

Prescription Drug Abuse: Trends, Surveillance, and Future Implications

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I. Prescription Drug Abuse

A. What is it?

B. What types of drugs are being abused?

1. Opioids, central nervous system depressants, sedatives, and tranquilizers

C. Epidemiology of prescription drug abuse: Who is abusing?

D. Poisoning and death from prescription drug abuse

II. Sources of Abused Prescription Drugs

A. Why prescription drugs?

1. How are they obtained?

III. Prescribing Trends

A. Over-prescribing

B. Under-prescribing

V. Future Implications

A. Screening by physicians

B. National and state prevention programs

1. What works?

VI. Surveillance and Monitoring (Annotated bibliography with corresponding websites)

Appendix A: Treatment and Recovery Resources

What is abuse?

Advancements in pharmacotherapy have enabled many people to be relieved of persistent and chronic pain and many Americans today benefit from appropriate use of prescription painkillers (ONDCP, 2008). However, when these drugs are used for nonmedical purposes they can alter brain activity and lead to dependence (NIDA, 2007).

Drug abuse is defined as the use of illicit drugs (NIH, 2007). Illicit drugs are classified as marijuana, phencyclidine (PCP), hallucinogens, stimulants, amphetamines, inhalants, and narcotics. While most illicit drugs are purchased from the street including, crack-cocaine or heroin, some of the deadliest illicit drugs are available in one's medicine cabinet. Many are prescribed narcotics to relieve chronic and acute pain; however prescription drug abuse is on the rise in the United States and appears to be contributing to a growing public health problem riddled with abuse and addiction (NSDUH, 2007). Prescription drug abuse and dependence is slightly more complex than illicit drug or alcohol abuse in that often times, a person is prescribed the drug of abuse for initial therapy to a pain issue. It can be said that no one is prescribed cocaine, marijuana, or alcohol.

Medline Plus states that prescription or over-the counter drugs may be abused if you take more than the normal or recommended amount of the medicine, or if you use them for illegal purposes (MedlinePlus, 2008). In a report to The Addiction Technology Transfer Center Network, Jane Carlisle Maxwell defines non-medical use of prescription drugs as the use of prescription-type drugs that are not prescribed for the individual by a physician or the drugs are used only for the experience or feeling they cause (Maxwell, 2006). The National Household Survey on Drug Abuse (NHSDA) has developed criteria to better define prescription drug abuse. According to NHSDA, "heavy use" is considered to be daily nonmedical use of one or more prescription drugs for at least two weeks in the past year (Wastila & Strickler, 2004). Additionally, NHSDA considers one to be abusing when two of the following five criteria are met: (1) inability to cut down; (2) getting less work done; (3) using substance in past month and being depressed,

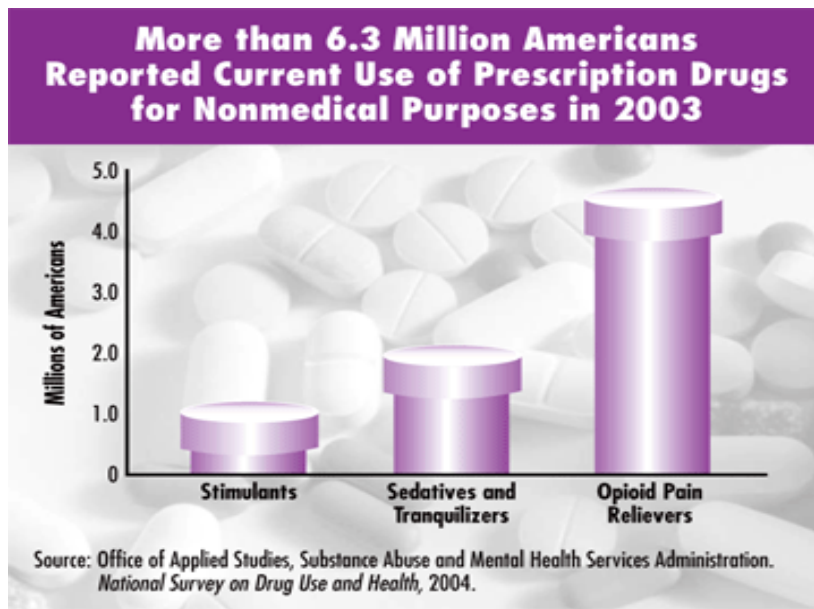
argumentative, anxious, or upset, feeling isolated, and/or having health problems and/or difficulty thinking clearly; (4) needing larger amounts; or (5) experiencing withdrawal symptoms (Epstein, 1995 & DSM-III, 1987). Addiction is a multi-stage process that involves the initiation of drug use, progression to intermittent and then regular use, followed by dependence or addiction, and frequently, relapses following withdrawal or slowing of drug use (Kreek, et al., 2005). Patients who deviate from their prescribed pain reliever program can be categorized as patients with problematic opioid use (Ballantyne & LaForge, 2007). The terms, abuse, misuse, and dependence are debatable, however the consequences of all three are quite real.

