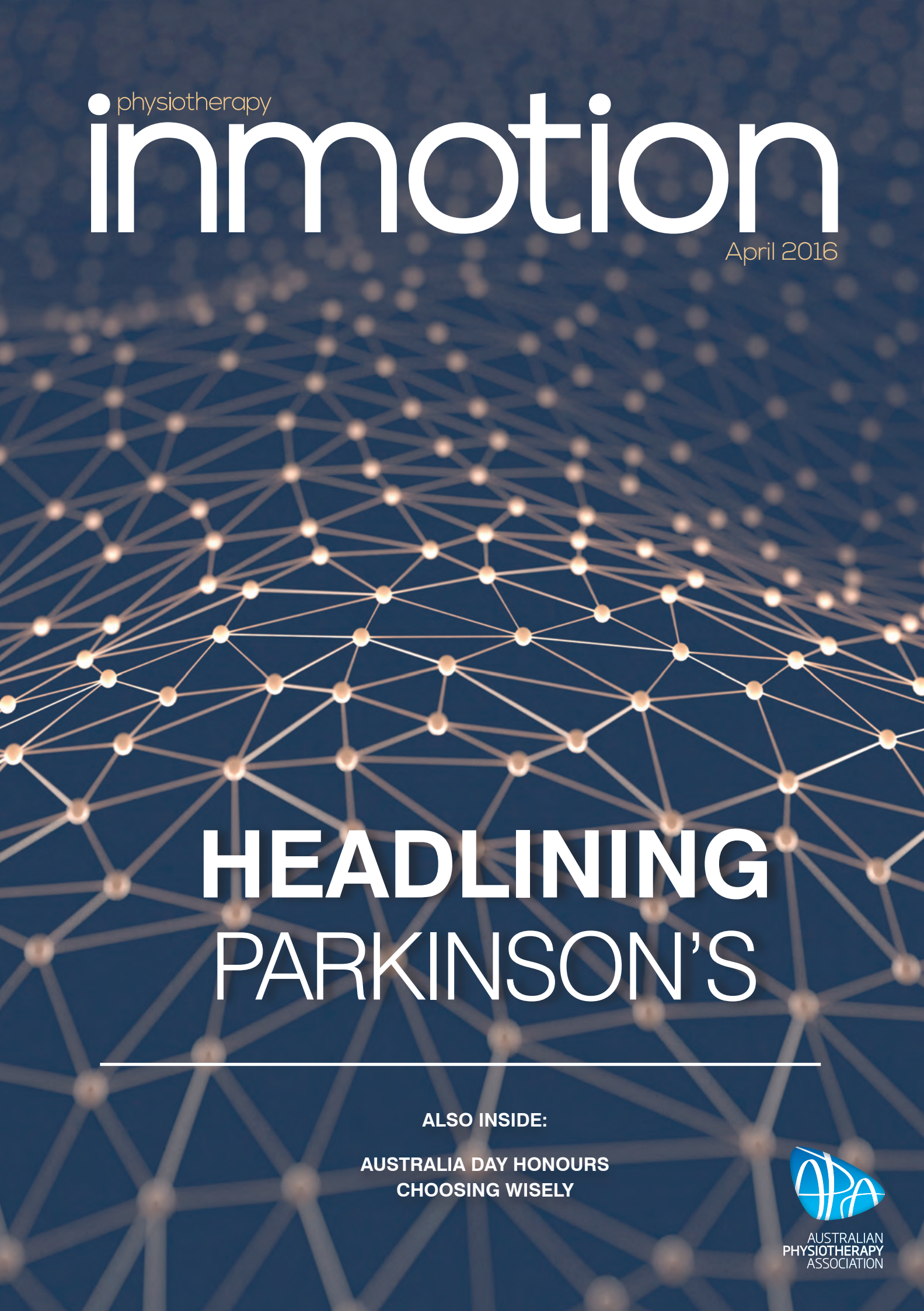
physiotherapy inmotion
April 2016



HEADLINING PARKINSON'S

ALSO INSIDE:

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JOB009

Editor's letter

INSIDE QUOTE:

'As physiotherapists we can have a global impact—we can impact underdeveloped health systems and help bridge the gap for those living in poverty.'

Page 19

Sensationalist headlines: we have all come across them. They tend to scream at us to capture our attention and they typically convey a particular bias that can misinform or alarm. Consider the following headline from earlier this year published in a UK newspaper: 'Millions of pounds wasted providing physiotherapy for Parkinson's, say researchers'.

This headline is the focus of the opening paragraph of our main story on page 42, which introduces a study that found that physiotherapy intervention was not effective in mild to moderate Parkinson's disease.

Captured and intrigued by the headline, and given that World Parkinson's Day falls on 11 April, we explored this further and sought comment from two prominent members in neurological physiotherapy: Professor Sandy Brauer and Specialist Neurological Physiotherapist Melissa McConaghy.

Both raise concerns with aspects of the study and its clinical usefulness. Ultimately they provide a couple of take-home messages: be assured that physiotherapy does have an important role in Parkinson's disease, and be wary of provocative headlines.

Also inside, we highlight four physiotherapists whose work was acknowledged during the Australia Day honours this year: Emeritus Professor Gwendolen Jull, who was made an Officer of the Order of Australia; and Professor Kathryn Refshauge, Nola Cecins and Associate Professor Sue Jenkins, each of whom were awarded the Medal of the Order of Australia. Turn to page 38 to read their respective professional achievements.

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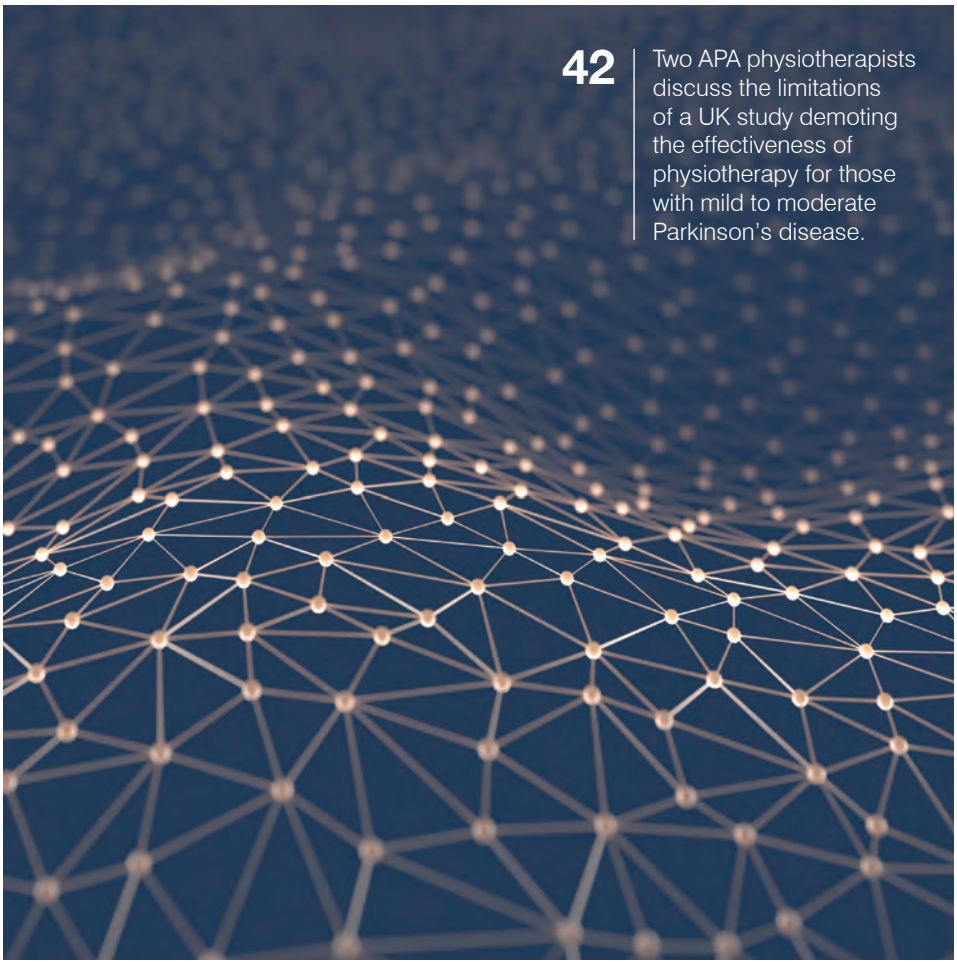

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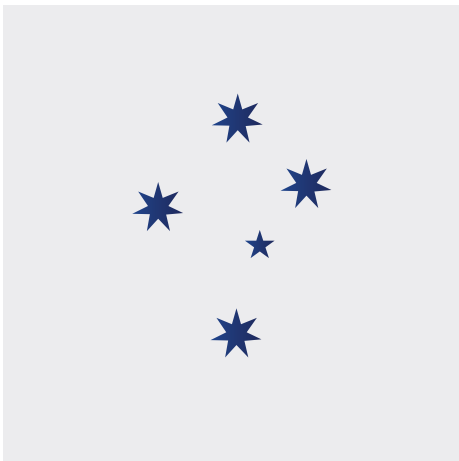

38 *InMotion* celebrates the professional achievements of four physiotherapists who were recently honoured with Australia Day awards.

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Cover illustration by **ktsdesign**/Shutterstock.com

Phil Calvert, APAM,
APA National Vice President

Evidence, experience and expectation

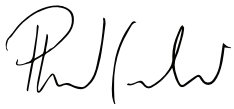
Being a thought leader in the healthcare environment means you have to be bold. It means putting yourself forward in a public way, to influence an outcome or issue. Sometimes as a member organisation this happens with other partners, and sometimes you go it alone. But the intent is to make a public statement about an issue you see as being important to the public and your members.

In proactively embracing the ethos of the Choosing Wisely initiative, the APA has joined a growing number of medical colleges, to support consumers in being actively involved and participating in their healthcare journey. Our role as a participating group is to put forward recommendations to Choosing Wisely around what changes to tests, procedures and care would improve health outcomes.

Member engagement is vital in an initiative like this. To inform our position, the APA formed an expert panel from nominees from the Australian College of Physiotherapy, directors of the Physiotherapy Evidence Database, clinical specialist APA members and academic physiotherapists. We asked our members to provide evidence about interventions related to physiotherapy that should be questioned. We received nearly 2800 responses to our Choosing Wisely survey, with all comments put to the panel to further refine those recommendations.

The recommendations are not prescriptive—we know that every clinical situation is unique. But we hope to start a conversation about what is appropriate and necessary, to build increasing collaboration between physios and their patients, and to continue the process of supporting appropriate consumer expectation.

People often ask me, 'Why see a physio?' The APA's active role in Choosing Wisely shows we care about the evidence that underpins our practice, that we take collaboration with our patients seriously, and that continuing to strengthen the quality of care our patients receive is critical. Our Choosing Wisely involvement has led to significant national news, radio and web coverage. It shows we care about the sustainability of a health system under stress, and will advocate for appropriate care in a very public way. This is why we are thought leaders on a national stage, and this is why consumers should indeed see a physio.



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Guiding social mores

This month, the APA will release its official social media guide. APA CEO **Cris Massis** explains its significance for APA members.

It may be obvious, but what does the APA social media guide hope to achieve?
The guide sets out to give members confidence to conduct themselves within the boundaries of the regulations, providing some clarity around what they should and shouldn't do, as well as how they can build and market their business and connect with the profession on local and global scales.

Our guide provides a roadmap for members who have never had a presence in the social media space and are unsure of where to start. It will lead to a more comprehensive course we will be delivering in partnership with APA members Mark Merolli and Karen Finnan, both of whom have vast professional expertise in this digital space and helped develop the APA guide.

All in all, we aim to dispel the apprehension that many APA members might have regarding social media use.

So why are some physios apprehensive about social media?
Generally I think we are still a conservative profession; physiotherapists are evidence-based and work in a regulated environment, so, naturally, the profession is a bit risk-adverse. As a consequence, when it comes to marketing their services, many physiotherapists are wary of the regulatory boundaries, as well as the sheer number of forms of social media now available.

In an effort to avoid misinterpreting the regulatory boundaries, including AHPRA's advertising guidelines and code of conduct, many physiotherapists are missing out on the benefits of social media, by staying off altogether.

What are the benefits of using social media, exactly?
Social media provides opportunities for physiotherapists to grow their business, build their professional profile as experts, and stay connected with the Australian and global physiotherapy communities.

Understanding what platforms suit your needs is pivotal. For example, on Facebook we are seeing a growth in the number of groups offering users a space to share tricky patient case studies and work collaboratively to find solutions. Twitter, on the other hand, is a great medium to aggregate news and access some of the leading thinkers in physiotherapy, health and policy, while LinkedIn is the primary destination for recruiters and journalists to connect with possible candidates and media spokespeople.

And in the last few years we have seen an explosion of one-to-one and video- and image-sharing platforms, like Snapchat, Periscope, Whatsapp and Instagram. These channels are stealing audiences away from the more traditional social media platforms, offering new avenues for APA members to engage with consumers. It has never been more important for physiotherapists to understand each platform's unique set of benefits and target audience.

I think our profession has a role to play by being at the leading edge of using these technologies and creating opportunities for the purpose of health and wellbeing for the Australian community. Not only that, social media has the ability to go internationally.

What does 'go internationally' mean for members and the profession?
There are more than a billion people in China, India and Indonesia in our Asia Western Pacific region, offering amazing opportunities for Australian physiotherapists to engage. Those markets have incredible internet and mobile data penetration, so that's a lot of eyes potentially seeing your messages and viewing your skills.

Online channels give us the opportunity to be the physiotherapist next door, and, collectively, the high-profile international leader that we strive to become in our strategic plan.

The current WCPT President, Emma Stokes, is a strong advocate for social media activity and its ability to establish a vibrant, global community where clinicians, researchers and academics can connect and collaborate. Such a critical mass would allow us to do some great things. That's the power of social media.

To read the APA's social media guide, go to physiotherapy.asn.au/SocialMediaGuide.

Darwin 2016

The landing page for this year's APA Business & Leadership Conference *DARWIN 2016* was recently launched.

Members can now go to physiotherapydarwin2016.asn.au to keep abreast of all news relating to the event in the lead-up to the opening session on Saturday 27 August.

Taking place over three days, the event will encompass a dynamic program exploring the theme of 'Driving innovation', and will include a range of engaging keynote speakers, invited speakers and abstract submissions.

With the event to be held in Darwin, all APA members are encouraged to register now and begin their preparations to make the trek up north.

Additionally, the call for submissions is currently open, with APA members invited to submit abstracts in order to present. This is an excellent opportunity to share your ideas, initiative, achievement, or research, while encouraging innovation and professional development collaboratively among the physiotherapy profession.

The APA, as well as the Conference Program Committee, is keen for members and non-members to be a part of the program as abstract presenters. By presenting to your peers, you are contributing to the profession, establishing your expertise in your field, and increasing your visibility and credibility.

To submit an abstract, go to physiotherapydarwin2016.asn.au.

Blue valentine

APA CEO Cris Massis joins fellow Bluearth founding partners in breaking up with their chairs.

Earlier this year, the APA announced a new partnership with Bluearth Foundation, a national non-for-profit organisation aiming to improve health and quality of life by getting Australians to move more and sit less.

With recent studies showing that the average office worker sits for more than 80 000 hours over their lifetime, the dangers of a sedentary lifestyle have never been more salient to discuss. In fact, sitting has often been described as 'the new smoking'.

As physiotherapists, APA members are well aware of these risks, and should take a leadership role in advocating for better body health. With this in mind, the APA recently participated in a Bluearth campaign urging Australian office works 'to break up with their chair for Valentine's day'.

To learn more about how you can encourage your patients to add more movement to their day, as well as current research investigating the risks of a sedentary lifestyle, go to movemoresitless.org.au.

Member showcase: iWrap

With no convenient or practical method to provide effective ice therapy and compression, APA members Hesham Azer and Dario Cusinato developed the concept of the iWrap in 2014.

Released the following year, the product of their ingenuity is a uniquely designed ice pack wrap that uses Velcro and an elasticised support to allow users to position and hold a gel ice pack in place while providing efficient compression. This is vital for soft tissue injuries as it helps to reduce pain, swelling and promote healing.

'It's been tried and tested on our patients and by other physiotherapists and all the feedback has been overwhelmingly positive.' Hesham says. 'It can be used in a different settings from the sporting field to post surgery.'

'It can be applied to any injured part, whether that's the ankle, knee, thigh, shoulder … lots of products on the market are only specific to one joint or one area, whereas this covers everything … it's a one-size-fits-all icepack.' Hesham says.

The physiotherapists' inventive nous saw them shortlisted for a Bank of Melbourne grant last year. The Small Business Grant Program searches for businesses which have viable commercial models and are finding innovative solutions to problems.

Unfortunately, the iWrap wasn't selected as a business grant-winner, but Hesham maintains his appreciation for the product's recognition.

'By making it as a finalist, a newspaper got hold of the story and ran with it so we got some publicity, which was great,' he says.

For more information, go to iwraphealthcare.com.au.

Physiotherapy Research Foundation

PRF vacancy

A vacancy has arisen on the Grant Review Committee (GRC) of the Physiotherapy Research Foundation (PRF). The primary role of the GRC is to review applications for clinical research grants submitted to the PRF, and to make recommendations on grant allocations for the consideration of the directors of the PRF corporate trustee. Members of the GRC are appointed by the Directors of the PRF corporate trustee.

For further information on this opportunity, email Jenine Fleming, PRF Bequest and Administration Officer: jenine.fleming@physiotherapy.asn.au.

Strengthen and enhance

The World Health Organization (WHO) predicts that diabetes will be the 7th leading cause of human death by 2030.

In light of such forecasts relating to the chronic disease's rapid rise, particularly in low- and middle-income countries, the WHO has decided to use World Health Day 2016 as a vehicle to spread the word about the diabetes epidemic.

Under a theme of 'scale up prevention, strengthen care, and enhance surveillance', this year's campaign, which takes place on 6 April, hopes to achieve three primary objectives: increase awareness about the rise in diabetes, in particular in low-and-middle-income countries; trigger a set of specific, effective and affordable actions to tackle the disease; and launch the first global report on diabetes.

For more information on the campaign, as well as to access a number of clinical factsheets, go to tinyurl.com/he6o5vc

Product partners

Below, two APA-endorsed product partners outline their consumer products.

With the majority of new parents purchasing a baby carrier for hands-free convenience, it is important physiotherapists are aware of what constitutes a quality carrier.

The organic manduca® baby carrier, designed in Germany, became an endorsed product of the APA in 2014.

The manduca carrier is comfortable for both wearer and baby, and features padded shoulder straps and a wide waist belt, which works to distribute the baby's weight while sitting in the orthopaedically-recommended 'M' spread/squat position, with their bottom lower than their knees.

Babies and toddlers from 3.5 to 20 kg can be seated comfortably in the carrier and very young or small babies (3–5 months) sit higher in an integrated newborn seat.

Distributor Fertile Mind is a trained partner with the Carrying Consultancy Network in Germany and can offer training for physiotherapy practices that stock manduca.

Manduca is sold at Baby Bunting, Babies R Us and selected baby stores listed at manduca.com.au. To become a stockist, contact Christine Kininmonth on christine@fertilemind.com.au.

Manduca Australia is a member of the Baby Carrier Industry Alliance, dedicated to promoting safe babywearing.

Source: Manduca

BakPhysio is committed to designing simple and effective self-treatment solutions for back pain and their product Bakballs is one such example.

Designed to match the anatomy of the spine, BakBalls provide direct therapeutic force and localised pressure onto the most commonly painful areas of the back. Ideal for thoracic stiffness/kyphosis, the self-treatment device can be used to help physiotherapy patients maintain the benefits of thoracic and lumbar mobilisations and keep their backs in a healthy condition in between conventional treatment sessions.

Managing Director of BakPhysio Mark Alexander, a former sports physiotherapist involved with the Australian Olympic Team and a former coordinator of the Latrobe University Master of Sports Physiotherapy degree, designed the device in 2003 and the product was endorsed by the APA in 2005.

BakBalls relieve back pain and stiffness by applying localised pressure directly onto painful stiff joints and tight muscles, replicating physiotherapy or massage treatments. They can be used in adjunct to back pain treatment and enable a patient to maintain treatment benefits for longer at home.

As well as alleviating pain in the back, BakBalls can also be used to relieve tightness and pain in areas such as the iliotibial band, piriformis, hip flexor, neck, shoulder, calf, hamstring and groin.

APA members can receive a wholesale discount for bulk orders and patients can order BakBalls directly from bakballs.com. For more information, contact 03 9502 0078 or mark.alexander@bakballs.com.

Source: BakPhysio

Letters to the Editor

Business knowledge is for all physios

With the demise of the *Business in Practice* publication as part of the APA review, I am very pleased to see business articles appearing in *InMotion*. Business knowledge is obviously important for those owning a private practice, but it is also valuable for any member working with teams, budgets, service options, payers and employers.

The article by Mark Alexander ('Strategic thinking', February *InMotion*, p 28) is an excellent overview of strategic positioning and recognition of where your patients may choose to spend their disposable income (aka competitors). He mentioned the '4 Ps marketing strategy', which, unsurprisingly, in view of his entrepreneurial product development, cites those relating to marketing tangible products: price, product, promotion and place.

