



**FACULTY OF PAIN MEDICINE**  
of the Royal College of Anaesthetists

**Early pre-screening for  
complex/problematic pain:  
Stakeholder engagement**

## Executive summary

This document identifies why early screening and management is important to help reduce the burden of pain; it outlines a process for early pre-screening. The aim is to develop consensus around the use of a brief tool that is extremely quick to use and can help with decisions about whether further screening, assessment and early management (including possible referrals) is necessary. It may prompt clinicians to introduce the Initial Assessment and Management Map of Medicine Pathway.

Although a number of individuals had been working on early pre-screening using terms such as ‘problematic pain’ or ‘pain non-coping’; the importance of the concept gained formal recognition following the English Pain Summit in 2011, and the Faculty of Pain Medicine adopted Recommendation A: *Clear standards and criteria must be agreed and implemented nationally for the identification, assessment and initial management of problematic pain.* This document presents information on the background and progress to date on the first part of this recommendation, which involves the identification of a ‘warning system’ to alert clinicians to the development of ‘problematic pain’.

Currently NHS services are reactive rather than proactive in managing people with pain. There is not enough emphasis on identifying those with acute pain who are at risk of developing chronicity (pain related disability) or people who have chronic pain and are not, or are no longer, coping with their pain. There have been anecdotal reports by a number of community based pain specialists that the acute and chronic pain definitions, with the emphasis on temporal characteristics, are not really helpful in practice. Also, there is a lack of clarity for those professionals who are not pain specialists,

about when and which screening tools should be used. There is also resistance, due to work pressures, to screen all people in pain visiting a health professional.

Pain is very common and much of it is complex; it can cause wide ranging biopsychosocial issues that are often unrecognised and unaddressed. However, there are many strategies available that can prevent many of the biopsychosocial issues, many of which are best/most effective when implemented early. Therefore, we need to, if possible, detect the potential of /or presence of these issues, as early as possible with a view to preventing them or minimising their impact. In supporting this agenda, we have undertaken a survey of GPs to ascertain their opinions regarding the idea of early pre-screening in primary care and the results for those that responded are, in the main very positive.

## Foreword

Pain is notoriously difficult to manage and creates an enormous burden across many domains not least for the patient and for those faced with the management of pain in the clinical arenas where it initially presents. Correct assessment in terms of identifying early pain problems which are unlikely to resolve, or persistent pain problems which are becoming disabling and overwhelming is however critical.

Such pain has been variably described with names including problematic and complex. Consensus has moved us to calling such pain complex.

This tool is to guide assessment of the initial presentation in identifying patients from both of those cohorts. The selection of patients whose pain is unresponsive to initial measures, and clearly complex or intractable allows them to be progressed to further screening, assessment, early proactive advice and management, and referred onwards where appropriate.

‘The right patient to the right health professional in a timely way – this is where we are headed.’

Dr Kate Grady

Dean of the Faculty of Pain Medicine of the Royal College of Anaesthetists

## Contents

Executive summary.....	2
Foreword.....	4
1. Introduction.....	6
1.1 Rationale .....	8
2. The burden of pain.....	11
3. Pre-screening, early recognition and management .....	15
3.1 Examples of early and brief screening tools .....	19
3.1.1. Brief screening/assessment for primary care prescribers of opioids .....	19
3.1.2 A brief psychosocial screening interview .....	20
4. Scoping Problematic/Complex pain .....	21
5. Early pre-screening in practice .....	24
6. RCGP GP survey .....	28
7. Pre-screening ‘toolkit’ .....	31
8. Audit tool .....	32
9. Actions .....	33
10. References.....	34
Appendix One: Response form.....	38
Appendix Two: Contributors .....	40
Appendix 3: The STOP! Chronic Back Pain Project.....	41

## 1. Introduction

This document identifies why early screening and management is important to help reduce the burden of pain. It outlines a process for early pre-screening; we are inviting comment from people with pain, those who care for people with pain, health carers and professionals (both pain specialists and others). The aim is to develop consensus around the use of a brief tool that is extremely quick to use and can help with decisions about whether further screening, assessment and early management (including possible referrals) is necessary. It may prompt clinicians to introduce the Initial Assessment and Management Map of Medicine Pathway (Taylor et al 2012). Although initially the term ‘problematic pain’ was used, there has been some debate around whether an alternative term would be more acceptable and others have been suggested (this will be addressed later in the document). For the purpose of this scoping document, problematic/complex pain will be used but part of the stakeholder engagement will be to decide upon the most appropriate term to use.

*Stakeholder engagement: while we are interested in all comments from the stakeholder groups, we specifically would like your thoughts on key items within this document; we have signposted these as identified here and have included a feedback form to collate specific and general comments.*

Although a number of individuals had been working on early pre-screening using terms such as ‘problematic pain’ or ‘pain non-coping’; the importance of the concept gained formal recognition following the English Pain Summit in 2011, and the Faculty of Pain Medicine adopted Recommendation A: *Clear standards and criteria must be agreed and implemented nationally for the identification, assessment and initial management of problematic pain.* This document presents information on the background and progress to date on the first part of this recommendation, which involves the identification of a ‘warning system’ to alert clinicians to the development of ‘problematic pain’.

Currently NHS services are reactive rather than proactive in managing people with pain. There is not enough emphasis on identifying those with acute pain who are at risk of developing chronicity (pain related disability) or people who have chronic pain and are not, or are no longer, coping with their pain. The STOP! Chronic Back Pain Project identified a lack of preventative programmes being available around the country, despite knowledge that early intervention prevents the onset of chronicity and invalidism (Das et al. personal communication). There have been anecdotal reports by a number of community based pain specialists that the acute and chronic pain definitions, with the emphasis on temporal characteristics, are not really helpful in practice. Also, there is a lack of clarity for those professionals who are not pain specialists, about when and which screening tools should be used. There is also resistance, due to work pressures, to screen all people in pain visiting a health professional.

A multiprofessional meeting was held on in April 2013 with the aim of planning the processes required and the participants needed to achieve a consensus statement for problematic/complex pain.

The aims include:

- To develop a consensus statement that defines ‘Problematic/Complex Pain’
- To develop a simple ‘early-use’ screening tool and also identify standardised, valid and reliable screening tools to address ‘at risk’ and ‘established persistent pain’ groups using one system, and delineate core primary care assessment tools.
- To prepare for NICE Quality Standards and/or Quality Outcome Framework (QOF) status and/or use of the Local Enhanced Schemes (LES)
- To develop a Read Code for problematic/complex pain
- To link into the potential development of ‘core standards’ of pain management for primary care
- To delineate how the Initial Assessment and Management Map of Medicine Pathway could be used following pre-screening
- To identify educational resources needed
- To help develop the e-learning Department of Health pain resources
- To identify future audit processes and research agendas

During the writing of this document, the FPM requested support from the RCGP in circulating a survey of GPs to ascertain their opinions regarding the use of a pre-screening tool to identify complex/problematic pain and the results are presented later in the document. This was deemed important before corporate engagement and then stakeholder engagement.

Given that this scoping document may be read by a range of people involved, those experiencing pain, those commissioning, running, referring to and establishing pain management services, and long term condition (LTC) and third sector organisations, an introduction to pain is provided with some key messages around why it is important to be far more proactive in managing pain.

Management of pain in this document will encompass pre-screening, screening, assessment and management and onward referral where necessary.

## **1.1 Rationale**

Work has been ongoing to refine and develop a pre-screening tool to alert clinicians to the fact that the person presenting with pain may have pain that is, or may become, complex/problematic. A number of reasons led to this work including the desire to intervene in the person's pain pathway sufficiently early enough to address and prevent chronicity and in the preparation of a Quality Standard/QoF/LES on pain management.