What drugs are being abused?

Prescription medications are increasingly being abused or used for nonmedical purposes and while the practice is illegal it can also be lethal in some cases. Commonly abused classes of prescription drugs include painkillers, sedatives, and stimulants (www.drugabuse.gov). Prescription psychotherapeutic drugs include pain relievers, tranquilizers, stimulants, and sedatives (Maxwell, 2006). Commonly abused classes of prescription drugs include opioids (often prescribed to treat pain), central nervous system depressants (prescribed to treat anxiety and sleep disorders), and stimulants (used to treat narcolepsy, attention deficit hyperactivity disorder, and obesity) (NIDA, 2007). Derived from opium poppies, opiates include morphine and codeine. Opioids have the same effect of morphine and codeine but are synthetically produced (MedlinePlus, 2008). Included in this class of drugs are oxycodone, heroin, hydromorphone, meperidine, propoxyphene, and methadone. Prescribed as pain killers, these drugs promote sedation, decrease anxiety, and block pain receptors in the brain in order to alleviate acute and

chronic pain (MedlinePlus, 2008). Commercially, these drugs are called, OxyContin, Darvon, Vicodin, Dilaudid, Demerol, and Lomotil (NIDA, 2007). On the street, however the commercial names are broken down further into slang such as, OC's, Perc's, OxyCoffin's, Hillbilly Heroin, Killer's, and Oxy's (SAMHSA, 2007). Common central nervous system depressants include barbiturates, such as Nembutol, and benzodiazepines such as Valium and Xanax (NIDA, 2007).

Painkillers such as Vicodin and OxyContin are very powerful medications against pain, however they need to be monitored and taken only under close supervision by a prescribing physician. When these controlled medications are taken inappropriately they can trigger addiction as they act on the same places in the brain as heroin. Long-term use of opioids or central nervous system depressants can lead to physical dependence. Taken in high doses, stimulants can lead to compulsive use, paranoia, dangerously high body temperatures, and irregular heartbeat (NIDA, 2007). Typically, time-released opioids, such as OxyContin, are chewed or crushed and inhaled to negate the time-release effect; there is also evidence that some abusers inject the drug intravenously (SAMHSA, 2007). The following table from the Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA) illustrates the breakdown of nonmedical prescription drug use in 2003.



