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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

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

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UW Medicine
UW SCHOOL OF MEDICINE

Integrated Care Training Program
UW Psychiatry & Behavioral Sciences

project ECHO

GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

None

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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

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COMMON CASE PRESENTATION

Intense Chronic Pain

- 54 year old Latino male
- Disabled, SSDI, Section 8 housing
- Bipolar II, PTSD, pervasive body pain focused mainly in hips, legs, and feet
- Hx of polysubstance abuse
- 10/10 pain, 10/10 pain interference
- Seroquel, trazadone, clonazepam
- Former dancer, now wheelchair bound, deconditioned, obese

Presents with…

- Loves his PCP
- Demanding in clinic, angry if roomed 5 min late
- Pain is #1 issue, no one is listening
- Demands opioids are all that helps, but no one will prescribe
- Admits buying opioids at times for pain flares

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WHAT'S GOING ON??

Differential Dx

- Substance abuse
- Deferring opioids – wants extra cash
- Poor motivation
- Poor engagement

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OPIOIDS ARE BAD… AND PRIMARY CARE CAN MAKE A DIFFERENCE

- Long-Term Opioid Therapy (LTOT) use for non-cancer pain doubled in the past decade
- 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 providers for long term management of common chronic pain conditions
- As LTOT patients who get tapered are at increased risk of overdose and mental health crises
- Primary care clinics (40%) won't prescribe opioids, 17% asked for more info

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3. Warner M, Chen L, Makuc D. Increase in Fatal Poisonings Involving Opioid Analgesics in the United States, 1999--2006. NCHS data brief number 22. 2009 [updated 2009; cited 2010 Mar 10]. Available from: http://www.cdc.gov/nchs/data/databriefs/db22.htm.
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SAFE OPIOID PRESCRIBING GUIDELINES – TOO HARD TO FOLLOW?

- Centers for Disease Control - 2016
  https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
- Washington State Agency Medical Directors' Group
  https://amdg.wa.gov/guidelines
- Bree Collaborative – Collaborative Care for Chronic Pain
  https://www.qualityhealth.org/bree/topic-areas/chronic-pain/
- LTOT guideline based care generally includes dimensions of when to initiate and continue LTOT, specifics for selecting and dosing opioids, and assessing for risk and harm of LTOT
- 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?

