Effective Communication with Patients Who May be Misusing Opioids or Other Medications

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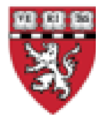

HARVARD MEDICAL SCHOOL
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Forming a Therapeutic Relationship

Learning Objectives

- Engage and talk with individuals who may be misusing their medications
- Acquire strategies to keep patients engaged in care and treatment
- Learn to use psychosocial strategies to form a rapport and impact positive change
- Understand how to bring risk reduction and safety strategies into conversations

Introduction (1)

- Misuse of opioids or other prescribed medication is common
- It's something all providers will encounter
- It can be frustrating to watch patients continuously struggle and misuse medication
- Providers may feel "lied to" or "manipulated"

Introduction (2)

- Some providers may have a hard time with difficult conversations and with saying “no”
- Understand patients are trying to get their needs met and may fear withdrawal - their treatment may need to be adjusted
- Remain nonjudgmental, compassionate, and use nonstigmatizing language

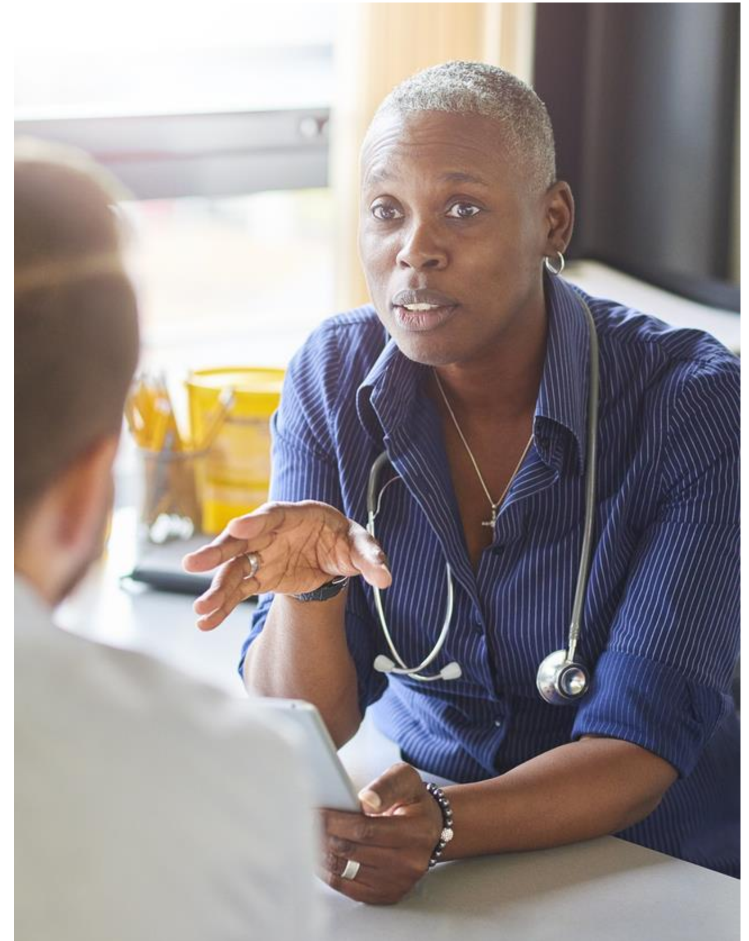
It's All About A (Therapeutic) Relationship (1)

- Many patients with SUD have had poor experiences within the medical system
- Many have experienced stigma related to their substance use
- Have learned to say what they think providers want to hear to get their needs met (resiliency, adaptability)
- Providers need to be able to manage our own reactions and remain objective

Stigma and People Who Use Drugs, DPA
Drug Users Peace Initiative Stigmatizing People Who Use Drugs, UNODC

It's All About A (Therapeutic) Relationship (2)

- Goal is to form a positive and trusting relationship with the patient to impact positive change and reduce misuse of substances
- Fostering honest communication is key



