CALL TO ACTION

Responding to New Hampshire's Prescription Drug Abuse Epidemic

A publication of the New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment

January 2012

Letter from the Commission

The Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment (hereafter referred to as "the Commission") was established by the state legislature in 2000, with its membership and duties articulated in RSA 12-J:4. These duties include the following:

- Developing and revising as necessary a statewide plan for the effective prevention of alcohol and drug abuse, particularly among youth; and a comprehensive system of intervention and treatment for individuals and families affected by alcohol and drug abuse;
- In partnership with the NH Department of Health and Human Services, overseeing disbursement of the Alcohol Abuse Prevention and Treatment Fund;
- Promoting collaboration between and among state government agencies and communities to foster the development of effective community-based alcohol and drug abuse prevention and treatment programs;
- Promoting the development of treatment services to meet the needs of citizens addicted to alcohol or other drugs; and
- Identifying unmet needs and identifying the resources required to reduce the incidence of alcohol and drug abuse in NH and to make recommendations to the Governor regarding legislation and funding to address such needs.

In its ongoing surveillance of substance use issues in the state, the Commission has noted the epidemic of prescription drug abuse as a public health crisis in New Hampshire, with an alarming increase in prescription drug related deaths now outpacing traffic fatalities in the state. Crimes related to prescription drug abuse are also on the rise, including theft and illegal distribution. Such abuse has both economic and social costs that are a burden to local communities and the state as a whole.

Over the past year the Commission has led an effort to respond to the crisis through the development of this comprehensive strategy document. This effort dovetails with similar work on the federal level, which was articulated by the Office of National Drug Control Policy (ONDCP) in its report, *Epidemic: Responding to America's Prescription Drug Abuse Crisis.* Gil Kerlikowske, Director of ONDCP, joined the Commission in October to review and comment on recommendations proposed in the New Hampshire *Call to Action,* along with stakeholders from law enforcement, health care, education, local and state government and business.

The Commission thanks the many stakeholders – both local and national – who participated in focus groups, convenings, and other efforts to gather data and develop this strategy document. Particular thanks goes to the New Hampshire Center for Excellence in Substance Abuse Prevention and Treatment, a co-funded initiative of the New Hampshire Bureau of Drug and Alcohol Services, the Commission and the New Hampshire Charitable Foundation, for their leadership in facilitating the strategy development process and producing this document for dissemination to the public.

The Commission looks forward to working with these stakeholders, the Legislature and the Governor's Office to ensure effective implementation of the recommendations contained herein. We are fortunate as a state to have seen local communities and others already begin implementation of a number of initiatives and policy efforts that we recommend here, but there remains much work to do to ensure we can turn the tide of this epidemic and reduce the negative economic and social impact prescription drug misuse and abuse has on our state.

We hope you will join us in responding to this *Call to Action*.

Timothy R. Rourke, Chairman

Joseph P. Harding, Executive Director

Executive Summary

New Hampshire's awareness of and response to the threat of prescription drug abuse began as early as 2004, when prescription drug-related deaths were on the rise and state agencies began to make policy changes in response to the emerging threat. In spite of these important strides, increased marketing and accessibility of prescription drugs, low perceptions of the risks associated with the misuse and abuse of prescription drugs, and a rise in prescription drug fraud have overtaken these early and isolated efforts.

According to the most recent data available, the number of deaths in New Hampshire attributable to drug-related deaths – the majority of which are prescription drug-related – has outnumbered traffic related fatalities in four out of the last five years, and the New Hampshire rate of young adults reporting nonmedical use of pain relievers in the past year is second highest among the states and territories.

These alarming statistics prompted the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment to lead a year-long effort to mine federal, national, state and local recommendations in order to develop a comprehensive action plan to respond to the threat in a more timely and comprehensive manner.

The assessment and planning work of the Commission and its task forces during 2011 led to key recommendations, including the following:

- Increase professional development and training within and across multiple sectors
- Improve prescribing, dispensing, storage, disposal and enforcement practices and policies
- Increase surveillance and monitoring at the individual (patient) and system level (population data)
- Increase public education and awareness (including patient education)

The Commission has engaged state agencies and regulatory authorities to support community stakeholders within health, safety, education, business and government sectors to consider and carry out the recommendations within this *Call to Action*. In so doing, the Commission seeks to reduce drug-related deaths and nonmedical use of pain relievers by 15% over the next five years to protect the safety and health of our citizens from the threat of prescription drug abuse.

Endorsers

This document is endorsed by the New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment whose mission by statutory obligation and professional commitment is to significantly reduce alcohol and drug problems and their behavioral, health and social consequences for the citizens of New Hampshire by advising the Governor regarding policy, funding and the delivery of effective, efficient, coordinated alcohol and drug abuse prevention, intervention, treatment, and recovery services.

Through the development, endorsement, dissemination and implementation of the enclosed plan to prevent and reduce prescription drug misuse and abuse, we serve our collective mission and the well-being of New Hampshire citizens.

Timothy Rourke
Commission Chair
New Hampshire Charitable Foundation

Joseph P. Harding
Commission Executive Director
New Hampshire Department of Health and Human Services, Bureau of Drug and Alcohol Services

Betsy Abrahams
Executive Director
Nashua Youth Council

Virginia Barry, PhD
Commissioner
New Hampshire Department of Education

John J. Barthelmes
Commissioner
New Hampshire Department of Safety

Thomas DeBlois
District #18 Senator
New Hampshire Senate

Michael A. Delaney
Attorney General
New Hampshire Department of Justice

Amelie Gooding
Director
Phoenix House Keene

Warren Groen
District #1 (Strafford) Representative
New Hampshire General Court

Honorable Edwin W. Kelly
Administrative Justice
New Hampshire Administrative Office of the Courts

Molly Kelly
District #10 Senator
New Hampshire Senate

Joseph Mollica
Chairman
New Hampshire Liquor Commission

Lisa Peakes
Executive Director
Friends of Recovery New Hampshire

Major General William N. Reddel, III
Adjutant General
New Hampshire National Guard

Stephanie Savard
Executive Director
Families in Transition

Dino A. Scala
District #5 (Carroll) Representative
New Hampshire General Court

Kathleen Taylor
New Hampshire General Court (former)

Nicholas A. Toumpas
Commissioner
New Hampshire Department of Health and Human Services

William L. Wrenn
Commissioner
New Hampshire Department of Corrections

Contributors

In addition to Commission members and the members of the Prevention Task Force of the Commission who initiated the plan's development, the following individuals provided significant time, expertise, consultation and contribution in the development and design of New Hampshire's response to prescription drug misuse and abuse. The Commission extends its deepest appreciation for their contributions.

Dr. Thomas Andrew
Chief Medical Examiner
New Hampshire Department of Justice

Trooper Marc Beaudoin
Investigator
New Hampshire Department of Safety
Drug Diversion Unit

Kathryn Bradley
Executive Director
New Hampshire Medical Society

Lisa Bujno
Administrator
New Hampshire Department of Health & Human Services, Division of Public Health Services

Karin Eckel
Assistant Attorney General
New Hampshire Department of Justice

Eddie Edwards
Director
New Hampshire Division of Liquor Enforcement

Rona Glines
Director of Physicians' Office Practice
Weeks Medical Center

Helen E. Hanks
Director of Medical & Forensic Services Division
New Hampshire Department of Corrections

Dr. Jonathan Huntington
Physician
Dartmouth-Hitchcock Medical Center

Tricia Lucas
Director of Advocacy
New Futures

Michael McAlister
Director of Field Services Division
New Hampshire Department of Corrections

Janet Monahan
Executive Director
New Hampshire Medical Society

James Queenan
Executive Director
New Hampshire Board of Pharmacy

Eric Riera
Director
New Hampshire Bureau of Behavioral Health

Patricia Rogers
Corporate Compliance/Risk Management
Weeks Medical Center

Dr. Seddon Savage
Director- DCARE
Dartmouth College Medical School

Chris Shambarger
Investigator
New Hampshire Department of Safety
Drug Diversion Unit

Jonathan Stewart
Regional Director
JSI Research & Training Institute

Major Michael Terry
Commander
New Hampshire National Guard
Counterdrug Task Force

Michael Vrakatitsis
Intelligence Analyst
U.S. Drug Enforcement Agency

Dr. Margaret Walker
Executive Director
New Hampshire Board of Nursing

Table of Contents

Introduction **1**

A Nation's Epidemic **3**

New Hampshire's Epidemic **5**

State Priorities **7**

Recommendations for Action **9**

- Health & Medical 13
- Safety & Law Enforcement 29
- Education 39
- Business 47
- Government 55
- Special Populations 67

Commitments to Action **73**

- Adjutant General of the New Hampshire National Guard 77
- New Hampshire Office of the Attorney General 79
- New Hampshire Board of Medicine 81
- New Hampshire Board of Pharmacy 83
- New Hampshire Bureau of Drug & Alcohol Services 85
- New Hampshire Department of Corrections 87
- New Hampshire Department of Education 89
- New Hampshire Department of Safety 91
- New Hampshire Division of Liquor Enforcement 93
- New Hampshire Division of Public Health Services 95
- New Hampshire Medical Society 97

Endnotes **99**

Appendices **102**

Introduction

The misuse and abuse of prescription drugs has become a leading cause of harm among New Hampshire adults, resulting in more deaths each year than those caused by car crashes. The rise of prescription drug abuse is rooted in multiple contributing factors, including increasing availability and accessibility, a misperception of low risk of harm relative to other illicitly obtained drugs, direct to consumer marketing of prescription medications, and a lack of education about the potential risks of misusing or abusing prescription drugs, including the risk of addiction and death.

Prescription medications include a wide range of abusable drugs, including opioids (for pain), central nervous system depressants (for anxiety and sleep disorders), and stimulants (for attention deficit disorder and narcolepsy).

CLASSES OF COMMONLY ABUSED PRESCRIPTION MEDICATIONS

OPIOIDS	CENTRAL NERVOUS SYSTEM DEPRESSANTS		STIMULANTS
hydrocodone / Vicodin® oxycodone / OxyContin® propoxyphene / Darvon® hydromorphone / Dilaudid® meperidine / Demerol® diphenoxylate / Lomotil®	Benzodiazepines: diazepam / Valium® alprazolam / Xanax® triazolam/Halcion® estazolam/ProSom® clonazepam/Klonopin®	Barbituates: pentobarbital sodium/ Nembutal® mephobarbital/Mebaral® phenobarbital /Luminal Sodium®	dextroamphetamine / Dexedrine® methylphenidate / Ritalin® & Concerta® amphetamines / Adderall® 

The most potent and addictive medications being prescribed are opioid pain relievers such as oxycodone. Opioids play a critical role in the quality of life for those with acute and/or chronic pain; however, it is imperative that prescribers and patients alike are aware of their potential harm.

According to the National Institute on Drug Abuse (NIDA) at the National Institutes of Health, *opioids* used in the treatment of pain pose several risks[1]:

ADDICTION Prescription opioids act on the same receptors as heroin and therefore can be highly addictive. People who abuse them sometimes alter the route of administration (e.g., snorting or injecting vs. taking orally) to intensify the effect; some even report moving from prescription opioids to heroin.

OVERDOSE Opioid abuse, alone or in combination with alcohol or other drugs, can depress respiration and lead to death. Overdose is a major concern, as the number of fatal poisonings involving prescription pain relievers has more than tripled since 1999.

HEIGHTENED HIV RISK Injecting opioids increases the risk of HIV and other infectious diseases through use of unsterile or shared equipment.

NIDA also has articulated the risks associated with the misuse or abuse of other prescription *central nervous system* (CNS) *depressants* used to treat anxiety and sleep disorders:

> **ADDICTION & DANGEROUS WITHDRAWAL SYMPTOMS** CNS depressants are addictive and, in chronic users or abusers, discontinuing them without a physician's guidance can bring about severe withdrawal symptoms, including life-threatening seizures.
>
> **OVERDOSE** High doses of CNS depressants can cause severe respiratory depression. This risk increases when CNS depressants are combined with other medications or alcohol.

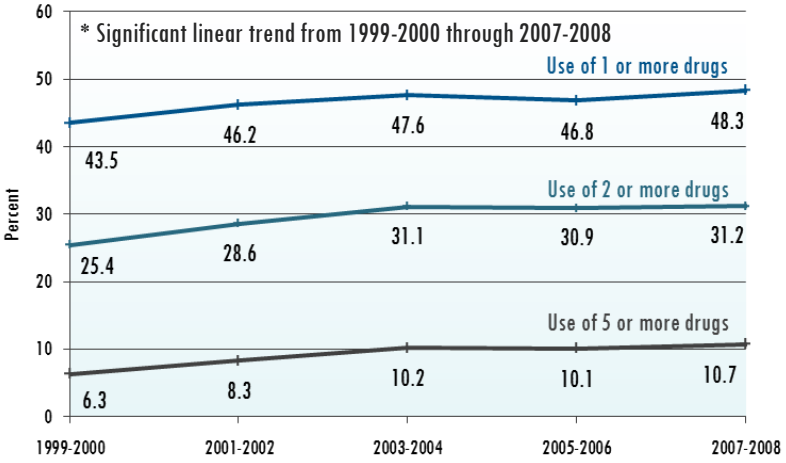
Stimulants used to treat attention deficit disorder and narcolepsy also pose risks including addiction, seizures, psychosis and cardiovascular complications.

Although swift and comprehensive action is necessary to prevent and reduce prescription drug misuse and abuse, it is imperative that critical pain treatment and medication management remain accessible to those for whom these medications are therapeutic and life-saving.

A Nation's Epidemic

National data show the quantity of medications made available through valid prescriptions steadily increasing since the 1990's, increasing overall accessibility and the potential for misuse and abuse. According to the White House Office of National Drug Control Policy, the milligram-per-person use of prescription opioids per year in the U.S. increased from 74 milligrams to 369 milligrams between 1997 and 2007, an increase of 399% in ten years,[2] and pharmacies dispensed 83 million more opioid prescriptions in 2009 compared to 2000, an increase of 48%.[3] According to a 2008 study by the International Narcotics Control Board, the United States consumes 99 percent of the world's hydrocodone and 83 percent of its oxycodone.[4]

Trends in the percentage of persons using prescription drugs (1999-2008)

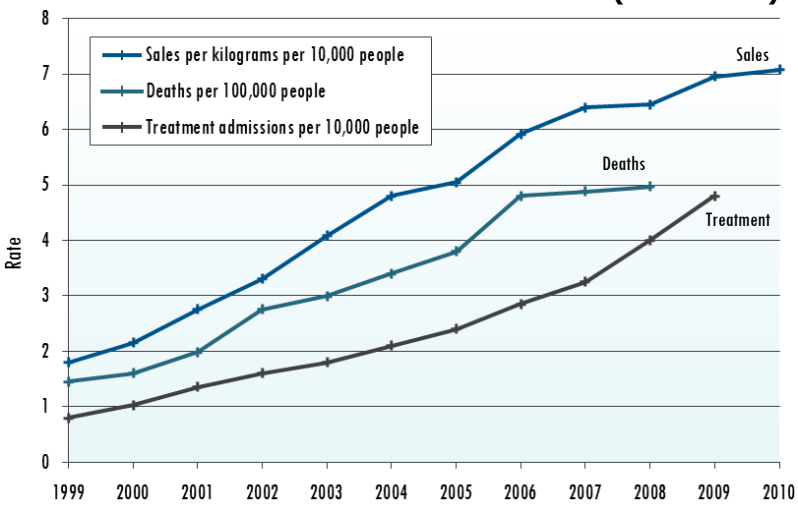


Source: CDC/NCHS, National Health and Nutrition Examination Survey

Note: Age adjusted by direct method to the year 2000 projected U.S. population

Increases in availability and accessibility have also led to drug-seeking crimes, referred to as "diversion", which include but are not limited to forged prescriptions, theft, and doctor shopping – the practice of contacting multiple doctors for the purpose of acquiring prescription medications for abuse or illicit resale. As prescribing has increased, there have been similar increases in the prevalence of fatal prescription overdoses and in the prevalence of treatment admissions for prescription painkiller abuse and dependence.

Rate of prescription painkiller sales, death and substance abuse treatment admissions (1999-2010)



The annual milligram-per-person use of prescription opioids in the U.S. increased

399%

from 1997 to 2007.

Source: White House Office of National Drug Control Policy

Sources: National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 1999-2010; Treatment Episode Data Set, 1999-2009

In response to the growing problem nationally, the Executive Office of the President of the United States issued a briefing in April 2011 titled, *Epidemic: Responding to America's Prescription Drug Abuse Crisis,* which encourages states to develop an effective response to "the Nation's fastest-growing drug problem". The briefing characterized prescription drug misuse as an epidemic based on the following indicators:

One in three people aged 12 and over who used drugs for the first time in 2009 began with the use of a prescription drug for nonmedical purposes;[5]

In 2008-2009, over 70% of those who abused pain relievers reported getting them from friends or relatives while 5% obtained them from a drug dealer or the internet;[6]

Prescription drugs are second only to marijuana as the most prevalent drug of abuse;[7]

Illicit drug abuse, particularly prescription drug abuse, among the military increased from 5% to 12% between 2005 and 2008;[8]

In 2009, retail pharmacies dispensed 48% more prescriptions for opioid pain relievers than in 2000;[9]

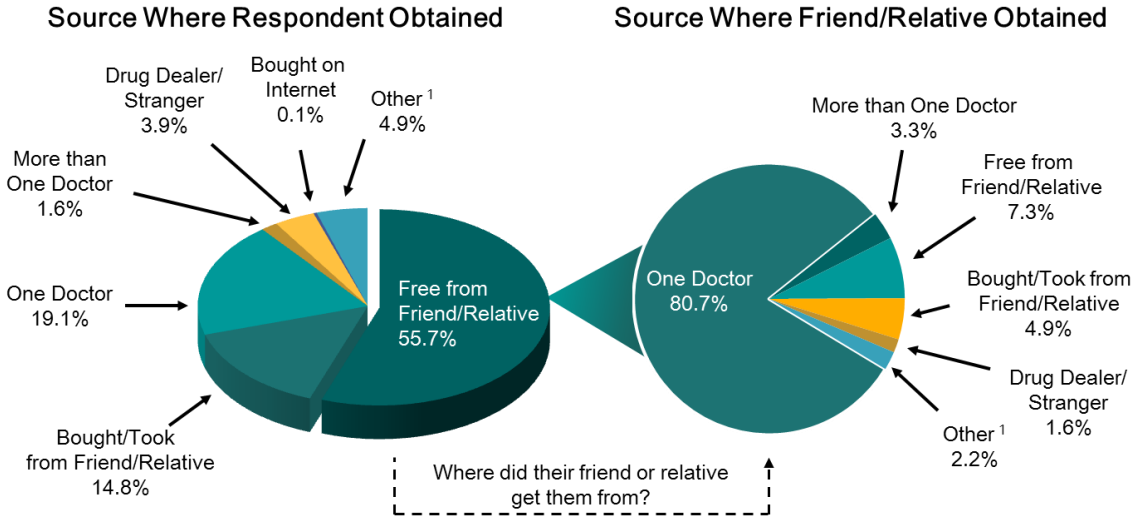
Opiate overdoses are increasing due to abuse of prescription pain relievers;[10]

Overall, opiates represent three-fourths of all prescription drugs being abused.[11]

Opiates represent **3/4** of all prescription drugs being abused.

Source: Epidemic: Responding to America's Prescription Drug Abuse Crisis

Source Where Pain Relievers Were Obtained for Most Recent Nonmedical Use Among Past Year Users Aged 12 or Older: 2010



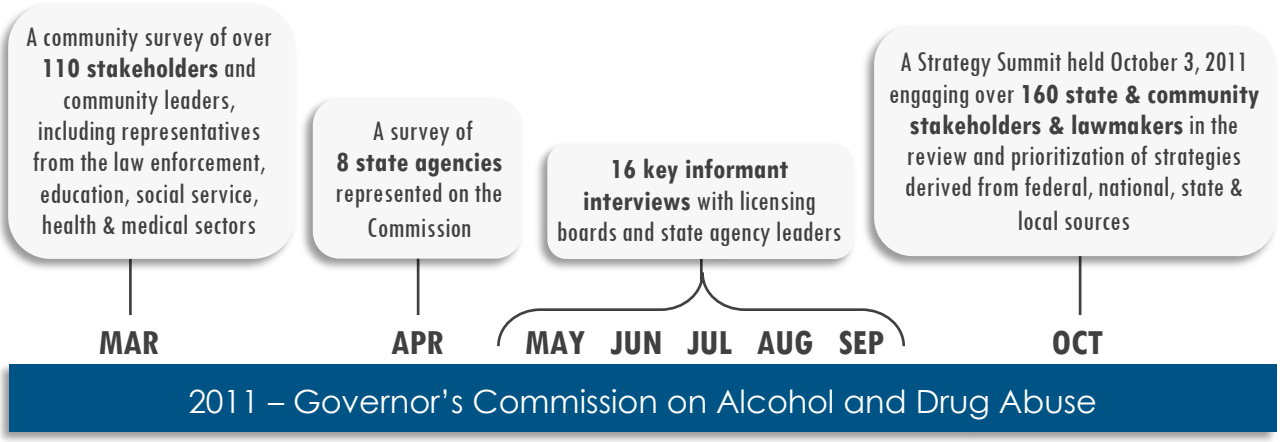
Note: Totals may not sum to 100% because of rounding or because suppressed estimates are not shown.

Source: NSDUH 2006[12]

New Hampshire's Epidemic

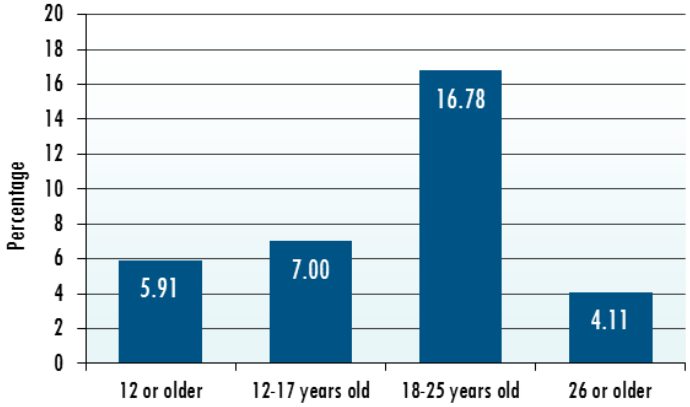
The most telling indicator of New Hampshire epidemic is the steady increase in total drug-related deaths since 2000, with the majority of the increase attributable to prescription drug overdose. The number of drug-related overdose deaths in the state increased substantially between 2002 and 2010, more than doubling from 80 deaths to 174 over the eight year period. Prescription opioids are the most prevalent drug of abuse leading to death.[13]

With such a devastating toll already evident in the state, the Commission initiated a community- and state-level assessment of the scope and severity of the threat, of current efforts to address the negative impacts affecting many aspects of public safety and health, and of opportunities for community- and state-level response and action. This assessment process, undertaken by the Commission and its prevention task force, is described below and is the genesis of this publication.



In addition to information derived through stakeholder engagement, quantitative data accessed by the Commission includes state-level data from the Youth Risk Behavior Survey, the National Survey on Drug Use and Health, the Client Event Data Set of state-funded treatment providers, Mental Health Intake Screening data of state corrections populations, and cause of death statistics from the New Hampshire Medical Examiner's Office. A summary of key findings from these data sources is provided as context for the Commission's *Call to Action*.

Past year nonmedical use of pain relievers by age groups in NH



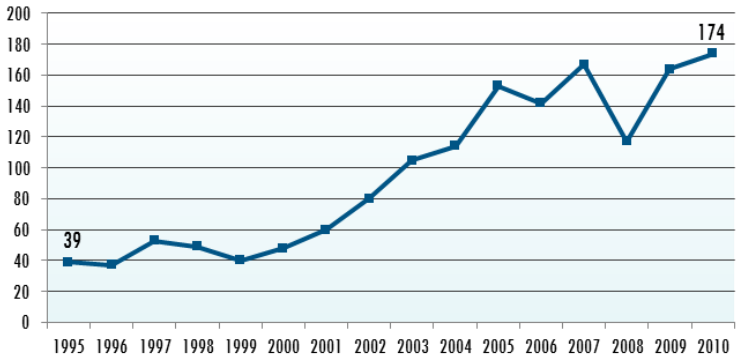
Source: 2008-2009 NSDUH [14]

According to the 2008-2009 National Survey on Drug Use and Health, New Hampshire's young adults are abusing pain medication at a significantly higher rate than young adults nationwide (NH =16.78% vs. US=11.94%); New Hampshire's rate of nonmedical use of pain relievers by 18 to 25 year olds is the second highest among the states and territories.

Between 2008 and 2010, the percentage of individuals entering state-funded substance abuse treatment for oxycodone increased by over 60%, from 11.6% of patients in 2008 to 18.7% of patients in 2010, while admissions for alcohol, cocaine, marijuana, and heroin either decreased or stayed the same. In 2010, oxycodone also became the second most prevalent drug of abuse after alcohol among those entering state-funded substance abuse treatment.[15]

According to the New Hampshire Medical Examiner's Office the number of New Hampshire deaths resulting from oxycodone has more than tripled since 2000. The total number of drug-related deaths rose to 174 in 2010. Almost 20% of these deaths (34) were determined to be suicides caused by intentional drug overdose.[16]

Number of Drug Related Deaths in NH



Source: Dr. Thomas Andrew, NH Medical Examiner's Office

In 2010 methadone and oxycodone became the first and second leading agents in the cause of drug-related deaths in New Hampshire.[17]

Approximately one in five (20.4%) New Hampshire high school students reported having taken a prescription drug without a doctor's prescription at least once in their lifetime, while one in ten (10.4%) reported having taken a prescription drug without a doctor's prescription at least once in the past 30 days.[18]

A 2005 national study of 7th through 12th graders found that 40% believed using prescription drugs was safer than using illegal drugs, 29% thought that pain relievers were not addictive, and 62% of teens who reported abusing prescription pain relievers said they do so because they are easily accessible through parents' medicine cabinets.[19]

In 2010 sixteen percent of substance abusing adults entering state correctional facilities reported prescription drugs as their drug of first preference.[20]

From April of 2010 to April of 2011, the Drug Diversion Unit of the NH Department of Safety initiated 32 investigations resulting in one search warrant, four consent searches, and 50 arrests related to prescription drug abuse.[21]

State Priorities

In this *Call to Action*, the Commission supports the federal recommendation[22] that the following long-term impacts be achieved within five years:

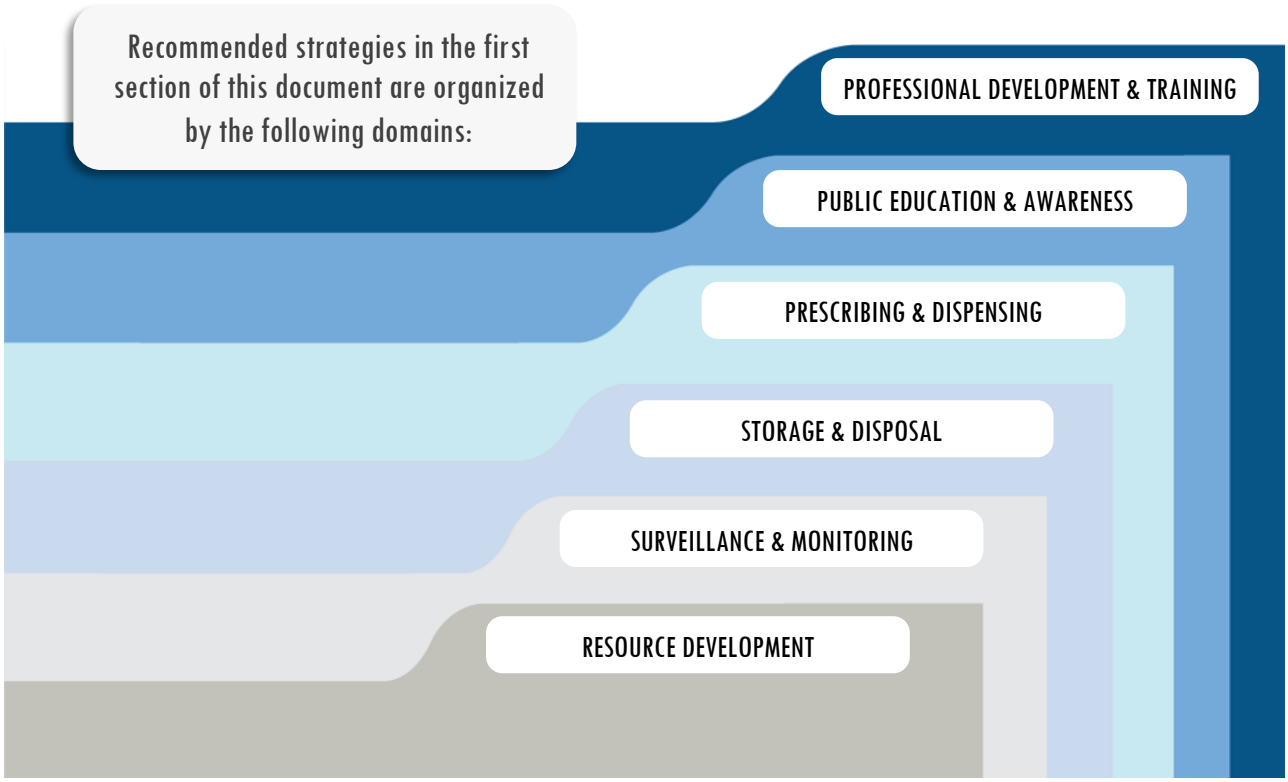
- ☑ **A reduction in the percentage of individuals 12 and older who report non-medical use of pain relievers in the past year by 15%**
- ☑ **A reduction in the number of drug-related overdose deaths by 15%**

To realize these goals, this *Call to Action* frames the issue in two parts:

Part I: Recommendations for Action
Recommended strategies by key stakeholder domains

Part II: Commitments to Action
Specific commitments to action by state level agencies and stakeholder groups

This two-tiered plan will ensure a wide range of opportunities for and commitments to actionable strategies that comprise the state's comprehensive response to the growing epidemic of prescription drug abuse. Strategies included in this document were prioritized as highly or moderately feasible with a high to moderate impact by stakeholders at the 2011 Prescription Drug Abuse Prevention Strategy Summit and/or in review by the task forces of the Governor's Commission. They are organized within the following domains:



RECOMMENDATIONS FOR ACTION

Recommendations for Action

Recommended strategies within this plan have broad implications from the practitioner at the community level to legislative policy at the government level and across key state and community sectors.

