



The **Ohio Substance Abuse
Monitoring Network**

January 2003-June 2003

A Rapid Response
Investigation

RAPID RESPONSE: PRESCRIPTION ANALGESIC ABUSE



A Report Prepared for the
Ohio Department of Alcohol
and Drug Addiction Services

In Collaboration with
Wright State University & The University of Akron

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**Ohio Department of Alcohol
and Drug Addiction Services**

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CONTENTS

Page

REPORTS

Akron-Canton (Summit & Stark Counties)	1
Rural Southeast (Athens, Vinton & Hocking Counties).	11
Cleveland (Cuyahoga County).	18
Columbus (Franklin County)	23
Dayton (Montgomery County).	34
Toledo (Lucas County).	49
Youngstown (Mahoning & Columbiana Counties)	57

**Prescription Analgesic Abuse
In Akron and Canton, Ohio**

An OSAM Rapid Response Report Prepared for the Ohio Department of Alcohol and Drug
Addiction Services.

January 2003 – June 2003

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I. Introduction

The Summit-Stark county region, with its population centers of Akron and Canton, is experiencing an increasing problem with prescription analgesic abuse that mirrors reported trends across the state and throughout the country. Over the past several years, crimes related to the use, possession, diversion, and sale of prescription analgesics have also increased. Accidental deaths, suicides, assaults and murders involving these substances have become increasingly frequent. Treatment programs are reporting increases in new admissions listing prescription analgesics as primary drugs of abuse. Reports indicate that users often combine them with other drugs (e.g., cocaine, methamphetamine, alcohol).

One particular scheduled prescription analgesic, OxyContin® (oxycodone controlled-release), has become a local flashpoint for these concerns, consistent with national reports. User-respondents, treatment providers, medical educators, forensic pathologists in the Summit-Stark area are all in agreement that prescription analgesics, particularly OxyContin®, are widely abused in the area. Other powerful controlled pharmaceutical analgesics, such as Duragesic® (fentanyl transdermal system), Stadol® (butarphanol), MSContin® (morphine sulfate), and Nubane® (nalbuphine) were reported to be illegally obtainable, if one is properly “connected.” Publicity about the availability and potential for abuse has heightened awareness of the problem, but has also reportedly attracted new groups of abusers. In particular, younger (16-25) and older (45+) groups are emerging.

The increasing availability and affordability of heroin in the area has also created a dangerous link between the use and abuse of prescription analgesics and heroin. Users sometimes report that the major issue involving these controlled drugs is how to make them available to those for whom they are essential for pain management, while at the same time preventing abuse. Some users and providers acknowledged that certain individuals seem to be predisposed to dependence, but believed that exposure to opioids when legally prescribed, increases a risk of dependence even among those who have no prior history of drug abuse.

Area Description

Summit County, located in Northeast Ohio, had a population of 546,381, according to the estimated July 1, 2002 census data. Approximately 83.5 % of county's residents are white, 13.2 % are black, and other ethnic/racial groups constitute the remaining 3.3 percent. The median household income of Summit County residents is estimated to be \$40,102. Approximately 11% of all people of all ages in Summit County are living in poverty, and approximately 17% of all children under age 18 live in poverty. Approximately 40% of the people in Summit County reside in the city of Akron, with a 2000 population of 217,074. Summit County contains several other incorporated cities. The largest of these cities is Cuyahoga Falls (containing approximately 9% of the population of Summit County), followed by Stow (6%), Barberton (5%), Green (4%), and Hudson (4%). The rest of Summit County's inhabitants live in smaller towns and townships.

The estimated 2002 (based on 2000 census) for Stark County was 377,940. The largest city, Canton, listed 80,806 residents in the 2000 census. Approximately 90.3% of Stark county residents are white, 7.2% are black and 3.5% are of other ethnic groups. The median household income for Stark County is estimated to be \$39,401 (2000 census). Approximately 10.5% of all people of all ages in Stark County are living in poverty, and approximately 16% of all children under age 18 live in poverty (2000 census). Approximately 23% of the people in Stark County

reside in the city of Canton. Stark County contains two other incorporated cities, Massillon (containing approximately 8% of the population of Stark County) and Alliance, which contains approximately 6% of the population. The rest of the inhabitants of Stark County live in surrounding villages and townships.

II. Methods

- **Interviews.** Seven individual interviews were conducted utilizing the Rapid Response Interview Guide for Pharmaceutical Analgesic Abuse, consisting of a structured questionnaire and open-ended qualitative questions. All participants were advised of confidentiality protections and each signed an informed consent. All sessions were audio-taped, with respondents using pseudonyms to identify themselves. Tapes were transcribed, and the responses were analyzed. Attempts were made to triangulate the data as much as possible to ensure accuracy. Where useful, quotes were included.

Attitudes of treatment providers and input from a focus group of newly-recovering users were included in the analysis. The treatment providers were key staff from an Akron area outpatient facility that has a large population of minority clients. The user group consisted of 5 recently-recovering individuals who are associated with each other through a 12-step organization for individuals with substance abuse problems. This group met in a private home. The focus group discussions of pharmaceutical analgesics were prompted by implementing the Adult Drug Trends Protocol (January 2000), a semi-structured instrument which easily facilitates narrative responses.

- **Availability and Price** estimates are provided by the focus group respondents, and individual interviews. Data are available through the Stark and Summit Counties Sheriffs' Departments and local suburban police/sheriff departments for January 2003-June 2003. Two brief telephone interviews were conducted with Narcotics officers.
- **Data on Deaths** where drug screens were performed in Summit County from June 2002 to May 2003 was obtained from the Summit County Medical Examiner. A brief face-to-face explanation of a data set provided on investigated deaths, and a telephone interview were given by a Medical Examiner's Office staff member. At the request of the medical examiner, the actual data set is not for publication, but some summary findings are part of this report.
- **Information on drug abuse** awareness training for doctors was obtained in an interview with the director of addictions studies, NEOUCOM in May 2003.

III. Demographics

Table 1. Individual Interviews

Age	Gender	Ethnicity	Drug use Hx		Summary
20	Female	Caucasian	<u>1st use:</u> <u>Path:</u> <u>Choice:</u> <u>#1 PA:</u> <u>IV:</u>	12- ETOH ETOH→MJ→ LSD→Coke→Meth→ Vicodin→OxyContin Meth OxyContin No	HS graduate, employed part-time, total drug use-5 yrs, first use of pharmaceutical analgesics—was prescribed Vicodin, preferred snorting, outpatient treatment (one time)..
25	Female	Asian	<u>1st use:</u> <u>Path:</u> <u>Choice:</u> <u>#1 PA:</u> <u>IV:</u>	12=ETOH ETOH→MJ→ Amphet→Hallucinogens→ Coke→OxyContin Heroin OxyContin Yes	Some college, employed part-time, total drug use-13 yrs, first use of prescription analgesics was Vicodin, IV user, residential treatment (one time).
26	Female	Caucasian	<u>1st use:</u> <u>Path:</u> <u>Choice:</u> <u>#1 PA:</u> <u>IV:</u>	13=ETOH,MJ, Coke ETOH,MJ, Coke→ Hallucinogens→ Meth→Multi-opiates Heroin Morphine, Tylox Yes	Some college, employed part-time, total drug use-13 yrs, first use of prescription analgesics was Vicodin, IV user, was in residential treatment (one time.)
29	Female	Caucasian	<u>1st use:</u> <u>Path:</u> <u>Choice:</u> <u>#1 PA:</u> <u>IV:</u>	12=MJ, Benzo MJ→ETOH→ Hallucinogens→Coke→ Dilaudid→Heroin Dilaudid Dilaudid Yes	3 ½ yrs college, student, total drug use-13 yrs, first use of prescription analgesics was Vicodin, IV user, was in residential treatment (one time).
43	Female	Caucasian	<u>1st use:</u> <u>Path:</u> <u>Choice:</u> <u>#1 PA:</u> <u>IV:</u>	14=ETOH ETOH→MJ→Speed→ Opiates Heroin Dilaudid Yes	Some college, employed part-time, total drug use-17 yrs, first use of prescription analgesics was Dilaudid, IV user, several detoxes-no treatment reports.
51	Male	Caucasian	<u>1st use:</u> <u>Path:</u> <u>Choice:</u> <u>#1 PA:</u> <u>IV:</u>	14=ETOH ETOH→MJ→Speed→PCP, LSD, Benzo→Heroin, Dilaudid, Percodan OxyContin, ETOH OxyContin Yes	HS graduate, employed full-time, total drug use-23 yrs (14 yrs sobriety), first use of pharmaceutical analgesics was Percodan, IV user (2 yrs,) residential treatment (2 times).
51	Female	Caucasian	<u>1st use:</u> <u>Path:</u> <u>Choice:</u> <u>#1 PA:</u> <u>IV:</u>	18= ETOH ETOH,MJ→Hallucinogens→ Coke→Demerol OxyContin OxyContin Yes	College graduate (BS), unemployed, total drug use-33 yrs, first use of prescription analgesic was Demerol, IV user (2yrs), residential treatment (3 times).

IV. Attitudes of Treatment Providers, Educators, Law Enforcement

There was general agreement among professional respondents who are involved with drug prevention, treatment, investigation, and education that there are at least nine factors of primary concern regarding the abuse of pharmaceutical analgesics:

1) There is an agreement among respondents that there is an increase in the abuse of these medications. Respondents believe that there was a period of relatively high abuse 15-20 years ago in the area which subsided for awhile, though there has always been a subculture which is abusing pharmaceutical analgesics. They believe that the appearance of OxyContin® has triggered a greater problem with pharmaceutical analgesics than has ever existed in this area. Other powerful opioids, such as fentanyl, Stadol®, Nubane®, and others are replacing “old standbys” such as Tylenol® with codeine, Darvocet®, Vicodin®, Percocet® and others, as drugs of interest to heavy users. Users are becoming more inventive at obtaining these medications. They are also increasingly being used in conjunction with other legal and illegal drugs.

2) The age range of users experiencing problems related to addiction is widening. Increasingly early onset of drug abuse among adolescents includes experimentation with pharmaceutical analgesics. Young users are drawn by the mystique of using dangerous substances. Initial use is usually oral or intranasal, avoiding the stigma associated with IV use. Dependence is often gradual, in that, after experimental adolescent use, users “rediscover” these prescription analgesics when they are more inclined to use regularly and are better able to obtain access to supplies. Older users are often introduced to prescription analgesics through legitimate medical interventions for chronic illnesses or following surgery. Because they may never have participated in recreational illegal drug abuse, they have difficulty identifying emerging problems and are unlikely to think of themselves as dependent.

3) The profitability of illegal diversion and sale of prescription analgesics is attractive to legitimate recipients of prescriptions for pain relief. For instance, older individuals on fixed incomes may be influenced by the flourishing, profitable market in these medications. They are reported to keep just enough for their own needs, and then sell the remainder. Healthcare professionals who work with severely ill patients also have access.

4) The medical community must decide when it is appropriate to prescribe. All respondents reported that this is a major problem. A medical educator said that teaching hospitals and medical colleges are including in their curricula more intense instruction in identifying and applying alternative pain management programs that do not rely so much on prescription analgesics. He added that interns and residents are often presented with case studies involving such issues. There is a stronger emphasis on patients’ psychosocial history as indicators of possible vulnerability to abuse and manipulation.

5) Some respondents believed that there are uninformed, gullible, or unscrupulous medical practitioners who over-prescribe. Several respondents called for stricter monitoring of dispensing of pharmaceutical analgesics. Respondents reported that they have clients who were on the same medication for more than 5 years. They recommended improved surveillance of pharmacies and inter-pharmacy networks to identify “doctor-shoppers.” Some respondents also implied that they believe the worst professional violators of over-prescription and unethical

distribution of pharmaceutical analgesics are likely dependent themselves. They recommended random drug screens for doctors and pharmacists, a difficult task because of assumptions of ethical behavior and responsibility in such high-status professions.

6) Individuals who have become addicted while following medical orders to take prescription analgesics have trouble seeking treatment. This is a very difficult problem, especially among older individuals, for a variety of reasons. Faith in the infallibility of medical professionals, inability to identify with drug abusers, real medical concerns and chronic pain, and perceptions of self-reliance make the prospect of participating in treatment an extreme effort on the part of these individuals. For both old and younger individuals with chronic pain, addiction may be seen as a necessary risk, considering the alternative of limited mobility and constant discomfort. Unfortunately, respondents added, in some cases the perception of chronic pain may be largely psychological in nature, a result of withdrawal symptoms.

7) There are secondary health problems related to the use of some pharmaceutical analgesics. Some preparations such as Vicodin® contain acetaminophen, which is hepatotoxic in large doses. Abusers may take 15-30 tablets per day, with each tablet containing 500 mg of acetaminophen. Many individuals who take prescribed analgesics also are often on other medications. For instance, medical professionals refer to OxyContin® as an “entourage” drug. Because of its time-release properties, it may be used with other “rescue” medications (Percodan®, Lortab®, etc.), intended to address breakthrough, or incident pain related to, for example, necessary physical activity. It is sometimes difficult to differentiate between suicide, accidental overdose, and unintended toxic reaction to polydrug ingestion. In data provided by the Summit County Medical Examiner, nearly one-fourth of investigated deaths between June 2002 and May 2003 (n=207) had drug screens containing pharmaceutical analgesics. Gunshot wounds, automobile accidents, and some other causes of death were not counted in this number, even though pharmaceutical analgesics were present in some of the drug screens.

8) Use of pharmaceutical analgesics often leads to the abuse of street drugs such as heroin when sources of prescription analgesics are unavailable. When chewed, inhaled, or injected, OxyContin® is reported by treatment providers’ clients to have an effect similar to heroin. Respondents all reported that they believe that heroin is increasingly available. Because of increased tolerance, OxyContin® users who avoided injection may begin doing so to achieve the desired effect. Another great area of concern is that OxyContin® is relatively expensive on the street (\$.50-1.00/mg, reported by various users). Heroin may be less expensive and more readily available. The necessity of avoiding withdrawal may compel users who were more comfortable with pharmaceutical doses to purchase heroin.

9) Publicity intended to encourage prevention may have the effect of attracting new users. Respondents believed that considerable media attention, local and national, acts as a magnet to some individuals who are looking for the next drug fad, or are looking to “cash in” on a lucrative product. Adolescents interested in gaining peer status by engaging in risky behavior are at particular risk of overdose, lacking the experience of more seasoned users.

V. User Responses

Primary Drugs of Choice

Among the recovering users interviewed, five of seven listed OxyContin® as their preference among prescription analgesics. Two of the older users preferred Dilaudid® or Demerol®, but had also recently used OxyContin®. Four respondents preferred heroin as their *overall* drug of choice, two listed OxyContin®, and one had methamphetamine as her primary drug. All but one respondent had a history of OxyContin® abuse. Pharmaceutical analgesics mentioned by respondents as being occasionally available were fentanyl, Ultram® (tramadol), Tylox® (oxycodone), MSContin®, and one respondent said that she had past access to Stadol® and Nubane®.

Drug Use History

The pathway to opiate dependence for the seven former users was fairly similar, despite age differences, and the fact that some might totally avoid the use of drugs that others would use with enthusiasm. For instance, alcohol use was an accompaniment to opiate use by some of the respondents, but was of little or no interest to the others. As indicated by this small sample of recovering users, there is variation in drug use history within the subgroup of opiate users. Respondents included six Caucasians, and one Asian; six of them were women and one man. All participants indicated that they believed that proportionally more whites than blacks use pharmaceutical analgesics, and the majority of users are male.

