



THE BRITISH PAIN SOCIETY

Recommended guidelines for Pain Management Programmes for adults

**A consensus statement prepared on behalf of
the British Pain Society
April 2007**

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1 Executive summary

- Pain management programmes (PMPs), based on cognitive behavioural principles, are the treatment of choice for people with persistent pain which adversely affects their quality of life.
- There is good evidence for efficacy of cognitive behavioural pain management programmes as a package, compared with either no treatment or treatment as usual, in improving pain experience, mood, coping, negative outlook on pain, and activity levels (Morley et al., 1999; Guzmán et al., 2001; European Guidelines, 2004; Koes et al. 2006; Hoffman et al., 2007; <http://www.besttreatments.co.uk/btuk/conditions/5816.jsp>).
- Rehabilitative and physical treatments (back school, functional restoration, and others) can be helpful, but where problems associated with pain are more complex, the psychological components of pain are best addressed in a PMP (Koes et al. 2006).
- PMPs consist of education on pain physiology, pain psychology, healthy function and self-management of pain problems; and of guided practice on setting goals and working towards them, identifying and changing unhelpful beliefs and ways of thinking, relaxation, and changing habits which contribute to disability. Participants practise these skills in their home and other environments to become expert in their application and integration.
- PMPs are delivered in a group format to normalise pain experience, to maximise possibilities of learning from other group members, and for economy.
- Evaluation of outcome should be standard practice, assessing distress/emotional impact of pain, beliefs and thinking biases, range and level of activity, pain experience, health care use, and work status where relevant.
- Return to work can be achieved where this is a specific or additional component of the programme.

- Greater length and intensity of programme usually achieve greater change. Economies of time, staff skills or other resources risk reducing the effectiveness of the programme towards zero; however, it is not possible to specify a minimum number of hours since change results from the interaction of patient needs and staff skills during treatment.
- Suitability for a PMP is based on the impact of pain. There are no grounds for discrimination on the basis of age, literacy, litigation, or judgement of motivation.
- A PMP is delivered by a multidisciplinary team where some competencies are shared and some are unique to particular professions. All staff use cognitive behavioural principles to deliver their component/s of the PMP.
- PMPs may be delivered in a primary or a secondary care setting: the resources required will be the same.

2 Background

- Persistent (chronic) pain is a widespread problem which cannot always be resolved by available medical and physical treatments. Pain management programmes (PMPs) aim to restore to as normal as possible the lives of people affected by persistent noncancer pain.
- In 1997, the Pain Society (now British Pain Society) published *Desirable Criteria for Pain Management Programmes* in response to the perceived need for information and guidance for those involved in the developing field. The document described for the first time what constituted a Pain Management Programme, though without any attempt at formal guidelines. It was used by both providers and purchasers of pain management services. This is the first revision of that document, extended and updated with reference to current practice and with particular attention to evidence.
- Since 1997 the status of pain management programmes has grown, both in evidence base and in the general awareness and acceptance of this form of care in the spectrum of provision for persistent pain. However, service development has not kept pace with these changes; demand continues to outstrip supply (Clinical Standards Advisory Group, 2000; Dr Foster, 2003). Shortcomings in quantity, combined with government-led efforts to reduce waiting times, create pressure to provide pain management services for patients using whatever staff, facilities and resources are available. This has implications for quality.
- Evidence of effectiveness of PMPs continues to accumulate (Morley et al., 1999, van Tulder et al., 2000; Guzmán et al., 2001; Hoffman et al., 2007). However, UK programmes aimed at helping patients manage their pain are diverse, and their design and procedures may be influenced as much by pragmatic concerns and available resources as by published studies and systematic reviews. These latter do not offer guidance on how to realise the best provision in any particular situation.

- Department of Health philosophy on the management of chronic illness has changed over this time, with emphasis now on self-management and community care (for instance, the 2005 National Service Framework for long term medical conditions (www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/fs/), and the 2006 Musculoskeletal Services Framework (www.18weeks.nhs.uk).
- These guidelines are written to promote the appropriate provision of evidence-based treatment and to maintain and improve the quality of treatment offered to patients. This requires some statement of criteria for minimum quality which, until data are available, has been achieved by consensus of involved professionals and by consultation with relevant bodies. Evaluation of clinical services remains important to ensure that they are achieving the expected results.
- These recommended guidelines are addressed to health care and related professionals providing pain management services, to those who refer patients to these services, and to those who purchase or commission them and who manage them at present or who have the opportunity to do so.

