Yoga for Pain *Down South*

Using non-traditional providers and local knowledge to increase options for people with, or at risk of, chronic pain in regional Australia.

Yoga for Pain *Down South* is a partnership between Yoga for Pain Care Australia and GP down south, targeting Warren-Blackwood, Margaret River-Augusta and Collie-Harvey. The program's first phase was February - July 2018 and was possible thanks to funding from WA Primary Health Alliance.

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Sep 6 2018

GP down south

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WAPHA

WA Primary Health Alliance

www.yogaforpaincare.com

EXECUTIVE SUMMARY

More people experience chronic pain in regional Australia than our cities, increasing the prevalence of unemployment, social isolation and mental illness - and their flow-on economic costs.

Chronic pain costs Australia $34b each year and affects 1 in 5 people, including children. In what can be a vicious cycle, pain can lead to depression, suicide ideation and social isolation - which are also its risk factors.

While pain education has increased for health professionals, specialist services are almost non-existent outside major cities. Even those who do access good medical care can "fall through the net". Tele-health trials by major hospitals increasingly provide patients with knowledge, but don't offer the ongoing support they need to practice pain management skills on their own, sometimes after years or decades of poor health.

Not-for-profit GP down south partnered with Yoga for Pain Care Australia, a national social enterprise that provides training for yoga teachers and health professionals in the **field of practice of Yoga for Pain**. Our aim was to create self-sustaining options for people with, or at risk of, persistent pain in regional Western Australia, specifically the South West. **To assist with increasing demands on Australia's health and social care systems, these programs would be designed to continue in the future, without funding.**

Informing premises underpinning the initiative included:

A. To *reduce existing chronic pain* we need to help people practice self-management long enough to retain the benefits.

B. To *reduce recurrence* of chronic pain we must also help them to develop protective factors, like physical activity, social interaction and mental wellbeing.

C. Those protective factors may *enable prevention* for those who are at risk.

D. With the right conditions, those protective factors also *enrich* life and community participation, improving community cohesion and longterm health outcomes.

Through WAPHA-funded Integrated Chronic Disease Care funding, we were able to co-create and pilot *Yoga for Pain Down South.* The initiative comprised four parts:

1) Development program for nine, competitively selected health professionals and yoga teachers

2) Eight pain care yoga pilot courses in chronic health hot spots

3) Community information and engagement

4) Subsidised pain care yoga classes for people with multiple health issues

Informed by global pain research, local knowledge and health promotion promotion principles, *Yoga for Pain Down South* ran from March to June 2018 across Warren-Blackwood, Margaret River-Augusta and Collie-Harvey.

Over 40 providers applied for the development program, which were offered on partial scholarship. Selection was based on demonstrated interest in chronic pain care, experience making a difference in their community and diversity of perspective they could contribute to the group learning. The cohort included yoga teachers, physiotherapists, one occupational therapist and an emergency nurse. They came from Collie, Harvey, Margaret River, Augusta and Northcliffe.

After a 4.5-day group training, each provider ran a four-week pain care yoga pilot course, supported through mentoring. These courses were full, with wait lists. *Yoga for Pain Down South* attracted media attention, including a video by ABC South West with over 10,000 views.

Trained providers join a **national community of Yoga for Pain Practitioners**, offering a range of services and price points for specific groups in their community.

This report explains the background, design process, research and execution of *Yoga for Pain Down South*. We discuss program innovations and key learnings that can inform a **proposed model for using non-traditional providers to provide chronic disease support and prevention in regional communities**.

Key numbers

- 100% training completion rate for selected providers, including assignments
- 8 four-week pain care yoga pilot courses full, with wait lists
- 89% of people with pain who attended said they were better able to manage their pain

When you see items in italics, they describe how we responded to learnings along the way. This is so readers get a glimpse into the action-research methodology.

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Program overview

1. Background

More people experience chronic pain in regional Australia than our cities, increasing the prevalence of unemployment, social isolation and mental illness - and their flow-on economic costs.

In Western Australia, pain services are almost non-existent outside of Perth. Tele-health trials by major hospitals increasingly provide patients with knowledge, but don't offer the ongoing support they need to practice pain management skills on their own, sometimes after years or decades of poor health.

To reduce pain, and its recurrence, we need to help people practice self-management long enough to retain the benefits, *and* to develop protective factors, like physical activity, social interaction and mental wellbeing that enrich life and community participation.

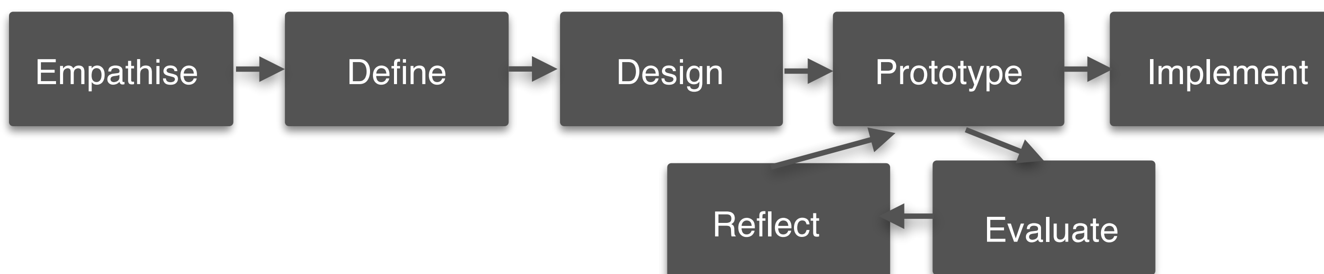
2. Aims

Yoga for Pain Care Australia partnered with GP Down South under WAPHA ICDC funding, to increase options for people with, or at risk of, persistent pain in South West WA chronic health hot spots. Specifically:

1. Increase availability of sustainable, community health programs in areas covered by GP down south's contract for chronic disease management.
2. Increase provision of effective services for people with, or at risk of, persistent pain, particularly those for whom traditional services are unsuitable, ineffective, or less accessible, and with other health conditions, and with a particular focus on self-management.
3. Providers we trained would become Yoga for Pain Practitioners, offering ongoing services and referrals into those services.

3. Design process

The design process was influenced by action-research, prototyping and co-design methodologies.

