SIRA draft document submission – [redacted]

I write this submission as a P[redacted]

Our Workcover system is NOT working! Over the years I have seen many changes however there continues to be inefficiency, wastage of resources and money, and poor outcomes for injured workers.

I appreciate the effort that the ACI has gone to with this draft submission for the management of low back pain, however there are points which need to be raised. This draft is based on a similar current 'system' which in theory 'should' work however it really does not. I will outline the failures in the proposed system using real life examples of workers who have suffered low back injuries and how the 'system' has failed them. To be honest I am tired working in a system which repeatedly fails injured workers so this time I'm being completely honest with my observations.

The first failure in this system comes with Principle 1 – Assessment – history and examination. This seems like a simple concept however I can assure you that this is where the whole system falls apart. Most GPs do not have the skills to carry out a proper / thorough physical assessment of a person with low back pain. In my experience most clients who I have treated have said that the GP just asked them some questions and got them to 'bend forwards' before making a diagnosis. This is NOT a proper evaluation and from this point onwards the whole system then falls apart because the GP has not done the proper assessment. GPs are very good at screening for red flags, however when it comes to yellow flags and the physical assessment, they are not the experts. Physiotherapists have more skills compared with GPs when it comes to finding out the actual cause of back pain in injured workers. As well as this – extended times for patients to even get a GP appointment further exacerbate peoples back pain because they go for days without any intervention (increasing the risk of yellow flags in recovery).

Another issue with assessment is that the three pathways suggested for managing back pain do not encompass all sources of back pain. People are not robots – you can't just 'slot' them into a pathway for treatment and expect this to work. This is not individualised or person-centred care at all and it's concerning that people who do not have the skills to manage these injuries might read the document and try to 'manage' these injuries based on a flow chart.

"Non Specific acute low back pain" is a title given to anyone who basically doesn't fit into the other pathways. However these people could have a multitude of reasons for their back pain. It might include muscle spasm, facet joint pain, SIJ pain just to name a few. These are all treatable in a quick timeframe with evidence-based practice. Evidence based practice encompasses three areas: research, practitioner experience, and client beliefs and preferences. Evidence based practice for management of low back pain is not 'hands off' therapy as many people have been led to believe. This 'hands off' approach may be the flavour of the month in some circles however it basically ignores two of the areas of evidence-based practice and favours a handful of research studies who say that a 'hands off' approach should be used. I agree it should be used for people who have chronic, centralised back pain – however using this approach for acute management of a physical issue (eg muscle spasm) increases the risk of that client developing chronic pain. For example – client hurts back at work and has muscle spasm. The initial management of this person is really important and I'll outline this using two real examples from my practice:

1. Client has 1-2 sessions of Physiotherapy where they get some manual work aimed at pain relief, some taping, reassurance and education, and a home program; and then regular follow up in first two weeks. After two weeks their back pain is gone, they do another few weeks of an exercise program, then workplace assessment and back to work.

2. Client goes to GP who doesn't complete physical diagnosis and is supposed to provide education and advice however instead sends them for an x-ray (unwarranted). Gets x-ray results and tells the client "you have the back of an 80 year old" (true story – this still happens regularly despite everything we know about imaging and incidental findings). Three months later when client still has pain and now a magnitude of yellow flags the GP finally refers to Physiotherapy and we are stuck trying to help a person who now has chronic pain.

Principle 2 is Risk Stratification, including screening for yellow flags. We have routinely used Orebro for all compensable clients for years. In my experience however GPs do not conduct this screening. Moreso – GPs and case managers are not familiar with these tools and when results are reported to them (for example with a concerning score) and the Physiotherapist asks for further intervention this request is mostly ignored. This has happened multiple times in our practice in the last two years. GPs, case workers and rehabilitation consultants need more training in this area to understand what the Orebro is, what the figures mean and when to refer on. If you want people screened, then the 'system' must either insist GPs conduct this screening, or refer onto someone who will. And when poor results are flagged, there must be some action / follow up from this.

Principle 3 is Only image those with suspected serious pathology. In reality this does not happen! I have so many examples of clients who come to us and they have no red flags and already have imaging completed by the GP. This is an ongoing issue and despite the RACGP guidelines for management of low back pain being out for years recommending no imaging unless red flags. Then when it comes to interpretation of the x-ray / scan the GP is relating incidental findings as a cause of the persons pain and using unhelpful terminology such as the '80 year old back' comment. I can't understand why insurance companies continue to agree to x-rays when there are clearly no red flags.

Principle 4 Patient Education. This is a great point. Patient education is key. I would like to see further guidance for clinicians on this point because again – having this in the guideline doesn't necessarily mean clinicians are doing this. I don't like to put it all on GPs however most of them don't have the time to provide the education regarding back pain, home exercises, expected timeframes for improvement, what to do in certain situations (eg if they are better / worse). Physiotherapists generally have more time with their clients and in my experience provide way more education. There also needs to be more education around using unhelpful language with patients.

Principle 5 Cognitive Behavioural approach – agree with this, very important.

