HOW DO I GET PAST TALKING ABOUT TREATING THEIR PAIN WITH OPIOIDS?

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GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

None
OBJECTIVES

1. Determine what is motivating a patient to focus only on opioids
2. Develop a stronger provider-patient alliance
3. Describe some brief evidence based behavioral strategies to engage patients in treatment
<table>
<thead>
<tr>
<th>Intense Chronic Pain</th>
<th>Presents with...</th>
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<tbody>
<tr>
<td>54 year old Latino male</td>
<td>Loves his PCP</td>
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<tr>
<td>Disabled, SSDI, Section 8 housing</td>
<td>Demanding in clinic, angry if roomed 5 min late</td>
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<tr>
<td>Bipolar II, PTSD, pervasive body pain focused mainly in hips, legs, and feet</td>
<td>Pain is #1 issue, no one is listening</td>
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<tr>
<td>Hx of polysubstance abuse</td>
<td>Demands opioids are all that helps, but no one will prescribe</td>
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<tr>
<td>10/10 pain, 10/10 pain interference</td>
<td>Admits buying opioids at times for pain flares</td>
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<tr>
<td>Seroquel, trazadone, clonazepam</td>
<td></td>
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<tr>
<td>Former dancer, now wheelchair bound, deconditioned, obese</td>
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WHAT’S GOING ON??

<table>
<thead>
<tr>
<th>Differential Dx</th>
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<tbody>
<tr>
<td>• Substance abuse</td>
</tr>
<tr>
<td>• Deferring opioids — wants extra cash</td>
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<tr>
<td>• Poor motivation</td>
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<tr>
<td>• Poor engagement</td>
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</table>
OPIOIDS ARE BAD... AND PRIMARY CARE CAN MAKE A DIFFERENCE

- Chronic Opioid Therapy (COT) use for non-cancer pain doubled in the past decade
- Fatal overdoses involving opioid analgesics increased four-fold from 1999 to 2009
- A large study showed - 87% of those who died of an opioid drug overdose obtained opioids by prescription in the prior year
- Most opioids are prescribed by primary care physicians for long term management of common chronic pain conditions
- As COT patients’ opioid doses are increased, they face an increasing risk of adverse events

SAFE OPIOID PRESCRIBING GUIDELINES – TOO HARD TO FOLLOW?

• Centers for Disease Control
  https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

• Washington State Agency Medical Directors’ Group

• COT guideline based care generally includes dimensions of when to initiate and continue COT, specifics for selecting and dosing opioids, and assessing for risk and harm of COT

• Tough ask - where does the patient-provider alliance fit in?
WHAT HAPPENS WHEN YOU HAVE A PATIENT ASKING FOR OPIOIDS?

• What does the patient do?

• What do you do in response?
PSYCHOTHERAPEUTIC PROCESS

Engagement

Assessment

Crisis management

Treatment - pain self management, medications, medical interventions, etc.
KEY #1
QUALITY OF ALLIANCE DETERMINES OUTCOMES

(COACHING, COUNSELING, MEDICINE, TEACHING, JOB TRAINING)

Strong alliance outcome  ➔  Good

Weak alliance  ➔  Poor outcome
PITFALLS

• Go for the bullseye and try to do treatment too soon
  – No engagement = no treatment adherence
  – Often makes patients angry and feel unheard

• Make assessment assumptions too quickly → “he’s med seeking and unmotivated”
  – Cuts off assessment too early
  – Difficult to solicit for patient-centered goals
WHAT TO DO?

• Spend extra time on engagement, schedule more visits if needed
• Take time to assess carefully to understand what’s motivating the persistent ask for opioids
• Forgo treatment until engagement is solid
• Let’s talk about how...
3 CRITICAL ELEMENTS OF ALLIANCE:
(ALL 3 MUST BE AGREED UPON BY THE PATIENT & PROVIDER)
RECIPROCAL CAUSALITY (EVERYTHING EFFECTS EVERYTHING)
KEY #2

NOT READY TO CHANGE / ENGAGE?

![Diagram showing the Transtheoretical Model of Change (Prochaska & DiClemente)]

Motivation/performance

- Denial
- Realisation
- Shock
- Confusion
- Resistance
- Anger
- Blame
- Defensive
- Letting go
- Searching
- Anxiety
- Uncertainty
- Fear
- Frustration
- Understanding change
- Some optimism
- Some ideas
- Change accepted
- Commitment
- Enthusiasm
- Trust

Stage 1: Endings
- Realisation
- Shock
- Confusion

Stage 2: Transitions
- Resistance
- Anger
- Blame
- Defensive
- Letting go
- Searching
- Anxiety
- Uncertainty
- Fear
- Frustration

Stage 3: New beginnings
- Understanding change
- Some optimism
- Some ideas
- Change accepted
- Commitment
- Enthusiasm
- Trust

Time

- I WILL DO IT
- I CAN DO IT
- I'LL TRY TO DO IT
- HOW DO I DO IT?
- I WANT TO DO IT
- I CAN'T DO IT
- I WON'T DO IT

Which step have you reached today?

- pre-contemplation
- contemplation
- preparation
- action
- maintainence
- relapse

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ASSESSING FOR READINESS...

- What can I do to be helpful?
- What are you hoping to get from your care?
- After health service assessment...
  - Agree on the initial task for next contact
  - Set mutual goals
SOME POTHOLEs TO AVOID...

• Question and answer trap (closed questions)
• Correcting wrong thoughts with rational explanations (telling them what to do)
• Avoiding the patient (hiding, acquiescing)

What are some you notice?
WHAT WAS HAPPENING WITH HIM?

Barriers

- Felt judged as an “addict”
- Felt like his pain wasn’t important to his medical pain providers
- Anxiety and personality style were making it difficult to interact
- He lacked education about pain self management
- Pain acceptance was low and wasn’t ready for pain self management
REFLECTIONS: EXAMPLES

It sounds like you are feeling...
It sounds like you are not happy with...
It sounds like you are a bit uncomfortable about...
So you are saying that you are having trouble...
So you are saying that you are no so sure about ...
You’re not ready to...
You’re having a problem with...
You’re feeling that...
It’s been difficult for you...
You’re struggling with...
GOOD REFLECTIONS PROVE YOU UNDERSTAND

• Most powerful technique for preventing and dealing with tough interactions
• Shows nonjudgmental understanding of the patient’s point of view
• Communicates respect and understanding of the patient’s experience
• Does **NOT** mean you agree with their explanatory model nor endorse maladaptive behavior choices!
ENGAGEMENT STEPS

• Elicit the story = understanding, summary of pros/cons to pain treatment
• Elicit treatment hopes and dreams
• Feedback = psychoeducation
• Address barriers: practical, psychological, cultural
• Elicit commitment
WHEN TO STEP UP ENGAGEMENT

- Lacking agreement on goals
- Lacking agreement on tasks
- Weak bond

- Can happen at any point in care...
WHAT DID WE DO?

What did we do?

• ENGAGE, ENGAGE, ENGAGE!
• Set patient-centered goals: lose weight, move more, get back to walking
• Address pain acceptance and educate about pain self management
• Address anxiety, anger issues, and family conflict
• Eventually...
  pain went to 9/10, pain interference 9/10, PHQ-9 20-0, GAD-7 17-0, PCL-C 50-23
RESOURCE

Great book:

“Motivational Interviewing in Health Care: Helping Patients Change Behavior”
- Rollnick, Miller, & Butler