Chartered Physiotherapists in Mental Healthcare Journal

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Editorial

Hello Readers,

Welcome to the winter 2012 and may I immediately thank Ross Farmer my new boss at the Maudsley Hospital who has assisted in putting this edition together.

We are anticipating that our next journal will appear in the autumn of next year and any articles, case reviews, updates or adverts would be gratefully received for this edition by the 31st August 2012. In the meantime Caroline Griffiths will be continuing to provide newsletter updates.

We have a few things to look to the year apart from the Olympics and the Diamond Jubilee. In February with have the International Conference held for the first time in the United Kingdom. Anne Parker is hosting this event in Edinburgh and a big thank you for her hard work in its organisation. I have deliberately offered a lot of coverage in this journal from the previous event two years ago in the hope it will persuade a few people who might be wondering whether to attend. Not so sure we can provide the snow and such scenic pictures but you never know. There are also a number of study days, AGMs and local and national study days advertised within.

Much has happened and is happening in the health service. Physiotherapy in mental health is certainly no exception to this. I wonder how many of you can remember how old the CPMH (formally the ACPP) is? We hoped that for the next edition we could capture members views and experiences spanning the decades of our contributions to the care of mental health care users to see the changing face of mental health practice. We would welcome contributions from members both working, retired and students perhaps researching mental health for the first time.

It just leaves me to wish you a happy new year and hope that with all the changes it is a successful one.

Take care

Jean Picton-Bentley
Journal Editor

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Chair's Update

We are now in 2012 and the start of what will be another busy year for all. The demands and challenges on us as practitioners and professionals will continue in particularly in relation to Any Qualified Provider and Payment by Results. For Physiotherapists working in mental health a key objective will be to ensure that Physiotherapy is recognised and included in the pathways for service users and that the role of Physiotherapy is recognised within all clusters.

Despite the challenges it is an exciting time for us. With an increasing focus on health and wellbeing this gives us greater opportunities to be able to demonstrate the role of Physiotherapy in the areas of exercise, health promotion and lifestyle management.

Within Older People's services the spotlight is on dementia care in particularly in general hospitals and we as mental health physiotherapy practitioners are well placed to advise and support our mainstream colleagues.

Our three strategies are now in the public domain and it is reassuring when interviewing possible candidates for Physiotherapy Posts that reference is made to the strategies and their contents.

As a committee we continue to work closely with the CSP and respond to any requests or queries. This last year we attended congress, ARC and professional network events and will continue to do so again this year.

Within CPMH we will continue to provide support and advice to members. 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!! We are also looking to run study days and courses both centrally and through our subgroups.

If you would like to become more involved with CPMH or would like to run or contribute to a study day either nationally or locally please contact us.

Best wishes for the New Year

Sharon Greensill

Letters to the editor

Editors note. – We are always happy to receive letters from members and for those who have had opportunity to experience mental heath settings. '

1. Key strategic needs

The provision of Physiotherapy to support health and well being needs in optimising function never has been more important as a key element in service design and delivery.
With the rising tide of long term conditions (LTC's) and the consumption health resources and occupation of beds up to 58% of beds are occupied by people with limiting LTC's *general household survey 2005 for England.* Also, 30% of the population in England report suffering with a LTC.
In mental health the health inequalities are well evidenced relative to both co-morbidity and survival rate post diagnosis of stroke, COPD, CHD and diabetes- *disability rights commission report 2006.* This is a group in which there is a massive coalescence of LTC's and neuro-musculo skeletal need.

However, my fear is how many people are accessing the re-enablement funds given to PCT's recently and how many mental health trusts are building on their capability to address the on incoming tide of LTC's and the increased emphasis through the white paper in mental health on reducing health inequalities and mortality?

I fear the problem is evidencing need through the clear capture of outcomes where the impact on services and the clinical benefits are quantified through use of outcome data. Payment by Results (PbR) clearly has had a focus on pathways and appropriate clustering alignment, however, there will come a point in time where by the payments- as they are now in acute, will be proportionately linked to the delivery of clinical and service outcomes or CQIN indicators(commissioning for quality, innovation payment framework).
My question to the membership is do you know the CQUIN targets for the services you work within?

