THE CONTINUUM OF INTENTIONALITY: EXPLORING UNDERLYING CAUSES OF INTENTIONAL AND UNINTENTIONAL DRUG OVERDOSES

BY: SAMIA BAIG
Opioid overdose-related deaths grew from 4,000 deaths in 1991 to about 16,500 in 2010 in the United States.

The rise is attributed to the increase in prescribing that quadrupled in 1999 for reasons related to curtailing inadequate pain management and increased marketing by pharmaceutical companies for opioid use for non-cancer pain.

Availability of more potent and less expensive drugs such as heroin and fentanyl are keeping the rates up, despite drops in the prescribing rates of opioids.
Public health departments use surveillance and data to determine specific patterns relevant to the crisis that can be targeted for policy making and interventional purposes.

If overdose death a suicide, homicide, and undetermined death, then falls under National Violent Death Reporting System

- Most overdose deaths fall in MVDRS for Maryland because of utility of “undetermined” category

Is this current system adequate in understanding behaviors associated with overdose deaths overdose deaths?
BACKGROUND: CURRENT CLASSIFICATION SYSTEM

- Dependent on ICD-10 codes that are used for vital statistics purposes and chief medical examiner determination
- “Drug-induced” deaths, including accidental poisoning, intentional self-harm, assault, and events of undetermined intent involving drugs and fall under the codes X40–X44, X60–X64, X85, and Y10–Y14.
- Use of discrete categories to classify overdose deaths—possibly inadequate
- Most states classify overdose deaths as intentional or intentional-Maryland is one of 3 states to use the “undetermined” category
“Death by drug self-intoxication” category developed by Dr. Ian Rockett of West Virginia University School of Public Health

Proposes a new way of looking at overdose deaths instead of the classic injury prevention terms

Possible solution to better determining actual suicide deaths

Look more at the variables and factors surrounding the death

Personal interest: looking at the neuropharmacological role in “ambivalence” resulting from opioid abuse
METHODS: APPLYING THIS TO DHMH

- Proposal: To create a database that follows the DDSI principal for DHMH
- 1) Evaluate the current sources 2) Evaluate the current data 3) Create a combined-dataset
METHODS: APPLYING TO DHMH

Current sources:
- 1) Maryland Violent Death Reporting System and 2) Overdose Fatality Review
- MVDRS contains suicides, homicides, undetermined, OFR contains accidental and undetermined Current data
- 1) Vital Statistics 2) Raw data from Office of Chief Medical Examiner

Combination
- Combine the MVDRS and OCME data
The MVDRS includes suicide, homicide and undetermined deaths from 2003 to 2013 whereas the OFR includes accidental and undetermined deaths from 2013 to present. The MVDRS had a total of 3,959 deaths with 398 of those deaths classified as suicides and 3,561 being undetermined. The OFR has 268 deaths.

The OCME raw data has all deaths investigated by OCME from 2007 to present.

Confusion surrounding certain causes of death: conclusion is to make more inclusive

A combined database of MVDRS and OCME was created
A continuum is difficult to define for quantitative purposes

Time spent on the project is a limiting factor

Bulk of analysis and insights will develop as the project continues
QUESTIONS?