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Managing pain in prison: staff perspectives

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Abstract

Purpose – *The purpose of this paper is to present the findings of one part of a larger study, funded by the National Institute for Health Research, which explored the management of pain in adult male prisoners in one large category B prison in England. In this paper, the authors focus on the attitudes and perceptions of prison staff towards pain management in prison.*

Design/methodology/approach – *A qualitative design was utilised to explore the staff perceptions of pain and pain management in one adult male prison. Questionnaires were provided for all staff with prisoner contact, and a follow up focus group was undertaken to further explore questionnaire data.*

Findings – *The questionnaire and focus group findings demonstrated that staff had a good awareness of pain and pain management in prison, with both physical and emotional pain identified. The frequency of approaches by prisoners to staff for pain relief was noted to be high, whilst awareness of how the prison environment could potentially exacerbate pain was discussed. The acquisition of analgesia by prisoners for secondary gain was identified as a challenge to both assessing levels of pain and providing pain relief in prison, illustrating the complexity of providing care within a custodial culture. The effect on staff of caring for prisoners found to be confrontational and deceitful was significant for participants, with feelings of anger and frustration reported.*

Research limitations/implications – *This study was undertaken in one adult male category B prison with a very high turnover of prisoners. Staff working in other types of prison, for example, higher security or those more stable with longer sentenced prisoners could provide alternative views, as may staff caring for younger offenders and women. The challenges to undertaking research in prison with staff who can understandably be reluctant to engage in reflection on their practice cannot be underestimated and impact significantly on available methodologies.*

Originality/value – *This qualitative research is the first of its kind to offer the perspectives of both health care professionals and prison staff working with prisoners complaining of pain in an English prison. It provides the groundwork for further research and development.*

Keywords Correctional health care, Prison staff, Analgesia

Paper type Research paper

Background

There are currently over 83,000 prisoners in custody (Ministry of Justice, 2013). Provision of health care services for those in custody has been commissioned by the National Health Service (NHS) since 2004. Prisons are associated with ill health (Smith, 2000; de Viggiani, 2007; Watson *et al.*, 2004), with the levels of health care need amongst prisoners being high for both physical and mental health care (Ginn, 2012; Jordan, 2011). There is evidence to suggest that prisoners suffer with disproportionate levels of physical and psychiatric disorders compared to the general population (Rennie *et al.*, 2009). It is argued that the prisoner community is entitled to the same level of care as is provided by the NHS including pain management services, despite the increased level of need and the context of custodial care (Her Majesty's Inspectorate of Prisons, 1996).

Commissioning and providing health care services in prison has proved challenging as the competing philosophies of caring and custody can collide in delivery of care (Walsh, 2009a; McDermot and Solokov, 2009; Smit and Kleinhans, 2010; Jordan, 2010). The impact of the

challenge to balance the requirements of prison security and prisoner health need on health care professionals and the therapeutic alliance is significant and tests professional resilience (Walsh, 2009b; Walsh and Freshwater, 2009).

The Department of Health (2009) aims to improve the health and wellbeing of offenders through key objectives which include working in partnership with criminal justice agencies and enhancing pathways to care. Of importance here is recognition that all staff working with prisoners have a role in care, including prison officers (Walsh, 2009b).

Physical pain in prison manifests itself in two ways, as both persistent (chronic) pain and as acute pain. Chronic pain is defined by Allcock *et al.* (2007, p. 249) as “a pain that lasts beyond the usual course of acute disease or expected time of healing and may continue indefinitely”. Acute pain is understood to be pain that begins suddenly as a result of surgery, injury, childbirth and acute illness (Quinlan, 2011), and which is resolved once the cause is alleviated. The service provision for people living with chronic pain is variable across the UK, with over a third of patients reporting inadequate control of their pain. NHS policy documents have consistently highlighted that paying attention to pain is essential to achieving good patient experiences (Department of Health, 2012; National Institute for Health and Clinical Excellence, 2012; National Clinical Guideline Centre, 2012).

The current pain research literature located within the prison/offender context focuses primarily on the management of cancer pain (Lin and Matthew, 2005) and where literature is available regarding prescribing practices in prison it has a focus on the appropriateness of medication prescribing for older prisoners (Williams *et al.*, 2010). Other prisoner health research reports frequency of prescribed analgesia in prison in Switzerland (Elger *et al.*, 2004) and Norway (Kjelsberg and Hartvig, 2005).

