WSMHA PERSISTENT PAIN SERVICE – PROGRAM OUTLINE (FINAL JULY 2016)

GOALS

- To provide a service that people experiencing a range of persistent pain conditions can be referred to.
- Open to referrals from a range of health professionals.
- To provide a service that is flexible and can respond to the individual needs of patients and referrers.
- To improve the knowledge and skills of practitioners working with persistent pain across region via the following strategies:
    - To coordinate training and professional development for allied health, nursing, and medical practitioners in the assessment and evidence based management of persistent pain.
    - To create and maintain an easy to use electronic resource (such as a shared drive) with a range of up to date educational materials, journal publications, and links to useful resources.
    - Promote and share peer learning by encouraging interested practitioners to attend and observe pain groups, conduct joint assessments, seek secondary consults and share care planning.

GENERAL OVERVIEW OF CLINIC PROCESS

- After intake, a multidisciplinary assessment is completed, and a treatment plan discussed with the patient and referrer. The treatment plan is sent to referrer, care co-ordinator and to other involved clinicians.
- Treatment options may include the following (depending on resources):
    - A brief educational group (1-2 days, similar to current HARP Start UP group)
    - Group treatment program (9-12 weeks) with scheduled follow up reviews
    - Post-program support group
    - Individual treatment as needed (Physiotherapy, OT, Psychology)
    - Secondary consults to patient's current clinicians
    - Referral to other services as appropriate

    It is envisaged that the group treatment program will be the cornerstone of the service, due to cost effectiveness and treatment efficacy. Individual treatment only (without group program) will be offered to the minority of patients who would not be able to participate in the group (see exclusion criteria) but are judged during assessment to be able to benefit from individual intervention.
- Services will be offered to patients who live away from Horsham through videoconferencing links. It is envisaged that VC will first be used with the brief educational program, individual

assessments and individual treatment sessions and then be rolled out to include the longer group program.

- When the patient completes their treatment (group program or individual intervention), a plan for ongoing self-management is developed with the patient. This is shared with referrer, care co-ordinator and other involved clinicians (with permission).

BEST PRACTICE GUIDELINES

The recommendations in this plan have been developed by reviewing recent research regarding pain management programs, meeting with the health services of the WSMHA and assessing their needs, and reviewing current best practice guidelines. The recommendations are in line with the following best practice guidelines:

- The NSW Agency for Clinical Innovation (ACI) provides a 'consensus view' regarding general best practice for Pain Management Programs (PMP's). Please refer to this table in Appendix B.
- The British Pain Society Guidelines for Pain Programs for Adults - www.britishpainsociety.org
- American Pain Society Clinical Practice Guidelines

BALLARAT HEALTH SERVICES PAIN CLINIC MODEL

The BHS pain clinic provides a 9-week group program as the sole treatment option. After patients have completed intake and returned their completed questionnaire package they are booked into the their brief educational group 'Start Understanding Pain' (Start UP). If, after the Start Up group, the patient wishes to commit to the 9-week program, they are assessed by one of the pain clinic practitioners. If suitable for the group program they are then scheduled into the next available group.

If the patient requires individual Psychology or Physiotherapy, they are referred to the Psychology or Physiotherapy department and placed on the waiting list for these services.

BHS run one Start Up group each month through the year and three 9-week group programs.

There are clearly some differences between how BHS run their service and what we can offer. Below I suggest the areas in which we could trial different approaches, and the reasons for these suggestions. I also make reference to best practice that we can aim for. When the suggestions are in line with BHS practice, this is noted in brackets (BHS).

REFERRALS

- Referrals will be accepted from a range of health professionals, including GP's, physios, OT's, surgeons, pharmacists, social work, nursing (BHS).

- Primary Care Partnerships and the Primary Health Network can help set up referral pathways (Donna to help set this up).

- Deirdre Rennick recommended using the standard Outpatient Clinic referral form as GP's are familiar with this.

