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Intermountain Project ECHO
Pain Management
Behavioral Health and Difficult Conversations with Pain Psychology
August 2, 2022

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Disclosure

We have no financial interest to disclose
Objectives

At the conclusion of this activity, participants should be able to successfully:

1. Prepare to discuss opioid and substance abuse disorder diagnosis.
2. Create a plan to discuss care with a patient who is suicidal.
3. Demonstrate to de-escalate an angry patient.
Opioids, Pain and Substance Use Disorder
DSM-5 criteria for SUD

DSM-5 Diagnostic Criteria

Opioid use disorder is defined as two or more of the following within a 12-month period:

• Using larger amounts of opioids or over a longer period than was intended
• Persistent desire to cut down or unsuccessful efforts to control use
• Great deal of time spent obtaining, using, or recovering from use
• Craving, or a strong desire or urge to use substance
• Failure to fulfill major role obligations at work, school, or home due to recurrent opioid use
• Continued use despite recurrent or persistent social or interpersonal problems caused or exacerbated by opioid use
• Giving up or reducing social, occupational, or recreational activities due to opioid use
• Recurrent opioid use in physically hazardous situations
• Continued opioid use despite physical or psychological problems caused or exacerbated by its use
• Tolerance (marked increase in amount; marked decrease in effect)
• Withdrawal syndrome as manifested by cessation of opioids or use of opioids (or a closely related substance) to relieve or avoid withdrawal symptoms.

Tolerance and withdrawal criteria are not considered to be met for those taking opioids solely under appropriate medical supervision.

Severity of opioid use disorder is categorized as mild (presence of 2-3 symptoms), moderate (4-5 symptoms), or severe (6 or more symptoms).

Chronic Pain and Psychiatric Disorders

Prevalence of comorbid chronic pain and mental health disorders.

• At least one Mood/Anxiety disorder: 35%
  o Affective disorders: 13%
  o Anxiety disorders: 21%

• At least one Personality Disorder: 16%
  o Cluster A: 3% (Paranoid, Schizoid, Schizotypal)
  o Cluster B: 4% (Antisocial, Borderline, Histrionic, Narcissistic)
  o Cluster C: 9% (Avoidant, Dependent, Obsessive-Compulsive)

Psychiatric Conditions and Opioid Risk

Prevalence of comorbid substance use disorders (SUD) and mental health disorders.
• Life time prevalence: 29%
• Those with alcohol abuse: 37% also have mental health disorder.
• Those with drug abuse (other than alcohol): 53% also have mental health disorder.
• Approximately 60% of opiate dependence associated with lifetime prevalence of any mental disorder.
• Comorbidity of SUD and mental disorders was highest among those with:
  o Antisocial PD (30x increased risk of SUD)
  o Bipolar disorder (7x increased risk of SUD)
  o Schizophrenia (5x increased risk of SUD)
  o Panic Disorder (3x increased risk of SUD)

Bottom line: Patients in chronic pain should be assessed for psychological and substance use disorders because they are at increased risk for abusing opioids.

Case Study

Patient information:

• 41 year-old Caucasian female
• Chief complaint: low back and bilateral buttock pain, right leg pain, right neck pain
Case Study, cont.

History

• Psychiatric Disorders
  o **Psychiatrically hospitalized** for depression/suicidal ideation 3 years prior
  o **Dx:** Bipolar Disorder
  o **Psychotropic Rx:** Cymbalta, Seroquel

• Pain behaviors, coping and tolerance
  o **Pain described as** shooting, sharp, cramping, burning, aching, tender, tiring, sickening
  o **Pain Catastrophizing Scale** – elevated risk suggesting helplessness, symptom magnification, rumination over physical condition
Case Study, cont.

History, cont.

• Psychosocial Factors
  
  o **Early trauma:** Mother committed suicide when she was 9, significant neglect/isolation by father/step-mother
  
  o **Psychosocial stressors:** Marital stress related to medication use, Financial stress, Caregiver for nieces and nephews
  
  o **Substance abuse history:** Remote history of marijuana abuse, Drinks 2 times/year, Smokes 1.5 PPD since age 19
  
  o **SOAPP-R** score = 32 (high risk)
  
  o **OQ-45** results – elevated psychological distress
Case Study, cont.