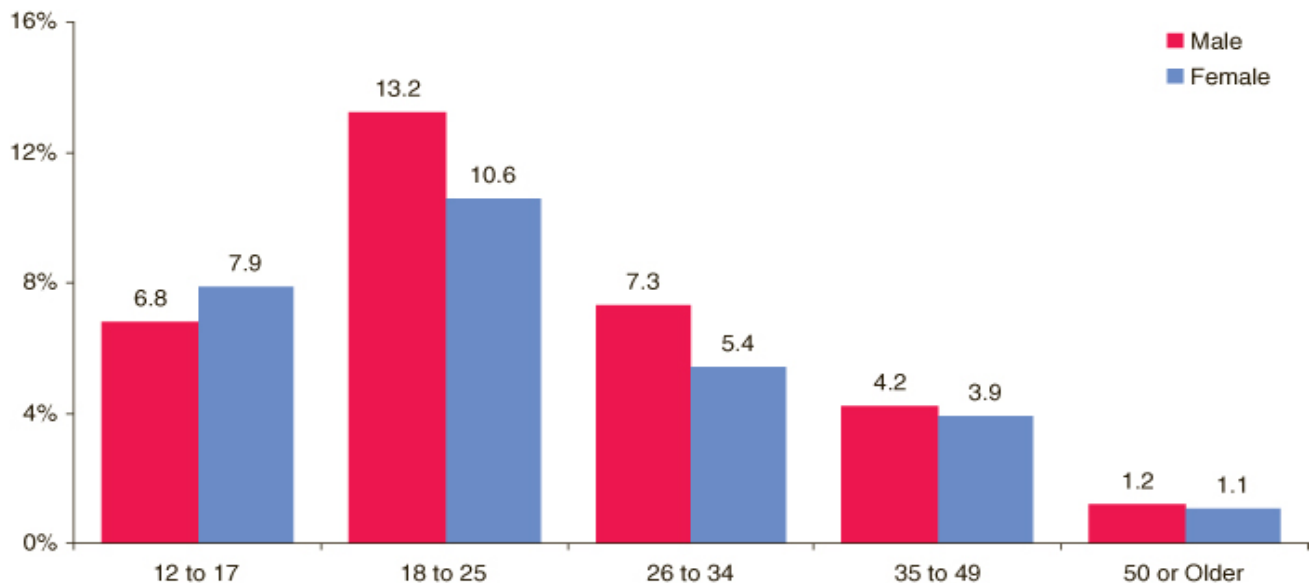
Opioid abuse exceeds stimulants, sedatives, and tranquilizers over sixty-percent and this trend has shown a continual incline since 2004 (NSDUH, 2004).

Epidemiology of Prescription Drug Abuse: Who is abusing?

The National Survey on Drug Use and Health (NSDUH) surveys persons aged 12 or older; nonmedical use is defined as use of prescription-type drugs not prescribed for the respondent by a physician or used only for the experience or feeling they caused (NSDUH, 2007). In 2002, the survey results reported that an estimated 29.6 million Americans had used pain relievers non-medically in their lifetimes. By 2005, the number had increased to 32.7 million (Maxwell, 2006). Non-medical use of prescription pain relievers was second only to marijuana use in terms of past-year use: 11.3 million were non-medical users of pain relievers as compared to 25.5 million past-year marijuana users, according to combined data (NSDUH, 2002). Between 1994-1991, opioid use increased from 44,518 to 99,317-a 123% increase in use (NIDA, 2004). Combined data from 2002 to 2005 indicate that 57.7% of persons who first used pain relievers

nonmedically in the past year used hydrocodone products and 21.7% used oxycodone products (NSDUH, 2007).

Dr. Howard Chilcoat of John Hopkins School of Public Health notes that overall, the number of people who abuse prescription drugs each year roughly equals the number who abuse cocaine-about two to four percent of the population (Zickler for NIDA, 2008). He goes on to say that whites are more likely than other racial or ethnic groups to abuse prescription drugs, and many people who abuse painkillers also have psychiatric disorders (NIDA, 2008). Males are also more likely than females to use prescription pain relievers nonmedically and young adults aged 18 to 25 have had the highest rates of nonmedical prescription drug use among all age groups (NSDUH, 2007). This is illustrated in the histogram below:



Percentage of Past Year Nonmedical Pain Reliever Use among Persons Aged 12 or Older, by Age Group and Gender: 2002-2005 *Source: SAMHSA, 2002-2005 NSDUH*

Among youths aged 12 to 17, females were more likely than males to have used pain relievers nonmedically in the past year, whereas males aged 18 to 25 and males aged 26

to 34 had higher rates than their female counterparts (NSDUH, 2007). The rates were similar among men and women aged 50 or older.

