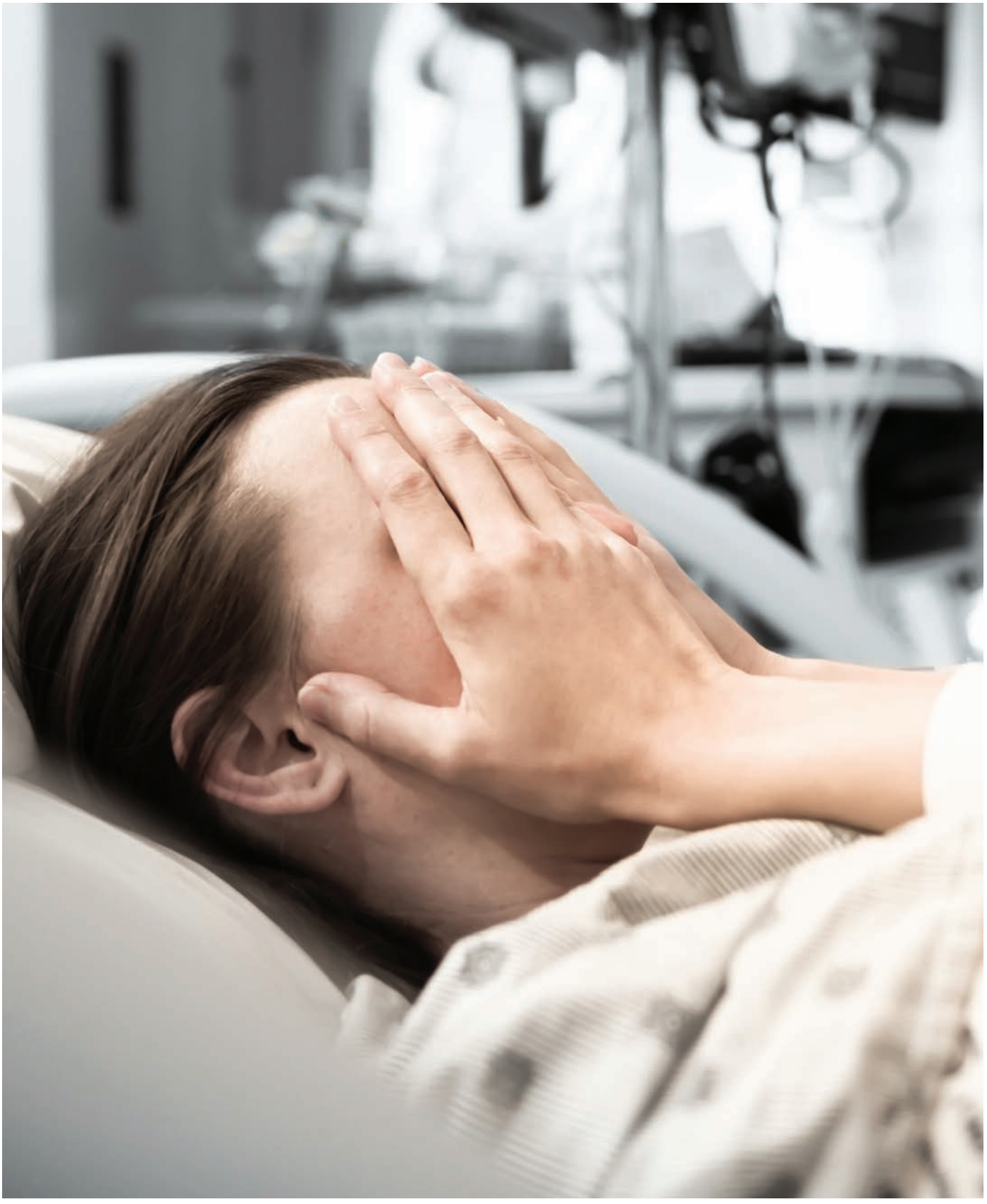

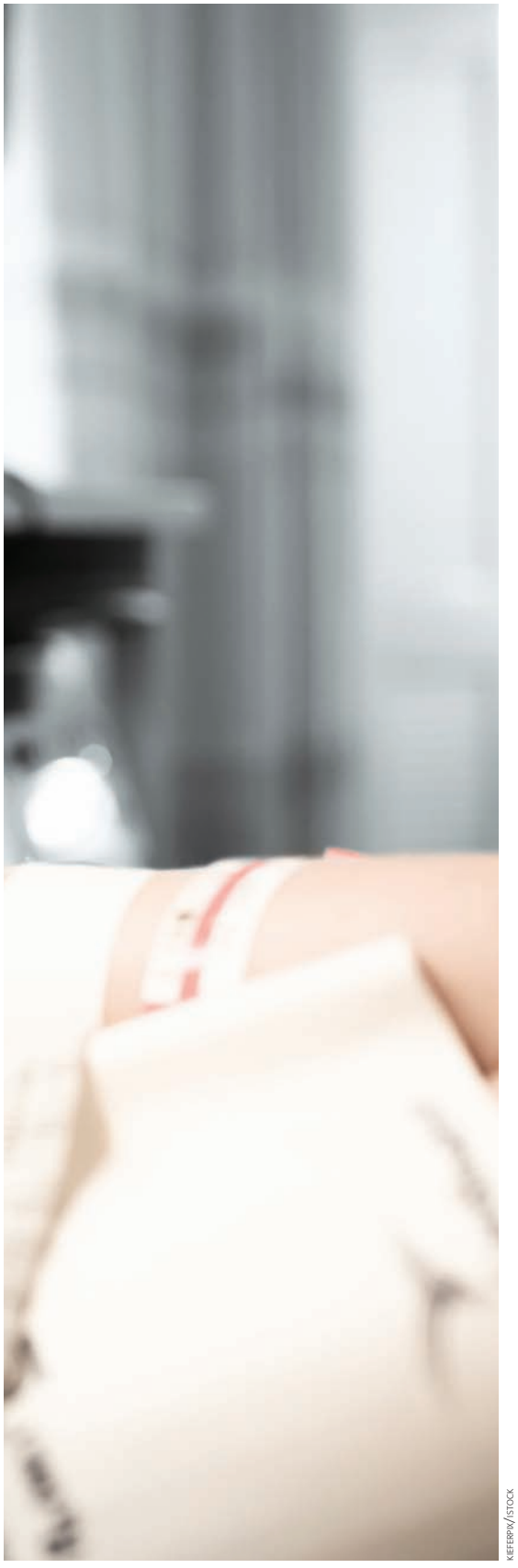

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Managing pain in seriously ill patients with substance use disorders

BY POLLY MAZANEC, PhD, ACNP-BC, AOCN, ACHPN, FPCN, FAAN; JUDY PAICE, PhD, RN, FAAN; GRACE CAMPBELL, PhD, MSW, CRRN; PAMELA K. GINEX, EdD, RN, OCN; MELODEE HARRIS, PhD, RN, FAAN; MARIANNE MATZO, PhD, APRN-CNP, AOCNP, ACHPN, FPCN, FAAN

Abstract: Managing pain can be challenging, especially in patients with serious illnesses and a history of substance use disorders. This article discusses the challenges of addressing pain in these patients and offers perspectives regarding their clinical management.

Keywords: opioid, opioid use disorder, pain, pain management, substance use disorder, SUD

PAIN AFFECTS more patients in the US than heart disease, diabetes, and cancer combined.[1] Persistent, chronic pain requires a multidisciplinary approach that utilizes evidence-based nonpharmacologic and pharmacologic therapies. Nurses have an ethical responsibility to manage and comfort patients experiencing pain.[2,3] This article describes the challenges of pain management in patients with serious illnesses and a history of substance use disorders (SUDs).