This cross-section of stakeholders and strategy domains is designed to harness the resources and opportunities that exist within the state and local communities to effect positive change in service to the state's goal of preventing and reducing prescription drug abuse.

Recommendations and opportunities for action are presented by key stakeholder sectors that exist within communities and state-level leadership. For each key sector, recommendations are provided that have been derived from a cross-section of national,[23,24] state[25] and local[26] sources. These sectors are the *health and medical* field, *safety and law enforcement*, *education*, *business*, and *government*.

HEALTH & MEDICAL

- Prescribers
- Dispensers
- Health Educators
- Addiction Treatment
- Emergency Care
- Behavioral Health
- Surgeons
- Injury Prevention
- Primary Care
- Institutional Care
- Pain Clinics
- Suicide Prevention

SAFETY & LAW ENFORCEMENT

- Local Law Enforcement
- Emergency Medical Technicians & First Responders
- Drug Diversion Investigators
- Police Standards & Training

EDUCATION

- Public & Private Schools
- Campus Health Services
- School Nurses
- Campus Police
- Student Assistance Counselors
- College Counseling Departments
- Staff & Administration
- Guidance Counselors & Social Workers

BUSINESS

- Business Owners & Operators
- Human Resource Departments
- Employee Assistance Programs
- Risk Management
- Senior Management
- Health Educators
- Safety Compliance Officers

GOVERNMENT

- Federal Government
- State Lawmakers
- County Officials
- Local Governing Boards
- State Agencies & Commissions

HEALTH & MEDICAL

Health & Medical Recommendations Overview

PROFESSIONAL DEVELOPMENT & TRAINING

1:1 Increase training availability and access for the health care workforce

1:2 Increase opportunities for cross-training between prescribers, dispensers, health educators, and law enforcement specializing in drug diversion

1:3 Increase training opportunities for addiction prevention and treatment professionals in evidence-based treatment and after-care relative to prescription drug abuse

1:4 Increase educational requirements for those seeking to enter the health and medical field

1:5 Increase professional collaboration between providers of primary care, behavioral health, addiction treatment, substance abuse prevention, and alternative therapies

PUBLIC EDUCATION & AWARENESS

1:6 Provide education to all patients and clients regarding the risks and warning signs of prescription drug abuse and misuse, proper storage and disposal of medications, and identify resources available for addiction treatment or recovery services

PRESCRIBING & DISPENSING

1:7 Prescribers should check a patient's prescription history before prescribing controlled substances

1:8 Prescribers should screen for substance abuse as part of standard clinical examination and assessment

1:9 Prescribers should provide medication guides and counseling to patients relative to potential harm, including addiction

1:10 Prescribers should closely evaluate, monitor and even test patients for prescription drug misuse and abuse

STORAGE & DISPOSAL

1:11 Patient education should include information about proper storage and disposal of unused medications

1:12 Health and medical staff and facilities should promote and support local "Take-Back" events to encourage safe and regular disposal of unused medications

1:13 Pharmacies may consider serving as medication disposal sites

SURVEILLANCE & MONITORING

1:14 Prescription drug monitoring should be instituted by means of a centralized database accessible to prescribers and dispensers

1:15 Prescribers and prescribing facilities may consider patient contracts and other protocols to monitor and detect prescription drug diversion and/or abuse

1:16 Dispensers should take increased precautions to protect stock and prevent unlawful access to prescription drugs

1:17 Licensing boards and authorities should monitor, investigate and enforce policies and encourage enhanced protocols to deter abuse and diversion

1:18 Referral to appropriate intervention or treatment should be provided if indications of abuse or dependence exist

Health & Medical Recommendations

Prescribers - Dispensers - Health Educators - Addiction Treatment

The health and medical sector within the state plays a unique and critical role in efforts to address the threat of prescription drug misuse and abuse in that they are one source of the medications that hold the potential for abuse. Prescribing physicians, surgeons, emergency room staff and other medical, dental and mental health professionals are in a difficult, front-line position of having a responsibility to treat chronic and acute conditions requiring pain and symptom relief within a changing landscape wherein patients may be seeking the drugs specifically for abuse or diversion for illicit activity.

Health and medical professionals also have unique opportunities to talk with patients about the danger of prescription drug abuse and addiction, to discuss ways to safeguard medications to prevent access by others, and to identify patients who may be abusing medications to refer them to treatment.

The *Call to Action* in the health and medical sector seeks to engage the broadest spectrum of professionals and practitioners in strategies to prevent and reduce prescription drug misuse and abuse in New Hampshire. The health and medical sector includes all members of the health care workforce and their employers, including but not limited to those indicated below.

PRESCRIBERS	DISPENSERS	HEALTH EDUCATORS	ADDICTION TREATMENT
Primary care practitioners, emergency room staff, surgeons, dentists & oral surgeons, pain care professionals, psychiatrists, nurse practitioners, and other medical professionals licensed to prescribe	Pharmacists, pain clinics, institutions such as nursing homes & correctional facilities licensed to dispense prescribed medication	Health educators in schools, communities, housing authorities, social service organizations, and institutional settings; injury prevention, suicide prevention, and poison control professionals	Licensed alcohol & drug counselors, therapeutic counselors, social workers, and recovery support workers

During this plan's development it was noted that individuals abusing pain medication may resort to extreme measures to gain access to medications that further complicate and challenge the practice of prescribing medication. For example, it was reported that there have been cases of drug seekers presenting in New Hampshire emergency rooms for dental pain that emergency room

staff may not be able to adequately assess, thereby potentially increasing the likelihood pain medication will be prescribed. Drug seekers may also leave dental or other medical problems untreated in order to maintain the condition that requires pain medication or the appearance of requiring pain medication. These and other conditions and situations are exploited by drug seekers to thwart a prescriber's reliance on objective means to determine the cause and severity of pain.

Interviews conducted in the development of this plan also revealed that many individuals who become drug seekers fall into their abuse and dependence as a result of a valid health or medical condition requiring pain or other symptom relief and that the health and medical field must give equal attention to treating symptoms and conditions as to preventing complications from such treatment, including the potential of abuse and addiction.

New Hampshire's health and medical field has already taken the lead in revising pain treatment guidelines and improving patient monitoring to deter prescription drug abuse. To assist stakeholders in responding to the *Call to Action*, resources and examples in support of recommended strategies are provided. These and other local efforts that have shown success are highlighted along with state and national resources, including websites, guidelines, and materials. Links to these resources are provided at the end of the *Health & Medical* section.

PROFESSIONAL DEVELOPMENT & TRAINING

1:1 Increase training availability and access for the health care workforce

All health care professionals licensed to prescribe medication should receive comprehensive training in the following areas to increase awareness of prescription drug misuse and abuse, to implement effective prevention approaches, and to intervene early if a problem arises.

PRESCRIBERS	DISPENSERS	HEALTH EDUCATORS	ADDICTION TREATMENT
Evaluation & treatment of pain Effective pain management Reviewing patient history Patient monitoring & contracts Abuse prevention Physiology of addiction Problem identification & referral Screening for abuse & dependence	Warning signs of abuse & dependence Internal drug diversion Monitoring of customer prescription drug fills & patterns External drug diversion	Safe storage & disposal of medication Warning signs of abuse & dependence Abuse prevention Problem identification & referral	Evidence-based treatment for opioid addiction Medication-assisted recovery Long-term recovery planning & support servi

Recommended training topics include but are not limited to those indicated above.

Federal legislation has been submitted recently to require a minimum training course for anyone licensed to prescribed medication. The legislation, the *Ryan Creedon Act of 2011*, H.R. 2119, was filed on June 3, 2011, by leaders of the Congressional Caucus on Prescription Drug Abuse and named after a constituent of U.S. Representative Mary Bono Mack who died from a prescription drug overdose.

This legislation seeks to amend the *Controlled Substances Act* to require practitioners to:

> Obtain particular training or special certification, approved by the Attorney General, on addiction to and abuse of controlled substances and appropriate and safe use of controlled substances in schedule II, III, IV, or V, and for other purposes.[27]

Additionally, in November 2011, the U.S. Food and Drug Administration (FDA) requested public comment on new risk evaluation and mitigation strategies (REMS) to be required of the sponsors of long-acting and extended-release (LA/ER) opioid drugs. The central component of the Opioid REMS is an education program for prescribers (e.g., physicians, nurse practitioners, physician assistants) so that LA/ER opioid drugs can be prescribed and used safely. The FDA announced that it expects drug sponsors to provide prescriber training conducted by accredited continuing education providers without cost to health care professionals.

The draft "Blueprint for Prescriber Continuing Education Program" is available at:

http://www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/UCM277916.pdf

This FDA requirement and resulting resources will play an important role in the accessibility of targeted professional development and training for prescribers and dispensers.

PROFESSIONAL DEVELOPMENT & TRAINING

1:2 Increase opportunities for cross-training between prescribers, dispensers, health educators, and law enforcement specializing in drug diversion

Cross-training opportunities that bring diverse disciplines together are advantageous to creating opportunities for collaborative and coordinated strategies to prevent prescription drug abuse and diversion. For example, the New Hampshire Board of Pharmacy is encouraging collaborative trainings and information-sharing between prescribers and dispensers to share ideas for more coordinated abuse prevention. Cross-training opportunities may also exist between medical and pharmacy schools such as Dartmouth College and the Massachusetts College of Pharmacy in Manchester, New Hampshire.

Additionally, in response to the growing prescription drug abuse problem in New Hampshire, the Department of Safety's Drug Diversion Unit was established to investigate various crimes involving diversion of pharmaceutical drugs, including prescription fraud, doctor shopping, illegal prescribing by medical professionals and employee thefts at pharmacies. In addition to this charge, the Drug Diversion Unit commits half of its staff time to provide free trainings both within law enforcement and other disciplines to prevent unlawful diversion of prescription medications.

PROFESSIONAL DEVELOPMENT & TRAINING

1:3 Increase training opportunities for addiction prevention and treatment professionals in evidence-based practices and after-care relative to prescription drug abuse

There are several state and regional training centers to support professionals in addiction services to expand their knowledge of effective treatment and after-care for individuals addicted to opioids. The New Hampshire Training Institute on Addictive Disorders offers low-cost trainings open to the public, including trainings on the physiology of addiction, evidence-based treatment, recovery support services, and drug trends. Additionally, the New England School of Addiction Studies and the Addiction Technology Transfer Center at Brown University are regional resources offering professional development and training in addiction, including problem identification and referral, evidence-based treatment for opioid addiction, and related topics.

PROFESSIONAL DEVELOPMENT & TRAINING

1:4 Increase educational requirements for those seeking to enter the health and medical field

Although several colleges and universities in New Hampshire have or are considering specialized coursework in addiction, it is recommended that all post-secondary educational programs preparing students for work in the health and medical professions expand or adjust required coursework to include training on addiction, prescription drug abuse, and related topics to increase the general knowledge of the health care workforce regardless of specialization. Similarly, it is recommended that medical schools require adequate training of medical students in pain management, the physiology of addiction, and its classification as a chronic, relapsing brain disease.

PROFESSIONAL DEVELOPMENT & TRAINING

1:5 Increase professional collaboration between providers of primary care, behavioral health, addiction treatment, substance abuse prevention, and alternative therapies

During the *Prescription Drug Abuse Strategy Summit* held October 3, 2011, primary care and addiction treatment professionals recognized the communication barriers between the fields of practice that may be hampering referrals to treatment or recovery support services. Interagency coordination is recommended to facilitate bi-directional referrals and care coordination between primary care and addiction treatment and recovery. Substance abuse prevention services may also play a role in serving individuals and families seeking to recover from addiction.

PUBLIC EDUCATION & AWARENESS

1:6 Provide education to all patients and clients regarding the risks and warning signs of prescription drug abuse, proper storage and disposal of medications, and identify resources available for addiction treatment or recovery services

Patient education is one means of growing public awareness of the potential harm of prescription drugs, particularly the risk of abuse and dependence and the potential harm of over-medicating. Providing meaningful information on risks and warning signs of dependence, the interactions of alcohol and other drugs with prescription medications, and when to contact a prescriber to discuss concerns is a vital component of patient education. Because prescription drug misuse is a growing epidemic, health and medical professionals should consider disseminating educational materials to patients in an overt way, such as through a direct conversation and proffered materials, in addition to passive means such as posters and brochures available in a waiting room.

Statistics show that most prescription drugs being abused are accessed through friends or family members. Patient education should include information on the importance of storing medication in places that are not visible or accessible to others. In addition, education should include proper means to dispose of unused medications such as local Take-Back events or secure drop boxes.

In addition to information on risk of abuse and safe storage and disposal, patients should receive information on accessing treatment and recovery services if a problem is identified. Implementing this strategy may also encourage partnerships between primary care or other health settings and addiction treatment and recovery practitioners in the community.

PRESCRIBING & DISPENSING

1:7 Prescribers should check a patient's prescription history before prescribing controlled substances

Prescribers should use available means to check a patient's history for signs of abuse before prescribing controlled drugs. Although a centralized database such as a prescription drug monitoring program discussed in other sections of this plan is one means, prescribers may use electronic health records to look for indications of abuse or drug-seeking behavior. In the absence of an electronic means, doctors may contact pharmacists directly to confer on individual cases. Once a centralized database is established for physicians to utilize in support of this recommendation, dispensers must report the dispensing of prescription medication in a way that makes this information readily available in real-time for effective use by prescribers. By reviewing a patient's history in real-time, opportunities for abuse or diversion will be reduced.

PRESCRIBING & DISPENSING

1:8 Prescribers should screen for substance abuse as part of standard clinical examination and assessment

Given that approximately one in ten adults (9.58%) in New Hampshire meet the criteria for abuse or dependence on alcohol or other drugs,[28] prescribing practices should include brief screenings for substance abuse or a substance abuse history, particularly when a prescription for opioids may be considered. A brief screen provides an opportunity for a discussion of a patient's history of substance use and consideration of the potential impact a prescription medication may have on a patient's use or sobriety, allowing for a substance use disorder to be considered in determining a strategy for the presenting medical condition.

PRESCRIBING & DISPENSING

1:9 Prescribers should provide medication guides and counseling to patients relative to potential harm, including addiction

Patient education should be provided whenever an opioid or any abusable medication is prescribed, detailing not only the risk of harm of taking the prescription in a way other than prescribed but also encouraging safe storage and disposal of unused medications to minimize possible harm to others. In particular, access to prescription drugs should be minimized to protect people, including youth, who may be seeking a recreational high and to protect against accidental or inappropriate use.

PRESCRIBING & DISPENSING

1:10 Prescribers should closely evaluate, monitor and even test patients for prescription drug misuse and abuse

In light of the prevalence of substance use disorders and the growing epidemic of prescription drug misuse and abuse, it is recommended that prescribers consider a means to effectively monitor patients who have been prescribed abusable drugs, particularly opioid pain relievers. One method that some New Hampshire clinics have adopted is patient contracts, discussed in *Recommendation 1:15* of this section. Contracts allow for ongoing testing and monitoring of patients to ensure opioids are taken as prescribed. See also *Appendix C* for a sample patient contract currently being used in New Hampshire to monitor patients who may be at risk for misuse or abuse.

STORAGE & DISPOSAL

1:11 Patient education should include information about proper storage and disposal of unused medications

As mentioned in the prescriber recommendations above, patient education should be provided whenever an opioid or any abusable medication is prescribed, encouraging safe storage and disposal of unused medications to minimize possible harm to others. In particular, access to prescription drugs should be minimized to protect young people who may be seeking a recreational high and to protect against theft, and accidental or inappropriate use.

STORAGE & DISPOSAL

1:12 Health and medical staff and facilities should promote and support local "Take-Back" events to encourage safe and regular disposal of unused medications

The success of state and local Take-Back events hosted by partnerships between law enforcement agencies, community anti-drug coalitions, pharmacies, and other organizations have underscored the abundance of unused medications in homes that may be accessed by drug seekers or that may pose a risk as a result of accidental or inappropriate use or abuse. Support for these initiatives by health and medical professionals will help send a consistent message to individuals and communities about the risks of prescription medication misuse, abuse and misdirection.

DEA's Third National Prescription Drug Take-Back Event Collects 188.5 Tons

NOV 03 - (WASHINGTON, D.C.) – Americans participating in the U.S. Drug Enforcement Administration's (DEA's) third National Prescription Drug Take-Back Day on October 29, 2011, turned in more than 377,086 pounds (188.5 tons) of unwanted or expired medications for safe and proper disposal at the 5,327 take-back sites that were available in all 50 states and U.S. territories. When the results of the three Take-Back Days to date are combined, the DEA and its state, local, and tribal law-enforcement and community partners have removed 995,185 pounds (498.5 tons) of medication from circulation in the past 13 months.

According to the Centers for Disease Control and Prevention, enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for one month. Purging America's home medicine cabinets of unwanted or expired medications is one of four action items outlined in the national strategy for reducing prescription drug abuse and diversion.

Excerpted from http://www.deadiversion.usdoj.gov/drug_disposal/takeback/takeback_102911.html

STORAGE & DISPOSAL

1:13 Pharmacies may consider serving as medication disposal sites

This recommendation is included to encourage exploration of opportunities to create a safe means to collect and dispose of unwanted medications to reduce environmental access and availability of prescription drugs. Pharmacies, however, are precluded from serving as medication disposal sites by federal law that is currently under review for possible changes that may allow them to serve in this capacity in the future. In the *Safety & Law Enforcement* section of this plan it is also noted that local police departments may serve as a secure location for permanent drop locations as they have secure areas and existing protocols for proper disposal.

SURVEILLANCE & MONITORING

1:14 Prescription drug monitoring should be instituted by means of a centralized database accessible to prescribers and dispensers

As of May 2011, Prescription Drug Monitoring Program (PMP) legislation has been adopted in 48 of 50 states, leaving New Hampshire as one of two states in the country without an electronic database accessible to prescribers and dispensers to monitor a patient's prescription drug history. Please see the *Government* section of this report for more information about the content and status of this pending legislation in New Hampshire.

For more information about prescription drug monitoring, visit the PMP Center for Excellence at Brandeis University. **www.PMPexcellence.org**

SURVEILLANCE & MONITORING

1:15 Prescribers and prescribing facilities may consider patient contracts and other protocols to monitor and detect prescription drug diversion and/or abuse

Several health care practices in the state have instituted patient contracts or patient agreements for those patients who are being prescribed narcotics over a period of time for chronic conditions or for those patients who may have a history of or potential for prescription drug misuse or abuse. Contracts may require that patients only fill prescriptions at one specified pharmacy, that they submit to pill counts or urine testing when requested, or other measures to deter abuse. Please see *Appendices C* and *D* of this report for sample contracts and protocols used in New Hampshire.

Weeks Medical Center – Lancaster, NH

Weeks Medical Center instituted patient contracts in 2010 for patients who were prescribed opioid pain relievers to treat chronic conditions. The contracts stipulated the risks associated with use and the consequences of violating the contract either as a result of misuse, abuse or diversion. Patients who are found to be in violation of the contract are terminated as pain patients but may remain under the care of the medical center for other health care needs. Please see *Appendix C* for a copy of the patient contract used by Weeks Medical Center.

Weeks Medical Center

SURVEILLANCE & MONITORING

1:16 Dispensers should take increased precautions to protect stock and prevent unlawful access to prescription drugs

Pharmacies and other dispensaries are increasingly becoming targets of theft and fraud. For example, in 2009, a Rite Aid pharmacy in Ossipee, NH, was burglarized four times by individuals seeking pain medication. Enhanced safety precautions and anti-theft measures are necessary to increase the safety of pharmacists, pharmacy technicians and the public and to prevent unlawful access to controlled drugs. Although the quantity of prescription drugs being stolen from pharmacies is on the decline in New Hampshire[29], this may be due to increased enforcement and/or alternative means to divert drugs.

SURVEILLANCE & MONITORING

1:17 Licensing boards and authorities should monitor, investigate and enforce policies and encourage enhanced protocols to deter abuse and diversion

The New Hampshire Board of Pharmacy, the New Hampshire Board of Nursing, and the New Hampshire Board of Medicine all support the monitoring, investigation and enforcement of policies, laws and protocols to deter abuse and diversion. Each provides access to professional development and training to support practitioners in ethical decision-making and abuse deterrence. Their training calendars are available on the web at the links provided at the end of this section. Licensing boards may also consider increasing public and professional awareness of how to register a concern regarding improper, unsafe, or questionable prescribing or dispensing practices.

Pharm/alert®

The New Hampshire Board of Pharmacy issues Pharm-ALERTs that are faxed to all pharmacies with intelligence reports from state law enforcement regarding immediate threats. The alerts provide the means of diversion (e.g. a stolen prescription pad from a specific hospital), the names under which fraudulent prescriptions have been sought, the doctor's name being used on the prescription, and the drugs being sought. These alerts have been effective in notifying dispensers of fraudulent activity discovered by authorities.

SURVEILLANCE & MONITORING

1:18 Referral to appropriate intervention or treatment should be provided if indications of abuse or dependence exist

One patient screening and referral model that has gained attention for its outcomes is the evidence-based Screening, Brief Intervention and Referral to Treatment (SBIRT) approach endorsed by the U.S. Substance Abuse and Mental Health Administration (SAMHSA). The model encourages a brief screening for alcohol or other drug abuse in primary practice, emergency rooms, or other settings. A screening indicating potential alcohol or drug abuse leads to an additional set of questions that determine if a practitioner should provide a brief intervention, such as motivational interviewing, or if referral to more intensive intervention or treatment is necessary. Although some service delivery systems, such as the state's community mental health system, does conduct brief alcohol and drug screenings of all clients, universal screening is not yet a widespread practice. Attention should be given within other care systems, such as the community health center system and hospital emergency rooms, to implement screening and appropriate interventions more broadly.

RESOURCES

PRESCRIBING

Guidelines for the Use of Controlled Substances in the Treatment of Pain
Adopted by the New Hampshire Medical Society, July 1998

Updated guidelines expected in Spring, 2012.

http://www.nhms.org/resources/painmgmt.php

The **New Hampshire Board of Nursing** provides continuing education opportunities for nurses, including Advance Practice Nurses licensed to prescribe medications.

http://www.nh.gov/nursing/education/index.html

NH Department of Corrections, Division of Medical and Forensic Services, **Clinical Guidelines for Prescribing Opioids for Treatment of Chronic Pain**, May 2009

http://www.nh.gov/nhdoc/documents/6-41.pdf

The Federation of State Medical Boards (FSMB), **Responsible Opioid Prescribing: A Physician's Guide**

http://www.fsmb.org/pain-overview.html

FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain, May 2004

http://www.fsmb.org/pdf/2004_grpol_Controlled_Substances.pdf

DISPENSING

The **New Hampshire Board of Pharmacy** provides continuing education for pharmacists and pharmacy technicians in a wide range of topics to prevent fraudulent access and to respond to identified problems.

http://www.nh.gov/pharmacy/pharmacists/ce_programs.htm

Massachusetts College of Pharmacy – Manchester, NH

http://www.mcphs.edu

DRUG DIVERSION

The **NH Drug Diversion Unit** trainings to prevent unlawful diversion of prescription medications

http://www.nh.gov/safety/divisions/nhsp/isb/narcotics/index.html

PATIENT EDUCATION

The American Society of Addiction Medicine introduced the Physician Clinical Support System for Primary Care (PCSS-P), a free, nationwide service to help primary care providers seeking to identify and advise their patients regarding alcohol and drug abuse before they evolve into life-threatening conditions.

http://www.nida.nih.gov/nidamed/pcss.php

PUBLIC EDUCATION & AWARENESS

The New Hampshire Department of Health and Human Services' Injury Prevention Program

http://www.dhhs.nh.gov/dphs/bchs/mch/injury.htm

The Northern New England Poison Control Program - New Hampshire

http://www.mmc.org/mmc_body.cfm?id=3090

Northeast Regional Injury Prevention Network - Poison Data Book (January 2004)

http://www.ask.hrsa.gov/downloads/poison_book.pdf

New Hampshire Alliance for the Mentally Ill (NAMI-NH)

http://www.naminh.org/education/suicide-prevention

SCREENING & BRIEF INTERVENTIONS

The National Institute on Drug Abuse (NIDA) Centers of Excellence for Physician Information provides science-based resources to help physicians identify patient drug use early and to prevent it from escalating to abuse or addiction as well as identify and refer patients in need of specialized addiction treatment.

http://www.drugabuse.gov/coe/

Online **Screening, Brief Intervention and Referral to Treatment (SBIRT)** training through the National Institute on Drug Abuse (NIDA).

http://www.sbirttraining.com/sbirtcore

ADDICTION TREATMENT

New Hampshire Training Institute on Addictive Disorders

http://www.nhadaca.org/training.html

New England School of Addiction Studies

http://www.neias.org/SATneias.html

New England Addiction Technology Transfer Center Training Calendar

http://www.nattc.org/regcenters/trainingevents.asp?rcid=8&ViewType=

SAFETY & LAW ENFORCEMENT

Safety & Law Enforcement Recommendations Overview

PROFESSIONAL DEVELOPMENT & TRAINING

2:1 Increase the number of trainings and professional development opportunities available to and accessed by law enforcement and other safety personnel

PUBLIC EDUCATION & AWARENESS

2:2 Develop and disseminate legal bulletins specific to prescription drug abuse and diversion

STORAGE & DISPOSAL

2:3 Participate in local Take-Back events to collected unused or unwanted medication

2:4 Serve as permanent disposal sites for the public

SURVEILLANCE & MONITORING

2:5 Continue and expand investigation and prosecution resources and efforts specific to prescription drug diversion

2:6 Designate an officer as a prescription drug diversion specialist for targeted training, community liaison, intelligence bulletins, and coordination of effort

Safety & Law Enforcement Recommendations

Local Law Enforcement - Emergency Medical Technicians - First Responders
Drug Diversion Specialists - Police Standards & Training

According to Section 309 of the federal Uniform Controlled Substances Act, drug diversion is the transfer of a controlled substance from a lawful to an unlawful channel of distribution or use. Because prescription drugs are legal substances when prescribed, dispensed, and used appropriately, enforcement of drug diversion laws is unique and requires a proactive commitment by law enforcement agencies to investigate and prosecute offenders.