While rates of prescription drug abuse show a negative trend in the United States, youths aged 12 to 17 have consistently higher abuse rates. Every day, 2,500 youth abuse a prescription pain reliever for the very first time (SAMHSA, 2007). Furthermore, prescription drugs tend to be the “drug of choice” among 12 to 13 year-olds (SAMHSA, 2007). In January, 2008 the Office of National Drug Control Policy reported that more teens abuse prescription drugs than any other illicit drug except marijuana and in 2006, more than 2.1 million teens abused prescription drugs (ONDCP, 2008). Teens are turning away from street drugs and using prescription drugs to get high. Indeed new users of prescription drugs have caught up with new users of marijuana (Kuehn, 2007). While the span of years is five, 13 is the mean age of first non-prescribed use of sedatives and stimulants. Sixty-percent of teens who have abused prescription painkillers first tried them before age 15; moreover, nearly one-fifth (18%) used them at least weekly in the past year (Wu, Pilowsky & Patkar, 2007). The National Institute on Drug Abuse’s (NIDA) 2003 Monitoring the Future (MTF) survey of 8th, 10th, and 12th graders found that 10.5 percent of 12th graders reported using Vicodin for non-medical reasons and 4.5 percent of 12th graders reported using OxyContin without a prescription (NIDA, 2007).

Poisoning and Death from Prescription Drug Abuse

With the increase in abuse rates, unintentional poisoning and death from nonmedical use of prescription drugs is also on the rise. Leonard J. Paulozzi of the Centers for Disease Control and Prevention, and colleagues found that opioid analgesic poisoning was documented to cause 5,528 deaths in 2002, more than heroin or cocaine

(Paulozzi, 2006). Unintentional poisoning deaths involving narcotics grew 55 percent from 1999 to 2004; poisoning deaths involving psychotherapeutic drugs, such as sedative-hypnotics and antidepressants, grew 84 percent during this time (CDC, 2007). In 2004, The Drug Abuse Warning Network Emergency Department report (DAWN ED) estimated that there were nearly 1.3 million emergency department visits associated with drug misuse or abuse, and nearly half a million involved nonmedical use of pharmaceuticals (Maxwell, 2006). The table below illustrates the emergency room visit drug mentions.

Drug	Mentions
Psychotherapeutic agents	275,430
Antidepressants	61,023
Antipsychotics	37,327
Antihypertensives, sedatives, and hypnotics	204,711
CNS stimulants	10,616
CNS agents	305,973
Analgesics	264,857
Respiratory agents	26,694
Cardiovascular agents	30,246

Number of ED Drug Mentions, Non-Medical Use of Selected Psychotherapeutics, 2005
Source: DAWN ED 2004

Nearly 30% of these visits involved opiates/opioids (DAWN ED, 2004). Data from the National Center for Health Statistics (NCHS) showed that opioid analgesics such as hydrocodone, oxycodone, and methadone were more likely than cocaine or heroin to be the cause of unintentional drug poisoning deaths in the United States between 1999 and 2002 (Maxwell, 2006).

Treatment facilities also report higher rates of admittance by abusers of prescription pain relievers. According to the Treatment Episode Data Set (TEDS), between 1995 and 2005, treatment admissions for abuse of prescription pain relievers grew more than 300 percent (TEDS, 2007). This same data set reports that from 1994 to 2004, the number of persons who were admitted to treatment programs across the U.S. with a primary problem with opiates other than heroin increased from 14,197 to 60,017 (TEDS, 2007).

Why prescription drugs?

Quite simply, these drugs are prescribed. Because of this, however they are often viewed as “safer” since they are prescribed by a physician. In fact, four out of ten teens believe this to be true, even if they are not prescribed by a doctor (PATS, 2006). Moreover, nearly one-third believe there is “nothing wrong” with using prescription medicines without a prescription once in a while; nearly three out of ten from this same group believe narcotics to not be addictive (PATS, 2006). It may be safe to assume that people aged 12 to 17 find these drugs readily available and less risky than street drugs. So, where are the prescription drugs coming from? Seventy-percent of people who abuse prescription pain relievers say they got them from friends or relatives (NSDUH, 2007). The following pie chart provides a breakdown of the resources from which teens are obtaining pain relievers.

