

The argument for enhanced use of complementary and alternative therapies in an integrated pain management service

- Demand:** Many patients don't go to GP but straight to private alternative therapy practitioner. This also creates a divide between those who can and cannot pay
 - The Clinical Standards Advisory Group (CSAG) found that *"most complementary therapies are provided outside the NHS but many chronic pain relief services offer acupuncture, hypnotherapy, reflexology, homeopathy or aromatherapy. A third of patients in pain clinics had tried complementary therapies. GPs would welcome guidelines and systematic reviews of effectiveness"*. (**CSAG report March 2000**)¹
 - There has been an increase in the use of complementary therapies for pain related problems (**Rao et al 1999**). See table below (item 5)
- There is a **need for preventive and remedial approach** to tackling pain issues:
 - Chronic pain does not exist without acute pain so, it makes sense to enhance acute pain service (mainly at primary care level through GPs. The CSAG recommended that *"Support research into the effectiveness of therapies, particularly those that may prevent acute pain becoming chronic pain, and review the existing research"*. (**Services for Patients with Pain Report – March 2000**)
 - Pain is present in virtually every medical condition (physical as well as mental/emotional).
 - Pain is frequently unexplained and therefore no 'scientific' protocol can be followed. In this case, complementary/alternative and conventional approaches stand – at least – on even ground.
- Balancing the need for drugs and their side-effects (risks v benefits):** especially with regards to children and the elderly. Two of the first-line analgesic treatments (NSAIDs and Cox2 inhibitors) have been shown to have sometimes lethal side-effects and rarely warrant their use as a long-term approach. (See also point 5.)
- Vulnerable groups:** Prof McEwan cited a good practice for pain management services publication by the Royal College of Anaesthetists and the Pain Society which recommended "specific arrangements for the treatment of vulnerable groups such as the elderly, children, non-verbal, disabled, intellectually handicapped and those whose language is not English". (**Chronic Pain Services In Scotland - July 2004 – Review commissioned by the Scottish Executive**) This already exists and should be incorporated into guidelines after re-assessment.
 - In their March 2000 report, the CSAG recommended a *"Review the value and appropriate use of pain assessment tools for children"*.
- Establishment of an audit system:** to initially assess effectiveness of complementary /alternative therapies in order to evaluate the need for further research. This would be a much more cost-effective way to evaluate therapies than launching directly into research subjects.
 - Janette Barrie's 'Best Practice Statement' also shows that there is evidence that "some complementary therapies have a positive effect on chronic pain" (SEE blue table below)
 - Glasgow Homoeopathic Hospital: An audit of the outpatient care of cancer patients and chronic pain clinic patients, provided by a doctor (Senior Registrar) in Palliative Medicine has been

¹ The content and recommendations of Prof McEwan's report are similar to those contained in various documents published by the Clinical Standards Advisory Group (CSAG) at national level and for this reason they are quoted throughout this document.

designed with the help of the clinical audit office, using sophisticated outcome measures. This started in early 1996 and is under development.

- The Research Council for Complementary Medicine, in partnership with the Royal London Homoeopathic Hospital and School of Integrated Health at the University of Westminster are to develop a Complementary and Alternative Medicine (CAM) Specialist library (NeLCAM) for the National electronic Library for Health (NeLH) www.nelh.nhs.uk.

14	With regard to outcome evaluation the contribution of complementary therapy, long-term outcomes, patient functioning and rehabilitation could usefully be included and linked to international research.	<p>Scottish Executive to consider this recommendation.</p> <p>The Chief Scientist Office is in general a response mode funder of research, judging applications on quality by peer and committee review rather than dedicating money to particular conditions. The CSO would welcome well founded applications for research into the use of complementary therapies.</p>
	<div style="border: 1px solid black; padding: 5px;"> <p>Government's response to Prof McEwan's recommendations (Andy Kerr's letter to Roseanna Cunningham)</p> </div>	

Statement	Reason for Statement	How to Demonstrate Statement is Being Achieved
Assessment of patients' use of complementary therapies is included in the comprehensive assessment.	There is evidence to suggest that some complementary therapies have a positive effect on chronic pain (Snyder & Wieland 2003, Stephenson & Dalton 2003).	Documentation reflects that the use of complementary therapies has been included in the patient's assessment.
Provision of information about the use of complementary therapies in the management of pain, both positive and negative, is part of the overall treatment plan.	There has been an increase in the use of complementary therapies for pain related problems (Rao et al 1999).	Extracted from DRAFT – Best Practice Statement – The Management of Chronic Pain in Adults (by Janette Barrie from NHS Quality Improvement Scotland)

Key Challenges:

