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Chronic Non-Cancer Pain in the ED: Are Nurses SBIRT-Ready?

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ABSTRACT
CHRONIC NON-CANCER PAIN IN THE ED:
ARE NURSES SBIRT READY?

Emergency department (ED) Registered Nurse (RN) understanding of chronic pain management is critically important. By some estimates, 30% of all opioid pain medications in the United States (US) are prescribed from EDs. At the same time, prescription drug abuse is America's fastest growing drug problem. While RNs have significant contact time with chronic pain patients who may also be drug abusers, RNs often use the stigmatizing label, "drug-seeking" for certain key patient behaviors and may not feel confident intervening constructively with these patients. This project reviews literature pertaining to SBIRT use for substance abuse in the ED and surveys ED nurses at one large, urban Northern California ED. The survey and accompanying discussion examines the relationship between RN professional insecurity in managing chronic pain patients and the tendency to stigmatize such patients. This project provides insight to one little-studied aspect of the complex topic of managing chronic pain patients in the emergency room—RN practice and attitudes towards the chronic, non-cancer pain patient and provides a needs assessment of RN readiness for SBIRT training.

Dorothy James Moore
May 2014

CHRONIC NON-CANCER PAIN IN THE ED: ARE NURSES
SBIRT-READY?

by
Dorothy James Moore

A project
submitted in partial
fulfillment of the requirements for the degree of
Doctor of Nursing Practice
in the School of Nursing
California State University, Fresno
May 2014

APPROVED

For the Department of Nursing:

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Table of Contents

Abstract.....	1
Theoretical Framework: Stigma Reduction.....	4
Background.....	5
Definition and History	5
Public Health Implications.....	6
Medical Efficacy of Long-Term Opioids for Chronic Non-Cancer Pain	6
Guidelines for Managing Chronic Non-Cancer Pain Patients	7
Nurses Caring for Chronic Non-Cancer Pain Patients in the ED	9
Literature Review: The Importance and Evidence for SBIRT	11
SBIRT in the Emergency Department	13
SBIRT's Failings	14
Quest for a Validated Screening Tool.....	15
Project Survey Methods.....	17
Instrumentation for Survey	17
Setting	18
Ethical Consideration (Human Subject Protections)	18
Bias	19
Population and Sample	19
Survey Design.....	21
Data Analysis Methods.....	24
Summary of Findings.....	25
Theme 1: Treatment Venue and Assessment Confidence	26
Theme 2: Addiction and Abuse Concerns	30
Theme 3: Doctor Shopping and Diversion	33
Theme 4: Stigmatization of Patients.....	34
Theme 5: Moral Tension.....	37
Theme 6: Communication Confidence	40
Theme 7: Constructive Practices or Knowledge.....	43
Assessment of Results	45
Limitations	46
Implications for Practice	47
Appendix A Text Responses to Survey Questions	60

List of Figures

Figure 1. Sample SBIRT three-question screening tool	16
Figure 2. Mind Map Used to Generate Survey Questions	23
Figure 3. Survey Questions on Attitudes and Beliefs of ED RNs Around Chronic Non-Cancer Pain Patients.....	24
Figure 4. Seven Themes for Survey Analysis.....	26
Figure 5. Theme 1: Treatment Venue and Assessment Confidence.....	27
Figure 6. Theme 2: Addiction and Abuse Concerns.....	30
Figure 7. Theme 3: Doctor Shopping and Diversion.....	34
Figure 8. Theme 4: Stigmatization of Patients.....	36
Figure 9. Theme 5: Moral Tensions.....	38
Figure 10. Theme 6: Communication Confidence.....	40
Figure 11. Theme 7: Constructive Practices or Knowledge	43
Figure 12. Practice Improvement Implications for SBIRT.....	48

List of Tables

Table 1. Ages of Survey Respondents (in Years)	20
Table 2. Years as an RN	20
Table 3. Nursing Education	20
Table 4. Non-Nursing Education (Nurses with Baccalaureate or Higher in Non-Nursing Fields) ..	21
Table 5. Time as ED RN, Grouped (in Years).....	21
Table 6. Other Nursing Specialties for Staff Experience.....	21
Table 7. Question 1: Believes the ED is Not the Place to Treat Chronic Pain.	27
Table 8. Question 5: Finds it Difficult to Adequately Assess 10/10 Pain	28
Table 9. Question 2: RNs Believe Pts Are Addicted to Pain Medicine.....	31
Table 10. Question 7: Some Pts Seeking Euphoria, Not Pain Relief	31
Table 11. Question 13: Concerned Pt. Might Overdose	31
Table 12. Question 6: RN Concerned when Pt has No Primary MD	33
Table 13. Question 12: RN Believes Diversion is a Real Problem	34
Table 14. Question 11: Sometimes Label Patients as “Drug-Seekers”	36
Table 15. Question 15: Finds Chronic Pain Patients Irritating or Annoying.....	37
Table 16. Question 16: Likely to Give Low Priority to “Frequent Flyers”	37
Table 17. Question 4: RN Feels He or She is Doing More Harm than Good.....	39
Table 18. Question 8: RN Feels Powerless to Help.....	39
Table 19. Question 9. Would Feel Comfortable Screening All ED Patients for Drug Abuse.....	41
Table 20. Question 10: Comfortable Talking with MD About Concerns.....	42
Table 21. Question 18: More Comfortable Talking About ETOH Use than Prescription Med Use.	42
Table 22. Question 3: RNs Educate Patient on Storage and Disposal.....	44
Table 23. Question 14: Makes an Attempt to See Pt Follows Up with Primary	44
Table 24. Question 17: Takes Time to Teach About Adjuvant Therapies	44
Table 25. Question 19: Aware of ACEP Guidelines	45

Abstract

Emergency department (ED) Registered Nurse (RN) understanding of chronic pain management is critically important. By some estimates, 30% of all opioid pain medications in the United States (US) are prescribed from EDs (Todd, Cowan, Kelly, & Homel, 2010). At the same time, prescription drug abuse is America's fastest growing drug problem (Paulozzi, Jones, Mack, & Rudd, 2011).

While RNs have significant contact time with chronic pain patients who may also be drug abusers, RNs often use the stigmatizing label, "drug-seeking" for certain key patient behaviors and may not feel confident intervening constructively with these patients (McCaffery, Grimm, Pasero, Ferrell, & Uman, 2005c). Literature on improving RN role confidence and reducing stigmatization of ED patients with substance abuse issues is limited. A study of student nurses demonstrated that the relationship between improved constructive intervention and care for substance abusers after Screening Brief Intervention and Referral to Treatment (SBIRT) training (Puskar et al., 2012).

This project reviews literature pertaining to SBIRT use for substance abuse in the ED and surveys ED nurses at one large, urban Northern California ED. The survey and accompanying discussion examines the relationship between RN professional insecurity in managing chronic pain patients and the tendency to stigmatize such patients. The survey demonstrates a mixed picture, with 61% of nurses admitting to using stigmatizing terminology. At the same time, RNs showed high levels of awareness of the public health problems caused prescription pain medication (77.6% agreed that drug diversion is a problem). This project provides insight to one little-studied aspect of the complex topic of managing chronic pain patients in the emergency

room—RN practice and attitudes towards the chronic, non-cancer pain patient and provides a needs assessment of RN readiness for SBIRT training.

Nurse Practice and Attitudes towards Chronic Non-Cancer Pain in the ED:**Assessing Readiness for SBIRT**

The Institute of Medicine of the National Academies estimates that chronic pain affects 116 million American adults at a cost of \$560 billion–\$630 billion annually. Up to 11% of all ED visits in the U.S. are specifically related to chronic non-cancer pain (Cordell et al., 2002). Thus, on any given shift, the ED RN is highly likely to care for a patient with chronic non-cancer pain that might include administering opioid pain medication or discharging a patient with an opioid medication prescription. Despite the frequency of RN care of chronic non-cancer pain patients in the ED, there is little research on RN practice and attitudes towards this group of patients.

This Doctor of Nursing Practice DNP Project is composed of two portions: 1) a literature review of the issue of chronic non-cancer pain care in the ED and the use of SBIRT (Screening Brief Intervention and Referral to Treatment) to screen for substance abuse; and 2) a survey of practices, beliefs and attitudes of ED RNs towards chronic non-cancer pain patients in one urban Northern California hospital. The survey sought information on RN tendency to stigmatize or label chronic non-cancer pain patients as “drug-seeking.” Also explored in the survey was RN confidence and knowledge in constructive care and intervention for these patients. In addition to increasing the body of knowledge regarding RN care of chronic non-cancer pain patients, the information gathered serves as a needs assessment for SBIRT training for RN staff at the surveyed hospital.