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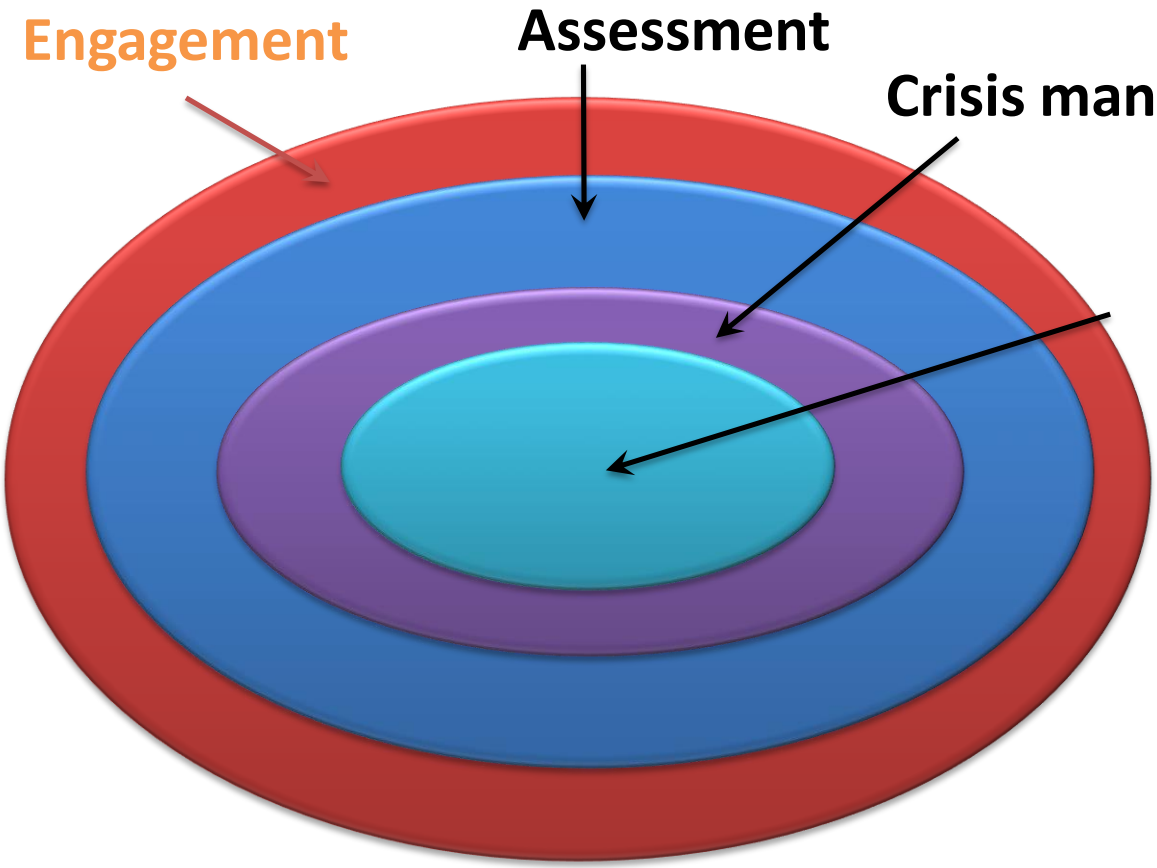
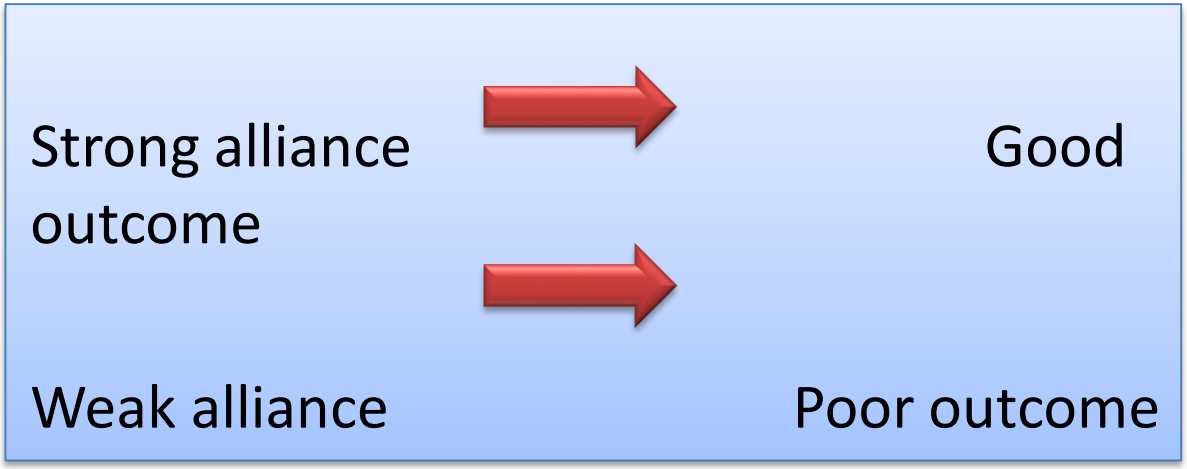
PSYCHOTHERAPEUTIC PROCESS



KEY #1

QUALITY OF ALLIANCE DETERMINES OUTCOMES

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



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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…

