SPECIAL EDITION

PGAP® News

News and updates from the PGAP, an evidence-based treatment program targeting psychosocial barriers to recovery and rehabilitation for clients suffering from debilitating health or mental health conditions.

The PGAP: Now in its 4th Edition

The 4th edition of the PGAP Treatment Manual has been released. The new edition features a number of enhancements over the 3rd edition. More detailed information is provided about techniques to address catastrophic thinking and perceptions of injustice; two risk factors that have been shown to be primary determinants of disability associated with a wide range of debilitating health and mental health conditions. The revised edition also provides more examples of PGAP techniques used with work-disabled clients with mental health conditions such as depression and post-traumatic stress disorder.

As readers are no doubt aware, our Centre is involved in ongoing research aimed at understanding how psychosocial factors impact on disability, and on the development of intervention approaches designed to specifically target psychosocial barriers to recovery and rehabilitation. One of the objectives of our work is to continue to make enhancements to the PGAP, informed by our ongoing program of research. It is within the spirit of these research activities that changes were made to the PGAP Treatment Manual.

In this Issue of the Newsletter, we take the opportunity to trace the evolution of the PGAP over the years, highlighting the important changes in the program from the 1st to the 4th editions. We also take the opportunity to describe the upcoming implementation of a Central Referral system that will permit us to work more closely with referral agents to ensure the best possible outcomes for clients referred to the PGAP.

Although originally developed to target pain-related psychosocial risk factors, the PGAP has been modified to make it relevant to the life participation challenges associated with a wide range of debilitating health and mental health conditions.

The Evolution of the PGAP

The PGAP is a risk-targeted intervention that was designed to reduce catastrophic thinking, symptom exacerbation fears, disability beliefs and perceived injustice. Proceeding from research highlighting the role of psychosocial factors in the development and maintenance of disability, we reasoned that an intervention specifically targeting disability-relevant psychosocial risk factors might yield positive outcomes for individuals who were work-disabled due to a debilitating health or mental health condition.

Although the PGAP was originally developed to target psychosocial risk factors associated with pain-related disability, ongoing research revealed that the determinants of disability showed striking similarity across a wide range of debilitating health and mental health conditions. It appears that individuals who have a catastrophic orientation toward their symptoms, individuals who are fearful of symptom exacerbations, individuals who believe they are helpless to overcome the challenges of their condition, and individuals who feel that they are suffering unjustly are more likely to exhibit high levels of disability. These risk factors contribute to heightened disability regardless of the nature of individuals' debilitating health or mental health condition.

In 2008, the PGAP underwent important modifications in order to broaden the range of health and mental health conditions for which it could be used. One of the changes was the modification of the screening measures used to assess a client's appropriateness for the intervention. The instructional set and the item content of the measures were modified such that they could be applicable to any debilitating health or mental health condition, as opposed to being specific to pain. The intervention techniques of the PGAP were also modified to make them relevant to the life participation challenges associated with different health and mental health conditions. To date, the PGAP has evolved into an intervention for targeting determinants of disability in 5 different disability groups: 1) pain and musculoskeletal conditions, 2) depression, 3) post-traumatic stress disorder, 4) cancer survivors, and 5) other chronic illnesses. Future planned modifications to the PGAP include adapting the PGAP for clients with spinal cord injuries, clients with traumatic brain injury, and clients recovering from orthopaedic surgery.

Prior to the development of the PGAP, our Centre had developed and tested the Pain-Disability Prevention (PDP) Program. In structure and in content, the PDP Program was very similar to the PGAP, with the exception that it was delivered by mental health professionals (e.g., psychologists, social workers). The PDP Program had been developed in the context of a population health approach to the management of pain-related disability in Nova Scotia,

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Canada. In collaboration with the Workers' Compensation Board of Nova Scotia, and with funding from the Canadian Institutes for Health Research (CIHR), we trained approximately 100 psychologists and social workers as PDP Providers. We were able to establish a network of PDP Providers across various regions of the province, and these psychologists became the providers of the PDP Program for a province-wide clinical trial.

Some of the questions addressed in the clinical trial of the PDP Program went beyond issues related to treatment effectiveness. A key factor in the utility and sustainability of a population health approach to intervention concerns the degree to which the intervention is acceptable to the client population. In the first study of the PDP program, we found that over 77% of clients to whom participation in the PDP Program was offered, agreed to enrol. We considered this to be a very positive enrolment rate given that the enrolment rate for clients referred to physiotherapy was only 66%. The return-to-work outcomes following participation in the PDP Program were also very promising. A sample of 104 WCB claimants completed the PDP Program and 60% returned to work. Given that the majority of claimants were already in the chronic phase of recovery (mean duration of work absence = 5 months), the 60% return to work rate at treatment termination was considered very promising. The positive outcomes associated with participation in the PDP Program have been documented in a number of research publications.

