MONTGOMERY COLLEGE

Drug-Free Schools and Communities Act

2019 Biennial Review

(Academic Years 2017-2018 and 2018-2019)

Appendix B Revised 08/26/2021

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Overview

Montgomery College actively ensures compliance with the Drug Free Schools and Campuses Regulations (34 CFR Part 86) of the Drug-Free Schools and Campuses (Appendix A). This requires the College to implement awareness and prevention programs regarding alcohol and drug use, abuse, and distribution by students and employees–across all three campuses located in Germantown, Rockville, and Takoma Park/Silver Spring, Maryland. In accordance to the regulations, this report outlines specific College efforts over the past two academic years– 2017- 2018 and 2018-2019. As required, we have reviewed our alcohol and other drug programs to determine compliance, effectiveness, and consistency of sanction enforcement. Additionally, we have determined appropriate and necessary changes to ensure program effectiveness. The results of this review are contained in this biennial report. Additionally, copies of the required annual notification pertaining to employees and students for all institutions of higher education are in (Appendix B).

Representatives of Administrative and Fiscal Services, Student Affairs, Academic Affairs, and the Office of Compliance, Risk, and Ethics have conducted this 2019 Biennial Review. Please note the following representatives:

2019 Biennial Review Committee Members:

- Ms. Maria Adams Davidson, Associate Compliance Specialist (Office of Compliance, Risk, and Ethics)
- Dr. Monique Davis, Interim Dean of Instruction Health Sciences and Director of Nursing (Academic Affairs)
- Ms. Rowena D'Souza, Human Resources Compliance Coordinator, Human Resources and Strategic Talent Management
- Mr. Marvin Mills, Vice President for Facilities and Public Safety (Administrative and Fiscal Services)
- Ms. Michelle Pagan, Executive Associate II (Administrative and Fiscal Services)
- Ms. Nadine Porter, Associate Senior Vice President for Administrative and Fiscal Services
- Mr. Adam Reid, Clery Act and Public Safety Manager (Administrative and Fiscal Services)
- Dr. Clemmie Solomon, Collegewide Dean of Student Engagement and Takoma Park/Silver Spring Dean of Student Affairs

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Introduction

Founded in 1946, Montgomery College began as an evening college at Bethesda-Chevy Chase High School, serving an initial student body of just 186 students. By 1950, the College acquired the buildings and land previously occupied by the Bliss Electrical School. This Takoma Park location became the College's first campus. The Rockville Campus opened in 1965 and the Germantown Campus opened in 1978.

Today, the College is a multicampus institution that serves approximately 54,000 students annually through a combination of credit and noncredit continuing education programs.

Chartered by the state of Maryland and governed by a 10-member Board of Trustees, Montgomery College is widely recognized for the quality and scope of its academic programs in liberal arts, humanities, sciences, business, and technologies.

Campuses are located in Germantown, Rockville, and Takoma Park/Silver Spring, complemented by Workforce Development & Continuing Education centers and other off-campus sites throughout Montgomery County. Montgomery College offers degrees and certificates in 96 programs of study, which prepare students to earn an associate's degree, transfer to a four-year college or university, enter the job market, upgrade career skills, complete an apprenticeship, or enhance life through enrichment experiences.

Montgomery College faculty and staff are highly accomplished and innovative in providing individualized instruction and a supportive learning environment. Affordable tuition and various extracurricular activities—athletic programs, performing arts, student clubs and multicultural organizations, student government—create a complete college experience for the county's culturally diverse student population. Courses and student services are provided year round for day, evening, and weekend students.

The College is an open-access, public education institution dedicated to academic excellence and committed to student success. The College offers a wide range of postsecondary academic programs, career training, and lifelong learning opportunities at moderate cost to residents, businesses, and other organizations within Montgomery County. The College provides an enriching and comprehensive learning experience for students, faculty, staff, and community members who enhance the College with a diversity of ethnicities, cultures, ages, and experiences. This diversity offers opportunities for students to appreciate individual differences and to communicate ideas. As an educational resource center, the College acknowledges its responsibility and participates actively with public and private agencies to search for solutions to community problems.

Part One: Description of Programs

All students and employees share the responsibility for protecting the Montgomery College environment, and all are expected to exemplify high standards of professional and personal conduct. The illegal or abusive use of drugs or alcohol by students or employees adversely affects the educational environment. Montgomery College is committed to maintaining a learning environment that is free of illegal drug use and alcohol abuse.

In keeping with its primary purpose, Montgomery College will utilize educational strategies as its major approach to this problem. Everyone should be aware, however, that any student or employee who uses illegal drugs or abuses any drug, including alcohol, may be subject to prosecution and punishment by the civil authorities and to disciplinary proceedings by the College. Individuals who are using drugs should stop. This policy does NOT punish people who seek rehabilitation. All information provided by people who voluntarily avail themselves of drug or alcohol counseling or rehabilitation services will be confidential. It will NOT be used against the individual.

With the passing of the Maryland Heroin and Opioid Education and Community Action Act of 2017, there are new requirements for policy development, prevention training, and reporting of overdose cases. In response to the policy requirement, Montgomery College has added the necessary language regarding heroin/opioid overdose prevention, response and reporting to our existing Policy 31005 and Procedure 31005CP–Drug and Alcohol Abuse Prevention. Also in compliance with this law all incoming full-time students must participate in heroin and opioid addiction and prevention awareness training and all part-time students be provided with resources concerning heroin/opioid abuse prevention and awareness. The law also requires designated employees to be trained in the administering of overdose-reversing medications (Naloxone). The Office of Public Safety has trained 65 officers in Naloxone administration since early 2017. Public safety officers who are trained in Naloxone administration may administer the medication to someone who has overdosed. To date, there have been no incidents of the Office of Public Safety needing to administer Naloxone. Montgomery College's Office of Public Safety stores Naloxone on each campus in readily accessible areas for immediate response, if needed, and annually reports to the Maryland Higher Education Commission the number of times the overdose-reversing medication was administered.

In accordance with the Drug-Free Schools and Community Act, Montgomery College notifies both employees and students each semester about the Drug and Alcohol Abuse Prevention program and the related policy and sanctions. Also, information is included about the adverse health effects of drug and alcohol abuse as well as a list of national and local resources available for treatment.

Drug/Alcohol Abuse Prevention Program for Students

Office of the Collegewide Dean of Student Engagement

Montgomery College continued to provide a broad range of programs and activities to promote the education, awareness and prevention of substance abuse among students since the 2018- 2019 academic year. During this time period, Dr. Clemmie Solomon served as the College's administrator in charge of facilitating the promotion of these activities. He also continues to serve as the College's representative to the Countywide Alliance to Prevent Youth Substance Abuse, an initiative of the Montgomery County Collaboration Council. The Alliance is also known as Many Voices for Smart Choices.

The following includes a review of several programs and activities that were specifically designed for students:

Substance Abuse Prevention Education Events for Students

TAKOMA PARK/SILVER SPRING CAMPUS		
DATE	**EVENT**	**ATTENDEES**
9/6/17	Volunteer Opportunity Fair–These organizations provided related services or resources about substance abuse: EveryMind, Lutheran Social Services, and Asian Pacific Islander Domestic Violence Resource Project, Help Africa, On Our Own of Montgomery County, VASAP, MADD, Montgomery County Coalition for the Homeless.	500
2017/2019	HIV Testing–HIV testing, resource information, drug abuse and prevention related to HIV. Collaborated with African American Health Program.	Confidential
10/18/17	Opioid Overdose Prevention Training–Student opioid training on terms, signs, how to respond, obtaining Naloxone and Good Samaritan Law. Partnership with Born Free Wellness Center.	60
10/31/17	Mental Health Fair–Held four documentaries surrounding Mental Health and Substance abuse. Included a fair that dispelled myths about Mental Health featured a graffiti wall, secret wall and brain and faction station.	300
2/6/18	Spring 2018 Volunteer Opportunity Fair–These organizations provided related services or resources about substance abuse: Lutheran Social Services, Asian Pacific Islander Domestic Violence Resource Project, JSSA, Raising a Village Magic Foundation and Jewish Social Service Agency.	400
2/7/18	Tabling for Substance Abuse–Provided information about substance abuse (including opioids) and resource information.	55
2/27/18	Documentary *Written Off*–Opioid film screening and panel discussion; 11 a.m.–1 p.m. in CM 211. *Written Off,* in partnership with Arise & Flourish. (Included one health and one ethics class as well as six nursing faculty). This event was approved by CPOD and fulfills MC's Multicultural and Diversity requirement. 8 panelists led this discussion.	80
4/12/18	Alternative Summer Break Pre-Trip Orientation–Training Alternative Break participants in alcohol and other-drug free trip policies.	15
5/20-24/18	Alternative Summer Break–Alternative Breaks conducts drug and alcohol-free trips that focus on direct service, issue education, and reflection. An important component of the 14 Y Breakaway trip is to take a "break" with other students that includes no use of alcohol or other drugs. It focuses on the community we are serving, the host institutions, the image of the Alternative Break movement, and participants' own health and safety, which is emphasized during pre-trip trainings and during the trip. Students on this trip also participated in Mental Health First Aid Certification.	14
9/18/18	Fall 2018 Volunteer Opportunity Fair–Listed organizations below attended a volunteer fair in the Student Services Building. These organizations provided related services or resources about substance abuse: Capital Caring, Global Resources and Supports, SOME.	500
11/12/18	Fall 2018 Mental Health Fair–Held four documentaries surrounding mental health and substance abuse. Included a fair that dispelled myths about mental health, featured a graffiti wall, secret wall, and brain and faction station.	300
3/9/19	Career Pathways in Service Day: Mental Health First Aid Certification–Students participated in an eight-hour Mental Health First Aid certification that teaches how to identify that a mental health problem may be occurring, how to respond appropriately, and how to be an ally for individuals who have a mental health disorder. Topics included substance use, dependence, and	32

TAKOMA PARK/SILVER SPRING CAMPUS		
DATE	**EVENT**	**ATTENDEES**
	abuse, and its relationship to mental health. 95% of attendees were "very satisfied" with this event.	
3/11/19	Career Pathways in Service Day: Opioid Overdose and Substance Abuse Training–Students watched the movie, *Heroin(e*), discussed data and stories of the opioid epidemic, were trained to respond to an opioid overdose, and proposed their own advocacy campaigns to raise awareness of community and campus resources. Participants also heard from professionals in criminal justice, mental health, and social services fields talk about their work.	23
3/21/19	Naloxone Training Event–Naloxone training event. Only 20 student participants allowed.	20
4/2/19	Know the Risks about Opioids–Provided transportation and lunch for four students to attend Germantown Opioid Forum/Panel and Naloxone Training. Facts presented about opioid misuse. Real-life success stories from those affected by the use disorder.	4

- Health science programs: To be compliant with clinical affiliate agreements, students enrolled in the Health sciences programs are required to complete annual drug/alcohol screenings. The programs use Castlebranch, which is an external vendor that manages the evaluation of the drug and alcohol screenings. Maryland Hospital Association (MHA) established this process. Upon evaluation of the drug/alcohol screening, students' results are determined to be clear (green), concerns with the urine sample (yellow), or positive (red). Students with yellow or red results must re-test. If results remain yellow or red, the student may not be able to attend clinical experiences. If a student displays unsafe clinical behaviors and substance use is suspected, student would be removed from the clinical site and the events are documented. Depending upon the severity of the behaviors in the classroom and/or clinical site, student consequences would follow the Student Affairs pathway for disruptive behavior.

ROCKVILLE CAMPUS		
DATE	**EVENT**	**ATTENDEES**
10/16/17	Alcohol and Texting Driving Simulator–CEP Inc., Health and Wellness Distracted Driving Program	117
2/5/18	Opioid Use and Abuse Training–Peer2Peer Program	15
4/20/18 5/20-24/18 5/19-22/19	Alternative Summer Break (Pre-Trip Orientation with information about substance abuse. Alternative Summer Breaks (Alcohol and Other Drug Free Trips) Workshops and service projects included HIV and STI prevention with the Whitman Walker Clinic, Mental Health First Aid Certification with the SHaW Center, and teen sexual health outreach with the Latin American Youth Center	17
4/17/18	Save a Life Montgomery! Opioid and Substance Abuse Community Forum Dean's Office, Montgomery County Health and Human Services	200
4/26/18	Montgomery College Lifesavers Opioid Overdose Training Certification & Presentation–Peer Educators presented on definitions and symptoms of substance abuse. Online training	19
6/14/18	New Student Orientation (NSO)–Presented information on substance abuse during NSO program	34

ROCKVILLE CAMPUS		
DATE	**EVENT**	**ATTENDEES**
7/19/18	New Student Orientation (NSO–Presented information on substance abuse during NSO program	25
8/8/18	New Student Orientation (NSO)–Presented information on substance abuse during NSO program	32
8/15/18	New Student Fair–Substance abuse information was distributed to incoming students	251
8/27-31/18	Welcome Week Activities–Substance abuse material was distributed throughout the week. SHaW Center tabled.	600+
10/3/18	Compliance and Ethics Awareness Fair with information about substance use and opioid abuse	200
10/4/18	Opioids Awareness–Peer2Peer Program	10
10/19/18	Opioids Awareness–Peer2Peer Program	16
10/25/18	Opioid Abuse/Narcan Training–Collaborated with Health Sciences Department.	15
11/7/18	Opioids Awareness–Peer2Peer Program	12
11/16/18	Opioids AwarenessPeer2Peer Program	7
11/16/18	Impact MC Stress Management Training–Leadership workshop training with Matt Frasca, retired MCPD and LGPC.	10
2/25/19	Opioid Use and Abuse Training–Peer2Peer	5
2/2019	Promoted participation in several City of Rockville “Rockville Goes Purple” initiative events to student service-learning courses and volunteer programs with posters and electronic communications	N/A
3/9/19	Career Pathways in Service Day: Mental Health First Aid Certification–Students participated in an eight-hour Mental Health First Aid certification.	32
3/11/19	Career Pathways in Service Day: Opioid overdose and substance abuse training–Watched the movie, *Heroin(e)*	23
3/30/19	Promoted Opioid Overdose Event with panel discussion and training hosted by City of Rockville at Rockville Campus with posters and electronic communications	100 reached
4/16/19	Opioid Use and Abuse Training–Peer2Peer	21
9/12/18	Club Rush Event fall and spring–The Mental Health Club had a tabling where it provided information about substance abuse that included opioids, advertisement for the opioids training in October, and other resource information	1000+
3/5/19	Club Rush Event fall and spring–The Mental Health Club had a tabling where it provided information about substance abuse that included opioids, advertisement for the opioids training in October, and other resource information.	500+
8/14/18	Inter-Club Council Meeting–Meet and Greet. Information and advertisement about the October 25, 2018 opioids training session were promoted. 39 clubs represented.	60
9/11/18	Inter-Club Council Meeting–Information and advertisement about the October 25, 2018, opioids training session were promoted. 47 clubs were represented.	54
10/2/18	Inter-Club Council Meeting. Information and advertisement about the October 25, 2018, opioids training session were promoted. 45 clubs were represented.	52
11/6/18	Student leaders who participated in the October 25, 2018, opioids training session conveyed their experiences and reflected on their participation. 45	64

ROCKVILLE CAMPUS		
DATE	**EVENT**	**ATTENDEES**
	clubs were represented	
11/6/18	Inter-Club Council Senior Leaders Team Meetings–During these leadership meetings the team developed, coordinated, and worked through efforts on how and who would promote the October 25, 2018, opioids training session	3
1/27/19	The Mental Health Club had a First Aid training event that included information about substance abuse regarding opioids, and other resource information.	20+
4/2/19	Substance Abuse Prevention Training–Collaborated with the Office of Student Life-Germantown, Montgomery County Collaborative Coalition, and the Department of Health and Human Services. Guest speakers and Narcan Training.	64
4/19/19	Opioid Use and Abuse Training–Peer2Peer Program	12
4/30/19	Opioid Use and Abuse Training–Peer2Peer Program	11
5/2/19	MC Lifesavers event with the MC Student Health and Wellness Center–Included information about mental health and stress management	40
5/9/19	Promoted HIV and STI Screening–Prevention and awareness with MC Student Health and Wellness Center and nonprofit Us Helping Us to student clubs and organizations.	N/A
4/18/18	Annual Health and Wellness Fair–Health and wellness assessments and information, HIV testing, blood pressure and depression screening, and substance dependency information.	300
4/10/18	Annual Health and Wellness Fair–Health and wellness assessments and information, HIV testing, blood pressure and depression screening, and substance dependency information.	300
6/12/19	New Student Orientation	24
7/9/19	New Student Orientation	91
1/30/18	Volunteer Fair–Substance Use and Mental Health Information tables with EveryMind, Montgomery County Health and Human Services, the MC Student Health and Wellness Center, and the Montgomery College Lifesavers	150
9/19/18	Give and Get Help Fair–Substance Use and Mental Health Information tables with EveryMind, Montgomery County Health and Human Services, the MC Student Health and Wellness Center, and the Montgomery College Lifesavers	250
2/6/19	Give and Get Help Fair–Substance Use and Mental Health Information tables with EveryMind, Montgomery County Health and Human Services, the MC Student Health and Wellness Center, and the Montgomery College Lifesavers	175

GERMANTOWN CAMPUS		
DATE	**EVENT**	**ATTENDEES**
9/19/17	Heroin and Opioid Information Table	13
10/12/17	Heroin and Opioid Information Table	12
11/6/17	Heroin and Opioid Information Table	11
10/24/18	Heroin and Opioid Information Table	48
11/29/18	Heroin and Opioid Information Table–Collaborated with MCPD	12
2/2019	Heroin and Opioid Information Table	16

GERMANTOWN CAMPUS		
DATE	**EVENT**	**ATTENDEES**
3/2019	Heroin and Opioid Information Table	13
3/21/18	Health and Wellness Fair–Representatives from Montgomery County, Crisis Center, General Outreach, STI Program and Narcotics Anonymous participated	75
10/12/17	National Collegiate Alcohol Awareness–DUI Simulator	80
4/19/18	National Collegiate Alcohol Awareness–DUI Simulator	51
4/25/18	Spring Fest–The end of the year barbeque for students, faculty and staff. A table is dedicated to providing information and handouts about alcohol and substance abuse.	200+
4/25/19	Spring Fest–The end of the year barbeque for students, faculty and staff. A table is dedicated to providing information and handouts about alcohol and substance abuse.	300
4/10/18	Substance Abuse Prevention Movie: *Written Off* o Discussion concentrating on certain populations of students (*e.g., athletes, student leaders, etc.*) o Collaborated with the Montgomery College Health Department o Counseling faculty led the discussion with two classes.	30+
10/29/18	Substance Abuse Prevention Event: "Speak Up, Save A Life": o Discussion concentrating on Heroin and Opioid and certain populations of students (e.g., athletes, student leaders, etc.) including expert speakers. o Collaborated with the Montgomery College Health Department and Athletics o Discussed Heroin and Opioid prevention.	62
4/2/19	Substance Abuse Prevention–"Know your Risks" Heroin and Opioid Forum & Narcan Training o Collaborated with the Office of Student Life-Germantown, Montgomery County Collaborative Coalition, and Montgomery County Department of Health and Human Services	64
2017-2018	HIV Testing–Once a month for school year	118
Fall 2018	HIV Testing–Once a month for school year	46
10/1/18	Compliance and Equity Fair–Student Life provided information about events focused on Substance Abuse Prevention.	36
6/22/17 7/19/17 8/8/17	Information on substance abuse prevent was provided during New Student Orientation (online and in-person)	160
8/25/17	Information on substance abuse prevention was provided during New Student Welcome Fair (online and in-person)	261
9/4-8/17	Information on substance abuse prevention was provided during Welcome Week and Student Life (front office and boards throughout the campus)	800+
6/12/19	Information on substance abuse prevention was provided during New Student Orientation (online and in-person)	69
7/9/19	Information on substance abuse prevention was provided during New Student Orientation (online and in-person)	92

Student Employment Services (SES)

2017–2018 Academic Year:

- SES coordinated with the MC Communications Office to email flyers and use social media to promote opioid addiction awareness events in 2017-2018 to all students, faculty, and staff.
- The collegewide Co-op program provided students educational information at all instructor lead sessions.
- SES staff attended Maryland Heroin and Opioid Emergency Task Force November 20, 2017, at the Takoma Park/Silver Spring Campus.

2018–2019 Academic Year:

- SES Team promoted the April 2, 2019, "Know the Risks of Opioid Forum" to students through the SES Centers.
- The SES team attended the "Know the Risks Opioid Forum" so they could better educate and assist students.
- The collegewide Co-op program provided opioid awareness training to students enrolled in the Co-op program.

Collegewide Athletics

Substance Abuse Prevention and Education discussions were included in the Department of Athletics Student Athlete Mandatory Orientation workshops during 2017–2018 and 2018–2019 academic years. The sport medicine staff provided valuable information to the student-athletes. The purpose of the presentation was to discourage the use of illegal drugs and the abuse of legal drugs and dietary supplements by the student athletes. Additionally, the staff discussed the abuse of alcohol and power/energy drinks. The student athletes were provided with information to contact Athletic Department staff/coaches, or campus resources if they feel they need assistance with any substance abuse issue.

Drug/Alcohol Training FY 2017/2018

Date	Campus	Attendance
8/16/17	Rockville	64
10/4/17	Rockville	27
2/27/18	Rockville	60
Total		151

2017/2018 Evaluation	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	**Total**
I have a better understanding of drug and alcohol abuse.	4	1	9	20	88	122

Student Athlete Mandatory Orientation–Dates and Attendance

Date	Campus	Attendance
10/4/18	Rockville	28
2/22/19	Rockville	51
4/2/19	Germantown*	12
Total		91

***** Opioid Prevention Forum

2018/2019 Evaluation	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	**Total**
I have a better understanding of drug and alcohol abuse.	0	0	2	6	71	79

Drug Free Sport administers comprehensive drug-testing programs, manages national and international collections, develops drug-testing policies, and provides educational services to their members. We are paying for a subscription through our NJCAA membership this year. The athletic director contacted them to get information on how they can supplement our student-athlete training and to get more information regarding using their database and other services (to include drug testing).

SHaW CENTER ACTIVITIES				
ACTIVITY	DESCRIPTION	DATE/TIME/ LOCATION	AUDIENCE	ATTENDANCE
Peer Educator Training the Trainer	Training peer educators on Opioid presentation and how to then present that to Montgomery College students	Wednesday, March 14, 2018 Time: 11 a.m.–1 p.m. Location: CT Building	Peer2Peer Educators	6
Mental Health First Aid	Evidence-based certification program on how to recognize and respond to someone who may be having a mental health crisis	Wednesday, June 6, 2018 Time: 8 a.m.–5 p.m. Location: CT Building	Faculty and staff	18
Mental Health First Aid	Evidence-based certification program on how to recognize and respond to someone who may be having a mental health crisis	Friday, June 8, 2018 Time: 9 a.m.–5 p.m. Location: Germantown	Faculty and staff	12
Mental Health First Aid	Evidence-based certification program on how to recognize and respond to someone who may be having a mental health crisis	Wednesday, August 22, 2018 Time: 8 a.m.–5 p.m. Location: Takoma Park/Silver Spring	Faculty and staff	7

SHaW CENTER ACTIVITIES				
ACTIVITY	DESCRIPTION	DATE/TIME/ LOCATION	AUDIENCE	ATTENDANCE
Technology, Entertainment, and Design (TED) Talks on Recovery	Showed two Technology, Entertainment, and Design (TED) Talks from individuals in recovery who tell their stories, and provide resource information from BornFree Wellness	Thursday, September 20, 2018 Time: Noon–1 p.m. Location: Germantown	Faculty, staff, and students	5
The Voices of Recovery	Speaker event in conjunction with Kolmac, individuals in recovery tell their stories, provide resource information *Moved to online/YouTube	Thursday, September 27, 2018 Time: 11 a.m.–1 p.m. Location: Rockville	Faculty, staff, and students	25 views
Peer Educator Training the Trainer	Training peer educators on Opioid presentation and how to then present that to Montgomery College students	Tuesday, October 2, 2018 Time: 3:30 p.m.–5 p.m. Location: CT Building	Peer2Peer Educators	2
Mental Health First Aid	Evidence-based certification program on how to recognize and respond to someone who may be having a mental health crisis	Sunday, October 14, 2018 Time: 8 a.m.–5 p.m. Location: Takoma Park/Silver Spring	Mental Health Club Students	7
Mental Health First Aid	Evidence-based certification program on how to recognize and respond to someone who may be having a mental health crisis	Wednesday, January 16, 2019 Time: 8 a.m.–5 p.m. Location: Germantown	Faculty and staff	6
Mental Health First Aid	Evidence-based certification program on how to recognize and respond to someone who may be having a mental health crisis	Sunday, January 27, 2019 Time: 8 a.m.–5 p.m. Location: Rockville	Mental Health Club Students	4
Mental Health First Aid	Evidence-based certification program on how to recognize and respond to someone who may be having a mental health crisis	Tuesdays, February 26 and March 5, 2019 Time: 1 p.m.–5 p.m. Location: Rockville	Faculty and staff	13
Mental Health First Aid	Evidence-based certification program on how to recognize and respond to someone who	Saturday, March 9, 2019 Time: 9 a.m.–6 p.m. Location: Takoma Park/Silver Spring	Students	30

SHaW CENTER ACTIVITIES				
ACTIVITY	DESCRIPTION	DATE/TIME/ LOCATION	AUDIENCE	ATTENDANCE
	may be having a mental health crisis			
Mental Health First Aid	Evidence-based certification program on how to recognize and respond to someone who may be having a mental health crisis	Monday and Tuesday, May 20 and 21, 2019 Time: 9 a.m.–1 p.m. Location: Steinbruck Center, DC	Alternative Summer Break Students	21
Mental Health First Aid	Evidence-based certification program on how to recognize and respond to someone who may be having a mental health crisis	Thursday May 30, 2019 Time: 8 a.m.–5 p.m. Location: CT Building	Faculty and staff	14
Mental Health First Aid	Evidence-based certification program on how to recognize and respond to someone who may be having a mental health crisis	Thursday, June 6, 2019 Time: 8 a.m.–5 p.m. Location: Germantown	Faculty and staff	19
Mental Health First Aid	Evidence-based certification program on how to recognize and respond to someone who may be having a mental health crisis	Wednesday June 12, 2019 Time: 8 a.m.-5 p.m. Location: Takoma Park/Silver Spring	Faculty and staff	10
Mental Health First Aid	Evidence-based certification program on how to recognize and respond to someone who may be having a mental health crisis	Tuesday June 18, 2019 Time: 8 a.m.-5 p.m. Location: Rockville	Faculty and staff	15

Drug/Alcohol Abuse Prevention Program for Employees

Employee Education and Notification Procedures

In accordance with Section III of College Policy and Procedure 31005, Drug and Alcohol Abuse Prevention, drug and alcohol education programs for employees are primarily provided through the Office of Human Resources and Strategic Talent Management. The mission is to promote responsible decision making regarding alcohol and drug use to students and employees through educational programs and other resources. Educational information is disseminated through workshops and training seminars, new employee orientation, Staff Enrichment Day, the intranet, and flyers placed on bulletin boards on all campuses. Current employees are notified via email of the Drug and Alcohol Abuse Prevention Policy twice per year at the beginning of the fall and spring semesters. Additional information on the College's Policy and Procedure 31005 mentioned periodically in this section can be accessed at: www.montgomerycollege.edu/policies-and-procedures

Drug/Alcohol Education Presentations

These presentations deliver information on alcohol and drug use to employees via a lecture and other interactive activities. The objectives of the program are to:

- Discuss the harmful effects of substance abuse,
- Explain the college's substance abuse policy; and
- Provide the consequences for violating the policy and to describe how employees can get help for substance abuse problems.

Presentations are delivered to College employees at training seminars, department meetings and workshops.

This information is also provided to employees when meeting with them on an individual basis to provide them with resources at the College to manage their medical conditions and stress related situations. At least 15 employees a week will ask to be provided with these resources.

DATE	EVENT	ATTENDEES
2017	MC Learns Drug and Alcohol Abuse Prevention Awareness	8
2018	MC Learns Drug and Alcohol Abuse Prevention Awareness	7
2019	MC Learns Drug and Alcohol Abuse Prevention Awareness	3
October 2–5, 2017	Compliance Fairs	Not tracked
October 1–4, 2018	Compliance Fairs	425
October 2, 2018	Ask HR Sessions	12
October 4, 2018	Ask HR Sessions	6
October 11, 2018	Ask HR Sessions	8
October 17, 2018	Ask HR Sessions	9

Faculty Staff Assistance Program

Employees that need assistance are referred to Section III of College Policy and Procedure 35002, Faculty Staff Assistance Program (FSAP). The FSAP is a voluntary, confidential assistance program available 24 hours a day, 7 days a week, and 365 days a year at no cost to employees. The FSAP provides telephonic and face-to-face sessions. It has licensed masters-level Employee Assistance Program specialists answering calls. It has a diverse and credentialed national and international affiliate network to provide face-to-face sessions. The FSAP provides short-term, solution-focused interventions and consultations. Additional information on the Faculty Staff Assistance Program can be accessed at: www.montgomerycollege.edu/policies-and-procedures

In 2017 there were 240 contacts made–0 were related to issues with alcohol
In 2018 there were 206 contacts made–0 were related to issues with alcohol
In 2019 there were 141 employee contacts made–3 were related to issues with alcohol

Tip Sheets

Tip sheets on topics related to substance abuse prevention are placed on bulletin boards on all three campuses and at eight satellite locations throughout Montgomery College. These tip sheets are also featured on Inside MC Online, which is an online newsletter that is accessible to all

employees and students. The tip sheets are run twice a month for the entire year. There have been over 822 “reads” on these topics:

- Alcoholism in the Workplace: A Managers Role
- Alcohol and the Family
- What Do You Know About Alcohol and Drugs?

Samples of tip sheets related to alcohol abuse has been provided in Appendix C.

New Employee Orientation

New employees are provided with a hard copy of College Policy and Procedure 31005, Drug and Alcohol Abuse Prevention. New employees are advised that short-term counseling is available to employees and eligible dependents at no cost via the Faculty Staff Assistance Program. A list of resources in the community related to substance abuse prevention and treatment is also provided to all new employees.

- New Staff Orientation–80 in FY 2018 (orientation is every other week)
- New Staff Orientation–89 in FY 2019 (orientation is every other week)
- Full-Time Faculty Orientation in FY 2018–22 attended
- New Supervisor Orientation–March 1 and March 29, 2019 (two-day orientation)–11 attended
- New Supervisor Orientation–June 5 and June 6, 2019 (two-day orientation)–20 attended

Staff Enrichment Day

Staff Enrichment Day is a day set aside to celebrate staff and to provide them with a wide variety of programs that will enrich their lives. Employees can attend workshops on various subjects of interest to them. Every year two workshops on Drug and Alcohol Abuse Prevention are offered to employees.

Workshop Objectives:

- Have a clear understanding of the Drug and Alcohol Abuse Prevention Policy and Procedure at Montgomery College
- Understand the supervisor’s responsibilities in maintaining a drug-free workplace
- Understand the effects of drugs and alcohol
- Know that help is available
- Identify resources for assistance with substance abuse problems

DATE	EVENT	ATTENDEES
March 13, 2018	Trabaja Inteligentemente: Equilibrar Trabajo ey Familia (Work Smart: Balance Work and Family)	32
March 12, 2019	Injury Reporting and Prevention a.m. session	9
	Injury Reporting and Prevention p.m. session	7
	Manejo de Riesgos y Permisos Laborales (Risk Management and Labor Policies p.m. session)	25

Prevention of Workplace Violence Workshops

In accordance with Section III of College Policy and Procedure 31011, Prevention of Bullying and Workplace Violence, approximately 17 managers and supervisors attended a Prevention of Workplace Violence training session offered on April 7, 2017. Information on the drug and alcohol abuse prevention policy and procedure, tools to recognize the signs of substance abuse, and the resources available to manage these situations are discussed at length with attendees. Real-life scenarios and case studies are presented and discussions are encouraged. Employees leave feeling empowered to manage these situations, knowledge of the policy, and how to get assistance as needed. Additional information on College policy and procedure 31011 can also be accessed at: www.montgomerycollege.edu/policies-and-procedures.

Employee Handbook

The employee handbook is provided to all new employees during orientation. The employee handbook is also available to all employees on the Human Resources website at: info.montgomerycollege.edu/offices/human-resources/.

The Drug and Alcohol Abuse Prevention Policy is published in the employee handbook along with community resources to address issues related to drug and alcohol abuse. New employees receive a summary of the College's drug-free workplace policy and sign a statement that confirms they received it when they complete their packet of new hire paperwork.

Appendix D contains a description of commonly abused drugs and health risks associated with the use of illicit drugs and abuse of alcohol and Appendix E contains information on alcohol and cancer risks.

For more detailed information concerning Montgomery College programs for students and employees to prevent drug/alcohol abuse, please consult the Drug-Free Schools and Community Act Biennial Review at: www.montgomerycollege.edu/heoa/.

Part Two: Policy Statement, Notification Process, and Sanctions

Policy on Drug and Alcohol Abuse Prevention

On May 15, 1989, the College's Board of Trustees underscored its commitment to drug and alcohol abuse prevention by adopting Policy and Procedure 31005 which states:

I. "The Board of Trustees is committed to the education of students, employees, and community members regarding substance abuse prevention, detection, and treatment services; to the continuation of a collegewide substance abuse prevention program and other ongoing efforts which will foster such education; and to the maintenance of a drug-free environment throughout the College.
II. The unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited at Montgomery College.
III. College students and employees are subject to appropriate disciplinary action for violation of this policy, in accordance with College policies and procedures regarding employee discipline and discharge and in accordance with the student code of conduct.
IV. The College president is authorized to establish procedures to implement this policy."

Notification Procedure and Standards of Conduct for Employees

Section III of College Policy and Procedure 31000, Code of Ethics and Employee Conduct, which can be accessed at: www.montgomerycollege.edu/policies-and-procedures states:

A. Notification to all employees at the time of hire and annually thereafter through handbooks and other informational means:

- The College's policy on drug and alcohol abuse prevention;
- Possession, use, or distribution of unlawful drugs and alcohol on its property or as part of any of its activities is prohibited;
- The College will impose disciplinary sanctions on students and employees for violations of the policy, up to and including expulsion or termination of employment;
- The availability of counseling services available through the Faculty/Staff Assistance Program for those who voluntarily seek assistance;
- Educational opportunities and training programs available for all students and employees concerning the adverse effects of alcohol and drug abuse and the identification of behaviors and conduct that may be indicative of alcohol and drug abuse; and
- Treatment options available locally.

Standards of Conduct for Employees

A. Employees should report for work fit for duty and free of any adverse effects of illegal drugs or alcohol. This does not prohibit employees from the lawful use and possession of prescribed medications. Employees must however, consult with their physicians about the medication's effect on their fitness for duty and the ability to work safely and promptly disclose restrictions to their supervisor. Employees should not however, disclose underlying medical conditions to supervisors, but should do so to the HIPPA Privacy Official in the Office of Human Resources and Strategic Talent Management.

B. The unlawful manufacture, sale, distribution, dispensing, possession or use of controlled substances, and the unlawful use or abuse (e.g., being intoxicated) of alcohol by anyone on College property (including any facilities leased or used by the College) or in College vehicles is prohibited. The use of alcohol by anyone under 21 years of age or the abuse of alcohol by anyone at any College sponsored or supervised activity off campus is also prohibited.

C. Notification of Criminal Conviction

1. As required by the Drug-Free Workplace Act of 1988, the Drug-Free Schools and Communities Act Amendments, the Maryland Higher Education Commission's Policies Concerning Drug and Alcohol Abuse Control, and as a condition of employment, employees must abide by the terms of this procedure and notify the Office of Human Resources and Strategic Talent Management in writing, of any criminal drug statute conviction for a violation occurring on or off Montgomery College property, no later than five calendar days after such conviction. Lack of compliance with these requirements may subject the employee to immediate disciplinary action, up to and including dismissal.

2. Upon receipt of notification of a conviction, the College will take the following actions as required by law:

   - Notify the appropriate federal agencies of such convictions; and
   - Take appropriate personnel action against the employee, up to and including termination; and/or
   - Require the employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a federal, state or local health, law enforcement, or other appropriate agency.

D. Consequences of Alcohol and Drug Abuse

1. The unlawful manufacture, distribution, use, sale, or possession (e.g., on the person or in a desk, or vehicle) of illegal drugs or of opened alcohol while on the job or on College leased or owned property is a dismissible offense and may result in criminal prosecution. Any illegal drugs found will be turned over to the appropriate law enforcement agency.

2. The illegal use or abuse of alcohol on campus or as a part of any College activity whether on College leased or owned property is prohibited in accordance with all applicable federal, state, and local laws and the Drug and Alcohol Abuse Prevention Policy. In addition to possible prosecution under the aforementioned laws, employees who violate the prohibitions of this policy are subject to College imposed disciplinary sanctions consistent with applicable procedures and regulations. Sanctions may include, but need not be limited to: suspension, termination of employment, or referral to appropriate authorities for prosecution. Any disciplinary sanction imposed may also include the completion of an appropriate rehabilitation program as a condition of reinstatement or continued employment.

Code of Conduct for Students

Students are expected to abide by College Policy and Procedure 42001, Student Code of Conduct which can be accessed at: www.montgomerycollege.edu/policies-and-procedures. This policy states:

A. The unlawful manufacture, sale, distribution, dispensing, possession or use of controlled substances, and the unlawful use or abuse (e.g., being intoxicated) of alcohol by students on College property (including any facilities leased or used by the College) or in College vehicles is prohibited. The use of alcohol by anyone under 21 years of age or the abuse of alcohol by students at any College sponsored or supervised activity off campus is also prohibited.

B. Consequences of Alcohol and Drug Abuse

1. The unlawful manufacture, distribution, use, sale, or possession (e.g., on the person or in a desk, or vehicle) of illegal drugs or of opened alcohol while on College leased or owned property may result in criminal prosecution. Any illegal drugs found will be turned over to the appropriate law enforcement agency.

2. The illegal use or abuse of alcohol on campus or as a part of any College activity whether on College leased or owned property is prohibited in accordance with all applicable Federal, State and local laws and the Drug and Alcohol Abuse Prevention Policy. In addition to possible prosecution under the aforementioned laws, students

who violate the prohibitions of this policy are subject to College imposed disciplinary sanctions consistent with applicable procedures and regulations. Sanctions may include, but need not be limited to: dismissal, suspension, disciplinary probation, community service, or referral to appropriate authorities for prosecution. Any disciplinary sanction imposed may also include the completion of an appropriate rehabilitation program as a condition of reinstatement or continued enrollment.

3. The dean of student affairs or designated instructional dean of Workforce Development and Continuing Education should be informed in writing about any situation that should be addressed through the formal disciplinary process. The faculty or staff member will provide the dean of student development with a written summary of the facts or conduct on which the referral is based within 48 hours of the incident for appropriate and effective disciplinary process, which must include the date, time, place, and a description of the incident.

Local, State, and Federal Sanctions

Students and employees are subject to federal, state, and local laws for the possession, use and distribution of illegal drugs. Federal law states that it is unlawful to possess controlled substances including cannabis, cocaine, LSD, PCP, heroin, designer drugs, etc. Possession and use of medical cannabis is a violation of the federal Controlled Substances Act, and compliance with Maryland State medical cannabis laws is not a legal defense to a violation of federal law.[1] The U.S. Department of Justice (DOJ) has the authority to enforce federal cannabis laws, even in states with authorized medical cannabis programs. If the substance is cocaine, or contains a cocaine base, the penalty for simple possession is a fine and/or imprisonment from 5 to 20 years.

For other illegal drugs, the penalty for simple possession is a fine of at least $1,000 and/or imprisonment up to three years. The penalties increase if the possession includes intent to manufacture, distribute, or dispense a controlled substance, especially if done near a public or private elementary, vocational, or secondary school or a public or private College or university. Additionally, any person who violates this law shall be liable for an amount up to $10,000 in civil penalties. Federal drug trafficking penalties are captured in Tables 1 and 2 on the following pages:

[1] Federal Law 21 USCA/sections 841 and 844 to 845a (1990)

Table 1

FEDERAL TRAFFICKING PENALTIES

DRUG/SCHEDULE	QUANTITY	PENALTIES	QUANTITY	PENALTIES
Cocaine (Schedule II)	500–4999 grams mixture	**First Offense:** Not less than 5 yrs, and not more than 40 yrs. If death or serious injury, not less than 20 or more than life. Fine of not more than $5 million if an individual, $25 million if not an individual. **Second Offense:** Not less than 10 yrs, and not more than life. If death or serious injury, life imprisonment. Fine of not more than $8 million if an individual, $50 million if not an individual.	5 kgs or more mixture	**First Offense:** Not less than 10 yrs, and not more than life. If death or serious injury, not less than 20 or more than life. Fine of not more than $10 million if an individual, $50 million if not an individual. **Second Offense:** Not less than 20 yrs, and not more than life. If death or serious injury, life imprisonment. Fine of not more than $20 million if an individual, $75 million if not an individual. **2 or More Prior Offenses:** Life imprisonment. Fine of not more than $20 million if an individual, $75 million if not an individual.
Cocaine Base (Schedule II)	28–279 grams mixture		280 grams or more mixture	
Fentanyl (Schedule II)	40–399 grams mixture		400 grams or more mixture	
Fentanyl Analogue (Schedule I)	10–99 grams mixture		100 grams or more mixture	
Heroin (Schedule I)	100–999 grams mixture		1 kg or more mixture	
LSD (Schedule I)	1–9 grams mixture		10 grams or more mixture	
Methamphetamine (Schedule II)	5–49 grams pure or 50–499 grams mixture		50 grams or more pure or 500 grams or more mixture	
PCP (Schedule II)	10–99 grams pure or 100–999 grams mixture		100 gm or more pure or 1 kg or more mixture	

		PENALTIES
Other Schedule I & II drugs (and any drug product containing Gamma Hydroxybutyric Acid)	Any amount	**First Offense:** Not more than 20 yrs. If death or serious injury, not less than 20 yrs, or more than life. Fine $1 million if an individual, $5 million if not an individual. **Second Offense:** Not more than 30 yrs. If death or serious bodily injury, life imprisonment. Fine $2 million if an individual, $10 million if not an individual.
Flunitrazepam (Schedule IV)	1 gram	
Other Schedule III drugs	Any amount	**First Offense:** Not more than 10 years. If death or serious injury, not more that 15 yrs. Fine not more than $500,000 if an individual, $2.5 million if not an individual. **Second Offense:** Not more than 20 yrs. If death or serious injury, not more than 30 yrs. Fine not more than $1 million if an individual, $5 million if not an individual.
All other Schedule IV drugs	Any amount	**First Offense:** Not more than 5 yrs. Fine not more than $250,000 if an individual, $1 million if not an individual. **Second Offense:** Not more than 10 yrs. Fine not more than $500,000 if an individual, $2 million if other than an individual.
Flunitrazepam (Schedule IV)	Other than 1 gram or more	
All Schedule V drugs	Any amount	**First Offense:** Not more than 1 yr. Fine not more than $100,000 if an individual, $250,000 if not an individual. **Second Offense:** Not more than 4 yrs. Fine not more than $200,000 if an individual, $500,000 if not an individual.

Table 2

FEDERAL TRAFFICKING PENALTIES—MARIJUANA

DRUG	QUANTITY	1st OFFENSE	2nd OFFENSE *
Marijuana (Schedule I)	1,000 kg or more marijuana mixture; or 1,000 or more marijuana plants	Not less than 10 yrs. or more than life. If death or serious bodily injury, not less than 20 yrs., or more than life. Fine not more than $10 million if an individual, $50 million if other than an individual.	Not less than 20 yrs. or more than life. If death or serious bodily injury, life imprisonment. Fine not more than $20 million if an individual, $75 million if other than an individual.
Marijuana (Schedule I)	100 kg to 999 kg marijuana mixture; or 100 to 999 marijuana plants	Not less than 5 yrs. or more than 40 yrs. If death or serious bodily injury, not less than 20 yrs. or more than life. Fine not more than $5 million if an individual, $25 million if other than an individual.	Not less than 10 yrs. or more than life. If death or serious bodily injury, life imprisonment. Fine not more than $20 million if an individual, $75million if other than an individual.
Marijuana (Schedule I)	More than 10 kgs hashish; 50 to 99 kg marijuana mixture More than 1 kg of hashish oil; 50 to 99 marijuana plants	Not more than 20 yrs. If death or serious bodily injury, not less than 20 yrs. or more than life. Fine $1 million if an individual, $5 million if other than an individual.	Not more than 30 yrs. If death or serious bodily injury, life imprisonment. Fine $2 million if an individual, $10 million if other than an individual.
Marijuana (Schedule I)	Less than 50 kilograms marijuana (but does not include 50 or more marijuana plants regard-less of weight) 1 to 49 marijuana plants;	Not more than 5 yrs. Fine not more than $250,000, $1 million if other than an individual.	Not more than 10 yrs. Fine $500,000 if an individual, $2 million if other than individual.
Hashish (Schedule I)	10 kg or less		
Hashish Oil (Schedule I)	1 kg or less		

*The minimum sentence for a violation after two or more prior convictions for a felony drug offense have become final is a mandatory term of life imprisonment without release and a fine up to $20 million if an individual and $75 million if other than an individual.

The state of Maryland has its own laws dealing with distribution, manufacturing, and possession of controlled substances. Detailed information on the Maryland criminal statutes regarding drug law violations and penalties may be obtained at govt.westlaw.com/mdc.

An Overview of the More Common Offenses

Possession for Personal Use in Maryland marijuana is listed as a Schedule I controlled hallucinogenic substance. Simple possession (possession without the intent to distribute) of less than 10 grams in Maryland is a civil offense (fine not exceeding $100 for first-time offenders, $250 for second-time offenders, and $500 for third or subsequent offenders). Possession of between 10 grams and less than 50 pounds of marijuana is a misdemeanor with a punishment of up to one-year imprisonment and a fine not exceeding $1,000. Possession of 50 pounds or more of marijuana carriers a punishment of a minimum of five years imprisonment and a fine not exceeding $100,000. Offenses involving the use of marijuana in public carries a civil fine of up to $500. Possession with intent to distribute less than 50 pounds of marijuana in Maryland is a felony with a punishment of up to five years imprisonment and a fine not exceeding $15,000. If a person is found to be in possession of 50 pounds or more of marijuana (acts in proceeding 90 days can be aggregated), then the punishment for this felony is imprisonment of not less than five years, and a fine not exceeding $100,000. Possessing marijuana with the intent to distribute in a school, vehicle, or in, on, or within 1,000 feet of real property owned by or leased to an elementary school or secondary school, is a felony, and is punishable by, for a first violation, imprisonment not

exceeding 20 years, and a fine not exceeding $20,000, and for each subsequent violation, imprisonment not less than five years, and not exceeding 40 years, and a fine not exceeding $40,000. These penalties are in addition to any other conviction. If an offender has been previously convicted of possession with intent to distribute, then there is a mandatory minimum sentence of two years. If an individual is found to be a "drug kingpin" (an organizer, supervisor, financier, or manager, who acts as a co-conspirator in a conspiracy to manufacture, distribute, dispense, transport in, or bring into the state a controlled dangerous substance), and dealt with 50 pounds or more of marijuana, then they are guilty of a felony, and subject to imprisonment for not less than 20 years and not exceeding 40 years without the possibility of parole, and a fine not exceeding $1,000,000. If an adult uses or solicits a minor in a conspiracy to distribute, deliver or manufacture marijuana, then the adult is guilty of a felony and is subject to imprisonment not exceeding 20 years or a fine not exceeding $20,000.

Under Maryland law, paraphernalia includes all equipment and materials used in the use, manufacture, or distribution of marijuana. This includes all agricultural materials used in the growing process, including electronic equipment and typical gardening supplies, such as lights, fertilizer, and top soil. §5-101 also includes under its definition items such as scales, plastic bags, and others used in the distribution process. Hash bubble sacks are paraphernalia. These items are joined by the typical forms of paraphernalia involved in the ingestion of marijuana, including pipes, bongs, and roach clips. Rolling papers and blunt wraps are not included under the statutory definition. Possession of marijuana-related paraphernalia is a civil violation. If a person is convicted of selling drug paraphernalia, then they are guilty of a misdemeanor and can be sentenced, for a first violation, a fine not exceeding $500, and for each subsequent violation, imprisonment not exceeding two years and a fine not exceeding $2,000. If a person is caught with possession of controlled paraphernalia and marijuana, then they are guilty of a misdemeanor and subject to imprisonment not exceeding one year and a fine not exceeding $1,000.

Mandatory Minimum Maryland has a mandatory minimum sentence for:

- repeat offenders who have been convicted of possession to distribute on two or more occasions (2 years),
- repeat offenders who have previously been convicted of possession with intent to distribute within 1,000 feet of a school on two or more occasions (5 years),
- any offender convicted of possessing 50 pounds or more of marijuana, including any acts of possession within the last 90 days (5 years),
- any offender convicted of being a "drug kingpin" who dealt in more than 50 pounds of marijuana (20 years),
- any offender who is in possession of a firearm at the time they are arrested for trafficking marijuana into MD (10 years).

There are no local laws in the jurisdictions where Montgomery College is located dealing with distribution, manufacturing, and possession of controlled substances, those jurisdictions recognize Maryland law.

Students and employees are subject to state and local laws for drinking and obtaining alcohol. It is illegal in the state of Maryland for any person under 21 to drink alcohol[2]. It is also illegal for a person under 21 to falsify or misrepresent his or her age to obtain alcohol, or to possess alcoholic beverages with the intent to consume them[3]. It is also illegal in most situations to furnish alcohol to a person under 21[4]. The penalty is a fine of up to $2,500 for a first offense, and up to $5,000 for

[2] *Md. Code Criminal Art. Section 10-114*
[3] *Md. Code Criminal Art Section 10-113*
[4] *Md. Code Criminal Art. Section 10-117*

repeat offenses[5]. Local alcohol laws for the jurisdictions where Montgomery College is located are primarily directed toward distribution, allowances, and licensing etc.

Sanctions

Student Sanctions

The chart on the following page shows the student cases involving drug/alcohol incidents reported in 2017–2018 and 2018–2019 academic years.

Student Cases Involving Drug/Alcohol Incidents

Campus	Date	Adult	Juvenile	Outcome
Germantown	2017–2018	2	0	One student conduct referral involving alcohol and one student conduct referral for possession of drug paraphernalia
	2018–2019	0	0	
Rockville	2017–2018	1	0	One student conduct referral involving alcohol.
	2018–2019	0	0	
Takoma Park/Silver Spring	2017–2018	1	0	One student conduct referral involving alcohol
	2018–2019	1	0	One student conduct referral involving alcohol

**Note: During the entire 2018 calendar year (Jan. 1 to Dec 31) there were no referrals for students involving drugs or alcohol.*

Employee Sanctions

There were no sanctions related to substance abuse on 2018 or 2019.

[5] *Md. Code Criminal Art. Section 10-121*

Part Three: Health Risks

HEALTH RISKS OF DRUGS AND ALCOHOL

DRUGS' EFFECTS ON THE BODY

*Source: Drugs of Abuse, U.S. Department of Justice Drug Enforcement Administration Resource Guide, 2017 Edition (See full report in **Appendix F**)*

All controlled substances have abuse potential or are immediate precursors to substances with abuse potential. Below is information about how drugs can affect the human mind and body.

Narcotics (Fentanyl, Heroin, Hydromorphone, Methadone, Morphine, Opium, Oxycodone)

- Effect on the Mind: Besides their medical use, narcotics/opioids produce a general sense of well-being by reducing tension, anxiety, and aggression. These effects are helpful in a therapeutic setting but contribute to the drugs' abuse. Narcotic/opioid use comes with a variety of unwanted effects, including drowsiness, inability to concentrate, and apathy.
- Effect on the Body: Narcotics/opioids are prescribed by doctors to treat pain, suppress cough, cure diarrhea, and put people to sleep. Effects depend heavily on the dose, how it's taken, and previous exposure to the drug. Negative effects include
  - slowed physical activity, constriction of the pupils, flushing of the face and neck, constipation, nausea, vomiting, and slowed breathing.

As the dose is increased, both the pain relief and the harmful effects become more pronounced. Some of these preparations are so potent that a single dose can be lethal to an inexperienced user.

However, except in cases of extreme intoxication, there is no loss of motor coordination or slurred speech.

Simulants (Amphetamines, Cocaine, Khat, Methamphetamine)

- Effect on the Mind: When used as drugs of abuse and not under a doctor's supervision, stimulants are frequently taken to:
  - produce a sense of exhilaration, enhance self-esteem, improve mental and physical performance, increase activity, reduce appetite, extend wakefulness for prolonged period, and "get high"

Chronic, high-dose use is frequently associated with agitation, hostility, panic, aggression, and suicidal or homicidal tendencies.

Paranoia, sometimes accompanied by both auditory and visual hallucinations, may also occur.

Tolerance, in which more and more drug is needed to produce the usual effects, can develop rapidly, and psychological dependence occurs. In fact, the strongest psychological dependence observed occurs with the more potent stimulants, such as amphetamine, methylphenidate, methamphetamine, cocaine, and methcathinone.

Abrupt cessation is commonly followed by depression, anxiety, drug craving, and extreme fatigue, known as a "crash."

- Effect on the Body: Stimulants are sometimes referred to as uppers and reverse the effects of fatigue on both mental and physical tasks. Therapeutic levels of stimulants can produce exhilaration, extended wakefulness, and loss of appetite. These effects are greatly intensified when large doses of stimulants are taken. Taking too large a dose at one time

or taking large doses over an extended period of time may cause such physical side effects as:

- Dizziness, tremors, headache, flushed skin, chest pain with palpitations, excessive sweating, vomiting, and abdominal cramps.

Depressants (Barbiturates, Benzodiazepines, GHB, Rohypnol)

- Effect on the Mind: Depressants used therapeutically do what they are prescribed for:
  - to induce sleep, relieve anxiety and muscle spasms, and prevent seizures.

They also:

- cause amnesia, leaving no memory of events that occur while under the influence, reduce reaction time, impair mental functioning and judgment, and cause confusion.

Long-term use of depressants produces psychological dependence and tolerance.

- Effect on the Body: Some depressants can relax the muscles. Unwanted physical effects include:
  - slurred speech, loss of motor coordination, weakness, headache, lightheadedness, blurred vision, dizziness, nausea, vomiting, low blood pressure, and slowed breathing

Prolonged use of depressants can lead to physical dependence even at doses recommended for medical treatment. Unlike barbiturates, large doses of benzodiazepines are rarely fatal unless combined with other drugs or alcohol. But unlike the withdrawal syndrome seen with most other drugs of abuse, withdrawal from depressants can be life threatening.

Hallucinogens (Ecstasy/MDMA, Ketamine, LSD, Peyote and Mescaline, Psilocybin)

- Effect on the Mind: Sensory effects include perceptual distortions that vary with dose, setting, and mood. Psychic effects include distortions of thought associated with time and space. Time may appear to stand still, and forms and colors seem to change and take on new significance. Weeks or even months after some hallucinogens have been taken, the user may experience flashbacks—fragmentary recurrences of certain aspects of the drug experience in the absence of actually taking the drug. The occurrence of a flashback is unpredictable, but is more likely to occur during times of stress and seems to occur more frequently in younger individuals. With time, these episodes diminish and become less intense.

- Effect on the Body: Physiological effects include elevated heart rate, increased blood pressure, and dilated pupils.

Marijuana/Cannabis

- Effect on the Mind: When marijuana is smoked, the tetrahydrocannabinol (THC) passes from the lungs and into the bloodstream, which carries the chemical to the organs throughout the body, including the brain. In the brain, the THC connects to specific sites called cannabinoid receptors on nerve cells and influences the activity of those cells. Many of these receptors are found in the parts of the brain that influence:
  - pleasure, memory, thought, concentration, sensory and time perception, and coordinated movement

The short-term effects of marijuana include:

- problems with memory and learning, distorted perception, difficulty in thinking and problem-solving, and loss of coordination

The effect of marijuana on perception and coordination are responsible for serious impairments in learning, associative processes, and psychomotor behavior (driving abilities). Long-term, regular use can lead to physical dependence and withdrawal following discontinuation, as well as psychic addiction or dependence.