More recent literature looking at services has added three more Ps to the mix: people, processes and physical evidence. The first is your team and its skills; the second relates to efficient, client-focused systems; and the third is the look and feel of your business as experienced by the client (think uniforms, cleanliness, layout, decor, etc).

James Schomburgk ('Growing your practice', February InMotion, p 30) alludes to these service characteristics in his article on the Net Promoter Score (NPS), which is a useful quantitative measure of how likely your clients are to recommend your business. However, the NPS does not offer any information as to why you are, or are not, being recommended. It is a superficial scan to identify a need for improvement but doesn't tell you in what area(s). I salute his improvement in the NPS; all physio clinics should consider a score of 80 to be the minimum given the close relationship with our clients.

Under the headline 'Growing your practice', Schomburgk states that 'clinical excellence leads to great client outcomes'. No argument from me; however, this alone may not grow your practice in terms of business outcomes. Cash flow and profitability allow re-investment in the business and those that work in it, so pricing strategy, cost management, efficient systems, strategic hiring and training must be aligned with the clinical excellence standards and consistently applied.

I look forward to reading further contributions on the business and leadership elements of successful physiotherapy practice, whether it is in the private, public or community arenas, where the challenges of managing resources, time and people in the delivery of quality care have more similarities than differences.

Craig Allingham, APAM
Director, Practitioner Business Academy

Balance and integration needed

I applaud the article by Sam Abbaszadah and the APA for publishing it ('A balancing act', February InMotion, p 14). It's a genuine concern: many of my clients have stated that I'm the first of the numerous physios they have seen who has applied hands-on techniques. Given the manual roots from which the profession has grown, I find that astounding.

Often, hands-off approaches do help where traditional manual therapies fail, particularly where chronic pain exists. Perhaps this failure relates more to how we are utilising the techniques—focusing on just treating where it hurts, addressing just the musculoskeletal system and applying techniques in a manner that attempts to force change upon the body.

Like Sam, I suggest therapists seek balance between the two styles of treatment. I also encourage physios to explore the emerging holistic and integrative manual therapy approaches which attempt to redress limitations in the traditional approach. After all, if we choose to ignore the very skills that helped establish physiotherapy, that niche may be gladly filled by other professions.

Haydn Gambling, APAM

New to *InMotion*
InMotion is now available to members as a downloadable PDF. To view the magazine online, as well as download the PDF, go to **physiotherapy.asn.au/inmotion**.

Questions over PD changes

I am writing to you in response to the new APA directive that 'courses in direct competition to APA's PD offer will no longer be advertised in *InMotion* or other APA communications,' as stated in a letter from the APA in November 2015.

The implication is that those courses that do not appear in *InMotion* yet are advertised on other platforms are not sanctioned by the APA for their PD. This goes to the very heart of our obligations regarding registration with AHPRA and maintaining a program of PD. As a provider of external PD courses, and as a member, I am disturbed by these developments and wonder if other APA members have considered the implications of this new directive from the APA.

I commend the APA initiatives regarding the career pathways since the titled/specialisation programs were not always meeting members' demands. However, I feel that the current directive will narrow members' choices and is restrictive in its approach. Also remember, as with the titled programs or the specialisation pathway this is not something that all members are seeking to achieve yet all members should have the same right to maintain a CPD program.

Let me use the example of the sacroiliac joint (SIJ)-pelvis, since this is the area in which the APA finds that I am in competition with their course. Since accreditation is no longer an option, how can the APA judge whether its course, my course or someone else's course is most appropriate for APA members? With more than 20 years of experience and having worked closely with eminent physiotherapists in the field, I can tell you that the area of SIJ-pelvic dysfunction or low back pain cannot be encapsulated in a single course; I dare say this applies to all areas of physiotherapy.

The point is that this is actually about CPD over the professional lifetime of a physiotherapist and not simply about ticking off a certain designated course topic. How will the APA ensure the continued PD of members if it now restricts available courses? Or is the APA saying that a single course for a specified area/topic is sufficient to meet your AHPRA obligations? Is this not disingenuous of the APA?

How will the APA ensure diversity in learning and the opportunity for exposure to different methods or approaches? By setting up a cookie-cutter approach to PD, new learning and clinical practice will stagnate. In Australia, we are fortunate that we have the expertise covering a wide range of topics and yet the APA wants to limit this. Without knowing the full extent of the career pathways and the form it will take, what confidence do members have that the APA is looking after their best interests?

Finally, if only a certain number of courses are the designated APA courses, how will the APA ensure that all members, including new graduates, have access to these courses? Will the APA ensure that courses are run repeatedly both in metropolitan as well as regional centres, or will it result in a massive waiting list and a lack of access to PD?

Taso Lambridis, APAM

Reply

The APA Career Pathways is a framework of quality-assured coursework, mentoring and research with clearly defined optional assessment points. Our clinical groups own this pathway and they have clearly directed that they would like an improved competency-based framework that has relevance and rewards in public and private settings, government and by insurers.

This framework joins the university, the APA and commercial professional development companies to share standards, competencies and learning outcomes at each step of a physiotherapist's career. By doing this, physiotherapists have greater choice on where, when and how they would like to access their learning. Physiotherapists should be able to undertake a coursework master's, or join university modules and APA coursework together towards titling and create their own pathway.

A necessary foundation for consistent educational design of CPD activities is a professional competency standard that describes practice competence at key points along the career/educational pathway. The pathway needs to be accredited by the Australian Physiotherapy Council (APC) as the profession's accreditor.

The APA would like all quality-assured providers of education to

participate in the framework and that's why we have asked all commercial PD providers to discuss a partnership with a standard competency framework and quality assurance.

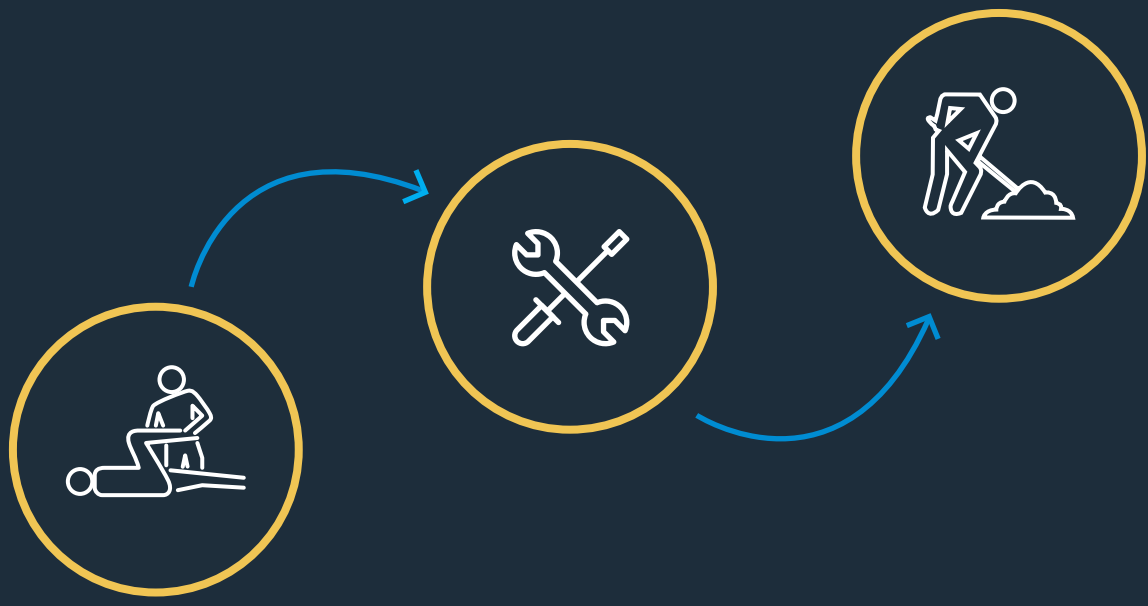
The APA will invest significant funds into mapping out the career pathways—it's our role for the profession. Our 200 committees will contribute enormous effort at shaping the framework. Although the organisation offers a range of PD now, the Career Pathway is not about the APA being commercial. Our delivery in training will be assessed on the very same accreditation standards set by the APC.

The APA chose to start the conversation through our advertising policies. Our first discussions were with commercial providers with no accreditation and duplicate content. Further conversations will include all commercial PD providers. The critical message is all universities, commercial PD providers and APA current course presenters are invited to participate in the framework as long as they meet the quality-assurance partnership model.

With a robust framework will come better learning opportunities, more choice, clearer recognition and, hopefully financial reward in funding and pay scales.

Over the coming months, the APA will provide members with ongoing information on the progress of the new framework. Our clinical committees are excited about this initiative and we look forward to sharing the journey with you.

James Fitzpatrick
General Manager, Professional Development and Member Groups



Back to work

Darren Beales, FACP, and **Tim Mitchell**, FACP, contemplate the current challenges healthcare practitioners face when managing injured workers with complex presentations.

Are you aware of the 'clinical framework' for the management of injured workers?

If you answered no to this question, you are not alone. We posed this question at a multidisciplinary symposium focused on the management of injured workers with complex musculoskeletal disorders in Perth last year. Of the 161 respondents, 43 per cent were not familiar with the framework. A further 32 per cent reported being somewhat familiar with it.

The Clinical Framework For the Delivery of Health Services was released in 2012 by TAC and WorkSafe Victoria. The clinical framework has been endorsed by over 20 statutory bodies and professional organisations, including the APA. It outlines five principles aimed to facilitate optimal recovery and return-to-work outcomes for injured workers. These principles encourage physiotherapists to:

- measure and demonstrate the effectiveness of treatment
- adopt a biopsychosocial approach
- empower the injured person to manage their injury
- implement goals focused on optimising function, participation and return to work
- base treatment on best available research evidence.

In line with these principles, we also asked participants about the use of formal screening tools for risk assessment during their initial interaction with injured workers. While screening injured workers for risk is supported by evidence-based practice guidelines, 47 per cent of participants reported they never perform formal risk assessment. It would be interesting to know if these patterns differ across Australian jurisdictions, where participants in workers compensation systems do operate in somewhat different environments.

A worker with dominant non-mechanical pain features should push through pain to increase their work capacity. Agree or disagree?

There is good evidence that early return to work for injured workers begets better outcomes. We were interested in how this concept is applied with injured workers with dominant non-mechanical pain features. Take the following scenario.

An injured worker has non-specific spinal pain (no significant MRI findings) with dominantly non-mechanical pain features. They present with increased pain sensitivity; allodynia with light touch, hyperalgesia with sharp and cold, pain flare-up with light physical activity, and minimal effective strategies for pain relief.

What was your response? Thirty-seven per cent of the participants disagreed with this statement, while 45 per cent agreed and 18 per cent weren't sure. Current pain science research suggests that pushing through pain in these circumstances may result in a worse, rather than better, outcome. Taken at face value, this survey result identifies a potential problem in the management of workers with this type of presentation. Injured workers can be subject to very conflicting opinions in their journey to build work capacity. This can result in significant confusion, potential conflict, and add to stress.

This worker will need formal psychological management to help get over their pain

There is a school of thought that physiotherapists currently focus too much on psychological factors in their management of injured workers. This is supported by the 76 per cent of respondents in our survey who agreed that the worker would need formal psychological management—despite there being no mention of negative psychological factors within the case study. While increased psychological distress (particularly depression) is a strong predictor of increased pain and disability, not every person with a persistent pain problem will have psychological distress at a level that will require formal psychological management. This further supports the utility of screening tools for health practitioners to identify psychological distress that requires targeted management. However, this does not mean that physiotherapists don't need to be skilled on managing the different psychosocial factors that strongly contribute to persistent pain disorders—this is another conversation for another time.

Recommendations

Evidence suggests that most injured workers make a good recovery in reasonable timeframes. The real challenge for the system, as well as healthcare practitioners, is in managing those that don't. We believe physiotherapy can and does make a significant positive contribution to the management of complex musculoskeletal work injuries, but there is room for improvement.

Below are three potential pathways that may be useful in this endeavor.

(1) Further promotion of the clinical framework is needed at undergraduate level

We acknowledge 'curriculum pressure' in undergraduate training; however, with the majority of new graduate physiotherapists being employed in the private sector, there is a need for knowledge for the management of injured workers, within and outside of workers' compensation claims.

(2) Lift our game in the use of screening tools

Screening tools are easy to administer, and rapid to score. There is mixed evidence on how clinicians perform in comparison to screening tools. We recommend use of screening tools as an adjunct to sound clinical reasoning. Also, in an area where there is a barrier to communication produced by varied use of terminology and jargon, a screening tool like the Orebro Musculoskeletal Pain Screening Questionnaire may offer a basis for shared understanding between practitioners.

(3) Physiotherapists need to embrace intra-professional referral in workers compensation

The use of screening tools can assist clinicians in understanding barriers to recovery in injured workers, and facilitate referral. Physiotherapists have historically embraced inter-professional referral in a responsible manner. We think more can be done in the area of intra-professional referral of injured workers. If you identify a more complex issue but don't know how to manage it, consider referring your patient to a physiotherapy colleague with expertise in that area—patients love it. The APA has a career structure in place that is highly suitable for guiding intra-professional referral.

Resources for practitioners

- The Clinical Framework For the Delivery of Health Services is available from the Transport Accident Commission of Victoria website: tac.vic.gov.au
- For access to the full report 'Knowledge and Use of the Clinical Framework For the Delivery of Health Services in Western Australia: Summary report of a survey of Workers Compensation stakeholders', visit the Pain Options website: painoptions.com.au/resources.html. Alternatively, go to the Curtin University e-space. This project was supported by funding from WorkCover WA
- Google 'Orebro screening tool' for links to copies of the most widely-used screening tool for injured workers. Shorter 10-item and 12-item versions are also available
- Available on the APA Research Portal, read this thought-provoking article on pacing: Nielson WR, Jensen MP, Karsdorp PA, Vlaeyen JW. Activity pacing in chronic pain: concepts, evidence, and future directions. Clin J Pain. 2013;29(5):461–8

Dr Darren Beales is a Specialist Musculoskeletal Physiotherapist (as awarded by the Australian College of Physiotherapists in 2008). His current interests centre on improving the understanding of the biopsychosocial nature of pain disorders from a lifespan perspective.

Dr Tim Mitchell is a Specialist Musculoskeletal Physiotherapist (as awarded by the Australian College of Physiotherapists in 2007). He has completed a PhD in the area of low back pain and has a special interest in the management of complex and chronic injuries and pain disorders.

Helping hands

Almost 10 million Filipinos are living with disability, according to United Nations statistics. Here, **Carlos Bello**, APAM, speaks to Kelli Hooks about an organisation striving to provide rehabilitation services in the Philippines to those who need it most.

While volunteering in his country of birth, Carlos observed the low, and sometimes non-existent, access to healthcare that Filipinos living in poverty have. Subsequently, in 2014, he launched Big Hands Australia, a not-for-profit organisation delivering rehabilitation services to impoverished communities.

'I spent a lot of time volunteering in the Philippines and I realised there were vast numbers of poor and disabled people … people who were congenitally disabled with cerebral palsy or people who had acquired a disability, through stroke or traumatic brain injury,' Carlos recalls.

'A poor person who has a disability has no access to their rehabilitation needs, is often severely effected in their productivity and income generation and within their family and community roles, and, as a result, can be swung into further poverty and burden their family.'

Furthermore, Carlos noted that the existing model of healthcare in the Philippines was mostly undertaken in large and under-resourced urban tertiary hospitals and was insufficient in meeting the needs of the community.

'There are hospitals that only have enough medication to get through half the day,' he says.

Aiming to combat this, the Australian-based organisation's innovative model of healthcare delivery comprises a combination of rehabilitative medical missions (undertaken bi-annually) in disadvantaged Filipino communities and telemedicine consultations (to provide healthcare information and services in remote locations).

Big Hands provides a range of rehabilitative services, including speech therapy and occupational therapy, alongside physiotherapy and has treated thousands of Filipinos since its inception.

'Within the last two years we have treated about 2000 poor people in the Philippines and we see about 50 patients in poor communities via telemedicine on an ongoing basis,' Carlos says.

And in an effort to further their reach, the organisation has undertaken a project aimed at effecting change at a local level by providing training to community healthcare workers and mentoring to local health professionals and therapists.

'We have health workers that we will train who will in turn train the Barangay health workers [community health workers] and that will multiply our effect,' he says. 'Currently, the Barangay have five days of formal health education and are sent off into communities, so their role has previously been really limited.'

However, the initiative is not without its challenges. Carlos notes that some of the biggest barriers to implementing adequate rehabilitative care in these communities can arise from conflicts of interest with ingrained cultural beliefs around health and rehabilitation.

'We need to promote better behaviours in people who have disabilities because there is a misconception in the Philippines that you are just supposed to wait and rest to get better. There's no such thing as an active rehabilitation,' Carlos says.

Traditional medicine practices, through healers known as Hilots, are also common in many Filipino communities and Carlos expresses

concern that such practices can, on occasion, be unsuitable. 'I've had patients who have had an acute stroke and are seeing a healer for massages; it's not appropriate,' he says. 'There is a role for traditional medicine but there is also a lack of education about where the scope of practice is for that.'

A further challenge lies in the perception of physiotherapy as a non-essential component of healthcare in the Philippines. Carlos is adamant about the importance of advocating for the prominent position physiotherapists can play in supporting disadvantaged communities.

'In the Philippines, physiotherapy is very underdeveloped as a profession. We are starting to look at some research so that we can promote physiotherapy over there,' he says

'At the moment, other health professionals such as midwives are seen as an essential … we want to put forward the idea that physiotherapists are an essential too. We want to research the impact of having physiotherapists lead a community.'

Looking ahead, Carlos is optimistic that Big Hands will expand its reach and positively impact the provision of healthcare in other developing countries.

'The vision of Big Hands Australia is universal healthcare and health literacy. We aim to affect the healthcare system and to be scalable to reach all over South East Asia and beyond,' he says.

'As Australian physiotherapists we can have a global impact—we can impact underdeveloped health systems and help to bridge the gap for those living in poverty.'

To learn more about Big Hands Australia, go to bighands.org.au or facebook.com/bighandsproject or email: bello.jc@gmail.com.

Research from the latest issue

Scientific Editor Associate Professor **Mark Elkins**, APAM, provides a content overview.

The April issue of *Journal of Physiotherapy* contains research with important implications for physiotherapists in a range of areas of clinical practice.

Dr Catherine Granger, APAM, presents an Invited Topical Review of physiotherapy management of people with lung cancer. The series of Invited Topical Reviews has been hugely popular—consistently among the journal's most downloaded papers—and this latest contribution is no exception. The review paper summarises extensive amounts of evidence into key recommendations. Key among these is the recommendation for exercise-based rehabilitation after surgery or curative treatment. For those undergoing surgery, this should be supplemented by pre-habilitation and post-operative shoulder and thoracic cage exercises.

Any Dennett and colleagues from Melbourne supplement this review with their new findings about the most appropriate intensity for exercise training in people with cancer. Their meta-regression of over 30 studies indicates that moderate intensity exercise has the best effects on fatigue and walking endurance.

At the other end of the spectrum are two sports physiotherapy papers. Guilherme Nunes and colleagues from Brazil present evidence that even in the most extreme endurance events, such as the 226 km Ironman, physiotherapists can reduce pain and fatigue among the competitors with post-event massage.

Stephanie Filbay and colleagues from Melbourne report that impairment of quality of life can persist for decades after anterior cruciate ligament reconstruction. More importantly, they identify that people who find a way of returning to some form of exercise report better quality of life than those who do not exercise. This highlights that physiotherapists don't just have an important role in ensuring that such patients achieve their best rehabilitation outcomes at the knee. Physiotherapists should also advise patients of the likelihood of re-injury with return to competitive sport, discuss the likely implications of not finding a way to return to some form of exercise, and help guide patients to identify a suitable form of exercise based on their clinical status after rehabilitation.

Anderson Jose and colleagues from Brazil compare inpatient exercise rehabilitation against respiratory interventions for people hospitalised for community-acquired pneumonia. This trial identifies superior effects on functional capacity, peripheral muscle strength and quality of life with inpatient exercise rehabilitation.

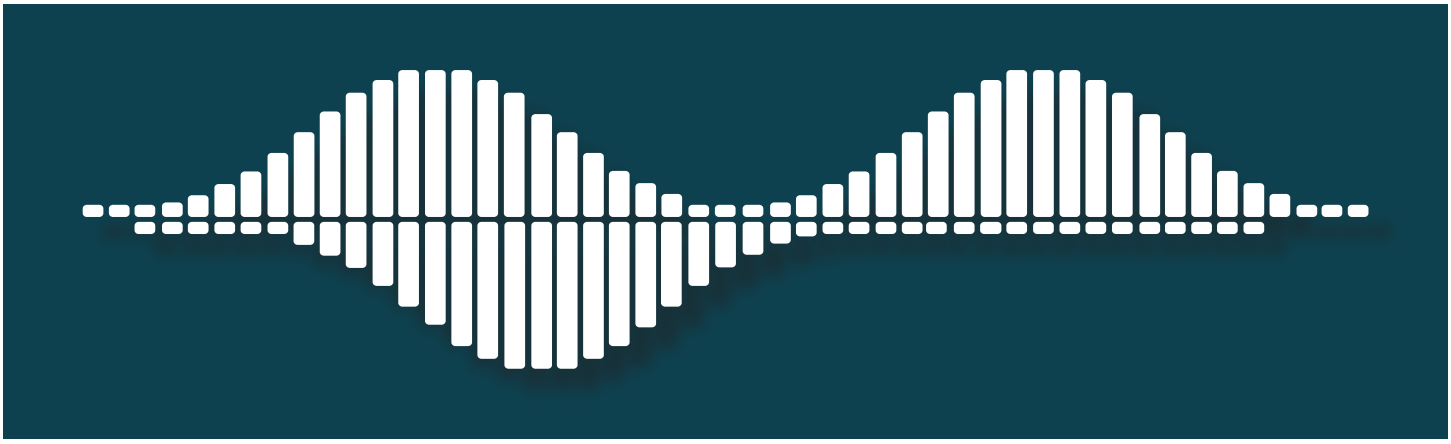
Professors Lisa Harvey and Mary Galea also report their large trial of hand rehabilitation with or without functional electrical stimulation in people with sub-acute spinal cord injury. Their findings contradict those of the smaller and lower quality trials of this intervention, so this paper also generates important clinical implications.

