The non-medical use and medical abuse of prescription drugs is now accepted to be in almost epidemic proportions. Over-the-counter and prescription opioids are linked to deaths in the community, killing more people than motor vehicle accidents in the United States of America and more recently, Australia. This has resulted in the development of increased regulation for opioids, however, paradoxically, there are simultaneous pressures to increase opioid prescribing for patients. In an effort to understand the place of prescription opioids a research group in 2014 commenced the 2-year cohort study of approximately 1,500 patients, called the Pain and Opioids IN Treatment (POINT) study. The POINT research has achieved an incredible list of publications, of which the salient findings are published in this newsletter. I would encourage everyone to take the time to read the dissemination of the Pain and Opioids IN Treatment (POINT) studies in this month’s newsletter, and access the full articles which begin to answer some complex questions.

It also seems that the politicians and ministers are beginning to understand the reality that pain is complex with some funding of early evidence-informed programs. The ability to document improvement in outcomes, is paramount. Susie Lord has provided a review of the paediatric PROMIS tools, which confirms that “legacy” questionnaires provide reliable outcome data which is significant to those using traditional validated outcome questionnaires. This is vital to the development of the electronic Persistent Pain Outcomes Collaboration (ePPOC) in Australia which is using “legacy” questionnaires for entry into interprofessional pain centres. The ‘take-home’ messages were that whilst PROMIS is promising it is not proven, and it is too early to throw out ‘legacy’ measures currently used in child and adolescent versions of ePPOC.

I am sure this information will be one of the many important topics to discuss at the Australian Pain Society conference in Perth, March 13-16, 2016.

Stephanie Davies
Editor
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- Professor Frank Birklein
- Dr Petra Schweinhardt
- Dr Barry Sessle and
- Professor David Yarnitsky

will share their knowledge and experience with you in a relaxed and informal breakfast setting. Numbers are strictly limited.

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Conference Gala Dinner

INTERNATIONAL KEYNOTE SPEAKERS

Professor Frank Birklein
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.

Dr Petra Schweinhardt
Dr Petra Schweinhardt is an Associate Professor and full time researcher in the Faculty of Dentistry and Department of Neurology and Neurosurgery, Faculty of Medicine at McGill University, Montreal, Canada.

Dr Barry Sessle
Dr Barry Sessle has been Professor in the University of Toronto Faculties of Dentistry and Medicine since 1976.

Professor David Yarnitsky
Professor David Yarnitsky is Chair of Neurology at Rambam Health Care Campus, and of the Clinical Neurophysiology Laboratory; Technion Faculty of Medicine, both in Haifa, Israel.

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.

Stephanie Davies, Editor
Plenty to gain from managing pain

By Andrew Kerr

It’s important that pharmacists have a broad comprehension of the concept of pain, as each year it exerts huge pressure on the Australian health system by broadly impacting hundreds of thousands of individuals as well as those closest to them. Chronic pain can adversely affect one’s ability to function and emotional wellbeing, not to mention having serious social and financial consequences. Olly Zekry won the QUM Award for Pain Management for Pharmacists across Australia in 2014. Ms Zekry holds a Masters in Pain Management from Sydney University and is the unit coordinator for the pharmacology unit of the course with the Sydney Medical School’s Pain Management and Research Centre at the Royal North Shore Hospital. She also works as a Clinical Pharmacist in the Pharmacy Department at the Royal Prince Alfred Hospital.

Ms Zekry has outlined a paradigm shift in pain management from a biomedical approach to a multidimensional, ‘biopsychosocial’ treatment model that helps gain an understanding of what is happening to the body, to the person and in the person’s world. Because there is often no cure for chronic pain, she believes the aim of pain management is to shift the patient’s focus from having a pain-centred life to improving function despite persisting pain.

“You need to look at the whole picture to help chronic pain sufferers to improve,” she said. “Applying the biopsychosocial model to assess each patient can easily be done by pharmacists and will help reduce the number of patients who go on the waiting lists at pain clinics. It can even help to save lives.

“But pharmacists have to be interested in the pain management area. They need the knowledge and they need to be passionate about helping their patients. Those who know about the biopsychosocial model and are applying it to patients in primary care, and use the proper tools, are the pharmacists who can really help patients.”

In terms of freely accessible tools, Ms Zekry highlights the value of the BPI (brief pain inventory) form, which can be downloaded for free.

“When someone comes in with chronic pain, it’s very important to sit down with them and complete the BPI,” she said. “It’s simple and it will give them a direction for their pain management plan.”

In accordance with a biopsychosocial approach, the first treatable causes of pain, if present, should be addressed to reduce pain generators. In the absence of treatable causes, the aim of analgesic therapy is not to eliminate the pain, but to reduce it to enable improvements in function and quality of life.

From a psychological perspective, the presence of comorbid conditions such as depression need to be managed as this can improve pain management. In addition, unhelpful behaviour and thoughts (so-called ‘yellow flags’) should be addressed.

From a social perspective, the aim is to reduce the impact of pain on function. The patient needs to be encouraged to increase activity to avoid secondary consequences of chronic pain, such as deconditioning and social isolation. The focus should be on enabling self-management and avoiding the long-term use of passive strategies or therapies.

Examples of self-management strategies include general exercise, activity pacing, physiotherapy programs (specific exercises or stretching to improve conditioning), work, social activities, relaxation/meditation and distraction.

Ms Zekry cites Australian research that suggests the use of self-management strategies among patients with chronic pain can be improved. One survey identified passive strategies as being more common than active strategies, with medication use (47 per cent) being the most popular therapy.

The biopsychosocial approach to pain management

**Biological**
- Assess all contributing pain diagnoses.
- Take a detailed pain history and conduct a physical examination, determine the location of the pain (anatomical) and, if possible, the pain mechanism, e.g. neuropathic, inflammatory, etc. Rule out red flags such as cancer, infection or fracture.

**Psychological**
- Assess psychological contributors, documenting psychological responses to pain such as catastrophising, coping style (active or passive) and low self-efficacy. Identify any yellow flags (e.g. attitudes and beliefs about pain, behaviour, emotions) that may impede the rehabilitation process. Identify the presence of major depression and general anxiety disorder.

**Social**
- Socioeconomic assessment. Document the socioeconomic consequences of pain, such as impact on employment and finances, social isolation, or levels of support. Consider extrinsic factors that will affect pain, such as physically strenuous employment or an adaptable work environment.
- Risk assessment for medication misuse. Assess the risk of developing problematic behaviour with medications such as opioid analogics, for example.

**Physical**
- Assess impact of pain on the ability to function and perform everyday tasks. Determine the patient's current functional status. 

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Preventing pain progression

Olly Zekry insists pharmacists can help prevent the progression of acute pain to chronic pain if they have the right education.

“It’s vital to be able to identify the difference between acute and chronic pain, and the difference between neuropathic pain and nociceptive pain,” she said. “If we can manage to treat the pain in the acute phase, we can prevent a patient falling into clinical depression, get people back to work, help with their social lives and so on. If pharmacists are making an effort and they’re passionate about it, they will succeed 100 per cent.

“Pharmacists can also play a big role in the active self-management of pain and this is an easy thing for pharmacists to do, especially if they have a close relationship with the patient and can influence the patient in self-management. There are so many resources now, such as the Agency for Clinical Innovation (ACI) website (www.aci.health.nsw.gov.au), where they can freely go through active self-management plans. There are also excellent books like Manage Your Pain by Dr Michael Nicholas.

