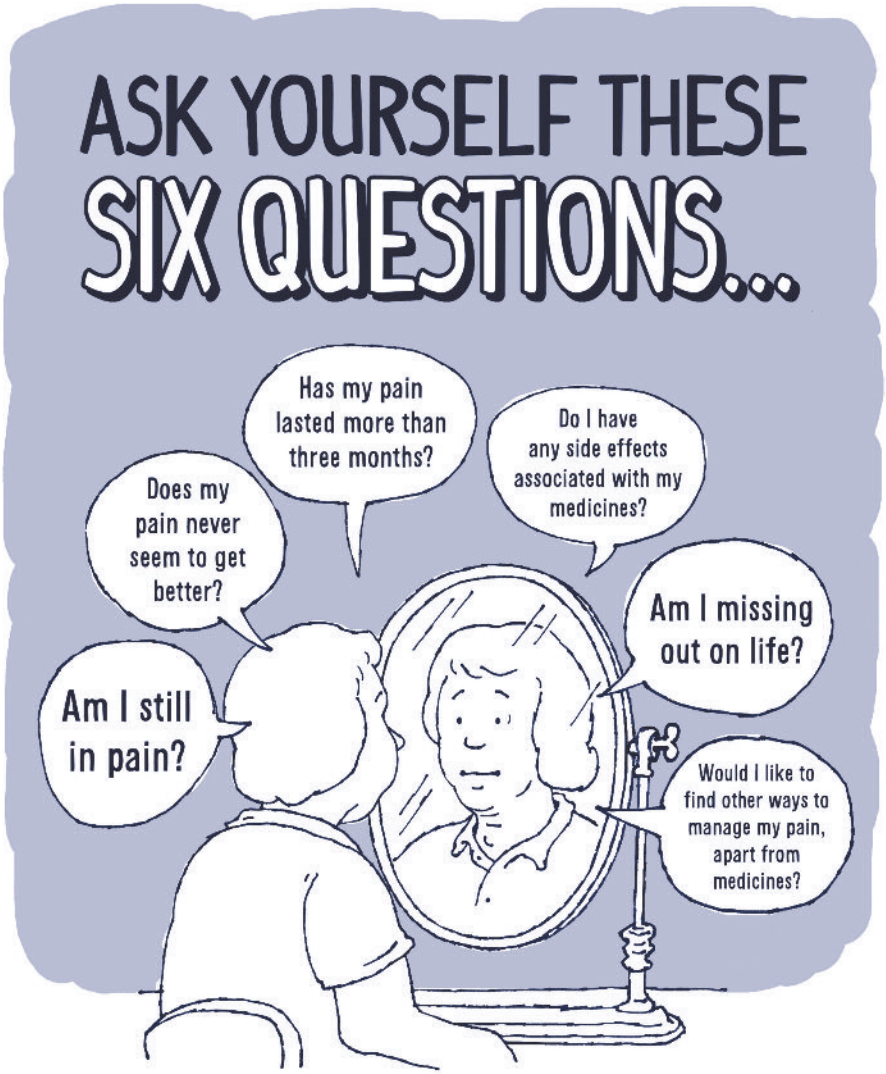
LiveWell with pain

clinician news from Live Well with Pain

really useful online resources: by clinicians, for clinicians

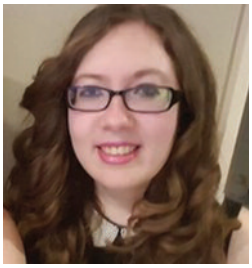
Issue 5 – May 2019 find more at: **www.livewellwithpain.co.uk**



The rise and rise of gabapentinoids: six questions people with pain should be asking – and how we can help patients to ask them *page 5*

Inside this issue

Poor sleep is a common complaint from people who live with pain and we know how impactful poor sleep is on a person's pain experience. Our colleague, **Adele DeGray** is an assistant psychologist in the Dorset Pain Management Service and has been using the *Sleep Well with Pain* leaflet with the people she supports. We asked Adele how she and her colleagues support people to sleep well with pain.



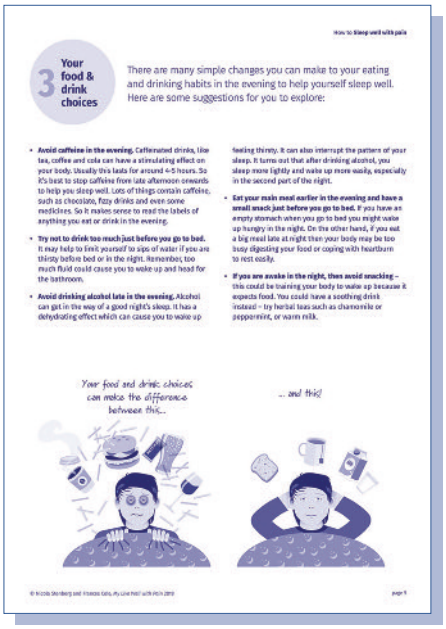
Adele DeGray is an assistant psychologist in the Dorset Pain Management Service

Getting with the programme

At the Dorset Pain Management Service, we have developed a multidisciplinary model of care in collaboration with our Service User volunteers. Our aims are to help patients develop new skills to improve their knowledge and confidence in coming to terms with their pain and adopt effective strategies for living life meaningfully.

