

## Management of Chronic Pain

### Position Statement

Patients living with chronic pain in the carceral setting should be treated with dignity and respect and have timely access to objective health care evaluations that are free from stigma or bias based on their race, ethnicity, age, gender, cognitive limitations, or co-occurring conditions such as substance use disorders.

Patients living with chronic pain should be evaluated using up-to-date evidence-based tools that assess objective measures such as the patient's level of function, including their ability to perform institutional activities of daily living.

Treatment plans for patients with chronic pain should be individualized, based on current evidence-based pain management guidelines, and implemented by interdisciplinary correctional health professionals who possess clinical competencies in pain management.

Noninvasive, nonpharmacologic interventions should be considered as first-line treatment for patients with certain chronic pain conditions in accordance with evidence-based guidelines.

Medications should be considered for certain patients with chronic pain while considering the limitations of their long-term efficacy and potential for adverse effects.

Nonopioids are preferred over opioids when medications are used to treat chronic pain.

If prescribed opioids are discontinued in patients with chronic pain, they should be tapered slowly in accordance with pain management guidelines. Patients should be monitored closely for suicidal ideation and mental health crises as opioids are tapered.

Hormonal contraceptive methods are often first-line treatment for certain chronic pelvic pain conditions, and correctional facilities should thus provide full, unrestricted access to these medications.

Correctional health care systems should expand patient access to interdisciplinary health care professionals who can provide an array of noninvasive, nonpharmacologic treatment interventions for chronic pain.

Mental health and substance use disorders associated with chronic pain should be thoroughly assessed and treated as an essential element of the patient's treatment plan. Suicide risk assessments should be conducted as clinically indicated when pain medications are discontinued or adjusted.

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Patients transitioning to the community should have their care coordinated with community providers to avoid disruption in pain management.

## Discussion

The National Commission on Correctional Health Care recognizes the importance of effectively evaluating and treating patients living with chronic pain in the carceral setting.

This position statement addresses the management of chronic pain as distinct from the management of acute pain, pain related to cancer, and pain related to sickle cell disease. Patients with cancer or histories of cancer and those with sickle cell disease should be managed in accordance with evidence-based guidelines that address their unique health care needs<sup>1,2,3</sup>. This position statement also assumes that all incarcerated patients with chronic pain have had a thorough history, physical examination, and clinically indicated diagnostic studies that could identify causes of pain that could be readily alleviated.

Chronic pain significantly affects patient quality of life and is one of the most common reasons for seeking primary care in the outpatient setting. In a 2021 federal survey, 21% of U.S. residents outside of noninstitutionalized settings had chronic pain, defined by experiencing pain on most days or every day in the past 3 months<sup>4</sup>. Although poorly quantified, incarcerated patient populations are similarly, if not more substantively, impacted by chronic pain.

Chronic pain commonly evolves from an acute pain associated with peripheral tissue injury to a more centralized pain that is multifocal in its clinical presentation. Chronic pain is often associated with comorbid symptoms such as fatigue, cognitive dysfunction, anxiety, and depression<sup>5</sup>. Co-occurring behavioral health conditions, such as psychiatric disorders and substance use disorders, and past exposure to physical, sexual, or emotional trauma can further complicate care<sup>6,7,8</sup>. Some patients living with chronic pain can be at increased risk of suicidal ideation and self-harm while receiving treatments and during the rapid tapering of prescribed opioids<sup>9,10,11</sup>. These factors underscore the importance of effectively treating chronic pain in incarcerated patients who have a high prevalence of co-occurring behavioral health disorders and integrating suicide prevention programs into chronic pain management programs.

If prescribed opioids are discontinued in patients with chronic pain, they should be tapered slowly in accordance with pain management guidelines. When patients are taking high doses of opioids (> 50 morphine milligram equivalents) and/or have significant physical or mental comorbidities that would increase their risk from tapering, consultation with a pain management expert should be considered to minimize harm to patients from tapering. Patients should be monitored closely for suicidal ideation and mental health crises as opioids are tapered. Additionally, many patients taking opioid chronic pain medication have unrecognized opioid use disorder. Thus, consideration should be given to evaluation by an addiction medicine expert to determine if the patient would benefit from treatment with medications used for opioid use disorder.

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Patients with chronic pain should receive objective health care evaluations free from stigma or bias. Certain patient populations, such as marginalized racial and ethnic groups, women, older people, and patients with cognitive impairments and substance use disorders may be more susceptible to inadequate pain assessments and treatment<sup>12</sup>. Correctional health professionals must be cognizant of the potential for professional biases in managing patients with chronic pain. Of particular concern is the recognition that physicians may not accurately recognize Black patients' pain or may be reluctant to treat Black patients' pain<sup>13</sup>. Additionally, chronic pelvic pain among females has a prevalence of 27% and is often overlooked and undertreated; it is similarly multifactorial and requires thorough work-up and multimodal treatment<sup>14</sup>.