INTAKE PATHWAY

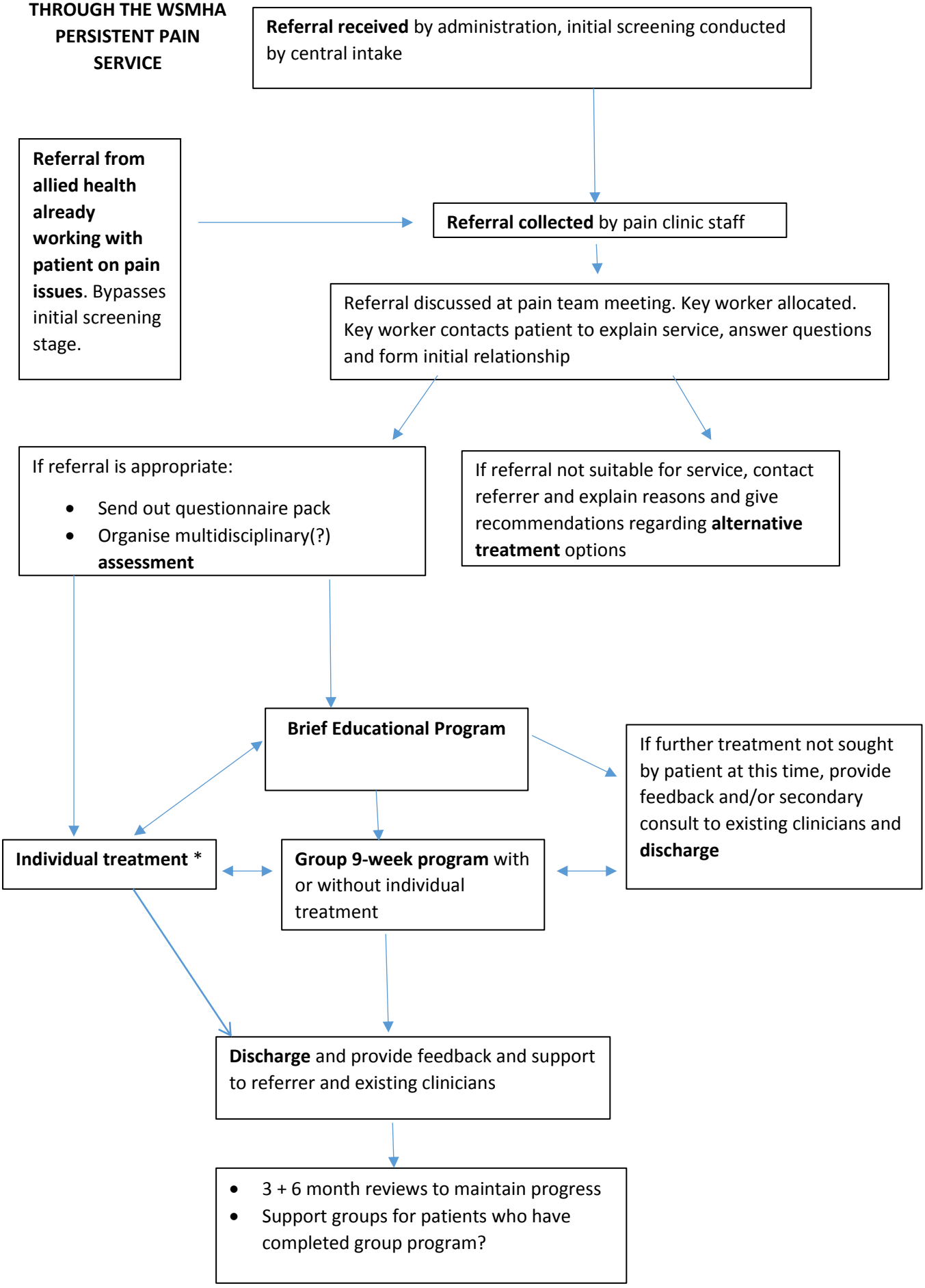
BHS Process

The general hospital intake team complete the referral administration and pain clinic staff complete intake and triaging. Many patients are somewhat resistant to the idea of a pain management program and hold many misconceptions about what this involves. By doing intake and triage themselves, the pain clinic staff are able to give patients information about what to expect from the program and complete an initial needs assessment. Outcome measures are sent out, and when completed outcome measures are received back, this triggers the patient being booking into the next Start UP group. An assessment is completed *after* the patient has completed the Start UP group if they wish to access further service.

WSMHA Model

If we will be providing individual treatment and secondary consults, as well as a group program, not all patients will be going into a brief educational program as their first step. Furthermore, if brief educational groups are offered three times each year, this is not a realistic 'first step' option. Therefore a more flexible pathway though intake, assessment and treatment modalities will be needed. A suggested pathway through our service is outlined on the following page.