As presented in this document, pain is very common and much of it is complex; it can cause wide ranging biopsychosocial issues that are often unrecognised and unaddressed. However, there are many strategies available that can prevent many of the biopsychosocial issues, many of which are best/most effective when implemented early. Therefore, we need to, if possible, detect the potential

of, or presence of these issues, as early as possible with a view to preventing them or minimising their impact.

If a quality standard was introduced, it would require a register of patients coded in a way that entered patients onto the register, and then primary care health professionals would need to complete some form of action to address the standard. Simply entering people with ‘persistent’ or ‘chronic non-malignant’ pain onto such a register would be unhelpful for those who manage their pain without the need for regular healthcare input. It would also omit those who have acute pain and are at risk of developing chronicity. The already significant burden of pain is likely to increase, and primary care must be proactive in screening risk and managing established persistent pain. To capture both groups in one GP register, it was initially proposed that the term ‘problematic/complex pain’ be used.

It could be argued that all pain is problematic; however, not all those with acute pain will develop chronic pain and there are people with such pain who are successfully self-managing. In a healthcare system that requires the appropriate cost effective allocation of resource to the appropriate patient, the stratification of risk and need is essential if both incidence and prevalence of this condition is to be effectively managed.

Education about pain amongst clinicians needs to be improved (Ellis et al 2012). Anaesthesia is the only medical speciality that has recognised post graduate pain training in medicine. Other health care professionals experience inadequate pain education as an undergraduate and unless they choose to undertake pain training through a post graduate route there is no recognised training. While basic pain assessment and management appears to be taught at undergraduate level to most healthcare professionals, the time spent on this is short and many argue it is too brief to be meaningful (Briggs

et al 2011). A British Pain Society survey of 19 higher education institutions delivering 108 programmes found that pain education, despite its high prevalence and burden accounted for less than 1% of programme hours for some disciplines (Briggs et al 2011). The impact of this is that those at risk of the most severe disruption to their lives may go unrecognised and inadequately managed until it is too late for management to be effective. In response to this the Faculty of Pain Medicine and British Pain Society have sponsored the development of multiple e-learning modules through the e-learning for Health programme “e-pain” (<http://www.e-lfh.org.uk/projects/pain-management/>). However, improvements in pain education and knowledge will not happen quickly and yet it is imperative that people experiencing problematic/complex pain are recognised early, as outlined in the next section. Pre-screening can help to drive this imperative and it is hoped will lead to non-pain specialist clinicians wanting to learn more about pain.

## 2. The burden of pain

Pain can have a major impact on individuals and their families; it also exerts a major burden on health care and on society as a whole. It can also be a complex condition to manage. It appears that it is not just the physical pain itself that results in this complexity but the way in which the individual attends to the pain (Eccleston and Crombez 1999; Buck and Morley 2006), the meaning that the pain has for the individual (Richardson et al. 2006; Foster et al. 2010; Main et al. 2010) and the pain-related behaviours that ensue (Newton-John and Williams 2006; Henschke et al. 2010). Indeed chronic pain has been defined as ‘an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage’ (Merskey and Bogduk 1994).

Professionals and carers working within the field of pain are aware of such impacts and complexities. However, for many who do not work within pain management the significant burden that pain has is not realised. Despite an increased understanding of the factors contributing to the maintenance of pain and disability, there has been only a moderate improvement in treatment outcomes over the last decade (Croft 2000; van der Windt et al. 2008). Significantly interventions, including pharmacological and non-pharmacological treatments, have shown at best, only moderate effects in reducing pain and disability in those suffering with chronic low back pain; the largest group of chronic pain sufferers (Chou and Huffman 2007a,b). There is similarly limited evidence for surgery for pain - both in patients with mechanical and radicular back pain. This may have been the result of the duration of pain; the longer a person experiences problematic/complex pain, the more difficult it is to manage for a variety of reasons. This is why early recognition and management of problematic/complex pain is vitally important.

In recognition of the burden of pain to the NHS, it was announced in Westminster Parliament on 1st February 2012 that chronic pain should be viewed as a Long Term Condition (LTC) (Hansard 2012). The Welsh and Scottish Government had previously acknowledged pain as a long term condition in 2008.

People with chronic pain, not only have to suffer with the physical pain itself but frequently have other co-morbidities to manage such as depression, anxiety, physical dysfunction and social isolation which can make pain management even more complex (National Pain Audit, 2012).

- 16% of sufferers feel their chronic pain is so bad that they sometimes want to die (Chief Medical Officer's Report 2008)
- 29% of patients with chronic pain experience depression (Chief Medical Officer's Report 2008)
- The average quality of life score was 0.4 where 1.0 is perfect health; overall quality of life for people with chronic pain is very poor (National Pain Audit 2012)
- Sufferers are more likely to be anxious or depressed; 69% with severe pain reported this (Health Survey for England 2012)

In a recent meta-ethnography that qualitatively looked at patients' experiences of chronic pain a number of themes were identified around these experiences (Toye et al 2013). These included:

- struggling to hold onto sense of self but not wanting to give in,
- unpredictability of the present
- the future and the need to understand what is causing the pain.

There is also sufficient evidence to illustrate that pain exerts a huge economic burden to the NHS.

- 4,825 (some 20% of its respondents) reported visiting Emergency Departments in the previous 6 months to seek help for their pain (National Pain Audit 2012)
- It also reported that some 3,469 respondents had more than 3 visits to healthcare providers (National Pain Audit 2012).
- Primary care management of patients with chronic pain has been estimated to account for 4.6million appointments per year; this is equivalent to 793 whole time GPs at a cost of approx. £69 million (Belsey 2002).

It is also important to compare the impact of chronic pain as a LTC to other conditions (see Table 1).

Table 1: Chronic pain and other LTCs

Chronic pain	Other LTCs
14 million people live with chronic pain in England (National Pain Audit 2012)	An estimated 3 million patients are affected by COPD (Health Commission 2006)
Annually >5 million people in the UK develop chronic pain but only 2/3 will recover (National Pain Audit 2012)	Asthma affects between 3 and 5.4 million people per year (NICE 2013)
Patients with chronic pain are likely to use the NHS 5 times more frequently than patients who do not suffer chronic pain (National Pain Audit 2012)	2.6 million people are diagnosed with diabetes in the UK (Diabetes UK 2010)

Chronic pain also has a major impact on society as a whole as The Health Survey for England (2012) illustrated.

- Almost one in four people experiencing pain had prevented individuals from performing usual activities (including work) on at least 14 days in the previous three months
- Chronic pain had a major impact on employers, through absenteeism or the reduced working capacity of their employees with pain
- Although chronic pain was more prevalent in older people, one in six 16-34 year olds were affected

And the CMO's report (2008) stated that:

- 25% of pain sufferers lose their jobs because of pain

Strategies are needed at a governmental level to address the burden of pain. Part of any strategy to effect change in practice will involve clinical guidelines, reducing variation in healthcare provision and producing greater consensus amongst professionals (Woolfe et al 1999). Guidelines for pain are generally considered to reduce disability by ensuring that patients are more likely to receive proactive care (Waddell et al 2010, Institute for Clinical Systems Improvement 2009). The Chief Medical Officer of England's report (2008) specifically recommended model pathways to guide practitioners in the management of pain. It is therefore proposed that pre-screening, early risk

stratification, assessment and management is part of a clinical guideline incorporating the work outlined in this document, the Initial Assessment and Management British Pain Society Map of Medicine Pathway, the Welsh Map of Medicine Pathways on Community Pain Assessment and Management Service and Pain Management Primary Care Pathway and the new SIGN Guideline on Chronic Pain.

