remind her that people are pretty focused on themselves, which leaves much less brain space for them to be concerned with what others do.

Friends, Family and Beyond: How Other Adults Can Help



Even if you're not a parent, you can still play a significant role in a child's life. Grandparents, aunts, uncles, older siblings, mentors, teachers and coaches can all help guide a child toward healthy choices at every stage of life.

For younger children, you can reinforce messages about eating healthy and staying active. And, as kids get older, your advice can help steer them toward positive decisions when they're up against tough choices.

Wondering how you can build a better relationship with the child in your life? Put the following tips to work.

Grandparents

You have a conversational leg up on most people in your grandchild's life; you have the inside scoop on what his parents were like as kids. Help take the

pressure to be perfect off of kids by telling them stories of their own parents' shortcomings when they were younger. The fact that Dad didn't make the varsity soccer team, but discovered he loved to draw soon after can be a big boost to your grandchild's own self-esteem. For more ways grandparents can better communicate with their teenage grandchildren and keep them healthy, download our free guide "[The Power of Grandparents](http://theparenttoolkit.org/media/detail/grandpar-ents-guide)" (<http://theparenttoolkit.org/media/detail/grandpar-ents-guide>).

"I think it's a really essential part of children's upbringing to have other significant adults — a teacher, extended family, older siblings — that they know they can be open and be themselves with. It gives them room to be real, to have the space to really express themselves, and to develop free from any judgment or fear of punishment."

— Dr. Jane Greer, marriage and family therapist

Aunts and Uncles

As kids get older, they tend to think that their aunts and uncles are somehow just a bit cooler than their parents. After all, they usually get to stay up past bedtime at your house. The cool factor you possess can help your niece or nephew feel comfortable opening up to you. Let your niece know that unless you think she's in danger, the things she talks to you about will stay just between the two of you. The best way to find out if something is bothering a tween or teen? "Keep it simple," says family therapist Dr. Jane Greer. An easy conversation starter: "You don't seem like yourself lately. Things going okay?"

Coaches and Mentors

Since coaches and mentors typically get to know

kids in performance-related activities, from sports to the school newspaper to debate team, they can notice changes in behavior and motivation. Use those changes as an opportunity to talk to the child you know and find out what's going on in his or her life. If a child seems off his game or is just acting out of sorts, pull him and ask questions like "What's going on today?" or "How come you're not paying attention?" suggests Bob Caruso, CFO of The Partnership at Drugfree.org and a basketball coach for teens. If you're not satisfied with the answer or your concerns continue, call the primary caregivers to see if they too have noticed any changes in their child. Find out more about how to talk with your young athlete about the risks of drugs, alcohol and performance-enhancing substances at [Healthy Competition](http://www.timetotalk.org/HealthyCompetition) (<http://www.timetotalk.org/HealthyCompetition>).

From a Distance: Out-of-Town Relatives

You may not get to see your niece, nephew or grandchild every day, but for long-distance relatives, the conversational opportunities still abound. From the time kids are small, ask to speak to them on the phone or use a webcam or Skype, and as they grow, let them know they can always call you to talk. Once the child has a phone or email address, text or write to him/her regularly with questions about his or her life. A simple "How was school today?" or "I love when you tell me stories about things you do with your friends" shows your young relative that you want to know what's going on in his or her life. And don't forget: kids of all ages love to get mail — especially if they're too young for an email account. Let them know you're thinking about them on a regular basis by sending a note their way that says, "Have a happy week," "I'm proud of you!" or simply, "I'm thinking about you."

If You're Worried

Worried about the child in your life? Then it's important that you talk to him, says Dr. Greer. "If you are concerned that there is something going on, be very genuine and very open and say, 'Hey, how are you doing? Is everything okay? You seem a little not yourself. You seem a little low energy. Anything we can talk about?' And then you might throw out a question or two, 'How are things going

with your friends?’ or ‘How are things going on the dating scene?’ depending on how much that niece or nephew has already shared with you.”

“If the child is not ready to talk,” says Greer, “continue by saying, ‘Okay, I’m just going to check in and, of course, you know I’m here.’ And then take the responsibility to make the phone calls, to send the emails, to stop by for the visits so that she not only hears that you’re there for her but really feels that you’re there for her and sees it.”



But if you’re truly worried and feel there’s a real problem, like drug use or depression, it’s better to be safe than sorry. While you want to maintain the trust you’ve developed with the child, his/her safety must come first. Contact his or her parent to share your concerns and see if there’s any way you can help.

If you have regular interaction with a child, you’ll be able to observe changes in behavior that could signify a mental health issue or problem with drugs and alcohol.



For More Information

For more about signs and symptoms of drug and alcohol use, please visit The Partnership at Drug-free.org at www.drugfree.org.

To speak to a parent specialist in about your teen’s substance abuse problem call our Parents Toll-Free Helpline at 1-855-DRUGFREE (1-855-378-4373) Monday to Friday 10am-6 pm ET.

6

PARENTING PRACTICES Help Reduce the Chances Your Child will Develop a Drug or Alcohol Problem

Here are 6 research-supported parenting practices to set you on the right path.



Get Started



6 PARENTING PRACTICES

Help Reduce the Chances Your Child will Develop a Drug or Alcohol Problem



No one ever said parenting would be easy. When children hit the teenage years, the challenges are great. There are more significant threats that can affect their health and safety, like drugs and alcohol. And, unfortunately, helpful and reliable resources are scarce. So when you are nervously sitting on your couch at 1 a.m. waiting for your 17 year old to come home, please know that you are not alone. Most parents go through this angst.

One very common complaint from parents is, “We didn’t know where to go for help” or “We were too ashamed to ask.” An Internet search can provide thousands of websites offering parenting advice, but the information across these sites is not consistent or consistently good. So how do you know what advice to follow?

When raising a teenager, it is natural to feel that there is little you can do to change his or her behavior. But there is scientific evidence

showing which parenting tips are most effective (and which are not).

Parents often think that friends are more important to their teenager than they are. But studies and clinical experience suggest that parents *can* influence their teens.

Here we share with you our expert opinions on parenting behaviors that are important in preventing your teenager from using drugs and alcohol. These recommendations are based on a sound review of scientific research. However, there are no guarantees — even the smartest, best-skilled, most caring parents in the world have problems with their children.

Information alone is unlikely to solve complicated problems and nothing takes the place of a good clinical opinion for serious issues. But getting reliable information is an important first step. Despite how powerless you may feel, we want to encourage you: **Don’t give up on your teenager or your power as a parent.**

Here are 6 ways to help you reduce the chance that your teenage child will drink, use drugs or engage in other risky behavior.



- 1 Build a Warm & Supportive Relationship with Your Child
- 2 Be a Good Role Model When It Comes To Drinking, Taking Medicine & Handling Stress
- 3 Know Your Child's Risk Level
- 4 Know Your Child's Friends
- 5 Monitor, Supervise & Set Boundaries
- 6 Have Ongoing Conversations & Provide Information About Drugs & Alcohol

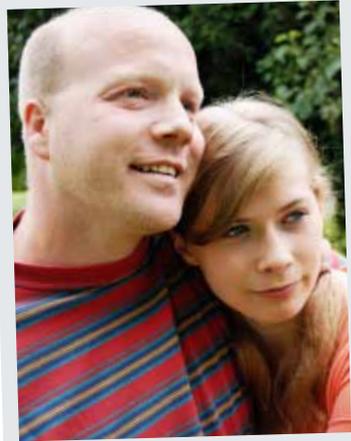
Read on to learn more »

► PROVIDE BASIC NEEDS

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We all know that the first job of any parent is to keep their child healthy, safe and developing properly. That means providing your child with the basics:

- Proper Nutrition
- Housing
- Clothing
- Health Care Monitoring (Ex: Regular checkups, dental care, etc.)
- Emotional Supports
- Home and Neighborhood Safety



1 BUILD A WARM & SUPPORTIVE RELATIONSHIP WITH YOUR CHILD

Children who have a warm and supportive relationship with their parents are less likely to use drugs or alcohol.

Research shows it's especially important to have a supportive relationship when your child is young.^[1] But it's also essential to maintain a close relationship with your child during the teen years. One reason is that by being close with your child, you'll face less conflict when it comes to monitoring his or her behavior and social life.^[2]

Not surprisingly, studies show that families who argue, fight and treat each other badly and parents who are degrading and physically punish their children have unsupportive relationships with their children. This increases the risk for drug and alcohol use.^[3]

➤ 7 Things You Can Do to Maintain a Close Relationship with Your Child:

- 1 Regularly discuss shared interests (Example: Sports, music, art, technology, movies). Take time to learn about your child's hobbies to help bond with him or her.
- 2 Engage in extracurricular activities with your child. (Example: Together, you and your teen train for a race; volunteer at a soup kitchen; cook dinner; attend a free concert.) For healthy teen extracurricular activities use our [Idea Generator](#).
- 3 Maintain low levels of anger and emotion when talking with your teen (Example: Keep a cool head, speak calmly, try not to be defensive, give praise and positive feedback).

Continued on page 4 »

➤ 7 Things You Can Do to Maintain a Close Relationship with Your Child:

- 4 Work through challenges together (Example: If your child had an argument with a close friend and feels his world has fallen apart, talk about how he feels, what might make him feel better, and what he can do to re-engage with his friend.)
- 5 Strive for honest and direct communication with your child. Find more tips for [having a conversation regarding drugs and alcohol](#).
- 6 Offer encouragement for achievements — both large and small — and be sure to attend at least some of your child’s activities so he knows what he’s doing is important to you. If you miss your child’s activities frequently, you might be sending him a message that what he does isn’t important. If you miss your child’s activities for reasons out of your control (Example: Your work schedule makes it impossible), then be sure to ask him about what happened.
- 7 Allow your child an appropriate degree of independence. Keeping your child sheltered or being a helicopter parent presents problems of its own. Let her go out with friends, but in the right settings. Let her negotiate with you about what is expected of her, her curfew, what her chores are, and when they need to be completed, etc. When there is a healthy two-way interaction between you and your teen and your expectations are clear it will help her learn to navigate the waters without you.



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Remember: “Warm and supportive” does NOT mean “lax or lenient.”

Just as research shows that parents who discipline by hitting and degrading their child have children at an increased risk for substance abuse, permissive/lenient parents who allow their children to do what they want when they want (because they either don’t want to deal with a child’s behavior or they don’t want their child to be angry with them) also place their children at increased risk.

An effective parenting strategy is to be warm and supportive but to also set (and stick to) clear boundaries and limits, so children can learn to be responsible for their actions.

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2 BE A GOOD ROLE MODEL WHEN IT COMES TO DRINKING, TAKING MEDICINE & HANDLING STRESS

Research shows that when it comes to alcohol and other drugs, children are likely to model their parents' behaviors — both healthy and unhealthy ones. ^[4]

Your attitude about drugs and alcohol can also influence your child's attitude about drugs and alcohol — and have an effect on his or her future behavior. Here are three ways that you can be a good role model for your child.

- ▶ **1** If you choose to drink alcohol, consume small amounts with a meal or for a celebratory occasion.

Don't become intoxicated in front of your children. Drinking alcohol in excess around your children or using illicit drugs increases the likelihood they will develop alcohol or drug problems.

- ▶ **2** When it comes to prescription drugs, be sure to follow the instructions properly. Do not use leftover prescription drugs in your house for casual, non-medical use. It's also important not share your prescription medications with other family members or friends. And be

sure to dispose of unused prescription drugs properly (Example: Use a drug-take back program.)

Don't save prescribed medications for when they may come in handy, use it later without a doctor's consent, or share the medications with others.

- ▶ **3** Children learn behavior by observing their parents' behavior. That means your child picks up on the way you cope with stressful situations and how you manage your emotions. When you are overwhelmed, try exercising or using other stress management techniques in order to teach your children that they do not need to drink or use drugs to cope with life's problems. Here are [tips on how to handle stress](#).

Don't use alcohol as a coping mechanism or to relieve stress. (Example: Saying to your kids, "I had a rough day — I need a few beers or a joint to relax.")

3 KNOW YOUR CHILD'S RISK LEVEL

Several decades of research shows that some teens are more at risk for developing a substance abuse problem than other teens.

Why is that? Well, there is no single factor. However, the more risk factors a teen has, the more likely he or she will abuse drugs or alcohol. Conversely, the fewer the number of risk factors, the less likely he or she will develop a drug or alcohol problem. Also, it's important to recognize that even children raised in the same home may have varying levels of risk.

It is important to keep in mind that risk factors do not determine a child's destiny. Instead, they provide a general gauge as to the likelihood of drug or alcohol abuse.

Addressing risk factors early and paying careful attention to children at higher risk can reduce that child's likelihood of a future problem with drugs or alcohol. Understanding risk factors is also very important when a child with more risk has already experimented with substances or has a problem. In that case, you will have a clearer picture of why things might have happened and know how to get the right kind of treatment.

Continued on page 7 »



Do: Think about your child's risk factors and review them at least annually (Example: On your child's birthday). If your child's risk factors are high or increase over time, watch more carefully for behavioral, psychological and social problems. Take action to address risk factors and don't hesitate to seek professional help if you cannot manage the problems yourself.

Don't: Ignore risk factors and assume your child will be okay or just ignore a problem because you think it is a stage of development. If you notice something, seek help.

➤ 4 Common Risk Factors Associated with Teen Drug and Alcohol Abuse:

● **Family History:** Family history of drug or alcohol problems, especially when it is the parent's history, can place a child at increased risk for developing a problem. Children can inherit genes that increase their risk of alcoholism, so having a parent or grandparent with alcohol problems may indicate increased risk for the child. Inheriting the gene does not mean the child will automatically become dependent on alcohol.

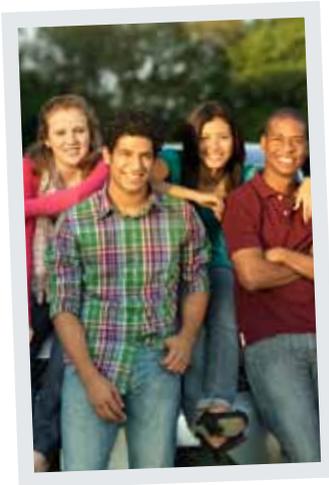
If there is a history of a dependence or addiction in your family, you should let your child know since he or she is at a higher risk for developing a drug or alcohol problem. These conversations should take place when you feel your child is able to understand the information.

2 **Mental or Behavioral Disorder:** If your child has a psychiatric condition like depression, anxiety or Attention Deficit Hyperactivity Disorder (ADHD), he or she is more at risk for developing a drug or alcohol problem. Although not all teenagers with these disorders will develop a substance abuse problem, the chances are higher when they have difficulty regulating their thoughts and emotions. Therefore, parents with children with psychiatric conditions should be vigilant about the possibility of their teen using drugs or alcohol.

It is also a good idea to talk with your health care providers about the connection between psychiatric conditions and substance use. Managing and treating underlying psychiatric conditions, or understanding how emotional and behavioral problems can trigger or escalate a substance use problem, is important for preventing or reducing risk.

3 **Trauma:** Children who have a history of traumatic events (such as witnessing or experiencing a car accident or natural disaster; being a victim of physical or sexual abuse) have been shown to be more at risk for substance use problems later in life. Therefore, it is important for parents to recognize and address the possible impact of trauma on their child and get help for their child.

4 **Impulse Control Problems:** Children who frequently take risks or have difficulty controlling impulses are more at risk for substance use problems. While most teens understand the dangers of taking risks, some have particular difficulty resisting impulses to engage in risky behavior.



4 KNOW YOUR CHILD'S FRIENDS

You, as the parent, set the foundation for your child's interaction with his friends. As your child gets older, his friends play a more important role in the choices he makes.

Your child's friends can influence him to take part in risky behaviors.^[5] This is especially true if your child is more reliant on his friends than he is on you.^[6]

Remember: Knowing who your child's friends are and what they are like helps you to be more prepared to intervene if a problem occurs. For example, let's say your child calls and tells you that she will be late because she planned on riding home with her friend Julia who was supposed to meet her 45 minutes ago. It is helpful to know if Julia is a brainy bookworm who becomes engrossed in reading and loses track of time, or if she is someone who never has a curfew, sometimes behaves a bit wildly, and is obsessed with boys.

Here are some tips to help you be better aware of your child's friends and assist your child in developing healthy friendships:

- ▶ Ask questions about their friends (Example: "What's your new friend Jake like? What kind of activities is Kira into?")

Continued on page 9 »

▶ Should I host a party with alcohol or "teach" my child to drink so he or she will learn in a safe environment?

It's NOT advisable to host teen parties where alcohol is available (and thus, condone underage drinking.) Also, contrary to popular belief, there is NO evidence that parents can "teach their children to drink responsibly." Quite the opposite is true — the more exposure to drinking in adolescence and parental acceptance of substance use, the higher the risk of later problems with alcohol and other drugs.

- ▶ Have direct conversations with your child’s friends whenever the opportunity presents itself so that you get to know them and their household rules in a positive context. (Note: A great time to have these conversations is in a car; so if possible, offer to drive your child and his or her friends to various activities, events, games, etc.) Developing these ties will allow you to guide your child and make it easier to communicate if a problem arises later.
- ▶ Explain that it’s normal to want to be accepted by others but it’s best to focus on friends who are not engaging in substance use. Remind your child that most teens do not drink or use drugs regularly. Let her know that she has a choice in how she interacts with her friends and if she is disappointed by her friends she is free to make new friends. Guide your teen toward opportunities to meet new people.
- ▶ Discuss with your teen the importance of choosing supportive, healthy friendships — and what it means to be a good friend. For example, a good friend is someone who is:
 - Loyal
 - Wants what’s best for you
 - Likes that you have different interests than he or she has
 - Roots for you
 - Celebrates your successes
- ▶ Share information about your own friends, colleagues and neighbors — describe your relationship with them, their interests, their personality traits, what you like about them, how they make you feel and how you resolve differences with them.

[Watch a video about teen friendships.](#)

Continued on page 10 »



▶ **If You Don’t Like Your Teen’s Friends, Follow Your Instinct.**

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Do you suspect they use drug or alcohol? Do you think they treat your child badly? Do you have a personality conflict?

No matter what the reason is, remember this: If you suspect that a friend is a bad influence, don’t wait. Keep a closer eye on him, talk to your teen and make your concerns and expectations clear. (Example: “I’m concerned because Tommy cuts school and has no curfew and I’m worried about these behaviors rubbing off on you.”) If necessary, help your child connect with a wider social circle.

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- Encourage your child to recognize and step in when a friend might be having difficulties or be tempted to use drugs or alcohol. She can be a powerful influence on her friends and help her friends make healthy choices. Not only will this help her friends, it will protect your child from being drawn in by the wrong crowd and also set her apart as a proactive and independent thinker.
- Check in with your teen's friends and their parents to find out if their household rules are similar or different than yours, particularly when it comes to their rules on serving alcohol to minors.^[7] If their household rules are different than yours (Example: The parents are okay serving alcohol to minors), you can speak with them directly about your rules. You can also make sure that most of the time spent with your child and his or her friend occurs in your home.

For more, read our [Healthy Friendships Tipsheet](#).

5 MONITOR, SUPERVISE & SET BOUNDARIES

Research shows that when parents monitor, supervise and set boundaries their teens are at a lowered risk for using drugs and alcohol.^[8]



To Monitor Your Child

- Know where your child is at all times.
- Be aware of your teen's activities, especially during the after-school period, which is a high-risk period for teen drug use.^[9]
- Know who your child is hanging out with.
- Keep track of your child's academic performance. Studies have shown that problems in school are a possible marker for alcohol and drug problems and that school involvement and academic achievement can protect against drug and alcohol use.^[10]

To Supervise Your Child

- Be present during recreational events and parties — or at least make your teen aware that there is another adult supervising.
- Help your child with her homework or other school-related projects. This will not only give you quality time with her and reinforce the importance of achievement, but also helps you recognize any difficulties she may be having with school or other activities.

► NOTE

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You don't want your "presence" to impinge on your child's need to develop a sense of independence, especially as your child grows older and needs to develop socialization skills. For example, simply being home when an older teen has friends over and periodically checking in and starting conversations with your child and his or her friends is better than constantly interrupting their time together.

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Continued on page 12 »



To Set Boundaries

Do

- Explain to your child why you are setting boundaries (Example: “I’m doing this to keep you healthy and safe.”)
- Firmly establish a rule that any drug or alcohol use will not be tolerated. Set a rule prohibiting underage alcohol consumption before age 21. Explain the risks of drinking while [his or her brain is still developing](#). While teens will often discount that risks will actually happen to them, helping your children become future-oriented thinkers is an important lesson. You may have to try a number of different strategies or ideas before one sticks.
- Set firm but reasonable rules (Example: Setting a curfew; expecting to be notified when plans change). [Be clear about the consequences](#) if the rules are not followed in advance and follow through consistently.

Don't

- Establish unreasonable rules (Example: Children have an 8 p.m. bedtime regardless of age or day of the week) or be overly harsh in punishment or consequences if they break rules (Example: Grounding children for a month for being late one time). This might push your child away and prevent him or her from opening up to you.

6 HAVE ONGOING CONVERSATIONS & PROVIDE INFORMATION ABOUT DRUGS & ALCOHOL

Having ongoing conversations with your child can help build a healthy, supportive relationship.

It can also help you and your child avoid or reduce conflict as situations arise throughout their teen years.

Here are tips for talking with your child:

- ▶ Talk regularly with your child about the risks of drug and alcohol use – especially in opportunistic situations (Example: Seeing someone intoxicated; a news story about addiction; before your child starts a new school.)
- ▶ State your disapproval of underage drinking and drug use. Research shows that this can decrease the chance that your child will try drugs or alcohol,^[11] and reduce the likelihood that he or she will transition from experimenting with drugs and alcohol to more regular or heavy use.^[12]
- ▶ Instead of a boring lecture, let your child know about the health and safety risks of teen drug and alcohol use. Teens who perceive alcohol and drugs as harmful are less likely to engage in underage drinking.^[13] [See our [Drug Guide for Parents \(pdf\)](#) to learn about the latest drugs.]

Continued on page 14 »



▶ 6 Skills to Practice When Talking to Your Teen: ^[16]

1 BE BRIEF:

Avoid long comments and conversations that might be seen as lecturing. Allow your teen to speak and let him know that he is being heard. Giving him the floor by asking brief open-ended questions such as, “What are some of the reasons you think those kids were drinking?,” can produce much more effective and interactive conversations than simply telling him why people who use drugs are making poor decisions.

2 BE POSITIVE:

Stay upbeat and avoid blaming. Teens need to hear the “good stuff” just like the rest of us. When you reward good behavior kids are likely to repeat it. (Example: “You did a great job leaving that situation early, it shows you are an independent person and I’m proud of you.”)

Continued on page 14 »



Here are tips for talking with your child (continued):

- ▶ Keep up-to-date on the [latest research and drug trends](#) — including the increased misuse and abuse of prescription drugs among teens.

If you feel uncomfortable striking up these conversations with your teen, one way to begin is to ask your child, “Have you ever been offered drugs or alcohol?”

In this way, your child might be more likely to open up than if asked about his or her own personal use. This can then lead to a discussion about:

- Why people might drink or use drugs (Example: social pressure)
- Your child’s own feelings about the risks and benefits of use
- The reasons to avoid use, even though some people might not be outwardly experiencing consequences
- Refusal skills and alternatives to drinking and using

And asking this question may also help you get a better picture of your child’s risk for personal use. This can set the stage for ongoing conversations about substance abuse throughout their adolescence.

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- ▶ Have conversations with your child on all topics — such as his or her activities, friends, school, job, hobbies, etc. In other words, be interested in your child’s life. This has been shown to protect against risk for teen tobacco use^[14] and the transition to drug and alcohol use.^[15] For tips on talking with your teen, visit www.timetotalk.org.

Remember: If you’re having trouble communicating with your teen, seek out help from a professional.

▶ 6 Skills to Practice When Talking to Your Teen (continued): ^[16]

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3 REFER TO SPECIFIC BEHAVIORS:

State what you want — not what you don’t want — and identify exactly what you want your child to do in terms of specific actions (Example: “I want you to be home by eleven o’clock.” versus “Don’t stay out late.”) Don’t ask your child to change his or her thoughts, feelings, or attitudes (Example: “You need to think more responsibly about when you come home.”)

4 LABEL YOUR FEELINGS:

State how you feel (not what you think) calmly in a non-judgmental manner (Example: “I care about you and I worry when you aren’t home on time.”) If your teen dismisses you and says, “Don’t worry,” acknowledge her feelings, but remind her that it is your job to protect her.

5 OFFER AN UNDERSTANDING STATEMENT:

Convey some understanding of your child’s perspective (Example: “I know you really want to fit in with your friends...”)

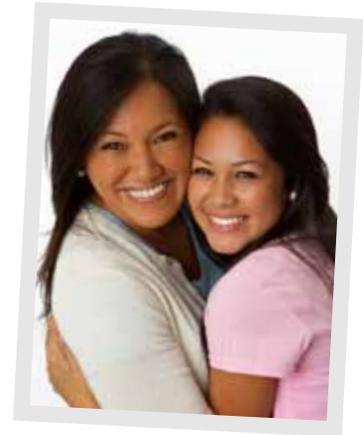
6 ACCEPT PARTIAL RESPONSIBILITY:

This is hard for some parents to do, but it can be very helpful in connecting with your child (Example: “I may not have told you what I expected as clearly as I could have...”)

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SOURCES

- [1] Brook, Brook, Zhang, et al., 2009; Catalano, Morrison, Wells, et al., 1992; Cohen, Richardson, LaBree, 1994; Pires and Jenkins, 2007
- [2] Nash, McQueen, Bray et al., 1995
- [3] Tschann, Flores, Marin et al., 2002; Chen, Storr, Anthony, 2005; Wright, Fitzpatrick, 2004
- [4] Bahr, Hoffman, Yang, 2005
- [5] Ary, Duncan, Biglan, 1999; Oetting, Beauvais, 1986
- [6] Barnes, Windle, 1987
- [7] Yu, 2003
- [8] Barnes and Farrell, 1992; Cleveland, Gibbons, Gerard, 2005; Griffin, Botvin, Scheier, et al., 2000; Pilgrim, Schulenberg, O'Malley et al., 2006; Rai, Stanton, Wu et al., 2003
- [9] Richardson, Radziszewski, Dent, et al., 1993
- [10] Guo, Hawkins, Hill, et al., 2001; Simons-Morton, 2004
- [11] Catalano, Morrison, Wells, et al., 1992; Simons-Morton, 2004
- [12] Wood, Read, Mitchell et al., 2004; Guilamo-Ramos, Turrisi, Jaccard, 2004
- [13] Cleveland, Gibbons, Gerrard, 2005
- [14] Hill, Hawkins, Catalano, 2004
- [15] Stronski, Ireland, Michaud et al., 2000
- [16] Smith & Meters, 2004



Disclaimer: Unfortunately, even with the “best” parenting practices, there is no guarantee that a teenager will refrain from starting to use drugs or alcohol, developing a drug problem, or even worse, experiencing serious drug-related consequences. Conversely, the worst of circumstances does not undeniably predispose a child to a life of addiction. While poor home environments and inadequate parenting certainly raise the risk of poor outcomes, children are remarkably resilient. Many children growing up with these kinds of disadvantages thrive and lead happy and sometimes extraordinary lives.

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For more information, please visit drugfree.org

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PRACTICAL ADVICE FOR PARENTS

As a parent, teach your teen to:

- **Respect** the power of medicine and use it properly.
- **Recognize** that all medicines, including prescription medications, have **risks** along with benefits. The risks tend to increase dramatically when medicines are abused.
- Take **responsibility** for learning how to take prescription medicines safely and appropriately, and seek help at the first sign of a problem for their own or a friend's abuse.

Here are some ways you can help:

- Speak to your teen about prescription medicines – do not presume that illegal drugs are the only threat, and remind them that taking someone else's prescription or sharing theirs with others is illegal.
- Encourage your teen to ask you or a doctor about the negative side effects of a prescribed medicine, how to watch for them, and what to do if a negative effect is suspected.
- Alert your family physician that you are concerned, and ask him or her to speak to your teen about the importance of proper use of prescription medicines.
- Keep prescription medicines in a safe place and avoid stockpiling them.
- Promptly and properly dispose of any unused prescription medicines.
- Provide a safe and open environment for your teen to talk about abuse issues.
- Monitor your teen's use of the Internet, especially for any illegal online purchases.

Please remember that prescription medicines, when used correctly and under a doctor's supervision, are usually safe and effective.

SMA-12-4676B1

RESOURCES

Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Helpline:
800-662-HELP (800-662-4357)
(Toll-Free) (English and Spanish)
800-487-4889 (TDD) (Toll-Free)

Substance Abuse and Mental Health Treatment Locator:
<http://www.samhsa.gov/treatment>

SAMHSA's website:
<http://www.samhsa.gov>

SAMHSA's **Recovery Month** website:
<http://www.recoverymonth.gov>

To order SAMHSA publications:
<http://store.samhsa.gov>

National Institute on Drug Abuse (NIDA) for Teens:
301-443-1124
<http://www.teens.drugabuse.gov>

NIDA for Parents and Teachers:
<http://www.drugabuse.gov/parent-teacher.html>

FDA Safe Disposal of Unused Medication:
<http://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187.htm>

National Council on Patient Information and Education (NCPIE):
301-340-3940
<http://www.talkaboutrx.org>



The statistics in this brochure are from SAMHSA's Drug Abuse Warning Network, 2009; National Estimates of Drug-Related Emergency Department Visits, and the Partnership at Drugfree.org's 2010 Partnership Attitude Tracking Study: Teens and Parents.

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TALKING

TO YOUR KIDS
about prescription drug abuse

Not Worth The Risk
even if it's legal

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

WHAT DO PARENTS NEED TO KNOW?

As a parent of a teenager, you may have spoken to your child about illegal drugs and their harmful effects. But did you know that legally prescribed medicines are also a cause of concern?

An alarming number of teenagers are more likely to have abused prescription and over-the-counter drugs than some illegal drugs, like ecstasy, cocaine, crack, and methamphetamines.

The dangers of prescription medicine abuse include dependence, slower brain activity, irregular heartbeats, dangerously high body temperature, heart failure, or lethal seizures. Prescription drug abuse also increases emergency room visits and suicide attempts. In 2009, more than 1 million emergency room visits involved the nonmedical use of prescription drugs.

The easiest way for teens to obtain prescription medicines is from their friends or their parents' medicine cabinet. It's so common that it could happen even in your house!

- Nearly one in four teens (23 percent) report taking a prescription drug not prescribed to them by a doctor at least once in their lives.
- Almost half of teens (47 percent) say it is easy to get prescription drugs from a parent's medicine cabinet.
- Teens are abusing everything from pain medicines to stimulants, sedatives, and tranquilizers.

Parents can make a difference. Kids who continue to learn about the risks of drugs at home are up to 50 percent less likely to use drugs than those who are not taught about the dangers. Only 22 percent of teens report discussing the risks of abusing any prescription drug without a doctor's prescription with their parents. **It's up to YOU to talk openly with your kids!**

UNDERSTANDING "GENERATION RX"

What causes today's teens to abuse prescription drugs to get high? Among the factors are a series of misconceptions, lack of information, and a carefree attitude toward the risks involved in using prescription medicines improperly.

Why do kids abuse prescription drugs?

- They are seeking psychological or physical pleasure.
- They want to fit in with groups of friends and are in search of acceptance and bonding.
- They do not realize the risks of taking medicines that have not been prescribed specifically for them or the danger of not following a prescription's directions.
- It is easier to get prescription drugs than illegal drugs.

Teens may believe the following misconceptions such as:

- Prescription medicines are much safer to use than illegal drugs.
- Prescription pain relievers cannot be addictive.
- There is nothing wrong with using prescription drugs without a doctor's prescription.

*As a parent, **YOU** need to explain to your teen the dangers of prescription drug abuse.*

RECOGNIZE THE SIGNS OF PRESCRIPTION DRUG ABUSE

The best way to prevent prescription drug abuse is to first educate yourself. That way, you can accurately and adequately present the facts when you talk with your teen.

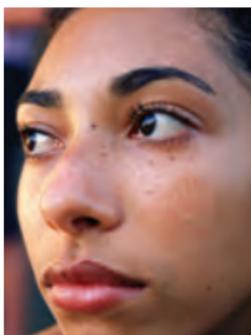
Be sure you can recognize the signs of prescription drug abuse:

- Fatigue, red or glazed eyes, and repeated health complaints
- Sudden mood changes, including irritability, negative attitude, personality changes, and general lack of interest in hobbies/activities
- Secretiveness and withdrawing from family
- Decreased or obsessive interest in school work
- Missing prescription medicines from your medicine cabinet
- Additional filled prescriptions on your pharmacy record that you did not order

Some of these warning signs might signal other problems as well. If you recognize any of these signs, refer to the resources provided in this brochure, or contact your teen's physician or other healthcare professional.



The Partnership
for a Drug-Free
America®



Getting High on Prescription and Over-the-Counter Drugs Is Dangerous

A guide to keeping your teenager
safe in a changing world

www.drugfree.org



❏ Prescription and over-the-counter (OTC) medications are fast becoming the new “party” drugs for many teenagers.

But many parents, who may be aware of their children’s familiarity with illegal street drugs, do not have “pharming”—that is, their kids’ using prescription and OTC drugs for recreational use—on their radar screens, even though nearly one in five teens has used powerful narcotic pain relievers for nonmedical reasons.

FRIGHTENING STATS

A survey of teenagers by the Partnership for a Drug-Free America found that:

- 1 in 5 teens has tried Vicodin, a powerful and addictive narcotic pain reliever
- 1 in 10 has tried OxyContin, another prescription narcotic
- 1 in 10 has used the stimulants Ritalin or Adderall for nonmedical purposes
- 1 in 11 teens has admitted to getting high on cough medicine



THE NEW PARTY DRUGS

Nor are parents aware that their own medicine cabinets and home computers are potential sources of these drugs for teenage abuse.

Prescription and OTC drugs are important and beneficial products that every year improve and save countless lives. They are effective, and they are also safe—but only if used as medically intended.

We're NOT talking about kids mistakenly taking the wrong dose of legal medicines or taking a stronger than-necessary medicine for an ailment. We're talking about drug abuse—kids using prescription and OTC drugs on purpose in order to get high.

If your teen gets in the habit of using medicines that are not medically intended for him or her, or of taking higher-than-recommended doses just for fun, bad things can happen: Dramatic increases in blood pressure and heart rate, organ damage, addiction, difficulty breathing, seizures, and possibly death.

➔ For more information, visit www.drugfree.org

Why is this increase in teenage prescription and OTC drug abuse happening now?

Awareness and access. Mainly for good reasons, our society is very familiar—and more and more comfortable—with prescription pharmaceuticals and OTC medicines. Products come to market, their images advertised in newspapers, magazines, and on television and the Internet, with educational programs to raise our understanding of the conditions they treat. Many new drugs replace older ones with safer and more effective formulations.

Caught in the Web

Then there's the Internet, which has been at the center of an explosion of information of all kinds, good and bad. You can find useful information on the Web about the risks from the nonmedical, recreational use of prescription and OTC drugs. But you can also learn how to abuse them. Many websites describe for would-be abusers what kinds of cough medicine they should buy, how much to take, and even how much to take to get high.

Most disturbingly, it is as easy for a teenager to buy narcotic pain relievers like Vicodin or stimulants like Adderall or sedatives like Xanax over the Internet as it is to buy a book or CD. Enter "no prescription Vicodin" in your Web browser's search bar, and you'll find numerous websites ready to sell your son or daughter various prescription drugs—without the nuisance of an actual prescription or even asking your child's age—delivered to your home in an unmarked package.

But the most immediate source of prescription and OTC drugs is your own medicine cabinet or the medicine cabinets in the homes of your child's friends. New and expired or forgotten prescriptions or last winter's OTC cough medicines could be inviting targets for the teenager looking to get high.

What to Do?

Some parents need to consider their own drug behavior. If you're casual about using prescription or OTC drugs, even if you're not looking to get high, you can set a bad example. Medications should be used by the person for whom they're intended, to treat the conditions for which they're intended. Don't use your kid's Ritalin to give you the energy and focus to complete a difficult work assignment. Regard these drugs seriously, and it's a good bet your child will, too. Start by taking an inventory of the drugs in your medicine cabinet.

It's up to you to educate yourself about the real dangers of prescription and OTC drug abuse and to discuss these risks with your teen. Kids need to hear from parents that **getting high on legal prescription and OTC drugs is not safer than getting high on illegal street drugs.**

And reaching out to have that discussion is not just an idle suggestion. It works. Research shows that kids who learn a lot about drug risks from their parents are up to half as likely to use drugs as kids who haven't had that conversation with Mom and Dad.

Unfortunately, research also shows that fewer parents today are talking to their teenagers about drugs than they were only a few years ago.

It's time to turn that stat around. This brochure can help. So can the information found on the website of the Partnership for a Drug-Free America—www.drugfree.org—or at the other resources listed at the end of this booklet.

Quite simply, if you're not educating your children about health risks they may encounter, you are not providing the protection they need in today's changing world.

What could be more basic to being a parent than protecting your child from harm?

Educate Yourself

If you're going to discuss prescription and OTC drug abuse with your kids, you need to know what you're talking about. You should be able to distinguish among the types and effects of drugs some teens use to get high. Some of these drugs are described below.

PRESCRIPTION (RX) DRUGS

Safe when used according to a doctor's instructions, **these medications should be taken only by the person for whom a doctor has prescribed them.** Using prescription drugs prescribed for others or without doctor's orders is unsafe and illegal.



Codeine

Pain Medications

Teenagers abuse narcotic pain relievers more than any other prescription medicine. Mentions of these very powerful drugs as reasons for emergency room visits have nearly tripled over the recent decade.

Vicodin (hydrocodone) ■ **OxyContin** (oxycodone) ■ **Percocet** (oxycodone and acetaminophen) ■ **Darvon** (propoxyphene) ■ **Codeine**

May be medically useful for:

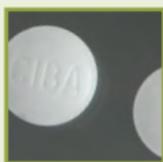
- Treating moderate-to-severe pain, such as after surgery or dental procedures.

Abused by teens to:

- Feel pleasure or sensations of well-being.

Dangerous because:

- Highly addictive. Over time, tolerance develops to certain effects of these drugs, resulting in the need to take more and more to get the same pleasant feelings. Addicted teens who suddenly stop using may go through withdrawal, a horrible physical experience of intense restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, and cold flashes.
- Taken in overdose, breathing slows down and eventually stops, and death may occur. Time-released products like OxyContin, designed to deliver pain-relieving medication into the system slowly over hours, may be crushed and snorted, causing the drug to enter the system all at once, sometimes resulting in death.
- Taken in combination with other prescription or OTC drugs or alcohol, the risk of life-threatening respiratory depression is increased.



Stimulants

Stimulants increase the amounts of circulating brain chemicals that raise blood pressure and heart rate, speed up breathing, decrease appetite, and deprive the user of sleep.

Ritalin, Concerta (methylphenidate) ■ **Adderall** (mixed amphetamine salts) ■ **Focalin** (dexmethylphenidate) ■ **Dexedrine** (dextroamphetamine)

May be medically useful for:

- Treating attention deficit/ hyperactivity disorder (ADHD), narcolepsy; short-term treatment of obesity.

Abused by teens to:

- Feel especially alert, focused, and full of energy. May help them to manage stressful schoolwork or "pull an all-nighter."
- Suppress appetite in order to lose weight.

Dangerous because:

- Can be addictive.
- High doses taken over a short time can lead to feelings of hostility, intense fear, and paranoia.
- High doses may result in dangerously high body temperature and irregular heartbeat, with possible cardiovascular failure or seizures.
- Use in combination with OTC decongestants can result in dangerously high blood pressure or irregular heart rhythms.
- Can cause insomnia, digestive problems, and erratic weight change.



Sedatives, Sedative-Hypnotics, and Tranquilizers

Sedatives, sedative-hypnotics, and tranquilizers affect brain systems to produce a drowsy or calming effect, sometimes to the point of inducing sleep.

Benzodiazepines: **Valium** (diazepam) ■ **Xanax** (alprazolam) ■ **Ativan** (lorazepam) ■ **Klonopin** (clonazepam) ■ **Restoril** (temazepam)

Non-Benzodiazepine Sedatives: **Ambien** (zolpidem) ■ **Lunesta** (eszopiclone)

Barbiturates: **Mebaral** (mephobarbital) ■ **Nembutal** (pentobarbital)

May be medically useful for:

- Treating anxiety, severe stress, panic attacks, and insomnia in the short-term, as well as some types of seizure disorders and muscle spasms.

Abused by teens to:

- Feel calm and sleepy with less tension, anxiety, or panic, feelings that go away as the body becomes drug-tolerant.

Dangerous because:

- Can be addictive; when use is reduced or stopped, seizures and other withdrawal symptoms may follow.
- Can be deadly in combination with prescription pain medications, some OTC cold and allergy drugs, or alcohol.

OVER-THE-COUNTER (OTC) DRUGS

OTC drugs are available at any pharmacy without a prescription. Like prescription drugs, they're safe when used according to packaged instructions or when recommended by a doctor familiar with your medical history and other medications you may be taking.

Cough Medicine



Cough Medicines

Teens can get high by taking cough medicine in excessive amounts. What makes them high is the cough suppressant ingredient called dextromethorphan, or DXM for short, found in more than 100 OTC products. In syrups, tablets, capsules, lozenges, and gelatin capsules, DXM can be found combined with other substances, such as antihistamines, expectorants, decongestants, and/or simple pain relievers.

Coricidin cough and cold tablets ■ Alka-Seltzer Plus cold and cough medicine ■ TheraFlu cough products ■ select Robitussin cough products ■ Tylenol cold and cough products ... and many others, including store brands. To know if a product contains DXM, look on the label for "dextromethorphan" in the list of active ingredients.

May be medically useful for:

- Treating coughs and colds safely and effectively, when used according to directions.

Abused by teens to:

- Experience DXM's effects, which range from euphoria to feelings of enhanced awareness to distortions of color and sound to visual hallucinations to "out-of-body" sensations, when users lose contact with their senses.

Dangerous because:

- DXM's negative physical effects from overdose include rapid heartbeat, high blood pressure, diarrhea, seizures, panic, drowsiness, confusion, dizziness, blurred vision, impaired physical coordination, and coma.
- Side effects may be worse when DXM is used with other medications or with alcohol or illegal drugs.
- Overdoses of other ingredients found in DXM-containing medicines have their own serious side effects, including:
 - **Acetaminophen** (pain reliever) = liver damage.
 - **Chlorpheniramine** (antihistamine) = increased heart rate, lack of coordination, seizures, and coma.
 - **Guaifenesin** (expectorant) = vomiting.
 - **Pseudoephedrine** (decongestant) = irregular heartbeat, headaches, difficulty breathing, anxiety, and seizures.

More Drugs, More Danger

Prescription and OTC drugs have side effects that range from the unpleasant to the dangerous for the teen using them recreationally. But the effects—and the dangers—are intensified when these drugs are combined with each other, with alcohol, or with illegal street drugs. Even when used at the recommended doses to treat medical conditions, combining multiple medications can be dangerous.

Use an Expert

Further educate yourself about teenage recreational use of prescription and OTC drugs by talking directly to an expert about your concerns. If you find drugs or drug paraphernalia in your child's room, but you're not certain what they are, show them to your child's physician or pharmacist, who are best able to identify suspect substances for you.

And if you need information quickly about the kinds of drugs teens may be abusing, how to talk to your child whom you suspect may be abusing drugs, or what to do if you know your child is definitely using drugs, visit www.drugfree.org.

WARNING SIGNS

Clues that your child may be abusing prescription or OTC drugs to get high:

- Visits to pro-drug Internet sites devoted to “how to” get and abuse prescription and OTC drugs.
- Cough or cold, prescription, or unidentifiable medications among personal effects with no evidence of illness.
- Unexplained disappearance of medicines from medicine cabinet.
- Declining grades, loss of interest in hobbies and usual activities.
- Changes in friends, physical appearance, hygiene, and general behavior.
- Disrupted eating or sleeping patterns.



As a parent, you are in the best position possible to help steer your child away from intentionally abusing prescription and OTC drugs. Some tips:

Set an Example

Don't abuse prescription and OTC drugs yourself. Use drugs as the doctor or label intends. Don't medicate today's headache or the sore muscles from yesterday's golf game with the prescription pain medication your doctor gave you after last year's surgery. Such a casual attitude may reinforce the false assumption that, because they were made by a pharmaceutical company, these drugs automatically must be safe to treat any condition or problem. If you have a physical complaint, see a doctor. But don't use another person's prescription drugs. Ever.

Use OTC medicines according to packaged instructions or your doctor's recommendations. Taking far more cough medicine than the label instructs will not make your cough go away any faster. It can, however, indicate to your teenager that it is alright to take more medicine than necessary. That's dangerous.

Connect with Your Kids

Get and stay closely involved with your kids' lives as they go through middle school and into high school. You won't connect well with your kids about serious health issues if you haven't been interested in the



day-to-day events of interest to them. Use part of your daily conversations to talk honestly about prescription and OTC drug abuse. Know the facts, clear up wrong information, but don't make it all a lecture: Listen to your children's questions and comments about their drug topics of concern.

Stop the Myth

Getting high with prescription and OTC medications is NOT safer than getting high with illicit street drugs. Prescription painkillers, stimulants, sedatives, tranquilizers, and OTC cough medicines are dangerous when used in excess and repeatedly to get high.

Help Your Child Make Good Decisions

Your child is more likely to be offered drugs by a friend than a stranger, and exposure to drugs can begin as early as age 12. He or she may be better equipped to avoid peer pressure to get high if there is a solid, explicit family policy against drug abuse to fall back on. Give your child the ammunition to make clear to his or her acquaintances that the consequences of abusing these drugs are too severe to risk. Set clear and consistent rules for behavior, and help your child come up with firm but friendly responses to use with friends who might urge drug abuse. Remind your child that a real friend won't care if he or she does not abuse these medications.

SAFEGUARD YOUR MEDICATIONS



■ A main source for teenagers of prescription and OTC drugs is the family medicine cabinet. Think about it: Pharmaceuticals are much easier to get—just a walk down the hall or a peek into a friend’s medicine cabinet—than illegal street drugs. Prescription and OTC drugs are beneficial and necessary, but if you are not in need of them right now, put them out of reach of younger children and teens to avoid accidental use or intentional abuse.

MEDICINE INVENTORY

- Do an inventory of the contents of your medicine cabinets, kitchen cabinets, bureau tops, or anywhere in the house where you may store medicines.
- If necessary, monitor the pill quantities and medicine levels in your prescription and OTC drug containers.
- Put drugs away. If you currently need these drugs, put them in a place where you can get to them easily but where your child is unlikely to look.
- If drugs in your house are left over from a previous condition or ailment, get rid of them.
- Urge your friends—especially the parents of your children’s friends—to perform medicine inventories of their own.



If you suspect you have a kid in trouble, act now!

Teenage drug abuse is tied to two basic urges:

1. The desire to experiment in order to feel good while wanting to follow the crowd to fit in.
2. The intention to self-medicate to help deal with the various sources of stress—schoolwork, relationships, or conflicts with friends or family members. Recent research estimates that as many as half of teens who abuse drugs also have mental health issues that need treating.

You DO have the power to influence your child's decision about whether or not to use prescription and OTC drugs for recreation. Research says that fear of upsetting parents is the number one reason why kids do not use drugs.

Intervention

If you're convinced your child has a drug abuse problem, consider an intervention. It doesn't have to be a formal confrontation; a simple but directed discussion will do. Here are some tips to keep the conversation going:

- Have your discussion when your child is not high and when you are calm and rational.
- Express your love and desire for your child's safety and well-being as the basis for your concern.
- Be as neutral and nonjudgmental as you can.
- Tell your child of the behavioral signs you've observed that made you concerned. Avoid direct accusations, but be open about your suspicions.
- Listen, listen, listen! Consider everything your child has to say. If he or she brings up a related problem, explain that you will address that issue next, but that what you need to talk about right now is prescription or OTC drug abuse.
- If you need help getting this conversation started, involve another family member, your child's guidance counselor, or a physician. Or check out the website of the Partnership for a Drug-Free America—www.drugfree.org—for more suggestions on raising the topic of drug abuse with your teen.



The Partnership for a Drug-Free America

www.drugfree.org • Comprehensive information, resources and tips from experts and other parents; opportunities to connect and share experiences with other families.

Substance Abuse and Mental Health Services Administration (SAMHSA)

www.samhsa.gov • Part of the U.S. Department of Health and Human Services: Provides information, statistics and articles on improving the quality and availability of drug and alcohol addiction treatment.

SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI)

<http://ncadi.samhsa.gov> or **1-877-SAMHSA7** • Part of the U.S. Department of Health and Human Services and the Substance Abuse and Mental Health Services Administration: A resource for federal government agency publications dealing with alcohol and drug use prevention and addiction treatment.

SAMHSA's Center on Substance Abuse Treatment (CSAT)

www.csat.samhsa.gov or **1-800-662-HELP** • Part of the U.S. Department of Health and Human Services: Toll-free treatment referral hotline provides callers with information and listings of treatment and recovery services for alcohol and drug problems.



National Institute on Drug Abuse (NIDA)

www.drugabuse.gov • Part of the U.S.

Department of Health and Human Services and one of the National Institutes of Health: Primary source of scientific studies and new discoveries on the effects of drugs of abuse and how best to prevent drug abuse and treat drug addiction.

National Institute of Mental Health (NIMH)

www.nimh.nih.gov • Part of the U.S.

Department of Health and Human Services and one of the National Institutes of Health: Primary source of scientific research on mental and behavioral disorders.

GET HELP

The important first step with any health issue is to get a professional evaluation of your child's condition. If you think your child needs professional help, your doctor, hospital, or school nurse may be able to help. Or you can call **1.800.662.HELP** or visit **www.drugfree.org/intervention** and click on "Find Treatment."



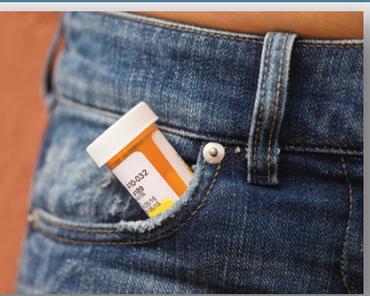
The Partnership for a Drug-Free America[®]
www.drugfree.org

Reckitt Benckiser Pharmaceuticals provided support to the Partnership for a Drug-Free America to print and distribute this brochure. Additional copies are available at 1-877-SAMHSA7.



GetSmartAboutDrugs
A DEA Resource for Parents

Prescription for Disaster How Teens Abuse Medicine



“As America faces an explosive prescription drug abuse problem, parents need to be aware that their family medicine cabinet and the Internet have become today’s back alley drug dealers. Teens need to understand that abusing prescription drugs is every bit as dangerous as abusing ‘street’ drugs. With this booklet, DEA shows the good news for families: That there are simple ways to limit access to these drugs and to keep our teens drug-free.”

Michele Leonhart, Administrator, Drug Enforcement Administration

Revised August 2012
First Edition December 2008

To locate your local Poison Control Center, or for assistance and counseling in identifying and responding to a pill or other medicine you find:

**www.poisonprevention.org/emergency.htm
Or call 800-222-1222, 24 hours a day, 7 days a week.**





Prescription for Disaster

How Teens Abuse Medicine

A DEA Resource for Parents

This publication is designed to be a guide to help the reader understand and identify the current medications that teens are abusing. It is not all-inclusive; every dosage unit or generic form of the medications cannot be listed due to space constraints and the frequent introduction of new drugs. For more information, go to www.dea.gov or consult the additional resources at the back of this book.

Millions of teens are using very powerful pain medications to get high. Some of these are the same medications doctors use to treat pain in terminal cancer patients.

For many teens, using prescription or over-the-counter medications is their first introduction to getting high. Until recently, teens began their drug use with marijuana.

USA Today, "Teens use Internet to Share Drug Stories"
by Donna Leinwand, June 19, 2007

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Prescription Drug Abuse



Although most people take prescription medications responsibly, an estimated 52 million people have used prescription drugs for non-medical reasons at least once in their lifetime. (NIDA, Nov. 2011)

Prescription medication, such as those used to treat pain, attention deficit disorders, and anxiety, are being abused at a rate second only to marijuana among illicit drug users. (NIDA, Nov. 2011)

In 2010, approximately 7 million people (2.7% of the U.S. population) were current users of psychotherapeutic drugs taken non-medically.

→ **5.1 million people used pain relievers**

→ **2.2 million people used tranquilizers**

→ **1.1 million people used stimulants**

→ **.4 million people used sedatives** (NSDUH 2010, Sept. 2011)

According to the 2010 National Survey on Drugs Use and Health, an estimated 2.4 million Americans used prescription drugs non-medically for the first time in the past year. This averages about 6,600 initiates per day, of which one-third are 12 to 17 years of age.

In 2010, about one-fourth (26%) of first time drug users began with non-medical use of prescription drugs. (NSDUH 2010)

In 2010, **one in every 20 people in the United States age 12 and older – a total of 12 million people** – reported using prescription painkillers non-medically. (NSDUH, CDC Press Release, Nov. 2011)

Almost 5,500 people start to misuse prescription painkillers every day. (Pamela Hyde, SAMHSA Administrator, CDC Press Release, Nov. 2011)

Over half a million emergency department visits in 2010 were due to people misusing or abusing prescription painkillers. (Highlights of the 2010 DAWN Findings on Drug-Related Emergency Department Visits, July 2012)

Non-medical use of prescription painkillers costs health insurers up to \$72.5 billion annually in direct health care costs.

How Teens Abuse Medicine



Despite recent reductions in several areas of teen drug use, teens are continuing to use prescription and over-the-counter medications to get high. It's a serious problem that affects all of us.

Many parents don't know enough about this problem, and many teens don't understand the dangers of using the medications to get high.

The latest attitude surveys tell us that:

Nearly one in five teens (17%) say they have used prescription medicine at least once in their lifetime to get high.

More than one in ten teens (12%) report lifetime use of over-the-counter cough or cold medicines to get high.

One out of ten teens (10%) report using pain medications (OxyContin® and Vicodin®) to get high in the past year; six percent say they've used pain medications in the past 30 days to get high.

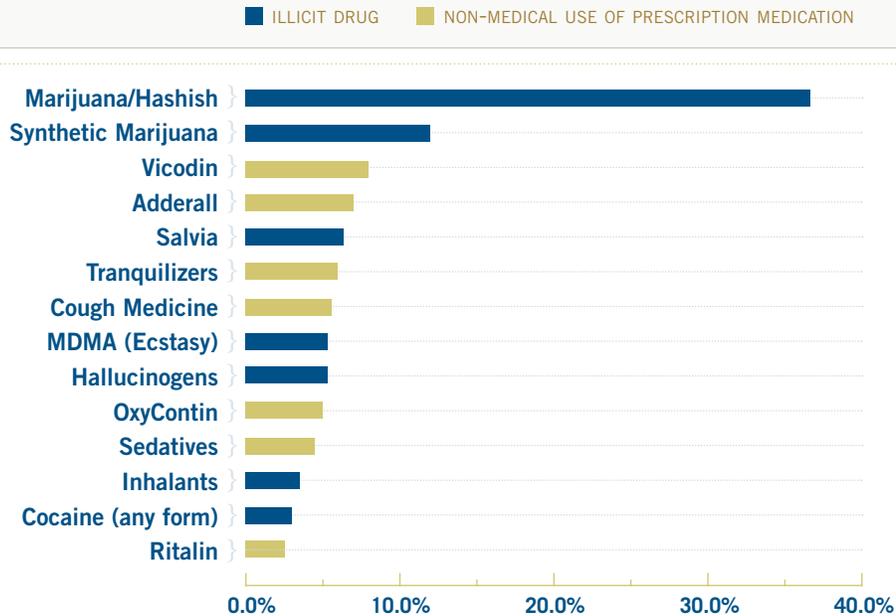
Emergency room visits, as a result of prescription medications, increased by 45% between 2004 and 2010 among children under the age of 20. (Highlights of the 2010 DAWN Findings, July 2012)

Nearly three in five teens (58%) now say that they strongly disapprove of their peers using prescription medication to get high. This is up from 52% in 2010.

Source: Partnership for a Drug Free America, 2011 Partnership Attitude Tracking Survey (PATS)

How Teens Abuse Medicine

Prescription and Over-the-Counter Medications Account for Most of the Commonly Abused Drugs: Past Year Use Among High School Seniors



Categories are not mutually exclusive

Source: University of Michigan, 2011 Monitoring the Future Study

Recent drug surveys also provide evidence that the problem of intentional medicine abuse has grown. Six of the top ten drugs abused by 12th graders are prescription and over-the-counter medications.

After marijuana, prescription and over-the-counter medications account for most of the top illicit drugs abused by 12th graders in the past year.

In 2011, **22% of 12th graders** indicated misuse of a prescription drug without medical supervision in their lifetime; and 15% over the past year.

One in 12 high school seniors reported past year non-medical use of the prescription pain reliever, Vicodin®.

One in 20 high school seniors report abusing OxyContin®.

Additionally, recent drug surveys found that teens generally get their prescription drugs from friends and family; **70% of 12th graders** said they were given the drugs by a friend or relative.

Source: 2011 Monitoring the Future

How Teens Abuse Medicine

In 2010, **three percent of youth 12 to 17** years of age were current medical users of psychotherapeutic drugs.

Of 12 to 13 year olds, two percent were current medical users of psychotherapeutic drugs.

Of 14 to 15 year olds, three percent were current medical users of psychotherapeutic drugs.

Of 16 to 17 year olds, almost four percent were current medical users of psychotherapeutic drugs.

Using prescription drugs to get high is not a problem limited to young teens.

The use of these drugs by college students has increased dramatically within the past decade. According to a 2007 report by the National Center for Addiction and Substance Abuse at Columbia University (CASA), “Wasting the Best and the Brightest: Substance Abuse at America’s Colleges and Universities,” between 1993 and 2005 the proportion of students abusing prescription drugs increased:

343% for opioids like Percocet®, Vicodin®, and OxyContin®

93% for abuse of stimulants like Ritalin® and Adderall®

450% for tranquilizers like Xanax® and Valium®

225% for sedatives like Nembutal® and Seconal®

In 2010, the abuse of prescription medications was highest among young adults aged 18–25 years of age, with 5.9% reporting non-medical use within the past month. *(NSDUH 2010)*

→ **The experts give some reasons why teens might turn to prescription drugs to get high:**

To party,

Self-medication,

Escape and boredom,

Preservation of friendships, romantic relationships, and family life,

Competing for college admission, including competition for advance placement and honors courses in high school,

To balance between schoolwork, grades, and extracurricular activities, like sports and clubs,

Academic stress in college, and

The desire to have the “ideal” physical appearance.

Prescription Drug Basics

A “prescription drug” is a drug that is available only with authorization from a healthcare practitioner to a pharmacist. An “over-the-counter” medication is a drug that is sold without a prescription.

