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Nursing Care for the Patient with Co-Existing Pain and Substance Misuse: Meeting the Patient's Needs

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Meeting the needs of the patient with co-existing pain and substance misuse is a complex ethical issue. As advocates for the patient, nurses participate in developing a patient-centered approach to care.

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A newly admitted patient complained of severe low back pain from an "old work injury." He rated his pain as 10 on a 0-10 intensity scale (with 0 being no pain and 10 the worst pain imaginable). He was grimacing and did not want to move from one position. Because the patient's chart had no orders for analgesia, the nurse called the admitting physician and was informed the patient had a history of substance abuse and addiction, with a urine toxicology screen done in the emergency room positive for marijuana. The physician gave orders to treat the patient's pain with acetaminophen. The nurse reminded the physician the patient's pain was severe and the patient took hydrocodone with acetaminophen at home for pain, but was unable to obtain additional orders.

Nurses encounter a variety of ethical dilemmas when caring for patients with complex social and medical issues. One such struggle involves advocating for the treatment of pain in patients who have past or current substance misuse problems. Treating a patient's pain is a high priority for nurses, but many obstacles may interfere, particularly when the patient has co-existing substance misuse (McCaffery & Vourakis, 1992; Morgan & White, 2009; Trafton, Olivia, Horst, Minkel, & Humphreys, 2003). To meet the patient's needs, nurses must understand both the physical and psychological elements associated with pain and substance misuse, as well as the consequences of unrelieved pain.

Pain

Between one-third and one-half of adults live with some form of daily or recurrent pain (Wiedemer, Harden, Arnde, & Gallagher, 2007). Pain is both a physiological sensation and psychological condition with physical, cognitive, emotional, and behavioral characteristics (Manchikanti et al., 2007). Physical consequences of unrelieved pain include increased heart rate, systemic vascular resistance, an increase in circulating catecholamines, decreased mobility and consequent loss of strength, disturbed sleep, and immune system impairment and susceptibility to disease. Some psychological consequences are dependence on medication and co-dependence on family members and caregivers. Individuals who live with chronic pain are four times more likely to suffer from depression or anxiety than persons without pain. Additionally, a postoperative patient is more likely to experience myocar-

dial ischemia, stroke, bleeding, and various other postoperative complications (Brennan, Obs, Carr, & Cousins, 2007).

Unrelieved pain can diminish quality of life, further weaken debilitated patients, and cause needless suffering. Living with pain can contribute to increased levels of anxiety and have a significant impact on the coping skills of the patient and loved ones (Morgan, 2006). Increased hospital length of stay, frequent re-admissions, increased outpatient and emergency department utilization, and patient loss of employment can have a financial impact on the patient (Brennan et al., 2007; Morgan, 2006; Morgan & White, 2009; Wiedemer et al., 2007).

Failure to treat acute pain can lead to chronic pain (Millard, 2007). Individuals with chronic pain are more than twice as likely to have difficulty working, suffer loss of wages, and experience nonproductivity in the home. Due to inadequately treated pain in employees, many companies see increased costs of worker compensation and disability payments, and many times costs are compounded by expenses related to litigation (Brennan et al., 2007).

Timely treatment of pain can prevent delays in healing and cause changes in the central nervous system, such as sensitization, neuronal plasticity, cortical reorganization, and spontaneous pain. Chronic stress, family stress, depression, job loss, and suicide also can be reduced or prevented (Wiedemer et al., 2007). Effective treatment of both acute and chronic pain can improve the overall quality of life, including preservation of independence and more enjoyable interactions with family and friends (Brennan et al., 2007).

Substance Misuse

The term *substance abuse* is defined as a pattern of maladaptive behavior involving repeated or continued substance use, resulting in clinically significant social or interpersonal impairment or distress (American Psychiatric Association, 2000; Hertz & Knight, 2006). Because substance abuse is a diagnosis, the term *substance misuse* has been used throughout this article to identify individuals who use drugs or medications for other than their intended purposes. *Pseudoaddiction* occurs when patients with inadequately treated pain exhibit drug-seeking behavior similar to that of addicts; unlike addiction, however, the behavior resolves when adequate pain management is achieved (Hertz & Knight, 2006; Kahan, Srivastava, Wilson, Gourlay, & Midmer, 2006). If chronic pain is treated as though it were acute pain, an individual's repeated requests for pain medication may appear falsely to be drug-seeking behavior (Millard, 2007). Often patients with undertreated pain exhibit behavior commonly called "clock watching." Watching the clock and asking for pain medications up to an hour in advance are more often signs of inadequately treated pain or pseudoaddiction than they are signs of substance misuse or drug-seeking behavior. Generally this behavior is the defense mechanism of patients trying to gain control over their pain or fearing loss of control over their pain (Morgan, 2006).

