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Editorial

Welcome to the Winter Edition of the CPMH journal and as the Christmas season embraces us let me wish you a happy Christmas and a happy successful new year. Hopefully it will be a successful year for physiotherapy within the mental health Unit. To pave the way we have the launch of the CPMH Strategy 'Recovering Mind and Body' in Response to New Ways of Working' to be held In Birmingham in just over a week's time. The programme is featured later in this edition and I hope that I will see many of you at the event in the fabulous old Cadbury family residence.

What hasn't been successful though is the loss of membership of the CPMH over the last couple of years. We are hoping to ascertain the reasons behind the loss but more importantly to get views from our members on our responsiveness to your needs. As Sharon goes on to say in her chairs report, the CPMH is a small but busy committee and has a number of roles and duties to cover. The committee is acting on your behalf and wants and needs to hear from its members. We are your voice piece so please if you have a few moments please complete and return the questionnaire to me. We have already considered the need to provide more training. To give you other examples of how the committee is involved on your behalf listed below are just some of the meetings/duties that three of our most senior officers are involved with.

Sharon Greensill is

- Chair CPMH
- Chair of the Clinical Interest Occupational Group Liaison Committee (CIGLC)
- The CIGLC rep on Professional Practice Committee
- On the Congress Programme Development Group
- On the Congress Management Group
- On the CIGLC Strategic Steering Group
- Last year I sat on NWW National Steering Group and was a member of subgroup that looked at Scope of Practice.

Catherine Pope is the

- Associate Director AHP Nottinghamshire Healthcare NHS Trust
- Honorary President CPMH
- East Midlands representative to CSP Council
- last year was on NWW AHP subgroup

Caroline Griffiths is on:-

- the CIGLC as my alternate
- CIGLC rep on Communications Group
- UK rep ICPP

Hope to see you on the 14th

Jean Picton-Bentley
Journal editor

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Autumn 2009

Chairs Letter

This is my first newsletter since becoming Chair a role I have yet to settle into fully. Taking over as chair is made more difficult having to follow in the footsteps of Caroline and Catherine before her but I will try my best!. I would like to take this opportunity to thank Caroline for all the hard work she has done on behalf of the Committee over the past few years and am pleased to say that she remains on the committee so we have not lost her altogether.

I would also like to thank Marie Donaghue , as you know Marie has been our President but has now retired from this position. Both Caroline and Marie have been key in raising the profile of Physiotherapy over the past few years at a time of significant change within the delivery of healthcare and wellbeing services. Their leadership has ensured that Physiotherapy has been an integral part of that process.
Catherine Pope has now accepted the position as President and we welcome her back .
We continue to have an excellent highly motivated committee and despite only being a small group we are always committed to promoting the role of Physiotherapy in Mental Healthcare at every opportunity!!

As you know we have now completed our strategy Recovering Mind and Body - A Framework for the Role of Physiotherapy in Mental Health and Wellbeing and along with this you will find a leaflet Commissioning Mental Health Services. Both these documents can be downloaded from our ICSP site or from the CSP website.

The strategy was developed as part of New Ways of Working in Mental Health and its aim is to give a clear vision to aid the development of Physiotherapy in Mental Healthcare. The CSP and CPMH have been involved in New Ways of Working from its start initially with Catherine Pope and then myself sitting on the National Steering Group. Catherine then represented Physiotherapy on the NWW AHP subgroup.

Through this we have been able to ensure that Physiotherapy is seen as an integrated profession within the field of mental healthcare. The NIMHE National Programme finished its' work in March 2009. The programme focused, in its early years, on workforce planning, recruitment and retention, New Ways of Working (NWW), new roles, learning and development and leadership, working collaboratively with the Changing Workforce Programme. The main focus in latter years has been on NWW, underpinned by the values articulated in the Ten Essential Shared Capabilities.

The strategy focused primarily on England but we will be working with our subgroups in Wales and Scotland to build on the strategy for their respective areas.

Further details and the NWW for AHP report can be found on

www.newwaysofworking.org.uk.

We are holding an event to launch the Strategy on the 14th December and details of this will be e mailed out to all members and will be posted onto ICSP.

This year again will be a busy year for us. Members of the Committee will be attending Congress, ARC and CIG events. We are also looking to run an Introduction to Mental Health Course for Physiotherapists . If you have any issues that you feel you would like to be put through as a motion at ARC please contact us. Also please read the motions when they appear in Frontline and pass any comments on to a Committee Member so that we can represent your views.

Best wishes

Sharon Greensill

Editors note. – We are always happy to receive letters from members and from those who have experiences to share in mental heath settings. '

Letter one:- **Letters to the editor**

Dear Editor,

I wanted to write to you to share my thoughts and feelings towards my placement as a physiotherapy student, within a mental health setting.

The night before I started my student placement, I was trying to conjure up in my mind what it would be like, working in a mental health setting. My first thought was of *One Flew Over a Cuckoo's Nest*, where the clients were 'rewarded' for bad behaviour with a lobotomy, or underwent controversial treatment using Electro Convulsive Therapy. I was asking myself if there would be scenes like in the film, with people sitting in a chair rocking backwards and forwards, making nonsense noises, or maybe there would be someone who I'd observe who was suicidal. I was unsure of what to expect, but most of all, I was full of preconceived idea's of people with mental health problems.

As a society, we can sometimes perceive someone who is mentally unwell as different. They are unable to function independently 100% of the time in our world, so therefore they must be less of a person? Wrong. Since starting my placement, I have met some amazing people. They are just like me.

The only difference is that I am fortunate enough to be able to cope better in stressful situations. And that I am lucky, to have been brought up in a loving and caring environment, without having been abused. However, I do have times where I am sad and vulnerable, and I feel like my world is ending, but unlike my client with manic depression, I can see the light at the end of the tunnel, and I know that once the worst is over, things can only get better. The people that I have met over the past four weeks have changed me.

I am no longer hesitant to interact with someone, for the sole reason that they have a different mental state. I have learnt how important it is to be patient. A client with a mental health problem can take so much longer than a 'normal' client to learn how to walk again, because they have a poor memory, or because they are anxious. Whatever the reason, you have to work at their pace, and not push them too hard because it is so easy to decline in both their physical and mental state.

Email for correspondence – stephanie.horn@kcl.ac.uk

Editor's note- A personal note form the journal's editor that pays comments to Clare Leonard's article fascinating article in Spring 2007 entitled "Pain Assessment in people with cognitive impairment". It also perhaps touches on new legislation surrounding Deprivation of Liberty

It is nigh on thirty years since I walked into the National Health Service as a Physiotherapy student following in my mother's footsteps, who, had herself come from a medical background and had been a Guys nurse and a physiotherapist. I moved across into mental health, more out of opportunity than intent, at an early stage in my career but I lived the NHS dream and fought tirelessly for his principles. I was left shattered and disillusioned as my father was so badly failed by the system that we all as a family had fought so hard to defend.

My father had been a lovable happy man and my parents were a very devoted couple. My Dad had been a chartered surveyor but had to retire early on ill health following a fall on a roof and subsequent difficulties with writing reports. In hindsight this was probably the first of a series of small strokes, that my Dad was latterly diagnosed with, that affected his word finding centre. Though he had a minor health issues during his retirement he was not formally diagnosed with a mental health condition until after my wedding seven years ago when he was at that time admitted to a mental health unit and looked after very well for eight weeks. He had had one psychotic episode during the remaining years but had happily managed in the family setting with attendance at memory clinic, memory medication, once a week attendance at a day hospital and during the last couple of years carers twice a day to for dressing as mum needed more physical help. He had been always dressed smartly and well Although he didn't speak well he did try and communicate with us although we needed time and patience.

There was some mild deterioration but we all anticipated that Dad and Mum would be together for a few more years in the family home and made plans for the ruby wedding anniversary scheduled in October 2009.
However Dad just after Christmas caught my husband's sickness germ. He was recovering but unfortunately a new carer who was visiting for the second time and who used to be a paramedic thought Dad's breathing was of concern and called an ambulance. I can only thing that he arrived just as Dad was going towards the toilet and probably started to chat to Mum in the hall. Dad often did get anxious when he wanted the toilet. It was something his family had teased him about over the years. He would always drive with a urine bottle in the boot of the car just in case he got stuck in the snow. He would also have the shovel, the Wellington boots, the thermal blanket.... Though I teased him I have sometimes been very grateful that he was always so well prepared.

That night my mum spent an hour trying to beg the ambulance people to leave Dad with her, that this was how he normally was and if he went into hospital he would probably catch something. But they still took him and as mum was looking after my daughter that night she couldn't go with him. She was angry and bitter for about a week and didn't appear to smile except when she was with him in the hospital. She hardly ate and was irritable and agitated and just couldn't understand why they had taken him away from her when she had been looking after him for so long.

The minute that I got back that Saturday night I went up to the hospital to see my

Dad looking just the same as I had left him earlier that evening although looking a bit sheepish if anything and not quite sure what was going on. I managed to speak to the Dr, as my Dad finds it hard to communicate, and the Dr also seemed a bit confused over the circumstances of his admission, but during their initial heart investigations they had revealed a large goitre that they wanted to investigate further. The consultant due to see him on the Monday was unable to see him that week and he stayed in the hospital. Eventually he was discharged home with an outpatient appointment pending.

A couple of days later he developed a high temperature and his visiting GP set him up with some antibiotics which he responded well to. Unfortunately on the following Saturday when I was out again Dad exhibited some unusual behaviour and Mum once again rang for a Dr. But being out of hours and with a recent admission to hospital an ambulance was automatically sent out and took him back to hospital. Again went I went up the next morning he was his usual self but was started on more antibiotics. Again he was to be seen by this consultant the next day for the goitre and though he could have gone home that day it was felt he should stay over night to see the consultant to save him coming up as an outpatient. Unfortunately the snow came and the Monday appointment could not be meet. It was well over a week later before he was seen and then we were told that he had probably had this goitre for a long time, that it was not an acute problem, that it may have contributed to his earlier mental health deterioration but that they wouldn't operate anyway on him and it probably wouldn't give him any trouble for several years. They changed his medication and we were allowed to bring him home.

But he found it so hard to walk and he went almost into a coma with the combination of thyroid medication and his anti psychotic medication. He was returned to hospital but that is when I started to grieve for my father because I thought I would never get him back. I had just arranged time off from work to look after my father for a couple of weeks but the ambulance again arrived one hour before I could get home and he was taken back to the hospital again.

So for a third time he went into hospital and he was again in a different ward with different nursing staff. This time he was diagnosed with MRSA and isolated in a single room. Although the nursing staff advised that he wasn't eating and drinking he took five glasses of fluid from me straight off and ate some biscuits and a yogurt. He did start to eat again but there were several occasions when the nurses informed us he wasn't eating his dinner although he would eat with us. Social workers set up a meeting for us and although we wanted him home it was decided that they would try him for intermediate care and try and regain his level of mobility to that of his admission. Dad had been able to do the normal things that most people do. He got up and walked around, as he wanted. Although he wore pads for the odd accident he used the toilet regularly. He was able to go the day hospital the dentist the barber. But during the admissions he had been kept in his room with cot sides up, the sheets tightly tucked around him and staff didn't seem to realise that he could walk and feed himself.
Although he did well initially he developed terrible thrush in his mouth, which never seemed to be cleaned. He became a little difficult possibly because of the pain in his mouth. So they decided that he could not go to a rehab unit and then the Drs started talking about him dying. On one occasion when I arrived to meet one of the ward Drs they were delayed so I said I would pop into Dad. But I wasn't allowed to go in to his room because of protected meal times to find an hour later after that magic time period had ended a cold plate of untouched food complete with Dad

faced the opposite way to the food and the cot sides between the food and my father. The ward did put a drip up on occasions but sometimes it didn't appear to be flowing and on one occasion we came in to find my father's hand and arm almost twice the size where the drip had tissued into his arm. When I asked the register what pain medication he was getting for this he sounded surprised and said that people with dementia don't feel pain but my Dad still flinched every- time they put an injection in him. He had been diagnosed with cervical spondylitis in his 60s and he had back problems. His neck looked very uncomfortable in the hospital. It was a terrible few months. And I was exhausted by the time he died. I needed to protect my family and I couldn't. I was too out of control and this balancing act of supporting parents, my daughter and working was completely destroyed by outside influence. Because of the MRSA my five-year-old daughter was not allowed to be in the room making visiting time a linguistic nightmare. Her school reports were poor that term but I had no choice but to drag her to the hospital every night. My poor Mum could not manage the hospital trip on her own. She does not drive or even walk well now and the long corridors and the confusing similarity of the corridors of the brand new hospital were too hard for her to negotiate on her own. The round trip by taxi would have been £40 a day. With the strict visiting times of two hours we were often unable to see Dad for longer than an hour a day.

I just felt so hopeless and I became angry as I was busy working with other patients in the NHS all day but they weren't even feeding my father. I got so tired and depressed. I knew he was going to die if he stayed there but I was just given enough hope to think that he might make it. He was visibly upset on some occasions and then one day turned to me and said 'I can't take this anymore". That was the last thing I heard him say to me a the day after he had so definitely said 'Yes' when I asked him if he wanted to be home with Mum - but I just couldn't seem to get him back there so they could be happy as they were before.

We were phoned a couple of days later to say that Dad was sinking fast and the family gathered from as far field as Birmingham to be with him. But again we noticed the drip fluid was up but not going through and an apologetic nurse quickly came in to adjust it. My father rallied for a few days. Then a few days later there was a phone call to my mum to say he was fading again, followed five minutes later by another one to say he had gone. The nurses said they had been trying to reach me on my mobile but there were no messages or missed calls. My father was a Christian man but we were never asked if he wanted to see a priest and none of his family were with him as he departed from this world.

Ironically the hospital that was all part of the old health authority that I had worked in for fifteen years. I had begged my mental health management to invest in intermediate care facilities for mental health clients but they felt this was solely the domain of the acute unit.

What was also so confusing and sad is that during those months I met some wonderful staff with some lovely caring nurses, social workers and excellent Doctors

But everything was so wrong for my poor dad. It left me feeling inadequate and helpless and with a sense of shame of belonging to an institution which seemed to fail so many of its most vulnerable guests in such basic needs.