Three of the respondents were over 40, and their typical progression toward opioid use was to begin with alcohol. They started drinking as early as 12, and as late as 18. Marijuana was the first illegal drug used. Among this older group, onset age of use of marijuana varied. Other drug experimentation (amphetamines, PCP, LSD, benzodiazepines, methaqualone, etc.) followed in the late teens or early 20's. First use of opioids came from use as a prescribed pain medication, or through the introduction by another user. A male participant, age 51, said that he tried heroin before any other opioids. One user who had an accident-related back injury referred to a list of prescribed prescription analgesics including OxyContin®, Vicodin®, MSContin®, Percodan®, and Duragesic® (fentanyl) patches. She also began purchasing through illegal sources the same medications she was prescribed. These three older respondents all said that they began taking prescription analgesics abusively practically from the outset. These three older users all became intravenous users at various points in their lives. Two of them had stopped injecting, but used OxyContin® orally- daily, if possible. One of the older respondents had an interesting revelation about the motivation to use opioids:

I was a 'bargain shopper.' I have to say that, when it came to the narcotics - this is probably a little different than what you're used to...I didn't use 'em to get wasted. I used 'em to deal with life, to take away my pain, make me happier, make me fit in, make me delightful, OK? So, I would say that, for, like seventy percent of the time, probably, people didn't know I was doin' it, OK?...Now there were times that, of course, I was really down and stuff, or I was mad or something, that I really abused it....

The four younger respondents had an average age of 25 years. Onset age of use of alcohol and/or drugs was typically about age 12. Marijuana was the first illegal drug used in each case, usually at the same time as first alcohol use. Cocaine, hallucinogens, LSD, amphetamines, and benzodiazepines often followed during a period of experimentation.

Increases in regularity of use varied among respondents. Parental supervision, school activities, and involvement with non-using peers were mitigating factors. Respondents were quick to add that, for them, these factors only postponed increased drug use.

Abuse of prescription analgesics began in various ways. Vicodin® was mentioned first by several participants, twice as a legally-prescribed medication. One respondent was introduced first to Dilaudid®, by a friend. The fourth respondent in this subgroup said the first prescription analgesic that she used was OxyContin®. Three of the younger respondents became intravenous drug users. Though primary users of heroin, they all said that they had abused OxyContin® within the previous six months. The fourth respondent reported using OxyContin® and Vicodin® orally prior to seeking treatment.

Obtaining Prescription Analgesics

According to the seven participants, the primary way in which prescription analgesics are obtained is either through personal prescriptions, or from friends or relatives, either by stealing them, or as part of a close-knit network. Several respondents admitted to manipulating doctors in the past, by not divulging existing prescriptions obtained from other physicians. None of these respondents said that they had ever forged fake prescriptions themselves, but believed that there are individuals who use this method to obtain prescription analgesics. Employment in healthcare or pharmacy positions creates opportunities for pilferage. When they referred to obtaining these drugs from the “street,” it usually means that they purchased them from individuals whose only connection to each other is for the sale of drugs. They said that there are urban areas where it is possible to purchase from actual street dealers, but they avoided such methods of obtaining because of the risks involved.

Prices for prescription analgesics were reported to vary somewhat, depending on the type of connection one had with the supplier. Obviously, purchasing them as a legitimate prescription would be the most economical way. Within the past six months, most respondents said that they had paid between \$.50-1.00/mg for OxyContin®. This represents an overall reduction from one year ago, when it was typically reported that OxyContin® was selling at least \$1/mg. Increasingly, because of popularity and negative publicity, 10 mg and 40 mg doses are predominately available, with the larger doses (i.e., 80mg, 120 mg, 160mg) being harder to obtain. Dilaudid® continues to be expensive, with 4 mg tablets going for between \$20-40. Vicodin® and Percodan® were reported to sell for between \$5-10 per tablet, depending on the dosage. Prices of some of the prescription analgesics that are harder to obtain (fentanyl, Lortab®, etc.) were not given, but respondents said they believe that they would be in the range of such things as Dilaudid®.

It is difficult to identify the typical daily cost of use among these respondents. A “typical” daily cost might be between \$50-500. Those who used prescription analgesics intravenously said that they believed they were getting the most “mileage” out of their daily investment. But all respondents said that they became adept utilizing various strategies to ensure a daily supply. Some women were aware that they had traded sex for drugs, but none of them felt that this was equivalent to prostitution. In the case of one respondent, she felt that her personal access to

supplies of prescription analgesics gave her an elevated status among her using friends. All respondents spoke of being part of using subgroups that “looked out for each other.” That is, they might operate a limited barter system, although one respondent added that there is little generosity among users during the height of their addiction.

Injection History

All but one of the seven respondents had a history of intravenous injection. Two of the six had not injected for several years. They were both over 50 years of age. They each reported that they used intravenously for two years. One preferred Dilaudid®, and said that she did not share needles, cookers, cottons, or water with anyone. The other respondent used heroin. He said that he did share injection paraphernalia with others about half the time. His rationale was that 25 years ago not much was known about HIV and AIDS. He did indicate that awareness of the risk was part of the reason for ceasing IV use. Both of these participants have been tested for HIV since their IV use.

The other four IV users had similarities in their responses to questions about injection practices. Three of them were primary heroin users, the fourth abused Dilaudid® and occasionally, used heroin. An interesting similarity among this group of women was the disclosure that they frequently shared injection paraphernalia with the male partners they were involved with at the time. All have been tested for HIV.

Treatment

Of the seven respondents, two were in treatment at the time of interview, four had completed treatment (residential or outpatient) within the past 11 months, and the seventh respondent had been in several detox programs, but not in intensive treatment. The general perception was that treatment in the area is not difficult to access, and that court officials are often anxious to refer to treatment, when the defendant’s problems are drug-related and do not involve extreme violence.

VI. Conclusion

There is a sense among all respondents that the abuse of prescription analgesics is increasing, encompassing new user groups, and is not responding very well to efforts to prevent the proliferation of abuse. In the past, users tended to be polydrug users who gradually gravitated toward the use of opioids. The physical and psychological effects of these drugs combine to create a powerful dependence. Many users refer to the energy and sense of well-being they derive from using these drugs. Despite the demands of physical dependence, individuals reported feeling content and secure in ways that they believe they are not able to achieve for themselves in less harmful ways.

A powerful paradox surrounds the great benefit from the appropriate use of prescription analgesics to relieve pain versus the potential for abuse. Medical professionals are particularly frustrated by the persistence and audacity used by some to obtain these drugs. A deep concern is the potential for powerful medications such as OxyContin® to result in accidental overdose. Yet, respondents indicated that the rash of publicity surrounding these drugs may attract those with a potential, or predisposition to drug abuse.

Prescription Analgesic Abuse
(Southeast, OH)

An OSAM Rapid Response Report Prepared for the Ohio Department of Alcohol and Drug
Addiction Services

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I. Introduction

According to past and current OSAM Network reports, prescription analgesic abuse has been increasing in most areas of the state. The current investigation was conducted to examine patterns of prescription analgesic abuse in Southeastern Ohio.

II. Methods

For the current study, in-depth, semi-structured interviews were conducted with three participants who self-reported abuse of pharmaceutical analgesics in the past 12 months. All participants were recruited through a large treatment center for alcohol and drug abuse in the Athens, Ohio, area. Recruitment was facilitated by a substance abuse case manager who was familiar with each participant's drug abuse and treatment history. The study was described, and informed consent was obtained from each participant prior to each individual interview.

Each interview lasted for about one hour and covered the following areas: participant sociodemographics (e.g., age, education, marital status), primary drug for which the individual had sought treatment, type(s) of analgesics each had abused, lifetime history of substance abuse, patterns of prescription analgesic abuse, perceived risks, treatment history for substance abuse, and injection risk practices. All individual interviews were audiotaped (after receiving each participant's consent), and themes and important comments in participants' responses were summarized.

III. Participant characteristics.

All three participants were white women, ages 23, 33 and 35. All of them were currently in recovery. More detailed information about each participant is presented in Table 1. The participants reported abuse of the following prescription analgesics: OxyContin® (oxycodone controlled-release), Vicodin® (hydrocodone), Percocet® (oxycodone & acetaminophen), Percodan® (oxycodone & aspirin), Demerol® (meperidine), and Tylenol® with codeine.

Table 1. Characteristics of the study participants

Part	Gender	Age	Education	Job Status	Marital Status	Primary drug of choice	Prescription analgesic of choice
1	Female	33	Some College	Unemployed	Divorced	Vicodin	Vicodin
2	Female	23	Some High School	Employed Full-time	Single	OxyContin	OxyContin
3	Female	35	Some High School	Employed Part-time	Divorced	Marijuana	Percocet

IV. Drug Abuse Histories

All three women had fairly extensive substance abuse histories. All of them reported using alcohol at a very early age. For example, a 35-year old woman commented:

I had a step dad, and he would make me get drunk with him... to get even with my mom, 'cause she worked at the bars, he would make me and my sister get drunk with him I was five and my sister a year older....

All women also reported early use of marijuana. A 35-year-old woman described her first experience with marijuana: *"With marijuana, I was 8 years old the first time I did it; my baby sitter got me and my sister high."*

A 35-year-old woman described that during her teenage years she went through an intense period of using alcohol and marijuana. About 9 years ago, after the death of her mother, she started abusing Klonopin® (clonazepam). A few years ago she started using prescription analgesics, primarily Percocet®. She reported that recently she experimented with crack cocaine.

A 33-year-old woman explained that she grew up in an orphanage and also became a heavy marijuana and alcohol user during her teenage years. When she turned 18 and got her "freedom," she started experimenting with powdered cocaine. Soon she discovered narcotic analgesics, which became her drug of choice since she had a medical condition for which she was able to obtain prescriptions. She also reported abuse of Valium® (diazepam) and Xanax® (alprazolam).

The youngest participant, a 23-year-old woman, also reported early onset of alcohol and marijuana use. At the age of 15 she started using methamphetamine. Soon after that she became pregnant and stopped using drugs for a while. After she had her second child at the age of 18, she had a hysterectomy and was prescribed OxyContin®. She eventually became dependent on narcotic analgesics. Besides prescription analgesics, she reported abuse of Valium® and Ritalin® (methylphenidate).

V. Prescription Analgesic Abuse

Introduction to prescription analgesics. Two participants reported that they were introduced to analgesics in a medical setting. For example, a 33-year-old woman described her first experience with prescription analgesics in her early 20s: *"First... Tylenol with codeine... I had my wisdom teeth pulled, and that was cool, I got that instant buzz, wow...."*

She further explained that a few years later she got diagnosed with a chronic back condition and started receiving prescriptions for pharmaceutical analgesics. She explained: *"It is almost like with that diagnosis I was given permission to really start taking them."* She reported receiving prescriptions and abusing Vicodin®, Demerol®, and eventually OxyContin®. She considered Vicodin® to be her pharmaceutical analgesic of choice.

The third participant, a 35-year-old woman, reported that she was introduced to Percocet® when she was in jail more than a year ago. She explained that she first started abusing Klonopin® after her mother died. Before that she tried to stay away from pharmaceuticals, even

though they were commonly abused in her family and among her friends, but “*after my mom died, I really did not care what they would do to me.*”

Two participants reported that they introduced other people to prescription analgesics; typically this occurred in social situations. A 33-year-old woman commented:

We would be partying, whatever, and I am like, you, guys, gonna try this [OxyContin], 'cause this was a buzz that lasted, 'cause it wasn't a buzz that you take it, and an hour later you come down crashing...

Reasons for abuse. Two women believed their dependence was partially due to the fact that they received a legitimate “flow” of prescriptions for narcotic analgesics. The third woman related her abuse of prescription analgesics to a traumatic experience several years prior. One participant further explained that in some cases prescription analgesic abuse might be related to stressful life circumstances, financial troubles, or “feeling that their life is not on track.” Two of the participants reported that alcohol and drug abuse was common in their families, factors that they considered to be an important influence on their life choices and drug abuse histories.

Patterns of prescription analgesic abuse and change over time. The 35-year-old woman reported she had been abusing prescription analgesics for over a year. The 33-year-old woman had abused them for about seven years, and the 23-year-old had abused them for about four years. They described how their tolerance increased and their use changed over time. For example, the 33-year-old woman, who started abusing Tylenol® with codeine eventually went to more powerful prescription analgesics:

Eventually, my body built up an “immunity to” it, and I went to Percodans or Percocets; they stopped working, then I went for like Vicodins and Demerol, and the “Oxys.”

Participants reported that they typically started abusing prescription analgesics orally, and then later switched to intranasal administration. This transition was especially common among OxyContin® abusers. According to participants, some prescription analgesics, such as Percocet® are typically taken orally, since they “burn” when inhaled intranasally. The 23-year-old woman reported an incident when she tried to shoot OxyContin®. According to her, this was “the biggest rush,” but she did not use it that way again because she did not like needles.

Concurrent use of other substances. One participant, a 35-year-old woman, reported that she would abuse alcohol and marijuana while taking prescription analgesics. More recently, she used Percocet® to come down from a crack high. Two other women reported that they would be taking prescription analgesics, especially OxyContin®, as “stimulants.” One participant even compared the OxyContin® high to the rush of energy that she would get from snorting powdered cocaine. Then they would take benzodiazepines, such as Valium® or Xanax®, to balance the high. For example, the 33-year-old woman commented:

They [prescription analgesics] kind of get you up, then I need something like a downer, like a Valium or Xanax. So I was taking pills to keep me up, and taking pills to bring me down.

Ways to obtain prescription analgesics and reported “street” prices. Two of the women had legitimate medical problems and were able to manipulate their health care providers and obtain more prescriptions than needed. The 23-year-old woman reported selling part of her OxyContin® prescriptions, which allowed her both to support her habit and pay her daily bills. The 33-year-old woman also reported sometimes sharing some of her prescription analgesics with her “party friends.” All of the participants reported that it was typically fairly easy to obtain prescriptions for narcotic analgesics. The 23-year-old women commented:

You can go to an emergency room and get a bunch.... I would use my back, because my girl's dad used to beat the crap out of me, and my spine is crooked and... they are too easy to get; they [doctors] pass them out, and here you go....

One participant, the 35-year-old woman, reported that she would obtain prescription analgesics from her family members who would typically buy the drugs off the street.

Participants reported the following street prices for pharmaceutical analgesics: OxyContin® sells for about \$1 per milligram; Vicodin® sells for between \$4-\$7 per tablet, Demerol® sells for between \$7-\$8 per tablet, Percocet® sells for between \$5-\$10 per tablet, and Percodan® sells for about \$8 per tablet.

Perceived risks and health effects. All three women thought that prescription analgesic abuse had very serious risks and health consequences. All of them knew friends or family members who had died from overdosing on OxyContin®. The 23-year-old woman reported, “*I had a heart attack, from too much [OxyContin], my heart could not handle it....*” Dependence and rapid progression into “major addiction” was cited as another important risk of abusing prescription analgesics. The 33-year-old woman talked about damaging effects to the liver and other organs.

Perceived treatment needs and barriers. All three women were currently in drug abuse treatment. While all of them had sought treatment for alcohol or other drug abuse in the past, each reported at least one occasion of relapse. Concerns about the well-being of their children was one of the major factors that lead them to seek treatment. One of them reported that she had to wait 7 months to get into treatment. The 33-year-old woman talked about lack of treatment facilities in the area “close to home,” where she had her major networks of social support. She commented:

Like with me, my support is right here in this area. If they gonna ship me three hours away, it is not gonna be any good, 'cause I need my support.

Trends of prescription analgesic abuse. All three participants considered prescription analgesic abuse to be increasing in the area. According to some, this increase was partially due to the fact that analgesics were very easy to obtain. Abuse was reportedly common among white individuals in their 30s, but the fastest growing user group was described as white youth between the ages of 16 and 25. The 23-year-old woman reported:

Many people on them [OxyContin], all [age] groups. I see little kids in high school doing them.... My sister brought a pill one day, she did not know what it was and they were popping it at school, and she just put it in the pocket, trying to look cool, like she took it.

And it was "Oxy" 20[mg], and she is a cheerleader... I am glad she brought it home; I am glad she did not take it...

