Annual Inter-Faith Institute on Recovery

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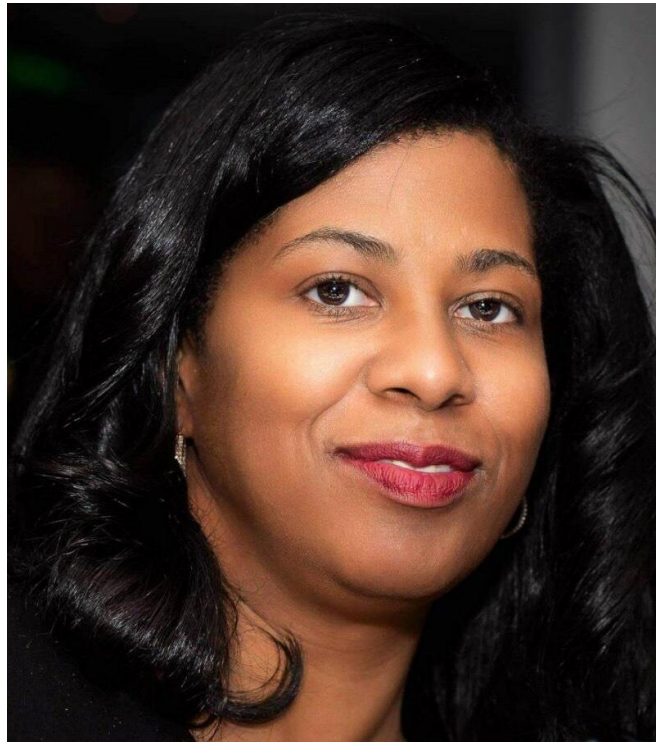
PROVIDING COMPASSIONATE CARE FOR PERSONS WITH SUD AND CHRONIC PAIN:

HOW TO ADDRESS ETHICAL DILEMMAS



WHAT WE WILL LEARN TODAY:

- How to provide compassionate ethical care when treating chronic pain patients with SUD
- Ethical Dilemmas treating chronic pain patients with SUD
- Best Practices to treating chronic pain patients with SUD

We will also talk about:

- Definition of chronic pain and the scope of this issue
- Patient Autonomy
- Quality of Life Enhancement
- Pain management as a human rights issue
- Barriers to pain management

Real-Life Stories

HOW CAN YOU RELATE TO CHRONIC PAIN????

WRITE IT IN THE CHAT BOX

Defining Chronic Pain and Identifying the Scope of Chronic Pain Issues

Pain can be defined as physical suffering or discomfort caused by illness or injury.

*****Pain is subjective and may not always be corroborated by objective data.

Chronic pain can be defined as pain that is moderate or severe, lasting 6 months or more, requiring long-term management.

Defining Chronic Pain and Identifying the Scope of Chronic Pain Issues.

The American Academy of Pain Medicine reports in 2018 100 million adults had chronic pain.

Goal of pain management: Maximize functionality while providing pain relief.

Common Dilemma: Although pain greatly impacts SUD patients it is often undertreated due to concerns related to SUD/the opioid epidemic.

Common Dilemma: Patients pain is often discounted and not believed since it cannot be seen.

Important that we as clinicians, pastors, physicians, addiction therapists, peer support, other professionals become educated on chronic pain to better help our patients and dispel myths.

Pain is acute or chronic

Acute – pain related to trauma, sudden onset, resolves with healing of injury.

Chronic – persists for weeks, months or longer and usually has an underlying cause.

Pain Impact on Health & Functioning

* Stress, Anxiety, Depression, Sleeplessness, relationships, quality of life, physical/mental health, mobility, independence, ability to work and cycle of more pain.

A Voice of a Chronic Pain Sufferer

Every single day I struggle beyond my own strength .

I battle my own body, my emotions,
and other people's judgement.

My pain level changes from moment to moment,
and I have no control over that.

I do my best to walk in the shoes I have.

Please accept me for who I am
and not for who
you want me
to be.

EFFECTIVE PAIN MANAGEMENT:

Effective CNCP management in patients with or in recovery from SUDs must address both conditions simultaneously. (Trafton, Oliva, Horst, Minkel, & Humphreys, 2004).

Effective Pain Management is a Human Right (entitlement and freedom all human beings hold), applies to persons with SUD.

AMA states, physicians have an obligation to relieve pain and suffering.

