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OREGON COORDINATOR MOVING ON

This is the last Northwest Evaluator DRE newsletter that I will publish and produce. Effective September 1, 2003, I am retiring from the Oregon State Police and handing the DRE State Coordinator duties over to Lieutenant Dale Rutledge, effective August 1, 2003. Dale has many years of dedicated service and experience in DRE operations and will do a great job as the new DRE Coordinator.

It has been a great ride with the Oregon State Police, and serving as the DRE State Coordinator was an honor and something that made my career with the Department even more rewarding. When we started the DEC Program in Oregon in 1995, I never dreamed it would be as successful as it is today. Our success can be directly attributed to the many dedicated people that have been involved in the program.

It has been a pleasure working with you all on DRE, SFST, and impaired driving issues. We have accomplished a lot, but there is much, much more work to be done. Although I am retiring from OSP, you can count on me to stay involved in impaired driving issues and remain part of DRE and the fight against impaired driving. Thank you all for the great job you do and the sacrifices you make in making our highways safer for all.

Captain Chuck Hayes
Oregon State Police
Oregon DRE State Coordinator

THE RIDING TREND OF PRESCRIPTION DRUG ABUSE

By Carol L. Falkowski
Director of Research, Hazelden

Approximately one year ago, President Bush's niece was arrested for fraudulently obtaining a controlled substance, the anti-anxiety prescription medication Xanax. Months later, at a medical clinic in rural St. Cloud, Minnesota, a 25-year-old man stabbed a physician who refused to prescribe him narcotics. The New York Times magazine ran a cover story in 2001 on OxyContin abuse, highlighting the emerging underground, illegal use and sales of the drug. In a growing number of rural areas, law enforcement agents describe OxyContin abuse as the fastest-growing drug abuse concern. Some authorities have called prescription drug abuse a national epidemic in the making.

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Used as medically directed, prescription medications dramatically improve functioning and the quality of life. Yet an estimated 5 million Americans over age 12 currently use prescription medications for non-medical purposes. The breakdown: pain medications (2.6 million); sedatives and tranquilizers (1.3 million); and stimulants (0.9 million) according to the 1999 National Household Survey on Drug Abuse. "Current use" is defined as any use in the past month.

In 1999, roughly 1.6 million people in the United States used prescription pain relievers non-medically for the first time - four times as many as in 1980. From 1990 to 1998, the number of first-time, non-medical users of prescription pain relievers rose 181 percent; stimulants rose 165 percent; tranquilizers rose 132 percent; and sedatives rose 90 percent. The largest increase in new, non-medical use of prescription drugs occurred in two age groups: Ages 12 to 17, and ages 18 to 25. There has been a dramatic surge in new, non-medical users of pain relievers from 1965 - 1999.

The most commonly abused prescription drugs are: Opioids - prescribed in the treatment of pain relief (e.g., Oxycodone, Propoxyphene, Hydrocodone, Hydromorphone); CNS depressants - used to treat anxiety, stress, and sleep disorders (e.g., barbiturates, benzodiazepines), and stimulants - prescribed to treat narcolepsy and attention deficit/hyperactivity disorder (e.g., methylphenidate, dextroamphetamine).

Historically, many U.S. physicians have been reluctant to prescribe powerful opioid pain medications because of the abuse liability and heightened addictive potential. Yet recent research finds that the overwhelming majority of people who use pain medication as directed do not become addicted. One study of 12,000 patients who were prescribed opioids for acute pain found that only four became addicted. In another study, of 38 patients given opioids for four to seven years for chronic pain, only two became addicted and both had a history of drug abuse.

Still, as the number of first-time, non-medical users of prescription medication grows, so does the associated addiction.

According to the Treatment Episode Data Set, a federal treatment data system, the number of people admitted to addiction treatment centers with non-medical use of pain medications as the primary drug problem rose from 14,044 in 1994 to over 20,000 in 1999. Nearly half of these patients (44 percent) reported no substances of abuse other than prescription painkillers.

Oxycodone, the semi-synthetic, opioid analgesic used for mild to moderate pain control, chronic pain syndromes and treatment of terminal cancer pain, was produced in a continuous release form in 1996. OxyContin has an 8 to 12 hour duration of action and contains no acetaminophen. Fatal overdoses of OxyContin have increased since 1997; an extensive review of autopsies performed by the U.S. Drug Enforcement Administration found OxyContin played a probable role in 282 deaths over a recent 19-month period.