In our work with the PDP Program, we were able to demonstrate that the skill set required to target psychosocial risk factors could be brought to a broad community of clinicians. In addition, we were able to show that the availability of this intervention led to meaningful reductions in work-disability. However, our work with the PDP Program also highlighted some accessibility challenges. Given the limited number of psychologists available to provide services to the work-injured population, particularly in rural or remote areas, the PDP Program had limited geographic accessibility.

The accessibility challenge was one of the driving forces behind the development of the PGAP. Our objective was to modify the PDP Program in such a manner that it could be delivered by rehabilitation professionals that did not necessarily have a background in mental health. The PGAP retained the same structure and objectives as the PDP Program; namely, a 10-week standardized, community-based intervention that aimed to reduce psychosocial risk factors for prolonged work disability.

Now in it's fourth edition, the PGAP consists of 10-weekly meetings between a trained PGAP provider and a client. An educational video is used to orient the client to the procedures of the intervention as well as to foster positive outcome expectancies. A Client Workbook is provided to the client and serves as the platform for the intervention techniques that are used.

The primary goals of the PGAP are to reduce psychosocial barriers to rehabilitation progress. These goals are achieved through the use of evidence-based techniques specifically designed to target psychosocial risk factors. The PGAP includes:

1) cognitive-behavioural techniques such as thought-monitoring and re-appraisal,
2) behavioural techniques such as graded exposure,
3) relational techniques such as disclosure and validation.

Since return-to-work is a primary objective of the PGAP, risk-targeted techniques are delivered within a framework that fosters activity mobilization and life-role re-integration.

In the initial weeks of the program, the focus is on the establishment of a strong working relationship through the use of disclosure and validation techniques. The focus then shifts to the development of a structured activity schedule in order to facilitate resumption of pre-injury/illness activities. Each session begins with a review of the client's activity log and ends with a discussion of planned activities for the coming week. Activity goals are established in order to promote resumption of family, social and occupational roles. Additional intervention techniques are used to target specific obstacles to rehabilitation progress. In the final stages of the program, the intervention focuses on activities that will facilitate re-integration into the workplace.

Since return-to-work is a primary objective of the PGAP, risk-targeted techniques are delivered within a framework that fosters activity mobilization and life-role re-integration.

The PGAP differs from many other rehabilitation interventions in that the techniques included in the intervention have the reduction of disability, as opposed to symptom-reduction, as their primary objective. There were several reasons for developing a program that focuses more on disability reduction than on symptom reduction. First, research in other areas of rehabilitation indicated clearly that symptom reduction was not a pre-condition to successful return to work. Second, symptom-reduction techniques, whether pharmacological or psychological tend to be passive in nature and passive techniques have been shown to be detrimental to return-to-work outcomes. Finally, a focus on symptom reduction might inadvertently reinforce individuals' beliefs that symptoms must be eradicated before occupational activities can be resumed.

Although the PGAP is described as a 10-week program, the intent is to emphasize that the program extends over a maximum of 10 sessions. Since the goal of the PGAP is to promote return-to-work, the program terminates when the client is ready to return to work. Clients will vary in terms of their rate of improvement through the program. Some clients will be ready to transition back to the workplace after 4 weeks of treatment; others will require all 10 sessions of the program. The PGAP never extends beyond 10 weeks.

In order to further increase the accessibility of the PGAP, the program was modified for telephonic delivery. The telephonic version of the PGAP, referred to as PGAP-Tel, contains all elements of the PGAP, but there is no face-to-face contact with the clinician. All aspects of the program are delivered by telephone. With respect to accessibility, PGAP-Tel can ostensibly be offered to anyone who owns a telephone.

The effectiveness of PGAP-Tel has been evaluated in two clinical trials. One trial was conducted with recipients of disability insurance with the Social Security Administration of the United States. Recipients of disability insurance were offered health care insurance, PGAP-Tel and benefits counselling. This group was compared to a group who only received health care insurance, and a group who received no additional services. The study sample included individuals with a variety of chronic debilitating chronic health and mental conditions. Results of the trial showed a re-employment advantage

of PGAP that was maintained at 2-year follow-up.

In a second trial, PGAP-Tel was compared to PGAP delivered face-to-face. With respect to return-to-work outcomes, the face-to-face delivery of PGAP proved to be more effective than PGAP-Tel. Taken together, the results of research conducted to date suggest that PGAP-Tel can be an effective intervention for increasing occupational involvement, but that in regions where both the face-to-face delivery and telephonic delivery are available, the face-to-face delivery will likely be associated with superior outcomes. Two Canadian and two US organizations are trained in PGAP-Tel delivery.

