A Pain & Addiction Clinic "Professional Synergy"

- if you can find an Addiction Specialist to work with.

If you work in Pain Medicine, there are three situations where liaison with local addiction services becomes necessary:

1. A patient already in an opioid substitution programme is admitted for surgery or referred to the Pain Management Clinic with a chronic pain problem.
2. A General Practitioner (GP) refers a patient having become concerned about dependency or opioid addiction to medication they are prescribing.
3. A patient discloses that they have become reliant or addicted to over-the-counter painkillers.

It was all three scenarios that led me, around a decade ago, to make contact and arrange joint clinics with a Consultant Psychiatrist in the Addiction Service.

What has been my experience of joint working?

It has led to better joined-up patient care between the Pain and Addiction teams and the GP. Over time, it has led to a more realistic understanding of the scope and limitations of both Pain and Addiction medicine. It has led to local protocols and pathways for the management of patients, both for acute pain and more generally for opioid addiction, being set up in the hospital. In clinic, it has led to discussions about the advantages/disadvantages of taking long-term opioids for persistent pain for people with lived experience of both. Such conversations can be difficult; but are necessary to support individuals and their GPs in order to clarify expectations of the reasons for and the outcomes of taking strong opioids and to help deal with any comorbid dependency, withdrawal symptoms or addiction. Alternatively, it can help stop reliance on opioids with either limited or no benefit, if people want to taper down and stop altogether, but are struggling with withdrawal symptoms. It is useful to manage transition and discharge from addiction services, when addiction support is no longer necessary.

Opioid prescribing can be thought of as contextual. The 'rules' in reality differ when used for acute pain, terminal illness, chronic pain and in addiction medicine. An increasing understanding of opioid pathophysiology, of how opioids can be antalgesic and sensitise the pain systems in some circumstances, demands a fundamental change in approach to prescribing and helps set the context. This reality is moving the prescribing agenda in persisting chronic pain states away from standard prescribing advice, and, current BNF recommendations look increasingly in need of a fundamental rethink.

It is often striking how strong opioids, even drugs with 'mixed' receptor effects like Methadone and Buprenorphine, used at high doses to manage addiction, can fail to provide a good quality of life or good quality analgesia in some people with chronic pain. In the field of addiction, pain sensitisation and hormonal changes relating to long-term opioid use have long been described in the literature. It has been fascinating noticing how differently opioid withdrawal impacts different people. That some become highly dependent on small amounts of opioids and display distressing and troublesome withdrawal symptoms and others don't would seem to point to a whole field of pharmacogenetics not fully unravelled.

On their own, opioids are seldom the answer to living with the impact of persisting pain. At best, they may be part of the answer in some circumstances. It is important to offer any patient with chronic pain and addiction problems the same opportunity to access learning skills to self-manage their pain, as anyone coming to a Pain Clinic should expect.

My personal experience of joint working has been enriching. Motivational Interviewing was developed in the field of addiction. I have learned a lot undertaking joint assessments with a Psychiatrist, both in terms of improving my mental state assessment and seeing modern humanistic approaches in mental health and Psychiatry. Working with a multidisciplinary addiction team and seeing the process in action is a valuable experience. Motivational interviewing when done well is barely noticeable and is merely an approach to discussion, centering around the patient's own thoughts and hopes around recovery. I see it as a way to help reactivate choices in those who may have lost sight of choice and possibilities in their suffering. Addiction teams have a wealth of experience that pain medicine doctors can and should access.

Sadly, probably the biggest threat to joint working is the decommissioning of addiction services from Psychiatric Trusts and their replacement with non-NHS providers. Service models may change and there may be organisational and commissioning barriers to joint working.

In summary

Working with an addiction specialist can be a necessary and helpful liaison, but finding someone to do joint working with is the first and sometimes, sadly, difficult step. If you can find someone, you will find local patient care will improve.

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