PROFESSIONAL DEVELOPMENT & TRAINING

2:1 Increase the number of trainings and professional development opportunities available to and accessed by law enforcement and other safety personnel

Diversion of prescription medication from its original recipient and/or intent is unlawful and requires unique law enforcement practice strategies distinct from those developed for illicit drugs. Determining the means and methods by which drug-seekers may be acquiring prescription drugs requires specialized training and proactive enforcement. Professional development and training for law enforcement and safety professionals should include training in prescription forgery and other diversion tactics such as doctor shopping, illicit prescription drug sales, and specialized investigation and enforcement. The New Hampshire Department of Safety's Drug Diversion Unit has developed a curriculum for trainings through the Police Standards and Training Council and other training providers.

In addition, the New Hampshire Division of Liquor Enforcement is leading the state's training effort relative to Drug Recognition Experts and Advanced Roadside Impairment Detection Enforcement (ARIDE) to help deter motor vehicle impairment due to prescription drug abuse or other substance abuse (See *Commitments to Action* on page 73). The state's federal partners also provide training opportunities for law enforcement. Federal training partners include the New England High Intensity Drug Trafficking Area and the U.S. Drug Enforcement Agency. Links to these and other resources are provided at the end of this section.

PUBLIC EDUCATION & AWARENESS

2:2 Develop and disseminate legal bulletins specific to prescription drug abuse and diversion

Legal bulletins can be an effective means to highlight the scope of the epidemic on a consistent basis and can be disseminated to a wide range of state and community stakeholders. The New Hampshire Attorney General's office and the New Hampshire Department of Safety are committed to summarizing prevalence and other statistics on prescription drug diversion and enforcement regularly to keep communities informed (see *Commitments to Action* on page 73). Local and county law enforcement agencies should consider similar practices to share information on investigations, prosecution, drug-seeking behaviors and tactics, and safety precautions. Legal bulletins can be disseminated through existing list serves, fax alert networks, public health networks, social media, and other communication routes.

STORAGE & DISPOSAL

2:3 Participate in local Take-Back events to collect unused or unwanted medication

Take-Back events are defined by the U.S. Drug Enforcement Administration as organized collection events designed to reduce the amount of unwanted or unused pharmaceutical products that may pose a risk to public health and safety, that may be accessible to diversion, or that otherwise may be disposed of in a manner that does not comply with State or Federal laws or regulations.[30] Once a controlled drug leaves the possession of the individual to whom it was prescribed, law enforcement are often the only institution with the legal authority to handle and dispose of the drugs. Therefore, the participation of local and county law enforcement has been critical to the success of the three national Take-Back events that have been hosted in New Hampshire communities over the past 15 months.

Because of legal concerns raised regarding the handling of the prescription drugs by individuals other than law enforcement during the Take-Back events, the New Hampshire Office of the Attorney General crafted legislation to accommodate the activities of the Take-Back events safely and legally. This legislation, introduced as House Bill 71, was passed by the New Hampshire Legislature this year and allows for "communities and private entities in conjunction with law enforcement officers to establish controlled and non-controlled pharmaceutical drug take-back programs" and requires rulemaking by the Department of Justice, the Board of Pharmacy, the Department of Safety, and the Department of Environmental Services to provide established guidelines for such Take-Back events. The legislation allows for individuals to drop off medications anonymously and lessens the disposal restrictions for drugs collected in this venue that are much more stringent as stipulated in RSA 318-B:17 for illicit drug disposal.[31] The formal rulemaking process has been initiated by the Department of Justice.

STORAGE & DISPOSAL

2:4 Serve as permanent disposal sites for the public

Many local police departments and safety units have supported local Take-Back initiatives in New Hampshire as one-time events, but several police departments across the state have or are considering serving as permanent drop-off locations for the public in support of prescription drug abuse prevention. Local police departments have been meeting the challenge of the prescription drug diversion through specialized enforcement but are also committing resources to serve as permanent disposal sites because they are uniquely suited to do so through their authority to receive and properly dispose of controlled drugs. In addition, locating a drop-box at a police department minimizes safety concerns relative to drug-seekers who may attempt to gain access to prescription drugs that have been dropped off for disposal. Once a permanent drop-off location is established, as in Keene, New Hampshire, local coalitions, health and medical professionals, schools, businesses, and other community organizations can begin to promote the site to the public to provide ongoing education and awareness and to reduce availability of unused medications.

SURVEILLANCE & MONITORING

2:5 Continue and expand investigation and prosecution resources and efforts specific to prescription drug diversion

The new era of prescription drug diversion has demanded a quick and specialized response from the law enforcement and safety sector at a time when resources are scarce and the demands on local, county and state law enforcement are high. Yet law enforcement officials in New Hampshire are more committed than ever to developing an adequate and effective response to the growing epidemic of prescription drug abuse. This commitment has led to specialized trainings offered through the Department of Safety's Drug Diversion Unit and through other state, regional and federal resources listed at the end of this section. Local and county law enforcement and safety officials are called to prioritize the epidemic of prescription drug abuse through expanded or enhanced diversion enforcement and prosecution and to collaborate with local, state and federal organizations to leverage resources in support of this strategy.

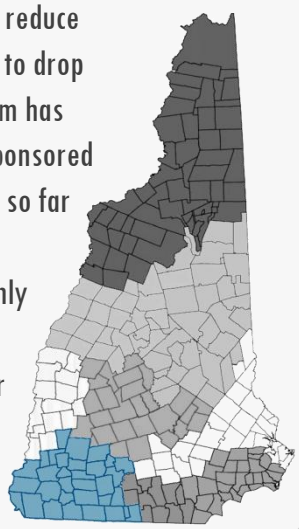
SURVEILLANCE & MONITORING

2:6 Designate an officer as a prescription drug diversion specialist for targeted training, community liaison, intelligence bulletins, and coordination of effort

Designating a specific officer(s) to serve as a liaison between state training and response efforts and community networks is an approach that has been successful with other alcohol and drug efforts such as underage drinking. A designated officer can coordinate comprehensive training schedules within their local department, serve as a "train the trainer" to bring specialized resources to his/her department, serve on community task forces working to prevent and reduce prescription drug abuse, and serve as a conduit of bi-directional information sharing such as through legal bulletins or data mining and analysis. A designated officer could also be trained as a Drug Recognition Expert to assist in prescription drug abuse cases when appropriate.

Community Spotlight: Take-Back Events in the Monadnock Region

For each of the three National Take-Back events held since the strategy was initiated by the U.S. Drug Enforcement Agency, *Monadnock Voices for Prevention* and its government partner, Cheshire County, have mobilized law enforcement agencies, schools, community organizations, health care partners and pharmacists to assist in the region-wide effort to reduce environmental access to prescription drugs by encouraging local residents to drop off unused medications at participating police departments. The momentum has led to a permanent secure drop-off location at a local police department sponsored by a local Rotary Club. In the Monadnock region, the one-day events have so far led to over 1,000 pounds of unused medications being safely disposed of. In the April 2011 Take-Back event, New Hampshire, with a population of only 1.3 million collected 10% of all medications gathered across the U.S. in similar events that day. For more information about Monadnock Voices for Prevention's prescription drug abuse prevention efforts, please visit:



http://www.monadnockvoices.org

RESOURCES

PROFESSIONAL DEVELOPMENT & TRAINING

The NH Drug Diversion Unit trainings to prevent unlawful diversion of prescription medications

http://www.nh.gov/safety/divisions/nhsp/isb/narcotics/index.html

New Hampshire Police Standards and Training Council training opportunities for law enforcement

http://www.pstc.nh.gov/TrainingCalendar.pdf

National Guard Northeast Counterdrug Training Center

http://www.counterdrug.org/NCTC/nctc.html

New England High Intensity Drug Trafficking Area (HIDTA) training opportunities

http://www.hidta.org/Training/training.asp

U.S. Drug Enforcement Agency training opportunities

http://www.justice.gov/dea/programs/training/part8.html

The **NH Division of Liquor Enforcement** drug recognition expert training program and alcohol/drug training for alcohol licensees

http://www.nh.gov/liquor/enforcement.shtml

Contact: Sgt. Chris Hutchins (603) 271-3521

GENERAL TECHNICAL ASSISTANCE

National Association of Drug Diversion Investigators

http://associationdatabase.com/aws/NADDI/pt/sp/resources_links

U.S. Department of Justice, Drug Enforcement Agency

http://www.deadiversion.usdoj.gov

TAKE-BACK PROTOCOLS

National Take-Back Network

http://www.takebacknetwork.com/pdf/Safe_Disposal_of_Unused_Controlled_Substances.pdf

EDUCATION

Education Recommendations Overview

PROFESSIONAL DEVELOPMENT & TRAINING

3:1 Increase the number of trainings and professional development opportunities available to and accessed by school personnel

PUBLIC EDUCATION & AWARENESS

3:2 Support the dissemination of public service announcements and bulletins to youth, students, parents, and communities relative to prescription drug misuse, abuse and diversion

3:3 Support the implementation of evidence-based health curricula that address prescription drug misuse and abuse

STORAGE & DISPOSAL

3:4 Help promote community Take-Back events to collect unused medication

3:5 Ensure that health and nursing services implement safe storage and dispensing of medications to deter abuse or diversion

SURVEILLANCE & MONITORING

3:6 Continue school-based data collection to gauge the prevalence and perceptions of prescription drug misuse and abuse

3:7 Establish, communicate and enforce drug-free policies and comprehensive approaches that include prevention of prescription drug misuse or abuse

3:8 Provide problem identification and referral for youth and adults within educational systems

Education Recommendations

School Safety Officers - Campus Health Services - School Nurses - Campus Police
Student Assistance Counselors - College Counseling Departments
Staff & Administration

PROFESSIONAL DEVELOPMENT & TRAINING

3:1 Increase the number of trainings and professional development opportunities available to and accessed by school personnel

Professional development and training for school nurses, health teachers, health services staff, administrators, school safety officers, alcohol and drug counselors and other staff will increase awareness of prescription drug abuse as a preventable epidemic and will provide specific strategies that school- and college-based health and safety professionals can implement to address misuse and abuse effectively. Training is available from a wide range of stakeholders in the state and region. Links to resources for the education sector are listed at the end of this section and throughout this report. For example, the New Hampshire Board of Nursing provides online training for school and campus nurses while the New Hampshire Drug Diversion Unit provides training appropriate for school resource officers and campus police. See also the *Commitments to Action* section of this document beginning on page 73 for the role of the New Hampshire Department of Education in professional development and training.

PUBLIC EDUCATION & AWARENESS

3:2 Support the dissemination of public service announcements and bulletins to youth, students, parents, and communities relative to prescription drug misuse, abuse and diversion

Public and private schools and institutions of higher education have effective, well-established communication channels that can be leveraged in service to the state's *Call to Action* for the purposes of educating youth and young adults on the risks associated with prescription drug misuse, abuse and diversion. During the development of this plan it was noted that youth leadership and advocacy groups such as local *Youth to Youth, Project Success* or *Peer Outreach* chapters can play an effective role in helping to communicate risks to their peers and the community-at-large. Communication channels may take the form of newsletters, emails, open letters to parents or campus communities, websites, social media, poster campaigns, blogs, and other forms.

It is recommended that schools, colleges and universities respond favorably to requests from state and community stakeholders to disseminate information on prescription drug abuse and actively schedule their own regular information dissemination on prescription drug abuse. Sources of information for such bulletins and messaging are provided at the end of this section.

PUBLIC EDUCATION & AWARENESS

3:3 Support the implementation of evidence-based health curricula that address prescription drug misuse and abuse

Elementary, middle and high schools as well as colleges and universities typically provide some form and duration of health education as a component to general education requirements. It is recommended that schools at all levels review their health curricula to ensure that alcohol and drug abuse is adequately covered as a health topic priority, that the curricula being used have evidence of effectiveness in increasing knowledge of risks (physical and otherwise) of alcohol abuse and drug use, and that the curricula specifically address prescription drug misuse and abuse. One comprehensive approach to prevention and early intervention that was implemented widely in New Hampshire schools before recent budget reductions is *Project Success*, an approach that combines youth and parent education with policy revision, more intensive prevention for high-risk populations, and early intervention strategies in the school setting. Resources to assist schools in this strategy are provided at the end of this section.

STORAGE & DISPOSAL

3:4 Help promote community Take-Back events to collect unused medication

As mentioned in other sections of the *Call to Action*, Take-Back events were established by the U.S. Drug Enforcement Agency to reduce environmental access to prescription drugs that pose significant risk to those who may misuse or abuse them. New Hampshire communities have participated in three such events over the last 15 months, with unprecedented amounts of medications collected and disposed of safely. Schools can help promote these events to parents and community members to build awareness and decrease unsafe access to narcotics and other prescription drugs.

STORAGE & DISPOSAL

3:5 Ensure that health and nursing services implement safe storage and dispensing of medications to deter abuse or diversion

As mentioned in the *Health & Medical* section of this document, safe storage of prescription medications is a means to deter abuse and diversion. School and campus nursing or health services may store medications for students and monitor the dispensing of prescribed medications. Schools and campuses should ensure medications are safely stored and regularly inventoried.

SURVEILLANCE & MONITORING

3:6 Continue school-based data collection to gauge the prevalence and perceptions of prescription drug misuse and abuse

Valuable data are collected from youth and young adults through surveys administered in school settings in New Hampshire as these settings reach the widest cross-section of children and young adults. The Youth Risk Behavior Survey, Teen Assessment Project survey, Communities That Care, and Pride surveys are all reliable instruments administered at the middle and high school level to collect local prevalence and perception data on alcohol and drug abuse, including prescription drug abuse. Additionally, the New Hampshire Higher Education Consortia has an alcohol and other drug committee that oversees the administration of the New Hampshire Higher Education Alcohol, Tobacco and Other Drug Survey at participating colleges and universities. These biannual surveys provide valuable data to health and safety stakeholders to design effective, data-driven responses to alcohol and drug abuse risks and trends. It is recommended that schools continue to allow for this data collection in school settings and to support the use of data to inform school and community responses to identified behaviors and misperceptions.

SURVEILLANCE & MONITORING

3:7 Establish, communicate and enforce drug-free policies and comprehensive approaches that include prevention of prescription drug misuse or abuse

Comprehensive school-based approaches to substance abuse include effective, well-monitored and consistently enforced policies to define, prevent, intervene in and appropriately address alcohol and other drug problems. As mentioned earlier in this section, *Project Success* is an evidence-based comprehensive approach that many New Hampshire schools have adopted to incorporate youth leadership, parent education, policy change and enforcement, early intervention for high-risk youth populations, and referral to treatment or recovery services for students with identified alcohol or drug problems.

SURVEILLANCE & MONITORING

3:8 Provide problem identification and referral for youth and adults within the educational systems

Problem identification and referral has been an effective approach to addressing alcohol abuse and drug use with those misusing and abusing substances. Schools, colleges and universities are in a unique position to identify individuals early and to provide brief interventions or referrals to more comprehensive services. In the *Health & Medical* section of this report, an evidence-based approach to problem identification and referral known as SBIRT (Screening, Brief Intervention and Referral to Treatment) is presented as one approach that has strong evidence of effectiveness in emergency room and primary care settings. SBIRT or a similar approach can be applied in school settings when a student is found to be in violation of an alcohol or drug policy or who requires medical attention as a result of alcohol abuse or drug use, including prescription drug misuse or abuse.

RESOURCES

PRESCRIBING & MONITORING

The **New Hampshire Board of Nursing** provides continuing education opportunities for nurses, including school and campus nurses.

http://www.nh.gov/nursing/education/index.html

SCREENING & BRIEF INTERVENTIONS

The U.S. **Substance Abuse and Mental Health Services Administration** (SAMHSA)'s SBIRT initiative has included grant programs, policy briefs, and training to encourage the implementation of SBIRT in a wide range of settings from emergency rooms to school-based health centers

http://www.samhsa.gov/samhsanewsletter/Volume_17_Number_6/SBIRT.aspx

DRUG DIVERSION

The NH Drug Diversion Unit trainings to prevent unlawful diversion of prescription medications

http://www.nh.gov/safety/divisions/nhsp/isb/narcotics/index.html

LAW ENFORCEMENT TRAINING

The NH Division of Liquor Enforcement drug recognition expert training program and alcohol/drug training for alcohol licensees

http://www.nh.gov/liquor/enforcement.shtml

Contact: Sgt. Chris Hutchins (603) 271-3521

GENERAL TECHNICAL ASSISTANCE (COLLEGES & UNIVERSITIES)

U.S. Department of Education's Higher Education Center for Alcohol, Drug and Violence Prevention provides recommendations for college campus responses to R_x drug abuse

http://www.higheredcenter.org/services/assistance/topics/prescription-drug-abuse-among-college-students-0

PUBLIC EDUCATION & AWARENESS

The White House Office of National Drug Control Policy oversees "Parents – the Anti-Drug" and other education and awareness campaigns, providing web links, print materials and other resources to support school- and community-based awareness and outreach

http://www.theantidrug.com/drug-information/otc-prescription-drug-abuse/prescription-drug-rx-abuse/default.aspx

NIDA for Teens: PeeRx, an engaging website for youth, teachers, and parents to learn about prescription drug abuse

http://teens.drugabuse.gov/peerx/

BUSINESS

Business Recommendations Overview

PROFESSIONAL DEVELOPMENT & TRAINING

4:1 Increase the number of trainings and professional development opportunities available to and accessed by the workforce and employers

PUBLIC EDUCATION & AWARENESS

4:2 Promote public education and awareness within the workplace

STORAGE & DISPOSAL

4:3 Help promote community Take-Back events to collect unused medication

4:4 Ensure that worksite policies and practices articulate safe storage and use of medications to deter abuse or diversion

SURVEILLANCE & MONITORING

4:5 Establish, communicate and enforce drug-free workplace policies that include prevention of prescription drug misuse or abuse

4:6 Provide problem identification and referral for employees

Business Recommendations

Risk Management - Health Educators - Employee Assistance Programs
Safety Compliance Officers - Human Resource Departments
Senior Management - Business Owners & Operators

Employers are often as affected by the substance use of their employees as the employees' families and friends. Of the estimated 19.3 million current illicit drug users aged 18 or older in 2009, 12.9 million (66.6%) were employed either full- or part-time.[32] The effects of workers who abuse alcohol, prescription medications or illicit drugs can range from lost work time to unsafe work conditions. Employers, however, hold powerful tools and leverage to prevent and deter substance use through workplace policies and employee assistance programs. The following strategies are recommended for businesses and employers to consider in support of the state's commitment to prevent and reduce prescription drug misuse and abuse and its harmful consequences.

PROFESSIONAL DEVELOPMENT & TRAINING

4:1 Increase the number of trainings and professional development opportunities available to and accessed by the workforce and employers

Professional development and training provide education and strategies to ensure workers are aware of the risks of prescription drug abuse and the consequences of misuse and abuse in the workplace. Professional development and training of risk managers, supervisors, and human resource departments also encourage appropriate enforcement of workplace standards and policies.

PUBLIC EDUCATION & AWARENESS

4:2 Promote public education and awareness within the workplace

Businesses can support public education and awareness through regular employee education programs that focus on worksite wellness and safety. Company websites and health and wellness initiatives offered by employers can be a means to communicate information about the health risks of alcohol and drug use, including prescription drug misuse and abuse.

STORAGE & DISPOSAL

4:3 Help promote community Take-Back events to collect unused medication

Businesses, particularly those in the health or safety field, can help promote community Take-Back events and even contribute resources for their successful implementation. Resources may take the form of sponsorship of space, promotional materials, or equipment to support such events. For example, a local Rotary Club in the Keene, NH area provided funding to support a permanent drop-box at a local police department for Take-Back opportunities outside of special events.

STORAGE & DISPOSAL

4:4 Ensure that worksite policies and practices articulate safe storage and use of medications to deter abuse or diversion

Employers can promote safe storage and medication use at job sites to deter abuse or diversion. Policies may require that employees inform employers if they are taking prescribed narcotics during work hours and receive guidelines on how and where to store and access medications on the job site when necessary. It is critical, however, that employers respect employees' rights and that policies do not interfere with privacy considerations.

SURVEILLANCE & MONITORING

4:5 Establish, communicate and enforce drug-free workplace policies that include prevention of prescription drug misuse or abuse

Model workplace policies include educating employees about the health and productivity hazards of alcohol abuse, prescription drug misuse and abuse, and illicit drug use. Company wellness programs and employee assistance programs can be leveraged to communicate company policies and ongoing health and safety promotion. More comprehensive policies may also include mandatory random drug testing; clearly communicated consequences for any alcohol or drug abuse; rules for how and where allowable prescription drugs should be stored or accessed during work hours; mandatory participation in regular education programs regarding the harm of addiction and the impact of substance use on worker productivity, workplace safety, and other considerations; and consistent enforcement of all workplace policies.

SURVEILLANCE & MONITORING

4:6 Provide problem identification and referral for employees

As noted in previous sections of this document, problem identification and referral is an important strategy in protecting individuals' health and safety. Through employee assistance programs or more informal arrangements within small businesses, brief conversations can allow employers and supervisors to identify and respond to problems early on. If an employee is at risk of developing a serious problem, he/she may receive a brief intervention that focuses on raising their awareness of substance abuse risks and motivating them to change their behavior while those who may need more extensive treatment receive referrals to specialty care.[33]

RESOURCES

MODEL WORKPLACE POLICES

U.S. Department of Labor "Policy Builder" provides guidance in developing and maintaining an effective workplace policy; samples included.

http://www.dol.gov/elaws/asp/drugfree/drugs

EMPLOYEE EDUCATION

U.S. Department of Labor Employee Education curriculum provides employee education modules on drugs and alcohol in the workplace, including business impact and safety. Download educational programs for use in the workplace.

http://www.dol.gov/asp/programs/drugs/workingpartners/dfworkplace/employee/impact.htm

INFORMATION DISSEMINATION

"Prescription Drug Abuse in the Workplace" – a publication of the U.S. Substance Abuse and Mental Health Services Administration

http://workplace.samhsa.gov/pdf/Prescription%20Drug%20Abuse%20Fact%20Sheet.pdf

GOVERNMENT

Government Recommendations Overview

PROFESSIONAL DEVELOPMENT & TRAINING

5:1 Support licensing boards in addressing concerns relative to prescribing and dispensing controlled drugs

PUBLIC EDUCATION & AWARENESS

5:2 Lead and/or support a public awareness campaign

5:3 Identify, promote and support evidence-based programs, policies and practices that communities can adopt to deter abuse

STORAGE & DISPOSAL

5:4 Continue to support state and local opportunities to collect and safely dispose of unused medication

SURVEILLANCE & MONITORING

5:5 Pass legislation to implement an electronic Prescription Drug Monitoring Program

5:6 Adjust existing state-level data collection to provide greater detail relative to the prevalence, causes, sources, and consequences of prescription drug abuse

5:7 Provide leadership and oversight in coordinated surveillance, monitoring and strategic planning

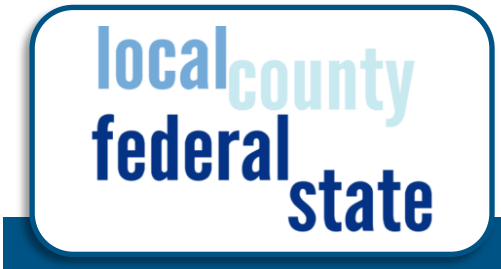
RESOURCE DEVELOPMENT

5:8 Provide reimbursement to health and medical practitioners for Screening, Brief Intervention and Referral to Treatment (SBIRT)

5:9 Expand funding for treatment to increase access for individuals requiring treatment for prescription drug abuse

5:10 Consider specialized or "therapeutic" courts that provide culturally sensitive assessments, treatment and recovery opportunities in place of traditional probation or incarceration

Government Recommendations



State Lawmakers - County Officials
Local Governance - State Agencies & Commissions

Local, county and state governments play a critical role in addressing the prescription drug abuse epidemic in that they are able to develop effective population-level laws and regulations and to direct resources to meet identified needs. In spite of the difficult economic pressures at all levels of government, lawmakers and elected officials can also bring much needed visibility, leadership, legislation, and collective commitment to combat the growing epidemic in New Hampshire. Resources in service to local, regional and state government actions are provided at the end of this section.

PRESCRIBING & DISPENSING

5:1 Support licensing boards in addressing concerns relative to prescribing and dispensing controlled drugs

The state government sector provides necessary oversight of prescribing and dispensing practices through its licensing boards. In New Hampshire, the Board of Medicine, the Board of Nursing and the Board of Pharmacy exist for the safety and protection of New Hampshire citizens. In light of the epidemic of prescription drug abuse it is recommended that government leaders and lawmakers ensure licensing boards have sufficient resources and authority to protect citizens through well-monitored and enforced prescribing and dispensing practices. Licensing boards should also encourage citizens and professionals alike to report concerns related to prescribing and dispensing.

PUBLIC EDUCATION & AWARENESS

5:2 Lead and/or support a public awareness campaign

The New Hampshire Bureau of Drug and Alcohol Services and the public education and awareness task force of the Governor's Commission on Alcohol and Drug Abuse work closely with the Partnership for a Drug Free New Hampshire and the National Guard Counterdrug Task Force to develop and disseminate public media campaigns and other public service announcements to prevent and reduce alcohol abuse and other drug use. Continuing and expanding the capacity of these partnerships and efforts in order to increase the public's awareness of the dangers of prescription drug misuse, abuse and diversion is a critical component of an effective state prevention strategy. All state agencies and divisions can assist in the dissemination of public service announcements and campaigns relative to prescription drug abuse in service to this *Call to Action*.

PUBLIC EDUCATION & AWARENESS

5:3 Identify, promote and support evidence-based programs, policies and practices that communities can adopt to deter abuse

Through the Bureau of Drug and Alcohol Services and its training and technical assistance contractors, evidence-based programs, policies and practices for schools, businesses, police departments, medical practices, and other community sectors can be identified and promoted. In addition, the Bureau's Regional Network System can be mobilized to support community sectors in their adoption of evidence-based prevention, intervention, and treatment policies and programs. Other state agencies such as the New Hampshire Department of Safety, the Department of Health and Human Services, the Department of Education, the National Guard, the Attorney General's Office, state licensing boards, and others may also identify and promote evidence-based efforts within their fields of practice and specialty in response to this *Call to Action*.

STORAGE & DISPOSAL

5:4 Continue to support state and local opportunities to collect and safely dispose of unused medication

As mentioned in the *Safety & Enforcement* section of this document, the New Hampshire Attorney General supported the passage of legislation (House Bill 71) to allow communities and private entities in conjunction with law enforcement to conduct local pharmaceutical drug Take-Back events and programs to collect, store, and dispose of unused controlled and uncontrolled prescription drugs in a safe and effective manner. The legislation allows for individuals to drop off medications anonymously and lessens the disposal restrictions for drugs collected in this venue that are much more stringent as stipulated in RSA 318-B:17 for illicit drug disposal.[34] At this time, the Department of Justice has initiated the formal rulemaking process.

