

HEALING HANDS



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Pain Management: Reducing Disparities for Homeless Patients

Although relief of pain and suffering is fundamental to the healing arts, analgesia is not available to all who seek it. Significant disparities in pain management persist, especially for medically underserved populations. This issue of Healing Hands explores some of the reasons why pain suffered by individuals who are homeless is often undertreated. Articles focus on pain assessment techniques, recommended treatment modalities to alleviate acute and chronic pain, and therapeutic challenges presented by patients who “self-medicate” with alcohol or illicit drugs to cope with unrelieved pain.

A survey conducted by the American Pain Society revealed that over 40 percent of people suffering moderate to severe pain are unable to obtain adequate pain relief, and 25 percent of pain patients change doctors at least three times due to unrelieved pain.¹ According to Health Care for the Homeless providers, displaced people are at higher risk than others for acute and chronic pain, but have more difficulty obtaining analgesia (alleviation of pain without inducing loss of consciousness).

Many homeless people suffer acute pain from trauma, unattended tooth decay and advanced gum disease, abscesses resulting from wound infections, and complications of illness or injury exacerbated by unsafe and unsanitary living conditions. Left untreated, acute pain can become chronic. HCH providers see a wide variety of chronic, non-malignant pain² —of musculoskeletal origin (low back pain, post-traumatic arthritis); neuropathic pain associated with diabetes, HIV, hepatitis, or alcoholic cirrhosis; and chronic pain secondary to advanced peripheral vascular disease, headaches, or incomplete recovery from surgical procedures, among other causes.

“We see chronic pain more frequently and at a younger age in homeless patients, because they have more opportunity for injuries and less opportunity for rehabilitation,” concludes **Barry Zevin, MD**, Medical Director of the Tom Waddell Health Center in San Francisco.

BARRIERS TO ANALGESIA Chronic pain may not compel homeless people to seek medical care; many either adapt to living with pain or seek relief in alcohol or illegal narcotics, providers

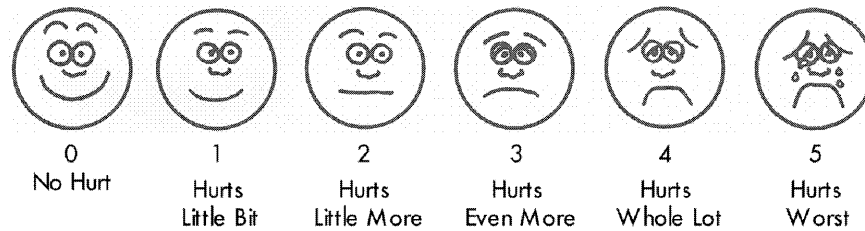
report. “If you’ve had uncontrolled pain for 20 years, why see someone about it?” asks **Ed Farrell, MD**, Medical Director of the Colorado Coalition for the Homeless’ Stout Street Clinic in Denver.

Barriers to effective pain management for homeless people include poor understanding of pain management in the general medical community, lack of health insurance limiting access to specialty care, minimal social supports, inadequate shelter, lack of resources to pay for pain medication (or even a firm mattress), and difficulty storing medications.²

Minority Status Among those most at risk for untreated pain are racial and ethnic minorities which are overrepresented among homeless people. Empirical data clearly indicate disparities in pain treatment based on race or ethnicity.³ A retrospective cohort study of 31 Hispanic and 108 non-Hispanic patients with isolated long bone fractures found that Hispanic patients were twice as likely to receive no analgesics. In another study, African-American patients were found to be less likely than Caucasian patients to receive emergency department analgesia, despite similar reports of pain in their medical records. Researchers speculate that reasons for such discrepancies include providers’ concerns about potential misuse of narcotics by minority patients, difficulties in pain assessment due to language and cultural differences, and patients’ low health literacy⁴ and lack of assertiveness in seeking care.⁵

Pharmacies in minority neighborhoods are less likely to carry narcotics. According to a survey published in the *New England Journal of*

Wong-Baker FACES Pain Rating Scale



From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P. *Wong's Essentials of Pediatric Nursing*, ed. 6, St. Louis, 2001, p.1301.

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Medicine, only 25 percent of pharmacies in predominantly nonwhite neighborhoods had opioid supplies that were sufficient to treat patients in severe pain, compared with 72 percent of pharmacies in predominantly white neighborhoods.⁶ Reasons pharmacists gave for having inadequate supplies of opioids included regulations regarding disposal, illicit use, and fraud; low demand; and fear of theft.