### 3. Pre-screening, early recognition and management

Given the above data, it is clear that much needs to be done, and done differently to reduce the impact and burden of pain. The impact and burden is going to grow worse as the population lives to an older age and with increasing obesity and inactivity. Therefore, the concept of early risk stratification leading to early assessment and management is desirable to people with pain, 'frontline' clinicians and commissioners/planners of services. Existing terms such as 'persistent', 'chronic', 'acute' and 'sub-acute' pain describes the chronology of pain but these do little to identify the risk or morbidity associated with pain. Most frontline clinicians will be familiar with the above temporal classifications however, there are no reliable data to indicate how many clinicians routinely offer diagnostic and prognostic assessment to acute or sub acute pain presentations (Health Survey for England 2012).

#### **Case study**

Following feedback from patients about referrals being delayed for pain management treatment, the STOP! Project Team piloted an early intervention programme to improve clinical effectiveness. Outcome data to date has indicated improved results when compared to local best practice likely to be due to the fact that patients were encouraged to learn pain management strategies earlier in their journey. Psychosocial factors which can lead to the development of problematic/complex pain were assessed and managed therapeutically to reduce their impact on the individual's pain (please see appendices for further information).

In the UK approximately a third of the population suffers from chronic pain (Health Survey for England 2012); however whilst there are reliable data to indicate the significant morbidity and healthcare usage associated with established chronic pain (Breivik et al 2006, Patel et al 2012, Torrance et al. 2010, Phillips 2011, Smith et al 2001) there is no reliable data on what proportion of

the chronic pain population do not have significant disability or distress or are self-managing. Blair et al (2001) have developed a tool to assess the level of expressed need in chronic pain populations.

By developing a system of early pre-screening using the concepts developed as part of the problematic/complex pain agenda, it may be possible to better identify pre-morbid chronic pain at an early (potentially preventable) stage, and also concentrate management strategies for those who have developed chronic pain and are most in need. There are two facets to consider:

- To help identify those at risk of chronicity while experiencing acute pain
- To help identify those with chronic pain who are struggling to manage it.

Much work has already been done in identifying risk factors for chronicity with many factors showing positive predictive value in this context (Kowal et al 2012, Gupta et al 2007, Ang et al 2010). Less is known about whether and in what degree these factors are modifiable in daily practice. However, there is evidence from musculoskeletal research that early intervention can be effective in the prevention of chronicity (Frank et al 1996, Linton 2002, Slater et al 2008, Gatchel et al 2003). Secondary or tertiary pain management clinics are uncommon places of referral for acute or sub-acute pain patients, as by definition, pain at that stage has yet to become chronic. The mean wait time for referral can be protracted for those with chronic problematic/complex pain (Lynch et al 2000, Boersma and Linton 2005). Therefore, in relation to both scenarios, better strategies need to exist to trigger further screening, assessment and early management to support non-pain specialists in preventing chronicity and in managing those with persistent pain until they are seen by pain specialists. Early identification may also reduce the multiple referrals to different specialists that is currently common practice.

Once pain has progressed to become chronic, the association with significant morbidity (in the form of distress and/or disability) has been well established (Boersma and Linton 2005, Linton 2005, Lopez-Martínez et al 2008, Turk and Okifuji 2002, Turner et al 2000). However, less is known about the population of patients who have chronic pain but do not suffer from significant distress and/or disability. Inferences can be made from existing data, which indicates there are substantial numbers of both people in chronic pain with major disability and distress, and those without major disability and distress (Smith et al 2001a,b). This leaves the frontline clinician with the difficulty of not only establishing whether or not the patient who is presenting with acute/sub-acute pain is at risk of chronicity, but whether or not those presenting with chronic pain require a more complex management plan for their condition.

It could be suggested that people being seen by a pain specialist are presenting with already diagnosed problematic/complex pain in terms of high pain intensity and associated disability, and/or distress. This cannot be said for all those people seeing clinicians in primary care, where it is the role of the practitioner to establish diagnosis, risk, and severity of, often multiple, co-morbid conditions to inform a future management plan. This is potentially a complex consultation, which is often led by a clinician with many generalist skills but who may be poorly equipped or supported to assess and manage such complex pain problems. Defining patients with chronic, acute or sub-acute pain in this setting therefore has little utility. Problematic/complex pain as a term therefore can reflect those at risk of chronicity, or those currently struggling to manage pain.

The concept of screening for chronicity was introduced in the 1990s in relation to back pain and saw the beginning of the Flag system; yellow, red, black, blue and orange flags (The New Zealand Guidelines Group 1997). Some specific tools have been developed assessing risk either for low back

pain or musculoskeletal pain, but unfortunately some of these are being inappropriately used for all pain. Existing screening tools include:

- The Orebro Musculoskeletal Pain Screening Questionnaire (OMPSQ)(Linton et al 1998, 2003, Dunstan et al 2005)
- The Low Back Pain Perception Scale (LBPPS) (Reis et al 2000)
- GP Prediction Rule (Jellema et al 2007)
- STarT Back Tool (Hill et al 2011)

The first three tools identified above are based upon a scoring system; the higher the score the more risk. The STarT Back tool, however, uses patients' scores to stratify individuals with back pain into low, medium and high risk of chronicity and thus relates to potential treatments. Initial work suggests the use of a stratified approach in primary care can have both increased health benefit and cost savings (Whitehurst et al 2012). There is also currently limited evidence that sub-grouping of low back pain into risk categories to guide decision-making can improve outcome (Brennan et al 2006). Anecdotally it has been found that STarT Back tool can improve the efficiency and utilisation of local health resources by reducing the need for referral in low risk categories but increasing proportionately the referral to more intensive services for those in high risk.

The use of screening tools can be unpopular and time consuming; however short screening tools have in some cases been shown to be as effective in identifying pathology as longer ones (Kroenke et al 2003) (two questions versus nine in the screening of depression). It is also possible that there is a role for ultra-short tools to help decide who needs more comprehensive screening with a previously validated tool (Arroll et al 2003). Anecdotally, it appears that screening tools that are easily accessible and used frequently often appeal to clinicians.

*Stakeholder engagement: On the feedback form, where indicated, please provide any examples of screening tools that you think may be useful to include in this document. Are the screening tools validated and/or have outcome data?*

### 3.1 Examples of early and brief screening tools

Primary care clinicians, and those practising in community settings, see the vast majority of people who present with pain and deliver the majority of pain management (Brevik et al 2006, Breuer et al 2010). In primary care, as in specialty pain management, those presenting with pain can benefit from systematic and consistent use of multidimensional assessment tools (Ashburn and Witkin 2012) and subsequent early proactive management. Use of screening and assessment can explicitly alert clinicians to significant biopsychosocial and co-morbid disorders before poor outcomes and treatment failures disappoint and frustrate patients, carers and providers. This can help inform management decisions.

#### 3.1.1. Brief screening/assessment for primary care prescribers of opioids

Von Korff et al have developed and validated a two-item pain intensity and interference scale (Washington State Agency Medical Directors’ Group 2010) specifically intended for use by primary care prescribers of opioids. Using two questions, it aims to assess the response to chronic opioid treatment in terms of pain intensity and physical function (Fig.1).