SURVEILLANCE & MONITORING

5:5 Pass legislation to implement an electronic Prescription Drug Monitoring Program

Legislation to allow for the establishment of an electronic controlled drug prescription monitoring program (PMP) will provide prescribers and dispensers timely access to information for the purposes of monitoring patients' prescriptions. Federal guidelines recommend that Schedule II through V medications be included in PMPs, although current pending legislation in New Hampshire includes Schedule II and III drugs only (Please see *Appendix G* for a list of controlled drugs by schedule classification). Legislation has been submitted and considered each year since 2008 and is currently in interim study as House Bill 332-FN. The most recent version of the house-initiated legislation recognizes that prescription drug abuse is a significant problem in the state and that individuals with substance use disorders may seek controlled drugs from health care providers. It also articulates that "allowing providers to have access to information suggesting that their patients have been 'doctor shopping' can help them provide better care for these patients."[35]

In December of 2011, the New Hampshire Senate also introduced PMP legislation (SB 286) titled, *Controlled Drug Prescription Health and Safety Program*. The recently filed bill states the General Court's belief that:

> A controlled drug prescription health and safety program that fully complies with all state and federal Health Insurance Portability and Accountability Act (HIPPA) privacy and security laws and regulations should be established as a tool to improve medical treatment. (IV)[36]

The bill further states that:

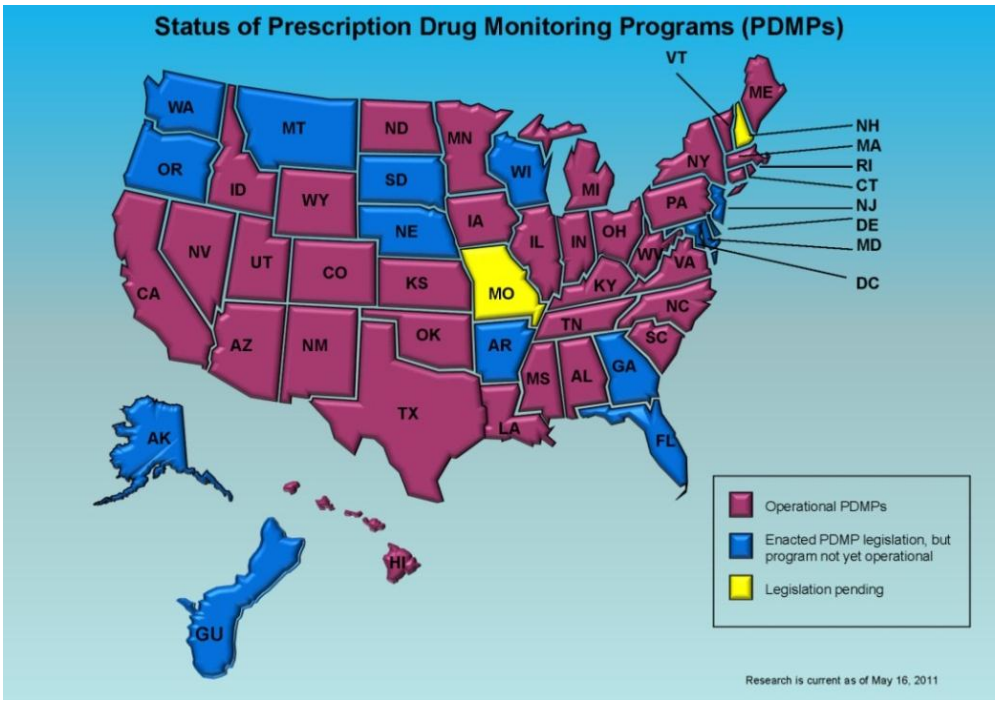
> a controlled drug prescription health and safety program will reduce patient morbidity and mortality associated with controlled drugs by providing a secure program through which the prescriber and the dispenser may access information on a patient's controlled drug prescription history. The program established by this act is designed to create a greater sense of safety, security, and comfort in the health practitioner-patient relationship when controlled drugs are prescribed. (V)[37]

This newly pending legislation in New Hampshire is to include Schedule II through IV controlled drugs and is sponsored by 15 of the state's 24 senators.

The effectiveness of prescription drug monitoring programs has been documented by independent evaluations of individual states' programs and by researchers working under contract with the U.S. Department of Justice. In an independent evaluation of Kentucky's PMP program known as KASPER, the University of Kentucky documented the state's adoption of a PMP program in 1998 and its enhancement in 2005 to a 24 hour real-time accessible system (eKASPER). The evaluation found that 86% of prescribers using the system indicated the information either confirmed a decision to prescribe a controlled drug or altered their decision. Only 4% of prescribers who utilized the system indicated that the information accessed had no impact on their prescribing decisions.[38]

In an evaluation of 20 states' PMP programs commissioned by the U.S. Department of Justice, researchers examined outcomes by PMP type, noting important distinctions between states with reactive versus proactive monitoring programs. The researchers defined "reactive" programs as those generating "solicited reports" only in response to a specific inquiry made by a prescriber, dispenser, or other party with appropriate authority, whereas "proactive" programs were defined as those generating "unsolicited reports" for identification or investigation or when the system deemed it was warranted. In this evaluation, researchers found that the presence of a PMP is associated statistically with a reduction in the per capita supply of prescription pain relievers and stimulants, and that this in turn reduces the probability of abuse. This finding was evident in states with both proactive and reactive PMPs, but was stronger in an aggregate of states with proactive programs.[39]

PMP legislation and resulting implementation of electronic systems to provide access to data on prescriptions being written and filled for individuals is one of the most universally recommended and adopted strategies by state governments to combat prescription drug misuse, abuse and diversion. New Hampshire is one of only two states that have not adopted PMP legislation to date.



SURVEILLANCE & MONITORING

5:6 Adjust existing state-level data collection to provide greater detail relative to the prevalence, causes, sources, and consequences of prescription drug abuse

The State of New Hampshire collects data regularly on the prevalence and perception of prescription drug misuse and abuse including surveys, death data, criminal offenses, and hospital and emergency room admissions and discharges. Survey-based data collection includes the state sample and local sample administration of the Youth Risk Behavior Survey (YRBS) of high school aged youth and the Behavioral Risk Factor Surveillance System (BRFSS) survey of adults in New Hampshire. The YRBS is a paper survey completed in a school setting and overseen by the New Hampshire Department of Education. The BRFSS is a phone survey conducted by the New Hampshire Department of Health and Human Services through the University of New Hampshire Survey Center. National and federal recommendations include the adjustment of survey questions to better differentiate misuse from abuse. Data are also collected by the New Hampshire Medical Examiner and the New Hampshire Department of Safety. Currently, existing state-level data collection such as during emergency room admissions or local police arrests may not provide adequate specificity for data mining relative to prescription drug misuse, abuse and diversion. Therefore, it is recommended that existing data collection efforts be expanded and/or enhanced to better monitor and respond to prescription drug misuse, abuse and diversion.

SURVEILLANCE & MONITORING

5:7 Provide leadership and oversight in coordinated state-level surveillance, monitoring and strategic planning

The New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment provides the structure and process for ongoing leadership and oversight of state-level surveillance, monitoring and strategic planning relative to prescription drug abuse. Its relationship to the State Epidemiological Outcome Workgroup for behavioral health and its prevention, treatment, public education and awareness, and health care task forces should be leveraged to provide integrated and coordinated surveillance and monitoring of the population-level data relative to prescription drug abuse as well as of the activities of community stakeholders and state agencies in support of this *Call to Action*. The Commission will determine if its current structure and operations will provide adequate leadership or oversight or if a special task force will be formed to provide an opportunity for state agencies and partnerships to provide activity updates relative to this *Call to Action*. Additionally, the Commission is responsible for the development and implementation of the state's five-year strategic plan to prevent, reduce and treat substance use disorders, currently slated for revision and publication in the fall of 2012. It is anticipated that prescription drug abuse prevention, intervention and treatment will be prominent in the revised five-year strategic plan.

SURVEILLANCE & MONITORING

5:8 Provide reimbursement to health and medical practitioners for Screening, Brief Intervention and Referral to Treatment (SBIRT)

Although financial resources are scarce for new initiatives, it is recommended that state government consider means to reimburse health and medical practitioners for SBIRT, explained in greater detail in the *Health & Medical* section of this document. Some private insurance plans include such reimbursement which, when coupled with necessary training and technical assistance, provides an incentive for prescribers to screen for alcohol or other drug problems, including prescription drug abuse, and to help patients recognize their own risk of abuse and to seek specialized care if a substance use disorder is evident. The federal Affordable Care Act may include reimbursement provisions in 2014 for SBIRT implementation.

RESOURCE DEVELOPMENT

5:9 Expand funding for treatment to increase access for individuals requiring treatment for prescription drug abuse

With the increase in individuals presenting in state-funded treatment programs for prescription drug abuse, sufficient capacity to effectively treat substance use disorders, particularly addiction to opioids, is critical. Treatment provides an opportunity for those struggling with addiction and dependence to receive effective and culturally sensitive care, to better manage mental and behavioral health conditions, and to restore their quality of life.

5:10 Consider specialized or "therapeutic" courts that provide culturally sensitive assessments, treatment and recovery opportunities in place of traditional probation or incarceration

Specialized courts such as drug courts[40] and mental health courts[41] exist in several court systems throughout the state. During the *Prescription Drug Abuse Strategy Summit* in October 2011, it was noted that the legislature had considered increasing the availability of drug courts throughout the state but that federal or other resources would be needed to implement this strategy. It was also noted that many intervention programs that in previous years provided education and treatment resources in place of traditional probation or incarceration have closed due to budget reductions but that leadership within the New Hampshire Superior Court system is promoting innovative approaches to alternative sentencing to better address addiction and mental health conditions.

List of locations where drug courts and mental health courts are operational.

Concord:	Drug Court (juvenile offenders only)
	Mental Health Court
Nashua:	Drug Court (juvenile offenders)
	Mental Health Court
Exeter:	Mental Health Court
Portsmouth:	Mental Health Court
Grafton:	Adult Felony Drug Court
Laconia:	Drug Court (juvenile offenders only)
Lebanon:	Mental Health Court
Littleton:	Mental Health Court
Manchester:	Mental Health Court
Keene:	Mental Health Court
Rochester:	Mental Health Court
Rockingham:	Adult Felony Drug Court
Strafford:	Adult Felony Drug Court

SOURCE: http://www.courts.state.nh.us/drugcourts/index.htm

RESOURCES

GOVERNMENT POLICY RECOMMENDATIONS

NATIONAL STRATEGY

Center for Lawful Access and Abuse Deterrence (CLAAD)

http://www.claad.org/resources/policy-recommendations

FEDERAL STRATEGY

White House Office of National Drug Control Policy

http://www.whitehouse.gov/ondcp/2011-national-drug-control-strategy

RELATED RESOURCES

Medscape – Substance Abuse & Addiction

http://www.medscape.com/resource/substance-abuse

Bureau of Justice Assistance – Mental Health Courts Program

http://www.ojp.gov/BJA/grant/mentalhealth.html

National Criminal Justice Reference Service – Drug Court Programs

https://www.ncjrs.gov/spotlight/drug_courts/summary.html

SPECIAL POPULATIONS

Special Populations

Special populations affected by prescription drug abuse include military personnel, individuals re-entering communities from correctional facilities, and older adults. Below are presented some data available for each focus population and strategies and resources recommended to address prescription drug abuse with each population of focus. Other focus populations and specific recommendations will be reviewed and considered in future Commission work.

MILITARY PERSONNEL

- Between 2002 and 2005, prescription drug abuse among military personnel doubled; and between 2005 and 2008 almost tripled, while tobacco use and illicit drug use decreased.[42]
- According to New Hampshire National Guard statistics, during Fiscal Year 2010, there were 39 substance abuse referrals into the Prevention, Treatment, and Outreach (PTO) program and of those, five were specific to prescription drug abuse.[43]

RECOMMENDATIONS

- ☑ Continue implementation of the comprehensive policy within armed forces that prohibits abusing any substance including prescription medications
- ☑ Continue required annual training for service members relative to prescription drug abuse, alcohol use and other drug use.
- ☑ Continue to disseminate "Harmful Interactions of Prescription Drugs" pamphlets and other materials relative to the risks and early warning signs of prescription drug abuse
- ☑ Continue random urinalysis testing to deter and intervene early in potential prescription drug abuse
- ☑ Continue to promote the PTO program as a service available to all members of the military needing help with alcohol abuse or drug use
- ☑ Through either self-referral or a positive urinalysis, continue to develop and monitor treatment plans based on a comprehensive assessment of needs

CORRECTIONS POPULATIONS

During 2010, 1,158 state prison inmates were screened for substance use disorders. Of those screened 57% reported using or abusing drugs, with 16% of that subset reporting prescription drug abuse.[44]

RECOMMENDATIONS

- ☑ Connect re-entry population with primary care settings and/or health homes, sharing re-entry plans with care providers including considerations for alcohol or drug abuse history, treatment, and recovery plans
- ☑ Consider special protocols for those working with re-entry populations in relapse prevention response
- ☑ Educate re-entry population on risks of prescription drug misuse and abuse within the context of health promotion and the prevention of relapse and/or recidivism
- ☑ Educate primary and specialty health and medical professionals in culturally sensitive care for re-entry populations
- ☑ Support education of families of re-entry population in risks, warning signs, and resources available

OLDER ADULTS

According to the National Institute on Drug Abuse, individuals aged 65 years and older comprise only 13 percent of the population, yet account for more than one-third of total outpatient spending on prescription medications in the United States.[45] Because older populations are more likely to be prescribed long-term and multiple prescriptions and more likely to experience cognitive decline, the potential for medication misuse may be heightened. Fixed incomes, interactions with alcohol consumption, age-related metabolism changes, untreated health conditions, over-the-counter medications, and other contributing factors may increase the risk of harm related to prescription drug use for older adults.

In New Hampshire, in 2010 deaths related to drug abuse, including prescription drug abuse, were most prevalent in the 41 to 50 year old age range, followed by the 51-60 year old age range.[46] Special attention should be given by prescribers, dispensers, and health educators to the prevention and early intervention of prescription drug misuse and abuse among older adults.

RECOMMENDATIONS

- ☑ Programs unique to New Hampshire, such as the *REAP program*, provide in-home based counseling to older adults in mental, emotional and physical health promotion and risk prevention. These and other programs within primary care may be tapped for increased education and awareness among older adults who may be a higher risk for prescription drug misuse and/or abuse.

- ☑ Health education and patient counseling sensitive to the unique conditions of older adults should be developed and implemented in a wide range of care settings, including hospitals, long-term care facilities, assisted living communities, and home- and community-based support systems.

- ☑ Problem identification and referral, such as Screening, Brief Intervention and Referral to Treatment (SBIRT) described in other sections of this report, may provide important opportunities for physicians, nurse practitioners, social workers, health educators, and other professionals working with older adults to increase awareness among older adults of prescription drug dangers and to intervene early if a problem exists.

COMMITMENTS TO ACTION

Commitments to Action

by State Agency or Stakeholder

This section of the *Call to Action* presents action plans developed and endorsed by key stakeholders and member agencies of the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment in service to the plan's goals. The Commission may establish a task force in 2012 to ensure ongoing implementation of action plans, collaboration in support of the shared commitments, and monitoring of activities and trend data to determine successful reductions in prescription drug abuse and its harmful consequences.

Key stakeholder & member agencies committing to specific action in service to the *Call to Action:*

- Adjutant General of the New Hampshire National Guard
- New Hampshire Office of the Attorney General
- New Hampshire Board of Medicine
- New Hampshire Board of Pharmacy
- New Hampshire Bureau of Drug & Alcohol Services
- New Hampshire Department of Corrections
- New Hampshire Department of Education
- New Hampshire Department of Safety
- New Hampshire Division of Liquor Enforcement
- New Hampshire Division of Public Health Services
- New Hampshire Medical Society

Adjutant General of the New Hampshire National Guard

The New Hampshire Office of the Adjutant General is committed the following objectives in service to the state plan to prevent and reduce prescription medication misuse, misdirection and abuse.

PUBLIC EDUCATION & AWARENESS

	Commitment	Action Indicator(s)	Time Frame	Notes
6:1	Continue Guard efforts to educate its soldiers and airmen about prescription drug abuse	Number of Guard members trained	SFY 2012 & ongoing	Existing training requirements for members of the NH National Guard may be leveraged to increase knowledge of prescription drug abuse.
6:2	Continue Guard efforts to support community coalitions and increase public awareness through the Guard's Counter Drug Task Force	Number of community coalition assistance requests supported by the Guard	SFY 2012 & ongoing	Members of the Guard's Counterdrug Task Force are currently assigned to the NH Bureau of Drug and Alcohol Services to support community coalition development through direct educational programs, information dissemination, media messaging, and technical assistance in support of community engagement in prevention.

STORAGE & DISPOSAL

	Commitment	Action Indicator(s)	Time Frame	Notes
6:3	Continue Guard efforts to support state-wide Take-Back events to collect unwanted prescription drugs	Data on Guard-supported R_x Take-Back events and outcomes	SFY 2012 & ongoing	The NH National Guard has been supporting state-wide Take-Back events since the strategy's inception in 2010. Three state-wide events have been held in NH since 2010 in conjunction with federally designated dates.

SURVEILLANCE & MONITORING

	Commitment	Action Indicator(s)	Time Frame	Notes
6:4	Continue random drug testing and reporting for prescription drug misuse and abuse among Guard members	Data from annual drug testing	SFY 2012 & ongoing	Department of Defense members regularly submit to random urinalysis testing. It is anticipated that testing for hydrocodone and benzodiazepine use will be added to the standard drug testing panel during federal FY'12.
6:5	Continue Guard efforts to provide federal, state, and local law enforcement agencies with investigative case and analyst support	Case/analysis contributions and outcomes	SFY 2012 & ongoing	The NH National Counterdrug Task Force currently provides investigative case and analyst support to numerous law enforcement agencies operating in the State of NH.

PROBLEM IDENTIFICATION & REFERRAL

	Commitment	Action Indicator(s)	Time Frame	Notes
6:6	Leverage existing counseling services and Access to Recovery (ATR) care coordination for Guard members referred for intervention or treatment	Number of Guard members educated about the referral process and counseling/ treatment services available	SFY 2012 & ongoing	ATR provides assessments and care coordination to support treatment and recovery plans for those Guard members with a diagnosable substance use disorder.

New Hampshire Office of the Attorney General

The New Hampshire Office of the Attorney General will be responsible for the following objectives in service to the state plan to prevent and reduce prescription medication misuse, misdirection and abuse.

PROFESSIONAL DEVELOPMENT & TRAINING

	Commitment	Action Indicator(s)	Time Frame	Notes
7:1	Increase the number of trainings and professional development opportunities available to and accessed by law enforcement & other safety personnel by a minimum of 2 per year	Number and participation of trainings/professional development offered and accessed	SFY 2012 & ongoing	The AG works in partnership with Policy Standards and Training Unit (PTSU) and other training organizations. Topics to include: Enforcing DWI laws applicable to influence of R_x drugs, investigating R_x drug forgery cases.
7:2	Co-develop and provide collaborative trainings with multiple stakeholders	Number of trainings developed, offered and accessed	SFY 2013 & ongoing	This action requires funding or in-kind resources including partnerships with training centers for key constituencies (e.g. health care professionals, safety & law enforcement, community coalitions/ networks, public health, businesses, health educators, and others).

PUBLIC EDUCATION & AWARENESS

	Commitment	Action Indicator(s)	Time Frame	Notes
7:3	Develop and disseminate Legal Bulletins specific to R_x Drug Abuse using the existing resources of the Attorney General's Office	Number of bulletins developed and disseminated	SFY 2013 & ongoing	This action will be implemented in partnership with New Hampshire Intelligence and Analysis Center (NHIAC), a clearinghouse developed to function as a focal point of two-way communication amongst all partners and other state agency information dissemination channels.

STORAGE & DISPOSAL

	Commitment	Action Indicator(s)	Time Frame	Notes
7:4	Support legislative rulemaking for "cooperative action" relative to periodic community and/or state R_x Drug Take-Back events	Rulemaking completed and disseminated	SFY 2012 & ongoing	The formal rulemaking process has been initiated by the Department of Justice. The rulemaking process generally takes several months to complete, requiring a public hearing, a review by attorneys at the Office of Legislative Services, preparation of fiscal impact statements by state agencies, and a hearing before the Legislature's Joint Legislative Committee on Administrative Rules.
7:5	Provide leadership, partnership, and support as needed to encourage periodic community-level R_x Take-Back events and locations	Data on R_x Take-Back events and outcomes	SFY 2012 & ongoing	This action will rely on partnerships with local law enforcement, federal law enforcement (DEA), prescribers, pharmacists, and community organizations and networks.

SURVEILLANCE & MONITORING				
	Commitment	Action Indicator(s)	Time Frame	Notes
7:6	Institute prescription drug monitoring program for prescribers and pharmacists through legislation	Legislation introduced, passed, enacted	SFY 2012 & ongoing	The Attorney General's Office continues to proactively support legislative initiatives to establish a prescription drug monitoring program.

New Hampshire Board of Medicine

The new Hampshire Board of medicine oversees licensing disciplinary action relative to physicians (M.D. and D.O.) and physician assistants (P.A.) practicing medicine in the State of New Hampshire. The Board investigates complaints and issues disciplinary action when appropriate. The Board is also involved in legislative policy and advocacy and the cultivation of continuing education for licensees. The New Hampshire Board of Medicine is committed to the following objectives in service to the state plan to prevent and reduce prescription medication misuse, misdirection and abuse.

PROFESSIONAL DEVELOPMENT & TRAINING

	Commitment	Action Indicator(s)	Time Frame	Notes
8:1	Increase availability of and access to continuing education for licensees relative to prescribing of opioids	Number of trainings/ professional development offered and accessed by prescribers	SFY 2012 & ongoing	Currently working with Boston University Medical School to bring training resources to NH licensees
8:2	Increase availability and access to continuing education through cross-training of prescribers, specialty care, behavioral health/ addiction treatment, law enforcement and others	Number of trainings/ professional development offered and accessed by prescribers	SFY 2012 & ongoing	Collaborative may emerge through prescription drug task force and will likely include relationships with the Board of Pharmacy, the Drug Diversion Unit, the Medical Society, and the Board of Nursing

PUBLIC EDUCATION & AWARENESS

	Commitment	Action Indicator(s)	Time Frame	Notes
8:3	Promote public education and awareness about the role of the Board of Medicine and how to file a complaint	Dissemination of announcements or postings	SFY 2012 & ongoing	Current website provides information to the public on how to file a complaint

SURVEILLANCE & MONITORING

	Commitment	Action Indicator(s)	Time Frame	Notes
8:4	Support legislation relative to electronic access to patient prescription drug data	Testimony and contributions to rulemaking	SFY 2012 & ongoing	Board of Medicine has and will testify in support of prescription drug monitoring legislation

New Hampshire Board of Pharmacy

The NH Board of Pharmacy inspects and investigates consumer and professional complaints against licensees or registrants. The Board of Pharmacy maintains five full-time staff to regulate 301 in-state pharmacies; 386 out-of-state pharmacies; 2,355 NH-licensed pharmacists; 2,329 NH-registered pharmacy technicians; 994 manufacturers and distributors; and 106 limited drug distributors. The Board of Pharmacy also conducts inspections of pain clinics in New Hampshire. The New Hampshire Board of Pharmacy is committed to the following activities in service to the state plan to prevent and reduce prescription medication misuse, misdirection and abuse.

PROFESSIONAL DEVELOPMENT & TRAINING

	Commitment	Action Indicator(s)	Time Frame	Notes
9:1	Increase the number of trainings and professional development opportunities accessed by pharmacists by a minimum of 2 per year	Number of trainings/ professional development offered and accessed by pharmacists	SFY 2012 & ongoing	Training topics will include Pharmacist-In-Charge responsibilities, R_x Patrol, fraudulent scripts, and other drug-seeking scams, R_x drug disposal/DEA Take-Back events and opportunities, challenges in pain management, PharmAssist program (impairment recovery program for pharmacists), and other trainings to deter abuse and drug diversion.

PUBLIC EDUCATION & AWARENESS

	Commitment	Action Indicator(s)	Time Frame	Notes
9:2	Develop a web portal for pharmacists and prescribers to share general information about problems and solutions relative to R_x drug abuse and diversion	Web portal live and accessible to pharmacists & prescribers	SFY 2012 & ongoing	This action item will not be actionable until funding or in-kind resources become available.
9:3	Update and disseminate the "Pharmacy Diversion Alert!" document to pharmacists and pharmacy staff	Manual updated and disseminated	SFY 2012 & ongoing	The Board of Pharmacy will explore funding opportunities to implement this action.
9:4	Develop and implement a "Pharmacy of the Month" program to educate pharmacies in best practices and to recognize successes in deterring R_x drug abuse	Program initiated and operational	SFY 2013 & ongoing	The Board of Pharmacy will explore funding opportunities to implement this activity.

STORAGE & DISPOSAL

	Commitment	Action Indicator(s)	Time Frame	Notes
9:5	Develop and provide collaborative trainings with multiple stakeholders	Number of trainings developed & accessed	SFY 2013 & ongoing	This action requires funding or in-kind resources including partnerships with the state's Regional Network System or similar stakeholder representation.

SURVEILLANCE & MONITORING				
	Commitment	Action Indicator(s)	Time Frame	Notes
9:6	Increase investigations of pharmacies relative to "internal" diversion	Increase in investigations conducted	SFY 2012 & ongoing	Funding will be required to increase investigative resources.
POLICY & LEGISLATION				
	Commitment	Action Indicator(s)	Time Frame	Notes
9:7	Work with the Attorney General's office to consider and/or introduce legislation to limit an individual's ability to fill a prescription written outside of the northeast to one fill per 10 days	Legislation researched and introduced	SFY 2012 & ongoing	This action is under consideration due to pharmacist concerns regarding the prevalence and pattern of prescriptions being seen from Florida and other states. The action may not be necessary if PMP legislation is passed.

New Hampshire Bureau of Drug & Alcohol Services

As the federal Single State Authority designee for alcohol and drug abuse efforts, the New Hampshire Bureau of Drug and Alcohol Services has its primary mission to reduce alcohol and other drug misuse and its social, health, and behavioral consequences for the citizens of New Hampshire through public policy and resource development, education, and by supporting initiatives that ensure the delivery of effective and coordinated prevention, intervention, treatment and recovery support services. The Bureau carries out its mission through a system of regional networks focused on community strategies to prevent alcohol and other drug abuse, including the misuse of prescription drugs, as well as through technical assistance, training, public information, treatment services and recovery supports to provide an effective continuum of care for individuals, families and communities.

Through its mission and service array, the Bureau is well poised to implement and promote state-, community- and provider-level strategies in service to the growing problem of prescription drug misuse and abuse. The New Hampshire Bureau of Drug and Alcohol Services is committed to the following objectives in service to the state plan to prevent and reduce prescription medication misuse, misdirection and abuse.

PROFESSIONAL DEVELOPMENT & TRAINING				
	Commitment	Action Indicator(s)	Time Frame	Notes
10:1	Increase the number and reach of training and professional development relative to evidence-based approaches to prescription drug misuse, including but not limited to opioid abuse	Number of trainings offered and accessed for prescription drug abuse prevention, intervention and treatment	SFY 2013 & ongoing	This action will seek to increasing training opportunities through existing resources such as the New Hampshire Training Institute on Addictive Disorders contractor, the New England School of Addiction Studies, state partners, the community college and university system, federal technical assistance systems, and other stakeholders.
10:2	Strengthen partnerships and capacity of state-funded treatment providers and primary care in support of medication-assisted recovery (e.g. suboxone)	Documentation of partnerships and capacity development	SFY 2013 & ongoing	This action will leverage systems change opportunities of the Affordable Care Act (ACA) to strengthen partnerships between and capacity of addiction treatment and primary care.
STORAGE & DISPOSAL				
	Commitment	Action Indicator(s)	Time Frame	Notes
10:3	Continue to encourage the Regional Network System to facilitate and/or support community Take-Back events to collect unwanted R_x drugs	Data on Regional Network-supported R_x Take-Back events and outcomes	SFY 2012 & ongoing	Efforts are already being undertaken by the Regional Network System and have been highlighted during Governor's Commission meetings and in this report.

