Programme 54: Opioids, memories and prison healthcare

Delving into the issues surrounding opioids and healthcare within prisons and investigating the relationship between memory and pain.

Paul Evans talks to Dr Cathy Stannard, a Consultant in Pain Medicine at Frenchay Hospital in Bristol, who outlines the use and misuse of opioids in chronic pain management. She points out that whilst opioids are a useful analgesic for some people, they can have a detrimental effect on others due to their strong side effects. She emphasises the need for healthcare professionals to be aware of how to use opioids effectively as a pain management resource.

Paul also meets Dr Rajesh Munglani, a Consultant in Pain Medicine in Cambridge, who has carried out research into the relationship between pain and memory. He describes chronic pain as a circuit that can be triggered by seemingly small events or memories and highlights the importance of context and memories on pain. He explains that medical or psychological intervention is needed to disrupt the circuit of pain.

Then Paul speaks to Dr Cathy Stannard and Dr Ian Brew, a prison GP, about healthcare within prisons. Stannard reveals some problems in this area, saying that some medicines are a tradable commodity in prisons and that often prisoners' accounts of pain are treated with mistrust. She reports that the situation is improving, as the healthcare needs assessment that prisoners receive when they arrive in prison now includes a section on pain, alongside the original sections on substance misuse and psychiatric disorders. Dr Ian Brew emphasises that prisoners deserve to receive the same quality of healthcare as those outside of prison and says evidence suggests that good healthcare, alongside other rehabilitation initiatives in prisons, can reduce the rate of re-offending.

Paul Evans: Hello. Welcome to ***Airing Pain***, a programme bought to you by Pain Concern, a UK based charity working to help, support and inform those of us who live with pain and healthcare professionals. This addition has been supported by a grant from the Scottish Government.

Opioids are drugs which either come from the opium poppy plant or are chemically related to those made from opium. Stronger opioid drugs include the likes of morphine and fentanyl.

Their use, overuse or abuse still creates confusion amongst patients and some health professionals. Dr Cathy Stannard is a consultant in pain medicine at Frenchay Hospital in Bristol. A leading expert in the use of opioids, she was chair of consensus group and editor of the British Pain Society guidelines on *Opioids for Persistent Pain: Good Practice*. In 2013 she gave a lecture to the society under the heading 'When the cure is worse than the disease: strategies for safe opioid prescribing'.

Dr Cathy Stannard: What is behind all that is that, particularly in North America, they have a huge problem with misuse of prescription drugs and I think that's largely about different choices that drug users make and the availability of prescription drugs is much easier, for example, in getting hold of heroin in the States, so prescription drugs are commonly a drug of abuse.

Now, this had led to a great deal of public and policy concern about the amount of prescription drugs I guess out there in the system. So what's happening is that there's been a great move to restrict clinicians or to try and educate clinicians to very much focus on who and for how long they target opioid medicines for. Now the thing that's a real public health problem, and I've worked with colleagues in the States, and I think they are tackling it responsibly – but I think what is a risk here is that we are concerned about what essentially are drug misuse practices in the States and maybe let that influence unduly our decision to treat the patient that's in front of us, who actually might benefit from opioids. Now, I think how it gets complicated is that as many people understand, chronic pain is really difficult to treat and what we end up doing most of the time is supporting people in their self-management strategies to improve their quality of life and all the various things we offer patients in terms of medical intervention are not very helpful.

So almost any sort of intervention you think of, whether it's a tablet or whatever will help about a third of people. Now that means that even very strong medicines like morphine are not going to help everybody: there are going to be more people that they don't help than they do help. And there are quite a lot of side effects of the drug. And I guess that what I am trying to support is the idea that we don't put people on morphine-like drugs and because there is nothing else, leave them exposed to all the harms of those drugs. But that we assess people and if they are helping, if the drugs are helping to improve quality of life, we support them on staying on them. But if they are not helping we take them off. And I think it's just about trying to target what is quite a strong class of medication with quite a lot of side effects, just trying to target it to people who are definitely getting the benefit.

Paul Evans: So is there or was there a danger, that if the morphine is not working now then just 'up the dose and up the dose and just keep going'?

Dr Cathy Stannard: No, and I think it is a very interesting point and I think that's maybe where we've gotten in a bit of muddle because the traditional teaching over decades ago for treating patients with cancer-related pain at the end of life, is if the correct dose is enough. So, if the first dose doesn't work, then double it, and double and double it. Now that would maybe work well for cancer pain in the short term at the end of life, so this is not for cancer pain with patients who have a long prognosis. It might also work for very short term pain like post-operative pain.