Despite the availability of nonopioid therapies for acute and chronic pain, patients with serious illnesses and comorbid SUDs often require opioid interventions.[4] Given the current opioid crisis, nurses should respond with compassion, expert knowledge, evidence-based nonpharmacologic and pharmacologic interventions, and risk mitigation.[5] As patient advocates, nurses understand that SUDs do not represent character flaws, lack of willpower, or moral failures; instead, these are distinct illnesses.[6]

Defining serious illnesses

Established by the National Consensus Project, the Clinical Practice Guidelines for Quality Palliative Care define serious illnesses as "health condition[s] that [carry] a high risk of mortality and either negatively [impact] a person's daily function or quality of life or excessively [strain] their caregiver."[7] Chronic conditions such as low back pain and fibromyalgia do not fall into this category

because they are not typically life-threatening.

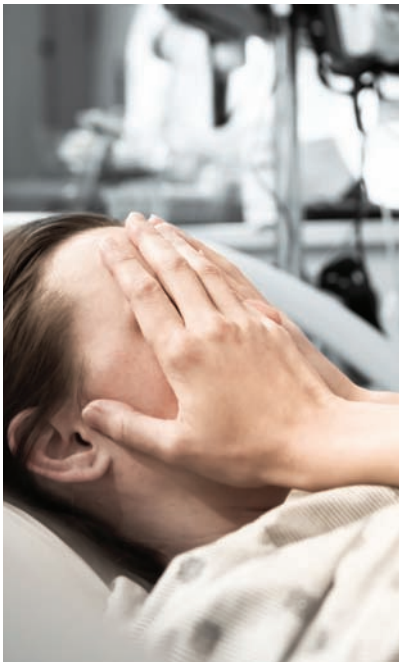
Acute, chronic, and acute exacerbation of chronic pain can have a physical, mental, economic, and psychosocial impact on patients, families, and communities, as well as an impact on the quality of life for patients, families, and communities.[1]

- ***Acute pain*** refers to a physiologic response to an adverse chemical, thermal, or mechanical stimulus that activates the pain receptors at the site of tissue damage. It usually lasts around 7 days.[8]
- ***Chronic pain*** lasts or recurs for more than 3 months and may result in diminished well-being, quality of life, and functional abilities.[9,10] Patients with uncontrolled chronic pain are at an increased risk for suicidal ideation and suicide.[11] Patient assessments to address any physical, psychological, social, and/or spiritual needs associated with serious illnesses and end-of-life care are crucial.
- ***Acute exacerbation of chronic pain*** refers to an acute episode of chronic pain, which can be challenging to assess and manage in the midst of long-standing pain.[12]

Substance use disorders

SUDs are characterized in the *Diagnostic and Statistical Manual of Mental Disorders,* 5th edition (DSM-5) as problematic patterns in the use of intoxicating substances such as alcohol or drugs.[13] The DSM-5 diagnostic criteria for these disorders include patients who:[13,14]

- take substances in larger doses and more often than prescribed or intended.
- want to control or curb usage without success.
- spend a lot of time obtaining, using, and recovering from substances.
- experience cravings or urges to use substances.
- fail to fulfill obligations, such as those related to work, school, or family.



Patients with SUDs may be reluctant to report pain due to feelings of weakness, shame, or being undeserving of relief.

- experience recurrent social or interpersonal issues that are worsened by use.
- give up social, recreational, or professional activities previously regarded as important.
- use substances recurrently despite physical risks.
- continue using substances despite physical or mental health concerns caused by use.
- develop a tolerance.
- experience withdrawal.

SUDs may be classified as mild (meeting two to three DSM-5 criteria), moderate (meeting four to five DSM-5 criteria), or severe (meeting six or more DSM-5 criteria) and lead to clinical impairment or distress in patients who meet two or more of 11 diagnostic criteria within a 12-month period.[13-15]

Impact of the opioid epidemic

Opioid use is one specific type of SUD. The opioid epidemic has increased vigilance about the safe use and prescription of these medications, but it has also escalated fears surrounding them. This can have a negative impact on the effectiveness of pain management strategies in patients with serious illnesses who may require opioids to function.[16]

