GPLO 2016: Perspectives on managing persistent pain, preparing a patient for a pain management program and supporting them afterwards

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In a follow up to my article on Network Pain in the previous issue of *InTouch*, three clinicians with extensive experience in managing persistent pain provide their perspectives.

Dr Jon Ford, APAM, will discuss how community-based physiotherapists can set realistic expectations and help prepare their clients prior to attending a pain management program (PMP). Jon is a Director of Advance Healthcare in Victoria, previously known as Spinal Management Clinics, which provides multidisciplinary pain management programs across multiple locations around the outer suburbs of Melbourne. Jon is also the Physiotherapy discipline Leader at LaTrobe University in Victoria.

Nick Economos, APAM, will discuss the content of PMPs and how primary health clinicians can be constructively involved after the completion of a program, including how to deal with the flare ups that are a normal but often disheartening part of persistent pain. Nick is a Director of Empower Rehab in Heidelberg, Victoria, and along with Dr Jacqui Stanford, psychologist, he provides 2 day Pain Management workshops to clinicians in order to extend their skills in managing complex and chronic pain conditions. These occur in Sydney, Brisbane and Melbourne twice each year.

Finally, Sara Brentnall, APAM, will discuss the range of PMPs that are available for public health clients. Sara is the Specialist Services Manager, Health Independence Programs, at Austin Health in Victoria.

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Ready for action

Dr Jon Ford explains how to prepare a client for a pain management program.

The aims of a pain management program (PMP) generally include improving coping skills, self-management, activity limitations and work engagement, by addressing specific biomedical, psychosocial and neurophysiological barriers to recovery. This can occur through a variety of interventions over a fixed timeframe program, including, but not limited to:

- client education, with a particular focus on the neurophysiology of pain medication review
- goal setting
- graded activity and exercise ± functional restoration/work hardening
- specific exercise (eg, motor control retraining)
- group and individual psychology
- sleep management
- return-to-work planning.

The first step in preparing a client for a PMP is to decide on suitability for referral. Clients failing to respond to standard medical and allied health management should be considered, particularly if they have:

- high scores on standardised questionnaires for predicting risk of poor outcome (eg, Orebro Musculoskeletal Pain Questionnaire) or the presence of other yellow flags
- no improvement in questionnaires or client reported measuring activity limitations (eg, Oswestry Disability Questionnaire)
- evidence of developing mood disorders associated with their persistent pain (eg, depression, anxiety and stress scale scores)
- failure to improve work hours and/or duties, particularly in compensable clients.

The first step in the pain management process is a comprehensive assessment of barriers to recovery by a multidisciplinary team, usually including a pain physician, physiotherapist and psychologist. Recommendation of the client commencing a PMP is a common outcome; however, multidisciplinary assessment may also recommend further investigation/ specific treatment, ongoing community based management (with specific additional recommendations) or specific work/vocational intervention. Once referral has been made, the period waiting for entry into a PMP is an ideal time for practitioners to provide client specific preparation.

WorkSafe/TAC have published the *Clinical Framework for the Delivery of Health Services* as a guideline for managing compensable clients. In general, treatment adhering to the Clinical Framework principles provides a sound preparation for clients commencing a PM program. Through practitioners ticking off on some or all of these principles described below, the client will be well prepared to make the most of their multidisciplinary program. This then also allows the team to focus on the core components of the program with greater efficiency.

1. Biomedical factors

Within the context of a biopsychosocial approach, practitioners should have identified and addressed relevant specific biomedical components of the client's problem when making a referral. This includes any red flags, as well as pathology that may be responsive to specific treatment. Although the multidisciplinary assessment will identify the need for any specific investigation and/or intervention, the pain management process is more streamlined for the client and stakeholders if this occurs before referral. The practitioner should also attempt to identify and commence treatment on any significant impairment-based abnormalities. If clients have unaddressed specific impairment abnormalities on entry into a PMP, the ability to achieve activity and exercise related goals can be delayed.

