Primary Care Behavioral Interventions for Pain and Prescription Opioid Misuse
Topics for this Workshop

- Overview of the Issues
- Terminology and Basics of Opioids
- Systems Strategies for Managing Risk
- Behavioral Interventions for Chronic Pain
Overview of the Issues: Chronic Pain in Primary Care
What is Chronic Pain?

- Pain that extends beyond expected healing period
  - > 3 months
- Can occur anywhere on the body
  - Back #1, head #2, joint #3
- No clear etiology
- No clear treatment for eliminating the pain
- Not an indication of harm
- Often involves significant deconditioning
Epidemiology

- 10-55% of population reports chronic pain
  - 30% in the U.S.
- Top 2 causes of disability involve chronic pain
  - #1 musculoskeletal, #2 back
- Co-morbidities: Depression, anxiety, insomnia
- Chronic pain is common complaint in PC
  - 10-20% of PC pts treated for chronic pain
    - And the number is rising
  - Most chronic pain pts are treated in PC
Primary Care and Chronic Pain

- Insufficient PCP training in all tx options
- Lack of specialty help
- Reliance on a bio-medical (symptom ↓) model
- Time
- Medication issues:
  - Addiction and Overuse (self-medicating)
  - Tolerance and Dependence
  - Diversion and Misuse (recreational)
  - Charges of under-treatment of pain
  - Unclear effectiveness and side effects
Commonly Used Opioids

- Vicodin and Lortab (hydrocodone)
- Oxycontin and Percocet (oxycodone)
- MS-Contin (morphine)
  - Usually for severe pain (e.g., post-surgery)
- Tylenol #2, #3, #4 (codeine)
  - For less severe pain
- Duragesic patch and Actiq (fentanyl)
- Dolophine (methadone)
  - Special license needed if used for opiate withdrawal
  - Considered less abuseable, yet is very lethal
The Opioid Abuse Epidemic

- Opioid abuse is major public health problem
  - Rate of death from O.D. tripled since 1990
    - Driven by 4-fold increase in opioid Rx since 1999
    - 3 of 4 overdoses due to opioids
      - Methadone: 1 of 3 opiate deaths
      - X5 more likely in Medicaid population
  - Vast majority of drugs used in O.D. come from PCP, dentist

- Benzos: 80% of abuse is polydrug
  - Enhance effects of opiates, etoh; alleviate w/drwl

- Stimulants: fewest reports of abuse
  - 2006: 750,000 of 6.5 M Rx drug abuse cases
Drug Overdose Rates by State (2008)
Related Opioid Problems

For every 1 death there are...

10 treatment admissions for abuse⁶
32 emergency dept visits for misuse or abuse⁶
130 people who abuse or are dependent⁷
825 nonmedical users⁷
Are Opioids Effective?

- Unclear effectiveness of opioids for *chronic* care
  - 2007 review showed unclear effectiveness after 4 mos
  - Lack of long-term studies
  - Studies often show dec’d pain but not inc’d fxn
  - Poorly detailed method and f/u
  - Use of inactive placebos
  - Small sample sizes

- Possible role for opioids (w/ screening, monitoring):
  - Low chronicity
  - Low complexity
  - Older age
Empirically-Supported Interventions

- **What does work for chronic pain?**
  - Interdisciplinary treatment
    - MD, OT, PT, SW, Psych
  - Non-opioid medications
    - SSRI, anti-epileptic, NSAID
  - PT (re-conditioning, TENS)
  - CBT and ACT
  - Exercise

- **Success measured in functional gains**
  - Pain elimination rarely occurs
Terminology and Basic Issues with Opioid Medications
Terminology and Basics

- “Tolerance” is either:
  - Need for incr’d dosage to achieve effect, or
  - Diminished effect from the same dosage
- “Dependence” is a state of adaptation evidenced by drug-specific withdrawal:
  - Normal w/ prolonged use; does not = addiction
- “Withdrawal” occurs w/ abrupt d/c of drug
- Controlled/Sustained release preferred
Terminate and Basics

- **Addiction (substance dependence) is ≥ 3:**
  - Tolerance
  - Withdrawal/Dependence
  - Heavier use than intended or prescribed
  - Unsuccessful efforts to decrease use
  - Much time spent obtaining or using
  - Adverse effect on important activities
  - Cont’d desire for meds despite problems
  - Medication “misuse” (see next slide)
Terminology and Basics

- “Misuse” is use of a medication for other than its intended purpose
  - Diversion (selling, giving away), recreation, use for a problem it was not prescribed for
- “Pseudoaddiction” is dramatic pain behavior sometimes seen w/ severe pain
  - Often confused with addiction
- “Long-term” use is > 3 consecutive months
Terminology and Basics: Opioids

- Aka narcotics, opiates
- Generally prescribed for:
  - Postsurgical pain relief
  - Management of acute or chronic pain
  - Relief of coughs and diarrhea
- Potential tolerance, dependence, abuse
- May lead to hyperalgesia
- Increased pain flares may result from prn use
Terminology and Basics: Opioids

- **Common side effects:**
  - Constipation, nausea, sedation, itching

- **Withdrawal symptoms:**
  - Sneezing, yawning, perspiration, aggression, insomnia, nausea/vomiting, spasms, aches, cramps...
  - Not generally harmful, but very uncomfortable
  - Sx peak 48-72 hrs after d/c, resolve after several days

- **Medications for withdrawal:**
  - Short-term: clonidine may reduce sx 50-75%; other symptomatic tx
  - Buprenorphine may help; can be used long term
  - Methadone may be used long term
Summary of Opioid Concerns