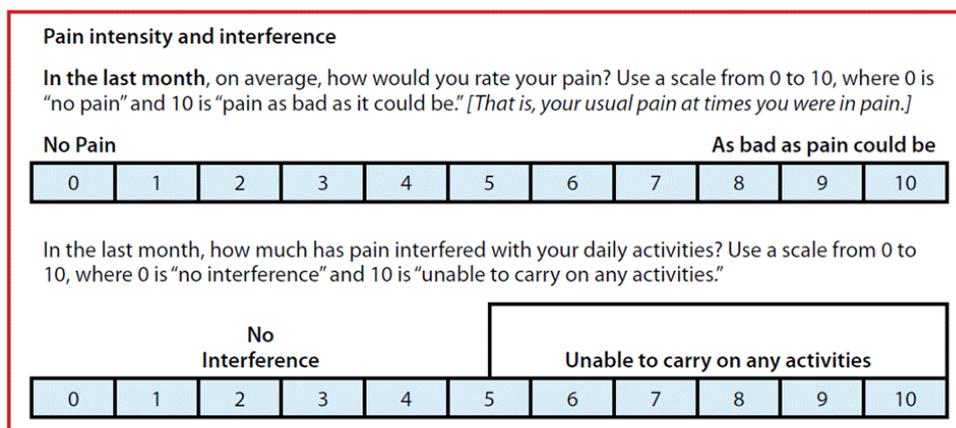


Fig.1. Two question pain intensity and interference measure

*Stakeholder engagement: Figure 1 has been included as it is a short assessment tool, it is validated for use in primary care and it contains a numerical rating score. We would be interested in your views of such a tool but specifically whether you feel a similar approach, regarding a numerical rating scale, would be useful for the pre-screening questions.*

### 3.1.2 A brief psychosocial screening interview

Dansie and Turk (2013) developed a tool to capture the salient psychosocial and behavioural issues that need to be explored when interviewing individuals with chronic pain. Again, this is a brief tool that can capture the factors that influence the subjective report of the characteristics of the pain. The tool can be best remembered by its acronym ‘ACT-UP’ (Activity, Coping, Think, Upset, People’s responses) (Fig.2.). However, ‘Coping’ may not be the best term and ‘self-managing’ may be more appropriate and in the ‘Activity’ work related issues are not mentioned. Pending the outcome of this screening interview, further, more detailed assessments can be conducted and/or the patient referred for specialist assessment and management.

1. Activities: how is your pain affecting your life (i.e. sleep, appetite, physical activities, and relationships)?
2. Coping: how do you deal/cope with your pain (what makes it better/worse)?
3. Think: do you think your pain will ever get better?
4. Upset: have you been feeling worried (anxious)/depressed (down, blue)?
5. People: how do people respond when you have pain?

Fig.2. ACT-UP

*Stakeholder engagement: Figure 2 has been included as it is a brief assessment tool to capture the salient psychosocial and behavioural aspects to cover in an interview with individuals who live with chronic pain. We would be interested in your views of such a tool.*

#### 4. Scoping Problematic/Complex pain

Developing a pre-screening tool for problematic/complex pain has its roots in the work that has been undertaken in depression (Arroll et al 2003). In this context, if the clinician considers depression may be present yet undiagnosed s/he asks the patient two questions:

- During the past month have you often been bothered by feeling down, depressed, or hopeless?
- During the past month have you often been bothered by little interest or pleasure in doing things?

In this study if a positive response was gained to either, the patient then completed a validated diagnostic tool to establish whether depression was present. This initial two-question screening tool showed high sensitivity and moderate specificity (97% and 67% respectively) against the validated depression screening tool. For a short consultation however it could be that the real utility of such a brief tool is to decide whether or not it is necessary to further assess a clinical problem in more depth.

Anecdotal reports from primary care practitioners are that they do not have the time to screen all patients presenting with pain and yet are not sure when to introduce screening for those patients whose pain is not resolving. Therefore, developing a pre-screening tool for pain would address this, as it has in screening for depression.

If the data from studies to establish risk of pain chronicity are evaluated closely, a picture starts to emerge from those risks that are frequently shown. Two large studies have reviewed risk for chronicity in detail (Mallen et al 2007, Linton 2000), and when the outcomes are combined, five key factors show strong prognostic validity:

- High pain intensity
- Longer pain duration
- High disability
- Distress (depression, anxiety and catastrophising)
- Multi-site pain

If problematic/complex pain is defined as ‘**Any pain associated with, or with the potential to cause, significant disability and/or distress**’, (defined at the initial scoping meeting), then when considering the outcomes bullet pointed above, these risks may help to formulate the questions to be asked of patients.

One omission, however, is multi-site pain; the research on risk factors to date has largely been in musculoskeletal and back pain where it is common to have multiple sites. However, as identified in the initial scoping meeting, there are many pain conditions that only affect one site e.g. pelvic pain, facial pain, etc, hence the exclusion of this outcome.

*Stakeholder engagement: on the feedback form please consider the definition of problematic/complex pain and provide your thoughts on it. Do you think it expresses what the authors are trying to capture in this document? Have you any modifications/suggestions you would like to include?*

In relationship to the definition and based largely on the work of Chris Barker, the initial scoping meeting representatives provided the following two questions for use as a pre-screening tool:

- ‘Over the past two weeks has pain been bad enough to interfere with your day to day activities?’
- ‘Over the past two weeks have you felt worried or low in mood because of this pain?’

Evaluating:

- |                                    |                              |
|------------------------------------|------------------------------|
| • Pain duration                    | ‘..past two weeks..’         |
| • Pain intensity                   | ‘..pain been bad enough..’   |
| • Level of pain related disability | ‘..day-to-day activities..’  |
| • Level of pain related distress   | ‘..worried or low in mood..’ |

In the initial scoping meeting and following informal discussions, a number of terms were suggested that could be used to address both acute and persistent pain and also signify that added help was required in terms of further screening and assessment and early management. Table 2 provides the terms that have been suggested. These are not tabled in any particular order or rank. To date, 'complex' has been the most acceptable term from a clinician's perspective.

Table 2: Suggested terms for the problematic/complex early pre-screening model

Chronic pain: it is just not about time	High Impact	Complex	Problematic	Pain requiring further help
Complicated	Bothersome	Profound	Refractory	Disabling
Unresolved	Debilitating	Intrusive	Complex and problematic	Devastating
Complicated	Bad	Horrible	Life-changing	Pain non-coping

Selecting a term may prove to be more difficult than describing the concept:

- 'High impact'
  - misses the point that the idea is to catch the pain before it becomes high impact
  - may even convey something positive and desirable. High impact factor journals....
  - conjures up sports people.
  - Pain that is not necessarily complex or indeed needing to be dealt with by specialists can still have a 'high' impact if for example it causes loss of an ability to work.
- 'Pain requiring further help" both rules out (severe) pain that is getting all the help it can get, and suggests that any 'help' should be external, discouraging self- help.
- 'Problematic'
  - seems to carry a judgement with it.
  - has too many problems including the connotation of 'problem patients'.
  - The worry is that people think that problematic will be used to describe the person, and causing problems for health services.....but this is not the case – the description is of the condition.
- 'Complex Pain'
  - may be confused with 'Complex Regional Pain Syndrome'
  - Not sure about the term complex, a cancer pain with nerve invasion and local nociceptive mechanisms could be considered complex
  - is close to 'complex patient' which is a term that it is too often used dualistically to mean 'psychosocial / non-medical'.
  - 'Complex' does not necessarily imply bad

- ‘Debilitating’
  - is associated with incapacity, in fact one definition suggested that the definition of debilitating is ‘to make legally incapable; disqualify’.
  - is too depressing and many patients would not understand it.
- Chronic- too tied into time-lines
- Terms, other than problematic or high impact, do not capture the impact on the patients and the huge biopscho-sexual, behavioural etc...

