DEWS Maryland Drug Early Warning System

DEWS INVESTIGATES

Who is Entering Treatment for Narcotic Pain Relievers in Maryland?

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HIGHLIGHTS

From FY 1999 to FY 2003, treatment admissions for misuse of other opiates, such as OxyContin®, morphine, and Demerol® (excluding heroin and methadone), have nearly tripled in Maryland to 3,655. In our June 2004 *DEWS Investigates* report we had speculated that this increase in recent admissions may be due to growth in the number of people who developed a problem with these drugs after legitimate prescribed use. We suspected that such users' drug problems might be limited to other opiates. However, DEWS staff conducted case studies of five people who were seeking private treatment for OxyContin abuse in Maryland and found that they all had extensive histories of other drug use.[1] To determine if polydrug use is typical of those seeking treatment for other opiate use in Maryland and whether other opiate only treatment seekers exist at all, we examined all treatment admissions for other opiate use in Maryland in FY 2004.

Key issues: Who seeks treatment for other opiate use? Are they different from people who seek treatment for other substances? Are there people whose drug problems are limited to other opiates? If so, how are people whose drug problems are limited to other opiates different from people who have sought treatment for use of other drugs in addition to other opiates?

Key Findings:

- Compared to treatment admissions for other drugs in FY 2004, admissions for other opiate use were more likely to be white, female, better educated, employed full-time, have private health insurance, and reside in suburban Baltimore and not Baltimore City than admissions for other drugs.
- More than 80% of people who sought treatment for other opiates in FY04 also sought treatment for other drugs from FY02 to FY04. However, a small but significant minority appeared to have no evidence of treatment entry for another drug in the prior two years.
- Compared to those who sought treatment for use of other opiates and street drugs (e.g., heroin, cocaine, marijuana, PCP), people who sought treatment only for other opiate use were older at treatment admission and when they first used other opiates, better educated, more likely to be employed full-time, and more likely to have private health insurance.

Recommendation:

More research is needed to determine if the minority (19%) of persons who appear to have sought treatment only for other opiate use developed their problems with these drugs after receiving legitimate prescriptions or using illicit drugs.

Misuse of Other Opiates

Within the past ten years, non-medical use of narcotic pain relievers available by prescription, such as OxyContin®, Vicodin®, and Percocet®, has increased markedly nationwide.[1] Consistent with these national trends, Maryland has seen substance abuse treatment admissions for narcotic pain relievers nearly triple in recent years (1,282 in FY 1999 to 3,655 FY 2003).[1] Little is known, however, about the people in Maryland who seek treatment for problems with these drugs or the reasons for increases in these admissions.

One possible scenario is that the increase in treatment admissions for narcotic pain relievers stems from a growing number of people who have no prior history of misusing other drugs, misused these drugs after legitimate prescription use. The nationwide increase in the non-medical use of narcotic pain relievers that began in 1995 coincided with the introduction of OxyContin, a more potent form of oxycodone than previously available. Also, during this time, there has been an increasing willingness among doctors to prescribe drugs for pain management, as evidenced by a rise in the number of prescriptions filled for narcotic pain relievers nationwide.[1] To examine this possibility, we studied how many people seeking treatment for narcotic pain relievers have evidence of other drug abuse.

A June 2004 *DEWS Investigates* report presented a case study of five people seeking private treatment in Maryland for problems with the narcotic pain reliever OxyContin.[1] We targeted private treatment because we hypothesized we would be most likely to find people in that setting who developed a problem with OxyContin after prescription use with no prior history of substance use.

DEWS Investigates provides a succinct report of the findings and implications of studies on important substance abuse-related issues in Maryland. Online copies are available at http://www.dewsonline.org. For more information, please contact Eric Wish at ewish@cesar.umd.edu or 301-405-9774.

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Table 1. Demographic Characteristics Associated with Treatment Admissions for Other Opiates and Other Substances in Maryland, FY 2004

Demographic characteristics	Admissions for other opiates[1] (N=4,620)	Admissions for all other substances (N=70,025)
Median age in years	33	35
	%	%
Female	44	32
White	89	50
Married	29	16
Education beyond high school	29	19
Employed full-time	38	30
Private health insurance	42	24
Region of residence in Maryland[2]		
Suburban Baltimore	38	25
Suburban DC	15	18
Eastern Shore	14	10
Baltimore City	12	34
Southern	7	5
Western	5	4
Out of state	9	4

[1]Any admission that included a mention of other opiates, regardless of whether other drugs were also mentioned, was classified as an other opiate admission. Other opiates include any drug with morphine-like effects such as OxyContin, codeine, dilaudid, morphine, demorol, fentanyl, and opium. Heroin and methadone are not classified as other opiates.

