Dinah Spratt
[redacted]

08 March 2021

Ms Jenny Mannering
Inquiry Secretary

Via email: rur@parliament.tas.gov.au

Re: Legislative Council Sessional Committee Government Administration A Sub-Committee: Rural Health Services Inquiry

Dear Members,

I write to you as a Chartered Physiotherapist, a Member of the Australian College of Physiotherapists, an Australian Physiotherapy Association Titled Pain Physiotherapist and also sit on the Board of the Australian Pain Society as its Tasmanian Director. As an allied health professional with a special interest in pain management, I would like to bring a number of points to your attention as you consider rural health services in Tasmania.

In 2019 there was considerable work done in developing the Tasmanian Pain Management Strategy; as a member of the working group, I have yet to see the final iteration of the strategy and would welcome information on its progress. There is also the Local Pain Educator Program, a state led multi-disciplinary approach to addressing pain management across all services that has the potential to help a considerable number of people in pain.

The National Strategic Action Plan for Pain Management (2019), identified as a key goal the need for 'health practitioners who are well informed on best practice evidence-based assessment and care and supported to deliver this care'. I feel that care is lacking for our rural members of the community who are involved in a workplace injury. Injured workers often have delayed access to allied health, non-GP specialist medical services, hospital services and Pain management services.

Chronic pain is responsible for an estimated 9.9 million absent days from work each year, which costs the economy $1.4 billion per annum, while the total cost of lost productivity is estimated at $11 billion per annum. (https://www.painaustralia.org.au/about-pain/who-it-affects/workers-workplaces).

I am a clinical physiotherapist treating spinal and other musculoskeletal conditions for over 30 years, 14 of which have been spent in Tasmania, treating patients with both acute and chronic pain conditions.

My interest in pain management evolved from treating injured workers on the workers compensation scheme soon after I arrived in Tasmania from the UK in 2006. It alarmed me that such a high proportion of injured workers did not return to work, despite the relatively minor injury they suffered at work. I witnessed patients transition from the acute phase of healing to chronic pain, disability, depression and great suffering. Often their marriages would fail during this period, and sadly, some patients resorted to suicide.

In 2014 I was fortunate to be awarded a SARRAH (Services for Australian Rural and Remote Allied Health) scholarship to study a Master's of Science in Medicine (Pain Management) at the University of Sydney, which I completed in 2018. I not only gained valuable knowledge and experience in how to manage workers comp patients from my studies, but also from my experiences learned from my patients and their families.

My interest in pain management of the workers comp patient has led me to educate others, using research-based evidence, on best methods of practice which may assist key stake holders in supporting the injured worker in the most efficient way to avoid this transition to chronic pain, and to encourage a smooth return to work. My target audiences have included rehab providers from QBE workers compensation insurance, the Australian Institute of Company Directors, General practitioners in the north and along the north-west coast, pain specialists and neurosurgeons, pain scientists and allied health staff such as physiotherapists, psychologists and exercise physiologists in a range of forums and professional development events. Part of this work has also involved engaging with Tasmanian politicians from all sides of politics on these issues.

Developing a therapeutic alliance with the workers comp patients is paramount in establishing positive outcomes as it builds trust. Therapeutic alliance is a part of my work I value highly, and I have delivered a talk on this subject at the Australian Physiotherapy Association's Tasmanian Branch Symposium in Devonport in 2019, whose theme was 'Pain regions, physiotherapy, multidisciplinary and research perspectives'. This symposium marked the launch of the 2018 Pain Revolution Tour with pain scientists Dr David Butler and Professor Lorimer Moseley AO at the helm.

I also deliver regular presentations to my workers comp patients on the topic of managing pain with a biopsychosocial approach, and during their rehabilitation, I regularly collaborate between the patient, rehab provider, and GP, in the hope of enabling a smooth return to work.

Psychosocial Risks of Poor Outcomes Unique to Workers

The members of the workforce in my community in the Latrobe municipality are largely made up of blue-collar skilled workers, such as care assistants in nursing homes and in community care, truck drivers, miners, labourers, supermarket workers, boilermakers, fitter/turners, childcare workers, plasterers and chefs.

Some of these community members, if they are unfortunate enough to sustain a workplace injury, will be at risk of developing chronic pain, long term disability and impaired mental and physical health, regardless of the severity or mildness of their injury. This is because they will be subjected to a variety of negative psychosocial influences which will have a major impact on their pain intensity, longevity and irritability, and consequently their ability to return to work. Research has shown that prolonged absence from work also increases their risk of never returning to work.