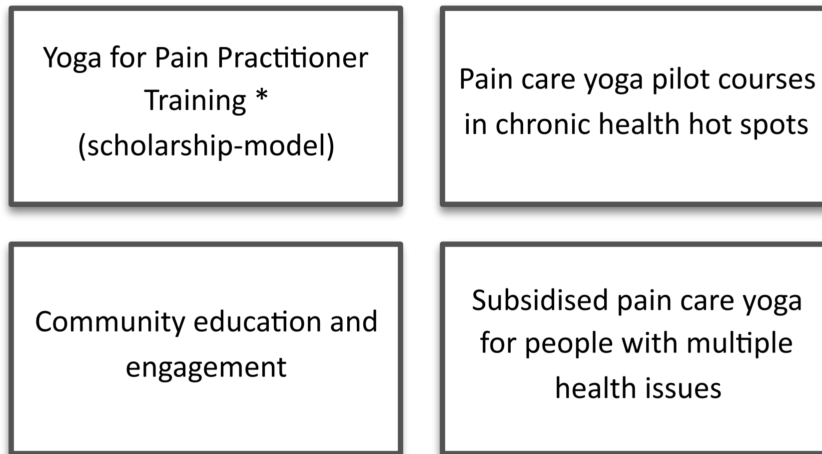


1. Empathise	YPCA interviewed GP Down South to understand broad regional needs. Desk research revealed regional health issues and social factors. Perspectives of applicants showed local issues, and professional capacity of non-traditional providers.
2. Define	Specified the key opportunity for a regional pain care yoga development program i.e. for this program the focus was self-management, whereas another region may be better to focus on prevention, a specific illness or integration with health care.
3. Design	YPCA proposed broad training content (including theory, practice and application of specific pain and yoga knowledge, health promotion/client engagement, and practitioner ethics) which GP Down South reviewed and confirmed. YPCA then mapped a 4.5-day training schedule.
4. Prototype	The 6-week mentoring program was developed once teachers finished the 4.5-day course. This meant we could work to their capacity, rather than a generic program that is too basic or too advanced. The community engagement plan, included traditional print, and social, media; class subsidies; promotion and community education. We observed critical elements for success, uncovering the key innovations midway through. Determine useful evaluation measures for future Reviewed against GP down south / WAPHA plans for community health
5. Integrate	Practitioners join the Community of Practice, with the needs for their region clear. Assess learnings from this initiative and the partnership, and identify next stage.

4. Yoga for Pain Down South: a 4-part program

Yoga for Pain Care Australia tailored its standard Yoga for Pain Practitioner Training (Level 1) to be region-specific, meeting GP down south's health care mandates and the agreed program focus of self-management.

The program was called **Yoga for Pain Down South** and comprised four parts:



*Yoga for Pain Practitioner Training was tailored to the region:

1. 4.5-day interprofessional training in Busselton April 6-10 2018

2. 6 weeks of mentoring for yoga teacher participants while they ran a four-week pilot

3. Ongoing support to build a regional community of providers in this new field of practice

5. Outputs

A. 9 new providers equipped with skills and knowledge for yoga-based self-management.

B. 8 pain care yoga courses in WA's southwest for 48 people with pain.

C. Project report.

6. Impact

By engaging non-traditional providers to deliver a new kind of pain care service (founded on interprofessional networks, local knowledge, and progressive inquiry) the 20% of people living in WA's South West with chronic pain will have increased access to varied and local services for self-management, and regional communities gain a new model for financially self-supporting programs that improve population health.

Background research

1. The organisation (GP down south)

GP down south is a not-for-profit community organisation, providing health and wellbeing services in the South West and Peel regions of WA. One of its key programs in the south west is the Integrated Chronic Disease Care (ICDC) program funded by WA Primary Health Alliance (WAPHA).

The ICDC program focuses on improving health outcomes of people with chronic conditions through improving integration and coordination of services and delivering programs that emphasise self-management.

The program specifically targets those who are socio-economically disadvantaged and living with chronic diabetes, cardiology, respiratory or musculoskeletal conditions. One aim of the program is for people in the catchment areas living with indicated chronic conditions (in particular musculoskeletal issues) to access sustainable locally accessible programs (i.e. that continue in the absence of external funding and are delivered by local people) that promote self-management.

GP down south sought the following outputs and outcomes from the training:

- At least two pain care yoga courses offered by each yoga teacher after the training
- Develop partnerships with interested course participants to provide ongoing Yoga to people with targeted chronic conditions in the local communities
- Increase knowledge and skills of participants re providing yoga for pain
- Specific skills related to arthritis for participants

Secondary aspirations

- Pain care yoga classes are well attended
- Training is evaluated
- Yoga is de-mystified

Yoga for Pain Care Australia recommended the program include: health professionals in the training who can learn what Yoga for Pain is and take info back to colleagues; referral protocols; evaluation forms for teachers to use with students; standard Practitioner membership, which includes a requirements to report on results.

2. Topical information

Alma Atma declaration explains the relationship of primary health care with social and economic conditions

In 1978, the Alma-Atma declaration on primary health care (PHC) recognized that the world's health issues required more than just hospital-based and physician-centred policies.

Ruana et al point out that the declaration says primary health care should be "promotive, preventive, curative and rehabilitative" towards "progressive improvement of comprehensive health care for all, and giving priority to those most in need".

Move towards self-management

Self-management is acknowledged to be critical for pain management and indeed a range of "chronic" health conditions (painaustralia). According to the Flinders Program, self-management is:

involves [the person with the chronic condition] engaging in activities that protect and promote health, monitoring and managing of symptoms and signs of illness, managing the impacts of illness on functioning, emotions and interpersonal relationships and adhering to treatment regimens"

However, self-management is not merely about a single person having sufficient will power or education. The Flinders Model, for example, states that self-management requires "prepared, informed, and motivated" individuals, significant others, carers, families, health care teams, and community partners"; accessible services and favourable policy. They quote leading researcher Kate Lorig (1993) who says self-management is about enabling:

… participants to make informed choices, to adapt new perspectives and generic skills that can be applied to new problems as they arise, to practice new health behaviours, and to maintain or regain emotional stability.

Adding:

Assumptions are that self-management, complements, rather than substitutes traditional health care consumer education, and that it is a sustainable, low cost intervention, with wide applicability and which may have a substantial public health effect (Lorig et al., 2001) (Flinders, p.6)

and further benefits:

- Improved wellbeing, strengthened self-determination and increased participation in health care
- Reduced health care use and health care costs (Bodenheimer, Lorig, Holman & Grumbach, 2002; Mortimer & Kelly, 2006)
- Improved clinical outcomes in a number of chronic diseases

Yoga for Pain Down South *sought to respond to social and economic conditions of the time, including a move toward sustainable health services in the absence of funding, adequate*

community education, and providing health care providers and participants with means to be prepared, informed and motivated.

Community health workers - advantages and challenges

Community Health Worker roles were created in part influenced by the Alma Atma declaration mentioned previously. Community health works have “no formal or professional training, delivering basic health services in the context of an intervention.” “They are selected by, and accountable to their community and are supported by the health system, even if they are not necessarily part of it [5,6].”

In Western Australia, there are three examples of this approach:

1. Indigenous healthcare

2. Disability services

3. Mental support

Anecdotally, the arrival of the NDIS, with South West WA as a trial site for a WA-model - combined with an influx of NGOs providing support services for people with disabilities - has led to a big push for people in need to be provided with support workers (conversation, Nicola Hilyard 2018). The support worker may have a university qualification (for example, occupational therapy, social work or provisional psychologist) but could equally have a more generic TAFE-type qualification. While these qualifications may be sufficient for certain roles, many clients serviced by NDIS have complex issues, and visits are typically in their homes which may not be safely and effectively tended to without appropriate training.