But I think that's a really important point because what we know from the literature about doses for long term pain is that there comes a point at not a very high dose, where when you put the dose up you get more harms but you really don't get any more benefit. So there is a rationale for starting somebody on a drug and then adjusting upwards a few times to get to a reasonable dose, but there comes a point when there's not going to be a benefit in taking the drug higher and I think that part of the problem is that people have borrowed from what we know about cancer pain and felt that if a drug isn't working it's because it's not being given in enough dose and the drug dose goes up and up and up and eventually the dose gets turned up to a level that is just not helpful to people's quality of life, because they can't concentrate, they can't invoke self-management strategies and they have other side effects.

Paul Evans: I was speaking to somebody few weeks ago, who I suspect is in that situation and he is desperately trying to reduce his dose to come off the drugs so that he could maintain some quality of life but balance the pain along with it. Is that usual?

Dr Cathy Stannard: I think that is and I talk a lot to prescribing doctors about this, and actually I think patients have a much better understanding. Because I can have a conversation with the patients about this and they will get it immediately and what I might say is that a patient might come to me and they would come to my service because they had pain that was impairing their quality of life. If they come to me with pain and they are on a very high dose of an opioid medication, I say to them well, it's not working because they've got pain. And I point out that if it's not working they might be better not taking it.

So there are sort of two health states: you can have a certain amount of pain and be on a lot of medication or you could come off the medication and be in the same amount of pain. And actually, as soon I explain it like that, without exception patients say, 'when can I start? How can I come off?' And I think that's something we all want to do as prescribers. If a patient is on a high dose and it's not helping – and this doesn't just apply to opioids, it applies to all the other drugs that patients take to support their pain management – is to try bringing it off and see what happens. And you might bring it off and find the pain's a lot worse, in which case it has been helping more than you think. But then when your pain doesn't get worse when you

come off, it's great 'cause you stay off it and you are freed from all the side effects of that drugs which in themselves can impair your quality of life.

Paul Evans: Dr Cathy Stannard and we will be hearing from her a little later in this program. I'll just remind you that whilst we at Pain Concern believe the information and opinions on *Airing Pain* are accurate and sound, based on the best judgements available, you should always consult your health professional on any matter relating to your health and wellbeing. He or she is the only person who knows you and your circumstances and therefore the appropriate action to take on your behalf.

Dr Rajesh Munglani is a consultant in Pain Medicine in the Cambridge area. He was also a lecturer in the University of Cambridge where he ran a laboratory looking at the mechanisms of chronic pain. So straight to the heart of the matter, what are they?

Dr Rajesh Munglani: I actually got into my research looking at memory formation and my initial question of that many years ago was, can you remember under anaesthesia. If you're having an operation, can you form memories and what we showed is that in fact you can in certain situations form memories despite the fact that you are not aware of what is going on. That is called implicit memory formation. Now the interesting thing is that as soon as I started doing the research I realised – and because my other interest was pain – that pain is a memory. And it is the same sort of thing, that if you, for example, have a really nice meal at a hotel and you … the smell of the restaurant you find that to re-experience that rather nice event, say, a few months later all you need is one smell, the smell of the food, and that will re-evoke the whole atmosphere.

In the same way chronic pain is a memory. It's a circuit that's been set up and it doesn't take much to keep it going. You don't have to have the initial trauma, say it was an accident or an operation. You can have just very light touches that set the whole thing off or a certain movement or a certain unpleasant experience that you experience emotionally, and it will set off the whole pain experience. If you say, 'does that mean it is not real?' The answer is 'no', it's actually very real because everything in our brain is related to memory, that's our identity. I don't know if you remember seeing *Blade Runner*, and the guy realises that the robots all have memories. And they don't know they're robots because the memories have been implanted and then he has to think about his own and he's sitting there playing the piano and looking at all the photographs, and it is really quite an important concept that what we are dealing with and what we are trying to disrupt if we need to is that circuit. And there are a lot of different ways of disrupting that circuit.

Paul Evans: So, I could go to a concert and I could experience wonderful a violin symphony and there would be somebody coughing next to me, somebody smelly next to me and I could go home and listen to the CD of that and I might have a completely different experience. Or perhaps whenever I listen to that music again I would have the smelly, noisy experience.

