Submission No. 003

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AUSTRALIAN PAIN MANAGEMENT ASSOCIATION

Australian Pain Management Association Inc. (APMA)

Submission to the Education, Tourism, Innovation & Small Business Committee in respect of The National Injury Insurance Scheme (Queensland) Bill May 2016



About the Australian Pain Management Association Inc.

The Australian Pain Management Association Inc. (APMA) is the national consumer health charity which advocates on behalf of the more than 3.2 million Australians from all walks of life estimated to be suffering from chronic (persistent) pain and supports individuals with chronic pain conditions, and their families across Australia.

The organisation was established in 2009 in response to the need for evidence-based information and services for people living with chronic pain, and to provide a voice and community support. It has hundreds of members in all States and Territories of Australia, in metropolitan, regional and remote locations, with a wide variety of pain conditions and associated co-morbidities such as depression, physical impairment and obesity.

APMA works with governments, health administrators, clinician, research and community organisations (including state, national and international groups) to raise awareness of chronic pain and pain management, and to ameliorate the effects and consequences for people living with pain.

APMA provides advice, advocacy and representations to governments, clinicians and health departments and administrators on behalf of people living with pain (see http://www.painmanagement.org.au/about_us/what-we-do-main-menu/assistance/advocacy.html).

APMA works with individuals through its networks of support groups to actively participate in the management of their chronic pain and does so within a socially enabling framework.

The organisation is run by and for people living with chronic pain and those supporting them.

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Submission Summary

The Australian Pain Management Association (APMA) calls upon the Committee to:

- Include moderate to severe chronic pain as part of the eligibility criteria and definitions adopted under the proposed Bill for personal injury.
- Introduce a mechanism to allow individuals with moderate to severe persistent pain following a motor vehicle accident to make a claim under the NIIS Scheme.
- Broaden the terms of Chapter 1, Part 3, Section 8 of the proposed Bill to include access to personal pain support, inclusive of peer support groups, health coaching for self-management, pain management education and other persistent pain management services.
- Acknowledge within the Bill, that 4 categories of catastrophic injury: spinal cord injury; severe traumatic brain injury; multiple or high level limb amputations; severe burns; and brachial plexus injuries (if adopted) all often result in significant chronic pain for which people who need ongoing health, social and community based supports in addition to the medical treatment required.



Australian Chronic Pain Experience

Chronic pain is a major health challenge for Australia. The management of pain in Australia remains shockingly inadequate, despite the efforts of health practitioners, consumer organisations and in recent years, State health authorities. One in five Australians will suffer persistent pain in their lifetime yet up to 80% living with this debilitating condition are missing out on treatment that could improve their health and quality of life. Access Economics in 2007 estimated that persistent pain costs the Australian economy \$34 billion per annum, is Australia's third most costly health problem and as the population ages the numbers and costs are only increasing¹.

Despite these figures, persistent pain is still not recognised as a chronic condition for the purpose of action in response to the growing impact on the health of Australians and the health care system².

It has been estimated that less than 50% of patients with cancer pain receive effective relief, and similar levels of patients with acute pain fail to receive effective relief – despite the capability of current techniques to relieve more than 90% of this pain. Improved management of acute pain would reduce the subsequent development of chronic pain. It has also been estimated that less than 10% of patients with chronic pain receive effective relief – again, despite the capability of current techniques to relieve more than 80% of such patients, and such relief being capable of reducing the worsening of conditions and symptomology³.

There are a range of different categories of pain, including the acute or chronic stages manifesting as: musculoskeletal, neuropathic (central or peripheral) or visceral related pain. Living with and managing persistent pain requires reliable and up-to-date medical treatment (including allied health and pharmaceutical assistance). It also needs self-management capability, utilising lifestyle information, activity and support. A combination of these measures can restore function and quality of life to individuals whose main disability is pain.