In our service, patients report one of their top pain management priorities is to improve sleep. Sleep is especially important for those in pain, helping to repair and recover and maintain good mental and physical health. Poor sleep interferes in many areas including mood, activity and wellbeing. It can also heighten sensitivity to pain, increasing pain symptoms. Pain patients with sleep disturbance also tend to report more mental health comorbidities such as higher levels of anxiety and depression.

The onset of chronic pain can serve as a precipitating factor for developing sleep difficulties. For instance, it is natural to experience short awakenings between each sleep cycle, however those in chronic pain, can find these arousals to be particularly disturbing to their sleep pattern. Despite there being an important biological element, it is how we think about sleep and the unhelpful habits we begin to develop that contribute to both the onset and maintenance of sleep difficulties over time forming a vicous cycle.


3 Your food & drink choices

There are many simple changes you can make to your eating and drinking habits in the evening to help yourself sleep well. Here are some suggestions for you to explore:

- **Avoid caffeine in the evening.** Caffeinated drinks, like tea, coffee and cola can have a stimulating effect on your body. Usually this lasts for around 4-5 hours. So it's best to stop caffeine from late afternoon onwards to help you sleep well. Lots of things contain caffeine, such as chocolate, fizzy drinks and even some medicines. So it makes sense to read the labels of anything you eat or drink in the evening.
- **Try not to drink too much just before you go to bed.** It may help to limit yourself to sips of water if you are thirsty before bed or in the night. Remember, too much fluid could cause you to wake up and head for the bathroom.
- **Avoid drinking alcohol late in the evening.** Alcohol can get in the way of a good night's sleep. It has a dehydrating effect which can cause you to wake up feeling thirsty. It can also interrupt the pattern of your sleep. It turns out that after drinking alcohol, you sleep more lightly and wake up more easily, especially in the second part of the night.
- **Eat your main meal earlier in the evening and have a small snack just before you go to bed.** If you have an empty stomach when you go to bed you might wake up hungry in the night. On the other hand, if you eat a big meal late at night then your body may be too busy digesting your food or coping with heartburn to rest easily.
- **If you are awake in the night, then avoid snacking** – this could be training your body to wake up because it expects food. You could have a soothing drink instead – try herbal teas such as chamomile or peppermint, or warm milk.

Your food and drink choices can make the difference between this...

...and this!

A page from *Live Well with Pain's* Sleep leaflet

Our four week sleep programme

Our programme aims to help patients alter their attitudes towards managing sleep in order to help break the pain-sleep viscous cycle. We do this using a Cognitive Behavioural model (CBT), shown to be effective in 70% of people (Espie, 2006). This approach can help patients develop healthier sleep patterns, begin to re-associate the bedroom with sleep, and establish a consistent sleep/wake cycle.

However, by just using a CBT model which generally focuses on symptom reduction, the viscous cycle can be perpetuated (Meadows, 2013). This is because patients are already hyper aroused to their pain sensations and perceived difficulties with sleep. Therefore, we also integrate elements of Acceptance and Commitment Therapy (ACT) to enable patients to adopt a more accepting attitude to their sleep. By encouraging a more flexible and individual approach to sleep, patients are able to use a 'menu' of techniques which help to reduce negative association and heightened arousal.

From the *Live Well with Pain* resources, we use the five areas to help with initial goal setting and the 'Sleep well plan' to identify SMART goals to work towards for our six week follow up.

Over the page...
Dorset's sleep programme: week-by-week

Week 1

In week one, we use the 'Why can't I sleep?' diagram to provide initial discussion in helping normalise the varying sleep difficulties people living with pain experience. We develop a 'hot cross bun' formulation focusing on thoughts, feelings and behaviours maintaining their difficulties.

Week 2

In week two, we introduce sleep science, review sleep and activity diaries and discuss environmental sleep hygiene strategies. It is important for patients to understand sleep science to recognise the principles behind sleep hygiene, for example, developing a wind down to 'cue' the brain for sleep.

Week 3

During week three we help patients to explore unhelpful thoughts and feelings impacting on sleep and encourage practice of a variety of cognitive techniques such as incorporating worry time into a daily routine, noticing the judging mind and taking alternative perspectives. These can help to change misconceptions around unrealistic expectations and the fear of the consequences of poor sleep. We also deliver stress management psychoeducation highlighting the importance of relaxation which can calm down the stress response and enable the body to engage the parasympathetic nervous system. This can help turn the volume down on pain and interfering intrusive thoughts. We encourage participants to carry out relaxation practices with us during the program, for example, using short breathing techniques, visualisations and cognitive defusion.