[2]Suburban Baltimore (Anne Arundel, Baltimore County, Carroll, Harford, Howard); Suburban DC (Fredrick, Montgomery, Prince George's); Eastern Shore (Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, Worcester); Southern (Calvert, Charles, St. Mary's); Western (Allegany, Garrett, Washington).

Note: These data reflect admissions, not persons. A person may have more than one admission.

Source: Adapted from data from the Maryland Alcohol and Drug Abuse Administration, April 2005.

Contrary to our expectations, all five people studied had extensive histories of drug use, including heroin, cocaine, and prescription drugs. Our findings prompted us to question whether the extensive drug use found in the five case studies is typical of those who seek treatment for OxyContin and other narcotic pain relievers in Maryland.

We set out to answer the following questions: Who seeks treatment for other opiate use? Are they different from people who seek treatment for other substances? Are there people whose drug problems are limited to other opiates? If so, how are people whose drug problems are limited to other opiates different from people who have sought treatment for use of other drugs in addition to other opiates?

To address these questions, we collaborated with the Maryland Alcohol and Drug Abuse Administration (ADAA) to analyze private and public substance abuse treatment admissions in Maryland in FY 2004. The ADAA maintains records of all Maryland treatment admissions within the Substance Abuse Management Information System (SAMIS). Problems with up to three drugs mentioned at each treatment admission are entered into SAMIS. OxyContin and other narcotic pain relievers, including codeine, dialudid, morphine, Demerol, fentanyl, and other drugs with morphine-like effects (excluding heroin or methadone), are coded in SAMIS as "other opiate" admissions. Although the data do not allow for the identification of the specific other opiate for which treatment is sought, nationally oxycodone and hydrocodone have been found to account for a large portion of the recent increase in misuse of narcotic pain relievers.[1,2] Throughout this paper, other opiates and narcotic pain relievers are used interchangeably.

Study Sample

There were 4,620 treatment admissions for other opiate use out of a total of 74,645 admissions for substance abuse treatment in Maryland in FY 2004. Other opiate admissions increased by 26% from FY 2003, but still accounted for only 6% of all treatment admissions in the state. It is important to note that the number of admissions is greater than the number of people who sought treatment, since a person may have multiple treatment admissions in the SAMIS database.

Who seeks treatment for other opiate use? Are they different from people who seek treatment for other substances?

Demographics.

Table 1 shows that, compared to treatment admissions for other substances in FY 2004, treatment admissions for other opiate use were about the same age (median age: 33 vs. 35 years), but were more likely to be female (44% vs. 32%), white (89% vs. 50%), and married (29% vs. 16%). Admissions for other opiate use were also more likely to have an education beyond high school (29% vs. 19%), be employed full-time (38% vs. 30%), and have private health insurance (42% vs. 24%). A larger portion of other opiate admissions were for people who were married, suggesting that this group may not only have been of higher socioeconomic status, but may have been more stable and had greater social support as they sought treatment, compared to other drug admissions. Regional differences were also evident, with other opiate admissions more likely to reside in suburban Baltimore (38% vs. 25%) and much less likely to reside in Baltimore City (12% vs. 34%) than admissions for other substances.

As shown in Table 2, compared to admissions for other substances, other opiate admissions were more likely to be referred to treatment by themselves or family members (49% vs. 28%) and by health care providers (27% vs. 18%) and were much less likely to be referred to treatment by the criminal justice system (15% vs. 44%). Other opiate treatment admissions may have been better equipped to seek treatment on their own initiative or to gain access to a referral from a health care provider because they were nearly twice as likely to have private health insurance and to have higher levels of education and full-time employment than other drug admissions.

Treatment modality also differed between the groups, with other opiate admissions more likely to enter residential treatment (24% vs. 19%), methadone maintenance (21% vs. 8%), or detoxification (17% vs. 11%) and less likely to enter outpatient treatment (21% vs. 42%). Finally, a mental health condition was more likely to have been noted at admission for other opiate use than for other substances (33% vs. 23%).