Theoretical Framework: Stigma Reduction

The framework for this project is stigma reduction for behavioral health issues. Stigma, both by health care providers and patients themselves (self-stigmatization), is a known barrier to delivering care to substance abuse and mental health patients, (Ahern, Stuber, & Galea, 2007), (Corrigan, 2004). Reduction of stigma by healthcare providers towards mental illness is a quality measure (Chinman et al., 2003). Most U.S. states now have anti-stigma programs supported by the Substance Abuse and Mental Health Services Administration (Mental illness, anti stigma at ADS center.) A growing body of evidence shows that stigmatization of behavioral health issues is an impediment to care (Rüsch, Angermeyer, & Corrigan, 2005).

It has been shown that nurses who show negative attitudes patients with chemical dependency problems are less willing to intervene in alcohol or chemical dependency-related issues (Skinner, Feather, Freeman, & Roche, 2007). Stigma not only reduces patients' access to healthcare, it can result in discrimination and abuse of patients, often robbing them of their dignity and ability to fully participate in society (Pescosolido et al., 2010). Stigmatization also causes patients to minimize their drug use, especially in the healthcare setting (Kurtz, Surratt, Kiley, & Inciardi, 2005). Healthcare providers who stigmatize patients are also likely to feel less willing to intervene positively and may feel role inadequacy or lack confidence in their ability to intervene (Aalto, Pekuri, & Seppä, 2001; Skinner et al., 2007).

Responding to a public policy that stigmatized substance abuse as a moral failing ("Just Say No" to drugs), the White House presented the President's national blueprint for drug policy, the 2013 National Drug Control Strategy (Currie, 2012), a research-based approach shifted focus to addiction as a chronic disease and public health issue (Volkow, Fowler, & Wang, 2004), (Volkow, McLellan, Cotto, Karithanom, & Weiss, 2011). This policy includes increased funding

for early detection and referral to treatment through Screening, Brief Intervention and Referral to Treatment (SBIRT). SBIRT is an evidence-based, nonstigmatizing approach for effectively screening and referring clients with substance abuse issues (Agerwala & McCance-Katz, 2012). SBIRT can be conducted by nurses in any area of practice from clinics to critical care (Finnell, 2012a). A cornerstone of the SBIRT approach is the destigmatization of behavioral conditions by offering universal screening (Babor et al., 2007).

Background

The subject of chronic non-cancer pain patients' treatment in the emergency department and their stigmatization by providers is a complex topic with medical, political, economic and ethical nuances. The following sections serve as an overview of this topic and are necessary for contextual understanding of the survey intervention included in this DNP Project.

Definition and History

Chronic non-cancer pain (CNCP) has various definitions in research literature but typically refers to pain lasting longer than 6 months, pain lasting longer than expected time to heal for the underlying injury, or pain that is due to an underlying neuropathic or nociceptive condition (Jovey et al., 2003). The long-term use of opioids for treating chronic pain is relatively recent and controversial in terms of effectiveness and safety (Nelson & Perrone, 2012). The broadening use of opioids for non-cancer chronic pain coincided with the lessening of restrictions on state medical boards on opioid prescriptions in 1990s, and with increased marketing efforts by the pharmaceutical industry for products such as Oxycontin®, which was approved by the U.S. Food and Drug Administration (FDA) in 1995. Also, in 2000, the Joint Commission on Accreditation of Healthcare Organization (JCAHO) began its Pain as the Fifth

Vital Sign initiative to increase awareness of pain assessment and treatment (Jayawant & Balkrishnan, 2005; Laxmaiah Manchikanti, Sairam Atluri, & Hans Hansen, 2014).

Public Health Implications

Prescription drug abuse is cited by the Centers for Disease Control (CDC) as America's fastest growing drug problem (Paulozzi et al., 2011). In 2010, there were 38,329 deaths in the United States by overdose, 16,651 of these from prescription opioids (Jones, Mack, & Paulozzi, 2013). In 2010 in the U.S. poisoning, mainly by prescription opioid overdose, became the leading cause of injury death for people aged 35-54 years, surpassing both firearm-related and motor vehicle-related deaths (Paulozzi et al., 2011). Additionally, a review by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the CDC of ED visits involving the nonmedical use of prescription drugs from the SAMHSA Drug Abuse Warning Network (DAWN) showed that the estimated number of ED visits for nonmedical use of opioid analgesics increased 111% during 2004-2008 (from 144,600 to 305,900 visits) and increased 29% during 2007-2008. The highest numbers of ED visits were recorded for oxycodone, hydrocodone, and methadone (Network, 2013). In its position statement on "Pain Management in Patients with Substance Use Disorders," the American Society for Pain Management Nursing (ASPMN) acknowledges the steady rise of hospital admissions for opioid misuse, citing statistics that show 40% of all pain patients may have problematic drug-taking behaviors, 20% demonstrate substance use disorder and 2%-5% demonstrate actual addiction disease (Oliver et al., 2012).

Medical Efficacy of Long-Term Opioids for Chronic Non-Cancer Pain

Evidence for long-term use of opioids to successfully treat chronic non-cancer pain is lacking (Manchikanti et al., 2011). A Cochrane review (Noble et al., 2010) found that for a well-

selected group of patients with no history of substance abuse, proper management of opioids can lead to long-term pain relief. However, the authors found weak evidence for this conclusion and cite the need for longer-term studies; they also found inconclusive evidence as to whether or not quality of life or functioning is improved.

And, while a history of addiction to other substances can be a predictor of prescription abuse, paradoxically, patients with addiction histories are much more likely to be prescribed opioid analgesia than persons with no substance abuse history (Edlund et al., 2010). There is expert acknowledgment that pain can be symptomatic of unresolved psychological issues, and at the same time impetus for depression (Giordano, 2011). A telephone survey of 144 adults receiving chronic opioid therapy found these patients associated their opioid use with a higher self-reported level of depression (than before opioid therapy) and wanted to cut down their opioid use (Sullivan, Von Korff, Banta-Green, Merrill, & Saunders, 2010). Mental health diagnoses as well as a past history of substance abuse, are strong predictors of future substance abuse (Edlund et al., 2010). And yet, a major study of some 150,000 Afghan and Iraqi war veterans, found a high correlation between mental health diagnoses, primarily Post Traumatic Stress Disorder (PTSD), and opioid pain prescription (Seal et al., 2012).

Guidelines for Managing Chronic Non-Cancer Pain Patients

Since 2005 several protocols and clinical guidelines for physicians have been developed for managing chronic pain patients by organizations such as the American Pain Society (Chou, Ballantyne, Fanciullo, Fine, & Miaskowski, 2009), the American Society of Interventional Pain Physicians (Trescot et al., 2008), and the American College of Emergency Physicians (Cantrill et al., 2012a). These guidelines recommend practices that include cautions regarding certain medications and upper dosing thresholds; guidelines on chronic pain treatment agreements (also

known as pain contracts); advice on the use of urine drug testing; encouragement of the use of prescription drug monitoring databases; and screening with validated assessment tools for risk of substance abuse, misuse or addiction (Nuckols et al., 2014). Though it should be noted that urine drug screens, because their high rates of inaccuracy, and pain contracts, which can be based on a lack of trust and can encourage, should not be the sole means for management of chronic non-cancer pain patients (Ahern et al., 2007; Oliver et al., 2012).

In the last year (2013-2014), numerous state and civic public health entities, notably the New York City (NYC) Department of Health and Mental Hygiene, have developed Emergency Department Discharge Opioid Prescribing Guidelines (Kunins, Farley, & Dowell, 2013). The New York Guidelines contain nine suggestions, including starting with the lowest possible dose if opioids are used; discharging patients with no more than a short course (three days) of opioid analgesics; assessing patients for substance abuse, using validated screening tools or targeted histories (such as those used with SBIRT); and providing patients with information about risk for overdose, dependence, as well as safe storage and disposal.

Nurses Caring for Chronic Non-Cancer Pain Patients in the ED

Because nurses directly assess patients and administer medications, they are at the frontline of managing chronic non-cancer pain patients in the ED. Past research on the topic of ED RN attitudes, beliefs and practices around this group of patients is sparse. An exploration of the term “drug-seeking patient,” (McCaffery, Grimm, Pasero, Ferrell, & Uman, 2005b) found that ED nurses (n = 35) were most likely (67.7%) to use the term “drug-seeking” in conversation versus general nurses (n = 295) or pain specialty nurses (n = 39). Traits emergency nurses associated with “drug-seeking” most often were “abusing pain medicine,” being “addicted to opioids,” and being “manipulative.” The authors caution that use of the term “drug-seeking,” while frequently used, is poorly defined and may interfere with respectful and professional patient care. A study of 394 Jordanian Emergency nurses (Hamdan-Mansour, Mahmoud, Asqalan, Alhasanat, & Alshibi, 2012) found that those nurses generally had negative attitudes towards patients they perceived as drug-seeking, and the nurses were limited in their ability or knowledge of how to intervene and assist patients who may display behavioral red flags. Furthermore, classic behaviors (e.g., complaint of 10+ pain, headache, back pain, dental pain, lost refill, out of medication) do not actually predict drug-seeking (Grover, Elder, Close, & Curry, 2012a).