USER FRIENDLY

WE KNOW OUR PATIENTS WHO USE ALCOHOL, DRUGS, AND CIGARETTES VALUE THEIR HEALTH

OUR GOAL IS TO PROVIDE EVERY PATIENT THE BEST MEDICAL CARE WE CAN

WE'RE HERE TO HELP YOU, NOT JUDGE YOU

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Design: Better World Advertising

http://harmreduction.org/drugs-and-drug-users/drug-tools/anti-stigma-poster/

The Misunderstood Society

#BreakTheStigma

https://cdn.thewatershed.com/wp-content/uploads/2014/02/breaking-the-stigma.jpg

Remaining Nonjudgmental (1)

- People who struggle with substance use disorders are often very sensitive to verbal and nonverbal cues
    - street smarts, intuition, ability to read people
- If a service provider is judgmental, patients can pick up on it

Remaining Nonjudgmental (2)

- Often one of the reasons why patients may act out, get angry, lie, do not return, etc.
- Just because someone misuses their medication, it does not mean that s/he should be mistreated or not respected

Cultural Humility (1)

- People who struggle with substance use disorders come from diverse backgrounds and have intersecting cultural identities
  - race, ethnicity, gender, sexual orientation, religion/spirituality, ability, age, socioeconomic status, language, etc.
  - drug using culture

Cultural Humility (2)

- People have unique relationships with substance use based on their experience and identity
  - some cultures may be more open to discussing substance use and seek treatment than others
- To facilitate open communication, providers need to foster an environment that is comfortable and welcoming to people of various intersecting cultural identities

Context and Language (1)

- It is important for providers to put behaviors in context and perspective
- Providers should use concepts and language that are neutral
- It can be helpful for providers to talk about the use of drugs in relation to medical conditions

Context and Language (2)

- Important to be **nonjudgmental** and to create an environment where people feel **comfortable** and **heard**

Creative, resilient, smart, strong, motivated, self-aware

Vignette 1: Susan

Susan is a 45-year-old white, unemployed, disabled woman. She is experiencing homelessness, and stays either at a shelter or with friends.

She is prescribed buprenorphine/naloxone, has been in substance use treatment for six months, and overall has been adherent.

In the last two months, Susan had requested a refill on her buprenorphine/naloxone on two occasions earlier than anticipated because she stated "they were stolen" at the shelter.

Her last toxicology screen was positive for unprescribed benzodiazepines.

This is the second time benzodiazepines have been present in the last two months.

You know that she struggles with anxiety, and had been prescribed benzodiazepines in the past.

When asked about the unprescribed benzodiazepines, Susan stated that she had a panic attack, and that she got one “from a friend.”

Client-Centered Principles

Vignette 1 - Possible Responses (1)

How am I to trust that you are committed to treatment if your urines are dirty?

I promise I'm committed to treatment, and I have no idea how my urines are dirty. I don't remember taking anything, please give me another chance!

Vignette 1 - Possible Responses (2)

This may close the door on having a productive and honest conversation about her potential use because she becomes defensive.

Vignette 1 - Possible Responses (3)

- **Remember to avoid words like "dirty" as this perpetuates stigma associated with substance use.**

Vignette 1 - Possible Responses (4)

I understand that it is hard to keep your belongings safe in the shelter, but can't you do a better job minding your belongings, especially your medication?

I do everything possible to keep my medications safe. I keep them with me at all time, but there are a bunch of thieves at the shelter and the shelter staff do nothing about it!

Vignette 1 - Possible Responses (5)

Because this statement blames the patient for not keeping her belongings safe, she may become defensive and not be able to think creatively to work with you on possible strategies to keep her medication safe.

Vignette 1 - Possible Responses (6)

For most of the time in treatment with us, there has not been evidence of unprescribed medication in your toxicology screens, and your medication has lasted you the entire time. What do you think has changed?

Well, I've been really down on myself lately, and staying at the shelter hasn't been easy. I get anxious a lot more, particularly at night. There is another woman at the shelter that has it out for me, and this makes me really nervous, and it is hard for me to relax and feel comfortable.

Vignette 1 - Possible Responses (7)

This statement is strengths-based and not judgmental. It allows the patient to think about what may be contributing to her misuse of medication and allows for a more open discussion.

