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Pain Management Nursing

PCSS-O Training
Prescribers' Clinical Support System for Opioid Therapies

Tips for Taming the Beast: Lessons Learned Working with Substance Use Disorder and Chronic Pain

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Objectives

- Describe the complexity of co-existing conditions of chronic pain and substance use disorder.
- List ways to address potential barriers that staff or patients may present.
- Describe ways to use motivational enhancement strategies to address these co-existing conditions.

Complexity of Co-Existing Conditions
Chronic Pain & Addiction

"Patients who experience either addiction or pain have historically shared being misunderstood, underdiagnosed, and undertreated. When individuals experience coexisting chemical dependency and pain, this experience is amplified." (Trafton, Oliva, Horst, Minkel, & Humphreys, 2004 as quoted from St. Marie, 2010 page 623)

Chronic Pain

- Pain is a universal experience. Common chronic pain conditions affect at least 116 million U.S. adults
- Costing $560–635 billion annually in direct medical treatment costs and lost productivity

Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Institute of Medicine Report June 29, 2011

What is Addiction

- Primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm and craving.

American Academy of Pain Medicine, American Pain Society, American Society of Pain Management Nurses, and American Society of Addiction Medicine

Updated Position Statement

- 40% of all pain patients exhibit problematic drug-taking behaviors
- 20% of these exhibit behaviors indicative of substance abuse
- 2-5% of these exhibit behaviors that may be indicative of addiction

September 2012 from Pain Management Nursing. Endorsed by International Nurses Society of Addictions (IntNSA) "American Society for Pain Management Nursing Position Statement: Pain Management in Patients with Substance Use Disorders"

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"The Elephant in the Living Room"

Addiction

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"The Elephant in the Living Room"

Chronic pain

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Bewildered by the Beast

- Programs not equipped
- Increased number of patients on opioids
- Increased polypharmacy
- Higher daily morphine equivalents
- Dissatisfaction of medication use by patients, providers, and families
- Multitude of risks associated with use of opioids

High Risk

- Co-morbidity of pain and substance use disorders
- Chronicity of both conditions
- No one knows how to deal with the “Beast”

Opioid Therapy for Chronic Pain

- Early 1990s national pain organizations challenged the nation to provide better pain management to all patients
- It was determined that there need not be an "upper limit" for opioid prescriptions for those in pain
- 1997 to 2006 - 90% increase in opioid prescriptions
- 2002-2012- 111% increase ED visits for non-medical use of prescription drugs
- Unintentional deaths related to opioids has reached an epidemic

Mayo Clinic Comprehensive Pain Rehabilitation Center (PRC)

- Three week program developed in 1974 in Rochester, MN
- Patients average length with chronic pain~ 12+ years
- Back pain, fibromyalgia & headache most common
- Participants range in age from 18 to 90
- Focus on functional restoration and quality of life
- Discontinuation of opioids for pain while learning other cognitive-behavioral strategies for coping

Overview of PRC

- Rolling admission
- 20-30 patients at any given time, divided in 2 teams
- Monday – Friday 8 a.m. to 5 p.m.
- 2-day family education program offered every week
- Aftercare program offered every 3 weeks
- PREP - 2 day pain rehabilitation executive program
- 3 week Adolescent program with extensive parent programming

Acknowledging the Beast in the Room

- Talking about our preconceptions and biases
- Improve knowledge and skill of tapering opioids- Clinical Opiate Withdrawal Scale
- Ongoing discussions with staff, patients/families
- Creating and using neutral language
- Allowing the process of change to occur

Taming the Beast

- Building rapport – developing trust
- Nonjudgmental approach
- Hybridized-skilled assessment
- Validating patient's personal experience
- Patient Advocate
- Establishment of safe medication tapers
- Knowledge and understanding of substance use disorders & pain

C.O.R.E. versus M.O.S.T.

- Continued Opportunity for Rehabilitative Experience
- More Opportunity for Successful Tomorrows

Which option?

- Criteria for recommendation

M.O.S.T Criteria

- Stronger focus on risks of mood altering substances misuse/abuse based on:
  - Past /present use of mood altering substances
  - Use of pain medications in ways other than prescribed, (i.e. anxiety, stress)
  - Concerns expressed by family or healthcare providers
  - Aberrant behaviors
  - Genetic predisposition
  - Health risks

M.O.S.T.

Goal: Increase awareness of substance use risks and provide ongoing education, recommendations and resources as needed.

Using Motivational Enhancement Skills

- Gathering information
  - Patient-history of substance use, current use, misuse/abuse of substances including medications, alcohol, illicit drugs, and patient concerns
  - Family and primary provider input
- PRC treatment team makes recommendation based on information gathered
- Patient can ultimately make the choice to attend M.O.S.T. group

What happens in MOST?

- Therapist style-**nonjudgmental**
- Confidential-trust within group (no labels, judgment, criticism, blame)
- Focus on how substance use affects life (not pain stories)
- Provide an environment for self reflection
- Education regarding substance use

Group Topics in MOST

- Physical/medical aspects of substance abuse including disease model
- Cycle of pain and substance use
- Family aspects, history, effects on relationship, family concerns
- Managing high risk situations, triggers for use, avoiding cross-addiction and other risks
- Personal use patterns-sharing time line

Use of Substance Use Timeline

Life Events	Age	Substance Used
• Born into alcoholic family	0	• N/A
• Stressful household /parent party	9	• Sips of parents beer
• Trouble in school	10	• Experiment with smoking
• Increased stress (parents divorce)	12	• Weekly drinking with peers
• Grades failing, increased anxiety	15	• 2-3 nights drinking with peers

Motivational Enhancement

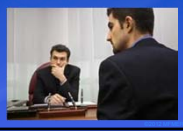
- Empathy
- Developing discrepancies
- Avoiding arguments
- Rolling with resistance
- Supporting self-efficacy

Empathy with a New Twist

- Acceptance facilitates change
- Use of skilled reflective listening
- "Thank you for explaining your situation. You deserve to have knowledge and appropriate treatment for these conditions" (pain and substance use)

Developing Discrepancies

- Increase their awareness of consequences
- Help them become aware of inconsistencies between their unhealthy behaviors and their personal goals and values
- "I hear you say that you take your pain medicine so you can do things with your family, but then you feel sleepy and have to give excitations to your family to not participate."