However, most of those at greater risk of these poor outcomes can be identified within a few weeks of their injury, making prevention a real possibility.

These negative and often devastating psychosocial influences are often unwittingly created by the very scheme that is meant to aid them in their recovery.

Most workers want a safe return to their pre injury duties. They need to feel reassured that the rehabilitation culture is not one of blame but rather of shared concern and that it is not a secret business.

And yet there is a view that patients on long term workers comp are somehow doing it for some kind of gain. This may be an implicit or explicit view held by key stakeholders involved with the worker's rehabilitation and recovery, including that of the rehabilitation provider (p.12 R Dana and Griffin 1992). Also, there is often an employer's hostility or unwillingness to provide an honest understanding with regards to the genuineness of their employee's injuries (Kenny 1995b). Evidence suggests that the nature of employment relationships may change once the injured worker is involved in a protracted claim. This change involves shifts in perception and subsequent commitment of the key parties involved in the rehabilitation process: e.g. no contact from work during the time off/ return to work (RTW) on light duties which were undermining / feelings of being shoved in a corner / feeling of being an outcast, judgement from workmates / remarks behind your back from supervisor / made to feel demoralised and hurt.

There is also the assumption from many employers that recovery has to be 100% before an employee can return to full duties.

Common psychosocial influences affecting the injured worker include:

- loss of self-esteem and identity
- financial loss (no overtime)
- exposure to an overwhelming number of professional strangers
- introduction to processes that appear alien and threatening
- loss of control/autonomy/grief/feelings of shame
- anger/stress/guilt anxiety, self-blame, and depression
- Inability to manage emotions

- Loss and change in many areas
- Diminished sense of social status in the workplace

People with chronic pain who become unemployed report numerous factors which they believe have been lost by not being involved in working: these include a financial reward, the feelings of participation, a role, a routine, self-esteem, social contact and self-worth.

A Worker's Story (Roberts-Yates 2003)

This excerpt identifies the key issues that many of my workers compensation patients are faced with, and raises important matters that need to be addressed:

> *"Hurting yourself at work has a stigma and I felt I was to blame. I returned to light duties but they were no good and didn't lead to anything. No-one told me anything. They messed up my paperwork. I was frightened of losing my job. There was no plan or program from the insurer and the case manager was inexperienced, ignorant and arrogant. I was totally stressed and my mental state was far worse than the injury at the end of the claim. I began to think I was imagining it.*
>
> *My pay was mixed up for weeks and the receipts were lost. It made me feel fearful and the fact that nobody listened to me had the biggest impact. I was very worried about how I would feed the family whilst my pay was being sorted out and I felt very depressed but received no help or counselling. I had problems with the mortgage and I began to mistrust everyone connected to my case. The process almost drowned me. There was a definite stigma. Relationships with workmates went through the window and I didn't tell anyone I had an injury unless I had to. Workmates were supportive at the time of the incident but it wore off, i.e. out of sight out of mind. It was stressful to hear them gossip. The medical process was stressful with medicos making decisions who did not know my case. Doctors were into quick fixes and magic pills. It is more difficult if you can't see the injury- people with visible injuries are better off. If you look alright and if the injury doesn't show, no-one takes any real notice. Work is my life and I didn't want to reaggravate. I just felt embarrassed.*
>
> *The hardest part was getting things done around the house with no help and little things became battle fields. I felt useless and a drain on everyone. There was information out there but I don't know what it is. No-one tells you anything about the process. I needed someone to explain the paperwork and explain what was expected form the employer and doctor. I felt out of control and guilty because I couldn't fix the problem. I had sleep problems and felt isolated and alone.*
>
> *My injury had a big impact on my family and I had a lot of unwanted advice as to how I should cope. I let the kids down and relationships with the in-laws plummeted. I wasn't allowed to grieve and too many people with no understandings were making judgements. There was a great indignity about it all. I wanted to be included but I felt very shut out. The*

first thing the doctor does is reach for the prescription pad and cases fall through the cracks as big as the Grand Canyon. I 'hurt' became the focus of my conversation. The relationship with my partner deteriorated and our sex life suffered. We lost our communication. I'm back at work now and need to make do with what I've got".

Addressing some of the specific issues within the Inquiry into Rural Health Services' Terms of Reference:

In turning to the Inquiry's terms of reference I would like to add additional points that may help to inform the Committee's deliberations.

