



INSTITUTE OF REGISTERED

MYOTHERAPISTS OF AUSTRALIA

SUBMISSION

**From the Institute of Registered Myotherapists of
Australia**

to

**Department of Health and Ageing's
Review of the Australian Government Rebate on Private
Health Insurance for Natural Therapies**

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1. Introduction

The Institute of Registered Myotherapists of Australia (IRMA) is the key professional association for registered myotherapists. This submission aims to provide a range of background information for the Department of Health and Ageing's Review of the Australian Government Rebate on Private Health Insurance for Natural Therapies. It includes:

- a definition of myotherapy
- an overview of the scientific base of myotherapy
- the key interventions utilised in practice and the key components of the evidence base for those treatment interventions
- an overview of the training requirements for myotherapists, and
- the centrality of evidence-based practice to the profession.

IRMA hopes that this material will both assist NHMRC in its literature review and also enable the Advisory Committee to place the literature review into context when making its recommendations to the Minister for Health.

2. What is myotherapy?

In summary, myotherapy is characterised by the following.

- Myotherapy is an extension of remedial massage and has emerged specifically in order to treat more complex conditions than remedial therapists are trained to address.
- Myotherapy is a relatively new specialised application of massage therapy that treats myofascial pain and dysfunction, conditions that are well documented, prevalent and have a significant impact on society.
- A myotherapist is expected to bring a wide range of knowledge, assessment and treatment skills to utilise in the preventative, corrective and rehabilitation phases of musculoskeletal care.
- However myotherapists also see themselves as part of the broader primary health care team, providing specialized care for the client that complements that provided by other practitioners. They often work from referrals from other practitioners including GPs. They aim to promote wellness and offer early intervention for myofascial pain and dysfunction, seeking to prevent conditions worsening and requiring other treatments. But myotherapists also refer on to other practitioners when clients' presenting conditions are beyond their scope of practice or training or require other approaches.
- All myotherapists initially complete the Certificate IV in Massage and a Diploma in Remedial Massage before specialising to focus on treating specific myofascial pain and dysfunction during the completion of the Advanced Diploma in Remedial Massage (Myotherapy). More recently, Myotherapists can complete a four year Bachelor of Health Science (Clinical Myotherapy) at the Southern School of Natural Therapies. This qualification has been accredited by the Tertiary Education Qualification Standards Agency (TEQSA).
- Graduates of the Advanced Diploma can then become a full member of IRMA, practice as a registered myotherapist. All IRMA members can be recognised with provider status by the private health insurance sector.
- An increasing number (currently 19%) of practitioners undertake more specialised training at Bachelor and postgraduate levels.

Myotherapy is a discipline recognised by the Australian Natural Therapists (ANTA) and accredited by the Australian Natural Therapists Accreditation Board (ANTAB). It is recognised by Medicare when practised by

a member of IRMA, ANTA and AMT. Myotherapy is also recognised by the relevant Work Cover organisation in each state.

The remainder of this section describes myotherapy in more detail.

2.1 Myofascial pain and dysfunction

Myotherapy is a specialised massage therapy that treats myofascial pain and dysfunction. 'Myo' means muscle and fascia is a type of connective tissue that separates bundles of fibres (muscle cells) within muscles, forms the muscle sheaths and divides muscles into functional groups. Therefore myofasciae are the muscles and all associated connective tissues. The clinical entity responsible for myofascial pain and dysfunction is the myofascial trigger point (MTrP). It is a localised, small section of complete contracture of some muscle fibres within a muscle. Myofascial trigger points occur at the nerve-muscle junction and have strong inputs into the central nervous system (CNS), as well as being affected by outputs from the CNS. Therefore, it is more accurate to say MTrPs are neuromuscular lesions that can affect more than muscle function alone.

Myofascial pain is a common dysfunction with a lifetime prevalence affecting up to 85% of the general population (Fleckenstein et al, 2010). According to a review paper published in the *Current Pain and Headache Reports* by Srbely (2010), *"myofascial pain syndrome presents a significant physical and financial burden to society. In view of the aging demographics, myofascial pain promises to be an even greater challenge to health care in the future"*.

Despite this pain condition affecting such a large cross-section of the population, there has been limited research funding into this condition. This gap has resulted in clinicians, training providers and professional bodies (including IRMA and the International Myopain Society (IMS)) working together to develop and adopt a model of treatment based on the best available evidence. This evidence base will obviously grow as research develops to further guide the practice of myotherapy.

Much of the early investigation into MTrPs was performed by pioneer clinician and researcher, Dr David Simons. In 2003 at the Focus on Pain conference in Orlando, Florida, he suggested that myofasciae was 'orphan tissue', as there was no medical specialty to specifically focus on this tissue and yet myofascial pain was the most common source of non-cancer related musculoskeletal pain occurring in the developed world (Simons et al, 1999, Ch 1). Pain arising from MTrPs is often identified as the main source of pain in tension headache (Bezov et al, 2011) and some migraines (Giamberardino et al, 2007); repetitive overload conditions such as tennis elbow (Fernández-Carnero et al, 2008), rotator cuff/shoulder pain (Bron et al, 2011), jaw pain (Alonso-Blanco et al 2012), patellofemoral knee pain (Roach et al, 2012) and heel pain (Cotchett et al, 2010); static or postural overload conditions such as lower back pain (Chen and Nizar, 2011) and neck pain (Sari et al, 2012); degenerative conditions such as knee osteoarthritis (Henry et al 2012); chronic pain conditions such as fibromyalgia syndrome (Giamberardino et al, 2011) and pelvic pain (Itza et al, 2010). Myofascial trigger point pain is also prevalent in white and blue-collar workers (Fernández-de-las-Peñas et al, 2012) and victims of strokes (Kalichman and Ratmansky, 2012)

Research to-date has focussed on understanding the underlying science. So once clinicians established that MTrPs were prevalent, painful, and affected a person's quality of life and ability to work, a phase of basic research was developed to understand the pathophysiology that occurs at the trigger point site at the nerve-muscle interface. More recently, discoveries about the relationships between MTrPs and other systems in the body, including the nervous, cardiovascular and endocrine systems, have been investigated and are beginning to establish the far-reaching effects of myofascial pain. (This is explored further below.) As the basic research consolidates the pathophysiology of MTrPs, more clinical trials to investigate treatment of MTrPs will be undertaken.

The two most common dysfunctions affecting the myofasciae causing pain, limiting movement and decreasing functional capacity are the:

- myofascial trigger point (contraction knots occurring within the muscle belly at the muscle-nerve interface (myoneural junction or motor endplate zone)) and
- collagen adhesions (which occur between layers within fascia and cause stiffness of connective tissue and result in painful or reduced mobility within fascia).