Client-Centered (1)

- Motivational interviewing is an evidence-based practice for working with individuals with SUDs
- By its nature, motivational interviewing is client-centered
- Client-centered treatment relies on the wisdom of the patient.
- Conversations are centered on the client's perspective

SAMHSA TIP 35

Client-Centered (2)

- The provider's stance is that of an equal partner collaborating with a patient to resolve the problem
- For more information on MI, refer to:
  - Blending MI CME/CE https://www.drugabuse.gov/blending-initiative/cme-ce-simulation
  - SAMHSA, HRSA Center for Integrated Health Solutions: http://www.integration.samhsa.gov/clinical-practice/motivational-interviewing

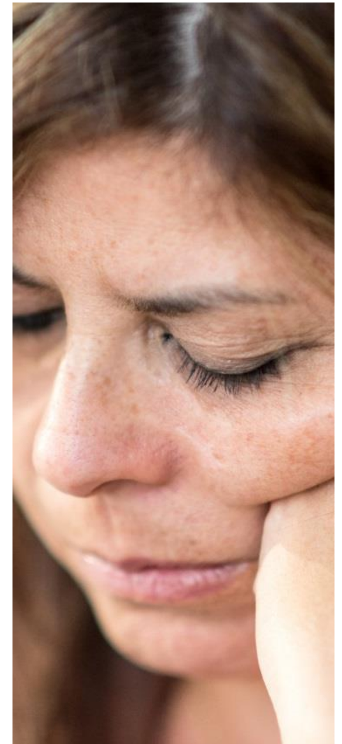
Client-Centered Principles (1)

- Our services exist to benefit the people we serve.
- Change is fundamentally self-change. Services facilitate the natural processes of change.
- People are the experts on themselves.
- We don’t have to come up with all the good ideas. Chances are we don’t have the best ones!

Miller, W. R., & Rollnick, S. (2012)

Client-Centered Principles (2)

- People have their own strengths, motivations, and resources that are necessary to activate change.
- Change requires a partnership, a collaboration of expertise.
- It's important that we understand the patient's own perspective of the situation.



Miller, W. R., & Rollnick, S. (2012)

Client-Centered Principles (3)

- Change is not a power struggle.
- Motivation for change is not installed, but evoked.
- People make their own decisions about what they will and will not do.

Miller, W. R., & Rollnick, S. (2012)