Psychosocial factors have the proven potential to affect musculoskeletal pain at three phases of the injury and return to work process:

1. At the onset of pain
2. The seeking and receiving of healthcare and income support
3. The development of chronic pain related disability and loss of employment

Common barriers to recovery in the acute phase of healing, related to delayed timeliness of health services:

- Lack of information for the patient in the acute phase of their tissue injury/usual recovery time frames. Many injured workers find the use of procedural medical language difficult to understand, and that there is a lack of information and often misunderstandings about their condition and rehab focus, which leads to dissatisfaction with treatment and return to work plans. Procedural language needs to be translated and understood so that workers know how to use it in their personal management of the rehabilitation and return to work process

- Lack of skills by the treating GP in recognising Physiotherapy as an essential need for the injured worker as soon as possible after initial physical injury (staying at home leads to catastrophising, fearing the worst, fear of their pain causing avoidance behaviours, and lack of understanding about when to stop resting and start actively mobilising or exercising)

- Lack of skills by the treating GP in recognising those injured workers who are at high risk of transitioning from acute to chronic pain and the need for early psychological intervention. If psychosocial factors are ignored, the elevation of pain from acute to chronic may be accelerated. Psychosocial factors should be recognised as important factors in the severity of injury, the effect on a person's quality of life, and ultimately the length of recovery.

- Lack of availability of psychologists on the north west coast who have experience in chronic pain management.

- For some patients with ‘red flag’ injuries: such as a severe cervical or lumbar vertebral disc protrusion causing considerable neurological weakness in a limb, the system fails them as they may have to wait until they have had two opinions from spinal specialists, plus an occupational health physician before funding is given for surgery, when, if they had not been under the workers compensation scheme they would have more likely have received a referral for emergency surgery via the Department of Emergency, or by using their private health cover, and gained significantly more positive outcomes. Often non-medical case managers can override a specialist’s advice with regards to emergency surgery and delay funding for years, causing increasing disability and high risk of the patients never returning to the workforce.

Common barriers to recovery in the chronic phase of care, related to delayed timeliness of health services

- Some injured workers have case managers who are based interstate, who (pre COVID) fly patients interstate to receive an assessment from an independent medical examiner on behalf of the insurance company. For these patients, it is mandatory for them to travel from their rural community to an alien environment away from their family and support. This can be overwhelming for the worker who is unfamiliar with flying or with the built-up city environment. Workers perceive the insurance company of using their rules and legislation to test for compliance and worthiness, and that it is assumed that they are’ fraudulent’ or ‘malingerers’ until they have proven otherwise. They feel that any lack of compliance is then used against them as validation of their ‘fraudulent’ behaviour. This then reinforces the worker’s need to adopt an adversarial role. In these cases, there is often a lack of contact between the case manager and treating doctors/specialists, causing further delay in the receival of appropriate management.

- Often non-medical case managers don’t recognise the need for pain education and won’t fund it, therefore the patient misses out on multidisciplinary pain management.

- For those workers who are allocated funding for multidisciplinary pain management, there is a lack of services on the north west coast that provide pain management services for workers compensation patients.

- Social support has been found to improve the psychological well-being and quality of life of patients suffering from chronic pain. Lack of social support in the work environment tends to negatively affect pain severity.

- Despite evidence supporting the notion that chronic pain is not necessarily attributed to delayed tissue healing or tissue damage, there is still ongoing confusion for the workers compensation patient as he is treated under the medical model, when it is more the psychosocial influences rather than the originally injured tissue that is driving the patient's pain. This happens due to lack of understanding from the case manager, rehab provider or treating practitioners that treatment should be geared towards managing the psychosocial influences rather than focussing on looking for the 'damaged tissue' with unnecessary scans, tests and procedures

- There is often major discontent between the patient and key stakeholders within the workers compensation system, related to lack of information, the view that their injuries were not believed to be legitimate, and the lack of attention and respect they received from these stakeholders. Some insurance doctors are often rude, sarcastic and arrogant (Kenny 1995b)

Potential Solutions

- Workers need a greater knowledge of the workers compensation process, including their rights and obligations, their medical diagnosis, treatment plan and entitlements in order for them to be willingly able to participate collaboratively and inclusively in their rehabilitation and return to work. An information package outlining the rehabilitation and return to work process and their entitlements at the onset of injury should be provided to the worker in simple language. Patients need to know what to do with their initial medical certificate given to them by the GP. Even basic information is not given to the patient, so that patients do not know their rights and feel powerless. They can feel that no one listens and there is no feedback.
- Upskilling GPs on the importance of involving allied health in the treatment and management of the injured worker as soon as possible following injury
- Timely surgical management of Red Flag conditions, whereby a treating specialist's opinion cannot be over ridden by the fundholding case manager
- Upskilling primary care clinicians in the use of predictive outcome questionnaires in the worker's acute phase of injury, so that those deemed at risk of developing chronic pain can be suitably managed early on

