To study the clinical practice of Allied Health Team Members (Occupational Therapy, Physiotherapy, Psychology) within Multidisciplinary Pain Management Centres, around the world. To use this knowledge to inform and develop current practice in Queensland and Australia.

Auckland New Zealand; Calgary Canada; Maastricht Holland; Bath UK.

April 2009 – July 2009

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Helen Rowe
2008 Churchill Fellow
19 September 2009
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Appendix 1

Conclusions and Recommendations

Information and Dissemination of Information

“The length of this document defends it well against the risk of its being read.”
Winston Churchill.
Introduction and Acknowledgements

As a clinician, the opportunity to travel overseas, observe and learn from experienced and skilled practitioners within Multidisciplinary Pain Centres around the world has been a privileged and humbling experience. Assisting people who suffer from chronic/persistent pain to live meaningful lives despite their pain is inherently complex and often frustrating. There are no simple solutions.

Such individuals’ experience of pain sits within a broader context of complex psychosocial influences. Current research supports a multidisciplinary pain approach as the most effective way of helping chronic pain patients live meaningful lives despite their pain. In the day-to-day clinical practice of working in a multidisciplinary program, there have arisen a myriad of questions I have wanted to ask of other experienced practitioners.

Thus, the opportunity provided to me by the Churchill Fellowship to personally observe clinical practice and actually ask those questions of others who work in centers of excellence around the world, is quite special. I was fortunate in extending my fellowship to include observation of two intensive programs; a three week program in Auckland and a four week program in Bath.

I subsequently offer my sincere thanks to the Winston Churchill Memorial Trust, its staff, the selection panel members and past fellows for enabling this unique opportunity. To my referees Professor Tess Cramond and Professor Jenny Strong, your support has been accepted with honour and sincere thanks.

Thank you to the Tess Cramond Multidisciplinary Pain Centre and to Queensland Health for supporting me in carrying out the Fellowship and being open to my findings.

I wish to acknowledge with grateful thanks the people working in the centres I visited around the world - The Auckland Regional Pain Service, Auckland, New Zealand; Chronic Pain Centre, Calgary Health Region, Calgary, Canada; The Dept of Rehabilitation, University Hospital, Maastricht, Netherlands and the Bath Centre for Pain Services, Royal National Hospital for Rheumatic Diseases, Bath, United Kingdom.

The professional and personal generosity of my international colleagues is entirely valued. Despite busy and demanding schedules, the staff of these centers were welcoming and supportive.

To my international colleagues, thank you for generously sharing your time, knowledge, skills and resources. I was not disappointed in my choices in visiting each and every one of your centres. I hope my learning and the connections I have made with you will enhance practice in the Professor Tess Cramond Multidisciplinary Pain Centre, Brisbane; in Queensland, in Australia and around the world.
Executive Summary

Churchill Fellow Details:
Helen Rowe, B. Occ Thy; Masters Counselling; P.Grad Dip Social Science; P.Grad Cert Clinical Hypnosis. Occupational Therapist and Rehabilitation Counsellor, the Tess Cramond Multidisciplinary Pain Centre, Royal Brisbane and Women's Hospital, Brisbane Australia. Occupational Therapist and Rehabilitation Counsellor in Private Practice, Paddington, Brisbane, Australia.

Address: The Tess Cramond Multidisciplinary Pain Centre, Royal Brisbane and Women's Hospital, Brisbane Australia.
Telephone: 07 3636 6141 Mobile: 0407 694 354 Email: helen_rowe@health.qld.gov.au

Project Description: This fellowship examined the clinical practice of Allied Health Team Members (Occupational Therapy, Physiotherapy, and Psychology) within Multidisciplinary Pain Management Centres, around the world

Centres visited:
- The Auckland Regional Pain Service (TARPS), Auckland, New Zealand.
  20/04/09 - 08/05/09 (3 weeks) Observed a full three week Pain Management Program. Key contacts: Clinical Director/Anaesthetist: Dr Kieran Davis, Occupational Therapist & host of 3 week Program: Diane Henare, Psychiatrist & past Clinical Director: Dr Bob Large.
- Chronic Pain Centre, Calgary Health Region, Calgary, Canada
  08/05/09 -15/05/09 (1 week) Attended multiple interviews with allied health, medical, nursing and management staff. Observed patient consultations, group sessions and staff case meetings. Key contacts: Martha Butler (Occ Therapist & Rehabilitation Lead), Karen Bannister, Administrative Coordinator, Marg Sorge, Chronic Pain Centre Manager, Sara Pereira, Director, Calgary Pain Program.
- The Dept of Rehabilitation, University Hospital, Maastricht, Netherlands.
  23/05/09 - 29/05/09 (1 week) Observed exposure in vivo therapy. Key contacts: Professor of Behavioural Medicine, Universities Leuven, Belgium & Maastricht: Johan WS Vlaeyen, Occ Therapist/Psychologist Marties Den Hollander, Behavioural Psychologist: Jeroen De Jong & Occ Therapist Christopher Loo.
- Bath Centre for Pain Services, Royal National Hospital for Rheumatic Diseases, Bath, United Kingdom. 1/06/09 - 26/06/09 (4 weeks) observed a 4 week intensive program. Key contacts: Beatrice Hannah, Senior Occ Therapist & Coordinator Visitor Program, Dr Lance McCracken, Clinical Director

Conclusions:
The fellowship supported the importance of:
- Attention to a whole of care model at national/state level.
- Multidisciplinary Pain Centres take on expert consultative and educational roles
- Development of an Interdisciplinary team model rather than a Multidisciplinary model.
- Programming considerations to include balancing of the need to meet unmet needs in the community
- A clear therapeutic framework (e.g. CCBT) applied to programs, applied consistently across all disciplines and woven through all interventions.
- Use of behavioural approaches focusing on improvement in functional activities despite pain and including importantly, active individualised physical conditioning.
- Intense programming to allow for behavioural change.
- An emphasis on patient commitment to full participation at commencement and throughout programs.
- Resources given to training for expert skill development of team members.
- A focus on careful selection of outcome measures
- Resources to support data collection and data management
- Research that informs and is informed by clinical application of expert and specialised approaches to management of chronic pain.
- The value of innovation

Information and Dissemination of Information:
Multiple presentations and workshops within the Tess Cramond Multidisciplinary Pain Centre, Royal Brisbane and Women's Hospital, Brisbane Australia as part of current review to facilitate change within the context of current state level planning.

Presentations and written contributions to Qld Health. Keynote speech Occupational Therapy Conference, Qld.

Input to Australian Pain Society, currently contributing to The National Pain Summit which is developing a National Pain Strategy aimed at making more effective, cost-effective and accessible healthcare solutions available to all Australians.

Facilitate opportunities for allied health collaboration and skill development in the area. E.g. Training and exploration of an active allied health collaboration across Australian Multidisciplinary Pain Centres.
My original Churchill Fellowship was proposed to run over seven weeks. It was extended to eleven weeks, with the generosity of 2 Pain Centres and fortunate timing allowing me to attend two complete intensive programs (3 weeks in Auckland and 4 weeks in Bath).

- **The Auckland Regional Pain Service (TARPS)**
  Building 7, Greenlane Clinical Centre, Greenlane West Auckland, New Zealand.
  20/04/09 - 08/05/09 (3 weeks)

  Clinical Director/Anaesthetist: Dr Kieran Davis
  Occupational Therapist and host of 3 week Program: Diane Henare

- **Chronic Pain Centre (CPC), Calgary, Canada**
  Chronic Pain Centre, Calgary Pain Program, Alberta Health Services,  #160, 2210 – 2nd Street SW Calgary, Alberta Canada T2S 3C3
  08/05/09 - 15/05/09 (1 week)

  Administrative Coordinator: Karen Bannister
  Director, Calgary Pain Program: Sara Pereira
  Chronic Pain Centre Manager: Marg Sorge
  Occupational Therapist & Rehabilitation Lead: Martha Butler

- **The Dept of Rehabilitation, University Hospital, Maastricht, Netherlands**
  23/05/09 - 29/05/09 (1 week)

  Professor of Behavioural Medicine, Universities Leuven, Belgium & Maastricht: Johan WS Vlaeyen
  Occ Therapist/Psychologist: Marlies Den Hollander
  Behavioural Psychologist: Jeroen De Jong
  Rehabilitation Specialist: Dr Joop Ruygrok
  Occupational Therapist: Christopher Loo
  Rehabilitation Specialist: Dr Jeanine Verbunt

- **Bath Centre for Pain Services, Royal National Hospital for Rheumatic Diseases, Bath, United Kingdom.**
  01/06/09 - 26/06/09 (4 weeks)

  Senior Occupational Therapist & Coordinator Visitor Program: Beatrice Hannah
  Senior Occupational Therapist & Directorate lead: Suzy Williams
  Senior Clinical Psychologist: Dr Jeremy Gauntlett-Gilbert
  Senior Physiotherapist: Sarah Wilson
  Clinical Psychologist: Nicola Chaloner
  Clinical Director: Dr Lance McCracken
  Nurse: Karen Draper
1. Introduction:

The International Association for the Study of Pain (IASP, 1986) defines pain as "An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage".

Pain does not just involve sensation in the physical body, it is always unpleasant and therefore also an emotional experience. As such, an individual’s cognitions (thoughts, beliefs, and memories), emotional responses and behaviors within the context of their environment are all contributors to the experience of persistent pain. There are no objective measures of pain given its subjective nature.

Chronic pain is pain that persists well beyond healing time (usually > 3 months) and while acute pain serves a protective purpose and is time limited, chronic pain has no biological purpose and no clear end-point or “cure”. There is sometimes an identifiable cause (e.g. spinal cord or nerve injury), but often there is no obvious reason why pain should persist. Some people suffer chronic pain without any past injury or evidence of body damage.

Chronic pain thus involves the individual experiencing persistent physical sensations of pain and persistent unpleasant and emotional experience, with potentially no end-point and frequently no clear explanation for its persistence; a situation with the potential to affect every aspect of that individual’s life, their family and the community in which they live.

The human impact is in fact considerable, with chronic pain affecting all life domains including health (physical -- deconditioning, lack of exercise; psychological -- depression, anxiety, adjustment problems; sleep disturbance), personal independence, family and friends, work (paid/non-paid work activity), learning and education, spirituality, involvement in community activity and recreation.

There is characteristically high and ongoing use of the health system across medical (medication, injection therapies, neurostimulation etc), allied health (physiotherapy, counselling) and even alternative therapies (naturopathy, massage therapy etc).

The cost of chronic pain to the individual, the family, community and Australia is high.

In November 2007, Access Economics produced a publication "The high price of pain: the economic impact of persistent pain in Australia". The report was commissioned by the MBF Foundation in collaboration with the University of Sydney Pain Management Research Institute.
The report estimated that 3.2 million Australians suffering from chronic pain in 2007 would increase to 5 million by 2050. The total cost of chronic pain in 2007 was estimated to be $34.3 billion, almost $11,000 per person with chronic pain; with productivity costs (impacting on work performance and employment) and burden of disease (cost of loss of well-being) being the largest components (both 34%), followed by health system costs (20%).

The bulk of this cost is borne at an individual and family level. Employers, government, non-government organisations, workers compensation groups, friends and family, co-workers, charities, community groups and other members of society also bear cost.

Treatment over the last 30 years has shifted from pure medical interventions to a biopsychosocial model. Because biological, psychological and environmental factors contribute to chronic pain, treatment needs to address as many facets of a person's life as possible, in the context of the community that they live in.

The Access Economics report asserted "the coordinated multidisciplinary approach is not only the most effective way of helping patients to manage their chronic pain, but it can also be the most cost-effective for more disabled chronic pain patients" (1).

The report notes that there is wide variability in pain clinics and that in terms of research, there is an absence of randomised controlled trials on treatments and combinations of treatments for every type of chronic pain.

The Access Economics Report (P.76) reviewed the evidence and stated multidisciplinary programs typically included Medical Practitioners, Nurses, Clinical Psychologists, Physiotherapists and Occupational Therapists working as a coordinated team and that core principles included Cognitive Behavioural Therapy (CBT), a structured exercise program (usually strength, fitness, stretch exercises), medication rationalisation and withdrawal.

The effectiveness of treatment was dependent on staff training/experience and selection of patients for the right program with patients with high disability, mood disturbance and medication dependence best for an intensive program (100 - 120 hours run over 3 to 4 weeks) with preadmission preparation and follow-up sessions. Patients with only moderate disability were said to have done as well in less intensive programs (30 - 70 hours over 4 to 6 weeks).

The report (Page 76) listed CBT treatment components including goal setting, structured plans for working towards achieving specific goals, activity pacing, problem solving, thought management and relaxation/meditation.

A recent Cochrane review of Psychological Therapies for the Management of Chronic Pain (excluding headache) in Adults (Eccleston, C. et al; 2009) aimed to evaluate the effectiveness of psychological therapies on pain disability and mood. It noted that while CBT was considered an effective treatment for chronic pain in adults, the diversity of
treatment content, quality length and assessment procedures meant they were unable to conclude which specific features of therapy were critical for outcome.

Whilst the research suggests Multidisciplinary approaches using a CBT approach are the most effective and most cost-effective means to assist those who suffer from persistent pain (Access Economics 2007), what constitutes an effective multidisciplinary program is often unclear, especially at the level of operationalisation. Research is not currently at the point where it can clearly identify exactly what to include and how to operationalise multidisciplinary programs. It is yet to definitively inform us which theoretical frameworks, treatment modalities and which specific interventions work best with which patients within which demographics.

Subsequently, as a clinician working within a multidisciplinary framework, there remain a myriad of questions about the delivery of multidisciplinary pain programs and as such there are a myriad of choices to be made in running such programs. While it is clear that further research is needed to guide the practitioner on how to develop and deliver appropriate Allied health multidisciplinary programs, in the meantime, clinicians must make choices based on the available evidence, the support of the organisations they work in, the funding guidelines they operate under and fully utilising the resources they have.

Such choices surround:
- Theoretical frameworks, modalities and interventions.
- Application of theoretical frameworks, modalities and interventions (the “how-to”).
- Quantity and timing of interventions.
- Delivery and teaching/learning styles of interventions.
- Teamwork.
- Management of patients from beginning to close of programming (external & internal referral processes, triage, waiting lists, often high rates of DNAs).
- Follow-up of patients.
- The use of assessment and outcome measures.
- The practicalities of assessment (who assesses and when).
- The importance of data collection and auditing of programs.
- Staffing -- the value of experienced and suitably trained staff, staff training.
- Practical delivery issues such as space, equipment, resources, patient transport problems, patient accommodation.

Working as an Occupational Therapist and Rehabilitation Counsellor within the largest tertiary multidisciplinary pain centre in Queensland, Australia (Professor Tess Cramond Multidisciplinary Pain Centre) and currently the largest educator of health professionals in Queensland; such questions and choices prompted my seeking out the opportunities offered by this current Churchill Fellowship. This Churchill Fellowship and offered me the opportunity to look at how leading centres around the world addressed such questions.

References

2. The Auckland Regional Pain Service (TARPS) 20/04/09 - 08/05/09 (3 weeks)

2.1 Fellowship Participation:

- Observed a complete 3 week Pain Management Program.
- Met with medical, nursing and allied health staff individually.
- Observed patient assessments (including joint medical & psychosocial assessment) and interviews, staff meetings & case conferences.
- TARPS generously provided written material, assessment protocols and patient handouts.

Key contacts during Fellowship:
Clinical Director/Anaesthetist: Dr Kieran Davis
Occupational Therapist & host of 3 week Program: Diane Henare
Psychiatrist & past Clinical Director: Dr Bob Large

Clinical Nurse Specialist: Kate McCallum
Physiotherapists: Lisa Ford, Murray Hames, Jamie Exton
Clinical & Health Psychologists: Peter Waddell, Lynette Dalgleish, and Debbie Bean
Specialist Anaesthetist: Dr Brigitte Gertoberens
Psychiatrist: Dr Tipu Aamir
Rheumatologist: Dr Michael Butler
2.2 About TARPS:

TARPS is a hospital based multidisciplinary tertiary service providing outpatient services in acute and chronic pain management to the Auckland region and to the counties Mankau to the south and Waitemata to the north of Auckland.

