An Overview of New Psychoactive Substances and the District of Columbia's Strategy for Tackling this Public Health Challenge
March 3, 2016

Stan Orchowsky: Who we have this afternoon, Kelly Crisp, who is a clinical service specialist for the Pretrial Service Agency for the district. Kelly has over 20 years in mental health and substance abuse treatment and is committed to creative and innovative ways to provide treatment services. Kelly has a Master’s of Social Work degree from Hunter College School of Social Work and is a licensed independent clinical social worker currently participating in a developmental assignment with a criminal justice coordinating council at the district.

Stan Orchowsky: Kelly, thank you for being here, and welcome.

Kelly R. Crisp: Thank you, Stan. I'm happy to be here today. My role at the Criminal Justice Coordinating Council is as a Substance Abuse Treatment and Mental Health Services Administration task force liaison. If I can get through that title, I think I can get through the rest of this presentation.

Kelly R. Crisp: For my developmental assignment, I'm working with the new psychoactive substances group, and I have been tasked with immersing myself into all things related to psychoactive substances. I'm very excited to be here today to speak with you about psychoactive substances and the work we are doing here in the District of Columbia.

Kelly R. Crisp: This is a very robust presentation with a lot of great information, so I will not be reading every slide word for word because that would drive us all crazy, especially me. I'm getting ahead of myself. I'm having technical difficulty.

Kelly R. Crisp: I'm going to start this presentation by providing a snapshot of the Criminal Justice Coordinating Council, otherwise known as the CJCC. I'm going to talk to you a little bit about who we are and what we do here. The CJCC is an independent agency dedicated to continually improving the administration of criminal justice in Washington, D.C. they serve as the forum to identify issues and their solutions, proposing actions, and facilitating cooperation to improve public safety and the criminal and juvenile systems. CJCC is comprised of local and federal agencies that develop recommendations and strategies. The guiding principles are creative collaboration, community involvement, and effective resource utilization.

Kelly R. Crisp: The objectives for today's presentation are to increase your knowledge of new psychoactive substances, to highlight the emerging trends in the
District of Columbia, explore the local and national responses to curbing the use and sale of new psychoactive substances.

Kelly R. Crisp: In this presentation, I'm going to use the acronym NPS because as I discovered very quickly, saying new psychoactive substances repeatedly is quite challenging. I'll refer to new psychoactive substances as NPS or either as new substances. This presentation si broken into three sections that will address each of the objectives.

Kelly R. Crisp: In the first section, I will provide an overview of new psychoactive substances, which will answer the questions, "What are these substances? What is the appeal? Where are they made and sold? What are the different types? The reasons they are so dangerous, and some of the many adverse affects."

Kelly R. Crisp: NIDA, or the National Institute for Drug Abuse, defines NPS as a category of unregulated psychoactive or mind-altering substances that have become newly available on the market and are intended to copy the effects of illegal drugs. Some of these substances have actually been around for years, but they have re-entered the market in altered chemical form or are the result of a new popularity.

Kelly R. Crisp: These substances were first identified in the US by the US Customs and Border Patrol in 2008. This graphic I'm showing now was taken from the United Nations Office on Drugs and Crime, global synthetic drugs assessment. You will see that over 500 new substances were identified between 2009 and 2014. If you look at the graph, you can see the number of new substances identified each year fluctuates, but what does remain consistent is the new substances are continually being manufactured. Recent data shows that in 2015, over 200 new substances were identified.

Kelly R. Crisp: What is the appeal of these substances? To start with, the packaging is very colorful. They're inexpensive, they're extremely potent, and the substances are unable to be detected in some drug tests. This is the perfect mix for people who are trying to get a cheap high and avoid a positive drug test.

Kelly R. Crisp: Where are these substances made and sold? They're manufactured mostly in China and India and shipped to the U.S. They're easily purchased online, in stores, or on the street. I included this slide to demonstrate how easy it is to buy new psychoactive substances online. I
simply did a search and put in, "Buy Bizarro," which is one of the substances we see here in D.C., and a number of sites came up. I clicked on one. This is the Plant Feed Shop. If you look, you see categories where you can purchase stimulants, [navenoids 00:06:19], psychedelics, research chemicals, and if you look at the upper right hand corner, you'll see that you can also get free shipping if you buy $100. These substances are very, very easy to get a hold of.

Kelly R. Crisp: In addition to the colorful packaging, the manufacturers mislead people into thinking these substances are harmless by labeling them as, "safe," or legal alternatives to controlled substances. They're most commonly marketed as herbal incense, potpourri, bath salts, jewelry cleaner, or plant food.

Kelly R. Crisp: The chemical composition is unknown and is often changed to avoid drug laws. They may be laced with toxic chemicals, and since these substances are new, they have not been thoroughly evaluated in research trials, so there is no definitive evidence of the long-term effects. They are classified as Schedule I drugs, which means the substance must not currently have an accepted medical use, has a high potential for abuse, they are of the most dangerous substances, and they have potential for severe psychological or physical dependence.