Ideas about prevention. All of the participants believed that health care providers need to be better informed about how users can fake injuries or conditions that require prescription analgesics. According to participants, health care providers over-prescribe pharmaceutical analgesics and under-utilize other pain management strategies, including physical therapy. They also pointed out the need for early education and after school activities, especially for those children who come from high risk families.

VI. Injection Drug Use Histories

Two of the three women reported histories of injection drug use. Specifically, one woman indicated that she injected cocaine (i.e., 2 to 3 times per week) and, to a lesser extent, OxyContin® (2 or 3 times in her life). One woman injected OxyContin® once, while in treatment for an OxyContin® addiction. Both women who reported injecting drugs indicated that they did not share syringes, spoons, or other paraphernalia (noting the risks involved in these types of sharing behaviors). Both of them have been tested for HIV infection.

VII. Conclusions

All three participants reported an early history of alcohol and marijuana use and experimentation with other substances, including powdered cocaine, methamphetamine, benzodiazepines and other drugs before they started using prescription analgesics. Two women reported that they were introduced to prescription analgesics as a result of legitimate medical prescriptions. Participants indicated that it was far too easy to obtain prescription analgesics, both at medical facilities and on the "streets." Participants associated many risks with prescription analgesic abuse, including dependence, overdose, and damage to liver and other organs. According to these participants, prescription analgesic abuse is increasing, especially among white youth between the ages of 16 and 25. Participants perceived a lack of treatment facilities in the area, and believed there was an urgent need for prevention initiatives targeting adolescent and adult populations.

Prescription Analgesic Abuse

Cleveland, Ohio

An OSAM Rapid Response Report Prepared for the Ohio Department of Alcohol and Drug
Addiction Services

January 2003-June 2003

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I. INTRODUCTION

According to the 2000 Census, Cuyahoga County had almost 1.4 million residents and is the most populous and urban of Ohio's 88 counties. Approximately 67% of the population self-identifies as white. Slightly more than half of the county's population is female and the median age of all residents is 37.3 years. Slightly more than 10% of the population use a language other than English at home. More than 80% of the population over the age of 25 have a high school diploma or equivalent, but only one-quarter have graduated from college. The median household income for 1999 was \$39,168. Just over 10% of families lived below the poverty level in 1999. Among families with related children under the age of 18, 16% lived under the poverty level. If one considers only those families with related children under the age of 5 years, more than one-fifth of these families lived under the poverty level. Census data for the year 2000 indicate that almost 40% of the county's population was not in the labor force and of those who were, over 6% of the civilian labor force was unemployed.

II. METHODS

Although a number of focus group participants for the drug trend report indicated that they had abused prescription analgesics during the previous year, many refused to participate in individual interviews. Consequently, it was difficult to identify users who were willing to be interviewed. Respondents for these individual interviews were ultimately recruited through a treatment facility. Respondents were limited to individuals 18 years of age or older, living in Cuyahoga County, who had abused prescription analgesics during the previous year. An informed consent was obtained from each individual prior to the interview. Each individual was paid \$20 for participation.

III. DEMOGRAPHICS

Three individuals were interviewed. Demographic characteristics of the interview participants are presented in Table 1. Two participants had not completed high school; one had an Associate's degree. None of them were employed at the time of their interview. All three were single and all three were in treatment for heroin abuse. Each of the respondents had abused prescription analgesics during the previous 3 to 4 months. The participants reported abuse of the following prescription analgesics: OxyContin® (oxycodone controlled-release), Darvocet® (propoxyphene & acetaminophen), Darvon® (propoxyphene), Percocet® (oxycodone & acetaminophen), Ultram® (tramadol), Vicodin® (hydrocodone), and methadone.

Table 1. Participant characteristics

Date	Age	Sex	Ethnicity	Drug use history
5/28/2003	36	Male	Hispanic	Drug of choice: heroin; used Percocet® and OxyContin®; in treatment for heroin
6/6/2003	34	Male	Hispanic	Drug of choice: heroin; used Ultram® and methadone (street); in treatment for heroin
6/6/2003	36	Male	Hispanic	Drug of choice: heroin; used Darvocet®, Darvon®, OxyContin®, Percocet®, Ultram®, Vicodin®; in treatment for heroin

IV. TREATMENT PROVIDER ATTITUDES

Providers reported an increase in the abuse of drugs such as OxyContin®, Percocet®, and Vicodin®. They noted that these drugs are often used at clubs or other social settings, typically in combination with alcohol. Treatment providers considered the abuse of prescription analgesics to be increasing, especially among white women.

V. INTERVIEWS WITH PRESCRIPTION ANALGESIC USERS

Drug Use History. Each of the participants indicated that he had begun using drugs while quite young, between the ages of 9 and 16. Alcohol and marijuana were the drugs that were initially used. Typically, drug use progressed to include heroin and powdered cocaine. Participants reported they started abusing prescription analgesics after they initiated heroin abuse. Usually, prescription analgesics were used as a replacement for heroin when heroin was unavailable.

Patterns of prescription analgesic abuse. One individual had been abusing analgesics for a relatively short period of time (about six months), but the other two reported that they had been abusing prescription analgesics for about 20 years.

During the previous six months, one individual used prescription analgesics almost every day for about four months. Another participant used prescription analgesics on only three separate occasions, and the third participant reported injecting prescription analgesics for approximately two and a half months.

All individuals had swallowed analgesics; two indicated that they had begun prescription analgesic abuse by swallowing the tablets and then progressed to smashing them and injecting the solution. One individual indicated that he had swallowed the drug at last use. The other two individuals injected pharmaceutical opioids and one also snorted them. All three respondents used heroin while using prescription analgesics; one of them reported concurrent abuse of LSD and mescaline. The third participant reported concurrent abuse of alcohol.

Two of the participants had introduced two or fewer individuals to analgesic abuse; the third respondent indicated that he had introduced less than 10 individuals. All three respondents indicated that they had introduced more people to heroin than to prescription analgesics.

Ways to obtain prescription analgesics and reported prices. The method of obtaining prescription analgesics varied. One individual stole them from his grandmother. Another obtained them from friends, sometimes in exchange for heroin. The third purchased them from a friend and “on the street.” The participants reported the following prices for prescription analgesics:

OxyContin®:	about \$0.50 per milligram.
Percocet®:	about \$5, and up to \$20
Ultram®:	about \$1 to \$3
Vicodin®:	about \$5

Trends of prescription analgesic abuse. Two respondents indicated that analgesic abuse is increasing; one indicated that it is stable. In general, respondents indicated that the abuse is increasing among young whites in the suburbs, with some increased use among long-time heroin users.

Perceived risks of prescription analgesic abuse. Overdose and death appear to be the major risks that are seen as being associated with prescription analgesic abuse. Increased education was recommended as a way to prevent the abuse of these drugs.

Perceived treatment needs and barriers. Since heroin was their primary drug of choice, none of the respondents had ever been in treatment for analgesic abuse. One participant indicated that he had previously been in treatment for heroin use and relied on a 12-step/detox program through a Hispanic agency. He indicated that there are inadequate treatment options and aftercare.

Injection-Related Risks. All three respondents indicated that they had injected heroin; one respondent indicated that he also injected OxyContin® and speedballs (heroin mixed with powdered cocaine). The duration of their injection drug use ranged from 2 months to 21 years. Two individuals indicated that they bought new needles; one said that he used bleach to clean his needles. One respondent had never shared needles; two indicated that they shared less than half of the time. One of those who shared needles said that he cleaned the needle prior to using it; the other individual said that he had to share because he did not know how to shoot up and needed assistance. Two of the three individuals, however, indicated that they shared their works. All three have been tested for HIV infection.

VI. CONCLUSIONS

Among the participants interviewed, pharmaceutical analgesics were often used when heroin, their drug of choice, was unavailable. Reportedly, prescription analgesic abuse is more common among young white individuals who reside in suburban communities. According to participant reports, prescription analgesics are generally more difficult to obtain than other street drugs, such as heroin.

Pharmaceutical Analgesic Abuse

(Columbus, Ohio)

An OSAM Rapid Response Report Prepared for the Ohio Department of Alcohol and Drug
Addiction Services

January 2003 – June 2003

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I. Introduction

For the past two years, OSAM reports have indicated increases in the abuse of pharmaceutical analgesics on a statewide basis. The current study is designed to learn more about how people are introduced to prescription opioid abuse, their general characteristics in terms of demographics and drug histories, the perceived barriers to treatment for pharmaceutical analgesic dependence, and perceived trends in their abuse, according to both active users and treatment providers.

II. Methods

Participants in the current study were recruited through the MDMA project in Columbus, Ohio. Participants were selected for their knowledge and history of abusing pharmaceutical analgesics, and in this particular area, tramadol (Ultram®/Ultracet®). All provided informed consent for the recording of the interviews, and no participants under the age of 18 were admitted into the study. Each participant was paid \$20 in cash upon completing an interview, which ranged from 20 to 45 minutes in length.

Thus, nine individual qualitative interviews were conducted and audiotaped in the MDMA project site offices in Columbus, Ohio in February, 2003. The interviews followed the semi-structured protocol entitled, "Ohio Substance Abuse Monitoring Network Pharmaceutical Analgesic Abuse Rapid Response Interview Guide." In addition, each of the nine participants was interviewed specifically in regard to his or her use of Ultram® (tramadol) and/or Ultracet® (tramadol & acetaminophen). Transcripts of the interviews were then generated and checked for accuracy against the recordings.

Data analysis consisted of preparing data tables summarizing demographic information, along with information pertaining to general drug use history, history and current practices related to the abuse of pharmaceutical analgesics in particular, as well as attitudes towards the risks associated with the abuse of pharmaceutical analgesics, and suggestions as to what might be done to curtail the abuse of these drugs in the state of Ohio. These tables provided a simplified means of comparing data supplied by the nine respondents.

Two tape-recorded focus groups, and two tape-recorded interviews with treatment providers in the central Ohio area were also conducted as a part of the regular OSAM data collection process for the period from January 2003 through June 2003. These treatment providers also provided informed consent and were compensated with lunches and \$20 cash payments for their time and input. In all, we spoke with 11 treatment providers who serve various populations in central Ohio, including adolescents, college students, homeless men and women, and opioid-dependent clients. The data which they provided in regard to the use of narcotic analgesics, as elicited by the standard OSAM focus group and interview guide, are presented here in support of the data collected with the nine active drug users mentioned above.

III. Demographics

Basic demographics and information regarding participants' drug histories are summarized in Table 1.

Table 1. Characteristics of the participants (n = 9).

RR #	Age	Gen.	Marital status	Education/ employ. status	Main drug of choice	Phar. analg. of choice	Additional drugs used over lifetime
1.	20	F	Living as married	College Sophomore/ Part-time employment	Adderall	Vicodin	Alcohol, Ecstasy, Marijuana, Cocaine, LSD, mushrooms, OxyContin®
2.	19	M	Living as married	College Sophomore/ Full-time employment	Marijuana	Vicodin	Darvocet®, Alcohol, Marijuana, mushrooms, Ecstasy, LSD, cocaine, Percocet®, Vicodin®, Ambien®, Zoloft®
3.	20	M	single	College Sophomore/ Part-time employment	Marijuana	Vicodin	Alcohol, Marijuana, LSD, Mushrooms, cocaine, Heroin, crack, ketamine, Ecstasy, Darvocet®, Vicodin®, codeine, Percodan®, Percocet®, OxyContin®
4.	19	M	single	College Sophomore/ No employment	Marijuana	Vicodin	Alcohol, Marijuana, Ecstasy, Vicodin®, Valium®, Percocet®, hydrocodone; Adderall®
5.	19	M	single	College Sophomore/ No employment	Marijuana	Vicodin	Alcohol, Marijuana, mushrooms, Ecstasy, Cocaine
6.	20	M	single	College Sophomore/ No employment	Marijuana	Vicodin	Alcohol, marijuana, cocaine, Ecstasy, mushrooms, OxyContin®, Percocet®, Adderall®
7.	20	M	single	College Junior/ No employment	Marijuana	Vicodin	Alcohol, Marijuana, Vicodin®, Percocet®, Tylenol® 4, mushrooms, Ecstasy, cocaine
8.	19	M	single	College Sophomore/ No employment	Heroin	Street Methadone wafers	Alcohol, marijuana, Ecstasy, a wide range of pharmaceutical analgesics, Heroin, Cocaine, Crack, and OxyContin®
9.	23	M	single	High school diploma/ No employment	Cocaine/ Alcohol	Oxy-Contin	Alcohol, Marijuana, Lorcet®, LSD, OxyContin®, Cocaine, Ecstasy, Heroin

In summary, our rapid response research population ranged in age from 19- to 23-years-old, with an average age of 19.8 years old. It included 8 males and 1 female, 7 of whom reported being single, and two of whom reported to be living as married. Educationally speaking, our population was fairly homogenous, with 8 respondents reporting current college enrollment (7 sophomores and one junior), and one reporting a high-school diploma with plans

to enroll in college. Only three of the respondents reported being employed, 2 of whom were part-time only. None has ever been admitted to a drug or alcohol treatment program.

Regarding general drug use and preferences, our sample included 6 individuals (66.6%) who reported marijuana as their drug of choice, with one mentioning Adderall (amphetamine mixed salts), one mentioning heroin, and one mentioning cocaine and alcohol. All reported currently using both alcohol and marijuana. In regard to the abuse of pharmaceutical analgesics, the average reported number of years abusing pharmaceutical analgesics was 2.6. When asked their pharmaceutical analgesic of choice, seven reported Vicodin® (hydrocodone), one reported Methadone wafers (non-prescription), and one reported OxyContin® (oxycodone controlled-release). More information on drug use histories can be found in the Results section of this report.

IV. Treatment Provider Attitudes Towards the Abuse of Narcotic Analgesics

In the current round of general reporting for OSAM, we conducted two focus groups and two individual interviews with a total of 11 treatment providers in the central Ohio area. They highlighted two noteworthy trends in regard to the abuse of pharmaceutical analgesics. These regard an apparent dichotomy between high school student and college student usage patterns, and a discussion of the relationships between the use and abuse of pharmaceutical analgesics and the rise in heroin usage in Columbus. Table 2 summarizes the general data regarding those treatment providers.

Table 2. Characteristics of treatment providers (n = 11).

FG or Ind. Int.	Ethnicity	Gender	Experience/Background
FG 1	African American	Female	Serves adolescence as a counselor in a comprehensive drug abuse treatment facility for ~4 months.
FG 1	Caucasian	Male	Licensed Independent Social Worker with 10+ years of experience in the AOD and mental health field. Currently serving adolescents as a director of programs in a comprehensive drug abuse treatment facility.
FG1	Caucasian	Male	Licensed Social Worker serving adolescents as a counselor in a comprehensive drug abuse treatment facility for nearly 2 years.
Interv.	Caucasian	Male	~10+years in the AOD field. Substance Abuse Specialist serving primarily college students and various clients in private practice.
FG 2	Caucasian	Female	Licensed Independent Social Worker working for 1+ years as an adolescent therapist.
FG 2	Caucasian	Male	Counselor for a variety of people (including a college population) in prevention and treatment of both AOD and psychiatric issues. Has 20+ years of experience in the field.
FG 2	Caucasian	Fem.	Has worked 13+ years as a Clinical Psychologist in a public health setting.
FG2	Caucasian	Male	Has 7+ years of experience in the field currently working with the homeless population with concurrent AOD and mental health issues.
FG 2	African American	Female	Student Intern completing practicum at large treatment facility for the indigent.
FG 2	African American	Male	Administrator in the alcohol/drug and mental health field.
FG 2	African American	Male	Administrator in the alcohol/drug and mental health field.
Interv.	Caucasian	Female	Has 20+ years of experience in the AOD field (primarily working with dual diagnosis) of which 13+ years have been in a clinical setting (with 10 of those serving primarily women in a drug rehabilitation program).

