

# Difficult Conversations

*Addressing non-medical opioid use in cancer patients*



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# Conflict of interest

- ▶ None to report

# Objectives

1. Describe the challenges and the importance of addressing non-medical opioid use in patients
2. Apply principles of trauma informed care, non-stigmatizing language, and motivational interviewing techniques in clinical care
3. Employ harm reduction strategies with appropriate patients
4. Explore appropriate communication strategies in addressing non-medical opioid use in cancer patients

# Importance and Challenges

- ▶ ~10 million people either diverted or misused opioids within a 12-month period) (7)
  - ▶ More than 9 million misused prescription pain relievers obtained from a family member or friend.
- ▶ 1 in 5 cancer patients receiving opioids have elevated risk for developing nonmedical opioid use. (1,2)
- ▶ Substance use disorder is highly stigmatized.
  - ▶ Engrained in the language used– terms like “abuser”, “addict”, “Drug seeking”, “narcotic” and “dirty” (3)
- ▶ Inadequate training on how to address misuse or addiction; and that SUDs are treatable chronic disease (4, 5, 6)
- ▶ Conversations could involve conflict, and strains the provider-patient relationship
  - ▶ Balancing worries, safety, attempting to address SUD may jeopardize patient's cancer treatment

# Definitions

- ▶ Non Medical Opioid use
  - ▶ Take a medicine in a way that is different from what a doctor prescribed – prescription drug abuse. It could be ( MEDLINEPLUS 8)
    - ▶ Taking a medicine that was prescribed for someone else
    - ▶ Taking a larger dose that you are supposed to
    - ▶ Taking the medicine in a different way that you are supposed to ( Crushing tablets and then snorting/injecting them)
    - ▶ Using the medication for another purpose, such as getting high
  - ▶ Non-medical use ( prescription drug abuse, illicit use) – intentional or unintentional use of legitimately prescribed medication in an unprescribed manner for its psychic effect ( either experimentation or recreationally , and/or deciding to increase the dose of one’s own medication (American College of Preventative Medicine 9)
  - ▶ Use of any form of prescription pain relievers that were not prescribed for you or that you took only for the experience or feeling they caused ( SAMHSA 10)

# Trauma informed care

- ▶ Trauma awareness - trauma impacts development and lead to a wide range of adaptations to cope and survive trauma
- ▶ Emphasis on safety and trustworthiness
- ▶ Ethical practice – requires self-awareness and prioritizing autonomy, dignity and rights (11,12)
- ▶ Opportunity for choice, collaboration and connection
  - ▶ Safe environments that foster a sense of efficacy, self determination, dignity and personal control for receiving care



# Trauma informed language

| FROM<br>(deficit perspective)              | TO<br>(Trauma – informed and Strengths-Based)  |   |
|--|--|---|
| What is wrong?                             | What has happened?   |   |
| Addict/User/<br>Alcoholic/Drunk/<br>Junkie | Person with substance use disorder   | Person first language (13)<br>Change shows that the person “has” a problem, rather than “is” the problem                |
| Clean                                      | Negative ( for a toxicology screen)<br>Not currently or activity using drugs, being in remission or recovery | Using clinically accurate , non-stigmatizing terminology the same way it would be used in other medical conditions (14) |
| Dirty                                      | Testing positive ( For a toxicology screen)<br>Person who uses drugs.(for non-toxicology purposes)           |   |
| Abuse                                      | Use ( for illicit drugs)<br>Misuse or non-medical use ( For prescription medications)                        | High association with negative judgement and punishment (14)  |



# Examples of conversation starters

- ▶ Trauma awareness (15)
  - ▶ “When a child experiences abuse or neglect, they feel helpless and trapped. These overwhelming, distressful feelings can change how the brain and body work and affect memory, thinking, and relationships. Many people don’t know it is still affective their lives so many years later.”
- ▶ Destigmatizing and normalizing responses
  - ▶ “the feeling of not being able to relax, high anxiety and always being on guard, the changes in your daily patterns and avoiding certain things, these are common responses to trauma. You are not going crazy”
- ▶ What happened is not their fault
  - ▶ “I am so sorry this has happened to you. What has happened to you is not okay. You have no control over the situation”



# Motivational Interviewing



- ▶ Collaborative patient centered counselling approach
  - ▶ Helps resolve ambivalence on change
  - ▶ Used in healthcare, substance use, mental health and chronic disease management
  - ▶ Supports forward movement without judgement



# MI Delivery - OARS

- ▶ Open-ended questions
  - ▶ Affirmation
  - ▶ Reflective listening
  - ▶ Summarize
- 