Kelly R. Crisp: There are four main categories of NPS: synthetic cannabinoids, synthetic cathinones, synthetic hallucinogens, and synthetic opioids. We'll start by taking a look at synthetic cannabinoids, which are commonly sold as herbal or liquid incense. Synthetic cannabinoids are humanly-made, mind-altering chemicals that are synthesized in laboratories. They are called cannabinoids because they are related to the chemical found in the marijuana plant. They mimic the biological effects of delta-9-tetrahydrocannabinol, or THC, which is the active ingredient in marijuana that causes the user to feel high. They act on the synthetic cannabinoid receptor agonists, which are the same receptors affected by the THC in marijuana. Some of the synthesized compounds in synthetic cannabinoids bind much more strongly to THC receptors than marijuana. As a result, they have been found to be 100 times more potent than the THC that is found in marijuana. This can lead to some very powerful, unpredictable, or dangerous effects.

Kelly R. Crisp: Some of the more common synthetic cannabinoids found in Washington, D.C. are K2, Bizarro, [inaudible 00:09:18], and [fife 00:09:18]. Synthetic
cannabinoids are dry, shredded plant material that's sprayed with designer drugs. It's misleadingly called, "fake weed," and it's labeled as a safe alternative to marijuana. It's smoked via vape pens, joints, cigarettes, or ingested as a tea.

Kelly R. Crisp: As you can see, there are multiple adverse affects of synthetic cannabinoids. They include, but are not limited to, hallucination, excited delirium, psychosis, sever anxiety and agitation, overdose, or death. As I said earlier, synthetic cannabinoids are classified ... I did not say earlier. Excuse me. Synthetic cannabinoids are classified as a Schedule I drug, so the long-term effects include sever potential for dependence and because they are newer substances and have not been fully researched, the psychological and physiological effects are unknown.

Kelly R. Crisp: Next we're going to talk about synthetic cathinones, which are commonly known as bath salts. I think this poster right here says it all. "Bath salts: innocent name, dangerous consequences. How drugs disguised as household products are wreaking havoc."

Kelly R. Crisp: Synthetic cathinones are human-made drugs that are chemically related to the khat plant. Khat is a shrub that is grown in east Africa and southern Arabia. [Inaudible 00:11:02] stimulant effect. Synthetic variants of khat can be much stronger and more dangerous. It comes in the form of white or brown crystal-like powder, and it's swallowed, snorted, smoked, or ingested. It's marketed as a cheap substitute for MDMA or ecstasy and Molly. You'll notice that there's a theme there that these substances are marketed as cheap substitutes for illegal drugs. As I stated, synthetic cathinones are marketed frequently as MDMA or Molly. In the district, these substances that are marketed and sold as Molly are actually pure cathinones.

Kelly R. Crisp: Brand names include, [Flocka 00:11:53], Cloud Nine, White Lightning, and Scarface. Like the synthetic cathinones, they're labeled not for human consumption to avoid laws, and they can be purchased online, in stores, or on the street. Many of you have seen the horrific stories on the news and many cities and states have been impacted by people experiencing the effects of using cathinones. There are a variety of adverse symptoms, including but not limited to, psychosis, excited delirium, increased heart rate, overdose, and death. Once again, the long-term effects are severe potential for dependence and the psychological and physiological effects are unknown.
Kelly R. Crisp: I'm going to move on and talk about synthetic hallucinogens. I want to clarify that when I talk about synthetic hallucinogens, these are the newer substances. It's not the other substances that have been on the market and have been around for decades like LSC. These are the newer substances. Synthetic hallucinogens alter perception, thought, and feeling. They are sold as powder, crystals, pills, or in blotter paper, and are taken orally, rectally, or by insufflation. I learned something new going through this presentation. Insufflation means blowing powder, vape, or gas, into a body cavity. It's a fancy way of saying they're snorting it. It's marketed as a cheaper form of LSD with much more powerful symptoms.

Kelly R. Crisp: If you look at the picture in the middle down at the bottom, one of the more popular types of synthetic hallucinogens are 251, NBOME, which is also known as, "N-bomb," and smile.

Kelly R. Crisp: Synthetic hallucinogens have many of the same adverse affects as synthetic cannabinoids and synthetic cathinones. These effects include but are not limited to seizures, kidney failure, delirium, significant rapid toxicity, and overdose or death.

Kelly R. Crisp: There is very little research into the long term effects, but because they are similar to other hallucinogens like LSD, we can make some connections. Some of the reported long-term effects include memory loss, speech impairment, anxiety, depression and suicidal thoughts, mood changes, and flashbacks.

Kelly R. Crisp: The last category we're going to talk about is synthetic opioids. The main different between synthetic opioids and opiates is that opiates are derived from the poppy plant and therefore are natural. Synthetic opioids are chemically manufactured narcotics that mimic the natural poppy plant. Synthetic opioids are substances that have psychoactive or mind-altering properties. They're injected, swallowed, smoked, or snorted, and they have medicinal uses, but they are taken for reasons or in ways not intended by a doctor, or taken by someone other than the person they have prescribed for. These substances include fentanyl, which is often mixed with cocaine and heroine, which increases the potency and danger, methadone, tramadol, and bupenorphine, which is Subtex or Suboxone.

