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The pains of imprisonment: challenging aspects of pain management in correctional settings



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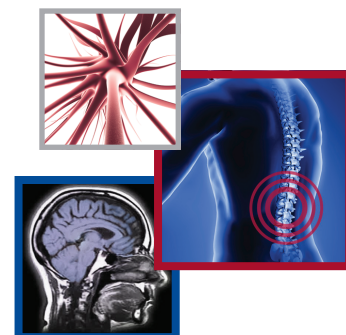
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While pain is the most common reason for seeking medical care [1,2], management of pain is among the most complex treatments that healthcare professionals have to deliver. Treating chronic pain in any setting can be experienced as frustrating or difficult for primary care providers [2]. Successful management of pain becomes even more complex and challenging in the setting of concomitant social or behavioral stressors, such as addiction disorders [3], mental health conditions [4] or a history of drug diversion to generate income [2]. In such cases, little research and few clinical algorithms exist to guide a rational approach to the clinical management of pain.

The complexity of providing pain management is particularly pronounced for healthcare professionals who treat patients in correctional settings (jails and prisons). The ethical provision of correctional healthcare is governed by the principle of equivalence, which mandates that the type

and quality of healthcare delivered to prisoners should be at least equivalent to that received by community members in the prisoner's given jurisdiction or country [5–7]. However, correctional clinicians' adherence to the principle of equivalence is not always straightforward. Instead, many experience conflicts of interest (dual loyalty) as they find themselves practicing medicine in an institution where optimal healthcare delivery is at times overruled by security concerns [8]. Moreover, correctional healthcare professionals are often confronted with a population of patients that is categorically different than the outside community in terms of age, health conditions and a high prevalence of behavioral health stressors.

While the correctional setting is unique and the medical needs of prisoners are often complex, research on optimizing pain management for prisoners is scarce. Few studies have investigated pain management among prisoners and those that have are often very



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- vulnerable patients

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specific, focusing only on certain types of pain (such as cancer pain) [9], a certain stage of illness or type of treatment (such as palliative care) [10] and/or specific demographic populations (such as older adults) [11]. While a focus on palliative care and pain management for older adults is understandable, given the rising numbers of older prisoners [11] and increasing numbers of prisoners dying while incarcerated due to longer sentences [10], few if any studies have comprehensively assessed the epidemiology of pain or approaches to pain management among a diverse population of prisoners. Rarely have studies compared differences in pain and pain management between prisoners and the community [9].

With a growing population of prisoners worldwide [12], a better understanding of prisoner health in general, and the development of an evidence-based approach to pain management among prisoners in particular, is of critical importance. As a first step, we introduce some of the institutional and patient level characteristics that may have a unique impact on the approach to pain management in correctional settings, and we identify areas where clinical interventions and epidemiologic research could make a significant impact on developing an evidence-based approach to pain management for patients in correctional settings.

Institution-level characteristics that can affect pain control in correctional settings

- **Restrictions on the ability to acquire ‘over-the-counter’ pain medication**

In the community, self-medication with ‘over-the-counter’ medications for chronic moderate to severe pain is common [13]. In many correctional facilities, patients rely exclusively on physicians or other healthcare professionals to prescribe pain medications – even those that would typically be available over the counter in the community [14]. However, while over-the-counter medications are often unavailable, prisoners living in jurisdictions where overcrowding is the norm may have restricted access to healthcare services. This, sometimes combined with mandatory visit copays, can further act as a deterrent for patients to attain the help they need to manage their pain.

- **Prisoners do not have the opportunity to choose their physician**

The vast majority of prisoners rely on the healthcare personnel that are present in their correctional

institution. The absence of physician choice may be especially difficult for the many foreign nationals who are incarcerated worldwide given the adverse impact of language barriers on communication [15]. In addition, cultural differences themselves might affect optimal pain management since studies have underscored the importance of ethnic influences on the perception of pain [16].

- **Prisoners are rarely afforded nonmedication alternatives to pain management**

Clear evidence supports the efficacy of non-pharmaceutical or ‘alternative’ approaches to the management of pain, such as transepidermal neurostimulation, cognitive–behavioral therapy, hypnosis, relaxation therapy and acupuncture [15], especially for chronic and severe pain. However, these treatments are oftentimes not available in correctional settings. The lack of availability may be, in part, because access to specialized services that require transport to the outside is restricted. As a result, correctional clinicians are left with few options beyond pharmaceutical approaches to pain management.

- **The correctional administration often has a role in system-level healthcare decisions**

In correctional healthcare settings, healthcare services are seldom completely independent from the ‘command and control’ portion of the institution even though the importance of such a separation has been stressed repeatedly [5,7–8]. This blurring of the lines between punishment and medical care can have an impact on pain management for prisoners [9]. For example, some correctional settings have severely restricted the availability of opioids even for patients with severe pain [10]. Additionally, in some instances prisoners can receive pain medications only at certain hours of the day (which may not coincide with when they are having pain). In other facilities, medications are dispensed by security officers rather than by medical personnel, which may have an adverse impact on physician–patient confidentiality by exposing the prisoners’ private medical information.