“If we manage to identify yellow flags [psychosocial risk factors for developing disability following the onset of musculoskeletal pain], then we can use our power and our patients’ trust to convince the patient to go and see a psychologist, for example.”

Ms Zekry considers the most important yellow flag to be catastrophising, where someone believes that the pain prevents them from doing almost any activity.

“They end up sitting in bed, they end up losing their job, gaining weight and being depressed,” she said. “If you pick up from the beginning that the patient is catastrophising and refer them to a physiotherapist for exercise, and to a psychologist, you can help them to get over that quickly and prevent all these other consequences.”

Patient attitude is clearly very important when discussing and committing to a pain management plan.

“The hardest patients are the ones on work compensation, because you find some of them don’t want to get better,” Ms Zekry said. “The other ones are the drug addicts. We have our limitations with people like that, but can refer them to the pain clinic and put them in the right hands.”

Australia also has an ageing and increasingly overweight population, which poses challenges for management strategies, but Ms Zekry proposes helpful new ideas that extend to a laughing group.

“Laughing can increase the amount of endogenous opioids in your body and relieve stress and we have adopted these groups from the Americans,” she said.

“You get a group of people with pain and you go walking together and they walk and walk, and stop suddenly, and look at each other, and they laugh. This is active self-management: walking is helping them for exercise and laughing is also good for them, helping to relieve their stress and causing them to forget about their pain, so it’s a diversion. Pharmacists in the community can organise a laughing group with the community support centre, for example.”

Two groups that Ms Zekry believes need considerable help are those relying exclusively on medication for pain management and those who have no form of therapy.

“I get some patients who might have arthritis that is preventing them sleeping at night, but they accept it as part of ageing and don’t want to take any medication,” she said.

“I get so mad when I hear that. Just because you’re getting older doesn’t mean that you have to suffer pain. On the other hand, there are others who say ‘Fix me or you’re not a good doctor and I’ll go to someone else’. They just want medication to fix all the problems.”

Establishing a network

Before a pharmacy develops a network for pain management, Ms Zekry insists they need to improve their knowledge about chronic pain.

“They need to be able to distinguish neuropathic pain from nociceptive pain and be assessed on this,” she said.

“The pharmacist needs to know how to engage patients in an active self-management plan and know what tools they’re going to use. Once we are confident that a certain pharmacist can do that, after they pass certain assessments, and they are proven to be legitimate and ethical, then you have to organise funds for their time.

“They have to have a system for helping patients with chronic pain. They can assess a patient using the BPI and employ the biopsychosocial model, and they have to have connections with a clinical psychologist who specialises in pain management and, very importantly, liaise with an exercise physiotherapist. They also require easy access to a GP that is specialising in pain management and will go along with your pain management plan, and they have to have access to a pain clinic.”

Ms Zekry says one of her next steps is to try to get pharmacists to work in the pain clinics.

“I have been selected as the executive representative on the ACI committee for pain management and I would like government funding so the pain clinics can employ a pharmacist one day a week,” she said.

“The pharmacist, as the drug expert, can take over the drug medication of the patients and review the medication, rather than the nurse. In Canada and the States, they have pharmacists in the pain clinics and they actually have pharmacists prescribing. Every pain clinic here now has one or two psychologists, but what about the pharmacists? I believe we have an equally important role compared with other professionals. I think the pharmacist should get in, prove themselves and play a big role in the pain management area.”

Thanks to APS member Olly Zekry for sharing this recent publication in Health Analgesics and Pain Management, April 2015.
In my overly simplified summary the characteristics of approximately 1,500 community-based recruited patients reported their progress whilst on opioids for chronic non-cancer pain (CNCP), of which some of the outcomes are associated with less than optimal progress. Overall, in people on opioids for CNCP:

- 1 in 10 was on a daily morphine equivalent dose of ≥200 mg
- Employment and income levels were low
- Two-thirds of the sample reported that their pain had impacted on their employment status
- Approximately 50% screened positive for current moderate-to-severe depression; and
- 1 in 5 had made a lifetime suicide attempt.

The younger groups experienced higher levels of pain and pain interference, more mental health and substance use issues, and barriers to treatment, compared with the older group.

This study found that the people who have been prescribed strong opioids for chronic pain have very complex demographic and clinical profiles. A low pain self-efficacy score was the only factor independently associated past 12 month suicidal ideation-to-action. Individuals on opioids for CNCP met lifetime criteria for dependence (ICD-11 ~ 10%).

In addition, one in six (16%) had used cannabis for pain relief, those using cannabis for pain had higher pain interference after controlling for reported pain severity. A significant minority, 8.5%, met criteria for lifetime ICD-10 pharmaceutical opioid dependence and 4.7% met criteria for past year ICD-10 pharmaceutical opioid dependence. One-third of participants reported benzodiazepine (BZD) use in the past month, and 17% reported daily BZD use. BZD use was associated with:

1. greater pain severity, pain interference with life, and lower feelings of self-efficacy with respect to their pain;
2. being prescribed “higher-risk” (>200 mg oral morphine equivalent) doses of opioids;
3. using antidepressant and/or antipsychotic medications;
4. substance use (including more illicit and injection drug use, alcohol use disorder, and daily nicotine use); and
5. greater mental health comorbidity.

After controlling for differences in demographic characteristics, physical and mental health, substance use, and opioid dose, BZD use was independently associated with greater past-month use of emergency health care such as ambulance or accident and emergency services.

Opioid use was not associated with sleep disturbance or respiratory sleep impairment. Six in ten (61%) on opioids for non-cancer pain reported lifetime depression, of those, almost half developed depression after pain and after they started opioid medications (68%). High rates of Complimentary and Alternative Medicines (CAM) mirror the use of opioids, which are limited in evidence for improving the life of those people with ongoing pain.
RECENT PUBLICATIONS

Thanks to APS members Milton Cohen, Bianca Hoban and colleagues who are working on the Pain and Opioids IN Treatment (POINT) study:

1. COHORT PROTOCOL: THE PAIN AND OPIOIDS IN TREATMENT (POINT) STUDY


BMC Pharmacology and Toxicology (2014), 15; 17
DOI: 10.1186/2050-6511-15-17
Published: 26 JAN 2016
Link: View webpage

ABSTRACT

Internationally, there is concern about the increased prescribing of pharmaceutical opioids for chronic non-cancer pain (CNCP). In part, this is related to limited knowledge about the long-term benefits and outcomes of opioid use for CNCP. There has also been increased injection of some pharmaceutical opioids by people who inject drugs, and for some patients, the development of problematic and/or dependent use.

To date, much of the research on the use of pharmaceutical opioids among people with CNCP have been clinical trials that have excluded patients with complex needs, and have been of limited duration (i.e. fewer than 12 weeks). The Pain and Opioids In Treatment (POINT) study is unique study that aims to: 1) examine patterns of opioid use in a cohort of patients prescribed opioids for CNCP; 2) examine demographic and clinical predictors of adverse events, including opioid abuse or dependence, medication diversion, other drug use, and overdose; and 3) identify factors predicting poor pain relief and other outcomes.

METHODS

The POINT cohort comprises 1,500 people across Australia prescribed pharmaceutical opioids for CNCP. Participants will be followed-up at four time points over a two year period. POINT will collect information on demographics, physical and medication use history, pain, mental health, drug and alcohol use, non-adherence, medication diversion, sleep, and quality of life. Data linkage will provide information on medications and services from Medicare (Australia’s national health care scheme). Data on those who receive opioid substitution therapy, and on mortality, will be linked.

