HB

327

26-LS1261\R.1
Luckhaupt
3/10/10

Pres #1

AMENDMENT

OFFERED IN THE HOUSE

TO: HB 327

Page 3, line 7:

Insert a new bill section to read:

"* **Sec. 3.** AS 11.71.170(b) is amended to read:

(b) Schedule IVA includes, unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances, including their salts, isomers and salts of isomers whenever the existence of these salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) barbital;

(2) chloral betaine;

(3) chloral hydrate;

(4) chlordiazepoxide;

(5) clonazepam;

(6) clorazepate;

(7) diazepam;

(8) ethclorvynol;

(9) ethinamate;

(10) flurazepam;

(11) **lorazepam** [LORAZEPAN];

(12) mebutamate;

(13) meprobamate;

(14) methohexital;

(15) methylphenobarbital, also known as mephobarbital;

(16) oxazepam;
(17) paraldehyde;
(18) petrichloral;
(19) phenobarbital;
(20) prazepam;
(21) alprazolam;
(22) halazepam;
(23) temazepam;
(24) triazolam;
(25) midazolam;
(26) quazepam;
(27) flunitrazepam;
(28) [REPEALED
(29)] ketamine hydrochloride."

Renumber the following bill sections accordingly.

Page 4, following line 1:

Insert a new bill section to read:

"* **Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. AS 11.71.170(b)(11), as amended by sec. 3 of this Act, corrects a typographical error in the spelling of "lorazepam" that has existed since its adoption in Chapter 45, SLA 1982. AS 11.71.170(b)(11), as amended by sec. 3 of this Act, applies to crimes committed before, on, or after the effective date of this Act."

ALASKA STATE LEGISLATURE

REPRESENTATIVE KYLE JOHANSEN
MAJORITY LEADER

SPONSOR STATEMENT

HB 327 – Relating to controlled substances and the sale of products containing dextromethorphan

HB 327 updates and strengthens the state's anti-drug laws. Specifically, this legislation does three things: it adds salvia divinorum to the list of schedule IIA drugs, moves buprenorphine from schedule VA up to Schedule IIIA, and limits the purchase of products that contain dextromethorphan (DXM) to Alaskans over the age of 18.

Salvia divinorum is a powerful hallucinogenic similar to mescaline and peyote. It is a perennial herb found in the mountainous regions of Mexico where it has a history of use as a vision inducing substance by the local Mazatec Indians. It is banned in several countries and an ever-growing number of states.

Buprenorphine is a synthetic opiate used in a similar manner to methadone as a treatment to opiate dependency. And, like methadone, it's abused as a recreational drug and leads to dependence.

DXM is a common ingredient in over-the-counter cough suppressants. DXM is safe when taken in the recommended doses. However, when it is taken in large doses it has an intoxicating affect. Over-the-counter products that contain DXM often also contain other ingredients such as acetaminophen and chlorpheniramine. Large doses of acetaminophen can cause liver damage and large doses of chlorpheniramine can cause increased heart rate and seizures.

All three proposed changes in statute would make these drugs either harder for our children and loved ones to obtain or increase the penalties for their use, creating deterrents that will strengthen our drug laws.

I urge your support.

Session: State Capitol, Juneau, AK 99801-1182 • (907) 465-3424 • Fax (907) 465-3793
Interim: 50 Front Street, Suite 203, Ketchikan, AK 99901 • (907) 247-4672 • Fax (907) 225-8546
Coffman Cove • Hollis • Ketchikan • Meyers Chuck • Saxman • Thorne Bay

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **HB 327**
() Publish Date:

Identifier (file name): HB327-LAW-CRIM-03-08-10
Dept. Affected: Law
Title: An Act relating to the scheduling and rescheduling of certain substances as controlled substances and to the sale of products containing dextromethorphan
RDU CRIMINAL
Component Criminal Justice Litigation
Sponsor Representative Johansen
Requester Judiciary
Component Number 2202

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	***	***	***	***	***	***	***
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	***	***	***	***	***	***	***

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

HB 327 adds salvia divinorum to Schedule IIA of Alaska's drug schedules; raises buprenorphine from Schedule VA to Schedule IIIA. And HB 327 provides that a person may not sell a product with dextromethorphan (a type of cough medicine) to a person under 18 years of age unless the person has a prescription for the medicine. A person who recklessly violates this prohibition could be charged with a class B misdemeanor. Therefore, the fiscal impact to the Department of Law is indeterminate.

Prepared by: Eileen Donahue, Division Operations Manager
Phone 465-5427
Division Administrative Services
Date/Time 3/8/10 12:30 PM
Approved by: Daniel S. Sullivan, Attorney General
Date 3/8/2010
Department of Law

(Revised 11/6/2009 OMB)

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **HB 327 (JUD)**
() Publish Date:

Identifier (file name): HB327-DPS-LAB-03-08-10
Title: Controlled substances and dextromethorphan
Sponsor: Representative Johansen
Requester: House Judiciary

Dept. Affected: Public Safety
RDU: Statewide Support
Component: Laboratory Services
Component Number: **527**

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

HB 327 "An Act relating to the scheduling and rescheduling of certain substances as controlled substances and to the sale of products containing dextromethorphan" proposes the addition of Salvia divinorum and Salvinorin A (Divinorin A) as a Schedule IIIA controlled substance and may have a significant impact to the Controlled Substance and Evidence Sections of the Alaska Scientific Crime Detection Laboratory.

To what extent these additions will impact the laboratory cannot be determined at this time.

Prepared by: Orin Dym, Lab Manager — Phone (907) 269-5743
Division: Scientific Crime Detection Laboratory — Date/Time 3/8/10 10:30 AM
Approved by: Joe Masters — Date 3/8/2010
Commissioner

(Revised 11/6/2009 OMB)

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **HB 327**
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Identifier (file name): HB327-LAW-CRIM-03-08-10
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Component Criminal Justice Litigation
Sponsor Representative Johansen
Requester Judiciary
Component Number 2202

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	***	***	***	***	***	***	***
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	***	***	***	***	***	***	***

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

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Prepared by: Eileen Donahue, Division Operations Manager
Phone 465-5427
Division Administrative Services
Date/Time 3/8/10 12:30 PM
Approved by: Daniel S. Sullivan, Attorney General
Date 3/8/2010
Department of Law

(Revised 11/6/2009 OMB)

Skip To Content

Emergency Department Visits Involving Dextromethorphan

The New DAWN Report: **Emergency Department Visits Involving Dextromethorphan**

- **HTML format**
- **PDF format (233 KB)**

Highlights:

- Dextromethorphan (DXM) is approved by the Food and Drug Administration and is a cough suppressant found in many over-the-counter cough and cold remedies. Dextromethorphan is generally safe when taken in recommended doses but in large amounts can cause dangerous side effects.
- According to SAMHSA's Drug Abuse Warning Network (DAWN) for 2004, an estimated 12,584 emergency department visits (0.7% of all drug related emergency department visits) involved pharmaceuticals containing dextromethorphan.
- The rate of emergency department visits resulting from nonmedical use of dextromethorphan for those aged 12 to 20 was 7.1 visits per 100,000 population compared with 2.6 visits or fewer per 100,000 for other age groups.
- Emergency department patients aged 12 to 20 accounted for almost half (48%) of all the emergency department visits resulting from nonmedical use of dextromethorphan.
- The rates of DAWN emergency department visits resulting from any type of use of dextromethorphan among those aged 12 to 20 was 10.3 per 100,000 population compared with 4.3 visits per 100,000 for the population overall.
- Alcohol was implicated in about a third (36%) of the DAWN emergency department visits involving nonmedical use of dextromethorphan for those aged 18 to 20 and in 13% of visits for those aged 12 to 17.

Other reports on dextromethorphan

Other specific drugs

Other topics

Other OAS publications and services

This Short Report, The New DAWN Report: **Emergency Department Visits Involving Dextromethorphan**, is based on the **Drug Abuse Warning Network (DAWN)**, the primary source of national data on drug related emergency department visits. DAWN is conducted by the Office of Applied Studies (OAS) in the Substance Abuse and Mental Health Services Administration (SAMHSA).

This page has been accessed **81622** times since 11/9/2006.

This page was last updated on January 10, 2008.

SAMHSA, an agency in the Department of Health and Human Services, is the Federal Government's lead agency for improving the quality and availability of substance abuse prevention, addiction treatment, and mental health services in the United States.

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New
The DAWN Report
Issue 32, 2006R
DRUG ABUSE WARNING NETWORK

Emergency Department Visits Involving Dextromethorphan

In Brief

According to the Drug Abuse Warning Network (DAWN) for 2004:

- An estimated 16,858 emergency department (ED) visits involved pharmaceuticals containing dextromethorphan (DXM). This was just under 1 percent of all drug-related ED visits.
- The rate of ED visits resulting from nonmedical use of DXM for those aged 12 to 20 was 8.0 visits per 100,000 population, compared with 2.5 visits or fewer per 100,000 for other age groups.
- ED patients aged 12 to 20 accounted for about half (51%) of the ED visits resulting from nonmedical use of DXM, compared with 33 percent of DXM-related ED visits overall.
- The rate of ED visits resulting from any type of use of DXM among those aged 12 to 20 was 14.7 per 100,000 population, compared with 5.7 visits per 100,000 for the population overall.
- Alcohol was implicated in 41 percent of ED visits involving nonmedical use of DXM for those aged 18 to 20 and in 13 percent of visits for those aged 12 to 17.

Dextromethorphan (DXM) is a cough suppressant approved by the Food and Drug Administration (FDA) that is found in many over-the-counter cough and cold remedies.[1] It is generally safe when taken at recommended doses. When taken in large amounts, though, DXM can produce hallucinations and a "high" similar to psychotropic drugs, such as phencyclidine (PCP). Dangerous side effects may include blurred vision, loss of physical coordination, abdominal pain, and rapid heartbeat. Side effects may be worsened if the ingested product also contains other pharmaceutical ingredients— such as acetaminophen, pseudoephedrine, antihistamines, or expectorants, which are commonly found in cough and cold medicines—or alcohol.[2]

In recent years DXM has become available, primarily over the Internet, in bulk powdered form, and concern has grown over the nonmedical use of DXM by teenagers. In May 2005, the FDA issued a warning about the dangers of DXM abuse involving over-the-counter products and DXM obtained from illicit sources.[3]

The Drug Abuse Warning Network (DAWN) collects data from a national sample of short-term, general, non-Federal hospitals[4] and publishes estimates of emergency department (ED) visits involving illicit drugs and nonmedical use of pharmaceuticals. This issue of *The DAWN Report* examines the characteristics of ED visits that involve DXM and products containing DXM.

The DAWN Report is published periodically by the Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA). This issue was written by Judy K. Ball, Ph.D., M.P.A., and David Skellan (SAMHSA/OAS).