SUGGESTED PATHWAY THROUGH THE WSMHA PERSISTENT PAIN SERVICE



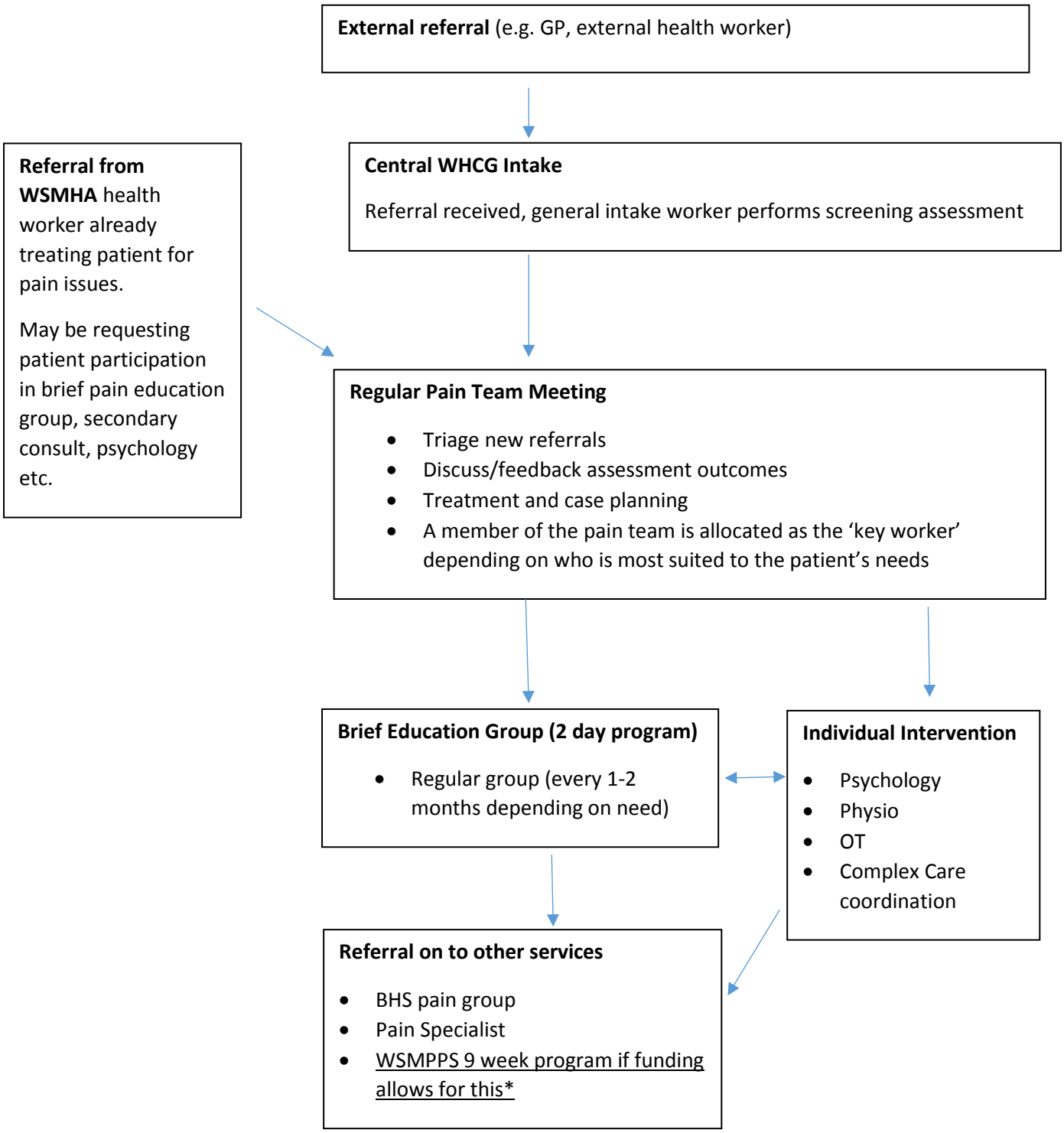
- *Individual treatment may be offered* in the form of time-limited intervention until the patient is ready for a group program, or to provide intervention until a place in a group program is available. It may also be offered as the only form of treatment for patients who would be unable to function in a group.

- *Brief educational groups for screening?* - The ACI note that many patients are referred to pain services who are not interested in the types of treatment offered through multidisciplinary pain services. Brief educational groups are valuable for 'screening out' these patients and thus shortening wait lists and reducing the number of patients who enrol in a longer pain group and then drop out early. However, if we offer only three brief educational groups each year these groups can not be used to 'screen' patients, as the wait time from referral to first treatment contact would be overly long. The frequency of brief educational groups and their use as a 'screening option' will likely need to be re-considered as the service begins to operate. It may be worthwhile offering more frequent brief educational groups and working 'smarter' versus conducting a large number of individual assessments.

Addition July 2016

Flowchart of Initial Wimmera/Southern Mallee Persistent Pain Service

Based on the assumption of no additional funding



*At this stage we hope to provide one 9-week program each year unless extra funding is secured. If patients need to access a program more urgently and are willing to travel, refer on to BHS pain service

ASSESSMENT PROCESS

BHS Practice

In the past, BHS conducted multidisciplinary assessments, with patients seeing multiple clinicians across multiple sessions during one 'assessment day'. They found that this was overly tiring for patients and so changed their process so that two clinicians conducted a joint multidisciplinary assessment in a single session.

BHS described two pitfalls of this model – it was resource intense, and there was a 'bottleneck' of assessments holding up patients moving from their Start UP group to the 9-week group program. They now have a standardised assessment interview that any of the pain clinic clinicians can administer. A single clinician administers the entire assessment and gives feedback to the team who then discuss treatment options.