Dr Rajesh Munglani: Absolutely. It's been modified and you can modify it and that's actually a very interesting way that you may have listened to that symphony in the past and you had a really nice attachment to it but then subsequently it is modified. One of the ways of an unpleasant memory being tackled is through the psychological approaches, and what you attach to that memory subsequently. And lots of different techniques are called – and some psychologists will be able to talk about this in a better way than I – but, for example, reframing, and you put different contexts around and different meaning to that memory. And it's very clever. I mean, it works for some people and doesn't work at all for others. Other people you have to just modify with drugs, trying to get rid of the circuit, and other people of course…

What I do, I spend my time finding the triggers, like we talked about the smell that evokes the restaurant. There are sometimes in the body little triggers that set off the central pain state and they're called peripheral triggers and the posh word is peripheral maintenance of central sensitization. Something from the periphery feeds in, keeping the whole thing going. And so what we can do is – as well as working on the central memory and modifying it through, say, psychology, through drugs – you can do something with a peripheral trigger. You can, for example, kill it off, numb it as I do sometimes, Botox it, take away the muscle spasm, and we know that that is not the whole pain but that's all you need, is to take down the evoking of that memory.

Paul Evans: Lots of people give the example – and you may have given it as well – that if I stamp on your toe and tell you 'oh, by the way, somebody has stolen all your money and your bank has gone bust', you will feel quite a lot of pain. But if I stamp on your toe and I say, 'oh and you won the lottery too,' the pain might not be so severe. So the pain isn't finite; it's everything else that feeds into it.

Dr Rajesh Munglani: Absolutely, it's a very, very important point, the context of suffering is very important. If you have a memory of a pain and it's associated with, for example, deeds of valour and you came out of it well. I mean, when I treat military guys, this is interesting – the way they stand up to certain pains, because of the context of the pain meant there was meaning to what they did, meaning to the outcome. It doesn't always work but this is – and it's not meant to sound condemnatory to anybody else – but if you had that experience like

having your leg blown off – I have seen people who, for example, had stepped on mines, had an amputation and still have severe phantom limb pain but they are now riding horses, running event companies. They have got back to normal life.

You see, others who have lost their leg in a road traffic accident [have] deep anger at the drunk driver involved who caused this to happen and the focus for them very much becomes the court case, the anger at the driver being allowed to go off with a relatively little fine, which often happens, and they have got the pain in the leg still. So you have this awful situation of trying to help them move on from that experience and of course that is where reframing that whole experience, trying to get them to come to terms with the pain is part of the healing process and letting them move on – and people do move on.

But sometimes you get stuck, and you can get stuck physically because the pain is just too severe to deal with. Because one of the issues is, if the pain is that severe, your brain cannot move on, the stump is painful. Every time the stump hurts, it triggers a whole phantom limb experience, it triggers the memory of the accident and you can't get them to move on and they can't do it for themselves. So this is where lots of interventions – do you numb the end, do you kill off some nerves, do you put in a pump in their back? As well as helping them move on with say, the court case, the medical or legal process, all of that needs to end to help them move on with their lives. Otherwise they are trapped. They are in a prison.

Paul Evans: Dr Rajesh Munglani, well from the prison of the mind to the physical prison of four walls, locks and keys. We heard Dr Cathy Stannard talking earlier about the issues surrounding the use of opioids. At the same British Pain Society Annual Scientific Meeting, she and Dr Ian Brew launched a National Guidance for prescribing non-medical management of chronic pain in secured environments.

Dr Cathy Stannard: The new prison guidelines are a project that I have been involved in. I've been interested in it, actually for the whole area for about a decade. And what has driven me to want to do something about this is hearing the stories of patients who have got very genuine pain complaints but who are not believed in prisons and have their pain managed poorly. And I think chronic pain is a great vulnerability for somebody in a secure environment. Now one of the problems around all this is that although there lots of strategies – I mean, we do not only use medications in pain management, medications do play a part in pain management – but the nature of the medications that we use make them in essence a tradable commodity within the prison setting where particularly illicit drugs are now much more difficult to get hold of. So I think hitherto people who are working in secure environment have been concerned about the overuse of the medications because of the risk as well that

that poses the patient in pain for being bullied or coerced and having their medications being taken away. And I think that this has resulted in people probably under-prescribing.

And I think also that as with many healthcare systems there is not always a good understanding about management of persistent pain. And so I think there is quite a learning curve for people working in secure environments to understand about persistent pain, to understand about the causes, what it is, how to diagnose it, the effect it has on people's lives. And what the piece of guidance is about – it's just a simple piece of guidance but a lot of it is about assessment and understanding patients' pain and understanding the influences on patients' pain. And having made that assessment we then try to talk about appropriate evidence-based treatment pathways.

And really what's quite interesting about the project is it's considered a kind of risky context in which to provide pain management services but I think it's focused everybody very much on thinking about quality and about best practice. And largely the sorts of recommendations we make about pain management in secure environments would really very much stand up for pain management in the community.

