**Good-bye Opioids - Hello Self-management**  
**Supporting Non-drug Alternatives for Persistent Pain**

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**OBJECTIVES**

1. Understand how framework of self-management can be used to guide pain research

2. Understand how community-based partners and patients can assist as collaborators in developing non-drug pain self-management approaches

*Take theory into practice!*
Opioids are all right

Excellent pain control in acute and terminal cases!
Appropriate and helpful for some chronic cases.
Need more options with fewer risks.
Nurses have ethical responsibility as patient advocate to inform on risks/benefits/options.

Evidence-based pain treatments are needed

Self-management of pain:
“An essential part of clinical practice guidelines” for rehabilitation of chronic pain

Who writes a prescription for self-management?
Who knows what it is or how you can access it?
Can self-management address the opioid conundrum?

The tasks individuals must undertake to live with chronic health conditions.

Long & Holman, 2003; Bender et al, 2011

- Goal-setting: Adopt new behaviors/skills
- Coping: Build confidence, self-efficacy
- Cognitions: Address thoughts & feelings

- Group persuasion: Social support/QOL
- Education: Adherence/Knowledge

Building the case for self-management

- Variety of modes
  - Flexible, dynamic
  - Web-based, in-person
  - Customized, person-centered
  - Individual, groups

- Does not rely on medical solutions
- Does not exclude medical solutions
- Builds confidence, empowerment

Individual and Family Self-management Theory

Ryan & Sawin 2008 Self-Management Science Center

- Knowledge & Beliefs (self-efficacy)
- Self-regulation skills & ability
- Social Facilitation

- Individual & Family Self Management Behaviors
- Health Status
- Quality of Life
- Cost of Health

Context
- Risks and Protective Factors
- Condition-Specific Factors
- Physical & Social Environment
- Individual & Family Factors

Process
- The Self Management Process

Outcome
- Proximal
- Distal
- Self-management Intervention
Individualized self-management for pain

- Migraines
- Diet/stress
- Back pain
- Exercise/yoga
- Neuropathic pain
- Tens unit

Integrative Medicine
Treats the “whole person”

- Bravewell (2012) study of 29 integrative medicine centers
- People come to them most often for chronic pain
- Most treatment success with chronic pain

Integrative Medicine

Most frequently offered:
- Yoga
- Massage
- Meditation
- Nutrition
- Supplements
- Acupuncture
- Pharmaceuticals

Anything missing??
Cognitive Behavioral Therapy (CBT)

- Most commonly used behavioral medicine approach for pain patients
- Thoughts contribute to symptoms
- Relaxation & controlled-breathing exercises are especially useful
  - Music, art, prayer, imagery, healing touch, virtual reality, acceptance, distraction, cognitive restructuring

Complementary/Alternative Medicine (CAM)

“Diagnosis, treatment and/or prevention which complements mainstream medicine by contributing to a common whole.”

- Comprises wide range of modalities
- Outside “conventional medicine”
- Emphasizes holistic approach
- Popular with patients, especially with pain
- Not meant to replace pharmacologic options

Evidence-based Chronic Pain Management (2011)
Stannard, C., Kalso, E., Ballantyne, J.

Strongest evidence for complementary therapies

- Cognitive Behavioral Therapy
- Exercise/Physical Medicine
- Self-management/Rehabilitation

Multimodal, multi-disciplinary approaches
New CDC Guidelines, 2016

Stannard et al., 2011; Rosenquist 2013
Most evidence for complementary therapies

- Music (weak)
- Yoga
- Tai chi

Crawford et al., 2014

Problems with evidence

- Few high quality studies
- Limits of randomized controlled trials
  - Difficulties measuring pain, subjectivity, variability
  - No therapy works for every patient and every type of pain
  - Small effects (CBT, SM)
- Difficulty separating out multiple modalities
- Few long-term studies

Limited evidence for specific pain conditions

- Hypnotherapy – cancer, acute procedural & post-op pain
- Guided imagery/relaxation – cancer, procedural, complex regional pain syndrome (CRPS), migraine
- Tens unit – neuropathy, post-op pain
Limited evidence

- Acupuncture – back pain, CRPS, osteoarthritis
- Spinal manipulation – back pain
- Biofeedback – fibromyalgia, migraine
- Massage – fibromyalgia, back/neck pain, arthritis, post-op pain
- Music – post-op pain
- Diet - rheumatoid arthritis

Few CAM therapies have been rigorously tested

- Yoga use increased 5.2% to 7.2% 2002-2012
- 20 million adults had chiropractic or osteopathic manipulation
- Nearly 18 million adults practiced meditation
- Safety and efficacy trials lacking

Clarke et al., 2015
Research and adoption into mainstream are needed!
Pyramid of Evidence

Non-Revenue
Evidence Summarized
Systematic Reviews
Other Low Level Evidence
Clinical Reference Texts
Case Reports, Case Series, Practice Guidelines, etc.
Other Reviews of the Literature
Clinical Research Evidence
Controlled Studies
RCT, Meta Analyses
Non-Randomized Research
Training, Licensing, Certification
Selected Sources
Peer Review
Key References
Acknowledgments

What's the Bottom Line?