Both kinds of drugs come with explicit instructions on how to use the drug, and these instructions should be followed to avoid adverse consequences. The Food and Drug Administration (FDA) approves all drugs on the market and provides sound advice to consumers.

Source: www.fda.gov

→ Over-The-Counter (OTC)

OTC drug labels contain information about ingredients, uses, warnings, and directions that are important to read and understand. The label also includes important information about possible drug interactions. Further, drug labels may change as new information becomes known. That’s why it’s especially important to read the label every time you use a drug.

→ Drug-Drug Interactions

Drug-drug interactions occur when two or more drugs react with each other. This may cause you to experience an unexpected side effect. For example, mixing a drug you take to help you sleep (a sedative) and a drug you take for allergies (an antihistamine) can slow your reactions and make driving a car or operating machinery dangerous.

→ Drug-Condition Interactions

Drug-condition interactions may occur when an existing medical condition makes certain drugs potentially harmful. For example, if you have high blood pressure, you could experience an unwanted reaction if you take a nasal decongestant.

It is also important to recognize that everyone’s metabolism and brain chemistry are different, and the same drugs can have very different effects on individuals. Experimenting with medicine to get high is extremely dangerous, and mixing drugs to get high can be deadly.

At What Costs?

→ Drug poisonings, emergency room visits, drugged driving

“Overdoses involving prescription pain killers are at epidemic levels and now kill more Americans than heroin and cocaine combined.”

CDC Director Thomas Frieden, MD, MPH, Nov. 1, 2011

Drug Poisonings

In 2009, the 39,147 drug-induced deaths exceeded the number of deaths from motor vehicle crashes (36,216).

The death toll from overdoses of prescription painkillers has more than tripled in the past decade. More than 40 people die every day from overdoses of narcotic pain relievers like hydrocodone (Vicodin®), methadone, oxycodone (OxyContin®), and oxymorphone (Oxpana®). (CDC Vital Signs Press Release, Nov. 2011)

There was a 91% increase in drug poisoning deaths among teens aged 15 – 19 between 2000 (30%) and 2009 (57%) due to prescription drug overdose. (CDC Press Release, April 16, 2012)

Drug induced deaths now outnumber gunshot deaths in America. (ONDCP Strategy)

Mark Bauer's father, Phil Bauer, writes: “A few years ago, my life was changed forever. On May 27, 2004, my youngest son, Mark, was a week away from graduating from high school. Mark’s day went something like this: He woke up and went to school and played in the student/staff basketball game. When he came home from school he lifted weights and ate dinner. He then went to work and returned home at about 9:30 that night. When he got home, Mark talked to us about the game that day, and we knew what a special day it had been for him.

“That was the last conversation we ever had with Mark. . . . He never woke up the next day. On Friday, May 28, 2004, his mom and I found his lifeless body in bed. Mark died from an accidental overdose of prescription drugs, including OxyContin® and morphine.”

a
PARENT'S
story

Emergency Room Visits

Emergency room visits involving misuse or abuse of pharmaceuticals increased 115% between 2004 and 2010, from 626,472 visits to 1,345,645 visits. This compares to about 1,171,024 emergency room visits involving illicit drugs in 2010. During this period, emergency room visits for misuse and abuse of pharmaceuticals for those 20 or younger increased 45%, from 116,176 to 168,409 people.

Of the 2.3 million emergency department visits involving drug misuse or abuse in 2010, 1.3 million visits involved pharmaceuticals.

People 20 years of age or younger accounted for 18.8% of all drug-related emergency department visits in 2010. About half of these visits involved drug misuse or abuse.

About half of emergency department visits (659,969) for misuse or abuse of pharmaceuticals involved pain relievers. Hydrocodone products were responsible for 115,739 visits and oxycodone products for 182,748 visits.

Source: The DAWN Report: Highlights of the 2010 DAWN Findings on Drug-Related Emergency Department Visits, SAMHSA, July 2012

Drugged Driving

Drugged driving is a public health threat and one that we all need to be concerned about, especially where our children are involved. Driving under the influence of any drugs that act on the brain impairs one's motor skills, reaction time, and judgment. This puts not only the driver at risk but also passengers and others who share the road. (NIDA, Drugged Driving)

Teens are the least experienced drivers, which increases their risk of being involved in an accident. When you combine the lack of experience with substances that impair cognitive and motor skills, you increase the chances of tragic results. Vehicle accidents are one of the leading causes of teen deaths.

An analysis of the National Highway Traffic Safety Administration's Fatality Reporting System revealed that almost one in four (23%) of fatally injured drivers who tested positive for drugs were under the age of 25. (ONDCP Press Release, Oct. 2011)

One in three (33%) motor vehicle accidents with known drug test results tested positive for drugs in 2009. (ONDCP Press Release, 2010)

Involvement of drugs in fatal crashes has increased by five percent over the past five years, even though the overall number of drivers killed by motor vehicle crashes has declined. (ONDCP Press Release, Nov. 2010)

Street Drugs vs. Pharmaceuticals

→ and OTC medicines

“Street drugs” is a term that refers to drugs that are commonly known as illegal drugs—cocaine, heroin, methamphetamine, marijuana, and others. Many teens mistakenly believe that pharmaceuticals (prescription drugs) are safer than “street drugs” for a variety of reasons:

- These are medicines.
- They can be obtained from doctors, pharmacies, friends or family members.
- It’s not necessary to buy them from traditional “drug dealers.”
- Information on the effects of these drugs is widely available in package inserts, advertisements, and on the Internet.

Parents and teens need to understand that when over-the-counter and prescribed medications are used to get high, they are every bit as dangerous as “street drugs.” And when prescribed drugs are used by or distributed to individuals without prescriptions, they are every bit as illegal.

{ HOW DOES IT WORK? }

Dr. Nora Volkow, Director of the National Institute on Drug Abuse (NIDA), explains how the legitimately prescribed drug Ritalin® (methylphenidate), when abused, can act in the same way as cocaine:

“For example, the stimulant methylphenidate (Ritalin®) has much in common with cocaine: they bind to similar sites in the brain, and they both increase the brain chemical dopamine through the same molecular targets. And when both drugs are administered intravenously, they cause a rapid and large increase in dopamine, which a person experiences as a rush or high. However, when methylphenidate is taken orally, as prescribed, it elicits a gradual and sustained increase in dopamine, which is not perceived as euphoria and instead produces the expected therapeutic effects seen in many patients.”

Source: Testimony before the House Government Reform Committee, July 26, 2006

Common Drugs of Abuse

Illegal drugs and legitimate medications are categorized according to their medical use, potential for abuse, and their potential for creating physical or psychological dependence.

Dependence means that the body adjusts to allow for them and can't function normally without them. When drugs are used in a manner that is inconsistent with the medical or social patterns of a culture, it is called drug abuse. Addiction is defined as compulsive, drug-seeking behavior where acquiring and using a drug becomes the most important activity in a user's life.

Some pharmaceuticals have the same potential for abuse, dependence, and addiction as heroin. They share many of the same properties and effects as "illegal drugs." It is important for parents to know and understand that using medications outside the scope of sound medical practice is drug abuse.

→ Categories of Drugs

There are five classes of drugs of abuse: **Narcotics, Stimulants, Depressants, Hallucinogens,** and **Anabolic Steroids.**

Within each class are substances that occur naturally and those created in laboratories (synthetics). When they are used appropriately in the practice of medicine, these substances can have very beneficial properties. When used for non-medical purposes, including the desire to get high, these drugs can cause great damage and even death.

→ Dangerous and Addictive

Drugs are placed into five different schedules by DEA according to their medical use and potential for abuse and dependence. Schedule I drugs have no accepted medical use and have not been shown to be safe for people to use. Drugs in Schedules II-V have medical uses and different potentials for abuse.

Within the five classes, individual drugs are ranked according to their abuse potential. When controlled substances are prescribed by a doctor and used according to directions, they can be safe and effective.

"Street drugs" and legitimate medications often have the exact same addictive properties. It is important to remember that people can react to drugs differently, and even drugs that are considered to have a low abuse potential can be addictive and possibly fatal to some users.

narcotics

→ substances that dull the senses and relieve pain

HEROIN, MORPHINE, METHADONE, AND OTHER OPIOIDS

Narcotic Medicines

Used to treat mild to severe pain (anything from dental surgery to terminal cancer). Also used to suppress coughs, treat diarrhea, induce anesthesia, and treat heroin addiction.

Forms

Liquid, tablet, capsule, skinpatch, powder, syrup, lollipop, diskette, suppository, and injectable forms.

Adverse Effects

Euphoria, drowsiness, slowed breathing. Skin, lung, and brain abscesses; endocarditis (inflammation of the lining of the heart); hepatitis; and AIDS are commonly found among narcotics abusers who inject drugs or engage in other risky behaviors.

OD

Slow and shallow breathing, clammy skin, confusion, convulsions, coma, possible death.

Narcotic medications available only with a prescription:

(Note: Lists are not all-inclusive.)

{ codeine cough syrup }

ROBITUSSIN A-C SYRUP® | MYTUSSIN AC COUGH SYRUP®

Cough syrups sometimes include other ingredients such as antihistamines (promethazine).

slang names: Lean, Purple Drank, Sippin Syrup

{ fentanyl }

DURAGESIC PATCH® | ACTIQ LOZENGE®

Fentanyl is a very powerful painkiller, 80 times more powerful than morphine. It is used in combination with other drugs to treat extreme pain. The biological effects of fentanyl are indistinguishable from those of heroin, with the exception that some forms of fentanyl may be hundreds of times more potent. Encounters with fentanyl that are not medically supervised are frequently fatal. This narcotic is most commonly used by wearing or chewing a patch or sucking on a lozenge, but like heroin, it may also be smoked or snorted. A new effervescent tablet, Fentora®, is now available to place between the cheek and gum.

slang names: Tango and Cash, Perc-a-Pop (Actiq®)

{ hydrocodone }

VICODIN® | LORTAB® | LORECET® | HYDROCODONE WITH ACETAMINOPHEN

Hydrocodone products are used for pain relief and cough suppression and produce effects comparable to oral morphine. Hydrocodone products are the most frequently prescribed opioids in the United States, and they are also the most abused narcotic in the United States.

narcotics

{ methadone }

DOLOPHINE® | METHADOSE®

Methadone has been used for years to treat heroin addicts. It is also used as a powerful painkiller. From 1999 to 2004, the Centers for Disease Control and Prevention (CDC) reported that the rate of methadone deaths in younger individuals (15-24) increased 11-fold. For people who are not regular users of methadone, the drug can be dangerous and must be used with a doctor's supervision.

{ oxycodone }

OXYCONTIN® | OXYCODONE WITH ACETAMINOPHEN | PERCODAN® | PERCOCET®

Oxycodone products are very powerful painkillers. Oxycodone is widely used in clinical medicine. It is marketed either alone as controlled release (OxyContin®) and immediate release formulations (OxyIR®, OxyFast®), or in combination with other non-narcotic analgesics such as aspirin (Percodan®) or acetaminophen (Percocet®). Oxycodone's behavioral effects can last up to five hours. The drug is most often administered orally. The controlled-release product, OxyContin®, has a longer duration of action (8-12 hours).

→ **slang names:** Oxycotton, Percs, OC, OX, Oxy, Hillbilly Heroin, Kicker.

Other abused narcotics

{ meperidine } DEMEROL®

{ hydromorphone } DILAUDID®

{ oxycodone with acetaminophen } ENDOCET®

{ codeine } FIORINAL®

{ morphine } ORAMORPH SR®

{ oxycodone with acetaminophen } ROXICET®

{ pentazocine } TALWIN®

{ cough syrup with hydrocodone } TUSSIONEX®

How are narcotics abused?

Oral (swallowing pills or liquid). In the case of fentanyl, Actiq® is sucked; fentanyl patches are worn on the skin, and abusers sometimes scrape off the fentanyl from the patch or chew the patch to get high. Hydrocodone and oxycodone pills are most frequently taken orally but can be crushed and snorted. Crushing the pills negates the time-release features of some medications, so the user experiences the full power and effect all at once. Cough syrups can be drunk or mixed in sodas or sports drinks.

Where would a teen obtain narcotics?

Friends, relatives, medicine cabinets, pharmacies, nursing homes, hospitals, hospices, doctors, Internet. They can also be purchased on the street.

narcotics



{ LORTAB® }



{ OXYCONTIN® }



{ VICODIN® }



{ ACTIQ® }

{ GLOSSARY }

With repeated use of narcotics, tolerance and dependence develop.

Tolerance is a state in which a drug user becomes less sensitive to the drug's effects after repeated use. The user must take more of a drug and take it more often to achieve the same painkilling, sedating, or euphoric effect. Tolerant users can consume doses far in excess of the dose they started with or that an average person could safely tolerate.

Physical Dependence is a state that develops as a result of repeated use of a drug. A dependent person must consume a drug in order to prevent a withdrawal syndrome. This syndrome can range from mild to severely unpleasant and life-threatening depending on the drug and pattern of use.

Psychological Dependence is marked by drug craving, an intense desire to take the drug, which can focus all of the person's thoughts and desires on obtaining and using the drug. While physical dependence will go away in days or weeks after drug use, psychological dependence can continue for years.

substances that stimulate bodily activity
and reverse fatigue (“uppers”)



Stimulant Medicines

Many stimulants have legitimate medical use and are scheduled by the DEA. Caffeine and nicotine are stimulants that are not controlled. Stimulant medicines are used to treat obesity, attention deficit and hyperactivity disorders (ADHD/ADD), and narcolepsy. Pseudoephedrine, found in allergy and cold medications to relieve sinus congestion and pressure, is also a stimulant chemical. Cocaine and methamphetamine have a currently accepted medical use in treatment. Crack cocaine and khat have no legitimate medical uses.

Forms

Powder, “rocks,” “crystal,” pills, and smokable and injectable forms.

Adverse Effects

Alertness, excitation, euphoria, increase in blood pressure and pulse rates, insomnia, loss of appetite. Abuse is often associated with a pattern of binge use—sporadically consuming large doses of stimulants over a short period of time. Heavy users may inject themselves every few hours, continuing until they have depleted their drug supply or reached a point of delirium, psychosis, and physical exhaustion. During this period of heavy use, all other interests become secondary to recreating the initial euphoric rush. Because accidental death is partially due to the effects of stimulants on the body’s cardiovascular and temperature-regulating systems, physical exertion increases the hazards of stimulant use.

OD

Agitation, increased body temperature, hallucinations, convulsions, possible death.

Stimulant medications available only with a prescription:

(Note: Methamphetamine and cocaine have limited legitimate medical uses. Lists are not all-inclusive.)

{ amphetamines }

ADDERALL® | DEXEDRINE® | DESOXYN® (methamphetamine)

Amphetamines are used to treat ADHD/ADD.

slang names: Ice, Crank, Speed, Bennies, Black Beauties, Uppers

{ methylphenidate and dexamethylphenidate }

CONCERTA® | RITALIN® | FOCALIN® | FOCALIN XR®

These drugs are used to treat ADHD/ADD.

slang names: Pellets, R-Ball, Skippy, Vitamin R, Illys

→ Other abused stimulants

{ phentermine } ADIPEX® | IONAMIN®

{ benzphetamine } DIDREX®

{ phendimetrazine } PRELU-2®

These drugs are used in weight control.

stimulants

How are stimulants abused?

Oral (swallowing pill forms of stimulants), smoked (crack, methamphetamine), crushed and snorted, injected.

Where would a teen obtain stimulants?

Friends, relatives, doctors, pharmacies, schools, medicine cabinets, Internet, street dealers.



{ RITALIN® }



{ ADIPEX® }

{ PROVIGIL® }



{ DEXEDRINE® }



{ FOCALIN® }

{ FOCALIN XR® }

depressants → and reduce anxiety (“downers”)



Depressant Medicines

Used to treat anxiety, insomnia, seizure disorders, and narcolepsy. Also used to relax muscles and to sedate.

Forms

Mainly pills and liquids. GHB is often found in liquid form.

Adverse Effects

Slurred speech, disorientation, drunken behavior without the odor of alcohol, impaired memory, vivid and disturbing dreams, amnesia.

OD

Shallow respiration, clammy skin, dilated pupils, weak and rapid pulse, coma, possible death.

Depressant medications available only with a prescription:

(Note: Lists are not all-inclusive)

{ benzodiazepines }

VALIUM® | XANAX® | HALCION® | ATIVAN® | KLONOPIN®

Benzodiazepines are used as sedatives, hypnotics, anti-convulsants, muscle relaxants, and to treat anxiety. Many times they are abused in combination with other drugs or to counteract the effects of other drugs.

slang names: **Downers, Benzos**

{ sleeping pills }

AMBIEN® | SONATA®

These depressants are used to treat insomnia.

→ Other abused depressants

{ **chloral hydrate** } SOMNATE®

{ **barbiturates**, such as amo-, seco- and pentobarbital }

{ **GHB** } XYREM®

{ **carisoprodol** } SOMA®

{ **ketamine** } KETALAR®, KETACET®

Please note that even though ketamine is a depressant, it is abused by kids for its psychedelic effects.

depressants

How are depressants abused?

Oral (swallowing pills).

Where would a teen obtain depressants?

Friends, relatives, medicine cabinet, doctors, hospitals, Internet, street dealers.

Jason Surks was 19 and in his second year of college, studying to be a pharmacist, when he died of an overdose of depressant pills. After his death, his parents discovered that he had been ordering controlled substances from an Internet pharmacy in Mexico. His mother, Linda, writes: “I thought to myself that this couldn’t be possible. I work in prevention, and Jason knew the dangers—we talked about it often. I think back to the last several months of my son’s life, trying to identify any signs I might have missed.

a
PARENT’S
story }

“I remember that during his first year in college, I discovered an unlabeled pill bottle in his room. I took the pills to my computer and identified them as a generic form of Ritalin. When I confronted Jason, he told me he got them from a friend who’d been prescribed the medication. He wanted to see if they would help him with his problem focusing in school. I took that opportunity to educate him on the dangers of abusing prescription drugs and told him that if he really thought he had ADD (Attention Deficit Disorder), we should pursue this with a clinician. He promised he would stop using the drug. But as a pre-pharmacy major, maybe he felt he knew more about these substances than he actually did and had a ‘professional curiosity’ about them.”

Source: As recounted on www.drugfree.org/memorials.



{ ATIVAN® }



{ RESTORIL® }



{ XANAX® }



{ XANAX XR® }



{ VALIUM® }



{ KLONOPIN® }

anabolic steroids →



Anabolic Steroids

Synthetically produced variants of the naturally occurring male hormone testosterone are used to promote muscle growth, enhance performance, or improve physical appearance. Prescribed by doctors for loss of testicle function, breast cancer, low red blood cell count, hypogonadism, delayed puberty, and debilitated states resulting from surgery or sickness (cancer and AIDS). Administered to animals by veterinarians to promote feed efficiency, improve weight gain, and treat anemia and tissue breakdown during illness or trauma.

Forms

Tablets, sublingual tablets, liquid drops, gels, transdermal patch, subdermal implant pellets, water-based injectable solutions, oil-based injectable solutions.

Adverse Effects

Males: In adults, shrinking of testicles, reduced sperm count, infertility, development of breasts, acne, fluid retention, increased risk of prostate cancer. In boys, early sexual development, acne, and stunted growth.

Females: Acne, oily skin, deepening of voice, increased body and facial hair, menstrual irregularities, fluid retention. Also, in girls, stunted growth.

Both: Harm to heart, liver dysfunction, liver tumors, liver cancer, increased blood pressure, increased LDL cholesterol, enlargement of the heart, heart attacks, stroke, hepatitis, HIV, anger, hostility, male pattern baldness.

Upon discontinuation: Prolonged periods of depression, restlessness, insomnia, loss of appetite, decreased sex drive, headaches, irritability.

Steroids available only with a prescription:

(Note: Lists are not all-inclusive)

{ anabolic steroids }

ANADROL® | ANDRO® | DECA-DURABOLIN® | DEPO-TESTOSTERONE® | DIANOBO®
DURABOLIN® | EQUIPOISE® | OXANDRIN® | THG® | WINSTROL®

There are over 100 different types of anabolic steroids.

slang names: Arnolds, Gym Candy, Pumpers, Roids, Stackers, Weight Trainers, Gear Juice

How are steroids abused?

Steroids are taken orally, injected, taken under the tongue, or applied with topical creams that allow steroids to enter the bloodstream. There are different regimens for taking steroids to increase body mass; they are widely published and available on the Internet.

Where would a teen obtain steroids?

Friends, gyms, school, teammates, coaches, trainers, Internet.

anabolic steroids

THREE PARENTS' STORIES

These three young men were athletes who sought ways to enhance their performance. Each of them turned to steroids, and each of them suffered the depression that comes when steroids are stopped.



{ DEPO-TESTOSTERONE® }

{ TAYLOR HOOTON }

Died at age 17. It took a while for his parents to connect Taylor's recent weight and muscle increases with his uncharacteristic mood swings and violent, angry behavior. He'd been using a cocktail of steroids and other hormones to bulk up, and the drugs were wreaking havoc on his body and emotions.... Taylor went to his room and hanged himself. It was only after his death that the whole picture came into focus.

{ ROB GARIBALDI }

Died at age 24. When supplements and workouts did not produce the desired results, Rob turned to steroids. According to Rob, he first obtained steroids from his trainer at the University of Southern California, whose name Rob never divulged. With a wink and a nod, they kept his use a secret. The desire and need to look bigger, be stronger, and avoid losing muscle gains already achieved prompted him to continue steroid use. Over time, Rob gained 50 pounds and became the powerhouse the steroids promised.... Drinking alcohol or taking any other drug, including prescription medication, compounds the adverse effects of steroids. The most dangerous effect of steroids is suicide. His parents said: "We know, without a doubt, steroids killed our son."

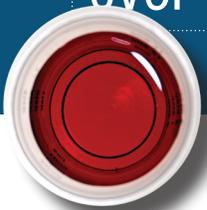
{ EFRAIN MARRERO }

Died at age 19. Efrain had been secretly using steroids to prepare for football season. He had been a standout offensive lineman in high school and was now playing at the junior college level. However, he decided he wanted to move from the offensive line to more of a "glory" position at middle linebacker. Any football fan seeing Efrain would recognize the significant physical transformation it would take for him to make that happen. As his parents tell it, "Efrain began using steroids, under the impression that it would make him bigger, stronger, faster, and earn him the title and recognition he so much desired." Unaware of the serious side effects of steroids, Efrain began to experience severe paranoia and deep depression. Frightened, he turned to his parents for help, who took him to the family doctor. The doctor assured them that the steroids would leave Efrain's system soon and that no further action was required. No one knew that quitting steroids cold turkey was unwise; the physician failed to provide an appropriate course of action. Three weeks later, Efrain shot himself in the head.

over-the-counter

→ medications with DXM (hallucinogen)

ROBITUSSIN®, CORICIDIN HBP®, NYQUIL®



OTC Medicines with DXM

There are well over 100 medicines that contain dextromethorphan (DXM), either as the only active ingredient or in combination with other active ingredients.

These medications (store brands as well as brand names) can be purchased over-the-counter in pharmacies, some grocery stores, and some other outlets.

Forms

Liquid, gelcaps, pills, powder.

Adverse Effects

High doses produce confusion, dizziness, double or blurred vision, slurred speech, loss of physical coordination, abdominal pain, nausea and vomiting, rapid heart beat, drowsiness, numbness of fingers and toes, and disorientation. DXM abusers describe different “plateaus” ranging from mild distortions of color and sound to visual hallucinations, “out-of-body” dissociative sensations, and loss of motor control. *(Note: Many OTC products listing DXM as an active ingredient may also contain antihistamines, acetaminophen, or other substances, which have other side effects.)*

OD

Unable to move, feel pain, or remember.

→ How are OTCs with DXM abused?

Cough syrup is drunk either alone or in combination with soft drinks or alcohol. Gelcaps and pills are swallowed or crushed and put into drinks.

Where would a teen obtain OTCs with DXM?

Friends, relatives, pharmacies, grocery stores, medicine cabinets. DXM is also available over the Internet.

There is little in current teen culture—music, movies, fashion, and entertainment—that promotes or even mentions cough medicine abuse. The one exception is the Internet. A number of disreputable websites promote the abuse of cough medicines containing dextromethorphan. The information on these sites includes recommending how much to take, suggesting other drugs to combine with DXM, instructing how to extract DXM from cough medicines, promoting drug abuse in general, and even selling a powder form of dextromethorphan for snorting. You should be aware of what your teen is doing on the Internet, the websites he or she visits, and the amount of the time he or she is logged on.

Source: Partnership for a Drug-Free America, “What Every Parent Needs to Know About Cough Medicine Abuse,” www.drugfree.org.

{ TRENDS

The Internet, Drugs, and Teens

RECOGNIZE THE SIGNS

Many teens obtain illegal drugs, particularly prescription drugs, from their families, friends, or relatives. Since prescription drugs are widely available in the home, teens often do not have to go far to find ways to get high. Other teens turn to the Internet for prescription drugs, and the world wide web plays a big role in providing information and advice to teens.

HERE ARE A FEW THINGS TO CONSIDER }

Your teen probably knows a lot more about the Internet than you do. It's never too late for parents to jump in and get acquainted with various websites, communication methods, networking systems, and the lingo teens use to fly under parents' radars.

{ ASHLEY DUFFY }

Ashley Duffy, 18, knew her parents wouldn't tap into her online journal, so she wrote freely about her drug use. She says she used the Internet to contact her dealer and connect at parties with people who had drugs.

"Kids are really open about it. I see posts from other people describing a night on acid or whatever," says Duffy of West Chester, Pennsylvania, who underwent treatment and says she has been drug-free for 16 months. "I think they think their parents are clueless. And I guess they are."

Source: USA Today, "Teens use Internet to Share Drug Stories" by Donna Leinwand, June 19, 2007

Some pharmacies operating on the Internet are legal, and some are not. Some of the legal Internet pharmacies have voluntarily sought certification as "Verified Internet Pharmacy Practice Sites" (VIPPS®) from the National Association of Boards of Pharmacies. "Rogue" pharmacies pretend to be authentic by operating websites that advertise powerful drugs without a prescription or with the "approval" of a "doctor" working for the drug trafficking network. Teens have access to these websites and are exposed to offers of prescription drugs through email spam or pop-ups. Parents should be aware of which sites their teens are visiting and should examine credit card and bank statements that may indicate drug purchases.

The Internet, Drugs, and Teens

{ RYAN HAIGHT }

Francine Haight, Ryan's mother, shares her son's story with the world: "Ryan Thomas Haight overdosed and died on February 12, 2001, on narcotics (Vicodin®) that he had easily purchased on the Internet. A medical doctor on the Internet that he never saw prescribed them, an Internet pharmacy mailed them to his home. He was only 17 when he purchased them; he was only 18 when he died.

"It is too easy to meet and chat with strangers on Internet websites that glorify the use of drugs and who can easily talk our children into experimenting. These websites encourage our children to take drugs and share their highs, which is extremely dangerous and can lead to death," Francine Haight said.

Source: USA Today, "Teens use Internet to Share Drug Stories" by Donna Leinwand, June 19, 2007

Through the efforts of Francine Haight and members of Congress, with support of DEA, the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 was enacted in October 2008. The act focuses on removal from the web and prosecution of unscrupulous or rogue internet pharmacies that exist to profit from the sale of controlled prescription medicines to buyers who have not seen a doctor and don't have a prescription from a registered physician. These pharmacies lack quality assurance and accountability, and their products pose a danger to buyers. This law makes it harder for cybercriminals to supply controlled substances and easier for DEA to prosecute them, and has resulted in the reduction of these online pharmacies.

Teens sometimes brag about their drugging and drinking on social networking sites such as Facebook, Twitter, and YouTube. Their behavior is out there in the open for future employers, college admissions offices, and others to see.

The Internet is a tremendous resource for teens to learn about the dangers of drug abuse. However, it is also full of information about how to use prescription drugs to get high—how much to use, what combinations work best, and what a user can expect to experience.

"Teens who spend more time on social networking sites are more likely to smoke, drink, and use drugs."

The survey of 12 to 17 year olds found that 70% spent time on social networking sites. Of the 70%, 40% have seen pictures on the sites of teens getting drunk, passed out, or using drugs. Half of these teens saw these pictures when they were 13 years of age or younger; 90% first saw them when they were 15 or younger.

The Internet, Drugs, and Teens

Compared to teens that have never seen pictures of kids getting drunk, passed out, or using drugs on social networking sites, teens that have seen these images are much likelier to have friends and classmates who abuse illegal and prescription drugs.

Compared to teens that do not watch suggestive teen programming, teens that watch one or more shows are more than one- and-a-half times likelier to try to get prescription drugs without a prescription within a day or less.

Source: CASA, National Survey XVI

There are thousands of websites dedicated to the proposition that drug use is a rite of passage. So-called experts are more than happy to walk your kids through a drug experience.

DON'T LET THEM.



“Enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for a month. Although most of these pills were prescribed for medical purposes, many ended up in the hands of people who misused or abused them.” (CDC Vital Signs, Nov. 2011)

We know that 70% of youth get their prescription drugs from family and friends, yet fewer parents report safeguarding prescription medications. “Anyone can access prescription medicines in the medicine cabinet” went from 50% in 2010 to 64% in 2011, meaning medications are available to anyone in their homes.

Slightly over two-thirds of parents of ninth through twelfth graders say they have ever had a discussion with their children about prescription medicine to get high. This is down from 82% in 2009.

Teens that report learning a lot from their parents about the risks of drugs are half as likely as those who learn nothing from their parents to have ever used prescription medicines to get high, but only 16% say they have discussed prescription medicine with their parents in the past year.

Take the time to talk to your children about prescription medications and over-the-counter drugs. Let them know that just because a doctor has prescribed it or you can buy it in the store does not mean it is safe for them to use. Just because it’s not bought from a drug dealer does not mean it’s safer. Just because you use it does not mean that it is safe for them to use.

Set an example. If your children see you taking drugs make sure they know what you are taking and why. Kids are smart, and they will know if you are abusing drugs. They watch and often emulate their parents.

Studies have also revealed that parents are increasingly misusing or abusing prescription medications themselves. Nearly one in five parents (18%) reports using a prescription medicine that was not prescribed to them three or more times in their lifetime. Fifteen percent of parents say they’ve used a prescription medicine not prescribed to them at least once in the past year, a 25% increase from 2010. More frequent past-year misuse of prescription medicines (three or more times) is up 50% from 2010 (5%) to 2011 (10%).

Source: PATS 2011

Keeping prescription drugs out of the hands of teens is important, and there are things you can do:

Get information about prescription drug medications abused by teens.

Learn what the medication is used for, what it looks like, its effects and interactions, and how teens are using it.

Understand the power and danger of these medications. Many drugs, particularly narcotic painkillers (opioid medications), are extremely powerful and are designed to relieve extreme pain. New medications are continually being approved for medical use, and it is important to be informed about the drugs' uses and properties.

Ask your teens what they are experiencing at school, at friends' homes, and at parties. Share with them what you have learned about the dangers of abusing prescription drugs.

Ask your doctor and pharmacist about the medications you are being prescribed. Ask about their side effects and potential addictiveness. Ask which category the drug is: Narcotic, stimulant, depressant, steroid?

Review what is in your medicine cabinet. Keep powerful medications in a safe place, not in the family medicine or kitchen cabinet, under lock if necessary. Count your pills when you receive them, and periodically check to see how many are in the container.

Read the labels. A drug label includes important information about a prescription drug. Many generic prescriptions are substituted for brand name drugs, and it may be easy to overlook the fact that the doctor has prescribed a very powerful narcotic painkiller, for example.

Different pharmaceutical companies produce many products that have the same basic ingredients. Usually, the generic name of the drug is printed in addition to the brand name, making it clearer that the customer is receiving ibuprofen/oxycodone HCL, for instance.

What You Can Do

Report Suspicious Internet Pharmacies

If you or your teen is aware of someone distributing prescription drugs or selling them on a suspicious internet pharmacy site, please call the DEA hotline. Callers will be able to make confidential reports by dialing toll free 1-877-RxAbuse (1-877-792-2873) around the clock, 365 days per year. The hotline is staffed by bilingual operators employed by DEA. This is a toll-free call from Mexico as well. During normal business hours, the caller will be connected directly to someone at the responsible DEA Domestic Field Office. After-hours tips will be forwarded by an internal, secure email system for further investigation and follow-up by DEA Special Agents and Diversion Investigators.

Medicine Take-Back Programs

Medicine Take-Back programs are an excellent way to remove expired, unwanted, or unused medicines from your home, and reduces the chances that others may accidentally or intentionally take the medicine.

In an effort to further address the abuse and misuse of unused controlled substances in households throughout the country, DEA, working with state and local law enforcement agencies, implemented the National Take-Back Initiative. The purpose of the initiative is to provide a venue for people who want to dispose of unwanted and unused prescription drugs, particularly controlled substances from our nation's medicine cabinets.

The first National Take-Back Day, September 25, 2010, citizens turned in over 121 tons of pills. Due to the success of this initiative, three more Take-Back days have been held. In total, over 774 tons of medication has now been removed from circulation.

In September, right after the first Take-Back Day Initiative, Congress passed the Secure and Responsible Drug Disposal Act of 2010, which amends the Controlled Substances Act to allow an “ultimate user” of controlled substance medications to dispose of them by delivering them to entities authorized by the Attorney General to accept them. This act also allows the Attorney General to authorize long term care facilities to dispose of their residents' controlled substances in certain instances. DEA is in the process of drafting regulations to implement the Act.

While a uniform system for prescription drug disposal is being finalized, DEA will continue to sponsor Take-Back opportunities in coordination with state and local organizations, as a service to our communities.

Additional information on the safe disposal of medications can be found on the U.S. Food and Drug Administration's website at www.fda.gov/Drugs/ResourcesForYou/Consumers.

DEA's Role



DEA plays a critical role in preventing prescription drug abuse.

DEA investigates physicians who sell prescriptions to drug dealers or abusers; pharmacists who falsify records and subsequently sell the drugs; employees who steal from inventory; executives who falsify orders to cover illicit sales; prescription forgers; and individuals who commit armed robbery of pharmacies and drug distributors.

DEA investigates unscrupulous Internet pharmacies. Rogue pharmacies exist to profit from the sale of controlled prescription medications to buyers who have not seen a doctor and don't have a prescription from a registered physician. The pharmacies lack quality assurance and accountability, and their products pose a danger to buyers.

DEA works with state, local, and foreign partners to interdict controlled substances and precursor chemicals.

DEA's authority to enforce laws and regulations comes from the Controlled Substances Act, Title 21 of the United States Code. DEA also provides objective and timely information to the public about the dangers of drugs through publications, websites and presentations.

ADDITIONAL RESOURCES



Community Anti-Drug Coalitions of America (CADCA), the Consumer Healthcare Products Association (CHPA), D.A.R.E., and the Partnership at DrugFree provide information on over-the-counter cough medicines at www.StopMedicineAbuse.org.

Drug Abuse Resistance Education (D.A.R.E.) provides an information kit and curricula on helping communities respond to Rx and OTC abuse at www.dare.com/home/features/RX.asp.

Drug Enforcement Administration (DEA) www.dea.gov

DEA's Office of Diversion Control www.deadiversion.usdoj.gov

DEA's teen website www.OnlyThinkTwice.com

DEA's parent website www.GetSmartAboutDrugs.com

Institute for Behavior and Health, Inc. provides information on drugged driving at www.stopdruggeddriving.org.

National Institute on Drug Abuse (NIDA) provides information on prescription and over-the-counter drugs at www.nida.nih.gov.

NIDA's teen website on prescription and over-the-counter drugs
www.teens.drugabuse.gov/peerx/

National Institute of Mental Health's Library of Medicine www.medlineplus.gov

Spanish version www.medlineplus.gov/Spanish

Office of National Drug Control Policy (ONDCP) www.whitehouse.gov/ondcp/

ONDCP's teen website www.abovetheinfluence.com

ONDCP's parent website www.theantidrug.com

Partnership at Drug Free provides information for parents on teen prescription drug abuse at www.drugfree.org.



GUIDE TO RESPONSIBLE FAMILY DRUG AND ALCOHOL TESTING

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THINKING ABOUT DRUG, ALCOHOL AND TOBACCO USE

This Guide is written to help families understand why a no-use drug and alcohol prevention standard that includes drug testing can be an important part of building a successful, happy family -- and future for your child.

All children, including teenagers, need actively involved, caring parents who set clear drug-free standards. Parents are most likely to succeed when their parental authority is unmistakably based on love and a commitment to the welfare of the children in the family, including a willingness to accept and even to celebrate the uniqueness of each child.

Families function best, and kids do best in their own lives, when the children grow up alcohol- and drug-free. *Children become adults and determine the rules governing their behaviors for themselves when they leave their parents' home AND FINANCIALLY SUPPORT THEMSELVES.* Until children are on their own and paying for their own way in life, it is important for parents to be engaged directly with behaviors that have a potential for harming their children, such as alcohol, drug and tobacco use, regardless of the child's age.

Drug and alcohol testing is routine in the workplace, and is used with increasing frequency in schools. Tobacco testing is widely used in healthcare settings by insurance companies when establishing premiums and increasingly in wellness or other health promotion programs that require "good health" verification and longevity determination. Family drug and alcohol testing prepares young people for the inevitable tests they will face when they leave school and seek employment, or when they are required to be drug tested as a part of school based athletics or other extra-curricular programs.

Establishing a family policy about children's use of alcohol, drugs of abuse and nicotine is the key to a successful family drug and alcohol testing process.

Drug and alcohol tests used wisely as part of a family drug and alcohol abuse prevention policy require careful thought about how parents and children relate to each other and about how drug and alcohol abuse develops among young people. Many families raising drug-free children are rooted in strong religious or moral values. In all

families substance abuse prevention is based on a commitment to healthy living and the stewardship of the children's precious opportunities to grow, learn and to serve the needs of others.

The establishment of a family contract in which every child in the family agrees, in writing, to refrain from the use of drugs and alcohol, and agrees to specific rewards for abiding by the policy and specific penalties for violating the policy, **and**, the parents, in writing, agree to enforce the policy fairly and reasonably *is the vital first step*. A sample family contract is provided on page 13. You can use this model as it is or use it to develop one of your own. What is important is that everyone in your family understands your family's rules when it comes to alcohol and other drug use.

An important part of your family drug and alcohol abuse prevention policy is to establish clear rewards for adhering to the alcohol- and drug-free standard and establish equally clear punishments for positive test results or other evidence of recent drug or alcohol use. Permission to spend the night at a friend's home, use of the family car, attendance at sporting or other recreational events, priority use of the family television set, or other benefits can be made contingent on negative drug tests which indicate freedom from recent drug, alcohol or tobacco use.

The consequences of a positive test for illegal drugs, alcohol, or tobacco should be prompt, certain, and unpleasant in order to deter drug and alcohol use. For some families, withholding the use of a car for 30 days is sufficient punishment for a positive drug or alcohol test, while other families will establish different consequences such as the young person's payment of a fine (to be sent to a designated charity, for example), withdrawal of participation in extracurricular activities, or grounding from social activities for a specific period of time. Another important option for responding to a positive drug or alcohol test is to get an evaluation and recommendations from a drug rehabilitation counselor or other mental health professional who has expertise in substance abuse.

There are no legal barriers to families instituting drug and alcohol testing. Parents not only have the right to know about the drug and alcohol use of their children, but they have a responsibility to know and to act forcefully to prevent and stop this use.

Use of marijuana, Ecstasy, Spice, and other nonmedical use of prescription drugs, such as OxyContin without a prescription for the user, is always illegal, regardless of age. For children under the age of 18 any use of tobacco is illegal. Twenty-one is the legal age for alcohol use. Not only is use of these substances by youth illegal, it is unwise, unhealthy and often a source of failure at school and in life. If you have questions or concerns about your particular problems when it comes to using tests, you should talk with a local addiction specialist before you start to test for drug or alcohol use. At the end of this report you will find a list of resources including how to find an addiction specialist.

Parents who have alcohol problems, or who use illicit drugs, are urged to seek and make use of treatment for their own sakes and for the welfare of their children.

Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are particularly recommended. Al-Anon is the 12-step program for family members who have to deal with another family member's drug and alcohol problems. These fellowships offer support and guidance for youth and adults and provide a consumer's perspective on local providers including treatment programs and counselors.

What Tests are Available for Alcohol, Drugs of Abuse, and Tobacco?

When people use alcohol it quickly finds its way into the bloodstream through absorption from the stomach and the intestines. The rapid circulation of the blood carries the alcohol to all parts of the body where it is absorbed into tissue including the lungs.

Alcohol tests usually are by breath analysis, though blood, saliva, and urine can also be tested. Breath drawn from blood vessels in the lungs (alveolar breath) contains alcohol in a consistent relation to the amount of alcohol in the blood at the time the sample of breath is taken. The breath alcohol test measures the presence of alcohol in the breath and reports it as the blood alcohol content (BAC) equivalent. Alcohol leaves the body rapidly at a predictable rate. There is nothing that one can do to speed up this rate of alcohol elimination. Therefore, a positive alcohol test indicates that a person who tests positive for alcohol has consumed alcohol within the few hours immediately preceding the alcohol test.

When people use drugs including tobacco, they are found in all parts of the body. The drugs (and their breakdown products called metabolites) are excreted in urine, laid down in the growing hair, and found in sweat and oral fluids (saliva).

The most commonly used drug test is a urine test. Hair tests are also widely used and increasingly sweat patches and oral swabs are used to detect drug use. The chemical tests used for each type of sample are the same beginning with an immunoassay screening test and going to a more sophisticated confirming test, when confirming tests are needed.

Most workplace and school-based drug testing use urine samples although saliva tests are increasingly common. Drugs are usually found in urine for 1 to 3 days after the most recent drug use. Marijuana can be detected for longer periods for people who smoke every day for weeks at a time but urine tests are usually negative for marijuana metabolites after a day or two after use for people who smoke marijuana only occasionally.

A standard hair sample is one and a half inches long. Since hair grows about one half inch each month, this length of hair has information about drug use over the prior 90 days. Sweat is tested by applying a patch to the skin. Drug use is detected over the period the patch is worn, usually 1 to 3 weeks. Oral fluids are tested by taking a swab from a person's mouth. They generally detect drug use within the past 10 to 24 hours.

What Are the Advantages and Disadvantages of Each Type of Test?

Testing for Alcohol

Breath tests for alcohol are easy to use and are less invasive, less troublesome, and less expensive than blood tests. Both provide accurate results. A urine test can determine recent presence of alcohol, but requires a series of voids to determine a level of impairment. As we note below, urine testing is subject to cheating on a much greater basis than any other type of alcohol or drugs of abuse test.

Alcohol can be tested in oral fluids but is not tested for in hair or sweat patches. Alcohol can be detected in continuous monitoring devices commonly worn as bracelets, often on ankles. Since alcohol is rapidly metabolized, when breath and oral fluids are tested the alcohol will be identified only for a few hours after the alcohol use has stopped. Urine, like oral fluids and breath, is in balance with the blood. However, because urine is collected internally for a few hours before voiding, it will be positive for a few hours longer after drinking stops than are breath and oral fluids. Many urine tests do not detect alcohol. There are inexpensive alcohol breath tests available for spot checks of alcohol use in the few hours prior to testing. These tests cost between \$3.00 and \$5.00 each. Oral fluid alcohol tests cost about \$8.00.

Testing for Drugs of Abuse

Urine is the most widely available test and generally least expensive when testing for drugs of abuse. There are home testing kits that can provide immediate screening results. They usually require that a small amount of the collected urine be placed in a reservoir and as the urine moves through the testing strips, results appear. Urine has to be collected in a bathroom and is subject to cheating since drug users – including teenagers – are often clever at substituting someone else's urine or adulterating their samples unless the collection is directly and carefully observed. To prevent this in family testing, it is usually wise to directly observe the urine leaving the tested person's body and going into the test cup to reduce cheating. The tested person should also be observed from the moment he or she is informed that a urine test will be taken to prevent the consumption of products designed to foil the test. Attempts to adulterate (beat the test) can be reduced by using a testing cup that checks for adulterants built into the device.

Hair samples require that a small amount of hair be cut from the back, above the ear, and top of the head and sent to the laboratory. The hair must be cut close to the scalp with the inch and a half closest to the scalp typically analyzed to identify drug use in the prior 90 days. Hair tests are less widely available than either urine or oral fluids and they are substantially more expensive (about \$60 per test compared to about \$15 for a urine test). Hair tests will not identify drug use within the most recent 7 to 10 days because that is the time it takes for new hair to appear that would contain the drug metabolite.

Hair samples are especially resistant to cheating. However, hair tests are not sensitive to occasional marijuana use. In general it requires marijuana use about twice a week for 90 days to produce a positive hair test for marijuana. In contrast to its insensitivity to marijuana, hair tests are very sensitive to the other drugs tested and can detect them after a few uses over the course of the 90 days the typical hair sample covers.

Oral fluid (saliva) testing requires a brief swab of the tested person's mouth. It requires no special training to take the swab and it is much less invasive than a urine test. It is also very difficult to cheat during an oral-fluid collection. However, the marijuana detection window is from ingestion to a maximum of 24 hrs after drug use. On-site oral fluids tests, like hair tests, are relatively insensitive to marijuana use. Oral fluid drug tests for home use that provide an immediate screening result cost less than \$20.00

Sweat patches are not available to families now but may be in the future. They can be used by physicians. They are resistant to cheating and cover longer periods of time than urine tests but not as long as hair.

Testing for Nicotine

Nicotine use is easily detected in urine, hair and sweat but commercially available tests seldom test for it using, hair or sweat. Home nicotine tests, which provide an immediate screening result using urine, cost less than \$5.00. Saliva tests for nicotine are now available in the \$10 range.

WHEN TO TEST?

A responsible family testing program should include both unannounced and event related testing. We recommend that unannounced testing occur at least four times a year. This frequency will provide enough testing to be a real deterrent, as well as provide the child with a believable explanation to peers for not using alcohol, drugs, or tobacco.

In addition, the family should establish event-oriented testing. For example, a testing *possibility* could always occur after a certain event, such as going out on Saturday night or after a party. A model that has been successfully used in these instances is to have the child roll a die. If a certain number comes up, then the child will be tested. If not, then there is no test – but the deterrent effect is reinforced. Another example would be to require a drug and alcohol test if the child violates a curfew. There are many other possibilities for event testing and families should agree on one or more that they think will provide a real deterrent without overburdening the child or the parents. Parents should also reserve the right to test children any time that the parents are concerned about possible use of alcohol, tobacco and other drugs.

Testing should always occur if the child smells of alcohol or tobacco, if his or her clothes smell smoky or musty, or the child is clearly behaving in an abnormal manner.

A “Family of Tests” Approach

Families should consider using testing methods that best support the specific reason for testing. For example, a family may want to use hair testing once or twice a year to reconfirm negative drug use and to provide the children with a persuasive excuse for not using when approached to do so by peers and others. An oral fluids test for breaking curfew or after a party is easily administered and not burdensome.

Nicotine and alcohol tests could be immediately available if there are any signs of recent use due to odor or behavior. Whichever approach a family takes, ensure that it truly supports the family policy of deterrence without becoming complicated or burdensome.

A Comparison of Home Testing Methods

Method	Normal Window of Detection	Ease of Collection	Limitations	Approximate Cost at Publication	Comments
Drug urine Test	1-3 days since last use	Need privacy & awkwardness or urine collection	Vulnerable to cheating without observed collection	\$12.00- \$15.00 for 5 drugs	Additional drug assays (e.g. barbiturates, benzodiazepines, Ecstasy, Oxycotone, Oxycodone more available)
Drug hair test	10-90 days since last use	Moderately easy; hard to cheat	Must be sent to laboratory; less sensitive to intermittent marijuana use	\$60.00 - \$65.00 for 6 drugs	Includes Ecstasy
Drug oral fluids (saliva) test	Up to 10 to 24 hours since last use	Very easy; hard to cheat	Less sensitive to all marijuana use	\$16.00	
Alcohol breath test	0-4 hours after last use	Very easy; hard to cheat	Not useful if used more than 6 hours after last use	\$4.00	
Alcohol oral fluids (saliva) test	0-4 hours after last use	Very easy; hard to cheat	Not useful if used more than 6 hours after last use	\$8.00	
Nicotine urine test	1-3 days since last use	Need privacy & awkwardness of urine collection	Vulnerable to cheating without observed collection	\$4.00 - \$5.00	
Nicotine saliva test	1-3 days since last use	Moderately easy to use, hard to cheat	Rapid result, can be sent to lab for confirmation	\$7.00 - \$13.00 plus cost of confirmation- \$25	

QUESTIONS AND ANSWERS

Here are answers to the most frequently asked questions about family-based drug, alcohol or nicotine testing.

Question:

How do I answer the charge that testing violates the basic trust which families establish between parents and children, especially if the test result is negative?

Answer:

Trust is one of the first casualties of alcohol and other drug use. **Lying, even by previously honest young people, is universal once drug use begins.** Families who rely on the word of their children when it comes to drug and alcohol use are engaged in dangerous wishful thinking, and often involved in denial of a potentially serious problem. Alcohol and other drug use promote the twin corrodors of family trust – denial and dishonesty. To the drug user, deceit and lying are a way of life. All of the love and caring in the world will not overcome this reality. Trust is earned through testing.

Drug and alcohol tests are the only objective way of establishing that a person has not recently used these substances. Then and only then can you know whether your child is telling the truth about alcohol and drug use. A negative test is reinforcement for open and honest communication between parents and children. A positive drug test is a call-to-action to end the use of drugs. Informed and involved parents are most likely to help their children grow up healthy, happy and drug-free.

Our experience is that the use of tests as a part of a family alcohol and drug prevention strategy often results in the establishment of stronger bonds of trust and love between family members because deceit and deception are removed from the discussion of the important issue.

Remember also that loving, involved parents routinely “check up” on their children. You may have checked with another parent to confirm that your child has his or her permission to eat a meal or stay overnight with a friend. Most parents have contacted other parents to determine if a party or other events their children will be attending will be chaperoned. You may have checked your child’s homework to ensure that the “Yes, I finished it” statement is true. *This is considered a part of routine parental responsibility. Using drug testing is an extension of that vitally important responsibility.*

Question:

How do I answer the “But you did it when you were young!” challenge from children who know their parents previously used illegal drugs? Or who presently use alcohol and/or nicotine?

Answer:

These are two important but separate questions. Just because a parent used alcohol, other drugs, or tobacco as a teen is no justification for a child to use it. In acknowledging such, parents need to emphasize that this was adolescent behavior and as they matured they came to realize much more fully the potential negative consequences of their actions: endangering the lives of themselves, their friends, and others, and endangering their chances to go to college, get a job, or hold a driver's license. Parents concern grows out of love for the child and caring for each and every member of the family.

Current parental use of tobacco or alcohol is an adult choice and is a choice children can make when they attain adulthood. However, discussion of parental alcohol and tobacco use is also an opportunity for parents to assess their own tobacco and/or alcohol use and determine whether it is a behavior that befits their family role model or promotes healthy living.

Question:

What does our family need to do before we use a drug or alcohol test?

Answer:

Drug and alcohol testing is best used as a prevention technique. In other words, the primary goal of testing is to provide a strong incentive not to use drugs or alcohol, especially young people.

The first step is to establish a family policy concerning the use of alcohol and such drugs as marijuana, cocaine, Ecstasy, and other drugs of abuse. This is best done by the adults working with the youth in the family. The earlier it is done, the better. It is useful to have this policy written out and understood before any drug testing is done.

Question:

What is the best time to take a drug test? An alcohol test? A nicotine test?

Answer:

For drug testing using urine, the best time to obtain a urine sample is right after a person wakes up in the morning and before he or she has had an opportunity to go to the bathroom. However, anytime during the day or night a person can provide an acceptable urine sample for testing is sufficient. For oral fluids testing, a sample should be taken within 24 hours of suspected drug use. Hair tests can be done at any time that is convenient.

For any alcohol test, the test should be done as soon as there is suspicion for alcohol use. Because alcohol leaves the body very quickly, an alcohol test 12 hours after suspected alcohol use will seldom reveal the presence of alcohol in the body. The liver metabolizes alcohol at the rate of about one drink each 60 - 90 minutes. That means that if a person has consumed 4 drinks in an evening, the blood alcohol concentration will be close to zero about 6 hours after the drinking stopped. For this calculation 1 drink equals 0.5 ounces of ethyl alcohol, the amount of alcohol in 12 ounces of beer, one and one-half ounces of distilled spirits (e.g. gin, vodka or whiskey) or 5 ounces of wine. The best time for an alcohol test is when the person first gets home after a drinking episode. Testing for alcohol the next morning is a waste of time and money since the alcohol will be fully metabolized unless the young person drank a prodigious quantity of alcohol (10 drinks or more) in the 8 hours prior to testing.

A nicotine test should be done as soon as there is suspicion of nicotine use. Because nicotine is identified in urine for 1 to 3 days after the most recent use the time the test is taken is not critical. This is true of the saliva test.

Question:

What if my child refuses to take a drug or alcohol test?

Answer:

The most straightforward way of handling a refusal to be tested is to consider the consequences of refusal to be the same as the consequences of a positive test and to impose the routine consequences for a positive test result. This is the standard used in the workplace and in school-based drug tests. There should be no reward for refusing to take a test.

Question:

Are there other ways to approach refusals?

Answer:

Yes. One alternative for unannounced tests is to agree to have all of the family tested so that the child will not feel singled out. Another is to suggest that the family doctor or the child's pediatrician do the collection. However, the consequences to any approach must be no less than the consequences for a positive test or else almost everyone using drugs or alcohol would refuse to be tested.

Question:

What if the child says he or she can't provide a urine sample?

Answer:

If you have chosen to use a urine testing kit, have the person drink some fluids and wait until he or she can urinate. Tell the child that if an acceptable urine sample is not given, the refusal will be treated the same as a positive test. Almost everybody can provide a urine sample within a few hours after drinking fluids. Oral fluids collections are seldom a problem. In the event of dry mouth give the person some water to sip. If there is no head hair available for testing, use one of the other methods or sample hair from any part of the body since all hair has drugs in it after repeated drug use.

Question:

Are drug and alcohol tests accurate?

Answer:

Yes! Drug tests are positive for specific drugs, not for “drugs in general.” For example, the tests are positive for marijuana or cocaine use, or for phencyclidine (PCP) or amphetamine/methamphetamine use. Drug tests do not confuse one chemical with another, and they are not positive for an abused drug on the basis of use of an over-the-counter or prescribed drug (unless the prescription was for the specific drug identified in the test, such as codeine). A cocaine positive urine test will not occur on the basis of the use of a cold tablet or an antibiotic, for example, and ibuprofen will not give a marijuana positive urine test result.

The urine, oral fluid, or hair sample taken will be analyzed only for those drugs to be tested, usually amphetamine, methamphetamine, cocaine, marijuana, PCP, codeine, heroin, and morphine. These drugs are the standard panel for most drug tests. Most urine testing is done using standards established by the U.S. Department of Health and Human Services (DHHS) which is also developing standards for hair and oral fluids testing. Hair testing also analyzes for Ecstasy.

Breath alcohol tests identify the presence of ethyl-alcohol that has come from the lungs. You can easily prevent “mouth alcohol” positives which can occur after a person uses an alcohol-containing mouthwash by simply having the individual wait fifteen minutes after putting anything in his or her mouth. Any “mouth” alcohol will completely dissipate during this time.

Question:

Is a confirming test needed or is a screening test sufficient for family drug testing?

Answer:

In general the screening tests for alcohol, drugs of abuse and nicotine are accurate and in most family testing situations they are sufficient. There are two exceptions to this

conclusion and one caveat to be understood. First, there are no other drugs or substances that cross-react with immunoassay tests for marijuana, cocaine or PCP. When one of these substances is detected it is usually safe to conclude the person tested recently used the drug which was detected.

Second, in contrast both the amphetamine/methamphetamine and the opiate tests are subject to misinterpretation. Cold medicines containing pseudoephedrine and stimulants used to treat Attention Deficit-Hyperactivity Disorder (ADHD) both can produce “positive” screening tests for amphetamine/methamphetamine. Poppy seeds can produce a positive urine test for opiates as can codeine-containing medicines.

When a positive screening test is obtained for either amphetamines/methamphetamines or opiates, and when the tested person denies drug use, then it is desirable to see an addiction professional and/or to consult a clinical toxicologist at a clinical laboratory for help in interpreting the drug test result.

The caveat: in workplace testing when an employee can lose a job for a single positive drug test, the gold standard is to have not only a confirming test done on all immunoassay, screening positive results but to use a Medical Review Officer (MRO) in the process for all drug results to ensure that rare and unusual circumstances cannot explain away the apparent positive result. In family drug testing, the child usually admits to alcohol or other drug use after a positive screening test making these additional steps unnecessary. If the child denies use of the detected use, the family can pursue the issue further in a variety of ways including getting a consultation from an addiction specialist as described later in this booklet.

Alcohol tests do not need a confirmation test.

Question:

What is a medical review?

Answer:

Medical review is performed by a physician with experience in the addictions to determine if there is any legitimate medical explanation for a laboratory confirmed test. For example, a doctor or dentist may prescribe a pain-killer such as Tylenol No. 3® which has codeine in it. Codeine is an opiate. If taken within a day or so of a drug test, codeine will probably cause a positive drug test for opiates. *You do not want to penalize a person for taking medicines which are properly prescribed and properly used.* You can find an MRO using the guide at the end of this booklet. Medical review can be done on a laboratory positive test to determine if there is a legitimate medical reason for the drug test result.

Question:

What if for my child gets angry during a drug, alcohol, or nicotine test?

Answer:

Parents do best when they remain calm about all sorts of teenage behavioral problems. Anger is most likely to lead to hasty or ill-conceived actions. Do not impose consequences on your child when you are angry. Your child and your family are best served by a steady and reasonable, but firm, approach to all sorts of problems, including drug use. Do not be ashamed or afraid to get expert help if you have worries about your choices or your feelings. Remember that Al-Anon is available to family members who are concerned about drug problems, including problems of their teenage children. *There is no charge for this program.* You can also speak to a local addiction specialist to advise and support your family.

We never recommend draconian punishments for youth who test positive for illegal drug or alcohol use. This goes even more strongly for a single positive test when the tested person denies use. If that happens in your family, and it is not a common outcome, get help and do not impose severe punishments. Keep an open mind, continue open communication and get expert help.

Question:

What does a positive drug test mean?

Answer:

A positive urine test result indicates use of the identified drug usually within the one to three days prior to the collection of the urine sample. A hair test positive means use of the identified drug during the previous three months, usually repeated use during that time. An oral fluids test positive means use of the identified drug within one to two days prior to the collection of the oral fluids sample.

Question:

What does a negative drug test mean?

Answer:

It can mean one of two things. Most often it means that your tested family member is drug-free. You should smile and give that person a hug and a “thank you” and celebrate the moment. Take this opportunity to reinforce the message that you care for your child or other family member and thank him or her for this drug-free behavior.