DISCUSSION

This study will rigorously examine prescription opioid use among CNCP patients, and examine its relationship to important health outcomes. The extent to which opioids for chronic pain is associated with pain reduction, quality of life, mental and physical health, aberrant medication behavior and substance use disorders will be extensively examined. Improved understanding of the longer-term outcomes of chronic opioid therapy will direct community-based interventions and health policy in Australia and internationally. The results of this study will assist clinicians to better identify those patients who are at risk of adverse outcomes and who therefore require alternative treatment strategies.

2. THE PAIN AND OPIOIDS IN TREATMENT (POINT) STUDY: CHARACTERISTICS OF A COHORT USING OPIOIDS TO MANAGE CHRONIC NON-CANCER PAIN.

Campbell, G., Nielsen, S., Bruno, R., Lintzeris, N., Cohen, M., Hall, W., Larance, B., Mattick, R.P., & Degenhardt, L.

Pain (2015) 156(2), pp.231-242
DOI: 10.1097/j.pain.0000460303.63948.8e
Link: View webpage
ABSTRACT

There has been a recent increase in public and professional concern about the prescription of strong prescription opioids for pain. Despite this, research to date has been limited due to a number of factors such as small sample sizes, exclusion of people with complex comorbidities, and studies of short duration. The Pain and Opioids IN Treatment (POINT) is a 2-year prospective cohort study of 1,500 people prescribed pharmaceutical opioids for their chronic pain. The current paper provides an overview of the demographic and clinical characteristics of the cohort using the baseline data of 1,514 community-based people across Australia.

Participants had been in pain for a period of 10 years and had been on prescription opioids for approximately four years. One-in-ten were on a daily morphine equivalent dose ≥ 200mg. Employment and income levels were low and two-thirds of the sample reported that their pain had impacted on their employment status. Approximately 50% screened positive for current moderate to severe depression and one-in-five had made a lifetime suicide attempt. There were a number of age-related differences. The younger groups experienced higher levels of pain and pain interference, more mental health and substance use issues and barriers to treatment, compared with the older group.

The current study found that the people who have been prescribed strong opioids for chronic pain have very complex demographic and clinical profiles. Major age-related differences in the experiences of pain, coping, mental health and substance use suggest the necessity of differential approaches to treatment.

3. DIVERSION OF PRESCRIBED OPIOIDS BY PEOPLE LIVING WITH CHRONIC PAIN: RESULTS FROM AN AUSTRALIAN COMMUNITY SAMPLE

Belcher, J., Nielsen, S., Campbell, G., Bruno, R., Larance, B., Lintzeris, N., & Degenhardt, L.

DOI: 10.1111/dar.12084
Link: View webpage

ABSTRACT

Introduction and aims
There has been an increase in the prescription of opioids for chronic non-cancer pain, and concern has arisen over possible diversion of prescription opioids from patients to the illicit market place. Recent media coverage suggests that elderly patients sell their prescribed opioids for additional income. This study investigated the extent to which an Australian community sample of chronic pain patients prescribed opioids reported supplying their prescribed opioids to others.

Results
Participants had been living with chronic pain for M=14.2 years; most common conditions included chronic back/neck problems and arthritis/rheumatism. Around half (43%) were currently prescribed one opioid; 55% had two to five opioids; the most common opioid prescribed was oxycodone. Forty-two participants (4%) reported ever supplying prescribed opioids to another person, and one participant reported receiving payment for supplying their friend with prescription opioids. Participants who reported supplying their opioids to another person were significantly younger (t (948) = -2.65, p = .008) and were more likely to engage in a greater number of aberrant behaviours (t(948) = 3.02, p = .003) compared to those who did not.

Design and methods
Participants living with chronic non-cancer pain and prescribed opioids for their pain (n=952) were recruited across Australia via advertisements at pharmacies. A telephone interview included questions about their pain condition and opioid medication.

Discussion and conclusion
Few people with chronic non-cancer pain divert their opioids to others. Media reports of elderly patients selling their opioids to supplement their income may be reflective of exceptional cases. Future studies may investigate the extent to which other patient groups divert prescription opioids to the illicit market place.
4. EXPERIENCE OF ADJUNCTIVE CANNABIS USE FOR CHRONIC NON-CANCER PAIN: FINDINGS FROM THE PAIN AND OPIOIDS IN TREATMENT (POINT) STUDY.


Drug and Alcohol Dependence (2015) 147, 144-150
DOI: 10.1016/j.drugalcdep.2014.11.031
Link: View webpage

ABSTRACT
Background
There is increasing debate about cannabis use for medical purposes, including for symptomatic treatment of chronic pain. We investigated patterns and correlates of cannabis use in a large community sample of people who had been prescribed opioids for chronic non-cancer pain.

Methods
The POINT study included 1,514 people who had been prescribed pharmaceutical opioids for chronic non-cancer pain. Data on cannabis use, ICD-10 cannabis use disorder and cannabis use for pain were collected. We explored associations between demographic, pain and other patient characteristics and cannabis use for pain.

Results
One in six (16%) had used cannabis for pain relief, with 6% having done so in the previous month. A quarter reported that they would use it for pain relief if they had access. Those using cannabis for pain were younger, reported greater pain severity, greater interference from and poorer coping with pain, and more days out of role in the past year. They had been prescribed opioids for longer, were on higher opioid doses, and were more likely to be non-adherent with their opioid use. Those using cannabis for pain had higher pain interference after controlling for reported pain severity. Almost half (43%) of the sample had ever used cannabis for recreational purposes, and 12% of the entire cohort met criteria for an ICD-10 cannabis use disorder.

Conclusions
Cannabis use for pain relief purposes appears common among people living with chronic non-cancer pain, and users report greater pain relief in combination with opioids than when opioids are used alone.

5. BENZODIAZEPINE USE AMONGST CHRONIC PAIN PATIENTS PRESCRIBED OPIOIDS: ASSOCIATIONS WITH PAIN, PHYSICAL AND MENTAL HEALTH AND HEALTH SERVICE UTILIZATION

Nielsen, S., Lintzeris, N., Bruno, R., Campbell, G., Larance, B., Hoban, B., Hall, W., Cohen, M., & Degenhardt, L.

DOI: 10.1111/pme.12594
Link: View webpage

ABSTRACT
Benzodiazepines (BZDs) are commonly used by chronic pain patients, despite limited evidence of any long term benefits and concerns regarding adverse events and drug interactions, particularly in older patients. This paper aims to: describe patterns of BZD use; the demographic, physical and mental health correlates of BZD use; and examine if negative health outcomes are independently associated with BZD use in a national sample of 1220 chronic non cancer pain (CNCP) patients prescribed opioids. One-third (32.6%) of patients reported BZD use in the past month. BZD use was associated with: 1) greater pain severity, pain interference with life and lower feelings of self-efficacy with respect to their pain; 2) being prescribed ‘higher-risk’ (> 200 oral morphine equivalent mg) doses of opioids; 3) using antidepressant and antipsychotic medications; 4) substance use and 3) greater mental health co-morbidity. Daily BZD use was independently associated with greater past-month use of emergency health care such as ambulance or accident and emergency services. CNCP patients using BZDs daily represent a high-risk group with multiple comorbid mental health conditions, and higher rates of emergency health care use. The high prevalence of BZD use is inconsistent with guidelines for the management of CNCP or chronic mental health conditions.
ABSTRACT
Study Objectives
To examine sleep disturbances in the POINT cohort study consisting of participants prescribed long-term opioids for chronic non-cancer pain (CNCP), and to examine the relationship between sleep and measures of pain, physical and mental health, substance use and medication use at the baseline interview.