Included are findings on the age of ED patients who used DXM and the reason for their visit to the ED. Also provided are the rates of DXM-related ED visits per 100,000 population for different age groups and the frequency with which DXM products are found in combination with alcohol. The ED visits considered here exclude the small number of patients who go to the ED to obtain admission to the hospital's detoxification or substance abuse treatment unit.

Overview

During 2004, there were about 106 million ED visits to short-term, general, non-Federal hospitals in the United States.[5] Of those, DAWN estimates that just over 2.5 million were drug related, with just under a half million involving nonmedical use of pharmaceuticals. Nearly 17,000, or just under 1 percent, of all drug-related ED visits in 2004 involved DXM or products containing DXM.

Reasons for ED visits

Nonmedical use of DXM products accounted for 5,962 (35%) of the estimated 16,858 DXM-related ED visits in 2004, and about half (51%) of these nonmedical visits involved patients aged 12 to 20 (Table 1).[6] The rate of ED visits resulting from nonmedical use of DXM products was 8.0 visits per 100,000 population for those aged 12 to 20, while the rate for other age groups was 2.5 or less (Table 1 and Figure 1).

Medical use of DXM included ED visits attributed to adverse reactions that occured when DXM products were used as prescribed (or according to directions for over-the-counter products). About 31 percent of all DXM-related ED visits in 2004 were a result of adverse reactions. Children aged 0 to 11 are the most likely to experience adverse reactions to DXM. Their rate of ED visits was higher than that for any other age group (3.9 per 100,000 population), and they constitute 36 percent of all ED visits involving adverse reactions to DXM.

About 16 percent of DXM-related ED visits involve accidental ingestion. As with adverse reactions, children aged 0 to 11 are also the most likely to accidentally ingest DXM or DXM-containing products. The rate of ED visits for accidental ingestion of DXM is 5.2 visits per 100,000 population, and over 95 percent of ED visits for accidental ingestion of DXM involve children in this age range.

Suicide attempts involving DXM products accounted for 17 percent of DXM-related ED visits. Patients

Table 1. ED visits involving DXM, by age and reason for visit

Age category	Estimated ED visits	Percent of visits[a]	ED visits per 100,000 population
Nonmedical use (35% of total)			
0-11	42	1%	0.1
12-20	3,016	51%	8.0
12-17	1,938	33%	7.6
18-20	1,078	18%	8.7
21-34	1,451	24%	2.5
35+	1,448	24%	1.0
Medical use (adverse reaction) (31% of total)			
0-11	1,879	36%	3.9
12-20	744	14%	2.0
12-17	701	13%	2.8
18-20	43	1%	0.4
21-34	682	13%	1.2
35+	1,890	36%	1.3
Accidental ingestion (15% of total)			
0-11	2,478	96%	5.2
12-20	—	0%	0.0
12-17	—	0%	0.0
18-20	—	0%	0.0
21-34	—	0%	0.0
35+	109	4%	0.1
Suicide attempt (17% of total)			
0-11	—	0%	0.0
12-20	1,610	55%	4.3
12-17	1,154	40%	4.5
18-20	456	16%	3.7
21-34	527	18%	0.9
35+	778	27%	0.5
Total[b]			
All ages	16,858	100%	5.7
0-11	4,399	26%	9.2
12-20	5,556	33%	14.7
12-17	3,970	24%	15.6
18-20	1,586	9%	12.8
21-34	2,662	16%	4.7
35+	4,236	25%	2.8

[a] Percentages may not sum to 100 percent due to rounding.

[b] This total includes only the four types of ED visits shown. This excludes patients who go to the ED to obtain admission to a hospital's detoxification or substance abuse treatment unit.

Note: — Estimates less than 30 are suppressed.

Source: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 2004 (03/2006 update).

aged 12 to 20 are more likely than patients in other age groups to use DXM products in a suicide attempt. This group has a rate of 4.3 DXM-related ED visits per 100,000 population, compared with rates of 0.0 for those aged 0 to 11 and less than 1.0 for those aged 21 or older.

Alcohol involvement

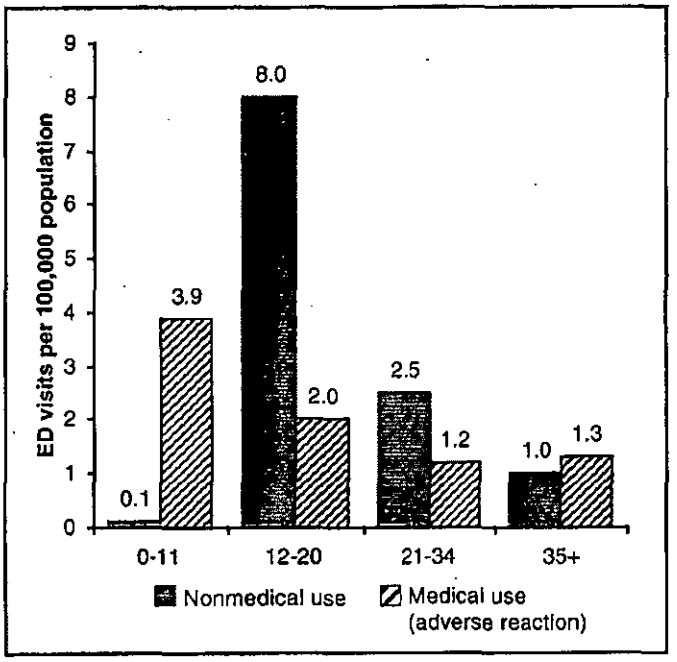
Alcohol was involved in about 13 percent of ED visits resulting from nonmedical use of DXM products for those aged 12 to 17 and in 41 percent of such visits for those aged 18 to 20 (Figure 2). Patients aged 35 to 54 had the highest involvement of alcohol (61%). For the youngest (aged 0 to 11) and oldest (aged 55 or older) patients, alcohol involvement was lower (0% and 2%, respectively).

Alcohol is also an ingredient in some cough medications. Some common products (e.g., NyQuil®) contain a mixture of DXM and up to 10 percent alcohol. In these cases, alcohol may play a role in the ED visit without being specifically documented in the ED medical record. Therefore, these findings may understate the involvement of alcohol and its contribution to the side effects leading to ED visits.

Notes

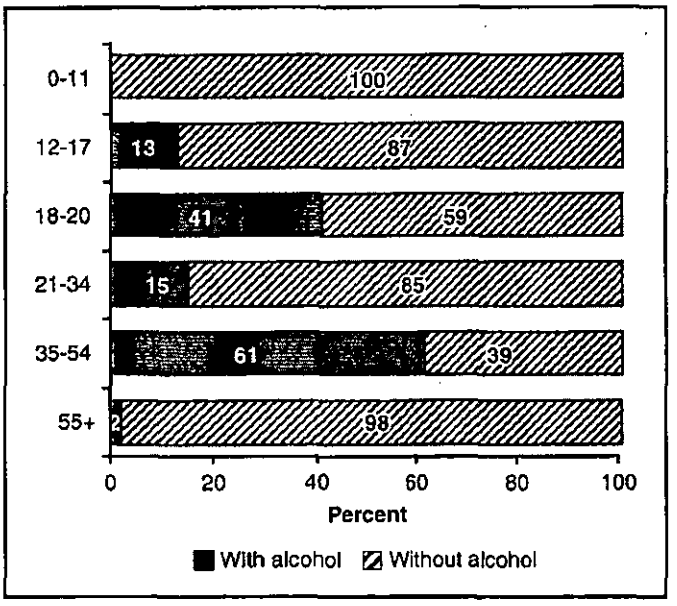
1. U.S. National Library of Medicine, National Institutes of Health. (2003, April 1). *Dextromethorphan.* Retrieved September 26, 2006, from http://www.nlm.nih.gov/medlineplus/druginfo/medmaster/a682492.html
2. National Institute on Drug Abuse. (2001, March). *Hallucinogens and dissociative drugs* (NIH Publication No. 01-4209). Retrieved September 29, 2006, from http://www.drugabuse.gov/ResearchReports/Hallucinogens/halluc4.html
3. Food and Drug Administration. (2005, May 20). *FDA warns against abuse of dextromethorphan (DXM)* (Talk Paper T05-23). Rockville, MD: National Press Office. Retrieved September 29, 2006, from http://www.fda.gov/bbs/topics/ANSWERS/2005/ANS01360.html
4. Specialty hospitals, including children's hospitals, are excluded from the DAWN sample.
5. American Hospital Association (AHA) Annual Survey Database, Fiscal Year 2003. Health Forum LLC, Copyright 2003, One North Franklin Street, Chicago, IL 60606.
6. Nonmedical use of DXM includes taking more than a prescribed or recommended dose and other forms of drug misuse or abuse.

Figure 1. Rates of ED visits for nonmedical and medical use of DXM, by age



Source: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 2004 (03/2008 update).

Figure 2. ED visits involving nonmedical use of DXM and alcohol, by age



Source: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 2004 (03/2008 update).

For change of address, corrections, or to be removed from this list, please e-mail: shortreports@samhsa.hhs.gov.

The DAWN Report — Emergency Department Visits Involving Dextromethorphan

In Brief

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The **Drug Abuse Warning Network (DAWN)** is a public health surveillance system that monitors drug-related morbidity and mortality. DAWN uses a probability sample of hospitals to produce estimates of drug-related emergency department (ED) visits for the United States and selected metropolitan areas annually. DAWN also produces annual profiles of drug-related deaths reviewed by medical examiners or coroners in selected metropolitan areas and States.

Any ED visit or death related to recent drug use is included in DAWN. All types of drugs—licit and illicit—are covered. Alcohol is included for adults when it occurs with another drug. Alcohol is always included for minors. DAWN's method of classifying drugs was derived from the Multum *Lexicon*, Copyright © 2008, Multum Information Services, Inc. The Multum Licensing Agreement can be found in DAWN annual publications and at http://www.multum.com/license.htm.

DAWN is one of three major surveys conducted by the Substance Abuse and Mental Health Services Administration's Office of Applied Studies (SAMHSA/OAS). For information on other OAS surveys, go to http://www.oas.samhsa.gov. SAMHSA has contracts with Westat (Rockville, MD) and RTI International (Research Triangle Park, NC) to operate the DAWN system and produce publications.

For publications and additional information about DAWN, go to http://DAWNinfo.samhsa.gov.

LEGISLATIVE RESEARCH SERVICES

Alaska State Legislature
Division of Legal and Research Services
State Capitol, Juneau, AK 99801

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November 6, 2009

Memorandum
TO: Representative Kyle Johansen
FROM: Daniel Lesh, Legislative Analyst DDL
RE: Regulation of Over-The-Counter Medications Containing Dextromethorphan
LRS Report 10.073

You asked about state regulations limiting the sale of commonly-abused over-the-counter medications containing the chemical dextromethorphan. Specifically, you wanted to know if any such limitations have been proposed in Alaska, or in other states. You also wanted to know of any over-the-counter medical products that the state of Alaska does not allow to be sold to minors or does not allow to be sold in large quantities.