My belief is that all clinical interventions needs to be seen in the light of how they add value to the service outcomes and impact on length of stay, employability of service users, impact on incidents, risk mitigation and Serious incident reporting. Correlating this information and seeking to triangulate this within teams, relative to physiotherapy in put is essential. In terms of evolving roles for physiotherapists in mental health, I believe there is a need to have more liaison and bridging with acute secondary care services. Physiotherapists are in a great place to be able to understand the capability within mental health to manages serious co-morbidity or functional impairment and understanding the need best placement for service users who may have significant functional limitation post trauma, or sudden onset of disabling conditions- eg head injury/strokes. In my experience, District General Hospitals (DGH's) are more than keen to refer people with severe and enduring mental health needs back to secondary mental health services- appropriate or not. Physiotherapists are well placed to address this interface and advocate for rehabilitation or even to undertake in reach roles and work with acute care staff to engage and overcome discriminatory practises or knowledge and skills gaps relative to mental health diagnoses, psychological mindedness and understanding issue of side effects and there impact on treatment planning and assessment findings.

In summation, I feel the future could be very bright for physiotherapists in mental health if the challenges can be met to objectively demonstrate the positive impact on people's lives in a meaningful way.

Sue Coffee
Head of AHP, Physical Health and Wellbeing services
Birmingham and Solihull Mental Health Trust

2. Time for Action

In 2008, the government asked Professor Sube Banerjee to carry out an independent report about the use of antipsychotic medication for people with dementia in the NHS in England. Professor Banerjee is a professor of mental health and ageing at the Institute of Psychiatry, part of King's College London. The review was commissioned as there had been increasing concerns over the about the use antipsychotics in dementia.

Time for action The use of antipsychotic medication for people with dementia was published

Professor Banerjee reported

- Each year, 180,000 people with dementia receive antipsychotics in England.
- Up to 36,000 of these people benefit to some degree from the treatment.
- Around 1,620 additional cerebrovascular adverse events (such as stroke) will result from the treatment. About half of these will be severe.
- Each year, about 1,800 additional deaths will be caused by the treatment in this frail population

The report refers to the management of behavioral and psychological symptoms of dementia and the need to up skill staff in non-pharmacological methods of management of BPSD and that further research should be carried out, including studies of non-pharmacological methods of treating behavioral problems in dementia and of alternative pharmacological treatments

Physiotherapists play a key role in the care and management of the patient with dementia who presents with BPSD. Evidence shows that both exercise and massage are effective, and the physiotherapist will be well placed in identifying any causes or triggers to BPSD such as pain and pain management.

We are keen to hear from any Physiotherapist who wants to share any success stories, case studies, or research proposals linked to the Non pharmocological management of BPSD.

Sharon Greensill

3. Initial thoughts of Physiotherapy in Mental Health

Dear CPMH membership,

Having just spent my first 3 months in a Mental Health Physiotherapy department, I thought it was time to reflect on the way it compares to some of my other experiences. I've had a very fluid background in Physiotherapy since graduating. Turning my hand to everything from premiership football, touring with dancers, PCT's, acute trusts, GP practices and more private practices then I can remember. With this in mind, here are a couple of things that stand out in Mental Health.

Firstly, the definition of the term "physical health". In an acute trust this means physiotherapy. With some 80-100 physios working across large acute trusts you can be sure that physiotherapy is a consideration on every ward; involved in handovers, ward rounds and always a key part in discharge planning. In Mental Health, physical health refers to ECGs, diabetics and nutrition, or what the acute trust would call medicine. We haven't even begun to scratch the surface of true physical health in mental health. I guess the term we will have to use here is "physical disability". Quite simply, ward after ward of persons who get inadequate stimulation, limited exercise and are degenerating right before our very eyes.

My frustration at the lack of our involvement in the physical health agenda is increased by the fact that I have seen patients (that's what I used to call service users) going through the regular systems. An environment that is obsessed with referral rates, protocols and through-put. Not what we know to be the gold standard of ensuring the cognitive needs of the individual are met so that they can fully participate in the treatment process. As a treating clinician you know in your heart that the chances of understanding, retention and adherence are almost zero but you have ticked your boxes and then its on to the next 850 people on your waiting list.

