Management of pain to tolerable levels, restraint of attendant symptoms and restoration of functionality form the mission statements of most chronic pain control programs. Few pain treaters claim to provide elimination of pain and fewer still rely solely on interventions or analgesic and co-analgesic prescriptions. The International Association for the Study of Pain (IASP) classed pain clinics into three broad types according to services provided:

a. Modality-oriented (psychological, interventional, acupuncture, etc.),
b. Disease-oriented (spinal cord injury, headache, etc.), and
c. Multidisciplinary/interdisciplinary.

Ideally, pain management should be pursued under fully trained, appropriately funded and clinically experienced interdisciplinary teams. In fact, these ideal circumstances usually only exist in urban and academic locales. Whereas neurologists, psychiatrists, surgeons, anesthesiologists, physiatrists, psychologists, physical therapists and specialty nurses are trained to recognize and manage acutely painful diagnoses, relatively few members of these health care disciplines train and consistently unite to jointly manage chronic pain syndromes, symptoms and behavior.

There are two approaches to multi-specialty treatment team pain management. The model of a multidisciplinary pain management program differs from an interdisciplinary pain management program in one fundamental fashion. In the multidisciplinary program, the disciplines are housed under one roof and have frequent interactions regarding patient participation and treatment. The advantages of this model are that the therapists are able to discuss difficulties, as they arise, with other team members. For example, most programs have discharge criteria for failure to participate in therapy. When an individual is to be discharged, especially where there is the potential for negative sequelae for the patient, for example, Worker's Compensation, it is important that the team be apprised of the imminent discharge to insure that everything possible is done to maximize the patient's potential for improvement and that the discharge is not related to a problem that may be solved. Having multiple sources of input allows processing of the problem to insure that the patient's needs are met. The ability to communicate rapidly and to increase the interactions among professional staff must be weighed against the expense of a multidisciplinary program and the individual autonomy of therapists. In an interdisciplinary program, typically the various therapies are provided but not in one location.

The goals of therapy remain the same in most cases. These goals, which may vary according to the needs of the individual, typically include some combination of the following general goals:
a. Achieve rapid pain reduction – with conservative treatments followed by medications, diagnostic/therapeutic nerve blocks, neuromodulation (electrostimulation), and surgery for specific indications if conservative care fails,
b. Improve or increase functional activity level
c. Decrease or eliminate the use of opiate medications
d. Increase strength, endurance, and cardiovascular fitness
e. Improve emotional well-being
f. Train appropriate body mechanics to prevent further injury
g. Establish physical work capacities and restrictions
h. Learn strategies for coping with pain
i. Return to work and other productive activities of living
j. Facilitate socioeconomic rehabilitation
k. Increase function with home based rehabilitation program

Both multidisciplinary and interdisciplinary programs include a physician, who is most often either an Anesthesiologist, who is Board Certified in Pain Management, or a Physiatrist. A Neuropsychologist, or Clinical Psychologist, trained in pain management, a Physical Therapist, an Occupational Therapist, and a Rehabilitation Nurse or Case Manager, are also core team members. This team may be supplemented by an exercise physiologist, a massage therapist, and recreational therapy. Medical management is provided by the physician and most often there is a requirement that the patient not receive treatment for pain from other physicians while the patient is participating in the program. This allows the physician to manage any problems that arise in treatment and prevents inadvertent "team splitting" by a physician who is not cognizant of the goals of therapy for the patient. The role of the Neuropsychologist or Clinical Psychologist is to provide assessment of the patient, including psychological testing, collateral evaluation (spouse, partner, or other family member), individual or group psychotherapy, pain education, and to assist the treatment team in behavioral interventions when counterproductive behaviors occur. The Physical and Occupational Therapists assist the participants in the awareness of anatomy and development of appropriate body mechanics as well as facilitating improvement if the patient's deconditioning. Through education that is provided both during structured education classes and during therapeutic activities, Physical Therapists and Occupational Therapists help the patient to understand the negative effects of avoidance of activity and the resultant deconditioning that ensues. Avoidance of activity is frequently seen in patients with chronic pain. This may occur as a result of a fear of additional injury. Thus is imperative that the Physician, the Physical Therapist, the Occupational Therapist, and other members of the treatment team reinforce the patient for appropriate activity. Communication among members of the treatment team regarding patient restrictions and activities which should be avoided for safety should be understood and reinforced by all members of the team as well as by the patient's family and external Medical Case Manager. Many multidisciplinary and
interdisciplinary programs have a model of functional restoration that lasts for four to six hours per day, five days per week, for four to six weeks. However, other programs offer different schedules that are adapted to the populations with whom they work. Different measurements are often used to determine outcomes for these programs and as a result, comparison is difficult. As might be expected, outcome is highly dependent on patient selection; many programs screen for patients with indicators for negative outcomes and discharge individuals who fail to make the expected progress.

References

The International Association for the Study of Pain.