2.2 Scientific basis of myotherapy: the pathophysiology of myofascial trigger points and adhesions

Myotherapy is an emerging specialisation and, as noted above, the initial research focus of the profession has been on gaining a deeper understanding the basic science of myofascial pain. The literature demonstrates a good understanding of what is going on in the tissues when people feel painful knots in the muscles and what signs have to be elicited in treatment in order to increase the likelihood of improvement.

In a landmark study first published in the *Journal of Applied Physiology* in 2005 and repeated in 2008 in the *Archives of Physical Medicine and Rehabilitation*, Shah and colleagues at the National Institutes of Health in Bethesda, Maryland, USA, were able to measure the biochemistry of the MTrP. They found significantly increased concentrations of pro-inflammatory cytokines and neuropeptides associated with the sensation of pain, as well as a decreased pH (also pain producing). The chemicals were returned to normal tissue levels within minutes of eliciting a local twitch response (LTR); a reflex twitch contraction of the muscle fibres containing the MTrP. A LTR is a spinal cord reflex and is an objective sign not under the voluntary control of the patient (Hsieh et al, 2011). Shah's group's work demonstrated that eliciting an LTR is associated with a normalising of the local biochemistry and a useful clinical sign to determine an MTrP has been identified and has been deactivated. Clinically an LTR is associated with the patient reporting a reduction in pain intensity that can last up to twelve weeks (Luis et al 2012; Bron et al, 2011).

Recently, research programs coordinated between a number of laboratories in Denmark and Spain, have been investigating the relationship between MTrPs and chronic pain. A number of key studies have been published demonstrating the initiating and perpetuating role that MTrPs in peripheral muscles can have in sensitising the central nervous system, resulting in long-term pain (Alonso-Blanco et al, 2011, Ge et al, 2011; Xu et al, 2010). As the potential to affect chronic pain states becomes clearer through basic research, clinical trials to investigate reducing or preventing myofascial chronic pain have been planned.

With regard to fascial function in myofascial pain patients, research performed by Helen Langevin's laboratory (2007-2013) and the group of Robert Schleip (2005-2012) has provided evidence regarding the significant effect collagen adhesions within layers of fascia have on myofascial function. Adhesions occur due to:

- Immobility caused by injury or pain, including MTrP pain.
- Overuse or misuse of muscles caused by injury or pain, including MTrP pain.
- Atrophy of muscles, usually caused by immobility or underuse of muscles secondary to injury or pain, including MTrP pain.

The clinical outcomes of fascial adhesions are stiffness of the myofasciae, uncoordinated movement and misleading feedback from the myofasciae to the CNS, also affecting movement and placing the patient at increased risk of further injury and pain. Scientists are exploring the pathophysiology of fascia, which will allow for future research into its treatment and management in the myofascial pain community.

Importantly, but not the focus of this submission, doctors (especially pain specialists) both in Australia and internationally also treat MTrPs. They do not usually provide manual therapy but use medical interventions such as injections. A review of the literature will demonstrate the effectiveness of lidocaine, cortisone,

botulinum toxin type A and vitamin B12 injections into MTrPs. In Australia, a myotherapist would refer a patient with recalcitrant MTrPs to a Sports Physician or Pain Medicine Specialist for injection therapy.

A history of the development of myotherapy is given in Appendix 1.

3. Evidence

3.1 Key myotherapy treatments

Over and above the techniques used in remedial massage, myotherapists utilise several key treatment interventions to treat myofascial pain:

- soft tissue mobilising techniques, particularly trigger point therapy
- myofascial dry needling
- therapeutic exercise and
- education.

More specifically and falling within these four headings, myotherapists also utilise cupping, thermal therapy / cryotherapy, TENS machines, postural assessment and correction, corrective exercises (stretches, strength), core stability exercises and workshops, general diet and nutritional advice.

3.2 Basic remedial massage therapy evidence

As noted above, myotherapy is a specialism built upon remedial massage. Almost all of the findings of the Australian Association of Massage Therapy 2008 literature review are therefore relevant and applicable (Ng & Cohen, 2008). This presented a range of evidence about the effectiveness of remedial massage, categorised by the 2000 NHMRC Body of Evidence levels. This is summarised below in Table 1. (The DOHA Review will utilise these NHMRC levels. For readers not familiar with their exact definition, see Appendix 2.)

Those relevant are as follows

Table 1: Summary of AAMT literature review (2008) findings

NHMRC Evidence level	Findings of literature review
<p>B: <i>Body of evidence provides moderate support to guide practice in most situations</i></p>	<ul style="list-style-type: none"> • Evidence was moderate in strength and fairly robust that massage therapy for sub-acute and chronic low back pain more effective than placebo, and comparable to spinal manipulative therapy. • Massage therapy achieved significant patient satisfaction and reduction in pain levels, both in the short and longer term, as well as potential benefit in acute on chronic low back pain. • Limited to moderate evidence supported the use of massage for delayed onset muscle soreness (DOMS). • Good evidence in managing anxiety, stress and promoting relaxation • Massage effective in modulating the physiological stress response as reflected in reduction of heart rate and blood pressure • Emerging moderate evidence for massage therapy in improving pulmonary function. • Moderate clinical benefit for symptom management, quality of life and promotion of positive wellbeing in patients with chronic diseases and terminal illnesses e.g. cancer, multiple sclerosis and HIV/AIDS.

<p>C: <i>Body of evidence provides limited support for recommendation(s) and care should be taken in its application</i></p>	<ul style="list-style-type: none"> • Limited evidence for massage therapy on obstetric patients; pre-partum (symptomatic management), intra-partum (labour pain) and post-partum (post-natal depression) • Positive outcome measures for infant and mother massage • Limited evidence for massage therapy in premenstrual syndrome • Limited evidence for massage therapy in musculoskeletal conditions, eg juvenile rheumatoid arthritis, myofascial pain, knee osteoarthritis, and temporomandibular dysfunction. • Consistent (positive) conclusions where massage therapy is commonly practised in conjunction with other treatments for fibromyalgia • Limited evidence for value in the managing the behavioural and psychological symptoms of dementia and of depression • Mixed evidence for massage therapy on acute low back pain, complaints of neck, arms and shoulder.
<p>D: <i>Body of evidence is weak and any recommendation must be applied with caution</i></p>	<p>Massage for four medical conditions namely cervical spondylosis, chronic constipation, and ilio-tibial band syndrome had inconclusive evidence.</p>
<p>E: <i>Body of evidence is insufficient to provide recommendation</i></p>	<p>Sixteen medical conditions where there was insufficient or no evidence.</p>

Safety

The AAMT review also concluded that adverse events with massage therapy were scarce and treatments safe when guidelines are adhered to and instituted by appropriately trained and/or qualified massage practitioners.