While TARPS was officially established in 1990, its history stretches back to 1972 when medical interventions such as nerve blocks were performed in Auckland Hospital as part of a pain management clinic. Over time a number of other specialists (Musculoskeletal Physician, Orthopaedic Surgeon, Rheumatologist and Psychiatrist) joined the team influenced by a growing international interest in nonpharmaceutical approaches to management of pain, and a growing recognition of the complex nature of chronic pain.

The team had access to allied health staff including Occupational Therapy, Social Work and Psychology and Nurses in general psychiatry, and commenced running groups in 1980. The service was running as a semiautonomous service with no dedicated staff and with access to hospital beds for several years.

Doctor Bob Large recalled vigorous debate between doctors regarding procedures, medical management and psychosocial management through the 1980s. In the late 1980s, when health systems became more scrutinised and there were significant political changes in the Health Department, the service almost closed down.

The group of medical and allied health practitioners made a case for an independent freestanding pain service and TARPS was created in 1990 with Doctor Bob Large as its clinical director and an allied health staff including an Occupational Therapist, Social Worker, Psychologist and Physiotherapist.

TARPS moved into its current premises in 1996 with Doctor Bob Large holding the clinical directorship over many years and shaping an inclusive team who have incorporated processes and strategies researched overseas as well as their own innovations into their own programs.

TARPS have developed clear criteria for referral, admission, discharge and processes in the management of patients with chronic pain, including follow up.

TARPS team approach is often more consistent with an interdisciplinary approach rather than multidisciplinary approach and in fact, this feature was seen by allied health staff members as a critical factor in their satisfaction as workers within the service.

An example of interdisciplinary teamwork includes the development of a dual assessment process, where a medical physician and psychosocial allied health team member assess patients together. Group programs involve all disciplines including medical specialists, nursing and allied health. Another example involves two team members of different
disciplines performing application interviews together prior to patients’ acceptance into group programming (Activity Focus Program or 3 Week Program).

Leadership style is collegial with minimal hierarchical structure and decision-making involving all members of the team.

Team members were observed as respectful and collaborative when working with patients.

2.3 Theoretical framework:

A client centered biopsychosocial model is well established with a predominant Cognitive Behavioural Therapy psychological focus. Behavioural Psychological concepts of fear avoidance, graded activity and exposure based interventions are integrated into the program across all allied health areas. An occupational performance perspective is applied to patient functioning.

There is some initial interest in the newer Contextual Cognitive Behavioural Therapy approach, with an interest in the use of mindfulness as a treatment strategy.

2.4 TARPS Procedures & Treatments:

TARPS provide the following procedures and treatments:

- Comprehensive pain assessment, including:
  - Individual assessment.
  - Joint assessment.
  - The triple assessment (physical assessment / review, psychosocial assessment / review and physical capacity evaluation).

- Medication management including:
  - Short/medium term analgesic maintenance.
  - Adjuvant medication trial.
  - Adjuvant medication maintenance.
  - Opioid trial in chronic pain of non-malignant origin.
  - Opioid maintenance of non-malignant origin.

- Medical interventions including:
  - Nerve blocks.
  - Joint Injections.
  - Medication infusions.
  - Externalised and implanted intrathecal pumps and spinal-cord stimulators. Patients are initially required to try other strategies before implantation.

- Individual or group pain management interventions including the following:
  - Management of psychiatric conditions.
  - Mood management.
  - Relaxation training.
- Cognitive coping skills training.
- Hypnosis for pain control.
- Psychotherapy -- individual/couples/family
- Assessment of Motor and Process Skills (AMPS) - Occupational Therapy
- Outpatient Physiotherapy.
- Applications Interview for pain management program
- Comprehensive 3 week Pain Management Program (approximately 9 per year. (See 2.12)
- Activity Focus Program. Approx 100 patients per year. (See 2.11).

2.5 Funding:

TARPS receives its funding relatively equally through the ACC (Accident and the Compensation Corporation) and the ADHB (Auckland District Health Board).

The ACC is a unique body providing comprehensive no-fault personal injury cover for all New Zealand residents and visitors to New Zealand. This system covers New Zealanders and visitors for all accidents including those occurring at work, whilst traveling and at home. It removes the interference of litigation in the rehabilitation process; there is a well documented association between litigation and poor pain outcomes. (Access Economics Report 1997).

TARPS holds contracts with ACC for assessment and treatment including the following:

- Progressive Goal Attainment Program (PGAP)
- Comprehensive Pain Assessments
- Functional Restoration Program (exercise based only)
- Activity Focus Program
- Multidisciplinary Pain Management Program + 3 follow up sessions (1, 6 & 12 months)
- Pain Management Psychological Services
- Pain Management Psychiatry Services
- Interventional Pain Management Services
- Four day individual programming involving 4 - 5 clinicians

Each of the contracts has different reporting and billing requirements, and considerable ongoing negotiation with ACC is a time-consuming factor, with a lack of consistency of case managers complicating negotiations. The system can be restrictive with regards to creativity of programming.

There is a significant difference between funded services through ACC & ADHB; for example, ACC can cover the costs of transport, hotel costs for programs etc. ADHB patients were funded at approximately 1/3 of the level of ACC patients.
Allied health are key negotiators with ACC in the development of programs and in ongoing communication regarding patients’ progress.

2.6 Assessments and Outcome Measures:

Copies of the New Patient Pre-assessment Pain Questionnaire and the Review Questionnaire were obtained. The review questionnaire is completed at 6 months and 12 months post group program. These are essentially the same questionnaire and include questions regarding:

- Referral source.
- Previous medical history and treatment.
- Employment/work/voluntary work/education.
- Pain diagram and visual analogue scale.
- Pain Disability Index.
- HADS.
- Tampa Scale for Kinesiophobia.
- Pain Self Efficacy Questionnaire.
- Medication information.

There is currently discussion regarding outcome measures’ capacity to accurately capture the clinical changes seen, with a perception that raw scores may not reflect the real changes.

It was noted that at 6 month follow-up patients scores deteriorated with the most significant positive changes being observed at the 12 month follow-up period.

The last significant review of outcome measures was performed in 1990. Results at 12months follow-up:

- 60 to 70% of patients compared to 25% of a control group not participating in the program achieved:
  - A slight decrease in pain
  - Marked increase in activity
  - Improved self efficacy
  - Slight decrease in medication use.

- The team performs regular audits in specific areas; for example audits from the data base in the areas such as return to work, changes in depression scores etc.

Copies of outcome measures were also obtained in discipline specific areas.

The current Physiotherapy Physical Capacity Evaluation assessment format includes the results of:
• A measure of function using Oswestry
• Pain Self Efficacy
• Tampa Scale for Kinesiophobia
• Pain Rating Scale and Pain Drawing
• Task performance in a 50 m speed walk, stand – supine- stand, a dynamic lift task.
• Strength/endurance in trunk extension, sit-ups, push-ups, grip strength
• Cardio respiratory tests
• Flexibility tasks including sit and reach, lumbar flexion/extension, cervical flexion/extension.
• Activity hierarchy evaluation using a New Zealand version of Phoda. Patients are asked to place each of 44 photographs along a thermometer line according to their response to the question “How concerned are you about doing this activity?” TARPS have been using Phoda for 7 years.
• Video assessment of the patient - walk, forward flexion, extension, rotation head to (L) & ®, lateral flexion head to (L) & ®, sit, stand, squat and raise arms above head.

• Psychosocial interviews are carried out by Psychologist and Occupational Therapists.

Examples of **Psychosocial interview** questions may include:

• Impact of chronic pain on function, work, finances, marriage and/relationship and social areas
• Coping skills and treatments
• Mood (e.g. irritable/low, enjoyment, signs of depression, suicidal ideation)
• Anxiety (worry, muscle tension, muscle pain, evidence of panic disorder)
• Health issues including sleep, fatigue, appetite, weight etc
• Cognitive issues such as memory and concentration
• Substance abuse
• Perceptions of pain (e.g. cause of pain, timeline, hurt versus harm)
• Background (family, childhood, school, work, marriage, children)
• Expectations of program/treatment

• **Occupational therapy specific** assessments include AMPS (Assessment of Motor Process Skills).

2.7 TARPS Processes:

2.7.1 Current Waiting Times:
• All referrals from ACC are managed within 3 weeks.
• All referrals from ADHB have to be seen within 6 months, once triaged.
• TARPS has sometimes managed waiting times by running evening clinics.

2.7.2 Referral:

- **Referral sources** include ACC and referral from general practitioners (funded through ADHB).
- **Demographics:** Currently no socio-economic statistics are kept, however the service sees patients from the very poor to the very wealthy.
- **Referral inclusions** include significant pain as the presenting problem or pain interfering with personal functioning and pain not responsive to primary and secondary level care.
- **Referral exclusions** include acute psychiatric disorder where immediate psychiatric intervention is required to control behaviour or to prevent suicidal homicide, and primary substance abuse disorder, unless the patient is in an established substance-abuse treatment program.
- Patients are requested to make all referrals in consultation with their general practitioner. There is an expectation that patients will have had a medical workup at the primary care level.

2.7.3 Admission criteria:

- **Urgent admission criteria** include severe pain where immediate intervention has a high probability of good outcome including pain due to malignant disease, severe post herpetic neuralgia/trigeminal neuralgia and peripheral vascular disease threat of loss of limb.
- **Semi-urgent admission criteria** include pain were early pain clinic intervention is indicated, early post-operative pain or pain where there are medical or psychosocial indications for early interventions. For example trigeminal neuralgia, CRPS syndrome, scar entrapment of nerves and post-traumatic/surgical joint pain.
- **Routine admission criteria** involve those suffering from chronic pain (pain persisted for 3 months) and including such conditions as long term musculoskeletal (neck/back) pain and +/- psychological distresses, headache, fibromyalgia syndrome, post-operative wound pain, abdominal pain, pelvic pain, atypical chest pain, CRPS, facial pain and neuropathic pain.
2.7.4 Process through centre:

- Referral is received and triaged (currently medical staff only are involved in the triage process); questionnaires sent out to patients and when completed a second triage process occurs.

- Appointment for assessment is made. This could be a single appointment, dual or triple assessment, dependent upon projected patient treatment. Assessments and subsequent treatment follows.

- Assessments are discussed at the multidisciplinary team at lunchtime meeting following each Monday and Tuesday clinic.

2.7.5 Discharge criteria require:

- The patient must have had a full clinical physical examination.
- The patient should have had a thorough discussion regarding the possible diagnosis.
- The patient could be satisfied that relevant investigations in relation to possible disease have been performed.
- Each patient should have had adequate control of appropriate therapies available within the pain clinic both pharmacological and other techniques (e.g. epidural, facet joint infections for low back pain or neck pain, Lumbar sympathectomy in peripheral vascular disease)
- Difficult cases refractory to treatment have had the option of cross referral within the clinic for additional advice.
- Where necessary, appropriate cases may be placed in a waiting list where techniques under investigation (e.g. spinal cord stimulation techniques).
- The issue of coping with pain should be discussed with each patient and referral made within the Pain Clinic for assessment were appropriate and the possible involvement in the Outpatient Pain Management Program.
- The option must be given to the patient and the GP preview on discharge from me Pain Clinic.
- Appropriate written reports have been forwarded.

2.7.6 DNA poliPcy patients are telephoned 1 week before appointments. If patients DNA without a telephone call they are directed back to the referrer and require a new referral.

2.8 Meetings:

- Monday Pain Management Program (PMP) group review 8.15am.
  Lunchtime Post clinic review meeting 12.15 – 1.00pm
- Tuesday Weekly team meeting including CME 8.00am – 9.00am
Monthly business meeting
Lunchtime Post clinic review meeting 12.15 – 1.00pm

- **Wednesday** Pain Management Program (PMP) group review 8.15am.
  Team meeting 2.00pm
- **Thursday** Pain Management Program (PMP) group review 8.15am.
- **Friday** Pain Management Program (PMP) group review 8.15am.
  Monthly team supervision.

### 2.9 Staffing:

#### Management, ADHB

- Gary Smith Chief Executive Officer
- Fionnagh Dougan General Manager
- Robyn Dunningham
- Christine Joy Team Leader
- Kieran Davies Clinical Director

#### Pain Management Program (PMP)

- **Anaesthetists**
  - Doctor Trevor Coe (0.5)
  - Doctor Kieran Davies (Clinical Director)
  - Doctor Brigitte Gertoberens (1.0)
  - Doctor Ted Hughes (0.5)
  - Doctor Martin Seay (0.01)
  - Doctor Jane Thomas (0.2)

- **Spinal-Cord Stimulator Team**
  - Doctor Alan Merry
  - Elaine Davies RN

- **Rheumatologist**
  - Doctor Michael Butler (0.5)

- **ORL**
  - Doctor Jim Bartley Otolaryngologist (0.2)

- **Psychiatrists**
  - Doctor Bob Large (0.6)
  - Doctor Tipu Aamir (0.8)

- **Physiotherapists**
  - Murray Hames
  - Jamie Exton
  - Lisa Ford
  - Conny Egli

- **Psychosocial Team**
  - Peter Waddell Clinical Psychologist (1.0)
  - Lynette Dalgleish Health Psychologist (0.5)
  - Debbie Bean Health Psychologist (1.0)
  - Julian Reeves (0.1)
  - Kate McCallum Clinical Nurse Specialist (1.0)
  - Diane Henare Occupational Therapist (1.0)
  - Health Psychology Intern (12 month placement)
  - Occupational Therapy Intern (6 month placement)

- **Support staff**
  - Arnie Van de Geer Clinic Scheduler (1.0)
  - Bhanu Exton ACC Referral Coordinator
  - Yvonne Middleton team support (0.5)
  - Dawn Petter DHB Referrals (0.4) & PMP coordinator (0.6)
  - Transcriptionists (1.4)

### 2.9.1 Staff training/Supervision

- **TARPS** provides training for Pain fellows (x1 at time of fellowship), registrars in Rheumatology, 1 x 12 month placement for Health Psychology intern and 6 month placement for Occupational Therapy intern. An information manual is provided to registrars, students, interns & all new staff to assist in the orientation process.
- **CME** weekly.
Education includes attendance at conferences and courses.
Staff receive monthly **group supervision** from a medical doctor, trained in psychotherapy.
There is a culture independent **supervision**.
While the Clinical Director is supportive of allied health training, a major barrier has been lack of funds. There is no built-in allowance for allied health staff. TARPS has recently organised a budget for allied health training.

### 2.10 Research:

- There is currently no dedicated time/allied health staffing component for research and most research involves audits from the database of outcome measures.

### 2.11 The 12 week Activity Focus Program

- Approximately 100 patients complete an Activity Focus Program per year.
- Aimed at increasing patient activity in fitness and re-engagement in a more normal activity despite persistent pain. Baselines function and valued goals are set.
- Program team includes physiotherapists, psychologist, psychiatrist, occupational therapist, clinical nurse specialist and anaesthetist.
- On commencement patient is seen by two members of the team to discuss the program, expectations and goals.
- Patient attends individual physiotherapy sessions and individual psychosocial sessions if required.
- Patient attends 3 group sessions on pain management education (Wednesday 1.00-3.30 pm). Topics include understanding chronic pain, lifestyle and personal development skills, goal setting, relapse management and guidance on returning to work.
- Self regulation skills are taught including relaxation, stress management, pacing and medication.