In the US, 9.9 million people age 12 or older (3.6% of the population) misused prescription opioids in 2019.[17] Of those, approximately 3.8 million (38.6%) obtained prescription opioids from friends or relatives.[17] Misuse refers to the improper or unhealthy use of substances such as medications, illicit drugs, and alcohol; examples include taking medications prescribed for another individual or using medications in ways other than prescribed.[15] Additionally, between 1999 and 2018, more than 450,000 deaths related to opioids have been reported nationally.[18] Since 2010, opioid prescriptions have decreased, however, and mortality is often associated with illicit opioid products such as heroin and illegally manufactured fentanyl.[18]

Barriers to pain management

Patients with SUDs may experience suboptimal pain management due to barriers related to the individual, the healthcare team, and/or the healthcare system.[19] Most patients who experience severe pain related to serious illnesses require opioids to manage pain and maintain activities of daily living (ADLs), as well as daily functioning such as working or going to school. However, those with comorbid SUDs may experience inadequate pain management related to serious illnesses, and even in end-of-life care, due to biases, fears, lack of knowledge about dosing patients with an established opioid tolerance, and misconceptions surrounding prescription opioid use.[16]

NURSE statements[26]

The NURSE acronym describes five strategies to support patients in distress. This table provides appropriate example statements in response to patients who are experiencing pain.

Definition	Statement
Naming/normalizing: Naming patients' feelings to help them understand that pain and the associated emotions are normal.	"Pain is a normal part of illness, and you are right where we would expect you to be."
Understanding: Validating patient emotions to demonstrate empathy. Active listening to patient concerns is an important part of this process.	"Pain can be overwhelming and even a little frightening."
Respecting: Demonstrating to patients that the nursing staff knows they are working hard.	"You sat out of bed for nearly an hour this morning. That was hard work, but it will help your recover."
Supporting: Assuring patients that they are not alone and the nursing staff is here to support them.	"We are here to help you. There are many options to help relieve your pain, such as heat or cold packs, relaxation videos, music, deep breathing exercises. Let's try one of these now."
Exploring: Learning about patient experiences, including what has worked in the past. Redirecting may be helpful if the patient continues to focus on opioids.	"You have done a good job of managing your pain during past episodes. What have you found to be helpful?" "Other than opioids, what other treatments, such as hot or cold applications and/or acupuncture, have helped alleviate your pain in the past?"

The featured communication skills materials were adapted from VitalTalk (VitalTalk.org); learn more here: Responding to Emotion: Respecting. VitalTalk. 2019. www.vitaltalk.org/guides/responding-to-emotion-respecting.

Patients with SUDs may be reluctant to report pain due to feelings of weakness, shame, or being undeserving of relief.[20] Additionally, some may choose not to take opioids to maintain their hard-earned sobriety. These patients are also at an increased risk for inadequate pain management from providers with limited knowledge about how to manage pain safely and effectively in patients with SUDs, as well as their preconceived biases about SUDs and fear of regulatory and legal repercussions.[6,21-24]

Inappropriately labeling patients with terms such as "drug seekers" and "frequent flyers" may perpetuate stigmas that reflect punitive judgment rather than compassion and empathy for this patient population.[25] Similarly, systemic barriers such as limited access to pain and addiction specialists may have a negative impact on adequate pain management for patients with SUDs. Reduced reimbursements for evidence-based nonpharmacologic interventions, such as physical and cognitive behavioral therapy, may further impede the availability of alternative pain management interventions.[16]

Addressing barriers

• **Establishing trust.** Patients with serious illnesses and comorbid SUDs should have confidence that their healthcare professionals will believe them when they say they are in pain and advocate for adequate pain management. Demonstrating support and building trust are crucial. If patients are upset about not receiving a particular medication or the desired amount and/or preferred route of that medication, nurses should listen and respond appropriately. For example, one response may be, "I wish we could provide what you are asking for, but this would not be safe. I have heard you, though, and will speak with the clinical team." The NURSE acronym (naming/normalizing, understanding, respecting, supporting, exploring) can help nurses remember supportive components of nurse-patient conversations (see *NURSE statements*).[26]

• **Assessing pain.** Compassionate and honest communication is essential to the assessment, management, and reassessment of pain. Nurses should listen empathically to patient concerns regarding pain and evaluate the effectiveness of pain management interventions.[27]

Another strategy for nurses to achieve safe and effective pain management in patients with serious illnesses and comorbid SUDs is a thorough assessment. This may include patient evaluations of the impact of their pain on ADLs and potential risk factors for misuse of pain medications. The emphasis on functional improvement over pain intensity represents a major shift in goals for pain management.[28]

Because it is difficult to predict which patients might misuse opioid medications, universal precautions are necessary.[29] As such, comprehensive nursing pain assessments should be performed on all patients

experiencing pain, regardless of their substance use history.