The issue also contains editorial and appraisal content, as well as the announcement of the journal's Paper of the Year for 2015: Corbetta D, Imeri F, Gatti R. Rehabilitation that incorporates virtual reality is more effective than standard rehabilitation for improving walking speed, balance and mobility after stroke: a systematic review. *Journal of Physiotherapy* 2015; 61: 117–124.

For unrestricted access to current and past Journal of Physiotherapy content, go to journalofphysiotherapy.com.

Points of discussion

With the APA recently launching its official podcast channel, a number of recordings related to work published in the *Journal of Physiotherapy* will soon be available to APA members.



Weight-training and lymphoedema

Each year, the *Journal of Physiotherapy's* International Advisory Board singles out a paper published in the last calendar year that best encompasses the intersection between scientific merit and clinical development.

Following a tied vote, the 2014 Paper of the Year award was awarded to two papers: 'Treadmill training provides a greater benefit to the subgroup of community-dwelling people after stroke who walk faster than 0.4 m/s: a randomised trial'; and 'Weight training is not harmful for women with breast cancer-related lymphoedema: a systematic review'.

Lead researcher of the second paper, Dr Vincent Paramanandam was present during last year's APA National Conference *CONNECT 2015* to accept his award, allowing him the opportunity to join Associate Professor Mark Elkins for a discussion relating to his research.

During the subsequent podcast, Vincent reveals how his frustration with existing clinical guidelines led him on his research journey, and asserts how his work should alter clinical practice.

AVERT trial

Australia's leading stroke rehabilitation trialist, Associate Professor Julie Bernhardt, recently completed the largest, international trial of early mobility-based rehabilitation ever conducted—the AVERT trial.

Featuring more thant 2000 patients from five different countries, the trial offered a unique perspective into both the burden of stroke-related disability as well as the rehabilitation interventions considered to encompass best practice.

In this podcast, Julie is joined by Mark Elkins to discuss the trajectory of the project.

'The surprising result from the trial was that early intervention resulted in less favourable outcomes for patients at three months after stroke,' she explains. 'That is a really important finding because it's telling us that having this frequent, early, "more is better" approach really doesn't apply in this early time period after stoke.'

The podcast finishes with Julie considering the magnitude of the AVERT trial and contemplating the other pieces of research that may emanate from its results.

'There are a lot of things that will be really interesting to look at further down the track. We will certainly be looking at inter-regional differences … people who have a stroke in Asia are different to people who have a stroke in Australia.

'We also have a health economic evaluation… so there is an enormous scope to talk about how care is different in these different countries, and even different sites.'

Changing view

While the benefits of exercise for pregnant women are well publicised, perhaps the advantages of water-based movement are less renowned.

According to APA member Amanda Brearley, and her observational study published in the *Journal of Physiotherapy* last year, the buoyancy properties of water herald unique benefits for pre- and post-natal women.

Despite such benefits, there has been much discussion around the safety of aqua-aerobics for this population, with a number of medical guidelines warning that overheating during exercise may harm the foetus.

In an effort to clear up this uncertainty, Amanda's research investigated body temperature response during exercise and pregnancy in water. In her study, Amanda and colleagues from the University of Melbourne measured the body temperature changes in pregnant women before, during and after an aqua-aerobics class, which involved moderate-intensity exercise in water at temperatures currently maintained in community pools.

Again facilitated by Mark Elkins, this podcast sees Amanda elaborate on the nature of her research, including how its results can inform current guidelines.

To access these podcasts, go to soundcloud.com/aus-physio-assoc.

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PD profile

Co-presenter **Lester Jones,** APAM, speaks to *InMotion* about the assessment and management of pain in clinical practice course.

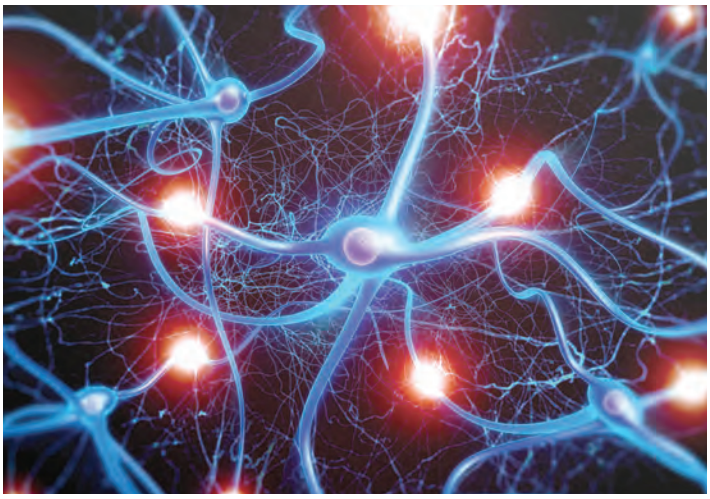

Photo: ©iStock.com/Henrik5000

Can you provide a brief overview of the course?
The course begins with a solid introduction to pain science; we bring in some of the new ideas about the role of the immune system integrating with the nervous system. We then look at some pain classification systems that people are using around the world and examine the Pain and Movement Reasoning Model, a tool that we will use throughout the two days. We look at the assessment of pain, including the assessment of the moderators and mediators that modulate pain, and the management of pain, where we briefly examine some of the medications that are used. We also include a psychologically-informed approach as to how we might put some of the key strategies for treating people with pain into practice.
Pain is more complicated than simply being the result of pathology and we will present the multiple factors known to influence pain whether acute or chronic.

What is some of the recent research underpinning new ideas in pain science that will be introduced in the course?
There's some pretty impressive evidence, particularly coming from people like Professor Mark Hutchinson in Adelaide, showing that the immune system has a memory or a response to previous episodes of danger and will consequently react in a more enhanced or primed way. Significant stressors across a person's life, and, particularly, relating to early childhood experiences, have been shown to prime the immune system in a way that can lead to a sensitive nervous system. When anyone presents with a pain problem, these things are probably already involved.

Given the complexity of the human pain experience, what have been some of the challenges physiotherapists have typically faced in their approach to pain presentations?
One of the key things is taking note of the pain science that's been uncovered in the last 10 years or so. I think the challenge for physiotherapists is to try and capture the complexity in their clinical practice so that they're not taking an unsophisticated approach to pain, which has traditionally been a more biomedical, pathoanatomical approach, and recognising that there are a whole range of factors that impact on pain.

What are some of the key assessment and management strategies that physiotherapists will learn during the course?
We will present a range of pain-specific strategies, including measures that indicate changes in the central nervous system might be contributing to the person's pain and the use of measures that capture the person's thinking and behaviour related to pain. Assessment strategies in a biopsychosocial framework are presented, utilising clinical reasoning strategies. This includes the assessment of patient perspectives and building trust with clients.

It is important to help people understand that different pain mechanisms can be predominate across the acute and chronic presentation spectrum. We will be undertaking some practical work to try and give people skills in the newer ideas around pain assessment, such as two-point discrimination, which is drawn from the neurological field. Two-point discrimination involves the ability for a person to distinguish between two points that are moved further apart. There's been some research to support that that could be a useful tool in pain assessment.

Two common measures that are used are the Pain Self Efficacy Questionnaire (PSEQ) and the Pain Catastrophising Scale (PCS). The PSEQ assesses a person's belief about their ability or confidence in managing their pain. We will look at the measure, what the score means, and how to respond to low PSEQ scores.

'The challenge for physiotherapists is to try and capture the complexity in their clinical practice so that they're not taking an unsophisticated approach to pain, which has traditionally been a more biomedical, pathoanatomical approach, and recognising that there are a whole range of factors that impact on pain.'

A management strategy that is common in practice, and can be helpful in improving self-efficacy, is setting SMART goals. Movement-based goals or functional-based goals can be really important for people in improving their self-efficacy, and has been one of the big things shown to impact on long-term disability.

The PCS is again based around someone's beliefs about their pain and reflects the perceived seriousness of the problem, how much time they spend thinking about the negative consequences, and also their need for support.

The key thing that we are trying to promote is that an understanding that pain, for acute through to chronic presentations, requires a sophisticated understanding of pain mechanisms which includes the stress and immune systems. We present a range of key strategies utilised in pain management including various coping strategies, immune boosting, sleep, relaxation, flare-up management, goal setting and graded exposure.

We are hoping that people will be able to use that broader understanding to develop a range of strategies—once you've got an understanding of the things that contribute to someone's pain then it opens up more treatment targets, and the physiotherapy interaction becomes more comprehensive in both assessment and management.

Seeking your input

If you haven't heard a lot about the National Injury Insurance Scheme (NIIS), you're not alone.

In August 2011, the Productivity Commission recommended the establishment of the two schemes—the National Disability Insurance Scheme (NDIS) and NIIS. The NIIS was developed to support people who sustain a catastrophic injury caused by four types of accidents: (1) motor vehicle accidents, (2) workplace accidents, (3) medical accidents, and (4) general accidents (occurring in the home or community).

The Australian government is working with states and territories to develop the NIIS as a federated model of separate, state-based no-fault schemes that provide lifetime care and support for people who have sustained a catastrophic injury.

The NIIS will build on existing state and territory accident compensation schemes (for example, for motor vehicle and workplace accidents) to complement the NDIS.

Currently, there is increasing discussion about the NDIS.

In addition, our policy team recently supported one of our state branches to provide input into planning for its NIIS.

We expressed concern about a number of issues, including the low investment planned for home modification and case management.

In the model we reviewed, home modification costs appeared to be in the tens of thousands. Our experience suggests that this will underestimate the costs of effective and substantial home modification. The proposal made no mention of what would occur for people who were renting.

We argued that the NIIS would need to provide a substantial, early payment so that people with profound injury could be assured of an ability to return to a safe home that maximises their independence.

In the model we reviewed, the case management costs appeared to decline in later years. We argued that this was contrary to the experience of physiotherapists. We suggested that the valuable informal support networks often act as 'case management'. We told the inquiry that we often saw a heavy reliance on formal case management much later when those networks frayed (eg, older parents could no longer manage the interactions; and therefore, the idea of reducing case management cost in later years was flawed).

The issues will play out across Australia and it important to know what you think.

What are the best aspects of your compensable schemes, and how should they be enshrined in the NIIS? What are the fundamental flaws in your compensable schemes, and what are the alternatives?

Email the policy team at policy@physiotherapy.asn.au.

Practice promotion

The APA policy team provides general advice about a variety of matters affecting members. You can find a wide range of advice on the FAQ page of the APA website.

For many, advertising and the use of testimonials is sometimes a hot topic.

Who regulates advertising?

AHPRA or the Australian Competition and Consumer Commission (ACCC) regulate the advertising of health services, depending on circumstances.

The ACCC legislation means it is illegal for a business to make false and misleading claims. This applies to their advertising, and any information provided by their staff. It also applies to any statements made by businesses in the media or online.

Similarly, under the National Law a person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that is, or is likely to be, false, misleading or deceptive. For example, although the word 'physio' is not protected, the National Law states that 'a title, word or description

[must not] induce a reasonable person to believe this person is a physiotherapist.'

The National Law and AHPRA's advertising guidelines establish how and what registered practitioners may advertise.

Advertising in any medium must not mislead, offer inducements such as a gift or discount (unless the relevant terms and conditions are also included), use testimonials, and/or create unreasonable expectations of beneficial treatment, or encourage the indiscriminate or unnecessary use of a service.

Many commercial concerns use testimonials to advertise their business. Registered health professionals must not use testimonials in any advertising.

Testimonials are statements making a recommendation about a service or its quality. The National Law prohibits testimonials when advertising a regulated health service. AHPRA publishes guidelines about their use. Some websites, like whitecoat.com.au, allow patients to leave comments or rate a health practitioner—we advise members to opt out of the consumer comments and ratings facility of such websites. Avoiding the use of testimonials reduces the risk of committing an offence under the National Law.

If you need more information, refer to the National Law and AHPRA's advertising guidelines, and consider seeking independent legal advice.

If you have concerns about the nature of advertising, you can notify the ACCC, AHPRA, or the Health Care Complaints Commission (HCCC) if you are in New South Wales or the Office of the Health Ombudsman (OHO) if you are in Queensland.

Collaborating for the consumer

In an effort to promote quality practice, and position physiotherapists as leaders in healthcare, the APA joined Choosing Wisely Australia. Here, Kelli Hooks speaks with APA National Vice President **Phil Calvert.**

In line with the current strategic plan, as part of the community pillar, the APA aims to partner with like-minded organisations and consumers to showcase physiotherapists as community leaders. The APA's involvement in Choosing Wisely Australia is one such example.

In mid-2015, the APA joined Choosing Wisely—the profession-led, and NPS MedicineWise-facilitated, initiative which aims to improve the quality of healthcare. Choosing Wisely raises awareness of unnecessary tests, treatments and procedures and encourages a conversation between patients and practitioners.

The APA recently submitted a list of six physiotherapy interventions that could be thought about differently. Phil Calvert notes that the recommendations should not be seen as prescriptive, but instead should start a conversation between clinicians and consumers about what is appropriate and necessary.

'As each situation is unique, physiotherapists and patients should use the recommendations to collaboratively formulate their own appropriate healthcare plan,' he says.

'We see the initiative as a really positive way to open a meaningful dialogue between patients and their physios, with a core function being to educate the public on what's appropriate and what may not be in some situations.'

To inform our position, the APA formed an expert panel which included nominees from the Australian College of Physiotherapy, directors of the Physiotherapy Evidence Database, and specialist APA members. Members were also asked to provide evidence about physiotherapy interventions that should be questioned.

A member survey garnered nearly 2800 responses and almost 1000 comments. The comments were then put to the panel to refine the recommendations. The final list was submitted to Choosing Wisely last December.

The recommendations are focused around non-specific low back pain, imaging for the neck after trauma, imaging for acute ankle injuries, as well as various types of interventions after abdominal and cardiac surgery and manual therapy at certain stages in the recovery from frozen shoulder.

The APA represents the only allied health profession, among 12 medical colleges and societies, to be involved in the campaign, and Phil suggests this places the profession in a positive position.

'It clearly demonstrates that the physiotherapy profession in Australia is prepared to show leadership in supporting quality practice, as well as working in close collaboration with our consumers,' he says.

'We are a profession that looks critically at what we do, and places a high level of importance on outcomes and measurement of these. The Choosing Wisely initiative places us with some highly respected medical colleges in taking a leadership role within healthcare in Australia.'

Choosing Wisely Australia launched to the public on 16 March. The launch provided the APA with an opportunity to share the stage with the various medical colleges and societies involved in the initiative. Following the launch, Phil says the APA will continue to work collaboratively with Choosing Wisely, for the benefit of consumers and members alike.

'We will educate consumers about the recommendations and will provide ongoing support to our members to assist them in increasing meaningful discussions with their patients, and in implementing the recommendations into practice.'

Looking to the future, Phil hopes that the campaign will contribute to a more sustainable healthcare system.

'Physiotherapists recognise the considerable pressure on the current health system. By promoting appropriate care and improving consumer expectations, we see this as a positive way to strengthen quality practice, and play an active role in making the healthcare system in Australia sustainable,' he says.

For more information on Choosing Wisely, and the full list of APA evidence-based recommendations,visit physiotherapy.asn.au/ChoosingWisely.

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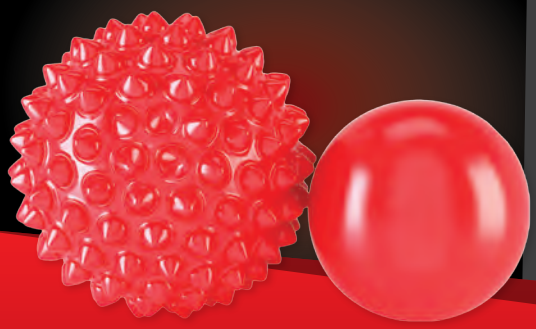

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Eye to the future

Justin Steer, the managing director of Steer Business Consulting, surveys the current state of private sector physiotherapy, before offering his tips for business leaders.

Justin Steer sums up his approach to business in one simple credo: do what you love, add value to the world, and the rest will follow.

In essence, it's a humble and positive approach to a sector that is often epitomised by its changing nature and inherent risks.

The founder and director of Steer Business Consulting—an organisation that specialises in helping physiotherapists improve their business—Justin's role requires him to understand the current climate of private practice to the nth degree, and, in doing so, isolate the common areas where owners are making professional mistakes.

Not afraid to admit his own professional mishaps in the past, Justin says that, first and foremost, private practice owners should assume a positive approach to these failures in order to grow professionally.

'Traditionally, I saw business mistakes as failures,' he explains. 'I beat myself up over them and tried to fix them as quickly as possible like they had never happened. I now understand that business mistakes shouldn't be seen in such a negative light … they are inevitable and happen in every business, regardless of its size or form.

'Acknowledging mistakes and understanding what went wrong is one of the best ways of learning. You learn what works, what doesn't, and if there are any improvements to be made in your own processes.'

Turning an eye to the most common mistakes that he currently finds business owners making in their day-to-day operations, Justin says that, most commonly, they are not adopting the necessary operating systems.

'Many businesses don't have the correct method or system in place to measure their KPIs, patient numbers, patient return rates, class numbers, and operating capacity,' he says. 'A good, successful clinic is embedded with operating systems like these and more.'

Another important, recurrent mistake that he sees businesses make relates to what they pay their staff.

'Practice owners are paying their practitioners too much, which significantly impacts their profit margin,' he asserts. 'Practice owners must pay their practitioners on a productivity-based bonus scheme and not on percentages, because when the clinic's fees go up, so do the practitioners' wages.

'Productivity-based bonus schemes are fair and reward hard work.' On the flipside, Justin reveals his belief that physiotherapy practices are continuing to undervalue their services.

'Most practices I see are still undercharging for their services,' he says. 'I advocate gap fees for compensable patients too.'

In many ways, these common mistakes are products of the current challenges faced by those working as leaders in private practice, but, as Justin contends, some of these challenge are environmental, while others are due to mismanagement.

To circumvent these issues, Justin's tips for physiotherapists are clear: don't underestimate good customer service; research and define your value proposition; and, most importantly, set aside time to 'work on your business, rather than in it'.

And, while Justin notes that the majority of the challenges that business leaders face are perennial by nature, he is adamant that the art of developing a successful business will only become more challenging in the near future.

'I think the prosperity of physiotherapy businesses over the next five years will become increasingly more difficult due to the specific changes emerging in the health industry, as well as the socio-economic trends that we are experiencing more generally,' he says.

Justin specifically isolates the anticipated increase in competition—an increase that he cites as being 'dramatic'—as a primary factor in augmenting the challenges faced by business leaders. 'It is anticipated there will be new major players in the physiotherapy space,' he says. 'There will also be an expected shift towards larger, multidisciplinary health practices.

'These entities will be well-equipped with highly developed business and operation capabilities, which can target their market share of clients as well as provide attractive opportunities for clinicians.'

In view of this professional evolution, Justin implores small practices to ready themselves now.

'Smaller practices will need to clearly understand their competitive advantage, their niche service that cannot be easily replicated by other competitors,' he says.

In Justin's eyes, the drive to establish this point of difference remains one of the most underrated aspects of creating a strong business.

'Be really clear on your value proposition—what you are going to do, how it will help, and how you will deliver it,' he says.

Considering those APA members looking to enter into private practice at this point in time, Justin implores these physiotherapists to seek out expert advice and not be afraid to ask questions.

'Learn as much as you can in the next few years about the profession and the industry,' he advises.

Turning an eye to the future, Justin is adamant that the physiotherapy profession is well-placed to assume a strong leadership role in the future composition of the health market.

'Physiotherapists are well-positioned as the heads of allied healthcare streams,' he says. 'The opportunity is there for physiotherapists to come together and form alliances and partnerships as a strategic approach to maintain and improve the control of the long-term positioning of the profession.'

Driving engagement

Key to the development of the APA's new social media guide, APA members **Mark Merolli** and **Karen Finnin** consider how practice owners can best capitalise on online platforms.

What should drive and shape a practice owner's social media strategy?

There are a number of things that physiotherapists should keep in mind when developing their online approach.

Your existing values are significant. Stay true to who you are, what you do and what you want to achieve. Be guided by your offline mission, and don't lose sight of why you love physiotherapy and helping patients. If you can answer this, it should help guide your online strategy.

