Original Article

Implementing Best Practice Guidelines in Pain Assessment and Management on a Women's Psychiatric Inpatient Unit: Exploring Patients' Perceptions

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Abstract:

Assessing and managing chronic pain in women with histories of interpersonal trauma, mood disorders and co-morbid addiction is complex. The aim of this paper is to report on the findings from a quality improvement project exploring women's experiences who have co-occurring mental health issues, addiction and chronic pain. Exploring perceptions was an initial step in implementing the Registered Nurses' Association of Ontario (RNAO) Best Practice Guideline (BPG) on the Assessment and Management of Pain. Focus group discussions were conducted using an exploratory design with 10 women who were hospitalized in an acute psychiatric unit. Our findings suggest that these women view their pain as complex and often feel powerless within an acute psychiatric setting resorting to coping through self management. The women expressed the importance of therapeutic relationships with clinicians in assessing and managing their pain. The implications of this study suggest that patients have a key role in informing the implementation and applicability of best practice guidelines. Validating the patient's personal pain management experience and particular psychological and physical therapies were suggested as strategies to enhance the patient's quality of life. Many clinicians working in mental health are knowledgeable about these therapies, but may not be aware of the application to managing physical pain.

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Received April 27, 2016; Revised March 2, 2017; Accepted March 6, 2017.

1524-9042/$36.00

http://dx.doi.org/10.1016/j.pmn.2017.03.002

Chronic pain can have incapacitating effects on an individual especially if their pain is not well managed or treated (Lynch, 2011; Råheim & Håland, 2006; Watt-Watson, Clark, Finley, & Watson, 1999). Managing chronic pain is complex for individuals receiving inpatient treatment for mental health and addictions care. Poor management of a patient's pain is often related to clinicians' attitudes and knowledge about pain and addiction and the impact of stigma, gender, and how patients view their pain (Côté & Coutu, 2010; Dewar, 2007; Gourlay & Heit, 2008; McCaffery, Grimm, Pasero, Ferrell, & Uman, 2005; Newton, Southall, Raphael, Ashford, & LeMarchand, 2013; Råheim & Håland, 2006; Sartorius, 2007).

Clinician barriers to effective pain treatment include misinformation and fears of addiction (Frey-Revere & Do, 2013). Administering medication for pain becomes challenging when the clinician believes that the patient's request is purely a symptom of substance dependence (Gourlay & Heit, 2008). When a patient has a mental illness and also experiences physical pain, clinicians do not take their pain seriously (Dewar, 2007); thus, the report of pain may not be fully investigated contributing to suboptimal care (van Boekel, Brouwers, van Weeghel, & Garretsen, 2013). Comprehensive assessments that focus on pain intensity, frequency, precipitating factors, alleviating factors, or tests to determine other physiological changes (Sartorius, 2007) may be omitted. Therefore, in order for clinicians to provide competent and ethical care to patients who have pain, it is important that they listen to the patient's subjective experience and that their practice is evidence-informed, which includes an understanding of the complex nature between chronic pain, addiction, and mental illness.

In addition, clinicians' interpretations of patients' experiences of pain could be influenced by the use of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013). The DSM contributes to stigma by often attributing physical symptoms to psychological processes as opposed to appreciating the complexity of pain mechanisms (Katz, Rosenbloom, & Fashler, 2015). As a consequence, the DSM has reinforced a belief that there is a linear relationship between stress and pain so that the clinician assumes that the physical pain of someone with a mental illness is not as real as the pain of a patient with an identified physiological cause (Oken, 2007).

Gender can impact whether or not a patient's disclosure of pain is believed by clinicians. Female stereotypes are prominent where women are perceived as being more emotional, lazy, having a lower threshold for pain, or that their pain is psychological in origin (Côté & Coutu, 2010; Newton et al., 2013). Women struggle with the tension between appearing either too healthy (feeling that they are expected to remain strong) or too sick in their efforts to be understood (Richardson, 2005; Newton et al., 2013; Wener & Malterud, 2003). Understanding this dynamic informs how clinicians interpret women's behaviors and whether or not they provide validation or prematurely make conclusions about the patient's needs.

How patients interpret their experience of pain is often tied to their diagnosis. Unlike patients with a known organic illness, patients with mental illness, such as depression, may not understand where their pain is coming from. As a result, the patients may begin self-medicating with prescription opioids for pain and/or nonpain symptoms, such as unresolved emotional and social distress (Chang & Compton, 2013). Consequently, the effect of the opioids can become a coping strategy in addition to medication to help diminish the physical pain (Arteta, Cobos, Hu, Jordan, & Howard, 2016). Therefore, validating the patient's emotional and physical experience and treating both concurrently is an important clinical intervention (Esteve, Ramirez-Maestre, & Lopez-Martinez, 2007).

The development of clinical interventions in the assessment and management of pain must be guided by the best evidence, which is critical in health care delivery and quality care (Cullen & Titler, 2004). To improve practices related to pain assessment and management, several guidelines and resources have been developed for nurses (RNAO, 2013). The Registered Nurse's Association of Ontario's (RNAO) Best Practice Guidelines (BPG) for the Assessment and Management of Pain have been implemented in acute care hospitals across Canada and internationally. Best practice guidelines are useful tools used to bridge the gap between scientific evidence and clinical practice (RNAO, 2013), more specifically, to positively impact the quality of care provided by nurses and improve patient outcomes. In Canada and internationally, health care organizations have partnered with the RNAO to implement and evaluate BPGs and become Best Practice Spotlight Organizations (BPSOs). BPGs are developed using diverse groups of experts who identify and rate evidence in a systematic way for each particular specialty area. Among the more than 50 BPGs developed by the RNAO, the BPG on the assessment and management of pain outlines general core competencies using evidence-based strategies in the context of the therapeutic relationship and supports a biopsychosocial approach (RNAO, 2013). Strategies recommended in the BPG include routine screening for pain; assessing and reassessing pain based on the patient's presentation, including the patient's response;