*Stakeholder engagement: On the feedback form please provide your thoughts on what term we should use. It is a term that can be coded so people in pain can be identified through the system of care. Please provide a brief rationale for your choice(s) and also identify terms that you have strong opinions against and again a rationale for why you would not like the term used.*

## 5. Early pre-screening in practice

The key objectives for pre-screening are:

- To move away from temporal definitions of pain
- To help identify those who are not able to or ready to use self-management
- To serve as an early trigger to the optimisation of self-management
- To promote early recognition and management of problematic/complex pain and the factors that are involved
- To act as a trigger for further assessment

Therefore, in practice, it is proposed that if people in pain visit their non-pain specialist clinician (mainly their GP, but can include Emergency Department visits, etc) more than once over a two week period and the pain is not resolving and/or the individual is unable to self-manage, then pre-screening is undertaken. If the person answers yes to either question, it should alert the clinician to undertake more in-depth risk assessment to establish if the pain is problematic/complex and at this stage, whether the pain is acute or persistent, self-management education is commenced. The subsequent steps are then outlined in the Initial Assessment and Management British Pain Society Map of Medicine Pathway.

The British Pain Society's (BPS') Initial Assessment and Management of Pain care pathway (one of five new BPS care pathways published by the Map of Medicine<sup>®</sup>) sets out how best to initially manage pain. This pathway focuses activities around self-management and self-care and recommends patient education from an early stage to support patients in making the best decisions. It leads on extremely well from pre-screening as the pathway assumes that a full diagnostic workup has not yet been completed.

The pathway embraces a generalist's approach grounded in best practice, and tries to support the clinician in terms of the language used in the consultation, the use of clinical decision management tools to aid stratification of care and measurement of therapeutic effect. The early identification of people at high risk of chronic disability should allow more intensive management i.e. specialist care provided by Pain Medicine specialists, better use of resources and reduction in disability. The pathway aims included:

- reducing variation in the initial management of any type of pain
- reducing the development of chronicity and associated disability in those presenting with an acutely painful condition
- recommending appropriate monitoring within a management plan.

The pathway draws upon the considerable body of evidence on identification and management of those at high risk of chronic disability and takes the non-specialist through a series of steps to ensure that pain is well managed alongside any ongoing investigations or treatments and, importantly, when pain appears to persist for no apparent reason. It can be applied to any type of pain and in any circumstance.

If pre-screening reveals that patients have problematic/complex pain, even at this early stage, tools should be offered to help self-management. This biopsychosocial assessment may require a number

of consultations with the clinician to fully assess the diagnostic aspects of the pain ('bio-'), and the aspects of risk, disability and distress ('-psychosocial'). Whilst this extended assessment is taking place it is essential to optimise an ongoing management plan, including education (with appropriate literature) and self-management. This should be independent of referral to a specialist. Following referral, wait time for specialist assessment can be protracted. It may be helpful for additional educational resources, not only for patients, but for their carers and their clinicians also. A recent report by the RCGP provides a valuable resource for LTC management: *Care Planning, Improving the Lives of People with Long Term Conditions* (2011) and The Year of Care Partnership information <http://healthandcare.dh.gov.uk/year-of-care/>.

It has not been established how much patients benefit from structured pain education. However, when extrapolating from other LTCs such as diabetes, alcohol dependency and the engagement in programmes such as the Self-Management UK, it is evident that a proportion are likely to benefit. However, those with problematic/complex pain may require a more significant investment; individualised care plans may be appropriate for these patients (Coulter et al 2006, Battersby et al 2010).

It is important to consider the use of language during the process of pre-screening and risk assessment. While metaphors can be useful in explaining pain (Gallagher et al 2013) it is important to avoid terms that are recognised as causing concern (Sloan and Walsh 2010). Enquiry into patient beliefs and expectations are fundamental to understanding why pain is problematic/complex. These often need some adjustment and the patient's myths and misconceptions addressed.

As already discussed, the Map of Medicine Initial Assessment and Management of Pain pathway reflects the above issues illustrating that assessment may be difficult because pain can be complex.

Coupled with this, patients may not present with pain itself but with its consequences such as employment issues, a threat to benefits, deteriorating mental health, or medication and / or treatment failure (Kendall et al 2009). This can make assessment extremely challenging.

In patients with problematic/complex pain, it is important to utilise the biopsychosocial model for both assessment and management. Once pre-screening has been completed and problematic/complex pain is diagnosed the pathway can aid the clinician in screening for risk and it provides a long list of recommendations of psychosocial interventions that may reduce disability, including a large section on self-management.

Biopsychosocial assessment facilitates a ‘patient centred’ consultation that can reveal undifferentiated problems and psychosocial issues. Other interventions in the pathway include ensuring a strong therapeutic alliance and shared decision making. If patients present with unresolving acute pain or with persistent pain that the patient no longer is able to cope with, it is important to check for a physical explanation for this but here is a risk that psychosocial factors are overlooked and unaddressed.

However the patient with problematic/complex pain is managed, follow up is extremely important and has been emphasised in the pathway. To aid this process, the pathway introduces the 4As mnemonic for robust clinical monitoring:

- Analgesia (pain relief)
- Activities of daily living (psychosocial functioning)
- Adverse effects (side effects)
- Aberrant drug taking (addiction-related outcomes).

*Stakeholder engagement: It would be really useful to have examples of models where early risk assessment, pain assessment and management has been achieved. Ideally pre-screening*

*could operate to facilitate entry to these models. Please provide, on the feedback form, a brief description of your model, website links if appropriate and 5 key outcomes and how these were measured.*

## 6. RCGP GP survey

A SurveyMonkey questionnaire was sent to all GPs in the UK via a link provided on the RCGP Chair's newsletter in April 2014. Participants were allowed 6 weeks to respond. The questionnaire was purposefully brief to improve participation. However, the 2 pre-screening questions may have been seen in isolation to a pathway of activity including moving on to biopsychosocial assessment and then management aligned to the BPS pathways. It is also acknowledged that this is a small sample of the total number of GPs. Questions with responses as follows.

*Currently NHS services can be reactive rather than proactive in managing people with pain. More emphasis could be placed upon a prognostic assessment identifying those with acute pain who are at risk of developing chronicity (pain related disability & distress), or people who have chronic pain and are struggling to cope with their pain.*

### 1. Do you agree with the above statement?

Yes/No

No	31
Yes	317

### 2. Do you think it reflects your practice?

Yes/No

No	140
Yes	202

*Strong evidence exists highlighting early appropriate management of pain can prevent chronicity. A brief pain pre-screening tool has been developed; it is designed to be quick to use and to help with*



**5. Do you think the two pre-screening questions are worded appropriately? Yes/No**

*If no, please indicate below how you would rework them:*

Use these as they stand 210

Use these subject to change 43

**5.a. Would you be willing to use these questions in your practice? Yes/No****5.b. Is there anything you would like to see added/amended? Yes/No**

Free text box for comments:

210 participants answered 'use these questions as they stand'

43 answered 'use these questions subject to change'

37 answered 'not use these screening questions at all'

And 58 did not respond to question 5.

Of the 43 that responded 'use these questions subject to change', 40 commented further.

Of the 37 who responded 'not use these screening questions at all', 25 commented further.

