

Minutes from Steven Passik, PhD
Aberrant Drug-Taking Behaviors: What do we Know?
April 24, 2008
3:00-5:00, State Office Building Auditorium

Notes on presentation:

- 3% of people will become addicted to narcotics
- Abuse-resistant opioids are being created
- High-risk patients (before we only worried about “pain patient” more than “nonmedical users”)
- Spikes in prescribing
- ONDCP (Office of National Drug Care Policy): main agenda to crack down on marijuana abuse
- Prescription meds are more dangerous now because kids use vicodin as gateway drug rather than marijuana
- Non supervised use of anything with addiction potential will most affect the vulnerable
- Need different educational approach for “self-treaters” than for doctors to approach addicts
- Need campaign on HOW to STORE YOUR MEDICINE
- Oxycodone is most abused drug in nation
- Methadone contributes most to deaths
- Utah has an excellent PMP (compared to the rest of the nation)
- Pain management docs spend 2 hrs/day to get DOPL reports on the 50-70 patients they see that day
- Addiction is usually expressed by age 35 so older people without past addictions are unlikely to be addicted with prescription exposure
- 180 mg—85% of doses in country are below 180mg/day
- Washington guidelines say physicians should have patients consult a pain specialists if the equivalent dose of morphine is above 120 mg/day
- Guidelines should reflect “package deal”: every patient should have risk assessment, DOPL check, frequency for urine screens, suggest consultations with psychotherapy, include doing an assessment
- Addiction is not about intelligence: 4 c’s: craving, out of control use, compulsive, continued
- Urine screens are available where 12 drugs tested in real time (if you have to send the drug screens away for 2 weeks, they have no clinical relevance)
- Risk factors for addiction to opioids: cigarette smoking predicts overuse of opioids
- Second chance agreement: frequent visits, less drug given, random urine screens, counseling (weight watchers for pain management)
- Dual program is needed (pain and substance abuse):
- Must address pain as well as addiction (can’t treat 1 without the other)
- A study that treated both pain and addiction resulted in fewer problems and reduction in all addiction for all patients.

Q. Surprised to hear there are so few dual programs

A. Yes, they are rare. A methadone maintenance clinic would be a good place to house dual programs.

Q. AA meetings have lots of chain smoking, is there some connection between that and rx drug use and smokers?

A. Some people may be co-morbid addiction. Nicotine is an analgesic.

Q. Is there an effort underway to link Prescription Monitoring Programs (PMPs) between states?

A. Yes—some advanced systems already are connected. Ohio can get WV, KY, Indiana. This is a crucial step for these programs.