

Session 1

# Talking with Patients About Chronic Pain & Addiction

Aram Mardian, MD

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# Session Learning Objectives

## **At the end of the session, you will be able to:**

- Create a script that engages the patient in a deeper understanding of chronic pain and substance use disorders as neurobiological conditions influenced by multiple factors
- Describe, in plain language, a multifaceted whole person approach to treatment emphasizing longitudinal care interventions and self-care techniques

# Poll Question

*Chronic pain activates different regions in the brain compared to acute pain.*

**A. True**

**B. False**

*An overview of key messaging  
when talking with patients  
about pain and addiction.*

*What is pain?*

# IASP Definition of Pain

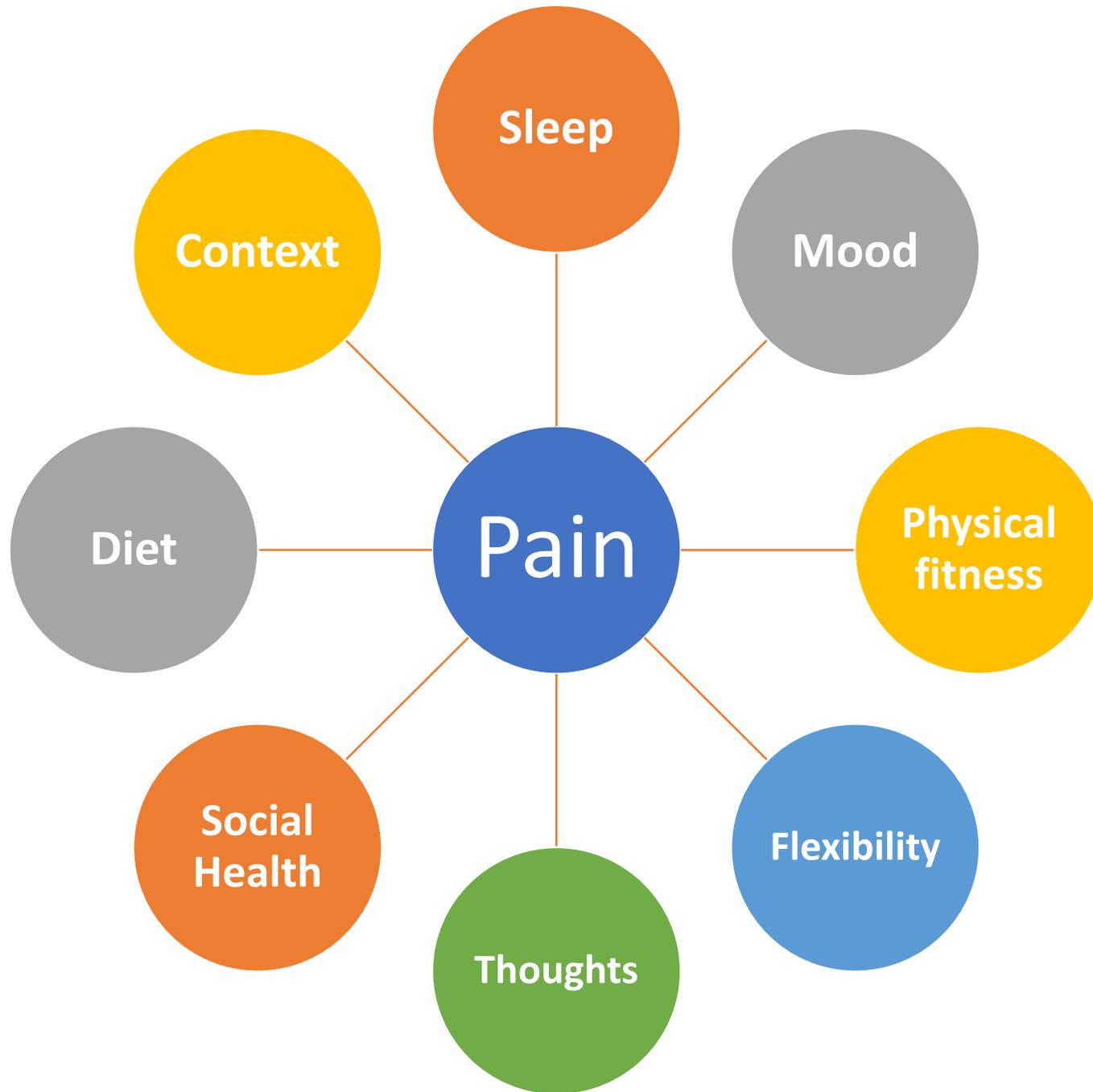


“An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage”

# Understanding Pain

- **Pain is always real**
  - Pain can be complicated
- **Pain does not equal tissue damage**
  - Hurt ≠ Harm
  - Sore but Safe
- **Pain equals protection**
- **Pain depends on context**
- **Pain system can be overprotective**
- **Retrain your pain system**





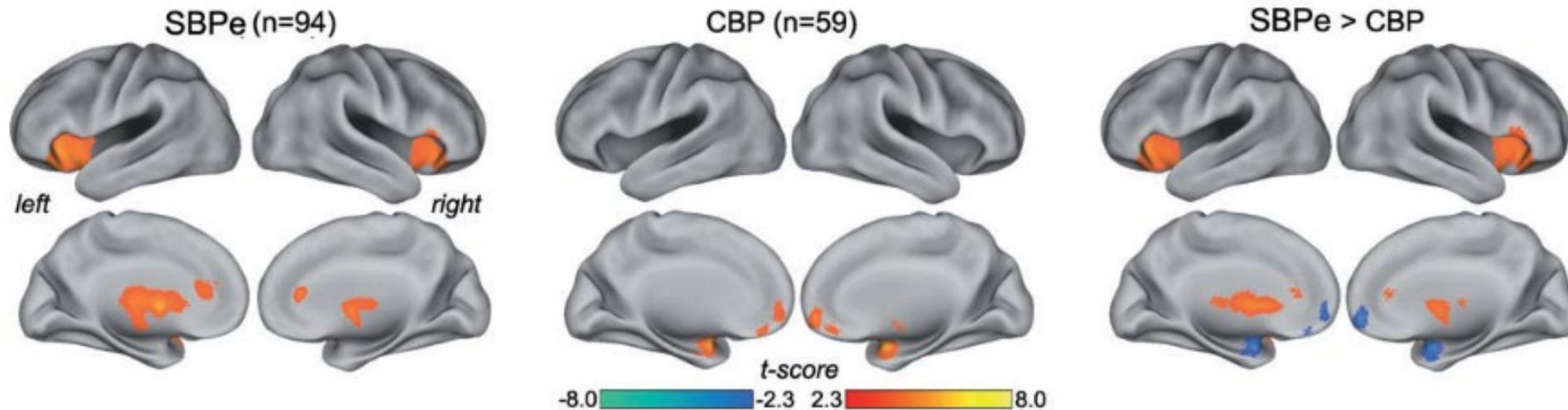
Acute  
Pain



Chronic  
Pain

## Shape shifting pain: chronification of back pain shifts brain representation from nociceptive to emotional circuits

Javeria A. Hashmi,<sup>1</sup> Marwan N. Baliki,<sup>1</sup> Lejian Huang,<sup>1</sup> Alex T. Baria,<sup>1</sup> Souraya Torbey,<sup>1</sup> Kristina M. Hermann,<sup>1</sup> Thomas J. Schnitzer<sup>2</sup> and A. Vania Apkarian<sup>1,3,\*</sup>



# Poll Question

*Chronic pain activates different regions in the brain compared to acute pain.*

**A. True**

B. False



## Predicting transition to chronic pain

*A. Vania Apkarian, Marwan N. Baliki, and Melissa A. Farmer*

### KEY POINTS

- End-organ parameters are not adequate to explain the transition to chronic pain.
- Brain function and structure reorganizes with chronic pain on local and global scales.
- The brain's emotional response to injury appears to predict who transitions to chronicity.

# Nociplastic pain: towards an understanding of prevalent pain conditions

Mary-Ann Fitzcharles, MBChB   • Prof Steven P Cohen, MD  • Prof Daniel J Clauw, MD •

Geoffrey Littlejohn, MD • Chie Usui, MD • Winfried Häuser, MD • [Show footnotes](#)

Published: May 29, 2021 • DOI: [https://doi.org/10.1016/S0140-6736\(21\)00392-5](https://doi.org/10.1016/S0140-6736(21)00392-5) •  Check for updates

THE LANCET

“...The mechanisms that underlie this type of pain are not entirely understood, but it is thought that **augmented CNS pain and sensory processing** and altered pain modulation play prominent roles.”

# Brain Changes in Chronic Pain

- Shift from sensory to emotional brain circuits
- Pain amplification/augmented CNS pain and sensory processing
- Treatment focuses on calming the nervous system/retraining brain and nervous system

# Alarm

- **Acute pain** is a useful alarm that demand immediate action to protect the person
- **Chronic pain** is unhelpful and adds to stress and results in more pain sensitivity/amplification



# Acute Pain

**In Acute Pain, there may be closer relationship between tissue damage and pain...**

**Hurt may signify harm**

**Adaptive** view for Acute Pain – which appropriately leads to immobilizing your broken arm which will help healing

# Chronic Pain

**In Chronic Pain, pain is often more related to sensitization of the nervous system, and...**

**Thinking that hurt = harm when you have chronic pain can lead to a vicious cycle of reduced activity and more pain.**

**Once serious conditions are ruled out, explain that**

**Hurt ~~=~~ Harm**

**Can be Sore but Safe**

**“I have pain in my L5  
vertebrae.”**



# Spine findings in **asymptomatic** patients by age

Imaging Finding	Age (yr)						
	20	30	40	50	60	70	80
Disk degeneration	37%	52%	68%	80%	88%	93%	96%
Disk signal loss	17%	33%	54%	73%	86%	94%	97%
Disk height loss	24%	34%	45%	56%	67%	76%	84%
Disk bulge	30%	40%	50%	60%	69%	77%	84%
Disk protrusion	29%	31%	33%	36%	38%	40%	43%
Annular fissure	19%	20%	22%	23%	25%	27%	29%
Facet degeneration	4%	9%	18%	32%	50%	69%	83%
Spondylolisthesis	3%	5%	8%	14%	23%	35%	50%

# Pain is Complex

- Pain is produced by the Brain and is always real
- Acute pain maximizes the chance of survival by signaling the need for protection
- But chronic pain is unhelpful
- Pain is distinct from tissue damage and nociception
- The nervous system can become over sensitive
- We can retrain the brain (and nervous system and body) so that signals from the body are dampened/filtered

*What is addiction?*

# ASAM definition of addiction

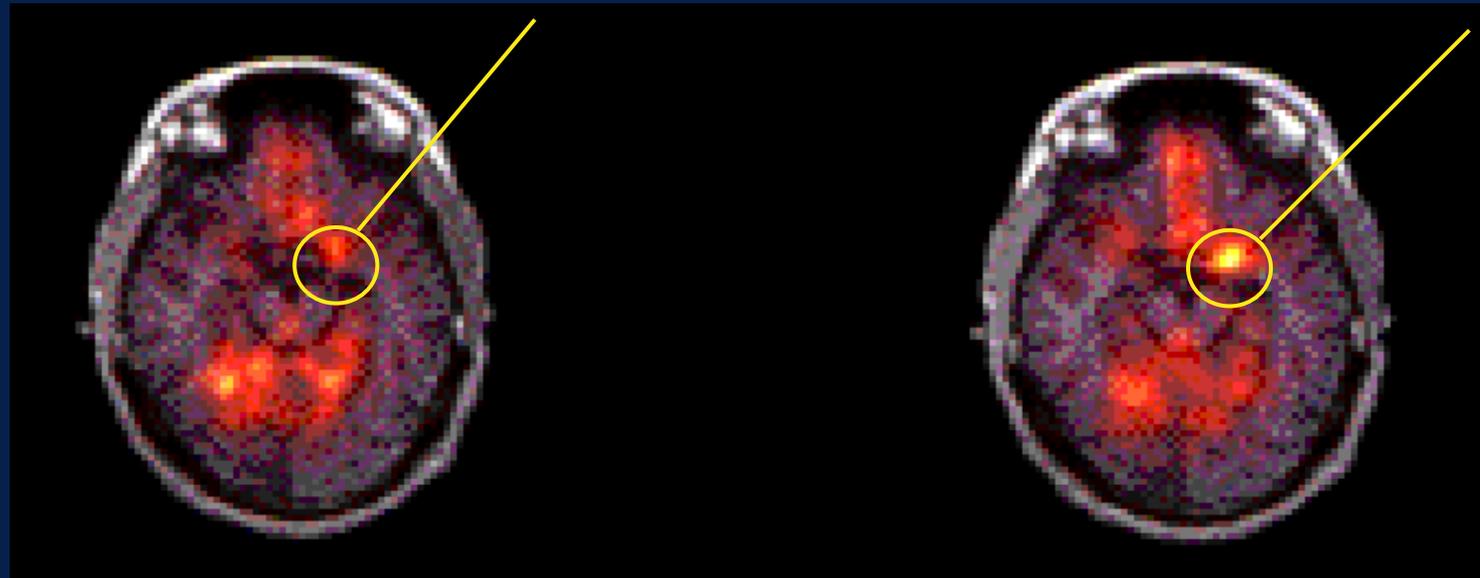
- Addiction is a **treatable**, chronic medical disease involving **complex interactions among brain circuits, genetics, the environment, and an individual's life experiences**. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.
- Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.



Similarly stimulant use, or even thinking of a drug you are addicted, to can set off an alarm.

*Amygdala  
not lit up*

*Amygdala  
activated*

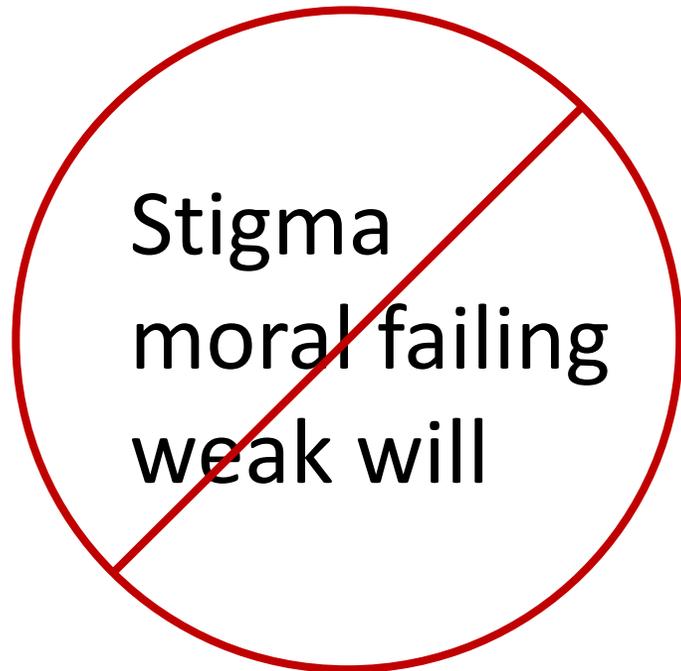


*Nature Video*

*Cocaine Video*

(Volkow courtesy of NIDA)

# Cultural Transformation in Addiction Care



# Person Centered Language



# Common Brain Mechanisms of Chronic Pain and Addiction

*Both Pain and Addiction involve:*

- **Low dopamine states** (reward deficiency)
  - Natural rewards less motivating
- **Increased stress neurohormones** (e.g., corticotropin releasing factor, dynorphin, norepinephrine) –anti-reward excess
- **Maladaptive learning**
  - Central sensitization/pain amplification in chronic pain
  - Drug related cues trigger craving in addiction

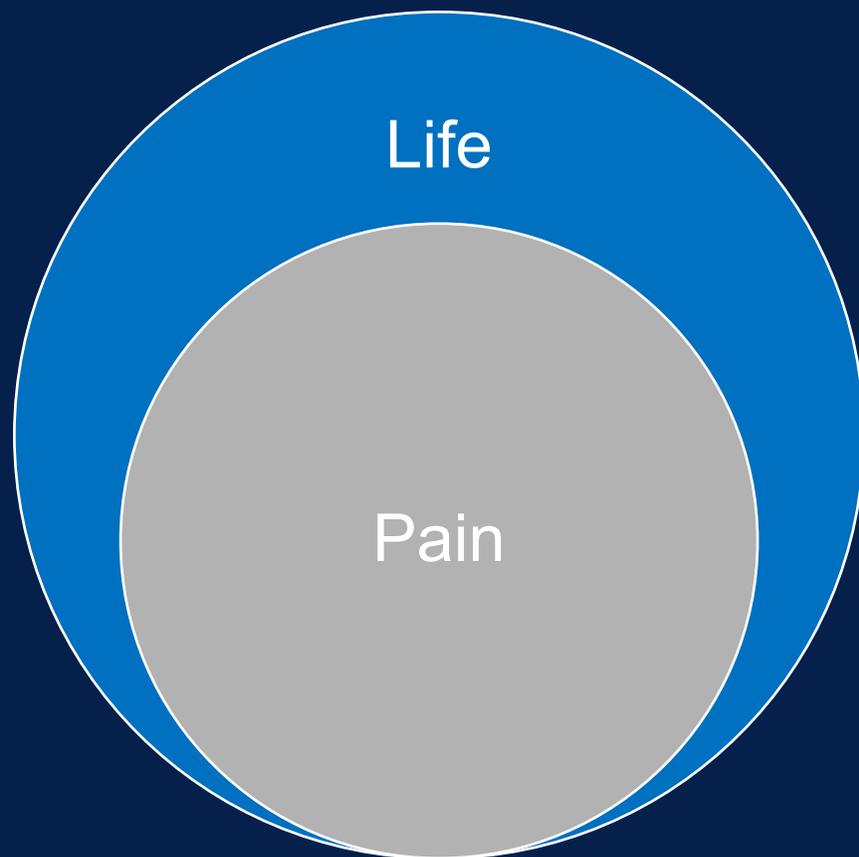
# *Empowering Patients Towards Functional Goals*

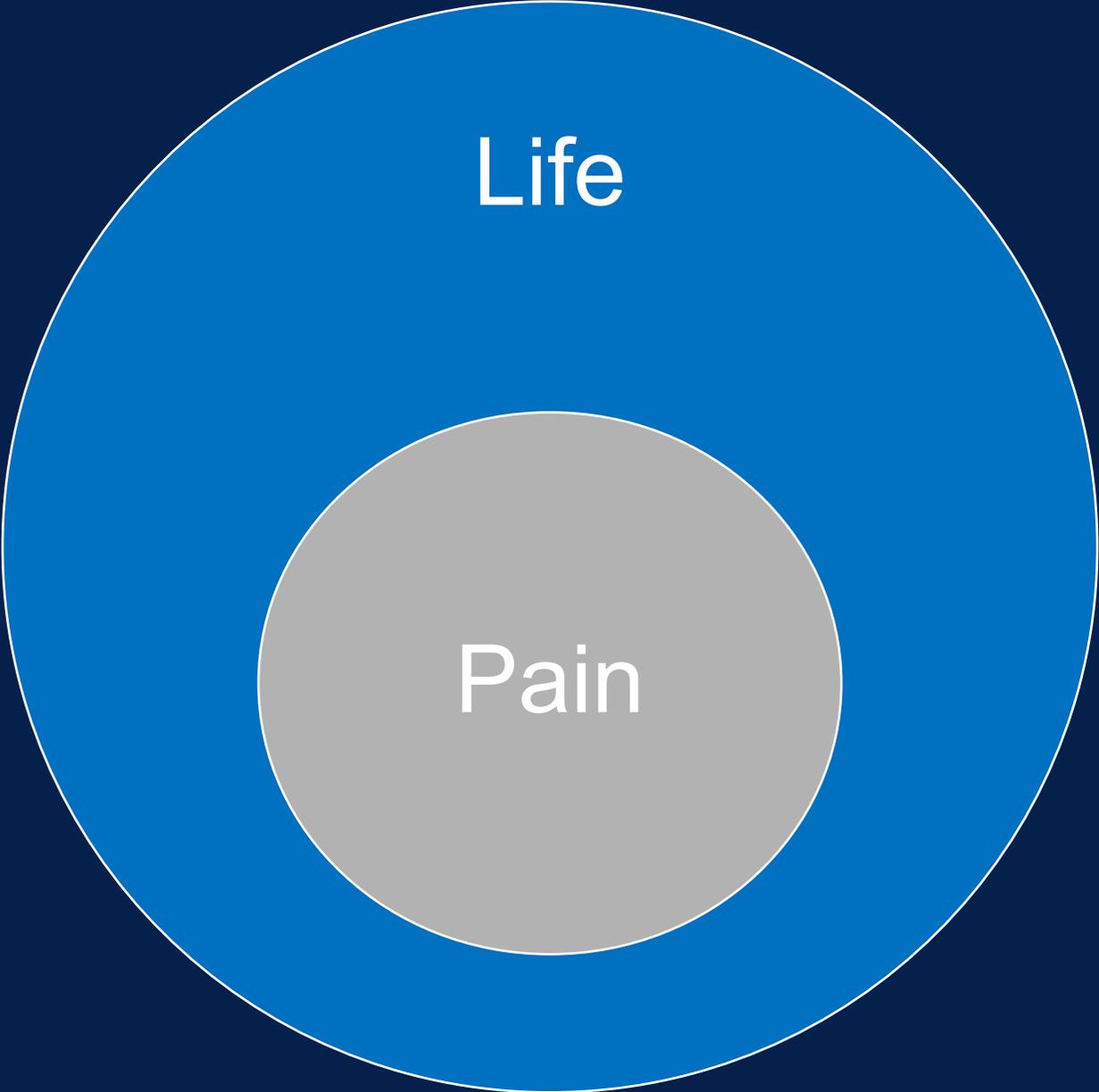
“Quick Fix”



## Whole Health System







Life

Pain



Life

Pain

# *Treatment Approaches*

# Primary Treatment Approaches for Chronic Pain

- Movement Therapies
- Psychological Therapies
- Integrated/Interdisciplinary Plans/Programs
- Evidence-based treatment of comorbidities
  - Sleep problems, obesity, diabetes, tobacco and substance use,
- Passive therapies that rely on a healthcare practitioner – focus on safety with goal of supporting adoption of evidence-based active therapies



Comparative Effectiveness Review  
Number 227

April 2020

## Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review Update

*Evidence Summary*



Comparative Effectiveness Review  
Number 228

April 2020

## Nonopioid Pharmacologic Treatments for Chronic Pain

*Evidence Summary*



Comparative Effectiveness Review  
Number 251

October 2021

## Integrated and Comprehensive Pain Management Programs: Effectiveness and Harms

*Evidence Summary*



Comparative Effectiveness Review  
Number 229

April 2020

## Opioid Treatments for Chronic Pain

*Evidence Summary*

<i>Evidence-Based Nonpharmacological Therapy for LBP (Chou, Ann Intern Med 2016)</i>	<i># of Trials</i>
Exercise	122
Chiropractic/manipulation	61
Acupuncture	49
Multidisciplinary rehabilitation	44
Psychological Therapy	32
Massage	26
Yoga	14
Mindfulness-based stress reduction	3
Tai Chi	2

LBP=low back pain; OA = osteoarthritis; FM=Fibromyalgia; Neuro = neuropathic pain



# Eight Med Classes in Four Common Conditions

	<i>Drug</i>	<i>LBP</i>	<i>OA</i>	<i>FM</i>	<i>Neuro</i>
1a	Acetaminophen		+		
1b	NSAIDs	+	+		
2a	Tricyclics			+	+
2b	Muscle Relaxants	+		+	
3a	Gabapentinoids			+	+
3b	SNRIs	+		+	+
4a	Tramadol	+	+	+	+
4b	Opioids	?	?		?
--	Topical analgesics	+	+		+

LBP=low back pain; OA = osteoarthritis; FM=Fibromyalgia; Neuro = neuropathic pain

(table courtesy of K. Kroenke - modified)



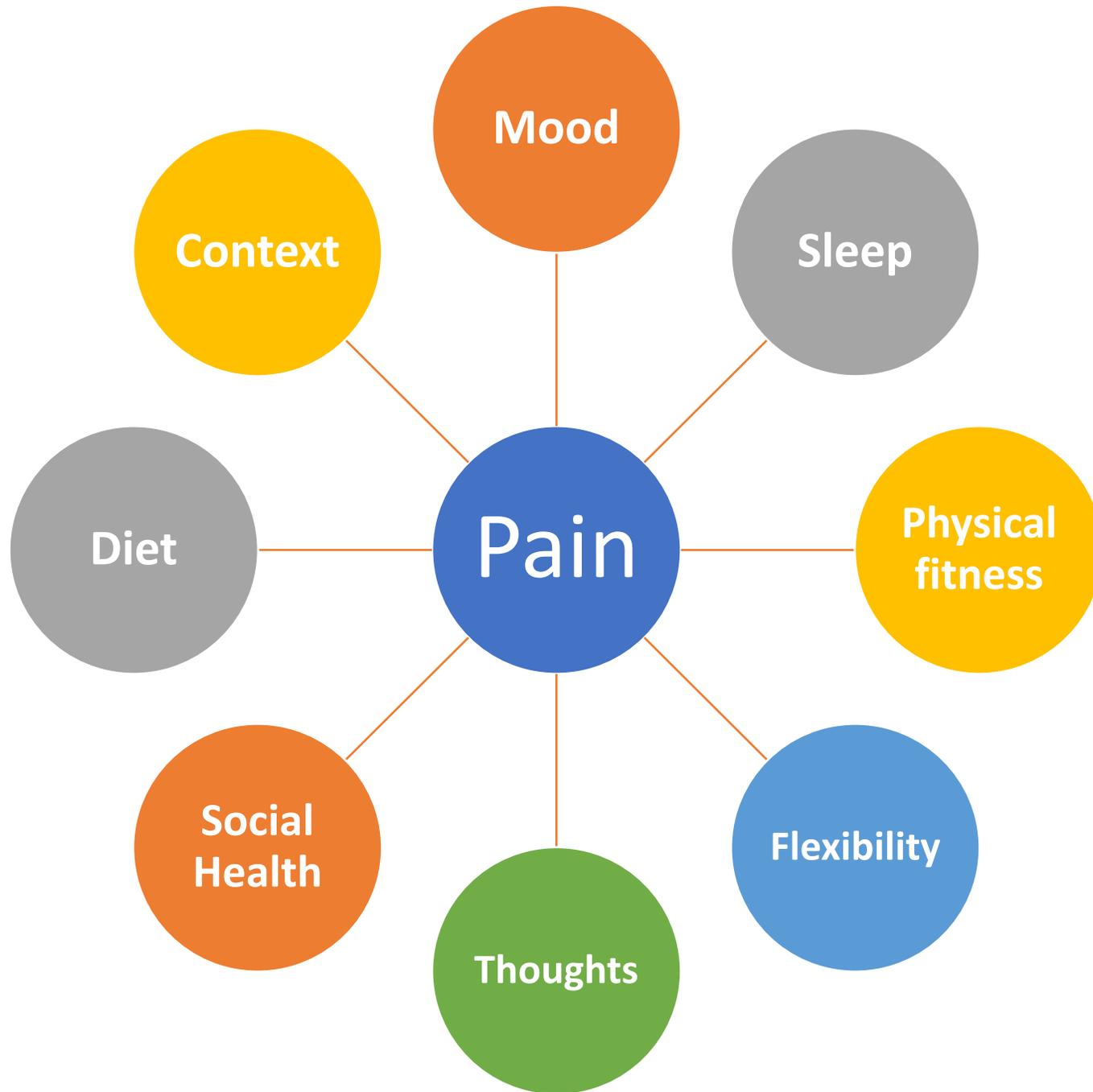


**Opioid Treatments for Chronic Pain  
Evidence Summary**

## Key Messages:

- **Short term follow-up (1-6 mo):**
  - opioids associated with small improvements vs placebo in pain and function, and increased risk of harms
  - No differences between opioids vs nonopioid meds in improvement in pain, function, mental health status, sleep, or depression
- **Long term follow-up (> 12 mo):**
  - Evidence of effectiveness is very limited, and there is evidence of increased risk of serious harms that appear to be dose dependent





