



This episode is produced in partnership with the British Pain Society.

Paul Evans

This is *Airing Pain*, a programme brought to you by Pain Concern, the UK charity providing information and support for those of us living with pain, our family and supporters, and the health professionals who care for us. I'm Paul Evans, and this edition of *Airing Pain* is produced in partnership with the British Pain Society.

Jane Quinlan

When doctors saw that the promotional literature said that this *New England Journal of Medicine* study says that addiction is rare in patients with pain, it gave huge amounts of confidence to clinicians to prescribe opioids like they're going out of fashion.

Emma Davies

Having long-term pain doesn't necessarily mean that there is something wrong, or that there's something that can be fixed, or that there's a tablet that's going to solve it. There's an awful lot that people can do for themselves that will massively improve their quality of life, their activity, getting them back to doing the things that they want to be able to do, and also reducing the amount of pain that they have.

Katy Vincent

It's not a conversation that they would have at the dinner table or on the sofa. You know, for many people, it's still an area that's really associated with shame and stigma.

Paul Evans

A recent study by the University of Oxford found that teenagers who experienced moderate or severe period pain, or dysmenorrhea, are

significantly more likely to develop chronic pain in adulthood. It found that those with severe period pain at age fifteen had a 76%-higher risk of chronic pain by age twenty-six, relative to those who reported no period pain. Katy Vincent is Professor of Gynaecological Pain at the University of Oxford, and she's a senior author of the study.

Katy Vincent

When we hear people in adulthood talk about their experiences of menstruation and particularly period pain as a teenager, a lot of them will talk about it as having been their first ever experience of pain, or of severe pain, or of repeated episodes of pain.

We know that most teenagers don't even go to the doctor about pain. We know that if they do, it's often normalised and they're told that it's just something that they will grow out of. We know that their parents often tell them that it's something that's normal, and either if their mothers experience very bad pain themselves, they'll expect that it's a normal thing because it's what they went through – or if their mothers didn't experience pain, then they may well tell them, don't be silly, it's fine, *I* coped with it fine. But I think that's a very limited understanding of quite how different people's experiences of periods can be. Quite recently, there have been a couple of high-profile cases of schools where the headteachers have said that they can't use period pain as an excuse not to come to school anymore, for example. And there's an increasing drive to limit access to toilets and to ask for doctor's letters if people need to manage their periods at school. So I think it's something that we really need to have a better understanding of, and an awareness more generally about, the problems that period pain can cause for teenagers.

Paul Evans

I do find it quite surprising and a little bit shocking that a teenage girl going through period pains is told to ignore them in school. 'Get on with it.'

Katy Vincent

I completely agree, and I think that we as a population are often guilty of assuming that normal and common are the same thing. Period pain is incredibly common. It depends how you define it. If you're talking about

any pain with periods, that's about 90%. If you're talking about severe pain, stopping people from going to school, doing their normal activities, you're looking at more like 30–40%, but that's still really common. But just because it's common doesn't mean that it's normal. It is a normal biological process to have a period. Why would we expect that it should be associated with pain? If everybody said every time I went to the toilet it was painful, we would say that's not normal. I think we've just been really guilty of assuming that these things are normal because they're common and that, well, if it's a normal part of being a woman and you're going to have to live with this for the rest of your reproductive life up until the menopause, then actually you're going to have to learn to get on with it. To me, that feels wrong because we have treatments available, but, in general, people don't come and seek help, at least during their teens, and often by the time they do come and seek help, their pain has become much more than just pain with their periods. Or the impact has already happened, it's already stopped them being a competitive swimmer, or stopped them dancing, or impacted on their academic achievement, for example.

Paul Evans

I'm going to use that word normal, but I'm going to use inverted commas before and after it. When is period pain not 'normal'?

Katy Vincent

That's a really good question. I'm going to compare that to heavy menstrual bleeding, first of all, just to put it in context. In the past we used to say heavy menstrual bleeding is losing more than 80 millilitres of blood with your period. Now, who goes around measuring their period loss? You use products to soak it up, you know, deal with it. You don't actually quantify it. We've really moved away from that now. We say, well, heavy menstrual bleeding is bleeding that is heavy enough to impact on your quality of life, or that you consider to be too heavy. And personally, that to me is what I think period pain should be.