Methods
A convenience sample of 1,243 participants with current CNCP and prescription opioid use were recruited from community settings and underwent a structured interview examining subjective sleep symptoms (Medical Outcomes Study (MOS) Sleep Scale and the Sleep Problems Index (SLP-9)), pain severity and interference using the Brief Pain Inventory, mental and physical health symptoms, recent substance and medication use. Linear regression models assessed independent predictors of SLP-9 scores.

Results
Median hours of sleep per night was 6 (IQR 5-7.5) with 26% reporting optimal sleep (seven to eight hours), and a mean SLP-9 score of 47.3 (SD 20.9). On multivariate analysis, age, frequent/severe headaches, total BPI pain severity and pain interference scores, moderate to severe anxiety or depression, daily tobacco use and past week benzodiazepine use were significant predictors of SLP-9 scores and sleep quality. Higher MOS respiratory impairment was observed in males, those with high BMI, frequent/severe headaches, high pain interference scores and in patients taking anticonvulsants and antipsychotic medications. Opioid use was not associated with SLP-9 or respiratory sleep impairment.

Conclusions
High levels of sleep problems were reported in this community sample of CNCP patients, and were associated with mental health problems and increased medication use. Non-medication approaches to addressing sleep problems should be prioritised in this population.

6. SLEEP QUALITY AMONG PEOPLE LIVING WITH CHRONIC NON-CANCER PAIN: FINDINGS FROM THE PAIN AND OPIOIDS IN TREATMENT (POINT) COHORT

Lintzeris, N., Campbell, G., Moodley, R., Bruno, R., Larance, B., Nielsen, S., & Degenhardt, L.

ABSTRACT
Study Objectives
To examine sleep disturbances in the POINT cohort study consisting of participants prescribed long-term opioids for chronic non-cancer pain (CNCP), and to examine the relationship between sleep and measures of pain, physical and mental health, substance use and medication use at the baseline interview.

Methods
A convenience sample of 1,243 participants with current CNCP and prescription opioid use were recruited from community settings and underwent a structured interview examining subjective sleep symptoms (Medical Outcomes Study (MOS) Sleep Scale and the Sleep Problems Index (SLP-9)), pain severity and interference using the Brief Pain Inventory, mental and physical health symptoms, recent substance and medication use. Linear regression models assessed independent predictors of SLP-9 scores.

Results
Median hours of sleep per night was 6 (IQR 5-7.5) with 26% reporting optimal sleep (seven to eight hours), and a mean SLP-9 score of 47.3 (SD 20.9). On multivariate analysis, age, frequent/severe headaches, total BPI pain severity and pain interference scores, moderate to severe anxiety or depression, daily tobacco use and past week benzodiazepine use were significant predictors of SLP-9 scores and sleep quality. Higher MOS respiratory impairment was observed in males, those with high BMI, frequent/severe headaches, high pain interference scores and in patients taking anticonvulsants and antipsychotic medications. Opioid use was not associated with SLP-9 or respiratory sleep impairment.

Conclusions
High levels of sleep problems were reported in this community sample of CNCP patients, and were associated with mental health problems and increased medication use. Non-medication approaches to addressing sleep problems should be prioritised in this population.

7. FACTORS ASSOCIATED WITH THE DEVELOPMENT OF DEPRESSION IN CHRONIC NON-CANCER PAIN PATIENTS FOLLOWING THE ONSET OF OPIOID TREATMENT FOR PAIN.


ABSTRACT
Background and aims
Pharmaceutical opioid prescription rates are increasing globally, however knowledge of their long-term effects on mental health, in particular depression remains limited. This study aimed to identify factors associated with the onset of depression post-opioid use that differ to factors associated with depression post-pain.

Method
Participants (N=1,418) were a national sample prescribed opioids for chronic non-cancer pain. Age at onset of depression, pain and commencement of opioid medications were collected via structured interview.

Results
Six in ten (61%) reported lifetime depression, of those, almost half developed depression after pain and after they started opioid medications (48%). Variables associated with post-opioid depression included lower pain self-efficacy and poorer social support, younger onset of opioid use, and difficulties and concerns with opioid medications.

Conclusions
The findings highlight the importance of monitoring for the emergence of mood dysfunction, particularly for those starting opioids for pain at a younger age, and consideration of psychological treatments that address self-efficacy that appears to be associated with post-opioid depression.
ABSTRACT

Objectives
The main objectives of the paper were (1) to examine the prevalence of suicidality in a large community-based chronic pain sample taking prescribed opioids for chronic pain; and (2) to examine general and pain-specific factors that predict such ideation, and the transition from ideation to making a suicide attempt (ideation-to-action).

Methods
Baseline data from the Pain and Opioids IN Treatment (POINT) study with a cohort of 1,514 community-based people prescribed opioids for chronic non-cancer pain across Australia.

Results
Past 12 month suicidal ideation was reported by 36.5% of the cohort and 16.4% had made a lifetime suicide attempt (2.5% in the last 12 months), after the onset of their pain condition. Suicidal ideation in the past 12 months was independently associated with a past suicide attempt (AOR 4.82, 95%CI 2.43-9.56) and past 12 month depression (AOR 4.07, 95%CI 1.88-8.78). Only a lower pain self-efficacy score was independently associated with past 12 month ideation-to-action (AOR 0.98, 95%CI0.88-0.99). Notably, only general suicide risk factors were associated with 12 month suicidal ideation; but for past-year ideation-to-action, pain specific factors also had independent associations.

Discussion
The study is one of the first to comprehensively examine general and pain-specific risk factors for suicidality in a large chronic pain sample in which suicidal ideation was common. A low pain self-efficacy score was the only factor independently associated past 12 month ideation-to-action.

ABSTRACT

Objective
To describe the use, and barriers to use of non-medication pain therapies, and identify the demographic and clinical correlates of different non-opioid pain treatments.

Method
A cohort (n = 1,514) of people prescribed pharmaceutical opioids for CNCP. Participants reported lifetime and past month use of healthcare services, mental and physical health, pain characteristics, current oral morphine equivalent (OME) daily doses, and financial and access barriers to healthcare services.

Results
Participants reported use of non-opioid pain treatments, both prior to and after commencing opioid therapy.

Conclusions
Patients on long-term opioid therapy report using multiple types of pain treatments.

Implications
High rates of CAM use are concerning given limited evidence of efficacy for some therapies and the low income status of most people with CNCP. Financial and insurance barriers highlight the importance of considering how different types of treatments are paid for and subsidised.
Reviewer: Dr Susie Lord, Clinical Lead, Children’s Complex Pain Service, John Hunter Children’s Hospital, Newcastle NSW, Australia.


Aims – To evaluate 1) construct validity; and 2) responsiveness to change of PROMIS pediatric measures in children presenting for outpatient treatment of chronic pain.

Study Group – English-speaking children 8-18 years, diagnosed with chronic pain by a paediatric pain physician or paediatric rheumatologist working in USA tertiary children’s hospitals. Exclusions: developmental delay or severe psychopathology interfering with comprehension or self-report.