Pain Management as a Human Right

International statements articulating pain management as a human right:

The Declaration of Montreal (2011)

“and recognizing the inherent dignity of all persons and that the withholding of pain treatment is profoundly wrong, leading to unnecessary suffering that is harmful, we declare that the following human rights must be recognized throughout the world”:

*”Article 1: The right of all people to have access to pain management without discrimination.
*”Article 2: The right of all people to have acknowledgment of their pain and to be informed about how it can be assessed and managed.
*Article 3: The right of all people in pain to have access to appropriate assessment and treatment of the pain by adequately trained health professionals.”

BARRIERS TO PAIN MANAGEMENT:

Despite prevalence of pain and its impact on patient functioning there is still concerns with undertreatment and unnecessary patient suffering due to barriers to pain management:

Barriers:

- Lack of training of health care providers
- Not acknowledging patient pain
- Racial biases/implicit biases
- Inadequate access to health care
- Opioid crisis restricts legitimate access to opioids
- Inadequate pain control
- Globally – disparity in access to opioids

The Right to Access to Pain Management

What is your ethical responsibility to clients regarding pain management?

According to the *World Health Assembly*:

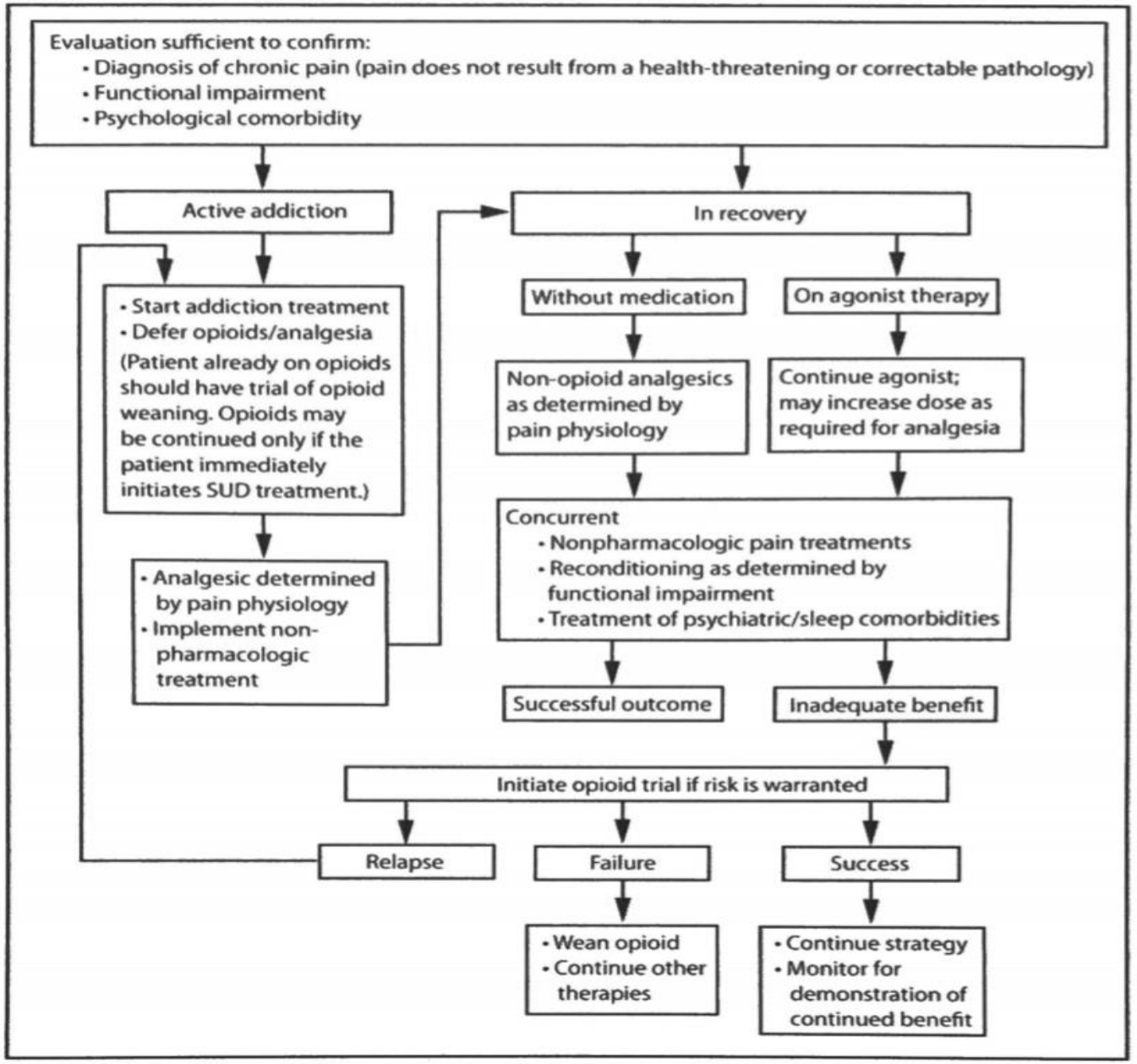
> It is an ethical duty of health care professionals to alleviate pain and suffering
>
> The right to pain management as a human right is part of the states obligations to ensure "health services are available, accessible, acceptable and of good quality" for all people including persons with a SUD