### 2.12 The 3 week Pain Management Program

- Approximately 90 patients complete a three-week program every year over 9 programs.
- A group program includes 10 - 11 people.
- Patients are accommodated locally (motels within walking distance) and attend the program on an outpatient basis 5 days per week over a 3-week period.
- Prior to acceptance on to a program, patients are interviewed (application interviews) by 2 allied health team members. The purpose of this interview is to inform patients of program goals, contents, clarify expectations (patient and TARPS) and assess readiness to participate. Telephone interviews can be organised.
- Patients additionally participate in a pre-program assessment, to which they can bring a family member or close friend.
The pain management program consists of 3 main parts:

- **Education.** Topics from a variety of speakers on understanding chronic pain, lifestyle and personal development skills, goal setting, relapse management, guidance on returning to work and the sharing of information on how family and other relationships are affected by pain. Speakers include all members of the team including allied health and medical team.

- **Relaxation.** The opportunity to learn more about the "Relaxation Response" as well as try a number of relaxation techniques to use in a variety of settings.

- **Activation.** A graduated program designed to improve general fitness and increased levels of activity. Individual baselines are set and patients work towards agreed individual goals.

  Patients participate in an exercise circuit daily, calculated using individual baselines and agreed goals.

  Baselines and tolerances are obtained using a calculation of recording a gym activity (repetitions, time, distance etc), averaging the activity; subtract 20% - 50%.

  Patient works toward goals progressively, aiming at an increase of 1-2 per day and working at ½ pace on bad days. Goals are preset.

  Patients participate in Individual Activation Program daily. This is an exercise program which is highly individualised to patient goals for functioning & uses the quota system to gain progression.

  Family & friends attend the last day. Education sessions repeated.

  Patients & staff participate in a celebration at the end of program. Patients prepare an inspiration and challenge (anything from a poem to a speech to drama to a musical act) which they perform in front of the group, family and staff.

  Group follow-ups are held at 1, 6 and 12 months.

  The **aim of the program** is to assist patients become more expert in understanding and coping with their pain.

  Patients are expected to enroll with the aim of helping themselves and it is made clear that they will need to be active participants and potentially challenge current approaches to activity in rest as well as their understanding about pain.

  Attendance expectations are clearly articulated.
### Programme Timetable (3 week Pain Management Program): Week 1

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<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
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<tbody>
<tr>
<td>8.15</td>
<td>Overview PMP Questionnaires</td>
<td>Review***</td>
<td>Review***</td>
<td>Weekend Planning</td>
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<tr>
<td>8.30</td>
<td>Introductions</td>
<td>Exercise circuit</td>
<td>Pain diagnosis</td>
<td>Exercise circuit</td>
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<tr>
<td></td>
<td>Dr Bob Large Psychiatrist</td>
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<td>Dr Butler Rheumatologist</td>
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<tr>
<td>9.30</td>
<td>Introduction to the gym</td>
<td>Introduction to Relaxation</td>
<td>Free time and Feedback with team/Medication review</td>
<td>Art session</td>
<td>Pain, loss and grief.</td>
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<td>Speed Walk</td>
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<td>Video assessment</td>
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<td>11.00</td>
<td>Benefits of Exercise</td>
<td>Relaxation continued</td>
<td>Exercise circuit</td>
<td>Ways of Thinking</td>
<td>Relaxation</td>
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<td>Peter Waddell Clinical Psychologist</td>
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<td>1.00</td>
<td>Adjustment to Pain</td>
<td>Intro to Activity Planning</td>
<td>Pain pathways Neuro-Physiology</td>
<td>Hurt not Harm</td>
<td>Overview of medication use</td>
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<td>Doctor Brigitte Gertoberens</td>
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<td>Intro to stress management</td>
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</table>

**Coursework Checklist**
- **Sessions attended by all/most of team & all of team participated in group activities involved in these Activation during weeks.**

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Helen Rowe 2008 Churchill Fellowship Report
Week 2

<table>
<thead>
<tr>
<th>Time</th>
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<tr>
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<td>Weekend review</td>
<td>Review ***</td>
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<td>Weekend planning</td>
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<td>Self Hypnosis</td>
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<td>Dr Bob Large Psychiatrist</td>
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<td>9.30</td>
<td>Mind/Body Connection</td>
<td>Creating a Productive Life</td>
<td>Free time and Feedback with team/Medication review</td>
<td>Anger Management</td>
<td>Relaxation</td>
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<td>Mood Management</td>
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<td>2.00</td>
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Coursework Checklist
Goal set & achieved by ……..
Planning for Inspiration & Challenge ……..
Activation During weekend ……
Relaxation during weekend ……..
### Week 3

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<td>Planning for Productivity</td>
<td>Free time and Feedback with</td>
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<td>Pacing</td>
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<td>Exercise circuit</td>
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<td>Family Issues</td>
<td>Radiology Session</td>
<td>Activity Planning</td>
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<td>Individual Activation Programme</td>
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</table>

Coursework Checklist
Setback plan & discharge summary for (date) ......
Planning for Inspiration & Challenge .......
Relaxation practice at home .......
2.12.2 Practical issues in delivery:

Space. The centre is located in a hospital, has a dedicated group room and some small treatment rooms. It has no dedicated consult rooms and uses rooms within the hospital.

Resources. The centre has access to the physiotherapy gym.

Patient transport. Auckland has a dedicated bus service traveling from the centre of Auckland to all 3 hospitals, linked buses. There is a problem with transfer to the centre if patients do not have a car.

2.12.3 Teaching/Presentation Style:

Presentations were quite varied, reflecting the individual style of the presenters, some using liberal doses of humour and drama; others referring to examples and stories to highlight their points. From an observer role, it appeared group members appreciated the variety. All presentations were respectful of the group and its members.

There was a mix of didactic lectures, power point presentations, structured exercises and activities; interactive activities, experiential exercises, small group exercises, role play and art session (collage and crayon).

Some presentations included handouts. There was no manual provided. A library of books was available throughout the program.

Most sessions were very interactive, presenters actively engaging the group members in the process often through questions directed at the group as a whole and to individual group members. Observed skilful facilitation of group dynamics by presenters.

The presentations by Dr Bob Large and Dr Mike Butler in particular, were excellent, both drawing on an incredible wealth of experience and knowledge in their engagement of the group. Recording these lectures was suggested.

2.13. Points of Significance/Highlights:

Key concepts emphasised to patients include:

- Self management
- Hurt ≠ Harm
- Applying the principles is what works
- Acceptance is important to moving forward

2.13.2 Allied Health Perception of Positives about TARPS

- Working in a well functioning interdisciplinary team with good relationships between team members.
- Leadership style is collegial and inclusive.
  A strong belief in the teams purpose and value in the work of TARPS - a determination and commitment of the team to ‘survive at all costs’
2.13.3. Allied Health Perception re Frustrations in working at TARPS

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>o</td>
<td>Frustrations with funding bodies, with 2 sources of funding create 2 tiers of service delivery ACC.</td>
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<tr>
<td>o</td>
<td>There are frustrations with both funding bodies in terms of their policies in relation to clinical practice.</td>
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<tr>
<td>o</td>
<td>A lack of public awareness regards to chronic pain.</td>
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<tr>
<td>o</td>
<td>A lack of primary health care awareness of chronic pain</td>
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</table>

2.13.4. Opportunity to participate in and observe TARPS confirmed the value of:

- A high functioning, committed and mutually inclusive team of experienced and knowledgeable practitioners, operating within a positive and respectful culture.

- **Strong collegial leadership** has shaped TARPS, its team and culture.

- **An interdisciplinary team approach.** Team is interdisciplinary with minimal hierarchical structure and decision-making involving all members of the team. Individual team members have opportunities to contribute at most levels. There is opportunity for creativity and utilisation of the personal and professional skills of team members. The current team functioning is highly valued by Allied health staff.

- **Respectful culture** is reflected in the well functioning team, satisfied staff and a client centered program. Team members were observed as respectful and collaborative when working with patients.

- **Consistent and constant refinement of service.** Current service delivery, treatments and programs reflect years of constantly refining processes, criteria, service options, programming content and presentation style based on international research and their own innovation. Ideally, increased resources to record and review outcome measures would further support service development.

- **Team consistency in emphasising key concepts** *(See 15.1)*

- Observations confirmed the value of **intense programming** *(3weeks, 5 days per week)* for patients with complex chronic pain. Group members were observed to show improvements in physical functioning, understanding of chronic pain and capacity to articulate and demonstrate improved coping skills over the 3-week period. Observations are supported by outcome measures.

- **Involvement of all team members** *(medical and allied health)* in 3-week program presentations, as presenters and participants in group activities including day 1 and the family day/inspiration and challenge. Team members attended morning reviews and participated in activities alongside patients.
New medical, allied health staff, pain fellows and students (Health Psychology and Occupational Therapy Interns) are encouraged to participate fully in the Pain Management Program, attending as many sessions as possible to gain a broad picture of the service.

- Observations confirmed the **value of intensive individualised physical conditioning programming**, especially where psychological principles were utilised to produce behavioural change. Use of video to record patient pre and post movement patterns was observed to be a particularly powerful convincer of the value of moving for group members.

- **Strong focus on goal setting and behavioural change** throughout the program.

- **Attention to group process and dynamics** facilitated respectful culture and behavioural change.

- Gaining **patient commitment to participation** in program. TARPS clearly articulates expectations and requirement for commitment to full participation prior to the program and throughout the program. (see 3.12)

- The **value of long term follow-up** post program is reflected in poorer outcome measures at 6 months improving at 12 months. It also opens questions regarding type quality and frequency of follow-up.

- The negative impact of litigation on rehabilitation is reduced due to New Zealand's Accident Compensation Corporation (ACC).

- A different session that was quite powerful in reinforcing the message of hurt ≠ harm was the Radiology Session. Patient x-rays and scans (CT, MRI Bone etc) are reviewed in a group setting. Explained results and normalised the presence of degenerative changes common to the general population.

- Hypnosis is explained and demystified. Group members experience hypnosis and are offered the opportunity for one-on-one work should they find it useful.
3. Chronic Pain Centre, Alberta Health Services, Calgary, Canada
08/05/09 – 15/05/09 (1 week)

3.1. About AHRCPC:

The Alberta Health Region Chronic Pain Centre (AHRCPC) is the largest interprofessional chronic pain centre in Canada employing > 60 diverse staff and servicing approximately 900 new clients per year (30,000 visits per year). It is part of a comprehensive approach to pain management - The Regional Pain Program (RPP), Alberta Health Services was established in 2004 and the first Regional Pain Program in Canada. RPP employs > 90 staff and had an operating budget of $5.2 million in 07/08. RPP consists of 3 distinct services – AHRCPC, CHAMP & Hospital Pain Services. (see diagram below). The centre provides a wide range of care related to pain management through 3 clinical streams. All the programs involve interdisciplinary/Interprofessional teams:

- 4 teams in Daily Headache.
- 3 teams in Chronic Pelvic Pain.
- 14 teams in Neuromusculoskeletal (NMSK).

Care is individually driven, potentially including individual treatment and/or multiple group programs; the sequence of which is individual and driven by client goals. Care is managed by interdisciplinary teams. Length of stay is on average 13 months, with a variance of 3 days/week to once every 3 months.

Key principles include client self management, a focus on restoration of function and Activities of Daily Living and reduced client use of health care resources.
3.2 Fellowship Participation:

My program at AHRCPC was expertly organised by Karen Bannister, Administrative Coordinator.

**Observed:**
- Pelvic Pain Rounds (case meeting)
- Smart Moves Group session
- Self Management Group session
- Mastering Activity group session
- Explaining Pain Group session
- Dr John Jarrell (Obstetrician & Gynecologist) consultations with patients with pelvic pain.

**Met with allied health staff individually:**
- Martha Butler (Occ Therapist & Rehabilitation Lead)
- Jennifer Bush (Social Worker)
- Arlene Cox (Psychology Lead)
- Angie Cox (Occ Therapist)
- Donna Balmain (Physiotherapist)
- Jennifer Williams (Kinesiologist)
- Tracy Ritchie (Pelvic Pain Physiotherapist)

**Met with Medical & Nursing Staff individually:**
- Suzanne Basiuk (Nurse Clinician)
- Diane McNamara (Musculoskeletal team Clinical Coordinator)
- Mariola Glistak (Pelvic Pain Program Clinical Coordinator)

**Met with Management staff individually:**
- Sara Pereira (Director, Calgary Pain Program)
- Marg Sorge Chronic Pain Centre Manager

**Key contacts during Fellowship:**
- Karen Bannister, Administrative Coordinator.
- Martha Butler, Occupational Therapist & Rehabilitation Lead)
- Marg Sorge, Chronic Pain Centre Manager
- Sara Pereira, Director, Calgary Pain Program
- Donna Balmain (Physiotherapist)
- Arlene Cox (Psychology Lead)
- Angie Cox (Occ Therapist)
- Jennifer Williams (Kinesiologist)
- Tracy Ritchie (Pelvic Pain Physiotherapist)
- Suzanne Basiuk (Nurse Clinician)
- Diane McNamara (Musculoskeletal team Clinical Coordinator)
- Mariola Glistak (Pelvic Pain Program Clinical Coordinator)
- Jennifer Bush, Social Worker
- Deborah Nicholson, transcriptionist and author play on chronic pain

AHRCPC generously provided PowerPoint presentations, written material, assessment protocols copies evaluation forms, patient handouts and patient forms.
AHRCPC commenced as a pilot project in 2000, joining with the Rockyview Pain Clinic in 2003, to become The Alberta Health Services Chronic Pain Centre. It is recognized as “Leading Practice” in Canada. An internal review in 2006 & an external review by Dr Paul Watson in 2007 saw significant changes in the AHRCPC. The internal review involved 30 hours of individual and group interviews with a 37 members of staff. The interviews followed a weekend workshop attended by most of the rehabilitation staff. Observations of several groups occurred.

Significant changes included:

- **Its vision, mission, and values were clarified.**
- **Changes to triage and assessment processes.** (May 2008)
  - Triage to identify less complex cases.
  - Protocols clarified.
- **Development of clear care pathways.**
  - Clients are expected to attend orientation session, explain pain educational session and goals session prior to individual assessments by care providers.
  - Patient flow reconstructed so that patients do not always see a physician first.
- **Change in emphasis to self management approach to care.** (May 2008)
  - Restoration of function a key outcome.
  - Client willingness to engage in a self management strategy is a prerequisite.
- **Shift to Interprofessional team model,** with collaborative efforts towards the programs common goals.
- **Group programs reviewed,** modified; new programs developed.
- **Emphasis on improving services in the community,** through joint ventures with primary care networks (e.g. including a dedicated telephone consult service).
- **Collaboration with the Chronic Disease Management Program to provide educational programs in the community through Living Well.**
- **Collaboration and partnering with Addiction Services.**
- **Strengthened links with the Inpatient Chronic Pain Service.**
- **Coordination with Acute Pain Services.**

### 3.3 The Context

#### 3.3.1 Funding

AHRCPC is publicly funded within a fixed budget and reimbursement for care is not on a fee for service basis. The health system is publicly administered and funded (health care funding comes from one-third of the entire provincial budget). The Alberta Health Care Insurance Plan gives Alberta residents full coverage. Albertans do not pay for medically necessary procedures or physician fees.

As noted above, **The Chronic Pain Centre (AHRCPC) operates within a comprehensive Regional Pain Program** throughout the Alberta Health, Canada; with allied health staff contributing across all chronic pain services. The Alberta Health Region provides Inpatient and Outpatient Pain Management services including Adult and Paediatric Services in Acute and Chronic Pain.
3.3.2 The Context - AHRCPC sits within a Region wide suite of Pain Management Services

As of April 1, 2009, the Calgary Health Region and 11 other provincial health authorities have joined together to form Alberta Health Services (AHS).
Regional Pain Program

3.3.3 RPP

Outpatient based self management program for difficult to treat migraines and other headache.

CHAMP

Calgary Headache Assessment & Management Program

Dr. John Clark, Medical Director
Marg Sorge, Manager

Centre visited.