# Optimized Antidepressant Therapy and Pain Self-management in Primary Care Patients With Depression and Musculoskeletal Pain

A Randomized Controlled Trial



Kroenke et al, 2009

**Intervention:** 12 weeks of optimized antidepressant therapy followed by 6 sessions of pain self-management program, then 6 month continuation phase

**Outcome:** depression and pain measures at 12 months

**Results:** at 12 months, intervention associated with improvements in depression and pain (RR 2.4 for  $\geq 30\%$  reduction in pain; RR 3.7 for global improvement in pain)

## Sleep and pain sensitivity in adults

Børge Sivertsen<sup>a,b,c,\*</sup>, Tea Lallukka<sup>d,e</sup>, Keith J. Petrie<sup>f</sup>, Ólöf Anna Steingrimsdóttir<sup>g</sup>, Audun Stubhaug<sup>h,i</sup>, Christopher Sivert Nielsen<sup>a</sup>

### *Key Points:*

- Poor sleep parameters were significantly associated with pain sensitivity
- Pain sensitivity increased with greater frequency and severity of insomnia, greater sleep onset latency, and lower sleep efficiency in a dose dependent manner

# Sleep and Pain

- Assess for sleep problems such as sleep apnea and insomnia
- Sleep hygiene is core interventional for all patients



**AASM** | **SLEEP EDUCATION**

<https://sleepeducation.org/healthy-sleep/healthy-sleep-habits/>

**CDC** Centers for Disease Control and Prevention  
CDC 24/7: Saving Lives, Protecting People™

[https://www.cdc.gov/sleep/about\\_sleep/sleep\\_hygiene.html](https://www.cdc.gov/sleep/about_sleep/sleep_hygiene.html)

# Primary Treatment Approaches for OUD



**GOLD STANDARD**

**Medication is the gold-standard treatment for OUD.**

**Buprenorphine**

**Methadone**

**Naltrexone XR**

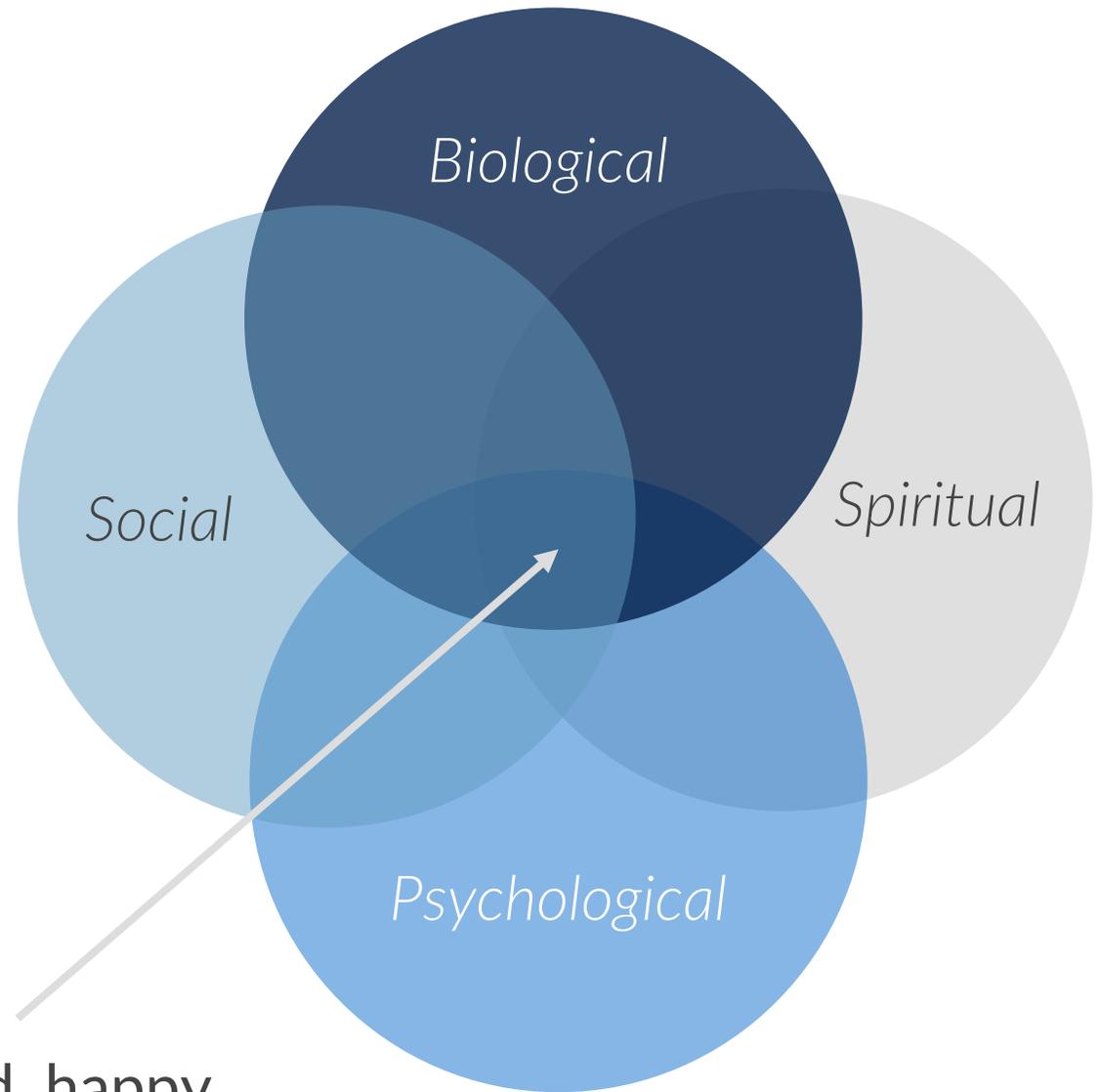
Identifying and Managing Opioid Use Disorder: [https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/508/IB10-933\\_OUD-ProviderAD-EducationalGuide\\_508Ready.pdf](https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/508/IB10-933_OUD-ProviderAD-EducationalGuide_508Ready.pdf)

# Medications for OUD

	Buprenorphine	Methadone	Naltrexone XR
Reduced mortality (primarily by opioid overdose)	✓	✓	?
Treatment retention	✓	✓	✓
Reduced illicit opioid use	✓	✓	✓
Reduced opioid cravings	✓	✓	✓
Improved patient health and well-being	✓	✓	?

✓: benefit of treatment; ?: neutral or no effect

# Whole Person Treatment Model for Pain, Addiction and Mental Health



Sustained, happy  
recovery.

# Pain and SUD Common Treatment Goals

- *Treat the person as a whole with aim to restore function and reduce suffering/distress*



# Pain and SUD Common Treatment Goals

- *Treat the person as a whole with aim to restore function and reduce suffering/distress*
- Use combination of non-pharmacological and pharmacological approaches (MOUD has strongest medication evidence)



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- Use combination of non-pharmacological and pharmacological approaches (MOUD has strongest medication evidence)
- Treat co-morbidities including mental health and sleep

# Pain and SUD Common Treatment Goals

- *Treat the person as a whole with aim to restore function and reduce suffering/distress*
- Use combination of non-pharmacological and pharmacological approaches (MOUD has strongest medication evidence)
- Treat co-morbidities including mental health and sleep
- Reduce/eliminate unnecessary or harmful medications and substances

# *Putting it All Together*

V

• Validate

E

• Educate

M

• Motivate

A

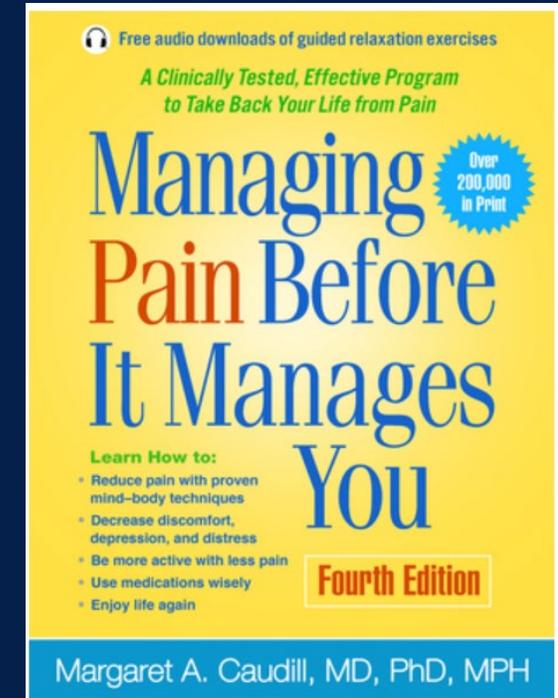
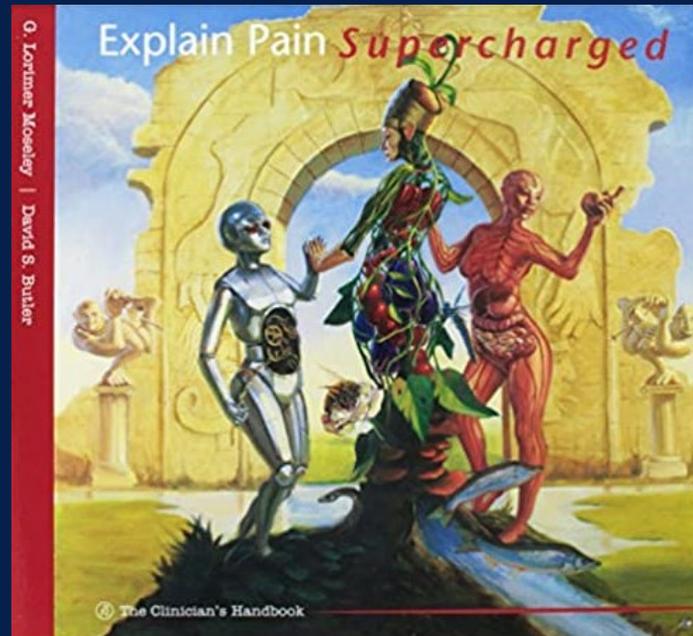
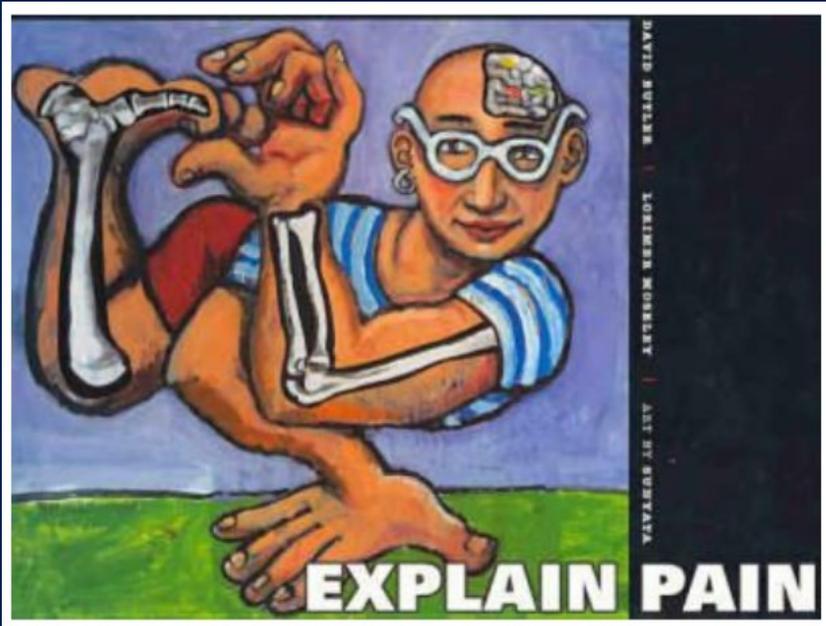
• Activate

# Talking with Your Patient

Focus on pain care being a process:  
“When pain has been around for a long time, it usually doesn’t have a simple fix. Improvement most often comes over time. I know that may not be what you hoped for. Would you be interested in learning about how we can work together to help you develop tools to better manage your pain over time?”

“We used to think abnormalities and changes on x-rays/MRIs meant something was wrong, but we have learned that most spines/knees/joints will have abnormal changes over time, and they don’t always or even usually correlate with pain.”

# References for Clinicians and Patients



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- <https://www.iasp-pain.org/publications/iasp-news/iasp-announces-revised-definition-of-pain/>
- VA Academic Detailing: Identifying and Managing Opioid Use Disorder: [https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/508/IB10-933\\_OUD-ProviderAD-EducationalGuide\\_508Ready.pdf](https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/508/IB10-933_OUD-ProviderAD-EducationalGuide_508Ready.pdf)

# Whiteboard

Use the NearPod link sent in the chat to share your responses to common statements by patients.

*“I just want to be out of pain, then I can exercise...go back to work...do chores...”*

# Whiteboard

Use the NearPod link sent in the chat to share your responses to common statements by patients.

*“My friend is on gabapentin and oxycodone. Can I have this for my lower back strain?”*

# Whiteboard

Use the NearPod link sent in the chat to share your responses to common statements by patients.

*“I tried everything else years ago for my knee arthritis but nothing else worked. I just want my hydromorphone 8 mg four times daily refilled – that’s all that helps.” (MEDD 180 mg)*

# Whiteboard

Use the NearPod link sent in the chat to share your responses to common statements by patients.

*“Why are you asking about my smoking? What does my father’s alcohol use have to do with anything? Substance use helps me cope with pain, so why should I consider cutting back?”*

# Whiteboard

Use the NearPod link sent in the chat to share your responses to common statements by patients.

*“If you don’t give me what I ask for I’ll buy it from a dealer, and if I overdose it is on you.”*

# Whiteboard

Use the NearPod link sent in the chat to share your responses to common statements by patients.

*“Why are you only giving me buprenorphine and methadone as choices when I have real pain that started my addiction?!”*

# Questions?

*Please unmute yourself or submit your question  
in the chat box*

11:00-11:15 am ET (15-mins)

BREAK

## Session 2

# Utilizing Screening & Assessment Tools in Your Practice

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Marianne Fingerhood DNP, ANP-BC, CNE

# Session Learning Objectives

1. Understand the difference between screening and assessment and the role of each in clinical practice.
2. Describe different screening tools available for providers.
3. Differentiate which screening tools to use in various healthcare settings and at different stages of treatment.
4. Understand the role of trauma in addiction and pain treatment.
5. Describe best practices for integrating screening tools into clinical practice.

# Whiteboard

Use the NearPod link sent in the chat to share your responses to the prompt

*What pain and addiction screening and assessment tools are you familiar with?*

# Whiteboard

Use the NearPod link sent in the chat to share your responses to the prompt

*What are 3 challenges you experienced when using screening, and assessment tools?*

# Background

- National Survey on Drug use and Health -2019 reported that:
  - 19.3 million adult Americans with SUD (7.7%)
  - 9.5 million adult Americans with SUD AND a mental health disorder (3.8%)
- Only 10% receive treatment
- During Covid-19 pandemic increase in addiction, overdoses, and mental health illnesses
- Tools are essential to properly and accurately diagnose to provide treatment

# Differentiating Screening & Assessment

## *Screening*

- Evaluation in people with no known risk factors
- Usually brief/short; quick appraisal
- Looking for potential disease in people who have no identifiable symptoms
- Outcome generally a simple yes or no/ presence or absence
- Goal is early detection and intervention
- Promote lifestyle changes as necessary
  - If screening took place at population level start enhanced surveillance
- Main goal is to decrease risk of potential disease OR detect it early enough for enhanced and optimal treatment

## *Assessment*

- Positive screen followed by a more detailed assessment
- In those with evidence disease
- Evaluation of severity disease and extent of disease
- Mitigating and associated factors for consideration
- Analyze aspects of additional risks

# Utility of Screening Tools



Way to standardize assessments and information obtained



May save time especially if patients fill out ahead of time and it is reviewed prior to time with patient



Ensures pertinent questions/topics are not missed



Useful in primary care, surgery, pain management, neurology other disciplines to discover disease that may not be evident



May achieve greater patient engagement in these settings compared to specialty addiction centers

# Basic Principles of Screening



Use clinical judgement when determining if intervention is needed for substance use.



When multiple substances are identified prioritize intervention to most acutely harmful first.

*Clinical judgement.*



May choose to address all substances at same time.



A good screening test will be accurate.

*High sensitivity.  
High specificity.  
Good predictive value.*

# United States Preventive Services Task Force USPSTF Recommendations

- **Recommends** screening with brief intervention for *alcohol use* routinely in all adults
- **Strongly recommends** screening all adults for *tobacco use* and provide tobacco cessation options for treatment
- **Insufficient evidence** routine screening and brief intervention to prevent or decrease *alcohol misuse* in children and adolescents
- **Insufficient evidence** routine screening and brief intervention to prevent or decrease *tobacco use* in children and adolescents
- **Insufficient evidence** to recommend general screening with brief intervention for *illicit substance use*

# Common Screening & Assessment Tools



# Screening & Assessment Tools – Pain/Opioid

*COMM*

*DIRE*

*ORT*

*SOAPP-R*

*PDUQ*

# COMM

## Current Opioid Misuse Measure (COMM)<sup>®</sup>

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	<input type="radio"/>				
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	<input type="radio"/>				
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	<input type="radio"/>				
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	<input type="radio"/>				
5. In the past 30 days, how often have you seriously thought about hurting yourself?	<input type="radio"/>				
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	<input type="radio"/>				

# COMM

	Never	Seldom	Sometimes	Often	Very Often
<b>Please answer the questions using the following scale:</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
7. In the past 30 days, how often have you been in an argument?	<input type="radio"/>				
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	<input type="radio"/>				
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	<input type="radio"/>				
10. In the past 30 days, how often have you been worried about how you're handling your medications?	<input type="radio"/>				
11. In the past 30 days, how often have others been worried about how you're handling your medications?	<input type="radio"/>				
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	<input type="radio"/>				
13. In the past 30 days, how often have you gotten angry with people?	<input type="radio"/>				
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	<input type="radio"/>				
15. In the past 30 days, how often have you borrowed pain medication from someone else?	<input type="radio"/>				
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	<input type="radio"/>				
17. In the past 30 days, how often have you had to visit the Emergency Room?	<input type="radio"/>				

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# DIRE

## D.I.R.E. Score: Patient Selection for Chronic Opioid Analgesia

For each factor, rate the patient's score from 1-3 based on the explanations in the right hand column.

Score	Factor	Explanation
	<u>Diagnosis</u>	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, nonspecific back pain. 2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
	<u>Intractability</u>	1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness). 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.
	<u>Risk</u>	(R = Total of P + C + R + S below)
	<u>Psychological:</u>	1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues. 2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder. 3 = Good communication with clinic. No significant personality dysfunction or mental illness.
	<u>Chemical Health:</u>	1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse. 2 = Chemical copier (uses medications to cope with stress) or history of CD in remission. 3 = No CD history. Not drug-focused or chemically reliant.
	<u>Reliability:</u>	1 = History of numerous problems: medication misuse, missed appointments, rarely follows through. 2 = Occasional difficulties with compliance, but generally reliable. 3 = Highly reliable patient with meds, appointments & treatment.
	<u>Social Support:</u>	1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles. 2 = Reduction in some relationships and life roles. 3 = Supportive family/close relationships. Involved in work or school and no social isolation.
	<u>Efficacy score</u>	1 = Poor function or minimal pain relief despite moderate to high doses. 2 = Moderate benefit with function improved in a number of ways (or insufficient info – hasn't tried opioid yet or very low doses or too short of a trial). 3 = Good improvement in pain and function and quality of life with stable doses over time.

\_\_\_ Total score = D + I + R + E

Score 7-13: Not a suitable candidate for long-term opioid analgesia

Score 14-21: May be a candidate for long-term opioid analgesia

# ORT

## Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
<b>Family history of substance abuse</b>		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
<b>Personal history of substance abuse</b>		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
<b>Age between 16—45 years</b>	1	1
<b>History of preadolescent sexual abuse</b>	3	0
<b>Psychological disease</b>		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
<b>Scoring totals</b>		

1. How often do you have mood swings?
2. How often have you felt a need for higher doses of medication to treat your pain?
3. How often have you felt impatient with your doctors?
4. How often have you felt that things are just too overwhelming that you can't handle them?
5. How often is there tension in the home?
6. How often have you counted pain pills to see how many are remaining?
7. How often have you been concerned that people will judge you for taking pain medication?
8. How often do you feel bored?
9. How often have you taken more pain medication than you were supposed to?
10. How often have you worried about being left alone?
11. How often have you felt a craving for medication?
12. How often have others expressed concern over your use of medication?
13. How often have any of your close friends had a problem with alcohol or drugs?
14. How often have others told you that you had a bad temper?
15. How often have you felt consumed by the need to get pain medication?
16. How often have you run out of pain medication early?
17. How often have others kept you from getting what you deserve?
18. How often, in your lifetime, have you had legal problems or been arrested?
19. How often have you attended an AA or NA meeting?
20. How often have you been in an argument that was so out of control that someone got hurt?
21. How often have you been sexually abused?
22. How often have others suggested that you have a drug or alcohol problem?
23. How often have you had to borrow pain medications from your family or friends?
24. How often have you been treated for an alcohol or drug problem?

SOAPP-R

# PDUQ

## Prescription Drug Use Questionnaire – Patient Version

*If you are currently taking any type of narcotic pain medication (such as Vicodin, Codeine, Percocet, Morphine, Darvon, etc.), please answer all the following questions. Circle either “Y” for a response of “Yes” or “N” for a response of “No” to each question.*

1. Do you have more than one painful condition? Y N
2. Are you disabled by pain (unable to work or participate fully in activities)? Y N
3. Are you receiving any disability payments (such as SSI, or VA disability)? Y N
4. Do you have any current lawsuits or claims related to your pain problem? Y N
5. Have you tried any non-medication treatments for your pain problem (such as physical therapy, TENS, biofeedback) Y N
6. Has your pain been adequately treated over the past 6 months? Y N
7. Do you feel at all angry or mistrustful toward your previous doctors? Y N
8. Have you been given pain medications from more than one clinic over the past 6 months? Y N
9. Have you ever been or do you think you might currently be addicted to pain medications? Y N
10. Has a doctor ever told you that you were addicted to pain medications? Y N
11. Have you had to increase the amount of pain medications you take over the past 6 months? Y N
12. Have you had to call in for more pain medications because your prescription ran out? Y N
13. Have you used the pain medications to help other symptoms such as problems sleeping, anxiety, or depression? Y N
14. Do you save up unused medications in case you might need them in the future? Y N

# Selected Screening & Assessment Tools - Pain

*McGill*

*Brief Pain  
Index*

*WPI  
SSS*





# WPI SSS

## Determining Your Widespread Pain Index (WPI): Part 1

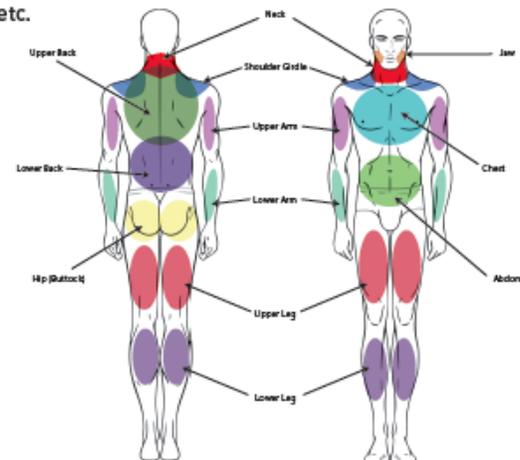
To answer the following questions, patients should take into consideration:

- how you felt the past week
- while taking your current therapies and treatments
- and exclude your pain or symptoms from other known illnesses such as arthritis, Lupus, Sjogren's, etc.

The WPI Index score is between 0 and 19.

Check each area you have felt pain in over the past week.

- |   |  |
|---|--|
| <input type="checkbox"/> Shoulder girdle, left  | <input type="checkbox"/> Lower leg, left     |
| <input type="checkbox"/> Shoulder girdle, right | <input type="checkbox"/> Lower leg, right    |
| <input type="checkbox"/> Upper arm, left        | <input type="checkbox"/> Jaw, left           |
| <input type="checkbox"/> Upper arm, right       | <input type="checkbox"/> Jaw, right          |
| <input type="checkbox"/> Lower arm, left        | <input type="checkbox"/> Chest               |
| <input type="checkbox"/> Lower arm, right       | <input type="checkbox"/> Abdomen             |
| <input type="checkbox"/> Hip (buttock), left    | <input type="checkbox"/> Neck                |
| <input type="checkbox"/> Hip (buttock), right   | <input type="checkbox"/> Upper back          |
| <input type="checkbox"/> Upper leg, left        | <input type="checkbox"/> Lower back          |
| <input type="checkbox"/> Upper leg, right       | <input type="checkbox"/> None of these areas |



Count up the number of areas checked and enter your Widespread Pain Index or WPI score here: \_\_\_\_\_

## Symptom Severity Score (SSS)- Part 2a

**Fatigue:** \_\_\_\_\_

- 0 = No problem
- 1 = Slight or mild problems; generally mild or intermittent
- 2 = Moderate; considerable problems; often present and/or at a moderate level
- 3 = Severe: pervasive, continuous, life disturbing problems

**Waking unrefreshed:** \_\_\_\_\_

- 0 = No problem
- 1 = Slight or mild problems; generally mild or intermittent
- 2 = Moderate; considerable problems; often present and/or at a moderate level
- 3 = Severe: pervasive, continuous, life disturbing problems

**Cognitive symptoms:** \_\_\_\_\_

- 0 = No problem
- 1 = Slight or mild problems; generally mild or intermittent
- 2 = Moderate; considerable problems; often present and/or at a moderate level
- 3 = Severe: pervasive, continuous, life disturbing problems

Tally your score for Part 2a (not the number of checkmarks) and enter it here: \_\_\_\_\_

# Screening & Assessment Tools Mental Health

*PHQ-9*

*GAD7*

*Beck  
Depression  
Inventory*

### PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Over the last 2 weeks, how often have you been bothered by any of the following problems?  
(use "✓" to indicate your answer)

	Not at all	Somewhat	More than	Nearly every
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns:    +    +    +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)    **TOTAL:** \_\_\_\_\_

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

PHQ - 9

FIGURE 1. Patient Health Questionnaire (PHQ-9). The PHQ-9 copyright 1999 Pfizer Inc. All rights reserved. Reproduced with permission.