3.3 Evidence on myotherapy

Additionally, myotherapy specifically focuses on using the four key interventions above (see 3.1). The following section is not intended a full summary of the literature about each of these four interventions but highlights the key evidence.

3.3.1 Soft tissue mobilising technique, especially trigger point therapy

Both the digital compression of soft tissues that occurs during MTrP therapy and various forms of myofascial stretching cause a localised short duration subcutaneous connective tissue stretch. These techniques are commonly used by myotherapists to treat patients with MTrPs and connective tissue adhesions. The best research underpinning the mechanisms stimulated by these treatment techniques comes from a number of animal studies from the laboratory of Helene Langevin. Her group have found that brief tissue stretch attenuates the usual increase in both soluble TGF-beta1 (ex vivo) and Type-1 procollagen (in vivo) following tissue injury. This may be the mechanism via which manual therapies improve soft tissue mobility and movement (Bouffard et al, 2008).

Evidence has emerged over the past five years that treating latent MTrPs (palpable contraction knots in skeletal muscle that are not spontaneously painful but elicit a pain response when stimulated with moderate digital pressure) can facilitate muscle contractions and optimise movement. There are a number of important studies that demonstrate the potential to not only decrease pain sensitivity and improve motor functions but also to prevent latent MTrPs from transforming into active MTrPs (spontaneously painful or painful upon contraction of the affected muscle), and hence prevent the development of myofascial pain syndrome (Ge et al, 2011, Lucas et al, 2007).

It is virtually impossible to perform placebo-controlled clinical trials testing the efficacy of manual therapies for muscle pain and dysfunction. Given this limitation, most clinical trials investigating treatment modalities for MTrPs compare various manual therapies to usual practice or use a waiting list control (no active treatment). While randomised clinical trials investigating MTrP treatment in various pain conditions are beginning to appear in the literature (Renan-Ordine R et al, 2011 for example), many of the trials published earlier might be more accurately described as pilot studies, helping to direct future trials with increased scientific rigour and therefore the potential to answer questions raised by earlier work.

3.3.2 Myofascial dry needling,

As is the case with trials investigating the efficacy of manual therapies, it is impossible to implement placebo needling in live research participants. The best attempts have involved touching or scratching the skin with a blunted needle, though this action still has neural input to the central nervous system via skin receptors.

There have been three systematic reviews on the subject of needling therapies for the treatment of MTrPs over the last decade (Vulfsons et al, 2012, Tough et al, 2009 and Cummings and White, 2001). While a definitive finding of the efficacy of this treatment has not yet been reached, with each systematic review the quality of the trials is improving and the trend toward establishing efficacy is moving toward clinical significance, if not statistical significance. Published more recently than these reviews is a randomised, placebo-controlled double blind trial that found that dry needling treatment is effective in relieving the pain and in improving the quality of life of patients with myofascial pain syndrome (Tekin et al, 2012).

In terms of adverse events secondary to dry needling MTrPs, the overwhelming findings are that only minor adverse events have occurred, such as transient mild or moderate pain and minor bleeding.

To summarise the findings of the most recent systematic review (Vulfsons and co-workers, 2012), the authors found that dry needling is an effective and safe method for the treatment of MTrPs when provided by adequately trained physicians or manual therapists. With regard to the physiological mechanisms underpinning the efficacy of dry needling for MTrPs, they also reiterated that eliciting a local twitch response through dry needling restores normal local biochemistry in the MTrP region. In addition to this mechanism, MTrP dry needling involves supraspinal pain control via midbrain periaqueductal grey matter activation and reduces proximal pain by means of the diffuse noxious inhibitory control.

3.3.3 Exercise therapy

The role Exercise Therapy plays in a myotherapy treatment program is to rectify any strength or movement deficits, empower the patient to participate in their treatment, consolidate the manual therapy gains to aid in the recalibration of the musculoskeletal system and reduce the likelihood of reoccurrence. It is therefore adjunctive to the mainstays of myotherapy treatment, that is soft tissue mobilisation, TrP therapy and myofascial dry needling.

Although there is substantial evidence espousing the positive effects of exercise generally, there are few studies specifically investigating the effects of exercise therapy on myofascial pain syndrome. There is however, one good quality trial that found that an eight-week water therapy program was effective for improving neck and shoulder/axillary pain, and reducing the presence of TrPs in breast cancer survivors as

compared with usual care (Cantarero-Villanueva et al, 2012). A recently published review by Thompson (2012) also provides a rationale as to the benefits of exercise for patients with myofascial pain and fibromyalgia.

3.3.4 Education including movement re-education/ activity modification

As with Exercise Therapy, education and advice play an important but adjunctive role in a myotherapy treatment program. Their main contribution is to optimise treatment outcomes by avoiding re-aggravation during the treatment phase, preventing re-occurrence of injury after treatment concludes and empowering patients with the knowledge to better manage themselves.

The addition of knowledge or education to the usual care interventions has demonstrated some improvement in pain for myofascial pain patients (Michelotti et al, 2012, Lin et al, 2010). Though only a small number of trials have looked specifically at the interaction between patient education and myofascial pain, there are good studies suggesting its value as a treatment modality in the broader chronic pain literature.

3.5 Future directions for research, including cost-effectiveness

While research continues into the underpinning pathophysiology of MTrPs and the physiological effects of treatment interventions that myotherapists use, there is now a need to develop, fund and publish more randomised, controlled clinical trials to continue to improve the basis on which myotherapists practice. Whilst it is difficult to design experiments for most manual therapies that work in the same way drug trials do, research is progressing. A search for *myofascial trigger points* on Clinicaltrials.gov results in 32 registered clinical trials (as at 9th Dec 2012). In addition, a search for *myofascial pain* on Clinicaltrials.gov results in a further 328 registered clinical trials (9th Dec 2012). IRMA keeps abreast of the clinical trials and basic research being conducted internationally via the International Myopain Society and their peer-reviewed journal, the Journal of Musculoskeletal Pain.

At this stage in the development of myotherapy, there have been no specific cost-effectiveness trials, and this too is a crucial area for future research.

3.6 References

A full list of references is given in Appendix 3.

4: Educational requirements for a Myotherapist

All myotherapists have to successfully undertaken relevant training by a government accredited educational institution. This has to meet the required minimum standards of delivery and competency as determined by the IRMA Board of Directors. See Appendix 4.

The current minimum qualification is an Advanced Diploma in Remedial Massage (Myotherapy).

A range of higher education options is also available and, as noted above, currently 19% of practicing myotherapists have myotherapy degrees.

Courses available include:

- Bachelor in Health Science (Clinical Myotherapy); Musculoskeletal Therapy, Clinical Science or Applied Science
- Masters by coursework in the areas of Natural Medicine; Musculoskeletal Therapy; Acupuncture or Rehabilitation.
- Masters by Research
- PhD.