In Australia, approximately 19% of the population are currently affected by moderate to

¹ Access Economics Pty Ltd *The High Price of Pain: The economic impact of persistent pain in Australia* MBF Foundation November 2007

² National Health Priority Action Council *National Chronic Disease Strategy* Australian Government Department, http://www.health.gov.au/internet/main/publishing.nsf/Content/pq-ncds-strat

³ National Pain Summit 2010 National Pain Strategy; Pain management for all Australians,

http://www.painaustralia.org.au/images/pain_australia/National%20Pain%20Strategy%202011%20Exec%20Su mmary.pdf



severe chronic pain. 33% of these sufferers have pain with high disability that is moderately to severely limiting. Overall, it has a considerable impact on quality of life, resulting in significant suffering and disability⁴. While in many cases it is accepted that a cure is unlikely, the impact on quality of life, mood and function can be greatly reduced by early and best practice measures.

Chronic pain not only has an impact on affected individuals and their families, it also has substantial economic costs. For example, health related expenditure on back pain alone was estimated to cost \$1.2 billion (1.8% of disease related spending) in 2008-09⁵. The vast majority of patients with back problems will be managed in the primary care sector. It is critically important that general practitioners (GPs) and other healthcare professionals have the best possible resources and support to manage their patients properly and have different modes of access to appropriate specialist services when required. The number of patients requiring GP services has grown from 2.7 of every 100 GP-patient visits in 2003–04 to 2.9 in 2012–13⁶. A proportion of patients will require access to specialist secondary and tertiary care pain services. From 2003–04 to 2012–13, the hospitalisation rate (aged 45+) for back problems increased from 762 per 100,000 to 882 per 100,000.⁷

Within Australia there is evidence of wide variation in clinical practice and resource provision across metropolitan areas, regional and rural Australia, with a widespread lack of knowledge about chronic pain and the management options that are available for long term back conditions and other chronic pain conditions.

A wide range of both pharmacological and non-pharmacological management strategies are necessary for chronic pain. In 2008-09 13.0% of all prescription pharmaceuticals (\$153 million) used were for low back pain, not including privately purchased over-the-counter medication. The amount patients spend on allied health treatment eg physiotherapy or accessing web based or other community resources has not been quantified as far as APMA can determine. The challenge is to understand the extensive published evidence for different treatments and to determine when and where to use them for the best long term outcomes for the patient. It is hoped that this inquiry will prompt the data collection and research required to improve clinical outcomes and quality of life for patients with chronic pain.

⁴ Australian Institute of Health and Welfare, Patient-based substudies from BEACH: abstracts and research tools 1999-2006, Prevalence and Management of Chronic Pain,

http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442456168

⁵<u>http://www.aihw.gov.au/back-problems/expenditure/</u>

http://www.aihw.gov.au/back-problems/treatment-by-gps/

⁷ <u>http://www.aihw.gov.au/back-problems/treatment-by-hospitals/</u>



Against this background APMA now makes the following recommendations in respect of the proposed The National Injury Insurance Scheme (Queensland) Bill.

1. Include chronic pain as part of the eligibility criteria and definitions adopted under the proposed Bill for personal injury.

The International Association for the Study of Pain defines chronic pain as pain that continues beyond the normal healing time of approximately three months⁸. If you have had pain for most days of the week for over three months it is considered to be chronic pain.⁹

Studies estimate that almost half of all victims of motor vehicle accidents (MVA) will experience such chronic pain. A 2009 Swiss longitudinal study further found that individuals with chronic pain also showed marked severity in symptoms of depression, anxiety, post-traumatic stress disorder, suicidal ideation and physical disablement and that this worsened over time without active intervention. Outcomes for individuals from low socio-economic environments are even poorer.

It is the view of APMA that best outcomes for victims of MVAs will be achieved through this Bill if recognition that chronic pain is a statistically significant consequence of personal injury and one that holds equal diagnostic weight with both physical and intellectual impairment is incorporated. It is well-recognised clinically (and strongly confirmed by our experience) that early identification of individuals at risk of chronic pain will be positively impacted across the life course through appropriate symptom management. This will not be possible unless those working within the proposed legislation synthesise chronic pain into claim assessments, treatment plans and financial approvals.

We are deeply concerned that chronic pain conditions, by definition, are not identified until some time post the MVA, and therefore are at risk of being lost to consideration in a whole of life care management plan, many of which will be settled well before a diagnosis of chronic pain can be established. We therefore call upon the Committee to expand the current eligibility criteria to include chronic pain as a critical component of personal injury.