As you may know, dextromethorphan is a drug included in many common cough medications, including cough syrups and cough pills. Individuals sometime abuse these medications by consuming many times the recommended dose, with dissociative, psychedelic effects. Dextromethorphan abuse has numerous negative side effects, but is not generally considered addictive or lethal. The most serious side effects, which can include death, are caused by consuming medications with other active ingredients besides dextromethorphan, such as acetaminophen, according to information we reviewed.

Alaska

It appears that no limitations on the sale of products containing dextromethorphan have been proposed in Alaska. No bills or resolutions introduced between 1983 and 2009—years for which electronic records are available—mention the word dextromethorphan. In addition, J. Kate Burkhart, executive director, Advisory Board on Alcoholism and Drug Abuse, Department of Health and Social Services, is not familiar with any such proposals, nor is she aware of any chronic misuse of these types of products in Alaska.[1]

According to Ms. Burkhart, the only over-the-counter medications with limitations on their sale in Alaska are those containing pseudoephedrine, ephedrine, and phenylpropanolamine—three drugs that are commonly used in the manufacture of methamphetamine.[2] These limitations are the result of federal and state law. The relevant federal law, the Combat Methamphetamine Epidemic Act of 2005, requires that retail establishments limit access to products containing these drugs; verify purchaser identity; keep a log of all purchases of products containing these drugs; and enforce daily and 30-day limits on the sale of these products to any one individual, among other requirements. A state law (AS 17.30.090) passed shortly after the Combat Methamphetamine Epidemic Act of 2005 mirrors and references that federal law. No other over-the-counter medical products in Alaska are limited in their sale by volume or by age of purchaser, according to Ms. Burkhart.

[1] Ms. Burkhart can be reached at (907) 465-8920. Rather than dextromethorphan, Ms. Burkhart highlighted oxycontin abuse as one of the major concerns facing the Alaska drug abuse prevention community.

[2] An example of an over-the-counter product containing pseudoephedrine is Sudafed.

Other States

It appears that no state regulates the sale of over-the-counter medications containing dextromethorphan, though proposals to do so have been introduced in a number of states. Similarly, proposals have been introduced in Congress, but never passed. However, one state (Illinois; 720 ILCS 570/218) does regulate the sale of pure, unfinished dextromethorphan.[3] Please see Table 1 for a list of relevant state and federal legislation located via *lexis.com* and *thomas.gov* searches.

It is important to note that many major pharmacies have voluntarily installed restrictions of the type you asked about. We were unable to locate a comprehensive list of which stores in which locations have imposed which restrictions. However, a list posted on a website that appears targeted at drug users provides a description of how easy it is to buy dextromethorphan-containing medications in 23 states.[4] The list suggests that in 19 of those states, "some stores" or "large chain stores" do not allow sales of dextromethorphan-containing medications to those less than 18 years of age.[5] The list also names three states (Arkansas, Colorado, and Iowa) where no stores are allowed to sell dextromethorphan to those under 18; however, a search of those states' statutes and regulations did not reveal any such laws.

[3] Unfinished dextromethorphan is already illegal to distribute under general FDA laws regarding packaging and labeling requirements, but state and federal laws have been introduced—and passed in Illinois—to clarify that distribution of unfinished dextromethorphan is illegal.

[4] This list was found on a website called Vaults of Erowid, located at *http://www.erowid.org/chemicals/dxm/dxm_law.shtml*.

[5] Names of stores listed as requiring purchasers to be at least 18 years of age include Wal-Mart, Dillons, Target, Walgreens, Meijers, and Rite-Aid.

Table 1: State and Federal Legislation to Regulate the Sale of Products Containing Dextromethorphan, 2005-2009			
State	2005-2006	2007-2008	2009
California	S.B. 307: Requires a prescription for sale to a person under 18 years of age		
Maryland	S.B. 450: Requires a prescription for sale to a person under 18 years of age. Requires vendors to verify identity of purchasers and keep a log of all sales of products containing dextromethorphan		
Massachussetts		H.B. 3742: Prohibits sale to those under 18 years of age; Requires inventories to be kept by pharmacies and retail providers; allows retail providers to limit consumers to certain quantities	
Michigan		S.B. 1538: Prohibits sale of products containing dextromethorphan to individuals under 18 years of age	
New Jersey	A.B. 4279 and S.B. 2709: Prohibits sale of products containing dextromethorphan to minors under 18 years of age	A.B. 2695 and S.B. 2251: Prohibits sale of products containing dextromethorphan to minors under 18 years of age	A.B. 3676: Prohibits sale of products containing dextromethorphan to minors under 18 years of age; A.B. 3837: Regulates the sale of dextromethorphan *see Attachment A for bill text*
New York	A.B. 4743 and S.B. 499: Makes it unlawful to give, sell or cause to be given or sold 2 or more containers of medicine containing dextromethorphan to any person under the age of 18	A.B. 7509 and S.B. 3444: Makes it unlawful to give, sell or cause to be given or sold 2 or more containers of medicine containing dextromethorphan to any person under the age of 18	A.B. 8276 and S.B. 5606: Requires placement behind the pharmacy or only accessible through the manager of a retail establishment *see Attachment B for bill text*
Oklahoma		S.B. 1794: Requires a valid ID; prohibits minors from purchasing such products; prohibits the sale and distribution of any product containing unfinished dextromethorphan without a license; revises legislative intent to include drug abuse education	

Table 1: State and Federal Legislation to Regulate the Sale of Products Containing Dextromethorphan, 2005-2009, continued			
State	2005-2006	2007-2008	2009
Pennsylvania	H.B. 1289: Provides for the registration and reporting of certain noncontrolled substances including Dextromethorphan		H.B. 1616: Provides that the chemical dextromethorphan be subject to registration *see Attachment C for bill text*
Rhode Island	S.B. 561: Prohibit the sale, without a prescription, of any solid oral product which contains more than twenty (20) milligrams of dextromethorphan either alone or in combination with other drugs	S.B. 635: Defines prohibited acts, and penalties for trafficking in dextromethorphan	S.B. 128 and S.B. 1071: Makes possession of one gram or more of pure dextromethorphan by a person other than a medical facility, medical practice, pharmacist or licensed pharmacy illegal *see Attachment D for bill text*
Virginia	H.B. 875: Restricts access to over the counter medications containing the drug Dextromethorphan		S.B. 952: Makes the sale of over-the-counter medicines containing dextromethorphan on school property a Class 1 misdemeanor *see Attachment E for bill text*
U.S. Congress	109th Congress: H.R. 5280: Prohibits the distribution of unfinished dextromethorphan, expect to certain registered entities	110th Congress: S. 2274: Requires a prescription for sale to a person under 18 years of age. H.R. 970: Prohibits the distribution of unfinished dextromethorphan, expect to certain registered entities	111th Congress: S. 1383: Requires a prescription for sale to a person under 18 years of age. *see Attachment F for bill text* H.R. 1259: Prohibits the distribution of unfinished dextromethorphan, expect to certain registered entities *see Attachment G for bill text*
Notes: Descriptions of bills are based on summary language provided by *lexis.com*. None of these bills were adopted as law. **Source:** State bills located via a 50-state search of *Lexis.com* for the term "dextromethorphan" in State Net Bill Tracking, All States, 2005-2009. Federal bills located via a *Thomas.gov* search for "dextromethorphan."			

I hope this information is useful. Please contact our office if you have additional questions.

INTELLIGENCE BULLETIN

DXM (Dextromethorphan)

Product No. 2004-L0424-029 OCTOBER 2004
U. S. DEPARTMENT OF JUSTICE

The abuse of DXM (dextromethorphan)—a common ingredient contained in over-the-counter cough and cold medicines—is an increasing concern for law enforcement officers in the United States. Adolescents are the primary abusers of the drug, most likely because it is inexpensive and relatively easy to obtain. Additionally, because DXM is a common ingredient in many cough and cold medicines, many adolescents do not perceive any risk in abusing the drug. Compounding the problem is that few parents know about the potential for abuse of the drug.

Background

DXM is a synthetically produced substance that is chemically related to codeine, though it is not an opiate. DXM is an ingredient in more than 140 over-the-counter cough and cold remedies and since the 1950s has gradually replaced codeine as the most widely used cough suppressant in the United States. It is available in capsule, liquid, liquid gelatin capsule, lozenge, and tablet forms. It also is available in powdered form on the Internet—typically for sale to laboratories conducting research on DXM.

When ingested at recommended dosage levels, DXM generally is a safe and highly effective cough suppressant; however, when ingested in larger amounts, DXM produces negative physiological effects. Reports of DXM abuse have resulted in monitoring by the Drug Enforcement Administration (DEA), and DXM could be added to the Controlled Substances Act if warranted. In 2003 legislation was introduced in Texas and North Dakota to prohibit the sale of DXM to minors. The proposed legislation did not pass in either state. A similar bill introduced in California this year was also defeated.

Slang terms for DXM include DM, robo, rojo, and velvet. Slang terms for DXM intoxication include robo tripping, skittling, and dexing.

Abuse

Most DXM abusers ingest the drug orally, although some snort the pure powdered form of the drug. Abusers ingest various amounts of DXM depending on their body weight and the effect or plateau that they are attempting to achieve (see text box on page 2). Some abusers ingest 250 to 1,500 milligrams in a single dosage, far more than the recommended therapeutic dose of 10 to 20 milligrams every 4 hours or 30 milligrams every 6 to 8 hours.

Over-the-counter products that contain DXM often contain other ingredients such as acetaminophen, chlorpheniramine, and guaifenesin. Large dosages of acetaminophen can cause liver damage; large dosages of chlorpheniramine can cause increased heart rate, lack of coordination, seizures, and coma; and large dosages of guaifenesin can cause vomiting. Some first-time users may not abuse DXM repeatedly if they experience negative

side effects—such as vomiting—commonly associated with the other ingredients contained in over-the-counter DXM medications. Nonetheless, some DXM abusers "robo shake," a practice whereby they drink a large amount of cough syrup containing DXM and then force themselves to vomit so as to absorb enough DXM through the stomach lining to achieve the desired effect while expelling the other ingredients. Some more experienced abusers use a chemical procedure to extract the DXM from the other ingredients contained in cough syrups to avoid such side effects. (This procedure cannot be used on DXM products sold in nonliquid form.)

NDIC

Figure 1. Cough medications with DXM may contain other active ingredients.

Recommended dosages of DXM generally are safe but can cause nausea, gastrointestinal disturbances, slight drowsiness, and dizziness. Acute dosages (between 250 and 1,500 milligrams) can cause blurred vision, body itching, rash, sweating, fever, hypertension, shallow respiration, diarrhea, toxic psychosis, coma, and an increase in heart rate, blood pressure, and body temperature. Some abusers become violent after ingesting the drug. Little is known about the long-term effects of DXM abuse; however, anecdotal reporting and limited clinical research suggest that extensive and prolonged abuse may cause learning and memory impairment. While studies indicate that DXM is not addictive, some former DXM abusers report experiencing cravings for the drug.