Clinical studies show that the physiological, psychological, and behavioral effects of marijuana vary among individuals and present a list of common responses to cannabinoids, as described in the scientific literature:

- Dizziness, nausea, tachycardia, facial flushing, dry mouth, and tremor initially
- Merriment, happiness, and even exhilaration at high doses
- Disinhibition, relaxation, increased sociability, and talkativeness
- Enhanced sensory perception, giving rise to increased appreciation of music, art, and touch
- Heightened imagination leading to a subjective sense of increased creativity
- Time distortions
- Illusions, delusions, and hallucinations are rare except at high doses
- Impaired judgment, reduced coordination, and ataxia, which can impede driving ability or lead to an increase in risk taking behavior
- Emotional lability, incongruity of affect, dysphoria, disorganized thinking, inability to converse logically, agitation, paranoia, confusion, restlessness, anxiety, drowsiness, and panic attacks may occur, especially in inexperienced users or in those who have taken a large dose
- Increased appetite and short-term memory impairment are common

- Effect on the Body: Short-term physical effects from marijuana use may include:
  - sedation, bloodshot eyes, increased heart rate, coughing from lung irritation, increased appetite, and decreased blood pressure

Marijuana smokers experience serious health problems such as bronchitis, emphysema, and bronchial asthma. Extended use may cause suppression of the immune system. Withdrawal from chronic use of high doses of marijuana causes physical signs including headache, shakiness, sweating, and stomach pains and nausea.

Withdrawal symptoms also include behavioral signs such as:

- Restlessness, irritability, sleep difficulties, and decreased appetite.

Steroids

- Effect on the Mind: Case studies and scientific research indicate that high doses of anabolic steroids may cause mood and behavioral effects. In some individuals, steroid use can cause dramatic mood swings, increased feelings of hostility, impaired judgment, and increased levels of aggression (often referred to as “roid rage”). When users stop taking steroids, they may experience depression that may be severe enough to lead one to commit suicide. Anabolic steroid use may also cause psychological dependence and addiction.

- Effect on the Body: A wide range of adverse effects is associated with the use or abuse of anabolic steroids. These effects depend on several factors including:
  - Age, sex, the anabolic steroid used, amount used, and duration of use

In adolescents, anabolic steroid use can stunt the ultimate height that an individual achieves.

In boys, steroid use can cause early sexual development, acne, and stunted growth.

In adolescent girls and women, anabolic steroid use can induce permanent physical changes, such as deepening of the voice, increased facial and body hair growth, menstrual irregularities, male pattern baldness, and lengthening of the clitoris.

In men, anabolic steroid use can cause shrinkage of the testicles, reduced sperm count, enlargement of the male breast tissue, sterility, and an increased risk of prostate cancer.

In both men and women, anabolic steroid use can cause high cholesterol levels, which may increase the risk of coronary artery disease, strokes, and heart attacks. Anabolic steroid use can also cause acne and fluid retention. Oral preparations of anabolic steroids, in particular, can damage the liver.

Users who inject steroids run the risk of contracting various infections due to non-sterile injection techniques, sharing of contaminated needles, and the use of steroid preparations manufactured in nonsterile environments. All these factors put users at risk for contracting viral infections such as HIV/AIDS or hepatitis B or C, and bacterial infections at the sight of injection. Users may also develop endocarditis, a bacterial infection that causes a potentially fatal inflammation of the heart lining.

Inhalants

- Effect on the Mind: Inhalant abuse can cause damage to the parts of the brain that control thinking, moving, seeing, and hearing. Cognitive abnormalities can range from mild impairment to severe dementia.

- Effect on the Body: Inhaled chemicals are rapidly absorbed through the lungs into the bloodstream and quickly distributed to the brain and other organs. Nearly all inhalants produce effects similar to anesthetics, which slow down the body's function. Depending on the degree of abuse, the user can experience slight stimulation, feeling of less inhibition, or loss of consciousness.

Within minutes of inhalation, the user experiences intoxication along with other effects similar to those produced by alcohol. These effects may include slurred speech, an inability to coordinate movements, euphoria, and dizziness. After heavy use of inhalants, users may feel drowsy for several hours and experience a lingering headache.

Additional symptoms exhibited by long-term inhalant users include:

- Weight loss, muscle weakness, disorientation, inattentiveness, lack of coordination, irritability, depression, and damage to the nervous system and other organs

Some of the damaging effects to the body may be at least partially reversible when inhalant abuse is stopped; however, many of the effects from prolonged abuse are irreversible.

Prolonged sniffing of the highly concentrated chemicals insolvents or aerosol sprays can induce irregular and rapid heart rhythms and lead to heart failure and death within minutes. There is a common link between inhalant use and problems in school—failing grades, chronic absences, and general apathy.

Other signs include:

- Paint or stains on body or clothing; spots or sores around the mouth; red or runny eyes or nose; chemical breath odor; drunk, dazed, or dizzy appearance; nausea; loss of appetite; anxiety; excitability; and irritability

Drugs of Concern (DXM, Kratom, Salvia Divinorum)

- Effect on the Mind: Some of the many psychoactive effects associated with high-dose DXM include: Confusion, inappropriate laughter, agitation, paranoia, and hallucinations

Other sensory changes, including the feeling of floating and changes in hearing and touch
Long-term abuse of DXM is associated with severe psychological dependence. Abusers of DXM describe the following four dose-dependent "plateaus."

- Effect on the Body: DXM intoxication involves: Over-excitability, lethargy, loss of coordination, slurred speech, sweating, hypertension, and involuntary spasmodic movement of the eyeballs

The use of high doses of DXM in combination with alcohol or other drugs is particularly dangerous, and deaths have been reported. Approximately five to 10 percent of Caucasians are poor DXM metabolizers and at increased risk for overdoses and deaths. DXM taken with antidepressants can be life threatening.

OTC products that contain DXM often contain other ingredients such as acetaminophen, chlorpheniramine, and guaifenesin that have their own effects, such as:

- Liver damage, rapid heart rate, lack of coordination, vomiting, seizures, and coma

To circumvent the many side effects associated with these other ingredients, a simple chemical extraction procedure has been developed and published on the Internet that removes most of these other ingredients in cough syrup.

Additional information on specific drugs, including designer drugs, can be found in the U.S. Department of Justice Drug Enforcement Administration's Resource Guide–Drugs of Abuse (2017 Edition), which can be found in Appendix E.

ALCOHOL'S EFFECTS ON THE BODY

Source: The National Institute on Alcohol Abuse and Alcoholism

Drinking too much—on a single occasion or over time—can take a serious toll on a person's health. Below is information about how alcohol can affect the human mind and body.

Brain
Alcohol interferes with the brain's communication pathways, and can affect the way the brain looks and works. These disruptions can change mood and behavior, and make it harder to think clearly and move with coordination.

- A hangover refers to a set of symptoms that occur as a consequence of excessive alcohol use. Typical symptoms include fatigue, weakness, thirst, headache, muscle aches, nausea, stomach pain, vertigo, sensitivity to light and sound, anxiety, irritability, sweating, and increased blood pressure. A hangover can vary from person to person.

Heart
Drinking a lot over a long time—or too much on a single occasion—can damage the heart, causing problems including:

- Cardiomyopathy–Stretching and drooping of heart muscle
- Arrhythmias–Irregular heart beat
- Stroke
- High blood pressure

Liver
Heavy drinking takes a toll on the liver, and can lead to a variety of problems and liver inflammations including:

- Steatosis or fatty liver
- Alcoholic hepatitis
- Fibrosis
- Cirrhosis

Pancreas
Alcohol causes the pancreas to produce toxic substances that can eventually lead to pancreatitis, a dangerous inflammation and swelling of the blood vessels in the pancreas that prevents proper digestion.

Cancer–*Source: National Cancer Institute–see:*
www.cancer.gov/about-cancer/causes-prevention/risk/alcohol/alcohol-fact-sheet

Based on extensive reviews of research studies, there is a strong scientific consensus of an association between alcohol drinking and several types of cancer. In its Report on Carcinogens, the National Toxicology Program of the U.S. Department of Health and Human Services lists consumption of alcoholic beverages as a known human carcinogen. The research evidence indicates that the more alcohol a person drinks—particularly the more alcohol a person drinks regularly over time—the higher his or her risk of developing an alcohol-associated cancer. Based on data from 2009, an estimated 3.5 percent of all cancer deaths in the United States (about 19,500 deaths) were alcohol related. Clear patterns have emerged between alcohol consumption and the development of the following types of cancer

- Head and neck cancer. Moderate to heavy alcohol consumption is associated with higher risks of certain head and neck cancers. Moderate drinkers have 1.8-fold higher risks of oral cavity (excluding the lips) and pharynx (throat) cancers and 1.4-fold higher risks of larynx (voice box) cancers than non-drinkers, and heavy drinkers have five-fold higher risks of oral cavity and pharynx cancers and 2.6-fold higher risks of larynx cancers. Moreover, the risks of these cancers are substantially higher among persons who consume this amount of alcohol and also use tobacco.

- Esophageal cancer. Alcohol consumption at any level is associated with an increased risk of a type of esophageal cancer called esophageal squamous cell carcinoma. The risks, compared with no alcohol consumption, range from 1.3-fold higher for light drinking to nearly five-fold higher for heavy drinking. In addition, people who inherit a deficiency in an enzyme that metabolizes alcohol have been found to have substantially increased risks of esophageal squamous cell carcinoma if they consume alcohol.

- Liver cancer. Heavy alcohol consumption is associated with approximately 2-fold increased risks of two types of liver cancer (hepatocellular carcinoma and intrahepatic cholangiocarcinoma).

- Breast cancer. Epidemiologic studies have consistently found an increased risk of breast cancer with increasing alcohol intake. Pooled data from 118 individual studies indicates that light drinkers have a slightly increased (1.04-fold higher) risk of breast cancer, compared with nondrinkers. The risk increase is greater in moderate drinkers (1.23-fold higher) and heavy drinkers (1.6-fold higher). An analysis of prospective data for 88,000 women participating in two U.S. cohort studies concluded that for women who have never smoked, light to moderate drinking was associated with a 1.13-fold increased risk of alcohol-related cancers (mostly breast cancer).

- Colorectal cancer. Moderate to heavy alcohol consumption is associated with 1.2- to 1.5-fold increased risks of cancers of the colon and rectum compared with no alcohol consumption.

Immune System
Drinking too much can weaken your immune system, making your body a much easier target for disease. Chronic drinkers are more liable to contract diseases like pneumonia and tuberculosis than people who do not drink too much. Drinking a lot on a single occasion slows your body's ability to ward off infections–even up to 24 hours after getting drunk.

Part Four: Program Effectiveness

Analysis of Strengths and Weaknesses

As a result of both employee and student drug/alcohol abuse prevention programs, the following strengths and weaknesses have been identified:

Strengths:

- Montgomery College is in full compliance with the Maryland Heroin and Opioid Education and Community Action Act of 2017 which serves to increase substance abuse awareness for both employees and students.
- There has been a considerable increase in substance abuse awareness activities that led to the College educating more students and staff about substance abuse.
- The New Student Orientation Program added substance abuse modules for both the in-person and virtual orientations.

Weaknesses:

- The College does not have an office or staff person whose primary responsibility is providing substance abuse education and awareness.
- The College could benefit from more assessment of substance abuse programs and activities for effectiveness.

Program Highlights Since 2017 Biennial Review

Student Program Progress

The College sent representatives to the annual Maryland Association of Prevention Professionals and Advocates (MAPPA) statewide conference held November 2018.

The College conducted its annual collegewide substance abuse awareness and prevention activity on April 2, 2019. Over 90 percent of program participants reported they strongly agreed in each of the following categories:

- The information was presented in a clear way.
- The presenters were knowledgeable about the topic.

- The presentations were presented in an engaging or interesting way.
- The presentations increased their knowledge/understanding.
- They would recommend the event to others.

Substance Abuse awareness information is available on the College's web page and can be accessed at: montgomerycollege.edu/life-at-mc/student-health-and-wellness/mental-health-and-wellness/index.html. In general, more programs and activities were provided and more individuals are participating in substance abuse awareness activities.

Additional recommendations for 2019 to provide the information in a different format that will be less threatening to employees and will not have the stigma associated with attending a substance abuse prevention workshop. The new format will be in the form of support circles with topics such as stress management, coping with change, managing life events etc. At these meetings information and resources pertaining to substance abuse prevention will be disseminated in a nonthreatening and information sharing method along with resources that employees can avail of. Guest speakers will be invited to share their knowledge and expertise with employees.

Statement of Goals

The goals of Montgomery College's drug/alcohol abuse prevention programs include the commitment to:

1. The education of students, employees, and community members regarding substance abuse prevention, detection and treatment services;
2. Continuing improvements to strengthen collegewide substance abuse programs;
3. Ensuring consistent sanctions for all students and employees in connection with violations to drug/alcohol policies; and,
4. Maintaining a drug-free environment throughout the College.

Recommendations for Program Revisions

Recommendations for Student Drug/Alcohol Abuse Prevention Program

- Increase the participation of college representatives involved in substance abuse awareness and prevention programs and activities.
- Improve capability to measure effectiveness of substance abuse programs and activities for students on each campus.
- Continue to partner with local substance abuse agencies and services to promote awareness and prevention activities at the College.
- Recruit additional College staff for participation with the Maryland Association of Prevention Professionals and Advocates (MAPPA) programs and activities, including the MAPPA statewide conference in November 2019.
- Select an additional College representative to serve as a representative on the Montgomery County Substance Abuse Coalition, also known as Many Voices Smart Choices.
- In FY20, continue to conduct an annual collegewide substance abuse awareness and prevention activity.

The Office of Student Affairs proposed programs for the remainder of 2019 and 2020

GERMANTOWN STUDENT LIFE CAMPUS	
DATE	**UPCOMING EVENTS**
2019-2020	HIV Testing–Once a month for school year
October/November 2019	Substance Abuse Prevention Speaker/Events
March 2020	Health and Wellness Fair New Student Welcome Fair
April 2020	Spring Fest
August 8, 2019 August 28, 2019	Will provide Substance Abuse Prevention Information during New Student Orientation • Online • In-person
September 2019	Welcome Week and Get Involved Week
	Student Life front office and campus boards provide information about substance abuse prevention throughout the school year.
ROCKVILLE STUDENT LIFE CAMPUS	
DATE	**UPCOMING EVENTS**
September 2019	National Collegiate Alcohol Awareness–DUI simulator
August 7, 2019	New Student Orientation
August 21, 2019	New Student Fair
STUDENT EMPLOYMENT SERVICES (SES)	
DATE	**UPCOMING EVENTS**
2019–2020	• Will distribute opioid awareness information and flyers through the Student Employment Services (SES) centers, individual appointments, and Student Employment Services (SES) bulletin boards. Will provide information at sign-in tables at job fair events and will send announcement about awareness events through Ejobs. • The collegewide Co-op program will provide Opioid Awareness Training to all students enrolled in the Co-op program. • Will assist with planning and delivering an opioid related forum to Montgomery College students.

The Office of Student Affairs also proposes additional recommendations for Student Drug/Alcohol Abuse Prevention Program for the remainder of academic year 2019–2020 and 2020–2021:

- In academic year 2019–2020, establish a collegewide substance abuse awareness and prevention team to actively plan and promote awareness and prevention activities.
- In academic year 2019–2020, increase collegewide representation on the Montgomery County Substance Abuse prevention coalition also known as Many Voices Smart Choices.
- In academic year 2019–2020, conduct the annual collegewide substance abuse prevention forum.
- In academic year 2020–2021, conduct a student club and organization poster session competition on each campus.
- In academic year 2020–2021, conduct a comprehensive assessment of substance abuse awareness activities.

The Office of Compliance, Risk, and Ethics has coordinated the disclosure of information to students and employees regarding the drug and alcohol abuse prevention programs, as part of a series of mandatory disclosure notices. The content of each employee communication is developed through Human Resources and Strategic Talent Management, and the content of each student communication is developed through Student Affairs. Employee and student disclosure messages regarding drug and alcohol abuse prevention has been distributed via email once each semester.

Starting in the 2019–2020 academic year, the Office of Compliance, Risk, and Ethics will begin sending the majority of the disclosure notifications on an annual basis in the fall semester, including an annual notice to both employees and students regarding the drug and alcohol abuse prevention programs. Furthermore, the Office of Compliance, Risk, and Ethics will consult with Public Safety and Student Affairs to explore opportunities for additional methods to notify students about the drug and alcohol abuse prevention program.

The Office of Human Resources and Strategic Talent Management–proposed programs for the remainder of 2019 and 2020

Program Highlights Since 2017 Biennial Review

Employee Program Progress

In 2017 a recommendation was made pertaining to risk factors associated with smoking and drinking to be publicized on electronic bulletin boards collegewide. To date, the College now has the technology in place to make this happen.

Recommendations for Employee Drug/Alcohol Abuse Prevention Program Revisions

- In fiscal year 2019–2020, develop a partnership with the Wellness Program to implement a tobacco cessation program for employees and to offer resources through current health insurance vendors to connect with wellness coaches that have expertise in preventive health care and behavior-change counseling. They use employee goals to create a customized action plan and discover techniques that work for you.
- In fiscal year 2019–2020, create a website with information on the health risks associated with the use of illicit drugs and abuse of alcohol and tobacco. The website will have links to related resources for substance abuse prevention, education programs and treatment options.
- Partner with the Wellness Program to create a wellness support committee in an effort to support employees in their overall health and wellness. Offering participants the opportunity to learn coping mechanisms, voice their stories, thoughts and opinions, and be provided with available resources to gain support from others with like experiences. Provide Wellness Coaching to employees through our health insurance vendors and our Faculty Staff Assistance Program. This will provide employees with the tools to boost their mood and improve their mental health with on-demand coaching 24/7. After completing a brief assessment they receive a program tailored to their needs that included interactive lessons and tools. They get access to a peer coach who is matched based on their symptoms. They can also join support communities focused on stress, anxiety, depression and more.
- The College Benefits Team negotiated waiving the fee for opioid antagonistic medications. This should relieve some of the financial burden for employees dealing with substance abuse and for their family members.

Appendices

Appendix A:
Drug-Free School and Campuses

PART 86--DRUG-FREE SCHOOLS AND CAMPUSES

Subpart A--General

Sec.

Subpart B--Institutions of Higher Education

Subpart C--State and Local Educational Agen-cies

Subpart D--Response and Sanctions Issued or Imposed by the Secretary for Violations by an IHE, SEA, or LEA

Subpart E--Appeal Procedures

Authority: 20 U.S.C. 1145g, 3224a.

PART 86--DRUG-FREE SCHOOLS AND CAMPUSES

Subpart A--General

Sec. 86.1 What is the purpose of the Drug-Free Schools and Campuses Regulations?

The purpose of the Drug-Free Schools and Campuses Regulations is to implement section 22 of the Drug-Free Schools and Communities Act Amendments of 1989, which adds section 1213 to the Higher Education Act and section 5145 to the Drug-Free Schools and Communities Act. These amendments require that, as a condition of receiving funds or any other form of financial assistance under any Federal program, an institution of higher education (IHE), State educational agency (SEA), or local educational agency (LEA) must certify that it has adopted and implemented a drug prevention program as described in this part.

(Authority: 20 U.S.C. 1145g, 3224a).

Sec. 86.2 What Federal programs are covered by this part?

The Federal programs covered by this part include—

(a) All programs administered by the Department of Education under which an IHE, SEA, or LEA may receive funds or any other form of Federal financial assistance; and

(b)All programs administered by any other Federal agency under which an IHE, SEA, or LEA may receive funds or any other form of Federal financial assistance.

(Authority: 20 U.S.C. 1145g, 3224a)

Sec. 86.3 What actions shall an IHE, SEA, or LEA take to comply with the requirements of this part?

(a) An IHE, SEA, or LEA shall adopt and implement a drug prevention program as described in Sec. 86.100 for IHEs, and Secs. 86.200 and 86.201 for SEAs and LEAs, to prevent the unlawful possession, use, or distribution of illicit drugs and alcohol by all students and employees on school premises or as part of any of its activities.

(b) An IHE, SEA, or LEA shall provide a written certification that it has adopted and implemented the drug prevention program described in Sec. 86.100 for IHEs, and Secs. 86.200 and 86.201 for SEAs and LEAs.

(Authority: 20 U.S.C. 1145g, 3224a)

(Approved by the Office of Management and Budget under control number 1880-0522)

Sec. 86.4 What are the procedures for submitting a drug prevention program certification?

(a) *IHE drug prevention program certification.* An IHE shall submit to the Secretary the drug prevention program certification required by Sec. 86.3(b).

(b) *SEA drug prevention program certification.* An SEA shall submit to the Secretary the drug prevention program certification required by Sec. 86.3(b).

(c) *LEA drug prevention program.*

(1) The SEA shall develop a drug prevention program certification form and a schedule for submission of the certification by each LEA within its jurisdiction.

(2) An LEA shall submit to the SEA the drug prevention program certification required by Sec. 86.3(b).

(3)(i) The SEA shall provide to the Secretary a list of LEAs that have not submitted drug prevention program certifications and certify that all other LEAs in the State have submitted drug prevention program certifications to the SEA.

(ii) The SEA shall submit updates to the Secretary so that the list of LEAs described in paragraph (c)(3)(i) of this section is accurate at all times.

(Authority: 20 U.S.C. 1145g, 3224a)

(Approved by the Office of Management and Budget under control number 1880-0522)

Sec. 86.5 What are the consequences if an IHE, SEA, or LEA fails to submit a drug prevention program certification?

(a) An IHE, SEA, or LEA that fails to submit a drug prevention program certification is not eligible to receive funds or any other form of financial assistance under any Federal program.

(b) The effect of loss of eligibility to receive funds or any other form of Federal financial assistance is determined by the statute and regulations governing the Federal programs under which an IHE, SEA, or LEA receives or desires to receive assistance.

(Authority: 20 U.S.C. 1145g, 3224a)

Sec. 86.6 When must an IHE, SEA, or LEA submit a drug prevention program certification?

(a) After October 1, 1990, except as provided in paragraph (b) of this section, an IHE, SEA, or LEA is not eligible to receive funds or any other form of financial assistance under any Federal program until the IHE, SEA, or LEA has submitted a drug prevention program certification.

(b)(1) The Secretary may allow an IHE, SEA, or LEA until not later than April 1, 1991, to submit the drug prevention program certification, only if the IHE, SEA, or LEA establishes that it has a need, other than administrative convenience, for more time to adopt and implement its drug prevention program.

(2) An IHE, SEA, or LEA that wants to receive an extension of time to submit its drug prevention program certification shall submit a written justification to the Secretary that--

(i) Describes each part of its drug prevention program, whether in effect or planned;

(ii) Provides a schedule to complete and implement its drug prevention program; and

(iii) Explains why it has a need, other than administrative convenience, for more time to adopt and implement its drug prevention program.

(3)(i) An IHE or SEA shall submit a request for an extension to the Secretary.

(ii)(A) An LEA shall submit any request for an extension to the SEA.

(B) The SEA shall transmit any such request for an extension to the Secretary.

(C) The SEA may include with the LEA's request a recommendation as to whether the Secretary should approve it.

(Authority: 20 U.S.C. 1145g, 3224a)

(Approved by the Office of Management and Budget under control number 1880-0522)

Sec. 86.7 What definitions apply to this part?

(a) *Definitions in the Drug-Free Schools and Communities Act.* The following terms used in this part are defined in the Act:

Drug abuse education and prevention
Illicit drug use

(b) *Definitions in EDGAR.* The following terms used in this part are defined in 34 CFR part 77:

Department
EDGAR
Local educational agency
Secretary
State educational agency.

(c) *Other definitions.* The following terms used in this part are defined as follows:

Compliance agreement means an agreement between the Secretary and an IHE, SEA, or LEA that is not in full compliance with its drug prevention program certification. The agreement specifies the steps the IHE, SEA, or LEA will take to comply fully with its drug prevention program certification, and provides a schedule for the accomplishment of those steps. A compliance agreement does not excuse or remedy past violations of this part.

Institution of higher education means—

(1) An institution of higher education, as defined in 34 CFR 600.4;

(2) A proprietary institution of higher education, as defined in 34 CFR 600.5;

(3) A postsecondary vocational institution, as defined in 34 CFR 600.6; and

(4) A vocational school, as defined in 34 CFR 600.7.

(Authority: 20 U.S.C. 1145g, 3224a)

Subpart B--Institutions of Higher Education

Sec. 86.100 What must the IHE's drug prevention program include?

The IHE's drug prevention program must, at a minimum, include the following:

(a) The annual distribution in writing to each employee, and to each student who is taking one or more classes for any type of academic credit except for continuing education units, regardless of the length of the student's program of study, of—

(1) Standards of conduct that clearly prohibit, at a minimum, the unlawful possession, use, or distribution of illicit drugs and alcohol by students and employees on its property or as part of any of its activities;

(2) A description of the applicable legal sanctions under local, State, or Federal law for the unlawful possession or distribution of illicit drugs and alcohol;

(3) A description of the health risks associated with the use of illicit drugs and the abuse of alcohol;

(4) A description of any drug or alcohol counseling, treatment, or rehabilitation or re-entry programs that are available to employees or students; and

(5) A clear statement that the IHE will impose disciplinary sanctions on students and employees (consistent with local, State, and Federal law), and a description of those sanctions, up to and including expulsion or termination of employment and referral for prosecution, for violations of the standards of conduct required by paragraph (a)(1) of this section. For the purpose of this section, a disciplinary sanction may include the completion of an appropriate rehabilitation program.

(b) A biennial review by the IHE of its program to—

(1) Determine its effectiveness and implement changes to the program if they are needed; and

(2) Ensure that the disciplinary sanctions described in paragraph (a)(6) of this section are consistently enforced.

(Authority: 20 U.S.C. 1145g)

(Approved by the Office of Management and Budget under control number 1880-0522)

Sec. 86.101 What review of IHE drug prevention programs does the Secretary conduct?

The Secretary annually reviews a representative sample of IHE drug prevention programs.

(Authority: 20 U.S.C. 1145g)

Sec. 86.102 What is required of an IHE that the Secretary selects for annual review?

If the Secretary selects an IHE for review under Sec. 86.101, the IHE shall provide the Secretary access to personnel, records, documents and any other necessary information requested by the Secretary to review the IHE's adoption and implementation of its drug prevention program.

(Authority: 20 U.S.C. 1145g)

(Approved by the Office of Management and Budget under control number 1880-0522)

Sec. 86.103 What records and information must an IHE make available to the Secretary and the public concerning its drug prevention program?

(a) Each IHE that provides the drug prevention program certification required by Sec. 86.3(b) shall, upon request, make available to the Secretary and the public a copy of each item required by Sec. 86.100(a) as well as the results of the biennial review required by Sec. 86.100(b).

(b)(1) An IHE shall retain the following records for three years after the fiscal year in which the record was created:

(i) The items described in paragraph (a) of this section.

(ii) Any other records reasonably related to the IHE's compliance with the drug prevention program certification.

(2) If any litigation, claim, negotiation, audit, review, or other action involving the records has been started before expiration of the three-year period, the IHE shall retain the records until completion of the action and resolution of all issues that arise from it, or until the end of the regular three-year period, whichever is later.

(Authority: 20 U.S.C. 1145g)

(Approved by the Office of Management and Budget under control number 1880-0552)

Subpart C--State and Local Educational Agencies

Sec. 86.200 What must the SEA's and LEA's drug prevention program for students include?

The SEA's and LEA's program for all students must, at a minimum, include the following:

(a) Age-appropriate, developmentally based drug and alcohol education and prevention programs (which address the legal, social, and health consequences of drug and alcohol use and which provide information about effective techniques for resisting peer pressure to use illicit drugs or alcohol) for all students in all grades of the schools operated or served by the SEA or LEA, from early childhood level through grade 12.

(b) A statement to students that the use of illicit drugs and the unlawful possession and use of alcohol is wrong and harmful.

(c) Standards of conduct that are applicable to students in all the SEA's and LEA's schools and that clearly prohibit, at a minimum, the unlawful possession, use, or distribution of illicit drugs and alcohol by students on school premises or as part of any of its activities.

(d) A clear statement that disciplinary sanctions (consistent with local, State, and Federal law), up to and including expulsion and referral for prosecution, will be imposed on students who violate the standards of conduct required by paragraph (c) of this section and a description of those sanctions. For the purpose of this section, a disciplinary sanction may include the completion of an appropriate rehabilitation program.

(e) Information about any drug and alcohol counseling and rehabilitation and re-entry programs that are available to students.

(f) A requirement that all parents and students be given a copy of the standards of conduct required by paragraph (c) of this section and the statement of disciplinary sanctions described in paragraph (d) of this section.

(g) Notification to parents and students that compliance with the standards of conduct required by paragraph (c) of this section is mandatory.

(h) A biennial review by the SEA or LEA of its program to—

(1) Determine its effectiveness and implement changes to the program if they are needed; and

(2) Ensure that the disciplinary sanctions described in paragraph (d) of this section are consistently enforced.

(Authority: 20 U.S.C. 3224a)

(Approved by the Office of Management and Budget under control number 1880-0522)

Sec. 86.201 What must the SEA's and LEA's drug prevention program for employees include?

The SEA's and LEA's program for all employees must, at a minimum, include the following:

(a) Standards of conduct applicable to employees that clearly prohibit, at a minimum, the unlawful possession, use, or distribution of illicit drugs and alcohol on school premises or as part of any of its activities.

(b) A clear statement that disciplinary sanctions (consistent with local, State, and Federal law) up to and including termination of employment and referral for prosecution, will be imposed on employees who violate the standards of conduct required by paragraph (a) of this section and a description of those sanctions. For the purpose of this section, a disciplinary sanction may include the completion of an appropriate rehabilitation program.

(c) Information about any drug and alcohol counseling and rehabilitation and re-entry programs that are available to employees.

(d) A requirement that employees be given a copy of the standards of conduct required by paragraph (a) of this section and the statement of disciplinary sanctions described in paragraph (b) of this section.

(e) Notification to employees that compliance with the standards of conduct required by paragraph (a) of this section is mandatory.

(f) A biennial review of the SEA and LEA of its program to—

(1) Determine its effectiveness and implement changes to the program if they are needed; and

(2) Ensure that the disciplinary sanctions described in paragraph (b) of this section are consistently enforced.

(Authority: 20 U.S.C. 3224a)

(Approved by the Office of Management and Budget under control number 1880-0522)

Sec. 86.202 What review of SEA and LEA drug prevention programs is required under this subpart?

(a)(1) An SEA shall annually review a representative sample of LEA programs.

(2) If an SEA finds, as a result of its annual review, that an LEA has failed to implement its program or consistently enforce its disciplinary sanctions, the SEA shall submit that information, along with the findings of its review, to the Secretary within thirty (30) days after completion of the review.

(b) The Secretary may annually select a representative sample of SEA programs for review.

(Authority: 20 U.S.C. 3224a)

(Approved by the Office of Management and Budget under control number 1880-0522)

Sec. 86.203 What is required of an SEA or LEA that is selected for review?

(a) If the Secretary selects an SEA for review under Sec. 86.202(b), the SEA shall provide the Secretary access to personnel, records, documents, and any other information necessary to review the adoption and implementation of its drug prevention program.

(b) If the SEA selects an LEA for review under Sec. 86.202(a), the LEA shall provide the SEA access to personnel, records, documents, and any other information necessary to review the adoption and implementation of its drug prevention program.

(Authority: 20 U.S.C. 3224a)

Sec. 86.204 What records and information must an SEA or LEA make available to the Secretary and the public concerning its drug prevention program?

(a)(1) Each SEA that provides the drug prevention program certification shall, upon request, make available to the Secretary and the public full information about the elements of its drug prevention program, including the results of its biennial review required by Secs. 86.200(h) and 86.201(F).

(2) The SEA that provides the drug prevention program certification shall provide the Secretary access to personnel, records, documents, and any other information related to the SEA's compliance with the certification.

(b)(1) Each LEA that provides the drug prevention program certification shall, upon request, make available to the Secretary, the SEA, and the public full information about the elements of its program, including the results of its biennial review required by Secs. 86.200(h) and 86.201(f).

(2) The LEA that provides the drug prevention program certification shall provide the Secretary access to personnel, records, documents, and any other information related to the LEA's compliance with the certification.

(c)(1) Each SEA or LEA shall retain the following records for three years after the fiscal year in which the record was created:

(i) The items described in paragraphs (a) and (b) of this section.

(ii) Any other records related to the SEA's or LEA's compliance with the certification.

(2) If any litigation, claim, negotiation, audit, review, or other action involving the records has been started before expiration of the three-year period, the SEA or LEA shall retain the records until completion of the action and resolution of all issues that arise from it, or until the end of the regular three-year period, whichever is later.

(Approved by the Office of Management and Budget under control number 1880-0522)

(Authority: 20 U.S.C. 3224a)

Subpart D--Responses and Sanctions Issued or Imposed by the Secretary for violations by an IHE, SEA, or LEA

Sec. 86.300 What constitutes a violation of this part by an IHE, SEA, or LEA?

An IHE, SEA, or LEA violates this part by—

(a) Receiving any form of Federal financial assistance after becoming ineligible to receive that assistance because of failure to submit a certification in accordance with Sec. 86.3(b); or

(b) Violating its certification. Violation of a certification includes failure of an IHE, SEA, or LEA to--

(1) Adopt or implement its drug prevention program; or

(2) Consistently enforce its disciplinary sanctions for violations by students and employees of the standards of conduct adopted by an IHE under Sec. 86.100(a)(1) or by an SEA or LEA under Secs. 86.200(c) and 86.201(a).

(Authority: 20 U.S.C. 1145g, 3224a)

Sec. 86.301 What actions may the Secretary take if an IHE, SEA, or LEA violates this part?

(a) If an IHE, SEA, or LEA violates its certification, the Secretary may issue a response to the IHE, SEA, or LEA. A response may include, but is not limited to—

(1) Provision of information and technical assistance; and

(2) Formulation of a compliance agreement designed to bring the IHE, SEA, or LEA into full compliance with this part as soon as feasible.

(b) If an IHE, SEA, or LEA receives any form of Federal financial assistance without having submitted a certification or violates its certification, the Secretary may impose one or more sanctions on the IHE, SEA, or LEA, including—

(1) Repayment of any or all forms of Federal financial assistance received by the IHE, SEA, or LEA when it was in violation of this part; and

(2) The termination of any or all forms of Federal financial assistance that—

(i)(A) Except as specified in paragraph (b)(2)(ii) of this section, ends an IHE's, SEA's, or LEA's eligibility to receive any or all forms of Federal financial assistance. The Secretary specifies which forms of Federal financial assistance would be affected; and

(B) Prohibits an IHE, SEA, or LEA from making any new obligations against Federal funds; and

(ii) For purposes of an IHE's participation in the student financial assistance programs authorized by title IV of the Higher Education Act of 1965 as amended, has the same effect as a termination under 34 CFR 668.94.

(Authority: 20 U.S.C. 1145g, 3224a)

Sec. 86.302 What are the procedures used by the Secretary for providing information or technical assistance?

(a) The Secretary provides information or technical assistance to an IHE, SEA, or LEA in writing, through site visits, or by other means.

(b) The IHE, SEA, or LEA shall inform the Secretary of any corrective action it has taken within a period specified by the Secretary.

(Authority: 20 U.S.C. 1145g, 3224a)

Sec. 86.303 What are the procedures used by the Secretary for issuing a response other than the formulation of a compliance agreement or the provision of information or technical assistance?

(a) If the Secretary intends to issue a response other than the formulation of a compliance agreement or the provision of information or technical assistance, the Secretary notifies the IHE, SEA, or LEA in writing of—

(1) The Secretary's determination that there are grounds to issue a response other than the formulation of a compliance agreement or providing information or technical assistance; and

(2) The response the Secretary intends to issue.

(b) An IHE, SEA, or LEA may submit written comments to the Secretary on the determination under paragraph (a)(1) of this section and the intended response under paragraph (a)(2) of this section within 30 days after the date the IHE, SEA, or LEA receives the notification of the Secretary's intent to issue a response.

(c) Based on the initial notification and the written comments of the IHE, SEA, or LEA, the Secretary makes a final determination and, if appropriate, issues a final response.

(d) The IHE, SEA, or LEA shall inform the Secretary of the corrective action it has taken in order to comply with the terms of the Secretary's response within a period specified by the Secretary.

(e) If an IHE, SEA, or LEA does not comply with the terms of a response issued by the Secretary, the Secretary may issue an additional response or impose a sanction on the IHE, SEA, or LEA in accordance with the procedures in Sec. 86.304.

(Authority: 20 U.S.C. 1145g, 3224a)

Sec. 86.304 What are the procedures used by the Secretary to demand repayment of Federal financial assistance or terminate an IHE's, SEA's, or LEA's eligibility for any or all forms of Federal financial assistance?

(a) A designated Department official begins a proceeding for repayment of Federal financial assistance or termination, or both, of an IHE's, SEA's, or LEA's eligibility for any or all forms of Federal financial assistance by sending the IHE, SEA, or LEA a notice by certified mail with return receipt requested. This notice—

(1) Informs the IHE, SEA, or LEA of the Secretary's intent to demand repayment of Federal financial assistance or to terminate, describes the consequences of that action, and identifies the alleged violations that constitute the basis for the action;

(2) Specifies, as appropriate—

(i) The amount of Federal financial assistance that must be repaid and the date by which the IHE, SEA, or LEA must repay the funds; and

(ii) The proposed effective date of the termination, which must be at least 30 days after the date of receipt of the notice of intent, and

(3) Informs the IHE, SEA, or LEA that the repayment of Federal financial assistance will not be required or that the termination will not be effective on the date specified in the notice if the designated Department official receives, within a 30-day period beginning on the date the IHE, SEA, or LEA receives the notice of intent described in this paragraph—

(i) Written material indicating why the repayment of Federal financial assistance or termination should not take place; or

(ii) A request for a hearing that contains a concise statement of disputed issues of law and fact, the IHE's, SEA's, or LEA's position with respect to these issues, and, if appropriate, a description of which Federal financial assistance the IHE, SEA, or LEA contends need not be repaid.

(b) If the IHE, SEA, or LEA does not request a hearing but submits written material—

(1) The IHE, SEA, or LEA receives no additional opportunity to request or receive a hearing; and

(2) The designated Department official, after considering the written material, notifies the IHE, SEA, or LEA in writing whether—

(i) Any or all of the Federal financial assistance must be repaid; or

(ii) The proposed termination is dismissed or imposed as of a specified date.

(Authority: 20 U.S.C. 1145g, 3224a)

Subpart E--Appeal Procedures

Sec. 86.400 What is the scope of this subpart?

(a) The procedures in this subpart are the exclusive procedures governing appeals of decisions by a designated Department official to demand the repayment of Federal financial assistance or terminate the eligibility of an IHE, SEA, or LEA to receive some or all forms of Federal financial assistance for violations of this part.

(b) An Administrative Law Judge (ALJ) hears appeals under this subpart.

(Authority: 20 U.S.C. 1145g, 3224a)

Sec. 86.401 What are the authority and responsibility of the ALJ?

(a) The ALJ regulates the course of the proceeding and conduct of the parties during the hearing and takes all steps necessary to conduct a fair and impartial proceeding.

(b) The ALJ is not authorized to issue subpoenas.

(c) The ALJ takes whatever measures are appropriate to expedite the proceeding. These measures may include, but are not limited to—

(1) Scheduling of conferences;

(2) Setting time limits for hearings and submission of written documents; and

(3) Terminating the hearing and issuing a decision against a party if that party does not meet those time limits.

(d) The scope of the ALJ's review is limited to determining whether—

(1) The IHE, SEA, or LEA received any form of Federal financial assistance after becoming ineligible to receive that assistance because of failure to submit a certification; or

(2) The IHE, SEA, or LEA violated its certification.

(Authority: 20 U.S.C. 1145g, 3224a)

Sec. 86.402 Who may be a party in a hearing under this subpart?

(a) Only the designated Department official and the IHE, SEA, or LEA that is the subject of the proposed termination or recovery of Federal financial assistance may be parties in a hearing under this subpart.

(b) Except as provided in this subpart, no person or organization other than a party may participate in a hearing under this subpart.

(Authority: 20 U.S.C. 1145g, 3224a)

Sec. 86.403 May a party be represented by counsel?

A party may be represented by counsel.

(Authority: 20 U.S.C. 1145g, 3224a)

Sec. 86.404 How may a party communicate with an ALJ?

(a) A party may not communicate with an ALJ on any fact at issue in the case or on any matter relevant to the merits of the case unless the other party is given notice and an opportunity to participate.

(b)(1) To obtain an order or ruling from an ALJ, a party shall make a motion to the ALJ.

(2) Except for a request for an extension of time, a motion must be made in writing unless the parties appear in person or participate in a conference telephone call. The ALJ may require a party to reduce an oral motion to writing.

(3) If a party files a written motion, the party shall do so in accordance with Sec. 86.405.

(4) Except for a request for an extension of time, the ALJ may not grant a party's written motion without the consent of the other party unless the other party has had at least 21 days from the date of service of the motion to respond. However, the ALJ may deny a motion without awaiting a response.

(5) The date of service of a motion is determined by the standards for determining a filing date in Sec. 86.405(d).

(Authority: 20 U.S.C. 1145g, 3224a)

Sec. 86.405 What are the requirements for filing written submissions?

(a) Any written submission under this subpart must be filed by hand-delivery or by mail through the U.S. Postal Service.

(b) If a party files a brief or other document, the party shall serve a copy of the filed material on the other party on the filing date by hand-delivery or by mail.

(c) Any written submission must be accompanied by a statement certifying the date that the filed material was filed and served on the other party.

(d)(1) The filing date for a written submission is either—

(i) The date of hand-delivery; or

(ii) The date of mailing.

(2) If a scheduled filing date falls on a Saturday, Sunday, or Federal holiday, the filing deadline is the next Federal business day.

(Authority: 20 U.S.C. 1145g, 3224a)

Sec. 86.406 What must the ALJ do if the parties enter settlement negotiations?

(a) If the parties to a case file a joint motion requesting a stay of the proceedings for settlement negotiations or for the parties to obtain approval of a settlement agreement, the ALJ grants the stay.

(b) The following are not admissible in any proceeding under this part:

(1) Evidence of conduct during settlement negotiations.

(2) Statements made during settlement negotiations.

(3) Terms of settlement offers.

(c) The parties may not disclose the contents of settlement negotiations to the ALJ. If the parties enter into a settlement and file a joint motion to dismiss the case, the ALJ grants the motion.

(Authority: 20 U.S.C. 1145g, 3224a)

Sec. 86.407 What are the procedures for scheduling a hearing?

(a) If the IHE, SEA, or LEA requests a hearing by the time specified in Sec. 86.403(a)(3), the designated Department official sets the date and the place.

(b)(1) The date is at least 15 days after the designated Department official receives the request and no later than 45 days after the request for hearing is received by the Department.

(2) On the motion of either or both parties, the ALJ may extend the period before the hearing is scheduled beyond the 45 days specified in paragraph (b)(1) of this section.

(c) No termination takes effect until after a hearing is held and a decision is issued by the Department.

(d) With the approval of the ALJ and the consent of the designated Department official and the IHE, SEA, or LEA, any time schedule specified in this section may be shortened.

(Authority: 20 U.S.C. 1145g, 3224a)

Sec. 86.408 What are the procedures for conducting a pre-hearing conference?

(a)(1) A pre-hearing conference may be convened by the ALJ if the ALJ thinks that such a conference would be useful, or if requested by—

(i) The designated Department official; or

(ii) The IHE, SEA, or LEA.

(2) The purpose of a pre-hearing conference is to allow the parties to settle, narrow, or clarify the dispute.

(b) A pre-hearing conference may consist of--

(1) A conference telephone call;

(2) An informal meeting; or

(3) The submission and exchange of written material.

(Authority: 20 U.S.C. 1145g, 3224a)

Sec. 86.409 What are the procedures for conducting a hearing on the record?

(a) A hearing on the record is an orderly presentation of arguments and evidence conducted by an ALJ.

(b) An ALJ conducts the hearing entirely on the basis of briefs and other written submissions unless—

(1) The ALJ determines, after reviewing all appropriate submissions, that an evidentiary hearing is needed to resolve a material factual issue in dispute; or

(2) The ALJ determines, after reviewing all appropriate submissions, that oral argument is needed to clarify the issues in the case.

(c) The hearing process may be expedited as agreed by the ALJ, the designated Department official, and the IHE, SEA, or LEA. Procedures to expedite may include, but are not limited to, the following:

(1) A restriction on the number or length of submissions.

(2) The conduct of the hearing by telephone conference call.

(3) A review limited to the written record.

(4) A certification by the parties to facts and legal authorities not in dispute.

(d)(1) The formal rules of evidence and procedures applicable to proceedings in a court of law are not applicable.

(2) The designated Department official has the burden of persuasion in any proceeding under this subpart.

(3)(i) The parties may agree to exchange relevant documents and information.

(ii) The ALJ may not order discovery, as provided for under the Federal Rules of Civil Procedure, or any other exchange between the parties of documents or information.

(4) The ALJ accepts only evidence that is relevant and material to the proceeding and is not unduly repetitious.

(e) The ALJ makes a transcribed record of any evidentiary hearing or oral argument that is held, and makes the record available to—

(1) The designated Department official; and

(2) The IHE, SEA, or LEA on its request and upon payment of a fee comparable to that prescribed under the Department of Education Freedom of Information Act regulations (34 CFR part 5).

(Authority: 20 U.S.C. 1145g, 3224a)

Sec. 86.410 What are the procedures for issuance of a decision?

(a)(1) The ALJ issues a written decision to the IHE, SEA, or LEA, the designated Department official, and the Secretary by certified mail, return receipt requested, within 30 days after—

(i) The last brief is filed;

(ii) The last day of the hearing if one is held; or

(iii) The date on which the ALJ terminates the hearing in accordance with Sec. 86.401(c)(3).

(2) The ALJ's decision states whether the violation or violations contained in the Secretary's notification occurred, and articulates the reasons for the ALJ's finding.

(3) The ALJ bases findings of fact only on evidence in the hearing record and on matters given judicial notice.

(b)(1) The ALJ's decision is the final decision of the agency. However, the Secretary reviews the decision on request of either party, and may review the decision on his or her own initiative.

(2) If the Secretary decides to review the decision on his or her own initiative, the Secretary informs the parties of his or her intention to review by written notice sent within 15 days of the Secretary's receipt of the ALJ's decision.

(c)(1) Either party may request review by the Secretary by submitting a brief or written material to the Secretary within 20 days of the party's receipt of the ALJ's decision. The submission must explain why the decision of the ALJ should be modified, reversed, or remanded. The other party shall respond within 20 days of receipt of the brief or written materials filed by the opposing party.

(2) Neither party may introduce new evidence on review.

(d) The decision of the ALJ ordering the repayment of Federal financial assistance or terminating the eligibility of an IHE, SEA, or LEA does not take effect pending the Secretary's review.

(e)(1) The Secretary reviews the ALJ's decision considering only evidence introduced into the record.

(2) The Secretary's decision may affirm, modify, reverse or remand the ALJ's decision and includes a statement of reasons for the decision.

(Authority: 20 U.S.C. 1145g, 3224a)

Sec. 86.411 What are the procedures for requesting reinstatement of eligibility?

(a)(1) An IHE, SEA, or LEA whose eligibility to receive any or all forms of Federal financial assistance has been terminated may file with the Department a request for reinstatement as an eligible entity no earlier than 18 months after the effective date of the termination.

(2) In order to be reinstated, the IHE, SEA, or LEA must demonstrate that it has corrected the violation or violations on which the termination was based and that it has met any repayment obligation imposed upon it under Sec. 86.301(b)(1) of this part.

(b) In addition to the requirements of paragraph (a) of this section, the IHE, SEA, or LEA shall comply with the requirements and procedures for reinstatement of eligibility applicable to any Federal program under which it desires to receive Federal financial assistance.

(Authority: 20 U.S.C. 1145g, 3224a)

Appendix A

Note: This appendix will not be codified in the Code of Federal Regulations.

This appendix contains a description of Federal trafficking (i.e., distribution) penalties for substances covered by the Controlled Substances Act (21 U.S.C. 811), and is taken from a Department of Justice publication entitled *Drugs of Abuse* (1989 Edition). Persons interested in acquiring the entire publication or in obtaining subsequent editions in the future should contact the Superintendent of Documents, Washington, DC 20402. This appendix also contains a description prepared by the Department of Justice of Federal penalties and sanctions for illegal possession of a controlled substance. Legal sanctions for the unlawful possession or distribution of alcohol are found primarily in State statutes.

The Department of Education is providing this information as an example of the minimum level of information that IHEs may provide to their students and employees in order to comply with the requirements in Sec. 86.100(a)(2) of these regulations relating to the distribution to students and employees of a description of the applicable legal sanctions under Federal law for the unlawful possession or distribution of illicit drugs and alcohol. The Secretary considers this description as meeting the requirements of the regulations, but IHEs are not precluded from distributing additional or more detailed information. In future years, IHEs should distribute the most current editions of these documents that are available.

APPENDIX A

Federal Trafficking Penalties

CSA	PENALTY		Quantity	DRUG	Quantity	PENALTY	
	2nd Offense	1st Offense				1st Offense	2nd Offense
I And II	Not less than 10 years. Not more than life. If death or serious injury, not less than life. Fine of not more than $4 million individual, $10 million other than individual.	Not less than 5 years. Not more than 40 years. If death or serious injury, not less than 20 years. Not more than life. Fine of not more than $2 million individual, $5 million other than individual.	10-99 gm or 100-999 gm mixture	METHAMPHETAMINE	100 gm or more or 1 kg[1] or more mixture	Not less than 10 years. Not more than life. If death or serious injury, not less than 20 years. Not more than life. Fine of not more than $4 million individual. $10 million other than individual.	Not less than 20 years. Not more than life. If death or serious injury, not less than life. Fine of not more than $8 million individual. $20 million other than individual.
			100-999 gm mixture	HEROIN	1 kg or more mixture		
			500-4.999 gm mixture	COCAINE	5 kg or more mixture		
			5-49 gm mixture	COCAINE BASE	50 gm or more mixture		
			0-99 gm or 100-999 gm mixture	PCP	100 gm or more or 1 kg or more mixture		
			1-10 gm mixture	LSD	10 gm or more mixture		
			40-399 gm mixture	FENTANYL	400 gm or more mixture		
			10-99 gm mixture	FENTANYL ANALOGUE	100 gm or more mixture		
	Drug	Quantity	First Offense		Second Offense		
	Others[2]	Any	Not more than 20 years. If death or serious injury, not less than 20 years, not more than life. Fine $1 million individual. $5 million not individual.		Not more than 30 years. If death or serious injury, life. Fine $2 million individual. $10 million not individual.		
III	All	Any	Not more than 5 years. Fine not more than $250,000 individual. $1 million not individual.		Not more than 10 years. Fine not more than $500,000 individual. $2 million not individual.		
IV	All	Any	Not more than 3 years. Fine not more than $250,000 individual. $1 million not individual.		Not more than 6 years. Fine not more than $500,000 individual. $2 million not individual.		
V	All	Any	Not more than 1 year. Fine not more than $100,000 individual. $250,000 not individual.		Not more than 2 years. Fine not more than $200,000 individual. $500,000 not individual.		

[1] Law as originally enacted states 100 gm. Congress requested to make technical correction to 1 kg.

[2] Does not include marijuana, hashish, or hash oil. (See separate chart.)

Federal Trafficking Penalties - Marijuana

As of November 18, 1988

Quantity	Description	First Offense	Second Offense
1,000 kg or more; or 1,000 or more plants	Marijuana Mixture containing detectable quantity*	Not less than 10 years, not more than life. If death or serious injury, not less than 20 years, not more than life. Fine not more than $4 million individual, $10 million other than individual.	Not less than 20 years, not more than life. If death or serious injury, not less than life. Fine not more than $8 million individual, $20 million other than individual.
100 kg to 1,000 kg; or 100-999 plants	Marijuana Mixture containing detectable quantity*	Not less than 5 years, not more than 40 years. If death or serious injury, not less than 20 years, not more than life. Fine not more than $2 million individual, $5 million other than individual.	Not less than 10 years, not more than life. If death or serious injury, not less than life. Fine not more than $4 million individual, $10 million other than individual.
50 to 100 kg	Marijuana	Not more than 20 years. If death or serious injury, not less than 20 years, not more than life. Fine $1 million individual, $5 million other than individual.	Not more than 30 years. If death or serious injury, life. Fine $2 million individual, $10 million other than individual.
10 to 100 kg	Hashish		
1 to 100 kg	Hashish Oil		
50-99 plants	Marijuana		
Less than 50 kg	Marijuana	Not more than 5 years. Fine not more than $250,000, $1 million other than individual.	Not more than 10 years. Fine $500,000 individual, $2 million other than individual.
Less than 10 kg	Hashish		
Less than 1 kg	Hashish Oil		

*Includes Hashish and Hashish Oil

(Marijuana is a Schedule I Controlled Substance)

Federal Penalties and Sanctions for Illegal Possession of a Controlled Substance

21 U.S.C. 844(a)

1st conviction: Up to 1 year imprisonment and fined at least $1,000 but not more than $100,000, or both.

After 1 prior drug conviction: At least 15 days in prison, not to exceed 2 years and fined at least $2,500 but not more than $250,000, or both.

After 2 or more prior drug convictions: At least 90 days in prison, not to exceed 3 years and fined at least $5,000 but not more than $250,000, or both.

Special sentencing provisions for possession of crack cocaine: Mandatory at least 5 years in prison, not to exceed 20 years and fined up to $250,000, or both, if:

(a) 1st conviction and the amount of crack possessed exceeds 5 grams.

(b) 2nd crack conviction and the amount of crack possessed exceeds 3 grams.

(c) 3rd or subsequent crack conviction and the amount of crack possessed exceeds 1 gram.

21 U.S.C. 853(a)(2) and 881(a)(7)

Forfeiture of personal and real property used to possess or to facilitate possession of a controlled substance if that offense is punishable by more than 1 year imprisonment. (See special sentencing provisions re: crack.)

21 U.S.C. 881(a)(4)

Forfeiture of vehicles, boats, aircraft or any other conveyance used to transport or conceal a controlled substance.

21 U.S.C. 844a

Civil fine of up to $10,000 (pending adoption of final regulations).

21 U.S.C. 853a

Denial of Federal benefits, such as student loans, grants, contracts, and professional and commercial licenses, up to 1 year for first offense, up to 5 years for second and subsequent offenses.

18 U.S.C. 922(g)

Ineligible to receive or purchase a firearm.

Miscellaneous

Revocation of certain Federal licenses and benefits, e.g. pilot licenses, public housing tenancy, etc., are vested within the authorities of individual Federal agencies.

Note: These are only Federal penalties and sanctions. Additional State penalties and sanctions may apply.

Appendix B

Note: This appendix will not be codified in the Code of Federal Regulations.

This appendix contains a description of health risks associated with substances covered by the Controlled Substances Act (21 U.S.C. 811), and is taken from a Department of Justice publication entitled *Drugs of Abuse* (1989 Edition). The appendix also includes a summary of health risks associated with alcohol, as described in *What Works: Schools Without Drugs* (1989 Edition), a Department of Education publication.

Persons interested in acquiring the publications or in obtaining subsequent editions in the future should contact the Superintendent of Documents, Washington, DC 20402, for *Drugs of Abuse*; and *Schools Without Drugs*, Pueblo, CO 81009, for *What Works: Schools Without Drugs*.

The Department of Education is providing this information as an example of the minimum level of information that IHEs may provide to their students and employees in order to comply with the requirement in Sec. 86.100(a)(3) of these regulations relating to the distribution of the health risks associated with the use of illicit drugs and the abuse of alcohol. The Secretary considers this information as meeting the requirements of the regulations, but IHEs are not precluded from distributing additional or more detailed information. If an IHE distributes this information in future years, it should use the most current editions of *Drugs of Abuse* and *Schools Without Drugs* that are available.