• **Managing pain**. Pain management for patients with serious illnesses and a history of SUDs may require multidisciplinary expertise, including specialty palliative care. Nurses should advocate for consultation and a comprehensive, multimodal approach to pain management, which refers to treatment strategies that incorporate both opioid and nonopioid medications as well as nonpharmacologic therapies.[27,30,31] Multimodal approaches to pain management address the physical, psychological, social, and spiritual factors of pain with a multidisciplinary team.[27] For example, patients with psychological concerns such as anxiety or depression would be referred to counseling; those with social concerns such as family, employment, or financial issues to a social worker; and those with spiritual or existential concerns to a chaplain or spiritual care provider.[27,30]

Combination nonpharmacologic and pharmacologic interventions may have an additive and even synergistic effect on pain management, especially in older adults.[32] As such, multidisciplinary teams should also consider nonopioid medications, such as nonsteroidal anti-inflammatory drugs, and nonpharmacologic pain management strategies such as cognitive behavioral therapy and spiritual care.[33] Holistic integrative therapies, such as massage or hypnosis, can also promote healing in those with serious illnesses.[34,35] (See *Nonpharmacologic pain management*.)

With serious illnesses, however, opioids may be necessary and patients with a history of SUDs may require higher doses to achieve pain relief due to tolerance than those who have no such history.[16,36,37] Because this patient population is often undertreated, nurses should be knowledgeable about past or current SUDs and make sure that the provider is aware so an appropriate dosage is prescribed.[22]

Medication for patients with opioid use disorder

Evidence suggests that SUD relapse rates do not increase with short-term opioid use; rather, unrelieved pain may be a more important predictor of relapse.[37] Medications for opioid use disorder (MOUDs), sometimes described as medication-assisted therapies, should be considered separate from the patient's pain regimen, as these medications are not intended to manage pain; rather, they are intended to manage SUDs.[36,38]

For patients with SUDs who receive MOUDs such as methadone, buprenorphine, or naltrexone, adherence to the established regimen is key to avoiding relapse or withdrawal.[39] Outpatient methadone-based MOUD programs do not have to be reported to state prescription drug monitoring programs (PDMPs), so clinicians should contact any outpatient treatment programs for a patient's MOUD dosage to calculate the appropriate analgesic dose for pain management.[36] State PDMPs offer an essential electronic database on patient prescription histories for safe practice and should be accessed and reviewed frequently to identify potential risks.[40]

Nonpharmacologic pain management[4,33-35,43-46]

Below are options for nonpharmacologic therapies to address pain. For most of these therapies, additional research is necessary.

Therapies	Key points
Behavioral approaches (cognitive behavioral therapy, relaxation techniques, guided imagery, mindfulness, distractions)	• Guided imagery allows patients to create an internal experience that connects the body, mind, and spirit. • Mindfulness can help to alleviate physical and emotional pain in patients with a history of SUDs, as pain, depression, and anxiety may increase during the first weeks of medication administration. • Distraction can be helpful for brief periods of pain.
Heat or cold applications	• Based on patient preference, cold applications may be helpful in infections, pruritus, muscle spasms, or acute injuries. Heat applications may be helpful for abdominal cramping.
Massage	• Massage may reduce patient perceptions of pain and improve the patient's overall sense of well-being and relaxation.
Music therapy	• Music can raise endorphin levels and lower adrenaline levels, promoting relaxation and a sense of well-being and decreasing pain intensity.
Prayer	• Spiritual practices or resources may relieve suffering and provide comfort by focusing attention on the sacred. • This is unique to the individual patient.