A. Narcotic Analgesic Abuse Within Student Populations

According to adolescent treatment providers in a focus group at a publicly-funded facility, OxyContin® is more available to the adolescents they treat—and more preferable to them—than are other weaker narcotic analgesics:

It's, it's amazing um, and they know, well, um, Oxy's stronger than a Vicodin, ya know, so they're gonna go right to [it]...gonna pop the pain pill and get a buzz. They're gonna go for the thing that's gonna give them the most, and so, and so, and I think, what's more available is probably Oxy because it's, it's more the pill du jour... Uh, and it's, it's ya know, king of the, the hill in terms of the pills... So, ya know, don't, if they're gonna be trying and popping some pills for that kind of purpose, they'll probably go for that [OxyContin].

Another treatment provider in the same focus group exclaimed, *"I think they've all at least tried it,"* in reference to the level of OxyContin® use among adolescents in residential treatment at that facility. A treatment provider to adolescents at a privately funded center in the suburbs agreed that she had seen an increase in the number of adolescents reporting the use of OxyContin® as well. It may be that a potentially dangerous—and apparently widespread—assumption regarding OxyContin is at play in these continued high rates of usage. As one treatment provider noted, many of her clients have operated under the assumption that *"It's [OxyContin] not dangerous because it's prescribed... because it's legal."* However, one college treatment provider did state that *"I still have not seen reported OxyContin use....A lot of students don't know what it is when I check it out with them."* Rather, he reported, *"Some [students] will supplement their pot and alcohol use with a Percocet or a Vicodin occasionally."*

B. Relationships Between Narcotic Analgesic Use/Abuse and Heroin Abuse

There were also several reports of heroin users switching over to OxyContin® because they liked the effect more or because it is perceived as being "a lot stronger than heroin" (25-year-old white female drug user). A 40-year-old African-American woman in recovery noted the same trend: *"That's what they're doin'—movin' from heroin to OxyContin."* However, the more prevalent trend—from OxyContin® use to heroin use—appears to be economically and practically motivated. With the price of heroin dropping so low, it is easy to understand why users would choose that over the much more expensive OxyContin®.

Several treatment providers recounted the experiences of people who were prescribed OxyContin® or other opioids to manage pain after surgery or injury, who then became dependent upon these medications, and who ultimately succumbed to intravenous heroin usage. As one treatment provider to homeless women explained:

We have a lot of clientele that come in, and they have gotten addicted because of surgeries and things, and then they move from painkillers to street drugs because, of course, they can't get the quantity they need for their tolerance build-up, and then they end up going to heroin.

She and other treatment providers propose that doctors should be educated more regarding the possibility of addiction that exists with OxyContin® and similar medications. Perhaps the recently-announced public awareness campaign by Purdue Pharma (ONN, 6/19/03) will serve to educate both doctors and potential patients of the possible risks of dependency related to this product.

V. Results

A. Details of General Drug Use Histories

All the participants in the Rapid Response initiative reported having fairly substantial drug use histories. In addition, there were a number of characteristics which most—if not all—of the participants shared. All nine began their history of drug experiences with alcohol. While one was only five years old when his parents began giving him beer, the other eight participants began using alcohol without their parents' knowledge within two years of starting high school. In addition, all of the nine respondents reported moving directly on to marijuana use after first using alcohol, with the average age for first marijuana use being 15.3 years old. Indeed, six (66.6%) individuals reported marijuana as his or her drug of choice.

Lifetime prevalence rates were similar in relation to a number of substances as well. In regard to hallucinogens and club drugs, all nine reported having used Ecstasy (MDMA) at least one time, and seven (77.7%) reported having used LSD, psilocybin, or both. However, only one reported a single use of ketamine, and none reported trying GHB or Rohypnol. Eight (88.8%) reported having used powdered cocaine, whereas only two (22.2%) reported having smoked crack, four reported having used non-prescribed Adderall, with two calling it a drug of choice. Finally, three (33.3%) reported having used heroin, two of whom also reported having injected it. These two respondents were the only injection drug users in the sample, with one injecting heroin and OxyContin®, and one having injected heroin, OxyContin®, and cocaine.

B. Details of Pharmaceutical Analgesic Use

The nine participants we interviewed had, in general, sampled a number of different narcotic analgesics, with the average length of abuse being 2.6 years. Years of abusing these drugs ranged from less than one to over 6 years. In regard to the reported pharmaceutical analgesic of choice, seven (77.7%) reported favoring Vicodin, one reported favoring non-prescribed methadone wafers, and one chose OxyContin®. The most commonly used pharmaceutical analgesics were reported as being Ultram®/Ultracet® and Vicodin® (both used by 100% of the sample), Percocet® (oxycodone & acetaminophen) (used by 6 or 66.6% of the sample), OxyContin® (used by five or 55.5% of the sample), and Darvocet® (propoxyphene & acetaminophen) (used by four or 44.4% of the sample). One or two participants also mentioned having used codeine, Percodan® (oxycodone & aspirin), Tylenol® 4, hydrocodone, non-prescribed methadone, Lorcet® (hydrocodone & acetaminophen) and Lortab® (hydrocodone & acetaminophen).

C. Patterns of Most Recent Pharmaceutical Analgesic Abuse

When questioned regarding their most recent use of a non-prescribed pharmaceutical analgesic, participants' responses varied from 1 day ago to 45 days ago. The most common response was "three days ago." The average of all their responses equaled 13.2 days ago. The most recently used substances included Ultram® (4 responses), Vicodin® (2 responses), and Darvocet® (2 responses). One participant did not mention the most recently used substance.

D. Methods of Administering Pharmaceutical Analgesics and Injection Practices

All participants reported having crushed and inhaled pharmaceutical analgesics, as well as having orally ingesting them, sometimes combining the two methods in one sitting. Two participants (22.2%) reported also having injected OxyContin®, one of whom had a one-year history of injecting, and one who reported injecting drugs for two years. Both respondents stated that they used new needles and never shared them, with one reporting that he had shared rinse water and cookers. He also reported eating cottons when he had finished using them; he had never been tested for HIV. The other participant reported that he always used all of his own supplies, and that he had just recently been tested for HIV, but he did not know the result of that test.

E. Use of Pharmaceutical Analgesics in Conjunction With Other Substances

Of the nine respondents eight (88.8%) reported using them in conjunction with alcohol. Of those eight, seven (77.7%) reported combining alcohol, marijuana, and pharmaceutical analgesics in one sitting. In total, eight (88.8%) reported using marijuana with various pharmaceutical analgesics. One stated that he had used them in conjunction with Ecstasy and cocaine, and another stated he had used them with “all sorts of stuff.”

F. Reported Reasons for Using Pharmaceutical Analgesics and Social Settings for Their Use

Participants’ stated reasons for their usage of pharmaceutical analgesics can be grouped into four basic response types. A number of them listed several rationales. Five stated that they use them to “catch a buzz.” Four stated that they use them to relax, particularly after a night of partying, one mentioned he used them to get to sleep, and one mentioned that he used them to sooth his neck pain (and “catch a buzz” at the same time).

Our respondents each listed several social settings in which they used narcotic analgesics. In the order of most to least common, they included: friends’ homes (7), parties (6), and one’s own home (2). It is interesting to note that the two respondents who listed “home” were also the two with the most varied experience with narcotic analgesics, the only two who had injected drugs, and the only two who admitted to seeking out this type of drug.

G. Methods of Obtaining Pharmaceutical Analgesics, Prices, & Rates of Introduction to Others

In regard to ways they obtained pharmaceutical analgesics, the most popular method was to obtain them from friends. These friends, in most cases, obtained them for surgeries or for injuries they had sustained. One friend common to eight of the respondents apparently obtained pharmaceutical analgesics from his girlfriend who in turn stole them from her father, a physician. Eight (88.8%) of the nine respondents included getting these substances from friends. Five of those eight stated that they were sometimes or always given the drugs for free; six reported purchasing tablets from friends on at least some occasions. Other methods of obtaining pharmaceutical analgesics included stealing them from relatives (3 respondents), stealing them from people in whose homes they were employed (1 respondent), or purchasing them from a “crooked doctor” (1 respondent).

Beyond the possibility of obtaining various pharmaceutical analgesics for free, participants provided prices per tablet for a number of the different products. However, only two stated that they actually went in search of them; the others claimed to use them only when they were readily available. The most commonly cited price ranges are presented below, with a ceiling price occasionally listed in parentheses.

Darvocet®	\$2 - \$3	(as high as \$5)
Lortab®	\$5 - \$7.50	
Lorcet®	\$5 - \$10	
Methadone (wafers)	\$25-30 each	
OxyContin®	\$10 for 20 mg	
	\$20 - \$60 for 40 mg	
	\$40-100 for 80mg	
Percocet®	\$1 - \$2	(as high as \$5)
Percodan®	\$1 - \$2	(as high as \$5)
Ultracet®	\$1.00	
Ultram®	\$0.50 - \$1	

Vicodin® \$1 - \$3 (as high as \$5)

When asked how many people each respondent had introduced to the use of pharmaceutical analgesics, the answers ranged for none to five, with the average number being 1.72. The most common response—coming from 4 respondents--was 2 people; three respondents stated they had introduced no one to this class of drugs.

H. Users' Perceived Risks of Pharmaceutical Analgesic Abuse

Participants reported having varying degrees of knowledge related to the risks of their usage practices. Six general responses emerged: no knowledge, complications with chemical interactions, addiction, overdose, toxicity, and brain damage. One 20-year-old man was not aware of any risks being associated with the abuse of these substances, saying "*I don't know of any risks.*" Two of the men we spoke with expressed ignorance of any dangers, but did recall a warning they had read: "*I don't know of any risks. I haven't heard of anyone O.D.-ing or getting sick. Most say on the bottles not to use it with alcohol.*"

The risks associated with mixing pharmaceutical analgesics with other substances of abuse were mentioned by two others. A 19-year-old man stated, "*If you mix them with other things like Coke and uppers, you could O.D... [and the] change of heart rate...*" A 23-year-old man—perhaps the most knowledgeable of the participants--phrased it this way: "*Pills—narcotics--can become addictive.... I like to study up on things like that 'cause, I like to know what's at risk, what drugs have interactions with others. I ain't tryin' to die; I'm just tryin' to get high.*" The possibility of addiction was mentioned by another man as well. Overdose came to one participant's mind: "*To get the desired effects, you have to take a lot of high dosage, so it's kind of tricky....you might die if you take too many*" (19-year-old man).

One 20-year-old woman noted, "*Toxicity, a strain on your liver.*" Finally, brain damage was mentioned in conjunction with the practice of inhaling the substances: "*When you blow [inhale] them, I'm blowing out my brain, so it's not very smart*" (19-year-old man). Despite these risks, none of the participants indicated that they would abstain from abusing pharmaceutical analgesics in the future. Thus, it seems that clearer, more powerful messages regarding the multiple risks of prescription analgesic abuse are needed. Perhaps just knowing the fact that "*The narcotic analgesics are the most common lethal prescription drugs*" in Franklin County would help to make them more wary of their actions (Franklin County Coroner's Office).

VI. Conclusions and Recommendations

Analysis of the collected data suggests that the college-age adults with whom we spoke were engaging in a great deal of drug experimentation for the most part. All of them were engaging in quite risky behaviors, some knowingly, and others much more naively. The possibility of death as a consequence of their substance abuse combinations appeared to be remote if present at all. In general, these behaviors were suggested by and enabled by friends through the diversion of legitimate prescriptions.

When asked whether they felt that the abuse of pharmaceutical analgesics was increasing, decreasing, or remaining stable as a trend among young people like themselves, four responded that use seemed to be increasing. Three suggested that the trend was stable,

and one suggested a decrease. One participant expressed that she did not know enough to make a guess. The Franklin County Coroner's toxicology report for 2001-2002 suggested a possible increase. In 2001, the list of the top ten toxic/lethal drugs (barring alcohol and carbon monoxide) in overdose/drug abuse cases included only two narcotic analgesics (oxycodone and methadone). There were 124 cases that year. However, in 2002, the number of cases had risen to 226, and four narcotic analgesics (morphine, oxycodone, methadone, and hydrocodone) were listed among the top six. The others were cocaine and acetaminophen, the later appearing arguably as an ingredient in a number of commonly abused narcotic analgesic preparations.

Suggestions from participants regarding ways that pharmaceutical analgesic abuse could be prevented focused on what doctors, parents, DARE programs, and pharmaceutical companies could do. One 20-year-old woman advised,

Go after the doctors...I've heard of a lot of doctor's just writing these things off... Parents need to be trained to keep them somewhere else as well [away from their kids].

A 20-year-old man agreed: *"I think it's the people who prescribe them....Doctors over-prescribe a lot."* Some focused on education as a method of prevention. For example, a 19-year-old man suggested:

They could try to make them harder to get....I think it's pretty hard to stop it...unless you just wanted to educate people, tell them not to do it, but that's about it....'you might die if you take too many,' something like that.

A 20-year-old man echoed this idea:

They should probably talk about it more in DARE and stuff. They never talked about anything like this or anything that actually worries me. They talked about marijuana more than anything.

It is interesting to note that only one of the respondents' suggestions included any recognition that responsibility or action might be taken on the part of the users or the friends who most commonly supply the substances. For example, a 23-year-old woman commented:

Instead of putting them in pill form, put them in like a capsule and then make them to where like they'll gel, so if they snort them, a gel's in their nose. Or, if they try to shoot them, it gels in the syringe or the spoon. I don't think DARE programs help because it's already in their mind. They go through it [DARE] because they have to, but it's their choice [to use drugs]. Either they do it, or they don't. It's also the society that you're brought up in—the community—and the...relationships between you and your friends and your parents. The way your parents live...

Whatever the approach, the final thought of one 19-year-old man illustrate well the urgent need for some kind of prevention and education programming for adult populations: *"I think it's fine. I don't really think...we need prevention methods."*

Pharmaceutical Analgesic Abuse

(Dayton, Ohio)

An OSAM Rapid Response Report Prepared for the Ohio Department of Alcohol and Drug
Addiction Services.

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I. Introduction

Because the OSAM Network has consistently found increasing abuse of pharmaceutical analgesics throughout the State since January 2000, the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) decided to utilize its OSAM Network to further investigate this trend. Consequently, the OSAM Network conducted a Rapid Response investigation for the January 2003 to June 2003 reporting period.

This report is part of that OSAM Network Rapid Response Initiative. The report details information obtained from active or recovering substance abusers who reported the abuse of pharmaceutical analgesics either as a primary drug of abuse or in conjunction with other drugs. In addition to the information presented by active or recovering users, substance abuse treatment professionals were interviewed to assess their perceptions of pharmaceutical analgesic abuse among the clients they serve.

II. Methods

Ten individual interviews were conducted with active and recovering substance abusers between March and April, 2003. Convenience sampling was used, but an attempt was made to include participants of different ethnic backgrounds, men and women, and recovering and active users. Participants were recruited by Outreach Workers working for Wright State University's Health Research Project.

Approval to conduct this study was received through Wright State University's Institutional Review Board. After obtaining Informed Consent from each participant, interviewers conducted semi-structured interviews following a protocol developed to gather information about pharmaceutical analgesic abuse. The areas covered by the protocol included demographic information, general substance abuse history, specific history of pharmaceutical analgesic abuse, including reasons for abuse, methods of obtaining pharmaceutical analgesics, changes in abuse over time, concurrent drug use, current trends in pharmaceutical analgesic abuse, perceived risks associated with pharmaceutical analgesic abuse, prevention and treatment issues, and drug injection risks.

Each interview was audio-taped with participants' permission. Tapes were transcribed, verified, and then coded using Folio Views, a qualitative data analysis software package. Major themes were identified. Notes and relevant quotes were documented.

Although the bulk of the information contained in this report is from the ten individual interviews with active and recovering substance abusers, some information was obtained from focus groups with substance abuse treatment professionals. This information was extracted from focus groups conducted as part of the OSAM Network's biannual Drug Trends investigation which covers the period of January 2003 through June 2003.