A seminal study of nurses’ feelings when confronted with patient suffering found that a nurse’s difficulty in dealing with patients’ emotional problems might stem from a sense of helplessness or inadequacy in being able to provide care (Davitz & Davitz, 1975). Nurses may be able to administer medication to reduce physical pain, but do not have similar techniques or means to relieve patients’ psychological distress. Nurses may build psychological defenses in order to maintain emotional distance. A systematic review of literature showed that negative

attitudes of health professionals towards patients with substance abuse disorders contribute to suboptimal delivery of healthcare by reducing collaboration between patients and providers, reducing these patients' self-esteem, and actually influencing treatment outcomes (van Boekel, Brouwers, van Weeghel, & Garretsen, 2013). Stigmatization also causes patients to minimize their drug use, especially in the healthcare setting (Kurtz et al., 2005).

“Drug-seeking” is a stigmatizing label that promotes prejudice towards patients and creates a shame-based context of care (McCaffery et al., 2005b). The ASPMN position states that stigma interferes with a therapeutic relationship between nurse and patient because it is rooted in guilt and shame. The nurse's role in eliminating stigma is to develop rapport with the patient and family, provide education on addiction as a disease, and offer reasonable alternatives when opioids are deemed inappropriate (Oliver et al., 2012). Healthcare providers who stigmatize patients may also feel less willing to intervene positively and may feel role inadequacy or lack confidence in their ability to intervene

Confidence and role responsibility predicted alcohol-related patient intervention in a study of emergency room physicians and nurses (Indig, Copeland, Conigrave, & Rotenko, 2009). But literature on improving nursing role confidence in substance abuse-related emergency room patients is limited. In a study of student nurses, SBIRT training correlated positively with improved confidence in ability to constructively intervene and care for patients who may have substance abuse disorders (Puskar et al., 2012).

One of the key recommendations from ASPMN and other expert sources is the Universal Precautions approach for screening all patients with persistent pain (Gourlay, Heit, & Almahrezi, 2005). Just as a clinician might take universal precautions against the spread of blood borne pathogens by treating all patients as potentially infected, all patients with chronic or persistent

pain should be screened for potential substance abuse or misuse. This practice is destigmatizing since all patients are treated equally, regardless of the profile they present to the clinician. And, the RN, who often spends the most time with the patient in the ED of any healthcare worker, is well poised to screen patients, intervene and provide counseling (Finnell, 2012a).

Literature Review: The Importance and Evidence for SBIRT

Universal screening of patients is integral to SBIRT, an evidence-based approach for treating patients who may have substance abuse or misuse issues. The SBIRT intervention is composed of three steps that can be learned and applied universally to emergency room patients:

1. Quick screening with standardized tools.
2. Brief intervention, if applicable. The intervention should be non-judgmental and seek to elicit a patient's willingness or interest in behavioral change.
3. Referral to treatment or specialty care, if indicated.

Nurse-led SBIRT for alcohol and substance abuse has been shown to provide cost-effective care. Registered nurses, working to the full extent of their education and licensure are in key roles as members of the interdisciplinary team to provide cost-effective SBIRT intervention (Broyles & Gordon, 2010).

SBIRT has been tested in a wide variety of settings around the world. The World Health Organization (WHO) has over the past decade conducted a worldwide study (Australia, Brazil, India and the United States) evaluating the effectiveness of a brief intervention for substance abuse (cannabis, cocaine, amphetamine-type stimulants and opioids (Humeniuk et al., 2012). The study was a prospective, randomized controlled trial in which participants who scored high on a screening tool (called the ASSIST) were either assigned to a 3-month waiting-list control

condition or received brief motivational counseling. The interventions were conducted at a variety of primary care sites involving 731 people by multiple levels of healthcare providers. The patients who received the brief intervention had significantly reduced ASSIST scores compared to the control group ($p < .005$). (Humeniuk et al., 2002). Humeniuk et al. concluded that brief interventions for substance abuse are effective, at least in the short-term duration of the study. It should be noted that the ASSIST inventory consists of multiple pages of questions and requires scoring; this intervention is therefore not well-suited to the fast-paced environment of an ED.

SAMHSA conducted an SBIRT service program to test SBIRT in a range of medical settings in six different states across a diverse population of Alaskan Natives, American Indians, Caucasians, Hispanics and African-Americans (Madras et al., 2009). Drug use was compared to data at intake and at a six-month follow up of randomly selected patients who had been screened as positive for substance abuse previously. This was a large study, 459,599 patients screened, with 22.7% of those positive for risky or problematic drug use. The study showed that at six months rates of illicit drug use in the group that had baseline misuse was 67.7% lower ($p < 0.001$). Findings were comparable across the many sites conducted SBIRT trials and across ethnicity, age and gender.

SBIRT in the Emergency Department

The Academic ED SBIRT Collaborative (2010) conducted a quasi-experimental study of patients selected from EDs who upon screening were found to have risky alcohol use. The study was conducted in 14 states from April to August 2004. The control group received a written handout only, while the intervention group participated in a brief interview with referral for treatment if indicated. The study included 1,132 participants. At three months, the SBIRT group reported drinking three drinks fewer per week than the control group ($p < 0.05$). But at 6 and 12 months post-intervention, there was no statistical significance in the difference between the two groups.

Vaca, Winn, Anderson, Kim, and Arcila (2011) conducted an observational study that measured the change in alcohol consumption at six months following an ED computerized alcohol screening intervention with referral to treatment. Forty-seven percent of the 221 subjects who were followed in the study were no longer drinking above the National Institute on Alcohol Abuse and Alcoholism (NIAA) recommended limits. According to the study, a readiness to change was the greatest predictor of successful change. The authors state that the computerized ED-SBIRT holds “promise” as a viable screening intervention for a wide range of emergency department patients, although the study was based on alcohol consumption only.

Washington State Department of Health and Social Services conducted a two-year program testing SBIRT at nine hospitals’ emergency departments in Washington (Estee, Wickizer, He, Shah, & Mancuso, 2010). Adults were screened for alcohol and substance abuse problems. This study examined Medicaid savings for patients who received SBIRT versus those who did not. The SBIRT group (1,557 patients) was associated with a \$366 per person Medicaid savings per month ($p = 0.05$) versus patients in the comparison group. The study concluded that

SBIRT in the ED is a successful intervention for alcohol and substance abuse from a cost-savings standpoint.

Krupski et al. (2010) examined SBIRT in a large, urban safety-net hospital in Seattle, WA where chemical dependency professionals screened patients for both alcohol and drug abuse issues. The authors had a double-hypothesis: 1) individuals with *possible* substance use disorders were more likely to be admitted to chemical dependency (CD) treatment after receiving a brief intervention than similar individuals who did not receive a brief intervention; 2) a brief treatment following a brief intervention would result in facilitating even higher admission to CD treatment. The authors found that people with possible substance abuse disorders who received a brief intervention, regardless of their participation in a brief treatment, were significantly more likely to enter into specialized chemical dependency treatment than similar persons who did not receive a brief intervention. The authors saw these results as positive confirmation that SBIRT successfully directed patients to appropriate services. The study relied on observational data, and as such, was not a true randomized controlled trial. However, Krupski et al. (2012b) have published a protocol for a registered clinical trial that will be a 1,000-patient RCT of SBIRT intervention for substance abuse patients.

SBIRT's Failings

Not all SBIRT research outcomes have been positive. Some ED SBIRT studies show little difference in alcohol consumption between people who have received SBIRT and controls (Nilsen et al., 2008). In an integrative review, Nilsen et al. examined 14 observational studies of the effectiveness of brief interventions delivered to patients in the emergency room after accidents involving alcohol. Of the 12 studies that compared pre- and post-brief intervention results, 11 observed a significant effect from the brief intervention on these outcomes: alcohol

intake, risky drinking practices, alcohol-related negative consequences, and injury frequency.

Two studies assessed only post-intervention results and were therefore not comparative. Five of the studies did not show significant differences between the behavioral interventional and non-interventional groups. These studies were dissimilar; they varied in their protocols, recruitment criteria, and screening and assessment methods. Therefore, it is difficult to draw large conclusions from the integrative review.

It is also important to understand that most large SBIRT studies have looked at alcohol use in the ED, while only a relative few randomized controlled trials have tested SBIRTs for substance abuse in the ED (E. Bernstein et al., 2007; Madras et al., 2009; Woolard et al., 2013), though these have pointed to its efficacy. However, additional arguments for using SBIRT in the ED include the fact that people who use illicit drugs are more likely to require ED care than those who do not (Cherpitel & Borges, 2004; Doran, Raven, & Rosenheck, 2013). As well, the ED is the only contact point with medical care for some patients and thus is a unique moment for substance abuse intervention through SBIRT screening.

