An MET/CBT Approach: Managing Pain, SUD Risk Reduction and Recovery

Joe Hyde LMHC, CAS
Technical Expert Lead
JBS International, Inc.

1

Welcome!!!!

Introductions:

- Name
- Your organization and role
- One interesting fact about yourself most people don't know

2

Workshop Ground Rules

- Participate Actively
- Ponder and Ask Questions
- Listen to Others
- Respect Confidentiality
- Work Hard
- Have FUN!
- Be respectful of others
- Be here, be prepared to stay the whole time
- While in training please turn off cell phones, texting, facetiming, face bookings and other such devices or apps.

3

What is

- **Chronic pain** is defined as pain that lasts three months or longer and interferes with functional status and quality of life.
- **Functional status** is an individual's ability to perform normal daily activities required to meet basic needs, fulfill usual roles, and maintain health and well-being.

Why?

- Is increasing your knowledge and counselor skills regarding pain and SUD important for you?

4

Why is it important

- An estimated 50 million Americans and more than one third of SUD treatment seeking adults experience moderate to severe chronic pain. (IOM 2011, Nahin 2015).
- This training address the behavioral health needs of "pain" patients with concerning substance use behaviors using action oriented evidence based practices.

5

What Makes Chronic Pain So Difficult For Clinicians?

- There is no cure for it (even successful treatment involves some residual pain)
- The help seeking, help rejecting stance of many patients. "My pain is at a 10, so don't ask me to do those morning stretches."
- Negative feedback loop…"You're not helping me!"…. makes it very unrewarding for the provider
- Fear of contributing to or enabling opioid use disorder, addiction and diversion with possible legal sanctions against the prescriber

6

What Makes Chronic Pain So Difficult For the Patient?

- Pervasive sense of isolation
- Loss of contact with a "normal day"
- Perception that others do not believe the pain is real
- Perception of being promised one thing (a cure), but delivered something far less by the medical establishment with an erosion of trust and confidence.
- Perception of being viewed as an "addict" by others because of dependency on narcotics
- Criticism from family members and friends for variable day to day performance
- Self criticism for not being able to "rise above the pain"
- Co-morbid depression, anxiety and SUD

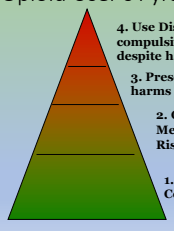
7

The Cycle of Uncontrolled Pain

Pain patients are a vulnerable population at high risk associated with their use of opioids and/or other substances and cooccurring mental issues.

8

Pain Patient Opioid User's Pyramid



4. Use Disorder (4 Cs: Loss of control, compulsive use, craving, continued use despite harm)

3. Prescription Drug Misuse (recurrent harms related to use)

2. Concerning (Aberrant) Medication Taking Behaviors &/or Risk Factors

1. Low Risk Patient with No Concerning Behaviors

P. Seale et al 2013

9

Concerning Medication Taking Behaviors

- Multiple "lost" or "stolen" opioid prescriptions
- Poor-adherence with monitoring requests (e.g. pill counts, urine drug tests)
- Deterioration in function at home and work
- Resistance to change of opioid therapy despite adverse effects (e.g. over-sedation)
- Running out early (i.e., unsanctioned dose escalation)
- Requests for specific opioid by name, "brand name only"
- Requests for increased opioid dose
- Poor follow through with recommended therapies (e.g., physical therapy, behavioral therapy, etc.)
- Illegal activities – forging scripts, selling opioid prescription, buying drugs from illicit sources
- Multiple Prescribers

Butler et al. Pain. 2007

10

So what to do

Increasingly Medical Providers are Exploring Team Based Approaches:

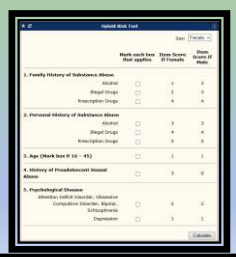
- Integrating medical and behavioral interventions within a single or coordinated care plan
- More assertive and integrated BH support and monitoring for
  - Patients managed on opioids longer than 30 days
  - Patients with known risk factors
- Increased use of non-opioid and non-pharmacological therapies

11

Screening for Risk Factors

Known risk factors for all types of SUD are **good predictors** of risk for problematic prescription opioid use

- ORT: Opioid Risk Tool
- AUDIT
- DAST
- ASSIST
- PHQ2/9
- GAD7



12

Monitoring Frameworks *as part of counseling*-- Why Use One?