III. Demographics

As seen in Table 1, participants ranged in age from 30 to 48 years of age (mean = 40.4). Five participants were female, five were Black and two had never been married. Education levels of participants ranged from 8th grade to college educated. Seven participants had dropped out of school with four later obtaining their GED. Nine participants were unemployed or disabled and

one participant worked part-time. Five participants described themselves as being in recovery or treatment, although two of these participants were still abusing pharmaceutical analgesics occasionally.

Table 1. Participant Demographics

No.	Age	Gender	Ethnicity	Education	Employment	Marital	Status
1	42	Male	White	GED	Unemployed	Divorced	Recovering
2	33	Male	White	GED	Disabled	Separated	Recovering
3	39	Female	White	8	Unemployed	Living as Married	Recovering
4	39	Female	Black	GED	Part-time	Married	Recovering
5	30	Female	White	9	Unemployed	Married	In Treatment Using
6	48	Female	White	Some College	Unemployed	Single	In Treatment Using
7	44	Female	Black	12	Unemployed	Divorced	Active User
8	47	Male	Black	BA Degree	Unemployed	Divorced	Active User
9	48	Male	Black	GED	Unemployed	Single	Recovering
10	34	Male	Black	11	Unemployed	Separated	Active User

IV. Treatment Provider Perceptions

According to treatment providers, OxyContin® continues to have the highest demand among all pharmaceutical analgesics. It is still highly available and easy to get, but front-line professionals reported some slight decreases in its availability. Typical OxyContin® users, according to the treatment providers, are white middle-class youth. Reportedly, they are often in denial that they have an addiction and consider themselves “superior” to heroin users. However, according to treatment providers working at the methadone clinic, OxyContin® addiction is one of the main pathways for white youth to become involved with heroin. This transition, however, is never easy. Usually, as tolerance increases and their OxyContin® habit becomes too expensive, these young individuals would try to “self-medicate” with various cheaper opioid medications, or “street” methadone, and only then would step down into “heroin territory.”

According to front-line professionals, other pharmaceutical analgesics, such as Percodan®, Percocet®, and especially Vicodin®, are also highly available, but they have much less value and demand than OxyContin®. In most cases, these less potent opioids would be used when OxyContin® was unavailable.

V. Drug Abuse History

The drug histories of the ten participants were varied, and in most cases, extensive. Eight participants began abusing alcohol and/or marijuana between the ages of 9 and 18. Two participants reported starting their drug abuse shortly after the age of 25. Only three participants reported never injecting drugs. Of the six participants reporting regular injection drug use, two reported first injecting drugs as early as age 13. One user reported injecting drugs only six different times in his life.

Five participants reported heroin to be their primary *illicit* drug of abuse. One participant reported crack cocaine as her primary *illicit* drug of abuse. Four participants reported a pharmaceutical analgesic as their primary drug of abuse. When asked to report the pharmaceutical analgesic they considered to be their primary drug of abuse, seven participants reported OxyContin® (oxycodone long-acting). The remaining participants reported Percocet (oxycodone and acetaminophen), Vicodin® (hydrocodone), Tylenol® 4 (acetaminophen and codeine), and Darvocet® (propoxyphene and acetaminophen) as pharmaceutical analgesics that they primarily abused. Seven participants were currently in substance abuse treatment or recovery with two of those individuals reporting that they occasionally used drugs while currently enrolled in their substance abuse treatment program.

VI. Analgesic Drug Abuse History

Pharmaceutical analgesic drug abuse was varied among the participants. For some individuals pharmaceutical analgesics were their major drug of abuse throughout most of their lives. For example, a 39-year-old white woman became addicted to pharmaceutical analgesics in her mid 20s, after she experienced several health problems and received continuous legitimate “flow” of pharmaceutical analgesic prescriptions. She did not report much experience with any other substances prior to that. Yet in other cases, individuals had more complicated histories of substance abuse, and pharmaceutical abuse was just one of the stages that they went through. For example, a 42-year-old white man who was currently in recovery from heroin and opioid addiction, explained that in his teen years he went through a barbiturate phase. Then at one point in his life he used Dilaudid®, which did not develop into a more serious problem because he could afford Dilaudid® only on the weekends. Then he described a phase when he used powdered cocaine and crank which he would take when he felt tired. After that, he went back to a more “mellow” phase, started using OxyContin® and eventually switched to heroin.

Participants reported total pharmaceutical analgesic abuse ranging from 11 years to as much as 26 years. When asked when they last abused a pharmaceutical analgesic, five participants reported that they had used less than two days prior to the interview (two of these participants reported being in drug abuse treatment/recovery). Five participants (who were in recovery) reported that they had not used a pharmaceutical analgesic in over two months. Prior to entering into drug abuse treatment, most participants were abusing analgesic drugs four to five times a week or more often.

First Experience. Most participants reported first using a pharmaceutical analgesic by the age of 18. The majority of individuals reported that their first use of a pharmaceutical analgesic drug was recreational. They were introduced to the drug at a social setting by friends or family

members. For example, a 42-year-old white man who was currently recovering from heroin and OxyContin® addiction described his first experience with pharmaceutical analgesics in the following way:

I went to a house.... and there was a few friends of mine that I hadn't seen for a while and there was a bunch of people in there and everybody was um, uh nodding and itching and scratching and smoking weed and everything.... I'd heard throughout the crowd I started hearing "morphine, morphine...." So I pulled someone aside, I said, "What's going on, man?" and they told me what's going on.... Sure I wanted to do it [morphine] and that's how it came about....

However, two participants reported first using a pharmaceutical analgesic drug when it was prescribed to them for pain. For example, a 33-year-old white man who was recovering from OxyContin® and heroin addiction was only 14 when he was first prescribed a pharmaceutical analgesic drug and soon after that started using it to experience the "high":

First pain pill I had it was.... I had a surgery and they gave me Vicodin and I was like at fourteen years old, I had appendicitis, and ya know I liked that and, and sometimes I'd go in the hospital and fake pain ya know or whatever so I could ya know get the narcotic....

In almost all situations pharmaceutical analgesic abuse was preceded by experimentation and abuse of other substances, usually alcohol and marijuana.

Furthermore, almost all participants reported that they grew up in an environment where substance abuse was very common. Many of them had parents or other relatives who were addicted to alcohol or other substances. Others lived in communities where drug dealing and abuse was almost a "normal" way of life. For example, a 47-year-old black man, who first injected heroin at the age of 13 and currently used heroin, crack cocaine and OxyContin®, described the influences that led to his first experiences with codeine:

Well, the area I lived in, and then out on the street everyday and around drugs.... uh drug houses, drug pushers, um you hear about it, ya know, about certain, certain highs and how it affect people....

Another 33-year-old white man who first became addicted to Vicodin® when he was a teenager and later switched to OxyContin®, explained that substance abuse was common in his family:

Interviewer: Why did you start using pharmaceuticals [analgesics]?.... like how, why did you get hooked on them?

Participant 2: I guess I just, I've got a very addictive personality, I was told, ya know, maybe that has something to do with it... Plus my parents both are alcoholics and use drugs and, ya know I was like brought up, ya know, around the environment, ya know, about my life so and I just, everybody else was doing it and so I just....

In other words, first experiences of pharmaceutical analgesic effects occurred either in recreational or in medical settings. In both cases, however, individuals directly or indirectly related their experimentation and subsequent dependence on pharmaceutical analgesics (and/or other drugs) to family and community influences.

Reasons for Abuse. Participants were asked to provide reasons why they would abuse pharmaceutical analgesics. In some cases, individuals explained that they used pharmaceutical drugs to manage emotional or mental pain, forget disappointments, stresses and hardships of everyday life. Their use was often related to major stressful life events. For example, a 34-year-old black man who first became addicted to Vicodin, later began abusing OxyContin and recently switched to heroin, explained that he started taking pharmaceutical analgesics when he was about 19 years old:

Interviewer: Why do you think you started using these pills?....

Participant 10: Um they made me feel better.... it took the pain away, cause I lost my mom and my father and my sister in the same year and.... I was hurting at the time.

In other cases, individuals explained that their use was purely recreational; they simply enjoyed the way pharmaceutical analgesics made them feel. Interestingly, individuals described two different experiences of the pharmaceutical analgesic high. Some indicated that they enjoyed these drugs because of their “downer” effects. For example, a 33-year-old white man who was addicted to heroin and OxyContin®, stated, *“It relaxed me, and made me sleep, nod, just in and out, coherent and then incoherent, coherent, incoherent.”* Yet other participants, all women, explained that these drugs affected them in a “speedy” way, provided energy to do a better job around the household or do more activities with their children. For example, a 48-year-old woman who abused Vicodin and later switched to OxyContin®, explained, *“It’s a lot like speed, to me it’s a lot like a combination of speed and cocaine... and it’s just, ya know, that blast of like, ya know, energy...”*

Another commonly heard reason for abuse was related to medical conditions and physical pain. In some cases, individuals received legitimate prescriptions for their health problems, and then eventually developed pharmaceutical analgesic dependence. A 39-year-old white woman, who was currently in recovery, explained that she had several repeated health problems and was on pain medication for a long time before she realized she developed a habit:

Then I broke my tail bone twice.... so after that it just kept going, I’ve had um ovary surgery.... so I took medication for that....and, that’s what really got me hooked on them [analgesics] was taking, ya know, having surgery and then going to the doctors....

In other cases, individuals would take pharmaceutical analgesics for certain health problems and body aches, but without a doctor’s prescription. For example, a 39-year-old black woman, recovering opioid user, had a long history of substance abuse. She started drinking at the age of 9, and then by the age of 19 she started injecting Dilaudid®, cocaine and other drugs. According to her, drug use at that time was more or less experimental, related to parties and certain friendships. When she was 21 years old she had a baby and soon after that her boyfriend introduced her to crack cocaine. At that time she also used heroin to come down from her crack cocaine high. When she was about 30 years old she went to treatment for crack-cocaine addiction and soon after that quit using crack cocaine all together. She felt she had her life back together again. However, a few years later, she found herself using Tylenol III for self-medicating purposes. She had some health problems that caused her to have pain in her back and legs. Tylenol® III relieved the pain. Eventually, she became addicted to codeine. In her mind, the codeine dependence she developed in her 30s was totally different from her previous phases of drug abuse. She made it very clear in her interview:

Honestly, this time [I] feel like I wasn't taking these pills to get high, I just gotta addicted to them.... you know what I'm saying.... I'm not in denial or anything, ya know what I'm saying, 'cause I know it's a problem but this time I wasn't taking the pills just to get high.... I really was just taking them to, to feel better and then, ya know, it's just that I got hooked on them where I had to have them everyday....

Interestingly, when she was younger and used drugs for “fun,” she injected various substances, including pharmaceutical analgesics. When she developed a new dependence to opioids in her 30s, she took Tylenol® III tablets orally and did not switch to other methods of administration.

Finally, in some other cases, analgesic drugs were used as a way to “come down” from the feeling of other drugs, specifically crack cocaine.

Interestingly, although most participants described being physically dependant on pharmaceutical analgesics or similar drugs at some point in their lives, only three participants reported abusing these drugs because they were physically dependant upon them.

Change in Abuse over Time. In general, participants reported that their use of pharmaceutical analgesics increased over time. For example, a 48-year-old white woman who was currently in treatment for OxyContin® abuse explained how her addiction to pharmaceutical analgesics developed over time:

***Participant 6:** [in the beginning] you take two [Vicodin tablets], maybe two in the morning and maybe two in the evening and then, ya know, we just, ya know, as we ya know developed a tolerance for them ya know it was like you'd have to eat ya know three or four to get off of them.... and then, and then it was like after a few months it was like we realized ya know we woke up one morning and it was like wow, we're addicted.... at the end of my using vicodins, I had a ninety dollar a day habit*

***Interviewer:** let's say is what, forty-five pills a day?*

***Participant 6:** oh yea, easy, yea, I'd eat four or five at a time, sometimes six....*

Participants reported that they not only began abusing larger and larger amounts of pharmaceutical analgesics, but that they would switch to what they considered to be *stronger* pharmaceutical analgesic drugs. For example, a couple of participants first started using Vicodin® and then switched to Percocet® or Percodan® or other pharmaceutical analgesics. Several participants described that their discovery of OxyContin® was really a turning point in their dependence. According to them, the OxyContin® high was such a powerful and dangerous experience, that they did not want to go back to less potent pharmaceutical analgesics, and their “disease” took a much more destructive and devastating course. For example, a 48-year-old white woman described that she and her girlfriend were addicted to Vicodin for some time, which was costing them quite a lot of money, but once they got introduced to OxyContin®, their habit took a much more serious turn:

My girlfriend, she took out 67,000 dollars.... she was gonna use that for retirement.... Ya know, we spent all but a thousand dollars of that on drugs.... in less than a year.... we were doing five hundred, six hundred dollars a day in oxys....,

According to participants, the discovery of OxyContin® occurred in several different circumstances. In some cases, individuals were introduced to OxyContin® by their friends, significant others or drug dealers. For example, a 30-year-old white woman who first received

Vicodin for legitimate medical reasons then became addicted to pharmaceutical analgesics and ended up using up to six or seven OxyContin® (80mg) tablets per day, described it in the following way:

One of my guy friends had come over and um told me and my husband to try these [OxyContin] and see what we thought.... and I liked them.... Ever since I tried them that first time, I called him back and told him to come back over and bring me some more....

Some other individuals described that their first experience with OxyContin® occurred when they received prescriptions for legitimate medical problems. For example, a 33-year-old white man who was recovering from OxyContin® and heroin addiction, stated:

Participant 2: *Um, I had surgery on my left leg and uh was prescribed [OxyContin].... that's when I was first introduced to them and*

Interviewer: *Before then did you know anything about it [OxyContin]?*

Participant 2: *no ma'am, no*

Three participants reported that OxyContin® abuse lead them to heroin addiction. They explained that they made this transition after they realized that heroin was more plentiful, less expensive and provided a better high. A 42-year-old white man explained it in the following way:

I can't remember what year it was. But I remember distinctly um, someone said to me you're spending all that money on those oxys, man, where as for twenty dollars you can buy an amount of heroin that would exceed any oxy that, that I was doing.... So and actually.... I wanted to try that, and um, after I tried the heroin, I didn't really want oxys, was nothing to me anymore....

All three individuals who described this transition from OxyContin® to heroin abuse had a rather extensive substance abuse history. For example, a 33-year-old man started abusing Vicodin® and other opioids when he was a teenager, then in his early 20s he went through a stage of crack cocaine use before getting into OxyContin® abuse and then eventually heroin use.

However, not every individual who became heavily involved in pharmaceutical analgesics had progressed to heroin abuse. For example, a 48-year-old woman who could spend over \$200 per day on OxyContin® never considered replacing it with heroin. According to her, heroin affected her in a different way; it was a downer, while OxyContin® had a "speedy" effect on her.

Administration of pharmaceutical analgesics typically progressed from ingestion (swallowing or chewing) to insufflation to injection. However, not every participant had progressed to the injection of analgesic drugs. Interestingly, some individuals who reported injecting illicit drugs such as heroin or cocaine stated that they never had injected a pharmaceutical drug.

Concurrent Drug Use. The majority of participants we interviewed reported concurrent use of other drugs while abusing pharmaceutical analgesics. These drugs included marijuana, cocaine, heroin and alcohol. Three basic reasons emerged as to why participants used other drugs in conjunction with pharmaceutical analgesics. Some individuals used other drugs (e.g., marijuana) with these drugs to enhance the effects of the pharmaceutical analgesics. A 42-year-old white man explained:

I could be high on OxyContin, it roughly lasts you, keep you good and high about eight hours... ya know what I mean, one good fix would last you about eight hours, say you're fixed, six and a half, seven hours later you don't feel the buzz that much, you reach over and grab a, a joint and smoke a joint, it will bring that oxy right back, it enhances all over again in your, it feels like you just done it all over again....