Quest for a Validated Screening Tool

One barrier to SBIRT use for substance abuse has been lack of consensus on the validity of screening tools, particularly a tool that might be used in an ED where time is at a premium. A literature review of 22 studies comparing validated substance abuse screening tools concluded that there is no single tool that can be applied universally to all patients who are on opioid therapy for chronic non-cancer pain (Solanki, Koyyalagunta, Shah, Silverman, & Manchikanti, 2011). However, more recent studies (Saitz, Cheng, Allensworth-Davies, Winter, & Smith, 2014) show that the accuracy of a single-question screening tool is sometimes better than longer instruments.

In a three-year study of nearly 150,000 patients at a nonprofit Level I trauma hospital, brief alcohol and drug screening questions were integrated into the electronic triage system and nurse triage process, with the result that 22% of patients screened positive for substance abuse and 60% of those received SBIRT intervention. The survey used single-item tobacco, alcohol and drug screening questions, each of which had been previously validated with good sensitivity and specificity (Johnson, Woychek, Vaughan, & Seale, 2013). The screening tool is shown below (Johnson et al., 2013).

<p>1. Have you used any tobacco products in the past 12 months?</p> <p>☐ Yes ☐ No</p> <p>2. (a) WOMEN: How many times in the past 12 months have you had 4 or more drinks in a day?</p> <p>☐ 25 or more times ☐ 13-24 times ☐ 6-12 times ☐ 1-5 times ☐ None</p> <p>(b) MEN: How many times in the past 12 months have you had 5 or more drinks in a day?</p> <p>☐ 25 or more times ☐ 13-24 times ☐ 6-12 times ☐ 1-5 times ☐ None</p> <p>3. In the past twelve months, did you smoke pot (marijuana), use another street drug, or use a prescription painkiller, stimulant, or sedative for a non-medical reason?</p> <p>☐ No ☐ Yes</p> <p>If yes, Which ones?</p>

Figure 1. Sample SBIRT three-question screening tool for tobacco, alcohol and street drug use

The U.S. Joint Commission for the Accreditation of Health Care Organizations, (Joint Commission), approved four new core-performance measures to track hospital rates of inpatient SBIRT screening of unhealthy alcohol use, brief alcohol and other drug-dependence treatment, and post-discharge substance use and treatment. Since January, 2012, hospitals have been able to report on these measures to the Joint Commission ((Goplerud, 2012).

The Affordable Care Act and recent White House policy emphasize the use of SBIRT and the adoption of a chronic care, nonstigmatizing approach to management of substance abuse issues. Many states have adopted codes that enable physicians and healthcare organizations to

be reimbursed for building SBIRT into their Electronic Health Records and for funding SBIRT training for providers (Kuehn, 2013). Screening all patients in the same nonstigmatizing manner, just as one would for hypertension or diabetes (instead of guessing at who may or may not have addictions issues), offers a chance for more referrals to treatment and better outcomes for patients.

Project Survey Methods

In order to gauge attitudes and practices of ED RNs towards chronic non-cancer pain patients who take opioids, a convenience survey was distributed to staff nurses at one urban Northern California hospital for a one week period in January, 2014 and made available in the nurses' break room. The survey was announced by email notice, brief mention in several pre-shift huddles, and via a flyer in the break room. The nurses placed the completed surveys in a sealed box that was located in the break room.

The purpose of the survey was two-fold: 1) to gauge generally the attitudes and practices of RNs at the ED and, 2) to test whether or not a tendency to stigmatize patients correlated with a lack of positive intervention or role confidence. The information gathered from this survey could serve as an assessment for further education, particularly in the areas of SBIRT training and non-cancer chronic pain management in the ED.

Instrumentation for Survey

The survey consisted of 19 Likert-scaled questions with five possible responses ranging from Strongly Disagree, Disagree, Neutral, Agree, to Strongly Agree. This survey was composed by the author, and as such, has no external validation. Eight of the questions provided free text space for short comments or responses. Demographic information regarding years as an

RN, level of nursing education, level of other education, birth year, length of time as an ED nurse, specialty nursing experience(s), and gender were collected as well.

Setting

The survey was conducted at an urban teaching hospital in Northern California. The hospital is a general acute care facility and the emergency department provides basic, non-trauma emergency services and is a certified stroke center.

Ethical Consideration (Human Subject Protections)

Letters of exemption from Internal Review Board (IRB) review were obtained from both the hospital where the survey was conducted and from the author's university, California State University, Fresno.

Care was taken to retain the anonymity of the nurse respondents by having them place the surveys in a sealed box after completion. As a further measure to protect the RN subjects responding to the survey, the raw data will not be shown to hospital management. In compiling the results from the survey, the author realized that in fact the identity of one or two of the older respondents could be deduced by their reported age. In the event that these data are ever published beyond this DNP project, care will be taken to report only bucketed age values. While the information in the survey touches on topics that the author believes should be more widely discussed—the ethics of managing pain in a patient who abuses drugs, the de-prioritization of frequent ED users, to name just two—the author is cognizant of the sensitivity of such material. The author therefore has taken additional care to protect the identification of individual respondents by decoupling the written text results from the Likert-scaled survey responses and demographic variables.

Bias

The survey was a convenience sampling offered to all nurses and answered by those who chose to do so. As such, there is inherently a degree of selection bias in the survey: only those interested in the topic, who have time to answer the questions, or who may want to please the author are likely to respond. As well, the survey may not have captured people with strong opinions who were reluctant to voice them. Further, since this survey is not a validated or pre-tested instrument, the author's own biases may have inadvertently affected the survey construction. Also, the Likert-scale format may prompt artificially enthusiastic responses, i.e., "strongly agree," or "strongly disagree," which polarize results.

Population and Sample

Forty-nine surveys were completed. There are approximately 180 ED RNs at the surveyed hospital, including staff, per diem, and contracted travelers. The survey was available to all nursing shifts.

The following demographic information was collected in the survey: RN age, years as an RN, educational level (including non-nursing higher education), time working as an ED RN, other specialty areas worked (Tables 1-6) and gender (39 female, 10 male).

Table 1. Ages of Survey Respondents (in Years)

	Age	Frequency	Percent
	27-30	4	8.2
	31-35	14	28.6
	36-40	5	10.2
	41-44	11	22.4
	45-50	9	18.4
	51-55	4	8.2
Total		47	95.9
Missing System		2	4.1
Total		49	100.0

Table 2. Years as an RN

	Frequency	Percent
< 3 yrs	1	2.0
3-5 yrs	13	26.5
6-10 yrs	23	46.9
11-15 yrs	7	14.3
> 15 yrs	5	10.2
Total	49	100

Table 3. Nursing Education

	Frequency	Percent
AA/License Only	12	24.4
BSN	32	65.3
MSN	5	10.2

Total	49	100.0
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*Table 4. Non-Nursing Education**(Nurses with Baccalaureate or Higher in Non-Nursing Fields)*

	Frequency	Percent
No	39	79.6
Yes	10	20.4
Total	49	100.0

Table 5. Time as ED RN, Grouped (in Years)

	Frequency	Percent
0 to 3	8	16.3
4 - 10	30	61.2
11 - 20	5	10.2
> 21	3	6.1
Missing System	3	6.1
Total	49	100.0

Table 6. Other Nursing Specialties for Staff Experience

	Frequency	Percent
One additional specialty	16	32.7
Two or more specialty areas	1	2.0
Total	49	100.0

Survey Design

The survey asked 19 Likert-type questions designed to gauge RN attitudes, beliefs and practices towards chronic non-cancer pain patients in the ED. The survey gauges current

practices and behaviors and serves as a needs assessment for practice change, which might include education on chronic, non-cancer pain patients, SBIRT training and implementation, and introduction of American College of Emergency Physician (ACEP) guidelines. Questions were based on the author's interviews with fellow nurses, observations, and previous studies on the topic, which were modified to fit the survey venue (Grover, Elder, Close, & Curry, 2012a; Hamdan-Mansour, Mahmoud, Asqalan, Alhasanat, & Alshibi, 2012; McCaffery, Grimm, Pasero, Ferrell, & Uman, 2005a; Wilsey, Fishman, Ogden, Tsodikov, & Bertakis, 2008a). Interview comments and potential survey questions were culled, then organized under seven topic headings in a Mind Map Diagram in order to create the final survey (Figure 2).

Figure 2. Mind Map Used to Generate Survey Questions

Figure 3 shows the 19 Likert-type questions asked in the survey. The responses to these are reported using descriptive statistics (percentage of responses to each category). This information serves as a needs assessment for future training and awareness activities.