Best Practice

Accepted best practice is to conduct a multidisciplinary assessment (1,2,4). A review of pain services across NSW and Victoria revealed that the vast majority of services conduct multidisciplinary assessments, with at least a Physiotherapist and Clinical Psychologist. This does not only include bigger metropolitan services, but also smaller services such as Barwon Health.

Given BHS's feedback that patients have found it overly tiring to see multiple clinician's in a day, it seems preferable that our service trial the model in which two clinicians from different disciplines conduct a joint assessment. This model also has the advantage of clinicians from different disciplines learning from each other and becoming more confident in assessing various aspects of pain when necessary.

- I would suggest that we trial the best practice approach of a multidisciplinary assessment, but be aware that we may need to change this to a single clinician assessment if necessary.
- The advantages of a multidisciplinary assessment include gaining more comprehensive and discipline specific information that then allows for a more individualised treatment plan (for example picking up psychological traits that may need careful management for successful group participation).
- A multidisciplinary assessment is more likely to pick up the discipline specific red flags.
- While running only a small number of brief educational groups and longer group programs, we may not encounter the 'bottleneck' problem that BHS experienced.

- Each patient going into the group program also needs an individual physiotherapy assessment and an exercise plan made up for the 'gym' component of the program. In most cases, the Physiotherapist at their local health service could complete this. This Physiotherapist will also likely be supervising the 'gym' sessions of the group program at their local hospital. For example, if a patient who lived in Warracknabeal was enrolled in the group program, part of their assessment would likely involve Brett Boyle (Physiotherapist at Warracknabeal who already does a significant amount of work with persistent pain)

designing an individual gentle exercise program that they would follow during the daily 'gym' hour of the program.

TREATMENT OPTIONS

It is envisaged that our service will offer some flexibility in treatment options. This will reflect patient needs and may involve a mixture of individual Psychology, OT, Physiotherapy and the group program. It is hoped that the group program will be the cornerstone of treatment, as research has demonstrated that multidisciplinary group treatment programs provide the best treatment outcomes in terms of reducing depression and anxiety, and improving function and quality of life in people with moderate to severe levels of dysfunction caused by persistent pain. This is also a relatively cost effective treatment option compared to individual therapy. It is envisaged that this group program will be between 9-12 weeks long, depending on resources.

Brief Educational Group

While BHS offer one Start UP group each month, it has been suggested that given resources, three of these types of groups per year is more realistic for our service.

BHS aim to book 30-35 patients into each Start UP, with between 10-13 actually attending.

Treatment Teams

Both **Rural Northwest Health** and **West Wimmera Health Service** have the allied health staff to provide individual Physiotherapy and OT to their patients. Pawel at Nhill and Brett and Warracknabeal, are both Physiotherapists with a strong interest in persistent pain, and could potentially be the main contacts for the service at their locations.

The persistent pain service will likely be used by these healthcare services to provide staff education and training, secondary consults, brief pain education programs and a group treatment program.

Individual Clinical Psychology can also be offered across the region (via visits and videoconferencing), although this will be a very limited resource. Alternatively, interested Social Workers and mental health workers (and these were identified at both services) could be supported by the pain service co-ordinator to develop their confidence working with patients with persistent pain. This is a more sustainable approach. Individual Psychology could be offered more frequently in the earlier stages of the service, while these clinicians are undergoing further education in pain specific intervention.

Kaye Borgelt at West Wimmera Health Service suggested that if there is sufficient demand, her allied health clinicians may be interested in running a program from their hospital in the future. Shadowing and mentoring could be provided by the persistent pain service, as well as sharing materials.

Dunmunkle Health Service – Dunmunkle have visiting allied health clinicians from West Wimmera Health Service who provide individual Physiotherapy and OT, similar to at West Wimmera. They also offer a range of community based exercise programs. The persistent pain service will likely offer similar services here as described above for West Wimmera and Rural Northwest Health.

Edenhope District Memorial Hospital – Most allied health work is contracted out to private clinicians. The 'WHY' program is funded through HACC, and involves Physiotherapists working with patients over 65 years who are at risk of hospitalisation.

Patients can access the brief educational groups and longer group program through videoconferencing. If a local interested Physiotherapist can be located, gym programs can be developed and supervised locally. Otherwise, patients not funded through the HACC 'WHY' program may need to travel to Horsham for this.

Social worker, Kathleen Ballinger, from Edenhope is interested in receiving further training in persistent pain specific psychological interventions. She could potentially facilitate their group during VC link ups with the main group and provide individual psychological intervention.

Use of Videoconferencing to Provide Service Through Entire Region

Facilitators from each health service can support their local participants with set up, facilitation of group activities, and sitting in during the video-conference. This will simultaneously up-skill these clinicians and familiarise them with the pain program content. VC processes used in the cardiac rehabilitation service can be used. Each health service would also be provided with their own supplies of any posters, cards, game materials etc. to be used with the help of their local facilitator.