Correctional clinicians should adopt evidence-based pain assessment tools, such as those that measure the patient's functional status in performing institutional activities of daily living within the correctional environment<sup>15</sup>. If pain intensity is measured, it should be assessed over time rather than on a single clinic visit. This evaluation approach is important therapeutically, since for many patients the treatment goal is not eliminating chronic pain but improving function and decreasing pain over time<sup>5</sup>.

Treatment plans for incarcerated patients with chronic pain should be individualized, based on evidence-based pain management guidelines, and supported, as feasible, by interdisciplinary health care teams<sup>15,16,17,18</sup>. Medications should be considered as a primary treatment intervention for certain patients based on their proven efficacy for certain chronic pain conditions. Medication options for treating chronic pain include, in part, acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), antidepressants, anticonvulsants, and topical analgesics. For females with chronic pelvic pain, hormonal contraceptive methods (including oral contraceptive pills, Depo-Provera, etonogestrel contraceptive implant, and levonorgestrel intrauterine devices) are often first-line treatment and should be made available to people in custody.

Treating clinicians must weigh the benefits of different pain medication options as well as their long-term limitations and potential for adverse effects. For example, NSAIDs have limited efficacy in treating chronic pain and have potential serious adverse effects, including a Food and Drug Administration warning of an increased risk for heart attack or stroke; gabapentin has a limited indication for treating neuropathic pain and has a considerable risk of diversion within the correctional setting; and opioids, including tramadol, have limited long-term efficacy in treating chronic pain while carrying considerable risks of addiction, abuse, and misuse, which can lead to overdose and death<sup>19,20,21</sup>. Federal guidelines for prescribing opioids recommend nonopioids over opioids for the treatment of chronic pain when medications are considered<sup>17,18</sup>. If opioids are considered for treating noncancer pain, the Veterans Affairs and the U.S. Department of Defense clinical practice guideline recommends buprenorphine instead of full agonist opioids<sup>18</sup>.

Noninvasive nonpharmacologic treatments should be considered as first-line treatment for many patients with chronic pain conditions. A wide array of nonpharmacologic interventions can be used to treat chronic pain; among these are restorative therapies such as therapeutic exercise, physiotherapy, osteopathic manipulation,

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and ultrasound; pelvic floor physical therapy for certain pelvic pain conditions; behavioral health approaches such as cognitive behavioral therapy and mindfulness-based stress reduction; complementary approaches such as acupuncture, yoga, and Tai Chi; and multidisciplinary rehabilitation that combines treatment modalities. A systematic review of nonpharmacologic research studies found that exercise, multidisciplinary rehabilitation, acupuncture, cognitive behavioral therapy, mindfulness practices, massage, and mind-body practices most consistently improve function and reduce pain for chronic pain conditions<sup>22</sup>. Similarly, the American College of Physicians clinical practice guideline for chronic low back pain recommends first-line treatments of exercise, multidisciplinary rehabilitation, acupuncture, and mindfulness-based stress reduction and consideration of other nonpharmacologic modalities as second-line treatments<sup>23</sup>.

Providing noninvasive, nonpharmacologic interventions to patients with chronic pain conditions in the correctional setting can be challenging for multiple reasons, including the unavailability of health care professionals who are educated, trained, and credentialed to provide the interventions within the correctional facility or local community; the lack of evidence-based support for treating some conditions with certain modalities; and the lack of understanding of the benefits and risks of nonpharmacologic interventions by some correctional primary care providers. These challenges underscore the importance of staffing interdisciplinary correctional health professionals who possess clinical competencies in pain management<sup>24</sup>.

Certain patients with chronic pain conditions may also be candidates for minimally invasive surgical procedures or image-guided interventional approaches that may include trigger point, peripheral nerve, and joint injections, radiofrequency ablation, and neuromodulation. These interventions should be considered on a case-by-case basis in accordance with evidence-based best practices and consultation with pain management specialists<sup>16</sup>.

Patients with chronic pain conditions should also be assessed and treated for behavioral health conditions that frequently complicate care and affect patient well-being. Medications and behavioral counseling can be highly effective in treating depression and anxiety and reducing pain catastrophizing. Similarly, the effective treatment of substance use disorders and post-traumatic stress disorder can be instrumental in reducing chronic pain symptoms and improving the quality of life for patients.

*October 16, 2011 - adopted by the National Commission on Correctional Health Care Board of Directors*

*April 2018 – reaffirmed with revision*

*August 2023 - reaffirmed with revision by the National Commission on Correctional Health Care Governance Board*

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