AGENDA ITEMS # 4 and 5

*Nevada Stats

*2015 Narcotics Annual Report

*Practice Advisory: FDA Boxed Warning on Immediate-Release Opioid Medications and All Prescription Opioids

Nevada Is Overmedicated

In 2012, healthcare providers wrote 259 million prescriptions of pain medications, which amounts to enough for

every American adult to possess one bottle of pills.

Center for Disease Control, Vital Signs, 2014

7

Number of prescriptions of Xanax filled **per Nevada resident** in 2008.

{52%} filled in Las Vegas

{18%} filled in Reno

{12%} filled in Henderson

94 painkiller prescriptions were written per **100** people in Nevada in 2012.

CDC Vital Signs, July 2014

In 2009, Nevada was one of the top ten states for non-medical use of painkillers among teenagers aged

12 to 17.

National Survey on Drug Use and Health 2009-2010

40

deaths per day are attributed to the misuse of prescription pain relievers.

National Drug Control Strategy; Executive Office of the President of the United States, July 2014

70%

of non-medical prescription drug users reported obtaining their drugs from a friend or relative.

SAMHSA, 2009 National Survey on Drug Use and Health, September 2010

Help us reduce prescription drug abuse.

JTNN

Join Together Northern Nevada

jtnn.org

Sponsored (in part) by SAMHSA and/or the Substance Abuse Prevention and Treatment Agency of Nevada (SAPTA).

LAS VEGAS METROPOLITAN POLICE DEPARTMENT

2015 Narcotics Annual Report

Prepared By: Major Violators and Narcotics Bureau Analyst

1/11/2016

Executive Summary

Heroin is one of the most significant drug threats to the Las Vegas Community, as evidenced by the 107% increase in the amount of heroin seized (110.5 pounds) during 2015 compared to 2014. Even though heroin arrests decreased slightly and there was a 57% decrease in heroin buys, the amount of heroin seized is indicative that heroin is readily available within the Las Vegas Community. Heroin will continue to be a threat as it is a cheaper alternative to opioid-based pharmaceuticals. According to the Clark County Coroner's Office in 2015, 71 deaths were attributed to heroin which is a 25% increase from 2014. Fentanyl has become an issue in many states; however, we have only one reported incident involving fentanyl. This occurred in March 2015, when members of the Interdiction Task Force found an individual in possession of 2.5 pounds of fentanyl that was traveling by Greyhound bus from San Diego, CA to New York City, NY. In 2016, heroin will continue to be readily available and we can expect to see heroin arrests and seizures to increase depending on enforcement levels.

Methamphetamine continues to be a significant drug threat to the Las Vegas Community; this is based upon the continued availability of methamphetamine as evidenced by the number of arrests, as well as the amount of methamphetamine seized (381.1 pounds). According to the Clark County Coroner's Office in 2015, 202 deaths were attributed to methamphetamine which is a 22% increase from 2014. In 2016, methamphetamine will continue to be readily available and we can expect methamphetamine arrests and seizures to remain consistent with 2015 numbers depending on enforcement levels.

Drug Deaths

When looking at drug deaths specifically related to pharmaceuticals, heroin and methamphetamine, the Clark County Coroner's Office provided data showing a slight increase of pharmaceutical related deaths and a more significant increase in heroin and methamphetamine related deaths.

Drug Deaths					
	2013	2014	% Change 2013 vs. 2014	2015	% Change 2014 vs. 2015
Pharmaceuticals	316	237	-25%	240	1%
Heroin	48	57	19%	71	25%
Methamphetamine	131	165	26%	202	22%

Source: Clark County Coroner's Office

Arrest Data

Individuals Arrested: To obtain an accurate picture we look at the number of individuals arrested for a narcotics offense and then the number of individuals arrested for a specific drug type. The narcotics arrests are based on an arrest warrant or probable cause arrest and are department-wide made by LVMPD officers.