COMMUNICATION

West Wimmera Health staff recommended using Connecting Care for easy sharing of patient information, given that many patients with persistent pain are seeing a number of clinicians.

Group Program – Clinicians involved in the group program would meet each morning before the program to review the day ahead and any potential issues. They would also meet briefly at the end of the day's program to debrief, discuss patient progress, any issues that need following up (BHS).

Formal Case Discussions and Treatment Planning

- After brief education program to discuss patients going into longer group program
- Midway through group program
- End of group program

When group programs are not running, consider scheduled case discussions planned for approximately monthly intervals with main pain service clinicians from across the five health services.

There is the opportunity to hold joint case discussions with BHS so that both services can discuss difficult, complex cases and provide peer support.

Referrer feedback

Feedback regarding treatment plans will be given to the referrer and other treating clinicians following assessment. Other referrals needed are discussed at this time (e.g. to a pain specialist).

Following completion of intervention, whether this is group program or individual treatment, a report will be written to the referrer outlining the treatment provided, progress and obstacles, recommendations for future treatment, and suggestions as to how the referrer can best support the patient. This report and a copy of the patient's 'self management plan' is sent to the referrer, care co-ordinator, GP and to other involved clinicians (with permission).

PAIN SPECIALIST INVOLVEMENT

There is an extremely long waiting list for the public pain specialist in Ballarat (3-4 years).

Anne Richards suggested using the services of the BHS Geriatrician and Rehabilitation Physicians who current consult for HARP programs, for high priority patients.

Donna and Catherine have begun exploring options regarding the costs and wait times of accessing a private pain specialist in Ballarat (Salim Khan, St John of God, Ballarat) and in Melbourne (Melbourne Pain Group). Melbourne Pain Group have been contacted and confirmed they are available to work with our patients. They must see the patient in person for the first assessment (in Melbourne) but can use tele-health for further sessions. Plexus Pain (Geelong) are planning to open a clinic in Ballarat, and are another option to explore. Leonie Lewis at BHS also reported that two pain specialists from BHS, Kieren Tippett and Mike Bassett, are planning to start a private practice.

Donna will put together a document for patients outlining different options for accessing pain specialists. This information will be presented in an easy to understand format so that patients can make informed decisions regarding the option that suits them.

INCLUSION/EXCLUSION CRITERIA

Inclusion Criteria

- Patient has been experiencing ongoing pain for over 3 months that is significantly interfering with their functioning and quality of life. This pain may be lasting longer than expected (i.e., tissue damage should have healed) or may be expected given underlying disorder (arthritis, diabetic neuropathy).

Exclusion criteria from service

- Cancer pain not in remission (BHS)
- Palliative care, limited life expectancy (BHS, 2)

RED FLAGS AND PRIORITISING

Psychological Red Flags – careful assessment needed. May be suitable for group program at a later date (e.g., when substance use reduces). Individual Intervention may be suitable on a case-by-case basis.

- Major Personality Disorder that is highly likely to disrupt group (evidence of significantly aggressive/disruptive behaviour, clear evidence of unwillingness to take any personal responsibility, marked irritation at having to 'share treatment' with a group') (1)
- Substance abuse disorder that is likely to result in difficulties with concentration, cooperation or participation (1)
- Active psychotic illness, disordered thinking, marked agitation (1,2, BHS)
- Significant Post Traumatic Stress Disorder with flashbacks (2)
- Traumatic brain injury or significantly impaired cognition (1,2)
- Suicidal ideation with more than low level of risk. For example, intent, history of attempts, some level of plan formed. Needs careful Psychological assessment. More intense treatment/support may be needed if takes part in a group program.
- Homicidal ideation (BHS)
- Depression so severe that cannot participate in a group program. (E.g., significantly slowed thinking and speech, very low level of activity) (BHS)

Physical Red Flags

- Possible Infection or Tumour
    - Age >50 or <20 years (3)
    - History of cancer (3)
    - Constitutional symptoms (fever, chills, weight loss) (3)
    - Recent bacterial infection (3)
    - IV drug use (3)
    - Immunosuppression (3)
    - Pain worsening at night or when supine (3)
- Evidence of significant neurological deficit
    - Severe or progressive sensory alteration or weakness (BHS, 3)
    - Bladder or bowel dysfunction (BHS, 3)
    - Cauda equine syndrome (urinary retention, faecal incontinence, widespread neurological symptoms in the lower limb including gait abnormality, saddle area numbness and lax anal sphincter)
- Significant physical trauma (BHS)
- Minor physical trauma in elderly or osteoporotic (BHS)

Indicators for Referral for Medical Assessment/Review or an Urgent Review (BHS)

- Specific request by a referring doctor for a medical review
- Complex Regional Pain Syndrome (CPRS) in the early stages
- High doses of opiates or other medication related issues
- Other issues that would mean a medical assessment or review such as red flags.

