



The Sussex Network of Pain Management Services (SNAPS) Comparing pain management programmes across four teams

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INTRODUCTION

On 12th May 2011 four pain management teams across Sussex met to share good practice and plan future developments. Representatives from clinical psychology, physiotherapy, occupational therapy, nursing and medicine were present. At this inaugural meeting, we chose as our title the Sussex Network of Advanced Pain Management Services. Pain Management Programmes have an excellent evidence base supporting their efficacy (Gatchel & Okifuji, 2006; Guzmán et al., 2001; Hoffman et al., 2007) and various guidelines recommending their use for restoration of physical functioning and quality of life for people with chronic pain (British Pain Society, 2007; National Institute of Clinical Excellence (NICE), 2009). As we opened our inaugural meeting, many of us were busy gathering information for the current National Pain Audit (Dr Foster and British Pain Society). In a similar spirit we wished to collate information about our respective services in order to inform service development.

METHOD

At our inaugural meeting, each team made a formal presentation which included information on their organisational context, referral criteria, PMP content and structure, staffing, activity levels and outcomes measures used for the financial year 2010-2011. Teams also shared PMP documentation given to patients and referrers. After the meeting, data was collated in an Excel database and further clarification was gained through follow-up emails and telephone calls.

RESULTS

Funding and organisational structure

All PMPs were coordinated by a psychologist employed by a mental health trust, which was commissioned by the acute hospital trust to provide a service to their patients with chronic pain. Funding streams differed across the four teams. Some were linked into the acute hospital's payment by results system, whereas others had a single budget. In some teams clear service level agreements between the commissioning trust and the mental health trust had been negotiated, whereas in at least one team expectations as to clinical activity and funding streams remained unclear. Professional and operational management structures were complex as all psychologists received professional management and clinical supervision through their employing mental health trust, whereas operational issues were largely influenced by policies and management structures within the acute hospital trust. Other members of the MDT such as physiotherapists, occupational therapists and pain nurses were contracted to provide a service to the PMPs in a variety of ways.

Referral criteria

While all teams broadly followed British Pain Society (2007) guidelines as a minimum, one team had further criteria regarding patients' motivation to change and continuing involvement in medical investigations.

PMP Structure

PMP session length: Length of PMPs varied considerably between sites, with the longest programme (Team C 41.25 hours) being 33% longer than the shortest (Team A 27.5 hrs). Number of sessions and amount of follow-up was also different. All programmes offered a 6 week follow-up, but two teams (B & D) also organised 6 and 12 month follow-ups.

Content: All PMPs followed a similar format with a largely cognitive behavioural slant mirroring the emerging consensus on PMP content outlined by Torrance et al., (2011). Some of our programmes were influenced by Acceptance and Commitment Therapy approaches to pain management

Table 1: PMP session length and activity

Team	Number PMPs	Number patients	Number sessions	Waiting times (wks)	Follow-up sessions	Total sessions	Total hours per PMP*	Total hours per year all PMPs
Team A	3	38	10	27	1	11	27.5	82.5
Team B	3	37	10	15	1	11	30.25	90.75
Team C	5	45	12	not recorded	3	15	41.25	206.25
Team D	3	26	7	16	3	10	30	90
MEAN	3.5	36.5	9.75	19	2	11.75	32.25	117.36

*Excluding breaks

Additional input to PMP

Pre-PMP preparation groups: After a psychology assessment patients in Teams A & B were offered a 2.5 hour 'Pain Foundation Course'. In Team D all patients at referral were offered a one-hour information group session.

Alternative groups to PMP: Team D offered a 16-hour mindfulness group and Team B a 20 hour fibromyalgia group. In Team C no additional groups were offered but five, rather than 3 PMPs were offered per year and assessments were longer than the other sites. Team A also had a service-user led follow-up support group.

Individual therapy: All teams offered one-to-one therapy, normally averaging 8 sessions.

Referrals

Across the four teams 665 referrals were received 2010-2011. The mean number of referrals per year was 175, with teams ranging from 106 to 275 referrals. All PMPs required a referral from a secondary care clinician located within the acute hospital.

Waiting times

Waiting times varied with Team B displaying the shortest wait (15 weeks) and Team A the longest (27 weeks).