Under human rights law we want to apply harm reduction strategies (Medication Assisted Programs) to protect and promote the health of substance users.

Danger of a highly regulatory response to the opioid crisis, persons who may truly need the medication, may not be able to obtain.

Clinicians should be trained in pain management and substance use to dispel myths and help provide the best ethical care to patients.

Exhibit 3-1 Algorithm for Managing Chronic Pain in Patients With SUD



Cross Addiction

Persons with chronic pain and SUD are increased risk for cross addiction to any medications that act on the brain as a reinforcing agent. (Edlund, Sullivan, Steffick, Harris, & Wells, 2007).

The Cycle of Pain

Seeking pain relief, having relief occur, experiencing pain again

If using medication or substances – may provide relief, tolerance develops, take more for relief, develop a physical dependence, increased pain when the substance is not present, may also experience withdrawal symptoms, ingest more of the substance.

Physical dependence – body requires a specific dose of a particular drug such as a prescription opioid to prevent withdrawal symptoms. Do not necessarily develop a SUD. The patient may experience some euphoria, yet has control over their use.

Addiction – compulsive behavior that manifests as cravings, inability to control use, continued use of the drug despite consequences,

Elements of a Comprehensive Patient Assessment

Element: Pain and Coping

• Location, character (e.g., shooting or stinging, continuous or intermittent) • Pain types (i.e., nociceptive, neuropathic, mixed) • Lowest and highest extent of pain in a typical day, on a 0-to-10 scale • Usual pain in a typical day, on a 0-to-10 scale • When and how the pain started • Exacerbating factors (e.g., exertion/activity, food consumption, elimination, stress, medical issues) • Palliating factors (e.g., heat, cold, stretching, rest, medications, complementary and alternative treatments) • Prior evaluations to determine the source of pain • Response to previous pain treatments, including complementary and alternative treatments and interventional treatments • Goals and expectations for pain relief

Mental Status: Medication focused • Somatic preoccupation • Mood • Suicidal ideation and behavior • Cognition (e.g., attentional capacity, memory)

Elements of a Comprehensive Patient Assessment

Element: Collateral Information: • Findings of other clinicians, prior and current • Family concerns, beliefs, and observations • Pharmacist concerns, where relevant • Data from State electronic prescription monitoring programs, if available • Medical records, including psychiatric and substance use disorders (SUDs) treatment records

Function: Effect of pain on: • Activities of daily living/ability to care for oneself • Sleep • Mood • Work/household responsibilities • Sex • Socialization and support systems • Recreation • Goals and expectations for restored function

Contingencies:• Family support of wellness versus illness behavior • Vocational incentives and disincentives • Financial incentives and disincentives • Insurance/legal incentives and disincentives • Environmental and social resources for wellness

Physical Exam: Relevant associated signs of pain disorder • Signs of substance abuse (e.g., track marks, hepatomegaly, residua of skin infections, nasal and oropharyngeal pathology)

Elements of a Comprehensive Patient Assessment (continued):

SUD history and Risk for Addiction: • Current use of substances, including tobacco, alcohol, over-the counter medications, prescription medications, and illicit drugs (confirmed by toxicology) • Focus on opioids to the exclusion of other treatments • Adverse consequences of use (e.g., functional impairment; legal, social, financial, family, work, medical problems) • Age at first use • Treatment history, including attendance at mutual-help groups • Periods of abstinence • Strength of recovery support network (e.g., sponsor, sober support network, mutual-help meetings) • Family history of SUD • History of physical, sexual, or emotional abuse or trauma

Co occurring Disorders: • Psychological conditions (e.g., depression, anxiety, post-traumatic stress disorder [PTSD], somatoform disorders) • Medical conditions (e.g., hepatic, renal, cardiovascular, metabolic) • Cognitive impairments (e.g., dementia, delirium, intoxication, traumatic brain injury)

“Caregivers are obligated to understand the complexities of their patients’ lives, their network of relationships, and their anguish in order to truly care for them. If you’re equipped to walk alongside the person who is suffering, you’ll experience a profound sense of purpose and meaning. This is why people go into healthcare. Compassion is the answer.”

