

What knowledge, skills, tools and resources do you need to support people to live well with pain



WordItOut

What do people need from practitioners to be confident to self-manage pain?



WordItOut

Live Well with Pain links

- Pain & Self Care Cycles - <https://livewellwithpain.co.uk/wp-content/uploads/2022/09/the-pain-cycle-v02.pdf>
- Iceberg Tool - <https://livewellwithpain.co.uk/wp-content/uploads/2022/09/iceberg-poster-v02.pdf>
- Health & Wellbeing Tool - <https://livewellwithpain.co.uk/wp-content/uploads/2022/12/LWWP-Health-and-Well-Being-Check-2023.pdf>
- Penny Drop Moments - <https://livewellwithpain.co.uk/practitioner-resources/skills-knowledge/supporting-self-management/penny-drop-moments/>
- Carers 10 Footsteps - <https://livewellwithpain.co.uk/resources-for-people-with-pain/ten-footsteps-for-carers/>
- share the stories of Louise and Chris in the Ten Footsteps <https://livewellwithpain.co.uk/resources-for-people-with-pain/true-stories/>
- The tool that is so helpful is the decision aid tool = OPIOID LOTTERY TOOL developed with a lead GP and LWWP team. This links to their story and life experience <https://livewellwithpain.co.uk/wp-content/uploads/2022/09/opioid-lottery-v03.pdf>
- Most of the tools we have developed at LWWP for medicines have come from you as front line practitioner's issues.... so Opioid Lottery Tool, Opioid Thermometer <https://livewellwithpain.co.uk/wp-content/uploads/2022/09/LWwP-Opioid-Thermometers.pdf>
- MEDICINE DECISION AID tool that Emma shared <https://livewellwithpain.co.uk/wp-content/uploads/2022/09/medicines-decision-guide-2023.pdf>
- Follow our Eventbrite page for new Ten Footsteps courses - <https://www.eventbrite.com/cc/ten-footsteps-training-1290979?utm-campaign=social&utm-content=creatorshare&utm-medium=discovery&utm-term=odclsxcollection&utm-source=cp&aff=escb> or email training@livewellwithpain.co.uk
- Decision aid tool for patients taking gabapentinoids <https://livewellwithpain.co.uk/wp-content/uploads/2022/09/ask-yourself-leaflet.pdf>
- Opioid thermometer Opioid Thermometer - <https://livewellwithpain.co.uk/wp-content/uploads/2022/09/LWwP-Opioid-Thermometers.pdf>

Non-LWwP Links

- NICE Guideline Diagram - <https://www.nice.org.uk/guidance/ng193/resources/visual-summary-pdf-9073473517>
- KM posted 'I like the PAW (Pain at Work) toolkit for managing chronic pain' <https://painconcern.org.uk/pain-at-work-paw-toolkit/>
- <https://painconcern.org.uk/pain-concern-carer-community/>
- grahamdunthorne posted CDC ICD11 diagnostic criteria for chronic pain https://cdn.who.int/media/docs/default-source/classification/cat-webinars/unlocking-the-potential-of-icd-11-for-chronic-pain/introduction-to-the-icd-11-chronic-pain-classification.pdf?sfvrsn=559119b5_1
- NICE Guidance Safe Prescribing and Withdrawal of dependence forming medicines NG215 - <https://www.nice.org.uk/guidance/ng215>

- Faculty of Pain Medicine - List of Long Term Harms - <https://fpm.ac.uk/opioids-aware-clinical-use-opioids/long-term-harms-opioids>
- Faculty of Pain Medicine Opioids Aware main page Opioids Aware - <https://fpm.ac.uk/opioids-aware>
- <https://www.nhsfife.org/services/all-services/pain-management-service/medication/>.
- <https://warwick.ac.uk/fac/sci/med/research/ctu/trials/iwatch/>