Helen Rowe

2008 Churchill Fellowship Report

33

Community based
Living Well
Courses.

CPC

Lecture Series.

Website resources

Hos

pital Pain Services

Medical director
Neurologists
Admin Support
Manager
Nurse Coordinator
Research Nurse

Kinesiologist
Psychologist
Staff nurse
Occupational Therapist
Neurologists
Admin Support
Manager
Nurse Coordinator
Research Nurse

Footnote:

571 consults in 2008
571 consults in 2007

Acute Pain Service

Consultative services for hospital patients with complex acute pain.

Education for health-care providers and patients on pain management.

Follows post surgical patients.

Chronic Pain Consultation Service

Offered at all 3 adult hospitals and are available Monday to Friday.

Team consists of Nurse Practitioner, admin support, nurse clinicians, and Chronic Pain Physician with access to Addiction Psychologist and Pharmacist.

424 consults in 2007

Chronic Pain Services

Offered at all 3 adult hospitals and are available 24/7.

Team includes clinical nurse specialist, admin support, nurse clinicians, and Chronic Pain Physician and Nurse Practitioner.

Primary Care Network

Long Term Care

Admin Support
Data Coordination/Evaluation

Dr. John Clark, Medical Director
Marg Sorge, Manager

Admin Support

Psychologists

Pharmacists

Social worker

Dietician

Nursing attendants

Transcriptionists

Physical therapists

Kinesiologists

Occupational therapists

Registered nurses

Physicians

Anaesthesia, General Practice, Psychiatry, Physiatry, Neurology

Obstetrician/Gynaecologist

Admin Support

Psychologists

Pharmacists

Social worker

Dietician

Nursing attendants

Transcriptionists

Physical therapists

Kinesiologists

Occupational therapists

Registered nurses

Physicians

Anaesthesia, General Practice, Psychiatry, Physiatry, Neurology

Obstetrician/Gynaecologist

Community based
Living Well
Courses.

CPC

Lecture Series.

Website resources
3.3.4 **The Regional Pain Program** includes Paediatric Services in 2 service areas:

- **Outpatient Paediatric Complex Pain Services - Children and Adolescents**
  Outpatient Interprofessional services, including medical management (nerve blocks, implantable devices), physiotherapy, acupuncture, individual and group therapy, family therapy, patient education in support, referral to adult chronic pain clinic.

- **Paediatric Acute Pain Inpatient Services** offered at Alberta Children's Hospital 24/7. Services follow children with complex acute pain problems and children who have undergone operations requiring specialised pain management post operatively. Team consists of Clinical Nurse Specialists, Nurse Practitioners and Anesthetists.

3.3.5 **AHRCPC accesses and contributes to community based courses and lectures:**

3.3.5.1 **Living Well Courses**

AHRCPC partners with Chronic Disease Management (CDM) who provides community-based accessible education classes, exercise classes and self management classes supporting those living chronic conditions including chronic pain.

AHRCPC (allied health) runs the Living Well Chronic Pain Program:

- Pain Self Management classes (free) - 7 run in 2008
- Explaining Pain education classes (free) - 2 run in 2008
- SMART Moves education classes (free) - this is a new class replacing a low registration class.

Run in 4 locations in Calgary by AHRCPC allied health staff.

Other Living Well Classes provided by CDM that are accessed by chronic pain patients:

- Supervised exercise classes ($80 a day subsidy available)
- Row Your Own Boat (chronic disease the management class: free)
- Lifestyle education classes (three)
- Food and mood (free)
- Coping with a chronic illness (free)

CDM Classes are held throughout the city and in rural areas in locations such as fitness facilities, community centres etc. Programs are offered during mornings, afternoons and evenings and weekends and are presented by a variety of Allied Health and Nursing staff.

3.3.5.2 **A comprehensive website** providing:

- **Access to Chronic Pain Lecture series.**
- Information on the Regional Pain Program's Acute and Chronic pain management programs.
- Referral forms.
• Information and tools for patients and families, the public and health care providers
• Links to other resources including:
  o Addiction services, mental health and addiction, Access Mental Health,
  o Anxiety Disorder Resource Centre.
  o [www.painexplained.ca](http://www.painexplained.ca), a vehicle for a cooperative campaign to raise awareness regarding prevention and management of all types of pain in Canada. It is sponsored by the Canadian Pain Society, Quebec Pain Association and the Chronic Pain Association of Canada.

3. 3.5.3 Chronic Pain Lectures

Available on [www.calgaryhealthregion.ca/programs/rpp/outpatient.chronicpain.htm](http://www.calgaryhealthregion.ca/programs/rpp/outpatient.chronicpain.htm)

**Chronic Pain Lecture Series:**

• Offers information about the nature of pain and the ways that the body’s systems are affected by pain.
• Provides basic information, so that other components of the Centre’s program may be better understood and incorporated into everyday life.
• Consists of ten lectures available in [PDF](#) which are repeated on an ongoing basis.
• Lectures are open to the public including family members and significant others.
• No referral is necessary, but clients must call the Chronic Pain Centre at least two days before the lecture to reserve a seat for the lecture.

The lecture series includes:

• Introduction to Pain
• Medications
• The Role of Exercise in Managing Pain
• Nutrition
• Pacing in Pain Management
• Attention and Memory
• Sleep
• Navigating the Healthcare System and Medical Investigations
• Anxiety, Depression and Chronic Pain.

Some of the lecture series are available in video format (10 minutes each) on-line
Including - Introduction to Pain (X6) & Medications (X 5).

3.4 The Interdisciplinary team.

A key feature is collaborative decision-making amongst all team members, with client goals as the focus. The team is not necessarily medically led. Treatments are not delivered by one professional at a time but are integrated and joint sessions feature regularly so that combined skills of different professions complement each other.
All professions have similar core skills including communication skills and the recognition and management of non-medical obstacles to rehabilitation.

Team members include medical and nursing staff as follows:
- Physicians assist the patient to understand their medical condition and medication options and may offer a limited variety of interventions. Physicians include Physiatrists (physical medicine + rehabilitation), neurologists, obstetrician/gynaecologists, palliative care specialists, anaesthetists.
- Psychiatrists work with clients with mental health issues requiring medication.
- Nurses organise client programs, provide support and advice and may manage medication changes.
- Pharmacist provides information about medications and side-effects and works with the medical staff to develop medication plans.

Team members include Allied health staff as follows:
- Occupational therapists (2) measures ability, activity goals and skills and assist in a return to productive life activity.
- Physical Therapists (7) assess movement patterns and help develop treatment plans.
- Psychologists (5) assess understanding of pain, impact on life and assist clients to develop skills to reduce the effect of pain on thoughts, feelings and actions.
- Social Worker (1) assists clients to reduce barriers to participation in the program (e.g. finances or transportation) and facilitates client access of community resources.
- Kinesiologists (4) provide exercise programs for clients.
- Dietician deals with nutrition, food sensitivities or digestion issues related to pain or medication.

3.5 The AHRCPC Care Pathway

3.5.1 Referral. Referral form (available on web site) must be completed by Family Physician.

3.5.2 Patients forwarded Pre-assessment Form → Referrals triaged after receipt form.
- Pre-assessment Form. This is a 36 page assessment which requires patients to provide information including:
  - Demographics
  - Questionnaire about pain (duration, intensity etc)
  - Questionnaire about medical information (height, weight, eating habits, sleep, smoking, alcohol consumption, medical providers, family medical history etc).
  - Medical neuromusculoskeletal specific questions (pain drawing, pain areas, pain descriptors,
  - Investigation history, treatment history, surgical history, use of aids and orthotics, self management strategies, physical therapy treatment, other treatment.
  - Current and past medication history.
- Questionnaire regarding pain and work including income source, workers compensation.
- The questionnaire regarding daily function including work at home, volunteer work patterns of activity, description of typical day.
- Psychology questionnaire targeting relationships, mental health history, history of abuse (childhood and adult ward).
- Questionnaire regarding treatment interests and expectations.
- Research information and consent form
- Outcome measure CESDR (Depression)
- Outcome measure SF36 V2 (Short form 36. measure of disability domain)
- Outcome measure PDI (Pain Disability Index)
- Outcome measure BPI (Brief Pain Inventory)
- Outcome measure PCS (Pain Catastrophising Scale)

If the AHRCHC has not received the completed questionnaire within 90 days the referral is closed and family physician notified.

Questionnaire is scanned into database, which flags potential triage streams (e.g. Psychology, medical management). Team triages.

3.5.3 Flow chart of Care Pathway

3.5.4 AHRCP Inclusion criteria
- Patient has had the pain problem for 6 months or longer (except CRPS, acute sciatica or new onset and hepatic neuralgia)
- Must have a family doctor prepared to work closely with a treatment team and provide follow-up.
- Must be cognitively capable of participating in assessment and treatment.
• Must be in a stable medical condition.
• Must not have a mental health condition that would preclude participation in assessment and treatment.
• Must not have a major narcotic addiction.
• Must be 18 years of age or older.
• Not receiving treatment through Workers Compensation Board.

3.5.5 Current Waiting Times. Average wait time for assessment - 248 days in 2008, with the largest wait time being in the neuromusculoskeletal stream.

While on the waitlist clients are expected to attend the chronic pain lecture series, attend the chronic pain Living Well classes and/or the other Living Well classes that would benefit people with chronic pain.

3.5.6 AHRCPC Process through centre
### 3.6 Groups Pathway

#### 3.6.1 Mandatory Groups

<table>
<thead>
<tr>
<th>Group</th>
<th>Content Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orientation Group</strong></td>
<td><em>first contact for the client at the centre</em></td>
</tr>
<tr>
<td><strong>When:</strong> One 2-hour session</td>
<td></td>
</tr>
<tr>
<td><strong>Taught by:</strong> Dietician, Nurse, Kinesiologist, Occupational Therapist, Physical Therapist, Physician, Psychologist or a Social Worker</td>
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<tr>
<td><strong>Content Goals:</strong></td>
<td></td>
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<tr>
<td>• Provide an overview of the centre, programs and staff</td>
<td></td>
</tr>
<tr>
<td>• Clarify who could benefit from services and describe responsibilities of clients and staff</td>
<td></td>
</tr>
<tr>
<td>• Provide information about chronic pain, its impact and the strategies taught for managing pain</td>
<td></td>
</tr>
<tr>
<td>• Describe pathways to graduation</td>
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</table>

| **Explaining Pain Group**                  | *Must be completed before other groups*                                      |
| **When:** One 2-hour session               |                                                                               |
| **Taught by:** Dietician, Nurse, Kinesiologist, Occupational Therapist, Physical Therapist, Physician, Psychologist or a Social Worker |
| **Content Goals:**                         |                                                                               |
| • Improve understanding of the neurobiology of pain |                                                                               |
| • Provide current knowledge about the causes of chronic or persistent pain |                                                                               |
| • Increase client awareness of the adaptability of the nervous system |                                                                               |
| • Provide a brief review of strategies that improve ability to influence the pain experience |                                                                               |

| **Goals Group**                            | *Explaining Pain must be completed first*                                    |
| **When:** Weekly for 2 x 1.5 hour sessions  |                                                                               |
| **Taught by:** Dietician, Nurse, Kinesiologist, Occupational Therapist, Physical Therapist, Physician, Psychologist or a Social Worker |
| **Content Goals:**                         |                                                                               |
| • Develop goal setting and problem solving skills |                                                                               |
| • Identify sabotages and barriers for goal attainment |                                                                               |
| • Identified 1 to 2 goals which will initially guide CPC programme |                                                                               |
| • Options for setting further goals as participate |                                                                               |
### 3.6.2 Rehabilitation Groups

#### Smart Moves Group
*Both Explaining Pain and Goals Group must be completed first*

**When:** Weekly for 4 x 1.5 hour sessions  
**Taught by:** Occupational Therapist, Physical Therapist, Dietician, Kinesiologist

**Content Goals:**
- Provide practical strategies to facilitate achievement of goals related to activity
- Establish and increase activity tolerances
- Provide suggestions for modification of activities
- Introduce the importance of nutrition
- Address posture and positioning during activities, including patterns of activity and pacing

**Outcome measure:** - Patient Specific Functional Scale

---

#### Mastering Activity Group
*Smart Moves must be completed first*

**When:** Weekly for 3 x 1.5 hour sessions  
**Taught by:** Occupational Therapist

**Content Goals:**
- Apply physical and psychological coping strategies to priority activities
- Use these, as well as appropriate adaptive equipment while doing usual activities
- Increase confidence and satisfaction in ability by completing activities in a manageable way

**Outcome measure:** - Canadian Occupational Performance Scale

---

#### Aqua Therapy Group
*Smart Moves and a Physical Therapy assessment must be completed first*

**When:** Weekly for 4 x 1 hour sessions  
**Taught by:** Kinesiologist

**Content Goals:**
- Instruct participants on water-based exercises to improve aerobic endurance, stability, strength and flexibility
- Educate participants on how to develop paper-based exercise program to follow in community activities
### 3.6.3 Core Fundamentals Groups

**Core Fundamentals– Upper:**  *Smart Moves*

**When:** Biweekly for 4 x 1.5 hour sessions  
**Taught by:** Kinesiologist or Physical Therapist

**Content Goals:**
- Educate participants on postural awareness and how to achieve neutral spine in various positions
- Develop core strength in the upper quadrant of the body
- Learn stretches for major muscle groups that often prevent individuals from achieving neutral spine
- Practice functional activities requiring neutral spine and using muscle groups strengthened in class

---

**Core Fundamentals– Lower:**  *Smart Moves*

**When:** Biweekly for 4 x 1.5 hour sessions  
**Taught by:** Kinesiologist or Physical Therapist

**Content Goals:**
- Educate participants on postural awareness and how to achieve neutral spine in various positions
- Develop core strength in the lower quadrant of the body
- Learn stretches for major muscle groups that often prevent individuals from achieving neutral spine
- Practice functional activities requiring neutral spine and using muscle groups strengthened in class

---

**Core Fundamentals– Pelvic:**  *Smart Moves*

**When:** Biweekly for 4 x 1.5 hour sessions  
**Taught by:** Kinesiologist or Physical Therapist from Pelvic Team

**Content Goals:**
- Educate participants on postural awareness and how to achieve neutral spine in various positions
- Develop awareness of the pelvic floor
- Learn stretches for major muscle groups that often prevent individuals from achieving neutral spine
- Instruction on exercises to recruit the core muscles, protect the pelvic floor and improve function
3.6.4 Functional Recovery Group

Smart Moves and Kinesiology, Occupational Therapy and Physical Therapy assessments must be completed first

When: 2 sessions available each week, continuous entry and exit
Taught by: Kinesiologist or Occupational Therapist

Content Goals:
- Provide supervised environment to work towards functional roles as identified by participants
- Instruct participants on various methods to build strength, endurance and tolerances for specific tasks or activity

3.6.5 Pelvic Stretch Group:

Smart Moves and Physical Therapy assessments must be completed first

When: Weekly for 3 x 1 hour sessions
Taught by: Pelvic Team Kinesiologist

Content Goals:
- Teach participants with pelvic pain individualised therapeutic stretching techniques
- Allow participants to develop skills to assess their own myofacial tightness and treat accordingly

3.6.6 Stretch Group – Upper & Lower:

Smart Moves and Physical Therapy assessments must be completed first

When: Weekly for 4 x 1 hour sessions (2 sessions target the upper body 2 sessions target the lower body)
Taught by: Pelvic Team Kinesiologist

Content Goals:
- Teach participants individualised therapeutic stretching techniques
- Allow participants to develop the skills to assess their own myofacial tightness and treat accordingly
3.6.7 Trigger Point group: Smart Moves and Physical Therapy assessments must be completed first

When: Weekly for 4 x 1 hour sessions
Taught by: Physical Therapist

Content Goals:
- Educate participants on what a trigger point is, why they occur and how they can be treated
- Instruct participants on self trigger point release for major muscle groups using equipment such as a shepherds hook, tennis balls and foam balls

3.6.8 Psycho educational groups

Relaxation: Explaining Pain and Goals Group must be completed first

When: Weekly for 6 x 1 hour sessions
Taught by: Occupational Therapist, Psychologist or Social Worker

Content Goals:
- Improve understanding of the stress and relaxation responses
- Practice 6 relaxation strategies

Self-Management: Explaining Pain and Goals Group must be completed first

When: Weekly for 8 x 2 hour sessions
Taught by: Occupational Therapist, Psychologist or Social Worker

Content Goals:
- Improve understanding of self management strategy for pain
- Introduce the big 5 skills: self monitoring, pacing, relaxation, self talk and communication
- Discuss the theory and practical application of self management strategies

Sleep: Self management and a psychology assessment must be completed first.