You know, if you rate your period pain as 8 out of 10, but it doesn't impact on you, you can take a couple of paracetamol, a couple of ibuprofen, you can go to school, you can do all the things you want to do, it doesn't stop you working, it doesn't stop you sleeping. Well then, just

because you say it's 8 out of 10, I don't need to make you treat it. But if you say your pain is 2 out of 10, but actually that to you is so bad that you miss two or three days of school, you've given up your hobbies, you don't feel able to leave the house, it's really impacting on your mental health. Well, I don't care what number you gave it. Again, that to me is bad enough that we should treat it. To me, painful periods are painful periods that get in the way of your life. They deserve to be treated.

Paul Evans

So, what do you do? What do you tell a young girl who's maybe fourteen, or as you said, even in primary school, an eleven-year-old?

Katy Evans

One of the first things that I do is talk about how our menstrual patterns have changed so much over the last couple of hundred years. If we go back historically, we were so much less well nourished and our lifestyles were so different, that women in general started their periods around the age of seventeen or eighteen, which was an age that you were then considered marriageable. And we didn't have any contraception, so you were probably pregnant within a year. You know, all the time that you're pregnant, you won't have a period. You would have then breastfed because there's no formula milk. You would have been undernourished, so you probably wouldn't have started your periods back again whilst you were breastfeeding, and as soon as your periods came back, you'd have then got pregnant again, and that cycle would be repeated, you know, throughout your life. You know, people had four or five live babies, but probably had some miscarriages in between, and you would probably have died before the menopause. So you'd probably have had about forty periods in your whole lifetime. If we think about the situation nowadays, you start your periods around the age of twelve, thirteen periods a year, and you keep going like that maybe until your late twenties before you have your first baby. You know, you could well have had four hundred periods in your life. So I like to say, actually, it's maybe not as normal as we think it is to be having periods every month throughout your adolescence.

Paul Evans

I'm just thinking about the embarrassment side of having a period in a co-ed school with a mixed staff.

Katy Vincent

Yep.

Paul Evans

I can't imagine what some girls have to go through.

Katy Vincent

Yeah I think you're absolutely right. And I think we really don't have as much understanding as we would like to about how people from different cultures and different backgrounds, even within, you know, your more traditional UK population, how they think about menstruation more generally, how they think about the use of hormones, how they think about talking about these things. I am a gynaecologist who has two teenage daughters who are so used to hearing me talk about periods all the time that they don't find that embarrassing, though they would think it was embarrassing if I said it in front of their friends. But for lots of people, it's not a conversation that they would have at the dinner table or on the sofa. For many people, it's still an area that's really associated with shame and stigma and a lot of misunderstandings and beliefs that have been perpetuated through many generations.

I think unless we understand that properly, it's going to be very hard for us to present our options and encourage people to come forward for treatments if we haven't really understood what it is that's stopping people coming forward.

So if we could put some sort of real, policy-type changes into school education. You know, we have menstrual education, but it doesn't really include pain within it. You know, people learn what a period is and how to manage their periods, but not that painful periods are abnormal and what to do about it. You know, we haven't educated teachers. We haven't educated the wider population. I think here's an area that is absolutely ripe for policy change.

Paul Evans

What advice would you give to a mum or a young girl who has very, very bad period pains? What should they do? Where should they go? When should they start?

Katy Vincent

The first thing is to say that you don't have to put up with it, that we have treatments available. I'd love to get that message out much more widely so that we see people much more early than we do, because often by the time we see them, they've had two or three years of period pain.

I tell them that they should use painkillers. If you can predict when your period is going to come, then get it ready, make sure that you're ready to start. You have some painkillers with you at the time that your period is due, and take them regularly whilst your period is painful. We know that non-steroidal anti-inflammatory drugs like ibuprofen are probably the best treatment in terms of painkillers for period pain because it is quite an inflammatory process. But paracetamol often works very well too. And you can juggle the two so you can wake up and take some ibuprofen and then a couple of hours later you can take some paracetamol. And as long as you don't take more than the recommended dose, you can absolutely do that for the first two or three days of your period every month. And that's not going to do you any harm. So that would be my first message. I think, again, it's really tricky in schools because lots of schools won't allow children to take painkillers with them. So they have to be held by the school nurse with a letter of permission from the parents. And then that makes quite an issue of it, that every three or four hours you're needing to go to the school nurse and ask for your painkillers. I think that is something that's challenging, though I absolutely understand why you wouldn't want to have a group of teenage girls sharing their medicines around in schools. There are reasons why these things are set up, but I think it makes it difficult for teenagers.