Functions of this document:

- To build on the concepts set out in the 1997 document, moving towards a set of standards of care and guidelines for provision of pain management.
- To provide pain clinicians of various disciplines with a synthesis of current best practice.
- To provide commissioners and provider organisations with an outline framework for effective and sustainable service provision.
- To update stakeholders on the scientific foundation of and quality issues relating to this treatment.

An accompanying document provides information specifically for patients about available provision.

3 Pain Management Programmes (PMPs)

PMP content, delivery and outcomes

- 3.1 A PMP aims to improve the physical, psychological, emotional and social dimensions of quality of life of people with persistent pain, using a multidisciplinary team working according to behavioural and cognitive principles. The problems of people with persistent pain are formulated in terms of the effects of persistent pain on the individual's physical and psychological wellbeing, rather than as disease or damage in biomedical terms, or as deficits in the individual's personality or mental health.
- 3.2 The principles underlying PMPs can be applied at an early stage to prevent the development of persistent pain and pain-related disability, with some evidence for efficacy (Pincus et al., 2001; Linton, 2000; Linton, 2005). As early identification of those at highest risk for the development of persistent pain improves, this intervention is likely to become more cost-effective (Pincus et al., 2001).

Content

- 3.3 PMP participants apply the programme content to goals important to them, where pain has had significant negative impact. They aim to improve their quality of life, working towards their optimal level of function and self-reliance in managing their persistent pain. Pain relief is not a primary goal, although improvements in pain have been reported (Morley et al., 1999; Van Tulder et al., 2000; Guzmán et al., 2001; Hoffman et al., 2007). Return to work or improved function at work is an important goal for many, but not for all.
- 3.4 A PMP consists of education and guided practice.

Education

- 3.4.1 Education is provided by all members of the multidisciplinary team, according to their expertise, using an interactive style to enable patients to raise and resolve difficulties in understanding material or in applying it to their particular situations or problems.

3.4.2 Some of the information refers to pain mechanisms, to associated pathologies, and to healthy function and normal processes:

- Anatomy and physiology of pain and pain pathways; differences between acute and persistent pain;
- Psychology and pain; fear and avoidance; stress, distress and depression;
- Safety and risk in relation to increased activity;
- Exercise for better health and improved function;
- Advantages and disadvantages of using aids, treatments and medication;
- Self-management of flare-ups and setbacks.

3.4.3 Other information introduces treatment principles and rationales, since these are not intuitively obvious, linking the information in 3.4.2 to the guided practice described below:

- Mutual influence of beliefs and ways of thinking, emotions, and behaviour;
- Using cognitive strategies to deal with the psychological effects of persistent pain and stress;
- Principles of goal-setting;
- Scheduling and regulating goal-directed activity, using pacing;
- Using cues and reinforcement to help change habits; generalisation and maintenance of changes;
- Strategies to improve sleep.

Guided Practice

- 3.4.4 Information alone is a weak way to change behaviour. PMPs are an opportunity for guided practice in use of the methods outlined above to abolish unhelpful habits and build helpful habits of activity and of thinking. Guided practice also enables participants to use help from staff to apply these changes to their individual goals, starting from their current level of performance and increasing at a manageable rate.

Participants are instructed to practise in their home and other environments, monitoring what they do and reviewing progress with staff regularly, adjusting goals and methods as necessary.

- 3.4.5 Exercise to improve fitness and mobility, to improve confidence in movement and activity, and to enable increases in goal-related activity. People with persistent pain who are fearful of activity-related pain or injury are less likely to transfer exercise gains to improvements in general function.
- 3.4.6 Gradual return to goal-defined activities, from self-care to work, social activities, and sports. This consists both of analysis of barriers and areas requiring specific change, and synthesis of the various movements, positions and tolerances into the integrated activity.
- 3.4.7 Pacing activity by quota: this is simplest with repetitive exercise which can be counted or timed and increased at a steady rate; it is more difficult with complex activities which require attention to breaks and on which there are environmental pressures against stopping and starting strictly to quota (such as driving). Goals involving reduction of medication and use of aids can be achieved using the same method.
- 3.4.8 Identification, elaboration and challenging of appraisals, beliefs and processing biases related to pain and activity, using cognitive therapeutic methods.