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ARTICLES AND RESEARCH

Title:-Stakeholders Perception of the Role, Responsibilities and Development of the Physiotherapist as a Member of a Rural Community Mental Health Service

Author:

Nicholas Errington-Evans (Hywel Dda NHS Trust, Withybush Hospital, Haverford west, SA61 2PZ)

Corresponding Author:

Nicholas Errington-Evans

(01437) 773162 Word Count: 2926

Address: Physiotherapy Department

Bro Cerwyn Centre

Fishguard Road

Haverfordwest

SA61 2PZ

ABSTRACT

Objectives:- To investigate the role, responsibilities and preferred development of the physiotherapist from the stakeholders' perspective. These stakeholders consist of both service users and staff members associated with adult services (acute admission ward, day hospital, Community Mental Health Teams) and older adult services (assessment ward, day hospital and Community Mental Health Teams).

Design of Study:- Exploratory focus groups.

Setting:- Rural mental health service in Wales.

Participants:- Seven service users and seven staff members.

Method:- Three focus groups were held, one for service users (five attending) and two for staff members (three and four attending respectively). Three questions were asked to initiate conversation, regarding role, responsibilities and their preferred direction of development for physiotherapy as a profession. These lasted under an hour and produced ample discussion, offering stakeholders perspectives, which were sorted into categories.

Conclusion:- Long-table analysis showed that advice and education was discussed most frequently, followed by exercise and then assessment and treatment of neuromusculoskeletal conditions, with mobility mentioned the least frequently. The skills and knowledge the physiotherapist brings to the mental health setting were highly regarded by both staff members and service users. Staff members strongly felt the physiotherapist should stay removed from the care co-ordinator role.

STAKEHOLDERS PERCEPTION OF THE ROLE, RESPONSIBILITIES AND DEVELOPMENT OF THE PHYSIOTHERAPIST AS A MEMBER OF A RURAL COMMUNITY MENTAL HEALTH SERVICE

INTRODUCTION

This research is an exploratory investigation of the role, responsibilities and preferred development of the physiotherapist from the stakeholders' perspective. Stakeholders are defined as those that work with, or those who receive physiotherapy either for themselves or those that they care for, associated with an adult acute admission ward, an adult day hospital, two adult Community Mental Health Teams (CMHT), an older adult assessment ward, an older adult day hospital and an older adult CMHT.

Background

The link between physical and mental health has been acknowledged throughout history, "A Healthy Mind in a Healthy Body" [1] and policy has continued to recognise this [2-6]. Conversely, there is a strong link between mental health and physical health problems, including hypertension, ischemic heart disease, diabetes, respiratory disease and obesity [7, 8], with patients suffering a severe mental health condition expected to die 10-15 years earlier that the general population [9].

The role of the physiotherapist working as a part of the CMHT is under review [10] and is expected to develop significantly. The Department of Health (DOH) publication "New Ways of Working for Psychiatrists" [10] identifies falls prevention, maintenance of independence and complex conditions (e.g. chronic pain, eating disorders, substance misuse, self-harm, anxiety, anger and mood disorders) as common roles of the physiotherapist within the CMHT. In conclusion, this document acknowledges that the benefits of physiotherapy are not widely recognised and suggests that the physiotherapist's role in mental health should be taken forward, with their becoming essential members of the CMHT. Physiotherapy is viewed as an essential part of many teams, dealing with Acute and Chronic Pain, Acute and Chronic Respiratory conditions, Orthopaedics, Rheumatology, Chronic conditions, etc [11], and as such, this progression within the mental health setting could be seen as a logical continuation of this trend.

This DOH guidance does not stand alone. Further guidance comes in the form of the National Service Framework (NSF) Mental Health [12], the Disability Rights Commission "Equal Treatment: Closing the Gap" [13], the National Institute for Health and Clinical Excellence (NICE) Falls guidelines [14], the NSF Older People [2], and the NICE guidelines for Dementia [15].

Despite this push towards improving the physical health of those suffering mental health conditions, anecdotal evidence suggests significant differences between trusts [11]. This leads to vast discrepancies between the physiotherapy service involvement in each CMHT [11].

LITERATURE REVIEW

A literature search was conducted using Blackwell-Synergy, British Medical Journals, Ingenta Connect, Ovid Online, AMED, Google Scholar, EMBASE and ScienceDirect search engines. The search was limited to articles published after 2000, "human" and "English language". Keywords were "physiotherapy", "team work", "interprofessional", "education", "communication", "mental health", "CMHT", "community mental health team", "roles", "responsibilities", "focus group" and "perception". Results were combined, and abstracts viewed. Relevant articles were obtained and reviewed, with references traced

forward or back.

This literature review found only one article, which further builds the rationale for this research. "Recovering Mind and Body" [16], suggests that the care co-ordinator role should be built on. Upon reviewing this document, the only non-physiotherapist contribution from mental health was from two service users and two carers. There was no involvement with psychiatrists, psychologists, mental health nurses, or voluntary services.

RESEARCH DESIGN

This design had both trust research and development department and local research ethics committee approval. This research used two semi-structured focus groups with up to three sessions per group [17], with a combination of structured questions, to give the sessions' direction, and prompt questions, to investigate points of interest and guide the group [18]. If saturation occurred prior to this point, it was identified by the facilitators and confirmed through discussion with the participants to ensure that no potential data was lost.

The focus group was conducted by two independent, experienced facilitators, recorded using a Dictaphone, with one guiding the session and the other noting any non-verbal information [19]. Discussions ensured the facilitators had a full understanding of the research aim. To allow maintenance of anonymity only the group make-up will be described. The recording will then be transcribed by another independent individual to give the most accurate record of the focus group.

The session structure was informal, with no enforced timeframe per question, with the questions: "How would you describe the role of the physiotherapist?", "How would you describe the responsibilities of the physiotherapist?" and "How do you think the role and responsibilities should change in the future?". The facilitators were to explore the discussion with prompt questions as required. Definitions of "Role" "Responsibilities" and "Development" taken from the Oxford English Dictionary [20] were offered to ensure all participants had equal understanding.

The method for analysis was a manual cutting and sorting "long table" approach [21], which should ensure the analysis is grounded in the data, reducing any potential bias [22]. Special attention was given to minority or unexpected responses to highlight the differences between subjects [23]. Interactions between subjects resulting in changes of opinion or showing a polarised viewpoint were identified and highlighted to ensure inclusion in analysis [19].

Participants

Participants were randomly selected from a convenient sample of those attending adult day hospital, a monthly support group for both clients and their carers (elderly), and staff from a centrally held list, with the same formulation of eight individuals attending up to three focus groups, with the option of stopping once saturation occurs. This was removed from the researcher to maintain anonymity. They were provided with information sheets and the opportunity to ask questions prior to signing the consent form.

FINDINGS

Attendance

The first observation is relatively poor attendance of the sessions. Of the eight individuals invited, only three staff attended the first group, four the second and only five service users attended their group, although additional comments were included in the analysis from letters written by one service user and one carer.

It has been well recorded that those with Mental Health conditions have poor attendance

[24], and that research with staff members as participants have poor attendance [25]. The staff focus groups attended twice, specifically due to such poor attendance of the first group, the service users/carers group only once. Saturation was achieved in each instance, with each session ending earlier than expected. The first staff groups consisted of: two older adult CMHT Community Psychiatric Nurse's (CPN's) and an adult day hospital Occupational Therapist (OT). The second group consisted of: an older adult Assistant Consultant Psychologist, older adult Ward Manager and two adult Day Hospital CPN's.

The service user group consisted of five adult service users. No older adults or carers attended, with some volunteering they had caring responsibilities, others due to travel logistics and one who felt that they would be unable to give useful information. One carer and one service user offered to write a letter to give their opinions. This information was incorporated into the data analysis.

Developed Themes

The results highlighted a number of themes, which are listed in order of frequency, which can reflect the perceived importance of each [26], although others disagree [21]. The topics mentioned in all three focus groups were:

- Advice and Education
- Exercise
- Assessment and Treatment of Neuromusculoskeletal conditions
- Mobility

The topics mentioned in both staff group sessions were:

- Being removed from the care co-ordinator role
- Specific mental health physiotherapist

The final topics were only mentioned in a single group session:

- Functional ability
- Liaison
- Mood
- Socialisation / support
- Using E-Face (E-Face is a trust-wide computer based record system)

These themes are discussed in relation to the research questions in the next section. Each question will be dealt with individually.

The Role of Physiotherapy

The main roles revolved around the core roles of physiotherapy, such as rehabilitation of injuries and fractures, mobility assessments, issuing exercises and advice regarding general fitness. Staff recognise that service users require specific mental health physiotherapy due to their problems with engaging with the Acute and Community A&C physiotherapy service:

> *"I think with mental health patients, they often, they would get discharged from the books over there because they might miss a week, or that they might find it hard to show the commitment needed so that they aren't committed, so they might be gone, whereas with the mental health side you might have that bit of leeway with them."*

Staff member one, staff group two

There is also an acknowledgement that the physiotherapist must have extended skills in assessing cognitive and behavioural factors:

> *"He has to be able to assess whether they will be able to retain the information or if they can work within the confines of that, I think he's pretty good at that."*

Staff member 3, staff group one

Understanding the practical aspects of the role are reassuring, as they show mental health staff members have a reasonable awareness of the types of service user who would respond to physiotherapy. An example of this is shown below:

"The two people that I've referred recently have been very successful, and I do use him to lure people into 'the day hospital'*, I say 'There's a physio there, they'll see you!' It's the lure of the physio that gets people into* 'day hospital'*!"*

Staff member 3, staff group one

This understanding is particularly important as mental health staff have little or no experience of working within the A&C setting and little opportunity to gain this knowledge. This also explains why the respiratory aspect of the physiotherapy role, a facet that few individuals experience, was not mentioned. Staff members would like further training on appropriate conditions to refer to physiotherapy, and this linked to one responsibility, promoting the physiotherapy service within mental health:

> *"Perhaps a responsibility for us to know what is exactly available to us or are we referring appropriately"*

Staff member 1, staff group one

A further role identified by the service users group, but not the staff group, was that the physiotherapist can make a judgement on the mental health status of an individual based on their performance and interactions within the gym setting:

> *"The support that you get through the contact is very important, and they help with the serious stuff as well. You form a bond, if you like, between the physiotherapist and the patient, which is very important."*

Participant 2, Service Users Group

The service users felt that this was a valuable resource, stimulating discussion, which would help to ease their depression, anxiety, etc. That this socialisation and support was not referred to by staff raises an aspect of education that should be highlighted.

Most interestingly, both staff groups agree the physiotherapist should not take on the care co-ordinator role. Partially this was due to the lack of resources, but also due to the care co-ordinator being associated with the staff member most associated with that service user. One staff member advocated the physiotherapist taking on the role when the rest of the service withdraws. In this situation these service users would be cared for by the A&C

services who have significantly more resources.

Responsibilities of the Physiotherapist

Both staff groups stated a major responsibility was to promote the range of conditions and injuries that could be successfully treated. Both agreed that mental health services lack a clear understanding of what a physiotherapist can do or how they do it:

"Maybe promoting his service as well, I mean, I don't know what he's done, but like you can ring him up and he can tell you all the things that you can do."

Staff member four, staff group two

The groups identified training, referral flow charts, etc. as something that would make them feel more confident regarding appropriate referrals. They inferred some service users were referred as an experiment, while others would not be referred for lack of understanding. This education would be relatively simple to implement through a basic teaching programme. Service users identified other staff required further training in this area:

> *"Role is to educate, train and develop other health care professionals in the multi-disciplinary team."*

Participant 5, Service Users Group

In the first staff group, communication was viewed as one of the most important responsibilities, linked to keeping the members of staff appraised of waiting times, the exercises set, progress reports and any other salient information. This point was also raised within the second staff group and the service users group. The service users assumed that those involved in their care would meet to discuss their progress or changes to their care plans. The service users identified the responsibility of preventing injury, which is a very reasonable expectation.

Development of the Physiotherapist

This question developed little conversation in total. The service users group discussed changes they would like within the group they attend, which was interesting, but not relevant. The first staff group reiterated that the physiotherapist should be kept away from the care co-ordinator role.

One individual stated that:

"I think that would be difficult to say, if we're not really sure what the roles and responsibilities of the physiotherapist currently are... I think there's always the feeling that you want more of it and you want it immediately"

Staff member one, staff group one

The second staff group felt the demands made on the service should be highlighted, with the aim of realising greater staffing levels. They further suggested training and feedback to the A&C service would be able to de-stigmatise the mental health service to a certain degree:

"Maybe he could be responsible for just telling them and feeding back what works, dispelling any myths that are around working here. You said they were all scared and stuff, it can be daunting at times."

Staff member four, staff group two

Related to this, they referred to the phlebotomy service, which had been withdrawn completely when one member of staff received verbal abuse, and the rotational junior physiotherapists, some of whom had been "terrified" throughout.

LIMITATIONS

The participants attending the focus group were unanimously involved with the adult service. Had participants been able to attend representing the older adult service, it is reasonable to suggest that some additional information could have been generated. The two letters written were incorporated into the analysis were brief and contained little information.

The second limitation related to attendance. There was a significant challenge orchestrating two independent facilitators plus sixteen participants. These factors meant that the three groups took nine months to occur. Individual interviews would have been more manageable but a counter-argument is that several individuals reversed their perspective through the course of a group lasting less than an hour. It would be reasonable to suggest that those who changed their opinion upon hearing comments made by others, or having their views challenged, would be unlikely to do so during a one-to-one interview.

Another limitation was that these groups only had a single session, rather than the three sessions scheduled. A counter-argument would be that these groups reached saturation and that while many focus groups deal with serious conditions, complex situations or emotive subjects, this is not the case here. The focus group described by Kitzinger [23] with over 50 sessions was unlikely to be dealing with simple topics.

CONCLUSION

This study aimed to investigate the perception of physiotherapy as a profession within the mental health setting. Data was generated from the focus group, analysed and interpreted directly from this data and a number of insights developed. The participants universally agreed physiotherapy was a valuable resource.

The topic of the role and responsibility for the physiotherapist working within the mental health setting has received little examination, especially from the stakeholder's perspective. There is limited guidance from the professional body regarding how a physiotherapist within this area should act. This research adds the perspective of the stakeholders in a service that spans both adult and older adult service users, dealing with inpatient wards, day hospitals and community visits in both age brackets.

The stakeholders had a very clear idea that the physiotherapist should be centred on the core skills of the physiotherapy. Equally important seems to be the fact that the physiotherapist should be removed from the care co-ordinator role, to prevent them becoming drawn into the time consuming aspects of paperwork and multi-agency liaison.

The stakeholders also had a clear idea regarding the responsibilities of the physiotherapist. These were to ensure adequate communication between the physiotherapist and the stakeholders and to promote the physiotherapy department in terms of skills available, suitable service users and conditions and it the inequality between supply and demand. They identified a significant responsibility in developing the skills of the staff through education.