In sum “community health worker” can mean a lot of things, but without due training, may cause issues around safety, boundaries and role definition.

This reflects a study in Panama where researchers noted different motivations for Community Health Workers workers. They (the researchers) reminded readers of the need to give attention to “keeping the high levels of commitment and integration within the health team as well as keeping up supervision and economic funds for the program.”

With regards to this program: Practitioners must know limitations. The GP in these communities is who holds ultimate duty of care, and it is to her or him that the client should be referred.

Regional Flexibility

Regional flexibility was identified in Productivity Commission for health care, the health department is supportive of sustainable community programs that remain when funding reduces and “Postcode health” has been made popular through a talk at Kripalu.

Evidence against pain medications and popular surgeries for knee and back pain

Recent studies found arthroscopies and spinal fusion are commonly given in Australia, yet yield no better outcomes than conservative treatment. As such, community education aims to reduce prevalence of these operations.

A potential benefit is that patients will now need to have conversations about their options. Therapeutic Goods Association, for example, held a GP education event 2018 (around the time codeine and other opiates were withdrawn from over-the-counter sale). They encouraged GPs to ask patients more questions to find alternative solutions to medications.

As a neurosurgery physiotherapist told us: “people are less likely to engage with self-management if they think surgery is an option.”

3. Available health services in the region

The three regions (Warren-Blackwood, Margaret River-August and Collie-Harvey) were chosen for this initiative as they are chronic health hotspots. Each of the three (and in fact, each town within them) are a distinct setting. Local knowledge can only enhance the care given.

Available pain management services

- Chronic pain counselling group in Busselton (no pain education and they have been struggling to get adequate numbers
- Some access metro services/referred up to Perth
- Tele-health from RPH

Community programs for chronic disease self-management

South West WA has some available community programs, with a move towards tele-health and online resources people can access themselves.

- Living Longer Living Stronger is offered at some community centres or recreation centres across the region - may not be consistent
- HEAL (healthy eating activity and lifestyle)
- DESMOND (for those newly diagnosed with Type 2 diabetes)
- Diabetes WA (Tele-health service)
- Respiratory: Asthma WA (Tele-health)

• Arthritis WA (online resources)

General medicine

A number of private practitioners across the region provide services through medicare. Some bulk bill, some with gaps.

Mental health

Services include: GP down south's mental health service; South West Counselling (in some areas, including online resources) and WACHS.

4. Health and social markers of South West WA

Physical health in South West WA

Respiratory, musculoskeletal, circulatory and mental health problems are the most common chronic conditions experienced in Country WA (Population Health Needs Assessment). Average life expectancy in regional WA is 5.9 years below national average (PHNA p13 - check for South West).

Chronic disease is the leading cause of death in country WA and 58% people in regional Australia have a risk factor for developing a chronic illness (PHNA p13) Furthermore, 1 in 4 people in the study in regional WA had two or more of the measured chronic conditions (arthritis, asthma, back pain and problems, cancer, cardiovascular disease, chronic obstructive airways disease, diabetes and mental health conditions) - up to 60% for over 64s (p14) Of note for this work, more than 30% with back pain also have mental illness (PHNA p14) Arthritis in South West is 22% significantly more than state level (PHNA p51).

Collie and Harvey identified as chronic health hot spots (Lessons from Location). In country WA more than 30% are obese (My Healthy Communities) compared to 20-25% in the city. 55-60% do insufficient physical activity (compared to 40-55% in Perth). My Healthy Community says results should be interpreted with care, estimating in 66% of cases, GP prescribed medication for arthritis or back pain (2009-13) and imaging in 15% of cases.

Include information for Practitioners on back pain red flags, evidence for back surgery and knee arthroscopies, shift from research "about yoga and pain" to more specific info course participants can extrapolate from, research on yoga and mental distress.

Psychological, mental and spiritual issues

Suicide risk in South West similar to the state average. More than 9% of women in South West experience severe psychological distress (PHNA p16) The same report shows 50% of women

considered at risk of harm due to alcohol consumption. Other lifestyle issues that put people at risk of chronic pain and chronic disease are higher in regional Australia.

Yoga for Pain Care Australia recommended including resources on things like: check iron levels for those with anxiety, referral pathways, info from GP down south about available programs in the region.

Social and economic factors.

The population in (the whole of) South West was 174,000 (2014). The indigenous population is just 2.4% aboriginal population, lowest of regional WA. By 2025 20% of South West population expected to be 65 or over. There are more long term unemployed than the Australia-wide average, but less than country WA overall.

South West WA in general has a booming economy. Of the towns in the whole of the South West, Collie and Manjimup are considered most socially disadvantaged, and Augusta-Margaret River one of the least disadvantaged (PHNA p50). In Collie 33% of children live in a jobless family (p51)

South West WA was the pilot location for the state model for NDIS.

Social isolation is more prevalent in rural areas, noting social disadvantage is an indicator of poor physical health and life expectancy.

Anecdotal evidence is that general knowledge of pain in regional Australia among providers and individuals is limited, and there may be community norms and aspirations related to family, support and beliefs.

GP down south elected that subsidised classes would be charged at $5-9 per classes, recognising the financial difficulties, while ensuring a level of personal investment in the service.

Chronic pain's link with other issues in the region

Nicola Hilyard from GP down south looked at the data and said most people referred to care co-ordination for musculo-skeletal conditions (i.e. arthritis and pain) have co-morbid conditions, especially diabetes and respiratory conditions. We also note people with persistent pain are high users of health services, including emergency.

Yoga for Pain Down South *is likely to offer benefits beyond pain management, with the potential to reduce reliance on GPs, and reduced risk of turning up in WACHS for those with, or at risk of, other forms of chronic disease*.

How we selected providers

An aim of *Yoga for Pain Down South* was that providers we trained continue to offer effective services in the region, as active Yoga for Pain Practitioners. It was therefore important for the initiative (both in terms of GPds' present investment, and future viability) that providers we trained become good representatives who enact the intention of the program, with integrity.

1. Selection process

Applications were open to health professionals, yoga teachers and providers in designated catchment areas within South West WA. Providers completed an online application form. Some were interviewed over the phone for more information.

We encouraged candidates at multiple points in the application process to carefully consider their responses. We also allowed them to edit responses after they had submitted their application, including after receiving an automatic email answering frequently asked questions.

2. Minimum requirements

Minimum requirements for selection were:

- required qualifications (L1 Yoga teacher, tertiary qualified health professional or social service provider)*
- understood what the program was about
- had something to learn from the training
- had a genuine interest in the field
- could conceive of being able to use it
- were committed to completing all parts of the course
- were committed and able to run courses (or relevant services)
- committed to the region
- general capacity to make sense of the (somewhat challenging) material

A crucial question for the Partnership was the capacity of non-traditional providers from the region to engage in this kind of service delivery. Our application form, therefore, was also designed to assess, as best we could, underlying competencies required for Yoga for Pain Practitioner Training, beyond minimum requirements.