A negative drug test can also mean the person submitting the sample has not used any illicit drug in the test panel in the three days immediately prior to the test, that the amount of drug in the urine or oral fluids is too low to be identified, or that a drug which was used was not tested for (such as inhalants, or LSD). If you get a negative urine drug test result and you think the child being tested had used other drugs nonmedically just before the test, you can consult an expert in addiction for help or discuss your concerns with a counselor.

Question:

What does a positive alcohol test mean?

Answer:

A positive alcohol test usually means that the person being tested has used alcohol within the previous four to six hours. Alcohol tests are usually read as a specific BAC. Highway alcohol test results for adults are considered “negative” when BACs are under 0.08. That is the legal threshold for “intoxication” and “impairment” on the highway. Many young - and older - drinkers are seriously impaired at BACs well under 0.08. BAC levels over 0.08 are not often seen in youth unless there has been very heavy drinking not only just before the test but many other times before in that person’s life.

When people under the age of 21 are tested, in contrast to adult testing, there is no alcohol level that is acceptable since any alcohol use in this age group is illegal.

Impairment of one’s decision making and cognitive skills occur in some people with test results as low as 0.02 BAC. ***We recommend that anything over 0.02 BAC be considered a positive alcohol test when anyone under 21 is tested.***

Question:

What does a negative alcohol test mean?

Answer:

Because alcohol is rapidly metabolized, a negative alcohol test means that the tested person has not used alcohol in the few hours before the test, or used so little alcohol so long ago that the BAC has returned essentially to zero by the time the test was conducted. For example if a young person drank one drink about 9:00 PM and came home after 11:00 PM and was tested when first arriving at the front door, the BAC would be close to zero. It would probably require the consumption of three or more drinks that evening to trigger a positive alcohol test even at 0.02 BAC if the drinking had stopped more than two hours before the young person came home and was tested.

Question:

What about tobacco (nicotine) testing?

Answer:

Nicotine, the addictive chemical found in tobacco, is rapidly metabolized to cotinine and other metabolites in the liver. It is cotinine that is detected in drug tests after the use of tobacco. Cotinine is identified for several days after the last tobacco use and can be detected in urine, hair, oral fluids and sweat. Many insurance companies test urine samples of people applying for insurance for cotinine to detect recent tobacco use. Most drug tests today do not test for cotinine although it is easy to identify this substance in all drug test samples. The only reason cotinine is not currently more widely identified in drug tests is that the market is too small for the drug test manufacturers to build this into their standard test panels. Look for tests that can identify nicotine use. It is important that test manufacturers see that the market for drug tests is interested in cotinine testing. When that happens, cotinine testing will become routine for all drug tests. This is especially important for youth drug testing.

Question:

What about drugs in addition to the standard 5-drug panel?

Answer:

Until recently, the drug test market was dominated by urine testing in the workplace done at laboratories. Taking a urine sample to a laboratory to be tested was the best way to test for drugs outside the 5-drug panel. Most laboratories however required a physician's order to conduct a clinical test (which is how they think of drug tests).

Today, however, there are a variety of home testing options for drugs in addition to the standard 5-drug panel. Currently, parents can purchase urine drug tests for Ecstasy, synthetic narcotics (e.g. Oxycontin®, oxycodone, hydrocodone), benzodiazepines (e.g. Valium®, Librium®, Xanax®), barbiturates, and methadone. Tests for other drugs such as LSD and GHB require urine tests performed by laboratories. In those instances, to get a laboratory test, parents are likely to need a physician to help them. This can be your child's pediatrician or an addiction specialist or a drug treatment program.

It is possible to identify additional drugs, in addition to the 5-drug panel (6-drug panel for hair) in hair, oral fluids, and sweat, but the manufacturers of these tests which are less often used than urine tests, seldom include a wide range of drugs since they have relatively small markets for even the 5-drug panel. In the future, as the drug test market grows there will be a wider range of drugs that can be identified in on-site urine drug testing as well as in tests using samples other than urine.

Question:

Where can I turn for help?

Answer:

You can find a physician expert in addiction near you by calling the American Society of Addiction Medicine (ASAM) at (301) 656-3920 (www.asam.org). You can also check your telephone directory under Alcohol and Drug Abuse Services to find your local alcohol or drug abuse treatment services or other programs in your area that can help you and your family. You might also find help from your local school system, particularly if it has a Student Assistance Program (SAP), or from an Employee Assistance Program (EAP) at your workplace.

One of the best ways for family members to get help with an alcohol or drug problem is to go to local meetings of Al-Anon, the 12-step support program affiliated with Alcoholics Anonymous (AA). You will find Al-Anon listed in your phone book's white pages, or you can find their 24-hour-a-day helpline by calling information. Call Al-Anon and find the most convenient meeting times and locations for you. Go to the meetings a few minutes early, introduce yourself by your first name, and say that you have come for help. At Al-Anon you will find other family members who are coping with the problems of nonmedical alcohol and other drug use. The members of Al-Anon have used many treatment and prevention services in your community. They can give you advice as to where to find the best local resources, since these are the active consumers of the services in your community.

Question:

Where can I get information on the effects of drugs, including alcohol and nicotine?

Answer:

At the end of this guide there is a list of organizations which provide information about the effects of drugs. Libraries and bookstores are additional sources of information. In recent years, specialty bookstores with a vast amount of information on addiction and recovery have become more widespread.

Question:

If our family needs drug treatment, how do I find the best program?

Answer:

Some of the best and the least expensive treatment in the country is provided by the Betty Ford Center in Rancho Mirage, California (800-434-7365), Hazelden in Center City, Minnesota (800-257-7810), Caron Foundation in Wernersville, Pennsylvania (800-

854-6023) and Father Martin's Ashley in Havre de Grace, Maryland (800-799-4673). You can find listings of local treatment programs in your telephone directory. You will also get a consumer's-eye view of alcohol and other drug abuse treatment programs from your local Al-Anon meetings.

In general, addiction treatment is only needed when you have exhausted less expensive and less intensive methods of handling the drug problem, including family-based prevention using urine drug testing linked to consequences for use of alcohol and other drugs. After treatment, family members go to Al-Anon and addicted people go to Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). You do not need to go to addiction treatment to use these entirely free fellowships.

The simple good advice is to **GO TO MEETINGS** of AA, NA, and Al-Anon—they really work!

In addition you can purchase, or read through a library, the book *The Selfish Brain—Learning From Addiction* by Robert L. DuPont, M.D. It is published by Hazelden, the largest publisher of books on addiction and recovery (www.hazelden.org).

Question:

Where can I purchase home drug or alcohol testing kits?

Answer:

Most pharmacies sell drug and alcohol testing kits. If you prefer to purchase them online, go on your favorite search engine (e.g., Google, Yahoo) and enter the search term "home drug test", "home alcohol test", or "home nicotine test." You will find vendors who will sell you one or more test kits. As of the printing of this booklet, the following sites were among those offering home test kits for alcohol, nicotine, and other drugs.

Sample Family Drug Prevention Contract

We commit ourselves as a family to working together as a team in the best interests of all family members. We are committed to our children growing up free of the use of nicotine, alcohol, and other drugs because we know that use of these addictive substances by children is harmful.

As part of our commitment, we will use drug tests routinely as well as when there is any question of possible use of alcohol, other drugs, or tobacco. The tests will be carefully collected and the results used with discretion in the child's best interests as judged by the parent(s).

The consequences of a positive drug test are:

The consequences of a negative urine drug test are:

Signed and dated:

Sources of Additional Information

The following are sources of information which you may wish to contact to find out more about problems associated with substance abuse and help which is available. The Institute for Behavior and Health, Inc. does not warrant any information received from these sources, but does believe that they represent generally recognized programs in the field.

TREATMENT/SUPPORT:

Al-Anon Family Groups

1600 Corporate Landing Pkwy
Virginia Beach, VA 23454
(757) 563-1600
www.al-anon.alateen.org

Alcoholics Anonymous World Services, Inc.

General Service Office
Box 459
Grand Central Station
New York, NY 10163
(212) 870-3400
www.aa.org

American Society of Addiction Medicine (ASAM)

4601 North Park Avenue, Upper Arcade #101
Chevy Chase, MD 20815
(301) 656-3920
www.asam.org

*ASAM also lists certified Medical Review Officers

Betty Ford Center

39000 Bob Hope Drive
Rancho Mirage, CA 92270
800-434-7365
www.bettyfordcenter.org

Caron Foundation

233 N. Galen Hall Road
Wernersville, PA 19565
800-854-6023
www.caron.org

Hazelden Treatment Inquiries

P.O. Box 11
Center City, MN 55012
(800) 257-7810
www.hazelden.org

Narcotics Anonymous World Services, Inc.

P.O. Box 9999
Van Nuys, CA 91409
(818) 780-3951
www.na.org

Phoenix House

164 W. 74th Street
New York, NY 10023
(212) 595-5810
(800) DRUG-HELP / (800) 378-4357
www.phoenixhouse.org

WASHINGTON, DC AREA TREATMENT**Father Martin's Ashley**

800 Tydings Lane
Havre de Grace, MD 21078
(800) 799-4673
(410) 273-6600
www.FatherMartinsAshley.org

Kolmac Clinic

15932-B Shady Grove Road
Gaithersburg, MD 20877
(301) 330-7696

1003 Spring Street
Silver Spring, MD 20910
(301) 589-0255

10632 Little Patuxent Pkwy
Suite 410
Columbia, MD 21044
(443) 276-0556

6525 N. Charles Street
The Gibson Building, Suite 085
Towson, MD 21204
(410) 296-2232

1411 K Street, NW Suite 703
Washington, DC:
(202) 638-1992
www.kolmac.com

Suburban Hospital
Behavioral Health 7300
8600 Old Georgetown Road
Bethesda MD 20814
(301) 896-3100

DRUG & ALCOHOL INFORMATION

Drug Enforcement Administration
Mailstop: AES
8701 Morrissette Drive
Springfield, VA 22152
(202) 307-1000
www.dea.gov

Drug Free America Foundation, Inc.
5999 Central Avenue, Suite 301
St. Petersburg, FL 33710
(727) 828-0211
www.dfaf.org

Hazelden Publishing
P.O. Box 176
Center City, MN 55012-0176
(800) 328-9000

Health Communications, Inc.
3201 South West 15th Street
Deerfield Beach, FL 33442
(800) 441-5569
www.hcibooks.com

PRIDE Youth Programs
4 West Oak Street
Fremont, MI 49412
(800) 668-9277
(231) 924-1662
www.prideyouthprograms.org

Substance Abuse and Mental Health Services Administration (SAMHSA)

1 Choke Cherry
Rockville, MD 20850
(240) 276-2000

www.samhsa.gov

SAMHSA Publications

<http://store.samhsa.gov/home>

SAMHSA provides free material and information on alcohol, tobacco, and other drug problem prevention and treatment.

PARENT-BASED GROUPS & INITIATIVES

Prevent Teen Drug Use

www.PreventTeenDrugUse.org

The Courage to Speak Foundation, Inc.

P. O. Box #1527
Norwalk, CT 06852
(877) 431-3295

www.couragetospeak.org

Drug Free Kids: America's Challenge

Joyce D. Nalepka, President
1805 Tilton Drive
Silver Spring, MD 20902
(301) 681-7861

AmerCares@aol.com

Drug Free Schools Coalition, Inc.

David G. Evans, Esq., Executive Director
146 Main Street
Flemington, NJ 08822
p) 908-788-7077 drugfreesc@aol.com

Families Anonymous

P.O. Box 3475
Culver City, CA 90231
(800) 736-9805

MOMSTELL

Encourages parental support and awareness. Learn what the signs of drug abuse are.

www.momstell.com/ParentsGuide.htm

Mothers Against Drunk Driving (MADD)

511 E. John Carpenter Freeway, Suite 700
Irving, TX 75062-8187
(800) 438-6233 www.madd.org

National Families in Action (NFIA)

P.O. Box 133136 Atlanta, GA 30333
(404) 248-9676
www.nationalfamilies.org

National Family Partnership (NFP)

(Formerly National Federation of Parents for Drug Free Youth)
2490 Coral Way, Suite 501
Miami, FL 33145
(305) 856-4886

Not in My House

Created by Partnership for Drug-Free America, this website addresses one of the most serious problems in drug abuse: prescription drug abuse among youth. More 12 to 17 year olds initiate prescription drug abuse than marijuana. Learn how to address this important issue with your children.

www.notinmyhouse.com

A Parent's Guide to the Teenage Brain

The Partnership for a Drug-Free America partnered with Treatment Research Institute and WGBH Educational Foundation to develop *A Parent's Guide to the Teen Brain*.

www.drugfree.org/teenbrain/

Parents: The Anti-Drug

Sponsored by the Office of National Drug Policy's Media Campaign: Parents, the Anti-Drug, gives parents tips and information about drugs and alcohol.

(800) 663-HELP / (800) 663-4357

www.theanti-drug.com

Time to Talk

Get help talking to your kids about drugs and alcohol.

www.timetotalk.org

Time to Act!

How to tell if your teen is using and taking action to intervene.

timetoact.drugfree.org

Time to Get Help!

How to get help for your teen for drug or alcohol problems.

<http://timetogethelp.drugfree.org/>

DRUG POLICY INFORMATION

Institute for Behavior and Health, Inc.

6191 Executive Blvd.
Rockville, MD 20852
(301) 231-9010

www.ibhinc.org

Prevention:

www.PreventTeenDrugUse.org

Non-punitive random student drug testing:

www.PreventionNotPunishment.org

Office of National Drug Control Policy (ONDCP)

750 17th Street, NW
Washington, DC 20503
(202) 395-6000

www.whitehousedrugpolicy.gov

Suggested Reading

Coombs, RF: Cool Parents, Drug-Free Kids: A Family Survival Guide. Boston, MA: Allyn & Bacon, 2002.

DuPont RL: The Selfish Brain – Learning From Addiction. Center City, MN: Hazelden, 2000.

DuPont, RL: Getting Tough on Gateway Drugs: A Guide for the Family. Washington, DC: American Psychiatric Press, Inc. 1984.

Mooney, AJ, Eisenberg, A & Eisenberg H: The Recovery Book. New York, NY: Workman Publishing, 1992.

Perkins, WM & McMurtrie-Perkins, N: Raising Drug-Free Kids in a Drug-Filled World. Center City, MN: Hazelden, 1986.

Rahrer, JS: Seven Sensible Strategies for Drug Free Kids. Washington, DC: Child and Family Press, 2003.

Somdahl, GL: Drugs and Kids: How Parents Can Keep Them Apart. Salem, OR: DIMI Press, 1996.

Sturz, EL: Dealing with Disruptive Adolescents and Drugs, Second Edition. New York, NY: Argus Community, Inc., 1994.

The Partnership at Drugfree.org. Synthetic Drugs: Bath Salts, K2/Spice: A guide for parents and other influencers. Parents360, 2012. Available: <http://www.drugfree.org/wp-content/uploads/2012/02/Parents360-Synthetics-Bath-Salts-K2-Spice-Parents-Guide-FINAL-2-13-12.pdf>

Tobias, JM: Kids & Drugs: A Handbook for Parents and Professionals, Second Edition. Annandale, VA: Panda Press, 1989.

Youngs, B, Youngs, JL, & Moreno T: A Teen's Guide to Living Drug-Free. Deerfield Beach, FL: HCI Teens, 2003.

Feedback and Updates

The authors intend to revise this guide from time to time as new technologies or products are introduced to the public market. They also are interested in reader feedback, particularly regarding family prevention strategies using testing that have been successful. Please provide any comments regarding this guide to ContactUs@ibhinc.org.

About the Authors

Robert L. DuPont, M.D.

Dr. Robert L. DuPont is Founder and President of the Institute for Behavior and Health, a non-profit organization that works to generate and implement new ideas for drug abuse prevention by encouraging creative collaboration among diverse disciplines and perspectives. Dr. DuPont was the White House "Drug Czar" from 1973 – 1975 and the Founding Director of the National Institute on Drug Abuse (NIDA). Since 1982, he has also been Senior Vice President of Bensinger, DuPont and Associates, a drug-free workplace consulting firm. Dr. DuPont is the author of many books and articles including *The Selfish Brain—Learning From Addiction* published by American Psychiatric Press.

Richard H. Bucher, Ph.D.

Dr. Richard H. Bucher has been involved in drug prevention efforts since 1972 when he worked at the White House Special Action Office for Drug Abuse Prevention. Between 1983 and 2004, he was principally involved in drug free workplace efforts for Bensinger, DuPont and Associates and is currently a consultant to industry in the same subject. He served as Chairman of DrugFree Kids: America's Challenge, a non-profit organization to encourage parents and others to actively support family and community drug prevention efforts and is a Board Member of the Institute for Behavior and Health.

Parents360

Synthetic Drugs: Bath Salts, K2/Spice:

A guide for parents and other influencers

THE PARTNERSHIP™
AT DRUGFREE.ORG

February 16, 2012

Parents360

**Synthetic Drugs:
Bath Salts, K2/Spice**

THE PARTNERSHIP™
AT DRUGFREE.ORG

Hello, and welcome to the Parents360 module that addresses issues pertaining to synthetic drugs such as Bath Salts and K2/Spice.

Some background to start: “Parents360 – Parents: You Matter” is a community education presentation that helps parents and other adults who care about kids learn how to communicate effectively with their children, look out for them and get them help if and when they need it. The presentation has a number of drug-specific modules that can be added to it. The one we’re talking about today is Synthetic Drugs such as Bath Salts and K2/Spice.

This is a very important topic to address because synthetic drugs **are** dangerous. They are not ‘safe’ as a second choice, or as an alternative to more well-known drugs, for your kids, and you must communicate that fact with them. This presentation will help provide you with the information and resources to have that discussion.

“Bath Salts” are not Bath Salts



The first thing that parents should know is that the drug called Bath Salts is very different from the product that you put into a bath. The only reason why they have the same name is because the products look similar like a fine powder.

What are “Bath Salts?”

- Stimulants: Manmade chemicals related to amphetamines (speed)
- Substituted cathinones -- Methylenedioxypropylvalerone (MDPV) and mephedrone, and methylone are the chemicals most often found in “bath salts”
- Consumed orally or nasally

Drug Enforcement Administration

So – what are Bath Salts anyway? They are a man-made, chemical (as opposed to organic) stimulant drug. Generally, stimulants are a class of drugs that elevate mood, increase feelings of well-being and increase energy and alertness. Amphetamines, or speed, are an example of stimulant drugs.

The technical term for Bath Salts is “substituted cathinone.” Now, what does that mean? You may have heard of Khat, a plant that is cultivated and used in East Africa and the Middle East. It has a stimulant effect on the user and can be quite dangerous. Substituted cathinones are synthetic, concentrated versions of the stimulant chemical in Khat. Methylenedioxypropylvalerone (MDPV), mephedrone and methylone are the chemicals most often found in “Bath Salts.”

They can be ingested orally or snorted through the nose.

How can you tell?



So – how can you tell if something that is labeled as a bath salt is really a drug?

Well, first off, if it is contained in a packet that is about the size of a moist towelette, it probably isn't designed for use in a bathtub that can hold anywhere from 30 to 60 gallons of water.

But if it also says, “not for human consumption,” says that it is “not illegal” (never a good sign) or that it is for “adults only,” it is probably a drug that was created for ingestion and not for a hot bath.

Many Brands and Names and Not Always Sold as Bath Salts



What makes this even trickier is that not all “Bath Salts” are marketed as Bath Salts.

Substituted cathinones and related drugs have been sold as plant feeder, insect repellent and even stain remover.

It is also important to note that there is no standard formulation for these drugs. The composition of chemicals that is sold in one packet may be completely different than what is sold in an identical packet.

So – why all of the mystery?

It is because when these drugs were legal, the people trying to sell them were working to exploit very specific loopholes in the law. For a period of time, these drugs were not illegal because the law did not include them. That has changed, and we will talk about that in a moment. But once word went out that Bath Salts were dangerous, the distributors of these drugs put them in new, deceiving packages.

Why Do Teens Use “Bath Salts”?

- For energy / alternative to illegal stimulants
- Perceived to be legal
- Not picked up on standard drug tests
- Available at retail outlets: convenience stores; head shops; online



So why would a teen or young adult, or anyone for that matter, make a decision to use “Bath Salts?”

First, we’ll look at some of the same reasons why people use stimulants. For some, it is to get high or escape, but for many others it is to get energy or endurance to make it through the day. Many people – not just teens – feel overworked and overstressed, and in those situations, a stimulant can have a lot of appeal.

Peer pressure or curiosity can play a large role, and often teens don’t know what the effects will be until it’s too late. Word of mouth can also play a big part in deciding to try it.

Anecdotally, potential users may think that Bath Salts are safer than methamphetamine. They may perceive them to be legal. They may think that they would not test positive – at work or at school – if they use it.

And these drugs are readily available – if you walk into some convenience stores or gas stations, you may see a whole display of pills and packages marked as “vitamins” or “energy boosters.” Some may be legal, and some may not be. Head shops – which are in the business of selling drug paraphernalia just within the limits of the law – may sell these drugs, and a search for Bath Salts online yields more than 1.3 million results.

Effects of “Bath Salts”

- Very severe paranoia that sometimes causes users to harm themselves or others.
- Speed of onset – 15 minutes; Length of high – 4-6 hours
- Long term effects: Unknown
- Effects reported to Poison Control Centers
 - Suicidal thoughts
 - Agitation; Combative/Violent; Confusion
 - Hallucinations / psychosis
 - Increased heart rate; Hypertension; Chest Pain
 - Death or serious injury

Source: American Association of Poison Control Centers

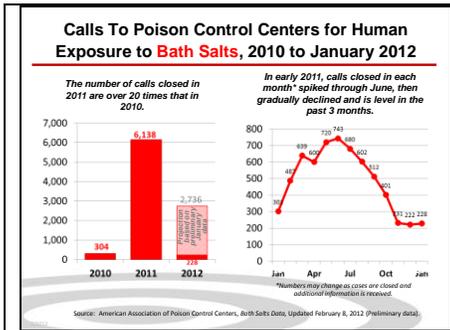
The effects of Bath Salts can be severe.

Very severe paranoia can sometimes cause users to harm themselves or others. Effects reported to Poison Control Centers include:

- Suicidal thoughts
- Agitation
- Combative/Violent behavior
- Confusion
- Hallucinations/psychosis
- Increased heart rate
- Hypertension
- Chest Pain
- Death or serious injury

The speed of onset is 15 minutes, while the length of the high from these drugs is four to six hours.

It is especially troubling that the long-term effects of the drug are unknown, because the drug has only been used widely within the past decade. We don’t know what the future will hold or exactly how people will be affected.



Poison centers first raised the alarm about Bath Salts in December 2010 after they started receiving calls about people having serious reactions to the chemicals, such as increased blood pressure and heart rate, agitation, hallucinations, extreme paranoia and delusions. In 2010, poison centers received 304 calls about exposures to Bath Salts. That number rose dramatically in 2011 when poison centers received 6,138 calls. In early 2011, calls closed in each month* spiked through June, then gradually declined and was level in November and December 2011 and January 2012. While this is notable progress, projections based on January 2012 data indicate that use will remain far above 2010 levels in 2012.

Synthetic Marijuana, K2 / "Spice"

We now make the move from salts to Spice.

- ### Synthetic Marijuana
- K2 or "Spice" are common names for synthetic marijuana, *however, the effects of synthetic marijuana can be very different from cultivated marijuana*
 - K2 or "Spice" is a mixture of herbs or dried, shredded plant material that is typically sprayed with chemicals that are similar to THC, the psychoactive ingredients in marijuana.
 - **Street names:** Bliss, Black Mamba, Bombay Blue, Blaze, Genie, Spice, Zohai, JWH-018, -073, -250

"K2" and "Spice" are street names for synthetic marijuana. Whatever perceptions people have of marijuana, they should not underestimate the risk of this drug or make the mistake that synthetic marijuana is somehow less dangerous than cultivated marijuana.

K2 or Spice is a mixture of herbs or other plant materials that have been sprayed with artificial chemicals that are supposed to mimic the effects of THC, the psychoactive ingredient in marijuana. One group of these artificial chemicals has the prefix "JWH," so you will see JWH-018, JWH-073 and others. It is important to note that K2/Spice is completely synthetic, so while these drugs may act on the same parts of the brain and body as THC, the effects can be very different.

In addition to the most common names, K2 and Spice, this product is sold under a number of trade names such as "Blaze," "Bliss," "Black Mamba," "Bombay Blue," "Genie" or by the names of the chemicals that are used in the production process such as JWH-018.

<p style="text-align: center;">Signs of Use</p> <ul style="list-style-type: none"> • Strong clove smell • Coffee grinder – finer the powder, easier to smoke • Drug paraphernalia (pipes, screens, etc.) • Typically smoked 	<p>One of the signs that parents can look for is a strong clove smell. K2/Spice is typically smoked, so parents may find a coffee grinder around the house – which is often used to reduce the product to a fine powder so that it is easier to smoke – and other drug paraphernalia such as pipes or screens.</p>
<p style="text-align: center;">Physical Signs of Use</p> <ul style="list-style-type: none"> • Loss of control • Lack of pain response • Increased agitation • Pale skin • Seizures • Vomiting • Profuse sweating • Uncontrolled / spastic body movements • Elevated blood pressure, heart rate, and palpitations  <p><small>Source: Prosecuting Attorneys Association of Michigan</small></p>	<p>The physical signs of use are very troubling.</p> <p>You may notice increased agitation, profuse sweating, pale skin or vomiting.</p> <p>But what may be of the greatest concern is the loss of physical control – a kind of brain-body disconnect. This is where you may see seizures, a lack of pain response or uncontrolled/spastic body movements.</p>
<p style="text-align: center;">Effects of Synthetic Marijuana</p> <ul style="list-style-type: none"> • Onset – 3-5 minutes • Length of duration – 1-8 hours • Short-term effects: In addition to physical signs of use, users may experience: <ul style="list-style-type: none"> – Dysphoria – the opposite of euphoria – Paranoia – similar to PCP / Angel Dust – Delusions, hallucinations and increased agitation • Long-term effects: Unknown  <p><small>Source: Prosecuting Attorneys Association of Michigan</small></p>	<p>Looking at the effects another way, parents should know that the onset of this drug is fairly quick, and – depending on a number of factors – the length of the high can last from one to eight hours.</p> <p>The paranoia that is associated with K2/Spice is closer to the psychological reaction to PCP or angel dust than to the paranoia associated with marijuana.</p> <p>One of the most frightening factors is that users may experience dysphoria. The best way to explain dysphoria is that it is the opposite of euphoria. A spice user posted a blog comment that read in part, “I felt as if I was in hell – this morbid place that I couldn’t get out of.” (http://cenblog.org/terra-sigillata/2010/09/07/whats-the-buzz-synthetic-marijuana-k2-spice-jwh-018/)</p> <p>As troubling as the short-term effects of this drug are, what is even more concerning is the fact that no one knows what their long-term effects will be. They simply haven’t been around long enough for medical professionals to know how users will be affected in 10 years, 20 years or even further in the future.</p>

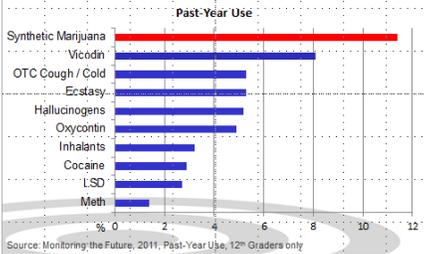
How is K2 obtained?

- K2 is typically sold in small, silvery plastic bags of dried leaves and marketed as incense that can be smoked. It is said to resemble potpourri.
- K2 is sold online, in convenience stores and in “head” shops, and is usually marketed as incense.



Like Bath Salts, K2/Spice is sold online, in convenience stores and in “head” shops. It is often marketed as incense.

K2 / Spice Use

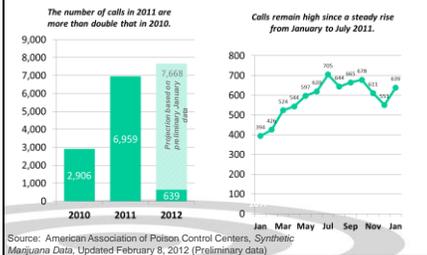


While these drugs may be “news” to many parents, more than one in 10 American high school seniors used synthetic marijuana in the prior year according to the “Monitoring the Future” study, a survey conducted by the University of Michigan,.

At 11.4 percent, the annual prevalence of synthetic marijuana is:
 41 percent greater than Vicodin (8.1 percent)
 Four times greater than inhalants (3.2 percent)
 Four times greater than cocaine (2.9 percent)
 Eight times greater than meth (1.4 percent)

It is also more common than hallucinogens, LSD and OxyContin and twice as likely to be used as over-the-counter cough/cold medicine.

Calls Received by Poison Control Centers for Human Exposure to Synthetic Marijuana, 2010 to January 2012



Calls to poison control centers for exposure to synthetic marijuana doubled between 2010 and 2011 and is on track to rise again in 2012.

DEA takes action

- On November 24, 2010, the Drug Enforcement Administration (DEA) took emergency action to temporarily control five chemicals used to make K2 and other "fake pot" products.
- On September 7, 2011, the DEA banned three of the drugs found in bath salts
- Possessing and selling these chemicals or the products that contain is now illegal in the U.S.
- The DEA will study these chemicals to determine if these products should be permanently controlled.
- Congress is also working to act on this issue.
- Regulators face the challenge of staying ahead of formulations

In the past two years, the Drug Enforcement Administration has taken emergency action to make both Bath Salts and K2/Spice illegal. There is now a study period taking place to determine if these bans will remain permanent.

The challenge for regulators and parents, however, is to stay ahead of the new formulas and versions of these drugs that may not be covered by current law.

Congress is also working to act on this issue.

However, regulators and parents face the challenge of staying ahead of new formulations.

Messages Parents Can Deliver

- It is impossible to know what these drugs contain, or who made them, or what you are going to get.
- Getting high – no matter how – carries risks of making unsafe or unhealthy decisions
- Just because a drug is legal – or is labeled as legal – does not mean that it is safe
- We don't know the long term effects of synthetic drugs because the drugs are so new

So what can parents and other influencers say to young people about the dangers of these drugs?

A good overarching message to kids is to avoid putting anything in their bodies that would change their feelings or emotions – whether it is something they would smoke, drink, take in pill form or shoot with a needle. The human brain is an incredible machine, and you need to be even more careful with a teenage brain because it is a work in progress.

Additional messages include:

- It is impossible to know what these drugs contain, who made them or what you are going to get.
- Getting high – no matter how – carries risks of making unsafe or unhealthy decisions.
- Just because a drug is legal – or is labeled as legal – does not mean that it is safe.
- We don't know the long-term effects of synthetic drugs because the drugs are so new.

Drugfree.org Resources

PREVENT

- [TimeToTalk](#) helps you start the conversation
- [Habla Con Tus Hijos](#)-Spanish-language version
- [The Decoder](#) blog
- [The Drug Guide for Parents](#)

INTERVENE

- [Time to Act](#) if you think or know your child is using.
- [Intervene](#) blog
- [Intervention eBook](#)

GET TREATMENT

- [Treatment eBook](#)
- [Time to Get Help](#) helps parents better understand teen and young adult substance abuse and addiction.

RECOVER

- [Time to Get Help community](#) connects parents who understand and have been there.

You are not alone

The Partnership at Drugfree.org’s “Time To Talk” resource, found at [TimeToTalk.org](#), offers easy-to-use, research-based tips to help you have ongoing conversations with your kids to keep them healthy and drug free.

[HablaConTusHijos.org](#) is the Spanish-language version of Time to Talk.

The Decoder blog addresses real issues that real parents face every day.

The Drug Guide for Parents shares facts about the top 13 drugs most commonly abused by teens.

Time to Act! provides parents with step-by-step guidance on what to do if they think or know that their child is using.

The Intervene blog is a forum for experts, parents and caring adults to share their experiences and insights.

The Intervention eBook provides parents with an additional way to learn about how to help their child.

The Treatment eBook provides parents with a guide to understanding what treatment is, how to pay for it, how to start treatment and more.

Time to Get Help gives parents a better understanding of teen and young adult substance abuse and addiction and a community to share their experiences and support one another.

A key message that we want to deliver to parents and other people who care about kids is that whether you are working to prevent use by their child, responding to it or supporting your child’s recovery, you are not alone

Connect with The Partnership at Drugfree.org



HELPLINE
1- 855 - DRUGFREE



FACEBOOK
/partnershipdrugfree



eNewsletter
News & tips in your inbox.



TWITTER
@drugnews

Drugfree.org/eNewsletters

We want families to connect with the Partnership.

The Partnership at Drugfree.org’s Parents Toll-Free Helpline offers assistance to parents who want to talk to someone about their child’s drug use and drinking.

Our Helpline is open Monday through Friday from 10:00 am to 6:00 pm ET. We are closed on weekends and holidays. The Helpline is not a crisis line. If you do not connect with a parent specialist, please leave a message and we will make every effort to get back to you by the next business day. If you are in need of immediate or emergency services please call 911 or a 24-hour crisis hotline.

Our eNewsletters are a great way to get updated information about substance abuse and actions parents can take to help their kids delivered directly to your inbox.

You can friend us on Facebook, or you can follow our Twitter feed.

We try to provide as many ways as possible to for you to keep in touch with us!

THE PARTNERSHIP™
AT DRUGFREE.ORG

PARENTS360
Thank You!



In the coming months, we will be creating additional slidecasts that use content from the Parents360 presentation and modules.

If you would like to be notified when these screencasts are published, please be sure to sign up for the Community Education newsletter at drugfree.org, or “like” The Partnership at Drugfree.org on Facebook.

Thank you for your time, your attention and for your concern for the young people in your life.

Acknowledgement

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The Tip Sheet

Here are important tips, resources and information you can use to give your kids happy, healthy and safe futures, and help them avoid the dangers of drugs and alcohol.

COMMUNICATE

1. Clearly communicate the risks of alcohol and drug use
2. Let your child know you disapprove of any drinking or drug use.
 - a. Kids who believe their parents will be upset if they try drugs are 43 percent less likely to do so.
3. Use teachable moments to talk about drinking and using drugs.
4. Frequently talk and listen to your kids about how things are going in their lives.

MONITOR

1. Know *WHO* your child is with
2. Know *WHAT* they're doing
3. Know *WHERE* your child will be
4. Know *WHEN* your child is expected home
5. Know who your teen's friends are – communicate with their parents
6. Establish and enforce rules – including a clear “no use” policy

SPOT ALCOHOL AND DRUG USE

- ✓ Here are **five** changes to watch for...
 1. Declining school work and grades
 2. Abrupt changes in friends, groups or behavior
 3. Sleeping habits and abnormal health issues
 4. Deteriorating relationships with family
 5. Less openness and honesty
- ✓ Be aware of special vulnerabilities

WHAT TO DO WHEN YOU SPOT ALCOHOL AND DRUG USE

1. Focus, you can do this
 - ✓ Don't panic, but act right away
2. Start talking
 - ✓ Let your child know you are concerned
 - ✓ Communicate your disapproval
3. Set limits, rules and consequences
4. Monitor – look for evidence, make lists, keep track
5. Get outside/professional help – you don't have to do this alone

TAKE ACTION AND LEARN MORE

1. Talk to your kids about the dangers of drinking and using drugs
2. Monitor your kid's whereabouts
3. Connect with other parents
4. Learn more about preventing teen drinking and drug use– go to www.drugfree.org

IMPORTANT RESOURCES FROM THE PARTNERSHIP AT DRUGFREE.ORG

1. www.drugfree.org – Main Site
2. www.timetotalk.org – Learn **how to start a conversation** with your child
3. www.drugfree.org/timetoact – Learn **what to do if you suspect or know** your child is using
4. www.drugfree.org/teenbrain – Learn about **teen brain development** and how you can help your teen make smart, healthy decisions
5. www.drugfree.org/parent – The Parent Tool Kit offers videos & articles on how to talk with your kids at any age

DRUG GUIDE FOR PARENTS: LEARN THE FACTS TO KEEP YOUR TEEN SAFE



	Alcohol	Cocaine/Crack	Cough Medicine/DXM	Ecstasy/MDMA	Heroin	Inhalants	Marijuana	Methamphetamine	Prescription Pain Relievers	Prescription Sedatives and/or Tranquilizers	Prescription Stimulants	Steroids	Tobacco
Street Names / Commercial	Booze	Big C, Blow, Bump, Coke, Nose Candy, Rock, Snow	Dex, Red Devils, Robo, Triple C, Tussin, Skittles, Syrup	Adam, Bean, E, Roll, X, XTC	Big H, Black Tar, Dope, Junk, Skunk, Smack	Whippets, Bagging, Huffing, Poppers, Snappers, Dusting	Blunt, Boom, Dope, Grass, Hash, Herb, Mary Jane, Pot, Reefer, Skunk, Weed	Ice, Chalk, Crank, Crystal, Fire, Glass, Meth, Speed	Codeine, OxyContin (Oxy, O.C.), Percocet (Percs), Vicodin (Vike, Vitamin V)	Mebaral, Quaaludes, Xanax, Valium	Adderall, Dexedrine, Ritalin	Juice, Rhoids, Stackers, Pumpers, Gym Candy	Cancer Sticks, Chew, Cigarettes, Dip, Fags, Smokes
Looks Like	Liquid (types include beer, wine, liquor)	White crystalline powder, chips, chunks or white rocks	Liquid, pills, powder, gel caps	Branded tablets (Playboy bunnies, Nike swoosh)	White to dark brown powder or tar-like substance	Paint thinners, glues, nail polish remover, whipped cream aerosol, air conditioner fluid (Freon) and more	A green or gray mixture of dried, shredded flowers and leaves of the hemp plant	White or slightly yellow crystal-like powder, large rock-like chunks	Tablets and capsules	Multi-colored tablets and capsules; some can be in liquid form	Tablets and capsules	Tablet, liquid or skin application	Brown, cut up leaves
How It's Used/Abused	Alcohol is drunk	Cocaine can be snorted or injected; crack can be smoked	Swallowed	Swallowed	Injected, smoked, freebased or snorted	Inhaled through nose or mouth	Smoked, brewed into tea or mixed into foods	Swallowed, injected, snorted or smoked	Swallowed or injected	Swallowed or injected	Swallowed, injected or snorted	Swallowed, applied to skin or injected	Smoked or chewed
What Teens Have Heard	Makes a boring night fun	Keeps you amped up; you'll be the life of the party	Causes a trippy high with various plateaus	Enhances the senses and you'll love everyone	Full-on euphoria, but super risky	A cheap, 20-minute high	Relaxing, not dangerous and often easier to get than alcohol	Can keep you going for days	A free high, straight from the medicine cabinet	A great release of tension	Keeps you attentive and focused	Will guarantee a spot on the starting lineup	An oral fixation and appetite suppressant
Dangerous Because	Impairs reasoning, clouds judgement. Long-term heavy drinking can lead to alcoholism and liver and heart disease	Can cause heart attacks, strokes and seizures. In rare cases, sudden death on the first use	Can cause abdominal pain, extreme nausea, liver damage	Can cause severe dehydration, liver and heart failure and even death	Chronic heroin users risk death by overdose	Chronic exposure can produce significant damage to the heart, lungs, liver and kidneys. Can induce death	Can cause memory and learning problems, hallucinations, delusions and depersonalization	Chronic long-term use, or high dosages, can cause psychotic behavior (including paranoia, delusions, hallucinations, violent behavior, insomnia and strokes)	A large single dose can cause severe respiratory depression that can lead to death	Slows down the brain's activity and when a user stops taking them, there can be a rebound effect, possibly leading to seizures and other harmful consequences	Taking high doses may result in dangerously high body temperatures and an irregular heartbeat. Potential for heart attacks or lethal seizures	Boys can develop breasts, girls can develop facial hair and a deepened voice. Can cause heart attacks and strokes	Cigarette smoking harms every organ in the body and causes coronary heart disease, and stroke, as well as many forms of cancer
Teen Usage (Grades 9-12)	1 in 2 teens drank alcohol in the last year	1 in 9 teens has abused cocaine or crack in their lifetime	1 in 8 teens has abused cough medicine in their lifetime	1 in 8 teens has abused Ecstasy in their lifetime	1 in 20 teens has abused heroin in their lifetime	1 in 6 teens has abused inhalants in their lifetime	1 in 3 teens has abused marijuana in their lifetime	1 in 14 teens has abused methamphetamine in their lifetime	1 in 5 teens has abused prescription pain relievers in their lifetime	1 in 11 12th graders has abused sedatives and/or tranquilizers in their lifetime	1 in 10 teens has abused Ritalin or Adderall in their lifetime	1 in 20 teens has abused steroids in their lifetime	1 in 4 teens smoked cigarettes in the last 30 days
Signs of Abuse	Slurred speech, lack of coordination, nausea, vomiting, hangovers	Nervous behavior, restlessness, bloody noses, high energy	Slurred speech, loss of coordination, disorientation, vomiting	Teeth clenching, chills, sweating, dehydration, anxiety, unusual displays of affection	Track marks on arms, slowed and slurred speech, vomiting	Missing household products, a drunk, dazed or dizzy appearance	Slowed thinking and reaction time, impaired coordination, paranoia	Nervous physical activity, scabs and open sores, decreased appetite, inability to sleep	Medicine bottles present without illness, Rx bottles missing, disrupted eating and sleeping patterns	Slurred speech, shallow breathing, sluggishness, disorientation, lack of coordination	Lack of appetite, increased alertness, attention span and energy	Rapid growth of muscles, opposite sex characteristics and extreme irritability	Smell on clothes and hair, yellowing of teeth and fingers that hold cigarettes
Important to Know	Being a child of an alcoholic places children at greater risk for developing alcohol problems	Cocaine is one of the most powerfully addictive drugs	The "high" from cough medicine is caused by ingesting a large amount of dextromethorphan (DXM), a common active ingredient	Can be addictive. A popular club drug because of its stimulant properties which allow users to dance for long periods of time	Heroin overdose is a particular risk on the street, where the purity of the drug cannot be accurately known	More than 1000 common products are potential inhalants that can kill on the first use or any time thereafter	Contrary to popular belief, marijuana can be addictive	Meth has a high potential for abuse and addiction, putting children at risk, increasing crime and causing environmental harm	Abusing prescription painkillers is just as dangerous, addictive and deadly as using heroin	Using prescription sedatives and tranquilizers with alcohol can slow both the heart and respiration and possibly lead to death	Many teens abuse this prescribed medication to help them cram for exams or suppress their appetite	Teens who abuse steroids before the typical adolescent growth spur risk staying short and never reaching their full adult height	Secondhand smoke contributes to more than 35,000 deaths related to cardiovascular disease

Find more tools and tips at www.drugfree.org.

Preventing Teen Abuse of Prescription Drugs Fact Sheet

What is prescription drug abuse?

The use of prescription medication to create an altered state, to get high, or for reasons — or by people — other than those intended by the prescribing doctor.

How many teens are doing this?

According to research conducted by Partnership for Drug-Free Kids (as well as other reputable national studies) as many as one in five teens say they have taken a prescription drug without having a prescription for it themselves. This behavior cuts across geographic, racial, ethnic and socioeconomic boundaries.



Why are some teens doing this?

For a variety of reasons. To party and get high, in some cases, but also to “manage” or “regulate” their lives. They’re abusing some stimulants such as Ritalin and Adderall to give them additional energy and ability to focus when they’re studying or taking tests. They’re abusing pain relievers like OxyContin and tranquilizers such as Xanax to cope with academic, social or emotional stress. They’re abusing prescription amphetamines to lose weight, or prescription steroids to bulk up.

What are the risks?

There are both acute (immediate) and longer term risks. In the short term, overdosing (especially on prescription pain relievers) can be fatal, as can mixing prescription drugs with over-the-counter medication and/or alcohol. In the longer term, prescription opioids (pain relievers) and other prescription medicines are potentially addictive. Coming to rely at a young age on prescription medicine (or any drug) to “manage” your life risks establishing a learned, lifelong pattern of dependency and limitation and prevents learning coping skills.

Where are teens getting these prescription drugs?

The vast majority of teens abusing prescription drugs are getting them from the medicine cabinets of friends, family and acquaintances. Some teens traffic among themselves – handing out or selling “extra” pills of their own, or pills they’ve acquired or stolen from classmates. A very small minority of teens say they get their prescription drugs illicitly from doctors, pharmacists or over the internet.

Are parents educating their children about the risks of this behavior?

Research conducted by Partnership for Drug-Free Kids shows that parents are not communicating the risks of prescription drug abuse to their children as often as they talk about illegal drugs. This is partly because some parents are unaware of the behavior (it wasn’t as prevalent when they were teenagers), and partly because those who are aware of teen abuse of medicine tend to underestimate the risks just as teens do. Finally, a recent study by Partnership for Drug-Free Kids showed that 28% of parents have themselves taken a prescription drug without having a prescription for it themselves. This is not necessarily abuse, but it sets a dangerous example for kids – that the recommended dosage of prescriptions need not be strictly followed.

What should parents do?

1. Educate yourselves – drugfree.org has lots of support, tools, resources and answers.
2. Communicate the risks of prescription drug abuse to your kids. Children who learn a lot about the risks of drugs are up to 50% less likely to use drugs.
3. Safeguard your own medicines. Keep prescription medicine in a secure place, count and monitor the number of pills you have.

Learn more at www.drugfree.org

The development of this fact sheet was sponsored by Cephalon, National Supporter, Parent Resources 2010

SAMHSA
Opioid Overdose
TOOLKIT

Facts for Community Members

Five Essential Steps for First Responders

Information for Prescribers

Safety Advice for Patients & Family Members

Recovering from Opioid Overdose



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FACTS FOR COMMUNITY MEMBERS

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.maclclearinghouse.org>.

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).

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].

Encourage providers and others to learn about preventing and managing opioid overdose.

Ensure access to treatment for individuals who are misusing or addicted to opioids or who have other substance use disorders.

FACTS FOR COMMUNITY MEMBERS

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](http://www.cdc.gov/HomeandRecreationalSafety/Poisoning/laws/immunity.html).

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.

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.

*Encourage
the public to
call 911.*

*Encourage
prescribers to
use state
Prescription
Drug Monitoring
Programs.*

FACTS FOR COMMUNITY MEMBERS

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].

FIVE ESSENTIAL STEPS FOR FIRST RESPONDERS

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-naïve 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].

FIVE ESSENTIAL STEPS FOR FIRST RESPONDERS

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.

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 through 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.

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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

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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

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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 consultations [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.

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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-naïve 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.

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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.prescribeprevent.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.pcass-o.org> or <http://www.pcassb.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>.

RECOVERING FROM OPIOID OVERDOSE

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.

RECOVERING FROM OPIOID OVERDOSE

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.jsp>

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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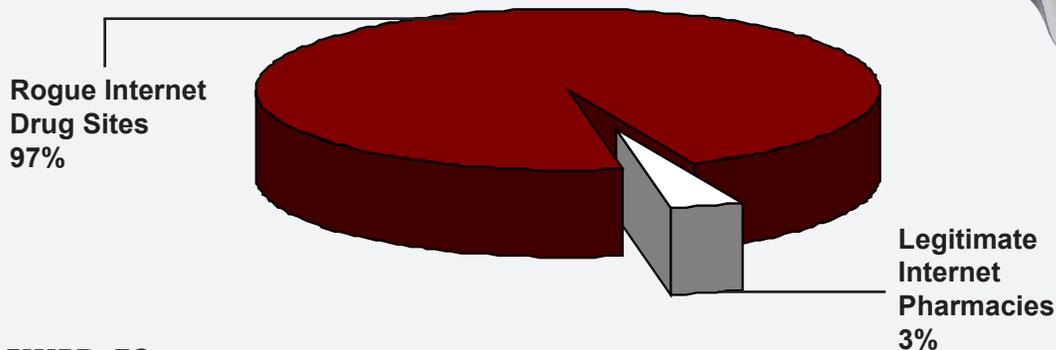


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Printed 2014

Internet Pharmacies and You



Buying prescription medicine online can be dangerous. Our findings may alarm you.



Are You AWARxE?

- NABP® has **reviewed** more than **10,000 Web sites** selling prescription drugs. By some estimates, as much as **90%** of the medication bought online may be fake.
- **Only 3%** of these sites appear to be **in compliance** with state and federal laws and NABP patient safety and pharmacy practice standards.
- The other **97%** of these sites are considered **rogue sites** and are listed as **Not Recommended** on the AWARxE® Web site, www.AWARERX.ORG.

For Your Protection, Look for the VIPPS Seal

- As seen on *60 Minutes*, *Dr Oz*, and *The Doctors*, look for sites accredited through the **VIPPS®** program. These sites are listed as **Recommended** at AWARERX.ORG.
- And don't forget about your **pets**. Protect them by looking for the **Vet-VIPPS®** Seal when purchasing their medications online.



AWARxE is a consumer protection program provided by the National Association of Boards of Pharmacy Foundation®. For more information, please visit www.AWARERX.ORG. NABP is an impartial professional organization that supports the state boards of pharmacy in creating uniform regulations to protect public health.



National Association of Boards of Pharmacy
www.nabp.net

National Resources and Discount Prescription Sources

National

- **VIPPS (Verified-Internet Pharmacy Practice Sites):**
Some VIPPS-accredited sites may offer discount prescription programs. Visit the AWA_Rx_E Web site for a full listing of the VIPPS sites: www.AWARERX.ORG.
- **Partnership for Prescription Assistance:** www.pparx.org (1-888/477-2669)
Helps match patients to appropriate health care and prescription assistance programs.
- **Medicare:** www.medicare.gov or www.medicare.gov/Publications/Pubs/pdf/11318.pdf
Lists resources for prescription drug coverage.
- **BenefitsCheckUp:** www.benefitscheckup.org
A service of the National Council on Aging.
Provides information about local, state, and federal as well as private prescription assistance programs.
- **NACo Prescription Discount Card Program:** www.naco.org/programs/residents/Pages/pdcp.aspx (1-877/321-2652)
A free program for residents of the National Association of Counties (NACo) member counties.



Does a Drug Dealer Lurk in Your Medicine Cabinet?

Proper Drug Disposal Protects
Your Loved Ones from Misuse

FACT: *Three in five teens say prescription pain relievers are easy to get from a parent's medicine cabinet, and more than 50% of people who abused prescription drugs in 2009 and 2010 got them from friends or family for free.*

Additional facts and resources about prescription drug abuse trends, safe medication use, and medication disposal are available on the AWA_Rx_E Web site.

GET INFORMED | www.AWARERX.ORG

Share the news to raise AWA_Rx_Eness across America among friends and family

- The next Drug Enforcement Administration (DEA) National Prescription Drug Take-Back Day will take place Saturday, October 26, 2013. More information is available at www.AWARERX.ORG.
- DEA drug take-back events, coordinated with local law enforcement agencies across the country, provide a safe means for the disposal of unwanted, unused prescription medications – including controlled substances – for authorized disposal. DEA plans to provide an online drug collection site locator prior to the event.
- Consumers disposed of 2.8 million pounds (1,409 tons) of unwanted medication during the first six DEA National Prescription Drug Take-Back Days and the sixth DEA take-back event on April 27, 2013, saw participation from 5,829 partners that provided take-back sites across all 50 states and the United States territories.



Most students use prescription drugs properly, but nearly one in five teens reports abusing them to get high. By their sophomore year in college, about half of all students have been offered the opportunity to abuse a prescription drug.

Consider these facts:

- Teens are engaging in dangerous activities, such as crushing pills, then snorting or injecting their contents. They also combine them with alcohol or illicit drugs. At “pharming parties,” they may dump a variety of drugs in a bowl and take them without knowing what they are.
- Teens most commonly abuse pain relievers (e.g., OxyContin® and Vicodin®), stimulants (e.g., Ritalin® and Adderall®), and sedatives and tranquilizers (e.g., Valium® and Xanax®).
- It is surprisingly easy for teens to gain access to prescription drugs from their families’ medicine cabinets, a friend’s purse, and even a schoolmate’s locker!
- Young people sometimes illegally order controlled prescription drugs from illegal Web sites.

Please remember that prescription medicines, when used correctly and under a doctor’s supervision, are safe and effective.

Additional Resources

Substance Abuse and Mental Health Services Administration (SAMHSA)
SAMHSA’s Health Information Network (SHIN)
1-877-SAMHSA-7 (1-877-726-4727)
www.SAMHSA.gov/shin

Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Substance Abuse Treatment (CSAT)
240-276-2750
www.csat.samhsa.gov

SAMHSA’s National Helpline
800-662-HELP (800-662-4357) (Toll-Free)
(English and Spanish)
800-487-4889 (TDD) (Toll-Free)
Substance Abuse Treatment Facility Locator:
240-276-2548
www.samhsa.gov/treatment

National Institute on Drug Abuse (NIDA)
www.nida.nih.gov/parent-teacher.html

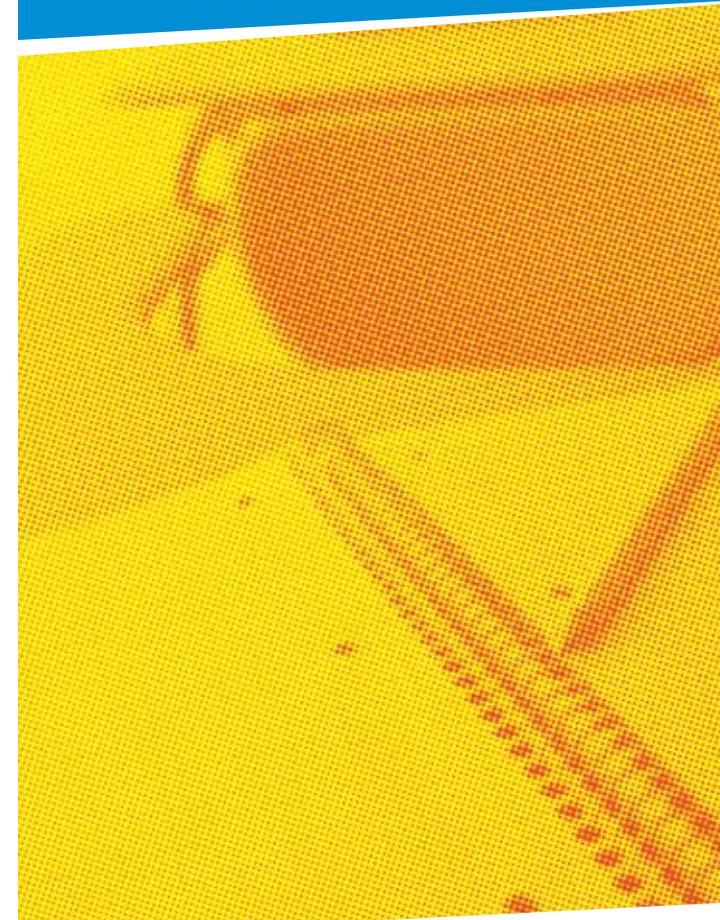
National Council on Patient Information and Education (NCPPIE)
301-656-8565
www.talkaboutrx.org

Drug Enforcement Agency (DEA)
www.getsmartaboutdrugs.com

National Association of School Nurses (NASN)
240-821-1130
www.nasn.org

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Not Worth The Risk
Xeve | it’s legal



What do
educators
need to know

You care about your students, and you know them as well as anyone. But did you know that while rates of drug abuse are down overall, more and more teens are abusing prescription drugs today?

AN IMPORTANT LESSON:
helping students avoid prescription drug abuse

SMA # 09-4446



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Health Ser
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

Many teens and adults, too, have carefree attitudes toward the use of prescription drugs. People ages 12 to 25 have among the highest rates of prescription drug abuse.

How can I understand “Generation Rx”?

People ages 12 to 25 have among the highest rates of prescription drug abuse. Parents and others often underestimate teens’ abuse of prescription drugs.

Teens may have carefree attitudes about prescription drug abuse and be unaware of the serious and potentially life-threatening risks.

Why do kids abuse prescription drugs?

- They are seeking psychological or physical pleasure.
- They do not understand the risks of taking drugs that were not prescribed specifically for them. They also fail to realize the danger of mixing prescription drugs with alcohol, other prescription drugs, and illegal drugs.
- It is easier to get prescription drugs than illegal drugs.
- There is pressure to get better grades or to fit in with friends. They also may not be aware of other, positive alternatives to help them deal with stress.

What do teens not always realize?

- Abusing prescription drugs, even if they are prescribed by a doctor, is *not* safer than abusing illegal drugs.
- Misusing prescription drugs *can* lead to addiction.
- Using prescription drugs without a doctor’s prescription or abusing someone else’s prescriptions—or your own—is *always* harmful, not to mention illegal.

How do I recognize the signs of prescription drug abuse?

- Decreased or obsessive interest in school work
- Fatigue, red or glazed eyes, and repeated health complaints
- Sudden mood changes, including irritability, negative attitude, personality changes, and general lack of interest in extracurricular activities
- An extreme change in groups of friends or hangout locations

What should I remind my students to do?

- **Respect** the power of medicine and use it properly.
- **Recognize** that all medicines, including prescription drugs, have risks along with benefits. The risks tend to increase dramatically when medicines are abused.
- Take **responsibility** for learning how to take prescription drugs safely and appropriately. Seek help at the first sign of their own or a friend’s problem.

Help your students understand prescription drug abuse—whether you are a health teacher or simply work closely with students as an athletic coach, mentor, or guidance counselor. Take even just a moment to have a brief conversation in the hallways or locker room. Remind your students that you are there to help.

How can I help?

- ✓ **Speak to your students** about prescription drug abuse—do not presume that illegal drugs are the only threat.
- ✓ **Alert parents** if you are concerned about their child. Let parents know what they can do. A brochure for parents, “Talking to your kids about prescription drug abuse,” is available at www.talkaboutrx.org.
- ✓ **Provide a safe and open environment** for your students to talk about abuse issues. Empathize with the stresses of growing up and identify positive outlets that can help relieve teens’ stress, such as sports teams and youth groups.
- ✓ **Hold interactive discussions** with your students to dispel myths and give them the facts.
- ✓ **Encourage students to speak with you** or another faculty member if they suspect a friend may have a problem. A brochure for teens, “Prescription drugs: They can help but also hurt,” is available at www.talkaboutrx.org.
- ✓ **Be observant** about discussions students may have in the hallways about prescription drug abuse. If you hear misconceptions, join in to correct them and show your support.



Corresponding Responsibility

It's the Law.

The California State Board of Pharmacy protects and promotes the health and safety of California consumers by pursuing the highest quality of pharmacist care and the appropriate use of pharmaceuticals through education, communication, licensing, legislation, regulation and enforcement.

California State Board of Pharmacy

1625 N. Market Blvd., N219

Sacramento, CA 95834

Phone: (916) 574-7900

Fax: (916) 574-8618

For more information, visit our website at www.pharmacy.ca.gov



California State Board of Pharmacy

A Pharmacist Has a Corresponding Responsibility

Precedential Decision



You, a pharmacist, are the last line of defense in preventing controlled substances from getting into the wrong hands.

In August 2013, the Board of Pharmacy made a 2012 license revocation case a precedential decision.

In this case, the board revoked the licenses of both a Huntington Beach pharmacy and its pharmacist because the pharmacist failed to comply with **corresponding responsibility** requirements in the distribution of opioid drugs. Four patients died as a result. The decision can be read online at <http://www.pharmacy.ca.gov/enforcement/fy1011/ac103802.pdf>.