Extensive literature associates pain with psychological disorders. Substance misuse is more prevalent in individuals who have experienced at least one major depressive episode in their lives, and serious psychological distress is correlated highly with substance dependence or misuse. Persons with a lifetime mental disorder have more than twice the risk of having an alcohol abuse disorder and over four times the risk of having another substance misuse disorder than persons who have never experienced a mental disorder (Manchikanti et al., 2007). Given the high incidence of co-occurrence between depression and substance misuse, some physicians recommend routine screening for substance misuse disorders in all patients with depression (Hertz & Knight, 2006).

As much as 10%-15% of the general population may suffer from substance misuse or chemical dependency disorders, including alcohol, tobacco, and illicit substances (Gourlay, 2007; Millard, 2007). Prolonged use of addictive substances can alter the biochemical structure and function of the brain, causing neuroadaptive changes, cortical reorganization, neuronal plasticity, and sensitization (Lafferty, Hunter, & Marsh, 2006; Wiedemer et al., 2007). A 2004 report by the National Survey on Drug Abuse and Health indicated more than 6 million Americans are engaged in non-medical use of prescription medications, including pain relievers, tranquilizers, stimulants, and sedatives (Hertz & Knight, 2006; Lafferty et al., 2006). An estimated 48 million individuals have used prescription medications for non-medically sanctioned reasons at some time in their lives (Hertz & Knight, 2006).

One report estimated a 94% increase in prescription medication misuse from 1992 to 2003 (Lafferty et al., 2006). This marked rise could be due to the relative ease of acquiring prescriptive medications. Risk of arrest and legal action related to buying and selling illicit drugs may make misuse of prescription medications more socially acceptable. The purity and concentration of prescriptive medications is monitored rigorously, making them safer than many illicit substances, and prescription medications have become a favorable substitute for illicit substances when a substance of choice is unavailable. Finally, prescriptive medications can be misused by individu-

als wanting to avoid withdrawal or detoxification from illicit substance use (Cicero et al., 2007).

Warning Signs of Substance Misuse

Signs of substance misuse include frequent late-night visits to the emergency room, long detailed excuses for losing a prescription, use of multiple names, stealing or forging prescriptions, and diverting or selling prescriptions or prescription medication. Patients also arouse suspicion if they are focused on a particular medication despite the offer of an alternative and explanation of its benefit, and despite experiencing uncomfortable side effects from the requested medication (Hertz & Knight, 2006; Kahan et al., 2006; Millard, 2007). Among other clinical features of prescriptive drug misuse are unsanctioned prescription medication use, such as hording pills then binging on them; altering the route of delivery (crushing sustained-release tablets); and accessing prescription medications from other sources (Hertz & Knight, 2006; Kahan et al., 2006). A patient requesting pure opioids and refusing an opioid/acetaminophen combination pill also may be suspect because opioids combined with acetaminophen are more difficult to misuse.

A patient's history can help the health care provider identify suspicion of substance misuse. Often the patient's pharmacy can verify the prescription refill history and identify if multiple prescribers are involved in his or her care. Unwillingness on the patient's part to provide preferred pharmacy information can be a strong indicator of substance misuse (Millard, 2007).

Several risk factors can predispose an individual to substance misuse. These include youth and current, past, or family history of substance misuse (Kahan et al., 2006). Concurrent psychiatric disorders and some social conditions, such as weak family structure, peer group pressures, growing up in a high-crime neighborhood, and a childhood history of sexual abuse, also are known risk factors for substance misuse (Gourlay, 2007; Kahan et al., 2006; Manchikanti et al., 2007). No single warning sign or indicator is indicative of substance misuse or prescription diversion. Every suspicion should be investigated carefully by the health care provider and considered as part of the whole patient history; a thorough pain assessment should be included in the overall assessment (Kahan et al., 2006; Manchikanti et al., 2007).

