



Professor Tess Cramond Multidisciplinary Pain Centre

Metro North Hospital and Health Service *Putting people first*

# Persistent Pain

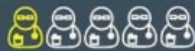
## Assessment & Management in Primary Care

# Objectives

1. Outline the opportunities and challenges associated with making a PPMS referral
2. Develop a detailed biopsychosocial persistent pain assessment
3. Develop a management plan for non-specific low back pain in primary care with attention to red flags
4. Develop a preliminary assessment and management plan for chronic widespread body (such as fibromyalgia) pain in primary care

## Australia's pain burden: a snapshot

**1** in **5** GP consultations involve a patient with chronic pain.

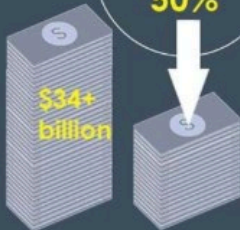


**40%** of forced early retirements in people of working age are due to chronic pain.

Chronic pain costs the Australian economy **\$34+ billion** per year.

Effective and timely treatment could reduce this cost by

**50%**



### Chronic pain affects:

**1** in **5** Australians (including kids and teens)



**1** in **3** over 65



**80%** of aged care residents



**30-40%** of Australians with chronic pain presenting for treatment have major depression.

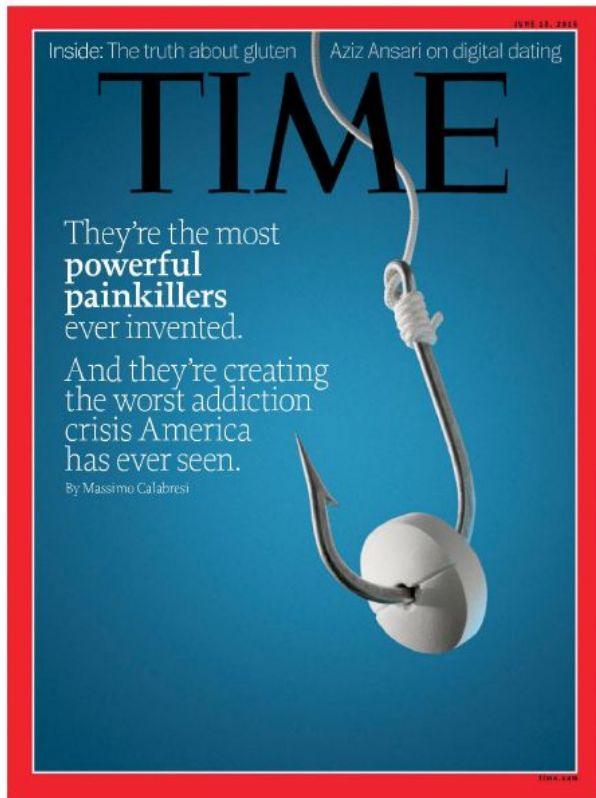
Suicidal behaviour is **2-3** times higher in people with chronic pain than the general population worldwide.



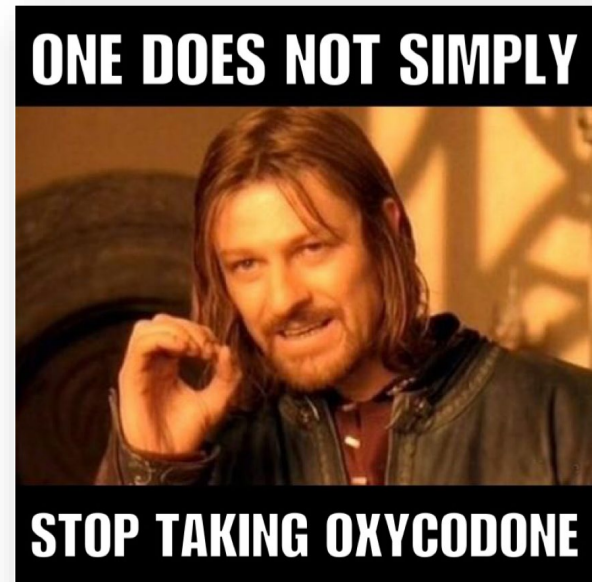
For help with ongoing pain visit: [www.painaustralia.org.au](http://www.painaustralia.org.au)

# The Need – Chronic Pain is common and expensive

**pain**australia

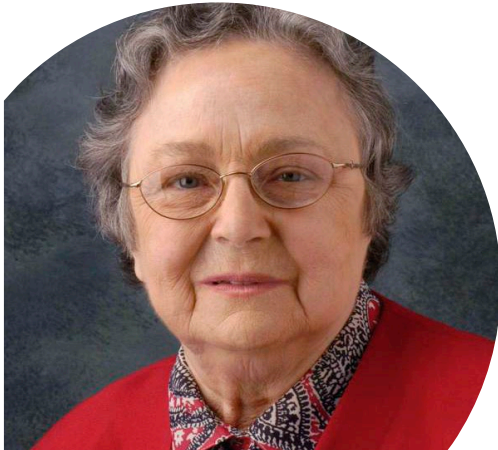


June 2015



# The Professor Tess Cramond Multidisciplinary Pain Centre

## Background and Overview



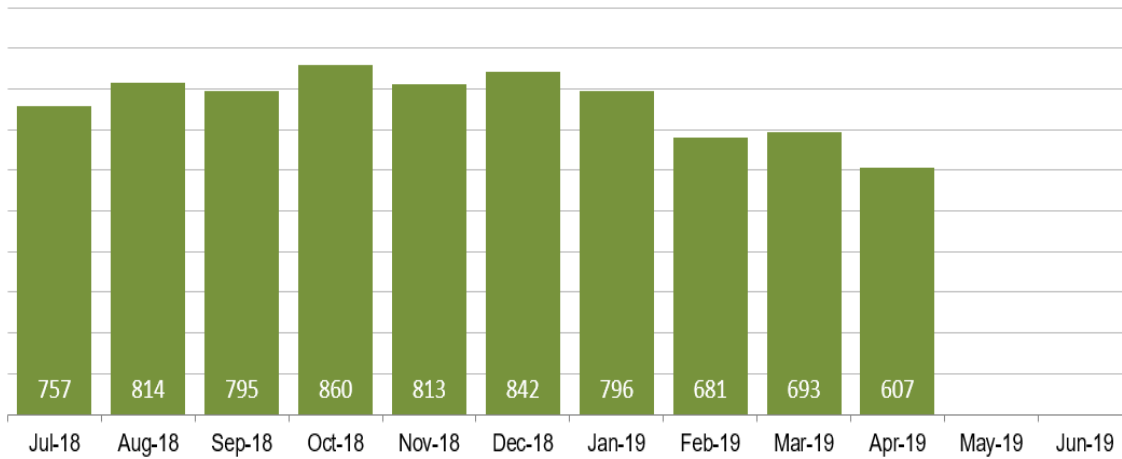
- First established by Tess Cramond in 1967
- 1<sup>st</sup> PPMS in Queensland; 2<sup>nd</sup> in Australia
- Now one of 6 PPMS's in Queensland
- Catchment of 1.5 million people
- FTE Pain Specialist – 3.5
- Remains the flagship
  - Patient care
  - Teaching
  - Education and
  - Research



THE UNIVERSITY  
OF QUEENSLAND  
AUSTRALIA



### Pain Management - Persistent Pain-SODC / Current Waitlist



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Pain Management - Persistent Pa	757	814	795	860	813	842	796	681	693	607		

### Pain Management - Persistent Pain-SODC Total wait List Grid

	Cat 1	Cat 2	Cat 3	Total
0 - 30 days	5	16	39	60
31 - 90 days	1	68	99	168
3 - 6 months		7	153	160
6 - 9 months		0	141	141
9 - 12 months		0	59	59
12 - 18 months		0	19	19
18 - 24 months		0	0	
2 - 3 years			0	
3 - 4 years				
4+ years			0	
<b>Total</b>	<b>6</b>	<b>91</b>	<b>510</b>	<b>607</b>

The above grid displays the Pain Management - Persistent Pain-SODC waitlist. Those which are 'In time' by category are in green, long waits graduate out to black.

# The Gap





## Pre referral - Primary Care Management



What community based  
treatments have been  
triallyed?



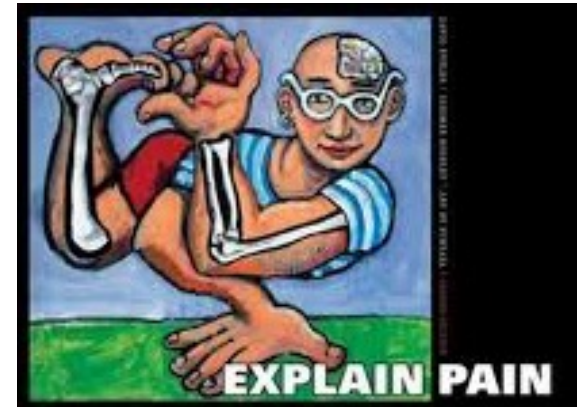
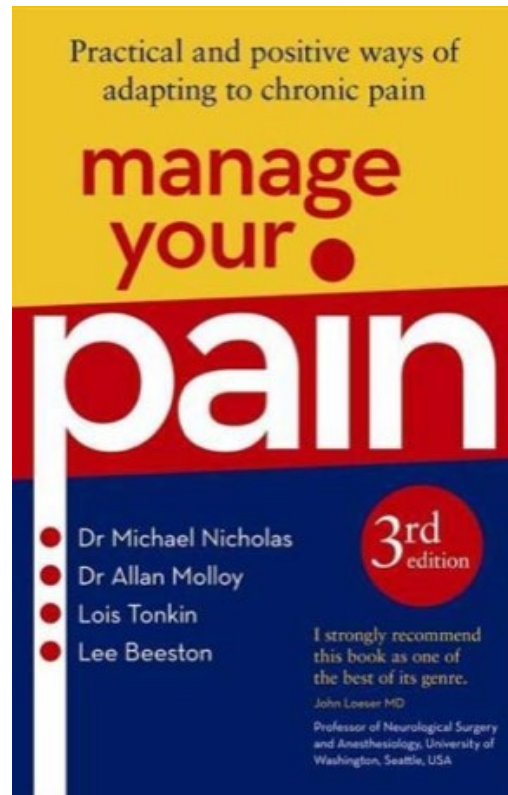
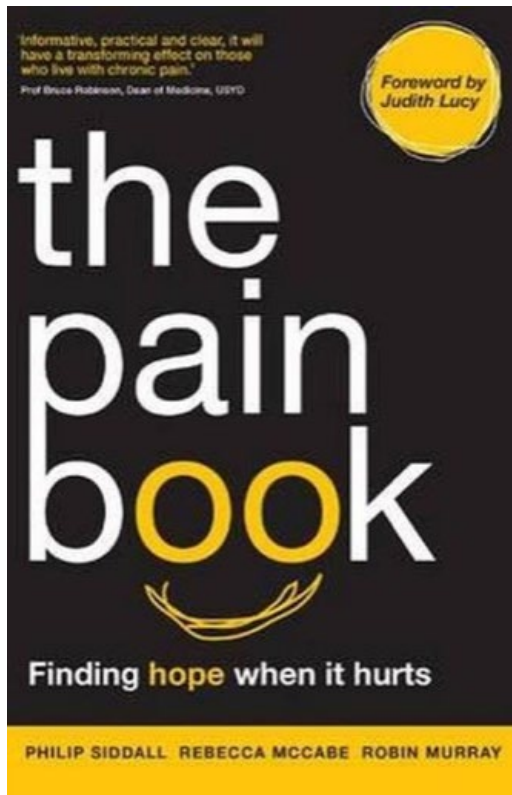
Examples of community  
management