Think about necessity. Why are you thinking of social media? Why are you thinking of using platform X versus platform Y? Is your patient community digital-ready themselves? Be systematic in your adoption of different platforms. There are so many, and not every single one may be suitable to your goals.

Focus on your budget. Social media's reach could save you money compared to some of your current offline initiatives, such as club sponsorships, printing flyers for letterbox drops, magazine ads, etc. Only you will really know what's currently working to bring patients in the door.

Time is an important factor. Considering your busy day in the clinic. Do you have time to engage with social media enough to do it justice? Or is this a 10pm job for you at the moment?

Continuing on from the previous point, do you have the digital skills or resources to use social media? Maybe one of your administration staff is more suitable? Maybe you should invest in some social media training for your staff.

You need to plan. Devise a plan before you get started. What do you want to achieve? Who are you targeting? What are the best ways to connect with this group? How will I measure the outcomes?

What are the biggest risks of social media use?

We'd group risks into two categories: regulatory and administrative . If physiotherapists are going to be active online, we need to remind ourselves of our professional obligations. The simplest explanation is that 'online' shouldn't be treated any different to 'offline'. The same scenarios need to be taken seriously: privacy/confidentiality, defamation, professional conduct, patient–professional boundaries and advertising. For some reason, some people lose their head online and all rhyme and reason as to how they should interact with people goes out the window. Social media offers great potential but only when used appropriately. APA members should brush up on the physiotherapy code of conduct and advertising guidelines.

From a business perspective and personal experience, there are a few things that spring to mind that you're at risk of experiencing. The first is time drain. Without knowing what you should be doing and how to do it well, you're at risk of spending hours on social media and really achieving nothing.

Money is another issue. While most social media vehicles still allow us to play around for free, the model is becoming more and more

Mark and Karen's social media tips:

- don't feel you need to be all over every social media platform
- do your research and educate yourself on using social media
- get help from friends/colleagues who can teach you how to use them
- get some quality training in social media use that is relevant and specific to the physiotherapy profession
- if you're a complete novice, wade in slowly (browse, scan, read, etc, before jumping in and posting, sharing, commenting, tweeting)
- if you find social media is starting to take over your life, schedule some offline time every day

'pay to play'. Facebook is the best example—if you have a page for your business, you can post content; however, unless you pay to boost it, it won't be shown to many people. There's good and bad from this. The good thing is that Facebook ads let you laser-target an audience of relevant people for your content like never before, but, without a concerted effort and strategy, you'll be spending money repetitively for no measurable return.

What are some of the interesting and exciting ways that you have seen private practice owners use social media?
A number of physiotherapists have really captured the essence of social networking, and have been able to turn their clinic pages into community hubs. They're posting content that seems to really engage with their community, such as quick 'how to' demonstrations, and are consequently getting a lot of interaction because of it.

We have also seen some great examples where coordinated discussions, video content, interviews and photos have then led to the organisation of face-face, in-clinic workshops and community days with great attendance.

The APA social media guide was recently released. How do you envision private practice owners will engage with and use the guide?
The guide is not an all-encompassing 'how to' but more of an intro to social media. We wrote it in conjunction with the APA because we recognised a real need for it. It's probably slanted more towards novices and those with a little 'know how' but no real online traction. The aim is really to give people a starting place, introducing what social media channels are, and what they are not, and some of the platforms to be aware of.

We try to highlight some of the key sticking points and also the opportunities to capitalise on, while referring to some important notes about professional obligations. We hope the guide, in conjunction with our upcoming socialmedia.physio online and in-person PD events, will provide the digital support we've long been craving.

Follow Mark (@merollim) and Karen (@physiosonline) on Twitter. Mark and Karen will be soon be holding a PD course, 'Connecting Physios', for APA members. For more information, go to socialmedia.physio or keep en eye out in the PD pages of *InMotion*.

Under the microscope

Results from the largest cluster randomised control trial ever undertaken into falls prevention was recently published in *The British Medical Journal*. Here, *InMotion* asks Associate Professor **Anna Barker**, the lead researcher behind the study, to elaborate on its findings.

Why do you think falls continues to remain such a serious issue in the hospital setting?

Falls are the result of a complex interaction between physiological, behavioural and environmental factors. People at risk of falling in the acute setting are often acutely unwell, with multiple comorbidities, and take a number of medications. Preventing patient falls is dependent not only on the knowledge, skills and behaviours of clinical staff, but also the cultural and physical environment, availability of resources, and the policies, incentives and penalties that govern and drive practice. In-hospital falls therefore represent a complex problem, affecting individuals with complex care needs in the environment of a complex system.

Falls prevention programs are also complex. They consist of many components or activities and involve several people, including the patient and the hospital staff. This multilevel complexity means falls are challenging to prevent, as demonstrated by a number of recent epidemiological studies that highlight in-hospital falls have not declined in recent years.

The 6-PACK program included a nine-item assessment tool and six individualised interventions. Can you elaborate on the composition of the assessment tool, as well as the six chosen interventions?

The risk tool used in the 6-PACK program was TNH-STRATIFY, which was developed at The Northern Hospital (TNH) in Melbourne, Australia. The tool is a modified version of the widely used STRATIFY tool developed in the UK that includes five risk factors: (1) recent history of falls; (2) mobility impairment; (3) agitated behaviour; (4) need for frequent toileting; and (5) visual impairment. An evaluation of the STRATIFY in TNH patients led to three risk factors being added to the tool to improve its prediction of fallers: (1) impaired balance; (2) age 80 years and older; and (3) drug and alcohol problems—and increased weighting of the past falls history item.

The 6-PACK program also includes individualised use of one or more of six interventions: (1) a 'falls alert' sign above the patients' bed; (2) supervision of patients in the bathroom; (3) ensuring patients' walking aids are within reach; (4) a toileting regime; (5) use of a low-low bed; and (6) use of a bed/chair alarm.

Photo: ©iStock.com/Angela Schmidt

How widely used are these types of interventions in hospitals across Australia?

National accreditation standards for Australian hospitals recommend the use of falls risk screening and assessment tools such as the TNH-STRATIFY. They also recommend the use of falls prevention equipment (eg, alert signs, low-low beds and bed/chair alarms) and other strategies recommended by best practice guidelines. Therefore, the use of risk tools similar to the TNH-STRATIFY and the six interventions included in the 6-PACK program are common in many hospitals in Australia.

How different was the assessment tool compared to what is usually used in the hospital setting?

The risk factors included on the TNH-STRATIFY risk tool are similar to the risk factors included on many falls risk tools used in Australian hospitals. The structure of the tool is also similar, whereby risk factors are scored, summed and then the overall score used to classify a patient as either being at low or high risk of falling during their admission.

Where and how was the 6-PACK program developed?

Quality improvement methods were used to develop, implement,

and refine the 6-PACK program as part of usual care at TNH, an acute, metropolitan, public teaching hospital located in Melbourne, Australia.

What results did the program garner at its original setting?
A nine-year observational study involving 271 095 patients from TNH indicated that falls injuries reduced following the implementation of the program. The program also appeared to be acceptable to clinical staff and feasible to implement within usual care resources.

In your opinion what were some of the strengths of the program? How did it differ from other similar endeavours?
Strengths of the 6-PACK program include the use of a simple, validated risk tool; a focus on a small number of interventions to enhance uptake; integration of the program documentation into existing patient documentation; frequent review of falls risk factors and status, and required interventions; and supported implementation including structured education, audit, reminders and feedback to enhance practice change.

Why was a RCT conducted? What was the research approach and what did it involve?
While the single-centre observational study at TNH suggested that the program may have positive impacts on falls injuries, a RCT was required to provide more robust evidence of effects (minimising measurement bias and confounding), and of generalisability of the program to hospitals other than where it was developed. The RCT involved 24 acute wards from six hospitals in Victoria and New South Wales and 46 245 patient admissions.

Wards were randomised so that 12 implemented the 6-PACK program (intervention group) and 12 continued with usual care (control group). Falls, falls injury and practice data were collected for a 12-month period and differences in outcomes and practice compared across groups to determine the effects of implementing the program on patient outcomes and practice.

What were the key findings of the trial?
The introduction of the 6-PACK program improved completion of a fall-risk tool and use of falls prevention interventions recommended by best practice guidelines; however, it had no effect on falls or falls injuries compared with usual care.

Falls remain a frequent and substantial source of harm for people admitted to acute hospitals. Rates for some wards in this trial approached 18 per 1000 occupied bed days for falls and four per 1000 occupied bed days for falls injuries. A study published in the *Medical Journal of Australia* conducted alongside the 6-PACK trial observed an eight-day increase in a patient's hospital stay and an additional $6669 in hospital costs for patients who experience an in-hospital fall, when compared to patients who did not fall.

Why do you think improved practice did not translate to improved patient outcomes?
Reasons for the lack of effect of the 6-PACK program on falls and falls injuries may relate to the interventions that were included in the program. Recent studies suggest that low-low beds and bed/chair alarms may have no effect on falls injuries. In-hospital falls prevention programs may need to have a greater focus on preventing delirium, which was not specifically covered in the 6-PACK program but is known to be a key risk factor for falls.

What can we learn from this finding? How can we use it to better approach clinical care?
Findings from the 6-PACK trial are consistent with those of earlier studies which show no effect for falls prevention interventions in acute hospitals.

Novel approaches to reducing harm from falls in acute hospitals are needed. Shock-absorbing flooring that minimise risk of injury and intelligent sensor systems that monitor patients identified as high falls risk may be more effective than current approaches.

Further investigation of strategies that aim to prevent and improve the management of acute confusion, optimise medications, and improve patient engagement should also be considered in future research.

Email inmotion@physiotherapy.asn.au for references.

Feeling the way

Eliza Isabella Campbell McAuley is arguably the most celebrated female pioneer physiotherapist in Victoria. Here, APA Honoured Member Professor Joan McMeeken AM explores Eliza's entry into the profession.

Eliza McAuley was born on 3 March 1866 in Upper Plenty, Victoria. Her father David was a farmer, born in County Donegal, Ireland. Her mother, Sarah Jane Hughes, too was Irish born from County Monahan. The family fortunes must have been generous as she was educated at Grace Park House, a private college for upper middle-class girls in Hawthorn. The youngest of four children and the third daughter, she followed one of the few paths available to educated women who wanted a career. She was first employed as a governess, then for 10 years with the Melbourne Tramway Company. Eliza perceived a more successful and interesting career as a masseuse, particularly as she already had a reputation for effective massage. Perhaps her name had extended to Thomas Fitzgerald, another Irishman who was building his fortune and standing as a surgeon.

Eliza McAuley (left) and 85 Collins Street in the 1950s.

Massage, Swedish remedial exercises and electrotherapy had become increasingly popular. Even Queen Victoria had been undergoing massage treatment in 1890. In 1892, an Australian newspaper promoted the occupation of masseuse in preference to teaching or nursing for young women.

The New South Wales Government too recognised the value of physiotherapy and in 1901 it provided, at government expense, a two-month course of massage and electrotherapy treatment for soldiers returned from the Boer War.

A chance event was propitious for both surgeon Thomas and masseuse Eliza. In 1894, while hunting, Lady Hopetoun, a highly skilled rider, and the wife of Lord Hopetoun, Governor of Victoria, was thrown from her horse.

Lifted back into the saddle, she went to the Riddell's Creek railway station and came back to Melbourne. Lady Hopetoun was taken to Thomas' private hospital, where his examination disclosed a broken nose and damage to the cartilage of the second and third ribs on her left side. She would remain in Thomas' hospital under his personal observation receiving 'every attention that medical skill can devise'. Eliza provided her attention as a masseuse and continued to treat Lady Hopetoun, possibly for her later neuralgia. Such eminent connections provided Eliza with an additional entrée to Melbourne's social elite. It was reported that the 'surgeon [Thomas] Fitzgerald was knighted because he restored Lady Hopetoun's nose to its pristine beauty'.

Recognising the importance of a more detailed understanding of the body for her practice, Eliza allegedly approached the then professor of anatomy, Harry Brookes Allen, to gain permission to undertake anatomy studies with two of the female medical students she knew at the University of Melbourne. Women experienced significant difficulties in studying at Australian universities in the nineteenth century. This problem was compounded for those wishing to study medicine and it was not until the 1880s that the first female medical students commenced at Sydney and Melbourne. The female medical students had a separate dissection room until 1895, indicating that Eliza's attendance occurred in that early period. However, no formal record of her attendance has been discovered.

Eliza spent two years gaining knowledge of anatomy and in the second year she also went to Melbourne Hospital and attended clinics run by Thomas. Eliza and Maurice Krone were the first physiotherapy honoraries appointed at the Melbourne Hospital in 1899. By 1901, Misses McAuley and Mead, Messrs Peters and Krone were listed like medical practitioners, as honoraries

at the hospital, which was then contemplating establishing a massage school. Honorary medical staff believed that, apart from its therapeutic value, physiotherapy would assist the more rapid emptying of beds.

A formal school did not eventuate at the hospital, but as physiotherapy was obviously necessary Eliza was persuaded to take a few students. According to Alison McArthur Campbell, a student from 1922 to 1924, by the early twentieth century Eliza's School of Massage was a nine-month course at the Melbourne Hospital and the University of Melbourne Medical School. Eliza also had her private practice, which she ran successfully for more than 20 years, at 85 Collins Street in the heart of Melbourne's medical precinct and near Dr John Springthorpe's house and consulting rooms. Springthorpe would advocate for physiotherapy, formal education and become the Australasian Physiotherapy Association's first president when it was formed in 1906.

As a key member of the new association, Eliza was a member of the provisional committee appointed to frame a constitution. Her colleague Thomas became patron and she was a member of the first Federal Council.

Read about the later years of Eliza's physiotherapy career as a clinical educator in the May issue of *InMotion*.

For a fully referenced article, email inmotion@physiotherapy.asn.au.

NATIONAL RECOGNITION

In January, four physiotherapists were honoured with Australia Day awards. Here, *InMotion* profiles their professional achievements.

GWENDOLEN JULL

In recognition of her significant contribution to physiotherapy, APA Honoured Member Emeritus Professor Gwendolen Jull was recently bestowed one of the Australia's highest honours—Officer of the Order of Australia (AO).

On Australia Day, Gwen was formally recognised for distinguished service to medical education in the field of physiotherapy as an academic, researcher and administrator, and to professional associations.

Gwen's commitment to physiotherapy education is impressive. She commenced her career in education in 1977, after working as a clinician for eight years. From 1999, she held the position of head of physiotherapy in the School of Health and Rehabilitation Sciences at the University of Queensland for eight years. Throughout

her career, she played an integral role in teaching and mentoring countless future physiotherapists. Underpinning her dedication to education is her undeniable passion for the profession.

'I really do believe that physiotherapy has a tremendous amount to offer the community. It's a profession that I care about quite passionately and I certainly want to ensure that standards of clinical practice continue to increase,' Gwen says.

Gwen has held several leadership positions in the profession. She was elected chair of the International Federation of Orthopaedic Manipulative Physical Therapists (IFOMPT) Educational Standards Committee in 1990. As a result, she became an integral player in the development of the first formal guidelines for an international curriculum and standards for musculoskeletal physiotherapy.

Alongside her role on IFOMPT, Gwen took up leadership positions with various other professional associations, serving as national president of the APA Musculoskeletal group from 1985–1987 and as President of the Australia College of Physiotherapists from 2000–2009. She was also appointed as the inaugural editor of the *Journal of Manual Therapy* in 1995.

Recognised as a pioneer in research, Gwen has undertaken extensive investigation into the pathophysiological features for motor, sensorimotor and sensory systems as related to neck disorders. Her innovation in clinical practice and research has led to the development of new treatments in the area of neck pain disorders, including headache.

'We can now far better characterise a cervicogenic headache and differentially diagnose it from other types of headaches,' she says. 'Researchers are now discovering the nature of pain mechanisms in various neck pain disorders and this is particularly going to help us in the challenging area of whiplash.'

Reflecting on her renowned career in its entirety, Gwen notes that observing the development of the profession, from her very first day as a practitioner in 1969, to her last day of formal clinical practice last year, has been a highlight.

'I'll never forget my first day of work, I was placed on the traction roster where we worked under doctors' instructions, which was to give all their patients with neck pain shortwave diathermy and traction three times a week, for three weeks, and four patients were booked every half hour. It was a bit of a nightmare,' she recalls.

'Compare that with my last day of formal clinical practice…I was working as a specialist musculoskeletal physiotherapist being consulted by patients with complex neck pain conditions, as well as working in collaboration with several medical specialists to, for example, assist in the differential diagnosis of patients with recurrent headache.'

Over the course of her career, Gwen witnessed the crucial shift in the role of the physiotherapist, from secondary providers with total dependence on referral and instruction from medical and dental professions, to becoming first-contact practitioners and acting in a true professional capacity.

'To be first-contact practitioners was the real catalyst for change. We readily took on the responsibility for developing our own science and clinical practice,' she recalls. 'I was lucky. I was in an era of phenomenal development of the profession, both clinically and educationally.'

And it's the continuous development and progression of the profession that Gwen emphasises remains vital going forward.

'It's important that this momentum continues and that physiotherapists continue to strive for clinical excellence in clinical practice, so that we can provide the community with optimal care' she says.

'I would like to see musculoskeletal physiotherapists be fully recognised as the leaders of musculoskeletal rehabilitation so often now we are the first point of contact, but I want physios recognised as the practitioners that people consult for musculoskeletal disorders with the ability to then make decisions on patients' medical or other care paths.'

KATHRYN REFSHAUGE

Professor Kathryn Refshauge, APA Musculoskeletal Physiotherapist, is resolute in her desire to educate physiotherapists who will be leaders in health and, as such, has dedicated more than 20 years to allied health mentorship, higher education reform and health research.

Dean of the Faculty of Health Sciences at the University of Sydney, Kathryn's dedication to the aforementioned areas recently saw the world-renowned musculoskeletal researcher awarded the Medal of the Order of Australia for service to physiotherapy and medical education.

Kathryn is a fellow of the Australian Academy of Health and Medical Sciences, and holds several honorary research appointments, including Honorary Professor at the University of Cardiff and University of Malaya, and Honorary Senior Research

Fellow at Neuroscience Research Australia and at St Vincent's Clinic, Sydney.

Throughout her career, she has played a pivotal role in teaching and mentoring both undergraduate and postgraduate musculoskeletal physiotherapy students and postgraduate exercise and sports science students, as well as supervising honours, masters and PhD students.

'Mentorship is incredibly important. We need to prepare our physiotherapy practitioners for now and for the future,' Kathryn says.

'We need to be making sure that we graduate confident practitioners who can be leaders, who will be at the table, who will help make decisions about the health system and who will be leaders in that system.'

She has received several awards acknowledging her outstanding supervision both nationally and within the university, including the Faculty Award in 2010, the Vice-Chancellor's Award for Excellence in Research Student Supervision in 2011, and a national award for Outstanding Contribution to Student Learning by the Australian Learning and Teaching Council in 2011.

A further feather in her cap, Kathryn holds a position on the executive committee of the Australian Council of Pro-Vice-Chancellors and Deans of Health Sciences (ACPDHS)—the peak representative body for Australian universities that provide undergraduate education in the clinical allied health sciences.

The Council aims to strengthen the training of allied health practitioners in Australia and Kathryn notes the importance of preparing physiotherapists to meet the needs of a changing health profile.

'We need to be on the front foot; there's an ageing population and as such there's a real thirst for physiotherapists in aged care. We should also be more involved in mental health—we know that physical health and mental health are very closely aligned,' she says.

'We need to be looking to the future and allowing these areas of practice to be part of physiotherapy programs.'

Kathryn is adamant about the significant role allied health practitioners, and particularly physiotherapists, have to play in the community and advocates the need for allied health professionals to assume leadership positions in a multitude of health areas.

'Physiotherapists, and other allied health practitioners, need to be recognised in ways that they previously haven't been. Allied health should be really leading a whole lot of initiatives in health,' she says.

'We will take our place where we need to be—as equal partners and leading some part of healthcare— and I'll be on the case until we do.'

NOLA CECINS AND SUE JENKINS

In 2013, the Australian Institute of Health and Welfare reported that less than 10 per cent of people with moderate to severe chronic obstructive pulmonary disease (COPD) had access to a pulmonary rehabilitation program—an intervention known to be more effective than most medications for chronic lung conditions.

It is damning statistics like this that continue to drive physiotherapists Nola Cecins and Dr Sue Jenkins' work. This year recognised with the Medal of the Order of Australia, the pair's service in the field of pulmonary rehabilitation has been prodigious to say the least.

After developing an evidence-based, outpatient service at Sir Charles Gardner Hospital almost 20 years ago, Nola and Sue turned their attention to cultivating the most effective program of care for those with chronic lung disease—an endeavour that has seen them publish more than 100 papers in peer-reviewed journals, as well as contribute to a number of national and international clinical management guidelines.

However, despite the status that they have each been able to achieve in the literature, perhaps Sue and Nola's greatest contribution to pulmonary rehabilitation has been their unwavering enthusiasm to improve clinical care via the transferring of knowledge to their fellow practitioners.

'Our passion has always been training physiotherapists who are interested in running pulmonary rehabilitation,' Nola says. 'We have completed 28 workshops—11 within Western Australia, eight interstate, and nine overseas.

'In many respects, our aim is to ensure that someone who attends one of our PD sessions can then go away and set up a program for themselves.'