The Decision and Order concluded that a pharmacist must inquire whenever a pharmacist believes that a prescription may not have been written for a legitimate medical purpose.

The pharmacist must not fill the prescription when the results of a reasonable inquiry do not overcome concern about a prescription being written for a legitimate medical purpose.

Just say "No." A pharmacist has a right and responsibility to deny a prescription if it does not seem legitimate. First, check CURES then call the prescriber, but don't rely on the number on the prescription form as it could be phony. Once verified with the prescriber, if a pharmacist still does not feel comfortable, refuse to fill the prescription.

The Law



According to Health and Safety Code section 11153, "a prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice."

While the prescriber has the responsibility for the proper prescribing and dispensing of controlled substances, the pharmacist filling the prescription has a **corresponding responsibility** to ensure the prescription is legal and not for purposes of abuse.

The criminal punishment for knowingly violating this law is imprisonment in county jail of up to one year and a fine of up to \$20,000.

Red Flags



The precedential decision included a list of some of the "red flags" that warn pharmacists there could be a problem with the prescription. A pharmacist must also rely on his or her professional judgment to discern when a prescription seems suspicious.

- ▶ Irregularities on the face of the prescription itself
- ▶ Nervous patient demeanor
- ▶ Age or presentation of patient (e.g., youthful patients seeking chronic pain medications)
- ▶ Multiple patients all with the same address
- ▶ Multiple prescribers for the same patient for duplicate therapy
- ▶ Cash payments
- ▶ Requests for early refills of prescriptions
- ▶ Prescriptions written for an unusually large quantity of drugs
- ▶ Prescriptions written for duplicative drug therapy
- ▶ Initial prescriptions written for strong opiates
- ▶ Long distances traveled from the patient's home to the prescriber's office or to the pharmacy
- ▶ Irregularities in the prescriber's qualifications in relation to the type of medication(s) prescribed
- ▶ Prescriptions that are written outside of the prescriber's medical specialty
- ▶ Prescriptions for medications with no logical connection to an illness or condition

More Red Flags from the DEA



- ▶ Patients coming to the pharmacy in groups, especially if their home addresses are outside of the pharmacy's local trade area, each with the same prescriptions issued by the same prescriber
- ▶ The same diagnosis codes for many patients
- ▶ Prescriptions written for potentially duplicative drug therapy
- ▶ The same combinations of drugs prescribed for multiple patients
- ▶ Excessively celebratory patient demeanor



Policy Impact: Prescription Painkiller Overdoses

What's the Issue?

In a period of nine months, a tiny Kentucky county of fewer than 12,000 people sees a 53-year-old mother, her 35-year-old son, and seven others die by overdosing on pain medications obtained from pain clinics in Florida.¹ In Utah, a 13-year-old fatally overdoses on oxycodone pills taken from a friend's grandmother.² A 20-year-old Boston man dies from an overdose of methadone, only a year after his friend also died from a prescription drug overdose.³

These are not isolated events. Drug overdose death rates in the United States have more than tripled since 1990 and have never been higher. In 2008, more than 36,000 people died from drug overdoses, and most of these deaths were caused by prescription drugs.⁴

100 people die from drug overdoses every day in the United States.⁴



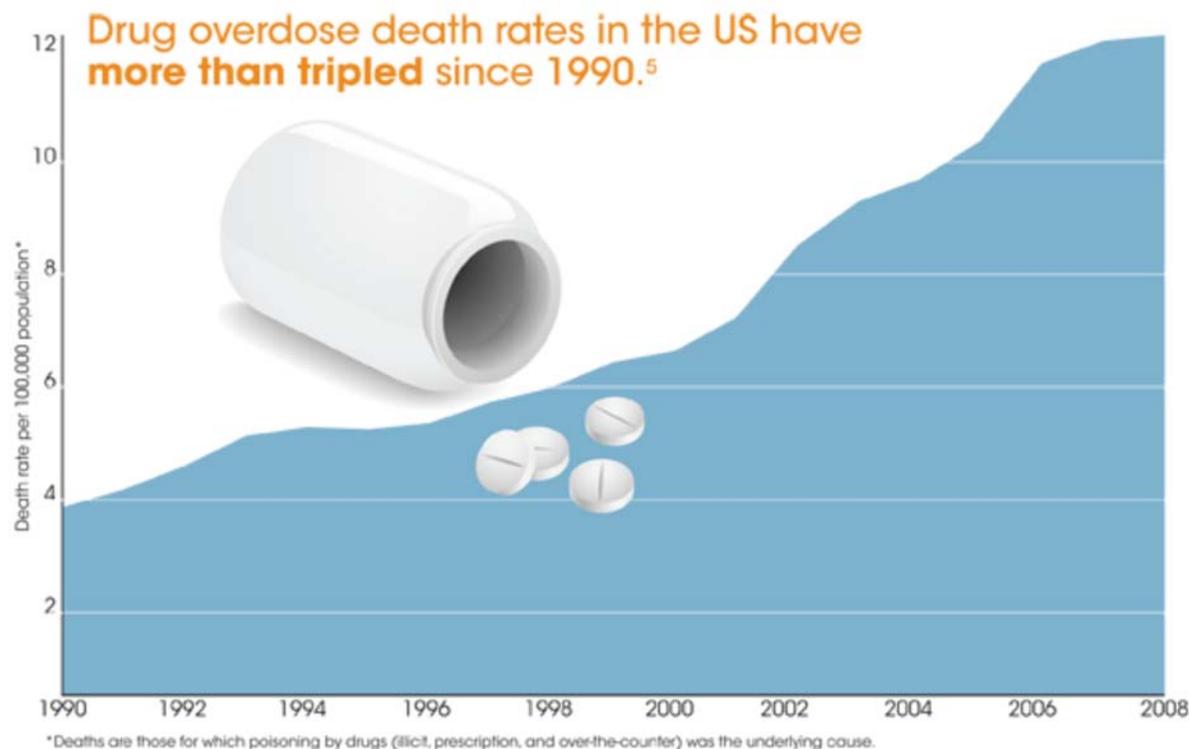
Policy Impact:

Prescription Painkiller Overdoses

[460KB, 12 pages]

[/HomeandRecreationalSafety/pdf/PolicyImpact-PrescriptionPainkillerOD.pdf](http://www.cdc.gov/homeandrecreationalafety/pdf/PolicyImpact-PrescriptionPainkillerOD.pdf)

Order Printed Copies (<http://www.cdc.gov/pubs/ncipc.aspx>)





What Do We Know?

The role of prescription painkillers

Although many types of prescription drugs are abused, there is currently a growing, deadly epidemic of prescription painkiller abuse. Nearly three out of four prescription drug overdoses are caused by prescription painkillers—also called opioid pain relievers. The unprecedented rise in overdose deaths in the US parallels a 300% increase since 1999 in the sale of these strong painkillers.⁴ These drugs were involved in 14,800 overdose deaths in 2008, more than cocaine and heroin combined.⁴

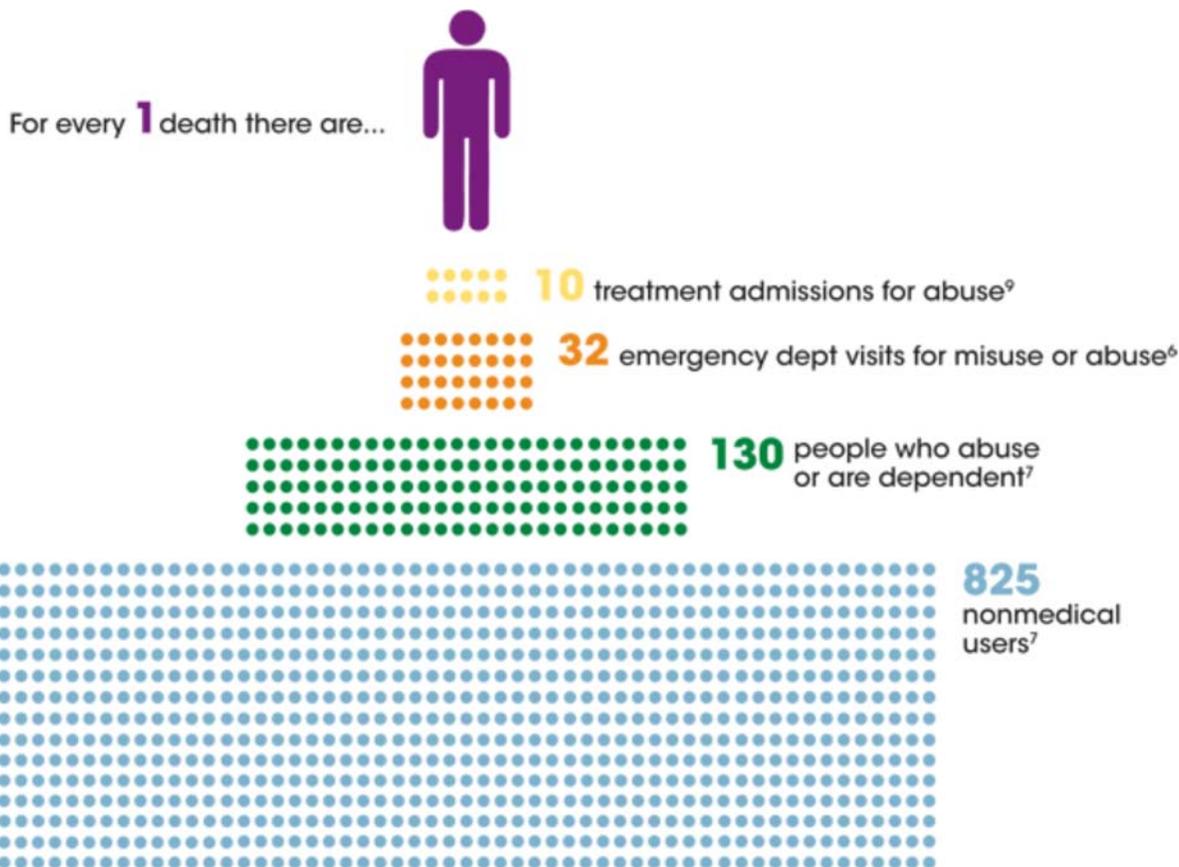
The misuse and abuse of prescription painkillers was responsible for more than 475,000 emergency department visits in 2009, a number that nearly doubled in just five years.⁶

More than 12 million people reported using prescription painkillers nonmedically in 2010, that is, using them without a prescription or for the feeling they cause.⁷

The role of alcohol and other drugs

About one-half of prescription painkiller deaths involve at least one other drug, including benzodiazepines, cocaine, and heroin. Alcohol is also involved in many overdose deaths.⁸

In 2008, there were 14,800 prescription painkiller deaths.⁴



How Prescription Painkiller Deaths Occur

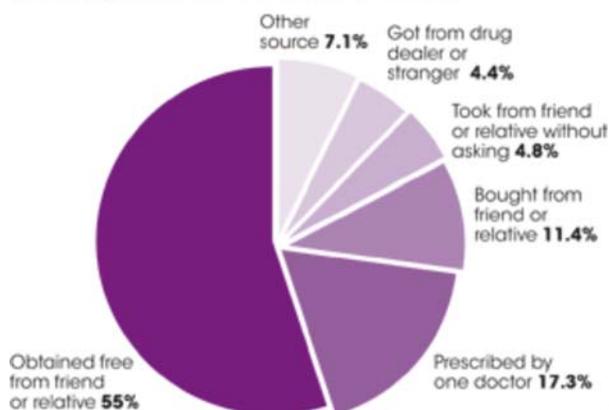
Prescription painkillers work by binding to receptors in the brain to decrease the perception of pain. These powerful drugs can create a feeling of euphoria, cause physical dependence, and, in some people, lead to addiction. Prescription painkillers also cause sedation and slow down a person's breathing.

A person who is abusing prescription painkillers might take larger doses to achieve a euphoric effect and reduce withdrawal symptoms. These larger doses can cause breathing to slow down so much that breathing stops, resulting in a fatal overdose.

In 2010, 2 million people reported using prescription painkillers nonmedically for the first time within the last year—nearly 5,500 a day.⁷

Where the drugs come from

People who abuse prescription painkillers get drugs from a variety of sources⁷



Almost all prescription drugs involved in overdoses come

from prescriptions originally; very few come from pharmacy theft. However, once they are prescribed and dispensed, prescription drugs are frequently diverted to people using them without prescriptions. More than three out of four people who misuse prescription painkillers use drugs prescribed to someone else.⁷

Most prescription painkillers are prescribed by primary care and internal medicine doctors and dentists, not specialists.¹⁰ Roughly 20% of prescribers prescribe 80% of all prescription painkillers.^{11,12,13}

Who is most at risk

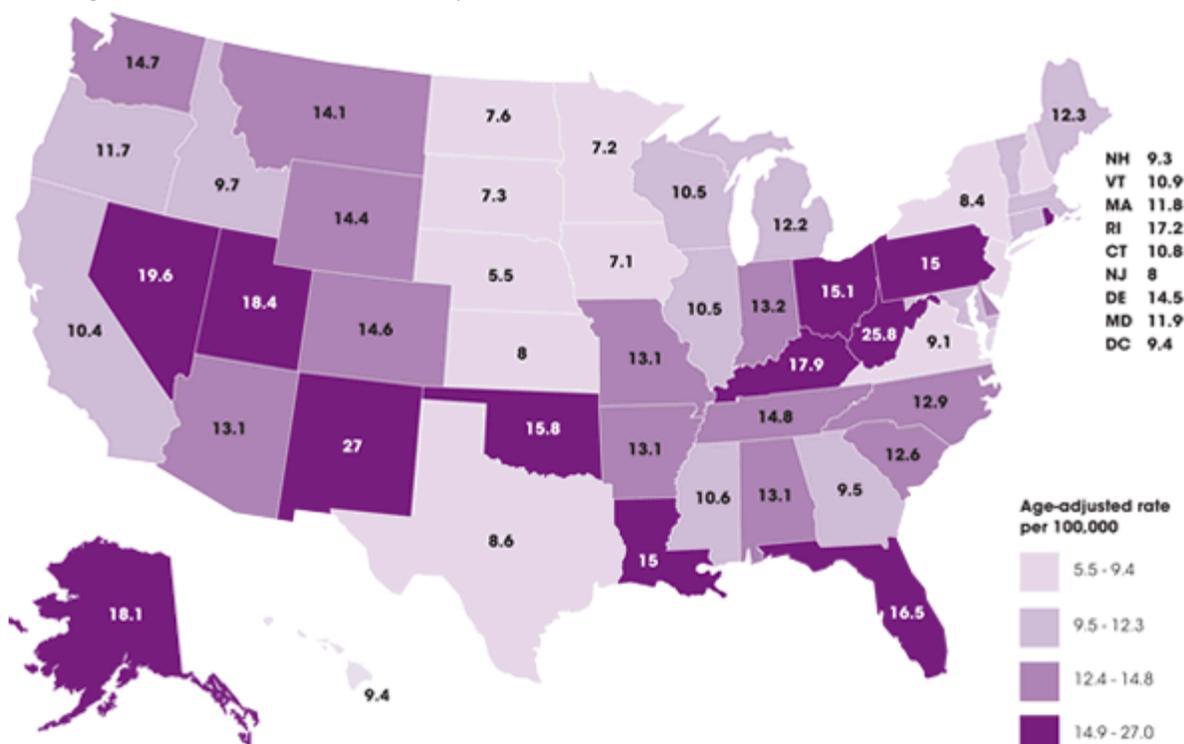
Understanding the groups at highest risk for overdose can help states target interventions. Research shows that some groups are particularly vulnerable to prescription drug overdose:

- People who obtain multiple controlled substance prescriptions from multiple providers—a practice known as “doctor shopping.”^{14,15}
- People who take high daily dosages of prescription painkillers and those who misuse multiple abuse-prone prescription drugs.^{15,16,17,18,19}
- Low-income people and those living in rural areas.
 - People on Medicaid are prescribed painkillers at twice the rate of non-Medicaid patients and are at six times the risk of prescription painkillers overdose.^{20,21} One Washington State study found that 45% of people who died from prescription painkiller overdoses were Medicaid enrollees.²⁰
- People with mental illness and those with a history of substance abuse.¹⁹

Where overdose deaths are the highest

The drug overdose epidemic is most severe in the Southwest and Appalachian region, and rates vary substantially between states. The highest drug overdose death rates in 2008 were found in New Mexico and West Virginia, which had rates nearly five times that of the state with the lowest rate, Nebraska.⁴

Drug Overdose Rates by State, 2008⁴



What Can We Do?

There are many different points of intervention to prevent prescription drug overdoses. States play a central role in protecting the public health and regulating health care and the practice of the health professions. As such, states are especially critical to reversing the prescription drug overdose epidemic.

The following state policies show promise in reducing prescription drug abuse while ensuring patients have access to safe, effective pain treatment.

CDC Recommendations

Prescription Drug Monitoring Programs

Thirty-six states have operational Prescription Drug Monitoring Programs.²²

Prescription Drug Monitoring Programs (PDMPs) are state-run electronic databases used to track the prescribing and dispensing of controlled prescription drugs to patients. They are designed to monitor this information for suspected abuse or diversion—that is, the channeling of the drug into an illegal use—and can give a prescriber or pharmacist critical information regarding a patient's controlled substance prescription history. This information can help prescribers and pharmacists identify high-risk patients who would benefit from early interventions.

CDC recommends that PDMPs focus their resources on

- patients at highest risk in terms of prescription painkiller dosage, numbers of controlled substance prescriptions, and numbers of prescribers; and
- prescribers who clearly deviate from accepted medical practice in terms of prescription painkiller dosage, numbers of prescriptions for controlled substances, and proportion of doctor shoppers among their patients.

CDC also recommends that PDMPs link to electronic health records systems so that PDMP information is better integrated into health care providers' day-to-day practices.

Patient review and restriction programs

State benefits programs (like Medicaid) and workers' compensation programs should consider monitoring prescription claims information and PDMP data (where applicable) for signs of inappropriate use of controlled prescription drugs. For patients whose use of multiple providers cannot be justified on medical grounds, such programs should consider reimbursing claims for controlled prescription drugs from a single designated physician and a single designated pharmacy. This can improve the coordination of care and use of medical services, as well as ensure appropriate access, for patients who are at high risk for overdose.

Health care provider accountability

States should ensure that providers follow evidence-based guidelines for the safe and effective use of prescription painkillers. Swift regulatory action taken against health care providers acting outside the limits of accepted medical practice can decrease provider behaviors that contribute to prescription painkiller abuse, diversion, and overdose.

Laws to prevent prescription drug abuse and diversion

States can enact and enforce laws to prevent doctor shopping, the operation of rogue pain clinics or

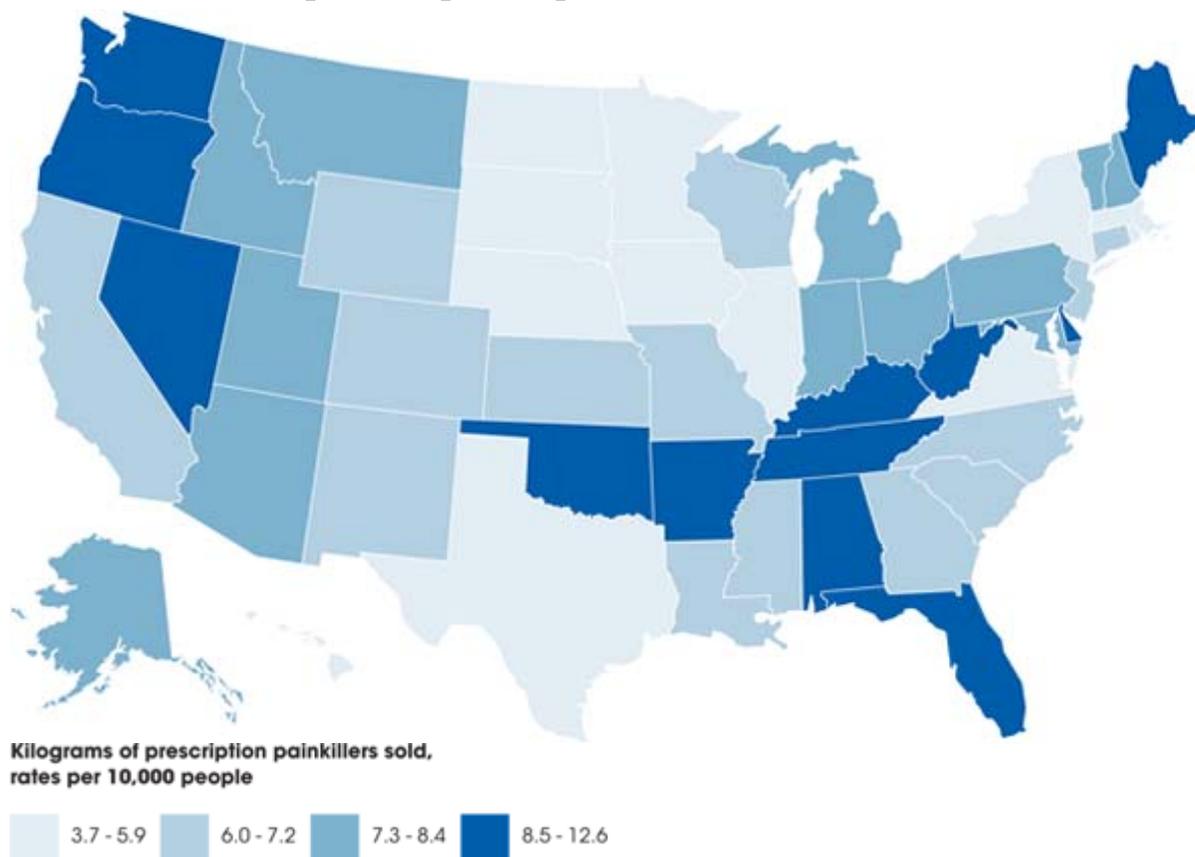
“pill mills,” and other laws to reduce prescription painkiller diversion and abuse while safeguarding legitimate access to pain management services. These laws should also be rigorously evaluated for their effectiveness. [View your state's prescription drug laws. \(/HomeandRecreationalSafety/Poisoning/laws/index.html\)](#)

Better access to substance abuse treatment

Effective, accessible substance abuse treatment programs could reduce overdose among people struggling with dependence and addiction. States should increase access to these important programs.

These recommendations are based on promising interventions and expert opinion. Additional research is needed to understand the impact of these interventions on reducing prescription drug overdose deaths.

The amount of prescription painkillers sold in states varies.⁴

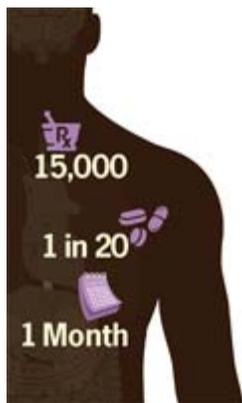


The quantity of prescription painkillers sold to pharmacies, hospitals, and doctors' offices was 4 times larger in 2010 than in 1999. Enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for one month.

Additional Resources

[CDC Vital Signs: Prescription Painkiller Overdoses in the US \(http://www.cdc.gov/vitalsigns/PainkillerOverdoses/index.html\)](http://www.cdc.gov/vitalsigns/PainkillerOverdoses/index.html)

[MMWR: Vital Signs: Overdoses of Prescription Opioid Pain Relievers --- United States, 1999--2008 \(http://www.cdc.gov/mmwr/preview/mmwrhtml/mm60e1101a1.htm\)](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm60e1101a1.htm)



CDC Feature Article: Prescription Painkiller Overdoses in the U.S.

(<http://www.cdc.gov/Features/Vitalsigns/PainkillerOverdoses/>)

Science Clips: CDC Vital Signs, Opioid Pain Reliever (OPR) Abuse

(<http://www.cdc.gov/phlic/sciclips/issues/v3issue44.html>)

CDC Vital Signs: Prescription Painkiller Overdoses - A Growing Epidemic, Especially Among Women (</vitalsigns/PrescriptionPainkillerOverdoses/index.html>)

Prescription Drug Overdose: State Laws (</HomeandRecreationalSafety/Poisoning/laws/index.html>)

Nearly 15,000 people die every year of overdoses involving prescription painkillers. In 2010, 1 in 20 people in the US (age 12 or older) reported using prescription painkillers for nonmedical reasons in the past year. Enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for a month.

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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.

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 (NCSSE), 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.



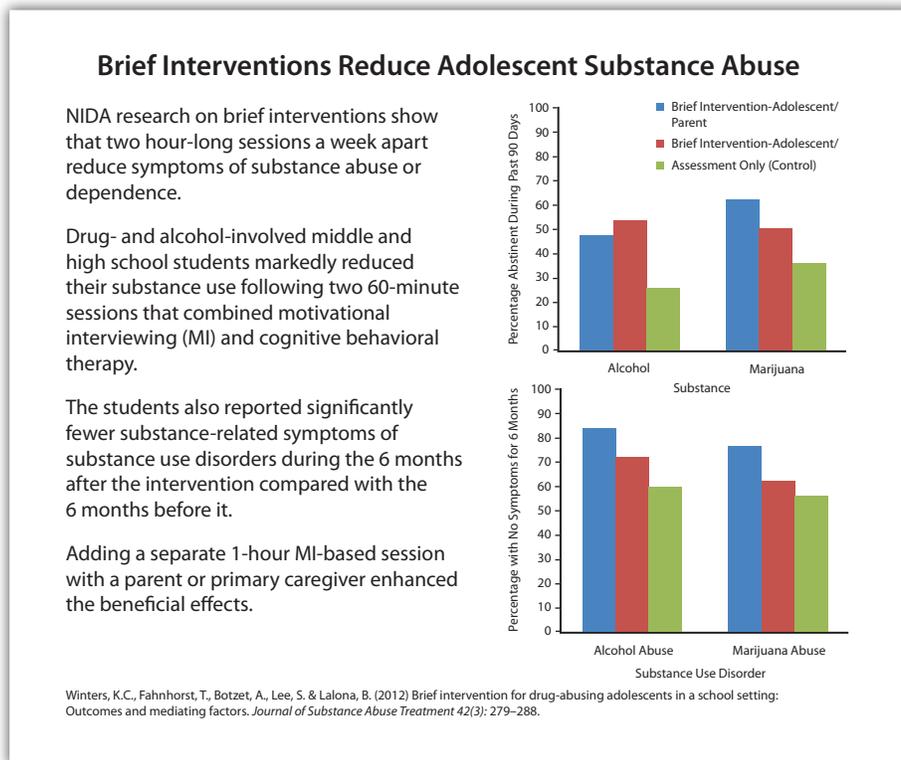
Chapter 2. Seek Early Intervention Opportunities in Health Care

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 Use²⁸



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 Strobe



Scott Strobe 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 Forum⁴¹ 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 Project⁶² 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 STONEGARDEN⁶³ 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 OCEDEF 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 exposures⁶⁹ to synthetic cannabinoids⁷⁰ 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 inter-agency 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.



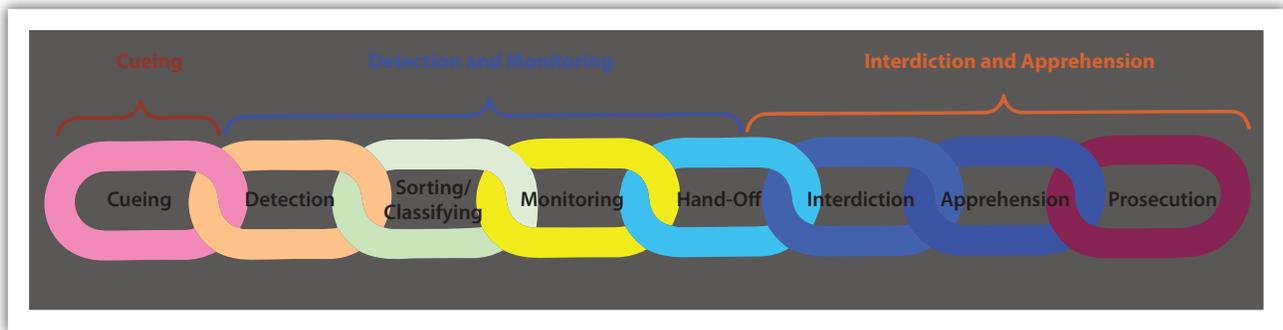
Chapter 6: Strengthen International Partnerships and Reduce the Availability of Foreign-Produced Drugs in the United States

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 non-existent. 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 percent 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 visits⁹⁰ 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.

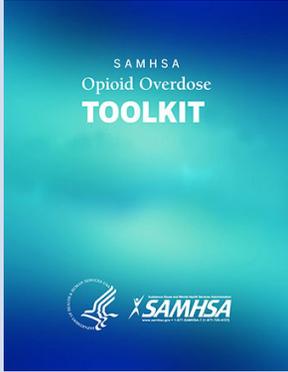
With the expansion of Tactical Diversion Squads across the country, the number of diversion-related criminal and administrative cases has increased significantly. Between FY 2008 and FY 2013, these Tactical

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

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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

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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

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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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Treatment eBook

How to find the right help for
your child with an alcohol or
drug problem

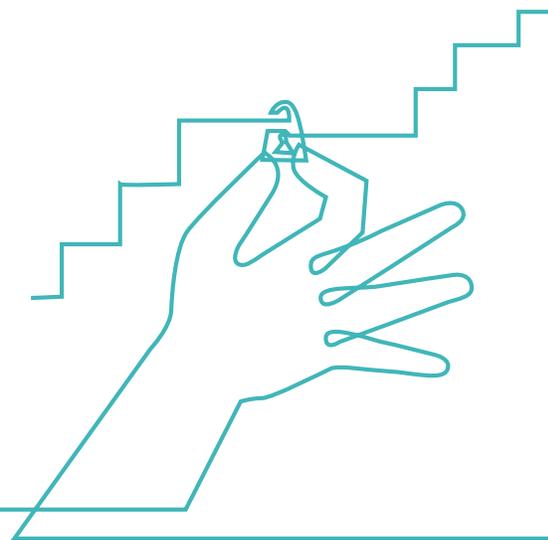


INCLUDES ANSWERS TO THESE QUESTIONS

- What is substance abuse treatment?
- How do I find the right treatment for my child?
- How do I pay for treatment?
- How do I get my child to start treatment?
- What can I do to cope better?

How to find the right help for your child with an alcohol or drug problem

This eBook provides you with information about adolescent and young-adult alcohol and other drug abuse treatment and will help you get the most appropriate care for your child and family. You will learn what alcohol and drug abuse treatment is, how to find the right type of treatment for your child, how to pay for treatment, and the importance of taking care of yourself and your family.



How to find the right help for your child with an alcohol or drug problem

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How to find the right help for your child with an alcohol or drug problem

A Note About This eBook

Before you start reading this eBook you should know that many teenagers and young adults who develop problems with alcohol or other drugs have risk factors that other youth may not. Some common risk factors include:

- Addiction in the family
- Co-occurring mental illness such as depression, bipolar disorder, and anxiety
- Trauma such as a death in the family, divorce, or a history of emotional, physical or sexual abuse
- Difficult transitions such as moving to a new community, changing schools, or a change in family composition

It is important to know about these risk factors when looking for help for your child so you can understand why and how your child may have developed his problem with alcohol or other drugs. This is not the time to say, *"If only..."* Now you need to put your energy into educating yourself and getting the best help for your child and your family.

You're taking a smart first step by reading this eBook. This book is going to make you an educated advocate for your child and help you find the best substance abuse treatment so he can get his life back on track and your family can begin the healing process.



How to find the right help for your child with an alcohol or drug problem

My Child Has an Alcohol or Other Drug Problem and May Need Treatment.

If the above sentence is true, then you've come to the right place. Realizing that your teenager or young-adult child needs help for his or her alcohol or other drug problem can fill you with a wide range of emotions. You may be scared for your child's* health or angry that things have gotten to this point. You may be motivated to dive right into the treatment-finding process, or you may have no idea where to begin. But no matter where you are emotionally, mentally, or physically, this eBook will provide helpful and realistic information and advice to aid you in steering your child — and your family — toward recovery.

**In this eBook, the word "child" can refer to your teenager (ages 12-17) or young adult (ages 18-24). However, by law, your child is only a minor until age 18, and is then a legal adult.*

PART I: WHAT IS TREATMENT?

When most people hear the term "substance abuse treatment," they think of either detox or a residential facility. But in reality, detox (detoxification) is not treatment and residential treatment is one of several types of treatment options available for somebody with a substance abuse problem. As you read throughout this eBook you'll discover treatment for abuse and dependence to alcohol or other drugs is actually a set of services.

Treatment occurs in a variety of settings, in different forms, and for different lengths of time. There are many addictive drugs, yet the treatment approach for addiction is generally similar regardless of the type of substance your loved one is addicted to. However, treatment is typically individualized to some degree based on the characteristics of the patient — treatment programs usually address an individual's physical, psychological, emotional, and social issues in addition to his or her alcohol or other drug use.

Unfortunately, when it comes to alcohol and other drug abuse and dependence as with other health conditions, there are no guarantees for the perfect treatment, and it is often difficult to access "quality treatment." Addiction is a manageable but chronic disease, just like diabetes or asthma. Because it is a chronic, relapsing disease, you should not think about treatment as a way to "cure" your loved one. You should look at treatment as a first step in helping your child

In the eBook we use the term abuse and dependence. Medical professionals and treatment providers may use other terms such as substance use disorder.



How to find the right help for your child with an alcohol or drug problem

learn how to manage his drug abuse and dependence. For youth, successful treatment is complete abstinence from all addictive substances, as well as sustained improvement in emotional, physical, and mental well-being and social functioning.

When looking into substance abuse treatment for your child, you may need to adjust your outlook and way of thinking. Here are some tips as you get started on this difficult journey:

Reconsider the way you measure success. In the past, you've probably hoped for your child to have 100% school attendance or to get an A on a test. But when it comes to substance abuse treatment, numbers indicating "success rate" or "effectiveness" look a little bit different. Because a drug problem for a teenager or young adult can be characterized by possible relapses, going through treatment once may not be sufficient to keep him or her drug free. Relapse doesn't mean that treatment hasn't worked. As with all chronic diseases, relapse is often part of getting better.

Remember that what works for one child may not work for another. At this point you may have heard of a couple of different approaches to getting help for an alcohol or other problem. Treatment for a substance abuse problem is not one-size fits all. Your child may not respond to a treatment program that worked really well for another child. Alternatively your child may do really well in a program that didn't work for somebody else. What works for one individual may not work for your child. Different approaches to treatment help different kinds of people. Before you make any decisions about how to get your child help, read this eBook to help you understand what your family's options are.

Acknowledge what you are going through as a parent.

At this point you may be angry, scared, disappointed, and unsure what to do. All of these feelings are normal. It is important to know that you should get help for yourself and your family as well as your child who has a substance abuse problem.

Do I Really Need To Do Something about My Child's Alcohol or Other Drug Use?

You may be wondering, *Does my child really need to get special help?* Often, by the time a parent discovers that his or her child is abusing alcohol or other drugs, the child has probably been doing so for some time. And the problem might be more severe than the parent first realizes. So, it's important for parents to educate themselves about alcohol and drug dependence treatment and recovery — so they can take the appropriate action. The more parents understand about this topic, the better their child's chances are for getting his or her life back under control.

PART II: HOW DO I FIND THE RIGHT TREATMENT FOR MY CHILD?

There are six important steps to take to get the right treatment for your child.

Along the way you will learn about teenage and young adult substance abuse, learn the importance of getting a screening and in-depth assessment, learn the importance of networking when looking for help for a health problem, learn about the different substance abuse treatment settings and types, and learn the types of questions you should ask of treatment providers when looking for a substance abuse treatment program.

How to find the right help for your child with an alcohol or drug problem

The six steps are:

Step 1: Educate Yourself

Step 2: Screening and In-Depth Professional Assessment

Step 3: Network

Step 4: Treatment Settings, Types of Treatment, Recovery Supports and Services Available

Step 5: Look at Location

Step 6: Make Calls and Ask questions

You will need to educate yourself to understand what quality adolescent substance abuse treatment consists of. Stay open-minded and don't give up. Your child's problem will not be solved overnight. But by educating yourself you are helping your child get his life back on track sooner rather than later.

STEP 1: EDUCATE YOURSELF.

One of the most important things you can do to help your child is to educate yourself about alcohol and other drug abuse and dependence and what treatment for abuse and dependence is. Reading through this guide is a smart first step. You need to learn which questions to ask programs (when we use the word 'program,' this includes all treatment settings including outpatient, inpatient, and residential) to figure out if that program is a good fit for your child and your family. You need to learn what good quality adolescent treatment consists of — the types of programs available and the services that will help your child get better. Educating yourself will make you an informed consumer and will save you time and money and should help your child get better sooner.

Research has shown there are nine key elements that are important for adolescent substance abuse treatment programs to be effective, according to Drug Strategies,¹ these elements include:

- 1. Screening and comprehensive assessment** — to ensure understanding of the full range of issues your child and family may need help with.²
- 2. Comprehensive services** — to address not only your child's substance abuse problem but any medical, mental health, familial, or education problems your child may need help with.
- 3. Family involvement in treatment** — parents' involvement in their child's treatment and recovery increases the success of treatment.
- 4. Services and therapies appropriate for adolescents** — to address the different needs and capabilities of teenagers.
- 5. Strategies or interventions to engage and keep teenagers in treatment** — to help teenagers recognize the value of getting help for their substance abuse problem.
- 6. Qualified staff** — staff should have knowledge of and experience working with adolescents/young adults with substance abuse problems, and their families.

1. Drug Strategies (2003). *Treating Teens: A Guide to Adolescent Drug Programs*.

2. SAMHSA Screening and Assessing Adolescents for Substance Use Disorders (TIP 31) Available: <http://ncadi.samhsa.gov/govpubs/bkd306/31k.aspx>

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7. Consideration of cultural and gender differences — this is important because you want your child to be as comfortable as possible.

8. After care — programs should plan for care after the formal treatment program is over to ensure support and successful recovery.

9. Data gathering to measure outcomes and success of the program — although formal evaluations are expensive and not typical, programs should measure patients' progress.

Is There a Difference Between Adolescent and Adult Treatment for a Substance Abuse Problem?

Yes, there are key differences between adolescent and adult treatment and treatment designed for adults will not be as effective for a teen or young adult.

Why? Teenagers need different types of services and have different drug and alcohol abusing experiences. Teenagers are still developing physically, emotionally, and psychologically and most importantly their brains are not fully developed. So, abusing alcohol and drugs can be especially detrimental for adolescents and young adults who have not finished maturing physically or emotionally. And, it is critical that programs for adolescents include the family in the treatment process and that staff are trained in adolescent development.

Adolescent treatment is more focused on acting out behaviors, family dynamics, education, appropriately separating oneself from his or her family, and peer issues. For day programs, in-house schooling is provided. Adolescent programs routinely use group therapy since teenagers are peer-focused, and respond well to group dynamics.

While there are few treatment programs exclusively for young adults (ages 18-25) there are a few adult programs that specialize in this age group. And, some adolescent treatment programs will accept young adults up to the age of 25. It depends on the program so we suggest calling adolescent programs to find out the age cutoff for the program. Otherwise this age group is treated within adult programs which may not be the best fit.

American Society of Addiction Medicine (ASAM) Levels of Care

There are five broad levels of care your child may be assigned to depending on the results of the assessment.³

- Level 0.5: Early Intervention Services
- Level I: Outpatient Treatment
- Level II: Intensive Outpatient / Partial Hospitalization Services
- Level III: Residential / Inpatient Treatment Services
- Level IV: Medically Managed Intensive Inpatient

3. ASAM Patient Placement Criteria Available: <http://www.asam.org/PatientPlacementCriteria.html>

How to find the right help for your child with an alcohol or drug problem

Frequently Asked Questions about Assessments

1. What is the purpose of an assessment?

The purpose of an assessment is to get a comprehensive picture of your child's problems to make sure that he or she is referred to the right type of treatment.

2. Who should conduct an assessment? And who else can help if a person with the appropriate credentials is NOT available?

Ideally, an Addiction Psychiatrist or American Society of Addiction Medicine (ASAM) certified addiction professional should conduct the screening and assessment. However, this type of professional may not be available to you. In that case, look for a licensed mental health or drug abuse counselor with clinical experience working with adolescents, or a general mental health counselor. The important piece is making sure you work with a professional to assess the situation and figure out next steps in your child's care. Ideally, the person conducting the assessment should have at least a master's degree in the mental health field (such as a social worker or mental health counselor).

3. What should an assessment consist of?

An assessment should include the use of at least one standardized instruments — either as an interview or self-administered. The content of the assessment should cover:

- a. Strengths and Competencies of the Adolescent/Young Adult
- b. Substance Use (including history and signs of abuse and dependence)
- c. Juvenile Justice Involvement
- d. Treatment History
- e. School Functioning
- f. Peer Relations
- g. Family Environment (including parenting practices and family functioning)
- h. Physical Health
- i. Mental Health (ADHD, conduct disorder, oppositional defiant disorder, anxiety, depression)

Identifying the strengths and competencies of the child in addition to problems will help the clinician set goals for the client and tap into resources to aid the individual in the treatment and recovery process.

4. How do I know if the assessment is asking the right questions?

Use the list above to ask if all the areas listed above are covered in the assessment. Make sure the professional is using a standardized tool or instrument to improve the likelihood of appropriate treatment placement.

5. What is the difference between an intake, a screening, and an assessment?

Intake: This is the first contact with the treatment provider and is an event where a screening or full assessment is conducted. At intake you will begin filling out all the necessary paperwork to enroll your child in substance abuse treatment.

Screening: Shorter assessment process, typically less than 30 minutes; ideally used to determine if a person needs a full assessment. A screening will give an indication but not a definitive diagnosis. Some providers may use a single urine screen as the only screening tool and this is not an adequate screen by itself. A highly trained professional is not needed to administer a screen. If a youth is positive on a screen for substance use disorders, or mental health problems it alerts the clinician to go further. It can be thought of as a first step.

Assessment: Usually refers to a more comprehensive or full assessment, typically 60 minutes or more. It should be comprehensive as outlined above and conducted by a licensed professional. It is important to understand that a one session or even two session assessment at the beginning of or prior to treatment no matter how comprehensive is still limited. A good program and a good counselor should be assessing and adjusting the treatment plan as necessarily throughout the treatment. Dr. Howard Liddle always likes to remind us that "Every assessment is an intervention, and every intervention is an assessment."

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STEP 2: GET A SCREENING AND IN-DEPTH PROFESSIONAL ASSESSMENT.

It's essential that you get a screening and in-depth assessment of your child by a qualified person.

Here's how the screening and assessment process works:

First: Your child should get a screening. A screening gives you a quick picture of your child's substance use problem and helps determine if your child needs additional evaluation.

Second: If that screening determines that your child has a problem, the next step is for your child to get a full professional assessment. An in-depth assessment should assess your child's educational problems (e.g. learning disabilities), family problems, substance use problems, legal problems, mental health issues (such as depression, anxiety, conduct disorder, ADHD), and any medical/physical issues.

As you'll read below the assessment doesn't just look at alcohol or other drug problems, it also helps to determine if there are educational issues, family issues, medical issues and mental health issues.

The results of the full comprehensive assessment will help the substance abuse treatment professional determine the level of care your child needs including how intense the services need to be and how long your child needs to be in professional care. Professionals in the field refer to this as the ASAM (American Society of Addiction Medicine) Patient Placement Criteria. The ASAM guidelines help match individuals to the appropriate level and type of care needed.

“An assessment is a very comprehensive picture of what's going on with your child,” says Amelia Arria, Ph.D.

An assessment should be a thorough look at the extent of drug and alcohol use, the child's mental and physical health as well as his personal, medical and family history.

“It may involve an assessment of the family dynamics, the child's education and the child's mental health to see if there's some underlying psychiatric disorders which have their onset in early adolescence and typically precede alcohol and drug problems,” explains Dr. Arria.

An assessment helps to determine:

- 1) How severe your child's problem is.
- 2) The level of treatment the child needs (e.g. early intervention, outpatient, intensive outpatient/partial hospitalization, residential / inpatient services — see chart below for more detail).
- 3) The types of services the child needs.

The purpose of an assessment is to help understand how the child is functioning, his quality of life and to determine the type of program the child needs.

How to find the right help for your child with an alcohol or drug problem

Find a professional who can give your child a screening and assessment

To find a clinic or professional who can give your child a screening and assessment, contact your Single State Agency for Substance Abuse Services <http://www.samhsa.gov/grants/SSADirectory.pdf> or call SAMHSA at 1-800-662-HELP (4357).

Each U.S. State and Territory offers information and support for substance use disorders through a local government office. These offices are known as Single State Agencies and offer information and support for individuals seeking help for a mental health illness as well. Single State Agencies may be stand alone agencies or may be part of a larger department such as a mental health or public health department. These agencies can help you find clinics and professionals in your area who can conduct a substance abuse screening and assessment.⁴ A good place to start is by searching on the Single State Agency's website.

Mental Health Benefits and Parity

1. The good news is that 46 states currently have laws requiring coverage (of varying degrees) for mental health services.

There are roughly three categories of coverage across states: *Mental Health Parity or Equal Coverage Laws*: These laws prohibit insurers or health care service plans from discriminating between coverage for mental illness, serious mental illness, substance abuse, and other physical disorders/diseases (such as heart disease or diabetes). This means you are entitled to the same level of benefits for mental illness, serious mental illness, or substance abuse services as you get for other physical disorders/diseases. How this works exactly varies by state. Click here to find out the type of coverage required in your state. <http://www.ncsl.org/default.aspx?tabid=14352>.⁵

2. Minimum Mandated Mental Health Benefit Laws:

States with these laws require some level of coverage to be provided for mental illness, serious mental illness, and substance abuse services. Although insurers are allowed to discriminate under these laws and provide less or different type of coverage for mental illness, serious mental illness, or substance abuse services some coverage is required.

3. Mandated Mental Health Offering Laws:

States with mandated offering laws do not require mental health services benefits be offered. With this law states have two options; to require that the option for mental health services be provided to the insured OR if mental health benefits are offered, they must be equal.

STEP 3: NETWORK.

One of the first — and most helpful — steps you can take in finding help for your child is to talk to the people around you. You may feel like you should keep your child's drug or alcohol problem a secret, but you shouldn't. Addiction is a chronic disease, not a moral failing on your part or your child's part. Always keep this in mind, and know that the people you hide your problem from may be the same people who could give you good advice or connect you to the help you need.

Again, be aware that what works for one child or family may not work for another. Friends, relatives, medical professionals, and other parents who have been in your shoes may all have great advice or experience to share — but ultimately, you know your child best.

4. SAMHSA (2009). *Directory of Single State Agencies Available* <http://www.samhsa.gov/Grants/ssadirectory.pdf>

5. *National Conference of State Legislators*

How to find the right help for your child with an alcohol or drug problem

Networking: How to Approach Others for Help

1. Do you know anyone who has had a similar experience with their child? Start by contacting your family and friends — as well as others you know from work, your neighborhood, your religious community, etc.) — who have experience getting help for someone with a substance abuse problem.
 2. Think about who can really help you. Even if your family and friends don't have experiences specifically with substance abuse, they can support you by helping you sort through programs, talk about your fears, anger, and concerns, and just be there for you as you make difficult decisions. Networking will not only help you get help for your child, it will help you feel less alone and give you support.
 3. Call, email and ask where and how did these others get help for their child? Do they know anyone who has experience with a child needing help? Do they know of programs for teenagers?
 4. Your insurance company can also suggest treatment locations and give you a sense of what will be covered.
- 5 There are many online resources available to help you get in touch with substance abuse experts and other parents of teens and young adults struggling with a drug or alcohol problem. (One example is Partnership for Drug-Free Kids Intervene blog www.drugfree.org/intervene). Be aware, however, that there is a lot of inaccurate information on the web.

STEP 4: UNDERSTAND EVERYTHING THAT'S AVAILABLE.

There are several different types of substance abuse treatment services — and one type you don't know about could end up being the best one for your child. And, treatment services take place in a variety of treatment settings including outpatient, inpatient, and residential settings. Before you make any decisions, look at the following charts which describes the different treatment services available for someone with a substance abuse problem. It is important to

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know the different types of services so that when you make a decision in consultation with the treatment professional that's based on your child's assessment, you will be a fully informed participant in the decision.

The **first chart** describes the different types of treatment settings including outpatient, intensive outpatient, inpatient, day treatment (also known as partial hospitalization) and residential.

The **second chart** describes the different types of treatment services that one may receive while in treatment for a substance use problem.

The **third chart** describes aftercare and provides some examples of recovery support and services available to individuals in recovery from a substance use problem.

Treatment Settings for Substance Use Disorders

TREATMENT SETTING	DESCRIPTION	HOURS*	INTENSITY	LENGTH	WHAT YOU SHOULD KNOW
Outpatient	<p>Client typically attends treatment at a specialty facility but lives at home.</p> <p>Many programs provide services in the evenings and on weekends so the individual can still attend school or work.</p>	<p>Adults typically attend treatment 9 hours a week or less.</p> <p>Teenagers typically attend treatment 6 hours per week or less.</p>	Low to Medium	Depends on individual's progress, goals, and treatment plan.	Your child may be required to attend the program daily or weekly depending on the severity of his/her substance use.
Intensive Outpatient	<p>Client attends treatment during the day but lives at home.</p> <p>Can require client to attend up to 20 hours of treatment activities per week.</p> <p>Treatment can last from 2 months to 1 year.</p>	<p>Adults typically attend 9 hours per week or more.</p> <p>Teenagers typically attend treatment 6 hours per week or more.</p> <p>Clients typically receive treatment services 2 to 3 times per week for two or more hours at a time.</p>	Medium to High	Depends on individual's progress, goals, and treatment plan.	For individuals who need multiple services, have any medical or psychological illnesses, or have not been successful in outpatient services.

*Substance Abuse and Mental Health Services Administration (2004). What is substance abuse treatment? DHHS Publication No. (SMA) 04-3955.

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Treatment Settings for Substance Use Disorders *(continued)*

TREATMENT SETTING	DESCRIPTION	HOURS*	INTENSITY	LENGTH	WHAT YOU SHOULD KNOW
Day Treatment/ Partial Hospitalization	<p>Client attends treatment during the day but lives at home.</p> <p>Treatment services are provided 4 to 8 hours a day.</p>	Client typically attends treatment 20 hours or more per week	Medium to High	Depends on individual's progress, goals, and treatment plan.	<p>Most families use partial hospitalization programs when their family member needs an intensive and structured treatment experience</p> <p>Day treatment can be appropriate for clients with complex cases that involve co-morbid mental health illnesses.</p>
Residential	These programs provide treatment services in a residential setting. Programs can last from 1 month to a year.	24 hours/day, 7 days/week	Medium to High	Depends on individual's progress, goals, and treatment plan.	<p>Typically, residents go through different phases as they progress through the program. During certain phases your child's contact with you may be limited.</p> <p>Ask about the program's policies and procedures.</p> <p>Ask if the program provides educational and vocational services.</p>

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Treatment Settings for Substance Use Disorders *(continued)*

TREATMENT SETTING	DESCRIPTION	HOURS	INTENSITY	LENGTH	WHAT YOU SHOULD KNOW
Inpatient	Treatment provided in specialty units of hospitals or medical clinics offering both detox and rehabilitation services.	24 hours/day, 7 days/week	High	Depends on individual's progress, goals, and treatment plan.	Not as common as other types of treatment. Typically used for people with serious medical conditions or mental disorders.
Medication Assisted Treatment	<p>Medication assisted treatment is for people physically dependent on drugs.</p> <p>Medications are available for individuals dependent on opioids and alcohol.</p> <p>Opioid Maintenance Therapy (OMT) is for individuals dependent on opioid drugs such as heroin, OxyContin, or Vicodin.</p> <p>Provided in a specialized outpatient setting.</p>	N/A	N/A	N/A	<p>There is not as much information available about using medication assisted therapies for adolescents as there is for adults.</p> <p>The treatment program should provide counseling and other treatment services along with the medication.</p>

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SERVICES OFFERED AT ADOLESCENT TREATMENT PROGRAMS

Most adolescent treatment programs offer the treatment services listed in the chart below. If these services are not offered at your child's program, the staff there should be able to help your family find them elsewhere. It is important that individuals with an alcohol or other drug problem receive a full comprehensive range of treatment services. Examples of treatment services include:

Services Offered at Adolescent Substance Abuse Treatment Programs		
TREATMENT SERVICE	DESCRIPTION	WHY IT'S IMPORTANT
Screening	<p>Shorter assessment process used to determine if a person needs a full assessment.</p> <p>A screening will just give an indication but not a definitive diagnosis.</p>	<p>Helps determine if your child needs an assessment. Even if the results indicate your child doesn't need an assessment, this will let your child know you're aware of his/her drug use.</p>
Assessment	<p>A thorough look at the extent and severity of drug or alcohol use, the child's mental and physical health, family functioning, educational needs, personal, medical and family history.</p>	<p>To help understand the severity of your child's alcohol or other drug use, how your child is functioning, his quality of life, his educational needs, and to determine if the program has the resources to get the child everything they need — or refer them elsewhere if they can't meet that need.</p>
Medical Care	<p>Many of substance abusers' medical symptoms may be complications of drug use and clear up after a period of sobriety, but there may be underlying medical conditions contributing to the development of the drug abuse and dependence.</p>	<p>Quality treatment programs evaluate patients for medical problems shortly after admission and offer appropriate medical care, including medication management if indicated.</p>
Recovery or Treatment Plan	<p>As with any health conditions, while there are standards of care it is important that an individualized treatment plan be created that addresses an individuals' specific needs, goals, strengths, and weaknesses. Treatment will vary depending on the characteristics of the patient, the treatment program, the patient's family, and functioning.</p>	<p>Treatment/Recovery plans must be tailored to address all issues identified in the assessment and must be examined weekly throughout treatment to identify progress and areas that may need additional or more intense attention.</p> <p>The plan should start from the first day of treatment and account for clinical services needed during formal treatment, aftercare services needed, and recovery services needed when the client has completed the formal specialty phase of the treatment.</p>

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Services Offered at Adolescent Substance Abuse Treatment Programs *(continued)*

TREATMENT SERVICE	DESCRIPTION	WHY IT'S IMPORTANT
Individual Counseling	Counseling that consists of the client and counselor in a one-on-one session.	Allows individual to explore personal problems and issues that he/she may not be comfortable discussing in a group setting.
Group Counseling	Many programs offer group counseling as a component of the treatment program. Group counseling usually consists of 6 to 10 people with one or two counselors facilitating the discussion.	Members of the group discuss their struggles, experiences, and problems.
Home Based Services	Substance abuse and mental health treatment services that are provided in the child's home.	Examples of these types of programs include: Adolescent Portable Therapy (APT) and Multidimensional Family Therapy (MDFT).
Educational Services	Grade appropriate classes (or GED classes) for teenagers still in school or older teenagers that have dropped out of high school.	Reduces the disruption of school, allows the individual to earn his/her high school diploma or GED while in treatment.
Vocational Services	Services to determine the vocational abilities, skills, interests, and needs of the individual. Teaches job skills, resume development, and other work readiness skills.	Help the individual become independent, learn important skills and responsibilities, and seek employment as part of his/her recovery.

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Services Offered at Adolescent Substance Abuse Treatment Programs *(continued)*

TREATMENT SERVICE	DESCRIPTION	WHY IT'S IMPORTANT
<p>Life Skills</p>	<p>Life skills classes teach individuals:</p> <ul style="list-style-type: none"> • Assertiveness • Communication • Decision Making • Coping with Anxiety • Learning Healthy Alternatives to Risky Behavior • Reducing and Preventing Health Risk Behaviors • Planning • Problem—Solving • Refusal Skills • Relaxation • Stress Management • Time Management • Understanding Consequences of Substance Abuse 	<p>Life skills are behavioral tools designed to help a teenager or young adult cope with the stresses and challenges of daily life, develop greater self—esteem, and manage their recovery process.</p>
<p>Treatment for Mental Illness</p>	<p>If your child has been diagnosed with a co-occurring mental illness, you should find him a treatment program that can treat his repetitive mental illness or refer him to a professional (e.g. psychiatrist) with experience working with adolescents with mental illness.</p> <p>Ideally, treatment for the substance use problem and the mental illness are integrated. If the treatment provider is unable to treat both the substance use disorder and the mental illness simultaneously, the treatment services should be coordinated with the substance use disorder treatment provider and the mental illness treatment provider coordinating services and care.</p>	<p>When a child has co-occurring disorders, he needs help treating all of his illnesses. Treating substance abuse and dependence/addiction alone will not help underlying mental illness, and treating a depressive disorder alone will not resolve the substance abuse and dependence.</p>

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Services Offered at Adolescent Substance Abuse Treatment Programs *(continued)*

TREATMENT SERVICE	DESCRIPTION	WHY IT'S IMPORTANT
Family Services/Involvement	Services for the family including family therapy, individual or group therapy for parents or siblings, education about substance abuse, treatment, and recovery.	In most cases, family involvement is an important element in treating adolescents for alcohol or other drug abuse. Family involvement in substance abuse treatment helps family members gain awareness and understanding of substance abuse and dependence as a chronic illness, helps the family to have realistic expectations and goals for treatment, helps to improve communication within the family and overall family functioning, and helps the family understand the treatment process.
After Care/Follow-up Care/Continuing Care	<p>Treatment prescribed after completion of a formal structured treatment program in any type of setting.</p> <p>Follow-up care is very important to help prevent relapse.</p>	<p><i>After Care</i> is different from recovery supports and services and is sometimes labeled follow-up care or continuing care. Typical after care services involve the treatment provider checking in with the client for an update on progress.</p> <p>May be as simple as a check-up phone call or an in-person session.</p> <p>Can consist of individual or group counseling or activities designed to help people stay in recovery.</p>

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RECOVERY SUPPORTS AND SERVICES

Recovery from a substance use disorder is more than abstinence. Recovery is about improving one's quality of life, being emotionally and physically healthy, succeeding in school or work, having healthy relationships, having a healthy social life, and living drug-free. For most people, maintaining recovery requires supports and services after formal treatment is completed. There is a wide range of recovery supports and services available to help individuals in recovery prevent relapses, get emotional support, maintain progress made in treatment, and live drug-free. Some examples of recovery supports and services include:

Recovery Supports and Services for Adolescent Substance Use Disorders		
RECOVERY SUPPORTS AND SERVICES	DESCRIPTION	WHAT YOU SHOULD KNOW
Recovery or Sober Houses	Transitional residences where people (adults 18 years and older) in recovery live together. Residences often have a small number of clients, a small professional staff, clear and enforced rules about abstinence, and a significant level of structure.	Residents are expected to become employed within several weeks of entry and participate in the upkeep of the residence. Potential residents should be able to make a 3–6 month commitment to live in a group situation where a major focus is remaining clean and sober.
Sober Dorms	Sober or “dry” dorms for college students in recovery from alcohol or other drug addiction.	Ask the university your child is interested in or is already enrolled in if there is a sober dorm. If not, you should ask about the procedure for establishing a sober dorm on campus. As requests for sober dorms increases, more universities will create them for young people in recovery.
Recovery High Schools	High schools that a state approved academic curriculum and recovery supports/services for teenagers in recovery from alcohol and other drug abuse or dependence.	Make sure the school meets state requirements for granting diplomas. For a list of recovery high schools and universities with sober dorms click here: www.recoveryschools.org
Alcoholics Anonymous (AA)	12-Step/Self-Help group of men and women that come together to share their experiences, provide support to one another, and stay sober.	It is important to find a group your child is comfortable with. He/she should look for meetings with other young people in recovery. There are also 12-Step/Self-Help groups for families of individuals in recovery.
Narcotics Anonymous (NA)	12-Step/Self-Help group that grew from the AA movement to focus on drugs other than alcohol.	It is important to find a group you feel comfortable with. Look for meetings with other young people in recovery. There are also 12-Step/Self-Help groups for families of individuals in recovery.