Week 4

Week four serves as a review. We continue exploring relaxation techniques and reflect on progress as well as any barriers to maintaining these changes and encourage patients to develop an action plan. We highlight the stages of change model and consider the difficulties in maintaining new habits.

Outcomes

To evaluate our program's effectiveness, we use five outcome measures which look at sleep hygiene strategies, perceived sleep quality and associated thoughts and beliefs about sleep. These are DBAS (Dysfunctional Beliefs About Sleep), ISI (Insomnia Severity Index), SHI (Sleep Hygiene Index), PSQI (Pittsburgh Sleep Quality Index) and GCTI (Glasgow Content of Thoughts Inventory).

The graph shows the pre and post mean scores for each of the measures with a reduction in scores in all outcomes.

This suggests patients were implementing sleep hygiene strategies effectively which had a positive impact on their overall sleep quality. Importantly, patients reported a clinically significant reduction in dysfunctional beliefs, along with an improvement in perceived insomnia severity: at pre group, the average patient score was in the clinical insomnia range; this reduced to subthreshold post group.

In addition to clinical outcomes, we also obtain patient feedback which has been positive to date with participants commenting on the value in sharing strategies as a group and being given confidence to put tools and information learnt into practice.

Here is a selection of comments from our patients regarding what they found helpful:

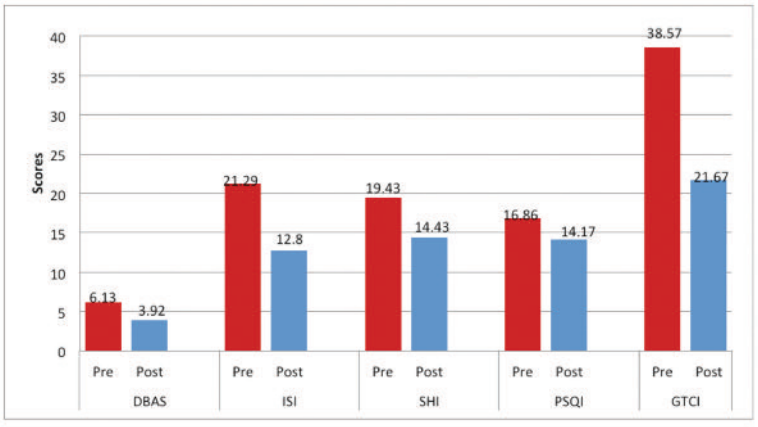
"Putting my myths about sleep to bed"

"Gave me confidence to try to read before I sleep and to wind down before bed"

"Lots of different techniques to try; whatever works for you. I have learnt sleep is individual"

"Good balance of delivering information with humour and kindness. Positive experience!"

Sleep programme pre and post scores



Medicinal Cannabis

Roger Knaggs is Associate Professor of Pharmacy Practice at Nottingham University

Roger Knaggs is Associate Professor of Pharmacy Practice at Nottingham University, provide weekly input to the Nottingham Community Pain Service, is newly appointed Vice-President of the British Pain Society and a member of the Advisory Council of Substance Misuse. He has taken time from his busy schedule to give us a brief update on Medicinal Cannabis, a subject we know many colleagues in Primary Care are being asked about at the moment.

Cannabis for medical indications has been the subject of much media and political attention over recent months. Where cannabis-based medicines have markedly reduced the number of seizures for the very few children who experience dozens of seizures a day, they appear to have a big impact. However, questions about the use of cannabis-based medicines for other conditions is a common question for many healthcare professionals.

Following changes to the law in November 2018 it is now possible to prescribe cannabis-based medicines, however only by doctors on the GMC specialist register and after licensed alternatives have been tried.

The cannabis plant contains at least 750 chemicals, among which are over 100 different cannabinoids with varying activities and effects, the most influential at present being delta- 9-tetrahydrocannabinol (THC) and cannabidiol (CBD).

At present there are few licensed cannabis-based medicines in the UK but they have very specific indications; nabilone for chemotherapy induced nausea and vomiting and cannabis extract oromucosal spray (Sativex) for spasticity associated with multiple sclerosis. Hence, if a cannabis-based medicine is considered appropriate for an individual person then it must be obtained by a specialist importer after relevant approvals. The route of administration (NB: Smoking cannabis remains illegal), as well as strength and purity of the product affect the dose and bioavailability. Two key uncertainties are about the current unlicensed medicines are the dose and the correct ratio of THC and CBD for an individual person.