Aberrant drug-related behaviors:
• Multiple minor aberrant behaviors following initial visit
• Rx: Suboxone (x-#) contingent on psych tx compliance

Treatment
• Individual psychotherapy
• NA attendance
• Group psychotherapy

Outcome
• Improved psychological distress
• Improved medication compliance
Opioid Risk Assessment

Subjective Data

- Psychiatric Disorders
  - Presence or history of psychiatric conditions
  - Psychotropic medications being prescribed
- Psychosocial Factors
  - Family background and history
  - Socio-economic/Legal history
  - Substance abuse history
  - Pain history
- Neuropsychological Factors
  - Acquired brain injury
  - Neurodegenerative diseases
  - Cognitive symptoms
- Pain behaviors, coping and tolerance
  - Adjustment to physical difficulties
Opioid Risk Assessment

Objective Data
- Screener and Opioid Assessment for Patients with Pain (SOAPP-R)
- PHQ-9 and GAD-7
- Current Opioid Misuse Measure (COMM)
- Substance Abuse Subtle Screening Inventory (SASSI-4)
- Brief Battery of Health Inventory (BBHI-2)
- Pain Catastrophizing Scale (PCS)
- UDS results
- DOPL report

Stratification of Risk
Formulation of psychological treatment plan
Occurrence of an aberrant drug behavior
Team Meeting
How well do we do?

REVIEW ARTICLE ON PREDICTING OPIOID MISUSE

OBJECTIVE:

To synthesize the evidence of published strategies for identifying at-risk patients to guide clinicians' decisions and practices for prescribing opioid treatment for chronic pain patients (CPP).

DATA SOURCES:

MEDLINE database search from 1966 to March 20, 2007 (about 41 years), related to screening for predictors of aberrant drug behaviors in CPP who were prescribed long-term opioids.

RESULTS:

We identified 6 published articles addressing clinician-based predictors of substance misuse of opioids and 9 published studies evaluating the predictive ability of clinical interviews and self-report measures for aberrant opioid behaviors in CPP.

Several attempts have been made to develop procedures to identify at-risk patients including urine toxicology screening, structured interviews, observation, and self-report questionnaires. In general, the psychometric properties of the published questionnaires and interview protocols are weak; moreover, the samples included in the studies are often small and unrepresentative. Thus, none of them can be recommended for use with any confidence.

How well do we do? There is HOPE!

OBJECTIVE: The ability to predict risk for violating opioid medication policies is critical for providing optimal treatment. Partially validated measures: the Screener and Opioid Assessment for Patients with Pain (SOAPP), the Diagnosis, Intractability, Risk, and Efficacy inventory (DIRE), and/or the Opioid Risk Tool (ORT). However, little is known about how these measures compare with each other in predicting aberrant drug-related behavior and discontinuance of opioid pain medications. The current study aimed to address this research question.

PATIENTS: Participants were 48 patients who attended a pain management center in Tennessee but were later discontinued from opioids for aberrant drug-related behavior. Patients referred for opioid medication for pain management participated in a semi-structured clinical interview with the staff psychologist and completed the aforementioned measures. Patients generally returned to the pain clinic on a monthly basis for medication management.

RESULTS: Analyses compared the sensitivity of each self-report measure and the clinical interview in predicting discontinuance for aberrant drug-related behavior. Results showed the highest sensitivity for the clinical interview (0.77) and the SOAPP (0.72), followed by the ORT (0.45) and the DIRE (0.17). Combining the clinical interview with the SOAPP increased sensitivity to 0.90.

CONCLUSIONS: Among patients who were discontinued from opioids for aberrant drug-related behaviors, the clinical interview and the SOAPP were most effective at predicting risk at baseline.

Poll:

Which one is NOT a risk factor for increased risk of opioid misuse or abuse?