Prioritising

- CRPS of less than 3 months duration (BHS, Alfred Hospital)
- Repeated ED presentations (Alfred Hospital)
- Risk of job loss (Alfred Hospital)
- Planning to have ketamine infusion (BHS) – this is to prepare patients for helpful pacing after ketamine, so as to prevent 'boom and bust' pattern.

OUTCOME MEASURES

The service will use Electronic Persistent Pain Outcomes Collaboration (ePPOC), which will be in line with what other services in Victoria, NSW and NZ are using. Advantages of being involved in this program include being provided with 6 monthly reports of our patient outcomes compared to other services, information about what other services are doing, and electronic administration of outcome measures with automatic scoring and progress tracking.

The following information was provided by Dr Hilarie Tardiff, director of the ePPOC program

"We analyse your data and provide a detailed report to every service twice a year. These reports show your data and compare it to aggregated data from all other participating services. So you get your data analysed and also the ability to compare your patient population and outcomes to what's happening elsewhere. We've also developed free to use software for the collection of the information and have made this software clinically useful with automatic scoring of the assessment tools, charts to follow patient progress and the ability for the patient to complete the assessment tools online/offsite."

It currently costs $5000 to join the project. Last year the Victorian Department of Health paid the cost for funded pain services to be part of ePPOC. This runs out in July 2016, and Hillarie is not sure as yet what the ongoing funding arrangements will be.

The ePPOC project services use the following outcome measures: Brief Pain Inventory, DASS21, Pain Catastrophising Scale, Pain Self-Efficacy Scale.

UPDATE MAY 2016 – funding for EPPOC membership will be provided by PHN.

PROGRAM INTENSITY - MATCHING THE PATIENT TO THE TREATMENT

- The Agency for Clinical Innovation in NSW has studied the usefulness of matching patients to the appropriate intensity of treatment versus taking a 'one size fits all model'.
- Several research studies have shown that patients who score above certain cut off scores on measures of disability, depression, and quality of life receive minimal benefit from a 'medium intensity' groups (e.g. 24-60 hours of treatment over 4-6 weeks).

- These patients do significantly better in a 'high intensity group' (e.g., 60-120 hours over 2-4 weeks with planned follow ups).
- Importantly, more severely affected patients treated in a 'high intensity' group remained significantly improved when followed up 3 years later. When treated in a 'medium intensity' group, their minimal gains had remained at the 'minimal' level 3 years later.
    - Many services offer different intensity group programs to meet these different patient needs. For example, offering one 'high intensity group' each year and several of the 'medium intensity groups'.
    - The 'light intensity' groups (such as the HARP Start UP group) are valuable as they can lead to improvements in people with relatively low levels of disability, and provide a service for those who are still working and cannot attend more intense treatment.
    - These groups also 'screen' to make sure people understand what can be offered in longer programs, and therefore minimize the number of patients who commit to a longer program but then drop out.
- An example of a 'high intensity' group used by several services in NSW and Victoria is the IMPACT program, which involves an intensive program of three weeks, five days each week (Mon-Fri), 9am-5pm. After this three-week period, patients are expected to practice strategies and exercise daily for four weeks themselves, before a follow up session. Further follow up is offered at 6 months and 12 months post program.
    - Barwon Health use this model, and are about to implement monthly review/support sessions for patients who have completed the group program and feel they need extra support, refreshers, or guidance.
- Measures of symptom severity should be used to guide decision-making regarding the type of treatment needed for each patient. Given that we are unlikely to be offering a 'high intensity group' (at least in the early stages of the project), we will need to carefully assess severely affected patients and make a case-by-case clinical decision regarding if they are likely to benefit from a 'medium intensity' program that we are likely to offer.

Please see the ACI's table in Appendix A for more details on matching patients with treatment intensity.

The British Pain Society Recommendations report that longer and more intensive programs are associated with more significant change and improvements. They recommend that a *standard program involve 12 weeks* of half-day sessions and comment that shortening a program can 'dilute' the treatment effect to the point that it is ineffective (1,2). Therefore it is worth considering a longer program if resources permit rather than automatically aiming for a 9 week program.

PROPOSED PHASES OF PROJECT

Phase 1: Outpatient pain service begins

- Begin accepting referrals (June 2016?)
- Patients go through intake and are then assessed by multidisciplinary team and treatment plan developed.
- Those suitable for pain group-program, go into a brief educational group as their first step. Patients may receive individual support while waiting for group, as needed.
- Set regular dates for brief educational groups
- Treatment plans are developed for those not suitable for group program (may involve 1:1 intervention or secondary consults with their existing practitioners).
- ? Consider whether realistic to offer VC links in brief educational group, for assessments and for individual work at this stage, or begin with Horsham based work only in early stages of project.