The Advanced Diploma and the Bachelors of Health Science are now described below.

Advanced Diploma of Remedial Massage (Myotherapy)

This course is accredited by Victorian Registration and Qualifications Authority (VRQA) and is entered on the Victorian State Register of Accredited Courses and Recognised Qualifications and the National Training Information Service. It is currently accredited until December 2013 and is available at several registered training institutions, including RMIT University.

To gain this award participants must complete all eleven (11) units of competency, made up of six common units:

- Manage knowledge and information
- Manage the organisation's finances, accounts and resources
- Utilise specialist communication skills to build strong relationships
- Provide leadership in promoting effective work practices in health
- Implement and monitor infection control policy and procedures
- Apply literature research findings to clinical practice

and five specialist units:

- Work within a myotherapy framework
- Apply myotherapy clinical assessment framework
- Perform myotherapy clinical assessment
- Plan myotherapy treatment strategy
- Provide myotherapy treatment.

Bachelor of Health Science (Clinical Myotherapy)

The only course currently in Australia is offered by the Southern School of Natural Therapies which has offered this accredited course since 2004. The course covers:

- Myotherapy theory
- Biological and social sciences
- Orthopaedic and neurological testing
- Postural evaluation

- Soft tissue and skeletal mobilisation
- Manual therapies
- Pain management.

Comparison with other practitioners

To place the above training in context, Appendix 7 compares the curricula of myotherapy training with that of exercise physiologists. Exercise physiology is another recognised and accepted profession and is not being reviewed as part of this DOHA review.

This comparison demonstrates that whilst some of the very specific focus of training is naturally different, the majority of education provided on both courses is actually very similar. The Bachelor degree clearly provides a closer comparison, given its comprehensive scientific content.

Place of evidence in myotherapy education

The Advanced Diploma and Bachelor degree include a focus on evidence-based practice in several ways. For example, in the Advanced Diploma, students are trained to '*apply literature research findings to clinical practice*' (in a unit of that name) to ensure they have the skills to constantly review new literature and appraise it.

Further the unit descriptions of the specialised myotherapy units include requirements to study:

- '[ensure that] myotherapy principles and role of therapy and therapist are evaluated'
- 'recent developments and new practices are integrated into client services'
- work practices are reviewed periodically to ensure skills and practices are kept current'
- 'how myotherapy works with the conventional medical model'.

5. Professional orientation of IRMA

IRMA takes its responsibilities as a professional body seriously. It is committed to ensuring and promoting the highest standards of practice among myotherapists. This takes several forms.

Registration

Once therapists have achieved an Advanced Diploma in Remedial Massage (Myotherapy), they are eligible to be a full member of IRMA, can represent to the public that they are members of IRMA, and may utilise the approved IRMA logo. They must obtain and maintain a current Practising Certificate and take out professional indemnity insurance of not less than \$1,000,000.

They must also hold and maintain a current Workplace Level Two (Senior) and/or Sports Trainers First Aid Certificate in addition to maintaining his/her Cardio Pulmonary Resuscitation (CPR) qualification every twelve months.

Professional development

Members of the Institute are required to participate in ongoing education in myotherapy in order to

maintain their annual membership eligibility. The IRMA Board is responsible for determining the value of the credit points attributable to any ongoing education. Currently all IRMA myotherapists are required to accrue a total of 30 points per 2-year cycle in order to retain membership.

Details of the professional development scheme are given in Appendix 5.

Promoting high standards and evidence based practice

IRMA is committed to promoting evidence-based practice and increasing the level of education of myotherapists. In addition to setting minimum educational standards, discussed above, this commitment is also illustrated by the following.

- The constitution of IRMA notes that its role is to: *represent and develop the education standards and professional status of the myotherapy profession.*
- The IRMA Code of Ethics (Appendix 6) states that myotherapists will: *maintain at all times the highest standard of professional competence, and strive continually to update and extend his/her professional knowledge and skill.*
- Through IRMA's Toni Moynihan Research Seminar held annually, members are able to practice and participate in the analysis of research papers, evaluate research findings and discuss their clinical relevance. The purpose of this seminar is to support members in developing critical analysis skills and to update their clinical practice based on latest research.
- More broadly within the profession and associated medical specialties, there is a clear commitment to increase standards and use of the latest evidence base. For example, in 2010, Dr Karen Lucas (myotherapist, Melbourne), Dr Geoffrey Littlejohn (rheumatologist, Melbourne) and Dr Richard Kwiatek (rheumatologist, Adelaide) made a successful bid to host the 10th World Congress of the International Myopain Society: *Myopain 2015*, in Sydney. This international meeting of the Society (see below) will provide local physicians, surgeons and therapists an opportunity to interact with world leaders in myofascial pain and fibromyalgia in Australia and share the latest evidence.
- As noted above, the IMS is a non-profit, international, interdisciplinary medical organisation for research scientists, physicians, allied health professionals, individuals in training toward a health-related career, institutions, foundations, and commercial companies interested in exchanging ideas, conducting research, or learning more about soft tissue pain syndromes like myofascial pain syndrome and fibromyalgia syndrome. IRMA has a strong relationship with IMS and its Treasurer, Dr Karen Lucas, is an IRMA member.

The 2013 program of IRMA run professional development includes sessions on:

- Tendinopathy
- Muscle Energy Technique
- Temporomandibular Dysfunction
- Tendinopathy
- Pre & Post Natal for Bodywork Practitioners
- Mindful Dry Needling – Lower Extremities
- Frozen Shoulder
- Pre & Post Natal for Bodywork Practitioners
- Mindful Dry Needling – Upper Extremities

Presenters include tertiary trained myotherapists, physiotherapists and one doctor of osteopathy.

Complaints processes and data

As noted above, there is that myotherapy has a good safety record. This is confirmed by very low rate of consumer complaints against myotherapists.

For example, IRMA has a formal Complaints Resolution Procedure, detailed within its Code of Practice. It has received only three formal complaints by consumers about treatment by myotherapists in the past three years, and has dealt with them satisfactorily under these procedures (i.e. the process was completed and there was no further complaint/appeal by consumers).

Additionally most myotherapists (currently at least 90%) practice in Victoria. The 2011 statistics from the main Victorian complaints body, the Office of the Health Services Commissioner, show that only two complaints were made against 'masseurs' out of a total of 1501. (This covered all types of massage therapists, not just myotherapists. More detailed data by type of masseur was not available.)