Survey Questions on Attitudes and Beliefs of ED RNs Around Chronic Non-Cancer Pain Patients	
1.	The ED is not the place to treat chronic pain.
2.	I believe that many chronic pain patients who come to the ED for pain medicine are addicted to their medication.
3.	I believe that ED RNs should educate patients on proper at home storage and disposal of narcotics.
4.	I sometimes feel reluctant to give chronic pain patients opioids because I feel that I am doing the patient more harm than good.
5.	I find it difficult to adequately assess “10/10” chronic pain.
6.	I am concerned when a chronic pain patient does not have a primary care physician.
7.	Some chronic pain patients are seeking opioids for a sense of euphoria, not for pain relief.
8.	I sometimes feel powerless to help chronic pain patients in the ED.
9.	I would feel comfortable screening all patients for drug abuse behaviors.
10.	I am comfortable talking with my physician colleague when I am concerned that a patient may be abusing opioids.
11.	I sometimes label chronic pain patients as “drug-seekers.”
12.	I believe that prescription opioid diversion is a real problem.
13.	I am concerned that some chronic pain patients who visit the ED may accidentally overdose at home.
14.	I make an attempt to see that chronic pain patients are following up with their primary doctor, or are seeking additional resources for pain management.
15.	I find chronic pain patients irritating or annoying.
16.	I am likely to give low priority to “frequent flyer” chronic pain patients.
17.	I take time to teach chronic pain patients about stretching, use of ice packs or warm packs and breathing techniques.
18.	I am more comfortable asking a patient about their daily alcohol usage than their prescription pain medication usage.
19.	I am aware of the American College of Emergency Physician (ACEP) guidelines for treating chronic pain with opioids.

Figure 3. Survey Questions on Attitudes and Beliefs of ED RNs Around Chronic Non-Cancer Pain Patients

Data Analysis Methods

Data were entered by hand into IBM SPSS Statistics Version 22, running on Mac OS 10.9.1. Simple descriptive tables were created showing the responses of participants by

question. Free text responses were transcribed and analyzed for content theme by examining recurring patterns and statements.

Summary of Findings

The summary tables for the 19 Likert-type questions are shown in Tables 8–27. These tables provide descriptive statistics for the 49 responding RNs. Questions 1, 5, 7, 8, 9, 10, 11 and 17 of the survey questions provided free text space, with an invitation for the RN to comment. The author reviewed these for emerging themes and patterns, which are discussed below. The text comments are displayed verbatim in Appendix A.

For purposes of discussion, questions have been regrouped into the following seven key themes: 1) Treatment Venue and Assessment Confidence; 2) Addiction and Abuse Concerns; 3) Doctor Shopping and Diversion; 4) Stigmatization of Patients; 5) Moral Tension; 6) Communication Confidence; and 7) Constructive Practices or Knowledge. Note that there is some content overlap among these groupings.

Figure 4. Seven Themes for Survey Analysis

Theme 1: Treatment Venue and Assessment Confidence

These questions asked whether or not RNs thought the ED was the appropriate venue for treating chronic pain (Question 1, Table 7) and how they assessed patients whose pain was reported as “10/10” (Question 5, Table 8). Responding to Question 1, a majority of the RNs (67%) agreed or strongly agreed that chronic pain patients should not be treated in the ED; in response to Question 5, 71% agreed or strongly agreed that they had difficulty assessing chronic pain patients with “10/10” pain. The results of Questions 1 and 5 are graphically displayed in Figure 5.

Figure 5. Theme 1: Treatment Venue and Assessment Confidence

Table 7. Question 1: Believes the ED is Not the Place to Treat Chronic Pain.

	Frequency	Percent
Disagree	8	16.3
Neutral	8	16.3
Agree	21	42.9
Strongly Agree	12	24.5
Total	49	100.0

Table 8. Question 5: Finds it Difficult to Adequately Assess 10/10 Pain

	Frequency	Percent
Disagree	8	16.3
Neutral	5	10.2
Agree	16	32.7
Strongly Agree	19	38.8
Total	48	98.0
Missing System	1	2.0
Total	49	100.0

Question 1 Discussion of Text Responses. There were 22 written free-text responses to Question 1. All of these stated in some way that treating chronic pain in the ED is appropriate under certain conditions. An emerging theme was that treatment was that giving narcotics for chronic pain was “OK with breakthrough pain.” Other statements indicated that the ED might be the treatment arena of last resort “ED is open 24/7”. In a comprehensive literature search for 1996 to June 2010, researchers found no significant scientific evidence for the existence breakthrough pain in chronic non-cancer pain patients on long-term opioid therapy (Manchikanti, Singh, Caraway, & Benyamin, 2011).

Further, these authors found that functional status generally does not improve for patients receiving medication for breakthrough pain, and that patients requesting breakthrough medication should be carefully evaluated for under-treatment, opioid hyperalgesia, new onset pathology, as well as drug misuse or abuse (Manchikanti et al., 2011). The American College of Emergency Physicians’ clinical policy guidelines found a paucity of evidence supporting prescription opioids on discharge from the ED of chronic non-cancer pain patients with breakthrough pain, recommending that physicians should avoid the routine prescription of

outpatient opioids for a patient with chronic non-cancer pain, prescribe the lowest practical dose of a limited duration, and consider the patient's risk for opioid misuse (Cantrill et al., 2012).

Question 5 Discussion of Text Responses. There were 16 text responses. Nurses wrote that beyond using the Numeric Pain Scale, they used physical signs and symptoms such as posturing, guarding and grimacing, as well as behaviors such as “eating and texting” to evaluate pain. Only one nurse named vital signs as an objective pain measurement. Emerging from these responses is that nurses often use the patient's reported Numeric Pain Scale, but also “free-text” in the electronic charting their own observations of the patients. Some stated they use FACES or FLACC tools for assessment. A consistent theme was observation of body language and any associated activities, “texting on the phone,” for instance. A cross-sectional cohort study of Veterans Administration clinic visits found that nurses who used informal pain screening techniques underestimated pain in 25% of visits and overestimated it in 7% (Shugarman et al., 2010).

A grounded theory study of chronic pain patients (Newton, Southall, Raphael, Ashford, & LeMarchand, 2013) describes the connection between being disbelieved as a chronic pain patient and the resultant stigmatization. Nurses, sometimes confronted by contradictory messages, such as the patient “texting” or “eating” while complaining of “10/10” pain, may turn to alternative means of assessment beyond the standard pain scale and in some instances discredit the patient's report of pain. Emerging in the literature is a need to move beyond the Numeric Pain Scale, particularly in assessing chronic pain patients. One tool, the Mankoski Pain Scale, developed by a chronic pain patient, uses subjective descriptors alongside the numbers 0 to 10 to assist in describing pain, was preferred by 46% of responding veterans with chronic

pain over the Numeric Scale, the Visual Analog Scale of the FACES Scale (Douglas, Randleman, DeLane, & Palmer, 2014).

Theme 2: Addiction and Abuse Concerns

Questions 2, 7 and 13 asked about RN concern or belief that their patient is addicted or misusing prescription drugs. In response to Question 2 (Table 9), a majority of RNs (63%) believed many patients who come to the ED for pain medication are addicted to pain medication. In response to Question 7 (Table 10), 69.4% agreed or strongly agreed that patients may be seeking a sense of euphoria when they ask for opioid pain medications. In response to Question 13 (Table 11), 59.2 % agreed or strongly agreed that a patient might accidentally overdose at home. The results of questions 2, 7 and 13 are graphically displayed in Figure 6.

Figure 6. Theme 2: Addiction and Abuse Concerns

Table 9. Question 2: RNs Believe Pts Are Addicted to Pain Medicine

	Frequency	Percent
Disagree	8	16.3
Neutral	10	20.4
Agree	22	44.9
Strongly Agree	9	18.4
Total	49	100.0

Table 10. Question 7: Some Pts Seeking Euphoria, Not Pain Relief

	Frequency	Percent
Strongly Disagree	2	4.1
Disagree	1	2.0
Neutral	12	24.5
Agree	27	55.1
Strongly Agree	7	14.3
Total	49	100.0

Table 11. Question 13: Concerned Pt. Might Overdose

	Frequency	Percent
Disagree	5	10.2
Neutral	15	30.6
Agree	20	40.8
Strongly Agree	9	18.4
Total	49	100.0

Question 7 Discussion of Text Responses. There were 15 free-text responses to Question 7, “Some chronic pain patients are seeking opioids for a sense of euphoria, not for pain relief.” Three respondents noted they try not to judge or pre-judge patients. Another stated that they have no way of knowing a patient’s motivation for seeking pain medication. One nurse stated that some but not most patients may be seeking euphoric responses from medication in the ED. Three respondents noted concern when a patient asks for IV pain meds to be “pushed fast.” McCaffery et al. (2005) investigated patient behaviors that would cause nurses to label patients as “drug-seeking” with the finding that 20% of emergency room nurses associated “how fast” to give the drug with drug-seeking behavior. In a study of emergency room providers that compared objective criteria from online drug-monitoring databases with provider observations of drug-seeking behavior, there was only fair agreement (Weiner et al., 2013).

