TRANSCRIPT

WEBINAR:
Strategies to support work participation for clients/ patients living with chronic pain

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Panellists:

- Dr. Irina Hollington
- Melanie Ianssen
- Catherine Ketsimur
- Professor Michael Nicholas

Facilitator: Professor Stephen Trumble (General Practitioner, VIC)

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Steve Trumble (00:01):

Good evening everybody and welcome to our webinar this evening. Before we start, MHPN would like to acknowledge the traditional custodians of the lands, seas, and waterways across Australia on which our webinar presenters and participants are located. We wish to pay our respects to the elders past, present, and for the memories, the traditions, the cultures, and the hopes of Aboriginal and Torres Strait Islander Australia. So my name's Steve Trumble and I'll be facilitating tonight's webinar. I'm on the lands of the Wrung people down on the surf coast of Victoria, and I'm a GP by training, but I've been involved in medical education for way too many years. This is the fourth webinar in the series that have been presented on behalf of Comcare. It's been a fabulous series. The other webinars are in the MHPN Webinar library. If you've missed any of them and want to catch up, there really have been some wonderful evenings, so please do that.

(00:59)
Now we've got a great panel again tonight. Their buyers have been circulated with the webinar invitation, but I will just run through and explain who we've got tonight. Firstly, we have Catherine Ketsimur, who's a physiotherapist from Queensland. We have Professor Michael Nicholas, who's a psychologist from New South Wales. We have Dr. Irina Hollington, who's a pain specialist and anaesthetist from South Australia. And for those who are expecting Erin O'Donnell, we don't have Erin O'Donnell, but we do have Melanie Ianssen from

Australia Post where she's the head of rehabilitation. Unfortunately, Erin couldn't make it at the last moment, so Melanie has thrusted herself in, which is fantastic. So welcome everybody. Now just to meet each of you very briefly, Catherine, let's start with you. Physiotherapy. My daughter's a physio, so I'm asking this with a vested interest. Why is it important to send patients to a pain physiotherapist compared to a physio who doesn't practise particularly in the area of pain?

Catherine Ketsimur (02:05):

Thanks, Steve. Yeah, it's not well known throughout the community that there is actually a difference between a pain physio and other physiotherapists. The main difference is that we would use what we call a psychologically informed management plan. So looking a little bit more at that whole bio-psychosocial model and looking at the environment in which people are working. We don't tend to do as much hands-on therapy. We'll still do a lot of rehab, but much more working in the sphere of education and pain management in that way.

Steve Trumble (02:40):

So not as much manipulation as in, I guess helping people find their own solutions. Great.

Catherine Ketsimur (02:46):

That's right, yeah, definitely more about self-management, almost coaching them through what they need to do to help themselves.

Steve Trumble (02:54):

Perfect. Alright, great. Thanks for that. So now Michael, you are involved in university in various training courses. I'm just wondering in those training courses, what's the most common myth of our pain medicine that you bust with health professionals who you're teaching? I think we can't hear you.

Prof Michael Nicholas (03:16):

I've got my, one of the most common is people treating or believing chronic pain is the same as acute pain and therefore they keep trying to kill the pain and attack the pain as a target when our treatments don't really work very well for relieving pain when it's chronic. But what we've got to move to is improving function when pain is chronic and that's a big mistake people make and that's where you get over medication, over reliance on passive treatments. They're actually aiming at the wrong goal or wrong target. They need to look at how can people function despite their pain.

Steve Trumble (04:01):

It's really important. Michael, that's actually been a very common question. People have been asking in the lead up to the webinar about what role pain plays in telling us what's going on with the person and their condition. And I guess if we're just blunting it with opiates, we're basically removing that form of communication. Looking forward to hearing much more about that. That's great, thank you. Now Irina, a pain specialist and anaesthetist and you've done a lot of your training some years ago now I guess in Germany and Switzerland. What's the major difference between the way you approach pain management in those countries compared to here in Australia?

Dr Irina Hollington (04:37):

Well, some things are the same, some things are different. So I guess they've got a different funding model in Switzerland and Germany where many payers would be a combination of Medicare and return to work system. So if we look at Australia Post, they probably would have their own Medicare system. The other thing that's really important is culture matters, so you need to pick up people in their belief system. And the Germans have traditionally a really long integrative medicine approach with homoeopathy and acupuncture playing a big role and they've also got a much higher emphasis on rehabilitation than we would fund through the Medicare system.

Steve Trumble (05:18):

And I just need to ask very quickly, Germans seem to have a lot of words for very unique things. Everything hurts on the end. Are German speaking people a whole lot better at describing their pain symptoms than those of us that speak English?

Dr Irina Hollington (05:33):

No, I don't think so. I think it's just a cultural thing that if you put enough nouns together, you can make one really long word out of it but it doesn't change the meaning.

Steve Trumble (05:41):

Okay, good to know. Thanks for that. I'll be more comfortable. And finally, Melanie, now managers are important obviously in the prevention and early intervention in a workplace, but who else on the team is important at your particular workplace?

Melanie Ianssen (05:58):

Look, you can't go past the work of being at the centre of everything. And I think so much of the research in this area speaks to self-efficacy being one of the highest determinants of a successful return to work. So how much control people feel like they have over their recovery. So in general, I would say it's crucial to have the GP support, but I think it's really important to be asking the worker who's really important within their sphere

and including those people in the recovery and return to work discussion because if people feel like they've got some control over the process, they're much more likely to have a successful outcome. So that might be a spouse, it could be their manager, it's pretty much always their GP and obviously I'm super biassed that the workplace rehab providers are really crucial person in that process.

Steve Trumble (06:53):

Absolutely. Alright, well great to hear. There's a team involved. Always works better when there's a team working functionally, so fantastic. Well it looks like we can hear everybody, which is great. And we've got all of you're really well-informed for tonight's panel. What's going to happen tonight is that each panellist is going to give a short presentation specific to their discipline and then there'll be questions and answers and discussion amongst the panel, which is where we really get down to the interesting stuff as well as the presentations from the participants of course or from the panellists. I won't go over the learning outcomes tonight, they've been circulated. Hopefully you know what to expect. And these are what we want you to evaluate the webinar on afterwards. So please make sure you're comfortable with that. But just to make sure you understand the aim of what you want to do, tonight's about chronic pain and also how we can help people with chronic pain to participate in work that benefits their health and wellbeing and the rest of the outcomes are there for you to see. I also won't be summarising the case because you've had a chance to read that as well. That's a woman obviously with fibro fibromyalgia, not caused by her work, but obviously having a big impact on it as far as we know. So we're going to hear from each of our four experts, five minutes each and we'll start off with you Irina Hollington please.