SURVEILLANCE & MONITORING

Commitment		Action Indicator(s)	Time Frame	Notes
10:4	Expand public education and awareness activities specific to R_x drug abuse prevention, intervention, treatment and recovery	Dissemination of R_x drug prevention media and other communications	SFY 2012 & ongoing	This action will leverage the existing capacity of Partnership for a Drug Free NH, the Bureau's Clearinghouse and Lending Library, and current communication conduits such as the Regional Network
10:5	Continue the biannual cooperative administration of the Youth Risk Behavior Survey (YRBS) with the NH Department of Education for data collection relative to youth Rx drug abuse prevalence, perceived risk, availability and perceived wrongness and ensure R_x drug questions are worded to maximize understanding of issue and causes	Number and nature of R_x drug questions on YRBS Number of schools & students participating Data outputs	SFY 2013 & ongoing	This action item relies on shared resourcing between the NH Bureau of Drug and Alcohol Services (BDAS) and the NH Department of Education. Data dissemination takes place through schools and the Bureau's Regional Network System serving community substance use prevention priorities
10:6	Continue to support the state's annual administration of the Behavioral Risk Factor Surveillance System (BRFSS) through DHHS Health Statistics and Data Management for data collection relative to R_x drug misuse and abuse	Annual BRFSS Data outputs relative to R_x drug abuse prevalence	SFY 2012 & ongoing	In SFY 2009 the Bureau contributed leadership and funding to add questions to the BRFSS relative to prescription drug misuse and abuse to collect data on adult prevalence and trends. This action is shared with the NH Department of Public Health Services.
10:7	Leverage the work of the State Epidemiological Outcomes Workgroup (SEOW) for increased analysis and indicator determinations to support the state's ongoing surveillance of prescription drug misuse, abuse, & impacts; make de-identified prescription data available to the SEOW for epidemiological analyses	SEOW data products	SFY 2012 & ongoing	The NH SEOW is making final revisions of an epidemiological data profile and recommendations for alcohol and drug monitoring, including prescription drug misuse and abuse. It is due for dissemination in January 2012.

New Hampshire Department of Corrections

The New Hampshire Department of Corrections will be responsible for the following objectives in service to the state's commitments to prevent and reduce prescription drug misuse, misdirection and abuse among corrections populations re-entering New Hampshire communities.
It is acknowledged here that the New Hampshire Department of Corrections launched a comprehensive, successful "in-house" response to the growing number of inmates who were entering correctional facilities with pain and addiction challenges by instituting a pain management clinic and new prescribing protocols that ensured inmates accessed a multi-disciplinary team to treat and manage chronic pain conditions through therapies including physical therapy, group therapy, diet and exercise rather than a single modality of just medication.

Between 2008 and 2010, the number of hydrocodone-acetaminophen (Vicodin) pills dispensed per month to New Hampshire inmates fell from 18,400 to 2,700. In addition, for those whose medications are managed within correctional facilities, the Department ensures that individuals who rely on prescription medication are prescribed those medications that will be accessible through Medicaid or other low-cost options, that inmates leaving correctional facilities have a 14-day supply of needed medications, and that, when possible, inmates leaving facilities are connected with a primary care facility. This strategy ensures that individuals will be able to access their prescriptions safely and affordably without having to resort to crime or inappropriate diversion for their medical needs. The activities below further reflect their ongoing commitment to supporting individuals in their re-entry to communities and traditional community health care and mental health care settings.

PROFESSIONAL DEVELOPMENT & TRAINING

	Commitment	Action Indicator(s)	Time Frame	Notes
11:1	Support increased training of parole/probation officers and applicable department of corrections staff regarding sensitivities of R_x medication with this population	Number of trainings offered and accessed	SFY 2012 & ongoing	This action requires interagency coordination and shared resources to support curriculum development and trainers. The action also requires dissemination channels and policy adaptation to encourage and/or require attendance at trainings. Topics may include the myths v. facts of high risk populations, due diligence of medical proof of R_x need such as x-rays or physical findings, the role of patient contracts, and other topics.

SURVEILLANCE & MONITORING

	Commitment	Action Indicator(s)	Time Frame	Notes
11:2	Continue screening and assessment of population for risk of prescription drug abuse upon intake and re-entry to community	Number of screenings and assessments	SFY 2012 & ongoing	With *Second Change Act* funding, the department has developed Memoranda of Understanding and/or contracts with community systems of care to support improved care and support as the population re-enters the community.

New Hampshire Department of Education

The New Hampshire Department of Education is committed the following objectives in service to the state plan to prevent and reduce prescription medication misuse, misdirection and abuse.

PROFESSIONAL DEVELOPMENT & TRAINING

	Commitment	Action Indicator(s)	Time Frame	Notes
12:1	Increase the number of trainings and professional development opportunities made available to school personnel relative to prevalence and prevention of R_x drug misuse and abuse	Number of trainings offered and accessed	SFY 2012 & ongoing	Training opportunities may be coordinated with the NH Drug Diversion Unit and other state-level partners.

PUBLIC EDUCATION & AWARENESS

	Commitment	Action Indicator(s)	Time Frame	Notes
12:2	Provide leadership on R_x drug abuse through Open Letters to principals and school communities noting importance of R_x drug awareness and abuse prevention	Number and dissemination of notices relative to R_x drug abuse originating from the Department	SFY 2012 & ongoing	Collaboration between the Department of Education and the Commission's prevention task force can support this.
12:3	Allow department communication channels to be used to disseminate information on R_x drug abuse prevention best practices, Take-Back events, training opportunities, public awareness, and related topics	Number and reach of communications disseminated using Department channels	SFY 2012 & ongoing	This action requires information sources to connect to the Department's communication channels, such as NH Drug Diversion Unit presentations to school principals, Partnership for a Drug Free NH messaging and materials to schools, local coalition and regional network messaging to school personnel and families, etc.

SURVEILLANCE & MONITORING

	Commitment	Action Indicator(s)	Time Frame	Notes
12:4	Continue the biannual administration of the Youth Risk Behavior Survey (YRBS) that includes questions relative to R_x drug abuse prevalence, perceived risk, availability and perceived wrongness; ensure R_x drug questions are worded to maximize understanding of issue and causes	Number & nature of R_x drug questions on YRBS Number of schools & students participating Data outputs	SFY 2012 & ongoing	This action item relies on shared resourcing between the NH Department of Education and the NH Bureau of Drug and Alcohol Services. Data dissemination takes place through schools and the Bureau's Regional Network System serving community substance use prevention priorities.

RESOURCE DEVELOPMENT				
	Commitment	Action Indicator(s)	Time Frame	Notes
12:5	Continue to seek grant funding and other resources to enhance and expand health promotion and risk prevention specific to R_x drug abuse	Resources sought and acquired	SFY 2013 & ongoing	The federal and state fiscal climate has affected resource opportunities such as the closure of the federal Safe and Drug Free Schools program), while ACA reform may provide more resources opportunities for school-based prevention and health promotion.

New Hampshire Department of Safety

The New Hampshire Department of Safety has been a leader in bringing visibility, attention and resources to the growing epidemic of prescription drug abuse in New Hampshire within the Department, within the Commission, and within the state at large to coordinate an effective response to the epidemic. Specifically, the Department launched a Drug Diversion Unit staffed by a state trooper and pharmacist who specialize in drug diversion investigations across the state and who commit 50% of their time to training and educating other law enforcement, safety and other professionals in prescription drug abuse and diversion.

The New Hampshire Department of Safety is committed the following objectives in service to the state plan to prevent and reduce prescription medication misuse, misdirection and abuse.

PROFESSIONAL DEVELOPMENT & TRAINING

	Commitment	Action Indicator(s)	Time Frame	Notes
13:1	Increase the number of trainings and professional development opportunities available to and accessed by law enforcement and other safety personnel (e.g. DWI of R_x Drugs, R_x drug forgery)	Number of training curricula developed, offered and accessed	SFY 2012 & ongoing	This action will be implemented in partnership with Policy Standards and Training Unit, the Drug Diversion Unit, and other stakeholders. Topics may include enforcing DWI laws applicable to influence of R_x drugs, investigating R_x drug forgery cases, investigating "Doctor Shopping", and other relevant topics.

PUBLIC EDUCATION & AWARENESS

	Commitment	Action Indicator(s)	Time Frame	Notes
13:2	Develop and disseminate Intelligence Bulletins specific to R_x drug abuse using the existing resources of the Intelligence Analysis Center (IAC)	Number and dissemination of bulletins developed	SFY 2012 & ongoing	In cooperation with the Attorney General's office, develop an intelligence bulletin strategy specific to the prescription drug threat to implement within the law enforcement and across multiple stakeholder systems such as pharmacies, hospitals, schools, practitioner associations, and local government.

New Hampshire Division of Liquor Enforcement

The New Hampshire Division of Liquor Enforcement is committed the following objectives in service to the state plan to prevent and reduce prescription medication misuse, misdirection and abuse.

PROFESSIONAL DEVELOPMENT & TRAINING

	Commitment	Action Indicator(s)	Time Frame	Notes
14:1	Increase the number of law enforcement personnel trained in Advanced Roadside Impairment Detection Enforcement (ARIDE)	Number of law enforcement trained in ARIDE annually	SFY 2012 & ongoing	ARIDE training helps officers become more proficient at detecting, apprehending, testing, and prosecuting impaired drivers and helps prosecutors familiarize themselves with drugs that impair driving and proper documentation needed to prosecute these types of cases.[47]
14:2	Increase the number of law enforcement and other personnel trained as Drug Recognition Experts (DREs)	Number of law enforcement and other personnel trained as DREs annually	SFY 2012 & ongoing	Drug Recognition Experts are able to determine if an individual is under the influence of a prescription drug and may increase the efficacy of law enforcement efforts relative to R_x drug abuse.

STORAGE & DISPOSAL

	Commitment	Action Indicator(s)	Time Frame	Notes
14:3	Continue to support local Take-Back events through shared resources with local law enforcement	Data Liquor Enforcement-supported R_x Take-Back events and outcomes	SFY 2012 & ongoing	The Division of Liquor Enforcement has provided support to several communities during local Take-Back events and is committed to continuing that effort.

New Hampshire Division of Public Health Services

The New Hampshire Division of Public Health Services is committed to being a responsive, expert, leadership organization that promotes optimal health and wellbeing for all. As the state public health department, the Division holds a unique leadership position in the state's public health system, setting direction based on science and the public health needs of our residents and serving as the steward for state and federal funds used to deliver essential public health services. The Division also holds the authority and accountability to enforce laws to protect the public's health.

The state's public health department oversees the community health center system, including one center that is involved in a national learning collaborative with the U.S. Centers for Medicaid & Medicare Services on better integration of patient education, prescribing practices and even an on-site pharmacy. Both this system and maternal and child health services are aware of increasing prescription drug misuse and abuse among patients and clients and have begun to focus attention to the problem.

Through its mission and service array, the Division of Public Health Services is well poised to support and promote state-, community-, and provider-level strategies in service to the growing problem of prescription drug misuse and abuse and is committed to the following objectives in service to the state plan to prevent and reduce prescription medication misuse, misdirection and abuse.

PROFESSIONAL DEVELOPMENT & TRAINING

	Commitment	Action Indicator(s)	Time Frame	Notes
15:1	Support access to and availability of training and professional development relative to evidence-based approaches to prevent prescription drug misuse and abuse	Number of trainings available and accessed	SFY 2012 & ongoing	This action item will leverage state partner agency resources for cross-training opportunities for systems of care overseen by the Division. These training resources may include those offered by the New Hampshire Training Institute on Addictive Disorders, the New Hampshire Department of Safety, and the boards of nursing, medicine, and pharmacy. Training topics may include patient education, prescribing practices, when to refer patients to specialized pain care, and problem identification and referral related to abuse or dependence.

PUBLIC EDUCATION & AWARENESS

	Commitment	Action Indicator(s)	Time Frame	Notes
15:2	Support public education and awareness activities specific to R_x drug abuse through existing dissemination channels and service delivery systems	Number and dissemination of R_x drug prevention media and other communications	SFY 2012 & ongoing	The Division will encourage dissemination of existing public education materials within public health service systems, including patient education and counseling opportunities.

SURVEILLANCE & MONITORING

	Commitment	Action Indicator(s)	Time Frame	Notes
15:3	Continue to collect and provide access to data relative to prescription drug misuse and abuse, including the state's annual administration of the Behavioral Risk Factor Surveillance System (BRFSS) and hospital/emergency room admissions and discharges through the Division of Health Statistics and Data Management; as PMP data become available, work with PMP to support periodic epidemiological analyses and reports on data trends and implications	Data collection and reporting activity	SFY 2012 & ongoing	The Division is committed to sustaining key data collection and monitoring systems to support prescription drug abuse surveillance and monitoring.

New Hampshire Medical Society

The New Hampshire Medical Society plays an active role in the landscape of prescription drug abuse prevention through support and leadership relative to legislative policy, professional development, standards and guidelines, and information dissemination. The Medical Society maintains a special task force on opioid pain management and provides a comprehensive list of resources to support practitioners in effective pain management and abuse deterrence. The New Hampshire Medical Society is committed the following objectives in service to the state plan to prevent and reduce prescription medication misuse, misdirection and abuse.

PROFESSIONAL DEVELOPMENT & TRAINING

	Commitment	Action Indicator(s)	Time Frame	Notes
16:1	Continue to provide access to training and professional development relative to prescription drug abuse and diversion	Number of trainings offered and accessed	SFY 2012 & ongoing	This action will leverage the cross-training opportunities with other stakeholders, including Department of Safety's Drug Diversion Unit and Board of Pharmacy.

PUBLIC EDUCATION & AWARENESS

	Commitment	Action Indicator(s)	Time Frame	Notes
16:2	Support legislation relative to electronic access to patient R_x drug data	Contributions to legislative efforts	SFY 2012 & ongoing	The Medical Society is actively engaged in the legislative process for current version of prescription drug monitoring program and supports data access for those prescribers not using electronic health records.
16:3	Utilize existing communication channels (e.g. list serves, web resources) to disseminate emerging data, recommendations, guidelines, and other information in support of effective prescribing practices	Dissemination data	SFY 2012	Disseminated information may include sample patient contracts, screening and assessment tools, guidelines for referral to addiction treatment, referring to specialty pain care, prevention of abuse/diversion, patient information cards, and other topics.

Endnotes

[1] "Prescription Drug Abuse: A Research Update from the National Institutes on Drug Abuse." *Topics in Brief.* May 2011. Accessed at: http://drugabuse.gov/pdf/tib/prescription.pdf

[2] Manchikanti L, Fellow B, Ailinani H, Pampati V. "Therapeutic Use, Abuse, and Nonmedical Use of Opioids: A Ten Year Perspective." *Pain Physician.* 13:401-435. 2010.

[3] U.S. Department of Health & Human Services Based on data from SDI, Vector One: National. Years 2000-2009. Accessed at: http://www.hhs.gov/asl/testify/2011/10/t20111004a.html#_ftn4

[4] As cited in the Associated Press by Hawley, Chris. "New powerful painkiller has abuse experts worried." December 26, 2011. Accessed at http://finance.yahoo.com/news/powerful-painkiller-abuse-experts-worried-180505140.html;_ylc=X3oDMTNuZmJwanQ2BF9TAzExODMzMDAxMDEEYWN0A21haWxfY2IEY3QDYQRpbnRsA3VzBGxhbmcDZW4tVVMEcGtnAzA0NmM1M2MyLTUzZDctMzY3Yi04MjQ3LTY2YjM3MmYxOGQxYQRzZWMDbWl0X3NoYXJlBHNsawNtYWlsBHRlc3QD;_ylv=3

[5] "Results from the 2009National Survey on Drug Use and Health: Volume I. Summary of National Findings." *Substance Abuse and Mental Health Services Administration,* 2010. (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10-4586 Findings). Rockville, MD. Accessed at: http://oas.samhsa.gov/NSDUH/2k9NSDUH/2k9ResultsP.pdf

[6] *Ibid.*

[7] "Monitoring the Future: A Synopsis of the 2009 Results of Trends in Teen Use of Illicit Drugs and Alcohol." *University of Michigan*, 2009.

[8] "Department of Defense 2008 Survey of Health Related Behaviors Among Active Duty Military Personnel." *Department of Defense*, 2009. Accessed at: http://www.tricare.mil/2008HealthBehaviors.pdf

[9] Based on data from SDI, Vector One: National. Years 2000-2009. Extracted June 2010. Accessed at: http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/AnestheticAndLifeSupportDrugsAdvisoryCommittee/UCM217510.pdf

[10] "Unintentional Drug Poisoning in the United States." *National Center for Injury Prevention and Control, Centers for Disease Control and Prevention*, July 2010.

[11] "Epidemic: Responding to America's Prescription Drug Abuse Crisis." *Office of National Drug Control Policy*, 2011. Accessed at: http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/rx_abuse_plan.pdf

[12] "Results from the 2006 National Survey on Drug Use and Health: National Findings." *Substance Abuse and Mental Health Services Administration*, 2007. (Office of Applied Studies, NSDUH Series H-32, DHHS Publication No.
SMA 07-4293). Rockville, MD. Accessed at: http://www.samhsa.gov/data/nsduh/2k6nsduh/2k6results.pdf

[13] Dr. Thomas Andrew, Chief Medical Examiner, NH Department of Safety. Interview with *NH Center for Excellence*, Spring 2011.

[14] "Nonmedical Use of Pain Relievers in Past Year among Persons Aged 12 or Older, by Age Group and Substate Region: Percentages, Annual Averages Based on 2006, 2007, and 2008 NSDUHs." (Table 8). *SAMHSA*, Office of Applied Studies, National Survey on Drug Use and Health, 2006, 2007, and 2008. Accessed at: http://oas.samhsa.gov/substate2k10/AgeGroupSpecificTbls/AgeTabs.pdf

[15] Client Event Data Set (CEDS) 2008-2010. *NH Bureau of Drug & Alcohol Services.*

[16] Dr. Thomas Andrew, Chief Medical Examiner, NH Department of Safety. Interview with *NH Center for Excellence*. 2011.

[17] *Ibid.*

[18] New Hampshire Youth Risk Behavior Survey (YRBS). 2009. Accessed at: http://www.education.nh.gov/instruction/school_health/documents/yrbs_report.pdf

[19] "The Partnership Attitude Tracking Study (PATS): Teens in Grades 7 through 12, 2005." *Partnership for a Drug-Free America*, May 16, 2006. Accessed at: http://www.drugfree.org/Files/Full_Teen_Report

[20] NH Department of Corrections: Division of Medical and Forensic Services. Data submission to BDAS on March 10, 2011.

[21] Findings from an assessment of community stakeholders led by *The Prevention Task Force of the NH Governor's Commission on Alcohol and Drug Abuse*, Spring 2011.

[22] "Epidemic: Responding to America's Prescription Drug Abuse Crisis" *White House Office of National Drug Control Policy*, 2011. Accessed at: http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/rx_abuse_plan.pdf

[23] "National Prescription Drug Abuse Strategy 2010." *Center for Lawful Access and Abuse Deterrence (CLAAD)*, 2010.

[24] "Epidemic: Responding to America's Prescription Drug Abuse Crisis" *White House Office of National Drug Control Policy*, 2011. Accessed at: http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/rx_abuse_plan.pdf

[25] Findings from an assessment of state agencies led by *New Hampshire Governor's Commission on Alcohol and Drug Abuse*, Spring 2011.

[26] Findings from an assessment of community stakeholders led by *The Prevention Task Force of the NH Governor's Commission on Alcohol and Drug Abuse*, Spring 2011.

[27] "Ryan Creedon Act of 2011." (H.R. 2119) Amendment to the Controlled Substances Act (21 U.S.C. 823) *112th Congress, First Session*, June 3, 2011. Accessed at: http://www.gpo.gov/fdsys/pkg/BILLS-112hr2119ih/pdf/BILLS-112hr2119ih.pdf

[28] Substance Abuse and Mental Health Services Administration. (2009*). Results from the 2008 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD. Accessed at: http://www.samhsa.gov/data/nsduh/2k8nsduh/2k8Results.htm

[29] Data from "DEA Form 106" (2008-2011) as reported by the *New Hampshire Board of Pharmacy*, 2011.

[30] "Safe Disposal of Unused Controlled Substances/Current Challenges and Opportunities for Reform." *Avalere Health*, 2008. Accessed at: http://www.takebacknetwork.com/pdf/Safe_Disposal_of_Unused_Controlled_Substances.pdf

[31] "Controlled and Non-Controlled Pharmaceutical Drug Take-Back Programs." *Chapter 318-E of New Hampshire House Bill 71*, July 1, 2011. Accessed at: http://gencourt.state.nh.us/legislation/2011/HB0071.html

[32] "Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings." *Substance Abuse and Mental Health Services Administration*, 2010. (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10-4586 Findings). Rockville, MD. Accessed at: http://oas.samhsa.gov/NSDUH/2k9NSDUH/2k9ResultsP.pdf

[33] "Screening, Brief Intervention, and Referral to Treatment" *SAMHSA News*, Volume 17 - Number 6, November/December 2009. Accessed at: http://www.samhsa.gov/samhsanewsletter/Volume_17_Number_6/NovemberDecember2009.pdf

[34] "Controlled and Non-Controlled Pharmaceutical Drug Take-Back Programs." *Chapter 318-E of New Hampshire House Bill 71*, July 1, 2011. Accessed at: http://gencourt.state.nh.us/legislation/2011/HB0071.html

[35] New Hampshire House Bill 332-FN, (June 14, 2011 version).

[36] New Hampshire Senate Bill 286. Accessed at: http://www.gencourt.state.nh.us/legislation/2012/SB0286.html

[37] *Ibid.*

[38] Blumenschein, Karen, PharmD et al. " Independent Evaluation of the Impact and Effectiveness of the Kentucky all Schedule Prescription Electronic Reporting Program (KASPER)." Institute for Pharmaceutical Outcomes and Policy, University of Kentucky (Lexington), October 2010.

[39] Simeone, Ronald and Lynn Holland. "An Evaluation of Prescription Drug Monitoring Programs," Simeone Associates, Albany, NY. September, 2006. Commissioned by the United States Department of Justice, Office of Justice Programs, Bureau of Justice Assistance (No. 2005PMBXK189).

[35] "In the Spotlight: Drug Courts." *National Criminal Justice Reference Service.* Accessed at: https://www.ncjrs.gov/spotlight/drug_courts/summary.html

[41] "Mental Health Courts Program." *Office of Justice Programs, Bureau of Justice Assistance.* Accessed at: http://www.ojp.gov/BJA/grant/mentalhealth.html

[42] "2008 Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel." *Department of Defense*, 2009. Accessed at: http://www.tricare.mil/2008HealthBehaviors.pdf

[43] Findings from an assessment of state agencies led by *NH Governor's Commission on Alcohol and Drug Abuse,* Spring 2011.

[44] CHOICES data set. *NH Department of Corrections*, 2010.

[45] "Prescription Drugs: Abuse and Addiction." *Research Report Series.* National Institute on Drug Abuse. Accessed at: http://www.drugabuse.gov/ResearchReports/Prescription/prescription5.html

[46] Dr. Thomas Andrew, Chief Medical Examiner, NH Department of Safety. Interview with *NH Center for Excellence*, Spring 2011.

[47] "Training Calendar 2011-2012." *New Hampshire Police Standards & Training Council*, 2011. Accessed at: http://www.pstc.nh.gov/TrainingCalendar.pdf

APPENDIX A

CONTENT OF EDUCATION PROGRAM

The training for prescribers required by the elements to assure safe use must contain the following content:

1. General information for safe opioid prescribing
    a. Patient selection and assessment
        i. Determine goal of therapy
        ii. Assessment of the risk of abuse, including history of substance abuse and serious mental illness
        iii. When relevant, determining if patient is opioid tolerant
    b. Considerations when prescribing opioids
        i. Pharmacokinetics and potential for overdose
        ii. Addiction, abuse, and misuse
        iii. Intentional abuse by patient or household contacts
        iv. Interactions with other medications/substances
    c. Managing patients taking opioids
        i. Establishing goals for treatment and evaluating pain control
        ii. Use of Patient Provider Agreements (PPAs)
        iii. Adherence to a treatment plan
        iv. Recognizing aberrant behavior
        v. Managing adverse events
    d. Initiating and modifying dosing of opioids for chronic pain
        i. As first opioid
        ii. Converting from one opioid to another
            1. Converting from immediate-release to extended-release and long-acting products
            2. Converting from one extended-release and long-acting product to another
        iii. Titrating to effect/tolerability
        iv. How to deal with missed doses
    e. Maintenance
        i. Reassessment over time

ii. Tolerance

f. Monitoring patients for misuse and abuse
    i. Utilization of prescription monitoring programs to identify potential abuse
    ii. Understanding the role of drug testing
    iii. Screening and referral for substance abuse treatment

g. How to discontinue opioid therapy when it is not needed any longer

2. Product Specific Information
    a. Pharmacokinetic characteristics
    b. Product specific toxicity
    c. Requirements for opioid tolerance for certain long-acting and extended-release products
    d. Individual product information modules
        i. Fentanyl transdermal system
        ii. Hydromorphone ER
        iii. Methadone (For the treatment of moderate to severe pain not responsive to non-narcotic analgesics)
        iv. Morphine ER
        v. Oxycodone ER
        vi. Oxymorphone ER
        vii. Buprenorphine (for the management of moderate to severe chronic pain in patients requiring a continuous, around-the-clock opioid analgesic for an extended period of time)
        viii. New products
3. Patient counseling
    a. Information about prescribed opioid
    b. How to take opioid properly
        i. Adherence to dosing regimen
        ii. Risk from breaking, chewing, crushing certain products
    c. Reporting adverse effects
    d. Concomitant use of other CNS depressants, alcohol, or illegal drugs
    e. Discontinuation of opioid

f. Risks associated with sharing, i.e., overdose prevention
g. Proper storage in the household
    i. Avoiding accidental exposure
h. Avoiding unsafe exposure by preventing theft and proper disposal
i. Purpose and content of Patient Provider Agreement

PATIENT EDUCATION

Materials to provide to patients as part of patient counseling must include:

1. How to take opioid properly
    a. Adherence to dosing regimen
    b. Risk from breaking, chewing, crushing certain products
    c. Symptoms of overdose
2. Reporting adverse effects
3. Concomitant use of other CNS depressants, alcohol, or illegal drugs
4. Discontinuation of opioid
5. Risks associated with sharing
6. Proper storage in the household
    a. Avoiding accidental exposure
7. Avoiding unsafe exposure by preventing theft and proper disposal
8. Purpose and content of Patient Treatment Agreement
9. Links to Web sites with more information about topics 1 through 8

REMS TEMPLATE
Initial REMS Approval: XX/XXXX
Most Recent Modification: XX/XXXX

Application number TRADE NAME (DRUG NAME)

Class of Product as per label

Applicant name

Address

Contact Information

RISK EVALUATION AND MITIGATION STRATEGY (REMS)

I. GOAL:

Reduce serious adverse outcomes resulting from inappropriate prescribing, misuse and abuse of extended-release (ER) and long-acting (LA) opioids while maintaining patient access to pain medications. Adverse outcomes of concern include addiction, unintentional overdose, and death.

II. REMS ELEMENTS:

A. Medication Guide or PPI

A Medication Guide will be dispensed with each [drug name] prescription. [Describe in detail how you will comply with 21 CFR 208.24.]

