# Chartered Physiotherapists in Mental Healthcare Journal


**Winter 2011/2012**
**Volume XXXIV**

# 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.

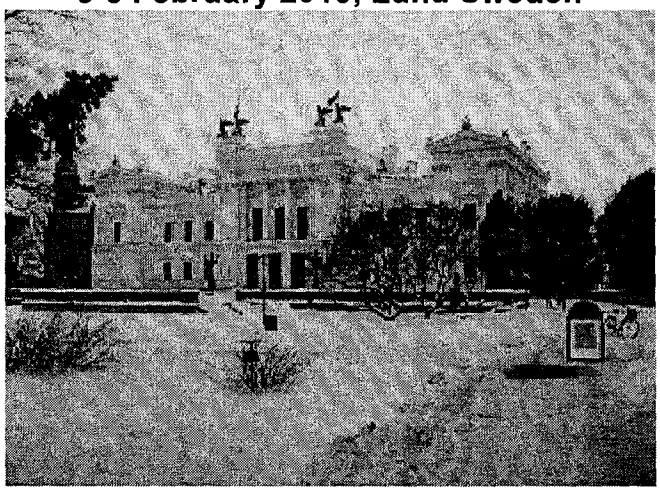
We wish him the best of luck in his future endeavours!

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

Griffiths and Anne Parker became contacts for the UK.

One of the main aims of the board at the moment is to work for IC-PPMH and mental health physiotherapy to gain sub-group status of the World Confederation of PT. We are currently not a recognised speciality . This work has been going on since the conference in Bergen, and in Lund the Head of the Norwegian PT Association, Elin Engeseth announced that they would propose the IC-PPMH to the World Conference in Amsterdam next year. It is necessary for one of the WCPT member groups to act as proposers for the IC-PPMH to become a sub-group of WCPT.

The ICPPMH Board
Michel Probst, Marit Nilssen, Gunvor Gard, Amanda Gylllensten, Liv Skjaerven

As with the two previous conferences the Lund conference had a varied programme of presentations and workshops on aspects of MH physiotherapy. It was interesting to be able to choose between the many subjects including physiotherapy for victims of torture and trauma and treatment approaches for body image in eating disorders.
I attended a presentation on psychomotor therapy at a day facility for dementia sufferers in the Czech republic. The conclusions were that the psychomotor therapy as a meaningful activity seemed to improve patients' quality of life but did not influence the course of the illness. A particularly interesting presentation by Riitta Keskinen-Rosenkvist that I attended described the physical symptoms along with the psychological distress experienced by individuals who were survivors of the Tsunami. Even 3 years after the event their physical symptoms persisted and highlighted the importance of physiotherapy for this patient group. The conclusions of the study were that "people get better"!

The round table discussions in the morning were tackling diverse subjects such as education, developing MH physiotherapy in your country, how to influence politicians about the value of MH PT, supervision and research. The contrast between the problems of working alone in Greenland and starting from scratch in Turkey were striking against those of us who complained of being short staffed and misunderstood in our area.

The workshops raised many interesting and important issues and approaches on mental health physiotherapy and how these can be put into practice. We were able to attend for Tai Chi for inner and outer harmony, how to apply touch in clinical settings for Eating Disorder patients and a practical demonstration of the Comprehensive Body examination as part of the Norwegian psychomotor therapy.

The General Assembly of the council of the IC-PPMH met on the second day and we were given an overview of the board and its work for the past two years outlining the structure and rules. The main purpose was to elect the new board and to choose the candidate for the next conference. The Czech Republic was proposing Prague and the Netherlands suggested Amsterdam, but the bid from Britain was successful. That means the next IC-PPMH conference will be in Edinburgh 22-24 February 2012!

The highlight of the conference was no doubt the now traditional banquet which was held in the University great Hall. A delicious three course meal accompanied by appropriate wines was served on long tables in the candle lit hall. Our entertainment was the members of the Student Choir, a male quartet who treated us to well-known student songs and Spirituals.

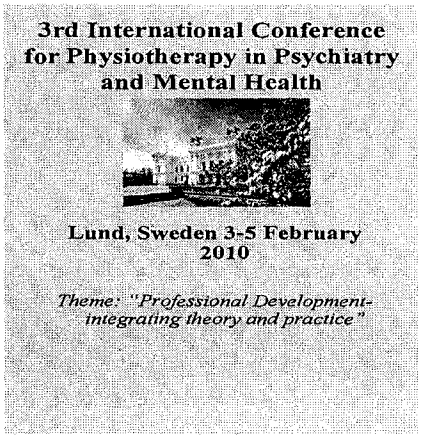
The most important aspect of this conference is that it is *for* physiotherapists *by* physiotherapists. That means we are looking for contributions from all CPMH members for the Edinburgh conference!