Then the next thing that we talk about, if that's not sufficient, is thinking about how we can manage periods themselves to reduce the periods, as well as reducing the pain, and our common approaches to that is to use hormone therapies. I think it's really important that we start talking about them as hormone therapies rather than as contraceptives, because we're

not using them for contraception. We're using them to manage the periods. They happen, most of them, to also be contraceptives, which means that they're easily available, and we have lots of experience of using them. But I think for many people, it can feel quite wrong to think about starting a young teenager on a contraceptive, whereas actually, if we're starting them on a hormone therapy for managing their periods, hopefully that feels acceptable to everybody.

Paul Evans

Professor Katy Vincent of the University of Oxford. My interview with Katy and all those in this edition of *Airing Pain* were recorded at the British Pain Society's Annual Scientific Meeting, held in 2025, in Newport, South Wales. The British Pain Society is the oldest and largest multidisciplinary professional organisation in the field of pain within the UK, and I've been going along to these meetings for the last fifteen years to keep us abreast of developments in the management of pain.

Over recent years, I've noticed how terms like patient-centred, self-compassion, mindfulness have gained traction from being, let's say, sideshow concepts of yesteryear to being the serious and proven components of today's management of pain. Wellbeing is another such term that's become something of a buzzword in recent years. It's not just the absence of ill health, according to NHS England, but includes the way that people feel about themselves and their lives. Phoebe Williams is a health and wellbeing coach working across Hammersmith and Fulham GP practices in London.

Phoebe Williams

What a health and wellbeing coach is, is essentially helping patients in primary care to identify what it is with either their health or their wellbeing that they want to set a goal with to work on, take a bit of control over, and we work over a number of sessions helping them to make changes. It's less of the medical prescribing model, it's working with people to identify what they want to change for themselves.

Paul Evans

So just explain how that works. I understand the health bit, but wellbeing, wellbeing has become a buzzword. Just explain to me what wellbeing is.

Phoebe Williams

The way I see wellbeing is really spending the time with the people who are allocated to me, with the patients, and identifying what it is that makes them feel happy, makes them feel fulfilled. That can have a physical element. So, getting out and going outside with your friends can be good for your wellbeing. But also there's the classic mental health element. If people are experiencing any sort of low mood or anxiety, doing things proactively that help alleviate those things, that is absolutely covering wellbeing.

Paul Evans

So, who do you see, who is sent to you for wellbeing coaching?

Phoebe Williams

On paper, the role of health and wellbeing coaching was created to help alleviate some patients who were seeing the GP multiple times a week, multiple times a month for long-term conditions. So, things that really affected them. On paper, that covers things like diabetes, it covers long COVID. I work a lot with things like low mood, things like anxiety. I work with women who have PCOS. Polycystic ovaries and chronic pain is a huge, huge thing. The reason that the role was created is because I have the flexibility to spend loads and loads of time with people. My appointments are about forty-five minutes, half an hour, forty-five minutes, and I can see them over loads and loads of weeks. So it's just that I'm able to create a longer-term relationship with people, which I really, really enjoy.

Paul Evans

So when somebody comes to you, I presume the GP or somebody else in the practice has said 'This person could do with wellbeing. They've lived with X conditions for any number of years'. How do they, the patient, react to, well, actually being told we can make you happier?

Phoebe Williams

Again, another reason I love my long appointment sessions is because it's quite a new role. It's quite a new idea for some people. Especially if we're looking at this with a chronic pain lens, people may have felt like they've been bounced around from appointment to appointment. So they sit with me for forty-five minutes and we really strip it back to basics. I ask them what is going to improve your life, basically. It's important for me to know the medical things that are going on, just for context, but I'm not going to advise you on anything medically. What is going to make you feel happier?