Finally, the stakeholders identified the direction of development centred on the physiotherapist being kept away from the care co-ordinator role. It seems a valuable point that this topic kept re-emerging through all three questions in the two different staff groups.

Stakeholders further suggested that the physiotherapist would be useful in aiding de-stigmatisation of the mental health service. While working in mental health can have risks, it should not automatically instil fear and anxiety. Risks associated with working in casualty are well known both nationally and internationally, and has been researched significantly [27], but do not have the associated stigma.

Physiotherapy within mental health has not been viewed as essential [11], but has gained support at a national level [10]. This research suggests support is present at the grass roots level with a good understanding of the benefits that it provides, and with support to increase the level of input available to the mental health services.

References

[1] Juvenal. (2007). *Classic Quotes*. [Online]. Quotations Page. Available from: www.Quotationspage.com/quote/29034.html. [Accessed: 17.02.09].

[2] Department of Health. (2001). *National Service Framework – For Older People.* Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066. [Accessed 17.02.09]. London, UK: HMSO.

[3] Department of Health. (2001). *Saving Lives: Our Healthier Nation White Paper.* Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4004289. [Accessed 17.02.09]. London, UK: HMSO.

[4] Department of Health. (2004). *At Least Five a Week: Evidence on the Impact of Physical Activity and its Relationship to Health.* Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4080994. [Accessed 17.02.09]. London, UK: HMSO.

[5] Welsh Assembly Government. (2005). *Adult Mental Health Services: Raising the Standard.* Available from: http://www.wales.nhs.uk/documents/WebsiteEnglishNSFandActionPlan.pdf. [Accessed 17.02.09]. Welsh Assembly Government, Cardiff.

[6] National Institute for Clinical Excellence. (2007). *Depressions: Management of Depression in Primary and Secondary Care*. [Online]. The British Psychological Society. Available from: http://guidance.nice.org.uk/CG23/guidance/pdf/English. [Accessed 17.02.09].

[7] Faulkner, G and Biddle, S. (1999). "Exercise as an Adjunct Treatment for Schizophrenia: A Review of the Literature". *Journal of Mental Health.* **8:5**. p. 441-457.

[8] Brown, S, Inskip, H and Barraclough, B. (2000). "Causes of the Excess Mortality of Schizophrenia". *British Journal of Psychiatry.* **177:3**. p. 212-217.

[9] Richardson, C, Faulkner, G, McDevitt, J, Skrinar, G, Hutchinson, D and Piette, J. (2005). "Integrating Physical Activity into Mental Health Services for Persons with Serious Mental Illness". *Psychiatric Services*. **56:3**. p. 324-331.

[10] Department of Health. (2005). *New Ways of Working for Psychiatrists: Enhancing Effective Person Centred Services Through New Ways of Working in Multi-Disciplinary Teams and Multi-Agency Contexts.* Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4122342. HMSO, [Accessed 17.02.09]. London, UK.

[11] Chartered Society of Physiotherapy. (2007). *Discussion and Exchange*. [Online]. Interactive CSP. Available from: www.interactivecsp.org.uk/forum.cfm. [Accessed: 17.02.09].

[12] Department of Health. (1999). *National Service Framework for Mental Health: Modern Standards and Service Models.* [Online]. HMSO. Available from:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598. [Accessed: 17.02.09].

[13] Disability Rights Commission. (2005). *Equal Treatment: Closing the Gap.* [Online]. Disability Rights Commission. Available from: http://www.library.nhs.uk/mentalhealth/ViewResource.aspx?resID=187303. [Accessed: 17.02.09]

[14] National Institute for Health and Clinical Excellence. (2004). *Falls: The Assessment and Prevention of Falls in Older People.* [Online]. The National Institute for Health and Clinical Excellence. Available from: http://www.nice.org.uk/nicemedia/pdf/CG021NICEguideline.pdf. [Accessed: 17.02.09]

[15] National Institute for Health and Clinical Excellence. (2006). *Dementia: Supporting People with Dementia and Their Carers in Health and Social Care.* [Online]. The National Institute for Health and Clinical Excellence. Available from: http://www.nice.org.uk/nicemedia/pdf/CG042NICEGuideline.pdf. [Accessed: 17.02.09].

[16] Chartered Society of Physiotherapy. (2008). *Recovering Mind and Body: A Framework for the Role of Physiotherapy in Mental Health and Wellbeing.* [Online]. Chartered Society of Physiotherapy. Available from: http://www.csp.org.uk/director/libraryandpublications/publications.cfm?item_id=2910D9C703CE7C69FC67873285DC6712. [Accessed: 17.02.09].

[17] Parahoo, K. (1997). *Nursing Research: Principles, Process and Issues.* (Basingstoke, UK: Palgrave Macmillan).

[18] Gibbs, A. (1997). "Focus Groups". *Social Research Update.* **19.** p. 1-7.

[19] Webb, C and Kevern, J. (2001). "Focus Groups as a Research Method: A Critique of Some Aspects of their Use in Nursing Research". *Journal of Advanced Nursing.* **33:6.** p. 798-805.

[20] Oxford English Dictionary. (2007). Oxford English Dictionary. [Online]. Available from: http://www.dictionary.oed.com/. [Accessed: 17.02.09].

[21] Kreuger, RA and Casey Sage Publications, Inc)., MA. (2000). *Focus Groups: A Practical Guide for Applied Research.* (London, UK:

[22] Robinson, N. (1999). "The Use of Focus Group Methodology – With Selected Examples from Sexual Health Research". *Journal of Advanced Nursing.* **29:4.** p. 905-913.

[23] Kitzinger, J. (1995). "Qualitative Research: Introducing Focus Groups". *British Medical Journal.* **311.** p. 299-302.

[24] Mitchell, A and Selmes, T. (2007). "Why Don't Patients Attend Their Appointments? Maintaining Engagement With Psychiatric Services". *Advances in Psychiatric Treatment.* **13.** p. 423-434.

[25] Jacobson, A, Warner, A, Flemming, E and Schmidt, B. (2008). "Factors Influencing Nurses Participation in Clinical Research". *Gastroenterology Nursing.* **31:3.** p. 198-208.

[26] Morgan, D. (1997). *Focus Groups as Qualitative Research.* (London, UK: Sage Publications Inc).

[27] Ferns, T. (2005). "Violence in the Accident and Emergency Department – An International Perspective". *Accident and Emergency Nursing.* **13:3.** p. 180-185.

Increasing The Awareness of Falls Prevention in Older People with Mental Health Problems

Lilian Mapeza, Acting Physiotherapy Service Manager
(lilian.mapeza@beh-mht.nhs.uk)

The following is a report on a Falls Prevention strategy adapted by a team working in North Central London as part of increasing awareness as well as minimising the risk of falls in older people with mental health problems. The physiotherapy team implemented the project working collaboratively with the multidisciplinary team in a day hospital.

Aim:
To provide an integrated MDT approach to increasing awareness of minimising the risk of falls in older people who present with mental health problems

To evaluate effectiveness of the intervention

Key words: Fall,

Background

A Fall is defined as an event reported either by the faller or a witness, resulting in a person inadvertently coming to rest on the ground or another lower level, with or without loss of consciousness or injury (Rubenstein 1990)

The National Service Framework (NSF) for Older People (Department of Health (DoH) 2001 highlighted the need to prevent or minimise the risk of falls in older people. In the UK, 30% of the population over 65 years, and 50% of the population over 80 years will fall each year. Falls account for approximately 50% of all causality attendance in people aged 65 years and over. A quarter of older fallers attending causality have cognitive impairment. Furthermore 2/3 of fallers will have a second fall within 6 months. The consequences of falls are many including associated mortality and physical injury. Falls can also result in decreased physical functioning, disability, and reduced quality of life. Loss of confidence and fear of falling can lead to further functional decline, depression, feelings of helplessness, and social isolation as reported by Rubenstein et al (1994).

Tinetti et al (1988) identified that amongst 336 people, 75 years and older, living in the community, 30% fell at least once; of those who fell 48% reported fear of falling and 28% were limiting their activities. Walker and Howland (1991) established that 41% of older people living in the community were restricting their activities due to fear of falling and 34% feared that they would fall again within a year. In a retrospective study, Fleming et al (2002) found out that people with mobility limited to mobilising within their houses had a higher incidence of falling than those who could still mobilise outdoors to the shops.

The Mental Health Services for Older People (MHSOP) multidisciplinary team implemented Physiotherapy led integrated approach to increasing awareness and

minimising risk of falls in older people with mental health problems. People with mental health problems often lack the insight into minimising the risk of falls.

The NSF for older people Standard Six (DoH 2001) supports the assessment and prevention of falls in older people as well as the National Institute for Clinical Excellence (NICE 2004). NICE directed local agencies to consider multi functional interventions aimed at identifying the risk as well as encouraging active participation of older people in falls prevention including education and information giving. The intervention included addressing one of the four priority areas in the white paper on "saving lives, our healthier nation" (DoH 1999) by increasing awareness of the need to reduce the rate of accidents resulting from falls.

Research commissioned by Help the Aged in 2005, carried out by the University of Southampton, investigated older people's attitudes towards falls prevention advice and identified ways to increase the uptake of services. The resulting report, "Encouraging Positive Attitudes Towards Falls Prevention in Later Life", demonstrated that older people are more likely to take up services and advice when the emphasis is on maintaining independence and mobility (Help the Aged 2005). The report identified that there was an urgent need to emphasize the potential to prevent falls by positive action – improving balance – rather than by the much less desirable method of restricting activity.

Programme Design

Patient Selection Criteria

The plan was to include only patients who had a history of falls as referred by the team. After the first session patients who were not included in the programme expressed their wish to be in the group as it offered a wide choice of balance and mobility exercises to improve or maintain level of independence as part of the prevention programme. The team quickly reviewed the criteria.

The group was changed to include all patients at risk of falling as part of the Victoria Day Unit (VDU) programme to minimise the risk of falls. Referral to group was open to all members attending Victoria Day Unit on a Thursday. Patients with a history of falls are prioritised to attend VDU on Thursdays. Clients from Laseron ward were occasionally included if their mental status was stable and were close to discharge from inpatient services.

Programme was designed as group sessions in blocks. After consultation with staff and patients sessions were named Stay Fit, Stay Steady, Sessions. MDT members co-facilitated sessions with the physiotherapy team. Each member delivered a presentation, which addressed specific issues pertaining to minimising the risk of falls with reference to MDT discipline and maintaining maximum independence. Each session was followed by an intensive exercise programme, which was aimed at motivating older people to take up physical activity as well as providing individualised postural stability exercise programmes. Exercises incorporated postural stability activities and Tai Chi.

A pre and post audit questionnaire was used with service users. MDT members contributed questions for audit. Finalised questionnaire was discussed with the Clinical Audit Team (BEH-MHT) who added further ethnic and age monitoring questions. Post sessions questionnaire included questions, which addressed clients' feelings with regard to falls. The questionnaire was piloted to members of

staff working in MHSOP (a total of ten). The questions were modified accordingly to suit the client group as per comments from pilot.

Objectives

- Increase awareness of the importance of good nutrition in the prevention of falls and delaying the onset or minimising the impact of osteoporosis
- Increase awareness of medical problems associated with risk of falls such as vision impairment, and the need to follow up appropriate referral and treatment
- Increase awareness of the need for home hazard assessment and intervention as well as awareness of perceived functional ability
- Increase awareness on the importance of medication review
- Reduce the risk of falls and related injury in older people with mental health problems by:-
    - Offering education to promote positive life styles, which reduce the risk of falls
    - Strength, balance and postural stability training
    - Minimise the negative factors associated with using walking aids
    - Increase awareness of the need to address fear of falling, reduced self-efficacy, reduced confidence and activity modification in the prevention of falls
    - To promote participation of older people and carers in the prevention of falls

Outline of Sessions:

Table 1: Stay Fit Stay Steady Sessions

MDT Session	Area of focus	Facilitator
Diet	Increase awareness of the importance of nutritional status	Dietician
Medical and Nursing	Increase awareness of the need for vision impairment reviews, medical problems review and referral, personal care	Medical and Nursing
Occupational Therapy	Increase awareness of the need for home hazard assessment and intervention Importance of maintaining independence in the home	Occupational Therapist
Pharmacy	Increase awareness of the importance of medication review,	Pharmacist
Physiotherapy	Increase awareness of the need for activity modification, use of balance aids in walking, Strength and balance training, individualised exercise programmes	Physiotherapist
Psychology	Awareness of the need to address fear of falling, reduced self-efficacy, reduced confidence and activity modification in the prevention of falls	Psychologist

Audit questionnaire

Questionnaire is attached in appendix A.

Four cycles of ten-week sessions were completed since programme was commenced that is between August 07 and December 08.

Results

Table 2: Outline of key audit questionnaire results

MDT	Audit Questionnaire	Pre-Session	Post Sessions	Comments
Dietician	Importance of Vitamin D in Calcium absorption	11.8% were aware of importance of Vit D	80% became more aware of the role of Vit D in calcium absorption	**Fig 1**
Medical and Nursing	Awareness of medical problems that might increase the risk of falls	35.3% were not aware	60% became aware of medical problems	**Fig 2**
Occupational Therapy	Did you attend demonstrations on prevention of falls Did you find the demonstrations useful	Yes= 23.5% Yes= 29.4%	Yes= 80% Yes= 50.0	**Fig 3**
Pharmacist	Awareness of medication that can increase risk of falls	Yes= 23.5% No= 52.9%	Yes= 80.0% No 20.0%	**Fig 4**
Physiotherapy	Are you limited in carrying out moderate activities	Yes, limited a lot =58.8% Yes limited a little= 17.6% No Not limited= 17.6%	Yes limited a lot= %tage reduced to 40% Yes limited a little= 20% No not limited= 40%	**Fig 5**
Psychology	How you feel can impact on how steady you are on your feet	Questions raised in post session evaluation	Yes= 100%	
Management	If Stay Fit Sessions run in you local area would you attend	Yes 41.2% No= 5.9% Not sure 47.1%	Yes 80.0% No=0% Not sure= 20%	**Fig 6**

Both members of staff and patients felt quite positive with the program.

Specific outcomes for each MDT session are included in the results. Sessions showed positive uptake of information and change of lifestyle, such as engaging in more structured physical activities in the community, understanding the need for a healthy diet or modifying home environment to minimise risk of falls. More patients are requesting for information about their medication.

