MANAGEMENT OF PERSISTENT PAIN IN SECURE ENVIRONMENTS

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Challenges, opportunities, rights and responsibilities

- **Challenges** in diagnosis, management and measurement of meaningful outcomes
- **Opportunities** to monitor progress and response to treatment
- It’s the **right** of every prisoner to have access to evidence based therapies
- Doctors must take **responsibility** for developing their understanding of current best practice in diagnosis and management
Our priorities when working in the secure estate

- Safety of the patient is paramount
- Clinical decision making must take into account propensity for diversion and misuse
- Joint decision making between competent practitioner and the patient with consistently high standards of record keeping
- Analgesic medication plays only a partial role in provision of effective management of long-term symptoms – consider shared management plans
Aims of the document

- Safer Prescribing in Prisons (RCGP 2011) has been well received – but there was an acknowledged need for an overview of best practice in management of persistent pain

- Consensus framework covers prisons, police custody and Immigration Removal Centres

- Aims to empower clinicians working in these settings by supporting evidence based clinical decision making
The Consensus Group

- Co chaired (Cathy Stannard, pain consultant, BPS) and Linda Harris RCGP Substance Misuse and Associated Health Unit

- Membership includes DH, specialist GPs, Pain Consultants, mental health, public health, commissioner, NTA, HMCIP, prison governors, pharmacy leads, academic pain consultants

- Evidence based
Size of the problem

- No current data to identify the prevalence of pain in the secure environment population
- Risk factors
  - High prevalence of mental health and substance misuse disorders
  - Histories of traumatic injury and emotional trauma
  - Anxiety increases experience of pain
  - Opioid detoxification can reveal chronic pain
  - Development of LTCs in the older age group results in more pain
Prescribing challenges and documented inconsistencies

- Accurate prescribing data for analgesics are unavailable for the prison population.
- Unable to distinguish between patients asking for medication because they have pain, and those with addiction/diversion.
- Some institutions have developed a ‘cultural’ problem with analgesic prescribing.
- Inconsistencies when
  - Implementing blanket ‘not in possession’ policies
  - Implementing ‘long acting’ alternatives first line
  - Saying ‘no’ to unsuitable requests
Female estate

- Women experience a number of risk factors, which not only may contribute to pain symptoms but may worsen the experience of pain and act as barriers to effective pain management and recovery
  - Sexual abuse and emotional trauma
  - Parental separation
  - Long term monitoring of responses to medication disrupted by short sentences
  - Women intimidated into sharing and giving away their medication
  - Misuse of certain drugs particularly sedatives is common
Other considerations in specific settings

- High security estate
  - Serious personality disorders are prevalent in male high security prisons and substance misuse disorders less common
  - Long-term medical conditions may have been previously poorly managed.
  - Challenging environment with risk of bullying, manipulation and intimidation for drugs
  - Fear of criticism, complaints and legal claims in relation to prescribing
  - Challenging recruitment and retention leads to prescribing inconsistencies
  - Staff isolated from mainstream clinical education and practice;
Clinical issues in pain management in secure settings

- Pain is a subjective experience
- Diagnosis can only be made by interpretation of the patients’ report
  - Note differences in patient presentations between secure and community settings
  - Acute signs (tachycardia, sweating, facial grimacing) are not reliable or even present in chronic pain
  - Routine investigations and tests may be unhelpful in making a diagnosis
- Ask Community Teams or GP about existing pain conditions and management plans prior to custody
  - Has there been a history of trauma or prolonged tissue damage, what’s the relationship between this and the symptoms
  - Is there a deficiency of function physically/socially emotionally
  - Does the presentation alter day to day
‘Different pains’

- Neuropathic pain
- Chronic Visceral / poorly defined disorders
Neuropathic pain is a consequence of disease or damage to pain conducting pathways. This results in abnormal signalling of pain in the nervous system.