Dr Irina Hollington (08:17):

Alright, thank you Steve. Well, I guess we start with the first slide. I really like this quote from Brown that behind every chronic pain patient is an acute pain patient who wonders what went wrong and in Emma's case, she's got a history of widespread pain, is single, working away from where she grew up and feels quite unsupported and that whole situation is getting really stressful. Now it's important. Next slide. It's important to recognise that there is a difference between acute and chronic pain as Michael Nicholas said right at the start, comparatively acute pain is simple and everyone knows about this because we all had painful experiences in our life, we usually define it as less than three months. And the role of it is that it is an alarm system that helps us to protect tissue from further injury. It comes with physiological responses that adopt to the environment and to the stimulus that has happened and it some response to the brain due to the unpleasant physical and emotional experience.

(09:19)
So the way it's really simple when we, most of us are born with pain senses and we learn to respond. So very simple example would be if you look at toddlers when they start walking, they first start running before they learn, by falling over and hurting themselves that they need to slow down and it takes quite a while for them to get used to this adopted behaviour of movement. And so I guess that's the important bit to understand. It has a big relationship with our learning and our memory capacity and hence pain is in that sense really important to progress and go further forward. Now only the patient knows what this pain feels like because

everyone's got different experiences. Next slide please. Now taking that is when we say there's a chronic pain trigger that has persisted for a longer part of the time and in this time the brain, the different parts of the brain, the emotions, the memory, the learning, the location, what is happening, where in which part of the body and also the assessment that comes out of that, that's located in the frontal part of our brain that tells us how important is this information makes this a response, which not always, but if provoked often enough over time can result in pain.

(10:45)
So a very typical story from acute pain, minimising all those things is when we hear stories of people having massive car accidents and horrendous injuries and being able to pick up their broken limbs and walk quite a while and only when they come to a place of safety and they get care and they realise that they are now safe and then the brain lets the stress response take over and they completely collapse. And so in chronic pain we don't have that feedback mechanism that stops because we get triggers all the time. Next slide please.

(11:20)
Now out of this is really important that we look into things from a very comprehensive side of things because if we are only looking for biomedical contributions to pains, so story, we may be running some blood tests, we may be looking if there's some joint involvement, we completely take out the whole processing part that the pain brain has, which is what's happening psychologically, what's happening socially because we obviously change our life according to the pain experience we're having. And so assessing where people are is a really important part of finding out what is bothering them most because sometimes the anticipation of not being able to do something makes our performance go down significantly. And that is really stressful. And as we've already established, Emma is in a quite stressful position. So focusing on treating a acute pain leads to the common side effect that she's experiencing where she's using a variety of medications to address pain, sleep, and mood.

(12:19)
And as a combination of all those things, she has a lot of side effects from the medication and is feeling rather groggy instead of getting extra help in how she's managing this in her workplace. And so that's where the faculty of pain medicine, that's the peak body for doctors in Australia that sort of guides how you approach chronic pain management is really emphasising to address, see the patient as a whole and look at all those things. So that means active listening, finding out what is relevant to Emma, is it her family, is it her workplace? Where can we address the social isolation that she clearly seems to be struggling with and what do she think she'd like to do because there's no point telling her to do some movement therapies if she wouldn't want to go into the swimming pool as she's chosen in the end.

(13:05)
So it has to be specific, it's important to listen really carefully to the story and allow people to let things off their chest. And that may take longer than one appointment for many doctors and it's really important that you sort of take a stepwise approach. There's no point in rushing things. It's taken quite a while for the pain brain to get into that state where it doesn't quite know which way to turn and there is no rush. And equally

there's no rush fixing things quickly. However, it is important to come up with a plan and work together towards achieving a few goals. Next slide.

(13:45)
Now when we think like a detective, it's not just down to a medical practitioner, the whole environment plays a role because there is a small contribution to making life for Emma better from a variety of positions as we can see in the case, sorry. And so it's important to sort of reach out who's there? Is it family? In Emma's case, maybe not, but maybe there are friendships build a team of supportive doctors, psychologists, healthcare professionals, but also support staff from work and maybe pharmacists around her to make sure that that interprofessional team can reen enhance the message of focusing on what's relevant to Emma and coming up with solutions that feed into each other and augment each other. Next slide.

(14:37)
So what's important to understand is that grand pain management is different to acute pain management. It is not just medication, not just procedures and interventions that may play a role in it, but it is only one of approaches. It's really important to individualise the pain treatment and to take the cultural background into account. So as we spoke at the start about the differences between my culture of origin and where I'm living now, it's important to use multimodal approaches and that means reaching out and including the other specialists that will talk after me. So physio psychology, pain education are really important and if we are looking into taking medication, it is important to combine a few things at the lower dose rather than using one medication only in a really high dose. We do know that they augment each other and you reduce side effects. The final thing is that things that affect the ability to process pain and come up with different pathways of managing it is not affected by medication. If I struggle with memory and concentration and motivation and I can't keep my eyes open, it's really hard to engage in other therapies and see a way out of this. And so from a medical perspective, I think our role is often to build that interest and provide that education and then support with rationalisation of medication that the right amount of medication is given to the patient so that they can explore those other treatments that really work towards their goals. Next slide.

(16:18)
Okay. I guess the one last thing I want to say is if you find treatment becomes passive, and that might well be that it wasn't the communication or it wasn't the goals that the patient found really helpful in this consultation. If there is an accumulation of missed appointments, if the medication goes up and mood gets worse, despite all those medication changes, if the pain doesn't get better despite all those medication changes and if there is additional conflict coming up, that's when we have to be particularly mindful that things aren't going the right way and we'll have to have that time and careful listening to provide avenues for the right treatment at the right time. Next slide. Alright, I'll hand over to Michael.