These were: openness to learning, discernment, and curiosity.

* Due to limited providers in some towns, we accepted one applicant who had not completed L1 level training but was a qualified fitness instructor and did well in other areas.

3. We aimed for diversity of profession, location and experience

As well as individuals in the group, for best outcomes we identified the group should be a diverse mix of backgrounds, locations and professions. Limitations and preferred inclusions:

- Maximum 50% total participants from any one of the three regions
- Maximum 30% from any one town
- Prefer 66% yoga teachers (able to deliver services through pilot course)
- Yoga teachers from beginner to senior, with more at the latter end
- Group that represents diversity of professions, ages, cultural backgrounds, and genders in region

4. What we learnt through the application process

We paid attention to *how* local providers applied, in order to ensure the selection process reflects the required quality and outcomes of the course, and to improve in future. We noted:

1. Many applicants did not read course dates and check their availability (even though they were specifically asked to check the box saying they were available for all sessions)
2. We received very few questions (by phone or email) about the course, despite the fact we provided very little information about actual course content.
3. Applicants often used more than the word limit (eg 50-word criteria)

Additional administration required to review poorly written answers and late applications led us to consider the impact of respectful behaviour (e.g. timely, considered applications) would have a longer-term impact on the program.

We concluded applicants need to be selected for their capacity to understand the material, to learn, and be a good part of a learning team.

While in this instance the presence of late submissions, responses that don't answer the question given and so on,were used as "red lights", we can be more specific about what indicates a good Practitioner for next time.

5. Selection criteria for future initiatives

Based on the above learnings, the table below lists key requirements for a Yoga for Pain Practitioner applicant, that we will specify in future.

Can and will enact relevant services	Will do so with integrity	Be an active part of a learning community	Self-management, forward-looking
Appropriate qualifications	Recognise this field has clear aims, principles and guidelines that are to be followed, including self-management and progression	Understand Practitioners by definition are part of a contributing group.	Understand intention to move clients forward i.e. towards general yoga, or beyond health care and medical/allied health.
Amenable to this type of client	Open to new information that challenges "their way" and guidance on that	Contribute to the learning of that group at the training, and on an ongoing basis	Health professionals who want to teach yoga in their physio clinic without regard to community participation may not be a good fit.
Capacity in their schedule	Respect for the knowledge offered, provider of that knowledge, and use of that knowledge.	See value of that group for their individual development, that of their clients and that of the field.	
Required Articulate time and place to run services + Clear reason to learn this material **Example** Current clients have pain and they want to help further			

We will also specify for future applicants that they will only be considered if their answers demonstrate they have read required requirements and complete the application according to the instructions.

Referral pathways into these new services

1. Current pathways for chronic pain management

General Practitioners are the first point of contact in the region. They will generally refer to WACHS, which has links to Perth service. In some instances, the GP may refer to outpatient clinics (eg physio) but this isn't same across region. Generally, patients go straight to tertiary.

2. Tertiary options for regional pain patients

Royal Perth Hospital recently piloted a tele-health pain education session, with Bunbury hospital providing outpatient services. SJoG is the private section of the hospital in Busselton and advised they no longer run a pain service.

3. Intended referral process for *Yoga for Pain Down South*

GP down south aims for referrals at 3 levels:

1. Health system: GPds advertise service into GPs and practice nurses, with flyer and referral form.
2. Social services: Target to other agencies.
3. Self-referral: such as private advertising, or SWAP. Yoga for Pain Practitioners will need to screen these clients, particularly if they are attending classes subsidised, or contracted, by GPds, to meet GPds requirements for inclusion and outcome measurements.

Question for observation: is it best for referrals to come through GPds or direct to the individual practitioner

4. Existing and required resources to help with the referral process

Existing	Required
Health Practitioner FAQ	GPds info sheet
Basic referral form	Updated referral form
Practitioner register	Region-specific register, or section on register
	Program-specific checklist, including eligibility, red flags and pathways to other services

Interest from providers and community

1. Interest from local providers

We received over 40 applications for the development program. Margaret River was the most represented town. In the application form, providers were asked to demonstrate interest, availability to offer services in the catchment areas, and how the program could enhance their work and community.

We offered 10 scholarships, of which nine accepted (the tenth discovered she had a clash with another event). The nine included eight yoga teachers, two physiotherapists, an occupational therapist and emergency nurse from Collie, Harvey, Margaret River, Northcliffe and Augusta.

Applicants were selected for their capacity to demonstrate their interest went beyond receiving low cost training, or earning more money; their experience working with pain; previous community contribution and diversity of perspective. The intention had been to offer up to 12 places: however, based on the high calibre of the original nine, and our requirements to form a diverse group that could support each other, we elected to keep to the nine.

2. Community engagement

- ABC South West did a 55 second social media video that generated 10k views, over 200 likes and 77 shares. This was far greater than other ABC videos in the same form.
- Many Practitioners filled their classes with their own wait list of clients, before public advertising

3. Initial reaction from local yoga teachers and health professionals

Initial reactions from local providers (i.e. potential participants in the development program) informed our approach to designing the program.

We noted:

- Practice nurses were enthusiastic about the service coming to town. They saw it could be an appropriate health and wellbeing strategy for a range of patients, i.e. not just for those with pain.

- The response from one GP reflected a common attitude and limited understanding of what Yoga for Pain is: “I’ve sent people to yoga before and the teachers haven’t been aware of how to manage people with pain”.
- We quickly received a large number of applications - though many teachers were concerned about missing existing classes they teach, and about our recommendation to minimise commitments during the training, due to the high demand of the course.

We provided selected training providers with early reading materials, and reminders about the opportunity they were being offered, including early notification of the Practitioner network. We also worked on information for local referrers.

4. System engagement

Background research by Yoga for Pain Care Australia meant the training was up to date with current trends in pain care. Symbiotic system interest included:

- GP down south was contacted by a physiotherapist who received Pain Revolution’s scholarship to up-skill as a pain educator, explaining she can provide community education sessions.
- To ABC South West’s video, many other yoga Teachers (particularly from outside our catchment area) posted that they will soon start teaching classes for pain. While these may not have the precision and educated system approach of a Yoga for Pain Practitioner, their work demonstrates the wider impact of this program.

As an addition, GP down south engaged a provider from Perth to run pain education for local health professionals.

How mentoring worked

The next two sections explain the method for designing the 6-week mentoring while providers ran their pain care yoga pilot course.

1. How we designed the mentoring program

We used an action-learning approach to design the Yoga for Pain Down South mentoring program. While a broad outline was developed up front, the "level" was determined after observing participants in the 4.5-day training and reviewing their assignments. Interviews with GP down south about pilot course constraints (such as pricing and types of clients) determined details, and decision-making was informed by administrative efficiency and what would allow long term data tracking if we so choose.

An action-learning approach meant the program could be adapted to participant capacity (which can change as the course progresses). However it was unfamiliar method for many of the participants and led those with less capacity to feel confused. It also became time-consuming to provide appropriate support to individuals. In future we will better explain the approach to participants, and include individual mentoring time in the program.