Alternative Referral  
pathways: ATODS, Spinal  
Hub, Rheumatology



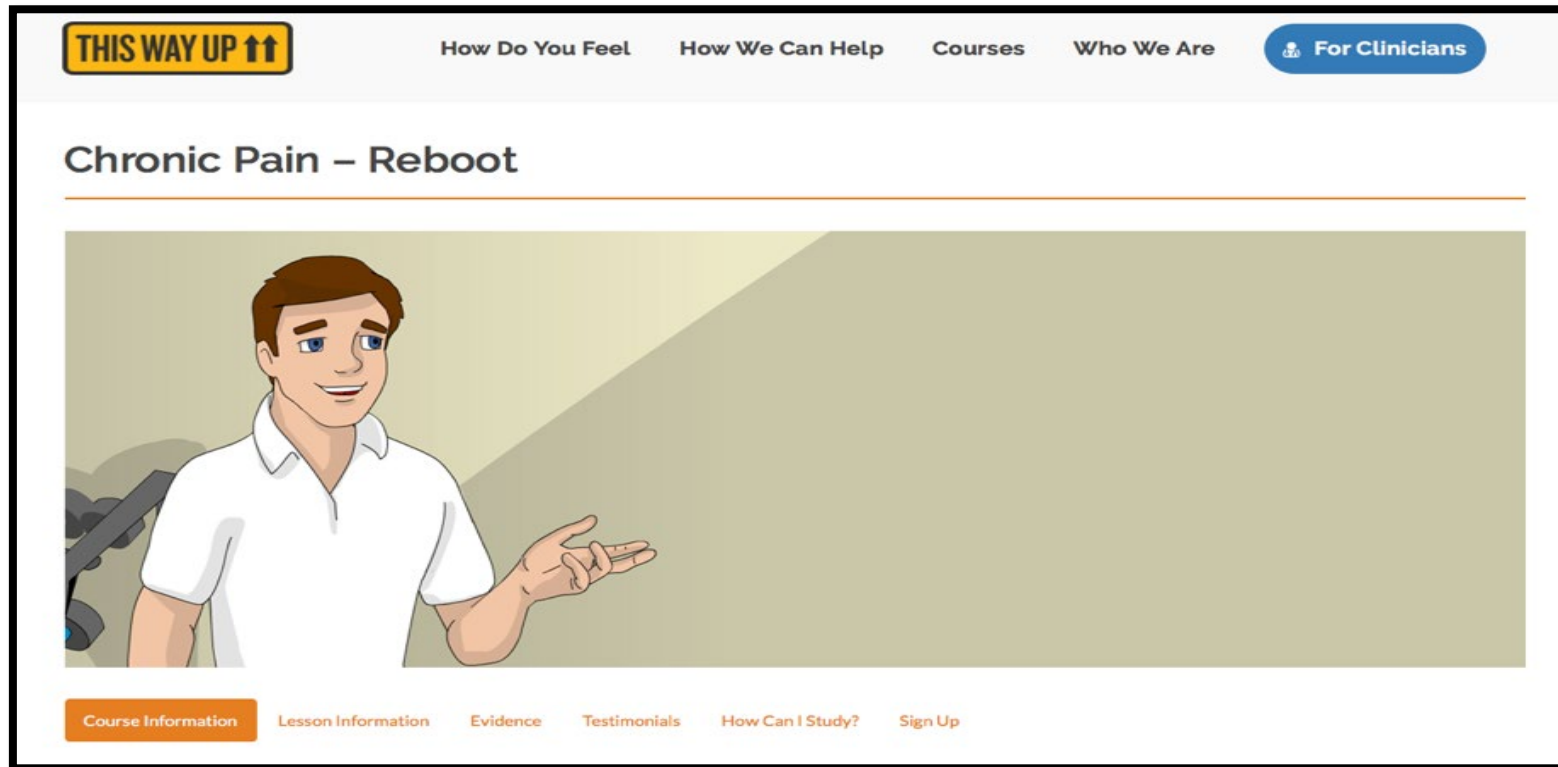
Not always clear what  
pathway is best and is often  
debated within our service



## Resources for Patients

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# Resources for Patients



[www.thiswayup.org.au](http://www.thiswayup.org.au)

8 lessons over 120 days

CBT based program

\$59 dollars

# Resources for Patients

MindSpot | Online assessment and treatment for anxiety and depression

Tel. 1800 61 44 34

[I Need Urgent Help](#)

[Home](#) [Why MindSpot?](#) [Conditions We Treat](#) [Assessments](#) [Our Treatment Courses](#) [Health Professionals](#) [Contact Us](#)

“My pain has changed my life in almost every way. I'm not managing, I feel so frustrated and helpless.”

[Start Your Online Assessment](#)

[Log In For Treatment](#)

Mindspot.org.au

Free

Especially for people with elements of anxiety and depression

# Resources for Patients – Consumer Groups

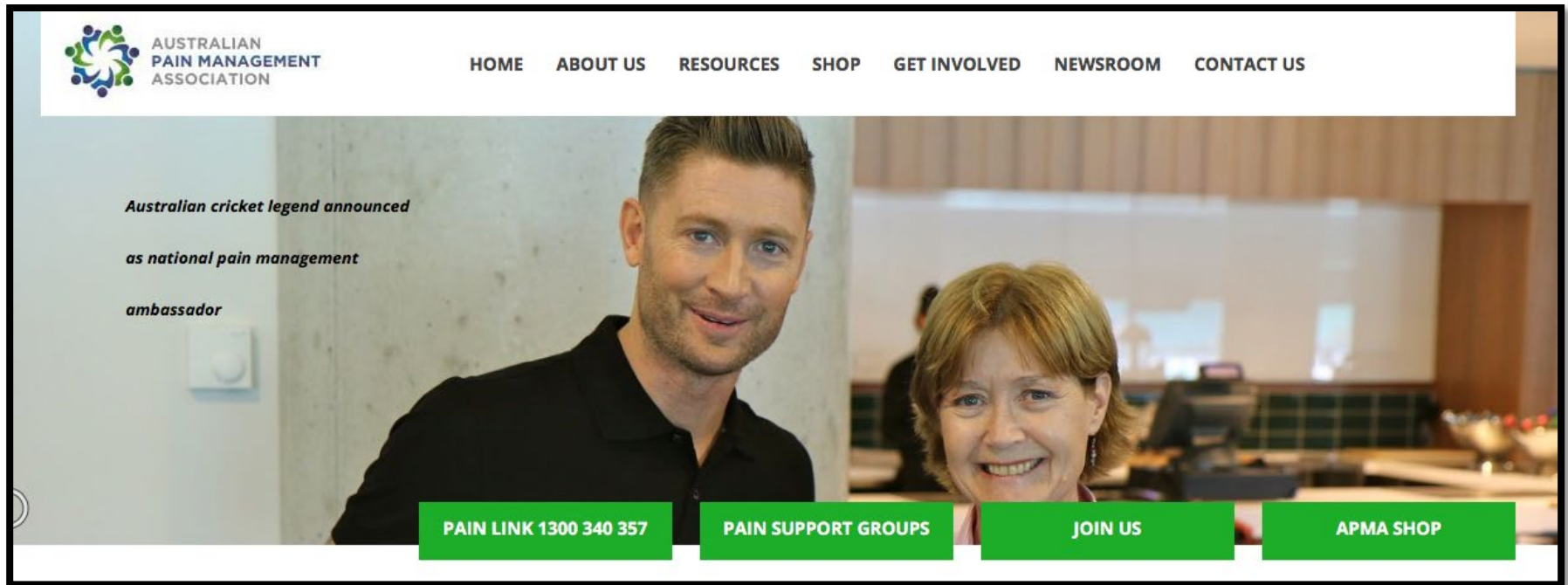
The screenshot displays the Chronic Pain Australia website interface. At the top left is the logo for Chronic Pain Australia, featuring a stylized green leaf icon. To the right of the logo are navigation links for [STORIES](#), [SUPPORT US](#), and [CONTACT](#). Below the logo is a horizontal menu with links for [HOME](#), [ABOUT US](#), [CHRONIC PAIN](#), [MEMBERS](#), [RESOURCES](#), [FORUM](#), and [NEWS](#). On the far right of this menu are social media icons for Twitter, Facebook, and Pinterest.

The main content area is divided into three primary sections:

- LIBRARY:** A green rectangular tile with a white border. The top half features an illustration of four people's profiles in profile, with colorful speech bubbles above them. The word "LIBRARY" is written in large white letters. At the bottom, it says "RESOURCES CENTRE" with a white arrow pointing to the right.
- THE PAIN JOURNEY:** A large orange rectangular tile with a white border. The top half has the text "THE PAIN JOURNEY" in white. The bottom half features a white paper-cut style illustration of a line of people holding hands, with paper clips at the top. At the bottom, it says "FIND OUT MORE ABOUT HOW TO LIVE WITH CHRONIC PAIN." with a white arrow pointing to the right.
- NPW 2017:** A green rectangular tile with a white border. The top half has the text "NPW 2017" in white. Below it, it says "WHAT IS HAPPENING THIS YEAR?" with a white arrow pointing to the right. The bottom half of the tile shows a photograph of a small green seedling growing out of cracked, dry brown soil.

On the right side of the page, there is a login and registration section. It includes a "Username" input field, a "Password" input field, a blue "Log in" button, and a grey "Register" button.

# Resources for Patients – Consumer Groups



The image shows a screenshot of the Australian Pain Management Association (APMA) website. At the top left is the APMA logo, which consists of a stylized human figure made of colorful dots, followed by the text "AUSTRALIAN PAIN MANAGEMENT ASSOCIATION". To the right of the logo is a navigation menu with the following items: HOME, ABOUT US, RESOURCES, SHOP, GET INVOLVED, NEWSROOM, and CONTACT US. Below the navigation menu is a large banner image featuring a man and a woman smiling. On the left side of the banner, there is text that reads: "Australian cricket legend announced as national pain management ambassador". At the bottom of the banner, there are four green buttons with white text: "PAIN LINK 1300 340 357", "PAIN SUPPORT GROUPS", "JOIN US", and "APMA SHOP".

**AUSTRALIAN PAIN MANAGEMENT ASSOCIATION**

HOME ABOUT US RESOURCES SHOP GET INVOLVED NEWSROOM CONTACT US

*Australian cricket legend announced  
as national pain management  
ambassador*

PAIN LINK 1300 340 357 PAIN SUPPORT GROUPS JOIN US APMA SHOP



# Resources for Patients – Consumer Groups



The image is a screenshot of the Pain Australia website. The top navigation bar is dark grey with the logo 'painaustralia™' in red and white, followed by the tagline 'working to prevent and manage pain'. To the right of the logo are links for 'CONTACT', 'LOGIN', and a 'DONATE' button. Further right are social media icons for Facebook, Twitter, and YouTube. Below the navigation bar is a horizontal menu with links: 'ABOUT US', 'ABOUT PAIN', 'GETTING HELP', 'IMPROVING POLICY', 'GET INVOLVED', 'HEALTH PROFESSIONALS', 'EVENTS', and 'MEDIA'. The main content area features a large background image of a blister pack of white, round tablets. Overlaid on the bottom left of this image is a dark grey box containing the text: 'Painaustralia codeine fact sheet' in a large white font, followed by 'October 2017' in a slightly smaller white font. Below this, in a smaller white font, is the text: 'Codeine changes need a national approach to ensure people with chronic pain can access pain services'.