When: 5 x 1.5 hour sessions over 8 weeks
Taught by: Occupational Therapist or Psychologist or Social Worker

Content Goals:
- Educate clients about sleep stages, causes of poor sleep and how to use a daily sleep diary
- Explore strategies for influencing sleep including sleep restriction
- Encourage the creation of a daily sleep plan and relapse plan
3.7 Teaching Style

Lecture, PowerPoint, small groups. Teaching style was observed to be very interactive with presenters posing questions to group members, even in didactic group presentations. Homework is integral to group programmes. Manuals are provided.
3.8 Data Management and Evaluation

A priority area. There is 1 FTE position (computer programmer) to collate data.

A 40 page Questionnaire is scanned, creating a report which flags individual needs (e.g. Medical management or Psychology) and guides the triage process.

Dr Paul Taenzer (Psychologist & foundation team member) is the principal contact re data analyses and research projects. Dr Taenzer analyses data; such analyses were integral in development of services and are ongoing in the development of services.

Evaluation of access to care shows improvement year by year with an overall decrease in wait times.

07/08 - 65% of clients gained benefit with:
- Improvement in pain scores. 30% ↓ Pain on average after treatment at AHRCHC
- Improvement in functional Activities. 30% ↓ Function after treatment at AHRCHC
- Improvement in mood
- Over 80% of clients are satisfied with care provided.
- 40% ↓ Pain after recommendations by AHRCHC

3.9 Research

AHRCHC is very active in research projects and grants, largely in medical areas.

Current research includes:
- Scheduled Telephone Consultation Service research project
- IVIG for treatment resistant neuropathic pain: A preliminary study
- Patient complexity score as a predictor of human resource utilization in an adult ambulatory multidisciplinary chronic pain treatment program (AHFMR)
- Improving chronic pain management in Canada - The STOP-PAIN project Phase I: Assessment of chronic pain burden and management (CIHR)

Allied health noted that they have no dedicated research time. All clinicians are involved in program development, but there is no decrease in patient load, resulting in longer wait times.

3.10 Future Development

- Support for 1st Nations Health Care Providers by RPP - working with native populations /reserves.
- Pain Clinics in Primary Care centres. Pilot project with 1 of the 30 Primary Care Networks in Alberta, offering education to PCN staff. Hoping to set up a non-complex pain satellite at a PCN with telephone support.
- Primary Care Training Programs including
  - Preceptorship for Physicians
- Small group learning for Interprofessional Health Care Providers by RPP.
- Look at nonphysician research.
- Starting a QA committee.
- Examining Service Gaps such as addiction.
- Develop evaluation of group programs, patient flow etc.
- Maintain collaboration with primary care network, long-term care, Living Well programs, mental health and addiction program.
- Keeping agendas aligned and forming and nurturing alliances.
- Approach universities and colleges to incorporate pain assessment and management into curriculum.
- Work closely with Canadian Pain Society on Multiple Projects (National Database, Research and Patient Education).

### 3.11. Points of Significance/Highlights

#### 3.11.1 Key concepts emphasised to patients include:

- Acceptance
- Self Monitoring
- Pacing
- Relaxation
- Self-talk
- Assertive Communication

#### 3.11.2. Allied Health Perception of Positives about AHRCHC

- Interprofessional team structure.
- Team members all consistent in emphasis of Self Management
- Mutual respect and support between staff with needs of client guiding that.
- Opportunities for staff to explore and improve roles; be creative & innovative.
- Well funded
- Committed staff
3.11.3 Allied Health Perception re Frustrations in working at AHRCHC

- The challenge of moving from an “Expert” model to one of self management.
- The challenge of moving from a focus on ‘impairment’ to ‘function’
- Size can be an issue. Where there is more diversity, it can be harder to ensure a quality product.
- A focus on moving numbers of clients through the programmes can put pressure on teams to discharge.
- Dealing with paperwork requests from medical insurance companies.
- Suboptimal accommodation. Have a lot of space but in an old building with subsequent problems.
- Administratively, pain is not top of the list in future planning.

3.11.4 Points of Significance/Highlights/ Opportunity to participate in and observe AHRCHC confirmed the value of:

- Value of working within a framework of comprehensive pain management service delivery (primary care, community health, secondary care to tertiary care) in Alberta Health region.

- Emphasis on patient commitment; AHRCHC clearly articulates expectations and requirement for commitment to full participation prior to the program and throughout the program.

- Emphasis on patient self management.

- Willingness to be innovative; review progress and innovate again.

- Value of a major review process (external and internal) and involving a majority of staff.

- Consistent and constant refinement of service.

- Shift to Interprofessional team structure.

- Collaborative decision-making amongst all team members, with client goals as the focus.

- Good utilisation of team members’ skills across program enabling opportunities for allied health staff to develop skills, work collaboratively and take on new roles.
• **Respectful culture** is reflected in the well functioning team, satisfied staff and a client centered program. Team members were observed as respectful and collaborative when working with patients.

• Team consistency in emphasis on key concepts and patient self management.

• Innovative Client access to education (online courses, public access courses).

• **AHRCHC’s** highly collaborative approach- maintaining alliances with other services (e.g. primary care network, long-term care, Living Well programs, mental health and addiction program).

• Emphasis on planning at state and national level.

• Well funded.

• Significant resources allocated to data collection.

• Utilisation of data collection in program (e.g. triage), program evaluation, research and future planning.

• Emphasis on research across areas with a commitment to looking at nonphysician research.
4. The Pain Clinic, Dept of Rehabilitation, Academic Hospital Maastricht  
(Dutch: Academisch Ziekenhuis Maastricht) or AZM, Netherlands  
23/05/09 – 29/05/09 (1 week) www.azm.nl

4.1 Fellowship Participation

The particular focus for this visit was to observe world leading clinical application of Exposure based treatments in the management of chronic pain. This report is a summation of observations and discussions; not an attempt to review the program or describe a detailed explanation/description of the approach.

- Met with medical and allied health staff individually.
- Observed patient assessments and treatment sessions for graded exposure therapy, multidisciplinary meeting and case conferences.
- The Pain Clinic generously provided written material, DVD, and protocols.
- The Pain Clinic even more generously spoke in English where possible and found patients who were prepared to also receive assessment and treatment in English.

Key contacts during Fellowship:  
Professor of Behavioural Medicine, Universities Leuven, Belgium & Maastricht: Johan WS Vlaeyen  
Occupational Therapist: Corine Cuypers  
Occ Therapist/Psychologist: Marlies Den Hollander  
Behavioural Psychologist: Jeroen De Jong  
Physiotherapist: Christopher Loo  
Rehabilitation Specialist: Dr Joop Ruygrok  
Occupational Therapist: Margot Van Melick  
Rehabilitation Specialist: Dr Jeanine Verbunt  
Occupational Therapist: Tanja Hermans

Thank you to Marlies for your help in planning my visit; your hospitality in the centre and during my stay in Maastricht. Thank you to Professor Vlaeyen for the offer to visit the clinic.
4.2 About The Pain Outpatient Clinic, Dept of Rehabilitation, Academic Hospital Maastricht, Maastricht, Netherlands.

The Academic Hospital Maastricht (Dutch: Academisch Ziekenhuis Maastricht) or AZM is the main hospital of the city of Maastricht and is closely affiliated with Maastricht University.

AZM is one of eight university hospitals in the Netherlands offering specialised services such as neurosurgery, cardiac surgery, a high-level emergency department and other services generally not found in smaller hospitals. AZM offers specialised assessment and treatment in chronic pain management in the Pain Outpatient Clinic.

4.3.1 History
The Pain Outpatient Clinic operates as part of the Dept of Rehabilitation, AZM. It was predominantly shaped by Professor Johan WS Vlaeyen and Behavioural Psychologist Jeroen de Jong who have developed and evaluated customised cognitive-behavioural strategies directed at functional treatment of chronic pain over approximately 10 years of research and clinical application. Treatment has subsequently moved from a medical model to a more psychologically inclusive one.

The work has sought to develop clear treatment principles, treatment protocols, patient selection and program evaluation.

Professor Johan WS Vlaeyen has recently moved to more experimental research into aspects of fear related responses at Leuven University, Belgium. Jeroen de Jong continues working clinically and researching within the Clinic. The Pain Outpatient Clinic remains very research based & is clinically focused on graded exposure therapy. Research is ongoing into application to particular pain conditions (CRPS, Fibromyalgia).

4.2.2 The Patients
The Pain Outpatient Clinic draws patients with chronic pain (musculoskeletal, CRPS, fibromyalgia) from all over the Netherlands because of its particular skill and treatment base. I was not able to obtain information regarding specific numbers of patients treated; however 2 new patients are seen weekly for exposure therapy and approximately 2-3 patients per year do not complete their graded in vivo exposure therapy.

4.3 The Multidisciplinary Team
Draws staff from different departments of the hospital (e.g. Neurology, Anesthesiology, Psychology, Occupational Therapy and Physiotherapy) who work with patients suffering from chronic pain on an individual basis.

Staff are not co-located, but assess and treat within the hospital facilities (e.g. In Occupational Therapy rooms, gymnasium, hydrotherapy pool) and often access the city of Maastricht for behavioural experiments. For example, therapists and patient might ride bicycles along roadways, if it matches that patient’s goals and hierarchy of fearful situations. The team meets on a regular basis. Exposure based and graded activity based therapy is usually done in pairs (e.g. Behaviour Therapist + Occupational Therapist).
Observation of patient behaviour and exploration of cognitions is intense and detailed and better achieved through 2 practitioners working together.

4.3.1 Team members (allied health) observed during visit included:
Behavioural Psychologist: Jeroen de Jong
Occupational Therapist/Psychologist: Marlies den Hollander
Physiotherapist: Corine Cuypers
Occupational Therapist: Christopher Loo
Occupational Therapist: Margot Van Melick
Occupational Therapist: Tanja Hermans

Observed an emphasis on mentoring/training in treatment principles and protocols with newer practitioners informing that their skill development took them between 1 -2 years to achieve a level of adequate competency. The capacity to work in pairs enables skill development to the standard observed during visit.

Observed a culture of genuine enthusiasm for the work of the clinic, with a commitment to theoretical approach, research & and the application of research to the clinical setting.

4.4 Patient Care Path

**Acute pain**
- Primary Care
  - General Practitioner
  - Private allied health

**Chronic pain > 3 mo**
- Specialist Consultation
  - Orthopedics
  - Neurology
  - Examinations X-Ray, CT

**Rehabilitation Approach**
Cognitive – Behavioural strategies of
- Graded Exposure Therapy
- Graded Activity Therapy

**Session 1.** Dual allied health Interview*
**Session 2.** PHODA - dual assessment*
**Session 3.** Education session + Family interview/education*

* Patient choice point re therapy (Patient commitment necessary)

**Treatment:** 2 X 1 hr sessions X 3 months (up to 20 sessions). Fewer sessions normally required for Graded Activity Therapy. 3 Month review.

**University Hospital, Maastricht Triage**

**Rehabilitation Specialists**
- Medical assessment
- Assess appropriateness for behavioural treatment
- TAMPA to assess level of fear
- Assess disability in daily life
- Medical readiness for behavioural treatment & set medical boundaries for treatment
- Assess level motivation for behavioural treatment.

**Medical Intervention**
- Medication
- Blocks
- Implants
- Medical treatment
- Other – e.g. Orthotics

**Patient Questionnaire**
GP or specialists can refer to The Pain Outpatient Clinic. The patient is forwarded a questionnaire (treatment history), which once returned enables an appointment with a Physician (Rehabilitation Specialist, Neurologist or Anesthesiologist). Following initial visit, treatment options will be discussed with the patient.

4.4.2 Rehabilitation Specialist Assessment
- Determines appropriate treatment path.
- Determination of patients’ medical fitness to participate in therapy.
- Sets the physical boundaries for treatment.
- Specialist looks for a relationship between fear and disability.
- Utilisation of Tampa Scale for Kinesiophobia (TAMPA) to assess fear of movement in addition to medical interview.
- Specialist assesses motivation to change/therapy. If they appear unmotivated, patients are given homework and reading material, with an invitation to return for another appointment in 6 – 8 weeks to discuss possible rehabilitation.
- Specialist looks at patient functional goals in assessing treatment options.
- Specialist begins the process of educating patient for therapy.

4.4.3 Dual Allied Health Initial 3 sessions
(Behavioural Therapist + Occupational Therapist/Physiotherapist)

4.4.4 Session 1 Initial assessment of patient and assessment of suitability for treatment. Interview addresses:
- Assessment of how much the patient’s disability is mainly determined by fear (fear of pain, extreme pain, injury, harm, permanent disability, movement, fear of future pain, fear of dependence etc).
- How much pain related fear acts to maintain the patient’s pain.
- Discussion of medical diagnosis and relationship to pain/harm (e.g. X-ray results may be seen by Pt as proof of serious injury and potential for more injury).
- History of pain, context of injury (e.g. where injured? associated emotional responses and circumstances etc).
- What increases, decreases pain?
- Patient perception of impact of pain on life; work, family, roles, recreation, household, finances etc.
- Exploration of other psychosocial issues currently affecting the patient.
- Patient expectations of therapy and pain.
- Patient expectations of therapy and function.

4.4.5 Session 2 utilises PHODA (Photograph Series of Daily Activities) to assist patient in determining hierarchy of feared activity & to develop specific functional goals.

The PHODA is a standardized tool, consisting of a 60 x 40 cm piece cardboard marked with a vertical line marked from 0 – 100 at intervals of 10 (fear thermometer). A series of photographs representing life activities such as lifting, walking, bike riding, household activities etc are examined and placed along the thermometer according to the extent to which they feel the activity is harmful. A computer version is available on-line www.psychology.unimaas.nl/phoda-sev.
Instructions: Imagine you have to do each of these activities right now. Place the photographs along the thermometer according to how worried you are about doing this activity. The higher it gets the more likely you are to avoid this activity.

Pt is instructed to rank the photographs according to the literal image and not to their adapted method of performing the task.

Therapist skill in questioning and exploring pain, its history (circumstances, associated fears, thoughts and emotions, contextual influences, patients beliefs about pain (causes, future expectations etc was observed as important in eliciting useful clinical information.

Patients may not recognise fear as an issue; rather attribute their problem to difficulty in performing a movement or activity. The practitioners’ exploration assists to identify the nature and degree of the threat/fear involved.

**Examples of therapist exploration observed:**
- Pt places squatting at 100 (greatest potential harm). Therapist exploration established pt suffered traumatic experience squatting, became ‘stuck’ and ‘had to call parent’. Noted associated fear of loss of control.
- Pt reported he stops walking. Exploration of what makes him stop? Exploration establishes it is altered sensations rather than pain that make him stop.
- Exploration of ‘worst case scenarios’.
- Exploration of activities performed in adjusted/modified ways.
- Exploration of what makes patients label an activity as (-) or (+).
- Exploration of origin of beliefs about specific pain/fears (learning).
- Exploration of the influence of vicarious learning. E.g. Pt watched another injured or fearful person performing activity.
- Exploration of what patient has learned from others verbally. E.g. A medical practitioner had informed that an activity was dangerous for pt.
- Exploring what it is about the activity that ranks it high or low. E.g. Driving was ranked highly because of a combination of force and pain.
- Exploration of how patients performed activity pre-pain.
- Careful exploration for safety behaviours related to pain.