- 3.4.9 Relaxation skills to enhance breaks, rest and sleep, and as foundation for attention control methods.
- 3.4.10 Graded increase in safe but feared activities, increasing according to resolution of anxiety.
- 3.4.11 Improvement of communication skills with family, friends and others, such as work colleagues, or health care professionals.

Delivery

- 3.5 The inclusion of additional components will depend on available resources but should always be properly evaluated. Sacrificing core components for other content for which evidence is poor or lacking is to be discouraged.
- 3.6 The dimensions in which programmes may vary in terms of clinical input to patients are intensity, length, size of group, individualisation of clinical input, and competence and training of staff.

Intensity and range

- 3.7 Historically, these programmes have been delivered as outpatient programmes, for days or part-days over weeks, or as more intensive, usually residential, programmes.
 - 3.7.1 Outpatient programmes of at least 25-30 hours have produced evidence of efficacy, but more intensive programmes achieve greater improvement (Williams et al., 1996, 1999; Guzmán et al., 2001). This advantage is maintained at one-year follow-up.
 - 3.7.2 It is common for programmes to offer post-treatment follow-up sessions, but these have not been shown to improve long-term outcome. (Nicholas, 1992)

Group format

- 3.8 PMPs are delivered to groups because this format normalises the experience of pain and maximises opportunities to draw on the experiences of group members. It is also cost effective.

- 3.8.1 Group size varies but most groups aim to have 8 to 12 participants. There is little research to guide group numbers, and a balance of staff resources (diluted among group members) and space considerations against demand and waiting times has to be achieved. Aspects of the group dynamic are weakened with smaller numbers.
- 3.8.2 Programme content is tailored to meet the needs of individual patients, as identified by patients and/or by staff. However, selecting treatment components based on patient choice alone is likely to undermine outcome (Morley & Williams, 2002).

Staff skills

- 3.9 Staff training is addressed in section 6; there are no data specifically from PMPs on staff skills in relation to outcome.

Outcomes

- 3.10 Commissioners, purchasers, referrers and patients expect providers to deliver an effective PMP. There is no single primary outcome, since multiple problems imply multiple outcomes, and goals are to a large extent determined by patients themselves. However, outcomes can generally be subsumed under the following domains, which were agreed at a National Consensus meeting in 2000 of staff from UK PMPs:
- reduced distress/emotional impact;
 - normalising of beliefs and information processing (fears, catastrophic thinking, self-efficacy);
 - increase in range and level of activity/physical performance (observed, self-rated);
 - reduced pain experience;
 - reduced healthcare use (e.g. medication, consultations);
 - improved work status where relevant.

- 3.11 Outcome evaluation should be standard practice so that pain management staff can describe to patients, referrers and purchasers the range of patients with whom they work and the range of changes which the PMP brings about, in both the short and longer term.

Evidence for effectiveness

- 3.12 There is good evidence for efficacy of both outpatient and inpatient programmes (www.thecochranelibrary.com; Williams et al., 1996; Williams et al., 1999; Morley et al., 1999; Van Tulder et al., 2001; Guzmán et al., 2001). Greater gains are achieved with the more intensive programmes (Williams et al., 1996, 1999; Guzmán et al., 2001).
- 3.13 PMPs have generally been evaluated as a complete package (see Morley & Williams, 2002). A number of systematic reviews have shown PMPs to significantly reduce distress and disability and to significantly enhance coping and improve various measures of physical performance (Morley et al., 1999; van Tulder et al., 2000; Guzmán et al., 2001). Where vocational training has been included in the package, return to work is also significantly enhanced (Hubbard et al., 1996; Watson et al., 2004). There is also evidence for decreased use of healthcare resources in terms of numbers of consultations and reduction of medication (see Morley et al., 1999). Cost effectiveness data are sparse but positive effects have been demonstrated in other healthcare systems (e.g. Turk, 2002; Gatchel & Okifuji, 2006).
- 3.14 Few of the components of a PMP have been evaluated individually. However,
- The physiotherapy component is drawn from established practice, supported by randomised controlled trials and by a systematic review (Hayden et al., 2005).
 - Each of the components in 3.4.6 to 3.4.11 is drawn from behavioural and/or cognitive therapy, with moderate to excellent evidence of efficacy in changing behaviour, beliefs and mood in psychological disorders (Roth & Fonagy, 2004), compared with no treatment or with most alternative treatments. Efficacy in psychological settings depends in part on the skills of the health care professional(s) delivering treatment (Roth & Fonagy, 2004).