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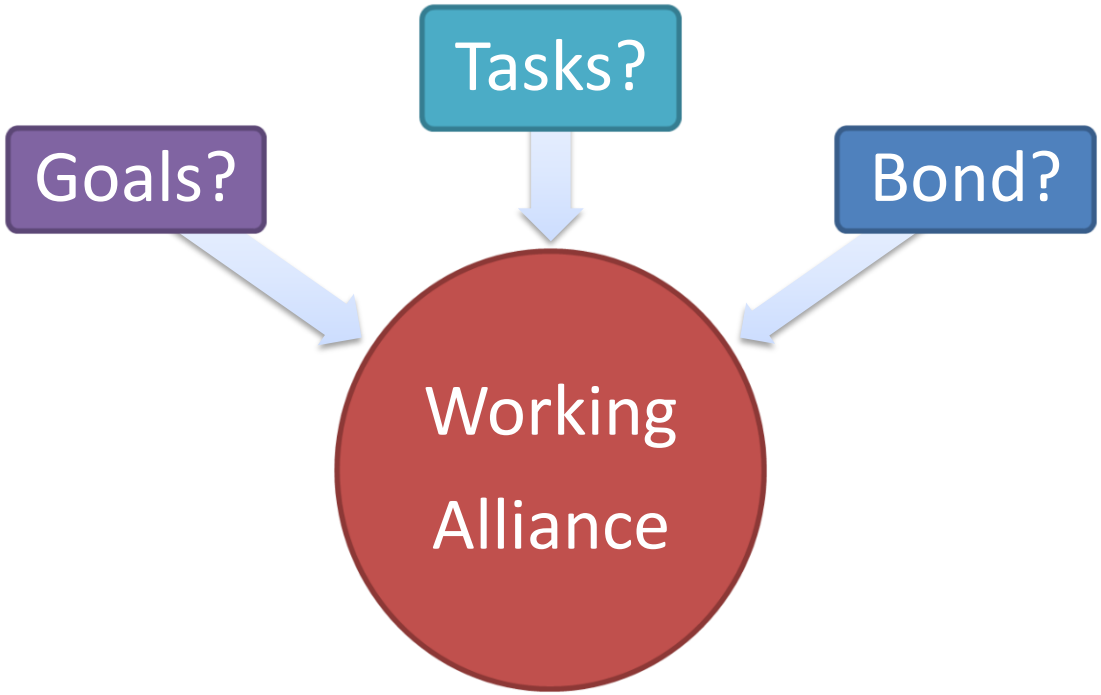
3 CRITICAL ELEMENTS OF ALLIANCE:
(ALL 3 MUST BE AGREED UPON BY THE PATIENT & PROVIDER)



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RECIPROCAL CAUSALITY (EVERYTHING EFFECTS EVERYTHING)

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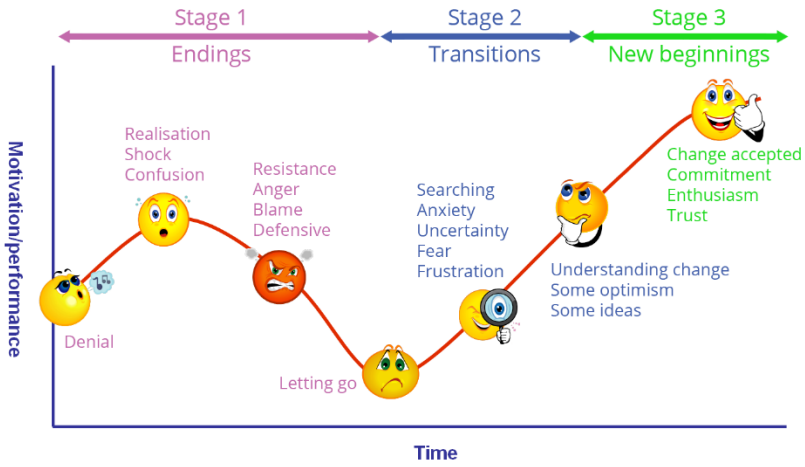
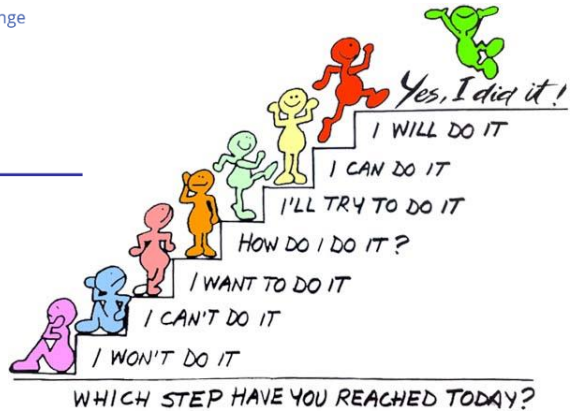
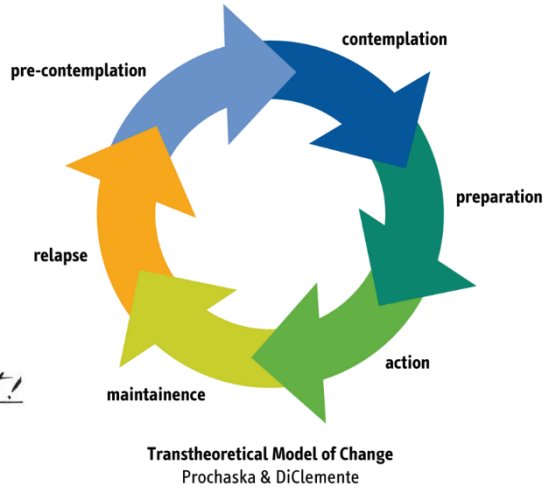
KEY #2

NOT READY TO CHANGE / ENGAGE?