Patients with serious illnesses and a history of SUDs may wish to maintain sobriety by avoiding opioid treatment. However, the pain and the associated anxiety patients may experience by foregoing short-term opioid use may put them at an increased risk for relapse.[41] Nurses have a responsibility to listen to patient and family fears and provide education on the importance of pain management for ADLs and improved quality of life. Patient goals should guide decision-making regarding nonpharmacologic and pharmacologic interventions.

Mitigating risks of opioid therapies

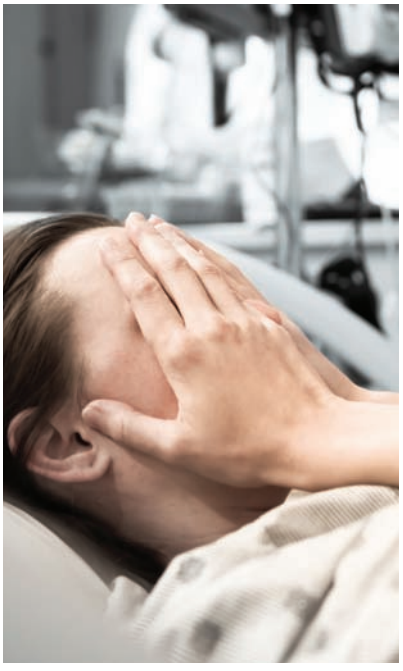
Ongoing monitoring is important throughout patient treatment, and management and follow-up for those on long-term opioid therapies are critical components of clinical care.[42] A regular review of prescription drug monitoring data should be conducted before any therapies are prescribed, including information on medication doses, quantities dispensed, payment methods, pharmacies, and prescribers.[36,40]

Nurses can educate patients and families on the use of lock boxes for opioid medications to protect against theft and to keep potentially lethal doses away from children or pets. Additionally, they can recommend that patients keep a diary of their pain and medication dosages. Patients should be cautioned that medications should never be shared, even with loved ones. Educating patients and families about proper disposal and local take-back programs can also protect the community and the environment.[22]

Case studies

The following examples illustrate appropriate pain management strategies for patients with three pain types.

• **Acute pain.** PG, 55, is a Hispanic male with stage IV lung cancer who is undergoing chemotherapy and will be starting radiation therapy shortly. He has a 35-year, pack-a-day history of tobacco use and has used marijuana and cocaine intermittently for 20 years, including several times in the past month.



With serious illnesses, opioids may be necessary and patients with a history of SUDs may require higher doses to achieve pain relief.

When PG was admitted to the hospital with severe, aching hip pain, imaging studies revealed metastatic disease. Movement and activities in the healthcare facility, such as radiation therapy, make his pain worse. PG is worried that he will not be able to perform ADLs because the pain is unbearable.

Among patients in a 2018 study, approximately 43% to 57% of those receiving curative-intent therapy experienced pain, but this percentage may be as high as 75% in those with advanced disease.[5] PG requires a scheduled extended-release opioid to control the acute hip pain from bone metastases, as well as a p.r.n. immediate-release opioid for breakthrough pain. However, some of the staff nurses are reluctant to administer this medication due to his recent history of SUD.

PG's nurse performs a detailed assessment of PG's breakthrough pain. He actively listens to PG's concerns and demonstrates thoughtful decision-making and compassion by administering the p.r.n. opioid medication before radiation therapy and activities that require movement.

• **Chronic pain.** MM, 45, has chronic obstructive pulmonary disease (COPD). If her COPD takes its normal course, her life expectancy is about 12 months. Additionally, MM has a history of SUD, having used heroin for 20 years, and has been sober for the past 3 years. She receives methadone to manage her MOUD from a local clinic. She was prescribed steroids to manage her COPD and has developed severe osteoporosis as a result, sustaining numerous fractures that have resulted in chronic pain. She was recently discharged from the hospital, where the palliative care team had been managing her signs and symptoms, and she has been prescribed morphine sulfate for pain management.