An example that always comes up for me is I had somebody that I was seeing for a number of weeks. She'd lived with chronic pain for years and years and years and years and years. Something that came up in our first conversation is that she really wanted to go out and see her friends, but she hadn't managed to get on a train by herself for many years. So that became the goal of our session, something that we really focused on. So we stripped it back. What things do we need to put into place for you to feel able to get on the train to go and see your friends. Is there anything you need to adapt in your day-to-day life? Do you need to pace yourself with other things you're doing so you have the energy to do it? It's really looking in such small detail at things that, as you know, in that instance, really, really made her happy to do that.

Paul Evans

I mean, things like that can be life-changing. You've blocked your mind out of things that you, just one thing or maybe many things, but maybe just one thing that you really want to do. But your mind is telling you that you can't do it.

Phoebe Williams

Yeah. Yeah. Absolutely. Your mind. And also, if you're living with pain, you feel like your body is telling you that as well. You know, ending most days feeling completely fatigued and exhausted, I guess a big part of the sessions that I do with patients, especially with chronic pain, is knowing that living with pain is the goal, really, if that makes sense. You know, when I'm not there to make the pain immediately go away. We're not here to fix things, because often it's just working with it, you know, what

can I do that I may well be having some pain that day, but I'm going to live with that pain in a way that works for me. And I'm going to go and see my friends. And it just opens up the world for people. I find that it can be so frustrating, and it can be really sad when people have felt bounced around from appointment to appointment and referral to referral, they're becoming increasingly more and more in pain, and their world becomes quite small because there are things that they feel they can't do. It's just about slowly kind of opening up that world for them. It just improves everything, really. It just gives everything a brighter lens for them.

Paul Evans

That was health and wellbeing coach Phoebe Williams. Well, it would be remiss of me, bearing in mind that this conference is held in Wales, to ignore the important work undertaken by NHS Wales Performance and Improvement. So, way back in 2019, the Welsh Government published its Living Well with Persistent Pain in Wales Guidance. Then COVID came along and all bets were off, and the document was refreshed in 2023. We at Pain Concern were at the relaunch and you can visit that by listening to *Airing Pain #139*. Well, a report is just the start of a process. So back in June 2025, I spoke with Emma Davies. She's the National Clinical Lead for Persistent Pain in NHS Wales Performance and Improvement.

Emma Davies

What we're doing at the moment is reviewing where health boards are up to, in terms of implementing the recommendations from that report. So we're doing that piece of work, we'll review where health boards are at the moment in terms of that, and then we will be supporting them to actually put the outstanding recommendations into place. This is all around moving services into primary and community care to make pain management support more accessible to everybody that needs it.

Paul Evans

How exactly are you going to get these things into primary care? When primary care GP health practices, they are struggling at the moment. I would have thought that one of the last things they need at the moment is to have new procedures put on them.

Emma Davies

It's actually not about getting GPs to do all this work. I think that's the important thing to say.

At the moment, a lot of our pain management support that health boards provide are sited in hospitals. They're in secondary care, and that actually makes them inaccessible to lots of people who actually need that support. The idea of moving services out is not just about uplifting those services and putting them into GP surgeries or asking GPs to just take on all the work. It's about looking at what people living with pain in Wales need, where they think that's best for them to be found, and then actually working with the people living with pain and with existing services to see what we can deliver using existing staff, but out close to home where people are living and where they need that support on a day-to-day basis. Ideally, what we'd like is for people to be able to access support really quickly when they need it, and if they do need to be seen in secondary care, on the rare occasion they might need an intervention of some sort, or if they need a higher level of complex support, that they can actually get to that when they need it – as opposed to now when there's very long waiting lists for lots of our pain services across Wales, and people that might do better with only a little bit of support, but out at home, are waiting just as long as people who need that more complex care.

Paul Evans

I think one of the really important things, I said GPs, but it's not just GPs, it's the multidiscipline side around a health service. There's the pharmacists, there's the nurses.

Emma Davies

There's the social prescribers. We've got physiotherapists out in practice, a whole range of different stuff. I think what we want to look at really is how do practices want to support their patients living with pain. We've been at the British Pain Society conference this week, and we've heard about lots of examples where actually this work is being done by GP practices, by the GPs and their multidisciplinary teams. But also what expertise can we take out of secondary care and put into the communities to support those teams? It takes a village, as we say, and that's perhaps how we need to look at it. Using all of the expertise available and

including people like Pain Concern and other third sector organisations as well, to make the most of all that support, but actually make it available to people.