# When to use MI

- ▶ Addiction recovery
  - ▶ Medication Adherence
  - ▶ Diet and lifestyle changes
  - ▶ Chronic illness self-management
  - ▶ Mental health engagement
- 

# HARM REDUCTION – key principles



## Non-judgmental care

Grounded in justice and human rights – positive change without judgement, coercion, discrimination

Respect + Dignity



## Patient centered

Meeting people where they are



## Practical and pragmatic approach



## Involvement of community and providers through education

# Harm reduction strategies

- ▶ Use of PDMP data
- ▶ UDS
- ▶ Pill/Patch counts
- ▶ Education regarding drug storage – Providing pill/lock boxes
- ▶ Naloxone administration and education about naloxone
  - ▶ What opioid overdose looks like vs what end of life looks like
- ▶ Frequency of visits
- ▶ Home visits
- ▶ Involvement of multidisciplinary team
- ▶ Safe, inclusive space to discuss drug use, receive care; without causing stigmatization and exclusion from care

# Communication Strategies

- ▶ Forming a therapeutic alliance (16)
- ▶ Validate patient's pain
  - ▶ Explore patient's physical and mental suffering – regardless of presence of substance use
  - ▶ Empathetic statements
    - ▶ “I cannot imagine what this must feel like. You have been through a lot” (17)
    - ▶ “Help me understand what you know about your cancer and what you're hoping for with your pain?”
- ▶ Being direct
  - ▶ Asking about non-medical use and substance use disorders
    - ▶ “Have you ever used heroin?” (vs you haven't used heroin, have you)
    - ▶ “Have you bought pills illicitly or taken pills from friends and family”
  - ▶ Length of sobriety
  - ▶ Have you been on medication assisted treatment like Suboxone, Methadone – how long

# Communication strategies contd.

- ▶ Harms associated with non-medical use of opioids (17)
  - ▶ “I am worried about the way you are taking your medications, and can harm you”
  - ▶ “primary goal is to keep you safe and improve your health”
- ▶ Setting clear boundaries
  - ▶ “If you run out of medications early, we will not be able to provide an early refill”
  - ▶ Setting realistic goals – collaborating with patient on what a ‘good’ day looks like, focusing on function, quality of life, not just eliminating pain completely.”
- ▶ Non-abandonment
  - ▶ “regardless we will still continue to take care of you, and have other options for pain management that are not opioids”
  - ▶ “I am here to help you through this, and we’ll work on it together”
- ▶ Discussing UDS
  - ▶ Timely discussions of results; being direct and providing explanations about the results we are seeing.
  - ▶ “Can you help me understand what could have happened to explain these results”
  - ▶ “What was going on at that time?”
- ▶ Prognosis
  - ▶ I appreciate you sharing that with me. It takes a lot of courage to talk about his



# Case discussion

- ▶ Ms. C
- ▶ Recurrent ovarian cancer – on Mirvetuximab – completed 9 cycles
- ▶ Cancer related pain – currently on Butrans 15mcg/hr + Hydrocodone/Acet 10-325 PRN
- ▶ Previously on Oxycontin +/- Oxycodone IR

# Factors to consider

## ▶ **Physical pain – chronic/cancer related**

- ▶ Characteristics – Sharp stabbing pain in pelvic/lower abdomen; non radiating; not worse with food/other factors.
- ▶ Chronic back pain; hx of falls - DJD
- ▶ Imaging - Good treatment response; stable tumour size

## ▶ **Psychosocial factors**

- ▶ Childhood trauma, Hx of sexual abuse, Complicated grief (loss of a child and her mother),
- ▶ Food insecurity
- ▶ Insurance issues with psychiatrist

## ▶ **Behavioral patterns**

- ▶ NMOU - Oxycodone use, Cocaine metabolites positive intermittently

## ▶ **Prognosis**

- ▶ Great treatment response; prognosis ~years.