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What about Boot Camps?

Another option you and your family may be considering is a boot camp or a wilderness program for troubled teenagers. It is important to know that boot camps and wilderness programs are not one of the levels of care defined by the American Society of Addiction Medicine. Although you may have heard success stories or read about how great boot camps are, we strongly suggest you look very carefully into any boot camp or wilderness program before sending your teen for substance abuse treatment. According to a government report (<http://www.gao.gov/new.items/d08146t.pdf>) these programs are not subjected to federal oversight and there have been thousands of reports of neglect and abuse at privately owned and operated boot camps and wilderness programs for troubled youth. We suggest if you are seriously considering a boot camp or wilderness program you check with the Better Business Bureau for any complaints against the program and ask a few questions including:

- 1) What specific substance abuse and mental health licensing and accreditation does the program have? If the providers are not licensed, do NOT send your child to the program.*
- 2) Has a child has ever died in their care and if so, why?*
- 3) What specific training (especially survival skills training for outdoor programs) do the counselors have?*
- 4) Have there have been any complaints of abuse or neglect at the camp?*
- 5) Can you put me in touch with a few families that have a child who have completed the program so that I can hear about their experience?*
- 6) Who is responsible for medical care? It should be a licensed medical doctor.*

Remember, addiction is a serious health issue and requires appropriate professional treatment by licensed professionals so that your child can learn how to manage his alcohol or other drug problem, how to handle relapse, and how to live an alcohol and drug free life.

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What Role Can the Criminal Justice System Play in the Treatment of Substance Abuse and Dependence?

Often, substance abusers find themselves in trouble with the law because of their drug using behaviors. If this is the case with your child, you can ask about the availability of juvenile (if the child is under 18 years) and adult (if the child is over 18 years) drug court for your child.

Drug Courts

Drug courts function within the court system for individuals identified as having problems with alcohol or other drugs.⁶ Typically, the drug court judge leads a team of professionals ranging from treatment, social services, school and vocational programs, law enforcement, and probation depending on the needs of the individual. Research shows that comprehensive treatment through the drug court system should include the family and if possible engage the larger community.

The goals of drug court are:

- 1. Provide immediate intervention to drug user through monitoring and supervision by the drug court judge. Typically the individual meets with the judge weekly;*
- 2. Address any problems that are contributing to continued alcohol or other drug use and build on the person's strengths so he can lead a drug free life;*
- 3. Provide the person with skills and training (educational, life skills, anger management) to lead a drug free life;*
- 4. Strengthen the capabilities and functioning of the families involved to improve the individual's immediate and long-term success of treatment; and*
- 5. Hold the person and agencies serving the individual accountable for the success of the treatment services.*

The most effective drug court models integrate criminal justice and drug treatment systems and services. Treatment and criminal justice personnel work together on plans and implementation of screening, placement, testing, monitoring, and supervision, as well as on the systematic use of sanctions and rewards for drug abusers in the criminal justice system. Treatment for incarcerated drug abusers must include continuing care, monitoring, and supervision after release and during parole.

STEP 5: LOOK AT LOCATION.

Once you've discussed the results of the assessment with the treatment professional and have determined the type of services that would be most helpful for your child and family, you should start looking for programs in your area that meet your requirements.

Location is an important factor when it comes to deciding on a treatment program for your child, because family involvement is a critical element of adolescent and young-adult substance abuse treatment. The closer the treatment program is to your home, work or community, the easier it will be for the entire family to participate in the treatment and recovery process.

6. Department of Justice (March 2003). *Juvenile Drug Courts: Strategies in Practice*

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You may live in an area that doesn't have the level of care your child needs. This could require your child participating in a program (such as inpatient or residential treatment) several hours away from your home — or even in another state. If this is the case, make sure you discuss with the program how your family will be involved (e.g. phone calls, emails, family visits, etc.)

If the treatment professional who gave your child the assessment cannot provide you with information for treatment services in your area, a good place to start your search is SAMHSA's Substance Abuse Treatment Facility Locator (<http://findtreatment.samhsa.gov/>), a searchable directory of more than 11,500 addiction treatment programs around the country that treat alcoholism, alcohol abuse, and drug abuse problems. The Locator includes outpatient, residential, partial hospitalization/day treatment, and inpatient programs for drug addiction and alcoholism in all 50 states, the District of Columbia, the Federated States of Micronesia, Guam, Puerto Rico, the Republic of Palau, and the Virgin Islands. You can also call SAMHSA's hotline at 1-800-662-4357 for the same information. Please note that the Locator is updated annually, so it is possible that a treatment program listed has changed or no longer exists.

You can also ask at your primary care doctor, your child's pediatrician, your child's school, the school nurse, social worker, local family or community center.

Here are some tips about finding treatment in your area from substance abuse professionals:

- **“Tap into the local mental health system,”** says Ken Winters, Ph.D., Professor, University of Minnesota and Senior Scientist at the Treatment Research Institute. “Many experienced and effective mental health counselors are equipped to help young people with substance abuse problems.” Dr. Winters adds that it's more important to find someone who is experienced in working with teenagers than it is to find someone with an addiction background.
- **If you're worried about how to pay for treatment ask the program if they have a sliding scale.** And if your child is 18 or older, find out if your child qualifies for Medicaid. (Find out more about paying for treatment on page 27.)
- **In partnership with the professional treatment provider, use the results of the assessment to guide decisions about the level of care and type of services your child needs.** Teenagers and young adults often don't need the most intense form of treatment to get better, according to experts. But you may feel because of what you and your family have been through that you want your child in a residential treatment program far away from home and friends. Remember, it is important — in consultation with the treatment professional — that you use the results of the assessment to guide decisions about the level of care you child receives.
- **A note about allowing your teen to be part of the process.** Discuss the results of the assessment with your child and what level of care is indicated from the assessment. Remind your teen that you love him and that is why you are getting the help he needs.
- **Before making any final decision,** make sure both parents (or primary caregivers) are involved in the decision about where to get help for your child and, most importantly, make your teen or young adult part of the decision process.

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How Are You Feeling?

You might be feeling frustrated, angry, disappointed or guilty. You may be mad at the things your child has done. You may have watched her encounter depression or face problems with her health, work/school or with money, or even an accident or DWIs/DUIs related to substance use — or perhaps she has stolen from you. You may be worried about the rest of your family. You may also feel scared, hurt, confused, or depressed. You, too, may feel very alone.

- **You are not alone.** Addiction is very common. Twenty-two million people have a current alcohol or other drug abuse problem and nearly 9 million of these people are under the age of 26. Many families are struggling (<http://intervene.drugfree.org/>) with the exact same problem as you.
- **People who have the disease of addiction are individuals like you, your neighbors, and your colleagues at work.** Addiction cuts across all walks of life, socio-economic and cultural backgrounds — affecting men and women, teenagers, young adults, adults and seniors, from the poor to the middle class to the rich, from the rural towns to the suburbs to the cities.
- **Addiction can happen to anyone.** Fortunately, anyone can recover with help.
- **Addiction is treatable.** Your child can get well. There have been parents who have been in your shoes and whose children are now in recovery.

It is Important to Find Help for Yourself and Your Family — Here's How:

You have to get help for yourself — it's also important for other children in the family to get support, and therapy if necessary.

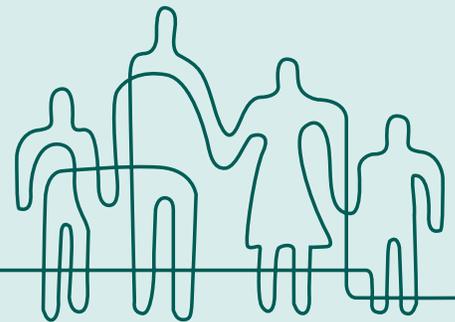
- Many human service agencies provide help, including counseling and guidance centers, mental health clinics, and substance use treatment programs. Your family physician may be able to provide a referral. Another option is your employer's employee assistance program (EAP), a confidential resource used and trusted by millions of people each year that helps employees and their family identify and resolve personal concerns. EAPs have a lot of experience in identifying substance use problems and finding ways to treat them. Ask your human resources department at work about EAP.

Family Therapy

Family Therapy is an important element in treating adolescents for alcohol and other drug abuse.

Family therapy focuses on repairing relationships and sustaining recovery, and healthy communication. By the time your child gets into treatment, you and other family members will probably be feeling angry, resentful, emotionally exhausted, physically tired, unable to trust, and hurt by your child's behavior when he was abusing drugs or alcohol. This is understandable and it is important to address the damage the family as a whole — and as individuals — has experienced by the drug or alcohol abuse.

Therapists help families talk about their feelings and experiences, helps repair relationships, create healthy communication patterns, and strategies to help the addicted individual stay sober. Just as your child needs to get healthy and recover from the drug or alcohol abuse, you and the family need help to recover from the pain of having a child who is addicted to alcohol or other drugs.



How to find the right help for your child with an alcohol or drug problem

- Ask your health insurance company for a referral to approved treatment programs for adolescents and a list of approved substance abuse treatment providers.
- **Al-Anon** is a Twelve-Step program providing support and guidance to help families and friends of people with alcohol problems recover from the effects of living with a problem drinker — whether the person is still drinking or not. Meetings are readily available in most communities across the country. To find an Al-Anon program, call 1-888-4AL-ANON or visit: <http://www.al-anon.org>.
- **Nar-Anon** is a support group for family members of drug users. http://www.nar-anon.org/Nar-Anon/Nar-Anon_Home.html.

“There are far more Al-Anon meetings in some areas than there are Nar-Anon meetings,” explains one Midwestern mother, Annette. *“So, if you can’t find a Nar-Anon meeting, you should feel free to attend an Al-Anon meeting — even if your loved one is using drugs, not alcohol. In my experience, Al-Anon has allowed everyone to participate who needs to,”* adds Annette.

STEP 6: MAKE CALLS, ASK QUESTIONS.

You cannot be sure if a program is the best fit for your child unless you get to talk to the people at that program and ask questions. This will be time-consuming — but worth it. The most important thing you can do to help your child is ask treatment programs/providers valuable questions so you can truly understand how their approach works. You cannot ask too many questions when selecting a provider to work with child.

Knowing what to ask — and comparing the answers from different programs — will help you determine which program your child should try. And, can help you save money (often thousands of dollars) by avoiding the mistake of sending your child to a program that wasn’t a good fit for him or your family.

Use your consumer education skills that you would use in any serious health care decision. Trust your judgment and your feelings about the answers you get from the people you talk to. The responses you receive should be clear and concise.

What if a program doesn’t have everything my child needs, like aftercare or integrated mental health treatment?

Unfortunately you may live in an area with limited adolescent treatment programs that do not offer everything your child needs. If this is the case, ask the program if they can provide referrals to the services your child needs. Ask the program if they can coordinate care between service providers so that your child is receiving all the services he or she needs to complete the treatment program.

A good treatment program should actively help your child tap into recovery supports and services such as a self-help group that is age appropriate (although she may have to “shop around” for one she feels comfortable in), alcohol and drug free social activities, and ongoing counseling.

How to find the right help for your child with an alcohol or drug problem

The following questions are provided to help guide your conversation with treatment programs in deciding which program is the best fit (and most appropriate based on the assessment) for your child and family. These questions are appropriate for ALL types of treatment settings (outpatient, intensive outpatient, inpatient, residential, day treatment) and should be asked regardless of the type of treatment setting your child needs.

Questions to ask about the Program and Staff:

1. Is the program licensed by the state?

Why this is important to ask: Every program must be licensed by the state to operate. Many programs also go through the process to receive accreditation. While national accreditation does not offer guarantees, accreditation is an indication that the program has been carefully reviewed by an independent organization. You may even want to call the accreditation organization to determine if the treatment program continues to be in good standing.

You may also ask other professionals in the community such as your primary care doctor, your child's pediatrician, psychologists, and social workers about the reputations of certain programs.

2. What is the staff-to-client ratio?

Why this is important to ask: If the caseloads of staff members are high, your child may not receive the individualized management and care she needs. Ask about the type (and hours per week) of individualized care your child will receive with her counselor.

3. What is the staff like? What is their background? What is their education? Are any of them in recovery? What is their experience working with adolescents/young adults? What is their experience working with adolescents / young adults with substance abuse problems?

Why this is important to ask: You want to make sure you are comfortable with the people who are caring for your child. It is important that staff knowledge of adolescent development and have experience working with adolescents with substance use disorders.

4. Is the facility clean, organized and well-run?

5. Does the treatment program address sexual orientation, physical disabilities, and provide age, gender, and culturally appropriate treatment services?

Why this is important to ask: It is important that the care your child receives is able to meet his or her needs. This means the treatment should take into account gender issues (boys and girls may have different experiences), age (younger and older teens could have different educational needs), disabilities (teens with a learning disability may need additional educational services), and sexual orientation (lesbian, gay, transgendered, or bisexual youth need culturally appropriate services).

How to find the right help for your child with an alcohol or drug problem

Questions to ask about how involved your family is going to be:

1. Does the program involve the family in the treatment process? And, how is the family involved in the treatment process?

Why this is important to ask: Family involvement is a critical element for treatment of substance abuse and dependence. The more involved the family is the more successful the treatment will be and the family will have the education and understanding to help the child maintain his/her recovery.

2. Is there family counseling? Are there services for parents and siblings of the parent? If not, can they refer the family to appropriate services?

Why this is important to ask: The family — parents and any siblings — need help learning how to trust again, build healthy relationships with their child or sibling, and learn how to function as a family with a child in recovery.

Questions to ask if your child has a Co-Morbidity, Psychiatric or Medical Issue:

1. Is the staff knowledgeable about and willing to consider the use of medication that may help treat addiction?

Why this is important to ask: Medications such as methadone, naltrexone, buprenorphine, and disulfiram (Antabuse) can be effective in helping some addicts. Treatment providers should discuss them with patients and determine if the patient could benefit from using an addiction medication. It is important to know that in younger populations (18 years and younger), there is not as much research on the use of medication assisted therapies to treat addiction. **If your child requires medication to help with his substance use disorder it is critical that he receive appropriate medical supervision and monitoring.**

2. Can the staff/program manage all of my child's medications if necessary? Are there medical doctors on staff to prescribe an addicted patient's other medical or mental health diagnoses? What type of professional (i.e. a medical doctor) provides medical and psychiatric care? What is their availability? How often do they see the clients? Is there emergency coverage?

Why this is important to ask: Many of addicted patients' medical symptoms may be complications of addiction and clear up after a period of sobriety, but this is not always the case.

How to find the right help for your child with an alcohol or drug problem

PART III: PAYING FOR TREATMENT

You may have heard stories about how expensive treatment is. You may have even called around for some quotes — it is shocking how expensive some treatment programs are. But there are options available that can help your family handle the financial burden of paying for substance abuse treatment. We know it is not easy but the more information you have the better able you will be to make good decisions for your child and family.

As you'll see below, there are several options when it comes to paying for substance abuse treatment for your child. These include private health insurance plan, Medicaid, Veterans Administration benefits (if you're a military family), Employee Assistance Programs (EAP), student health services, clinical trials, financial aid, payment plan and a sliding fee scale. These options don't cover everyone, but you may be able to cut personal costs by using one or more of the following:

- **Most private health insurance plans provide coverage for some substance abuse treatment.** Note that coverage for mental health and substance abuse treatment varies state by state and by health plan. If you have private health insurance, call the toll-free number on the back of your card and ask about your treatment benefits, or talk to your employer's employee assistance program (EAP). Precertification may be required before the child enters a program. Make sure you know all the out of pocket costs you will be responsible for before making any arrangements. You don't want to be blindsided by hidden costs. In the event your insurance denies treatment, refer to your benefits plan for instructions on how to appeal. The appeal process varies by state, and there is often a time limit for you to file. The Kaiser Family Foundation provides a guide for handling disputes with your employer or private health plan <http://www.kff.org/consumerguide/7350.cfm>
- **Medicaid is an insurance program for people who lack private health insurance and meet certain financial thresholds.** Your child may be eligible for Medicaid which should pay for substance abuse treatment. Individuals must apply for coverage in their state, and Medicaid services and the types of individuals covered vary by state. To find out if you're eligible, visit: <http://cms.hhs.gov/medicaid/statemap.asp>. If your family is ineligible for Medicaid, the Children's Health Insurance

7. National Conference of State Legislators (Feb 2009).

Mental Health Benefits and Parity

Mental Health and Substance Abuse services are an important part of medical care that has not always been covered by health insurance companies. The lack of coverage, limited coverage, associated costs, and availability of services has generated much discussion in the political and medical communities. On October 3, 2009 the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) became effective for group health insurance plans. This law requires health insurance plans that offer mental health coverage to provide the same financial and treatment coverage offered for other physical illnesses. This includes deductibles, co-payments, out-of-pocket expenses, coinsurance, covered hospital stays, and covered outpatient visits. This federal law does not require health insurance plans to provide coverage for mental health services, only to provide equal coverage IF mental health services are provided.⁷

How to find the right help for your child with an alcohol or drug problem

Program (CHIP) may be an option for your family. CHIP was previously known as the State Children's Health Insurance Plan (SCHIP). CHIP is available for families that make too much money to qualify for Medicaid but not enough to purchase private health insurance. Coverage and services provided under CHIP varies by state. Some states treat CHIP as an expansion of Medicaid services and other states treat it as a free standing program. Start with your state's Medicaid Office web site to learn about the options available to your child and family.

- **Veterans Administration benefits** are available to veterans and their families. To learn more, call 1-877-222-VETS (8387).
- **Some companies have employee assistance programs available for employed individuals.** Services may be provided on-site, or you may receive a list of substance use professionals in your area. Contact your company's human resources office to learn more about this option.
- **For college students,** student health services often provide group and individual counseling for people with substance use problems. Contact the health or counseling center at the school.
- **Clinical trials** are research studies used to determine the safety and effectiveness of a range of treatment methods, including counseling and medications. These services are provided free of charge because they are part of government funded research. Your child may be eligible to participate in a clinical trial. If you live in or near a college town, addiction expert Gayle Dakof, Ph.D., suggests contacting the university. Schools often have safe and free clinical trials, and your child may be able to participate in one. To learn more about clinical trials go to <http://www.clinicaltrials.gov>. To find a clinical trial, visit the National Institute on Drug Abuse Clinical Trial Network at <http://www.drugabuse.gov/Funding/CTI.html>.

Points to Discuss with a Specific Treatment Program:

- Many treatment centers have financial aid that helps defray the expense. Contact treatment centers directly about the availability of these funds.

Co Occurring Disorders

Many adolescents suffer from depression, bi-polar disorder or some other mental illness often undiagnosed. Unfortunately, many teenagers turn to alcohol or other drugs to self-medicate. In fact, the majority of adolescents and young adults battling substance abuse and dependence may have an undiagnosed, untreated mental illness, such as depression, anxiety, ADHD, or bipolar disorder. When a child gets diagnosed with mental health disorder in addition to alcohol or drug abuse and dependence, he has "co-occurring disorders," also known as a "dual diagnosis" or "co-morbidity."

When a child has co-occurring disorders, he needs treatment for each of his diagnoses. Treating alcohol or other drug abuse and dependence alone does not help underlying mental disorders, and similarly, treating a depressive disorder alone will not treat addiction. If your child has been diagnosed with co-occurring disorders, you should find him a treatment program that specializes in treating co-occurring disorders or can make referrals to services to help treat your child's mental disorder while simultaneously getting treatment for alcohol or other drug abuse and dependence. Make sure to ask treatment providers whether their program is equipped to handle this.

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- Ask your treatment provider to help you create a payment plan. Treatment providers will often work with family members who need to pay for treatment out of their own resources so that the entire sum does not need to be paid at the beginning of treatment.
- Many treatment programs offer a sliding fee scale — a flexible payment scale based on income — so be sure to should ask about this option. Because the fee depends on your family's income, the treatment provider will ask to look at your pay stubs and tax returns to decide what percentage of the actual cost you would pay out of pocket. If you want to only research programs with a sliding fee scale, use the SAMHSA Treatment Facility Locator (see page 22 of this guide) and select the “sliding fee scale/payment assistance” box in the detailed search.

PART IV: GETTING YOUR CHILD INTO TREATMENT

Some parents fear that getting their child to the treatment program — either outpatient or residential — on the first day will be a major challenge for them. So you may find comfort in knowing that many good adolescent treatment programs know how to engage teenagers and young adults in treatment and help them see the importance of getting treatment. If you have concerns about getting your teenager to begin treatment, you should seek help from the program you have selected. This is a good opportunity for you to talk to your child about your concerns for his life, health, and safety. Talk to your child about how the decision to enroll him in treatment comes from your love for him and that you know he may be scared but ultimately it will allow him to live a healthier better life.

Depending on the state you live in, your child may have to agree to treatment. Even if your child is under 18, some programs won't accept you if your child doesn't agree to attend. You may have legal options available to you but it depends on the specific laws in your state.

Some teens and young adults may resist getting help. They may:

- **Not believe they have a problem**
- **Think they can stop on their own**
- **Fear withdrawal**
- **Fear living sober**

Overlooked Resource: Your Insurance Case Manager

It can be frustrating to learn what insurance will and will not cover when it comes to treatment, but Pat Aussem, a mother who has helped both of her sons fight addiction, suggests that you build a good relationship with your insurance case manager. Think of him or her as a partner. “Insurance case managers are a great source of information on resources and can help you navigate benefits,” Aussem says. “I was absolutely amazed at how willing the insurance company was to be flexible and help us.” Here are two ways that Aussem's case manager was able to assist her family:

1. “When we started running out of outpatient days, our case manager told us that we had a certain amount of inpatient days that could be converted on a 1:3 basis to outpatient days,” explains Aussem. This means under her family's plan, one inpatient day was equivalent to three outpatient days.
2. “One of the therapists my son saw was not an in-network provider,” explains Aussem. “The insurance case manager agreed to execute an agreement with the therapist where he would join their network of providers, but my son would be his only patient under this agreement and the provider would be paid his going rate, not the usual nominal contract rate. I was absolutely amazed at how willing the insurance company was to be flexible and help us.”

While dealing with health insurance red tape can often be a headache, Pat Aussem encourages parents to, “be careful not to let your anger get the best of you.”

Remember the age old saying; you catch more flies with honey than vinegar.

How to find the right help for your child with an alcohol or drug problem

Contrary to Popular Belief, a Person Does Not Need to “Hit Rock Bottom” on His Own to Get Help for an Alcohol or Drug Problem.

Registering Your Child for Treatment

What should you expect when you register your teen or young adult for treatment? Although the registration process can vary from program to program, here are some things you should be prepared for:

- **Most treatment programs require a pre-screening over the phone.** When you contact a treatment provider, you or your child may be interviewed over the phone, but that doesn't mean your child will (or should) end up in that program. If the program is not a good fit for your child, the provider should refer your family to a different program that better meets your needs.
- **There is a lot of paperwork.** However, the paperwork is for your family's benefit — it tells you your rights, guarantees you confidentiality and gives the treatment provider permission to speak to outside sources if it will help your child. You may feel overwhelmed but it is important that you read the paperwork carefully and not just sign at the dotted line.
- **There will be a full intake process.** You and your child will be asked questions about your child's drug use, your family, your child's medical history, educational history and mental health.
- **There may be a search of the individual and his or her belongings.** It is not uncommon for patients to try to sneak drugs or alcohol into a residential treatment center. So be aware that they may take your teenager into a private room and search her clothes for hidden alcohol and drugs. They may also search through her belongings. For some parents and teenagers this will feel like an invasion of privacy, but it is important part of the treatment process to ensure that your child is going into a substance free environment.
- **Aftercare should be part of your child's treatment plan.** “Treatment is not over after discharge from the program; rather, that is when treatment is really just beginning,” says addiction psychiatrist Dr. Harold C. Urschel. “You need to create a successful discharge plan that can be realistically implemented immediately following discharge.”
- **Waitlists exist.** Not all treatment programs are guaranteed to have an open spot when your child needs it. If the program you choose isn't available, you'll have to decide whether to put your child on the waitlist or look into another program.

How to find the right help for your child with an alcohol or drug problem

We've Been Wait Listed...Now What?

Getting put on the wait list for the program of your choice is one of the frustrating realities of finding treatment for your child. You may feel stuck, desperate, and wonder what to do next. Here are answers to some tough questions about wait lists.

How long will my child be on the wait list? It's impossible to say. Every program's system is different. A good rule of thumb is to think about how many other substance abuse treatment resources are in the area. If resources are limited you may have to wait several weeks. Many programs offer pre-treatment services for individuals that have been wait listed. Ask the program if they offer pre-treatment services and how your child can access pre-treatment services while waiting to enter the formal treatment program.

Should I put my child in a different program with no wait list instead? This depends on the severity of your child's substance abuse. You should decide this in partnership with the professional that conducted the assessment. This can also be a good time to engage your child in the decision making process. If you decide to wait for an opening and use pre-treatment services (see above) in the meantime,

ask your child about the type of pre-treatment services he thinks would be beneficial. Talk to your child about your concerns about waiting to get into the formal program.

Some addicted teenagers and young adults need some form of treatment as quickly as possible. If this is the case, ask the treatment provider to refer your family to other similar programs. Tell them it is critical your child get help now, especially if you're worried about your child's safety. But if you have picked out a program that seems to be the best fit for your child and family, it may be worth waiting for an available spot if you can.

What should we do in the meantime? Ask the treatment provider for assistance in restricting your child's alcohol and drug use. They can help your family come up with an effective limits-and-consequences plan <http://timetoact.drugfree.org/know-set-limits.html> to use until the program has an opening. If your child is on the waitlist for an inpatient program, enroll him immediately in a local outpatient program with an available spot. That way, he'll receive care while waiting to start the more intensive program — and he'll have an alcohol- and drug-free routine to return to when he comes back home.

Once your child has a guaranteed spot in a treatment program, you, your child, and your other family members will probably feel a whole range of intense emotions, all of which are normal. Your child may be angry, scared, apologetic, sullen, or in a few cases, relieved. You might feel sad, relieved, embarrassed, doubtful, mad, guilty, grateful — or all of the above. If you're sending your child to a residential or inpatient program, you may also experience the same feelings that come with dropping a child off at college: separation anxiety, fear, and loss.

It's hard to predict how your child will act when she's about to go to treatment for the first time. Your child may beg, cry, plead and no parent likes to see or hear their child in so much pain. It will break your heart but remember by getting your child the treatment she needs, you're not only potentially saving your child's life; you're helping her live a fuller, healthier life.

Explain that it's very difficult to stop using alcohol or other drugs without professional help once a person becomes addicted. Acknowledge that your child may be angry and scared but she still has to get help. If your child offers to drive herself, say no in the beginning until you feel certain that she is engaged in and committed to treatment. Your child may have good intentions, but at this point, you need to make sure she gets to treatment.

How to find the right help for your child with an alcohol or drug problem

PART V: TAKING CARE OF YOURSELF

Recognizing that your child needs substance abuse treatment is frightening and alarming; and you may feel that the process of finding and getting your child into treatment has taken over your life. Although you are probably not thinking about yourself right now, one of the smartest things you can do for your child in trouble and your family is to take care of yourself so that you remain strong, healthy, and sane. Many parents with a sick child forget about their own emotional and physical health but remember, just as your child needs to get healthy and learn life without drugs and alcohol you and your family also need to get healthy and stay healthy.

Seeking professional counseling for yourself is just as important as getting help for your addicted child. While your child is battling an alcohol or other drug problem, you're also struggling with serious issues. "The pain, blame, shame, helplessness, and worry that parents feel are huge," Dr. Gayle Dakof explains. "You need to feel that you are not alone, and I believe parents and caregivers need professional help to help them address feelings of blame and shame."

Lastly, you may find it helpful to visit an online community of parents of addicted teens or young adults such as The Partnership at Drugfree.org Intervene blog www.drugfree.org/intervene. There are established national groups such as Al-Anon and Nar-Anon that have meetings all over the country, and there are smaller, local groups that can be found through a basic web search or the phone book. Like treatment programs, not all support groups are well-run or a good fit for you personally. Shop around and go to different meetings until you find the group that is right for you.

PART VI: EXPERT ADVICE FROM OTHERS

While creating this guide, Partnership for Drug-Free Kids spoke to many adolescent treatment experts, from treatment providers and addiction psychologists to public health officials and parents whose teenagers are in recovery. Some of these experts were asked to give their most valuable pieces of advice for parents whose children are in need of treatment. Here's what they said:

Who Should Bring My Child to Treatment?

If possible, both parents should drive a teen or young adult to treatment the first time — even if you're divorced. Now more than ever, you and your child's other parent need to present a united front, and if one of you stays home, it could send the message that you disagree with the need for treatment or the program being used. Your child should not be able to label either parent the "good, nice parent" or the "bad, mean parent."



How to find the right help for your child with an alcohol or drug problem

“ Seek professional help if you suspect your teen has a substance abuse problem. There are so many talented, knowledgeable and caring people willing to help you if you just ask. I encourage you to take action, especially before your teen turns eighteen and control is out of your hands. Intervene – you just might be saving your loved one’s life.”

—Pat Aussem, mother

“ Your child may direct a lot of anger at you, but that doesn’t mean you’re wrong. Kids’ anger at their parents almost always dissipates over time.”

—Tessa Vining, director of Phoenix House’s Intervention Moves Parents and Children Together (IMPACT) program

“ Stick it out – don’t give up! And don’t feel like you’re overreacting. Adolescent drug addiction is a child health crisis, and should be treated like other health crises. If your child had a tumor, you would do everything you could to treat it. Drug addiction is no different than a tumor – it’s not going to go away if you ignore it.”

—Naomi Weinstein, director of the Phoenix House Center on Addiction and the Family

“ You cannot outsource solutions to this problem. You must be involved in your teen’s recovery. Treatment of teen addiction requires a lot of hard work from the provider/therapist, the parents, and the teen.”

—Gayle Dakof, Ph.D., Associate Research Professor, Center for Treatment Research on Adolescent Drug Abuse, University of Miami, Miller School of Medicine

How to find the right help for your child with an alcohol or drug problem

“ Get involved in the treatment process, including post-treatment relapse prevention. ”

—Ken Winters, Ph.D., Senior Scientist at Treatment Research Institute

“ You are doing the right thing. It is hard to do this and you do it because you love your son/daughter. It gets better once the family sessions begin. ”

—Ralph Lopez, M.D., adolescent medicine specialist

“ Never give up or stop advocating for your child. Learn the difference between encouraging and enabling and get yourself some support and education. As dire as a situation with your youngster might seem, hope is new each morning. Raise the bottom, don't let them bottom out and know what the difference is. Utilize invaluable resources like drugfree.org and stay in the loop, stay connected with others, and remember, knowledge is power. Reach out. Ask for help. Receive. ”

—Lea Minalga, mother

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The parents of adolescents at Dynamic Youth Center, Brooklyn, NY

Dr. Harold C. Urschel, M.D., founder of Urschel Recovery Science Institute and author of Healing the Addicted Brain

Tessa Vining, director of Phoenix House's Intervention Moves Parents and Children Together (IMPACT) Program

* Last name left off intentionally

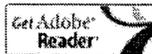


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Naloxone Information

- [Naloxone Media Release](#)
- [Naloxone Protocol](#)
- [Naloxone Fact Sheet \(English\)](#)
- [Naloxone Fact Sheet \(Spanish\)](#)
- [Naloxone Fact Sheet \(Traditional Chinese\)](#)
- [Naloxone Fact Sheet \(Korean\)](#)
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NEWS RELEASE

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OVERDOSE RESCUE DRUG NOW AVAILABLE WITHOUT PRESCRIPTION

Pharmacists Can Furnish Naloxone for Opioid Overdose

SACRAMENTO -- The California State Board of Pharmacy has approved emergency regulations allowing pharmacists to furnish, without a prescription, an antidote to reverse opioid overdose. The new regulation was effective April 10, 2015.

Naloxone hydrochloride, an opioid overdose rescue drug, will now be available by request or at the suggestion of a pharmacist in California pharmacies.

Pharmacists dispensing the potentially life-saving medication must successfully complete one hour of continuing education on the use of naloxone hydrochloride, screen for any hypersensitivity and must provide the recipient with training in opioid overdose prevention, recognition, response and on the administration of naloxone hydrochloride.

Opioids are narcotic prescription medications, which are prescribed for severe pain. The street drug heroin is also an opioid.

According to the California Department of Public Health, California deaths involving prescription pain medications have increased 16.5 percent since 2006. From 2008 to 2012, there were 7,428 prescription opioid-related deaths in the state.

In 2012 alone, there were more than 1,800 opioid-related deaths in California and 72 percent of those deaths involved prescription pain medications.

Morphine, codeine, hydrocodone, hydromorphone, methadone, oxycodone, fentanyl, buprenorphine and oxymorphone are some of the generic names of prescription opioid medications. Brand name opioids include Vicodin, Norco, Zohydor, Percocet, OxyContin, Roxicodone, Demerol, Dilaudid, Opana and Suboxone.

Accidentally taking too much of a prescribed opioid, combining it with alcohol or other drugs, or abusing it can lead to overdose, depressed respiration and death.

Naloxone hydrochloride is a low-cost, non-narcotic, prescription drug that reverses the effects of opiate overdose, but it must be administered while also calling 911 for medical assistance. Naloxone blocks the receptors in the brain from the effects of the opioids and can restore breathing. It may be administered by intramuscular injection, intranasal spray or auto-injector.

This authority was established by AB 1535 (Bloom), which was passed in 2014 and authorizes the furnishing of naloxone hydrochloride pursuant to a protocol that was developed by the Board of Pharmacy and approved by the Medical Board of California.

(More)

“This will save lives,” said Stan Weisser, Board of Pharmacy president.

“We are empowering pharmacists to put this rescue medication in the hands of those who are in a position to help an opioid overdose victim,” he said.

Click here to view the emergency regulation:

http://www.pharmacy.ca.gov/publications/naloxone_protocol.pdf

Click here to view the naloxone fact sheet:

http://www.pharmacy.ca.gov/publications/naloxone_fact_sheet.pdf

Click here to view the Board of Pharmacy Prescription Drug Abuse Prevention page and public service announcement video:

http://www.pharmacy.ca.gov/consumers/rx_abuse_prevention.shtml

Click here to view AB 1535 (Bloom):

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB1535&search_keywords

For more information on the Board of Pharmacy, go to <http://www.pharmacy.ca.gov/>.

The CA State Board of Pharmacy protects and promotes the health and safety of California consumers by pursuing the highest quality of pharmacist care and the appropriate use of pharmaceuticals through education, communication, licensing, legislation, regulation and enforcement.

###

Title 16. Board of Pharmacy. Adopt §1746.3, which is new regulation text, as follows:

§1746.3 Protocol for Pharmacists Furnishing Naloxone Hydrochloride

(a) A pharmacist furnishing naloxone hydrochloride pursuant to Section 4052.01 of the Business and Professions Code shall follow the protocol specified in subdivision (b) of this section.

(b) Protocol for Pharmacists Furnishing Naloxone Hydrochloride

(1) Authority: Section 4052.01(a) of the California Business and Professions Code authorizes a pharmacist to furnish naloxone hydrochloride in accordance with a protocol approved by the California State Board of Pharmacy and the Medical Board of California. Use of the protocol in this section satisfies that requirement.

(2) Purpose: To provide access to naloxone hydrochloride via standardized procedures so that pharmacists may educate about and furnish naloxone hydrochloride to decrease harm from opioid¹ overdose.

(3) Procedure: When someone requests naloxone hydrochloride, or when a pharmacist in his or her professional judgment decides to advise of the availability and appropriateness of naloxone hydrochloride, the pharmacist shall complete the following steps:

(A) Screen for the following conditions:²

- (i.) Whether the potential recipient³ currently uses or has a history of using illicit or prescription opioids (If yes, skip question ii and continue with Procedure);
- (ii.) Whether the potential recipient is in contact with anyone who uses or has a history of using illicit or prescription opioids (If yes, continue with Procedure);
- (iii.) Whether the person to whom the naloxone hydrochloride would be administered has a known hypersensitivity to naloxone? (If yes, do not furnish).

(B) Provide training in opioid overdose prevention, recognition, response, and administration of the antidote naloxone.

(C) When naloxone hydrochloride is furnished:

- (i.) The pharmacist shall provide the recipient with appropriate counseling and information on the product furnished, including dosing, effectiveness, adverse effects, storage conditions, shelf-life, and safety. The recipient is not permitted to waive the required consultation.

¹ For purposes of this protocol, "opioid" is used generally to cover both naturally derived opiates and synthetic and semi-synthetic opioids.

² These screening questions shall be made available in alternate languages for patients whose primary language is not English.

³ For purposes of this protocol, "recipient" means the person to whom naloxone hydrochloride is furnished.

- (ii.) The pharmacist shall provide the recipient with any informational resources on hand and/or referrals to appropriate resources if the recipient indicates interest in addiction treatment, recovery services, or medication disposal resources at this time.
- (iii.) The pharmacist shall answer any questions the recipient may have regarding naloxone hydrochloride.

(4) Product Selection: Naloxone hydrochloride may be supplied as an intramuscular injection, intranasal spray, and auto-injector. Other FDA approved products may be used. Those administering naloxone should choose the route of administration based on the formulation available, how well they can administer it, the setting, and local context.

(5) Suggested Kit Labeling:

Intramuscular	Intranasal	Auto-Injector
<p>Naloxone 0.4mg/1ml single dose vial, # 2 vials SIG: Inject 1 ml intramuscularly upon signs of opioid overdose. Call 911. May repeat x 1.</p> <p>Syringe 3ml 25G X 1" # 2 SIG: Use as directed for naloxone administration.</p> <p>Kit should contain 2 vials and 2 syringes.</p>	<p>Naloxone 2ml prefilled needleless syringe (1mg/1ml concentration), # 2 syringes SIG: Spray one-half (1ml) of the naloxone into each nostril upon signs of opioid overdose. Call 911. May repeat x 1.</p> <p>Mucosal Atomization Device (MAD) # 2 SIG: Use as directed for naloxone administration.</p> <p>Kit should contain 2 prefilled needleless syringes and 2 atomizers.</p>	<p>Naloxone 0.4 mg/0.4 ml #1 twin pack SIG: Use one auto-injector upon signs of opioid overdose. Call 911. May repeat x 1.</p> <p>Kit is commercially available as a twin pack with directions for administration included.</p>

Optional items for the kits include alcohol pads, rescue breathing masks, and rubber gloves.

Kit labels shall include an expiration date for the naloxone hydrochloride furnished. An example of appropriate labeling is available on the Board of Pharmacy website.

(6) Fact Sheet: The pharmacist shall provide the recipient a copy of the current naloxone fact sheet approved by the Board of Pharmacy. This fact sheet shall be

made available in alternate languages for patients whose primary language is not English.

(7) Notifications: If the recipient of the naloxone hydrochloride is also the person to whom the naloxone hydrochloride would be administered, then the naloxone recipient is considered a patient for purposes of this protocol and notification may be required under this section.

If the patient gives verbal or written consent, then the pharmacist shall notify the patient's primary care provider of any drug(s) and/or device(s) furnished, or enter the appropriate information in a patient record system shared with the primary care provider, as permitted by the patient and that primary care provider.

If the patient does not have a primary care provider, or chooses not to give notification consent, then the pharmacist shall provide a written record of the drug(s) and/or device(s) furnished and advise the patient to consult an appropriate health care provider of the patient's choice.

(8) Documentation: Each naloxone hydrochloride product furnished by a pharmacist pursuant to this protocol shall be documented in a medication record for the naloxone recipient, and securely stored within the originating pharmacy or health care facility for a period of at least three years from the date of dispense. The medication record shall be maintained in an automated data processing or manual record mode such that the required information under title 16, sections 1717 and 1707.1 of the California Code of Regulations is readily retrievable during the pharmacy or facility's normal operating hours.

(9) Training: Prior to furnishing naloxone hydrochloride, pharmacists who participate in this protocol must have successfully completed a minimum of one hour of an approved continuing education program specific to the use of naloxone hydrochloride, or an equivalent curriculum-based training program completed in a board recognized school of pharmacy.

(10) Privacy: All pharmacists furnishing naloxone hydrochloride in a pharmacy or health care facility shall operate under the pharmacy or facility's policies and procedures to ensure that recipient confidentiality and privacy are maintained.

What is an opioid overdose?



Opioids can cause bad reactions that make your breathing slow or even stop. This can happen if your body can't handle the opioids that you take that day.

TO AVOID AN ACCIDENTAL OPIOID OVERDOSE:

- Try not to mix your opioids with alcohol, benzodiazepines (Xanax, Ativan, Klonopin, Valium), or medicines that make you sleepy.
- Be extra careful if you miss or change doses, feel ill, or start new medications.

Now that you have naloxone...

Tell someone where it is and how to use it.

Common opioids include:

GENERIC	BRAND NAME
Hydrocodone	Vicodin, Lorcet, Lortab, Norco, Zohydro
Oxycodone	Percocet, OxyContin, Roxicodone, Percodan
Morphine	MSContin, Kadian, Embeda, Avinza
Codeine	Tylenol with Codeine, TyCo, Tylenol #3
Fentanyl	Duragesic
Hydromorphone	Dilaudid
Oxymorphone	Opana
Meperidine	Demerol
Methadone	Dolophine, Methadose
Buprenorphine	Suboxone, Subutex, Zubsolv, Bunavail, Butrans

* Heroin is also an opioid.

For patient education, videos and additional materials, please visit www.prescribetoprevent.org



SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
CALIFORNIA STATE BOARD OF PHARMACY

Opioid safety and how to use naloxone



A GUIDE FOR PATIENTS AND CAREGIVERS

DEVELOPED BY
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

How to identify an opioid overdose:

Look for these common signs:

- The person won't wake up even if you shake them or say their name
- Breathing slows or even stops
- Lips and fingernails turn blue or gray
- Skin gets pale, clammy

In case of overdose:

1 Call 911 and give naloxone

If no reaction in 3 minutes, give second naloxone dose

2 Do rescue breathing or chest compressions

Follow 911 dispatcher instructions

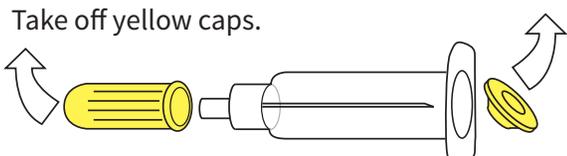
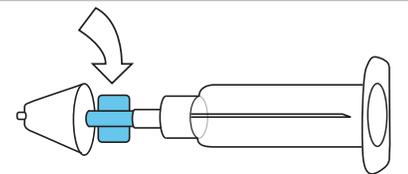
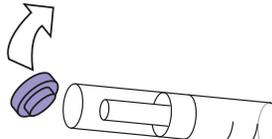
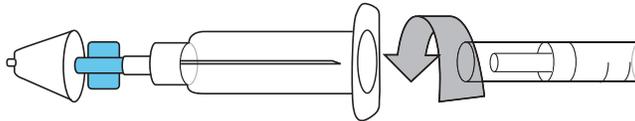
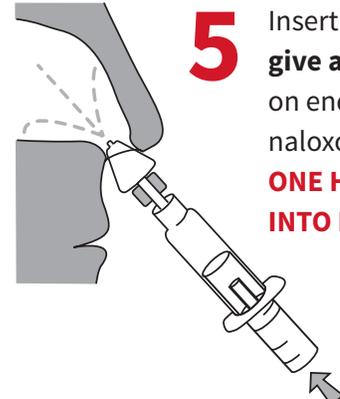
3 After naloxone

Stay with person for at least 3 hours or until help arrives

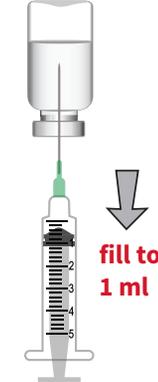
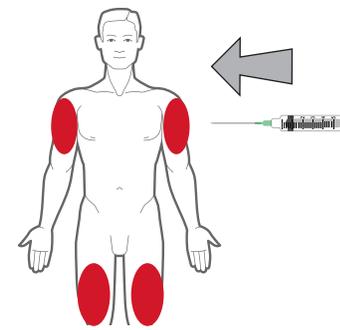
How to give naloxone:

There are 3 ways to give naloxone. Follow the instructions for the type you have.

Nasal spray naloxone

- 1** Take off yellow caps. 
- 2** Screw on white cone. 
- 3** Take purple cap off capsule of naloxone. 
- 4** Gently screw capsule of naloxone into barrel of syringe. 
- 5** Insert white cone into nostril; give a short, strong push on end of capsule to spray naloxone into nose: **ONE HALF OF THE CAPSULE INTO EACH NOSTRIL.**  Push to spray.
- 6** If no reaction in 3 minutes, give second dose.

Injectable naloxone

- 1** Remove cap from naloxone vial and uncover the needle. 
- 2** Insert needle through rubber plug with vial upside down. Pull back on plunger and take up 1 ml.  fill to 1 ml
- 3** Inject 1 ml of naloxone into an upper arm or thigh muscle. 
- 4** If no reaction in 3 minutes, give second dose.

Auto-injector

The naloxone auto-injector is FDA approved for use by anyone in the community. It contains a speaker that provides instructions to inject naloxone into the outer thigh, through clothing if needed.

¿Qué es una sobredosis de opioides?



Los opioides pueden causar malas reacciones haciendo que su respiración sea más lenta o incluso se detenga. Esto podría suceder si su cuerpo no puede soportar los opioides que haya tomado ese día.

PARA EVITAR UNA SOBREDOSIS ACCIDENTAL DE OPIOIDES:

- Trate de no mezclar sus opioides con alcohol, benzodiazepinas (Xanax, Ativan, Klonopin, Valium), ni medicamentos que le produzcan somnolencia.
- Tenga mucho cuidado si se le olvida tomar una dosis o la modifica, si se siente enfermo o empieza a tomar un nuevo medicamento.

Ahora que cuenta con naloxona...

Dígale a alguien en dónde está y cómo utilizarla.

Opioides comunes incluyen:

GENÉRICO	MARCA
Hidrocodona	Vicodin, Lorcet, Lortab, Norco, Zohydro
Oxicodona	Percocet, OxyContin, Roxicodone, Percodan
Morfina	MSContin, Kadian, Embeda, Avinza
Codeína	Tylenol with Codeine, TyCo, Tylenol #3
Fentanilo	Duragesic
Hidromorfona	Dilaudid
Oximorfona	Opana
Meperidina	Demerol
Metadona	Dolophine, Methadose
Buprenorfina	Suboxone, Subutex, Zubsolv, Bunavail, Butrans

* La heroína también es un opioide.

Para obtener materiales educativos para pacientes, como videos y demás, visite www.prescribtoprevent.org



SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
CALIFORNIA STATE BOARD OF PHARMACY

Medidas de seguridad con los opioides y cómo usar naloxona



UNA GUÍA PARA PACIENTES Y ENCARGADOS DEL CUIDADO

DESARROLLADO POR

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Cómo identificar una sobredosis de opioides:

Observe los siguientes síntomas:

- La persona no despierta, así la sacuda o llame por su nombre
- La respiración se hace más lenta o incluso se detiene
- Los labios y las uñas se vuelven azules o grises
- La piel se torna pálida, fría y húmeda

En caso de sobredosis:

1 Llame al 911 y administre la naloxona

Si no hay una reacción en 3 minutos, administre una segunda dosis de naloxona

2 Comience a dar respiración de boca a boca o compresiones cardíacas

Siga las instrucciones del operador del 911

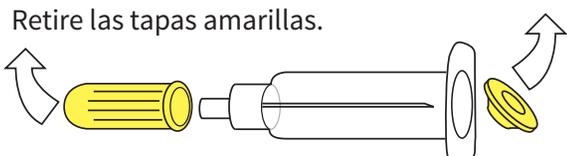
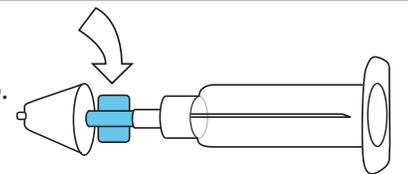
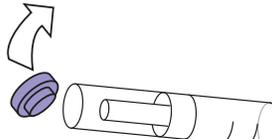
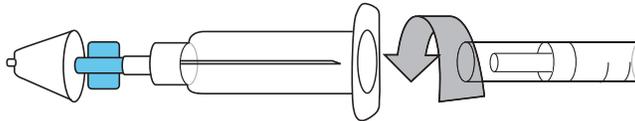
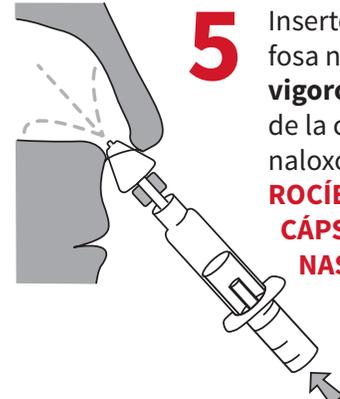
3 Después de administrar la naloxona

Permanezca con la persona por al menos 3 horas o hasta que llegue la ayuda

Cómo administrar la naloxona:

Hay 3 formas de administrar la naloxona. Siga las instrucciones del tipo con el que cuenta.

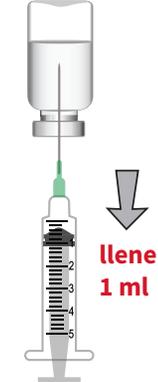
Aerosol nasal de naloxona

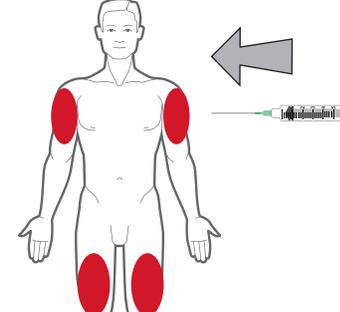
- 1** Retire las tapas amarillas.

- 2** Enrosque el cono blanco.

- 3** Quite la tapa morada de la cápsula de naloxona.

- 4** Enrosque suavemente la cápsula de naloxona en el barril de la jeringa.

- 5** Inserte el cono blanco en la fosa nasal; **empuje rápida y vigorosamente** el extremo de la cápsula para rociar la naloxona dentro de la nariz: **ROCÍE LA MITAD DE LA CÁPSULA EN CADA FOSA NASAL.**


Empuje para rociar.
- 6** Si no hay una reacción en 3 minutos, administre una segunda dosis.

Naloxona inyectable

- 1** Retire la tapa del vial de naloxona y quite el protector de la aguja.

- 2** Inserte la aguja por el tapón con el vial al revés. Tire del émbolo y llene la jeringa con 1 ml.


llene 1 ml
- 3** Inyecte 1 ml de naloxona en el músculo de la parte superior del brazo o el muslo.

- 4** Si no hay una reacción en 3 minutos, administre una segunda dosis.

Inyector automático

El inyector automático de naloxona ha sido aprobado por la FDA para ser utilizado por cualquier persona. Contiene un parlante que proporciona instrucciones para inyectar naloxona en la parte exterior del muslo, a través de la ropa de ser necesario.

什麼是類鴉片過量？



類鴉片會引起不良反應，導致您的呼吸減慢甚至停止。

如果您的身體不能消化當日服下的類鴉片，这种情况就可能發生。

欲避免意外攝入過量的類鴉片：

- 請勿在服用類鴉片時飲酒，或服用苯二氮平類藥物（贊安諾、安定文錠、克諾平、瓦利姆）或導致您瞌睡的藥物。
- 如果您忘記服藥或服錯劑量、身體感到不適或開始服用新藥時，請格外當心。

如果您有納洛酮……

請告訴別人它存放的位置及服用方法。

常見的類鴉片包括：

類別	商品名
氫可酮	維柯丁、洛塞特、Lortab、諾科、Zohydro
經考酮	波拷賽特、奧施康定、Roxicodone、Percodan
嗎啡	美施康定、Kadian、Embeda、Avinza
可待因	含有可待因的泰勒諾、泰科、泰勒諾 3 號
芬太尼	多瑞吉
氫嗎啡酮	地勞迪德
經嗎啡酮	歐帕鈉
派替啶	德美羅
美沙酮	多羅芬、Methadose
丁丙諾啡	舒倍生、速百騰、Zubsolv、Bunavail、Butrans

*海洛英也是類鴉片的一種。

欲取得患者教育、
視頻和額外材料，請瀏覽

www.prescribetoprevent.org



SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
CALIFORNIA STATE BOARD OF PHARMACY

類鴉片的安全性 及納洛酮的 使用方法



患者及護理者指南

開發者

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

如何鑒定類鴉片過量：

請注意以下常見症狀：

- 即使您搖晃或呼喚他，他也無法醒來
- 呼吸減慢甚至停止
- 嘴唇和指甲變藍或變灰
- 皮膚變得蒼白、濕冷

如果服用過量：

1 請撥打 911 並服用納洛酮

如果3分鐘後還沒有反應，請再服用一次納洛酮。

2 進行人工呼吸或胸外按壓

請聽從 911 調度員的指示

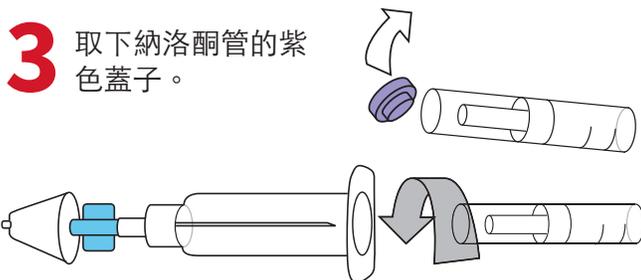
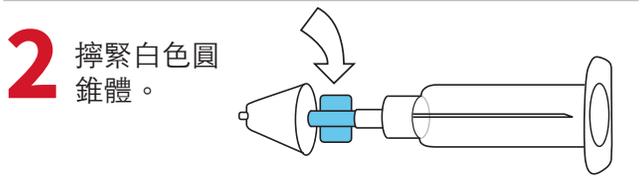
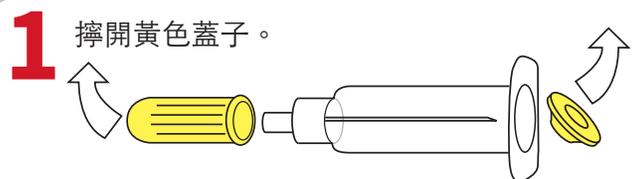
3 服用納洛酮後

請陪在患者身邊至少 3 個小時或直至救護人員抵達

如何服用納洛酮：

服用納洛酮有 3 種方式。請根據您現有納洛酮的類型按以下說明操作。

納洛酮噴鼻劑

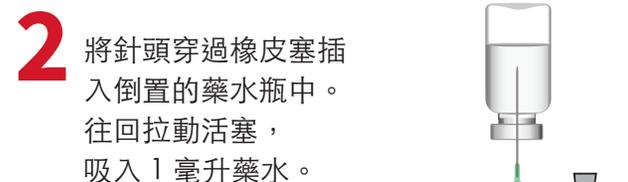
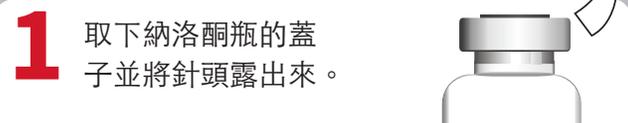


4 輕輕地將納洛酮管擰緊於針筒注射器中。

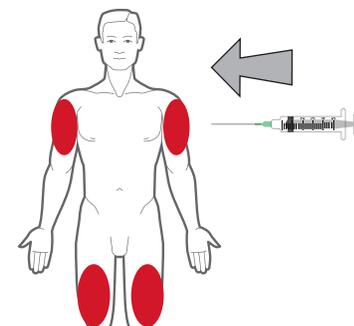


6 如果 3 分鐘後還沒有反應，請再噴一次。

可注射式納洛酮



3 在上臂或大腿肌肉注射 1 毫升的納洛酮。



4 如果 3 分鐘後還沒有反應，請再注射一次。

自動注射器

納洛酮自動注射器經由食品藥品監督管理局 (FDA) 批准，適合每一個人使用。它附帶一個揚聲器，指示如何將納洛酮注入大腿外側。在需要時可以隔著衣服進行注射。

마약성 진통제 (OPIOID) 과용이란?



마약성 진통제 (Opioid)를 복용하면 호흡이 느려지거나 심지어 멈출 수 있습니다. 당일 복용한 마약성 진통제 (Opioid)를 과용하면 이러한 증상이 나타날 수 있습니다.

마약성진통제 (OPIOD) 과용 예방법:

- 알콜, 벤조디아제핀 (제넥스, 아티반, 클로노핀, 바륨) 또는 졸립게 하는 약물과 마약성 진통제 (Opioid)를 혼용하지 마십시오.
- 약 복용 시간을 놓치거나 복용법을 바꾸거나 아프거나 새로운 약을 복용하기 시작할 때 특히 주의하셔야 합니다.

넬낙손(NALOXONE) 보관시...

다른 사람에게 보관 장소와 사용법을 알려 주십시오.

흔한 마약성 진통제 (OPIOID) 제품:

성분명	상표명
하이드로콘 (Hydrocodone)	비코딘 (Vicodin), 로셋 (Lorcet), 로렙Lortab, 놀코 (Norco), 조하이드로 (Zohydro)
옥시코돈 (Oxycodone)	펄코셋 (Percocet), 옥시코틴 (OxyContin), 록시코돈 (Roxicodone), 펄코단 (Percodan)
모르핀 (Morphine)	엠에스코틴 (MSContin), 카디안 (Kadian), 엠베다 (Embeda), 아빈자 (Avinza)
코데인 (Codeine)	코데인 함유 타이레놀 (Tylenol with Codeine), 타이코 (TyCo), 타이레놀 #3 (Tylenol #3)
펜타닐 (Fentanyl)	듀라제식 (Duragesic)
하이드로몰폰 (Hydromorphone)	딜리디드 (Dilaudid)
옥시몰폰 (Oxymorphone)	오파나 (Opana)
메페리딘 (Meperidine)	데머롤 (Demerol)
메타돈 (Methadone)	돌로핀 (Dolophine), 메타도스 (Methadose)
부프레노르핀 (Buprenorphine)	서복손 (Suboxone), (서버텍스) Subutex, 저브솔브(Zubsolv), 버나베일 (Bunavail), 버트란스 (Butrans)

* 헤로인도 마약성진통제 (Opiod)입니다.