Key themes emerging from the comments provided for both options were very similar:

- Language and cultural barriers to questions
  - with a subtheme of adapting the wording (especially in regards to the second question and the word 'worried')
- Require further understanding of managing patients and their pain
  - Subthemes – lacking access to appropriate services, lack of knowledge/training in chronic pain (e.g. 'The issue is not detecting these patients but having appropriate mdt services with psychological input to refer to...we are increasingly being asked to identify conditions without services being available', 'I would really value some training in chronic pain from the RCGP')
- Require further understanding of the evidence-base for the 2Qs
  - including usefulness of the 2Q's
  - the suitability of the two-week timeframe
  - the preferable use of the holistic/narrative approach and open-ended questions
  - having an awareness of the 2Qs but using it as a guide and adapting format

The only difference in themes which emerged from the comments of those that answered 'not use these screening questions at all' seem to focus on:

- Lacking capacity and time to ask the 2Qs ('I think the questions are excellent. The issue is finding the time to be proactive!', 'We have enough to do without this sort of box ticking')

Thanks to Hannah Traynor (Psych Asst – Southport & Ormskirk NHS Trust) for Q5 thematic analysis

## 7. Pre-screening 'toolkit'

It was proposed at the scoping meeting to have a toolkit to support the introduction of the pre-screening concept, to raise awareness of the Initial Assessment and Management Pathway and to facilitate an early approach to risk assessment, pain assessment and management. This toolkit would be appropriate to primary care settings but should reflect that the concept can be introduced into a number of different settings such as emergency departments, outpatient departments and nursing and residential homes.

In a cost conscious NHS, it is important to build in mechanisms that lead to coding of those with problematic/complex pain so that their journey through the health care system can not only be tracked but also costed. This toolkit will define what tools could be used and at what time points they would be most beneficial. If this concept is to become a Quality Framework/QoF/LES, it is envisaged that the pre-screening would be the collectable data to be held on a register and GPs would gain points then for completing the risk assessment and stratification.

The toolkit was considered by the scoping group to include:

- Description of the process and how the 2 questions could be used to diagnose problematic/complex pain
- The Pain Toolkit as the self-management approach that is advocated to patients
- A pre-amble of why this concept is needed
- An evidence review of what is known about chronicity and how pre-screening and early risk identification would benefit patients
- A description of how it would benefit clinicians to encourage the use of this concept
- Tools for subsequent screening and assessment (after the pre-screening questions) including descriptions of the tools and how to use them
  - Numerical rating scale
  - EQ5D
  - Brief Pain Inventory
  - LANSS
  - STartBack (back pain only)
  - DoloTest
- Details on Read coding

- Examples to illustrate pre-screening, early identification of risk factors with subsequent early pain assessment and management both within primary care and other settings
- Shared decision making tools to support shared management planning
- Service evaluation tool
- Resources

*Stakeholder engagement: we would welcome your thoughts on whether a toolkit would be useful and if it would, what other points need including in the toolkit. From a health economist perspective, what tools would be useful and at what time points do you think that using such tools would have maximum impact in costing this approach? Please use the feedback form for your suggestions.*

## 8. Audit tool

It is clear that this is a new concept in the management of pain and therefore some data would be useful from the pilot sites that have agreed to trial the Ask2Questions tool. To support the pilot sites, the following may be useful.

- A pilot or service evaluation could be considered for a 4 week period in the first instance
- A simple email approach to reduce time burden on the GPs would be to ask once a week if they had used the Ask2Questions ‘Yes’, ‘No’.
- At the end of the 4 week period, follow up on a representative group from ‘Yes’ and ‘No’ with a surveymonkey:
  - Do you think that the concept of early pre-screening for complex/problematic pain is appropriate in your day-to-day practice? Yes/No
  - Did the questions help in defining those that needed further assessment? Yes/No
    - If ‘Yes’ what tools did you use to further assess the patient? Comment
  - Did the questions help in usefully assessing pain related disability and pain related distress? Yes/No

- Did the questions help in defining those that needed more intensive pain management? Yes/No
  - If 'Yes' what did the questions lead to in terms of management? Comment
- Do you think the two pre-screening questions are worded appropriately? Yes/No
- Is there anything you would like to see added/amended? Yes/No (Comments)

## 9. Actions

The following is being progressed:

1. Circulate for stakeholder engagement
  - a. In parallel, pilot pre-screening tool and potentially toolkit in a number of sites in the UK
    - i. Seek volunteers to pilot in primary care
  - b. Link with primary research groups to develop a grant proposal for a research agenda using the pilot data

## 10. References

- Ang DC, Bair MJ, Damush TM, et al. (2010). Predictors of pain outcomes in patients with chronic musculoskeletal pain co-morbid with depression: results from a randomised trial. *Pain Med* **11**: 482-491.
- Arroll B, Khin N, Kerse N. (2003). Screening for depression in primary care with two verbally asked questions: cross sectional study. *BMJ* **327**: 1144–1146.
- Ashburn MA, Witkin L. (2012). Integrating outcome data collection into the care of the patient with pain. *Pain* **153**:1549-50.
- Battersby M, Von Korff M, Schaefer J et al. (2010). Twelve evidence-based principles for implementing self-management support in primary care. *Jt Comm J Qual Patient Saf* **36**: 561-570.
- Belsey J. (2002). Primary care workload in the management of chronic pain: a retrospective cohort study using a GP database to identify resource implications for UK primary care. *J Med Economics* **5**: 39-50.
- Boersma K and Linton S. (2005). How does persistent pain develop? An analysis of the relationship between psychological variables, pain and function across stages of chronicity. *Behav Res Ther* **43**: 1495–1507.
- Breivik H, Collett B, Ventafridda V, et al. (2006). Survey of chronic pain in Europe: prevalence, impact on daily life, and treatment. *Eur J Pain* **10**: 287-333.
- Brennan GP, Fritz JM, Hunter SJ, et al. 2006). Identifying subgroups of patients with acute/sub-acute ‘nonspecific’ low back pain: results of a randomized clinical trial. *Spine* **31**: 623–631.
- Breuer B, Cruciani R, Portenoy RK. (2010). Pain management by primary care physicians, pain physicians, chiropractors, and acupuncturists: a national survey. *South Med J* **103**: 738-47.
- Bridges S. (2011). *Heath Survey for England 2011: Chronic Pain (Chapter 9)*. London: NHS Health and Social Care Information Centre.
- Briggs EV, Carr ECJ, Whittaker MS. (2011). Survey of undergraduate pain curricula for healthcare professionals in the United Kingdom. *Eur J Pain* **15**: 789-795.
- Buck R, and Morley S. (2006). A daily process design study of attentional pain control strategies in the self-management of cancer pain. *Eur J Pain* **10**: 385-398.
- Chou R, Huffman LH. (2007a). Medications for acute and chronic low back pain: a review of the evidence for an American Pain Society/American College of Physicians clinical practice guideline. *Ann Intern Med* **147**: 505-514.
- Chou R, Huffman LH. (2007b). Non-pharmacologic therapies for acute and chronic low back pain: a review of the evidence for an American Pain Society/American College of Physicians clinical practice guideline. *Ann Intern Med* **147**: 492-504.
- Coulter A, Ellins J. (2006). *Patient-Focused Interventions: a Review of the Evidence*. London: Health Foundation, 2006.
- Croft P. (2000). Is life becoming more of a pain? *BMJ* **320**:1552-1553.
- Dansie EJ, Turk DC. (2013). Assessment of patients with chronic pain. *Br J Anaesth* **111**:19-25.
- Diabetes UK. (2010). *Diabetes in the UK 2010: Key Statistics on Diabetes*. London: Diabetes UK.
- Donaldson L. (2008). *CMO’s 150<sup>th</sup> Annual Report, Pain: Breaking Through the Barrier*. London: The Stationary Office.
- Dunstan DA, Covic T, Tyson GA, et al. (2005). Does the OMPQ predict outcomes following a work related compensable injury? *Int J Rehabil Res* **28**: 369–370.
- Eccleston C, and Crombez G. (1999). Pain demands attention: a cognitive-affective model of the interruptive function of pain. *Psychol Bull* **125**: 356-366.
- Ellis B, Johnson M, Taylor AM. (2012). Education as part of wider health policy and improvement strategies. *BJPain* **6**: 54-58.