Sessions were run with great enthusiasm and were of high standards in terms of the following:

- Punctuality and good timing
- Keeping patients well motivated
- Achieving objectives outlined
- Addressing specific falls prevention strategies related to each discipline's background
- Positively involving service users in health promotion discussions

Results were analyzed using SPSS (Statistics Package for Social Sciences) version 16.

Average attendance for the group sessions varied between 7 and 10 patients. A total of 20 questionnaires were handed pre and post sessions. 17 pre-session questionnaires were returned and 7 post session questionnaires were collected of which two were discarded due to incomplete information. The pre session's questionnaires were collected between April and December 2008 as sessions were running and new patients continued to join the group whereas post sessions were collected at the end of each ten-week block period.

Patients expressed that promoting good mobility is a good way of preventing falls. Percentage was high both pre and post sessions questionnaire. Pre sessions were 94.4%, Post sessions was 80%.

Objective 1

Increase awareness of the importance of good nutrition in the prevention of falls and minimising the onset or impact of osteoporosis

Alongside many nutritional factors the dietician emphasised the importance of

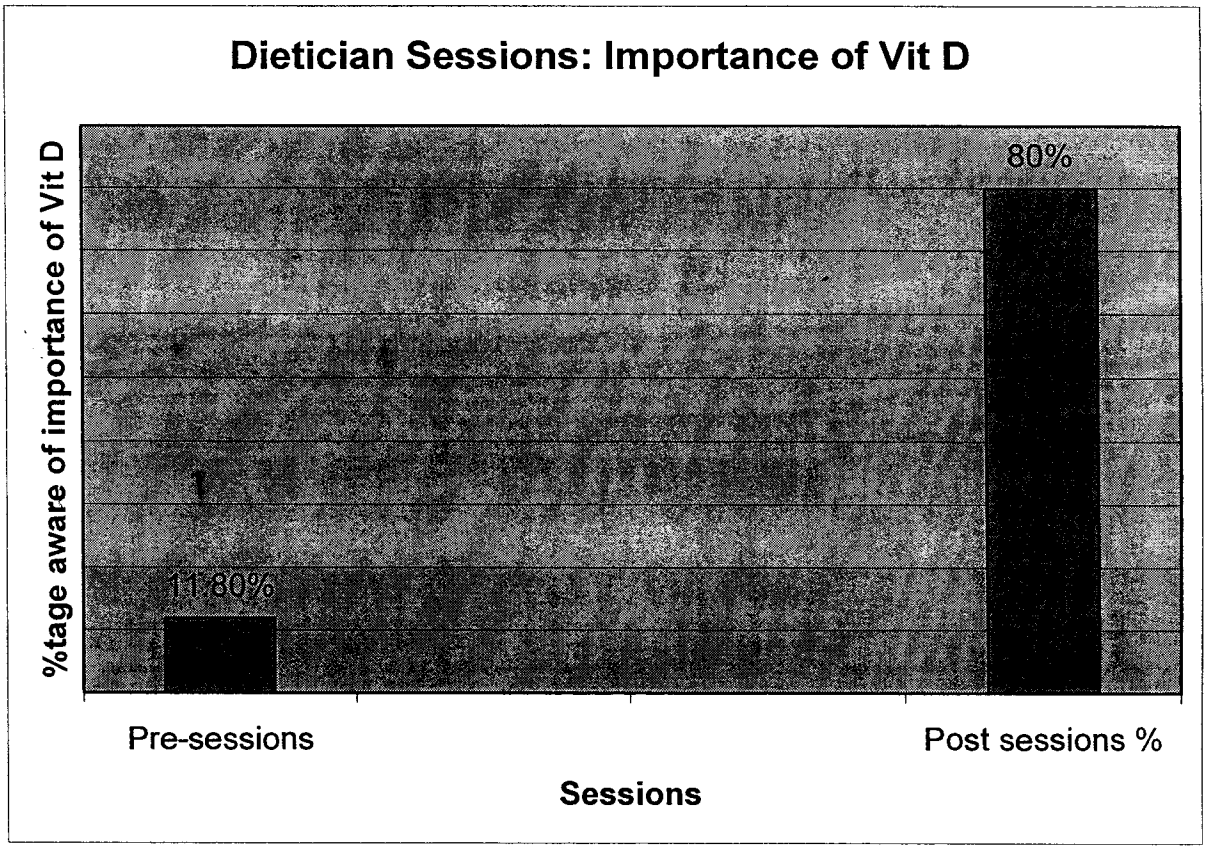


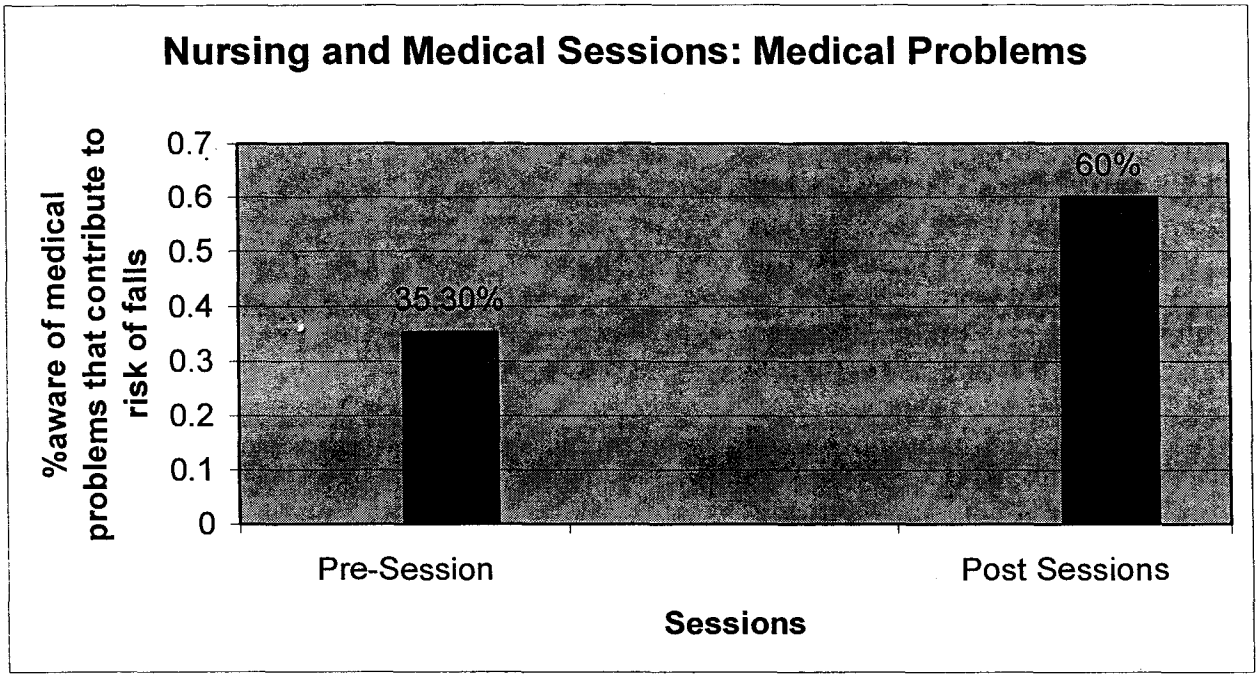
Figure 1 Dietician Session: Importance of Vitamin D

calcium intake and adequate Vitamin D. Interestingly many clients were not aware of the relationship of Vitamin D, osteoporosis and the prevention of falls. Percentage increased from 11.8 to 80%

Objective 2

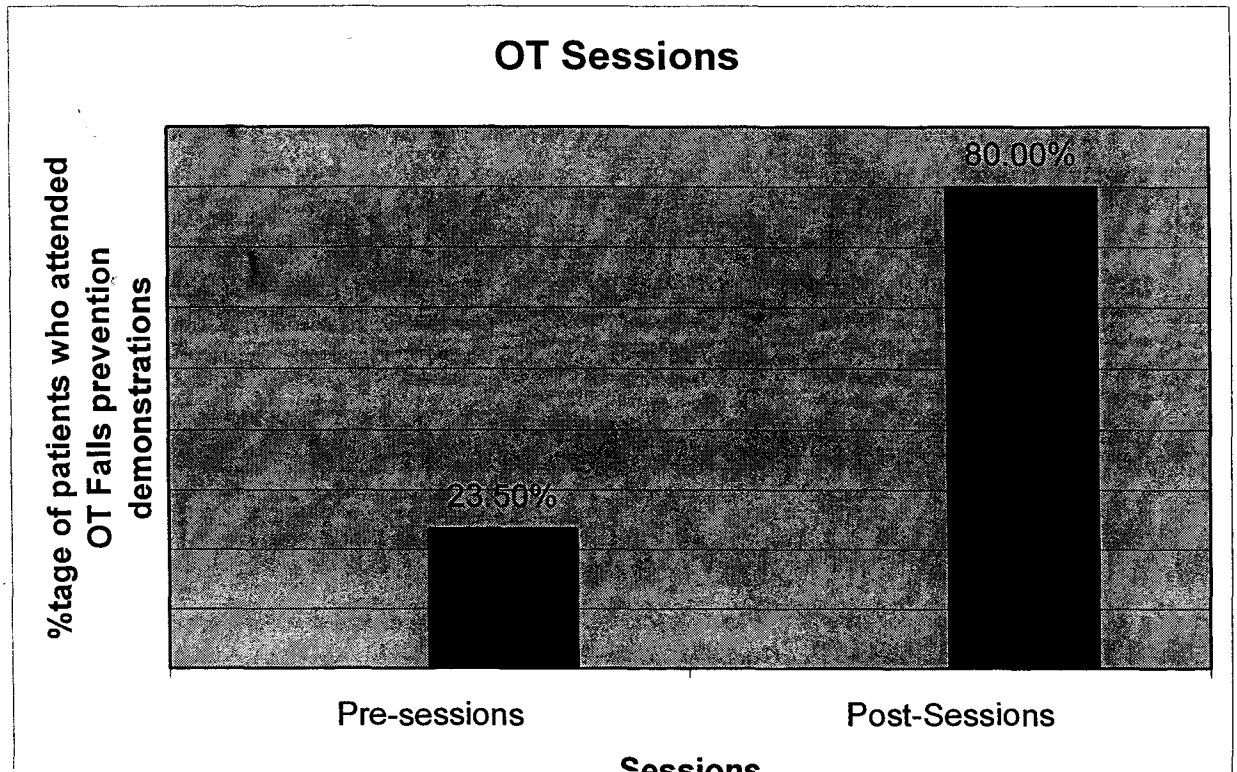
Increase awareness of medical problems associated with risk of falls such as vision impairment, and the need to follow up appropriate referral and treatment. Discussion with medical and nursing team highlighted medical problems associated with increased risk of falling. Clients were quite receptive.

Fig 2: Nursing and Medical Session: Awareness of Medical Problems



Objective 3 Increase awareness of the need for home hazard assessment and intervention as well as awareness of perceived functional ability. The percentage of clients who attended Occupational Therapy demonstrations on the prevention of falls increased from 23.5 to 80%. Some patients showed interest by requesting for further information in writing.

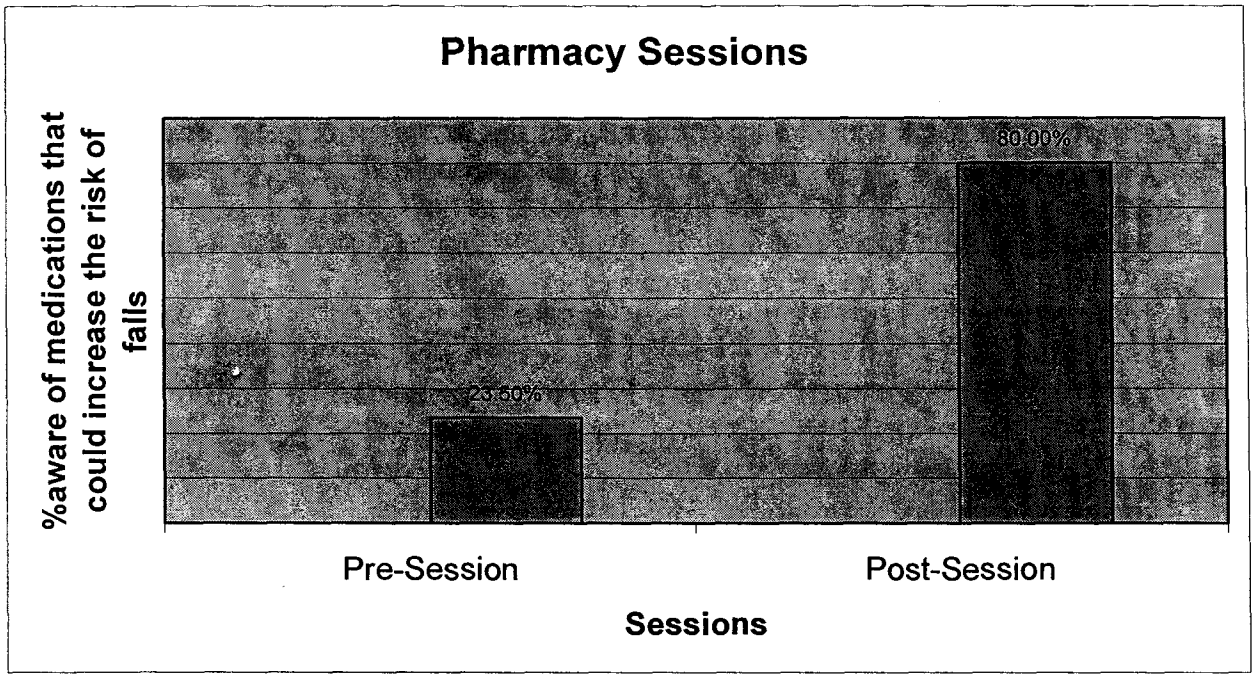
Fig 3: Occupational Therapy Session: Falls Prevention Demonstrations



Objective 4

Increase awareness on the importance of medication review. Patients demonstrated good understanding of the need for medication review as shown in Figure 4.