Barriers to Effective Pain Management

One of the most commonly accepted definitions for pain is that "pain exists whenever the patient says it does" (Modesto-Lowe, Johnson, & Petry, 2007, p. 424). No accurate measure of pain exists other than patient self-report. Pain is a purely subjective phenomenon. Research has found no significant association between self-reported pain and the patient's vital signs, which have been used historically as part of a pain assessment (Marco, Plewa, Buderer, Hymel, & Cooper, 2006; Millard, 2007). The use of a pain intensity scale has become common practice in most hospitals in the United States, but it is complicated by variation in patients' pain thresholds, perceptions, and communication styles (McCaffery & Vourakis, 1992; Millard, 2007).

One study of pain management in persons with substance abuse disorders investigated the prescriptive practices for pain management in addicted and nonaddicted individuals. Clinicians were issued case studies involving patients suffering from severe burns either with or without addiction history, and asked to recommend analgesia. The study found a significant undertreatment of patients with addiction history. The authors recommended further research to determine barriers that might impede clinicians from prescribing adequate analgesia and suggested increased awareness of this problem by nurses may improve proper assessment and treatment of pain (Cook, Sefcik, & Stetina, 2004).

Many health care providers have little or no training in pain management, and many people in pain are not aware they can ask for pain treatment. A health care provider's attitude or bias regarding pain can have devastating consequences for effective patient communication and successful pain management. Provider knowledge deficits also can have a major impact on effective pain management. Many clinicians do not feel adequately prepared to care for patients with co-existing pain and addiction, and therefore may be reluctant to treat those individuals. Both provider and patient fear of addiction to pain medication can hinder effective pain management (Morgan, 2006). Patients as well may hide their current or past substance misuse problems for fear of negative attitudes or stigmatization, concern regarding punishment or unfair treatment, or fear of personal, professional, or legal repercussions (McCaffery & Vourakis, 1992). Clinician skepticism toward patients complaining of chronic pain can promote stigmatization, opiophobia (fear of using opioids related to the stigma surrounding their use), and undertreatment of legitimate problems (Brennan et al., 2007; Millard, 2007). One common error is withholding pain medication from patients with a history of substance misuse due to fear that prescribing analgesics may exacerbate the problem. However, withholding analgesics from patients with a history of substance misuse has never been shown to increase their likelihood

of recovery, and prescribing analgesics has never been shown to worsen substance misuse problems (McCaffery & Vourakis, 1992).

Ethics and Law

The relief of pain, discomfort, or suffering is a core ethical duty of health care professionals (Johnson, 2007). Any barrier to pain management is essentially a question of ethics. Many of the warning signs or indicators used to screen drug seekers are ineffective, inaccurate, and unethical (e.g., keeping lists of habitual patients) (Millard, 2007). Systems for identifying individuals seeking drugs (such as drug-seeker lists in the emergency room) cause injustice in the health care delivery system by creating bias and possibly compromising privacy, and they often can lead to entire groups of individuals getting ineffective care due to irrelevant characteristics (Johnson, 2007; Millard, 2007).

According to the American Nurses Association (ANA, 2001), "Nursing encompasses…the alleviation of suffering" (p. 5). This statement from the *Code of Ethics* is a call for all nurses to be aware of a patient's pain and discomfort, regardless of extraneous factors, and take necessary measures to address that individual's pain management needs. Unfortunately, lack of knowledge of pain management and substance misuse, as well as an apparent stigma surrounding substance misuse, are potential barriers to effective pain management and the alleviation of suffering (Morgan & White, 2009).

Many ethical principles apply to the proper and prompt treatment of pain. *Beneficence* is the duty to prevent harm, reduce, or remove harm that is already in action, and bring about good. To relieve an individual's pain and suffering is considered a good and beneficent act. The principle of *nonmaleficence* (to do no harm) also applies. Failing to offer reasonable treatment for an individual's pain can cause harm because persistent, inadequately treated pain has both physical and psychological effects. *Autonomy* is the patient's right to make personal decisions independently and without coercion (Purtilo, 2005). Pain can consume a patient to the extent that it can impinge on his or her ability to make choices regarding care. Relieving pain and providing comfort can relax the patient and allow him or her to evaluate benefits of different treatment options without the distraction of the pain in order to make a fully informed treatment decision (Brennan et al., 2007).

