



Appendix B

International Association for the Study of Pain: desirable characteristics for pain treatment facilities

Task Force on Guidelines for Desirable Characteristics for Pain Treatment Facilities

DESIRABLE CHARACTERISTICS FOR PAIN TREATMENT FACILITIES

Facilities for the treatment of patients with chronic pain have developed rapidly in the past fifteen years. There have been few, if any, governmental or professional standards or controls for such patient care facilities, even in the developed nations of the world. In the United States of America, pain treatment facilities that exist within hospitals are theoretically evaluated under the aegis of the Joint Committee on the Accreditation of Hospitals, but the accreditation process does not specifically assess the pain treatment facility. Free-standing pain treatment programs and those within hospitals may also obtain voluntary certification from the Commission on Accreditation of Rehabilitation Facilities through a program instituted with assistance from the American Pain Society in 1983. In other countries, both governmental agencies and the national chapters of the International Association for the study of Pain (IASP) have developed some standards. Governmental health care systems in some countries regulate all aspects of the provision of health care, and the freedom to establish new types of health care delivery is limited.

The International Association for the Study of Pain believes that patients throughout the world would benefit from the establishment of a set of desirable characteristics for pain treatment facilities. Although IASP itself does not plan to offer certification on accreditation, the standards set forth in this document can serve as a guideline for both practitioners and those governmental or professional organisations involved in the establishment of standards for this type of health care delivery. The field of pain management has been viewed with scepticism by many physicians and health policy and funding administrators*, reasonable guidelines should be established and adhered to by reputable treatment facilities.

It is important to recognise that not every patient referred to a pain treatment facility requires the services of a large number of health care professionals. Nonetheless, many pain patients do require the services of multiple disciplines and resources must be available to effectively manage the patient. It is on the basis of the types of resources available that the following classification scheme has been proposed.

This Task Force has not addressed the issues of pain management in the post-operative or post-trauma setting. Such treatment programs may occur within a pain treatment facility, but they are not required for the assessment and treatment of patients with chronic pain.

This document has been prepared by a Task Force appointed by the President of IASP Dr Michael J. Cousins, and chaired by the Secretary of IASP Dr John D. Loeser. Members of the Task Force were:

**John D Loeser, MD, Chairman
Multidisciplinary Pain Centre RC-95
University of Washington
Seattle, WA 98195 USA**

**Francois Boureau, MD, PhD
Hospital Saint-Antoine, Unite de
Traitement de 11 Douleur
184 rue de Faubourg St. Antoine
75012 Paris, France**

**Peter Brooks, MBBS, MD FRACP FRACM
Dept. of Rheumatology
Royal. North Shore Hospital
Sydney, NSW 2065, Australia**

**Teresa Ferrer-Brechner, MD
Dept. of Anaesthesiology
UCLA Medical Ctr CHS 56125
Los Angeles, CA 90024 USA**

**Howard L. Fields, MD, PhD
Dept. of Neurology, Box 0114
University of California
San Francisco, CA 94143 USA**

**Corey D. Fox, PhD
Pain Management Centre
Dept. of Neurology
Mount Sinai Hospital
Hartford, CT 06112 USA**

**Hans U. Gerbershagen, MD
DRK-Schmerzzentrum
Auf der Steig 14
Mainz, Federal Republic of Germany**

**Martin Grabois, MD
13511 Tosca Lane
Houston
TX 77079 USA**

**Douglas M. Justins, MBBS, FFARCS
Dept. of Anaesthetics
St. Thomas' Hospital
London SE1 7EH, United Kingdom**

**Yves Lazorthes, MD
Neurosurgery Clinic
CHU Rangueil
Chemin du Vallon,
31054 Toulouse, France**

**Terrence F Little, MBBS, FFARCS
Pain Management Centre
Southern Memorial Hospital
260 Kooyong Road
Caulfield, VIC 3162 Australia**

**George Mendelson, MBBS, MD,
FRANZCP, Suite 730 Queens Rd
Melbourne, VIC 3004 Australia**

**Isaac Pinter, PhD
Ortho-Arthritis Pain Centre
Orthopaedic Institute
301 East 17th Street
New York, NY 10003 USA**

**Russell K. Portenoy, MD
Memorial Hospital
1275 York Avenue
New York, NY 10021 USA**

**Robyn J. Quinn, RMN
64 Elgin Street
Gordon, NSW 2072 Australia**

**Howard L. Rosner, MD
Dept. of Anaesthesiology
Columbia-Presbyterian Medical
Centre, 622 W. 168th Street
New York, NY 10032 USA**