A common example of this principle is the client with repeated failed knee surgery and persistent pain. Our team has seen a number of clients with a range of complex barriers to recovery, but a primary problem of functional knee instability due to insufficient inner range quadriceps control. These clients complain of their knee giving way sometimes, associated with falls resulting in secondary pain complaints in other body regions. Despite the presence of significant psychosocial factors and central sensitisation, such clients respond to specific inner range quadriceps retraining

in non-weight bearing progressing to functional positions including gait re-education. However, addressing these specific impairments takes significant time and is best done before multidisciplinary intervention.

2. Passive treatment

Clients referred for a PMP have not responded to medical and allied health treatment which usually includes passive interventions such as manual therapy, massage and electrotherapy. Within a PMP, clients generally cease all passive treatment and learn self management strategies to deal with ongoing symptoms and exacerbations. Practitioners providing passive treatment prior to a PMP should educate the client regarding the limitations of passive treatment and negotiate a weaning program if possible. Although at times challenging, when presented with sufficient information, a weaning program and self management strategies, most clients can cease passive treatment relatively quickly.

3. Goal setting

Establishing 'SMART' (**S**pecific, **M**easurable, **A**ttainable, **R**elevant and **T**imely) goals is a critical component of a PM program which can take considerable time for the practitioner and client to set collaboratively. In preparing a client for a PMP, the practitioner can assist by discussing goal setting in areas such as health (physical and psychological), work, home/leisure/recreation (activity limitations) and relationships. Long-term (6–12 months) goals can be used to then establish medium-term (1–2 months) and short-term (1–2 weeks) goals that provide the client with the opportunity to 'hit some targets' in a manner that provides motivation. Goals should be meaningful to the client (relating to their personal values) and not be 'cure' based (eg, 'to be pain free').

An example of an appropriate long-term goal for a client with moderate to marked activity limitation might be to go on a three day fishing/camping trip with the family. Through exploratory questioning, the practitioner could identify that this goal related to the client's personal value of the family. A number of physical requirements are important to achieving this goal, including sitting/driving capacity, the ability to bend/lift in loading and setting up camping gear, and standing/walking tolerance for fishing from a river bank. Short and medium-term goals around position tolerances and exercise (eg, lifting, squatting, lunges) dosages can be negotiated with the client. By relating exercise to a meaningful goal, clients are more likely to comply and problem solve when barriers to exercise (like post exercise soreness) come up. Short to medium-term goals regarding driving,

camping in the back yard, and day fishing trips with the family could also be useful to motivate the client regarding progress made.

4. Educate regarding the PMP process and set realistic expectations

Many clients attending a PMP assessment have very little understanding of why they have been referred. WorkSafe/TAC have developed a handout titled *Network Pain Management Programs—Information for Injured Workers* which can be of value for compensable clients. Depending on the knowledge and skills of the practitioner, a process of client education can also begin that sets the scene for a PMP. This explanation should assist the client in understanding why they have been referred and include important concepts such as:

- the complexity of persistent pain and potential influence of psychosocial and neurophysiological factors
- further specific investigation and treatment to diagnose and 'cure' the problem (including passive treatment) is unlikely to assist long-term improvement in pain and activity limitation
- the value of a comprehensive assessment and treatment performed by a multidisciplinary team that identifies and addresses all barriers to recovery.

Most importantly, practitioners can strongly influence the client's expectations regarding the possible outcomes of a PMP. Appropriate expectations are improved coping skills, activity limitations, self management skills, medication effectiveness and capacity to work. While reduction of pain commonly occurs during or after a PMP, the client should understand that this is not a primary goal, and that significant improvement in quality of life can occur in the absence of improvement in pain.

5. Communication

General practitioners, informed by their clinical interaction with the client, are in an excellent position to communicate with the team on biomedical, psychosocial and neurophysiological barriers to recovery. Correspondence before the initial assessment will improve the multidisciplinary team's ability to develop a personalised and effective treatment program. Communication with the team ideally will also provide information on specific treatment provided to date, any difficulties in ceasing passive treatment, goals identified and client expectations

regarding the referral. The WorkSafe/TAC providers have a particular emphasis on work, and detailed information regarding barriers to a durable return to work is also of value for compensable cases.