When one considers that, since their involvement in the field, the number of pulmonary rehabilitation programs in Western Australia has grown from three to 22, it appears that the pair's hard work has played its part in procuring such positive results.

Nonetheless, despite this growth, the two physiotherapists highlight the current unmet need for pulmonary rehabilitation across the country.

'At the moment about two-thirds of all the programs take place in hospitals … and while there is certainly a role for hospital-based programs, we need far more programs in the community,' Sue explains. 'For example, we've been reasonably successful in the metropolitan area in Perth because we've always played a big training role in this area, but there is a big gap in the availability of programs close to people's homes.'

Echoing Sue's concerns, Nola explains that the primary reason behind this discrepancy is funding.

'It is never clear whether funding for these programs will be ongoing,' she says. 'Within a hospital, it's really up to the physiotherapy department to use funds to run a pulmonary rehabilitation program. However, community-based programs have more difficulty accessing ongoing funding. The current ABF [activity based funding] environment raises challenges to this funding … some of the programs have been able to access ABF, some haven't.

'For example, GPs can't easily refer to these programs currently because they don't fall under ABF.'

In order to remedy this, Lung Foundation Australia recently submitted an application for an MBS item number for pulmonary rehabilitation—a submission that both Sue and Nola were involved in developing.

'That [the application] is going through the process and who knows if it will get up,' Sue says. 'But if it does go out as an MBF item number that will create a big need for training because, as physios working in our area would attest to, the majority of health professionals working in these community settings don't have all the necessary skills to provide the pulmonary rehabilitation programs in accordance with evidence-based guidelines.'

Sue Jenkins (left) and Nola Cecins

In light of this uncertainty, both Nola and Sue express their hope that their Australia Day honours can continue to raise the profile of pulmonary rehabilitation and the crucial service that it provides to the Australian population.

Headlining Parkinson's disease

Illustration by ktsdesign/Shutterstock.com

A recent study demoting the effectiveness of physiotherapy intervention for those with mild-to-moderate Parkinson's disease may not be as clinically meaningful as it appears, finds Michael Tarquinio.

Earlier this year, under the headline, 'Millions of pounds wasted providing physiotherapy for Parkinson's, say researchers', The Telegraph cited a UK study published in The Journal of the American Medical Association by a group of researchers from Birmingham University.

The 15-month randomised clinical trial involving more than 700 individuals, undertaken by Professor Carl Clarke and colleagues, demonstrated that current therapies do not yield improvements in patients with mild-to-moderate forms of the condition.

Predominantly assessing any changes in the patients' activities of daily living and quality of life, the researchers found that both physiotherapy and occupational therapy—the two forms of rehabilitative therapy recommended for this population in national British guidelines—had little positive effect.

However, despite the negative nature of the results for the physiotherapy profession, the study has been criticised for the composition of its physiotherapy intervention component—itself encompassing a 'traditional' physiotherapy approach that, despite encapsulating current treatment strategies, did not fall in line with what the current literature is saying about best practice.

With a lengthy involvement in neurological research, the University of Queensland's Professor Sandy Brauer, APAM, queries the approach adopted by the University of Birmingham researchers. She asserts that, while the study drew on 'the latest clinical practice guidelines in Europe', the dosage and chosen form of the physiotherapy intervention impacted on the therapy's ability to garner positive results.

'The volume of exercise was very low,' she says, alluding to the study's average of four physiotherapy visits of one hour over eight weeks. 'We know from other studies that the amount of intervention that it takes to show change is much greater than that, so it's not surprising that only an average of four hours wouldn't make a difference.'

Sandy similarly highlights the limited information expressed in the paper relating to the type of physiotherapy administered to the participants.

'While it is a little difficult for us to know exactly what the physiotherapists did in the intervention, they indicated that most included gait training, but that's a very broad term,' she says. 'There is variation in the aims and what you could actually do as gait training for people with Parkinson's disease.'

'There is certainly a big push to ensure people with Parkinson's disease exercise, particularly early on after diagnosis,' she says. 'There have been a couple of recent Cochrane reviews by Tomlinson and colleagues [2013 and 2014] … one looked at 39 trials and one looked at 43 trials. When the researchers compared a number of different forms of physiotherapy and other exercise to no care, there was definitely an improvement in gait, balance and general function.

'There is evidence that physiotherapy makes a difference to those factors in people with mild-to-moderate Parkinson's disease.'

Another clinical focus that has been building momentum in the literature over the past decade has been the motivation to determine if Parkinson's disease treatment can be neuroprotective.

'There is evidence in rodents that have been given a form of Parkinson's disease of promising cortical changes after exercise on a treadmill. When researchers sacrificed the animals and studied their brains, they found there were a variety of positive

changes, such as a reduced loss of dopamine-producing neurons and a greater sensitivity of receptors to dopamine, which is the chemical that is depleted in people with Parkinson's disease,' Sandy explains.

While Sandy reveals that, due to measurement issues, there have not yet been any trials investigating a neuroprotective effect in humans, she says that the findings in the animal model have led to a great deal of excitement in the field.

'Because it is so promising in animals, certainly it is strongly advocated to do exercise early in people with Parkinson's disease,' she says.

Another point of contention in the study by Clarke and colleagues relates to their primary outcome measure. To assess the efficacy of both physiotherapy and occupational therapy in the study's cohort, the researchers utilised the Nottingham Extended Activities of Daily Living scale (NEADL). Originally designed to assess quality of life of patients with stroke upon returning to the community, Sandy contends that the scale was not sensitive to likely changes induced by physiotherapy for people with mild-to-moderate Parkinson's disease.

'It's not likely that what the study's practitioners were doing for the physiotherapy intervention was actually targeting what they were measuring in the scale,' she says. 'For example, some of the questions involved in the scale were "do you read newspapers or books?" and "can you manage your own money when you are out?"

'Only six of the 22 questions directly relate to mobility. The rest examines activities of daily living tasks that we really wouldn't expect a change in after effective physiotherapy intervention.

'This scale may be a lot more relevant to assess occupational therapy because it touches on meal preparation, housework, and activities of that nature. It's just not the right measure to be using to determine if typical physiotherapy has an effect.'

In addition, Sandy points to the study participants' high scores on the NEADL scale at baseline as representative of not only the population's mild diagnosis, but of the limitation in this scale to show change.

'The vast majority of people had very few concerns to begin with. They were already scoring on average 51/66 on the scale [approximately 77% per cent], so there wasn't very much room for improvement,' she says.

The University of Birmingham researchers also analysed quality of life—a decision that Sandy says, while very important, is influenced by a multitude of factors.

'In this population [people with mild-to-moderate Parkinson's disease], quality of life tends to be more linked to non-motor symptoms than motor symptoms,' she says. 'For people with the disease, their main problem might not be that they have some limitations to movement but, instead, it's their depression or anxiety or their autonomic function.

'We've got to consider these patients holistically as often their greatest concerns may be non-motor symptoms and beyond our expertise. We need to consider the full multidisciplinary team and refer appropriately.'

'We've got to consider these patients holistically as often their greatest concerns may be non-motor symptoms and beyond our expertise. We need to consider the full multidisciplinary team and refer appropriately.'

Considering the clinical usefulness of Clarke and colleagues' work, Sandy says that their paper acts as a timely reminder for Australian physiotherapists to always exercise critical thinking when engaging with research.

'This is a good example of a paper that has headline-grabbing conclusions; practitioners need to read the full paper so they can determine if these results are clinically useful,' she says. 'The researchers did all the right things in terms of study design, but if you look at the clinical usefulness of what's coming out of that paper, it's really not helpful for the profession at all. It's not using the type of intervention that we do, and it's not measuring an effect that the intervention is specifically targeting.

'We need to delve beyond the headlines, and educate others to do the same thing.'

Director and Principal for PD Warrior, Melissa McConaghy, Specialist Neurological Physiotherapist, shares many of Sandy's concerns with the nature of Clarke and colleagues' findings.

Drawing on her history of clinical involvement treating individuals with Parkinson's disease, Melissa echoes Sandy's criticism of the study's low-dose approach to physiotherapy intervention.

'The fact that the researchers didn't see a positive result from physiotherapy treatment came as no surprise,' she says. 'Those with mild-to-moderate Parkinson's disease really need an intensive intervention to be effective and the low dosage certainly wasn't sufficient to deliver that.

'The study's four sessions of physiotherapy over eight weeks is an incredibly low dosage, especially given that people with Parkinson's disease often have cognitive impairment, difficulty learning new and novel tasks and may also be battling with depression, apathy and anxiety.'

In this way, Melissa contends that the researchers would have been better advised to dismiss the 'traditional approach' to physiotherapy and instead adopt an approach epitomising an intensive exercise program tailored to treat individual symptoms.

'Broadly speaking, physiotherapy can help to manage some of the symptoms brought on by the lack of dopamine in a patient's system, by teaching their brain how to re-wire itself through neuro-active exercise,' she wrote on her blog—pdwarrior.com—in response to the article in *The Telegraph*. 'It is by applying the principles of neuroplasticity in your exercise program that your movement can be improved.'

Elaborating on an approach centred on neuroplasticity, Melissa says that in her 15 years treating people with the condition she has never seen any other treatment procure more effective results. 'Instead of using compensatory movement strategies, which follows the traditional model, a neuroplastic approach is often more appropriate as an early intervention.' she says.

Melissa says that when treating those who have mild-to-moderate Parkinson's disease—like the participants in Clarke and colleagues' study—an approach incorporating a focus on neuroplasticity is significantly more beneficial compared with traditional physiotherapy care.

'Individuals might be presenting with very minimal symptoms. Five years ago, before I started using this approach, I would have sent these people away and asked them to continue with a very general exercise program,' she says. 'But, currently, being fully aware of the literature, we certainly know that we can tailor programs that are incredibly effective for this population.

'Unfortunately this is still considered quite a radical approach, despite the fact that "neuroplasticity" is not a new term.'

However, in spite of the existing scepticism, Melissa references the growing literature base as an indicator that best practice is set to change.

'There's a body of work that has been emerging over the last decade. There has probably been upward of 100 articles looking at the role of intensive exercise in driving neuroplastic change in the brain,' she says. 'There have also been a lot of published studies in the past few years in both rodent and human studies demonstrating the possible role of exercise in neuroprotection, which is such an exciting prospect.

'That just takes it one step further. We know that medication for Parkinson's disease doesn't slow the condition down, but there is emerging evidence to suggest that exercise can slow down the condition's progression.'

Returning to Clarke and colleagues' study, Melissa also points to the fact that only three patients in the study were provided with specific Parkinson's disease exercise advice as representing the study's failure to tap into current best practice philosophies.

'You can't just deliver a treatment as a one-off and expect people to adhere to it and for it to have long-term effects. Treatment really needs to incorporate a self-efficacy approach,' she says. 'People need to be educated about what they are doing and how they can create strategies to cope and continue when it gets tough.'

Acknowledging the progressive nature of the disease, Melissa says patient empowerment is crucial for clinicians.

'That is certainly something that we have seen in this population … through education they suddenly start to feel that they can manage their condition. It's not just about popping pills anymore,' she says.

'I've surveyed this population and one of the things they feel on diagnosis is a loss of control. They just don't know how they are going to control their condition in the future. I think giving them the opportunity to control something in the form of exercise is really important and it shows them they can do a lot more than they think they can.'

In light of the shortcomings of the physiotherapy intervention used in Clark and colleague's trial, Melissa underlines the need for Australian physiotherapists to understand a best practice approach to Parkinson's disease, especially considering the condition's prevalence in the community.

'More often than not, people will go to their local physiotherapist because they've got a shoulder complaint, which is often misdiagnosed as frozen shoulder,' she says. 'I think the disease is getting seen a lot and is widely under-treated.'

Melissa says that remedying this issue by educating physiotherapists to identify these issues earlier will not only help patients' clinical outcomes but will also enable the physiotherapy profession to underline itself as leaders in the area of Parkinson's disease care.

'We are the best profession to be able to do this,' she says. 'We understand neuroplasticity and skill acquisition, we understand the biomechanics and kinematics, and we understand the pathology and pathophysiology of Parkinson's disease.

'If we don't embrace it, we're going to lose the ability to lead healthcare in this direction. However, to really embrace this, we need to start educating ourselves as a profession.'

Investigative insight

The lead researcher of the randomised clinical trial in question, Dr Carl Clarke, responds to some questions about his study's research approach.

Your study's Cochrane review found that while physiotherapy appeared to have small but significant effects on motor function for those with Parkinson's disease, studies were small with short-term follow-up. Why do you this has been the case?

It costs around £2 million to complete a trial like this. Previous studies focusing on Parkinson's disease were conducted with a smaller budget, hence smaller numbers and shorter follow-up periods.

Why did you decide to focus on subjects with mild-to-moderate Parkinson's disease?

This was the group of individuals whom we were uncertain about the effectiveness of the therapies. The trial is based on the 'uncertainty principle'. We did not randomise more severe patients as we felt they had to have therapies.

What was the thinking behind utilising the NEADL scale?

NEADL has been used in stroke and ageing trials before. We used this scale so that we could compare the magnitude of change in Parkinson's disease with that in other conditions. It is also worth noting that NEADL, although developed as a measure of community independence after stroke, has been used in studies of aging in groups that include individuals with Parkinson's disease.

How would you sum up the results of your study?

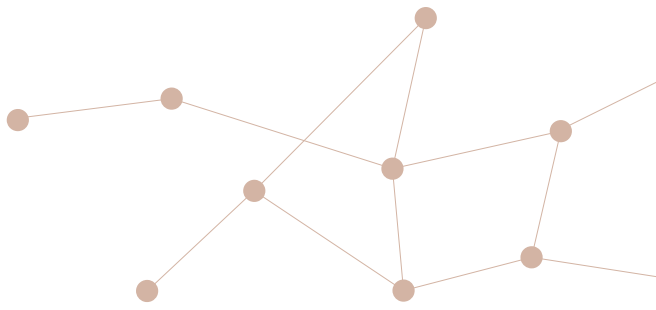
Physiotherapy and occupational therapy were not associated with immediate or medium-term clinically meaningful improvements in ADL or quality of life in mild-to-moderate PD. This evidence does not support the use of low-dose, patient-centred, goal-directed physiotherapy and occupational therapy in patients in the early stages of Parkinson's disease.

Drawing on your results, what should be the focus of future research endeavours?

Future research should explore the development and testing of more structured and intensive physical and occupational therapy programs in patients with all stages of Parkinson's disease.

What can physiotherapists take away from your study?

Do not be disheartened. It is useful to find out what works and what does not. This is the only way we move forwards. Please work towards finding more intensive exercise programs with prescription progression which can engage a large number of semi-sedentary patients.



PRESSING RESET

Dr **Susie Morris**, APAM, was last year awarded the ISPEN award, along with her patient, Terry. Here, Susie provides an account of Terry's six-year rehabilitation journey.

Illustration: ©iStock.com/art_of_sun

When Terry was 47 years old, he had a left internal carotid artery aneurysm, which burst and left him with a severe acquired brain injury (ABI) in February 2009.

Terry was initially discharged to a nursing home, before being admitted to an ABI unit for rehabilitation towards the end of 2010. Following this, Terry moved to a residential aged care facility—a distressing prospect given that Terry was only 49 years old at the time—to await the sourcing of suitable and wheelchair-accessible accommodation.

After nine months of waiting, Terry was accepted into the Slow to Recover program in May 2011. It was here that I first began providing physiotherapy treatment to Terry. Up until this time, he had limited rehabilitation input, but, once the funding commenced, weekly physiotherapy sessions started. Assessment revealed multiple significant physical impairments. There was significant right-sided paresis with associated spasticity, especially in the gastrocs and soleus muscles. There were contractures at the ankle, which left Terry with 20 degrees of plantarflexion and 40 degrees of knee flexion. This had a significant impact on his ability to stand and weight-bear through his right side. Understandably, Terry was fearful and anxious when attempting to stand. He was also dyspraxic and expressively dysphasic. He had neglect—especially of his right arm—and was unable to eat so he was fed via percutaneous endosophic gastrostomy. Terry could not write spontaneously and he was unable to copy words. He could move his right arm but the movements were limited to about 60 degrees of forward flexion and abduction. Finger movements were clumsy and only happened when cued; he did not use his right arm outside of therapy. At this early time, Terry fatigued quickly, was distractible, unmotivated and, at times, had verbal outbursts. He did not want to participate in therapy; he often did not get out of bed.

Terry did not want to do physiotherapy, so many of the early sessions were only as long as 15 minutes. If Terry had had enough, the session was ceased with the promise that we would do another session in a few days. Initially, we just focused on his right arm, trying to get Terry to pick up familiar objects like his comb, shaver, or deodorant. We introduced a balloon to tap and kick, against a background of chat about football, cricket—anything to lighten the mood and build trust and rapport. While Terry still indicated he didn't want to do physiotherapy, he would participate and session times built up to 45 minutes twice weekly. Sessions not only targeted his right-sided dyspraxia, but also his fear of standing. By the year's end, Terry could stand at a rail with assistance. Additionally, he could turn over a full pack of cards with his right hand in under eight minutes (it had previously taken him 18 minutes). Terry was also completing a sliding board transfer to get on and off the bed with supervision.

At the start of 2012, a change in therapist to Zhao Teoh [APAM] was necessary as my role with the Neurological Rehabilitation Group changed. Terry was keen to try and walk but he was exceedingly fearful. Botulinum toxin injections into the right soleus and gastrocs settled the clonus that was interfering with weight-bearing on the right leg. To facilitate walking, Terry had to feel confident that he was safe and could not fall. Room-based therapy was commenced so that a body-weight support (BWS) harness could be implemented while Terry stepped in a frame. Adjunct therapy involved tilt table with single-leg stepping as well as stepping in parallel bars.

Within two months the use of the BWS had proved effective; Terry had progressed to walking up to five metres in a two-wheeled gutter frame with only light assistance Fatigue and anxiety were still the key factors limiting the distance, but Terry continued to persevere. Treatment focused on facilitation of normal movement incorporating Bobath techniques, particularly for pelvic control, functional strengthening, and repetitive motor learning of functional tasks. Multiple joint sessions were carried out involving different team members and family to identify and address the impairments contributing to Terry's functional limitations, with the ultimate goal to get Terry home.

In 2013 there was a shift back to therapy at the residential facility under the supervision of Scott Edwards, senior physiotherapist at the Neurological Rehabilitation Group. Further botulinum injections were given into the right calf muscles and Terry transitioned to walking inside with a four-wheel frame. A gym program was commenced which was supported by his carers. Therapy focused on balance training in standing and gait re-education. The right knee flexion contracture was problematic, but, despite different attempts at bracing (three-point brace), Terry would not tolerate its application outside of therapy sessions. As a consequence, a flexed knee gait was going to be a permanent gait abnormality. As Terry made gains with his mobility and use of his right arm, this was complemented with a greater focus on increasing Terry's participation in daily activities.

Another 12 months passed and Amy Blencowe [APAM], his next therapist, facilitated an ongoing functional approach to therapy. Terry did best when he could appreciate the relevance of the treatment. He was already doing some meal preparation with his carers but there was

still no spontaneous use of his right arm. Terry loves his coffee, so a specific goal was formulated in conjunction with Terry and his brother, Darryl, to have Terry make his own cup of coffee. A specific routine to maximise Terry's use of his right arm was implemented, as well as prompts for Terry to use the right arm more, such as opening a door, and washing the family dishes. Outside of therapy, Terry relied on his power wheelchair for mobility. While he would walk out of his bedroom each morning, there was no other incidental walking throughout the day. Because of Terry's fatigue and reduced endurance, a graduated approach using his frame with his carers was commenced. By 2014 Terry was walking into the kitchen to stand at the bench to wash the dishes or make a coffee and then he walked back to the lounge to rest in his recliner.

By 2015, Terry could walk with a four-point stick, but it was accompanied by high levels of anxiety. Yet Terry persisted and grew in confidence. With his increased mobility, Terry had greater opportunity to engage in his community. Weekly visits to the Men's Shed, gym and local shops became the norm. By this time, Terry was living at home with his brothers, with support, four nights a week. Although there are some bureaucratic barriers, the aim remains to just live in the family home.

The Ipsen Award for Achievement in Neurological Physiotherapy is awarded every APA conference year. The award recognises outstanding client-therapist partnerships in neurological rehabilitation, acknowledging the achievements of individuals who have overcome a major neurological injury or disability and the physiotherapists who have assisted them to achieve their goals.

Double returns

Three years ago, the Student Led Neurological and Falls Physiotherapy clinic at University of Canberra's Faculty of Health Clinics established an exercise program for people with Parkinson's disease. Here, Emma Breheny talks to **Allyson Flynn**, APAM, a physiotherapy clinical educator at the university who helped to establish the program.

'We saw two opportunities: we could provide clinical education to physiotherapy students while also fulfilling the need for a community-based service for people with Parkinson's disease in Canberra,' she explains.

The program involves group-based classes, overseen by a clinical supervisor and two students who do the majority of the assessments and work with the clients. Allyson guides the students and ensures they are working within clinical guidelines.

The model makes supervised exercise affordable while also providing a continuous source of clinical placements for students at the university. Other student-led clinics in the faculty include musculoskeletal physiotherapy, nutrition and dietetics, clinical psychology, and occupational therapy. This particular clinic addresses a range of neurological disorders, depending on what clients present with. Exercises for those with Parkinson's range from dual task training through to bed mobility.