Controlled Substances – Uses and Effects

DRUGS CSA SCHEDULES	TRADE OR OTHER NAMES	MEDICAL USES	DEPENDENCE Physical	 Psychological	TOLER- ANCE	DURATION (Hours)	USUAL METHODS OF ADMINIS- TRATION	POSSIBLE EFFECTS	EFFECTS OF OVERDOSE	WITHDRAWAL SYNDROME
NARCOTICS										
Opium II III V	Dover's Powder, Paregoric, Parepectolin	Analgesic, Antidiarrheal	High	High	Yes	3-6	Oral, smoked	Euphoria, drowsiness, respiratory depression, constricted pupils, nausea	Slow and shallow breathing, clammy skin, convulsions, coma, possible death	Watery eyes, runny nose, yawning, loss of appetite, irritability, tremors, panic, cramps, nausea, chills, and sweating
Morphine II III	Morphine, MS-Contin, Roxanol, Roxanol-SR	Analgesic, Antitussive	High	High	Yes	3-6	Oral, smoked, injected			
Codeine	Tylenol w/Codeine, Empirin w/Codeine, Robitussan A-C, Fiorinal w/Codeine	Analgesic, Antitussive	Moderate	Moderate	Yes	3-6	Oral, injected			
Heroin I	Diacetylmorphine, Horse, Smack	None	High	High	Yes	3-6	Injected, sniffed, smoked			
Hydromorphone II	Dilaudid	Analgesic	High	High	Yes	3-6	Oral, injected			
Meperidine (Pethidine) II	Demerol, Mepergan	Analgesic	High	High	Yes	3-6	Oral, injected			
Methadone II	Dolophine, Methadone, Methadose	Analgesic	High	High-Low	Yes	12-24	Oral, injected			
Other NarcoticsI II III IV V	Numorphan, Percodan, Percocet, Tylox, Tussionex, Fentanyl, Darvon, Lomotil, Talwin	Analgesic, antidiarrheal, antitussive	High-Low	High-Low	Yes	Variable	Oral, injected			
DEPRESSANTS										
Chloral Hydrate IV	Noctec	Hypnotic	Moderate	Moderate	Yes	5-8	Oral	Slurred speech, disorientation, drunken behavior without odor of alcohol	Shallow respiration, clammy skin, dilated pupils, weak and rapid pulse, coma, possible death	Anxiety, insomnia, tremors, delirium, convulsions, possible death
Barbiturates II III IV	Amytal, Butisol, Florinal, Lotusate, Nembutal, Seconal, Tuinal, Phenobarbital	Anesthetic, anticonvulsant, sedative, hypnotic, veterinary euthanasic agent	High-Mod.	High-Mod.	Yes	1-16	Oral			
Benzodiazepines IV	Ativan, Dalmane, Dlazepam, Librium, Xanax, Serax, Valium, Tranxexe, Verstran, Versed, Halcion, Paxipam, Restoril	Antianxiety, anticonvulsant, sedative, hypnotic	Low	Low	Yes	4-8	Oral			
Methaqualone I	Quaalude	Sedative, hypnotic	High	High	Yes	4-8	Oral			
Glutethimide III	Doriden	Sedative, hypnotic	High	Moderate	Yes	4-8	Oral			
Other Depressants III IV	Equanil, Miltown, Noludar, Placidyl, Valmid	Antianxiety, sedative, hypnotic	Moderate	Moderate	Yes	4-8	Oral			

Controlled Substances - Uses and Effects

DRUGS CSA SCHEDULES	TRADE OR OTHER NAMES	MEDICAL USES	DEPENDENCE Physical	DEPENDENCE Psychological	TOLER- ANCE	DURATION (Hours)	USUAL METHODS OF ADMINIS- TRATION	POSSIBLE EFFECTS	EFFECTS OF OVERDOSE	WITHDRAWAL SYNDROME
STIMULANTS										
Cocaine[1] II	Coke, Flake, Snow, Crack	Local anesthetic	Possible	High	Yes	1-2	Sniffed, smoked, injected	Increased alertness, excitation, euphoria, increased pulse rate and blood pressure, insomnia, loss of appetite	Agitation, increase in body temperature, hallucinations, convulsions, possible death	Apathy, long periods of sleep, irritability, depression, disorientation
Amphetamines II	Biphetamine, Delcobase, Desoxyn, Dexedrine, Obetrol	Attention deficit disorders, narcolepsy, weight control	Possible	High	Yes	2-4	Oral, injected			
Phenmetrazine II	Preludin	Weight control	Possible	High	Yes	2-4	Oral, injected			
Methylphenidate II	Ritalin	Attention deficit disorders, narcolepsy	Possible	Moderate	Yes	2-4	Oral, injected			
Other Stimulants III IV	Adipex, Cylert, Didrex, Ionamin, Mellat, Plagine, Sanorex, Tenuate, Taperul, Prelu-2	Weight control	Possible	High	Yes	2-4	Oral, injected			
HALLUCINOGENS										
LSD I	Acid, Microdot	None	None	Unknown	Yes	8-12	Oral	Illusions and hallucinations, poor perception of time and distance	Longer, more intense "trip" episodes, psychosis, possible death	Withdrawal syndrome not reported
Mescaline and Peyote I	Mexc, Buttons, Cactus	None	None	Unknown	Yes	8-12	Oral			
Amphetamine Variants I	2.5-DMA, PMA, STP, MDA, MDMA, TMA, DOM, DOB	None	Unknown	Unknown	Yes	Variable	Oral, injected			
Phencyclidine II	PCP, Angel Dust, Hog	None	Unknown	High	Yes	Days	Smoked, oral, injected			
Phencyclidine Analogues I	PCE, PCPy, TCP	None	Unknown	High	Yes	Days	Smoked, oral, injected			
Other Hallucinogens I	Buloterine, Ibogaine, DMT, DET, Psilocybin, Psilocyn	None	None	Unknown	Possible	Variable	Smoked, oral, injected, sniffed			
CANNABIS										
Marijuana I	Pot, Acapulco Gold, Grass, Reefer, Sinsemilla, Thai Sticks	None	Unknown	Moderate	Yes	2-4	Smoked, oral	Euphoria, relaxed inhibitions, increased appetite, disoriented behavior	Fatigue, paranoia, possible psychosis	Insomnia, hyperactivity, and decreased appetite occasionally reported
Tetrahydrocannabinol I II	THC, Marinol	Cancer chemotherapy, antinauseant	Unknown	Moderate	Yes	2-4	Smoked, oral			
Hashish I	Hash	None	Unknown	Moderate	Yes	2-4	Smoked, oral			
Hashish Oil I	Hash Oil	None	Unknown	Moderate	Yes	2-4	Smoked, oral			

[1] Designated a narcotic under the GSA. [2] Not designated a narcotic under the GSA.

APPENDIX B

Alcohol

Effects

Alcohol consumption causes a number of marked changes in behavior. Even low doses significantly impair the judgement and coordination required to drive a car safely, increasing the likelihood that the driver will be involved in an accident. Low to moderate doses of alcohol also increase the incidence of a variety of aggressive acts, including spouse and child abuse. Moderate to high doses of alcohol cause marked impairments in higher mental functions, severely altering a person's ability to learn and remember information. Very high doses cause respiratory depression and death. If combined with other depressants of the central nervous system, much lower doses of alcohol will produce the effects just described.

Repeated use of alcohol can lead to dependence. Sudden cessation of alcohol intake is likely to produce withdrawal symptoms, including severe anxiety, tremors, hallucinations, and convulsions. Alcohol withdrawal can be life-threatening. Long-term consumption of large quantities of alcohol, particularly when combined with poor nutrition, can also lead to permanent damage to vital organs such as the brain and the liver.

Mothers who drink alcohol during pregnancy may give birth to infants with fetal alcohol syndrome. These infants have irreversible physical abnormalities and mental retardation. In addition, research indicates that children of alcoholic parents are at greater risk than other youngsters of becoming alcoholics.

Appendix B:
Disclosure Notifications:
a. Employees

Revised Page 81 - 08/26/2021

To: Montgomery College Employees

From: Robert Roop, Chief Human Resources Officer

Subject: **Montgomery College Drug and Alcohol Abuse Prevention Program**
Drug-Free Schools and Communities Act Disclosure

Date: February 13, 2019

Montgomery College is required under the Drug-Free Schools and Communities Act to annually notify employees about our Drug and Alcohol Abuse Prevention program.

Montgomery College's commitment to drug and alcohol abuse prevention is underscored by the following policy #31005 adopted on May 15, 1989 by the College Board of Trustees.

I. The Board of Trustees is committed to the education of students, employees, and community members regarding substance abuse prevention, detection, and treatment services; to the continuation of a collegewide substance abuse prevention program and other ongoing efforts that will foster such education; and to the maintenance of a drug-free environment throughout the College.
II. The unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited at Montgomery College.
III. College employees and students are subject to appropriate disciplinary action for violation of this policy, in accordance with College policies and procedures regarding employee discipline and discharge and in accordance with the student code of conduct.
IV. The College president is authorized to establish procedures to implement this policy.

Per 31005CP, II, the following standards of conduct are applicable to employees:

A. Employees should report for work fit for duty and free of any adverse effects of illegal drugs or alcohol. This does not prohibit employees from the lawful use and possession of prescribed medications. Employees must, however, consult with their physicians about the medication's effect on their fitness for duty and the ability to work safely and promptly disclose restrictions to their supervisor. Employees should not, however, disclose underlying medical conditions to supervisors, but should do so to the HIPAA Privacy Official in the Office of Human Resources and Strategic Talent Management.

B. Employees may be required to undergo a medical examination pursuant to College Policy 31105—Medical Examinations when the employee's observable behavior creates a reasonable belief that the employee cannot perform the essential job functions or that the employee poses a threat to the health and safety of the employee or others, or to College property, as a result of the effects of drugs or alcohol.

C. The unlawful manufacture, sale, distribution, dispensing, possession or use of controlled substances, and the unlawful use or abuse (e.g., being intoxicated) of alcohol by anyone on College property (including any facilities leased or used by the College) or in College vehicles is prohibited. The use of alcohol by anyone under 21 years of age or the abuse of alcohol by anyone at any College sponsored or supervised activity off campus is also prohibited.

D. Notification of Criminal Conviction

1. As required by the Drug-Free Workplace Act of 1988, the Drug-Free Schools and Communities Act Amendments, the Maryland Higher Education Commission's Policies Concerning Drug and Alcohol Abuse Control, and as a condition of employment, employees must abide by the terms of this procedure and notify the Office of Human Resources and Strategic Talent Management in writing, of any criminal drug statute conviction for a violation occurring on or off Montgomery College property, no later than five calendar days after such conviction. Lack of compliance with these requirements may subject the employee to immediate disciplinary action, up to and including discharge.

2. Upon receipt of notification of a conviction, the College will take the following actions as required by law:
   a. Notify the appropriate federal agencies of such convictions, and
   b. Take appropriate personnel action against the employee, up to and including discharge; and/or
   c. Require the employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a federal, state or local health, law enforcement, or other appropriate agency.

E. Consequences of Alcohol and Drug Abuse

1. The unlawful manufacture, distribution, use, sale, or possession (e.g., on the person or in a desk, or vehicle) of illegal drugs or of opened alcohol while on the job or on College leased or owned property is an offense punishable by discharge and may result in criminal prosecution. Any illegal drugs found will be turned over to the appropriate law enforcement agency.

2. The illegal use or abuse of alcohol on campus or as a part of any College activity whether on College leased or owned property is prohibited in accordance with all applicable Federal, State and local laws and the Drug and Alcohol Abuse Prevention Policy. In addition to possible prosecution under the aforementioned laws, employees who violate the prohibitions of this policy are subject to College imposed disciplinary sanctions consistent with applicable procedures and regulations. Sanctions may include, but need not be limited to, suspension, discharge, or referral to appropriate authorities for prosecution. Any disciplinary sanction imposed may also include the completion of an appropriate rehabilitation program as a condition of reinstatement or continued employment.

Health Risks of Alcohol Abuse
For information about the health risks of alcohol abuse, click here.

*Health Risks Associated with the Use of Illicit Drugs
For a description of health risks associated with the use of illicit drugs and abuse of alcohol see attachment. For additional information click here.

You may also access free, confidential assistance through the **Faculty Staff Assistance Program** guidanceresources.com or call 844-236-2668 (TDD: 800-697-0353). To register use Organization Web ID: MCC.

Drug and Alcohol Abuse Treatment Resources and Clinical Services
For information about national and local resources available for drug and alcohol abuse treatment, please see attachment.

For more information on the Drug and Alcohol Abuse Prevention Program for Employees, please see the Drug and Alcohol Abuse Prevention Biennial Review report or contact Ms. Rowena D'Souza, Risk Management Coordinator / HIPAA Privacy Official at rowena.dsouza@montgomerycollege.edu.

*Attachment

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Rockville, MD 20850
240-777-1770 or 240-777-4710
http://www.montgomerycountymd.gov/

NATIONAL HOTLINES and RESOURCES

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https://americanaddictioncenters.org/rehab-guide/free/

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National Institute on Drug Abuse (NIDA)
301-443-1124
https://www.drugabuse.gov/

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301-443-3860
www.niaaa.nih.gov

Substance Abuse and Mental Health Services Administration (SAMHSA)
Treatment Facility Locator
https://dasis3.samhsa.gov

LOCAL RESOURCES

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301-762-5613 (Intermediate care)
301-279-8828 (Combined care)

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http://bilingualcounselingcenter.com/
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Group for cocaine abusers
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301-963-7222

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https://www.addicted.org/directory/item/hannahs-aftercare-and-rehab-center.html
1-800-304-2219

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Rockville, MD 20850
301-294-4015

Kolmac Clinic
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Silver Spring, MD 20910
301-589-0255
https://www.kolmac.com/

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301-896-3100

Washington Adventist Hospital
7600 Carroll Ave. Takoma Park, MD 20912
www.adventisthealthcare.com
301-891-7600 or 301-891-5600

To: Montgomery College Employees

From: Robert Roop, Chief Human Resources Officer

Subject: **Montgomery College Drug and Alcohol Abuse Prevention Program Drug-Free Schools and Communities Act Disclosure**

Date: September 18, 2018

Montgomery College is required under the Drug-Free Schools and Communities Act to annually notify employees about our Drug and Alcohol Abuse Prevention program.

Montgomery College's commitment to drug and alcohol abuse prevention is underscored by the following policy #31005 adopted on May 15, 1989 by the College Board of Trustees.

I. The Board of Trustees is committed to the education of students, employees, and community members regarding substance abuse prevention, detection, and treatment services; to the continuation of a collegewide substance abuse prevention program and other ongoing efforts that will foster such education; and to the maintenance of a drug-free environment throughout the College.
II. The unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited at Montgomery College.
III. College employees and students are subject to appropriate disciplinary action for violation of this policy, in accordance with College policies and procedures regarding employee discipline and discharge and in accordance with the student code of conduct.
IV. The College president is authorized to establish procedures to implement this policy.

Per 31005CP, II, the following standards of conduct are applicable to employees:

A. Employees should report for work fit for duty and free of any adverse effects of illegal drugs or alcohol. This does not prohibit employees from the lawful use and possession of prescribed medications. Employees must, however, consult with their physicians about the medication's effect on their fitness for duty and the ability to work safely and promptly disclose restrictions to their supervisor. Employees should not, however, disclose underlying medical conditions to supervisors, but should do so to the HIPAA Privacy Official in the Office of Human Resources and Strategic Talent Management.

B. Employees may be required to undergo a medical examination pursuant to College Policy 31105—Medical Examinations when the employee's observable behavior creates a reasonable belief that the employee cannot perform the essential job functions or that the employee poses a threat to the health and safety of the employee or others, or to College property, as a result of the effects of drugs or alcohol.

C. The unlawful manufacture, sale, distribution, dispensing, possession or use of controlled substances, and the unlawful use or abuse (e.g., being intoxicated) of alcohol by anyone on College property (including any facilities leased or used by the College) or in College vehicles is prohibited. The use of alcohol by anyone under 21 years of age or the abuse of alcohol by anyone at any College sponsored or supervised activity off campus is also prohibited.

D. Notification of Criminal Conviction

1. As required by the Drug-Free Workplace Act of 1988, the Drug-Free Schools and Communities Act Amendments, the Maryland Higher Education Commission's Policies Concerning Drug and Alcohol Abuse Control, and as a condition of employment, employees must abide by the terms of this procedure and notify the Office of Human Resources and Strategic Talent Management in writing, of any criminal drug statute conviction for a violation occurring on or off Montgomery College property, no later than five calendar days after such conviction. Lack of compliance with these requirements may subject the employee to immediate disciplinary action, up to and including discharge.

2. Upon receipt of notification of a conviction, the College will take the following actions as required by law:
   a. Notify the appropriate federal agencies of such convictions, and
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Health Risks of Alcohol Abuse
For information about the health risks of alcohol abuse, click here.

*Health Risks Associated with the Use of Illicit Drugs
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You may also access free, confidential assistance through the **Faculty Staff Assistance Program** guidanceresources.com or call 844-236-2668 (TDD: 800-697-0353). To register use Organization Web ID: MCC.

Drug and Alcohol Abuse Treatment Resources and Clinical Services
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For more information on the Drug and Alcohol Abuse Prevention Program for Employees, please see the Drug and Alcohol Abuse Prevention Biennial Review report or contact Ms. Rowena D'Souza, Risk Management Coordinator / HIPAA Privacy Official at rowena.dsouza@montgomerycollege.edu.

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MONTGOMERY COLLEGE
Office of Human Resources and Strategic Talent Management

February 23, 2018

MEMORANDUM

To: Montgomery College Employees

From: Robert G. Roop, Chief Human Resources Officer

Subject: Montgomery College Drug and Alcohol Abuse Prevention Program - Drug-Free Schools and Communities Act Disclosure

Montgomery College is required under the Drug-Free Schools and Communities Act to annually notify employees about our Drug and Alcohol Abuse Prevention program.

Montgomery College's commitment to drug and alcohol abuse prevention is underscored by the following policy #31005 adopted on May 15, 1989 by the College Board of Trustees.

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Information provided for each organization:
Name, Address, Contact Information Distance in Miles, Maps
Primary Focus
Services Provided, Type of Care
Special Programs/Groups
Forms of Payment Accepted, Payment Assistance

SELF-HELP GROUPS Alcoholics Anonymous
Self-help group for alcoholic and alcohol abusers
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Takoma Park, MD 20912
www.adventisthealthcare.com
Phone: 301-981-7600
301-981-5600

White Flint Recovery Inc.
1335 Rockville Pike
Rockville, MD 20852
Phone: 301-294-6545

Counseling Plus Inc.
8561 Fenton Street
Silver Spring, MD 20910
Phone: 301-565-9001

Family Health Center Psychological Services
16220 S. Frederick Avenue
Gaithersburg, MD 20877
www.sober.com
Phone: 301-963-7222

Hannah's Aftercare and Rehab
1201 Millgrove Road
Silver Spring, MD 20905
www.hanahsaftercareandrehabcenterfaithweb.com
Phone: 301-384-1615

Journeys Adult Program
402 Hungerford Drive
Rockville, MD 20850
Phone: 301-294-4015

Kolmac Clinic
1003 Spring Street
Silver Spring, MD 20910
Phone: 301-589-0255
www.kolmac.com

DESCRIPTION OF HEALTH RISKS ASSOCIATED WITH THE USE OF ILLICIT DRUGS AND ABUSE OF ALCOHOL

Controlled Substances - *Uses & Effects*

Classification	Drug Name	Common or Brand	Dependence	Potential	Acute Effects	Health Risks and Effects of Long-term Use*	Overdose Effects
			Physical	Psycho-logical			
ALCOHOL	Ethanol	Beer Wine Distilled Liquor	High High High	High High High	• Lowered Inhibitions • Impaired Judgement, Vision • Loss of Motor Skills, Coordination • Slurred Speech	• Hypertension • Liver Damage • Cardiovascular Disease • Toxic Psychosis • Neurologic Damage • Addiction with Severe Withdrawal	• Coma • Possible Death
NARCOTICS	[1]Opium Morphine Codeine [1]Heroin Meperidine Other	[2]Paregoric, Dover S Power [2]Morphine [2]Tylenol W/Codeine, Robitussin Heroin [2]Demerol, Pethadol [2]Dilaudid, Lentine, Percodan	High High High High High High	High High High High High High	• Euphoria, Drowsiness • Respiratory Depression • Constricted Pupils • Nausea, Vomit • Analgesia (Pain Relief)	• Loss of Appetite • Constipation • Risk of AIDS & Hepatitis from I.V. Drug Use	• Shallow Perspiration • Clammy Skin • Convulsions, Coma • Possible Death • May be Toxic if Mixed with Alcohol
DEPRESSANTS	Chloral Hydrate Barbiturates Gamma Hydroxybutric Acid Gamma Butyrolactone Glutethimide Ketamine Methaqualone Tranquilizers	[2]Noctec, Somnos [2]Nembutal, Phonobarbitol, Seconal, Tuinol Date Rape Drug, Liquid Ecstacy, Cherrymeth, GBL [2]Doriden Special K, K [2]Optimil, Parest, Quaalude, Sopor [2] Equanil, Valium, Tranxene Serax, Xanax, Rohyphal, Dalmane, Dormate, Placidyl, Valmid	Moderate High Moderate-High Unknown High Unknown High Moderate	Moderate High High Unknown High Unknown High High	• Slurred Speech • Disorientation • Drunken Behavior Without the Odor of Alcohol • Euphoria • Lowered Inhibitions • Loss of Motor Skills • Blackouts • Relaxation, Depression • Hallucinations	• Addiction with Withdrawal • Toxic Psychosis • Weak, Rapid Pulse • Hallucinations • Nausea • Seizures • Insomnia • Anxiety • Tremors • Dizziness • Loss of Peripheral Vision High	• Shallow Respiration • Cold, Clammy Skin • Blackout • Coma • Possible Death • May be Toxic if mixed with Alcohol High
STIMULANTS	[1]Cocaine [1]Amphetamine Phenmetrazine Methylphenidate Other Methylenedioxy-methamphetamine	Cocaine Hydrochloride [2]Benzedrine, Biphetamine, Desoxyn, Dexedrine [2]Preludin [2]Ritalin [2]Cylert, Didrex, Pre-Sate, Sanorex, Voranil Ecstacy, MDMA	Possible Possible Possible Possible Possible Low	High High High High High High	• Feeling of Well-Being • Excitation, Euphoria • Increased Alertness • Increased Blood Pressure, Pulse • Insomnia, Appetite Loss	• Delusions, Hallucinations (Toxic Psychosis) • Possible Organ/Tissue Damage	• Agitation • Temperature Increase • Hallucinations • Convulsions • Heart Attack, Stroke • High Blood Pressure • Loss of Consciousness • Seizures
HALLUNCINO-GENICS	[1]LSD [1]Mescaline [1]Psilocybin [1]MDA [1]PCP	Acid, Lysergic Acid Peyote, Peyote Buttons, Mescalitor Magic Mushrooms, Shrooms Angel Dust, Crystal, Cernylan (Veterinary)	Low Low Low Unknown Unknown	Unknown Unknown Unknown Unknown Unknown	• Dilated Pupils • Increased Blood Pressure, Pulse • Delusions/Hallucinations • Distorted Perception of Time, Space, and Reality	• Hallucinogens, Especially LSD, may Intensify Existing Psychosis • Possible Violent Behavior	• Intense Bad Trips • Psychosis • Possible Sudden Death
INHALANTS	Airplane Glue Lighter Fluid Aerosols Spray Paints Paint Thinner Gasoline Poppers	Active Ingredient: Toluene Active Ingredient: Naphalene Active Ingred.: Chloroplourocarbon Active Ingred.: Petroleum Distillate Active Ingred.: Petroleum Distillate Active Ingred.: Petroleum Distillate Active Ingred.: Amyl/butyl Nitrite	Unknown Unknown Unknown Unknown Unknown Unknown Unknown	Unknown Unknown Unknown Unknown Unknown Unknown Unknown	• Slurred Speech • Drunken Behavior • Impaired Judgement • Poor Coordination	• Hallucinations • Possible Damage to Bone Marrow, Lungs, Kidneys, Liver, Heart, Brain, Eyes	• Unconsciousness • Coma • Possible Toxic Reaction • Possible Sudden Death
CANNABIS	[1]Marijuana [1]Hashish [1]Hash Oil	Grass, Pot, Weed, Dope Hash	Low Low Low	Moderate Moderate Moderate	• Tachycardia, Reddened Eyes • Euphoria, Profound Humor • Altered Time/Space Perception • Short-Term Memory Loss • Increased Appetite	• Cardiovascular Damage as with Smoking Tobacco	• Insomnia, Hyperactivity • Panic Attacks, Paranoia • Possible Toxic Reaction if Treated w/other Chemicals
TOBACCO	Nicotine	Cigarettes Cigars	Moderate Moderate	High High	• Relaxation • Stimulation	• Cardiovascular Disease • Respiratory Illness	• Possible Death at very High Dosage Levels

* Alcohol and other drug use during pregnancy increases risk of physical harm to fetus

[2] Psychoactive drug effects refer to use at a greater than prescribed therapeutic dosage level

[1] Additional risk of harm from toxic impurities in street drugs

MONTGOMERY COLLEGE
Office of Human Resources and Strategic Talent Management

September 19, 2017

MEMORANDUM

To: Montgomery College Employees

From: Robert Roop, Chief Human Resources Officer

Subject: Montgomery College Drug and Alcohol Abuse Prevention Program - Drug-Free Schools and Communities Act Disclosure

Montgomery College is required under the Drug-Free Schools and Communities Act to annually notify employees about our Drug and Alcohol Abuse Prevention program.

Montgomery College's commitment to drug and alcohol abuse prevention is underscored by the following policy #31005 adopted on May 15, 1989 by the College Board of Trustees.

I. The Board of Trustees is committed to the education of students, employees, and community members regarding substance abuse prevention, detection, and treatment services; to the continuation of a collegewide substance abuse prevention program and other ongoing efforts that will foster such education; and to the maintenance of a drug-free environment throughout the College.

II. The unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited at Montgomery College.

III. College employees and students are subject to appropriate disciplinary action for violation of this policy, in accordance with College policies and procedures regarding employee discipline and discharge and in accordance with the student code of conduct.

IV. The College President is authorized to establish procedures to implement this policy.

V. Per 31005CP, II, the following standards of conduct are applicable to employees:

A. Employees should report for work fit for duty and free of any adverse effects of illegal drugs or alcohol. This does not prohibit employees from the lawful use and possession of prescribed medications. Employees must however, consult with their physicians about the medication's effect on their fitness for duty and the ability to work safely and promptly disclose restrictions to their supervisor. Employees should not, however disclose underlying medical conditions to supervisors, but should do so to the HIPAA Privacy Official in the Office of Human Resources and Strategic Talent Management.

B. Employees may be required to undergo a medical examination pursuant to College Policy 31105-Medical Examinations when the employee's observable behavior creates a reasonable belief that the employee cannot perform the essential job functions or that the employee poses a threat to the health and safety of the employee or others, or to College property, as a result of the effects of drugs or alcohol.

C. The unlawful manufacture, sale, distribution, dispensing, possession or use of controlled substances, and the unlawful use or abuse (e.g., being intoxicated) of alcohol by anyone on College property (including any facilities leased or used by the College) or in College vehicles is prohibited. The use of alcohol by anyone under 21 years of age or the abuse of alcohol by anyone at any College sponsored or supervised activity off campus is also prohibited.

D. Notification of Criminal Conviction

1. As required by the Drug-Free Workplace Act of 1988, the Drug-Free Schools and Communities Act Amendments, the Maryland Higher Education Commission's Policies Concerning Drug and Alcohol Abuse Control, and as a condition of employment, employees must abide by the terms of this procedure and notify the Office of Human Resources and Strategic Talent Management in writing, of any criminal drug statute conviction for a violation occurring on or off Montgomery College property, no later than five calendar days after such conviction. Lack of compliance with these requirements may subject the employee to immediate disciplinary action, up to and including termination.

2. Upon receipt of notification of a conviction, the College will take the following actions as required by law:
    a. Notify the appropriate federal agencies of such convictions, and
    b. Take appropriate personnel action against the employee, up to and including termination; and/or
    c. Require the employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a federal, state or local health, law enforcement, or other appropriate agency.

E. Consequences of Alcohol and Drug Abuse

1. The unlawful manufacture, distribution, use, sale, or possession (e.g., on the person or in a desk, or vehicle) of illegal drugs or of opened alcohol while on the job or on College leased or owned property is a dismissible offense and may result in criminal prosecution. Any illegal drugs found will be turned over to the appropriate law enforcement agency.

2. The illegal use or abuse of alcohol on campus or as a part of any College activity whether on College leased or owned property is prohibited in accordance with all applicable Federal, State and local laws and the Drug and Alcohol Abuse Prevention Policy. In addition to possible prosecution under the aforementioned laws, employees who violate the prohibitions of this policy are subject to College imposed disciplinary sanctions consistent with applicable procedures and regulations. Sanctions may include, but need not be limited to, suspension, termination of employment, or referral to appropriate authorities for prosecution. Any disciplinary sanction imposed may also include the completion of an appropriate rehabilitation program as a condition of reinstatement or continued employment.

-

Health Risks of Alcohol Abuse

For information about the health risks of alcohol abuse, click here.

*Health Risks Associated with the Use of Illicit Drugs

For a description of health risks associated with the use of illicit drugs and abuse of alcohol see attachment. For additional information click here.

You may also access free, confidential assistance through the **Faculty Staff Assistance Program** Guidanceresources.com or call 844-236-2668 (TDD: 800-697-0353). To register use Organization Web ID: MCC.

Drug and Alcohol Abuse Treatment Resources and Clinical Services
For information about national and local resources available for drug and alcohol abuse treatment, please see attachment.

For more information on the Drug and Alcohol Abuse Prevention Program for Employees, please see the Drug and Alcohol Abuse Prevention Biennial Review report or contact Ms. Rowena D'Souza, Risk Management Coordinator/ HIPAA Privacy Official at rowena.dsouza@montgomerycollege.edu.

*Attachment

DRUG AND ALCOHOL RESOURCES AND CLINICAL SERVICES

Montgomery College Faculty/Staff Assistance Program
Guidanceresources.com
TDD:800-697-0353
Call: 844-236-2668
WebID: MCC
Available 24/7

Montgomery County Department of Health and Human Services
Behavioral Health – Addiction Services
255 Rockville Pike #145
Rockville, MD 20850
240-777-1770 or 240-777-4710
Behavioral Health – Outpatient Addiction Services
240-777-1680
http://www.montgomerycountymd.gov/

Mental Health Association of Montgomery County
1000 Twinbrook Parkway
Rockville, MD 20851
301-738-9697 - Youth Hotline
301-738-2255 - General Hotline

Crisis Center
1301 Piccard Drive
Rockville, MD 20850
240-777-4000
Available 24 hours a day, 7 days per week

NATIONAL HOTLINES

Alcohol Hotline
Information and referral 24 hour
1- 800-ALCOHOL (252-6465)

National Treatment Referral
1-800-662-HELP (4357)

National Suicide Prevention Lifeline
1-800-273-TALK (8255)

Substance Abuse and Mental Health Services Administration (SAMHSA)
Treatment Facility Locator
http://www.smhsa.gov/treatment/index.aspx

SELF- HELP GROUPS

Alcoholics Anonymous
Self-help group for alcoholic and alcohol abusers
202-966-9115 (DC, MD, VA)
www.aa-dc.org

Avery House (Group)
14705 Avery Road
Rockville, MD 20853
Phone: 301-762-4651
Women/Children - **Phone: 301-762-5613**
Intermediate Care - **Phone: 301-279-8828**
Combined Care – 301-279-8828

Bilingual Counseling Center
11301 Georgia Avenue
Silver Spring, MD 20902
Phone: 301-942-7821

Circle Treatment Center PC
424 N. Fredrick Avenue
Gaithersburg, MD 20877
www.circletreatment.com
Phone: 301-258-2626

Montgomery Recovery Services Inc.
14636 Rothgeb Drive
Rockville, MD 20850
www.drugtreatment.net
Phone: 301-762-5300

Narcotics Anonymous
Group for narcotics abusers
202-399-5316 DC and MD
www.na.org

New Beginnings at Potomac Valley Nursing and Wellness Center
1235 Potomac Valley Road
Rockville, MD 20850
www.potomacvalley.com
Phone: 301-762-0700

Potomac Ridge Behavioral Health
14901 Broschart
Rockville, MD 20850
Phone: 301-251-4500

Cocaine Anonymous National Referral Line
Group for cocaine abusers
800-347-8998 24 hours
www.ca.org

Counseling Plus Inc
8561 Fenton Street
Silver Spring, MD 20910
Phone: 301-565-9001

Family Health Center Psychological Services
16220 S. Frederick Avenue
Gaithersburg, MD 20877
www.sober.com
Phone: 301-963-7222

Journeys Adult Program
402 Hungerford Drive
Rockville, MD 20850
Phone: 301-294-4015

Kolmac Clinic
1003 Spring Street
Silver Spring, MD 20910
www.kolmac.com
Phone: 301-589-0255

Lawrence Court Halfway House
1 Lawrence Court
Rockville, MD 20850
Link Removed 08/26/2021
Phone: 301-251-8920

Metro Counseling Service Inc.
15719 Crabbs Branch Way
Derwood, MD 20855
Phone: 301-670-6161

Montgomery County Dept. Health/Human Services/ Outpatient Addiction Services
751 Twinbrook Parkway
Rockville, MD 20851
www.montgomerycountymd.gov
Phone: 240-777-1680

Montgomery General Hospital Addiction and Mental Health Center
18101 Prince Philip Drive
Olney, MD 20832
www.montgomerygeneral.com
Phone: 301-774-8800

Prince George's County Addictions Treatment Centers(Group)
3003 Hospital Drive
Cheverly, MD 20785
Phone: 301-583-5920
(Clinton)**301-856-9400**

Step Ahead Program of KHI Services
20528 Boland Farm Road
Germantown, MD 20876
Phone: 240-686-0707

Suburban Hospital Addiction Treatment Center Outpatient Services
6001 Montrose Road
Rockville, MD 20852
www.suburbanhospital.org
Phone: 301-896-2036

Suburban Hospital Behavioral Health
8600 Old Georgetown Road
Bethesda, MD 20814
Phone: 301-896-2564 (or) 301-896-3100

Washington Adventist Hospital
7600 Carroll Avenue
Takoma Park, MD 20912
www.adventisthealthcare.com
Phone: 301-891-7600(or) 301-891-5600

White Flint Recovery Inc.
1335 Rockville Pike
Rockville, MD 20852
Phone: 301-294-6545

Appendix B:
Disclosure Notifications:
b. Students

Revised Pages 86, 91, 96, and 101 - 08/26/2021

To: Montgomery College Students

From: Dr. Monica Brown, Senior Vice President for Student Affairs

Subject: **Drug-Free Schools and Communities Act Disclosure**

Date: February 13, 2019

Montgomery College is required under the Drug-Free Schools and Communities Act to annually notify students about our Drug and Alcohol Abuse Prevention program.

Policy and Sanctions

Montgomery College's commitment to drug and alcohol abuse prevention is underscored by the following policy adopted on May 15, 1989 by the College Board of Trustees:

I. The Board of Trustees is committed to the education of students, employees, and community members regarding substance abuse prevention, detection, and treatment services; to the continuation of a collegewide substance abuse prevention program and other ongoing efforts that will foster such education; and to the maintenance of a drug-free environment throughout the College.
II. The unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited at Montgomery College.
III. College students and employees are subject to appropriate disciplinary action for violation of this policy, in accordance with College policies and procedures regarding employee discipline and discharge and in accordance with the student code of conduct.
IV. The College president is authorized to establish procedures to implement this policy.

Students are responsible, as citizens, for knowing about and complying with the provisions of federal, state, and local law regarding illegal substances. Any student who possesses, uses, or sells alcoholic beverages or illegal drugs is subject to College disciplinary action. Additionally, prosecution and punishment by civil authorities may occur, through enforcement of Maryland and Federal laws. This includes enforcement of Maryland's underage drinking law.

The College will initiate its own disciplinary proceedings against a student when the alleged conduct is deemed a violation of College policies and procedures. Penalties will be imposed by the College in accordance with procedural safeguards applicable to disciplinary actions against students. Penalties range from written warning to expulsion from enrollment. In accordance with Board policy, students are subject to disciplinary action as set forth in the student code of conduct.

Heroin and Opioid Education and Community Action Act of 2017

The Maryland legislature passed the Heroin and Opioid Education and Community Action Act of 2017 (HB 1082) which was signed into law by Governor Larry Hogan in June 2017. The law will combat the opioid epidemic by increasing treatment access, prevention efforts, and public awareness and education. The new law requires public schools, including higher education

institutions, to provide addiction and prevention education programs on substance use disorders and train personnel to respond to an opioid overdose. Please review the Act in detail at the following link: http://mgaleg.maryland.gov/2017RS/chapters_noln/Ch_573_hb1082E.pdf.

See also, Heroin and Opioid Awareness & Prevention Toolkit.

Health Risks of Alcohol Abuse
For information concerning the health risks of alcohol abuse, click here.

*Health Risks Associated with the Use of Illicit Drugs
For the health risks associated with the use of illicit and controlled drugs, please see the attached document.

*Drug and Alcohol Abuse Treatment Resources and Clinical Services
For information about national and local resources available for drug and alcohol abuse treatment, please see the attached document.

For more information on the Drug and Alcohol Abuse Prevention Program for Students, see the 2017 Drug and Alcohol Abuse Prevention Program Biennial Review report or contact Dr. Clemmie Solomon, collegewide dean of student engagement and Takoma Park/Silver Spring campus dean of student affairs.

*Attachments

DRUG AND ALCOHOL RESOURCES AND CLINICAL SERVICES

Montgomery College Faculty/Staff Assistance Program
www.guidanceresources.com
TDD:800-697-0353
Call: 844-236-2668
WebID: MCC
Available 24/7

Montgomery County Department of Health and Human Services
Behavioral Health – Addiction Services
255 Rockville Pike #145
Rockville, MD 20850
240-777-1770 (or) 240-777-4710
Behavioral Health – Outpatient Addiction Services
240-777-1680
http://www.montgomerycountymd.gov/

Mental Health Association of Montgomery County
1000 Twinbrook Parkway
Rockville, MD 20851
301-738-9697 – Youth Hotline
301-738-2255 – General Hotline

Crisis Center
1301 Piccard Drive
Rockville, MD 20850
240-777-4000
Available 24 hours a day, 7 days per week

NATIONAL HOTLINES

Alcohol Hotline
Information and referral 24 hour
1- 800-ALCOHOL (252-6465)

National Treatment Referral
1-800-662-HELP (4357)

National Suicide Prevention Lifeline
1-800-273-TALK (8255)

Substance Abuse and Mental Health Services Administration (SAMHSA)
Treatment Facility Locator
http://www.samhsa.gov/treatment/index.aspx

SELF-HELP GROUPS

Alcoholics Anonymous
Self-help group for alcoholic and alcohol abusers
202-966-9115 (DC, MD, VA)
www.aa-dc.org

Avery House (Group)
14705 Avery Road
Rockville, MD 20853
Phone: 301-762-4651
Women/Children – **Phone: 301-762-5613**
Intermediate Care – **Phone: 301-279-8828**
Combined Care – 301-279-8828

Behavioral Health Services
3003 Hospital Drive
Cheverly, MD 20785
Phone: 301-583-5920
(Clinton) **301-856-9400**

Bilingual Counseling Center
11301 Georgia Avenue
Silver Spring, MD 20902
Phone: 301-942-7821

Circle Treatment Center PC
424 N. Fredrick Avenue
Gaithersburg, MD 20877
www.sobernation.com
Phone: 301-258-2626

Cocaine Anonymous National Referral Line
Group for cocaine abusers
800-347-8998 24 hours
www.ca.org

Counseling Plus Inc.
8561 Fenton Street
Silver Spring, MD 20910
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Family Health Center Psychological Services
16220 S. Frederick Avenue
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www.sober.com
Phone: 301-963-7222

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www.medstarmontgomery.org
Phone: 301-774-8800

Narcotics Anonymous
Group for narcotics abusers
202-399-5316 DC and MD
www.na.org

Potomac Ridge Behavioral Health
14901 Broschart
Rockville, MD 20850
Phone: 301-251-4500

Suburban Hospital Addiction Treatment Center Outpatient Services
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Rockville, MD 20852
www.suburbanhospital.org
Phone: 301-896-2036

Washington Adventist Hospital
7600 Carroll Avenue
Takoma Park, MD 20912
www.adventisthealthcare.com
Phone: 301-891-7600 (or) 301-891-5600

Lawrence Court Halfway House
1 Lawrence Court
Rockville, MD 20850

Link Removed 08/26/2021
Phone: 301-251-8920

Montgomery County Dept. Health/Human Services/ Outpatient Addiction Services
751 Twinbrook Parkway
Rockville, MD 20851
www.montgomerycountymd.gov
Phone: 240-777-1680

Montgomery Recovery Services Inc.
14636 Rothgeb Drive
Rockville, MD 20850
www.drugtreatment.net
Phone: 301-762-5300

New Beginnings at Potomac Valley Nursing and Wellness Center
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Rockville, MD 20850
www.potomacvalley.com
Phone: 301-762-0700

Step Ahead Program of KHI Services
20528 Boland Farm Road
Germantown, MD 20876
Phone: 240-686-0707

Suburban Hospital Behavioral Health
8600 Old Georgetown Road
Bethesda, MD 20814
Phone: 301-896-2564 (or) 301-896-3100

White Flint Recovery Inc.
1335 Rockville Pike
Rockville, MD 20852
Phone: 301-294-6545

Heroin and Opioid Awareness & Prevention Toolkit
Maryland State Department of Education
http://www.marylandpublicschools.org/Documents/heroinprevention/HeroinToolkit.pdf

Journeys Adult Program
40 Hungerford Drive
Rockville, MD 20850
Phone: 301-294-4015

DESCRIPTION OF HEALTH RISKS ASSOCIATED WITH THE USE OF ILLICIT DRUGS AND ABUSE OF ALCOHOL

Controlled Substances - *Uses & Effects*

Classification	Drug Name	Common or Brand	Dependence	Potential	Acute Effects	Health Risks and Effects of Long-term Use*	Overdose Effects
			Physical	Psycho-logical			
ALCOHOL	Ethanol	Beer Wine Distilled Liquor	High High High	High High High	• Lowered Inhibitions • Impaired Judgement, Vision • Loss of Motor Skills, Coordination • Slurred Speech	• Hypertension • Liver Damage • Cardiovascular Disease • Toxic Psychosis • Neurologic Damage • Addiction with Severe Withdrawal	• Coma • Possible Death
NARCOTICS	[1]Opium Morphine Codeine [1]Heroin Meperidine Other	[2]Paregoric, Dover S Power [2]Morphine [2]Tylenol W/Codeine, Robitussin Heroin [2]Demerol, Pethadol [2]Dilaudid, Lentine, Percodan	High High High High High High	High High High High High High	• Euphoria, Drowsiness • Respiratory Depression • Constricted Pupils • Nausea, Vomit • Analgesia (Pain Relief)	• Loss of Appetite • Constipation • Risk of AIDS & Hepatitis from I.V. Drug Use	• Shallow Perspiration • Clammy Skin • Convulsions, Coma • Possible Death • May be Toxic if Mixed with Alcohol
DEPRESSANTS	Chloral Hydrate Barbiturates Gamma Hydroxybutric Acid Gamma Butyrolactone Glutethimide Ketamine Methaqualone Tranquilizers	[2]Noctec, Somnos [2]Nembutal, Phonobarbitol, Seconal, Tuinol Date Rape Drug, Liquid Ecstacy, Cherrymeth, GBL [2]Doriden Special K, K [2]Optimil, Parest, Quaalude, Sopor [2] Equanil, Valium, Tranxene Serax, Xanax, Rohyphal, Dalmane, Dormate, Placidyl, Valmid	Moderate High Moderate-High Unknown High Unknown High Moderate	Moderate High High Unknown High Unknown High High	• Slurred Speech • Disorientation • Drunken Behavior Without the Odor of Alcohol • Euphoria • Lowered Inhibitions • Loss of Motor Skills • Blackouts • Relaxation, Depression • Hallucinations	• Addiction with Withdrawal • Toxic Psychosis • Weak, Rapid Pulse • Hallucinations • Nausea • Seizures • Insomnia • Anxiety • Tremors • Dizziness • Loss of Peripheral Vision High	• Shallow Respiration • Cold, Clammy Skin • Blackout • Coma • Possible Death • May be Toxic if mixed with Alcohol High
STIMULANTS	[1]Cocaine [1]Amphetamine Phenmetrazine Methylphenidate Other Methylenedioxy-methamphetamine	Cocaine Hydrochloride [2]Benzedrine, Biphetamine, Desoxyn, Dexedrine [2]Preludin [2]Ritalin [2]Cylert, Didrex, Pre-Sate, Sanorex, Voranil Ecstacy, MDMA	Possible Possible Possible Possible Possible Low	High High High High High High	• Feeling of Well-Being • Excitation, Euphoria • Increased Alertness • Increased Blood Pressure, Pulse • Insomnia, Appetite Loss	• Delusions, Hallucinations (Toxic Psychosis) • Possible Organ/Tissue Damage	• Agitation • Temperature Increase • Hallucinations • Convulsions • Heart Attack, Stroke • High Blood Pressure • Loss of Consciousness • Seizures
HALLUNCINO-GENICS	[1]LSD [1]Mescaline [1]Psilocybin [1]MDA [1]PCP	Acid, Lysergic Acid Peyote, Peyote Buttons, Mescalitor Magic Mushrooms, Shrooms Angel Dust, Crystal, Cernylan (Veterinary)	Low Low Low Unknown Unknown	Unknown Unknown Unknown Unknown Unknown	• Dilated Pupils • Increased Blood Pressure, Pulse • Delusions/Hallucinations • Distorted Perception of Time, Space, and Reality	• Hallucinogens, Especially LSD, may Intensify Existing Psychosis • Possible Violent Behavior	• Intense Bad Trips • Psychosis • Possible Sudden Death
INHALANTS	Airplane Glue Lighter Fluid Aerosols Spray Paints Paint Thinner Gasoline Poppers	Active Ingredient: Toluene Active Ingredient: Naphalene Active Ingred.: Chloroplourocarbon Active Ingred.: Petroleum Distillate Active Ingred.: Petroleum Distillate Active Ingred.: Petroleum Distillate Active Ingred.: Amyl/butyl Nitrite	Unknown Unknown Unknown Unknown Unknown Unknown Unknown	Unknown Unknown Unknown Unknown Unknown Unknown Unknown	• Slurred Speech • Drunken Behavior • Impaired Judgement • Poor Coordination	• Hallucinations • Possible Damage to Bone Marrow, Lungs, Kidneys, Liver, Heart, Brain, Eyes	• Unconsciousness • Coma • Possible Toxic Reaction • Possible Sudden Death
CANNABIS	[1]Marijuana [1]Hashish [1]Hash Oil	Grass, Pot, Weed, Dope Hash	Low Low Low	Moderate Moderate Moderate	• Tachycardia, Reddened Eyes • Euphoria, Profound Humor • Altered Time/Space Perception • Short-Term Memory Loss • Increased Appetite	• Cardiovascular Damage as with Smoking Tobacco	• Insomnia, Hyperactivity • Panic Attacks, Paranoia • Possible Toxic Reaction if Treated w/other Chemicals
TOBACCO	Nicotine	Cigarettes Cigars	Moderate Moderate	High High	• Relaxation • Stimulation	• Cardiovascular Disease • Respiratory Illness	• Possible Death at very High Dosage Levels

* Alcohol and other drug use during pregnancy increases risk of physical harm to fetus

[2] Psychoactive drug effects refer to use at a greater than prescribed therapeutic dosage level

[1] Additional risk of harm from toxic impurities in street drugs

To: Montgomery College Students

From: Dr. Monica Brown, Senior Vice President for Student Affairs

Subject: **Drug-Free Schools and Communities Act Disclosure**

Date: September 18, 2018

Montgomery College is required under the Drug-Free Schools and Communities Act to annually notify students about our Drug and Alcohol Abuse Prevention program.

Policy and Sanctions

Montgomery College's commitment to drug and alcohol abuse prevention is underscored by the following policy adopted on May 15, 1989 by the College Board of Trustees:

I. The Board of Trustees is committed to the education of students, employees, and community members regarding substance abuse prevention, detection, and treatment services; to the continuation of a collegewide substance abuse prevention program and other ongoing efforts that will foster such education; and to the maintenance of a drug-free environment throughout the College.
II. The unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited at Montgomery College.
III. College students and employees are subject to appropriate disciplinary action for violation of this policy, in accordance with College policies and procedures regarding employee discipline and discharge and in accordance with the student code of conduct.
IV. The College president is authorized to establish procedures to implement this policy.

Students are responsible, as citizens, for knowing about and complying with the provisions of federal, state, and local law regarding illegal substances. Any student who possesses, uses, or sells alcoholic beverages or illegal drugs is subject to College disciplinary action. Additionally, prosecution and punishment by civil authorities may occur, through enforcement of Maryland and Federal laws. This includes enforcement of Maryland's underage drinking law.

The College will initiate its own disciplinary proceedings against a student when the alleged conduct is deemed a violation of College policies and procedures. Penalties will be imposed by the College in accordance with procedural safeguards applicable to disciplinary actions against students. Penalties range from written warning to expulsion from enrollment. In accordance with Board policy, students are subject to disciplinary action as set forth in the student code of conduct.

Heroin and Opioid Education and Community Action Act of 2017

The Maryland legislature passed the Heroin and Opioid Education and Community Action Act of 2017 (HB 1082) which was signed into law by Governor Larry Hogan in June 2017. The law will combat the opioid epidemic by increasing treatment access, prevention efforts, and public awareness and education. The new law requires public schools, including higher education institutions, to provide addiction and prevention education programs on substance use disorders and train personnel to respond to an opioid overdose. Please review the Act in detail at the following link:
http://mgaleg.maryland.gov/2017RS/chapters_noln/Ch_573_hb1082E.pdf.

See also, Heroin and Opioid Awareness & Prevention Toolkit.

Health Risks of Alcohol Abuse
For information concerning the health risks of alcohol abuse, click here.

*Health Risks Associated with the Use of Illicit Drugs
For the health risks associated with the use of illicit and controlled drugs, please see the attached document.

*Drug and Alcohol Abuse Treatment Resources and Clinical Services
For information about national and local resources available for drug and alcohol abuse treatment, please see the attached document.

For more information on the Drug and Alcohol Abuse Prevention Program for Students, see the 2017 Drug and Alcohol Abuse Prevention Program Biennial Review report or contact Dr. Clemmie Solomon, collegewide dean of student engagement and Takoma Park/Silver Spring campus dean of student affairs.

*Attachments

DRUG AND ALCOHOL RESOURCES AND CLINICAL SERVICES

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Available 24/7

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Rockville, MD 20850
240-777-1770 or 240-777-4710
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http://www.montgomerycountymd.gov/

Mental Health Association of Montgomery County
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301-738-9697 - Youth Hotline
301-738-2255 - General Hotline

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Available 24 hours a day, 7 days per week

NATIONAL HOTLINES

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Information and referral 24 hour
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National Treatment Referral
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Substance Abuse and Mental Health Services Administration (SAMHSA)
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SELF- HELP GROUPS

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www.aa-dc.org

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Phone: 301-762-4651
Women/Children - **Phone: 301-762-5613**
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Heroin and Opioid Awareness & Prevention Toolkit

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DESCRIPTION OF HEALTH RISKS ASSOCIATED WITH THE USE OF ILLICIT DRUGS AND ABUSE OF ALCOHOL

Controlled Substances - *Uses & Effects*

Classification	Drug Name	Common or Brand	Dependence	Potential	Acute Effects	Health Risks and Effects of Long-term Use*	Overdose Effects
			Physical	Psycho-logical			
ALCOHOL	Ethanol	Beer Wine Distilled Liquor	High High High	High High High	• Lowered Inhibitions • Impaired Judgement, Vision • Loss of Motor Skills, Coordination • Slurred Speech	• Hypertension • Liver Damage • Cardiovascular Disease • Toxic Psychosis • Neurologic Damage • Addiction with Severe Withdrawal	• Coma • Possible Death
NARCOTICS	[1]Opium Morphine Codeine [1]Heroin Meperidine Other	[2]Paregoric, Dover S Power [2]Morphine [2]Tylenol W/Codeine, Robitussin Heroin [2]Demerol, Pethadol [2]Dilaudid, Lentine, Percodan	High High High High High High	High High High High High High	• Euphoria, Drowsiness • Respiratory Depression • Constricted Pupils • Nausea, Vomit • Analgesia (Pain Relief)	• Loss of Appetite • Constipation • Risk of AIDS & Hepatitis from I.V. Drug Use	• Shallow Perspiration • Clammy Skin • Convulsions, Coma • Possible Death • May be Toxic if Mixed with Alcohol
DEPRESSANTS	Chloral Hydrate Barbiturates Gamma Hydroxybutric Acid Gamma Butyrolactone Glutethimide Ketamine Methaqualone Tranquilizers	[2]Noctec, Somnos [2]Nembutal, Phonobarbitol, Seconal, Tuinol Date Rape Drug, Liquid Ecstacy, Cherrymeth, GBL [2]Doriden Special K, K [2]Optimil, Parest, Quaalude, Sopor [2] Equanil, Valium, Tranxene Serax, Xanax, Rohyphal, Dalmane, Dormate, Placidyl, Valmid	Moderate High Moderate-High Unknown High Unknown High Moderate	Moderate High High Unknown High Unknown High High	• Slurred Speech • Disorientation • Drunken Behavior Without the Odor of Alcohol • Euphoria • Lowered Inhibitions • Loss of Motor Skills • Blackouts • Relaxation, Depression • Hallucinations	• Addiction with Withdrawal • Toxic Psychosis • Weak, Rapid Pulse • Hallucinations • Nausea • Seizures • Insomnia • Anxiety • Tremors • Dizziness • Loss of Peripheral Vision High	• Shallow Respiration • Cold, Clammy Skin • Blackout • Coma • Possible Death • May be Toxic if mixed with Alcohol High
STIMULANTS	[1]Cocaine [1]Amphetamine Phenmetrazine Methylphenidate Other Methylenedioxy-methamphetamine	Cocaine Hydrochloride [2]Benzedrine, Biphetamine, Desoxyn, Dexedrine [2]Preludin [2]Ritalin [2]Cylert, Didrex, Pre-Sate, Sanorex, Voranil Ecstacy, MDMA	Possible Possible Possible Possible Possible Low	High High High High High High	• Feeling of Well-Being • Excitation, Euphoria • Increased Alertness • Increased Blood Pressure, Pulse • Insomnia, Appetite Loss	• Delusions, Hallucinations (Toxic Psychosis) • Possible Organ/Tissue Damage	• Agitation • Temperature Increase • Hallucinations • Convulsions • Heart Attack, Stroke • High Blood Pressure • Loss of Consciousness • Seizures
HALLUNCINO-GENICS	[1]LSD [1]Mescaline [1]Psilocybin [1]MDA [1]PCP	Acid, Lysergic Acid Peyote, Peyote Buttons, Mescalitor Magic Mushrooms, Shrooms Angel Dust, Crystal, Cernylan (Veterinary)	Low Low Low Unknown Unknown	Unknown Unknown Unknown Unknown Unknown	• Dilated Pupils • Increased Blood Pressure, Pulse • Delusions/Hallucinations • Distorted Perception of Time, Space, and Reality	• Hallucinogens, Especially LSD, may Intensify Existing Psychosis • Possible Violent Behavior	• Intense Bad Trips • Psychosis • Possible Sudden Death
INHALANTS	Airplane Glue Lighter Fluid Aerosols Spray Paints Paint Thinner Gasoline Poppers	Active Ingredient: Toluene Active Ingredient: Naphalene Active Ingred.: Chloroplourocarbon Active Ingred.: Petroleum Distillate Active Ingred.: Petroleum Distillate Active Ingred.: Petroleum Distillate Active Ingred.: Amyl/butyl Nitrite	Unknown Unknown Unknown Unknown Unknown Unknown Unknown	Unknown Unknown Unknown Unknown Unknown Unknown Unknown	• Slurred Speech • Drunken Behavior • Impaired Judgement • Poor Coordination	• Hallucinations • Possible Damage to Bone Marrow, Lungs, Kidneys, Liver, Heart, Brain, Eyes	• Unconsciousness • Coma • Possible Toxic Reaction • Possible Sudden Death
CANNABIS	[1]Marijuana [1]Hashish [1]Hash Oil	Grass, Pot, Weed, Dope Hash	Low Low Low	Moderate Moderate Moderate	• Tachycardia, Reddened Eyes • Euphoria, Profound Humor • Altered Time/Space Perception • Short-Term Memory Loss • Increased Appetite	• Cardiovascular Damage as with Smoking Tobacco	• Insomnia, Hyperactivity • Panic Attacks, Paranoia • Possible Toxic Reaction if Treated w/other Chemicals
TOBACCO	Nicotine	Cigarettes Cigars	Moderate Moderate	High High	• Relaxation • Stimulation	• Cardiovascular Disease • Respiratory Illness	• Possible Death at very High Dosage Levels

* Alcohol and other drug use during pregnancy increases risk of physical harm to fetus

[2] Psychoactive drug effects refer to use at a greater than prescribed therapeutic dosage level

[1] Additional risk of harm from toxic impurities in street drugs

MONTGOMERY COLLEGE
Office of the Senior Vice President for Student Affairs

February 15, 2018

MEMORANDUM

To: Montgomery College Students

From: Dr. Monica Brown, Senior Vice President for Student Affairs

Subject: Drug-Free Schools and Communities Act Disclosure

Montgomery College is required under the Drug-Free Schools and Communities Act to annually notify students about our Drug and Alcohol Abuse Prevention program.