Legal Restrictions According to the U.S. Drug Enforcement Administration (DEA), which regulates controlled substances, "...the physician must issue prescriptions for controlled substances only for legitimate medical purposes and in the usual course of professional practice." However, federal laws and regulations do not define "legitimate medical purposes" or "the usual course of professional practice"—states do; and many state laws are more restrictive than the federal statute.

For example, some states limit the amount of a controlled substance that can be prescribed at one time or restrict the use of narcotics for people with known or suspected drug addiction.⁸ Apprehension of physicians for violating these standards, though rare, may inhibit prescribing practices somewhat, suggests **Stefan Kertesz, MD, MSc**, Assistant Professor at the University of Alabama Birmingham School of Medicine and staff physician at Birmingham Health Care. He recommends that providers carefully document justifications for pain treatment decisions in patient files.

ASSESSING PAIN Pain, defined as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage,"⁹ is considered the fifth vital sign that practitioners should assess in addition to pulse, blood pressure, core temperature, and respiration.¹⁰ The other four can be measured objectively, but "if you want to know about a patient's pain, you have to ask him," explains **Joshua Bamberger, MD**, Medical Director of Housing and Urban Health in the San Francisco Department of Public Health.

Subjective Rating Scales The subjective nature of pain makes it difficult to assess. A variety of verbal and visual scales have been developed to help patients describe the pain they experience. Commonly used pain assessment tools include the following:¹¹

- **Verbal rating scale:** none, mild, moderate, and severe.
- **Numeric rating scale:** 0 to 10, with 0 indicating no pain and 10 the worst pain imaginable.

- **Visual analog scale:** a 10 cm line with one end labeled "no pain" and the other end labeled "worst pain imaginable." The patient marks the line and the length of the line is measured.
- **Faces pain scale:** 6 to 8 different facial expressions from a smiling face (no pain) to a face that is crying (worst pain possible) – useful in young children, patients who have mild to moderate cognitive impairment, and patients with other language barriers.

In addition to the patient's self-report, doctors conduct a thorough history and physical exam. Vital signs associated with acute pain, such as elevated pulse and blood pressure, may not be evident in a person with chronic pain. "Their cardiovascular system acclimates to the pain," explains **Susan Louisa Montauk, MD**, Professor of Clinical Family Medicine at the University of Cincinnati College of Medicine and staff physician on the Cincinnati HCH mobile van.

Even tests such as magnetic resonance imaging (MRI) may be problematic. "There can be objective findings that correlate with a person's pain, but there don't have to be," says Dr. Bamberger. "You have to get to know the person and find out what is going on in his life." Sometimes individuals have co-morbid conditions, such as depression or posttraumatic stress disorder (PTSD), which may amplify pain secondary to the underlying pathology, Dr. Farrell says. Pain and depression are inextricably linked; treating one may help the other.¹²

Assessing pain in children can be easier because "they will often tell you where it hurts," says **Lois Thetford, PA-C**, with the 45th Street Clinic, part of the Seattle-King County HCH Network. While pain tends to wear adults down, children find ways to distract themselves, notes **Janice Putnam, MS, FNP**, Coordinator of Homeless Youth Medical Outreach, a program of Phoenix Children's Hospital.

TREATMENT OPTIONS The goals of pain treatment are straightforward: reduce pain and suffering, enhance quality of life, increase ability to function, and minimize risk of adverse effects. But treatment modalities are various and involve a good deal of trial and error. Successful treatment depends on setting realistic expectations, HCH providers agree. "I have to let my patients know I can't perform miracles," Dr. Farrell says. Indeed, most patients treated with opioids will not be pain free, but can live more comfortably with reduced pain, according to Dr. Kertesz.

Narcotic Drug Therapy “Opioids are indicated for moderate to severe pain that has a significant impact on functionality and quality of life or when non-opioid pharmacotherapy has failed.”² Many HCH providers prescribe a short course of narcotics for patients in acute pain (e.g., from a fracture), though formularies may limit their choice of drugs. Tylenol® with codeine is frequently the only option available to patients without health insurance. The use of opioids for chronic pain management is more controversial.

