

OPIOIDS

Opioid Use Disorders: Facts & Figures

NSDUH 2015 Data:

Past Month Use of Illicit Drugs, U.S. Population

12 and Older

| Illicit Drugs | Use % (estimate) |
|-----------------------|-------------------|
| Marijuana | 8.3% (27,080,000) |
| Psychotherapeutics* | 2.4% (6,365,000) |
| Opioid Pain Relievers | 1.4% (3,775,000) |
| Cocaine | 0.7% (1,876,000) |
| Hallucinogens | 0.5% (1,240,000) |
| Inhalants | 0.2% (527,000) |
| Heroin | 0.1% (329,000) |

*Psychotherapeutics are prescription medications such as opioid pain relievers, tranquilizers, stimulants, and sedatives.

Past Month Use, Nonmedical Users of Opioid Pain Relievers/ Heroin Users

By Age

| Age | Use % (estimate) |
|--|-------------------|
| Nonmedical Users of Opioid Pain Relievers | |
| 12-17 | 7.3% (276,000) |
| 18-25 | 21.8% (829,000) |
| 26 and older | 70.9% (2,700,000) |
| Heroin Users | |
| 12-17 | 1.5% (5,000) |
| 18-25 | 26.7% (88,000) |
| 26 and older | 71.7% (236,000) |

By Gender, 12 and Older

| Gender | Use % (estimate) |
|--|------------------|
| Nonmedical Users of Opioid Pain Relievers | |
| Female | 44% (1,665,000) |
| Male | 56% (2,110,000) |
| Heroin Users (TEDS, 2014)* | |
| Female | 34% (121,889) |
| Male | 66% (235,320) |

By Race/Ethnicity, 12 and Older

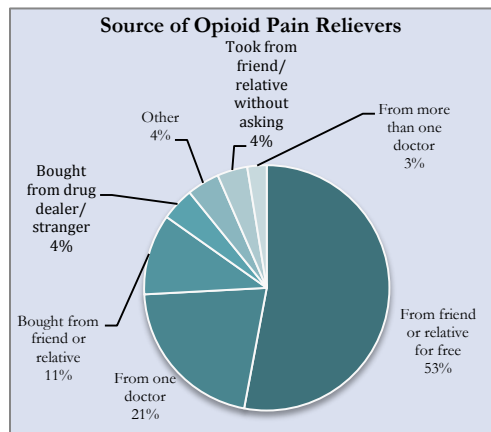
| Primary Race/Ethnicity | Use % (estimate) |
|--|-------------------|
| Nonmedical Users of Opioid Pain Relievers | |
| White | 67.3% (2,441,000) |
| Black | 11.9% (432,000) |
| Hispanic | 18.9% (688,000) |
| Am. Indian/AK Native | 0.4% (16,000) |
| Asian | 1.4% (52,000) |
| Heroin Users (TEDS, 2014)* | |
| White/Hispanic | 72.3% (244,917) |
| Black | 12.1% (40,832) |
| Hispanic | 15.0% (50,940) |
| Am. Indian/AK Native | 1.0% (3,445) |
| Asian | 0.5% (1,968) |

*Most recently available national demographic information on individuals who use heroin.

Overview

Opioids are derived from the seed pod of the Asian opium poppy plant. When opioids enter the brain they bind to “opioid receptors.” These receptors are located throughout the brain and are involved in how we perceive pain and reward. There are also opioid receptors in the brain stem that affect critical life processes such as blood pressure and respiration. **Excess opioids in the brain can interfere with respiration, leading to overdose and possible death.**¹ Opioids are used in a variety of illicit and licit ways. Patients with severe acute or chronic pain may be prescribed opioid-based medications such as morphine, oxycodone, or hydrocodone as a means to relieve patients’ pain and discomfort. Others may use these pain relievers non-medically to achieve a euphoria or “high.”¹ For the purposes of discussing problem use and addiction issues, this fact sheet refers specifically to the non-medical use of opioid pain relievers. Heroin is also derived from poppy plants. Heroin is usually found as a white or brown powder or black sticky substance and can be injected, inhaled, or smoked, all of which deliver a rapid dose to the brain contributing to its high risk of overdose and other serious health consequences.¹ Heroin can also be laced with other substances adding additional health risks.

An estimated **12,462,000 Americans aged 12 and older misused opioid pain relievers in 2015**, and roughly **828,000 individuals used heroin.**² In addition, opioid pain relievers were cited as the primary substance of abuse in 8.2% (132,387) of treatment admissions and heroin was cited in 22.2% (357,293) of admissions in 2014, exceeding alcohol as the primary substance of abuse.³



Opioid Pain Relievers

According to results from the 2015 National Survey on Drug Use and Health (NSDUH), 3.8 million Americans aged 12 or older were currently (during the past month) misusing opioid pain relievers.⁴ Non-medical prescription opioid use is the most common type of illicit drug use after marijuana. The vast majority of Americans who misuse opioid pain relievers receive them from a friend or relative for free (53%) or from one doctor (21%).⁴ Admissions to treatment for opioid pain relievers increased by 113% from 2004-2014.³

Individuals who misuse prescription opioid painkillers are 40 times more likely to become addicted to heroin.⁵ Prior prescription drug use appears to be a common initial step on the pathway to heroin addiction, with 80% of new heroin users previously misusing prescription opioids.⁶ This shift from prescription drug misuse to heroin use can be attributed to the pharmacologic similarities of the two types of opioids and to the affordability and accessibility of heroin.⁷