4 Related pain treatment services

- 4.1 Other rehabilitation programmes, **Back School**, **Functional Restoration Programme** (FRP), and **Expert Patient Programme** (EPP) may use the same nomenclature of pain management and/or some of the same terminology to describe content. However, these programmes do not use the full set of methods described in section 3, often serve a different population, and have produced less robust evidence for efficacy (European Guidelines, 2004).

- 4.1.1 **Back School** is a form of physical therapy intervention offered to some patients with acute, recurrent or persistent low back pain and delivered in groups. Education on proper back care, usually with an exercise regimen, aims to reduce pain and related problems and to restore function. The content of Back Schools has diversified recently (Heymans et al., 2005)

There is moderate evidence from randomised controlled trials, in an occupational setting, for people with recurrent and persistent low back pain, that Back Schools reduce pain and improve function and work status in the short and intermediate term (Cohen et al., 1994; Heymans et al., 2005) compared to exercise alone, manipulation, advice, placebo or waiting list control.

- 4.1.2 **Functional Restoration Programme** (FRP) is a term commonly used to describe a physical intervention for patients disabled by persistent pain, and which is delivered in groups. It takes a physical therapy or sports medicine approach, with the main aim of restoring physical function through targeted increases in physical performance. It is often based within orthopaedic or physiotherapy services; it may use cognitive and behavioural principles but usually without the direct involvement of a clinical psychologist or cognitive behavioural therapist (Frost et al., 1995).

Evidence from a small number of randomised controlled trials (Frost et al., 1995; Bendix et al., 2000) indicates lasting benefits in mobility and overall function.

- 4.1.3 An **Expert Patients Programme** (EPP) is a community-based self-management programme for people with long term health conditions, including persistent pain, and conducted to a protocol by trained leaders, typically themselves with long term health conditions. The EPP is usually run over a six week period (NHS Expert Patients Programme, 2002; Singh, 2005).

The only UK randomised controlled trial showed changes in confidence and energy, but not in health care use, over 6 months (Kennedy et al. 2007). Uncontrolled studies, mainly from the USA, largely describe people with rheumatoid arthritis who show high satisfaction but rather modest gains in function and reduced health care use (<http://patienteducation.stanford.edu/programs/>; Lorig et al., 2000).

- 4.2 **Return to Work** programmes (directed at people with persistent pain) vary widely, from individualised case management which might incorporate physical and psychological intervention, to a physical and psychological rehabilitative programme aiming to return people to their previous work. Single studies show efficacy (Watson et al., 2004).

Condition Management Programmes are planned as an extension of the Pathways to Work pilot schemes jointly administered by Jobcentre Plus and the NHS. It is envisaged that Condition Management Programmes will be delivered primarily by the private and voluntary sectors with payment by results (<http://www.dwp.gov.uk/medical/>).

- 4.3 UK provision for people with persistent pain incorporates combinations of the interventions described above, or elements of PMPs as described in section 3. Many of these interventions have originated in physiotherapy services, to which at least 90% of people with persistent pain are referred at least once (CSAG, 2000; Dr Foster, 2003), and use behavioural principles and often cognitive principles to achieve behaviour change. Evaluation of efficacy for patients with specified problems, and of cost-effectiveness, will establish whether these aims have been met: so far, randomised controlled trials show satisfactory gains compared to 'treatment as usual' for those with sub-acute rather than persistent pain, and for those with mild to moderate levels of disability (Hay et al., 2005), but these gains are often less evident at long-term follow-up.