John C. Rowlingson, MD
Dept. of Anaesthesiology, Box 238
University of Virginia Medical Centre
Charlottesville, VA 22908 USA

Bengt H. Sjolund, MD, PhD
Pain Clinic
Malmo General Hospital
214 01 Malmo, Sweden

Peter J. Vicente, PhD
6593 Madeira Hills Dr.
Cincinnati, OH 45243 USA

C. Peter N. Watson, MD
Smythe Pain Clinic
Toronto General Hospital
Toronto, ON M5G 1L7 Canada

Michael Wood, PhD
Dept. of Psychology
Flinders University
Bedford Park, SA 5042 Australia

DEFINITION OF TERMS

The following terms will be briefly defined in this section; a more complete description of the characteristics of each type of facility appears in subsequent portions of this report.

1. **Pain treatment facility:**

A generic term used to describe all forms of pain treatment facilities without regard to personnel involved or types of patients served. Pain unit is a synonym for pain treatment facility.

2. **Multidisciplinary pain centre:**

An organisation of health care professionals and basic scientists which includes research, teaching and Patient are related to acute and chronic pain. This is the largest and most complex of the pain treatment facilities and ideally would exist as a component of a medical school or teaching hospital. Clinical programs must be supervised by an appropriately trained and licensed clinical director; a wide array of health care specialists is required, such as physicians, psychologists, nurses, physical therapists, occupational therapists, vocational counsellors, social workers and other specialised health care providers.

The disciplines of health care providers required is a function of the varieties of patients seen and the health care resources of the community. The members of the treatment team must communicate with each other on a regular basis, both about specific patients and about overall development. Health care services in a multidisciplinary pain clinic must be integrated and based upon multidisciplinary assessment and management of the patient. Inpatient and outpatient programs are offered in such a facility.

3. **Multidisciplinary pain clinic:**

A health care delivery facility staffed by physicians of different specialties and other non-physician health care providers who specialise in the diagnosis and management of patients with chronic pain.

This type of facility differs from a Multidisciplinary Pain Centre only because it does not include research and teaching activities in its regular programs. A Multidisciplinary pain clinic may have diagnostic and treatment Facilities which are outpatient, inpatient or both.

4. Pain Clinic:

A health care delivery facility focusing upon the diagnosis and management of patients with chronic pain. A pain clinic may specialise in specific diagnoses or in pains related to a specific region of the body. A pain clinic may be large or small but it should never be a label for an isolated solo practitioner. A single physician functioning within a complex health care institution which offers appropriate consultative and therapeutic services could qualify as a pain clinic, if chronic pain patients were suitably assessed and managed. The absence of interdisciplinary assessment and management distinguishes this type of facility from a multidisciplinary pain centre or clinic. Pain clinics can, and should be encouraged to, carry out research, but it is not a required characteristic of this type of facility.

5. Modality-oriented clinic

This is a health care facility which offers a specific type of treatment and does not provide comprehensive assessment or management. Examples include nerve block clinic, transcutaneous nerve stimulation clinic, acupuncture clinic, biofeedback clinic etc. Such a facility may have one or more health care providers with different professional training; because of its limited treatment options and the lack of an integrated, comprehensive approach, it does not qualify for the term, multidisciplinary.

DESIRABLE CHARACTERISTICS OF MULTIDISCIPLINARY PAIN CENTRES

- 1. A multidisciplinary pain centre (MPC) should have on its staff a variety of health care providers capable of assessing and treating physical, psychological, medical, vocational and social aspects of chronic pain. These can include physicians, nurses, psychologists, physical therapists, occupational therapists, vocational counsellors, social workers and any other type of health care professional who can make a contribution to patient diagnosis or treatment.**
- 2. At least three medical specialities should be represented on the staff of a multidisciplinary pain centre. If one of the physicians is not a psychiatrist, physicians from two specialities and a clinical psychologist are the minimum required. A multidisciplinary pain centre must be able to assess and treat both the physical and the psychosocial aspects of a patient's complaints. The need for other types of health care providers should be determined on the basis of the populations served by the MPC.**
- 3. The health care professionals should communicate with each other on a regular basis both about individual patients and the programs which are offered in the pain treatment facility.**
- 4. There should be a Director or Co-ordinator of the MPC. He or she needs not be a physician, but if not, there should be a Director of Medical Services who will be responsible for monitoring of the medical services provided.**

