Pain Management in Secure Settings

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Overview

- Introduction
- Context
- The complexity of pain management in secure environments
- Opioids
- Neuropathic pain
- The acute presentation
- The pain formulary for prisons
- Case studies

Introduction

- Pain in secure environments very hot topic
- Multi agency work to produce guidance
  - BPS
  - RCGP
  - Department of Health
  - HM Inspectorate of Prisons
- RSCH run outreach pain clinic at HMP Send

Introduction

- Outreach pain clinic at HMP Send been running nearly 1 year
- DNAs in hospital clinic led to taking the clinic to the patients
- Multi-disciplinary clinic with liaison with prison GP and healthcare nurse in the clinic
- Patients and staff find the clinic valuable

Context

- It is the right of every person in custody to have access to evidence based pain management that can be safely delivered to them
- Medications are properly a cause for concern
- Medications play a partial role only in pain management

Context

- The prevalence of long term pain in the secure environment population is unknown
- A number of risk factors for chronic pain exist in this population including mental health and substance misuse disorders, physical and emotional trauma
- There may be difficulty in distinguishing patients needing medication for pain and those requesting drugs to continue substance misuse or as a commodity for trade
- The secure environment offers an opportunity for regular assessment of the effect of analgesic medications on pain and function
- Professional isolation and fear of criticism and complaints erode confidence in prescribing decisions

Diagnosis of pain

- Pain is a subjective experience and the diagnosis can only be made by interpretation of the patients' report
- Good communication with the patients' community healthcare providers helps identify pre-existing painful conditions
- Onset of pain can usually be related to an obvious inciting event including trauma or other tissue damage
- Pain is usually associated with an observable (but variable) decrement in physical functioning
- Diagnosis of neuropathic pain can be supported by the history (nerve injury or damage) and by abnormal findings on sensory examination
- Understanding the complexity of origin of visceral pain and of poorly defined disorders can help in planning realistic interventions.

The complexity of pain management in secure environments

- Opioid abuse
- Abuse of other substances
- Diversion of prescribed medication
- Coercion and bullying
- Use of certain medications to cause harm

Opioids

Why are opioids prescribed?

Because….

- they are strong analgesics
- persistent pain is hard to treat so something strong is a tempting idea
- pain sufferers exhibit distress
- distress makes clinicians want to do something
- we know there are risks but think we can handle them

Opioids

- The number of prescriptions for opioids has increased
- The number of prescriptions for opioids in non-cancer pain has increased dramatically

Opioid use is associated with:

- Report of moderate/severe pain
- Poor self-related health
- Unemployment
- Increased use of healthcare system
- Negative influence on QOL

Opioid adverse effects

- No pain relief
- Worsening of pain
- Cognitive impairment/somnolence precluding effective engagement with pain management strategies
- Endocrine and immune effects
- Addiction

Key points: Opioids for persistent 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
- 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

Opioids aware

What is it?

- Evidence-based resource reviewing the harms and benefits of opioids
- Prescribers can use to make an informed clinical decision for an individual patient, influenced of course by the individual's clinical presentation, comorbidities and circumstances
- On-line prescribing resource hosted by FPM
- Extensive links to other sources

What it is NOT

- Guidance
- A manual about how to prescribe opioids safely
- Re-statement of information from other sources

Standards and Commissioning
Events
For Trainees
Membership
Training and Assessment
A Career in Pain Medicine
FFPMRCA Examinations
Workforce
Quality Assurance
Revalidation and CPD
Evidence Base
e-PAIN
Essential Pain Management
ASK2QUESTIONS
Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain
Pain in Secure Environments
Patient Information Leaflets
Guidelines and Publications
Transmitter
Surveys, Useful Links and Innovations
For Patients and Relatives
Contact us

Public Health England

A Public Health England funded project

Good practice in prescribing opioid medicines for pain should reflect fundamental principles in prescribing generally. The decision to prescribe is underpinned by applying best professional practice; understanding the condition, the patient and their context and understanding the clinical use of the drug. This resource, developed by UK healthcare professionals and policymakers, provides the information to support a safe and effective prescribing decision.

1. Opioids are very good analgesics for acute pain and for pain at the end of life but there is little evidence that they are helpful for long term pain.
2. A small proportion of people may obtain good pain relief with opioids in the long-term if the dose can be kept low and especially if their use is intermittent (however it is difficult to identify these people at the point of opioid initiation).
3. The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit.
4. If a patient is using opioids but is still in pain, the opioids are not effective and should be discontinued, even if no other treatment is available.
5. Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential.

Best Professional Practice

Opioids and the law, writing opioid prescriptions, patient safety, reporting harms, record keeping, prescribing

The Condition, The Patient, The Context

Assessment and challenges of long-term pain, the role of medicines, a stepped approach to opioid prescribing

Clinical Use of Opioids

Opioids for different types of pain, their effectiveness and harms, dependence and addiction

A Structured Approach to Opioid Prescribing

Patient assessment, the opioid trial, long-term prescribing, stopping opioids, equivalents, the addicted patient

Information for Patients

Types of pain, thinking about starting opioid medication and frequently asked questions about taking opioids

About the Resource

- Purpose
- Who will use this resource?
- How to use this resource?
- Trends in opioid prescribing
- Professional, regulatory and public concerns

Contents

Quick Links

- Pain assessment
- The opioid trial
- Dose equivalence
- Oxford Analgesic League Table

What's New?