Appendix 1: The development of Myotherapy in Australia

The Myotherapy qualification was implemented in response to a realisation in the remedial massage industry that as primary contact therapists, they were working with clients that had more complex presentations than these therapists had been exposed to during their training. A training package was developed by industry representatives and training providers that contained the suite of qualifications including the Certificate IV in Massage, the Diploma in Remedial Massage and the Advanced Diploma in Remedial Massage (Myotherapy), with each qualification building on the competencies of the previous training program. This resulted in a pathway from the more generalised massage therapy, through to the complex cases of muscle pain and dysfunction seen in myofascial pain syndrome and fibromyalgia patients. In 2002, a Bachelor of Health (Clinical Myotherapy) was developed to further increase the quality of myotherapy training in Australia.

From the time that Myotherapy was born in Australia (early 1990s) through to the current healthcare environment, no other manual therapy profession makes the treatment and management of myofascial pain and dysfunction its primary focus. From its inception in Australia, Myotherapy treatment was based on the early clinical research of eminent American doctors Janet Travell and David Simons. Since their work was published in 1983, a small but dedicated group of international physicians and manual therapists have been building the knowledge base that underpins this common musculoskeletal condition. Initially clinical characteristics were identified, then basic research was undertaken to establish the pathophysiology of the myofascial trigger point. As a greater understanding of the nature of myofascial pain is gained, clinical trials to investigate treatment interventions will add to the scientific basis of myotherapy treatment.

The Institute of Registered Myotherapists of Australia (IRMA) is the primary professional body representing myotherapists and regulating the development of the myotherapy profession. IRMA is dedicated to best-evidence practice and hold regular workshops, seminars and conferences with highly qualified and experienced presenters, so as to facilitate the ongoing development of its members in order to provide efficacious, cost-effective and safe treatment for the Australian public.

Appendix 2: NHMRC Evidence framework

Table 2.1: Hierarchy of evidence (2000)

Level & Study Design	Characteristics
I Systematic review*	Collation of studies, with methods of search, appraisal and synthesis specified
II Randomized controlled trials (RCTs)	Subjects randomly allocated to groups
III Comparative studies 1 - Pseudo-RCTs	Subjects allocated to groups but not at random
2 - Comparative study	Comparison between groups: no allocation or matching of subjects in groups
3 - Historical	Comparison with a historical control
IV Case-studies/series	No comparison group

* A systematic review will only be assigned a level of evidence as high as the studies it contains, excepting where those studies are of level II evidence

Note that the NHMRC Hierarchy of Evidence does not rank cross-sectional studies.

Table 2.2: Body of evidence matrix (NHMRC 2009)

RECOMMENDATION	A	B	C	D	E
Evidence Base	1-2 high quality RCTs or multiple (≥ 4) poor to fair quality RCT/CCTs <i>and/or</i> recommended for clinical application by author	3-4 poor to fair quality RCT/CCTs <i>and/or</i> recommended for further research of high methodological quality	1-2 poor to fair quality RCT/CCTs which may or may not be statistically significant <i>and</i> further research recommended	Conclusions were not apparent from included studies	≤ 1 RCT/CCT of poor quality <i>or</i> no studies available
Rating of Evidence	Strong	Good	Limited	Poor	Insufficient
Clinical Impact	Substantial	Moderate	Restricted	Minimal	No

Table 2.3: Definition of grades of recommendations (NHMRC 2009)

Grade of Recommendation	Description
A	Body of evidence can be trusted to guide practice
B	Body of evidence provides moderate support to guide practice in most situations
C	Body of evidence provides limited support for recommendation(s) and care should be taken in its application
D	Body of evidence is weak and any recommendation must be applied with caution
E	Body of evidence is insufficient to provide recommendation

Appendix 3: Key References

1. Alonso-Blanco C, Fernández-de-las-Peñas C, Morales-Cabezas M, Zarco-Moreno P, Ge HY, Florez-García M. Multiple active myofascial trigger points reproduce the overall spontaneous pain pattern in women with fibromyalgia and are related to widespread mechanical hypersensitivity. *Clin J Pain*. 2011 Jun;27(5):405-13.
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Appendix 4: IRMA Minimum Standards of Delivery and Competency

The following is a course outline of a list of recommended key core competencies, which may be undertaken in not less than two years of full time study (but ideally three years), which the Institute's Board of Directors consider essential to the adequate delivery of the Advanced Diploma of Myotherapy or an Associate Diploma of Applied Science (Myotherapy), such subjects meeting the required minimum standards of delivery and competency as determined by the Board from time to time:

Basic entry requirement

Entry to the Advanced Diploma of Remedial Massage (Myotherapy) requires entrants to have gained competencies equivalent to those defined by the qualification NTIS Code: HLT50307 – Diploma of Remedial Massage from the HLT07 – Health Training Package and meaning they must have already gained competencies equivalent to the following (1020 nominal hours):

- *Develop professional expertise*
- *Manage a practice*
- *Reflect and improve upon professional practice*
- *Implement and monitor compliance with legal and ethical requirements*
- *Analyse health information*
- *Maintain an effective health work environment*
- *Provide remedial massage treatment*
- *Plan remedial massage treatment strategy*
- *Apply remedial massage assessment framework*
- *Perform remedial massage health assessment*
- *Provide specialised remedial massage treatments*

Advanced Diploma curriculum

To gain the award of Advanced Diploma of Remedial Massage (Myotherapy) participants must complete all eleven (11) units of competency, made up of:

six common units:

- Manage knowledge and information
- Manage the organisation's finances, accounts and resources
- Utilise specialist communication skills to build strong relationships
- Provide leadership in promoting effective work practices in health
- Implement and monitor infection control policy and procedures
- Apply literature research findings to clinical practice

and five specialist units:

- Work within a myotherapy framework
- Apply myotherapy clinical assessment framework
- Perform myotherapy clinical assessment
- Plan myotherapy treatment strategy
- Provide myotherapy treatment

APPENDIX 5: IRMA and Professional Development

The Professional Development Points (PDPs) Cycle:

- PDPs are accumulated over a two (2) year period from 1st July – 30th June. The current PDP cycle ends on 30th June, 2013.
- All IRMA Myotherapists are required to accrue a total of 30 points per 2-year cycle.
- There are two categories 1(A & B) and 2, a minimum of 15 points must be accumulated in category 1 per 2 year cycle (minimum of 3 points must be from category 1A).

Why is it important?

- PD is for members of IRMA to maintain industry currency
- PD is very important to develop yourself, the profession, and for maintaining a high level of competency
- PD is important to maintain credibility within the Allied Health industry
- PD is a requirement to maintain accreditation with Health Funds that recognise Myotherapy
- PD will enable us to gain credibility with Health Industry and other institutions that do not currently recognise Myotherapy
- PDPs are a system of point's allocation for professional development training
- PDPs need to be gained on an ongoing basis to ensure recognition from Health Funds, Workcover, Government, and to maintain IRMA membership

Professional Development that is recognised:

- Includes but is not limited to any courses, workshops, and conferences etc. that are directly related to mainstream Myotherapy or can be used as an adjunct to mainstream Myotherapy.