The Partnership Attitude Tracking Survey (PATS) surveyed 7,218 adolescents in the spring of 2005. This self-administered measure identified reasons for using prescription pain relievers. Among the top reasons were:

- Easy to get from parents medicine cabinets (62%)
- Are available everywhere (52%)

- They are not illegal (51%)
- Easy to get through other people's prescriptions (50%)
- They are cheap (43%)
- Safer to use than illegal drugs (35%)
- Less shame attached to using (33%)
- Easy to purchase over the internet (32%)
- Fewer side effects than street drugs (32%)
- Can be used as study aids (25%)
- Parents don't care as much if you get caught (21%) (PATS, 2006)

It is evident through these responses that non-medical uses of prescription drugs are shrouded with misperceptions. Between 2004 and 2005, the proportion of teens that thought there was a great risk in trying prescription pain relievers that were not prescribed for them dropped from 48% to 44% (PATS, 2006). While most adolescents cite the availability of pills from their homes, others obtain pain medications via "doctor shopping" (moving from physician to physician in an effort to obtain multiple prescriptions for pain relievers), the internet, and theft from hospitals and pharmacies (Kuehn, 2007). In a health policy review led by Laxmaiah Manchikant, MD, it was determined that the majority of prescription controlled substances for non-medical use are obtained for free from a friend or relative (60%), purchased from a friend or relative (8%), taken from a friend or relative without asking (4%), and from prescriptions from one doctor (17%) (Manchikanti, 2007). When teens abuse prescription drugs, they often characterize their use as "safe", "controlled", or "responsible", with the perception that the prescription drugs are somehow safer than street drugs (Friedman, 2006). In addition, more than one-third of teens say they feel some pressure to abuse prescription drugs, and 9 percent say using prescription drugs to get high is an important part of fitting in with their friends (Friedman, 2006).

Prescribing Trends: Over and under prescribing

There are two public health crises occurring simultaneously in the US: one is under treated pain; the other is prescription drug abuse (Kuehn, 2007). Between 1999 and 2002 oxycodone prescriptions increased 50% to 29 million; fentanyl prescriptions increased 150% to 4.6 million and morphine prescriptions increased 60% to 3.8 million (Compton & Volkow, 2006). By far the most commonly used prescription analgesic in the United States is hydrocodone/acetaminophen, which has been the most prescribed medication of any category for at least the past 5 years. In 2004, the United States used 99% of the global supply of the opioid, hydrocodone (Kuehn, 2007). In a 2005 report by the International Narcotics Control Board, between 2000 and 2004, medical use of hydrocodone increased 60 percent domestically (Kuehn, 2007).

Both physicians and patients worry about long term treatment with opioids. Physician concerns about prescribing opioids include risk of addiction, physical dependence and withdrawal, patient misuse, reinforcing pain behaviors, and the hassle factor which includes increased monitoring, documentation, and perceived legal and regulatory liability (Fishman, et al., 2004). Patient opioid concerns include an exaggerated fear of addiction, tolerance and side effects, reluctance to report pain, and concerns about the “meaning” of the pain (Fishman, et al., 2004). Regulatory agencies report several categories of physician errors when prescribing opiates: (1) no history or physical to support the need for opiates; (2) no diagnosis prior to starting treatment; (3) no discussion with prior physician or review of old records; (4) no documentation of diagnosis, treatment plans, goals of treatment, need for continued opiates; (5) no screening for addictive behavior, no understanding of drug testing; (6) no documentation

of opiate contract violations and their resolution, and no confirmation of the patient's story (OSMB, 2004). As noted earlier, many abusers are obtaining prescribed medications from friends and family members; this raises concerns among physicians and may speak to the phenomenon of "opiophobia".