But I think one thing I would say that's quite important, because there might be misunderstanding about this, is that some drugs for pain are more popular as a commodity in prison than others. And what we have said in the guidance is if a patient is assessed as having pain, and if a less risky drug is more likely to help, given that not all drugs help, we would always start with the less risky drug. It's better for the patient, because they will not be bullied or coerced for their medication. And we would be choosing that drug not just on the grounds of its tradability but because we have it as the best bet for managing pain. Now, if that doesn't work we would then move down the list. The drugs down the list may be less good for managing pain, but are also somewhat more risky in that setting.

So actually it's turned out in a way I think quite well that the less risky drugs are the more effective drugs. And what we hope is that… we had a lot of contacts from groups who have read this guidance who tell us very sad tales about people who had very poor treatment of pain in prison. But actually I think that what is a good road test is when I plug in all those patients narratives to this piece of guidance, in every case the patient would have had a much better deal if they had been managed according to this guidance.

And I think we have the policy makers behind us and one of the things that I think is very important is that on reception into prison, patients are given a needs assessment in relation to their health, and a lot of that is often around substance abuse and related disorders, psychiatric disorders. But actually now pain is going to be right there within the few minutes

of assessment and asking prisoners if they have pain and then assessing that, evaluating it and moving them on down through appropriate pain management pathway. So I think it will take time, but I am very reassured. I have been going around the country to do different groupings of prison health professionals and commissioners of health services. And everyone is terribly enthusiastic to take this up, really keen, soaking it up like a sponge. And I think people really want to change things and make things better. So, I would really hope that the sort of bad stories that we hear now will become much fewer and far between as this becomes much more embedded in regular practice.

Paul Evans: One of Dr Cathy Stannard's collaborators in those National Guidance for prescribing and non-medical management of chronic pain in secure environments was Dr Ian Brew. He is a GP who has been working in prisons since 2001.

Dr Ian Brew: We have spent the last 10 years mainstreaming prison practise so that prisoners hopefully get primary care equivalent to that that they receive outside, which certainly wasn't always the case . It's a challenging environment. There is lots of learning to do along the way but it's a fascinating environment with a very vulnerable group of patients who really deserve the best healthcare. And there is some evidence that good healthcare can reduce reoffending rates by giving some of the patients some self-esteem which they have long lacked.

Paul Evans: What are the main differences, then, between your community and an outside community?

Dr Ian Brew: The community is very similar. The biggest difference is that 70% of our patients are drug users or drug dependant, and about 10% are alcoholic, and a very large concentration of mental health problems. It's sad that up to 90% of the patients in prison have a diagnosable mental health problem. So it's similar to an outside community, but more concentrated mental health problems, I would say.

Paul Evans: In terms of chronic pain, how does that affect prisoners?

Dr Ian Brew: Chronic pain is a big problem for a lot of our patients. Their opioid abuse may make them more susceptible to pain and may make them less able to cope with pain when it comes along. Some of the medications that are used in chronic pain are very desirable to drug users because of the other effects that they get whether they're sedation or euphoria or whether the drugs just make their prescribed opioids more effective. So chronic pain is a problem. But patients complain of chronic pain probably sometimes when they haven't really got pain. That's part of their drug seeking behaviour. So it's a mixture of the two.

Paul Evans: How did you decide who is in the latter group, rather than the real chronic pain user?

Dr Ian Brew: Yes sure. Patients complain of nerve pain and nerve damage. If a genuine patient has nerve damage, there will be some evidence of a cause for that, whether it's diabetes, whether it is a neurological problem or whether there is some scarring from burns or surgery or injuries or whatever. Patients who are drug seeking will tend to fabricate their symptoms and they won't be anatomically logical. So in other words, they might complain of pains affecting areas that aren't supplied by the nerve that goes through damaged area, if that makes sense. So non-anatomical pain distribution is one thing that would make us think that this is drug seeking and the other is, patients who are genuine are grateful for the suggestions that their clinicians give them. Patients who are drug seeking have one drug in mind. They usually name it and they usually argue if it's not suggested.

Paul Evans: So if I were a drug abuser then and you offered me like some psychological approach…

Dr Ian Brew: My experience and that of my colleague is usually that would usually end in an argument, that's right, yes.

Paul Evans: So let's concentrate on the people with genuine chronic pain. How do you treat them?