The latest approved courses for PDPs can be found in the PD section of the IRMA website.

Not all courses run outside of IRMA immediately qualify for PDPs. Documentation of presenter qualifications and course/seminar content needs to be submitted to IRMA no later than two weeks before course date, and the PD committee will then assign the category and amount of PDPs if deemed relevant.

All PD courses will be examined by the PD committee which reserves the right to deny PDPs should the programme or activity fail to fulfil the stated requirements.

How Can I Participate in Professional Development?

The IRMA Board and the PD committee have compiled specific standards needed for the PD program. A number of facilities are available to IRMA members such as:

- ☒ _Evening and/or weekend seminars organised by IRMA or other professional bodies
- ☒ _Key speaker programs
- ☒ _Articles for the *Myobserver* and publications relevant to Myotherapy
- ☒ _Work performed as a Myotherapist
- ☒ _Correspondence courses/DVD's
- ☒ _Relevant journal subscriptions

Distant members will be advised of other vocational and learning programs to assist in the accumulation of PDPs.

Appendix 6: IRMA Code of Ethics

A member of the Institute of Registered Myotherapists of Australia shall:

1. Be bound by this Code of Ethics.
2. Respect at all times the rights and dignity of the patient, and provide the best treatment of which he/she is capable.
3. Maintain at all times the highest standard of professional competence, and strive continually to update and extend his/her professional knowledge and skill.
4. Maintain the premises from which he/she operates in a suitable hygienic and professional manner and in accordance with any current council regulations.
5. Maintain at all times professional confidentiality of all personal information entrusted to them by the patient, except where the patient consents to inter-professional communication.
6. Ensure information about the treatment to be provided is specified and understood and that consultation, assessment and subsequent treatment is only carried out with the informed consent of the patient.
7. Upon referral of a patient by a medical practitioner, scrupulously carry out the instructions given at the time of referral.
8. Refer to the appropriate health professional, any person who presents with a problem or condition which is outside the member's competence and professional expertise.
9. Recognise the extent and limitations of his/her competence, and undertake only those activities which are within the scope of his/her professional expertise.
10. Accept the responsibility of confirming with the patient whether or not he/she is currently receiving treatment from another health practitioner.
11. Not to state or present misleading information with regard to skills or qualifications which the member does not possess.
12. Not to use the title "Doctor" or initials "Dr." on statement of their own name, business address, card, letterhead or published article, unless entitled to do so by virtue of the award of a medical degree, Doctor of Philosophy, or equivalent degree.
13. Co-operate with members of the health care and related professions so that the best interests of the community are served.
14. Be aware of his/her legal responsibilities.
15. Not to act in a way that would be detrimental to the myotherapy profession, or in any way bring the profession into disrepute.

Appendix 7: Comparison of Myotherapy Training with that required for Exercise Physiologists

An overview of the basic training required for myotherapists and exercise physiologists is given below.

	Myotherapy	Exercise physiologist
Minimum educational requirement	Two -2.5 year Advanced Diploma in Remedial Massage (Myotherapy)	Three year bachelor degree
Registration with AHPRA	No	No
Registration with private health insurance funds	Yes	Yes
Evidence base being reviewed by DOHA Natural Therapies PHI Review 2013	Yes	No

The following section lists the mandatory criteria required for accreditation for exercise physiology undergraduate and postgraduate courses, and these are compared against that required for myotherapists (with an Advanced Diploma and with Bachelors degree).

Comparison Exercise Physiologist and Myotherapist qualifications

The following section lists the mandatory criteria required for accreditation at the level of exercise physiology for both undergraduate and postgraduate courses, and these are compared against that required for myotherapists (with an Advanced Diploma and with Bachelors degree). There are two types of criteria:

- *knowledge*, which refers to possessing and understanding information
- *application*, which refers to using new knowledge to develop skills and competencies for practice as a clinical exercise practitioner or myotherapist.

Note that the elements of knowledge and practice below have been amended to also refer to myotherapists in *italics*, so that terms make sense when applying to myotherapy.

Area 1: Scope of practice of exercise physiologist (<i>myotherapist</i>)				
<i>Knowledge</i>		B. Exercise Phys.	Ad.Dip. Remedial Massage (Myo.)	B. H.S. (Clin.Myo.)
1.1	Knowledge of the professional roles available to the accredited exercise physiologist (AEP) <i>or myotherapist</i> within the following two broad categories (1.1.1 and 1.1.2):			
1.1.1	Knowledge of chronic disease management (rehabilitation and secondary prevention).	y	Y	Y
1.1.2	Knowledge of functional conditioning, incorporating both work conditioning and conditioning for activities of daily living.	y	Y	Y

1.2	Understanding of the broad classifications of pathology in the context of the AEP <i>or myotherapy</i> .	y	Y	Y
1.3	Knowledge of the roles of other health practitioners in the context of clinical exercise practice.	y	Y	Y
Application				
1.4	Articulation of the scope of professional roles available to the AEP <i>or myotherapy</i> .	y	Y	Y
1.5	Experience in referring to, and/or use of a referral letter from an allied health professional and medical practitioner	y	Y	Y
Area 2: Compensation schemes: legislation, systems, policies and procedures				
Knowledge				
2.1	An understanding of national compensation schemes and legislation that includes clinical exercise practice.	y	Y	Y
2.2	Knowledge of workers' compensation and compulsory third-party legislation and frameworks.	y	Y	Y
Application				
2.3	Capacity to deliver appropriate workers' compensation and compulsory third-party services in the role of the:			
2.3.1	AEP/ <i>myotherapist</i>	y	Y	Y
2.3.2	Case manager.	y	Y	Y
4.4 Area 3: Ethics				
Knowledge				
3.1	Knowledge of ESSA/ <i>IRMA</i> code of professional conduct and ethical practice.	y	Y	Y
Application				
3.2	Categorise professional behaviour according to the ESSA/ <i>IRMA</i> ethics charter.	y	Y	Y
Area 4: Pathophysiology				
Knowledge				
4.1	Understanding of pathological and pathophysiological bases of the AEP/ <i>myotherapy</i> target pathologies, including diagnostic procedures.	y	Y	Y
4.2	Understanding of the stages of disease, risk factors, complications and comorbidities that must be accounted for in exercise/ <i>myotherapy</i> interventions.	y	Y	Y
Area 5: Medical and allied health management: effects on clinical status				
Knowledge				
5.1	Knowledge of the purpose, methods and typical clinical outcomes of common surgical, medical and allied health treatments for AEP/ <i>myotherapy</i> target	y	Y	Y