Transtheoretical Model of Change
Prochaska & DiClemente

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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

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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?

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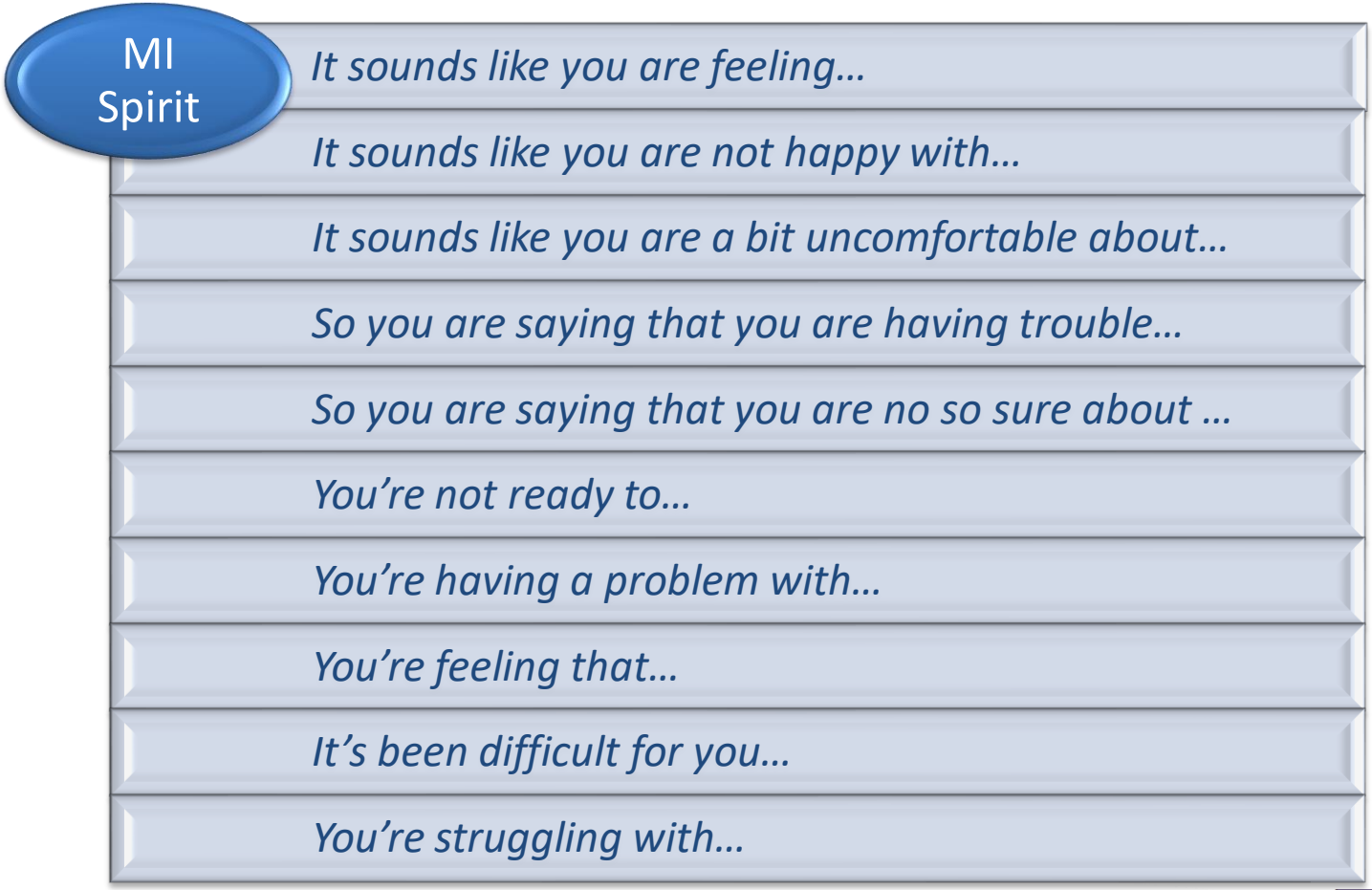
WHAT WAS HAPPENING WITH HIM?

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**



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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!

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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

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WHEN TO STEP UP ENGAGEMENT

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

- Can happen at any point in care…

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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

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RESOURCE

Great book:

"Motivational Interviewing in Health Care: Helping Patients Change Behavior"

- Rollnick, Miller, & Butler

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