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Behavioral Management During Opioid Tapering Part II: Q&A

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Introduction and Disclosure

- ▣ The views expressed here are my own and do not necessarily reflect those of VHA, the national pain management office, or mental health services
- ▣ I am a pain psychologist with pain medicine and management expertise, not a prescriber



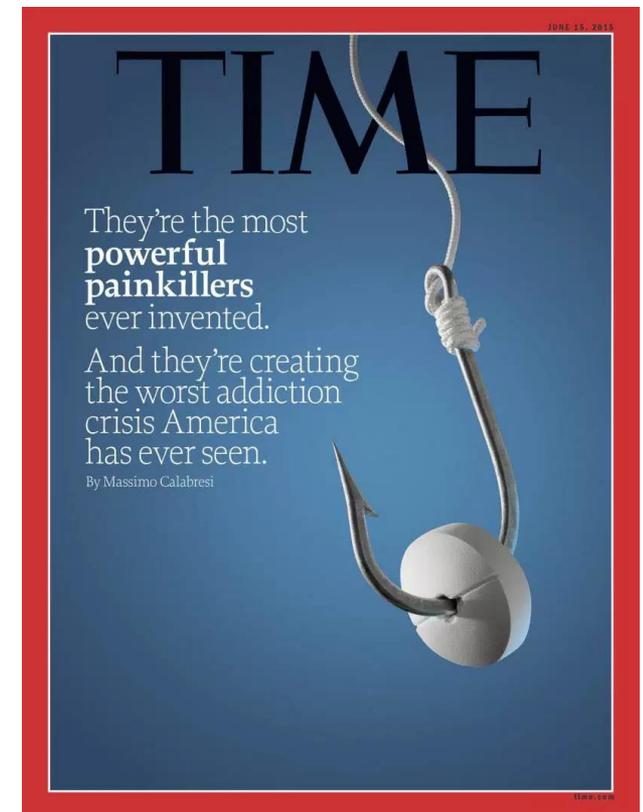
Hello
my name is

Objectives

- ▣ Provide brief overview of previous HSR&D Cyberseminar on May 3, 2016
- ▣ Answer questions received from field between May meeting and today, highlighting major themes/topics
- ▣ Open up discussion to those who have additional questions today

Focus on Opioid Safety

- ▣ Increased attention on opioids due to dramatic increase in prescribing and opioid-related deaths
- ▣ VA's Opioid Safety Initiative
 - ▣ Action plan to improve patient safety specific to opioid therapy
- ▣ CDC Guidelines released March 2016
- ▣ New VA/DoD Chronic Opioid Therapy CPG forthcoming



Why We Taper

- ▣ Adverse effects
- ▣ Diminishing/absent analgesia
- ▣ Opioid use disorder, misuse, diversion
- ▣ **Reduced/inadequate functioning and quality of life**
- ▣ **Lack of evidence for chronic opioid therapy benefits; significant evidence of chronic opioid therapy risks**



But When We Taper...

- ❑ At times, tapering is not/has not been handled in the most clinically sensitive/therapeutic manner
 - ❑ Providers may struggle with directives, not know how to manage patient reactions
 - ❑ Behavioral health and other staff may feel underprepared to address challenges
 - ❑ Information/explanation provided to patients may be insufficient

Considerations in Approach

- Patients may be suspicious of healthcare providers and angry at system because of perceived injustices
 - Treated/labeled unfairly; feel misunderstood/not “heard”
 - Want pain to be “fixed” and have not received optimal pain education or long-term management plan
- MUST develop rapport early – provide empathy and normalize feelings while not colluding
- Evaluate the whole person and identify relevant issues in *how* tapering should be discussed – where to focus/find motivation

The Challenge

- ❑ Often the patients who need opioid tapering the most are the ones who want it the least
- ❑ Many have not fully acknowledged and/or may not be fully aware of how opioids:
 - ❑ Have impacted their lives in negative ways
 - ❑ Are not beneficial to functioning
 - ❑ Have potential risks for long-term use
- ❑ Others may not care because at least it “takes the edge off”



The Fear Factor

- ▣ The single greatest challenge in initiating a taper is **FEAR**
- ▣ Even when ineffective or minimally effective, it may be difficult to imagine life without opioids
- ▣ Often, it is a fear of the unknown
 - ▣ Maybe the hell you know is better than the one you don't
 - ▣ What if...