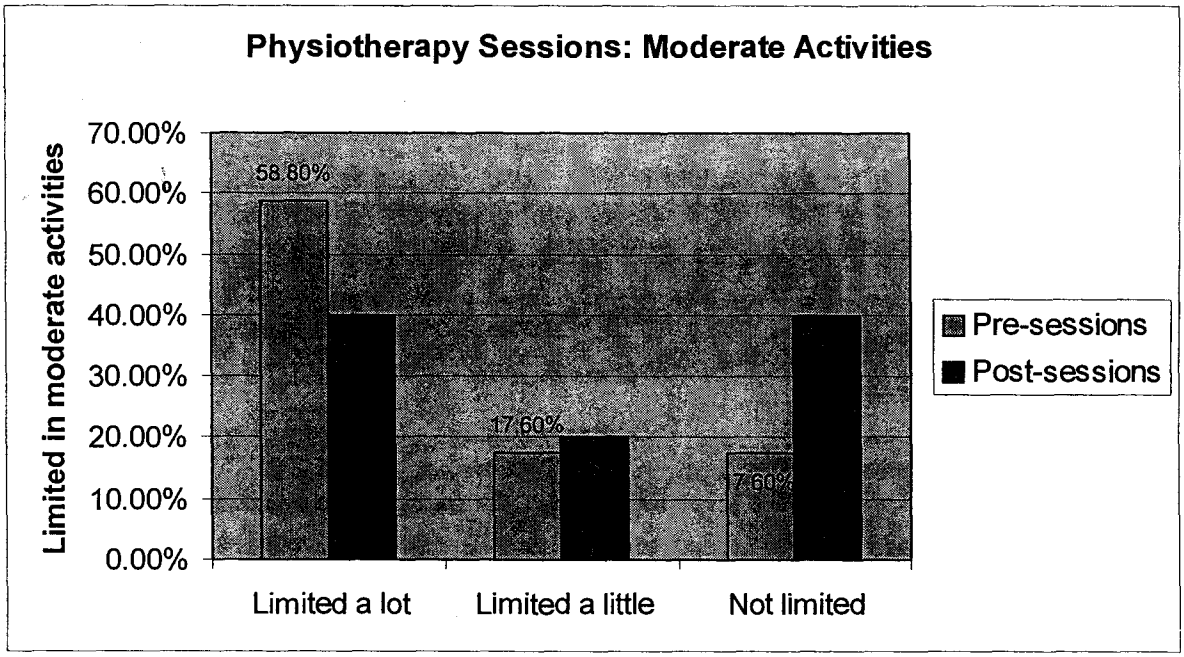
Fig 4 Pharmacy Sessions: Awareness of medication related to risk of falls



Objective 5 -Reduce the risk of falls and related injury in older people with mental health problems. Offering education to promote positive life styles, which reduce the risk of falls. Strength, balance and postural stability training. Minimise the negative factors associated with using walking aids

The results demonstrated that more patients were taking up physical activities. About 58.8% were limited a lot in carrying out moderate activities prior to group sessions whereas post sessions the percentage dropped to about 40%. Functionally taking up regular activities reduces limitation in carrying out daily activities.

Fig 5: Physiotherapy Sessions: Limitations in participating in moderate activities



Objective 6

Increase awareness of the need to address fear of falling, reduced self-efficacy reduced confidence and activity modification in the prevention of falls.

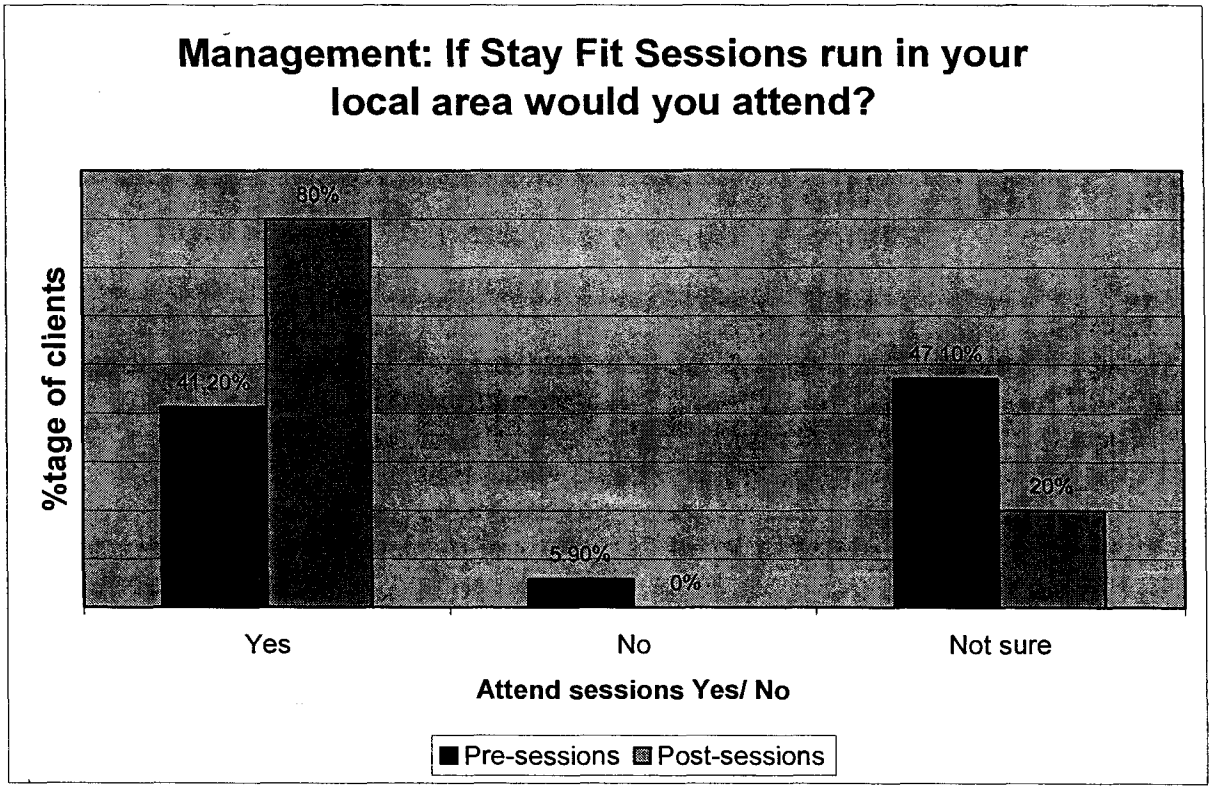
The psychologist held discussions around reducing the fear of falling, which generated a lot of interest among clients, as they felt more comfortable to share their experiences.

Objective 7

To promote participation of older people and carers in the prevention of falls

A higher percentage (80%- post sessions compared to 41.2%- pre-sessions) of clients responded positively to showing interest in participating in similar sessions if they were run in their local area.

Fig 6: Management: Stay Fit Stay Steady Uptake



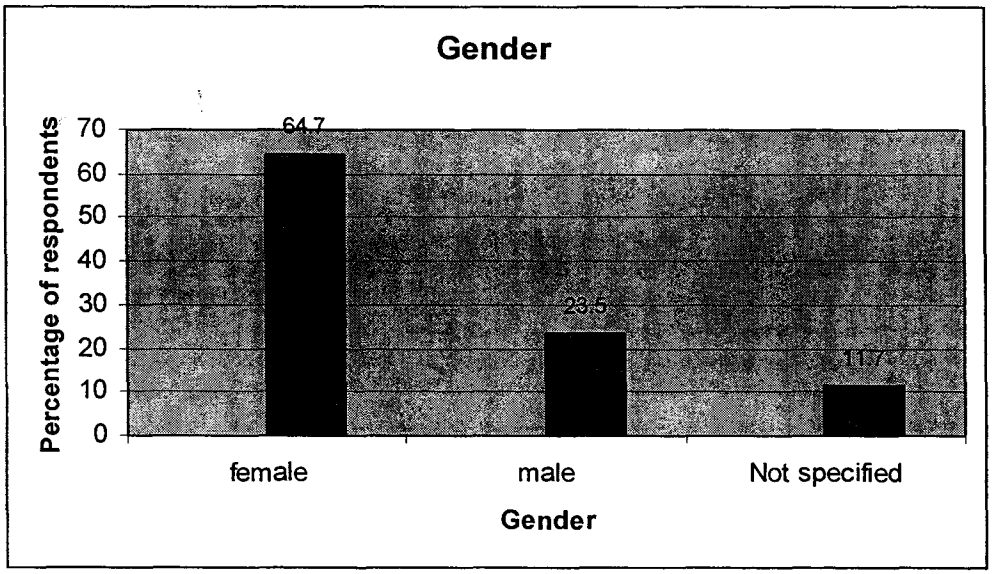
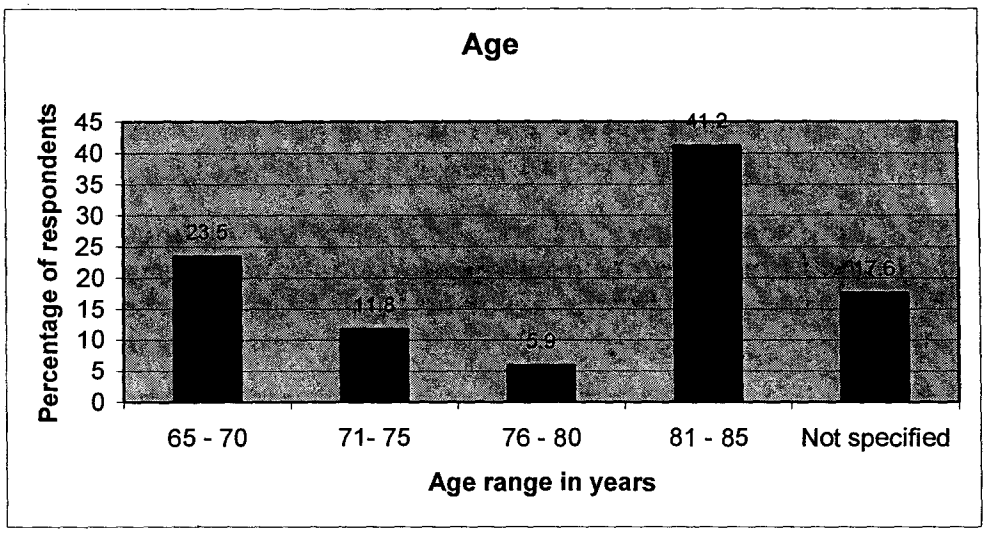


Fig 7(a)

Fig 7(b)



Discussion

This is the first program of its type, jointly facilitated by MDT members with a specific aim of addressing falls prevention in older people with mental health problems. The adoption of a specific evaluation outcome tool, the audit questionnaire, compiled in consultation with all MDT members has its advantages of keeping sessions well focused as well as maintaining a good level of motivation amongst service users.

MDT members are able to address specific issues for individual patients as needed based on feedback. For example one client requested for the OT demonstration to be summarised for her in writing as a reference and reminder for her daily activities. A few patients requested for physical activity programs to use in their home environment.

The more we can keep patients active in later life the more we can minimise the risk of falls. Once patients experience a fall they are more likely to avoid physical activities. The psychological sessions addressed boosting up confidence which patients found helpful.

Stay Fit, Stay Steady sessions are one approach of ensuring both continuity of physical activities in later life as well as minimising risk of falls by sharing important information with service user hence improving quality of life as a long term benefit.

Limitations

High turn over of patients on VDU

The post session's respondents' sample was proportionally less than the pre-sessions sample. However in future sessions will be evaluated on a weekly basis.

Recommendations

It is important that MDT members continue to work jointly in raising awareness and educating patients on factors that minimise the risk of falling.

Sessions will be evaluated on a weekly basis based on the theme for each week. Patients are often either discharged or might not attend VDU on the last day for evaluation.

Its important to follow up patients who attended sessions and check if program made an impact on the incidence of falls.

Patients with a history of falls need to be prioritised to attend the VDU on Thursday as part of their care plan in preventing falls.

The next stage of project would be to follow up the care pathway for patients who have had falls in the past and to ensure that their management is meeting the minimum standards for managing and preventing subsequent falls.

Liaising with GPs and the Falls Clinic on screening for osteoporosis and commencement of medication inline with NICE guidelines is recommended. This includes patients who pass through our acute admission ward as part of their physical health screen.

Exploring the possibility of rolling out sessions into the community infrastructure and allow more patients to access the service.

References

Department of Health (2001) National Service Framework for Older People London, Stationary Office

National Institute for Clinical Excellence (2004) The assessment and prevention of falls in older people. London [Online] Available from:
http://guidance.nice.org.uk

Department of Health (1999) *Saving Lives-Our Healthier Nation by 2010*
London [Online] Available from:
http://www.dh.gov.uk

Dowsell, T. (1999) Accidental falls: fatalities and injuries. An examination of the data sources and review of the literature on preventive strategies: Report prepared for the DTI, University of Newcastle upon Tyne, and London

DTI (1999) Accidental falls in the home: regional distribution of cases involving people aged over 65 in the UK. London.

Fleming, J. & Bryan, C. (2002) Circumstances and consequences of falls reported retrospectively by over-90-year-olds: the Cambridge City Over-75s Cohort Study, 5th International Conference on Falls and Postural Stability, Manchester, 7 Sept 2004

Help the Aged (2005) Encouraging Positive Attitudes to Falls Prevention in Later Life, London.

Hill, L.D., Haslam, P.A., Brooke-Wavell, K. & Sloane, J.E. (2001) Safety of Older People on Stairs: Behavioural factors, Loughborough University.

Rubenstein L.Z., Josephson K.R. & Robbins A.S., (1994) Falls in the nursing home. *Annals of Internal Medicine* **121** 442–51.

Rubenstein L.Z., Robbins A. S., Josephson K.R., Schulman B.L. & Osterweil D., (1990) The value of assessing falls in elderly population. A randomized clinical trial. *Annals of Internal Medicine* 113 **4** 308-16

Tinnetti M. (1986) Falls risk index for elderly patients based on number of chronic disabilities. American journal of medicine.
Todd (1995) Differences in mortality after fracture of hip: the East Anglian audit, *British Medical Journal* **310** 904–8.

APPENDICES

Appendix A
Audit Questionnaire

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Please share your views on awareness of factors that promote good mobility in prevention of falls (***If you need assistance in completing questionnaire please do ask. All responses are anonymous)***

Are you aware of "Stay Fit, Be Steady" sessions offered on Victoria Day Unit?

Yes ☐ No ☐

2. Did you attend any "Stay Fit, Be Steady" sessions run on Victoria Day Unit?

Yes ☐ No ☐

3. Do you think promoting good mobility is a way of preventing falls?

Yes ☐ No ☐

If No please comment

.....
.....

Are you aware of any **medical problems** that can contribute to risk of falls?

Yes ☐ No ☐ Not sure ☐

If you can think of them please list:

.....
.....

Are you aware of any **medication** that can increase the risk of falls?

Yes ☐ No ☐ Not sure ☐

If you can remember them please list:

.....
.....