In 2015, we saw a 17% decrease in the total number of individuals arrested for a narcotics offense. When looking at the number of individuals arrested for a specific drug type we saw significant decreases in cocaine, marijuana, MDMA and Spice arrests, but only slight decreases in heroin and methamphetamine arrests. A significant decline in the number of individuals arrested started in July 2015 and continued through December 2015. During July – September 2015, there was a 29% decrease and during October – December 2015, there was a 24% decrease in individuals arrested.

Analyst Comments: Some may say this decrease is due to decentralization of the narcotics street teams, which I would disagree with. The majority of narcotics arrests are made by patrol officers not detectives. The number of narcotics detectives that were decentralized would not cause a 17% decrease in the number of individuals arrested for a narcotics offense. In 2013, individuals arrested by narcotics detectives accounted for 7% (460) of the 6,464 individuals; 2014 7% (405) of the 6,014 individuals; and 2015 6% (300) of the 5,004 individuals. One reason for the decrease could be patrol officers not having sufficient time to be proactive and/or not being proactive in the right areas.

Individuals Arrested					
	2013	2014	% Change 2013 vs. 2014	2015	% Change 2014 vs. 2015
Total Individuals	6,464	6,014	-7%	5,004	-17%
Cocaine	748	744	-1%	585	-21%
Heroin	492	519	5%	508	-2%
Marijuana	1,747	1,715	-2%	1,231	-28%
Methamphetamine	1,994	2,141	7%	2,092	-2%
MDMA	199	224	13%	177	-21%
Pharmaceuticals	289	322	11%	337	5%
Spice	223	147	-34%	92	-37%

Source: ITAG

Arrest Demographics: When looking specifically at heroin and methamphetamine arrests for 2015, we can identify some demographic information (race, sex and age ranges) concerning those individuals that are trafficking heroin and methamphetamine as well as those who are users.

Heroin Traffickers: There were 75 individuals arrested for trafficking heroin which equates to 15% of the individuals arrested for a heroin offense. Hispanic males accounted for 43% of the traffickers arrested and white males accounted for 32% of the traffickers.

- Hispanic males age ranges:
  - 44% between 18 – 25 years of age
  - 44% between 26 – 40 years of age
- White males age ranges:
  - 54% between 26 – 35 years of age
  - 33% between 36 – 52 years of age

Heroin Users: There were 408 individuals arrested for possession of user amounts of heroin which equates to 80% of the individuals arrested for a heroin offense. White females accounted for 24% of the users arrested and white males accounted for 50% of the users.

- White females age ranges:
  - 27% between 18 – 25 years of age
  - 60% between 26 – 35 years of age
- White males age ranges:
  - 30% between 18 – 25 years of age
  - 43% between 26 – 35 years of age
  - 27% between 36 – 63 years of age

Methamphetamine Traffickers: There were 384 individuals arrested for trafficking methamphetamine which equates to 18% of the individuals arrested for a methamphetamine offense. Hispanic males accounted for 30% of the traffickers arrested while white males accounted for 29% and white females accounted for 14% of the traffickers arrested.

- Hispanic males age ranges:
  - 27% between 18 – 25 years of age
  - 29% between 26 – 35 years of age
  - 25% between 36 – 45 years of age
- White males age ranges:
  - 8% between 18 – 25 years of age
  - 41% between 26 – 35 years of age
  - 23% between 36 – 45 years of age
  - 27% between 46 – 62 years of age
- White females age ranges:
  - 20% between 18 – 25 years of age
  - 41% between 26 – 35 years of age
  - 39% between 36 – 67 years of age

Methamphetamine Users: There were 1,676 individuals arrested for possession of user amounts of methamphetamine which equates to 80% of the individuals arrested for a methamphetamine offense. White males accounted for 37% of the users arrested while black males accounted for 19%, Hispanic males accounted for 18% and white females accounted for 15% of the users arrested.