5. The MPC should offer diagnostic and therapeutic services which include medication management, referral for appropriate medical consultation, review of prior medical records and diagnostic tests, physical examination, psychological assessment and treatment, physical therapy vocational assessment and counselling and other facilities as appropriate.
6. The MPC should have a designated space for its activities. The MPC should include facilities for inpatient services and outpatient services.
7. The MPC should maintain records on its patients so as to be able to assess individual treatment outcomes and to evaluate overall program effectiveness.
8. The MPC should have adequate support staff to carry out its activities.
9. Health care providers active in a MPC should have appropriate knowledge of both the basic sciences and clinical practices relevant to chronic pain patients.
10. The MPC should have a medically trained professional available to deal with patient referrals and emergencies.
11. All health care providers in an MPC should be appropriately licensed in the country or state in which they practice.
12. The MPC should be able to deal with a wide variety of chronic pain patients, including those with pain due to cancer and pain due to other diseases
13. An MPC should establish protocols for patient management and assess their efficacy periodically.
14. An MPC should see an adequate number and variety of patients for its professional staff to maintain their skills in diagnosis and treatment.
15. Members of a MPC should be carrying out research on chronic pain. This does not mean that everyone should be doing both research and patient care. Some will only function in one arena, but the institution should have ongoing research activities.
16. The MPC should be active in educational programs for a wide variety of health care providers including undergraduate, graduate and postdoctoral levels.
17. The MPC should be part of or closely affiliated with a major health sciences educational or research institution.

DESIRABLE CHARACTERISTICS FOR A MULTIDISCIPLINARY PAIN CLINIC

The distinction between a Multidisciplinary Pain Centre and a Multidisciplinary Pain Clinic is that the former has research and teaching components that need not be present in the latter. Hence, items 15, 16 and 17 above are not required for a Multidisciplinary Pain Clinic. All of the other items should be present.

DESIRABLE CHARACTERISTICS FOR A PAIN CLINIC

- 1. A Pain Clinic should have access to and regular interaction with at least three types of medical specialities or health care providers. If one of the physicians is not a psychiatrist, a clinical psychologist is essential.**
- 2. The health care providers should communicate with each other on a regular basis both about individual patients and programs offered in the pain treatment facility.**
- 3. There should be a Director or Co-ordinator of the Pain Clinic. If he or she is not a physician, there should be a Director of Medical Services who is responsible for the monitoring of medical services which are provided to the patients.**
- 4. The Pain Clinic should offer both diagnostic and therapeutic services.**
- 5. The Pain Clinic should have designated space for its activities.**
- 6. The Pain Clinic should maintain records on its patients so as to be able to assess individual treatment outcomes and to evaluate overall program effectiveness.**
- 7. The Pain Clinic should have adequate support staff to carry out its activities.**
- 8. Health care providers working in a Pain Clinic should have appropriate knowledge of both the basic sciences and clinical practices relevant to pain patients.**
- 9. The Pain Clinic should have a trained health care professional available to deal with patient referrals and emergencies.**
- 10. All health care providers in a Pain Clinic should be appropriately licensed in the country and state in which they practice.**

DISCUSSION

The Task Force is strongly committed to the idea that a multidisciplinary approach to diagnosis and treatment is the preferred method of delivering health care to patients with chronic pain of any etiology. Not every patient referred to a pain treatment facility is in need of multidisciplinary diagnosis or treatment, but the facility should have those resources available when they are appropriate. Although the Task Force recognises that health care resources are not uniformly distributed throughout any country or the world and that compromises will be necessary, all health care providers should strive to attain the standards set forth in this document for the care of patients with chronic pain. Health care providers in pain treatment facilities should be encouraged and expected to be members of IASP and its national chapters in order to facilitate exchange of information and research activities.