Steve Trumble (17:05):

Fabulous. So thank you so much Irina, and you've touched on many things that people were asking about his questions before the webinar, so we'll talk about some of those things later on in the discussion. Thanks for your presentation now. Now we're moving on Now to hear from Michael and I guess it's quite likely that the

GP would've made a referral as was in the case to a psychologist. So thank you for telling us your perspective, Michael.

Prof Michael Nicholas (17:34):

Thanks Stephen. Firstly, it's important to clarify what the problems are that she has identified or she's concerned about and there's a list here that you could get from her account. So next slide. And we should also review what treatments has she been having so far. And you can see, as I said, multimodal treatment is most common for chronic pain conditions and you could see that she's having a number of treatments, but what I'd be concerned about is how coordinated are they? So next slide. If we look at the recent guidelines from the US about managing or helping people to manage chronic pain, these are the key points that they have identified and you can download this account, as you see is taking us individualised patient-centered approach. So not a one size fits all. It's also focusing on outcomes that really functional in nature rather than simply trying to reduce pain scores.

(18:49)
Quality of life is important, no doubt if someone's leading a healthy lifestyle, they'll be much less troubled by their pain. Of course, working in this area is not a matter of just dolling out a treatment, it's actually working with the person and we call this collaborative care or a therapeutic alliance needs to be established with the patient because they've actually got to do the pain management. We don't really do that. It's done by the person in pain. As I said, a multimodal approaches widely recommended taking a bio-psychosocial model of care, looking at the biological, the psychological and social environmental contributors to this person's problems. So that means an assessment along the lines that we've just been hearing about and of course we want to minimise adverse outcomes. Next slide.

(19:43)
Now one way I've found that's quite helpful in confirming with the patient that you've listened to them, you've heard them, is to draw it out on a piece of paper, the sort of experiences they've had and the linkages that you start to see between a lot of those problems are listed earlier. So often with musculoskeletal pain there might be some nociceptive mechanisms leading to pain, but over time there'll be changes in the central nervous system and immune system. And these often manifest through things like sensitization where positions or movements felt as painful when they wouldn't normally be painful. So we've got more contributing to the pain than perhaps where it started. And so we need to think more broadly as Irina said, and this is really what is happening with chronic pain as far as we understand today. But in turn the pain affects activities, people stop doing things and next slide please.

(20:48)
And they've become unpredictable. What's going to stir up the pain? So people often start to avoid activities in case they're painful, they may develop unhelpful beliefs and worries about what's going on and why can't they fix my pain? The treatments fail or don't deliver what the person was hoping for. And this is a recurring let down. Some of the treatments themselves will be taken long-term and they as well may well actually have adverse side effects. And that can become a problem too, as we've seen with the problems with things like

opioids and benzos, the impact on a person in this case, Emma's loss of work, financial stress and so on that we could see that's all part of her life, but it's all going on in a context. So next slide.

(21:40)
And so what you see is an impact on physical functioning. She's likely to put on weight because she's not doing as much and then anything she does do will stir the pain up because of the less activities. She's going to start feeling more depressed, she's reporting more sleep and we know that poor sleep is associated with worse pain and that gets into a vicious cycle. Lethargy contributes as well. But all these things are linked together and I think that's the important thing with this sort of diagram with someone like Emma is just drawing it out from her account. Next slide. But it's also then important to draw it all together because it's all going on in this one person and it's occurring in a context and I've listed the sort of things we could see in this description of living alone, minimal family support and so on.

(22:32)
So it's important to acknowledge those and once you've done this, you can then check with Emma, have you actually got it right? Is this really what's been happening? And because it's all come from her, that's very likely she will agree. Next slide. So once you've got that agreement, then you can say, well, what might we do about it? And there are a number of options that can target all of those elements. And so rather than just throwing a whole lot of stuff at Emma, what we need to do is work in a selective way, identifying things that might help. There might be some exercises, it might be relaxation, it might be some medication, some education, so on. But explaining to her where they all fit in, why some might be best addressed with a psychologist, other parts by physiotherapist and so on to help Emma make sense of the treatment plan. And finally, because it's a chronic problem, it's not a new problem, we need a maintenance plan just like you do for other chronic conditions. And so these are the strategies we can help her with. So this is a way of integrating things in a way that will make sense to Emma and she can take away with her.

Steve Trumble (23:45):

Thank you. Right. Thank you so much Michael. I've been jotting down questions here from what people are already asking and we are going to cover those when we get there, but certainly we need to talk a bit more about how to approach the person who has fear of their pain getting worse if they do things. So we'll circle back to that as they say in the classics. So thank you so much Michael. And now the next slide I think we'll move on to Catherine. Here you go. So the pain physio and already the questions been asked, Catherine, where do you find pain physios? But we'll talk about that.

Catherine Ketsimur (24:27):

Thank you. Yeah, there are more and more of us out there. They are sometimes hard to find though. I definitely agree with you on that one. From a physiotherapy point of view, the main thing that we find people have a challenge with either getting back to or remaining within their workplace is the pain itself that's central to their experience and that's central to their fears and worries and what they can and can't do. So they're concerned that their pain will get worse or that their pain will stop them from being able to perform. So

they're looking at their own task and environment. What kind of tasks do they have? For Emma, it's very much a seated type environment, but she's also going to meetings and there's things such as the amount of time she needs to spend on those that will be limited by her pain.

(25:16)
Unfortunately, once you get into that cycle of reduced activity like Michael was showing in his formulation, your strength will go down, your fitness goes down and your actual joint mobility as well. So you become less physically able to do certain things that then compounds the pain problem even more. You're also looking at expectations. So what does the employee themselves expect? What do they want to be able to do? What would they like to be able to do and is that realistic? What is the employer expecting from them as well? And then ask this physios, what's our part in this whole picture? What is everyone else thinking? Okay, this would be good if we could achieve. And that's where you need that collaborative model so that everyone's on the same page. One of the things obviously a few people have touched on is their fear and one of the big fears is around the pain itself and them actually worsening it by going back to work.