Increasing evidence that structured care can assist patients in reducing or resolving concerning behaviors and improves outcomes.

In addition to monitoring for substance use, counselors should routinely check in on pain, pain interference and cooccurring issues.

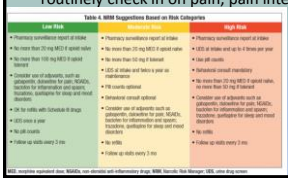


Table 4. MRM Suggestions Based on Risk Categories

Low Risk	Moderate Risk	High Risk
• Pharmacy surveillance report at intake • No more than 20 mg MED if opioid naïve • No more than 100 mg MED if opioid tolerant • Consider use of adjuvants, such as gabapentin, duloxetine for pain, NSAIDs, baclofen for inflammation and spasm, trazadone, quetiapine for sleep and mood disorders • Rx for refills with Schedule III drugs • UDS once a year • No pill counts • Follow up visits every 3 mo	• Pharmacy surveillance report at intake • No more than 20 mg MED if opioid naïve • No more than 50 mg if tolerant • UDS at intake and twice a year as maintenance • Pill counts optional • Behavioral consult optional • Consider use of adjuvants such as gabapentin, duloxetine for pain, NSAIDs, baclofen for inflammation and spasm, trazadone, quetiapine for sleep and mood disorders • No refills • Follow up visits every 3 mo	• Pharmacy surveillance report at intake • UDS at intake and up to 4 times per year • Use pill counts • Behavioral consult mandatory • No more than 20 mg MED if opioid naïve, no more than 50 mg if tolerant • Consider use of adjuvants such as gabapentin, duloxetine for pain, NSAIDs, baclofen for inflammation and spasm, trazadone, quetiapine for sleep and mood disorders • No refills • Follow up visits every 3 mo

MED, morphine equivalent dose; NSAIDs, non-steroidal anti-inflammatory drugs; MRM, Narcotic Risk Manager; UDS, urine drug screen

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

13

Ongoing Monitoring: Why We Do It

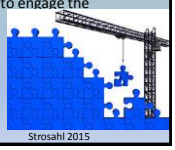
- Focus on patient safety
- Focus on improving functional Status
- Adoption of health promoting coping skills
- Early identification and intervention of concerning behaviors

14

14

Pain Intervention and Counseling Framework

- Pain (just like SUD) must be assessed and treated within a biopsychosocial framework
- The goal of treatment is not the elimination of pain, but the restoration of functioning and to maximize quality of like
- Any treatment that is not improving functional status should not be continued
- Evidence based care is the strongest platform from which to engage the patient
- Ongoing monitoring of whole person functioning
- Team communication



Strosahl 2015

15

Defining Treatment Goals

- Work with patient to identify **specific, measurable, realistic,** and functional goals
- **Improved Functional Status and Improved Quality of Life is the Primary Goal of Treatment and Recovery**
  - In this context: pain, substance misuse and SUD are viewed as major barriers to successful recovery
- Use these goals collaboratively to measure benefit

16

16

Our Counseling Focus: Evidence Based Behavioral Interventions for Pain and SUD

- Motivational Interviewing/Motivation Enhancement
- Cognitive Behavioral Therapy with behavioral activation
- Mindfulness/Mediation
- Yoga
- Appropriate regimens of exercise aimed at stretching and limbering

17

An MI/CBT Approach to Pain and SUD

- Medications alone are rarely enough to successfully manage chronic pain.
- Evidence based interventions for SUD and Pain
- Helping clients understand and accept the new personal reality
- Adequate coping skills are viewed as essential for successfully managing pain and SUD treatment and recovery
- Common goals of maximizing functional status and quality of life.

18

Getting Started

- A biopsychosocial/integrated care model is generally thought to be the most useful and effective approach.
- A care plan should include ongoing patient evaluation and monitoring, communication with medical provider re: prescription medications, exercise and other treatments informed by a physical therapist or MD, and motivational enhancement and cognitive behavioral treatment by a behavioral health provider.
- This approach aligns with the Center for Disease Control and Prevention Guideline for prescribing Opioids for Chronic Pain.