Some products containing 'pure' CBD are available to buy without a prescription as it is not a controlled drug and these products are considered as food supplements without making claims about medical use. However, this means that the quality may vary markedly between different brands and even batches of the same product. In addition, some of the many of these products may contain THC, and hence illegal. The doses recommended are much lower than those that have been used in clinical trials.

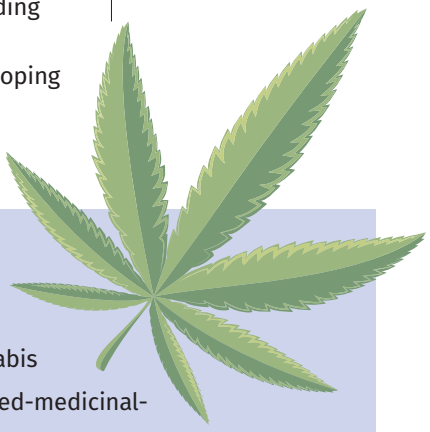
At present the evidence for the use of cannabis-based products for pain indications is very limited, although the quality of many trials is poor. Meta-analyses of studies on cannabinoids for the management of numerous types of pain including neuropathic pain, chronic non-malignant pain and cancer pain, conclude that they benefit only a very small number of people (NNT=24) but that many more will experience side effects (NNH=6).

There is need for much greater understanding about how to maximise the potential for cannabis-based medicines. NICE are developing clinical guidance at present that is due for publication before the end of the year.

Relevant publications

Mücke M, Phillips T, Radbruch L, Petzke F, Häuser W. *Cannabis-based medicines for chronic neuropathic pain in adults.* Cochrane Database of Systematic Reviews 2018, Issue 3. Art. No.: CD012182. DOI: 10.1002/14651858. CD012182.pub2

Stockings E, Campbell G, Hall WD, Nielsen S, Zagic D, Rahman R, et al. *Cannabis and cannabinoids for the treatment of people with chronic non-cancer pain conditions: a systematic review and meta-analysis of controlled and observational studies.* PAIN. 2018; 159: 1932-54.



Useful resources

NHS

www.nhs.uk/conditions/medical-cannabis

www.sps.nhs.uk/articles/cannabis-based-medicinal-products-potential-drug-interactions

RCP

www.rcplondon.ac.uk/projects/outputs/recommendations-cannabis-based-products-medicinal-use

RCGP

Cannabis-based medication: an interim desktop guide.
www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/cannabis-based-medication.aspx

If your clinical experience is telling you that the number of people receiving gabapentinoids is on the rise for conditions such as back pain, widespread pain and pain of unknown aetiology – you'd be right. **Emma Davies** looks at the reasons behind this, and why we should all be concerned about...

The rise and rise of gabapentinoids

There have been significant increases in the number of people receiving prescriptions for gabapentin and pregabalin, in the United Kingdom over the last 10 years.

It has been estimated that as many as 50% of prescriptions are for off-licence indications – conditions other than epilepsy, neuropathic pain, migraine and generalised anxiety disorder.

Speaking to colleagues around the UK, it seems the reasons for this are many – uncertainty about whether we've missed something and so add it in just in case there is neuropathic pain, advice from secondary care specialists – often for a variety of reasons, desperation that nothing else seems to be helping the person and the professional desire to help and to 'do something'.

Whatever the reasons for the increases, concerns about the use of these medicines have grown almost as rapidly as the number of prescriptions. It is five years since Public Health England issued advice on the risk of misuse of gabapentin and pregabalin and yet prescription numbers have continued to rise.

It's now five years since Public Health England issued advice on the risk of misuse of gabapentin and pregabalin and yet prescription numbers have continued to rise

Similar to opioids, a major concern with gabapentinoids is their lack of benefit for at least half of people taking them. Studies have cast doubt on the benefit of gabapentinoids in conditions where they are currently recommended, such as sciatica. Side-effects are similar to opioids; including sedation, change in cognition, memory loss, weight gain, reduced libido, headaches and more...

There is also the interaction with opioids that we need to be aware of. A number of studies have reinforced the increased risk of opioid toxicity and death in people who take opioids and gabapentinoids – particularly as doses of either or both increase. This has sometimes been dressed up as 'opioid sparing' effects of gabapentinoids – in hindsight, this is more likely to be people reaching a threshold of tolerance to the combined effect of both, thus preventing any further increases. Either way, the crucial thing is how we support the people that we see on both opioids and either gabapentin or pregabalin, without experiencing any meaningful improvement in their function.

To add another layer, in April, gabapentin and pregabalin were rescheduled under the Misuse of Drugs Act and are now schedule 3 controlled drugs. Whilst most of the changes impact their dispensing in community pharmacy more so than Primary Care Practices, it is a good opportunity to review people receiving prescriptions for either medicine.