A retrospective chart review of 178 patients who made a total of 2,486 emergency room visits in a single year showed that classic drug-seeking behaviors were only found with low to moderate frequency (Grover et al., 2012a). Thus, research evidence suggests that nurse belief in an ability to correctly perceive a patient’s motives may be inflated. Such studies suggest the need for a reliable screening tool for potential for drug abuse or risky behavior, since it is not possible to know *a priori* who is at risk and who is not, merely by observing a patient’s behavior.

In response to Question 7, 69.4% of respondents agreed or strongly agreed that “some chronic pain patients are seeking opioids for a sense of euphoria, not for pain relief.” This question is implicitly judgmental, designed to ask whether or not the nurse believes that some patients are addicts and whether or not they are in the ED merely to “get high.”

Theme 3: Doctor Shopping and Diversion

In response to Question 12, 78% of RNs agreed or strongly agreed that pain medication diversion is a real problem in their community. In response to Question 6, 97% stated they agreed or strongly agreed that a chronic pain patient who presents without a primary physician is cause for concern. The results of Questions 6 and 12 are graphically represented in Figure 7.

Data from the California Prescription Drug Monitoring Program show that individuals who used more than five different prescribers for Schedule II opioids in a calendar year were at three times higher risk for addiction than was the general population, underscoring the importance of a primary provider for chronic pain management of these patients (Han, Kass, Wilsey, & Li, 2014). RN awareness of the potential harm by opioid prescriptions, reflected in this survey, is consistent with National Vital Statistics data that reports prescription drugs overdose to be the second leading cause of death in the United States in 2010, the majority of these, 75.2%, were from opioids (Jones, Mack, & Paulozzi, 2013; Paulozzi et al., 2011).

Table 12. Question 6: RN Concerned when Pt has No Primary MD

	Frequency	Percent
Neutral	1	2.0
Agree	13	26.5
Strongly Agree	35	71.4
Total	49	100.0

Table 13. Question 12: RN Believes Diversion is a Real Problem

	Frequency	Percent
Disagree	1	2.0
Neutral	10	20.4
Agree	24	49.0
Strongly Agree	14	28.6
Total	49	100.0

Figure 7. Theme 3: Doctor Shopping and Diversion

Theme 4: Stigmatization of Patients

Question 11 asked about RNs “labeling” patients as drug-seekers; Question 15 asked whether RNs found chronic pain patients irritating or annoying; and Question 16 asked whether or not RNs gave these patients low priority. The results of these questions are compared graphically in Figure 8, page 36.

The term, “drug-seeking” is a stigmatizing label which can create prejudice and cause the patient shame (McCaffery, Grimm, Pasero, Ferrell, & Uman, 2005b); its use is discouraged by the American Society for Pain Management Nurse (ASPMN). However, it is a term employed frequently today in research literature as well as in clinical practice. (A simple Google Scholar query for “drug seeking” yields about 1,200,000 results.) A review of 178 patient charts (Grover, Elder, Close, & Curry, 2012b) found only a low frequency of patients who actually are drug-seeking (feigning pain to obtain drugs illicitly) and who exhibit classically described characteristics (i.e., know which drugs they want, know how to administer the medication, etc.). Hence, it is not possible to know *a priori* by simple observation which patients might actually be presenting with the intention to abuse or misuse medication.

Thirty of the RNs (61%) stated they use the term drug-seeker. Only 28.6% agreed or strongly agreed that they found chronic non-cancer pain patients irritating or annoying. Slightly more than half (53.1%) said they would give lower priority to “frequent flyer” pain patients. This last finding is consistent with study comparing RN, MD and patient attitudes and beliefs surrounding chronic pain management in the ED, which showed that both providers and patients believe that treating chronic pain has a lower priority than acute conditions in the ED (Wilsey et al., 2008a).

Figure 8. Theme 4: Stigmatization of Patients

Table 14. Question 11: Sometimes Label Patients as "Drug-Seekers"

	Frequency	Percent
Strongly Disagree	3	6.1
Disagree	9	18.4
Neutral	7	14.3
Agree	28	57.1
Strongly Agree	2	4.1
Total	49	100.0

Table 15. Question 15: Finds Chronic Pain Patients Irritating or Annoying

	Frequency	Percent
Strongly Disagree	3	6.1
Disagree	10	20.4
Neutral	22	44.9
Agree	12	24.5
Strongly Agree	2	4.1
Total	49	100.0

Table 16. Question 16: Likely to Give Low Priority to “Frequent Flyers”

	Frequency	Percent
Strongly Disagree	2	4.1
Disagree	9	18.4
Neutral	12	24.5
Agree	24	49.0
Strongly Agree	2	4.1
Total	49	100.0

Theme 5: Moral Tension

Questions 4 and 8 were intended to probe whether the RN felt any sense of ethical conflict or moral tension in regards to chronic non-cancer pain patients. Responses are compared graphically in Figure 8. Forty-three percent of RNs indicated they sometimes felt they were doing chronic non-cancer pain patients more harm than good (Table 17), and 71% indicated they felt “powerless to help” these patients (Table 18).

An analysis of the moral and ethical issues involved in chronic pain is complex and brings no simple solution. At issue always are the principles of beneficence, doing good by

relieving the patient's pain, and doing no harm, non-maleficence, by possibly preventing drug misuse (Novy, Ritter, & McNeill, 2009). In the emergency department, this tension is ever present and places the RN in the position of trusting the patient's report of pain, and of being charged to fulfill orders to medicate a patient or, as is sometimes more challenging, to explain to a demanding patient why pain medication cannot be given. Trust in the patient's report of pain is at the core of a nurse's assessment and actions (Peter & Watt-Watson, 2002).

Figure 9. Theme 5: Moral Tensions

Table 17. Question 4: RN Feels He or She is Doing More Harm than Good

	Frequency	Percent
Strongly Disagree	6	12.2
Disagree	14	28.6
Neutral	8	16.3
Agree	17	34.7
Strongly Agree	4	8.2
Total	49	100.0

Table 18. Question 8: RN Feels Powerless to Help

	Frequency	Percent
Strongly Disagree	2	4.1
Disagree	4	8.2
Neutral	7	14.3
Agree	28	57.1
Strongly Agree	7	14.3
Total	48	98.0
Missing System	1	2.0
Total	49	100.0

Question 8 Discussion of Text Responses. This question revealed a rich variety of responses that would be well-served by qualitative research involving nurse interviews. Responses of note included “lack of time,” “contributing to addiction,” “offering only a short term solution.” The linkage between a sense of powerlessness to act, moral distress, and nurse burnout has been discussed throughout nursing literature. Moral distress can manifest in concern about one’s ability to meet fundamental challenges and commitments; moral distress can be tied to moral disempowerment (Carse, 2013).

Theme 6: Communication Confidence

Answering Question 9, (Table 19) 49% of RNs surveyed said they would be comfortable screening all patients for drug abuse, a practice which could be included in an SBIRT program that offers a nonstigmatizing “universal precautions” approach (Barnard, 2009). In response to Question 10 (Table 20), 94% were comfortable talking with their physician colleagues when they had concerns regarding a patient’s potential misuse of drugs. In response to Question 18 (Table 21), 24% said they were more comfortable talking to patients about daily alcohol use than prescription drug use. The results of these questions are graphically compared in Figure 10.

Figure 10. Theme 6: Communication Confidence

*Table 19. Question 9. Would Feel Comfortable Screening All ED Patients
for Drug Abuse*

	Frequency	Percent
Strongly Disagree	4	8.2
Disagree	14	28.6
Neutral	7	14.3
Agree	16	32.7
Strongly Agree	8	16.3
Total	49	100.0

Question 9 Discussion of Text Responses. Those RNs who provided written responses to the concept of universal screening noted concern over lack of time. Another concern was that universal screening might be counterproductive and lead to labeling patients. Here, the survey results showed an interest in screening patients for substance abuse (49% agreed or strongly agreed with the concept), but the text responses indicated questions about time that would be needed for screening and process. Responses suggested that there was a need for training about the need for and the concept of universal precautions towards substance abuse. By taking an approach of screening everyone for addiction disease, in the same way that one would check for diabetes or hypertension, the disease is destigmatized, and there is a greater likelihood of appropriate referral.

The incidence of alcohol and drug abuse is higher among patients who visit the ED than there is in the general population. In a study of one urban emergency department, 19,055 patients were screened over a 20-month period. In this sample, nearly 30% of all patients presenting to the ED screened positive to a pre-screening questionnaire, indicating alcohol consumption above recommended levels, or any illegal drug use. Over 20% of those patients

with positive prescreens showed high-risk or probable alcohol dependence, and over 20% screening positive for drugs were in the high risk and probable dependent category as well. In the same study, 15.6% of patients who presented to the ED screened positive for drug use, with most patients screening positive for either marijuana or cocaine use (Hankin, Daugherty, Bethea, & Haley, 2013). Screening via electronic health records, using a brief, three-question screening tool, particularly at triage time, has been shown to be successful in identifying patients who may need a brief intervention or more intensive treatment (Johnson et al., 2013).