- Psychiatric conditions
- History of personal or family substance abuse
- Childhood sexual abuse
- Chronic pain
- Use of meds for reasons other than indicated
Suicidality and Pain
CASE EXAMPLE:
80 year-old widowed female with multiple pain generators including migraine with aura and fibromyalgia. The patient has comorbid depression, anxiety and sleep-onset insomnia. Patient presents in her intake appointment stating that she often thinks about death. She would like to be with her husband again as her family does not seem to care about her. She does not believe there is any other way to decrease her pain. She has previously leaned on religious beliefs when coping with depression, but lately she has started to believe that God would not fault her if she took her own life. She has never attempted suicide or known anyone who has, but she states that she often thinks about overusing her medication, as she knows that this could stop her breathing and end her life.
Prevalence and Correlates:
-1 in every 5 adults attending primary care in any year have chronic non-malignant pain (1).
-Chronic pain was independently associated with lifetime suicidality after controlling for demographic, mental health and substance use disorders (3).
- Chronic pain patients found to be at least twice as likely to report suicidal behaviors and complete suicide (2).
- The odds of lifetime suicidality and suicidality in the past 12 months were 2-3 times greater in people with chronic pain (3).

Suicide and Opioid Tapering:
- In 2019 the FDA reported receiving reports of serious harm with sudden discontinuation/rapid taper of opioids in physically dependent patients. Harms included “serious withdrawal symptoms, uncontrolled pain, psychological distress, and suicide.”(1)
- Various studies demonstrate association between discontinuation of long-term opioid use and increased risks of suicide/self-harm and overdose. (2,3,4)
- Per HHS Oct 2019: “There are serious risks to noncollaborative tapering in physically dependent patients, including acute withdrawal, pain exacerbation, anxiety, depression, suicidal ideation, self-harm, ruptured trust, and patients seeking opioids from high-risk sources” (5)

Risk Factors for Suicidality in Chronic Pain:
- Meta-analysis identified eight risk factors for suicide in chronic pain patients, 4 general and 4 pain-specific (1):
  - family history of suicide, previous suicide attempt, being female, presence of comorbid depression, location and type of pain (widespread body pain, migraine with aura, abdominal pain), high intensity pain, long pain duration, comorbid insomnia
- Suicidality is more related to psychosocial factors than physical factors, such as pain characteristics and physical status (2).
- Psychosocial factors: employment, depression, anger, harmful health habits, childhood or adulthood adversity, family history, mental defeat, pain catastrophizing, hopelessness, perceived burdensomeness and thwarted belongingness (2).

# Assessing Suicide Risk:

<table>
<thead>
<tr>
<th>AREAS TO ASSESS</th>
<th>DETAILS ON INQUIRY AND DOCUMENTATION</th>
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</thead>
</table>
| Risk Factors    | - Current/past psychiatric diagnoses: Especially mood disorders, psychotic disorders, alcohol/substance abuse, cluster B personality disorders. Comorbidity and recent onset of illness increase risk  
- Key symptoms: Anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations  
- Suicidal behavior: Hx of prior suicide attempts, aborted suicide attempts or self-injurious behavior  
- Family hx: Of suicide, attempts of suicide, psychiatric diagnoses requiring hospitalization  
- Precipitants/stressors: Triggering events leading to humiliation, shame or despair, ongoing medical illness (especially CNS disorders, pain), hx of abuse or neglect, intoxication  
- Access to firearms |
Assessing Suicide Risk, cont.:

<table>
<thead>
<tr>
<th>AREAS TO ASSESS</th>
<th>DETAILS ON INQUIRY AND DOCUMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protective Factors:</td>
<td>Internal: Ability to cope with stress, religious beliefs, frustration tolerance, absence of psychosis</td>
</tr>
<tr>
<td></td>
<td>External: Responsibility to children or beloved pets, positive therapeutic relationships, social supports</td>
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</table>
### Assessing Suicide Risk, cont.: AREAS TO ASSESS