Kelly R. Crisp: Short term effects include nausea and vomiting, constipation, confusion, slowed breathing, and death from overdose. While looking at the long-
term effects, you'll see there's infection, damage to the heart, depression, and risk of infectious disease from shared needles.

Kelly R. Crisp: We're going to now move to the second section where we take a look at the trends and we're looking at using data to monitor trends in the District of Columbia. I'm actually going to start with a brief overview of two of the data sources that are tracked nationally. These are reflective of the trends that we see here in DC. Then I will move right into the trends that we are seeing in DC.

Kelly R. Crisp: The first national data source is the 2015 Monitoring the Future Study. This is a study that was funded by research grants from NIDA and was conducted at the survey research center in the Institute for Social Research at the University of Michigan. This is a study of ongoing national behaviors, added to values of secondary school student, college students, and young adults. The studies were mailed out to approximately 44,900 8th, 10th, and 12th graders, and around 382 schools. All this data is based on self-reports.

Kelly R. Crisp: The studies found that in 2015, use of synthetic cannabinoids was approximately 3% of 8th graders, 4% of 10th graders, and 5% of 12th graders. Use rates for 8th, 10th, and 12th graders did not exceed 0.9% for the entire year. The second bullet has an error. It should say 8th, 10th, or 12th graders. These results are good news. They represent a statistically significant decline from 2012. Just to give you some context, in 2012, the rates were 4% for 8th graders, 9% for 10th graders, and 11% for 12th graders. These results are really good news. The decline was associated with an increase in a perceived risk of taking synthetic cannabinoids once or twice.

Kelly R. Crisp: The second source of national data is the American Association of Poison Control Centers. This data reflects the period between January 1 and December 31, 2015. Data from the American Association of Poison Control Centers is updated every eight minutes and is a very useful tool in tracking public health threats and risk. The poison centers received reports of a little over 770 exposures to synthetic cannabinoids. They received 520 exposures to bath salts, and DC actually ranked number two for the number of calls to the poison control center.

Kelly R. Crisp: We’ll move right into talking about the trends and the stats for the District of Columbia. The District first became aware that NPS might be a problem in 2012. There were some incidents that came to light, and the
CJCC was asked to investigate. The findings lead to the district's first synthetic drugs symposium, and DC has since had two more symposiums to address NPS with the most recent one being in September 2015.

Kelly R. Crisp: The district has taken a collaborative approach to tracking and respond to the emergence of these substances. The majority of the data collected in the district reflects synthetic cannabinoid use is the primary substance that is used here. The data on synthetic cannabinoid use is collected from two sources: DC Fire and Emergency Medical Services transports and drug test results. Drug test results are pulled from two different populations. The first is hospitals who are now required to collect the blood or urine specimen if a patient presents with symptoms of synthetic cannabinoids. The second is people under supervision in the criminal justice system. I will talk a little bit more about those populations as we move forward.

Kelly R. Crisp: Let's start by looking at the emergency transport. This data reflects the period between April and December 2015. The numbers are based on suspected synthetic cannabinoid use as reported by the transport provider. There are a little over 2100 transports, with 15 of those being for juveniles. The total number of EMS transports peaked at around 611 in September 2015. In October 2015, the number of suspected synthetic cannabinoid transports was 576 patients. The age range was from age 13 to 78. The median age is 36, with the majority being male at 83% and the minority being female at 17%.

Kelly R. Crisp: It's important to note that synthetic cannabinoid use is reported by the emergency services provider based on self-report from the patient or an acquaintance or determined by the provider. Many people in the district use K2 as a catch all for synthetic substances. This data may not accurately reflect synthetic cannabinoid use, but it does reflect the number of people who had [inaudible 00:22:33].

Kelly R. Crisp: Let's take a look at drug testing. We'll start with the emergency room and hospital admissions. These numbers are determined by people who are either transported to the hospital, report to the ER on their own, or admitted into the hospital for another reason. The January numbers actually represent a slight decrease in the percentages of positive testing as compared to the data from October and December 2015. This number, this most recent number of the January data, is representative of the overall trend. In January, 367 adult and juvenile specimens were tested.
Around 111 or 30.2% were positive for synthetic cannabinoid and another drug. 102 or 27.8% were positive for synthetic cannabinoids only.

Kelly R. Crisp: We will now look at drug testing among persons under supervision. The pre-trial services agency for the District of Columbia tests people who are under supervision. This includes defendants that are in lock-up, those on pre-trial release under PSA supervision, those on probation, parole, or supervised release under the court services and offender supervision agency, and juveniles and adults in the DC superior court family court.

Kelly R. Crisp: The partner agencies from DC participated in the community drug early warning systems study in 2013 and 2015, which now helps identify emerging trends and the need revisit how we drug test under supervision. After the first study, PSA partnered with the Office of the Chief Medical Examiner to research and develop methods for analyzing and testing for synthetic cannabinoids.