DXM Plateaus

Abusers describe the DXM experience as occurring on four different plateaus. Abusers ingest increasing amounts of DXM (based on their weight) to reach each succeeding plateau. Abusers report the following effects occurring in each plateau:

First Plateau: Mild inebriation.

Second Plateau: An effect similar to alcohol intoxication and, occasionally, mild hallucinations. The abuser's speech can become slurred, and short-term memory may be temporarily impaired.

Third Plateau: An altered state of consciousness. The abuser's senses, particularly vision, can become impaired.

Fourth Plateau: Mind and body dissociation or an "out-of-body" experience. The abuser can lose some or all contact with his or her senses. The effects at this plateau are comparable to the effects caused by ketamine or PCP (phencyclidine).

Deaths caused by DXM overdoses are rare as most abusers ingest DXM products that contain other ingredients that cause vomiting, which expels the DXM from their bodies. Most DXM-related deaths are caused by ingesting the drug in combination with other drugs. DXM-related deaths also occur from impairment of the senses, which can lead to accidents. In 2003, a 14-year-old boy in Colorado who abused DXM died when he was hit by two cars as he attempted to cross a highway. State law enforcement investigators suspect that the drug affected the boy's depth perception and caused him to misjudge the distance and speed of the oncoming vehicles.

DXM abuse levels are difficult to determine. Commonly used drug toxicology screens and field

tests do not accurately detect the presence of DXM. Therefore, more thorough laboratory testing must be performed. DEA recommends the gas chromatography/mass spectrometer (GC/MS) test, as other laboratory tests may produce false positives. National surveys conducted to estimate rates of drug abuse do not include questions regarding DXM. However, the American Association of Poison Control Centers reports that the total number of calls to centers nationwide involving DXM abuse or misuse have increased since 2000 (see Table 1). Calls involving abuse or misuse of DXM by teenagers increased approximately 100 percent from 2000 (1,623) through 2003 (3,271). Calls involving abuse by other age groups increased 21 percent from 2000 through 2002, before decreasing slightly in 2003.

Table 1. Calls Involving Abuse or Misuse of DXM to Poison Control Centers

Year	Teenagers	All Other Age Groups
2000	1,623	900
2001	2,276	1,107
2002	2,881	1,139
2003	3,271	1,111

Source: American Association of Poison Control Centers.

Availability

DXM abusers can obtain the drug at almost any pharmacy or supermarket. Most seek out products that have a high concentration of the drug. One of the most frequently abused products containing DXM is Coricidin® HBP Cough & Cold, which contains 30 milligrams of DXM per tablet. Abusers often refer to Coricidin® HBP Cough & Cold as triple C because of the three Cs imprinted on the red tablets. Other slang terms include skittles, dex, candy, and red devils. Another frequently abused product containing DXM is Robitussin® DM, a syrup that contains 2 milligrams of DXM per milliliter.

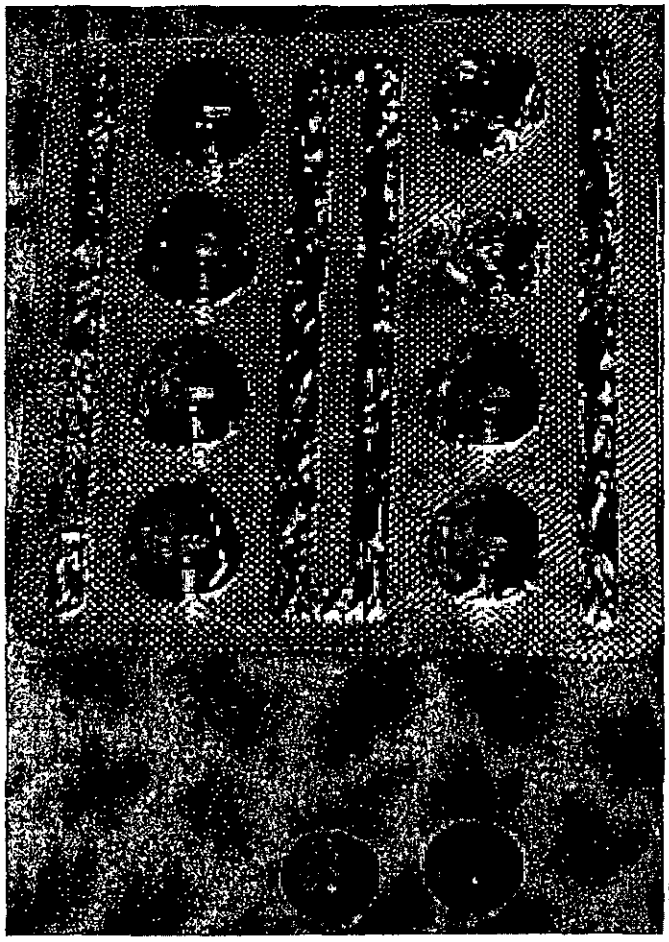

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Figure 2. Coricidin® HBP Cough & Cold tablets.

Concerns about shoplifting and abuse of products containing DXM have resulted in some stores instituting new policies and procedures regarding access and sales of such products. Specifically, some stores place such products where consumers must ask for them, and some have limited the number of packages that can be sold to each customer.

DXM frequently is available at raves and other venues where youths congregate. At such events, DXM occasionally is sold as another drug or in combination with other drugs. For example, DXM sometimes is sold in tablet form by drug dealers who claim that the tablet contains MDMA (3,4-methylenedioxymethamphetamine, also known as ecstasy). When DXM is used in combination with MDMA, the combination can increase the risk of life-threatening hyperthermia. Drug dealers also have distributed DXM to abusers who thought they were purchasing heroin or ketamine.

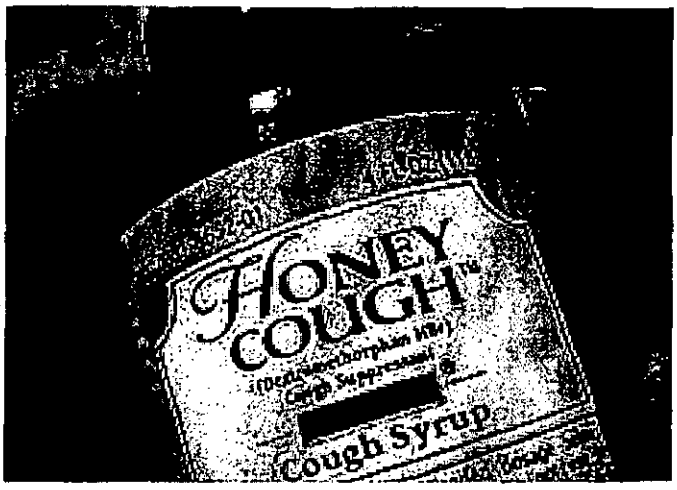

Figure 3. Cough syrup with DXM.

Pure powdered DXM—typically intended for sale to laboratories conducting research on the drug—is available from some Internet web sites. DXM purchased from such sites contains no other ingredients, which substantially increases the risk of overdose. Two powdered DXM-related deaths occurred in Illinois—one in September 2003 and the other in February 2004. One incident was ruled a suicide; the other was an accidental overdose.

Outlook

DXM abuse among adolescents most likely will increase as the drug is relatively easy to obtain and inexpensive. Moreover, adolescents perceive the risk in abusing the drug as low. Stemming DXM abuse will require increased public awareness of the drug's potential for abuse, increased awareness of the inherent risks associated with abusing DXM, and increased diligence of parents, educators, health care providers, law enforcement personnel, and retailers who market products containing DXM.

Sources

American Association of Poison Control Centers

American Journal of Health-System Pharmacy

Associated Press

Columbia University

DrugAbuse.com

Drug Enforcement Administration

Maryland Poison Control Center

Office of National Drug Control Policy

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021706

Gov. Doyle signs bill outlawing hallucinogenic drug salvia divinorum

By Ashley Davis

Published: Friday, March 5, 2010
Updated: Friday, March 5, 2010

Gov. Jim Doyle signed a bill Thursday outlawing salvia divinorum, a hallucinogenic herb.
The bill was originally authored by former state Rep. Sheldon Wasserman in 2007 when he learned of salvia's potential to induce intense hallucinations when used recreationally.

"You can find out quickly, this has the potential for danger," Wasserman said.

The legislation regulating salvia has since been re-introduced and passed in the Senate last month. Wasserman worked with Rep. David Cullen, D-Milwaukee, who was previously co-author of the bill and is now the primary author, to see the bill become a law.

"We worked together on this thing to really make this happen," Wasserman said.

Danny Marchewka / The Daily Cardinal

Local shops like Amsterdam on Gilman St. will no longer be able to sell salvia divinorum after the recent legislation outlawed the substance.

The legislation prohibits manufacturing, distributing or delivering the active chemical ingredient and instates a maximum fine of $10,000 for violators. Wasserman said the legislation is directed more toward the distributor and less toward the user.

Business owners currently selling salvia maintain a different belief about the drug. The owner of Amsterdam, the store located at 447 W. Gilman Street, says the shop has not had any problems in the ten years it has been selling salvia.

She said salvia is marketed as incense and works to facilitate a deep state of meditation. It was meant to be burned like regular incense and she said she has no knowledge of its misusage.

"If people are smoking it, we don't know about it because we are not selling it as that," she said.

She also said her most loyal customers are age 40 and above and kids are not as interested in it.

Wasserman disagreed.

"[Salvia's] main use was to get high," he said. "There was never any thought that it was anything but a recreational drug."

Drug Enforcement Administration
Office of Diversion Control
Drug & Chemical Evaluation Section
Washington, D.C. 20537

SALVIA DIVINORUM AND SALVINORIN A

(Street Names: Maria Pastora, Sage of the Seers, Diviner's Sage, Salvia, Sally-D, Magic Mint)

November 2008
DEA/OD/ODE

Introduction:

Salvia divinorum is a perennial herb in the mint family native to certain areas of the Sierra Mazateca region of Oaxaca, Mexico. The plant, which can grow to over three feet in height, has large green leaves, hollow square stems and white flowers with purple calyces, can also be grown successfully outside of this region. *Salvia divinorum* has been used by the Mazatec Indians for its ritual divination and healing. The active constituent of *Salvia divinorum* has been identified as salvinorin A. Currently, neither *Salvia divinorum* nor any of its constituents, including salvinorin A, are controlled under the federal Controlled Substances Act (CSA).

Licit Uses:

Neither *Salvia divinorum* nor its active constituent salvinorin A has an approved medical use in the U.S.

Chemistry and Pharmacology:

Salvinorin A, also called Divinorin A, is believed to be the ingredient responsible for the hallucinogenic effects of *Salvia divinorum*. Chemically, it is a neoclerodane diterpene found primarily in the leaves, and to a lesser extent in the stems. Although several other substances have been isolated from the plant, none have been shown to be psychoactive.