**painaustralia™**  
working to prevent and manage pain

CONTACT | LOGIN | DONATE

ABOUT US | ABOUT PAIN | GETTING HELP | IMPROVING POLICY | GET INVOLVED | HEALTH PROFESSIONALS | EVENTS | MEDIA

f t y

## Painaustralia codeine fact sheet

### October 2017

Codeine changes need a national approach to ensure people with chronic pain can access pain services

# PainAustralia – Resources for Patients

## For your patients

The following fact sheets are available for you to download and print for your patients.

- ◆ The Nature and Science of Pain (Painaustralia)
- ◆ Prevalence and the Human and Social Cost of Pain (Painaustralia)
- ◆ Clinical Assessment of Pain (Painaustralia)
- ◆ Multidisciplinary Pain Management (Painaustralia)
- ◆ Spinal Cord Stimulation (Painaustralia)
- ◆ Targeted Drug Delivery (Painaustralia)
- ◆ Chronic Pain – A Major Issue in Rural Australia (National Rural Health Alliance)
- ◆ Chronic Physical Illness, Anxiety and Depression (Beyond Blue)
- ◆ TENS; Transcutaneous Electrical Nerve Stimulation (Painaustralia)
- ◆ Neuropathic (Nerve) Pain (Painaustralia)
- ◆ Self-Managing Chronic Pain
- ◆ Shingles – Busting the myths (Seqirus)
- ◆ The Pain Toolkit Australia ([www.pain toolkit.org](http://www.pain toolkit.org))
- ◆ Chronic Pain Management Strategies (NSW ACI)
- ◆ Communicating and building your healthcare team (NSW ACI)
- ◆ Pain and Physical Activity (NSW ACI)





# Neuropathic (Nerve) Pain

## Key Points

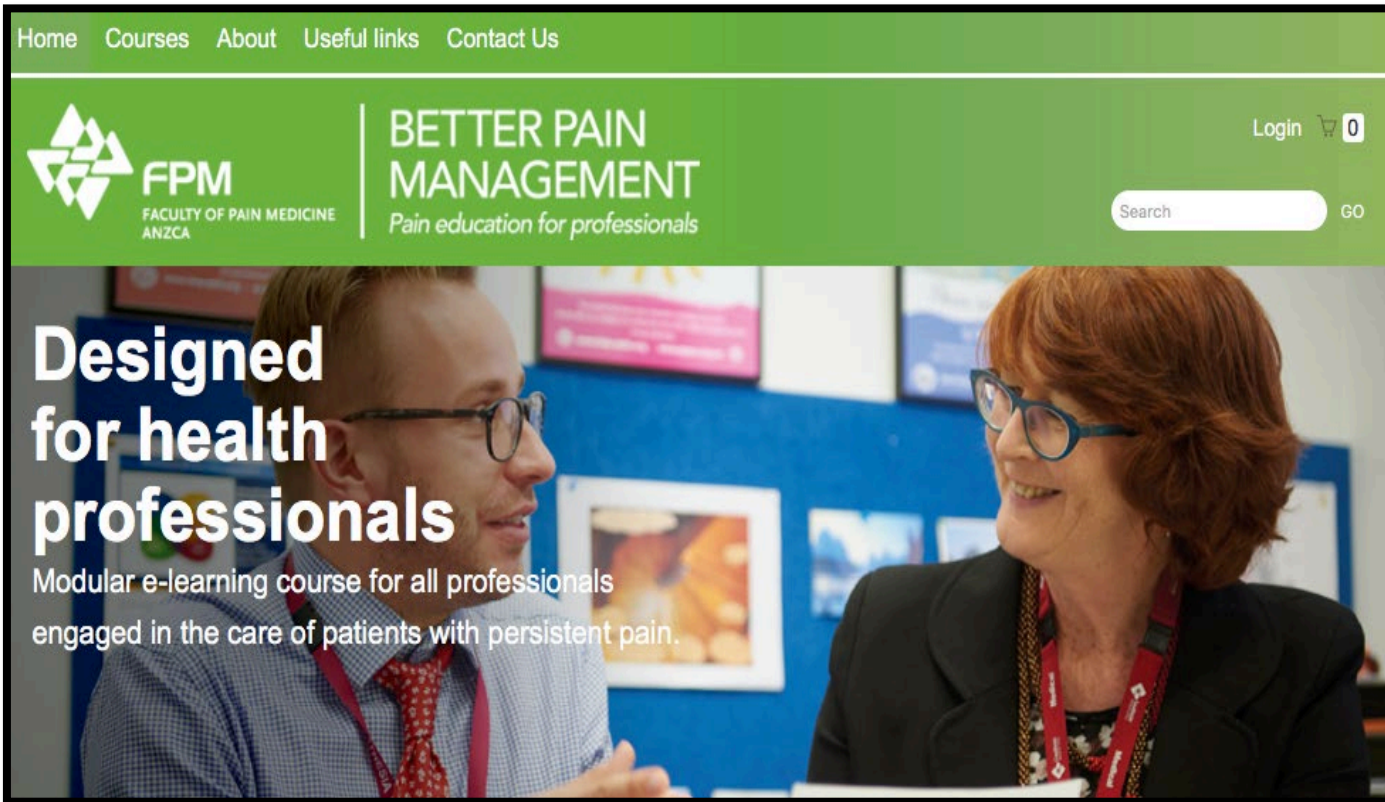
- Neuropathic (nerve) pain is caused by damage, disease or dysfunction in the nervous system.
- Neuropathic pain can include any or several of the following: shooting, radiating, tingling, crawling, stabbing or burning pain; feeling heat or coldness; pins and needles; electric shocks; numbness.
- In many cases of neuropathic pain, external stimuli that are not normally painful (such as a breeze) can cause pain.
- Untreated pain can have a significant impact on quality of life.
- Medication alone is not the answer; a multimodal approach to treatment is required.
- Pain management is most effective when patients implement pain management strategies in their everyday lives (self-management).

Because the nervous system is dynamic, changes in its structure can allow pain messages through to the brain, long after the original source of pain has healed. For example, where nerves are compressed or inflamed for a long time due to chronic low back pain, even after treatment has removed pressure on the nerves, they can continue to send impulses to the brain. This 'pain memory' leads to what is known as 'pain sensitisation', where the nervous system is sending the wrong signals to the brain.

Whatever your pain feels like, it will not always feel like anyone else's pain, even though it may have the same underlying cause. This is because pain is an individual experience, and it depends on many factors including your beliefs, attitudes, coping style, support networks and your environment.

## What conditions cause neuropathic pain and who is at risk?

# Resources for Health Professionals

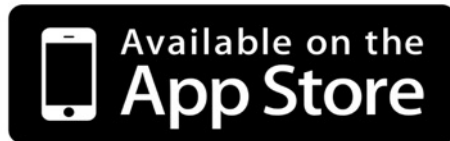


The image shows a screenshot of the Faculty of Pain Medicine (FPM) website. The header is green and contains navigation links: Home, Courses, About, Useful links, and Contact Us. The FPM logo is on the left, and the text 'BETTER PAIN MANAGEMENT' is prominently displayed in the center, with the tagline 'Pain education for professionals' below it. A search bar and a 'Login' button with a shopping cart icon are on the right. The main content area features a photograph of two healthcare professionals, a man and a woman, engaged in conversation. Overlaid on the left side of the photo is the text 'Designed for health professionals' in large white font, followed by 'Modular e-learning course for all professionals engaged in the care of patients with persistent pain.' in a smaller white font.

12 Modules

1 hour each

CPD Points



Search:

“Opioid calculator”

The screenshot shows the "Opioids" calculator interface. At the top, there are navigation options: a back arrow, the title "Opioids", and buttons for "Reset", "Pref", and "Convert". A red banner displays "Total Morphine oral ~ 107 mg/day" with a sub-note: "Reset the selected preferences by tapping on Pref". The interface is divided into sections for different routes of administration: ORAL, SUBLINGUAL, TRANSDERMAL, and PARENTERAL. Each section lists a drug with its unit and a numerical input field with minus and plus buttons. The current values are: ORAL Tramadol (empty), SUBLINGUAL Buprenorphine (800, with "Morphine 32" below it), TRANSDERMAL Buprenorphine (empty), and TRANSDERMAL Fentanyl (25, with "Morphine 75" below it). The PARENTERAL section is partially visible at the bottom.

Route	Drug	Unit	Value
ORAL	Tramadol	mg/day	
SUBLINGUAL	Buprenorphine	mcg/day	800
	Morphine 32		
TRANSDERMAL	Buprenorphine	mcg/hr	
TRANSDERMAL	Fentanyl	mcg/hr	25
	Morphine 75		
PARENTERAL		mg/day	

# Referral Process

- Referral process
  - Referral letter, inclusive of minimal referral information
  - As per CPC
- Who can refer
  - Internal medical/NP or GP for CAT 1 only
  - GP/NP for CAT 1, 2 or 3
- Triage
  - Consultant and Nurse with allied health advice
  - Triage clinic 2 sessions per week + additional nursing time for coordination
- Phone Advice
  - Non-urgent: via the PTCMPC Reception
  - Urgent: via the RBWH switch for the 'on call' medical staff

## Minimum Referral Criteria

<p><b>Category 1</b> (appointment within 30 calendar days)</p>	<ul style="list-style-type: none"> <li>• Cancer pain where the patient’s specialist treating team is requesting Persistent Pain Management Service (PPMS) input</li> <li>• Patients on a palliative care pathway where the patient’s specialist treating team is requesting PPMS input</li> <li>• New onset neuropathic pain of less than 6 weeks duration relating to a recent diagnosis of a condition for example:             <ul style="list-style-type: none"> <li>◦ herpes zoster (risk for post herpetic neuralgia)</li> <li>◦ ischaemic pain</li> <li>◦ trigeminal neuralgia</li> <li>◦ brachial plexopathy</li> <li>◦ diabetic neuropathy</li> <li>◦ multiple sclerosis</li> <li>◦ spinal cord injury</li> <li>◦ post stroke pain</li> </ul> </li> <li>• Worsening post-surgical pain of less than 3 months duration (where a post-operative complication has been excluded)</li> <li>• Newly diagnosed or suspected <a href="#">complex regional pain syndrome</a> (CRPS). Note that this is a diagnosis of exclusion. Diagnosis becomes more reliable greater than 6 weeks after the triggering event and can often not be made before 4 weeks.</li> </ul>
<p><b>Category 2</b> (appointment within 90 calendar days)</p>	<ul style="list-style-type: none"> <li>• Sub-acute pain (defined as lasting 6 to 12 weeks) with risk of functional deterioration</li> <li>• Exacerbation of neuropathic pain from pre-existing conditions as listed in Category 1</li> <li>• Patients with frequent emergency department / primary care presentations for exacerbations of persistent pain despite attempts at management</li> <li>• Complex pain presentation resulting in marked psychological distress (note that patient must also be under the care of a mental health clinician)</li> <li>• Complex pain presentation resulting in marked functional impairment</li> <li>• Pain with onset less than 6 months ago that is resulting in psychological and/or functional impairment, that is not responding to primary care management</li> <li>• Functional impairment as a result of severe or complex side effects from pain medications that are not able to be managed in primary care</li> </ul>
<p><b>Category 3</b> (appointment within 365 calendar days)</p>	<ul style="list-style-type: none"> <li>• Pain with onset more than 6 months ago that is resulting in psychological and/or functional impairment, that is not responding to primary care management</li> </ul>