pathologies.				
Area 6: Surgical, medical and allied health interventions: effects on exercise capacity				
Knowledge				
6.1	Knowledge of the typical effects of common surgical, medical and allied health treatments on exercise responses for clients with AEP/ <i>myotherapy</i> target pathologies.	y	Y	Y
Application				
6.2	Access and use information on the effects of common surgical, medical and allied health treatments on the expected acute and chronic exercise responses.	y	Y	Y
4.8 Area 7: Medications: effects on exercise responses				
Knowledge				
7.1	Knowledge of the mode of action and indications of medications commonly prescribed in AEP/ <i>myotherapy</i> target pathologies.	y	Y	Y
7.2	Knowledge of the effects of the following commonly prescribed medication classes on acute and chronic exercise blockers:			
7.2.1	Cardiovascular: beta blockers, alpha blockers, angiotensin converting enzyme inhibitors, calcium channel blockers, anti-anginal agents, cardiac glycosides (e.g. digoxin), diuretics, statins, anti-arrhythmic agents, antithrombogenic agents.	y	Y	Y
7.2.2	Respiratory: relievers, symptom controllers, preventers and emergency medicine.	y	Y	Y
7.2.3	Metabolic: hypoglycaemic agents; insulin: fast and slow acting; sugar to treat hypoglycaemia; agents to treat obesity. Includes sulfonylureas, meglitinides, biguanides, thiazolidinediones, alpha-glucosidase inhibitors.	y	Y in general	Y as general knowledge
7.2.4	Musculoskeletal: nonsteroidal anti-inflammatory drugs, corticosteroids and opioids.	y	Y in detail	Y
7.2.5	Neurological/neuromuscular: antispasm medications, psychotropic, antidepressants.	y	Y well	Y
Application				
7.3	Experience with details of clients' current medications, including:			
7.3.1	Accessing information on the actions of prescribed medications (e.g. using MIMS).	y	y	Y
7.3.2	Explaining to clients in plain language the purpose(s) of their prescribed medications.	y	Y within obvious limits	Y Generally
7.3.3	Explaining to clients the importance of compliance to prescribed medication regimes.	y	Y	Y

7.3.4	Accessing and using information on medications with respect to the associated acute and chronic exercise responses.	y	Y	Y
4.9 Area 8: Exercise interventions: effects on clinical outcomes				
Knowledge				
8.1	Knowledge of the evidence with regard to mode of exercise, intensity, duration, frequency, volume and progression for AEP/ <i>myotherapy</i> target pathologies.	y	Y	Y
Application				
8.2	Experience with the assessment of clinical outcomes following exercise interventions by:			
8.2.1	Accessing clinical data (e.g. request data from medical practitioners).	y	Y	Y
8.2.2	Interpreting clinical data (e.g. blood tests) with reference to the clinical literature.	y	Y	Y
8.2.3	Measuring the clinical outcomes (e.g. blood pressure).	y	Y	Y
8.2.4	Use the data above to inform own practice.	y	Y	Y
4.10 Area 9: Risk factor stratification				
Knowledge				
9.1	Understanding of typical risk factors (e.g. biological, sociocultural, behavioural and environmental), alleviating factors and aggravating factors for AEP/ <i>myotherapy</i> target pathologies and comorbidities.	y	y	Y
Application				
9.2	Selection and application of appropriate instruments to assess the risk of (exercise) participation for clients with AEP/ <i>myotherapy</i> target pathologies and comorbidities.	y	N/A	Y
4.11 Area 10: Assessments of exercise capacity				
Knowledge				
10.1	Experience with using appropriate (to the client and situation) exercise/ <i>myotherapy</i> tests	y	Y	Y
10.2	Experience in determining safe (client-centred) exercise/ <i>myotherapy</i> limits and effective ranges for exercise and physical activity/ <i>therapy</i> .	y	Y	Y
4.12 Area 11: Functional capacity, functional conditioning and occupational rehabilitation				
Knowledge				
11.1	Understanding of the core principles of occupational rehabilitation.	y	Y	Y
11.2	Understanding of the ergonomic principles within workplace environments and how these apply functionally to the individual.	y	Y	Y

11.3	Understanding of the core principles of case management.	y	Y	Y
11.4	Knowledge of functional capacity evaluations (FCE) that are widely used and accepted in industry and professional practice.	y	Y limited	Y
11.5	Understanding of how to transfer FCEs into functional conditioning programs and strategies.	y	Y limited	Y
11.6	Knowledge of the tests for activities of daily living that are widely used and accepted in professional practice.	y	Y	Y
11.7	Basic understanding of the ergonomic principles within home environments.	y	Y	Y

4.12 Area 11: Functional capacity, functional conditioning and occupational rehabilitation (continued)			
Application			
11.8 Experience with:			
11.8.1 Designing, processing and being responsible for developing and adhering to treatment plans.	y	y	Y
11.8.2 Running workplace ergonomic assessments/worksites visits to make functional modifications or recommend suitable duties relative to an individual's capacity and injuries/conditions.	y	Y In conjunction with others	Y
11.8.3 Providing concise, objective reports and return-to-work plans that meet the needs of all relevant parties (e.g. employee, employer, medical/allied health professionals, insurer, and relevant legislative requirements).	y	Y In conjunction with others	Y
11.8.4 Evaluating functional capacity (both for individuals with injuries/conditions or for pre-employment assessments).	y	Y In conjunction with others	Y
11.8.5 Transferring baseline functional capacity information into functional exercise programs and understanding functional body mechanics as it pertains to manual handling in the workplace environment and safe ergonomic principles.	y	Y In conjunction with others	Y
11.9 Experience in generic functional capacity/conditioning services:			
11.9.1 Activities of daily living (ADLs).	y	Y	Y
11.9.2 Designed, delivered and evaluated exercise programs to improve activities of daily living capacities in people with AEP/ <i>myotherapy</i> target pathologies.	y	Y	Y
11.9.3 Ergonomic assessments within home environments.	y	Y In conjunction with others	Y
4.13 Area 12: Monitoring			
Knowledge			
12.1 The ability to monitor and interpret at rest, exercise and recovery:			
12.1.1 Self-report scales (e.g. RPE and fatigue, visual analogue scales, dyspnoea scales, pain, physical activity or relevant <i>myotherapy</i> scales).	y	Y	Y
12.1.2 Heart rate, rhythm and oxygen saturation (e.g. palpitation, heart rate monitor, ECG, pulse oximetry).	y	Y	Y
12.1.3 Blood pressure.	y	Y	Y
12.1.4 Breathing (e.g. visual observations, spirometry).	y	Y	Y
12.1.5 Balance and movement patterns (e.g. static and	y	Y	Y