Kelly R. Crisp: In October 2015, PSA began using immunoassay screens for synthetic cannabinoids for all incoming specimens. Specimens of people who had a strong indication of synthetic cannabinoids were referred for additional testing at the OCME. For instance, if a pre-trail services officer or community supervision officer or court personnel believe that the person was using synthetic cannabinoids, those specimens are flagged and sent out for additional testing.

Kelly R. Crisp: Between September and December 2015, a little over 1200 specimens were tested for synthetic cannabinoids. 619 of those were positive, which is 48%. In January 2016, 10 specimens were tested for synthetic cannabinoids, with nine being positive. 90% of the total. The high percentage of positive tests was attributed to these samples being tested pursuant to staff/court referrals. As I said, if someone had a suspicion of using, they were referred for testing. These figures represent figures that were obtained from the pre-trial or probation in the juvenile population.

Kelly R. Crisp: Pre-trial services has an in-house certified laboratory staffed by credentialed professionals. They recently acquired the LC/MS/MS 80:40 Shimadzu to test for NPS. That’s their new drug testing apparatus. They are in the final, final stages of validation and once the machine is validated, PSA will be doing all their testing in-house.
Kelly R. Crisp: The data that's been collected to date suggests use of synthetic cannabinoids is decreasing. Since November 2015, there's been a significant decrease in hospital transport and a decrease in positive tests for synthetic cannabinoids. There are some limitations to the data's being collected, starting with the fact that the NPS compounds change so frequently that the metabolites they're drug testing may not always be available. The data does not capture people who have not had contact with emergency services, hospitals, or criminal justice systems. People who are in the community that might be using have not been tested at this point. Some of the self-reported data may be inaccurate.

Kelly R. Crisp: We're moving into our final section, curbing use and sale of NPS. We'll look at the national response, the district's response, and then talk about some next steps. I'm going to touch on the main points of the national response to NPS since the focus of this presentation is on the district's response. A little ahead of myself there. Okay.

Kelly R. Crisp: We're going to start with the national response. The Office of National Drug Control Policy, or ONDCP, coordinates drug-control activities and funding across the Federal government. The inaugural national drug control strategy was published in 2010 by the Obama administration, and it established two overarching goals to reduce drug use and its consequences by 2015. The first is to curtail illicit drug consumption in America. The second is to improve the public health and public safety of the American people by reducing the consequences of drug abuse.

Kelly R. Crisp: The national response involves tracking emerging trends, education and research, prevention, and reduction of manufacturing and distribution. I'll touch briefly on each one of those. There are multiple sources of all of these areas. There's no way I could cover all of them during this webinar, so I'm going to focus on a few of the key initiatives. Let's start with looking at tracking emerging trends. National trends are tracked by using community warning systems, such as the community and national drug early warning systems, national surveys such as the survey on drug use and health, as well as data on national reporting agencies such as the American Association for Poison Control Centers. As a reference, at the end of this presentation, I've included links to all these resources so you can do some further research.

Kelly R. Crisp: For education and research, there are a ton of education materials out there on new psychoactive substances. NIDA has a lot of really great fact
sheets that are available on their website. There's tons of webinars that are out there, so there's a good source of information and data. There's also a lot of research grants. NIDA and SAMHSA, or the Substance Abuse Mental Health Services Administration, has funded in 2014, they funded over $4 million in synthetic cannabinoid research, $37,000 for synthetic cathinone research, and over $760,000 for research into synthetic hallucinogens.

Kelly R. Crisp: One of the key prevention initiatives is the Drug Free Communities Support Program. This is a federal grant program that provides funding to community-based coalitions that organize to prevent youth substance use. In the fiscal year 2015, $86 million was allocated to 697 community-based programs.

Kelly R. Crisp: We take a look at reduction of manufacturing and distribution. Interdiction is a key part of this response. There is the high intensity drug trafficking program, or the HIDA program, whose purpose is to reduce drug trafficking introduction in the US offered by the assistance of federal, state, local, and tribal law enforcement agencies in critical drug trafficking regions.

Kelly R. Crisp: In addition, federal legislation has evolved to reflect the ever-changing landscape of psychoactive substances. The Controlled Substance Analogue Enforcement Act of 1986 - Federal Analogue Act allows many of these substances to be treated as controlled substances if they are proven to be chemically or pharmacologically similar to a Schedule I or II controlled substance.

Kelly R. Crisp: In 2011, the DEA exercised its emergency scheduling authority to control five prices of synthetic cannabinoid and three of the synthetic substances used to synthesize synthetic cathinones. All but one of these substances were scheduled as part of the Synthetic Drug Abuse Prevention Act of 2012. This act permanently places 26 types of synthetic cannabinoids and cathinones into Schedule I. It also changed the maximum period of time the DEA can schedule substances under its emergency scheduling authority. It was previously 18 months and is now 36 months.