Table 20. Question 10: Comfortable Talking with MD About Concerns

	Frequency	Percent
Neutral	3	6.1
Agree	22	44.9
Strongly Agree	24	49.0
Total	49	100.0

Table 21. Question 18: More Comfortable Talking About ETOH Use than Prescription Med Use

	Frequency	Percent
Strongly Disagree	6	12.2
Disagree	19	38.8
Neutral	12	24.5
Agree	10	20.4
Strongly Agree	2	4.1
Total	49	100.0

Theme 7: Constructive Practices or Knowledge

The remainder of the survey questions asked about RNs constructive practices towards chronic pain patients. Here, the results were divided. In response to Question 3 (Table 22), 47% percent of RNS agreed or strongly agreed that they took time to provide discharge teaching to patients on storage and disposal of narcotics. In response to Question 14 (Table 23), 43% said they attempt to see that patients have a follow-up plan with a primary provider. Thirty-four percent answered Question 17 (Table 24), saying that they took time to teach about adjuvant therapies such as stretching and hot and cold packs. No RNs agreed that they had heard of the ACEP policy for prescribing opioids in the emergency department (Table 25).

Figure 11. Theme 7: Constructive Practices or Knowledge

Table 22. Question 3: RNs Educate Patient on Storage and Disposal

	Frequency	Percent
Disagree	10	12.2
Neutral	16	32.7
Agree	18	37.3
Strongly Agree	5	6.1
Total	49	100.0

Table 23. Question 14: Makes an Attempt to See Pt Follows Up with Primary

	Frequency	Percent
Strongly Disagree	4	8.2
Disagree	11	22.4
Neutral	13	26.5
Agree	19	38.8
Strongly Agree	2	4.1
Total	49	100.0

Table 24. Question 17: Takes Time to Teach About Adjuvant Therapies

	Frequency	Percent
Strongly Disagree	6	12.2
Disagree	15	30.6
Neutral	11	22.4
Agree	15	30.6
Strongly Agree	2	4.1
Total	49	100.0

Table 25. Question 19: Aware of ACEP Guidelines

	Frequency	Percent
Strongly Disagree	20	40.8
Disagree	18	36.7
Neutral	10	20.4
Agree	0	0.0
Strongly Agree	1	2.0
Total	49	100.0

Assessment of Results

The results of the survey, when seen in the context of RN readiness for SBIRT, present a complex interplay between numerous factors, all of which affect the RNs ability to assess and treat chronic non-cancer pain patients effectively and without stigmatizing prejudice. Not surprisingly to the author, RNs showed a tendency to label patients as drug-seeking (61.2% agreed or strongly agreed they labeled patients). As well, a large number, 71.4% of nurses, agreed or strongly agreed that they felt powerless to help chronic non-cancer pain patients. These factors, labeling patients, as well as moral tension, can cause healthcare providers to stigmatize patients and ultimately result in a degraded level of care (Ahern et al., 2007; Corrigan, 2004; Jimenez, Bartels, Cardenas, & Alegría, 2013).

But, while the survey revealed RNs state a strong tendency to stigmatize chronic non-cancer pain patients, at the same time, RNs showed high levels of awareness of the problems caused by drug diversion (77.6% agreed diversion is a problem) and the potential for patient overdose (59.2% agreed it is a concern), and fully 97.9% said they were concerned when a chronic pain patient does not have a primary physician. Most RNs (93.9%) responded they were

comfortable talking with their physician colleagues if they concerns about potential opioid misuse and 49% said they would be open to screening all patients for drug abuse (a key feature of SBIRT). Finally, a majority of respondents, 77.5% indicated they had not heard of the ACEP clinical guidelines for prescribing opioids to adult patients in the emergency room. Thus, the response pattern is as complex as the issue itself; it is possible for an RN to have a high level of knowledge on the topic of chronic non-cancer pain patients, and yet still evidence prejudice or the tendency to stigmatize this group of patients.

Limitations

This project casts a wide net in an effort for the author to better understand a complex issue—how to treat chronic non-cancer pain patients who present to the ED using a nonstigmatizing approach such as SBIRT. This survey and its analysis are purely descriptive and as such apply only to the population sample. Whether or not the survey has external validity, and hence can be generalized to the larger population of ED nurses, would require a more rigorous examination using an inferential approach. However, the survey provides a needs assessment for the surveyed ED, pointing to knowledge gaps and areas of concerns. And, it is a first step at qualifying the issues ED nurses face when treating chronic non-cancer pain patients. The limitations imposed by bias are numerous: there is selection bias reflected by who chose to answer the survey—were the respondents friends with the author, did they have a special interest in the topic, etc.? As well, the Likert question format where a person picks a response that ranges from “strongly disagrees” to “strongly agrees,” might favor enthusiastic responders who gravitate to the superlative. Finally, the author herself is well aware of the many biases her own

frame of reference brings to the project, causing her to choose one question over another or emphasize a certain wording.

Implications for Practice

Employing SBIRT in the emergency department to screen and intervene therapeutically with substance abuse has been shown to be successful (Agerwala & McCance-Katz, 2012; S. L. Bernstein & D'Onofrio, 2013; Desy & Perhats, 2008; Estee, Wickizer, He, Shah, & Mancuso, 2010). These and other studies demonstrated improved patient outcomes in increased referrals to treatment and decreased repeat visits to the emergency department (Barnard, 2009). An SBIRT protocol requires the screening of every patient by using a brief screening tool in the same manner that many EDs now screen for domestic abuse, suicidality, or any of the other psychosocial screeners that are built into many ED triage protocols and often included in EHR triage or assessment tools.

SBIRT's use in the ED has several important implications for nursing practice, including: public health benefits, better patient outcomes, improved patient satisfaction, cost savings for institutions, and improved RN role confidence to positively manage chronic non-cancer pain patients (Figure 12).

Practice Improvement Implications for SBIRT

Figure 12. Practice Improvement Implications for SBIRT

The DNP project survey administered to staff ED nurses at a large urban Northern California hospital reveals some important considerations before beginning an SBIRT initiative: many nurses surveyed report to using stigmatizing language or to giving patients with chronic pain who are frequent users of the ED lower priority. Thirty of the RNs (61%) stated they use the term, “drug-seeker” and more than half (53.1%) said they would give lower priority to “frequent flyer” pain patients.

At the same time, some nurses in the same surveyed cohort describe some very positive actions towards these patients: taking time for extra teaching (47%), taking care to provide adequate discharge instructions (43%); and openly consulting with their physician colleagues (93.9%). The author had anticipated results that would be more polarized, i.e., high scores on tendency to stigmatize, and low scores on constructive intervention and interest in discussing issues with physicians, etc. The very mixed results of this survey point to a complex pattern of behaviors by RNs in the ED towards a very complex group of patients.

Because of prescription drug abuse's large and deleterious impact on public health (Jones et al., 2013; Paulozzi et al., 2011), it is critical that issues of overdose, addiction and diversion are handled in a systematic, evidence-based manner (Kuehn, 2013; Volkow & McLellan, 2011). SBIRT offers a means for RNs to address this issue as it presents in the ED. The ED is the most frequent point of medical contact for most patients, and indeed in some cases the only point of medical care, and as such is the ideal venue for SBIRT interventions. Estimates on the number of hospitalized patients who have substance use disorders range from 5% to 14% to higher (Specker, Meller, & Thurber, 2009), and it is thought that many patients pass through the medical system without any form of screening or counseling.

In the DNP project survey, RNs showed strong awareness of the potential lethality of prescription opioids as well as the public health implications of misuse of these drugs, (78% of RNs agreed or strongly agreed that pain medication diversion is a real problem in their community), and 97% stated they agreed or strongly agreed that a chronic pain patient who presents without a primary physician is cause for concern).

Recent studies have demonstrated the efficacy of incorporating a brief screening tool into the ED triage process (Estee et al., 2010; Murphy, Bijur, Rosenbloom, Bernstein, & Gallagher,

2013; Vaca, Winn, Anderson, Kim, & Arcila, 2011; Woodhouse, Peterson, Campbell, & Gathercoal, 2010). Broyles (2012) reported that a majority of hospitalized patients (95%) found it acceptable for nurses to screen for risky behaviors and ask about or discuss alcohol use during their hospitalization. However, the converse may not be true. In the DNP project survey, only 49% of RNs agreed or strongly agreed that they would feel comfortable screening all patients for drug abuse behaviors.

