Editor’s Note

I looked over the pre-production of this month’s newsletter with considerable satisfaction. There is a range of articles which I expect will be of wide interest.

And the poster produced by Chronic Pain Australia for promotion of the imminent National Pain Week is a gem: you’ll find it within. Thanks to the many contributors with, as always, particular thanks to Tracy Hallen at DC Conferences for her energy and application.

Cheers,

Will Howard
PAIN MANAGEMENT AND PHARMACY

This article first appeared in the Australian Journal of Pharmacists (AJP) AJP.com.au on 23APR15 and an abridged version is reproduced here with kind permission

Pain is a universal symptom and yet pharmacists—as the most accessible healthcare providers—can play a vital role in helping patients take action and assisting them in safe and effective pain management, writes Leanne Philpott.

In addition to its core dispensing role, the pharmacy can offer competencies and services relevant to those people living with acute and chronic pain such as home medication reviews (HMRs), enhanced self-care support to protect against overuse or misuse of analgesics and Non Steroidal Anti Inflammatory Drugs (NSAIDs), assessment tools to identify persistent pain risks—while also facilitating multidisciplinary support through referrals and the provision of information.

Broken Hill community pharmacist Alex Page, winner of the 2013 Pharmaceutical Society of Australia (PSA) Award for Quality Use of Medicines (QUM) in Pain Management, says, “The biggest hurdle to improving pain management is changing patients understanding of pain and how it is best managed. Unfortunately everyone believes there is a ‘silver bullet’ medication that will ‘kill’ their pain.”

Page tells The AJP that he loathes the term ‘pain killer’ and explains that through HMRs, Medschecks and patient counseling, he tries to help patients conceptualise their pain better so they can understand that medication is a very small aspect of pain management.

“He says, ‘HMRs present an unparalleled opportunity for a health professional to assess the coping mechanisms of a patient with chronic pain and view how their living environment and family impact their pain management."

“In health we are often forced to rely on information given to us by the patient, which may not always be accurate so it is invaluable to have an opportunity to assess a patient’s coping strategies in an objective and accurate fashion.

“You can assess a person’s level of functioning during a HMR, which is a far better indicator of disability than pain intensity. It also has a stronger correlation to depression than pain intensity,” says Page.

Elizabeth Carrigan, CEO of Australian Pain Management Association Inc. (APMA), says that expanding the role of pharmacist in pain management from dispensing to educating patients, for example about side effects and also the unintended consequences of some drugs, is important.

She adds, “Some of the ways that pharmacists can and do assist are by checking that patients are on an optimal dose of analgesics, monitoring repeat prescriptions as well as patients’ self-medication with

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1 Issued by the Pharmaceutical Society of Australia (PSA)
2 Pharmacist requires a written referral from the GP to conduct a HMR and after interviewing the patients must prepare a clinical report with their recommendations to the GP. Only pharmacists accredited by the Australian Association of Consultant Pharmacists (AACP) can conduct HMRs.
3 Sponsored by Mundipharma
4 Medications review conducted by the pharmacist in the pharmacy without a written referral from or follow up with the GP. Pharmacists are not required to be AACP accredited to conduct Medschecks
over the counter (OTC) analgesics in combination with prescribed analgesics. This provides necessary checks and balances in the medications system resulting in less adverse events.

“Pharmacists should be examining a patient’s medicines and discussing treatment with their doctor with the view to optimising medicines and minimising potential problems. Pharmacy reviews are important for the successful management of chronic pain,” she says.

Having been a community pharmacist for six years, Page says he is frequently reminded about the extensive and widespread use of codeine. “While there are many patients who use codeine-containing analgesics appropriately, there still appears to be a large number who do not,” he says.

Page explains how he took action to address this behaviour. “Limiting the supply of codeine to a maximum of five days was a good initial step but we found that it was still hard to gauge how often someone used codeine-containing analgesics as they would obtain it from multiple pharmacies. To address this all the community pharmacies in Broken Hill decided to record the sale of codeine-containing analgesics through the Project Stop database. In the three years we have been doing this we have dramatically reduced the inappropriate use of codeine-containing analgesics and, perhaps most importantly, it has allowed us a counseling opportunity as we can talk to those who are regular users of codeine-containing analgesics.”

Health literacy and advice

In 2014 APMA produced Getting back on track, an accessible consumer low back pain management brochure, which Carrigan says could be used to back-up pharmacist advice about medication use and safety, fear avoidance and staying physically active with lower back pain.

She says, “The brochure, coupled with pharmacist verbal counselling to reinforce key messages, could focus on making patients more active participants in their own pain care. Having pharmacists make use of the information means current, evidence-based and easy-to-understand information is immediately accessible to consumers at the community level.

“Chronic low back pain is the leading cause of consumers leaving the workplace because of poor health in Australia. Yet pharmacists have the capability to bring together more realistic beliefs and behaviours to improve patient outcomes with chronic pain. Simple and cost effective partnerships with community organisations can help the millions with lower back pain to remain in the workforce or keep their lifestyle going to improve their back health,” says Carrigan.

United front

Page says, “HMR-accredited pharmacists play a huge role in referral and instigating multidisciplinary support for customers with chronic pain. Pharmacists are still somewhat of an isolated branch on the primary healthcare tree but this has steadily improved as Universities and professional bodies continue to push the multidisciplinary care model.

“Pharmacists would connect with more patients in a given day than any other health profession, so we are a crucial cog in identifying which customers could benefit from support from another health care professional. The referral part is trickier as community pharmacists can seldom directly refer to another health professional, especially those who are subsidised by Medicare. I see this as a priority to improving the management of not only chronic pain, but many other chronic illnesses,” says Page.

e-health—potential for better pain services

Carrigan says that given the shortage of pain medication specialists, e-Health has the potential to increase the capacity.

