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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 14<sup>th</sup>

Jean Picton-Bentley  
Journal editor

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Chairman's report

## CHAIRS LETTER 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*.

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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](http://www.newwaysofworking.org.uk).

We are holding an event to launch the Strategy on the 14<sup>th</sup> 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 health 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 ideas 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](mailto:stephanie.horn@kcl.ac.uk)

***Editor's note- A personal note from 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 met. 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 tissue 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.





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

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**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 than 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

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