The National Institute on Drug Abuse (NIDA) has observed that health care providers underprescribe painkillers because they overestimate the potential for patients to become addicted to medications such as morphine and codeine, this fear has been appropriately deemed, "opiophobia (NIDA, 2007). The issues of underprescribing opioids for pain have led to the development of guidelines for treatment. In her editorial, *Opioid Prescriptions Soar*, Bridget M. Kuehn quotes Seddon Savage, MD, and American Pain Society Board member and Director of the Dartmouth Center on Addiction, Recovery, and Education in Hanover, NH: "It is important for physicians to be educated about the mechanism of opioid analgesics and appropriate management of patients who are taking them" (Kuehn, 2007).

This education Savage speaks of is provided by regulatory agencies that offer prescribing protocols to physicians. Many state medical, pharmacy, and nursing boards are issuing joint statements emphasizing the need to use these drugs in appropriate circumstances while taking steps to avoid abuse and diversion. The Federation of State Medical Boards has crafted a model policy, adopted by many states, on regulating the use of controlled substances. The policy emphasizes both the need to achieve adequate pain control and the need for physicians to periodically monitor patients to prevent abuse (FSMB, 2004).

Future Implications: What works?

As the Federation of State Medical Boards has disseminated a model policy to regulate the use of controlled substance, some call for a “public health approach” to avoid opioid abuse and diversion (Joranson & Gilson, 2006). Improved data collection leading to more complete databases, information about the motivations for drug use, and more knowledge about the sources of abused drugs are all vital to decreasing abuse and diversion (Joranson & Gilson, 2006). Between 2000 and 2003, there were nearly 13,000 incidents of prescription controlled substances diverted by theft (Novak, et al., 2004). It is also known that hydrocodone, exclusively was diverted twice as much as any other controlled prescription pain reliever (Sees, et al., 2005). We have learned that there are nonmedical sources of diversion as well; however these statistics send an alarming message to health care providers as well as anyone being prescribed scheduled medications. Obtaining a better understanding of the etiology of drug abuse will better inform future programs intended to curb the health crisis at hand.

Physicians can effectively reduce prescription drug abuse and diversion by screening for history of substance abuse before initiating treatment. Several measures for the assessment of chronic pain have been developed but a “gold standard” has yet to emerge (Butler, et al., 2007). The Prescription Drug Use Questionnaire (PDUQ) is a 42-item measure designed to be used in interview format (Chabal, et al., 1997). In it, five criteria make up an abuse checklist; if patients meet three of the five criteria, they are considered to be opiate abusers (Chabal, et al., 1997). Other office-based screening measures include the Current Opioid Misuse Measure (COMM) (Butler, et al., 2007); the Screening Instrument for Substance Abuse Potential (SISAP) (Coombs, et al., 1996); the

Pain Assessment and Documentation Tool (PADT) (Passik, et al., 2004); and the Pain Medication Questionnaire (PMQ) (Adams, et al., 2004). While all of these screening tools are useful in evaluating opioid misuse and abuse, no one scale has been determined to be superior in assessing opioid abuse (Butler, et al., 2004).

In February of 2008, the Office of National Drug Control Policy (ONDCP) launched a new media campaign directed to parents regarding prescription drug abuse (ONDCP, 2008). In a television advertisement, a drug dealer is depicted as being “out of work” and “not the one selling your kid drugs”. This suggests that teens are obtaining these substances from their own medicine cabinets, from doctors, and from friends. This particular ad was aimed to make parents aware of the dangers posed by prescription drug abuse (ONDCP, 2008). With the rise of abuse rates in prescription drugs, the ONDCP has launched a national effort to raise awareness about the risks of narcotics abuse.

The ONDCP is also contracted with non-governmental organizations as well such as, Community Anti-Drug Coalitions of America (CADCA) to provide training and technical assistance through its National Coalition Institute (ONDCP, 2008). This collaboration ensures that local representatives from various geographic locations are represented in the fight against drug abuse. CADCA members include representatives from law officials, schools, faith-based organizations, fraternal organizations, media, parents, and state and local government agencies (ONDCP, 2008). By including members of the community, CADCA, in partnership with ONDCP, are working to establish a network of leaders to address the spread of the prescription drug abuse epidemic.