**Occupational Therapy** may also administer a Canadian Occupational Performance Measure (COPM), an individualized outcome measure designed for use by Occupational Therapists. The measure is designed to detect change in a client's self-perception of occupational performance over time.

**Occupational Therapy** may alternatively administer an IPA (Impact on Participation and Autonomy) a tool developed in the Netherlands. The English version was adapted for use in English by the Universities of Southampton and Nottingham. It focuses on two aspects of participation - perceived participation and the experience of problems. It examines autonomy as opposed to dependency and was designed for use with adults with chronic conditions.
4.4.6 Session 3 Observation of Education session.

- Patients family members are encouraged to attend this session

- Key messages are that Pain is a condition that can be self managed and restoration of function is the goal.

- Explanation of fear avoidance model, using the patients own beliefs, symptoms & behaviours to illustrate how pain is maintained. Therapist draws a flow chart (see below for example) on butchers paper using the individuals story and own words to contextualise the teaching process.

- Therapist educates regarding pain physiology during the process.

- Therapist explores patients cognitions about pain; the ‘rules’ one begins to live by with the pain. Therapist draws out patient specific experiences and responses to illustrate this relationship. Therapist explores the origins of the cognitions (e.g. previous advice given, own experience etc).

- Patient learns how the mind struggles (ideas, beliefs etc) and adjustments and /or avoidance of activities begins. The idea that there is a relationship between the activity and pain is challenged - if avoidance and /or adjustments were effective the patient would not be needing help.

  An awareness of the impact of fear is facilitated – fear increases attention to the pain and hypervigilance to pain occurs. There is subsequently greater attention, greater energy given to the pain. Education works to validate the idea that the patient’s disability is determined by their fears.

- Patients informed that during therapy pain will initially increase and while they cannot expect pain intensity to decrease overall, they can expect to become much more functional with therapy.

- Patients informed that the therapeutic process involves performing activities the patient is fearful of, but performing them in a safe place. Patient is encouraged to experiment with ideas & beliefs bout pain in the safe environment.

- Goals explored in the context of the fear avoidance model.

- This session offered a choice point re proceeding with therapy.

- Facilitation of patient’s willingness /commitment to treatment and re-engagement in activity observed. If patient wishes to proceed, expectations re their commitment are clarified and a treatment plan outlined.
4.4.7 Session 3 Example Pain Education Flow chart

After injuries have healed, many people still experience pain: after 3 months, we call it “chronic”. This does not mean “forever”, it reflects the complexity of ongoing pain.

Onset of pain.
Acute pain due to damage to ligament.

Treatments tried
- Drugs – no relief
- DMSO cream – no relief
- Splint – provides stability but no pain relief
- Nerve blocks - mixed relief
- Spinal stimulator - mixed relief

Current pain – Chronic, complex.

Does pain have +ive consequences for you?

Negative Consequences
- Sad & frustrated
- Easily irritated followed by guilt
- Increased body tension & fatigue
- Decreased fitness
- Less energy

Attention

Avoidance
- Avoids standing, uses a stool a lot
- Avoids going to daughters swimming lessons
- Avoids shopping, crowds, high heels, getting touched on foot, biking.
- Adjustments – using stool, splint, rollator, adjusting bedding.
- Take more breaks.

Anxiety/ Fear
- Fearful thoughts & emotions
- Fear of pain
- Fear of future
- Fear of worsening CRPS
- Social fear of others reactions

Thoughts & Ideas about pain
Based on patient experiences or professional advice.
- I try to do things as much as I can, but at a certain point I have to stop.
- There is too much risk to go snowboarding.
- If I had had rehab the first time, I might not have had a 2nd CRPS (guilt).
- If I have to choose, I can’t do work, housework and childcare at same time.
- If I have pain, I cannot enjoy things, especially my children.
- If I pace activities, I will have less pain.
- If I tell people about my pain, they will think less of me.
- If my boot swells during the day, I panic & worry people will judge me.

Pt with CRPS (L) foot. Pt had previous History of CRPS ® foot, which she had Self managed using same principles.
4.5 Treatment
Medical and Rehabilitation treatment is offered dependent upon initial assessment by the Rehabilitation Specialist. Previous to development of current rehabilitation approach, a medically interventionalist approach was offered first. This is no longer the case and the initial assessment acts as the first stage of education in progression through the Clinic.

Rehabilitation Treatment uses standardized treatment protocols, which are evidence based. Concurrent research at The Pain Outpatient Clinic, AZM and Maastricht University both informs and directs treatment into the future.

Rehabilitation treatment is individual and on an outpatient basis.

There is currently no group based treatment at The Pain Outpatient Clinic, AZM. Rehabilitation treatments include Graded In Vivo Exposure interventions and Graded Activity.

Rehabilitation Specialist, Dr Jeanine Verbunt noted that the work at The Pain Outpatient Clinic, AZM works with ‘a select group of patients’. She estimated that 1/5-6 patients are suitable for graded in vivo exposure.

She noted no current evidence base for Fibromyalgia or CRPS and Exposure based treatment yet, but research is either underway or anticipated.

4.5.1 Graded In Vivo Exposure
- Establishes treatment goals.
- Establishes an individual hierarchy of pain-related fear stimuli and includes activities based on the fear hierarchy.
- Gradually increases activity levels despite pain.
- Explores and integrates the specifics of fear stimuli into exposure.
- Exposure to feared stimuli / activities activates fear responses.
- Expectations are challenged using behavioural experiences.

In Treatment
- Functional goals are identified.
- Fears explored.
- A hypothesis is made about what will happen when pt has to perform an activity.
- Process of constantly responding and experimenting - Is the hypothesis correct?
- Pt asked to rate expected outcome on a scale 0………………………………100, before and after the activity exposure.
- Perform activity (Behavioural Experiment)
- Evaluate. Q Was it as expected? What was learned?
- Activities are specifically tailored to the individual according to hierarchy (PHODA) and to the idiosyncratic nature of the fears (e.g. Pt with neck pain was specifically fearful of jarring whilst riding bike, so was exposed to riding over curbs).
• Activities with intrinsic reward (fun, enjoyable) act to reduce negative cognitions during the performance.
• **Suitability** for Graded *In Vivo* Exposure treatment – when the patient’s disability is mainly determined by fear (fear of pain, injury, harm, movement etc) and pain related fear acts to maintain the pain.
• Homework is integral

**4.5.2 Graded Activity Programme**

• Gradually increases activity levels despite pain.
• Determine a pre-defined quota of activities.
• Positive reinforcement provided when quotas met.
• Includes individual exercises according to functional capacity and observed individual work demands.
• **Suitability for Graded Activity Program** – when the patient’s disability is less determined by fear.

Exposure based and graded activity based therapies are usually performed in pairs (e.g. Behaviour Therapist + Occupational Therapist/Physiotherapist); observation of patient behaviour and exploration of cognitions is intense and detailed and better achieved through 2 practitioners working together.

Exposure based therapy requires a high level of therapist confidence in the approach because of the nature of fear & expectations of patients to face fearful stimuli.

**4.6 Research**

*The Pain Outpatient Clinic, AZM* & Maastricht University generates world leading research into Psychological approaches to chronic pain management, specifically the fear avoidance model of pain perception and cognitive-behavioural model of fear of movement/injury.

There is currently ongoing research into exposure based therapy for CRPS. Professor Johan WS Vlaeyen and his team are currently examining the paradoxical situation where negative mood leads to behaviours of persistence rather than avoidance and to the behavioural responses to pain related goal conflicts (e.g. Avoid pain, choose to maintain social interaction)

**4.7 Funding** The budget for *The Pain Outpatient Clinic, AZM* is administered from the Rehabilitation Centre at Hoersbrock. This hospital administers the monies from Health Insurance companies.

**Health care in The Netherlands** is financed by obligatory health insurance and all insurance companies are obliged to provide a package with a defined set of insured treatments. This system came into effect in January 2006. For those who would otherwise have insufficient income, an extra government allowance is paid to make sure everyone can pay for their health care insurance. Source: Ministry of Health, Welfare and Sport, Netherlands web site.

Helen Rowe 2008 Churchill Fellowship Report 57
4.8 Effectiveness
While the research evidence suggests that decreased pain-related fear is associated with improved daily functioning (2), the 2009 Cochrane review of published Psychological Therapies for the Management of Chronic Pain was only able to broadly find ‘CBT has some small positive effects for pain, disability and mood’. The review was not able to conclude which specific features of therapy may be critical for outcome. The review did note that trials of targeted therapies for specific outcomes such as Graded In Vivo Exposure were to be encouraged.

Clinically, therapists reported excellent outcomes for their patients. Outcome measures are used pre and post sessions. It was noted that current data collection in the clinical setting would benefit from more focused collection and processing to support therapists’ observations of patient outcomes.

4.9 Points of Significance/Highlights

4.9.1 Key concepts emphasised to patients include

- Pain ≠ harm
- It is normal to be affected by pain, but pain need not rule your life.
- Pain shouldn't stop you from living your life how you want to live it; you have a choice.

4.9.2 Allied Health Perception of Positives about the Pain Outpatient Clinic

- The opportunity to give people a new perspective on life despite pain.
- Working in a team with the same vision & approach; a team that has shared the same successes and failures together.
- Management support in terms of resources and time.
- The sense that the therapy is dynamic and still growing.

4.9.3 Allied Health Perception re Frustrations in working at the Pain Outpatient Clinic

- The general medical world has little understanding of chronic pain.
- Budget issues
- Limited space to work with patients.
4.9.4 Points of Significance / Highlights

• Value of Psychological approach to chronic pain management, specifically the fear avoidance model of pain perception and cognitive-behavioural model of fear of movement/injury.

• Rehabilitation Treatment uses standardized treatment protocols, which are evidence based. Concurrent research at The Pain Outpatient Clinic, AZM and Maastricht University both informs and directs treatment into the future.

• Observed an emphasis on mentoring/training in treatment principles and protocols with newer practitioners informing that their skill development to a level of adequate competency, took them between 1 -2 years to achieve.

• Value of targeted treatment approach and development of a very high level of expertise in assessment, patient matching to treatment approach and delivery of treatment. There is value in being very good at what services you do offer.

• The capacity to work in pairs enables skill development to the standard observed during visit and acted to ensure quality of assessment and treatment.

• Observed a culture of genuine enthusiasm for the work of the clinic, with a commitment to theoretical approach, research and the application of research to the clinical setting. Observed a genuine enthusiasm for making a positive difference in people’s lives.

• Importance of team commitment and consistency in approach.

• Importance of patient selection for particular therapeutic approach.

• Importance of patient education.

• Emphasis on goal of improving functional outcomes.

• Importance of patient commitment to treatment.

References:

5. Bath Centre for Pain Services, Royal National Hospital for Rheumatic Diseases, Upper Borough Walls, Bath, United Kingdom [www.bathcentreforpainservices.nhs.uk](http://www.bathcentreforpainservices.nhs.uk)
1/06/09 - 26/06/09 (4 weeks)

5.1 Fellowship Participation:
- Met with clinical director, allied health & nursing staff individually.
- Observed patient group sessions, interview for program, patient physical assessments, staff meetings & case conferences.
- BCPS generously provided written material, assessment protocols, forms and patient handouts.

5.1.1 Key contacts during Fellowship:
- Beatrice Hannah, Senior Occupational Therapist & Coordinator Visitor Program
- Suzy Williams, Senior Occupational Therapist & Directorate lead
- Dr Jeremy Gauntlett-Gilbert, Senior Clinical Psychologist
- Sarah Wilson, Senior Physiotherapist
- Nicola Chaloner, Clinical Psychologist
- Dr Lance McCracken, Clinical Director
- Karen Draper, Nurse

Thank you to the staff of BCPS for your generosity and patience in supporting this Fellowship, despite the intense and very busy nature of your work. It is greatly appreciated.
5.2 About Bath Centre for Pain Services (BCPS)

BCPS has an international reputation in the research, development of and provision of tertiary care pain management services. It provides intensive group programs for adults, young adults and adolescents and intensive individual hospital based programs for patients from all over the UK.

BCPS uses leading edge contextual cognitive behavioural therapies in programs which are both informed by and inform ongoing research. BCPS provides training to health practitioners principally in the UK and internationally.

BCPS is the only psychologically led centre in the UK. Programs are provided by interdisciplinary teams.

5.3 Vision & Aims

The BCPS vision is “Enabling people to reduce the impact of pain on their lives and influencing society’s attitude to pain”.

Treatment aims to enhance daily functioning, allowing individuals to return to activities that are important to them, whether their pain is reduced or not. Additional aims include improved overall health and fitness.

The evidence based contextual cognitive behavioural therapies are aimed at facilitating changes in behaviour patterns enabling meaningful engagement in life.

5.4 History

The Bath Pain Management Unit was established in 1994 with Professor Chris Eccelston as Clinical Director to provide intensive treatment for adults with chronic pain and research the effectiveness of treatment. It was expanded in 1999 to include an intensive program for adolescents with chronic pain. Dr Lance McCracken took over the clinical directorship in 2000 and moved the centre to a contextual cognitive behavioural model.

With an expansion of services, the unit name was changed to the Bath Centre for Pain Services (BCPS) in 2008. Its international reputation as a specialist centre has grown over the past 10 years and its research has had international impact on service provision for persons with chronic pain in the UK and around the world.

5.7 Context

The UK is currently looking to widen access to high-quality pain services. There is recognition that systems and infrastructure are not adequate to meet need or demand for the 5 million people who develop chronic pain in the UK each year. Only 14% of people with pain saw a pain specialist in 2005.

See Appendix 1 for Recommendations made in this report.
Source: "Pain Breaking through the Barrier", 2008/2009 Annual report of the Chief Medical Officer, Department of Health, UK. www.dh.gov.uk

BCPS offers intensive residential programs at the tertiary level and in a non-medical environment.
Primary care options available in the patient’s local community may include their GP, community based back pain classes, local physiotherapy and expert patient led programs.

Secondary care interventions may include local Pain Clinics and Outpatient CBT based Multidisciplinary Pain Management Programs.

BCPS specifically targets patients whose complex presentation (psychosocial complexities, high level of disability, complex co-morbidities) may preclude successful participation at the secondary care level and who require long-term inpatient or residential care programs.

BCPS is ideally located for cognitive behavioural residential programs, with shops, gymnasium, recreational facilities all located within short distances from the hospital. Locale offers varied opportunities for behavioural experimentation.

BCPS saw 140 patients in 2008/2009, with an average of 32 patients per month. This is an increase of 17 patients from 2007/2008.

5.8 Interdisciplinary Team
Consists of 5 Clinical Psychologists, 4 physiotherapists, 3 Occupational Therapists, 2 part time medical staff, 1 nurse & managerial and administration staff.

All allied health and nursing staff’s work within a Contextual CBT model.

<table>
<thead>
<tr>
<th>Clinical Psychology X 5</th>
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<tbody>
<tr>
<td>• Dr Lance McCracken  <strong>Clinical &amp; Academic Director, Consult Clinical Psychologist</strong> Clinical and research lead for BCPS.</td>
</tr>
<tr>
<td>• Dr Hannah Connell,  <strong>Paediatric Consultant Clinical Psychologist</strong> Lead for Adolescent and Young Adult Services.</td>
</tr>
<tr>
<td>• Dr Jeremy Gauntlett-Gilbert <strong>Senior Clinical Psychologist</strong></td>
</tr>
<tr>
<td>• Nicola Chaloner <strong>Clinical Psychologist</strong></td>
</tr>
<tr>
<td>• Miles Thompson <strong>Clinical Psychologist</strong></td>
</tr>
<tr>
<td>• Jane Zhao-O’Brien, Jennifer Williams <strong>Assistant Psychologists</strong></td>
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Carry out all assessments and jointly with patients make decisions regarding the most appropriate treatment pathway. Deliver daily group sessions on programmes, using a contextual cognitive behavioural approach.