A tool built into the EHR offers the additional administrative benefit of being able to readily capture and code the screening and flag for possible patient intervention and referral, as well as for possible Medicare or other insurer reimbursement (Kuehn, 2013; Marlowe, Capobianco, & Greenberg, 2014).

By utilizing SBIRT, not only are patient outcomes improved, but patient satisfaction increases. In a study of RN, physician and patient attitudes and beliefs surrounding chronic pain management in the ED, the one point of consensus among the three groups was that treating chronic pain in the ED has a low priority (Wilsey, Fishman, Ogden, Tsodikov, & Bertakis, 2008b). SBIRT encourages open discourse between provider and patient, and a non-judgmental approach to this patient population and might serve to reduce the feeling from patients of being marginalized.

The Institute of Medicine's Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm (Institute of Medicine (IOM), 2012) series reports the need for clinicians to change their negative attitudes and practices towards substance abuse in order to improve quality of care for these marginalized patients. One study of undergraduate nurses who underwent SBIRT training showed a reduction in negative attitudes towards patients who are

alcohol and substance abusers (Puskar et al., 2013) and experienced an increase in positive role confidence.

More may be required at the level of nursing education. Not only RN training in SBIRT technique (how to provide the screening, counseling techniques for intervention), but a more formal introduction to non-cancer pain patients in the ED may be indicated, beginning at the undergraduate level. Finnel (2012) calls for RNs to become SBIRT experts, practicing to the full extent of their licenses, across the patient care continuum. Yet, the literature on education and training for nursing undergraduates on addiction disease is scant (Rassool & Rawaf, 2008). Given the prevalence of addiction disease, there devastating consequences, and the various roles of caretaker, educator, counselor, etc., that the RN assumes, some believe the topic of substance abuse and treatment should be a standard part of the undergraduate curriculum (Broyles, Kraemer, Kengor, & Gordon, 2013; Murphy-Parker, 2013). Training nurses to view substance abuse as a chronic disease would not only reduce stigmatization of these patients, but in the case of the chronic non-cancer pain patient, help separate the often justified concern of addiction from the work of treating pain.

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Appendix A Text Responses to Survey Questions

This Appendix contains the verbatim free-text responses to the project survey.

Text Responses to Question 1, The ED is not the place to treat chronic pain

1. Not an effective place, not the best place.
2. Sometimes if (pain is) completely out of control.
3. Consider after hour pain control clinics
4. Always some legitimate exception.
5. Pain can come in surges, or pt may need breakthrough.
6. Breakthrough pain OK
7. Chronic is the key here. Acute pain as part of a chronic pain condition is different that is likely best treated in the ED since that department is open 24/7.
8. Chronic pain doesn't occur M-F during business hours.
9. We treat all pain in the ED.
10. See primary care MD first if possible.
11. OK for breakthrough pain.
12. Depends on how the pt presents.
13. I believe the ED is not place to manage chronic pain. However, in periods of exacerbation and lack of other suitable options, the pt's DO need treatments and the ED is always open.
14. Acute on chronic pain OK.
15. Depends on if they are having breakthrough pain.
16. If they come, we will treat. But pain clinic or PMD preferred.
17. Exceptions would be new injury or breakthrough
18. Unless pt. has pain with meds he is already taking.
19. Breakthrough pain only.

Text Responses to Question 5, I find it difficult to adequately assess 10/10 pain:

1. VS changes. Signs rather than symptoms.
2. What is their baseline level? 9/10 normally? Now 10/10? Not that different.

3. I take into account/ask about how often the pt. is in pain, what is their typical pain level; often a pt. who is always in 7/10 pain can tolerate 10/10 pain without guarding/grimacing, etc.
4. I try to separate pts.' complaints of chronic pain from new onset or flare-up pain. No real place for this on the Health Connect assessment form, but if possible, I write a note.
5. Pt.'s behavior and activities. Appearance, history.
6. Posturing, guarding, grimace. Texting? Eating?
7. In ability to be distracted from pain, restlessness and skin signs (i.e., diaphoresis, pale).
8. Does your pain ever get below "10/10"? If so, when and how? Q. when it gets below 10/10, how long does that relief last? Q. Do you, as the patient, think you can achieve a pain level of less than 10/10 without using narcotics?
9. Is this the worst episode? How close is it to being the worst?
10. Apparent level of comfort by my personal assessment (super subjective)
11. What the patient is doing when I am present and when I am out of the room.
12. Are they crying? Wincing? BP elevated?
13. Observation is key, body language, if time available, sit down, talk with patient. There is usually underlying circumstances.
14. Activity at time of assessment (talking on phone, laughing, watching TV). VS, sleeping, sedation level, positioning diaphoresis
15. Non-verbal cues, such as facial grimace, muscle tone.
16. How much worse is this pain than your usual, baseline pain?

Text Responses to Question 7, Some chronic pain patients are seeking opioids for a sense of euphoria, not for pain relief.

1. Some pts with and without chronic pain seek opioids for euphoria. Some also have pain.
2. Some, not all.
3. I don't have any way of knowing this.
4. Often have depression too.
5. I try not to prejudge, rather remain open-minded and judge case by case.

6. Don't feel it's my job as ED RN to assess or judge this. If I was in chronic pain, perhaps euphoria might be OK every now and then.
7. Some. I don't believe that is true for most.
 1. Do they think about their narcs when not in pain and take a narc when not in pain, because they're used to it?
 2. I had a patient one time that commanded me to "push it fast" when I gave him IV morphine.
 3. When pt asks you to "push" med quickly, I am concerned.
 4. Maybe some if true chronic pain, people are seeking relief.
 5. Though often go hand-in-hand; i.e., NEEDS meds for pain, but asks for "fast-push" or complains until "snowed."
 6. Maybe. I usually figure chronic pain patients are seeking meds for pain relief.
 7. I would answer yes if we differentiate between being a chronic pain pt. and someone that commonly requests pain meds.
 8. Also, to avoid painful withdrawal symptoms.

Text Responses Question 11, I sometimes label chronic pain patients as "drug-seekers."

1. I try to avoid doing this.
2. I try to never use this terminology

Text responses to Question 16, I am likely to give low priority to "frequent flyer" chronic pain patients.

1. Drug seekers can also be same as with poorly controlled chronic pain.
2. I see these terms as linked, but not synonymous.
3. Sometimes I will expect the behaviors from chronic pain patients, but don't automatically label them. As I have no idea what they're going through and have no chronic pain conditions.
4. If they aren't following their medication schedule, then yes.

Text Responses to Question 8, I sometimes feel powerless to help chronic pain patients in the ED:

1. Some patients willing to go to pain clinic.
2. Powerless, no but sometimes feel like a contributor to the addiction. But once again, it's the physician who is in control.
3. One ED visit is too time limited for treatment. RN and MD time with each pt often too short to address situation appropriately.
4. Some pain syndromes only partially helped by the strongest of pain regimens.
5. On one hand, you have the power, you have the power to lessen the pain with narcotics. In this way, you are helping them. On a chronic [longterm] level, not at all.
6. I feel chronic pain would be best served with integrative medicine: meds, alternative therapy and psych. I feel totally helpless in the ED to provide holistic care, which I believe the pt.'s need.

Text Responses to Question 9, I would feel comfortable screening all patients for drug abuse behaviors.

1. This would take a significant amount of time.
2. It would be interesting to see the results of screening for public education purposes.
3. Not sure how helpful. Would do only if saw benefit down the line.
4. I worry that once labeled, pts may not get the help they need.
5. I am comfortable talking with my physician colleagues when I am concerned that a patient may be abusing opioids.
6. On what criteria!
7. I would need convincing that this was helpful. Likely to be counter-therapeutic.

Text Responses to Question 10, I am comfortable talking with my physician colleague when I am concerned that a patient may be abusing opioids.

1. I spend more time with the pts. than the docs do.
2. I work in a good environment with good communication.

Text Responses to Question 17, I take time to teach chronic pain patients about stretching, use of ice packs or warm packs and breathing techniques.

1. What time!
2. I do this for the first few times I see a pt., but not for pts I have previously seen or educated.
1. Not really. Great idea but not top priority when busy night.
2. Usually too busy in our ED
3. I try but they don't want to hear it.
4. It is important to review chronic pain pt's meds and regimen. Many times pts are not using them correctly and MD is prescribing short-acting narcs for long-term coverage.
5. I don't feel ED provides good advice/teaching for chronic pain except refer to pain clinic, the experts.
6. If I believe the pt to be in pain, I do tend to spend more time trying to educate pt.
7. Limited time for additional teaching.
8. Typically wouldn't feel comfortable advising stretching unless I got the green light from the MD. It's possible to do more harm than good.
9. Depends on the rapport I am able to develop with the pt.

Text Responses to Question 14, I make an attempt to see that chronic pain patients are following up with their primary doctor or are seeking additional resources for pain management.

1. This is NOT an ED nurse's job.