The primary goal for a pain treatment facility is to provide effective, humane care for those who suffer from chronic pain. The complexities of the chronic pain patient must be recognised to accomplish these goals. In the modern era, however, the issue of cost effectiveness must also be considered and we cannot erect standards for chronic pain treatment which are above and beyond the

standards for patients with other types of complaints. Moreover, health care delivery systems are rapidly changing and standards that prevent innovation and progress should not be proposed.

All patients with chronic pain should be appropriately evaluated before treatment is implemented. Facilities that offer only one type of treatment or have limited access to professionals in various disciplines must demonstrate appropriate patient selection prior to the initiation of therapy. Patients who attend such a health care facility should have been fully evaluated elsewhere before such a referral is made. For example, if a "pain clinic" specialises in headache patients and offers only biofeedback therapy, the patients referred to such a facility must have an appropriate medical evaluation prior to embarking on this treatment program. Pain treatment facilities must go beyond this stereotypic approach and determine what services the patient needs prior to embarking upon one or another type of treatment. If what the patient needs is not available, the patient should be referred elsewhere.

Resources and patient demands vary throughout the world, and there is no single guideline that can be made which will apply to every location. In developing nations, pain treatment facilities may appropriately consist of a small number of health care professionals with limited resources. Such groups may mainly see chronic pain due to cancer or to nervous system injuries; the problems of chronic pain as seen in the industrialised nations may have not yet arrived. Treatments may be limited to nerve blocks and drugs if economic conditions preclude more expensive treatment strategies. It is unlikely that research activities will be carried out in such an environment, but the mission of teaching other health care providers should never be overlooked.

In the developed nations of the world, there would seem to be no reason to allow an isolated practitioner to call himself a pain clinic. The diagnosis and management of patients with chronic pain has become so complex that multiple skills and knowledge are required. There are many possible combinations, but such a facility must have at least one physician who assumes responsibility for obtaining a complete history and performing a screening physical examination. Old records must also be reviewed. The speciality of the physician performing this review is not particularly relevant, but clearly someone with expertise in the type of disease process responsible for the patient's chronic pain should be either the referring physician or part of the pain treatment facility's assessment team. At least two other medical specialities as well as other types of health care providers should be represented to justify the term, multidisciplinary pain clinic. There is some question as to whether any pain management facilities which are not multidisciplinary should exist in a developed nation.

Other types of health care professionals are of great value in a pain treatment facility. These include psychologists, nurses, physical therapists, occupational therapists, social workers, vocational counsellors and others. The variety and number will be determined by the types of patients seen and the number of visits per year to the facility. We should remember that the etiologies of chronic pain are not well understood; medical treatments have already misled many of these patients and effective evaluation and treatment may be administered by other health care professionals.

In summary, the developed nations should require that any facility calling itself a pain clinic or pain centre offer a multidisciplinary array of diagnostic and treatment facilities. Single modality therapy programs should be identified by the modality they utilise; e.g. "Biofeedback Clinic" rather than the term, "Pain Clinic". Neurosurgeons who perform pain-relieving procedures do not call themselves a "Pain Clinic", nor should any other solitary specialist. Health care facilities which specialise in one region of the body should be identified by that region in their title; e.g. "Headache Clinic", rather

than "Pain Clinic". A Multidisciplinary Pain Clinic or Centre should provide comprehensive, integrated approaches to both assessment and treatment.

In developing nations, it may not be immediately possible to amass the professional and physical resources to establish a multidisciplinary pain clinic. A single health care provider may initiate a health care facility with the goals of adding other personnel as the institution evolves. This should be encouraged by IASP even though the health care facility at its inception may not meet the desired standards.

Pain Clinics and Pain Centres require not only physical resources but also specially trained health care providers. There is no specific training program in pain management at this time, so all health care providers have entered this area from existing specialities. Fellowships in pain management are beginning to develop, and those individuals who wish to specialise in pain management should be encouraged to obtain such a period of training. Others become reasonably skilled through their work with pain patients, but the field should move toward the establishment of specific training programs in pain management and the development of a method of evaluation and certification of individual health care providers by responsible leaders.