New resource to help with gabapentinoid reviews

Our colleagues at Collingwood Health Group, North Tyneside approached us recently with a draft leaflet to raise awareness about the side-effects of gabapentin and pregabalin. Similar to the 'Great opioid lottery' leaflet the same team worked with us to produce; they wanted to encourage people to seek further information and support to reduce their medicines but also to find out about self-management as part of improving the management of their pain.

Many of the side-effects of gabapentinoids creep up on people. Whilst sedation, dizziness and fatigue can be common from the beginning of

treatment, others such as changes in thinking, changes in mood and weight can take longer to develop or to be noticed. People using gabapentinoids might not realise the detrimental effect the medicines were having on them until they are reduced. Similarly to opioids, many people are fearful of reducing these medicines, but when done slowly and with support, people will frequently report feeling much better without any change in their pain experience.

The result was *Ask Yourself Six Questions*, a leaflet that introduces many of these issues to patients in a way that is accessible and easy to digest, and uses illustration to make the subject more approachable.

Idea for using in practice

A colleague has been sending out the *Ask Yourself Six Questions* leaflet with a letter inviting people prescribed pregabalin, in to the practice for a review. They report that when people attend, they comment that they didn't realise some of the experiences they were having could be due to their medicines.

This has helped develop discussion about any benefits they feel they have had since taking pregabalin but also exploring the side-effects and how dose adjustment or tapering might help them to resolve.

The *Ask Yourself Six Questions* leaflet can be downloaded and printed free from *Live Well with Pain* at:

https://livewellwithpain.co.uk/resources/resources-for-patients/six-questions-to-ask-yourself/

Key Messages

- **Gabapentin and pregabalin prescribing should be for licensed indications only**
- **Both drugs should be used at a stable therapeutic dose for 4-6 weeks to determine effect, and slowly reduced and stopped if no benefit is reported**
- **If patients report 'no-effect' with gabapentin then consider alternative drugs e.g. amitriptyline or duloxetine for neuropathic pain where appropriate, rather than pregabalin**
- **Review the need to continue treatment in patients: receiving gabapentinoids for more than a year; whose dose has not been appropriately titrated or who have no clear indication for use**
- **Gabapentinoids should be prescribed cautiously in people who have current or known history of substance misuse or have recently been released from prison**

From chronic pain to health coaching and activation

A voyage of professional discovery, by **Dr Ollie Hart**

Some of you may remember myself and my colleague Dr Tim Wiliams as GPs with special interest in Chronic pain. We met each other working in Sheffield's hospital based pain clinic back in 2004. We developed a shared affinity for working with people living with chronic pain, which we have maintained in our ongoing roles as GPs.

One thing we both discovered in the pain clinic was how effective it was to work with people, understanding their unique set of circumstances, and helping them to tap into their personal resources for living well with chronic pain. We know this is not easy, but we recognised again and again the people that could do this, however small they started, tended to do better.

Living with a chronic condition like long-term pain is very tough, and requires sustained resilience and constant adaption. These assets rarely come in a pill, or on the end of a needle. Compassionate and capable healthcare workers of all varieties can get good at the skills need to nurture and develop these capabilities in people who have to live with long-term conditions.

Little did we know back then in the pain clinic, these skills are those of health coaching. Health coaching combines the knowledge and skills we have as learned and experienced health care professionals with the science and techniques of coaching and behaviour change. We think this is a winning combination in working well with people living with a long-term condition, making the best of both skillsets in a synergistic combination. The evidence base is ever growing, and Personalisation is now a core part of the NHS 10 year plan, with their universal model.

Tim and I have both been working in Sheffield in the field of person centred care. For the last five years we've been developing approaches and systems that support the personalised approach to care. As well as health coaching we have become interested in the concept and measure of patient activation. Patient activation is a term (and yes it's just a term!) to describe the skills knowledge and confidence people have to self manage, or at least their perception of their capabilities. It is measured by a set of 10 questions. It does require people to feel easeful enough to think well and answer honestly, but assuming people have the responses to these questions can be very valuable in personalizing care.

> 'Little did we know back then in the pain clinic, that the skills we were using were those of health coaching'

Dr Ollie Hart is a Sheffield-based GP. Ollie is a founder member of the NHS England PAM (Person Activation Measure) learning set. He is also the Royal College GP National lead for Activation, and Northern lead for Person Centred Care.

Ollie is a doctor for BBC Radio Sheffield, and has a regular Column in the *Sheffield Telegraph*. As well as this he is a keen runner and triathlete, a husband and a dad.