1. Complementary therapies need to be individualised to suit each patient.
2. Health professionals need to convey a balanced attitude towards the use of complementary therapies.
3. Giving people sufficient information to make informed choices about the use of complementary therapies. **[who is best qualified to do it?]**
4. **Creation of audit mechanisms would create supporting evidence for some therapies (PQ) (See 6. below)**

Best Practice Statement: The Management of Chronic Pain in Adults (Draft) – Janette Barrie

6. **Training:** It would be desirable if funds / subsidies were available to offer CPD training in specialist pain management within the various types of alternative and complementary disciplines

It seems that specialist training is required for all health providers and is part of a list of requests/recommendations made by the Cross-party Group on Chronic Pain (see Mary Scanlon's letter to Andy Kerr dated 09/10/05 – Bullet 3: "Will the necessary training in pain management be provided for physiotherapists, GP's and all those working in Primary Care?").

If this is the case and specialist training needs to be provided, it means that the same training can be provided to complementary therapy practitioners – or even better – there could be cross-disciplinary training in pain management with unconventional, complementary evidence-based protocols being taught to Primary Care professionals.

The use of **unconventional therapies both in acute and chronic pain management as a first-line approach choice** at primary care level together with conventional approaches would have the benefit of freeing valuable specialist resources for more complex cases. This is also supported by the Clinical Standards Advisory Group statement that *“It is important to recognise that only a minority of patients with pain will need treatment by specialist pain services”*. (**published in Services for Patients with Pain - 1 84182 157 8**)

7. This would come at levels 1 and 2 in the protocol suggested by Dr Nicola Stuckey at the chronic pain conference. [She said there was a shortage of clinical psychologists but that care could be provided by properly trained people on three levels.

Level 1 can include all clinicians and involves basic skills like listening to people.

Level 2 involves specially trained clinicians providing interventions like relaxation techniques

*Level 3 is for more complex cases and involves clinical psychologists.] (**Chronic Pain Conference - Friday 8 July 2005**)*

- This would also mean that unconventional therapies could be offered at community level (as they are usually delivered by local voluntary organisations already situated in areas of greatest needs and, in many cases publicly-funded)
- It would save on financial resources as drugs are not usually used in CAM – except, on occasion, as short-term symptomatic relief
- It would positively affect other areas of health, as some forms of unconventional pain management treatments use nutrition, for instance, as a means to achieve mental/emotional and physical wellbeing. Many unconventional therapies have a multi-layered positive health support
- This fits in very well with the current principles of CHPs.

8. **Evidence of effectiveness:** Research reviews of on the effectiveness of complementary therapies (such as the Cochrane library and the Centre for Reviews and Dissemination²) tend to show inconclusive evidence for effectiveness rather than conclusive evidence of ineffectiveness or harm.

Nevertheless, there is enough evidence that some complementary and alternative therapies can be effective in some cases justifying serious consideration in employing some of those less conventional approaches in pain management. (e.g. the (positive) effects of massage therapy for non-specific low-back pain).

There is also conflicting views about the effectiveness of some mainstream approaches to pain management, according to the Clinical Standards Advisory Group (**Services for Patients with Pain - 1 84182 157 8 – p12 quoting McQuay et al, 1997**)

On the other hand, there seems to be a widespread agreement that cognitive-behavioural psychological interventions are effective. CBT is generally delivered by psychologists but can also be delivered by counsellors and psychotherapists trained in that field (see item 10 below) probably reducing the cost for extra funding for psychologist posts.

9. **Filling services gaps:** Alternative and unconventional evidence-based approaches to pain management can fill gaps in the service or, in certain circumstances, provided pain management support in areas where access to pain management service is restricted or nonexistent. This can also be used as a buffer until more refined and complete service can be developed in any one area.

² The Centre for Reviews and Dissemination (CRD) was established in January 1994, and aims to provide research-based information about the effects of interventions used in health and social care

Example: One organisation alone (massage) has over 50 therapists operating within the NHS Highland area where there are no pain management services (as reported through the CPG on Chronic Pain).

10. There is a **misconception that unconventional therapists are not well trained** medically and/or not qualified enough to provide pain management – which is not entirely true. This view has recently been expressed by xxxxx xxxxxxxx, xxxxxxxx xxxxxxxx xxxxxxxxxx, Pain Services , Glasgow, and supported by others. [This view has now been clarified as far as xxxxx xxxxx and psychologists are concerned. On an email circulated to all members of the CPG on Chronic Pain, Mr xxxxx has clarified that he supports the use of CAM in pain management. His only concern is with respect to the application of Cognitive / Behavioural Therapies by counsellors and psychotherapists.]
- GPs, nurses, physiotherapists, psychologists and other practitioners of conventional medicine often have some training in alternative approaches e.g. homoeopathy, massage, acupuncture, hypnotherapy, to mention just a few.
 - Most CAM organisations offer CPD training to their members. This is more often than not, a requirement for membership (and for being accepted for indemnity insurance)
 - Whilst it may be true that a clinical psychologist's input may be necessary in very complex cases, the vast majority of patients' pain is of musculoskeletal origin, rheumatologic and other known (and unknown origins), which have been demonstrated to respond favourably to therapies outside mainstream protocols.