I think a lot of people in Wales don't even know what support is available to them. They don't know about the local groups that are already running. They're just out of the loop and we need to get them back into it.

Paul Evans

I think there's a big education job to do, not just to healthcare professionals, but to patients as well, to understand that people in their practice who aren't the GPs are experts in their own fields and sometimes, dare I say, know more about conditions in their field than the GPs. They are the experts.

Emma Davies

I think that's a fair point. I would say that, I'm a pharmacist, but I think you're absolutely correct that nowadays within healthcare we have a really wide range of practitioners who are super specialist and who do have an awful lot to offer. And I think you're right that we probably haven't got those messages across to the public in the way that we should have done. So we certainly don't want people feeling fobbed off if they're seeing a physiotherapist instead of a GP for their bad back, but actually the physio is probably the best person for them.

I think the other thing around this is that we haven't done enough to raise awareness of pain in public perception, so there's still this idea, I think, that people develop pain, that there must be something wrong and they need to see a medical practitioner and there needs to be something done about it, when actually, again, as we've heard so much this week at the conference, having long-term pain doesn't necessarily mean that there is something wrong or that there's something that can be fixed, or that there's a tablet that's going to solve it. There's an awful lot that people can do for themselves that will massively improve their quality of life, their activity, getting them back to doing the things that they want to be able to do, and also reducing the amount of pain that they have. But I don't think we've done enough to get that into the public awareness. So that's another thing that's on my agenda to do as well, because if we don't change the expectation of people coming in to see us in practice, if

you're offered something that doesn't sound like going to see a consultant in a clinic, you might feel that, well, people are just giving up and they don't believe me, or they don't think this is affecting me as much as it is, when in actual fact, what we're probably doing is directing them towards the best evidence option for them to learn how to live for a longer time with their pain.

Paul Evans

They talk about self-management of pain, which can be interpreted wrongly as 'you're on your own'. Or, correctly, as 'we will help you look after yourself with our support'.

Emma Davies

I prefer supported self-management because I think, as you say, if you're just told self-management, it does sound like, well we've all given up. Off you go. There's nothing else. When actually there's still a lot of support that people need. I was listening to one of the presentations yesterday from Benjamin Ellis, who is a consultant rheumatologist, but also does an awful lot of good work with Versus Arthritis. He made the very good point that people can go through a pain management programme and learn lots of skills and do really well, but then something happens, because life happens, and they sort of fall off the rails a little bit, and at that point they need support to get pushed back on, to remember the things that actually worked for them and to get them back on track. That's one of the really good reasons to actually make sure that the majority of services are out in primary care, because that's where that person will be when that happens.

Paul Evans

That's Emma Davies, National Clinical Lead for Persistent Pain in NHS Wales Performance and Improvement. Well, that was recorded in June 2025. Eight months on as I record this edition of *Airing Pain* in February 2026, I can tell you that progress is being made. I, along with others living with persistent pain, contribute to its development as members of the Musculoskeletal Lived Experience Group and the Clinical Implementation Networks. In short, it's where clinicians, policymakers and patients all have a say in the future of pain management in Wales.

And it wasn't so very long ago that the patient voice seemed like the least important component of their own pain management. But remember, doctor knows best.

Tim Atkinson is Vice Chair of the British Pain Society Expert Patients and Carer Committee. He's lived with inflammatory arthritis for over thirty years. He's author of *Where Does it Hurt?*, about life with chronic pain, and he's a lived experience trainer with the Live Well with Pain programme. Incidentally, Emma Davis, who we've just heard, is one of its founders. Check it out at [livewellwithpain](http://livewellwithpain.co.uk), no gaps there, livewellwithpain.co.uk.

Tim Atkinson

It exists primarily, I think, to train healthcare professionals of all hues, from consultants to GPs, down to social prescribers, in elements of strategic pain management that they can deliver with supported resources to their patients on a very straightforward basis. So, I take part as a lived-experience trainer in some of their training sessions. I've done some face-to-face sessions, though we're mostly online these days, and we just aim to go through what's called the Ten Footsteps Programme. It breaks down elements like pain in the brain, a bit of scientific understanding at a very user-friendly level, and then works through practical techniques like mindfulness and relaxation acceptance. All the ten footsteps follow from one to the other and build up into a comprehensive toolkit, really, for patient self-management.