Comments

- Riaz Ahmed *I've always found the most challenging cases are where chronic pain is coupled with mental health issues.*
- Sue Crisfield *Very powerful Quotation from LWWP leaflet - 'Self-management is about shrinking the part of your life that is about pain, and growing the other parts of your life, so that pain no longer dominates'.*
- grahamdunthorne *Moving the conversation towards what people 'can' do.*
- Frances Cole *"Start anywhere as chosen by the person Footstep 1."*
- Sue Crisfield *"Enable people to learn to recognise the negative thoughts and counter with positive I can thoughts"*
- Sam Powell *"we're so scared to fail, or look an idiot. it's helping people loosen up around "getting it right". pain is so often linked with those personality types of conscientiousness/ perfectionism/ being driven. in my experience"*
- Frances Cole *"Health check used early can support you and the person to find appropriate support earlier by helping them to focus on the impact of pain. This can shape conversations about medicines as well - how many of the issues will be resolved by medicines?"*
- Frances Cole **Key messages: antidepressants helpful as people with pain have an increased perception of threat; so often more anxious, fearful or depressed and medicines help a more helpful balanced perspective rather than a catastrophic thinking pattern**
 - Graham Dunthorne *"And important that this is in the general chronic pain population - people with severe mental illness are usually excluded from pain research"*
 - Frances Cole *"Remember - people with pain have very poor concentration and memory due to pain, depression and medication.... so pacing collaboration and treatment plans is crucial"*
 - From Emma Blundy to Everyone: *"Yet my most complex patients are often those who have both mental illness and chronic pain, so it does make evidence based management challenging."*
 - From Frances Cole to Everyone: *"Skilled practitioners - understand the role of guidelines and can understand individual cases where a wise different approach may well be helpful AND it is important to measure the outcome"*

change for the patient.... e.g. self confidence, improvement in mental health well-being or lessening of pain distress, intensity”

- From Raj Spurway Jain to Everyone: *An excellent patient clinician relationship is important. Clinicians need to be thoughtful communicators. Getting that initial rapport, especially on telephone, is paramount to successful outcomes.”*
- From Aysha Ahmed to Everyone: *“Ongoing developments and new interventions pharmacological and non pharmacological - important to explain this to the patient to allow them understand where we may advise, discuss, agree management plans from with them.”*
- Sue Crisfield to Everyone: *“Social prescribing is hugely important here. Living with pain is so isolating so connection with others is really helpful, especially those who are also sharing experience of living with pain.”*
- From Sam Powell to Everyone: *“There are networks for Drs who are interested in these things, happy to be contacted if people interested in joining in. samanthapowell@nhs.net. sorry I can't help the pharmacists”*
- From Dean to Everyone: *“We find reductions and deprescribing result in patient scored improvements across - Overall quality of life, level of activity, sleep, mood, anxiety, and PAIN!”*
 - From Frances Cole to Everyone: *“Great news Dean.... can you share with us to help promote to others and we can ensure your work is helping make a difference leadershipteam@livewellwithpain.co.uk”*
- From Sam Powell to Everyone: *“I have set up an AccuRx with a list of resources for pts to look at - some web based, like Live well with pain and TMS wiki,, some books, like Alan Gordon's The way out, and some podcasts like "tell me about your pain" or the "Cambridge progressive medicine" podcast”*
- If you want to build your skills further do consider Ten Footsteps Footsteps programme apply LWWP Admin lwwp.training@gmail.com
 - 12 hour programme over 8 weeks in three four hour sessions: = £180/per course or discount for a group

What are the barriers to medicine reduction you have experienced?

- Fear of increased pain.
- I find with patients - that they say it's not working or helping enough, but as soon as mentioning coming off them or reducing (even with explanation)- they suddenly change their mind and want to stay on them
- Worried that if they can't tolerate reduced dose that it won't be able to be increased to starting dose
- Dependency
- Patient fear is a big thing to understand
- Perceived increase of pain
- Patient reluctant to engage with management other than medication
- Cost cutting exercise
- patient fear, of change, reduction, of increased pain