19

Behavioral Health Concerns of Pain Patients

- *Depression and Anxiety*
- *Concerning Medication Behaviors and other substance misuse and abuse*
- *Isolation and diminished social connectedness*
- *Inadequate coping skills*
- *Loss of Purpose*

20

Counseling Issues

- Insufficient social supports, coping skills deficits and co-occurring conditions critically influence treatment retention and sustained abstinence from opioids and other substances.
- The clinician is encouraged to have the patient complete the substance use awareness session (i.e., functional analysis), to gain a further understanding of opioid and other substance use and what are contributing factors to address in change plan activities.

21

MI/CBT Multiple and Interrelated Strategies

- Rapport and Collaboration
- An evidence based delivery framework that includes behavioral activation
- Patient driven individualized care
- Ongoing motivational enhancement
- Self awareness and mindfulness
- Activation
- Skill building in communication, problem solving, managing uncomfortable feelings and thoughts, mindfulness and meditation
- Enhanced social supports
- Healthy replacement activities

22

An evidence based counseling delivery framework that includes behavioral activation

First Third	Second Third	Third Third
Rapport Review of progress Review of home practice	Provide rationale and teach skills Model role-play and practice *In session activation* Provide patient demonstration	Summarize Assign real-life practice Get commitment

23

Opening Activity: an MI warmup

MI Warmup

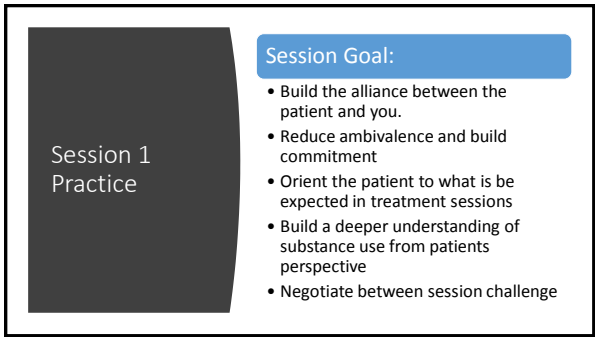
- An activity you truly enjoy and would like to do more often
- Dyads
- Interviewer – OARS only with a twist…..
- Interviewee
- 5 minutes each person
- Understand the essence
- Be curious in a deep way!

24

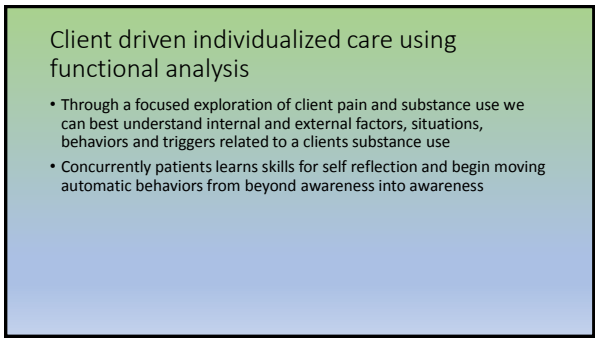
24


Rapport and Collaboration and Ongoing Motivational Enhancement
Session 1.
All your (MI) Skill building engagement and collaboration

25


Session 1 Practice
Session Goal:
• Build the alliance between the patient and you.
• Reduce ambivalence and build commitment
• Orient the patient to what is be expected in treatment sessions
• Build a deeper understanding of substance use from patients perspective
• Negotiate between session challenge

26


Client driven individualized care using functional analysis
• Through a focused exploration of client pain and substance use we can best understand internal and external factors, situations, behaviors and triggers related to a clients substance use
• Concurrently patients learns skills for self reflection and begin moving automatic behaviors from beyond awareness into awareness

27

Specifics of the Awaremenss Records

Content: What happens? When it happens, what do you think, remember, imagine, feel, or do?

Context 1 (obvious): When does it happen? Where? With whom (if anyone)? With what consequences?

Context 2 (not so obvious): How does it relate to your thoughts, feelings or beliefs about how things are or ought to be?