She explains, “e-Health enables consultations between specialists and GPs to occur via video link. As well, GPs are able to book meetings with the specialists to get advice on a complex medical case.

“Pharmacists could be involved in these meetings. Some pain clinics, like the Gold Coast Persistent Pain Service, have a pharmacist involved. Private specialists could be more involved and local GPs could also involve the local pharmacist.

“Community pharmacists need to be able to access the electronic health systems that are being rolled out by States, such as the Enterprise Patient Administration System (EPAS) in SA. When it is fully implemented it could make a marvellous difference to healthcare, particularly for the “frequent flyers” in the public.
system. EPAS has the potential for hospital-based scripts to be filled by community pharmacists—producing a streamlined hospital-based prescribing and community pharmacy dispensing system.

“Potentially, if community pharmacies are integrated into eHealth records systems, medication safety could improve as could optimal use of medicines due to better continuity of patient information.

“Beyond the pharmacy itself, scope exists for pharmacists to be located in general practices and community health centres, giving people better access to their services—particularly large primary health care practices, which are already providing consumer management and prevention education,” Carrigan says.

Case study

Olly Zekry, is a clinical consultant pharmacist and winner of the PSA QUM in Pain Management Award 2014.

Zekry explains, “One of my patients, Jackie, was a 58-year-old medical receptionist with a six-year history of lower back pain and a three-year history of type 2 diabetes. I visited her at home for a HMR.

“Apart from the fact the house was very messy and the kitchen was a little smelly, an indicator that she may be having difficulty coping, I noticed she winced when sitting down but she didn’t complain. I asked if she was okay and she replied, “My back is still bad”. I questioned further and she told me that she hadn’t been walking regularly for the past two months due to the problems with her back.

“In terms of pain history, her average Visual Analogue Scale (VAS) score is 6/10 and her worst VAS score 7/10. The pain is in the lumbar spine and at its worst it radiates in the thigh region. Pain is reduced with bed rest. Her dose of paracetamol/codeine had been at the prescribed maximum (1000/60mg four times daily) for the past two months with no relief.

“When I interviewed Jackie I realised she has two potential red flag indicators; firstly she is aged over 50 and secondly her condition hasn’t improved after one month. However, she has no history of cancer and her back pain was first reported five years ago at the age of 50 years.

“In Jackie’s case, her largest issues seem to be about her ability to do things—general activity, work and walking. As conservative analgesic therapy hasn’t enabled Jackie to implement active self-management strategies effectively, the decision is to consider the use of stronger analgesics.

“Jackie’s suitability for an opioid trial is assessed using the Opioid Risk Tool (ORT). She scores 2 points due to her sister’s past use of marijuana. Her score places her in the low-risk category of developing aberrant drug-related behaviours so I recommended the following to the GP as part of her pain management plan:

1. Cease paracetamol/codeine
2. Start patient on buprenorphine patch 5mcg/ph
3. Continue with heat packs
4. Encourage Jackie to increase her level of physical activity and the frequency of walking from every second day to daily
5. Encourage patient to lose weight.”

“Jackie’s opioid use is monitored by the GP using the ‘5 As’ opioid therapy monitoring tool. After 2 weeks her VAS score went down to 5/10 so the GP increased her buprenorphine dose from 5mcg p/h to 10mcg /ph.

“At week six I reviewed her progress. She achieved all of her goals successively, except for her goal regarding weight loss.

“As the period of the buprenorphine trial had ended a decision needed to be made regarding ongoing use of this therapy. The combination of buprenorphine and the implementation of self-management strategies had helped to reduce pain levels and enabled her to increase her level of activity, so she agreed to continue the use of buprenorphine patches. I updated the treatment goals in her records. Her progress is monitored by monthly reviews and her GP will discuss stopping opioid therapy once she has achieved her goals and her physical condition has improved.”

5 A’s opioid therapy monitoring tool:
1. Activity
2. Analgesic
3. Adverse effects
4. Aberrant behaviours
5. Affect

The Australian Pain Society Newsletter, Volume 35, Issue 4 - June 2015
WHOLE PERSON ENGAGEMENT FOR THE TREATMENT OF PEOPLE IN PAIN

Pain can be, and often is, complex to understand, so it is not surprising that it can be a challenge to treat. Pain is a subjective experience and objective measures of its presence and consequences are not achieved by modalities usually used by medicine such as blood assays and imaging. Alternative measures which explore the psychosocial effects of chronic pain need to be used. Chronic pain is not amenable to the paradigms of biomedical treatment which promote passive management; in particular there are significant limitations to the role of analgesics. These issues are explored in this article and an effective management approach, pioneered in Western Australia, is described.

For most people with pain there aren’t any current biochemical markers for pain that show up on blood tests.

Pain is invisible on routinely available radiological imaging. Hence, the disconnect between pathology routinely reported on radiological imaging and the presence or absence of concordant pain. Changes seen in spinal x-rays are age-related and often unaccompanied by pain. By contrast, spinal pain can be present in the absence of such changes. It is important to remember that imaging does not show pain – imaging shows anatomy. Magnetic resonance imaging (MRI) can provide additional information, for example, high intensity zones associated with discogenic pain, chemical radiculitis and fat infiltration of lumbar multifidi muscles associated with lumbar back pain in adults (not adolescents), however these findings are not always reported. Functional MRI’s, including spinal cord imaging, might provide more information on the motor and sensory networks in the future.

Studies at a microscopic level do demonstrate changes in the nervous system – for example in immune-responsive glia, in neurotransmitters and in receptors. These changes within the nerves, spinal cord and brain are known to occur, but are hard to quantify whilst the patients are alive - notwithstanding fascinating studies using functional MRIs which show differences in blood flow to regions of the brain when pain is studied across a range of changeable factors including mindfulness, virtual reality, and empathy.