환자 교육, 비디오와 그 외 자료가 필요하시면 다음 웹사이트 를 방문해 주십시오.

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마약성진통제 (Opiod)의 안전사용과 넬낙손 (Naloxone) 사용법



환자와 간병인을 위한 안내서

개발

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

마약성진통제 (OPIOD) 과용 구별법:

일반적인 징후:

- 흔들거나 이름을 불러도 깨어나지 않는다.
- 호흡이 느려지거나 멈춘다.
- 입술과 손톱이 파래지거나 회색으로 변한다.
- 피부가 창백해지고 식은 땀이 난다.

과용의 경우:

1 911에 전화하고, 넬락손 (Naloxone)을 투여하십시오

3분 안에 반응이 나타나지 않으면, 두번째 넬락손 (Naloxone)을 투여하십시오.

2 인공호흡이나 흉부 압박을 시행하십시오

911 대원의 지시에 따르십시오.

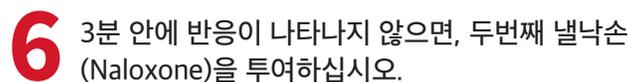
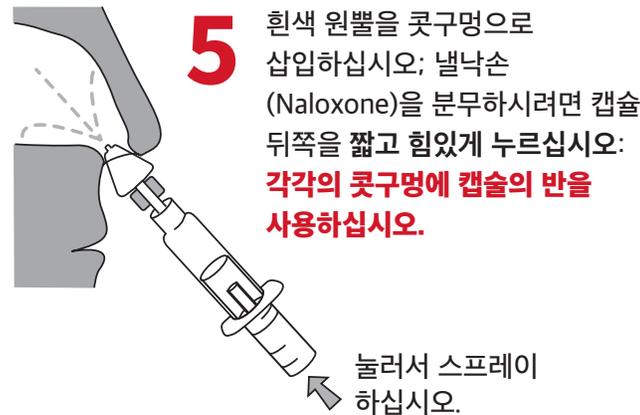
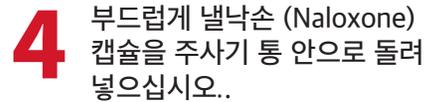
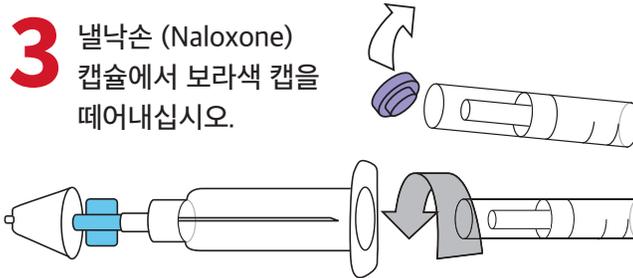
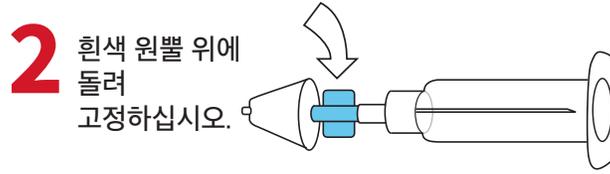
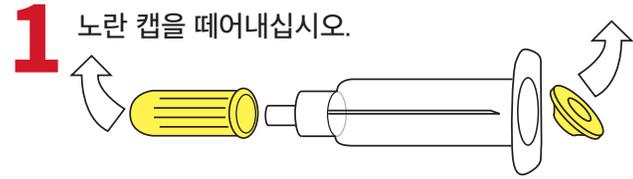
3 넬락손 (Naloxone)을 투여한후

도와줄 사람이 올 때 까지 적어도 3시간 이상 환자 옆에서 떠나지 마십시오.

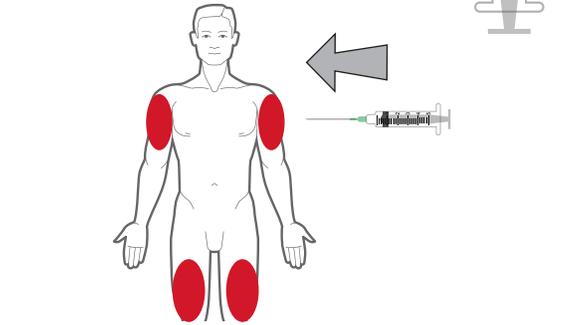
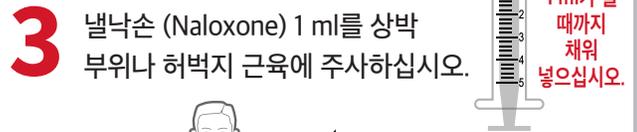
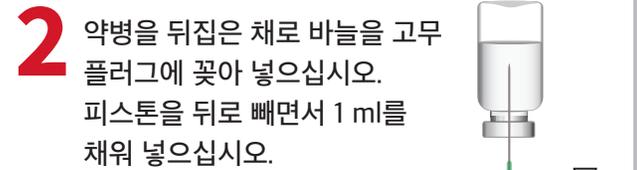
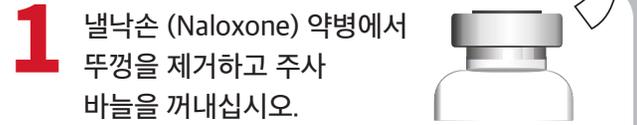
넬락손 (NALOXONE)을 투여법:

넬락손 (Naloxone)을 투여하는 방법은 세가지입니다. 가능한 방법을 선택하셔서 다음의 지시에 따르셔야합니다.

코 스프레이형 넬락손 (Naloxone)



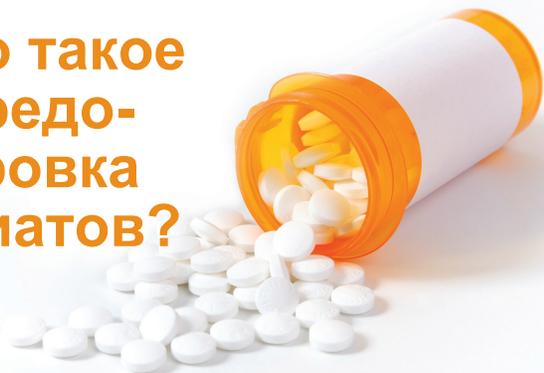
주사기형 넬락손 (Naloxone)



자동-주사기

넬락손 (Naloxone) 자동 주사기는 누구나 사용할 수 있도록 FDA 인증을 받은 제품입니다. 스피커가 포함되어 있어서 필요시 옷 위에서, 넬락손 (Naloxone)을 바깥쪽 허벅지에 주사할 수 있도록 사용법을 알려줍니다.

Что такое передозировка опиатов?



Употребление опиатов вызывает такие реакции, как замедление дыхания вплоть до его остановки. Это происходит в случае, если организм не справляется с количеством принятых опиатов.

- Старайтесь избегать одновременного приема опиатов с алкоголем, бензодиазепинами (Ксанакс, Ативан, Клонопин, Валиум) и снотворными средствами.
- Соблюдайте предельную осторожность в случае, если вы пропустили прием препарата или изменили дозировку, неважно чувствуете себя либо начали прием новых медикаментов.

Принимая налоксон...

Расскажите кому-нибудь, где вы его храните и как его вводить.

В состав обычных опиатов входят следующие вещества:

ДЕЙСТВУЮЩЕЕ ВЕЩЕСТВО	ТОРГОВОЕ НАЗВАНИЕ
Гидрокодон	Викодин, Лорсет, Лортаб, Норко, Зогидро
Оксикодон	Перкоцет, ОксиКонтин, Роксикодон, Перкодан
Морфин	МС-Контин, Кадан, Эмбеда, Авинза
Кодеин	Тайленол с кодеином, ТайКо, Тайленол №3
Фентанил	Дюрогезик
Гидроморфин	Дилаудид
Оксиморфон	Опана
Меперидин	Демерол
Метадон	Долофин, Метадоз
Бупренорфин	Субоксон, Субутекс, Зубсолв, Бунавейл, Бутранс

* Героин также является опиатом.

Образовательные материалы для пациентов, видео и дополнительные материалы можно найти на сайте www.prescribtoprevent.org



SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
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Меры предосторожности при приеме опиатов и инструкции по применению налоксона



РУКОВОДСТВО ДЛЯ ПАЦИЕНТОВ И ЛИЦ, ОСУЩЕСТВЛЯЮЩИХ УХОД

РАЗРАБОТАНО

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Симптомы

передозировки опиатов:

Типичные признаки:

- Пациент не просыпается, даже если его потрясти или позвать его по имени
- Дыхание замедленное или отсутствует вовсе
- Губы и ногти на руках приобрели синеватый или сероватый оттенок
- Кожа стала липкой, побледнела

В случае передозировки:

1 Вызовите скорую помощь и введите налоксон

Если через 3 минуты реакции не наблюдается, введите еще одну дозу налоксона

2 Начните делать искусственное дыхание или непрямой массаж сердца

Следуйте инструкциям диспетчера скорой помощи

3 После введения налоксона

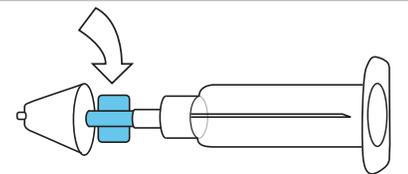
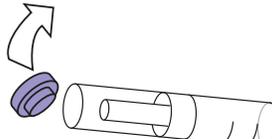
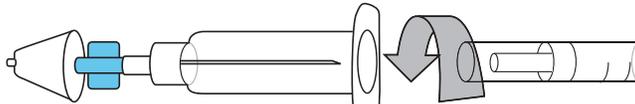
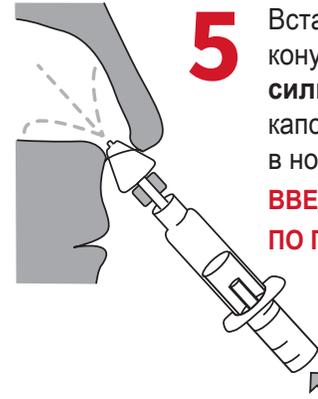
Оставайтесь рядом с пациентом, как минимум, в течение 3 часов или до момента прибытия бригады скорой помощи

Инструкция по введению налоксона:

Существует 3 способа введения налоксона. Соблюдайте инструкцию по применению для имеющейся у вас формы выпуска налоксона.

Налоксон в виде назального спрея

- 1** Снимите желтые колпачки.

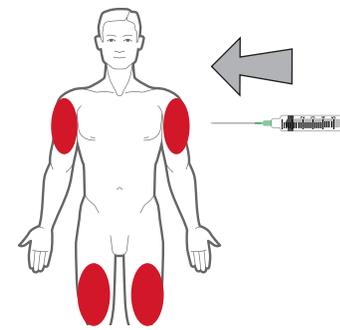
- 2** Установите белый наконечник-конус.

- 3** Снимите сиреневый колпачок с капсулы с налоксоном.

- 4** Аккуратно вкрутите капсулу с налоксоном в цилиндр шприца.

- 5** Вставьте белый наконечник-конус в ноздрю. **Коротким, сильным нажатием** на дно капсулы распылите налоксон в нос:
ВВЕДИТЕ В КАЖДУЮ НОЗДРЮ ПО ПОЛОВИНЕ КАПСУЛЫ.


Нажмите чтобы распылить спрей.
- 6** Если через 3 минуты реакции не наблюдается, введите еще одну дозу налоксона.

Налоксон в виде инъекций

- 1** Снимите колпачок с ампулы налоксона и защитный колпачок с иглы.

- 2** Введите иглу в ампулу через резиновую крышку, держа при этом ампулу крышкой вниз. Потяните за поршень и наберите 1 мл налоксона в шприц.


наполните до отметки 1 мл
- 3** Введите 1 мл налоксона в плечевую или бедренную мышцу.

- 4** Если через 3 минуты реакции не наблюдается, введите еще одну дозу налоксона.

Автоматический шприц

Налоксон в виде автоматического шприца одобрен Управлением по контролю качества пищевых продуктов и лекарственных препаратов (США) для использования во внебольничных условиях. В его состав входит динамик, который дает инструкции по введению налоксона в мышцу внешней части бедра, при необходимости через одежду.

Ano ang opioid labis na dosis?



Ang Opioids ay nakapagdudulot ng masamang epekto na nagreresulta sa pagbagal na iyong paghinga o di kaya ay paghinto nito. Maaari itong mangyari kapag hindi kaya ng iyong katawan ang opioids na ininom sa araw na iyon.

PAANO MAIIWASAN ANG HINDI SINASADYANG LABIS NA DOSIS NG OPIOID?

- Huwag ihalo ang opioids sa alkohol, benzodiazepines (Xanax, Ativan, Klonopin, Valium) o mga gamot na nakakaantok.
- Maging maingat kung nagmintis sa pag-inom o nag-iba ng dosis, nagkasakit o nagsimula ng bagong medikasyon.

Ngayong meron ka nang naloxone...

Ipaalam sa isang tao kung nasaan at paano ito gamitin.

Ang mga pangkaraniwang opioids ay kabilang ang:

PANLAHAT	PANGALAN NG TATAK
Hydrocodone	Vicodin, Lorcet, Lortab, Norco, Zohydro
Oxycodone	Percocet, OxyContin, Roxicodone, Percodan
Morpina	MSContin, Kadian, Embeda, Avinza
Kuodin	Tylenol with Codeine, TyCo, Tylenol #3
Fentanyl	Duragesic
Hydromorphone	Dilaudid
Oxymorphone	Opana
Meperidine	Demerol
Methadone	Dolophine, Methadose
Buprenorphine	Suboxone, Subutex, Zubsolv, Bunavail, Butrans

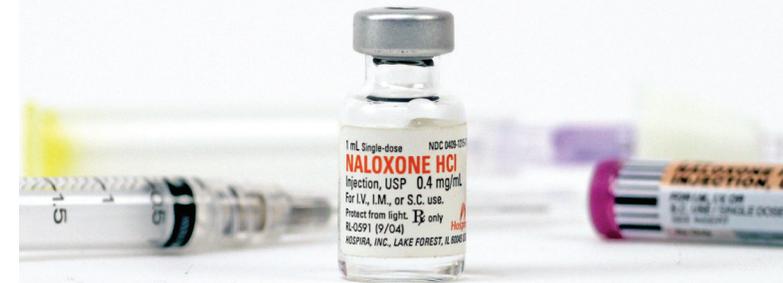
* Ang heroin ay isang opioid din.

Para sa edukasyon ng pasyente, mga bidyo at karagdagang materyales, maaaring bumisita sa www.prescribetoprevent.org



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Kaligtasan sa Opioid at paano gamitin ang naloxone



GABAY PARA SA MGA PASYENTE AT SA MGA TAGAPAG-ALAGA

NILIKHA NG

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Paano malalaman kung ang isang tao ay may labis na dosis ng opioid:

Hanapin ang mga ganitong pangkaraniwang sintomas:

- Ang tao ay hindi gumigising kahit na siya ay iyong yugyugin o tawagin sa kanyang pangalan.
- Mabagal na paghinga o pagtigil nito
- Ang labi at ang mga kuko ay nagkukulay asul o kulay-abo
- Ang balat ay namumutla, nanlalamig at nagpapawis

Kung sakaling nagkaroon ng labis na dosis:

1 Tumawag sa 911 at magbigay ng naloxone

Kung walang naging reaksiyon sa loob ng tatlong minuto, muling magbigay ng dosis ng naloxone

2 Magbigay ng rescue breathing o chest compressions

Sundan ang mga direksyong ibinibigay ng despatsador ng 911

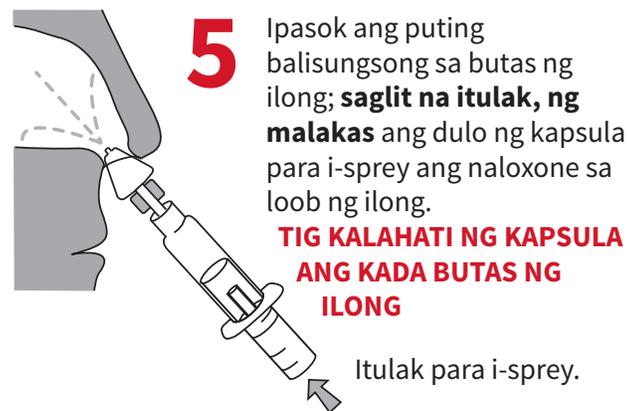
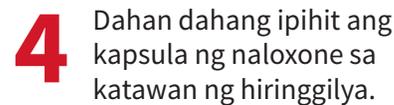
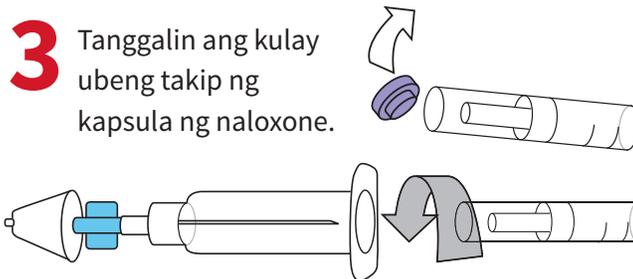
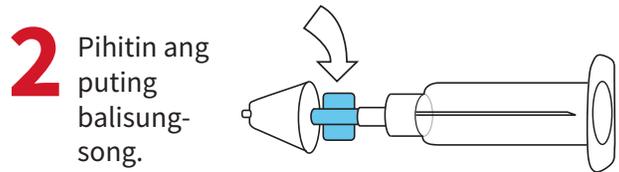
3 Pagkatapos maibigay ang naloxone

Bantayan ang pasyente sa loob ng tatlong oras o hanggang sa makarating ang tulong

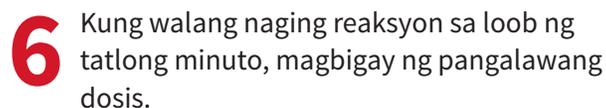
Paano magbigay ng naloxone:

May tatlong paraan sa pagbibigay ng naloxone. Sundan ang direksyon ayon sa klase ng naloxone na meron ka.

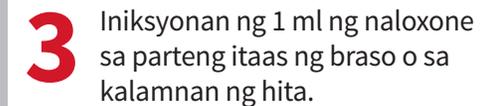
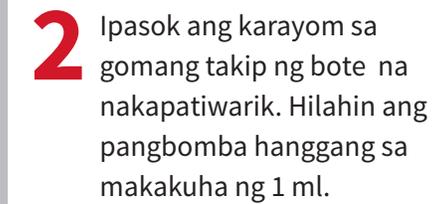
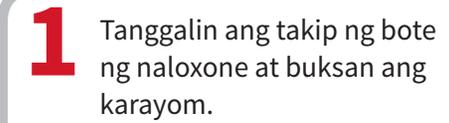
Naloxone na ini-sprey sa ilong



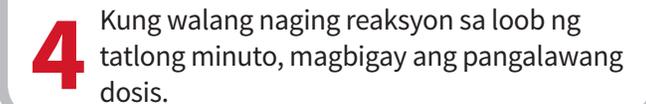
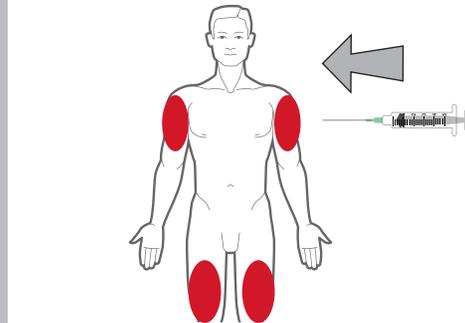
Itulak para i-sprey.



Itinuturok na naloxone



Punuin hanggang 1 ml.



Auto-injector

Ang naloxone auto-injector ay aprubado ng FDA para gamitin ng kahit na sino sa komunidad. Ito ay may kasamang ispiker na nagbibigay ng direksyon kung paano mag-iniksyon sa labas ng hita sa pamamagitan ng damit kung kinakailangan.

Quá liều opioid (chất dạng thuốc phiện) là gì?



Opioid có thể gây ra những phản ứng xấu làm chậm hoặc thậm chí ngưng thở. Điều này có thể xảy ra nếu cơ thể bạn không thể xử lý các opioid mà bạn dùng trong ngày hôm đó.

ĐỂ TRÁNH SỢ Ý DÙNG QUÁ LIỀU OPIOID:

- Cố gắng không dùng chung opioid với rượu, nhóm thuốc an thần benzodiazepine (Xanax, Ativan, Klonopin, Valium), hoặc các loại thuốc gây buồn ngủ.
- Hãy thật cẩn thận nếu bạn bỏ lỡ hoặc thay đổi liều, cảm thấy mệt, hoặc bắt đầu loại thuốc mới.

Bây giờ bạn có naloxone...

Hãy nói cho một ai đó xuất xứ và cách sử dụng nó.

Các opioid thường gặp bao gồm:

TÊN CHUNG	TÊN NHÃN HIỆU
Hydrocodone	Vicodin, Lorcet, Lortab, Norco, Zohydro
Oxycodone	Percocet, OxyContin, Roxicodone, Percodan
Morphine	MSContin, Kadian, Embeda, Avinza
Codeine	Tylenol with Codeine, TyCo, Tylenol #3
Fentanyl	Duragesic
Hydromorphone	Dilaudid
Oxymorphone	Opana
Meperidine	Demerol
Methadone	Dolophine, Methadose
Buprenorphine	Suboxone, Subutex, Zubsolv, Bunavail, Butrans

* Heroin cũng là một opioid.

Để xem thông tin về giáo dục bệnh nhân, video và tài liệu bổ sung, vui lòng truy cập www.prescribtoprevent.org



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An toàn opioid và cách sử dụng naloxone



HƯỚNG DẪN CHO BỆNH NHÂN VÀ NGƯỜI CHĂM SÓC

ĐƯỢC PHÁT TRIỂN BỞI

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Cách xác định quá liều opioid:

Hãy tìm những biểu hiện phổ biến sau:

- Người bệnh không tỉnh dậy ngay cả khi bạn lắc họ hoặc gọi tên họ
- Thở chậm hoặc thậm chí ngừng thở
- Môi và móng tay chuyển sang màu xanh hoặc xám
- Da nhợt nhạt, lạnh và rịn mồ hôi

Trong trường hợp quá liều:

1 Gọi 911 và cho dùng naloxone

Nếu không có phản ứng trong 3 phút, hãy cho liều naloxone thứ hai

2 Làm hô hấp nhân tạo hoặc ép ngực

Thực hiện theo hướng dẫn của điều phối viên 911

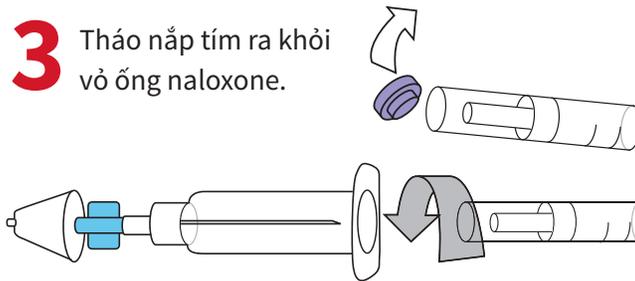
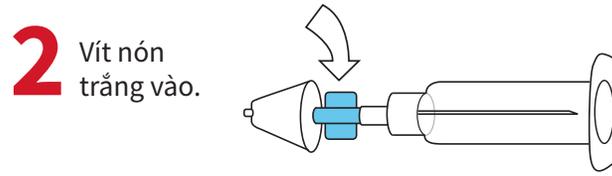
3 Sau khi cho dùng naloxone

Hãy ở lại với bệnh nhân ít nhất 3 tiếng hoặc tới khi có người đến giúp

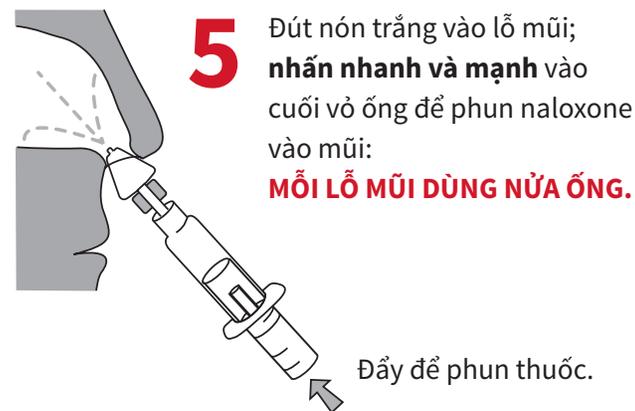
Cách cho dùng naloxone:

Có 3 cách để cho dùng naloxone. Thực hiện theo các hướng dẫn cho loại mà bạn có.

Naloxone xịt mũi

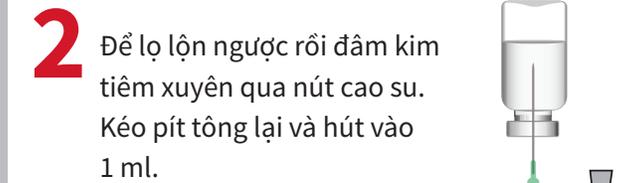
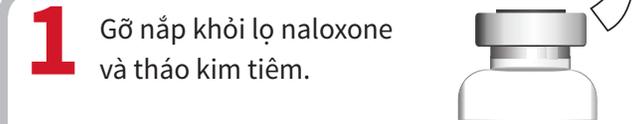


4 Nhẹ nhàng vít vỏ ống naloxone vào chuỗi ống bơm.

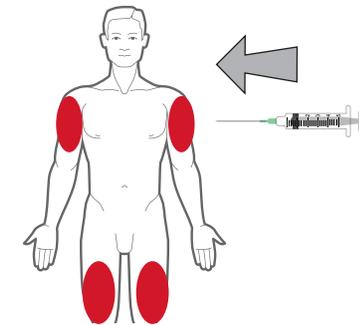


6 Nếu không có phản ứng trong 3 phút, hãy cho liều thứ hai.

Naloxone tiêm



3 Tiêm 1 ml naloxone vào một cánh tay hoặc bắp đùi trên.



4 Nếu không có phản ứng trong 3 phút, cho liều thứ hai.

Máy chích tự động

Máy chích naloxone tự động được FDA chấp thuận cho phép sử dụng bởi bất kỳ ai trong cộng đồng. Nó có chứa một loa phát cung cấp các hướng dẫn để tiêm naloxone vào đùi ngoài, thông qua quần áo nếu cần thiết.

Attachment 10

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For Teenagers, Adult-Sized Opioid Addiction Treatment Doesn't Fit

By Heidi Benson | NPR (<http://www.npr.org/>)

Friday, January 15, 2016



Trina Dalziel / Illustration Works/Getty Images

Addicted to prescription painkillers after a high-school sports injury, Cameron Burke moved on to heroin, which was cheaper and more easily accessible. His parents tried everything, more than once sending him out of state for treatment.

"It was never enough," Jennifer Weiss-Burke of Albuquerque, N.M., told a local TV reporter last year. "Thirty days here, 30 days there, maybe detox for five days. It was never long-term, and that's what he needed. Recovery from heroin addiction requires long-term treatment."

During the course of two years, Cameron would seem to recover, only to relapse. In 2011, Weiss-Burke found him dead in his room.

Weiss-Burke turned her grief into action, lobbying for state legislation that would require all medical practitioners to complete a course in addiction and pain management when their licenses are renewed, and pushing for the creation of Serenity Mesa, a long-term treatment center for youths in Albuquerque that opened its doors last year.

Although drug addiction was described as a disease as long ago as the 1700s, addiction medicine has been neglected by the medical system, according to a [2012 study](http://www.casacolumbia.org/newsroom/press-releases/addiction-medicine-report-1) (<http://www.casacolumbia.org/newsroom/press-releases/addiction-medicine-report-1>) by the [National Center on Addiction and Substance Abuse](http://www.casacolumbia.org/) (<http://www.casacolumbia.org/>) at Columbia University.

"While a wide range of evidence-based screening, intervention, treatment and disease management tools and practices exist, they are rarely employed," the report found.

Lack of effective treatment in the teen years can blight an entire life. "When substance use disorders occur in adolescence, they affect key developmental and social transitions, and they can interfere with normal brain maturation," the National Institute on Drug Abuse reported in 2014 (<http://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/acknowledgements>). "These potentially lifelong consequences make addressing adolescent drug use an urgent matter."

The first line of defense is primary health care, according to Dr. David E. Smith, an addiction medical specialist who founded the Haight Ashbury Free Clinics in San Francisco. To increase the number of physicians trained to diagnose and treat addiction and to recognize early signs of adolescent substance use disorder, Smith would like to see addiction medicine mandatory in medical school.

"Engaging people earlier in their addiction improves their chances of recovery and overall better health," Smith said. "Meanwhile, costs for the health care system are dramatically reduced."

A youth-centered approach

Deaths from heroin overdose in all age groups doubled from 2010 to 2012, according to a 2014 [study](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6339a1.htm) (<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6339a1.htm>) from the [Centers for Disease Control and Prevention](http://www.cdc.gov/) (<http://www.cdc.gov/>).

In response, communities are seeking new strategies to treat addiction and speed access to care. That includes trying to meet the unique needs of youth after years of addiction treatments geared to adults. Serenity Mesa is one of those youth-centered efforts.

Such programs offer evidence-based treatment, types of therapy that have shown scientifically validated results. They include: Screening, Brief Intervention and Referral to Treatment ([SBIRT](http://www.samhsa.gov/sbirt) (<http://www.samhsa.gov/sbirt>)), a preventative protocol for early detection;

Motivational Interviewing (<http://www.motivationalinterviewing.org/>), a counseling approach that guides individuals to set goals; and Functional Family Therapy (FFT) (<http://www.fftllc.com/>), which treats teens in a family setting.

While public policy and social attitudes have begun to catch up with science, treatment for teens lags far behind. The 2012 National Survey on Drug Use and Health (<http://archive.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/Index.aspx>) found that 90 percent of drug-addicted youth ages 12 to 17 get no treatment at all.

"Twenty years ago, we were just beginning to focus on evidence-based treatment for drug-involved youth," says Dr. Holly Waldron, a senior scientist at the Oregon Research Institute who studies adolescent behavior. "Historically, interventions for addictive behaviors have included confrontational approaches, but we've learned that confrontation does not produce effective change in substance-abuse behavior."

Instead, Waldron and her colleagues favor evidence-based interventions including functional family therapy and cognitive behavioral treatments for adolescent substance abuse.

"We're actively involved in taking these treatments to community settings," she said. "If we can connect kids to treatment, we know they'll improve."

Most health insurers now require proof that addiction programs use evidence-based treatment, a sign of efficacy. And since the 2010 Affordable Care Act expanded the Mental Health Parity and Addiction Equity Act (<http://www.dol.gov/ebsa/mentalhealthparity/>), more adolescents have better access to insurance coverage.

Yet, teenagers rarely enter rehab voluntarily. "Clinicians are dependent on systems like juvenile justice and the schools to get teens connected to treatment," Waldron said.

Making family therapy work

Some treatments for teens with substance use disorder engage the whole family. Functional Family Therapy uses a dozen or more one-hour sessions to defuse negativity, then teach skills training in family communication, parenting, problem solving and conflict management. Later sessions strengthen a family's capacity to navigate community resources, which can prevent relapse.

Waldron is also testing the effectiveness of delivering therapy to New Mexico's scattered rural population via videoconference. Privacy is one benefit of videoconferencing, Waldron noted. "If you live in a small town and your car is parked in the lot at the mental health clinic, everybody knows that's your car," she says. "In Native American communities, if you go to a tribal counselor, it's more likely people will know your business." So talking at home over the Internet offers greater confidentiality. "That's important to families."

Videoconference dynamics can be complicated, however. "It's harder to discern over a video stream how people are responding," Waldron said. "If they're quiet, if they're becoming emotional, we might not see cues."

To compensate, "the therapist has to do verbal check-ins with each member of the family," Waldron explained. She posed an example, meant to invite participants to describe their feelings: "I hear you being quiet. Does this topic hit close to home for you all?"

The study ran through November, and Waldron said preliminary data shows the online treatment is as effective as treatment delivered face-to-face at home. If, as Waldron expects, the final data shows measurably improved outcomes such as a decline in drug use and better family dynamics, she hopes that the results can be reproduced elsewhere.

"It will mean that it's possible to get the best treatment to kids who would never have access otherwise," she said.

Treating addiction with medication

At HealthRIGHT 360, a nonprofit in San Francisco created in 2011 when the Haight-Ashbury Clinic merged with the local residential center Walden House, treatment can include individual or group therapy, family therapy and mindfulness meditation. All can be used in combination with medications (<http://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat>) such as methadone.

While methadone can be effective in addiction recovery for adults, it is not well-suited for teens, according to Dr. Ako Jacintho, HealthRIGHT 360's medical director.

Methadone is highly regulated and can only be administered at methadone clinics. The drug must be taken daily, so trips to and from the clinic, often far from home and work, can be especially difficult for teens. And, Jacintho noted, teens may encounter other addicts at the clinic, as well as opportunities to buy drugs.

The maintenance drug often prescribed for teens is Suboxone (<http://www.suboxone.com/>), a combination of buprenorphine (<http://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine>), an opiate substitute that eliminates craving, and naloxone (<http://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone>), which blocks euphoric effects. Suboxone doesn't cause drowsiness, and, the equilibrium it provides can make it easier to identify and treat co-occurring disorders like depression or anxiety. The dosage is eventually tapered.

A 2014 Yale School of Medicine study (<http://archinte.jamanetwork.com/article.aspx?articleid=1916910>) showed that ongoing maintenance treatment with Suboxone is more effective than detoxification and abstinence alone.

"There is strong data on Suboxone," Jacintho said. When combined with behavioral therapy, he says, Suboxone can reduce relapses and promote recovery. And, it can be prescribed and given by a trained and certified primary care physician — in a doctor's office, rather than a clinic, Jacintho noted. "We get better outcomes when we change from methadone clinics to primary care."

As education and training around addiction improve, Smith hopes more attention will be paid to the people he calls "role models of recovery."

Vitka Eisen, CEO of HealthRIGHT 360, is one of them. She was a heroin addict from age 19 to 25, until the Haight Ashbury Free Clinic and Walden House put her back on her feet. Three college degrees later, including a doctorate in education from Harvard University, she's proud to call herself "a 1987 Walden House graduate."

Having been homeless during periods of her addiction, Eisen knows the difficulties teenage addicts may face.

"It's hard for these kids to get off heroin, because they lead such challenging lives. If a kid's using heroin, there's a high likelihood of trauma exposure" from school, work or family life, she said. "Drugs may seem like the best thing in their life, the thing that helped them deal with how they experience the circumstances of their lives."

The most effective treatments for teens, she says, build on the individual's strengths while empowering them to better handle stressful circumstances.

And these treatments can gain in effectiveness when used in combination with medications such as Suboxone.

Jacintho also says there soon will be greater acceptance of integrated treatment for teens. "The data is going to show positive health outcomes," he predicted.

Smith is cautiously optimistic, too. "Every interface with a health care professional should give a consistent message," he said. "We care."

This story was produced by Youth Today (<http://www.youthtoday.org/>), the national news source for youth-service professionals, including child welfare and juvenile justice, youth development and out-of-school-time programming.

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REVIEW ARTICLE

Dan L. Longo, M.D., *Editor*

Relationship between Nonmedical Prescription-Opioid Use and Heroin Use

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THE NONMEDICAL USE OF PRESCRIPTION OPIOIDS IS A MAJOR PUBLIC health issue in the United States, both because of the overall high prevalence and because of marked increases in associated morbidity and mortality.¹ In 2014, a total of 10.3 million persons reported using prescription opioids nonmedically (i.e., using medications that were not prescribed for them or were taken only for the experience or feeling that they caused).² Emergency department visits involving misuse or abuse of prescription opioids increased 153% between 2004 and 2011, and admissions to substance-abuse treatment programs linked to prescription opioids more than quadrupled between 2002 and 2012.^{3,4} Most troubling, between 2000 and 2014 the rates of death from prescription-opioid overdose nearly quadrupled (from 1.5 to 5.9 deaths per 100,000 persons) (Fig. 1).

The pattern of nonmedical use of prescription opioids varies, from infrequent use once or twice per year to daily or compulsive heavy use and addiction. A key underlying characteristic of the epidemic is the association between the increasing rate of opioid prescribing and increasing opioid-related morbidity and mortality.⁶⁻⁹ Pain has also been identified as a poorly addressed clinical and public health problem for which treatment with prescription opioids may play an important role.¹⁰ Taken together, these trends suggest the need for balanced prevention responses that aim to reduce the rates of nonmedical use and overdose while maintaining access to prescription opioids when indicated.

In response to these interrelated public health problems, federal, state, and other vested interests are implementing a variety of policies and programs aimed at curbing inappropriate prescribing.^{1,6,11-16} These efforts include educating health professionals and the public about appropriate use, implementing prescription-drug monitoring programs, taking enforcement and regulatory actions to address egregious prescribing (e.g., eliminating “pill mills”), and developing prescription opioids that incorporate abuse-deterrent technologies.

Although more rigorous evaluation is needed, there are some indications that these initiatives are beginning to show some success. A recent study showed that the rate of opioid prescribing in the United States stabilized between 2010 and 2012, with some medical specialties showing declines in the rate of opioid prescribing after consistent increases for a number of years.¹⁷ States and localities that took the most decisive action are seeing a decrease in the availability of prescription opioids coupled with a decline in the rate of deaths from overdose.¹³⁻¹⁵ Using national data, the Centers for Disease Control and Prevention reported that there were 16,007 and 16,235 overdose-related deaths in 2012 and 2013, respectively, involving opioid analgesic agents, down from a peak of 16,917 deaths in 2011; however, the 18,893 deaths reported in 2014 suggest continued concerns.⁵ An-

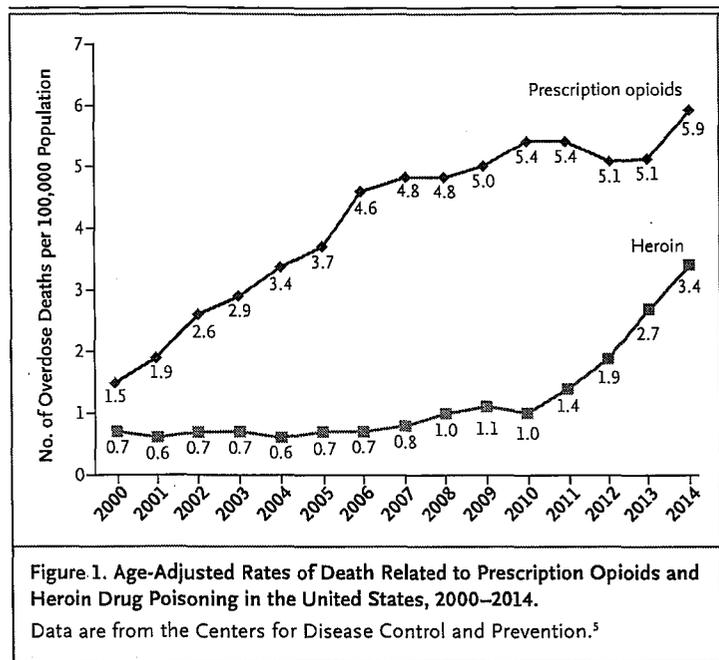
other study showed that abuse of prescription opioids increased between 2002 and 2010 and then plateaued between 2011 and 2013.¹⁸

Coinciding with these efforts to reduce non-medical prescription-opioid use and overdose are reports of increases in the rates of heroin use (including both injection and noninjection routes of administration) and deaths from heroin overdose. According to national surveillance data, 914,000 people reported heroin use in 2014, a 145% increase since 2007,² and mortality due to heroin overdose more than quintupled, from 1842 deaths in 2000 to 10,574 deaths in 2014.⁵ Some researchers suggest that the very policies and practices that have been designed to address inappropriate prescribing are now fueling the increases in rates of heroin use and death.^{16,18} This is the key question addressed in this review.

Some persons certainly use heroin when they are unable to obtain their preferred prescription opioid; however, whether the increases in heroin trends in the overall population are driven by changes in policies and practices regarding prescription opioids is much less clear. As an alternative explanation, we explore the complexity and reciprocal nature of this relationship and review the pharmacologic basis for heroin use among people who use prescription opioids non-medically, the patterns of heroin use among people who use prescription opioids nonmedically, the current trends in heroin use and their correlates, and the effects on heroin use of policies aimed at curbing inappropriate prescribing of opioids. A clearer understanding of these relationships will help to guide clinical practice and public health interventions and avoid the error of simply shifting the problem from one drug to another.

PHARMACOLOGIC SIMILARITIES OF HEROIN AND PRESCRIPTION OPIOIDS

Heroin is pharmacologically similar to prescription opioids. All these drugs produce their action through endogenous opioid systems that regulate a wide range of functions through three major types of G-protein-coupled receptors: mu, delta, and kappa, with particularly potent agonist activity at the mu receptor and weak activity at the delta and kappa receptors.^{19,20} Mu-receptor activation by an agonist such as heroin or a pre-



scription opioid triggers a complex cascade of intracellular signaling events, which ultimately lead to an increase in dopamine release in the shell of the nucleus accumbens.^{19,20} The resulting burst of dopamine in this critical area of the reward circuitry becomes strongly coupled with the subjective “high” that is caused by drugs of abuse.²¹

The abuse liability of an opioid is determined by multiple factors, including the lipophilicity of the drug (i.e., its ability to cross the blood–brain barrier rapidly), its binding affinity for the mu receptor, and various pharmacokinetic and physicochemical characteristics (e.g., the ease with which it can be abused by means of injection and insufflation routes of administration).^{22,23} Thus, although prescription opioids and heroin both have the potential to use similar pharmacologic mechanisms to induce euphoria (or analgesia), different opioid molecules have different euphorogenic properties and withdrawal-syndrome patterns.

These factors could also influence the potential for abuse of the various opioid drugs, because opioid drug-taking behavior is likely to be influenced by the balance between positive and negative subjective ratings engendered by a specific opioid. For example, a study involving heroin abusers showed that the reinforcing effects of oxycodone were similar to those produced by

morphine or heroin, but unlike morphine or heroin, oxycodone produced no “bad” effects in the participants in the study.²³ Similar considerations may help explain why several prescription opioids — such as hydromorphone, fentanyl, morphine, and oxycodone — have a potential for abuse that is similar to, and in some cases even higher than, the potential for abuse with heroin.^{22,23} Finally, these differential properties and effects are likely to interact with interindividual variability in powerful, complex, and incompletely predictable ways, so that some persons who abuse prescription opioids could find heroin less rewarding than prescription opioids, similarly rewarding, or even more rewarding.^{24,25}

HEROIN USE AMONG PEOPLE
WHO USE PRESCRIPTION OPIOIDS
NONMEDICALLY

Studies that address the patterns of heroin use in nonmedical users of prescription opioids are mostly observational and descriptive (i.e., nonexperimental). Thus, conclusions about cause and effect are uncertain. Yet, certain consistent findings of a positive association between nonmedical use of prescription opioids and heroin use are highly suggestive and plausible, given the common pharmacologic principles described above.

Using national-level data, Becker et al. found that heroin users were 3.9 times as likely to report nonmedical use of opioids in the previous year, and 2.9 times as likely to meet the criteria for abuse or dependence on opioids, as persons who did not use heroin.²⁶ Grau et al. found that nonmedical use of multiple opioids was associated with transitioning to heroin.²⁷ Similarly, Muhuri et al. found that the incidence of heroin use among people who reported prior nonmedical use of prescription opioids was 19 times as high as the incidence among persons who reported no previous nonmedical use.²⁸ Additional studies involving persons from various geographic, economic, and drug-using backgrounds have shown similar associations.²⁹⁻³³

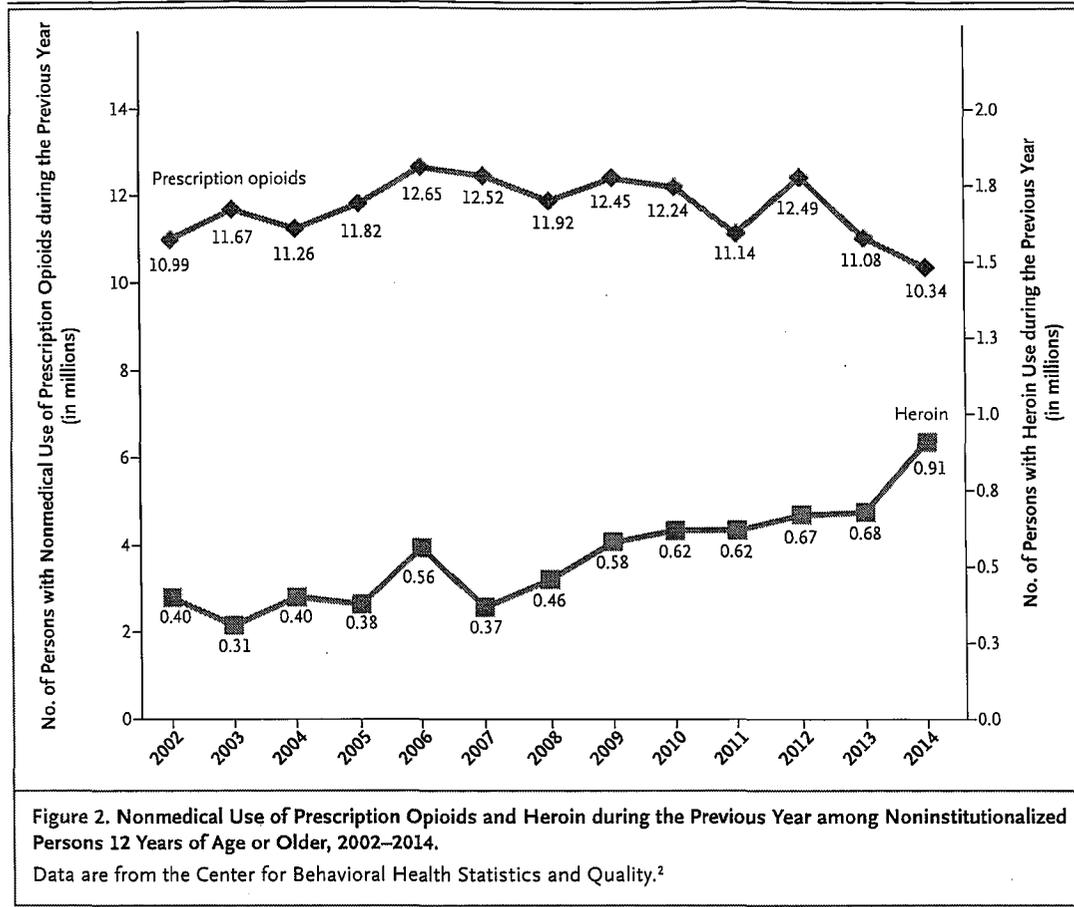
A limited number of small studies examined the sequence of and trajectories from nonmedical use of prescription opioids to heroin use. In 2003, Siegal et al. were among the first to suggest the pathway from nonmedical use of opioids to heroin use.³⁴ They found that in Ohio, 50% of persons 18 to 33 years of age who had

recently begun using heroin reported having abused opioids, primarily OxyContin, before initiating heroin use.³⁴ A larger study involving young urban people who used injected heroin in New York and Los Angeles in 2008 and 2009 showed that 86% had used opioids nonmedically before using heroin.³⁵ Similar studies conducted in San Diego, Seattle, and New York showed that 40%, 39%, and 70% of heroin users, respectively, reported that they had used prescription opioids nonmedically before initiating heroin use.³⁶⁻³⁸

Trajectory analysis of patterns of nonmedical use of prescription opioids suggests that persons most often start with oral nonmedical use of opioids. They move to more efficient routes of administration, such as insufflation, smoking, or injection, as tolerance to opioids develops and it becomes more costly to maintain their abuse patterns. By the time they initiate heroin use, usually through contact with drug users, sexual partners, or drug dealers, they view heroin as reliably available, more potent, easier to manipulate for nonoral routes, and more cost-effective than prescription opioids.^{34-36,38-41}

In an effort to examine whether the findings from these small studies were consistent with findings in the broader population of nonmedical users, the sequence regarding initiation of use was assessed with the use of both treatment-population data and general-population data. Among heroin users entering substance-abuse treatment programs, Cicero et al. found significant shifts in the pattern of the first opioid used by those with recent onset as compared with those started using opioids 40 to 50 years ago.⁴¹ Among persons who began their opioid use in the 1960s, more than 80% reported that their first opioid was heroin; conversely, in the 2000s, a total of 75% of users initiated opioid use with prescription opioids.⁴¹

Using national-level, general-population data, Jones found that in the period from 2008 through 2010, among people who used both prescription opioids for nonmedical reasons and heroin during the previous year, 77.4% reported using prescription opioids before initiating heroin use.⁴² Similarly, Muhuri and colleagues found that 79.5% of persons who recently began using heroin had used prescription opioids nonmedically before initiating heroin use.²⁸ Both studies showed that heroin use was most common among persons who were frequent users of



nonmedical opioids.^{28,42} A recent study with data through 2013 showed that prescription-opioid abuse or dependence was associated with a likelihood of heroin abuse or dependence that was 40 times as great as the likelihood with no prescription-opioid abuse or dependence, even after accounting for sociodemographic, geographic, and other substance abuse or dependence characteristics.⁴³ These studies suggest a clear link between nonmedical use of prescription opioids and heroin use, especially among persons with frequent nonmedical use or those with prescription-opioid abuse or dependence.

CURRENT TRENDS IN HEROIN USE AND THEIR CORRELATES

Heroin use has been increasing in the United States for the past 10 years, especially since 2007 (Fig. 2), an increase that has occurred in the context of broad use of multiple substances.⁴³ As seen in Table 1, in addition to the 138.9% increase in heroin use among nonmedical users of

prescription opioids between the period of 2002–2004 and the period of 2011–2013, heroin use increased 97.5% among nonmedical users of other prescription drugs (stimulants, tranquilizers, and sedatives), 87.3% among users of cocaine, 57.3% among people who binge drink, and 45.4% among marijuana users.⁴³ Moreover, heroin users increasingly report abuse of or dependence on other substances.⁴³ There have also been shifts in the demographic characteristics associated with heroin use; the rate has increased particularly steeply among persons 18 to 25 years of age, and increases have been observed in both large urban areas and other geographic regions, in both sexes but more among women than among men, and in all races and ethnic groups but more among non-Hispanic whites than among others.⁴³

Table 2 shows the sociodemographic, geographic, and substance-use groups that are associated with the greatest risk of heroin abuse or dependence during the previous year in the period of 2011–2013.⁴³ Other studies have shown

Table 1. Annual Average Rates of Heroin Use during the Previous Year, According to Substance-Use Characteristic and Time Period, in the United States, 2002–2013.*

Characteristic	2002–2004		2005–2007		2008–2010		2011–2013		Percent Change		P Value†
	Rate (95% CI)	P Value	Rate (95% CI)	P Value	Rate (95% CI)	P Value	Rate (95% CI)	P Value	2008–2010 to 2011–2013	2002–2004 to 2011–2013	
Binge drinking during previous month	3.7 (3.0–4.5)	0.001	4.1 (3.3–5.1)	0.02	5.2 (4.3–6.3)	0.38	5.8 (4.4–6.4)	5.8	12.30	57.3	0.006
Marijuana use during previous year	11.6 (9.5–14.1)	0.004	13.2 (10.6–16.4)	0.07	14.4 (12.6–16.6)	0.16	16.9 (14.4–19.8)	16.9	16.70	45.4†	0.004
Cocaine use during previous year	48.9 (40.2–59.3)	<0.001	57.6 (45.9–72.2)	<0.001	68.3 (55.4–83.9)	0.02	91.5 (78.2–106.8)	91.5	34.00	87.3†	<0.001
Nonmedical use of prescription opioid during previous year	17.8 (14.3–22.0)	<0.001	25.1 (19.9–31.7)	<0.001	34.0 (28.9–39.8)	0.048	42.4 (36.6–49.1)	42.4	24.80	138.9†	<0.001
Nonmedical use of other psychotherapeutic agent during previous year‡	23.1 (18.6–28.7)	<0.001	28.5 (23.1–35.1)	<0.001	41.6 (33.8–51.0)	0.48	45.6 (38.9–53.4)	45.6	9.70	97.5†	<0.001

* Data are from Jones et al.⁴³ The rate is per 1000 population in each analytic group. P values are for the comparison with the rate in the period of 2011–2013.

† The P values are for trend.

‡ Other psychotherapeutic agents included tranquilizers, sedatives, and stimulants.

that recent cohorts of heroin users entering treatment have been likely to be white, middle-class, and living in nonurban areas; this result mirrors the populations that have had the largest increases in rates of nonmedical use of prescription opioids since 2002.^{2,41,42,44} These findings are generally consistent with those from a number of smaller studies.^{34–40}

A key factor underlying the recent increases in rates of heroin use and overdose may be the low cost and high purity of heroin.^{45,46} The price in retail purchases has been lower than \$600 per pure gram every year since 2001, with costs of \$465 in 2012 and \$552 in 2002, as compared with \$1237 in 1992 and \$2690 in 1982.⁴⁵ A recent study showed that each \$100 decrease in the price per pure gram of heroin resulted in a 2.9% increase in the number of hospitalizations for heroin overdose.⁴⁶ In addition, regions of the United States that are not typically centers for heroin distribution or availability have seen marked increases in recent years.^{47,48}

In the context of marked increases in the rates of heroin use, it is important to note that only a small percentage of nonmedical users of prescription opioids initiate heroin use. Muhuri and colleagues found that 3.6% of nonmedical users initiated heroin use within 5 years after beginning nonmedical use of prescription opioids.²⁸ Jones et al. found that approximately 4.2% of persons who had used prescription opioids nonmedically during the previous year in the period of 2011–2013 also reported using heroin during the previous year.⁴³ Of note, given the large number of nonmedical users, even a small percentage who initiate heroin use translates into several hundred thousand new heroin users. Yet, taken in total, the available data suggest that nonmedical prescription-opioid use is neither necessary nor sufficient for the initiation of heroin use and that other factors are contributing to the increase in the rate of heroin use and related mortality.

EFFECTS OF OPIOID-PRESCRIBING INTERVENTIONS ON HEROIN USE

Multiple studies that have examined why some persons who abuse prescription opioids initiate heroin use indicate that the cost and availability of heroin were primary factors in this process. These reasons were generally consistent across

time periods from the late 1990s through 2013.³⁴⁻⁴¹ Some interviewees made reference to doctors generally being less willing to prescribe opioids as well as to increased attention to the issue by law enforcement, which may have affected the available supply of opioids locally.^{38,40} It should be noted that most of these studies were conducted before 2009 — a time when few policies targeting opioid prescribing were implemented.

It appears that the shift toward heroin use among some nonmedical users of prescription opioids was occurring before the recent policy focus on prescription-opioid abuse took hold. This observation is supported by data on heroin use reported to U.S. poison control centers that show increases starting in 2006,¹⁸ as well as national surveillance data that show a rise in heroin use starting in 2007.² Similarly, a study examining hospitalizations for heroin overdose between 1993 and 2009 showed that the rate of such hospitalizations increased 69% between 1993 and 2006 and then rose more sharply, by 44%, between 2005 and 2009.⁴⁹ Furthermore, this study showed that these increases occurred in the context of continued increases in the rate of hospitalization for overdose of prescription opioids.

The results of the studies by Dart et al. and Cicero et al. suggest an association between the introduction of an abuse-deterrent formulation of OxyContin and increases in rates of heroin use.^{16,18} Dart et al. found evidence that rates of heroin use increased after the introduction of the abuse-deterrent formulation, but they also reported that the rate of heroin use was increasing previously.¹⁸ Cicero et al. found that a decrease in the rate of OxyContin abuse corresponded with an increase in the rate of heroin use over the 2 years after the introduction of the abuse-deterrent formulation.¹⁶ However, in a follow-up study, Cicero and Ellis found that over the ensuing 18 months, the rates of OxyContin abuse no longer decreased whereas the rates of heroin use continued to increase.⁵⁰ Moreover, a separate study involving patients who were being screened for substance-abuse treatment showed no significant differences between the prevalence of heroin use before the introduction of the reformulation and the prevalence after the reformulated drug was available.⁵¹

Five recent quantitative studies provide addi-

Table 2. Demographic and Substance-Use Characteristics Associated with Heroin Abuse or Dependence during the Previous Year in the United States, 2011–2013.*

Characteristic	Adjusted Odds Ratio (95% CI)	P Value
Sex		
Male	2.1 (1.4–3.0)	<0.001
Female	1.0	
Age group		
12–17 yr	0.3 (0.1–0.6)	0.001
18–25 yr	1.0	
≥26 yr	0.6 (0.4–0.9)	0.008
Race or ethnic group†		
Non-Hispanic white	3.1 (1.8–5.1)	<0.001
Other	1.0	
Geographic region of residence		
CBSA with ≥1 million persons	2.4 (1.5–3.6)	<0.001
Other	1.0	
Annual household income		
<\$20,000	1.0	
\$20,000–\$49,999	0.5 (0.3–0.7)	0.001
≥\$50,000	0.6 (0.3–0.9)	0.02
Insurance coverage		
No insurance	3.1 (2.2–4.3)	<0.001
Medicaid	3.2 (1.9–5.4)	<0.001
Private or other insurance	1.0	
Substance abuse or dependence in previous year		
None	1.0	
Alcohol	1.8 (1.2–2.9)	0.009
Marijuana	2.6 (1.5–4.6)	0.002
Cocaine	14.7 (7.4–29.2)	<0.001
Prescription opioid	40.0 (24.6–65.3)	<0.001
Other psychotherapeutic agent‡	1.6 (0.8–3.2)	0.22

* Odds ratios and 95% confidence intervals were calculated with the use of multivariable logistic-regression analyses. Data are from Jones et al.⁴³ CBSA denotes core-based statistical area.

† Race and ethnic group were based on survey respondents' self-classification of racial and ethnic origin and identification according to the classifications developed by the U.S. Census Bureau.

‡ Other psychotherapeutic agents included tranquilizers, sedatives, and stimulants.

tional insights into the relationship between opioid-prescribing policies and practices and heroin use and overdose. First was an analysis of deaths due to overdose in North Carolina be-

tween 2007 and 2013, which documented a shift toward an increasing risk of death due to heroin use.⁵² However, the shift began in 2009, before changes such as the introduction of abuse-deterrent formulations of opioids were in effect.⁵² The second study showed that heroin-related emergency department visits, hospital admissions, and overdose deaths in Wisconsin started to increase in 2007.⁵³ Furthermore, these increases in rates of heroin overdose were superimposed on continued increases in rates of prescription-opioid overdoses through 2012.⁵³

The third study examined deaths from overdose in Florida through 2012.^{13,54} Florida had a well-documented prescription-opioid problem.⁵⁴ Between 2010 and 2011, Florida instituted a series of major policy changes that were designed to reduce the inappropriate supply of prescription opioids. After these policies were implemented, prescriptions were curtailed and the rate of death from prescription-opioid overdose declined 27% between 2010 and 2012.^{13,54} Moreover, these significant declines in prescription-opioid mortality were accompanied by an increase of only 60 deaths related to heroin, with the overall number of total deaths from overdose declining by 535 between 2010 and 2012.¹³

The fourth study, which examined opioid overdoses in New York, showed a 29% reduction in the rate of death from prescription-opioid overdose coupled with declines in the rates of overall and high-dose opioid prescribing in Staten Island, New York, in 2013 after the implementation of targeted and general public health initiatives, including a heavy focus on prescribing behaviors.¹⁵ Importantly, these decreases were not offset by increases in mortality from heroin-involved overdose during the same time period.¹⁵

Finally, in an investigation of deaths related to heroin and prescription-opioid use in 28 states between 2010 and 2012, Rudd and colleagues found no association between declines in prescription-opioid-related mortality and increases in heroin-related mortality.⁵⁵ In fact, they found that increases in the rates of death due to heroin overdose were associated with increases in the rates of death due to prescription-opioid overdose in these states.⁵⁵

Although none of these studies can disprove a potential relationship between policies that are aimed at decreasing the availability of inappro-

propriately prescribed opioids and the motivation for heroin use in some people, the results of these studies consistently suggest that the transition to heroin use was occurring before most of these policies were enacted, and such policies do not appear to have directly led to the overall increases in the rates of heroin use.