The number of participants invited/refused was not reported. 145 participants completed baseline measures – 82 being treated in a multidisciplinary chronic pain clinic and 63 in an intensive 3-4 week daily-treatment program. 83% were female and 93% White Caucasian. Retention rates were reasonable with 83% remaining at first follow-up and 68% at second follow-up.

Study Method – 7 PROMIS Short Form Version 1 questionnaires were studied: Pain Interference, Fatigue, Anxiety, Depression, Mobility, Upper Extremity Function and Peer Relationships (58 items in total). Computer adaptive technology was not used or evaluated in this study.

At the chronic pain clinic these were co-administered with the clinic’s standard dataset – the so-called ‘legacy’ measures – that included the Pain Intensity Numeric Rating Scale (NRS), Functional Disability Index (FDI), Pediatric Quality of Life Inventory (PedsQL), and Children’s Depression Inventory (CDI). The order of administration of PROMIS and ‘legacy’ measures was not reported.

At the intensive program, only PROMIS measures were administered so those data could only be used to address the second aim – evaluating the PROMIS measures responsiveness to change.

The authors justify their statistical method persuasively. They used parallel process longitudinal (latent) growth models (LGMs) to examine congruence between the 6 PROMIS constructs for which there was a roughly-equivalent ‘legacy’ measure. To examine sensitivity to change over time, they employed single process LGMs then added conditions to determine whether there were differences by treatment site (clinic vs program), and then site by time interaction.

Summary of Results – PROMIS Fatigue Short Form could not be evaluated for congruence with any standard measure as none was used in the clinic studied.

The other 6 PROMIS measures – Pain Interference, Anxiety, Depression, Mobility, Upper Extremity Function and Peer Relationships – generally performed similarly to ‘legacy’ measures.

All 7 measures were responsive to change. However, the slope of the improvement curve was slightly steeper for ‘legacy’ measures.

Authors’ Conclusions – The results provided preliminary support for the construct validity and responsiveness of PROMIS measures in a clinical population presenting with paediatric chronic pain.

Critique – This paper is highly relevant to our deliberations about future ePPOC revisions.

At the ISPP in Seattle, June 2015, it was clear that our US colleagues had already invested in PROMIS measures, incorporating them into CHOIR (Collaborative Health Outcomes Information Registry, AKA Stanford-NIH Pain Registry) for both adults’ and children’s pain services. The relegation of all non-PROMIS measures to the ‘legacy’ label (meaning: superseded but difficult to replace because of wide-spread use) is propaganda consistent with this investment. That is not to say this is a bad investment; it is just not as yet secured with sufficient evidence.

During the development of ePPOC, Australian and NZ PinC SIG members discussed the politics and benefits of a common international outcomes dataset for children’s chronic pain services. However, validation of PROMIS in children and across cultures was thought vital before replacing measures that have established validity, clinical and research utility (FDI, PedsQL and Bath Adolescent Pain Questionnaire).
This paper is the first to yield evidence that PROMIS measures may have construct validity and sensitivity to change in clinical paediatric chronic pain contexts. At best, however, these data demonstrate equivalence with the ‘legacy’ measures they studied (and used in ePPOC). The other PROMIS benefits that the authors cite are moot. Their battery of 7 PROMIS Short Form questionnaires appears to carry no lower respondent burden, being 58 items in total (compared with 45 items for adolescent ePPOC). They have not explored, in this study at least, the enormous potential for computer adaptive technology (CAT) to optimise fidelity using fewer items.

Moreover, by the authors’ own acquiescence, their results may not be generalizable to groups not represented in their small sample: children with recurrent abdominal pain, headache, disease-related pain, or diverse cultural or geographical differences. Much work remains.

'Take-home' Messages

• PROMIS is promising but not proven
• It is too early to throw out ‘legacy’ measures currently used in child and adolescent versions of ePPOC
• Australia and NZ could contribute to this work by applying, through ePPOC/ethics processes, to further evaluate PROMIS along-side current ePPOC measures for a limited time.
• Given the small number of children’s pain services against which to benchmark in Australia and NZ, we should continue to work toward a common international outcomes dataset to facilitate clinical improvement and research in the interests of children.

SCHOLARSHIP FEATURE

Current Scholars

<table>
<thead>
<tr>
<th>PhD Scholarship Sponsor</th>
<th>Scholar</th>
<th>Topic</th>
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<tr>
<td>Mundipharma #3-APS-APRA</td>
<td>Audrey Wang</td>
<td>“An investigation of the role of the brain in recovery from CRPS, using fMRI”</td>
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<tr>
<td>Janssen Cilag #2-APS-APRA</td>
<td>Sarah Kissiwa</td>
<td>“Pain induced synaptic plasticity in the amygdala”</td>
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<td>APS #5-APRA</td>
<td>James Kang</td>
<td>“Epigenetic influence in cognitive impairments in chronic neuropathic pain”</td>
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<td>PhD Scholarship Sponsor Scholar Completed Topic</td>
<td>APS #1-APRA Samantha South 1999</td>
<td>“Antinociceptive pharmacology of morphine and its major glucuronide metabolites”</td>
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<td>PhD Scholarship Sponsor Scholar Completed Topic</td>
<td>CSL #1-APS-APRA Lara Winter 2004</td>
<td>“Antinociceptive properties of the neurosteroid alphadolone”</td>
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<td>PhD Scholarship Sponsor Scholar Completed Topic</td>
<td>CSL #2-APS-APRA Anne Pitcher 2006</td>
<td>“Conditional comfort: A grounded theory study in nursing approaches to acknowledging and responding to pain in nursing home residents with dementia”</td>
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<td>PhD Scholarship Sponsor Scholar Completed Topic</td>
<td>APS #2-APRA Debbie Tsui 2008</td>
<td>“Preclinical studies in painful diabetic neuropathy”</td>
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<tr>
<td>PhD Scholarship Sponsor Scholar Completed Topic</td>
<td>Mundipharma #2-APS-APRA Zoe Brett 2011</td>
<td>“Individual differences in vulnerability to the development of chronic pain following injury”</td>
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<tr>
<td>PhD Scholarship Sponsor Scholar Completed Topic</td>
<td>APS #3-APRA Susan Slatyer 2013</td>
<td>“Caring for patients experiencing episodes of severe pain in an acute care hospital: Nurses’ perspective”</td>
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<tr>
<td>PhD Scholarship Sponsor Scholar Completed Topic</td>
<td>APS #4-APRA Amelia Edington 2013</td>
<td>“Defining inhibitor binding sites unique to the glycine transporter, GLYT2: A potential target for the treatment of chronic pain”</td>
</tr>
<tr>
<td>PhD Scholarship Sponsor Scholar Completed Topic</td>
<td>Janssen Cilag #1-APS-APRA Mary Roberts Due 2016</td>
<td>“An investigation of the role of sleep in chronic pain”</td>
</tr>
</tbody>
</table>
PhD Opportunity and Scholarship

A PhD scholarship is available for a suitable student to work on a project investigating neurobiological mechanisms underlying the development of chronic neck pain.

Neck pain and its disability is ranked 16th among the top 50 health problems globally. Approximately 332 million people suffer from neck pain worldwide and it is ranked the 4th highest condition for years lived with disability. A major clinical problem is that 50-80% of people who have no apparent on-going cause for their neck pain develop pain lasting years.