B. Communication Plan

A communication plan is not required.

C. Elements To Assure Safe Use

1. The sponsor must ensure that training is provided to prescribers who prescribe DRUG. An outline of the content for this information is described in Appendix A. The training must include successful completion of a knowledge assessment and proof of successful program completion. To assure access to DRUG and minimize the burden on the healthcare delivery system, FDA expects that the training will be conducted by accredited, independent continuing medical education (CME) providers, to the extent practicable.

2. The sponsor must provide to prescribers information that the prescriber can use to educate patients in the safe use, storage, and disposal of opioids. An outline of the content for this information is described in Appendix B.

3. The sponsor must inform prescribers of the existence of the REMS and the need to successfully complete the necessary training.

D. Implementation Plan

An implementation plan is not required.

E. Timetable for Submission of Assessments

COMPANY will submit REMS Assessments to the FDA no less frequent than 6 months, 12 months, and annually after the REMS is initially approved from the date of approval of the REMS. To facilitate inclusion of as much information as possible while allowing reasonable time to prepare the submission, the reporting interval covered by each assessment should conclude no earlier than 60 days before the submission date for that assessment. COMPANY will submit each assessment so that it will be received by the FDA on or before the due date.

APPENDIX B

PAIN MANAGEMENT OVERVIEW BY STATE

STATE	Action Taken by State Medical or Osteo Board	Related Statutes, Rules, and Regulations	Notes/Legislation
AL*	Guidelines for the Use of Controlled Substances for the Treatment of Pain	Ala. Admin. Code r. 540-X-4-08.	
AK		Prescribing controlled substances, *Alaska Admin. Code tit. 12, § 40.975. *AS 11.71 Controlled Substances *AS 08.80.030(11) PMP Established AS 17.30.200 Controlled substance Rx Database	*The Use of Controlled Substances for the Treatment of Pain by Advanced Nurse Practitioners: http://www.commerce.state.ak.us/occ/pub/nur1808.pdf (Adopted June 2006)
AZ*	Guidelines for the Use of Controlled Substances for the Treatment of Chronic Pain (Approved 09/24/97, Revised 06/03; Spring 2006) http://www.azmd.gov/Statutes-Rules/7_policy.aspx	*Arizona Revised Statutes section 41-1033 *Ariz. Rev. Stat. Sect. 13-3412.01 * A.R.S. Controlled Substances, Title 36, Ch 27- Uniform Controlled Substances Act *A.A.C. Title 4, Ch 23, Article 5- Board of Pharmacy- Controlled Substances Rules	
AZ-O*	Guidelines: The Prescribing of Controlled Substances for the Treatment of Pain Management (Approved 01/22/00) http://www.azdo.gov/Statutes-Rules/Policy-1.aspx	*See above	*Advisory Opinion: Use of Controlled Substances for the treatment of Pain Management (Nursing Board Guideline 1/2009): http://www.azbn.gov/documents/advisory_opinion/AO%20Controlled%20Substances-Use%20For%20Treatment%20of%20Chronic%20Pain%20rev%20Jan09.pdf
AR*	* Regulation 2(6) (Effective 03/13/97, Amended 12/3/98)	*Chronic Intractable Pain Treatment Act, Ark. Code Ann. § 17-95-701 through 17-95-707. *Arkansas Code Sect. 5-64-201 through 5-64-210 *http://www.healthy.arkansas.gov/aboutADH/RulesRegs/ControlledSubstances.pdf */http://www.healthy.arkansas.gov/aboutADH/RulesRegs/controlled_substances_list.pdf	
CA*	* Guidelines for Prescribing Controlled Substances for Intractable Pain (Adopted in 1994, revised in 2007) http://www.medbd.ca.gov/pain_guidelines.html * Statement by the Board (Issued 07/94)	* Intractable Pain Treatment Act, Prescription or administration of dangerous drugs or prescription controlled substances for treatment of pain or condition causing pain, Cal. Bus. & Prof. Code § 2241.5. * Pain Patient's Bill of Rights, Findings and declarations; opiate drugs; pain management, Health & Safety Code § 124960.	*Board of Pharmacy: http://www.pharmacy.ca.gov/licensing/prescribe_dispense.shtml *Board of Registered Nursing: http://www.rn.ca.gov/pdfs/regulations/npr-b-09.pdf *California guidelines resulted from a state sponsored summit in which 120 health care practitioners, professional and public educators, representatives from professional schools and associations and health care consumers met to

STATE	Action Taken by State Medical or Osteo Board	Related Statutes, Rules, and Regulations	Notes/Legislation
		*Uniform Controlled Substances Act: Cal. Health & Safety Code, Div. 10 Sec 11000	recommend solutions to legal, professional, and educational barriers to effective pain management. A report, *Summit on Effective Pain Management: Removing Impediments to Appropriate Prescribing*, was issued by the Governor of California
CA-O	See CA above		
CO*	(1) Guidelines for Prescribing Controlled Substances for Intractable Pain (Adopted 05/16/96) (2) Model Policy for the use of Controlled Substances for the Treatment of Pain (Revised 11/18/04) http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobheadername1=Content-Disposition&blobheadername2=MDT-Type&blobheadervalue1=inline%3B+filename%3D47%2F586%2Fguidelines+for+prescribing+controlled+substances.pdf&blobheadervalue2=abinary%3B+charset%3DUTF-8&blobkey=id&blobtable=MungoBlobs&blobwhere=1251616362183&ssbinary=true	* **Adopted FSMB Model Policy** *Controlled Substances Act: Colo. Rev. Stat. Sect 18-18-308 *Intractable Pain Treatment Act: 12-36-117	
CT*	Statement on the Use of Controlled Substances for the Treatment of Pain (Adopted 02/15/05; Revised 06/2005) http://www.ct.gov/dph/lib/dph/phho/medical_board/guidelines/statementoftheconnecticutmedicalexaminingboardrevised62005.pdf	* **Adopted FSMB Model Policy**	*Nursing Board Policy Statement also adopted FSMB Model Policy (12/06): http://aspi.wisc.edu/documents/pdf/CTnursepolicy.pdf
DE*	Model Policy for the use of Controlled Substances for the Treatment of Pain (Adopted 06/02/09) http://dpr.delaware.gov/boards/medicalpractice/adoptedpainpolicy.shtml	* **Adopted FSMB Model Policy** *16 Del. C., Ch 47 Sect 4701-4701-4796 (DE Office of Controlled Substances) *Controlled Substances Rules: http://regulations.delaware.gov/AdminCode/title24/Uniform%20Controlled%20Substances%20Act%20Regulations.pdf	
DC	Standards for the Use of Controlled Substances for the Treatment of Pain http://hpla.doh.dc.gov/hpla/frames.asp?doc=/hpla/lib/hpla/medicine/updated_regs_6_30_2008.pdf	D.C. Mun. Regs. tit. 17, § 4614.	*Pharmaceutical Control Division/Health Regulation & Licensing Administration

STATE	Action Taken by State Medical or Osteo Board	Related Statutes, Rules, and Regulations	Notes/Legislation
FL*	* Management of Pain Using Dangerous Drugs and Controlled Substances-General Practice Guideline (Adopted 10/25/96) * Joint Statement on Pain Management-Florida Boards of Medicine, Nursing, Osteopathic Medicine and Pharmacy (Approved 09/19/05)	* Fla. Stat. § 458.326. * Pain Management and Palliative Care, Fla. Stat. § 765.1103. * Fla. Admin. Code. Ann. r. 64B8-9 Standards of Practice for Medical Doctors: https://www.flrules.org/gateway/RuleNo.asp?title=STANDARDS OF PRACTICE FOR MEDICAL DOCTORS&ID=64B8-9.013 (effective 11/28/10) *Pain Clinics (effective 10/1/10): http://www.doh.state.fl.us/mqa/medical/info_SB2272.pdf (was SB 2272; SB2722 CH 2010-211)	
FL-O*	*Standards for the Use of Controlled Substances for Treatment of Pain (Adopted 03/9/00) * Joint Statement on Pain Management-Florida Boards of Medicine, Nursing, Osteopathic Medicine and Pharmacy (Approved 09/19/05)	* Fla. Admin. Code. Ann. r. 64B15-14.005.	
GA	* Guidelines for the Use of Controlled Substances for Treatment of Pain: Ten Steps (Adopted 01/11/08)	*GA Ann. Tit. 16, Ch 13 *GA State Board of Pharmacy Rule 480-22	
Guam	None found		
HI *	*Pain Management Guidelines (Adopted 01/06, modified 03/08/06)	* **Adopted FSMB Model Policy**	
ID*	*Guidelines: Prescribing Opioids for Chronic Pain (Effective 03/95) * Model Policy for the use of Controlled Substances for the Treatment of Pain (Adopted 08/05)	* **Adopted FSMB Model Policy** * Uniform Controlled Substances Act: Title 37, Ch 27	
IL		*Controlled Substances Act: Admin. Code Title 77, Ch VI, Part 1650	
IN		*Title 35 Article 48: Controlled Substances	
IA*	* Standards of practice--appropriate pain management * Joint Statement on Pain by the Iowa Boards of Medicine, Nursing, Pharmacy and Physician Assistants	* Iowa Admin. Code r. 653-13.2(148,272C).	
KS*	* Guidelines for the Use of Controlled Substances for the Treatment of Pain (Adopted 10/17/98)	* **Adopted FSMB Model Policy** * Legislative findings on pain treatment, Kan. Stat. Ann § 65-4976.	

STATE	Action Taken by State Medical or Osteo Board	Related Statutes, Rules, and Regulations	Notes/Legislation
	http://www.ksbha.org/misc/painmgmt.html * Joint Policy Statement of the Kansas Boards of Healing Arts, Nursing and Pharmacy on the Use of Controlled Substances for the Treatment of Pain (Effective 07/17/02) http://www.ksbha.org/misc/jointpainmgmt.html	*Persons suffering from pain; use of controlled substances for pain treatment, Kan. Stat. Ann § 65-4977 and 4101 * K.A.R. 68-20-1	
KY*	* Model Guidelines for the Use of Controlled Substances in Pain Treatment (Adopted 03/22/01, Revised 09/18/03; 10-10-08) http://kbml.ky.gov/NR/rdonlyres/B0538843-6E6D-48B2-B67B-A5D0E6C37C77/0/BoardOpinionUseofControlledSubstances.pdf * Guidelines for Prescribing Controlled Substances (Adopted 06/20/96)	*KY Controlled Substances Act: *KRS 218A; and KRS 217- Food Drug and Cosmetic Act	*Operates KY All Schedule Prescription Electronic Reporting (KASPER) System
LA*	*Medications used in the Treatment of Non-Cancer-Related Chronic or Intractable Pain *Opinion: Interventional Pain Management (06/2006): http://www.lsbme.louisiana.gov/Statements%20of%20Position/Interventional%20Pain%20Management.pdf	*La. Admin Code. tit. 46, pt. XLV, §§ 6915; 6917; 6919; 6921; 6923	
ME*	*Use of Controlled Substances for Treatment of Pain (Effective 06/13/2010)	* **Adopted FSMB Model Policy (added section on end of life pain therapy)** *Code Me. R 02-373 Ch. 11, § 1 through 3 *32 MRSA §3269(3), (7)	
ME-O*	* Use of Controlled Substances for Treatment of Pain (Effective 06/13/2010)	* **Adopted FSMB Model Policy (added section on end of life pain therapy)** *Code Me. R 02-383 Ch. 11, § 1 through 3. *32 MRSA §2562	
MD*	*Guidelines for Prescribing Controlled Drugs (Adopted 03/96)	Source: Maryland BPQA Newsletter, Vol. 4, num. 1, pp. 1-3, Mar. 1996 (Similar to FSMB)	
MA*	* Prescribing Practices, Policy and Guidelines (Adopted 05/3/89, Amended 5/19/2010) * Guidelines for the Use of Controlled Substances for the Treatment of Pain	* **Adopted FSMB Model Policy** *http://www.massmedboard.org/regs/pdf/Prescribing_Guidelines_FINAL_2010.pdf	

STATE	Action Taken by State Medical or Osteo Board	Related Statutes, Rules, and Regulations	Notes/Legislation
	(Adopted 12/12/01)		
MI*	Guidelines for the Use of Controlled Substances for the Treatment of Pain (Adopted in 2003)	* **Adopted FSMB Model Policy** *Mich. Comp.Laws Sect 333.16204a (advisory cmte on pain and symptom management) *Intractable Pain: Mich. Comp. Laws sect 333.16204b-c *To develop a booklet on intractable pain 333.16204d	
MI-O*	Guidelines for the Use of Controlled Substances for the Treatment of Pain (Adopted in 2003)	* **Adopted FSMB Model Policy**	
MN*	*Endorsed Model Policy for the Appropriate Use of Controlled Substances for the Treatment of Pain *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Adopted Fall 2000) * Joint Statement on Pain Management (Adopted 09/04) *Present a Chronic Pain Management Seminar 10/28/10 *Article: 12/31/2009 http://www.state.mn.us/mn/externalDocs/BMP/New_Article_on_Pain_Management_020110034248_monograph_dec_07_final.pdf	* **Adopted FSMB Model Policy** * Intractable Pain, Minn. Stat. § 152.125.	
MS	* Use of Controlled Substances for Chronic (Non-Terminal) Pain (Effective 04/18/99) *Pain, Pain Management and Mississippi State Board of Medical Licensure Scrutiny (Effective Fall 1997) MSBML Newsletter - Fall 1997 - Vol.1, No.10	* Code Miss. Rules 50 013 001. Ch. 25 Sec. 6.	
MO*	*Guidelines for the Use of Controlled Substances for the Treatment of Pain (Effective 11/01/01) http://pr.mo.gov/boards/healingarts/CSGUIDE.pdf *A Guide: http://pr.mo.gov/boards/healingarts/TaskforceGuideline.pdf (Jan 2009 Taskforce)	* **Adopted FSMB Model Policy** * Intractable Pain Treatment Act—definitions, Mo. Rev. Stat. § 334.105. * Prescription, administration, and dispensing controlled substances for intractable pain--therapeutic use--drug dependency, Mo. Rev. Stat. § 334.106.	*JOINT STATEMENT OF THE MISSOURI STATE BOARD OF REGISTRATION FOR THE HEALING ARTS AND THE MISSOURI BOARD OF PHARMACY ON INTERNET PRESCRIBING AND DISPENSING: http://pr.mo.gov/boards/healingarts/PharmInternetPrescribeDispense.pdf
MT	* Statement on the use of Controlled Substances in the Treatment of Intractable Pain (Adopted 03/15/96) *Joint Board Policy Statement of the prescribing and filling of	* **Adopted FSMB Model Policy** (adopted 1/23/09; rev. 3/27/09) *MT Medical Assoc. Bulletin, Vol. 51, num. 1, March 15, 1996, pp3-4	

STATE	Action Taken by State Medical or Osteo Board	Related Statutes, Rules, and Regulations	Notes/Legislation
	controlled substances in the treatment of chronic pain (Adopted 07/27/02)		
NE*	* Guidelines for the Use of Controlled Substances for the Treatment of Pain (Effective 02/7/99) (2) Model Policy for the use of Controlled Substances for the Treatment of Pain (Adopted 06/05)	* **Adopted FSMB Model Policy** * Ch. 71. Public Health & Welfare, Art. 24., (D) Drugs, Pain Management, Neb. Rev. Stat. §§ 71-2418 through 71-2420.	
NV*	* Guidelines for the Use of Controlled Substances for the Treatment of Pain (Adopted 07/19/00) NAC 630.187 * Model Policy for the Use of Controlled Substances for the Treatment of Pain	* **Adopted FSMB Model Policy** * Adoption by reference, Nev. Admin. Code ch. 630, s 187. * Prescribing or administering certain controlled substances for treatment of intractable pain not grounds for disciplinary action, Nev. Rev. Stat. § 630.3066. * Exemption from grounds: "Intractable pain" defined, Nev. Rev. Stat. § 630:255.	
NV-O		*NRS 633.521	
NH*	* Guidelines for the Use of Controlled Substances in the Management of Chronic Pain (Amended 03/08/09)	* **Adopted FSMB Model Policy** * N.H. Admin. R. Ann. Med 501.02.	
NJ	* Limitations on prescribing, administering or dispensing of controlled substances; special exceptions for management of pain N.J. Admin. Code 13:35-7.6.		
NM*	* Guidelines on Prescribing for Pain (Effective 04/05/99) * Management of Chronic Pain with Controlled Substances (Effective 01/20/03) * Joint Statement on the Management of Chronic Pain (Adopted 05/2005)	* Pain Relief Act, N.M. Stat. Ann. §§ 24-2D-1 through 24-2D-6. * N.M. Admin. Code tit. 16, § 10.14. http://www.nmmb.state.nm.us/policiesandpositions.html	
NM-O	*Joint Statement on the Management of Chronic Pain (Adopted 08/2005)		
NY	*Policy Statement for the Use of Controlled Substances for the Treatment of Pain (Effective 03/00)	http://www.health.state.ny.us/publications/4179.pdf	
NC*	* Management of Chronic Non-Malignant Pain Statement (Adopted 09/13/96) *End-Of-Life Responsibilities and Palliative Care Statement (Adopted 10/21/99) * Joint Statement on Pain Management and End-Of-Life	* **Adopted FSMB Model Policy** *****North Carolina Board of Medical Examiners Source: Forum, num. 4, December, 1996 *http://www.ncmedboard.org/position_statements/by_tag/tag/pain/	

STATE	Action Taken by State Medical or Osteo Board	Related Statutes, Rules, and Regulations	Notes/Legislation
	Care (Adopted 10/21/99) * Policy for the Use of Controlled Substances for the Treatment of Pain (Adopted 07/05)		
ND	*Controlled Substances for Care and Treatment (Effective 08/1/95, Revised 03/14/05)	*N.D. Cent. Code §§ 19-03.3-01 through 19-03.3-06.	*ND Board of Nursing Statement on Pain: https://www.ndbon.org//opinions/role%20of%20nurse%20in%20pain%20mgmt.asp
NMI	None found		
OH	*Position Paper-Scheduled Drug Therapy Including Narcotics for Chronic Benign Pain (Effective 06/14/95-Revised 08/14/96)	* Authority to treat intractable pain with dangerous drugs, Ohio Rev. Code Ann. § 4731.052; Continuing medical education course on treating intractable pain, Ohio Rev. Code Ann. § 4731.283 * Intractable Pain Treatment, Ohio Admin. Code §§ 4731-21-01 to 4731-21-06.	
OK*	* Guidelines for Prescribing Controlled Substances for Intractable Pain (Effective in 1995) * Use of Controlled Substances for the Treatment of Pain (Effective 03/10/05)	* **Adopted FSMB Model Policy** * Appropriate pain management--high dosages of controlled dangerous drugs, Okla. Stat. tit. 63, § 2-551. * Use of controlled substances for the management of chronic pain, Okla. Admin. Code § 435:10-7-11.	
OK-O		*OAC 510:5-9-1 Through 5-9-3	
OR	* Statement of Philosophy-Appropriate Prescribing of Controlled Substances (Adopted 05/20/91) * Statement of Philosophy-Pain Management in Acute Conditions and in Terminal Illness (Adopted 04/95) * Current Statement of Philosophy on Pain Management (Adopted 04/16/99, Revised 07/9/04)	* Pain Treatment Act, Or. Rev. Stat. Ann. §§ 677.470 through 677.480. * Written Notice Disclosing the Material Risks Associated with Prescribed or Administered Controlled Substances for the Treatment of "Intractable Pain," Or. Admin. R §§ 847-015-0030.	*The Pain Management Commission is established within the Department of Human Services (SB885 2001)
PA*	* Guidelines for the Use of Controlled Substances for the Treatment of Pain (Effective 10/20/98) State Board of Medicine bulletin, Winter 1998/99, pp. 4-5	* **Adopted FSMB Model Policy** * Prescribing, administering and dispensing controlled substances, Pa. Code tit. 49, § 16.92.	
PA-O			
PR	None found		
RI*	* Guidelines for Long Term Pain Management (Adopted 05/10/95-Referenced CA policy) Newsletter of the Rhode Island Board of Medical	* Intractable Pain Treatment, R. I. Gen. Laws §§ 5-37.4-1 through 5-37.4-3. *2002, Pain Assessment Act: RI Pub Laws 331	

STATE	Action Taken by State Medical or Osteo Board	Related Statutes, Rules, and Regulations	Notes/Legislation
	Licensure and Discipline, Summer 1995, p.2	*Practitioners Immunity from disciplinary action for prescription for pain management RI Pub. Laws 046	
SC*	*Guidelines for the Use of Controlled Substances for the Treatment of Pain (Adopted 02/99)	* **Adopted FSMB Model Policy**	*Joint Position Statement on Pain Management for The South Carolina Board of Nursing and The South Carolina Board of Pharmacy
SD*	Guidelines for the Use of Controlled Substances for the Treatment of Pain (Adopted 01/99)	* **Adopted FSMB Model Policy**	
TN*	*Management of Prescribing with Emphasis on Addictive or Dependence Producing Drugs Statement (Approved 09/19/95) *9 Step Process Similar to NC and MN	* Authority of Physician to Prescribe for the Treatment of Pain, Tenn. Comp. R. & Regs. 0880-2-.14(6). * Intractable Pain Treatment Act, Tenn. Code Ann. §§ 63-6-1101 through 63-6-1111. (2001 Tenn. Pub. Acts 327)	
TN-O*	Guidelines for the Use of Controlled Substances for the Treatment of Pain	Tenn. Comp. R. & Regs. 1050-2-.13(5).	
TX*	*Pain Control Statement (Adopted Spring/Summer 1993) Newsletter, Volume 15, num. 1, Spring/Summer 1993, p.1 * Board Rules, Administrative Code, Title 22, Part 9, Chapter 170, Pain Management (Effective 01/04/07)	* Intractable Pain Treatment Act, Tex. Occupations Code §§ 107.001 through 107.201. * Pain Management, Tex. Admin. Code tit. 22, §§ 170.1 - 170.3. * Texas Controlled Substances Act, Chapter 481 of the Texas Health and Safety Code, relating to the prescribing and dispensing of controlled substances	*Effective September 1, 2010, a pain management clinic may not operate in Texas without obtaining a certificate from the Texas Medical Board (TMB)
UT*	* Guidelines for the Use of Controlled Substances for the Treatment of Pain (Effective 02/10/99) * Prescribing Controlled Substances for Cancer Pain: Position Paper (Adopted 04/10/92)	* **Adopted FSMB Model Policy** * Unprofessional Conduct, Utah Admin. Code r.156-1-502.(6).	* HB 28: active prescribing practitioners are required to register with the Controlled Substance Database by September 30, 2010 http://www.commerce.utah.gov/releases/10-10-26_opl-csd-growth.pdf *****HB 89 License for Controlled Substances Amendments (Rep Morley) - modifies the Controlled Substance Precursor Act; provides for the Division of Occupational and Professional Licensing to issue a controlled substance precursor license, which combines the current controlled substance precursor purchaser and controlled substance distributor licenses.
UT-O	See UT above		
VT*	*Report of the Prescribing Practices Committee (Adopted 06/05/96) * Policy for the Use of Controlled Substances for the Treatment of Pain (Adopted	* **Adopted FSMB Model Policy**	

STATE	Action Taken by State Medical or Osteo Board	Related Statutes, Rules, and Regulations	Notes/Legislation
	12/07/05)		
VT-O	See VT above		
VA*	* Guidelines for the Use of Opioids in the Management of Chronic, Noncancer Pain (Adopted 02/05/98) * Model Policy for the Use of Controlled Substances for the Treatment of Pain (Adopted 06/24/04)	* **Adopted FSMB Model Policy** *Prescription in excess of recommended dosage in certain cases, Va. Code Ann. §§ 54.1-3408.1, § 54.1-2971.01.	
VI	None found		
WA	* Guidelines for Management of Pain (Approved 04/18/96)	[* Regulation of Manufacture, Distribution and Dispensing of Controlled Substances, Prescriptions, Wash. Rev. Code § 69-50-308(g). * Pain Management, Wash. Admin. Code §§ 246-919-800 through 830.]	**A new section is added to chapter 18.57A RCW 35 to read as follows: 36 (1) By June 30, 2011, the board shall repeal its rules on pain 37 management, WAC 246-854-120 through 246-854-150. ESHB 2876.PL p. 4 1 (2) By June 30, 2011, the board shall adopt new rules on chronic, 2 noncancer pain management that contain the following elements: 3 (a)(i) Dosing criteria, including: 4 (A) A dosage amount that must not be exceeded unless an osteopathic 5 physician's assistant first consults with a practitioner specializing 6 in pain management; and 7 (B) Exigent or special circumstances under which the dosage amount 8 may be exceeded without consultation with a practitioner specializing 9 in pain management. 10 (ii) The rules regarding consultation with a practitioner 11 specializing in pain management must, to the extent practicable, take 12 into account: 13 (A) Circumstances under which repeated consultations would not be 14 necessary or appropriate for a patient undergoing a stable, ongoing 15 course of treatment for pain management; 16 (B) Minimum training and experience that is sufficient to exempt an 17 osteopathic physician's assistant from the specialty consultation 18 requirement; 19 (C) Methods for enhancing the availability of consultations; 20 (D) Allowing the efficient use of resources; and 21 (E) Minimizing the burden on practitioners and patients. 22 (b) Guidance on when to seek specialty consultation and ways in

STATE	Action Taken by State Medical or Osteo Board	Related Statutes, Rules, and Regulations	Notes/Legislation
			23 which electronic specialty consultations may be sought; 24 (c) Guidance on tracking clinical progress by using assessment 25 tools focusing on pain interference, physical function, and overall 26 risk for poor outcome; and 27 (d) Guidance on tracking the use of opioids, particularly in the 28 emergency department. 29 (3) The board shall consult with the agency medical directors' 30 group, the department of health, the University of Washington, and the 31 largest association of osteopathic physician's assistants in the state. 32 (4) The rules adopted under this section do not apply: 33 (a) To the provision of palliative, hospice, or other end-of-life 34 care; or 35 (b) To the management of acute pain caused by an injury or a 36 surgical procedure.
WA-O			
WV*	* Position Statement on the Use of Opioids for the Treatment of Chronic Non-Malignant Pain (Adopted 07/14/97) * Model Policy for the Use of Controlled Substances for the Treatment of Pain (Adopted 01/10/05) *Rational prescribing practices or how to avoid board scrutiny, 92 West Virginia Medical Journal 256 (September/October 1996) *Joint Policy Statement on Pain Management at the End of Life (Approved 03/12/01)	* **Adopted FSMB Model Policy** * Management of Intractable Pain, W. Va. Code §§ 30-3A-1 through 30-3A-4.	
WV-O*	*Model Policy for the Use of Controlled Substances for the Treatment of Pain (Adopted 11/04/04) *West Virginia Boards of Examiners for Registered Nurses, Medicine, Osteopathy, and Pharmacy Joint Policy Statement on Pain Management at the End of Life Approved: March 12, 2001	* **Adopted FSMB Model Policy**	
WI*	* Model Policy for the Use of Controlled Substances for the Treatment of Pain	* **Adopted FSMB Model Policy** (2) Wis. Stat. §§ 961.001 and 961.38.	

STATE	Action Taken by State Medical or Osteo Board	Related Statutes, Rules, and Regulations	Notes/Legislation
WY	*Policy Number 40-01 adopting Wyoming Health Care Licensing Boards' Uniform Policy for the Use of Controlled Substances in the Treatment of Pain(Issued 02/13/09)	***35-25-206. Pain Management** creating a pain management advisory committee (2007)	

For informational purposes only: This document is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. Non-cited laws, regulation, and/or policy could impact analysis on a case-by-case or state-by-state basis. All information should be verified independently.

* by the states abbrv. indicates policy same or similar to FSMB policy.