6. Did you seek advice about your medication in the past six months?

Yes ☐ No ☐

If yes please state where you get advice?

.....

a) Does your health limit you in any of the following activities? To what extent?

	YES, Limited a lot	YES, Limited a little	NO, Not limited
VIGOROUS ACTIVITIES (such as managing exercises for 30 minutes, lifting a heavy object)			
MODERATE ACTIVITIES (such as vacuuming, bowling or golf, visiting friends,)			
Carrying a few groceries			
Climbing up a flight of stairs			
Bending or kneeling down			
Walking about half a mile			
Walking 100 yards (about 150-200 paces)			
Bathing and dressing yourself			

7. b) If Yes to any section on Question 7(a) did you speak to any medical professional about your limitations?

Yes ☐ No ☐ Not applicable ☐

If yes please state the medical professional you consulted?

.....

8. At least how many times per week should we try to engage in physical exercise?

[Physical exercise includes activities that

Once ☐ twice ☐ three times ☐

Five times ☐ not sure ☐

9. During the last week how long did you spend on each of the following activities?

	None	Up to 20 minutes	20 to 30 minutes	More than 30 minutes
Walking, including walking for pleasure, shopping, etc				
Housework/Childcare				
Gardening/DIY				
Exercises in a group				
Other Activities, *please specify*				

10. Are the following statements **TRUE** or **FALSE?**

	True	False	Not sure
Vitamin D plays a key role in assisting calcium absorption from foods?			
Good sources of calcium are from milk and dairy products			
Adequate protein is essential for preserving bone mass with ageing?			

11. Have you attended any demonstrations on preventing falls in the home in the last 6 months?

Yes ☐ No ☐

If No to Q 11 please go question 13

12. Did you find the demonstrations on preventing falls useful?

Yes ☐ No ☐

13. Do you think that how you feel can impact on how steady you are on your feet?

Yes ☐ No ☐

If no to question 13 (a) please go to question 16

If yes to Q13 what sort of feelings can negatively affect your confidence in being steady on your feet?

.....

.....

What might you do in the future to help manage the feelings you listed on Q14, so that you can be more confident about your ability to be steady on your feet?

.....

.....

If we were to run "Stay Fit, Be Steady" Sessions in your local community would you be interested in attending?

Yes ☐ No ☐ Not sure ☐

Do you have any suggestions for improving "Stay Fit Be Steady Sessions" for?
Prevention falls?

Yes ☐ No ☐

Please specify.....

Please tell us more about yourself?

18. Your gender

Female ☐ Male ☐

19. How old are you?

65-70 years ☐ 71 –75 years ☐

76 –80 years ☐ 81 – 85 years ☐

Over 86 years ☐

20. Please tick one of the following that you most strongly identify with: -

White	**Black or Black British**	Mixed	Asian or Asian British
British ☐	African ☐	Mixed white & Black Caribbean ☐	Indian ☐
Irish ☐	Caribbean ☐	Mixed white & Black African ☐	Pakistani ☐
Greek Cypriot ☐	Any other black background ☐ Please write in	White & Asian ☐	Bangladeshi ☐
Turkish Cypriot ☐	----------	Any other mixed background Please write in	East African Asian ☐
Kurdish ☐	**Chinese** ☐	----------	Any other Asian Background Please write in
Turkish ☐	Any other ethnic group Please write in		----------
Any other white ☐	----------		
Please write in ----------			

If you would like to make further comments please use the box below

If you would like individual feedback on any questions please give your details

Name.....

Thank you for your cooperation in answering these questions.

If you need to contact the Victoria Day Unit Team running "Stay Fit, Be Steady" Sessions
You can either call on 020 8442 6160 /6422 or e-mail
Lilian.mapeza@beh-mht. Nhs.uk
By post Q2 Therapy Centre, St Ann's Hospital, St Ann's Rd, N15 3TH

Editors note A big thank you to all those who responded to the posture observation project advertised in the last journal. Please find below the results of the survey

Gait and Postural Disturbances in Mental Health Practice: Preliminary Observations by Physiotherapy

Picton-Bentley J.A, Tallis R, Horgan O.J, Beck L,

Introduction

There are several reasons for anticipating that patients with mental health problems may have disturbances of posture and gait. These include: the direct impact of organic mental illnesses such as apraxia seen in patients with dementia: the effects of psychotropic drugs: and, more interestingly, the direct effect o longstanding mental illness on posture and distribution of muscle tone. This has implications for the provision of services and is one of the reasons why the physiotherapist's role within the healthcare team' should be reconsidered..
. For this reason, we felt that it would be useful to make preliminary observations of gait and posture disturbances noted by physiotherapists in mental health care settings. We therefore conducted a limited survey of such problems.

Methods

The survey built on preliminary work classifying gait and posture disturbances in mental health care patients. At an initial meeting of five senior physiotherapists, a list was drawn up of types of gait disturbances that those physiotherapists had observed during the course of their clinical work. This list was then circulated to physiotherapists in the special interest group who had registered an interest in this project. This resulted in an augmented and refined list of observed postures and gaits. The revised list was circulated again by posting on the Interactive CSP Professional Discussion Forum and also entered into the CPMH journal. On the basis of this feedback a definitive list was drawn up and formed the basis for the postal enquiry.

Figure 1- Types of observed Gait and Postural Variation

1.) Tigger type gait (bouncy gait)
2.) Pisa phenomenon (leaning to the side)
3.) Skating gait
4.) Backward leaner (sway back, pushing hips forward)
5.) Parkinson type gait (flexed trunk, lack of arm swing, shuffling gait)
6.) Rigid gait (lack of rotation, limbs held in extension)
7.) Ballismus of the limbs (involuntary violent flinging movements)
8) Head back posture (arms flexed at the elbow, reduced trunk rotation general extension throughout spine
9) Hemi posture wooden leg gait (the arm is held at the side and the whole side advances in one piece then the other leg takes a short step to level with or slightly past the affected side

Copies of a form, listing the types of gait and postural impairment were incorporated in an n issue of this CPMH journal. Readers were invited to observe patients over a three-month period September to December 2008. They were also encouraged to made any other observations they thought might be of interest.

	M/F	Age	Mental health Diagnosis	Observer and Gait type /posture observed										
					1	2	3	4	5	6	7	8	9	O
2	M	69	DEPRESSION	A									X	
11	F	67	DEPRESSION	B					X					
13	F	78	DEPRESSION	B					X					
27	F	72	DEPRESSION	E		X								
38	F	80	DEPRESSION	G					X					
57	F	85	DEPRESSION	I				X						
61	F	83	DEPRESSION	J					X					
63	M	72	DEPRESSION	K										X
71	F	83	DEPRESSION	K					X					
72	M		SEVERE DEPRESSIONn	K					X					
50	M	71	LOW MOOD HALLUCINATIONS	I					X					
4	F	66	DEPRESSION & LEWY BOD	A								X		
54	M	68	AGITATED DEPRESSION	I					X					
10	M	68	SCHIZOPHRENIA	B	X									
31	F	64	SCHIZOPHRENIA	F					X					
33	M	61	SCHIZOPHRENIA	F	X									
34	M	70	SCHIZOPHRENIA	F				X						
36	M	75	SCHIZOPRENIA/DEMENTIA	G			X						X	
37	M	75	SCHIZOPHRENIA/DEMENTIA	G							X			
51	F	63	ANXIETY	I										X1
56	F	93	ANXIETY	I				X						
62	M	73	ANXIETY	K					X					
66	F	74	ANXIETY	K										X
67	F	86	ANXIETY	K										X
44	F	28	ANOREXIA NERVOSA	H					X					
45	F	28	ANOREXIA NERVOSA	H	X									
46	F	19	ANOREXIA NERVOSA	H					X					
47	F	43	ANOREXIA NERVOSA	H		X								
8	F	48	ANOREXIA NERVOSA	H					X					
49	F	44	ANOREXIA NERVOSA	H				X						
21	F	38	EATING DISORDER	D					X					
5	M	86	DEMENTIA	A					X					
6	M	82	DEMENTIA	A					X					
12	F	82	DEMENTIA	B				X						
18	F	77	AZSHEIMERS	C					X					
14	M	85	ALZHEIMERS DISEASE	C				X						
15	M	83	DEMENTIA SYNDROME	C					X					
16	F	76	DEMENTIA	C										X
20	F	66	DEMENTIA	C						X				
25	M	65	DEMENTIA	E		X								
26	M	70	DEMENTIA	E		X								
28	F	80	DEMENTIA	E				X						
29	M	75	OLDER ADULT	E			X							
30	M	65	DEMENTIA	E							X			
32	F	73	DEMENTIA	F					X					
35	F	79	DEMENTIA	F				X						
41	M	68	DEMENTIA	G		X								
52	F	79	AGGRESSION/COG IMPAIR	I				X						
55	F	80	COGNITIVE IMPAIRMENT	I					X2					
42	F	76	DEMENTIA	G										X
64	F	78	DEMENTIA	K										X
68	M	85	DEMENTIA	K					X					
69	M	74	DEMENTIA	K					X					
65	F	81	DEMENTIA	K										X
58	M	82	COGNITIVE IMPAIRMENT	I				X						
59	M	74	DEMENTIA	J					X					
1	M	82	BI-POLAR	A					X					
9	M	30	PARANOID SCHIZ	B						X				
22	F	38	PARANOID SCHIZ	D					X					
39	M	48	PARANOID SCHIZOPHRENIA	G				X						
40	M	54	PARANOID SCHIZOPHRENIA	G				X						
17	F	74	PSYCHOSIS	C					X					
19	F	74	PSYCHOSIS	C						X				
3	F	73	PSYCHOSIS	A							X		X	
60	F	78	PYCHOSIS	J			X							
70	F	78	PSYCHOSIS	K			X							
23	F	32	L DIS& PERS DIS	D									X	
24	F	35	PERSONALITY DISORDER	D										X
7	M		HEAD INJURY	A									X	
8	M	80	SUPRANUCLEAR PALSY	B	X									
53	F	71	FOLIE AUX DEUX	I					X					

. Figure 2 results of postal Survey September to December 2008

Results

The results are given in Figures 2, 3, 4, which lists age and sex, diagnoses and gait and posture abnormalities. As can be seen there was a broad age range M median being seventy-four. There were more women noted then men. The commonest diagnosis was dementia (25), Depression (12) Eating disorder (7) Schizophrenia (12) with other diagnosises observed on only a small number of occasions. With two clients two types of postural disturbance were recorded.

A total of 72 observations were made. By far the commonest observations were of the Parkinsonian gait and the backward leaner. The more exotic gaits were rarely recorded.

Figure 3 – Variations by mental health diagnosis

AGE GENDER	TOTAL	18-35		36-49		50-64		65-75		76-100	
		M	F	M	F	M	F	M	F	M	F
Depression	13							3	5	1	4
Schizophrenia	6					1	1	4			
Anxiety	5						1		2		2
Eating Disorder	7		3		4						
Dementia	25							7	4	6	10
Bi-polar	1									1	
Paranoid Schizophrenia	4	1		1	1	1					
Psychosis	5								3		2
Learning Disability/personality Disorder	2		2								
Other	4							2			
Total	72	1	6	1	5	2	2	18	12	7	18

Discussion.

The majority of responses related to older people, which is as might be expected, given that the majority of physiotherapists working with people with mental health problems are now in Older People's Services, reflecting the political pressures determining the allocation of resources

Figure 4 Breakdown by Suggested variations

AGE GENDER	M	F	T	18-35		36-49		50-64		65-75		76-86	
				M	F	M	F	M	F	M	F	M	F
1. Tigger Type	3	1	4		1			1		1		1	
2. Pisa phenomenon	3	2	5				1			3	1		
3. Skating gait	2	2	4							2			2
4. Backward Leaner	5	7	12			1	1	1		1		2	6
5. Parkinson type gait	11	17	28		3		3		1	7	4	4	6
6. Rigid gait	1	2	3	1							2		
7. Ballismus	2	1	3							2	1		
8. Head back posture		1	1								1		
9. Hemi posture wooden leg	2	3	5		1					2	2		
Others	2	7	9		1				1	1	1	1	4
Totals	31	43	74	1	6	1	5	2	2	19	12	8	18

The findings are clearly preliminary in several respects. Firstly, only a small number of patients were surveyed. Secondly, and most importantly, it was uncertain what population of patients was being drawn on, so in the absence of a denominator, we cannot translate the

figures in to frequencies or prevalence. Thirdly, further refinement is needed of the classification of gait and postural disturbances; in particular the need to check inter-observer reliability.

Finally the data obtained did not allow us to determine the extent to which the abnormalities were due to drug treatment, to the underlying neurology, or to the impact of mood and mental state on gait, particularly as we do not have information about the duration of the illness. An additional problem is the absence of good evaluation tools appropriate for [patients in this setting and to measure the impact of physiotherapy interventions.

These limitations not withstanding, we have shown that it is possible to carry out a survey of gait and posture problems in this group of patients. There is however a good deal of work to be done before we can draw sound conclusions about the prevalence of the problems we have studied and the underlying causes. In view of the size of the challenge and the overlap of patients between special Interest Group, this would seem to be a task that might be taken on by CSP driven initiatives such as the SKIPP project, (supporting knowledge in Physiotherapy Practice scheme.