The aim of this project is to investigate the role that the brain and spinal cord play in the development of chronic neck pain.

Interested persons should contact Professor Philip Bolton:
Philip.Bolton@newcastle.edu.au at the University of Newcastle.

Applications close 31 March 2016.

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INDIGENOUS PAIN GROUP MEETING IN PERTH

Tuesday 15 March 2016, Afternoon Tea, 3-3:30pm, Room M10

Any APS members with an interest in Indigenous Pain are invited to an informal meeting with like-minded professionals at the Annual Scientific Meeting to be held in Perth.

Fiona Hodson, President-Elect, will chair this meeting and a summary of the discussion will feedback to the APS Board. Afternoon Tea will be served in the room to maximise the discussion time.

We look forward to meeting with you and discussing this important topic.

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GOAL SETTING PRACTICE IN CHRONIC LOW BACK PAIN

The University of Sydney is conducting a survey looking at the goal setting practices in Chronic Low Back Pain. Along with the survey, a participant information sheet is attached outlining the study as well as a self-addressed envelope for you to return the completed survey.

We are inviting physiotherapists currently practicing in primary care, who treat patients with chronic low back pain, to complete this survey – it should take only 10 minutes of your time.
For those that complete the survey you will have the chance to enter a lucky draw to win a $200 gift voucher.

If you are interested in helping with our research and a chance to win click here

The survey will be open until 31 March 2016.
Thank you for your consideration. If you have any further questions please contact Tania Gardner email: tgar4750@uni.sydney.edu.au.
will be held at the Annual Scientific Meeting from 7:30 – 8:45am in Rooms M1 & M2 on Wednesday 16 March 2016 at the Perth Convention & Exhibition Centre, Perth, WA

A General Business Meeting (GBM) will immediately follow the AGM.

**Breakfast will be served at this meeting** and, to assist with catering, we request that you indicate your attendance when you register. If your choice changes, please contact the Conference Secretariat.

The AGM Information Pack was emailed to members and includes:

- Notice of AGM
- AGM Agenda
- Minutes from previous AGM and GBM
- Advice of By Law updates
- Office Bearer Nominee Information
- Proxy Form

If you are unable to attend the AGM please send your:

- Apology and
- Proxy form

to the Secretariat by 5pm Tuesday 8th March 2016.

**SUBMISSIONS TO THE NEWSLETTER**

We welcome submissions, whether brief or extended, about matters of interest to our readers - for example, reports of educational activities or articles about basic science or clinical research. Please allow time for modifications to be made to optimise a submission’s suitability for publication. In general it will be unlikely that a submission received after the 15th of each month will be published in the newsletter of the following month.

*Stephanie Davies, Editor*
CALLING ALL HEALTH PROFESSIONALS!

ANNOUNCING OUR FIFTH INTER-PROFESSIONAL WORKSHOP
“MAKING SENSE OF PAIN” EXPRESSIONS OF INTEREST ARE INVITED

Date: Thursday 10th - Friday 11th March 2016.
Venue: Wyllie Arthritis Centre, 17 Lemnos St. SHENTON PARK WA 6008
To register: https://www.arthritiswa.org.au/events/details/id/247/

This meeting continues to explore the diversifying science and therapeutic applications of neuromodulation in pain and other applications

When: 12 – 13 March 2016
Where: Perth Convention and Exhibition Centre, Western Australia

THE PROGRAM WILL INCLUDE:

• An exciting and enticing group of international and local invited speakers
• Presentations on recent landmark research, including recent pivotal studies from the US that are evolving the quality of evidence in this space
• A special interest session for pain trainees and novice implanters
• A nursing and allied health breakout session
• A focus session on sacral stimulation

YOU ARE INVITED TO ATTEND THE ACUTE PAIN DAY PRE-CONFERENCE WORKSHOP

This workshop is aimed at anyone with an interest in acute pain management.

When: Sunday 13 March 2016, 8.45 am – 5.00 pm
Where: Perth Convention and Exhibition Centre, WA
Cost: $185 per person
Early Bird Deadline: 29 January 2016
YOU ARE INVITED TO ATTEND THE FUNDAMENTALS OF PAIN PRE-CONFERENCE WORKSHOP

This workshop will equip participants with the basic knowledge of pain neurobiology, psychology and therapeutic agents, using an interactive case study and multimedia. This workshop is aimed at all allied health and general practitioners, or anyone wishing to update their knowledge on the pathophysiology and treatment of pain.

**When:** Sunday 13 March 2016, 8.30 am – 5.00 pm  
**Where:** Perth Convention and Exhibition Centre, WA  
**Cost:** $185 per person  
**Early Bird Deadline:** 29 January 2016

YOU ARE INVITED TO ATTEND THE PHYSIOTHERAPY IN PAIN MANAGEMENT PRE-CONFERENCE WORKSHOP

**Fear, Pain and Movement**
What it looks like, the underlying basis of it, how we measure it and practical strategies to address it in clinical practice...
This workshop is for physiotherapists, and will explore the issue of fear avoidance as seen in a range of clinical situations. The construct of fear avoidance will be discussed, and then attendees will have the opportunity to explore specific approaches for managing fear avoidance in a clinical setting.

**When:** Sunday 13 March 2016, 1.30 pm – 5.00 pm  
**Where:** Perth Convention and Exhibition Centre, WA  
**Cost:** $135 per person  
**Early Bird Deadline:** 29 January 2016

YOU ARE INVITED TO ATTEND THE PHARMACOLOGICAL MANAGEMENT IN PAIN PRE-CONFERENCE WORKSHOP

The aim of the Pharmacological Management in Pain half-day workshop is to make a significant contribution to the optimisation of pain treatment by bringing experts together to discuss the latest scientific findings within the pain management clinical pharmacology field.
The target audience for this workshop consists of clinical pharmacologists, pharmacists, industry researchers, pain specialists, paediatricians, clinical nurse consultants, government representatives and other experts with an interest in clinical pharmacology.

**When:** Sunday 13 March 2016, 8.30 am – 12.30 pm  
**Where:** Perth Convention and Exhibition Centre, WA  
**Cost:** $135 per person  
**Early Bird Deadline:** 29 January 2016
YOU ARE INVITED TO ATTEND THE PAIN IN CHILDHOOD PRE-CONFERENCE WORKSHOP

This workshop is intended for clinicians from all disciplines with an interest in pain in childhood.

When: Sunday 13 March 2016, 1.00 pm – 5.00 pm
Where: Perth Convention and Exhibition Centre, WA
Cost: $135 per person
Early Bird Deadline: 29 January 2016

To register or for further information please visit, www.dcconferences.com.au/aps2016/Pre-Conference_Workshop

YOU ARE INVITED TO ATTEND THE PAIN IN CHILDHOOD PRE-CONFERENCE WORKSHOP

When: Sunday 13 March 2016, 1.00 pm – 5.00 pm
Where: Perth Convention and Exhibition Centre, WA
Cost: $135 per person
Early Bird Deadline: 29 January 2016

To register or for further information please visit, www.dcconferences.com.au/aps2016/Pre-Conference_Workshop

Are you living with pain? Do you have an interest in pain?