Others reported using pharmaceutical analgesic drugs while on a methadone maintenance plan. This was to supplement what they considered too low a dose of methadone. Some used heroin in conjunction with pharmaceutical analgesic drugs in an attempt to increase the effect of the pharmaceutical analgesic drug and/or reduce the amount of drug needed to feel an effect, thereby reducing the associated costs.

Methods to Obtain Pharmaceutical Analgesics. All participants reported obtaining pharmaceutical analgesics off the streets. In most cases, this included exchanging money for the drugs from a friend or associate or someone in the community known to be dealing pharmaceutical drugs. In some instances, participants reported that they had relationships with individuals who received legitimate prescriptions for pharmaceutical analgesics but these individuals preferred illicit drugs. As such, participants would purchase illicit drugs for these individuals in exchange for the pharmaceutical analgesics. Participants indicated that usually they did not have any trouble obtaining pharmaceutical analgesics off the streets. They knew a network of people who were “peddling” these drugs and would call or go straight to their residence to obtain the drugs. For example, a 48-year-old white woman explained it in the following way:

I mean I'm telling you I have had so, I had so many... I had a little black book and I could call one person and if they didn't have any, I mean I went down the list, I'd call twenty people and somebody out of that twenty would have something...

Nearly every participant reported manipulating physicians and other health care providers in some manner in order to obtain pharmaceutical analgesics. This included faking pain and seeing several different doctors for the same problem (real or fake). The manipulation of physicians included persuading physicians to prescribe certain types of (or preferred) pharmaceutical analgesics. The following excerpt from a 47-year-old black man illustrates this form of manipulation:

...I kinda helped manipulate the doctor in the way of... they might want to prescribe something else for me that, that's not so powerful and I might suggest to them that a certain pill that had worked for me in the past... I would give them the name... tell them something like Percodan, that's working, ya know pretty well for me in the past uh but, but certain pain, especially if I'm gonna get them to give me something else that I don't know about, and that I, I know I can't really get high off of or whatever...I would uh give them that suggestion and most of the time um, I get what I wanted...

Interestingly, some participants perceived dentists as being easier to manipulate in order to obtain pain medication. In some cases, participants reported that they could just simply call their dentist and complain of pain associated with a past visit and the dentist would have a prescription issued over the telephone. A 30-year-old white woman explained:

...call on the phone and act like you're a patient of a dentist or something... and they would call something in for me... and uh, I'd go pick it up. I'd do that constantly, I did that with like, like me and my uh children, my first two oldest kids, their dad, me and him would get on the phone on the weekend and call every dentist in the phone book that we could to... get pain medicine, call it in for us and go pick them up...

Hospital Emergency Rooms were another health care setting that participants perceived as easy to manipulate. Given that there are several different Emergency Rooms and that it is typical to see a different physician each time an individual visited an Emergency Room, it was relatively easy to obtain pharmaceutical analgesic drugs without being identified as an abuser who is actually manipulating the system. However, one participant reported that he had frequented emergency rooms so often for similar problems that he eventually came to be identified as a drug abuser and physicians would either refuse to prescribe him medications or would only prescribe him less powerful, less addictive pharmaceutical medications.

A much less reported method to obtain pharmaceutical analgesics was to forge or alter prescriptions. Three participants reported that they had forged or altered prescriptions in the past in order to obtain pharmaceutical analgesics. This method was perceived as difficult because it required that the individual either alter an existing prescription or have access to a prescription pad (stolen from a health care facility or physician's office). Individuals who indicated that they forged or altered prescriptions reported that they had done so only on occasion.

Introduction of Pharmaceutical Analgesics to Others. Half of the individuals we interviewed reported that they had introduced others to pharmaceutical analgesic drugs. Some had introduced only a few people to these drugs, while others introduced as many as nine people to the drugs. Friends, family, and significant others were the most frequently mentioned people being introduced to pharmaceutical analgesics.

A few participants we interviewed reported that they had encouraged others to use OxyContin because it was considered a better, stronger pharmaceutical analgesic drug. However, this is not to say that these other individuals were not already addicted to or abusing other pharmaceutical analgesic drugs.

The other half of our participants reported that they did not promote the use of pharmaceutical analgesics; however, they reportedly did not discourage the use of these drugs either.

VII. Pharmaceutical Analgesic Drug Abuse Trends

An overwhelming majority of the individuals we interviewed agreed that pharmaceutical analgesic abuse was increasing in the Dayton area. Participants perceived that this increase was especially evident among teens and young adults ranging in age from 15 to 25. Increases in pharmaceutical analgesic abuse was perceived to be primarily among whites and evenly distributed between genders. As a 42-year-old white man explained:

I'm telling you these, oxys are just making, I mean every week you have, ya know, eight or ten new people going to [the methadone clinic] and I'd say maybe, maybe three out of those ten are really young and have never seen heroin...

Some participants expressed an opinion that Blacks had less economic resources to afford pharmaceutical analgesics and that is why they often go straight to heroin—a cheaper alternative. For example, a 39-year-old Black woman who was recovering from codeine addiction explained it in the following way:

Well more, more whites are taking the pills where as the blacks are still taking the heroin, like instead of like the OxyContin and stuff, basically because of finances ya know...

Although the price of pharmaceutical analgesics varies depending on location, buyer, and seller, participants reported the price of OxyContin to be approximately fifty cents per milligram. Vicodin tablets ranged in price from \$2 to \$7 (depending on the strength), and Percocet was reported to cost between \$4 and \$5. OxyContin, Vicodin, and Percocet were the analgesic drugs our participants most frequently reported, and OxyContin was described as the pharmaceutical analgesic drug most sought after. These prices are consistent with previous OSAM Network Drug Trend reports and have remained relatively stable over the past year

VIII. Risks Associated with Pharmaceutical Analgesic Drug Abuse

The majority of individuals we interviewed believed that the abuse of pharmaceutical analgesics resulted in the deterioration of their physical health. Specifically, participants believed that pharmaceutical analgesic abuse caused liver damage, hampered the immune system, wore down the body (e.g., made it appear older), deteriorated bones (e.g., calcium deficiency), damaged kidneys, increased chance of heart attack or stroke, and resulted in unwanted weight loss.

Interestingly, only two participants remarked that one of the dangers of abusing pharmaceutical analgesics is the potential to overdose on the drugs. One participant commented on the dangers (e.g., HIV) associated with sharing needles and other related paraphernalia if users administered pharmaceutical analgesics intravenously.

Most participants indicated that although they perceived dangers associated with the abuse of pharmaceutical analgesics, they did not think about those dangers when they were getting high. One participant we interviewed did not perceive pharmaceutical analgesic drug abuse as dangerous at all. This 34-year-old black man explained:

Interviewer: *Okay, and what risks are associated with abuse of these pain killer pills, what are the dangers or risks of taking these pills, what do you think?*

Participant 10: *There's no danger in them.*

Interviewer: *There's no danger, it's safe right?*

Participant 10: *Yes, yes...*

Interviewer: *But how do you think it... does it affect your health or your life?*

Participant 10: *No, it doesn't, from what I see it betters your life...*

Interviewer: *Really?*

Participant 10: *Yes, it takes the... eases the pain of people just dealing with different problems and situations...*

Several participants discussed the danger and health risks associated with the addictive potential of pharmaceutical analgesic drugs. Interestingly, some of them remembered that when they first started using analgesics, they were not fully aware, or did not want to believe that they could become dependent on them. A 34-year-old black man explained:

But I wasn't realizing that how powerful these pills could be on down the line... and they also can be addictive, which my doctor kept telling me but I wasn't paying any attention. And uh I just kept using and using until it got worst.

IX. Substance Abuse Treatment

The majority of participants reported that they had been in drug abuse treatment in the past. The number of past substance abuse treatment episodes ranged from one to six. One participant reported being involved in a 12-step program in the past, but no formal treatment in a substance abuse treatment program.

More than half of the individuals we interviewed believed that the time it took to get into substance abuse treatment was too long. In some cases, participants waited four weeks before beginning a substance abuse treatment program. However, most participants we interviewed were able to access treatment in about two weeks. Many participants expressed the need to be able to access treatment immediately, given the physical discomfort associated with withdrawal from pharmaceutical analgesics and similar drugs. Some participants reported that they had supplemented their methadone with pharmaceutical analgesics or similar drugs until the level of methadone they were taking was high enough to prevent painful withdrawal symptoms. A 42-year-old recovering white man stated:

...a good two weeks man is what it will take you before you get it, medicated that first time and you know a lot of those times how bad I wanted it, it's like I told you I'm homeless and I got a ten speed right, okay, I'm home, I stay over on the east end if you're familiar with Dayton, and I ride to [the treatment program]... I ride that everyday. Before I was medicated you had to be there at certain times of the morning to do these groups or do whatever you had to do to get in this program and get on the methadone and a lot of times man I couldn't get myself to get morning fix before I go out up there, but I knew I needed it, I knew this was the only answer cause this was all that was left for me, this was it and man it, I rode my bicycle day after day across town, sick, big old gorilla on my back...

Four individuals believed that more substance abuse treatment programs or more treatment slots needed to be made available in Montgomery County. Some individuals were displeased that some existing substance abuse treatment programs were poorly located (e.g., near high drug-trafficking areas).

Several participants described that they tried to quit opioid dependence on their own, without professional assistance. For example, a 39-year-old black woman who was in recovery from

codeine addiction explained that she tried to apply the same “tools” that helped her to recover from crack-cocaine addiction, but they did not work this time.

Another participant, a 34-year-old black man did not feel that he needed professional treatment. He had many of his family and friends go through numerous treatments, but their dependence only got worse. He thought that his faith and prayers were his “counseling sessions” that helped him remain a “functional” and “moderate” user:

Interviewer: *Do you think you need that [treatment], or not really?*

Participant 10: *Uh the way I live my life uh, I look for the Lord for my uh, counseling... And uh by me going to church, I think that's about all the counseling I need... It helps, it helps soothe me...*

X. Injection-related Risks

Most participants reported that they were concerned about getting diseases such as HIV or hepatitis by sharing needles or other paraphernalia associated with intravenous drug use. However, this concern did not discourage all the individuals we spoke with from sharing needles or other drug injection paraphernalia. Of the seven participants who reported injecting drugs, three reported sharing needles at least some of the time, and four reported that they had shared rinse water, cookers, and cottons in the past.

XI. Summary and Recommendations

In summary, participants we interviewed had diverse and typically extensive histories of drug abuse, including both illicit and pharmaceutical analgesic drug abuse. Some began their histories of drug abuse as early as age nine—one injecting drugs by the age of 13.

Five participants were actively using pharmaceutical analgesics (although some were currently in treatment) and five had been in recovery two or more months. Prior to accessing substance abuse treatment, participants reported abusing pharmaceutical analgesics approximately 4-5 times a week.

Participants perceived increases in the abuse of pharmaceutical analgesics in the Dayton area. This increase was reportedly most common among white youth and young adults between the ages of 15 and 25. Participants believed OxyContin® to be the most sought after pharmaceutical analgesic, and reported that it was typically the most difficult pharmaceutical analgesic to obtain. Pharmaceutical analgesics such as Vicodin®, Percocet®, Percodan®, and Tylenol® 4 were reportedly popular among the drug abusing population and somewhat easier to obtain.

Most participants believed that the time to access substance abuse treatment was too long—many waiting two weeks. Participants expressed a need for more immediate access to treatment, specifically because of the painful withdrawal symptoms typically associated with dependence to pharmaceutical analgesic drugs.

Based on our study, the following recommendations can be made:

- Participants believed that access to substance abuse treatment needed to be more immediate. Participants we interviewed typically waited two weeks before gaining access to substance abuse treatment.
 - Participants reported that because of the physical discomfort associated with withdrawal from pharmaceutical analgesics, immediate substance abuse treatment is necessary.
 - Participants also reported that while waiting to access treatment the desire to get help can fade quickly and the individual may return to abusing drugs.
- Participants felt that more substance abuse treatment resources were needed. This included more beds in existing programs and/or additional substance abuse programs.
- Participants voiced a need for drug prevention programs specifically educating youth about the dangers of pharmaceutical drugs and heroin. These programs should stress the potential for physical addiction.
- Stricter control of pharmaceutical analgesics, especially OxyContin® was stressed as a need. Participants believed that some physicians, dentists, and other health care professionals were too quick to prescribe powerful analgesic drugs. Participants believed that many physicians could be easily manipulated into prescribing these medications.
- Participants believed that more effort was needed in educating individuals about the potential dangers of using pharmaceutical analgesics (e.g., side effects and physical dependence).

Pharmaceutical Analgesic Abuse

(Toledo, Ohio)

An OSAM Rapid Response Report Prepared for the Ohio Department of Alcohol and Drug
Addiction Services.

January 2003 – June 2003

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I. Introduction

According to previous OSAM Network reports, prescription analgesic abuse has increased during the last two years in the Toledo area and many other areas of the state. This Rapid Response initiative aims to further investigate patterns of prescription analgesic abuse, perceived risks, and treatment needs. Data obtained will help policy makers to plan treatment and prevention strategies.

II. Methods

Four recovering users with a recent history of prescription analgesic abuse were recruited for the current study (Table 1). An informed consent was obtained from each participant. Each interview followed a) a structured questionnaire that covered basic demographic and drug abuse questions, and b) an open-ended qualitative interview guide that addressed substance abuse history, initiation to prescription analgesics, patterns of abuse, etc. Each interview was tape-recorded. The interviews were analyzed searching for recurrent themes related to prescription analgesic abuse patterns, history of substance abuse, initiation patterns, perceived risks, and treatment needs.

III. Demographics

Three participants were women; age ranged from 30 to 43. Three individuals were white, and one individual self-identified as bi-racial (Black and white). One woman considered her primary drug of choice as marijuana, two individuals were primarily heroin users, and the fourth participant reported that her primary drug of choice was OxyContin® (oxycodone controlled-release). Detailed information about the participants is presented in Table 2. In addition to OxyContin®, participants reported abuse of the following prescription analgesics: Vicodin® (hydrocodone), Percocet® (oxycodone & acetaminophen), Darvocet® (propoxyphene & acetaminophen), Tylenol® with codeine, Dilaudid® (hydromorphone), Demerol® (meperidine), MS Contin® (morphine), and Ultram® (tramadol).

Table 1. Interviews Conducted

Date of Individual Interview	Number of Participants	Description
5/16/03	1	<i>User in Recovery</i>
5/28/03	1	User in Recovery
5/29/03	1	<i>User in Recovery</i>
6/3/03	1	User in Recovery

Table 2. Information About Participants

May 16, 2003: Individual Interview with a User in Recovery				
Participant	Age	Ethnicity	Gender	Experience/Background
1	30	Caucasian	Female	In recovery; primary drug of choice was marijuana
May 28, 2003: Individual Interview with a User in Recovery				
Participant	Age	Ethnicity	Gender	Experience/Background
2	43	Caucasian	Male	6 months in recovery; drug of choice was heroin and OxyContin
May 29, 2003: Individual Interview with a User in Recovery				
Participant	Age	Ethnicity	Gender	Experience/Background
3	40	Caucasian	Female	3 months in recovery; drug of choice was Heroin and OxyContin
May 16, 2003: Individual Interview with a User in Recovery				
Participant	Age	Ethnicity	Gender	Experience/Background
4	37	Bi-racial	Female	In recovery; drug of choice was OxyContin

IV. Treatment Provider Attitudes

According to treatment providers interviewed for the general drug use trend report, abuse of prescription analgesics continues to increase in the area. OxyContin® and Vicodin® are among the most commonly abused prescription analgesics. Prescription analgesic abuse continues to be more common among whites. However, some treatment providers reported increasing abuse in the Black and Hispanic communities. Drug abusers with a history of heroin use constitute a large population of OxyContin® abusers.