According to the Prison Reform Trust (2012) citing the UK Drug Policy Commission (2008), between a third and a half of all new receptions into prison in England and Wales are estimated to be offenders with drug-related problems. Many prisoners are abusers of opioids, rendering analgesic prescribing in this population challenging. In addition, diversion of opioids by the prisoner is a significant problem, driven by illicit abuse and use as currency (British Pain Society, 2010). Consequently, doctors may be placed under significant pressure to prescribe opioids with the risk of inappropriate over-prescribing. Opioids are one of the main pharmacological interventions for acute and chronic pain (World Health Organisation, 2011; National Institute for Health and Clinical Excellence, 2008, 2010); however, their use is often restricted in prisons, Worcestershire Primary Care Trust (2009). Recent guidance from Public Health England (2013) notes the complexities of supporting patients with chronic persistent pain in secure settings in terms of assessment, diagnosis, management and measuring meaningful outcomes.

This paper reports the findings of part of a study funded by the National Institute for Health Research (NIHR), which explored the management of pain in adult male prisoners in one large adult male prison in England. This study was a three-phase study, with the first part being the development of a systematic map to highlight specific areas and foci of the literature regarding pain management in prison. The second phase of the study explored current practices and staff attitudes towards, and a large-scale statistical analysis of analgesic prescribing practices. The third part explored prisoner perceptions and attitudes towards pain management in prison. For the purposes of this paper, we report only the findings of our exploration of the staff perspectives pertaining to pain management in prison, which was undertaken in part 2 of the larger study.

The aim of the part of the study reported here was to investigate the attitudes of both health care and prison discipline officer staff towards prisoners seeking pain relief and their current pain management practices. “Staff” in this context refers to all those who have contact with prisoners, including prison officers and health care professionals. Whilst this paper provides insight into the attitudes and perceptions of staff working in one adult male prison, it contributes to the growing body of knowledge underpinning the development of practice in prison.

Method

Given the research questions, the current paucity of literature regarding staff perception of pain management in prison, and the need to explore a previously under researched area of health care, a qualitative approach was utilised. A staff questionnaire was constructed by the project team that was informed by earlier stages of the project, and distributed to all staff at the prison via residential wing managers. Further copies of the questionnaire were accessible to staff in communal staff areas. Following collation and analysis of the questionnaire, a staff focus group was held in order to further explore areas raised in the questionnaire.

Participants

The questionnaire was distributed across the prison for all staff with direct prisoner contact to complete and return if they chose to do so. Approximately 450 questionnaires were placed strategically around the prison to enable access to all staff that would be eligible. In total, only 23 questionnaires were returned out of an estimated staff group of 200. Returned questionnaires included ten health care staff, nine prison officers, one probation officer, one charity worker, the deputy governor and one manager. The average length of service in this prison was seven years and eight months.

The final page of the questionnaire was designed as a form for participants to complete if they were interested in being part of a staff focus group. This page was detached from the questionnaire and posted directly to the research team.

In total, ten completed forms were received from staff indicating interest in joining the focus group. In total, four of those originally expressing interest in the focus group attended. These included a probation officer, prison officer, physiotherapist and general practitioner. In addition to these four staff members, the clinical director for the prison also attended as whilst he did not express interest via the questionnaire, did verbally request involvement. This meant that the focus group comprised five staff members in total. This breadth of professional expertise with regards to working with prisoners was valuable as we noted a continuum of involvement with prisoners from the prison officer working directly with prisoners 24 hours a day to the health care professionals and probation officer whose interactions with prisoners, whilst frequent, are not of the same intensity and duration as the discipline staff. In addition, this range of professionals provided perspectives on health care from all angles. For example, the probation officer considered health care and discipline issues through a probationary lens whereas the discipline officer considered practice through a security lens. This variation in perspectives when combined in conversation and reflection on practice provided a useful combination.

Data collection

Data were collected through a staff questionnaire and a focus group. The staff questionnaire was constructed by the project team and informed by information collected from earlier phases in the wider study that related to the prisoner experience of pain management and relevant literature. It comprised 12 questions that provided demographic information, quantitative data and qualitative data. The questions used were:

1. What is your role in the prison?
2. How long have you worked at HM Prison?
3. What sort of pain do you see prisoners suffering with?
4. How many times would you estimate per week that you have prisoners complaining to you that they are in pain?
5. Do you think the prison environment can cause pain?
6. How do you think pain is treated in prison?
7. How do you think pain should be treated in prison?
8. Have you ever heard about or witnessed prisoners trading pain medication?