What does the evidence say about massage?

- A lot of research has been carried out on the effects of massage therapy, but the evidence is mixed.
- While massage has been shown to provide some relief from acute pain, it may be less effective for chronic pain.
- Massage may be beneficial for stress reduction, relaxation, and improving quality of life for people with depression, cancer, and HIV/AIDS.

What do we know about the safety of massage?

- Massage is generally safe when performed by trained professionals, but it can be dangerous for people with certain medical conditions.
- Pregnant women should consult with their healthcare provider before receiving massage.

What is massage therapy for? What can it help with?

- Massage therapy can be used for a variety of conditions, including pain management, stress reduction, relaxation, and improving overall health and wellness.
- It can be used as a complementary therapy in conjunction with other treatments.

How to use massage therapy:

- It is best to consult with a trained professional to determine the appropriate type of massage therapy for your needs.
- It is important to communicate with the practitioner about any previous medical conditions or current medications that may affect the massage.

Find a massage professional:

- You can search online directories or ask for recommendations from friends or family members.
- Make sure the practitioner is licensed and qualified in massage therapy.

Additional resources:

- National Center for Complementary and Integrative Health (NCCIH)
- American Massage Therapy Association (AMTA)
- Massachusetts Board of Licensed Massage Therapists

For more information:

- Visit the NCCIH website at https://nccih.nih.gov/health
- Search the NCCIH database for massage therapy information.
What to do if there is limited evidence?

Massage
- Feasible, inexpensive, acceptable
- Moderate research evidence

Create it yourself!

Feasibility Study to Implement Nurse-Delivered Massage for Pain Management

Implementing nurse-delivered massage to promote comfort among hospitalized inpatients

Introduction
Non-pharmacologic comfort measures provide benefit, yet are inaccessible for many hospitalized patients due to cost and feasibility. We implemented a massage program to engage direct care nurses in promoting a biopsychosocial model of pain care.

Methods
We describe here secondary analysis of pilot study data on the types and frequencies of brief bedside massages nurses provided to patients.

Findings
- Nurses most often administered massage to relieve patient symptoms of stress and pain.
- Massage encounters lasted on average 10 minutes.
- Length of massage was negatively associated with number of patients in care assignment ($r = -0.23, p < 0.001$).
- Total number of massages delivered was positively associated with nurses' compassion satisfaction measurements on post-test surveys ($r = 0.32, p = 0.02$), and negatively associated with nurses' education level ($r = -0.39, p = 0.04$).
- No relationship was observed between massage frequency and nurses' age, unit type (critical or non-critical), or years of nursing experience.

Conclusion
Nurses working in critical and non-critical patient care settings have the capability to implement massage after receiving education and encouragement. Nurses with higher education and fewer patients assigned may be most able to deliver a brief bedside massage.

Increasing non-pharmacologic options is an important goal for patient comfort and satisfaction. Patients from diverse inpatient settings are receptive to massage as a complementary therapy. Impacts of delivering massage on nurses' compassion fatigue and compassion satisfaction deserves further exploration.

Nurse-delivered massage should be further investigated for its ability to:
1) reduce patients' dependency on medication and a biomedical model of pain care
2) limit pain and associated side effects and symptoms, and
3) promote therapeutic nurse-patient relationships.

Acknowledgement
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Now is our opportunity to move away from an “opioid-centric” paradigm

- National Pain Strategy  March, 2016
- Improving patient self-management strategies
- Patient access to quality, multidisciplinary care
- Care that does not depend solely on prescription medications

Finally self-management recognized!

Americans consume:

- 80% of the global opioid supply
- 99% of the global hydrocodone supply
- 2/3 of the world’s illegal drugs
  (Manchikanti, 2008)

NEW CDC RECOMMENDATIONS

- Nonpharmacologic, nonopioid pharmacologic therapies preferred for chronic pain.
- Combine opioids with nonopioid/nonpharmacologic therapies.
- Primary care providers can incorporate CBT elements into care.
- Taper dose when no clinically meaningful improvements, risks greater than benefits, opioids not needed.
- Discuss risk/benefits at initiation.
Can self-management strategies address suboptimal pain treatment?