In the U.S., plant material is typically either chewed or smoked. When chewed, the leaf mass and juice are maintained within the cheek area with absorption occurring across the lining of the oral mucosa (buccal). Effects first appear within 5 to 10 minutes. Dried leaves, as well as extract-enhanced leaves purported to be enriched with salvinorin A, are also smoked. Smoking pure salvinorin A, at a dose of 200-500 micrograms, results in effects within 30 seconds and lasts about 30 minutes.

A limited number of studies have reported the effects of using either plant material or salvinorin A. Psychic effects include perceptions of bright lights, vivid colors and shapes, as well as body movements and body or object distortions. Other effects include dysphoria, uncontrolled laughter, a sense of loss of body, overlapping realities, and hallucinations (seeing objects that are not present). Adverse physical effects may include incoordination, dizziness, and slurred speech.

Scientific studies show that salvinorin A is a potent and selective kappa opioid receptor agonist. Other drugs that act at the kappa opioid receptor also produce hallucinogenic effects and dysphoria similar to that produced by salvinorin A. Salvinorin A does not activate the serotonin 2A receptor, which mediates the effects of other schedule I hallucinogens.

Illicit Uses:

Salvinorin A and *Salvia divinorum* products are abused for their ability to evoke hallucinogenic effects, which, in general, are similar to those of other scheduled hallucinogenic substances.

User Population:

According to a National Survey on Drug Use and Health Report published by SAMHSA in February 2008, it is estimated that 1.8 million persons aged 12 or older used Salvia divinorum in their lifetime, a approximately 750,000 did so in the past year. Use was more common among young adults (18 to 25 years old) as opposed to older adults (>26 years of age). Young adults were 3 times more likely than youths aged 12 to 17 to have used *Salvia divinorum* in the past year. Use is more common in males than females.

Illicit Distribution:

Salvia divinorum is grown domestically and imported from Mexico and Central and South America. The Internet is used for the promotion and distribution of *Salvia divinorum*. It is sold as seeds, plant cuttings, whole plants, fresh and dried leaves, extract-enhanced leaves of various strengths (e.g., 5x, 10x, 20x, 30x), and liquid extracts purported to contain salvinorin A. These products are also sold at local shops (e.g., head shops and tobacco shops).

Control Status:

Salvia divinorum and salvinorin A are not currently controlled under the CSA. However, a number of states have placed controls on *Salvia divinorum* and/or salvinorin A. As of November 2008, thirteen states have enacted legislation placing regulatory controls on *Salvia divinorum* and/or salvinorin A. Delaware, Florida, Illinois, Kansas, Mississippi, Missouri, North Dakota, Oklahoma, and Virginia have placed *Salvia divinorum* and/or salvinorin A into schedule I of state law. California, Louisiana, Maine and Tennessee enacted other forms of legislation restricting the distribution of the plant. States in which legislative bills proposing regulatory controls died are Alabama, Alaska, Hawaii, Indiana, Iowa, Minnesota, Nebraska, Oregon, South Carolina, and Utah. Legislative bills proposing regulatory controls are pending in Michigan, New Jersey, New York, Ohio, Pennsylvania, Texas and Wisconsin.

Salvinorin A and/or *Salvia divinorum* have been placed under regulatory controls in Australia, Belgium, Denmark, Estonia, Finland, Italy, Japan, Spain, and Sweden.

Comments and additional information are welcomed by the Drug and Chemical Evaluation Section, FAX 202-353-1263 or telephone 202-307-7183.

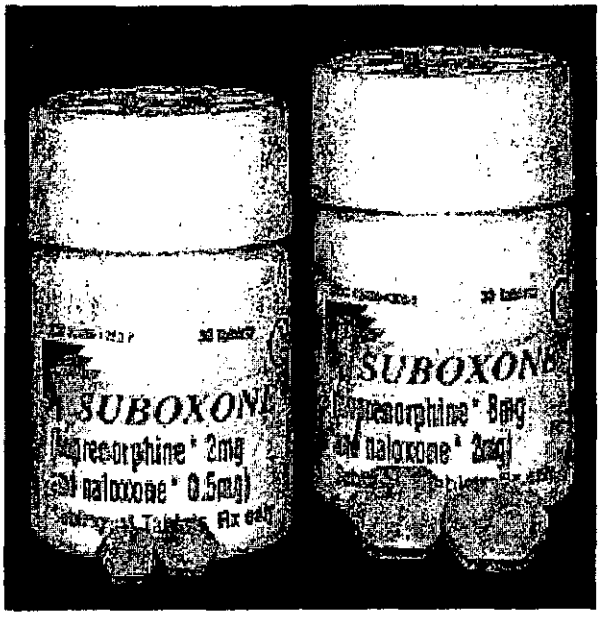
NATIONAL DRUG INTELLIGENCE CENTER

INTELLIGENCE BULLETIN

Buprenorphine: Potential for Abuse

Product No. 2004-L0424-013 SEPTEMBER 2004

U.S. DEPARTMENT OF JUSTICE



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Within the past 2 years buprenorphine—a Schedule III drug—has been made available for use in opiate addiction therapy. Two formulations of the drug are used in such therapy. Subutex, which is pure buprenorphine, is designed to be used in the initial stages of addiction treatment. Suboxone, which contains an antiabuse component, is designed to be used in the maintenance stage of treatment. Both block the effects of opiates while reducing opiate cravings and easing withdrawal symptoms. Buprenorphine is the only opiate addiction therapy drug that can be prescribed in a physician's office; others must be dispensed in a clinic. This method of distribution is advantageous to many opiate addiction therapy patients because it is more convenient and less stigmatizing than clinic-based therapy, which typically involves methadone. Like methadone, however, buprenorphine is susceptible to abuse. Despite safety measures in place to guard against diversion of the drug, illegal distribution and abuse of buprenorphine have been reported in the United States, primarily in the Northeast region.

Background

Currently, the drug most commonly used in opiate addiction therapy in the United States is methadone, a Schedule II synthetic opiate. Methadone helps addicted individuals to stop abusing opiates by reducing opiate cravings and symptoms of withdrawal; however, there are several disadvantages to methadone-based opiate addiction therapy. Methadone can be prescribed only in licensed methadone treatment clinics, and patients must deal with the stigma attached to making daily trips to a methadone clinic. Also, these clinics commonly are located in or near urban centers, so patients in rural areas must drive long distances each day to obtain methadone. Finally, methadone abuse is increasing throughout the Northeast region, where abuse of heroin and other opiates is common, and increasingly is a factor in overdose deaths.

In a move away from clinic-based therapy, the Drug Addiction Treatment Act of 2000 (DATA) passed by Congress in 2000 allows physicians who receive specialized training to treat opiate addiction in their offices with Schedule III, IV, and V medications approved by the Food and Drug Administration (FDA) specifically to treat opiate addiction. However, at the time DATA 2000 was passed, no medications had yet been approved by FDA for that purpose.

On October 8, 2002, FDA approved buprenorphine in two formulations, Subutex and Suboxone, for use in opiate addiction therapy. Subutex (buprenorphine hydrochloride) is used in the initial stages of therapy while Suboxone (buprenorphine hydrochloride and naloxone hydrochloride) is used in the maintenance stage. Today, only these two formulations of buprenorphine meet DATA 2000 specifications; therefore, buprenorphine is the only drug that can be prescribed in a physician's office to treat opiate addiction. (A third, Buprenex, is marketed as a pain relief medication that cannot be used to treat opiate addiction.) While most commonly used to treat addiction to heroin, buprenorphine can be used to treat addiction to any type of opiate, including oxycodones such as OxyContin and Percocet.

Safeguards were put in place before buprenorphine was made available to the public because of widespread pharmaceutical diversion and increased prescription drug abuse in the nation. In fact, Suboxone was designed specifically to meet FDA requirements for a more diversion-proof drug for use in opiate addiction therapy and is available only in the United States. The naloxone contained in Suboxone guards against abuse—if an abuser crushes and injects or snorts the Suboxone tablet, the naloxone in it precipitates withdrawal symptoms. Naloxone (Narcan) reverses the effects of opiates. Further, in 2002 the Drug Enforcement Administration (DEA) reassessed the potential for abuse of, diversion of, and addiction to buprenorphine and rescheduled it from a Schedule V drug to a Schedule III drug, thus increasing the penalties for illegally obtaining, possessing, or abusing buprenorphine.

To further safeguard buprenorphine from diversion, physicians prescribing the drug in either of the formulations approved for treating opiate addiction must become certified by attending a special training course and submitting their qualifications to the Substance Abuse and Mental Health Services Administration (SAMHSA). Physicians also must agree to refer patients for drug addiction counseling. After registering with SAMHSA, physicians receive a special identification number from DEA that appears on all buprenorphine prescriptions they administer. The DEA-issued identification number assigned to each certified physician aids law enforcement and antidiversion officials in tracking any diversion of the drugs.

Physicians prescribing buprenorphine therapy must maintain a log of all patients using Subutex and Suboxone and record the medication that has been prescribed to them. The medical records of these patients are subject to periodic DEA and FDA review. FDA also has stipulated that the manufacturer of Subutex and Suboxone, Reckitt Benckiser Pharmaceuticals, must investigate any reports of diversion.

More than 1,700 physicians or group practices in the United States—over 700 located in the Northeast—are certified to prescribe buprenorphine. Physicians currently are prohibited from prescribing Subutex and Suboxone to more than 30 patients at any given time. The 30-patient limit also applies to group practices. For example, a group practice of three certified physicians may prescribe Subutex and Suboxone to only 30 patients, not 90. However, Congress is considering the Drug Addiction Treatment Expansion Act of 2003. This legislation, if passed, will amend DATA 2000 by lifting the 30-patient limit imposed on group practices and allowing each physician in a group practice to prescribe buprenorphine to 30 patients.

Effects

Buprenorphine is a derivative of thebaine, an extract of opium. The drug is an opioid (synthetic opiate) partial agonist and thus can produce the euphoria, analgesia, and sedation associated with opiates; however, while it stimulates the same brain receptors as full opiate agonists such as heroin and morphine, buprenorphine produces a lesser degree of sedation and respiratory depression than those drugs and causes no significant impairment of cognitive or motor skills. Like methadone, buprenorphine reduces cravings for heroin and other opiates and reduces withdrawal symptoms, thus helping

addicted individuals to stop abusing opiates. Also like methadone, buprenorphine blocks the effects of heroin by binding to the same opiate receptors as heroin; consequently, opiate addicts who use buprenorphine are not able to get a high from heroin.

Buprenorphine also has a "ceiling effect" whereby increased doses of the drug do not produce increased effects after a certain point, or ceiling. In fact, high doses of the drug can actually precipitate withdrawal symptoms in opiate addicted individuals. Because of this ceiling effect, buprenorphine is less susceptible to abuse than other opiates; however, because high doses of the drug can cause withdrawal symptoms, buprenorphine is not as effective as methadone in treating severely opiate-addicted individuals who require larger doses of opiates in order to maintain treatment therapy. SAMHSA advises that the best candidates for buprenorphine therapy are those patients receiving 30 milligrams or less of methadone. Buprenorphine is estimated to be effective for approximately one-half to two-thirds of the opiate abuser population.