V. Drug Abuse Histories

All participants reported fairly complicated substance abuse histories. Typically, they started drinking alcohol and experimenting with marijuana in their teenage years, some between the ages of 12 and 15. For example, a 30-year-old white woman explained: *“I grew up like that too... drinking and weed smoking... that was like a natural thing.”*

Two individuals, a 42-year-old man and a 40-year-old woman were primarily heroin users when they entered treatment. However, the history of their heroin dependence was significantly different. A 42-year-old man first became dependent on heroin about 25 years ago and

occasionally substituted heroin with prescription analgesics. A 40-year-old woman developed prescription analgesic dependence early in life and then switched to heroin as a less expensive and more available alternative. The third participant, a 30-year-old woman, reported that marijuana was her primary drug of choice for about 15 years. In the past two years, however, she went through a period where she would use prescription analgesics in combination with marijuana and alcohol. The fourth participant, a 37-year-old woman, reported that her primary drug of choice was OxyContin®, and she had been abusing prescription analgesics for over 16 years.

VI. Prescription Analgesic Abuse.

Initiation patterns. One individual, a 42-year old heroin user, was introduced to OxyContin® by his teenage daughter, who obtained them from a terminally ill friend. He commented:

Actually my daughter [introduced me to OxyContin]... She knew I liked opiates, and she ran across some four years ago.... She knew one gentleman... he mentioned the fact that they were injectable, right away she thought of me, knowing that I was a heroin addict.

Three other participants, all women, reported that they were introduced to prescription analgesics in a medical setting when they received prescriptions for legitimate medical problems. For example, a 30-year-old woman reported that she had a knee surgery and was prescribed various prescription analgesics:

Pharmaceuticals started at 28 when I had my surgery. First I started with morphine, then I went to Percocets, then I went to Darvocets; they gave me Ultrams, they [doctors] just switched it up, because they did not want me to get addicted....

She further explained that she did not feel that much pain, but since her doctor was prescribing the drugs “so easily,” she started faking her pain so that she would keep getting narcotic analgesics.

Another participant, a 40-year-old woman was introduced to prescription analgesics when she was a child. She reported being sexually abused when she was little, and had recurrent health problems related to her abuse. She received numerous prescriptions for narcotics when she was a child. She developed dependence to opioids and became a heroin injector in her 20s. Later in life she managed to quit using heroin; however, while into the seventh year of her recovery, she was diagnosed with cancer and was prescribed narcotic analgesics. She feels she again was introduced to using narcotics and received legitimate prescriptions for Darvocet®, Tylenol® with codeine, then Vicodin®, and finally OxyContin®.

Reasons for abuse. A few participants reported that they became fond of prescription analgesics because they allowed them to escape from the emotionally distressful realities of their everyday lives. For example, a 40-year-old woman was sexually abused as a child, and prescription analgesics helped her deal with emotional pain when she was a teenager. In some other situations, participants felt that numerous medical prescriptions for chronic health problems made them dependent on narcotic analgesics. Typically, in such cases an individual would have a prior history of drug abuse. Enjoying the high and not being fully aware of the dangers of addiction were cited as other reasons for prescription analgesic abuse and dependence.

Patterns of prescription analgesic abuse and change over time. Each participant described different patterns of prescription analgesic abuse and its change over time. One individual, a 37-year-old woman, was dependent on prescription analgesics; she has used them for over 16 years and was a daily user. Another participant, a 40-year-old woman, first became dependent on prescription analgesics. She described how her tolerance increased rapidly while she was on legitimate medical prescriptions:

I had a lot of pain and the doctor started me up with Darvocets, and then it went to Tylenol 3, 4, and then eventually I became tolerant to those, so I ended up doing Vicodins and then Percocets, and then Oxys, and once they got to the “Oxys,” I was really strung out.

When the doctor quit prescribing narcotics, she started obtaining them “on the streets.” From a “legitimate addict,” as she puts it, she turned into “a street addict.” Eventually, she started injecting OxyContin®, and as it became too expensive, she switched to heroin.

A 42-year-old man had a high tolerance for heroin and other opioids, when he was introduced to OxyContin®. For some time he injected OxyContin® instead of using heroin. At the time he was able to get OxyContin® tablets for a relatively low price, and it was a less expensive alternative to using heroin. He commented:

When I saw how strong they [OxyContin] were, everybody that I used to get high with, I called and said, you are not gonna believe how much buzz I can get for \$20... We were in heaven, man...

When OxyContin® became more expensive he substituted with less potent narcotic analgesics and went back to using heroin.

A 30-year-old woman abused prescription analgesics, typically Vicodin® and sometimes OxyContin®, in combination with marijuana and alcohol. She explained:

Marijuana led me to take pills, because I wanted to add them all together, like OxyContin, “Vics” [Vicodin]. I smoke blunts, I took the “Oxys” and I would drink, they don’t recommend you drinking with OxyContin, they have very strong... you can kill yourself, and everybody knows, and we still do it, because we know that this is gonna be the ultimate high, we gonna get there eventually...

She reported abusing prescription analgesics for about six months, as long as she received prescriptions for them. Once her leg began to heal and the doctor stopped the prescriptions, she “went cold turkey” and quit using them. She explained she was afraid her tolerance was increasing, and she did not want to “spend all that money.” Instead, she continued to drink and use marijuana.

Ways to obtain prescription analgesics and reported “street” prices. All participants believed that it was relatively easy to obtain prescription analgesics. For three users, the main sources of narcotic analgesics were legitimate medical prescriptions. They reported receiving a very high supply of diverse analgesics, even though they felt they might have done well enough

with less potent drugs. The fourth participant, a 42-year-old heroin user also reported receiving medical prescriptions for OxyContin® for a short period of time when he injured his shoulder.

The participants also reported buying prescription analgesics off the streets. Some knew people who would sell their own prescriptions for a relatively low price. One participant, a 30-year-old woman, reported selling half of her own prescriptions as well as other people's prescriptions at the bars, "side by side" with Ecstasy (MDMA) dealers and making fairly good profit out of them. She typically sold Vicodin and did not want to deal with OxyContin®. She explained: "*I don't want to go that way, because that drug [OxyContin] is a serious drug and that is gonna start killing people, and that is not a joke.*"

The participants reported that OxyContin® was currently selling for about \$0.50 per mg. Some reported much lower prices several years ago, when the drug just hit the market. The participant who admitted selling prescription analgesics, reported that at the bars Vicodin® ES would sell for about \$10-\$15 per tablet, and a 500mg tablet of Vicodin® would sell for about \$5-\$8.

Perceived risks. Rapid progression of addiction was cited as one of the most important risks associated with prescription analgesic abuse. For example, a 42-year-old man described how his teenage daughter went from being a recreational user of OxyContin® to a "hard-core addict" and eventually switched to heroin injection:

Risk of addiction... I watched progression, what happened to my daughter... She had her job, had her own trailer, I have a grandson, he is four. She has been using them [OxyContin] almost 4 years on and off, but she has really been addicted hard for the last year. She went from that 'till the last 6 months she switched over to heroin, 'cause it was cheaper... started smoking crack, now she is out... I am raising her son... and I see her engage into high risk behaviors, multiple sex partners, sex for money... you see the addiction process happening...

Two participants cited overdose as another risk of abusing prescription analgesics, especially OxyContin®. However, some expressed the opinion that prescription analgesics nevertheless have less risk than "street drugs" since they are prescribed by doctors. For example, a 40-year-old woman commented:

My logical thinking is that they (pharmaceuticals) come from a doctor; they're not made on the streets so they have to be a lot safer than what I get out on the streets. So if I'm going to be hooked on something, I'd rather be hooked on pharmaceuticals.

Trends of prescription analgesic abuse. The participants agreed that abuse of prescription analgesics has been increasing in recent years, especially among white youth between ages 18 and 25. A 42-year-old man commented:

I think people are using pharmaceuticals a lot more; it's the biggest growth drug I've seen, especially OxyContin. Because of the OxyContin, people are having withdrawals and they're taking Percocet, Tylenol 3, Vicodin. I have a daughter in that age group [18 to 21] and almost everyone she knows takes them at one time or another.

A 40-year-old woman described a similar situation:

I recently got remarried and my two step-daughters [ages 17 and 19] are strung out on OxyContin. The 19-year-old is off and running; she's shooting heroin and smoking crack and all this is a result of taking OxyContin. Last summer she started taking Percocet, then OxyContin. She lost her kid and now she's turning tricks to support her OxyContin and heroin use. The other daughter is not as bad, but she can't function without taking OxyContin.

The participants reported that the majority of these young users first started using OxyContin® recreationally, at parties or other social events. At that time they were not fully aware of its addictive potential. For example, a 42-year-old man reported that his teenage daughter did not understand well what was happening to her when she lost her OxyContin® “connection” and started experiencing withdrawals. He commented:

My daughter was... she was 17 or 18 years old, and never been addicted to anything, and did not realize she was addicted [to OxyContin] until this guy ran out. And she got into withdrawals, and she did not know how to substitute them you know, so...

Perceived treatment needs. All participants were currently in treatment and all have tried hard to turn their lives around and stay sober. They felt that they have lost too much because of their dependence, and wanted a better life for themselves and for their families. As a 40-year-old woman, recovering from heroin and OxyContin® dependence reported, “*I just want a life, I really really want one. I want one so bad...*”

A few participants reported that they have tried to quit using prescription analgesics by themselves. When their efforts failed, they went to look for professional assistance. In several cases they reported that they had difficulties getting into treatment because of long waiting lists.

VII. Injection practices

Two of the participants, a 40-year-old woman and a 43-year-old man reported having injected drugs, including heroin, OxyContin®, crack cocaine, and powdered cocaine. They have injected for 6 and 25 years, respectively. Both reported that they knew about safe injection practices, but were not always careful to follow them. Both of them were tested for HIV.

VIII. Summary and Recommendations

The participants had diverse and complicated substance abuse histories and reported different patterns of prescription analgesic abuse. OxyContin® continues to have the highest demand, followed by Vicodin®. Some participants were introduced to prescription analgesics in medical settings and felt that their dependence was partially due to the fact that medical doctors tend to over-prescribe narcotic analgesics. Participants reported several cases where individuals who first became addicted to OxyContin® eventually transitioned to intravenous heroin use. Prevention efforts addressing different patterns of initiation to prescription analgesics are urgently needed.

**Pharmaceutical Analgesic Abuse
(Mahoning & Columbiana Counties)**

An OSAM Rapid Response Report, Prepared for the Ohio Department of Alcohol and Drug
Addiction Services

January 2003 – June 2003

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I. Introduction

According to the previous OSAM Network reports, abuse of OxyContin® (oxycodone controlled-release) and other pharmaceutical analgesics has been increasing significantly in recent years. The aim of this Rapid Response initiative is to further assess patterns of prescription analgesic abuse, perceived risks and perceived treatment needs. The data will serve for treatment and prevention planning.

II. Methods

For the current study, six recovering users and one active user were interviewed. All individuals reported prescription analgesic abuse within the last year. All participants were over the age of 18. Detailed information about each participant is presented in Table 1.

Each individual read and signed an informed consent form. A structured questionnaire and a semi-structured qualitative interview guide were used to conduct the interviews. Each interview was recorded and hand-written notes were taken during the interviews. Each interview lasted approximately one hour. Tapes were reviewed for clarity of statement and point of view.

Table 1. Information about individual rapid response interview participants.

Number 1 Conducted on April 21, 2003: Substance abuser, in early recovery

Age	Ethnicity	Gender	Experience/Background
21	White	Male	Started selling marijuana and other drugs when he was a student; completed 1 ½ years of college in Columbus; currently unemployed, previously had construction jobs and worked as a cook in small restaurants; single, with no dependents; described himself as a user of OxyContin® (and “all pills”), heroin, cocaine, and marijuana.

Recruitment Procedure: *Call to detoxification/inpatient treatment facility, requested interview and scheduled time to meet.*

Number 2 Conducted on April 23, 2003: Substance abuser, in early recovery

Age	Ethnicity	Gender	Experience/Background
38	White	Female	Described herself as medical secretary who has not worked in the past 3 years. A high school graduate, reports 15 year pain history from past alcohol-related car accident. A single-parent, mother of one 8-year-old child. She and her daughter live with her adoptive parents. She has been diagnosed with Obsessive Compulsive Disorder; a user of Vicodin®, Percocet® and OxyContin®.

Recruitment Procedure: *Call to detoxification/inpatient treatment facility, requested interview and scheduled time to meet.*

Number 3 Conducted on May 7, 2003: Substance abuser.

Age	Ethnicity	Gender	Experience/Background
37	White	Female	"Not working and not on disability;" in the past worked as a waitress and small business owner. Received GED. A divorced single-parent, mother of one 5-year-old child, both currently live with her parents. Reports chronic pain issues over the last 5 years. Receiving treatment from psychiatrist for Anxiety Disorder. Reports self as a user of Vicodin®, Lorcet®, and Ultram®.

Recruitment Procedure: *Referral from Interview #2, called requested interview and scheduled time to meet, after arranging to use room at inpatient facility.*

Number 4 May 9, 2003: Substance abuser, in early recovery

Age	Ethnicity	Gender	Experience/Background
40	White	Female	Reports being on "disability" for brain disorder, first diagnosed in 1998. A high school graduate, no work history reported. Mother of 3 children, separated from her husband. Reports self as a user of OxyContin®, Vicodin®, Valium®, Soma® and heroin.

Recruitment Procedure: *Call to outpatient treatment facility, requested interview, Clinical Supervisor made arrangements to coincide with end of focus group and provided transportation for client and provided room for interview.*

Number 5 May 19, 2003: Substance abuser, in early recovery

Age	Ethnicity	Gender	Experience/Background
21	White	Female	Reports self as not working, no work history. A single parent of a 3-month-old child. A high school graduate, she reports pain issues resulting from car accident in which other driver was intoxicated. Reports her father as a current user of heroin and crack and her mother as user of alcohol. Reports self as user of OxyContin® and heroin.

Recruitment Procedure: *Called detoxification/inpatient facility and requested interview and scheduled time to meet, after arranging room at inpatient facility.*

Number 6 Conducted on May 30, 2003: Substance user, in early recovery

Age	Ethnicity	Gender	Experience/Background
23	White	Male	Currently unemployed, in past worked as a laborer cleaning carpets. Reports a 2-year degree in welding from a school in PA. Has been diagnosed with Adult Attention Deficit Disorder and on medication prescribed by psychiatrist. No dependents, was living at home with his single-parent mother. A user of OxyContin® and heroin.

Recruitment Procedure: *Interview arranged by Clinical Director of residential program, time and place set with counselor of men's facility.*

Number 7 May 30, 2003: Substance user, in early recovery

Age	Ethnicity	Gender	Experience/Background
22	White	Male	Reports no current employment, in past was computer assisted drafter. Has two-year Associate Degree received in Youngstown. No dependents, was living in own apartment. A user of OxyContin® and heroin.

Recruitment Procedure: *Interview arranged by Clinical Director of residential program, time and place set with counselor of men's facility.*

III. Treatment Provider Attitudes

According to the treatment providers and pharmacy board representatives, among all prescription analgesics, OxyContin® (oxycodone controlled-release) abuse was the most frequently mentioned in the area. Several treatment providers reported seeing users progress from swallowing or chewing the tablets, to snorting the drug, then processing the drug and administering by injection. Some treatment providers pointed out that some OxyContin® users transition to heroin, a less expensive and more available alternative. According to the treatment providers, the fastest growing user group was described as white individuals between the ages 18 and 25, both males and females, who often come from the "middle class" background. OxyContin® was reported as being secured in a variety of ways including legitimate prescriptions, faking medical conditions and "doctor shopping." OxyContin® was reported as often diverted by medical personnel from nursing homes, hospitals and other health care facilities.

Percocet® (oxycodone and acetaminophen) and Vicodin® (hydrocodone) were reported by most treatment provider groups as the most prominent other pharmaceutical analgesics being abused in Mahoning and Columbiana Counties. Looking at the cumulative information in Table 2 and 3 below, both treatment provider groups and recent abusers of pharmaceutical analgesics are reporting very similar trends of availability and prices across Mahoning and Columbiana counties.