- No convincing evidence supports opioids as superior to non-opioids for long-term treatment
- Non-opioids are preferred treatment; lowest possible dose

Opioid-induced hyperalgesia (OIH) = paradoxical adverse effect

- Increased/more widespread pain from opioid exposure
- Pain often improves when opioids are discontinued

No evidence “all are addicted” - stigma exists

- 11.5% Aberrant drug-related behaviors
  Doctor shopping, frequent lost or request early prescriptions

Complex Opioid Dependency secondary to Chronic Pain (COD\ COP)

“Aberrant behaviors suggest impaired control over substance use related to treatment of chronic pain”

Self-management can improve self-efficacy, reduce opioid use and misuse behaviors

Self-management strategies may help close research-practice gaps

- What potential solutions from research literature can you implement and evaluate?
- What alternatives to opioids can be offered?
- Can patients help?

Questions & Collaborations

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References on request
PAIN MANAGEMENT MORE THAN JUST ANOTHER SCRIPT

It’s time for a paradigm shift!

Ron Weaver
Director, A Way Forward, LLC

Disclaimer

- A Way Forward is an LLC
- Founder and director
  - Potential for conflict of interest

My Background

- Low back pain early
- Undiagnosed
- Typical treatment
- Heart issues, eye inflammation and bad back

- Diagnosed with ankylosing spondylitis
My past “pain” treatment road

- My treatment is the typical medical model
- Never got “The Talk”
- No different than thousands

Results for me

- Brain and body demanded Hydrocodone
- Tremendous fear of not getting meds
- Vomiting blood
- Constantly sick
- Lacked energy
- *Hospitalized for opioid dependence*

Thus, began “A Way Forward”

- A Way Forward is my personal journey through pain
- Peer-led, evidence-based program
- Teach techniques that allow people with pain to improve their lives
- Group meetings are content-driven with group support
Specific things that helped me:

- *The Mindfulness Solution to Pain*
  by Jackie Gardner-Nix, MD, PhD

- *Cognitive Therapy for Chronic Pain*
  by Beverly E. Thorn, PhD

- *When Painkillers Become Dangerous*
  by Drew Pinsky, MD

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**The A Way Forward program**

- An 8-module program
  - Emotional labels
  - Charting pain - triggers and soothers
  - Stress and pain
  - Replacing negative thoughts/catastrophizing
  - Significant Others #1
  - Significant Others #2
  - Alternative treatments
  - Wellness plan and wrap up

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**A WAY FORWARD**

PRELIMINARY FINDINGS
FROM SESSIONS 1 & 2
Challenges: voluntary data collection, 50% missing data, attrition

Participant Satisfaction

- Information easy to understand: 6.7
- Easy to find information needed to complete program: 5.9
- Felt comfortable engaging in program: 6.6
- Could effectively complete tasks: 5.8
- Satisfied with available support: 6.7
- Satisfaction with amount of time needed: 5.7
- Overall satisfaction with ease of program: 6.3

Any changes since participating in program?

- Initiated changes in my medicines – stopped Ambien
- Taking less oxycodone/hydrocodone
- Bought a Fitbit, walking a mile most days
- Keeping away from negative friends
- Bought a hot tub, using daily
- Started walking four miles a day
- Trying to change the way I think and not be so negative
“It was great hearing other peoples’ stories – it made me feel less alone.”

“Having conversations with people that know what life with pain is all about was comforting.”

“The program created an atmosphere of sympathy, empathy, and encouragement.”

Next Steps

- Piloting the program with Heritage Health - FQHC in Coeur d’ Alene, Idaho

- Shared Medical Appointment Model

- Awaiting IRB approval for randomized controlled trial
  - Primary Investigator Dr. Marian Wilson, Washington State University College of Nursing
  - Inland Northwest Community Foundation Grant

What does this mean to you?

- Patients and providers need education about chronic pain treatments
- The difficult thing is “The Talk”
- Without it, we just do what has already been done with all its weaknesses
- Do not discuss pill use until you have a clear plan for their pain
Understand the mental state of your patient

- Patients may only know one path - the pills
- Fear is the dominant emotion

They do not know what you know about opioids

- They don’t know about hyperalgesia
- They don’t know about neuroplasticity
- They don’t know that the pain may not be as bad as they expect
- In short, what they don’t know is killing them

What won’t work

I have one firm rule.

Never talk to person with pain about his pills until you have talked about a plan for his pain!
What does that leave you with?

- Multiple paradigm shifts are needed
  - Patients believe providers can fix everything with a pill
  - Providers often believe that the pills are what the patient wants and what works

We have a pain management vacuum

- We have help for alcoholics.
- We have help for recreational drug addicts.
- We don’t have an established program and support system for people with legitimate pain issues that have become tolerant (dependent) on opioids.

Why am I speaking to you today?

- Because I am one of them, and I want no one to ever walk out of a hospital or medical clinic door like I did.
- The *A Way Forward* program may be a tool that can be useful to you and your organization as this paradigm shifts.
Thank you for listening

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- Facebook

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For more information visit: www.pcss-o.org
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