Examples of outcome questionnaires which can predict risk are:

1. Keele STarT Back Screening Tool 9 (predicts those at low, medium or high risk of persistent disabling symptoms)
2. Orebro Musculoskeletal Pain Screening Questionnaire (predicts long term disability and failure to return to work when completed four to twelve weeks following a soft tissue injury)

3. DASS21 (measures the negative emotional states of depression, anxiety and stress suffered by the injured worker)
4. TAMPA (measures a worker's fear of movement related to chronic pain)
5. Pain catastrophising tool (measures a worker's tendency to magnify the threat value of pain as well as an inability to inhibit pain-related thoughts)

- Upskilling key stakeholders (both medical and non-medical) on the impact and subsequent management of psychosocial factors following workplace injury. Resources include Module 2 of the Better Pain Management Modules, developed by the Faculty of Pain Medicine (ANZCA), which can be accessed online
- Funding to provide more multidisciplinary pain services which are accessible to the workers comp patient on the north west coast, and whose members receive mandatory training in the treatment and management of the injured worker.
- Upskilling treating medical experts in the benefits of referring injured workers to multidisciplinary pain management who are showing signs of chronic pain and psychosocial influences.
- Access to local social support should be provided for all workers under the workers compensation scheme
- Utilising our state occupational health physicians to carry out Independent Medical Assessments, instead of patients having to fly interstate.
- Promoting respectful ongoing communication between the claimant and the treating medical experts, with a strong emphasis on therapeutic alliance and collaboration, and involving the worker in the decision-making process with regards to management options, so that the patient doesn't feel forgotten and undervalued. This could be done regularly in a meeting format, either face to face or on zoom. The worker should be regularly informed about their medical condition and suggested treatment regimens by the treating medical experts in respectful, clear and simple language. Encouraging a degree of empowerment and active participation by the worker would enable to more successful return to work and therefore reduce costs
- Upskilling medical stakeholders in treating the injury in terms of the whole person, rather than focussing on the tissues that were originally damaged.
- Once a worker leaves the workers comp scheme (either due to recovery or due to a compensation pay-out), their past medical history should remain confidential so that they hold a fair and equal right to future employment

As a context to my comment and observations above I view this inquiry through the lenses of a strategic perspective in the provision of pain management services, and from having been deeply involved in supporting workers compensation patients with pain as a practicing health professional.

My goal is to see such patients being able to manage their pain in such a way that allows them to lead a full and active life.

Yours sincerely,

Dinah Spratt

Dinah Spratt

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https://www.betterpainmanagement.com/product?catalog=BPM-Complete-Program
Module 2: The impact and management of psychological factors in pain
Recognise patients at risk for long-term distress and disability. Develop a management plan for psychosocial comorbidities in patients with chronic pain

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Ms Jenny Manning
Inquiry Secretary

Via email: rur@parliament.tas.gov.au

10th March 2021

Dear Ms Manning,

Re: Legislative Council Sessional Committee Government Administration A Sub-Committee: Rural Health Services Inquiry

We write to express our support for the submission made by Mrs Dinah Spratt regarding the Tasmanian Rural Health Services Inquiry.

Chronic pain is one of Australia's most costly health conditions. It is associated with marked physical and psychological impairment, sub-optimal workforce engagement, early retirement and increased suicidality. Despite this, less than 0.02% of adults with persistent pain will visit a tertiary pain service and around 80% will be unable to access treatment that could improve their functioning or quality of life. The situation is far worse for rural and remote communities, for whom access to evidence-based multidisciplinary care in the community is exceedingly limited. Medicare item number reforms may ease this situation in the longer term, but immediate action is required to improve the lives of people living with chronic pain and remediate the fiscal and societal impact of this condition.

We believe that access to effective pain treatment is a fundamental human right. We commend the Tasmania Government and Legislative Council Sessional Committee for undertaking this inquiry and for specifically identifying pain management services as an area for consideration, and we look forward to learning the outcomes of this review in the hope that they will advance pain care for all Tasmanians.

Yours sincerely

A Burke

Associate Professor Anne Burke
President
Australian Pain Society