Paul Evans

What you're saying now sounds to me like a programme that is targeted at patients, people living with pain, not necessarily pain professionals.

Tim Atkinson

It's dual purpose. That's, I think, the real beauty of it, its selling point. Its USP is that it's got this dual-pronged attack. They train the professionals to deliver the materials, which are actually targeted at the patients. So it's not as simple as giving a GP some leaflets or a website to recommend to a patient. It's far more structured and integrated than that, but it does give patient resources to busy healthcare professionals who might not

otherwise have the time to explain in detail some of those self-management techniques.

Paul Evans

What sort of the reaction do you get from the GPs or other healthcare professionals?

Tim Atkinson

Overwhelmingly supportive. What they get, I think, is the confidence to deliver something which is not necessarily part of routine medical armoury. A lot of healthcare professionals don't feel they've got a good understanding of it, they've not had the training in it, but it's an increasing need. Obviously, we know about the mushrooming of chronic pain as a condition and the frightening implications of that over the next few years. So it gives people the confidence to deal with it in a way that's more likely to have a long-lasting beneficial effect, rather than just sending a patient out with a prescription and hoping for the best. It's a very broad but very well-structured resource which has got scientific credibility. There is the empirical evidence to show, for example, that participation in the programme does lead to a reduction in opioid prescriptions.

Paul Evans

That's Tim Atkinson, Vice Chair of the British Pain Society Expert Patients and Carer Committee.

Well, he brought up the subject of prescribed opioids. So what's wrong with them? Jane Quinlan is a consultant in pain management in Oxford. She works in acute pain management, helping manage people's pain after surgery or trauma whilst they're in hospital. But she also runs a clinic for people with chronic pain to help them reduce or give up their long-term use of opioid medications. Here's the background to what became the opioid crisis.

Jane Quinlan

In 1980, there was a letter written to the *New England Journal of Medicine*, so a very prestigious journal, from two authors in America

called Porter and Jick. Now, what they did was they wrote this letter and said, we've just noticed that we've all seen 40,000 patients go through our hospital with acute pain. They have all received opioids for their acute pain. But to our knowledge, only four people have developed addiction. Their conclusion is a five-sentence letter. The conclusion was, we can therefore say that despite widespread use of narcotics, another word for opioids, addiction is very rare.

That was published in 1980. In 2017, that letter had been cited, had been referred to, 600 times, and particularly it had been referred to in promotional literature from pharmaceutical companies marketing opioids to say addiction is rare with opioids if you have pain. The original letter was for acute pain patients only, and it wasn't a proper study. They didn't follow them up. They didn't define addiction. It just was a bit of a chat in a pub, essentially. But when doctors saw that the promotional literature said that this *New England Journal of Medicine* study says that addiction is rare in patients with pain, it gave huge amounts of confidence to clinicians to prescribe opioids like they're going out of fashion.

That letter was one of the drivers. There were other drivers to the opioid crisis in the United States. It was never intended to be anything of the kind. I think we all know about the opioid crisis in the United States, where all these patients were suddenly put on these drugs that didn't help their pain, but did get them addicted. And we, as the acute pain community, accidentally were part of that.

Paul Evans

And now the issue is trying to draw back from that.

Jane Quinlan

Completely. Completely. So, opioids, and what we mean by those, we're talking about morphine, oxycodone, fentanyl, codeine or tramadol, are great for acute pain after surgery or trauma, when the pain system is working exactly as it should do. The pain system is telling us that we have damaged ourselves and we need to be careful. And opioids work really well there.

What we know now that we didn't know twenty years ago was that chronic pain, pain that's been going on for longer than three months, represents a dysfunctional pain system. Your pain system isn't telling you

anything helpful. It's gone wrong. And it's giving you all these awful messages of pain even though there's nothing actually wrong with your body. Opioids don't work for chronic pain, not for the majority of patients, at least.

And opioids are quite dangerous drugs, so they can slow down your breathing, they can give you constipation. They can affect your memory and your concentration. They can reduce your sleep at night. We now know there were long-term effects on your hormones. Some men on opioids have sexual dysfunction without realising that that's why. And of course, they're addictive drugs. If you take them for a long time, your body can become dependent on them, and occasionally you can become addicted to them. And that means that the opioids start controlling you, rather than you controlling the opioids. And there's an increased risk of death.