All pain clinics should work toward the use of a single method of coding diagnoses and treatments. Although the ICD-9 system is utilised in many countries, it is not particularly good for illnesses in which pain is the major complaint. The IASP Taxonomy system is a step in the right direction, but it will need further refinement before it becomes clinically acceptable. Nonetheless, excellence in pain management will require a standardised reporting system which can be used by all types of treatment facilities throughout the world.

Finally, excellence is dependent upon education of young health care providers who may wish to enter this field. Pain Centres need to establish educational programs on all levels to accomplish this goal. These programs should attempt to integrate with degree granting institutions in all the health sciences as well as post-graduate educational programs.

Reprinted with permission – Copyright 1990 by the International Association for the Study of Pain (IASP). All rights reserved. This monograph is protected by copyright; no part of it may be duplicated or reproduced without written permission of the publisher (IASP).



Appendix C

Organisations and individuals contributing evidence and information

Action for Sick Children

Action Research

Association of Anaesthetists of Great Britain & Ireland*

Association of British Neurologists*

Association of Community Health Councils for England & Wales

Association of Medical Research Charities

Association for Palliative Medicine of Great Britain and Ireland

Audit Commission

Breast Cancer Care*

British Association of Medical Managers (BAMM)*

British Chiropractic Association

British Diabetic Association

British Heart Foundation*

British Medical Acupuncture Society

British Medical Association

British Osteopathic Association

British Psychological Society for Children

British Shaitsu Society

British Society of Rheumatology

Cancer Care Society

Centre for Health Services Research - University of Newcastle *

Chartered Society of Physiotherapy

Children Nationwide

College of Health

College of Pharmacy Practice*

Department of Complementary Medicine, Exeter University

English National Board (ENB)

Fibromyalgia Association (including local Fibromyalgia support groups)

General Council and Register of Osteopaths

Harrogate Health Care

Health Services Research Unit

Hospice Information Service

King's Fund

Kings Healthcare NHS Trust

Macmillan Foundation*

Motor Neurone Disease Association

NAPP

National Audit Office

National Backpain Association

National Board for Nursing, Midwifery & Health Visiting (Ireland)

National Board for Nursing, Midwifery & Health Visiting (Scotland)*

National Osteoporosis Society
National Pharmaceutical Association
Occupational Therapists Board
Osteopathic Association of Great Britain .
Pain and Nociceptive Group (PANG)
Pain Association (Scotland)
Pain- Concern UK
Pain Management Unit, Royal National Hospital for Rheumatic Diseases
Pain Society
Patients Forum
Physiotherapy Pain Association
Research Council for Complementary Medicine
Rheumatic Diseases Centre
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Nursing
Royal College of Obstetricians & Gynaecologists
Royal College of Physicians & Surgeons of Glasgow
Royal College of Surgeons of Edinburgh
Royal London Homeopathic Hospital
Scottish Association of Health Councils
Scottish Partnership Agency (Palliative Care) .
Special Interest Group of Pain Society
St John's Ambulance*
Standing Committee on Postgraduate Medical and Dental Education (SCOPME)
Stroke Association Therapy Research Unit
United Kingdom Central Council (UKCC) for Nursing, Midwifery & Health Visiting
University of Dundee, Ninewells Hospital and Medical School (for North British Pain Society)*
Welsh National Board (WNB)
West Sussex Health Authority

*(*responded but unable to provide Avant information)*

The researchers would also like to thank all those who contributed to the study by completing questionnaires and giving interviews.



Appendix D

A summary of national and international clinical guidelines relevant to acute and chronic pain services (available in 1997)