Some HCH providers are reluctant to prescribe narcotics for patients with substance use disorders, especially street dwellers, whose medicine may be lost, sold, or stolen. (See the following article for tips on managing chronic pain in patients with a history of substance abuse.) Patients may be reluctant to use narcotics because they fear becoming addicted or have concerns about potential side effects, such as mental clouding, nausea, and constipation.

Some clinics have a policy against prescribing any narcotic pain relief (see May 2004 issue of *Healing Hands*), to discourage drug seekers and remove an incentive for theft. Physicians fear that if they are known to prescribe narcotics, they may open themselves to ongoing demand for pain medications. For this reason, **Ryan Huckeby, DMD**, Dental Director at Partnership Health Center Dental Clinic in Missoula, MT, does not prescribe narcotic pain medication for acute or chronic dental pain unless the patient agrees to let him treat the source of the pain.

Nevertheless, HCH providers acknowledge that there are times when narcotic therapy for relief of chronic pain is both appropriate and humane. “I frequently prescribe long-acting opiates to homeless people with severe, intractable, chronic pain,” reports Dr. Zevin. “Most of the time, the results are positive, and patients’ ability to function improves.”

To delineate patient and provider responsibilities when narcotics are prescribed for chronic pain, and to highlight potential risks of using opioids, many doctors ask their pain patients to co-sign a contract or therapeutic agreement. Treatment can be terminated if the agreement is broken (e.g., by seeking narcotics from another provider or altering a prescription). “Therapeutic agreements help us minimize potential problems, but we have little objective evidence that they prevent misuse,” Dr. Kertesz admits.

Non-Narcotic Analgesics For chronic pain, narcotics are rarely the first line of defense. In addition to acetaminophen, providers use such non-steroidal anti-inflammatory drugs (NSAIDs) as ibuprofen or some of the newer COX-2 inhibitors, which may be easier on the GI tract. (On September 30th, Merck & Co. voluntarily withdrew its COX-2 anti-inflammatory drug Vioxx® from the market because an ongoing trial confirmed the medication increases the risk of heart attack and stroke.)

To increase the effectiveness of acetaminophen and reduce the risk of liver toxicity, providers may alternate Tylenol® with an NSAID. This

is the approach Thetford uses for children younger than 7. For adult patients, particularly those with co-morbid depression, she may combine an NSAID with a tricyclic antidepressant; antidepressants have been shown to have analgesic effects apart from their effect on depression.¹² Anticonvulsant drugs such as Neurontin® may be effective for neuropathic pain.

Agreement for Use of Chronic Controlled Substances

Date: _____

I _____, understand that I will receive _____ as part of my care from Health Care Provider _____.

RISKS: I am aware that this medicine has the potential for addiction, abuse or dangerous consequences if taken improperly.

CONDITIONS:

- I understand that Dr. _____ or his/her associate at the clinic will be the only people to write this prescription.
- I will take the medicine as prescribed.
Medicine: _____.
- I will not get prescriptions for this or any similar medication from anywhere except for (this clinic).
- If an emergency occurs or I get hospitalized and some other doctor must prescribe this medication, I will inform (this clinic) as soon as possible.
- I will use only one pharmacy to fill these prescriptions and that will be: _____. My providers at (this clinic) have my permission to speak with the pharmacy about prescriptions at any time. If I choose to change pharmacies at any time, I will first notify my provider.
- I have fully informed my provider of any current or prior use of alcohol, medications, or illegal drugs, and I consent to undergo urine or blood tests if my doctor requests those tests to confirm that I am holding to this agreement.
- I will not abuse alcohol or use any illegal drugs while taking this medication. I agree to let my provider check my urine or blood at any time for alcohol or drugs.
- I will not sell these medications or share them with anyone.
- I am aware that prescriptions will not be provided for more than one month at a time and that refills are not available at nights, on weekends or by telephone. It is my responsibility to obtain prescription refills before they run out.
- I will give (this clinic) permission to communicate with any of my other providers about my use of controlled substances.

I understand that if I fail to meet all the agreements of this contract, then Dr. _____ and clinic staff will review the conditions of my care and may decide to stop prescribing this medicine to me.

Patient: _____ Date: _____

Provider: _____ Date: _____

Nurse: _____ Date: _____

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Non-Drug Therapies HCH providers also rely on a host of adjunct, non-drug therapies for patients in chronic pain. Putnam teaches teens with chronic headaches to massage those areas where they feel the most pressure. She gives them tennis balls to lie or lean on for neck and back pain and teaches stretching exercises. “They are very good about doing their exercises,” Putnam says. Other localized remedies include ice and moist heat. Providing ice can be as simple as putting snow in a plastic bag during the winter months, Dr. Farrell notes.