	dynamic postures, coordination, mobility, gait).			
4.14 Area 13: Safety: precautions and contraindications				
Knowledge				
13.1	Knowledge of modes, intensities and volumes of exercise/ <i>therapy</i> that may cause deterioration of clients (physical and/or cognitive) and/or adverse events.	y	Y	Y
Application				
13.2	Identification of modes, intensities and volumes of exercise/ <i>myotherapy</i> that are contraindicated for clients with AEP/ <i>myotherapy</i> target pathologies.	y	Y	Y
4.15 Area 14: Safety: signs and symptoms				
Knowledge				
14.1	Knowledge of adverse signs and symptoms that may arise during exercise or recovery for the list of AEP/ <i>myotherapy</i> target pathologies.	y	Y	Y
14.2	Knowledge of when to modify, stop or not start an exercise, test, exercise session or , program / <i>therapy</i> or <i>myotherapy</i> in the event of the appearance of new or recurring adverse observations or measurements, or new or recurring signs or symptoms.	y	Y	Y
Application				
14.3	Experience in monitoring signs and symptoms before, during and after exercise/ <i>therapy</i> that may indicate important changes relating to an injury or disease status or progression.	y	Y limited	Y
14.4	Confidence in dealing with clients (either via reassurance and/or referral) for whom a test, exercise session or, program or, <i>therapy</i> is modified, stopped or not started due to the presence of signs, symptoms or adverse observations or measurements.	y	Y	Y

4.16 Area 15: Design of clinical exercise interventions			
Application			
15.1	Experience in designing, implementing, evaluating, modifying and advancing individual exercises or exercise programs <i>or/ myotherapy strategies</i> , accounting for:		
15.1.1	Presenting pathology and comorbidities (may be extracted from referral).	y	Y
15.1.2	Current treatment(s), including medical, pharmacological and allied health.	y	Y
15.1.3	Risk factors, aggravating factors, alleviating factors.	y	Y
15.1.4	Interpersonal communication.	y	Y
15.1.5	Goals, likes and dislikes, barriers (e.g. sociocultural, socioeconomic and sociopsychological factors).	y	Y
15.1.6	Subjective and objective measurements or observations.	y	Y
15.1.7	Current exercise and functional capacities.	y	Y
15.2	Exercise programs/ <i>therapy</i> should account for mode, intensity, duration, frequency, volume and progression, and should reflect a concord between the AEP/ <i>myotherapy</i> and the client.	y	Y
4.17 Area 16: Exercise/ myotherapy leadership			
Application			
16.1	Motivation and leadership of individuals and groups of clients with AEP/ <i>myotherapy</i> target pathologies in exercise and physical activity programs <i>or other activities</i> ; providing feedback to clients, including correcting poor or unsafe techniques.	y	Y to a limited degree
4.18 Area 17: Interpersonal communication and behaviour change			
Knowledge			
17.1	Knowledge of basic lifestyle strategies, programs and resources, including government and community-based population-wide strategies.	y	Y
17.2	Knowledge of nutrition at the level needed to provide basic lifestyle advice, with emphasis on AEP/ <i>myotherapy</i> target pathologies.	y	Y
17.3	Understanding of the psychology of living with chronic medical conditions, pain, anxiety, depression and bereavement.	y	Y to a limited degree
17.4	Knowledge of the strategies to deal with clients who may be hostile, resistant, noncompliant, anxious, depressed or psychotic.	y	Y to a limited degree
17.5	Understanding of models of behaviour change.	y	N

17.6	Knowledge of factors that affect long-term exercise/ <i>therapy</i> adherence and concordance, and sociocultural factors that must be considered when supporting clients in their endeavours towards self-management of healthy lifestyle, exercise and physical activity.	y	Y to a limited degree	Y
Application				
17.7	Experience in interviewing clients to compile a relevant history beyond the referral and risk-factor documentation, including exercise and work histories, the client's perspectives on the cause(s) of disease/mechanisms of injury, comorbidities, barriers to participation, pain, goals, likes and dislikes, and opportunities.	y	Y to a limited degree	Y
17.8	Provision of assistance and guidance to clients, and, where appropriate, referrers, to develop appropriate short, medium and long-term goals that are appropriate to medical, physical, psychosocial, functional and environmental influences.	y	Y to a limited degree	Y
17.9	Experience in counselling and working with clients though behaviour change.	y	N	Y
17.10	Provision of counselling and support for clients in their development of self-management strategies to promote independence.	y	Y to a limited degree	Y
17.11	Ability to explain, advise or provide information to help clients to understand AEP/ myotherapy target pathologies, risk factors and the relationship with exercise.	y	Y to a limited degree	Y
17.12	Provision of basic education on AEP/ myotherapy target pathologies or risk factors, and related benefits of exercise and healthy lifestyle.	y	Y	Y
4.19 Area 18: Communication				
Knowledge				
18.1	Knowledge of the challenges and opportunities for delivering culturally appropriate exercise and healthy lifestyle programs for communities and individuals from culturally and linguistically diverse (CALD) backgrounds.	y	N	N
Application				
18.2	Communication (verbal, written, electronic) using brief and concise language, and in appropriate syntax (subjective, objective, assessment, plan [; lay; medical) for other AEPs/ <i>myotherapists</i> , medical practitioners, health professionals, compensable authorities/agents (e.g. insurers) and clients	y	Y	Y
18.3	The design and delivery of culturally appropriate exercise and healthy lifestyle programs to CALD	y	N	N

	communities and individuals. Communication must be sympathetic to sociocultural diversity (e.g. CALD clients or colleagues, and diversity/minority groups). Know when to work with an interpreter.			
18.4	Using SOAP/planning notes, practice in clinical documentation, including the compilation of a client's file and clinical note taking.	y	Y	Y
4.20 Area 19: Evidence-based practice				
Knowledge				
19.1	Awareness of evidence bases of the effects of exercise for people living with, or at risk of, AEP or <i>myotherapy</i> target pathologies.	y	Y	Y
19.2	Understanding of evidence-based practice models of clinical decision -making.	y	Y	Y
Application				
19.3	Experience in assessing, comprehending, critically analysing, collating and disseminating the clinical exercise/ <i>myotherapy</i> scientific literature.	y	Y	Y
19.4	Experience in making informed judgements of the claims made in the original research articles versus the strength of the evidence provided.	y	Y	Y

Bachelors Health Science (Clinical Myotherapy)

The Bachelors degree has seven key areas of study, namely:

- Myotherapy theory
- Biological and social sciences
- Orthopaedic and neurological testing
- Postural evaluation
- Soft tissue and skeletal mobilisation
- Manual therapies
- Pain management.

Hence it is focussed more on building more depth of knowledge, rather than more specialised treatment techniques. For example it includes developing a more in-depth understanding of the underpinning science, complex situations and chronic pain, and the necessary background knowledge in sociology and psychology.