A New Form of Buprenorphine Administration

A new, extended-release formulation of buprenorphine, called a depot formulation, currently is being developed. This depot formulation is an injectable solution that contains tiny biodegradable capsules of buprenorphine. As the capsules disintegrate, they slowly release the drug over several weeks. This new formulation of buprenorphine is designed for administration in a physician's office once every 4 to 6 weeks and could further safeguard against diversion by eliminating the need for patients to possess buprenorphine in tablet form.

Advantages

The use of Subutex and Suboxone in opiate addiction therapy is likely to become more common because of several advantages. Buprenorphine can be prescribed by a local doctor and obtained from a local pharmacy, providing patients with convenient access to treatment. Further, if DATA 2003 is passed, the number of patients that can be treated by group practices will increase. Because patients can visit their local doctors, buprenorphine therapy is far more discreet, making it preferable for many patients who must deal with the stigma attached to making daily trips to a methadone clinic. This treatment option also is more convenient than methadone therapy for many abusers who would otherwise have to drive long distances each day to obtain methadone. Further, buprenorphine therapy can provide treatment in rural areas with inadequate access to treatment and in areas where methadone clinics have reached full capacity.

While it is possible to overdose on buprenorphine, it is safer than methadone because of its ceiling effect and decreased degree of respiratory depression. Also, because of the various safeguards in place, buprenorphine is more difficult to divert than methadone. The abuse of methadone poses a growing threat as evidenced by increasing mortality rates associated with it, whether diverted or legally prescribed. (See text box.)

Methadone Overdose Deaths

The abuse of methadone has contributed to an increase in overdose deaths, particularly in the Northeast region. For example, medical examiner data indicate that methadone is increasingly involved in overdose deaths in Maine. The number of overdose deaths in Maine where methadone was listed as the cause of death fluctuated, but increased overall from 4 in 1997 to 14 in 2001. In the first 6 months of 2002, methadone was listed as the cause of death in 18 deaths. Furthermore, methadone appeared as a factor in 33 percent of all accidental overdose deaths in Maine from 1997 through 2003, one of the two highest percentages of all drugs during that period.

Diversion

Buprenorphine is a synthetic opiate and produces the euphoric effects sought by opiate abusers; therefore, it is susceptible to abuse in both of the forms approved for treating opiate addiction. Subutex, the form that does not contain naloxone, is more vulnerable to abuse because it can be crushed and injected or snorted without causing withdrawal symptoms in the abuser. The FDA recommends that physicians limit the use of Subutex to supervised administration sessions; however, physicians are not required to do so, creating opportunities for Subutex diversion. Subutex has been prescribed legally for years in some foreign countries, where its diversion for illicit use is common. There are lucrative black markets for diverted Subutex in Germany, New Zealand, and the United Kingdom. In France, India, and Scotland, where buprenorphine is far more common in opiate addiction therapy than methadone, many individuals are addicted to Subutex. Suboxone is not available in these countries.

Suboxone also can be diverted and abused; however, it is more likely to be abused by individuals who are addicted to low doses of opiates since it can precipitate withdrawal symptoms in high doses. The naloxone in Suboxone guards against abuse by causing withdrawal symptoms in abusers who crush and either inject or snort the drug; however, law enforcement and pharmacist reporting indicates that Suboxone is being abused successfully when snorted.

Using buprenorphine and heroin in combination does not produce increased effects, but if buprenorphine and methadone are abused together, the effects of both drugs are enhanced. Consequently, diverted buprenorphine may be attractive to patients currently using methadone for opiate addiction therapy.

Despite controls designed to make buprenorphine diversion-proof, there have been reports of buprenorphine diversion throughout the United States, primarily in the Northeast region.

- **Chittenden County, Vermont.** A pharmacist in this area reports that Suboxone is being diverted and sold for $25 per 8-milligram tablet. Abusers are grinding the tablets and snorting them.
- **Washington County, Maine.** The Washington County Sheriff's Office reports that buprenorphine is being diverted in that area and sold for $50 per tablet. The size of the tablet is unknown, and it is unclear whether Subutex or Suboxone tablets are being diverted in this case.
- **Pennsylvania.** The Pennsylvania Department of Health reports that diverted Subutex and Suboxone are being illegally distributed on the street. Specific locations have not been identified.

Outlook

It is unlikely that buprenorphine will render methadone therapy obsolete because it is not as effective in patients who require large doses of opiates in maintenance therapy. However, buprenorphine can provide opiate addiction therapy to individuals addicted to lower doses of opiates, to those in rural areas with inadequate access to treatment, and to those in areas where methadone clinics have reached full capacity. With more physicians obtaining certification to prescribe buprenorphine every day, this form of therapy has the potential to become as common as methadone therapy.

Because of its ceiling effect and ability to precipitate withdrawal symptoms if taken in high doses, buprenorphine is more susceptible to abuse by individuals who are addicted to low doses of opiates or individuals in the early stages of opiate addiction. The drug also can be abused in combination with methadone, making buprenorphine diversion more problematic in areas where heroin abuse and methadone therapy are common, such as the Northeast region. As buprenorphine therapy becomes more widespread, the potential for increased diversion of Subutex and Suboxone should be closely monitored.

Sources

State

Maine

Washington County Sheriff's Office

Pennsylvania

Department of Health

Federal

U.S. Department of Health and Human Services

Food and Drug Administration

National Institutes of Health

National Institute on Drug Abuse

Substance Abuse and Mental Health Services Administration

Air Force
Print News Today
Air Force news from around the world

General Order No. 1 bans intoxicating substances

by Airman 1st Class Christopher Gross
3rd Wing Public Affairs

3/5/2010 - **ELMENDORF AIR FORCE BASE, Alaska** -- The use of any intoxicating substances other than alcohol, caffeine, tobacco or lawfully-used prescription medications has been banned here and throughout bases in the Pacific.

This ban is the result of reports of PACAF Airmen being involved with the use of Salvia and the intoxicant "spice," there have also been reports of inhaling household chemicals and other chemical inhalants along with abusing over-the-counter medications.

"The abuse of these products by military members contradicts the nature of our profession of arms, threatens our military readiness and diminishes our ability to conduct the mission entrusted to us," said Gen. Gary North, PACAF commander.

The General Order No. 1 prohibits the following actions:

· Possessing, distributing, inhaling, smoking, chewing, consuming or introducing into the body in any manner Salvia Divinorum, Salvinorin A or the intoxicant "spice" in any form.

· Inhaling household chemicals and other chemical inhalants for the purpose of becoming intoxicated, high, altering mood or function, or achieving a psychoactive effect.

· Abusing over-the-counter non-prescription medications for the purpose of becoming intoxicated, high, altering mood or function, or achieving a psychoactive effect.
This order applies to all members either assigned or attached to PACAF and also includes tenant units located on PACAF bases.

"Our Wing's four priorities are to generate, deploy and employ combat mission ready air power; maintain Elmendorf as a combat ready warfighting platform, provide world-class support to our fellow Arctic Warriors and their families; and develop professional Airmen," said Col. Thomas Bergeson, 3rd Wing commander. "Not only is it illegal to get "high" on drugs, chemicals or inhalants, that kind of behavior threatens all four of these vital missions and is incompatible with our ability to Fly, Fight and Win!"

Failure to obey these orders is a violation of Article 92 under the Uniform Code of Military Justice, and may result in criminal, administrative or other disciplinary action.

CHPA

founded 1881

March 10, 2010

CHPA Comments on House Bill 327

Members of the Alaska House Judiciary Committee:

Thank you for the opportunity to comment on House Bill 327 on behalf of the Consumer Healthcare Products Association (CHPA). CHPA is the 129 year-old trade association representing the nation's leading over-the-counter medicine (OTC) and nutritional supplement manufacturers. H.B. 327 prohibits the sale of a product containing dextromethorphan to an individual younger than 18, unless the individual has a prescription. It also requires the seller to either clearly mark the products as for sale only to persons 18 years of age or older or by prescription, or place the products behind the counter. While CHPA applauds the purpose of this legislation and supports the age-18 sales restrictions, CHPA strongly opposes language that limits consumer access to dextromethorphan products or requires special labeling.

Dextromethorphan (DXM) is a safe and effective ingredient found in over 100 OTC cough and cold products. First approved by the U.S. Food and Drug Administration in the 1950's, it is a highly effective, non-narcotic cough suppressant that works by raising the coughing threshold in the brain; it has no pain relieving properties and is not addictive. While dextromethorphan is used safely by millions of Americans each year to relieve coughs due to the common cold or flu, we know that some young people are intentionally abusing products containing dextromethorphan in an effort to get high.

The nonprescription medicine industry takes very seriously the intentional abuse of cough medicine and has been engaged in educational efforts to curb abuse for a number of years. CHPA has teamed with the Community Anti-Drug Coalitions of America (CADCA), the Partnership for a Drug-Free America (PDFA), D.A.R.E. America, and WebMD to raise awareness among parents and in communities about the dangers of OTC cough medicine abuse. In 2009, these efforts were combined into one comprehensive web site: StopMedicineAbuse.org. This web site provides access to all the industry's initiatives and interactive programs to engage parents and community leaders in the fight against teen cough medicine abuse. Highlights of our campaign including the following:

Consumer Healthcare Products Association
900 19th Street, NW, Suite 700
Washington, DC 20006
T 202.429.9260 F 202.223.6835
www.chpa-info.org

- CHPA, in conjunction with PDFA, launched the Rx and OTC Medicine Abuse Education Campaign in May 2006. This multi-year communications campaign helps parents and families understand and prevent cough medicine abuse among teenagers and young adults.
- Since 2005, CHPA and CADCA have conducted nearly 20 town hall meetings nationwide to help alert communities to the issue of teen medicine abuse.
- In 2009, CHPA launched a collaborative destination on cough medicine abuse with WebMD. The site provides parents with information about abuse and its risks, and also gives parents practical tips to recognize the signs of abuse and methods to keep teens drug-free.
- CHPA has partnered with D.A.R.E., Abbott Labs, and PhRMA to produce lessons for 5th, 7th, and 9th graders, as well as a community program.
- In May 2007, CHPA launched "Five Moms: Stopping Cough Medicine Abuse," an online grassroots campaign to help parents fight teen medicine abuse. The Five Moms' goal is to get the word out to as many parents as possible that cough medicine abuse is happening in their homes, and that the Internet is a driving force. In 2009, the Five Moms Campaign became part of CHPA's overall Stop Medicine Abuse initiatives. Through the web site, parents can sign up for the electronic newsletter, view the "viral video," or use the "tell-a-friend" tool to spread the word about this teen substance abuse behavior.