Acupuncture is a popular alternative to medication for various types of pain, but insurance coverage and funding for acupuncture programs may be victims of budget cuts. In Oregon, Medicaid will cover office visits but not the procedure itself, though clients of the Portland Alternative Health Center (PAHC), a program of Central City Concern, can avail themselves of a full range of Chinese medicine, including acupuncture for addiction and for pain. “We don’t know the mechanism of action in acupuncture, but there is a good deal of empirical research which shows that it works,” says PAHC Director **David Eisen, MSW**, a licensed acupuncturist with a doctorate in Oriental Medicine. **Lynne Clark, RN, MPH**, mental health nurse practitioner with Central City Concern’s Community Engagement Program, reports that 90 percent of her patients who try acupuncture believe it helps their pain.

Specialty Care Pain clinics, physical therapy, and other specialty care are out of reach for most homeless patients unless they have

Medicaid coverage that includes such benefits. One exception is in Cincinnati, which has had a levy passed every 5 years since 1966 that covers indigent care. Homeless people without Medicaid can be treated at University of Cincinnati pain clinics, though they, like others attending the clinics, may have to wait many weeks for their initial appointment, Dr. Montauk says.

To help homeless and uninsured patients gain access to pain specialists, the Crusader Clinic in Rockford, IL, is opening its own pain clinic. The clinic will contract with pain specialists who will be available one day a month to help manage chronic pain. “These specialists will be able to use procedures such as steroid injections directly into a joint, which have never been available to the majority of our patients before,” says Medical Director **Bechara Choucair, MD**.

Holistic Care In the end, says Dr. Bamberger, “The cornerstone of good pain management is an open, honest relationship with the patient.” A multidisciplinary approach that uses both pharmacologic and non-pharmacologic approaches and is tailored to individual needs is likely to be most successful.²

Attending to other needs in a person’s life may reduce suffering, even when some pain persists, Dr. Zevin reminds us. In fact, the use of narcotics (whether prescribed or illicit) declines when people become housed, notes Dr. Bamberger. Housing should be a component of any treatment strategy to relieve chronic pain.

Substance Abuse Should Not Preclude Use of Analgesics

Although it is generally accepted that addiction should not interfere with adequate treatment of acute or cancer-related pain, treatment of chronic, non-malignant pain is more complex, controversial (as noted above), and presents special challenges.²

People with substance use disorders often have significant unrelieved pain and may use illegal narcotics to treat their pain. Others have become addicted to legal narcotics prescribed for pain that were inappropriately monitored. Ineffective pain management may be an obstacle to recovery from addiction, and addiction complicates pain management.

Drug use in patients with chronic pain is a Catch-22 situation, says **Laura Guzman, JD**, Director of the Mission Neighborhood Resource Center in San Francisco. “Sometimes the only way our patients can cope with pain also contributes to their pain.” She relates the story of a homeless woman with severe phlebitis in her legs,

exacerbated by spending all day on her feet, trying to find drugs to control her pain.

“To leave pain untreated in a person with a substance use disorder is a drastic measure that goes against the Hippocratic Oath,” contends **Mark Nemiroff, MD**, Director of Pain Management Services at Frankford Bucks Hospital in Langhorne, PA. What’s more, addiction and pain are distinct conditions, and appropriate treatments are available for both, notes Dr. Joshua Bamberger.

STRUCTURED APPROACH Most experts agree that treating chronic pain in patients with concurrent substance use disorders requires a highly structured therapeutic strategy.^{13,14} Elements might include a written contract, more frequent visits, prescribing smaller amounts, periodic urine screens, and concurrent psychotherapy.

The use of long-acting medications which provide stable blood levels with slower onset

(such as MS Contin[®]) are preferred by HCH providers over shorter acting medications (such as OxyContin[®]). The latter is safe and efficacious but may be misused. OxyContin[®] sells for \$1 a milligram on the street (\$4,800 for 60 80mg tablets), Dr. Nemiroff points out.

Short-acting medications, sometimes called “rescue doses,” can be added to long-acting medications to address breakthrough pain. Combination drugs that include a narcotic pain reliever with acetaminophen, such as Tylenol 3[®] or Vicodin[®], are less easily diverted or injected because the acetaminophen causes a sensation of burning under the skin, Dr. Bamberger says.