(26:10)
So the degree of self-efficacy and confidence they have can be very challenging when you're looking at helping them with their work. Next slide. Thanks. So from our point of view as a physiotherapist, we're obviously in the remit of looking at the more physical elements of the client, but we can't look at that in isolation. So you've got to look at the condition that they have, what are the biomedical aspects of that condition, what do they need or want to be able to do as far as activities, participation in not only work but outside activities as well. What are their social things that they enjoy? What's the general environment in which they're working and living? And part of that is the personal factors. So their own internal environment, what's their general health, what's their psychological and emotional health? What kind of coping facilities do they have? So there's all of these things that we need to take into account. So as a physio, if you focus purely on the physical, you're going to miss a lot and you're not going to achieve what you're aiming to achieve. Next slide. Thanks.

(27:21)
So some of the things that we really need to look at as physical therapists is what is our knowledge of the job and what they have to do. So sometimes this can involve something like a workplace visit to actually have a look at the environment and look at what they're doing, how can we break tasks down, how can we give them the appropriate rehabilitation so that we're helping them really achieve their goals from them personally and not just in a very general go and do these exercises kind of way. Unhelpful beliefs can actually be practitioner beliefs as well as employee or employer beliefs. Things like I can't do this because it will make my pain worse. And the special strong belief that we really need to work on getting the message is that pain is not harmful to them and that's that change from the acute pain model into the chronic pain model is that it's okay to do things with some pain.

(28:17)
Okay? Communication is one of the big things I find when we are looking at either remaining or returning to work that all members of the team need to be involved in this collaborative model so that basically we're all

giving the same messages and everyone is aware of what's happening every step of the way. It's really important that everyone is aware of what the patient's goals are and how we can all contribute to helping them achieve those goals. Lack of engagement can be difficult and there's many reasons for lack of engagement I find generally the main one is fear and people's fear around if I do this, will I hurt myself or will they take benefits away? There's lots and lots of reasons for them to be fearful and that sometimes causes a lack of engagement from the patient. Also from employees unfortunately at times or employers, sorry at times is that they may not be willing to make adaptations that are necessary or to help the client get back to where they want to be.

(29:18)
Obviously then every other aspect of that person and their whole being is important. So their mental health, psychological, social and any other factors can obviously contribute. And as a physical therapist or a physiotherapist, we need to be aware of those. Obviously some of those things are outside of our scope to manage, but our awareness and our contribution to either asking for help from other people or making sure that they are getting that help from other people advocating for them is really something that we need to make sure that we address too. Next slide. Thanks. So risks and opportunities. Of course there are risks with returning to work and that's obviously one of the big things that people are concerned about from both viewpoints, the employee and the employer. What happens if, does the pain get worse? Are they going to cope? Can they do what they need to be able to do?

(30:16)
Obviously all of these things can contribute to increased stress, poor sleep and a failed return. However, if these things are managed well, the vast opportunity and health and wellbeing benefits from returning to work are huge. One of the things I find is having routine and purpose is really beneficial to someone. So helping them be themselves and be the best themselves they can be is obviously financial reward from being able to work. And then there's all the physical benefits from moving more, being fit, being stronger and being able to engage in not only the workplace but also in their social and whether they have other community things that they're involved in, sports and things like that. So hugely beneficial and the risks will only be there if it's not managed well, next slide. Thanks. So from a physiotherapist point of view, the main thing firstly is really making sure we get a thorough and holistic assessment.

(31:21)
We use evidence-based outcome measures, things like the short form Aribo is one I use all the time, and the patient specific functional scale is also a nice one. It allows 'em to pick three to five functional tasks and rate that on a scale of zero to 10, how they can do it now. Then that's just used to repeat and review and say, are we on the right track? Are we achieving your goals? We need to make sure that they're attainable and collaborative goals for everyone. And that from a physical therapist point of view is that we're using psychologically informed management. So from a practical point of view, one of the things we do is a lot of education and that might be based around pacing. So how much can I do at any one time? Do I need to have a break? Do I need to change tasks and so on.

(32:10)
Problem solving, if this happens, what do I do? So if I'm at work and I'm sitting down and I get pain, what do I do to manage that? And flare up planning is obviously a big part of that because most people with chronic pain will have flare ups from time to time. Early return is really important. Getting people back into that structure and routine and making sure that any adaptations and adjustments are made. From my point of view, I find task practise really important. So figuring out if they can do things and if not problem solving through how they can do differently and still achieve the outcome. Main thing is to give them the tools that they then put in their own toolbox to help themselves so they can independently manage in feel the confidence that they can get back to work or stay at work without needing someone else to hold their hand. Although obviously you want to give them that support, but eventually they need to go out and keep looking after themselves. That's it. Thank you.

Steve Trumble (33:16):

Lovely. Thank you so much Catherine. And I think a few people have mentioned that the video's frozen for them. I think if you're on a crummy connection like me, you might need to refresh if the slides are not advancing, just refresh and come back and it should pick up from there. So last but by no means least to the employer side of the table and we're going to hear from Melanie about Australia post's rehabilitation approach.

Melanie Ianssen (33:46):

Thanks Steve and appreciate the opportunity to speak about this from the employee's perspective. Probably one of the great things about being the last speaker is some of the themes that have come through from all of the speakers definitely ring true from my perspective that bio-psychosocial holistic approach to injury management and recovery is definitely the linchpin by which we run our rehab programme at Australia Post. I guess addressing specific case study, we've got a few things jumped out at me. Some things were obviously done really well around definitely the employer's response you would say would be gold standard. And from a pain management perspective, it looks like all of the right avenues were followed. For me there was a few things missing where from that biopsychosocial response where from an activities of daily living perspective, what's important to her, what gives her joy and meaning and purpose.

(34:49)
We know that she's disconnected from family, we know that she's had to move closer to work. And so I think it's really important to look at the whole person and not just look at the barriers. It's really easy, particularly in occupational rehabilitation to really focus on return to work barriers and all the things that have gone wrong or can go wrong and not focusing in much on what those are, return to work enablers, what motivates someone, what gives them joy to help reduce some of the more stressful parts of managing an injury and recovery. From Australia post perspective, we've got an in-house rehabilitation model and we very much believe in the health benefits of good work. Obviously we're medically appropriate.