Table 2. Treatment Characteristics Associated with Admissions for Other Opiates and Other Substances in Maryland, FY 2004

Treatment characteristics	Admissions for other opiates[1] (N=4,620)	Admissions for all other substances (N=70,025)
	%	%
Source of referral		
Self/family	49	28
Health care provider	27	18
Criminal justice	15	44
Community referral	9	11
Modality		
Residential	24	19
Outpatient	21	42
Methadone maintenance	21	8
Detoxification	17	11
Intensive outpatient	16	15
Correctional	2	5
Mental health problem noted at admission	33	23

[1]Any admission that included a mention of other opiates, regardless of whether other drugs were mentioned, was classified as an other opiate admission. Other opiates include any drug with morphine-like effects such as OxyContin, codeine, dilaudid, morphine, demorol, fentanyl, and opium. Heroin and methadone are not classified as other opiates.

Note: These data reflect admissions, not persons. A person may have more than one admission. Category totals may not sum to 100 percent due to rounding

Source: Adapted from data from the Maryland Alcohol and Drug Abuse Administration, April 2005.

Are there people whose drug problems are limited to other opiates?

The 4,620 other opiate admissions in FY 2004 involved 3,635 different individuals. We examined each person's first other opiates admission in FY 2004 and found that more than three-quarters (N=2,770) of them involved another drug problem. Thus, only 24% of the people (N=865) had no evidence of another drug problem at that initial admission. To determine if these 865 people had recently sought treatment for other drugs, we examined their prior treatment admissions through FY 2002 and found 22% had sought treatment for other drugs in the past.

Thus, as Figure 1 shows, 81% of the 3,635 people who sought treatment for other opiate use in FY 2004 also sought treatment for use of another drug in the period studied. The majority (66%) of people who sought treatment for other opiate use also sought treatment for street drug use (i.e., heroin, cocaine, marijuana, PCP, methamphetamine, hallucinogens, and inhalants), with or without alcohol and/or prescription drug use. Fifteen percent of people who sought treatment for other opiate use also sought treatment during that time for alcohol and/or prescription drug use. Only 19% of people sought treatment only for other opiate use.

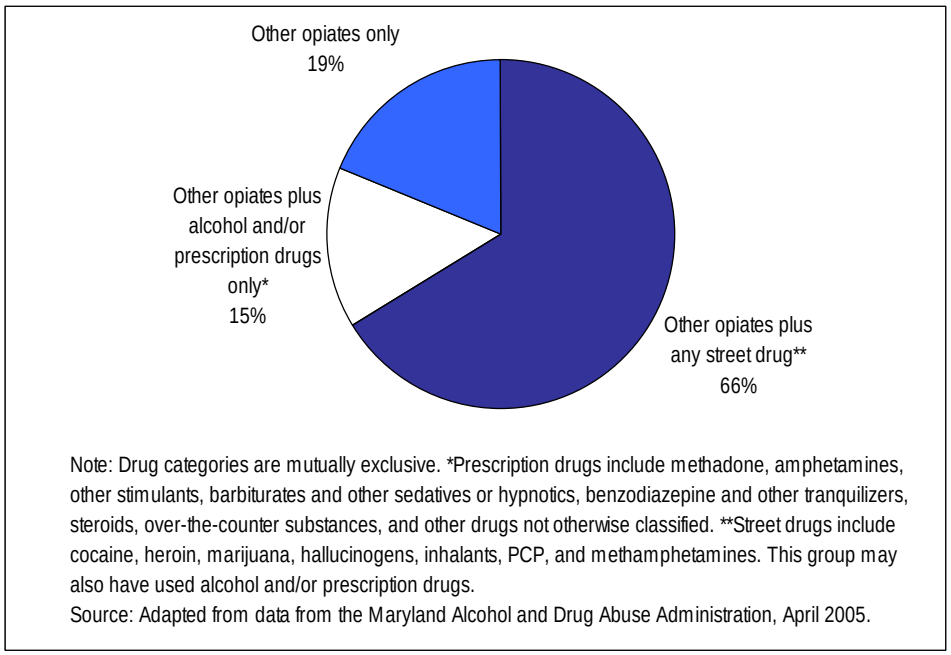
How are people whose drug problems are limited to other opiates different from people who have sought treatment for use of other drugs in addition to other opiates?