- White males age ranges:
  - 13% between 18 – 25 years of age
  - 34% between 26 – 35 years of age
  - 25% between 36 – 45 years of age
  - 28% between 46 – 67 years of age
- Black males age ranges:
  - 12% between 18 – 25 years of age
  - 34% between 26 – 35 years of age
  - 27% between 36 – 45 years of age
  - 27% between 46 – 65 years of age
- Hispanic males age ranges:
  - 23% between 18 – 25 years of age
  - 41% between 26 – 35 years of age
  - 26% between 36 – 45 years of age
  - 10% between 46 – 65 years of age
- White females age ranges:
  - 18% between 18 – 25 years of age
  - 41% between 26 – 35 years of age
  - 24% between 36 – 45 years of age
  - 17% between 46 – 65 years of age

Narcotics Buys

The narcotics buys shows the proactive efforts of the Narcotics Section in targeting those individuals distributing narcotics within the Las Vegas Community. In 2015, we saw decreases in each drug category with the exception of MDMA buys. The decreases are primarily attributed to the decentralization of the Street Teams in July 2015. In 2013 and 2014 the Street Teams accounted for approximately 75% of narcotics buys while the HIDTA initiatives accounted for 25% of the narcotics buys. During 2015, the HIDTA initiatives accounted for 73% of the narcotics buys. This is attributed to SCORE focusing on illegal marijuana delivery services buy programs and a mission shift of the other HIDTA initiatives to focus on violent offenders and gang members trafficking narcotics.

Narcotics Buys					
	2,013	2,014	% Change 2013 vs. 2014	2,015	% Change 2014 vs. 2015
All Sales	1,063	885	-17%	607	-31%
Powder Cocaine	149	152	2%	104	-32%
Rock Cocaine	1	19	1800%	16	-16%
Heroin	188	169	-10%	73	-57%
Marijuana	156	158	1%	125	-21%
Methamphetamine	443	299	-33%	174	-42%
MDMA	50	75	50%	85	13%
Pharmaceuticals	58	53	-9%	24	-55%
Spice	47	27	-43%	35	30%

Source: Narcotics Logs

When decentralization occurred in July 2015, low level street narcotics enforcement became the responsibility of the area commands. To establish a mechanism to track the proactive narcotics enforcement at the area commands, the Narcotics Section asked each area command to provide a weekly narcotics log documenting their activity. Narcotics buys are a critical part of proactive narcotics enforcement and below is a chart depicting those efforts by each area command.

Area Commands Narcotics Buys (July - December 2015)									
	BAC	CCAC	DTAC	EAC	NEAC	NWAC	SCAC	SEAC	Total
Powder Cocaine			5				1		6
Rock Cocaine	12		22						34
Heroin	3		3	2		3	2	2	15
Marijuana	1				2	1		1	5
Methamphetamine			20		5	7	7	7	46
MDMA									0
Pharmaceuticals						1		1	2
Totals	16	0	50	2	7	12	10	11	108

Source: Area Commands Narcotics Logs

Marijuana

In 2015, we continued to see a decrease in the number of indoor marijuana grow operations dismantled. This decrease can be attributed to the proactive measures of SCORE over the last several years in identifying individuals cultivating marijuana and dismantling their grow operations. Another factor in this decrease is the opening of legal medical marijuana dispensaries, cultivation and production facilities. Also with the legal dispensaries beginning to open for business we started seeing a significant number of illegal marijuana delivery services advertising on-line and operating throughout the valley.

These illegal marijuana delivery services became a focus for SCORE in 2015 and they initiated buy program investigations on 21 illegal marijuana delivery services. Those investigations resulted in 61 marijuana buys; 26 arrests; 30 search warrants; 55 firearms seized; $193,059.19 in U.S. currency seized; 102 pounds of marijuana seized; 6.3 pounds of THC wax seized; 109 pounds of THC oil seized; and 503 pounds of THC edibles seized.

Another focus area for SCORE in 2015, was Spice (synthetic marijuana) being sold out of local Smoke Shops. SCORE working jointly with Homeland Security Investigations (HIS) initiated Spice buy program investigations on 16 local Smoke Shops. Those investigations resulted in 33 Spice buys; 4 arrests; 13 search warrants; $88,579.51 in U.S. currency seized; and 388 pounds of Spice seized.