9. Do you think prisoners ever access health care services to obtain pain medication that they do not need?
10. Do you think you use your intuition when deciding if a prisoner complaining of pain is genuine?
11. Have you ever had any training in how to deal with prisoners who are in pain?
 - If you answered no to question 11, would you like any training in how to deal with prisoners who are in pain?
12. Do you think prisoners should be able to buy paracetamol and ibuprofen through the canteen?

Following completion of the questionnaire, [...] discussion in the subsequent staff focus group was centred around eight key questions which explored staff perceptions of the nature of pain in prison, thoughts about prisoners complaining of pain, the treatment of pain in this prison, differences and similarities between prison and the community/different types of prison and the community, thought about responsibility for pain management and use of intuition in dealing with prisoners complaining of pain.

Data analysis

Data obtained from the questionnaire were analysed using qualitative thematic analysis and statistics derived from measuring averages. This was undertaken by one researcher. Findings were discussed amongst members of the project team who had reviewed the questionnaires to ascertain the extent to which findings represented the views of participants. The findings from the questionnaire then informed the direction of the focus group.

Qualitative data obtained from the focus group were analysed separately using a qualitative conventional content analysis approach (Hsieh and Shannon, 2005). Open coding was utilised, to identify meaning units/codes. These are words and short phrases containing particular aspects that were felt to be significant, which were then related to each other through their content and context. Codes were grouped into sub-categories, categories and finally themes to demonstrate staff perceptions of pain management in prison. One researcher analysed the focus group material then presented it to project team members who were present in the focus group for scrutiny and agreement.

Ethical approval

This study was funded by the NIHR Programme Grants for Applied Research Programme. Ethical approval for the study was provided by the Research Ethics Committee for Wales, which is one of four who deal with applications for prison research in England and Wales. Governance approvals were obtained from the National Offender Management Service and local NHS Trust research and development office. The final approval to conduct this study was provided by the Governing Governor of the prison in which the study took place.

Findings

In order to provide clarity for the reader, the findings from the questionnaire and focus group are presented separately, however, the implications of the findings are drawn together in the discussion.

Questionnaire findings

It is estimated that there were approximately 200 staff with prisoner contact working in the prison. Whilst only 23 people returned the questionnaire, a wide range of staff completed it ranging from governor grades to prison officers and charity workers. The average length of service in the prison was recorded as seven years and eight months. Four key themes were identified during the thematic and statistical analysis of the questionnaires: awareness, causes, treatment and secondary gain.

Awareness. Respondents demonstrated an awareness of prisoner pain, with some staff stating that managing pain in prisoners took a significant amount of their workload. One general

practitioner estimated that complaints of pain took around a third of their workload. Reports of pain to health care staff outweighed reports to non-health care staff. However, almost all respondents noted that they tend to be approached by prisoners complaining of pain almost daily with one staff member stating that the complaint could often be from the same prisoner several times over the course of the week. Staffs were asked what type of pain prisoners were complaining of. Some respondents included a list in their response, whereas others named one or two types of pain. Figure 1 illustrates the various kinds of pain reported to non-health care staff by prisoners. It is not intended to provide any indication of prevalence, nor is acute or chronic pain distinguished by prison staff. Rather it is an indication of the perception of prisoner pain as reported by prison officers.

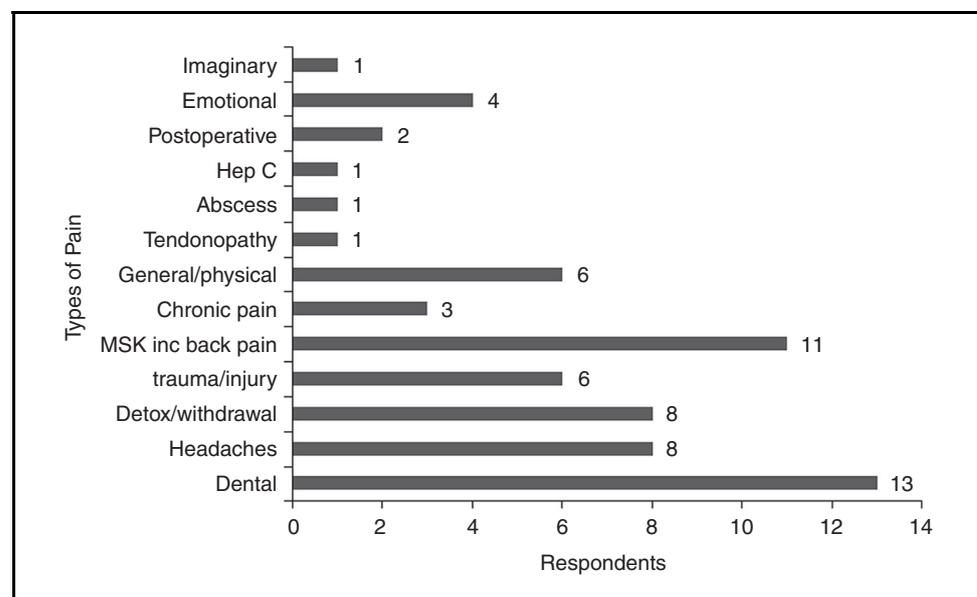
Causes. Staffs were asked if they thought prison could cause pain, or indeed exacerbate it. Respondents felt that whilst prison may not cause pain, the social and affective nature and reality of imprisonment could aggravate existing conditions. Many issues were thought by respondents to impact on pain in prison. These included depression, having excessive time to reflect, having restricted access to illegal drugs leading to withdrawal, lack of natural light and hard beds/pillows/mattresses. One respondent felt that the prison environment did cause pain as prisoners are thought to do limited exercise. They felt that “through lack of exercise, joints and muscles get stiff and painful” (R7).