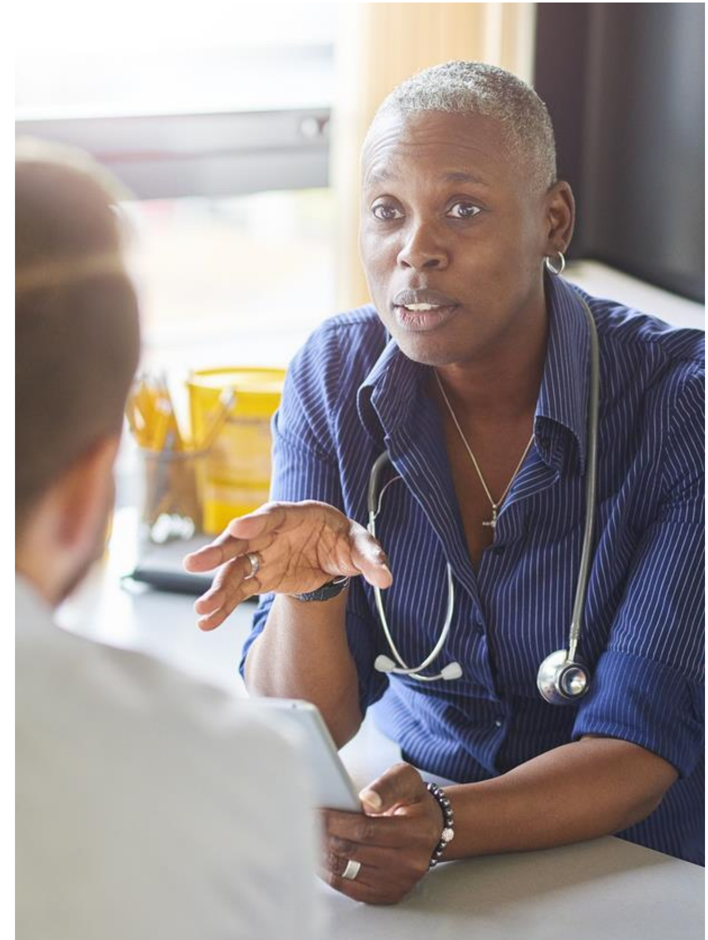
Asking Open-Ended Questions

Open-Ended Questions

- Provides an 'open door'
- Invites a person to think a bit before responding
- Cannot be answered by yes, no, maybe, or any single word answer:
  - Did you take more medication than prescribed?

Miller, W. R., & Rollnick, S. (2012)

- Examples of open-ended questions:
    - What are the benefits of taking more medication than prescribed?
    - What do you feel like when you run out of medication early?



Miller, W. R., & Rollnick, S. (2012)

Vignette 2: Julie

Julie is a 28-year-old woman, who is mandated to substance use and mental health treatment from the Department of Family Services following the birth of her 11-month-old child because unprescribed opioids were detected at the time of birth. Both her 11-month-old child and 2-year-old child live with her ex-boyfriend's (father of the children) mother.

Julie is working to regain custody. Currently, she is only allowed supervised visits with her children.

She lives with her mother, and is unemployed. Her mother told her that she needs to pay rent or she will no longer be able to live in the home.

She has regularly missed appointments and has not been able to regularly adhere to the program guidelines, which has put her at risk for dismissal.

She is diagnosed with opioid use disorder, anxiety disorder, and posttraumatic stress disorder.

When Julie sees you, her prescriber, she says the following…

I'm sick of this, everything just keeps getting messed up. I do good for a week and don’t use. But something bad always happens --- and I screw up and take more pills! I thought I was going to get this job, but then I didn’t. That’s why I missed my last two appointments here. My mother has been giving me a hard time, telling me I need to move out of the house. The only thing that keeps me going is knowing that I may be able to get my children back if I stop using and get my life together. And now they tell me you may not be able to give me any more medication! How am I going to get through the next week! I promise I won’t use more than I was prescribed this time.

Offering Affirmation

Vignette 2, Possible Responses

What kind of things do you think would be helpful to manage your stress?

Patient may say:

Seeing my kids, walking, watching TV, spending time with my sister.

Do you think you will be able to adhere to the program going forward?

Patient may say:

Of course.

Vignette 2, Possible Responses

Describe how you'll be able to take the medications as prescribed?

Patient may say: I'll use a pill box, and maybe see if my mother can hold them, that worked in the past.

Do you want to stay in this program?

Patient may say: Absolutely.

Vignette 2, Possible Responses

Aren't you going to be upset when you can't see your kids?

Patient may say:

Very

What strategies do you think would be helpful to you, so you can remember your appointments?

Patient may say:

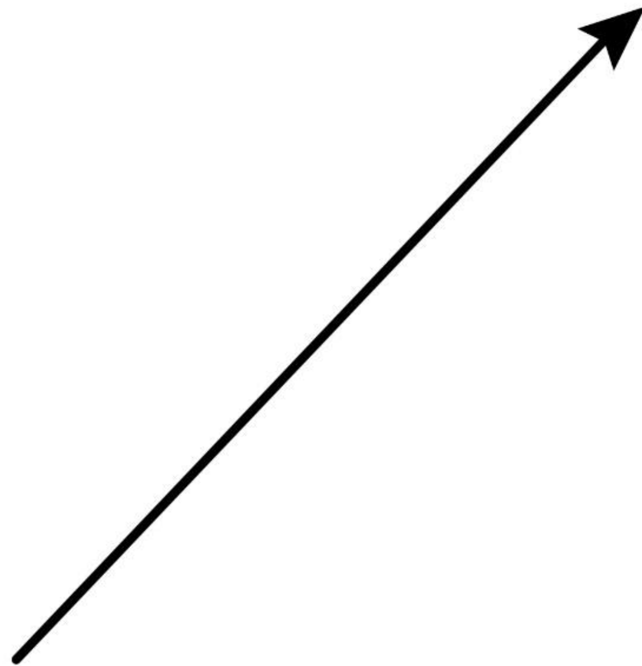
I'll use the calendar on my phone to remind me, and will ask my sister for a ride in advance.