# GAD-7 Anxiety

Over the <u>last two weeks</u> , how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals    \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ =  
*Total score*    \_\_\_\_\_

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all                  Somewhat difficult                  Very difficult                  Extremely difficult



### Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
  - 0 I do not feel sad.
  - 1 I feel sad.
  - 2 I am sad all the time and I can't snap out of it.
  - 3 I am so sad and unhappy that I can't stand it.
2.
  - 0 I am not particularly discouraged about the future.
  - 1 I feel discouraged about the future.
  - 2 I feel I have nothing to look forward to.
  - 3 I feel the future is hopeless and that things cannot improve.
3.
  - 0 I do not feel like a failure.
  - 1 I feel I have failed more than the average person.
  - 2 As I look back on my life, all I can see is a lot of failures.
  - 3 I feel I am a complete failure as a person.
4.
  - 0 I get as much satisfaction out of things as I used to.
  - 1 I don't enjoy things the way I used to.
  - 2 I don't get real satisfaction out of anything anymore.
  - 3 I am dissatisfied or bored with everything.
5.
  - 0 I don't feel particularly guilty.
  - 1 I feel guilty a good part of the time.
  - 2 I feel quite guilty most of the time.
  - 3 I feel guilty all of the time.
6.
  - 0 I don't feel I am being punished.
  - 1 I feel I may be punished.
  - 2 I expect to be punished.
  - 3 I feel I am being punished.
7.
  - 0 I don't feel disappointed in myself.
  - 1 I am disappointed in myself.
  - 2 I am disgusted with myself.
  - 3 I hate myself.
8.
  - 0 I don't feel I am any worse than anybody else.
  - 1 I am critical of myself for my weaknesses or mistakes.
  - 2 I blame myself all the time for my faults.
  - 3 I blame myself for everything bad that happens.
9.
  - 0 I don't have any thoughts of killing myself.
  - 1 I have thoughts of killing myself, but I would not carry them out.
  - 2 I would like to kill myself.
  - 3 I would kill myself if I had the chance.
10.
  - 0 I don't cry any more than usual.
  - 1 I cry more now than I used to.
  - 2 I cry all the time now.
  - 3 I used to be able to cry, but now I can't cry even though I want to.

# Beck's Depression Inventory

11.  
0 I am no more irritated by things than I ever was.  
1 I am slightly more irritated now than usual.  
2 I am quite annoyed or irritated a good deal of the time.  
3 I feel irritated all the time.
12.  
0 I have not lost interest in other people.  
1 I am less interested in other people than I used to be.  
2 I have lost most of my interest in other people.  
3 I have lost all of my interest in other people.
13.  
0 I make decisions about as well as I ever could.  
1 I put off making decisions more than I used to.  
2 I have greater difficulty in making decisions more than I used to.  
3 I can't make decisions at all anymore.
14.  
0 I don't feel that I look any worse than I used to.  
1 I am worried that I am looking old or unattractive.  
2 I feel there are permanent changes in my appearance that make me look unattractive.  
3 I believe that I look ugly.
15.  
0 I can work about as well as before.  
1 It takes an extra effort to get started at doing something.  
2 I have to push myself very hard to do anything.  
3 I can't do any work at all.
16.  
0 I can sleep as well as usual.  
1 I don't sleep as well as I used to.  
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.  
3 I wake up several hours earlier than I used to and cannot get back to sleep.
17.  
0 I don't get more tired than usual.  
1 I get tired more easily than I used to.  
2 I get tired from doing almost anything.  
3 I am too tired to do anything.
18.  
0 My appetite is no worse than usual.  
1 My appetite is not as good as it used to be.  
2 My appetite is much worse now.  
3 I have no appetite at all anymore.
19.  
0 I haven't lost much weight, if any, lately.  
1 I have lost more than five pounds.  
2 I have lost more than ten pounds.  
3 I have lost more than fifteen pounds.

# Beck's Depression Inventory

- 20.
- 0 I am no more worried about my health than usual.
  - 1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
  - 2 I am very worried about physical problems and it's hard to think of much else.
  - 3 I am so worried about my physical problems that I cannot think of anything else.

- 21.
- 0 I have not noticed any recent change in my interest in sex.
  - 1 I am less interested in sex than I used to be.
  - 2 I have almost no interest in sex.
  - 3 I have lost interest in sex completely.

### INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score _____	Levels of Depression
1-10 _____	These ups and downs are considered normal
11-16 _____	Mild mood disturbance
17-20 _____	Borderline clinical depression
21-30 _____	Moderate depression
31-40 _____	Severe depression
over 40 _____	Extreme depression

# Beck's Depression Inventory

[http://www.med.navy.mil/sites/NIMCP2/PatientServices/SleepClinicLab/Documents/Beck\\_Depression\\_Inventory.pdf](http://www.med.navy.mil/sites/NIMCP2/PatientServices/SleepClinicLab/Documents/Beck_Depression_Inventory.pdf)

# Trauma & Substance Use Disorders

- ***Self-medication hypothesis:*** People with PTSD use substances to aid them in coping cope with or countering their symptoms
- ***High-risk hypothesis:*** People with substance use disorders have higher rates of trauma as a result of their substance use (secondary to lifestyle choices related to substance use)
- ***Susceptibility hypothesis:*** People who use substances are at higher risk of developing PTSD after exposure to trauma than those who do not use substances

# Screening & Assessment Tools Trauma/PTSD

*PC-PTSD-5*

*SPRINT*

*TSQ*

In the past month, have you...

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?

YES NO

2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?

YES NO

3. been constantly on guard, watchful, or easily startled?

YES NO

4. felt numb or detached from people, activities, or your surroundings?

YES NO

5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

YES NO

PC-PTSD-5

In the past week. . . . .		<i>not at all</i>	<i>a little bit</i>	<i>moderately</i>	<i>quite a lot</i>	<i>very much</i>						
1	How much have you been bothered by unwanted memories, nightmares, or reminders of the event?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4						
2	How much effort have you made to avoid thinking or talking about the event, or doing things which remind you of what happened?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4						
3	To what extent have you lost enjoyment for things, kept your distance from people, or found it difficult to experience feelings?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4						
4	How much have you been bothered by poor sleep, poor concentration, jumpiness, irritability, or feeling watchful around you?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4						
5	How much have you been bothered by pain, aches, or tiredness?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4						
6	How much would you get upset when stressful events or setbacks happen to you?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4						
7	How much have the above symptoms interfered with your ability to work or carry out daily activities?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4						
8	How much have the above symptoms interfered with your relationships with family or friends?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4						
9	How much better do you feel since beginning treatment? (as a percentage)					<b>total</b> <input type="text"/>						
		<input type="radio"/> 0	<input type="radio"/> 10	<input type="radio"/> 20	<input type="radio"/> 30	<input type="radio"/> 40	<input type="radio"/> 50	<input type="radio"/> 60	<input type="radio"/> 70	<input type="radio"/> 80	<input type="radio"/> 90	<input type="radio"/> 100
10	How much have the above symptoms improved since starting treatment?	<input type="radio"/> 1 worse <input type="radio"/> 2 no change <input type="radio"/> 3 minimally <input type="radio"/> 4 much <input type="radio"/> 5 very much										

# SPRINT



# Trauma Screening Questionnaire (TSQ)

If you have recently been exposed to a potentially traumatic event (a PTE), here is a tool that may help you to identify whether or not you should seek additional help in recovering from its effects. Have you recently experienced any of the following:

	YES at least twice in the past week	NO
1. Upsetting thoughts or memories about the event that have come into your mind against your will		
2. Upsetting dreams about the event		
3. Acting or feeling as though the event were happening again		
4. Feeling upset by reminders of the event		
5. Bodily reactions (such as fast heartbeat, stomach churning)		
6. Difficulty falling or staying asleep		
7. Irritability or outbursts of anger		
8. Difficulty concentrating		
9. Heightened awareness of potential dangers to yourself and others		
10. Feeling jumpy or being startled by something unexpected		

TSQ



It is recommended that the TSQ be offered 3-4 weeks post-trauma, to allow time for normal recovery processes to take place. If at that point an individual has 6 or more YES answers, a referral to a behavioral health practitioner is indicated.

C. R. Brewin, et al, 2002. (Used by permission)



<https://www.everyonegoeshome.com/wp-content/uploads/sites/2/2014/04/FLSI13TSQ.pdf>.  
Accessed 8/23/21.

# Selected Screening & Assessment Tools - Disability

*PDI*

*PEG*

*ODI*



## Figure 1. Pain Disability Index

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Pain Disability Index:** The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the seven categories of life activity listed, please circle the number on the scale which describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

**Family/home responsibilities:** This category refers to activities related to the home or family. It includes chores or duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

No disability    0    1    2    3    4    5    6    7    8    9    10    Worst disability

**Recreation:** This category includes hobbies, sports and other similar leisure time activities.

No disability    0    1    2    3    4    5    6    7    8    9    10    Worst disability

**Social Activity:** This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out and other social functions.

No disability    0    1    2    3    4    5    6    7    8    9    10    Worst disability

**Occupation:** This category refers to activities that are a part or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.

No disability    0    1    2    3    4    5    6    7    8    9    10    Worst disability

**Sexual behavior:** This category refers to the frequency and quality of one's sex life.

No disability    0    1    2    3    4    5    6    7    8    9    10    Worst disability

**Self-care:** This category includes activities that involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed, etc.)

No disability    0    1    2    3    4    5    6    7    8    9    10    Worst disability

**Life-support Activities:** This category refers to basic life-supporting behaviors such as eating, sleeping and breathing.

No disability    0    1    2    3    4    5    6    7    8    9    10    Worst disability

*Reprinted with permission from Pallard CA. The relationship of family environment to chronic pain disability. (Doctoral dissertation, California School of Professional Psychology—San Diego) Dissertation Abstracts International 1981;42,2077B.*

**SECTION 1 - PAIN INTENSITY**

- I can tolerate the pain I have without having to use painkillers.
- The pain is bad but I manage without taking painkillers.
- Painkillers give complete relief from pain.
- Painkillers give moderate relief from pain.
- Painkillers give very little relief from pain.
- Painkillers have no effect on the pain and I do not use them.

**SECTION 2 - PERSONAL CARE (washing, dressing etc.)**

- I can look after myself normally, without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help, but manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty and stay in bed.

**SECTION 3 - LIFTING**

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

**SECTION 4 - WALKING**

- Pain does not prevent my walking any distance.
- Pain prevents me walking more than 1 mile.
- Pain prevents me walking more than ½ of mile.
- Pain prevents me walking more than ¼ mile.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

**SECTION 5 - SITTING**

- I can sit in any chair as long as I like.
- I can sit in my favourite chair as long as I like.
- Pain prevents me sitting more than 1 hour.
- Pain prevents me from sitting more than ½ an hour.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

**SECTION 6 - STANDING**

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

**SECTION 7 - SLEEPING**

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets, I have less than 6 hours sleep.
- Even when I take tablets, I have less than 4 hours sleep.
- Even when I take tablets, I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

**SECTION 8 - SEX LIFE (If applicable)**

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

**SECTION 9 - SOCIAL LIFE**

- My social life is normal and gives me no extra pain.
- My social life is normal, but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

**SECTION 10 - TRAVELLING**

- I can travel anywhere without extra pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys over 2 hours.
- Pain restricts me to journeys of less than 1 hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents travel except to the doctor or hospital.



**1. What number best describes your pain on average in the past week:**

0    1    2    3    4    5    6    7    8    9    10

---

No pain

Pain as bad as  
you can imagine

**2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?**

0    1    2    3    4    5    6    7    8    9    10

---

Does not  
interfere

Completely  
interferes

**3. What number best describes how, during the past week, pain has interfered with your general activity?**

0    1    2    3    4    5    6    7    8    9    10

---

Does not  
interfere

Completely  
interferes

Krebs EE, Lorenz KA, Bair MJ, Damush TA, Wu J, Sutherland JM, Asch SM, Kroenke K. Development and initial validation of the PEG, a 3-item scale assessing pain intensity and interference. *Journal of General Internal Medicine*. 2009 Jun;24:733-738.



# Screening & Assessment Tools - Addiction

*5As*

*AUDIT*

*CUDIT*

*NIDA Progressive  
Screening*

*AUDIT-C*

*DAST*

*NM-ASSIST*

# 5 A's

## Ask

- Ask questions to assess risk
- Learn about personal experience with substance use
- This determines the intervention provided

## Advise

- Give facts in an objective manner
- Provide clear message that behavior change is recommended based on information gathered
- Strong language should be used related to health effects
- Personalize message

## Assess

- Evaluate problem severity
- Evaluate readiness to change

## Assist

- Develop treatment plan based on their goals
- Use S.M.A.R.T. goals technique
- Ensure actionable and measurable
- Use motivational interviewing
- Provide medical addiction treatment if necessary
- Screen for common comorbidities as appropriate
- HIV , STDs, Hepatitis, other mental illness

## Arrange

- Make follow up appointments
- Provide appropriate referrals
- Encourage treatment with an addiction subspecialist
- Give information about self-help groups

# NIDA (National Institute on Drug Abuse) Progressive Screening

- One question.
- Ask if there was any substance use in prior year.
- An answer in the affirmative warrants further queries.
- Ask then about risk level and offer brief intervention.
- An answer in the negative ends screening process.

# NM-Assist (NIDA Modified Assist) Quick Screen

## STEP 1 – Ask the NIDA Quick Screen Question

**Instructions:** Using the sample language below, introduce yourself to your patient, then ask about **past year** drug use, using the NIDA *Quick Screen*. For each substance, **mark in the appropriate column**. For example, if the patient has used cocaine monthly in the past year, put a mark in the “Monthly” column in the “illegal drug” row.

### Introduction (Please read to patient)

*Hi, I’m \_\_\_\_\_, nice to meet you. If it’s okay with you, I’d like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we’ll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I’ll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.*

Quick Screen Question:	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
<b><u>In the past year</u></b> , how often have you used the following?					
<b>Alcohol</b>					
<ul style="list-style-type: none"> <li>For men, 5 or more drinks a day</li> <li>For women, 4 or more drinks a day</li> </ul>					
<b>Tobacco Products</b>					
<b>Prescription Drugs for Non-Medical Reasons</b>					
<b>Illegal Drugs</b>					

- If the patient says “NO” for all drugs in the Quick Screen, reinforce abstinence. **Screening is complete.**

# NM-Assist (NIDA Modified Assist) Full Screen

Ask the following questions for each drug mentioned in Question 1:

	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
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Q2. <i>In the past 3 months</i> , how often have you used (insert name of drug)?	0	2	3	4	6
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**If the answer to Question 2 is "never", skip to Question 6. Otherwise, continue with Questions 3**

Q3. <i>In the past 3 months</i> , how often have you had a strong desire or urge to use (insert name of drug)?	0	3	4	5	6
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Q4. <i>In the past 3 months</i> , how often has your use of (insert name of drug) led to health, social, legal or financial problems?	0	4	5	6	7
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Q5. <i>In the past 3 months</i> , how often have you failed to do what was normally expected of you because of your use of (insert name of drug)?	0	5	6	7	8
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<b>Ask Questions 6 &amp; 7 for all substances <i>ever used</i> (i.e., those mentioned in Question 1) :</b>	<b>NO</b>	<b>YES, but not in the last 3 months</b>	<b>YES, in the past three months</b>
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Q6. Has a friend or relative or anyone else ever expressed concern about your use of (insert name of drug)?	0	3	6
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Q7. Have you ever tried and failed to control, cut down, or stop using (insert name of drug)?	0	3	6
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**Instructions: Ask Question 8 if patient mentions ANY drug that might be injected, including those that might be listed in the 'Other' category (e.g., steroids). Circle appropriate response.**

Q8. Have you ever used any drug (including steroids) by injection? <ul style="list-style-type: none"> <li>Indicate you are referring to non-medical use only.</li> </ul>	No, never	Yes, but not in the last 3 months	Yes, in the past 3 months
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**Substance Involvement (SI) Score** 

(add all numbers circled in the questions)



# Audit

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence



# Audit - C

Questions	Scoring Table					Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than Monthly	Monthly	Weekly	Daily or almost Daily	



# DAST

## DAST-10 Questionnaire

I'm going to read you a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.

<b>These questions refer to the past 12 months.</b>	<b>No</b>	<b>Yes</b>
1. Have you used drugs other than those required for medical reasons?	0	1
2. Do you abuse more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes.")	1	0
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No."	0	1
6. Does your spouse (or parents) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	0	1

# DAST

## Interpreting the DAST 10

In these statements, the term "drug abuse" refers to the use of medications at a level that exceeds the instructions, and/or any non-medical use of drugs. Patients receive 1 point for every "yes" answer with the exception of question #3, for which a "no" answer receives 1 point. DAST-10 Score Degree of Problems Related to Drug Abuse Suggested Action.

DAST-10 Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1–2	Low level	Monitor, re-assess at a later date
3–5	Moderate level	Further investigation
6–8	Substantial level	Intensive assessment
9–10	Severe level	Intensive assessment

Skinner, H. A. (1982). The Drug Abuse Screening Test. *Addictive Behavior*, 7(4),363–371.

# Screening & Assessment Tools - Withdrawal

COWS

SOWS

CIWA-A

# COWS Clinical Opiate Withdrawal Scale

Resting Pulse Rate: _____ beats/minute <i>Measured after patient is sitting or lying for one minute</i>	GI Upset: <i>over last 1/2 hour</i>
0 Pulse rate 80 or below	0 No GI symptoms
1 Pulse rate 81-100	1 Stomach cramps
2 Pulse rate 101-120	2 Nausea or loose stool
4 Pulse rate greater than 120	3 Vomiting or diarrhea
	5 Multiple episodes of diarrhea or vomiting
Sweating: <i>over past 1/2 hour not accounted for by room temperature or patient activity.</i>	Tremor <i>observation of outstretched hands</i>
0 No report of chills or flushing	0 No tremor
1 Subjective report of chills or flushing	1 Tremor can be felt, but not observed
2 Flushed or observable moistness on face	2 Slight tremor observable
3 Beads of sweat on brow or face	4 Gross tremor or muscle twitching
4 Sweat streaming off face	
Restlessness <i>Observation during assessment</i>	Yawning <i>Observation during assessment</i>
0 Able to sit still	0 No yawning
1 Reports difficulty sitting still, but is able to do so	1 Yawning once or twice during assessment
3 Frequent shifting or extraneous movements of legs/arms	2 Yawning three or more times during assessment
5 Unable to sit still for more than a few seconds	4 Yawning several times/minute
Pupil size	Anxiety or irritability
0 Pupils pinned or normal size for room light	0 None
1 Pupils possibly larger than normal for room light	1 Patient reports increasing irritability or anxiousness
2 Pupils moderately dilated	2 Patient obviously irritable anxious
5 Pupils so dilated that only the rim of the iris is visible	4 Patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches <i>If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</i>	Gooseflesh skin
0 Not present	0 Skin is smooth
1 Mild diffuse discomfort	3 Piloerection of skin can be felt or hairs standing up on arms
2 Patient reports severe diffuse aching of joints/ muscles	5 Prominent piloerection
4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort	
Runny nose or tearing <i>Not accounted for by cold symptoms or allergies</i>	Total Score _____
0 Not present	The total score is the sum of all 11 items
1 Nasal stuffiness or unusually moist eyes	Initials of person completing Assessment: _____
2 Nose running or tearing	
4 Nose constantly running or tears streaming down cheeks	

Score: 5-12 mild; 13-24 moderate; 25-36 moderately severe; more than 36 = severe withdrawal

COWS

## THE SUBJECTIVE OPIATE WITHDRAWAL SCALE (SOWS)

In the column below in today's date and time, and in the column underneath, write in a number from 0-4 corresponding to how you feel about each symptom RIGHT NOW.

Scale: 0 = not at all 1 = a little 2 = moderately 3 = Quite a bit 4 = extremely

<b>DATE</b>					
<b>TIME</b>					

	SYMPTOM	SCORE	SCORE	SCORE	SCORE	SCORE
1	I feel anxious					
2	I feel like yawning					
3	I am perspiring					
4	My eyes are teary					
5	My nose is running					
6	I have goosebumps					
7	I am shaking					
8	I have hot flushes					
9	I have cold flushes					
10	My bones and muscles ache					
11	I feel restless					
12	I feel nauseous					
13	I feel like vomiting					
14	My muscles twitch					
15	I have stomach cramps					
16	I feel like using now					
	<b>TOTAL</b>					

SOWS

# CIWA-AR

## Clinical Institute Withdrawal Assessment for Alcohol – revised (CIWA-Ar) scale

<b>Clinical Institute Withdrawal Assessment for Alcohol revised</b>	
<b>Symptoms</b>	<b>Range of scores</b>
Nausea or vomiting	0 (no nausea, no vomiting) – 7 (constant nausea and/or vomiting)
Tremor	0 (no tremor) – 7 (severe tremors, even with arms not extended)
Paroxysmal sweats	0 (no sweat visible) – 7 (drenching sweats)
Anxiety	0 (no anxiety, at ease) – 7 (acute panic states)
Agitation	0 (normal activity) – 7 (constantly trashes about)
Tactile disturbances	0 (none) – 7 (continuous hallucinations)
Auditory disturbances	0 (not present) – 7 (continuous hallucinations)
Visual disturbances	0 (not present) – 7 (continuous hallucinations)
Headache	0 (not present) – 7 (extremely severe)
Orientation/clouding of sensorium	0 (orientated, can do serial additions) – 4 (Disorientated for place and/or person)

# Case Study

- MT 43 year old cis gender female presents complaining of worsening bilateral foot and lower leg pain
- Describes pain as burning at times 10/10 worse at night
- Endorses difficulty falling asleep and increased forgetfulness.
- Went to the ED concerning pain over the weekend
- She is married to cis gender male for 23 years with 1 son (22) and 1 granddaughter (2) and is an Elementary school teacher
- Medical Hx – DM, HTN, hyperlipidemia, peripheral neuropathy

# Case Study Cont.

- Family history: Parents both have DM brother and sister well
- Surgical history: None
- Lifestyle: Quit smoking 5 years ago, alcohol: glass of wine 1-2 times per year, Drugs: intranasal cocaine 2-3 times week
- Medications: Methadone 20 mg TID, Gabapentin 600 mg TID, Amitriptyline 10 mg QHS, Lisinopril 40 mg, Simvastatin 40 mg, Metformin 500 mg BID
- Physical examination is notable for BMI 35, BP 150/88,
- Labs: Blood sugar 170, HgA1c 7.8%, liver enzymes, renal function and complete blood count are within normal limits

# Case Study – Useful Screening Tools

*Which screening and assessment tools would be most appropriate for this patient?*

*Pain with Potential  
Addiction*

*Pain*

**Assessments**

*Mental Health  
PTSD*

*Disability*

# Breakout Rooms

1. We will send you to a breakout room with other attendees
2. As a group, discuss the prompts →
3. Select a “representative” to report back to the large group what you discussed

## 5-Minutes to Discuss:

1. *What screening tools would you use with this case and why?*
2. *What are the pros and cons of those tools?*

# Large Group Discussion

*What were the common themes  
among your group?*

# Strategies for Practice Integration

- Use clinical judgement when determining if intervention is needed for substance use
- When multiple substances are identified prioritize intervention to most acutely harmful first
- May choose to address all substances at same time

# Strategies for Practice Integration

- Screenings for substance use disorders tend to fall into two categories
  - **Brief screens** - six or fewer items that can be asked orally in the context of an interview or other exchange
  - **Longer written questionnaires** that are completed by the respondent
- **Oral screens** may be more practical for fieldwork and home visits
- **Written screens** more appropriate for office use - while people are waiting for appointments

# Strategies for Practice Integration

- ***Delegation***- based on staff present and their expertise, training, comfort, skill level,
- ***Automation***- should be built into processes and protocols (EMR or intake forms)
- ***Clinical Assessment***- appropriate for patient, appropriate for population (stage of disease e.g., screening vs assessment, evaluation scalable, consistent)
- ***Appropriate follow up*** – immediate intervention if appropriate, suitable referrals, timely/evidence-based treatment

# Strategies for Practice

- Consider social determinants of health and their impact on disease
- Consider how systemic racism, disenfranchisement, discrimination or social stigma (based on skin color, gender, sexual orientation, disability status) might have affected their diagnosis, access to treatment, treatment options
- Be committed to empathy, health justice, health equity, highest quality of care standards

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# Questions?