- they say I want something done, but not any of your ideas!
 - E.g., what next? what will replace it ??
 - Fear of change of long term management
 - Fear of taking away the only thing that is perceived to help
 - Fear that wont be able to cope without them
 - Fear seems to be key
 - non consistency from the practice
 - Most people have missed a few days and experienced withdrawals - these they often suppose are a baseline pain level without meds
 - taking doses to 'take them away from the pain' and what will they do?
 - Patient has poor perception of other strategies like mindfulness
 - From health practitioners they often thing too difficult/ time consuming and not often successful
 - It's going to take too long
 - fear that healthcare professional thinks they are abusing the medicines and that's why they are trying to get them off it
 - not believing they are dependent on them and that the meds could be causing symptoms rather than their chronic pain condition
 - I've found patients with severe mental health and social issues have become very psychologically reliant on medicines and their hypnotic effects to numb their issues...difficult to reduce pain without addressing MH/social issues first
 - "I'm in pain now, how much pain will I be in then?!"
 - flares of pain will be interpreted and managed by other clinicians by increasing again and reinforcing that they need it
 - I actually use a bit of reverse psychology- where plant the see that they are still in pain whilst on x y z and how is that helping if they think about it...let them express and think and then say about trial and error, explaining the pros, cons, monitoring and also back up plan for reassurance but allow them to make decision in conjunction with clinician to feel empowered and can try but we have support/back up. (In good scenario case)
 - barrier is time for HCP. pt barriers include concerns regards deprescribing
 - Worried that other professionals involved that the patient has a good rapport with may not be singing from the same hymn sheet as you and the patient loses faith in you.
 - Increased risk of pain and not giving an alternative. We also have a problem with practitioner's not all being on board and then re-prescribing.
 - "why rock the boat" this was a response of one of my patients to taper down opioids
- Frances Cole *"Rock the boat..... the medicines are causing a range of health issues some you will know and some you will not be aware of..... can I/we explore further.... perhaps you could explore this tool "* <https://livewellwithpain.co.uk/wp-content/uploads/2022/09/opioid-lottery-v03.pdf>
- people believe the pain will worsen
 - Agree, we have letters from hospital asking them to manage their pain!
 - often pain clinic saying increase pain meds as well! nightmare for us to go against them
 - Opposite side- they state the 'GP' or consultant has said to be on this medication/long term and perhaps been told cannot do anything else in some scenarios so the type of vibe no one else can stop this or change it so why are you trying?
 - It is in their mindset
 - I find MSK physios often ask GP to increase painkillers as patient is in too much pain to do exercises

Graham Dunthorne *"A very common idea unfortunately. Instead - we should be supporting an individual to find a baseline of activity that they 'can' manage despite their ongoing pain"*

- I often get told "My doctor knows I'm on these and they are happy with my medicines"
- Pain clinic often sends a long list of meds to try

Graham Dunthorne *"Other specialties will often recommend 'pain management' and I find it helpful to validate that, but explain that pain management doesn't necessarily mean pain medication"*

Questions (Additional answers provided by Emma Davies)

- **How many interactions with your GP practice were pro-active or were they reactive?**
 - Louise explained that most interactions she had with healthcare services were reactive to her approach. Things are changing with people being called in for medicines reviews, long-term condition reviews although this does not seem standard for pain reviews still.
- **Hi Louise, how did the nurse explain to you about the side effects/ negative effects of opioids? What convinced you?**
 - Louise has said to me previously that it wasn't just having the issues pointed out that convinced her, but that it was done repeatedly over time. She also had a number of emergency admissions to hospital with bowel obstruction and it was during one of these admissions that things started to change in terms of her thinking. Also, Louise's wife would attend the appointments and so was able to reiterate the messages at home, as well as point out where she was noticing the medicines having a detrimental effect on Louise and their life generally. It is frequently the conversations outside of appointment times that have the greatest effect.
 - When discussing concerns about opioid use with people, it is worth spending a bit of time looking at their specific issues and linking them back to the analgesics they're taking. Making it make sense to them e.g., someone with COPD and taking opioids and gabapentinoids – gently alert them to the significantly increased risk of ventilatory impairment and death from the combination. Same combination in someone with a history of depression or anxiety – explain that the medicines have been shown to lead to higher rates of re-emergence of depression or worsening mood.
- **Are there any thoughts why chronic pain prevalence is increasing at such a rate? Our lifestyles?**
 - Lifestyle issues almost certainly contribute. There are also thoughts that as we have become more aware of pain as a condition in its own right, we are more alert to it – the old, is this happening more or are we just asking about it?
 - Another consideration is represented by a quote I use all the time from a psychologist who was based in Sweden – Joanne Dahl, *"When pain was unavoidable, we tolerated it. When pain became avoidable, it became intolerable. What we have created, with all of our painkillers and pain management strategies, is an intolerance and increased sensitivity to pain."*