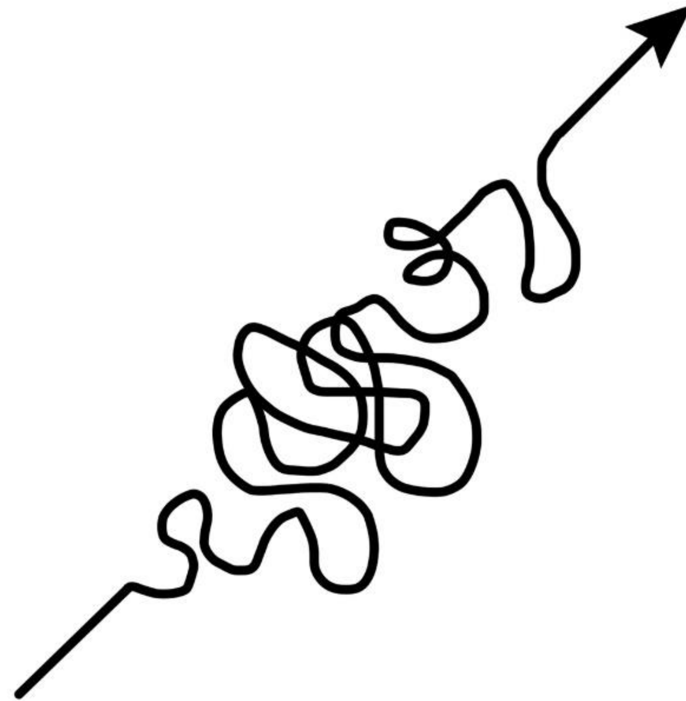
Affirmations (1)

- Identifies something positive about the client and gives credit
  - A trait, behavior, feeling, or accomplishment
- Two examples:
  - “The way you are approaching this problem is very organized and logical, and this can help you to succeed.”
  - “You showed a lot of courage by leaving that situation where your friends were using heroin.”
- Avoid “I” statements which emphasize the provider instead of the patient

Miller, W. R., & Rollnick, S. (2012)

Affirmations (2)





http://thecreatormind.com/wp-content/uploads/2013/12/what-success-really-looks-like.jpg

Affirmations are acknowledgements of:

- Struggles or difficulties
- Successes
- Skills and/or strengths
- Goals and values
- Notice and appreciate a positive action

Risk Reduction and Safety

General Practice Guidelines

- Talk less than the patient
- Be an effective listener
- Ensure you're sensitive to the person's point of view
- Normalize the person's struggle and ambivalence (it is part of any change process)
- Manage your own opinions or judgement
- Use positive body language to invite the person to explore his/her own beliefs and perspective

Miller, W. R., & Rollnick, S. (2012)

Risk Reduction and Safety (1)

- People who use opioids are at high risk for relapse and overdose.
- Talk about risk-reduction strategies with patients who may be using opioids, alcohol, or other substances.

Fentanyl, CDC.org
SAMHSA Opioid Overdose Prevention Toolkit

Risk Reduction and Safety (2)

- Heroin and other drugs may be adulterated with fentanyl, which is 50 to 100 times stronger than morphine and has led to increased overdoses nationwide.
- Risks from injecting drugs include overdose, HIV, hepatitis C, endocarditis, septicemia, abscesses, and collapsed veins.

Fentanyl, CDC.org
SAMHSA Opioid Overdose Prevention Toolkit

Risk Reduction and Safety (3)

- Tolerance develops when someone uses an opioid regularly.
- The body becomes accustomed to the drug and needs a larger or more frequent dose to experience the same effect.
- Loss of tolerance occurs when someone *stops* taking an opioid after long-term use. **This can happen in a matter of days.**
- When people lose tolerance, then take opioids again, they can experience serious adverse effects, including overdose, even if they take an amount that caused them no problem in the past.