# Patient Journey

- **Entry**
  - Most Category 3 patients are invited to the “Introduction to Pain Management Group Program”
  - Individual – Medical +/- Allied Health consultation
- **Therapy**
  - Groups
  - Individual appointments
  - Telehealth Service
  - Interventional procedures
  - Infusions



# Key Messages

Role of pain

Acute & chronic pain  
different

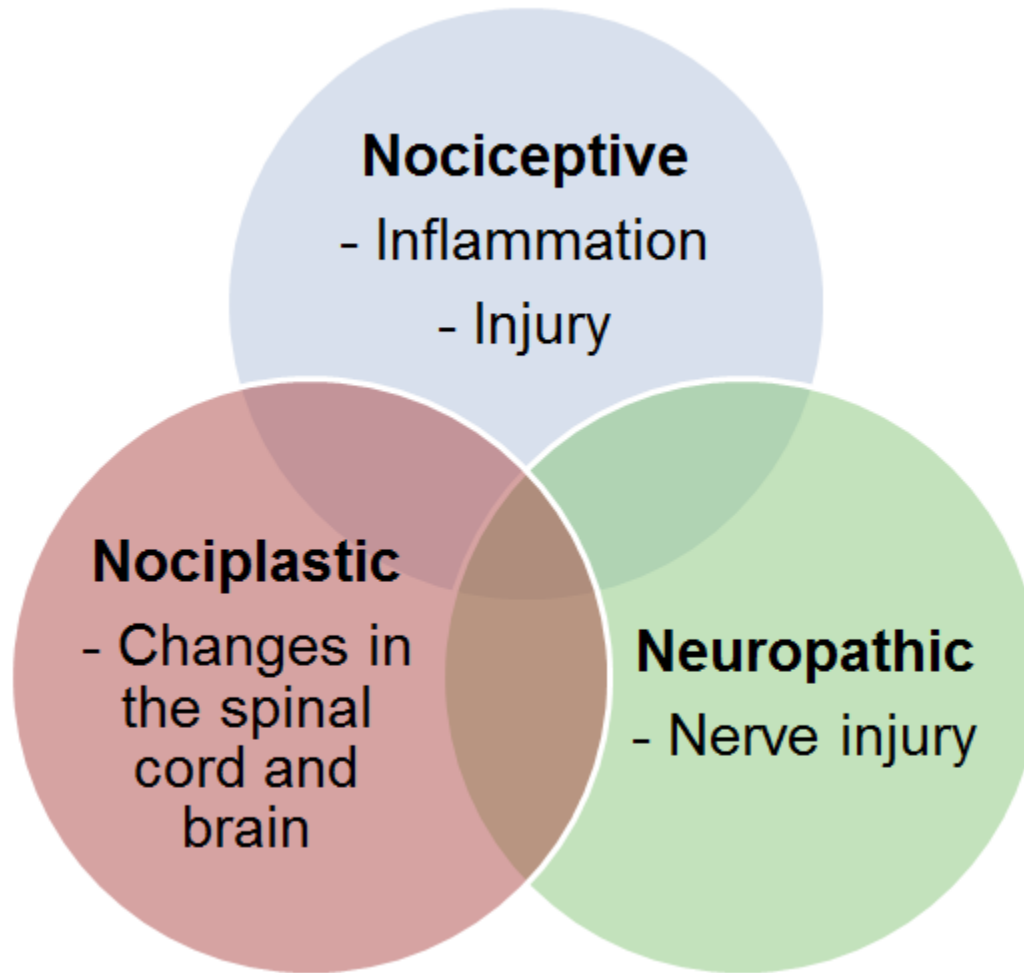
Patient role in chronic pain

Clinician role in chronic  
pain

Assessment of drivers



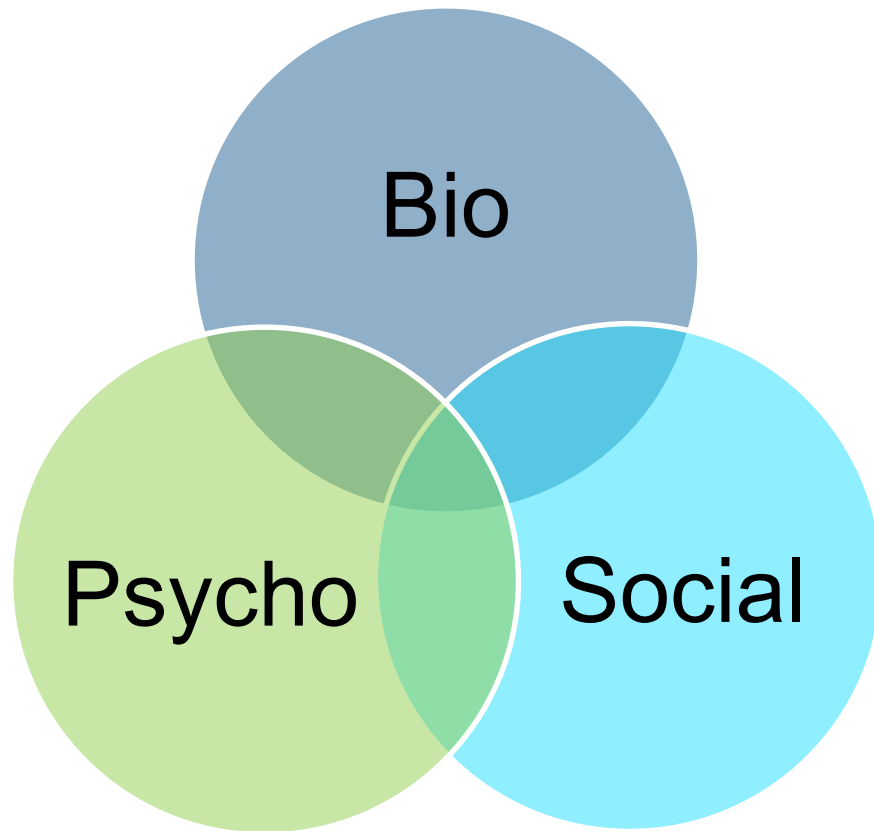
# Pain





# Chronic pain is complex

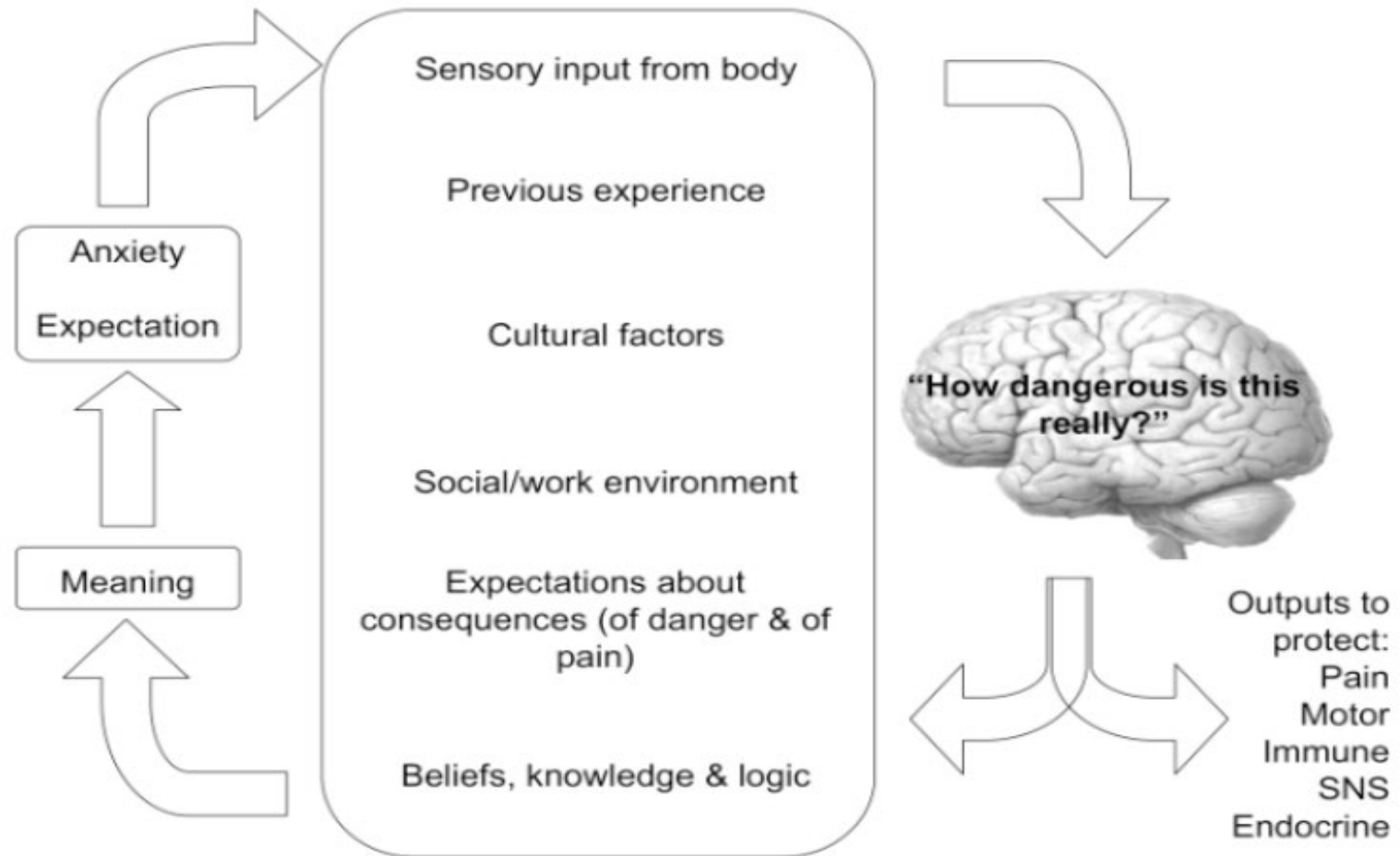
- It affects the body
- It affects thoughts
- It affects behaviour
- It affects emotions