- **What experiment would you suggest to patients to try?**
 - An example could be discussing an activity or 'something' the person currently thinks they can't do or they're worried about doing (not always for pain related reasons). The 'experiment' might be set up via conversation such as, 'What do you think will happen if' why not try Explore what the barriers might be, "What do you worry might happen? and how might you manage that if it happened? Then see what 'actually' happens - often, peoples fears are not borne out by reality, but the fear of failure stops them trying. Confidence and having the support behind them can make a massive difference.
 - An example from my own practice – lady who was struggling going to church, something that was important to her socially. She couldn't sit through the whole service but wanted to sit near the front due to her 'standing' in that community. She thought if she stood up, everyone would look at her, be appalled, she might be spoken about or criticised and consequently lose her social status. We discussed the likelihood that people would be critical, especially given the place this was happening and what actions she could take e.g., just stand up when she needed to, sit at the side or the back of the church so she was less noticeable if she stood, speak to her friends and tell them what she was planning to do – we went through what she considered the pros and cons of each. She decided she would try sitting at the back for one service and stand when she needed to. She came back reporting that she had done that and nothing had happened, no one mentioned it, she was able to mix with her friends afterwards more easily as she'd not been stuck sitting down for an hour beforehand. She was happy with this and moved her plan on to mention it to her friend who, it turned out, joined her at the back so that she too could stand up as she needed to.
 - This might sound a bit trite but it focussed on what really mattered to the patient and led to her trying more things that she'd been avoiding because realised she could plan it and had the confidence that the worse case scenario didn't happen.

- **When you are tapering opioids, do you taper the MR 'background' opioid, or try to remove the prn opioid that is more difficult to control prescription quantity wise**
 - Horribly grey answer - it depends. MR opioids are more problematic than standard release in fact - in complete contrast to the messages that have been given for years. It is thought that the constant exposure to opioids via MR preparations likely contributes to hypersensitivity which in turn, leads pain to increase rather than reduce (opioid induced hyperalgesia).
 - Possibly - people often feel the prn is the thing that works, in which case support them to reduce the thing they feel less helpful. The key is controlling quantities and supporting their understanding of the pain and what other things help and don't, so they don't start increasing the prn in response to reducing the MR
 - Can also use the box tool to talk about the place of medicines in pain management - medicines may be the largest part of their tool box at the start, we need to support people to make their toolbox bigger