*Please unmute yourself or submit your question  
in the chat box*

12:15-1:00 pm ET (45-mins)

LUNCH BREAK

## Session 3

# Adding to your Toolbox: Behavior Change Techniques to Engage Patients in Treatment

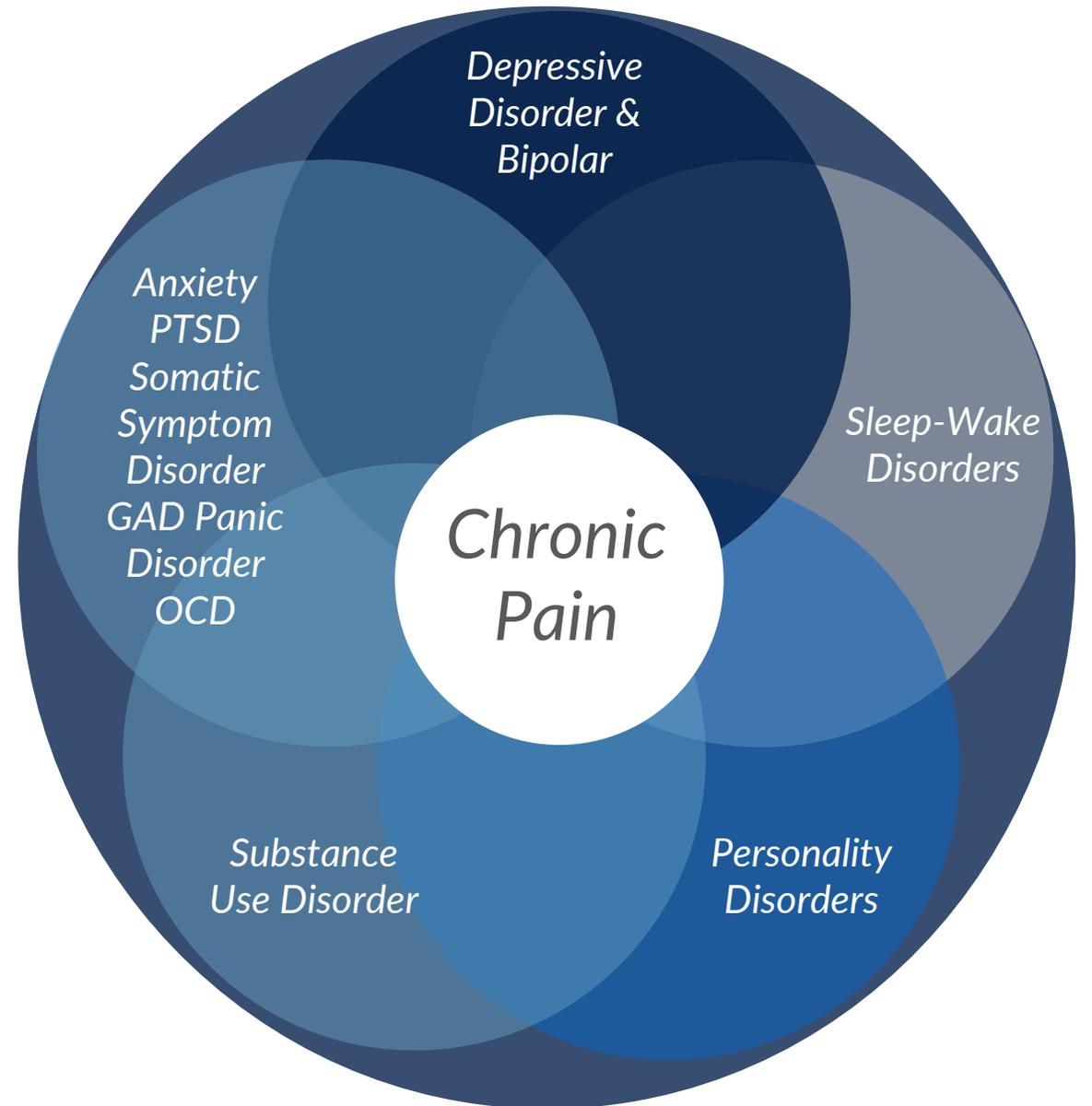
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**Greg Rudolf MD, DFASAM**

# Outline of Presentation

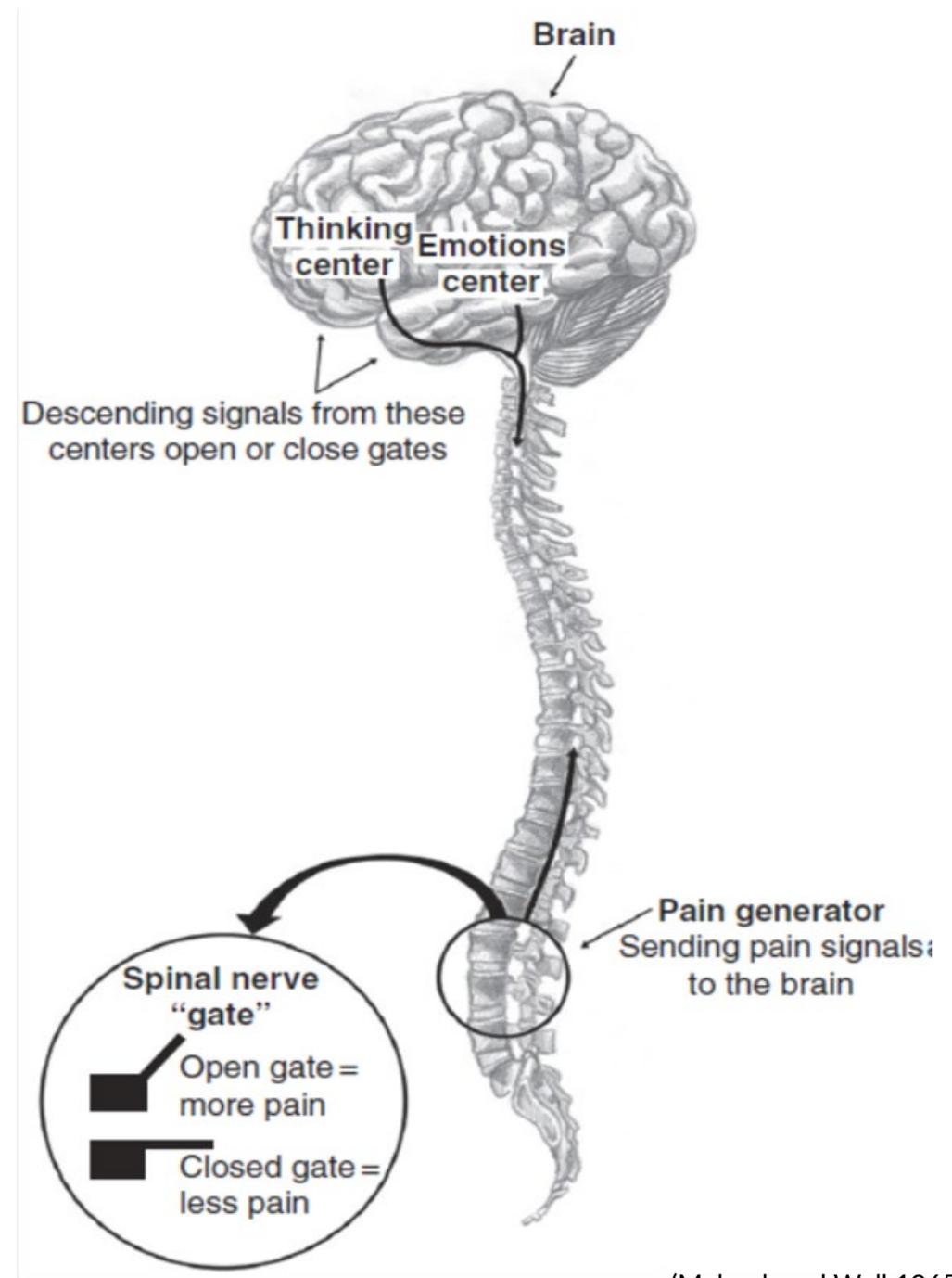
1. Discuss concepts important to contextualize behavioral treatment of chronic pain
2. Introduce behavioral change theory
3. Review specific techniques for behavioral change that can be done during a routine office visit by any medical provider (SBIRT, MI, brief CBT)
4. Discuss effective counseling techniques for chronic pain employed by mental health specialists (CBT, MBSR, ACT)

# Chronic & Co-occurring Mental Disorder



# Neuromatrix Model: “Gate Theory”

- **Gate openers:**
  - Overactivity and/or underactivity
  - Feeling depressed, anxious, angry, fearful, or other negative moods
  - Unhelpful, catastrophic, negative thoughts
  - Too much pain medicine over a long period of time
- **Gate closers:**
  - Meditation, yoga, physical activity
  - Mindfulness
  - Present-moment awareness
  - Pacing your activities without underdoing or overdoing



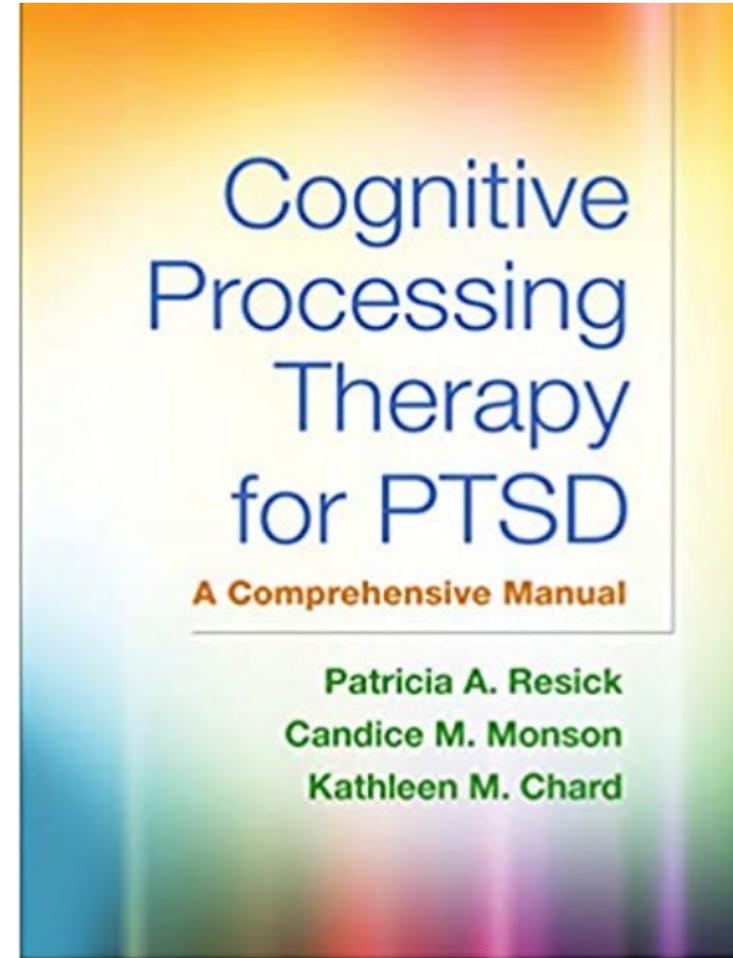
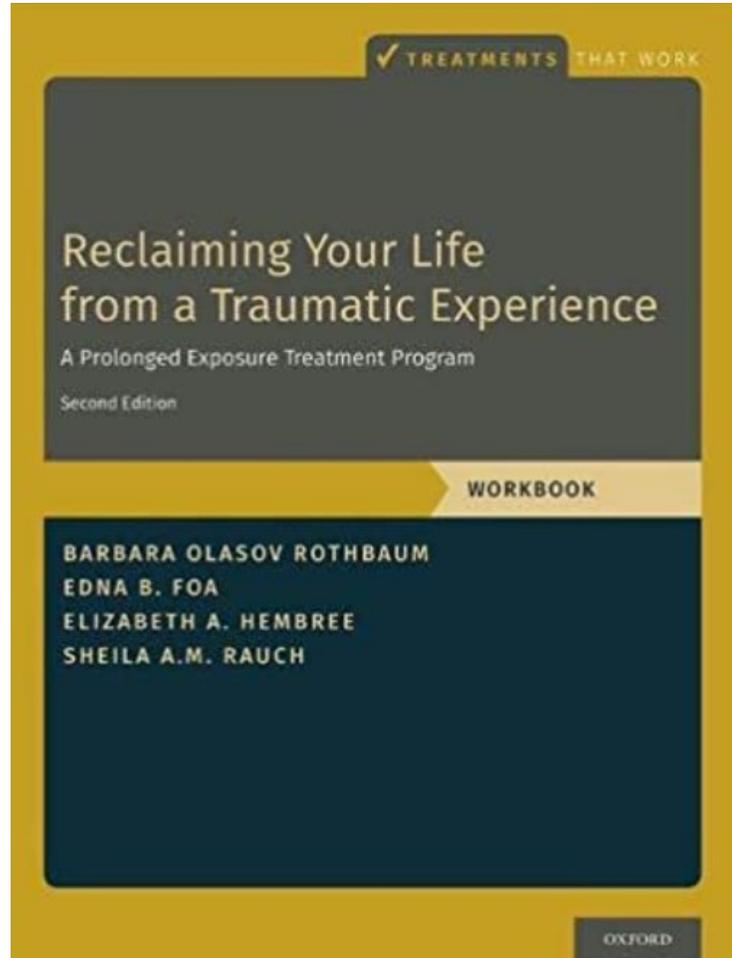
(Melzack and Wall 1965)

# History of Trauma Highly Prevalent in Chronic Pain

- PTSD prevalence of 35% in chronic pain patients, compared to 3.5% in the general population.
- In a study of patients with chronic low back pain, 51% of the patients had significant PTSD symptoms
- Adult survivors of childhood abuse tend to be more at risk for developing certain types of chronic pain later in their lives.
- The most common forms of chronic pain for trauma survivors involve pain in the pelvis, lower back, face, and bladder; fibromyalgia; interstitial cystitis; and non-remitting whiplash syndromes.

Asmundson et al., 1; Kessler et al., 2; Scaer et al.,  
3. <https://www.ptsd.va.gov/professional/assessment/screens/index.asp>

# Evidence-Based Resources for PTSD Treatment for the Patient and Provider



# Getting Unstuck: Behavioral Change Theory

- Common influences on health-related change:
  - *Social*: peers, media, family
  - *Biological*: medication, non-pharmacologic treatment (e.g., PT to help kinesiphobia), exercise/self-care practices
  - *Counseling*
- In Change Theory, internal motivation drives progress.
  - *Motivation for change is not static*, it evolves gradually over time.



# Stages of Change Model



Prochaska and Di Clemente 1977

# Pain Management: Follow up Interview (10-Mins)



# Group Discussion

- 1. What was done well and what wasn't done well?*
- 2. Did you like the style of the practitioner?*
- 3. How does this differ from your usual practice?*

# Brief Screening and Counseling Technique for Behavioral Change: *SBIRT*

- **SBIRT**: screening, *brief intervention*, and *referral to treatment*
  - Designed for primary care, ED, med/surg hospital, community health setting, NOT SUD specialty care
  - BRIEF (usually 5-10 min, 1-5 sessions)
  - Universal screening (all populations) with risk stratification (low, medium, high) to assess severity
    - Use validated screening tools such as AUDIT-C for alcohol, etc.

# Best Practices for Implementation of SBIRT in Primary Care (Cont.)

- ***Develop relationships with referral partners.***
  - Ideally coordinate SBIRT process and plans with referral venue
- ***Institute ongoing SBIRT training optimized to office flow, including EHR integration***
  - Consult with your facility's IT support team



# Brief Counseling Techniques: Motivational Interviewing

ASAM's virtual full-day Motivational Interviewing course:

- <https://www.asam.org/education/live-online-cme/motivational-interviewing>

Motivational Interviewing Network of Trainers (MINT) trainings:

- <https://motivationalinterviewing.org>

# The 5 Principles of MI

1. Express empathy through reflective listening.
2. Develop discrepancy between clients' goals or values and their current behavior.
3. Avoid argument and direct confrontation.
4. Roll with resistance, it disrupts the struggle.
5. Support self-efficacy, essential for behavior change.

- Develop strategies to elicit the patient's own motivation to change.
- Refine your listening skills and respond by encouraging **change talk** from the patient.

# Engaging in MI: Putting Aside Judgment

**O**

*Open-ended questions* that allow patients to give more information, including their feelings, attitudes, and understanding.

**A**

*Affirmations* to help overcome self-sabotaging or negative thoughts.

**R**

*Reflections* to express ambivalence.

**S**

*Summarize* to let your patient know that they are being heard.

# Characteristics of MI

- Guiding, more than directing.
- Dancing, rather than wrestling.
- Listening, as much as telling.
- Collaborative conversation.
- Evokes from a person what they already has.
- Honoring a person's autonomy.



# Motivational Interviewing Role Play(8-Mins)



# Poll Question

*Do you use elements of MI in your practice?*

A. Yes

B. No

# Group Discussion

- 1. What MI techniques did the provider use?*
- 2. What did the provider do well?*
- 3. What could have been improved?*

# Strategies for Eliciting Motivation

- **Agenda setting:**
  - *Are you ready to focus on chronic pain or trauma? Or is there some other topic that you would prefer to talk about?*
- **Pros and Cons:**
  - *I want to understand your marijuana use from your perspective. Can I ask you what marijuana does for your pain, mood, and sleep?*
- **Assessing importance and confidence:**
  - *How important is it for you to...*
  - *How confident do you feel about...*

# Strategies for Eliciting Motivation

- **Exchange information ("Elicit-Provide-Elicit"):**
  - *“Ok, can I check your understanding of the situation? What do you know about the risks of not moving when you have chronic pain?” (Elicit understanding.)*
  - *“Well, you are right that pain can make movement harder, and people can become deconditioned. It also tends to make pain worse in the long run, unfortunately.” (Provide information.)*
  - *How do you think this information applies to you?” (Elicit patient's interpretation.)*
- **Making decisions:**
  - *“It sounds like you really want to rely less on opioids, but you are struggling to imagine how you can do it. You are worried that you wouldn't be able to cope with pain.” (Summarizing patient's situation.)*

# Psychological Therapies in Chronic Pain Treatment

- Why do counseling for chronic pain?
  - chronic pain is a complex biopsychosocial problem, frequently unresolved with medical management
  - targets improvement in physical, emotional, social, and occupational functioning
  - Includes medication use, activity/movement, cognitive patterns/beliefs, quality of life concerns
  - Changes in pain intensity often secondary

# Psychological Therapies in Chronic Pain Treatment Cont.

- Three suitable targets for psychological intervention:
  1. *Pain catastrophizing*: magnification of negative effects of pain
  2. *Pain-related fear*: fear of injury or worsening of condition with activities that may trigger pain
  3. *Psychological flexibility*: model which fosters attitude of acceptance, non-judgmentally acknowledging pain, stopping maladaptive attempts to control pain, learning to live richer life despite pain

# Four Basic Types of Psychological Therapies for Pain

## **1. *Cognitive-Behavioral Therapy***

- Psychoeducation about pain, behavior and mood; cognitive restructuring; strategies for relaxation, scheduling positive events, behavioral pacing, effective communication

## **2. *Mindfulness-Based Stress Reduction***

- Promotes “in the moment” non-judgmental approach to responses to pain through daily practice of mindful meditation, breathing, activity

# Four Basic Types of Psychological Therapies for Pain

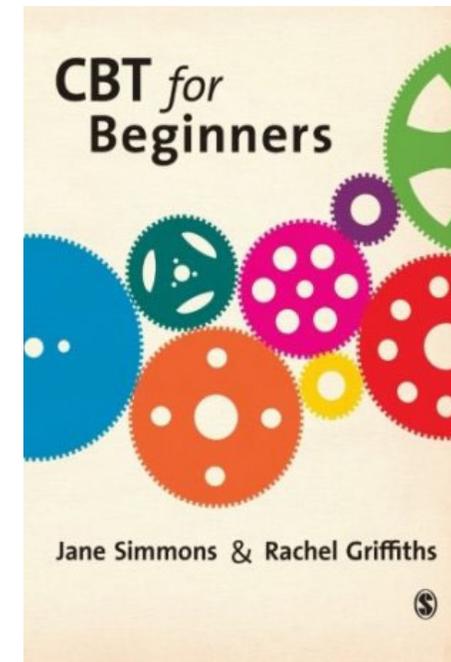
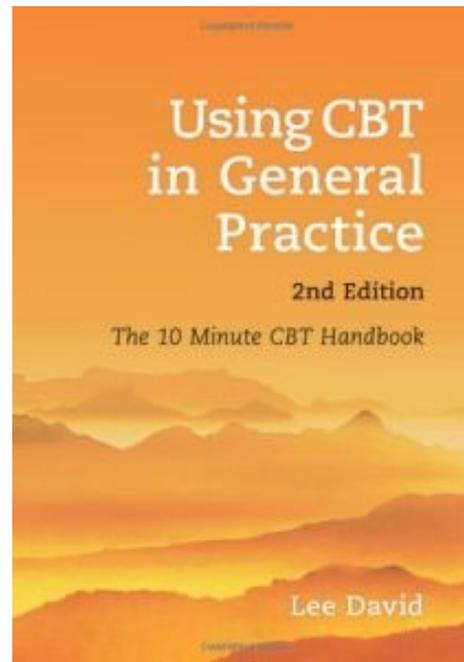
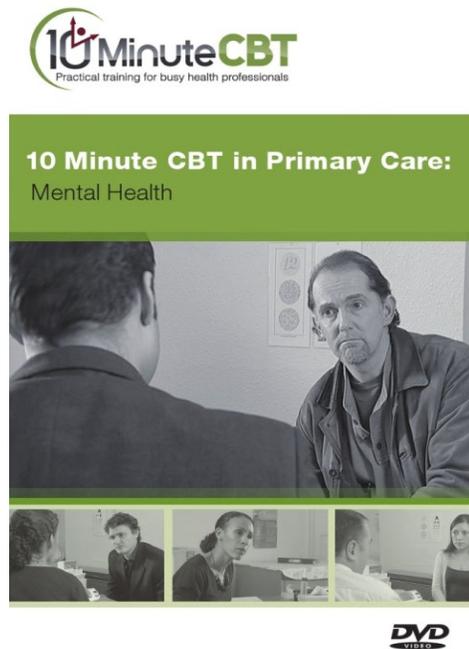
## 3. *Acceptance and Commitment Therapy*

- Based on psychological flexibility model of acceptance of pain, ceasing maladaptive behaviors, pursuit of goals

## 4. *Operant-Behavioral*

- Altering maladaptive behaviors through positive or negative reinforcement contingencies, proactively decreasing perceived harmfulness of activity

# Brief Counseling Techniques: Cognitive-Behavioral Therapy (CBT)



*Not just for mental health specialty providers!*

# Cognitive-Behavioral Therapy (CBT)

- “Gold standard” counseling intervention for pain
- *Cognitive restructuring*: replacing unhelpful/false beliefs about pain with positive adaptive behaviors
- Meta-analysis shows effect on pain and functioning comparable to standard medical management (Williams, 2012)
  - Yields longer term improvement on disability beyond usual medical care
- Valuable component of interdisciplinary pain rehab programs

# The ABCs of CBT (4-Mins)



# Poll Question

*Do you use elements of CBT in your practice?*

A. Yes

B. No

# Group Discussion

- 1. What are challenges you experience when utilizing CBT with your patients? What is the hardest part?*
- 2. What other behavior change techniques do you use often with your patients with pain and addiction?*

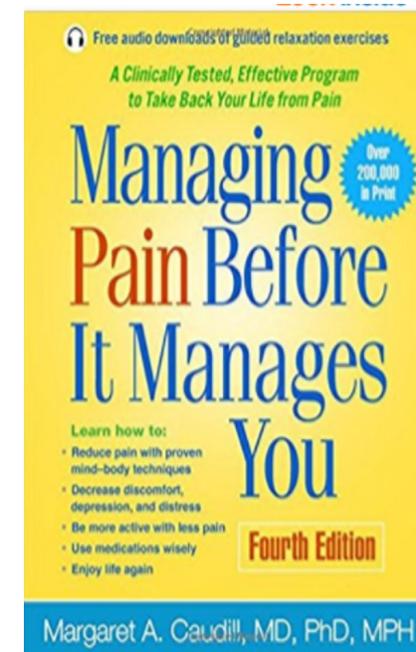
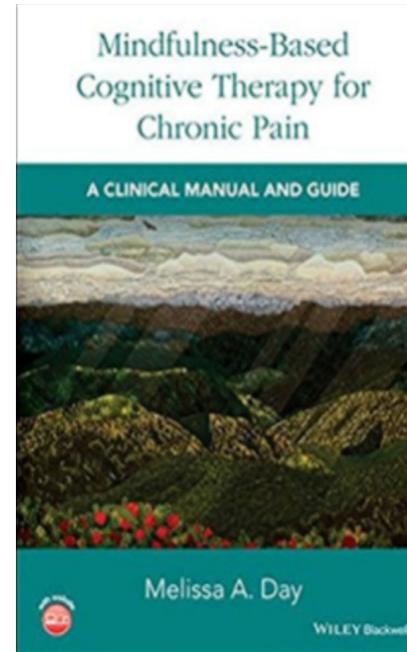
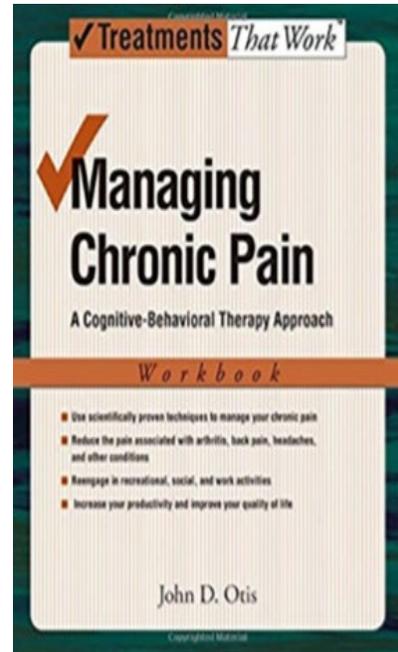
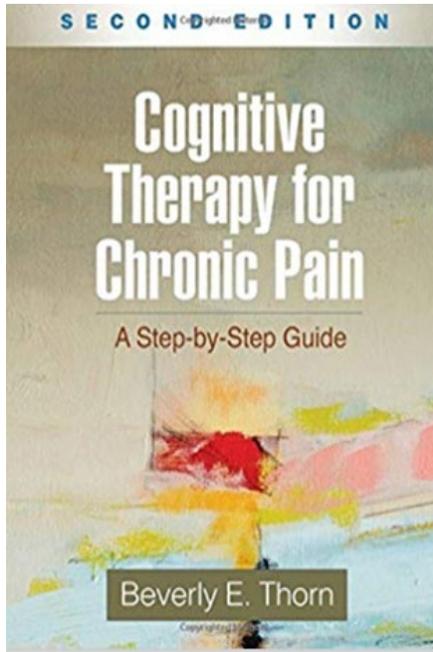
# Mindfulness-based Stress Reduction (MBSR)

- **Seeks to uncouple sensory aspects of pain from the evaluative/emotional aspect**
  - **Promotes "detached awareness" of pain signals**
- **Developed from Eastern philosophy and adapted by ancient Roman and Greek Stoic philosophers**
- **Taught over a series of sessions (eg 1-2 hrs each x 10 sessions), then becomes a self-care technique**
- **Differs from CBT in that no judgment is attached to thoughts, only awareness that they are discrete events**
- **No goals are sought, only observation**
- **One study showed equivalent effectiveness with CBT with lower cost over time (Herman, 2017)**

# Acceptance and Commitment Therapy (ACT)

- **Purposeful acknowledgment and acceptance of pain and associated thoughts and emotions**
  - fostering awareness of the present and one's ability to adjust behavior in a manner c/w goals and values
  - focus not on reducing pain, but on fulfilling functional and behavioral goals despite pain
- **Unlike MBSR, meditation is not part of ACT**
  - Goals/values of patient need to be identified

# Evidence-based Psychotherapy for Chronic Pain



# Where to Refer Patients

Psychology Today



***SAMHSA***

Substance Abuse and Mental Health  
Services Administration

**Behavioral Health Treatment Services Locator**



**PSYCHOLOGIST LOCATOR**

An official product of the American Psychological Association

# References

1. Baer RA. Mindfulness training as a clinical intervention: a conceptual and empirical review. *Clinical Psychology: Scientific Practice*. 2003; 10(2):125-143.
2. Hargraves et al. Implementing SBIRT (Screening, Brief Intervention and Referral to Treatment) in primary care: lessons learned from a multipractice evaluation portfolio. *Public Health Reviews* (2017) 38:31.
3. Herman, PM et al. Cost-effectiveness of Mindfulness-based Stress Reduction Versus Cognitive Behavioral Therapy or Usual Care Among Adults With Chronic Low Back Pain. *Spine*. 2017 Oct 15;42(20):1511-1520.
4. Kabat-Zinn J. An outpatient program for chronic pain patients based on the practice of mindfulness meditation: theoretical considerations and preliminary results. *General Hospital Psychiatry*. 1982;4(1):33-47.