2. Format of mentoring

Practitioners received six 1.5-hour group mentoring sessions delivered via Skype (audio). During this time they completed a 4-week pilot course in their area, for which they had to plan, deliver and review. They were provided with templates and additional resources in accordance with the group capacity and interest.

Skype allowed Practitioners to participate from different locations across the region. However some tuned in (for example) while driving, which limited their capacity to participate fully.

3. How we assessed Practitioners in mentoring

Practitioners needed to attend at least five out of six mentoring sessions. They needed to submit a lesson plan for each of their classes, one completed "learn-as-you-go" template, and a two-page reflection within three weeks of completion. They also had to demonstrate:

- Their course had a well-considered course outcome relevant to the provided constraints
- An inquiry-based approach, including that they could make improvements along the way
- Reflective learning throughout, such as anticipating errors before they occurred
- Active participation in group discussion

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• Effective use of provided resources, such as templates, sign-up sheets and evaluation forms

4. Overview of mentoring

Week/ theme	Content	Templates and resources	Outputs
Pre-mentoring Get ready	How mentoring will work Systems we will use Advertising pilot courses Feedback on 4.5-day assignments	Scoping template pdf Course constraints (by GPds)	Scoping template draft Shared googledoc Filing systems ready Pilot course dates
Weekly	Each week, two practitioners share what they planned, what actually happened, and what they learned		
1. Lay of the land	Review 4.5-day course basics Notes on 4.5-day assignments Confidentiality Organising information Familiarise with Skype and Dropbox; number and structure of mentoring sessions; pilot format; where to find things; how to start Addressing immediate concerns Begin action-learning approach	• "Advanced" lesson planning template • “Advanced” learn-as-you-go template (pdf) • GP down south design boundaries • Dropbox links	Scoping document Lesson plan 1
2. Planning	How to plan lesson 1 Work through worries, risks & concerns Manage problems & learn Group discussion of ideas Different ways of getting feedback	Followup email with notes on “Keep asking why” and “Prevent v fix”	Lesson plan 2 Risk management in place
3. Refining, integrating and moving forward	Learning from lesson 1 Student followup eg homework Am I taking a progressive, standard or catchup approach? What was challenging or surprising in my first lesson? Am I managing risk?	Learn-as-you-go template (.doc, Pages) Shared resources “Ethics of practice (dependency)” “Admin ideas”	Lesson plan 3
4. Am I on track?	Am I on track to achieve my aim? Will my classes be pain-friendly, pain-specific or a Yoga for Pain course? Can, or will, my students be able to move without exacerbating pain or nervous system?	Mid-course student feedback form	Lesson plan 4
5. Ready to finish	What is a Yoga for Pain Practitioner? What do I need/want? How to turn classes into a course	End of course student feedback form	Student feedback Shared resource page for future use
6. Close-out to continue	Group problem solving as a Yoga for Pain Practitioner Guidelines for 2-page reflections Reflection: where am I individually?Where is my group? Did they develop self-management skills? What will I do next?	Reflection template guidelines	2-page reflection due within 21 days

Pilot pain care yoga courses

1. Overview

During mentoring, Practitioners ran four-week pain care yoga courses. These were advertised as pilots, so all parties could feel comfortable that it was a learning opportunity and do their best to take advantage of that. Courses were advertised publicly and participants with pain paid a nominal amount of $20 for the four classes.

Four weeks is a good length to get participating commitment; charging a fee reflected a perhaps common (but rarely executed) belief that free services discourage attendance and value-ing; public advertising raised awareness in the community of pain, how yoga can help and the innovative program GPds was offering; public advertising also attracted interest from other providers in the pain space, creating new networks.

2. Design constraints

During the 4.5-day course that preceded mentoring, Practitioners were given templates to help them research, scope, design and monitor a 4-week pain care yoga course. They used the templates to design a course for a specific demographic (for example, farmers in Warren-Blackwood, teenagers with rheumatoid arthritis, or near-retirees with a range of pain conditions).

For the pilots, however, the Partnership decided a "general" pain care yoga course would be most beneficial. This would make initial recruitment easier (i.e. anyone interested could attend) and mentoring more efficient, especially given the group was quite large.

Design constraints provided to Practitioners to plan their pilot were based on GP down south funding and assessment of community needs. They were:

D. $20-$25 per class price range (i.e. course won't include time-intensive resources)

E. Bookings will come from the community so will likely include a range of people and pain issues.

F. Focus on musculoskeletal pain (such as arthritis, back pain etc., no cancer-related pain)

G. Ages 16+

H. Focus on self-management, which includes what students can do for themselves, and the way they access integrated services in their community

I. At course end, students decide a next step, such as to repeat a pain care course, join a gentle class at the studio, do a home practice or take up a similar, relevant activity.

3. How we collected data

Data collection is critical for demonstrating the impact and results of programs. Four feedback systems were implemented:

a) GPds end-of-course participant form (1 page)

b) YPCA end-of-course detailed feedback form (2 pages)

c) Practitioners ask participants questions during their pilots and record answers.

d) Central booking system (Eventbrite) so Partnership has contact details for future research.

Some practitioners used other methods of data capture, such as inviting participants to keep diaries, or collating discussions on a whiteboard.

Advantages: Central depository of data gives the potential to collate a good cross-section of data for over 50 people with pain over a long period of time; a range of feedback mechanisms are in place.

Challenges: Big administration effort for GP down south to set up and track bookings, names and payments; some people couldn't manage the technology to enrol; how to manage the paperwork of submitted feedback forms is still uncertain.

4. Future resource opportunities

To make pilot programs and ongoing courses more effective in future, additional resources that would be beneficial include:

- Intake form to ensure participants meet GP down south target areas
- Evidence-based evaluation form
- List of existing support/programs in the regions (GPds web page?)
- Technically written evidence for yoga and pain
- Measures that include EPPOC pain measurements and prevention/health promotion measures

Results and learnings for teachers in pain care yoga pilots

By and large, Practitioners reported good results from their classes. The style of teaching was new for many and they were surprised at how positively people responded.

> *"Even the seemingly fitter and stronger ones benefited from slowing down."*

1. You have to really slow down with this group

In the first week particularly, most Practitioners were surprised at how long things took:

> *"I tried to fit way too much in. I have to cut my next class right down."*
>
> *"It actually took a long time to explain the props to people."*

Group mentoring meant each could learn from others, and change future lesson plans based on the revelations of those who started their course earlier.

2. These clients are complex

Practitioners disclosed participants in their pilot courses had different things going on compared to their usual students.

> *"Most have never done yoga before."*
>
> *"None could get on the floor."*
>
> *"Two are recently bereaved."*

This helped each Practitioner recognise the need to recognise the boundaries of their own capacity, and the importance of referring back to their professional and Yoga for Pain Practitioner Ethics to ensure an action in good faith doesn't unintentionally cause more harm.