a) National

**1 National Guidelines relating to Chronic Pain – Non Malignant
Includes Curriculum Guidelines)**

<p>1.1 <i>Clinical Guidelines for the Management Of Acute Low Back Pain 1996</i> (Royal College of General Practitioners (RCGP))</p>	<p>Provides clinical guidelines and supporting base of research evidence for clinicians in the management of acute back pain international evidence and makes recommendations on case-management. These guidelines are proposed for use by all health professionals who advise people with acute back pain.</p>
<p>1.2 <i>Back Pain 1994</i> (Clinical Standards Advisory Group)</p>	<p>Examines epidemiology of low back pain and associated disability; suggests guidelines; reviews current NHS services and service developments; and makes recommendations on the future organisation of NHS services for patients with back pain.</p>
<p>1.3 <i>The Management Of Patients with Chronic Pain 1994</i> (Scottish Home Office and Health Department)</p>	<p>Gives an account of the definition, classification and management of chronic pain; describes how pain services are organised in Scotland; and makes recommendations for future developments.</p>
<p>1.4 <i>Anaesthetists and Non-acute Pain Management. 1993</i> (Association of Anaesthetists, the Royal College of Anaesthetists and The Pain Society)</p>	<p>Examines non-acute pain management provision; describes the provision of pain management services and the training required at both undergraduate and postgraduate level in non-acute pain relief and makes recommendations on the organisation of pain management services.</p>
<p>1.5 <i>Standards for Physiotherapists working in Pain Management Programmes 1997</i> (Physiotherapy Pain Association)</p>	<p>Provides standards appertaining to physiotherapy practice within interdisciplinary Pain Management Programmes</p>
<p>1.6 <i>The Curriculum Framework 1996</i> (Chartered Society of Physiotherapy and the Council for Professions Supplementary to Medicine)</p>	<p>Describes the core skills needed in a PMP that are part of physiotherapy pre-qualifying and post-qualifying education.</p>

2. National Guidelines relating to pain within Palliative Care

	<i>Description of contents</i>
2.1 <i>Information for purchasers: Background to available specialist palliative care services 1995</i> (National Council for Hospice and Specialist Palliative Care Services (NCHSPCS))	Provides information and guidance for purchasers on palliative care services.
2.2 <i>Outcome Measures in Palliative Care 1995</i> (NCHSPCS)	Provides information on outcome measures which have been used or are proposed for use in palliative care,
2.3 <i>Guidelines for Managing Cancer Pain in Adults 1994</i> (NCHSPCS)	Guidelines for health professionals on cancer pain; pharmacological management; adjuvants; non-pharmacological interventions and on other aspects of management
2.4 <i>Protocol for Investment in Health Gain: Pain, Discomfort and Palliative Care 1992</i> (Welsh Health Planning Forum, Welsh Office NHS Directorate.	Covers issues regarding pain, discomfort and palliative care. Protocol covers areas such as neurological, musculoskeletal, genito-urinary, gynaecological and gastrointestinal conditions. It also identifies where further investment could bring health gain.
2.5 <i>Palliative care. Guidelines for Good Practice and Audit Me- 1991</i> (Royal College of Physicians of London (RCP))	Guidelines and audit measures on palliative care for professionals.

3. National Guidelines-Acute Pain

	<i>Description of contents</i>
3.2 <i>Acute Pain Management. A Quick Reference Guide 1997</i> (NHS Wales)	A reference document based on the full guide (3.3) This guide provides clinicians with a practical approach to acute Pain assessment and management.
3.3 <i>A Guide to Pain Management 1997</i> (NHS Wales)	A guide which assists health care staff in the management of patients' pain and covers advice on: pain assessment; options to prevent and control postoperative pain; site specific pain control; patient with special needs: treatment of side-effects; and information on the acute pain team.
3.4 <i>The Provision of Services for Acute Postoperative Pain in Scotland 1996</i> (Scottish Office Department of Health)	Describes the role of an acute pain service; addresses the care of patients with acute postoperative pain and discusses how postoperative pain is managed.
3.5 <i>Day Case Surgery. The Anaesthetist's Role in Promoting High Quality Care 1994</i> (Association of Anaesthetists)	Describes effective day case surgery practice and discusses: patient selection; staffing arrangements; documentation; anaesthetic management; recovery, discharge procedures; audit; and contractual arrangements.
3.6 <i>Report of the Working Party on Pain After Surgery 1990</i> (Royal Colleges of surgeons and of Anaesthetists)	Examines the nature of current management of postoperative pain in the UK; finds the management of pain after surgery to be unsatisfactory and makes recommendations on how to improve the management of postoperative pain (e.g. establishment of acute pain teams in all major hospitals.)