Major advances have occurred in understanding how glia and immune cells in the nervous system respond to painful inputs and contribute to persistent pain. Some very clever researchers are showing that immune-like cells in the brain, spinal cord and peripheral nerves play a major role in all forms of pain. In the central nervous system there is an immune-like response when an organism is under danger or threat: microglia and astrocytes become activated. Examples of such threats are infection and psychosocial stresses. The glia detect and remember “threats”; if significant noceception (hyper-nociception) occurs, the response is transformed by the “glial memory”. Thus these two components – glial activation and hyper-nociception -- rewire the nervous system to maintain persistent pain.

Anger, stress and distress increase the “threat” value of pain and therefore they increase the likelihood of persistent pain and disability. The implication of this is that feelings of stress, worry and being under threat need to be removed. This is a key point, because pain intrinsically makes make people feel anxious or worried: this results in pain being an effective alarm signal so that survival of the organism increases by avoiding the threat. However, if a potential threat is more perceived rather than an actual threat, then the resultant persistent pain is amplified without benefit to the organism surviving. That is, we are all wired as a biological imperative to respond to and avoid pain and injury, but unhelpful amplification of “threat” results in unhelpful “alloplastic” pain. One of the major roles an effective health professional can play is to reduce the threat value of pain. Therefore it is critical to use tools which assess the patient’s psychosocial situation, including their beliefs about their pain and disability.

**Alloplastic pain means the ‘other’, ‘changeable’ pain and reflects complex, interactive and systemic (holistic) processes, occurring in-and-around the organism in pain. Such processes are likely to be active at a cellular, genetic, neurological (including psycho-cognitive & autonomic), immunological, endocrine and environmental level which together may be seen as systemic core-pain responses. See: What is Pain? E.Visser, S.Davies. Australian Anaesthesia 2009**
WHOLE PERSON ENGAGEMENT FOR THE TREATMENT OF PEOPLE IN PAIN

Dr Stephanie Davies
Director, WA Specialist Pain Services (WASPS)

In WA, it has been uncommon to see assessments that include validated questionnaires that measure the injured worker’s biopsychosocial risk of disability such as the Orebro musculoskeletal questionnaire (OMPQ for persistent pain) or StartBack (low back pain). Further, it is not routine practice, outside of pain medicine, to use screening questionnaires for neuropathic pain (such as Pain Detect); nor pain and function (such as Brief Pain Inventory, Pain Disability, Roland Morris or Oswestry); whilst the use of instruments that are validated for people with persistent pain to measure anxiety and depression such as HADS and the DASS are not seen outside multidisciplinary pain services – yet anxiety is enmeshed in the experience of pain.

The biopsychosocial model of assessment and management of people with pain isn’t new. It has been part of the teaching of pain medicine to doctors and health care professionals since I was a registrar in the mid 1990’s.

What is new is that in the last decade a range of healthcare professionals and managers have worked extremely hard to provide systems that easily provide both pain education and skills to be taught as the ’first-line’ treatment to people with complex persistent pain.

In 2007, Fremantle Hospital & Health Service Pain Medicine Unit introduced the Self-Training Educative Pain Sessions (STEPS), an eight hour pre-program held over two days, which 70-80% of people attend prior to individual consultations. This was funded via a translational research grant in 2007-2008 from SHRAC (WA DOH).

The STEPS pre-program, i.e. before entry to the clinic, taught pain knowledge including neuroplasticity, and skills such as pacing, pain approach, mindfulness, making sense of pain, and medical options. The key healthcare professionals were pain physicians, musculoskeletal physiotherapists, behavioural psychologists and occupational therapists. In this tertiary sector, from 2007 to 2014 approximately 3000 patients attended the Fremantle Hospital STEPS program, halving the unit cost of a referred new patient as well as dramatically reducing waiting time as the capacity of the unit to see new patients increased (doubled) because patients were able to more readily engage and implement with non-medically focused options. Sir Charles Gairdner Hospital and Royal Perth Hospital have similar pre-entry group programs.

The focus is shifted to what the patient can do, such as pacing activities, paced daily walk, non-vigorous movements, pain approach, mindfulness, relaxation, acceptance, and reduction of life stressors. This last point is vital as many people are juggling several or many life stressors.

One of the skills we teach patients is to reduce the time spent thinking on issues that can’t be worked on, or solved, any time soon. Each minute spent running through the problems (in their head) makes them feel bad and pushes mood down. Patients are encouraged to try using the ‘3 D’s approach’ – “Do it, Delegate it, or Dump it” (I use this as my mantra): “do it” can be implemented by devising realistic achievable goals; “dump it” can be implemented by avoiding unhelpful emotions when negative events occur, using the analogy of the “dead bat” (definition as per www.wikpedia.com).

Our tracking of the Fremantle Hospital participants who returned validated questionnaires from October 2007 to the end of 2009 showed that the hundreds of participants had implemented an increased number of active pain strategies and had improved abilities to do daily chores, i.e. they had less disability.

The expansion of co-ordinated pain services to Medicare Locals, STEPS-PNML, STEPS-BAML and STEPS-PSCML, started in 2011: to date about 300 patients have attended these group programs. Its intent was to bridge the gap in primary to secondary care for people with persistent pain who had a less complex mix of co-morbidities. It comprises attendance at the two day STEPS program combined with a one-off pain team
WHOLE PERSON ENGAGEMENT FOR THE TREATMENT OF PEOPLE IN PAIN

Dr Stephanie Davies
Director, WA Specialist Pain Services (WASPS)

assessment (physiotherapist, behavioural psychologist, pain physician) to provide support to the patient (and significant others) as well as community healthcare professionals.