(35:45)
If you could jump to the next slide, I'll just introduce you to a study we ran with Professor Michael Nicholas actually, and we looked at using that short form rebo that was just mentioned within seven to 10 days of someone having an injury. And the research that Michael introduced us to really told us that a score of 48 to 50 or above was indicative of someone who might go on to have some mental health challenges as a result of their injury. And so we ran a study for 18 months with Professor Nicholas around looking at putting some match care protocols together for people who scored in that high risk range and looking more at those psychosocial issues that might cause barriers to return to work, but also barriers to recovery. Workers' compensation particularly loves to push people down a particular medical model and that's not always in their best interest in the long run.

(36:49)
We put a few simple things in place. We offered counselling right at the beginning of the process, so one session a week for six weeks and after the first session we had a case conference. So as everybody else has mentioned, that importance of everybody in the process working together. So the counsellor, the worker, the rehab provider, and the doctor, we'd have a meeting together after that first session with the psychologist and put together a match care plan that looked at what the barriers were. And what we really tried to do as an employer is not just focus solely on what we can do from an employment perspective, but look at how we can assist with any issues that someone's having as a result of their injury. One example that came up a few months ago, which I really particularly liked was we had a gentleman from a Mediterranean background and he was in his early sixties and he was in quite a serious motorbike accident when he was delivering and he had a shoulder injury that was going to take six to 12 months to recover from.

(37:59)
His arbra score was absolutely through the roof as was his das and a few other markers. And he was really struggling with his recovery and with the efficacy of his treatment. After that first session with the council when they had the case conference, it came up that he had a small plot of land with his house and within the next few weeks he needed to plant crops that he planted every year and he gave vegetables to his whole extended family and that was a really important part of his identity, his purpose and that real sense of family, which was really important to him. And if you sort of miss that deadline, then that's something that he couldn't do that year and it was actually really distressing for him. And so we decided to pay to get a specialist gardener to come in, it cost us about $400.

(38:51)
It was a one day thing and we got all of that planted for him and it was amazing. Within a week he was really open to return to work discussions, his anxiety scores came right down and I think he felt quite heard and really it was quite simple for us from a rehab perspective, but it's I guess something we wouldn't traditionally have looked at from mock rehab. But that importance of really listening and bringing everybody on that journey and he went on to his treatment was a lot more effective. All of his scores came down quite significantly. So that's what we're really trying to do, but really focused at the front end as much as possible. So not waiting for things to escalate and get worse and really trying to take a preventative approach, quite a

simple that match care process is quite simple. And this 18 month study we found on average people in the intervention group as opposed to the control had about a 35% improvement in their mental health outcomes.

(39:56)
They returned to work to their pre-injury duties 51 days faster than people in our control group and they had 44% reduction in capacity costs. And I'm a big believer that if you focus on quality rehab at the beginning, you don't actually have to really focus in on your costs because really they'll come quite naturally from there. So really that's our approach to rehab now is to try to identify who's likely to fall into that cohort early on and put a management plan in place rather than waiting years down the track and then sending them to Paul, Michael Nicholas and saying he's a pain management referral. We don't know what else to do. You're our last hope. If you could just go to the next slide.

(40:50)
So for this particular case study we're looking at, we probably would look at something like an ergonomic assessment. The workplace adjustments have been addressed. I do wonder the worker brings up early on that she thought she might go and then that was a little bit glossed over and the employees, well if you can work more hours, just work more hours. And I do wonder whether that may have been a better outcome and I think that's something that you would really want to talk through with someone when she says, I want to go part-time, was that something that might've allowed her economically? If she could have done it, maybe that would've been a better outcome. Maybe she would've had some time to focus on some social interactions, doing some hobbies, some things that might've been beneficial from a pain management perspective. Obviously if she was really distressed by it and couldn't afford it, that would be different, but I think that's probably one part of the case study.

(41:47)
I thought, well that might've been something, especially from an employer perspective just saying not a lot of employees are going to be able to say just work more when you can work more. And if they do, that might be something over time that's not sustainable. So I think that's something maybe we could have fleshed out a little bit more. The collaborative return to work. Look, it's been the theme through everybody's presentation today. That importance of everybody within the process talking to each other and working together. And for us coaching and educating line managers just such a crucial part of the process. It's one thing for rehab to come in and offer lots of support and lots of services, but if you've got a manager who you've worked with for 20 years and they make you feel like they're not believed or that you're malingering or they're not showing you that care, that's always going to have a much more impactful impact on someone.

(42:47)
Then rehab, just calling and saying, how are you doing? So we've got some managers who do it beautifully and there's some managers who need their handheld a little bit to say, Hey, can you just give this person a call? Not to ask for a medical certificate, but just really to ask how they are. We have a very long tenure at Australia Post. We have a lot of people who's worked for us since they were 16 and they might get to 60 before they have their first injury and a lot of their identities tied up in work, a lot of their friendships are at work, a lot of them live alone. And so taking them away from the workplace is actually taking away a lot more than work.

It's taking away a lot of support. So if people genuinely can't be at work, we try to do things like if the facility has a barbecue once a month that someone goes and picks them up and takes them in so they're still part of the workplace and have that support network with them because we see often quite quickly that people's mental health deteriorates when they have extended periods of time away from the workforce.

(43:58)
I think I probably hit my five minutes I must. I could go on and on, but I think that's probably me.

Steve Trumble (44:03):

You've done exceptionally well, Melanie. It's always said that using somebody else's PowerPoint is like using somebody else's toothbrush. It does the job but it's not pleasant. So you've done fabulously well, thank you so much. And to pick up on a question that's already come in about your role, do many organisations have a setup like Australia Post with that in-house approach to supporting people that came from Natalie Bartel?

Melanie Ianssen (44:30):

No, they don't. I think within the Comcast scheme, maybe to a smaller extent, a few people have that sort of dual function rehab case manager return to work provider. But yeah, I think we're fairly unique. We've got about 45 in-house providers and look, the benefit from my perspective is they know the physical and psychological requirements backwards of absolutely everything, every role within the business. So our ability to get in there quickly, we don't wait for a claim to be lodged or accepted. We get an incident report through and we try to manage that from day one. But yes, it is quite a unique setup, but I think a good one

Steve Trumble (45:14):

In that case I'll take it to the rest of the panel. And Marla asked a question early on in the presentations, they found the case study a little bit unrealistic in the gold standard approach that you mentioned. What do others think? Is this an idealistic situation for Emma or have you seen it work this well in real life?