4 National guidelines covering both acute and chronic pain, including in children

4.1 <i>The Provision of Pain Services</i> 1997 (Association of Anaesthetists and The Pain Society)	Describes pain management services in Great Britain and gives information to purchasers and providers on: components of service provision; content of an appropriate business plan; financial consideration; research; audit and education.
4.2 <i>The Prevention and Control of Pain in Children. A Manual for Health Professionals</i> 1997 (Royal College] of Paediatrics and Child Health)	Provider advice on detecting pain and its pharmacological and non-pharmacological management.
4.3 <i>Guidance for Purchasers on Pain Management Services</i> 1997 (Royal College of Anaesthetists)	Provides guidance for purchasers on purchasing pain management services (includes acute pain and non-acute pain)
4.4 <i>Guidelines for analgesia in children in the A&F departments</i> 1997 (British Association for Accident and Emergency Medicine)	Provides guidance for professionals on treatment for various categories of pain.

b) International Guidelines

5. International Guidelines relating to Chronic Pain - other than cancer pain (Includes Curriculum Guidelines).

5.1 <i>Desirable Criteria for Pain Management Programmes</i> 1997 (Pain Society (British and Irish Chapter 'of IASP))	Describes: the desirable criteria for pain Management Programmes content of a PMP; patient referral and selection for PMPs; resources and training required; and the importance of audit and research.
5.2 <i>New Zealand Acute Low Back Pain Guide</i> 1997 (Accident Rehabilitation and Compensation Insurance Corporation)	Discusses acute low back pain. Defines 'Red' and 'Yellow' flag system to improve prediction of chronicity, proposes early intervention to prevent chronicity.
5.3 <i>Guide to Assessing Psychosocial Yellow Flags in Acute Low Back Pain: Risk Factors for Long-term Disability and Work Loss</i> 1997 (Accident Rehabilitation and Compensation Insurance Corporation)	Provides an overview of psycho-social risk factors for long-term disability and work loss from low back pain and provides a method for assessment; it also allows for the identification of those at risk to allow for early intervention to prevent chronic pain and disability.
5.4 <i>Core Curriculum for Professional Education in Pain</i> 1995 (IASP)	Reference for designing training programs and for assisting health professionals plan services for patients with pain.
5.5 <i>Back Pain in the Workplace</i> 1995 (IASP)	Describes the relationship of pain to suffering, impairment and disability; looks at the problems facing workers with non-specific low back pain; suggests strategies for dealing with non-specific low back pain and makes recommendations
5.6 <i>Acute Low Back Problems in Adults: Assessment and Treatment, Quick reference Guide for Clinicians</i> 1997 (AHCPR)	Provides guidelines for the evaluation and treatment of acute low back problems in adults; which includes providing clinicians with information on the detection of spinal pathology as well as non-spinal pathology.

5.7 <i>Curriculum on Pain for Students in Psychology 1997 (IASP)</i>	Describes a pain curriculum' for psychology students.
5.8 <i>Pain Curriculum for Students in Occupational Therapy or Physical Therapy 1994 (IASP)</i>	Describes a 'pain curriculum' for students in occupational therapy or physical therapy.
5.9 <i>Pain Curriculum for Basic Nursing Education 1993 (IASP)</i>	Describes a 'pain curriculum for basic nurse education.
5.10 <i>Pain Proposed Model of Pre-doctoral Curriculum on Pain for Dental Schools 1993 (IASP)</i>	Describes a proposed curriculum on pain for dental students.
5.11 <i>Desirable Characteristics for Pain Treatment Facilities 1990 (IASP)</i>	Describes standards which serve as guidelines for clinicians in establishing pain treatment facilities, specifies staging and treatment components, assists researchers and purchasers commissioners to classify pain services according to degree of sophistication.
5.12 <i>An Outline Curriculum on Pain for Medical Schools 1988 (IASP)</i>	An editorial which provides an outline 'model pain course for those involved in medical school curriculum development.
5.13 <i>Proposed Curriculum on Pain for Pharmacy Students 1988 (IASP)</i>	Describes a proposal curriculum on pain for pharmacy students.