Subsequent care is filtered to either primary care (less complex) or tertiary care (more complex) depending on the management plan made by the pain team. These programs help people with pain to improve function and return to a more normal life. The positive feedback from patients and their families recognising that they feel empowered, with more control, is significant, as well as improving health outcomes for these participants and leading to significantly reduced waiting times at the tertiary pain clinics in WA.

Patients with a high number of complex issues continue to require access to existing tertiary services to access the expertise and experience of specialised healthcare professionals, investigations, interventional pain procedures, non-PBS medications, and to receive the ongoing care that is required for people in pain with multiple medical co-morbidities, co-existing mental health conditions, and complex medication regimes (including S8 opioids); also they may need to attend more intense (longer) cognitive behavioural group programs.

Future analysis of the triage information will enable – hopefully – a simple tool for assisting services in determining the optimal referral pathway between primary-secondary and tertiary services.

The emphasis here is that pain is often complex and requires a multi-modal approach to address the multidimensional nature of pain. An engaging patient-centred approach drawing upon the expertise of multiple healthcare disciplines is emerging as the best practice to tackle pain (as well as other chronic conditions).

I feel it will take clinical leaders working with health managers and politicians to produce sustainable systems to allow growth in the future for people in pain and people with other complex conditions. The current challenge is how to move forward in a health-economic responsible manner.

Dr Stephanie Davies is also Adj. A/Prof, Curtin University, School of Physiotherapy; Senior Lecturer, UWA, School of Medicine and Pharmacology; Chair State Wide Pain Services (SWPS); Co-Chair Pain Health Working Group (PHWG); and Director of Cocare.io and WA Specialist Pain Services (WASPS).

The author gratefully acknowledges the extensive consultation with Dr Will Howard when revising this article for publication in the APS Newsletter.

5 Eippert and Tracey. The spinal cord is never at rest. eLife 2014;3:e03811. DOI: 10.7554/eLife.03811
NEW PRIMARY HEALTH NETWORKS MAY LEAD TO BETTER ACCESS TO PAIN SERVICES

New South Wales - 10
1. Central and Eastern Sydney
2. Northern Sydney
3. Western Sydney
4. Nepean Blue Mountains
5. South Western Sydney
6. South Eastern NSW
7. Western NSW
8. Hunter New England and Central Coast
9. North Coast
10. Murrumbidgee

Victoria - 6
11. North Western Melbourne
12. Eastern Melbourne
13. South Eastern Melbourne
14. Gippsland
15. Murray
16. Western Victoria

Queensland - 7
17. Brisbane North
18. Brisbane South
19. Gold Coast
20. Darling Downs and West Moreton
21. Western Queensland
22. Central Queensland and Sunshine Coast

South Australia - 2
24. Adelaide
25. Country SA

Western Australia - 3
26. Perth North
27. Perth South
28. Country WA

Tasmania - 1
29. Tasmania

Northern Territory - 1
30. Northern Territory

Australian Capital Territory - 1
NEW PRIMARY HEALTH NETWORKS MAY LEAD TO BETTER ACCESS TO PAIN SERVICES

Lesley Brydon

Painaustralia hopes the long-awaited formation of the new Primary Health Networks (PHNs) will lead to improved access to pain services in primary care, as recommended in the National Pain Strategy.

Announcing the successful tenders to manage the PHNs last month, the Federal Minister for Health Sussan Ley said the PHNs are closely aligned with state Local Hospital Networks and so are able to ensure better integration between primary and acute care services.

All state governments and the Australian Capital Territory have now supported the recommendations of the National Pain Strategy and most have invested funds to enhance hospital-based pain services.

However, the vast majority of people with persisting or chronic pain are best managed in the community or at primary care level with a team led by a GP and ongoing support for self-care.

More effective assessment and management of pain in primary care will help prevent development of chronic pain and free up the specialist pain clinics in public hospitals to treat more complex patients.

Training in multidisciplinary team-based pain management has been identified as a key area of need in Painaustralia’s 2014 review of progress with the National Pain Strategy and is highlighted in a recent report from NSW Agency for Clinical Innovation, which evaluated progress with NSW State-wide pain plan.

Painaustralia is keen to demonstrate the benefits and cost savings that can be achieved through early assessment and intervention for people with pain and has proposed a trial to evaluate this once the PHNs are operational. The study would be conducted by a team led by Painaustralia Director and Chair of Health Economics at the University of Sydney, Professor Deborah Schofield, in collaboration with Professor Michael Nicholas at the Pain management Research Institute.

With many of the PHN managers being consortiums, there is an ideal opportunity for collaboration between general practice, allied health providers, private health providers and insurers along with some of the former Medical Locals.

In addition to general health, PHNs will have six key work priorities: mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, eHealth and aged care.

An improved focus on the management of acute, chronic and cancer pain management is vital in all these areas. A total of 31 new PHNs will replace 61 Medicare Locals (MLs), with the roll out beginning from 1 July 2015. Painaustralia looks forward to working with the new PHNs, to continue the work of Medicare Locals with regard to chronic pain programs and services, and in particular to contribute to the long-term health of our workforce.
Pain: Meeting the Challenge
2016 Australian Pain Society
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KEYNOTE SPEAKERS

**Professor Frank Birklein**
has been head of Peripheral Nerve Disorders and Pain Research and Treatment at the Department of Neurology, University Medical Centre Mainz, Germany since 2001. His research focuses on the mechanisms of neuropathic pain in particular CRPS, and on mechanisms of autonomous nervous system regulation. He is the leading author of the German guidelines for CRPS diagnosis and treatment, has widely published in his research fields and has been awarded numerous scientific grants. His main interest now is the immune system contribution to posttraumatic pain.