The Schwartz Center for Compassionate Healthcare, Beth Lown, MD, Medical Dir.

QUOTES ON COMPASSION

“If you want others to be happy, practice compassion. If you want to be happy, practice compassion”. Dalai Lama

“Love and compassion are necessities, not luxuries. Without them humanity cannot survive”. Dalai Lama

“The purpose of human life is to serve, and to show compassion and the will to help others” . Albert Schweitzer

“As I get older, the more I stay focused on the acceptance of myself and others, and choose compassion over judgment and curiosity over fear”. Tracee Ellis Ross

“Our sorrow and wounds are healed only when we touch them with compassion”. Jack Kornfield

WHAT DOES YOUR EVERYDAY LANGUAGE SAY ABOUT YOUR PATIENTS?? DOES IT STIGMATIZE INDIVIDUALS WITH CHRONIC PAIN AND SUD.

DOES YOUR CLINIC USE TERMS SUCH AS:

FREQUENT FLYER
DRUG SEEKING
OTHER:

REPEATED EXPOSURE TO PATIENTS SUFFERING WITH CHRONIC PAIN AND SUD CAN REINFORCE NEGATIVE EMOTIONS AND CREATE COGNITIVE BIASES TOWARDS PUNITIVE JUDGMENTS VERSUS COMPASSION

IS IT POSSIBLE TO REPLACE LANGUAGE WITH TERMS SUCH AS COMFORT SEEKING VERSUS DRUG SEEKING?

SHIFT FROM JUDGMENT TO COMPASSION

PROVIDER ATTITUDES, ASSUMPTIONS, STIGMA'S, IMPLICIT STEREOTYPES, HAVE AN IMPACT ON PATIENT CARE.

IMPLICIT BIAS

Clinicians should be aware of their implicit bias when working with chronic patients having SUD

Unconscious bias have an impact on the medical care our patients receive.

Implicit Bias: Attitudes or stereotypes that affect our understanding, actions and decisions in an unconscious manner

Recognize where implicit bias may exist
Be aware of unconscious decision making and the consequences
Own your own stuff
Expose yourself to people and experiences outside of your normal circle

Take the implicit bias test - **Harvard's Project Implicit**

Ask yourself????

Who are your 3 best friends –implicit bias and stereotypes continue through lack of contact with others outside of the group you are comfortable with

Do you automatically exclude certain neighborhoods as places you might live or send your kids to school?

A landmark study found that once a neighborhood reaches a “tipping point” of minorities, whites left. Racially tolerant whites had a higher tipping point.

Do you only date a certain type??

Ethical Duty to reduce Patient suffering (not alleviate pain)

Patient Suffering – once we understand it we can take action
Inherent Suffering (comes with the diagnosis and treatment)
Avoidable suffering (suffering we as caregivers can provoke or make worse due to dysfunctional systems) – waiting, unsafe environment, lack of empathy, not connecting with patient/family, not working as a team, repetitive questioning, labeling “our patient”, etc.

Caregiver Suffering – stress of the job, complex patients

Answer to Suffering
Remember why we got into this field – we are here to help our patients heal

Roots of Suffering in Healthcare

Healthcare no longer emphasizes the reduction of suffering
Society does not prioritize personal connections
Provider education change the way we train providers (online and simulated)
Performance reviews not based on client experiences.

Best Practices:

Quantifying Suffering

Engagement survey asking about patient and caregiver suffering
Ask about pain management, degree to which your emotional needs were addressed, responsiveness of staff, cleanliness of environment, do you feel safe at the clinic.
Patient and family give detailed responses on unmet needs – which causes suffering.

Best Practices:

Compassionate Connected Care

Acknowledge a patient's suffering – be empathetic and provide compassionate responses; validate patient concerns to get to the root of their issues.

Body Language Makes a Difference:

Eye contact, body position, elbow bump.

Reduce uncertainty and anxiety to show understanding for patient suffering

use reassuring phrases, check in frequently in a purposeful way to check on their pain/concerns.

Coordinate Care: Show concern for patient when they go home to help them have a successful recovery program. Follow up call/referrals.