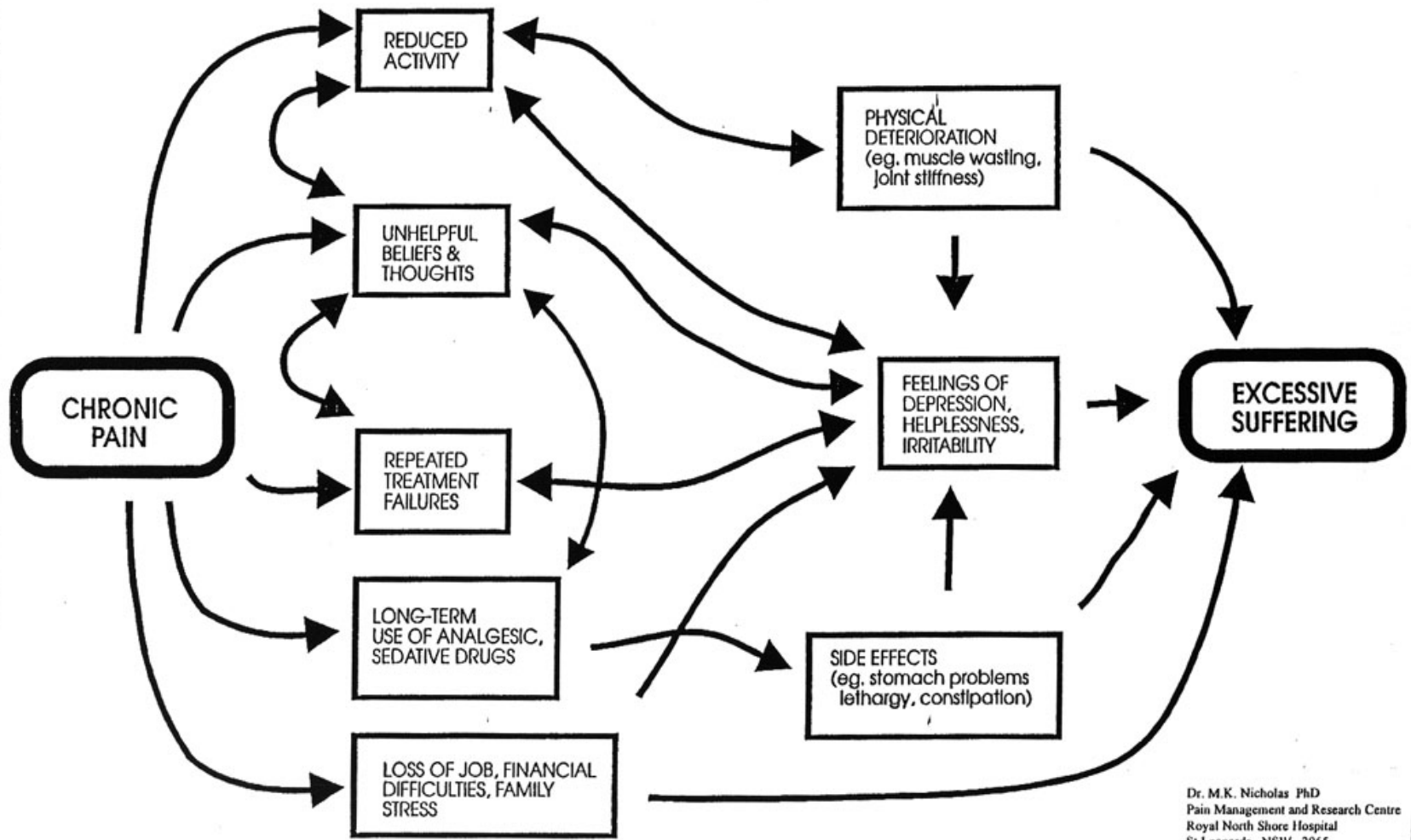
# Pain Physiology

(from "The Sensitive Nervous System" Butler, D 2000)

RECONCEPTUALISING PAIN ACCORDING TO MODERN PAIN SCIENCE



# OVERVIEW OF PROBLEMS CAUSED BY CHRONIC PAIN



Dr. M.K. Nicholas PhD  
Pain Management and Research Centre  
Royal North Shore Hospital  
St Leonards, NSW 2065  
AUSTRALIA

# Bio-Psycho-Social Formulation

- Why is it helpful?
  - A thorough assessment
  - Takes into account the complexity of pain
  - Helps us to provide better outcomes to our patients
- How do you do one?
  - This is what we will cover in the next few slides

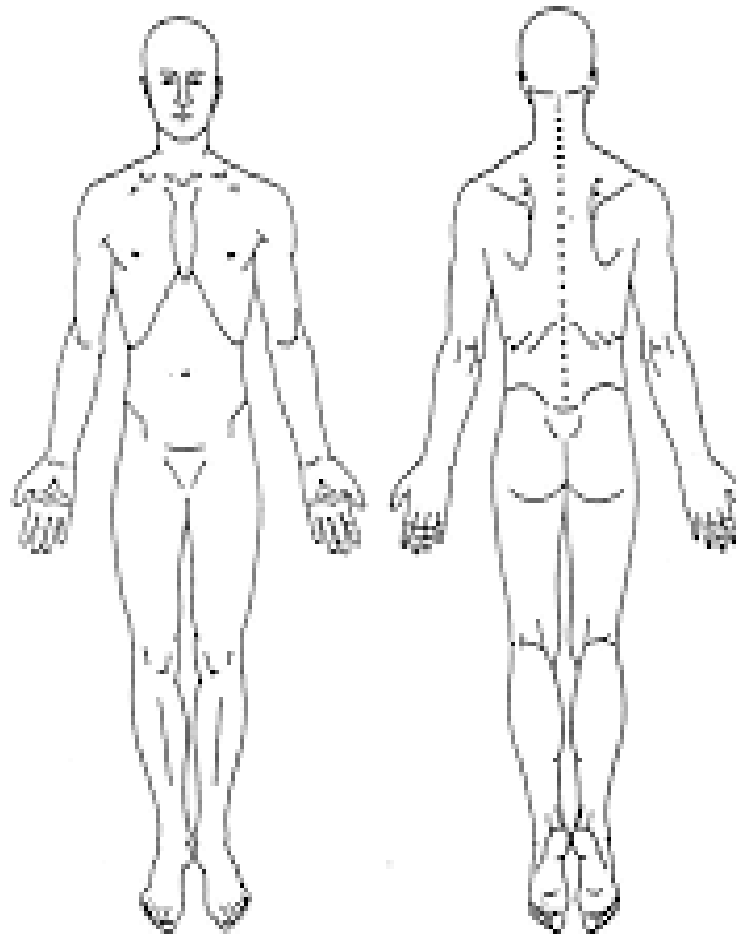


# Assessment

- Pain is individual experience
- Relationship between state of tissues, pathology, pain & disability highly variable
- Consider how these factors influence clinical presentation
- Assessment should reflect multi-dimensional nature of pain & disability
- Assist in addressing all relevant factors including tissue based factors
- Tissue based factor usually dominant contributing factor
- Well assessed and then informed decision making

# Biological

- Nature
- Intensity
- Location
- Duration
- Onset
- Contributing
- Aggravating
- Alleviating
- Frequency
- Impact
- Attribution
- Treatment



# Physical Assessment

- Posture
- Gait
- Transfer
- Weight bearing
- Active range of movement
- Straight leg raise
- Lower limb neurological
- Assessment of Red Flags both via subjective and objective?
- Mismatch between voluntary and involuntary how to interpret this.
- Looking for consistency in presentation across information sources

# Don't forget

- Medication list
- Procedures and interventions trialed so far
- Imaging



# Psycho-Social Assessment

- Explore for common mental health disorders, e.g. generalised anxiety, PTSD, depression, bi-polar
- Psychology is not just about treatment of obvious mental health issues
- Psychological variables that perpetuate and predispose persistent pain include: catastrophising, fear avoidance, perceived injustice, passive coping, low self efficacy and low self worth “I am useless now”
- Fear avoidance could be the cause of poor attendance to allied health clinicians rather than resistance or motivation
- If you can identify a patient would benefit from psychology but is not yet agreeable to this, a allied health referral (e.g. OT and physio) can be a stepping stone towards this.

# Functional Assessment



## At home

- Self-Care (e.g. showering , dressing)
- Housework (e.g. meal prep, vacuuming)
- Gardening and yard work
- Leisure/relaxation
- Sleep
- Relationship with family members (incl intimacy)

## Community participation

- Driving and transport
- Work
- Study
- Volunteering
- Socialising
- Hobbies and leisure activities

## Routine

- Boom bust
- Activity avoidance
- Activity cessation

# CASE STUDY

Develop a management plan for non-specific low back pain in primary care with attention to red flags

- Preliminary assessment of lower back pain.
- Non specific lower back pain in primary care
- Outline of guidelines and recommendations and when to seek further guidance and imaging.
- Red flags

# Guidelines in primary care for LBP

(AJGP Vol 47, N0.9, September 2018)

- Low back pain most common musculoskeletal presentation (1:4/1:7)
- Most often self limiting
- 10-40% develop persistent symptoms
- Specific pathoanatomical cause identified in 8-15%
- Red flags: spinal fracture, metastasis, infection, spondyloarthritis, cauda equina
- All others "NON-SPECIFIC LBP"
- Symptoms often do not correlate with identifiable pathology
- CLBP-evidence of central processes having greater contribution to chronicity
- Yellow flags (psychosocial factors, cognitive, catastrophising, invalidation, self-efficacy)

# Guideline Recommendations

(AJGP Vol 47, N0.9, September 2018)

- Exclude alternative diagnoses
- Avoid using routine imaging
- Offer high quality education
- Encourage graded return to normal/usual activities
- Encourage physical exercise/activity
- Advise use of simple analgesia with cautious use of opioid analgesia
- Offer planned reviews in first weeks as appropriate

# Guidelines in Primary Care for LBP

(AJGP Vol 47, N0.9, September 2018)

Important messages to communicate

- Rarely serious pathology
- Positive communication from clinician to patient is important
- Most NSLBP improves after 4-6 weeks and return to normal activity is most beneficial
- Evidence shows no benefit of routine imaging (potentially negative impact)
- Radiological abnormalities are common & often don't correlate with clinical presentation
- Imaging findings including 'age related changes' should be explained to the patient with epidemiological context and with non-threatening language
- Referral to other health professionals may aid in patient education & improved recovery

**Age-specific prevalence estimates of degenerative spine imaging findings in asymptomatic patients<sup>a</sup>**

<b>Imaging Finding</b>	<b>Age (yr)</b>						
	<b>20</b>	<b>30</b>	<b>40</b>	<b>50</b>	<b>60</b>	<b>70</b>	<b>80</b>
Disk degeneration	37%	52%	68%	80%	88%	93%	96%
Disk signal loss	17%	33%	54%	73%	86%	94%	97%
Disk height loss	24%	34%	45%	56%	67%	76%	84%
Disk bulge	30%	40%	50%	60%	69%	77%	84%
Disk protrusion	29%	31%	33%	36%	38%	40%	43%
Annular fissure	19%	20%	22%	23%	25%	27%	29%
Facet degeneration	4%	9%	18%	32%	50%	69%	83%
Spondylolisthesis	3%	5%	8%	14%	23%	35%	50%

<sup>a</sup>Prevalence rates estimated with a generalized linear mixed-effects model for the age-specific prevalence estimate (binomial outcome) clustering on study and adjusting for the midpoint of each reported age interval of the study.