With all of those things, we now know that people taking long-term opioids for chronic pain actually have a worse quality of life and increased risk compared to those with chronic pain who are not taking opioids, they're not helping. But because twenty years ago, we thought they were a good idea, we as a medical profession started lots of patients on them. So now we as a medical profession have to take responsibility and support people coming off, which is a difficult thing to do. So we have to make sure that it's gradual, that patients understand the importance of that, and we give them a lot of support when we're doing that.

Paul Evans

Is it a difficult equation to balance, really, when people think they're taking opioids medication because it is making them better, but actually they're having no effect on the pain?

Jane Quinlan

Yeah, yeah. We see that a lot. A lot of patients I see really feel very strongly that the opioids are helping them and are giving them a better quality of life. So it's pretty terrifying when someone like me comes along to say, actually, we're going to take your opioids away, because they panic, because things are going to get much worse. But actually, most patients I see who are taking long-term opioids also describe severe pain. What that tells me is that this isn't an opioid-sensitive pain that they've

got. If it was a pain where opioids were going to help, they'd be on much lower doses and they wouldn't have any pain. If you're taking opioids and you still have severe pain, if we take the opioids away, your pain will stay the same because they weren't doing anything. But that's a huge leap of faith, and I understand completely. That can be very scary for people.

Paul Evans

And I suppose it's very tempting to prescribe something. It's not working. Increase it. Not working. Increase it. It's not working.

Jane Quinlan

Exactly. And we see that all the time. We see a lot of patients on very high doses, not because they wanted the high doses necessarily, but they were told by doctors, we'll just increase it until it starts working. And now we know it was never going to work. And so again, coming off high doses is a really difficult thing. So we do a really gradual reduction. We warn patients that as they're coming down the pain may get worse. Anxiety and depression may get worse because your body has got so used to them over these last years, and your brain chemistry has got so used to them, that your brain is thinking, what? Where have they gone? And it feels a very scary time. But that's not how life will be long-term. It's just your brain readjusting to life without opioids and that extra pain, extra anxiety, extra depression, settle down as the doses come down.

Paul Evans

And I have talked to people, I know it can be very, very, well, life-changing to come off those high-opioid medications. People say it's changed my life.

Jane Quinlan

Absolutely, absolutely. And I'm back to the person I used to be. And a lot of them will say, I've suddenly realised that I was almost asleep for all those years. You often hear that from family members as well, saying it's really lovely to see our family member back again, because they've been so dopey, they've been so down, they've not been leaving the house, everything's been awful for years, they've now got themselves back, which is lovely.

Paul Evans

That was consultant in pain medicine Professor Jane Quinlan. I'll remind you, as I always do, that whilst we in Pain Concern believe the information and opinions on *Airing Pain* are accurate and sound, based on the best judgements available, you should always consult your health professionals on any matter related to your health and wellbeing. They are the only people who know you and your circumstances and therefore the appropriate action to take on your behalf. Now, it's important for us at Pain Concern to have your feedback on these podcasts so that we know that what we're doing is relevant and useful, and to know what we're doing well, or maybe not so well. So do please leave your comments or ratings on whichever platform you're listening to this on, or the Pain Concern website. Of course, it's painconcern.org.uk, and that'll help us develop and plan future editions of *Airing Pain*.

I'll leave you with some important and potentially life-saving advice about the disposal of leftover medicines, particularly opioids, from consultant Jane Quinlan.

Jane Quinlan

Take the leftover opioids to a pharmacy.

Do not, as most people do, leave it in your bathroom cabinet, because we know there's a risk of overdose for toddlers if they find tablets that they don't know what they are.

There's a risk for teenagers who know that there are opioids in the cupboard and want to just give drugs a try, which is terrifying. An interesting study in the States recently said that 50% of opioid addicts in the States had started with prescribed opioids from family or friends.

Yeah, I know.

And then the third thing we've got to be careful of is if at home you're not sleeping very well, you're having a bad day, you sprained your ankle, and there were these painkillers in your bathroom cabinet, you might start thinking, I'll just have a couple of those. And then that is really dangerous behaviour.

By trying to educate patients to use their opioids wisely, stop them as the pain settles and take the leftovers to a pharmacy, that would make things much safer for patients.