⁸ see <u>http://www.iasp-pain.org/</u>

⁹ NPS MedicineWise <u>http://www.nps.org.au/conditions/nervous-system-problems/pain/for-individuals/pain-</u> conditions/chronic-pain/for-individuals/what-it-is Accessed 1/5/16



2. Introduce a mechanism to allow individuals with persistent pain following a motor vehicle accident to make a claim under the NIIS Scheme.

APMA's members include many who are themselves victims of MVA's. As a result of this collective experience we are aware that whilst some of the physical manifestations of immediate injury recede, what is often left is progressive and persistent pain, which can be complex to manage. Best practice currently suggests a multi-disciplinary approach to chronic pain management which includes assisting individuals to self-manage their condition through an active engagement with their care program as well as education about their pain condition. This takes post MVA care planning beyond a purely medical model to a more holistic and person centred model.

To this end, APMA believes that it is essential that victims of MVAs are able to claim under their care plan for a range of appropriate pain management and pain prevention strategies. This approach requires the adoption of a separate claiming item under the legislation to enable such claims to be made.

Given the high costs of long term disablement, APMA sees the inclusion of a chronic health item, as a significant benefit to individuals as well as to the scheme and economy. This is particularly important as we know that chronic pain sufferers living without suitable treatment support are known to experience difficulties retaining, obtaining and holding employment, and are placing a greater and greater burden on health and mental health services. There is also a sizeable body of empirical evidence to suggest that the pain associated with acquired physical disability, left unaddressed, leads individuals to adopt maladaptive pain strategies, placing an unrelated burden on health and mental health services.

It is our belief, that without a separate claiming item, individuals who develop chronic pain as a consequence of a MVA will not be equitably dealt with under the scheme and that the scheme will have failed a considerable number of individuals living within this state.

3. Broaden the terms of Chapter 1, Part 3, Section 8 of the proposed Bill to include access to personal pain support, inclusive of peer support groups, health coaching for self-management, pain management education and other persistent pain management services.

There is much evidence to support the efficacy of psycho social supports, such as APMA's pain support groups, in the treatment of individuals living with chronic pain conditions. We



therefore believe that any expression of funded supports under the legislation should be expanded to include access to peer to peer and professionally led pain support groups, pain related information services (such as APMA's Pain Link), opportunities for self-education as well as other pain management services including access to pain management clinics.

Jensen et al., in their 2011 meta-analysis (29 studies), clearly demonstrate the enduring benefits of biopsychosocial models of support for people living with chronic pain as the result of physical injury. These supports included cognitive as well as social interventions, suggesting that how individuals perceive their pain and its impact on their lives can be more damaging to the individual than the original injury. They also stress the importance of maintaining social connections through involvement in support groups as being key to managing the negative self-attributions of injury related chronic pain, often made worse by the impact some pain relieving medications have upon the neurological functioning.

APMA's experience in this regard shows that regular connection to peer to peer support opportunities can have significant insulating effects for depression, feelings of isolation and of pain acuity. We note that many of our members report a reduction in pain and a greater sense of a positive self with exposure to education about pain and pain management techniques. Specifically, APMA's pain support groups seek to enable individuals to work in partnership with treating professionals to manage their chronic pain. This is achieved through education about the pain process, sharing of pain management strategies and practice of techniques that all work to put the individual back into an active rather than a passive role within their own health journey.

It is essential therefore, that the Committee consider expanding the current treatment paradigms to include these psychosocial elements.



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- 4. Acknowledge within the Bill, that 4 categories of catastrophic injury: spinal cord injury; severe traumatic brain injury; multiple or high level limb amputations; severe burns; and brachial plexus injuries (if adopted) all often result in significant chronic pain for which people need ongoing health, social and community based supports in addition to the medical treatment required.