28

Exercise: Using the Self Awareness Record

- Builds awareness and understanding for client and counselor
- Individualized Care

29

Individualizing Care:

Tailored Treatment Based on Functional Analysis

Internal and external factors/triggers

- Limited Network of Support
- Interpersonal Functioning
- Inadequate Coping Skills
- Social Isolation
- Limited Self Awareness
- Problem Solving Ability
- Replacement Activities
- Managing Uncomfortable Thoughts and Feelings
- Symptoms of Depressions

Skills focused Sessions

Behavioral Activation
Learning Assertive Communication
Supporting Recovery through Enhanced Social Supports
Heathy Replacement Activities
Problem Solving
Handling Urges, Cravings, and Discomfort (Urge Surfing)
Making Important Life Decisions
Enhancing Self-Awareness, Mindfulness and Meditation
Working with Thoughts
Working With Emotions: Fostering Some, Dissolving Others
Having a daily and weekly plan
Use of Medication in Support of Treatment and Recovery
Engagement With Self-Help

Care Coordination with other members of the team

30

Treatment Planning

- A pain/quality of life (QOL) functional analysis process, similar to that of substance use awareness record.
- The patient and the clinician gain a nuanced understanding of how chronic pain effects the patients functioning and QOL.
- Guides care planning and session delivery

31

Clinical Sessions

32

Behavioral Activation
We are what we do. We do what we choose.
Alan Wheelis

- Behavioral activation (BA) (an evidence based practice) based on the belief that the best way to make positive change is to become aware of the a) life areas that are most important to you, 2) your values in those life areas, and 3) choose activities you can and will do to live according to your values.
- For treatment and recovery BA is a necessary ingredient
- BA should be part of every session
- Accountability

33

Activities in our Daily Lives

- The daily activities of our lives provide structure, happiness and social connections and are often disrupted associated with our pain conditions.
- Rebuilding is essential to recovery.
- Routine Activities, Necessary Activities, Pleasurable, Mastery and "Moving Ahead" Activities

34

Clinical Session: Building Positive Weekly Structures

Session activities

- Reestablish rapport and check in
- Discuss session rationale
- Briefly review and discuss types of activities
- Complete weekly plan using the 4-step process handout
- Negotiate between-session challenge
- Summarize and conclude the session

35

4 Steps of Weekly Planning

- Create a list of Routine, Necessary and Pleasurable Activities
- Schedule the activities using a blank weekly planner including some from each category
- Commit to doing the activities
- Review the week with someone who will help you be accountable
- Negotiate a between session challenge that the patient will complete at least 90% of the activities committed to in this week's plan.

36

Building Positive Weekly Structures

Practice Session

37

Mindfulness

- Mindfulness is the ability to be present, aware of where we are and what we're doing, feeling or thinking and not being overly reactive by what's going on within or around us.

38

Skills in communication, problem solving, managing uncomfortable feelings and thoughts

Learning Assertive Communication
Problem Solving
Making Important Life Decisions

39

Enhanced social supports

- Supporting Recovery through Enhanced Social Supports
- Engagement With Self-Help
- Reestablishing a daily and weekly schedule

40

Health replacement activities

- Supporting Recovery through Heathy Replacement Activities

41

Practice Session

42

Counseling session(s) supporting MAT induction and stabilization

- As the patient stabilizes on buprenorphine or methadone(i.e., little to no withdrawal symptoms and little to no sedation), counseling sessions should target behavioral, social, and psychological triggers that contributed to drug use and may pose risks for recurrence.
- It is not unusual for a patient to experience irritability, depression, impatience, frustration, moodiness, stress and anxiety during the induction phase.

43

Your Next Steps

- Your professional goals
- Indepth MI Training and CBT Training
- Practice
- Supervision and mentoring

44

Thanks!

- Questions? Comments? Suggestions?

45

Recognition to contributions in areas of Pain and Substance Use Disorders

- Seddon Savage M.D., M.S
- J. Paul Seale, M.D., FAAFP
- Daniel P. Alford, M.D., M.P.H., FACP, FASAM
- H. E. Woodall, M.D., FAAFP, FAAHPM
- John Otis Ph.D.
- Kirk Strosahl Ph.D.
- Bill McFeature Ph.D.

46