CPMH Committee Members 2009

Chairperson Sharon Greensill	Physiotherapy Department Mental Health Unit, Rotherham General Hospital, Rotherham, South Yorkshire S60 2UD	01709 820000 ext 5946 sharon.greensill@dsh.nhs.uk
CIGLC Liaison Caroline Griffiths	Physiotherapy Department Warneford Hospital, Oxford, OX3 7JU	01865 223811 caroline.griffiths@obmh.nhs.uk
Treasurer Victoria Welsh	Physiotherapy dept West Mendip Hospital Old Wells Road Glastonbury Somerset BA6 8JD	victoria.welsh@somcomhealth.nhs.uk'
Membership Secretary Nicky Atherton	Clinical Trials Unit Medical School Building University of Warwick Coventry, CV4 7AL	024 7657 4651 n.atherton@warwick.ac.uk
Secretary Clare Leonard	Older Person Mental Health Services, Victoria Centre, 53 Downs Way, Swindon, Wilts,SN3 6BW	01793 327933 Clare.leonard@awp.nhs.uk
Journal editor Jean Picton-Bentley	Physiotherapy Department Maudsley Hospital Denmark Hill London, SE5 8AZ	0203 228 5028 jean.picton-bentley@slam.nhs.uk
Congress/Conference Coordinator/Diverstiy Officer Lilian Mapeza	Q2 Therapy Centre St Ann's Hospital St Ann's Road London N15 3TH	0208 442 6160 lilian.mapeza@beh-mht.nhs.uk
ICSP Moderator Anthony Hegarty	Physiotherapy Department West London Mental Health NHS Trust "E" Block, St Bernard's Wing Ealing Hospital, Uxbridge Rd Southall, London,UB1 3EU	Anthony.hegarty@wlmht.nhs.uk Tel - 0208 354 8164 Fax - 0208 354 8560
Promotion/ Development Olivia Horgan	Birmingham and Solihull mental health trust north. Croft Physiotherapy Department, 190 Reservoir road Erdington Birmingham B23 6DW	0121 685 7430
Scottish representative Ann Parker	Superintendent Physiotherapist Royal Edinburgh Hospital	0131 537 6367 anne.parker@nhslothian.scot.nhs.uk
Research and education Brendan Stubbs	Physiotherapy Department St Andrew's Healthcare Billing Road Northampton,NN1 5DG	01604 616251 bstubbs@standrew.co.uk
Marketing Advisor Sue Coffee	Head of AHP, Physical Health and well being services Birmingham and Solihull MHT	0121 3011048 Sue.coffee@bsmnt.nhs.uk

Chartered Society of Physiotherapists in mental Health- Committee Business.

MINUTES OF THE ANNUAL GENERAL MEETING OF THE CHARTERED SOCIETY OF PHYSIOTHERAPISTS IN MENTAL HEALTH CARE
23RD JANUARY 2009 MEETING HELD AT THE CHARTERED SOCIETY PHYSIOTHERAPY HEADQUARTERS IN LONDON

Apologies received:
Hilary Haynes
Judith Bentley
Rhonda Neil
Nicky Atherton
Victoria Welsh

Present:
25 members and 5 Committee members.

Matters Arising
None were identified.

Individual reports.
Chair : Caroline Griffiths.
Caroline has had her major work with writing the framework for physiotherapy: recovering mind and body. She is very pleased with the outcome and now we think need to think about how we are going to put it into practice.
Caroline attended the European Conference of Physiotherapy in Psychiatry in Bergen and was able to network with other physios and did a presentation on our framework. The next conference is in Sweden in 2010 and there is a request out for papers and this can go through CPMH.
Catherine Pope asked if we could support someone to attend the conference and to look at best practice. We did support two people this year who were talking and we would like to invite some speakers to come and present here possibly at Congress.
The constitution has been looked at. We were re-recognised last year continuing to reviewing this and there was a question whether it was on the website. **ACTION FOR** Sharon Greensill to check that.
Caroline has now resigned from her chair and there are now some spaces on the committee as well.

Treasurer - Victoria Welsh
Victoria had sent a copy of the accounts and they were made available and there was no verbal report given and no questions to the accounts.

Secretary – Clare Leonard
This year it has been taking minutes and messages. Clare is also sitting on a Steering Group for EVIDEM a research organisation and they are looking at some research into exercise for people to improve the physiological and psychology symptoms of dementia. Clare also spoke at Congress last year on overcoming negative attitudes to older people.

Research and Education – Brendan Stubbs
Brendan is keen to support people into research and to share his education with other CPMH members but would he would just to talk about the things that would need some support. Looking at the award there isn't so much money around and we still need to keep this but we may need to review this. Any feedback to Brendan.

Journal Editor – Jean Picton-Bentley

Changed the publications to Summer and Winter. There are two journals rather than journal and newsletter. Jean is still requesting ideas and things to go into those journals. Jean had asked for any returns for her forms on the posture research and if anybody would like to fill a form out they can ask her. Also student projects can be published in the journal. Jackie Clifford's MSc will be published and shared and she gives her thanks to those who supported her.

CIG Representative – Sharon Greensill

Working together. To review the roles and responsibilities of the Clinical Interest Occupational groups.
What do they do
Different roles and responsibilities
What strategic roles do they have
What shared roles should the CIG/OG's and CSP have
What should the recognition be based on
Accountability and governance.

To identify the best model for supporting the CIG/OG's and the CSP in their business.
Looks at group's structure, operation, membership criteria, Training requirements, resource support.

- Partnership Event
- Charting the Future. CSP's vision for contribution of physiotherapy to the health and well-being of the UK population over the coming years, also looking at its role in stakeholders.
- Advertising on ICSP. Castings arrange to allow CIGs to use ICSP to promote their courses events etc. Up to £30 per delegate per day no charge. £31-£100 £30.00 charge plus VAT. Over £100 per delegate per day £100 plus VAT.
- Frontline Articles List of all CIGs who have expressed interest for submission into Frontline. CIGs to have one page to promote their CIG to members.
- Pebble Pad Online CPD tool available for all members.
- ARC and agenda – September meeting included presentation and refresher on ARC and how to write motions etc.
- Congress 2008 success with plans for 2009 well underway. 2009 to be held in Liverpool with a theme of We can Work it Out and Mathew Pinsent as Keynote Speaker. 6 themes including Health Work and Well-being led jointly between Sue Coffee CPMH and CSP officer. Congress 2009 International Event.
- CIG Exec committee Training Treasurers held. CIGLC now looking at next training needs.
- CSP Corporate Strategy 2011-2013
- Clinical Content – Generic and reusable templates and forms that enable clinicians to record patient related information through any system within operational and practising environments. Looking at building a library of accredited clinical content (e.g outcome measures, questionnaires, templates, proformas) that can be available from one place e.g. national database and implemented in a standardised format across many different information systems. The clinical content team have approached professional bodies for their knowledge and expertise.
- Map of Medicine – a based clinical support tool, Care Pathway tool with access to specialist knowledge and evidence based practice, spanning patient journey primary and secondary care. Aims to provide different forms of evidence to support decision making e.g. guidelines, consensus statements, expert opinion. Concern at present as there is only a small amount of information about physiotherapy. Map of medicine management

- Data Protection – work undertaken by Fran Fitch looking at sharing information.
- Equality and Diversity – raised by Learning Disability group re what Cognitive's have to provide for disabled members. Draft paper produced which focused on need to take 'reasonable steps'. Statement produced but decision at PPC for further work on this seeking advice from Equality and Diversity group to possibly produce paper. Possible financial support for smaller CIGs where there may be cost implications to meet the diversity needs of their members.
- Website for CIGs free through CSP website review programme.
- Comments on papers/involvement on working parties:
  Patients seeking concurrent treatment
  Scope of Practice

- My work over the past year. CSP/CPMH rep on New Ways of Working National Steering Group. Contribution to AHP New Ways of Working and production of Physiotherapy contribution for the document. Review and physiotherapy contribution in Scottish Health and Well-being Paper. Member of PPC Scope of Practice subgroup which reviewed the scope of physiotherapy practice for the profession. Development of Mental Health Strategy working with Catherine Pope, Caroline Griffiths and Dawn Wheeler Deputy Direct at CSP.

- Attendance at NWW National Steering Group. Royal College of Psychiatrists steering group on AMHP/AMHC. Represented CSP at Mental Health Workforce Development Consultation Event. Represented CPMH at ARC and at CIG Conference. Attended Congress and contributed to programme. Chair CIGLC Committee. Attendance at CIGLC action group meetings. CIGLC rep on Professional Practice Committee. Sit on Congress Management Group. Sit on Congress Programme Development Group. Chair of Strategic steering group for Working Together project. Caroline represents CIGLC on ? group.

<u>Equality and Diversity- Lilian Mapeza</u>

Three groups are included in the equality and diversity network:

- Disabled Members
- Black and Minority Ethnic Members
- Lesbian Gay Bisexual and Transgender Right Members Network groups.

Following an ARC motion in previous years CSP recommended that all interest group have a diversity officer.

I was elected into office in March 2008. I attended Equality and Diversity Network study day organised by CSP October 2008.

Study Day addressed various issues:

- Cultural Competence. Mel Stewart (Convenor of Black and Minority Ethnic (BME) Members Network) delivered a session on cultural competence. She defined cultural competence as "a set of congruent behaviours, attitudes and policies that come together in a system agency or among professionals that enables effective work in cross cultural situations". (HHSOMH 2000). The session covered issues such as clarifying a culturally competent physiotherapist who recognises how they communicate their own culture and adapts practice accordingly to support health outcome improvements (Main 2006).

- Cliff Towson (Convenor of Disabled Members' Network) gave a feedback on TUC and Access to Work Campaign, which was presented at the last TUC conference.

- The CSP is working on increasing awareness on equality and diversity issues. A draft on Equalities and Diversity Strategy was in circulation in October last year. It addresses specific strategy priorities and objectives. It includes issues such as supporting members in achieving Dimension 6 on the NHS KSF.

- CSP runs training for members elected into office and there should be one coming up soon.

- If members have any issues pertaining to Equality and Diversity CSP will support you.

Key Facts

Information on how to network with others is available on icsp. Equality and Diversity Network (BME) will submit an Arc Motion to CSP requesting HPC to consider/look into why many members who often end up getting struck off the register are from BME. How does it happen that they get registered and get struck off again for professional misconduct?

TUC is coming up in April and an Arc motion is being drafted around diversity and health inequalities.

Updates and Reports

Equality Bill (from icsp)

The long awaited Single Equality bill is expected to be presented direct to Parliament in the New Year, without any further consultation. On the plus side, the Government's response to the previous consultation has confirmed some promising decisions. These include specifically that:

- The Public Sector duty will cover all strands and there will be no retreat from the specific duties that have given strength to the existing (race, disability and gender) duties.

- A working group is looking at improving the current very tight definition of who is counted as a trans person.

- Indirect discrimination and 'association' provisions will be extended to cover gender reassignment.

- One of the unknown areas is how the new law will deal with the outcome of the European Maruko case which ruled against time limits for same sex partner access to benefits (as remain in Regulation 25 of our Employment Equality (Sexual Orientation) Regulations).

- Much will be left to secondary legislation, however, so will remain unknown until that time. It is certain that there will be very vigorous campaigning, lobbying and amendments put down by/on behalf of the same fundamentalist groups that have campaigned against all recent LGBT equality legislation to secure exemptions.

Co-Conference co-ordinator report

Study Days/Conferences

- National Study day 23rd January 2009. Theme on Capturing the Evidence
- LGBT two day conference coming up on the 27th Feb, more information available on icsp.
- Basic Body Awareness Course coming up in May at St. Andrews Hospital.

Any conferences or study days will be announced in due course. If anyone has a conference or study day to run CPMH will support you.

Membership Secretary – Nicky Atherton

We have 102 paid up members but last year we did have 137. Nicky thanked everybody who responded to the icsp for updates on memberships. Membership cards have been sent out. Some e-mails and posters have bounced back. There were a few committee members due to retire and Jackie Clifford was nominated and seconded by ? and Jackie has offered Sue Coffee on her Congress work that she is involved with.

AOB

Marie Donaghy has been President and has stepped down now. Catherine Pope was proposed to be President and she has agreed to take on that role.

There was a request for somebody to write to Marie to thank her for her work and to think about a gift for her. ACTION Clare

The CSP are revamping their website. It will be a free website the same setup up as the CSP but it will be independent and will be responsible for the content but the CSP will maintain the site.
Our CIG gets priority because we expressed an early wish to join with the CSP on their website.

Thanks were given to Caroline Griffiths for all her hard work and support for CPMH over the years that she has been chairing it.

Meeting closed at 2.15pm.

Note: The over spend was planned and was to fund the writing and printing of the physiotherapy in mental health strategy.

CPMH ACCOUNTS

cpmh accounts

ACCOUNTS FOR PERIOD: 1 September 2007 to 31 august 2008

Income & Expenditure Account

	2007-8	2006-7
INCOME		
SUBS	2,205.00	2,510.00
CAP FEES		-
BANK INTEREST	114.18	
COURSE FEES/ CONGRESS	290.00	282.55
TOTAL INCOME	**2,609.18**	**2,792.55**

EXPENDITURE

ACCOUNTANCY	140.00	135.00
COMMITTEEE EXPENSES	1,926.41	1,267.60
JOURNAL EXPENSES	1,387.41	1,117.30
LECTURE FEES	-	-
EDUCATION GRANT	645.00	
COURSES	124.00	708.10
OTHER	3,000.00	125.00
TOTAL EXPENDITURE	**7,222.82**	**3,353.00**
SURPLUS/(DEFICIT) FOR PERIOD	**(4,613.64)**	**(560.45)**

Balance Sheet

		2007-8	2006-7
Assets	year end		
	CASH IN HAND	-	
	BANK: CURRENT ACC	1,767.74	2,035.80
	BANK: DEPOSIT ACC	9,840.17	14,725.99
		11,607.91	**16,761.79**

Funded by

OPENING RESERVES	16,221.55	16,782.00
SURPLUS/(DEFICIT) FOR PERIOD	(4,613.64)	(560.45)
	11,607.91	**16,221.55**

Note: The over spend was planned and was to fund the writing and printing of the physiotherapy in mental health strategy.

FORTHCOMING EVENTS

OFFICIAL LAUNCH

Recovering Mind and Body –

A Framework for the Role of Physiotherapy in Mental Health and Wellbeing.

Commissioning Mental Health Services

6th November 2009

Dear Sir/Madam,

On behalf of the Chartered Physiotherapists in Mental Healthcare and the Chartered Society of Physiotherapy we would like to invite you to the Launch of our National Strategy for Physiotherapy in Mental Health, Recovering Mind and Body.

The strategy was developed as part of the Physiotherapy action plan for New Ways of Working. The framework and its sister document for commissioners provide a clear vision for Physiotherapy within a modern mental health service. It identifies four building blocks to aid the development of physiotherapy within mental health: new ways of working; leadership; learning and development; delivering the evidence base, and emphasises the contribution physiotherapy can make in the delivery of high quality evidence based mental health and well being services.

The practical action plans help this development process and will support the education of physiotherapists in an ever-changing health environment.

We would be extremely pleased if you could support this event.
The date of the launch is Dec 14th, at the Uffculme Centre, Queensbridge Road, Moseley, Birmingham.