# References

5. **Leeuw M, Goosens ME et al. The fear-avoidance model of musculoskeletal pain: current state of scientific evidence. Journal of Behavioral Medicine. 2007; 30(1):77-94.**
6. **Sturgeon JA. Psychological therapies for the management of chronic pain. Psychology Research and Behavioral Management. 2014;7:115-124.**
7. **Turk DC, Audette J et al. Assessment and treatment of psychosocial comorbidities in patients with neuropathic pain. Mayo Clinic Proceedings. 2010; 85:S42-S50.**
8. **Williams AC et al. Psychological therapies for the management of chronic pain (excluding headache) in adults. Cochrane Database Systematic Review. 2021;11:CD007407.**
9. **Young Casey C, Greenberg MA et al. Transition from acute to chronic pain and disability: a model including cognitive, affective, and trauma factors. Pain. 2008; 134(1-2):69-79.**

# Questions?

*Please unmute yourself or submit your question  
in the chat*

2:00-2:15 pm ET (15-mins)

BREAK

## Session 4

# Non-Pharmacologic Treatment Options for Chronic Pain: Identifying Appropriate Treatments & Creating a Referral Network

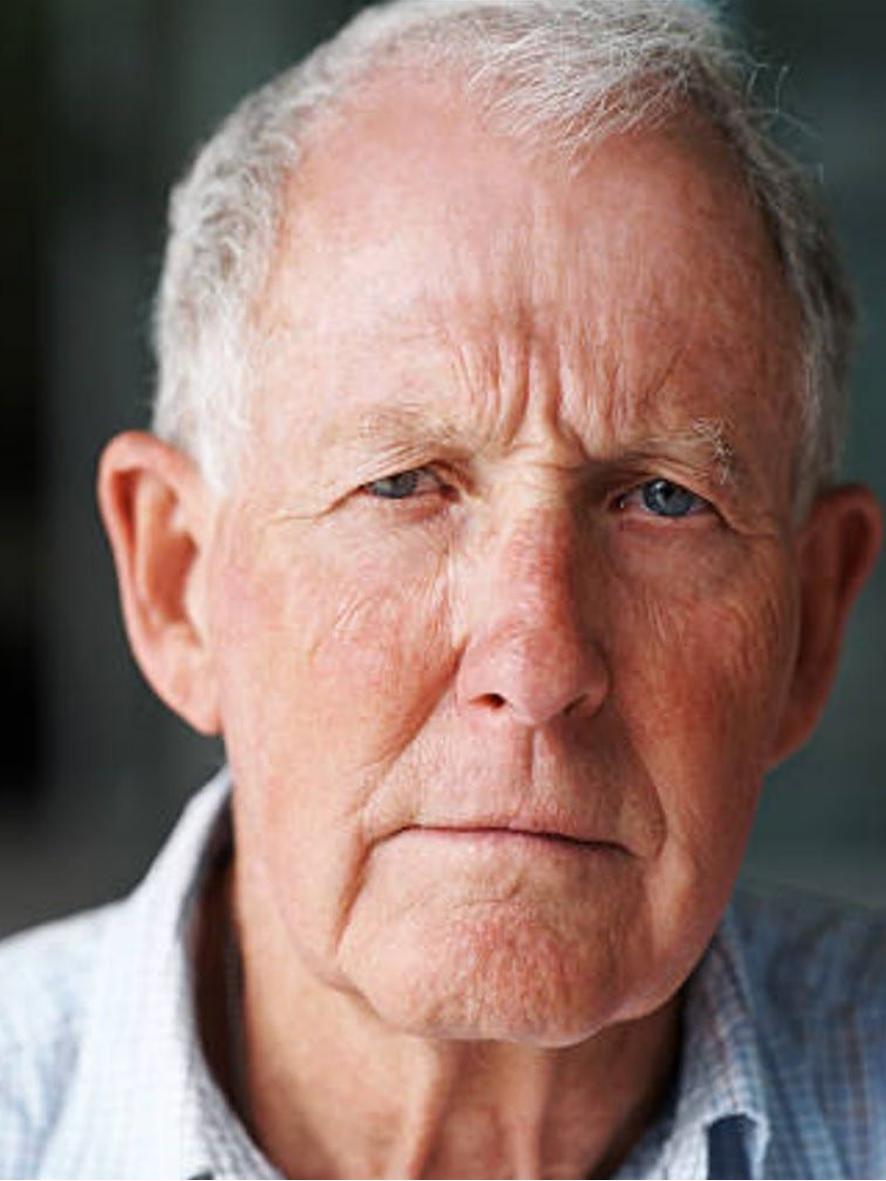
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Aram Mardian, MD

# Session Learning Objectives

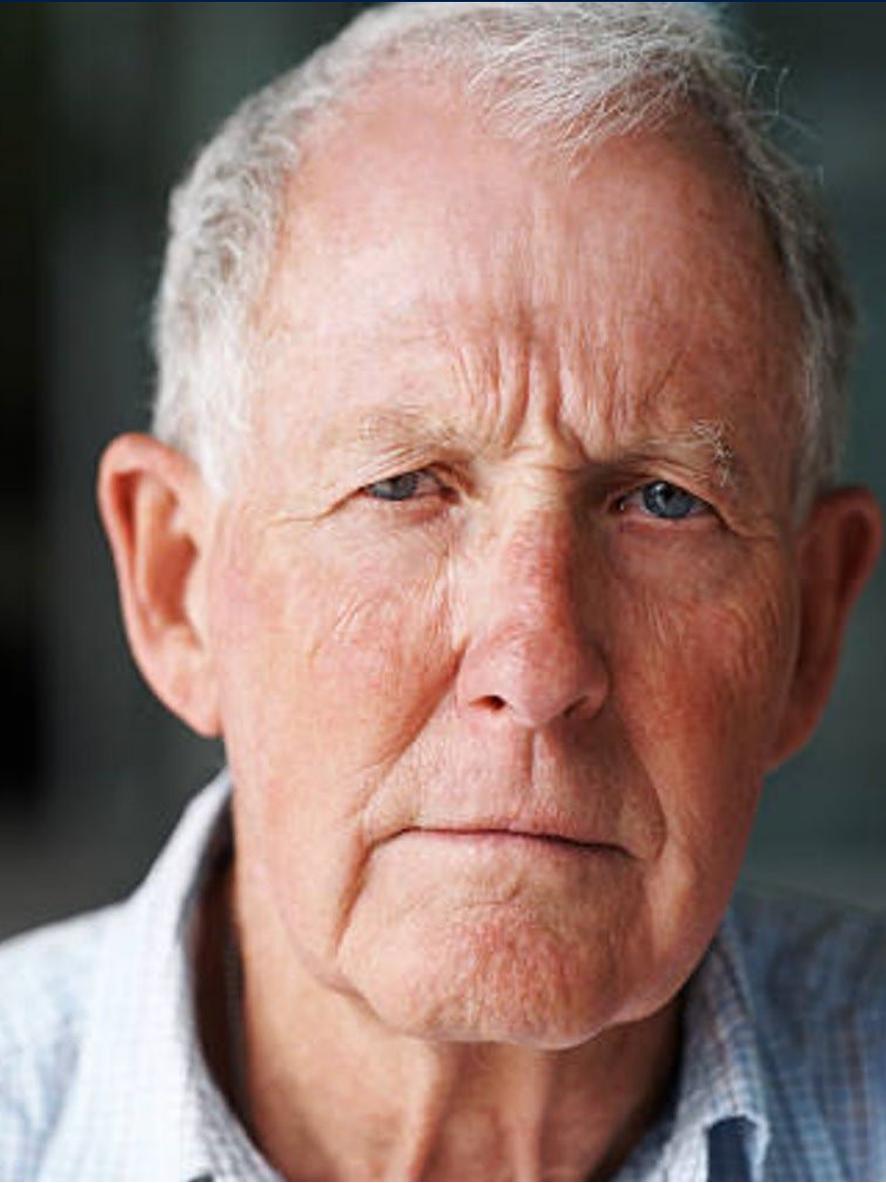
1. Apply non-pharmacological treatment methods to a complex patient a history of addiction
2. Understand how to optimize your own potential impact as a clinician before referring to other healthcare practitioners
3. Discuss how to identify a referral team and build your referral network
4. Understand interdisciplinary pain rehabilitation programs and Complementary and Integrative Health (CIH) treatments for pain

# Case: Tom



- 67-year-old male with low back pain
- History of L4-5 fusion 2017
- Axial low back pain with radiation to RLE (80% back/20% leg)
- “I’m miserable, doc.”
- Referred for pain/addiction eval by new PCP who recently inherited his medication management

# Case: Tom



## **Medications:**

- Oxycodone 10 mg 6x/day, #180/30 days
  - MED 90
  - No misuse in 4 years “but I’m sure tempted a lot”
- Alprazolam 1mg QHS x 3 years
- Stopped gabapentin, duloxetine, NSAIDs, acetaminophen, muscle relaxants due to lack of benefit and/or adverse effects

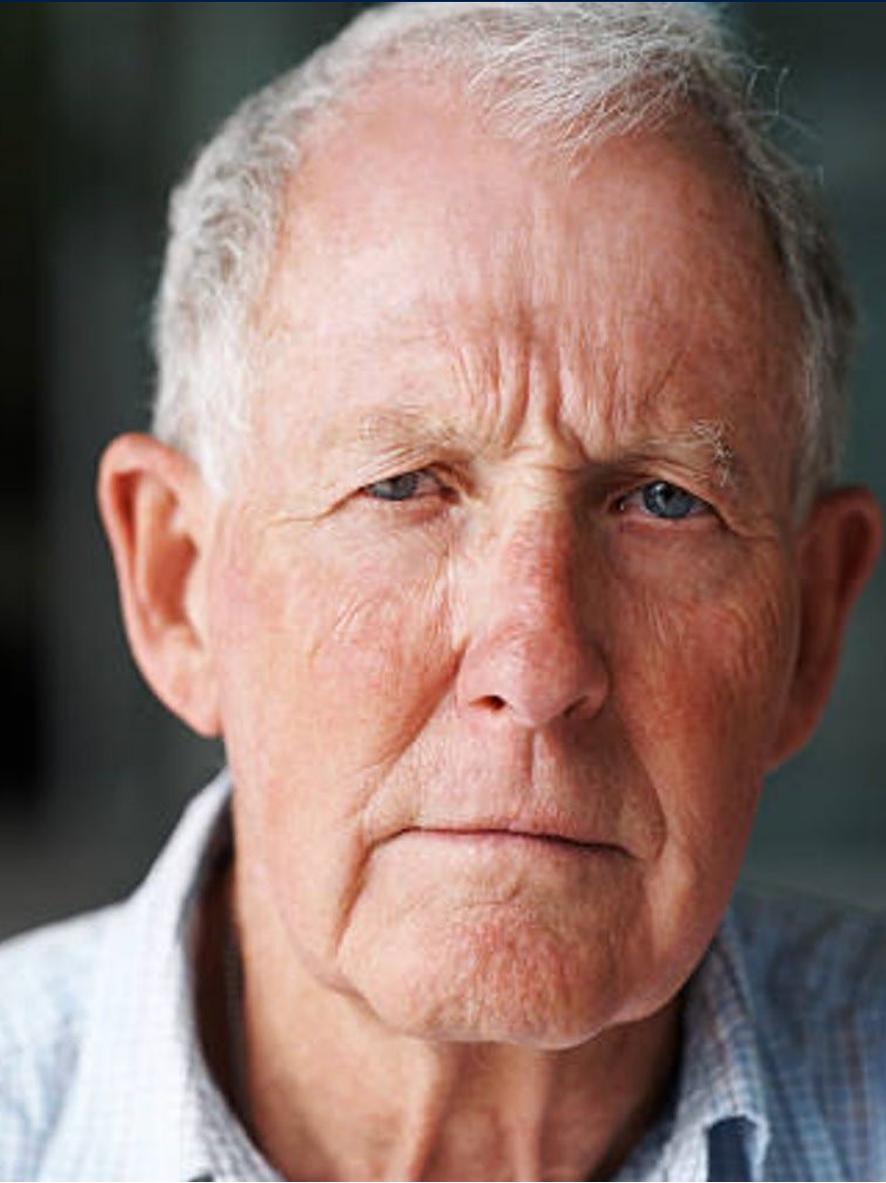
## **Other Treatment/Self-care**

- Not engaging in any particular non-pharmacologic treatment or self-care
- Avoids movement and exercise due to fear of pain flaring

## **Social/SUD Hx:**

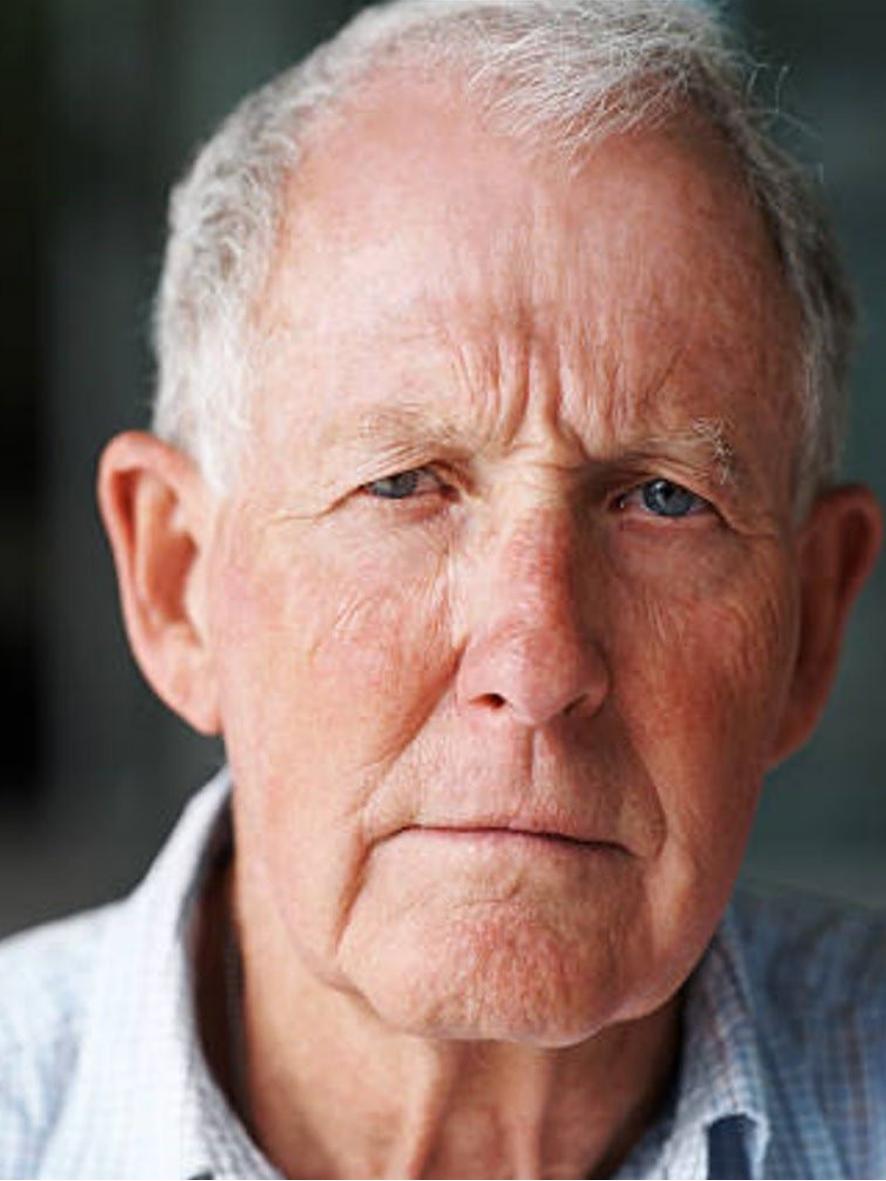
- ETOH: past “problem” → inpatient treatment 10 years ago → abstinent since
- Did AA for first 3-4 years then stopped
- Tobacco: quit in treatment 10 yrs ago
- Wife supportive with no SUD hx. Loves to spend time with 4 grandkids

# Case: Tom



- **PMH** significant for well-controlled HTN, otherwise negative
- **PE:**
  - Mild tenderness in L4-S1 region in paraspinal musculature and in Rt PSIS
  - Gait antalgic, uses a cane
  - No motor or sensory deficits
- **ROS:**
  - + insomnia, irritable mood (“I’m no fun to be around anymore”)
  - no red flags
  - Opioids “help a lot but only for about 3 hours”, denies sedation/cognitive impairment
- **Data:** Last MRI was before surgery in 2017
  - Showed moderate L4-5 canal stenosis and moderate Rt NF stenosis

# Case: Tom



## ***For your consideration:***

- Is Tom's opioid regimen serving him well?
- Has he developed OUD?
- Has he optimized evidence-based treatment approaches?
- Is he engaging in potentially helpful self-care practices?

# Whiteboard

Use the NearPod link sent in the chat to share your thoughts.

*What other providers should we get involved right away?”*

# Preparation

## Before Visit

Understand  
Evidence

Create Your  
Team

Hone Your  
Language

## During Visit

Build Rapport

Engage in MI



Comparative Effectiveness Review  
Number 227

April 2020

## Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review Update

*Evidence Summary*



Comparative Effectiveness Review  
Number 228

April 2020

## Nonopioid Pharmacologic Treatments for Chronic Pain

*Evidence Summary*



Comparative Effectiveness Review  
Number 251

October 2021

## Integrated and Comprehensive Pain Management Programs: Effectiveness and Harms

*Evidence Summary*



Comparative Effectiveness Review  
Number 229

April 2020

## Opioid Treatments for Chronic Pain

*Evidence Summary*



Comparative Effectiveness Review  
Number 227

April 2020

# Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review Update

*Evidence Summary*





Comparative Effectiveness Review  
Number 227

April 2020

**Noninvasive Nonpharmacological  
Treatment for Chronic Pain: A  
Systematic Review Update**

***Evidence Summary***

## Key Messages:

Interventions that improved function and/or pain for  $\geq 1$  mo

- **Low back pain:** Exercise, psychological therapy, mindfulness-based stress reduction, yoga, acupuncture, multidisciplinary rehabilitation, spinal manipulation, low-level laser therapy, massage
- **Serious harms were not observed** with the interventions.



Comparative Effectiveness Review  
Number 227

April 2020

**Noninvasive Nonpharmacological  
Treatment for Chronic Pain: A  
Systematic Review Update**

**Evidence Summary**

## Key Messages:

Interventions that improved function and/or pain for  $\geq 1$  mo

- **Neck pain:** Exercise, mind-body practices, acupuncture, low-level laser, low-level laser
- **Knee osteoarthritis:** Exercise, cognitive behavioral therapy
- **Hip osteoarthritis:** Exercise, manual therapies
- **Fibromyalgia:** Exercise, CBT, myofascial release massage, mindfulness practices, tai chi, qigong, acupuncture, multidisciplinary rehabilitation
- **Tension headache:** Spinal manipulation
- **Serious harms were not observed with the interventions.**



**Comparative Effectiveness Review  
Number 251**

**October 2021**

**Integrated and Comprehensive Pain  
Management Programs: Effectiveness and  
Harms**

***Evidence Summary***



## Key Messages:

- Multidisciplinary pain treatment (both in primary care and specialty environments) may provide **small to moderate improvements in function and small improvements in pain** vs usual care and may be more effective than medications alone
- No clear evidence on program types, components, duration/dose



**Comparative Effectiveness Review  
Number 228**

**April 2020**

# **Nonopioid Pharmacologic Treatments for Chronic Pain**

***Evidence Summary***



## Nonopioid Pharmacologic Treatments for Chronic Pain

### *Evidence Summary*

### Key Messages:

- **Common Categories:** antidepressants, anticonvulsants, NSAIDs, acetaminophen, topicals
- **Common Conditions:** fibromyalgia, osteoarthritis, low back pain, neuropathic pain, inflammatory arthritis
- Medications can provide small-moderate short-term improvement in pain and function for neuropathic pain and fibromyalgia (antidepressants and anticonvulsants) and OA/inflammatory arthritis (NSAIDs)
- Small to moderate, dose-dependent withdrawal from treatment due to side effects
- NSAIDs have increased risk of serious GI, liver, renal, CV adverse events

**VA/DoD Clinical Practice Guideline**

# **Diagnosis and Treatment of Low Back Pain**

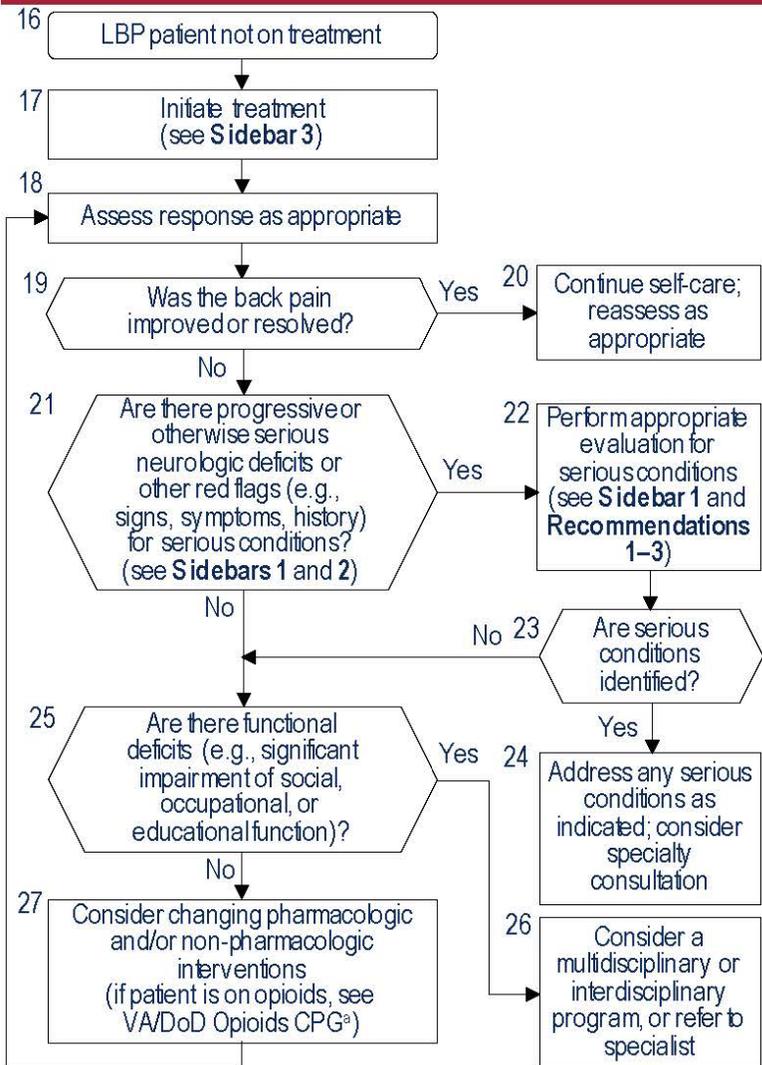


**VA/DoD Evidence Based Practice**

## Diagnosis and Treatment of Low Back Pain (LBP) (2022) - VA/DoD Clinical Practice Guidelines

- [Full Guideline](#)
- [Clinician Summary](#)
- [Pocket Card](#)
- [Patient Summary](#)

Module B: Management of Low Back Pain



Sidebar 2: Evaluation for Possible Other Conditions<sup>a</sup>

Possible Other Conditions	Red Flags (e.g., signs, symptoms, history)	Suggested Evaluation <sup>b</sup>
Herniated disc	<ul style="list-style-type: none"> <li>• Radicular back pain (e.g., sciatica)</li> <li>• Lower extremity dysesthesia and/or paresthesia</li> </ul>	None
	<ul style="list-style-type: none"> <li>• Severe/progressive lower extremity neurologic deficits</li> <li>• Symptoms present &gt;1 month</li> </ul>	MRI <sup>c</sup>
Spinal stenosis	<ul style="list-style-type: none"> <li>• Radicular back pain (e.g., sciatica)</li> <li>• Lower extremity dysesthesia and/or paresthesia</li> <li>• Neurogenic claudication</li> <li>• Older age</li> </ul>	None
	<ul style="list-style-type: none"> <li>• Severe/progressive lower extremity neurologic deficits</li> <li>• Symptoms present &gt;1 month</li> </ul>	MRI <sup>c</sup>
Inflammatory LBP	<ul style="list-style-type: none"> <li>• Morning stiffness</li> <li>• Improvement with exercise</li> <li>• Alternating buttock pain</li> <li>• Awakening due to LBP during the second part of the night (early morning awakening)</li> <li>• Younger age</li> </ul>	Radiography of pelvis, SI joint, and spine area of interest

<sup>a</sup> These conditions usually do not require urgent diagnostic evaluation  
<sup>b</sup> Consider specialty consultation  
<sup>c</sup> Some patients may have contraindications to MRI, contrast usually not required

Sidebar 3: Management of Low Back Pain

Category	Intervention (listed alphabetically by category)	Low Back Pain Duration <sup>a</sup>	
		Acute <4 Weeks	Subacute or Chronic ≥4 Weeks
Self-care	Advice to remain active	X	X
	Acupuncture		X Recommendation 34
Non-pharmacologic treatment	CBT and/or MBSR		X Recommendation 8 and Recommendation 12
	Clinician-directed exercise program		X Recommendation 9
	Spinal mobilization/manipulation		X Recommendation 10
Pharmacologic treatment	Duloxetine		X Recommendation 18
	NSAIDs	X Recommendation 19	X Recommendation 19
Other treatment	Multidisciplinary or interdisciplinary program		X Recommendation 39

<sup>a</sup> Recommendations can be accessed in the full guideline. Available at: <https://www.healthquality.va.gov/>.