11. **Clearer definition of alternative/complementary therapies:** In the United States and Great Britain chiropractic and osteopathy are clearly separate entities with relevant professional organisations while in other European Union countries certain osteopathic or chiropractic techniques are used by physicians. Some interventions are considered almost part of standard care (manipulation for acute low back pain) in some countries while they are complementary or alternative in others.

The very question about which terminology to use (complementary, alternative, conventional, mainstream, unconventional, etc) is, in reality, a key issue for the effective development of policies on the integration of the various modalities of health delivery and is more important than it seems at first.

It is important to choose a term which can unambiguously differentiate between approaches to health delivery (i.e. the biochemical, mainstream approach versus the non-drug approach) and to find the appropriate term to describe the therapies themselves, which is more difficult e.g. alternative, complementary, unconventional therapies).

Much of the published arguments for and against different terminologies seem to be based on largely artificial boundaries, which create an unhealthy 'them and us' attitude, blurring the positive aspects of mainstream and more unconventional contributions to health. A good illustration of the paradox these artificial boundaries create was a question given to me once: When a specialist at one of the London hospitals successfully uses maggots to treat his patients' infected or necrotic wounds (without large randomised control trials), how do we categorise the treatment? It was alternative but also mainstream.

12. **What is needed is a more complete integration** of (selected) voluntary organisations and independent therapists within the NHS and, in this case, within the chronic pain management service. This can be done in a variety of ways (not discussed in this document). Proper integration would preserve the integrity of conventional treatments and provide multi-faceted benefits to patients, health providers and the NHS.

APPENDIX I

Pain services – remits

[Extracted from CSAG reports: Services for Patients with Pain 1 84182 157 8]

The chronic pain service

2.8 The aims in the provision of a chronic pain service are to relieve chronic pain and associated disability when possible, and to give appropriate advice and support to those patients in pain for which no treatment is available. Chronic pain services are now provided in the majority of teaching and district general hospitals, and include outpatient sessions for the assessment of new patients, the review of current or previous patients and the administration of some treatments. Further treatments may involve day case or inpatient admission, sometimes requiring special facilities such as X-ray.

2.9 Referrals to chronic pain services generally come from the specialties of orthopaedics, rheumatology, palliative medicine, and oncology, and, to a lesser extent, surgery and neurology. In a minority of centres there are examples of the integration of services, such as joint outpatient sessions and some joint appointments with palliative care or rheumatology. GPs can often refer patients directly to pain services, although at some hospitals referral occurs only via other hospital specialties. Patterns of referral behaviour appear to vary markedly across the UK. It is important to recognise that only a minority of patients with pain will need treatment by specialist pain services.

2.10 The International Association for the Study of Pain (IASP) has classified pain services according to the level of specialisation of the service. The IASP classification has been derived from a task force on the desirable characteristics of pain treatment facilities (IASP 1990). (See Appendix B.)

The palliative care service

2.11 Palliative care has its origins in the modern hospice movement. The aim of a palliative care service has been described as care for patients whose disease is not responsive to curative treatment.

Control of pain, of other symptoms, and of psychological, social and spiritual problems, is Paramount.

The goal of palliative care is achievement of the best quality of life for patients and their families.” (World Health Organization, 1990). Palliative care describes the care offered by a team of doctors, nurses, therapists, social workers, clergy and volunteers. Palliative medicine (which describes the work done by doctors) was recognised as a medical speciality in 1987 and defined as - the study and management of patients with active, progressive, far-advanced disease, for whom the prognosis is limited and the focus of care is quality of life” (Association of Palliative Medicine. 1992).

Patients suffering with Pain from cancer may be managed by specialists in palliative medicine, by chronic pain services or by both services working together.

Pain management programmes

2.12 The aim of providing pain management programmes is to reduce the disability and distress caused by chronic pain that is resistant to treatment. Sufferers are taught physical, psychological and practical techniques intended to improve quality of life and to enable patients to be as self-reliant as possible; pain relief is not the primary goal. Such programmes may be conducted on an inpatient or outpatient basis. In general, pain management programmes are led by those working in professions allied to medicine (PAMs); most are hospital based, but some are also held in primary and community care settings. Only small numbers of patients are selected for treatment within these

programmes; they are not available in every locality.

Pain rehabilitation programmes

2.13 In some areas of the UK there are physiotherapy-led rehabilitation programmes for Patients with pain; these are variously described as back schools, active rehabilitation programmes, fitness programmes or functional restoration programmes.