Ongoing reinforcement

Nick Economos discusses how you can maximise your client's recovery following a PMP.

If a person is not managing to participate in meaningful life activities because of a persistent pain condition, a pain management program (PMP) should be considered. PMPs do not aim to cure pain; however, it is reasonable to expect that pain levels are more effectively controlled. Through challenging unhelpful beliefs about pain, and promoting more sustainable behaviour and new skills, the participants' self-efficacy for self-management of their pain is enhanced. Empowering participants to independently manage their pain is the key outcome.

A pain management team may include a psychologist, physiotherapist, occupational therapist and medical specialist. They identify and address the range of inter-related biopsychosocial factors impacting on a client's functioning in order to develop a comprehensive treatment plan with the client. An effective team is able to provide a consistent approach that reinforces the key outcome of the program. They are often provided for a limited period of time, usually up to three months. Functional goals may include a return to suitable work, independence with domestic activities, re-engagement in leisure activities, and a reduction or cessation of some medications.

A physiotherapist's involvement incorporates an active rather than passive approach. A passive approach is when treatment is 'done' to the client and the client is overly reliant on their treater. This not only includes hands on treatment or electrotherapy, but also an excessively supervised exercise program where the client is unable to confidently modify their exercise program. In contrast, an active approach empowers a client to understand their condition, utilises supervised exercise as a 'training ground' to teach the client how to independently upgrade (or temporarily downgrade) their exercise program, and how to implement strategies independently to cope with any setbacks. Physiotherapy sessions may include the provision of education to challenge a client's fear that all pain relates to further injury or harm, a graded increase in exercise and activity, general exercise for global reconditioning and to improve mood levels, goal setting and the

development of a range of self management strategies that the client may confidently implement to prevent flare ups in pain or to manage exacerbations in pain. The physiotherapist needs to adopt a coaching role, assisting the client to problem solve, rather than a traditional treatment plan.

Ideally, a person who has completed a PMP will be able to confidently self-manage their chronic pain condition. However, this often requires a significant reinterpretation of pain beliefs effecting complex behaviour change. It is unlikely to be straightforward or easy, and people with chronic pain may experience regular set backs following completion of a program. Indeed, it may take many episodes for the person to be consistently confident that they can effectively self-manage.

When a client returns to you following completion of a PMP, it will be helpful if you are familiar with the aims and strategies employed in the program. It can be very useful to contact the program to discuss how to assist the person to manage their pain. Obtaining a copy of the discharge report might highlight strategies developed for specific difficulties which may need reinforcing. One of the key strengths of a pain management team is the consistent approach and message provided. It is important that all community healthcare providers continue to reinforce this message.

Your client may have set some new functional goals following completion of a PMP and your role can be to facilitate the achievement of these goals. One goal may be to vacuum the whole house (three rooms) in a day, and the current tolerance may be one room per day. Treatment may include developing a plan to gradually increase the amount of vacuuming completed each day to achieve this goal over a set time frame. Treatment may incorporate the progression of an exercise program based at home or a local gym to assist in the achievement of this goal. This may include lunges and cable exercises with increasing resistance to simulate the motion of pulling the vacuum cleaner forward. Treatment may also include the progression of an aerobic exercise program to harness the pain relieving (endorphin releasing) effects of general exercise. Regular reviews may maximise compliance with an exercise program and allows for problem solving any barriers that impact on the achievement of this goal (eg, thinking ‘I felt good, so I kept going until I finished the whole house’ may have lead to overdoing this activity, a flare up in pain, and a fear of attempting to achieve this goal).

One of your long-term clients, Sue, who you referred to the PMP, has returned to see you after a period of time. She walks into your clinic, obviously in distress, and tells you that her back pain

‘hurts so much’, worse than it has been for a long time. She states that ‘the pain program hasn’t worked’ and is concerned that she has ‘ripped my disc badly’. Sue asks, ‘What can you do?’