<table>
<thead>
<tr>
<th>AREAS TO ASSESS</th>
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</table>
| Suicide Inquiry | Ideation: Frequency, intensity, duration - in last 24 hours, past month and worst ever  
Plan: Timing, location, lethality, availability, preparatory acts  
Behaviors: Past attempts, aborted attempts, rehearsals (typing note, leading gun), versus non-suicidal self-injurious actions  
Intent: Extent to which the patient 1) expects to carry out the plan and 2) believes the plan/act to be lethal vs self-injurious - explore ambivalence, reasons to die vs reasons to live  
Homicidal Inquiry: When indicated, especially postpartum, and in character disordered or paranoid males dealing with loss or humiliation, inquire in four areas listed above. |
## Stratifying suicide risk:

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Risk/Protective Factors</th>
<th>Suicidality</th>
<th>Possible Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant</td>
<td>Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal</td>
<td>Admission generally indicated unless a significant change reduces risk. Suicide precautions.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Multiple risk factors, few protective factors</td>
<td>Suicidal ideation with plan, but no intent or behavior</td>
<td>Admission may be necessary depending on risk factors. Develop crisis plan, give local/national emergency info</td>
</tr>
<tr>
<td>Low</td>
<td>Modifiable risk factors, strong protective factors</td>
<td>Thoughts of death, no plan, intent, or behavior</td>
<td>Outpatient referral, symptom reduction, give local/national emergency info</td>
</tr>
</tbody>
</table>

**Document:** rationale for risk level, the treatment plan to address/reduce the current risk (e.g. medication, setting, contact with significant others, consultation) and firearm instructions, if relevant.
Poll:

Which of the following is NOT a risk factor for suicidality in chronic pain patients

A. Family history of dementia.
B. Childhood or adulthood adversities.
C. Pain catastrophizing, hopelessness, perceived burdensomeness and thwarted belonging
D. Anger problems
E. Comorbid insomnia
Anger, Aggression, Violence and Pain
CASE EXAMPLE:
43 year-old woman with chronic abdominal pain, arrived at her first visit with a new primary care physician. She felt that her prior doctors had not adequately addressed her pain or completed a thorough workup. She was convinced that she had Crohn’s disease and was angry because her physicians had not agreed with her diagnosis. After the new physician took a history and determined that Crohn’s disease was unlikely, she became agitated and declared, “No one listens to me. I know my body better than all of you.”
Definitions:
Anger – A negative emotional state that is generally accompanied by physiologic arousal and antagonistic thoughts directed toward a person or object viewed as the cause of an adverse event. (Among psychiatric patients, anger is one of the strongest predictors of aggression) (1)
Aggression – A hostile behavior or threat of attack (7)
Violence – Use of physical force, verbal abuse, threat or intimidation, which can result in harm, hurt or injury to another person (7)

Anger and Pain (1):
- Higher anger expressions have been linked with decreased experimental pain tolerance and greater reported pain intensity in headache, fibromyalgia, CRPS, back pain and other pain conditions
- Higher anger expression has been linked with detrimental health behaviors, maladaptive coping responses, poor sleep quality, less social support, greater interpersonal conflict
- Anger is associated with elevated anxiety and depression symptoms

Anger and Pain, cont.:
- Study (1): 96 chronic pain patients completed questionnaire to evaluated levels of anger, pain, distress and disability.
  - 70% reported angry feelings
  - 74% of those reported anger at themselves
  - 62% of those reported anger at health care professionals
  - Anger toward self was associated with elevated pain and depression symptoms
  - Overall anger was associated with perceived disability

• Why Learn to Identify and Appropriately Respond? (1)
  - disruption the doctor-patient relationship
  - missed appointments
  - less adherent to medication regimens
  - worse health outcomes
  - contributes to many malpractice suits (when physicians and hospitals address patient anger by admitting mistakes and apologizing, the rate of malpractice lawsuits declines)

The Continuum of Anger (1):
1. Calm and nonthreatening: a patient may be frustrated but fail to show overt signs of agitation (capable of thinking logically and responding appropriately)
2. Verbally agitated: Verbal and behavioral agitation noted. (E.g., A patient may say, “This is ridiculous. I can’t believe I have been sitting in here for 45 minutes,” as he or she paces while waiting for physician who is running later.)
3. Verbally hostile: Language is more targeted (E.g., A patient may shift from offering phrases of discontent to unkind phrase such as “this doctor is incompetent and this entire practice is a sham.”)