Indoor Marijuana Grows

	2013	2014	% Change 2013 vs. 2014	2,015	% Change 2014 vs. 2015
Grows	111	82	-26%	60	-27%
Plants	12,592	6,180	-51%	4,869	-21%
Weight	1,424,528.10	937,110.90	-34%	774,431.20	-17%
Firearms	81	118	46%	89	-25%

Source: Narcotics Logs ****Weight of narcotics are in grams***

Over the last eight years, Enterprise Area Command has seen the most indoor marijuana grow sites with 220 followed by Northwest Area Command with 168.

Indoor Grows by Area Command									
	2008	2009	2010	2011	2012	2013	2014	2015	Total
BA	8	13	9	9	12	9	7	5	72
CC	1	0	1	0	3	0	1	0	6
DT	6	4	4	0	4	6	1	1	26
EA	19	35	25	41	31	30	25	14	220
NE	9	7	8	11	9	7	6	7	64
NW	23	21	24	32	25	23	10	10	168
SC	10	5	21	13	13	13	11	7	93
SE	6	8	13	14	6	6	7	2	62
HN	6	9	7	3	25	11	10	9	80
NLV	1	4	5	19	11	6	3	5	54
RES	0	2	1	4	3	0	1	0	11

Narcotics Seizures

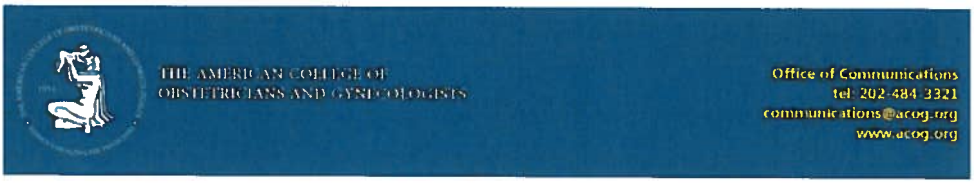
The narcotics seizure statistics are seizures made solely by the Narcotics Section. In 2015, we saw increases in currency, firearms, heroin, MDMA, pharmaceuticals and Spice seized. The most significant seizure increase was heroin, as this is the most heroin (110.5 pounds) seized during a calendar year in the last 10 years.

Narcotics Seizures (Narcotics Section)					
	2013	2014	% Change 2013 vs. 2014	2015	% Change 2014 vs. 2015
Search Warrants	451	340	-25%	298	-12%
Currency(State)	$2,512,382.56	$1,385,599.27	-45%	$1,722,274.46	24%
Currency(Fed)	$3,359,577.95	$840,829.38	-75%	$1,293,628.00	54%
Total Currency	$5,871,960.51	$2,226,428.65	-62%	$3,015,902.46	35%
Firearms	328	289	-12%	341	18%
Vehicles	34	23	-32%	14	-39%
Powder Cocaine	154,563.40	38,079.27	-75%	30,197.40	-21%
Rock Cocaine	92.60	671.22	625%	444.31	-34%
Heroin	36,420.80	24,179.19	-34%	50,160.39	107%
Marijuana	2,243,456.17	1,531,768.39	-32%	1,507,118.71	-2%
MDMA	11,318.00	15,969.43	41%	44,302.48	177%
Methamphetamine	177,650.19	223,047.55	26%	172,883.83	-22%
Pharmaceuticals	43,817.71	4,439.13	-90%	7,401.73	67%
Spice	1,283,355.48	87,571.10	-93%	289,824.24	231%

Source: Narcotics Logs **Weights of narcotics are in grams*

The point of contact for this document is Analyst George Thomas at 828-2647 or g6856t@lvmpd.com.

Practice Advisory: FDA Boxed Warning on Immediate-Release Opioid Medications and All Prescription Opioids



March 24, 2016

Background

On March 22nd, 2016, the US Food and Drug Administration (FDA) announced required, class-wide safety labeling changes for immediate-release opioid pain medications. As part of these changes, the FDA is now requiring a new boxed warning ("black box" warning) about the serious risks of misuse, abuse, addiction, overdose, and death on all prescription opioids. The boxed warning will also include a precaution that chronic maternal opioid use during pregnancy can result in neonatal abstinence syndrome (NAS, referred to in the FDA warning as "neonatal opioid withdrawal syndrome or "NOWS"), described as a condition that "may be life-threatening if not recognized and treated using protocols developed by neonatology experts." The FDA has included messaging that treatment should not be abruptly stopped in a physically dependent patient, although this is not specifically stated in regards to a pregnant patient, nor is this messaging in the boxed warning.