LIVING WELL WITH PAIN
Consumer Symposium & Forum

Your chance to hear leading Australian pain management experts

Register online www.trybooking.com/168559 or call (02) 9694 0993

PRESENTERS

Dr Stephanie Davies - New Pain Strategies to Rewire Your Pain
Director, WA Specialist Pain Services

Dr Nicholas Cooke - The Power In Your Pocket: Useful Phone Apps & Technology
Medical Adviser, WA Specialist Pain Services

Q&A Session - Consumer and Carer Perspective
Pip Brennan, Executive Director, Health Consumers' Council WA
Lesley Oliver, Hospital Program Coordinator, Carers WA

Professor Milton Cohen (Chair Afternoon)
Specialist Pain Medicine Physician, St Vincent's Campus

Professor Eric Visser - Managing Neuropathic Pain
Churack Chair of Chronic Pain Education and Research

Dr Susan Evans - Pelvic Pain: The Big Picture
Gynaecologist, Specialist Pain Medicine Physician

Consumer Forum
Chronic Pain: Ignorance and Stigma - what can be done to fix this?
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Pain: Meeting the Challenge
2016 Australian Pain Society
36th Annual Scientific Meeting

13-16 March 2016 | Perth Convention and Exhibition Centre


For sponsorship and exhibition opportunities or more information please contact the APS Secretariat
DC Conferences Pty Ltd | P 61 2 9954 4400 | E aps2016@dcconferences.com.au

SUBMISSION DEADLINES
Free Papers & Posters
2 October 2015

Early Bird Registration
29 January 2016
Complementing daily physiotherapy practice, Kevin’s highly practical workshops explore the complexity of chronic pain from the well-researched model of Acceptance and Commitment Therapy (ACT). Upon completion participants will be able to identify treatment targets for those in chronic pain, and offer strategies to facilitate acceptance, mindfulness, and values-based action. Workshops combine training in clinically-applicable skills, supported by theory and research.

This is a rare opportunity to learn from Kevin, an expert clinical psychologist, and the world’s leading exponent of ACT for chronic pain. He has published over 65 papers on this topic while at the Centre for Pain Research (University of Bath) and Arthritis Research UK. He is currently Assoc. Prof. at the University of New Mexico.

Venue: Neuroscience Research Australia, Randwick, NSW
Early-bird rate: $500 until 1st January 2016
Contact: Martin Rabey FACP, (02) 9399 1870, m.rabey@neura.edu.au
Information: http://neura.edu.au/research/themes/mcauley-group/courses
30% Discount on Registration for APS Members!

Key Dates
- Registration opens: 28 September 2015
- Scholarship Applications close: 23 November 2015
- Early Bird closes: 29 January 2016

For more information: AusACPDM 2016 Conference Secretariat
E: ausacpdm2016@dcconferences.com.au | P: 61 2 9954 4400

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8th Biennial Conference

30 March - 2 April 2016
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Develop specialised assessment techniques for your clients with persistent pain

Implement practical techniques to empower your clients to achieve their goals

"Given me skills and insights for difficult patients who are getting stuck" - Physiotherapist

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Brisbane  16th June 2016
Sydney  21st July 2016

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ITEMS OF INTEREST FOR OUR MEMBERS


ePPOC: electronic Persistent Pain Outcomes Collaboration
For more information about ePPOC, refer to the website: http://ahsri.uow.edu.au/eppoc/index.html

Indigenous health education and guides

NSW Therapeutic Advisory Group

MJA 203(6), 21SEP15

Four Corners
“Wasted” by Dr Norman Swan and Jaya Balendra, aired 28SEP15: http://www.abc.net.au/4corners/stories/2015/09/28/4318883.htm

SMH National

PainHEALTH website
Phase 1 Updates released 29NOV15: http://painhealth.csse.uwa.edu.au/
Comprehensive update of all conditions and pain management content with the addition of new resources and key literature effective to OCT15 (systematic reviews; meta-analysis; RCT). Update of Further Assistance (including the addition of the Australian Pain Society Facility Directory).

WHO Statement against regulating Ketamine
Released 09DEC15: http://www.who.int/medicines/access/controlled-substances/recommends_against_ick/en/

Congratulations to Prof Kathy Eagar
2015 recipient of the Health Services Research Association of Australia & New Zealand (HSRAANZ) Professional Award: http://croakey.org/profiling-an-award-winning-health-services-researcher-and-her-vision-for-better-health-care/

Pain Series
An excellent series of articles run late 2015 by The Conversation: https://theconversation.com/au/topics/pain-series

Low Back Pain (LBP) in Aboriginal Australians
A very informative series of 5 videos developed by WA Centre for Rural Health about low back pain in Aboriginal Australians: https://www.youtube.com/playlist?list=PLGsL0Kp0YWFWulyKi1oCG7NwFucLfyVlJ

The Australian
FYI


BBC World Service Exchanges at the Frontier “Is Pain an Emotion?” Radio interview with Prof Irene Tracey. Released 14FEB16: http://www.bbc.co.uk/programmes/p03hv43v

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE (ACSQHC) RESOURCES:


NPS MEDICINEWISE RESOURCES


Choosing Wisely Update, Spring 2015: http://www.elabs12.com/functions/message_view.html?mid=908725&mlid=20420&siteid=2012000746&uid=3e29b7747d&hq_e=el&hq_m=908725&hq_l=1&hq_v=3e29b7747d

NSW AGENCY FOR CLINICAL INNOVATION RESOURCES:


Member Listing

This standard feature is available to all members and allows basic location and contact details for individuals and their organisations/practices to be accessible to other APS members in the MEMBERS ONLY area of our website. It’s a great way to stay in touch.

The listing is completely voluntary for members:

- You may select and un-select the “Private Membership Listing” option on your member profile at any time.
- Only information entered by you in the “Work Contact” section of your member profile will be listed and available to other members.

Use the blue “Member Login” button located on every APS webpage and select “Member Listing” from the top menu bar to find the Member Listing.

You can search for colleagues by Name, Discipline and/or State.

Refer sample image:
## NEW MEMBERS

<table>
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<th>Title</th>
<th>First Name</th>
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<td>Gemma</td>
<td>Barter</td>
<td>Psychology</td>
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<tr>
<td>Mrs</td>
<td>Kathryn</td>
<td>Benson-Rooney</td>
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<tr>
<td>Ms</td>
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<td>Miss</td>
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<td>Di Mento</td>
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<tr>
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<td>Emma</td>
<td>Farrugia</td>
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<tr>
<td>Mr</td>
<td>Nicolas</td>
<td>Fenwick</td>
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<tr>
<td>Dr</td>
<td>Adeline</td>
<td>Fong</td>
<td>Pain Medicine Physician</td>
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<td>Holland</td>
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<td>Mrs</td>
<td>Bronwyn</td>
<td>Innes</td>
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<tr>
<td>Mrs</td>
<td>Stacey</td>
<td>Jackson</td>
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<td>Dr</td>
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<td>Mrs</td>
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<td>Miss</td>
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<td>Mrs</td>
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<td>Dr</td>
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<td>Ramachandran</td>
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<td>Mr</td>
<td>Shahrul Azmin</td>
<td>Rani</td>
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<td>Ms</td>
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<td>Cathy Ann</td>
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<td>Miss</td>
<td>Anne - Marie</td>
<td>Williams</td>
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RENEWAL NOTICES FOR 2016 HAVE BEEN SENT TO MEMBERS BY EMAIL.

Thank you for your continued support and membership of the APS.

We understand that circumstances change, so each year we ask you to select your appropriate level of membership.