The National Pain Care Policy Act of 2007 was designed to address many barriers to effective pain management by improving pain care research, education, training, access, outreach, and care (American Pain Society, 2007). The Act launched a public awareness campaign to educate consumers about the significance of pain as a national public health problem and identify resources available to patients (American Pain Society, 2007). The American Hospital Association (1998) published the *Patient's Bill of Rights* to affirm, among other things, the patient's right to make autonomous decisions and receive considerate and respectful care. The patient thus has a right to be informed of pain care options and be a part of the decision-making process regarding pain treatment. Use of the *Patient's Bill of Rights* is now a widespread practice in hospitals across the country. Additionally, the Joint Commission has issued the *Pain Standards* with the minimum criteria for the assessment and treatment of pain for institutions seeking accreditation (Joint Commission Resources, 2009). The standards place the onus on health care organizations to manage pain and meet comfort needs of patients. The National Institutes of Health have issued guidelines for pain management as well (Cook et al., 2004).

Pain, existing alone and without any other physical injury, can be considered as an injury under the law. Thus, the patient who suffers pain can seek recourse in the courts (Johnson, 2007). In addition, failing to manage pain effectively in a person with a substance misuse history can be viewed as a form of discrimination (Orr & Cabaj, 2006).

Assessment of the Patient with Co-Existing Pain and Substance Misuse

The nurse should begin with a thorough assessment of both acute and chronic pain. Current pain levels often are assessed using a pain intensity scale, such as rating pain from 0-10 (0 equals no pain and 10 represents the worst pain) or by ranking pain as "none," "mild," "moderate," "severe," or "very severe" (Krebs, Carey, & Weinberger, 2007). Assessment of chronic pain should include home management strategies, such as analgesic doses and non-pharmacologic methods employed by the individual. Substance misuse indicators should be considered when assessing a patient's pain, and history of or current substance misuse should be integrated into the whole patient history (Millard, 2007; Morgan & White, 2009).

Many screening tools can help physicians and nurses identify individuals with substance misuse histories and treat them appropriately. A careful baseline history of both pain and substance misuse for all patients, as well as careful observation for signs of misuse or diversion, are essential (Kahan et al., 2006). For instance, the CAGE questionnaire, commonly used to screen patients with alcoholism, can determine if the patient has ever tried to *Cut down* or *Change* the pattern of drinking, has ever been *Annoyed* or *Angry* because of others' concern about drinking,

has ever felt *Guilty* regarding the consequences of drinking, or had ever needed to drink in the morning as an *Eye-opener* to decrease withdrawal symptoms. The CAGE questionnaire can be adapted for use with other substances by substituting the word *drug* for *drink* (Kahan et al., 2006; Millard, 2007). Other tools include the Opioid Risk Tool (which identifies abuse risk factors, such as family history, age, and psychiatric disorders) and the Pain Medicine Questionnaire (a 26-item questionnaire that evaluates chronic pain and attempts to isolate pain-related variables that may suggest misuse liability) (Kahan et al., 2006; Manchikanti et al., 2007). One prescription misuse checklist focuses on five different criteria that might indicate higher risk for substance misuse: overwhelming focus on opioid issues persisting beyond the third clinic treatment session, a persistent pattern of early refills, multiple telephone calls or office visits requesting more opioids, reports of consistent problems associated with the opioid prescription (lost, spilled, stolen medications), and opioids obtained from multiple providers, emergency rooms, or illegal sources (Manchikanti et al., 2007). The information from these screening tools can be presented to the clinician to assist in meeting the patient's pain care needs safely.

A practical starting point is to request records from previous providers or from the patient's pharmacies (Kahan et al., 2006). Rational polypharmacy, including careful prescribing and ongoing vigilance for signs of misuse, time-limited trials of structured opioid therapy, daily-to-weekly dispensing, pill counts, and cautious tapering of opioid doses, is critical (Kahan et al., 2006; Wiedemer et al., 2007). Complementary modalities, such as physical therapy, psychotherapy, family therapy, and interventional pain management (such as epidurals or nerve blocks), also may be valuable (Wiedemer et al., 2007). Many clinicians suggest the use of urine toxicology screens prior to writing prescriptions, as well as performing random urine toxicology screens during treatment to monitor the patient for self-medicating behavior. Treatment may be discontinued if illicit substances are detected (Hertz & Knight, 2006; Kahan et al., 2006; Millard, 2007; Wiedemer et al., 2007).