5 Patient referral and selection

- 5.1 Historically, patients have been referred to a PMP only when many other treatments have failed. This is illogical: it is now recognised that this treatment should be offered when indicated by persistent pain causing distress, disability, and a negative impact on quality of life.
- 5.2 The delays and disappointments inherent in serial treatment by medical and physical methods, eventually followed by a PMP, are not in patients' best interests. Pain management components should be offered alongside the treatments intended to abolish or reduce the pain. Initial results on the efficacy of combining pain management methods with disease management in cancer, osteoarthritis and rheumatoid arthritis (Keefe et al., 2004) are encouraging.
- 5.3 The optimal timing of a PMP in relation to other treatment will vary in individual patients but will always entail careful discussion between patient and therapist/s.
- 5.4 Any persistent pain may be accessible to pain management methods. Although most people attending PMPs have musculoskeletal pain, a minority have visceral, neuropathic, phantom, or central pain, and/or pain from identified disease such as osteoarthritis and rheumatoid arthritis. For headache, there is a better chance of identifying and reducing stressors which precipitate it, thus reducing pain incidence and severity, so attention to these stressors is crucial and stress management forms a large part of headache management (Martin, 1993).
- 5.5 Patients are referred from primary care and secondary care specialists (orthopaedic surgeons and rheumatologists in particular). In either case, referral may be initiated at the request of the patient him/herself to GP or specialist. Most patients will have received specialist care.
- 5.6 Assessment for inclusion in a PMP should include appropriate medical screening to exclude treatable disease, to discuss treatment options or the lack of them, and to introduce the concepts of persistent pain and pain management if this has not already been done. This may be done in primary or specialist settings, according to expertise.

- 5.7 Assessment for a PMP is made by one or more members of the clinical staff, possibly the whole team, in relation to inclusion and exclusion criteria, to arrive at a clinical judgement about the extent to which the PMP can address the individual's needs, and to agree the proposed plan.
- 5.8 Because it is important that they have accurate expectations of the treatment, it is helpful to give potential participants written information about the nature and scope of the proposed treatment.
- 5.9 Common inclusion criteria:
- Presence of persistent pain causing significant disability and/or distress;
 - The patient is able to communicate in the language in which the PMP is conducted; a trained independent interpreter may facilitate successful participation;
 - The patient is willing to participate in a group.
- 5.10 Common exclusion criteria:
- The patient has a limited life expectancy or rapidly deteriorating disease or condition.
 - Psychosis and severe cognitive impairment are contraindications.
- 5.11 There are some obstacles which mean that the person is not usually suitable for PMP until they have been resolved:
- Primary drug or alcohol problems;
 - Psychological or psychiatric problems which require urgent attention, or which preclude the use of cognitive and behavioural methods in a group;
 - Severe disability such that the basic requirements of attending treatment exceed the patient's current capacity. This depends in

part on the physical characteristics of the treatment setting and access to it.

5.12 There are other issues which have been treated as obstacles but for which there is no evidence that alone they render treatment unsuitable:

- Age: there is no evidence that older patients are any less able to benefit from pain management programmes;
- Written and spoken English are poor;
- Ongoing litigation may place patients in a dilemma in that improved function will reduce their anticipated compensation. Patients receiving welfare benefits which depend on poor function are often in a similar position. Evidence is inconsistent on whether this affects outcome adversely;
- The individual is judged to be poorly motivated. It is important that potential participants receive an adequate explanation of the aims of the programme in relation to their pain-related problems. Clinician judgements of 'motivation' are most likely to exclude already disadvantaged patients.

6 Resources

- 6.1 PMPs should be properly resourced with time, personnel, and facilities. Efficacy has been demonstrated for the entire package, rather than for specific components, so reduction of any of these may adversely affect outcome. Pressure to treat the maximum number of patients for minimum outlay is likely to result in an intervention of low to negligible efficacy. Behavioural interventions, like drugs, can be diluted until they are no longer effective. This can demoralise both patients and staff. Serious consideration needs to be given to the utility of poorly resourced PMPs and to honest evaluation of their results across the range of intended outcomes.

Time

- 6.2 Shortening a programme may reduce its efficacy or render it ineffective (see sections 3.4 to 3.6)
- 6.3 A crucial principle of pain management programmes is interdisciplinary work, close teamwork between diverse professionals who together have the necessary skills and competencies to provide the assessment and programme content. In this context, the combined competencies of the team are as important as individual qualifications.