Overdose Risk

- Use heroin, or any illicit opioid
- Use opioids for long-term management of chronic pain
- Are completing opioid detoxification
- Are abstinent for a period of time, even just a couple of days
- Are recently released from incarceration

Vignette 3: Ralph

Ralph is a 35-year-old Latino man. You are aware he has a past history of substance use, including marijuana and cocaine use. He also binge drinks on the weekends and has about eight beers and will do a few “shots” of hard liquor.

Four months ago he was in a motorcycle accident and has been prescribed opioids to manage his pain, and he continues to be prescribed the opioids.

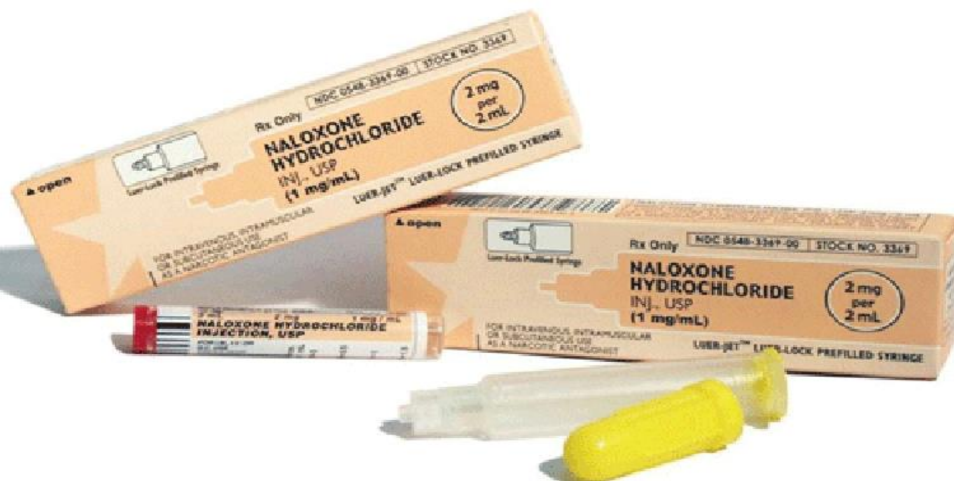
- When he comes to the appointment, you notice he appears drowsy and appears to be slurring his words.
- When asked how he is doing, he says he has been working extra shifts at his job and he is tired.
- He also admits to sometimes taking more of the opioid medication than prescribed because his job is strenuous and exacerbates his pain.

Overdose Prevention Strategies

Overdose Prevention Strategies (1)

Health care providers can:

- Provide naloxone or a prescription for naloxone
- Provide training on how to administer
- Train family or friend – a better strategy, as people cannot use naloxone on their own



SAMHSA Opioid Overdose Prevention Toolkit

Overdose Prevention Strategies (2)

For people to minimize their own overdose risk:

- Use with others – don't use alone.
- Use in a familiar, safe, and clean environment.
- Do not mix drugs and alcohol. Benzodiazepines contribute to increased overdose risk. Naloxone only works on opioids.
- Do a tester shot. Use slowly. Test drugs (especially if from new source or have not used in a while). Drugs are often adulterated and can include stronger substances, such as fentanyl.
- Remember that opioids are stronger than ever!

Overdose Prevention Myths

Common myths to prevent or respond to an overdose:

- walk around
- take a cold shower/bath
- drink coffee
- have the person vomit
- inject with saltwater

Remind people that these are myths and do not work.

Recognizing and Responding to an Overdose

- Labored breathing
- Change of skin color
- Unconsciousness (different than heavy nod)
    - Tap on shoulder or do sternum rub –

  If they respond they do not need naloxone, but monitor

Fentanyl, CDC.org
SAMHSA Opioid Overdose Prevention Toolkit

If determined it is overdose:

- Call 911
- Rescue breathing (if not breathing) very important, do even if naloxone is not available
- Administer naloxone
- Continue rescue breathing
- Administer naloxone (multiple doses of naloxone may need to be administered because of fentanyl's high potency relative to other opioids.)