# The use of language

***“The Impact of choosing words carefully: an investigation into imaging reporting strategies & effective reassurance for low back pain”*** Karran, EL; Moseley, GL et al

- current guidelines recommend against ordering imaging other than in specific circumstances
- Imaging is however frequently requested in primary care
- Study looked at 4 varied approaches to imaging reporting & influences on patient perception regarding their back, concerns about recovery & plans to engage in activity
- Also compared the reassuring value of receiving spinal imaging with 'best practice' care: the delivery of best quality information without imaging

## ***Outcome:***

- High quality information without imaging associated with more positive back related perceptions & higher satisfaction
- Often thought that imaging results are reassuring



## What should doctors say?

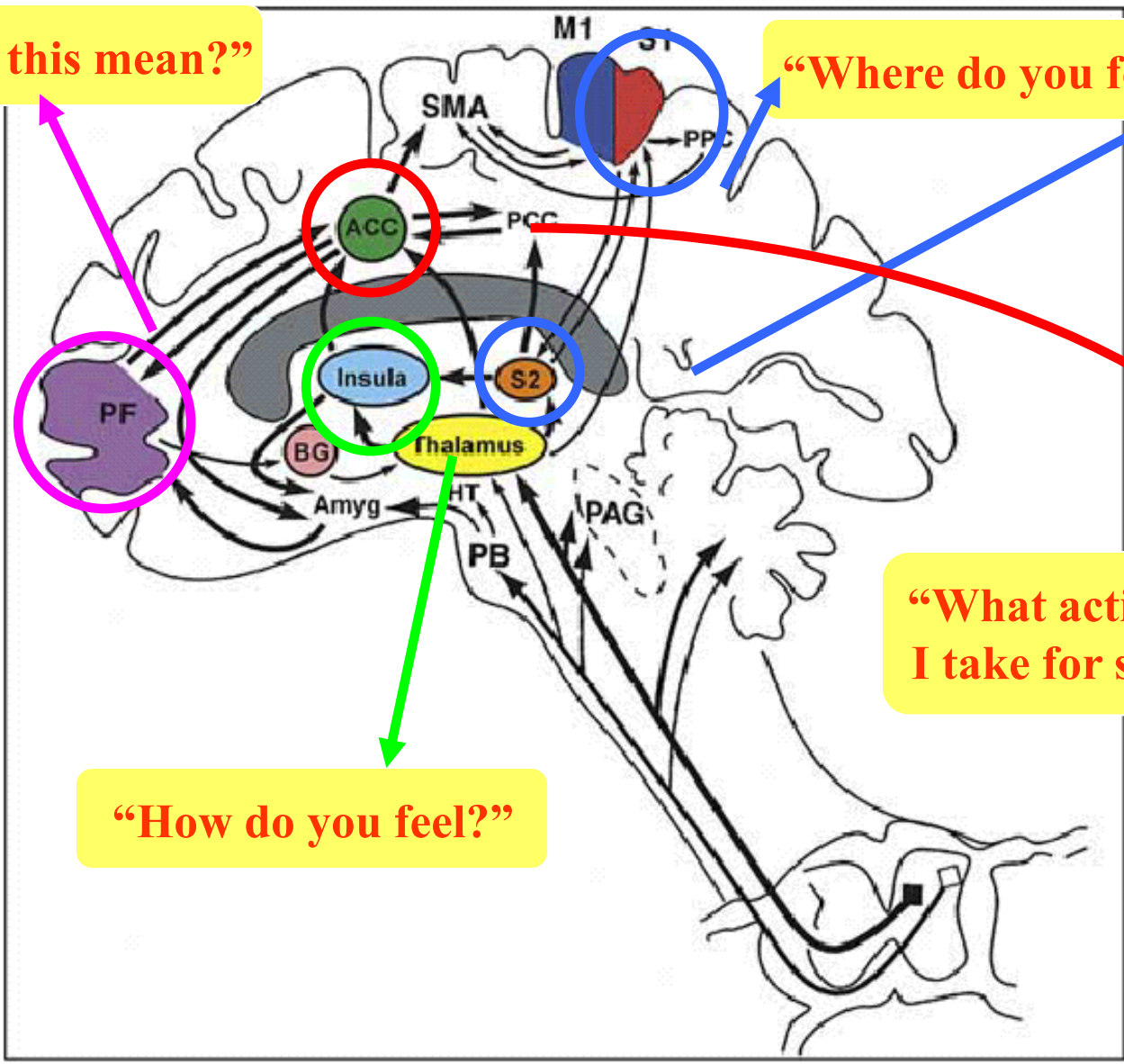
***“The Impact of choosing words carefully: an investigation into imaging reporting strategies & effective reassurance for low back pain”*** Karran, EL; Moseley, GL et al

- Most people experience back pain-it's quite normal & almost always gets better
- Whilst it hurts & you can't do usual activities very unlikely to be sign of serious damage or disease
- back pain improves a lot in the first 2 weeks, but often takes several weeks to completely and can take a couple of months. It is usually possible & highly recommended to gradually increase your activity during this time
- Scans of your back are usually not helpful & don't change treatment plan
- Best thing is to limit things that make pain worse and gradually do more of other things
- Respect your pain but don't be afraid of it - pain protects you in the early stages after injury, but gradually returning to normal activity helps to assist this protective system back to normal



**“What does this mean?”**

**“Where do you feel?”**



**Prefrontal Cortex / Association Area**  
 (Associating experiences necessary for production of ideas, judgment, emotional feeling & personality)

**Somatosensory Cortex (S1 and S2)**

**“What action should I take for survival?”**

**“How do you feel?”**

**Insular Region**  
 response to sensations from body

**Limbic System**  
**Anterior Cingulate Cortex** -  
 Involved in motivational behaviours

*Reproduced from Apkarian A.V., et al 2005*

# Patient “Gary” - Summary

- 48 year old BMI 38
- Truck driver since he was 30
- Landscaping work in the past
- 2 kids, divorced
- Some minor tweaks at work, missing a day or two over the years but now has persistent AND recurrent acute pain episodes
- He has not had any back surgeries but relies on massage, heat packs, creams and oral medications
- He has presented five times to ED in the past year for pain relief
- He presents bent over, walking slowly and holding his lower back
- His employer is not providing him with time off
- He needs analgesia to be able work

# Patient “Gary” - Self reported

- “Constant 5/10 aching across back and shooting pain down my left leg.”
- “Work Cover want me to go back to work but I can’t”
- “Leg gives way and I hate stairs”
- “Sleep is terrible”
- “When it flares I’m bed bound for a week, its 20/10 and nothing works”
- “Like someone jamming a knife in my back”
- “Gets worse in the afternoon”
- “I have to lean on the trolley when I go food shopping”
- “Hardly walk at all anymore and can only drive for 15 minute blocks”
- “My house mate hangs my washing up for me”

# Physical Assessment

- Posture
- Gait
- Transfer
- Weight bearing
- Active range of movement
- Straight leg raise
- Lower limb neurological
- Assessment of Red Flags both via subjective and objective?
- Mismatch between voluntary and involuntary how to interpret this.
- Looking for consistency in presentation across information sources

# Functional Assessment



## At home

- Self-Care (e.g. showering , dressing)
- Housework (e.g. meal prep, vacuuming)
- Gardening and yard work
- Leisure/relaxation
- Sleep
- Relationship with family members (incl intimacy)

## Community participation

- Driving and transport
- Work
- Study
- Volunteering
- Socialising
- Hobbies and leisure activities

## Routine

- Boom bust
- Activity avoidance
- Activity cessation

# Functional Assessment

## Factor Impacting on Function

- Physical
- Sensory
- Cognitive
- Finances
- Medication side effects
- Fatigue
- *Psycho-social*

## Goals

"Do you want to be able to do this?"

"What do you want to do more of?"

"What area of your life do you want to focus on?"



# Psychology Assessment Purpose

- Obtain psychosocial history and functioning to establish:
  - Factors that predispose the patient to their situation.
  - Current factors that are perpetuating their problem.
  - Strengths for the patient to draw upon – ability to adapt in the past.





# Psychological yellow flags



- **Pain modelling**
  - Family maladaptive health behaviours and coping with distress
- **Catastrophizing**
  - Highly distressed with pain
- **Passive coping strategy**
  - Reliance on medication with no change in function
- **External locus of control/Low self-efficacy**
  - “you need to fix this”
  - “there’s nothing I can do”
  - “Nothing helps”
- **Avoidance (behavioural or fear)**
  - Hypervigilance to pain or perceived damage
- **Perceived injustice**
  - “what did I do to deserve this”
  - May present as unrelenting anger towards organisations/people
- **Early childhood trauma (toxic stress)**
- **Ongoing need to prove disability** (e.g. litigation)
- **Family overprotection or conversely invalidation**

# Predisposing/Perpetuating risk factors – Passive Coping

*Accepting or allowing what happens or what others do, without active response*

Passive Coping	Active Coping
Less likely to improve function	More likely to improve function
Associated with worse pain intensity	Associated with less pain intensity
Associated with higher levels of psychological distress and depression	Associated with lower levels of psychological distress and depression

Covic, et al. Rheumatology, 2000;39(9):1027-1030 Snow-Turek, et al. Pain, 1996;64:445-462

# Predisposing/Perpetuating risk factors – Passive Coping

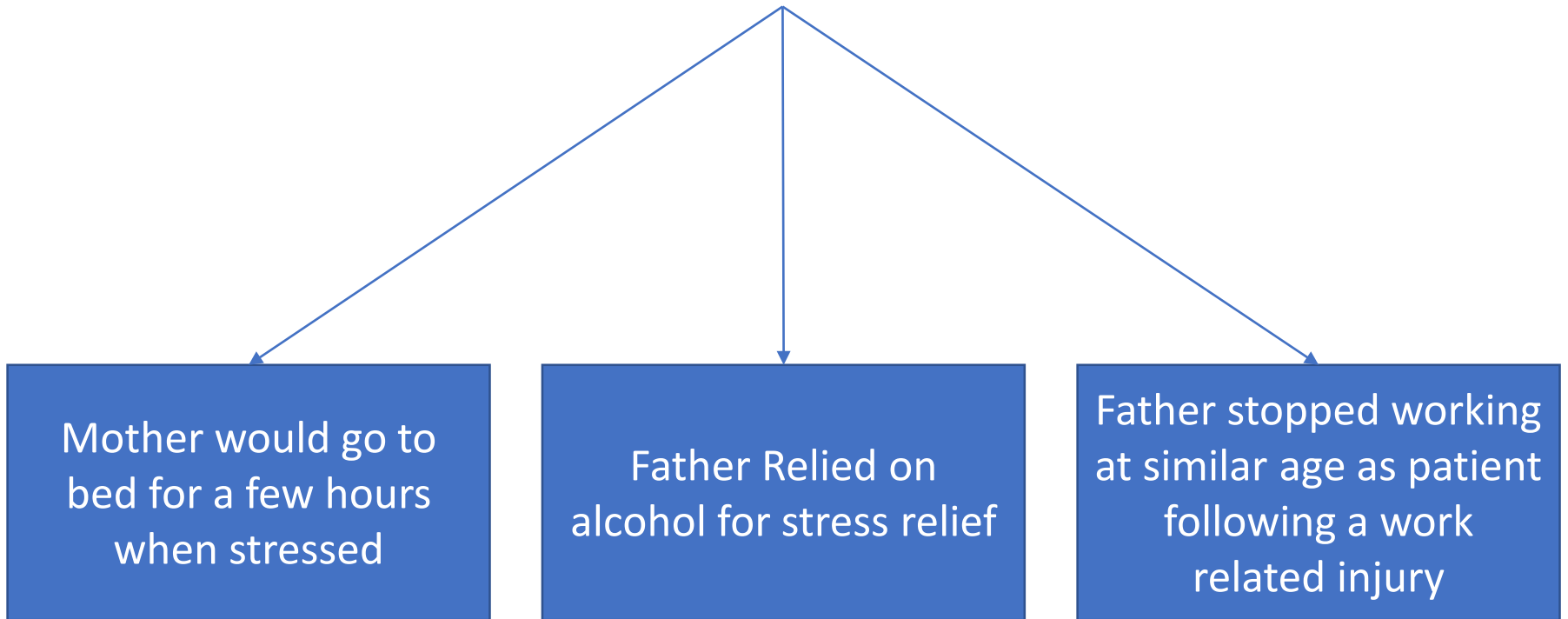
Examples:

- Reliance on others
- medication
- interventions
- substance
- Praying for relief
- Cancelling social activities
- Excessive use of rest

