National Commission on Correctional Health Care

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POSITION STATEMENT

Management of Noncancer Chronic Pain

Introduction

The National Commission on Correctional Health Care recognizes the importance of evaluating and managing patients with chronic pain in correctional settings. The management of chronic pain is different from the management of acute pain. Likewise, end-of-life treatment of painful conditions is managed differently than noncancer chronic pain. This position statement addresses noncancer chronic pain in correctional environments.

In 2012, health care providers wrote 259 million prescriptions for opioid pain medication, enough for every adult in the United States to have a bottle of pills (Dowell, Haegerich, & Chou, 2016). According to the U.S. Surgeon General, “every day in America, 41 people die from a prescription opioid overdose” (Murthy, 2016). The opioid epidemic has emerged as one of our nation’s most urgent public health threats. This prescription drug epidemic and concern for patient safety combined with limited evidence regarding long-term benefits of opioids prompted the White House Office of National Drug Control Policy (2011) to call for mandated training of physicians who prescribe opioids. For the same reasons, experts recommend "smarter, more responsible practices," declaring that "long-term opioid therapy carries too many risks to justify use without improvements in health status" (McLellan & Turner, 2010).

Because complaints of chronic pain are common in corrections, corrections clinicians must address the challenges presented. The use of adjunctive medications such as opiates or GABA analogues is particularly troublesome in the correctional environment because a very high percentage of inmates have a history of substance abuse, chemical dependency, and misuse of prescription medications. In-facility diversion and sales of these "desirable" medications are a potential problem. Every time a prescription is written for one of these medications, patient risk must be considered.

On the other hand, the confinement environment provides opportunities to obtain information (e.g., a patient’s physical activities in the housing unit, at recreation, and at work) that can be important when assessing function and when reviewing the efficacy of treatment. In addition, the availability of directly observed therapy may help in mitigating risk.

Therefore, when patient function remains poor and pain is not well controlled, and other options have been exhausted, a therapeutic trial of medication, including opioids, should be considered.

Chronic pain should be addressed in a manner similar to other chronic medical conditions: It should be recognized as a multifactorial, complex entity and evaluated and managed relying on national guidelines adapted for correctional use. Clinicians should not approach the treatment of chronic pain as a decision regarding the use or nonuse of opioids (as in acute pain). Rather, clinicians should consider all aspects of the problem and all available proven modalities.

Clinicians should learn to recognize and interpret chronic pain findings through observation, history taking, physical examination, and reports from others who have an opportunity to observe the patient’s function.

As with any chronic medical problem, treatment plans—including specific quantifiable treatment goals and regularly scheduled follow-up visits—should be established. Treatment goals related to improving or maintaining function are as important as reducing the chronic pain. Depression, substance abuse, and other mental health comorbidities should be evaluated and treated in the overall treatment plan.

Complex chronic care patients are common in the correctional environment. Although consultation should be available with mental health clinicians and pain management specialists—particularly those who may help with palliative procedures—primary care providers must develop the expertise to manage inmates' chronic noncancer pain. For this reason, correctional clinicians should attain, as necessary, additional training in assessment, management, and the science of chronic pain.

Position Statement

1. Chronic pain is a multifactorial, complex clinical entity, requiring an understanding of pain mechanisms, evaluation, and treatment options.

2. Because a fundamental knowledge of the correctional health care environment and their patients is needed, properly trained primary care clinicians are uniquely qualified to treat chronic pain in correctional settings.

3. Medical directors and other responsible health authorities should facilitate and encourage appropriate training covering the requisite skills to make reliable diagnoses, establish appropriate treatment plans, and monitor progress for patients with chronic noncancer pain.

4. Nationally recognized guidelines regarding the care and treatment of chronic pain should be referenced and adapted to the correctional environment.

5. Chronic pain should be addressed like other chronic medical conditions, in a systematic, objective, structured manner beginning with diagnosis and treatment planning and proceeding with structured and regular monitoring of progress.

6. Clinicians should establish measurable treatment goals for chronic pain and measure progress against them. Treatment goals should be discussed with the patient but determined by the clinician. They must be functional in nature, measured against the patient's established baseline, and monitored. The elimination of chronic pain is usually not a realistic goal. Patient expectations must be addressed early.

7. Documentation of clinical encounters to address chronic pain should include the patient's self-reported comments, the clinician's assessment, and the treatment goals, as well as appropriate follow-up as clinically indicated.

8. Most chronic pain can be managed through primary care clinicians. However, an interdisciplinary team approach is often beneficial, and specialty care, including pain management, should be available for patients whose function and chronic pain are not improved with treatment and for patients requiring end-of-life care.

9. Accepted and evidence-based therapeutic options, including nonpharmacologic management, should be available when medically necessary. A multifaceted and biopsychosocial approach is optimal when possible

10. Policies banning opioids should be eschewed. Opiates should be considered with caution after weighing all treatment options.

11. Medication use should be judicious. Benefits and risks for the patient (including abuse) and the facility (potential for diversion) must be considered, recognizing that problems with substance abuse, chemical dependency, and management of prescription medications are common in correctional populations.

12. Continuity of care planning is important, including consideration of resources and reentry into the community. Care coordination should be ensured to avoid interruption in pain treatment.

Adopted by the National Commission on Correctional Health Care Board of Directors
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