Policy and Sanctions

Montgomery College's commitment to drug and alcohol abuse prevention is underscored by the following policy adopted on May 15, 1989 by the College Board of Trustee's:

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See also, Heroin and Opioid Awareness & Prevention Toolkit.

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*Drug and Alcohol Abuse Treatment Resources and Clinical Services

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For more information on the Drug and Alcohol Abuse Prevention Program for Students, see the 2017 Drug and Alcohol Abuse Prevention Program Biennial Review report or contact Dr. Clemmie Solomon, collegewide dean of student engagement and Takoma Park/Silver Spring campus dean of student affairs.

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DESCRIPTION OF HEALTH RISKS ASSOCIATED WITH THE USE OF ILLICIT DRUGS AND ABUSE OF ALCOHOL

Controlled Substances - *Uses & Effects*

Classification	Drug Name	Common or Brand	Dependence	Potential	Acute Effects	Health Risks and Effects of Long-term Use*	Overdose Effects
			Physical	Psycho-logical			
ALCOHOL	Ethanol	Beer Wine Distilled Liquor	High High High	High High High	• Lowered Inhibitions • Impaired Judgement, Vision • Loss of Motor Skills, Coordination • Slurred Speech	• Hypertension • Liver Damage • Cardiovascular Disease • Toxic Psychosis • Neurologic Damage • Addiction with Severe Withdrawal	• Coma • Possible Death
NARCOTICS	[1]Opium Morphine Codeine [1]Heroin Meperidine Other	[2]Paregoric, Dover S Power [2]Morphine [2]Tylenol W/Codeine, Robitussin Heroin [2]Demerol, Pethadol [2]Dilaudid, Lentine, Percodan	High High High High High High	High High High High High High	• Euphoria, Drowsiness • Respiratory Depression • Constricted Pupils • Nausea, Vomit • Analgesia (Pain Relief)	• Loss of Appetite • Constipation • Risk of AIDS & Hepatitis from I.V. Drug Use	• Shallow Perspiration • Clammy Skin • Convulsions, Coma • Possible Death • May be Toxic if Mixed with Alcohol
DEPRESSANTS	Chloral Hydrate Barbiturates Gamma Hydroxybutric Acid Gamma Butyrolactone Glutethimide Ketamine Methaqualone Tranquilizers	[2]Noctec, Somnos [2]Nembutal, Phonobarbitol, Seconal, Tuinol Date Rape Drug, Liquid Ecstacy, Cherrymeth, GBL [2]Doriden Special K, K [2]Optimil, Parest, Quaalude, Sopor [2] Equanil, Valium, Tranxene Serax, Xanax, Rohyphal, Dalmane, Dormate, Placidyl, Valmid	Moderate High Moderate-High Unknown High Unknown High Moderate	Moderate High High Unknown High Unknown High High	• Slurred Speech • Disorientation • Drunken Behavior Without the Odor of Alcohol • Euphoria • Lowered Inhibitions • Loss of Motor Skills • Blackouts • Relaxation, Depression • Hallucinations	• Addiction with Withdrawal • Toxic Psychosis • Weak, Rapid Pulse • Hallucinations • Nausea • Seizures • Insomnia • Anxiety • Tremors • Dizziness • Loss of Peripheral Vision High	• Shallow Respiration • Cold, Clammy Skin • Blackout • Coma • Possible Death • May be Toxic if mixed with Alcohol High
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MONTGOMERY COLLEGE
Office of the Senior Vice President for Student Affairs

September 27, 2017

MEMORANDUM

To: Montgomery College Students

From: Dr. Monica Brown, Senior Vice President for Student Affairs

Subject: Drug-Free Schools and Communities Act Disclosure

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Alcohol Hotline
Information and referral 24 hour
1- 800-ALCOHOL (252-6465)

National Treatment Referral
1-800-662-HELP (4357)

National Suicide Prevention Lifeline
1-800-273-TALK (8255)

Substance Abuse and Mental Health Services Administration (SAMHSA)
Treatment Facility Locator
http://www.smhsa.gov/treatment/index.aspx

SELF- HELP GROUPS

Alcoholics Anonymous
Self-help group for alcoholic and alcohol abusers
202-966-9115 (DC, MD, VA)
www.aa-dc.org

Avery House (Group)
14705 Avery Road
Rockville, MD 20853
Phone: 301-762-4651
Women/Children - **Phone: 301-762-5613**
Intermediate Care - **Phone: 301-279-8828**
Combined Care – 301-279-8828

Bilingual Counseling Center
11301 Georgia Avenue
Silver Spring, MD 20902
Phone: 301-942-7821

Circle Treatment Center PC
424 N. Fredrick Avenue
Gaithersburg, MD 20877
www.circletreatment.com
Phone: 301-258-2626

Montgomery Recovery Services Inc.
14636 Rothgeb Drive
Rockville, MD 20850
www.drugtreatment.net
Phone: 301-762-5300

Narcotics Anonymous
Group for narcotics abusers
202-399-5316 DC and MD
www.na.org

New Beginnings at Potomac Valley Nursing and Wellness Center
1235 Potomac Valley Road
Rockville, MD 20850
www.potomacvalley.com
Phone: 301-762-0700

Potomac Ridge Behavioral Health
14901 Broschart
Rockville, MD 20850
Phone: 301-251-4500

Cocaine Anonymous National Referral Line
Group for cocaine abusers
800-347-8998 24 hours
www.ca.org

Counseling Plus Inc
8561 Fenton Street
Silver Spring, MD 20910
Phone: 301-565-9001

Family Health Center Psychological Services
16220 S. Frederick Avenue
Gaithersburg, MD 20877
www.sober.com
Phone: 301-963-7222

Heroin and Opioid Awareness & Prevention Toolkit

Maryland State Department of Education

http://www.marylandpublicschools.org/Documents/heroinprevention/HeroinToolkit.pdf

Journeys Adult Program
40 Hungerford Drive
Rockville, MD 20850
Phone: 301-294-4015

Kolmac Clinic
1003 Spring Street
Silver Spring, MD 20910
www.kolmac.com
Phone: 301-589-0255

Lawrence Court Halfway House
1 Lawrence Court
Rockville, MD 20850
Link Removed 08/26/2021
Phone: 301-251-8920

Metro Counseling Service Inc.
15719 Crabbs Branch Way
Derwood, MD 20855
Phone: 301-670-6161

Montgomery County Dept. Health/Human Services/ Outpatient Addiction Services
751 Twinbrook Parkway
Rockville, MD 20851
www.montgomerycountymd.gov
Phone: 240-777-1680

Montgomery General Hospital Addiction and Mental Health Center
18101 Prince Philip Drive
Olney, MD 20832
www.montgomerygeneral.com
Phone: 301-774-8800

Prince George's County Addictions Treatment Centers(Group)
3003 Hospital Drive
Cheverly, MD 20785
Phone: 301-583-5920
(Clinton)**301-856-9400**

Step Ahead Program of KHI Services
20528 Boland Farm Road
Germantown, MD 20876
Phone: 240-686-0707

Suburban Hospital Addiction Treatment Center Outpatient Services
6001 Montrose Road
Rockville, MD 20852
www.suburbanhospital.org
Phone: 301-896-2036

Suburban Hospital Behavioral Health
8600 Old Georgetown Road
Bethesda, MD 20814
Phone: 301-896-2564 (or) 301-896-3100

Washington Adventist Hospital
7600 Carroll Avenue
Takoma Park, MD 20912
www.adventisthealthcare.com
Phone: 301-891-7600(or) 301-891-5600

White Flint Recovery Inc.
1335 Rockville Pike
Rockville, MD 20852
Phone: 301-294-6545

DESCRIPTION OF HEALTH RISKS ASSOCIATED WITH THE USE OF ILLICIT DRUGS AND ABUSE OF ALCOHOL

Controlled Substances - *Uses & Effects*

Classification	Drug Name	Common or Brand	Dependence	Potential	Acute Effects	Health Risks and Effects of Long-term Use*	Overdose Effects
			Physical	Psycho-logical			
ALCOHOL	Ethanol	Beer Wine Distilled Liquor	High High High	High High High	• Lowered Inhibitions • Impaired Judgement, Vision • Loss of Motor Skills, Coordination • Slurred Speech	• Hypertension • Liver Damage • Cardiovascular Disease • Toxic Psychosis • Neurologic Damage • Addiction with Severe Withdrawal	• Coma • Possible Death
NARCOTICS	[1]Opium Morphine Codeine [1]Heroin Meperidine Other	[2]Paregoric, Dover S Power [2]Morphine [2]Tylenol W/Codeine, Robitussin Heroin [2]Demerol, Pethadol [2]Dilaudid, Lentine, Percodan	High High High High High High	High High High High High High	• Euphoria, Drowsiness • Respiratory Depression • Constricted Pupils • Nausea, Vomit • Analgesia (Pain Relief)	• Loss of Appetite • Constipation • Risk of AIDS & Hepatitis from I.V. Drug Use	• Shallow Perspiration • Clammy Skin • Convulsions, Coma • Possible Death • May be Toxic if Mixed with Alcohol
DEPRESSANTS	Chloral Hydrate Barbiturates Gamma Hydroxybutric Acid Gamma Butyrolactone Glutethimide Ketamine Methaqualone Tranquilizers	[2]Noctec, Somnos [2]Nembutal, Phonobarbitol, Seconal, Tuinol Date Rape Drug, Liquid Ecstacy, Cherrymeth, GBL [2]Doriden Special K, K [2]Optimil, Parest, Quaalude, Sopor [2] Equanil, Valium, Tranxene Serax, Xanax, Rohyphal, Dalmane, Dormate, Placidyl, Valmid	Moderate High Moderate-High Unknown High Unknown High Moderate	Moderate High High Unknown High Unknown High High	• Slurred Speech • Disorientation • Drunken Behavior Without the Odor of Alcohol • Euphoria • Lowered Inhibitions • Loss of Motor Skills • Blackouts • Relaxation, Depression • Hallucinations	• Addiction with Withdrawal • Toxic Psychosis • Weak, Rapid Pulse • Hallucinations • Nausea • Seizures • Insomnia • Anxiety • Tremors • Dizziness • Loss of Peripheral Vision High	• Shallow Respiration • Cold, Clammy Skin • Blackout • Coma • Possible Death • May be Toxic if mixed with Alcohol High
STIMULANTS	[1]Cocaine [1]Amphetamine Phenmetrazine Methylphenidate Other Methylenedioxy-methamphetamine	Cocaine Hydrochloride [2]Benzedrine, Biphetamine, Desoxyn, Dexedrine [2]Preludin [2]Ritalin [2]Cylert, Didrex, Pre-Sate, Sanorex, Voranil Ecstacy, MDMA	Possible Possible Possible Possible Possible Low	High High High High High High	• Feeling of Well-Being • Excitation, Euphoria • Increased Alertness • Increased Blood Pressure, Pulse • Insomnia, Appetite Loss	• Delusions, Hallucinations (Toxic Psychosis) • Possible Organ/Tissue Damage	• Agitation • Temperature Increase • Hallucinations • Convulsions • Heart Attack, Stroke • High Blood Pressure • Loss of Consciousness • Seizures
HALLUNCINO-GENICS	[1]LSD [1]Mescaline [1]Psilocybin [1]MDA [1]PCP	Acid, Lysergic Acid Peyote, Peyote Buttons, Mescalitor Magic Mushrooms, Shrooms Angel Dust, Crystal, Cernylan (Veterinary)	Low Low Low Unknown Unknown	Unknown Unknown Unknown Unknown Unknown	• Dilated Pupils • Increased Blood Pressure, Pulse • Delusions/Hallucinations • Distorted Perception of Time, Space, and Reality	• Hallucinogens, Especially LSD, may Intensify Existing Psychosis • Possible Violent Behavior	• Intense Bad Trips • Psychosis • Possible Sudden Death
INHALANTS	Airplane Glue Lighter Fluid Aerosols Spray Paints Paint Thinner Gasoline Poppers	Active Ingredient: Toluene Active Ingredient: Naphalene Active Ingred.: Chloroplourocarbon Active Ingred.: Petroleum Distillate Active Ingred.: Petroleum Distillate Active Ingred.: Petroleum Distillate Active Ingred.: Amyl/butyl Nitrite	Unknown Unknown Unknown Unknown Unknown Unknown Unknown	Unknown Unknown Unknown Unknown Unknown Unknown Unknown	• Slurred Speech • Drunken Behavior • Impaired Judgement • Poor Coordination	• Hallucinations • Possible Damage to Bone Marrow, Lungs, Kidneys, Liver, Heart, Brain, Eyes	• Unconsciousness • Coma • Possible Toxic Reaction • Possible Sudden Death
CANNABIS	[1]Marijuana [1]Hashish [1]Hash Oil	Grass, Pot, Weed, Dope Hash	Low Low Low	Moderate Moderate Moderate	• Tachycardia, Reddened Eyes • Euphoria, Profound Humor • Altered Time/Space Perception • Short-Term Memory Loss • Increased Appetite	• Cardiovascular Damage as with Smoking Tobacco	• Insomnia, Hyperactivity • Panic Attacks, Paranoia • Possible Toxic Reaction if Treated w/other Chemicals
TOBACCO	Nicotine	Cigarettes Cigars	Moderate Moderate	High High	• Relaxation • Stimulation	• Cardiovascular Disease • Respiratory Illness	• Possible Death at very High Dosage Levels

* Alcohol and other drug use during pregnancy increases risk of physical harm to fetus

[2] Psychoactive drug effects refer to use at a greater than prescribed therapeutic dosage level

[1] Additional risk of harm from toxic impurities in street drugs

Appendix C:
Tip Sheets

APPENDIX C

GuidanceResources® Online

Alcoholism and Alcohol Abuse

Many people are uncertain about the facts and realities associated with alcoholism. What exactly is alcoholism? How does it differ from alcohol abuse? When should a person seek help for a problem related to his or her drinking? The following information explains alcoholism and alcohol abuse, the symptoms of each, when and where to seek help and treatment choices.

- What is alcoholism?
- What is alcohol abuse?
- Signs of an Alcohol Problem
- The Decision to Get Help
- Alcoholism Treatment
- Alcoholics Anonymous
- Can alcoholism be cured?
- Help for Alcohol Abuse
- Resources

What is alcoholism?

Alcoholism, also known as "alcohol dependence," is a disease that includes four symptoms:

- **Craving:** A craving is a strong need or compulsion to drink.
- **Loss of control:** Alcoholics are unable to limit their drinking on any given occasion.
- **Physical dependence:** Withdrawal symptoms such as nausea, sweating, shakiness and anxiety occur when alcohol use is stopped after a period of heavy drinking.
- **Tolerance:** Alcoholics need to drink greater amounts of alcohol in order to feel its effect.

People who are not alcoholic sometimes do not understand why an alcoholic cannot just "use a little willpower" to stop drinking. However, this disease has little to do with willpower. Alcoholics are in the grip of a powerful craving, or uncontrollable need, for alcohol that overrides their ability to stop drinking. This need can be as strong as the need for food or water

A person's risk for developing alcoholism can increase based on the person's environment, including where and how he or she lives; family, friends, and culture;

peer pressure; and even how easy it is to get alcohol.

What is alcohol abuse?

Alcohol abuse differs from alcoholism in that it does not include an extremely strong craving for alcohol, loss of control over drinking, or physical dependence. Alcohol abuse is defined as a pattern of drinking that results in one or more of the following situations within a 12-month period:

- Failure to fulfill major work, school or home responsibilities
- Drinking in situations that are physically dangerous, such as while driving a car or operating machinery
- Having recurring alcohol-related legal problems, such as being arrested for driving under the influence of alcohol or for physically hurting someone while drunk
- Continued drinking despite having ongoing relationship problems that are caused or worsened by the drinking

Although alcohol abuse is basically different from alcoholism, many effects of alcohol abuse are also experienced by alcoholics.

Signs of an Alcohol Problem

How can you tell whether you may have a drinking problem? Answering the following questions can help you find out:

- Have you ever felt you should cut down on your drinking?
- Have people annoyed you by criticizing your drinking?
- Have you ever felt bad or guilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
- Have your friends or family ever suggested that you cut down on your drinking?

One "yes" answer suggests a possible alcohol problem. If you answered "yes" to more than one question, it is highly likely that a problem exists. In either case, it is important that you see your doctor or other health care provider right away to discuss your drinking habits. He or she can help you determine whether you have a drinking problem and, if so, recommend the best course of action.

Even if you answered "no" to all of the above questions, if you encounter drinking-related problems any concerns you may have about discussing drinking-related problems with your health care provider may stem from common misconceptions about alcoholism. In our society, the myth prevails that an alcohol problem is a sign of moral weakness.

As a result, you may feel that to seek help is to admit some type of shameful defect in yourself. In fact, alcoholism is a disease that is no more a sign of weakness than is asthma. Moreover, taking steps to identify a possible drinking problem has an enormous payoff: a chance for a healthier, more rewarding life.

When you visit your health care provider, he or she will ask you a number of questions about your alcohol use to determine whether you are having problems related to your drinking. Try to answer these questions as fully and honestly as you can. You also will be given a physical examination. If your health care provider concludes that you may be dependent on alcohol, he or she may recommend that you see a specialist in treating alcoholism. You should be involved in any referral decisions and have all treatment choices explained to you.

Alcoholism Treatment

The type of treatment you receive depends on the severity of your alcoholism and the resources that are available in your community. Treatment may include detoxification (the process of safely getting alcohol out of your system); taking doctor-prescribed medications to help prevent a return (or relapse) to drinking once you have stopped; and individual or group counseling. There are promising types of counseling that teach alcoholics to identify situations and feelings that trigger the urge to drink and to find new ways to cope that do not include alcohol use. These treatments are often provided on an outpatient basis.

Because the support of family members is important to the recovery process, many programs also offer brief marital counseling and family therapy as part of the treatment process. Programs may also link individuals with vital community resources, such as legal assistance, job training, childcare and parenting classes.

Alcoholics Anonymous

Virtually all alcoholism treatment programs also include Alcoholics Anonymous (AA) meetings. AA describes itself as a "worldwide fellowship of men and women who help each other to stay sober." Although AA is generally recognized as an effective mutual help program for recovering alcoholics, not everyone responds to AA's style or message, and other recovery approaches are available.
Even people who are helped by AA usually find that the program works best in combination with other forms of treatment including counseling and medical care.

Alcohol Poisoning

Excessive alcohol consumption can lead to a condition called alcohol poisoning. Rapid binge drinking (which often happens on a bet or a dare) is especially dangerous because the victim can ingest a fatal dose before becoming unconscious. It can cause the aspiration of vomit leading to asphyxiation, or the poisoning of the respiratory center in the brain. Both of these occurrences can result in death, and even if the victim lives, an alcohol overdose can lead to irreversible brain damage. Understanding the facts, myths and dangers of alcohol poisoning can help prevent many alcohol-related tragedies.

What happens to a person who gets alcohol poisoning?

Alcohol depresses nerves that control involuntary actions such as breathing and the gag reflex (which prevents choking). A fatal dose of alcohol can stop these primary body functions.

It is common for someone who drank excessive alcohol to vomit since alcohol is an irritant to the stomach. There is then the danger of choking on vomit, which could cause death by asphyxiation in a person who is not conscious because of intoxication.

Also, a person's blood alcohol concentration (BAC) can continue to rise even while he or she is passed out. Even after a person stops drinking, alcohol in the stomach and intestine continues to enter the bloodstream and circulate throughout the body. It is dangerous to assume the person will be fine by sleeping it off.

Signs of Alcohol Poisoning

There are several signs of alcohol poisoning, including:

If you suspect somebody may have consumed too much alcohol and is now dealing with alcohol poisoning you should do the following:

- Know and identify the danger signals.
- Do not wait for all symptoms to be present.
- Be aware that a person who has passed out may die.
- If there is any suspicion of an alcohol overdose, call 911 for help. Do not try to guess the person's level of intoxication.

Things that could happen to a person if alcohol poisoning goes untreated include:

- Choking on his or her vomit (untreated severe dehydration from vomiting can cause seizures, permanent brain damage or death).
- Breathing slows, becomes irregular or stops.
- Heart beats irregularly or stops.
- Hypothermia (low body temperature).
- Hypoglycemia (too little blood sugar}, leading to seizures.

Do not be afraid to seek medical help for a friend who has had too much to drink. Do not worry that your friend may become angry or embarrassed. It is always better to be safe than sorry when alcohol poisoning is a possibility.

Resources

If you think you or a loved one may have an alcohol problem, help is available. Call your EAP to get the counseling and assistance you need. For further help with your problem or more information, consider contacting these organizations:

- Alcoholics Anonymous (AA): (212) 870-3400 or www.aa.org (http://www.aa.org)
- National Council on Alcoholism and Drug Dependence (NCADD): (800} NCA-CALL or www.ncadd.org (http://www.ncadd.org}
- National Institute on Alcohol Abuse and Alcoholism: www.niaaa.nih.gov (http://www.niaaa.nih.gov)

Some content on this page was gathered from documents found on the U.S. government's College Drinking Prevention website: www.collegedrinkingprevention.gov (http://www.collegedrinkingprevention.gov).

Alcoholism in the Workplace

As far as an employer is concerned, an employee's decision to drink is that individual's personal business. However, when the use or abuse of alcohol interferes with the employee's ability to perform his or her duties, the employer does have legitimate concerns, including the proper performance of duties, health and safety issues, and employee conduct at the workplace.

Supervisor's Role **back to top**

As a supervisor, you have an important role in dealing with alcohol problems in the workplace, along with other agency officials. You have the day-to-day responsibility to monitor the work and on-the-job conduct of your employees. You are not responsible for diagnosing alcoholism in employees. Basic supervisory responsibilities include:

- Assigning, monitoring, reviewing and appraising work and performance
- Setting work schedules and approving or disapproving leave requests
- Taking necessary corrective and disciplinary actions when performance or conduct problems surface
- Referring employees to your agency's Employee Assistance Program (EAP).

At some point, you will likely encounter employees with problems related to alcohol in dealing with performance, conduct and leave problems. In some cases, you may not know that there is an alcohol problem. In other cases, you may know, either because the employee admits to being an alcoholic or because the problem is self-evident.

For example, an employee may become intoxicated while on duty or be arrested for drunk driving. Your role is not to diagnose the alcohol problem, but to exercise responsibility in dealing with the performance or conduct problem, hold the employee accountable, refer the employee to the EAP, and take any appropriate disciplinary action.

Your role in dealing with alcoholism in the workplace is crucial. The most effective way to get an alcoholic to deal with the problem is to make the alcoholic aware that his or her job is on the line and that he or she must get help and improve performance and conduct or else face serious consequences, including the possibility of losing his or her job.

Signs to Look For **back to top**

Even though you must not try to diagnose the problem, there are many signs that may indicate a problem with alcohol and should trigger a referral to the EAP.

Leave and Attendance

- Unexplained or unauthorized absences from work
- Frequent tardiness
- Excessive use of sick leave
- Patterns of absence, such as the day after payday or frequent Monday or Friday absences
- Frequent unplanned absences due to "emergencies" (e.g., household repairs, car trouble, family emergencies, legal problems).

The employee may also be absent from his or her duty station without explanation or permission for significant periods of time.

Performance Problems

- Missed deadlines
- Careless or sloppy work or incomplete assignments
- Production quotas not met
- Many excuses for incomplete assignments or missed deadlines
- Faulty analysis.

In jobs requiring long-term projects or detailed analysis, an employee may be able to hide a performance problem for quite some time.

Relationships at Work

Relationships with co-workers may become strained. The employee may be belligerent, argumentative or short-tempered, especially in the mornings or after weekends or holidays, or the employee may become a "loner."

The employee may also have noticeable financial problems evidenced by borrowing money from other employees or receiving phone calls at work from creditors or collection companies.

Behavior at Work

The appearance of being inebriated or under the influence of alcohol might include:

- The smell of alcohol
- Staggering or an unsteady gait
- Bloodshot eyes
- Smell of alcohol on the breath
- Mood and behavior changes, such as excessive laughter and inappropriate loud talk
- Excessive use of mouthwash or breath mints
- Avoidance of supervisory contact, especially after lunch
- Tremors
- Sleeping on duty.

Not any one of these signs means that an employee is an alcoholic. However, when there are performance and conduct problems coupled with any number of these signs, it is time to make a referral to the EAP for an assessment so that the employee can get help if it is needed.

Resources **back to top**

- Alcoholics Anonymous: www.aa.org
- National Council on Alcoholism and Drug Dependence: www.ncadd.org
- National Institute on Alcohol Abuse and Alcoholism: www.niaaa.nih.gov
- U.S. Office of Personnel Management: www.opm.gov

Appendix D:
Commonly Abused Drugs

Commonly Abused Drugs

Many misused drugs can alter a person's thinking and judgment, leading to health risks, including addiction, drugged driving, and infectious disease. Most drugs could potentially harm an unborn baby; pregnancy-related issues are listed in the chart below for drugs where there is enough scientific evidence to connect the drug use to specific negative effects.

For information about treatment options for drug addiction, see NIDA's Treatment pages. For drug use trends, see our Trends and Statistics page.

The following drugs are included in this resource:

- Alcohol
- Ayahuasca
- Central Nervous System Depressants
- Cocaine
- DMT
- GHB
- Hallucinogens
- Heroin
- Inhalants
- Ketamine
- Khat
- Kratom
- LSD
- Marijuana (Cannabis)
- MDMA (Ecstasy/Molly)
- Mescaline (Peyote)
- Methamphetamine
- Over-the-Counter Medicines--Dextromethorphan (DXM)
- Over-the-Counter Medicines--Loperamide
- PCP
- Prescription Opioids
- Prescription Stimulants
- Psilocybin
- Rohypnol® (Flunitrazepam)
- Salvia
- Steroids (Anabolic)
- Synthetic Cannabinoids
- Synthetic Cathinones ("Bath Salts")
- Tobacco

**The Drug Enforcement Agency (DEA) schedule indicates the drug's acceptable medical use and its potential for misuse or dependence. The most up-to-date scheduling information can be found on the DEA website.

Alcohol

People drink to socialize, celebrate, and relax. Alcohol often has a strong effect on people—and throughout history, people have struggled to understand and manage alcohol's power. Why does alcohol cause people to act and feel differently? How much is too much? Why do some people become addicted while others do not? The National Institute on Alcohol Abuse and Alcoholism is researching the answers to these and many other questions about alcohol. Here's what is known:

Alcohol's effects vary from person to person, depending on a variety of factors, including:

- How much you drink
- How often you drink
- Your age
- Your health status
- Your family history

While drinking alcohol is itself not necessarily a problem—drinking too much can cause a range of consequences, and increase your risk for a variety of problems. For more information on alcohol's effects on the body, please see the National Institute on Alcohol Abuse and Alcoholism's related web page describing alcohol's effects on the body.

Ayahuasca				
A hallucinogenic tea made in the Amazon from a DMT-containing plant (*Psychotria viridis*) along with another vine (*Banisteriopsis caapi*) that contains an MAO inhibitor preventing the natural breakdown of DMT in the digestive system, thereby enhancing serotonergic activity. It was used historically in Amazonian religious and healing rituals. For more information, see the Hallucinogens and Dissociative Drugs Research Report.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Aya, Yagé, Hoasca	No commercial uses	Brewed as tea	Swallowed as tea	DMT is Schedule I, but plants containing it are not controlled
Possible Health Effects				
Short-term	Strong hallucinations including altered visual and auditory perceptions; increased heart rate and blood pressure; nausea; burning sensation in the stomach; tingling sensations and increased skin sensitivity.			
Long-term	Possible changes to the serotoninergic and immune systems, although more research is needed.			
Other Health-related Issues	Unknown.			
In Combination with Alcohol	Unknown.			
Withdrawal Symptoms	Unknown.			
Treatment Options				
Medications	It is not known whether ayahuasca is addictive. There are no FDA-approved medications to treat addiction to ayahuasca or other hallucinogens.			
Behavioral Therapies	More research is needed to find out if ayahuasca is addictive and, if so, whether behavioral therapies are effective.			

Central Nervous System Depressants				
Medications that slow brain activity, which makes them useful for treating anxiety and sleep problems. For more information, see the Misuse of Prescription Drugs Research Report.				
Street Names	**Commercial Names (Common)**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Barbs, Phennies, Red Birds, Reds, Tooies, Yellow Jackets, Yellows	Barbiturates: pentobarbital (Nembutal®)	Pill, capsule, liquid	Swallowed, injected	II, III, IV
Candy, Downers, Sleeping Pills, Tranks	Benzodiazepines: alprazolam (Xanax®), chlorodiazepoxide (Librium®), diazepam (Valium®), lorazepam (Ativan®), triazolam (Halicon®)	Pill, capsule, liquid	Swallowed, snorted	IV
Forget-me Pill, Mexican Valium, R2, Roche, Roofies, Roofinol, Rope, Rophies	Sleep Medications: eszopiclone (Lunesta®), zaleplon (Sonata®), zolpidem (Ambien®)	Pill, capsule, liquid	Swallowed, snorted	IV
Possible Health Effects				
Short-term	Drowsiness, slurred speech, poor concentration, confusion, dizziness, problems with movement and memory, lowered blood pressure, slowed breathing.			
Long-term	Unknown.			
Other Health-related Issues	Sleep medications are sometimes used as date rape drugs. Risk of HIV, hepatitis, and other infectious diseases from shared needles.			
In Combination with Alcohol	Further slows heart rate and breathing, which can lead to death.			
Withdrawal Symptoms	Must be discussed with a health care provider; barbiturate withdrawal can cause a serious abstinence syndrome that may even include seizures.			
Treatment Options				
Medications	There are no FDA-approved medications to treat addiction to prescription sedatives; lowering the dose over time must be done with the help of a health care provider.			
Behavioral Therapies	More research is needed to find out if behavioral therapies can be used to treat addiction to prescription sedatives.			

Cocaine				
A powerfully addictive stimulant drug made from the leaves of the coca plant native to South America. For more information, see the Cocaine Research Report.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Blow, Bump, C, Candy, Charlie, Coke, Crack, Flake, Rock, Snow, Toot	Cocaine hydrochloride topical solution (anesthetic rarely used in medical procedures)	White powder, whitish rock crystal	Snorted, smoked, injected	II
Possible Health Effects				
Short-term	Narrowed blood vessels; enlarged pupils; increased body temperature, heart rate, and blood pressure; headache; abdominal pain and nausea; euphoria; increased energy, alertness; insomnia, restlessness; anxiety; erratic and violent behavior, panic attacks, paranoia, psychosis; heart rhythm problems, heart attack; stroke, seizure, coma.			
Long-term	Loss of sense of smell, nosebleeds, nasal damage and trouble swallowing from snorting; infection and death of bowel tissue from decreased blood flow; poor nutrition and weight loss; lung damage from smoking.			
Other Health-related Issues	Pregnancy: premature delivery, low birth weight, deficits in self-regulation and attention in school-aged children prenatally exposed. Risk of HIV, hepatitis, and other infectious diseases from shared needles.			
In Combination with Alcohol	Greater risk of cardiac toxicity than from either drug alone.			
Withdrawal Symptoms	Depression, tiredness, increased appetite, insomnia, vivid unpleasant dreams, slowed movement, restlessness.			
Treatment Options				
Medications	There are no FDA-approved medications to treat cocaine addiction.			
Behavioral Therapies	• Cognitive-behavioral therapy (CBT) • Contingency management, or motivational incentives, including vouchers • The Matrix Model • Community-based recovery groups, such as 12-Step programs • Mobile medical application: reSET®			

DMT				
A synthetic drug producing intense but relatively short-lived hallucinogenic experiences; also naturally occurring in some South American plants (See Ayahuasca). For more information, see the Hallucinogens and Dissociative Drugs Research Report.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
DMT, Dimitri	No commercial uses	White or yellow crystalline powder	Smoked, injected	I
Possible Health Effects				
Short-term	Intense visual hallucinations, depersonalization, auditory distortions, and an altered perception of time and body image, usually peaking in about 30 minutes when drank as tea. Physical effects include hypertension, increased heart rate, agitation, seizures, dilated pupils.			
Long-term	Unknown			
Other Health-related Issues	At high doses, cardiac and respiratory arrest have occurred.			
In Combination with Alcohol	Unknown.			
Withdrawal Symptoms	Unknown.			
Treatment Options				
Medications	It is not known whether DMT is addictive. There are no FDA-approved medications to treat addiction to DMT or other hallucinogens.			
Behavioral Therapies	More research is needed to find out if DMT is addictive and, if so, whether behavioral therapies are effective.			

GHB				
A depressant approved for use in the treatment of narcolepsy, a disorder that causes daytime "sleep attacks."				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
G, Georgia Home Boy, Goop, Grievous Bodily Harm, Liquid Ecstasy, Liquid X, Soap, Scoop	Gamma-hydroxybutyrate or sodium oxybate (Xyrem®)	Colorless liquid, white powder	Swallowed (often combined with alcohol or other beverages)	I

Possible Health Effects	
Short-term	Euphoria, drowsiness, nausea, vomiting, confusion, memory loss, unconsciousness, slowed heart rate and breathing, lower body temperature, seizures, coma, death.
Long-term	Unknown.
Other Health-related Issues	Sometimes used as a date rape drug.
In Combination with Alcohol	Nausea, problems with breathing, greatly increased depressant effects.
Withdrawal Symptoms	Insomnia, anxiety, tremors, sweating, increased heart rate and blood pressure, psychotic thoughts.
Treatment Options	
Medications	Benzodiazepines
Behavioral Therapies	More research is needed to find out if behavioral therapies can be used to treat GHB addiction.

Hallucinogens
Drugs that cause profound distortions in a person's perceptions of reality, such as ketamine, LSD, mescaline (peyote), PCP, psilocybin, salvia, DMT, and ayahuasca. For more information, see the Hallucinogens and Dissociative Drugs Research Report.

Heroin				
An opioid drug made from morphine, a natural substance extracted from the seed pod of various opium poppy plants. For more information, see the Heroin Research Report.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Brown sugar, China White, Dope, H, Horse, Junk, Skag, Skunk, Smack, White Horse *With OTC cold medicine and antihistamine:* Cheese	No commercial uses	White or brownish powder, or black sticky substance known as "black tar heroin"	Injected, smoked, snorted	I

Possible Health Effects	
Short-term	Euphoria; dry mouth; itching; nausea; vomiting; analgesia; slowed breathing and heart rate.
Long-term	Collapsed veins; abscesses (swollen tissue with pus); infection of the lining and valves in the heart; constipation and stomach cramps; liver or kidney disease.
Other Health-related Issues	Pregnancy: miscarriage, low birth weight, neonatal abstinence syndrome. Risk of HIV, hepatitis, and other infectious diseases from shared needles.
In Combination with Alcohol	Dangerous slowdown of heart rate and breathing, coma, death.
Withdrawal Symptoms	Restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes with goose bumps ("cold turkey").

Treatment Options	
Medications	• Methadone • Buprenorphine • Naltrexone (short- and long-acting forms)
Behavioral Therapies	• Contingency management, or motivational incentives • 12-Step facilitation therapy

Inhalants				
Solvents, aerosols, and gases found in household products such as spray paints, markers, glues, and cleaning fluids; also nitrites (e.g., amyl nitrite), which are prescription medications for chest pain. For more information, see the Inhalants Research Report.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Poppers, snappers, whippets, laughing gas	Various	Paint thinners or removers, degreasers, dry-cleaning fluids, gasoline, lighter fluids, correction fluids, permanent markers, electronics cleaners and freeze sprays, glue, spray paint, hair or deodorant sprays, fabric protector sprays, aerosol computer cleaning products, vegetable oil sprays, butane lighters, propane tanks, whipped cream aerosol containers, refrigerant gases, ether, chloroform, halothane, nitrous oxide	Inhaled through the nose or mouth	Not scheduled
Possible Health Effects				
Short-term	Confusion; nausea; slurred speech; lack of coordination; euphoria; dizziness; drowsiness; disinhibition, lightheadedness, hallucinations/delusions; headaches; sudden sniffing death due to heart failure (from butane, propane, and other chemicals in aerosols); death from asphyxiation, suffocation, convulsions or seizures, coma, or choking. Nitrites: enlarged blood vessels, enhanced sexual pleasure, increased heart rate, brief sensation of heat and excitement, dizziness, headache.			
Long-term	Liver and kidney damage; bone marrow damage; limb spasms due to nerve damage; brain damage from lack of oxygen that can cause problems with thinking, movement, vision, and hearing. Nitrites: increased risk of pneumonia.			
Other Health-related Issues	Pregnancy: low birth weight, bone problems, delayed behavioral development due to brain problems, altered metabolism and body composition.			
In Combination with Alcohol	Unknown.			
Withdrawal Symptoms	Nausea, tremors, irritability, problems sleeping, and mood changes.			
Treatment Options				
Medications	There are no FDA-approved medications to treat inhalant addiction.			
Behavioral Therapies	More research is needed to find out if behavioral therapies can be used to treat inhalant addiction.			

Ketamine				
A dissociative drug used as an anesthetic in veterinary practice. Dissociative drugs are hallucinogens that cause the user to feel detached from reality. For more information, see the Hallucinogens and Dissociative Drugs Research Report.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Cat Valium, K, Special K, Vitamin K	Ketalar®	Liquid, white powder	Injected, snorted, smoked (powder added to tobacco or marijuana cigarettes), swallowed	III

Possible Health Effects	
Short-term	Problems with attention, learning, and memory; dreamlike states, hallucinations; sedation; confusion; loss of memory; raised blood pressure; unconsciousness; dangerously slowed breathing.
Long-term	Ulcers and pain in the bladder; kidney problems; stomach pain; depression; poor memory.
Other Health-related Issues	Sometimes used as a date rape drug. Risk of HIV, hepatitis, and other infectious diseases from shared needles.
In Combination with Alcohol	Increased risk of adverse effects.
Withdrawal Symptoms	Unknown.
Treatment Options	
Medications	There are no FDA-approved medications to treat addiction to ketamine or other dissociative drugs.
Behavioral Therapies	More research is needed to find out if behavioral therapies can be used to treat addiction to dissociative drugs.

Khat

Pronounced "cot," a shrub (*Catha edulis*) found in East Africa and southern Arabia; contains the psychoactive chemicals cathinone and cathine. People from African and Arabian regions (up to an estimated 20 million worldwide) have used khat for centuries as part of cultural tradition and for its stimulant-like effects.

Street Names	Commercial Names	Common Forms	Common Ways Taken	DEA Schedule
Abyssinian Tea, African Salad, Catha, Chat, Kat, Oat	No commercial uses	Fresh or dried leaves	Chewed, brewed as tea	Cathinone is a Schedule I drug, making khat use illegal, but the khat plant is not controlled

Possible Health Effects	
Short-term	Euphoria, increased alertness and arousal, increased blood pressure and heart rate, depression, paranoia, headaches, loss of appetite, insomnia, fine tremors, loss of short-term memory.
Long-term	Gastrointestinal disorders such as constipation, ulcers, and stomach inflammation; and increased risk of heart attack.
Other Health-related Issues	In rare cases associated with heavy use: psychotic reactions such as fear, anxiety, grandiose delusions (fantastical beliefs that one has superior qualities such as fame, power, and wealth), hallucinations, and paranoia.
In Combination with Alcohol	Unknown.
Withdrawal Symptoms	Depression, nightmares, low blood pressure, and lack of energy.

Treatment Options	
Medications	It is not known whether khat is addictive. There are no FDA-approved medications to treat addiction to khat.
Behavioral Therapies	More research is needed to find out if khat is addictive and, if so, whether behavioral therapies are effective.

Kratom

A tropical deciduous tree (*Mitragyna speciosa*) native to Southeast Asia, with leaves that contain many compounds, including mitragynine, a psychotropic (mind-altering) opioid. Kratom is consumed for mood-lifting effects and pain relief and as an aphrodisiac. For more information, see the Kratom DrugFacts.

Street Names	Commercial Names	Common Forms	Common Ways Taken	DEA Schedule
Herbal Speedball, Biak-biak, Ketum, Kahuam, Ithang, Thom	None	Fresh or dried leaves, powder, liquid, gum	Chewed (whole leaves); eaten (mixed in food or brewed as tea); occasionally smoked	Not scheduled

Possible Health Effects	
Short-term	Nausea, dizziness, itching, sweating, dry mouth, constipation, loss of appetite. Low doses: increased energy, sociability, alertness. High doses: sedation, euphoria, decreased pain.
Long-term	Anorexia, weight loss, insomnia, skin darkening, constipation. Hallucination and paranoia with long-term use at high doses.
Other Health-related Issues	Unknown.
In Combination with Alcohol	Unknown.
Withdrawal Symptoms	Muscle aches, insomnia, hostility, aggression, emotional changes, runny nose, jerky movements.

Treatment Options	
Medications	No clinical trials have been conducted on medications for kratom addiction.
Behavioral Therapies	More research is needed to find out if behavioral therapies can be used to treat addiction to kratom.

LSD				
A hallucinogen manufactured from lysergic acid, which is found in ergot, a fungus that grows on rye and other grains. LSD is an abbreviation of the scientific name *lysergic acid diethylamide*. For more information, see the Hallucinogens and Dissociative Drugs Research Report.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Acid, Blotter, Blue Heaven, Cubes, Microdot, Yellow Sunshine	No commercial uses	Tablet; capsule; clear liquid; small, decorated squares of absorbent paper that liquid has been added to	Swallowed, absorbed through mouth tissues (paper squares)	I

Possible Health Effects	
Short-term	Rapid emotional swings; distortion of a person's ability to recognize reality, think rationally, or communicate with others; raised blood pressure, heart rate, body temperature; dizziness; loss of appetite; tremors; enlarged pupils.
Long-term	Frightening flashbacks (called Hallucinogen Persisting Perception Disorder [HPPD]); ongoing visual disturbances, disorganized thinking, paranoia, and mood swings.
Other Health-related Issues	Unknown.
In Combination with Alcohol	Unknown.
Withdrawal Symptoms	Unknown.
Treatment Options	
Medications	There are no FDA-approved medications to treat addiction to LSD or other hallucinogens.
Behavioral Therapies	More research is needed to find out if behavioral therapies can be used to treat addiction to hallucinogens.

Marijuana (Cannabis)				
Marijuana is made from the hemp plant, *Cannabis sativa*. The main psychoactive (mind-altering) chemical in marijuana is delta-9-tetrahydrocannabinol, or THC. For more information, see the Marijuana Research Report.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Blunt, Bud, Dope, Ganja, Grass, Green, Herb, Joint, Mary Jane, Pot, Reefer, Sinsemilla, Skunk, Smoke, Trees, Weed; Hashish: Boom, Gangster, Hash, Hemp	Various brand names in states where the sale of marijuana is legal	Greenish-gray mixture of dried, shredded leaves, stems, seeds, and/or flowers; resin (hashish) or sticky, black liquid (hash oil)	Smoked, eaten (mixed in food or brewed as tea)	I

Possible Health Effects	
Short-term	Enhanced sensory perception and euphoria followed by drowsiness/relaxation; slowed reaction time; problems with balance and coordination; increased heart rate and appetite; problems with learning and memory; anxiety.
Long-term	Mental health problems, chronic cough, frequent respiratory infections.
Other Health-related Issues	Youth: possible loss of IQ points when repeated use begins in adolescence. Pregnancy: babies born with problems with attention, memory, and problem solving; increased risk of preterm births.
In Combination with Alcohol	Increased heart rate, blood pressure; further slowing of mental processing and reaction time.
Withdrawal Symptoms	Irritability, trouble sleeping, decreased appetite, anxiety.

Treatment Options	
Medications	There are no FDA-approved medications to treat marijuana addiction.
Behavioral Therapies	• Cognitive-behavioral therapy (CBT) • Contingency management, or motivational incentives • Motivational Enhancement Therapy (MET) • Behavioral treatments geared to adolescents • Mobile medical application: reSET®

MDMA (Ecstasy/Molly)				
A synthetic, psychoactive drug that has similarities to both the stimulant amphetamine and the hallucinogen mescaline. MDMA is an abbreviation of the scientific name *3,4-methylenedioxy-methamphetamine.* For more information, see the MDMA (Ecstasy) Abuse Research Report.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Adam, Clarity, Eve, Lover's Speed, Peace, Uppers	No commercial uses	Colorful tablets with imprinted logos, capsules, powder, liquid	Swallowed, snorted	I
Possible Health Effects				
Short-term	Lowered inhibition; enhanced sensory perception; increased heart rate and blood pressure; muscle tension; nausea; faintness; chills or sweating; sharp rise in body temperature leading to kidney failure or death.			
Long-term	Long-lasting confusion, depression, problems with attention, memory, and sleep; increased anxiety, impulsiveness; less interest in sex.			
Other Health-related Issues	Unknown.			
In Combination with Alcohol	MDMA decreases some of alcohol's effects. Alcohol can increase plasma concentrations of MDMA, which may increase the risk of neurotoxic effects.			
Withdrawal Symptoms	Fatigue, loss of appetite, depression, trouble concentrating.			
Treatment Options				
Medications	There is conflicting evidence about whether MDMA is addictive. There are no FDA-approved medications to treat MDMA addiction.			
Behavioral Therapies	More research is needed to find out if behavioral therapies can be used to treat MDMA addiction.			

Mescaline (Peyote)				
A hallucinogen found in disk-shaped "buttons" in the crown of several cacti, including peyote. For more information, see the Hallucinogens and Dissociative Drugs Research Report.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Buttons, Cactus, Mesc	No commercial uses	Fresh or dried buttons, capsule	Swallowed (chewed or soaked in water and drunk)	I
Possible Health Effects				
Short-term	Enhanced perception and feeling; hallucinations; euphoria; anxiety; increased body temperature, heart rate, blood pressure; sweating; problems with movement.			
Long-term	Unknown.			
Other Health-related Issues	Unknown.			
In Combination with Alcohol	Unknown.			
Withdrawal Symptoms	Unknown.			
Treatment Options				
Medications	There are no FDA-approved medications to treat addiction to mescaline or other hallucinogens.			
Behavioral Therapies	More research is needed to find out if behavioral therapies can be used to treat addiction to hallucinogens.			

Methamphetamine				
An extremely addictive stimulant amphetamine drug. For more information, see the Methamphetamine Research Report.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Crank, Chalk, Crystal, Fire, Glass, Go Fast, Ice, Meth, Speed	Desoxyn®	White powder or pill; crystal meth looks like pieces of glass or shiny blue-white "rocks" of different sizes	Swallowed, snorted, smoked, injected	II

Possible Health Effects	
Short-term	Increased wakefulness and physical activity; decreased appetite; increased breathing, heart rate, blood pressure, temperature; irregular heartbeat.
Long-term	Anxiety, confusion, insomnia, mood problems, violent behavior, paranoia, hallucinations, delusions, weight loss, severe dental problems ("meth mouth"), intense itching leading to skin sores from scratching.
Other Health-related Issues	Pregnancy: premature delivery; separation of the placenta from the uterus; low birth weight; lethargy; heart and brain problems. Risk of HIV, hepatitis, and other infectious diseases from shared needles.
In Combination with Alcohol	Masks the depressant effect of alcohol, increasing risk of alcohol overdose; may increase blood pressure.
Withdrawal Symptoms	Depression, anxiety, tiredness.

Treatment Options	
Medications	There are no FDA-approved medications to treat methamphetamine addiction.
Behavioral Therapies	• Cognitive-behavioral therapy (CBT) • Contingency management, or motivational incentives • The Matrix Model • 12-Step facilitation therapy • Mobile medical application: reSET®

Over-the-Counter Medicines--Dextromethorphan (DXM)				
Psychoactive when taken in higher-than-recommended amounts. For more information, see the Over-the-Counter Medicines DrugFacts.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Robotripping, Robo, Triple C	Various (many brand names include "DM")	Syrup, capsule	Swallowed	Not scheduled
Possible Health Effects				
Short-term	Cough relief; euphoria; slurred speech; increased heart rate and blood pressure; dizziness; nausea; vomiting;			
Long-term	Unknown.			
Other Health-related Issues	Breathing problems, seizures, and increased heart rate may occur from other ingredients in cough/cold medicines.			
In Combination with Alcohol	Unknown.			
Withdrawal Symptoms	Unknown.			
Treatment Options				
Medications	There are no FDA-approved medications to treat addiction to dextromethorphan.			
Behavioral Therapies	More research is needed to find out if behavioral therapies can be used to treat addiction to dextromethorphan.			

Over-the-Counter Medicines--Loperamide				
An anti-diarrheal that can cause euphoria when taken in higher-than-recommended doses. For more information, see the Over-the-Counter Medicines DrugFacts.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
None	Immodium	Tablet, capsule, or liquid	Swallowed	Not scheduled
Possible Health Effects				
Short-term	Controls diarrhea symptoms. In high does, can produce euphoria. May lessen cravings and withdrawal symptoms of other drugs.			
Long-term	Unknown.			
Other Health-related Issues	Fainting, stomach pain, constipation, loss of consciousness, cardiovascular toxicity, pupil dilation, and kidney failure from urinary retention.			
In Combination with Alcohol	Unknown.			
Withdrawal Symptoms	Severe anxiety, vomiting, and diarrhea.			
Treatment Options				
Medications	There are no FDA-approved medications to treat loperamide addiction.			
Behavioral Therapies	• The same behavioral therapies that have helped treat addiction to heroin may be used to treat addiction to loperamide. • Contingency management, or motivational incentives			

PCP				
A dissociative drug developed as an intravenous anesthetic that has been discontinued due to serious adverse effects. Dissociative drugs are hallucinogens that cause the user to feel detached from reality. PCP is an abbreviation of the scientific name*, phencyclidine.* For more information, see the Hallucinogens and Dissociative Drugs Research Report.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Angel Dust, Boat, Hog, Love Boat, Peace Pill	No commercial uses	White or colored powder, tablet, or capsule; clear liquid	Injected, snorted, swallowed, smoked (powder added to mint, parsley, oregano, or marijuana)	I, II
Possible Health Effects				
Short-term	Delusions, hallucinations, paranoia, problems thinking, a sense of distance from one's environment, anxiety. Low doses: slight increase in breathing rate; increased blood pressure and heart rate; shallow breathing; face redness and sweating; numbness of the hands or feet; problems with movement. High doses: nausea; vomiting; flicking up and down of the eyes; drooling; loss of balance; dizziness; violence; seizures, coma, and death.			
Long-term	Memory loss, problems with speech and thinking, loss of appetite, anxiety.			
Other Health-related Issues	PCP has been linked to self-injury. Risk of HIV, hepatitis, and other infectious diseases from shared needles.			
In Combination with Alcohol	Unknown.			
Withdrawal Symptoms	Headaches, increased appetite, sleepiness, depression			
Treatment Options				
Medications	There are no FDA-approved medications to treat addiction to PCP or other dissociative drugs.			
Behavioral Therapies	More research is needed to find out if behavioral therapies can be used to treat addiction to dissociative drugs.			

Prescription Opioids				
Pain relievers with an origin similar to that of heroin. Opioids can cause euphoria and are often used nonmedically, leading to overdose deaths. For more information, see the Misuse of Prescription Drugs Research Report.				
Street Names	**Commercial Names (Common)**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Captain Cody, Cody, Lean, Schoolboy, Sizzurp, Purple Drank *With glutethimide:* Doors & Fours, Loads, Pancakes and Syrup	Codeine (various brand names)	Tablet, capsule, liquid	Injected, swallowed (often mixed with soda and flavorings)	II, III, V
Apache, China Girl, China White, Dance Fever, Friend, Goodfella, Jackpot, Murder 8, Tango and Cash, TNT	Fentanyl (Actiq®, Duragesic®, Sublimaze®)	Lozenge, sublingual tablet, film, buccal tablet	Injected, smoked, snorted	II
Vike, Watson-387	Hydrocodone or dihydrocodeinone (Vicodin®, Norco®, Zohydro®, and others)	Capsule, liquid, tablet	Swallowed, snorted, injected	II
D, Dillies, Footballs, Juice, Smack	Hydromorphone (Dilaudid®)	Liquid, suppository	Injected, rectal	II
Demmies, Pain Killer	Meperidine (Demerol®)	Tablet, liquid	Swallowed, snorted, injected	II
Amidone, Fizzies *With MDMA:* Chocolate Chip Cookies	Methadone (Dolophine®, Methadose®)	Tablet, dispersible tablet, liquid	Swallowed, injected	II
M, Miss Emma, Monkey, White Stuff	Morphine (Duramorph®, MS Contin®)	Tablet, liquid, capsule, suppository	Injected, swallowed, smoked	II, III
O.C., Oxycet, Oxycotton, Oxy, Hillbilly Heroin, Percs	Oxycodone (OxyContin®, Percodan®, Percocet®, and others)	Capsule, liquid, tablet	Swallowed, snorted, injected	II
Biscuits, Blue Heaven, Blues, Mrs. O, O Bomb, Octagons, Stop Signs	Oxymorphone (Opana®)	Tablet	Swallowed, snorted, injected	II

Possible Health Effects	
Short-term	Pain relief, drowsiness, nausea, constipation, euphoria, slowed breathing, death.
Long-term	Increased risk of overdose or addiction if misused.
Other Health-related Issues	Pregnancy: Miscarriage, low birth weight, neonatal abstinence syndrome. Older adults: higher risk of accidental misuse because many older adults have multiple prescriptions, increasing the risk of drug-drug interactions, and breakdown of drugs slows with age; also, many older adults are treated with prescription medications for pain. Risk of HIV, hepatitis, and other infectious diseases from shared needles.
In Combination with Alcohol	Dangerous slowing of heart rate and breathing leading to coma or death.
Withdrawal Symptoms	Restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes with goose bumps ("cold turkey"), leg movements.
Treatment Options	
Medications	• Methadone • Buprenorphine • Naltrexone (short- and long-acting)
Behavioral Therapies	The same behavioral therapies that have helped treat addiction to heroin are used to treat prescription opioid addiction.