Encouraging recovery from addiction while treating pain is critical, providers say. At the Portland (OR) Alternative Health Center, pain patients with substance use disorders must be enrolled in the center’s alcohol and drug addiction treatment program. “If we

have to use narcotics in patients with substance use disorders, we stabilize their pain and then wean them from the drug,” says Director David Eisen.

Pain patients at PAHC also must be housed. Central City Concern, PAHC’s parent agency, operates emergency, transitional, low income, and permanent supportive housing. “We guard against the use of narcotics for our street population,” Eisen says.

Other providers don’t require but strongly encourage pain patients with substance use disorders to enroll in treatment, where available. “We talk to our patients about the potential for abuse,” Dr. Ryan Huckeby says. “If someone is actively using addictive substances, I don’t say, ‘I’m not going to treat your pain.’ At the same time, I won’t do anything to put their health in jeopardy.”

RISK OF ADDICTION Studies show that short-term use of narcotics rarely leads to addiction for patients who have no personal or family history of abuse or addiction, no affiliation with a substance using subculture, and no significant premorbid psychopathology. However, co-occurring substance use disorders and mental illnesses are common among the patients HCH providers serve. Further, these studies concentrate primarily on short-term use of narcotics in inpatient settings. “The studies are less definitive on the odds of developing addiction after long-term exposure to narcotics, with or without a prior history of addiction. We don’t know how big the risk is,” says Dr. Stefan Kertesz.

Pain management for people with substance use disorders is complicated by different definitions of the terms ‘tolerance,’ ‘dependence,’ and ‘addiction’ used by researchers, clinicians, regulators, and the public. In 2001, the American Academy of Pain Medicine, American Pain Society, and American Society of Addiction Medicine defined these terms to address misunderstandings about the risk of addiction in people being treated for pain. Physical dependence (characterized by withdrawal syndrome) and tolerance (in which the patient requires higher doses to achieve the same pain relief) are normal responses to pre-

Definitions Related to the Use of Opioids for the Treatment of Pain

The American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine recognize the following definitions and recommend their use.

Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

Physical dependence is a state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

Tolerance is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug’s effects over time.

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scribed narcotics and should not be considered sufficient evidence of addiction, the groups conclude.

The term ‘pseudoaddiction’ is used to describe what appears to be inappropriate drug-seeking behavior in a person with unrelieved pain. Some of these behaviors are considered more aberrant than others. For example, says Dr. Kertesz, “Forging a prescription may be a sign of addiction. Aggressively complaining may or may not be.”

Other behaviors that are less predictive of addiction include drug hoarding during periods of reduced symptoms, unapproved use of

an addictive drug to treat other symptoms, and requesting specific drugs. Concurrent use of related illicit drugs, recurrent prescription losses, and obtaining prescription drugs from non-medical sources are more indicative of substance abuse or addiction.¹⁵ Although impulsive drug use may suggest abuse or addiction, it may also be indicative of a co-occurring psychiatric disorder. With pseudoaddiction, drug-seeking behaviors stop when pain is effectively treated; with true addiction, these behaviors persist despite pain relief.⁵

LOWER PAIN THRESHOLDS The need for increased amounts of narcotics in patients with substance use disorders is another potential obstacle to effective pain management. Heroin users have “depleted their endogenous pain killers,” so they need more pain medication to achieve the same result, Guzman says. They have, in effect, lowered their pain threshold. According to Dr. Bamberger, research indicates that opiate users will pull their hand out of a bucket of extremely cold water before subjects who do not use opiates.

Methamphetamines act as a local anesthetic that renders dental anesthesia less effective, notes Dr. Huckeby. “Because individuals using this drug need more pain medication to begin with, giving them the same dosage or less than you would give a non-user is setting them up for drug abuse,” he says.

The problem, Dr. Kertesz points out, is that “available science doesn’t tell us how much to increase medicine doses, or for how long.” Clinicians must focus on self-reported pain, functional status, adverse effects, and aberrant behaviors that may indicate medication misused or addiction in deciding how to manage pain relief in any particular patient, he adds.

People with substance use disorders fear inadequate pain relief; it is important to reassure them that you’re committed to working with them, says Dr. Kertesz. Ultimately, Guzman concludes, “You have to weigh the risks and benefits and consider what the patient’s quality of life will be without pain medication.”

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