- Opioids and driving

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Best Professional Practice

0

Good Practice in Prescribing

Advice on good practice when prescribing opioids

Opioids and the Law

Legislation surrounding controlled drugs, the role of CDAO and information on the new drug driving legilsation

Writing Opioid Prescriptions

Best practice and legal requirements of writing opioid prescriptions

Record Keeping

Guidance on clear and accurate record keeping

Improving Patient Safety and Minimising Harms

Improving patient safety and reporting and learning from medicine incidents

Reporting Adverse Effects

Information on Yellow Card Reporting

Non-Medical Prescribing

Guidance on supplementary and independent prescribing

The Role of Pharmacists

The role of pharmacists in supporting safe opioid prescribing

Opioid substitution therapy

- Methadone
- Buprenorphine
- Suboxone

  - 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

Neuropathic pain: pharmacotherapy

- Medications are the best way to treat neuropathic pain but fewer than a third of patients will respond to a given drug
- Pain relief from neuropathic pain medications is modest
- Tricyclic antidepressants are the most effective treatment of neuropathic pain
- Carbamazepine may be effective in the management of neuropathic pain
- Gabapentin and pregabalin are unsuitable as first-line drugs for use in secure environments

Non-pharmacological management of pain

- It is important to address fears and mistaken beliefs about the causes and consequences of pain
- Co-morbid depression and other psychological disorders should be treated as part of pain management

- There is good evidence for active physical techniques in the management of pain
- Physical rehabilitation is best combined with cognitive and behavioural interventions
- Interventions such as TENS and acupuncture are poorly supported by evidence for benefit but may support self-management of pain

The acute presentation

- Multi-modal analgesia
- Take into account baseline opioid use
- Methadone can be split into two divided doses
- Buprenorphine dose can also be split
- Don't worry too much about the partial agonist effect of buprenorphine
- Gabapentinoids are highly tradable and should be avoided

Pain formulary for prisons

- NHS England document

NHS England

Pain Management Formulary for Prisons:

The Formulary

for acute, persistent and neuropathic pain

Dosage Equivalences

The current BNF has been used for all doses and dosage equivalences within the formulary. All dosage equivalences are determined in relation to the available products and available strengths.

Formulary Key

1st line formulary choice	✓	Lowest risk of harm and misuse in prison
2nd line formulary choice	2	Also low risk use in prison, use when 1st line treatment is inappropriate or unsuccessful
3rd/4th line formulary choice	!	Only consider when other choices are inappropriate or unsuccessful, prescribe with caution
Limited use only	L	When all other options have failed, only use in the client group defined in the formulary
Avoid use and review patients	X	Considered inappropriate due to clinical or safety reasons

Abbreviations

C = capsule	MR = modified release	SR = sustained release
L = liquid	S = suspension	T = tablet

Overview Information

At first presentation, a sequential approach of simple analgesia and opioids for persistent pain is suggested.

On first presentation of acute pain analgesia should be prescribed in a stepwise manner. Full dose paracetamol should be prescribed and supplemented with non-steroidal drugs (NSAIDs) unless contraindicated.

Pain in secure environments

Challenges

- Limited resources accessible for pain management
- Substance abuse
- Drug seeking behaviour
- Safety

Opportunities

- Corroborative information from staff
- Ability to redress the balance of pain management
- Real time information about efficacy of treatments

Case studies

D

- Prostitute
- Recurrent nose fracture reset herself
- Neuropathic pain side of nose
- Opioid misuse
- Successfully completed methadone reduction program
- Amitriptyline ineffective
- Not sleeping
- Allodynia

D

- Asked for pregabalin as was using on the outside
- Doesn't want codeine or any other opioid

- Warning bells!

D

- Suggested:
  - Duloxetine
  - EMLA
  - 2% menthol cream

D follow up

- Looked terrible
- Sleep much worse
- Previous suggestions ineffective
- Buying pregabalin on wing when could afford it
- Recommended pregabalin trial to GP
- Caveat of attending gym and weekly yoga session
- Concerns flagged to GP

D outcome

- Found to be concealing and pregabalin withdrawn

J

- Large lady
- OA hip
- Deemed too young for replacement
- Already on fentanyl 100mcg/hr patch
- Still has pain
- Working outside the gate in preparation for release

J

- As unsure if patch working we agreed to reduce it to 87mcg/hr keeping a diary to see affect
- Attend gym and try exercice
- Book for hip injection

J follow up

- Not had injection yet
- Pain much worse
- Also some degree of withdrawal (patient definitely using patch)
- No evidence of diversion
- Difficulty attending work

J

- Fentanyl increased
- Attendance at work vital
- Expedite hip injection and try again