Prescription Stimulants				
Medications that increase alertness, attention, energy, blood pressure, heart rate, and breathing rate. For more information, see the Misuse of Prescription Drugs Research Report.				
Street Names	**Commercial Names (Common)**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Bennies, Black Beauties, Crosses, Hearts, LA Turnaround, Speed, Truck Drivers, Uppers	Amphetamine (Adderall®)	Tablet, capsule	Swallowed, snorted, smoked, injected	II
JIF, MPH, R-ball, Skippy, The Smart Drug, Vitamin R	Methylphenidate (Concerta®, Ritalin®)	Liquid, tablet, chewable tablet, capsule	Swallowed, snorted, smoked, injected, chewed	II
Possible Health Effects				
Short-term	Increased alertness, attention, energy; increased blood pressure and heart rate; narrowed blood vessels; increased blood sugar; opened-up breathing passages. High doses: dangerously high body temperature and irregular heartbeat; heart disease; seizures.			
Long-term	Heart problems, psychosis, anger, paranoia.			
Other Health-related Issues	Risk of HIV, hepatitis, and other infectious diseases from shared needles.			
In Combination with Alcohol	Masks the depressant action of alcohol, increasing risk of alcohol overdose; may increase blood pressure.			
Withdrawal Symptoms	Depression, tiredness, sleep problems.			
Treatment Options				
Medications	There are no FDA-approved medications to treat stimulant addiction.			
Behavioral Therapies	• Behavioral therapies that have helped treat addiction to cocaine or methamphetamine may be useful in treating prescription stimulant addiction. • Mobile medical application: reSET®			

Psilocybin				
A hallucinogen in certain types of mushrooms that grow in parts of South America, Mexico, and the United States. For more information, see the Hallucinogens and Dissociative Drugs Research Report.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Little Smoke, Magic Mushrooms, Purple Passion, Shrooms	No commercial uses	Fresh or dried mushrooms with long, slender stems topped by caps with dark gills	Swallowed (eaten, brewed as tea, or added to other foods)	I
Possible Health Effects				
Short-term	Hallucinations, altered perception of time, inability to tell fantasy from reality, panic, muscle relaxation or weakness, problems with movement, enlarged pupils, nausea, vomiting, drowsiness.			
Long-term	Risk of flashbacks and memory problems.			
Other Health-related Issues	Risk of poisoning if a poisonous mushroom is accidentally used.			
In Combination with Alcohol	May decrease the perceived effects of alcohol.			
Withdrawal symptoms	Unknown.			
Treatment Options				
Medications	It is not known whether psilocybin is addictive. There are no FDA-approved medications to treat addiction to psilocybin or other hallucinogens.			
Behavioral Therapies	More research is needed to find out if psilocybin is addictive and whether behavioral therapies can be used to treat addiction to this or other hallucinogens.			

Rohypnol® (Flunitrazepam)

A benzodiazepine chemically similar to prescription sedatives such as Valium® and Xanax®. Teens and young adults tend to misuse this drug at bars, nightclubs, concerts, and parties. It has been used to commit sexual assaults due to its ability to sedate and incapacitate unsuspecting victims.

Street Names	Commercial Names	Common Forms	Common Ways Taken	DEA Schedule
Circles, Date Rape Drug, Forget Pill, Forget-Me Pill, La Rocha, Lunch Money, Mexican Valium, Mind Eraser, Pingus, R2, Reynolds, Rib, Roach, Roach 2, Roaches, Roachies, Roapies, Rochas Dos, Roofies, Rope, Rophies, Row-Shay, Ruffies, Trip-and-Fall, Wolfies	Flunitrazepam, Rohypnol®	Tablet	Swallowed (as a pill or as dissolved in a drink), snorted	IV Rohypnol® is not approved for medical use in the United States; it is available as a prescription sleep aid in other countries.

Possible Health Effects	
Short-term	Drowsiness, sedation, sleep; amnesia, blackout; decreased anxiety; muscle relaxation, impaired reaction time and motor coordination; impaired mental functioning and judgment; confusion; aggression; excitability; slurred speech; headache; slowed breathing and heart rate.
Long-term	Unknown.
Other Health-related Issues	Unknown.
In Combination with Alcohol	Severe sedation, unconsciousness, and slowed heart rate and breathing, which can lead to death.
Withdrawal Symptoms	Headache; muscle pain; extreme anxiety, tension, restlessness, confusion, irritability; numbness and tingling of hands or feet; hallucinations, delirium, convulsions, seizures, or shock.

Treatment Options	
Medications	There are no FDA-approved medications to treat addiction to Rohypnol® or other prescription sedatives.
Behavioral Therapies	More research is needed to find out if behavioral therapies can be used to treat addiction to Rohypnol® or other prescription sedatives.

Salvia				
A dissociative drug (*Salvia divinorum*) that is an herb in the mint family native to southern Mexico. Dissociative drugs are hallucinogens that cause the user to feel detached from reality. For more information, see the Hallucinogens and Dissociative Drugs Research Report.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Magic mint, Maria Pastora, Sally-D, Shepherdess's Herb, Diviner's Sage	Sold legally in most states as *Salvia divinorum*	Fresh or dried leaves	Smoked, chewed, or brewed as tea	Not Scheduled (but labeled drug of concern by DEA and illegal in some states)
Possible Health Effects				
Short-term	Short-lived but intense hallucinations; altered visual perception, mood, body sensations; mood swings, feelings of detachment from one's body; sweating.			
Long-term	Unknown.			
Other Health-related Issues	Unknown.			
In Combination with Alcohol	Unknown.			
Withdrawal Symptoms	Unknown.			
Treatment Options				
Medications	It is not known whether salvia is addictive. There are no FDA-approved medications to treat addiction to salvia or other dissociative drugs.			
Behavioral Therapies	More research is needed to find out if salvia is addictive, but behavioral therapies can be used to treat addiction to dissociative drugs.			

Steroids (Anabolic)				
Man-made substances used to treat conditions caused by low levels of steroid hormones in the body and misused to enhance athletic and sexual performance and physical appearance. For more information, see the Steroids and Other Appearance and Performance Enhancing Drugs (APEDs) Research Report.				
Street Names	**Commercial Names (Common)**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Juice, Gym Candy, Pumpers, Roids	Nandrolone (Oxandrin®), oxandrolone (Anadrol®), oxymetholone (Anadrol-50®), testosterone cypionate (Depo-testosterone®)	Tablet, capsule, liquid drops, gel, cream, patch, injectable solution	Injected, swallowed, applied to skin	III
Possible Health Effects				
Short-term	Builds muscles, improved athletic performance. Acne, fluid retention (especially in the hands and feet), oily skin, yellowing of the skin, infection.			
Long-term	Kidney damage or failure; liver damage; high blood pressure, enlarged heart, or changes in cholesterol leading to increased risk of stroke or heart attack, even in young people; aggression; extreme mood swings; anger ("roid rage"); extreme irritability; delusions; impaired judgment.			
Other Health-related Issues	Males: shrunken testicles, lowered sperm count, infertility, baldness, development of breasts. Females: facial hair, male-pattern baldness, enlargement of the clitoris, deepened voice. Adolescents: stunted growth. Risk of HIV, hepatitis, and other infectious diseases from shared needles.			
In Combination with Alcohol	Increased risk of violent behavior.			
Withdrawal Symptoms	Mood swings; tiredness; restlessness; loss of appetite; insomnia; lowered sex drive; depression, sometimes leading to suicide attempts.			
Treatment Options				
Medications	Hormone therapy.			
Behavioral Therapies	More research is needed to find out if behavioral therapies can be used to treat steroid addiction.			

Synthetic Cannabinoids				
A wide variety of herbal mixtures containing man-made cannabinoid chemicals related to THC in marijuana but often much stronger and more dangerous. Sometimes misleadingly called "synthetic marijuana" and marketed as a "natural," "safe," legal alternative to marijuana. For more information, see the Synthetic Cannabinoids DrugFacts.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
K2, Spice, Black Mamba, Bliss, Bombay Blue, Fake Weed, Fire, Genie, Moon Rocks, Skunk, Smacked, Yucatan, Zohai	No commercial uses	Dried, shredded plant material that looks like potpourri and is sometimes sold as "incense"	Smoked, swallowed (brewed as tea)	I

Possible Health Effects	
Short-term	Increased heart rate; vomiting; agitation; confusion; hallucinations, anxiety, paranoia; increased blood pressure.
Long-term	Unknown.
Other Health-related Issues	Use of synthetic cannabinoids has led to an increase in emergency room visits in certain areas.
In Combination with Alcohol	Unknown.
Withdrawal Symptoms	Headaches, anxiety, depression, irritability.

Treatment Options	
Medications	There are no FDA-approved medications to treat synthetic cannabinoid addiction.
Behavioral Therapies	More research is needed to find out if behavioral therapies can be used to treat synthetic cannabinoid addiction.

Synthetic Cathinones ("Bath Salts")				
An emerging family of drugs containing one or more synthetic chemicals related to cathinone, a stimulant found naturally in the khat plant. Examples of such chemicals include mephedrone, methylone, and 3,4-methylenedioxypyrovalerone (MDPV). For more information, see the Synthetic Cathinones ("Bath Salts") DrugFacts.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
Bloom, Cloud Nine, Cosmic Blast, Flakka, Ivory Wave, Lunar Wave, Scarface, Vanilla Sky, White Lightning	No commercial uses for ingested "bath salts"	White or brown crystalline powder sold in small plastic or foil packages labeled "not for human consumption" and sometimes sold as jewelry cleaner; tablet, capsule, liquid	Swallowed, snorted, injected	I Some formulations have been banned by the DEA

Possible Health Effects	
Short-term	Increased heart rate and blood pressure; euphoria; increased sociability and sex drive; paranoia, agitation, and hallucinations; violent behavior; sweating; nausea, vomiting; insomnia; irritability; dizziness; depression; panic attacks; reduced motor control; cloudy thinking.
Long-term	Death.
Other Health-related Issues	Risk of HIV, hepatitis, and other infectious diseases from shared needles.
In Combination with Alcohol	Unknown.
Withdrawal Symptoms	Depression, anxiety.

Treatment Options	
Medications	There are no FDA-approved medications to treat addiction to synthetic cathinones.
Behavioral Therapies	• Cognitive-behavioral therapy (CBT) • Contingency management, or motivational incentives • Motivational Enhancement Therapy (MET) • Behavioral treatments geared to teens

Tobacco				
Plant grown for its leaves, which are dried and fermented before use. For more information, see the Tobacco/Nicotine Research Report.				
Street Names	**Commercial Names**	**Common Forms**	**Common Ways Taken**	**DEA Schedule**
None	Multiple brand names	cigarettes, cigars, bidis, hookahs, smokeless tobacco (snuff, spit tobacco, chew)	Smoked, snorted, chewed, vaporized	Not Scheduled

Possible Health Effects	
Short-term	Increased blood pressure, breathing, and heart rate.
Long-term	Greatly increased risk of cancer, especially lung cancer when smoked and oral cancers when chewed; chronic bronchitis; emphysema; heart disease; leukemia; cataracts; pneumonia.
Other Health-related Issues	Pregnancy: miscarriage, low birth weight, stillbirth, learning and behavior problems.
In Combination with Alcohol	Unknown.
Withdrawal Symptoms	Irritability, attention and sleep problems, depression, increased appetite.

Treatment Options	
Medications	• Bupropion (Zyban®) • Varenicline (Chantix®) • Nicotine replacement (gum, patch, lozenge)
Behavioral Therapies	• Cognitive-behavioral therapy (CBT) • Self-help materials • Mail, phone, and Internet quit resources

Appendix E:
Alcohol and Cancer Risk

NIH NATIONAL CANCER INSTITUTE

Alcohol and Cancer Risk

What is alcohol?

Alcohol is the common term for ethanol or ethyl alcohol, a chemical substance found in alcoholic beverages such as beer, hard cider, malt liquor, wines, and distilled spirits (liquor). Alcohol is produced by the fermentation of sugars and starches by yeast. Alcohol is also found in some medicines, mouthwashes, and household products (including vanilla extract and other flavorings). This fact sheet focuses on cancer risks associated with the consumption of alcoholic beverages.

According to the National Institute on Alcohol Abuse and Alcoholism, a standard alcoholic drink in the United States contains 14.0 grams (0.6 ounces) of pure alcohol. Generally, this amount of pure alcohol is found in

- 12 ounces of beer
- 8-9 ounces of malt liquor
- 5 ounces of wine
- 1.5 ounces, or a "shot," of 80-proof distilled spirits (liquor)

These amounts are used by public health experts in developing health guidelines about alcohol consumption and to provide a way for people to compare the amounts of alcohol they consume. However, they may not reflect the typical serving sizes people may encounter in daily life.

According to the federal government's *Dietary Guidelines for Americans 2015-2020*, individuals who do not drink alcohol should not start drinking for any reason. It recommends that if alcohol is consumed, it should be done in moderation and defines **moderate alcohol drinking** as up to one drink per day for women and up to two drinks per day for men. **Heavy alcohol drinking** is defined as having 4 or more drinks on any day or 8 or more drinks per week for women and 5 or more drinks on any day or 15 or more drinks per week for men. **Binge drinking** is defined as consuming 4 or more drinks for women and 5 or more drinks for men in one sitting (typically in about 2 hours).

What is the evidence that alcohol drinking can cause cancer?

There is a strong scientific consensus that alcohol drinking can cause several types of cancer (1, 2). In its Report on Carcinogens, the National Toxicology Program of the US Department of Health and Human Services lists consumption of alcoholic beverages as a known human carcinogen.

The evidence indicates that the more alcohol a person drinks—particularly the more alcohol a person drinks regularly over time—the higher his or her risk of developing an alcohol-associated cancer. Even light drinkers (those who have no more than one drink per day) and binge drinkers have a modestly increased risk of some cancers (3–7). Based on data from 2009, an estimated 3.5% of cancer deaths in the United States (about 19,500 deaths) were alcohol related (8).

Clear patterns have emerged between alcohol consumption and the development of the following types of cancer:

- **Head and neck cancer**: Moderate to heavy alcohol consumption is associated with higher risks of certain head and neck cancers. Moderate drinkers have 1.8-fold higher risks of oral cavity (excluding the lips) and pharynx (throat) cancers and 1.4-fold higher risks of larynx (voice box) cancers than non-drinkers, and heavy drinkers have 5-fold higher risks of oral cavity and pharynx cancers and 2.6-fold higher risks of larynx cancers (4, 9). Moreover, the risks of these cancers are substantially higher among persons who consume this amount of alcohol and also use tobacco (10).
- **Esophageal cancer**: Alcohol consumption at any level is associated with an increased risk of a type of esophageal cancer called esophageal squamous cell carcinoma. The risks, compared with no alcohol consumption, range from 1.3-fold higher for light drinking to nearly 5-fold higher for heavy drinking (4, 9). In addition, people who inherit a deficiency in an enzyme that metabolizes alcohol have been found to have substantially increased risks of esophageal squamous cell carcinoma if they consume alcohol (11).
- **Liver cancer**: Heavy alcohol consumption is associated with approximately 2-fold increased risks of two types of liver cancer (hepatocellular carcinoma and intrahepatic cholangiocarcinoma) (4, 9, 12, 13).
- **Breast cancer**: Epidemiologic studies have consistently found an increased risk of breast cancer with increasing alcohol intake. Pooled data from 118 individual studies indicates that light drinkers have a slightly increased (1.04-fold higher) risk of breast cancer, compared with nondrinkers. The risk increase is greater in moderate drinkers (1.23-fold higher) and heavy drinkers (1.6-fold higher) (4, 9). An analysis of prospective data for 88,000 women participating in two US cohort studies concluded that for women who have never smoked, light to moderate drinking was associated with a 1.13-fold increased risk of alcohol-related cancers (mostly breast cancer) (5).
- **Colorectal cancer:** Moderate to heavy alcohol consumption is associated with 1.2- to 1.5-fold increased risks of cancers of the colon and rectum compared with no alcohol consumption (4, 9, 14).

Numerous studies have examined whether there is an association between alcohol consumption and the risk of other cancers. Evidence is accumulating that alcohol is associated with increased risks of melanoma and of prostate and pancreatic cancers (4, 15). However, for cancers of the ovary, prostate, stomach, uterus, and bladder, either no association with alcohol use has been found or the evidence for an association is inconsistent.

Alcohol consumption has also been associated with decreased risks of kidney cancers (16–18), and non-Hodgkin lymphoma (19, 20) in multiple studies. However, any potential benefits of alcohol consumption for reducing the risks of some cancers are likely outweighed by the harms of alcohol consumption. In fact, a recent study that included data from more than 1000 alcohol studies and data sources, as well as death and disability records from 195 countries and territories from 1990 to 2016, concluded that the optimal number of drinks to consume per day to minimize the overall risk to health is zero (21). That study did not include data on kidney cancer or non-Hodgkin lymphoma.

Alcohol consumption may also be associated with an increased risk of second primary cancers. For example, a meta-analysis of data from 19 studies showed that among patients with cancer of the upper aerodigestive tract (UADT)—which includes the oral cavity, pharynx, larynx, and esophagus—for every 10 grams of alcohol consumed per day before the first UADT cancer diagnosis there was a 1.09-fold higher risk of a second primary UADT cancer (22). It is less clear whether alcohol consumption increases the risk of second primary cancers at other sites, such as the breast (23–25).

How does alcohol affect the risk of cancer?

Researchers have hypothesized multiple ways that alcohol may increase the risk of cancer, including:

- metabolizing (breaking down) ethanol in alcoholic drinks to acetaldehyde, which is a toxic chemical and a probable human carcinogen; acetaldehyde can damage both DNA (the genetic material that makes up genes) and proteins
- generating reactive oxygen species (chemically reactive molecules that contain oxygen), which can damage DNA, proteins, and lipids (fats) in the body through a process called oxidation
- impairing the body's ability to break down and absorb a variety of nutrients that may be associated with cancer risk, including vitamin A; nutrients in the vitamin B complex, such as folate; vitamin C; vitamin D; vitamin E; and carotenoids
- increasing blood levels of estrogen, a sex hormone linked to the risk of breast cancer

Alcoholic beverages may also contain a variety of carcinogenic contaminants that are introduced during fermentation and production, such as nitrosamines, asbestos fibers, phenols, and hydrocarbons.

The mechanisms by which alcohol consumption may decrease the risks of some cancers are not understood and may be indirect.

How does the combination of alcohol and tobacco affect cancer risk?

Epidemiologic research shows that people who use both alcohol and tobacco have much greater risks of developing cancers of the oral cavity, pharynx (throat), larynx, and esophagus than people who use either alcohol or tobacco alone. In fact, for oral and pharyngeal cancers, the risks associated with using both alcohol and tobacco are multiplicative; that is, they are greater than would be expected from adding the individual risks associated with alcohol and tobacco together (10, 26).

Can people's genes affect their risk of alcohol-related cancers?

A person's risk of alcohol-related cancers is influenced by their genes, specifically the genes that encode enzymes involved in metabolizing (breaking down) alcohol (27).

For example, one way the body metabolizes alcohol is through the activity of an enzyme called alcohol dehydrogenase, or ADH, which converts ethanol into the carcinogenic metabolite acetaldehyde, mainly in the liver. Recent evidence suggests that acetaldehyde production also occurs in the oral cavity and may be influenced by factors such as the oral microbiome (28, 29).

Many individuals of East Asian descent carry a version of the gene for ADH that codes for a "superactive" form of the enzyme. This superactive ADH enzyme speeds the conversion of alcohol (ethanol) to toxic acetaldehyde. Among people of Japanese descent, those who have this form of ADH have a higher risk of pancreatic cancer than those with the more common form of ADH (30).

Another enzyme, called aldehyde dehydrogenase 2 (ALDH2), metabolizes toxic acetaldehyde to non-toxic substances. Some people, particularly those of East Asian descent, carry a variant of the gene for ALDH2 that encodes a defective form of the enzyme. In people who produce the defective enzyme, acetaldehyde builds up when they drink alcohol. The accumulation of acetaldehyde has such unpleasant effects (including facial flushing and heart palpitations) that most people who have inherited the ALDH2 variant are unable to consume large amounts of alcohol and therefore have a low risk of developing alcohol-related cancers.

However, some individuals with the defective form of ALDH2 can become tolerant to the unpleasant effects of acetaldehyde and consume large amounts of alcohol. Epidemiologic studies have shown that such individuals have a higher risk of alcohol-related esophageal cancer, as well as of head and neck cancers, than individuals with the fully active enzyme who drink comparable amounts of alcohol (31). These increased risks are seen only among people who carry the ALDH2 variant and drink alcohol—they are not observed in people who carry the variant but do not drink alcohol.

Can drinking red wine help prevent cancer?

The plant secondary compound resveratrol, found in grapes used to make red wine and some other plants, has been investigated for many possible health effects, including cancer prevention. However, researchers have found no association between moderate consumption of red wine and the risk of developing prostate cancer (32) or colorectal cancer (33).

What happens to cancer risk after a person stops drinking alcohol?

Most of the studies that have examined whether cancer risk declines after a person stops drinking alcohol have focused on head and neck cancers and on esophageal cancer. In general, these studies have found that stopping alcohol consumption is not associated with immediate reductions in cancer risk. The cancer risks eventually decline, although it may take years for the risks of cancer to return to those of never drinkers.

For example, ex-drinkers still had higher risks of oral cavity and pharyngeal cancers than never drinkers even 16 years after they stopped drinking alcohol, although it was lower than before they stopped drinking (34). One study estimated that it would take more than 35 years for the higher risks of laryngeal and pharyngeal cancers associated with alcohol consumption to decrease to the level of never drinkers (35).

Is it safe for someone to drink alcohol while undergoing cancer chemotherapy?

As with most questions related to a specific individual's cancer treatment, it is best for patients to check with their health care team about whether it is safe to drink alcohol during or immediately following chemotherapy treatment. The doctors and nurses administering the treatment will be able to give specific advice about whether it is safe to consume alcohol while undergoing specific cancer treatments.

Selected References

1. IARC Working Group on the Evaluation of Carcinogenic Risks to Humans. Alcohol consumption and ethyl carbamate. IARC Monographs on the Evaluation of Carcinogenic Risks in Humans 2010;96:3-1383.
2. IARC Working Group on the Evaluation of Carcinogenic Risks to Humans. Personal habits and indoor combustions. Volume 100 E. A review of human carcinogens. IARC Monographs on the Evaluation of Carcinogenic Risks in Humans 2012;100(Pt E):373-472.
3. Bagnardi V, Rota M, Botteri E, et al. Light alcohol drinking and cancer: a meta-analysis. *Annals of Oncology* 2013; 24(2):301-308. [PubMed Abstract]
4. Bagnardi V, Rota M, Botteri E, et al. Alcohol consumption and site-specific cancer risk: a comprehensive dose-response meta-analysis. *British Journal of Cancer* 2015; 112(3):580-593. [PubMed Abstract]
5. Cao Y, Willett WC, Rimm EB, Stampfer MJ, Giovannucci EL. Light to moderate intake of alcohol, drinking patterns, and risk of cancer: results from two prospective US cohort studies. *BMJ* 2015; 351:h4238. [PubMed Abstract]
6. Chen WY, Rosner B, Hankinson SE, Colditz GA, Willett WC. Moderate alcohol consumption during adult life, drinking patterns, and breast cancer risk. *JAMA* 2011; 306(17):1884-1890. [PubMed Abstract]
7. White AJ, DeRoo LA, Weinberg CR, Sandler DP. Lifetime alcohol intake, binge drinking behaviors, and breast cancer risk. *American Journal of Epidemiology* 2017; 186(5):541-549. [PubMed Abstract]
8. Nelson DE, Jarman DW, Rehm J, et al. Alcohol-attributable cancer deaths and years of potential life lost in the United States. American Journal of Public Health 2013;103(4):641-648. [PubMed Abstract]
9. LoConte NK, Brewster AM, Kaur JS, Merrill JK, Alberg AJ. Alcohol and cancer: A statement of the American Society of Clinical Oncology. *Journal of Clinical Oncology* 2018; 36(1):83-93. [PubMed Abstract]
10. Hashibe M, Brennan P, Chuang SC, et al. Interaction between tobacco and alcohol use and the risk of head and neck cancer: pooled analysis in the International Head and Neck Cancer Epidemiology Consortium. Cancer Epidemiology, Biomarkers & Prevention 2009;18(2):541-550. [PubMed Abstract]
11. Wu C, Wang Z, Song X, et al. Joint analysis of three genome-wide association studies of esophageal squamous cell carcinoma in Chinese populations. *Nature Genetics* 2014; 46(9):1001-1006. [PubMed Abstract]
12. Grewal P, Viswanathen VA. Liver cancer and alcohol. Clinics in Liver Disease 2012;16(4):839-850. [PubMed Abstract]
13. Petrick JL, Campbell PT, Koshiol J, et al. Tobacco, alcohol use and risk of hepatocellular carcinoma and intrahepatic cholangiocarcinoma: The Liver Cancer Pooling Project. *British Journal of Cancer* 2018; 118(7):1005-1012. [PubMed Abstract]
14. Fedirko V, Tramacere I, Bagnardi V, et al. Alcohol drinking and colorectal cancer risk: an overall and dose-response meta-analysis of published studies. Annals of Oncology 2011;22(9):1958-1972. [PubMed Abstract]
15. Zhao J, Stockwell T, Roemer A, Chikritzhs T. Is alcohol consumption a risk factor for prostate cancer? A systematic review and meta-analysis. *BMC Cancer* 2016; 16(1):845. [PubMed Abstract]
16. Mahabir S, Leitzmann MF, Virtanen MJ, et al. Prospective study of alcohol drinking and renal cell cancer risk in a cohort of finnish male smokers. *Cancer Epidemiology, Biomarkers & Prevention* 2005; 14(1):170-175. [PubMed Abstract]
17. Rashidkhani B, Akesson A, Lindblad P, Wolk A. Alcohol consumption and risk of renal cell carcinoma: a prospective study of Swedish women. *International Journal of Cancer* 2005; 117(5):848-853. [PubMed Abstract]
18. Lee JE, Hunter DJ, Spiegelman D, et al. Alcohol intake and renal cell cancer in a pooled analysis of 12 prospective studies. *Journal of the National Cancer Institute* 2007; 99(10):801-810. [PubMed Abstract]
19. Tramacere I, Pelucchi C, Bonifazi M, et al. Alcohol drinking and non-Hodgkin lymphoma risk: a systematic review and a meta-analysis. *Annals of Oncology* 2012; 23(11):2791-2798. [PubMed Abstract]
20. Psaltopoulou T, Sergentanis TN, Ntanasis-Stathopoulos I, et al. Alcohol consumption and risk of hematological malignancies: A meta-analysis of prospective studies. *International Journal of Cancer* 2018; 143(3):486-495. [PubMed Abstract]
21. GBD 2016 Alcohol Collaborators. Alcohol use and burden for 195 countries and territories, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet* 2018; doi: 10.1016/S0140-6736(18)31310-2. [PubMed Abstract]
22. Druesne-Pecollo N, Keita Y, Touvier M, et al. Alcohol drinking and second primary cancer risk in patients with upper aerodigestive tract cancers: a systematic review and meta-analysis of observational studies. *Cancer Epidemiology, Biomarkers & Prevention* 2014; 23(2):324-331. [PubMed Abstract]
23. Simapivapan P, Boltong A, Hodge A. To what extent is alcohol consumption associated with breast cancer recurrence and second primary breast cancer?: A systematic review. *Cancer Treatment Reviews* 2016; 50:155-167. [PubMed Abstract]
24. Park SM, Li T, Wu S, et al. Risk of second primary cancer associated with pre-diagnostic smoking, alcohol, and obesity in women with keratinocyte carcinoma. *Cancer Epidemiology* 2017; 47:106-113. [PubMed Abstract]
25. Knight JA, Fan J, Malone KE, et al. Alcohol consumption and cigarette smoking in combination: A predictor of contralateral breast cancer risk in the WECARE study. *International Journal of Cancer* 2017; 141(5):916-924. [PubMed Abstract]
26. Turati F, Garavello W, Tramacere I, et al. A meta-analysis of alcohol drinking and oral and pharyngeal cancers: results from subgroup analyses. Alcohol and Alcoholism 2013;48(1):107-118. [PubMed Abstract]
27. Druesne-Pecollo N, Tehard B, Mallet Y, et al. Alcohol and genetic polymorphisms: effect on risk of alcohol-related cancer. Lancet Oncology 2009;10(2):173-180. [PubMed Abstract]
28. Stornetta A, Guidolin V, Balbo S. Alcohol-derived acetaldehyde exposure in the oral cavity. *Cancers* 2018; 10(1). pii: E20. [PubMed Abstract]

29. Fan X, Peters BA, Jacobs EJ, et al. Drinking alcohol is associated with variation in the human oral microbiome in a large study of American adults. *Microbiome* 2018; 6(1):59. [PubMed Abstract]
30. Kanda J, Matsuo K, Suzuki T, et al. Impact of alcohol consumption with polymorphisms in alcohol-metabolizing enzymes on pancreatic cancer risk in Japanese. Cancer Science 2009;100(2):296-302. [PubMed Abstract]
31. Yokoyama A, Omori T. Genetic polymorphisms of alcohol and aldehyde dehydrogenases and risk for esophageal and head and neck cancers. Alcohol 2005;35(3):175-185.
32. Vartolomei MD, Kimura S, Ferro M, et al. The impact of moderate wine consumption on the risk of developing prostate cancer. *Clinical Epidemiology* 2018; 10:431-444. [PubMed Abstract]
33. Chao C, Haque R, Caan BJ, et al. Red wine consumption not associated with reduced risk of colorectal cancer. *Nutrition and Cancer* 2010; 62(6):849-855. [PubMed Abstract]
34. Rehm J, Patra J, Popova S. Alcohol drinking cessation and its effect on esophageal and head and neck cancers: a pooled analysis. International Journal of Cancer 2007;121(5):1132-1137. [PubMed Abstract]
35. Ahmad Kiadaliri A, Jarl J, Gavriilidis G, Gerdtham UG. Alcohol drinking cessation and the risk of laryngeal and pharyngeal cancers: a systematic review and meta-analysis. *PLoS One* 2013; 8(3):e58158. [PubMed Abstract]

Related Resources

Chemotherapy and You: Support for People With Cancer
Head and Neck Cancers
MedlinePlus topic page: Alcohol
National Institute of Alcohol Abuse and Alcoholism
Smokefree.gov
Tobacco
U.S. Centers for Disease Control and Prevention topic page: Alcohol and Public Health

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Appendix F:
Drugs of Abuse

U.S. DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION

Drugs of Abuse

A DEA RESOURCE GUIDE 2017 EDITION

Drugs of Abuse

A DEA RESOURCE GUIDE

PRODUCED AND PUBLISHED BY
Drug Enforcement Administration • U.S. Department of Justice

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Contents

Welcome

TO THE LATEST EDITION OF DRUGS OF ABUSE

Education plays a critical role in preventing substance abuse. *Drugs of Abuse, A DEA Resource Guide*, is designed to be a reliable resource on the most commonly abused and misused drugs in the United States. This comprehensive guide provides important information about the harms and consequences of drug use by describing a drug's effects on the body and mind, overdose potential, origin, legal status, and other key facts.

Drugs of Abuse also offers a list of additional drug education and prevention resources, including the DEA websites:

www.DEA.gov; www.JustThinkTwice.com, aimed at teenagers; www.GetSmartAboutDrugs.com, designed for parents, educators, and caregivers; and www.operationprevention.com.

I. Controlled Substances Act

CONTROLLING DRUGS OR OTHER SUBSTANCES THROUGH FORMAL SCHEDULING

The Controlled Substances Act (CSA) places all substances which were in some manner regulated under existing federal law into one of five schedules. This placement is based upon the substance's medical use, potential for abuse, and safety or dependence liability. The Act also provides a mechanism for substances to be controlled (added to or transferred between schedules) or decontrolled (removed from control). The procedure for these actions is found in Section 201 of the Act (21U.S.C. §811).

Proceedings to add, delete, or change the schedule of a drug or other substance may be initiated by the Drug Enforcement Administration (DEA), the Department of Health and Human Services (HHS), or by petition from any interested party, including:

- The manufacturer of a drug
- A medical society or association
- A pharmacy association
- A public interest group concerned with drug abuse
- A state or local government agency
- An individual citizen

When a petition is received by the DEA, the agency begins its own investigation of the drug. The DEA also may begin an investigation of a drug at any time based upon information received from law enforcement laboratories, state and local law enforcement and regulatory agencies, or other sources of information.

Once the DEA has collected the necessary data, the DEA Administrator, by authority of the Attorney General, requests from HHS a scientific and medical evaluation and recommendation as to whether the drug or other substance should be controlled or removed from control. This request is sent to the Assistant Secretary for Health of HHS.

The Assistant Secretary, by authority of the Secretary, compiles the information and transmits back to the DEA: a medical and scientific evaluation regarding the drug or other substance, a recommendation as to whether the drug should be controlled, and in what schedule it should be placed.

The medical and scientific evaluations are binding on the DEA with respect to scientific and medical matters and form a part of the scheduling decision.

Once the DEA has received the scientific and medical evaluation from HHS, the Administrator will evaluate all available data and make a final decision whether to propose that a drug or other substance should be removed or controlled and into which schedule it should be placed.

If a drug does not have a potential for abuse, it cannot be controlled. Although the term "potential for abuse" is not defined in the CSA, there is much discussion of the term in the legislative history of the Act. The following items are indicators that a drug or other substance has a potential for abuse:

(1) There is evidence that individuals are taking the drug or other substance in amounts sufficient to create a hazard to their health or to the safety of other individuals or to the community.

(2) There is significant diversion of the drug or other substance from legitimate drug channels.

(3) Individuals are taking the drug or other substance on their own initiative rather than on the basis of medical advice from a practitioner.

(4) The drug is a new drug so related in its action to a drug or other substance already listed as having a potential for abuse to make it likely that the drug will have the same potential for abuse as such drugs, thus making it reasonable to assume that there may be significant diversions from legitimate channels, significant use contrary to or without medical advice, or that it has a substantial capability of creating hazards to the

health of the user or to the safety of the community. Of course, evidence of actual abuse of a substance is indicative that a drug has a potential for abuse.

In determining into which schedule a drug or other substance should be placed, or whether a substance should be decontrolled or rescheduled, certain factors are required to be considered. These factors are listed in Section 201 (c), [21 U.S.C. § 811 (c)] of the CSA as follows:

(1) *The drug's actual or relative potential for abuse.*

(2) *Scientific evidence of the drug's pharmacological effect, if known.* The state of knowledge with respect to the effects of a specific drug is, of course, a major consideration. For example, it is vital to know whether or not a drug has a hallucinogenic effect if it is to be controlled due to that effect.

The best available knowledge of the pharmacological properties of a drug should be considered.

(3) *The state of current scientific knowledge regarding the substance.* Criteria (2) and (3) are closely related. However, (2) is primarily concerned with pharmacological effects and (3) deals with all scientific knowledge with respect to the substance.

(4) *Its history and current pattern of abuse.* To determine whether or not a drug should be controlled, it is important to know the pattern of abuse of that substance.

(5) *The scope, duration, and significance of abuse.* In evaluating existing abuse, the DEA Administrator must know not only the pattern of abuse, but also whether the abuse is widespread.

(6) *What, if any, risk there is to the public health.* If a drug creates dangers to the public health, in addition to or because of its abuse potential, then these dangers must also be considered by the Administrator.

(7) *The drug's psychic or physiological dependence liability.* There must be an assessment of the extent to which a drug is physically addictive or psychologically habit forming.

(8) *Whether the substance is an immediate precursor of a substance already controlled.* The CSA allows inclusion of immediate precursors on this basis alone into the appropriate schedule and thus safeguards against possibilities of clandestine manufacture. After considering the above listed factors, the Administrator must make specific findings concerning the drug or other substance. This will determine into which schedule the drug or other substance will be placed. These schedules are established by the CSA. They are as follows:

Schedule I

- The drug or other substance has a high potential for abuse.
- The drug or other substance has no currently accepted medical use in treatment in the United States.
- There is a lack of accepted safety for use of the drug or other substance under medical supervision.
- Examples of Schedule I substances include heroin, gamma hydroxybutyric acid (GHB), lysergic acid diethylamide (LSD), marijuana, and methaqualone.

Schedule II

- The drug or other substance has a high potential for abuse.
- The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.
- Abuse of the drug or other substance may lead to severe psychological or physical dependence.
- Examples of Schedule II substances include morphine, phencyclidine (PCP), cocaine, methadone, hydrocodone, fentanyl, and methamphetamine.

Schedule III

- The drug or other substance has less potential for abuse than the drugs or other substances in Schedules I and II.
- The drug or other substance has a currently accepted medical use in treatment in the United States.
- Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.
- Anabolic steroids, codeine products with aspirin or Tylenol, and some barbiturates are examples of Schedule III substances.

Schedule IV

- The drug or other substance has a low potential for abuse relative to the drugs or other substances in Schedule III.
- The drug or other substance has a currently accepted medical use in treatment in the United States.
- Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule III.
- Examples of drugs included in Schedule IV are alprazolam, clonazepam, and diazepam.

Schedule V

- The drug or other substance has a low potential for abuse relative to the drugs or other substances in Schedule IV.
- The drug or other substance has a currently accepted medical use in treatment in the United States.
- Abuse of the drug or other substances may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule IV.
- Cough medicines with codeine are examples of Schedule V drugs.

When the DEA Administrator has determined that a drug or other substance should be controlled, decontrolled, or rescheduled, a proposal to take action is published in the Federal Register. The proposal invites all interested persons to file comments with the DEA and may also request a hearing with the DEA. If no hearing is requested, the DEA will evaluate all comments received and publish a final order in the Federal Register, controlling the drug as proposed or with modifications based upon the written comments filed. This order will set the effective dates for imposing the various requirements of the CSA.

If a hearing is requested, the DEA will enter into discussions with the party or parties requesting a hearing in an attempt to narrow the issue for litigation. If necessary, a hearing will then be held before an Administrative Law Judge. The judge will take evidence on factual issues and hear arguments on legal questions regarding the control of the drug. Depending on the scope and complexity of the issues, the hearing may be brief or quite extensive. The Administrative Law Judge, at the close of the hearing, prepares findings of fact and conclusions of law and a recommended decision that is submitted to the DEA Administrator. The DEA Administrator will review these documents, as well as the underlying material, and prepare his/her own findings of fact and conclusions of law (which may or may not be the same as those drafted by the Administrative Law Judge). The DEA Administrator then publishes a final order in the Federal Register either scheduling the drug or other substance or declining to do so.

Once the final order is published in the Federal Register, interested parties have 30 days to appeal to a U.S. Court of Appeals to challenge the order. Findings of fact by the Administrator are deemed conclusive if supported by "substantial evidence." The order imposing controls is not stayed during the appeal, however, unless so ordered by the Court.

Emergency or Temporary Scheduling

The CSA was amended by the Comprehensive Crime Control Act of 1984. This Act included a provision which allows the DEA Administrator to place a substance, on a temporary basis, into Schedule I, when necessary, to avoid an imminent hazard to public safety.

This emergency scheduling authority permits the scheduling of a substance which is not currently controlled, is being abused, and is a risk to public health while the formal rulemaking procedures described in the CSA are being conducted. This emergency scheduling applies only to substances with no accepted medical use.

A temporary scheduling order may be issued for two years with a possible extension of up to one year if formal scheduling procedures have been initiated. The notice of intent and order are published in the Federal Register, as are the proposals and orders for formal scheduling. [21 U.S.C. § 811 (h)]

Controlled Substance analogues

Controlled substance analogues are substances that are not formally controlled substances, but may be found in illicit trafficking. They are structurally or pharmacologically similar to Schedule I or II controlled substances and have no legitimate medical use. A substance that meets the definition of a controlled substance analogue and is intended for human consumption may be treated under the CSA as if it were a controlled substance in Schedule I. [21 U.S.C. § 802(32), 21 U.S.C. § 813]

International treaty obligations

United States treaty obligations may require that a drug or other substance be controlled under the CSA, or rescheduled if existing controls are less stringent than those required by a treaty. The procedures for these scheduling actions are found in Section 201 (d) of the Act. [21 U.S.C. § 811 (d)]

The United States is a party to the Single Convention on Narcotic Drugs of 1961, which was designed to establish effective control over international and domestic traffic in narcotics, coca leaf, cocaine, and cannabis. A second treaty, the Convention on Psychotropic Substances of 1971, which entered into force in 1976 and was ratified by Congress in 1980, is designed to establish comparable control over stimulants, depressants, and hallucinogens.

REGULATION

The CSA creates a closed system of distribution for controlled substances.

The cornerstone of this system is the registration of all those authorized by DEA to handle controlled substances. All individuals and firms that are registered are required to maintain complete and accurate inventories, and records of all transactions involving controlled substances, as well as security for the storage of controlled substances.

Registration

Any person who handles or intends to handle controlled substances must obtain a registration issued by DEA. A unique number is assigned to each legitimate handler of controlled drugs such as importer, exporter, manufacturer, distributor, hospital, pharmacy, practitioner, and researcher.

This number must be made available to the supplier by the customer prior to the purchase of a controlled substance, and its validity can be verified online through the Diversion Control Division website at www.DEAdiversion.usdoj.gov. Thus, the opportunity for unauthorized transactions is greatly diminished.

Recordkeeping and Reporting

The CSA requires that complete and accurate records be kept of all quantities of controlled substances manufactured, imported, exported, received, delivered, distributed, dispensed, or otherwise disposed. Each substance must be physically inventoried every two years. Some limited exceptions to the recordkeeping requirements apply to certain categories of registrants.

From these records it is possible to trace the flow of any drug from the time it is first imported or manufactured, through the distribution level, to the pharmacy or hospital that dispensed it, and then to the actual patient who received the drug. The mere existence of this requirement is sufficient to discourage many forms of diversion. It actually serves large drug corporations as an internal check to uncover diversion, such as pilferage by employees.

There is one distinction between scheduled items for record keeping requirements. Records for Schedule I and II drugs must be kept separate from all other records maintained by the registrant. Records for Schedule III, IV, and V substances must be kept in a "readily retrievable" form, or maintained separately from all other records.

Distribution

Maintaining records is required for distribution of a controlled substance from one manufacturer to another, from manufacturer to distributor, and from distributor to dispenser. In the case of Schedule I and II drugs, the supplier must first receive a special order from the customer. This order form (DEA Form 222) is issued by DEA only to persons who are properly registered to handle Schedule I and II controlled substances.

The form is preprinted with the name and address of the customer. The drugs must be shipped to this name and address. The use of this form is a special reinforcement of the registration requirement; it ensures that only authorized individuals may obtain Schedule I and II drugs.

Controlled Substance Ordering System (CSOS) – Electronic Order Forms

Any registrant permitted to order Schedule II controlled substances may do so electronically via the DEA Controlled Substance Ordering System (CSOS). The use of electronic orders is optional; registrants may continue to issue orders on a paper DEA Form 222. CSOS allows for secure electronic transmission of controlled substance orders without the supporting paper DEA Form 222. The adoption of the CSOS standards is the only allowance for the electronic transmission of Schedule II controlled substance orders between controlled substance manufacturers, distributors, pharmacies, and other DEA authorized entities. CSOS uses Public Key Infrastructure (PKI) technology, which requires CSOS users to obtain a CSOS digital certificate for electronic ordering. The electronic orders must be signed using a digital signature issued by a Certification Authority (CA) operated by DEA.

Digital certificates can be obtained only by registrants and individuals granted power of attorney by registrants to sign orders. A registrant must appoint a CSOS coordinator who will serve as that registrant's recognized agent regarding issues pertaining to issuance of, revocation of, and changes to, digital certificates issued under that registrant's DEA registration. A CSOS digital certificate will be valid until the DEA registration under which it is issued expires or until the CSOS CA is notified that the certificate should be revoked. Certificates will be revoked if the certificate holder is no longer authorized to sign Schedule II orders for the registrant, if the information on which the certificate is based changes, or if the digital certificate used to sign electronic orders has been compromised, stolen, or lost.

One benefit of using the CSOS system is that participants who are registered in other schedules in addition to schedule II can then use this same system to also order those other controlled substances.

Another benefit of the DEA Form 222 is the special monitoring it permits. The form is issued in triplicate: the customer keeps one copy; two copies go to the supplier, who, after filling the order, keeps a copy and forwards the third copy to the nearest DEA office.

For drugs in Schedules III, IV, and V, no order form is necessary, but both the supplier and the purchaser must still maintain records of all transactions involving these controlled substances and those records must contain specific information required by DEA regulation.

The supplier in each case, however, is under an obligation to verify the authenticity of the customer. The supplier is held fully accountable for any drugs that are shipped to a purchaser who does not have a valid registration. Manufacturers must submit periodic reports of the Schedule I and II controlled substances they produce in bulk and dosage forms.

They also report the manufactured quantity and form of each narcotic substance listed in Schedule III. Distributors of controlled substances must report the quantity and form of all their transactions of controlled drugs listed in Schedules I and II, narcotics listed in Schedule III, and GHB. Both manufacturers and distributors are required to provide reports of their annual inventories of these controlled substances. This data is entered into a system called the Automated Reports and Consolidated Orders System (ARCOS). It enables the DEA to monitor the distribution of controlled substances throughout the country, and to identify retail level registrants that receive unusual quantities of controlled substances.

Dispensing to Patients

The dispensing of a controlled substance is the delivery by a practitioner of the controlled substance to the ultimate user, who may be a patient or research subject. Special control mechanisms operate here as well. Schedule I drugs are those that have no currently accepted medical use in the United States; therefore, they may be used in the United States only in research situations. They generally are supplied by only a limited number of firms to properly registered and qualified researchers. Controlled substances may be dispensed by a practitioner by direct administration, by prescription, or by dispensing.

Records must be maintained by the practitioner of all dispensing of controlled substances and of certain administrations.

The CSA does not require the practitioner to maintain copies of prescriptions unless such substances are prescribed in the course of maintenance or detoxification treatment of an individual. Certain states require the use of multiple-copy prescriptions for Schedule II and other specified controlled substances.

The determination to place drugs on prescription is within the jurisdiction of the FDA. Unlike other prescription drugs, however, controlled substances are subject to additional restrictions. Schedule II prescription orders must be written and signed by the practitioner; they may not be telephoned into the pharmacy except in an emergency. In addition, a prescription for a Schedule II drug may not be refilled. For Schedule III and IV drugs, the prescription order may be either written or oral (that is, by telephone to the pharmacy). In addition, the patient may (if authorized by the practitioner) have the prescription refilled up to five times and at any time within six months from the date the prescription was issued.

Schedule V includes some prescription drugs and many narcotic preparations, including antitussives and antidiarrheals. Even here, however, the law imposes restrictions beyond those normally required for the over-the-counter sales; for example, the patient must be at least 18 years of age, must offer some form of identification, and have his or her name entered into a special log maintained by the pharmacist as part of a special record.

Electronic Prescriptions

On March 31, 2010, DEA published in the Federal Register the Electronic Prescriptions for Controlled Substances interim final rule which became effective June 1, 2010. The rule provides practitioners with the option of writing prescriptions for controlled substances electronically and also permits pharmacies to receive, dispense, and archive these electronic prescriptions.

Persons who wish to dispense controlled substances using electronic prescriptions must select software that meets the requirements of this rule. As of June 1, 2010, only those electronic applications that comply with all of DEA's requirements as set forth in 21 C.F.R. §1311 may be used to electronically create, transmit, receive/archive controlled substances prescriptions, and dispense controlled substances based on those prescriptions.

Ryan Haight Online Pharmacy Consumer Protection Act of 2008

On October 15, 2008, the President signed into law the Ryan Haight Online Pharmacy Consumer Protection Act of 2008, often referred to as the Ryan Haight Act. This law amends the CSA by adding a series of new regulatory requirements and criminal provisions designed to combat the proliferation of so-called "rogue Internet sites" that unlawfully dispense controlled substances by means of the Internet. The Ryan Haight Act applies to all controlled substances in all schedules. An online pharmacy is a person, entity, or Internet site, whether in the United States or abroad, that knowingly or intentionally delivers, distributes, or dispenses, or offers or attempts to deliver, distribute, or dispense, a controlled substance by means of the Internet.

This law became effective April 13, 2009. As of that date, it is illegal under federal law to deliver, distribute, or dispense a controlled substance by means of the Internet unless the online pharmacy holds a modification of DEA registration authorizing it to operate as an online pharmacy.

Quotas

DEA limits the quantity of Schedule I and II controlled substances and specific List I chemicals (pseudoephedrine, ephedrine, and phenylpropanolamine) that may be produced in the United States in any given calendar year for legitimate medical, scientific and research needs, inventory, and lawful exports. By utilizing available data on sales and inventories of these controlled substances, and taking into account estimates of drug usage provided by the FDA, the DEA establishes annual aggregate production quotas for Schedule I and II controlled substances and the List I chemicals pseudoephedrine, ephedrine, and phenylpropanolamine.

The aggregate production quotas and the assessment of annual needs are allocated among the various manufacturers who are registered to manufacture the specific substance or listed chemical. DEA also allocates the amount of bulk material that may be procured by those DEA registered manufacturers that prepare the substances into dosage units.

Security

DEA registrants are required by regulation to maintain certain security for the storage and distribution of controlled substances. Manufacturers and distributors of Schedule I and II substances must store controlled substances in specially constructed vaults or highly rated safes, and maintain electronic security for all storage areas. Lesser physical security requirements apply to retail level registrants such as hospitals and pharmacies. All registrants are required to make every effort to ensure that controlled substances in their possession are not diverted into the illicit market. This requires operational as well as physical security. For example, registrants are responsible for ensuring that controlled substances are distributed only to other registrants that are authorized to receive them, or to legitimate patients.

Controlled Substance Theft or Significant Loss

Should a theft or significant loss of any controlled substance occur, a registrant must implement the following procedures within one business day of the discovery of the theft or loss.

A. Notify DEA and Local Police

The theft of controlled substances from a registrant is a criminal act and a source of diversion that requires notification to DEA.

A registrant must notify in writing the local DEA Diversion Field Office within one business day of discovery of a theft or significant loss of a controlled substance. Although not specifically required by federal law or regulations, the registrant should also notify local law enforcement and state regulatory agencies. Prompt notification to enforcement agencies will allow them to investigate the incident and prosecute those responsible for the diversion. If there is a question as to whether a theft has occurred or a loss is significant, a registrant should err on the side of caution and report it to DEA and local law enforcement authorities.

DEA must be notified directly. This requirement is not satisfied by reporting the theft or significant loss in any other manner. For example, a corporation which owns or operates multiple registered sites and wishes to channel all notifications through corporate management or any other internal department responsible for security, must still provide notice directly to DEA in writing within one business day upon discovery and keep a copy of that notice for its records. The notice must be signed by an authorized individual of the registrant.

B. Complete DEA Form 106

A registrant must also complete a DEA Form 106 (Report of Theft or Loss of Controlled Substances) which can be found online at www.DEAdiversion.usdoj.gov under the Quick Links

section. The DEA Form 106 is used to document the actual circumstances of the theft or significant loss and the quantities of controlled substances involved. A paper version of the form may also be obtained by writing to the Drug Enforcement Administration. If completing the paper version, the registrant should send the original DEA Form 106 to the local DEA Diversion Field Office and keep a copy for its records.

PENALTIES

The CSA provides penalties for unlawful manufacturing, distribution, and dispensing of controlled substances. The penalties are basically determined by the schedule of the drug or other substance, and sometimes are specified by drug name, as in the case of marijuana. As the statute has been amended since its initial passage in 1970, the penalties have been altered by Congress. The following charts are an overview of the penalties for trafficking or unlawful distribution of controlled substances. This is not inclusive of the penalties provided under the CSA.

User Accountability/Personal Use Penalties

On November 19, 1988, Congress passed the Anti-Drug Abuse Act of 1988, P. L. 100-690. Two sections of this Act represent the U.S. Government's attempt to reduce drug abuse by dealing not just with the person who sells the illegal drug, but also with the person who buys it. The first new section is titled "User Accountability," and is codified at 21 U.S.C. § 862 and various sections of Title 42, U.S.C. The second involves "personal use amounts" of illegal drugs, and is codified at 21 U.S.C. § 844a.

User Accountability

The purpose of User Accountability is to not only make the public aware of the federal government's position on drug abuse, but to describe new programs intended to decrease drug abuse by holding drug users personally responsible for their illegal activities, and imposing civil penalties on those who violate drug laws.

It is important to remember that these penalties are in addition to the criminal penalties drug users are already given, and do not replace those criminal penalties.

The new User Accountability programs call for more instruction in schools, kindergarten through senior high, to educate children on the dangers of drug abuse. These programs will include participation by students, parents, teachers, local businesses and the local, state, and federal government.

User Accountability also targets businesses interested in doing business with the federal government. This program requires those businesses to maintain a drug-free workplace, principally through educating employees on the dangers of drug abuse, and by informing employees of the penalties they face if they engage in illegal drug activity on company property. There is also a provision in the law that makes public housing projects drug-free by evicting those residents who allow their units to be used for illegal drug activity, and denies federal benefits, such as housing assistance and student loans, to individuals convicted of illegal drug activity. Depending on the offense, an individual may be prohibited from ever receiving any benefit provided by the federal government.

Personal Use Amounts

This section of the 1988 Act allows the government to punish minor drug offenders without giving the offender a criminal record if the offender is in possession of only a small amount of drugs. This law is designed to impact the "user" of illicit drugs, while simultaneously saving the government the costs of a full-blown criminal investigation. Under this section, the government has the option of imposing only a civil fine on individuals possessing only a small quantity of an illegal drug. Possession of this small quantity, identified as a "personal use amount," carries a civil fine of up to $10,000.

In determining the amount of the fine in a particular case, the drug offender's income and assets will be considered. This is accomplished through an administrative proceeding rather than a criminal trial, thus reducing the exposure of the offender to the entire criminal justice system, and reducing the costs to the offender and the government.

The value of this section is that it allows the government to punish a minor drug offender, gives the drug offender the opportunity to fully redeem himself or herself, and have all public record of the proceeding destroyed. If this was the drug offender's first offense, and the offender has paid all fines, can pass a drug test, and has not been convicted of a crime after three years, the offender can request that all proceedings be dismissed.

If the proceeding is dismissed, the drug offender can lawfully say he or she had never been prosecuted, either criminally or civilly, for a drug offense.

The law has imposed two limitations on this section's use. It may not be used if (1) the drug offender has been previously convicted of a federal or state drug offense; or (2) the offender has already been fined twice under this section.

DRUG SCHEDULING

This document is a general reference and not a comprehensive list. This list describes the basic or parent chemical and does not describe the salts, isomers and salts of isomers, esters, ethers, and derivatives which may also be controlled substances. While some positional isomers have been identified here, they are shown as examples, and the chart does not include every potential positional isomer. Cannabimimetic agents as defined under the Food and Drug Administration Safety and Innovation Act were placed into Schedule I even though they are not included in this particular list. Please visit https://go.usa.gov/59 for the most recent updates to the list.