- Frances Cole to Everyone: Let the person understand the drugs and what they do and then ask their choice and then offer your choice and why too and then agree a best option to try use the relevant tools already suggested.
- Frances Cole to Everyone: *"Please offer medicines / non drug treatments to manage some key side effects like constipation..... and continue focus on medication reduction with person in control"*
- **So reduce MR and leave prn is first line?**
 - I ask people which of the medicines they feel is most effective. I would say the majority tend to say the standard release medicines work better – so if that is the case then reduce the MR one first. Also really important to stress that 'breakthrough' pain is not really a 'thing' in chronic pain in the way we think about that in e.g., palliative care. Pain fluctuates and it is important to normalise that. Support people to recognise things they do or situations that make pain more difficult or easier to manage and then focus on changing their approach to that, rather than reaching for medicines. They may have periods where pain increases for longer-periods – we call this a flare-up or a setback. Making a plan of how they manage those situations can be really useful. It might include medicines but shouldn't consist only of that.
 - We should be trying to avoid MR opioids generally in acute and chronic pain conditions – the evidence now clearly demonstrates that people who target opioids to higher levels of pain, rather than regular use, will have lower overall exposure, fewer adverse effects and most importantly more effective pain relief.
- **What is your experience with adrenal suppression with opioids? and at what doses have you seen this?**
 - I've seen it a lot. It tends to happen with higher doses but doesn't necessarily link to duration of prescribing. If people are using other medicines that might contribute to endocrine suppression e.g., oral or inhaled steroids or who have other conditions that might pre-dispose them to the effects, then even the dose matters less. Sometimes people present symptomatically but their blood tests are inconclusive. Some areas I understand have recommended annual testosterone/progesterone/oestrogen tests part of their pathways for opioid prescribing. We can't guarantee that reducing/stopping opioids will reverse these effects and there is some evidence that e.g., testosterone replacement will have benefit even if opioids are continued – however, if people have got to that position, the likelihood is that they will be getting limited benefit which is almost certainly outweighed by the harm. It tends to get recognised more in men than in women, where more things will get dismissed as 'hormonal' or the effects reported are not considered as important to treat e.g., loss of libido or sexual functioning.
- **Do you have a support group for Pharmacy tech/clinical pharmacy teams to help with questions to help with guidance if needed? Somewhere where we can continue to share ideas etc.,**
 - We don't run a forum like this – I think there are probably things around, certainly Morph training have a pain group on Telegram and the Primary Care Pharmacy Association (PCPA) and UK Clinical Pharmacy Association (UKCPA)

both have pain interest groups and both also have discussion forums / question boards, so worth having a look at them.

- If you think this is something that would be helpful for LWwP to set up, let us know and we will investigate it if there is a lot of interest.
- **Do you offer any medications for short term flare up management and if so - what would you start with?**
 - There may be some benefit in providing something for a time limited period. What that will be will depend on what the person is already taking. NSAIDs are often underused in these situations but if suitable, can be helpful for those periods.
 - Some people have a small supply of a low dose opioid that they access when they feel a flare up coming or when they're in one, to try to break the pain intensity cycle. They may have agreed a week or 2 maximum with their prescriber.
 - We have information about flare-up or setback plans on the website – even if someone has 'setback medicines' available, they will be effective only if used in combination with other management e.g., managing activity by pacing more, increasing rest time during a flare-up, focussing on relaxation until the flare-up starts to settle. Medicines should be used in these periods to maintain a level of function rather than being the plan in and of themselves.
- **How is Live well with Pain funded?**
 - LWWP is funded by training workshops and occasional grants from Durham University.... we are not for profit. There is no NHS funding directly and we are motivated to enable practitioners become confident in their K+ Skills to support self-care
 - We also do not take any funding from Pharma companies
- **Do degenerative conditions count as acute or chronic pain??**
 - This may partly depend on presentation but if you're thinking about conditions such as osteoarthritis or even multiple sclerosis, then they would be classed as chronic pain conditions. This is even if the individual experiences short periods of increased pain intensity.
 - Acute pain would be something like trauma, post-operative pain- things which are relatively short-lived and most frequently have clear causation. See the links section for further information about the ICD11 diagnostic criteria for chronic pain, which may help.
- **Do you know why Tramadol has a typically Opioid type (poss sedating) effect for some, but a stimulant type effect for others?**
 - Likely due to the dual action and people can have a pretty awful response to the serotonin effects especially. David Juurlink refers to giving tramadol as throwing venlafaxine and morphine at people in different quantities each time. There is a podcast where he talks about tramadol which is worth a listen, via this link <https://geripal.org/tramadont-dangers-of-tramadol/>

- **Would you advise we reduce one drug dose at a time...and what advice do you have re med reduction during a setback in pain control?**
 - Always introduce or reduce one medicine at a time whenever possible. It's the most reliable way to know whether something works or not, causes adverse effects or not.
 - (FC) Self-management starts steadily and allow most patients to then start reduction at one type of medicine at a time.... multiple drugs used and the time taken to stop one by one over time = 9-12 months in my/our experience
 - If they have a setback or flare-up or even if something else happens e.g., they have a family event, then you can pause a reduction and return to it - try not to go backwards. For most people, things will settle down and if they don't then consider whether the issue is something new or requires additional support – which still may not be increasing medicines again, but a different approach.

