



What is Persistent Pain?

Pain is classified as persistent pain (or chronic pain) when it has continued beyond normal healing time after injury or illness and occurs in about 20% of the population. Persistent pain is a condition in its own right because of the changes in the nervous system unrelated to the original diagnosis or injury, if there was one.

Consequently, for this group of people, their persistent pain can be characterised by ongoing pain, as well as flare ups in pain; depression, anxiety, stress and sleep difficulties can become significant issues, as can fear of engaging in activities due to a fear of an increase in pain or fear of re-injury. As a result of this low mood and activity avoidance, the person can become physically deconditioned and find it harder to cope with everyday activities and common stressors.¹

Sometimes people can get 'stuck' in a medical 'merry-go-round' of treatments in the search for a cure for their pain, when there may not be a cure. This can lead to feelings of hopelessness, despair, depression and anxiety. The combination of pain and psychological symptoms can create a negative or perpetuating cycle.

A few key things to keep in mind with persistent pain are:

- A person's report of an experience as pain should always be respected. It is always real and it is impossible to prove whether someone has or does not have pain.
- Pain is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors.
- Pain is influenced by many past and present factors, as well as the physical injury.
- A range of psychosocial risk factors that are present soon after an injury can increase the likelihood of pain becoming persistent. These can include increased anxiety and depression, poor expectations of recovery, sleep disturbance, fear of pain relating to further damage and avoidance of activities.
- Early identification and addressing of psychosocial risk factors can lead to earlier recovery.

Best practice management in line with the clinical framework

Persistent pain may not be one single condition, and may originate from a range of injuries, however the principles of managing persistent pain are as follows:

- A comprehensive assessment needs to consider the whole person by assessing the biological, psychological and social (**biopsychosocial**) factors in order to develop a coordinated treatment plan.
- Utilise a multi or interdisciplinary approach by involving medical pain specialists, psychologists and physiotherapists who have specific training in the management of persistent pain.
- Exclude red flag conditions (such as fracture or other conditions needing immediate attention)





- Appropriately evaluate treatments, procedures, and trials of medication for persistent pain to ensure they are **evidenced based treatments** that lead to measurable sustained **functional improvements**, otherwise they should be ceased.
- Treat comorbidities which may be impacting on the person's ability to manage their pain – these may include depression, anxiety and medication dependence.
- Ensure the person with pain is actively engaged in their recovery, including discussions regarding any new treatments such as a multidisciplinary pain management program, and that treatment has a focus on **self-management**.

Treatments recommended for persistent pain

For any treatment to be considered effective it needs to result in a reduction in symptoms and an increase in function.

Medications

- A range of medications may be appropriate, including Paracetamol and Non-steroidal anti-inflammatory drugs (NSAIDs) such as aspirin or ibuprofen. Anti-depressants and Anti-convulsants may also be appropriate in reducing pain. Opioids may be considered but only for short bursts (from several days up to two weeks). Benzodiazepines are considered to be unsuitable for long-term use with people with persistent pain.^{1,2} The role of medical cannabis remains undefined at this time.³

Multidisciplinary pain management programs (PMP)¹

PMPs usually run one to three times per week over 6-12 weeks. They can be delivered in an individual or group based setting depending on the individual. They can involve education sessions from different clinicians, medication reduction or cessation plans, exercise programs, graded increase in function, relaxation, sleep strategies and cognitive behavioural therapy. Importantly, they require active engagement on behalf of the person with pain in order to learn and practice new skills and the worker's readiness to make changes needs to be regularly assessed and addressed by the treating team.

The aim of PMPs is to increase function (within personal, domestic, work, social and leisure activities), reduce pain and reduce distress and there is good evidence supporting their effect. *Improvements can be expected during and immediately after the PMP, and continue to occur following a program as the strategies are continued to be implemented.* They should aim to increase a worker's confidence to effectively self manage their persistent pain without the need for ongoing treatment.

Interventional procedures

Injections of anaesthetic and/or steroid, radiofrequency denervation (see [Clinical Guideline](#) – Diagnostic Medial Branch Blocks and Radiofrequency Denervation) and neurostimulation device implantation are all forms of interventional procedures. Injections are expected to have an impact in the short term (weeks), radiofrequency denervation over the medium term (months to a year) and neurostimulation over the longer term (years). The evidence for and effectiveness of these procedures varies greatly. These therapies should not usually be considered in conjunction with a PMP or in the 6-12 months following PMP.