**M. Catherine Bushnell PhD**
is Scientific Director at the National Center for Complementary and Integrative Health, National Institutes of Health, Bethesda, Maryland, USA. Dr Bushnell spent 12 years at the University of Montreal and 16 years as the Harold Griffith Professor of Anesthesia at McGill University before returning to NIH in 2012. Among her honors are a Lifetime Achievement Award from the Canadian Pain Society and the American Pain Society Frederick Kerr Research Award. Her mission is to understand the brain’s role in perceiving, modifying, and managing pain, with special emphasis on non-pharmacological modulation of pain.

**Professor David Yarnitsky**
is the Chair of Neurology at Rambam Health Care Campus, and Chair of the Clinical Neurophysiology Laboratory in the Technion Faculty of Medicine, both in Haifa, Israel. He is widely published in pain psychophysics and neurophysiology, in health, as well as in clinical pain syndromes such as migraine, painful neuropathy and post-operative pain. His current research interests are targeted at assessment of pain modulation, mainly by the CPM (Conditioned Pain Modulation) mechanism, and its implementation in pain therapy.

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AN ANALYSIS OF MULTIDISCIPLINARY STAFFING LEVELS AND CLINICAL ACTIVITY IN AUSTRALIAN TERTIARY PERSISTENT PAIN SERVICES
Anne L. J. Burke, Linley A. Denson, Jane L. Mathias and Malcolm N. Hogg

Article first published online: 28 FEB 2015
American Academy of Pain Medicine 2015 DOI: 10.1111/pme.12723

ABSTRACT

Objective
To document staffing (medical, nursing, allied health [AH], administrative) in Australian multidisciplinary persistent pain services and relate them to clinical activity levels.

Methods
Of the 68 adult outpatient persistent pain services approached (Dec ’08–Jan ’10), 45 agreed to participate, received over 100 referrals/year, and met the contemporaneous International Association for the Study of Pain criteria for Level 1 or 2 multidisciplinary services. Structured interviews with Clinical Directors collected quantitative data regarding staff resources (disciplines, amount), services provided, funding models, and activity levels.

Results
Compared with Level 2 clinics, Level 1 centers reported higher annual demand (referrals), clinical activity (patient numbers) and absolute numbers of medical, nursing and administrative staff, but comparable numbers of AH staff. When staffing was assessed against activity levels, medical and nursing resources were consistent across services, but Level 1 clinics had relatively fewer AH and administrative staff. Metropolitan and rural services reported comparable activity levels and discipline-specific staff ratios (except occupational therapy). The mean annual AH staffing for pain management group programs was 0.03 full-time equivalent staff per patient.

Conclusions
Reasonable consistency was demonstrated in the range and mix of most disciplines employed, suggesting they represented workable clinical structures. The greater number of medical and nursing staff within Level 1 clinics may indicate a lower multidisciplinary focus, but this needs further exploration. As the first multidisciplinary staffing data for persistent pain clinics, this provides critical information for designing and implementing clinical services. Mapping against clinical outcomes to demonstrate the impact of staffing patterns on safe and efficacious treatment delivery is required.
QUIET ABOUT PAIN: EXPERIENCES OF ABORIGINAL PEOPLE IN TWO RURAL COMMUNITIES

Jenny Strong, Mandy Nielsen, Michael Williams, Jackie Huggins and Roland Sussex

Article first published online: 6 MAY 2015
Australian Journal of Rural Health 2015 DOI: 10.1111/ajr.12185

ABSTRACT

Objective
This study explores communications experienced by Aboriginal people in health care encounters about pain. It examines barriers that can impact upon effective pain management for Aboriginal patients. (This article refers to Aboriginal people, as these were the study participants. It is not intended to exclude Torres Strait Islander people.)

Design
A qualitative study using focus groups.

Setting
Two Aboriginal communities in South East Queensland.

Participants
The participants were 20 men and 20 women who identified a health condition with associated pain for which they had sought health care, including pain relief. Their conditions included arthritis, orthopaedic injuries, back pain and coronary artery disease.

Results
Physical pains associated with participants’ health conditions were accorded a second place to deep emotional pain attributed to dispossession, dislocation and loss. At health facilities, prominent perceptions were that health professionals held a negative attitude towards them, and lacked respect and caring. Participants experienced that the language used by health professionals in consultations was complex.

Conclusions
Aboriginal people often do not report pain, on the basis of previous negative encounters with the health system. Other perceived barriers to effective pain management included discriminatory attitudes of health professionals and communication problems.
The Explain Pain Handbook: Protectometer represents the next step in the Explain Pain Revolution. Ten years in the making, the Handbook represents the most up to date thinking, and many hours of espresso fuelled debate, from Moseley and Butler. The Handbook distils the latest in neuroimmune pain science into an easily accessible book for patients and introduces the ‘Protectometer’ – a ground breaking pain treatment tool. Ongoing pain is the most costly health problem facing the world. Based on decades of research, Explain Pain (2003) launched what can only be called a revolution – the Explain Pain Revolution. Explaining Pain has become one of the world’s most effective and inexpensive treatments for pain. It is now the cornerstone of modern pain treatment and rehabilitation – with clinical studies showing its benefits across cultures, conditions and communities. In this patient-targeted handbook, we combine unique and original artwork with material that has been refined over the last twenty years. Scientists now agree that pain happens when the credible evidence of DANGER to your body is greater than the credible evidence of SAFETY to your body. Using this knowledge, we have developed the Protectometer – an easy to use tool that will help you apply this principle to understand and deal with your pain. Co-author Dr David Butler, founder of the Neuro Orthopaedic Institute, says that “it is no longer acceptable that pain be just managed: we must expect that it can be treated, and sufferers can alter it themselves through education.”

Check out this YouTube clip.
HAVE YOU HAD AN ARTICLE ACCEPTED FOR PUBLICATION THIS YEAR?

Reminder that we are keen that members inform us when they have publications so that this can be shared with your APS colleagues. Please send the newsletter editor (via the APS Secretariat, aps@apsoc.org.au) the title, authors and reference (i.e. the journal, volume etc.) of the article, preferably with a short explanatory note to give our readers the gist of the article, e.g. the conclusions part of the abstract; if you would like to supply a short commentary on the article, even better.