If we don't treat these individuals when they are sat (for what can be weeks or months) on our wards, then these non-urgent chronic conditions are going to continue to fester, only resulting in a referral when a continuing care bed becomes concerned with falls or manual handling issues.

The second point is profile. I had no idea on interviewing for this post exactly what Mental Health physio was. Something, I hasten to add I am still learning. It turned our here we have a profession full of physiotherapists using every imaginable scope of practice there is. One day a respiratory physiotherapist, the next neuro or orthopaedic. For this reason alone, this setting should be at the core of student teaching and an ideal candidate for a band 5 core rotation. Not to mention the communication skills you develop. Levels so advance that any communications teacher would feel total out of their depth (except for maybe a friend of mine who works in this field after a career as a hostage negotiator). Finally on this point, what about the huge surge in understanding being adopted by the musculoskeletal arena in pain and the brain? Why are those of us in mental health not at the forefront of this movement helping our once mechanically minded friends discover what has been the mental health physiotherapists best kept secret for many years?

I look forward to the years ahead in mental health and meeting you all at the next CPMH event.

Yours Sincerely

Ross Farmer
Head of Physiotherapy & Clinical Exercise

Member's news

Mick Skelly Retires.

After obtaining a Diploma of Art and Design, training at the Laban Centre for Movement and Dance and working as a labourer on British Rail Mick Skelly managed to talk his way on to a Physiotherapy course at Leeds.

Mick qualified as a physiotherapist and went to work at St. James Hospital in Leeds in January 1983 as a basic grade. The key lessons he took from his basic grade rotations were in neurology and elderly care.

In the former he learnt that as long as you have good clinical reasoning behind you do not give up on patients just because the 'experts' tell you they have gone beyond some arbitrary recovery date.

Whilst working in elderly care Mick took the advice of a friend, Martin Watson and volunteered to cover 'Psychiatry', this was back in the days before Mental Health had been invented. Mick realised that there was tremendous scope for physiotherapists in every area of 'Psychiatry' and subsequently attended a course run by the Association of Chartered Physiotherapists in Psychiatry, (ACPP). The late great Eireann Ricketts inspired Mick in a barnstorming lecture, providing the keys for working in Mental Health.

"As a physiotherapist other professionals will expect you to know a lot less than they do, they will expect you to only be able to work with the less challenging patients and they will expect you to work nine to five, Monday to Friday. I advise you to be humble but to have superior knowledge."

These early influences determined Mick's career and his approach to working in Mental Health.

In 1985 he began work as a Senior 2 in Psychiatry in Rotherham.

Mick became 'Education Officer' for the Yorkshire Branch of the ACPP and eventually became 'Education Officer' for the National Committee of the ACPP in which roles he was involved in many courses.

He also became a CSP Steward and a regular attendee at ARC either as a Branch rep. or an ACPP rep. often along with the redoubtable Tina Everett.

In 1989 he became Superintendent 111 in Mental Health in Barnsley working with a tremendous, if small, group of physiotherapists who were determined to make radical changes to the service.

It was during this period that he met another great influence on his professional life, the inimitable, tireless and incredibly hardworking Marie Donaghy who completed her career as a Professor only last year and has made a tremendous contribution both to Physiotherapy in Mental Health and to the profession overall. Mick was involved in providing chapters for books primarily edited by Professor Donaghy.

In 1992 Mick took a drop in grade in order to work with a multi-agency specialist Dementia Care Community Mental Health Team in Hull. This work gave Mick clear insights into close multi-agency team working and in operating the Care Programme Approach, (CPA).

Mick once more became a CSP steward and as a CPMH National Committee member attended the CSP as CIG's Liaison Committee rep. and also became the CPMH representative to the Joint National Forum hosted by the Royal College of Psychiatrists.

He became Superintendent 111 in Mental Health in Hull and, was again, lucky in the physiotherapists he recruited in to working in Mental Health. He gained further experience in working in forensic psychiatry and in child and adolescent work.

Whilst working at Hull Mick began his part-time Masters degree course and met his wife to be, Alex Bairstow.

They jointly decided to relocate to Scotland with Alex being the first to get a job at the Thistle Foundation. Subsequently Mick talked him self in to a job and a career change taking responsibility for the Midlothian Low Back Problem Project.