SCHEDULE I

SUBSTANCE	DEA NUMBER	NARCOTIC	OTHER NAMES
1-(1-Phenylcyclohexyl)pyrrolidine	7458	N	PCPy, PHP, rolicyclidine
1-(2-Phenylethyl)-4-phenyl-4-acetoxypiperidine	9663	Y	PEPAP, synthetic heroin
1-[1-(2-thienyl)cyclohexyl]piperidine	7470	N	tCP, tenocyclidine
1-[1-(2-thienyl)cyclohexyl]pyrrolidine	7473	N	tCPy
1-Methyl-4-phenyl-4-propionoxypiperidine	9661	Y	MPPP, synthetic heroin
2,5-dimethoxy-4-(n)-propylthiophenethylamine	7348	N	2C-t-7
2,5-dimethoxy-4-ethylamphetamine	7399	N	doEt
2,5-dimethoxyamphetamine	7396	N	dMA, 2,5-dMA
2C-C (2-(4-Chloro-2,5-dimethoxyphenyl) ethanamine	7519	N	2C-C, synthetic hallucinogen
2C-D (2-(2,5-Dimethoxy-4-methylphenyl) ethanamine	7508	N	2C-D, synthetic hallucinogen
2C-N (2-(2.5-Dimethoxy-4-nitro-phenyl) ethanamine	7521	N	2C-N
2C-E (2-(2,5-Dimethoxy-4-ethylphenyl) ethanamine	7509	N	2C-D, synthetic hallucinogen
2C-H (2-(2,5-Dimethoxyphenyl) ethanamine	7517	N	2C-H, synthetic hallucinogen
2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl) ethanamine (25B-NBOMe)	7536	N	25B-NBOMe, 2C-B-NBOMe, 25B, Cimbi-36
2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl) ethanamine (25C-NBOMe)	7537	N	25C-NBOMe, 2C-C-NBOMe, 25C, Cimbi-82
2C-I (2-(4-iodo-2,5-dimethoxyphenyl) ethanamine)	7518	N	2C-I, synthetic hallucinogen
2C-P (2-(2,5-Dimethoxy-4-(n)-propylphenyl) ethanamine)	7524	N	2C-P, synthetic hallucinogen
2C-T-2 (2-(4-Ethylthio-2,5-dimethoxyphenyl) ethanamine)	7385	N	2C-T-2, synthetic hallucinogen
2C-T-4 (2-(4-Isopropylthio)-2,5-dimethoxyphenyl) ethanamine)	7532	N	2C-T-4, synthetic hallucinogen
2-(4-iodo-2,5-dimethoxyphenyl-N-(2-methoxybenzyl) ethanamine (25I-NBOMe)	7538	N	25I-NBOMe, 2C-I-NBOMe, 25I, Cimbi-5
3,4,5-trimethoxyamphetamine	7390	N	tMA
3,4-Methylenedioxyamphetamine	7400	N	MdA, Love drug
3,4-Methylenedioxymethamphetamine	7405	N	MdMA, Ecstasy, XtC
3,4-Methylenedioxy-n-ethylamphetamine	7404	N	n-ethyl MdA, MdE, MdEA
3-Fluoro-N-methylcathinone (3-FMC)	1233	N	1-3-fluorophenyl-2-(methylamino)propan-1-one) (Positional isomer: 2-FMC)
3-Methylfentanyl	9813	Y	China White, fentanyl
3-Methylthiofentanyl	9833	Y	China White, fentanyl

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SUBSTANCE	DEA NUMBER	NARCOTIC	OTHER NAMES
4-Bromo-2,5-dimethoxyamphetamine	7391	N	doB, 4-bromo-dMA
4-Bromo-2,5-dimethoxyphenethylamine	7392	N	nexus, 2-CB, has been sold as Ecstasy, i.e. MdMA
4-Fluoro-N-methylcathinone (4-FMC)	1238	N	flephedrone; 1-(4-fluorophenyl)-2-(methylamino) propan-1-one) (Positional isomer: 2-FMC)
4-Methoxyamphetamine	7411	N	PMA
4-Methyl-2,5-dimethoxyamphetamine	7395	N	doM, StP
4-Methyl-alphapyrrolidinopropiophenone (4-MePPP)	7498	N	MePPP, 4-methl-a-pyrrolidinopropio-phenone, 1-(4-methylphenyl)-2-(pyrrolidin-1-yl)-propan-1-one)
4-Methylaminorex (cis isomer)	1590	N	U4Euh, Mcn-422
4-Methyl-N-ethylcathinone (4-MEC)	1249	N	2-(ethylamino)-1-(4-methylphenyl)propan-1-one) (Positional Isomers:3-methyle-thcathinone (3-MEC), 4-ethylmethcathinone (4-EMC), 4-meth-ylbuphedrone (4-MeMABP;4-MeBP), 3,4-dimethylmethcathinone(3,4-DMMC),N-ethylbuphedrone (NEB), N-ethyl-N-methylcathinone(EMC)
5-Methoxy-3,4-methylenedioxyamphetamine	7401	N	MMdA
5-Flouro-UR-144 and XLR11 [1-5-Fluoro-pentyl) 1H-indol-3-yl]	7011	N	5-Flouro-UR-144, XLR-11 and XLR11
(2,2,3,3-tetramethylcyclopropyl)methanone 5F-PB-22 (Quinolin-8-yl 1-(5-fluoropentyl)-1H-indol-3-carboxylate)	7225	N	5-Fluoro-PB-22; 5F-PB-22
5-Methoxy-n,n-diisopropyltryptamine	7439	N	5-Meo-diPt
5-Methoxy-N-N-dimethyltryptamine	7431	N	5-MeO-DMT (Positional Isomer: 4-Mthoxy -N, N-dimethyltryptamine (4-MeO-DMT)
AB-CHMINACA (N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide	7031	N	AB-CHMINACA
AB-FUBINACA (N-1-amino-3-methl-1-oxobutan-2-yl)-1-1-(4-fluorobenzy)-1H-indazole-3-carboxamide)	7012	N	AB-FUBINACA
AB-PINACA (N-(1-amino-3-methyl-1-oxobutan -2-yl)-1-pentyl-1H-indazole-3-carboxamide)	7023	N	AB-PINACA
Acetorphine	9319	Y	
Acetyl Fentanyl (N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide	9821	Y	
Acetyl-alpha-methylfentanyl	9815	Y	
Acetyldihydrocodeine	9051	Y	Acetylcodone
Acetylmethadol	9601	Y	Methadyl acetate
ADB-PINACA (N-(1-amino-3,3-dimethy-1-oxobutan-2-yl)-1-pentyl-1H-indazole-3-carboxamide)	7035	N	ADB-PINACA
AH-7921 (3,4-dichloro-N-[(1-dimethylamino)cy-clohexylmethy] benzamide	9551	Y	AH-7921
Alpha-Methylfentanyl	9814	Y	China White, fentanyl

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SUBSTANCE	DEA NUMBER	NARCOTIC	OTHER NAMES
Alpha-Methylthiofentanyl	9832	Y	China White, fentanyl
Alpha-methyltryptamine	7432	N	AMt
alpha-pyrrolidinobutiophenone (a-PBP)	7546	N	1-phenyl-2-(pyrrolidin-1-yl)butan-1-one)
alpha-pyrrolidinopentiophenone (aPVP)	7545	N	a-pyrrolidinovalerophenone, 1-phenyl-2-
AM-694 (1-(5-Fluoropentyl)-3-(2-iodobenzoyl) indole)	7694	N	(pyrrolidin-1-yl)pentan-1-one)(Positional isomers: 4-methyl-a-pyrrolidinobutiophenone (4-MePBP), 1-phenyl-2-(piperidin-1-yl)butan -1-one) AM-694, synthetic marijuana
AM-2201 (1-(5-Fluoropentyl)-3-(1-naphthoyl) indole)	7201	N	AM-2201, synthetic marijuana
Aminorex	1585	N	has been sold as methamphetamine
Benzethidine	9606	Y	
Benzylmorphine	9052	Y	
Betacetylmethadol	9607	Y	
Beta-hydroxy-3-methylfentanyl	9831	Y	China White, fentanyl
Beta-hydroxyfentanyl	9830	Y	China White, fentanyl
Beta-hydroxythiofentanyl	9836	Y	N-[1-[2-hydroxy-2-(thiophen-2-yl) ethyl]piperidin-4-yl]-N-phenylpropionamide, N-[1-[2-hydroxy-2-(2-thienyl)ethl]-4-piperidinyl]-N-phenylpropanamide
Betameprodine	9608	Y	
Betamethadol	9609	Y	
Betaprodine	9611	Y	
Bufotenine	7433	N	Mappine, n,n-dimethylserotonin
Butylone	7541	N	bk-MBDB; 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one) (Positional isomers: ethylone (bk-MDEA: MDEC), dimethylone (bk-MDDMA; MDDMC))
Butyryl Fentanyl	9822	Y	N-(1-phenethylpiperidin-4-yl)-N-phenylbutyramide, N-(1-phenethylpiperidin-4-yl)-N-phenylbutanamide
Cathinone	1235	N	Constituent of "Khat" plant
Clonitazene	9612	Y	
Codeine methylbromide	9070	Y	
Codeine-n-oxide	9053	Y	
CP-47497 (5-(1,1-Dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl-phenol)	7297	N	CP- 47497, synthetic marijuana
CP-47497 C8-homolog (5-(1,1-Dimethyloctyl)-2-[(1R,3S)3-hydroxycyclohexyl-phenol)	7298	N	CP-47497 C8-homolog, synthetic marijuana
Cyprenorphine	9054	Y	
desomorphine	9055	Y	
dextromoramide	9613	Y	Palfium, Jetrium, narcolo
diampromide	9615	Y	
diethylthiambutene	9616	Y	

SCHEDULE I

SUBSTANCE	DEA NUMBER	NARCOTIC	OTHER NAMES
Allylprodine	9602	Y	
Alphacetylmethadol except levo-alphacetylmethadol	9603	Y	
Alpha-Ethyltryptamine	7249	N	ET, trip
Alphameprodine	9604	Y	
Alphamethadol	9605	Y	
Alpha-Methylfentanyl	9814	Y	China White, fentanyl
Alpha-Methylthiofentanyl	9832	Y	China White, fentanyl
Alpha-methyltryptamine	7432	N	AMt
alpha-pyrrolidinobutiophenone (a-PBP)	7546	N	1-phenyl-2-(pyrrolidin-1-yl)butan-1-one)
alpha-pyrrolidinopentiophenone (aPVP)	7545	N	a-pyrrolidinovalerophenone, 1-phenyl-2-
AM-694 (1-(5-Fluoropentyl)-3-(2-iodobenzoyl) indole)	7694	N	(pyrrolidin-1-yl)pentan-1-one)(Positional isomers: 4-methyl-a-pyrrolidinobutiophenone (4-MePBP), 1-phenyl-2-(piperidin-1-yl)butan -1-one) AM-694, synthetic marijuana
AM-2201 (1-(5-Fluoropentyl)-3-(1-naphthoyl) indole)	7201	N	AM-2201, synthetic marijuana
Aminorex	1585	N	has been sold as methamphetamine
Benzethidine	9606	Y	
Benzylmorphine	9052	Y	
Betacetylmethadol	9607	Y	
Beta-hydroxy-3-methylfentanyl	9831	Y	China White, fentanyl
Beta-hydroxyfentanyl Beta-hydroxythiofentanyl	9830 9836	Y Y	China White, fentanyl N-[1-[2-hydroxy-2-(thiophen-2-yl) ethyl]piperidin-4-yl]-N-phenylpropionamide, N-[1-[2-hydroxy-2-(2-thienyl)ethl]-4-piperidinyl]-N-phenylpropanamide
Betameprodine	9608	Y	
Betamethadol	9609	Y	
Betaprodine	9611	Y	
Bufotenine Butylone	7433 7541	N N	Mappine, n,n-dimethylserotonin bk-MBDB; 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one) (Positional isomers: ethylone (bk-MDEA: MDEC), dimethylone (bk-MDDMA; MDDMC))
Butyryl Fentanyl Cathinone	9822 1235	Y N	N-(1-phenethylpiperidin-4-yl)-N-phenylbutyramide, N-(1-phenethylpiperidin-4-yl)-N-phenylbutanamide Constituent of "Khat" plant
Clonitazene	9612	Y	
Codeine methylbromide	9070	Y	
Codeine-n-oxide	9053	Y	
CP-47497 (5-(1,1-Dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl-phenol)	7297	N	CP- 47497, synthetic marijuana
CP-47497 C8-homolog (5-(1,1-Dimethyloctyl)-2-[(1R,3S)3-hydroxycyclohexyl-phenol)	7298	N	CP-47497 C8-homolog, synthetic marijuana

SCHEDULE I

SUBSTANCE	DEA NUMBER	NARCOTIC	OTHER NAMES
Cyprenorphine	9054	Y	
desomorphine	9055	Y	
dextromoramide	9613	Y	Palfium, Jetrium, narcolo
diampromide	9615	Y	
diethylthiambutene	9616	Y	
diethyltryptamine	7434	N	dEt
difenoxin	9168	Y	Lyspafen
dihydromorphine	9145	Y	
dimenoxadol	9617	Y	
dimepheptanol	9618	Y	
dimethylthiambutene	9619	Y	
dimethyltryptamine	7435	N	dMt
dioxaphetyl butyrate	9621	Y	
dipipanone	9622	Y	dipipan, phenylpiperone HCl, diconal, Wellconal
drotebanol	9335	Y	Metebanyl, oxymethebanol
Ethylmethylthiambutene	9623	Y	
Etonitazene	9624	Y	
Etorphine (except HCl)	9056	Y	
Etoxeridine	9625	Y	
Fenethylline	1503	N	Captagon, amfetyline, ethyltheophyl-line amphetamine
Furanyl fentanyl (N-(1-phenethylpiperidin-4-yl)-N-phenylfuran-2-carboxamide)	9834	Y	
Furethidine	9626	Y	
Gama Hydroxybutyric Acid	2010	N	GHB, gama hydroxybutyrate, sodium oxybate
Heroin	9200	Y	diacetylmorphine, diamorphine
Hydromorphinol	9301	Y	
Hydroxypethidine	9627	Y	
ibogaine	7260	N	Constituent of "tabernanthe iboga" plant
JWH-018 (known as AM-678) (1-Pentyl-3-(1-naph-thoyl) indole)	7118	N	JWH-018 and AM-678
JWH-073 (1-Butyl-3-(1-naphthoyl) indole)	7173	N	JWH-073
JWH-019 (1-Hexyl-3-(1-naphthoyl) indole	7019	N	JWH-019
JWH-200 (1-[2-(4-Morpholinyl)ethyl]-3-(1-naph-thoyl) indole)	7200	N	JWH-200
JWH-250 (1-Pentyl-3-(2-methoxyphenylacetyl) indole)	6250	N	JWH-250
JWH-081 (1-Pentyl-3-(1-(4-methoxynaphthoyl) indole)	7081	N	JWH-081
JWH-122 (1-Pentyl-3-(4-methyl-1-naphthoyl) indole)	7122	N	JWH-122
JWH-398 (1-Pentyl-3-(4-chloro-1-naphthoyl) indole)	7398	N	JWH-398
JWH-203 (1-Pentyl-3-(2-chlorophenylacetyl) indole)	7203	N	JWH-203
Ketobemidone	9628	Y	Cliradon

SCHEDULE I

SUBSTANCE	DEA NUMBER	NARCOTIC	OTHER NAMES
Levomoramide	9629	Y	
Levophenacylmorphan	9631	Y	
Lysergic acid diethylamide	7315	N	LSd, lysergide
MAB-CHMINACA (N-(1-amino-3,3dimethyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide)	7032	N N	MAB-CHMINACA and ADB-CHMINACA
Marijuana Marijuana Extract	7360 7350	N	Cannabis, marijuana
MDPV (3,4-Methylenedioxypyrovalerone)	7535	N	MDPV, bath salt
Mecloqualone	2572	N	nubarene
Mephedrone (4-Methyl-N-methylcathinone)	1248	N	Mephedrone, bath salt
Mescaline	7381	N	Constituent of "Peyote" cacti
Methaqualone	2565	N	Quaalude, Parest, Somnafac, opitimil, Mandrax
Methcathinone	1237	N	n-Methylcathinone, "cat"
Methyldesorphine	9302	Y	
Methyldihydromorphine	9304	Y	
Morpheridine	9632	Y	
Morphine methylbromide	9305	Y	
Morphine methylsulfonate	9306	Y	
Morphine-n-oxide	9307	Y	
Myrophine	9308	Y	
n,n-dimethylamphetamine	1480	N	
Naphyrone	1258	N	naphthylpyrovalerone; 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl)pentan-1-one) (Positional Isomer: a-naphyrone)
n-Benzylpiperazine	7493	N	BZP, 1-benzylpiperazine
n-Ethyl-1-phenylcyclohexylamine	7455	N	PCE
n-Ethyl-3-piperidyl benzilate	7482	N	JB 323
n-Ethylamphetamine	1475	N	nEA
n-Hydroxy-3,4-methylenedioxyamphetamine	7402	N	n-hydroxy MdA
nicocodeine	9309	Y	
nicomorphine	9312	Y	Vilan
n-Methyl-3-piperidyl benzilate	7484	N	JB 336
noracymethadol	9633	Y	
norlevorphanol	9634	Y	
normethadone	9635	Y	Phenyldimazone
normorphine	9313	Y	
norpipanone	9636	Y	
Para-Fluorofentanyl	9812	Y	China White, fentanyl

SCHEDULE I

SUBSTANCE	DEA NUMBER	NARCOTIC	OTHER NAMES
Parahexyl	7374	N	Synhexyl,
PB-22 (Quinolin-8-yl 1-pentyl-1H-dole-3-carboxylate)	7222	N	QUPIC: PB-22
Pentedrone (a-methylaminovalerophenone)	1246	N	2-(methylamino)-1-phenylpentan-1-one)(Positional Isomers:3-methylethcathinone (3-MEC), 4-ethylmethcathinone (4-EMC), 4-methylbuphedrone (4-MeMABP;4-MeBP), 3,4-dimethylmethcathinone (3,4-DMMC), N-ethylbuphedrone (NEB),N-ethyl-N-methylinone(EMC)
Pentylone	7542	N	bk-MBDP; 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one) (Positional Isomer:dibutyllone (bk-DMBDB)
Peyote	7415	N	Cactus which contains mescaline
Phenadoxone	9637	Y	
Phenampromide	9638	Y	
Phenomorphan	9647	Y	
Phenoperidine	9641	Y	operidine, Lealgin
Pholcodine	9314	Y	Copholco, Adaphol, Codisol, Lantuss, Pholcolin
Piritramide	9642	Y	Piridolan
Proheptazine	9643	Y	
Properidine	9644	Y	
Propiram	9649	Y	Algeril
Psilocybin	7438	N	Psilocin, constituent of "Magic mushrooms"
Racemoramide	9645	Y	
SR-18 (known as RCS-8)			
(1-Cyclohexylethyl-3-(2-methoxyphenylacetyl) indole)	7008	N	SR-18 & RCS-8, synthetic marijuana
SR-19 (known as RCS-4)(1-Pentyl-3-[(4-methoxy)-benzoyl] indole	7104	N	SR-19 & RCS-4, synthetic marijuana
Tetrahydrocannabinols	7370	N	tHC, delta-8 tHC, delta-9 tHC, dronabinol and others
Thebacon	9315	Y	Acetylhydrocodone, Acedicon, thebacetyl
Thiofentanyl	9835	Y	Chine white, fentanyl
THJ-2201 [1-(5-fluoropentyl)-1H-indazol-3-yl] (naphthhalen-1-yl)methanone	7024	N	THJ-2201
Tilidine	9750	Y	tilidate, Valoron, Kitadol, Lak, tilsa
Trimeperidine	9646	Y	Promedolum
U-47700 (3,4-dichloro-N-[2-dimethylamino) cyclohexyl]-N-methylbenzamide)	9547	Y	U-47700
UR-144 (1-Pentyl-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropy)methanone	7144	N	UR-144

SCHEDULE II

SUBSTANCE	DEA NUMBER	NARCOTIC	OTHER NAMES
1-Phenylcyclohexylamine	7460	N	Precusor of PCP
1-Piperidinocyclohexanecarbonitrile	8603	N	PCC, precusor of PCP
4-Anilino-N-phenethyl-4-piperidine (ANPP)	8333	N	ANPP
Alfentanil	9737	Y	Alfenta
Alphaprodine	9010	Y	Nisentil
Amobarbital	2125	N	Amytal, Tuinal
Amphetamine	1100	N	Dexedrine, Adderall, Obetrol
Anileridine	9020	Y	Leritine
Benzoylecgonine	9180	Y	Cocaine metabolite
Bezitramide	9800	Y	Burgodin
Carfentanil	9743	Y	Wildnil
Coca Leaves	9040	Y	
Cocaine	9041	N	Methyl benzoylecgonine, Crack
Codeine	9050	Y	Morphine methyl ester, methyl morphine
Dextropropoxyphene, bulk (non-dosage forms)	9273	Y	Propoxyphene
Dihydrocodeine	9120	Y	Didrate, Parzone
Dihydroetorphine	9334	Y	DHE
Diphenoxylate	9170	Y	
Diprenorphine	9058	Y	M50-50
Ecgonine	9180	Y	Cocaine precursor, in Coca leaves
Ethylmorphine	9190	Y	Dionin
Etorphine	9059	Y	M 99
Fentanyl	9801	Y	Duragesic, Oralet, Actiq, Sublimaze, Innovar
Glutethimide	2550	N	Doriden, Dorimide
Hydrocodone	9193	Y	dihydrocodeinone
Hydromorphone	9150	Y	Dilaudid, dihydromorphinone
Isomethadone	9226	Y	Isoamidone
Levo-alphacetylmethadol	9648	Y	LAAM, long acting methadone, levomethadyl acetate
Levomethorphan	9210	Y	
Levorphanol	9220	Y	Levo-Dromoran
Lisdexamfetamine	1205	N	Vyvans
Meperidine	9230	Y	Demerol, Mepergan, pethidine
Meperidine intermediate-A	9232	Y	Meperidine precursor
Meperidine intermediate-B	9233	Y	Meperidine precursor, normeperidine
Meperidine intermediate-C	9234	Y	Meperidine precursor
Metazocine	9240	Y	
Methadone	9250	Y	Dolophine, Methadose, Amidone
Methadone intermediate	9254	Y	Methadone precursor
Methamphetamine	1105	N	Desoxyn, D-desoxyephedrine, ICE, Crank, Speed
Methylphenidate	1724	N	Concerta, Ritalin, Methylin
Metopon	9260	Y	

SCHEDULE II

SUBSTANCE	DEA NUMBER	NARCOTIC	OTHER NAMES
Moramide-intermediate	9802	Y	
Morphine	9300	Y	MS Contin, Roxanol, Oramorph, RMS, MSIR
Nabilone	7379	N	Cesamet
Opium extracts	9610	Y	
Opium fluid extract	9620	Y	
Opium poppy	9650	Y	Papaver somniferum
Opium tincture	9630	Y	Laudanum
Opium, granulated	9640	Y	Granulated opium
Opium, powdered	9639	Y	Powdered Opium
Opium, raw	9600	Y	Raw opium, gum opium
Oripavine	9330	Y	
Oxycodone	9143	Y	OxyContin, Percocet, Endocet, Roxicodone, Roxicet
Oxymorphone	9652	Y	Numorphan
Pentobarbital	2270	N	Nembutal
Phenazocine	9715	Y	Narphen, Prinadol
Phencyclidine	7471	N	PCP, Sernylan
Phenmetrazine	1631	N	Preludin
Phenylacetone	8501	N	P2P, phenyl-2-propanone, benzyl methyl ketone
Piminodine	9730	Y	
Poppy Straw	9650	Y	Opium poppy capsules, poppy heads
Poppy Straw Concentrate	9670	Y	Concentrate of Poppy Straw, CPS
Racemethorphan	9732	Y	
Racemorphan	9733	Y	Dromoran
Remifentanil	9739	Y	Ultiva
Secobarbital	2315	N	Seconal, Tuinal
Sufentanil	9740	Y	Sufenta
Tapentadol	9780	Y	
Thebaine	9333	Y	Precursor of many narcotics
Thiafentanil	9729	Y	Thianil

SCHEDULE III

SUBSTANCE	DEA NUMBER	NARCOTIC	OTHER NAMES
13Beta-ethyl-17beta-hydroxygon-4-en-3-one	4000	N	
17Alpha-methyl-3alpha,17beta-dihydroxy-5alphaandrostane	4000	N	
17Alpha-methyl-3beta,17beta-dihydroxy-5alphaandrostane	4000	N	
17Alpha-methyl-3beta,17beta-dihydroxyandrost-4-ene	4000	N	
17Alpha-methyl-4-hydroxynandrolone (17alpha-methyl-4-hydroxy-17beta-hydroxyestr-4-en-3-one)	4000	N	
17Alpha-methyl-delta1-dihydrotestosterone (17beta-hydroxy-17alpha-methyl-5alpha-androst-1-en-3-one)	4000	N	17-Alpha-methyl-1-testosterone
19-Nor-4,9(10)-androstadienedione	4000	N	
19-Nor-4-androstenedione (estr-4-en-3,17-dione) 4000 III N	4000	N	
19-Nor-5-androstenediol (3beta,17beta-dihydroxyestr-5-ene; 3alpha,17beta-dihydroxyestr-5-ene)	4000	N	
19-Nor-5-androstenedione (estr-5-en-3,17-dione)	4000	N	
1-Androstenediol (3beta,17beta-dihydroxy-5alphaandrost-1-ene; 3alpha,17beta-dihydroxy-5alphaandrost-1-ene)	4000	N	
1-Androstenedione (5alpha-androst-1-en-3,17-dione)	4000	N	
3Alpha,17beta-dihydroxy-5alpha-androstane	4000	N	
3Beta,17beta-dihydroxy-5alpha-androstane	4000	N	
4-Androstenediol (3beta,17beta-dihydroxy-androst-4-ene)	4000	N	4-AD
4-Androstenedione (androst-4-en-3,17-dione)	4000	N	
4-Dihydrotestosterone (17beta-hydroxyandrostan-3-one)	4000	N	Anabolex, Andractim, Pesomax, Stanolone
4-Hydroxy-19-nortestosterone (4,17beta-dihydroxyestr-4-en-3-one)	4000	N	
4-Hydroxytestosterone (4,17beta-dihydroxyandrost-4-en-3-one)	4000	N	
5-Androstenediol (3beta,17beta-dihydroxy-androst-5-ene)	4000	N	
5-Androstenedione (androst-5-en-3,17-dione)	4000	N	
Amobarbital & noncontrolled active ingred.	2126	N	
Amobarbital suppository dosage form	2126	N	
Anabolic steroids	4000	N	Body Building drugs
Androstanedione (5alpha-androstan-3,17-dione)	4000	N	
Aprobarbital	2100	N	Alurate
Barbituric acid derivative	2100	N	Barbiturates not specifically listed
Benzphetamine	1228	N	Didrex, Inapetyl
Bolasterone (7alpha,17alpha-dimethyl-17beta-hydroxyandrost-4-en-3-one)	4000	N	
Boldenone (17beta-hydroxyandrost-1,4-diene-3-one)	4000	N	Equipoise, Parenabol, Vebonol, dehydrotestosterone
Boldione	4000	N	
Buprenorphine	9064	Y	Buprenex, Temgesic, Subutex, Suboxone
Butabarbital (secbutabarbital)	2100	N	Butisol, Butibel
Butalbital	2100	N	Fiorinal, Butalbital with aspirin
Butobarbital (butethal)	2100	N	Soneryl (UK)

SCHEDULE III

SUBSTANCE	DEA NUMBER	NARCOTIC	OTHER NAMES
Calusterone (7beta,17alpha-dimethyl-17betahydroxyandrost-4-en-3-one)	4000	N	Methosarb
Chlorhexadol	2510	N	Mechloral, Mecoral, Medodorm, Chloralodol
Chlorphentermine	1645	N	Pre-Sate, Lucofen, Apsedon, Desopimon
Clortermine	1647	N	Voranil
Clostebol (4-chloro-17beta-hydroxyandrost-4-en-3-one)	4000	N	Alfa-Trofodermin, Clostene, 4-chlorotestosterone
Codeine & isoquinoline alkaloid 90 mg/du	9803	Y	Codeine with papaverine or noscapine
Codeine combination product 90 mg/du	9804	Y	Empirin,Fiorinal,Tylenol,ASA or APAP w/codeine
Dehydrochloromethyltestosterone (4-chloro-17betahydroxy-17alpha-methylandrost-1,4-dien-3-one)	4000	N	Oral-Turinabol
Delta1-dihydrotestosterone (17beta-hydroxy-5alphaandrost-1-en-3-one)	4000	N	1-Testosterone
Desoxymethyltestosterone	4000	N	
Dihydrocodeine combination product 90 mg/du	9807	Y	Synalgos-DC, Compal
Dronabinol (synthetic) in sesame oil in soft gelatin capsule as approved by FDA	7369	N	Marinol, synthetic THC in sesame oil/soft gelatin as approved by FDA
Drostanolone (17beta-hydroxy-2alpha-methyl-5alphaandrostan-3-one)	4000	N	Drolban, Masterid, Permastril
Embutramide	2020	N	Tributane
Ethylestrenol (17alpha-ethyl-17beta-hydroxyestr-4-ene)	4000	N	Maxibolin, Orabolin, Durabolin-O, Duraboral
Ethylmorphine combination product 15 mg/du	9808	Y	
Fluoxymesterone (9-fluoro-17alpha-methyl-11beta, 17beta-dihydroxyandrost-4-en-3-one)	4000	N	Anadroid-F, Halotestin, Ora-Testryl
Formebolone (2-formyl-17alpha-methyl-11alpha, 17beta-dihydroxyandrost-1,4-dien-3-one)	4000	N	Esiclene, Hubernol
Furazabol (17alpha-methyl-17betahydroxyandrostano[2,3-c]-furazan)	4000	N	Frazalon, Miotolon, Qu Zhi Shu
Gamma Hydroxybutyric Acid preparations	2012	N	Xyrem
Hydrocodone & isoquinoline alkaloid <15 mg/du	9805	Y	Dihydrocodeinone+papaverine or noscapine
Hydrocodone combination product <15 mg/du	9806	Y	Lorcet, Lortab,Vicodin, Vicoprofen,Tussionex, Norco
Ketamine	7285	N	Ketaset, Ketalar, Special K, K
Lysergic acid	7300	N	LSD precursor
Lysergic acid amide	7310	N	LSD precursor
Mestanolone (17alpha-methyl-17beta-hydroxy-5alphaandrostan-3-one)	4000	N	Assimil, Ermalone, Methybol, Tantarone
Mesterolone (1alpha-methyl-17beta-hydroxy-5alphaandrostan-3-one)	4000	N	Androviron, Proviron, Testiwop
Methandienone (17alpha-methyl-17betahydroxyandrost-1, 4-diene-3-one)	4000	N	Dianabol, Metabolina, Nerobol, Perbolin
Methandriol (17alpha-methyl-3beta, 17betadihydroxyandrost-5-ene)	4000	N	Sinesex, Stenediol, Troformone
Methasterone (2alpha,17alpha-dimethyl-5alpha-androstan-17beta-ol-3-one)	4000	N	Methasterone

SCHEDULE III

SUBSTANCE	DEA NUMBER	NARCOTIC	OTHER NAMES
Methenolone (1-methyl-17beta-hydroxy-5alpha-androst-1-en-3-one)	4000	N	Primobolan, Primobolan Depot, Primobolan S
Methyldienolone (17alpha-methyl-17beta-hydroxyestr-4,9(10)-dien-3-one)	4000	N	
Methyltestosterone (17alpha-methyl-17betahydroxyandrost-4-en-3-one)	4000	N	Android, Oreton, Testred, Virilon
Methyltrienolone (17alpha-methyl-17beta-hydroxyestr-4,9,11-trien-3-one)	4000	N	Metribolone
Methyprylon	2575	N	Noludar
Mibolerone (7alpha,17alpha-dimethyl-17betahydroxyestr-4-en-3-one)	4000	N	Cheque, Matenon
Morphine combination product/50 mg/100 ml or gm	9810	Y	
Nalorphine	9400	Y	Nalline
Nandrolone (17beta-hydroxyestr-4-en-3-one)	4000	N	Deca-Durabolin, Durabolin, Durabolin-50
Norbolethone (13beta,17alpha-diethyl-17betahydroxygon-4-en-3-one)	4000	N	Genabol
Norclostebol (4-chloro-17beta-hydroxyestr-4-en-3-one)	4000	N	Anabol-4-19, Lentabol
Norethandrolone (17alpha-ethyl-17beta-hydroxyestr-4-en-3-one)	4000	N	Nilevar, Pronabol, Solevar
Normethandrolone (17alpha-methyl-17betahydroxyestr-4-en-3-one)	4000	N	Lutenin, Matronal, Orgasteron
Opium combination product 25 mg/du	9809	Y	Paregoric, other combination products
Oxandrolone (17alpha-methyl-17beta-hydroxy-2-oxa-5alpha-androstan-3-one)	4000	N	Anavar, Lonavar, Oxandrin, Provitar, Vasorome
Oxymesterone (17alpha-methyl-4, 17betadihydroxyandrost-4-en-3-one)	4000	N	Anamidol, Balnimax, Oranabol, Oranabol 10
Oxymetholone (17alpha-methyl-2-hydroxymethylene-17beta-hydroxy-5alpha-androstan-3-one)	4000	N	Anadrol-50, Adroyd, Anapolon, Anasteron, Pardroyd
Pentobarbital & noncontrolled active ingred.	2271	N	FP-3
Pentobarbital suppository dosage form	2271	N	WANS
Perampanel	2261	N	Fycompa, [2-2oxo-l-phenyl-5-pyridin-2-yl-l, 2-dihydropyridin-3-yl) benzonitrile]
Phendimetrazine	1615	N	Plegine, Prelu-2, Bontril, Melfiat, Statobex
Prostanozol (17beta-hydroxy-5alpha-androstano[3,2-c]pyrazole)	4000	N	Prostanozol
Secobarbital & noncontrolled active ingred	2316	N	
Secobarbital suppository dosage form	2316	N	
Stanozolol (17alpha-methyl-17beta-hydroxy-5alpha-androst-2-eno[3,2-c]-pyrazole)	4000	N	Winstrol, Winstrol-V
Stanozolol (17alpha-methyl-17beta-hydroxy-5alphaandrost-2-eno[3,2-c]-pyrazole)	4000	N	N Winstrol, Winstrol-V
Stenbolone (17beta-hydroxy-2-methyl-5alpha-androst-1-en-3-one)	4000	N	
Stimulant compounds previously excepted	1405	N	Mediatric
Sulfondiethylmethane	2600	N	
Sulfonethylmethane	2605	N	
Sulfonmethane	2610	N	

SCHEDULE III

SUBSTANCE	DEA NUMBER	NARCOTIC	OTHER NAMES
Talbutal	2100	N	Lotusate
Testolactone (13-hydroxy-3-oxo-13,17-secoandrosta-1, 4-dien-17-oic acid lactone)	4000	N	Teolit, Teslac
Testosterone (17beta-hydroxyandrost-4-en-3-one)	4000	N	Android-T, Androlan, Depotest, Delatestryl
Tetrahydrogestrinone (13beta,17alpha-diethyl-17betahydroxygon-4,9,11-trien-3-one)	4000	N	THG
Thiamylal	2100	N	Surital
Thiopental	2100	N	Pentothal
Tiletamine & Zolazepam Combination Product	7295		Telazol
Trenbolone (17beta-hydroxyestr-4,9,11-trien-3-one)	4000	N	Finaplix-S, Finajet, Parabolan
Vinbarbital	2100	N	Delvinal, vinbarbitone

SCHEDULE IV

SUBSTANCE	DEA NUMBER	NARCOTIC	OTHER NAMES
Alfaxalone	2731	N	Alfaxan, 5a-pregnan-3a-ol-11,20-dione
Alprazolam	2882	N	Xanax
Barbital	2145	N	Veronal, Plexonal, barbitone
Bromazepam	2748	N	Lexotan, Lexatin, Lexotanil
Butorphanol	9720	N	Stadol, Stadol NS, Torbugesic, Torbutrol
Camazepam	2749	N	Albego, Limpidon, Paxor
Carisoprodol	8192	N	Soma
Cathine	1230	N	Constituent of "Khat" plant, (+)-norpseudoephedrine
Chloral betaine	2460	N	Beta Chlor
Chloral hydrate	2465	N	Noctec
Chlordiazepoxide	2744	N	Librium, Libritabs, Limbitrol, SK-Lygen
Clobazam	2751	N	Urbadan, Urbanyl
Clonazepam	2737	N	Klonopin, Clonopin
Clorazepate	2768	N	Tranxene
Clotiazepam	2752	N	Trecalmo, Rize, Clozan, Veratran
Cloxazolam	2753	N	Akton, Lubalix, Olcadil, Sepazon
Delorazepam	2754	N	
Dexfenfluramine	1670	N	Redux
Dextropropoxyphene dosage forms	9278	Y	Darvon, propoxyphene, Darvocet, Propacet
Diazepam	2765	N	Valium, Diastat
Dichloralphenazone	2467	N	Midrin, dichloralantipyrine
Diethylpropion	1610	N	Tenuate, Tepanil
Difenoxin 1 mg/25 ug AtSO4/du	9167	Y	Motofen
Eluxadoline	9725	N	VIBERZI

SCHEDULE IV

SUBSTANCE	DEA NUMBER	NARCOTIC	OTHER NAMES
Estazolam	2756	N	ProSom, Domnamid, Eurodin, Nuctalon
Ethchlorvynol	2540	N	Placidyl
Ethinamate	2545	N	Valmid, Valamin
Ethyl loflazepate	2758	N	
Fencamfamin	1760	N	Reactivan
Fenfluramine	1670	N	Pondimin, Ponderal
Fenproporex	1575	N	Gacilin, Solvolip
Fludiazepam	2759	N	
Flunitrazepam	2763	N	Rohypnol, Narcozep, Darkene, Roipnol
Flurazepam	2767	N	Dalmane
Fospropofol	2138	N	Lusedra
Halazepam	2762	N	Paxipam
Haloxazolam	2771	N	
Ketazolam	2772	N	Anxon, Loftran, Solatran, Contamex
Loprazolam	2773	N	
Lorazepam	2885	N	Ativan
Lorcaserin	1625	N	Belviq
Lormetazepam	2774	N	Noctamid
Mazindol	1605	N	Sanorex, Mazanor
Mebutamate	2800	N	Capla
Medazepam	2836	N	Nobrium
Mefenorex	1580	N	Anorexic, Amexate, Doracil, Pondinil
Meprobamate	2820	N	Miltown, Equanil, Deprol, Equagesic, Meprospan
Methohexital	2264	N	Brevital
Methylphenobarbital (mephobarbital)	2250	N	Mebaral, mephobarbital
Midazolam	2884	N	Versed
Modafinil	1680	N	Provigil
Nimetazepam	2837	N	Erimin
Nitrazepam	2834	N	Mogadon
Nordiazepam	2838	N	Nordazepam, Demadar, Madar
Oxazepam	2835	N	Serax, Serenid-D
Oxazolam	2839	N	Serenal, Convertal
Paraldehyde	2585	N	Paral
Pemoline	1530	N	Cylert
Pentazocine	9709	N	Talwin, Talwin NX, Talacen, Talwin Compound
Petrichloral	2591	N	Pentaerythritol chloral, Periclor
Phenobarbital	2285	N	Luminal, Donnatal, Bellergal-S
Phentermine	1640	N	Ionamin, Fastin, Adipex-P, Obe-Nix, Zantryl
Pinazepam	2883	N	Domar

SCHEDULE IV

SUBSTANCE	DEA NUMBER	NARCOTIC	OTHER NAMES
Pipradrol	1750	N	Detaril, Stimolag Fortis
Prazepam	2764	N	Centrax
Quazepam	2881	N	Doral
Sibutramine	1675	N	Meridia
SPA	1635	N	1-dimethylamino-1,2-diphenylethane, Lefetamine
Suvorexant	2223	N	MK-4305, [(7R)-4-(5-chloro-1,3-benzoxazol-2-yl)-7-methyl-1,4-diazepan-1-yl][5-methyl-2-(2H-1,2,3-triazol-2-yl)phenyl]methanone
Temazepam	2925	N	Restoril
Tetrazepam	2886	N	Myolastan, Musaril
Tramadol (2-[dimethylamino)methyl]-1-(3-methoxy-phenyl)cyclohexanol)	9752		Tramadol
Triazolam	2887	N	Halcion
Zaleplon	2781	N	Sonata
Zolpidem	2783	N	Ambien, Ivadal, Stilnoct, Stilnox
Zopiclone	2784	N	Lunesta

SCHEDULE V

SUBSTANCE	DEA NUMBER	NARCOTIC	OTHER NAMES
Brivaracetam	2710	N	BRV, UCB-34714, Briviact, ((2S)-2-[4R)-2-oxo-4-propyl-pyrrolidin-1-yl] butanamide)
Codeine preparations - 200 mg/100 ml or 100 gm		Y	Cosanyl,Robitussin AC, Cheracol, Cerose, Pediacof
Difenoxin preparations - 0.5 mg/25 ug AtSO4/du		Y	Motofen
Dihydrocodeine preparations 10 mg/100 ml or 100 gm		Y	Cophene-S, various others
Diphenoxylate preparations 2.5 mg/25 ug AtSO4		Y	Lomotil, Logen
Ethylmorphine preparations 100 mg/100 ml or 100 gm		Y	
Ezogabine	2779	N	Potiga
Lacosamide	2746	N	Vimpat
Opium preparations - 100 mg/100 ml or gm		Y	Parepectolin, Kapectolin PG, Kaolin Pectin P.G.
Pregabalin	2782	N	Lyrica
Pyrovalerone	1485	N	Centroton, Thymergix

FEDERAL TRAFFICKING PENALTIES

DRUG/SCHEDULE	QUANTITY	PENALTIES	QUANTITY	PENALTIES
Cocaine (Schedule II)	500–4999 grams mixture	**First Offense:** Not less than 5 yrs, and not more than 40 yrs. If death or serious injury, not less than 20 or more than life. Fine of not more than $5 million if an individual, $25 million if not an individual. **Second Offense:** Not less than 10 yrs, and not more than life. If death or serious injury, life imprisonment. Fine of not more than $8 million if an individual, $50 million if not an individual.	5 kgs or more mixture	**First Offense:** Not less than 10 yrs, and not more than life. If death or serious injury, not less than 20 or more than life. Fine of not more than $10 million if an individual, $50 million if not an individual. **Second Offense:** Not less than 20 yrs, and not more than life. If death or serious injury, life imprisonment. Fine of not more than $20 million if an individual, $75 million if not an individual. **2 or More Prior Offenses:** Life imprisonment. Fine of not more than $20 million if an individual, $75 million if not an individual.
Cocaine Base (Schedule II)	28–279 grams mixture		280 grams or more mixture	
Fentanyl (Schedule II)	40–399 grams mixture		400 grams or more mixture	
Fentanyl Analogue (Schedule I)	10–99 grams mixture		100 grams or more mixture	
Heroin (Schedule I)	100–999 grams mixture		1 kg or more mixture	
LSD (Schedule I)	1–9 grams mixture		10 grams or more mixture	
Methamphetamine (Schedule II)	5–49 grams pure or 50–499 grams mixture		50 grams or more pure or 500 grams or more mixture	
PCP (Schedule II)	10–99 grams pure or 100–999 grams mixture		100 gm or more pure or 1 kg or more mixture	

		PENALTIES
Other Schedule I & II drugs (and any drug product containing Gamma Hydroxybutyric Acid) Flunitrazepam (Schedule IV)	Any amount 1 gram	**First Offense:** Not more than 20 yrs. If death or serious injury, not less than 20 yrs, or more than life. Fine $1 million if an individual, $5 million if not an individual. **Second Offense:** Not more than 30 yrs. If death or serious bodily injury, life imprisonment. Fine $2 million if an individual, $10 million if not an individual.
Other Schedule III drugs	Any amount	**First Offense:** Not more than 10 years. If death or serious injury, not more that 15 yrs. Fine not more than $500,000 if an individual, $2.5 million if not an individual. **Second Offense:** Not more than 20 yrs. If death or serious injury, not more than 30 yrs. Fine not more than $1 million if an individual, $5 million if not an individual.
All other Schedule IV drugs Flunitrazepam (Schedule IV)	Any amount Other than 1 gram or more	**First Offense:** Not more than 5 yrs. Fine not more than $250,000 if an individual, $1 million if not an individual. **Second Offense:** Not more than 10 yrs. Fine not more than $500,000 if an individual, $2 million if other than an individual.
All Schedule V drugs	Any amount	**First Offense:** Not more than 1 yr. Fine not more than $100,000 if an individual, $250,000 if not an individual. **Second Offense:** Not more than 4 yrs. Fine not more than $200,000 if an individual, $500,000 if not an individual.

FEDERAL TRAFFICKING PENALTIES—MARIJUANA

DRUG	QUANTITY	1st OFFENSE	2nd OFFENSE *
Marijuana (Schedule I)	1,000 kg or more marijuana mixture; or 1,000 or more marijuana plants	Not less than 10 yrs. or more than life. If death or serious bodily injury, not less than 20 yrs., or more than life. Fine not more than $10 million if an individual, $50 million if other than an individual.	Not less than 20 yrs. or more than life. If death or serious bodily injury, life imprisonment. Fine not more than $20 million if an individual, $75 million if other than an individual.
Marijuana (Schedule I)	100 kg to 999 kg marijuana mixture; or 100 to 999 marijuana plants	Not less than 5 yrs. or more than 40 yrs. If death or serious bodily injury, not less than 20 yrs. or more than life. Fine not more than $5 million if an individual, $25 million if other than an individual.	Not less than 10 yrs. or more than life. If death or serious bodily injury, life imprisonment. Fine not more than $20 million if an individual, $75million if other than an individual.
Marijuana (Schedule I)	More than 10 kgs hashish; 50 to 99 kg marijuana mixture More than 1 kg of hashish oil; 50 to 99 marijuana plants	Not more than 20 yrs. If death or serious bodily injury, not less than 20 yrs. or more than life. Fine $1 million if an individual, $5 million if other than an individual.	Not more than 30 yrs. If death or serious bodily injury, life imprisonment. Fine $2 million if an individual, $10 million if other than an individual.
Marijuana (Schedule I)	Less than 50 kilograms marijuana (but does not include 50 or more marijuana plants regard-less of weight) 1 to 49 marijuana plants;	Not more than 5 yrs. Fine not more than $250,000, $1 million if other than an individual.	Not more than 10 yrs. Fine $500,000 if an individual, $2 million if other than individual.
Hashish (Schedule I)	10 kg or less		
Hashish Oil (Schedule I)	1 kg or less		

*The minimum sentence for a violation after two or more prior convictions for a felony drug offense have become final is a mandatory term of life imprisonment without release and a fine up to $20 million if an individual and $75 million if other than an individual.

II. U.S. Chemical Control

The Drug Enforcement Administration (DEA) employs a multi-faceted approach to combat drug trafficking which includes enforcement, interdiction, and education. A lesser known approach which combines elements from all three of these facets is chemical control. Large quantities of chemicals are required to synthesize, extract, and purify most illicit drugs. The DEA has long recognized the need to monitor these chemicals as part of its overall drug control strategy.

During the 1980s there was a tremendous increase in the clandestine production of controlled substances, particularly methamphetamine. There was also a proliferation of clandestine laboratories producing controlled substance analogues, very potent and dangerous variations of controlled narcotics, stimulants, and hallucinogens. Furthermore, DEA learned that U.S. firms were exporting large quantities of chemicals, such as acetone, methylethylketone, and potassium permanganate to cocaine producing countries. Significant amounts of these chemicals ultimately were diverted to clandestine cocaine laboratories. It became clear that mandatory controls were needed to control the distribution of these chemicals in order to have an impact on the clandestine laboratory problem.

DEA embarked upon a broad chemical control program in 1989 that began with the Chemical Diversion and Trafficking Act (CDTA) of 1988. The CDTA regulated 12 precursor chemicals, eight essential chemicals, tableting machines, and encapsulating machines by imposing recordkeeping and import/export reporting requirements on transactions involving these products. It resulted in effectively reducing the supply of illicit methamphetamine. The number of clandestine laboratories seized in the first three years following the law's implementation reversed the trend of the previous three decades and resulted in a decline. Currently, DEA monitors 41 chemicals which are commonly used in illicit drug production.

Maintaining this success requires continuous effort to thwart traffickers' never-ending search for new methods of diversion and new precursor materials.

The foundation of the government's program to prevent chemical diversion is based on additional laws such as the Domestic Chemical Diversion Control Act of 1993 (DCDCA), the Comprehensive Methamphetamine Control Act of 1996 (MCA), the Methamphetamine Anti-Proliferation Act of 2000 (MAPA), and the Combat Methamphetamine Epidemic Act of 2005 (CMEA). This is illustrated by changes in the patterns of diversion:

- When the quantity of U.S. chemicals shipped to cocaine manufacturing areas declined, chemical suppliers from other parts of the world emerged as new sources of supply. The U.S. government then undertook an aggressive international campaign to educate and elicit the support of other nations in establishing chemical controls. Today, there is a broad level of international agreement regarding the actions that must be taken to achieve chemical control. Many nations have passed laws to prevent the diversion of chemicals.
- As a result of government controls, ephedrine and other chemicals used to manufacture methamphetamine became more difficult to divert. Traffickers then began using over-the-counter capsules and tablets that contained these ingredients. As chemicals rendered into legitimate medicines purportedly for the commercial market, these products were exempted from the CDTA requirements. The DCDCA closed this loophole and required DEA registration for all manufacturers, distributors, importers, and exporters of List I chemicals. It also established recordkeeping and reporting requirements for transactions in single-entity ephedrine products.
- When single-entity ephedrine products became regulated, drug traffickers turned to pseudoephedrine. This was addressed by the MCA which expanded regulatory control of lawfully marketed drug products containing ephedrine,

pseudoephedrine, and phenylpropanolamine (PPA)[1].

- MAPA focused on the continuing retail level diversion by constricting retail transactions of pseudoephedrine and PPA drug products. It reduced the threshold for such transactions from 24 grams to nine grams of pseudoephedrine or PPA base in a single transaction and limited package sizes to contain no more than three grams of pseudoephedrine or PPA base. The Act also increased penalties for chemical diversion and provided for restitution to the government for cleanup costs.
- The CMEA further restricted retail level transactions by redefining nonprescription products that contain ephedrine, pseudoephedrine, and PPA as "scheduled listed chemical products (SLCPs)." The Act requires all regulated sellers of SLCPs to complete a required training and self-certification process effective September 30, 2006. On this date, stores were required to keep all SLCPs behind the counter or in a locked cabinet. Consumers wishing to purchase SLCPs are required to show identification and sign a logbook for each purchase. The Act also implements daily sales limits of 3.6 grams per purchaser and purchase limits of nine grams of these products in a 30 day period to any person.

All of these federal laws (CDTA, DCDCA, MCA, MAPA, and CMEA) imposed varying degrees of reporting requirements on the chemical and pharmaceutical industries. Yet the involvement of private industry and the public should not be limited to the laws passed by Congress. The voluntary support by industry constitutes a powerful resource for protecting the health and safety of the nation. DEA encourages each firm to be vigilant and to become a partner in combating the diversion of chemicals used in illegal drug production.

It is DEA's goal to effectively regulate while maintaining a positive working relationship with the regulated community and to educate the regulated community on the various laws regarding precursor chemicals and their implementing regulations. DEA understands that it can best serve the public interest by working in voluntary cooperation with the chemical industry in developing programs designed to prevent the diversion of regulated chemicals into the illicit market.

1 Due to concerns regarding harmful side effects that phenylpropanolamine (PPA) can have, on November 6, 2000, the Food and Drug Administration invoked a voluntary withdrawal of over-the counter PPA products intended for human consumption.

Listed Chemicals regulated under the Controlled Substances Act

See 21, C.F.R. §§ 1309, 1310, and 1314 for details

March 2017

LIST I

	CONTROLLED SUBSTANCE PRODUCED																	
	Amphetamine	Cocaine	N, N-Dimethylamphetamine	Ethylamphetamine	Fentanyl & Analogues	GHB	Heroin	LSD	MDA	MDE	MDMA	Methamphetamine	Methaqulone	Methcathinone	4-Methylaminorex	Phencyclidine (PCP)	Phenyl-2-Propanone	THRESHOLDS
1. N-Acetylanthranilic Acid [2]												▲					40	40
2. Anthranilic Acid [2]												▲					30	30
3. Benzaldehyde	▲															▲	4	4
4. Benzyl Cyanide																▲	1	1
5. Ephedrine [3&7]											▲		▲				0	0
6. Ergonovine [1]							▲										0.010	0.010
7. Ergotamine [1]							▲										0.020	0.020
8. Ethylamine [1]				▲					▲								1	1
9. Gamma-Butyrolactone (GBL)						▲											0	0
10. Hydriodic Acid											■						1.7	1.7
11. Hypophosphorous Acid [1]	■										■						0	0
12. Iodine	■										■						0	0
13. Isosafrole								▲	▲	▲							4	4
14. Methylamine [1]										▲	▲						1	1
15. 3, 4-Methylenedioxyphenyl-2-Propanone								▲	▲	▲							4	4
16. N-Methylephedrine [3]			▲														1	1
17. N-Methylpseudoephedrine [3]			▲														1	1
18. N-phenethyl-4-Piperidone (NPP)					▲												0	0
19. Nitroethane	▲							▲								▲	2.5	2.5
20. Norpseudoephedrine [3]	▲													▲			2.5	2.5
21. Phenylacetic Acid [2]																▲	1	1
22. Phenylpropanolamine [3&7]	▲													▲			2.5	2.5
23. Phosphorus (red)	■										■						0	0
24. Phosphorus (white or yellow)	■										■						0	0
25. Piperidine [1]															▲		0.500	0.500
26. Piperonal (heliotropin)								▲	▲	▲							4	4
27. Propionic Anhydride					▲												0.001	0.001
28. Pseudoephedrine [3&7]											▲		▲				1	1
29. Safrole								▲	▲	▲							4	4
																	DOMESTIC	IMPORTS & EXPORTS
																	KILOGRAMS	

■ Reagent ▲ Precursor

Listed Chemicals regulated under the Controlled Substances Act

See 21, C.F.R. §§ 1309, 1310, and 1314 for details

March 2017

CONTROLLED SUBSTANCE PRODUCED

LIST II

	Amphetamine	Cocaine	N, N-Dimethylamphetamine	Ethylamphetamine	Fentanyl & Analogues	GHB	Heroin	LSD	MDA	MDE	MDMA	Methamphetamine	Methaqulone	Methcathinone	4-Methylaminorex	Phencyclidine (PCP)	Phenyl-2-Propanone	THRESHOLDS DOMESTIC	THRESHOLDS IMPORTS & EXPORTS
																		KILOGRAMS	KILOGRAMS
30. Acetic Anhydride							▲						▲				▲	1,023	1,023
31. Acetone		●					●	●	●	●	●	●						150	1,500
32. Benzyl Chloride												▲						1	4
33. Ethyl Ether	●	●			●		●	●	●	●	●	●	●	●		●	●	135.8	1,364
34. Hydrochloric Acid [5&6]	■	■	■	■	■		■	■	■	■	■	■	■	■		■		N/C	222.3
34a. Hydrogen Chloride Gas [5&6]	■	■	■	■	■		■	■	■	■	■	■	■	■		■		0	27
35. Methyl Ethyl Ketone (2-Butanone)		●					●		●	●		●						145	1.455
36. Methyl Isobutyl Ketone [4]		●					●		●	●		●						N/C	1.523
37. Potassium Permanganate		■																55	500
38. Sodium Permanganate		■																55	500
39. Sulfuric Acid [5&6]	■	■							■	■	■	■					■	N/C	347
40. Toluene		●			●								●			●	●	159	1,591

KEY

● = Solvent ■ = Reagent ▲ = Precursor

[1] and its salts
[2] and its salts and esters
[3] and its salts, optical isomers, and salts of optical isomers
[4] Exports only, to all Western Hemisphere except Canada
[5] Exports to all South American countries & Panama — Domestic for HCl gas
[6] Threshold for HCl acid and sulfuric acid is 50 gallons, the equivalent weight in kilograms is shown
[7] For pseudoephedrine, phenylpropanolamine, and ephedrine drug products, see 21 USC § 802 (45)(A) and 21 CFR Part 1314
N/C = Not Controlled

III. Introduction to Drug Classes

The Controlled Substances Act (CSA) regulates five classes of drugs:

- Narcotics
- Depressants
- Stimulants
- Hallucinogens
- Anabolic steroids

Each class has distinguishing properties, and drugs within each class often produce similar effects. However, all controlled substances, regardless of class, share a number of common features. This introduction will familiarize you with these shared features and define the terms frequently associated with these drugs.

All controlled substances have abuse potential or are immediate precursors to substances with abuse potential. With the exception of anabolic steroids, controlled substances are abused to alter mood, thought, and feeling through their actions on the central nervous system (brain and spinal cord). Some of these drugs alleviate pain, anxiety, or depression. Some induce sleep and others energize.

Though some controlled substances are therapeutically useful, the "feel good" effects of these drugs contribute to their abuse. The extent to which a substance is reliably capable of producing intensely pleasurable feelings (euphoria) increases the likelihood of that substance being abused.

DRUG ABUSE

When controlled substances are used in a manner or amount inconsistent with the legitimate medical use, it is called drug abuse. The non-sanctioned use of substances controlled in Schedules I through V of the CSA is considered drug abuse. While legal pharmaceuticals placed under control in the CSA are prescribed and used by patients for medical treatment, the use of these same pharmaceuticals outside the scope of sound medical practice is drug abuse.

DEPENDENCE

In addition to having abuse potential, most controlled substances are capable of producing dependence, either physical or psychological.

Physical Dependence

Physical dependence refers to the changes that have occurred in the body after repeated use of a drug that necessitates the continued administration of the drug to prevent a withdrawal syndrome. This withdrawal syndrome can range from mildly unpleasant to life-threatening and is dependent on a number of factors, such as:

- The drug being used
- The dose and route of administration
- Concurrent use of other drugs
- Frequency and duration of drug use
- The age, sex, health, and genetic makeup of the user

Psychological Dependence

Psychological dependence refers to the perceived "need" or "craving" for a drug. Individuals who are psychologically dependent on a particular substance often feel that they cannot function without continued use of that substance. While physical dependence disappears within days or weeks after drug use stops, psychological dependence can last much longer and is one of the primary reasons for relapse (initiation of drug use after a period of abstinence).

Contrary to common belief, physical dependence is not addiction. While individuals with a substance use disorder are usually physically dependent on the drug they are abusing, physical dependence can exist without addiction. For example,

patients who take narcotics for chronic pain management or benzodiazepines to treat anxiety are likely to be physically dependent on that medication.