Dr Ian Brew: I would like to think that we treat them the same as I would treat such a patient outside the prison walls. The changes that we make are not because of the imprisonment. It's crucial to understand that patients are entitled to equivalent health care, that may not be identical but it's equivalent to the care that they would receive outside otherwise. So, if somebody came to me with very good evidence of nerve damage causing chronic pain then I would assess them by taking their history and listening to them, which can be helpful in itself. I would examine them looking for evidence to support the diagnosis, and if necessary arrange tests that would help to confirm that. Nerve conduction studies is one example. They can show damage to nerves which will confirm beyond doubt the presence of neuropathic or nerve-related pain. Then I am very happy to treat people as the national guidelines suggest. The NICE guidelines from three or four years ago suggest some drug treatments, they suggest physical treatments, and they suggest some psychological treatments as well. And we would certainly look to go down that route. I think some of the programs that you have done previously look as if they would be very helpful to our patients so I am going to suggest that we give them access to those on CD. Unfortunately most of our patients don't have access to the internet.

Paul Evans: I am really glad to hear that our programs are useful. But for prisoners there are certain constraints put on them that would make approaches that would, say, be used on me, psychological approaches, virtually impossible – facing things like depression and what my GP would tell me to do, what my pain management people would tell me to do, involve the outside world.

Dr Ian Brew: Yes, it's certainly true to say that some aspects of psychological approaches may not be easily available to people in prison, but others will be. Cognitive behavioural therapy is already used for patients who suffer with anxiety and through increasing access to psychological therapies, or IAPT, prisoners are able to access psychological therapies much more than ever they were before. So whilst I take your point that there are some things prisoners won't be able to do there are a lot of others that they can and they have certainly got very good access to gymnasium facilities and physiotherapy, far better than I have. So overall the holistic approach is going to be useful for prisoners, I think.

Paul Evans: What evidence is there that a healthy, pain-free prisoner will not go back to reoffend?

Dr Ian Brew: Certainly prisoner patients who come in for the first time or the first few times are very often very low in their self-esteem; they haven't taken care of themselves. These patients don't access health care facilities readily outside, maybe because of fear of authority figures, maybe because of chaotic lifestyles, meaning appointments gets missed.

Coming into prison is a real opportunity to take charge of patient's healthcare. They can take charge of it themselves, take some personal responsibility, and through seeing their health improve in the prison setting, because they are accessing healthcare, they are eating well, hopefully their illegal drug use is considerably reduced, and they are getting support for any mental problems that they have. And also the prisons these days are very good at helping with training, with employment skills, with housing if people are on more than very short sentences. All of this will help to contribute to an increase in self-esteem.

I always say to the young men who come into prison, if you don't have any self-respect, it's very difficult to respect other people. And if you don't respect other people, you won't respect their stuff. So these guys will perceive nothing wrong with stealing and damaging themselves. By giving them some self-respect, they can develop respectful relationships with other people, and there is good evidence that that helps to reduce reoffending. So clearly sending someone out healthier than he came in, whether it's in terms of pain, drug use, mental health or all three, that's got to help in the rehabilitation of the offender and reduce reoffending for that individual.

Paul Evans: Dr Ian Brew. Now before we finish this edition of *Airing Pain*, I'll remind you that you can download all editions of ***Airing Pain*** from painconcern.org.uk, CD copies are also available direct from Pain Concern. Please do visit the website where you can find all sorts of essential information about pain management, including details of ***Pain Matters***, our magazine that complements and expands on issues covered with ***Airing Pain***. It's now also available as an enhanced digital download. So please do check it out at the Pain Concern website. Once again, it's painconcern.org.uk. And finally in talking to Dr Ian Brew about those guidelines for treating prisoners with chronic pain, I was interested to know why a GP who could have opted to work in a much more conventional, and presumably less stressful environment, should have opted for one within the walls of her majesty's prisons.

Dr Ian Brew: My Mum and dad often say, 'What are you doing working in a place like that, why don't you get a proper job out in the suburbs somewhere?' And I just think that it's so rewarding, working with this very vulnerable group. A success for me is not seeing the patient again, which is quite bizarre for a GP. Most GPs go into primary care because of the lifelong relationship, the therapeutic relationship they can build up with people. I enjoy the therapeutic relationship with vulnerable people who can be helped to help themselves, and when I see someone outside the prison who hasn't been back for a few years, it makes the day worthwhile. It's really great to see people who are doing well. We do get a bit of skewed view, because of course, the people we see are the ones who aren't ready to end their offending career. So we can sometimes feel that we're not doing much good. But as I say, one guy in the supermarket – 'Hello Dr Brew, how are you doing? I haven't seen you for years,' I'll say, just makes the whole thing worthwhile.

Contributors

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