Personnel

- 6.4 Competencies can be described as core and specific:
- Core competencies relate to the knowledge and skills required to be part of a multidisciplinary team and to deliver cognitive behavioural therapy in a group environment. These are transferable, in that all members of the team should be able to provide these effectively;
 - Specific competencies are the knowledge base and specific skills with which specialist training equips the individual. These are not transferable.

Core staff

- 6.5 A pain management programme should not be delivered without input from a medically qualified person. This will normally be a consultant with sessions in a pain clinic, but the role can be filled by any medical specialist, such as GP, neurologist, or rheumatologist, with appropriate training.
- The rationale is that medical personnel are needed to exclude cases where definitive treatment is more appropriate (in particular where there are “red flags”: Waddell, 2004), and to add credibility and validity of the PMP from the perspective of patients and referrers (usually doctors).
 - Their role is in assessment, management of medical needs of patients, and in patient and staff education and training.
- 6.6. Chartered clinical psychologist or BABCP¹ -registered cognitive behavioural therapist with appropriate training and supervision.
- The rationale is that the cognitive behavioural elements fundamental to the delivery of PMPs require high levels of competence in providing an effective service to patients and in training and supervising staff not formally trained in psychological techniques.
 - Their role is in assessment, implementation of psychological principles, CBT, staff education, training, and supervision.
 - The lead psychologist must have adequate training in cognitive and behavioural techniques in psychological and physical health problems, and experience of group work.
- 6.7 Physiotherapist (State Registered). Standards of practice for work in pain management programmes are described on www.ppaonline.co.uk/standards.html.
- The rationale is that physical reactivation is a crucial part of the programme, requiring the expertise of a physiotherapist.

¹ British Association for Behavioural and Cognitive Psychotherapy: www.babcp.org.uk

- Their role is in patient education, design and implementation of exercise, stretch, and activity increases, in analysis of physical difficulties and limitations of patients, and in assessment.

Other clinical staff

- 6.8 A number of other health professionals have skills which are extremely useful for the delivery of PMPs and may bring added value.
- 6.9 Occupational therapist, whose training includes many relevant aspects and whose role covers group work, goal setting, planning and pacing a return to activities, retraining and return to work. Occupational therapist training requirements for work in PMPs are described on www.notpa.org.uk/.
- 6.10 Nurse, whose role may include medication review, rationalisation and reduction when agreed; health advice and information; and liaison with the patient's family and other agencies, such as primary care practitioner, pharmacist, etc. Recommendations for nursing practice in pain services, including in pain management, are described within www.britishtpainsociety.org/pdf/nurse_doc.pdf.
- 6.11 Pharmacist, whose role includes education and planning of medication adjustment.
- 6.12 Assistant psychologists can have an important role, for example, in data collection and analysis, and in implementing graded exposure programmes.

Non-clinical staff

- 6.13 Administrative/secretarial staff. A pain management programme needs secretarial and administrative support appropriate to its organisational needs. This will entail liaison activities, the organisation of assessments and of sessions; collation and distribution of assessments and discharge summaries; correspondence; and assistance with the production of course materials.
- 6.14 Graduate patient whose role includes patient education and serving as a role model for patients.

- 6.15 It is crucial that PMPs evaluate their outcomes (see 3.10 and 3.11) and audit their work: this requires personnel for distribution and collection of assessment materials and data entry. Such skills are often provided by assistant psychologists.

Leadership

- 6.16 Leadership within local management structures and in the daily running of the team and programme is crucial. The discipline or title of the leader/s is less important than their identification and recognition of these roles. Consideration should be given to professional and clinical support and supervision for the post-holder/s.
- 6.17 Most NHS staff are accustomed to management hierarchies within their discipline. True interdisciplinary teams require cross-discipline management structures.

Team Working

- 6.18 The coexistence of staff with a shared purpose does not make a team. Working together as a team requires time to meet and arrive at shared understandings of patients' needs and staff provision. Team members also need to appreciate one another's areas of unique and shared expertise.
- 6.19 All staff can benefit from discussion with the clinical psychologist or equivalent on the application of cognitive and behavioural principles to their area of work.