Treatment. Respondents thought that the most common treatment for pain in this prison was medication. One respondent felt that the prisoner’s expectations of pain management are different to those outside prison which leads to particular demands for treatment, usually medication. With respect to the treatment of pain, one respondent felt that “part of the problem is lots of men in here have never had to manage pain without illegal meds. They have no idea what ‘normal’ pain is and so find it hard to cope. You don’t want to say ‘man up’ but many of them need to know that what they are feeling is a normal amount of pain and they have to get on with it like people in the community do quite happily” (R10).

Despite availability of physiotherapy in this prison, hopes were expressed by many respondents for other approaches to pain management including physiotherapy, cognitive behavioural therapy, acupuncture, TENS machine and psychological support. One respondent wrote “more physical/self-help approach I believe would be more suitable” (R7).

Although respondents felt that overall, pain is quite well managed in this prison, there were issues highlighted by staff that impacted on the treatment of pain. These included concern that

Figure 1 Types of pain



analgesia was being sought to meet addiction issues, concerns about prescribing due to drugs being traded in the prison, prisoners being bullied for their medication and the manipulation of staff to access analgesia. One respondent felt that prisoner patients might not trust staff to understand and believe their complaint of pain, thus leading to prisoners exaggerating their symptoms.

Secondary gain. In total, 21 of the 23 respondents reported that they had witnessed or heard about prisoners trading medications. This was through placing prisoners on report or being involved in adjudication hearings for offenders being placed on report. All 23 respondents felt that prisoners access health care services to obtain pain medication that they do not need, with opiate drugs being the most popular for trading.

Reasons other than trading medication were proposed by staff, to account for prisoners seeking analgesia inappropriately. These included the use of non-opioid analgesia used to bulk out illicit drugs and to sell on. One respondent wrote "it's very easy for prisoners to 'blag' pain relief. They even crush up pain killers and sell them as illicit drugs" (R13).

Other respondents suggested prisoners sought analgesia for secondary gain due to general habitual drug seeking behaviour, the need to pay off debt, wanting to hoard in order to overdose and commit suicide or to gain access to an outside hospital to make good an escape from custody. One respondent noted that they had heard of prisoners storing analgesia for use at a later date and qualified it with "I do however feel that all staff should imagine having a headache and no paracetamol whilst locked in a cell. I would store up medication and self-treat" (R14).

Focus group findings

The overall aim of the staff only focus group was to explore staff perceptions of prisoners reporting pain. Qualitative analysis of the focus group recording and reflective notes made by the facilitator and researchers highlighted three distinct themes concerning staff perceptions of prisoners reporting pain: prisoner characteristics, presentation and treatment.

Prisoner patient characteristics. Health care professional participants reported that in their experience, prisoners are generally unwell and/or unfit when they enter prison, and continued to suggest that prison exacerbated poor health and fitness through allowing physical de-conditioning. This was attributed to the weakening of postural muscles through lack of exercise, drug taking and generally getting run down. When asked to clarify what was meant by de-conditioning, one participant stated:

It generally means generally unfit, people who have avoided moving, avoided normal activity 1 [...] generally being weak and they have generally done lots of drugs so it makes you unfit and not very happy (P4).