Will Howard, Editor
Feedback from people living in pain has a consistent major theme - It is the invisible burden that we don’t want to talk about - Let’s break the silence and reduce the stigma of living with chronic pain. This year the National Pain Week team is in two cities, Brisbane and Sydney and again riding around in the Big Red Bus. Chronic Pain Australia has invited pain clinics in Sydney and Brisbane to get involved during National Pain Week. 2015 will be the second year of our Snapshot Survey. For a full report on the findings from 2014’s surveys go to the National Pain Week website.

What you can do:
1. If you work in a pain clinic in Sydney or Brisbane, contact us to explore how we can work together with you and your patients to showcase what you are doing for people in pain. No cost!
2. If you are in Sydney, join us for lunch, music, conference and Q and A panel at the State Library of NSW on 24th July. Professor Phil Siddall, Petrea King and a host of other guests will be speaking about the issues for people living with chronic pain – don’t miss out as tickets are limited $15 or $10 early bird.
3. Spread the word among your patients and network – National Pain Week – get involved

Let’s start talking
npw@chronicpainaustralia.org.au
www.nationalpainweek.org.au
BUDGET OVERLOOKS OPPORTUNITY TO KEEP OLDER AUSTRALIANS IN THE WORKFORCE

The Federal Government Budget overlooks the opportunity to increase workforce participation by older Australians and improve productivity through prevention and better management of chronic pain.

Back problems and arthritis, both associated with chronic pain are the most common reason people aged between 45 and 64 drop out of the workforce, impacting negatively on productivity and taxation revenue and increasing welfare costs.

If we expect older Australians to keep working longer, we need a better model of care for prevention and management of chronic pain that is readily accessible in all communities and supported in the workplace.

Doctors cannot manage people with complex chronic conditions in a 20 minute consultation, and medication alone is not helpful for people with chronic pain.

Equally, the person in pain cannot operate in an information vacuum to become an informed engaged consumer without a component of expert guidance.

Ideally, we need a program like the Coordinated Veterans Care Program (CVC) which remunerates General Practitioners (GPs), supported by a practice nurse, to coordinate a team care arrangement involving specially trained allied health professionals and specialist care as needed.

Supporting people with chronic conditions with self-management strategies that reduce reliance on health services - including medication and surgery – has clear economic benefits. This calls for a new strategic national approach which involves:

- Incentives, including adequate funding by Medicare, for GPs and allied health professionals to collaborate to provide community-based pain programs with an emphasis on prevention and self-management of chronic conditions, including chronic pain.

- Provision of pain services from primary care (less complex patients / conditions) to tertiary care (more complex patients / conditions)

- Incentives for employers to provide flexible working environments, ergonomic assessments, and work-based exercise programs such as daily walking, mindfulness, Feldenkrais, Tai Chi and Yoga.

It is ironic that a person with a back problem or arthritis can get rebated for $40,000 or more for surgery – but cannot get adequate support for a special exercise program, hydrotherapy or cognitive behavioural program which would delay or prevent the need for surgery.

Government and health insurers alike would benefit financially from making highly effective, low cost community interventions available for managing chronic pain. The value of such programs is already being recognised by Workcover insurers.

Access to drug free strategies will help minimise the harm caused by misuse of medications, as recommended in the National Pharmaceutical Drug Misuse Framework for Action.

The proposal to rename the E Health system currently known as the Personally Controlled Electronic Health Record (PCEHR) is a move for the better, since most people would never use something they can’t pronounce. The new user-friendly name “My Health Records” may help overcome a major barrier to take up this potentially valuable tool. However clinicians may require incentives to fully participate.

Improving access to services for the one in five Australians who live with chronic pain and one in three people over 65, must be a priority for the new Primary Health Networks, as part of a national strategy to prevent and manage chronic illness – a major burden on the economy and the community.

Lesley Brydon, CEO Painaustralia
Phone: 02 9130 6086 or 0413 990 991
Email: lesley.brydon@painaustralia.org.au

May 2015
### SCHOLARSHIP FEATURE

Current Scholars

<table>
<thead>
<tr>
<th>PhD Scholarship Sponsor</th>
<th>Scholar</th>
<th>Topic</th>
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<tbody>
<tr>
<td></td>
<td>Mundipharma #3-APS-APRA</td>
<td>Audrey Wang</td>
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<tr>
<td></td>
<td>Topic</td>
<td>“An investigation of the role of the brain in recovery from CRPS, using fMRI”</td>
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<td></td>
<td>Janssen Cilag #2-APS-APRA</td>
<td>Sarah Kissiwaa</td>
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<td>Topic</td>
<td>“Pain induced synaptic plasticity in the amygdala”</td>
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<td>APS #5-APS-APRA</td>
<td>James Kang</td>
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<td>Topic</td>
<td>“Epigenetic influence in cognitive impairments in chronic neuropathic pain”</td>
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<tr>
<td>PhD Scholarship Sponsor</td>
<td>APS #1-APRA</td>
<td>Samantha South</td>
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<tr>
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<tr>
<td>CSL #1-APS-APRA</td>
<td>Lara Winter</td>
<td>2004</td>
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<tr>
<td>CSL #2-APS-APRA</td>
<td>Anne Pitcher</td>
<td>2006</td>
</tr>
<tr>
<td>APS #2-APRA</td>
<td>Debbie Tsui</td>
<td>2008</td>
</tr>
<tr>
<td>Mundipharma #2-APS-APRA</td>
<td>Zoe Brett</td>
<td>2011</td>
</tr>
<tr>
<td>APS #3-APRA</td>
<td>Susan Slatyer</td>
<td>2013</td>
</tr>
<tr>
<td>Janssen Cilag #1-APS-APRA</td>
<td>Mary Roberts</td>
<td>Due 2015</td>
</tr>
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</table>
Endometriosis is a silent torment for thousands of women and young girls. One in ten women suffer from Endo and yet most people have never heard of it. Girls as young as ten miss out on school because of severe pelvic pain associated with Endo. Diagnosis is often slow and misunderstood and Endo frequently results in infertility. It costs Australia 7.7 billion dollars every year.