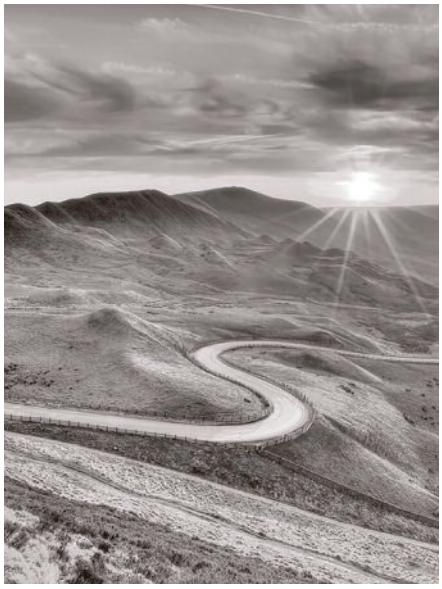
PAM stratifies people into 4 levels of capability – allowing you to personalise your support and track progress, both individually and on a population level.

Tim and I were encouraged by a range of local and national NHS bodies to focus our experience into considering how we can combine health coaching and activation, developing planning and educational resources to share. We've been doing this for some time in Sheffield, and learnt a lot. We've developed models like this quadrant model to describe potential pragmatic approaches to using activation, coaching and social prescribing in holistic models of care.

In the last two years we have developed our approaches into commercial training opportunities. Tim and I set up www.peakhealthcoaching.com to roll out the training outside Sheffield. We offer education and training in health Coaching tailored to levels of activation. We use Tim's STOPIT DOIT model of health coaching, drawn from years of his experience in pain clinics and general practice (he's an old man now!)

So yes we have a conflict of interest now in recommending activation and health coaching. But we have worked this way for over a decade now, and know it works. Probably most importantly learning to work in partnership with our patients, helping them find their own solutions rather than offering fixes, has reinvigorated our careers. Work with people with chronic health conditions is never easy, but working as a health coach is always interesting and worthwhile.

In brief



Reach your peak

If Dr Ollie Hart's article (see previous page) piqued your interest, visit **www.peakhealthcoaching.com** for the latest courses in patient activation and tailored health coaching.

Peak Health Coaching are providers of high quality health coaching, patient activation training, mentoring and consultancy services for health and social care professionals and their organisations.

Experiential courses designed to change your practice and make your work much more enjoyable and effective... from surviving to thriving!

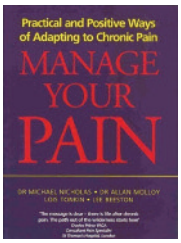
Dr Ollie Hart taking the bull by the horns!

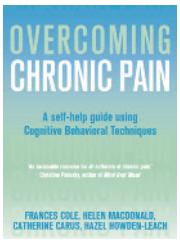
Books for patients with long term pain

Overcoming Chronic Pain: A self help guide to using cognitive behavioural techniques
by Frances Cole, Catherine Carus and Helen Macdonald

Manage Your Pain
by Michael Nicholas, Alan Molloy, Lois Tonkin and Lee Beeston

Both these books are always available and free to access in all UK public libraries. They are part of the national scheme for books on health in public libraries and recommended by the RCGP, RCP and patient groups.





The problem is that many people just struggle with books... so other options are also suggested.

https://reading-well.org.uk/books/books-on-prescription/long-term-conditions

https://reading-well.org.uk/books/books-on-prescription/mental-health/common-conditions

Getting hold of these books; try this local book seller and if people want to order it from an independent small book shop then this bookseller in Harrogate will help. Email: books@imaginedthings.co.uk

Chronic opioid use in non-cancer pain

The University of East Anglia have launched a toolkit for tackling chronic opioid use in non-cancer pain. As part of this development, the team requested experiential data from clinicians around the UK. The document signposts useful resources developed by Medicines Management teams, CCG and Live Well with Pain. The toolkit can be downloaded from: **http://www.uea.ac.uk/pharmacy/research/chronic-opioid-use-in-non-cancer-pain/toolkit**

The all-in-one handout for patients to start their self care journey

Do remember the handy all-in-one A4 sheet of probably the best of the resources for people with pain to start and continue their self-management journey.

Download the sheet to print and give to your patients here:

https://livewellwithpain.co.uk/resources/resources-for-patients/resources-sheet/

In brief

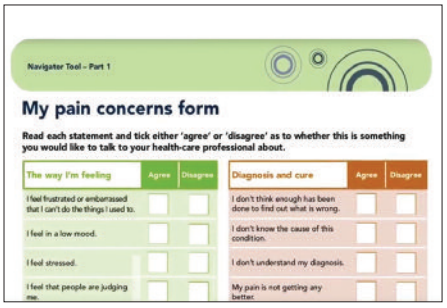
Some useful updates of self-management resources

Pain Concern

has revitalised its resources and tools, so do look at the website and especially suggest it to people with pain as a guide for their self-management. Practical and with a range of videos to explore. **http://painconcern.org.uk/**

Helpline

Pain Concern also has a helpline for people with pain to call for support – in itself an unusual resource for people with pain and their carers. **0300 123 0789**


Navigator Tool - Part 1

My pain concerns form

Read each statement and tick either 'agree' or 'disagree' as to whether this is something you would like to talk to your health-care professional about.

