

## Short title: Multidisciplinary and interdisciplinary care in specialist pain services and specialised pain units

### 1. Purpose

This document sets out the Faculty of Pain Medicine's (faculty/FPM) of the Australian and New Zealand College of Anaesthetists (College/ANZCA) position on the essential role of multidisciplinary and interdisciplinary care in specialised pain units under the supervision of FFPMANZCAs, and on the service, workforce and system conditions required to support safe, equitable and evidence-informed pain care across the life course in Australia and Aotearoa New Zealand.

This position statement should be read alongside the accompanying background paper, which summarises the conceptual and empirical evidence supporting multidisciplinary and interdisciplinary care and outlines key implementation considerations for specialist pain services.

### 2. Scope

This position statement applies to pain units and specialist pain services providing care to children, adolescents and adults in Australia and New Zealand.

This statement is intended to inform professional expectations focusing on the provision of high value care, service development, accreditation-related discussions, advocacy, workforce planning and future policy work relevant to specialist pain medicine services.

### 3. Background

Persistent pain is common, frequently associated with disability and distress, and often requires care that addresses biomedical, psychological and social contributors to suffering and functional impact. Contemporary pain medicine therefore depends on coordinated models of care that integrate medical, psychological, physical and rehabilitative expertise.

Specialist pain units occupy a distinct role in the health system by providing specialist assessment and management for people with complex, high-impact or treatment-resistant pain presentations. For these patients, multidisciplinary and interdisciplinary care is a defining feature of contemporary specialist practice rather than an optional enhancement. Where services care for children and young people, assessment and management should be developmentally appropriate and, where needed, draw on paediatric expertise and interdisciplinary care centred around the needs of the child and their family.

These developments reflect strong evidence that coordinated multidisciplinary and especially interdisciplinary programs deliver better functional and psychosocial outcomes than fragmented or unimodal care.

### 4. Definitions

For the purposes of this document:

- **Multidisciplinary care** means care delivered by professionals from multiple disciplines within a shared service or program, with each discipline contributing assessment and treatment relevant to the person's needs.
- **Interdisciplinary care** means coordinated team-based care in which professionals from multiple disciplines work together, and in partnership with the patient and, where appropriate, their family or

carers, with shared goals, regular communication and joint responsibility for formulating, delivering and reviewing a shared sociopsychobiomedical management plan.

- **Specialised pain unit** means a specialist pain service that is recognised, or is seeking recognition, through relevant FPM/ANZCA accreditation and governance processes as meeting standards for specialist pain medicine practice, supervision, safety, quality and training.
- **Specialist pain medicine physician** means a Fellow of the Faculty of Pain Medicine of ANZCA (FFPMANZCA), or a medical practitioner whose specialisation in pain medicine is formally recognised by the relevant national regulatory authority, whose scope of practice includes the comprehensive assessment and management of people with complex pain, working as part of, and not in substitution for, an expert multidisciplinary team. In New Zealand, the Health New Zealand | Te Whatu Ora Pain Management Service Specification requires the interdisciplinary team to include a physician holding FPM Fellowship together with a vocational scope of pain medicine recognised by the Medical Council of New Zealand.
- **Specialist pain service** means a medically led clinical service providing assessment and treatment under the clinical leadership of a specialist pain medicine physician, using multidisciplinary or interdisciplinary pain management.

## 5. Position

### 5.1 Multidisciplinary and interdisciplinary care

The faculty considers multidisciplinary and interdisciplinary care to be foundational standards of contemporary specialist pain medicine practice in specialist pain services.

For people with complex persistent pain, clinically effective care commonly requires integrated sociopsychobiomedical assessment, coordinated treatment planning, active rehabilitation, self-management support and communication across disciplines and care settings.

Specialist pain services should embed these principles within stepped and scalable models of care, rather than treating them as optional enhancements.

### 5.2 Role of the specialist pain medicine physician

The specialist pain medicine physician has a distinct role within specialised pain units in diagnosis, formulating a sociopsychobiomedical understanding of the person's pain and context, medical management, clinical leadership and integration of treatment options within a whole-person plan of care.