According to participants legitimate pain issues resulting from work injuries or auto accidents are often a starting point for abuse of pharmaceutical analgesics. Treatment providers reported difficult withdrawal symptoms during detoxification and a high rate of relapse among users of OxyContin® and other prescription analgesics.

Table 2. Availability and prices of prescription analgesics as discussed by treatment providers and pharmacy board representatives.

Drug	Focus gr. 5/9/03	Focus gr. 5/13/03	Focus gr. 5/15/03	Focus gr. 5/29/03	Focus gr. 6/2/03	Focus gr. 6/6/03
Darvocet®		Yes	Rare	Yes \$6	Yes \$3	Yes
Darvon®				Yes	Rare	
Demerol®					Yes	
Dilaudid®			Rare			
Fentanyl Patches	Yes	Yes	Yes	Yes	Yes	Yes
Other Fent.					Yes	
Lorcet/tab®			Yes		Yes	
Methadone		Yes	Yes	Yes	Yes \$10 – 5 \$20-10	Yes
Morphine		Rare	Yes	Rare	Yes	
MS Contin®			Yes	Yes	Yes	
OxyContin®	Yes \$15 – 20mg \$60 – 80mg	Yes	Yes \$1 per mg.	Yes \$40 – 80mg \$20 – 40mg	Yes \$40 – 80mg, up to \$1 per mg. Quant.- \$18 – 80 mg.	Yes \$1 per mg.
Percocet®	Yes \$2-\$3	Yes	Yes \$5 - \$6	Yes \$10 - \$15	Yes	Yes
Percodan®		Yes	Yes	Yes	Yes	
Talwin®						
Tylenol®		Yes (3)	Yes (3) \$3	Yes	Rare	
Tylox®						
Ultracet®		Yes	Yes	Yes	Yes	
Ultram®		Yes	Yes	Yes	Yes	
Vicodin®	Yes \$4	Yes	Yes	Yes \$10	Yes	Yes

*No response indicates little or no use seen by that group, prices unknown.

The following indicates groups interview by date:

5/9/03 Treatment providers from outpatient treatment facility, Columbiana County

5/13/03 Assessment counselor from detox-inpatient and outpatient facility, serving Mahoning and Columbiana Counties

5/15/03 Treatment providers from detox-inpatient and outpatient facility, serving Mahoning and Columbiana Counties

5/29/03 Treatment providers from residential facility, serving Mahoning and Columbiana Counties

6/2/03 Representatives of the Ohio Pharmacy Board, serving Mahoning and Columbiana Counties

6/6/03 Treatment providers from outpatient facility, including methadone program, serving Mahoning and Columbiana Counties

Table 3. Availability and prices of prescription analgesics as discussed by drug users

Drug	Part. 1	Part. 2	Part. 3	Part. 4	Part. 5	Part. 6	Part. 7
Darvocet®	Yes \$3 - \$4	Yes \$1	Yes	Yes	Yes	Yes \$1- \$2	
Darvon®					Yes		
Demerol®							
Dilaudid®							
Fentanyl Patches	Yes \$75 100 mg.				Yes	Yes \$10- 25mg.\$25 -50 mg	Yes \$25
Other Fentanyl							
Lorcet®		Yes \$5- \$7		Yes		Yes \$.75	Yes \$5
Methadone	Yes \$10 20 wafer				Yes	Yes \$20 wafer	Yes \$20 wafer
Morphine	Yes \$15 or \$20						
MS Contin®							Yes \$30
Oxy Contin®	Yes \$30 – 40 Col. \$50- 80 mg.	Yes \$20 - \$30 40 mg.	Yes	Yes	Yes \$40 – 80 mg.	Yes \$40- \$50 80mg.	Yes \$40- 80mg.
Percocet®	Yes \$5	Yes \$4 - \$5	Yes	Yes	Yes	Yes \$3- \$5	Yes \$2
Percodan®		Yes \$4 - \$5	Yes	Yes			
Talwin®							
Tylenol®		Yes \$1			Yes	Yes \$.50 \$1	Yes \$1- \$2
Tylox®							
Ultracet®						Yes \$1	Yes \$1
Ultram®	Yes \$3 in jail	Yes free – drug reps	Yes			Yes \$2	Yes \$1
Vicodin®	Yes \$5	Yes \$2- \$3	Yes	Yes	Yes	Yes \$3- \$5	Yes \$5 HP \$4 ES \$2 babies

*No entry indicates user did not know if available, or did not know price.

Participant 1 also indicated abusing Valium®, Ativan®, which sell for \$1.50 a piece, and Klonopin® for \$3 per tablet.

Participant 2 also indicated abusing Vicoprofin® \$2- \$3 a piece.

Participant 3 also indicated abusing Soma® prescribed by a doctor.

Participant 4 also indicated abusing Soma® and Valium®.

Participant 6 also indicated abusing Xanax® \$2, Ativan® \$1-\$2, Valium® \$1-\$2 and Soma® \$2.

Participant 7 also indicated abusing Xanax® \$3 (blue) \$5 (white), Valium® \$2, Soma® \$2.

IV. Results of the interviews with analgesic drug abusers

Drug Use History

All participants indicated other drug use prior to onset of pharmaceutical analgesic abuse. One 38-year-old woman considered that her substance abuse started with use of cigarettes at age 9. Two individuals indicated beginning alcohol use at age 13. Three reported first using alcohol at age 15-16. One individual reported starting alcohol abuse at the age of 18. In summary, six participants reported having used alcohol in their teenage years. Two participants reported Driving Under the Influence (DUI) charges as adults, one with one DUI and Disorderly Conduct (at a concert) and the other with two DUIs.

Five individuals reported quickly progressing to marijuana use, and three of them eventually becoming daily marijuana users. Four individuals reported experimenting with various other substances during their teenage years, including hallucinogens, benzodiazepines, prescription analgesics, powdered cocaine, and MDMA (Ecstasy). All of these four individuals, who reported polysubstance abuse as teenagers, eventually became heroin injectors.

Two other participants reported that they started using multiple substances, including prescription analgesics, benzodiazepines, powdered cocaine, heroin and crack in their adult years.

Abuse of prescription analgesics

Participants were introduced to pharmaceutical analgesics in a variety of ways. Some started using recreationally; 1) first receiving drugs free of charge from friends working in a pharmacy who would steal some tablets, 2) buying tablets from a college buddy who got them from his terminally ill father (the father making part of the money), 3) through meeting a new "girlfriend" at a bar, who when revealing her own addiction to pharmaceuticals, offered them. The other four participants reported that they were "introduced" to the drug through legitimate health problems and chronic pain. Two of them reported complications from C-Section deliveries, another reported back and leg pain from a brain disorder and the last reported receiving prescription medications from severe injuries from an automobile accident.

Of the seven interviewees, three reported the cost of pharmaceuticals abused averages about \$100, \$160 and even \$300 per day. Only one person reported mainly abusing their own prescriptions along with getting additional tablets from friends, usually "free" of charge or for a very low cost.

Reported duration of prescription analgesic abuse ranged from 6 months to 15 years with 5 years as average length and 3.5 as the median. Three participants reported a pattern of use starting with swallowing, then snorting, eventually progressing to regular injection use over an extended period of time. Two users reported the pattern of initial swallowing, then snorting for an extended period of time. One indicated two weeks of injection use and one indicated injection use only once prior to treatment admission. One person reported only swallowing and snorting for the entire 15 years of abuse of pharmaceuticals, although this individual went through a two month period of shooting cocaine about 15 years ago. One person reported the route of administration as swallowing only, after first breaking pharmaceutical tablets in half.

Pharmaceutical analgesics were obtained in a variety of ways including:

- 6 reports of stealing from friends and relatives
- 5 reports of purchasing off the street
- 2 reports of working as health care workers and stealing from employers
- 3 reports of selling/bringing clientele/buy one drug, trade for another
- 1 report of doctor shopping
- 1 report of faking toothaches
- 1 report of selling own clothes
- 1 report of giving plasma

Four of the respondents indicated they had abused their own pharmaceutical analgesic prescriptions.

Five of the seven people interviewed reported OxyContin® and heroin as the last illicit drugs they used prior to coming to treatment. Users of heroin reported that lower price and higher availability were the main reasons for using heroin instead of OxyContin®. One woman reported that she abused OxyContin® when she could afford it, but Percocet® and Vicodin® were the drugs that she abused most recently. Finally, once individual reported that the only drugs recently abused were Lorcet® and Vicodin®.

One 22-year-old participant reported introducing 20 of his “old neighborhood friends” to OxyContin®. He explained that they would “try it one time and that was it.” Two participants reported giving two tablets to two friends. In one case it was while they were playing PlayStation. One participant reported giving one tablet to her sister when her sister “wasn’t feeling well” and another participant offered the drug to “a girl who wanted to go out” with him. Another woman indicated using OxyContin® with her 16 and 19-year-old sons and 10 of their friends. This Columbiana County woman further discussed an incident where one of her son’s friends, while on OxyContin® and seeking more OxyContin®, stabbed his uncle when he would not give him more. The interviewee indicated this young man is currently in prison.

The following reasons for abusing pharmaceutical analgesics were given in statements by the respondents:

- Just like downers. Very fond of the “itching.”
- Trying to escape reality. Couldn’t function without it, then it became a habit.
- Thinking the pain will go away.
- Didn’t know it could lead to that. Doctors don’t explain. At the time thought it was because of the illness...now don’t think these were the right “meds” to prescribe.
- Started with pain, but really like the way it made me feel. When my friend died, it was a way to ‘numb out.’
- Mellows me out at the same time it speeds me up.
- Liked the ‘itch.’ Because of the ‘high.’

Physical concerns reported by pharmaceutical analgesic abusers were kidney or liver damage, worry about bone structure and brain cells being “destroyed,” and dealing with resultant irritable bowel syndrome. One 21-year-old spoke of the risk of arrest. Additionally, one 22-year-old male OxyContin® and heroin user reported concern about the “extreme addiction...that people don’t know what they are getting into” also stating that “it will lead them to worse things...(they) won’t get high...and will switch to heroin.” Another woman, a mother of three, reported “you loose your home, vehicle, children, family, job...yourself.”

Pharmaceutical Analgesic Drug Trends

All of the seven participants reported increases in pharmaceutical analgesic drug abuse in general. One stated “big time,” and another stated “*it’s crazy out there...I can’t believe it.*” She continued “...*a lot of people used to go out drinking, now it’s the pill thing...people like to take pills.*” One user reported both “increase and decrease,” with the decrease due to “kids” using pharmaceuticals but quickly progressing to heroin use. All seven interviewed indicated that new users of “street” pharmaceutical analgesics are nearly exclusively Whites, with only one person indicating knowing a few Black individuals who use them. For OxyContin® use, participants indicated that the majority of OxyContin® users are approximately 15 to 30-years-old. Two individuals reported that more females are abusing the drug, while one participant had an opposite opinion and believed that more males are using the drug. Another participant believed that OxyContin® abuse is increasing among both males and females. One participant expressed an opinion that abuse of Percocet® and Vicodin HP® and Vicodin ES® may be on the increase due to the high price of OxyContin®.

The majority of the participants indicated that they had at least one friend who died from abuse of pharmaceutical analgesics. For example, one participant reported that four friends had died recently and one dealer of pharmaceuticals had also died in the last year. Another individual, who was an OxyContin® and heroin abuser indicated that three of her friends had recently overdosed on a combination of OxyContin® and heroin, and that her significant other, his father and another close friend had each been resuscitated and taken to a local emergency room.

Drug Treatment

A 21-year-old reported two past detoxification episodes for three days each, stating that the “*day I got out, went and used again.*” He indicated that he had come to Mahoning County to attend 30 days inpatient, then 60 days of residential treatment after recently spending 40 days in jail where he went through detoxification with no counseling.

Six participants reported past treatment. One individual had no prior treatment experience. Three reported two prior treatments, two participants reported three past treatments and one reported four past treatment episodes. At the time of the interview, three participants were in inpatient and another three were in residential treatment. One participant has been clean for close to one year, the others for 50 days, 40 days, 30 days, 14 days and 2 days. An active user reported having abused Ultram® on the day of the interview.

Three participants discussed funding issues in relation to treatment accessibility. Some commented that “*it’s hard without a medical card.*” One mentioned a deceased acquaintance having been unable to pay for treatment, indicating her belief that a “walk-in” option for treatment would have been helpful. Another participant discussed a long waiting time for female residential treatment in her county, and indicated that she was accepted to treatment faster because she was considered a “suicidal and homicidal” case. None described significant problems with getting into detoxification. One participant reported satisfaction stating he called every day, and by the fourth day got into treatment. Another described a wait list for rehab, indicating belief that there are “not enough” services. One interviewee described a complication when being admitted (e.g. a rule that prescribed mental health medications must be brought in).

Injection Drug Use

Interviewee Number 2 indicated that when she was 19, she went through a two month period of injecting powdered cocaine. She reported that she shared needles with her boyfriend. She indicated *“we didn’t know about HIV then,”* but reported she was glad to be offered the test at a prior treatment experience, stating *“we need to know if we have it.”* Interviewee Number 3, a current user, indicated no injection use. She went on to justify her use by stating, *“that’s why I feel like I’m not doing nothing wrong, cause I never did nothing that bad.”* Neither of these two participants indicated OxyContin® or heroin use as primary drugs of abuse.

Five of the seven respondents indicated some experience with injection as a route of administration of illicit drugs. One woman described that she injected heroin on only one occasion, immediately prior to coming to treatment. She reported that the person who injected her was diabetic, and used a new needle. She indicated having had an HIV test while in treatment. She further indicated that this experience really “scared” her. Another participant reported a two week period of injecting heroin, using new needles with a girlfriend, stating he also had unprotected sex. He reported no HIV test.

The three remaining users indicated that their first injected drug was OxyContin®, followed by heroin. Two of them, both males between ages 21 and 22, reported one year of injection use, the third one, a 21-year-old woman, reported 1 ½ years of use. One participant reported only using his own needles at first, but later he began *“shooting with really good friends”* on some occasions. He reported having been tested for HIV. Another participant reported that he called the hospital and they told him how to clean the needles with “Clorox.” He nevertheless reported sharing needles less than half the time, also with a “buddy.” Not wanting to “catch anything” or get AIDS was given as the reason for caution. He reported not having an HIV test. The third individual reported using clean needles because her grandfather is diabetic. She reported sharing a few times with her boyfriend only, stating she did not want to get Hepatitis or HIV. She reported having been tested for HIV. Of these three, one shared other injection paraphernalia less than half of the time, another about half of the time and one almost always.

V. Conclusions

OxyContin® remains the most sought after pharmaceutical analgesic being abused in Mahoning and Columbiana Counties. Vicodin® and Percocet® are also readily available and being abused, with lower price being a determining factor for some users. The progression of swallowing, then snorting and finally progressing to daily injection use is a common pattern with OxyContin® users. The pattern of switching to heroin after injection use of OxyContin® was clearly seen among the interviewed participants. In most cases, a lower price and higher availability of heroin were the major determinants of this transition.

Self-medication during chronic pain episodes as well as recreational use were two main ways participants started abusing pharmaceutical analgesics. Nearly all of the participants had a history of problematic use of alcohol and most had used other “street drugs” prior to pharmaceutical drug abuse.

Many different forms of obtaining the drugs were reported by the participants. Some reported stealing from friends and families as well as from health care settings. Others reported

purchasing on the street, trading and selling to get one's own supply. Most indicated they had introduced others to pharmaceutical use. Some reported a few instances where large numbers of people were introduced to pharmaceutical analgesics in the "party atmosphere."

None of those interviewed reported major problems getting into treatment; however, concern was expressed for others who may not have Medicaid or some other form of medical coverage.

The majority of the participants had some experience with injection use. All of those who had a history of injecting drugs were concerned about both HIV and Hepatitis. Nevertheless, the majority of them reported unsafe injection practices.