ACOG has been, and remains, extremely active in addressing clinical, advocacy, and legal issues related to opioid use and misuse, particularly as it relates to pregnancy-related and neonatal effects. As part of these efforts, ACOG has communicated with both the Centers for Disease Control and Prevention (CDC) and FDA regarding these issues; an ACOG statement, released March 16, 2016, includes information regarding communications with the CDC.

Neonatal Abstinence Syndrome

Neonatal abstinence syndrome is the most established risk to newborns from chronic use of opioids in pregnancy, but it is expected and treatable, and does not appear to pose permanent risks to the neonate. The FDA warning emphasizes the potential greater risk if NAS is "unexpected" or "unrecognized" but there is no data that supports the distinction between recognized and unrecognized opioid use and subsequent neonatal death. In fact death is incredibly rare and, although it has occurred in context of opioid withdrawal, NAS was not the cause of neonatal death (1). Furthermore, concerns related to "unexpected" or "unrecognized" NAS are related to the process of identifying women using chronic opioids and are not a direct result of the medication or drug itself. While opioid use clearly contributes to the clinical spectrum of NAS, the identification of women who use opioids chronically is a separate issue. Opposite to the intended effect of FDA's new labeling rules, this identification may become more challenging with the universal implementation of a boxed warning on opioids.

Impact on Care of Pregnant Women

The concern with the new boxed warning is the interpretation of the warning and potential impact on care of the pregnant woman. Health care providers and patients who may not be fully aware of these nuances surrounding opioid prescribing for pregnant women may assign an inordinate amount of attention to the boxed warning. As a result, patients may be denied access to medically-indicated opioid prescriptions (either for pain management or opioid-assisted therapy), potentially resulting in an abrupt discontinuation of opioids. Evidence clearly shows that withdrawal from opioid use during pregnancy may be associated with relapse and potentially severe adverse outcomes (2). In balancing risks and benefits of continuing opioids, the balance is often in favor of continuing medically-prescribed opioids, preferably with opioid-assisted therapy, to minimize the risks to the woman and fetus/neonate.

It is also concerning that this boxed warning was specifically assigned to immediate-release formulations. Immediate-release formulations can certainly be used or abused chronically, but there are clearly appropriate indications for the use of opioids for pain management in pregnancy and the postpartum period, such as trauma, surgery, renal lithiasis, and other conditions. ACOG agrees with the CDC and FDA that opioids should only be used for treatment of pain when

alternatives are not appropriate nor effective. However, a boxed warning may negatively impact the appropriate use of opioids in acute pain management for pregnant women, further limiting appropriate pain management options.

For Obstetrician–Gynecologists and Other Obstetric Providers

- Obstetrician–gynecologists and other obstetric providers should not hesitate to offer opioids for appropriate indications in pregnant women based on a concern for NAS.
- Obstetrician–gynecologists and other obstetric providers and the patient should together carefully weigh risks and benefits when making decisions about whether to initiate opioid therapy for chronic pain (3).
- For women, including pregnant women, with an opioid use disorder, the standard of care is opioid-assisted therapy (2). For pregnant women with opioid use disorder, opioid-assisted therapy has been associated with improved maternal outcomes and should be offered (2, 3).
- The possibility of an infant developing NAS should be discussed with patients on both chronic opioid therapy for pain and use disorder.
- Obstetrician–gynecologists and other obstetric providers caring for pregnant women receiving opioids for pain or receiving buprenorphine or methadone for opioid use disorder should arrange for delivery at a facility prepared to monitor, evaluate for, and treat neonatal abstinence syndrome. In instances when travel to such a facility would present an undue burden on the pregnant woman, it is appropriate to deliver locally, monitor and evaluate the newborn for neonatal abstinence syndrome, and transfer the newborn for additional treatment if needed (3).