Traumatic injury is the primary cause of death and disability for younger adults worldwide and in Australia vehicular accidents are the leading cause of death and hospitalisations for the 12 - 24 age group. ¹⁰

The most common trauma related injuries among adults under forty-five years old are musculoskeletal, which often cross many body areas, and may frequently require surgical intervention. The individuals, who survive their trauma, do often have disability and approx. one-third suffer chronic, moderate to severe neuropathic pain, four or more months after injury, once musculoskeletal injuries could be held to have healed. ¹¹ It is surprising that inadequate pain management, including analgesic medication, physical and psychological pain management occurs both in hospital for acute pain associated with pain related to trauma and in the community. ¹²

The pain of spinal cord injury (SCI) is a serious neurological condition that is frequently experienced by patients which can exceed the impact of other consequences of the SCI. This pain may be difficult to treat and severely impact on quality of life. One high level study inspecting the patients' knowledge, experience and hopes for therapy reported that patients with SCI show a reticence to taking analgesic drugs and prefer complementary treatments including knowledge of how to cope with pain; sometimes challenging the options that health professionals offer. The treatments and strategies that the patients found to be helpful for pain relief included: warmth eg hot water,

¹⁰ Eldridge D 2008. Injury among young Australians. AIHW bulletin no. 60. Cat. no. AUS 102. Canberra: AIHW. Viewed 1 May 2016 <u>http://www.aihw.gov.au/publication-detail/?id=6442468094</u>.

¹¹ Predicting pain outcomes after traumatic musculoskeletal injury, Brittany N. Rosenbloom, Joel Katz, Kelly Chin, et al, PAIN Publish Ahead of Print, DOI: 10.1097/j.pain.00000000000000580



calming and distracting activities, physical movement and maintaining a balance between activity and rest. Patients also requested pain management programs to learn to cope with pain. These programs are able to increase understanding of pain, reduce depression, and lessen fears associated with pain and assist with social participation.¹³

Traumatic brain damage can be a devastating consequence of motor vehicle accidents. Following traumatic brain injury (TBI), patients can develop relentless chronic pain although the mechanisms for predisposition to chronic pain in TBI are unknown. Complaints of acute (58%) and chronic (75%) headache after TBI are common with negative impacts on mood and sleep quality may occur. In moderate-to-severe TBI with pain, the risk for developing prolonged depression after twelve months was approximately seven times greater than without TBI induced chronic pain.

Patients with moderate-to-severe TBI described their chronic pain as mainly located on one side body but covering multiple sites. Patients used terms such as pricking, numb, or burning, having a neuropathic character. The headache pain and often low mood can greatly affect quality of life and daily functioning.¹⁴

The goal of amputation following a severe motor vehicle accident is to take away damaged tissue and pain. However, pain is a common feature of amputee's recovery. For example, residual limb pain arises from different parts of the remaining limb such as skin, bone and nerves or neuromas. The pain can range from stabbing, tingling to feeling like electric shocks. When pain is severe it can be a barrier to recovery.

Nearly all amputees continue to feel their missing limb as if it still existed. However, amputation can lead to painful sensations referred to the missing limb – phantom limb pain (PLP) The limb may be absent but evidence shows

¹³ Pain in patients with spinal cord injury, Nanna Brix Finnerup, PAIN 154 (2013) S71–S76

¹⁴ Pain and sleep in post-concussion/mild traumatic brain injury, Gilles Lavigne, Samar Khoury, Jean-Marc Chauny, Alex Desautels, PAIN 156 (2015) S75–S85



the pain is real. Approximately 85% of amputees experience PLP - a neuropathic pain syndrome. $^{\rm 15}$

Last century PLP was thought to be a symptom of a psychological disorder; however improvements in medical science show PLP to be a natural and common response to limb loss that has a physical basis. Neuroplasticity – the brain's ability to change itself by forming new neural connections throughout life - can lead to the nervous system adapting or regenerating after trauma. PLP is triggered by the loss of sensory (nerve) input from the missing limb to the brain which causes abnormal brain activity and involves increased activity of the spinal neurons. These neuroplastic changes also follow spinal cord injury.¹⁶

The loss of a limb can cause considerable distress which can be worsened by PLP and which could delay recovery, rehabilitation and cause sleeplessness and negative impacts on quality of life. ¹⁷

PLP remains challenging condition to treat because medicines can be less effective for PLP. Best practice treatment targets the biological factors as well as the psychological and environmental variables which influence pain and function.

Most research supports the superiority of the holistic pain management (biopsycho-social) over more restrictive treatment methods that focus solely on biological factors. Health professionals can assist amputees to build strategies to deal with pain such as: diverting attention, meditation and slowly increasing activity levels. These have shown significant improvements in adjusting to a tolerable level of pain.