- E.g. diabetic neuropathy, post herpetic neuralgia, phantom limb pain, pain after stroke
- Pain can be continuous or intermittent
- Distribution of pain can make anatomical sense
- A number of screening tools exist for diagnosis of neuropathic pain
- A positive history or a positive screen should be corroborated with physical examination that confirms nerve damage, or physical evidence of abnormal function
Chronic visceral/poorly defined

- Occurs in men and women
- Examples include: chronic pelvic pain, irritable bowel syndrome, painful bladder syndrome and prostatodynia
- There is an association with sexual and physical abuse in childhood and as an adult, but causality is unclear.
- Understanding the complexity of origin of visceral pain and of poorly defined disorders can help in planning realistic interventions.
Role of opioids in the management of persistent pain

- The WHO analgesic ladder has poor applicability in the treatment of neuropathic pain
- Evidence for effectiveness of opioids in management of long term pain is lacking, particularly in relation to important functional outcomes
- Opioid therapy should be used to support other strategies for pain management e.g. physiotherapy
- If useful relief of symptoms is not achieved at doses of 120mg morphine equivalent/day, the drugs should be tapered and stopped
- Both strong and weak opioids should be prescribed with caution
- Consider a trial of therapy starting with a low dose and discontinuing therapy if, after suitable dose adjustment, pain is not relieved and/or improvement in function cannot be demonstrated
Role of opioids in the management of persistent pain (2)

- There is no evidence that any opioid produces superior pain relief to morphine.
- Symptoms should usually be treated with sustained release opioid preparations.
- Fast acting preparations should not be used for the treatment of persistent pain.
- Methadone has an established role in the treatment of long-term pain: patients with a diagnosis of pain receiving methadone opioid substitution therapy can be managed by maintaining an effective daily dose of methadone given in two divided increments.
- Conversion ratios between opioids vary substantially especially when converting to or from methadone. Cautious conversion ratios should be used and the effect reviewed regularly.
Pharmacological management of neuropathic pain

- Neuropathic pain is difficult to treat
- Medications are probably the most effective intervention but fewer than a third of patients respond to any given drug.
- Different classes of drug have distinct and relevant mechanisms of action so if the first drug class tried does not work try an alternative medication.
- Pain reduction with all types of drug used in neuropathic pain is modest - most drugs serve to reduce the intrusiveness of pain rather than providing substantial pain relief.
Pharmacological management of neuropathic pain (2)

- Tricyclic antidepressants (given as a once daily dose) are the most effective first line treatment
- Carbamazepine is also an effective drug
- Gabapentin and pregabalin are also effective in some cases but should not be used first line, and should only be used with caution in a prison setting because of the risk of misuse and diversion. (NB pregabalin should be prescribed as a twice daily dose; gabapentin as a three times daily dose)
- Start low, go slow’ is a good principle for titration.
- If no perceptible benefit after four weeks of titrating to effective dose, the drug should be tapered and stopped
- If all of the above fails consider a trail of opioid therapy
Pharmacological management of chronic visceral pain and poorly defined disorders

- Psychological interventions are the mainstay of management of visceral pain and poorly defined disorders
- Tricyclic antidepressant drugs may play a role in the management of pain associated with irritable bowel syndrome
Non pharmacological management of pain

- Address fears and mistaken beliefs about the cause and implications of pain
- Challenge any ‘myths’ about the illness and its likely progress
- Information and education often needs to be supported by demonstration, e.g. guided by a physiotherapist
- Assess, treat and manage anxiety and depression in accordance with evidenced knowledge and avoid attributing pain to these conditions – rather with the patient how these conditions interrupt recovery and act as barriers to effective pain treatment
Physical rehabilitation

- There is good evidence for active techniques, such as exercise classes, working towards activity goals and general better health.
- Techniques are best combined with cognitive and behavioural interventions to achieve rehabilitation, and need to be individually adjusted to set a realistic baseline and rate of progress.
- Evidence for other non-pharmacological physical interventions is poor e.g. acupuncture and TENS – both of which are commonly used.
Key references