Yours faithfully,

Sharon Greensill

Chair
Chartered Physiotherapists in Mental Healthcare

CHARTERED PHYSIOTHERAPISTS IN MENTAL HEALTH

Time	Topic	Speaker
11.00 to 11.05	Welcome to the trust and venue	Chris Tidman Deputy CEO BSMHFT
11.05 to 11.10	Introduction to the day	Sharon Greensill Chair CPMH
11.10 to 11.20	CSP Perspective	Phil Gray CEO CSP
11.20 to 11.50	Launch of the document and how it relates to health care objectives in mental health QIPP	Karen Middleton CHPO
11.50- 12.00	Vote of thanks	Ann Green Chair of CSP Council
12 00 to 12 30	Recovering Mind & Body – the future	**Catherine Pope Chair Steering Group**
12.30 to 13 30	**Lunch**	
13 30 to 14 00	Physiotherapy and Dementia care	Claire Leonard CPMH
14 00 to 14 30	Health and Well Being an integrated approach	Sue Coffee CPMH
14 30 to 14 45	Mental Health – Everybody' s business	Sharon Greensill CPMH
14 45 to 15 00	**Coffee break**	
15 00 to 15 45	Demand defined services – what does this mean? Questions to panel	**Chaired by Professor Tallis**
15 45 to 15 50	Summary and closing of proceedings	

AGM -2010

Please note tin The CPMH Annual Study Day at the CSP on Monday 25th of January 2010 has been cancelled.
New date to be advised

Chartered Physiotherapists in Mental Health

Introduction to Mental Health (for) Physiotherapy Course

Friday 5th of March 2010

Venue: **Physiotherapy Department, ST Bernard's Wing, E Block, Ealing Hospital, Uxbridge Road, Southall, UB1 3EU**

Cost: **£55 for non CPMH members (This fee includes membership of CPMH)**
£45 for CPMH members
£35 for students and retired members of CSP 2. Introduction to Mental Health (for)
Accommodation available if booked in advance.

This course is being provided by experienced physiotherapists in mental health to cover an outline of mental health conditions, the role of physiotherapists in mental health, understanding signs and symptoms of mental health, adaptive approaches in communication and treatments in mental health, setting and awareness of mental health services. This includes practical workshops in popular treatments and presentations. Suitable for student physiotherapists, Technical Instructors, Physiotherapist Assistants, and Junior physiotherapists with an interest in mental health or those about to embark on a rotation in mental health or senior physiotherapists who have a responsibility for mental health patients.

Contact details:
Anthony Hegarty
Superintendent Physiotherapist
West London Mental Health Trust
T.P: 0208 354 8164/Fax: 0208 354 8560
Anthony.Hegarty@wlmht.nhs.uk

NEWS AND EVENTS

SPECIAL INTEREST GROUPS

Midlands CPMH Group

Contact 'Lauren.Reuter@leicspart.nhs.uk'

London and Southeast CPMH Group

Contacts:- Kashif Arthur [Kashif.Arthur@wlmht.nhs.uk] - Secretary
Anthony Hegarty Anthony.Hegarty@wlmht.nhs.uk - Chair

Please find attached the prog for the next CPMH London and Surrey Borders meeting to be held on 15 December, 09. 9.30-12PM. Discussion Topic and Presentation - Acupuncture

The venue is:
Physiotherapy Department-WLMHT, St. Bernard's Wing, E-Block, Uxbridge Road, Southall UB1 3EU. Tel:0208 354 8164/8897

SPECIAL INTEREST GROUPS - Feature on the Scottish Branch

Bibliography

Anne Parker – member of CPMH (Scotland) committee and Scottish representative on the CPMH committee
Representing Britain on the International Council of Physiotherapists in Psychiatry and Mental Health (IC-PPMH)

Superintendent Physiotherapist at the Royal Edinburgh Hospital
Basic Body Awareness Therapist and BBAT teacher trainee
Main interests – PTSD, Borderline PD, Chronic Fatigue, Anxiety/panic
Areas that I work in: Specialist psychological trauma, Forensic, Intensive Psychiatric care, Adolescents, General Psychiatry and Rehab of Enduring Mental Disorders.
Worked in mental health for 16 years
Previous experience: General medicine, orthopaedics, outpatients, sports injuries, neurology, care of the elderly
Formative influences: both sisters are physiotherapists, one with a PhD in orthopaedics (Cruciate ligament injuries) the other has a MacKenzie qualification.

Interests and passions: family, music and gardening. I play the viola in quartets and orchestras and undertake a perennial trek to Norway (country of origin) to attend chamber-music week and see family and friends at family cottage.

CPMH Scotland

History

CPMH Scotland has been active in supporting and developing physiotherapy in Mental Health (MH) for over thirty years. Over this time there have been many changes but the committee have always been able to keep ahead and provide a useful source of support and mentorship for physiotherapists working in mental health. The core members of the current committee have many years experience of working in mental health and have developed specialism within mental health such as acute adult psychiatry, PTSD, addiction and so are able to be an expert resource.

Current membership

About thirty physiotherapists are current CPMH members. However within Scotland there are approximately seventy to eighty physiotherapist working in MH, so CPMH only manages to reach about 40% of potential members. There are pools of CPMH members in areas such as Edinburgh, Aberdeen and Ayrshire. There are some areas of Scotland where membership to CPMH is low in spite of having a large population where MH health problems are significant such as Glasgow.
We have links to the National CPMH through our representative on the main branch committee.

Mental health in Scotland

There are many differences for physiotherapists working in MH within NHS in Scotland and this is due to several factors. We have a devolved Government in Scotland, with the Scottish National Party winning power in 2007. Within the Health budget there has been a stronger focus on MH. A driver for change has been the document Delivering for Mental Health (2006). This document has focused attention on some of the main areas and set targets for improvements in Mental Health. The main targets are: to reduce the high suicide rate within the adult population; to reduce the prescription of anti depressant prescribing; to improve the physical health of people with severe mental illness and to reduce the impact of alcohol addiction.

Within Scotland we have the equivalent of NICE called Scottish Intercollegiate Guidelines Network (SIGN). The most recent guideline produced was on the non pharmacological management of depression (2009). The use of exercise in the management of depression came out as one of the key interventions which was backed by a strong evidence base.
Within Scotland we have our own CSP office and we have worked closely with the CSP policy officer to strengthen the links between the CSP, Scottish Government and CPMH (Scotland). There is strong case for CPMH Scotland writing our own version of Recovering Mind and Body which would highlight our goals of Physio in MH Scotland for the next five years.

Aims of CPMH (Scotland)

1. To support and develop MH physiotherapy in Scotland
2. To inform and share our knowledge and skills with other MH practitioners
3. To provide a resource to our fellow physiotherapist in treating patients with mental health problems
4. To increase the access to MH physiotherapy for patients in community based MH settings
5. To develop the specialism of MH physiotherapy by producing a structured career pathway from junior grade rotational posts up to consultant level
6. To improve the links with universities and increase the knowledge base of MH conditions which are relevant to physiotherapy at undergraduate and post graduate levels.

Current projects - CPMH Scotland

1) A Scottish government backed AHP action group has been set up which will influence AHP s role within MH. Some members of the CPMH committee have direct input to this action group and there are several work stands which are coming out of this.
a) To refresh of the Delivering for Mental Health (2006) document will highlight the role of AHPs including physiotherapy in improving the mental health and well being of the population. This document will be the template which NHS boards across Scotland will plan and manage their MH services.
b) To develop new AHP, including physiotherapy, strategies to help improve the physical health of people with severe mental health problems
c) To conduct a workforce and education scoping exercise into how many MH physiotherapist work where, doing what and with whom? The scoping exercise will also identify which MH physiotherapy sites provide access to placements at undergraduate and post graduate levels.
d) To set up an AHP conference which will highlight the work Scottish Physiotherapists in MH are doing.
2) We organize two national study days per year. Some of the recent study days have included management of anxiety and depression, lifestyle management, Basic Body Awareness Therapy and acupuncture. These study days are relevant to our ongoing CPD requirements
3) We are currently producing an annual CPMH newsletter with information about our projects as well as our planned study days.
4) We are in the process of writing our mental health physiotherapy document, a Scottish equivalent of Recovering Mind and Body (2008)

Future

Within the next five years we would like to have a more cohesive mental health physiotherapy base in Scotland. From this base we and others, could easily identify why Physiotherapists in MH have core skills and knowledge which make us a distinct specialism working in mental health.

Delivering for Mental Health (2006) Scottish Government, Edinburgh.
Non pharmacological management of depression (2008) SIGN Guidelines, Edinburgh.
Recovering Mind and Body (2008) CSP Publications, London.

This report was written on behalf of CPMH (Scotland) committee by Rosalind Johnstone (Treasurer) 18 June 2009

CPMH EDUCATION AND RESEARCH FUND

Aim

To encourage education and research by physiotherapists and assistants for the benefit of patients with mental health problems

The Awards

The total amount available each year will be £1000. This will be reviewed annually. Grants will be warded up to this sum. Any money not awarded will be carried forwards to the next year. The awards are at the discretion f the CPMH Executive Committee, whose decision will be final. Awards will be grated for programmes started in the four months prior to (and still continuing) or 12 months following the closing dare fro application.

Priority will be given to: -

1) Research in areas identified by the CSP's evidence based practice in mental healthcare.
2) Participants in M-level mental health courses or the introduction to health courses or he introduction to mental healthcare course.

To Apply

Please complete application form. The committee will be looking for relevance of the programme to mental healthcare: how patients will benefit and how the knowledge gained will be sheared with others.

The committee intends to spread the money amongst several applicants and are therefore likely to offer a percentage of the total cost (depending on demand). Please show other sources of funding applied for and whether you have been successful to date.

If successful

1) Applicants must notify their acceptance in writing within 28 days
2) Applicants must supply evidence that they have been accepted onto the programme (e.g. receipts of fees, letter of registration) before the grant is paid.
3) Recipients undertaking research should submit an abstract on completion, and those on a course will be asked to supply evidence that it was completed.
4) All recipients will be expected to supply a short report for publication in the CPMH Journal (although we would not wish to prejudice publication in any other journal)

The committee retains the right to request repayment of the award if the course/research I not completed.

Please send applications to

The closing date for applications is July 31st

Application to CPMH Education and Research Fund

Name .....E-mail.....

Address.....

Date of qualification or length of service if a physiotherapy assistant

MCSP number (or PAB number for assistants).....

Place of work.....

Please describe briefly your work role.....

.....

.....

Course applied for/or area of intended research.....

.....

Venue of course/educational body.....

Date of course /research commencement and completion.....

If you have already been accepted onto the programme please supply evidence of this (e.g. receipt fees, letter of registration)

Total estimated costs please give a brief breakdown).....

Other sources of funding applied for (please indicate if any have been successful)

.....

.....

Please return the form to Physiotherapy Department:-

Brendon Stubbs
St Andrew's Healthcare
Billing Road
Northampton,NN1 5DG
bstubbs@standrew.co.uk

CPMH Journal Questionnaire –Summer 2009

Editors note: We are always hoping to be responsive to the needs and preferences of our membership and readers and would be grateful if you could spend a few minutes to complete and return this questionnaire to Jean Picton-Bentley at Physiotherapy Department , Maudsley Hospital, Denmark Hill London SE5 8AZ

	How long have you been a member of the CPMH.....
Do you belong to a local branch of the CPMH	Which one Midlands | London and south East | Scottish Other .....
What is your current banding?	3 | 4 | 5 | 6 | 7 | 8a | 8b | 8c Other.....
What is your trust	Specialist mental health | Acute trust | Community trust/
.	Would a list of experienced mentors be useful in local areas for staff to support them in finding professiona supervision opportunities Yes | No | Comment.....
Do you have professional supervision through	Mental health Physiotherapist | Acute unit physiotherapist | Community Physiotherapist | Other AHP
Do you have line management through	Specialist mental health Physiotherapist | Acute unit physiotherapist | Service manager
	Do you think others would be interested in these courses
Would you like more formalised training	Introductory one day course for students and basic grades | One week course for experienced band 5s and six's working in mental health | MSC style on Mental Health
	Reasons you think have caused membership to fall.
	Do you read the journal yes | no | Why not
What is of interest to you	Research articles | Events | Letters | Committee News | Other tick all that apply
What could be added	
What could be taken away	
Further thoughts /comments on attracting membership	
	Would you like to continue to receive hard copy of the CPMH Journal?

Chartered Physiotherapists in Mental Health
Clinical Interest Group

MEMBERSHIP APPLICATION/RENEWAL FORM

PERSONAL

TITLE: Mr, Mrs, Miss, Ms, Dr, Prof. . . . . LAST NAME: . . . . . .

FIRST NAME(S): . . . . . JOB TITLE/GRADE: . . . . . .

DEPARTMENT: . . . . . HOSPITAL/CLINIC/UNIT: . . . . . .

2. CONTACT

Address: . . . . . Telephone: . . . . . .
. . . . . e-mail: . . . . . .
. . . . . CPMH often needs to contact the membership to ask for
TOWN/CITY: . . . . . opinions/feedback, or to send out information. It is
Post Code: . . . . . preferred to use e-mail for this purpose. If you do not
Country: . . . . . wish to be contacted in this way, please let me know

3. SPECIAL INTERESTS

e.g. Adult acute MH, Forensic, Elderly MH; Dementia, CFS/ME, Chronic pain, Eating Disorders, CBT, Cranio-Sacral therapy, Basic Body-Awareness therapy etc. (Please circle those appropriate and add any others below.)

. . . . . .

. . . . . .

4. LOCAL GROUPS

Do you belong to a local group? Yes/No

If so – which region/area? . . . . . .

4. DECLARATION

The CPMH occasionally receive requests for information from physiotherapy students and other physiotherapy professionals. In the instances people will be directed to the CPMH section of iCSP to post a message on the website.

Information supplied on *this* form will be used only for the purposes of the Clinical Interest Group and the Chartered Society of Physiotherapy.

Signed: . . . . . **Date:** . . . . . .

Membership is open to CSP and non-CSP members: 1st yr Fees £17.50, £15 annually thereafter; £10 Assistants/PTIs, £5 students

The membership year runs from Sept 1 to Aug 31. I enclose my cheque for £ . . . . . in payment of the subscription for membership year 2007-2008, or

I wish to pay by standing ☐ order Please complete a standing order form and attach to this application.

Please return this form together with your remittance to:
Nicky Atherton, Clinical Trials Unit, Medical School Building, University of Warwick, CV4 7AL, n.atherton@warwick.ac.uk

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For joint accounts where both signatures are required

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Postcode _____

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FORM B

To:-

Victoria Welsh
Physiotherapy dept
West Mendip Hospital
Old Wells Road
Glastonbury
Somerset
BA6 8JD

I ..... have instructed my bank ..... to pay my annual subscription of £15.00 on the 1st October each year until further notice.

Name:-

Contact Address:-

Date .....

Signature .....

Please detach form B and return it to the above address, then forward A to your bank.