¹⁵ Cognitions, coping and social environment predict adjustment to phantom limb pain Mark P. Jensen, Dawn M. Ehde, Amy J. Hoffman, David R. Patterson, Joseph M. Czerniecki, Lawrence R. Robinson, Pain 95 (2002) 133–142

¹⁶ Motor and parietal cortex stimulation for phantom limb pain and sensations, Nadia Bolognini, Elena Olgiati, Angelo Maravita, Francesco Ferraro, Felipe Fregni, PAIN 154 (2013) 1274–1280

¹⁷ The relationship of phantom limb pain to other phantom limb phenomena in upper extremity amputees, Pedro Montoya, Wolfgang Larbig, Norbert Grulke, Herta Flor, Edward Taub, Niels Birbaumer, Pain 72 (1997) 87–93



Burns patients require effective pain management during the acute phase although inadequate pain management is still encountered. The insufficient relief of pain can negatively affect recovery and it can contribute to the development of chronic pain. There is also a connection between less than optimal pain relief and the onset of some psychiatric conditions, for example, depression and post-traumatic stress disorder.¹⁸

Medication is the main effective pain treatment in burn patients. As well a multidisciplinary approach to also reduce fears and pain is critical, due to the complex nature of pain. Non-drug therapy is an important measure in addition to medication to reduce pain and anxiety in burn patients and should be initiated as early as possible in order to lessen the impact of anxiety and post-traumatic stress disorder which can prolong the pain experience.¹⁹

Traumatic injuries to the brachial plexus frequently produce a chronic pain syndrome with constant and spontaneous pain. Patients describe this pain as feeling like: stabbing, shooting and burning pain in the furthest part of the affected limb and is not uncommon for the pain to continue for many years. Long term neuropathic pain is difficult to treat and nerve regrowth occurs at the slow rate of 1mm/day so recovery may take many months, making the management of brachial plexus injury challenging because of the nature of neurorehabilitation. Recent improvements have been made in the areas of early diagnosis and surgical techniques. In contrast, the rehabilitation of brachial plexus injury is still relatively unexplored in research. However, the long-term detrimental effects on patients are evident. First, brachial plexus injury can end in severe and long term impairments requiring acute as well as long-lasting treatment. Second, nerve damage causes sensory and motor disorders including: pain, muscle atrophy and weakness and deformities. The Central Nervous System has the capacity to rewire itself and be associated with the underuse of arms, further complicating rehabilitation. Lastly, pain creates psychological problems, for example, fear of movement which may further

¹⁸ Pain Management in Burn Patients, Rodrigo José Alencar de Castro, Plínio Cunha Leal, Rioko Kimiko Sakata, Rev Bras Anestesiol. 2013;63(1):149-158

¹⁹ Ibid



limit rehabilitation and increase disability. The complexity of the pain and functional impairment requires an ongoing multidisciplinary approach incorporating various therapies in order to improve patient outcomes.²⁰

It has been APMA's experience from our six years of delivering services to people disabled by MVAs, particularly the Pain Link helpline, that patients are still taking high level opioids long after their injuries have healed. Many of these patients have vastly higher expectations of the drugs, that is, zero pain, than the analgesics can deliver long term. Apart from the risk of addiction, these patients may become disillusioned and depressed because they mistakenly believe that there are no other effective remedies.

Conclusion

For patients surviving catastrophic injuries, these often result in severe acute pain during the healing phase and intractable chronic pain once healing has occurred. In addition to the limitation on function that these injuries cause, it is often the pain that further limits motivation and physical activity. It is also pain that has a profound impact on the emotional, psychological and social wellbeing of patients. In consideration of this Bill, it is timely to acknowledge the severe pain associated with traumatic MVAs as well as the post hospital community based services that are required to manage it.

APMA thanks the Committee for its consideration of this submission in respect of The National Injury Insurance Scheme (Queensland) Bill.

²⁰ Rehabilitation of brachial plexus injuries in adults and children., Smania N1, Berto G, La Marchina E, Melotti C, Midiri A, Roncari L, Zenorini A, Ianes P, Picelli A, Waldner A, Faccioli S, Gandolfi M, Eur J Phys Rehabil Med. 2012 Sep;48(3):483-506.