Phase 2: Group program and role out VC

- Run first group program (by end of 2016?)
- Set regular dates for longer group programs
- Incorporate VC links for individual and brief educational groups if not already done in Stage 1

Phase 3: Expand VC Use

- Incorporate VC links for longer pain program and other aspects of service that are appropriate for VC (early 2017?)

Phase 4: Preventative Program

- Consider developing a preventative/transitional pain service, to provide brief, educational focused interventions to patients who are at high risk of developing persistent pain after surgery or injury.

*Throughout these phases, work will be continuous in terms of coordinating training and professional development for staff throughout the region. An emphasis will be placed on involving interested staff in all aspects of the service so that skills are shared among practitioners.

REFERENCES

1 Main, C.J., Sullivan, J.L., Watson, P.J. (2008) Pain Management: Practical Applications of the Biopsychosocial Perspective in Clnical and Occupational Settings. Elsevier Science.

2 British Pain Society (2013): Guidelines for Pain Management Programmes for Adults, an Evidence Based Review Prepared on Behalf of the British Pain Society.

3 Hunter Integrated Health Care (NSW) Practice

4 ACI website http://www.aci.health.nsw.gov.au/resources/pain-management

APPENDIX A

ACI - GUIDE FOR SELECTION OF PATIENTS FOR DIFFERENT PAIN PROGRAMS

TREATMENT FORMAT	STAFF/RESOURCES	SUITABLE PATIENTS
INDIVIDUAL PATIENT SESSIONS		
• **Format:** 1-10 sessions, 30-60 minutes each, 1-3 weeks apart • **Total Time:** 30 minutes - 6 hours	• **One or more staff** Practitioners with appropriate skills, working in coordinated way (eg. clinical psychologist + physiotherapist + GP/ Specialist) • **Consult room**	**Disability:** **Pain intensity:** <5 on BPI intensity **Pain interference:** <5 on BPI interference **Depression:** <13 on depression scale of DASS (or very high >30; see below) **Pain self-efficacy:** >35 on Pain Self Efficacy Questionnaire (PSEQ) **Catastrophising:** <25 on Pain Catastrophising Scale (PCS) **Reliance on medication:** low – simple analgesics, non steroidal anti-inflammatory drugs (NSAIDs), antidepressants, anxiolytics, low level anticonvulsants, sleeping tablets **Specific problem area:** (e.g. sleep disturbance, anger, low acceptance, poor activity pacing) which can be targeted effectively in limited number of individual sessions **ALSO:** **When group is unsuitable,** or person unwilling or unable to participate in a group program (e.g. Culturally and Linguistically Diverse (CALD), and/ or Aboriginal and Torres Strait Islander, low literacy, aged, co-morbidity, Mental health) **Patients needing work up to high intensity program:** e.g. undergoing supervised withdrawal from medications; extreme low level of activity, excessive bed rest; severe depression

PAIN MANAGEMENT PROGRAM FORMAT	STAFF/RESOURCES	SUITABLE PATIENTS
LOW INTENSITY GROUP		
• **Format:** 2-6 sessions (1-3 hours a session) over 2-4 weeks • **Time:** 6-24 hours	• **Two or more staff** (may include psychologist, physiotherapist, occupational therapist, nurse) Coordinated with medical management • **Group room** (exercise area, white boards, chairs)	**Disability:** **Pain intensity:** <5 on BPI Intensity **Pain interference:** <5 on BPI interference **Depression:** <13 on depression scale of DASS **Pain self-efficacy:** >35 on PSEQ **Catastrophising:** <20 on PCS **Reliance on medication:** low – simple analgesics, NSAIDs, antidepressants, anxiolytics, low level anticonvulsants, sleeping tablets **Multiple problem areas** (e.g. sleep, mood, avoidance of multiple activities, interpersonal conflict at home/work, poor pain coping strategies) but at low levels. Still functional and reasonably active e.g. working or minding children **ALSO:** **Other responsibilities** (Need to maintain attendance at work, school or family duties) thus unable to attend more intensive program

PAIN MANAGEMENT PROGRAM FORMAT	STAFF/RESOURCES	SUITABLE PATIENTS
MEDIUM INTENSITY GROUP		
• **Format:** 2 part days or 1 full day per week for 4-6 weeks • **Time:** approx. 24 hours, up to 60	• **Two or more staff** (may include psychologist, physiotherapist, occupational therapist, nurse) Coordinated with medical management • **Group room** (exercise area, white boards, chairs)	**Disability:** **Pain intensity:** 5-8 on BPI intensity **Pain interference:** 5-8 on BPI interference **Depression:** 14-20 on depression scale DASS **Pain self-efficacy:** 20-35 on PSEQ **Catastrophising:** 20-30 on PCS **Reliance on medication:** low-moderate. As above plus low to moderate regular opioid use: 20-50 mg morphine equivalent daily or 6-8 Panadeine Forte **Multiple problem areas** (e.g. sleep, mood, avoidance of multiple activities, interpersonal conflict at home/work, poor pain coping strategies) but still reasonably functional and reasonably active, e.g. working or minding children **ALSO:** **Other responsibilities** (Need to maintain attendance at work, school or family duties) thus unable to attend full time program