Patient-level characteristics that can affect pain control in correctional settings

- **A high prevalence of poor health, mental health disorders & behavioral health risk factors**

Rates of both physical and mental health morbidity among prisoners generally exceed those

“...the complexities of addressing pain management in correctional settings reflect the complexities of practicing medicine in a correctional setting in general.”

found in noncorrectional populations [17,18]. For example, infectious diseases such as tuberculosis, HIV or hepatitis C are more prevalent among prisoners, and prisoners disproportionately experience both mental health disorders and other social stressors such as a history of homelessness or trauma [5]. Rates of substance use disorders are also high among prisoners [5,17]. All of these conditions are associated with a higher prevalence of pain [3–4,11].

In addition, these prevalent health characteristics can also affect optimal pain management. Serious mental health disorders can render pain assessment more difficult [15]. Persons with substance use disorders, especially those with opiate addiction, are at higher risk of undertreatment, often because physicians fear their patients will misuse or abuse prescribed medications [3]. As it is in the community, this can be a significant concern in correctional settings as pain medication is an exchange value to be consumed recreationally [2], and medication hoarding and trafficking is at times revealed during security personnel searches. It is possible that the hoarding of pain medication is even more pronounced in correctional settings since it is sometimes triggered by a fear of untreated pain or to reclaim autonomy in an environment where it is severely limited [14]. In any case, it always represents a potential threat to prison healthcare professionals and the prison administration as they fear patients will use it to harm themselves [14,15].

Where do we go from here? Future steps for adequate pain management in prison

Many health professionals working in jails and prisons have to face these unique pain assessment and management challenges with little or no training or guidance. This makes it increasingly difficult for them to adhere to the fundamental principles governing the ethical delivery of correctional healthcare, including of equivalence, confidentiality and independence (freedom from dual loyalty) [7]. The following first steps could be taken to develop an evidence-based approach to pain management in correctional settings.

• Training & support of correctional healthcare professionals

The training of correctional clinicians should be adapted to the environment in which they practice. For example, since the experience of pain in any setting (including in correctional settings) is often multidimensional and complex,

the assessment of the symptomatology should include assessing non-pain symptoms (nausea, shortness of breath or insomnia); psychosocial symptoms (anxiety and depression); social suffering (loneliness) and existential or spiritual suffering. Such symptoms are likely to be quite pronounced in the correctional setting. Social suffering, such as loneliness can come from social isolation, which is widespread as relationships in prison are usually experienced as distrustful, also because of fear of violence and ties to the outside are limited and often even lost completely. Additionally, the environment of deprivation in correctional settings can magnify fears and other emotions that can enhance the experience of pain [14].

• Strengthening the doctor–patient relationship

The doctor–patient relationship is of critical importance in successful pain management [2,9,19]. Indeed, a strong doctor–patient relationship can serve to explain the paradox of patient satisfaction in the setting of inadequate pain management [19]. For the treatment of chronic pain, Matthias *et al.* suggest adopting patient-centered care so as to improve communication and to enhance empathy [2]. This is because a lack of trust between patients and providers is a profound barrier to chronic pain management. Similarly, Lin *et al.* found that limitations in trust were major obstacles to the treatment of cancer pain in prison and influence the prescribing behavior of primary care physicians [9]. In their study, the importance of doctor–patient trust exceeded its importance when compared with the community. Because trust in the doctor–patient relationship is rooted in adhering to the norms of medical ethics, it is critical that correctional health professionals are supported to overcome the unique barriers to the ethical practice of medicine in correctional settings [7,20].

• The need for research to develop evidence based best-practice guidelines for pain management

Clinical guidelines or pain management algorithms for the correctional setting should include guidance for dealing with difficult situations such as hoarding and trafficking medication, patient distrust of clinicians and evidence-based approaches to managing pain in patients with concomitant social or behavioral health stressors.

“...training, with a focus on attending to trust in the doctor–patient relationship, combined with additional research focused on the development of evidence-based pain management algorithms are important first steps in developing a rational approach to the assessment and treatment of pain in correctional settings.”

Overall, the complexities of addressing pain management in correctional settings reflect the complexities of practicing medicine in a correctional setting in general. As healthcare delivery sites, prisons and jails are unique – clinicians practice in surroundings where healthcare is not always the paramount concern, while serving a population of patients who exhibit a very high prevalence of physical, mental and behavioral health risk factors. Solutions for optimizing correctional healthcare in general are rooted in fully guaranteeing the independence of healthcare practitioners from security portion of the correctional setting (e.g., allowing clinicians rather than wardens determine the availability of opioids in an institution). Additionally, medical professional societies dedicated to enhancing training for correctional healthcare professionals, such as the Society for Correctional Physicians, are of paramount importance. In recent years, medical fellowships have been designed to

provide postresidency training in the ethical and effective delivery of correctional healthcare to clinicians aspiring to practice in correctional settings. Such training, with a focus on attending to trust in the doctor–patient relationship, combined with additional research focused on the development of evidence-based pain management algorithms are important first steps in developing a rational approach to the assessment and treatment of pain in correctional settings.

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