At present, a number of different professional disciplines are represented as PGAP providers. These include occupational therapy, physiotherapy, kinesiology, nursing, psychology, social work, vocational rehabilitation counselling, and medicine. To become PGAP providers, clinicians enrol in a two-day training workshop to acquire the skill set necessary to deliver the intervention.

We chose to make PGAP training open to a number of rehabilitation disciplines because 'work disability' is not discipline specific. The intervention techniques contained within the PGAP are not intended to treat the client's underlying health or mental health problem, they are intended to treat the disability associated with the client's health or mental health condition. In the PGAP, disability is construed as a reduction in participation in important life activities; disability reduction then becomes a process of re-engaging the client in important life activities. Reducing disability and promoting re-integration in important life activities are objectives that are common to many rehabilitation disciplines. As such, it seemed unnecessary to restrict PGAP training to only a subgroup of rehabilitation disciplines.

Psychosocial interventions are now more likely to be considered in the treatment of a work-injured client than they were 10 years ago. Over time, insurers have been more aware that appropriate psychosocial interventions could augment the rate of recovery of injury, and shorten the work-disability period. Although many insurers will consider referrals for psychosocial interventions for work-disabled clients, unfortunately, referrals for psychosocial interventions tend to be offered only once the transition to chronicity has occurred. In many cases, a referral to a psychosocial intervention will only be made once all medical avenues of assessment and treatment have been attempted and have failed. This approach unfortunately ensures that a client will have been work-disabled for an extended period of time, and will have become completely demoralized by repeated failure by the time he or she is offered a psychosocial intervention.

Resources still need to be invested in educating insurer representatives (e.g., Case Managers) on the negative consequences of exposure to unnecessary medical assessments or involvement in medical interventions with low probability of success. Clients exposed to repeated failures in medical treatments ultimately develop negative expectancies for recovery that further compromise their recovery potential.

Psychosocial screening should occur as early as possible in the rehabilitation process. For musculoskeletal conditions, the most cost-effective period in which to offer a psychosocial intervention such as the PGAP is probably between 4 and 12 weeks post-injury. The PGAP has also been shown to be a cost-effective intervention for individuals who have been work-disabled for several years, but understandably, the return-to-work outcomes are more modest than when PGAP is initiated earlier in the disability process.

Overall, the results of several clinical trials point to a number of advantages of the PGAP. The PGAP has consistently been associated with high enrolment rates, indicating that the majority of individuals to whom the program is offered, agree to participate. When compared to other rehabilitation interventions such as physical therapy, participation in PGAP has been shown to increase successful resumption of occupational activities in individuals with low back pain, individuals with whiplash injuries, and individuals with fibromyalgia. Randomized clinical trials have also supported the effectiveness of the PGAP for work-disabled clients who are suffering from a wide range of debilitating health and mental health conditions. Gains achieved through the PGAP have been maintained even when assessed 12 months following termination of treatment. In 2013, the Official Disability Guidelines published by the Work Loss Data Institute listed the PGAP as an evidence-based intervention for the treatment of work-disability.

PGAP or CBT?

Recently, a number of insurers have asked about the similarities and the differences between the PGAP and cognitive behaviour therapy (CBT). Conceptually, the techniques used in the PGAP would be considered cognitive-behavioural techniques, and as such, the PGAP would be considered a CBT intervention. However, this is an oversimplification. To understand where the PGAP fits in the broader context of CBT interventions, a brief explanation of the nature of CBT is required.

Cognitive-behavioural programs for pain began to appear in the 1980s. The objective of many CBT programs was to equip individuals with the psychological 'tools' necessary to adequately meet challenges of coping with persistent pain. CBT interventions were designed primarily as pain management interventions where symptom control and the reduction of emotional distress were the primary objectives. There is considerable evidence to suggest that cognitive-behavioural interventions can lead to moderate reductions in physical and emotional distress. However, a recent Cochrane systematic review reveals that CBT-based interventions have not been shown to have meaningful impact on objective indices of disability such as return-to-work.

It is important to note that the term cognitive-behavioural does not refer to a specific intervention, but rather, to a class of intervention strategies. The strategies included under the heading of cognitive-behavioural interventions vary widely and may include self-instruction (e.g., motivational self-talk), relaxation or biofeedback, developing coping strategies (e.g., distraction, imagery), increasing assertiveness, minimizing negative or self-defeating thoughts, changing maladaptive beliefs about pain, and goal setting. A client referred for cognitive-behavioural intervention may be exposed to varying selections of these strategies. Given the passive nature of many CBT techniques, it is not surprising that return-to-work would be an unlikely outcome of many CBT interventions.