Accommodation & Staffing

Accommodation availability and quality varied greatly. All PMPs were staffed by a minimum of one psychologist and a physiotherapist. Team C and Team B had regular input from an OT, whereas Team D and Team A had a pain nurse. Staff to patient ratios varied widely. It was notable that the best-resourced team offered more, and longer PMPs.

Evaluation methods

The most popular self report measures were the HADs, and Roland & Morris. All teams administered outcome measures pre and post-treatment. Some also evaluated patient progress at follow-up.

Table 2: Measures used

	Mood		General health	Pain specific measures				Physical measures		
	HADs	BDI/BAI		PCS	R&M	BPI	PSEQ	2 min walk	5 Sit to stands	Arm circling
Team A	x		x		x			x	x	
Team B	x		x					x	x	
Team C		x		x	x		x			
Team D	x			x	x	x	x	x	x	x
TOTALS	3	1	2	2	3	1	2	3	3	1

HADs – Hospital Anxiety Depression Scale. BDI/BAI – Beck Depression/Anxiety Scale. SF36- Health Survey. PCS-Pain Catastrophising scale. R&M – Roland & Morris Disability Questionnaire. BPI- Brief Pain Inventory. PSEQ – Pain Self-Efficacy Questionnaire.

DISCUSSION

Strengths

- Variety of interventions offered: Dr Foster (2003) pointed out that 58% of acute hospitals do not provide PMPs and 33% do not provide individual psychological therapy. In the Sussex area we can therefore be said to be relatively well-resourced in comparison to other parts of the country. Also, as teams have developed relatively independently a range of solutions have emerged to meet the challenges of their unique contexts.
- Audit: The Dr Foster (2003) report pointed out 30% of pain management clinics do not collect routine outcome data and of those who do, very few make it available within the hospital. However, all our teams collected routine outcome measures and therefore are well placed to develop their research agenda further and potentially engage in practise-based evidence studies

- Meeting BPS (2007) guidelines: All teams exceeded minimum guidelines on core staffing and all programmes, fell within the recommended 25-30 hours. While there was a high degree of uniformity in referral criteria, there was one exception (Team D). This team had a significantly lower staff to patient ratio and more stringent inclusion criteria may have evolved as a way of managing waiting times.
- Professional leadership and networks within mental health trust: All psychologists were employed by the same mental health trust which provides clinical supervision and professional leadership. This facilitated communication across sites and provided support to teams that might otherwise be operating in isolation.

Weaknesses

- Resources: In most teams ability to meet clinical demand was hampered by access to suitable accommodation. As Dr Foster (2003) highlighted, pain management has often not been recognised as a distinct specialty within hospitals and facilities are often shared with other departments, and as a result they are often "cramped", crowded" and "inadequate"
- Variable opportunities for informal MDT working: The potential for MDT working was in some cases limited by staff availability (especially where staff were employed part time) and accommodation.
- Waiting times: In some teams waiting times approached a year. One aim of brief pre-PMP groups was to divert patients with lower levels of distress from the PMP, so reducing the number of people waiting for a PMP. While this was only partially effective, the pre PMP groups have been successful in providing an initial intervention more quickly.
- Outcome measures: Our teams use 11 different measures with none achieving consensus. Furthermore, currently half of our teams do not measure the domain of cognitive appraisals/coping/self-efficacy, which is widely considered to be both a crucial mediating factor (Turner et al., 2007) and highly sensitive to change in PMPs. Finding a consensus would enable teams to combine and compare data more usefully.

Opportunities

- Pooling and automating data collection to facilitate future practise-based research projects: Functions of this would include facilitation of practice-based evidence research (Barkham & Mellor Clark, 2003), and demonstration of our added value to commissioners.
- Investigate optimal session length of PMPs: consideration of alternatives to face to face contact and alternative groups to PMPs (such as pain condition specific groups, for which there is some evidence (Scascighini et al., 2008))
- Investigate the effect of brief pre-PMP groups on patient outcome and on referral numbers to PMPs
- Investigate methods of reducing waiting times: As some of our teams are facing long waiting times, it is arguable that experimenting with larger groups sizes, or narrowing referral criteria may succeed in cutting waiting times but denies recommendations by the BPS.

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