Dr Irina Hollington (45:35):

Well, I have to say in South Australia I work quite a bit with return to work as a, and we've done a lot of training with the case managers to exactly Emma emphasise what we've had for Melanie earlier, that you have to start from day one and you have to listen and find out what is it that they need at this moment in time. So really act upon before the baby is tipped out with the bath water. I think it's fair enough to say it is tricky to access all those services, but one of the things that I think we are doing better and better is having just general good pain education out there. So in the places I work when you get referred, you get a whole range of publicly available homepages and resources and often with that I find that people can start tapping into developing the language and the understanding around chronic pain, but also thinking around what they think they need because it's sometimes really tricky when you haven't had access to a concept such as chronic pain and you come with the expectation this is just like acute pain, it's really hard to know.

(46:52)
What do you tell your providers? How much do you open up about your other struggles psychologically within the family, within the workplace place because people tend to want to filter it a little bit and by having more general resources out there, you can start before you see and build your team, think about a little bit, where do you want to go? And I think that's probably one of the most important things we've seen in Australia over the last five years. It's just developing more free resources and having through some of the patient support groups, really good stuff available for everyone that doesn't, an arm and a leg, but that facilitates those first couple of steps.

Steve Trumble (47:32):

That's good to know. And you sort of touched on it a little bit there, but there has been a question that I'm very keen to address because it probably was the most frequently asked question as we're leading into the webinar, which was really about what we do when employers do not seem to be as committed to the workers' recovery or improvement as they might be. What strategies have the panellists found work best in working with employers? And we'll talk about the worker as well next, but with employers who don't seem to be fully on board, it looked like you were going to say something, Catherine, or were you?

Catherine Ketsimur (48:09):

I think one of the things that I've found most helpful is going directly to them and talking to them because often we are getting third party messages via the GP because obviously your GP is your central hub in these cases. Most of these return to work cases and the gps are lovely, don't get me wrong, but sometimes that almost like Chinese whispers is like the messages get lost. So I've quite frequently found that talking directly to them and in fact doing a visit, which not everyone can do, but being able to go into the workplace and to work with both the client and the either direct line manager and look at what tasks are needed is really quite helpful for everyone.

Steve Trumble (48:54):

Great. What about anybody else? Michael, do you ever thought about that? The person?

Prof Michael Nicholas (48:59):

Yes. Well, as Melanie said, I worked with her to develop that study and I think it was quite instructive that I didn't go and say do this, do that. I went and sat down with them and said, well, how does it work at Australia Post? So I talked to the employer and representatives and it was her team and we worked out the steps that people go through when they make an injury claim at work and looked at, well, what we know is we need to identify those people at risk of delayed recovery or long periods of work. A lot of people actually get better quite quickly and there's not a problem. I think we have to identify those who are lucky to have a problem. And that's what she was referring to you by using the screening measure, the O-M-P-S-Q that Catherine also uses that it gives you a heads up on who to really and what sort of issues might be going on with this person.

(50:00)
They can then be followed up with the person to clarify and that's what they did at Australia Post and they organised and it's very individual, they organised responses. So that was I think instructor and another study I did in New South Wales with New South Wales Health with hospital workers. I actually went to each hospital involved and I spent time talking to their senior executives and managers about this approach so that they would support their rehab team, their return to work providers and so on at the workplace. So it wasn't going in once they had a case because the sort of horses bolted, but rather to get in early with an understanding of this approach, which is screening and then responding to that screening. And that's really becoming quite well supported around the world. And SIRA and New South Wales is just trying to implement this at the moment as well, but I think you cannot see these workplace injuries as simply injuries.

(51:06)
They occur in a context, but it's not fair to expect the employer to know what to do unless they've had some preparation and some discussion on options. So that's why it needs, we talk about holistic, but holistic means taking the key people, key stakeholders and the workers' environment into our confidence upfront and then working from there. And so this is a lot of work. The same has got to happen at the insurance end that the claims managers, they need a lot of training to follow this because it's a terrible job being in a claims office. They've got people screaming at you all day. And so they've got I think mental health trouble too, but they need to be part of this plan. And then of course you've got the GPS who are the key, the hub as we mentioned earlier. So you've got to actually take all of these players into account. If you can do it in advance before you have an injured worker, you'll find I think it works a lot better. But

Steve Trumble (52:16):

I'm thinking of the key player too though in particular. Michael, you were, and I think we had that lovely example from Melanie about helping the elderly Greek man with his gardening to get his crop in. Exactly. Anything else you found, Melanie, that in particular you find is helpful on the other side when maybe a worker is reluctant to return to work for fear or as David Elvis mentioned in one of the questions, the stigma of chronic pain and returning to the workplace. What do you do to make it a more welcoming environment?

Melanie Ianssen (52:51):

Look, I think the GP is just so crucial in that process. There's a lot of times where we'll work with the GP to put together a proposed return to work plan and we always make it, we want to set people up for success, so we always make it even a little bit less than we think they can do because we want them to gradually increase. We don't want them to have a stop start rehab process. And where things get a little bit difficult I think is where, and I think to Catherine's point, it's that fear of re-injury or sometimes it's when people haven't had an injury before and I think they start to panic often around, especially when they've had the same job for a long time. If I can't do this, then what will I do? And they get a little bit protective sometimes the frustration of ours is we'll get that agreement from the doctor and then at the 11th hour someone will go back and say to usually their family gp, I've changed my mind.

(53:47)
I don't feel like I can do this. And the doctor will have them unfit really more based on the worker's thoughts rather than the functional capacity of the person. So I think early case conferences with the doctor and sometimes the doctor just needs to see us to see that we genuinely are trying to do the right thing here. We want a safe and sustainable return to work. We are not pushing for return to work at any cost. And I think once they can get on board with that, sometimes there's a role there for them to do a bit of education with the worker around even their prognosis that they're not going to reinjure themselves and to just really not have that period of time away from work any longer than it needs to be because we know the longer that is, the harder it's to get people back. And we don't really want independent medicals at 50 paces. We would rather work with the GP and everyone feel like it's not an adversarial process.

