Managing Pain on the Inpatient Psychiatric Unit

Last updated June 2024

Introduction: When you manage pain in inpatient psychiatric settings, you will face unique challenges, including the risk drug interactions, the potential for substance misuse, and the worry that inadequately managed pain will exacerbate psychiatric conditions like depression and anxiety. This guide outlines strategies for managing varying degrees of pain in psychiatric inpatients. Be sure to collaborate with pain specialists, nurses, and physical therapists for the best outcomes.

Identify the Cause of Pain

- Common causes of pain in psychiatric inpatients include recent injuries, infections, chronic conditions like arthritis or gout, neurological disorders, gastrointestinal issues, and headaches. Cancer-related and postoperative pain are also significant concerns.
- Obtain a history of the treatment of the root cause as well as the pain syndrome itself. If there has been no clear treatment, start the process of getting medical consultation and making referrals for outpatient treatment.

Assess Pain Severity

- Use a simple pain scale to assess severity and monitor treatment response, particularly for moderate to severe pain.
    - 1-10 scale: "Can you tell me how bad your pain feels right now on a scale from 1 to 10? With 1 being very little pain, almost none, and 10 being the worst pain you can imagine, like if you hurt yourself really badly. What number would you say your pain is at right now?"
    - Faces scale: Here is a link to the Wong-Baker FACES Pain Rating scale that you can use: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://wongbakerfaces.org/wp-content/uploads/2016/05/FACES_English_Blue_w-instructions.pdf

Non-Pharmacological Interventions

- Cognitive Behavioral Therapy (CBT): Can help modify pain perception and is particularly beneficial for chronic pain.
- Physical Therapy: Customized exercises can alleviate specific types of pain, like back pain.
- Relaxation Techniques: Meditation, deep breathing, and progressive muscle relaxation can reduce stress and pain sensation (*see fact sheet on relaxation techniques*).

Pharmacological Interventions

1. Mild Pain:

- Acetaminophen (Tylenol): Safe with most psychiatric medications. Dose at 325 mg - 650 mg every 4- 6 hrs. Max dose is 4000 mg daily. Monitor for liver toxicity, especially when used with other potentially hepatotoxic medications like valproate.
- Non-Steroidal Anti-Inflammatory Drugs (NSAIDs): Ibuprofen 400-600 mg every 6 hours as needed. Use caution with SSRIs due to an increased risk of gastrointestinal bleeding.

2. Moderate Pain:

- Tramadol: 50-100 mg every 4-6 hours as needed. Watch for serotonin syndrome with SSRIs and SNRIs.
- Codeine: Often combined with acetaminophen. Start with low doses (e.g., codeine 15 mg combined with acetaminophen 300 mg) to minimize the risk of dependence and interactions with CYP2D6-metabolized drugs.
- Gabapentin: Particularly useful for neuropathic pain. Starting doses range from 100-300 mg at bedtime, with gradual titration up to 1800 mg/day divided into three doses. Also has anxiolytic effects.
- Pregabalin (Lyrica): For neuropathic pain and fibromyalgia, start at 75 mg twice a day or 50 mg three times a day, up to a maximum of 600 mg/day. Also works as an anxiolytic.

- SNRIs (e.g., Duloxetine, Venlafaxine): Effective for chronic pain, including neuropathic pain and fibromyalgia. Start with a low dosage and adjust based on pain relief and tolerability. They're particularly useful in patients with comorbid depressive or anxiety disorders along.
- Nortriptyline: Another antidepressant that is effective for neuropathic pain. Start at 10-25 mg at night and increase as needed. Monitor for anticholinergic side effects and potential cardiac effects, especially in older adults.

3. Severe Pain:

- Involve your hospital's pain specialists. Typical recommendations include:
    - Morphine: Begin with low doses, such as 2.5-5 mg every 4 hours as needed, and closely monitor for respiratory depression and potential interactions with benzodiazepines.
    - Oxycodone: Use with caution due to the risk of dependence and overdose. Doses: 5 mg to 15 mg every 4 to 6 hours as needed for pain, with careful monitoring for signs of opioid dependence and respiratory depression.

Additional Medications and Considerations:

- Topical Analgesics: topical NSAIDs (e.g., diclofenac gel) or capsaicin cream, have lower systemic absorption and might be preferable for patients at risk of systemic side effects.
- Muscle Relaxants: In cases of muscle spasms contributing to pain, use muscle relaxants (e.g., cyclobenzaprine 5-10 mg TID) on a short-term basis. Watch for their sedative effects.
- Lidocaine Patches: For neuropathic pain or localized areas of intense pain, lidocaine patches can provide targeted relief with minimal systemic effects.

Special Populations:

- Elderly Patients: Use lower starting doses and increase the dose gradually.
- Patients with Substance Use History: Use non-opioid pain alternatives when possible and remain vigilant for discrepancies between reported pain and observed behavior.