Avoiding Arguments

- Counterproductive and creates defensiveness
- Resistance is a signal to us to change our strategies
- Avoid labeling
- "I understand how frustrating this must be for you. I am your advocate. You deserve to have information to make good decisions. Let's talk about how these substances have been helpful for you and what you like and don't like about them."

Rolling with Resistance

- Staff do not oppose patients' resistance
- New perceptions are invited but not imposed
- Staff recognize patient is the primary source of answers and solutions
- Provider invites them to gain new perspective of behavior and focuses on their goals

Example of Rolling with Resistance

- Patient: "I don't have a problem with marijuana or alcohol, I can stop whenever I want to. I've had evaluations before and no one has said I have an addiction. I use this for my pain."
- Staff: "Thank you for explaining this to me. If you would have an interest, I would be glad to share some information about chronic pain and effectiveness of substances. Having some knowledge about this may be helpful for you."

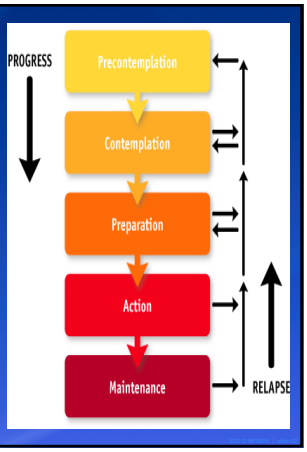
Supporting Self-efficacy

- Express belief it is possible to make a change
- Emphasize patient has ability to choose and carry out a plan to personally change their behavior. "You made a good choice by….
- Instill hope.
- CBT and SMART goal setting to acknowledge success
- Leaving with plan, positive outlook, structure and support

Choices

- "Given a choice between changing and proving that it is not necessary, most people get busy with the proof."

  John Galbraith



Possible Next Steps for MOST Patients

- When the patient is ready
  - Using SAMSHA, provide information about treatment programs
  - Provide support and encouragement during transition
- When the patient is not ready
  - Provide a clear message to patient, his/her support persons, and home providers about PRC recommendation for treatment
  - Using SAMSHA, provide information about treatment programs
  - Keeping the doors open

Patient Identified Barriers

- Being labeled, stigma associated
- Multiple fears i.e. “What if my pain is really bad and nothing works?”
- Stereotypes held by friends and family
- Anxiety that diagnosis in record ≠ no treatment for pain
- Having to deal with emotions without the numbing effect of substances
- Losing their “Trump Card”

What have we Learned this Past Year

Patients are fearful:

- having uncontrolled pain
- actually being addicted
- of being misunderstood
- of being judged by their family, health care providers and by society.

What have we Learned this Past Year

HCPs are a part of this problem:

- giving too many pain medications, not understanding other modalities
- not prescribing any pain medications due to belief that they may activate a substance use disorder
- Not understanding best practice for dual disorders

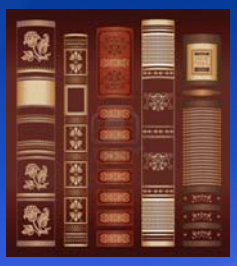
What have we Learned this Past Year

Frustration

- Difficult population to work with
- Denial is high, patients provoke arguments, challenging the staff/program/philosophy.
- Staff need additional support, resources and nurturing to work in this environment for the long haul.

MOST and CORE help with frustration of patients and staff.

What have we Learned this Past Year



Demographics	CORE (n=458)	MOST (n=451)
Age	48	47
Education (years)	15	15
% Married	77%	62%
Duration of pain (years)	11.3	11.4
Years taking opioids	5.6	5.1
Admit MSO_4 Equivalents *	57.3	128.5
% Smoker	9%	31%
Admit BMI	29.5	29.5

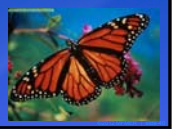
* 60% of patients are on opioids at admission

Hope

Some patients are fortunate enough to gain understanding about their addiction and pain issues and are willing to address them.

Some staff have been willing to set aside their fear and preconceived ideas and judgments and have learned new skills to work with this population.

The ASPMN/ IntNSA position statement is leading the way for all HCP's to confidently and compassionately care for "the Beast".



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Please save these dates for our next webinars!
November 15, 2012 – 1 pm Eastern/12 pm Central
Caring for the Patient who has Comorbid Diagnosis of Pain and Substance Abuse
Speaker: Ann Quinlan-Colwell, PhD, RN-BC, FAAPM
November 29, 2012 – 1 pm Eastern/12 pm Central
The Challenge of Helping People Who Undergo Methadone Maintenance Rx When Hospitalized
Speaker: Ann Quinlan-Colwell, PhD, RN-BC, FAAPM
December 11, 2012 -- 1 pm Eastern/12 pm Central
Adherence Monitoring to Mitigate Risk with Opioids
Speaker: Deborah Matteliano, PhD, ANP, FNP-BC
For More Information Contact: aspmn@goamp.com
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