MM is now being seen by a home healthcare nurse who assesses her COPD management post-hospitalization. The nurse has little experience with methadone and is concerned about the potential risk for relapse and respiratory depression with the administration of an additional opioid. She contacts the palliative care team to determine why MM would be taking an opioid for pain management given that she is already receiving methadone and she has a history of SUD. The nurse reports that the patient is experiencing very little bone pain and can ambulate around her one-bedroom apartment without much difficulty.

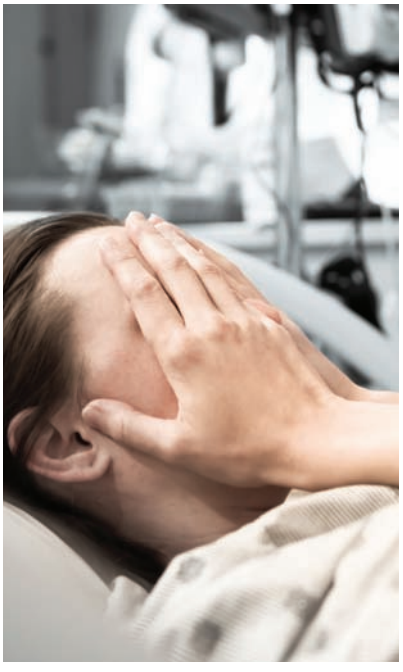
The palliative team explains that nonpharmacologic interventions failed to manage her pain, and that the methadone MM receives to manage her SUD does not manage her pain. As such, her prescribed morphine should improve her comfort and ability to perform ADLs.

• **Acute exacerbation of chronic pain.** RJ, 45, is a Black male patient with sickle cell disease, complicated by oxygen-dependent progressive pulmonary fibrosis and avascular necrosis in his left hip. He was admitted to the hospital with an acute sickle cell crisis and is experiencing severe bone pain in his left upper arm, which he describes as "sharp and excruciating, feeling like a tourniquet around my arm." He also has a history of SUD and reports a 3-year history of regular cocaine use until 2 years ago.

RJ was prescribed oxycodone, which had controlled the ongoing chronic pain. For 48 hours before his admission to the healthcare facility, however, he had been taking p.r.n. oxycodone as prescribed without relief of the acute pain. On a pain intensity scale of 1 to 10 (with 10 representing the highest pain possible), RJ reported his pain at a 10.

The hospitalist questions if RJ's pain is real because he has been observed watching TV and visiting with friends with no apparent discomfort. Because of the patient's history of SUD, the hospitalist is reluctant to increase RJ's opioid dosage in response to this pain crisis.

RJ's nurse understands that the hospitalist has a preconceived idea of what patients in acute pain should look like, which is not grounded in literature. She believes RJ's report of pain, advocates for I.V. titration of his opioid therapy, and educates the hospitalist on how patients sometimes use distraction to manage pain.



Patients may wish to maintain sobriety by avoiding opioid treatment, but foregoing short-term opioid use may put them at an increased risk for relapse.

Meeting a clinical challenge

Managing pain can be challenging, especially in patients with serious illnesses and comorbid SUDs. Nurses should establish a trusting relationship, perform comprehensive assessments, provide nonjudgmental and compassionate care, integrate risk management strategies, and advocate for their patients. They should also be knowledgeable about the use of both nonpharmacologic and pharmacologic interventions and provide education to patients and families to ensure safe and effective pain management. ■

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Polly Mazanec is a visiting associate professor at Case Western Reserve University in Cleveland, Ohio; Judy Paice is director of the cancer pain program at Northwestern University in Chicago, Ill.; Grace Campbell is an assistant professor at the University of Pittsburgh in Pittsburgh, Pa.; Pamela K. Ginex is a senior manager of evidence-based practice and inquiry at the Oncology Nursing Society in Pittsburgh, Pa.; Melodee Harris is an associate professor at the University of Arkansas in Little Rock, Ark.; and. Marianne Matzo is the former director of research at the Hospice and Palliative Nurses Association in Pittsburgh, Pa.

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