Kelly R. Crisp: Most recently, the Synthetic Drug Control Act of 2015 was introduced and is a bipartisan congressional effort sponsored by congressman Charlie Dent of Pennsylvania, Jim Hines of Connecticut, David Jolly of Florida, and congresswoman Eleanor Holmes Norton. This act strengthens the Federal Analogue Act. It will facilitate the prosecution of
distributors, adds to the list of new psychoactive substances identified by the DEA into Schedule I, and focuses on distributors rather than users. To date, over 44 states have taken action to control synthetic cannabinoids and cathinones.

Kelly R. Crisp: Now we're going to talk about the district's response to curbing use and sales of NPS. The district's response focuses on partnerships and collaboration between elected officials and public health and law enforcement agencies. In response with imminent [inaudible 00:34:38] public health, safety, and welfare, response to NPS has been swift, progressive, and targeted. The focus is on the data collection and information sharing.

Kelly R. Crisp: As I said earlier, 2012 was the year DC began to take action to curb the use and sales of NPS. The District of Columbia's Omnibus Criminal Code Amendments Act of 2012 added over 20 new substances to the district's schedule of controlled substances. In April 2014, the Department of Consumer and Regulatory Affairs, or DCRA, adopted new regulations that are aimed at curbing the sale and use of these substances. It allows the district to take important action against a business that is selling synthetic drugs consisting of substances identified on a controlled substances list, or new variations and derivatives of those substances.

Kelly R. Crisp: The DCRA launched the Right Choice campaign in the summer of 2014 with the goal of educating store owners about new laws. The campaign also includes a pledge that stores can sign.

Kelly R. Crisp: In February 2015, the DCRA adopted regulations targeting the packaging and price of NPS. It shifted the focus from the contents. It allowed district officials to treat products that exorbitantly expensive to contain unusual warning of NPS. For instance, a substance that smelled of potpourri that's in a small packet and costs $30 would be something that is exorbitantly expensive for what the product is supposed to be. Last time I bought potpourri, it was about $10 worth, big old vat. Anytime you see potpourri in a small package, you should be suspicious of that. Businesses can seek clarification from DCRA about whether the product qualifies as a NPS.

Kelly R. Crisp: Moving into July 2015, emergency ruling requires the collection of urine or blood samples for patients presenting with symptoms consistent with having synthetic cannabinoids.
That takes us into our most recent legislation. The Synthetic Abatement and Full Enforcement Drug Control Act (Safe DC) was introduced in November 2015 by the chairman of DC council at the request of the office of the Attorney General. This is a collaboration of the DC office of the Attorney General’s Emerging Trends Task Force, the DC Department of Forensic Sciences, and other local and federal partners.

This act would address the limitations of relying on prohibitive analogue statutes by listing specific compounds on the DC controlled substance list. This makes lab testing for synthetic cannabinoids and cathinones more efficient. More specifically, it makes it easier to test for and prosecute cases and codifies certain DC Department of Health synthetic cannabinoids and cathinone regulations.

The Narcotics and Special Investigations Division-Drug Interdiction Unit, which is a part of the metropolitan police department, has a special unit that's designated to conduct enforcement operations related to NPS. They are responsible for street-level enforcement, store inspections, and investigations. They partner with federal, state, and local law enforcement agencies and the US Postal Service to investigate NPS trafficking in the district.

You may have heard that recently this unit partnered with DA, homeland security and the customs and border control and local agencies in a 15 month nation wide interdiction operation that resulted in 151 arrests in 15 states, and over $15 million in cash and assets received. They were a big part of an investigation that really took a lot of drugs off the streets that were headed directly for Washington, D.C.

Moving on to drug testing, drug testing and data collected from testing supports agencies efforts to track emerging trends, inform legislation/regulations, develop initiatives aimed at education and prevention. It helps us determine risk as well as supervision and treatment needs, and it deters use. Drug testing is critical because studies suggest that individuals will use an NPS as a way to avoid getting positive drug test results. The research suggests that the drug trends in high-risk criminal justice populations may predict future trends for the general population. It's really important for this data to be collected.

This is a poster that was posted in the pre-trial services field unit. It's a warning for defendants that pre-trial services will begin testing for synthetic cannabinoids and other new psychoactive substances. The
campaign started in October 2016, and it was designed to increase defendants' awareness of drug testing and also to deter future use. This is actually a great segue into my next section on education and prevention.

Kelly R. Crisp: The K-2 zombie campaign is an award-winning campaign that was launched in 2013 by the DC department of behavioral health. The K-2 zombie campaign won nine awards and targets youth between the ages of 12 and 16. It's designed to raise awareness and highlight the dangers of NPS use. 92% of youth that were surveyed have seen or heard about the campaign, and of those, 88% said they were less likely to purchase or use NPS within 90 days. The campaign was useful in getting the word out to our young people about the dangers, particularly of synthetic cannabinoids. It also helps deter from use. There is a campaign for other at-risk populations in development. Considering our age range for emergency transports was 13 to 78, this other campaign would target people who are adults and also we’ve had a lot of cases of homeless people using new psychoactive substances. The campaign would target those populations.