Group members discussed their experiences of the way in which consultations for pain management could often become aggressive, with the prisoner patient using their complaint of pain as a way of exerting power over the health care professional:

There are lots of consultations where you can predict completely how it's going to go e.g. "I've tried that, that doesn't work" so you come up with another drug, "I had that years ago and that didn't work". You are quite sceptical about whether that's the reality or not. So there's a certain empowerment they have by throwing out all this negativity and sort of throwing something in your face and it's like a competition then isn't it? It feels combative really quite often (P3).

Group members reported that when prisoner patients are denied the medication that they want and feel they need, they can become quite aggressive and intimidating:

[...] if they feel that they won't get what they want they will be quite happy to keep you there all day, and that's powerful. They'll spin out the consultation. That is power. That is kicking at the system. There are some, would say the minority but it's very overt. Not all but some of it is "I want this drug because it does have a euphoric effect and I can sell it, therefore I get financial results [...] its tradable", now if you're not going to get that, the last resort is to verbally abuse you or threaten legal action against you (P6).

Further discussion centred on the way in which some staff perceived prisoners to have an attitude of entitlement to treatment and the perspective of being a victim:

[...] there is a strong sense of victim, a strong sense of entitlement, you know, if you come in and say "look, the police have beaten me up, look at my arm, dog bite, therefore I should have" (P6).

Overall, there was a feeling in the group that patients in a prison context are constructed by practitioners as demanding, impatient, entitled and combative.

Presentation. The general practitioner in the focus group expressed their shock at the scale and prevalence of chronic pain in prison when compared to their experience in the community. In discussing prisoner patient characteristics and constructions, participants spent time reflecting on their experiences of dealing with prisoners complaining of pain. Pain was viewed by the focus group as multi-faceted, with both physical and mental pain noted. The complexity of emotional pain was clearly identified by one group member:

At lot of them have had incredible emotional and physical traumas and its easier for them to articulate in their own way, maybe not in a very lucid or therapeutic way, but to demonstrate how they have been wronged themselves and blame others for their predicament rather than internalise it to their own behaviour. Again it will come through as I'm in raging pain, but often it will be an internal pain which is somehow transferring to a physical form (P7).

It was felt that there are often inconsistencies in the way in which pain is presented to the professional vs the behaviour of the prisoner when away from the consultation:

[...] there is patently a lot of manipulative behaviour that they come limping in and when they have extracted out of you what they want they go hopping, you know, running down the corridor out of the room and they've clearly scored a goal (P3).

This led to consideration of the way in which the complaint of pain for secondary gain is commonplace in prison. There are secondary gains to be had in terms of compensation for injury (often related to arrest, e.g. police dog bites), applications for disability living allowance once released from prison, sympathy from a parole board and improved access to prison facilities and resources such as the gym:

[...] there's a lot of those trauma type injuries that people get that they'll live with that pain all the time there is potential for compensation (P7).

The presentation of pain for secondary gain was felt to be a challenge for prison staff in terms of ascertaining genuine suffering and therefore appropriate treatment. Feelings of anger and frustration were reported on the part of staff with potential consequences on their ability to provide impartial care, thus leading to further frustration.

Treatment. The discussion concerning how best to treat and manage pain in adult male prisoners provided different ideas about alternatives to pharmaceutical interventions. There was discussion about healthy people in general being reluctant to take medication which was linked to the perception that prisoners tend to be unhealthy and enthusiastic to turn to medication, as opposed to other therapies, such as "talking therapies":

I think there's also this thing about the magic bullet, you know, quite often they don't want to go through talking therapies, you know, they will say just give me something to take away the pain (P7).

This was felt to be for a number of reasons including the perception that medication is a very passive approach to managing pain and requires very little action on the part of the patient. Active approaches to pain management were felt to include talking therapies and physiotherapy, which require some engagement by the patient and which were often resisted in prison. The physiotherapist in the group talked about the value of a "hands on" approach to pain management when working with patients who held onto their pain through immobilising limbs. The desire for a "passive" response to pain management by prisoners was constructed by the group as an illustration of an "entitlement" culture in prison, whereby prisoners are felt to be reluctant to take any responsibility for themselves or their own health.

Discussion also crossed into considering the importance of distraction as a way of managing pain, where boredom is seen to exacerbate pain and promote rumination. Providing activity for

prisoners was described by the group as a “tonic”. Providing purposeful activity for prisoners was seen by the probation officer as a way of empowering prisoners:

Life doesn't stop just because you are in custody. It is about giving them meaningful things to do. Empowering people helps their pain (P7).