Heroin

According to NSDUH 2015 results, 329,000 individuals aged 12 or older were currently (during the past month) using heroin.² The share of admissions to treatment for heroin increased by 25% from 2010 to 2014,⁴ and according to NASADAD data, 39 States reported increases in treatment admissions for heroin in 2015. The National Institute on Drug Abuse (NIDA) estimates that approximately 23% of individuals who use heroin will become dependent on it.¹ Given that heroin is often injected, users are at higher risk of contracting blood/bodily fluid borne diseases such as HIV and hepatitis C.¹ This higher risk can be mitigated by not sharing or reusing needles and

other injection drug equipment, along with abstinence. Individuals who use heroin chronically may also develop collapsed veins, heart infections, abscesses, gastrointestinal cramping, liver disease, or kidney disease.¹

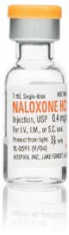
Evidence-Based, Cost-Effective Treatment

Medication-Assisted Treatment

Treatment plans should be based on individual patient needs and include the full spectrum of clinically appropriate care (e.g.; comprehensive screening and assessment, detoxification, cognitive behavioral therapy, contingency management), access to appropriate settings (e.g.; outpatient, residential, therapeutic community), and adequate lengths of stay. Medication-assisted treatment (MAT) is one such intervention that should be available to patients with opioid use disorders. There are currently three FDA-approved medications to treat opioid dependence: methadone, buprenorphine (including buprenorphine implant), and naltrexone (oral and extended-release injectable). They are each available in various clinical settings including regulated opioid treatment programs (methadone, buprenorphine, naltrexone) and physicians’ offices (buprenorphine,

naltrexone). Use of these medications in conjunction with counseling has been shown to be effective in treating opioid dependence,^{8,9,10} with long-term maintenance on these medications providing the highest rates of sustained abstinence.^{11,12} Additional research on methadone and buprenorphine has shown associations with improved social functioning, reduced infectious disease transmission, reduced criminal activity, and reduced overdose risk. In 2013, NASADAD approved a policy statement supporting the use of medications in treatment.¹³

Reversing Overdose, Saving Lives



Opioid overdose is a serious risk for any user of opioids. It causes respiratory depression and can become fatal. In 2015, **33,091 Americans lost their lives to an opioid pain reliever or heroin overdose**, exceeding deaths caused by car accidents.¹⁴ Naloxone is a prescription medication that is used to reverse the effects of an opioid overdose. Making naloxone available for bystanders and first responders, as well as in emergency departments, can save lives.¹⁵⁻¹⁷ As of September 2015, 38 States and the District of Columbia had passed laws to increase access to naloxone.¹⁸ In 2014, NASADAD approved a policy statement supporting strategies to prevent overdose deaths.¹⁹

The Role of State Alcohol and Drug Authorities in Prevention, Treatment, and Recovery

State Alcohol and Drug Authority Directors design, manage, and evaluate the publicly funded substance abuse prevention, treatment, and recovery system in each State. State Directors provide leadership by promoting standards of care, evidence-based services, and continuous quality improvement innovations. State Directors also ensure that public dollars are dedicated to programs that work through the use of performance data management and reporting, contract monitoring, corrective action planning, on site-reviews, and technical assistance.

Key Federal Programs and Agencies

The Substance Abuse and Mental Health Services Administration's (SAMHSA) **Substance Abuse Prevention and Treatment (SAPT) Block Grant** is a formula grant awarded to every State and Territory. The SAPT Block Grant accounts for an estimated 65% of State Substance Abuse Agencies' expenditures on prevention.²⁰ SAPT Block Grant funds enable more than 1.5 million Americans to receive treatment annually. In addition, more than 18.6 million Americans received SAPT Block Grant-funded prevention services in individual-based programs, and more than 500 million (duplicated count of persons) were served in population-based programs in 2015.²⁰ During the same period, at discharge from block grant-funded programs, 70% of clients demonstrated abstinence from illegal drug use, 83% were abstinent from alcohol use, 89% had stable housing, and 93% had no arrests.

SAMHSA's **Center for Substance Abuse Treatment (CSAT)** works to improve and expand existing substance use disorder treatment programs under the SAPT Block Grant. SAMHSA's Division of Pharmacologic Therapies (DPT) oversees the accreditation and certification process for opioid treatment programs and physician waivers to prescribe buprenorphine.

SAMHSA's **Center for Substance Abuse Prevention (CSAP)** leads efforts to stop drug use before it starts. CSAP's Partnerships for Success Program provides funding for States to develop comprehensive Statewide approaches to address prescription drug abuse or other problems unique to that State.

The 21st Century Cures Act, enacted in December 2016, authorized the **State Targeted Response to the Opioid Crisis Grant program**. This two-year grant program, administered by SAMHSA, aims to increase opioid use disorder prevention, treatment, and recovery services. Congress appropriated \$500 million in FY 2017 for this program. Grants will be awarded to Alcohol and Drug Authorities in the States and territories via a formula that is based on unmet need for opioid use disorder treatment, as well as drug overdose deaths. Applications for the first year of the program are due on February 17th, 2017.

The **Office of National Drug Control Policy (ONDCP)** provides federal leadership on addiction prevention, treatment, and recovery policy. Among its many initiatives designed to address the opioid crisis, ONDCP issued a comprehensive plan to address prescription drug abuse in 2014, framing the opioid crisis as a public health and public safety issue, and recognizing addiction as a disease.

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