Kelly R. Crisp: The last section I talked about information sharing. The CJCC new psychoactive substance work group has representatives from DC and federal government. They evaluate the current policies and legislative options. They educate the public and focus on coordination of information, detection, and legislation. We are in the process of expanding new psychoactive work group to include representatives from not only the district, but also Maryland and Virginia. There's a sharepoint site for partners who can go to research information and reference new psychoactive substances.

Kelly R. Crisp: This is just a list of all of the partner agencies that are involved in the CJCC NPS work group. They're in no order of importance, but you'll notice all the DC agencies are at the top until you get down to pretrial services, and all the agencies including pretrial services are federal agencies.

Kelly R. Crisp: The district's response to NPS is built on collaboration and partnerships with the local and federal agencies. This is just an example to focus on information sharing, legislation enforcement, education and prevention, and drug testing.

Kelly R. Crisp: Next steps. I think it's important for us to look at some of the implications for treatment. First off, looking at the question and answering the
question, "How can we better diagnose and intervene with individuals who have not come into the system yet?" For instance, those who are not drug testing or those who have not come into contact with the hospitals. Also take a look at developing treatment protocols for medical mental health and substance abuse disorder professionals. Because this is a new phenomenon, there's not a lot of information out about whether there's any specific approaches that should be taken when treating individuals who are using new psychoactive substances. As far as research goes, we're really taking a look at what are the long term effects of these substances. Again, there's not a lot of research that has been done, so it'll be important to find out what the long-term effects truly are. Also, try to get a better idea of how many people are actually using since the data we currently have is not capturing everybody. That ties into my last bullet, which is continuing to explore alternate sources of data.

Kelly R. Crisp: It's important to look at expanded detection, particularly the ability to test for NPS in treatment programs and professions where public safety is a concern, for instance, those who drive the subway, those who drive the metro buses, and also expanding access to testing for other jurisdictions. Lastly, we're committed to looking at continued education and prevention. The top of that list is combating misconceptions about fake weed, and that term really makes it seem like synthetic cannabinoids are not that harmful. Fake weed is oregano. Synthetic cannabinoids are substances that are really, really dangerous. We want to educate the public and encourage people to stop using that term, fake weed. Lastly, continued education on NPS. New substances are continually emerging and it will be important to find out what the impact that they're having on people, how [inaudible 00:46:26] are being mixed into substances we're already familiar with.

Kelly R. Crisp: That concludes my presentation. I included a number of resources. There's a ton of resources out there, so I included ones that I thought were most helpful. I'm not going to go through them, but I'll just show you. Locally, we have a website for our K-2 zombie drug prevention campaign. You see there the Drug Free Youth website, which has a list of DC prevention centers. Then there's multiple resources from the DEA, NIDA, ONDCP [inaudible 00:47:09]. Then I also attached the references I used. I did exhaustive research on this topic, so there's a ton of references.
Kelly R. Crisp: I want to say thank you particularly to a number of my NPS work group members. You're all very, very helpful in helping me to collect information I needed for this presentation. If anyone has any questions or needs additional information, my email is attached. My current email is Kelly.Crisp@dc.gov. I'll be detailed to the CJCC until about mid-April, and after that I can be reached at my home base at pretrial services at Kelly.Crisp@psa.gov.

Stan Orchowsky: Thanks Kelly. Let me just mention that Kelly's presentation will be posted on our website, so if you would like to avail yourself of those additional resources, you'll be able to get to that from the website. I also wanted to remind you that if you have questions, please send a chat to the host or to see my name, to me. We'll make sure we get those questions answered for you. In the mean time, I have some questions, if you don't mind. I guess the first thing I'm curious about is the very beginning of the story and what the impetus was for all of this. How did it come to your attention that launched all of this data collection and analysis and legislative responses and so forth?

Kelly R. Crisp: In 2013, a pretrial services agency, and I think the [crosstalk 00:49:23] participated in the community drug early warning system, which is a study at the University of Maryland. As a result of the findings from that study, one of the things that really stood out was that the population that was being drug tested in the criminal justice system was probably getting over. They were using psychoactive substances, a variety of substances, but they weren't showing up in the drug test. I can say from experience of working in the street and [inaudible 00:49:58] at pretrial services that we've had people that come into the program and you can tell that there's something going on with them. Their eyes are rolled back in their head. They're glassy. They're stumbling and incoherent, and you take them for a drug test and they'd come up negative.

Kelly R. Crisp: We didn't really know what was happening until we started to learn more about these substances. As a result, the CJCC started doing some research and they put together the first symposium in 2013, and they had a second one in 2014. The most recent one was in September of 2015. That's how it all got started. That's how it actually came to light.

Kelly R. Crisp: Actually, before that, let me back up one second. Before that, it actually first came to light when a person was under the community court services [inaudible 00:50:55] agency, which is our parole and probation
supervision agency. The person that came to the attention of one of the community supervision officers, then there was a second incident where someone was displaying erratic behavior. It was brought to the attention of the CJCC. From there they started looking into it. That's how it started.

Stan Orchowsky: Okay, thanks. Do you have any sense, or could you characterize, the typical user? Are these folks who are using this when they wouldn't be this, they would be using other substances? Do you have any sense of that?