- Visit http://www.medsch.wisc.edu/painpolicy/index.htm for guidelines and statutes by state on the Pain and Policy Studies Group website at the University of Wisconsin
- Newfoundland Medical Council adopted FSMB Model Guidelines in 2000
- National Association of State Controlled Substances Authorities endorsed FSMB Model Guidelines 10/29/1999
- National Association of State Controlled Substances Authorities endorsed FSMB Model Policy 10/23/2004

APPENDIX C

Weeks Medical Center

170 Middle Street
Lancaster, NH 03584
Phone: 603-788-2521
Fax: 603-788-5092

PO Box 240
Whitefield, NH 03598
Phone: 603-837-9005
Fax: 603-788-5072

47 Church Street
Groveton, NH 03582
Phone: 603-636-1101
Fax: 603-788-5059

Informed Consent and Controlled Substance Agreement

A. Patient Consent

I, _____, understand and agree to follow
Please print your full name Date of Birth
the policies regarding the use of opioids, narcotics, or other controlled substances for management of chronic conditions. I understand that _____ is under no obligation to prescribe these
Provider's Name
medications for me. I also understand that breaking the terms within this agreement may lead to its termination and/or my dismissal from treatment. I have tried other medical treatments which have not worked to control my condition. I also understand that these medications are not expected to entirely eliminate all of my symptoms, but are intended to help me to improve my quality of life. This is a decision that I have made after fully discussing the risks, benefits, as well as alternatives to this treatment with my provider.

B. Risks of Medications

I understand that treatment of my condition with medications does have risks including but not limited to:

- **Physical symptoms** -constipation; sleepiness or drowsiness; problems with coordination or balance that may make it unsafe to operate dangerous equipment or vehicles, agitation, confusion; decreased appetite; problems urinating; sexual difficulties.
- **Physical dependence** – meaning that abrupt discontinuation of the drug may lead to withdrawal symptoms including: runny nose, diarrhea, abdominal cramping, "goose flesh," and/or anxiety. I understand that this may be uncomfortable but not life-threatening and the worse symptoms generally resolve within 72 hours.
- **Psychological dependence** – meaning it is possible that discontinuation of the drug may cause me to miss it or crave it.
- **Known or unknown risk to unborn and nursing children.** Contraception is highly recommended. _____(initials)

C. Your responsibilities and Conditions of the Agreement:

1. I will inform my Provider of any history of problems with substance abuse, illegal drugs, or drug dependence.
2. I am currently not involved in the sale, illegal possession, diversion or transport of controlled substances, nor do I live with or associate with individuals who do. If a Weeks Medical Center Provider has reason to believe I am diverting my medication(s) covered under this contract, it will be immediately reported to the appropriate law enforcement agency. Information provided to law enforcement will include my name, date of birth and last known address.
3. I will immediately contact the clinic if any severe depression, thoughts of suicide or harming others occurs.
4. **I agree to obtain controlled medications only from my provider. I will notify my provider with 24 hours of any prescriptions for controlled substances provided by other providers.**

5. I WILL USE ONLY_____FOR FILLING MY PRESCRIPTIONS.
Name of Pharmacy

6. I WILL NOT CHANGE THE AMOUNT OR THE FREQUENCY OF THESE MEDICATIONS WITHOUT PRIOR APPROVAL OF MY PROVIDER.
7. I WILL INFORM MY PROVIDER OF ANY ALCOHOL CONSUMPTION BECAUSE IT MAY INTERACT WITH THE MEDICATIONS PRESCRIBED.
8. I GIVE PERMISSION TO MY PROVIDER OR THEIR AGENTS TO COMMUNICATE WITH EMERGENCY DEPARTMENTS, PHARMACISTS, LAW ENFORCEMENT, OTHER PROVIDERS, DENTISTS OR OTHERS AS REQUIRED TO ENSURE MY SAFETY DURING MY TREATMENT WITH CONTROLLED SUBSTANCES.
9. IF RECOMMENDED BY MY PROVIDER, I WILL PARTICIPATE IN ALL HEALTH CARE CONSULTATIONS, REFERRALS, EVALUATIONS, OR ALTERNATIVE TREATMENT MODALITIES TO INCLUDE PSYCHIATRIC EVALUATION, ACUPUNCTURIST, PHYSICAL THERAPY, OCCUPATIONAL THERAPY, OR OTHER TREATMENT METHODS PRESCRIBED BY MY PROVIDER. I WILL KEEP ALL SCHEDULED APPOINTMENTS AND UNDERSTAND THAT THIS AGREEMENT MAY BE CANCELLED IF I MISS ANY APPOINTMENTS WITH MY PROVIDER OR ANY RECOMMENDED TREATMENTS.
10. I UNDERSTAND AND CONSENT TO HAVE UNANNOUNCED BLOOD SCREEN, URINE TESTS, OR PILL COUNTS IN ORDER TO ASSESS MY COMPLIANCE WITH MY MEDICAL REGIMEN AND IDENTIFY ANY OTHER MEDICATIONS OR SUBSTANCES THAT I AM TAKING. IF NOTIFIED, I WILL HAVE 24 HOURS TO COMPLY WITH THE REQUEST. I AM AWARE THERE ARE CHARGES FOR THESE SERVICES, AND I WILL BE RESPONSIBLE FOR THEM.
11. I WILL KEEP MY PROVIDER INFORMED OF CURRENT CONTACT INFORMATION INCLUDING PHONE NUMBER AND ADDRESS.
12. I UNDERSTAND, IN GENERAL, ALLOWANCES WILL NOT BE MADE FOR LOST, STOLEN, OR DAMAGED DRUGS OR PRESCRIPTIONS.
13. I WILL NOT CALL THE CLINIC REQUESTING REFILLS PRIOR TO THE DATE DUE.
14. REQUESTS FOR REFILLS MUST BE MADE BEFORE 12 NOON, 72 HOURS PRIOR TO EXPIRATION OF THE PRESCRIPTION DURING NORMAL OFFICE HOURS MONDAY- FRIDAY
15. THE EMERGENCY DEPARTMENT WILL NOT BE USED FOR CONTROLLED SUBSTANCE MEDICATION REFILLS AND GENERALLY, IF PRESENTING TO THE EMERGENCY DEPARTMENT FOR REFILLS, THE REQUEST WILL BE DENIED
_____(INITIALS)

D. CONFIRMATION AND UNDERSTANDING

1. I UNDERSTAND THAT, IN GENERAL, MY CONTROLLED MEDICATIONS MAY BE DISCONTINUED IF ANY OF THE FOLLOWING OCCUR:

- PROVIDER FINDS THAT THE MEDICATIONS ARE NOT EFFECTIVE
- I GIVE, SELL, OR MISUSE DRUGS
- I OBTAIN CONTROLLED SUBSTANCES FROM OTHER SOURCES
- TEST RESULTS INDICATE THE IMPROPER USE OF MY PRESCRIBED MEDICATIONS OR THE USE OF ILLEGAL DRUGS
- **I VIOLATE ANY OF THE TERMS OF THIS CONSENT AGREEMENT.**

2. I AGREE THAT A COPY OF THIS DOCUMENT MAY BE GIVEN TO MY PRIMARY CARE PROVIDER, EMERGENCY DEPARTMENTS, MY PHARMACIST, OR OTHER HEALTH CARE PROVIDERS INVOLVED IN MY TREATMENT.

3. I AGREE THAT MY PROVIDER OR THEIR AGENTS MAY CONTACT LAW ENFORCEMENT IF THERE IS SUSPICION OF MY COMMITTING ILLEGAL ACTIVITIES BUT NOT LIMITED TO SELLING DRUGS AND/OR SHARING MY MEDICATIONS.

Weeks Medical Center

170 Middle Street
Lancaster, NH 03584
Phone: 603-788-2521
Fax: 603-788-5092

PO Box 240
Whitefield, NH 03598
Phone: 603-837-9005
Fax: 603-788-5072

47 Church Street
Groveton, NH 03582
Phone: 603-636-1101
Fax: 603-788-5059

I HAVE READ THIS DOCUMENT AND UNDERSTAND IT. I CONSENT TO THE USE OF MEDICATIONS TO HELP CONTROL MY SYMPTOMS, AND I UNDERSTAND THAT MY TREATMENT WITH THESE MEDICATIONS WILL BE CARRIED OUT IN ACCORDANCE WITH THE CONDITION STATED ABOVE.

Patient's Signature	**Date**
Witness	**Date**

E. PROVIDERS CERTIFICATION

I CERTIFY THAT THE ABOVE NAMED PATIENT OR RESPONSIBLE INDIVIDUAL HAS RECEIVED A CAREFUL EXPLANATION OF THE TREATMENT TO BE PROVIDED INCLUDING THE RISKS AND BENEFITS TO BE EXPECTED. I HAVE DISCLOSED ALTERNATIVE METHODS OF TREATMENT THAT MIGHT BE APPROPRIATE FOR THIS PATIENT. I HAVE OFFERED TO ANSWER ANY QUESTIONS BY THE PATIENT AND/OR RESPONSIBLE INDIVIDUAL REGARDING THIS TREATMENT.

Provider's Signature	**Date**

PROCEDURE FOR OBTAINING CONTROLLED SUBSTANCE PRESCRIPTIONS

1) A PHOTO ID SHALL BE PRESENTED TO THE RECEPTIONIST TO VERIFY IDENTITY.
2) IF SOMEONE OTHER THAN YOU WILL BE PICKING UP THE PRESCRIPTIONS, THAT PERSON MUST PRESENT A PHOTO ID AND SIGN AS INDICATED IN #3 BELOW.
3) A SIGNATURE WILL BE OBTAINED WHEN PICKING UP CONTROLLED SUBSTANCE PRESCRIPTIONS
4) IF THERE IS NO PHOTO ID PRESENTED, THE PRESCRIPTION FOR CONTROLLED SUBSTANCES WILL NOT BE GIVEN OUT UNDER ANY CIRCUMSTANCES.

BY SIGNING YOU UNDERSTAND THE PROCEDURE FOR OBTAINING THE PRESCRIPTIONS FOR CONTROLLED SUBSTANCES. COMPLIANCE IS PART OF YOUR CONTRACT.

PATIENT'S PRINTED NAME

PATIENT'S SIGNATURE

APPENDIX D

Weeks Medical Center

170 Middle Street
Lancaster, NH 03584
Phone: 603-788-2521
Fax: 603-788-5092

PO Box 240
Whitefield, NH 03598
Phone: 603-837-9005
Fax: 603-788-5072

47 Church Street
Groveton, NH 03582
Phone: 603-636-1101
Fax: 603-788-5059

February 24, 2009

«FirstName» «LastName»
«MailingAddress1»
«MailingAddress2»

Dear «FirstName»,

It has come to our attention that you have broken your pain agreement with your provider at Weeks Medical Center. The section of the agreement that was broken is:

- ☐ Prescriptions for controlled substances not filled at the designated pharmacy
- ☐ Prescriptions for controlled substances obtained from multiple providers
- ☐ Prescriptions for controlled substances filled at multiple pharmacies.
- ☐ Recurrent requests to fill controlled substances before they were due to be refilled.
- ☐ Failure to follow up as agreed.
- ☐ Failed urine drug screening test.
- ☐ Failed pill count.
- ☐ Failure to take controlled substances as directed as confirmed by a negative urine test.
- ☐ Notification by authorities of use, sale, diversion, or transport of illegally obtained controlled substances (narcotics or illegal drugs).

Consequently,

☐ **You will no longer be able to obtain care at Weeks Medical Center Physician Offices**. If we are treating you for other medical problems not related to pain management, we will continue to provide services for these conditions for the next 30 days to give you time to establish care with another provider. Upon notice we will forward your records to your new provider at no charge. No additional narcotics will be prescribed to you. In the event of an emergency, you should seek care at the nearest emergency room.

☐ **Weeks Medical Center providers will not prescribe controlled substances to you**, but your current PCP is willing to continue to treat you for your other healthcare issues.

Your current controlled substance prescription will not be refilled. If you have any questions regarding this letter, please call the office.

Sincerely,

APPENDIX E

Prescription Drug Abuse

NIDAMED Patient Resources Series

To download this and other flyers in this series, visit http://www.drugabuse.gov/nidamed.

What You Need To Know

Prescription drug abuse is the use of a medication not prescribed for you, in a way other than prescribed (for example, taking too much), or to get high.

When abused, prescription drugs can be as dangerous as "street" drugs, with similar effects on the brain, including the possibility of addiction.

Prescription drug abuse is illegal, even though most abusers get them from friends and family.

Almost 2.2 million people 12 and older abused prescription opioids, including pain relievers, stimulants, and sedatives, for the first time in 2009 (similar to marijuana).

Treatment Options

Available treatments depend on the type of medication being abused.

For Pain Relievers: Addiction treaments include medications combined with behavioral therapy.

For Stimulants: Behavioral therapies can be useful; studies are under way to discover effective medications.

For Sedatives: Addicted patients should undergo medically supervised detoxification combined with behavioral therapy.

Resources

NIDA's Web site (http://www.drugabuse.gov) has information on all aspects of drug abuse, such as drug effects on the brain and body, prevention of drug use among young people, latest research on addiction treatment, and U.S. trends and statistics.

NIDA also has a teen Web site devoted to information about prescription drug abuse: http://teens.drugabuse.gov/peerx.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has many reports and bulletins available on prescription drug abuse http://oas.samhsa.gov/prescription.htm. Their Web site also includes a treatment locator (http://findtreatment.samhsa.gov) and other useful information.

NATIONAL INSTITUTES OF HEALTH

NIDA
NATIONAL INSTITUTE
ON DRUG ABUSE

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

APPENDIX F

CDC Vitalsigns™
November 2011

Prescription Painkiller Overdoses in the US

15,000

Nearly 15,000 people die every year of overdoses involving prescription painkillers.

1 in 20

In 2010, 1 in 20 people in the US (age 12 or older) reported using prescription painkillers for nonmedical reasons in the past year.

1 Month

Enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for a month.

Deaths from prescription painkillers* have reached epidemic levels in the past decade. The number of overdose deaths is now greater than those of deaths from heroin and cocaine combined. A big part of the problem is nonmedical use of prescription painkillers—using drugs without a prescription, or using drugs just for the "high" they cause. In 2010, about 12 million Americans (age 12 or older) reported nonmedical use of prescription painkillers in the past year.

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 a medical purpose, many ended up in the hands of people who misused or abused them.

Improving the way prescription painkillers are prescribed can reduce the number of people who misuse, abuse or overdose from these powerful drugs, while making sure patients have access to safe, effective treatment.

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

→ See page 4

Want to learn more? Visit

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

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

Problem

Overdose deaths from prescription painkillers have skyrocketed during the past decade.

Prescription painkiller overdoses are a public health epidemic.

- Prescription painkiller overdoses killed nearly 15,000 people in the US in 2008. This is more than 3 times the 4,000 people killed by these drugs in 1999.
- In 2010, about 12 million Americans (age 12 or older) reported nonmedical use of prescription painkillers in the past year.
- Nearly half a million emergency department visits in 2009 were due to people misusing or abusing prescription painkillers.
- Nonmedical use of prescription painkillers costs health insurers up to $72.5 billion annually in direct health care costs.

Certain groups are more likely to abuse or overdose on prescription painkillers.

- Many more men than women die of overdoses from prescription painkillers.
- Middle-aged adults have the highest prescription painkiller overdose rates.
- People in rural counties are about two times as likely to overdose on prescription painkillers as people in big cities.
- Whites and American Indian or Alaska Natives are more likely to overdose on prescription painkillers.
- About 1 in 10 American Indian or Alaska Natives age 12 or older used prescription painkillers for nonmedical reasons in the past year, compared to 1 in 20 whites and 1 in 30 blacks.

The supply of prescription painkillers is larger than ever.

- The quantity of prescription painkillers sold to pharmacies, hospitals, and doctors' offices was 4 times larger in 2010 than in 1999.
- Many states report problems with "pill mills" where doctors prescribe large quantities of painkillers to people who don't need them medically. Some people also obtain prescriptions from multiple prescribers by "doctor shopping."

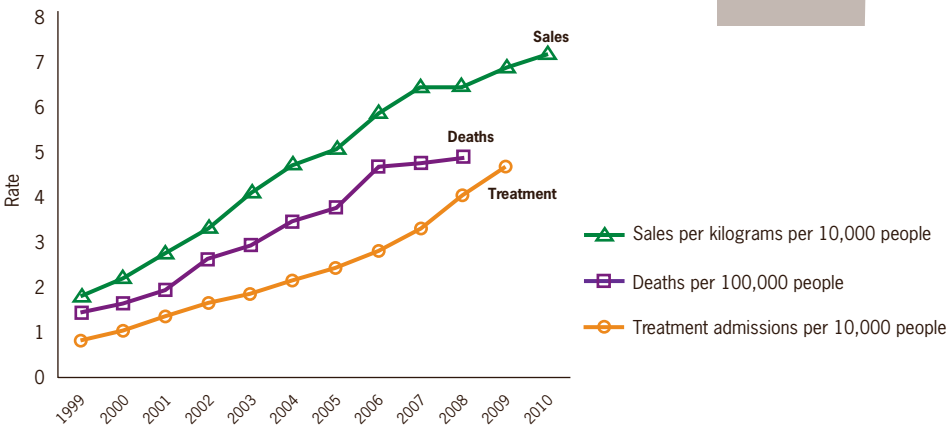
Some states have a bigger problem with prescription painkillers than others.

- Prescription painkiller sales per person were more than 3 times higher in Florida, which has the highest rate, than in Illinois, which has the lowest.
- In 2008/2009, nonmedical use of painkillers in the past year ranged from 1 in 12 people (age 12 or older) in Oklahoma to 1 in 30 in Nebraska.
- States with higher sales per person and more nonmedical use of prescription painkillers tend to have more deaths from drug overdoses.

Real-life stories of the epidemic

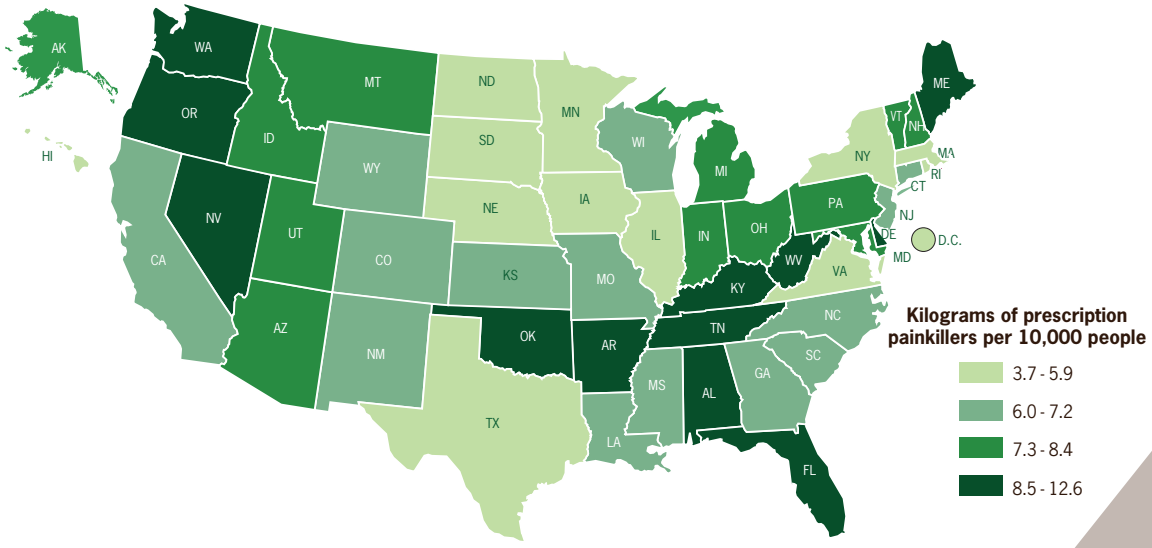
A West Virginia father, age 26, struggling for years with pain and addiction after shattering his elbow in a car crash, died from a prescription painkiller one week after telling his mother he wanted to go to rehab. In New Hampshire, a 20-year-old man overdosed on a prescription painkiller bought from a friend, becoming the 9th person that year to die from drug overdose in his community of 17,000. Stories such as these are all too common.

Rates of prescription painkiller sales, deaths and substance abuse treatment admissions (1999-2010)



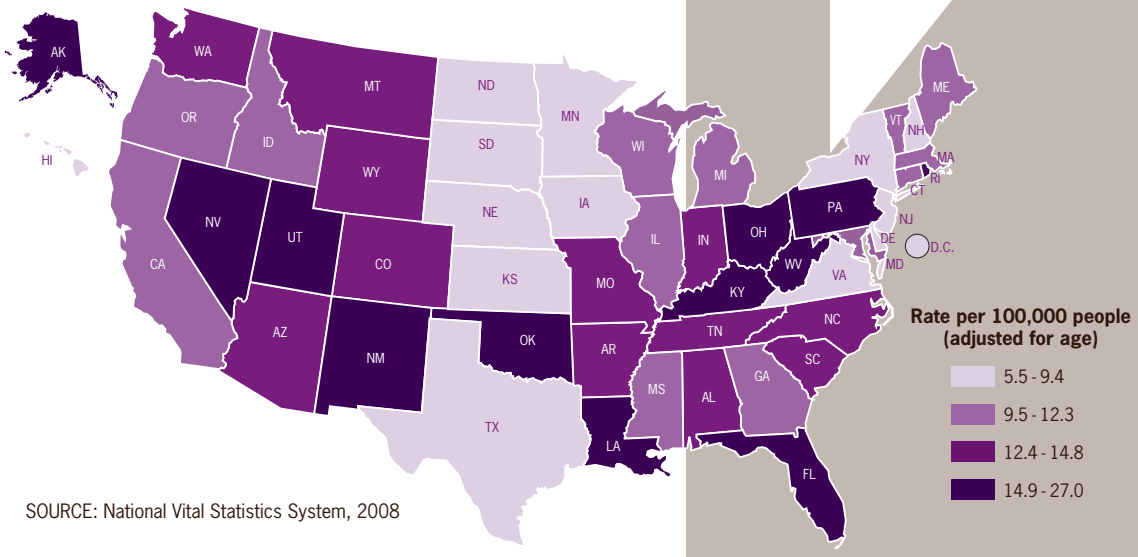
SOURCES: National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 1999-2010; Treatment Episode Data Set, 1999-2009

Amount of prescription painkillers sold by state per 10,000 people (2010)



SOURCE: Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 2010

Drug overdose death rates by state per 100,000 people (2008)



SOURCE: National Vital Statistics System, 2008

What Can Be Done

The US government is

- ◇ Tracking prescription drug overdose trends to better understand the epidemic.
- ◇ Educating health care providers and the public about prescription drug abuse and overdose.
- ◇ Developing, evaluating and promoting programs and policies shown to prevent and treat prescription drug abuse and overdose, while making sure patients have access to safe, effective pain treatment.

States can

- ◇ Start or improve prescription drug monitoring programs (PDMPs), which are electronic databases that track all prescriptions for painkillers in the state.
- ◇ Use PDMP, Medicaid, and workers' compensation data to identify improper prescribing of painkillers.
- ◇ Set up programs for Medicaid, workers' compensation programs, and state-run health plans that identify and address improper patient use of painkillers.
- ◇ Pass, enforce and evaluate pill mill, doctor shopping and other laws to reduce prescription painkiller abuse.
- ◇ Encourage professional licensing boards to take action against inappropriate prescribing.
- ◇ Increase access to substance abuse treatment.

Individuals can

- ◇ Use prescription painkillers only as directed by a health care provider.
- ◇ Make sure they are the only one to use their prescription painkillers. Not selling or sharing them with others helps prevent misuse and abuse.
- ◇ Store prescription painkillers in a secure place and dispose of them properly.*
- ◇ Get help for substance abuse problems if needed (1-800-662-HELP).

Health insurers can

- ◇ Set up prescription claims review programs to identify and address improper prescribing and use of painkillers.
- ◇ Increase coverage for other treatments to reduce pain, such as physical therapy, and for substance abuse treatment.

Health care providers can

- ◇ Follow guidelines for responsible painkiller prescribing, including
  - Screening and monitoring for substance abuse and mental health problems.
  - Prescribing painkillers only when other treatments have not been effective for pain.
  - Prescribing only the quantity of painkillers needed based on the expected length of pain.
  - Using patient-provider agreements combined with urine drug tests for people using prescription painkillers long term.
  - Talking with patients about safely using, storing and disposing of prescription painkillers.*
- ◇ Use PDMPs to identify patients who are improperly using prescription painkillers.

* Information on the proper storage and disposal of medications can be found at www.cdc.gov/HomeandRecreationalSafety/Poisoning/preventiontips.htm.