Lesley Freedman and her daughter Sylvia have been extremely proactive in raising awareness of Endometriosis and have formed a consumer group called EndoActive which now has over 5000 followers on Facebook. When they discovered that the drug Visanne was not available in Australia despite evidence that it helped reduce the lesions of Endo, they set up a petition on Change.org and ended up with 74,619 signatures, which led to Bayer reversing their decision on distributing the drug in Australia.

So it was with this great enthusiasm that the Freedmans planned the inaugural EndoActive Conference at the University of Sydney this May. Over 200 young women, often with partners or parents, as well as many health professionals attended to hear more about this debilitating disease.

One of the impressive line-up of speakers was Dr Susan Evans, a member of the Australian Pain Society and Founder of the Pelvic Pain Foundation who spoke about Endometriosis and Pelvic Pain. Other topics covered Endo and Fertility, Global Research, the Immune System and Endo, Endo in Primary Care and the Medical Management of the disease.

The conference was filmed and there are plans to seek funding for an educational DVD for consumers and healthcare professionals in rural areas.
PROFILE: APS WEBSITE FEATURES FOR MEMBERS

SUBMIT POSITION VACANT

This feature is only available in the Members Area of the APS website and allows members to submit Positions Vacant in a defined format with selected information as compulsory fields for listing consistency.

In addition to the compulsory information, members are given the opportunity to upload a PDF, JPG, JPEG or GIF file with a maximum size of 4Mb, which may further expand on the role available.

Submitted positions vacant are not automatically listed on the website.

All submitted position vacant are reviewed by the secretariat prior to being made available on the members area of the website. Only current APS members may list positions vacant.

The following sample image may help acquaint you with this new feature:
TOPICAL SESSION SUBMISSIONS NOW OPEN!

On behalf of the Scientific Program Committee and the Local Organising Committee, we are pleased to advise topical session submissions for the APS 2016 ASM is now open.

The deadline for Topical Session submissions is:

**WEDNESDAY 22 JULY 2015**

View the topical session submission guidelines

Visit the online topical session submission page

We look forward to receiving your submissions. Should you have any queries regarding your submission or the process, please contact the Conference Secretariat

ABSTRACT SUBMISSIONS FOR FREE PAPERS AND POSTERS WILL OPEN ON 20 JULY 2015
“MAKING SENSE OF PAIN”

AN INTER-DISCIPLINARY WORKSHOP
FOR ALL HEALTH PROFESSIONALS
Friday 26th-Saturday 27th June 2015

For details and registration: https://www.arthritiswa.org.au/events/details/id/247/

Contacts: Melanie Galbraith, MelgieG@arthritiswa.org.au; John Quintner, jgu33431@bigpond.net.au
The Organising Committee extends a warm invitation to all nurse practitioners and those interested in advanced nursing practice to attend the 10th Conference of the Australian College of Nurse Practitioners, to be held in Melbourne from 6-8 September 2015. The 6th Australian Emergency Nurse Practitioner Symposium will follow ACNP from 9-10 September 2015.

The conference theme Celebrating the Past and Embracing the Future, aims to consolidate past learnings and focus on new directions.

Program themes include:
- Acute and emergency care
- Primary Care
- Private Practice
- Chronic Diseases
- Professional Issues
- Leadership and research

The conference provides an opportunity for delegates to come together from a wide variety of backgrounds to share information, exchange ideas and network with others.
FYI

Items of interest for our members:


**ePPOC: electronic Persistent Pain Outcomes Collaboration**

**IASP Curricula**
These curricula outlines are helpful for establishing teaching courses on acute, chronic and cancer pain at both the undergraduate and graduate level. [http://www.iasp-pain.org/Education/CurriculaList.aspx?navItemNumber=647](http://www.iasp-pain.org/Education/CurriculaList.aspx?navItemNumber=647)

By Pamela E Macintyre and Stephan A Schug

**Pelvic Pain Foundation of Australia**

**Fast Facts: Chronic and Cancer Pain, Third Edition**
By Michael J Cousins and Rollin M Gallagher
Price: US $25 - Special 20% Discount for APS members, use code: CCP20:

**Primary Health Networks (PHNs)**
28 of the 31 PHNs were announced on 13 April 2015. See the listing on our website: [http://www.apsoc.org.au/PDF/Useful_Links/Primary_Health_Network_List_at_13APR15.pdf](http://www.apsoc.org.au/PDF/Useful_Links/Primary_Health_Network_List_at_13APR15.pdf)

**Choosing Wisely Australia**
Launched 29 April 2015:

**Explain Pain Handbook**
By David Butler and Lorimer Moseley:
[https://www.youtube.com/watch?v=VKBMcRRWdSI](https://www.youtube.com/watch?v=VKBMcRRWdSI)

**Can your brain reduce your pain?**
ABC Radio National podcast 21 May 2015:
POSITION VACANT & NEW MEMBERS

PSYCHOLOGIST

Capital Pain & Rehabilitation Clinic, ACT

Employment Status: Contract/Consulting  
Hours per week: Negotiable  
Contact: Rebecca Mack (T: 02 6282 6240; E: rebecca@capitalrehab.com.au)  
Applications Close: 05JUN15

Capital Pain and Rehabilitation Clinic is a well-established private practice in Canberra looking for a dynamic, self-motivated psychologist with well-developed clinical skills to join our team. The successful applicant will be part of a clinic providing high quality assessments, group and individual interventions to a range of clients generally with persistent pain problems.