ACOG appreciates the efforts of organizations, including the FDA, to address the opioid epidemic. However, we have significant concerns regarding the unintended consequences and potential negative impact of the boxed warning on the care of pregnant women. NAS is certainly an important clinical entity which can be managed without long-term consequences. However, the boxed warning overemphasizes the risks of NAS without appropriately acknowledging that there are even greater risks associated with abrupt cessation of opioids in the population most effected: pregnant women who chronically use these medications. It is imperative that all stakeholders work together to provide critically important messaging regarding this issue for both health care providers and patients.

Clinical information and resources relevant to chronic opioid use in pregnancy, as well as NAS, are available at www.acog.org/Opioids. These resources include Committee Opinion 524: Opioid Abuse, Dependence, and Addiction in Pregnancy and Committee Opinion 633: Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice. We strongly recommend obstetrician–gynecologists and other obstetric providers refer to these clinical resources while caring for pregnant women who use opioids.

References

1. Kelly LE, Rieder MJ, Bridgman-Acker K, Lauwers A, Madadi P, Koren G. Are infants exposed to methadone in utero at an increased risk for mortality? J Popul Ther Clin Pharmacol 2012;19:e160–5. PMID: 22580362.
2. Opioid abuse, dependence, and addiction in pregnancy. Committee Opinion No. 524. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;119:1070–6. PMID: 22525931.
3. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain – United States, 2016. Centers for Disease Control and Prevention. MMWR Recomm Rep 2016;65:1–49. PMID: 26987082.

This Practice Advisory was developed by the American College of Obstetricians and Gynecologists in collaboration with Christopher M. Zahn, MD and Mishka Terplan, MD.

A Practice Advisory is issued when information on an emergent clinical issue (e.g. clinical study, scientific report, draft regulation) is released that requires an immediate or rapid response, particularly if it is anticipated that it will generate a multitude of inquiries. A Practice Advisory is a brief, focused statement issued within 24–48 hours of the release of this evolving information and constitutes ACOG clinical guidance. A Practice Advisory is issued only on-line for Fellows but may also be used by patients and the media. Practice Advisories are reviewed periodically for reaffirmation, revision, withdrawal or incorporation into other ACOG guidelines.

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

AGENDA ITEM #6

Letter from the U.S. Dept. of Justice, Drug Enforcement Administration regarding

Prescription Drug Take Back Day

Presenter change:

Daniel Neill, Assistant Special Agent in Charge
Eddie Pierce, Group Supervisor

U. S. Department of Justice
Drug Enforcement Administration
8701 Morrissette Drive
Springfield, Virginia 22152

www.dea.gov

MAR 1 4 2016

The Honorable Adam Paul Laxalt
Attorney General of Nevada
Old Supreme Court Building
100 N. Carson Street
Carson City, Nevada 89701

Dear Attorney General Laxalt:

The Drug Enforcement Administration (DEA) has scheduled the Eleventh National Prescription Drug Take Back Day for April 30, 2016, for the disposal of unused, unneeded, or expired prescription controlled substances. These take back days over the last five years (September 2010 – September 2015) were overwhelmingly successful and resulted in the collection and disposal of over 2,789 tons of pharmaceuticals. The success of the past events is in no small part due to the cooperative efforts of the offices of Attorneys General in encouraging participation by state, local, and tribal law enforcement agencies. Your outreach is greatly appreciated.

The upcoming take back day will provide another opportunity for the public who have accumulated prescription controlled substances to surrender these substances to law enforcement officers for proper disposal. We, again, request your support and hope you will join us in this effort by encouraging participation by law enforcement organizations within your state. Collection locations staffed by duly authorized law enforcement officials are planned from 10:00 a.m. to 2:00 p.m. at community sites. Destruction will be accomplished in accordance with all applicable federal and state laws and regulations. Local departments may contact the DEA office in their area of jurisdiction for collection day protocols.

Thank you for your consideration of this important project. If you have questions concerning this matter, please feel free to contact me at (202) 307-7165. In the alternative, your staff may contact Liaison and Policy Section Chief Ruth A. Carter at (202) 353-1604.

Sincerely,

Louis J. Milione
Deputy Assistant Administrator
Office of Diversion Control