Best Practices:

Compassionate Connected Care (continued)

***Loss of Autonomy increases suffering:

Give the client a voice and allow options

Compassionate Care goes beyond the medical diagnosis:

See the client as more than a person in recovery with chronic pain. Find a way to connect and not see the person as client #2222. Do you have any personal touches or anything you do to provide care for the client/family.

Best Practices:

Compassionate Connected Caregiver

56 second conversation to connect with your client

Offer choices

Talk with clients about their pain

Frequent sessions/connections to demonstrate empathy, compassion and a desire to serve.

Critical thinking is key

Cultivate your resistance so your compassion tank is not empty– need to survive the inherent suffering in healthcare and provide compassionate connected care – utilize mindfulness, positive thinking, care for self,

Best Practices:

How to integrate compassion into your practice:

- Compassionate connected teams mitigate suffering
- Improve team huddle
- Compassion Huddle
- Hope Huddle
- Interdisciplinary Rounds
- Shift Reports
- Provide seamless team-based care

Ways for chronic pain patients with SUD to reduce suffering:

Goal to Restore/Enhance

- Mobility
- Interaction
- Independence
- Validation
- Love

Ways for chronic pain patients with SUD to reduce suffering:

- Be your own advocate
- Body Maintenance/Exercise
- Identify and set boundaries
- Analyze your resource spending
- Manage concentration and cognitive abilities
- Alternative therapies – Acupuncture, aromatherapy, chiropractor, hypnosis, etc.
- Support groups
- Retrain your nervous system
- Mindfulness and meditation
- Mental Health care
- Finding calm in the storm
- Reframing harmful thoughts
- Ignite creativity – dance, music, at therapy, knitting – meaning comes from creativity

Ways to reduce suffering:

Spirituality
Medicine of Movement
Let your food be medicine
Recharge, get mental health help, research your pain
Gain treatment perspective
Build a “pain free village” – connect with others going through the same thing
Build a conventional and complementary provider network
Manage your pain at work, home and while traveling
Acceptance – accept your new reality, accept that you are a new person, accept the good, let the rest go.
Stay connected to your spouse/partner
Build a network of friends and family

Bibliography:

Chronic Pain Recovery, A Practical Guide to Putting Your Life Back Together After Everything has Fallen Apart, Jennifer Kane2017

Conquer Your Chronic Pain, Peter Abachi, MD 2016

The Antidote to Suffering, Christine Dempsey, 2018

Heal, Sumter M Carmichael, MD2012

Taming Chronic Pain, Amy Orr, 2019

American Overdose, Chris McGreal, 2018

Avoiding Opioid Abuse, Lynn R. Webster, MD & Beth Dove 2007

Some Assembly Required, Dan Mager, MSW 2013

TIP, Managing Chronic Pain in Adults with or in Recovery from SUD, SAMHSA, 2012

What Happens to Compassion During an Opioid Epidemic, Beth Lown, MD, 2017

Harm Reduction, Compassionate Care of Persons with Addiction, Robin Bartlett, PhD, RN, Laura Brown, BSN, RN, Mona Shattell, PhD, RN, Thelma Wright, BS, and Lynne Lewallen, PhD, RN, ANEF, 2013

Bibliography (continued):

Pain Management in Patients with Substance Use Disorders, Valerie Prince, Pharm, DFAP,hA, BCPS,
Chronic Pain Impact, NCBI.NLM.NIH.gov, TIP, Series Number 54, SAMSHA 2012
Treating Pain in Addicted Patients: Recommendations from an Expert Panel, Martin Cheatle, Phd, Dominique Comer, PharmD and Yeshwant Reddy, MD, Population Health Management, 2014
Management of Chronic Pain with Chronic Opioid Therapy in Patients with Substance Use Disorders, Yu-Ping Chang and Peggy Compton, Addiction Science and Clinical Practice 2013
Challenges in using opioids to treat pain in persons with substance use disorders, Seddon R Savage, MD, MS, Kenneth L Kirsti, PhD and Steven D Passik, PhD, Addiction Science and Clinical Practice
Access to Pain Management as a Human Right, Frank Breenan, MBBS, DCH, DIP Obs, FRACP, FAChPM, LLB, Diederik Lohman, MA and Liz Gwyther, MBChB, FCFP, Msci, American Journal of Public Health, Jan 2019
Chronic Pain Management, Tip 54, SAMSHA
4 Ways you may be displaying bias in everyday life, Emanuella Grinberg, CNN 2015

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QUESTIONS/FEEDBACK