OxyContin is diverted from legitimate use by way of pharmacy theft, "doctor shopping," and improper prescribing by unscrupulous physicians. The drug is sought out and abused by seasoned drug abusers for its strong, heroin-like, euphoric effects. The pills are crushed and then either snorted or cooked down and injected to overcome the time-release mechanism. Many drug abusers prefer the predictable purity level that comes with a prescribed drug vs. one purchased on the street, such as heroin.

Entrepreneurs who hope to cash in on its resale value in the illicit market - in particular, drug abusers and dealers, as well as people who live on extremely limited income, also seek out OxyContin. A bottle of 100 40-mg tablets that sell at a retail pharmacy for \$400 can have a resale value of \$2,000 to \$4,000 in the illicit market.

The National Institute on Drug Abuse (NIDA) recently launched a national initiative to promote research and educate the public - including health care providers - about the misuse and abuse of prescription medication. The Drug Enforcement Agency has also launched a plan to aggressively target fraudulent prescriptions, reduce doctor shopping, and halt other illegal practices related specifically to the abuse of OxyContin. Purdue Pharma, the manufacturer of

OxyContin, is also working on development of an abuse-resistance formulation that could contain opioid antagonists.

Clearly, physicians and clinical staff play a significant role in assessing and diagnosing this problem. The need to take extra care with suspicious patients, guard their prescriptions, and contact law enforcement when confronted with attempted diversion or theft of prescription medications. Yet disappointingly, less than one-third of U.S. primary care physicians recently surveyed by Columbia University felt "very prepared" to recognize prescription drug abuse among their patients, and more than 46 percent said they were uncomfortable discussing the issue. Patients, especially those in recovery from addiction, need to take extra caution when prescribed medications with addictive potential and share their concerns up-front with the prescribing physicians.

Source: The Hazelden Voice - Winter 2003

DEA TEMPORARILY DESIGNATES TWO HALLUCINOGENS AS SCHEDULE I SUBSTANCES

On April 4, 2003, DEA temporarily designated alpha-methyltryptamine (AMT) and 5-methoxy-*N,N*-diisopropyltryptamine (5-MeO-DIPT) - known as Foxy - as Schedule I substances under the Controlled Substances Act. DEA exercised its authority to temporarily place the substances in Schedule I because the Deputy Administrator of DEA determined that the trafficking and abuse of these substances pose an imminent hazard to public safety, and because the substances have a high potential for abuse. Further, the Deputy Administrator determined that there is no currently accepted medical use, and that the substances are not safe for use under medical supervision. DEA has the authority to temporarily place substances into Schedule I for one year and the U.S. Attorney General may extend the term for an additional six months.

Both AMT and 5-MeO-DIPT typically are administered orally. According to DEA, the effects of AMT include hallucinations, mood elevation, nervousness, inability to sleep, and

excessive pupil dilation. The effects of 15 to 40 milligrams of AMT typically begin 3 or 4 hours after ingestion and gradually subside over 12 to 24 hours, but may last up to two days. The effects of ingesting six to ten milligrams of 5-MeO-DIPT generally include hallucinations, talkativeness, loss of inhibitions, and excessive dilation of the pupils. The effects of 5-MeO-DIPT often begin in 20 to 30 minutes, peak after one hour, and last between three to six hours. DEA reports that AMT and 5-MeO-DIPT are distributed at nightclubs and raves in Arizona, California, Florida, and New York, and that a gram of either substance typically costs less than \$150. DEA also reports that clandestine laboratory operators have attempted to produce AMT and 5-MeO-DIPT in Nevada, Virginia, and Washington, D.C., although the degree to which these attempts were successful is unclear.

Source: National Drug Threat Assessment Unit

LATEST EDITION OF DRUGS OF ABUSE RELEASED

The highly anticipated release of the latest edition of Drugs of Abuse has arrived! The fifty-plus page publication is your A to Z guide for drug history, effects, and identification information. Drugs of Abuse offers easy-to-read scientific information about drugs combined with scores of precise photographs shot to scale. Previous editions were heralded by law enforcement officers, educators, and public health practitioners as one of the most comprehensive drug guides available. You can browse or print the publication at www.dea.gov/pubs/abuse/index.html.

Source: DEA Update April 2003

Captain Chuck Hayes' Retirement Dinner is scheduled for September 26th at the Willamette Valley Vineyards in Salem.

Anyone interested in receiving additional information, please contact Sharri Dowling @ (503) 378-3720 x4205 or email @ Sharri.Dowling@state.or.us

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