- **What other specific pain management strategies would you advise that they use as an alternative to medication whilst reducing the doses?**
 - Will be down to the individual to think about their personal goals and what they think is achievable. You may want to help them set some goals and start that before making the first reduction - so they've seen some progress and then the aim is to maintain that. Really basic - walking between lamp posts on their street - visual reminder of their progress which can be helpful. Always remind people they need to be able to walk back and not just in one direction!! I had a lady who kept setting off but had her husband collect her at the end because she pushed herself on the outward walk and hadn't factored in getting home!
 - Also think about creative things - people don't always want to 'exercise' as a way of increasing movement but they may feel able to go outside and potter in the garden or paint, take photographs etc. They may need to walk in order to do it but the pleasure they gain from the activity outweighs the concern of the activity

- **What about using accurx - to send patient questionnaires to identify patients ready to start this journey. Any HCP tried this route**
 - Yes, we have AccuRx questionnaires available based on LWWP Health Check tool and talking with them today later. Get in touch with me direct frcole60@gmail.com

- **Would you use the same resources/principles regarding diazepam use or are they are any specific resources on this?**
 - Really similar principles - lots of medicines reductions need a similar approach of finding what the problem is the patient is really dealing with, how effective is the medicines in terms of helping make a difference

- **What would you do if GP not on board, I have one particular GP who feels there is a place for long term opioids in pain and feels he need to prescribe something for all of these patients?**

- This can be a tricky situation, especially if everyone else in the practice feels a different approach is more appropriate. It can lead to ‘doctor shopping’ by some people who become aware of the ‘weak link’, which can lead to difficult relationships within practices as well.
 - I think it can be helpful to approach things as a whole group e.g., via practice meetings, education sessions etc., rather than directly with the individual – when we feel targeted, we can sometimes dig our heels in which doesn’t aide things. If discussing analgesic use and concerns about opioid use in chronic pain, stick to the evidence – use guidelines, research papers etc., to illustrate the concerns. Maybe discuss a case that isn’t linked to the GP, to illustrate some of the problems you’re seeing in practice and encourage discussion about how different practitioners would approach things. How does the GP justify continuing opioids when people are not doing better? What are they basing their practice on and how do they review the effectiveness of their approach? If everyone is involved in this discussion, they might hear colleagues approaches and then start trying it out without having to publicly back down. It can also be helpful to share some of the coroners reports or real stories of people who have come to harm from long-term opioid prescribing. We all think it won’t happen to us until it does. Faye’s story is pretty powerful <https://www.england.nhs.uk/patient-safety/fayes-story-good-practice-when-prescribing-opioids-for-chronic-pain/>
 - Does the GP feel they need to prescribe because they don’t know what else to do? It may not be that they think opioids are helpful but that they don’t feel equipped to offer any alternatives. I’ve worked in a practice where a GP said they just couldn’t deal with pain patients anymore – they didn’t have any confidence and was concerned they just resorted to path of least resistance. I thought this was brave of them and the agreement after a practice meeting was that that GP wouldn’t see chronic pain patients unless it was a new acute problem (not pain related). They also attended training on pain management. It worked well for about a year until they said they now felt they could take it back on.
- **Louise, a very cheeky question, and please feel free not to answer. Do you currently take any regular meds to manage your pain, or do you manage flares as they occur with meds & use other strategies routinely? Thanks for your insights today**
 - “I only take paracetamol & rarely codeine if my flare is extremely bad, or in an acute situation.”
 - Louise paces her activity and has found that staying active is helpful. Her film on the website illustrates how she took to walking daily as a major part of her recovery and now she leads a weekly walk for people with long-term health conditions. She also goes cold water swimming in the sea near where she lives.
 - **What if someone is on an incredibly high, unsafe dose and despite discussions does not wish to engage in a reduction?**
 - Most people who actively self-manage are almost on no drugs or minimal at 12 months. Project work in GP practice in Darlington four years on from opioid reduction programme still as no people on strong opioids for chronic

pain two years on..... you can AIM for this providing all other prescribers are doing the same consistent practice policy for this group of patients.