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<thead>
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<th>Physiotherapy</th>
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<td>• Sarah Wilson, Rosie Passingham, Cath Morgan, Jane Clarke</td>
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Physiotherapy at BCPS is not ‘hands on’ treatment and is aimed at improving patient’s awareness of and understanding of their bodies and building fitness despite pain.
Physiotherapists utilise contextual cognitive behavioural therapy in their delivery.

### Occupational Therapy

- Suzy Williams **Senior Occupational Therapist & Directorate lead**
- Beatrice Hannah **Senior Occupational Therapist & Coordinator Visitor Program**
- Emma Wheatley **Occupational Therapist & Coordinator Education team**

Occupational Therapy works with patients on ways to increase function in areas such as self-care, family roles, communication, structuring activity, and returning to work, education and leisure.

Occupational Therapists utilise contextual cognitive behavioural therapy in their delivery.

### Medical Team x 2 part time

- Dr Peter Brook, **Consultant in Pain Management**
- Dr Jacqui Clinch, **Consultant in Paediatric Rheumatology and Chronic Pain**

Medical staff assesses all patients to ensure appropriate conventional medical treatment and investigations are completed. They provide information and education to patients attending programmes on the mechanisms of chronic pain, the management of medication and the role of the doctor in this. They are available to see patients during group sessions or individually to work on issues such as medication management.

### Nurse 1FTE

- Karen Draper

Nurse is responsible for issues such as patient safety and infection control; delivers group sessions on healthy living and works closely with the doctors in helping patients with medication management.

### Management and Administration team

- Lisa Self **Service Manager and Project lead**
- Michelle Cray **Funding administrator**
- Ann Flint **Administration Asst**
5.7 Programs Offered

BCPS offers services for adults, adolescence and young adults. There are 3 adult programs, 1 young adult program, 1 adolescent program and intensive individualised programs as follows:

### Adult programs (18+)

1. Intensive 3-week group pain management program. Offers intensive physical and psychological rehabilitation for people with severe and complex chronic pain. The course aims to achieve significant improvements in functioning and self-management.

   Patients are accommodated in nearby self catering flats.

   Source: Brochure Feb 2009

### Adult programs (18+)

2. **Intensive (+) 4 week program offering intensive physical and psychological rehabilitation for individuals with particularly complex pain associated disability or highly inflexible behaviour patterns that require extended treatment to facilitate sustained behaviour change.**

   Patients are accommodated in nearby self catering flats (see 5.23).

3. High Dependency Program (3 weeks treatment over 4 week period). As above with additional rehabilitation components designed to meet the needs of patients with extremely limited self-care, mobility, or abilities to live independently. Patients are accommodated in the hospital.  

   Source: Brochure Feb 2009  

   Programme (2) bolded was observed during Fellowship

- The average adult patient is 44 years old, has suffered pain for 11 years, has consulted an average of 6 physicians in the past and is female (64%). 10% of patients are working full or part-time at an average of 48 months out of work. 72% are using opioid analgesics and 40% had had surgery for pain.

   Source: McCracken et al. (2005) Behaviour Research and Therapy, 43, 1335 -- 1346

- 58% suffer back pain  
  14% suffer lower limb pain  
  7% suffer neck pain  
  7% suffer upper limb pain  
  5% suffer head/face pain  
  9% other pain
• Diagnoses may include Complex Regional Pain Syndrome (CRPS), fibromyalgia, recurrent abdominal pain, pelvic pain, Back pain, musculoskeletal pain, headache, post-cancer pain, arthritis pain, inflammatory bowel disease.

**Young adults program** (18 to 30 years)

• Intensive 3-week residential program - treatment focuses on education, work, leaving home and relationships - areas that are particular to this age group.

Parents/partners/family members also attend parts of treatment and are accommodated in nearby flats.

Source: Brochure Feb 2009

**Adolescent programs** (11 – 18 years)

• Family focused intensive group pain management programs.
• Intensive 3-week residential group program
• 6 young people and accompanying adults are accommodated in nearby self-catering flats

Program focuses on increasing function and return to age appropriate activity such as school. Participants learn the skills and strategies of pain management including:
• graded exercise, including gymnasium
• goal setting, planning and pacing activity
• mood management
• life skills, including healthy eating and communication
• medication and chronic pain
• return to education or work as appropriate

Source: Brochure Feb 2009

**Individual Programs**

• Individual hospital admissions for highly disabled patients needing flexible and individualised intensive interdisciplinary rehabilitation.
• Programme may act as a precursor to a group treatment program.

Source: Brochure Feb 2009

### 5.8 Theoretical framework

**BCPS** programs are based on Contextual Cognitive Behaviour Therapy, sometimes referred to as the 3rd wave, following behaviour therapy (1st wave) and CBT (2nd wave).
Traditional CBT programs generally include training in coping and methods designed predominantly to "control" or decrease the experience of pain (physical and emotional components) and change thoughts and beliefs about pain.

In CCBT the attempt to control or change (struggle) is seen as problematic in that it can dominate the patient's life without actually working. It moves the individual way from things that are valued and important for them (e.g. friends, family, health, work etc). The struggle to control emotions, thoughts and physical sensations can worsen the situation.

CCBT aims to help patients create a rich full and meaningful life, despite pain and stress by teaching psychological skills to deal with painful thoughts and feelings effectively and helping to clarify what is truly important and meaningful to the individual (their values) then using that knowledge to guide and motivate towards meaningful living.

CCBT includes the processes of acceptance, cognitive defusion, mindfulness and values.

Values are explored in response to the question “What do you want your life to be about?” despite pain. Values are explored across the life domains of family relationships, intimate relationships, social/friends relationships, work/career/school, education and learning, self development, recreation/leisure, spirituality, community, health/physical well-being.

Acceptance involves the engagement in activity despite pain & allowing self to experience pain without struggling to change it. The individual’s efforts are directed at controlling what is controllable, rather than what is not.

The concepts of creative hopelessness (why keep doing what does not work?), workability (what does work, both in the short and long term?) and willingness (willingness to sit with the negative emotions, thoughts, physical sensations) are central and are progressively explored through experiential exercises.

Cognitive defusion refers to the capacity to separate out oneself from thoughts, beliefs, emotions and physical sensations to create greater psychological flexibility. Exercises utilise metaphor (e.g. who is driving the bus?), humour and experiential tasks to illustrate the problems caused by a lack of awareness of the influence of unconscious thoughts on ones actions.

Central to CCBT is Mindfulness. This is the awareness of the present moment with acceptance and without judgment. Exercises in mindfulness are woven throughout the BCPS programmes in all sessions.

Mindfulness improves conscious awareness enabling subsequent greater choice about ones subsequent actions.

BCPS encourages a simple “Check –In” process to help facilitate mindfulness.
5.9 The “Check in” Diagram

The situation

![Diagram]

Patients are encouraged to stop and notice, to “check-in” on a regular basis, using this information to guide their actions.

The metaphor of a car journey illustrates mindfulness – before one goes on a long car journey they would be advised to check the oil, water and petrol. “Checking in” is simply that process.

5.10 Program Content

5.10.1 Physical Conditioning Strategies (observation & discussion)

Patients engage in a graded fitness program both at BCPS and at a local gymnasium.

Patients are encouraged to find a level of exercise that they can sustain day in, day out, on a good day and on a bad day. Patients use the "check-in" process to assess thoughts, body sensations and emotions occurring during exercise, and grade their exercises according to their current ability.

Current ability is determined by noticing changes in the quality of their movement during exercise. Patients are encouraged to notice physical sensations such as heart rate, breathing, heaviness in legs and arms, light-headedness, shaking, jittery/jerky movement, sweating etc in response to exercise. This information informs and guides the patient to notice the quality of their movement and to assess their current ability.

Patients graded exercise program is individually developed using assessment of current ability for a series of exercises and stretches including stand-ups, side bends, arm circles, step ups, squats, arm raises, leg balance, walk, forward reach, leg raises, knee rolls, press ups, bridging, sit ups and lower abdominal exercises.
Grading includes modifying the exercise as needed. For example forward reach could be performed in sitting → in standing; arm circling may be adapted by changing the size of the circles, by sitting or standing, by the position of the arms etc.

The check-in process is integral to determining **current ability**. Patients are encouraged to notice the thoughts and emotions surrounding exercise that might affect their ability to exercise. For example **thoughts** such as "I’ll just go another five minutes", "I can't do it", "and I'm a failure" or “I will hurt/damage myself” can affect the action one takes (exercise/not exercise etc). Similarly, emotions such as fear, anger, frustration, sadness etc may affect exercise.

**Current ability** is used to inform sustainable goal setting. Goals for exercise are planned for the week, weekends and for post program.

5.10.2 Strategies to restore daily functioning (observation/discussion)

Sessions are aimed at improving function in areas such as self-care, family roles, communication and structuring activity, returning to work, education and leisure.

Large group, small-group, pen and paper exercises, homework exercises and experiential exercises both within the Centre and in Bath (e.g. experiments in shops etc) were utilised. The “check in” process is central to the sessions. Activity management, values exercises, problem solving exercises, goal setting (Smart goals), exploration of "personal rules" guiding participation in activity (defusion), planning for weekend and a return home, planning for setbacks are included in the context of each individual patient's life and circumstances.

Activity management - prioritisation, planning, communication, current ability and challenging habitual/old patterns is explored. Patterns of activity are explored. Pacing is explored -- more than the minimum on a good day and less than the maximum on a bad day, breaking activities up, using "check-in" and noticing the quality of movement, changing positions, noticing breathing, remaining in the present. Time contingent pacing is replaced by the application of mindfulness.

Patients are encouraged to consider choice and consequences and consistency of their actions/activity with their own personal values. Patients are encouraged to consider workability in the short term and the long term. “If you do what you've always done, you'll get what you've always got”.

Those patients who wished to pursue employment were able to access an appointment with an adviser from an employment agency during the program.

Patients drew up an end of program contract with self sheet with exploration of questions such as “what is it you would most like to tell us you'd like to have done more achieved at three-month follow-up?” and "what is the thing that's most likely to get in your way?". The contract is based on planning for the future.
5.10.3 Medical and Nursing Education (observation)
Medical sessions included discussion about patients’ experience of their journey through the medical world in relation to pain; the role of medicine in the treatment of chronic pain at primary, secondary and tertiary levels; medical treatments and investigations; current medical knowledge about chronic pain; mechanisms of chronic pain and the management of medication. Nursing sessions included sleep, sleep restriction and intimacy.

5.10.4 Contextual Cognitive Behavioural Therapy
Large group, small group, role play, experiential exercises in clinic and within Bath were utilised in the therapeutic application of Contextual CBT. (See 5.8 Theoretical Framework and 5.9 Teaching style. This work forms the basis of the program.

Early sessions focus on familiarising patients with group processes (speaking within a group, role plays etc). Skillful use of group dynamics is integral.

Sessions progress through the CCBT processes of acceptance, cognitive defusion, mindfulness and values as per theoretical framework. (See 5.8).

5.11 The BCPS Care Pathway
5.11.1 Referral
Referrals are generated by GPs in the primary health care and Pain Clinics in secondary health care. Services are diagnostically non-specific; aetiology may be unclear but may stem from rheumatological, orthopaedic, gynaecological, neurological or failed surgery conditions.

Referrals are directed to the Clinical Director and triaged by Physician and Clinical Psychologist. If there are significant questions about patient’s independence, a Physiotherapist or Occupational Therapist may telephone to clarify the situation.

BCPS is a national service, and accepts referrals from throughout the UK.

Guidelines provided to referrers
- The need to reduce high doses of medication and dependency on health-care services
- The need for a more intensive dose of pain management than is available through local services such as Expert Patient Programs or Pain Clinics offering only medically oriented treatments (e.g. joint injections, medication management).
- The need for more supported and intensive context to help patients move towards changes that they have so far been unable to make and continuous time away from home/work/social environments to provide an opportunity for them to move towards the sustained behaviour change.
- Where the patient is so avoidant (physically or emotionally) that they would be unlikely to attend an outpatient programme.
- Where the patient often appears compliant with health professionals, but avoids engaging in activities that would help them improve physical or psychological functioning.
- Where the patient is in an inappropriate setting for rehabilitation e.g. on an acute ward or in a continuing care environment.

Source: BCPS Brochure 2009
### Adult 4 – Week Program

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<td>9.00 Welcome</td>
<td>9.00 Welcome</td>
<td>9.30 CBT/Mindfulness (Psychology led)</td>
<td>9.15 CBT/Mindfulness (Psychology led)</td>
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<td>9.30 Assessments Check in with key worker</td>
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<td>11.00 Communication</td>
<td>11.00 Body Conditioning (Physio led)</td>
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<td>12.00 CBT</td>
<td>12.00 Activity (Occupational Therapy led)</td>
<td>12.00 Medical Session</td>
<td>12.00 Individual sessions with key worker</td>
<td>12.00 Activity (Occupational Therapy led)</td>
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<td>Team meeting</td>
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<td>2.00 Introduction To Body Conditioning (Physiotherapy Led)</td>
<td>2.00 Introduction to Healthy Living Diet &amp; Sleep (Nurse led)</td>
<td>2.00 Activity (Occupational Therapy led)</td>
<td>2.00 Body Conditioning (Physio led)</td>
<td>2.00 Gym at Fitness First, Bath (Physio led)</td>
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<td>3.30 Introduction to Activity (Occupational Therapy led)</td>
<td>3.15 Gym Induction at Fitness First, Bath (Physio led)</td>
<td>3.30 Body Conditioning (Physio led)</td>
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**Adult group 165**
# Adult 4 – Week Program

**Adult group 165**

## Week 2

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## Adult 4 – Week Program

### Adult group 165

- **Week 3**

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| **8.45**  
Weekend Review | **8.45 Stretch** | **8.45 Stretch in flats**  
Staff Meeting | **8.45 Stretch** | **Day at home** |
| **9.15**  
CBT/Mindfulness (Psychology led) | **9.00**  
CBT/Mindfulness (Psychology led) | **9.30**  
CBT/Mindfulness (Psychology led) | **9.00**  
CBT/Mindfulness (Psychology led) |
| **10.45 Break** | **10.30 Break** | **10.45 Break** | **10.30 Break** |
| **11.15**  
Body Conditioning (Physio led) | **11.00**  
Body Conditioning (Physio led) | **11.00**  
Body Conditioning (Physio led) | **11.00**  
Body Conditioning (Physio led) |
| **12.00**  
Activity (Occupational Therapy led ) | **12.00**  
Medical Session | **12.00**  
Healthy Living Intimacy  
(Nurse led) | **12.00**  
Communication |
| **1.00 Lunch**  
Team meeting | **1.00 Lunch**  
Team meeting | **1.00 Lunch**  
Team meeting | **1.00 Lunch**  
Team meeting |
| **2.00**  
**Individual sessions with key worker** | **2.00**  
Activity (Occupational Therapy led ) | **2.00**  
Activity (Occupational Therapy led ) | **2.00**  
Activity (Occupational Therapy led ) |
| **3.00 Break** | **3.00 Break** | **3.00 Break** | **3.00 Break** |
| **3.15**  
Gym at Fitness First, Bath (Physio led) | **3.30**  
Body Conditioning (Physio led) | **3.15**  
Gym at Fitness First, Bath (Physio led) | **3.30**  
Body Conditioning (Physio led) |
| **4.45 Finish** | **4.30 Finish** | **4.45 Finish** | **4.30 Finish** |
### Adult 4 – Week Program

#### Adult group 165

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<td>Psychology &amp; Nurse</td>
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5.13 Inclusion Criteria

- Pain is persistent (longer than 3 months)
- Pain should have been fully and appropriately investigated.
- Pain has failed to respond to interventions from other specialities.