3. Attendance was surprisingly high

Health professionals often report that pain patients don't attend booked health care services. This could be due to other appointments, health issues and pain itself. By comparison, attendance at the yoga pilots seemed relatively high. Some, however, couldn't attend all four classes:

> *"The big storm meant people couldn't get here, which I was expecting."*
>
> *"Only one person attended all four lessons. I felt sad for them because this was their opportunity, but they did generally have genuine reasons - one had whooping cough!"*

(The latter was from the teacher who only had three bookings to begin with. She later discovered people hadn't booked in because they couldn't work the online booking system.)

Generally they said students were pleased to be there:*"They are quite receptive and engaging."*

4. Other observations

Mentoring placed a big emphasis on observation, reflection and learning. This is so Practitioners get more skilful working with the little things that make the biggest difference for their clients. Practitioners' observations were varied, and included the use of language, how they felt and behaved personally, how clients responded, and their venue. They also observed the dynamic between Practitioners.

> *"I realised I would say one thing, and each of the six people would have a different interpretation of what I had just said. it kept me on my toes."*
>
> *"One lady with lower back pain said the burning sensation was gone!"*
>
> *"I've decided to take a progressive approach to my engagement with mentoring, rather than 'catchup'".*
>
> *"Having the support of the group and forming connections has been helpful."*
>
> *"I noticed other teachers don't want to do lesson planning. I've offered to help but they aren't interested."*
>
> *"…Just how much trouble this one lady had - but I saw how her movement improved after just one exercise."*
>
> *"One lady didn't come back and I thought she was sick. It turned out she found it too Buddhist, which I was confused by since I don't do any Buddhism Then another student pointed out there was a big Buddha head in the yoga room! It's these little details."*
>
> *"The one person who came to all four sessions got the most out of it."*

5. Creative teaching methods

Practitioners experimented with different formats, such as using the whiteboard, giving journals, and showing a pain video then discussing it.

6. Challenges Practitioners faced

The main challenges Practitioner disclosed (directly and indirectly) fell into three categories:

1) Technology

2) Difference between the new approach and ways they are accustomed to working

3) Managing personal commitments

Technology

As mentioned previously, many Practitioners said their internet dropped out and they missed what was said. Two tuned into Skype while driving (for one this meant she couldn't contribute verbally). Information issued before mentoring explained they would require access to good internet. Others took time to get used to Dropbox and Skype, such as using the mute button and other basics.

Learnings: The convenience of Skype also means people may not take the same care for participation as a physical environment.

Q. Is internet in these towns bad everywhere, or do they need to go somewhere more effective?

A new approach

Yoga for Pain Practitioner Training isn't a tick-box kind of training. It requires doing an activity, learning from it, and adapting in future, with the support of a community. While the results long term are stronger, it can be discombobulating short term:

"I'm trained as a yoga therapist and I am used to giving techniques to fix specific illnesses."

"I don't see why I should have to do lesson planning. You have to change it as soon as you start."

Managing personal schedules

Booking conditions and contracts expressed that scholarships required full participation. To decide the mentoring time, Practitioners were asked (before the 4.5-day course) which times they would prefer. Friday 2pm was chosen as the most convenient. One Practitioner who had said she could make all of these later organised to work and missed 1.5 mentoring sessions.

Learning: Tweak communications from the Partnership to highlight that all parts of the program work together for the benefit of Practitioners, the group and the community.

Who attended pain care yoga and what they said

Of 48 people who attended pain care yoga classes, the Partnership received 28 feedback forms.

1. Pain conditions were diverse

Pain issues disclosed by participants were diverse and many experienced more than one.

Fibromyalgia (1)	Rheumatoid arthritis (6)	Osteoarthritis (4)	Knee pain (2)
Headaches (1)	Neck pain (3)	Upper back pain (1)	Lower back pain (6)
Shoulder (2)	Bursitis (1)		

Participants also disclosed: Hashimotos (1) COPD (2) Anxiety/ depression (2)

2. 89% said they can better manage their pain

After the four, mostly one-hour classes, 25 of the 28 (89%) participants said they were better able to manage their pain. One of the three who said she couldn't better manage her pain wrote: "I can see how this will help but four weeks isn't enough to know what to do at home." She said she felt more hope and confidence and will definitely continue yoga.

3. Benefits for people with pain had five key themes

Themes were **realising yoga could help** in general, **specific techniques** they learned, experiencing **less pain**, becoming **more aware** (of knowledge and themselves) and feeling **more confident**.

"Realising some forms of yoga and movement can help."

"Breathing techniques."

"The gentle movement is beneficial for pain control."

"Props to assist me to be able to do yoga poses without pain."

"Relaxation techniques - knowing stress and pain interrelatedness."

"Being aware of more of what your body is telling you."

"Becoming mindful of how my body is feeling."

"Gaining greater understanding of how pain works."

"Gentleness is OK, it's allowed."

"Acknowledging it is important to take time for myself to relax."

"Confidence to attend regular yoga classes."

"Confidence to practice at home.

Measures of success

Program success required sufficient interest from local providers to train as Yoga for Pain Practitioners; community interest in pain care yoga; and results for people with pain in pain care yoga pilots. We will also track data over time about whether pain patients continue with yoga.

1. How we determined what success would look like

Medical measures of pain reduction are insufficient to enact long term change in Australian pain care. Social determinants are critical for prevention and recovery, and self-management requires ongoing action, access to services and personal efficacy.

We note Western Australia is undergoing a "sustainable health review" yet health care system measures still focus on number of bed days as indicators of success. The "pointy bit of health care" (high health system users) is largely due to chronic disease, and this "pointy bit" will get bigger if we don't focus on community wellbeing and prevention now.

Regarding yoga specifically, there is significant evidence that yoga, and yoga-related activities such as mindfulness and appropriate exercise, benefit pain. However to get these benefits, people need access to classes that suit their long term needs, and they must attend often enough..

*We therefore wanted **measures of access, participation and engagement,** rather than simply medical measures which are insufficient to systemically address the pain challenge.*

2. How we collect that data

Media observations, and enrolment in classesBasic GP down south client data sheet, Extended YPCA form Annual social impact survey for Yoga for Pain Practitioners.

3. Overview of measures

	Participant Providers	Participant individual community	System/community
Interest	No. applications (43)	No. EOI Social media interest No. bookings in pilot (full)	Engagement from related bodies
Immediate result (outputs)	Full attendance (100%) Course satisfaction Key learnings No. pilot courses run (8)	No. people who fully participate in pilot course Results (currently qualitative as we don't have resources for full EPPOCC)	
Longer term observations	No. pain care yoga providers in 12 months?	No. new people starting pain care yoga No. people continuing beyond pain care yoga	Impact on provision through non-traditional providers

4. Future measurement

With additional resources we could track (for example) preventative measures, how people become engaged in pain care yoga, and measures related to Flinders Partners in Health Scale.

The 3 program innovations

We began this initiative with an aim to increase options for people with pain in South West WA. The action-research approach uncovered 3 key innovations that could fill a big gap in pain care in this region.