'Our work is grouped into three areas: exercise to increase physical capacity, practice to improve motor learning and skill acquisition, and strategy training to assist people as the disease progresses. We aim to cover all three depending on the person's assessment,' Allyson says.

Each person's initial assessment identifies goals and issues, and sets outcome measures.

'One of the challenges is ensuring we balance the ability of the participants in each class, because we work across the spectrum of Parkinson's.'

Allyson is currently working on standardising data collection so that outcomes can be properly analysed. So far there appears to be a general trend of increased walking speed. There have also been social and emotional benefits for both clients and their carers. Carers often get coffee together while the class is running and share their experiences. In class, participants are doing the same, proving that an improvement in overall wellbeing is not simply an improvement in clinical outcomes.

Photo: ©iStock.com/Steve Debenport

'When the clients talk with one another, the other person has a real understanding of what they're saying. People without the disease can show concern, but often they don't have that same level of understanding.'

Students also report benefits for their clinical skills, including dealing with a range of clients and, more unique to this clinic, working with multiple clients simultaneously.

The clinic has steadily grown under Allyson's watch from one weekly class to 13 classes per week. Over the next two years, there are plans for the clinic and classes to be the centre of formal research, with the outcomes being incorporated into the program.

In dealing with a problem today, this clinic is also giving tomorrow's physiotherapists a taste of what's ahead.

Future focus at NSW Symposium

Professor **Maria Fiatarone Singh**, a geriatrician and researcher at University of Sydney, will be speaking at the upcoming APA NSW Symposium, which is themed around the future of physiotherapy. Emma Breheny spoke with Maria about her 30 years of experience researching cognitive function and exercise.

Maria Fiatarone Singh and her team are currently conducting research into whether exercise interventions are beneficial to cognitive, functional or psychological outcomes in two groups: those with a mild cognitive impairment, which can increase the risk of developing dementia, and those with established dementia. Specifically, those with established Lewis body dementia, which is similar to Parkinson's disease, will be the focus.

Two studies will also look at the role of technology in delivering physical activity interventions using mobile apps and FaceTime video conferencing.

'For prevention of dementia, it's a reasonable approach because you're basically addressing a lot of the risk factors that happen. Risk factors have previously been addressed in remotely-delivered interventions for managing obesity and hypertension and so on.

'However, it's not so clear whether this works with people who have already developed a mild cognitive impairment or dementia. We don't yet know if they would be able to adopt an intervention without any face-to-face contact, or, in fact, if it would be safe,' she says.

As digital technologies gradually spread and tech-savvy generations grow older, the implications for healthcare delivery across Australia are significant.

For now, Maria advocates a combination of face-to-face and remote interventions with technology playing the all-important role of ensuring adherence to exercise prescription and facilitating long-term behavioural change.

'These days it isn't that hard to see somebody in their home via FaceTime, for example, and watch them do something and give them feedback on their form,' she says.

Maria's belief in the preventive benefits of exercise is evident in the way she talks about the right types of exercise to prescribe and the dangers of disuse of our bodies.

'A lot of the problems that are related to ageing are actually related to disuse, rather than ageing itself, whether it's cognitive, musculoskeletal or cardiovascular disuse.'

She warns those prescribing exercise to maintain intensity and progressions regardless of age, pointing to the evidence base for high-intensity exercise.

'In the realm of strength training, I still see an awful lot of low-intensity, non-progressive exercises prescribed that are called strength training but clearly aren't. Challenging a muscle with uncustomary force is still the key to adaptation. The older you are, the more necessary it is to stick to that principle.'

The APA NSW Symposium is on Saturday 25 June at Rosehill Gardens, Sydney. For the latest information on this event, check physiotherapy.asn.au/events regularly.

Evaluating a Dance for Parkinson's program

With approximately one in 350 Australians living with Parkinson's disease, effective community-based programs are a key part of managing the disease. Professor **Sandy Brauer**, APAM, of University of Queensland was involved in an evaluation of Queensland Ballet's Dance for Parkinson's program, a pilot that was established in 2013.

The program, which started in New York and is now run around the world, improves people's dual task gait performance, social and emotional wellbeing, and confidence in their physical ability. A body of research now shows that commencing exercise early and maintaining a regular regime has many benefits for those living with the disease. Queensland has led the way with a tailored dance program, but Dance for Parkinson's Australia now have classes in seven of Australia's states and territories.

Sandy Brauer has researched interventions to improve gait and balance in Parkinson's disease for 15 years. This evaluation study was performed by Sandy and a team of researchers that represented physiotherapy at University of Queensland (UQ), Dance within Creative Industries at Queensland University of Technology (QUT) and the School of Exercise and Movement Sciences at QUT, in conjunction with Queensland Ballet. The other physiotherapy researchers were Dr Robyn Lamont, APAM, and Katrina Kemp. Here, Sandy outlines the evaluation's key findings and what happens at a Dance for Parkinson's class.

What did the Dance for Parkinson's program involve?
Participants came to the Queensland Ballet studios once a week for a 75-minute dance class followed by afternoon tea—very important! A pianist from Queensland Ballet played music and Erica-Rose Jeffrey, the Australian program coordinator and a trained dancer, led the class, with three to four dancers or staff from Queensland Ballet also participating in the session. A carer or support person for each participant was also allowed to participate in the class. The movements and music were taken from the current repertoire of Queensland Ballet, for example around Christmas it was *The Nutcracker*.

The dancing itself was a mix of dance styles, adapted for either standing or sitting, depending on individual capabilities. This allowed people to participate to their own level. There were mirrors around the studio, which helped people see what kind of movement they should be doing. With Parkinson's, people often lose that concept of what's normal in terms of the size, tempo and effort required in their movement.

On top of the weekly dancing, the people with Parkinson's were invited to events like open classes where they could see Queensland Ballet dancers taking a class and they received complimentary tickets to the current Queensland Ballet productions. This allowed this group to form their own community.

Did these social components show up in the evaluation findings?
Yes, the qualitative reports from participants showed that in addition to feeling that they had improved physically, they also reported that the program facilitated strong social connections with others facing similar challenges, that it helped them express themselves artistically and that it gave them something to look forward to. It also gave people the confidence to go out socially and to try another physical activity.

What else did your evaluation show?
People's ability to walk and do a second task at the same time (dual task ability) tended to improve. We had nine out of 11 participants who improved in their timed up-and-go test with added tasks, and the same number who improved their walking speed over 10 metres with added tasks. This wasn't surprising because the dancing involved moving and thinking about your next move at the same time. While we only had 11 people participate in the evaluation, our findings were still statistically significant.

What was the study design?
We used a mixed methods approach where we looked at both quantitative and qualitative measures before and after six months of participation. The quantitative assessment involved using

Photo: Christian Tiger

force plates, a GAITrite Mat (which quantifies people's walking) and clinical measures of balance. We also did interviews with participants to get an indication of how the program impacted their life. While there were up to 40 people attending the classes by the time we finished our study, there were only 11 who registered interest from the start, so these formed the subjects of our study.

Did you expect the findings to show what they did?
There probably hasn't been as much research on the social, emotional and artistic impact of physical activity interventions in this population so there was no benchmark there, but given the high degree of social interaction, we weren't surprised at these positive findings. Our results showing physical improvements were somewhat surprising. Usually you need to have a greater volume and intensity of exercise to show an effect, but having said that, in the Dance for Parkinson's program I think participants were quite challenged at times and that's perhaps why they showed an improvement in dual tasking.

Also, the program follows principles we use in physiotherapy that are backed by evidence, for example large amplitude movement, rotation exercises, big efforts, multi-tasking. Dancing is just one way to deliver the intervention and it's what some people really like. It won't be for everyone, but there are lots of alternatives like treadmill training, Tai Chi, other physiotherapy-led classes or boxing.

How did you distribute the evaluation findings?
We presented them at the Parkinson's Australia National Conference in May 2015 and we are submitting them for publication at the moment. A summary report was also published by Queensland Ballet and is available on their website.

What are the next steps?
Queensland Ballet is keen to expand the program beyond Brisbane and deliver it in regional centres across Queensland. Erica-Rose has run a teacher-training workshop in Brisbane, which has trained some people from regional centres, including a physiotherapist, I believe, and then Queensland Ballet plans to visit these centres to provide support.

We're also working with Queensland Ballet and QUT to explore the possibility of additional research.

The work of change

New Branch President **Martin Van Der Linden**, APAM, took some time out to chat with Emma Breheny about his experience and introduce himself to South Australian members.

Photo: ©iStock.com/Kenishirotie

After graduating, Martin Van Der Linden spent some time in Berri, a rural town in South Australia's Riverland region, and at Royal Adelaide Hospital before finding his passion for occupational health. He now works for Corporate Health Group as Allied Health Manager.

'The thing that attracted me to occupational health was being able to apply my physio skills and knowledge in unique and interesting environments, like mine sites or manufacturing businesses or smelters, rather than just staying in the clinic,' he says.

Around the time he began working in occupational health, Martin joined the state chapter of the APA's Occupational Health group. That was 15 years ago, and Martin has moved through several roles on APA committees since, including the South Australian Branch Council.

'My major role in Branch Council has been chairing the compensable bodies group, which looks at what physiotherapists and insurers want out of the compensable system and then tries to negotiate on behalf of the APA to get outcomes,' he says.

During his involvement, Martin has worked towards increasing the fees for a standard consult to better reflect private practice physiotherapy fees. He's also helped to improve the relationship between the profession and the South Australian worker's compensation body, and influence the model of care used.

'There's no doubt that there is a much more collaborative relationship with ReturnToWorkSA than there was 10 years ago. Now, they really look to us for our thoughts and opinions on good strategies to put in place,' he reflects.

This ability to negotiate and advocate for members is a key attribute Martin brings to the role of Branch President.

'I believe that I'm able to understand different perspectives of a problem or situation and present a solution that creates common benefits, even where that solution may not be initially apparent.'

Along with other Branch Council members, Martin wants to be more visible at member events and meetings to ensure that lines of communication are kept open. With the APA's many entities and a surge in membership, the need for a more integrated professional association is at the front of his mind.

Another burning issue is ensuring that major changes to allied health and rehabilitation under the Transforming Health initiative create opportunities to improve patient outcomes, rather than compromising the quality of services that physiotherapists already provide in the public health system.

Wider recognition of physiotherapy titling and specialisation is also in his top three priorities.

'It's important that we link internal APA processes with the community understanding of those processes. If the community don't recognise or value what specialisation means, we run the risk that it won't continue.'

Securing a home for rehabilitation

A key aspect of the South Australian Government's Transforming Health (TH) plan is the closure of Hampstead Rehabilitation Centre and integration of its stand-alone rehabilitation services into The Queen Elizabeth Hospital (TQEH). As Emma Breheny reports, the APA is encouraging the government to act on the recommendations of physiotherapists working in both facilities when they finalise plans for TQEH.

Ian Watts and Andrew Zoerner, Senior Manager Physiotherapy – Hampstead Rehabilitation Centre, at the facility in February.

The overarching principle behind the decision to relocate Hampstead's rehabilitation services is that patients should have access to rehabilitation within the acute hospital setting, which would allow rehabilitation to begin sooner after surgery or stroke.

The APA agrees with this; however, there are concerns that the proposed build and remodelling at TQEH may not be large enough to accommodate existing general rehabilitation services, let alone the state-of-the-art services being transferred from HRC.

Late last year, the APA approached Minister for Health Jack Snelling with these concerns; since then, the upgrade at TQEH has been paused. This was very welcome news, allowing the APA and others additional time to provide input into what rehabilitation space is needed to maintain high-quality physiotherapy services.

The APA used its January response to the proposed models of care for rehabilitation at TQEH to again stress the need for a design that's in sync with Transforming Health objectives and the views of clinicians experienced in working within rehabilitation facilities.

'The proposal includes likely demand for services, an audit of use and some suggested priorities for any planning decisions. This will then be provided to SA Health.'

SA Branch Coordinator Carolyn Coleman and APA General Manager, Policy and Government Relations Ian Watts recently visited the HRC campus and TQEH rehabilitation areas and met with senior physiotherapists there. Ian has consulted extensively on health facility design and says that it's usually the clinicians who can provide the best assessment of needs.

To reiterate the need for planners to include clinician expertise in their final proposals, Carolyn and Ian have supported APA members to draft a proposal that clearly articulates the recommended space and facilities for high-quality physiotherapy services. The proposal includes likely demand for services, an audit of use and some suggested priorities for any planning decisions. This will then be provided to SA Health.

The APA is doing its best to influence the decision makers on this build and will continue to put forward member-driven propositions, as it has for the past six months. Experience shows that if the shared rehabilitation space provided for inpatient and ambulatory care is not adequate, patients and health outcomes will suffer. For Transforming Health to succeed, it's critical to get this right.

Carolyn Coleman and **Ian Watts** contributed to this article.

Growing pains

Opening a business can be a daunting prospect, but in Tasmania there's a renewed confidence among the island's business owners, including Belinda Jeffries who co-owns a physiotherapy practice in Hobart's suburbs. Despite this confidence, she tells Emma Breheny that finding physiotherapists to fill vacancies continues to be a challenge.

Figures from the final quarter Sensis Business Index of 2015 showed that small business confidence in Tasmania is soaring, with a two-fold increase since March 2015. After many years of poor economic performance, the report heralded new optimism.

Belinda Jeffries, practice manager at Back In Motion Rosny Park, echoes the positive sentiment but is careful to warn that growth can be a double-edged sword.

'The biggest challenge to continued growth in Tasmania is the skills gap. We can't just recruit a new physio because we've got excess demand. It takes such a long time.'

Belinda is well-versed in supply and demand principles. She left a stockbroking career over 10 years ago and has since pursued the unconventional path of health management. After joining a Hobart Back In Motion practice as practice manager in 2011 Belinda took the leap to franchisee, eventually opening the Rosny Park location in December 2014.

She feels that her unusual background has contributed to the success of the business. More than one year after opening, the practice has grown from two staff to eight, including one graduate employee. However, only one of the five employed physiotherapists was raised in Tasmania.

There are currently no physiotherapy courses offered in the state, meaning undergraduates from a related health discipline must travel interstate to do postgraduate study. Most related undergraduate degrees are only offered at University of Tasmania's Launceston campus, creating an additional barrier for some students. Many Tasmanian physiotherapy employers know all too well that if young people do leave for the mainland to study more specialised courses, their chances of returning decrease.

'I'm really confident about the future of our business, but if we lost one or two physios because they decided to move on, it's not like I could just put an ad in the paper and get a new physio tomorrow.'

TIPS FOR MANAGING A PRACTICE

Be prepared to work long hours in your first few months

Reach out to your local community via sponsorship or volunteering

Use your personal connections to create word-of-mouth referrals

Know your strengths: a combination of clinical and non-clinical expertise works well

Value your staff– you can't grow without them

Prepare for the worst: timelines will blow out and things will go wrong

Despite this challenge, Belinda has no regrets about her change of career path.

'It's a completely different environment to work in, rather than coming to work and finding you've either made or lost someone a million dollars.'

Physiotherapy part of the return-to-work picture

With data showing that physiotherapists have a positive impact on return-to-work outcomes, WorkSafe Victoria is encouraging more physiotherapists to work with compensables clients, just as physiotherapist **Giac Du** does.

Giac Du, a private practice physiotherapist in Melbourne's west, writes more return-to-work certificates than any other physiotherapist in Victoria. He attributes his high rate of certification to good communication with GPs and feeling confident about working in the compensables system. Giac completed WorkSafe Victoria's Occupational Physiotherapy Program that outlines the process and requirements of certification, best practices, and tips for navigating the system.

'I learnt a lot about how you communicate with the doctors, the employers and the patient,' he says.

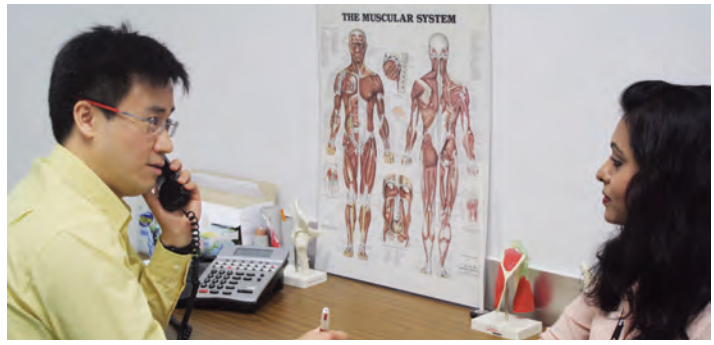
Now, Giac has well-established relationships with several doctors who are repeat referrers. They also encourage newer doctors at their clinics to refer return-to-work assessments to him.

Despite physiotherapists in Victoria being able to write subsequent certificates after a doctor or specialist writes the initial one, rates of certification are still low, with GPs writing the bulk of certificates. However, physiotherapists' training puts them in a position to make good assessments of people's functional status and deliver better long-term outcomes, according to Paul Coburn, Clinical Lead – Allied Health at WorkSafe Victoria.

'Physiotherapists have a lot of great skills, but one of their most underrated is their ability to assess function. If they can pick the function correctly, the person is more likely to be able to get back to work in a safe way,' he says.

From 2008 to 2013, Victoria implemented a trial physiotherapy provider network, the Occupational Physiotherapy Program, that trained selected physiotherapists and compared their patients' outcomes with those of physiotherapists who hadn't completed the training. Compensation costs were also measured.

WorkSafe's data showed that average medical costs and income support costs were lower among the providers they had trained, despite a fee increase for physiotherapists. Patients were also more likely to return to work if they were seen by an Occupational Health Program physiotherapist, with patients 1.8 times more likely to have returned to work after three months and 3.3 times more likely after six months. Based on these positive outcomes, WorkSafe would like to see more physiotherapists writing certificates in Victoria.



Giac Du puts his high rate of return-to-work certification down to good communication skills.

'Currently, physiotherapists are writing about four and a half per cent of all certificates, which is still a small amount but it's gone up considerably in the last six years,' Paul says.

In addition to online training and forthcoming webinars by Harry Papagoras, APAM, WorkSafe are encouraging physiotherapists to build positive relationships with GPs, as Giac has done.

'Working in the compensables system is not about learning brand new physiotherapy skills. It's just superimposing work on that,' Paul says.

For Giac, the pay-off is in getting people back to work sooner.

'I want patients to get on with life again, because when something develops into a chronic problem, their psychological profile blows out of the water. And it's going to be really hard to get them back to work.'

Advocating for tomorrow

Photo: ©iStock.com/Courtney Keating

'We need to educate more people about the breadth of our profession, including our expertise, level of education and professional achievements.'

I am delighted to contribute to the future of physiotherapy through my new appointment to the Victorian Branch Council. I'm passionate about our profession and I hope to be able to advocate for our benefit.

Although my substantive professional work is now non-clinical, I have maintained close links with my physiotherapy networks—we are a small community after all. My physiotherapy career includes five years in Ballarat, where I gained an appreciation for rural healthcare, as well as roles in two of Melbourne's largest metropolitan health services, where I cemented my adult and paediatric critical care skills. I continue to work on weekends in these settings. In addition to my public sector experience, I have also worked in remote Australia in industry, addressing workplace health, injury and safety.

Complementing my broad clinical experience, I hold a Master of Public Health, which I pursued due to my interest in broader policy and my desire to influence the 'big picture' in health. This qualification has developed my skills in advocacy and allowed me to work in a number of health-focused organisations in policy and projects, including during the evolution of Primary Health Networks from Medicare Locals (and Divisions of General Practice prior to this).

All of this has given me a strong understanding of the reform process, the current state and federal political landscape, and how this landscape relates to health.

There are a number of key issues facing Australian physiotherapists. We are a highly skilled and diverse workforce that is able to influence health outcomes across the continuum of care, including prevention. However, we must establish greater recognition of the valuable role we play—and have the potential to play—in health. To achieve this, we need to educate more people about the breadth of our profession, including our expertise, level of education and professional achievements.

We need better support to work to our full scope of practice and safely extend this, consistent with evidence. The under-utilisation of physiotherapists is particularly relevant in the current fiscal environment, which demands service efficiencies and productivity improvements with little other policy support.

The potential for physiotherapy is largely unrecognised in the Australian context, and I am grateful for the opportunity to represent my colleagues in our shared work to shape the future of health outcomes and service provision.

I encourage all APA members to get in touch with your Branch Council on these or any other issues you'd like addressed.

Weif Yee, APAM
VIC Branch Councillor

Pain on the agenda

Dr **Stephanie Davies** of WA Specialist Pain Services, which delivers Painless Clinics, will be presenting at the upcoming APA WA Symposium on the pharmacological and behavioural options of managing pain. Emma Breheny spoke with Stephanie about her upcoming presentation and the current issues in pain management.

Stephanie Davies' training as an anaesthetist gives her a thorough understanding of the medical options that can complement behavioural strategies for managing pain. It's these two threads that she wants to bring together in her presentation to physiotherapists at the WA Symposium.

'The main focus will be explaining conventional medical options that have been shown to benefit patients and have a relatively low risk profile.

'However, I'll also be focusing on behavioural options, including many pain strategies that a lot of physiotherapists would already be aware of and be teaching their patients, as well as other behavioural strategies that might more traditionally sit with other healthcare professionals.'