Principle 6 Active Physical Therapy Encouraged. I agree with the injured worker staying active however this shouldn't be confused with self-management or a hands-off approach. I have already outlined above why a hands-off approach is not evidence-based practice. Staying active comes through good education, regular monitoring and support. Self-management suggests that the injured worker will do this independently without help of a clinician. Leaving someone to self-manage without adequate support will result in poor pain beliefs, pain avoidance behaviour and they will be more likely to develop chronic pain.

Principle 7 Begin with simple analgesic medicines. This is good. Tell the GPs who prescribe opioids on the first visit! On the other hand – you need to offer workers some form of pain relief and this is where Physiotherapy can really help in the acute stages. Even just 5 minutes of soft tissue work on a

back which has muscle spasm can deliver good pain relief for a client. This then allows them to move better and stay active.

Principle 8: Judicious use of complex medicines. Agree.

Principle 9: Pre-determined times for review. This point needs clarification. Do you mean for GP review? Physiotherapist review? Nurse review? I also disagree that pre-determined times should be set. I mean, no two people are the same are they? One person may be fine for two weeks, however most people would struggle and would start to develop yellow flags and pain avoidance behaviours if seen once and then let go for two weeks. Also the reference for this is a rheumatology paper which isn't too relevant in management of acute back pain.

Principle 10: Timely referral and access to specialist services. I would like to know who is a 'musculoskeletal specialist'? Is that an orthopaedic surgeon, sports doctor, titled physiotherapist etc? Needs clarification.

That covers the principles – I would also like to comment on the change of title in the document from 'physiotherapists' to 'treating allied health practitioners'. I would like some clarification as to why this change has occurred and which other allied health practitioners would be involved in the treatment of acute low back pain. The rumour circulating on the internet is that this name change has occurred so that Exercise Physiologists can manage clients with low back pain. Now I value Exercise Physiologists – we have one at our clinic and he is great. However they do not have the skills firstly to assess (Principle 1) as they aren't allowed to diagnose. This means that if they were going to manage low back pain the model of care would deteriorate from the start.

Another area where the whole system falls apart is where Rehabilitation Providers become involved unnecessarily. This has happened to be both as a practitioner and as an injured worker. Many times I have had them complicate the process (for example giving exercises to my back pain client and telling them not to do the exercises I had prescribed when they hadn't even completed an assessment; telling injured workers that their back pain is from some incidental scan finding when it wasn't related – and again no assessment; using unhelpful language). Rehab providers also regularly ask Physiotherapists for 'reports' – and use this information to put into their own 'reports' to the insurers and hence the insurance company is being billed twice to gain that information when they could have just requested that from the Physiotherapist. In many cases it just seems like a waste of money and I think more selective use of Rehabilitation providers in specific cases should be implemented rather than have them involved in the most simple of cases.

To address the questions on the SIRA site:

1. Do you have feedback on how the model can best be **implemented** to ensure people with low back pain receive best practice treatment?
2. Are there any barriers to implementation?
3. What resources would facilitate adoption of these recommendations in practice?

1. Don't implement this 'model'. People are individuals. You can't treat an individual with a medical condition using a flow chart. It's a recipe for disaster based on my points above.
2. The main barriers to the whole workcover system is poor assessment of injured workers, unnecessary imaging, using poor language, and no follow up of 'yellow flags' early when concerns are raised by treating health care professionals. The other barrier is this obsession

with a ‘hands off’ approach which delays appropriate treatment of conditions and pushes people into a chronic pain cycle.

3. Don’t adopt these recommendations. Simple. Treat each person as an individual. Give them a proper assessment, good evidence based treatment, address yellow flags early, and don’t use unhelpful language.

I’ll finish my submission with words from a colleague:

"I think trying to simplify such a varied and often complicated "condition" is never going to work. I understand that low back pain costs the system a lot of money and something has to be done to minimise wasted costs, however this seems to be aimed at over simplifying treatment which will result in less qualified participants like Exercise Physiologists and case managers guiding patients down the wrong treatment pathway because of what's written on the document and not based on the real challenges the injured person is facing, which will lead to disillusion and psychosocial barriers which generally are the hardest things to overcome in the first place.

To suggest that practitioners such as Exercise Physiologists and "other" health practitioners should have anything to do with acute low back pain is counter productive, given the 1st and probably most important principle of "Assess" is not something that is within the scope of professions outside of specialists and physiotherapists (and some GPs). I understand the reasoning behind promoting "hands-off" treatment and aiming towards as much self-efficacy as possible, but I think the hands-off approach is merely the latest "fashion" in the industry and whilst there are a small % of patients who do tend to fall into a pattern of reliance on passive treatments, or physios who overservice with passive treatments beyond a point where it is necessary, I think without utilising the many "hands-on" skills that physios have to offer in the treatment of acute low back pain, a much higher % of injured persons will have prolonged symptoms, slower return to work and potentially more complications from their injury the longer they are in pain.

Guiding an individual through the different stages in their recovery is very important and I think it is just too ambitious trying to pigeonhole everybody into the same generic treatment pathway. I have seen how patients react when case managers tell them they should have been better because their guidelines say that they should be recovered within 4 weeks, it isn't pretty and is more often than not counter-productive to their return to work outcomes. I don't disagree with a lot of the principles in the document but can see it being misinterpreted and applied in the wrong way."