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
***TTY*: 1-888-232-6348**
E-mail: cdcinfo@cdc.gov
Web: www.cdc.gov
Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Publication date: 11/01/2011

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

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

CS227796-B

APPENDIX G

Controlled Substances

- by DEA Drug Code Number -

SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Codeine preparations - 200 mg/(100 ml or 100 gm)		V	Y	Cosanyl,Robitussin A-C,Cheracol,Cerose,Pediacof
Difenoxin preparations - 0.5 mg/25 ug AtSO4/du		V	Y	Motofen
Dihydrocodeine preparations 10 mg/(100 ml or 100 gm)		V	Y	Cophene-S, various others
Diphenoxylate preparations 2.5 mg/25 ug AtSO4		V	Y	Lomotil, Logen
Ethylmorphine preparations 100 mg/(100 ml or 100 gm)		V	Y	
Opium preparations - 100 mg/(100 ml or 100 gm)		V	Y	Parepectolin, Kapectolin PG, Kaolin Pectin P.G.
Amphetamine	1100	II	N	Dexedrine, Adderall, Obetrol
Methamphetamine	1105	II	N	Desoxyn, D-desoxyephedrine, ICE, Crank, Speed
Lisdexamfetamine	1205	II	N	Vyvanse
Benzphetamine	1228	III	N	Didrex, Inapetyl
Cathine	1230	IV	N	Constituent of "Khat" plant, (+)-norpseudoephedrine
Cathinone	1235	I	N	Constituent of "Khat" plant
Methcathinone	1237	I	N	N-Methylcathinone, "cat"
4-Methyl-N-methylcathinone	1248	I	N	Mephedrone
Stimulant compounds previously excepted	1405	III	N	Mediatric
N-Ethylamphetamine	1475	I	N	NEA
N,N-Dimethylamphetamine	1480	I	N	
Pyrovalerone	1485	V	N	Centroton, Thymergix
Fenethylline	1503	I	N	Captagon,amfetyline,ethyltheophylline amphetamine
Pemoline	1530	IV	N	Cylert
Fenproporex	1575	IV	N	Gacilin, Solvolip
Mefenorex	1580	IV	N	Anorexic, Amexate, Doracil, Pondinil
Aminorex	1585	I	N	has been sold as methamphetamine
4-Methylaminorex (cis isomer)	1590	I	N	U4Euh, McN-422
Mazindol	1605	IV	N	Sanorex, Mazanor
Diethylpropion	1610	IV	N	Tenuate, Tepanil
Phendimetrazine	1615	III	N	Plegine, Prelu-2, Bontril, Melfiat, Statobex
Phenmetrazine	1631	II	N	Preludin
SPA	1635	IV	N	1-dimethylamino-1,2-diphenylethane, Lefetamine
Phentermine	1640	IV	N	Ionamin, Fastin, Adipex-P, Obe-Nix, Zantryl
Chlorphentermine	1645	III	N	Pre-Sate, Lucofen, Apsedon, Desopimon
Clortermine	1647	III	N	Voranil
Dexfenfluramine	1670	IV	N	Redux

SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Fenfluramine	1670	IV	N	Pondimin, Ponderal
Sibutramine	1675	IV	N	Meridia
Modafinil	1680	IV	N	Provigil
Methylphenidate	1724	II	N	Concerta, Ritalin, Methylin
Pipradrol	1750	IV	N	Detaril, Stimolag Fortis
Fencamfamin	1760	IV	N	Reactivan
Gamma Hydroxybutyric Acid	2010	I	N	GHB, gamma hydroxybutyrate, sodium oxybate
Gamma Hydroxybutyric Acid preparations	2012	III	N	Xyrem
Embutramide	2020	III	N	Tributane
Aprobarbital	2100	III	N	Alurate
Barbituric acid derivative	2100	III	N	Barbiturates not specifically listed
Butabarbital (secbutabarbital)	2100	III	N	Butisol, Butibel
Butalbital	2100	III	N	Fiorinal, Butalbital with aspirin
Butobarbital (butethal)	2100	III	N	Soneryl (UK)
Talbutal	2100	III	N	Lotusate
Thiamylal	2100	III	N	Surital
Thiopental	2100	III	N	Pentothal
Vinbarbital	2100	III	N	Delvinal, vinbarbitone
Amobarbital	2125	II	N	Amytal, Tuinal
Amobarbital & noncontrolled active ingred.	2126	III	N	
Amobarbital suppository dosage form	2126	III	N	
Fospropofol	2138	IV	N	Lusedra
Barbital	2145	IV	N	Veronal, Plexonal, barbitone
Methylphenobarbital (mephobarbital)	2250	IV	N	Mebaral, mephobarbital
Methohexital	2264	IV	N	Brevital
Pentobarbital	2270	II	N	Nembutal
Pentobarbital & noncontrolled active ingred.	2271	III	N	FP-3
Pentobarbital suppository dosage form	2271	III	N	WANS
Phenobarbital	2285	IV	N	Luminal, Donnatal, Bellergal-S
Secobarbital	2315	II	N	Seconal, Tuinal
Secobarbital & noncontrolled active ingred	2316	III	N	
Secobarbital suppository dosage form	2316	III	N	
Chloral betaine	2460	IV	N	Beta Chlor
Chloral hydrate	2465	IV	N	Noctec
Dichloralphenazone	2467	IV	N	Midrin, dichloralantipyrine
Chlorhexadol	2510	III	N	Mechloral, Mecoral, Medodorm, Chloralodol
Ethchlorvynol	2540	IV	N	Placidyl

SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Ethinamate	2545	IV	N	Valmid, Valamin
Glutethimide	2550	II	N	Doriden, Dorimide
Methaqualone	2565	I	N	Quaalude, Parest, Somnafac, Opitimil, Mandrax
Mecloqualone	2572	I	N	Nubarene
Methyprylon	2575	III	N	Noludar
Paraldehyde	2585	IV	N	Paral
Petrichloral	2591	IV	N	Pentaerythritol chloral, Periclor
Sulfondiethylmethane	2600	III	N	
Sulfonethylmethane	2605	III	N	
Sulfonmethane	2610	III	N	
Clonazepam	2737	IV	N	Klonopin, Clonopin
Chlordiazepoxide	2744	IV	N	Librium, Libritabs, Limbitrol, SK-Lygen
Lacosamide	2746	V	N	Vimpat
Bromazepam	2748	IV	N	Lexotan, Lexatin, Lexotanil
Camazepam	2749	IV	N	Albego, Limpidon, Paxor
Clobazam	2751	IV	N	Urbadan, Urbanyl
Clotiazepam	2752	IV	N	Trecalmo, Rize, Clozan, Veratran
Cloxazolam	2753	IV	N	Akton, Lubalix, Olcadil, Sepazon
Delorazepam	2754	IV	N	
Estazolam	2756	IV	N	ProSom, Domnamid, Eurodin, Nuctalon
Ethyl loflazepate	2758	IV	N	
Fludiazepam	2759	IV	N	
Halazepam	2762	IV	N	Paxipam
Flunitrazepam	2763	IV	N	Rohypnol, Narcozep, Darkene, Roipnol
Prazepam	2764	IV	N	Centrax
Diazepam	2765	IV	N	Valium, Diastat
Flurazepam	2767	IV	N	Dalmane
Clorazepate	2768	IV	N	Tranxene
Haloxazolam	2771	IV	N	
Ketazolam	2772	IV	N	Anxon, Loftran, Solatran, Contamex
Loprazolam	2773	IV	N	
Lormetazepam	2774	IV	N	Noctamid
Zaleplon	2781	IV	N	Sonata
Pregabalin	2782	V	N	Lyrica
Zolpidem	2783	IV	N	Ambien, Ivadal, Stilnoct, Stilnox
Zopiclone	2784	IV	N	Lunesta
Mebutamate	2800	IV	N	Capla

SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Meprobamate	2820	IV	N	Miltown, Equanil, Micrainin, Equagesic, Meprospan
Nitrazepam	2834	IV	N	Mogadon
Oxazepam	2835	IV	N	Serax, Serenid-D
Medazepam	2836	IV	N	Nobrium
Nimetazepam	2837	IV	N	Erimin
Nordiazepam	2838	IV	N	Nordazepam, Demadar, Madar
Oxazolam	2839	IV	N	Serenal, Convertal
Quazepam	2881	IV	N	Doral
Alprazolam	2882	IV	N	Xanax
Pinazepam	2883	IV	N	Domar
Midazolam	2884	IV	N	Versed
Lorazepam	2885	IV	N	Ativan
Tetrazepam	2886	IV	N	Myolastan, Musaril
Triazolam	2887	IV	N	Halcion
Temazepam	2925	IV	N	Restoril
13Beta-ethyl-17beta-hydroxygon-4-en-3-one	4000	III	N	
17Alpha-methyl-3alpha,17beta-dihydroxy-5alpha-androstane	4000	III	N	
17Alpha-methyl-3beta,17beta-dihydroxy-5alpha-androstane	4000	III	N	
17Alpha-methyl-3beta,17beta-dihydroxyandrost-4-ene	4000	III	N	
17Alpha-methyl-4-hydroxynandrolone (17alpha-methyl-4-hydroxy-17beta-hydroxyestr-4-en-3-one)	4000	III	N	
17Alpha-methyl-delta1-dihydrotestosterone (17beta-hydroxy-17alpha-methyl-5alpha-androst-1-en-3-one)	4000	III	N	17-Alpha-methyl-1-testosterone
19-Nor-4,9(10)-androstadienedione	4000	III	N	
19-Nor-4-androstenediol (3beta,17beta-dihydroxyestr-4-ene; 3alpha,17beta-dihydroxyestr-4-ene)	4000	III	N	
19-Nor-4-androstenedione (estr-4-en-3,17-dione)	4000	III	N	
19-Nor-5-androstenediol (3beta,17beta-dihydroxyestr-5-ene; 3alpha,17beta-dihydroxyestr-5-ene)	4000	III	N	
19-Nor-5-androstenedione (estr-5-en-3,17-dione)	4000	III	N	
1-Androstenediol (3beta,17beta-dihydroxy-5alpha-androst-1-ene; 3alpha,17beta-dihydroxy-5alpha-androst-1-ene)	4000	III	N	
1-Androstenedione (5alpha-androst-1-en-3,17-dione)	4000	III	N	
3Alpha,17beta-dihydroxy-5alpha-androstane	4000	III	N	
3Beta,17beta-dihydroxy-5alpha-androstane	4000	III	N	
4-Androstenediol (3beta,17beta-dihydroxy-androst-4-ene)	4000	III	N	4-AD
4-Androstenedione (androst-4-en-3,17-dione)	4000	III	N	
4-Dihydrotestosterone (17beta-hydroxyandrostan-3-one)	4000	III	N	Anabolex, Andractim, Pesomax, Stanolone

SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
4-Hydroxy-19-nortestosterone (4,17beta-dihydroxyestr-4-en-3-one)	4000	III	N	
4-Hydroxytestosterone (4,17beta-dihydroxyandrost-4-en-3-one)	4000	III	N	
5-Androstenediol (3beta,17beta-dihydroxy-androst-5-ene)	4000	III	N	
5-Androstenedione (androst-5-en-3,17-dione)	4000	III	N	
Anabolic steroids	4000	III	N	"Body Building" drugs
Androstanedione (5alpha-androstan-3,17-dione)	4000	III	N	
Bolasterone (7alpha,17alpha-dimethyl-17beta-hydroxyandrost-4-en-3-one)	4000	III	N	
Boldenone (17beta-hydroxyandrost-1,4-diene-3-one)	4000	III	N	Equipoise, Parenabol, Vebonol, dehydrotestosterone
Boldione	4000	III	N	
Calusterone (7beta,17alpha-dimethyl-17beta-hydroxyandrost-4-en-3-one)	4000	III	N	Methosarb
Clostebol (4-chloro-17beta-hydroxyandrost-4-en-3-one)	4000	III	N	Alfa-Trofodermin, Clostene, 4-chlorotestosterone
Dehydrochloromethyltestosterone (4-chloro-17beta-hydroxy-17alpha-methylandrost-1,4-dien-3-one)	4000	III	N	Oral-Turinabol
Delta1-dihydrotestosterone (17beta-hydroxy-5alpha-androst-1-en-3-one)	4000	III	N	1-Testosterone
Desoxymethyltestosterone	4000	III	N	
Drostanolone (17beta-hydroxy-2alpha-methyl-5alpha-androstan-3-one)	4000	III	N	Drolban, Masterid, Permastril
Ethylestrenol (17alpha-ethyl-17beta-hydroxyestr-4-ene)	4000	III	N	Maxibolin, Orabolin, Durabolin-O, Duraboral
Fluoxymesterone (9-fluoro-17alpha-methyl-11beta,17beta-dihydroxyandrost-4-en-3-one)	4000	III	N	Anadroid-F, Halotestin, Ora-Testryl
Formebolone (2-formyl-17alpha-methyl-11alpha,17beta-dihydroxyandrost-1,4-dien-3-one)	4000	III	N	Esiclene, Hubernol
Furazabol (17alpha-methyl-17beta-hydroxyandrostano[2,3-c]-furazan)	4000	III	N	Frazalon, Miotolon, Qu Zhi Shu
Mestanolone (17alpha-methyl-17beta-hydroxy-5alpha-androstan-3-one)	4000	III	N	Assimil, Ermalone, Methybol, Tantarone
Mesterolone (1alpha-methyl-17beta-hydroxy-5alpha-androstan-3-one)	4000	III	N	Androviron, Proviron, Testiwop
Methandienone (17alpha-methyl-17beta-hydroxyandrost-1,4-diene-3-one)	4000	III	N	Dianabol, Metabolina, Nerobol, Perbolin
Methandriol (17alpha-methyl-3beta,17beta-dihydroxyandrost-5-ene)	4000	III	N	Sinesex, Stenediol, Troformone
Methenolone (1-methyl-17beta-hydroxy-5alpha-androst-1-en-3-one)	4000	III	N	Primobolan, Primobolan Depot, Primobolan S
Methyldienolone (17alpha-methyl-17beta-hydroxyestr-4,9(10)-dien-3-one)	4000	III	N	
Methyltestosterone (17alpha-methyl-17beta-hydroxyandrost-4-en-3-one)	4000	III	N	Android, Oreton, Testred, Virilon
Methyltrienolone (17alpha-methyl-17beta-hydroxyestr-4,9,11-trien-3-one)	4000	III	N	Metribolone
Mibolerone (7alpha,17alpha-dimethyl-17beta-hydroxyestr-4-en-3-one)	4000	III	N	Cheque, Matenon
Nandrolone (17beta-hydroxyestr-4-en-3-one)	4000	III	N	Deca-Durabolin, Durabolin, Durabolin-50

SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Norbolethone (13beta,17alpha-diethyl-17beta-hydroxygon-4-en-3-one)	4000	III	N	Genabol
Norclostebol (4-chloro-17beta-hydroxyestr-4-en-3-one	4000	III	N	Anabol-4-19, Lentabol
Norethandrolone (17alpha-ethyl-17beta-hydroxyestr-4-en-3-one)	4000	III	N	Nilevar, Pronabol, Solevar
Normethandrolone (17alpha-methyl-17beta-hydroxyestr-4-en-3-one)	4000	III	N	Lutenin, Matronal, Orgasteron
Oxandrolone (17alpha-methyl-17beta-hydroxy-2-oxa-5alpha-androstan-3-one)	4000	III	N	Anavar, Lonavar, Oxandrin, Provitar, Vasorome
Oxymesterone (17alpha-methyl-4,17beta-dihydroxyandrost-4-en-3-one)	4000	III	N	Anamidol, Balnimax, Oranabol, Oranabol 10
Oxymetholone (17alpha-methyl-2-hydroxymethylene-17beta-hydroxy-5alpha-androstan-3-one)	4000	III	N	Anadrol-50, Adroyd, Anapolon, Anasteron, Pardroyd
Stanozolol (17alpha-methyl-17beta-hydroxy-5alpha-androst-2-eno[3,2-c]-pyrazole)	4000	III	N	Winstrol, Winstrol-V
Stenbolone (17beta-hydroxy-2-methyl--5alpha-androst-1-en-3-one)	4000	III	N	
Testolactone (13-hydroxy-3-oxo-13,17-secoandrosta-1,4-dien-17-oic acid lactone)	4000	III	N	Teolit, Teslac
Testosterone (17beta-hydroxyandrost-4-en-3-one)	4000	III	N	Android-T, Androlan, Depotest, Delatestryl
Tetrahydrogestrinone (13beta,17alpha-diethyl-17beta-hydroxygon-4,9,11-trien-3-one)	4000	III	N	THG
Trenbolone (17beta-hydroxyestr-4,9,11-trien-3-one)	4000	III	N	Finaplix-S, Finajet, Parabolan
JWH-018 (also known as AM678)	7118	I	N	1-Pentyl-3-(1-naphthoyl)indole
JWH-073	7173	I	N	1-Butyl-3-(1-naphthoyl)indole
JWH-200	7200	I	N	1-[2-(4-Morpholinyl)ethyl]-3-(1-naphthoyl)indole
Alpha-ethyltryptamine	7249	I	N	ET, Trip
Ibogaine	7260	I	N	Constituent of "Tabernanthe iboga" plant
Ketamine	7285	III	N	Ketaset, Ketalar, Special K, K
Tiletamine & Zolazepam Combination Product	7295	III	N	Telazol
CP-47497	7297	I	N	5-(1,1-Dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl-phenol
CP-47497 C8 Homologue	7298	I	N	5-(1,1-Dimethyloctyl)-2-[(1R,3S)3-hydroxycyclohexyl-phenol
Lysergic acid	7300	III	N	LSD precursor
Lysergic acid amide	7310	III	N	LSD precursor
Lysergic acid diethylamide	7315	I	N	LSD, lysergide
2,5-Dimethoxy-4-(n)-propylthiophenethylamine	7348	I	N	2C-T-7
Marihuana	7360	I	N	Cannabis, marijuana
Dronabinol (synthetic) in sesame oil in soft gelatin capsule as approved by FDA	7369	III	N	Marinol, synthetic THC in sesame oil/soft gelatin as approved by FDA
Tetrahydrocannabinols	7370	I	N	THC, Delta-8 THC, Delta-9 THC, dronabinol and others
Parahexyl	7374	I	N	Synhexyl,
Nabilone	7379	II	N	Cesamet
Mescaline	7381	I	N	Constituent of "Peyote" cacti

SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
3,4,5-Trimethoxyamphetamine	7390	I	N	TMA
4-Bromo-2,5-dimethoxyamphetamine	7391	I	N	DOB, 4-bromo-DMA
4-Bromo-2,5-dimethoxyphenethylamine	7392	I	N	2C-B, Nexus, has been sold as Ecstasy, i.e. MDMA
4-Methyl-2,5-dimethoxyamphetamine	7395	I	N	DOM, STP
2,5-Dimethoxyamphetamine	7396	I	N	DMA, 2,5-DMA
2,5-Dimethoxy-4-ethylamphetamine	7399	I	N	DOET
3,4-Methylenedioxyamphetamine	7400	I	N	MDA, Love Drug
5-Methoxy-3,4-methylenedioxyamphetamine	7401	I	N	MMDA
N-Hydroxy-3,4-methylenedioxyamphetamine	7402	I	N	N-hydroxy MDA
3,4-Methylenedioxy-N-ethylamphetamine	7404	I	N	N-ethyl MDA, MDE, MDEA
3,4-Methylenedioxymethamphetamine	7405	I	N	MDMA, Ecstasy, XTC
4-Methoxyamphetamine	7411	I	N	PMA
Peyote	7415	I	N	Cactus which contains mescaline
5-Methoxy-N-N-dimethyltryptamine	7431	I	N	5-MeO-DMT
Alpha-methyltryptamine	7432	I	N	AMT
Bufotenine	7433	I	N	Mappine, N,N-dimethylserotonin
Diethyltryptamine	7434	I	N	DET
Dimethyltryptamine	7435	I	N	DMT
Psilocybin	7437	I	N	Constituent of "Magic mushrooms"
Psilocyn	7438	I	N	Psilocin, constituent of "Magic mushrooms"
5-Methoxy-N,N-diisopropyltryptamine	7439	I	N	5-MeO-DIPT
N-Ethyl-1-phenylcyclohexylamine	7455	I	N	PCE
1-(1-Phenylcyclohexyl)pyrrolidine	7458	I	N	PCPy, PHP, rolicyclidine
1-Phenylcyclohexylamine	7460	II	N	PCP precursor
1-[1-(2-Thienyl)cyclohexyl]piperidine	7470	I	N	TCP, tenocyclidine
Phencyclidine	7471	II	N	PCP, Sernylan
1-[1-(2-Thienyl)cyclohexyl]pyrrolidine	7473	I	N	TCPy
N-Ethyl-3-piperidyl benzilate	7482	I	N	JB 323
N-Methyl-3-piperidyl benzilate	7484	I	N	JB 336
N-Benzylpiperazine	7493	I	N	BZP, 1-benzylpiperazine
3,4-Methylenedioxypyrovalerone	7535	I	N	MDPV
3,4-Methylenedioxy-N-methylcathinone	7540	I	N	Methylone
4-Anilino-N-phenethyl-4-piperidine (ANPP)	8333	II	N	ANPP
Phenylacetone	8501	II	N	P2P, phenyl-2-propanone, benzyl methyl ketone
1-Piperidinocyclohexanecarbonitrile	8603	II	N	PCC, PCP precursor
Alphaprodine	9010	II	Y	Nisentil
Anileridine	9020	II	Y	Leritine

SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Coca Leaves	9040	II	Y	
Cocaine	9041	II	Y	Methyl benzoylecgonine, Crack
Codeine	9050	II	Y	Morphine methyl ester, methyl morphine
Acetyldihydrocodeine	9051	I	Y	Acetylcodone
Benzylmorphine	9052	I	Y	
Codeine-N-oxide	9053	I	Y	
Cyprenorphine	9054	I	Y	
Desomorphine	9055	I	Y	
Etorphine (except HCl)	9056	I	Y	
Etorphine HCl	9059	II	Y	M 99
Buprenorphine	9064	III	Y	Buprenex, Temgesic, Subutex, Suboxone
Codeine methylbromide	9070	I	Y	
Dihydrocodeine	9120	II	Y	Didrate, Parzone
Oxycodone	9143	II	Y	OxyContin, Percocet, Endocet, Roxicodone, Roxicet,
Dihydromorphine	9145	I	Y	
Hydromorphone	9150	II	Y	Dilaudid, dihydromorphinone
Difenoxin 1 mg/25 ug AtSO4/du	9167	IV	Y	Motofen
Difenoxin	9168	I	Y	Lyspafen
Diphenoxylate	9170	II	Y	
Benzoylecgonine	9180	II	Y	Cocaine metabolite
Ecgonine	9180	II	Y	Cocaine precursor, in Coca leaves
Ethylmorphine	9190	II	Y	Dionin
Hydrocodone	9193	II	Y	dihydrocodeinone
Heroin	9200	I	Y	Diacetylmorphine, diamorphine
Levomethorphan	9210	II	Y	
Levorphanol	9220	II	Y	Levo-Dromoran
Isomethadone	9226	II	Y	Isoamidone
Meperidine	9230	II	Y	Demerol, Mepergan, pethidine
Meperidine intermediate-A	9232	II	Y	Meperidine precursor
Meperidine intermediate-B	9233	II	Y	Meperidine precursor, normeperidine
Meperidine intermediate-C	9234	II	Y	Meperidine precursor
Metazocine	9240	II	Y	
Methadone	9250	II	Y	Dolophine, Methadose, Amidone
Methadone intermediate	9254	II	Y	Methadone precursor
Metopon	9260	II	Y	
Dextropropoxyphene, bulk (non-dosage forms)	9273	II	Y	Propoxyphene
Dextropropoxyphene dosage forms	9278	IV	Y	Darvon, propoxyphene, Darvocet, Propacet

SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Morphine	9300	II	Y	MS Contin, Roxanol, Oramorph, RMS, MSIR
Hydromorphinol	9301	I	Y	
Methyldesorphine	9302	I	Y	
Methyldihydromorphine	9304	I	Y	
Morphine methylbromide	9305	I	Y	
Morphine methylsulfonate	9306	I	Y	
Morphine-N-oxide	9307	I	Y	
Myrophine	9308	I	Y	
Nicocodeine	9309	I	Y	
Nicomorphine	9312	I	Y	Vilan
Normorphine	9313	I	Y	
Pholcodine	9314	I	Y	Copholco, Adaphol, Codisol, Lantuss, Pholcolin
Thebacon	9315	I	Y	Acetylhydrocodone, Acedicon, Thebacetyl
Acetorphine	9319	I	Y	
Oripavine	9330	II	Y	
Thebaine	9333	II	Y	Precursor of many narcotics
Dihydroetorphine	9334	II	Y	DHE
Drotebanol	9335	I	Y	Metebanyl, oxymethebanol
Nalorphine	9400	III	Y	Nalline
Opium, raw	9600	II	Y	Raw opium, gum opium
Acetylmethadol	9601	I	Y	Methadyl acetate
Allylprodine	9602	I	Y	
Alphacetylmethadol except levo-alphacetylmethadol	9603	I	Y	
Alphameprodine	9604	I	Y	
Alphamethadol	9605	I	Y	
Benzethidine	9606	I	Y	
Betacetylmethadol	9607	I	Y	
Betameprodine	9608	I	Y	
Betamethadol	9609	I	Y	
Opium extracts	9610	II	Y	
Betaprodine	9611	I	Y	
Clonitazene	9612	I	Y	
Dextromoramide	9613	I	Y	Palfium, Jetrium, Narcolo
Diampromide	9615	I	Y	
Diethylthiambutene	9616	I	Y	
Dimenoxadol	9617	I	Y	
Dimepheptanol	9618	I	Y	

SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Dimethylthiambutene	9619	I	Y	
Opium fluid extract	9620	II	Y	
Dioxaphetyl butyrate	9621	I	Y	
Dipipanone	9622	I	Y	Dipipan, phenylpiperone HCl, Diconal, Wellconal
Ethylmethylthiambutene	9623	I	Y	
Etonitazene	9624	I	Y	
Etoxeridine	9625	I	Y	
Furethidine	9626	I	Y	
Hydroxypethidine	9627	I	Y	
Ketobemidone	9628	I	Y	Cliradon
Levomoramide	9629	I	Y	
Opium tincture	9630	II	Y	Laudanum
Levophenacylmorphan	9631	I	Y	
Morpheridine	9632	I	Y	
Noracymethadol	9633	I	Y	
Norlevorphanol	9634	I	Y	
Normethadone	9635	I	Y	Phenyldimazone
Norpipanone	9636	I	Y	
Phenadoxone	9637	I	Y	
Phenampromide	9638	I	Y	
Opium, powdered	9639	II	Y	Powdered opium
Opium, granulated	9640	II	Y	Granulated opium
Phenoperidine	9641	I	Y	Operidine, Lealgin
Piritramide	9642	I	Y	Piridolan
Proheptazine	9643	I	Y	
Properidine	9644	I	Y	
Racemoramide	9645	I	Y	
Trimeperidine	9646	I	Y	Promedolum
Phenomorphan	9647	I	Y	
Levo-alphacetylmethadol	9648	II	Y	LAAM, long acting methadone, levomethadyl acetate
Propiram	9649	I	Y	Algeril
Opium poppy	9650	II	Y	Papaver somniferum
Poppy Straw	9650	II	Y	Opium poppy capsules, poppy heads
Oxymorphone	9652	II	Y	Numorphan
1-Methyl-4-phenyl-4-propionoxypiperidine	9661	I	Y	MPPP, synthetic heroin
1-(2-Phenylethyl)-4-phenyl-4-acetoxypiperidine	9663	I	Y	PEPAP, synthetic heroin
Poppy Straw Concentrate	9670	II	Y	Concentrate of Poppy Straw, CPS

SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Pentazocine	9709	IV	N	Talwin, Talwin NX, Talacen, Talwin Compound
Phenazocine	9715	II	Y	Narphen, Prinadol
Butorphanol	9720	IV	N	Stadol, Stadol NS, Torbugesic, Torbutrol
Piminodine	9730	II	Y	
Racemethorphan	9732	II	Y	
Racemorphan	9733	II	Y	Dromoran
Alfentanil	9737	II	Y	Alfenta
Remifentanil	9739	II	Y	Ultiva
Sufentanil	9740	II	Y	Sufenta
Carfentanil	9743	II	Y	Wildnil
Tilidine	9750	I	Y	Tilidate, Valoron, Kitadol, Lak, Tilsa
Tapentadol	9780	II	Y	
Bezitramide	9800	II	Y	Burgodin
Fentanyl	9801	II	Y	Duragesic, Oralet, Actiq, Sublimaze, Innovar
Moramide-intermediate	9802	II	Y	
Codeine & isoquinoline alkaloid 90 mg/du	9803	III	Y	Codeine with papaverine or noscapine
Codeine combination product 90 mg/du	9804	III	Y	Empirin,Fiorinal,Tylenol,ASA or APAP w/codeine
Hydrocodone & isoquinoline alkaloid <15 mg/du	9805	III	Y	Dihydrocodeinone+papaverine or noscapine
Hydrocodone combination product <15 mg/du	9806	III	Y	Lorcet, Lortab,Vicodin, Vicoprofen,Tussionex, Norco
Dihydrocodeine combination product 90 mg/du	9807	III	Y	Synalgos-DC, Compal
Ethylmorphine combination product 15 mg/du	9808	III	Y	
Opium combination product 25 mg/du	9809	III	Y	Paregoric, other combination products
Morphine combination product/50 mg/(100 ml or 100 gm)	9810	III	Y	
Para-Fluorofentanyl	9812	I	Y	China White, fentanyl
3-Methylfentanyl	9813	I	Y	China White, fentanyl
Alpha-methylfentanyl	9814	I	Y	China White, fentanyl
Acetyl-alpha-methylfentanyl	9815	I	Y	
Beta-hydroxyfentanyl	9830	I	Y	China White, fentanyl
Beta-hydroxy-3-methylfentanyl	9831	I	Y	China White, fentanyl
Alpha-methylthiofentanyl	9832	I	Y	China White, fentanyl
3-Methylthiofentanyl	9833	I	Y	Chine White, fentanyl
Thiofentanyl	9835	I	Y	Chine white, fentanyl

For more information about the work of the Commission and implementation of prescription drug abuse prevention strategies, please contact:

Joseph P. Harding, Director
New Hampshire Department of Health & Human Services
Bureau of Drug and Alcohol Services
105 pleasant Street
Concord, NH 03301

(603) 271-6110
Joseph.p.harding@dhhs.state.nh.us

For more information about the development and compilation of this publication, please contact:

Lisa Muré, Director
New Hampshire Center for Excellence
Community Health Institute/JSI Research & Training Institute
501 South Street, 2nd Floor
Bow, NH 03304

(603) 573-3311
lmure@jsi.com

This document was prepared for The New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment by the Community Health Institute/JSI under the New Hampshire Center for Excellence contract funded by the New Hampshire Bureau of Drug and Alcohol Services/Governor's Commission on Alcohol and Drug Abuse (Contract # 1003181) and the New Hampshire Charitable Foundation.