This system of self-reporting subscription levels was implemented in 2009 for the benefit and fairness of all members.

Before renewing online, please ensure you review and update your member profile.

Payments can be made by Credit Card or Cheque.

Login here and renew online via the APS Website.

Your prompt renewal is greatly appreciated.
CALENDAR OF EVENTS

5-6 Mar 2016
Pain Association of Singapore
Annual Scientific Meeting 2016
Suntec Singapore Convention & Exhibition Centre, Singapore, Singapore

10-11 Mar 2016
Arthritis & Osteoporosis WA
Making Sense of Pain - a workshop for Health Professionals
Wylie Arthritis Centre, Perth, WA

12-13 Mar 2016
Neuromodulation Society of Australia and New Zealand
Neuromodulation: Mainstream Medicine
Perth Convention & Exhibition Centre, Perth, WA

13 March 2016
Painaustralia
Living Well with Pain Consumer Symposium & Forum
University of Notre Dame, Fremantle, WA

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

Various dates from 14-22 Mar 2016
Byron Clinic - Dr Bessel van der Kolk
Recognising & Resolving Traumatic Stress
Various venues, Sydney, Melbourne, Brisbane, NSW, VIC, QLD
http://byronclinic.com/bessel-van-der-kolk-trauma-workshops-2016/
CALENDAR OF EVENTS

15-17 Mar 2016
Australian Healthcare & Hospitals Association AHHA
6th Australian Healthcare Week
Australian Technology Park, Sydney, NSW
http://www.austhealthweek.com.au

19-20 Mar 2016
Neuroscience Research Australia
A/Prof Kevin Vowles: Working with Acceptance, Mindfulness and Values in Chronic Pain: A Skills Building Workshop
Neuroscience Research Australia, Sydney, NSW
http://neura.edu.au/research/themes/mcauley-group/courses

21-22 Mar 2016
National Dementia Congress
7th Annual Congress 2016
Novotel, Brisbane, QLD

1-3 Apr 2016
Neuro Othopaedic Institute Explain Pain 2016
EP3 by the sea
Stamford Grand Hotel, Glenelg, Adelaide, SA

4 Apr 2016
PainAdelaide
2016 Scientific Meeting
National Wine Centre, Adelaide, SA
http://painadelaide.org/2015/08/18/save-the-date/

7-9 Apr 2016
New Zealand Pain Society Annual Scientific Meeting
Surfing the Pain Wave
The Devon Hotel, New Plymouth, New Zealand
http://www.nzps2016.org.nz
CALENDAR OF EVENTS

17-19 Apr 2016  
Children’s Healthcare Australasia & National Rural Health Alliance Inc  
Caring for Country Kids  
Alice Springs Convention Centre, Alice Springs, NT  
http://www.countrykids.org.au

29 Apr 2016  
Faculty of Pain Medicine (FPM)  
Refresher Course Day - Extremes of Pain  
Crowne Plaza, Auckland, New Zealand  
http://www.fpm.anzca.edu.au/events/2016-refresher-course-day

30 Apr-4 May 2016  
Australian and New Zealand College of Anaesthetists (ANZCA) Annual Scientific Meeting 2016  
Closer to the Edge  
Aotea Centre, Auckland, New Zealand  
http://asm.anzca.edu.au

30 Apr-4 May 2016  
Australian Rheumatology Association with the Rheumatology Health Professionals Association  
57th Annual Scientific Meeting  
Darwin Convention Centre, Darwin, NT  
http://www.araconference.com

Various dates from 5-17 May 2016  
Byron Clinic - Dr Norman Doidge  
The Brain’s Way of Healing  
Various venues, Brisbane, Sydney, Melbourne, QLD, NSW, VIC  
http://byronclinic.com/norman-doidge-2016/

Various dates from 12 May to 17 Nov 2016  
Empower Rehab  
Pain Management in Practice 2 day workshop  
Various venues, Melbourne, Brisbane, Sydney, VIC, QLD, NSW  
CALENDAR OF EVENTS

20-23 May 2016
World Institute of Pain (WIP)
8th World Congress
Hilton NYC, New York, USA
http://wip2016.kenes.com

26-29 May 2016
Korean Pain Society
1st International Congress on Spinal Pain - ICSP 2016
Kimdaejung Convention Center, Gwangju, Korea
http://www.spinemeeting.org/

10-11 Jun 2016
Occupational Therapy Australia
Breaking Down Barriers Through Participation
Pan Pacific, Perth, WA

22-25 Jun 2016
Australian Association for Cognitive and Behaviour Therapy (AACBT)
8th World Congress of Behavioural and Cognitive Therapies
Melbourne Convention and Exhibition Centre, Melbourne, VIC

29-31 Jul 2016
Pharmaceutical Society of Australia - PSA16
Leading Pharmacy Innovation
Four Points by Sheraton, Darling Harbour, Sydney, NSW
http://www.psa.org.au/psa16

6-7 Aug 2016
PCS 2nd Annual Global Pain Conference 2016
New Gateway from East to West
Radisson Blu Hotel, Moscow, Russia
CALENDAR OF EVENTS

18-21 Aug 2016
Asian and Oceanian Association of Neurology: 15th Asian and Oceanian Congress of Neurology
Advanced Education in Neurology in Asian Oceania Region
Kuala Lumpur Convention Centre, Kuala Lumpur, Malaysia
http://aocn2016.com

26-28 Aug 2016
Australian Physiotherapy Association
2016 Business and Leadership Conference
Darwin, Darwin, NT

30 Aug-2 Sep 2016
Australian College of Nurse Practitioners 11th Conference incorporating 7th Aust Emergency Nurse Practitioner Symposium
The Centre of Care
Alice Springs Convention Centre, Alice Springs, NT

13-16 Sep 2016
Australian Psychological Society 2016 Congress
Psychology United for the Future
Melbourne Convention and Exhibition Centre, Melbourne, VIC

26-30 Sep 2016
International Association for the Study of Pain (IASP)
16th World Congress on Pain
Pacifico Yokohama Convention Complex, Yokohama, Japan
http://www.iasp-pain.org/Yokohama

29 Sep-1 Oct 2016
RACGP - GP16
Clinical, Digital, Leadership
Perth Convention & Exhibition Centre, Perth, WA
CALENDAR OF EVENTS

1-3 Dec 2016
Indigenous Conference Services
International Indigenous Allied Health Conference
Pullman, Cairns, QLD

1-3 Dec 2016
Indigenous Conference Services
Closing the Gap 2016 International Indigenous Health Conference
Pullman, Cairns, QLD
http://www.indigenousconferences.com/#l2016-indigenous-health-conference/sta1q

6-9 Jul 2017
IASP Pain in Childhood SIG, Malaysian Association for the Study of Pain and College of Anaesthesiologists
11th International Symposium on Pediatric Pain: Understanding Pain In Children - Take the First Step
Shangri-la, Kuala Lumpur, Malaysia
http://www.ispp2017.org

THE AUSTRALIAN PAIN SOCIETY

VISION:
All people will have optimal access to pain prevention and management throughout their life.

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

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 pain-related evidence-based research
• To share and promote the expertise of all disciplines involved in the treatment of pain
• To foster and support the prevention of persistent pain
• To promote and facilitate evidence-based pain related education for health professionals and the community
• To promote the development and use of standards and outcome measures in everyday clinical practice
### DIRECTORS

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
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<th>Contact Information</th>
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</tr>
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