5.14 Assessments and Outcome Measures

Patients complete a questionnaire pack pre, post & follow up. Assistant Psychologists enter the data, which is used to inform future programming and in research. Many of the outcome measures used by BCPS were developed by BCPS.

Outcome Measures include:

- Pain Questionnaire. Current pain intensity, usual intensity over the last week, the lowest intensity over the last week, hires to pain intensity over the last week, level of distress over the last week are measured on a visual analogue scale. Details are sought about medications, the number of hours of patients spent walking or standing, resting or sleeping, sleep at night on a typical day during the past week.
- Sickness Impact Profile (SIP). A 136 item scale assessing the impact of an illness on the various domains of daily functioning, containing three subscales: physical disability, psychosocial disability and other disabilities.
- Briefs Pain Response Inventory.
- British Columbia Major Depression Inventory (PC - MDI). 820 item self report method of depression based on DSMIV.
- Chronic Pain Values Inventory (CPEI). Measures success in six domains of patient values, including family, intimate relationships, friends, work, health and growth or learning.
- Pain Anxiety Symptoms Scale (PASS). A 20 item measure of fear, avoidance and other anxiety responses to pain.
- Chronic Pain Acceptance Questionnaire (CPAQ). A 20 item scale assessing levels of acceptance to pain. Consists of 2 subscales: activity engagement and pain willingness.
- Mindfulness Attention Awareness Scale (MAAS). A 15 item measure of mindfulness. Mindfulness is defined as the skill focused attention and non-reactivity to private experiences.
- Acceptance Action Questionnaire (AAQ-11). This scale assesses people's ability to accept their undesirable thoughts and feelings, and pursue the goals they wish to achieve in the presence of difficult private experiences.

Physical Assessment (Physiotherapist)

- Pre, post and follow up to program.
- Measures 2 minute walk + sit stand (Video); height, weight; flexibility.

5.15 Assessment

All appropriate referrals receive a detailed assessment from a Clinical Psychologist and Consultant Physician. Medical assessment assesses medical stability, ensures all investigations are completed and assesses medical appropriateness for treatment. Clinical psychology assessment establishes if treatment will meet patient needs.
Assessments are carried out within 3 weeks of receiving funding approval from PCI (see Funding 5.17)

- **A Clinical Psychology assessment was observed.** Assessment included all psychosocial areas pre-and post injury, participation in functional and daily activities, treatment past and present, patients understanding of the condition, patient motivation etc.

Considerable time was spent educating the patient about BCPS approach to treatment and articulating expectations for the patient. For example, patient can expect an increase in pain and an increase in function during the programme; patient will stay in a flat potentially with 7 steps; patient must be able to fully participate 5 days per week and be open to the therapy.

The patient would need to prepare for the program by increasing activity level and increasing sitting tolerance to feel confident about sitting in a room all day. The patient may need to begin structuring their day (e.g. get up the same time every day) so that they will cope with the programme.

If a patient is on large amounts of medication they may be required to reduce levels prior to participation in the program. There is a preference that patients are not medicated with short acting opioids. Assessment of appropriate programme is made.

Patients who are not able to climb a small number of stairs, walk short distances and manage self-care independently maybe streamed into a high dependency program, nursing assistance available.

In hospital programs require the patient to manage their own medication.

### 5.16 BCPS Patient monitoring through the Program

- Each patient has a **key worker** who is responsible for initial "clerking in" (gain consent, check patient personal details etc), checking for changes since the original assessment such as new symptoms, changes in work status etc and documenting current medication.

The key worker meets the patient weekly to address progress. Team members generally manage 2 patients per program. The key worker is available for telephone follow up post program.

- **Handover between sessions,** each practitioner/presenter completes file notes & debriefs with the next practitioner/presenter.

- **Lunchtime team meetings** (Monday, Wednesday & Friday) address practical issues (e.g. timetabling issues, temperature, accommodation issues etc) and case discussion at individual and group levels. Each practitioner gives an overview of the activity/content of their session and speaks to the progress of each patient through the
session. Patient's progress is discussed and formulations for treatment are documented.

- **Follow Up** Adult programs involve group follow up at 3 months and 9 months post programme. Currently this is an unstructured session reviewing achievements and problem solving any difficulties that have arisen. Where patients live a significant distance from Bath, alternative arrangements may be made; for example staff may travel to the patients.

Adolescent programs involve follow-up at 3, 6 and 9 months.

Group members are able to contact their key worker between follow-up to discuss progress by phone.

**BCPS** review follow-up procedures on a consistent basis in an effort to ensure effective follow-up.

### 5.17 Funding
In the UK, the National Health Service (NHS) is the name commonly used to refer to the four publicly funded healthcare systems (England, Northern Ireland, Wales & Scotland). Each system operates independently, is funded by and is politically accountable to the relevant government.

NHS commissions health-care services on behalf of their population through Primary Care Trusts (PCTs). Primary care includes visits to the local doctor, dentist, optician or pharmacist, NHS walk-in centres and the NHS Direct phone line service. There are currently 152 PCTs in England.

PCTs are local trusts which work with local authorities and other agencies to provide health and social care. PCTs are at the centre of the NHS and control 80% of the NHS budget.

**BCPS** is funded by negotiation with each patient’s referring PCT for services. **BCPS** also accepts private referrals. Assessments and treatment are negotiated separately, with a usual 6 month gap. Program cost was quoted at approximately £10,000 in June 2009.

Source: NHS website [www.nhs.uk](http://www.nhs.uk) 27/09/09

### 5.18 Staff Meetings & Training
- Business meeting and CME occur Wednesday a.m.

- CME observed during Fellowship was physiotherapy lead and involved staff using/wearing crutches, wheelchairs, collars and hand splints into Bath; they were required to use mindfulness in the same way patients are required to during the programme. Staff reflected on their experiences on return.
Where possible staff take advantage of training. All staff participated in 2 days of training with Kelly Wilson (Associate Director of the Centre for Contextual Psychology at the University of Nevada, Reno) in late 2008.

5.19 Teaching Style
Teaching style encourages active participation with very little didactic lecture style presentation. Therapists actively elicited patient participation. There was no PowerPoint used; principally whiteboard and butchers paper/flip board. Small-group work, role-play, pencil and paper tasks and experiential exercises were utilised.

A communication session involved use of a video camera to record role-play, which was then replayed on a laptop computer. This was a particularly powerful session, providing immediate feedback and the opportunity to practice communicating differently.

5.20 Professional Visitor Scheme
BCPS offers a formal visitor program, accessed to complete this Churchill Fellowship. Applications are made to Beatrice Hannah Senior Occupational Therapist & Coordinator Visitor Program.

5.21 Training and Education
BCPS offers study days, team training and training for primary care to practitioners in the UK. An events schedule is accessible on line.

Example:

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Acceptance and Commitment Therapy in Chronic Pain Management A Two Day Event
Thursday 29th and Friday 30th October 2009 £295 both days (£275 early rate*); £180 first day only(* early rates apply to bookings before 31st August 2009)

The BCPS will be running this popular event for the fifth consecutive year in 2009. Our study days provide an introduction to Acceptance Commitment and Therapy (ACT) for chronic pain. They cover the theoretical basis for this approach, a review of research evidence and include workshops focused on clinical application.

The study days are suitable for health professionals working in pain management and other clinical settings where chronic pain patients are seen. Past attendees have included physiotherapists, occupational therapists, psychologists, nurses and doctors.

Workshops will be led by a psychologist, occupational therapist and physiotherapist and provide:
An overview of important conceptual issues
Demonstration of techniques used in clinical work
Experiential exercises

Source: BCPS website 02/10/09
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5.22 Research

BCPS’s team of researchers based at the University of Bath is prolific in publication of scientific papers in peer reviewed journals, presenting internationally. The team holds editorial board positions with the top European and international journals in the field.

The Bath Centre for Pain Services (BCPS) is an evidence-based service; clinical work is grounded on research findings. Research is closely linked to clinical work and informs improvements in treatment and service delivery.

Patients and relatives attending the centre are able to take part in research. Recent examples of patient involvement have included taking part in focus groups, being interviewed about their pain experiences, and completing questionnaires.

All research is undertaken in compliance with the Research Governance Framework and complies with local and national research ethics regulations, data protection legislation and local and regional NHS research priorities.

The BCPS works closely with the Bath Centre for Pain Research at the University of Bath. Source BCPS website 02/10/09

5.23 Effectiveness

Adult patients show an average increase of 30% in their general ability to function with their current level of pain, evidenced in areas of physical, social, and emotional functioning including self-report measures and on directly assessed physical performances, such as walking speed.

BCPS data demonstrates that fear and avoidance related to pain are reduced by over 20%.

Levels of physical disability are reduced by approximately 30%. levels of psychosocial disability are reduced by an even greater percentage.

Another important indication of improvement is demonstrated in a nearly 50% reduction in patients visits to their GP in the three months following treatment compared to the start of program.

There is a three-fold increase in patients who improve their level of work involvement. Further outcome data is available on the BCPS website. Source BCPS website 02/10/09

5.24 Patient Accommodation

Participants either stay in the hospital or in flats situated next to the hospital depending on clinical need identified at assessment. The flats are fully equipped for cooking and are supplied with breakfast cereals, bread and milk. Hot meals are served at lunchtime in the hospital restaurant however cooking facilities in the flats enable flexibility for self catering. Laundry facilities are also available. Patients are provided with a map of local shops where they are able to purchase food etc.
There are usually three adult group members per flat, adolescent patients are able to flat with accompanying adults.

5.25 Points of Significance/Highlights

- Confirmed the value of intense psychologically focused approach to management of Chronic Pain – specifically Contextual Cognitive Behavioural Therapy.

- Strong leadership driving application of CCBT through research and clinical application of research; each informing the other.

- The value of BCPS role in taking a lead position at national and international levels in offering opportunities for health practitioners to visit and training health professionals in the application of CCBT.

- Strong focus on development and application of outcome measures, data collection and management.

- Highly skilled team, consistent in their application of CCBT throughout the entire program. Each discipline was well trained and able to apply principles of CCBT across content.

- Impressed by the quite different approach to physiotherapy in application of CCBT.

- Importance of team commitment and consistency in approach.

- BCPS innovative and responsive to needs. E.g. development of young adult & adolescent programs.

- Importance of emphasis on goal of improving functional outcomes.

- Importance of patient match to treatment.

- Importance of patient commitment to treatment.

- High priority placed on interdisciplinary team functioning evidenced in tight management of patient progress through the program (handover sessions, team meetings etc).

- Value of allocating a case/key worker.

- Emphasis on experiential exercises, including behavioural experimentation and practice in the local community.

- Importance of follow up.
The cost of chronic pain to the individual, the family, community and Australia is high.

The bulk of this cost is borne at an individual and family level. Employers, government, non-government organisations, workers compensation groups, friends and family, co-workers, charities, community groups and other members of society also bear cost.

Treatment over the last 30 years has shifted from pure medical interventions to a biopsychosocial model. Whilst current research suggests Multidisciplinary approaches using a CBT approach are the most effective and most cost-effective means to assist those who suffer from persistent pain (Access Economics 2007), what constitutes an effective multidisciplinary program is often unclear, especially at the level of operationalisation.

This Churchill Fellowship offered me the opportunity to observe leading multidisciplinary pain centres around the world in their delivery of programs considering the available evidence, the support of the organisations they work in, the funding guidelines they operate under and fully utilising the resources they have.

Such choices surrounded theoretical frameworks, modalities and interventions; application of theoretical frameworks, modalities and interventions (the “how-to”); quantity and timing of interventions; delivery and teaching/learning styles of interventions; teamwork; management of patients from beginning to close of programming (external & internal referral processes, triage, waiting lists; follow-up of patients; the use of assessment and outcome measures the practicalities of assessment (who assesses and when); the importance of data collection and auditing of programs; staffing -- the value of experienced and suitably trained staff, staff training and practical delivery issues such as space, equipment, resources, patient transport problems, patient accommodation.

The fellowship observations supported the value of:

- Attention to a whole of care model at national/state level. There is value in a framework of comprehensive and coordinated pain management service delivery including primary care, community care to tertiary level care. Early assessment and intervention is central to prevention of the level of disability commonly encountered in tertiary services.

Multidisciplinary Pain Centres can take on expert consultative and educational roles.

- Development of an Interdisciplinary team model rather than a Multidisciplinary model. All centres visited functioned and supported an interdisciplinary team model approach. A key feature of the Interdisciplinary team is collaborative decision-making amongst all team members, with client goals as the focus.
Treatments are not delivered by one professional at a time but are integrated and joint sessions feature regularly so that combined skills of different professions complement each other.

All professions have similar core skills including communication skills and the recognition and management of non-medical obstacles to rehabilitation. Potential allied health involvement at all stages of the program is recommended including triage and assessment.

Allied health staff expressed significant support for an Interdisciplinary team model as a factor in continued interest in employment in the area of chronic pain. The approach enables opportunities for allied health staff to develop skills, work collaboratively and take on new roles and as such offers opportunities for innovative models of care.

- Programming considerations to include balancing of the need to meet unmet needs in the community (e.g. where a need for services for adolescents is identified) and matching of patients to therapeutic interventions. Not all services can provide a service for everyone.

- A clear therapeutic framework (e.g. CCBT) applied to programs, applied consistently across all disciplines and woven through all interventions.

- Use of behavioural approaches focusing on improvement in functional activities despite pain and including importantly, active individualised physical conditioning.

- Intense programming to allow for behavioural change. Focused management of patients through programs. Consideration of key workers attached to patients.

- An emphasis on patient commitment to full participation at commencement and throughout programs.

- Resources given to training for expert skill development of team members. There is support for the value of experienced and skilled allied health staff.

- A focus on careful selection of outcome measures that measure what you want to measure, within the context of broader research, given potential Multicentre research. Inclusion of patient satisfaction measures.

- Resources to support data collection and data management to inform and direct programs (evaluation, research).

- The value of research that informs and is informed by clinical application of expert and specialised approaches to management of chronic pain.

- The value of innovation.
Australia is currently fortunate to in having pain medicine as an approved independent medical speciality, with a faculty of pain medicine including representatives of all the five specialities of anaesthesia, medicine, psychiatry, surgery and rehabilitation medicine.

It is suggested that Allied health consider a similar cooperative approach to facilitate knowledge and skills building and research.

Consider the concept of allied health therapists specialising in pain medicine to act as a community resource possibly in early intervention and education.

Chronic pain is a chronic condition. The importance of follow up. Several centres noted that greatest gains on outcome measures were observed at 12 months post program, with deterioration in measures at 6 months. Consideration of type quality & frequency of follow-up is recommended.

Information and Dissemination of Information:

- Multiple presentations and workshops within the Tess Cramond Multidisciplinary Pain Centre, Royal Brisbane and Women's Hospital, Brisbane Australia as part of current review to facilitate change within the context of current state level planning.

- Presentations and written contributions to Qld Health.

- Keynote speech Occupational Therapy Conference, Qld.

- Input to Australian Pain Society, currently contributing to The National Pain Summit* which is developing a National Pain Strategy aimed at making more effective, cost-effective and accessible healthcare solutions available to all Australians.

- Facilitate opportunities for allied health collaboration and skill development in the area. E.g. Training and exploration of active allied health collaboration across Australian Multidisciplinary Pain Centres.

* The development of a national pain strategy has arisen from the recommendations of the Access Economics report of 2007 the Australian pain Society (APS) has formally agreed to partner with the faculty of pain medicine and other consumer and professional groups in a national pain summit with the goal of developing a national strategy using evidence base models of care to take to the Federal government for future policy and health funding initiatives.
The National Pain Summit is developing a National Pain Strategy aiming at making more effective, cost-effective and accessible healthcare solutions available to all Australians. A key objective is to achieve agreement for a national strategy for implementation of the model of best practice treatment of persistent pain and new standards for treatment of pain patients. (Presidents report, APS newsletter September 2009)

References