- Foster NE, Thomas E, Bishop A, Dunn KM, Main CJ. (2010). Distinctiveness of psychological obstacles to recovery in low back pain patients in primary care. *Pain* **148**: 398-406.
- Frank, JW, Kerr MS, Brooker A, et al. (1996). Disability resulting from occupational low back pain. Part 1: what do we know about primary prevention? A review of the scientific evidence on prevention before disability begins. *Spine***21**: 2908-2917.
- Gallagher L, McAuley J, Moseley GL. (2013). A randomized-controlled trial of using a book of metaphors to reconceptualize pain and decrease catastrophizing in people with chronic pain. *Clin J Pain* **29**: 20-5.
- Gatchel RJ, Polatin PB, Noe C, et al. (2003). Treatment- and cost-effectiveness of early intervention for acute low-back pain patients: a one-year prospective study. *J Occup Rehabil* **13**: 1-9.
- Gupta A, Sullivan AJ, Ray D, et al. (2007). The role of psychosocial factors in predicting the onset of chronic widespread pain: results from a prospective population based study. *Rheumatol (Oxford)* **46**: 666-671.
- Hansard HC. (2012). *House of Common's Debate*. London: Houses of Parliament.
- Healthcare Commission. (2006). *Clearing the Air: A National Study of Chronic Obstructive Pulmonary Disease*. London: Commission for Healthcare Audit and Inspection.
- Henschke N, Ostelo RW, van Tulder MW, et al. (2010). Behavioural treatment for chronic low-back pain. *Cochrane Database Syst Rev*: CD002014.
- Hill JC, Whitehurst DG, Lewis M, et al. (2011). Comparison of stratified primary care management for low back pain with current best practice (STarT Back): a randomised controlled trial. *Lancet* **378**: 1560-1571.
- Institute for Clinical Systems Improvement (ICSI). (2009). *Health Care Guideline: Assessment and Management of Chronic Pain*. Bloomington, MN: ICSI.
- Jellema P, Van der Windt DAWM, van der Horst HE, et al. (2007). Prediction of an unfavourable course of low back pain in general practice: comparison of four instruments. *Br J Gen Pract* **57**: 15-22.
- Kendall NA, Burton AK, Main CJ, et al. (2009). *Tackling Musculoskeletal Problems: a Guide for the Clinic and Workplace: Identifying Obstacles using the Psychosocial Flags Framework*. London: The Stationary Office.
- Kowal J, Wilson KG, McWilliams LA, et al. (2012). Self-perceived burden in chronic pain: relevance, prevalence and predictors. *Pain* **153**: 1735-1741.
- Kroenke K, Spitzer RL, Williams JB. (2003). The Patient Health Questionnaire-2: validity of a two-item depression screener. *Med Care* **41**: 1284-1292.
- Linton S. (2005). Do psychological factors increase the risk for back pain in the general population in both a cross-sectional and prospective analysis? *Eur J Pain* **9**: 355-361.
- Linton SJ, Boersma K. (2003). Early identification of patients at risk of developing a persistent back problem: the predictive validity of the Örebro Musculoskeletal Pain Questionnaire. *Clin J Pain* **19**: 80-86.
- Linton SJ, Hallden K. (1998). Can we screen for problematic back pain? A screening questionnaire for predicting outcome in acute and sub-acute back pain. *Clin J Pain* **3**: 209-215.
- Linton SJ. (2000). A review of psychological risk factors in back and neck pain. *Spine* **25**: 1148-1156.
- Linton SJ. (2002). Early identification and intervention in the prevention of musculoskeletal pain. *Am J Ind Med* **41**: 433-442.
- Lopez-Martínez A, Esteve-Zarazaga R and Ramirez-Maestre C. Perceived social support and coping responses are independent variables explaining pain adjustment among chronic pain patients. *J Pain* 2008; 9: 373-379.
- Lynch ME, Campbell F, Clark AJ, et al. (2008). A systematic review of the effect of waiting for treatment for chronic pain. *Pain* **136**: 97-116.

- Main CJ, Foster N, Buchbinder R. (2010). How important are back pain beliefs and expectations for satisfactory recovery from back pain? *Best Pract Res Clin Rheumatol* **24**: 205-217.
- Mallen CD, Peat G, Thomas E, et al. (2007). Prognostic factors for musculoskeletal pain in primary care: a systematic review. *Br J Gen Pract* **57**: 655-661.
- Merskey H, Bogduk N. (1994). *Pain terms: Classification of Chronic Pain*. Second ed. Seattle: International Association for the Study of Pain.
- National Institute for Health and Care Excellence (NICE). (2013). *Quality Statement 25: Quality Standard for Asthma*. London: National Institute for Health and Care Excellence.
- National Pain Audit. *National Pain Audit: Final Report*.  
<http://www.nationalpinaudit.org/media/files/NationalPainAudit-2012.pdf>. London 2010-2012.
- New Zealand Guidelines Group. (1997). *Guide to Assessing Psychosocial Yellow Flags in Acute Low Back Pain*. Wellington, New Zealand: New Zealand Guidelines Group.
- Newton-John TR, Williams AC. (2006). Chronic pain couples: perceived marital interactions and pain behaviours. *Pain* **123**:53-63.
- Patel AS, Farquharson R, Carroll D, et al. (2012). The impact and burden of chronic pain in the workplace: a qualitative systematic review. *Pain Pract* **12**: 578-589.
- Phillips C. (2011). *The Economics of Pain*. PainCommunityCentre.org.  
<http://paincommunitycentre.org/article/economics-pain> (accessed 10th December 2013).
- Reis S, Hermoni D, Borkan J, et al. (2000). *The RMBAM Israeli Sentinel Practice Network The LBP Patient Perception Scale: a New Predictor of Chronicity and Other Episode Outcomes Among Primary Care Patients*. Eilat, Israel: Abstract book, The Fourth International Forum for Primary Care Research on Low Back Pain.
- Richardson JC, Ong BN, Sim J. (2006). Remaking the future: contemplating a life with chronic widespread pain. *Chronic Illn* **2**: 209-218.
- Slater MA, Weickgenant AL, Greenberg MA, et al. (2009). Preventing progression to chronicity in first onset, subacute low back pain: an exploratory study. *Arch Phys Med Rehabil* **90**: 545-552.
- Sloan TJ, Walsh DA. (2010). Explanatory and diagnostic labels and perceived prognosis in chronic low back pain. *Spine* **35**: E1120-1125.
- Smith BH, Elliott AM, Chambers WA, et al. (2001a). The impact of chronic pain in the community. *Fam Pract* **18**: 292-299.
- Smith BH, Penny KI, Elliott AM, et al. (2001b) The Level of Expressed Need – a measure of help-seeking behaviour for chronic pain in the community. *Eur J Pain* **5**: 257-66.
- Taylor AM, et al. (2012). *Initial Assessments and Early Management of Pain*. London: The Map of Medicine and the British Pain Society.
- Torrance N, Elliott AM, Lee AJ, Smith BH. (2010). Severe chronic pain is associated with increased 10 year mortality. A cohort record linkage study. *Eur J Pain* **14**: 380-386.
- Toye F, Seers K, Carr E, et al. (2013). *An Adversarial Struggle to be Me*. NIHR Health Service and Delivery Research Programme, project number 09/2001/09.
- Turk DC and Okifuji A. (2002). Psychological factors in chronic pain: evolution and revolution. *J Consult Clin Psychol* **70**: 678-690.
- Turner JA, Jensen MP and Romano JM. (2000). Do beliefs, coping, and catastrophizing independently predict functioning in patients with chronic pain? *Pain* **85**: 115-125.
- van der Windt D, Hay E, Jellema P, Main C. (2008). Psychosocial interventions for low back pain in primary care: lessons learned from recent trials. *Spine (Phila Pa 1976)* **33**: 81-89.
- Waddell G, Aylward M. (2010). *Models of Sickness and Disability Applied to Common Health Problems*. London: Royal Society of Medicine Press.
- Washington State Agency Medical Directors' Group. (2010). *Interagency Guideline on Opioid Dosing for Chronic Non-Cancer Pain: an Educational Aid to Improve Care and Safety with Opioid Treatment*. Olympia (WA): Washington State Department of Labor and Industries; 55 p.