This can be a very challenging situation. Sue appears concerned that she may have caused further damage to her back. An important part of a review session would be to determine the likelihood that further injury may account for the significant increase in pain. When asked, Sue denies any falls or other significant events prior to the increase in her pain, other than vacuuming her whole house without resting rather than pacing her vacuuming to one room each day. She denies any referred pain or neurological symptoms. There is no evidence that Sue has experienced a new injury and an important component of treatment is to explain this to her and reassure her that her significant increase in pain appears to be related to overdoing an activity that has flared up her pain rather than an ‘acute’ injury requiring ‘acute’ injury management principles. Your role in providing this reassurance is crucial in reducing Sue’s distress relating to her pain and requires time within a session. Providing this reassurance can encourage Sue to re-engage in her activities (albeit in a graded manner) following an exacerbation of pain.

A discussion about the strategies provided by the PMP and Sue’s preferred flare up strategies will provide options to implement during this flare up in pain. Sue may have a list of strategies including the use of ‘break through’ medication, using relaxation or mindfulness techniques, stretches, use of a massage ball, short walks, heat, pacing down of activities including reducing her sitting and standing limits for a short period, but not avoiding all activities, avoiding prolonged periods lying down, calling a friend or playing music. Active self management strategies are essentially those that are in control of the client. Use of a massage ball is an active strategy, whereas Sue’s husband massaging her back or a physiotherapist provided manual therapy is a passive strategy. A return to ‘passive therapies’ is likely to undermine previous efforts made by the pain management team to empower a client in pain to gain control over their pain. Achieving self management is not easy for most people who experience chronic or persistent pain. The risk with providing passive techniques for pain relief is that it may erode a person’s confidence to self-manage and may lead to a dependency for passive treatment.

Clients may feel like the PMP has not been effective or that they have failed because they have experienced such a significant flare up in pain. However, flare ups are common (and expected) and the ability to cope with a flare up independently is a skill that requires practice. It is important to

reassure your client that the program was not a waste of time and that flare ups are part of the natural course of chronic pain. A pain management program is exactly that—a management program, not cure program.

Finding the right option

Sara Brentnall gives an overview of public health pain management programs.

The availability of pain management programs (PMPs) in public health varies from state to state within Australia, but often the big tertiary hospitals have a pain service, and offer some sort of PMP. These vary greatly in format, length, number of contact hours and commitment required from participants/clients. Some services offer an initial education session on how acute and persistent pain differ, information about the neurobiology of pain, specifics of what their program involves, and what options the client may have in accessing their services. This early education may help the client to understand the required change in paradigm: from a focus on cure and total pain relief to management, and a shift from passive recipient to an active participant.

Most pain services offer some choice, often with the opportunity of group sessions and/or individual therapy. This may or may not include a formal PMP. There are advantages and disadvantages to both group and individual sessions, but a choice often enables your client to tailor their own program to their lifestyle and individual needs. Unfortunately, most programs have a waiting list varying from months to more than a year or more. Some PMPs are only available if all pain medications are ceased prior to commencement, while others are more focused on an outcome of medication reduction as a reflection of the client's decreased reliance on passive strategies. The best way to discover what is available in your local area is to contact individual centres or search their websites.

Many community health centres are also providing education and lifestyle advice that will benefit clients with persistent pain—along the same lines as the self-management and living with chronic disease programs. Depending on the level of disability and distress in your client, these may be useful, and aim to empower participants with the tools to take control of their own management. Some clients may be able to apply this knowledge to their situation and may not require a more intensive program.

How do clinicians help their patients access a PMP?

Most PMPs require a doctor's referral so that the client can access all members of the multidisciplinary team if needed. Early and concise communication will help to enable this. Some centres do not have access to medical staff, and have an allied health only program. The more information that you can provide about the client's history, co-morbidities, treatment to date, and an assessment of their ability to engage in an active program will enable the service to triage your client appropriately.

Early referral to a PMP may be appropriate if you become aware of factors associated with poor prognosis, such as fear avoidance behaviour, catastrophising, low levels of self efficacy and so on. At this point, the sooner your client is referred the better. Some centres give clients who have had pain for less than 12 months priority, as they may require a less intense program. Addressing other factors such as depression or anxiety prior to entering a PMP may also enhance the efficacy of the program.