When caring for children and young people, the specialist pain medicine physician should ensure access to, or collaboration with, paediatric expertise where required.

The specialist pain medicine physician contributes to decisions about diagnostic and therapeutic procedures by ensuring that proposed interventions are considered in the context of comprehensive sociopsychobiomedical assessment, individualised treatment goals, expected benefits and harms, and the person's broader rehabilitation and self-management plan. Where a procedure is clinically indicated but not provided by the treating service or physician, the specialist pain medicine physician should support timely referral, communication and continuity of care with an appropriately credentialed procedural clinician.

The specialist pain medicine physician's role is complementary to, and does not replace, the expertise of psychology, physiotherapy, nursing, occupational therapy and other relevant disciplines.

### 5.3 Service standards for specialised pain units

For the purposes of this document, a specialised pain unit is defined by its interdisciplinary, sociopsychobiomedical model of care rather than by training accreditation tier or procedural volume.

Specialised pain units may include fully accredited core training stage (CTS) units, practice-development stage (PDS) units and other specialist pain services run by SPMPs, provided they meet the following minimum standards.

Specialised pain units should demonstrate structures and processes that support genuine interdisciplinary practice. These include:

- access to core multidisciplinary capability appropriate to the population served and local service scope, as described in section 5.6;
- access to developmentally appropriate expertise and pathways when the service provides care to children and young people;
- coordinated sociopsychobiomedical assessment and shared case formulation;
- shared treatment planning and regular multidisciplinary review;
- active rehabilitation and self-management approaches as central modalities, with procedures used in an appropriate, bounded role;
- appropriate medication review and stewardship;
- diagnostic and therapeutic procedures, where clinically indicated, may complement, but do not replace, active rehabilitation, self-management and other components of an individualised multidisciplinary management plan;
- timely, appropriately governed access to clinically indicated procedures, in accordance with PS11(PM) Procedures in Pain Medicine Clinical Care Standard;
- communication with referring clinicians and other care providers;
- effective consultation, liaison and shared-care arrangements with primary care, community-based services and relevant inpatient and outpatient services, supporting follow-up and capability-building beyond the tertiary setting and reflecting local service scope and capability;
- systems for safety, quality improvement and multidimensional outcome measurement, including mechanisms to seek, consider and respond to consumer and lived-experience input in service evaluation, quality improvement, service development.

FPM/ANZCA accreditation processes (CTS and PDS) remain important for training and college governance, but do not in themselves define whether a service meets these interdisciplinary care standards.

#### **5.4 Access, triage and stepped care**

Specialist pain services should support timely access to specialist care through transparent referral criteria, triage processes and models of care that match intervention intensity to patient need.

Triage processes should consider not only pain intensity but also functional limitation, psychosocial context, medication risk, vocational factors, and clinician judgement when determining the level and format of care.

These may include group programs, telehealth, shared care, outreach, digitally supported care, and other stepped-care pathways. Where appropriate and when supported by evidence, interventional procedures should be offered to patients, provided that multidisciplinary and interdisciplinary principles are maintained.

#### **5.5 Equity**

The faculty supports equitable access to evidence-informed pain care across Australia and New Zealand.

Service design should seek to reduce barriers related to geography, culture, language, disability, socioeconomic disadvantage and other forms of inequity, including for Aboriginal and Torres Strait Islander peoples, Māori, Pacific peoples, and people living in rural and remote communities.

In New Zealand, service design and delivery should be consistent with obligations under Te Tiriti o Waitangi, including partnership with Māori and culturally safe care informed by Māori models of health such as Te Whare Tapa Whā.

Funding and commissioning arrangements should support equitable access to interdisciplinary pain care across injury-related and non-injury pathways; differences between funding streams should not determine whether people can access appropriate care.

## **5.6 Workforce and capability**

The faculty supports recognition, development and sustainability of the specialist pain medicine workforce and the broader multidisciplinary workforce required for specialist pain services.

This includes appropriate staffing, role clarity, supervision, professional development, pain-specific training and protected time for interdisciplinary work.