Stephanie has worked very closely with physiotherapists in her clinical practice and, in 2007, she developed a two-day pain program, Self-Training Educative Pain Sessions (STEPS), at Fremantle Hospital's pain medicine unit. The program taught referred patients behavioural skills to assist them in managing their own pain, while partners and carers were invited along to understand pain and its management.

A multidisciplinary team made up of a physiotherapist, clinical psychologist, occupational therapist and pain doctor worked with patients in a group setting, which was both cost-effective and provided a peer-to-peer learning model. The group environment also addressed any social isolation that some patients may feel.

Since it began, the STEPS model has been the subject of two papers in *Pain Medicine* and has been replicated in at least eight sites around the country, with more to follow.

Stephanie believes that communication with the patient and among health professionals is the major factor that determines success in multidisciplinary care.

'If a healthcare professional discusses with the patient how important it is to get the appropriate level of expertise, and that this may be from a range of healthcare professionals, I find patients are fairly open to that approach. But if it's not mentioned I don't think patients will necessarily know this approach has benefits.

'If we all understand what we're doing between us, we can explain it to the patient. And I think that makes the patient feel more secure,' she explains.

At the WA Symposium, Stephanie is hoping to impart some of the lessons learned through STEPS to the physiotherapists present. 'Traditionally, as a doctor, you discuss a lot of pharmacological and sometimes procedural options with patients, but if you combine those more effective treatments with good behavioural strategies, patients actually do a lot better.

'I want to get that combination to happen almost as a routine for all patients.'

She will be outlining the pharmacy options appropriate for different types of pain, what's new in medication, what pain procedures are available and when they are appropriate, and how to use triage processes to improve management. She will also mention incorporating technology like web-based apps, wearables and mobile phones.

'In the next 10 years, I'd love to see us using technology to implement the evidence-based practices that we know are most useful for the patient, and hopefully are the most cost-effective for them and the system,' Stephanie says.

Her passion for innovation and practice-based solutions have led her to write a book (Rewire Your Pain), edit the Australian Pain Society's newsletter, deliver presentations to consumers and establish educational websites like PainHEALTH.

On her upcoming presentation, she says, 'If I go listen to a physiotherapy talk I'll often learn more than if I go to a medical talk. So I'm hoping that will be the case for physiotherapists in this instance.'

GET BEHIND YOUR PROFESSION

WA APA Branch Awards are open for nominations, with all entries due by 9 April.

Branch Awards recognise the contribution that local physiotherapists make to the profession and to the wider community. Awards like these are a useful way to send a message to the community about the importance and significance of physiotherapy.

Some of WA's most prominent and well-respected physiotherapists have received these awards. Recipients tell me that they feel that their effort is appreciated and they feel empowered to continue with projects and research. More materially, a WA Branch Award raises a recipient's profile and opens doors for future opportunities. It is with excitement and enthusiasm that I encourage physiotherapists from WA to come forward and nominate for the awards.

The awards happen every two years, with categories including physiotherapy research, education, outstanding contribution for rural and regional physiotherapy, and Aboriginal and Torres Strait Islander health. Potential recipients are encouraged to nominate themselves, so please put aside your modesty and shine a light on the excellent work of our profession. After all, healthcare is changing and we must ensure our work is respected into the future.

Rahul Madan, APAM
WA Branch President

For full event descriptions and registration, go to **physiotherapy.asn.au/events.**
Pre-registration for all events is essential.

T.P Titling pathway
NEW New product

Clinical and special interest areas

Acupuncture and dry needling

Type	Title	CPD Hours	Date/s	Location	State
Course	Acupuncture, muscles and pain	16	2–3 April	Kent Town	SA
Course	Musculoskeletal segmental and dry needling for physios	16	28–29 May	Silverwater	NSW
Course	Acupuncture, muscles and pain	16	25–26 June	Nedlands	WA

Aquatic

Type	Title	CPD Hours	Date/s	Location	State
Course	Aquatic physiotherapy Level 1	16	9–10 April	Heidelberg West	VIC
Course	Aquatic physiotherapy Level 2 unit A: applied physics	8	18–29 April	Online	NAT
Course	Ai Chi workshop: integrated meditation, movement and relaxation	8	30 April	Heidelberg West	VIC
Course	Aquatic physiotherapy Level 2 unit B : applied physiology	8	9–25 May	Online	NAT
Course	Aquatic physiotherapy Level 2 unit C: clinical reasoning	8	27 May–7 June	Online	NAT
Course	RLSSA hydrotherapy rescue update	4	15 June	St Albans	VIC
Course	Aquatic physiotherapy Level 1	16	16–17 July	Randwick	NSW
Course	Aquatic physiotherapy Level 1	14	23–24 July	Nedlands	WA

Cardiorespiratory

Type	Title	CPD Hours	Date/s	Location	State
Course	Cardiorespiratory physiotherapy Level 1 T.P	16	16–17 April	Herston	QLD
Course	Cardiorespiratory physiotherapy Level 1 T.P	16	16–17 April	Nedlands	WA

Continence and women's health

Type	Title	CPD Hours	Date/s	Location	State
Lecture	Facilitating optimal breastfeeding	1	4 April	Silverwater	NSW
Lecture	Musculoskeletal conditions in pregnancy and postnatal period	1.5	14 April	Camberwell	VIC
Course	The lactating breast for physiotherapists: part 1	19	29 April–1 May	Meadowbrook	QLD
Lecture	An evening with Dr Tonia Mezzini—sexual health physician	1.5	2 May	Kent Town	SA
Course	Male pelvic floor, continence and prostate surgery NEW	8	14 May	Eight Mile Plains	QLD
Course	Continence and women's health Level 1 T.P	17.5	20 May	Kent Town	SA
Course	Continence and women's health Level 1 T.P	17.5	20–21 May	Kent Town	SA
Course	Update on RTUS for core and pelvic floor assessment	3.5	28 May	Sydney	NSW
Course	The lactating breast for physiotherapists: part 1	19	24–26 June	Kent Town	SA
Lecture	Dietary management of pelvic pain disorders and IBS	1.5	5 July	Kent Town	SA

Emergency department

Type	Title	CPD Hours	Date/s	Location	State
Course	Emergency department physiotherapy Level 1	18	18–19 June	Camberwell	VIC

For full event descriptions and registration, go to **physiotherapy.asn.au/events.**
Pre-registration for all events is essential.

Gerontology

Type	Title	CPD Hours	Date/s	Location	State
Lecture	Tai Chi for health and falls prevention	1.5	5 April	Silverwater	NSW
DVD	Prevention of falls in hospitals	1.5	11 April	RHH, MCH, NWRH and LGH	TAS
Course	Introduction to vestibular rehabilitation in adults of all ages	15	6–7 May	Nedlands	WA
DVD	Prevention of falls in hospitals	1.5	15 April	Sale	VIC
Course	Gerontological physiotherapy Level 1 T-P	17	21–22 May	Eight Mile Plains	QLD
Course	Manual handling in aged care	8	28 May	TBA	SA
Course	Introduction to vestibular rehabilitation in adults of all ages	15	18–19 June	Callaghan	NSW
Course	Soft tissue massage for older people NEW	6	2 July	Silverwater	NSW
Course	Gerontological physiotherapy Level 1 T-P	17	9–10 July	Kent Town	SA
Course	Gerontological physiotherapy Level 2 T-P	16	23–24 July	Bentley	WA

Musculoskeletal

Type	Title	CPD Hours	Date/s	Location	State
Course	Practical physiotherapy management for low back pain	15	16–17 April	Eight Mile Plains	QLD
Course	Spinal physiotherapy Level 2 T-P	25	16–17 April and 30 April–1 May	Parkville	VIC
Course	The everyday foot and ankle	7	30 April	Silverwater	NSW
Course	Jenny McConnell's approach to problem shoulders	16	30 April–1 May	Merimbula	NSW
Course	Spinal physiotherapy Level 2 T-P	32	14–15 May and 4–5 June	Townsville	QLD
Course	Optimising 3D biomechanics of the pelvis and lumbar spine	16	14–15 May	Kent Town	SA
Course	Spinal physiotherapy Level 1 T-P	32	21–22 May and 18–19 June	St Leonards	NSW
Course	A dynamic approach to the assessment and treatment of the pelvis and hip region: part 1	7	28 May	Parkville	VIC
Course	A dynamic approach to the assessment and treatment of the pelvis and hip region: part 2	7	29 May	Parkville	VIC
Course	Assessment and management of pain in clinical practice	14.25	4–5 June	Camberwell	VIC
Course	Practical physiotherapy management for low back pain	15	18–19 June	Perth	WA
Course	Spinal physiotherapy Level 1 T-P	32	18–19 June and 2–3 July	St Albans	VIC
Course	Mulligan's lower quarter	17	18–19 June	Adelaide	SA
Course	Assessment and management of pain in clinical practice	14.25	25–26 June	Eight Mile Plains	QLD
Course	Functional anatomy and biomechanics of the upper limb	9.5	9 July	Crawley	WA

Neurology

Type	Title	CPD Hours	Date/s	Location	State
Lecture	An overview of management of adult acquired hypertonia	2	1 April	Nedlands	WA
Course	Functional electrical stimulation—upper and lower limb NEW	3.5	8–10 April	Daw Park	SA
Course	Working with people with ataxia	15	16–17 April	St Lucia	QLD
Lecture	Walking after stroke—from ED to community	2	4 May	Bruce	ACT
Course	Introduction to vestibular rehabilitation in adults of all ages	15	6–7 May	Nedlands	WA
DVD	The musculoskeletal shoulder versus the neurological shoulder	1.5	9 May	RHH, MCH, NWRH and LGH	TAS
Course	Neurosensory motor development in children NEW	15	13–14 May	Randwick	NSW
Lecture	Progressive ataxias—an overview and update	1.5	23 May	Camberwell	VIC
Course	Introduction to vestibular rehabilitation in adults of all ages	15	18–19 June	Callaghan	NSW
Course	What is normal movement? pelvis, spine and thorax	14.5	9 July	Sydney	NSW

PROFESSIONAL DEVELOPMENT

For full event descriptions and registration, go to **physiotherapy.asn.au/events.**
Pre-registration for all events is essential.

T.P Titling pathway
NEW New product

Occupational health

Type	Title	CPD Hours	Date/s	Location	State
Course	Occupational health physiotherapy Level 1 T.P	15	22–23 April	Camberwell	VIC
Course	Occupational health physiotherapy Level 1 T.P	15	4–5 June	Kent Town	SA
Course	Occupational health physiotherapy Level 1 T.P	15	17–19 June	Silverwater	NSW
Course	Occupational health physiotherapy Level 1 T.P	15	18–19 June	Rockhampton	QLD
Lecture	New directions in ergonomics	1	13 July	Melbourne	VIC

Orthopaedic

Type	Title	CPD Hours	Date/s	Location	State
Course	Basic plaster	7.5	16 April	Port Macquarie	NSW
Course	Synthetic casting	7.5	17 April	Port Macquarie	NSW
Course	Assessment and management of pain in clinical practice	14.25	4–5 June	Camberwell	VIC
Lecture	Understanding total knee replacement—arthrokinematics	1.5	22 June	Deakin	ACT
Cowurse	Assessment and management of pain in clinical practice	14.25	25–26 June	Eight Mile Plains	QLD

Paediatric

Type	Title	CPD Hours	Date/s	Location	State
Course	Paediatric physiotherapy Level 1 T.P	16	9–10 April	Bentley	WA
Course	Neurosensory motor development in children NEW	15	13–14 May	Randwick	NSW
DVD	Persistent pain in paediatrics	1.5	4 July	RHH, MCH, NWRH and LGH	TAS
Course	Paediatric physiotherapy Level 1 T.P	16	9–10 July	Camberwell	VIC
Lecture	Paediatric continence	2.5	9 July	Eight Mile Plains	QLD

Pain

Type	Title	CPD Hours	Date/s	Location	State
Dinner	Illawarra dinner lecture—complex pain x2 lectures	3	7 April	Wollongong	NSW
Lecture	Using psychology in pain management	1	7 April	St Leonards	NSW
Course	Practical physiotherapy management for low back pain	15	16–17 April	Eight Mile Plains	QLD
Course	Assessment and management of pain in clinical practice	14.25	4–5 June	Camberwell	VIC
DVD	Pain and movement reasoning model—covering all the angles	1.5	6 June	RHH, MCH, NWRH and LGH	TAS
Course	Practical physiotherapy management for low back pain	15	18–19 June	Perth	WA
Course	Assessment and management of pain in clinical practice	14.25	25–26 June	Eight Mile Plains	QLD

Sports

Type	Title	CPD Hours	Date/s	Location	State
Course	Foot and ankle in dance	8	16 April	Kent Town	SA
Course	Sports physiotherapy Level 1 T.P	17	16–17 April	Camberwell	VIC
Course	Sports physiotherapy Level 1 T.P	18	16–17 April	Warners Bay	NSW
Course	Practical physiotherapy management for low back pain	15	16–17 April	Eight Mile Plains	QLD
Lecture	Student sports career lecture	1.5	19 April	Bruce	ACT
Course	Sports physiotherapy Level 2 T.P	30	29 April–1 May	Camberwell	VIC
Course	Sports physiotherapy Level 1 T.P	17	30 April–1 May	Bentley	WA
Course	Sports physiotherapy Level 2 T.P	30	6–8 May	Darwin	NT
Course	Foot and ankle in dance	8	7 May	Sydney	NSW
Lecture	Student event: soft tissue techniques for student physios	2	11 May	Bruce	ACT
Course	Lower limb tendinopathy	9	21 May	Silverwater	NSW

For full event descriptions and registration, go to **physiotherapy.asn.au/events.**
Pre-registration for all events is essential.

Course	Foot and ankle in dance	8	21 May	Melbourne	VIC
Course	The sporting spine	16	21–22 May	Newcastle	NSW
Course	Screening and conditioning for dancers NEW	6	22 May	Camberwell	VIC
Course	The sporting elbow, wrist and hand		1 June	Sydney	NSW
Course	Assessment and management of pain in clinical practice	14.25	4–5 June	Camberwell	VIC
Course	Sports physiotherapy Level 1 T-P	16.5	11–12 June	Rockhampton	QLD
Course	Practical physiotherapy management for low back pain	15	18–19 June	Perth	WA
Course	Assessment and management of pain in clinical practice	14.25	25–26 June	Eight Mile Plains	QLD
Course	Sports physiotherapy Level 2 T-P	30	8–10 July	Silverwater	NSW
Course	Level 1 ASCA Strength and Conditioning Coaching		22 May	Brisbane	QLD

Student

Type	Title	CPD Hours	Date/s	Location	State
Lecture	Basic taping	1	4 April	Kent Town	SA
Lecture	Advanced taping	2	5 April	St Lucia	QLD
Lecture	Student sports career lecture	1.5	19 April	Bruce	ACT
Lecture	Vestibular disorders	2	19 April	Banyo	QLD
Lect ure	Vestibular disorders	2	10 May	St Lucia	QLD
Lecture	Neurodynamics	2	25 May	Kent Town	SA
Lecture	Taping of the knee	1	6 June	Kent Town	SA

For full event descriptions and registration, go to **physiotherapy.asn.au/events.**
Pre-registration for all events is essential.

T.P Titling pathway
NEW New product

Professional interest events

Type	Title	CPD Hours	Date/s	Location	State
Lecture	Graduate awards	1.5	6 April	Hackney	SA
Lecture	Treating the industrial athlete	2	28 April	Eight Mile Plains	QLD
Lecture	Bringing the care home—a team approach	1.5	12 May	Eight Mile Plains	QLD
Symposium	WA Branch Symposium	9	21 May	Bentley	WA
Symposium	NSW Symposium	9	25 June	Rosehill	NSW
Dinner	Illawarra dinner lecture: complex pain x 2 lectures	3	7 April	Wollongong	NSW
DVD	Spondylolisthesis assessment and management	2	4 April	Mildura	VIC
DVD	Parkinson's—putting theory into practice	1.5	2 May	Mildura	VIC
DVD	Diving into the customer's mind	1.5	6 June	Mildura	VIC

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Category	Title	CPD Hours
Course	Entire mentoring series: 20 modules	30
Course	KALSI clinical education series	14
Course	Masterclasses in musculoskeletal clinical reasoning—Bill Vicenzino	1.5
Member Value Webinar	Exploring social media in physiotherapy—risk management tips and developing a social media policy for your organisation	1
Webinar	Tendinopathy management and rehabilitation update	1

Male pelvic floor, continence and prostate surgery

CPD hours: 8

14 May: Brisbane, QLD and 22 October: Melbourne, VIC
This is an advanced course for pelvic floor and continence physiotherapists on the assessment and treatment of male incontinence and pelvic pain.

Topics covered will include:

- anatomy of the male pelvic floor
- diagnosis and management of prostate cancer by a urologist
- physiotherapy assessment of the male pelvic floor
- treatment of post prostatectomy incontinence
- pelvic floor muscle training in men
- pelvic pain in the male pelvis
- erectile dysfunction.

Occupational health physiotherapy Level 1

CPD hours: 15.5

8–9 April: Melbourne, VIC; **4–5 June:** Adelaide, SA; **17–18 June:** Sydney, NSW; **18–19 June:** Rockhampton, QLD and **18–19 November:** Melbourne, VIC

This course provides a solid and valuable grounding in the growing field of occupational health physiotherapy (OHP). It is a mandatory component of the experiential titling pathway in OHP.
At the completion of this course, you should be able to:

- identify the professional performance standards for OHP
- describe key statements of relevant workplace health and safety legislation in Australia
- describe and understand the principles of risk management and hierarchy of risk control
- identify key criteria for performing worksite assessment and job safety analysis.

Course	Website	Phone
Active release technique—upper limb, lower limb, spine	Peak sports and spine centre	07 3399 3318
Acupuncture and dry needling	precisepoints.com.au	0439622030
Advanced knee course—diagnoses and rehabilitation	ersportsphysio.com.au	0433 214 623
Cardiorespiratory physiotheray (CROP) overseas-qualified physiotherapists		07 3646 6504
Dry needling advanced course	info@cpdhealthcourses.com	03 9589 3777
Dry needling techniques	info@cpdhealthcourses.com	03 9589 3777
Essentials of effective scoliosis management	scolicare.com.au/seminars	1300 883 884
Evidence-based relaxation	artandscienceofrelaxation.com	0419 433 961
Forget about the upper limb patterns—the foundation of trunk control through the PNF approach (introduction to PNF)	pnfaustralia@bigpond.com	02 9382 4784
Gait rehabilitation and retraining	smartmovement.com.au	
Heartmoves for falls prevention	heartmoves.org.au	03 9693 9777
Heartmoves for people with multiple sclerosis	heartmoves.org.au	03 9693 9777
Heartmoves for stroke	heartmoves.org.au	03 9693 9777
Heartmoves leader training course	heartmoves.org.au	03 9693 9777
Heartmoves practical leader training workshop	heartmoves.org.au	03 9693 9777
Inflammatory arthritis education and self-management program	Arthritis WA	08 9388 2199
Innovations in hip and knee arthritis	admin@selsie.com.au	
Kinesiology and power taping course (Rocktape): full day	rocktape.com.au	0406 109 041
Kinesiology and power taping workshop (Rocktape): half day	rocktape.com.au	0406 109 041
Mental health first aid standard course	mhfa.com.au	
Musculoskeletal anatomy for exercise practitioners	a.johnstoncraig@uq.edu.au	
Neurogym—evidence-based exercises for brain and body	neurogymfitness.com	
Neuromuscular dry needling Level 1	dryneedlingcourses.com	0405 014 123
Neuromuscular dry needling Level 2	dryneedlingcourses.com	0405 014 123
Neuromuscular dry needling lower limb specifics	dryneedlingcourses.com	0405 014 123
Online X-ray—acute interpretation in physiotherapy	lightboxradiology.com.au	07 5449 2717
Optimising 3D biomechanics of pelvis and lumbar spine: assessment and treatment	bbclasses.com.au	
Physiotherapy and critical care management (PaCCMan)	Clinical Skills Development Services	07 3646 6500
Physiotherapy X-ray interpretation in conjunction with emergency X-ray interpretation	lightboxradiology.com.au	07 5449 2717
Pulmonary rehabilitation training	lungfoundation.com.au	1800 654 301
Risk management course for patients with abnormal breast structures	niim.com.au	03 9804 0646
Splinting and casting workshop for the upper and lower limb	cerebralpalsy.org.au	1300 136 140
Trigger point dry needling: advanced	gemtinfo.com.au	03 9583 5248
Trigger point dry needling: introductory	gemtinfo.com.au	03 9583 5248

2016 Professional Development Courses

NEW: Neurosensory motor development in children

At the completion of this course, you will:

- learn about assessing neurosensory motor development in infants and children
- understand the classification of motor developmental performance
- find out how tests can be used in research
- grow your career in neurology or paediatric physiotherapy.

Date	Location
13–14 May	Sydney, NSW

For more information and to register, visit physiotherapy.asn.au/events

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

LDPD13

2016 Professional Development Courses

Assessment and management of pain in clinical practice

This specially designed course for musculoskeletal, orthopaedic and sports physiotherapists is now going national. Improve your skills in assessing and treating acute and chronic pain as you learn about:

- subjective and objective information relating to pain
- risk factors for the development of persistent pain
- management plans that reflect pain's complexity
- specific strategies for assessment and treatment.