6. International Guidelines relating to Palliative Care

6.1 <i>Looking Forward to Cancer Pain Relief or All International Consensus on the Management of Cancer Pain 1997 (World Health Organisation (WHO))</i>	Provides information for clinicians on cancer pain, WHO method for relief of cancer pain pain evaluation ethical issues affecting patients with cancer education and issues in clinical research.
6.2 <i>Cancer Pain Relief 2nd Edition – with a guide to opioid availability 19% (WHO)</i>	Describes cancer pain relief and opioid availability, including guidelines for health professionals directly involved in dispensing opioids.
6.3 <i>Practice Guidelines for Cancer Pain Management 1996 (ASA)</i>	Provides guidelines for cancer pain management which focus on the skills and interventions that are essential components for effective management of pain and pain-related problems in patients with cancer.
6.4 <i>Management of Cancer Pain. Clinical Practice Guideline No.9 1994 (AHCPR)</i>	Guideline which is designed to help clinicians who work with oncology patients to understand the assessment and treatment of pain and associated symptoms.
6.5 <i>Cancer Pain Assessment and Treatment Curriculum Guidelines 1992 (American Society of Clinical Oncology)</i>	Guidelines represent an effort to promote formal instruction on the assessment and treatment of cancer pain in training programs and continuing education courses.
6.6 <i>Cancer Pain Relief and Palliative Care 1990 (WHO)</i>	Describes and reviews the current status of cancer care and pain relief and produces recommendations and guidelines for improving quality of life of cancer patients.

6.7 <i>Palliative Cancer Care. Policy statement based on the recommendations of a WHO consultation 1989 (WHO)</i>	Provides professionals with information on cancer prevalence in order to look at long-term planning; looks at the allocation of resources to palliative care compared with curative care ; and provides guidance for service planning
6.8 <i>Cancer Pain Relief 1986 (WHO)</i>	Provides information for professionals on the management of cancer Pain; provides an outline for the use of pain relief drugs.

7. International Guidelines relating to Acute Pain Services

7.1 <i>Practice Guidelines for Acute Pain Management in the Perioperative Setting 1995 (American Society of Anesthesiologists (ASA))</i>	Report by the ASA taskforce on pain management in the postoperative period.
7.2 <i>Management of Acute Pain: A Practical Guide 1992 (International Association for the Study of Pain (IASP))</i>	Provides a practical guide and information to clinicians on the management of acute pain ; provides guidelines for the application of particular drugs or techniques in differing clinical situations .
7.3 <i>Acute Pain Management: Operative or Medical Procedures and Trauma. Clinical Practice Guideline 1992 (AHCPR)</i>	Guideline designed to help clinicians and others to understand the assessment and treatment of postoperative and other acute pain in both adults and children . Includes strategies for pain control as well as site specific pain control.
7.4 <i>Acute Pain Management in Adults: Operative Procedures Quick Reference Guide for Clinicians (AHCPR)</i>	Quick reference guide based on the document (7.3) .

8. International general guidelines, for both acute and chronic, including children

8.1 <i>Manual of Acute Pain Management in Children 1997 (McKenzie I, Gaukroger PB, Ragg P, Brown TCK Churchill Livingstone Edinburgh.)</i>	Provides practical information for anyone involved in acute pain management ; and provides guidance on analgesia for infants and children .
a.2 <i>Quality Improvement Guidelines for the Treatment of Acute and Cancer Pain 1995 (American Pain Society)</i>	Develops quality improvement guidelines and programs to improve outcomes for Patients with acute pain and cancer Pain.
8.3 <i>Acute Pain Management in Infants, Children and Adolescents: Operative and Medical Procedures. Quick Reference Guide for Clinicians 1992 (Agency for Healthcare Policy and Research (AHCPR))</i>	Addresses the assessment and management of postoperative and procedure-related pain in children. It also contains excerpts from the <i>clinical Practice Guidelines for Acute Pain Management: Operative or Medical Procedures and Trauma (7.3)</i> .

c) Scientific Review

<p>9.1 <i>In-patient vs out-patient pain management programmes that adopt a cognitive behavioural approach</i> 19% (DEC Report No 70 NHS Executive South & West R&D Directorate)</p>	<p>Reviews data comparing the relative efficacy of inpatient and outpatient programmes.</p>
<p>9.2 <i>Systematic Review Of Outpatient Services for Chronic Pain</i> Control 1997 (Health Technology Assessment)</p>	<p>Reviews the evidence about the effectiveness of treatments for chronic pain; reports on the effectiveness of physical interventions; pharmacological interventions; psychological approaches and cost.</p>