Core multidisciplinary capability should include, at minimum, specialist pain medicine physicians, nursing, psychology, physiotherapy, and access to psychiatry and administrative support, recognising that larger services will have broader teams.

## **5.7 Education and professional standards**

The faculty affirms that high-quality pain care depends on high-quality pain management education across the health workforce. FPM supports the implementation of the Australian Standards for Health Practitioner Pain Management Education and recognises its leadership role in developing nationally consistent, contemporary and evidence-informed standards for pain education. FPM also supports the development, in partnership with Māori and New Zealand stakeholders, of aligned and contextually appropriate approaches to pain management education that reflect Te Tiriti o Waitangi and hauora Māori models of health.

Specialist pain services should involve consumer representatives and people with lived experience of pain, where feasible and appropriate, in the design, delivery and evaluation of pain education and service-improvement activities.

Specialist pain services should contribute to pain education through supervision, interprofessional learning, modelling of sociopsychobiomedical and person-centred care, and support for capability development across medical, nursing, allied health and other relevant disciplines. FPM also supports alignment between specialist pain services, health practitioner education providers and continuing professional development activities so that education strengthens access to safe, collaborative and equitable pain care.

## **5.8 Data, outcomes and benchmarking**

Specialist pain services should participate in routine outcome measurement, benchmarking and quality-improvement activity appropriate to specialist pain practice.

Outcome assessment should be multidimensional and may include measures of pain interference, function, psychological health, self-efficacy, participation, medication use, and patient experience, in addition to pain severity where relevant. Services should use patient- and family-reported experience, and consumer and lived-experience input, to inform interpretation of outcomes and priorities for quality improvement.

For procedures, services should monitor outcomes beyond pain intensity alone, including function, quality of life, participation, medication use, adverse events, subsequent health-service utilisation and achievement of patient-defined goals. Procedural outcomes should inform patient selection, clinical review, audit and quality improvement.

Where clinical registries relevant to procedural practice are available, participation in such registries should be considered to be a basic element of good clinical practice.

Participation in structured, binational or national benchmarking systems should remain an important aspirational goal for specialised pain units as contemporary, sustainable outcomes platforms are redeveloped.

## **5.9 Funding and system support**

The faculty supports funding and policy settings that recognise the complexity and coordination requirements of contemporary pain medicine.

Health systems and funders should support models of care that enable comprehensive assessment, case review, interdisciplinary planning, rehabilitation, self-management support and longitudinal follow-up for people with complex persistent pain. In New Zealand, publicly funded specialist pain services should be implemented in line with the Health New Zealand | Te Whatu Ora Pain Management Service Specification. The standards in this statement apply to specialist pain services irrespective of funder, including services purchased by ACC, and funding arrangements across injury-related and non-injury pathways should support equitable access to interdisciplinary care of comparable quality

Funding and commissioning arrangements should recognise the infrastructure, workforce, safety and governance requirements of pain procedures where these are clinically indicated. Services that do not provide a procedure directly should nevertheless be supported to maintain timely, equitable and clinically integrated referral and shared-care pathways to appropriately credentialed procedural providers.

## **5.10 Collaboration**

The faculty will work with governments, regulators, professional groups, health services, educators, consumer representatives, people living with pain and other stakeholders to promote consistent expectations for specialist pain services and to strengthen access to best-practice pain care.

## **6. Related documents**

This document should be read and interpreted in conjunction with FPM's other Position Statements and standards.

## **7. Disclaimer**

This document is intended as a professional position statement of the Faculty of Pain Medicine. It is not a clinical practice guideline and does not replace clinical judgement, local policy, statutory obligations, or the need to consider individual patient circumstances.

## **Faculty of Pain Medicine professional documents**

**POLICY** – A document that formally states principle, plan and/or course of action that is prescriptive and mandatory.

**STATEMENT** – A document that describes where the college stands on a particular issue. This may include areas that lack clarity or where opinions vary. A statement is not prescriptive.

GUIDELINE – A document that offers advice on a particular subject, ideally based on best practice recommendations and information, available evidence and/or expert consensus. A guideline is not prescriptive.

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