The PGAP would be considered a CBT intervention with a return-to-work focus. Several CBT techniques such as cognitive re-appraisal and emotional problem-solving, graduated exposure, goal setting and maximizing success and achievement experiences are included in the PGAP.

However, these techniques have been modified such that 'disability reduction' is the central objective of using these techniques rather than 'pain management'. In order to have maximal impact on disability reduction, there are no passive or palliative techniques used within the PGAP.

Given that the PGAP would be considered a CBT intervention, it would be difficult to justify a referral for CBT instead of the PGAP. One of the advantages of the PGAP is that it can be offered by clinicians from a variety of rehabilitation disciplines. Traditionally, CBT has been provided only by clinicians with a background in mental health. The wider range of disciplines able to provide the PGAP greatly increases the accessibility of the program.

The standardization of the PGAP is an additional strength. As noted earlier, CBT interventions are not standardized which can lead to significant cross-clinician variations in the nature of the treatment provided. The PGAP is standardized such that all PGAP providers follow a specific set of intervention guidelines designed to have the greatest impact on reducing the client's psychosocial risk profile. Finally, the evidence base speaks clearly in favour of the PGAP, particularly as it pertains to return-to-work outcomes. In clinical trials of CBT pain management interventions, return-to-work is rarely included as an outcome variable. In all clinical trials of the PGAP, return to work has been the primary outcome variable.

2014 PGAP Workshops

June 20 & 21, 2014
Calgary, Alberta
Registration Forms available now

October 24 & 25, 2014
Toronto, Ontario
Registration opens May 06

PGAP Developments

Please note our Order Forms for PGAP materials have changed. To receive orders in a timely fashion, please ensure you download the new form.

We are also pleased to announce that the Spanish PAIN DVD is now available.

Please check our website:
http://www.pdp-pgap.com/pgap/en/workshops.html

The Implementation of a Central Referral Service for the PGAP

The University Centre for Research on Pain and Disability in collaboration with the Centre for Rehabilitation and Health (CRH) has established a Central Referral Service for PGAP-related clinical services. Our Centres will be working collaboratively to promote PGAP services to insurers and the medical practice community across Canada. Referrals received through the Central Referral Service will be distributed to PGAP providers who are part of the PGAP Provider Network.

The toll free number for the PGAP Central Referral Service is

1-844-297-7427

By establishing a Central Referral Service, our objective is to adopt a quality controlled service delivery model for PGAP services. Some of the features of the Central Referral Service include the following:

- A coordinator with the PGAP Provider Network collects referral information and identifies a PGAP trained provider in the region of residence of the client.
- A supervisor is assigned to each case whose responsibilities include ensuring adherence to PGAP protocol, mentoring the PGAP provider in PGAP-related intervention skills, monitoring case progress, and acting as a liaison between the referral agent and community integration resources (e.g., the employer).
- A coordinator with the PGAP Provider Network assesses the referral agent's satisfaction with treatment services following termination of treatment.

The PGAP Provider Network operates nationwide. Members of the PGAP Provider Network are clinicians who have completed the two-day PGAP training workshop offered by the University Centre for Research on Pain and Disability. There is no cost associated with membership in the PGAP Provider Network but there are a number of conditions of membership. Clinicians who wish to become members of the PGAP Provider Network must be considered in 'good standing' by the official regulatory body for their profession. Clinicians who wish to become members of the PGAP Provider Network must be willing to be supervised by a senior PGAP supervisor. Clinicians who are interested in joining the PGAP Provider Network should contact Anna Ksenych at anna@centreforrehabilitationandhealth.com.

The PGAP Provider Network is distinguished from the PGAP Directory. The PGAP Directory is a listing of the names and contact information of PGAP trained clinicians who have requested to be listed on the University Centre for Research on Pain and Disability website.

Referral agents can access a PGAP trained clinician either through the Central Referral Service or by consulting the PGAP Directory. However, quality controlled services applies only to PGAP services accessed through the PGAP Central Referral Service. For more information about the PGAP Provider Network Service and the different options for accessing a PGAP trained clinician, please contact Heather Barkhouse at heather.barkhouse@pgapworks.com.

Please note the Central Referral Service will initially operate in all provinces except Quebec. We anticipate that Quebec will be included as part of the Central Referral Service by the Autumn 2014.

Please check our website for further information.

http://www.pdp-pgap.com

Centre for Rehabilitation & Health
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