Steve Trumble (54:44):

Oh gosh, that massive conflict that comes in once you do start getting dualing lawyers, it is so unfortunate, but you do what you can. And actually Dina Lancaster has picked us up on not having mentioned families at this stage. What's the panelist's view about the role families can play in supporting people? I mean you might have them in the workplace for eight hours a day or less. What happens in the other 16 hours that people are home with their families? What supports can you offer via family?

Prof Michael Nicholas (55:14):

I think it's the same principle as the workplace that it is case by case and what their role is. Emma described the older gentleman his family situation and it's clearly very important. Emma is rather distant from her family, so they're not going to attend any sessions. But I think it's important where if the workers would, like I'm talking about injured workers would like their family involvement or you detect from your assessment, they could be getting different messages when it's chronic. Often there's a history then of irritability getting angry, frustrated and people reacting to that and so on. And often the spouse is actually probably more depressed than the person in pain. So definitely that they need attention, but I think you can't just assume that will be a problem. Again, you need to inquire in that assessment process. I think I is spelled out the range of things you do need to consider in that assessment. I think that's really a critical thing in this whole process is that assessment as comprehensive as possible. Then doing that formulation to work out what you think is happening, get the agreement of the person and all the players, which could well include family but also employer and then work on this developing a plan whether they can see where each player fits in and that will be much more coordinated than just firing off all sorts of things at them.

(56:59)
Go ahead, Irina.

Dr Irina Hollington (57:00):

Yeah, I think it's really important to sort of see the family as potentially the best cheerleaders you can have in your team. And I guess another aspect to it is that we know that when you are feeling unwell and you're

stressed, you only hear about 20, 25% of any conversation. So I think one of the other aspects is to have your closest and dearest and the people you trust attend joint appointments or review the situation and regular intervals with you. So whether that means they ask for a handout from the practitioners or they attend meetings together as sort of the support person in the background, I think that's a really untapped resource we haven't really spoken about. Then again, it comes also down to you need to make that journey together in your understanding. If you come with an acute pain understanding and it isn't improving and you're now three, six months down the track, if no one has clarified that concept of that chronic pain is more than an acute injury and that all the other things need to be taken into account to turn that Titanic around.

(58:18)
If you don't get that team work happening particularly at home, then it doesn't really matter what we say on the outside. So I think communication is the most important thing and really consistency of messaging. And I really strongly believe that, and I had that in one of my slides. There are a few hall markers where we all can see that things are not going well when medication goes up. People don't want to go to appointments. There is conflict, whether it's in the family or with a case worker or in the workplace. Those are the things where I think we're already seeing it's not going well. We should then just really see what can we step up. And so one of the things I often say is you might not have found the right team yet so extend and there's no point making another appointment with the same GP or the same physio or same psychologist if it isn't working because the person doesn't attend.

(59:17)
It might be time to get someone else onto the team and just sort of see, can we go sideways? Have we not matched this to the understanding and the belief system and the goals of this patient? And just rather than wait until it deteriorates further, really make early on a step and review and regular intervals. And I think that's where caseworkers are often can be a really great resource, particularly if they've had some introduction to the chronic pain concepts that they can really be good and say, okay, this isn't working, so how about we get that person in. I think it carries obviously the difficulty with fragmentation of care and that's again, it comes down to the communication and really having consistency of the same messaging.

Steve Trumble (01:00:07):

Thank you very much. And I do want to pick up on a question that came in earlier and there's also been a further one from Mohan Matala about pain physio. So straight to you Catherine, what happens? How do we know when it's time, when somebody's been using TheraBands for months and not getting any better and things are getting worse, when do we know it's time for somebody to move to a pain physio and where do we find you?

Catherine Ketsimur (01:00:33):

Yes. Well, sometimes the finding can be quite hard. I know when I talked last time we were talking about the Australian Physiotherapy Association having a list, but I'm not even sure if that has happened yet. So generally the best way would be via the pain clinics. So talk to your local pain clinic and ask them who they would refer

to because they will know who's in the area and who they use. So that's one of looking about it. Otherwise, good old Mr. Google is the other way of looking for it as well, but that is limited. Sometimes the workers' compensation themselves, they will have people that they are aware of and can pass that on. So again, it's just talking to people, communication and asking that question. As far as when to refer, I've done some work with Michael on early intervention and the earlier you can pick those things up, the better.

(01:01:27)
We're definitely trying to promote amongst physios that they use something like the ARIBO is a screening tool and then go into that risk stratification. So how likely is this person to be limited by their beliefs or their fears with their rehabilitation? So anyone that works in first contact, I would definitely say get onto the aribo and use that. The questions are very informative even when you pick apart the questions on their own as well. So it's really useful to use a screening tool of some sort. Also a time factor, I guess if someone is not improving as they should, hopefully physios are using outcome measures and if those outcome measures are not driving towards the goals and those goals are not being achieved, then it is time to have that conversation.

Steve Trumble (01:02:16):

Right. Thank you for that. And I'm just wondering very briefly before we start to round up, because the time's just galloped by, does anybody have any thoughts about a CT acceptance and commitment therapy and is that the gold standard psychological treatment or A few people have been asking questions about that. We have had other people asking about hypnotherapy, medical marijuana, all sorts of things. Where does a CT fit? Michael?

Prof Michael Nicholas (01:02:43):

No. ACT is actually just a form of cognitive behavioural therapy. I think you're just better to use cognitive behavioural therapy. It makes more sense to most patients. It's got actually better evidence when it weren't done well. So I think this leaping around from one of these things to another like cannabis or other modalities, is again chasing symptoms. And that's the message we're trying to get across to get away from chasing pain scores, chasing symptoms and focus on function, improving sleep, improving activities of daily living and returning to work in graded manner, working with the employer to create that environment and if necessary, engaging and educating the family and how to support. If you do all those things, what you call it doesn't really matter. There isn't the magic bullet and none of those things going to do this hypnosis again, it's just relaxation. And of course we should all do some relaxation, but you can call it meditation or tai chi. A lot of Asian patients, they already do tai chi, so I would just say keep doing that, but you've got to do other things. But some way of calming yourself down through the day is very useful. The main thing is to use it. And that's what we have found in our research is actually you've got to do things. You can't just have conversations with people. They've got to do things, but so do the people around them and I think that's what Australia Post has demonstrated. Create a system that encourages recovery, then you'll get recovery.