Our campaign's reach extends to communities in Alaska. CADCA has coalitions in Anchorage, Kenai, Juneau, Yakutat, and Valdez, and D.A.R.E. has trained officers in our joint Rx/OTC abuse lessons in Fort Richardson, Cordova, Kodiak, Barrow, Soldotna, Fort Greely, Kenai, Nenana, Pilot Station, North Pole, and Anchorage. With CADCA, CHPA has produced a comprehensive, informational online video that allows interested community members to host their own town halls or hold multiple town halls. CHPA and its partners will continue these efforts to raise awareness and are interested in expanding programming into additional regions of the state.

CHPA also supports an age-18 restriction on sales of dextromethorphan-containing medicines. We believe this approach supplants the need to place these products behind the counter. Moving these products behind the counter would greatly reduce the consumer's ability to self select and significantly diminish the value that OTC medicines provide the healthcare system. More importantly, if products are moved behind the counter, consumers will not

have the ability to read labels and compare ingredients when making purchasing decisions. Further restriction could also result in retailers removing these products from their stores entirely and lead to a widespread access problem, which would be of great concern especially in the more remote areas of Alaska.

Finally, adding a labeling requirement for these products could increase the cost to the consumer because manufacturers would need to produce special labels only for those products sold in Alaska. CHPA member companies have voluntarily adopted the StopMedicineAbuse educational icon, which appears on thousands of dextromethorphan-containing medicines, so there would be little added benefit from additional labeling.

As outlined above, the industry has taken an aggressive approach and invested significant resources to combat cough medicine abuse. With so many campaigns and initiatives, we have a number of assets already in place that are useful, cost-effective, and will make a great impact in Alaska, without unnecessary restrictions on consumer access. It is our sincere hope that these issues can be adequately addressed so that CHPA can lend its unequivocal support to this legislation. However, in its current form, CHPA respectfully opposes H.B. 327.

Respectfully submitted by Rend Al-Mondhiry, State Legislative Counsel

To learn more about CHPA's efforts to promote safe medicine use, please visit:

- www.StopMedicineAbuse.org

NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

March 5, 2010

To the Honorable Members of the Alaska State House of Representatives Judiciary Committee
Juneau, Alaska

RE: House Bill 327 – Dextromethorphan (DXM) sales restrictions

Dear Members of the House of Representatives:

On behalf of the members of the National Association of Chain Drug Stores (NACDS) operating in the State of Alaska, I am offering this letter of opposition to House Bill 327 – sales restrictions on common cold products containing Dextromethorphan. Members of NACDS operating in Alaska include: Costco, Walgreens and Wal-Mart. These three companies operate 14 of the 45 chain pharmacies operating in Alaska. Collectively community pharmacy (chain and independents) employ over 8,300 full and part-time employees and pay in excess of $8 million in state and local taxes.

Dextromethorphan is a safe and effective ingredient found in over 100 over-the-counter cough and cold products. First approved by the U.S. Food and Drug Administration in the 1950's, it is an effective, **non-narcotic** cough suppressant that works by raising the coughing threshold in the brain. It has no pain relieving properties and is **not addictive.**

With this in mind, the members of NACDS respectfully oppose the passage of House Bill 327 for the following reasons:

- **DXM is vastly different from pseudoephedrine (PSE).**
  - DXM is not addictive, and cannot be converted into an addictive substance.
  - DXM abusers usually do not commit crimes related to DXM abuse.
  - DXM is abused for a quick high that is not physically addictive.

- **Unlike PSE, there is no practical alternative to DXM available.**
  - There are no other FDA-approved over-the-counter cough suppressants available in the United States.

- **The issue of teen substance abuse must be the focus of legislators, as DXM is not unsafe.**
  - Parents must be involved in the actions of their children.
  - Legislators should focus on educating parents, teachers, coaches, and teens about the dangers of drug abuse, including DXM.
  - Teens are also known to abuse household aerosols, cleaning fluids, glue, gasoline and other products that produce a "high." Teen abuse is not limited to DXM only. The bigger picture of product abuse should be addressed.

- According to the Partnership for a Drug-Free America, children who "learn a lot about the risks of drugs" from their parents are up to half as likely to use them. Only 32% of teens "learn a lot about the risks of drugs" from their parents.
- According to the Partnership for a Drug-Free America, teens reasons for using DXM are "to get high" and "to deal with stress and depression."

❖ **DXM is an inherently safe product. To experience a hallucinogenic effect, one must take a dose *approximately 25 times* the recommended adult dose.**
- DXM has few side effects when taken in therapeutic doses.
- DXM is not addictive, even when taken in massive doses.
- DXM is used to suppress coughing in people of all ages, from infants to the elderly.
- DXM has very few contraindications. It can be taken by almost any patient suffering from almost any disease state.
- DXM interacts with very few medications; it can be taken safely by almost anyone taking almost any medication.
- Because it is non-addictive, DXM must be readily available for anyone with a cough or cold that has a problem with addiction to drugs or alcohol.

NACDS along with the Partnership for a Drug-Free America continues to work to educate parents and families as to the potential abuse of medicines containing DXM.

Please set this bill aside and assist us in promoting an educational component instead of taking away the ability to procure legitimate cold products in a timely fashion.

Sincerely,

Lis Houchen
NW Regional Director
National Association of Chain Drug Stores
130-18th Avenue SE
Olympia, WA 98501
(360) 480-6990
lhouchen@nacds.org

SALVIA DIVINORUM IS CURRENTLY NOT A CONTROLLED SUBSTANCE.

HB 327 WOULD SCHEDULE SALVIA DIVINORUM A SCHEDULE IIA CONTROLLED SUBSTANCE.

4TH DEGREE MISCONDUCT INVOLVING A CONTROLLED SUBSTANCE

- CLASS C FELONY ($50,000 & 5 YEARS)
- POSSESSION

3rd DEGREE MISCONDUCT INVOLVING A CONTROLLED SUBSTANCE

- CLASS B FELONY ($100,000 & 10 YEARS)
- POSSESSION WITH INTENT TO DISTRIBUTE
- POSSESSION WITH 500 FEET OF SCHOOL RECREATION OR YOUTH CENTER, OR ON A SCHOOL BUS

1ST DEGREE MISCONDUCT INVOLVING A CONTROLLED SUBSTANCE

- UNCLASSIFIED FELONY ($500,000 & 99 YEARS)
- DELIVERS ANY AMOUNT OF SCHEDULE IIA TO PERSON UNDER 19 YEARS OF AGE

BUPRENORPHINE IS CURRENTLY A SCHEDULE VA CONTROLLED SUBSTANCE

HB 327 WOULD RESCHEDULE BUPRENORPHINE TO IIIA.

SCHEDULE VA

5TH DEGREE MISCONDUCT INVOLVING A CONTROLLED SUBSTANCE

- CLASS A MISDEMEANOR ($10,000 & 365 DAYS)
- POSSESSION OF LESS THAN 50 TABLETS

4TH DEGREE MISCONDUCT INVOLVING A CONTROLLED SUBSTANCE

- CLASS C FELONY ($50,000 & 5 YEARS)
- POSSESSION WITH INTENT TO DELIVER
- POSSESSION WITHIN 500 FEET OF SCHOOL YOUTH RECREATION AREA

3rd DEGREE MISCONDUCT INVOLVING A CONTROLLED SUBSTANCE

- CLASS B FELONY ($100,000 & 10 YEARS)
- DELIVERS ANY AMOUNT OF SCHEDULE VA TO PERSON UNDER 19 YEARS OF AGE

SCHEDULE IIIA

5TH DEGREE MISCONDUCT INVOLVING A CONTROLLED SUBSTANCE

- CLASS A MISDEMEANOR ($10,000 & 365 DAYS)
- LESS THAN 3 GRAMS OF PREPERATIONS, COMPOUNDS, OR MIXTURES

4TH DEGREE MISCONDUCT INVOLVING A CONTROLLED SUBSTANCE

- CLASS C FELONY ($50,000 & 5 YEARS)
- POSSESS 25 OR MORE TABLETS
- POSSESSION WITHIN 500 FEET OF SCHOOL OR YOUTH RECREATION CENTER

3rd DEGREE MISCONDUCT INVOLVING A CONTROLLED SUBSTANCE

- CLASS B FELONY ($100,000 & 10 YEARS)
- POSSESS WITH INTENT TO DELIVER

1ST DEGREE MISCONDUCT INVOLVING A CONTROLLED SUBSTANCE

- UNCLASSIFIED FELONY ($500,000 & 99 YEARS)
- DELIVERS ANY AMOUNT OF SCHEDULE VA TO PERSON UNDER 19 YEARS OF AGE

STATE OFFICE
ALASKA PEACE OFFICERS ASSOCIATION

P.O. Box 240106 Anchorage, Alaska 99524-0106 Phone (907) 277-0515 Fax (907) 272-5355

March 9, 2010

Representative Kyle Johansen
House of Representatives
State Capitol
Juneau AK 99801-1182

Dear Representative Johansen:

On behalf of the Alaska Peace Officers Association (APOA), I would like to thank you for introducing HB 327, an act relating to the scheduling and rescheduling of certain substances as controlled substances and to the sale of products containing dextromethorphan.

The APOA Executive Board's Legislative Committee recently reviewed this proposed legislation and decided to unanimously support this bill.

We thank you for addressing this issue. Please contact the APOA office in Anchorage at 277-0515, if there is anything our organization can do to assist in the passage of this bill.

Sincerely,

John Lucking, Jr.
State President

ORIGINAL IN MAIL

LEGISLATIVE RESEARCH SERVICES

Alaska State Legislature
Division of Legal and Research Services
State Capitol, Juneau, AK 99801

(907) 465-3991 phone
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research@legis.state.ak.us

March 9, 2010

Memorandum

TO: Representative Kyle Johansen
FROM: Patricia Young, Manager
RE: State Laws Regulating *Salvia Divinorum*
LRS Report 10.201

You asked for information on state regulation of *salvia divinorum*. According to a recent compilation by the National Conference of State Legislatures (NCSL), at least 17 states criminalize some aspect of the use, possession, or distribution of this substance. We include this document as Attachment A.

Attachment B is a copy of "The Legal Status of *Salvia Divinorum*," by Daniel Siebert, an independent researcher who closely follows this issue. Mr. Siebert's article, last updated on March 4, 2010, identifies 19 states with laws addressing the legality of *salvia divinorum*. This article also provides further discussion of pending bills and passed legislation in states as well as in 20 countries that prohibit some aspect of the possession, sale, or use of the substance. For your convenience, we insert a table from Mr. Siebert's article here:

US States with Laws Prohibiting Salvia	**Other Countries with Laws Prohibiting Salvia**
Illegal (Schedule I)	**Illegal to Possess or Sell**
Delaware	Australia
Florida	Belgium
Hawaii	Croatia
Illinois	Denmark
Kansas	Germany
Mississippi	Italy
Missouri	Japan
Nebraska	Latvia
North Dakota	Lithuania
Ohio	Poland
Oklahoma	Romania
South Dakota	South Korea
Virginia	Sweden
Only Legal When Not Intended for Human Consumption	**Illegal to Sell, but Legal to Possess**
Louisiana	Chile
North Carolina	Spain
Tennessee	**Illegal to Grow or Sell, but Legal to Possess**
Legal for Adults, but Illegal To Sell to Minors	Russia
California	**Treated as a Medicinal Herb that Requires a Doctor's Prescription**
Maine (possession by minors also illegal)	Estonia
Illegal to Manufacture, Deliver, or Sell Salvinorin A, but Legal to Possess	Finland
Wisconsin	Iceland
	Norway
Source: Daniel Siebert, "The Legal Status of Salvia Divinorum," updated, March 4, 2010.	