Date	Location
4–5 June	Melbourne, VIC
25–26 June	Brisbane, QLD
13–14 August	Darwin, NT
8–9 October	Perth, WA

For more information and to register, visit physiotherapy.asn.au/events

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

LDPD05

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PORTUGAL September 2016

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Instructors: Kim Robinson, Dr Toby Hall

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If you work in a clinic that regularly uses exercise therapy, these workshop series should not be missed.

Presenter, Dr. Henry Wajswelner is a specialist Sports Physiotherapist working in sports and spinal for over 30 years. His past working history includes the AIS.

Co-presenter, Domenic Trimboli is an expert in 'end-stage' rehabilitation. He has over 25 years experience having worked exclusively with elite Australian athletes.

Co-presenter, Frank Care is and APA Sports Physiotherapist and currently completing his Clinical Doctorate at La Trobe University in exercise rehabilitation for chronic spinal pathologies.

Presenters

Dr. Henry Wajswelner
Frank Care
Domenic Trimboli

Cost

$399 per module
morning, lunch and afternoon tea provided

PD Points

7 per module

Workshops

Module A
Lumbar spine

Module B
Thoracic/cervical spine

Module C
Shoulder joint

Module D
Hip gluteal tendinopathy

Dates

Melbourne	
March 19th	Lumbar spine
March 20th	Thoracic/cervical spine
May 28th	Shoulder joint
May 29th	Hip gluteal tendinopathy
Sydney	
April 30th	Lumbar spine
May 1st	Thoracic/cervical spine
October 22nd	Hip gluteal tendinopathy
Adelaide	
April 16th	Lumbar spine
April 17th	Thoracic/cervical spine
August 20th	Shoulder joint
August 21st	Hip gluteal tendinopathy
Perth	
July 23rd	Lumbar spine
July 24th	Hip gluteal tendinopathy
Brisbane	
August 6th	Lumbar spine
August 7th	Hip gluteal tendinopathy

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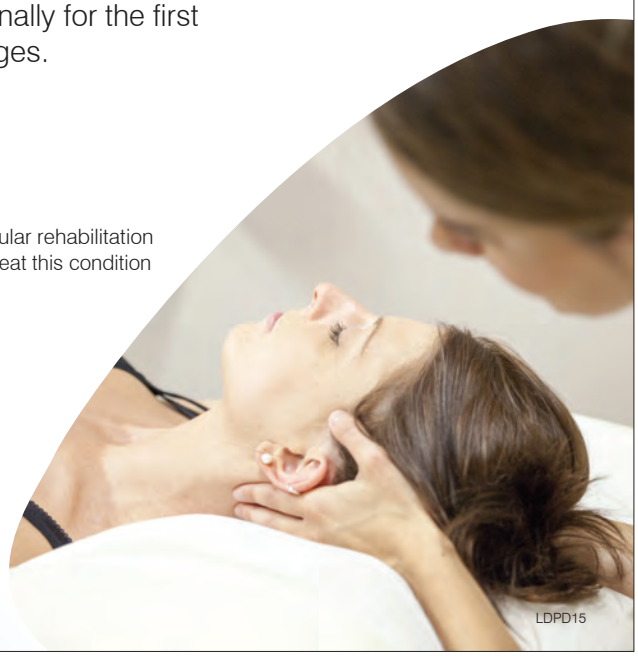

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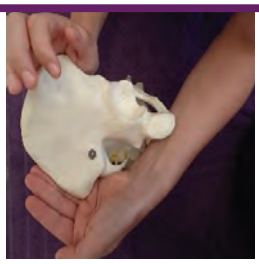

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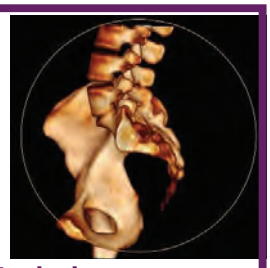

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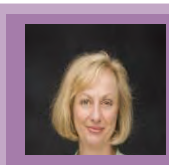

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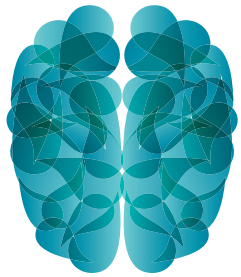

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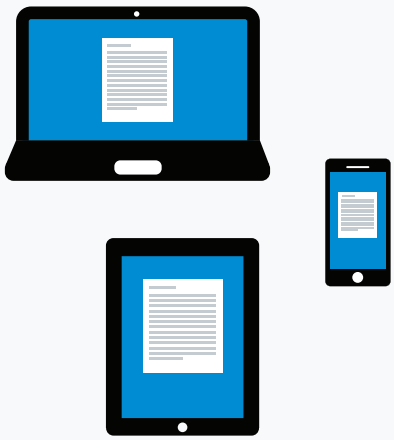

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Chronic low back pain

As part of the Australian College of Physiotherapists specialisation process, candidates must undertake a case study. Here, **Michelle du Plessis** underlines the need for a therapist to utilise the biopsychosocial approach when treating one of the most common musculoskeletal injuries.

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Low back pain (LBP) is the leading specific cause of years lived with disability (Morlion 2013). It is the most common musculoskeletal pain complaint and the most common reason for medical visits (Deyo et al 2009). Chronic low back pain (CLBP) affects 20–30 per cent of the population and is often characterised by high levels of disability and pain (Morlion 2013). Current Western practice demonstrates an increasing reliance on radiological imaging that direct biomedical management options, such as the use of spinal injections, opioid analgesics, medications, and spinal surgery (Morlion 2013, Deyo et al 2009). This has resulted in escalated levels of disability in association with a blow-out in costs (Deyo et al 2009).

This trend is in spite of a greater understanding of pain science coupled with clinical practice guidelines recommending self-management of CLBP, including physical activation and behavioural approaches (Gatchel et al 2007). There is growing evidence that pain and disability associated with CLBP is driven by a complex combination of neurophysiological, psychological, and unhelpful physical and lifestyle behaviours (Gatchel et al 2007, O'Sullivan 2014). Current research suggests that directing management of these modifiable factors may result in better outcomes (Gatchel et al 2007, O'Sullivan 2014, Vibe et al 2013, Schutze et al 2014).

Clinical presentation

A 75-year-old retired male engineer presented to physiotherapy via referral from his pain specialist, who requested an evaluation of his CLBP disorder and prescription of a self-management exercise program. At the time of initial consultation, the patient reported a 50-year history of CLBP and left-sided leg pain and weakness. The LBP started in his early 20s after falls off a motorbike.

The pain progressively increased and the first lumbar fusion was performed at L5-S1 and L5 laminectomy at age 35 with short-term benefit. However, the pain escalated and in 2011 another lumbar fusion from L1-S1 was performed due to the finding of multilevel lumbar spondylosis. The reported lumbar surgeries did not relieve the low back or leg pain. Three spinal cord stimulators were inserted between 2011 and 2013 and numerous epidurals, nerve root sleeve and facet-joint injections were given to manage the high levels of pain. Limited pain relief was reported from these procedures. Various analgesic medications were trialled, which provided limited pain relief. The patient attended a rehabilitation centre two years ago for six months with no significant benefit.

Over the last year, the patient had become more physically disabled. This was evident with his reduced ability to walk more than 10 metres without the aid of his walking stick, his inability to stand for more than a minute, and pain and difficulty when moving from sit to stand. He slept fairly well but avoided sleeping on his sides due to discomfort from the spinal cord stimulator battery packs.

During the clinical interview he reported constant bilateral 'crushing' low back pain rated 8–10/10 on the numeric pain rating scale (NPRS), with constant numbness/pain in the posterior aspect of left leg and plantar aspect of both feet. He described weakness of both legs with the left greater than the right. The pain was aggravated when extending his back, standing and walking. His coping strategies were lying or sitting down, smoking, drinking alcohol and using hot packs.

It also became evident during the examination that the patient had very specific thoughts and beliefs about his LBP. He thought that his bone would eventually become brittle and the internal fixation screws would pull out. At the time of assessment, he thought something was 'out' in his back. He reported feeling frustrated, angry, non-productive, useless and depressed. He reported that the pain caused him to become significantly less active, socially withdrawn, unable to enjoy his retirement, and resulted in his decision to sell his olive farm. His goals for treatment were to understand why pain has persisted, increase his activity levels, and have more manageable levels of pain.

Several questionnaires were utilised to measure different domains relevant to the patient's presenting problem. To summarise, the patient measured high on the domains of pain, depression, psychosocial and catastrophising. High levels of disability were measured with the Oswestry Disability Index (ODI), and low self-efficacy with the Pain Self-Efficacy Questionnaire (PSEQ). Pre- and post-outcome measures are reported in Table 1.

Table 1. Outcome measures after six months

DOMAIN	OUTCOME MEASURES	PRE	POST
Pain	Visual Analogue Scale	8/10	4/10
Disability	Oswestry Disability Index	56/100	32/100
Self-efficacy	Pain Self-Efficacy Questionnaire	19/60	52/60
Catastrophising	Pain Catastrophizing Scale	29/52	8/52
Depression/anxiety/ stress	Depression Anxiety and Stress Scale	22/42	1/42
Multidimensional screening	Short Form Orebro	72/100	33/100
Sensory profile	Cold testing (ice cube) R L4-S1 – NPRS Forward bending Light palpation R L4-S1	8/10 8/10 8/10	2/10 0/10 0/10
Physical activity	Walking with stick	10m	1km

Physical examination

The key findings were:

- pain-related functional behaviours—including provocative movements (sit to stand [STS]), walking, bending—were associated with high levels of trunk muscle co-contraction, protective behaviours (eg, using arm rests) and breath-holding/rapid apical breathing and increased pain
- pain behavioural tests of body relaxation and diaphragmatic breathing reduced his resting pain in supine. Abolishing pain behaviours of breath-holding, and propping with hands with moving from STS, also reduced his pain experience
- neurological examination found bilateral absent reflexes of L5/S1 and left L3/4. Pain inhibition and general deconditioning limited valid objective findings regarding power. Reduced light and sharp touch in bilateral L5 and S1 dermatomes
- sensory testing identified widespread but non-dermatomal allodynia and hyperalgesia. These findings indicate a mixed pain presentation with central and peripheral mechanisms.

Diagnosis

The diagnosis of chronic non-specific low back pain was confirmed. Contributing factors from different dimensions were identified. They included:

- cognitive—negative beliefs about his back, fear, catastrophising, hypervigilance, passive coping strategies, low levels of self-efficacy
- psychological—low mood, pain-related anxiety
- social—socially isolated

- lifestyle—low activity levels, smoking, alcohol
- physical factors—maladaptive, protective and fear-avoidant movement behaviours, deconditioned
- neurophysiological factors—a mixed pain pattern with signs of dominant central pain mechanisms.

Management

Multiple contributing factors were identified which informed an individualised cognitive functional therapy (CFT) approach targeting the patient's beliefs, emotions, coping strategies, as well as his functional and lifestyle behaviours. The cognitive component of management addressed his negative thoughts and beliefs. A personalised explanation was given to the patient regarding the persistent nature of his pain. It was explained to him that his thoughts, fears, frustrations, behaviours and inactivity had resulted in a vicious cycle of pain and disability, causing increased sensitisation of the nervous system (O'Sullivan 2014, Nijs et al 2014). Pain-related behaviours were managed with body relaxation and normalising postural and movement behaviours. He was encouraged to increase his daily physical activity levels (stationary cycling and walking) and to resume previous hobbies and interests (eg, sculpting, consulting). This was introduced in a graded manner with respect to his pain sensitivity profile. The patient was seen on average for 30 minutes twice a week over a six-month period.

Outcome

At the end of six months of rehabilitation, the patient reported less pain and disability, improved mood, reduced distress and fear, increased confidence, more control of his problem and less catastrophic thoughts and reduced stress (Table 1). At the end of the six-month intervention, the patient was able to walk daily for one kilometre and do 30 minutes on the stationary bike. All of the domains measured showed a greater improvement than the minimal clinically important change of 30 per cent (Balague et al 2012).

Discussion

This case describes a patient with a 50-year history of CLBP, which culminated in him having a multilevel fusion L1-S1 in 2010 with subsequent interventions and surgeries. These approaches focused on treating patho-anatomical aspects of the patient's problem and symptom palliation. Contemporary evidence suggests that following diagnostic triage, optimising treatment success in patients with chronic pain, multiple dimensions (eg, cognitive, emotional, behavioural and neural processing) should be targeted in their management (Gatchel et al 2007), while considering the person's general health and comorbidities (Koes et al 2010).

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Several biopsychosocial factors were identified during assessment that were considered significant contributors to the patient's presentation using valid and reliable measures for reassessment (Balague et al 2012, Fishbain et al 2013, Dagfinrud et al 2013). Epidemiological studies have demonstrated that psychological factors—such as unhelpful beliefs related to patho-anatomy, pain-related fear, catastrophising, low level of self-efficacy, and high levels of emotional distress—are prognostic of persistent pain and disability (Foster 2011). There is growing evidence that education from healthcare professionals focusing on a biomedical understanding of LBP can lead to misunderstandings and increased fear (Barker et al 2009, Bunzli et al 2013). The patient interpreted that degenerative changes in his back would result in the bones becoming brittle and the fusion pulling out of the bone. In the absence of these thoughts being addressed, the patient was convinced that the reason for the persisting pain in his back was the belief that 'something was out in his back', reinforcing his fear and protective behaviours.

On observation, the patient was hypervigilant, presenting with autonomic arousal (rapid apical breathing) and exhibited pain-related movement and postural behaviours in response to pain (Vlaeyen et al 2012). These included breath-holding, bracing of the back and abdominal wall, and propping with the hands during movement from STS. Research has demonstrated that these behaviours are associated with higher levels of catastrophising (Sullivan et al 2005). He avoided any weight-bearing activities (eg, walking/standing, which had led him to become very deconditioned). The widespread hyperalgesia and allodynia are an indication of centrally mediated pain (Nijs et al 2014). However, in spite of this, reassurance combined with body relaxation, and normalising his postural and

'This case demonstrates the need for a biopsychosocial perspective of CLBP in order to direct self-management at the modifiable drivers of pain and disability. Further research is needed to support the use of CFT in the management of persistent with the multilevel lumbar fusions.'

movement behaviours, resulted in immediate pain relief, reflecting his capacity to exercise control over his pain (O'Sullivan 2014). This may be reflective of underlying peripheral structural sensitisation.

Based on the clinical reasoning described above, the management approach selected was CFT, as it could comprehensively address all of the modifiable contributing factors to his problem (Vibe et al 2013, Vlaeyen et al 2000). The cognitive component of therapy was used to challenge the patient's maladaptive pain cognitions and perceptions, as this is crucial to improve motivation and adherence to the rehabilitation program (Nijs et al 2011). The patient was educated about his pain sensitivity and the persistent pain was explained to him as a vicious cycle being reinforced by his worry, distress, protective behaviours and inactivity. This provided him a personalised understanding of his CLBP, which has been proven to be successful in improving pain relief and pain self-efficacy (Nijs et al 2014). Motivational interviewing was employed to elicit reasons/goals for change from the patient, to create a sense of autonomy, and was done in a spirit of collaboration. This empowers the patient and builds a strong therapeutic alliance (Hall & Lubman 2012). The patient was reassured that his spine was strong, the fusion was safe and that pain does not equal harm.

The functional component of management targeted the pain-related functional behaviours. The patient participated in a tailored, graduated functional rehabilitation program, which addressed his maladaptive postures and movement behaviours and postures in a graded and mindful manner (Vibe et al 2013, Schutz et al 2014). Targeting the feared and pain-provocative postures and movements with body relaxation, and discouraging pain behaviours such as breath-holding, propping with hands and bracing when moving from STS, has proven to be effective in reducing pain and improving functional ability (O'Sullivan 2005). Breathing was consciously applied throughout rehabilitation as it proved to be effective in reducing pain and relaxing the trunk muscles. This is consistent with current evidence reporting that deep slow breathing is an important inhibitory pain modulator and has the ability to improve mood states (Busch et al 2012).

The final component of management was to integrate the cognitive and functional components into his daily life. Physical exercise was encouraged on a daily basis. This was an important part of his rehabilitation as it symbolised a change in his lifestyle and became part of his active coping strategies (May 2010). He was encouraged to gradually start to participate in previous enjoyable activities, such as sculpting, socialising and consulting. Incorporating this into the program was demonstrating to him that his goals were achievable and gave him a sense of control over his pain (Vibe et al 2013).

The outcome measures used reflected the patient's personal lived experience of CLBP.

All of the domains measured showed a greater improvement than the minimal clinically important change of 30 per cent (Balague et al 2012). It can be hypothesised that the patient's improvement was due to an individualised and holistic model of care, which empowered the patient, improved his pain self-efficacy and reduced his functional disability (Balague et al 2012, Gatchel et al 2007, May 2010, Helmhout et al 2010).

Conclusion

This case demonstrates the need for a biopsychosocial perspective of CLBP in order to direct self-management at the modifiable drivers of pain and disability. Further research is needed to support the use of CFT in the management of persistent pain in patients with multilevel lumbar fusions.

Michelle Du Plessis is completing her Specialist Musculoskeletal Fellowship at the Australian College of Physiotherapists. She currently holds a Master of Manual Therapy qualification and a postgraduate diploma in Sports Manual Therapy (both attained through the University of Western Australia).

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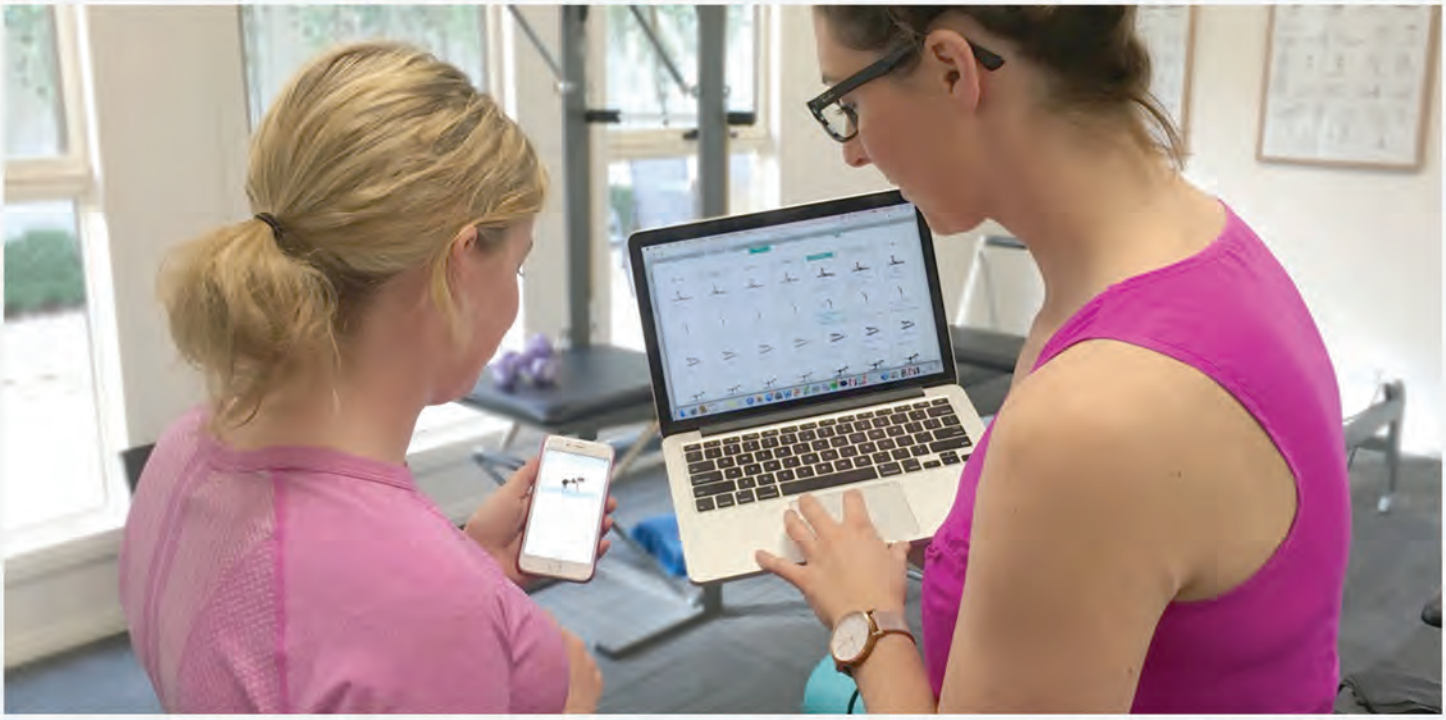

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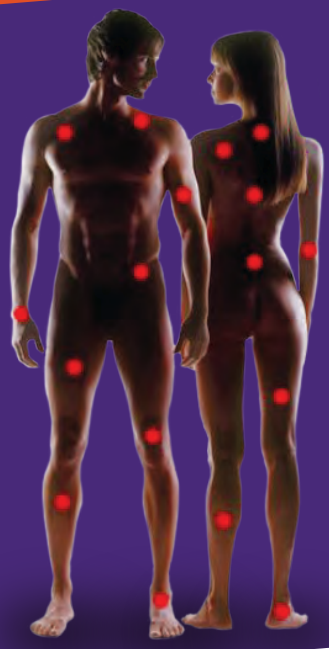

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