PAIN MANAGEMENT PROGRAM FORMAT	STAFF/RESOURCES	SUITABLE PATIENTS
HIGH INTENSITY GROUP		
• **Format:** • 3-5 days a week for 2-4 weeks), with planned follow-up, or; • 5 hours /day, 2x / week, with structured homework between sessions • **Time:** 60-120 hours	• **Three or more staff** (may include: psychologist, physiotherapist, occupational therapist, nurse, psychiatry in paediatrics), with specific medical input (for medication and education) • **Group/activity room** (exercise area, white boards, chairs) + refreshments)	**Disability:** **Pain intensity:** >8 on BPI intensity **Pain interference:** > 8 on BPI interference **Depression:** >20 on depression scale of DASS **Pain self-efficacy:** <20 on PSEQ **Catastrophising:** >30 on PCS **Reliance on medication:** As above plus higher level of regular opioid use: > 50 mg morphine equivalent **Multiple problem areas** (e.g. sleep, mood, avoidance of multiple activities, interpersonal conflict at home/work, poor pain coping strategies, generally limited physical function)

APPENDIX B: ACI CHRONIC PAIN MANAGEMENT PROGRAMS - A CONSENSUS VIEW

NB: This table applies to individual or group programs, at high or low intensity, once the person has been deemed suitable to participate

GUIDING PRINCIPLES
1. A person/family centred approach should determine timing of and suitability to participate in an appropriate pain programme
2. Structured, time-limited interventions, tailored to the individual are aimed at improving pain self-management
3. Admission to a PMP should follow appropriate multidisciplinary assessment to confirm suitability and identify relevant individual goals.
4. Inclusion and exclusion criteria for all types of pain programme should be specified with as little as possible reliance on personal opinion (e.g. making predictions).
5. Where relevant to participation in the programme and potential benefit, inclusion and consideration of the support network including family, carers and healthcare providers is essential
6. A PMP may be part of a series of interventions but these should be planned to ensure effective engagement of the person and the consistent support of his/her treatment providers.
7. A pain management programme is typically conducted by a multidisciplinary[1] team that works in an interdisciplinary[2] way.
8. Broad programme goals include reduced interference in daily activities due to pain (or return to normal lifestyle despite persisting pain); improved mood; improved personal relationships; and reduced use of health healthcare services. Specific, person-centred goals should also be identified prior to admission.
9. Some reduction in pain severity is possible, but is not the primary goal
10. Mechanisms for promoting the maintenance of gains over long-term are also important features of these programmes (this could include involvement of significant others, like families)
11. Evaluation of outcomes (in terms of achievement of specific goals and common functions, e.g. disability, mood, pain, health care utilisation) is essential (e.g. 1/12, 3/12, 6/12, 12/12 follow up)
12. PMP require staff with appropriate skills and training (so provision must be made to ensure this is the case for all staff).
13. To date, the most consistent evidence is that a background understanding and knowledge of cognitive behavioural management therapies, principles and methods is appropriate for all participating staff.
14. Recognition that co-morbid conditions (e.g. spinal cord injuries, diabetes, Post-Traumatic Stress Disorder, Major Depression, Personality Disorders) can complicate participation in a PMP and need to be addressed on an individual basis (e.g. with individual therapy in conjunction with PMP)

1. Multidisciplinary refers to more than one healthcare discipline

2: Interdisciplinary refers to multiple disciplines working in a coordinated and collaborative way

COMMON FEATURES OF A PAIN PROGRAM
1. Timetable and specified content for each session (ideally, with a patient manual)
2. Tailored education about pain (acute, chronic , contributing mechanisms and treatments)
3. Skills training in pain self-management (e.g. exercise, activity pacing, relaxation) facilitating generalizability to the usual environment
4. The use of interactive discussions
5. Application and practice of self management skills in patient's normal environment, and working towards functional goals
6. Preparation for participation in programme
7. Preparation for discharge/maintenance of gains

GOALS OF A PAIN PROGRAM
1. To improve patients understanding of chronic pain and its effects
2. To improve level of physical function and promote return to daily living tasks
3. To modify perceived level of pain, disability and suffering
4. To provide coping strategies for dealing with pain, disability and distress
5. To promote self management
6. To reduce or achieve appropriate future utilisation of healthcare services related to pain
7. Preparation for discharge/maintenance of gains