Abbreviations: CBT: cognitive behavioral therapy; CPG: clinical practice guideline; DoD: Department of Defense; LBP: low back pain; MBSR: mindfulness-based stress reduction; MRI: magnetic resonance imaging; NSAIDs: nonsteroidal anti-inflammatory drugs; SI: sacroiliac; VA: Department of Veterans Affairs



<sup>a</sup> See the VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain. Available at: <https://www.healthquality.va.gov/>.

# Before Discussing Referrals – Optimize your Own Potential for Impact



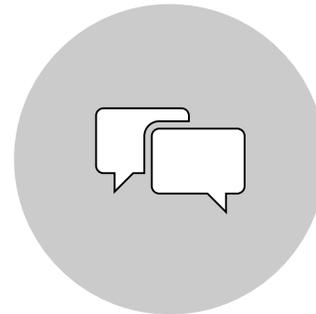
**Build Rapport**



**Assess readiness to participate in non-pharmacologic treatments**



**Match your approach to the patient's readiness to engage**



**Use MI to enhance patient's internal motivation**

# Maximize Your Impact

- **Build Rapport**
  - Strength of relationship predicts outcomes
  - VEMA
  - Join through common goals
- Assess your patient's readiness to participate in evidence based non-pharmacologic treatments
- Match your approach to the patient's readiness to engage
- Use MI to enhance patient's internal motivation

# Maximize Your Impact

- Build Rapport
- Assess your patient's readiness to participate in evidence based non-pharmacologic treatments
  - Stages of Change
  - precontemplation, contemplation, preparation, action, maintenance
- Match your approach to the patient's readiness to engage
- Use MI to enhance patient's internal motivation
  - “Roll with resistance”
  - Elicit change talk

# Maximize Your Impact

- Build Rapport
- Assess your patient's readiness to participate in evidence based non-pharmacologic treatments
- Match your approach to the patient's readiness to engage
- Use MI to enhance patient's internal motivation



# Maximize Your Impact

- Build Rapport
- Assess your patient's readiness to participate in evidence based non-pharmacologic treatments
- Match your approach to the patient's readiness to engage
- Use MI to enhance patient's internal motivation
  - “Roll with resistance”
  - Elicit change talk

# Before Discussing Referrals

*Address a problematic medication regimen early*

# Address Problematic Medication Regimen

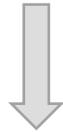
- *Engage in MI around opioid use* and unintended negative consequences of this regimen to pt's QOL
  - Tolerance/hyperalgesia
  - “Negative feedback loop” between doses → dysphoria, insomnia, rebound pain
  - Possibly impaired alertness/cognitive functioning

# Short Term Use

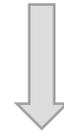
8AM -  
patient wakes  
up takes  
10mg  
Oxycodone



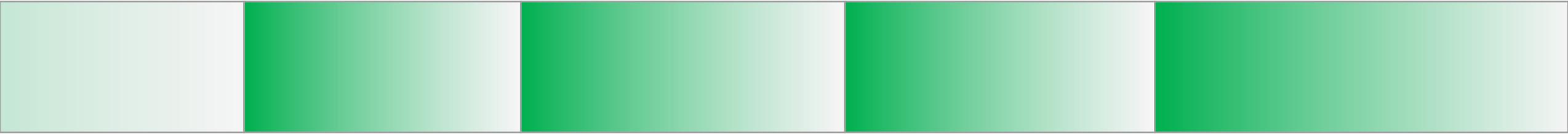
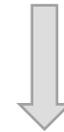
Noon - 10mg  
Oxycodone



5P - 10mg  
Oxycodone

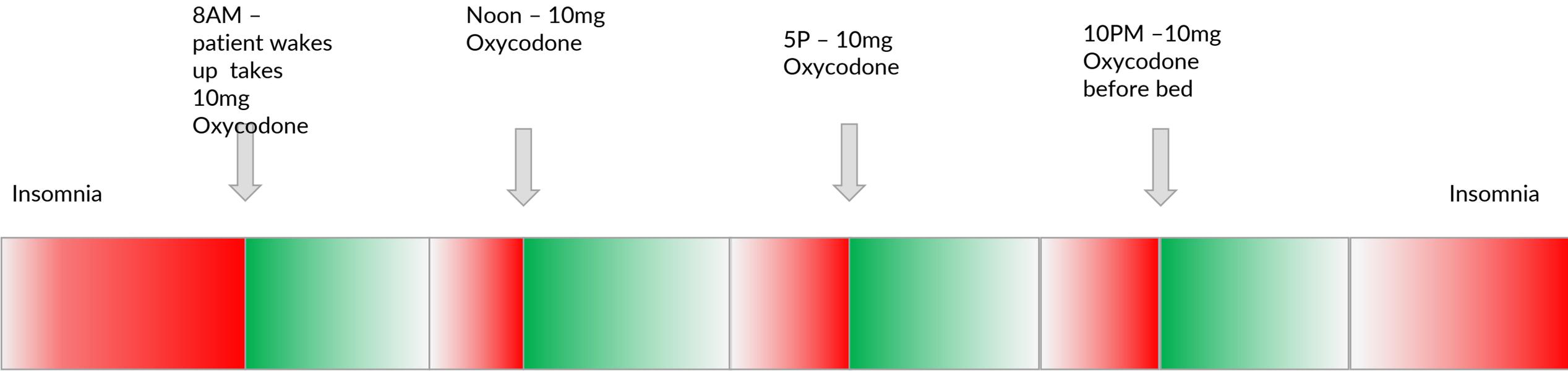


10PM - 10mg  
Oxycodone  
before bed



 Opioid effects: reduced physical pain,  
calm, sense of wellbeing

# Long Term Use - Tolerance/Hyperalgesia



Opioid effects: reduced physical pain, calm, sense of wellbeing



Opioid opponent effects: increased physical pain, irritability, anxiety, restless, insomnia

# Long Term Use – Prominent Tolerance/Hyperalgesia

8AM –  
patient wakes  
up takes  
10mg  
Oxycodone

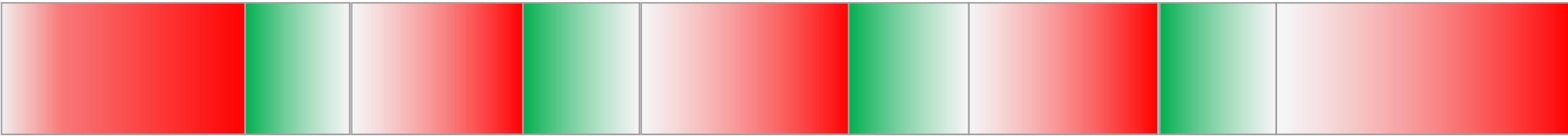
Noon – 10mg  
Oxycodone

5P – 10mg  
Oxycodone

10PM – 10mg  
Oxycodone  
before bed

Insomnia

Insomnia



Opioid effects: reduced physical pain, calm, sense of wellbeing



Opioid opponent effects: increased physical pain, irritability, anxiety, restless, insomnia

# Address Problematic Medication Regimen

- **Buprenorphine options**
  - Strong evidence if OUD identified
  - Preferred vs full agonist if daily opioids used for chronic pain



*Seek out practitioners who communicate well  
with you and with the patient*

- **Communication between disciplines**
  - Identify other disciplines who support your overall plan/language
  - Seek out practitioners who open to both receiving and providing input at initial referral and throughout treatment
  - Expect progress notes from the consultant

- **Communication with your patients**
  - Do your patients “feel heard” by the consulting practitioner?
  - Are your patients involved in *collaborative* decision making?
  - Are the consultants’ recommendations consistent with best practices and appropriate (i.e. not more frequent or invasive than indicated)?

## *Where to start?*

- **Patient-centered** recommendations
  - Discuss evidence-based options
  - Ask patient what most interests them (e.g., the best form of exercise is the one the patient will do)
- **Emphasize active therapies** that will provide patient with long-term self-management options
  - MI around maladaptive beliefs
  - Recognize and validate lack of readiness

# Menu of Options

- Try to settle on one intervention to start with, or possibly two if patient appears highly motivated
- **Core Active Therapies**
  - Incorporate gentle movement and increase activity tolerance
    - Often need to address kinesiophobia
  - Counseling such as CBT with a pain psychologist can assist with addressing maladaptive beliefs/behaviors
  - Promoting and training in evidence-based self-care strategies like MBSR
- **Supporting Passive Therapies (relies on healthcare practitioner)**
  - Acupuncture treatment with a skilled provider would likely help pain and functioning and would be a safe, sustainable maintenance approach if effective
  - Epidural steroid injection may help subacute severe radiculopathy component

# Interdisciplinary Pain Rehabilitation Program

## *What constitutes an Interdisciplinary Pain Rehabilitation program?*

- physical and occupational therapy
- pain psychology
- medical pain management
- vocational rehabilitation
- biofeedback
- relaxation training
- nursing education

→ *Team members meet regularly to discuss patients collaboratively*



# Interdisciplinary Multimodal Pain Rehabilitation Programs

- ***Strengths***

- Recommended by Evidence Based Guidelines
- Evidence for long term (> 12 mo) benefit in pain and function
- Best option for patients highly impacted by chronic pain

- ***Limitations***

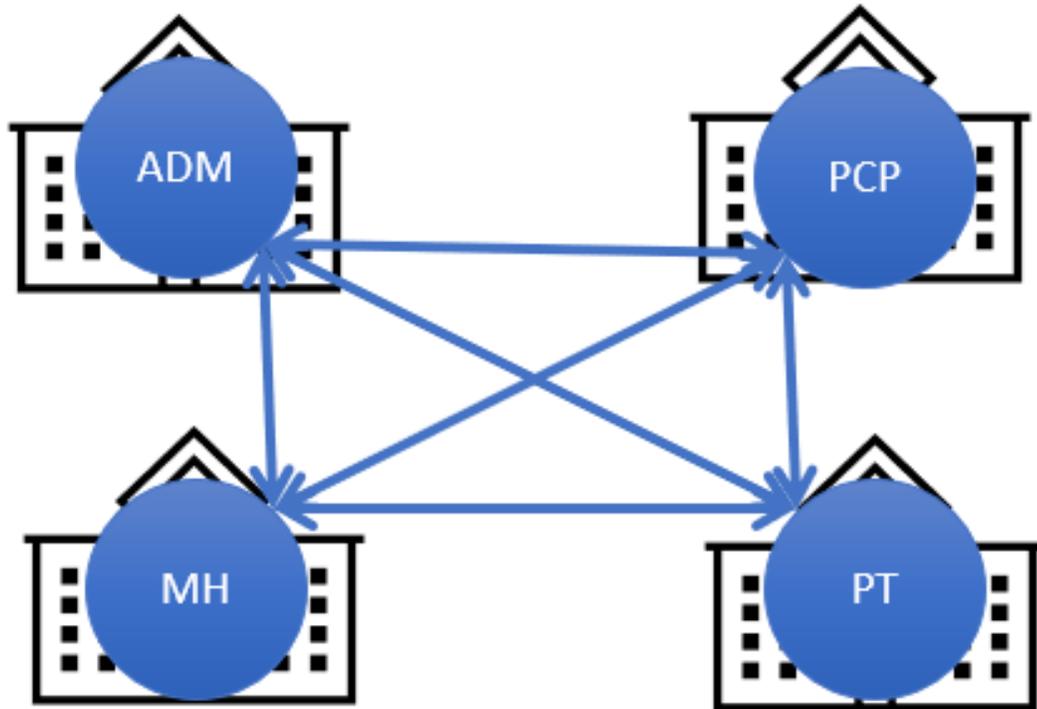
- Limited availability for patients
- Require time commitment and high degree of motivation

# Build the best possible (virtual) interdisciplinary team

## What constitutes an Interdisciplinary Pain Rehabilitation **PLAN**?

- ✓ physical and occupational therapy
- ✓ pain psychology
- ✓ medical pain management

→ *Team of practitioners from various disciplines who have a **common treatment philosophy, develop shared goals, and use similar language***



# Complementary/Integrative Health (CIH) Treatment for Pain

## *What's the bottom line?*

- **Regarding effectiveness:**
  - Evidence reviews indicate acupuncture, mindfulness meditation, spinal manipulation, tai chi, yoga, hypnosis, and massage, can help to manage some painful conditions.

**QUERI**

---

**Massage for Pain:  
An Evidence Map**

---

September 2016

**QUERI**

---

**Evidence Map  
of Mindfulness**

---

October 2014

**QUERI**

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**Evidence Map of Tai Chi**

---

September 2014

**QUERI**

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**Evidence Map of Yoga for  
High-Impact Conditions  
Affecting Veterans**

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August 2014

**QUERI**

---

**Evidence Map of Acupuncture**

---

January 2014

**Guided Imagery, Biofeedback, and  
Hypnosis: A Map of the Evidence**

---

February 2019



# Complementary/Integrative Health (CIH) Treatment for Pain

## *What's the bottom line?*

- Regarding safety:
  - Although CIH approaches (e.g., acupuncture, meditation, yoga, massage) studied for chronic pain have good safety records, that doesn't mean that they're risk-free for everyone.
    - Consider special circumstances (such as pregnancy) that may affect the safety of these approaches.
- Natural doesn't mean safe

# Non-Surgical Procedural Interventions

## VA/DoD Clinical Practice Guideline

### Diagnosis and Treatment of Low Back Pain



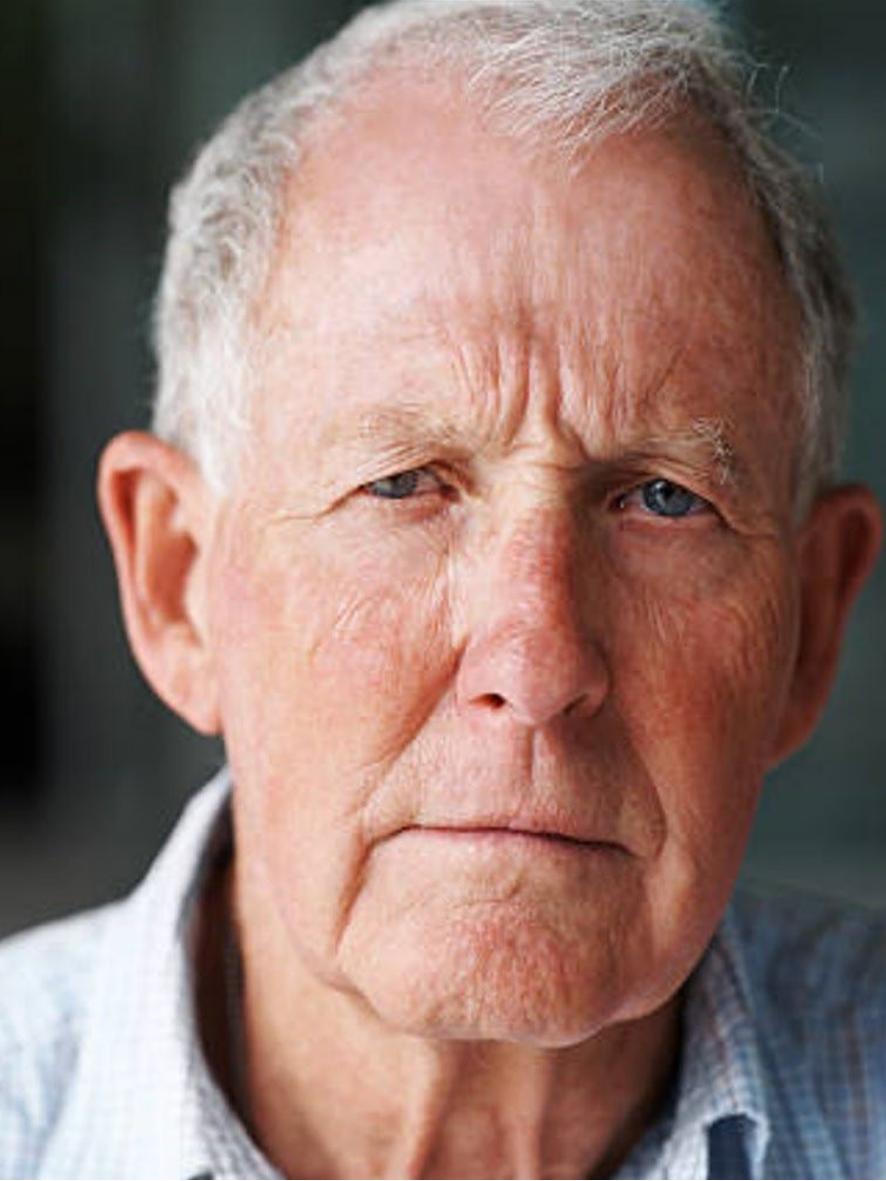
VA/DoD Evidence Based Practice

Topic	#	Recommendation	Strength <sup>a</sup>	Category <sup>b</sup>
Non-surgical Invasive Therapy	31.	For patients with chronic low back pain, we suggest lumbar medial branch and/or sacral lateral branch radiofrequency ablation.	Weak for	Reviewed, New-replaced
	32.	For patients with low back pain, there is insufficient evidence to recommend for or against sacroiliac joint injections.	Neither for nor against	Reviewed, New-added
	33.	For patients with low back pain, we suggest against the injection of corticosteroids for intra-articular facet joint injections and therapeutic medial branch blocks with steroid.	Weak against	Reviewed, New-replaced
	34.	For patients with chronic low back pain, we suggest acupuncture.	Weak for	Reviewed, Amended
	35.	For patients with acute low back pain, there is insufficient evidence to recommend for or against acupuncture.	Neither for nor against	Reviewed, Amended
	36.	For patients with low back pain, there is insufficient evidence to recommend for or against ortho-biologics (e.g., platelet-rich plasma, stem cells).	Neither for nor against	Reviewed, New-added
	37.	For patients with low back pain, with radicular symptoms, there is insufficient evidence to recommend for or against epidural steroid injections.	Neither for nor against	Reviewed, New-replaced
	38.	For patients with low back pain, we suggest against spinal cord stimulation.	Weak against	Reviewed, New-added

# Non-Surgical Procedural Interventions

- Oliveira CB, Maher CG et al. **Epidural corticosteroid injections for lumbosacral radicular pain.** Cochrane Database Syst Rev. 2020 Apr 9;4(4):CD013577. doi: 10.1002/14651858.CD013577. PMID: 32271952; PMCID: PMC7145384.
  - *“ESI probably slightly reduced leg pain and disability at short-term follow-up in people with lumbosacral radicular pain.”*
  - *“...Although the current review identified additional clinical trials, the available evidence still provides only limited support for the use of epidural corticosteroid injections in people with lumbosacral radicular pain as the treatment effects are small, mainly evident at short-term follow-up and may not be considered clinically important by patients and clinicians (i.e. mean difference lower than 10%)”*

# Case: Tom



## *Back to the Case: Helping Tom Move Forward*

*After taking an hour with Tom to build rapport, do thorough H&P and record review, and discuss menu of options:*

- Tom expresses an open mind toward finding an alternative to oxycodone and is willing to consider buprenorphine. Also willing to find an alternative to alprazolam for sleep.
- He is open to trying acupuncture
- He likes the idea of the clinic's interdisciplinary pain rehab program but is not ready to commit
- Does not dismiss counseling but thinks it fits best in the rehab program
- He thanks you for “giving me some hope”

# Summary & Key Points

- There is *no one “one-size-fits-all” approach to manage chronic pain*, but there are evidence-based non-pharmacologic approaches

# Summary & Key Points

- There is *no one “one-size-fits-all” approach to manage chronic pain*, but there are evidence-based non-pharmacologic approaches
- Try to *address a problematic medication regimen ASAP*

# Summary & Key Points

- There is *no one “one-size-fits-all” approach to manage chronic pain*, but there are evidence-based non-pharmacologic approaches
- Try to *address a problematic medication regimen ASAP*
- Emphasize *safe, sustainable, non-invasive interventions*

# Summary & Key Points

- There is *no one “one-size-fits-all” approach to manage chronic pain*, but there are evidence-based non-pharmacologic approaches
- Try to *address a problematic medication regimen ASAP*
- Emphasize *safe, sustainable, non-invasive interventions*
- *Develop relationships with local providers* who communicate well with you and the patient at all stages of care

# Summary & Key Points

- There is *no one “one-size-fits-all” approach to manage chronic pain*, but there are evidence-based non-pharmacologic approaches
- Try to *address a problematic medication regimen ASAP*
- Emphasize *safe, sustainable, non-invasive interventions*
- *Develop relationships with local providers* who communicate well with you and the patient at all stages of care
- Give your patient the opportunity to choose from a menu of options; *keep it simple*

# Summary & Key Points

- There is *no one “one-size-fits-all” approach to manage chronic pain*, but there are evidence-based non-pharmacologic approaches
- Try to *address a problematic medication regimen ASAP*
- Emphasize *safe, sustainable, non-invasive interventions*
- *Develop relationships with local providers* who communicate well with you and the patient at all stages of care
- Give your patient the opportunity to choose from a menu of options; *keep it simple*
- Develop an *interdisciplinary pain rehab* plan, if patient is motivated/ready to participate

# Summary & Key Points

- There is *no one “one-size-fits-all” approach to manage chronic pain*, but there are evidence-based non-pharmacologic approaches
- Try to *address a problematic medication regimen ASAP*
- Emphasize *safe, sustainable, non-invasive interventions*
- *Develop relationships with local providers* who communicate well with you and the patient at all stages of care
- Give your patient the opportunity to choose from a menu of options; *keep it simple*
- Develop an *interdisciplinary pain rehab* plan, if patient is motivated/ready to participate
- Match your approach to patient’s readiness to change
  - Provide positivity/hope and consistent recommendations and don’t get discouraged if patients are not ready for active treatments

# References

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- McDonagh MS, Selph SS, Buckley DI, Holmes RS, Mauer K, Ramirez S, et al. Nonopioid Pharmacologic Treatments for Chronic Pain. 2020 Apr. doi:10.23970/AHRQEPCCER228
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- Stanos, S. Focused Review of Interdisciplinary Pain Rehabilitation Programs for Chronic Pain Management. Curr Pain Headache Rep 16, 147–152 (2012)
- VA/DoD Clinical Practice Guideline [Diagnosis and Treatment of Low Back Pain](#)
- [VA Evidence Synthesis Program Reports](#)

# Breakout Rooms

1. We will send you to a breakout room with other attendees
2. As a group, discuss the prompts →
3. Select a “representative” to report back to the large group what you discussed

## 10-Minutes to Discuss:

1. *How are you making connections in your practice/community?*
2. *What are the challenges you are experiencing expanding and referring to your network?*
3. *What are the strengths/gaps in your network?*

# Large Group Discussion

## **Report Back:**

*What were the common themes among your group?*

## **Discuss:**

*What are some tools/resources that providers in resource poor settings can use?*

# Questions?

*Please unmute yourself or submit your question  
in the chat box*

3:15-3:30 pm ET (15-mins)

BREAK

Session 5

# Complex Pharmacologic Concepts and Treatment Techniques in Pain And Addiction

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**Greg Rudolf MD, DFASAM**



# Session Learning Objectives

1. Review clinical considerations for opioid tapering
2. Describe buprenorphine options for pain and factors influencing choice of formulation and dosing
3. Understand principles of buprenorphine initiation via both direct transition and low dose initiation protocols
4. Consider safe pharmacotherapy options for treatment of anxiety and insomnia, and strategies for tapering benzodiazepines
5. Review alternatives to controlled substances for pain management

# Common Chronic Pain Scenarios with Medication Management Challenges

## ***Chronic pain with co-occurring***

- Untreated opioid use disorder (OUD)
- OUD on buprenorphine maintenance
- OUD on methadone maintenance
- Opioid dependence (long term Rx opioid use) without OUD
- Alcohol use disorder
- Benzodiazepine use or use disorder
- Clinical recommendations may require different strategies in various chronic pain patient subpopulations
  - *Special subgroups (pregnancy, elderly, unstable mental health, adolescent, employment considerations, etc)*

# Opioid Use and Chronic Pain



- *Chronic opioid administration dysregulates the reward and stress systems to lower reward function over time and increase pain and stress*
  - Opioid induced hyperalgesia (OIH) and hyperkatifeia (increased intensity of negative emotional state with use, especially between doses)
- Role of Substance P
  - neuropeptide that plays a role in the behavioral response to opioids, stress, initiation and potentiation of addictive behaviors
  - works largely in the nucleus accumbens and ventral tegmental area
  - involved in the neurotransmission of pain signals (ascending pathway)
  - has proinflammatory effects

Commons KG. Neuronal pathways linking substance P to drug addiction and stress. Brain Res. 2010;1314:175-182.

# Opioid Use and Chronic Pain



- Role of kappa opioid receptor and dynorphin
  - Contributes to hyperalgesia, anxiety/depression, drug-seeking behavior
    - Buprenorphine is a KOR *antagonist* → **REVERSES HYPERALGESIA AND DYSPHORIA**
- Periaqueductal gray is critical in modulating somatic and emotional pain signaling output from the extended amygdala

Marchette RCN, Gregory-Flores A, Tunstall B et al. K-opioid receptor antagonism reverses heroin withdrawal-induced hyperalgesia in male and female rats. *Neurobiology of Stress*. May 2021; 14: 100325

# OUD vs Opioid Dependence



- DSM-5 criteria: note presence of craving (not diagnostic by itself)
  - *Not necessarily straightforward to diagnose OUD* for pts on chronic Rx opioid therapy (COT) for pain
  - Tolerance and withdrawal upon cessation don't count for pts on COT
  - Patients with chronic pain who express resistance to tapering and/or experience difficulty managing it do not necessarily meet criteria for OUD
- Both OUD and **opioid dependence without OUD** occur quicker with multiple-time daily, routine use of short-acting opioids
  - Neurobiology of *negative reinforcement loops* driving use is common to both
- Tolerance can eventually evolve to include amplification of pain signals → opioid-induced hyperalgesia (OIH)

Ballantyne JC, Sullivan MD, Kolodny A. Opioid Dependence vs Addiction: A Distinction Without a Difference? Arch Intern Med. 2012; 172(17): 1342-3.

Ballantyne JC, Sullivan MD, and Koob GF. Refractory dependence on opioid analgesics. Pain. 2019;160:2655-2660.