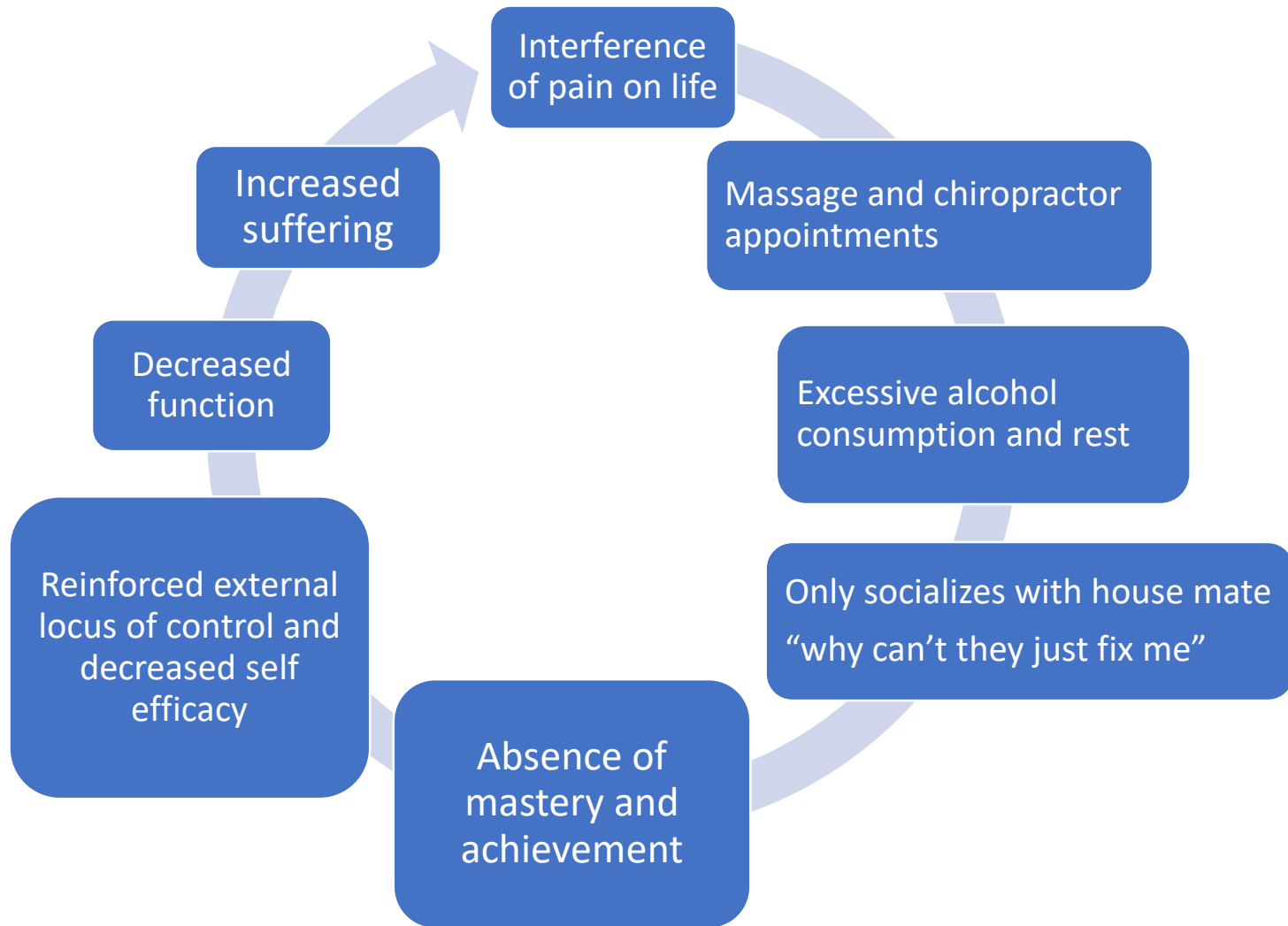


# Predisposing – Passive Coping “Gary”

History that increases the likelihood of someone relying on passive coping



# Perpetuating – Passive Coping “Gary”



# Predisposing/Perpetuating risk factors – Pain Catastrophising

- A set of exaggerated and negative cognitive and emotional schema brought to bear during actual or anticipated painful stimulation.
- Is predictive of poor prognosis in chronic pain management
- Degree of catastrophizing is associated with:
  - Pain Intensity
  - Disability
  - Employment status

# Pain Catastrophising

## Magnification

I wonder whether something serious may happen

I become afraid that the pain will get worse

I keep thinking of other painful events

## Rumination

I anxiously want the pain to go away

I can't seem to get it out of my mind

I keep thinking about how much it hurts

I keep thinking about how badly I want the pain to stop

## Helplessness

I feel I can't go on

I feel I can't stand it anymore

There's nothing I can do to reduce the intensity of the pain

It's terrible and I think it's never going to get any better

I worry all the time whether it will end

It's awful and I feel that I overwhelms me

# Predisposing – Pain Catastrophising “Gary”

History that increases the likelihood of  
pain catastrophizing

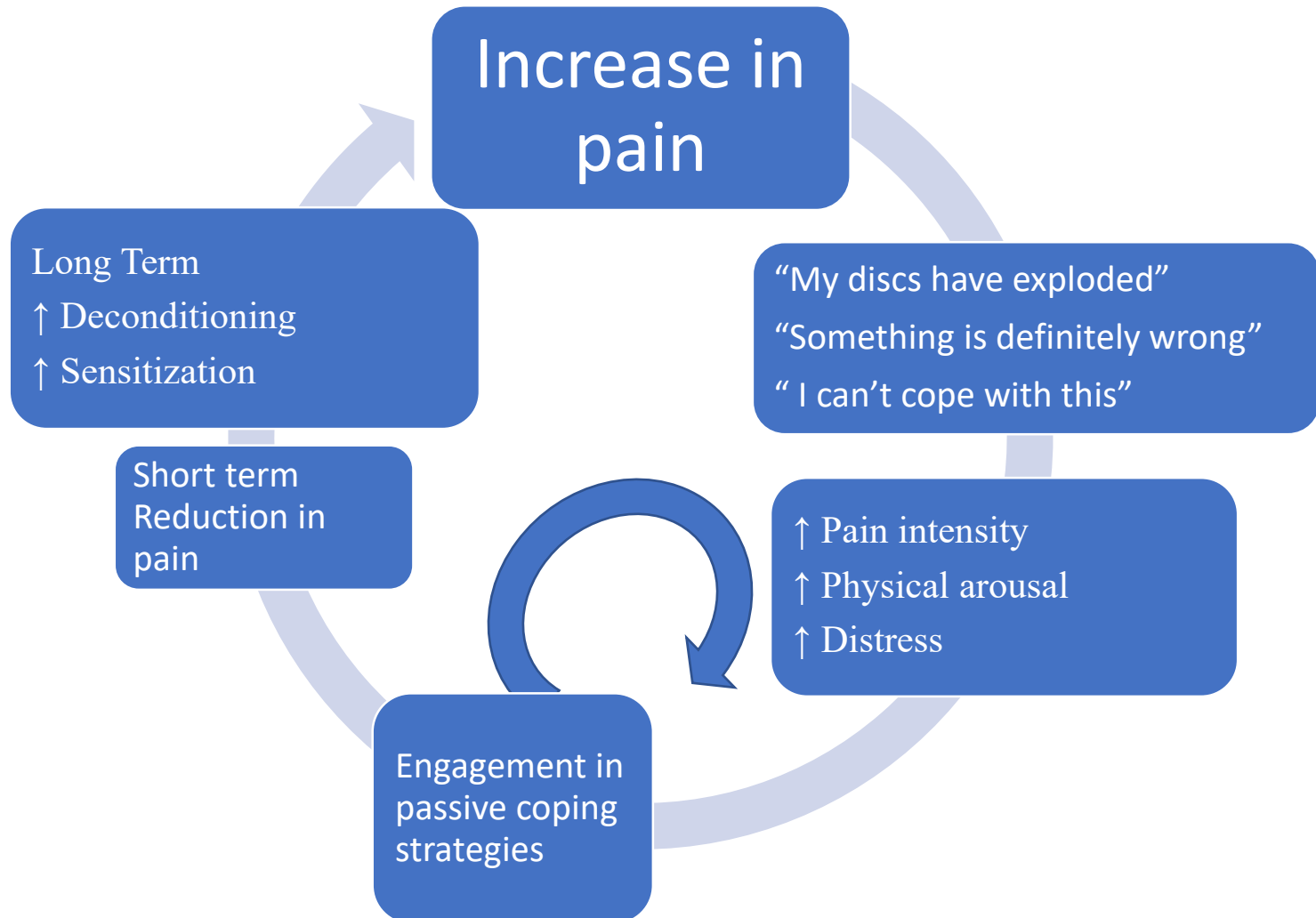
Distressing asthma attacks  
as a child

Doctors and health  
professionals making  
statements like “you will  
end up in a wheel chair”

Needs often ignored by  
parents unless he was  
unwell



# Perpetuating – Pain Catastrophising “Gary”



# Pain Catastrophising and health practitioners

## **Gary told by G.P**

- “You have the back of an 80 year old”
- “The report here says you have degenerative changes in your spine”

## **Gary told by Chiropractor**

- “You could end up in a wheel chair”

## **Gary told by the masseuse**

- “I have never seen a back like this before”

# What do your patients think about their pain?

“ When I look up, the nerves get squashed under the metal plate in my neck!”

“ It’s like walking on eggshells, I could crumble at any time”

“I have degeneration in my spine”

“....I have explained to X that this was a serious injury that she will never fully recover from.”  
(health record information cc. to patient)

“I worried if I do any more damage I could end up in a wheelchair!”

# How would this experience effect you?

- Increased fear of movement?
- Excessive protection?
- Vigilance to sensations in your back?



Is this helpful for recovery?

# Pain Language

Descriptors of test results used without normalising can have a profound impact on the patients interpretation of the severity of injury and thus likelihood of recovery...

- “Fractured, bulging, crushed, broken, slipped disc”
- “Bone on bone, grinding, no cartilage”
- “Pinched nerve”
- “Shattered or crumbling bones”
- “Degenerative disc changes”



# Health literacy

- Giving a medical description to a patient assumes a level of health literacy
- The more room for misunderstanding the greater risk of catastrophising
- Remember Gary reporting his “discs have exploded”
- This speaks to a fundamental lack of understanding

# Excessive Bio-medical focus

- Can form a component of passive coping
- Patient's may attempt to reduce their distress from pain catastrophising with bio-medical investigations and interventions.
- Shifts focus to cure rather than management.





# Treatment is designed to target the perpetuating factors that are identified with the patient

Perpetuating  
Factor

**Pain Catastrophising**

**Passive Coping**

Treatment

- Pain education
- Gradual behavioural exposure
- Cognitive restructuring
- Relaxation training

- Pain education
- Motivational interviewing
- Positive event scheduling
- Skills training



# How do we challenge catastrophising?

## Education

- Providing patient with pain education tailored to their level of understanding.
- Repeating this education and utilising metaphors that make sense to the individual.
- Continually reinforcing this education by relating it to patient examples.
- A single individual or group pain education session can have a significant effect on pain intensity and catastrophising. (Jones, Lookatch, & Moore, 2013; Moseley et al., 2004)

# How do we challenge catastrophising?

## Cognitive restructuring

- Clear pain education forms the basis of cognitive restructuring
- It is achieved via 2 key processes:
  - Direct challenging of the veracity of patient's thoughts
  - Behavioural experiments
  - Shifting from “My discs have exploded” to “I have stirred up my sensitive nervous system”
- Key behavioural experiment of getting the patient moving and exercising with the assistance of physiotherapy.