1. Non-medical providers offer pain care services in a community setting

Whereas traditional pain management is delivered in a medical or health care setting, the model for *Yoga for Pain Down South* Pain enables transitional pain care provision in a community setting, delivered by informed but non-medical providers. The service is particularly useful for those transitioning from medical care to self-management, and as a way to engage those who are at risk of persistent pain.

2. Specifically targeting areas of high need

Pain is generally considered a medical issue, but your risk of getting chronic pain, your likelihood of recovery, and your access to services are all affected by social and economic factors. By targeting yoga teachers and health professionals from towns identified as chronic health hotspots and offering partial scholarships we increased services in areas of need, by providers with local knowledge. People on low incomes with certain health conditions were offered subsidised places which further increased accessibility.

3. The intention is lifelong support and wellbeing

Most chronic pain management aims to rule out causes of pain, and teach self-management. The risk is that people do not continue with self-management adequately, or that life stresses triggers a pain recurrence. Providers we trained as Yoga for Pain Practitioners may support their clients for many years, as clients progress into more advanced classes over time. This allows clients to progress, enrich their health and meaning over the course of their life, beyond pain.

Recognising that achieving this outcome would require more than just training for providers, Yoga for Pain Down South *was subsequently used to refer to the entire program, comprising Practitioner development, pilot courses, community education and subsidised pain care yoga courses.*

PROGRAM LEARNINGS

This section explains what we have learnt so far through Yoga for Pain Down South. (While previous sections explain learnings from specific parts of the initiative, this is a more systemic look at the overall approach.) These learnings will be used to improve the Partnership, Yoga for Pain Practitioner Training, and Yoga for Pain Care Australia's model for regional pain care.

1. Attracting students took a whole-of-community approach

Classes in Margaret River and Cowaramup booked out within a day. This was largely due to teachers advertising courses themselves. Local papers attracted inquiries for Collie. Northcliffe bookings were very slow: yet within a day of GP down south reaching out to its (analogue) networks the course was over-subscribed.

Learning: existing networks in the South West are a community asset to getting people to services.

2. Local media was a useful outlet, and helped raise community awareness

The project attracted:

1 x story Dunsborough-Busselton paper (print and online)

2 x stories MR times (one repeated in The West online)

1 x story Collie times (print and online)

ABC South West interview + social media video with over 10,000 views.

Painaustralia shared a story about a Practitioner which generated 18 shares.

Learnings: The community is interested in this. Media regard the initiative as a community asset.

3. All Practitioners completed with a 99% attendance rate

All Practitioners selected for the scholarship to Yoga for Pain Practitioner Training completed the 4.5-day training, mentoring, pilot and required assignments. Out of a combined total of 540 hours training for all nine practitioners, just 5 hours of contact time were missed, representing less than 1%. (This is the first Practitioner Training where all participants in the cohort have submitted assignments required to complete.)

Learnings: Application process attracted committed providers.

4. Our program initiated related events and education for GPs, health professionals and the community

Early in the project we discussed developing resources for local doctors and health professionals with an aim to co-ordinate with other services. Interestingly, local newspapers and social media promotion generated professional interest as well as community engagement. For example, a local physiotherapist contacted GP down south to say she had received a scholarship to become a pain educator, through Pain Revolution. She will run pain education sessions for health professionals and the community over the next year.

Learning: a community-approach to pain education is possible.

5. *Yoga for Pain Down South* may have led to Yoga for Pain-inspired services

A number of yoga teachers who applied for scholarships and were ineligible have offered new yoga courses, around pain, stress and community.

Learning: there is possibly a flow-on impact of Yoga for Pain Down South that could be harnessed, and measured.

6. Symbiotic timeliness: pain awareness and sustainable health care

2018 has been a big year for pain awareness. Painaustralia has spent many years influencing policy and their efforts led to an announcement this year of pain as a priority by Minister Greg Hunt. Major health reviews point to the need to develop more sustainable services, and reduce ineffective ones. In particular, media (including ABC 4 Corners and SBS Insight) increasingly cites the lack of evidence for common operations like knee arthroscopies and spinal fusion.

In the Background Research for this program [see previous section in this report] we considered "topical health information", such as spinal fusion evidence, and providers Practitioners with these up-to-date protocols. We also included the opportunities that this new knowledge entailed - namely, that knowing surgery won't work means patients are more open to (and need) other options.

This background preparation has led to a timeliness, and a somewhat symbiotic relationship between these different pieces of education and available services: increased awareness raises the need for new options, and new options require better education to ensure uptake.

7. *Yoga for Pain Down South* is part of a broader change project for health and social care delivery

Yoga for Pain Down South was a courageous project, particularly for GP down south as a not-for-profit community health agency. It is a completely new model for connecting health care with community.

Both partners spent more time on the project than budgeted and there were many "unknown" (sometimes anxiety-causing) moments. The steep learning curve referred to in other sections in some ways parallels work done (for example) introducing the Flinders Model for chronic disease management into the region, and Pain Revolution's work in regional Victoria. The latter took a long time to reach full fruition, and the former has come up against the reality of implementing a new model within existing systems.

Learning: It is important to emphasise Yoga for Pain Down South *was not simply a yoga teacher training that can be replicated en masse. Its effectiveness is more in being tailored to the needs and direction of this community and its health care dynamics.*

8. Reflective and inquiry-based learning is not familiar to all providers

Reflective learning, being curious in the face of challenge, and contributing knowledge to the community is an inherent part of Yoga for Pain Practitioner Training. These are critical skills Practitioners will need to respond nimbly to changing needs of Australian pain care.

Typically, Practitioners develop these capabilities over some years, slowly progressing through training modules. Due to funding deadlines, *Yoga for Pain Down South* program moved faster, and the learning was unfamiliar to many of the providers.

Learning: We have begun to detail a training rubric, that includes relational competencies. In future application forms we will explain what we mean by reflective learning - to ensure applicants are at least exposed to it.

9. Practitioners should consider working relationships with care

Practitioners from Margaret River formed a group as soon as the 4.5-day course was over. They created a website and flyers. The Partnership didn't want to quash enthusiasm as it showed they were looking forward, which is motivating.

However, we later realised this group represented more than half of all Practitioners in Yoga for Pain Down South, and inadvertently excluded others. It also presented a potential for problems among them if not everyone completes.

Learning: Explain to future Practitioners that, based on previous experience, that we recommend they wait until the course is complete and each has worked out their own direction, before forming professional alliances.

10. People feel better able to manage pain after just four weeks of pain care yoga

Most teachers ran four, 1-hour or 1.25 hour classes. 90% of their students said they felt better able to manage pain and an additional 3 % said they would definitely continue yoga. At $20-$25 for each class, the cost to clients paying full price is less than the most of many individual physiotherapy sessions, and participants receive multiple benefits, not just pain "relief".

Opportunity: 4 weeks is a manageable time to get people started and see benefits. Short courses may illicit interest, and show them the time commitment is not so onerous, so they can then feel comfortable signing up for a longer course.