- Tolerance, eventually reaching ceiling
- Dependence, leading to withdrawal
- Addiction
- Misuse and Diversion
- Lack of long-term effectiveness
- Side effects
- Hyperalgesia, Incr’d pain flares (opiates)
Managing the Risk of Medication Abuse: Systems-Level Approaches
Systems-Level Approaches: The BHC Role

- Assess risk of abusing meds
  - Gather history, review old records
- Offer behavioral assistance
  - 1:1 interventions
  - Group visits
  - Help for drug abuse, dependence
- Co-manage care (complete CSA; measure progress)
- Participate in pathway development
- Assist in PCP-patient conflicts
Systems-Level Approaches:
Screening for Risk of Medication Abuse

- Commonly used paper-and-pencil screens
  - SOAPP
  - ORT
- Urine drug screen at initial visit—matches hx?
- Substance use hx
- Review old records
  - Problems w/ past Drs? Inconsistent history?

SEE HANDOUT: SOAPP
Systems-Level Approaches: Screening for Risk of Medication Abuse

• Aberrant behaviors past or present?
  – Changed Drs to get meds
  – Use of etoh, drugs (+ meds) for sx relief
  – Use of meds for other than intended purpose
  – Refusal of non-medications programs, e.g. PT
  – Refusal of long-acting meds
  – Refusal of non-controlled substances (e.g., NSAID, SSRI)

  SEE HANDOUT: ABERRANT BEHAVIOR LIST
Systems-Level Approaches: Controlled Substance Agreements

- **Purposes of a CSA**
  - *Decrease*: abuse/diversion, self-dosing, urgent pt calls, conflicts w/ staff, early RF
  - *Increase*: discussion about meds issues, PCP satisfaction

- **Components of a helpful agreement**
  - Education, conditions for RF, *functional goals*

- **Important to use routinely (not after a problem is suspected)**

- **SEE HANDBOUT: CSA**
Systems-Level Approaches: Develop a Clinical Pathway

- Could be very simple. For example:
  - Every pt sees BHC for risk assessment, CSA (w/ fxnl goal) before 3rd opioid RF
  - Regular opioid user must alternate BHC/PCP

- Could be more involved.
  - Initial risk assessment stratifies care protocol
  - Process for regular CSA, planned UDS
  - Group/class substitutes for PCP visit

- SEE HANDOUT: PATHWAY EXAMPLE
Systems-Level Approaches: Manage Care

- Use long-acting meds
- Avoid prn use of opioids
- Regular UDS
  - At refill and other visits
  - Problems:
    - Illicit drugs
    - Non-prescribed meds
    - Absence of prescribed meds
- Establish functional goals and track
Behavioral Interventions for Chronic Pain in Primary Care
General Points about Primary Care

- Primary care is deluged with behavioral issues
- Specialty care will never meet demand
- Behavioral health providers must adapt to be effective part of the primary care team
Key Adaptations

- High patient volume, fast pace
- Heterogenous problem and patient mix
- Longitudinal care perspective
- Team care model
- Dynamic schedule focused on access
- Population-based care
- Consultant role
Behavioral Interventions: Summary

- Acceptance
- Education
- Importance of exercise
- Distraction
- Relaxation strategies
- Catastrophizing/Fear of pain
- Activity-pacing
- Family education
Acceptance

What you can do:
- Believe the pt’s pain (don’t make pt prove it!)
- Openly discuss limits in your ability to help
- Focus on functioning rather than pain intensity

Signs of change:
- Pt stops requesting inapprop tests, labs, etc.
- Pt talks about what s/he can do (not you)
- Pt focus on life goals, not pain intensity
Education

- **What You Can Do:**
  - Educate pt about the difference b/w acute and chronic pain
    - The role of rest
    - Pain ≠ Harm
  - Educate pt about “red flags” requiring attention

- **Signs of Change:**
  - Pt self-manages flare-up if no red flag present
  - Less fear of chronic pain, less avoidance
Exercise

- **What you can do:**
  - Explain deconditioning
  - Collaborate w/ pt to set activity goals
    - Let pt choose activity
    - Help pt set frequency, duration, intensity goals

- **Signs of Change:**
  - Pt is more active
Distraction

- **What you can do:**
  - Explain that focus on pain increases intensity
  - Help pt brainstorm distracting activities
- **Signs of change:**
  - Pt engages more in distracting activities
Relaxation Strategies

**What you can do:**
- Ask pt if s/he notices stress/pain connection
- Explain that stress produces muscle tension, which can increase pain and decrease fxn
- Suggest relaxation strategies, give handout

**Signs of change:**
- Pt more aware of muscle tension
- Pt practices relaxation on regular & prn basis
Catastrophizing/Fear of Pain

What you can do:
- Correct the belief that pain means harm
- Explain that fear of pain → activity avoidance
- Encourage exposure to feared situations
- Explain that worry → ↑ tension → ↑ pain

Signs of change:
- Less avoidance of activity
- Less fearful of pain
Activity-Pacing

- **What you can do:**
  - Discourage pt from varying activity level based on pain intensity
  - Encourage consistent activity level
- **Signs of change:**
  - Pt does no more activity on “good” days, no less on “bad” days
Family Education

• **What you can do:**
  - Ask pt to bring key family members to visits
  - Educate family about chronic pain basics
  - Discourage family from taking over pt roles

• **Signs of change:**
  - Pt continuing/resuming key roles, tasks
  - Family provides “tough love”
In Sum...

- Primary care holds both tremendous challenges, and tremendous opportunities, for improving treatment of chronic pain
- Behavioral health can have a very important role to play, but...
- Success involves attention to multiple patient and team and population variables

- THANK YOU!