- (ED) This is a tricky situation, but the medico-legal view is that where there is evidence of harm as a result of continuing prescribing, the prescriber should take appropriate action to make the patient safe and reduce the harm.
- It is important to discuss this issue as widely as possible – what support is there from Health Board, PCN, ICB etc., and not just within the practice itself. Is there a strategy that is aimed at reducing prescribing and if so, what is built into that to support and protect the prescribers should things go wrong – either harm from the prescribing or complaints following withdrawal of prescribing.
- **I've had flat refusal from a legacy patient to reduce a mix of Actiq 800mcg TDS and Zomorph 100mg BD (over ten years of combined therapy). So made her aware of red-flags and placed under quarterly review.**
 - (FC) this is fine and at quarterly review undertake assessment of side effects and even blood tests to ensure they are informed and noted in medical records should a significant event occur e.g. severe unusual infection, cancer diagnosis emerges etc.
 - (ED) I tend to do a deep dive on the notes and find if there is evidence of harm arising e.g., frequent chest infections in asthmatic / COPD patients, evidence of sleep apnoea or other respiratory problems, combination with other high risk medicines e.g., gabapentinoids, benzodiazepines. Renal failure and so on. All of these increase the risk to the patient and strengthen the prescriber's hand to withdraw medicines due to safety risks.
 - At some point, we need to have an open discussion with the public about the fact that there is no entitlement to a prescription. People can expect to receive appropriate treatment, but this does not necessarily mean a prescription. It is the prescriber who carries the liability and so we need to take some of the power back in that regard.
 - People are often worried about the changes because they don't really understand the risks in the first place, they don't recognise the changes that have occurred because they have happened over such a long time e.g., they don't have an accurate memory of the time before the medicines. We also need to accept that the analgesics changes cognition and so people are likely less reliable historian than they believe – again because this happens over extended periods. The medicines check can start helping that conversation because it can draw attention to difficulties being caused by medicines or problems that are not solved by them. Finding ways of opening that conversation can take time and requires building the trust of the patient that nothing is going to happen quickly or without their knowledge.
 - Try asking what is better now than before – what tangible change can they point to – too frequently, these same people are still reporting high levels of pain and/or disability.

Comments from attendees to this discussion point

- I have had a few where patient adamant not willing to reduce and different reasons given such as GP wants me to be on this. It is often helpful to have a joint consultation with the GP and yourself- team approach.

- "As an HCP, I want people to be on the lowest dose of effective medicines"
- "I say something along the lines of "there's no point doing something that isn't working, let's look at what else we can put in there that might be helpful".
- "We're working with a patient on 570mg Morphine daily - after 6-9 months of motivational work he's now reducing at 10mg per month only 3 1/2 years to go :-)"
- Thanks! Not to sound defeatist in attitude but not much more I can do. I'm well aware of the clinical responsibility of signing the prescriptions. But making sure the patient is aware of sudden fatal outcomes is documented.
- I advise pain meds fall into the category of 'symptom control meds' as opposed to 'disease control meds'... therefore they won't address the underlying issue of why they are experiencing pain - changes their thoughts about pain meds.
- weirdly I sometimes get pushback from the relatives I don't want them complaining again.... they aren't bothering me while they are on it

- **These comments highlight the difficulties we all face out in practice. Getting practices to agree and even advertise how they will approach opioid prescribing generally or problematic dosing more specifically can be helpful in raising awareness amongst the population. Feeding some of the messages into medicines reviews e.g., sending Opioid lottery or medicines check along with medicines review appointment letter can assist with that, as an example.**

- **The other thing is to have something else to offer – starting the discussions about self-management and starting to support people to 'grow the box' before making changes to medicines, may feel like putting things off but will pay dividends because people always want to know what they are getting instead of the medicine you are taking away.**