The Continuum of Anger, continued:

4. Verbally threatening: Making demands or threats (E.g., A patient may demand an apology or threaten to sue.)
5. Physically threatening: Body language becomes aggressive (E.g., A patient may take a fighter’s stance and make fist)
6. Physically violent: A violent behavior is enacted (E.g., A patient may throw a punch at a provider)

Factors in Angry Patient Situations:

<table>
<thead>
<tr>
<th>PROVIDER FACTORS</th>
<th>PATIENT FACTORS</th>
<th>SYSTEMIC FACTORS</th>
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<tbody>
<tr>
<td>Misdiagnosis, medical error</td>
<td>Chronic pain</td>
<td>High cost of care</td>
</tr>
<tr>
<td>Poor bedside manner</td>
<td>Substance use</td>
<td>Lacking physician education on how to manage patient anger</td>
</tr>
<tr>
<td>Giving bad news</td>
<td>Underlying illness</td>
<td>Physician burnout</td>
</tr>
<tr>
<td>Running late</td>
<td>Not feeling listened to</td>
<td>Systemic inefficiency</td>
</tr>
<tr>
<td>Poor communication</td>
<td>Cultural/ religious misunderstandings</td>
<td>Unaddressed complications/ side effects from treatment</td>
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<tr>
<td>Lack of responsiveness</td>
<td>Psychosocial stressors in patient’s life</td>
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<tr>
<td>No acknowledging or exploring a patient’s belief</td>
<td>Anger over difficult diagnosis</td>
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<tr>
<td></td>
<td>Transference</td>
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<td></td>
<td>Low anger threshold</td>
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</table>

Factors in Angry Patient Situations, cont.:

<table>
<thead>
<tr>
<th>MEDICAL CAUSES</th>
<th>SUBSTANCE-RELATED CAUSES</th>
<th>PSYCHOSOCIAL CAUSES</th>
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</thead>
<tbody>
<tr>
<td>Alzheimer’s disease</td>
<td>Steroids</td>
<td>Mania or depression</td>
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<tr>
<td>Hypothyroidism</td>
<td>Methamphetamine</td>
<td>Pain</td>
</tr>
<tr>
<td>Hypoglycemia</td>
<td>Phencyclidine</td>
<td>Personality disorder</td>
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<tr>
<td>Insomnia</td>
<td>Alcohol intoxication</td>
<td>Posttraumatic Stress disorder</td>
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<td>Lead poisoning</td>
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<td>Pemenstraldysphoric disorder</td>
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<td>Temporal lobe epilepsy</td>
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<tr>
<td>Traumatic brain injury</td>
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<td>Delerium</td>
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De-escalation Techniques:

<table>
<thead>
<tr>
<th>COMMUNICATION</th>
<th>APPROACHES</th>
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<tbody>
<tr>
<td>Behavior: respect personal space, keep a safe distance, avoid touching patient, neutral posture, sincere eye contact, stay at same height as patient, avoid sudden movements</td>
<td>De-escalation: acknowledge grievance and frustration, focus on solving problem</td>
</tr>
<tr>
<td>Verbal: speak in a calm, clear manner, personalize yourself, avoid confrontation, offer to solve the problem</td>
<td>Align goals: emphasize common ground, focus on big picture, find ways to make small concessions</td>
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<td></td>
<td>Monitoring: be aware of progress, know when to disengage, don’t insist on having the last word, have staff member sit with the patient</td>
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</table>
Poll:

Which of the following is NOT a de-escalation technique suggested for working with angry patients?

A. Acknowledge the patient’s grievance and frustration
B. Emphasize common ground
C. Insist on having the last word
D. Have a staff member sit with the patient
E. Find ways to make small concessions
Bibliography/References


7. HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics. U.S. Department of Health and Human Services, October 2019