CONCLUSIONS

Available data indicate that the nonmedical use of prescription opioids is a strong risk factor for heroin use. Yet, although the majority of current heroin users report having used prescription opioids nonmedically before they initiated heroin use, heroin use among people who use prescription opioids for nonmedical reasons is rare, and the transition to heroin use appears to occur at a low rate.

The transition from nonmedical use of prescription opioids to heroin use appears to be part of the progression of addiction in a subgroup of nonmedical users of prescription opioids, primarily among persons with frequent nonmedical use and those with prescription opioid abuse or dependence. Although some authors suggest that there is an association between policy-driven reductions in the availability of prescription opioids and increases in the rates of heroin use,^{16,18} the timing of these shifts, many of which began before policies were robustly implemented, makes a causal link unlikely.

In the majority of studies, the increase in the rates of heroin use preceded changes in prescription-opioid policies, and there is no consistent evidence of an association between the implementation of policies related to prescription opioids and increases in the rates of heroin use or deaths, although the data are relatively sparse. Alternatively, heroin market forces, including increased accessibility, reduced price, and high purity of heroin appear to be major drivers of the recent increases in rates of heroin use.^{46,56} Regardless of the causes of the high rates of both nonmedical prescription-opioid use and heroin use, in order to minimize overall opioid-related morbidity and mortality, efforts are needed to help people who are already addicted, in parallel with efforts to prevent people from becoming addicted in the first place.

Addressing the combined and interrelated

opioid epidemics requires comprehensive action, including the prevention of the initiation of non-medical use of opioids, interventions for persons who have clinically significant complications from opioid use, and improved treatment for those with opioid-use disorders. Prevention efforts should target the major risk factors for the initiation of opioid use, including the excess availability of prescription opioids; these risk factors may be addressed with policy and practice interventions such as the enhanced use of prescription-drug monitoring programs and the development of clinical guidelines to educate clinicians.^{14,57} Universal family-based drug-abuse prevention, which has been shown to reduce the rates of initiation of nonmedical use of prescription opioids, may also play an important role.⁵⁸ Whether the opioid is heroin or a prescription medication, interventions to reduce morbidity and mortality include expanded access to naloxone in

contexts in which overdoses occur⁵⁹⁻⁶¹ and increased use of effective treatment for opioid-use disorders, particularly medication-assisted treatment administered for an adequate duration.⁶²⁻⁶⁵

Fundamentally, prescription opioids and heroin are each elements of a larger epidemic of opioid-related disorders and death. Viewing them from a unified perspective is essential to improving public health. The perniciousness of this epidemic requires a multipronged interventional approach that engages all sectors of society.^{14,66}

The views expressed in this article are those of the authors and do not necessarily represent those of the National Institute on Drug Abuse, the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control and Prevention, or the Department of Health and Human Services.

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Prescription Drug Safety News

Doctors Are Unaware Patients Overdose on Prescription Opioids, Continue to Prescribe Opioids Afterward

Over 90% of patients who survived an overdose from prescription opioids continued to receive prescriptions for the drugs after the overdose event, indicates a new report published in the December 28, 2015 issue of the *Annals of Internal Medicine*. These incidents occur because the doctors who prescribe the drugs often do not receive a record of the overdose from emergency departments, and patients who are dependent on opioids are less likely to report to their prescribing physician that they overdosed and were in the emergency room.

The study found that patients who continued taking drugs such as OxyContin[®], Vicodin[®], and Percocet[®] following an overdose were two times more likely to experience another overdose within two years, notes [MedlinePlus](#). Oxycodone and hydrocodone are the most frequently prescribed opioids, and according to the study, cause more overdose deaths than any other narcotic, indicates [MedlinePlus](#). To conduct the study, researchers used an insurance claims database to gather data on nearly 3,000 people who overdosed on prescription opioids over 12 years. Dr Marc Larochelle, lead researcher of the study, suggests that improving communication between emergency departments and prescribing physicians is one step to addressing this problem.



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Non-medical Use of Prescription Opioids Among Teens Increases Likelihood of Heroin Use

The more frequently a teen uses prescription opioids for non-medical reasons, the higher the risk that he or she will become dependent on opioids, indicates a new study. Specifically, over 77% of teens who reported using heroin also reported using prescription opioids, indicates [MedlinePlus](#). Joseph Palamar, lead researcher of the study, noted that teens who become dependent on prescription opioids often begin using heroin because it is cheaper and more available than illicit prescription pain pills. Further, nearly one-quarter of teens who reported taking prescription opioids over 40 times also reported using heroin. The [article](#), "Nonmedical Opioid Use and Heroin Use in a Nationally Representative Sample of US High School Seniors," is published in the journal *Drug and Alcohol Dependence*.

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Massachusetts House Proposes Law Aimed at Addressing Opioid Abuse and Overdose Deaths

Aimed to address opioid abuse and overdose deaths, Massachusetts lawmakers have proposed a bill that would put restrictions on certain opioid prescriptions and require an evaluation of patients seen in emergency rooms for opioid overdoses. Specifically, the house bill would limit initial prescriptions for opioids to a seven-day supply, and would "require an in-depth evaluation be made by a licensed medical professional to anyone who shows up in an emergency room with an opiate-related overdose," indicates [WBUR](#). The law would also require an individual who is admitted to the hospital and deemed to be experiencing an opiate-related overdose to receive substance abuse evaluation within 24 hours. The patient's substance use disorder must be documented in the diagnosis. Hospitals would be prohibited from releasing a patient within 24 hours without first completing the evaluation.

In addition, the bill includes legal protections for anyone administering Narcan, the overdose reversal drug naloxone, to a person during an opiate overdose. The bill also requires a doctor to check the state's Prescription Monitoring Program each time a patient is prescribed a "high-risk" opiate medication. The House and Senate versions of the bill are expected to go to a conference committee before going to Governor Charlie Baker, indicates [WBUR](#).

Weight Loss Dietary Supplements Recalled Due to Undeclared Ingredients

BeeXtreme LLC, is recalling all lots of the weight loss

dietary supplements LaTrim Plus, Oasis, and Jenesis. Food and Drug Administration (FDA) analysis confirmed that the recalled products contain undeclared sibutramine and phenolphthalein. Sibutramine and phenolphthalein pose a significant health hazard, indicates a [press release](#) on the FDA website.

Sibutramine is an appetite suppressant that was withdrawn from the United States market in October 2010. It is known to substantially increase blood pressure and/or pulse rate in some patients and may present a significant risk for patients with a history of coronary artery disease, congestive heart failure, arrhythmias, or stroke. Phenolphthalein is an ingredient previously used in over-the-counter laxatives. Because of concerns of carcinogenicity, phenolphthalein is not currently approved for marketing in the US. Health risks associated with phenolphthalein include potentially serious, gastrointestinal disturbances, irregular heartbeat, and cancer with long-term use.

As noted in the FDA safety alert, consumers are advised to discontinue use and dispose of the recalled products. Contact information for BeeXtreme is available in the alert on FDA's website.

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Panel recommends FDA approve implant to treat opiate addiction

 **Liz Szabo, USA TODAY** 3:30 p.m. PST January 12, 2016



(Photo: Braeburn Pharmaceuticals)

An advisory committee recommended Tuesday that the Food and Drug Administration (FDA) approve an implant designed to reduce addicts' cravings for heroin or prescription painkillers.

The implant, probuphine, provides a steady dose of buprenorphine, which has been shown to ease withdrawal symptoms, decrease cravings and cut the risk of relapse. Buprenorphine is currently available only as a pill or dissolvable film that's placed under the tongue. Although it can be life-saving, it carries major risks: some addicts sell their supplies to get money for other drugs.

Probuphine's manufacturer, New Jersey-based Braeburn Pharmaceuticals, says the implant eliminates that risk. The FDA typically follows committees' advice.

Probuphine's development comes at a time when addiction to opiates — which include illegal drugs such as heroin, as well as prescription painkillers such as morphine and OxyContin — has been called an epidemic.

The death rate from drug overdoses more than doubled from 1999 to 2013, according to the Centers for Disease Control and Prevention. Drug overdoses now kill 44,000 Americans a year — more than car accidents.

At the advisory panel's meeting Tuesday, several witnesses described how opiate addiction has harmed them or their families. Two fathers described how their sons died from drug overdoses, and both asked the committee to recommend approving probuphine.

Medications to treat addiction are strictly regulated.

Methadone is available only at specialized clinics, where patients typically must go every day to receive a dose. Buprenorphine is considered safer than methadone because it's less likely to cause an overdose. Patients can receive buprenorphine at a doctor's office, but physicians prescribing the drug must be certified to dispense it and are only allowed to treat 100 patients at a time.

Like all pills, buprenorphine can be accidentally swallowed by children. About 1 million people took buprenorphine in 2012, according to the FDA.

The White House has recommended expanding the use of medications that treat opiate addiction. Addicts who are given such "medication-assisted treatment" cut their risk of death in half, according to the Substance Abuse and Mental Health Services Administration. The medications also halve a person's risk of becoming infected with HIV, the virus that causes AIDS.



USA TODAY

[Advocates push to expand use of medications to treat addiction](#)

[\(http://www.usatoday.com/story/news/2015/07/08/addiction-treatment-debate/29819285/\)](http://www.usatoday.com/story/news/2015/07/08/addiction-treatment-debate/29819285/)

Probuphine works like a contraceptive implant, such as Norplant. Four implanted rods, each smaller than a match stick, provide a steady amount of medication for up to 6 months. The FDA is considering approving it for a specific population: "stable" patients who are already taking the dissolvable buprenorphine film at a low dose. The committee voted 12-5 in favor of probuphine.

"I think this will save some folks' lives," said advisory committee member David Pickar, an adjunct professor of psychiatry at Johns Hopkins Medical School in Baltimore.

Doctors who want to prescribe probuphine would have to refer patients to providers trained to implant medical devices, or undergo training to learn how to safely implant and remove it, said Behshad Sheldon, president and CEO of Braeburn Pharmaceuticals, who spoke at Tuesday's advisory committee hearing.

Implanting probuphine takes 10 to 15 minutes and removing it takes about 20 minutes, said Steven Chavoustie, a physician involved in a clinical trial of the device.

Pharmacist Tracy Rupp urged the committee to reject probuphine, noting that its manufacturer presented only one clinical study showing the drug was effective.

In the study, doctors compared the use of probuphine implants and buprenorphine film, Sheldon said. Patients in the study were considered "stable" because they had been safely using the films. After 6 months, 85% of those given probuphine tested negative for illegal drugs, compared to 72% of those given the film.

The study had multiple flaws, said Rupp, director of public health policy initiatives at the National Center for Health Research, a nonpartisan group that analyzes health data.

Some missing urine tests were counted as negative, as if the patient had no drugs in their system. But Rupp noted that people addicted to opiates "often skip tests to avoid a positive test." That could skew the results, Rupp said.

"It is disappointing that the advisory committee set such a low bar for safety and effectiveness," Rupp said after the vote. "Is probuphine effective? We still don't know because the study was poorly designed and missing data."

Judith Kramer, the committee's acting chairwoman, said she voted against recommending probuphine's approval because doctors don't yet know if it's effective for more than 6 months. Many people who are addicted to opiates need to take medication for years, she added.

"We all desperately want something to be available" to treat opiate addiction, said Kramer, a professor emerita at Duke University in Durham, N.C. Yet she added: "I'm very concerned about the precedent this sets."



USA TODAY

Addiction treatment hard to find, even as overdose deaths soar

(<http://www.usatoday.com/story/news/2015/05/24/addiction-treatment-shortage/27181773/>)

Some addiction specialists say they're concerned about probuphine's safety.

Doctors don't yet know how to safely transition patients from buprenorphine films to the implant, said pharmacist Tracy Rupp, director of public health policy initiatives at the National Center for Health Research, a nonpartisan group that analyzes health data.

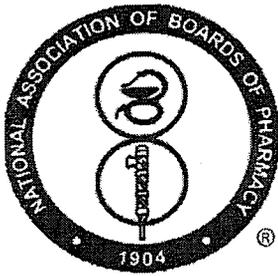
Rupp, who recommended the committee reject probuphine, said it takes up to four weeks for the implant to provide the same level of medication provided by the film strips. That suggests patients will need to continue taking buprenorphine by mouth for the first few weeks after receiving the implant, Rupp said.

Rupp said she's worried patients could relapse during that transition. "This is an unacceptable risk for stable patients," Rupp said.

Rupp also said the study didn't match the demographics of addicts in real life, noting 84% of the patients in the study were white. Jennifer Higgins, the committee's acting consumer representative, said she would like the FDA to require studies in more diverse populations.

"This is not the real world of opioid addiction," Rupp said. "Many of these patients will require treatment for years. We need long-term safety data from diverse populations. Patients will require a new incision every 6 months, creating an ongoing risk of harm due to bleeding and infectious complications."

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nabp

National Association of Boards of Pharmacy

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TO: EXECUTIVE OFFICERS – STATE BOARDS OF PHARMACY
FROM: Carmen A. Catizone, Executive Director/Secretary
DATE: January 7, 2016
RE: Live Student and Healthcare Professional Continuing Education Webinar Hosted by FDA's Division of Drug Information

The National Association of Boards of Pharmacy (NABP) is pleased to announce that the Food and Drug Administration (FDA) Center for Drug Evaluation and Research, Division of Drug Information is presenting a series of continuing educational webinars targeted toward students and health care professionals who wish to learn more about FDA and drug regulation. The webinars are presented by FDA staff.

The first webinar of 2016:

Introduction to FDA's MedWatch Adverse Event Reporting Program

Date: Tuesday, January 26, 2016

Time: 1 PM EST | 10 AM PST

Duration: 60 minutes

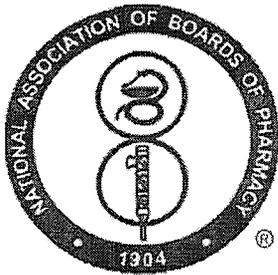
This webinar will give an overview of the FDA MedWatch Adverse Event reporting program, how and why to report adverse events to MedWatch, and where to find clinically relevant information from MedWatch. This is part one of a two-part series of webinars with information on safety reporting. Part two will be held on February 9, 2016.

The FDA Center for Drug Evaluation and Research is accredited by the Accreditation Council for Pharmacy Education (ACPE) as a Provider of continuing pharmacy education. (ACPE Universal Activity No. 0601-0000-16-001-L04-P). This program meets the criteria for (0.1 CEU -1 contact hour) of pharmacy education.

NABP encourages you to forward this information to your staff and to health care professionals in your state.

For more information and to learn about future webinars, please visit www.fda.gov/DDIWebinars.

cc: NABP Executive Committee



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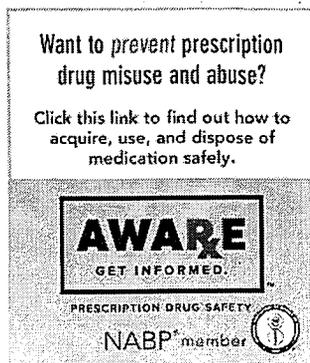
nabp

TO: EXECUTIVE OFFICERS – STATE BOARDS OF PHARMACY
FROM: Carmen A. Catzone, Executive Director/Secretary
DATE: January 7, 2016
RE: New AWARE URL and Web Ad Available

As communicated in a National Association of Boards of Pharmacy[®] news release on Friday, November 6, 2015, the Association launched a redesigned website for the AWARE[®] Prescription Drug Safety Program that day. In addition, the URL of the site changed to www.AWARErx.pharmacy, helping consumers identify the site as a safe and legitimate source for pharmacy-related information.

If your board of pharmacy website has a link to AWARE, please ask your website administrator to update the link to www.AWARErx.pharmacy (the former URL was www.AWARErx.org); this will help keep our site prominent in search results. If you do not currently link to AWARE, please consider adding this helpful consumer website as a resource to your board of pharmacy's website.

In addition, some boards of pharmacy may have posted the AWARE web ad that was distributed in October 2012. If so, a redesigned web ad and the program's new logo are available to update your board's website. When your website administrator adds either image to your website, he or she can add a link that users can click to visit the AWARE website. The images shown are attached to this memo as .png files, if you would like to add them to your board's website.



If you have any questions, please feel free to contact Executive Office staff at 847/391-4400 or via email at exec-office@nabp.net; if you have any questions about AWARE, please contact Larissa Doucette, communications and marketing senior manager, at 847/391-4468 or via email at ldoucette@nabp.net.



Drug overdose deaths hit record numbers in 2014

Over 47,000 deaths last year, mostly due to opioid pain relievers and heroin

Press Release

Embargoed Until: Friday, December 18, 2015, 2:00 p.m. ET

Contact: [Media Relations \(http://www.cdc.gov/media\)](http://www.cdc.gov/media)

(404) 639-3286

From 2000 to 2014 nearly half a million Americans died from drug overdoses. Opioid overdose deaths, including both opioid pain relievers and heroin, hit record levels in 2014, with an alarming 14 percent increase in just one year, according to new data published today in CDC's *Morbidity and Mortality Weekly Report* (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm64e1218a1.htm?s_cid=mm64e1218a1_w).

The most commonly prescribed opioid pain relievers, those classified as natural or semi-synthetic opioids such as oxycodone and hydrocodone, continue to be involved in more overdose deaths than any other opioid type. These deaths increased by 9 percent (813 more deaths in 2014 than 2013).

Increases in prescription opioid pain reliever and heroin deaths are the biggest driver of the drug overdose epidemic. Deaths from heroin increased in 2014, continuing a sharp rise that has seen heroin overdoses triple since 2010. Deaths involving illicitly made fentanyl, a potent opioid often added to or sold as heroin, also are on the upswing.

“The increasing number of deaths from opioid overdose is alarming,” said CDC Director Tom Frieden, M.D., M.P.H. “The opioid epidemic is devastating American families and communities. To curb these trends and save lives, we must help prevent addiction and provide support and treatment to those who suffer from opioid use disorders. This report also shows how important it is that law enforcement intensify efforts to reduce the availability of heroin, illegal fentanyl, and other illegal opioids.”

Drug overdose deaths are up in both men and women, in non-Hispanic whites and blacks, and in adults of nearly all ages. Rates of drug overdose deaths were highest among five states: West Virginia, New Mexico, New Hampshire, Kentucky, and Ohio. A map of drug overdose deaths by state (2013 and 2014) is available at <http://www.cdc.gov/drugoverdose/data/statedeaths.html> (<http://www.cdc.gov/drugoverdose/data/statedeaths.html>).

Intertwined trends drive overdose deaths

The findings show that two distinct but intertwined trends are driving America's overdose epidemic: a 15-year increase in deaths from prescription opioid pain reliever overdoses as a result of misuse and abuse, and a recent surge in illicit drug overdoses driven mainly by heroin. Both of these trends worsened in 2014.

More than six out of 10 drug overdose deaths in 2014 involved opioids, including opioid pain relievers and heroin. The largest increase in opioid overdose deaths involved synthetic opioids (not including methadone), which were involved in 5,500 deaths in 2014, nearly twice as many as the year before. Many of these overdoses are believed to involve illicitly-made fentanyl, a short-acting opioid.

In addition, heroin-related death rates increased 26 percent from 2013–2014, totaling 10,574 deaths in 2014. Past misuse of prescription opioids is the strongest risk factor for heroin initiation and use—especially among people who became dependent upon or abused prescription opioids in the past year. The increased availability of heroin, its relatively low price (compared to prescription opioids), and high purity appear to be major drivers of the upward trend in heroin use, overdoses, and deaths.

How to stop the epidemic

The new findings point to four ways to prevent overdose deaths:

- Limit initiation into opioid misuse and addiction. Opioid pain reliever prescribing has quadrupled since 1999. Providing health care professionals with additional tools and information—including safer guidelines for prescribing these drugs—can help them make more informed prescribing decisions.
- Expand access to evidence-based substance use disorder treatment—including Medication-Assisted Treatment—for people who suffer from opioid use disorder.
- Protect people with opioid use disorder by expanding access and use of naloxone—a critical drug that can reverse the symptoms of an opioid overdose and save lives.
- State and local public health agencies, medical examiners and coroners, and law enforcement agencies must work together to improve detection of and response to illicit opioid overdose outbreaks to address this emerging threat to public health and safety.

CDC works with states, communities, and prescribers to prevent opioid misuse and overdose by tracking and monitoring the epidemic and helping states scale up effective programs. CDC also improves patient safety by equipping health care providers with data, tools, and guidance so they can make informed treatment decisions. Learn more at www.cdc.gov/drugoverdose (<http://www.cdc.gov/drugoverdose>).

Secretary Burwell has made addressing opioid abuse, dependence, and overdose a priority and work is underway within HHS on this important issue. [The evidence-based initiative](http://www.hhs.gov/news/press/2015pres/03/20150326a.html) (<http://www.hhs.gov/news/press/2015pres/03/20150326a.html>) focuses on three promising areas: informing opioid prescribing practices, increasing the use of naloxone, and using Medication-Assisted Treatment to move people out of opioid addiction.

These efforts build on work that began in 2010, when the President released his first National Drug Control Strategy, which emphasized the need for action to address opioid use disorders and overdose, while ensuring that individuals with pain receive safe, effective treatment. The next year, the White House released its national [Prescription Drug Abuse Prevention Plan](https://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/rx_abuse_plan.pdf) (https://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/rx_abuse_plan.pdf) to outline goals for addressing prescription drug misuse and overdose. Since then, the Administration has supported and expanded community-based efforts to prevent drug use, pursue “smart on crime” approaches to drug enforcement, improve prescribing practices for pain medication, increase access to treatment, work to reduce overdose deaths, and support the millions of Americans in recovery.

###

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Page last reviewed: December 18, 2015

Page last updated: December 18, 2015

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Centers for Disease Control and Prevention

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Morbidity and Mortality Weekly Report (MMWR)

Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014

*Weekly***January 1, 2016 / 64(50);1378-82**Rose A. Rudd, MSPH¹; Noah Aleshire, JD¹; Jon E. Zibbell, PhD¹; R. Matthew Gladden, PhD¹*On December 18, this report was posted as an MMWR Early Release on the MMWR website (<http://www.cdc.gov/mmwr>).*

The United States is experiencing an epidemic of drug overdose (poisoning) deaths. Since 2000, the rate of deaths from drug overdoses has increased 137%, including a 200% increase in the rate of overdose deaths involving opioids (opioid pain relievers and heroin). CDC analyzed recent multiple cause-of-death mortality data to examine current trends and characteristics of drug overdose deaths, including the types of opioids associated with drug overdose deaths. During 2014, a total of 47,055 drug overdose deaths occurred in the United States, representing a 1-year increase of 6.5%, from 13.8 per 100,000 persons in 2013 to 14.7 per 100,000 persons in 2014. The rate of drug overdose deaths increased significantly for both sexes, persons aged 25–44 years and ≥55 years, non-Hispanic whites and non-Hispanic blacks, and in the Northeastern, Midwestern, and Southern regions of the United States. Rates of opioid overdose deaths also increased significantly, from 7.9 per 100,000 in 2013 to 9.0 per 100,000 in 2014, a 14% increase. Historically, CDC has programmatically characterized all opioid pain reliever deaths (natural and semisynthetic opioids, methadone, and other synthetic opioids) as "prescription" opioid overdoses (1). Between 2013 and 2014, the age-adjusted rate of death involving methadone remained unchanged; however, the age-adjusted rate of death involving natural and semisynthetic opioid pain relievers, heroin, and synthetic opioids, other than methadone (e.g., fentanyl) increased 9%, 26%, and 80%, respectively. The sharp increase in deaths involving synthetic opioids, other than methadone, in 2014 coincided with law enforcement reports of increased availability of illicitly manufactured fentanyl, a synthetic opioid; however, illicitly manufactured fentanyl cannot be distinguished from prescription fentanyl in death certificate data. These findings indicate that the opioid overdose epidemic is worsening. There is a need for continued action to prevent opioid abuse, dependence, and death, improve treatment capacity for opioid use disorders, and reduce the supply of illicit opioids, particularly heroin and illicit fentanyl.

The National Vital Statistics System multiple cause-of-death mortality files were used to identify drug overdose deaths.* Drug overdose deaths were classified using the *International Classification of Disease, Tenth Revision* (ICD-10), based on the ICD-10 underlying cause-of-death codes X40–44 (unintentional), X60–64 (suicide), X85 (homicide), or Y10–Y14 (undetermined intent) (2). Among the deaths with drug overdose as the underlying cause, the type of opioid involved is indicated by the following ICD-10 multiple cause-of-death codes: opioids (T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6); natural and semisynthetic opioids (T40.2); methadone (T40.3); synthetic opioids, other than methadone (T40.4); and heroin

(T40.1). Some deaths involve more than one type of opioid; these deaths were included in the rates for each category (e.g., a death involving both a synthetic opioid and heroin would be included in the rates for synthetic opioid deaths and in the rates for heroin deaths). Age-adjusted death rates were calculated by applying age-specific death rates to the 2000 U.S. standard population age distribution (3). Significance testing was based on the z-test at a significance level of 0.05.

During 2014, 47,055 drug overdose deaths occurred in the United States. Since 2000, the age-adjusted drug overdose death rate has more than doubled, from 6.2 per 100,000 persons in 2000 to 14.7 per 100,000 in 2014 (Figure 1). The overall number and rate of drug overdose deaths increased significantly from 2013 to 2014, with an additional 3,073 deaths occurring in 2014 (Table), resulting in a 6.5% increase in the age-adjusted rate. From 2013 to 2014, statistically significant increases in drug overdose death rates were seen for both males and females, persons aged 25–34 years, 35–44 years, 55–64 years, and ≥65 years; non-Hispanic whites and non-Hispanic blacks; and residents in the Northeast, Midwest and South Census Regions (Table). In 2014, the five states with the highest rates of drug overdose deaths were West Virginia (35.5 deaths per 100,000), New Mexico (27.3), New Hampshire (26.2), Kentucky (24.7) and Ohio (24.6).† States with statistically significant increases in the rate of drug overdose deaths from 2013 to 2014 included Alabama, Georgia, Illinois, Indiana, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Mexico, North Dakota, Ohio, Pennsylvania, and Virginia.

In 2014, 61% (28,647, data not shown) of drug overdose deaths involved some type of opioid, including heroin. The age-adjusted rate of drug overdose deaths involving opioids increased significantly from 2000 to 2014, increasing 14% from 2013 (7.9 per 100,000) to 2014 (9.0) (Figure 1). From 2013 to 2014, the largest increase in the rate of drug overdose deaths involved synthetic opioids, other than methadone (e.g., fentanyl and tramadol), which nearly doubled from 1.0 per 100,000 to 1.8 per 100,000 (Figure 2). Heroin overdose death rates increased by 26% from 2013 to 2014 and have more than tripled since 2010, from 1.0 per 100,000 in 2010 to 3.4 per 100,000 in 2014 (Figure 2). In 2014, the rate of drug overdose deaths involving natural and semisynthetic opioids (e.g., morphine, oxycodone, and hydrocodone), 3.8 per 100,000, was the highest among opioid overdose deaths, and increased 9% from 3.5 per 100,000 in 2013. The rate of drug overdose deaths involving methadone, a synthetic opioid classified separately from other synthetic opioids, was similar in 2013 and 2014.

Discussion

More persons died from drug overdoses in the United States in 2014 than during any previous year on record. From 2000 to 2014 nearly half a million persons in the United States have died from drug overdoses. In 2014, there were approximately one and a half times more drug overdose deaths in the United States than deaths from motor vehicle crashes (4). Opioids, primarily prescription pain relievers and heroin, are the main drugs associated with overdose deaths. In 2014, opioids were involved in 28,647 deaths, or 61% of all drug overdose deaths; the rate of opioid overdoses has tripled since 2000. The 2014 data demonstrate that the United States' opioid overdose epidemic includes two distinct but interrelated trends: a 15-year increase in overdose deaths involving prescription opioid pain relievers and a recent surge in illicit opioid overdose deaths, driven largely by heroin.

Natural and semisynthetic opioids, which include the most commonly prescribed opioid pain relievers, oxycodone and hydrocodone, continue to be involved in more overdose deaths than any other opioid type. Although this category of opioid drug overdose death had declined in 2012 compared with 2011, and had held steady in 2013, there was a 9% increase in 2014.

Drug overdose deaths involving heroin continued to climb sharply, with heroin overdoses more than tripling in 4 years. This increase mirrors large increases in heroin use across the country (5) and has been shown to be closely tied to opioid pain reliever misuse and dependence. Past misuse of prescription opioids is the strongest risk factor for heroin initiation and use, specifically among persons who report past-year dependence or abuse (5). The increased availability of heroin, combined with its relatively low price (compared with diverted prescription opioids) and high purity appear to be major drivers of the upward trend in heroin use and overdose (6).

The rate of drug overdose deaths involving synthetic opioids nearly doubled between 2013 and 2014. This category includes both prescription synthetic opioids (e.g., fentanyl and tramadol) and non-pharmaceutical fentanyl manufactured in illegal laboratories (illicit fentanyl). Toxicology tests used by coroners and medical examiners are unable to distinguish between prescription and illicit fentanyl. Based on reports from states and drug seizure data, however, a substantial portion of the increase in synthetic opioid deaths appears to be related to increased availability of illicit fentanyl (7), although this cannot be confirmed with mortality data. For example, five jurisdictions (Florida, Maryland, Maine, Ohio, and Philadelphia, Pennsylvania) that reported sharp increases in illicit fentanyl seizures, and screened persons who died from a suspected drug overdose for fentanyl, detected similarly sharp increases in fentanyl-related deaths (7).§ Finally, illicit fentanyl is often combined with heroin or sold as heroin. Illicit fentanyl might be contributing to recent increases in drug overdose deaths involving heroin. Therefore, increases in illicit fentanyl-associated deaths might represent an emerging and troubling feature of the rise in illicit opioid overdoses that has been driven by heroin.

The findings in this report are subject to at least three limitations. First, several factors related to death investigation might affect estimates of death rates involving specific drugs. At autopsy, toxicological laboratory tests might be performed to determine the type of drugs present; however, the substances tested for and circumstances under which the tests are performed vary by jurisdiction. Second, in 2013 and 2014, 22% and 19% of drug overdose deaths, respectively, did not include information on the death certificate about the specific types of drugs involved. The percent of overdose deaths with specific drugs identified on the death certificate varies widely by state. Some of these deaths might have involved opioids. This increase in the reporting of specific drugs in 2014 might have contributed to some of the observed increases in drug overdose death rates involving different types of opioids from 2013 to 2014. Finally, some heroin deaths might be misclassified as morphine because morphine and heroin are metabolized similarly (8), which might result in an underreporting of heroin overdose deaths.

To reverse the epidemic of opioid drug overdose deaths and prevent opioid-related morbidity, efforts to improve safer prescribing of prescription opioids must be intensified. Opioid pain reliever prescribing has quadrupled since 1999 and has increased in parallel with overdoses involving the most commonly used opioid pain relievers (1). CDC has developed a draft guideline for the prescribing of opioids for chronic pain to address this need.¶

In addition, efforts are needed to protect persons already dependent on opioids from overdose and other harms. This includes expanding access to and use of naloxone (a safe and effective antidote for all opioid-related overdoses)** and increasing access to medication-assisted treatment, in combination with behavioral therapies (9). Efforts to ensure access to integrated prevention services, including access to syringe service programs when available, is also an important consideration to prevent the spread of hepatitis C virus and human immunodeficiency virus infections from injection drug use.

Public health agencies, medical examiners and coroners, and law enforcement agencies can work collaboratively to improve detection of outbreaks of drug overdose deaths involving illicit opioids (including heroin and illicit fentanyl) through improved investigation and testing as well as reporting and monitoring of specific drugs, and facilitate a rapid and effective response that can address this emerging threat to public health and safety (7). Efforts are needed to distinguish the drugs contributing to overdoses to better understand this trend.

¹Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC.

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* Additional information available at http://www.cdc.gov/nchs/nvss/mortality_public_use_data.htm.

† Additional information available at <http://www.cdc.gov/drugoverdose/data/statedeaths.html>.

§ Additional information available at <http://pub.lucidpress.com/NDEWSFentanyl/>.

¶ Additional information available at <http://www.cdc.gov/drugoverdose/prescribing/guideline.html>.

** Additional information available at [https://store.samhsa.gov/shin/content/SMA13-4742/Overdose Toolkit 2014 Jan.pdf](https://store.samhsa.gov/shin/content/SMA13-4742/Overdose_Toolkit_2014_Jan.pdf).

Summary

What is already known on this topic?

The rate for drug overdose deaths has increased approximately 140% since 2000, driven largely by opioid overdose deaths. After increasing since the 1990s, deaths involving the most commonly prescribed opioid pain relievers (i.e., natural and semisynthetic opioids) declined slightly in 2012 and remained steady in 2013, showing some signs of progress. Heroin overdose deaths have been sharply increasing since 2010.

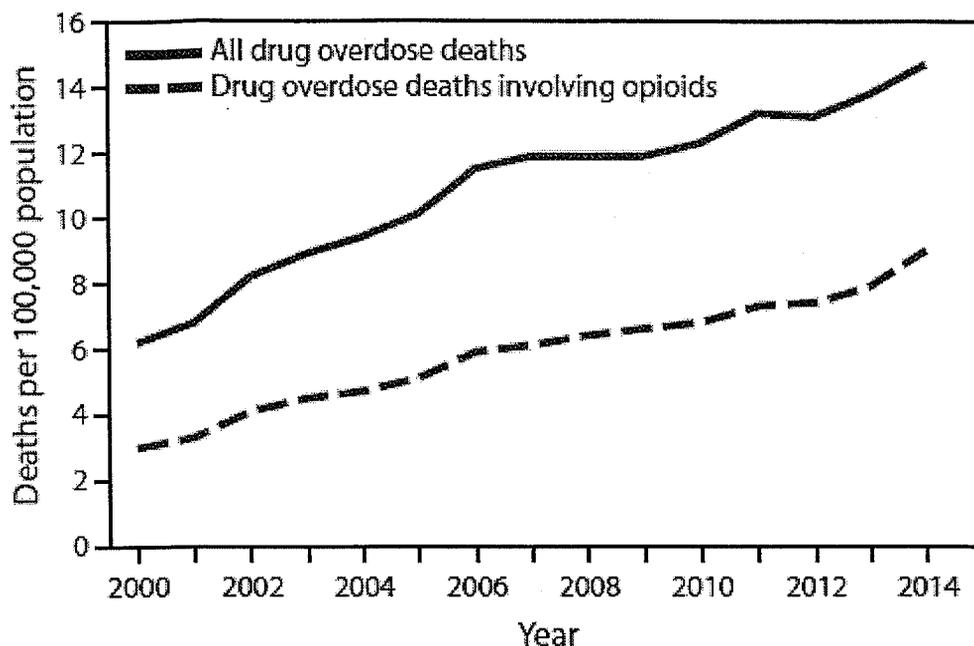
What is added by this report?

Drug overdose deaths increased significantly from 2013 to 2014. Increases in opioid overdose deaths were the main factor in the increase in drug overdose deaths. The death rate from the most commonly prescribed opioid pain relievers (natural and semisynthetic opioids) increased 9%, the death rate from heroin increased 26%, and the death rate from synthetic opioids, a category that includes illicitly manufactured fentanyl and synthetic opioid pain relievers other than methadone, increased 80%. Nearly every aspect of the opioid overdose death epidemic worsened in 2014.

What are the implications for public health practice?

Efforts to encourage safer prescribing of opioid pain relievers should be strengthened. Other key prevention strategies include expanding availability and access to naloxone (an antidote for all opioid-related overdoses), increasing access to medication-assisted treatment in combination with behavioral therapies, and increasing access to syringe service programs to prevent the spread of hepatitis C virus infection and human immunodeficiency virus infections. Public health agencies, medical examiners and coroners, and law enforcement agencies can work collaboratively to improve detection of and response to outbreaks associated with drug overdoses related to illicit opioids.

FIGURE 1. Age-adjusted rate* of drug overdose deaths[†] and drug overdose deaths involving opioids^{§,¶} — United States, 2000–2014



Source: National Vital Statistics System, Mortality file.

* Age-adjusted death rates were calculated by applying age-specific death rates to the 2000 U.S. standard population age distribution.

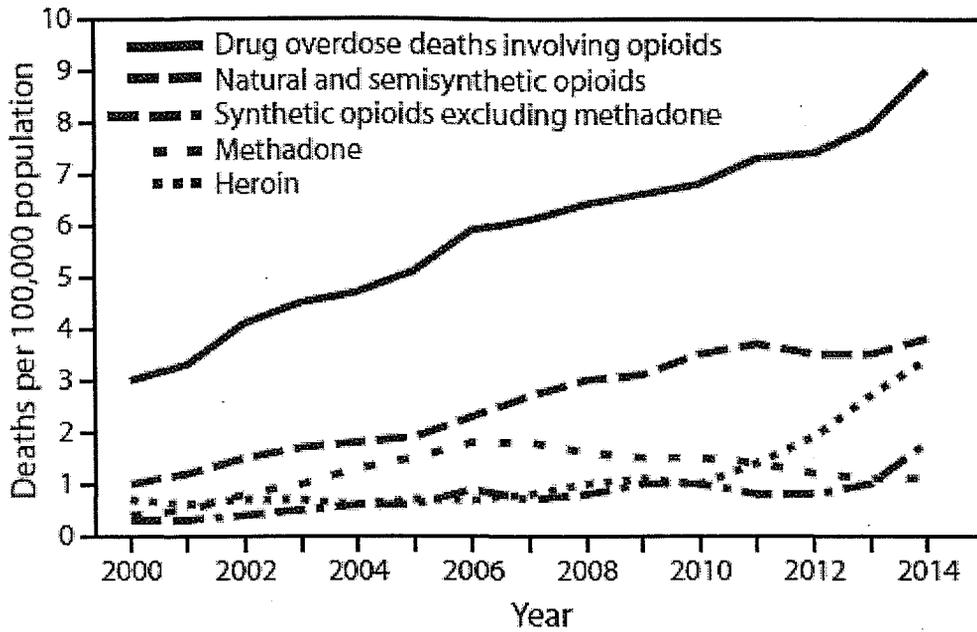
† Drug overdose deaths are identified using *International Classification of Diseases, Tenth Revision* underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14.

§ Drug overdose deaths involving opioids are drug overdose deaths with a multiple cause-of-death code of T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6. Approximately one fifth of drug overdose deaths lack information on the specific drugs involved. Some of these deaths might involve opioids.

¶ Opioids include drugs such as morphine, oxycodone, hydrocodone, heroin, methadone, fentanyl, and tramadol.

Alternate Text: The figure above is a line chart showing the age-adjusted rates of drug overdose deaths and drug overdose deaths involving opioids in the United States during 2000–2014.

FIGURE 2. Drug overdose deaths* involving opioids,†,§ by type of opioid¶ — United States, 2000–2014



Source: National Vital Statistics System, Mortality file.

* Age-adjusted death rates were calculated by applying age-specific death rates to the 2000 U.S. standard population age distribution.

† Drug overdose deaths involving opioids are identified using *International Classification of Diseases, Tenth Revision* underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14 with a multiple cause code of T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6.

§ Opioids include drugs such as morphine, oxycodone, hydrocodone, heroin, methadone, fentanyl, and tramadol.

¶ For each type of opioid, the multiple cause-of-death code was T40.1 for heroin, T40.2 for natural and semisynthetic opioids (e.g., oxycodone and hydrocodone), T40.3 for methadone, and T40.4 for synthetic opioids excluding methadone (e.g., fentanyl and tramadol). Deaths might involve more than one drug thus categories are not exclusive.

Alternate Text: The figure above is a line chart showing drug overdose deaths involving opioids, by type of opioid, in the United States during 2000-2014.

TABLE. Number and age-adjusted rates of drug overdose deaths,* by sex, age, race and Hispanic origin,† Census region, and state —United States, 2013 and 2014

Decedent characteristic	2013		2014		% change from 2013 to 2014
	No.	Age-adjusted rate	No.	Age-adjusted rate	
All	43,982	13.8	47,055	14.7	6.5§
Sex					
Male	26,799	17.0	28,812	18.3	7.6§

Female	17,183	10.6	18,243	11.1	4.7§
Age group (yrs)					
0–14	105	0.2	109	0.2	0.0
15–24	3,664	8.3	3,798	8.6	3.6
25–34	8,947	20.9	10,055	23.1	10.5§
35–44	9,320	23.0	10,134	25.0	8.7§
45–54	12,045	27.5	12,263	28.2	2.5
55–64	7,551	19.2	8,122	20.3	5.7§
≥65	2,344	5.2	2,568	5.6	7.7§
Race and Hispanic origin†					
White, non-Hispanic	35,581	17.6	37,945	19.0	8.0§
Black, non-Hispanic	3,928	9.7	4,323	10.5	8.2§
Hispanic	3,345	6.7	3,504	6.7	0.0
Census region of residence					
Northeast	8,403	14.8	9,077	16.1	8.8§
Midwest	9,745	14.6	10,647	16.0	9.6§
South	15,519	13.1	16,777	14.0	6.9§
West	10,315	13.6	10,554	13.7	0.7
State of residence					
Alabama	598	12.7	723	15.2	19.7§
Alaska	105	14.4	124	16.8	16.7
Arizona	1,222	18.7	1,211	18.2	-2.7
Arkansas	319	11.1	356	12.6	13.5
California	4,452	11.1	4,521	11.1	0.0
Colorado	846	15.5	899	16.3	5.2
Connecticut	582	16.0	623	17.6	10.0
Delaware	166	18.7	189	20.9	11.8

District of Columbia	102	15.0	96	14.2	-5.3
Florida	2,474	12.6	2,634	13.2	4.8
Georgia	1,098	10.8	1,206	11.9	10.2§
Hawaii	158	11.0	157	10.9	-0.9
Idaho	207	13.4	212	13.7	2.2
Illinois	1,579	12.1	1,705	13.1	8.3§
Indiana	1,064	16.6	1,172	18.2	9.6§
Iowa	275	9.3	264	8.8	-5.4
Kansas	331	12.0	332	11.7	-2.5
Kentucky	1,019	23.7	1,077	24.7	4.2
Louisiana	809	17.8	777	16.9	-5.1
Maine	174	13.2	216	16.8	27.3§
Maryland	892	14.6	1,070	17.4	19.2§
Massachusetts	1,081	16.0	1,289	19.0	18.8§
Michigan	1,553	15.9	1,762	18.0	13.2§
Minnesota	523	9.6	517	9.6	0.0
Mississippi	316	10.8	336	11.6	7.4
Missouri	1,025	17.5	1,067	18.2	4.0
Montana	137	14.5	125	12.4	-14.5
Nebraska	117	6.5	125	7.2	10.8
Nevada	614	21.1	545	18.4	-12.8
New Hampshire	203	15.1	334	26.2	73.5§
New Jersey	1,294	14.5	1,253	14.0	-3.4
New Mexico	458	22.6	547	27.3	20.8§
New York	2,309	11.3	2,300	11.3	0.0
North Carolina	1,259	12.9	1,358	13.8	7.0
North Dakota	20	2.8	43	6.3	125.0§

Ohio	2,347	20.8	2,744	24.6	18.3§
Oklahoma	790	20.6	777	20.3	-1.5
Oregon	455	11.3	522	12.8	13.3

TABLE. (Continued) Number and age-adjusted rates of drug overdose deaths,* by sex, age, race and Hispanic origin,† Census region, and state — United States, 2013 and 2014

Decedent characteristic	2013		2014		% change from 2013 to 2014
	No.	Age-adjusted rate	No.	Age-adjusted rate	
Pennsylvania	2,426	19.4	2,732	21.9	12.9§
Rhode Island	241	22.4	247	23.4	4.5
South Carolina	620	13.0	701	14.4	10.8
South Dakota	55	6.9	63	7.8	13.0
Tennessee	1,187	18.1	1,269	19.5	7.7
Texas	2,446	9.3	2,601	9.7	4.3
Utah	594	22.1	603	22.4	1.4
Vermont	93	15.1	83	13.9	-7.9
Virginia	854	10.2	980	11.7	14.7§
Washington	969	13.4	979	13.3	-0.7
West Virginia	570	32.2	627	35.5	10.2
Wisconsin	856	15.0	853	15.1	0.7
Wyoming	98	17.2	109	19.4	12.8

Source: National Vital Statistics System, Mortality file.

* Deaths are classified using the *International Classification of Diseases, Tenth Revision* (ICD-10). Drug overdose deaths are identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Age-adjusted death rates were calculated by applying age-specific death rates to the 2000 U.S standard population age distribution.

† Data for Hispanic origin should be interpreted with caution; studies comparing Hispanic origin on death certificates and on census surveys have shown inconsistent reporting on Hispanic ethnicity.

§ Statistically significant change from 2013 to 2014.

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PUBLIC RELEASE: 29-DEC-2015

Temple study finds opioid prescribing guideline significantly decreases prescription rates

TEMPLE UNIVERSITY HEALTH SYSTEM

(Philadelphia, PA) - Emergency medicine physicians at Temple University Hospital have found that an opioid prescribing guideline had an immediate and sustained impact on opioid prescribing rates for minor conditions and chronic noncancer pain in an acute care setting. The results of the study are published in the January 2016 *Journal of Emergency Medicine*.

The United States is in the midst of a crisis regarding the abuse of prescription drug opioids. According to the Centers for Disease Control and Prevention, the U.S. death rate from prescription opioid overdose now exceeds the combined death rates from heroin and cocaine.

Acute care settings are a major source of opioid prescriptions, often for minor conditions and chronic noncancer pain. Emergency physicians have identified themselves as targets for patients who seek opioids for nonmedical purposes. Given the difficulty in striking a balance that provides appropriate analgesia for patients without creating or exacerbating drug dependence, the U.S. Department of Health and Human Services recommends the synthesis of pain management guidelines and the creation of clinical decision support tools.

Temple University Hospital (TUH) and Temple University Hospital-Episcopal Campus (TUH-Episcopal) were among those that created a guideline for prescribing opioids in order to maximize safety and avoid misuse.

"The impact of this type of guideline had never been studied in an acute care setting," says Daniel del Portal, MD, FAAEM, Assistant Professor of Clinical Emergency Medicine at the Lewis Katz School of Medicine at Temple University, Assistant Director of Clinical Operations at TUH and Jeanes Hospital, and principal investigator of the study. "We hypothesized that the rate at which opioids were prescribed in the emergency department for dental, neck/back and chronic pain would decrease after adoption of the guideline. We also hypothesized that physicians would support the use of the guideline."

The retrospective observational study compared the rate of opioid prescriptions for dental, neck/back and chronic noncancer pain before and after adoption of the guideline in January 2013. The research team used data from 13,187 patients aged 18 years or older who met the diagnosis criteria and were discharged from the emergency departments at TUH and TUH-Episcopal.

The team also administered a survey to the faculty emergency medicine physicians who were practicing in the two emergency departments.

Results showed the prescribing guideline had an immediate and sustained impact in reducing opioid prescribing rates for all age groups and for each of the three categories of complaints with a high degree of statistical significance. Also, 100% of physicians surveyed supported implementation of the voluntary guideline. Most (97%) felt the guideline had facilitated discussions with patients when opioids were being withheld, and nearly three-quarters of respondents reported encountering less hostility from patients since adoption of the guideline.

"Emergency physicians and other acute care providers can use various tools to promote the rational prescribing of dangerous opioid medications," adds Dr. del Portal. "In contrast to electronic prescription drug monitoring programs, which show promise but require significant infrastructure and regulation (and are as yet unavailable to prescribers in Pennsylvania), an easily implemented guideline empowers physicians and protects patients from the well documented dangers of opioid misuse."

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Other physicians contributing to the study include Dr. Robert M. McNamara, Dr. Megan E. Healy and Dr. Wayne A. Satz from the Department of Emergency Medicine at the Lewis Katz School of Medicine.

About Temple Health

Temple University Health System (TUHS) is a \$1.6 billion academic health system dedicated to providing access to quality patient care and supporting excellence in medical education and research. The Health System consists of Temple University Hospital (TUH), ranked among the 'Best Hospitals' in the region by *U.S. News & World Report*; TUH-Episcopal Campus; TUH-Northeastern Campus; Fox Chase Cancer Center, an NCI-designated comprehensive cancer center; Jeanes Hospital, a community-based hospital offering medical, surgical and emergency services; Temple Transport Team, a ground and air-ambulance company; and Temple Physicians, Inc., a network of community-based specialty and primary-care physician practices. TUHS is affiliated with the Lewis Katz School of Medicine at Temple University.

The Lewis Katz School of Medicine (LKSOM), established in 1901, is one of the nation's leading medical schools. Each year, the School of Medicine educates approximately 840 medical students and 140 graduate students. Based on its level of funding from the National Institutes of Health, the Katz School of Medicine is the second-highest ranked medical school in Philadelphia and the third-highest in the Commonwealth of Pennsylvania. According to *U.S. News & World Report*, LKSOM is among the top 10 most applied-to medical schools in the nation.

Temple Health refers to the health, education and research activities carried out by the affiliates of Temple University Health System (TUHS) and by the Katz School of Medicine. TUHS neither provides nor controls the provision of health care. All health care is provided by its member organizations or independent health care providers affiliated with TUHS member organizations. Each TUHS member organization is owned and operated pursuant to its governing documents.

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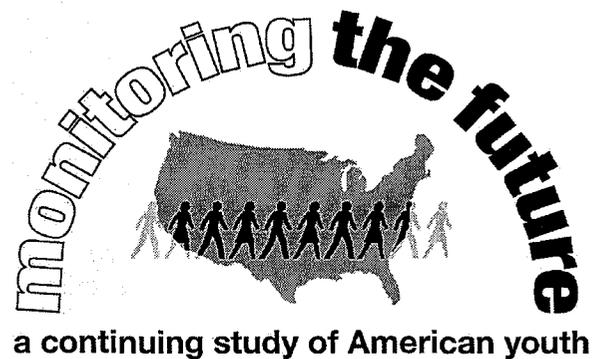
Wednesday, December 16, 2015

Drug use trends remain stable or decline among teens

NIH's 2015 Monitoring the Future survey shows long term decline in illicit drug use, prescription opioid abuse, cigarette and alcohol use among the nation's youth.

The 2015 Monitoring the Future survey (MTF) shows decreasing use of a number of substances, including cigarettes, alcohol, prescription opioid pain relievers, and synthetic cannabinoids ("synthetic marijuana"). Other drug use remains stable, including marijuana, with continued high rates of daily use reported among 12th graders, and ongoing declines in perception of its harms.

The MTF survey measures drug use and attitudes among eighth, 10th, and 12th graders, and is funded by the National Institute on Drug Abuse (NIDA), part of the National Institutes of Health. The survey has been conducted by researchers at the University of Michigan at Ann Arbor since 1975.



For the first time, daily marijuana use exceeds daily tobacco cigarette use among 12th graders.

Daily marijuana use for this group remained relatively stable at 6 percent, compared to 5.5 percent reporting daily cigarette smoking (down from 6.7 percent in 2014).

"We are heartened to see that most illicit drug use is not increasing, non-medical use of prescription opioids is decreasing, and there is improvement in alcohol and cigarette use rates," said Nora D. Volkow, M.D., director of NIDA. "However, continued areas of concern are the high rate of daily marijuana smoking seen among high school students, because of marijuana's potential deleterious effects on the developing brains of teenagers, and the high rates of overall tobacco products and nicotine containing e-cigarettes usage."

"This year's Monitoring the Future data continue the promising trends from last year with declining rates of adolescent substance use, and support the value of evidence-based prevention, treatment, and recovery," said National Drug Control Policy Director Michael Botticelli. "Efforts to prevent drug use from ever starting are particularly important as we work to reduce the rising number of drug overdoses across the country. I encourage parents, teachers, coaches, and mentors to have a conversation with the young people in their lives about making the healthy decisions that will keep them on a path toward a successful future."

"We are very encouraged by the continued decline in underage drinking illustrated in these data," said George F. Koob, Ph.D., director of the National Institute on Alcohol Abuse and Alcoholism. "However, the percent of underage individuals

drinking still remains unacceptably high. For example, approximately 40 percent of 12th graders have reported being drunk in the past year and binge drinking remains a significant problem.”

Other highlights from the 2015 survey:

Drugs

- Use of many illicit drugs has trended down. Among high school seniors, 23.6 percent report using an illicit drug in the past month, with 7.6 percent reporting they used an illicit drug other than marijuana.
- Perception of marijuana use as risky continues to decline, with 31.9 percent of seniors saying regular use could be harmful, compared to 36.1 percent last year.
- Past year use of synthetic cannabinoids (“synthetic marijuana”) is at 5.2 percent for 12th graders, down significantly from 11.4 in 2011, the first year it was measured in the survey.
- Past year use of heroin, typically very low among teens, is at an all-time low at 0.3 percent for eighth graders, and 0.5 for 10th and 12th graders.
- Use of MDMA (also known as Ecstasy or Molly), inhalants, and LSD are generally stable or down. In 2015, 3.6 percent of seniors reported past year use of MDMA, compared to 5 percent in 2014.
- Non-medical use of the prescription amphetamine Adderall, typically given for ADHD, remains high at 7.5 percent among 12th graders.
- Use of prescription opioids continues its downward trend, with 4.4 percent of high school seniors reporting non-medical use of Vicodin (hydrocodone and acetaminophen), down from a peak of 10.5 percent in 2003.
- Most teens abusing prescription opioids report getting them from friends or family members. However, one-third report getting them from their own prescriptions, underscoring the need to monitor teens taking opioids and evaluate prescribing practices.

Tobacco

- Cigarette smoking rates have greatly declined among teens in recent years. For example, among 10th graders, there has been a 54.9 percent drop in daily smoking in just five years, reported at just 3 percent this year compared to 6.6 percent five years ago.
- However, rates of use of other tobacco products, while not significantly changed from 2014, remain high with 12th graders, reporting rates of past year use of hookah and small cigars of 19.8 percent and 15.9 percent, respectively.
- More than 75 percent of high school seniors view smoking a pack or more a day as harmful, compared to 51.3 percent in 1975, first year of the survey.
- As e-cigarettes are currently unregulated, there is limited data on what chemicals teens are actually smoking. However, when asked what they inhaled the last time they used an e-cigarette, only about 20 percent said they were using nicotine. Most say they inhaled flavoring alone and many admitted they were unsure what they inhaled. In fact, about 13 percent of eighth graders who use e-cigarettes said they did not know what was in the device they used. Furthermore, some products labeled nicotine-free may actually contain nicotine.
- Roughly twice as many boys as girls report using e-cigarettes (21.5 percent to 10.9 percent).

Alcohol

- Alcohol use continues its gradual downward trend among teens, with significant changes seen in the past five years in nearly all measures.
- Binge drinking (described as having five or more drinks in a row within the past two weeks) is 17.2 percent among seniors, down from 19.4 percent last year and down from peak rates in 1998 at 31.5 percent.
- 37.7 percent of 12th graders say they have been drunk in the past year, compared to 41.4 percent in 2014 and 53.2 percent in 2001, when rates were highest for that group.
- High school seniors see a distinction in potential harmfulness between one or two drinks nearly every day (21.5 percent) versus four to five drinks nearly every day (59.1 percent).

Overall, 44,892 students from 382 public and private schools participated in this year's MTF survey. Since 1975, the survey has measured drug, alcohol, and cigarette use and related attitudes in 12th graders nationwide. Eighth and 10th graders were added to the survey in 1991. Survey participants generally report their drug use behaviors across three time periods: lifetime, past year, and past month. Questions are also asked about daily cigarette and marijuana use. NIDA has provided funding for the survey since its inception by a team of investigators at the University of Michigan at Ann Arbor, led by Drs. Lloyd Johnston and Richard Miech. MTF is funded under grant number DA001411. Additional information on the MTF Survey, as well as comments from Dr. Volkow, can be found at www.drugabuse.gov/drugpages/MTF.html. The University of Michigan press release can be found at <http://monitoringthefuture.org>.

MTF is one of three major surveys sponsored by the U.S. Department of Health and Human Services that provide data on substance use among youth. The others are the National Survey on Drug Use and Health and the Youth Risk Behavior Survey. The MTF website is: www.monitoringthefuture.org. Follow Monitoring the Future 2015 news on Twitter at @NIDANews, or join the conversation by using: #MTF2015. Additional survey results can be found at www.hhs.gov/news or www.whitehouse.gov/ondcp. Information on all of the surveyed drugs can be found on NIDA's Web site: www.drugabuse.gov.

The National Survey on Drug Use and Health, sponsored by the Substance Abuse and Mental Health Services Administration, is the primary source of statistical information on substance use in the U.S. population 12 years of age and older. More information is available at: <http://www.samhsa.gov/data/population-data-nsduh>.

The Youth Risk Behavior Survey, part of HHS's Centers for Disease Control and Prevention's (CDC) Youth Risk Behavior Surveillance System, is a school-based survey that collects data from students in grades nine–12. The survey includes questions on a wide variety of health-related risk behaviors, including substance abuse. More information is available at www.cdc.gov/HealthyYouth/yrbs/index.htm. Additionally, the National Youth Tobacco Survey, a school-based survey of U.S. students in grades six-12 conducted by the CDC in collaboration with the Food and Drug Administration, collects data on the use of multiple tobacco products, including e-cigarettes. More information is available at www.cdc.gov/tobacco/data_statistics/surveys/NYTS/.