Opioid-Related Provider Issues

- ▣ Often feel pulled, pressure
- ▣ As a provider, be aware of own reactions and how those may contribute to interaction
- ▣ Be FACT-based not emotion-based
 - ▣ DO NOT let emotions prevail over facts and reason
 - ▣ Emotional pleas pull for emotional reactions – the right thing is often the difficult thing for providers

Tapering Considerations

- ▣ Sensible outpatient taper should mitigate significant withdrawal symptoms
- ▣ Often times the numbing element is the most powerful – the softening of life, including psychiatric symptoms, that may not be managed in any other way
 - ▣ Assess psychiatric symptoms and provide treatment options to address
- ▣ “What does this drug do for you?”



Key Messages

- ▣ Reassure patient that *you are not abandoning them*
 - ▣ Share that the right/best things are often tough...
assure they will get through and support is there
- ▣ Goal is to assure safety while supporting and educating
- ▣ This is the therapeutic thing – the role of opioids are at best limited in the chronic pain management plan: medication is one piece of a very big puzzle

Questions from the Field

Tapering Guidance

- ▣ *Determining how quickly you taper or when you choose to slow a taper*
- ▣ *Do you negotiate slower tapers when Veteran's PTSD symptoms appear to be aggravated by withdrawal symptoms, especially anxiety?*

Tapering Guidance

- ▣ Taper determined using individual assessment, clinical judgment, and facts as guide
 - ▣ Slowest, fast, rapid tapering options
 - ▣ Guidance from Academic Detailing forthcoming
- ▣ Gradual tapers can be completed over a few months in most cases
 - ▣ Longer the duration of previous opioid therapy, the longer the tapering schedule
 - ▣ More rapid tapers may be indicated in some cases

Tapering Guidance

- ❑ Be thoughtful about tapering schedule *at initiation*
- ❑ If you are, minimal reasons to slow in my opinion
 - ❑ Increased anxiety, explore and respond appropriately with mental health evaluation and treatment
 - ❑ If known to have PTSD or other mental health condition, this should already be in place at taper initiation
 - ❑ Normalize fears, LISTEN, de-escalate, remind why this course of treatment is in their best interest long term
 - ❑ Responding to fears with taper adjustment may just reinforce the ‘need’ for opioids and support them as answer

Tapering Guidance

- *How do you work with patients around the concept that going off opioids will not increase their pain, and may in fact improve functioning. Do you do some sort of "hypothesis testing" and monitor pain scores before, during, and after opioid withdrawal to test out the hypothesis and get more buy in?*

Tapering Guidance

- ❑ Conversation guided by why this is the right decision in terms of patient safety and how to maximize function and self-management moving forward – focus should not be on pain intensity but address fears
- ❑ Share information re: the tendency for pain to remain stable or decrease, possibility for improved functioning due to being less sedated, more engaged, etc.
- ❑ If the medically appropriate decision is to taper, “buy in” is ideal but not needed – may be a *process*

Tapering Guidance

- ▣ *More about how to speak with individuals who have been on opioids for a long time about reasons for tapering*
- ▣ The fact that someone has been on opioids for a “long time” may be even more of a reason to taper as they are more likely to be at risk of undesirable effects related to chronic use
- ▣ Discuss and address specific fears
- ▣ Focus on function

Aberrant Behavior

- ▣ *Please share more tips for managing the involuntary immediate tapering imposed on patients because of patient behavior or policies*
- ▣ *How to motivate a Veteran prescribed methadone to adhere to taper. He is mailed his pills and eats all in the 1st week.*