The way I'm feeling	Agree	Disagree	Diagnosis and cure	Agree	Disagree
I feel frustrated or embarrassed that I can't do the things I used to.			I don't think enough has been done to find out what is wrong.		
I feel in a low mood.			I don't know the cause of this condition.		
I feel stressed.			I don't understand my diagnosis.		
I feel that people are judging me.			My pain is not getting any better.		

Navigator Tool

This is a new resource for clinicians and health coaches, health trainers who support self-management. A range of video resources enable better communication between the clinician and the patient about the individual's needs and priorities.

Do explore and give us feedback on its use. **http://painconcern.org.uk/navigator-tool/**

Chronic pain and opiates

Reproduced from Red Whale e-newsletter, May 2019

In recent days, the media has focused again on the issue of opiate use and misuse with coverage of the trial of John Kapoor, "the first pharmaceutical boss to be convicted in a case linked to the US opioid crisis".

Early last year, we sent out a newsletter on the chronic pain and opioid issue. The headlines this time around have been less sensational, simply asking the question, "Does the UK have an opioid problem?" Highlighting that in the United States, President Donald Trump has declared a national health emergency because 130 people die every day from opioid-related drug overdoses, the BBC asks, "But are we really on the precipice of our own epidemic?"

The BBC notes that prescriptions for opioid painkillers have increased by 60% in the UK during the past decade, and the number of codeine-related deaths in England and Wales has more than doubled. It quotes Secretary of State for Health, Matt Hancock, saying the Government is planning to put prominent warnings about the dangers of addiction on the packaging of opioid medicines to protect people from "the darker side of painkillers."

A Guardian article in February 2019 highlighted the higher rates of opiate prescribing in poorer parts of the country, and considered the complex social factors involved in a thoughtful way. It concluded that Britain is a long way from an opioid crisis on the US scale, and that the mere existence of the NHS has prevented the abuses which produced the US crisis. But the article added that it should be possible to do much more for those currently without access to multidisciplinary teams for the help they need.

So, how can we help patients with chronic pain? How can we avoid escalating prescribing and creating addiction? What are the better options for management of chronic pain?

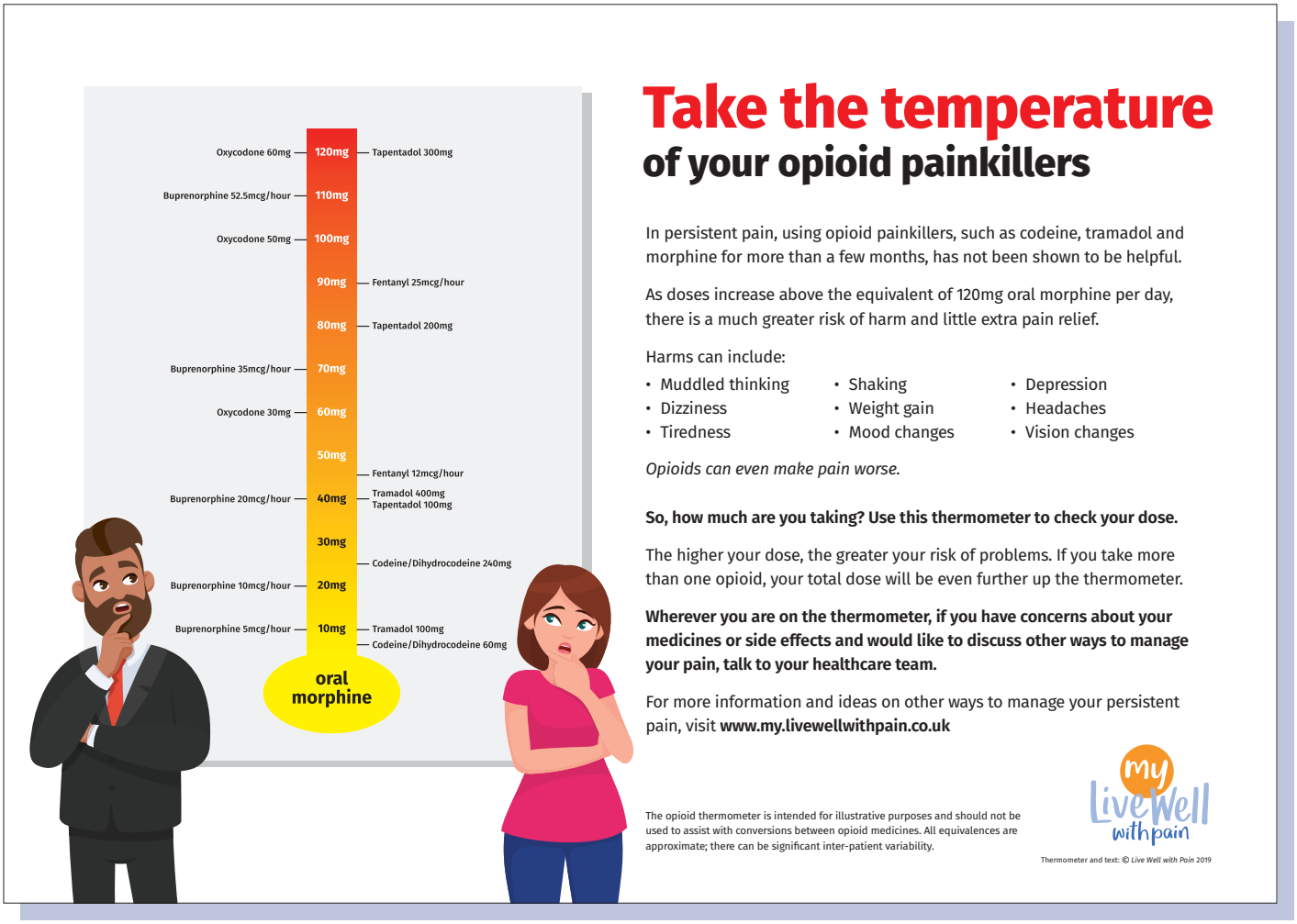
There have been a number of articles recently in the Lancet, the BMJ and JAMA looking at the problem of opiate prescribing in non-cancer chronic pain, and reviewing the management of chronic pain. The Royal College of Anaesthetists has produced a helpful resource, Opioids Aware. The JAMA article reviews CDC guidelines for prescribing opiates in chronic pain.