Discussion

From the literature highlighted earlier, it is clear that the context within which care is provided and therefore pain is managed, has a significant impact on both prisoner patient care and professional wellbeing (Lin and Matthew, 2005; Walsh and Freshwater, 2009).

Through both the questionnaire and focus group, staff in this study demonstrated a good awareness of prisoner pain and identified both physical and emotional pain as being present. Both health care and non-health care staff all reported being frequently approached for assistance with pain management and all had an awareness of how the prison environment could potentially exacerbate painful conditions. Hard mattresses and pillows were felt to affect painful back problems, whilst either excessive time to reflect or reactive depression exacerbated emotional and psychological pain.

Although there is a pain clinic available to prisoners and physiotherapy services, the treatment of pain in this prison is predominantly through a pharmaceutical route. However, many staff reported feeling that alternative approaches could prove valuable, such as the use of cognitive behaviour therapy and physiotherapy. Further exploration of the barriers to these alternative treatments centred on the perception that prisoners would resist anything other than an immediate cure, which is how staff report that analgesics are constructed by prisoners.

Effective prisoner patient pain management is clearly challenged by the perception of prisoners by staff and the common view that fictitious pain is frequently reported to obtain analgesia for secondary gain rather than actual pain relief. Concern that analgesia will be diverted to other prisoners for illegal purposes, stockpiled for a suicide attempt or overdosed to enable visits to an outside hospital to escape custody are just three of the reasons given by staff to illustrate potential reasons for complaints of pain. The way in which pain is reported is also an issue for staff, as prisoners are positioned as being very demanding and confrontational in their interactions with health care professionals. The way staff react to this perceived lack of prisoner credibility and confrontation manifests itself in prescribing practices where particular drugs are prohibited/restricted; attitudes towards prisoners complaining of pain where evidence other than prisoner report is required to prove suffering, and in many ways, staff wellbeing, with staff reporting feelings of anger and frustration when prisoners are deceitful and take advantage.

It can be seen from both the questionnaire and focus group data that the management of pain in prison is a complex and challenging area of care for both health care professionals and prison staff. Support is required for staff working in this difficult caring culture to ensure that prisoner patient care is not affected by the culture to the detriment of patients legitimately requiring pain relief.

Limitations

The research was undertaken in one large adult male prison, housing category B prisoners. Scott (2007) explains that category B prisoners are those who do not require high-secure conditions, but for who escape must be made very difficult. It is not a high-secure establishment, nor does it have a particularly stable population as prisoners are on remand and recently sentenced which results in a high turnover. Therefore, a high-secure prison, housing high-risk prisoners may have a different culture that could impact differently on staff attitudes to pain management. Similarly, a prison with a more stable, long-term prison population may also provide a different perspective on pain management, given the potential to develop sustained staff prisoner relationships.

This study focuses on adult male prisoners and therefore omits any consideration of female prisoners or young people in prison. It is anticipated that both these groups will have particular issues related to gender and age and therefore research that considers them separately is welcomed.

There are some limitations related to the actual environment within which this research was conducted. Prisons are notoriously challenging places to undertake research for reasons related

to security, culture and researcher vulnerability (Drake, 1998; Liebling, 1999; Wakai *et al.*, 2009). The focus group methodology employed in this study relies on participants engaging in open and frank discussion that opens up practice for scrutiny. It is known that the use of open methodologies that encourage reflection on practice in closed systems such as prisons can be problematic (see Freshwater *et al.*, 2012) where participants are asked to discuss their practice. Prison culture lends itself to disengagement from practice as a defence against anxiety (Menzies-Lyth, 1988) and to provide a way to manage emotional labour (Walsh, 2009b). The relatively low-response rate to the questionnaire and interest in the focus group from prison discipline officers and nurses illustrates our point here. Nevertheless our empirical research is one of the first to explore this topic in the challenging setting of the prison.

Conclusion

This paper has reported the findings of a small part of a wider project to explore the management of pain in adult male prisoners. In this part of the project, the thoughts, attitudes and perspectives of the staff group caring for male adult prisoners complaining of and being treated for pain were explored. Prison staff and health care professionals caring for prisoners report high levels of need for pain management, however, to what extent this need is real is continually questioned. Staff report significant challenges to caring for prisoners complaining of pain which are related to the need to maintain security and manage risk.

Further research is required to develop, implement and evaluate pain management programmes in prison that take account of the complexities of the culture and environment. We suggest that more research is essential in order to ascertain the extent to which pain management provision in prison is safe and effective whilst simultaneously meeting the security requirements of the prison.

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