Aberrant Behavior

- ❑ If evidence supports aberrant behavior, patient must be tapered – person has signed an agreement and violated
 - ❑ Conditions of agreement exist to maximize safety and minimize risk
- ❑ Maximize other medical and other treatment options
- ❑ **OUD needs to be addressed and treated** in cases of misuse – taper is not going to be agreeable but that does not mean that it is not the right thing to do
 - ❑ Resistance among opioid using population vs traditional SUD

Tapering Guidance

- *Any ideas for establishing insight with persons who are at that "No one should be made to suffer as I am suffering" (case managing Veteran whose Dr. has removed him from opioids)*
- How can we help reduce suffering? How we react to pain has much to do with suffering and there are many options for improving response so that we decrease impact of pain and enhance quality of life

Resistance to Alternatives

- *Often times when you introduce some of the alternative therapies/interventions patients will respond they've had this pain for years and have tried everything. How can we get these patients to be willing to try other things?*

Resistance to Alternatives

- ▣ What does “tried everything” mean?
 - ▣ Ask for details – often medical and PT only
 - ▣ Why didn’t PT work? (*“They almost killed me...”*)
 - ▣ Opportunity for education about PT and need for biopsychosocial approach
- ▣ Create a Pain Orientation Group at your hospital
 - ▣ Provide basic pain education and options
 - ▣ Chance for discussion, explanation, dispel fears

Resistance to Alternatives

- ▣ *What are some strategies for effectively working with patients who refuse to trial any treatment modalities other than opioids?*

Resistance to Alternatives

- ▣ Ask questions: Why are they ‘refusing’? Answers can help guide discussion and treatment planning
- ▣ Motivational Interviewing
 - ▣ Facilitate intrinsic motivation within patient to change behavior
 - ▣ Respectful “change talk” to reveal positive drives
 - ▣ Patients are in charge of their decisions/behaviors

Lack of Alternatives

- ▣ *Recommendations for non-pharm management strategies when resources limited at VA (e.g., no pool, no RT, limited PT)*

Lack of Alternatives

- ❑ Behavioral health options (e.g., CBT-CP groups)
- ❑ Pain school with combined disciplines to ease burden
- ❑ Community options (e.g., Vet-focused rec & service orgs)
- ❑ American Chronic Pain Association
- ❑ Patient books
 - ❑ Managing Pain Before It Manages You, Caudill
 - ❑ The Pain Survival Guide, Turk & Winter
 - ❑ Living Beyond Your Pain, Dahl & Lundgren

Support for Providers: PCP

- ▣ *Since PCPs are managing opioids much of the time, how can PCPs be supported during taper conversations, particularly given the short duration of appts?*
- ▣ *Handling variations in providers practices around opioids triggering repeated patient provider change requests*

Support for Providers: PCP

- ▣ Various options for support to PCPs such as:
 - ▣ Opioid education groups
 - ▣ Pain resource nurses embedded
 - ▣ Ambulatory Pain Clinics with opioid expertise
 - ▣ E-consults
- ▣ VA is working through OSI and other mechanisms to increase consistency in prescribing across the system – while we cannot prevent a request, we can encourage better communication among providers so this behavior is not reinforced

Behavioral Health Treatment

- ▣ *What DSM-5 dx do you use?*
 - ▣ Somatic Symptom Disorder, with Predominant Pain, Persistent, Mild-Severe
- ▣ *What behavioral management approaches would you suggest for patients being discontinued for abuse of opioid or non-opioid substance abuse?*

Behavioral Health Treatment

- ▣ Refer for substance abuse treatment so that the primary issue can be addressed directly – those with OUD may resist traditional SUD treatment for various reasons, often that the drug originated with an MD which should be acknowledged however...
- ▣ Discuss similar process that must be addressed – opioids are running their lives: schedules and plans around when they can take and when/how they can/will get, disrupted relationships, central concern despite any negative consequences

Suicide Assessment

- ▣ *Do you have any recommendations around suicide risk assessment and management in relation to the opioid taper?*
- ▣ *“I don’t think I can go on living without these medications”*