Kelly R. Crisp: I think it's a combination. The age range for people using is pretty much 13 to 78. Young people are using I think because they were [inaudible 00:51:57] marketed to young people. Beyond that, we've had people up to age 78 using synthetics. I think that over the summer we had a spike in EMS transports, and a lot of those people were actually homeless. There was a big spike in overdoses and transports to homeless shelters. I don't know that there is a typical user. I think that is a combination. I do know that once pretrial started testing for synthetic cannabinoids and other NPS, the positive tests started decreasing rapidly. I think a lot of people were using to try to avoid the drug test, and when they found out they couldn't then they just stopped. Some people might switch to other stuff, but yeah.

Stan Orchowsky: You mention the transports. I was just looking at the data. The numbers are going down. I don't know how typical that will be going forward into the future, but it looked like at one point in the summer, it was like 20 a day which seems like an awfully high number to me. I guess I was wondering, do you know what happens to those folks? Do you know what the outcomes were for those people in terms of these are people that are being taken to hospitals, I assume? Do you have any way to follow up and see how they fared?

Kelly R. Crisp: The protocol if someone reports to the hospital and there's evidence of a substance use problem, that they would be referred to services through the Department of Behavioral Health. Those referrals are volunteered. Unless the person is under court supervision or is under probation, then there's no mechanism to force treatment, but they are getting referrals to services.

Stan Orchowsky: What about medically? Do you have any sense of ...
Kelly R. Crisp: There have been protocols that are developed to treat people in emergency rooms, but even just recently there was a public hearing on the number of ... When the burden is put on the ER doctors and nurses because of these people coming in and not being familiar with how to treat them. Those protocols are in development. It's something that hit us pretty quickly that they overdose and and they ration people going into the ER and into the hospital came really fast. They had to do a really quick tutorial and catch up really fast.

Stan Orchowsky: Okay. One of our participants has asked what I happen to know is a really good question in DC, which is how often does the chemical makeup of these substances change, and how do you keep your testing up to the tech of these substances?

Kelly R. Crisp: We have a couple of local subject matter experts on the line, and one of them is the director of the pretrial officers forensic toxicology, Dr. [Adasi]. I hope he's on the line. He could answer just that question. Dr. Adasi, we're trying to unmute you.

Kelly R. Crisp: I answer that question.

Stan Orchowsky: From what I recall from the conference, the answer to the first part of the question is often, that the compounds change rapidly, as I recall. A lot of times it can be a small change from a chemical perspective but, I think part of the problem as I recall, is that nobody really knows what's in these things.

Kelly R. Crisp: Right. If you refer back to the graph I put up from the Global [inaudible] study, there were over 500 new substances in 2015 alone, just worldwide. It's just really difficult to keep up with their changes all the time. A lot of times they're changing to avoid the laws. As soon as you make one substance illegal, they change it to another substance, which is why it's really important that these analogue laws focuses on substances that are similar pharmacologically and chemically.

Stan Orchowsky: Looking for more questions folks. If you have other questions out there for Kelly, let me know. You mentioned the states that I think it was 44 states have already done ... Do you have any sense of what people are doing, what those state responses consist of?

Kelly R. Crisp: [crosstalk]
Dr. Adasi: Are we on now?

Kelly R. Crisp: They're outlawing the compound and focusing on the analogue laws. A lot of states and counties and cities are starting in the stores and they're going after stores and shutting stores down, give a warning and put signs in stores that say they're not allowed to sell synthetic drugs [inaudible 00:58:18]. It's very similar to what's happening here. It's a combination of those things. Then drug and law enforcement effort as well. Dr. Adasi?

Dr. Adasi: Yes. Kelly, are you there?

Kelly R. Crisp: Yes. We had a question about how do we keep up with the drug testing.

Dr. Adasi: Yes. Can you hear it now? Can you hear it now, Kelly? I'm having some difficulties.

Kelly R. Crisp: We're having technical difficulties. We'll come back to Dr. Adasi.

Kelly R. Crisp: Apparently, people on the conference line can hear Dr. Adasi, so Dr. Adasi, can you answer that question about how do you keep up with the testing considering that the compounds are always changing?

Dr. Adasi: Yes, very good. Thank you for the update. I want to go first back to how quickly the chemical substances change and pick it up from there. In terms of the frequency of change, nobody really knows. Based on the types of chemical substances we are detecting, we've noticed that, first of all, there were the [inaudible 01:00:08], and then of course came the XLR11 and the UR144. Majority of the cases, majority of the chemical substances we are fighting now, are the [inaudible 01:00:21], the PB22 metabolites, and the [fuginakas 01:00:28]. In terms of how quickly the chemical changes, I think the best profile we have will be the users. Based on the types of responses we're getting now from the users, it looks like every two, three months or so, we are seeing some new substances come in. In fact, when we started testing back in October last year, out numbers, and this was just screening of course, our numbers were about 3 to 5%, and now they're down to much less than 3%. More like 2%. The indication is that the chemical structure and the composition may have changed. That is what we're dealing with now.