Whitehurst DG, Bryan S, Lewis M, et al. (2012). Exploring the cost-utility of stratified primary care management for low back pain compared with current best practice within risk-defined subgroups. *Ann Rheum Dis* **71**: 1796-1802.

Wilson JMG, Jungner G. (1968). Principles and practice of screening for disease. *WHO Chron* **22**: 473.

Woolf SH, Grol R, Hutchinson A, et al. (1999). Potential benefits, limitations and harm of clinical guidelines. *BMJ* **318**: 527-530.

## Appendix One: Response form

<b>Stakeholder organisation</b>	
<b>Name of commentator</b>	
<b>Potential conflicts of interest</b>	
<b>Stakeholder engagement box responses</b>	<b>Comments</b>
<i>Please provide any examples of screening tools that you think may be useful to include in this document. Are the screening tools validated and/or have outcome data?</i>	
<i>Figure 1 has been included as it is a short assessment tool, it is validated for use in primary care and it contains a numerical rating score. We would be interested in your views of such a tool but specifically whether you feel a similar approach, regarding a numerical rating scale, would be useful for the pre-screening questions.</i>	
<i>Figure 2 has been included as it is a brief assessment tool to capture the salient psychosocial and behavioural aspects to cover in an interview with individuals who live with chronic pain. We would be interested in your views of such a tool.</i>	
<i>Please consider the definition of problematic/complex pain and provide your thoughts on it. Do you think it expresses what the authors are trying to capture in this document? Have you any modifications/suggestions you would like to include?</i>	

<p><i>Please provide your thoughts on what term we should use (problematic/complex currently in use in the document). It is a term that can be coded so people in pain can be identified through the system of care. Please provide a brief rationale for your choice(s) and also identify terms that you have strong opinions against and again a rationale for why you would not like the term used.</i></p>		
<p><i>It would be really useful to have examples of models where early risk assessment, pain assessment and management has been achieved. Ideally pre-screening could operate to facilitate entry to these models. Please provide a brief description of your model, website links if appropriate and up to 5 key outcomes and how these were measured.</i></p>		
<p><i>We would welcome your thoughts on whether a toolkit would be useful and if it would, what other points need including in the toolkit. From a health economist perspective, what tools would be useful and at what time points do you think that using such tools would have maximum impact in costing this approach?</i></p>		
<p><b>Other suggestions</b></p>		<p><b>Comments</b></p>
<p>Item number</p>	<p>Page number</p>	
		<p>Please add more rows as needed</p>

## Appendix Two: Contributors

Dr Chris Barker (Chair)  
Dr Ann Taylor (Project Lead)  
Mrs Sian Guest (Project manager)  
Dr Nick Allcock  
Dr Andrew Baranowski  
Mr Neil Berry  
Mr Neil Betteridge  
Dr Dee Burrows  
Mr Paul Cameron  
Mr Antony Chuter  
Dr Frances Cole  
Dr Beverly Collett  
Ms Meherzin Das  
Ms Emma Davies  
Dr Steve Gilbert  
Dr Kate Grady  
Dr Ollie Hart  
Dr Elaine Hay  
Mr Owen Hughes  
Dr Martin Johnson  
Mr Pete Moore  
Dr Andrew Nicolaou  
Prof Ceri Phillips  
Dr Cathy Price  
Dr Pat Roche  
Prof Blair Smith  
Prof David Taylor  
Dr Johanna Theron

### Appendix 3: The STOP! Chronic Back Pain Project

Self-management and timely intervention: An Opportunity for the Prevention of Chronic Back Pain

Funded by Shine 2011 Award for Innovation in Health Care from The Health Foundation

The STOP! Chronic Back Pain Project demonstrated that the early intervention approach, i.e., working with people earlier in their pain journey, helps prevent chronicity by teaching people how to manage their pain, identifying and dealing therapeutically with complex personal needs which may interfere with effective pain management.

**Background:** feedback from patients at the Dorset Pain Management Unit suggested that pain management programmes were reasonably effective but were offered too late to facilitate significant change. Sequential linear referrals to secondary care services can cause years of delay between the onset of pain and treatment in a pain clinic, by which time pain can become intractable with a heavy personal burden for individuals and their families. Multiple losses, e.g., of employment and finances, role within the family, social life and well-being accrue; combined physical and mental health co-morbidities reinforce a sense of disability. Increased dependence on the healthcare profession correlates with reduced personal efficacy and people manage their pain in particular and life in general from a position of disempowerment.

**Methods:** the main objective of the STOP! Chronic Back Pain Project was to provide early assessment and appropriate clinical intervention to prevent chronicity and pain complexity from developing. Referrals were solicited from all GPs in Dorset and several physiotherapy departments in acute and community settings, for people suffering between 3 and 18 months of back pain, with either their first episode or with pain relating to a current episode with remission of pain between episodes. Participants were assessed through clinical interviews with a multi-disciplinary team with the aim of separating people who had demonstrable psychosocial barriers to recovery. People who were identified as needing help for anxiety, depression or mental illness from the clinical

psychologist or employment support from the occupational therapist were diverted to this pathway and received 1-1 support. People who did not indicate this need attended the pain management programme (PMP). PMPs were conducted for 1 day/week for 7 weeks across three sites in Dorset and sessions were provided on each day of the PMP by our health professional team. In addition, peer support during and after the programme was provided for current patients by past patients, through 1-1 mentoring via telephone/web support under the umbrella of our 'Pain Chain', which has the motto, 'Each One Reach One'.

**Results:** clinically significant reduction in scores for pain catastrophising, depression, disability, quality of life, physical fitness and self-reported improvement were achieved across all age-ranges and gender. Outcomes were superior to local best practice, i.e., PMPs offered to people as part of their traditional treatment pathway at the pain clinic. Participants reported this programme to be a 'life changing' experience. GPs on the project team reported a change in practice from prescribing to mentoring as a result of new learning. The pan-Dorset Clinical Commissioning Group adopted the STOP! model for the newly commissioned Dorset Community Pain Service which has two arms:

1. Early Intervention: to focus on Preventable Pain for people newly diagnosed with pain
2. Chronic pain management: to work with people who meet the traditional temporal definition of chronic pain

**Conclusions:** strategically, clinical resources which are currently committed to chronic pain may need to be diverted to prevent sub-acute pain from becoming problematic. Primary care clinicians need training and tools to identify people with complicating factors such as psychosocial barriers to recovery, and to help these people to become less vulnerable to developing complex pain.

**Prepared by:** Mrs Meherzin Das, Project Lead, STOP! Chronic Back Pain, on behalf of the STOP! Project Team, December 2013.