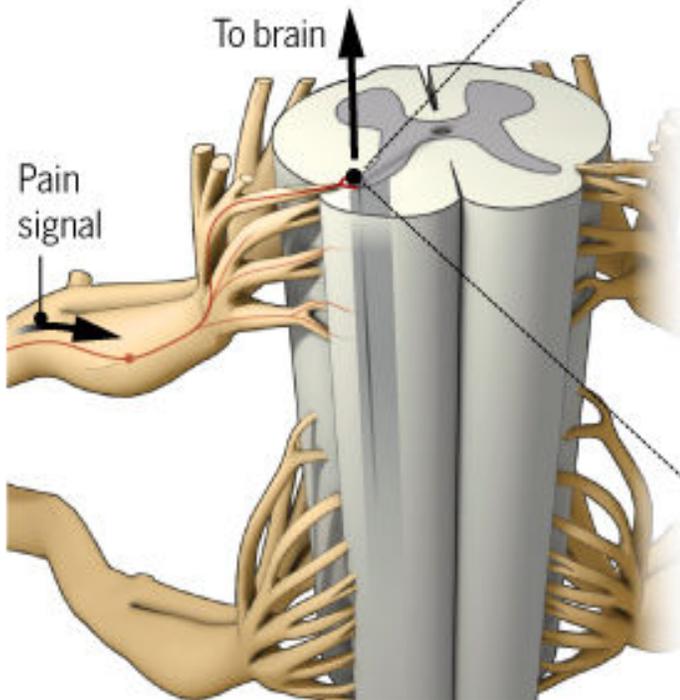
# Opioid-Induced Hyperalgesia

## Turning down the volume

Animal studies have revealed several ways in which opioids may amplify pain signals in the central nervous system, suggesting targets for drugs that could counter the effect.

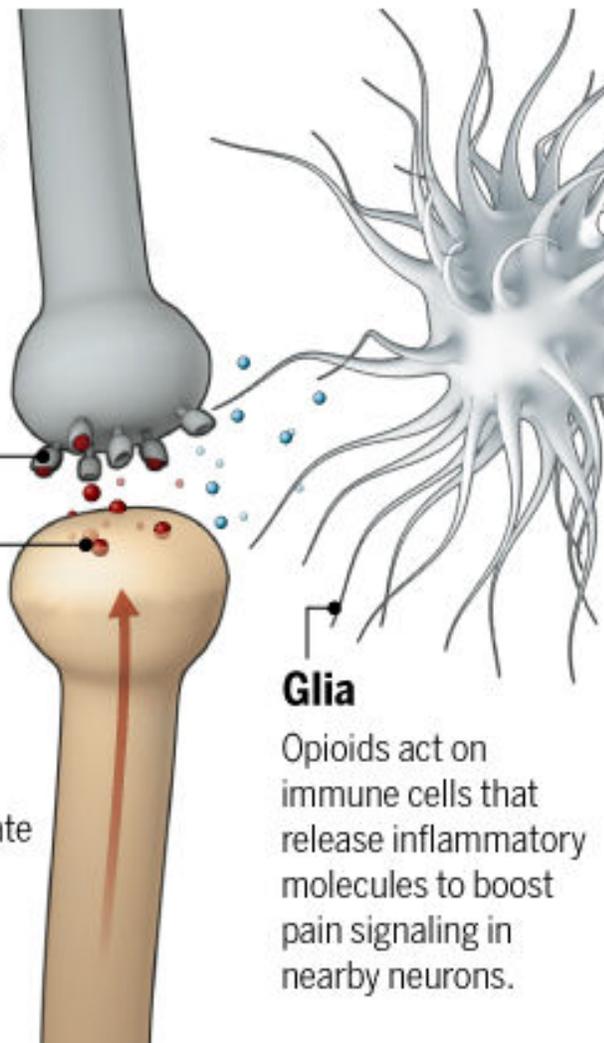
### Pain's waystation

In a column of gray matter of the spinal cord, chemical signals from nerves throughout the body excite neurons that project pain signals to the brain.



### NMDA receptors

As opioids stimulate spinal cord neurons, their N-methyl-D-aspartate receptors may become more sensitive to incoming pain signals.



### Glutamate

Nerves bringing pain signals from the body may respond to opioid stimulation by releasing more of the excitatory neurotransmitter glutamate in the spinal cord.

### Glia

Opioids act on immune cells that release inflammatory molecules to boost pain signaling in nearby neurons.

# Factors Associated with Opioid Treatment Failure

- Utilization of long term short-acting opioids
  - Large quantity of pills prescribed monthly
- Poor communication between patient and provider
  - Failure to clearly outline treatment goals and align expectations
  - Failure to monitor for misuse/problems associated with use
    - Urine drug screens, PMP checks, periodic behavioral/mental health/opioid use screening tests
- Tolerance → opioid-induced hyperalgesia
  - Opioid-induced hyperkatifeia (negative emotional state)
- Failure to adjust treatment plan according according to clinical course
- *Reluctance of patients/providers to consider buprenorphine as pain management alternative (usually due to lack of knowledge/understanding)*

# Factors Associated with Positive Treatment Outcomes

- Team approach
  - pain psychology or other counseling
  - pain education (consider utilizing **RN**)
  - PT/OT, any movement-based therapy
  - Acupuncture/massage/chiropractic/OMT
  - *Ideally the treatment team is communicating*
- Address patient concerns, create safe environment
- Empower patient to work on addressing other factors that impact pain
  - sleep, mood, activity level, nutrition, *substance use*
- Provide the patient with a “menu of options” for treatment
- Utilize S.M.A.R.T. goals
- Demonstrate empathy and support while revisiting and upholding shared goals and expectations
  - *Uncover and address any unrealistic expectations the pt may have (esp about role and effectiveness of medications)*

# Treatment of opioid dependence without OUD in chronic pain patients

- It may be reasonable to continue the usual opioid dose
  - Provide additional monitoring and support if attempts to taper result in a deterioration in function and quality of life
- **Buprenorphine should be offered to treat pain and opioid dependence**, and may obviate the need to continue patient's usual opioid dose or attempt taper
  - If presented confidently as a potentially preferable option, pt may choose it
  - Transition can be handled in multiple ways
- Utilizing the term 'opioid dependence' rather than 'opioid use disorder' where appropriate can help prevent stigma and possible employment/child custody/medical repercussions of an OUD diagnosis
  - Use this term in chart documentation and when seeking authorization for SL buprenorphine for pain

# Forces Are Mobilizing and Gaining Traction for Removal of the “X-waiver” for treatment of OUD

## [www.endsud.org](http://www.endsud.org)

- Grass roots campaign to push through federal legislation to fully remove restrictions from Rx'ing buprenorphine for all licensed independent practitioners to treat OUD

*“Talking Points” for benefits of removing X-waiver:*

[https://drive.google.com/file/d/19AarJB\\_MSy6NAnhTWkXxTP\\_aiRyaoonF/view](https://drive.google.com/file/d/19AarJB_MSy6NAnhTWkXxTP_aiRyaoonF/view)

*Contrary to some providers’ beliefs, there has never been a training or licensing requirement to prescribe buprenorphine for pain other than regular DEA license*

# Buprenorphine Background and Pharmacology Pearls for Providers and Chronic Pain Patients to Understand

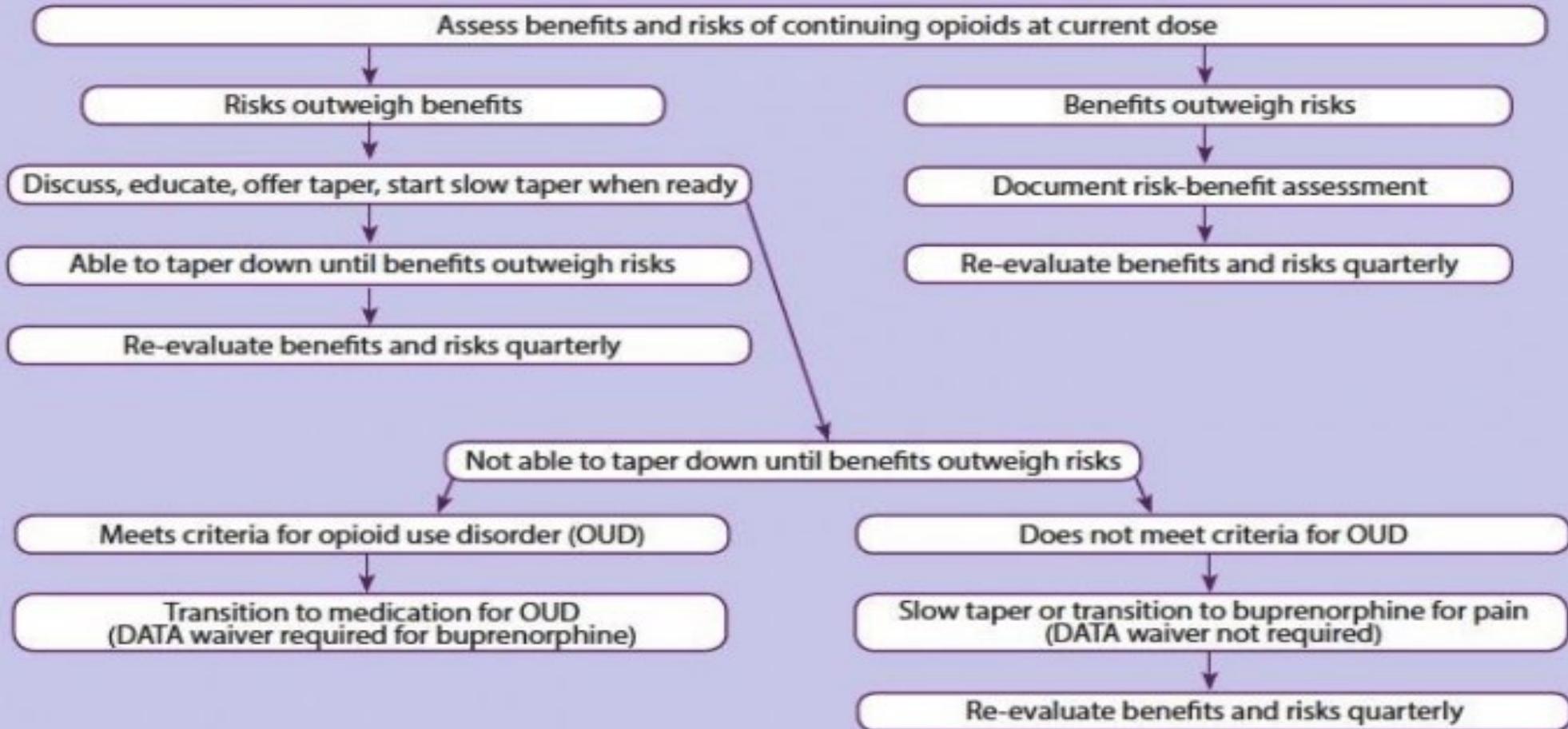
- Synthetic opioid used in pain since late 1980's, long before used to tx OUD
- Active metabolite norbuprenorphine does not cross blood brain barrier due to blocking effect of P-glycoprotein → limited CNS effects, ceiling on respiratory depression
- Potent mu OR agonist >50x morphine, **NO CEILING EFFECT FOR PAIN**
  - SL is the most potent of the products used in chronic pain, others are transdermal patch (weekly) and buccal BID film
  - Selecting best formulation to use for a given patient and clinical scenario is dependent on both clinical and non-clinical factors (ie insurance coverage)

# Buprenorphine Background and Pharmacology Pearls for Providers and Chronic Pain Patients to Understand

- All formulations are long-acting → even levels throughout the 24 hour cycle
- Kappa OR antagonist → “reboot” tolerance/hyperalgesia, anti-depressant effect
- Sodium channel blocker → additional anti-hyperalgesia
- Naloxone component of bup/nx products does not block other opioids, it is there to prevent misuse of buprenorphine (“abuse-deterrent”)

# Tapering Opioids for Chronic Pain

## Opioid Tapering Flowchart



Adapted from Oregon Pain Guidance. Tapering – Guidance & Tools. Available at <https://www.oregonpainguidance.org/guideline/tapering/>.

# When should tapering be strongly considered?

## Tapering Opioids for Chronic Pain

- No pain reduction, no improvement in function or patient requests to discontinue therapy
- Severe unmanageable adverse effects (e.g., drowsiness, constipation, cognitive impairment)
- Dosage indicates high risk of adverse events (e.g., doses of 90 MEDD\* and higher)

- Non-adherence to the treatment plan or unsafe behaviors\*\* (e.g., early refills, lost/stolen prescription, buying or borrowing opioids, failure to obtain or aberrant UDT\*\*)
- Concerns related to an increased risk of SUD\*\*\* (e.g., behaviors, age < 30, family history, personal history of SUD†)
- Overdose event involving opioids

- Medical comorbidities that can increase risk (e.g., lung disease, sleep apnea, liver disease, renal disease, fall risk, advanced age)
- Concomitant use of medications that increase risk (e.g., benzodiazepines)
- Mental health comorbidities that can worsen with opioid therapy (e.g., PTSD, depression, anxiety)

**Consider Tapering Opioid**



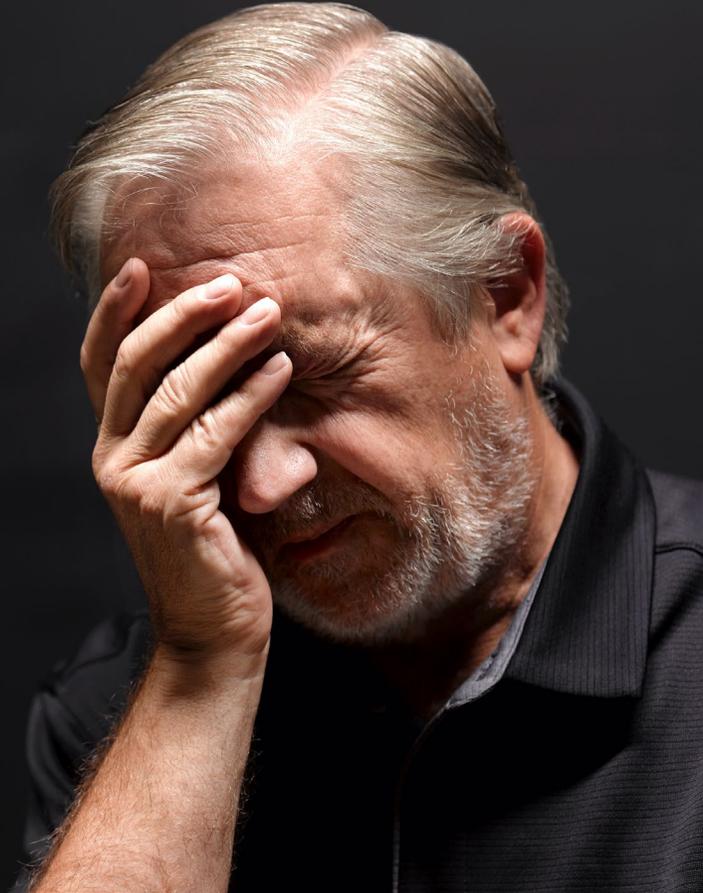
# Tapering Opioids for Chronic Pain

**2019 HHS Guideline** for clinicians on the appropriate dosage reduction or discontinuation of long-term opioid analgesics proposed:

- Opioids should not be tapered rapidly or discontinued suddenly due to the risks of significant somatic and emotional distress
  - Risks of rapid tapering or sudden discontinuation of opioids in physically dependent patients include acute withdrawal symptoms, exacerbation of pain, serious psychological distress, and thoughts of suicide
  - Patients may seek other sources of opioids, potentially including illicit opioids, as a way to treat their pain or withdrawal symptoms
- Unless there are indications of a life-threatening concern, such as warning signs of impending overdose, HHS does not recommend abrupt opioid dose reduction or discontinuation

[https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage\\_Reduction\\_Discontinuation.pdf](https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf)

# Opioid Withdrawal Management– *End Goal*



## *Considerations for formulation of taper plan:*

- *Determine if the initial goal is dose reduction or complete discontinuation*
  - If dose reduction, subsequent reassessment may indicate that complete discontinuation is preferable, or vice versa
  - Bup should be offered repeatedly
- *Speed of taper:*
  - Slower, more gradual tapers are often the most tolerable and can be completed over several months to years based on the opioid dose
  - The longer the duration of previous opioid therapy, the longer the taper may take

# Key Concepts for Better Outcomes

- Learn to navigate the gray zone between opioid use disorder (OUD) and opioid dependence without OUD
  - Get comfortable and confident discussing tolerance and opioid-induced hyperalgesia
  - Recommend buprenorphine for chronic pain, facilitate transition and stabilization
- Decide on treatment plan in collaboration with the patient
  - Assess their level of motivation and commitment to change/engage (use MI)
  - Empower pt to formulate own goals, verbalize and commit to them
- Avoid involuntary abrupt cessation of prescribed controlled substances
  - Help the patient to outline a safe, guided withdrawal/cessation plan if needed
- Encourage incorporation of counseling, intentional self-care, peer support, and safe, evidence-based non-pharmacologic treatment

# Withdrawal Management of Opioids – Examples

[https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain\\_Opioid\\_Taper\\_Tool\\_IB\\_10\\_939\\_P96820.pdf](https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf)



Example Tapers for Opioids <sup>3-9</sup>			
<p><b>Slowest Taper (over years)</b> Reduce by 2 to 10% every 4 to 8 weeks with pauses in taper as needed <i>Consider for patients taking high doses of long-acting opioids for many years</i></p>	<p><b>Slower Taper (over months or years)</b> Reduce by 5 to 20% every 4 weeks with pauses in taper as needed <b>MOST COMMON TAPER</b></p>	<p><b>Faster Taper (over weeks)<sup>****</sup></b> Reduce by 10 to 20% every week</p>	<p><b>Rapid Taper (over days)<sup>*****</sup></b> Reduce by 20 to 50% of first dose if needed, then reduce by 10 to 20% every day</p>
<p>Ex: morphine SR 90 mg Q8h = 270 MEDD <b>Month 1:</b> 90 mg SR qam, 75 mg noon, 90 mg qpm [5% reduction] <b>Month 2:</b> 75 mg SR qam, 75 mg noon, 90 mg qpm <b>Month 3:</b> 75 mg SR (60 mg + 15 mg) Q8h <b>Month 4:</b> 75 mg SR qam, 60 mg noon, 75 mg qpm <b>Month 5:</b> 60 mg SR qam, 60 mg noon, 75 mg qpm <b>Month 6:</b> 60 mg SR Q8h <b>Month 7:</b> 60 mg SR qam, 45 mg noon, 60 mg qpm <b>Month 8:</b> 45 mg SR qam, 45 mg noon, 60 mg qpm <b>Month 9:</b> 45 mg SR Q8h<sup>†</sup></p>	<p>Ex: morphine SR 90 mg Q8h = 270 MEDD <b>Month 1:</b> 75 mg (60 mg + 15 mg) SR Q8h [16% reduction] <b>Month 2:</b> 60 mg SR Q8h <b>Month 3:</b> 45 mg SR Q8h <b>Month 4:</b> 30 mg SR Q8h <b>Month 5:</b> 15 mg SR Q8h <b>Month 6:</b> 15 mg SR Q12h <b>Month 7:</b> 15 mg SR QHS, then stop<sup>††</sup></p>	<p>Ex: morphine SR 90 mg Q8h = 270 MEDD <b>Week 1:</b> 75 mg SR Q8h [16% reduction] <b>Week 2:</b> 60 mg SR (15 mg x 4) Q8h <b>Week 3:</b> 45 mg SR (15 mg x 3) Q8h <b>Week 4:</b> 30 mg SR (15 mg x 2) Q8h <b>Week 5:</b> 15 mg SR Q8h <b>Week 6:</b> 15 mg SR Q12h <b>Week 7:</b> 15 mg SR QHS x 7 days, then stop<sup>†††</sup></p>	<p>Ex: morphine SR 90 mg Q8h = 270 MEDD <b>Day 1:</b> 60 mg SR (15 mg x 4) Q8h [33% reduction] <b>Day 2:</b> 45 mg SR (15 mg x 3) Q8h <b>Day 3:</b> 30 mg SR (15 mg x 2) Q8h <b>Day 4:</b> 15 mg SR Q8h <b>Days 5-7:</b> 15 mg SR Q12h <b>Days 8-11:</b> 15 mg SR QHS, then stop<sup>††††</sup></p>

<sup>†</sup>Continue the taper based on Veteran response. Pauses in the taper may allow the patient time to acquire new skills for management of pain and emotional distress

# Opioid Withdrawal Management- *Setting*



## *Considerations for withdrawal management setting:*

- Utilize **outpatient** management for patients who
  - are prescribed opioids for pain who are “on board” with gradual taper or transition to buprenorphine
  - have no major active medical or psychiatric concerns that require round-the-clock monitoring during withdrawal
  - prefer outpatient setting
- Consider **inpatient** withdrawal management services for patients who
  - have intense fear of withdrawal
  - have active significant medical or psychiatric disorders
  - prefer inpatient setting, have an accessible venue
  - are using BZDs that would be best stopped (Rx’d or not) at the same time as opioids
  - are using alcohol at a level that may require withdrawal management
  - would benefit from efficient, supervised transition to buprenorphine using low dose initiation or direct transition

# Buprenorphine Initiation Strategies

## “Traditional”

- Period of abstinence
- Wait until moderate (or worse) withdrawal – usually 48-72 hours
- Then start at 2 mg & titrate to therapeutic dose

## Low Dose Initiation with Concurrent Full $\mu$ OR Agonist

- Eliminates need for period of abstinence
- Gradual initiation of low doses (0.5 mg) with slow up-titration
- Concurrent full  $\mu$ OR agonist is managing withdrawal
- Once at therapeutic dose of bup, stop full  $\mu$ OR agonist
- 5-10 days to therapeutic dose

## Rapid Low Dose Initiation

- Eliminates need for period of abstinence
- Start very low doses, every 3-4 hours, gradually increase dose
- “Sneak” on to the receptors
- Withdrawal symptoms managed with ancillary medications
- Minimizes full  $\mu$ OR agonist; may use as needed
- 2-4 days to therapeutic dose

Wong, James SH, et al. "Comparing rapid micro-induction and standard induction of buprenorphine/naloxone for treatment of opioid use disorder: protocol for an open-label, parallel-group, superiority, randomized controlled trial." *Addiction Science & Clinical Practice* 16.1 (2021): 1-10.

Ahmed, Saeed, et al. "Microinduction of buprenorphine/naloxone: a review of the literature." *The American Journal on Addictions* 30.4 (2021): 305-315.

# Terminology

“Low Dose Initiation”= OK

- Strategy for initiation
- goal to titrate to therapeutic dose
- More medically accurate

“Microdose”= Not OK

- Pharmacology term for subtherapeutic doses
- Lay media/literature: hallucinogen microdosing

Weimer, Melissa B., and David A. Fiellin. "Low-and very low-dose buprenorphine induction: new (ish) uses for an old (ish) medication?." *Addiction* 117.6 (2022): 1507-1509.

Google

microdose

Q All Shopping News Images Videos More



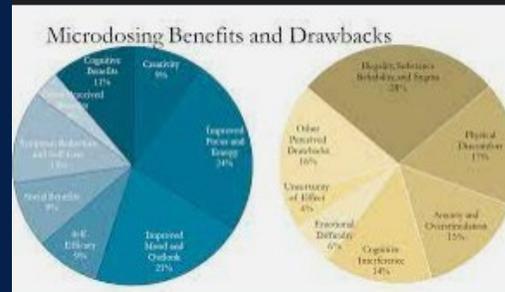
A Breakdown of Microdosing healthline.com



Microdosing: Definition, benefits, and ... medicalnewstoday.com



Microdosing: The people taking LSD with ... bbc.com



How and why people 'microdose' tiny ... cbc.ca



A Microdosing High is Mostly a Placebo ... technologynetworks.com



Microdosing Psychedelics Is Trendy, B ... forbes.com



Placebo effect may explain reported ...



Microdosing: A Complete Gu...



A Breakdown of Microdosing

# Current Novel Research in Buprenorphine LDI vs Standard Transition

- Current open-label, parallel-group, superiority, randomized controlled trial currently being conducted comparing rapid low dose initiation and standard direct transition technique protocols for buprenorphine naloxone
- *First study of its kind:*

> [Addict Sci Clin Pract.](#) 2021 Feb 12;16(1):11. doi: 10.1186/s13722-021-00220-2.

## **Comparing rapid micro-induction and standard induction of buprenorphine/naloxone for treatment of opioid use disorder: protocol for an open-label, parallel-group, superiority, randomized controlled trial**

[James S H Wong](#)<sup>1</sup>, [Mohammadali Nikoo](#)<sup>2</sup>, [Jean N Westenberg](#)<sup>2</sup>, [Janet G Suen](#)<sup>2</sup>,  
[Jennifer Y C Wong](#)<sup>2</sup>, [Reinhard M Krausz](#)<sup>2</sup>, [Christian G Schütz](#)<sup>3</sup>, [Marc Vogel](#)<sup>4</sup>, [Jesse A Sidhu](#)<sup>5</sup>,  
[Jessica Moe](#)<sup>6 7</sup>, [Shane Arishenkoff](#)<sup>8</sup>, [Donald Griesdale](#)<sup>9</sup>, [Nickie Mathew](#)<sup># 5 10</sup>,  
[Pouya Azar](#)<sup># 5</sup>

# Ancillary medication protocol for opioid withdrawal → transition to buprenorphine or naltrexone

> [Am J Drug Alcohol Abuse](#). 2018;44(3):302-309. doi: 10.1080/00952990.2017.1334209.

Epub 2017 Aug 10.

## **A novel non-opioid protocol for medically supervised opioid withdrawal and transition to antagonist treatment**

Gregory Rudolf <sup>1</sup>, Jim Walsh <sup>2</sup>, Abigail Plawman <sup>2</sup>, Paul Gianutsos <sup>3</sup>, William Alto <sup>3</sup>, Lloyd Mancl <sup>4</sup>, Vania Rudolf <sup>2</sup>

Scheduled dosing of:

- Tizanidine 4mg q6h
- Gabapentin 300mg q6h
- Hydroxyzine 50mg q6h

Plus Trazodone 50mg qhs or Mirtazapine 15mg qhs for insomnia

Dicyclomine 20mg q6h prn abdominal cramping

Ropinarole 1mg q8h prn restlessness

# Bup LDI Practical Techniques and Applications

*Consider for fentanyl, methadone, during convalescing phase of acute pain tx*

## ***LDI with chronic pain and OUD:***

- Use buprenorphine transdermal patch at the outset of induction
- Add ancillary meds for withdrawal
  - Bup does not need to do all the work!