Steve Trumble (01:04:39):

Alright, well thank you to you all so much for those discussions. We will now move to the final phase of the webinar. Don't leave us people because this is a really important part where each person just sums up their final thoughts about this topic and I think we'll start with you Irina.

Dr Irina Hollington (01:04:55):

Okay. Well I think as you've heard from us, acute and chronic pain are different and chronic pain may need to be managed lifelong. The treatment goal is to focus on quality of life and function and do the things that are important to you. It's not focusing on pain scores. To do that, the patient needs to have the chance to build a team around them and to get a really individualised plan related to what they believe and what is important to them, what their cultural background may propose. And part of this should be pain education. So everyone speaks the same language. It should include really good communication between all the team members involved and it is a variety of therapies whether they come from a medical physiotherapy or psychological background.

Steve Trumble (01:05:51):

Great, thank you very much indeed. We'll go now to Michael for your two minutes.

Prof Michael Nicholas (01:05:57):

Oh, two minutes now. Well, I think we can see already where it's all heading and what I said earlier, don't start treating before you've assessed what the problem is or the problems are. So I presented you with a list of problems from Emma, and then we try to look with Emma at how those have developed and their likely interactions, which I call a formulation of their problems. Once the person has agreed to that, which really shows you've listened to 'em. And then that's the first big lesson is you've got to listen to the person in pain that the injured worker must feel listened to. If they feel treated as a number and not taken account of, then you've lost them and takes a lot of work to get back. So start off by treating them with respect and listen to them, but also show you've listened to them.

(01:06:56)
And that's why that diagram I call a formulation is very helpful. They can take that home with them and show their partner or their spouse what we are doing. And it's not about a diagnosis, it's about all these things going on, but things that we can do something about. So that gives them a sense of hope. And so that's the next big thing is to show them that there's a reason to hope here because we may not be able to cure their pain, but we can definitely help them gradually increase their level of activity. They can improve their sleep, they can improve their depression, their frustrations, they can get off unhelpful medication and they can get back into doing the things they like to do that gives their lives meaning. And if we work at that level and not medicalize the whole thing, then I think we've got a chance. The evidence is, as Kat said, the earlier you do this and Melanie showed you can do that within a week of the injury, you can make a start, then you'll avoid a lot of these problems. So prevention really is an option and as there are no cures, once pain becomes chronic.

Steve Trumble (01:08:08):

Thanks for your input, Michael. Great. Now we'll go to Catherine your final two minutes. Thank you.

Catherine Ketsimur (01:08:15):

Yeah, from a physiotherapy point of view, I think the main thing is to remember that the person in this case, Emma, doesn't exist in a vacuum. There's all the rest of their life going on around them. There's all those internal things that we've talked about, their psychological and emotional health as well as their physical health. So we as physios need to make sure that we look at the person holistically and don't just focus in on the physical or the biomedical elements of their care. Communication is probably the biggest thing, as everyone else has said, making sure that we as a team that is supporting this person, are all talking to each other, we're giving the same messages and that we are consistent in making sure we support them and help them get back to what they want to do. I think that thought of the fact that they don't just exist at work, that outside of work, there's so many hours in the day and there's hobbies that they like to do, there's sports, there's activities, there's other important people in their lives and all of that needs to be taken into account and to be helped to get them back to their normal selves.

Steve Trumble (01:09:23):

Great, thank you. Thanks for your input tonight and we'll finish up it again with Melanie.

Melanie Ianssen (01:09:30):

Yeah, just wholeheartedly support everything that's been said before me. I think prevention rather than cure always the early intervention we know is just so important and I would for us, we've just tried to take that concept not within the first couple of months, but within the first couple of days. And for us to really not focus on rehab or recovery by numbers. Really trying to take that bio-psychosocial approach as Catherine just said, of how's this impacting the whole person? And I would love to have got the case study a little bit earlier, especially before they moved away from their family and all their social supports to see whether there's something we could have done differently there. So for me, the key takeaways from what everybody said is just that vital importance of early intervention and looking at the person as a whole and trying to work together and not in isolation to assist people. So I think it's all been well covered, but I definitely agree with all of my fellow panellists.

Steve Trumble (01:10:33):

Thanks, Melanie. Thanks again for filling in a short notice. You've been wonderful tonight. Everybody's been wonderful tonight. It's been really informative. I've learned an enormous amount. You've stuck to time, which has been fantastic. Just a few things to do before we finish up. I realise I probably should also make an apology. I've been having camera problems and I look like I should be going out to dinner in Canberra tonight. I'm all incredibly red in the face, but I'll try to get it fixed before the next webinar. I promise. Please do

complete the exit survey and provide feedback to us so we know what has met your needs and what hasn't. We've probably had more questions tonight than I think any other I've been involved in. There's been lots that have come in. I'm sorry I couldn't get to them all. You can click the banner above or scan the QR code that will come up in a moment when we get there.

(01:11:23)
There it is to go to the SurveyMonkey, which will be at the end of the webinar as well. If you want to know more about Comcare, then there is a Comcare website that you can go to. comcare.gov au URLs are never all that imaginative. It says what it is. So that's where you'll find information about Comcare. The next webinars at MHPN have identifying and treating Acrophobia, which is coming up on Tuesday the 19th of March seven 15. And also in the Emerging Minds series navigating cultural differences. And that actually did come up a few times tonight. We didn't get to it in any great detail. But culturally responsive practise supporting families, that's on the 25th March at seven 15. Please don't forget m mh PNS Networking Programme, which supports practitioners to meet and network with others in their local community. There are more than 350 across the country and the websites there that you can visit to join your local group.

(01:12:20)
And if you want to start one up rip in the emails there that you can get in touch and get supported in setting up a group of your own. Before I close tonight though, and I do acknowledge we haven't had somebody specifically with lived experience on the panel tonight, but hopefully we have considered the importance of that person as being the centre of everything we do. I would like to acknowledge the lived experience of people and carers who have lived with mental illness in the past and those who continue to live with mental illness in the present. So please do complete the evaluation for us and thank you to everyone for your participation this evening. Thank you. Goodnight. Bye.