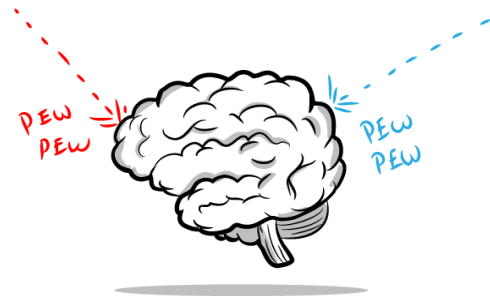
# How do we challenge catastrophising?

## Cognitive restructuring

By being more active and experiencing pain in a safe environment patients develop evidence that challenges their fears.

The more normal patients use their bodies the less catastrophic they will view their “injuries” and sensations.

Direct thought challenging is a stepping stone to behavioural changes which are more powerful.



# Chronic pain itself is a risk factor for the development of mood and anxiety disorders

de Heer, E. W., ten Have, M., van Marwijk, H. W., Dekker, J., de Graaf, R., Beekman, A. T., & van der Feltz-Cornelis, C. M. (2018). Pain as a risk factor for common mental disorders. Results from the Netherlands Mental Health Survey and Incidence Study-2: a longitudinal, population-based study. *Pain, 159*(4), 712-718.

# CASE STUDY

Develop a preliminary assessment and management plan for chronic widespread body (such as fibromyalgia) pain in primary care

- Example role play to be delivered



# Patient “Anita” – Summary

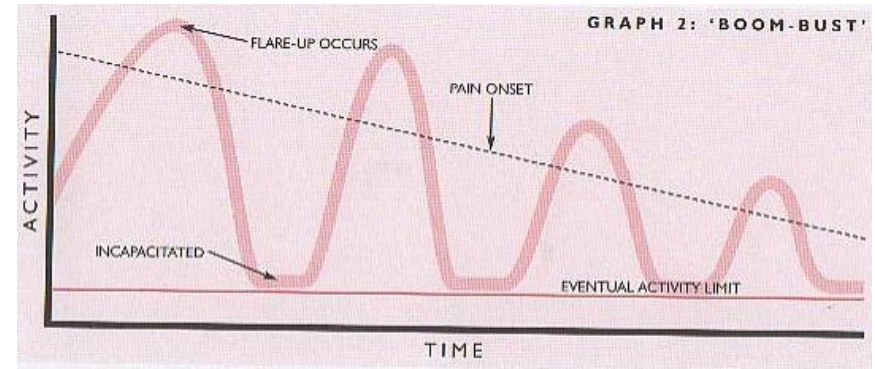
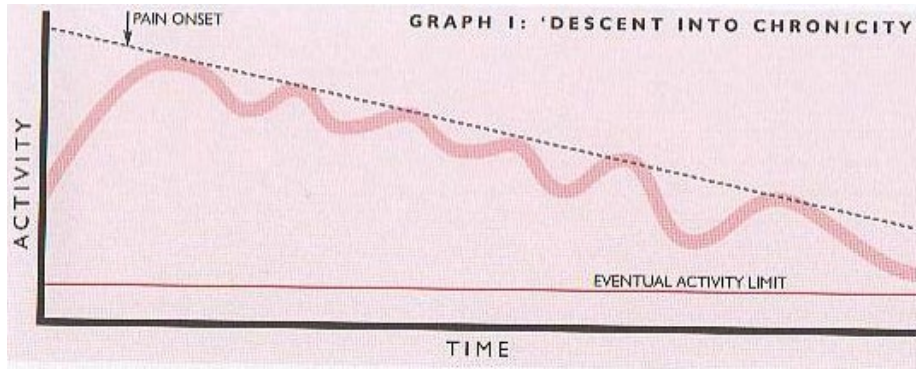
- 37 year old female, one teenage daughter.
- Not currently in a relationship
- Works as a part time administration officer-boom bust approach
- She has presented several times to her GP for fluctuating pain sites since late teens.
- Total body pain



# Where to start

- Does the patient really want to know, care or willing to change?
- What would you want to know as a patient?
- Explain what needs explaining
- Medical Management
- Psychological
- Physiotherapist and Functional Management Plan

# Why do we need to pace?

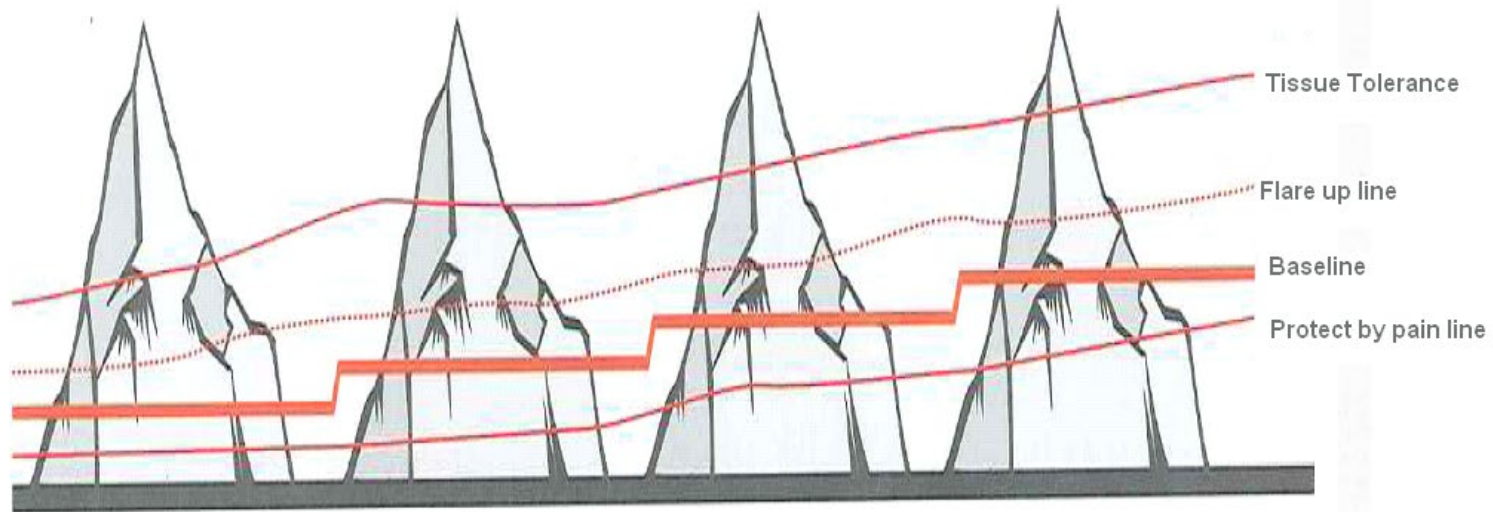


- Activity levels have reduced because pain has become the master
- Need to be aware of the above patterns of activity decline and avoid this happening
- Use of pacing techniques will help to start to turn this around





# Pacing enables graduated activity



PACING & GRADED EXPOSURE



# RECAP

Role of pain

Acute & chronic pain different

Patient role in chronic pain

Clinician role in chronic pain

Assessment of drivers



# Role of pain

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Warning

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Linked to survival

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Designed to be on /off response

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Primary protective response-hardwired

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Influences other output responses

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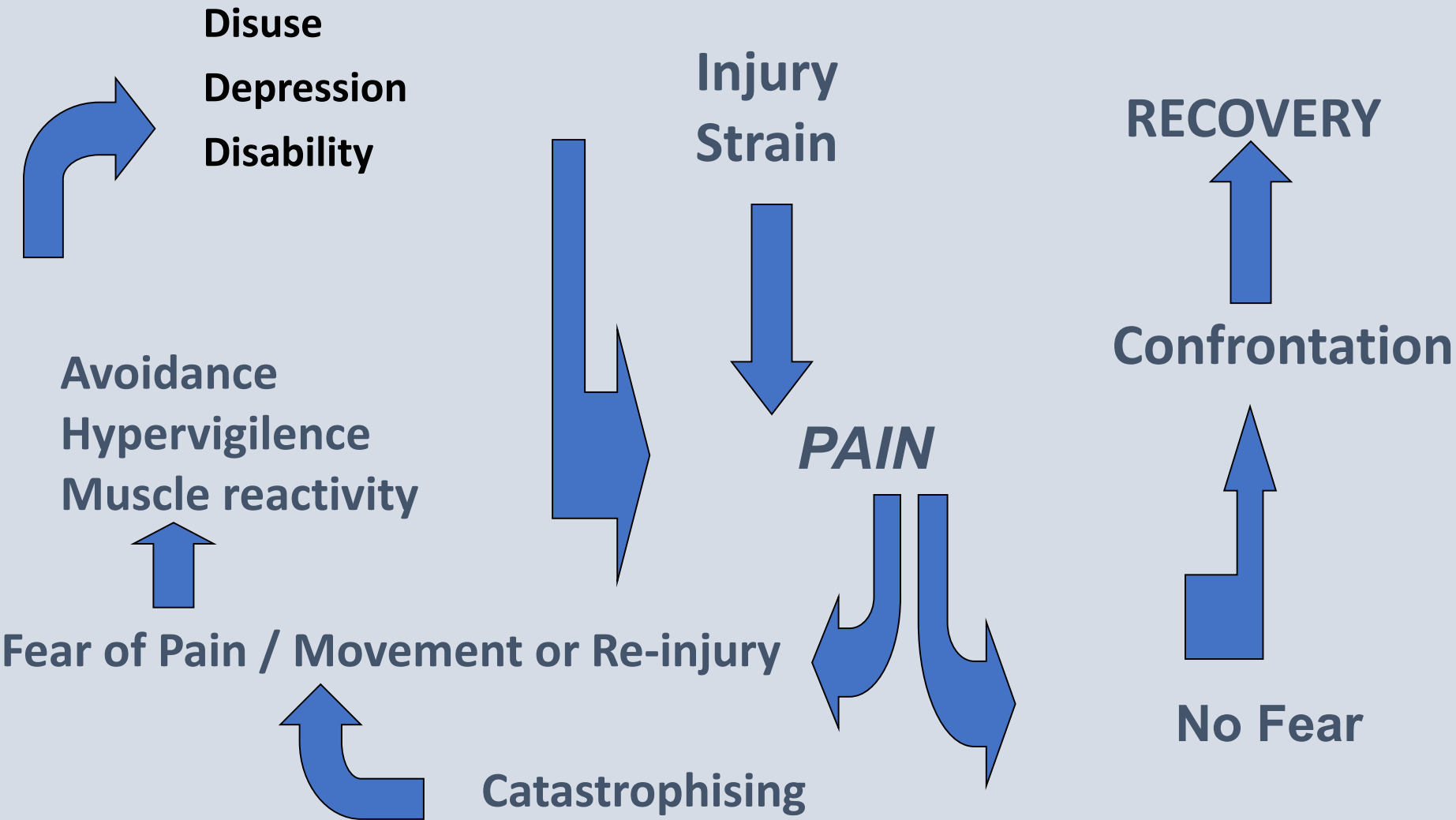
Chronic pain reflects alteration in response which becomes sustained

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Longer term effects.....

# Cognitive Behavioural Model of Pain Related Fear

(Vlayen, Linton 2000)



# Thank you

- PHN for your support of the evening
- GPLO Team for coordinating the event
- Metro North GP's for your valuable expertise and role in the community management of persistent pain