Psychological therapy¹

Targeted psychological therapy (**Link to policy on 6 sessions**) focusing on addressing identified psychosocial risk factors soon after an injury (in combination with an active rehabilitation approach) can reduce the likelihood of developing persistent pain, disability and distress in those identified as high risk.

Some people may benefit from seeing a psychologist to address sleep issues, grief, adjustment to changed functional capacity, managing emotions, including depression and anxiety, addressing anger and injustice beliefs and communication and conflict strategies. This may occur within or separate to a PMP. Some people may also benefit from having some additional psychological therapy following a PMP to assist with adherence to the behavioural changes made during a PMP and further develop skills and address barriers to recovery.

Exercise therapies¹

Exercise and activity are key strategies in a PMP. Following the program there may be some benefit in the person independently attending a pool or gym. There may be benefit in some periodic reviews with a physiotherapist or exercise physiologist to facilitate further upgrades in physical capacity whilst empowering self-management.

Treatments that are not recommended for persistent pain

Passive therapies (massage, spinal adjustment/manipulation or other manual therapies)

Passive treatments do not rely on worker participation to be performed. In contrast active therapies (such as exercise programs, relaxation practices, homework set by the treater) rely on the patient to actively participate in these techniques at home, away from the provider. Ongoing passive therapies do not usually have a role in the management of persistent pain. This is because over time they become less effective and limit opportunities for the person with pain to undertake their own independent pain management.

Measures and assessment

Persistent pain is best evaluated by examining the ways in which the pain is impacting on the whole person, and it is important that treatment is helping them achieve improvement in their function, and as such the achievement of SMART goals indicates the effectiveness of treatment. A range patient self-reported outcome measures may be administered by their treaters to monitor progress as well, such as: The Brief Pain Inventory (BPI), The Depression Anxiety and Stress Scale (DASS), The Pain Self Efficacy Questionnaire (PSEQ).

Considerations for clinical justification

Clinicians should justify any requests for treatments / interventions / pain management programs. In other words:

1. The clinician will set Specific, Measured, Agreed, Realistic, Timed (**SMART**) goals in collaboration with the person before commencing any new treatment. These goals should reflect functional and vocational aspects pertinent to the person and will be reviewed in conjunction with **outcome measures** to ensure treatment is leading to improvement.





2. The clinician will consider whether the treatment adequately considers the person's **biopsychosocial context**. For example, the person's mental health and ability to consent and to engage with an intervention or to cope with an intervention not being effective.
3. The clinician will aim for the **empowerment of the person** to manage their ongoing condition. This may include firm timelines to discharge or discontinuation of a treatment if goals aren't met and the inclusion of self-management strategies that the person agrees to implement.

What could I say to a provider?

- What are your and the worker's expectations for this treatment?
- What goals have you and the worker set and how are you progressing towards meeting the worker's goals?
- Do you have all the necessary information required in order to treat the worker?
- How can I support you to assist in the worker's recovery?
- How are you preparing the worker for self-management and when do you expect them to be ready for this? Would introducing a structured plan at this point be helpful in achieving this?
- WorkSafe aligns with the Clinical Framework for the Provision of Health Services when there are not specific NHMRC guidelines. This treatment plan does not seem in alignment with this. Please provide evidence / your rationale for the treatment and its effectiveness in people like this worker.

What could I say to the worker?

- How are things going for you since you started the new treatment / had that intervention?
- What goals have you set with your treater?
- If you haven't noticed any benefits within 3 months you may want to go back and speak with your clinician.
- Many people with persistent pain find that their mood goes downhill and they can struggle to sleep or cope with their day to day life. If you feel like this is an issue for you, I can approve some sessions with a psychologist. They can give you strategies to help improve your mood and sleep.
- Have you heard of Pain Management Programs, or being referred to a pain physician? These programs involve a team who provide active rehabilitation by looking at you as a whole person. Many people report their ability to function improves and their pain and need for pain medications reduces. You can go along for an assessment for a 2nd opinion and find out more whilst still seeing your current

Where can I get further information?



Further information can be found in the Claims Manual in section

- 4.5.33 Pain management & network pain management programs

Also, here are some websites that have some great information, these website can be provided to workers if they would like to learn more about treatment options:

<https://www.painaustralia.org.au/about-pain/what-is-pain>

<https://www.painaustralia.org.au/getting-help/getting-the-right-care>

<https://painhealth.csse.uwa.edu.au>



Clinical Guidelines Persistent Pain Reference Guide

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