Training

- 6.20 There is currently no recognised pain management training in the UK or elsewhere directly relevant to PMP work. Staff bring generic and specific skills from professional training and learn from peers in the pain management field and from published accounts. Acquiring skills in pain management is an issue for all staff of PMPs. It is a mistake to think that generic single discipline training is sufficient for transfer to the needs of an effective cognitive behavioural intervention.
- 6.21 There is an urgent need for high quality theoretical and practical training courses of various lengths and depths in the application of CBT to persistent pain problems. Appropriate areas of knowledge and skill are set out in the IASP core curriculum (<http://www.iasp-pain.org>).

Continuing Professional Development

- 6.22 All staff working as part of an interdisciplinary PMP should have adequate access to continued within-discipline education and development specific to the area of pain, as well as to their own broader areas of professional interest. This should entail attending relevant national meetings and special interest groups and networking with fellow professionals in PMPs outside their geographical area.

Start-up needs

- 6.23 When a PMP is established, several weeks' start-up time is required for the team to develop the programme content and procedures, to write patient materials, to develop links with referrers, and to complete other tasks which will allow them to run an effective programme from the outset
- 6.24 Meetings for clinical training and education within the staff team should be held at least every 2 months. On occasion, these may involve other staff involved in the treatment of pain patients, for mutual education and liaison.

Facilities

- 6.25 A PMP requires designated space suitable for its activities and where any necessary equipment can be accommodated, including:
- A disabled-friendly venue;
 - Access to public transport;
 - A room large enough for the group;
 - Adequate floor space for exercise and relaxation practice;
 - Availability of private area/s for individual discussion;
 - Easily accessible toilet facilities;
 - Refreshment facilities;
 - Office space.

- 6.26 PMPs are often delivered within hospitals or health centres, but alternative venues such as gyms or community centres are also suitable.
- 6.27 Accessibility is an important consideration. For current reimbursement policy see <http://www.dh.gov.uk/assetRoot/04/11/86/92/04118692.pdf>

7 References

Bendix T., Bendix A., Labriola M., Hæstrup C., Ebbenhøj N. (2000). Functional restoration versus outpatient physical training in chronic low back pain: a randomized comparative study. *Spine* 25, 2494–2500

British Pain Society www.britishpainsociety.org/

Clinical Standards Advisory Group (2000). *Services for Patients with Pain*. London: Department of Health.

Cochrane library www.thecochranelibrary.com or via www.nelh.nhs.uk/cochrane.asp.

Cohen J.E., Goel V., Frank J.W., Bombardier C., Peloso P., Guillemin S. (1994). Group interventions for people with low back pain: an overview of the literature. *Spine* 19, 1214–22.

Dr Foster (2003). *Your guide to better health. Adult chronic pain services in the UK*. London: Dr Foster & Pain Society. Available on www.britishpainsociety.org/

European Guidelines for the management of non-specific low back pain (2004) www.backpain europe.org/web/files/WC2_Guidelines.pdf

Frost H., Lamb C., Klaber-Moffett J., Fairbank J., Moser J.S. (1999). A fitness programme for patients with chronic low back pain: two year follow up of randomised controlled trial. *Pain* 7, 273 – 279.

Gatchel R.J. Okifuji A. (2006) Evidence-based scientific data documenting the treatment and cost-effectiveness of comprehensive pain programs for chronic nonmalignant pain. *Journal of Pain* 7, 779–798.

Guzmán J., Esmail R., Karjalainen K., Irvin E., Bombardier C. (2001). Multidisciplinary rehabilitation for chronic low back pain: systematic review. *British Medical Journal* 322, 511–516.

Hay E.M., Mullis R., Lewis M., Vohora K., Main C.J., Watson P., Dziedzic K.S., Sim J., Minns Lowe C., Croft P.R. (2005). Comparison of physical treatments versus a brief pain management programme for back pain in primary care: a randomised clinical trial in physiotherapy practice. *Lancet* 365, 2024–2030.

Hayden J.A., van Tulder M.W., Malmivaara A.V., Koes B.W. (2005) Meta-analysis: exercise therapy for nonspecific low back pain. *Annals of Internal Medicine* 142, 765–775.