Another program that seems to be effective is random drug testing in schools. A randomized controlled study conducted in Oregon revealed that, after two full school years, schools that had random drug and alcohol testing in place reported significantly less drug use compared to students at the control schools without random drug testing (Goldberg, et al., 2007). In the event a student tested positive for drug use, parents or guardians were notified and mandatory counseling ensued (Goldberg, et al., 2007). The hope is that random drug testing in the workplace might yield the same results. A study evaluating the impact of workplace substance abuse prevention programs on occupational injury highlights not only a reduction in substance abuse rates, but also a cost savings. The combination of random drug testing and a peer-based program reflected an estimated savings of \$1,850 in employer injury costs per employee (Miller, et al., 2007).

In the both the school and workplace, random drug testing promotes deterrence from initiating drug use, identifies those who have just begun drug use in order to intervene before dependency begins, and identifies students and workers with dependency issues in order to refer them to appropriate treatment facilities (ONDCP, 2008).

In order to direct abusers of prescription drugs to the best available treatment programs, access to recovery must also be improved. The “Access to Recovery” (ATR) initiative attempts to close the treatment gap to ensure providers are equipped with the knowledge and tools necessary to properly conduct treatment mechanisms. In 2003, the President announced the ATR program in order to, “expand substance abuse treatment capacity, promote choices in recovery paths and services, increase the number and types of providers, and link clinical treatment to important recovery support services”

(SAMSHA, 2007). In September of 2007, the ATR program was awarded continued funding in order to meet the needs of some 170,000 people with abuse problems who have utilized the services of the program (SAMHSA, 2007). Additional federal programs have also been initiated to curb drug abuse in the United States.

In February 2007, the White House Office of National Drug Control Policy (ONDCP) issued new guidelines for the disposal of unused, unneeded, or expired prescription drugs (ONDCP, 2007). Apart from preventing prescription diversion, the Environmental Protection Agency feels such guidelines will protect waterways and keep pharmaceuticals out of the hands of potential abusers (ONDCP, 2007). Other federal programs include funding for school-based intervention programs as well as increased screening among federal employees (ONDCP, 2007).

Surveillance and Monitoring

To address the growing concern of the rise in prescription drug abuse, many federal and state agencies have developed systems for monitoring the abuse and misuse of opioids and other narcotics. In fact, Purdue Pharma, L.P., producers of OxyContin have sponsored the development of a proactive abuse surveillance program, named the Researched Abuse, Diversion and Addiction-Related Surveillance (RADARS) system (Cicero, et al., 2005). The following section serves as a bibliography to monitoring and surveillance systems.

Researched Abuse, Diversion and Addiction-Related Surveillance (RADARS) system <http://www.radars.org>

Relying primarily on data collection, analysis, expert review, data reporting, and publication the RADARS system measures rates of abuse, misuse, and diversion throughout the United States, contributing to the understanding of trends and informing intervention development.

Drug Abuse Warning Network (DAWN)

<http://dawninfo.samhsa.gov/>

DAWN is operated by the Substance Abuse and Mental Health Services Administration (SAMHSA) and is contracted with a private research corporation to manage the agency's data. DAWN is a public health surveillance network that monitors drug-related visits to the emergency department (DAWN ED) and drug-related deaths investigated by medical examiners and coroners (DAWN ME).

Monitoring the Future Survey (MFS)

<http://monitoringthefuture.org/>

This is an ongoing study of behaviors, attitudes, and values of U.S. middle and high school students, college students, and young adults. Each year, approximately 50,000 8th, 10th, and 12th grade students are surveyed. This has been in effect since 1975. The MTF is conducted at the Survey research Center in the Institute for Social Research at the University of Michigan.