Suicide Assessment

- ▣ Those with chronic pain are at greater risk for suicide so thorough assessment is necessary and contact with mental health essential for further evaluation
- ▣ Caution: Once tapered, lose tolerance in as little as a week so overdose risk upon resumption of same dose is heightened
- ▣ In the face of suicidal threats around opioid demands, enlist assistance of pain psychology when possible – often can be de-escalated and effective treatment plan developed
 - ▣ If hospitalization is indicated, can also assist in that process

Family/Significant Others

- ▣ *Suggestions for gaining buy-in from family members/social circle?*
- ▣ *What are your tips for engaging mental health services for families/support system of Vets going through opioid tapering?*

Family/Significant Others

- Providing general education to families about chronic pain, the role of opioids and medication as well as the potential hazards, and the issues that may occur during tapering is critical
- Group option – information shared and also be with others who may be in similar situations as loved ones which can be comforting

Resources: CPRP and CBT-CP

- ▣ *How do you make a referral to the program for tapering?*
 - ▣ www.tampa.va.gov/chronicpain/
 - ▣ For Professional page provides directions for information needed for long distance referral, sent via encrypted email
 - ▣ Email me directly with any questions including clinical

Resources: CPRP and CBT-CP

- ▣ *Is there a centralized VA site where we can get CBT-CP and ACT-CP manuals for use at our local facilities?*
- ▣ The only VA evidence based psychotherapy (EBP) for chronic pain is CBT
- ▣ The CBT-CP Therapist Manual (Murphy et al., 2014) can be ordered through TMS
 - ▣ Participation in EBP recommended

More Resources

- National Center for Telehealth and Technology/T2
 - <http://t2health.dcoe.mil/products/mobile-apps>
 - <https://mobile.va.gov/appstore>
 - Virtual Hope Box
 - Tactical Breather/Breathe2Relax
 - PTSD Coach/PE/CPT
 - Mindfulness and ACT Coach
 - CBT-i Coach



More Resources

- ▣ VA Pain Management Website
 - ▣ <http://www.va.gov/painmanagement/>
- ▣ VA Pain Listserv
 - ▣ Directions on VA pain site for how to join
- ▣ VA Pain Psychology listserv
 - ▣ Email: Stacey.Sandusky@va.gov

More Resources

- ▣ Pathways to Safer Opioid Use
 - ▣ <http://health.gov/hcq/trainings/pathways/>
- ▣ VISN 20 Patient and Provider Education
 - ▣ Email: Anthony.Mariano2@va.gov



Create A Pain Action Plan

- ▣ Offer treatment options – options are good!
 - ▣ Pain rehabilitation program
 - ▣ CBT-CP/ACT-CP
 - ▣ Other rehab options
 - ▣ Aquatic therapy, physical therapy, rec therapy
- ▣ Many safe analgesic options that may not have been trialed or trialed appropriately
- ▣ Developing a concrete plan with the patient is very comforting and works well to quell fears/panic



- ▣ Provide support and remind of reasons, personal and medical, that this is occurring
- ▣ Reinforce rationale for decision which is based on maximizing safety for patient and minimizing risk
- ▣ Do all possible to create an environment where patient makes the most adaptive choice – the choices, however, are ultimately personal/individual and left to them
- ▣ Share success stories of others; have peers share directly if possible/positive testimonials



Remember...

- ❑ Patients may refuse treatment which is their decision and right – responsibility of provider is to make choices/recommendations available
- ❑ Not obligated to provide opioids; obligated to provide the best level of clinical care
- ❑ Most things referred to as “alternative” treatments are actually the ones with the strongest empirical support for pain management (e.g., CBT, interdisciplinary rehabilitation, relaxation techniques)



Key Messages

- ▣ As a provider, stay the course
 - ▣ Focus on minimizing mental and physical distress
 - ▣ Addressing fears
 - ▣ Ensuring safety
 - ▣ Be empathic but not apologetic
 - ▣ The right thing is often not the easy thing – this is an appropriate medical decision and the therapeutic choice

- ▣ This is what helping looks like!

Thank You! Questions?



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