Heymans M.W., van Tulder M.W., Esmail R., Bombardier C., Koes B.W. (2005) Back schools for non-specific low-back pain. The Cochrane Library, (Oxford), 2005, no. 1, (ID #CD000261)

Hoffman B.M., Papas R.K., Chatkoff D.K., Kerns R.D. (2007) Meta-analysis of psychological interventions for chronic low back pain. *Health Psychology* 26, 1-9.

Keefe F.J., Rumble M.E., Scipio C.D., Giordano L.A., Perri L.M. (2004). Psychological aspects of persistent pain: current state of the science. *Journal of Pain* 5, 195-211.

Kennedy A., Reeves D., Bower P., Lee V., Middleton E., Richardson G., Gardner C., Gately C., Rogers A. (2007). The effectiveness and cost effectiveness of a national lay-led self care support programme for patients with long-term conditions: a pragmatic randomised controlled trial. *Journal of Epidemiology & Community Health* 61, 254-261.

Koes, B. W., van Tulder, M. W., & Thomas, S. (2006) Diagnosis and treatment of low back pain. *British Medical Journal* 332, 1430-1434

Linton S.J. (2000). A review of psychological risk factors in back and neck pain. *Spine* 25, 1148-1156.

Linton S.J. (2005). Do psychological factors increase the risk for back pain in the general population in both a cross-sectional and prospective analysis? *European Journal of Pain* 9, 355-361.

Lorig K., Fries J.F., Gecht M.R. (2000). *The Arthritis Self-Help Book*. Cambridge, MA, Perseus Books.

Martin P.R. (1993). *Psychological management of chronic headaches*. New York, Guilford Press.

Morley S., Eccleston C., Williams A. (1999). Systematic review and meta-analysis of randomised controlled trials of cognitive behaviour therapy and behaviour therapy for chronic pain in adults, excluding headache. *Pain* 80, 1-13.

Morley S., Williams A.C.deC. (2002). Conducting and evaluating treatment outcome studies. In D.C. Turk & R. Gatchel (eds.), *Psychological Approaches to Pain Management: A Practitioners Handbook, 2nd Edition*. New York: Guilford Press, pp. 52-68.

NHS Expert Patients Programme (2002) *Self-management of long-term health conditions. A handbook for people with chronic disease*. Bull Publishing Company.

Nicholas MK (1992). Chronic pain. In PH Wilson (ed.), *Principles and practice of relapse prevention*. New York: Guilford Press (pp. 255-289).

Pincus T., Burton A.K., Vogel S., Field A.P. (2001). A systematic review of psychological factors as predictors of disability in prospective cohorts of low back pain. *Spine* 27, 109-120.

Roth A.D., Fonagy P. (2005). *What works for whom: a critical review of psychotherapy research, 2nd edition*. New York: Guilford Press.

Singh D. (2005). *Transforming chronic care: evidence for improving care for people with long term conditions*. University of Birmingham/HSMC/Surrey & Sussex PCT Alliance 2005.

Turk, D.C. (2002) Clinical effectiveness and cost-effectiveness of treatments for patients with chronic pain. *Clinical Journal of Pain* 18, 355-365.

Van Tulder M.W., Ostelo R., Vlaeyen J.W.S., Linton S.J., Morley S.J., Assendelft W.J. (2000). Behavioral treatment of for chronic low back pain: a systematic review within the framework of the Cochrane Back Review Group. *Spine* 25, 2688-2699.

Waddell G. (2004) *The Back Pain Revolution, 2nd edition*. London, Churchill Livingstone.

Watson P.J., Booker C.K., Moores L., Main C.J. (2004). Returning the chronically unemployed with low back pain to employment. *European Journal of Pain* 8, 359-369.

Williams A.C.de C., Richardson P.H., Nicholas M.K., Pither C., Harding V.R., Ridout K.L., Ralphs J.A., Richardson I.H., Justins D.M., Chamberlain J.H. (1996). Inpatient vs outpatient pain management: results of a randomised controlled trial. *Pain* 66, 13-22.

Williams A.C.de C., Nicholas M.K., Richardson P.H., Pither C.E., Fernandes J. (1999) Generalizing from a controlled trial: the effects of patient preference versus randomization on the outcome of inpatient versus outpatient chronic pain management. *Pain* 83, 57-65.

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Thank you to all those who responded to the consultation.

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