The position offers very competitive remuneration, supervision is available, regular case conferences and team meetings, and professional development opportunities are fostered. Hours would be negotiable for the successful candidate.

NEW MEMBERS

<table>
<thead>
<tr>
<th>Title</th>
<th>First Name</th>
<th>Last Name</th>
<th>Discipline Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr</td>
<td>Patrick</td>
<td>Gibney</td>
<td>General Practice</td>
</tr>
<tr>
<td>Dr</td>
<td>Diarmuid</td>
<td>McCoy</td>
<td>Pain Medicine Physician</td>
</tr>
<tr>
<td>Mr</td>
<td>Thomas</td>
<td>Park</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Miss</td>
<td>Usanee</td>
<td>Tangyotkajohn</td>
<td>Physiotherapy</td>
</tr>
</tbody>
</table>
**CALENDAR OF EVENTS**

3-4 Jun 2015  
**WIP Benelux 2015**  
*6th International Evidence-based Interventional Pain Medicine Symposium*  
Crowne Plaza Maastricht, Maastricht, The Netherlands  
[http://www.wipbenelux.org](http://www.wipbenelux.org)  

6-11 Jun 2015  
**INS International Neuromodulation Society 12th World Congress**  
*Neuromodulation - Medicine Evolving Through Technology*  
Fairmont Queen Elizabeth Hotel, Montreal, Quebec, Canada  

13-14 Jun 2015  
**Rehabilitation Medicine Society of Australia and New Zealand Inaugural Workshop**  
*Rehabilitation Snapshots 2015*  
Amora Hotel Jamison Sydney NSW  

16-18 Jun 2015  
**National Aboriginal Community Controlled Health Organisation**  
*2015 NACCHO Health Summit*  
Gold Coast Convention and Exhibition Centre, Gold Coast, QLD  

25-26 Jun 2015  
**Urological Society of Australia and New Zealand**  
*1st USANZ Functional Urology Symposium incorporating the 3rd Biennial Male LUTS Symposium*  
Sheraton on the Park Sydney, NSW  

26-27 Jun 2015  
**Arthritis & Osteoporosis WA**  
*Making Sense of Pain - a workshop for Health Professionals*  
Wylie Arthritis Centre, Perth, WA  

1-3 Jul 2015  
**Occupational Therapy Australia**  
*Changes, Challenges, Choices*  
Melbourne Convention and Exhibition Centre, Melbourne, VIC  
## CALENDAR OF EVENTS

### 27-28 Jul 2015
**Urological Society of Australia and New Zealand**
*8th Asia Pacific Photoselective Vaporisation of the Prostate Workshop*
Sydney Adventist Hospital Sydney, NSW

### 13-14 Aug 2015
**Drug and Alcohol Nurses of Australasia – DANA**
*Many Faces of Addiction Forum 2015*
Novotel Sydney Central, Sydney, NSW
http://danaconference.com.au

### Various dates from 20 Aug-22 Oct 2015
**Empower Rehab**
*Pain Management in Practice 2 day workshop*
Various venues, Brisbane, Melbourne, Sydney
http://www.empowerehab.com/workshops/

### 6-10 Sep 2015
**Australian College of Nurse Practitioners (ACNP) 10th Conference & 6th Australian Emergency Nurse Practitioner Symposium**
*Celebrating the past and embracing the future*
Pullman, Albert Park, Melbourne, VIC

### 10-11 Sep 2015
**Australian Disease Management Association (ADMA) 11th Annual National Conference**
*Count me in: Partnerships in chronic care*
Brisbane Convention & Exhibition Centre, Brisbane, QLD

### 28 Sep - 2 Oct 2015
**Australian Psychological Society 2015 Annual Conference**
*50th Anniversary Conference*
Gold Coast, Gold Coast, QLD
CALENDAR OF EVENTS

3-6 Oct 2015
Australian Physiotherapy Association
APA Conference 2015
Gold Coast Convention and Exhibition Centre, Gold Coast, QLD

14-16 Oct 2015
Australian College of Nursing
The National Nursing Forum 2015 - Advancing nurse leadership
Brisbane Convention & Exhibition Centre, Brisbane, QLD

23 Oct 2015
Pain Interest Group Nursing Issues (PIGNI)
Inside Joint Pain - Professional Development One-Day Program
Le Montage, Lilyfield Sydney, NSW

8-18 Feb 2016
University of Sydney - Sydney Medical School - Pain Management Research Institute
Pain Management Multidisciplinary Workshop 2016
Kolling Building, Royal North Shore Hospital, St Leonards, Sydney, NSW

13-16 Mar 2016
Australian Pain Society 36th Annual Scientific Meeting
Pain: Meeting the Challenge
Perth Convention and Exhibition Centre, Perth, WA

20-23 May 2016
World Institute of Pain (WIP)
8th World Congress
Hilton NYC, New York, USA
http://wip2016.kenes.com
VISION:
All people will have timely recognition, prevention and management of pain across their lifespan.

MISSION:
The Australian Pain Society is a multidisciplinary body aiming to relieve pain and related suffering through leadership in clinical practice, education, research and public advocacy.

AIMS:
- To promote the provision of healthcare services for pain management
- To promote equity of access to pain management services
- To actively engage with key stakeholders and contribute to their activities
- To provide a contemporary forum to discuss issues relating to pain research and treatment
- To foster and support a broad spectrum of pain-related research
- To share and promote the expertise of all disciplines involved in the treatment of pain
- To promote the formulation and use of Evidence Based Guidelines as they relate to pain
- To foster and support the prevention of persistent pain
- To promote and facilitate pain related education for health professionals and the community
- To promote the development and use of standards and outcome measures in everyday clinical practice
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