In short:

- **Opiates are minimally effective in non-cancer pain. We have overestimated their benefits and seriously underestimated their risks.**
- **We should broaden our approach to chronic pain. For most, the drugs don't work – so, wherever possible, don't start opioids. But if we do prescribe, we should avoid high-risk doses.**
- **We should think about opioid dependence in those for whom we are prescribing opiates.**

The Advisory Council on the Misuse of Drugs (ACMD) feels that pregabalin and gabapentin present a similar risk of addiction and harm to tramadol; they were reclassified as schedule 3 controlled drugs on 1 April 2019.

We recently launched another new information poster. *The Opioid Thermometer* was devised by Nina Barnett, Consultant Pharmacist at London North West University Healthcare NHS Trust and Emma Davies, Advanced Pharmacist Practitioner in Pain Management for Swansea Bay University Health Board and *Live Well with Pain* editor. We have been slightly taken aback with the response to the thermometer, with lots of requests to incorporate it into guidelines, newsletters, and websites around the UK. We are always happy to work with colleagues to develop new posters and leaflets that might be helpful in practice. Please get in touch if you have any ideas you would like us to help with.



The *Opioid Thermometer* poster is available to download and print free from *Live Well with Pain* at:

https://livewellwithpain.co.uk/resources/resources-for-patients/opioid-thermometer-for-patients/

Get connected, stay connected

... with us and other clinicians

Get connected to share thinking and ideas on chronic pain and its management. In response to several clinicians' request in primary care *Live Well with Pain* has set up a Google Group for clinicians to connect and share. If you'd like to join this closed group, email us at *Live Well with Pain.*

Send us your contact information, including your name, professional group and current registration number and you will be invited to join.

Send your request to
info@livewellwithpain.co.uk

Get the *Live Well with Pain* newsletter straight to your inbox

For the latest and best in clinical expertise on all things persistent pain-related, make sure you sign up for this newsletter, at:

www.livewellwithpain.co.uk/news/sign-up-for-our-newsletter

About *Live Well with Pain*

Live Well with Pain is a collaborative project, led by Dr Frances Cole, Emma Davies and Eve Jenner, with support from other clinicians. It is for clinicians who want to develop their patients' self confidence to live well with pain through better knowledge, skills and resources to guide them. *Live Well with Pain* has an online presence at **www.livewellwithpain.co.uk** where clinicians can access a wealth of resources for free, to use with their patients who are experiencing persistent pain.

Live Well with Pain does not receive any support from the pharmceutical industry or other commercial interests, and is reliant on occasional grant support plus individual donations from clinical colleagues.

We reached 500!

We now have more than 500 followers on Twitter, which we are absolutely delighted about. Social media is another way for us to share our resources but also allows us to highlight interesting articles and developments in Pain Management that our 'followers' might be interested in. We are always pleased to receive feedback about the website and the resources we share, whether directly or via our twitter page. Here are a few recent tweets from colleagues, letting us know how they have been using some *Live Well with Pain* posters:

twitter.com/livewellpain

Live Well with pain

really useful online resources:
by clinicians, for clinicians
www.livewellwithpain.co.uk