ADDICTION

Addiction is defined as compulsive drug-seeking behavior where acquiring and using a drug becomes the most important activity in the user's life. This definition implies a loss of control regarding drug use, and the person with a substance use disorder will continue to use a drug despite serious medical and/or social consequences. In 2015, an estimated 27.1 million Americans aged 12 or older were current (past month) illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview. This estimate represents 10.1 percent of the population aged 12 or older. Illicit drugs include marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, methamphetamine, or prescription psychotherapeutics (including pain relievers, tranquilizers, stimulants, and sedatives) that were misused. [1]

Drugs within a class are often compared with each other with terms like potency and efficacy. Potency refers to the amount of a drug that must be taken to produce a certain effect, while efficacy refers to whether or not a drug is capable of producing a given effect regardless of dose. Both the strength and the ability of a substance to produce certain effects play a role in whether that drug is selected by the drug user.

It is important to keep in mind that the effects produced by any drug can vary significantly and is largely dependent on the dose and route of administration. Concurrent use of other drugs can enhance or block an effect, and substance abusers often take more than one drug to boost the desired effects or counter unwanted side effects. The risks associated with drug abuse cannot be accurately predicted because each user has his/her own unique sensitivity to a drug. There are a number of theories that attempt to explain these differences, and it is clear that a genetic component may predispose an individual to certain toxicities or even addictive behavior.

Youth are especially vulnerable to drug abuse. According to the National Institute on Drug Abuse, young Americans engaged in extraordinary levels of illicit drug use in the last third of the twentieth century. Today, about 48 percent of young people have used an illicit drug by the time they leave high school and about 7 percent of eighth graders, 16 percent of tenth graders, and 24 percent of twelfth graders are current (within the past month) users. [2]

Substance abuse in youth can result in tragic consequences with untold harm to themselves, their families, and others. The 2016 Surgeon General's Report on Alcohol, Drugs, and Health identified risk factors for youth which might lead them into substance abuse. These include being raised in a home where the parents or other relatives use drugs, living in neighborhoods and going to schools where drug use is common, and associating with peers who use substances. Nearly 70 percent of those who try an illicit drug before the age of 13 develop a substance use disorder in the next 7 years, compared with 27 percent of those who first try an illicit drug after the age of 17. [3]

In the sections that follow, each of the five classes of drugs is reviewed and various drugs within each class are profiled. Although marijuana is classified in the CSA as a hallucinogen, a separate section is dedicated to that topic. There are also a number of substances that are abused but not regulated under the CSA. Alcohol and tobacco, for example, are specifically exempt from control by the CSA. In addition, a whole group of substances called inhalants are commonly available and widely abused by children. Control of these substances under the CSA would not only impede legitimate commerce, but also would likely have little effect on the abuse of these substances by youngsters. An energetic campaign aimed at educating both adults and youth about inhalants is more likely to prevent their abuse. To that end, a section is dedicated to providing information on inhalants.

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[1] *Results from the 2015 National Survey on Drug Use and Health: Detailed Tables; U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration*

2 *Monitoring the Future Survey, 2016; National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services*

3 *Facing Addiction in America. The Surgeon General's Report on Alcohol, Drugs, and Health, October 2016. U.S. Department of Health and Human Services.*

IV. Narcotics

WHAT ARE NARCOTICS?

Also known as "opioids," the term "narcotic" comes from the Greek word for "stupor" and originally referred to a variety of substances that dulled the senses and relieved pain. Though some people still refer to all drugs as "narcotics," today "narcotic" refers to opium, opium derivatives, and their semi-synthetic substitutes. A more current term for these drugs, with less uncertainty regarding its meaning, is "opioid." Examples include the illicit drug heroin and pharmaceutical drugs like OxyContin, Vicodin, codeine, morphine, methadone, and fentanyl.

WHAT IS THEIR ORIGIN?

The poppy Papaver somniferum is the source for all natural opioids, whereas synthetic opioids are made entirely in a lab and include meperidine, fentanyl, and methadone. Semi-synthetic opioids are synthesized from naturally occurring opium products, such as morphine and codeine, and include heroin, oxycodone, hydrocodone, and hydromorphone. Teens can obtain narcotics from friends, family members, medicine cabinets, pharmacies, nursing homes, hospitals, hospices, doctors, and the Internet.

OxyContin 160 mg tablet

Heroin

What are common street names?

Street names for various narcotics/opioids include:

- Smack, Horse, Mud, Brown Sugar, Junk, Black Tat, Big H, Paregoric, Dover's Powder, MPTP (New Heroin), Hilbilly Heroin, Lean or Purple Drank, OC, Ox, Oxy, Oxycotton, Sippin Syrup

What do they look like?

Narcotics/opioids come in various forms, including:

- Tablets, capsules, skin patches, powder, chunks in varying colors (from white to shades of brown and black), liquid form for oral use and injection, syrups, suppositories, and lollipops

How are they abused?

- Narcotics/opioids can be swallowed, smoked, sniffed, or injected.

What is their effect on the mind?

Besides their medical use, narcotics/opioids produce a general sense of well-being by reducing tension, anxiety, and aggression. These effects are helpful in a therapeutic setting but contribute to the drugs' abuse. Narcotic/opioid use comes with a variety of unwanted effects, including drowsiness, inability to concentrate, and apathy.

Psychological dependence

Use can create psychological dependence. Long after the physical need for the drug has passed, the addict may continue to think and talk about using drugs and feel overwhelmed coping with daily activities. Relapse is common if there are not changes to the physical environment or the behavioral motivators that prompted the abuse in the first place.

What is their effect on the body?

Narcotics/opioids are prescribed by doctors to treat pain, suppress cough, cure diarrhea, and put people to sleep. Effects depend heavily on the dose, how it's taken, and previous exposure to the drug. Negative effects include:

- Slowed physical activity, constriction of the pupils, flushing of the face and neck, constipation, nausea, vomiting, and slowed breathing

As the dose is increased, both the pain relief and the harmful effects become more pronounced. Some of these preparations are so potent that a single dose can be lethal to an inexperienced user. However, except in cases of extreme intoxication, there is no loss of motor coordination or slurred speech.

Physical dependence and withdrawal

Physical dependence is a consequence of chronic opioid use, and withdrawal takes place when drug use is discontinued. The intensity and character of the physical symptoms experienced during withdrawal are directly related to the particular drug used, the total daily dose, the interval between doses, the duration of use, and the health and personality of the user. These symptoms usually appear shortly before the time of the next scheduled dose.

Early withdrawal symptoms often include:

- Watery eyes, runny nose, yawning, and sweating

As the withdrawal worsens, symptoms can include:

- Restlessness, irritability, loss of appetite, nausea, tremors, drug craving, severe depression, vomiting, increased heart rate and blood pressure, and chills alternating with flushing and excessive sweating

However, without intervention, the withdrawal usually runs its course, and most physical symptoms disappear within days or weeks, depending on the particular drug.

What are their overdose effects?

Overdoses of narcotics are not uncommon and can be fatal. Physical signs of narcotics/opioid overdose include:

- Constricted (pinpoint) pupils, cold clammy skin, confusion, convulsions, extreme drowsiness, and slowed breathing

Which drugs cause similar effects?

With the exception of pain relief and cough suppression, most central nervous system depressants (like barbiturates, benzodiazepines, and alcohol) have similar effects, including slowed breathing, tolerance, and dependence.

What is their legal status in the United States?

Narcotics/opioids are controlled substances that vary from Schedule I to Schedule V, depending on their medical usefulness, abuse potential, safety, and drug dependence profile. Schedule I narcotics, like heroin, have no medical use in the U.S. and are illegal to distribute, purchase, or use outside of medical research.

Fentanyl

Fentanyl

WHAT IS FENTANYL?

Fentanyl is a potent synthetic opioid drug approved by the Food and Drug Administration for use as an analgesic (pain relief) and anesthetic. It is approximately 100 times more potent than morphine and 50 times more potent than heroin as an analgesic.

WHAT IS ITS ORIGIN?

Fentanyl was first developed in 1959 and introduced in the 1960s as an intravenous anesthetic. It is legally manufactured and distributed in the United States. Licit fentanyl pharmaceutical products are diverted via theft, fraudulent prescriptions, and illicit distribution by patients, physicians, and pharmacists.

From 2005 through 2007, both fatal overdoses associated with abuse of clandestinely produced fentanyl and law enforcement encounters increased markedly. According to the Centers for Disease Control and Prevention, there were 1,013 fatal overdoses recorded from April 2005 to March 2007. More recently, there has been a re-emergence of trafficking, distribution, and abuse of illicitly produced fentanyl with an associated dramatic increase in overdose fatalities.

What are common street names?

Common street names include:

Apache, China Girl, China Town, Dance Fever, Friend, Goodfellas, Great Bear, He-Man, Jackpot, King Ivory, Murder 8, and Tango & Cash.

What does it look like?

Fentanyl pharmaceutical products are currently available in the following dosage forms: oral transmucosal lozenges commonly referred to as fentanyl "lollipops" (Actiq), effervescent buccal tablets (Fentora), sublingual tablets (Abstral), sublingual sprays (Subsys), nasal sprays (Lazanda), transdermal patches (Duragesic), and injectable formulations.

Clandestinely produced fentanyl is encountered either as a powder or in counterfeit tablets and is sold alone or in combination with other drugs such as heroin or cocaine.

How is it abused?

Fentanyl can be injected, snorted/sniffed, smoked, taken orally by pill or tablet, and spiked onto blotter paper. Fentanyl patches are abused by removing its gel contents and then injecting or ingest-

ing these contents. Patches have also been frozen, cut into pieces, and placed under the tongue or in the cheek cavity. Illicitly produced fentanyl is sold alone or in combination with heroin and other substances and has been identified in counterfeit pills, mimicking pharmaceutical drugs such as oxycodone. According to the National Forensic Laboratory Information System, reports on fentanyl (both pharmaceutical and clandestinely produced) increased from nearly 5,400 in 2014 to over 14,600 in 2015, as reported by federal, state, and local forensic laboratories in the United States.

What is the effect on the body?

Fentanyl, similar to other commonly used opioid analgesics(e.g., morphine), produces effects such as relaxation, euphoria, pain relief, sedation, confusion, drowsiness, dizziness, nausea, vomiting, urinary retention, pupillary constriction, and respiratory depression.

What are the overdose effects?

Overdose may result in stupor, changes in pupillary size, cold and clammy skin, cyanosis, coma, and respiratory failure leading to death. The presence of triad of symptoms such as coma, pinpoint pupils, and respiratory depression are strongly suggestive of opioid poisoning.

Which drugs cause similar effects?

Drugs that cause similar effects include other opioids such as morphine, hydrocodone, oxycodone, hydromorphone, methadone, and heroin.

What is the legal status in the Federal Control Substances Act?

Fentanyl is a Schedule II narcotic under the United States Controlled Substances Act of 1970.

Heroin

WHAT IS HEROIN?

Heroin is a highly addictive drug and it is a rapidly acting opioid.

WHAT IS ITS ORIGIN?

Heroin is processed from morphine, a naturally occurring substance extracted from the seed pod of certain varieties of poppy plants grown in:

- Mexico, South America, Southwest Asia (Afghanistan and Pakistan), and Southeast Asia (Thailand, Laos, and Myanmar (Burma))

Heroin comes in several forms, primarily white powder from Mexico and South America; and "black tar" and brown powder from Mexico.

What are common street names?

Common street names for heroin include:

- Big H, Black Tar, Chiva, Hell Dust, Horse, Negra, Smack, and Thunder

What does it look like?

Heroin is typically sold as a white or brownish powder, or as the black sticky substance known on the streets as "black tar heroin." Although purer heroin is becoming more common, most street heroin is "cut" with other drugs or with substances such as sugar, starch, powdered milk, or quinine.

How is it abused?

Heroin can be injected, smoked, or sniffed/snorted. High purity heroin is usually snorted or smoked.

What is its effect on the mind?

Because it enters the brain so rapidly, heroin is particularly addictive, both psychologically and physically. Heroin users report feeling a surge of euphoria or "rush," followed by a twilight state of sleep and wakefulness.

Heroin

What is its effect on the body?

One of the most significant effects of heroin use is addiction. With regular heroin use, tolerance to the drug develops. Once this happens, the person must use more heroin to achieve the same intensity. As higher doses of the drug are used over time, physical dependence and addiction to the drug develop.

Effects of heroin use include:

- Drowsiness, respiratory depression, constricted pupils, nausea, a warm flushing of the skin, dry mouth, and heavy extremities

What are its overdose effects?

Because heroin users do not know the actual strength of the drug or its true contents, they are at a high risk of overdose or death.

The effects of a heroin overdose are:

- Slow and shallow breathing, blue lips and fingernails, clammy skin, convulsions, coma, and possible death

Which drugs cause similar effects?

Other opioids such as OxyContin®, Vicodin®, codeine, morphine, methadone, and fentanyl can cause similar effects as heroin.

What is its legal status in the United States?

Heroin is a Schedule I substance under the Controlled Substances Act meaning that it has a high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety for use under medical supervision.

Hydromorphone

WHAT IS HYDROMORPHONE?

Hydromorphone belongs to a class of drugs called "opioids," which includes morphine. It has an analgesic potency of two to eight times greater than that of morphine and has a rapid onset of action.

WHAT IS ITS ORIGIN?

Hydromorphone is legally manufactured and distributed in the United States. However, users can obtain hydromorphone from forged prescriptions, "doctor-shopping," theft from pharmacies, and from friends and acquaintances.

What are the street names?

Common street names include:

- D, Dillies, Dust, Footballs, Juice, and Smack

What does it look like?

Hydromorphone comes in:

- Tablets, capsules, oral solutions, and injectable formulations

How is it abused?

Users may abuse hydromorphone tablets by ingesting them. Injectable solutions, as well as tablets that have been crushed and dissolved in a solution may be injected as a substitute for heroin.

What is its effect on the mind?

When used as a drug of abuse, and not under a doctor's supervision, hydromorphone is taken to produce feelings of euphoria, relaxation, sedation, and reduced anxiety. It may also cause mental clouding, changes in mood, nervousness, and restlessness. It works centrally (in the brain) to reduce pain and suppress cough. Hydromorphone use is associated with both physiological and psychological dependence.

What is its effect on the body?

Hydromorphone may cause:

- Constipation, pupillary constriction, urinary retention, nausea, vomiting, respiratory depression, dizziness, impaired coordination, loss of appetite, rash, slow or rapid heartbeat, and changes in blood pressure

What are its overdose effects?

Acute overdose of hydromorphone can produce:

- Severe respiratory depression, drowsiness progressing to stupor or coma, lack of skeletal muscle tone, cold and clammy skin, constricted pupils, and reduction in blood pressure and heart rate

Severe overdose may result in death due to respiratory depression.

Which drugs cause similar effects?

Drugs that have similar effects include:

- Heroin, morphine, hydrocodone, fentanyl, and oxycodone

What is its legal status in the United States?

Hydromorphone is a Schedule II drug under the Controlled Substances Act with an accepted medical use as a pain reliever. Hydromorphone has a high potential for abuse and use may lead to severe psychological or physical dependence.

Methadone

WHAT IS METHADONE?

Methadone is a synthetic (man-made) narcotic.

WHAT IS ITS ORIGIN?

German scientists synthesized methadone during World War II because of a shortage of morphine. Methadone was introduced into the United States in 1947 as an analgesic (Dolophinel).

What are common street names?

Common street names include:

- Amidone, Chocolate Chip Cookies, Fizzies, Maria, Pastora, Salvia, Street Methadone, and Wafer

What does it look like?

Methadone is available as a tablet, oral solution, or injectable liquid. Tablets are available in 5 mg and 10 mg formulations. As of January 1, 2008, manufacturers of methadone hydrochloride tablets 40 mg (dispersible) have voluntarily agreed to restrict distribution of this formulation to only those facilities authorized for detoxification and maintenance treatment of opioid addiction, and hospitals. Manufacturers will instruct their wholesale distributors to discontinue supplying this formulation to any facility not meeting the above criteria.

How is it abused?

Methodone can be swallowed or injected.

What is its effect on the mind?

Abuse of methadone can lead to psychological dependence.

What is its effect on the body?

When an individual uses methadone, he/she may experience physical symptoms like sweating, itchy skin, or sleepiness. Individuals who abuse methadone risk becoming tolerant of and physically dependent on the drug.

When use is stopped, individuals may experience withdrawal symptoms including:

- Anxiety, muscle tremors, nausea, diarrhea, vomiting, and abdominal cramps

What are its overdose effects?

The effects of a methadone overdose are:

- Slow and shallow breathing, blue fingernails and lips, stomach spasms, clammy skin, convulsions, weak pulse, coma, and possible death

Which drugs cause similar effects?

Although chemically unlike morphine or heroin, methadone produces many of the same effects.

What is its legal status in the United States?

Methadone is a Schedule II drug under the Controlled Substances Act. While it may legally be used under a doctor's supervision, its non-medical use is illegal.

Methadone

Morphine

WHAT IS MORPHINE?

Morphine is a non-synthetic narcotic with a high potential for abuse and is derived from opium. It is used for the treatment of pain.

WHAT IS ITS ORIGIN?

In the United States, a small percentage of the morphine obtained from opium is used directly for pharmaceutical products. The remaining morphine is processed into codeine and other derivatives.

What are common street names?

Common street names include:

- Dreamer, Emsel, First Line, God's Drug, Hows, M.S., Mister Blue, Morf, Morpho, and Unkie

What does it look like?

Morphine is marketed under generic and brand name products, including:

- MS-Contin, Oramorph SR, MSIR, Roxanol, Kadian, and RMS

How is it abused?

Traditionally, morphine was almost exclusively used by injection, but the variety of pharmaceutical forms that it is marketed as today support its use by oral and other routes of administration.

Forms include:

- Oral solutions, immediate-and extended-release tablets and capsules, and injectable preparations

Those dependent on morphine prefer injection because the drug enters the bloodstream more quickly.

What is its effect on the mind?

Morphine's effects include euphoria and relief of pain. Chronic use of morphine results in tolerance and physical and psychological dependence.

What is its effect on the body?

Morphine use results in relief from physical pain, decrease in hunger, and inhibition of the cough reflex.

What are its overdose effects?

Overdose effects include:

- Cold and clammy skin, lowered blood pressure, sleepiness, slowed breathing, slow pulse rate, coma, and possible death

Which drugs cause similar effects?

Drugs causing similar effects as morphine include:

- Opium, codeine, heroin, methadone, hydrocodone, fentanyl, and oxycodone

What is its legal status in the United States?

Morphine is a Schedule II narcotic under the Controlled Substances Act.

Opium

WHAT IS OPIUM?

Opium is a highly addictive non-synthetic narcotic that is extracted from the poppy plant, Papaver somniferum. The opium poppy is the key source for many narcotics, including morphine, codeine, and heroin.

WHAT IS ITS ORIGIN?

The poppy plant, Papaver somniferum, is the source of opium. It was grown in the Mediterranean region as early as 5000 B.C., and has since been cultivated in a number of countries throughout the world. The milky fluid that seeps from its incisions in the unripe seed pod of this poppy has been scraped by hand and air-dried to produce what is known as opium.

A more modern method of harvesting for pharmaceutical use is by the industrial poppy straw process of extracting alkaloids from the mature dried plant (concentrate of poppy straw). All opium and poppy straw used for pharmaceutical products are imported into the United States from legitimate sources in regulated countries.

What are common street names?

Common street names include:

- Ah-pen-yen, Aunti, Aunti Emma, Big O, Black Pill, Chandoo, Chandu, Chinese Molasses, Chinese Tobacco, Dopium, Dover's Powder, Dream Gun, Dream Stick, Dreams, Easing Powder, Fi-do-nie, Gee, God's Medicine, Gondola, Goric, Great Tobacco, Guma, Hop/hops, Joy Plant, Midnight Oil, Mira, O, O.P., Ope, Pen Yan, Pin Gon, Pox, Skee, Toxy, Toys, When-shee, Ze, and Zero

What does it look like?

Opium can be a liquid, solid, or powder, but most poppy straw concentrate is available commercially as a fine brownish powder.

How is it abused?

Opium can be smoked, intravenously injected, or taken in pill form. Opium is also abused in combination with other drugs. For example, "Black" is a combination of marijuana, opium, and methamphetamine, and "Buddha" is potent marijuana spiked with opium.

What is its effect on the mind?

The intensity of opium's euphoric effects on the brain depends on the dose and route of administration. It works quickly when smoked because the opiate chemicals pass into the lungs, where they are quickly absorbed and then sent to the brain. An opium "high" is very similar to a heroin "high"; users experience a euphoric rush, followed by relaxation and the relief of physical pain.

What is its effect on the body?

Opium inhibits muscle movement in the bowels leading to constipation. It also can dry out the mouth and mucous membranes in the nose. Opium use leads to physical and psychological dependence, and can lead to overdose.

What are its overdose effects?

Overdose effects include:

- Slow breathing, seizures, dizziness, weakness, loss of consciousness, coma, and possible death

Which drugs cause similar effects?

Drugs that cause similar effects include:

- Morphine, codeine, heroin, methadone, hydroquinone, fentanyl, and oxycodone

What is its legal status in the United States?

Opium is a Schedule II drug under the Controlled Substances Act. Most opioids are Schedule II, III, IV, or V drugs. Some drugs that are derived from opium, such as heroin, are Schedule I drugs.

Oxycodone

WHAT IS OXYCODONE?

Oxycodone is a semi-synthetic narcotic analgesic and historically has been a popular drug of abuse among the narcotic abusing population.

WHAT IS ITS ORIGIN?

Oxycodone is synthesized from thebaine, a constituent of the poppy plants.

What are common street names?

Common street names include:

- Hillbilly Heroin, Kicker, OC, Ox, Roxy, Perc, and Oxy

What does it look like?

Oxycodone is marketed alone as OxyContin in 10, 20, 40 and 80 mg extended-release tablets and other immediate-release capsules like 5 mg OxyIR. It is also marketed in combination products with aspirin such as Percodan or acetaminophen such as Roxicet.

How is it abused?

Oxycodone is abused orally or intravenously. The tablets are crushed and sniffed or dissolved in water and injected. Others heat a tablet that has been placed on a piece of foil then inhale the vapors.

What is its effect on the mind?

Euphoria and feelings of relaxation are the most common effects of oxycodone on the brain, which explains its high potential for abuse.

What is its effect on the body?

Physiological effects of oxycodone include:

- Pain relief, sedation, respiratory depression, constipation, papillary constriction, and cough suppression. Extended or chronic use of oxycodone containing acetaminophen may cause severe liver damage

What are its overdose effects?

Overdose effects include:

- Extreme drowsiness, muscle weakness, confusion, cold and clammy skin, pinpoint pupils, shallow breathing, slow heart rate, fainting, coma, and possible death

Which drugs cause similar effects?

Drugs that cause similar effects to Oxycodone include:

- Opium, codeine, heroin, methadone, hydrocodone, fentanyl, and morphine

What is its legal status in the United States?

Oxycodone products are in Schedule II of the Controlled Substances Act.

V. Stimulants

WHAT ARE STIMULANTS?

- Stimulants speed up the body's systems. This class of drugs includes:
- Prescription drugs such as amphetamines [Adderall and dexedrine], methylphenidate [Concerta and Ritalin], diet aids [such as didrex, Bontril, Preludin, Fastin, Adipex P, ionomin, and Meridia] and illicitly produced drugs such as methamphetamine, cocaine, and methcathinone.

WHAT IS THEIR ORIGIN?

Stimulants are diverted from legitimate channels and clandestinely manufactured exclusively for the illicit market.

Ritalin SR 20mg tablet

Crack Cocaine

What are common street names?

Common street names for stimulants include:

- Bennies, Black Beauties, Cat, Coke, Crank, Crystal, Flake, Ice, Pellets, R-Ball, Skippy, Snow, Speed, Uppers, and Vitamin R

What do they look like?

Stimulants come in the form of:

- Pills, powder, rocks, and injectable liquids

How are they abused?

Stimulants can be pills or capsules that are swallowed. Smoking, snorting, or injecting stimulants produces a sudden sensation known as a "rush" or a "flash."

Abuse is often associated with a pattern of binge use — sporadically consuming large doses of stimulants over a short period of time. Heavy users may inject themselves every few hours, continuing until they have depleted their drug supply or reached a point of delirium, psychosis, and physical exhaustion. During heavy use, all other interests become secondary to recreating the initial euphoric rush.

What is their effect on the mind?

When used as drugs of abuse and not under a doctor's supervision, stimulants are frequently taken to:

- Produce a sense of exhilaration, enhance self-esteem, improve mental and physical performance, increase activity, reduce appetite, extend wakefulness for prolonged period, and "get high"

Chronic, high-dose use is frequently associated with agitation, hostility, panic, aggression, and suicidal or homicidal tendencies.

Paranoia, sometimes accompanied by both auditory and visual hallucinations, may also occur.

Tolerance, in which more and more drug is needed to produce the usual effects, can develop rapidly, and psychological dependence occurs. In fact, the strongest psychological dependence observed occurs with the more potent stimulants,

such as amphetamine, methylphenidate, methamphetamine, cocaine, and methcathinone.

Abrupt cessation is commonly followed by depression, anxiety, drug craving, and extreme fatigue, known as a "crash."

What is their effect on the body?

Stimulants are sometimes referred to as uppers and reverse the effects of fatigue on both mental and physical tasks. Therapeutic levels of stimulants can produce exhilaration, extended wakefulness, and loss of appetite. These effects are greatly intensified when large doses of stimulants are taken.

Taking too large a dose at one time or taking large doses over an extended period of time may cause such physical side effects as:

- Dizziness, tremors, headache, flushed skin, chest pain with palpitations, excessive sweating, vomiting, and abdominal cramps.

What are their overdose effects?

In overdose, unless there is medical intervention, high fever, convulsions, and cardiovascular collapse may precede death. Because accidental death is partially due to the effects of stimulants on the body's cardiovascular and temperature-regulating systems, physical exertion increases the hazards of stimulant use.

Which drugs cause similar effects?

Some hallucinogenic substances, such as ecstasy, have a stimulant component to their activity.

What is their legal status in the United States?

A number of stimulants have no medical use in the United States but have a high potential for abuse. These stimulants are controlled in Schedule I. Some prescription stimulants are not controlled, and some stimulants like tobacco and caffeine don't require a prescription — though society's recognition of their adverse effects has resulted in a proliferation of caffeine-free products and efforts to discourage cigarette smoking.

Stimulant chemicals in over-the-counter products, such as ephedrine and pseudoephedrine, can be found in allergy and cold medicine. As required by The Combat Methamphetamine Epidemic Act of 2005, a retail outlet must store these products out of reach of customers, either behind the counter or in a locked cabinet. Regulated sellers are required to maintain a written or electronic form of a logbook to record sales of these products. In order to purchase these products, customers must now show a photo identification issued by a state or federal government. They are also required to write or enter into the logbook: their name, signature, address, date, and time of sale. In addition to the above, there are daily and monthly sales limits set for customers.

Amphetamines

WHAT ARE AMPHETAMINES?

Amphetamines are stimulants that speed up the body's system. Many are legally prescribed and used to treat attention-deficit hyperactivity disorder (ADHD).

WHAT IS THEIR ORIGIN?

Amphetamine was first marketed in the 1930s as Benzedrine in an over-the-counter inhaler to treat nasal congestion. By 1937 amphetamine was available by prescription in tablet form and was used in the treatment of the sleeping disorder narcolepsy and ADHD.

Over the years, the use and abuse of clandestinely produced amphetamines have spread. Today, clandestine laboratory production of amphetamines has mushroomed, and the abuse of the drug has increased dramatically.

What are common street names?

Common street names include:

- Bennies, Black Beauties, Crank, Ice, Speed, and Uppers

What do they look like?

Amphetamines can look like pills or powder. Common prescription amphetamines include methylphenidate (Ritalin or Ritalin SR), amphetamine and dextroamphetamine (Adderall), and dextroamphetamine (Dexedrine).

How are they abused?

Amphetamines are generally taken orally or injected. However, the addition of "ice," the slang name of crystallized methamphetamine hydrochloride, has promoted smoking as another mode of administration. Just as "crack" is smokable cocaine, "ice" is smokable methamphetamine.

What is their effect on the mind?

The effects of amphetamines and methamphetamine are similar to cocaine, but their onset is slower and their duration is longer. In contrast to cocaine, which is quickly removed from the brain and is almost completely metabolized, methamphetamine remains in the central nervous system longer, and a larger percentage of the drug remains unchanged in the body, producing prolonged stimulant effects.

Chronic abuse produces a psychosis that resembles schizophrenia and is characterized by paranoia, picking at the skin, preoccupation with one's own thoughts, and auditory and visual hallucinations. Violent and erratic behavior is frequently seen among chronic users of amphetamines and methamphetamine.

What is their effect on the body?

Physical effects of amphetamine use include:

- Increased blood pressure and pulse rates, insomnia, loss of appetite, and physical exhaustion

What are their overdose effects?

Overdose effects include:

- Agitation, increased body temperature, hallucinations, convulsions, and possible death

Which drugs cause similar effects?

Drugs that cause similar effects include:

- Dexmethylphendiate, phentermine, benzphetamine, phendimetrazine, cocaine, crack, methamphetamine, and khat

What is their legal status in the United States?

Amphetamines are Schedule II stimulants, which means that they have a high potential for abuse and a currently acceptable medical use (in FDA-approved products). Pharmaceutical products are available only through a prescription that cannot be refilled.

Cocaine

WHAT IS COCAINE?

Cocaine is an intense, euphoria-producing stimulant drug with strong addictive potential.

WHAT IS ITS ORIGIN?

Cocaine is derived from coca leaves grown in Bolivia, Peru, and Colombia. The cocaine manufacturing process takes place in remote jungle labs where the raw product undergoes a series of chemical transformations. Colombia produces about 90 percent of the cocaine powder reaching the United States. Most of the cocaine entering the United States comes through Mexico.

What are common street names?

Common street names include:

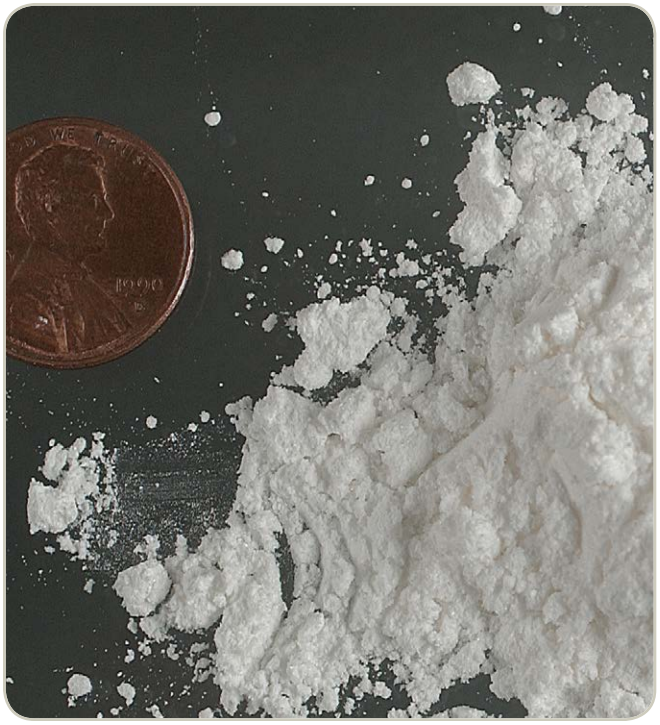
- Coca, Coke, Crack, Flake, Snow, and Soda Cot

What does it look like?

Cocaine is usually distributed as a white, crystalline powder. Cocaine is often diluted ("cut") with a variety of substances, the most common of which are sugars and local anesthetics. It is "cut" to stretch the amount of the product and increase profits for dealers. In contrast, cocaine base (crack) looks like small, irregularly shaped chunks (or "rocks") of a whitish solid.

How is it abused?

Powdered cocaine can be snorted or injected into the veins after dissolving in water. Cocaine base (crack) is smoked, either alone or on marijuana or tobacco. Cocaine is also used in combination with an opiate, like heroin, a practice known as "speedballing." Although injecting into veins or muscles, snorting, and smoking are the common ways of using cocaine, all mucous membranes readily absorb cocaine. Cocaine users typically binge on the drug until they are exhausted or run out of cocaine.



Cocaine powder

What is its effect on the mind?

The intensity of cocaine's euphoric effects depends on how quickly the drug reaches the brain, which depends on the dose and method of abuse. Following smoking or intravenous injection, cocaine reaches the brain in seconds, with a rapid buildup in levels. This results in a rapid-onset, intense euphoric effect known as a "rush."

By contrast, the euphoria caused by snorting cocaine is less intense and does not happen as quickly due to the slower build-up of the drug in the brain. Other effects include increased alertness and excitation, as well as restlessness, irritability, and anxiety.

Tolerance to cocaine's effects develops rapidly, causing users to take higher and higher doses. Taking high doses of cocaine or prolonged use, such as binging, usually causes paranoia. The crash that follows euphoria is characterized by mental and physical exhaustion, sleep, and depression lasting several days. Following the crash, users experience a craving to use cocaine again.

What is its effect on the body?

Physiological effects of cocaine include increased blood pressure and heart rate, dilated pupils, insomnia, and loss of appetite. The widespread abuse of highly pure street cocaine has led to many severe adverse health consequences such as:

- Cardiac arrhythmias, ischemic heart conditions, sudden cardiac arrest, convulsions, strokes, and death

In some users, the long-term use of inhaled cocaine has led to a unique respiratory syndrome, and chronic snorting of cocaine has led to the erosion of the upper nasal cavity.

Which drugs cause similar effects?

Other stimulants, such as methamphetamine, cause effects similar to cocaine that vary mainly in degree.

What is its legal status in the United States?

Cocaine is a Schedule II drug under the Controlled Substances Act, meaning it has a high potential for abuse and has an accepted medical use for treatment in the United States. Cocaine hydrochloride solution (4 percent and 10 percent) is used primarily as a topical local anesthetic for the upper respiratory tract. It also is used to reduce bleeding of the mucous membranes in the mouth, throat, and nasal cavities. However, better products have been developed for these purposes, and cocaine is rarely used medically in the United States.

Cocaine bricks, seized by DEA

Khat

WHAT IS KHAT?

Khat is a flowering evergreen shrub that is abused for its stimulant-like effect. Khat has two active ingredients, cathine and cathinone.

WHAT IS ITS ORIGIN?

Khat is native to East Africa and the Arabian Peninsula, where the use of it is an established cultural tradition for many social situations.

Khat plant

What are common street names?

Common street names for Khat include:

- Abyssinian Tea, African Salad, Catha, Chat, Kat, and Oat

What does it look like?

Khat is a flowering evergreen shrub. Khat that is sold and abused is usually just the leaves, twigs, and shoots of the Khat shrub.

How is it abused?

Khat is typically chewed like tobacco, then retained in the cheek and chewed intermittently to release the active drug, which produces a stimulant-like effect. Dried Khat leaves can be made into tea or a chewable paste, and Khat can also be smoked and even sprinkled on food.

What is its effect on the mind?

Khat can induce manic behavior with:

- Grandiose delusions, paranoia, nightmares, hallucinations, and hyperactivity

Chronic Khat abuse can result in violence and suicidal depression.

What is its effect on the body?

Khat causes an immediate increase in blood pressure and heart rate. Khat can also cause a brown staining of the teeth, insomnia, and gastric disorders. Chronic abuse of Khat can cause physical exhaustion.

What are its overdose effects?

The dose needed to constitute an overdose is not known, however it has been historically associated with those who are long-term chewers of the leaves. Symptoms of toxicity include:

- Delusions, loss of appetite, difficulty with breathing, and increases in both blood pressure and heart rate

Additionally, there are reports of liver damage (chemical hepatitis) and of cardiac complications, specifically myocardial infarctions. This mostly occurs among long-term chewers of khat or those who have chewed too large a dose.

Which drugs cause similar effects?

Khat's effects are similar to other stimulants, such as cocaine, amphetamine, and methamphetamine.

What is its legal status in the United States?

The chemicals found in khat are controlled under the Controlled Substances Act. Cathine is a Schedule IV stimulant, and cathinone is a Schedule I stimulant under the Controlled Substances Act, meaning that it has a high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety for use under medical supervision.

Methamphetamine

WHAT IS METHAMPHETAMINE?

Methamphetamine (meth) is a stimulant. The FDA-approved brand-name medication is Desoxyn.

WHAT IS ITS ORIGIN?

Mexican drug trafficking organizations have become the primary manufacturers and distributors of methamphetamine to cities throughout the United States, including in Hawaii. Domestic clandestine laboratory operators also produce and distribute meth but usually on a smaller scale. The methods used depend on the availability of precursor chemicals.

Currently, this domestic clandestinely produced meth is mainly made with diverted products that contain pseudoephedrine. Mexican methamphetamine is made with different precursor chemicals. The Combat Methamphetamine Epidemic Act of 2005 requires retailers of non-prescription products containing pseudoephedrine, ephedrine, or phenylpropanolamine to place these products behind the counter or in a locked cabinet. Consumers must show identification and sign a logbook for each purchase.

What are common street names?

Common street names include:

- Batu, Bikers Coffee, Black Beauties, Chalk, Chicken Feed, Crank, Crystal, Glass, Go-Fast, Hiropon, Ice, Meth, Methlies Quick, Poor Man's Cocaine, Shabu, Shards, Speed, Stove Top, Tina, Trash, Tweak, Uppers, Ventana, Vidrio, Yaba, and Yellow Bam

What does it look like?

Regular meth is a pill or powder. Crystal meth resembles glass fragments or shiny blue-white "rocks" of various sizes.

How is it abused?

Meth is swallowed, snorted, injected, or smoked. To intensify the effects, users may take higher doses of the drug, take it more frequently, or change their method of intake.

Methamphetamine in finished form

What is its effect on the mind?

Meth is a highly addictive drug with potent central nervous system (CNS) stimulant properties.

Those who smoke or inject it report a brief, intense sensation, or rush. Oral ingestion or snorting produces a long-lasting high instead of a rush, which reportedly can continue for as long as half a day. Both the rush and the high are believed to result from the release of very high levels of the neurotransmitter dopamine into areas of the brain that regulate feelings of pleasure. Long-term meth use results in many damaging effects, including addiction.

Chronic meth users can exhibit violent behavior, anxiety, confusion, insomnia, and psychotic features including paranoia, aggression, visual and auditory hallucinations, mood disturbances, and delusions — such as the sensation of insects creeping on or under the skin.

Methamphetamine in finished form

Such paranoia can result in homicidal or suicidal thoughts. Researchers have reported that as much as 50 percent of the dopamine-producing cells in the brain can be damaged after prolonged exposure to relatively low levels of meth. Researchers also have found that serotonin-containing nerve cells may be damaged even more extensively.

What is its effect on the body?

Taking even small amounts of meth can result in:

- Increased wakefulness, increased physical activity, decreased appetite, rapid breathing and heart rate, irregular heartbeat, increased blood pressure, and hyperthermia (overheating)

High doses can elevate body temperature to dangerous, sometimes lethal, levels, and cause convulsions and even cardiovascular collapse and death. Meth use may also cause extreme anorexia, memory loss, and severe dental problems.

What are its overdose effects?

High doses may result in death from stroke, heart attack, or multiple organ problems caused by overheating.

Which drugs cause similar effects?

Cocaine and potent stimulant pharmaceuticals, such as amphetamines and methylphenidate, produce similar effects.

What is its legal status in the United States?

Methamphetamine is a Schedule II stimulant under the Controlled Substances Act, which means that it has a high potential for abuse and a currently accepted medical use (in FDA-approved products). It is available only through a prescription that cannot be refilled. Today there is only one legal meth product, Desoxyn. It is currently marketed in 5-milligram tablets and has very limited use in the treatment of obesity and attention deficit hyperactivity disorder (ADHD).

VI. Depressants

WHAT ARE DEPRESSANTS?

Depressants will put you to sleep, relieve anxiety and muscle spasms, and prevent seizures.

Barbiturates are older drugs and include butalbital (Fiorina), phenobarbital, Pentothal, Seconal, and Nembutal. A person can rapidly develop dependence on and tolerance to barbiturates, meaning a person needs more and more of them to feel and function normally. This makes them unsafe, increasing the likelihood of coma or death.

Benzodiazepines were developed to replace barbiturates, though they still share many of the undesirable side effects including tolerance and dependence. Some examples are Valium, Xanax, Halcion, Ativan, Klonopin, and Restoril. Rohypnol is a benzodiazepine that is not manufactured or legally marketed in the United States, but it is used illegally.

Lunesta, Ambien, and Sonata are sedative-hypnotic medications approved for the short-term treatment of insomnia that share many of the properties of benzodiazepines. Other CNS depressants include meprobamate, methaqualone (Quaalude), and the illicit drug GHB.

WHAT IS THEIR ORIGIN?

Generally, legitimate pharmaceutical products are diverted to the illicit market. Teens can obtain depressants from the family medicine cabinet, friends, family members, the Internet, doctors, and hospitals.

Klonopin 5mg tablet

Blister pack of Rohypnol tablets

What are common street names?

Common street names for depressants include:

- Barbs, Benzos, Downers, Georgia Home Boy, GHB, Grievous Bodily Harm, Liquid X, Nerve Pills, Phennies, R2, Reds, Roofies, Rophies, Tranks, and Yellows

What do they look like?

Depressants come in the form of pills, syrups, and injectable liquids.

How are they abused?

Individuals abuse depressants to experience euphoria. Depressants are also used with other drugs to add to the other drugs' high or to deal with their side effects. Users take higher doses than people taking the drugs under a doctor's supervision for therapeutic purposes. Depressants like GHB and Rohypnol are also misused to facilitate sexual assault.

What is their effect on the mind?

Depressants used therapeutically do what they are prescribed for:

- To induce sleep, relieve anxiety and muscle spasms, and prevent seizures

They also:

- Cause amnesia, leaving no memory of events that occur while under the influence, reduce reaction time, impair mental functioning and judgment, and cause confusion

Long-term use of depressants produces psychological dependence and tolerance.

What is their effect on the body?

Some depressants can relax the muscles. Unwanted physical effects include:

- Slurred speech, loss of motor coordination, weakness, headache, lightheadedness, blurred vision, dizziness, nausea, vomiting, low blood pressure, and slowed breathing

Prolonged use of depressants can lead to physical dependence even at doses recommended for medical treatment. Unlike barbiturates, large doses of benzodiazepines are rarely fatal unless combined with other drugs or alcohol. But unlike the withdrawal syndrome seen with most other drugs of abuse, withdrawal from depressants can be life threatening.

Vials containing GHB

What is their legal status in the United States?

Most depressants are controlled substances that range from Schedule I to Schedule IV under the Controlled Substances Act, depending on their risk for abuse and whether they currently have an accepted medical use. Many of the depressants have FDA-approved medical uses. Rohypnol and Quaaludes are not manufactured or legally marketed in the United States.

Barbiturates

WHAT ARE BARBITURATES?

Barbiturates are depressants that produce a wide spectrum of central nervous system depression from mild sedation to coma. They also have been used as sedatives, hypnotics, anesthetics, and anticonvulsants.

Barbiturates are classified as:

- Ultrashort, Short, Intermediate, Long-acting

WHAT IS THEIR ORIGIN?

Barbiturates were first introduced for medical use in the 1900s, and today about 12 substances are in medical use.

What are common street names?

Common street names include:

- Barbs, Block Busters, Christmas Trees, Goof Balls, Pinks, Red Devils, Reds & Blues, and Yellow Jackets

What do they look like?

Barbiturates come in a variety of multicolored pills and tablets. Users prefer the short-acting and intermediate barbiturates such as Amytal and Seconal.

How are they abused?

Barbiturates are abused by swallowing a pill or injecting a liquid form. Barbiturates are generally abused to reduce anxiety, decrease inhibitions, and treat unwanted effects of illicit drugs. Barbiturates can be extremely dangerous because overdoses can occur easily and lead to death.

What is their effect on the mind?

Barbiturates cause:

- Mild euphoria, lack of inhibition, relief of anxiety, and sleepiness

Higher doses cause:

- Impairment of memory, judgment, and coordination; irritability; and paranoid and suicidal ideation

Tolerance develops quickly and larger doses are then needed to produce the same effect, increasing the danger of an overdose.

What is their effect on the body?

Barbiturates slow down the central nervous system and cause sleepiness.

What are their overdose effects?

Effects of overdose include:

- Shallow respiration, clammy skin, dilated pupils, weak and rapid pulse, coma, and possible death

Which drugs cause similar effects?

Drugs with similar effects include:

- Alcohol, benzodiazepines like Valium and Xanax, tranquilizers, sleeping pills, Rohypnol, and GHB

What is their legal status in the United States?

Barbiturates are Schedule II, III, and IV depressants under the Controlled Substances Act.

Benzodiazepines

WHAT ARE BENZODIAZEPINES?

Benzodiazepines are depressants that produce sedation and hypnosis, relieve anxiety and muscle spasms, and reduce seizures.

WHAT IS THEIR ORIGIN?

Benzodiazepines are only legally available through prescription. Many users maintain their drug supply by getting prescriptions from several doctors, forging prescriptions, or buying them illicitly. Alprazolam and diazepam are the two most frequently encountered benzodiazepines on the illicit market.

What are common street names?

Common street names include Benzos and Downers.

What do they look like?

The most common benzodiazepines are the prescription drugs Valium, Xanax, Halcion, Ativan, and Klonopin. Tolerance can develop, although at variable rates and to different degrees. Shorter-acting benzodiazepines used to manage insomnia include estazolam (ProSom), flurazepam (Dalmane), temazepam (Restoril), and triazolam (Halcion). Midazolam (Versed), a short-acting benzodiazepine, is utilized for sedation, anxiety, and amnesia in critical care settings and prior to anesthesia. It is available in the United States as an injectable preparation and as a syrup (primarily for pediatric patients).

Benzodiazepines with a longer duration of action are utilized to treat insomnia in patients with daytime anxiety. These benzodiazepines include alprazolam (Xanax), chlordiazepoxide (Librium), clorazepate (Tranxene), diazepam (Valium), halazepam (Paxipam), lorzepam (Ativan), oxazepam (Serax), prazepam (Centrax), and quazepam (Doral). Clonazepam (Klonopin), diazepam, and clorazepate are also used as anticonvulsants.

How are they abused?

Abuse is frequently associated with adolescents and young adults who take the drug orally or crush it up and snort it to get high. Abuse is particularly high among heroin and cocaine users.

What is their effect on the mind?

Benzodiazepines are associated with amnesia, hostility, irritability, and vivid or disturbing dreams.

What is their effect on the body?

Benzodiazepines slow down the central nervous system and may cause sleepiness.

What are their overdose effects?

Effects of overdose include:

- Shallow respiration, clammy skin, dilated pupils, weak and rapid pulse, coma, and possible death

Which drugs cause similar effects?

Drugs that cause similar effects include:

- Alcohol, barbiturates, sleeping pills, and GHB

What is their legal status in the United States?

Benzodiazepines are controlled in Schedule IV of the Controlled Substances Act.

GHB

WHAT IS GHB?

Gamma-Hydroxybutyric acid (GHB) is another name for the generic drug sodium oxybate. Xyrem (which is sodium oxybate) is the trade name of the Food and Drug Administration (FDA)-approved prescription medication.

Analogues that are often substituted for GHB include GBL (gamma butyrolactone) and 1,4 BD (also called just "BD"), which is 1,4-butanediol. These analogues are available legally as industrial solvents used to produce polyurethane, pesticides, elastic fibers, pharmaceuticals, coatings on metal or plastic, and other products. They are also sold illicitly as supplements for bodybuilding, fat loss, reversal of baldness, improved eyesight, and to combat aging, depression, drug addiction, and insomnia.

GBL and BD are sold as "fish tank cleaner," "ink stain remover," "ink cartridge cleaner," and "nail enamel remover" for approximately $100 per bottle — much more expensive than comparable products. Attempts to identify the abuse of GHB analogues are hampered by the fact that routine toxicological screens do not detect the presence of these analogues.

WHAT IS ITS ORIGIN?

GHB is produced illegally in both domestic and foreign clandestine laboratories. The major source of GHB on the street is through clandestine synthesis by local operators. At bars or "rave" parties, GHB is typically sold in liquid form by the capful or "swig" for $5 to $25 per cap. Xyrem has the potential for diversion and abuse like any other pharmaceutical containing a controlled substance.

GHB has been encountered in nearly every region of the country.

What are common street names?

Common street names include:

- Easy Lay, G, Georgia Home Boy, GHB, Goop, Grievous Bodily Harm, Liquid Ecstasy, Liquid X, and Scoop

Vials containing GHB

What does it look like?

GHB is usually sold as a liquid or as a white powder that is dissolved in a liquid, such as water, juice, or alcohol. GHB dissolved in liquid has been packaged in small vials or small water bottles. In liquid form, GHB is clear and colorless and slightly salty in taste.

How is it abused?

GHB and its analogues are abused for their euphoric and calming effects and because some people believe they build muscles and cause weight loss.

GHB and its analogues are also misused for their ability to increase libido, suggestibility, passivity, and to cause amnesia (no memory of events while under the influence of the substance) — traits that make users vulnerable to sexual assault and other criminal acts.

GHB abuse became popular among teens and young adults at dance clubs and "raves" in the 1990s and gained notoriety as a date rape drug. GHB is taken alone or in combination with other drugs, such as alcohol (primarily), other depressants, stimulants, hallucinogens, and marijuana.

The average dose ranges from 1 to 5 grams (depending on the purity of the compound, this can be 1-2 teaspoons mixed in a beverage). However, the concentrations of these "home-brews" have varied so much that users are usually unaware of the actual dose they are drinking.

What is its effect on the mind?

GHB occurs naturally in the central nervous system in very small amounts. Use of GHB produces Central Nervous System (CNS) depressant effects including:

- Euphoria, drowsiness, decreased anxiety, confusion, and memory impairment

GHB can also produce both visual hallucinations and — paradoxically — excited and aggressive behavior. GHB greatly increases the CNS depressant effects of alcohol and other depressants.

What is its effect on the body?

GHB takes effect in 15 to 30 minutes, and the effects last 3 to 6 hours. Low doses of GHB produce nausea.

At high doses, GHB overdose can result in:

- Unconsciousness, seizures, slowed heart rate, greatly slowed breathing, lower body temperature, vomiting, nausea, coma, and death

Regular use of GHB can lead to addiction and withdrawal that includes:

- Insomnia, anxiety, tremors, increased heart rate and blood pressure, and occasional psychotic thoughts

Currently, there is no antidote available for GHB intoxication. GHB analogues are known to produce side effects such as:

- Topical irritation to the skin and eyes, nausea, vomiting, incontinence, loss of consciousness, seizures, liver damage, kidney failure, respiratory depression, and death

What are its overdose effects?

GHB overdose can cause death.

Which drugs cause similar effects?

GHB analogues are often abused in place of GHB. Both GBL and BD metabolize to GHB when taken and produce effects similar to GHB.

CNS depressants such as barbiturates and methaqualone also produce effects similar to GHB.

What is its legal status in the United States?

GHB is a Schedule I controlled substance, meaning that it has a high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety for use under medical supervision. FDA-approved GHB products are Schedule III substances under the Controlled Substances Act. In addition, GBL is a List I chemical.

It was placed on Schedule I of the Controlled Substances Act in March 2000. However, when sold as FDA-approved GHB products (such as Xyrem), it is considered Schedule III, one of several drugs that are listed in multiple schedules.

Rohypnol

WHAT IS ROHYPNOL?

Rohypnol is a trade name for flunitrazepam, a central nervous system (CNS) depressant that belongs to a class of drugs known as benzodiazepines. Flunitrazepam is also marketed as generic preparations and other trade name products outside of the United States.

Like other benzodiazepines, Rohypnol produces sedative-hypnotic, anti-anxiety, and muscle relaxant effects. This drug has never been approved for medical use in the United States by the Food and Drug Administration. Outside the United States, Rohypnol is commonly prescribed to treat insomnia. Rohypnol is also referred to as a "date rape" drug.

WHAT IS ITS ORIGIN?

Rohypnol is smuggled into the United States from other countries, such as Mexico.

What are common street names?

Common street names include:

- Circles, Forget Pill, Forget-Me-Pill, La Rocha, Lunch Money Drug, Mexican Valium, Pingus, R2, Reynolds, Roach, Roach 2, Roaches, Roachies, Roapies, Robutal, Rochas Dos, Rohypnol, Roofies, Rophies, Ropies, Roples, Row-Shay, Ruffies, and Wolfies

What does it look like?

Prior to 1997, Rohypnol was manufactured as a white tablet (0.5-2 milligrams per tablet), and when mixed in drinks, was colorless, tasteless, and odorless. In 1997, the manufacturer responded to concerns about the drug's role in sexual assaults by reformulating the drug.

Rohypnol is now manufactured as an oblong olive green tablet with a speckled blue core that when dissolved in light-colored drinks will dye the liquid blue. However, generic versions of the drug may not contain the blue dye.

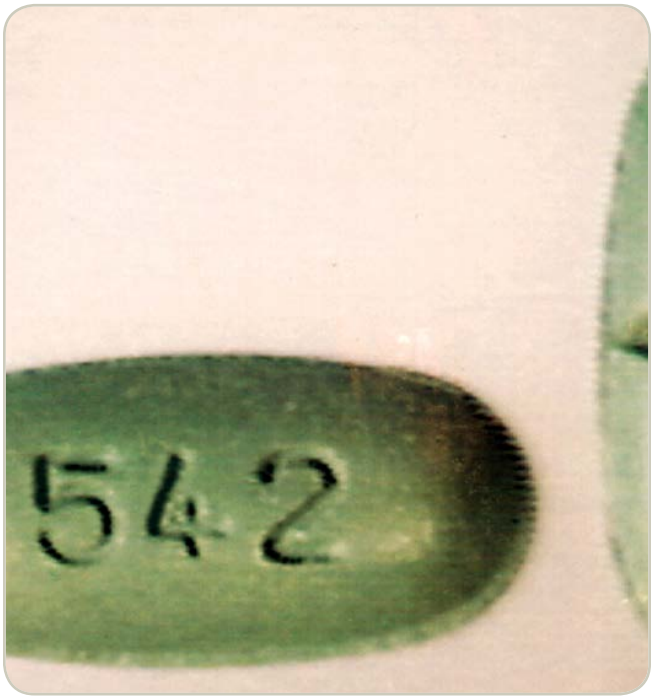
How is it abused?

The tablet can be swallowed whole, crushed and snorted, or dissolved in liquid. Adolescents may abuse Rohypnol to produce a euphoric effect often described as a "high." While high, they experience reduced inhibitions and impaired judgment.

Rohypnol is also used in combination with alcohol to produce an exaggerated intoxication.

In addition, abuse of Rohypnol may be associated with multiple-substance abuse. For example, cocaine users may use benzodiazepines such as Rohypnol to relieve the side effects (e.g., irritability and agitation) associated with cocaine binges.

Rohypnol is also misused to physically and psychologically incapacitate victims targeted for sexual assault. The drug is usually placed in the alcoholic drink of an unsuspecting victim to incapacitate them and prevent resistance to sexual assault. The drug leaves the victim unaware of what has happened to them.



Rohypnol tablets

What is its effect on the mind?

Like other benzodiazepines, Rohypnol slows down the functioning of the CNS producing:

- Drowsiness (sedation), sleep (pharmacological hypnosis), decreased anxiety, and amnesia (no memory of events while under the influence of the substance)

Rohypnol can also cause:

- Increased or decreased reaction time, impaired mental functioning and judgment, confusion, aggression, and excitability

What is its effect on the body?

Rohypnol causes muscle relaxation. Adverse physical effects include:

- Slurred speech, loss of motor coordination, weakness, headache, and respiratory depression

Rohypnol also can produce physical dependence when taken regularly over a period of time.

What are its overdose effects?

High doses of Rohypnol, particularly when combined with CNS depressant drugs such as alcohol and heroin, can cause severe sedation, unconsciousness, slow heart rate, and suppression of respiration that may be sufficient to result in death.

Which drugs cause similar effects?

Drugs that cause similar effects include GHB (gamma hydroxybutyrate) and other benzodiazepines such as alprazolam (e.g., Xanax), clonazepam (e.g., Klonopin), and diazepam (e.g., Valium).

What is its legal status in the United States?