## ***LDI for OUD without chronic pain***

- In United States cannot use buprenorphine transdermal patch without pain diagnosis
- Perform LDI with buprenorphine/naloxone film
  - Cut the 2 mg film into quarter (0.5mg) for BID dosing, then half (1mg), then full 2mg film BID
  - At this point the patient should be encouraged to stop other opioids (fentanyl) and use bup with other ancillary meds for withdrawal

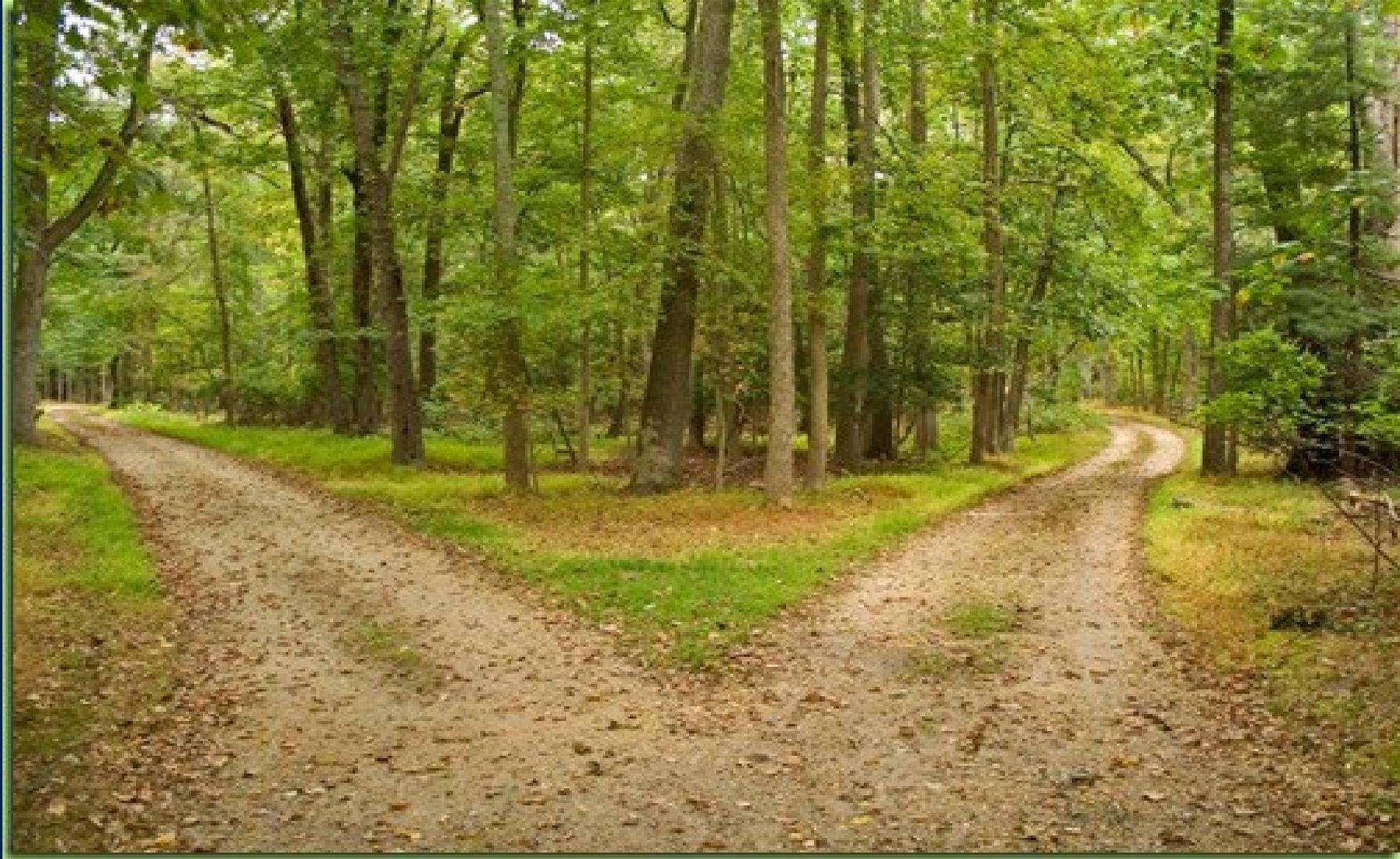
# Case 1: Ms. Olivia



73 yo female with h/o COPD, chronic opioid therapy for fibromyalgia

- Oxycodone 10mg q3-4h (6/day) for 15 years → MED 90
- Pain specialist demanded she present in person after 6 months of refills via telehealth → ride fell through, had to cancel same day
- Pts 42 yo son offered her oxycodone he got from an illicit source
- Pt now using pills from the street for past 2 weeks and believes they may contain fentanyl
- Presents with honesty back to pain medicine and UDS confirms fentanyl

How to proceed...?



# Buprenorphine Low Dose Initiation – Inpatient setting

## Buprenorphine solution (Buprenex™)

- 0.075mgSL/IV q4h x 2
- 0.15mg SL/IV q4h x 2
- 0.3mgSL/IV q4h x 2
- 0.6mg SL q4h x 2

OR

## Buprenorphine SL film/tab

- 0.5mg SL q4h x 2
- 1mg SL q4h x 2
- 2mg SL q4h x 2
- 4mg SL q4h x 2
- 8mg SL TID ongoing (OK to increase to QID)

1. Bup dose at least 24 hours from last fentanyl use
2. Scheduled ancillary medications until 24 hrs + on 8 mg SL TID

Tizanidine 4 mg Q6h

Hydroxyzine 50 mg Q6h

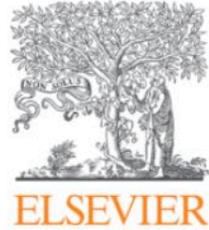
Gabapentin 300 mg Q6h

Mirtazapine 15 mg QHS

Dicyclomine 20 mg Q6h

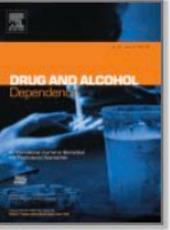
3. If using full agonist opioid: Hydromorphone 2-4 mg Q4h PRN COWS > 7

# Low Dose Buprenorphine Initiation– *Inpatient*



Drug and Alcohol Dependence

Volume 237, 1 August 2022, 109541



## Development of an intravenous low-dose buprenorphine initiation protocol

Lindsay A. Jablonski <sup>a</sup>  , Alia R. Bodnar <sup>b</sup>, Rosalyn W. Stewart <sup>b</sup>

- Cases were categorized based on adherence to a dosing strategy and LDI indication
  - OUD and acute pain
  - non-prescribed fentanyl exposure
  - transition from methadone

# Buprenorphine Formulations

<i>Dosage Form</i>	<i>Indications</i>	<i>Dosing</i>
Sublingual tablet or film	Opioid use disorder, Chronic pain	Induction then maintenance 6-32mg/day
Subcutaneous injection, extended-release	Opioid use disorder	300mg monthly x 2 months then 100mg monthly (Dose at least 26 days apart)
Subdermal implant	Opioid use disorder	4 implants in upper arm 12-24 hours after last transmucosal dose. Remove 6 months later. After one insertion in each arm, discontinue use.
Buccal film	Chronic pain	<u>Naïve</u> : 75mcg daily or Q12h if tolerated <u>Tolerant</u> : Taper to no more than 30mg MMED then 150mcg Q12h
IV solution	Acute pain management (immediate-release)	0.3mg every 6-8hrs as needed. May repeat initial dose once in 30-60 min
Transdermal patch	Chronic pain	<u>Naïve</u> : 5mcg/hr every 7 days <u>Tolerant</u> : Taper to no more than 30MMED then 10mcg/hr every 7 days



# Key Concepts for Better Outcomes

- Learn to navigate the gray zone between opioid use disorder (OUD) and opioid dependence without OUD
  - Get comfortable and confident discussing tolerance and opioid-induced hyperalgesia
  - Recommend buprenorphine for chronic pain, facilitate transition and stabilization
- Decide on treatment plan in collaboration with the patient
  - Assess their level of motivation and commitment to change/engage (use MI)
  - Empower pt to formulate own goals, verbalize and commit to them
- Avoid involuntary abrupt cessation of prescribed controlled substances
  - Help the patient to outline a safe, guided withdrawal/cessation plan if needed
- Encourage incorporation of counseling, intentional self-care, peer support, and safe, evidence-based non-pharmacologic treatment

# Questions?

*Please unmute yourself or submit your question  
in the chat box*

4:30-4:45 pm ET (15-mins)

BREAK

## Case 2: Mr. A



- Mr. A is a 65-year-old male who presents to your outpatient addiction medicine clinic as a transfer patient requesting continuation of his buprenorphine for co-occurring pain/OD
- His HPI is significant for
  - chronic pain secondary to arthritis, worst in B/L hips and knees
    - Has had 2 of those replaced, candidate for other 2 “if I can quit smoking” This Photo by Unknown Author is licensed under CC BY
  - daily alcohol use of 3-5 16 oz beers nightly
  - maintenance dose of buprenorphine 8 mg PO daily for opioid use disorder for the past 3 years after developed pattern of overusing Rx'd oxycodone
    - Smokes 1ppd since his 20s
- UDS is positive for EtG, buprenorphine

## Case 2: Mr A

- *What are your primary considerations/concerns?*
- *What questions should you ask this patient?*
- *What might be some of your treatment goals? Do they align with the patient's?*
- *What could be some of your first steps in the treatment process?*

# Alcohol Use Disorder & Chronic Pain

- Chronic pain is highly prevalent in people with alcohol use disorder
- Alcohol use disorder is considered a risk factor both for the development of chronic pain
  - Neurotoxic effects and vit B1 deficiency cause alcohol-induced PN
  - More severe and prolonged leads to higher risk, like 100g x years
    - Starts mild and progresses slowly, patients often do not detect until severe
    - Also affects ANS → abnormal heart rate, swallowing problems, sleep apnea, sexual impotence
- Patients with AUD and pain are also more likely to have concomitant opioid use

# Alcohol Use Disorder & Chronic Pain

## Treatment options:

- gabapentin (can help anxiety as well)
  - pregabalin
  - amitriptyline
  - duloxetine
- 
- Naltrexone (both ER-IM and daily oral) can be considered if concomitant OUD and AUD
    - Efficacy for treatment both disorders
    - “Low dose naltrexone” used for generalized CNS-mediated pain syndromes like fibromyalgia, may help alcoholic neuropathy

# Withdrawal Management of Alcohol

- Plan strategy based on final desired outcome, level of use, medical comorbidities
  - Some prefer to aim for controlled use in mild-moderate AUD
    - severe AUD advocate for abstinence
- Alcohol withdrawal potentially life-threatening (seizures, delirium tremens) → low threshold to recommend inpatient withdrawal treatment and rehab
  - Rule of thumb for expecting withdrawal is at least a 6 pack of beer, bottle of wine, or pint of hard liquor daily
    - Less for women than men, very variable
- Phenobarbital being used increasingly as a preferable withdrawal treatment strategy vs BZDs
  - Rapid onset, long half-life, linear pharmacokinetics, large therapeutic window
- Disulfiram can be effective in facilitating abstinence when the patient can not or will not admit for inpatient treatment and no active withdrawal concern
  - Outcomes better with daily observed dosing

# Withdrawal Management of Alcohol – *Outpatient*

- Patients who are in relatively good physical health
  - No significant medical comorbidities
- No history of seizures
- Responsible/reliable, strong support system
- Fixed-dose protocol
- Can be shorter in duration compared to outpatient
  - 3-5 day taper
  - long-acting sedative
    - Diazepam, chlordiazepoxide, clonazepam, phenobarbital
- Alternative short acting sedative
  - Lorazepam, oxazepam
    - Safer in patients with significant liver disease

# Withdrawal Management of Alcohol – *Outpatient*

- With either benzodiazepine or phenobarbital use same general procedure
- Provide loading dose
  - Depends on tolerance
- Take dose every 6 hours
  - e.g., phenobarbital 30 mg q6h
  - Can prescribe thirty 15 mg pills without refill
- See patient daily
- Maintain standing dose for 2-3 days then taper slowly
- 7-10-day taper is reasonable in most cases

# Withdrawal Management of Alcohol – *Outpatient*

- Anticonvulsants can be used as replacement or adjunct
  - Gabapentin, carbamazepine
    - Less abuse potential or prolongation of dependence compared to BZDs
    - Less evidence of effectiveness, less clinical use

# Withdrawal Management of Alcohol – *Outpatient*

- Recommended loading dose of sedatives
  - Phenobarbital 30 mg q6h
  - Diazepam 10 mg q6h
  - Chlordiazepoxide 25 mg q6h
  - Clonazepam 0.5 mg – 1 mg q6h

# Withdrawal Management of Alcohol- Outpatient Regimen with Phenobarbital

	<i>Day 1</i>	<i>Day 2</i>	<i>Day 3</i>	<i>Day 4</i>	<i>Day 5</i>	<i>Day 6</i>	<i>Day 7</i>	<i>Day 8</i>	<i>Day 9</i>	<i>Day 10</i>
6 am	15, 15	15, 15	15, 15	15, 15	15	15	15 Three Times A Day	15 Two Times A Day	15 Once A Day	15 Once A Day Every few days until cessation
12 pm	15, 15	15, 15	15	15	15					
6 pm	15, 15	15, 15	15, 15	15	15					
12 am	15, 15	15, 15	15, 15	15, 15	15, 15	15				

# Withdrawal Management of Alcohol – *Outpatient*

- Comfort medications
  - Anxiety/Irritability/withdrawal - gabapentin 300 to 600/800 mg
  - Anxiety – hydroxyzine 50mg q6h
  - Insomnia –trazodone 50 mg qhs, or mirtazapine 15mg qhs
  - Nausea- ondansetron 4-8mg

# Withdrawal Management of Sedatives (Benzodiazepines)

## ***When to taper benzodiazepines:***

- Any patient taking benzodiazepines daily for longer than one month, especially persons:
  - Older than 65 years (because of the risk of injury from falls and other cognitive adverse effects)
  - Taking multiple benzodiazepines, benzodiazepines combined with prescribed opioids or amphetamines, other CNS affecting drugs, or supratherapeutic/impairing dosages
  - With a cognitive disorder, history of traumatic brain injury, or current or history of substance use disorder, especially sedative-hypnotic or alcohol use disorder

# Implementing alternatives for anxiety with chronic pain/SUD

- Gabapentin/pregabalin
- Hydroxyzine
- Buspirone
- SSRIs (sertraline, citalopram)
- TCAs
- Beta Blockers
- Exercise
- Mindfulness/meditation/visualization
- Pain psychology counseling
- Nutritional balance
- Caffeine avoidance
- Smoking cessation

# Potential Contributors to Insomnia

## Potential Contributors to Insomnia

Medications/Substances that Interfere with Sleep <sup>23,24</sup>			
Alcohol	Caffeine	Thyroid Hormone	
Phenytoin	Central Nervous System Stimulants	Nicotine	
Anticholinesterase Inhibitors	Decongestants (e.g. pseudoephedrine)	SSRIs/SNRIs	
Bupropion	Diuretics	Theophylline	
SSRI = selective serotonin reuptake inhibitor; SNRI = serotonin norepinephrine reuptake inhibitor			
Co-Morbid Conditions that Interfere with Sleep <sup>23</sup>			
Asthma	Chronic Pain Disorders (e.g. arthritis, neuropathic pain)	Irritable Bowel Syndrome	Epilepsy
COPD	Cardiac (e.g. congestive heart failure, angina)	Reflux (GERD)	Parkinsons Disease
Sleep Apnea	Hyperthyroidism	Nocturia	Restless Legs Syndrome
Psychiatric Disorders			
Substance Use	Anxiety Disorders	Depression	PTSD
COPD = Chronic Obstructive Pulmonary Disease; GERD = Gastroesophageal Reflux Disease; PTSD = Posttraumatic Stress Disorder			

# Implementing Alternatives for Insomnia

- Melatonin
- Ramelteon
- Trazodone
- Mirtazapine
- Doxepin
- Hydroxyzine
- Exercise
- CBT
- Guided imagery
- Yoga
- Biofeedback
- Massage/acupuncture
  
- Avoid antipsychotics
- Discuss sleep hygiene

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## Session 6

# Be SMART: Partnering with Your Patients to Create Treatment Plans

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CNE

# Session Learning Objectives

1. Explain how developing SMART objectives and goals can be applied to pain and addiction treatment planning
2. Utilize treatment planning best practices with patient case examples
3. Practice asking patients prompting questions to develop a patient-centered treatment plan

# Behavior Change

- Behavior change is the *foundation of addiction medicine and integral in pain management*
- Change of thought patterns and behaviors are essential for effective treatment
- For successful treatment outcomes to take place, patients must often alter life-long behavior patterns

# Behavior Change

## *The transtheoretical model of behavior change*

- Six stages of change: precontemplation, contemplation, preparation, action, maintenance, and termination

## *Motivational interviewing*

- Incorporating certain qualities into the goal setting process makes them more likely to be achieved

# Benefit of Partnering With Patients

- ✓ Creates a sense of ownership and responsibility for their treatment outcomes
- ✓ Improved understanding of goals and outcomes
- ✓ Enhances confidence
- ✓ Improved patient experience
- ✓ Increased adherence to treatment plan
- ✓ Improved understanding of goals
- ✓ Allows patient know provider is willing to assist and they have support

# Introduction to SMART Goals

- First was utilized in 1981 - George T. Doran
- Utilized in setting measurable and achievable goals



Specific

Measurable

Attainable

Relevant

Time-Bound

# Introduction to S.M.A.R.T. Goals



Specific	Measurable	Attainable	Relevant	Time-Bound
Make sure your goals are focused and identify a tangible outcome. Without the specifics, your goal runs the risk of being too vague to achieve. Being more specific helps you identify what you want to achieve. You should also identify what resources you are going to leverage to achieve success.	You should have some clear definition of success. This will help you to evaluate achievement and also progress. This component often answers how much or how many and highlights how you'll know you achieved your goal.	Your goal should be challenging, but still reasonable to achieve. Reflecting on this component can reveal any potential barriers that you may need to overcome to realize success. Outline the steps you're planning to take to achieve your goal.	This is about getting real with yourself and ensuring what you're trying to achieve is worthwhile to you. Determining if this is aligned to your values and if it is a priority focus for you. This helps you answer the why.	Every goal needs a target date, something that motivates you to really apply the focus and discipline necessary to achieve it. This answers when. It's important to set a realistic time frame to achieve your goal to ensure you don't get discouraged.

# *S.M.A.R.T. Goals in Pain and Addiction Treatment Planning*

# S.M.A.R.T. - S

- S: Specific
- For a goal to be effective, it needs to be specific – be detailed
- A specific goal answers questions like:
  - What objective needs to be accomplished?
  - Who is responsible for it?
  - What steps will you take to achieve it?

# S.M.A.R.T. - M

- M: Measurable
- Specificity is a very practical start but does not include numerical metrics i.e., numbers
- Quantifying goals by ensuring there is a way to measure them allows them to be tracked so progress and the end point can be identified
- Incorporate benchmarks that can be measured and tracked

# S.M.A.R.T. - A

- A: Attainable
- Goals should be realistic — not something that just sounds ideal but also achievable
- Ensuring that the goal is within reach
- Consider any obstacles that might impede achievement of goal

# S.M.A.R.T. - R

- R: Relevant
- There should be a benefit to achieving the goal
- It should be aligned with other goals and desired outcomes
  - Fit into big picture of other goals
- evaluate why the goal matters to individual and those who matter to them
- Ensure that a “why” can be identified

# S.M.A.R.T. - R

- R: Realistic
- A SMART goal must be realistic
  - Is the goal within reach?
  - Is the goal achievable, given the time and resources?
  - Are you able to commit to attaining the goal?

# S.M.A.R.T. - T

- T: Time-bound/time-based/timely
- Good goals should have an endpoint
- Work with patient regarding when goal is to be accomplished
- Helps to prevent procrastination and avoidance of progression to goal
- Build in time-related parameters
- Include others who may need to partner with patient to achieve goal to also stay on track

# Utility of S.M.A.R.T. Mnemonic in Treatment Planning

- Helps ensure goals are achieved within a specific time frame
- Decreases sense of feeling overwhelmed by tasks
- Creates a straight-forward, easily replicable roadmap for successful goal achievement
- Provides way to engage patient, partner with them and elicit their input
- Empowers patient with tool they can use in other areas of life

# S.M.A.R.T. and Addiction Treatment

- Recovery is a multi-step and life-long process
- Recovery can be overwhelming and seem unattainable
  - May be something they have not ever succeeded at before
- Smart goals will help outline where to start and prioritize what to start with
  - Something to work towards
- Good to start with short terms goals
  - Patient able to experience success and celebrate achievements

# S.M.A.R.T. and Addiction Treatment

- Build confidence to work towards other goals
- Can couple with other strategies
  - Visualization
  - Motivational interviewing
  - Mindfulness
  - Acceptance and commitment therapy
    - Present Moment Awareness

# S.M.A.R.T. and Addiction Treatment

- S.M.A.R.T. GOALS
  - Aid in providing much needed stability and structure
  - Aids in avoiding depression, stagnation or hopelessness
  - Allow patients to enjoy the entire journey and the recovery experience
    - Relish improvements/ new feelings/new insights
  - Helps give life meaning and purpose

# S.M.A.R.T. and Addiction Treatment

- To increase probability of success in achieving the goals
  - Write goals down
  - Have patients share them with others who will aid in accountability
  - Do not expect perfection in achieving goals
    - Prepare for setbacks
    - Create alternate paths to achieve the same goal
  - Utilize a team approach
    - Make use of professionals in network
      - Psychotherapist, counselor, social worker, peer recovery coach, sponsor, medical provider

# S.M.A.R.T. and Pain Treatment

- Chronic Pain experience is complex, subjective and influenced by psychological, emotional and other external factors
- Allow patient to indicate what is important to them
- Unrealistic to indicate the absence of pain as goal
- Useful to set goals around function and behaviors rather than pain score
  - Avoid using pain intensity as goal
  - Consider physical, emotional, social aspects of function
- Create goals around quality-of-life indicators
  - Emotional stability
  - Sleep
  - Physical activity -Social and recreational activities

# S.M.A.R.T. and Pain Treatment

- Also focus on
  - Decreasing medications and reducing side effects
  - Changing maladaptive behavior
  - Correcting postural abnormalities
  - Weakness and overuse
- Partner with patient to document progress as patient may not notice improvements
- If a goal is not achieved modify/revise it
  - break it down into a smaller steps with short term goals
- Celebrate all progress even if it is slow

# *Recap/Integration of Course Content Into Treatment Planning*

# Case 1- Mr. M



## *Alcohol Use*

- Alcohol use started at age 13
- Daily drinking started in college
- Has had periods of sobriety over the years
- Last period of sobriety 2 years ago for 6 months
- Recently put on probation at work for absences
- Wife has asked to leave the family home “Don’t come back until you can stay sober”

# Large Group Discussion



## Case 1- Mr. M

- **Problem:** “I will lose my family if I do not stop drinking.”
- **Patient Goal:** Begin to resolve family conflict while maintaining a program free of substance use.

*What are some possible SMART objectives that could help this patient reach their goal?*

# Alcohol Treatment Plan

## Potential SMART Goals:

- Verbalize specific family conflicts that led to substance use and times substance use led to family conflict
- Complete a worksheet to review with family.
- Identify three non using friends to socialize with include activity and frequency
- Identify high stress situations with family that might lead to drinking and a plan for resolution

# Alcohol Treatment Plan

## Intervention:

- Explore relationship between substance use and family conflict during individual sessions using motivational interviewing and cbt;
- Assist with expanding social support that includes non using friends.

*Frequency: weekly 60-minute individual sessions Duration: 4 months*

## Case 2- Ms. L



### *Substance Use*

- Alcohol and THC use began in high school
- Prescription drug use after sports injury
- Began buying oxycodone from a “friend” about 3 years ago
- Cocaine use intermittently
- Two overdoses in the past 6 months
- Has had several attempts at recovery longest has been 3 months each attempt after an overdose
- Recently lost a close friend to overdose

# Large Group Discussion



## Case 2- Ms. L

- **Problem**: ““I'm addicted to drugs; it's something that's controlling my life.”
- **Patient Goal**: “I have to figure out a way to make recovery work”

*What are some possible SMART objectives that could help this patient reach their goal?*

# Recovery Treatment Plan

## Potential SMART Goals

- Explore previous recovery attempts including substances, length in recovery and previous treatment
- Identify triggers that can lead to relapse
- Develop new ways to cope with high-risk situations as evidenced by...
- Expand social support by identifying activities that are substance free

# Recovery Treatment Plan

## Intervention:

- Review the chemical use hx, and attempts at recovery.
- Assist in identifying triggers and educate about high-risk situations
- Address potential ambivalence through the use of MI and CBT
- Assist with expanding social support that includes non using friends,
- Generate ideas for social activities, including the benefits of a healthier lifestyle.

*Frequency: weekly 60-minute individual sessions Duration: 3 months*

## Case 3- Mr. N



## *Pain, Alcohol, and Opioids*

- Back injury 20 years ago
- Treatment was initially opioids
- Due to insurance restrictions “cut off” 2 years ago
- Had been an occasional drinker – no binging, no more than 2 at a time less than twice a week
- Since opioids stopped – drinking every day “to fall asleep liquor – fifth – 2 days
- In the past 9 months has been getting oxycodone 30 mg (30 pills a month) “from a lady friend”
- Alternating alcohol and opioids

# Large Group Discussion



## Case 3- Mr. N

- **Problem**: “My low back pain is just unbearable. The alcohol and drugs help relieve my pain.”
- **Patient Goal**: “I would really like to manage my pain in a healthier manner”

*What are some possible SMART objectives that could help this patient reach their goal?*

# Pain Treatment Plan Learning Activity

## Potential SMART Goals:

- Identify any triggers for the back pain and what may exacerbate it once it begins
- Initiate smoking cessation with specific quit date and methods as nicotine is known to exacerbate chronic pain
- Devise a diet and movement plan to lose 10 lbs over the next 3 months

# Sample Treatment Plan Learning Activity

## Intervention:

- Explore a history of abuse/neglect/trauma
- Identify thought patterns surrounding the pain that are destructive.
- Educate about sleep hygiene, diet and physical activity
- Address potential ambivalence using MI and CBT and work through any resistance;
- Assist with expanding community activities/engagement
- Recommend a good pain support group
- Benefits of a healthier lifestyle
- Explain opioid-induced hyperalgesia, sedation/cognitive defects

# Questions Appropriate for Treatment Planning

What would you like your life to be like: A month from now? 6 month? A year? 5 years?

What are your top three goals and objectives for treatment?

Have you tried to obtain these goals before?

What might be your greatest obstacles?

Who is supportive of you in this process/for these goals?

# Questions Appropriate for Treatment Planning

Who might be a hindrance or disagree with this treatment plan and objectives?

Do you have any fears or concerns about this process?

How to do you think I can best help and support you in achieving your goals?

Do you have any role models who have done what you plan to achieve?

Is anything unclear about this treatment plan?

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# Questions?

*Please unmute yourself or submit your question  
in the chat box*