Developing a Patient-Centered Approach

A patient-centered approach is a way of delivering compassionate, competent care by acknowledging the need for all health care providers to work as a team with the patient at its center (Morgan & White, 2009). Components of a patient-centered approach include involving the patient in planning the pain treatment, maintaining a respectful attitude toward the patient, enhancing the patient's support systems, providing verbal and written information/delivering information in the patient's preferred learning style, providing ongoing education and support, maintaining consistency and dependability, fostering open discussions regarding pain and substance misuse without passing judgment, and establishing realistic goals for treatment (Morgan & White, 2009).

In one grounded theory study, patients were interviewed to gain a better understanding of the problem of pain management in persons with a substance misuse history. Two strong themes emerged: feeling respected/not respected, and strategizing to get pain relief. Many patients in the study voiced concern over not feeling respected by nurses. Strategizing to get pain medications happened regardless of feeling respected by the nurse. If the patient felt respected, strategizing became a collaborative effort between the patient and nurse to find the most effective regimen of currently ordered medications or to collaborate further with the physician if no effective regimen could be established. If the patient did not feel respected, strategizing often was unsuccessful (Morgan, 2006).

Clinicians should be committed to reducing patient suffering without minimizing the patient's self-worth due to a substance misuse problem (Brennan et al., 2007). The provider should remember the patient who specifies a drug and dosage may simply be well educated on his or her condition and medical needs. With the advent of Internet education, many individuals research their conditions, sometimes before even approaching a health care professional (Millard, 2007).

A nurse practitioner-driven study tested the Pain Medicine and Primary Care Community Rehabilitation Model and suggested an approach based on the following principles: evidence-based primary care treatment; timely access to pain medicine in order to prevent or reduce morbidity and improve functional outcomes; goal-oriented, outcomes-driven care; and efficient use of available community resources, such as pharmacists, support groups, and outreach clinics (Wiedemer et al., 2007). A consult with a pain management specialist may be indicated when available. Alternately, a consult with a clinical pharmacist can guide the primary provider in prescribing analgesia. Consulting the social worker or case manager for discharge planning also is a crucial aspect of care. The case manager can help the patient choose an addiction treatment center or rehabilitation facility for detoxification, address modifiable lifestyle risk factors, and identify sources of support for the patient's recovery.

Opioid contracts, also known as opioid treatment agreements, are used commonly and may

prove helpful in some cases of substance misuse. They often contain content pertaining to the facility's policies and responsibilities, and may include language prohibiting drug seeking in emergency departments. However, these contracts are not legally binding, are difficult to enforce, vary widely in content, and are not always read or understood (Hertz & Knight, 2006; Kahan et al., 2006; Millard, 2007; Wiedemer et al., 2007). Habitual patient lists (formal or informal) can be potentially beneficial. They keep a handy record of patients who routinely seek pain medication. However, they also can introduce bias by leading staff to assume a patient is drug-seeking when that may be unrelated to the current complaint, can compromise patient privacy (requiring rigorous safeguards), and can become a vehicle for staff retaliation against unsavory patients (Millard, 2007).

Nursing Implications

A thorough understanding of the consequences of untreated pain and an awareness of available resources are vital to providing effective, holistic nursing care. Providing the patient with a copy of the *Patient's Bill of Rights* and including the patient in developing a treatment plan for pain are key elements in creating a patient-centered approach (Morgan & White, 2009). All members of the dynamic health care team must be involved, with the patient at the center of the team. Community and institutional resources, such as clinical pharmacists, pain management specialists, and social workers or cases managers, should be used (Morgan & White, 2009; Wiedemer et al., 2007). Nurses must maintain a respectful attitude toward the patient and involve him or her in planning pain treatment, providing ongoing education and helping the patient enhance and expand support systems (Morgan & White, 2009). Written opioid contracts or treatment agreements may be used if they are consistent with institutional policy (Hertz & Knight, 2006; Kahan et al., 2006; Millard, 2007).

Nurses working in inpatient environments need to be aware of patients who watch the clock and evaluate their behavior for signs of pseudoaddiction vs. drug seeking (Morgan, 2006). Because pain is subjective, nurses should accept and respect the patient's report of pain (McCaffery & Vourakis, 1992; Modesto-Lowe et al., 2007). Nurses also need to be aware of their own feelings and potential biases regarding individuals with substance misuse problems. It is imperative to be aware of the stigma surrounding the patient with substance misuse, and foster open discussion regarding pain medication and substance misuse with the patient, fellow clinicians, and administrators (Morgan, 2006; Morgan & White, 2009). ■

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