Rohypnol is a Schedule IV substance under the Controlled Substances Act. Rohypnol is not approved for manufacture, sale, use, or importation to the United States. It is legally manufactured and marketed in many countries. Penalties for possession, trafficking, and distribution involving one gram or more are the same as those of a Schedule I drug.

Blister pack of Rohypnol tablets

VII. Hallucinogens

WHAT ARE HALLUCINOGENS?

Hallucinogens are found in plants and fungi or are synthetically produced and are among the oldest known group of drugs used for their ability to alter human perception and mood.

WHAT IS THEIR ORIGIN?

Hallucinogens can be synthetically produced in illicit laboratories or are found in plants.

MDMA/Ecstasy pills

LSD Blotter Sheet

What are common street names?

Common street names include:

- Acid, Blotter, Blotter Acid, Cubes, Doses, Fry, Mind Candy, Mushrooms, Shrooms, Special K, STP, X, and XTC

What do they look like?

Hallucinogens come in a variety of forms. MDMA or ecstasy tablets are sold in many colors with a variety of logos to attract youth. LSD is sold in the form of impregnated paper (blotter acid), typically imprinted with colorful graphic designs.

How are they abused?

The most commonly abused hallucinogens among junior and senior high school students are hallucinogenic mushrooms, LSD, and MDMA (ecstasy). Hallucinogens are typically taken orally or can be smoked.

What is their effect on the mind?

Sensory effects include perceptual distortions that vary with dose, setting, and mood. Psychic effects include distortions of thought associated with time and space. Time may appear to stand still, and forms and

LSD powder and capsules

colors seem to change and take on new significance. Weeks or even months after some hallucinogens have been taken, the user may experience flashbacks — fragmentary recurrences of certain aspects of the drug experience in the absence of actually taking the drug. The occurrence of a flashback is unpredictable, but is more likely to occur during times of stress and seems to occur more frequently in younger individuals. With time, these episodes diminish and become less intense.

What is their effect on the body?

Physiological effects include elevated heart rate, increased blood pressure, and dilated pupils.

What are their overdose effects?

Deaths exclusively from acute overdose of LSD, magic mushrooms, and mescaline are extremely rare. Deaths generally occur due to suicide, accidents, and dangerous behavior, or due to the person inadvertently eating poisonous plant material.

A severe overdose of PCP and ketamine can result in:

- Respiratory depression, coma, convulsions, seizures, and death due to respiratory arrest

What is their legal status in the United States?

Many hallucinogens are Schedule I under the Controlled Substances Act, meaning that they have a high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety for use under medical supervision.

Ecstasy/MDMA

WHAT IS ECSTASY/MDMA?

MDMA acts as both a stimulant and psychedelic, producing an energizing effect, distortions in time and perception, and enhanced enjoyment of tactile experiences.

Adolescents and young adults use it to reduce inhibitions and to promote:

- Euphoria, feelings of closeness, empathy, and sexuality

Although MDMA is known among users as ecstasy, researchers have determined that many ecstasy tablets contain not only MDMA but also a number of other drugs or drug combinations that can be harmful, such as:

- Methamphetamine, ketamine, cocaine, the over-the-counter cough suppressant dextromethorphan (DXM), the diet drug ephedrine, and caffeine

In addition, other drugs similar to MDMA, such as MDA or PMA, are often sold as ecstasy, which can lead to overdose and death when the user takes additional doses to obtain the desired effect.

WHAT IS ITS ORIGIN?

MDMA is a synthetic chemical made in labs. Seized MDMA in the U.S. is primarily manufactured in, and smuggled across our borders from, clandestine laboratories in Canada and, to a lesser extent, the Netherlands. A small number of MDMA clandestine laboratories have also been identified operating in the U.S.

What are common street names?

Common street names include:

- Adam, Beans, Clarity, Disco Biscuit, E, Ecstasy, Eve, Go, Hug Drug, Lover's Speed, MDMA, Peace, STP, X, and XTC

What does it look like?

MDMA is mainly distributed in tablet form. MDMA tablets are sold with logos, creating brand names for users to seek out. The colorful pills are often hidden among colorful candies. MDMA is also distributed in capsules, powder, and liquid forms.

How is it abused?

MDMA use mainly involves swallowing tablets (50-150 mg), which are sometimes crushed and snorted, occasionally smoked but rarely injected. MDMA is also available as a powder.

MDMA users usually take MDMA by "stacking" (taking three or more tablets at once) or by "piggy-backing" (taking a series of tablets over a short period of time). One trend among young adults is "candy flipping," which is the co-abuse of MDMA and LSD.

MDMA is considered a "party drug." As with many other drugs of abuse, MDMA is rarely used alone. It is common for users to mix MDMA with other substances, such as alcohol and marijuana.

What is its effect on the mind?

MDMA mainly affects brain cells that use the chemical serotonin to communicate with each other. Serotonin helps to regulate mood, aggression, sexual activity, sleep, and sensitivity to pain. Clinical studies suggest that MDMA may increase the risk of long-term, perhaps permanent, problems with memory and learning.

MDMA causes changes in perception, including euphoria and increased sensitivity to touch, energy, sensual and sexual arousal, need to be touched, and need for stimulation.

Some unwanted psychological effects include:

- Confusion, anxiety, depression, paranoia, sleep problems, and drug craving

All these effects usually occur within 30 to 45 minutes of swallowing the drug and usually last 4 to 6 hours, but they may occur or last weeks after ingestion.

What is its effect on the body? Users of MDMA experience many of the same effects and face many of the same risks as users of other stimulants such as cocaine and amphetamines. These include increased motor activity, alertness, heart rate, and blood pressure.

MDMA/Ecstasy pills

Some unwanted physical effects include:

- Muscle tension, tremors, involuntary teeth clenching, muscle cramps, nausea, faintness, chills, sweating, and blurred vision

High doses of MDMA can interfere with the ability to regulate body temperature, resulting in a sharp increase in body temperature (hyperthermia), leading to liver, kidney, and cardiovascular failure.

Severe dehydration can result from the combination of the drug's effects and the crowded and hot conditions in which the drug is often taken.

Studies suggest chronic use of MDMA can produce damage to the serotonin system. It is ironic that a drug that is taken to increase pleasure may cause damage that reduces a person's ability to feel pleasure.

What are its overdose effects?

In high doses, MDMA can interfere with the body's ability to regulate temperature. On occasions, this can lead to a sharp increase in body temperature (hyperthermia), resulting in liver, kidney, and cardiovascular system failure, and death. Because MDMA can interfere with its own metabolism (that is, its breakdown within the body), potentially harmful levels can be reached by repeated drug use within short intervals.

Which drugs cause similar effects?

MDMA produces both amphetamine-like stimulation and mild mescaline-like hallucinations.

What is its legal status in the United States?

MDMA is a Schedule I drug under the Controlled Substances Act, meaning it has a high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety for use under medical supervision.

Ketamine

WHAT IS KETAMINE?

Ketamine is a dissociative anesthetic that has some hallucinogenic effects. It distorts perceptions of sight and sound and makes the user feel disconnected and not in control. It is an injectable, short-acting anesthetic for use in humans and animals. It is referred to as a "dissociative anesthetic" because it makes patients feel detached from their pain and environment.

Ketamine can induce a state of sedation (feeling calm and relaxed), immobility, relief from pain, and amnesia (no memory of events while under the influence of the drug). It is abused for its ability to produce dissociative sensations and hallucinations. Ketamine has also been used to facilitate sexual assault.

WHAT IS ITS ORIGIN?

Ketamine is produced commercially in a number of countries, including the United States. Most of the ketamine illegally distributed in the United States is diverted or stolen from legitimate sources, particularly veterinary clinics, or smuggled into the United States from Mexico.

Distribution of ketamine typically occurs among friends and acquaintances, most often at raves, nightclubs, and at private parties; street sales of ketamine are rare.

What are common street names?

Common street names include:

- Cat Tranquilizer, Cat Valium, Jet K, Kit Kat, Purple, Special K, Special La Coke, Super Acid, Super K, and Vitamin K

What does it look like?

Ketamine comes in a clear liquid and a white or off-white powder. Powdered ketamine (100 milligrams to 200 milligrams) typically is packaged in small glass vials, small plastic bags, and capsules as well as paper, glassine, or aluminum foil folds.

Vials containing liquid ketamine

How is it abused?

Ketamine, along with the other "club drugs," has become popular among teens and young adults at dance clubs and "raves." Ketamine is manufactured commercially as a powder or liquid. Powdered ketamine is also formed from pharmaceutical ketamine by evaporating the liquid using hot plates, warming trays, or microwave ovens, a process that results in the formation of crystals, which are then ground into powder.

Powdered ketamine is cut into lines known as bumps and snorted, or it is smoked, typically in marijuana or tobacco cigarettes. Liquid ketamine is injected or mixed into drinks. Ketamine is found by itself or often in combination with MDMA, amphetamine, methamphetamine, or cocaine.

What is its effect on the mind?

Ketamine produces hallucinations. It distorts perceptions of sight and sound and makes the user feel disconnected and not in control. A "Special K" trip is touted as better than that of LSD or PCP because its hallucinatory effects are relatively short in duration, lasting approximately 30 to 60 minutes as opposed to several hours.

Slang for experiences related to Ketamine or effects of ketamine include:

- "K-land" (refers to a mellow & colorful experience)
- "K-hole" (refers to the out-of-body, near death experience)
- "Baby food" (users sink in to blissful, infantile inertia)
- "God" (users are convinced that they have met their maker)

The onset of effects is rapid and often occurs within a few minutes of taking the drug, though taking it orally results in a slightly slower onset of effects. Flashbacks have been reported several weeks after ketamine is used. Ketamine may also cause agitation, depression, cognitive difficulties, unconsciousness, and amnesia.

What is its effect on the body?

A couple of minutes after taking the drug, the user may experience an increase in heart rate and blood pressure that gradually decreases over the next 10 to 20 minutes. Ketamine can make users unresponsive to stimuli. When in this state, users experience:

- Involuntarily rapid eye movement, dilated pupils, salivation, tear secretions, and stiffening of the muscles

This drug can also cause nausea.

What are its overdose effects?

An overdose can cause unconsciousness and dangerously slowed breathing.

Which drugs cause similar effects?

Other hallucinogenic drugs such as LSD, PCP, and mescaline can cause hallucinations. There are also several drugs such as GHB, Rohypnol, and other depressants that are misused for their amnesiac or sedative properties to facilitate sexual assault.

Ketamine in various forms

What is its legal status in the United States?

Since the 1970s, ketamine has been marketed in the United States as an injectable, short-acting anesthetic for use in humans and animals. In 1999, ketamine including its salts, isomers and salts of isomers, became a Schedule III non-narcotic substance under the Controlled Substances Act. It has a currently accepted medical use but some potential for abuse, which may lead to moderate or low physical dependence or high psychological dependence.

LSD

WHAT IS LSD?

LSD is a potent hallucinogen that has a high potential for abuse and currently has no accepted medical use in treatment in the United States.

WHAT IS ITS ORIGIN?

LSD is produced in clandestine laboratories in the United States.

What are common street names?

Common names for LSD include:

- Acid, Blotter Acid, Dots, Mellow Yellow, and Window Pane

What does it look like?

LSD is sold on the street in tablets, capsules, and occasionally in liquid form. It is an odorless and colorless substance with a slightly bitter taste. LSD is often added to absorbent paper, such as blotter paper, and divided into small decorated squares, with each square representing one dose.

How is it abused?

LSD is abused orally.

What is its effect on the mind?

During the first hour after ingestion, users may experience visual changes with extreme changes in mood. While hallucinating, the user may suffer impaired depth and time perception accompanied by distorted perception of the shape and size of objects, movements, colors, sound, touch, and the user's own body image.

The ability to make sound judgments and see common dangers is impaired, making the user susceptible to personal injury. It is possible for users to suffer acute anxiety and depression after an LSD "trip" and flashbacks have been reported days, and even months, after taking the last dose.

LSD powder

What is its effect on the body?

The physical effects include:

- Dilated pupils, higher body temperature, increased heart rate and blood pressure, sweating, loss of appetite, sleeplessness, dry mouth, and tremors

What are its overdose effects?

Longer, more intense "trip" episodes, psychosis, and possible death

Which drugs cause similar effects?

LSD's effects are similar to other hallucinogens, such as PCP, mescaline, and peyote.

What is its legal status in the United States?

LSD is a Schedule I substance under the Controlled Substances Act. Schedule I substances have a high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety for use under medical supervision.

Peyote & Mescaline

WHAT ARE PEYOTE AND MESCALINE?

Peyote is a small, spineless cactus. The active ingredient in peyote is the hallucinogen mescaline.

WHAT IS ITS ORIGIN?

From earliest recorded time, peyote has been used by natives in northern Mexico and the southwestern United States as a part of their religious rites. Mescaline can be extracted from peyote or produced synthetically.

What are common street names?

Common street names include:

- Buttons, Cactus, Mesc, and Peyoto

What does it look like?

The top of the peyote cactus is referred to as the "crown" and consists of disc-shaped buttons that are cut off.

How is it abused?

The fresh or dried buttons are chewed or soaked in water to produce an intoxicating liquid. Peyote buttons may also be ground into a powder that can be placed inside gelatin capsules to be swallowed, or smoked with a leaf material such as cannabis or tobacco.

What is its effect on the mind?

Abuse of peyote and mescaline will cause varying degrees of:

- Illusions, hallucinations, altered perception of space and time, and altered body image

Users may also experience euphoria, which is sometimes followed by feelings of anxiety.

What is its effect on the body?

Following the consumption of peyote and mescaline, users may experience:

- Intense nausea, vomiting, dilation of the pupils, increased heart rate, increased blood pressure, a rise in body temperature that causes heavy perspiration, headaches, muscle weakness, and impaired motor coordination

Which drugs cause similar effects?

Other hallucinogens like LSD, psilocybin (mushrooms), and PCP

What is its legal status in the United States?

Peyote and mescaline are Schedule I substances under the Controlled Substances Act, meaning that they have a high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety for use under medical supervision.

Peyote cactus

Psilocybin

WHAT IS PSILOCYBIN?

Psilocybin is a chemical obtained from certain types of fresh or dried mushrooms.

WHAT IS ITS ORIGIN?

Psilocybin mushrooms are found in Mexico, Central America, and the United States.

What are common street names?

Common street names include:

- Magic Mushrooms, Mushrooms, and Shrooms

What does it look like?

Mushrooms containing psilocybin are available fresh or dried and have long, slender stems topped by caps with dark gills on the underside. Fresh mushrooms have white or whitish-gray stems; the caps are dark brown around the edges and light brown or white in the center. Dried mushrooms are usually rusty brown with isolated areas of off-white.

How is it abused?

Psilocybin mushrooms are ingested orally. They may also be brewed as a tea or added to other foods to mask their bitter flavor.

What is its effect on the mind?

The psychological consequences of psilocybin use include hallucinations and an inability to discern fantasy from reality. Panic reactions and psychosis also may occur, particularly if a user ingests a large dose.

Psilocybin mushrooms

What is its effect on the body?

The physical effects include:

- Nausea, vomiting, muscle weakness, and lack of coordination

What are its overdose effects?

Effects of overdose include:

- Longer, more intense "trip" episodes, psychosis, and possible death

Abuse of psilocybin mushrooms could also lead to poisoning if one of the many varieties of poisonous mushrooms is incorrectly identified as a psilocybin mushroom.

Which drugs cause similar effects?

Psilocybin effects are similar to other hallucinogens, such as mescaline and peyote.

What is its legal status in the United States?

Psilocybin is a Schedule I substance under the Controlled Substances Act, meaning that it has a high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety for use under medical supervision.

VIII. Marijuana/Cannabis

WHAT IS MARIJUANA?

Marijuana is a mind-altering (psychoactive) drug, produced by the Cannabis sativa plant. Marijuana contains over 480 constituents. THC (delta-9-tetrahydrocannabinol) is believed to be the main ingredient that produces the psychoactive effect.

WHAT IS ITS ORIGIN?

Marijuana is grown in the United States, Canada, Mexico, South America, Caribbean, and Asia. It can be cultivated in both outdoor and indoor settings.

What are common street names?

Common street names include:

- Aunt Mary, BC Bud, Blunts, Boom, Chronic, Dope, Gangster, Ganja, Grass, Hash, Herb, Hydro, Indo, Joint, Kif, Mary Jane, Mota, Pot, Reefer, Sinsemilla, Skunk, Smoke, Weed, and Yerba

What does it look like?

Marijuana is a dry, shredded green/brown mix of flowers, stems, seeds, and leaves from the Cannabis sativa plant. The mixture typically is green, brown, or gray in color and may resemble tobacco.

How is it abused?

Marijuana is usually smoked as a cigarette (called a joint) or in a pipe or bong. It is also smoked in blunts, which are cigars that have been emptied of tobacco and refilled with marijuana, sometimes in combination with another drug. Marijuana is also mixed with foods or brewed as a tea.

What is its effect on the mind?

When marijuana is smoked, the THC passes from the lungs and into the bloodstream, which carries the chemical to the organs throughout the body, including the brain. In the brain, the THC connects to specific sites called cannabinoid receptors on nerve cells and influences the activity of those cells.

Many of these receptors are found in the parts of the brain that influence:

- Pleasure, memory, thought, concentration, sensory and time perception, and coordinated movement

The short-term effects of marijuana include:

- Problems with memory and learning, distorted perception, difficulty in thinking and problem-solving, and loss of coordination

The effect of marijuana on perception and coordination are responsible for serious impairments in learning, associative processes, and psychomotor behavior (driving abilities). Long term, regular use can lead to physical dependence and withdrawal following discontinuation, as well as psychic addiction or dependence.

Clinical studies show that the physiological, psychological, and behavioral effects of marijuana vary among individuals and present a list of common responses to cannabinoids, as described in the scientific literature:

- Dizziness, nausea, tachycardia, facial flushing, dry mouth, and tremor initially
- Merriment, happiness, and even exhilaration at high doses
- Disinhibition, relaxation, increased sociability, and talkativeness
- Enhanced sensory perception, giving rise to increased appreciation of music, art, and touch

- Heightened imagination leading to a subjective sense of increased creativity
- Time distortions
- Illusions, delusions, and hallucinations are rare except at high doses
- Impaired judgment, reduced coordination, and ataxia, which can impede driving ability or lead to an increase in risk-taking behavior
- Emotional lability, incongruity of affect, dysphoria, disorganized thinking, inability to converse logically, agitation, paranoia, confusion, restlessness, anxiety, drowsiness, and panic attacks may occur, especially in inexperienced users or in those who have taken a large dose
- Increased appetite and short-term memory impairment are common

What is its effect on the body?

Short-term physical effects from marijuana use may include:

- Sedation, bloodshot eyes, increased heart rate, coughing from lung irritation, increased appetite, and decreased blood pressure

Marijuana smokers experience serious health problems such as bronchitis, emphysema, and bronchial asthma. Extended use may cause suppression of the immune system. Withdrawal from chronic use of high doses of marijuana causes physical signs including headache, shakiness, sweating, and stomach pains and nausea.

Withdrawal symptoms also include behavioral signs such as:

- Restlessness, irritability, sleep difficulties, and decreased appetite

What are its overdose effects?

No deaths from overdose of marijuana have been reported.

Which drugs cause similar effects?

Hashish and hashish oil are drugs made from the cannabis plant that are like marijuana, only stronger.

Hashish (hash) consists of the THC-rich resinous material of the cannabis plant, which is collected, dried, and then compressed into a variety of forms, such as balls, cakes, or cookie like sheets. Pieces are then broken off, placed in pipes or mixed with tobacco and placed in pipes or cigarettes, and smoked.

Leaf of marijuana plant

The main sources of hashish are the Middle East, North Africa, Pakistan, and Afghanistan.

Hashish Oil (hash oil, liquid hash, cannabis oil) is produced by extracting the cannabinoids from the plant material with a solvent. The color and odor of the extract will vary, depending on the solvent used. A drop or two of this liquid on a cigarette is equal to a single marijuana joint. Like marijuana, hashish and hashish oil are both Schedule I drugs.

What is its legal status in the United States?

Marijuana is a Schedule I substance under the Controlled Substances Act, meaning that it has a high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety for use under medical supervision.

Although some states within the United States have allowed the use of marijuana for medicinal purpose, it is the U.S. Food and Drug Administration that has the federal authority to approve drugs for medicinal use in the U.S. To date, the FDA has not approved a marketing application for any marijuana product for any clinical indication. Consistent therewith, the FDA and DEA have concluded that marijuana has no federally approved medical use for treatment in the U.S. and thus it remains as a Schedule I controlled substance under federal law.

Marinol, a synthetic version of THC, the active ingredient found in the marijuana plant, can be prescribed for the control of nausea and vomiting caused by chemotherapeutic agents used in the treatment of cancer and to stimulate appetite in AIDS patients. Marinol is a Schedule III substance under the Controlled Substances Act.

Marijuana Concentrates

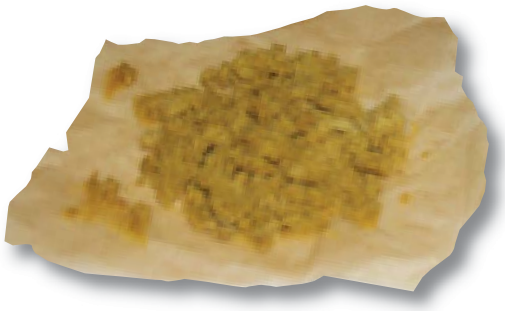
Also Known As: THC Extractions

WHAT ARE MARIJUANA CONCENTRATES?

A marijuana concentrate is a highly potent THC concentrated mass that is most similar in appearance to either honey or butter, which is why it is referred to or known on the street as "honey oil" or "budder."

WHAT IS ITS ORIGIN?

Marijuana concentrates contain extraordinarily high THC levels that could range from 40 to 80 percent. This form of marijuana can be up to four times stronger in THC content than high grade or top shelf marijuana, which normally measures around 20 percent THC levels.



Marijuana concentrate

Many methods are utilized to convert or "manufacture" marijuana into marijuana concentrates. One method is the butane extraction process. This process is particularly dangerous because it uses highly flammable butane to extract the THC from the cannabis plant. Given the extremely volatile nature of butane, this process has resulted in violent explosions. THC extraction labs are being reported nationwide, particularly in the western states and in states where local and state marijuana laws are more relaxed.

What are common street names?

Common street names include:

- 710 (the word "OIL" flipped and spelled backwards), wax, ear wax, honey oil, budder, butane hash oil, butane honey oil (BHO), shatter, dabs (dabbing), black glass, and errl.

What does it look like?

Marijuana concentrates are similar in appearance to honey or butter and are either brown or gold in color.

Marijuana concentrate

How is it abused?

One form of abuse occurs orally by infusing marijuana concentrates in various food or drink products; however, smoking remains the most popular form of ingestion by use of water or oil pipes. A disturbing aspect of this emerging threat is the ingestion of concentrates via electronic cigarettes (also known as e-cigarettes) or vaporizers. Many users of marijuana concentrates prefer the e-cigarette/vaporizer because it's smokeless, odorless, and easy to hide or conceal. The user takes a small amount of marijuana concentrate, referred to as a "dab," then heats the substance using the e-cigarette/vaporizer producing vapors that ensures an instant "high" effect upon the user. Using an e-cigarette/vaporizer to ingest marijuana concentrates is commonly referred to as "dabbing" or "vaping."

What are the Effects of Using Marijuana Concentrates?

Being a highly concentrated form of marijuana, the effects upon the user may be more psychologically and physically intense than plant marijuana use. To date, long term effects of marijuana concentrate use are not yet fully known; but, the effects of plant marijuana use are known. These effects include paranoia, anxiety, panic attacks, and hallucinations. Additionally, the use of plant marijuana increases one's heart rate and blood pressure. Plant marijuana users may also experience withdrawal and addiction problems.

IX. Steroids

WHAT ARE STEROIDS?

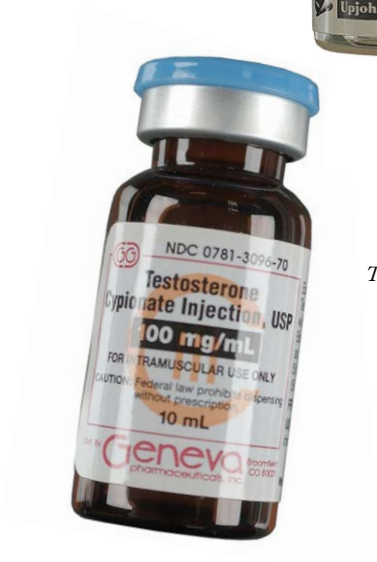
Anabolic steroids are synthetically produced variants of the naturally occurring male hormone testosterone that are abused in an attempt to promote muscle growth, enhance athletic or other physical performance, and improve physical appearance.

Testosterone, nandrolone, stanozolol, methandienone, and boldenone are some of the most frequently abused anabolic steroids.

WHAT IS THEIR ORIGIN?

Most illicit steroids are smuggled into the U.S. from abroad. Steroids are also illegally diverted from legitimate sources (theft or inappropriate prescribing). The Internet is the most widely used means of buying and selling anabolic steroids. Steroids are also bought and sold at gyms, bodybuilding competitions, and schools from teammates, coaches, and trainers.

Depo-Testosterone



Testosternone Cypionate Injection, USB

What are common street names?

Common street names include:

- Arnolds, Juice, Pumpers, Roids, Stackers, and Weight Gainers

What do they look like?

Steroids are available in:

- Tablets and capsules, sublingual-tablets, liquid drops, gels, creams, transdermal patches, subdermal implant pellets, and water-based and oil-based injectable solutions

The appearance of these products varies depending on the type and manufacturer.

How are they abused?

Steroids are ingested orally, injected intramuscularly, or applied to the skin. The doses abused are often 10 to 100 times higher than the approved therapeutic and medical treatment dosages. Users typically take two or more anabolic steroids at the same time in a cyclic manner, believing that this will improve their effectiveness and minimize the adverse effects.

What is their effect on the mind?

Case studies and scientific research indicate that high doses of anabolic steroids may cause mood and behavioral effects.

In some individuals, steroid use can cause dramatic mood swings, increased feelings of hostility, impaired judgment, and increased levels of aggression (often referred to as "roid rage").

When users stop taking steroids, they may experience depression that may be severe enough to lead one to commit suicide. Anabolic steroid use may also cause psychological dependence and addiction.

What is their effect on the body?

A wide range of adverse effects is associated with the use or abuse of anabolic steroids. These effects depend on several factors including:

- Age, sex, the anabolic steroid used, amount used, and duration of use

In adolescents, anabolic steroid use can stunt the ultimate height that an individual achieves.

In boys, steroid use can cause early sexual development, acne, and stunted growth.

In adolescent girls and women, anabolic steroid use can induce permanent physical changes, such as deepening of the voice, increased facial and body hair growth, menstrual irregularities, male pattern baldness, and lengthening of the clitoris.

In men, anabolic steroid use can cause shrinkage of the testicles, reduced sperm count, enlargement of the male breast tissue, sterility, and an increased risk of prostate cancer.

In both men and women, anabolic steroid use can cause high cholesterol levels, which may increase the risk of coronary artery disease, strokes, and heart attacks. Anabolic steroid use can also cause acne and fluid retention. Oral preparations of anabolic steroids, in particular, can damage the liver.

Users who inject steroids run the risk of contracting various infections due to non-sterile injection techniques, sharing of contaminated needles, and the use of steroid preparations manufactured in non-sterile environments. All these factors put users at risk for contracting viral infections such as HIV/AIDS or hepatitis B or C, and bacterial infections at the sight of injection.

Users may also develop endocarditis, a bacterial infection that causes a potentially fatal inflammation of the heart lining.

What are their overdose effects?

Anabolic steroids are not associated with overdoses. The adverse effects a user would experience develop from the use of steroids over time.

Which drugs cause similar effects?

There are several substances that produce effects similar to those of anabolic steroids. These include human growth hormone (hHG), clenbuterol, gonadotropins, and erythropoietin.

What is their legal status in the United States?

Anabolic steroids are Schedule III substances under the Controlled Substances Act. Only a small number of anabolic steroids are approved for either human or veterinary use. Steroids may be prescribed by a licensed physician for the treatment of testosterone deficiency, delayed puberty, low red blood cell count, breast cancer, and tissue wasting resulting from AIDS.

X. Inhalants

WHAT ARE INHALANTS?

Inhalants are invisible, volatile substances found in common household products that produce chemical vapors that are inhaled to induce psychoactive or mind altering effects.

WHAT IS THEIR ORIGIN?

There are more than 1,000 products that are very dangerous when inhaled — things like typewriter correction fluid, air conditioning refrigerant, felt tip markers, spray paint, air freshener, butane, and even cooking spray. See products abused as inhalants at www.inhalants.org/product.htm (National Inhalant Prevention Coalition).

Highlighter markers

Paint thinner

What are common street names?

Common street names include:

- Gluey, Huff, Rush, and Whippets

What do they look like?

Common household products such as glue, lighter fluid, cleaning fluids, and paint all produce chemical vapors that can be inhaled.

How are they abused?

Although other abused substances can be inhaled, the term "inhalants" is used to describe a variety of substances whose main common characteristic is that they are rarely, if ever, taken by any route other than inhalation.

Inhalants are breathed in through the nose or the mouth in a variety of ways, such as:

- "Sniffing" or "snorting"
- "Bagging" — sniffing or inhaling fumes from substances sprayed or deposited inside a plastic or paper bag
- "Huffing" from an inhalant-soaked rag stuffed in the mouth, or inhaling from balloons filled with nitrous oxide

Inhalants are often among the first drugs that young children use. About 1 in 5 kids report having used inhalants by the eighth grade. Inhalants are also one of the few substances abused more by younger children than by older ones.

What is their effect on the mind?

Inhalant abuse can cause damage to the parts of the brain that control thinking, moving, seeing, and hearing. Cognitive abnormalities can range from mild impairment to severe dementia.

What is their effect on the body?

Inhaled chemicals are rapidly absorbed through the lungs into the bloodstream and quickly distributed to the brain and other organs. Nearly all inhalants produce effects similar to anesthetics, which slow down the body's function. Depending on the degree of abuse, the user can experience slight stimulation, feeling of less inhibition, or loss of consciousness.

Within minutes of inhalation, the user experiences intoxication along with other effects similar to those produced by alcohol. These effects may include slurred speech, an inability to coordinate movements, euphoria, and dizziness. After heavy use of inhalants, users may feel drowsy for several hours and experience a lingering headache.

Additional symptoms exhibited by long-term inhalant users include:

- Weight loss, muscle weakness, disorientation, inattentiveness, lack of coordination, irritability, depression, and damage to the nervous system and other organs

Some of the damaging effects to the body may be at least partially reversible when inhalant abuse is stopped; however, many of the effects from prolonged abuse are irreversible.

Prolonged sniffing of the highly concentrated chemicals in solvents or aerosol sprays can induce irregular and rapid heart rhythms and lead to heart failure and death within minutes. There is a common link between inhalant use and problems in school — failing grades, chronic absences, and general apathy.

Other signs include:

- Paint or stains on body or clothing; spots or sores around the mouth; red or runny eyes or nose; chemical breath odor; drunk, dazed, or dizzy appearance; nausea; loss of appetite; anxiety; excitability; and irritability

What are their overdose effects?

Because intoxication lasts only a few minutes, users try to prolong the high by continuing to inhale repeatedly over the course of several hours, which is a very dangerous practice. With successive inhalations, users may suffer loss of consciousness and/or death.

"Sudden sniffing death" can result from a single session of inhalant use by an otherwise healthy young person. Sudden sniffing death is particularly associated with the abuse of butane, propane, and chemicals in aerosols.

Inhalant abuse can also cause death by asphyxiation from repeated inhalations, which lead to high concentrations of inhaled fumes displacing the available oxygen in the lungs, suffocation by blocking air from entering the lungs when inhaling fumes from a plastic bag placed over the head, and choking from swallowing vomit after inhaling substances.

Which drugs cause similar effects?

Most inhalants produce a rapid high that is similar to the effects of alcohol intoxication.

What is their legal status in the United States?

The common household products that are misused as inhalants are legally available for their intended and legitimate uses. Many state legislatures have attempted to deter youth who buy legal products to get high by placing restriction on the sale of these products to minors.

Even though some substances are not currently controlled by the Controlled Substances Act, they pose risks to individuals who abuse them. The following section describes these drugs of concern and their associated risks.

XI. Drugs of Concern

Even though some substances are not currently controlled by the Controlled Substances Act, they pose risks to individuals who abuse them. The following section describes these drugs of concern and their associated risks.

DXM

WHAT IS DXM?

DXM is a cough suppressor found in more than 120 over-the-counter (OTC) cold medications, either alone or in combination with other drugs such as analgesics (e.g., acetaminophen), antihistamines (e.g., chlorpheniramine), decongestants (e.g., pseudoephedrine), and/or expectorants (e.g., guaifenesin). The typical adult dose for cough is 15 or 30 mg taken three to four times daily. The cough-suppressing effects of DXM persist for 5 to 6 hours after ingestion. When taken as directed, side effects are rarely observed.

WHAT IS ITS ORIGIN?

DXM users can obtain the drug at almost any pharmacy or supermarket, seeking out the products with the highest concentration of the drug from among all the OTC cough and cold remedies that contain it. DXM products and powder can also be purchased on the Internet.

DXM powder

What are common street names?

Common street names include:

- CCC, Dex, DXM, Poor Man's PCP, Robo, Rojo, Skittles, Triple C, and Velvet

What does it look like?

DXM can come in the form of:

- Cough syrup, tablets, capsules, or powder

How is it abused?

DXM is abused in high doses to experience euphoria and visual and auditory hallucinations. Users take various amounts depending on their body weight and the effect they are attempting to achieve. Some users ingest 250 to 1,500 milligrams in a single dosage, far more than the recommended therapeutic dosages described above.

Illicit use of DXM is referred to on the street as "Robo-tripping," "skittling," or "dexing." The first two terms are derived from the products that are most commonly abused, Robitussin and Coricidin HBP. DXM abuse has traditionally involved drinking large volumes of the OTC liquid cough preparations. More recently, however, abuse of tablet and gel capsule preparations has increased.

These newer, high-dose DXM products have particular appeal for users. They are much easier to consume, eliminate the need to drink large volumes of unpleasant-tasting syrup, and are easily portable and concealed, allowing an abuser to continue to abuse DXM throughout the day, whether at school or work.

DXM powder, sold over the Internet, is also a source of DXM for abuse. (The powdered form of DXM poses additional risks to the user due to the uncertainty of composition and dose.)

DXM is also distributed in illicitly manufactured tablets containing

only DXM or mixed with other drugs such as pseudoephedrine and/or methamphetamine.

DXM is abused by individuals of all ages, but its abuse by teenagers and young adults is of particular concern. This abuse is fueled by DXM's OTC availability and extensive "how to" abuse information on various websites.

What is its effect on the mind?

Some of the many psychoactive effects associated with high-dose DXM include:

Confusion, inappropriate laughter, agitation, paranoia, and hallucinations

Other sensory changes, including the feeling of floating and changes in hearing and touch

Long-term abuse of DXM is associated with severe psychological dependence. Abusers of DXM describe the following four dose-dependent "plateaus":

PLATEAU	DOSE (MG)	BEHAVIORAL EFFECTS
1st	100 - 200	Mild stimulation
2nd	200 - 400	Euphoria and hallucinations
3rd	300 - 600	Distorted visual perceptions Loss of motor coordination
4th	500 - 1500	Out-of-body sensations

What is its effect on the body?

DXM intoxication involves:

Over-excitability, lethargy, loss of coordination, slurred speech, sweating, hypertension, and involuntary spasmodic movement of the eyeballs

The use of high doses of DXM in combination with alcohol or other drugs is particularly dangerous, and deaths have been reported. Approximately 5-10 percent of Caucasians are poor DXM metabolizers and at increased risk for overdoses and deaths. DXM taken with antidepressants can be life threatening.

OTC products that contain DXM often contain other ingredients such as acetaminophen, chlorpheniramine, and guaifenesin that have their own effects, such as:

- Liver damage, rapid heart rate, lack of coordination, vomiting, seizures, and coma

To circumvent the many side effects associated with these other ingredients, a simple chemical extraction procedure has been developed and published on the Internet that removes most of these other ingredients in cough syrup.

What are its overdose effects?

DXM overdose can be treated in an emergency room setting and generally does not result in severe medical consequences or death. 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.

Which drugs cause similar effects?

Depending on the dose, DXM can have effects similar to marijuana or ecstasy. In high doses its out-of-body effects are similar to those of ketamine or PCP.

What is its legal status in the United States?

DXM is a legally marketed cough suppressant that is neither a controlled substance nor a regulated chemical under the Controlled Substances Act.

Kratom

WHAT IS KRATOM?

Kratom is a tropical tree native to Southeast Asia. Consumption of its leaves produces both stimulant effects (in low doses) and sedative effects (in high doses), and can lead to psychotic symptoms, and psychological and physiological dependence. The psychoactive ingredient is found in the leaves from the kratom tree. These leaves are subsequently crushed and then smoked, brewed with tea, or placed into gel capsules. Kratom has a long history of use in Southeast Asia, where it is commonly known as thang, kakuam, thom, ketum, and biak. In the U.S., the abuse of kratom has increased markedly in recent years.

How is it abused?

Mostly abused by oral ingestion in the form of a tablet, capsule, or extract. Kratom leaves may also be dried or powdered and ingested as a tea, or the kratom leaf may be chewed.

What are the effects?

At low doses, kratom produces stimulant effects with users reporting increased alertness, physical energy, and talkativeness. At high doses, users experience sedative effects. Kratom consumption can lead to addiction.

Several cases of psychosis resulting from use of kratom have been reported, where individuals addicted to kratom exhibited psychotic symptoms, including hallucinations, delusion, and confusion.

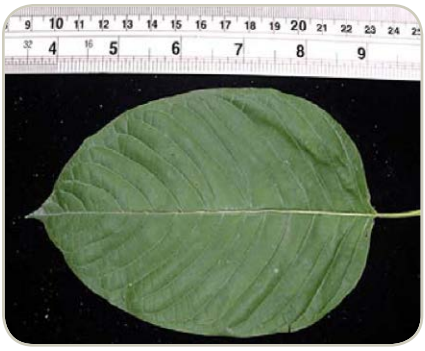
What does it do to your body?

Kratom's effects on the body include nausea, itching, sweating, dry mouth, constipation, increased urination, tachycardia, vomiting, drowsiness, and loss of appetite. Users of kratom have also experienced anorexia, weight loss, insomnia, hepatotoxicity, seizure, and hallucinations.

What is its legal status?

Kratom is not controlled under the Federal Controlled Substances Act; however, there may be some state regulations or prohibitions against the possession and use of kratom. The FDA has not approved Kratom for any medical use. In addition, DEA has listed kratom as a Drug and Chemical of Concern.

Kratom tree



Leaf of kratom tree

Kratom capsules

Salvia Divinorum

WHAT IS SALVIA DIVINORUM?

Salvia divinorum is a perennial herb in the mint family that is abused for its hallucinogenic effects.

WHAT IS ITS ORIGIN?

Salvia is native to certain areas of the Sierra Mazaleca region of Oaxaca, Mexico. It is one of several plants that are used by Mazatec Indians for ritual divination. Salvia divinorum plants can be grown successfully outside of this region. They can be grown indoors and outdoors, especially in humid semitropical climates.

What are common street names?

Common street names include:

- Maria Pastora, Sally-D, and Salvia

What does it look like?

The plant has spade-shaped variegated green leaves that look similar to mint. The plants themselves grow to more than three feet high, have large green leaves, hollow square stems, and white flowers with purple calyces.

How is it abused?

Salvia can be chewed, smoked, or vaporized.

What is its effect on the mind?

Psychic effects include perceptions of bright lights, vivid colors, shapes, and body movement, as well as body or object distortions. Salvia divinorum may also cause fear and panic, uncontrollable laughter, a sense of overlapping realities, and hallucinations.

Salvinorin A is believed to be the ingredient responsible for the psychoactive effects of Salvia divinorum.

What is its effect on the body?

Adverse physical effects may include:

- Loss of coordination, dizziness, and slurred speech

Which drugs cause similar effects?

When Salvia divinorum is chewed or smoked, the hallucinogenic effects elicited are similar to those induced by other Scheduled hallucinogenic substances.

What is its legal status in the United States?

Neither Salvia divinorum nor its active constituent Salvinorin A has an approved medical use in the United States. Salvia is not controlled under the Controlled Substances Act. Salvia divinorum is, however, controlled by a number of states. Since Salvia is not controlled by the CSA, some online botanical companies and drug promotional sites have advertised Salvia as a legal alternative to other plant hallucinogens like mescaline.

Leaves of the salvia divinorum plant

XII. Designer Drugs

Recently, the abuse of clandestinely synthesized drugs has re-emerged as a major worldwide problem. These drugs are illicitly produced with the intent of developing substances that differ slightly from controlled substances in their chemical structure while retaining their pharmacological effects. These substances are commonly known as designer drugs and fall under several drug categories. The following section describes these drugs of concern and their associated risks.

Bath Salts or Designer Cathinones *(Synthetic Stimulants)*

WHAT ARE "BATH SALTS?"

Synthetic stimulants often referred to as "bath salts" are from the synthetic cathinone class of drugs. Synthetic cathinones are central nervous stimulants and are designed to mimic effects similar to those produced by cocaine, methamphetamine, and MDMA (ecstasy). These substances are often marketed as "bath salts," "research chemicals," "plant food," "glass cleaner," and labeled "not for human consumption," in order to circumvent application of the Controlled Substance Analogue Enforcement Act. Marketing in this manner attempts to hide the true reason for the products' existence—the distribution of a psychoactive/stimulant substance for abuse.

WHAT IS THEIR ORIGIN?

Synthetic cathinones are manufactured in East Asia and have been distributed at wholesale levels throughout Europe, North America, Australia, and other parts of the world.

Bath salts

What are common street names?

- Bliss, Blue Silk, Cloud Nine, Drone, Energy-1, Ivory Wave, Lunar Wave, Meow Meow, Ocean Burst, Pure Ivory, Purple Wave, Red Dove, Snow Leopard, Stardust, Vanilla Sky, White Dove, White Knight, White Lightning

What does it look like?

Websites have listed products containing these synthetic stimulants as "plant food" or "bath salts," however, the powdered form is also compressed in gelatin capsules. The synthetic stimulants are sold at smoke shops, head shops, convenience stores, adult book stores, gas stations, and on Internet sites and often labeled "not for human consumption."

How are they abused?

"Bath salts" are usually ingested by sniffing/snorting. They can also be taken orally, smoked, or put into a solution and injected into veins.

What is their effect on the mind?

These synthetic substances are abused for their desired effects, such as euphoria and alertness. Other effects that have been reported from the use of these drugs include psychological effects such as confusion, acute psychosis, agitation, combativeness, aggressive, violent, and self-destructive behavior.

What is their effect on the body?

Adverse or toxic effects associated with the abuse of cathinones, including synthetic cathinones, include rapid heartbeat; hypertension; hyperthermia; prolonged dilation of the pupil of the eye; breakdown of muscle fibers that leads to release of muscle fiber contents into bloodstream; teeth grinding; sweating; headaches; palpitations; seizures; as well as paranoia, hallucinations, and delusions.

What are their overdose effects?

In addition to effects above, reports of death from individuals abusing drugs in this class indicate the seriousness of the risk users are taking when ingesting these products.

Which drugs cause similar effects?

They cause effects similar to those of other stimulants such as methamphetamine, MDMA, and cocaine.

What is their legal status in the United States?

In July 2012, the U.S. Government passed Pub.L. 112- 144, the Synthetic Drug Abuse Prevention Act (SDAPA), that classified a number of synthetic substances under Schedule I of the Controlled Substances Act. SDAPA placed these substances in the most restrictive category of controlled substances. Cannabimimetic agents, including 15 synthetic cannabinoid compounds identified by name, two synthetic cathinone compounds (mephedrone and MDPV), and nine synthetic hallucinogens known as the 2C family, are now restricted by this law. In addition, methylone was permanently controlled by DEA through the administrative process, and another 10 synthetic cathinones became subject to temporary control.

Other synthetic cathinones may be subject to prosecution under the Controlled Substance Analogue Enforcement Act which allows these dangerous substances to be treated as Schedule I controlled substances if certain criteria can be met.

K2 / Spice

WHAT IS K2?

K2 and Spice are just two of the many trade names or brands for synthetic designer drugs that are intended to mimic THC, the main active ingredient of marijuana. These designer synthetic drugs are from the synthetic cannabinoid class of drugs that are often marketed and sold under the guise of "herbal incense" or "potpourri."

Synthetic cannabinoids are not organic, but are chemical compounds created in a laboratory. Since 2009, law enforcement has encountered numerous different synthetic cannabinoids that are being sold as "legal" alternatives to marijuana. These products are being abused for their psychoactive properties and are packaged without information as to their health and safety risks.

Synthetic cannabinoids are sold as "herbal incense" and "potpourri" under names like K2 and Spice, as well as many other names, at small convenience stores, head shops, gas stations, and via the Internet from both domestic and international sources. These products are labeled "not for human consumption" in an attempt to shield the manufacturers, distributors, and retail sellers from criminal prosecution. This type of marketing is nothing more than a means to make dangerous, psychoactive substances widely available to the public.

WHAT IS ITS ORIGIN?

The vast majority of synthetic cannabinoids are manufactured in Asia without manufacturing requirements or quality control standards. The bulk products are smuggled into the United States typically as misbranded imports and have no legitimate medical or industrial use.

What are common street names?

There are numerous and various street names of synthetic cannabinoids as drug manufacturers try to appeal and entice youth and young adults by labeling these products with exotic and extravagant names. Some of the many street names of synthetic marijuana are: "Spice,""K2," Blaze, RedX Dawn, Paradise, Demon, Black Magic, Spike, Mr. Nice Guy, Ninja, Zohai, Dream, Genie, Sence, Smoke, Skunk, Serenity, Yucatan, Fire, and Crazy Clown.

K2/Spice

What does it look like?

These chemical compounds are generally found in bulk powder form, and then dissolved in solvents, such as acetone, before being applied to dry plant material to make the "herbal incense" products. After local distributors apply the drug to the dry plant material, they package it for retail distribution, again without pharmaceutical-grade chemical purity standards, as these have no accepted medical use, and ignoring any control mechanisms to prevent contamination or to ensure a consistent, uniform concentration of the powerful and dangerous drug in each package.

How is it abused?

Spraying or mixing the synthetic cannabinoids on plant material provides a vehicle for the most common route of administration - smoking (using a pipe, a water pipe, or rolling the drug-laced plant material in cigarette papers). In addition to the cannabinoids laced on plant material and sold as potpourri and incense, liquid cannabinoids have been designed to be vaporized through both disposable and reusable electronic cigarettes.

What are its overdose effects?

Overdose deaths have been attributed to the abuse of synthetic cannabinoids, including death by heart attack. Acute kidney injury requiring hospitalization and dialysis in several patients reportedly having smoked synthetic cannabinoids has also been reported by the Centers for Disease Control and Prevention.

Which drugs cause similar effects?

THC, the main psychoactive constituent of marijuana.

What is its effect on the mind?

Acute psychotic episodes, dependence, and withdrawal are associated with use of these synthetic cannabinoids. Some individuals have suffered from intense hallucinations. Other effects include severe agitation, disorganized thoughts, paranoid delusions, and violence after smoking products laced with these substances.

What is its effect on the body?

State public health and poison centers have issued warnings in response to adverse health effects associated with abuse of herbal incense products containing these synthetic cannabinoids. These adverse effects included tachycardia (elevated heart rate), elevated blood pressure, unconsciousness, tremors, seizures, vomiting, hallucinations, agitation, anxiety, pallor, numbness, and tingling. This is in addition to the numerous public health and poison centers which have similarly issued warnings regarding the abuse of these synthetic cannabinoids.

What is its legal status in the United States?

These substances have no accepted medical use in the United States and have been reported to produce adverse health effects. Currently, 26 substances are specifically listed as Schedule I substances under the Controlled Substances Act either through legislation or regulatory action. In addition there are many other synthetic cannabinoids that meet the definition for "cannabimimetic agent" under the Controlled Substances Act and thus are Schedule I substances.

There are many synthetic cannabinoid substances that are being sold as "incense," "potpourri," and other products that are not controlled substances. However, synthetic cannabinoids may be subject to prosecution under the Controlled Substance Analogue Enforcement Act which allows non-controlled drugs to be treated as Schedule I controlled substances if certain criteria can be met. The DEA has successfully investigated and prosecuted individuals trafficking and selling these dangerous substances using the Controlled Substance Analogue Enforcement Act.

K2/Spice

Synthetic Opioids

WHAT ARE SYNTHETIC OPIOIDS?

Synthetic opioids are substances that are synthesized in a laboratory and that act on the same targets in the brain as natural opioids (e.g., morphine and codeine) to produce analgesic (pain relief) effects. In contrast, natural opioids are naturally occurring substances extracted from the seed pod of certain varieties of poppy plants. Some synthetic opioids, such as fentanyl and methadone, have been approved for medical use.

Clandestinely produced synthetic opioids structurally related to the Schedule II opioid analgesic fentanyl were trafficked and abused on the West Coast in the late 1970s and 1980s. In the 1980s, DEA controlled several of these illicitly produced synthetic opioids such as alpha-methylfentanyl, 3-methylthiofentanyl, acetyl-alpha-methylfentanyl, beta-hydroxy-3-methylfentanyl, alpha-methylthiofentanyl, thiofentanyl, beta-hydroxyfentanyl, para-fluorofentanyl, and 3-methylfentanyl.

As of 2013, there has been a re-emergence in the trafficking and abuse of various clandestinely produced synthetic opioids, including several substances related to fentanyl. Some common illicitly produced synthetic opioids that are currently encountered by law enforcement include, but are not limited to, acetyl fentanyl, butyryl fentanyl, beta-hydroxythiofentanyl, furanyl fentanyl, 4-fluoroisobutyryl fentanyl, acryl fentanyl, and U-47700.

WHAT IS THEIR ORIGIN?

Synthetic opioids are believed to be synthesized abroad and then imported into the United States.

What do they look like?

Clandestinely produced synthetic opioids have been encountered in powder form and were identified on bottle caps and spoons, detected within glassine bags, on digital scales, and on sifters which demonstrates the abuse of these substances as replacements for heroin or other opioids. These drugs are also encountered as tablets, mimicking pharmaceutical opioid products. Clandestinely produced synthetic opioids are encountered as a single substance in combination with other opioids (fentanyl, heroin, U-47700) or other substances.

Clandestinely produced counterfeit oxycodone tablets that contain fentanyl.

Opioid powder U-47700.

How are they abused?

Abuse of clandestinely produced synthetic opioids parallels that of heroin and prescription opioid analgesics. Many of these illicitly produced synthetic opioids are more potent than morphine and heroin and thus have the potential to result in a fatal overdose.

What are their effects?

Some effects of clandestinely produced synthetic opioids, similar to other commonly used opioid analgesics (e.g., morphine), may include relaxation, euphoria, pain relief, sedation, confusion, drowsiness, dizziness, nausea, vomiting, urinary retention, pupillary constriction, and respiratory depression.

What are their overdose effects?

Overdose effects of clandestinely produced synthetic opioids are similar to other opioid analgesics. These effects may include stupor, changes in pupillary size, cold and clammy skin, cyanosis, coma, and respiratory failure leading to death. The presence of triad of symptoms such as coma, pinpoint pupils, and respiratory depression are strongly suggestive of opioid poisoning.

Which drugs cause similar effects?

Some drugs that cause similar effects include other opioids such as morphine, hydrocodone, oxycodone, hydromorphone, methadone, and heroin.

What is their legal status in the United States?

Several synthetic opioids are currently controlled under the Controlled Substances Act. Recently, the DEA temporarily placed U-47700 and several other substances that are structurally related to fentanyl, such as acetyl fentanyl, butyryl fentanyl, beta-hydroxythiofentanyl, and furanyl fentanyl, in Schedule I of the Controlled Substances Act. Other synthetic opioid substances may be subject to prosecution under the Controlled Substance Analogue Enforcement Act which allows non-controlled substances to be treated as Schedule I substances if certain criteria are met. The DEA has successfully investigated and prosecuted individuals trafficking and selling these dangerous substances using the Controlled Substances Analogue Enforcement Act.

XIII. Resources

DRUG USE PREVENTION RESOURCES

Drug prevention programs are designed and implemented on many levels. The federal government has instituted a number of national drug prevention programs which reach targeted populations through public service announcements, grant programs, educational programs, and the sharing of expertise. State and local governments also have a significant number of prevention programs that are tailored to address particular problems and needs. Law enforcement and the military have brought drug prevention expertise into classrooms and communities; businesses have also contributed significantly to drug prevention through sponsored programs, drug-free policies, and corporate support for community initiatives. Other segments of society, including faith-based institutions, civic organizations, and private foundations are also active forces in drug prevention.

Below is a partial list of drug prevention agencies and programs. There are many other outstanding efforts which are ongoing across the nation; it is impossible to include them all. Some programs are aimed at particular populations or specific drugs. Within a given agency, there may be many prevention programs which are aimed at different audiences.

FEDERAL DRUG PREVENTION AGENCIES AND PROGRAMS:

Drug Enforcement Administration (DEA):

In addition to dismantling major drug trafficking organizations, DEA is committed to reducing the demand for drugs in America. DEA's Demand Reduction Program is carried out by Special Agents across the United States who work in communities to share expertise and information on drug trends, emerging problems, and the dangers of drugs.

www.dea.gov
www.JustThinkTwice.com
www.GetSmartAboutDrugs.com
www.operationprevention.com

Office of National Drug Control Policy (ONDCP):

This office reports to the President of the United States.

www.whitehousedrugpolicy.gov

Substance Abuse and Mental Health Services Administration (SAMHSA):

This organization is responsible for overseeing and administering mental health, drug prevention, and drug treatment programs around the nation. The Center for Substance Abuse Prevention (CSAP) and the Center for Substance Abuse Treatment (CSAT) are part of SAMHSA.

www.samhsa.gov
www.samhsa.gov/prevention
www.samhsa.gov/about-us/who-we-are/

U.S. Department of Education (ED):

ED's anti-drug program is housed in the Office of Safe and Healthy Students.

www.ed.gov

National Institute on Drug Abuse (NIDA):

NIDA conducts and disseminates the results of research about the effects of drugs on the body and the brain. NIDA is an excellent source of information on drug addiction.

www.nida.nih.gov

Other Anti-Drug Organizations:

National Association of State Alcohol and Drug Abuse Directors (NASADAD)
www.nasadad.org

Community Anti-Drug Coalitions Of America (CADCA)
www.cadca.org

National Crime Prevention Council (NCPC)
www.ncpc.org

National Families in Action (NFIA)
www.nationalfamilies.org

You can obtain free anti-drug information from:

Substance Abuse and Mental Health Services Administration
www.store.samhsa.gov

The National Center on Addiction and Substance Abuse at Columbia University (CASA)
www.casacolumbia.org

Elks Drug Awareness Program
www.elks.org/dap

Partnership for Drug-Free Kids
www.drugfree.org

American Council for Drug Education (ACDE)
www.acde.org

Drug Strategies
www.drugstrategies.org

Youth Anti-Drug Organizations:

Young Marines
www.youngmarines.com

Drug Abuse Resistance Education (DARE)
www.dare.com

Students Against Destructive Decisions (SADD)
www.sadd.org

Law Enforcement Exploring
exploring.learningforlife.org/services/career-exploring/law-enforcement/


GET THE FACTS ABOUT DRUGS
JUST THINK TWICE
A Resource for Teens
www.justthinktwice.com


GET SMART
ABOUT DRUGS
A DEA RESOURCE FOR PARENTS, EDUCATORS & CAREGIVERS
WWW.GETSMARTABOUTDRUGS.COM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OPERATION
PREVENTION
The Science Behind
Opioid Addiction
www.operationprevention.com

Certification Statement

CERTIFICATION STATEMENT

In compliance with the Drug-Free Schools and Communities Act (DFSCA) as articulated in the Education Department General Administrative Regulations (EDGAR) Part 86, the undersigned official of Montgomery College certifies that she has reviewed and approved Montgomery College's 2019 Biennial Review.

DeRionne P. Pollard, PhD
President
Montgomery College

11/18/19
Date