We hope this information is useful. If you have questions or need additional information, please let us know.

Attachment A

National Conference of State Legislatures, "State Laws on *Salvia Divinorum*," March 2010

State Laws on Salvia Divinorum

In recent years, the drug Salvia Divinorum, or Salvia, has gained the attention of state legislators. Since 2006, at least 17 states have passed laws regulating or controlling the drug.

Salvia is an herb related to mint that is known for its psychoactive effects. The plant is native to parts of Mexico, where historically it has been used as part of indigenous religious rituals. Common methods of ingestion include infusing leaves into a tea; smoking dried herbs; and chewing. In the United States, use of Salvia is most common among 18-25 year olds and to a much lesser extent among adolescents (see chart below).

Percentages and Standard Errors (SE) of Past Year Hallucinogen Use among Persons Aged 12 or Older, by Age Group: 2006

	12 or Older		12 to 17		18 to 25		26 or Older	
Hallucinogen	Percent	SE	Percent	SE	Percent	SE	Percent	SE
LSD	0.3%	0.02	0.4%	0.05	1.2%	0.10	0.1%	0.02
PCP	0.1%	0.02	0.2%	0.04	0.2%	0.04	0.0+%	0.02
Ecstasy	0.9%	0.04	1.2%	0.09	3.8%	0.19	0.3%	0.04
Ketamine	0.1%	0.02	0.1%	0.03	0.2%	0.04	0.1%	0.02
DMT/AMT/Foxy	0.0+%	0.01	0.1%	0.02	0.2%	0.05	0.0+%	0.01
Salvia divinorum	0.3%	0.02	0.6%	0.06	1.7%	0.12	0.0+%	0.01

Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (February 14, 2008). *The NSDUH Report - - Use of Specific Hallucinogens: 2006.* Rockville, MD. http://www.oas.samhsa.gov/2k8/hallucinogens/hallucinogens.htm

Effects of Salvia

Salvia originally became popular as a legal alternative to marijuana. However, the effects are markedly different. The effects of Salvia are hallucinogenic and vary based on method of ingestion. For example, smoking Salvia can lead to strong, instantaneous effects, whereas chewing or drinking tea can lead to longer lasting scenarios, but less intense. Some common effects include uncontrollable laughter, visions, dysphoria, experiencing multiple realities, and loss of physical coordination. So far, there has been limited study into the long-term effects of Salvia or its potential for addiction or abuse or its potential medicinal benefits. Initial studies have found that since Salvia increases dopamine levels in the brain, it contains potential as an addictive substance. Other studies, though, have found that Salvia could have potential as a treatment for gastrointestinal disorders.

Legal Status

No Federal statutes control or regulate distribution of Salvia. So far, at least 17 states have felt the need to act, passing laws ranging from banning possession or sale for minors to outright bans. Some states have classified Salvia as a Schedule 1 substance, modeled after the federal Controlled Substances Act, where Schedule 1 substances are considered to have a high potential for dependency and no accepted

medical use.

State Laws Regulating Salvia Divinorum (Current as of March 2010)	
California Penal Code Section 379	Every person who sells, dispenses, distributes, furnishes, administers, gives, or offers to sell, dispense, distribute, furnish, administer, or give Salvia divinorum or Salvinorin A, or any substance or material containing Salvia divinorum or Salvinorin A, to any person who is less than 18 years of age, is guilty of a misdemeanor punishable by imprisonment in a county jail not exceeding six months, or by a fine not exceeding one thousand dollars ($1,000), or by both that fine and imprisonment.
Delaware 16 Del.C. § 4714	Lists Salvia as a Schedule I controlled substance.
Florida Annotated Title XLVI, Crimes Chapter 893. Drug Abuse Prevention and Control 893.03.	Lists Salvia as a Schedule I controlled substance.
Illinois Illinois Compiled Statutes Annotated, Chapter 720. Criminal Offenses, Act 570. Illinois Controlled Substances Act, Article II. Schedules of Controlled Substances	Lists Salvia as a Schedule I controlled substance.
Kansas Statute 61-4104, Controlled Substances	Lists Salvia as a Schedule I controlled substance.
Louisiana Louisiana Revised Statutes, Title 40—Public Health and Safety. Chapter 4—Food and Drugs. Part X. §989.1	Lists Salvia as a Schedule I controlled substance.
Maine Maine Revised Statute Title 17: CRIMES. Chapter 70: Salvia Divinorum	A person may not transfer Salvia divinorum to a minor. A minor may not Purchase, possess or use Salvia divinorum
Mississippi Miss. Code Ann. § 41-29-113	Lists Salvia as a Schedule I controlled substance.
Missouri Missouri Revised Statutes, Chapter 195, Drug Regulations, Section 195.017	Lists Salvia as a Schedule I controlled substance.
North Dakota CHAPTER 19-03.1, UNIFORM CONTROLLED SUBSTANCES ACT	Lists Salvia as a Schedule I controlled substance.
Nebraska Nebraska Revised Statutes 28-405	Lists Salvia as a Schedule I controlled substance.
North Carolina North Carolina General Statutes Annotated 14-401.23	(a) It shall be unlawful for any person to knowingly or intentionally manufacture, sell or deliver, or possess with intent to manufacture, sell or deliver Salvia divinorum or Salvinorin A. (b) It shall be unlawful for any person to knowingly or intentionally possess Salvia

	divinorum or Salvinorin A.
Ohio Ohio Revised Code Title 37, Chapter 3719.41, Controlled substance schedules.	Lists Salvia as a Schedule I controlled substance.
Oklahoma Oklahoma Statutes Citationized Title 63. Public Health and Safety Chapter 2 - Uniform Controlled Dangerous Substances Act, Article 2 - Standards and Schedules, Section 2-204 - Schedule I	Lists Salvia as a Schedule I controlled substance.
South Dakota South Dakota Codified Laws 22-42-22	Possession of Salvia divinorum or salvinorin A prohibited--Felony or misdemeanor. No person may knowingly possess Salvia divinorum or salvinorin A. It is a Class 1 misdemeanor to possess two ounces or less of Salvia divinorum or salvinorin A. It is a Class 6 felony to possess more than two ounces of Salvia divinorum or salvinorin A.
Tennessee Tennessee Code Annotated 39-17-438	(a) It is an offense to knowingly produce, manufacture, distribute, possess or possess with intent to produce, manufacture, or distribute the active chemical ingredient in the hallucinogenic plant Salvia divinorum A. (b) The provisions of this section shall not apply to the possession, planting, cultivation, growing, or harvesting of the hallucinogenic plant strictly for aesthetic, landscaping, or decorative purposes. (c) The provisions of this section shall not apply to any dosage form that is legally obtainable from a retail establishment without a prescription and is recognized by the Federal Food and Drug Administration as a homeopathic drug. (d) A violation of subsection (a) is a Class A misdemeanor.
Wisconsin Wisconsin Statute 941.318	Except as provided in sub. (3), whoever manufactures, distributes, or delivers salvinorin A with intent that it be consumed by an individual may be fined not more than $10,000. (3) (a) Subsection (2) does not apply to the manufacture of any dosage form of salvinorin A that may be obtained from a retail establishment without a prescription and that is recognized by the U.S. Food and Drug Administration as a homeopathic drug. (b) Subsection (2) does not apply to the distribution or delivery to an individual who is 18 years of age or older of any dosage form of salvinorin A that may be obtained from a retail establishment without a prescription and that is recognized by the U.S. Food and Drug Administration as a homeopathic drug.

For more information, contact

Matthew Gever
Policy Specialist
Forum for State Health Policy Leadership
National Conference of State Legislatures
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Advisory Board on Alcoholism
and Drug Abuse

abada
amhb

Alaska Mental Health Board

ALASKA MENTAL HEALTH BOARD
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
431 NORTH FRANKLIN STREET, SUITE 200
JUNEAU, ALASKA 99801
(907) 465-8920

March 9, 2010

Representative Kyle Johansen
Alaska State Capitol, Room 204
Juneau, Alaska 99801

Re: HB 327 — Controlled Substances

Dear Representative Johansen,

The Advisory Board on Alcohol and Drug Abuse appreciates your recognition of the need to limit the availability of dangerous substances like *salvia divinorum* ("salvia") and dextromethorphan ("DXM"). Both pose a danger to Alaska's young people and should be regulated better.

Salvia is a hallucinogen — a drug that distorts perception of reality. It has been identified by the Substance Abuse and Mental Health Services Administration and the U.S. Department of Justice Drug Enforcement Administration as an emerging chemical or drug "of concern." According to the National Survey on Drug Use and Health (NSDUH), salvia has emerged as an "herbal high" being used by young people. The 2006 NSDUH reflects that adolescents and young adults are using salvia at a rate higher than LSD or PCP, and nearly as high as Ecstasy. More than 750,000 people age 12 years and older reported using salvia in 2005. Some researchers do site that there could be possible medical applications for salvia in the future, and have concern that regulation may slow research. However, the effects of salvia are such that regulation is appropriate.

DXM is the active ingredient in cold medicines, like Tylenol. While it has benefits as an over-the-counter medicine, it can be deadly when misused or abused. The Alaska Injury Prevention Center reports that, of the 1,223 unique cases of hospitalization due to attempted suicide reviewed for 2001-2001, 77% involved an overdose by Tylenol or prescription medication. Of completed suicides, 11% are attributed to poisoning (defined primarily as overdoses).

With this information, we see that limiting access to these substances is in the best interests of our children. Thank you for your work, and please let us know if the Advisory Board on Alcoholism and Drug Abuse can assist in the effort to pass this important legislation.

Sincerely,

James Duncan, Chair
Advisory Board on Alcoholism and Drug Abuse

Representative Jay Ramras
Chair, Judiciary
Chair, Economic Development, Trade & Tourism
Energy
Military & Veteran Affairs
Joint Armed Service
State Capitol, Room 118
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Alaska State Legislature

House of Representatives

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From: Jane W. Pierson

Date: March 10, 2010

Re: CS for HB327

Jerry,

Today HJUD passed out HB327, please draft a CS to include the following amendments:

Amendment 26-LS1261\R.1

Conceptual amendment at P.3,Ll.12, after "18 years of age" insert exemption for emancipated minors, married folks, and parents of minor children.

Thank you

Representative_Jay_Ramras@legis.state.ak.us