The National Institute on Drug Abuse (NIDA) is a component of the National Institutes of Health, U.S. Department of Health and Human Services. NIDA supports most of the world's research on the health aspects of drug abuse and addiction. The Institute carries out a large variety of programs to inform policy and improve practice. Fact sheets on the health effects of drugs of abuse and information on NIDA research and other activities can be found at <http://www.drugabuse.gov>, which is now compatible with your smartphone, iPad or tablet. To order publications in English or Spanish, call NIDA's DrugPubs research dissemination center at 1-877-NIDA-NIH or 240-645-0228 (TDD) or email requests to drugpubs@nida.nih.gov. Online ordering is available at <http://drugpubs.drugabuse.gov>. NIDA's media guide can be found at <http://drugabuse.gov/mediaguide>, and its easy-to-read website can be found at <http://www.easyread.drugabuse.gov>

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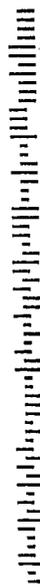
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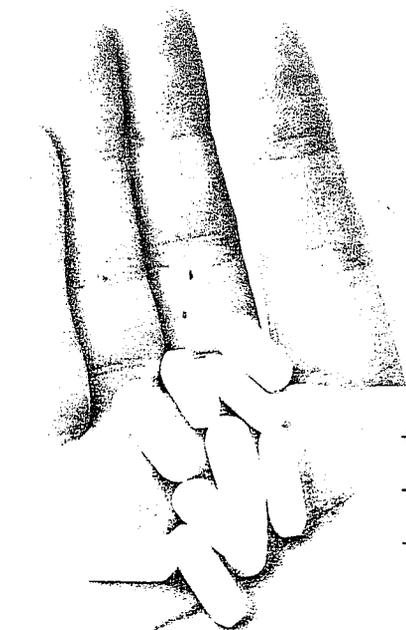
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If you suspect Fido's owner is diverting prescription pain meds meant for the pet, checking your state's drug monitoring database may not help

by Ann M. Philbrick, PharmD, BCPS

The Centers for Disease Control and Prevention has declared prescription drug abuse an epidemic in the United States. Results from the National Survey on Drug Use and Health estimated that 4.5 million Americans age 12 and over were current nonmedical users of pain relievers in 2013. In 2012, more than 16,000 deaths in the United States were attributed to opioid analgesic overdose. Prescription drug abuse has even started to overflow into other disease states. A May 2015 outbreak of human immunodeficiency virus (HIV) infection in southern Indiana has been linked to injection of the prescription drug oxymorphone.

Prescription drug monitoring programs (PDMPs) have been enacted to help combat prescription drug abuse. Forty-nine states, plus the District of Columbia and Guam, have PDMPs. (Missouri does not have a PDMP.) PDMPs are designed to be a central database of all controlled substances dispensed for a patient. In turn, prescribers, and sometimes pharmacists, are allowed to access this information and use it to aid in decision making regarding prescription authorization and dispensing. Despite their usefulness, there are some shortfalls of PDMPs. The first is the varied time in which states require pharmacies to upload data to the PDMP. This can range from daily to monthly. Another limitation is that a patient's name and date of birth must be entered exactly the same, from writing the prescription, to filling in the pharmacy, to querying the database. Errors and inconsistencies at any of these steps can create an inadequate picture of exactly what controlled substances a patient is receiving. Additionally, there is variation in what controlled substances each state tracks. The majority

of states track and monitor schedule II – V controlled substances. However 15 states only track schedule II – IV controlled substances (see chart), and one state only tracks schedule II (Pennsylvania). A final limitation is a lack of communication between state PDMPs. Currently, 30 states (www.nabp.net/programs/pmp-interconnect/nabp-pmp-interconnect) participate in interstate data sharing (see chart). While this increases sharing of information within PDMPs, there are many states that do not share this information, which can be a detriment, especially in those towns that lie on state lines.

With these limitations of state PDMPs comes an additional list of limitations regarding controlled substances dispensed to animals. While more pet owners are choosing to fill medications at "human" pharmacies, the primary dispensing location for animal prescriptions remains within the veterinarian's office. Only 14 states require veterinarians to report controlled substance dispensing within their practice setting (see chart), leaving a majority of them unreported. Interestingly, in South Car-

olina, veterinarians are only required to submit a report to the PDMP if the day supply is greater than five days. Additionally, phenobarbital prescriptions up to a 31-day supply do not need to be reported.

The purpose of this article is to shed light on how states handle animal prescriptions within their PDMPs and offer suggestions for improvement.

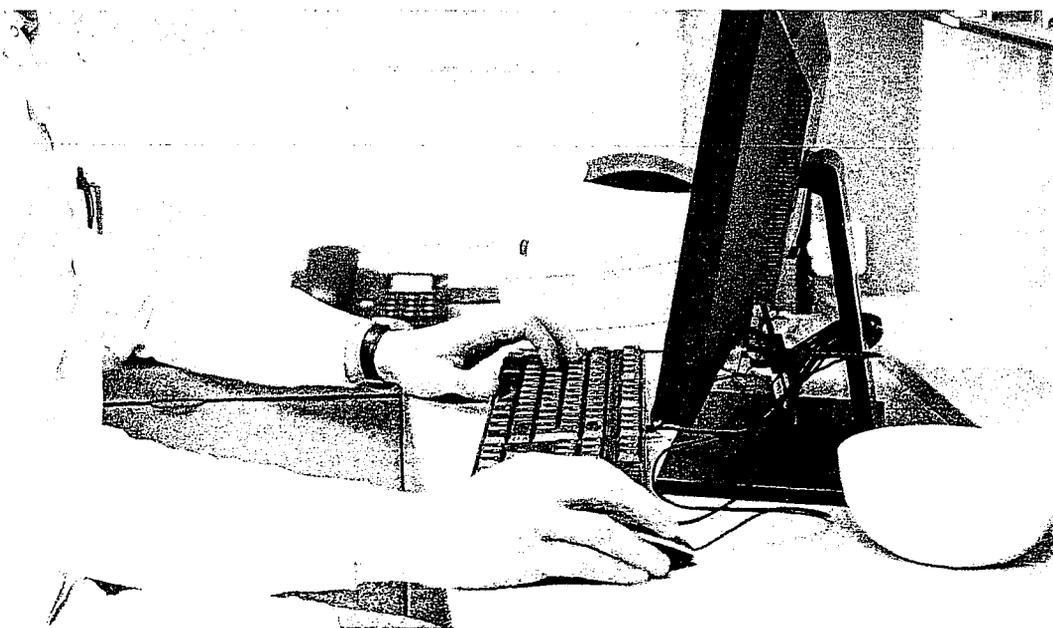
Another shortcoming of PDMPs with regard to animal prescriptions is the entry of animals into the database itself. It is common for owners to not know the exact date of birth of their pet, leading to the potential for several birthdates being used in the database. Fido Smith, with a date of birth of 1/1/2015, could have a

separate entry than Fido Smith with a birthdate of 1/2/2015. Furthermore, it is also common for two owners with different last names to own the same animal. If John Smith and Jane Doe both shared the ownership of their cat, Fluffy, it could result in a variety of permutations within the PDMP, including Fluffy Smith, Fluffy Doe, Fluffy Smith-Doe, and Fluffy Doe-Smith. Additionally, it is unclear if the owner is in any way linked to the pet's profile, which would be helpful if a prescriber or pharmacist suspects diversion.

The purpose of this article is to shed light on how states handle animal prescriptions within their PDMPs and offer suggestions for improvement.

METHODS

The PDMPs for 49 states and Guam were contacted via email. Missouri was not contacted because they do not have a PDMP, and the District of Columbia was not contacted as its program has been approved but has not been enacted yet. Up to three email attempts were made. The email had open-ended questions regarding the handling of pet prescriptions with



Alabama
 Arizona
 Arkansas
 Colorado
 Connecticut
 Delaware
 Illinois
 Indiana
 Kansas
 Kentucky
 Louisiana

Maine
 Michigan
 Minnesota
 Mississippi
 North Dakota
 New Jersey
 New Mexico
 Nevada
 Ohio
 Oklahoma
 Rhode Island

South Carolina
 South Dakota
 Tennessee
 Utah
 Virginia
 Wisconsin
 West Virginia (allows for the sharing
 of prescription data across state lines)

States That Track Schedule II Prescription Data

Alabama
 Alaska
 Arizona
 California
 Connecticut
 Delaware
 Hawaii
 Illinois
 Indiana
 Michigan
 New York
 Oklahoma
 South Carolina
 Washington

States That Track Schedule II Controlled Substances

Arizona
 California
 Florida
 Iowa
 Kansas
 Maine
 Nevada
 New Hampshire
 Oregon
 Rhode Island
 South Carolina
 Vermont
 Virginia
 West Virginia
 Wyoming

Note: Pennsylvania only tracks schedule II

regard to the PDMP, and whether a pharmacist would be allowed to query the PDMP on the owner if they suspected diversion. Qualitative feedback was then analyzed to detect common themes. Of the 50 entities that were contacted, seven states either did not respond, or declined to respond because of the research nature of the question (Illinois, Indiana, Mississippi, New York, Tennessee, Texas, and Wisconsin). Of the remaining 43 states that responded, four states were excluded as their PDMP specifically does not collect data regarding animal controlled substance prescriptions (Kentucky, Montana, Nebraska, and Oregon). This left 39 states that were

included in the analysis. This study was exempt from review by the University of Minnesota Investigational Review Board.

RESULTS

When asked whether the animal's records are separate from the owner's records, 28 (71.8 percent) respondents replied yes, five (12.8 percent) responded no (New Hampshire, Oklahoma, Rhode Island, Utah, and West Virginia), three (7.7 percent) respondents did not answer (Arizona, Kansas, and Pennsylvania), and three (7.7 percent) respondents replied that it depended on how the animal was entered as a patient in the pharmacy's

computer system (Ohio, Virginia, and Vermont). Respondents in these states replied that there is no consistency in which pharmacies enter animals into their prescription software, so depending on how the animal was entered, it could result in merging of owner and pet profiles. One state (New Hampshire) specifically reported that it uses the owner's date of birth for the animal, which is how the two profiles are linked together. Six states stated that they use a species code to identify non-human patients (Alabama, Arizona, California, Connecticut, Massachusetts, and Washington), although one state (Washington) stated that this was not required to report.

Two states (Oklahoma and West Virginia) responded that they also required that pharmacies provide information regarding who picked up the controlled substance. Guam reported that it will eventually require this information.

PDMPs were also asked whether a pharmacist was allowed to query the database if they suspected an owner of diversion. Of these, 10 (25.6 percent) respondents replied yes (Arizona, Guam, Hawaii, New Hampshire, North Carolina, North Dakota, Oklahoma, Rhode Island, West Virginia, and Wyoming), 12 (30.8 percent) responded no (Alaska, Arkansas, California, Idaho, Maryland, Minnesota, New Mexico, Ohio, Pennsylvania, South Carolina, Utah, and Washington), and six (15.4 percent) responded yes, but only if the owner was also a patient of the pharmacy (Georgia, Iowa, Louisiana, Maine, Nevada, and New Jersey). The remaining 11 states (28.2 percent) did not provide an answer. One respondent (North Carolina) replied that while a pharmacist is allowed to access this information, a formal complaint would need to go through the department of health and human services, but could use results as grounds to refuse to fill a prescription.

DISCUSSION

The results of this study show that a majority of states do not link an animal's prescription record to the owner's prescription record within the state's PDMP. Furthermore, among approximately a third of respondents, if a pharmacist suspects an owner of diversion, they are unable to query the PDMP to investigate those suspicions. This disturbing situation, along with the knowledge that many veterinarians dispensing controlled substances within their office do not need to report dispensing, allows for the potential for unchecked diversion of controlled substances intended to be used for a companion animal.

Based on the results of this study, there are a few suggestions on how to increase the efficiency of each state or territory's PDMP to decrease diversion of animal prescriptions. First, states should mandate the reporting of controlled substances dispensed at the veterinarian's office. Second, a consistent method creating an animal's profile should be adopted within each state or territory, and preferably among all states involved in data sharing. A suggested method would be to adopt generic birthdate (such as Jan. 1 of the likely birth year year), use the first name of the pet with the last name of the owner(s), list last names of multiple owners in alphabetical order, and use a species code. Finally, animal PDMP profiles need to be linked to all adult owners' PDMP profiles, and pharmacists need to have authority to query the database if diversion is suspected.

CONCLUSION

Prescription drug abuse is a serious problem in the United States. PDMPs have been enacted to combat this problem, but there are a number of shortcomings of these programs, especially when it comes to animal prescriptions. The results of this study show that there is indeed a wide variety among how states and Guam handle animal prescriptions. However, these shortcomings can be overcome with some standardization with how PDMPs approach how animals are entered into their databases.

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For the list of references used in this article, please contact America's Pharmacist Managing Editor Chris Linville at 703-838-2680, or at chris.linville@ncpanet.org.



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At Walgreens and CVS, a push to collect customer health data by dangling discounts

Money At Walgreens and CVS, a push to collect customer health data by dangling discounts

By Rebecca Robbins

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Alissa Ambrose/STAT



Want \$50 off your next purchase at Walgreens? You'll have to run 2,000 miles. Or step on a scale 2,000 times. Or take 2,000 readings of your blood glucose level.

And you'll have to let the global pharmacy chain track all that data — and give them permission to mine it to target you with ads.

Walgreens this month launched a new smartphone app that customers can sync up wirelessly with their blood glucose and blood pressure monitors so they can feed their personal health information directly into the chain's data system in exchange for discounts. The app is novel. But the practice is increasingly familiar.

Pharmacies across the US are dangling perks to coax their customers to relinquish all sorts of personal information, ranging from daily fluctuations in their weight to their progress in quitting smoking to their real-time location every minute of the day.

At CVS, you can get \$5 back for every 10 prescription refills — if you waive your right to health care privacy protected under the federal health law known as HIPAA. And Rite Aid is experimenting with a service that other retailers are using to collect tons of data: special lockers that you can use to charge your cell phone for free, if you'll give up your phone number, insurance costs, and shopping preferences.

Drugstores say they're collecting your data to encourage you to be healthy and save you money. But the growing practice is also a boon for their bottom line because it helps them target their marketing efforts more precisely.

How precisely? If you allow your drugstore to track your location, you might get a text offering a coupon for a specific cough syrup or recommending that you try a neti pot for sinus relief — while you're standing in the aisle that sells cold and flu medication.

The trend alarms consumer and privacy advocates.

"It's extremely concerning," said Paul Stephens, director of policy and advocacy at the nonprofit Privacy Rights Clearinghouse.

In exchange for modest discounts, he said, patients are giving up "very, very valuable" information and leaving themselves open to a barrage of advertising about potentially sensitive health conditions. They may also be at risk of having their data shared more widely than they want — or even stolen.

"There is no free lunch," Stephens said.

Consumers are giving up "very, very valuable" information, including extensive data on their health.

Paul Stephens, Privacy Rights Clearinghouse.

Michelle De Mooy, a consumer privacy advocate at the Center for Democracy & Technology, worries that these programs have the potential to be discriminatory in their impact. Low-income customers may not be able to afford to say no to a discount, even at the cost of personal data they would otherwise keep private, she said.

Retailers of all stripes have long mined purchase data obtained through their loyalty rewards programs for clues about their customers. What's new is that drugstores are increasingly taking advantage of the proliferation of "connection points" available to them, according to Alan Lipson, a retail industry marketing manager for the analytics firm SAS.

"Now it's coming on your smartphone, and they're texting you, and they're being more invasive," Lipson said.

And while a grocery store may know how many boxes of Cheerios you buy in a week or what brand of pasta sauce you prefer, Walgreens can collect far more sensitive data about your health, down to how many milligrams of sugar per deciliter of blood you have in your veins. And you have to share an awful lot of those data points to earn the discount.

You don't have to earn your reward points by giving the chain just one kind of data, of course. You can report all sorts of "healthy behaviors," like using a nicotine patch or setting a weight loss goal or biking for 10 miles, earning points for each bit of information you feed the app. (You can also earn rewards for refilling prescriptions or spending money at Walgreens, but you're capped at a certain number of points per day and month.)

Walgreens vice president Adam Pellegrini wouldn't disclose how many customers had downloaded the new app, called "Walgreens Connect," which makes it easier and quicker for customers to transmit their blood pressure and blood glucose readings in exchange for rewards. (They used to have to go to a website to log all their health data.)

But Pellegrini said the company had doled out 2 billion rewards points — the equivalent of 50,000 discounts of \$50 — since it started rewarding customers for logging their health data last year.

The new Walgreens app lets you wirelessly send your blood pressure and blood glucose data directly to the pharmacy chain.

When asked how Walgreens was using all that health data, company spokeswoman Mailee Garcia said the company "does not sell personally identifiable information to third parties," but may sell de-identified information.

Garcia said Walgreens is not currently using health data to market to the customers who provide it. But the app's privacy policy explicitly states that Walgreens may use customer data to personalize advertising. The store can also combine data entered into the health app with personal information collected by other companies to create a more robust profile of individual customers.

The policy also gives Walgreens the right to change its privacy terms at any time and says customer data will be sold as an asset if Walgreens is acquired by another company.

All that concerns De Mooy, the consumer privacy advocate.

"It's becoming less and less possible to truly de-identify data, especially when it's at such a detailed personal level," she said. "When you're talking about really specific biometric information like your blood pressure or other metrics like that, the bar needs to be raised very high" in terms of data privacy, security, and transparency, she said.

Rite Aid, which recently agreed to be acquired by Walgreens, is testing out another way of trading perks for customer data. The drugstore is among a number of retailers — including Bloomingdale's, Whole Foods, and Nordstrom — that have installed stations where customers can securely store and charge their cell phones at no cost while they're shopping.

Rite Aid spokeswoman Kristin Kellum said the company has not collected or retained any customer information from the program, but that doesn't mean it can't in the future. The charging stations are designed to collect information from shoppers, including phone numbers, insurance plan benefits, and shopping preferences — with the free power source serving as enticement for volunteering the data.

"It's really important for the retailer to offer something in return for getting information," said Doug Baldasare, chief executive of the Philadelphia-based startup ChargeItSpot, which installs the phone-charging stations.

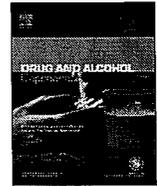
The pharmacy chain Duane Reade — a Walgreens subsidiary — is experimenting with another way to reach customers: tracking their physical locations through the GPS on their phones and then pushing out relevant promotions through an app. Duane Reade is testing the tactic in 10 of its New York City stores. Last year, Walmart said it was rolling out the technology in some of its stores, as well, but the company didn't respond to multiple requests for comment on how it's being used.

Customers don't even have to be in the stores to get targeted.

An older Walgreens app can beam smartphone users a notification offering them a discount when they're nearby a Walgreens location.

Every time Lipson goes to see his mother in Raleigh, N.C., he drives past a Walgreens and — once he's within the range of about a block — he gets a mobile notification hawking him a promotion via his Walgreens app. "Sometimes," he said, "I just want to turn it off."

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Full length article

Nonmedical opioid use and heroin use in a nationally representative sample of us high school seniors[☆]

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Background: Nonmedical use of opioids has become increasingly problematic in recent years with increases in overdoses, treatment admissions, and deaths. Use also appears to be contributing to heroin initiation, which has increased in recent years. Further research is needed to examine which adolescents are at highest risk for nonmedical use of opioids and heroin and to explore potential links between nonmedical opioid use and heroin use.

Methods: Data were analyzed from a nationally representative sample of American high school seniors in the Monitoring the Future study (2009–2013, Weighted $N = 67,822$). We examined associations between frequency and recency of nonmedical use of opioids and heroin. Sociodemographic correlates of use of each drug were also examined.

Results: 12.4% of students reported lifetime nonmedical opioid use and 1.2% reported lifetime heroin use. As frequency of lifetime nonmedical opioid use increased, so too did the odds for reporting heroin use, with over three-quarters (77.3%) of heroin users reporting lifetime nonmedical opioid use. Recent (30-day) nonmedical opioid use was a robust risk factor for heroin use and almost a quarter (23.2%) of students who reported using opioids ≥ 40 times reported lifetime heroin use. Black and Hispanic students were less likely to report nonmedical opioid or heroin use than white students, but they were more likely to report heroin use in absence of nonmedical opioid use.

Discussion: Recent and frequent nonmedical opioid use are risk factors for heroin use among adolescents. Prevention needs to be targeted to those at highest risk.

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1. Introduction

Nonmedical use of prescription opioids (i.e., narcotics, analgesics, pain killers) has become increasingly problematic in the US over the last decade. Although results from national surveys suggest prevalence of use has begun to decrease in recent years (Miech et al., 2015; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a), overdoses, emergency

department (ED) visits, treatment admissions, and deaths related to use have increased (Centers for Disease Control and Prevention (CDC), 2012; Chen et al., 2014; SAMHSA, 2013, 2014b). However, a new concern is that a subset of opioid users may be transitioning to heroin, which is often more likely to lead to deleterious outcomes. Research is needed to help identify adolescents at risk for nonmedical opioid and/or heroin use, and to delineate which opioid users are at highest risk for heroin use.

While medical use of opioids tends to be efficacious when used as prescribed to treat pain, nonmedical use – often through over-prescribing or diversion from doctors (Wang et al., 2014; Shei et al., 2015) – has become a major public health issue. From 2004 to 2011, ED visits involving prescription opioids increased by 183% (SAMHSA, 2013) and opioid-related admissions to substance abuse treatment centers increased from 2% in 2002 to 10%

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in 2012 (SAMHSA, 2014b). Results from National Vital Statistics demonstrate that the rate of opioid overdose deaths nearly quadrupled from 1999 to 2011, growing from 1.4 per 100,000 to 5.4 per 100,000 (Chen et al., 2014), and according to the CDC (2012), almost three out of every four prescription medication overdoses were associated with opioids. While the rate of increase in overdoses has slowed somewhat since 2006 (Chen et al., 2014), there is now concern that these decelerating rates of opioid-related deaths may be related to recent increases in heroin use, as individuals dependent on prescription opioids may be transitioning to heroin, which tends to be less expensive and more freely available (Cicero et al., 2014; Kanouse and Compton, 2015; Mateu-Gelabert et al., 2015). Heroin is among the most dangerous illicit drugs (Nutt et al., 2007; Gable, 2004) and use is associated with high rates of dependence, overdose, death, transmission of pathogens such as HIV and HCV, and social marginalization (Demaret et al., 2013; Hser et al., 2015; Hosztafi, 2011; Brown, 2015; Zhou et al., 2015). Heroin overdose deaths have increased since 2002, rising from 0.7 deaths per 100,000 to 2.7 deaths per 100,000 in 2013 (Jones et al., 2015). This rise was particularly dramatic from 2011 to 2013, when rates almost doubled.

Heroin user demographics appear to be shifting in the US. While rates of heroin initiation were similar between whites and non-whites decades ago (Cicero et al., 2014), now whites are at a higher risk for nonmedical prescription opioid use, as well as heroin use (Cicero et al., 2014; Fischer et al., 2008; Peavy et al., 2012; Pollini et al., 2011). While women previously used at substantially lower rates than men (Cicero et al., 2014), their use of opioids and transition to heroin is increasing, with prescription opioids appearing to serve as a stepping stone (Cotto et al., 2010). Furthermore, use of heroin is increasing (Cicero et al., 2015), particularly among individuals living in non-urban areas, whereas it used to be a predominantly urban phenomenon (Cicero et al., 2014). A recent analysis of the National Surveys on Drug Use and Health (NSDUH), a nationally representative sample of non-institutionalized individuals in the US, compared data from 2002–2004 to 2008–2010, and found that past-year heroin use increased among many sociodemographic groups, including whites, those with higher income and those with health insurance (Jones et al., 2015). Whites, young adults (age 18–25), and those with opioid abuse/dependence were also found to be at high risk for heroin use/dependence. Alarming, this recent study found that between 2002 and 2013 there was a 138% increase in heroin use among nonmedical opioid users. Other studies have also found that many heroin users have moved onto heroin after nonmedical opioid use (Lankenau et al., 2012; Peavy et al., 2012; Mateu-Gelabert et al., 2015). Nonmedical opioid users have been found to transition to heroin as they considered heroin more “practical” as it is reportedly less expensive and easier to acquire (Cicero et al., 2014; Mars et al., 2014), especially as availability is reduced due to abuse-deterrent formulations and prescription monitoring programs (Cassidy et al., 2014; Worley, 2012).

Nonmedical opioid use is associated with poor health outcomes such as opioid dependency, sexual violence, overdose, and death (Jamison and Mao, 2015; Frank et al., 2015; Jessell et al., 2015); however, moving onto heroin from prescription opioids appears to be a dangerous (and understudied) emerging pattern among younger populations. While studies focusing on national data have begun to examine associations between nonmedical opioid use and heroin use and dependence, more information is needed regarding frequency and recency of nonmedical opioid use as it relates to heroin use—in both a bivariable and multivariable manner. Assessing the risk factors associated with nonmedical opioid use, and how its use may increase risk for heroin use is critical to developing appropriate prevention, intervention, and harm reduction programming geared toward adolescents at highest risk. An examination of a nationally representative sample

of adolescents allows us to determine which subgroups of high school students are at highest risk for nonmedical opioid use and heroin use. This study examines the correlates of nonmedical use of opioids and heroin and examines how frequency and recency of opioid use relates to heroin use in a nationally representative sample of high school seniors.

2. Methods

2.1. Procedure

Monitoring the Future (MTF) is a nationally representative cross-sectional study of US high school students. Approximately 15,000 high school seniors (12th graders) are surveyed every year from approximately 130 public and private schools throughout 48 states. MTF uses a multi-stage random sampling procedure: geographic areas are selected, then schools within areas are selected, and then classes within schools are selected. Since the main outcome (heroin use) is rare, in order to have adequate power, this analysis focused on aggregated data collected from the five most recent cohorts with available data (2009–2013). MTF protocols were approved by the University of Michigan Institutional Review Board (IRB) and the authors' IRB deemed this secondary data analysis exempt from review.

2.2. Drug use

Students were asked about lifetime heroin use, and answer options were use on (1) 0 occasions, (2) 1–2 occasions, (3) 3–5 occasions, (4) 6–9 occasions, (5) 10–19 occasions, (6) 20–39 occasions, and (7) 40 or more occasions. Students were also asked about nonmedical use of opioids (“narcotics other than heroin”). They were first informed that, “There are a number of narcotics other than heroin, such as methadone, opium, morphine, codeine, Demerol, Vicodin, OxyContin, and Percocet. These are sometimes prescribed by doctors.” They were then asked, “On how many occasions (if any) have you taken narcotics other than heroin on your own—that is, without a doctor telling you to take them...in your lifetime?” They were also asked the same question with regard to use in the last 12 months and the last 30 days, with the same ordinal response options.

In order to examine frequency of use of opioids and heroin, we created a series of dichotomous variables indicating lifetime use (ever used; ≥ 1 times), and use ≥ 6 times, ≥ 10 times, and ≥ 40 times. Ordinal cutoffs were based on previous MTF studies that focused on use of other drugs (Boyd et al., 2015; Palamar and Acosta, 2015; Palamar et al., 2014a, 2015a,b). In order to examine recency of use, for both opioids and heroin we also created categorical variables (which were also examined as indicator variables) with the following categories: (1) no use, (2) lifetime use, but not 12-month use, (3) 12-month use, but not 30-day use, and (4) 30-day use.

2.3. Sociodemographic variables

Students reported their sex, age (public data predefined by MTF as <18 , ≥ 18 years) and race/ethnicity (i.e., black, white, Hispanic). Population density of students' residences were defined as non-, small-, or large-metropolitan statistical areas (MSAs). Small MSAs are counties or groups of counties with at least one city of $\geq 50,000$ inhabitants and the 24 largest MSAs are defined as large MSAs. Non-MSAs are the remaining areas. Level of religiosity was assessed via two ordinal items asking about level of religious attendance and importance. We computed these items into a composite and divided it into tertiles to indicate low (1.0–2.0), moderate (2.5–3.0) and high (3.5–4.0) religiosity. To assess family composition, we examined the number of parents students resided with. Answers were coded into two parents vs. no parents or one. Students were also asked about level of educational attainment of each parent and answer options were (1) grade school, (2) some high school, (3) high school graduate, (4) some college, (5) college graduate, and (6) graduate school. A mean score for both parents (or a raw score if only one parent) was coded into tertiles to represent low (1.0–3.0), medium (3.5–4.0), and high (4.5–6.0) education. Students were asked how much money they earn during the average week from (1) a job or other work, and (2) from other sources. Responses for each of these two items were coded into \$10 or less, \$11–50, or \$51 or more. Coding of sociodemographic variables was based on previous MTF analyses that focused largely on socioeconomic status (SES; Palamar et al., 2014b; Palamar and Ompad, 2014; Wallace et al., 2009).

2.4. Statistical analyses

Analyses focused on students with complete opioid and heroin use data (Weighted $N=67,822$; Unweighted $N=67,896$). We first examined descriptive statistics for all variables. We then examined how lifetime opioid use related to lifetime heroin use in a bivariable manner using Rao–Scott χ^2 tests (Rao and Scott, 1984). We examined potential differences between opioid frequency and recency and whether lifetime heroin use was reported (yes/no). We then repeated these computations, but to examine potential differences by heroin use ≥ 6 times, ≥ 10 times, and ≥ 40 times. To test if and how each level of opioid use relates to lifetime heroin use, we constructed two separate logistic regression models, controlling for all sociodemographic variables. Thus, each level of opioid use in both models

was compared to never-use. The bivariable tests were then repeated, but with the recency of heroin use variable as the outcome. Multivariable statistics were not possible with any heroin categories other than overall lifetime use as rates of more frequent or more recent use were very rare ($\leq 0.5\%$).

To further investigate correlates of use of opioids and heroin, we fit all sociodemographic variables into a multivariable logistic regression model to determine conditional associations (controlling for all variables in the model) between each variable and lifetime opioid use. The same model was repeated with (1) frequent opioid use (used ≥ 40 times), and (2) lifetime heroin use as the outcome. We considered lifetime opioid use and heroin use non-independent outcomes; therefore, we applied a Bonferroni correction ($\alpha = 0.05/2 = 0.025$) in order to reduce potential Type I Error. These models resulted in an adjusted odds ratio (AOR) for each covariate (in each model). Finally, within the heroin-using subsample we repeated this logistic regression model to examine potential correlates of the 22.7% who did not report nonmedical opioid use.

We controlled for potential cohort and/or secular trends in all multivariable models by entering indicator variables for cohort (with 2009 as the comparison). In addition, missing data indicators were entered into multivariable models for covariates with missing data instead of deleting these cases. For example, for the 14.4% who were missing race, an additional indicator was included to account for missing race (Palamar and Ompad, 2014; Terry-McElrath et al., 2013). Retaining these cases allowed us to maintain power and allowed rates to match published nationally representative MTF rates (Miech et al., 2015). All analyses were design-based for survey data (Heeringa et al., 2010) and sample weights were included. We used SAS 9.3 software (SAS Institute, 2011) for all analyses.

3. Results

Sample characteristics are presented in Table 1. Nonmedical opioid and heroin use are presented in Table 2. About 12% of the sample reported using opioids at least once and using it 1–2 times was most common among users. About one out of 100 students reported lifetime use of heroin.

Table 3 presents associations between level of lifetime opioid use and heroin use. We found that 7.5% of nonmedical opioid users reported ever using heroin, and the higher the frequency of opioid use, the higher the odds of reporting lifetime heroin use (with all else being equal). A dose-response was observed, with more frequent use being highly associated with heroin use. Using opioids ≥ 40 times was associated with an extreme increase in odds for lifetime heroin use (AOR = 88.05). With regard to recency of opioid use, more recent use (within the last 30 days) was most highly associated with lifetime heroin use (AOR = 44.01). Although we could not model more frequent heroin use, the raw percentages (displayed in Supplemental Table 1¹) suggest that more frequent and recent opioid use is also associated with more frequent heroin use (e.g., 3.3% of opioid users who reported using ≥ 40 times also reported using heroin ≥ 40 times). Supplemental Table 2² presents the same opioid variables, but by recency of heroin use. More frequent opioid use was associated with increases in all levels of recency of heroin use. More recent opioid use (specifically, 30-day use) was associated with recent (12-month or 30-day) use of heroin; 6.9% of those who used opioids in the last 30 days also reported using heroin in the last 30 days.

Table 4 presents conditional associations between covariates and opioid and heroin use. Females were at lower odds for opioid use (both infrequent and frequent use) and heroin use. While older students were not at risk for opioid use, they were in fact at increased odds for heroin use (AOR = 1.22, $p = 0.024$). Compared to white students, black and Hispanic students were less likely to report nonmedical use of opioids, especially more frequent use, yet protective effects were less robust for heroin use. With regard to population density, students residing in large MSAs were at low odds for reporting frequent nonmedical opioid use

Table 1
Sample characteristics (weighted $N = 67,822$).

Variable	Weighted N	(%)
Sex		
Male	32,339	46.7
Female	33,311	49.1
Missing	2172	3.2
Age (years)		
<18 Years	28,840	42.5
≥ 18 Years	38,675	57.0
Missing	307	0.5
Race		
White	40,215	59.3
Black	7598	11.2
Hispanic	10,228	15.1
Missing	9781	14.4
Population density		
Non-MSA	13,939	20.6
Small MSA	33,620	49.6
Large MSA	20,262	29.9
Religiosity		
Low	20,735	30.6
Moderate	14,538	21.4
High	15,992	23.6
Missing	16,557	24.4
Parent education		
Low	20,489	30.2
Moderate	18,741	27.6
High	25,644	37.8
Missing	2,947	4.3
Family composition		
0–1 Parents	22,254	32.8
2 Parents	18,195	26.8
Missing	767	1.1
Income from job		
\$10 or less	30,645	45.2
\$11–50	7320	10.8
\$51 or more	25,837	38.1
Missing	4019	5.9
Income from other source		
\$10 or less	35,222	51.9
\$11–50	21,243	31.3
\$51 or more	6462	9.5
Missing	4895	7.2

Note. MSA = metropolitan statistical area.

(AOR = 0.73, $p = 0.005$). Moderate and high levels of religiosity, and residing with two parents, was consistently protective against opioid use and heroin use. Parent education, however, had mixed results. Moderate education was a risk factor for ever-using opioids (AOR = 1.12, $p = 0.002$), but not for frequent use. Higher parent education, however, was a protective factor against heroin use (AOR = 0.72, $p = 0.002$). Higher weekly student income – especially from sources other than a job – was often a robust risk factor for opioid use, especially frequent use. Results were similar for heroin, but results were not as robust as they were for frequent opioid use.

Finally, focusing on the subsample of heroin users, we delineated correlates of not reporting lifetime nonmedical opioid use (as only 22.7% of heroin users did not report nonmedical opioid use). Controlling for all covariates, race/ethnicity was the only significant correlate of heroin use. Specifically, Blacks (AOR = 2.73, 95% CI: 1.26–5.95, $p = 0.011$) and Hispanics (AOR = 3.05, 95% CI: 1.68–5.53, $p < 0.001$) were at increased odds for reporting lifetime heroin use without ever using opioids.

4. Discussion

For a substantial number of individuals, especially young, white males, nonmedical opioid use is an important correlate of use of a more dangerous substance—heroin (Mateu-Gelabert et al., 2015; Peavy et al., 2012; Brands et al., 2005; Lankenau et al., 2012; Mars et al., 2014; Jones, 2013). Considering this alarming trend, it is

¹ Supplementary material can be found by accessing the online version of this paper at <http://dx.doi.org> and by entering doi: 10.1016/j.drugalcdep.2015.11.005.

² Supplementary material can be found by accessing the online version of this paper at <http://dx.doi.org> and by entering doi: 10.1016/j.drugalcdep.2015.11.005.

Table 2
Frequency and recency of nonmedical opioid and heroin use.

	Lifetime nonmedical opioid use		Lifetime heroin use	
	Weighted N	(%)	Weighted N	(%)
Used 0 times	59,419	87.6	67,002	98.8
Used 1–2 times	3121	4.6	388	0.6
Used 3–5 times	1684	2.5	102	0.2
Used 6–9 times	1005	1.5	70	0.1
Used 10–19 times	1009	1.5	55	0.1
Used 20–39 times	593	0.9	47	0.1
Used 40+ Times	993	1.5	157	0.2
Lifetime use, but not 12-month use	2815	4.2	365	0.5
12-Month use, but not 30-Day use	3292	4.9	216	0.3
30-Day use	2296	3.4	240	0.4

essential to determine the risk factors for nonmedical use of opioids and heroin use. Although longitudinal data would most adequately allow us to delineate correlates of transition to heroin, our study is among the first to elucidate and compare correlates of use of opioids and heroin among a sample of adolescents approaching adulthood. These findings add to a growing literature describing how nonmedical opioid use relates to heroin use in a large nationally representative sample.

We found that among students who did use opioids or heroin, “experimentation” (using only 1–2 times) was most common (for both drugs). However, the subset of students that had reported any nonmedical use of opioids was at increased odds for reporting lifetime heroin use. In fact, a dose-response was observed with students who reported more frequent opioid use being at greater odds of reporting lifetime heroin use. Frequent use (e.g., ≥ 40 times) was associated with an increase in odds of reporting heroin use by 8700% with all else being equal. In addition those students who reported recent use (in the last 30 days) were also much more likely to report heroin use. While temporality could not be determined, this study does confirm that nonmedical use – especially more frequent and recent use – is a robust correlate for heroin use.

Females were less likely to report use of opioids or heroin than their male counterparts. This finding was not fully consistent with the literature, which provides somewhat conflicting information about gender and opioid use in young people. An analysis of data from the NSDUH found that for young individuals, age 12 to 25 years, patterns of use were different by sex, with nonmedical use of prescription-type pain medications more frequent by females than males (Cotto et al., 2010). In a sample of individuals seeking treatment, Cicero et al. (2014) found that while men were more likely to seek treatment for opioids and heroin decades ago;

currently, men and women seek treatment at similar rates. However, our results were derived from a large nationally representative sample, and we examined associations using multivariable models that controlled for multiple demographic confounders.

Increased risk of heroin use was particularly distinct among white and male students, and these findings suggest that whites are at higher odds of using heroin than racial minorities. But, while black and Hispanic students are less likely to use heroin, they are more likely to use heroin without having used prescription opioids. Importantly, this seems to indicate a different pathway to heroin use by race/ethnicity. This is consistent with a study by Fischer et al. (2008) evaluating the differences between individuals who use heroin only or illicit prescription opioids only, which found that prescription opioid users were more likely to be white. Results from one study suggest it may be more difficult for black patients to obtain prescription opioids than white patients (Hausmann et al., 2013), and another study found that blacks and Hispanics are less likely to “doctor shop” compared to whites (Weiner et al., 2015). Peavy et al. (2012) also found that heroin injectors reporting opioid dependence prior to heroin were predominantly white, and national data shows that whites are more likely to receive treatment for opioids and heroin (SAMSHA, 2014b). Recent research suggests that many individuals who begin using heroin today do so after using or becoming dependent on prescription opioids (Mateu-Gelabert et al., 2015; Cicero et al., 2014; Jones, 2013; Lankenau et al., 2012; Mars et al., 2014; Peavy et al., 2012); thus, blacks and Hispanics do appear to be at lower risk for heroin initiation through the mechanism of prescription opioid dependence.

Thus, this study supports calls for efforts to prevent students from engaging in nonmedical use of prescription opioids in order

Table 3
Lifetime heroin use according to frequency and recency of lifetime nonmedical opioid use.

Lifetime Opioid Use	Raw percentages		Adjusted model	
	Ever used heroin		AOR	95% CI
0 Times	0.3		1.00	
1–2 Times	2.7		8.71	(6.41, 11.82)
3–5 Times	4.6		14.74	(10.78, 20.17)
6–9 Times	8.5		27.03	(19.05, 38.37)
10–19 Times	8.4		27.31	(19.80, 37.67)
20–39 Times	11.8		39.34	(27.54, 56.18)
40+ Times	23.2		88.05	(67.42, 115.00)
Ever used	7.5			
Lifetime opioid use	Ever used heroin		AOR	95% CI
Never used	0.3		1.00	
Lifetime use, but not 12-month use	5.5		17.12	(13.07, 22.43)
12-Month use, but not 30-Day use	4.9		15.36	(11.80, 20.01)
30-Day use	13.8		44.01	(35.01, 55.32)

Note. AOR = adjusted odds ratio (controlling for sex, age, race, population density, religiosity, family structure, parent education, weekly income from job, and weekly income from other sources); CI = confidence interval. All AORs presented are $p < 0.0001$.

Table 4
Logistic regression models delineating sociodemographic correlates of lifetime nonmedical opioid and heroin use.

	Lifetime opioid use (used ≥ 1 times)		Frequent lifetime opioid use (used ≥ 40 times)		Lifetime heroin use (used ≥ 1 times)	
	AOR	95% CI	AOR	95% CI	AOR	95% CI
Sex						
Male	1.00		1.00		1.00	
Female	0.79***	(0.75, 0.84)	0.59***	(0.50, 0.69)	0.57***	(0.48, 0.68)
Age (years)						
<18	1.00		1.00		1.00	
≥18	1.02	(0.96, 1.08)	1.11	(0.94, 1.30)	1.22*	(1.03, 1.45)
Race						
White	1.00		1.00		1.00	
Black	0.36***	(0.32, 0.41)	0.26***	(0.18, 0.39)	0.52***	(0.38, 0.73)
Hispanic	0.54***	(0.49, 0.60)	0.38***	(0.28, 0.54)	0.71*	(0.54, 0.93)
Population density						
Non-MSA	1.00		1.00		1.00	
Small MSA	1.04	(0.97, 1.12)	0.85	(0.71, 1.01)	1.20	(0.97, 1.48)
Large MSA	1.01	(0.93, 1.09)	0.73**	(0.59, 0.91)	1.12	(0.88, 1.43)
Religiosity						
Low	1.00		1.00		1.00	
Moderate	0.74***	(0.69, 0.80)	0.60***	(0.49, 0.74)	0.74***	(0.56, 0.91)
High	0.43***	(0.40, 0.47)	0.33***	(0.26, 0.43)	0.45***	(0.35, 0.59)
Family structure						
0–1 Parents	1.00		1.00		1.00	
2 Parents	0.70***	(0.66, 0.74)	0.67***	(0.57, 0.79)	0.56***	(0.47, 0.66)
Parent education						
Low	1.00		1.00		1.00	
Moderate	1.12**	(1.04, 1.21)	1.11	(0.92, 1.36)	0.80	(0.64, 0.99)
High	0.94	(0.87, 1.01)	0.85	(0.69, 1.04)	0.71**	(0.59, 0.89)
Weekly income from job						
\$10 or Less	1.00		1.00		1.00	
\$11–50	1.16**	(1.06, 1.28)	0.78	(0.57, 1.06)	1.40*	(1.05, 1.86)
\$51 or More	1.53***	(1.44, 1.63)	1.78***	(1.50, 2.12)	1.65***	(1.36, 2.01)
Weekly income from other source						
\$10 or Less	1.00		1.00		1.00	
\$11–50	1.48***	(1.39, 1.57)	1.80***	(1.50, 2.16)	1.27***	(1.03, 1.56)
\$51 or More	1.85***	(1.69, 2.03)	3.27***	(2.64, 4.04)	2.66***	(2.10, 3.38)

Note. The models contain all covariates presented in the table. MSA = metropolitan statistical area, AOR = adjusted odds ratio, CI = confidence interval. All models included cohort indicators and missing data indicators.

* $p < 0.025$.

** $p < 0.01$.

*** $p < 0.001$.

to prevent possible future heroin use. Such efforts may not be as effective for many racial/ethnic minority students, as previous non-medical opioid use does not appear to be a determinant of their heroin use. Thus, although black and Hispanic students are still at low risk for heroin use, prevention efforts may need to consider race/ethnicity as they appear to be taking a different pathway to heroin use than their white counterparts. Our findings also suggest that students who live in large cities had lower risk of frequent opioid use than those who live in non-MSAs. These findings are consistent with Cicero et al. (2014), who suggest that heroin users (who have largely started on prescription opioids) are now more likely to reside in less-urban areas and these individuals were also more likely to use opioids concurrently with heroin.

We also found that higher student weekly income is a risk factor for opioid and heroin use among high school seniors. This finding corroborated an analysis of the National Health and Wellness Survey, which also found that higher income was associated with opioid abuse (Vietri et al., 2014). Furthermore, other studies have found that student disposable income is a risk factor for adolescent use of alcohol, tobacco, hookah, marijuana, ecstasy (MDMA, "Molly"), synthetic marijuana, "bath salts", and cocaine (Martin et al., 2009; Scragg et al., 2002; Zhang et al., 2008; Palamar, 2015; Palamar et al., 2015a,b). This suggests that higher student income appears to be a common risk factor for various drugs, as income is often needed to pay for the drug. We have confirmed that this is no exception for opioids and heroin. However, we did find that higher

student income (from sources other than a job) was more robustly associated with frequent nonmedical opioid use than heroin use. More research is needed, but this might suggest that those with higher incomes can in fact afford high-frequency opioid use, as prescription opioids tend to be more expensive than heroin. However, it should be noted that Cerdá et al. (2015) found that income was not associated with transition from opioids to heroin in a sample of youth who reported nonmedical use of opioids at a young age; however, this measure was of family income as opposed to student disposable income.

4.1. Limitations

High school dropouts were not surveyed and this could have affected the generalizability of our findings. As these data are cross-sectional, it is not possible to determine temporal order or causality so we cannot rule out that in some instances heroin use may have taken place prior to use of other opioids. Multivariable analysis could not be utilized to examine more frequent (or recent) heroin use as an outcome as frequent and recent use was too rare. We used missing data indicators to maintain the full sample while including those with incomplete data. We compared analyses with the case-complete sample and the sample containing missing data indicators yielded similar results. Although, it should be noted that 1.9% of students ($N = 1288$) from the full dataset had to be excluded from analyses due to missing opioid and/or heroin data. Black and

Hispanic students, and students with highest income from sources other than a job were more likely to have been excluded due to missing opioid and/or heroin data, and females, students residing with both parents, and those with higher parent education were less likely to have been excluded due to missing opioid and/or heroin data (all $ps < 0.01$). Thus, it is possible that this systematic missingness may have biased results. MTF's definition of opioids ("narcotics other than heroin") contained a list of common opioids such as Oxycontin and Vicodin, but the list was not exhaustive, potentially leading to underreporting. The list included opium, a nonprescription opiate, as well as methadone, which is commonly used to treat addiction, and we were unable to select such cases out as there was no specific opium or methadone question. However, we note that methadone is also often diverted and used for nonmedical purposes (Ompad et al., 2008). Finally, family income data were not available. This is important to consider with respect to our findings related to students' income.

5. Conclusions

Increases in heroin use in the last decade may be related to opioid use and transition from opioid to heroin use, particularly among young, white, non-urban males. We found a dose-response indicating that greater frequency and more recent use of nonmedical opioids result in substantially greater odds of heroin use. Future interventions should be aimed at decreasing nonmedical opioid use among adolescents and young adults before initiation of heroin use, with special attention given to individuals who use opioids more frequently. Targeting this group may prevent future heroin initiation, and decrease the troubling trend in opiate-related deaths.

Author disclosures

Role of funding source

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Contributors

All authors are responsible for this reported research. J. Palamar conceptualized and designed the study, and conducted the statistical analyses. J. Shearston and E. Dawson drafted the initial manuscript. J. Palamar, P. Mateu-Gelabert, and D. Ompad helped draft the manuscript, interpreted results, and critically reviewed the manuscript. All authors reviewed and revised the manuscript, and all authors approved the final manuscript as submitted.

Conflict of interest statement

The authors declare no conflict of interest.

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Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at <http://dx.doi.org/10.1016/j.drugalcdep.2015.11.005>.

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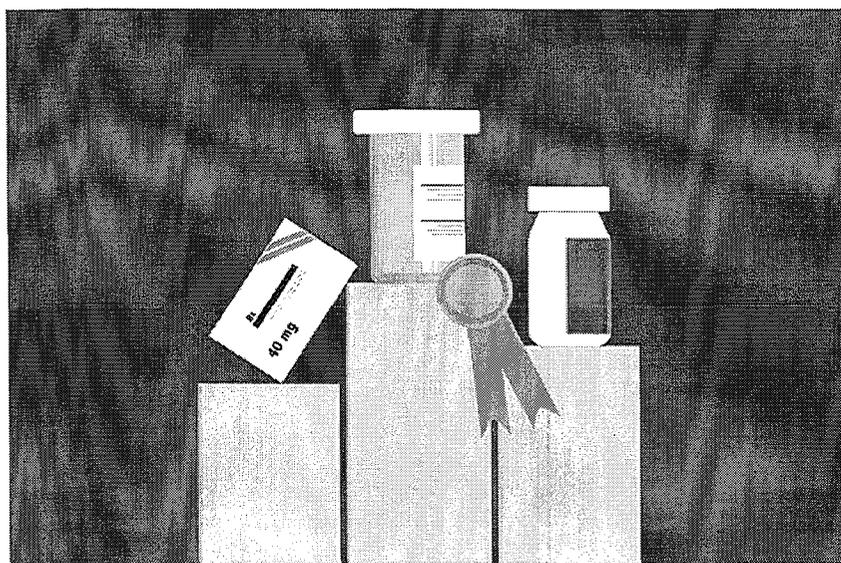


The Prescribers
Inside the Government's Drug Data

Brand-Name Drugs Increase Cost But Not Patient Satisfaction

As presidential candidates focus more on drug prices, new data from the website Iodine shows that generics scored highest among users in three popular drug categories. ProPublica has teamed up with Iodine to add user reviews to our Prescriber Checkup tool.

by Charles Ornstein
ProPublica, Nov. 19, 2015, 1:59 p.m.



(Emily Martinez/ProPublica)

This story was co-published with NPR's Shots blog.

In recent days, presidential candidates and even the American Medical Association have griped about rising drug prices, pointing to brand-name blockbusters with splashy ad campaigns.

When it comes to patient satisfaction, however, there isn't much difference between brands and generics, according to data collected by the website Iodine, which is building a repository of user reviews on drugs.

ProPublica has teamed up with Iodine, which launched last year, to add data from reviews to our Prescriber Checkup tool, which allows users to see their doctors' prescribing habits in the Medicare Part D program and compare them with others in the same specialty

Prescriber Checkup

Medicare's popular prescription-drug program serves 39 million people and pays for more than one of every four prescriptions written nationwide. Use this tool to find and compare doctors and other providers in Part D in 2013. [Explore the app](#)

and state. Our drug pages (take, for example, the antipsychotic Abilify) will now include consumers' user reviews, usage statistics by state and a listing of the top prescribers in the country.

"What is it actually like to take these medications?" asked Thomas Goetz, Iodine's co-founder and chief executive. "That is the nub of what we're trying to measure...The fact that a drug is a brand drug or a generic drug, for us, is immaterial to the patient experience."

ProPublica compared the reviews of brands and generics in three drug categories: antipsychotic medications that treat schizophrenia, antidepressants, and drugs that lower cholesterol. Iodine asks people if a drug is worth it, whether it's a hassle to take and if it works well. For each category of drug, a generic scored best on each of the three questions.



Dr. Joseph Ross, an associate professor of medicine and a health policy researcher at Yale University School of Medicine, said he wasn't surprised that patient reviews of generic and brand-name medications were similar.

"Generic medications are manufactured to be equivalent in all ways (except appearances) to brand-name medications," he said in an e-mail. "Unfortunately, many patients and physicians are convinced to spend more and use the brand-name medication by marketing initiatives, including advertisements on the television or drug coupons that promise similar out-of-pocket expenses for the higher-cost brand-name medications."

Consider antidepressants. Most drugs in the class, including Prozac, Celexa and Zoloft, are now available as generics and cost under \$20 for 30 pills at Costco. By comparison, the brand-name drug Pristiq, manufactured by Pfizer, has a cash price of about \$283 for 30 pills. (Those with insurance pay less, but probably still more than for a generic.) Pristiq fares worse in satisfaction than many of the cheaper alternatives.

Pfizer spokesman MacKay Jameson said that depression manifests itself differently in different people, meaning treatment effectiveness may vary, too.

"Patients should work with their doctors to determine whether to use an antidepressant and, if so, which type of medication might be best for them," he said in an e-mail. "Any treatment of depression or anxiety disorders, whether it's medication or otherwise, must be monitored carefully by a qualified health care professional."

A similar phenomenon plays out for cholesterol-lowering drugs, known as statins. Zocor and Lipitor are now available as generics and are inexpensive. The drug Crestor, made by AstraZeneca, continues to have patent protection and costs more than \$230 for 30 pills at Costco. (Again, insurance discounts would lower that price.) Crestor's user satisfaction score was about the same as the generic alternatives.

AstraZeneca spokeswoman Michele Meixell said not all statins are alike. "The efficacy and safety of Crestor has been studied in more than 120 ongoing [or] completed trials and more than 67,000 patients worldwide over the past 13 years," she said in an e-mail. "Crestor is one of the two high intensity statins available and AstraZeneca believes it's a clinically important option for many patients, who are unable to reach their cholesterol goal with diet and exercise alone."

Brand Names, Generics Have Similar Satisfaction

Based on user reviews on the website Iodine, generic drugs performed similarly, if not better than, their brand-name counterparts. Note: Some of the drugs have many more reviews than others.

Percentage of Patients Who Say Drug Is 'Worth It':

Generic cholesterol drugs

Both Pfizer and AstraZeneca noted that patients can receive discounts from the company.

Some drugs have many more Iodine reviews than others, which may affect the results. All told, Goetz said Iodine has reviews from more than 100,000 Americans covering the approximately 500 drugs in its database.

Goetz said he doesn't know why generics sometimes have higher satisfaction than brand-name drugs, but he offered one theory. "People might have outsize expectations for what a heavily marketed drug is going to do for them," he said. "They may watch the commercials and think that any given drug is going to be the answer to all their problems. And the reality of medicine and the reality of pharmacology is that every drug has some benefits for some people and some side effects for some people, and that's the whole balance."

Generics may have another advantage over newly launched drugs in the same class. By definition, a generic has been on the market a long time, so doctors know how it works, and any major problems or side effects would have already surfaced. By comparison, the studies that help brand-name drugs win approval may not have picked up safety problems or side effects that, while uncommon, can represent an issue once a medicine is taken widely.

Questions about cost and quality are likely to intensify. This week, the AMA called for a ban on direct-to-consumer advertising of drugs and medical devices. AMA board chair-elect Patrice A. Harris cited "concerns among physicians about the negative impact of commercially-driven promotions, and the role that marketing costs play in fueling escalating drug prices."

Ross, the Yale researcher, said eventually the costs of brand-name medications "will catch up with us, either in the form of higher out-of-pocket payments once the coupons run out or higher health insurance premium costs."

And, he added, "just because something is more expensive in health care does not mean it works better or is safer."

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Pravastatin (Pravachol)	54
Lovastatin (Mevacor)	43
Simvastatin (Zocor)	60
Atorvastatin (Lipitor)	64

Brand-name cholesterol drugs

Crestor	61
Vytorin	51
Antara	24
Zetia	41

Generic antidepressant drugs

Fluoxetine (Prozac)	59
Duloxetine (Cymbalta)	61
Bupropion (Wellbutrin)	55
Citalopram (Celexa)	58
Sertraline (Zoloft)	57
Escitalopram (Lexapro)	58
Venlafaxine (Effexor)	60

Brand-name antidepressant drugs

Oleptro	47
Pristiq	38

Source: Iodine. Data collected on Nov. 18, 2015.

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Newsroom

Sticking With It

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"The biggest challenge in health care today isn't lack of new drugs or their cost — it's simply getting patients to adhere to taking their current medications," says Adah Almutairi, PhD, associate professor in the Skaggs School of Pharmacy and Pharmaceutical Sciences and director of the Center for Excellence in Nanomedicine at UC San Diego.



People usually don't remember or want to take a pill every day and that's a big hurdle to researchers like Almutairi, who are developing new therapeutics for a variety of diseases. "We can have the most brilliant idea, but if a patient won't or can't do it, we have to go back to the drawing board," she says.

How big is the problem? According to the American Medical Association (AMA), approximately one-quarter of new prescriptions are never filled, and patients take their

medications as prescribed roughly 50 percent of the time.

That adds up to more than \$300 billion in preventable hospital costs related to failure to take medications as directed, says Jonathan Watanabe, PharmD, PhD, assistant professor of clinical pharmacy in the Skaggs School of Pharmacy.

Lack of medication adherence is a burden, says Watanabe, who studies factors that keep patients prescribed cholesterol-lowering statins from taking them, because "doctors and pharmacists often assume patients are taking

never really know how well the original drug and dose could have worked if taken properly.”

Just plain forgetting

Often times a person isn't intentionally forgoing medication – we all forget sometimes. How can you make sure you take your medication on time, every time? Watanabe has a few simple tricks:

Make it a habit – always do something else at the same time you take your medication, eating dinner, for example.

Set a recurring alarm or calendar alert on your cell phone.

Organize your pills in labeled pill boxes or opt for medications in blister packs — once the pills are laid out, you always know what you've already taken or need to take.

If it can be done safely, keep your medications out in a place where you can't miss them — on top of your laptop, for example, where you are forced to pick up the bottle in order to open it.

Even if taking your medication on time, every time isn't always realistic, every bit counts. “There's a big difference between 80 and 90 percent adherence,” Watanabe says. “Moving the needle up just a little bit can translate into big clinical improvements.”

Intentional nonadherence



In a recent report, the AMA outlined eight reasons patients intentionally fail to fill their prescriptions or take their medications. These include fear of potential side effects, cost, misunderstanding (as in misunderstanding the need for medication, nature of side effects and time necessary to see results), too many medications, lack of symptoms, concerns about becoming dependent on

medication, depression and mistrust of the doctor's motivations behind the prescription.

“We find that simply getting to the pharmacy to get a prescription filled is huge barrier for a lot of patients,” Watanabe says. “We can greatly increase the likelihood a patient will take their medications if we can at least shorten the time interval between doctor's visit and pharmacy visit. That's why clinics that include an on-site pharmacy can be very effective. We also use free samples, vouchers and cheaper medication copayments to try to boost adherence to starting a new medication.”

Education is also a key factor in helping patients stick to their drug treatments plans, Watanabe says. “It's not as simple as handing over a prescription. There needs to be a dialogue between patient and doctor or pharmacist. Patients should feel empowered to ask questions and take the time to truly understand what the medication is, what it will do and what they can expect in terms of side effects. This is especially important for the so-called ‘silent syndromes’ — conditions such as hypertension and high cholesterol, where the patient doesn't experience symptoms and so it can be easy to forget why it's important to take those types of medications.”

The future of pharmacy

medications in an average patient visit. Pharmacists like him are now increasingly filling that gap, acting as a new type of primary health care provider. In 2014, California became the fourth state to allow pharmacists to initiate and monitor a patient's drug therapy, rather than simply fulfill a doctor's prescription.

More pharmaceutical advances are on the horizon. Watanabe says that pharmacists are trying to make drug regimens less complicated and lessen the "pill burden" with combination pills. They are also trying to reduce redundancies, so patients can take fewer medications and save money. Technological advances may help, too — "smart" pill dispensers can monitor a patient's adherence in real time, for example.

Watanabe sees a future where doctors and pharmacists treat adherence like its own syndrome — a condition that needs to be fully recognized and remedied, just like anything else.

Meanwhile, Almutairi hopes researchers will eventually be able to take the patient out of the equation entirely.

"I want to find ways to have patients see a doctor or pharmacist just once a year to get their drugs administered, then they can forget about it while an implanted device continues to release the right doses and the right time," she says. "Taking medications should be like paying bills — it used to be time intensive, but now we set up autopay and forget about it."

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