People who only sought treatment for use of other opiates had a very similar demographic profile to those who sought treatment for use of other opiates and alcohol and/or prescription drugs, but differed from those who sought treatment for use of other opiates and street drugs. Nevertheless, all three groups were characterized as predominately white, having slightly more males than females, having entered treatment as a result of self- or family-referral, with approximately 40 percent of each group residing in suburban Baltimore (see Table 3, page 4). People who sought treatment for use of other opiates alone or with alcohol and/or prescription drugs were older at admission and older when they first used other opiates and more likely to be married, have education beyond high school, be employed full-time, have private health insurance, and reside in the Maryland suburbs of Washington, D.C., than people who sought treatment for use of other opiates and street drugs. Compared to the other two groups, people who sought treatment for use of other opiates only were less likely to have a mental health problem noted at the time of admission, to have entered treatment as a result of criminal justice referral, and to enter residential treatment and were more likely to have entered treatment as a result of self- or family-referral and to enter methadone maintenance.

Conclusions

Consistent with our June 2004 *DEWS Investigates* report, the vast majority of people (81%) who sought treatment for misuse of other opi-

Figure 1. Drug Problems Mentioned by People with an FY 2004 Other Opiate Treatment Admission in the 2 Years Up to and including Their First FY 2004 Other Opiate Admission (N=3,635 people)



Note: Drug categories are mutually exclusive. *Prescription drugs include methadone, amphetamines, other stimulants, barbiturates and other sedatives or hypnotics, benzodiazepine and other tranquilizers, steroids, over-the-counter substances, and other drugs not otherwise classified. **Street drugs include cocaine, heroin, marijuana, hallucinogens, inhalants, PCP, and methamphetamines. This group may also have used alcohol and/or prescription drugs.
Source: Adapted from data from the Maryland Alcohol and Drug Abuse Administration, April 2005.

Table 3. Characteristics of People who Sought Treatment in Maryland for Other Opiates in FY 2004, by the Drugs for which they Sought Treatment (FY 2002 through First FY 2004 Other Opiate Admission)

	Other opiates only (N=679)	Other opiates with	
		Alcohol and/or prescription drugs only[1] (N=546)	Any street drugs[2] (N=2,410)
Median age at admission	36	41	29
Median age first used other opiates	27	28	20
	%	%	%
Female	46	47	43
White	90	91	86
Married	43	43	21
Education beyond high school	39	43	21
Employed full-time	51	46	32
Private health insurance	54	54	33
Resident of Suburban Baltimore	41	39	39
Resident of Suburban Washington, DC	20	17	12
Source of referral			
Self/family	59	47	49
Health care provider	21	28	24
Criminal justice	9	13	19
Community referral	11	12	8
Modality			
Residential	9	25	21
Outpatient	21	20	21
Methadone maintenance	32	11	25
Detoxification	21	27	16
Intensive outpatient	17	15	12
Correctional	<1	1	4
Mental health problem noted at admission	26	37	33

[1]Street drugs include cocaine, heroin, marijuana, hallucinogens, inhalants, PCP, and methamphetamines.
[2]Prescription drugs include methadone, amphetamines, other stimulants, barbiturates and other sedatives or hypnotics, benzodiazepine and other tranquilizers, steroids, over-the-counter substances, and other drugs not otherwise classified.
Note: All data reflect time of first FY 2004 other opiate treatment admission.
Source: Adapted from data from the Maryland Alcohol and Drug Abuse Administration, April 2005.

ates in FY 2004 also sought treatment for other drugs, if not concomitantly, then in admissions to treatment during the prior two years. Still, 19% of people did appear to seek treatment only for their use of other opiates. This relatively small group of clients was very similar to those who sought treatment for use of alcohol and/or prescription drugs in addition to other opiates, but differed from those who sought treatment for use of other opiates and street drugs. It may be that people who sought treatment for use of other opiates only or other opiates along with alcohol and/or prescription drugs were more likely to have developed their problem after legitimate prescribed use, as they may have been more likely to have access to health care. A greater proportion had private health insurance and higher socioeconomic status than people who sought treatment for use of other opiates and street drugs.

These findings therefore appear to lend little support to the possibility that the recent increases in treatment admissions for other opiates can be attributed primarily to non-drug abusing persons who developed an addiction to other opiates after receiving legitimate prescriptions. Additional research is needed to more precisely describe the small group of people who appears to seek treatment only for use of other opiates.

Limitations

First, we were unable to identify the specific types of other opiates for which people are seeking treatment because this information was not captured within SAMIS at that time (in FY 2006 SAMIS was revised to capture specific other opiates). Second, the proportion of those who seek treatment for other opiate use and have problems with other drugs may be even higher than reported here, because our analyses only assessed prior treatment admissions in Maryland within a two-year period in the state and would not have accounted for people who may have sought treatment for other drug problems before our study period.

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