## ▶ **Performance status**

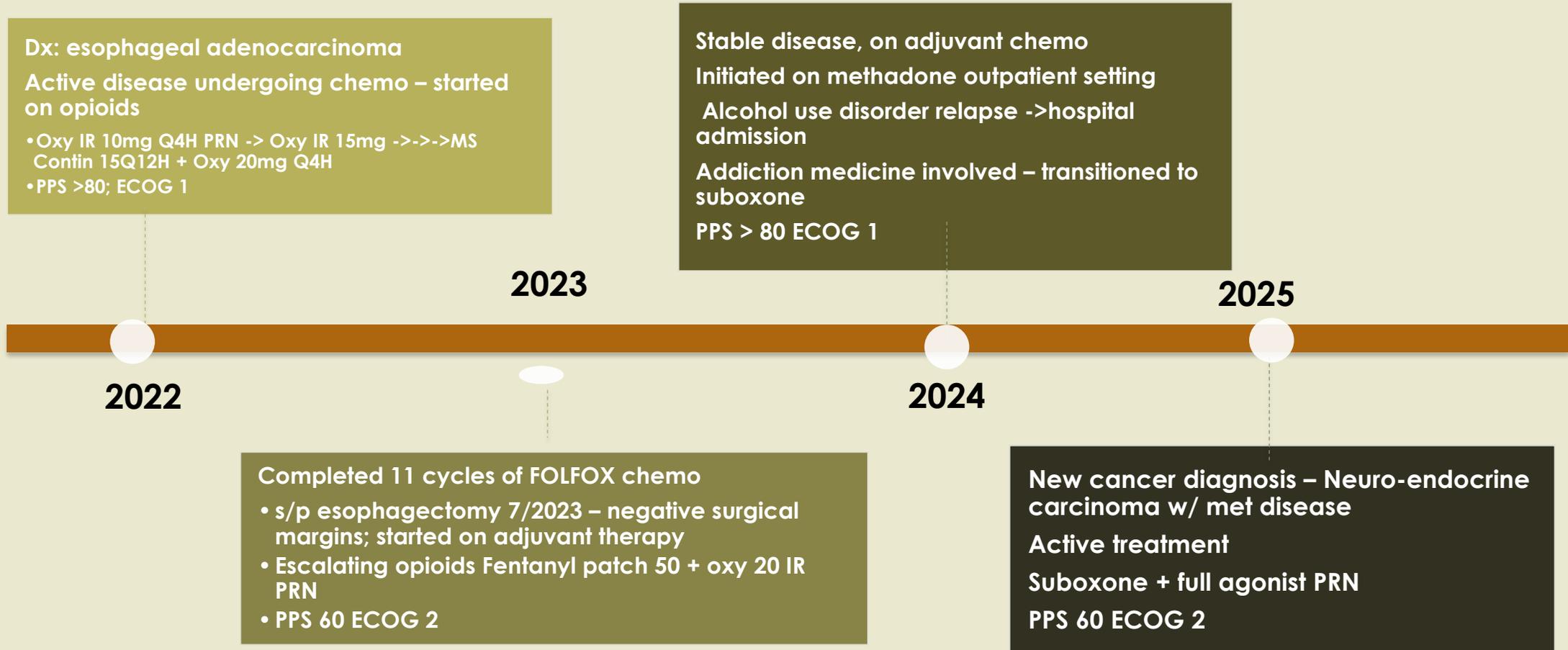
- ▶ PPS 80



# Key points

- ▶ Safe opioid use, naloxone education
- ▶ Harms vs benefits of opioids, discussing biophysical psychosocial model of pain
- ▶ Judicious use of PRNs - Limit PRN, with weekly prescriptions for PRN – giving clear instructions on how many pills she can take
- ▶ Discussing UDS
  - ▶ “What was going on for you at that time?” Could you tell me more about what you were feeling?
- ▶ Exploring emotions and responding to emotion
  - ▶ Open ended questions “ how did that situation make you feel?”
  - ▶ NURS – Name, Understand, Respect, Support (VITAL TALK)
- ▶ Communicating prognosis
- ▶ Non-abandonement – not withholding care when patients make mistakes
- ▶ “What are your goals? How does the use of non-prescription oxycodone fit in with other things that are happening in your life?”

# Case 2 Mr. L - Timeline





# Factors to consider

- ▶ Physical pain – chronic/cancer related
  - ▶ Characteristics – esophageal pain, epigastric pain/upper abdominal pain
  - ▶ Rib pain from falls/fractures
  - ▶ Neuropathy
- ▶ Psychosocial factors
  - ▶ Anxiety
  - ▶ Likely fueling alcohol use via potential diversion of prescribed opioids.
- ▶ Behavioral patterns
  - ▶ UDS intermittently negative for the opioids being prescribed
  - ▶ Running out of prescriptions early/asking for early refills
  - ▶ Did not require as many PRNs in inpatient setting.
- ▶ Prognosis
  - ▶ Initially stable disease; recurrence in 2025 with poor prognosis and passed away May 2025
- ▶ Performance status
  - ▶ 2022-2024 PPS 80 and above; 2025 PPS < 50

# Key points

- ▶ Addressing Alcohol use disorder
- ▶ Counselling on not obtaining non-prescribed opioids
- ▶ Transitioning to Methadone
- ▶ Hospitalization + Switching to Suboxone + PRN full agonist use
- ▶ Goal setting/Boundaries, reviewing UDS
- ▶ Had Narcan at home; reviewing signs and symptoms of overdose
- ▶ Counselling on alcohol use
- ▶ Non-abandonement

Discussion



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