*For more information, refer to Course 2, Unit 7

Fentanyl, CDC.org
SAMHSA Opioid Overdose Prevention Toolkit

Injection Drug Use – Risk Reduction (1)

The following strategies reduce risk associated with HIV, hepatitis C, endocarditis, septicemia, abscesses and collapsed veins.

- Use sharp, new sterile syringes each time—even if syringes are not shared, they have risk of endocarditis, septicemia, abscesses and collapsed veins
- Use smallest needle possible
- Rotate veins
- Clean injection spot with alcohol pads

Injection Drug Use – Risk Reduction (2)

- Sterile water—do not share water
- Use own new/clean cooker and cotton (filter) each time
- Use on a clean surface

** Refer to Syringe Exchange Program - staff at syringe exchanges are experts in helping people inject drugs in the safest way possible.*

Wrap Up

- People may misuse prescription opioids or other medications for a variety of reasons.
- To provide effective treatment as well as incorporate risk-reduction techniques, it is important to be able to understand the patients' perspectives on why they misuse their medication.
- Motivational interviewing is an evidence-based approach that can be useful in forming a positive therapeutic relationship, which can lead to reduced risk and improved treatment outcomes for individuals who may misuse their medications.

Carroll et al., 2006

Unit References & Resources

- Benzodiazepine use during buprenorphine treatment for opioid dependence: Clinical and safety outcomes: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3916951/
- Blending MI CME/CE https://www.drugabuse.gov/blending-initiative/cme-ce-simulation
- Cost-Effectiveness of Syringe Exchange Programs: http://harmreduction.org/wp-content/uploads/2012/01/CostEffectivenessofSyringeExchangePrograms.pdf
- Drug Users Peace Initiative, Stigmatizing People who Use Drugs: https://www.unodc.org/documents/ungass2016/Contributions/Civil/INPUD/DUPI-Stigmatising_People_who_Use_Drugs-Web.pdf
- Fentanyl: http://www.cdc.gov/drugoverdose/opioids/fentanyl.html
- Getting off Right: http://harmreduction.org/wp-content/uploads/2011/12/getting-off-right.pdf

- Miller, W. R., & Rollnick, S. (2012). Motivational interviewing: Helping people change (3rd ed.). New York, NY: Guilford Press.
- Opioid Overdose Education and Naloxone Distribution MDPH Naloxone pilot project Core Competencies: http://www.mass.gov/eohhs/docs/dph/substance-abuse/core-competencies-for-naloxone-pilot-participants.pdf
- SAMHSA, HRSA Center for Integrated Health Solutions: http://www.integration.samhsa.gov/clinical-practice/motivational-interviewing
- SAMHSA Opioid Overdose Prevention TOOLKIT: http://store.samhsa.gov/shin/content//SMA14-4742/Overdose_Toolkit.pdf
- SAMHSA Overarching principles to address the needs of persons with co-occurring disorders. http://store.samhsa.gov/shin/content/PHD1132/PHD1132.pdf

- TIP 35 Enhancing Motivation For Change in Substance Abuse Treatment http://store.samhsa.gov/shin/content//SMA13-4212/SMA13-4212.pdf
- TIP 59: Improving Cultural Competencehttp://store.samhsa.gov/shin/content/SMA14-4849/SMA14-4849.pdf
- Talking to Patients About Sensitive Topics: Communication and Screening Techniques for Increasing the Reliability of Patient Self-Reporthttps://www.drugabuse.gov/sites/default/files/sensitive-topics-handout_0.pdf
- Stigma and People Who Use Drugs: http://www.drugpolicy.org/sites/default/files/DPA_Fact_Sheet_Stigma_and_People_Who_Use_Drugs.pdf
- The Words We Use Matter. Reducing Stigma through Language: https://www.naabt.org/documents/NAABT_Language.pdf