His MSc. work had enabled him to recognise the parallels between stress, Mental Health problems and chronic pain, particularly Fibromyalgia Syndrome, (FMS), and related conditions. This is an area of particular interest for Mick as he has a diagnosis of FMS.

From 1998 Mick worked in Midlothian primarily and became Superintendent 111 in Mental Health for Midlothian and East Lothian in 2001.

Mick has remained active in the CPMH to the end of his career being CSP Mental Health representative to the Scottish Government, backed by Roz Johnstone who has now taken this role, via the work of Elaine Hunter. The Scottish National CPMH Committee and Kenryck Lloyd-Jones, CSP Scotland, provided invaluable support to him in this role.

In Midlothian and East Lothian Mick feels that he has worked with some 'brilliant staff'

from all professions and with people who, like Eireann Ricketts, have real 'fire in their bellies' regarding their dedication to working with people with Mental Health problems.

The list of people Mick would like to thank for influencing and helping him along the way is too long to recount. However he holds that his best teachers, the people he owes most to have been the service users and carers he has had the privilege to work with over twenty-seven years.

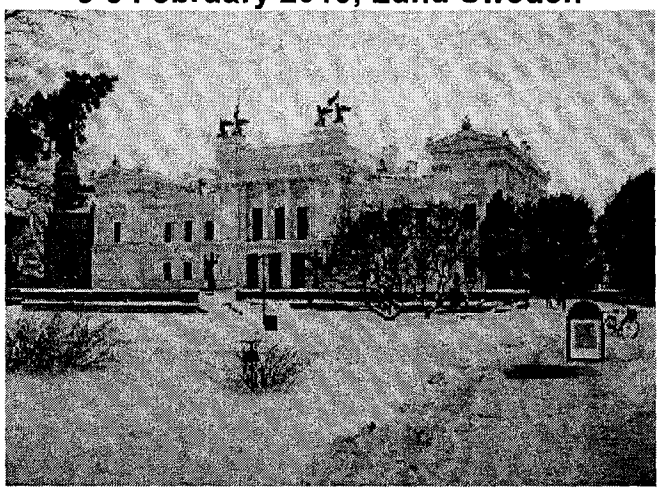
We wish him the best of luck in his future endeavours!

Jo Gordon

Physiotherapist
Midlothian Joint Mental Health Team
CSP Steward East and Midlothian

Reports from the 3rd International Conference of Physiotherapists in Psychiatry and Mental Health- (IC-PPMH)

1. "Professional Development – integrating Theory and Practice" 3-5 February 2010, Lund Sweden



The conference took place at the University which is right in the centre of the city. Lund is one of the oldest Universities in Europe and now one of the biggest with branches in many of the major towns in southern Sweden.
We were welcomed to the conference by Amanda Gyllensten who along with Gunvor Gard was the conference organisers. The Rector and Chancellor gave an amusing overview of the University, making the point that we would not remember much of what he said but that we would at least be able to recall that the University is big! The head of physiotherapy at the University, Professor Charlotte Ekdahl and the President of the Swedish CSP, Anna Herting wished us a profitable three days of knowledge sharing and networking.
The Keynote speaker was Michel Probst who described how he started in MH as a male physiotherapist in a new eating disorders unit with all these young girls with issues around body image. He had to develop some new strategies to make it work.
He also gave us insight into how the first conference came about. When two physiotherapists from Norway visited Belgium to observe the treatments offered at the Leuwen Hospital specialist Eating Disorders unit that is managed by Michel, they discussed how it would be to create a network across borders as MH physiotherapy is so specialised and small. Michel took up the challenge and invited all his contacts, and as I knew one of the Norwegians from the Basic Body Awareness Methodology course I became the British contact and member of the scientific committee. Soon a network was established. In 2006 the first conference was held in Leuwen, Belgium and 110 people from twenty countries attended.
The conference in Bergen was held in 2008 with 120 participants and the Lund conference held this year had 139 participants from 37 countries and 5 continents.

At the Bergen conference a Board was elected consisting of 5 people:
President: Michel Probst,
Vice president: Liv Skjerven,
Contacts and members -Marit Nilssen,
Amanda Gyllensten, Gunvor Gard – were elected and tasked with arranging the conference in Lund 2010
Contact persons for each of the member countries were also appointed. Caroline