11. Measure success at individual, group, community and program level

During our project scoping phase, we discussed outcomes. YPCA's suggestion was to align with WAPHA KPIs. However, in the end, captured outcomes were program outputs (number of new Practitioners, new classes and number of attendees in their courses) and individual outcomes (via GP down south feedback form).

Practitioners were given longer feedback forms to capture in-depth feedback but not all used them. As the initiative gained momentum it also became clear there were innovations in the program that are not standard pain measures and so would be missed in standard forms.

Learning: Program could be assessed against individual, program and community outcomes, depending on intended use of data.

12. Summary of learnings for future of the program and partnership

In future we will:

Design process

- Continue to emphasise the extensive research phase to meet community needs
- Continue to engage with local media and use responses to "sense" community engagement
- Emphasise there will be a "learning curve" for all!

- Remind everyone that even though something similar has been done in other communities, each area is different.
- Not assume everyone will complete the course and demonstrate qualities of a Yoga for Pain Practitioner

Application process

- Invite participants to apply for mentoring once they have completed the 4.5 day course, and/or have a more exhaustive interview process
- New learning rubric with relational qualities to be over-emphasised in application process

Partnership communication

- Schedule a regular Skype call for project debriefs
- Clarify roles

Communications with practitioners

- Communicate more *as* the Partnership
- Discourage Practitioners from making collaborative working arrangements prior to completing: explain not everyone may complete and we have seen other groups experience difficulties
- Explain early on that group discussion outside the Practitioner environment may lead to errors

Evaluation

- Build in formal evaluation at individual, partnership and community level (and budget for this)

APPENDICES

1. Post-training interview (Rachael West interviews Nicola Hilyard)

What were the main reasons for wanting to pilot a program with us? To provide something that is self-management focused, different, accessible and based in the local community. Part of it is that you came to us with the idea, and it fit well with what we want to achieve. It seems to be fortuitous (but maybe this is just because I'm more aware) that there is a lot of other stuff happening around pain, such as in the ABC, "surgery is not the answer" and Abby getting the scholarship with Pain Revolution, research around knee and back operations. [RW note - yes, we timed it this way and kept up-to-date!]

How did this fit with your funding and metrics? We've targeted something that isn't just applicable to one issue, it affects people across many of the chronic conditions in our ICDC program. In particular, arthritis is higher in our area than other places in the state. I also have a personal interest in the co-morbidities around pain and mental health. Also targets around lack of services - actually it's not so much lack of services but lack of co-ordination.

Did you achieve those? In regards to co-ordination of services I didn't try to make that happen, it just sort of evolved! When you start offering something, people start contacting you to get involved. This (including the media) has helped raise awareness of how they can self-manage, increased awareness of chronic pain in the community. [RW note: we discussed co-ordination in scoping stage of documentation so have evidently done something that has created the conditions for others to get involved] I have an awareness of just how big an issue it is.

When we started we weren't sure if we would get enough people applying. What did you think when 42 people applied? Demonstrates people are keen for the opportunity to provide people with things that are health and wellbeing, not just medical. Also that they are keen for the opportunity for training.

The ABC South West story seemed to get a lot of interest and you mentioned practice nurses thought it was positive. Do you think overall there is community interest in this? The media was excellent. [RW note - NH mentioned this before prompting with this specific question about media] Yes, this story worked really well. Local media coverage was great too, in the way it built networks and referrals in. People who really engaged.

Was ABC and any other media useful for GP down south generally?)

In the end we had 9 new practitioners trained, 8 pilot courses of 4-weeks each (with a total of about 50 people enrolled) Some of the feedback from those clients was: …. Is this for you a good outcome? Yes, on two levels:

1) We've got the 9 people trained who can deliver in local communities

2) Pilot was fully booked - people are willing to engage. Self-management is what people are looking for.

We focused on self-management because of ICDC. You also mentioned that some of the practice nurses saw this could be of benefit for non-pain clients. Can you say how you see Yoga for Pain helping different clients you need to help in the region? A key learning from our ICDC program is that even though we have trained practitioners in the Flinders model (of self-management) many will struggle. It's more challenging than we thought. Part of this is their individual capacity to do it, but largely integrating into their clinical model. I.e. there are layers - system wise (MBS), practice level and individual. [RW note this is useful - Finders is a well regarded model and fact it didn't just fall into place means new systems of working are recognised as taking longer]

Do the conditions covered under ICDC get worse when people don't look after their health? Yes. For next year, as well as access to allied health, we are going to focus on exercise physiologists who can get them exercising. They'll get three sessions to implement a program, not necessarily in the gym. Their idea here is to focus on people making changes to a risk factor i.e. physical activity, which works well with the yoga. In the research this is the one thing that can make a difference.

What have been the successes of the pilot partnership? "I don't know, it's been a huge learning curve. It was a really brave thing to do! Not traditionally something that funded agencies do. It's seen as innovative and valued. Developing as we go has actually worked well."

Any indirect results? RW - my observation is that as a result of our work, GP down south got a lot more interested in pain and noticed all the info. There has been a big push lately so I suspect we got in at a good time for them to see their role in this. A common message has been lack of knowledge/services in regional Australia so I guess we helped this trickle down. NH: as a result, people started to get in touch, so those referral systems happened naturally. "Jacinta came down and did an education session for clinics?" Abby who got the Pain Revolution scholarship will do community education." [Note NH heartened by how long it took Pain Revolution to get going.

Who signed it off? Is he happy? Graham is happy, yes! He's pro-community development approach, including upskilling. He believes that is a more successful model.

What does WAPHA think about it? Don't know, and not likely to! They'll wait for reports etc.

I know you put a lot of hard work in, for example raising awareness in the community. Can you talk about that? Was it frustrating or unexpected? It wasn't frustrating, part of the learning curve. But it was anxiety-provoking at times and I'm not usually an anxious person. It was fine - problem-solving.[RW: "Do you mean this was new territory and when a problem came up there wasn't an answer so we had to make time to think about it? NH: Yes] Also highlighted issues with our internal processes (eg Eventbrite)

What can we improve for next time?

a) Getting really clear on outcomes e.g. using a standardised measurement tool to show benefits to participants. [YPCA suggested aligning with WAPHA ICDC indicators. May be that now GPds is more aware of chronic pain, able to think about what to measure]

b) Something about managing expectations for Practitioners about what happens next. The lack of certainty was anxiety-provoking (ongoing contracts with GPds?). I thought we were really clear. [RW: I went back over the email trail and we were really clear. I think we've learnt that people need to complete course, then plan what they will offer, rather than getting together outside of the course which has led to problems]

c) Evidence-based fact sheet for those who like the logic, like the thing you mentioned the anaesthetist did at SCGH. [RW suggested we co-apply for funding to produce this]

d) At times my availability (Nicola's) wasn't as much as other times, so a scheduled Skype catchup would be good.

e) Better define and co-ordinate NH and RW's roles

f) NH said she can be more available for the training and mentoring

g) Give attention to all providers. MR were very pro-active (which was problematic) and need to ensure all get attention.

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