Dr. Adasi: The second part of the question deals with ... What was the second part of the question? Kelly, what was the second part of the question that they wanted us to address?
An Overview of New Psychoactive Substances and the District of Columbia's Strategy for Tackling this Public Health Challenge
March 3, 2016

Kelly R. Crisp: We cannot hear Dr. Adasi. Are you finished Dr. Adasi?

Dr. Adasi: Yeah, we finished the first part of the question, which deals with the changes in the chemical composition.

Kelly R. Crisp: Oh, repeating the second part. The second part of the question was how are you able to keep up with drug testing considering the chemical compounds change so frequently?

Jerry Robinson: Hello Kelly. This is Jerry Robinson. Can you hear me?

Kelly R. Crisp: Hello, Dr. Robinson. The participants can hear you, we cannot. We're getting emails when people are finished.

Jerry Robinson: The first question, to add on to Dr. Adasi says, is we keep abreast of what's going on in the scientific community, what they're picking up there, also in the criminal justice system and also organizations like DEA and [inaudible 01:02:56], we keep abreast of what's being reported. We have contact with detectives or police who have a tab on what they're picking up on the street. Detective Alvarez has been really instrumental in helping us stay on top of what they're picking up. It's on top of what's being deemed by the different organizations, by the DEA and so on, and then we use that to try to figure out what we can do to look for these compounds.

Jerry Robinson: Also, the compounds that the pick up are the parent compounds, and the samples we do are urine samples, so we can only look at the metabolite. It's a challenge there because they don't always make metabolites for the specific drugs. That's how we've been able to keep up. Fortunately, there's some reference labs that will make or have provided metabolite for these different compounds that we've been able to stay on top of that for the most part. However, there's a lot of new compounds that they've been picking up, specifically the DEA, and they don't all have metabolites. We may be aware of new drugs coming in, but we can't analyze them immediately. The first question is it did change a lot. We had to go through about three or four iterations to keep our profile up. The problem now is trying to stay on top of that and it's more difficult now because they're coming in with more substances, different substances, and we can't look for it because we're not doing substances. We're doing biological samples and we have to look for metabolites. It's a challenge, and we do our best to try to stay on top of it.
Kelly R. Crisp: I recognize we have some of our [inaudible 01:05:13] partners on the line, so if you could give some insight into what your experiences are, we would love to hear from you.

Eric Alvarado: Good afternoon. Can you hear me?

Kelly R. Crisp: Yes, we can.

Eric Alvarado: I'm Detective Eric Alvarado from the Drug Interdiction Unit of the Metropolitan Police Department. Good afternoon. In reference to how we picked up new chemicals that are being introduced in the market, we rely on the analysis from the Drug Enforcement Administration's lab when those analysis come back to the Assistant US Attorney's office. Also, we rely on information from other jurisdictions when they've made [inaudible 01:05:56] that were destined for Washington, D.C. and they let us know what chemicals were those [inaudible 01:06:04]. We communicate that, again, to Dr. Robinson and all the other members that are cooperating with us and tracking these chemicals.

Kelly R. Crisp: Thank you Detective Alvarado.

Stan Orchowsky: Folks, we're going to go ahead and launch our poll. If you could just look for those questions on your screen while we continue on with the webinar, thanks.

Kelly R. Crisp: Thank you. I know we also have some of our partners from the DC public schools on the line. If you have anything you want to add or why this is important we're dealing with young people.

Benita Banson: Yes, this is Benita Banson. Can you hear me?

Kelly R. Crisp: I can. Hello?

Benita Banson: I just wanted to say, I was very surprised to see the data that [inaudible 01:07:06]. That was new information for me.

Kelly R. Crisp: That is very different.

Benita Banson: It actually reflects what we're seeing. Were only seeing [inaudible 01:07:27] in data towards youth.
Kelly R. Crisp: Okay. We have a few more minutes. If anyone has any other questions, we're happy to answer them. I know we have representatives from the Office of the Attorney General on the line if you'd like to chime in and add some insight into what's happening from the legislative perspective, that would be great.

Speaker 7: Hello. It's [inaudible 01:08:18] the office of the attorney general. Can you all hear me? Can you hear me Kelly?

Kelly R. Crisp: I can. We need to unmute you.

Speaker 7: Oh. It's under Habid's name. We're all just in his office.

Kelly R. Crisp: We can hear you.

Speaker 7: As far as the legislation goes, the Office of the Attorney General has proposed DC Safe. Oh, Safe DC. Basically, it criminalizes synthetic cannabinoids as you had in your slides by class group. It was coming up for a hearing in two weeks before the DC council. That's pretty much it, unless there are any other questions.

Kelly R. Crisp: That's great, thank you.

Stan Orchowsky: Thank you. Not seeing any other questions from our participants. Thank you all for joining us. Thank you, Kelly, and thank you everybody else who was able to join from DC. We appreciate your input. Again, I just want to remind everybody that the webinar slides and content will be posted on JRSA’s website, www.JRSA.org. Give us a few days to do that. Thank you again to Kelly and thank you to everyone in the audience for joining us today. Have a great afternoon.