The National Survey on Drug Use and Health (NSDUH)

<https://nsduhweb.rti.org/>

A nationwide survey, the NSDUH involves interviews with approximately 70,000 randomly selected individuals aged 12 and older. The Substance Abuse and Mental Health Services Administration (SAMHSA) is an agency within the U.S. Public Health Service, part of the U.S. Department of Health and Human Services. The goals of the NSDUH are to provide accurate data on the level and patterns of licit and illicit substance use, track trends in the use of alcohol and drugs, assess the consequences of substance use and abuse, and identify high risk groups for substance abuse and use.

The White House Office of National Drug Control Policy (ONDCP)

<http://www.whitehousedrugpolicy.gov/index.html>

This agency was established by the Anti-Drug Abuse Act of 1988. Its main purpose is to establish policies, priorities, and objectives for the Nation's drug control program. The ONDCP believes that central to drug prevention is "the development and implementation of programs that prevent illicit drug use, keep drugs out of neighborhoods and schools, and provide a safe and secure environment for all people."

It is also the role of the ONDCP to provide communities with the science-based tools to prevent drug abuse; to have research in several emerging areas of prevention.

The Treatment Episode Data Set (TEDS)

www.oas.samhsa.gov/dasis.htm

This data is maintained by the Office of Applied Studies, SAMHSA. The TEDS system includes records from 1.5 million substance abuse treatment admissions annually and comprises data that are routinely collected by states in monitoring their individual substance abuse treatment systems. It is an admission-based system though it does not represent individuals.

The Partnership Attitude Study (PATs)

www.whitehousedrugpolicy.gov/publications/pats/final_rpt.pdf (available in PDF format)

This study tracks the attitudes about illegal drugs, providing research about the thoughts and perceptions of the Partnerships' target audience. There are two samples: a teen sample for students in grades seven through twelve, and a parent sample with children under the age of nineteen. Data were collected from March through June 2005 and February through April 2006, respectively.

The National Center for Health Statistics (NCHS)

<http://www.cdc.gov/nchs/>

Operating out of the Centers for Disease Control (CDC), the NCHS compile statistical information to guide actions and policies to improve the health of the nation. Examples of statistics they provide include, physician office visits, hospital outpatient department visits, and emergency department visits. NCHS also monitor trends in health status and health care delivery.

Ohio Substance Abuse Monitoring Network (OSAM)

<http://med.wright.edu/citar/osam.html>

The OSAM is a collaborative funded by the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) through Wright State University in Dayton, Ohio. The mission of OSAM is to provide a “dynamic picture of substance abuse trends and newly emerging problem populations.” OSAM also provides information on drug addiction services, prevention services, and a response to drug and alcohol problems among underserved populations across Ohio.

See Appendix A for additional treatment and recovery resources.

Appendix A: Treatment and Recovery Resources

Narcotics Anonymous

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

Narcotics Anonymous is an international, community-based association of recovering drug addicts with more than 43,900 weekly meetings in over 127 countries worldwide. Ohio residents visit: <http://www.naohio.org/>

The Betty Ford Center

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

To provide effective alcohol and other drug dependency treatment services, including programs of education and research to help women, men and families begin the process of recovery.

Addiction Treatment Watchdog

<http://www.atwatchdog.org/index.html>

This unique site offers services to those who are being medically treated for opiate addiction including clinic reports, a discussion forum, and resources for caregivers and family members.

The National Drug Court Institute (NDCI)

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

Drug courts handle cases involving drug-addicted criminals through extensive supervision and recovery programs. The NDCI promotes education, research, and scholarship.

Glenbeigh Treatment Institute

<http://www.glenbeigh.com/Home/tabid/36/Default.aspx>

Located in Ohio and an affiliate of the Cleveland Clinic, Glenbeigh is a substance abuse treatment center that offers inpatient and outpatient recovery services.

Substance Abuse Treatment Facility Locator: Substance Abuse Mental Health Services Administration

<http://dasis3.samhsa.gov/>

Offered through the Department of Health and Human Services, SAMHSA's treatment facility locator enables visitors to locate treatment facilities across the United States via an interactive map.

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