Anne Parker
Superintendent physiotherapist
Royal Edinburgh Hospital

*Organiser of the Edinburgh ICPPMH Conference 2012.*

## 2. LUND IC-PPMH

Lovely AND VERY SNOWY Lund University was the venue for
the 3rd International Conference for Physiotherapy in Psychiatry and Mental Health




We had a fantastic time and enjoyed intellectual and social stimulation ranging from debate to young men singing folk songs.
During the conference I presented a poster on the Well Being programme in our Trust and the role of the physiotherapist in that. There was a great deal of interest in our work and we are planning a professional visit to the Trust from Dutch physiotherapists who are part of the Psychomotor Therapy Federation in Europe.

Among some fascinating presentations a couple really stood out for me. One was fantastic core skill physiotherapy reminding me of the neuro- anatomy and physiology which was once my bread and butter. Jannine Moorman from South Africa described how in her private practice physical interventions were getting people back to work

had been misdiagnosed as purely caused by work stress.
Belgium physiotherapists presented research on physical therapy with young men diagnosed with schizophrenia and the Scandanavian psychomotor therapists provided even more research into body awareness therapy in all areas of Mental Health.
I would recommend scanning through the presentation abstract document, you might be surprised!

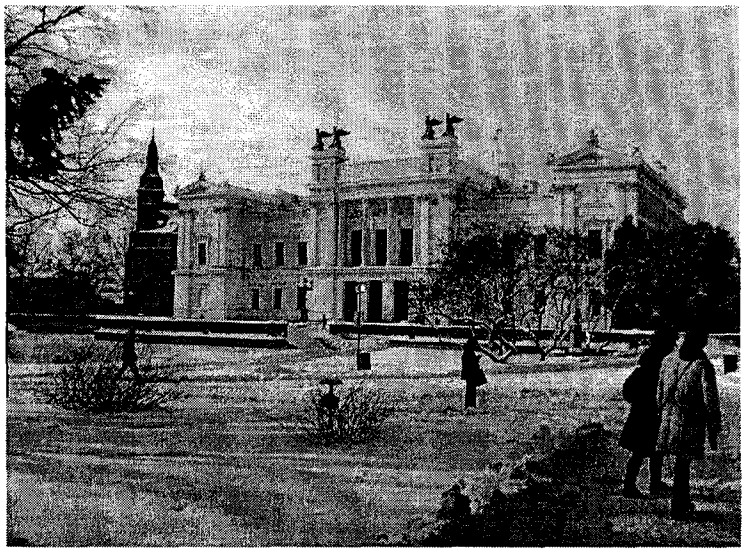
www.ic-ppmh.org

The best end to the conference was the selection of Edinburgh as the location for the next IPPM conference in 2012.
WATCH THIS SPACE.

Caroline Griffiths

### 3. The 3rd International Conference of Physiotherapy in Psychiatry and Mental Health

This conference took place on the 3rd – 5th February 2010 and was held within the site of Lund University, Sweden. The conference theme was 'Professional development – integrating theory and practice' and was attended by 140 participants mainly from Europe, but also travelling from countries such as South Africa, Australia, Japan and Canada.



Main Building, Lund University

We arrived following heavy snow falls to be greeted by shin deep snow. This was especially exciting when moving between buildings for different sessions throughout the 2 ½ days; leading to improved international bonding as we clutched participants from other countries (any country) in our attempts to stay upright. This, of course, became a new extreme sport after the 5 wine courses presented to us at the Conference Dinner on the Thursday night.

Conference Dinner: Marloes (Netherlands), Bev (Wales), Nathalie (Netherlands) & Caroline (England)

The conference itself provided a rich variety of sessions to attend. The days were structured so that we could move through en masse keynote lectures, to a choice of parallel sessions for scientific and special interest report presentations, round table discussion groups, workshops, poster presentations and discussion seminars.

The conference provided the opportunity to explore and develop knowledge and understanding of a huge number of topics. These topics covered areas such as:

**Therapeutic concepts**: Body Awareness Therapy, Psychomotor Therapy, Psychosomatic Therapy, Dance Therapy, Psychophysical physiotherapy;

**Therapeutic management strategies**: pain management, cognitive dysfunction, postural awareness, Mindfulness, massage ;

**Condition specific topics**: eating disorders, dementia, Work related stress and burnout, schizophrenia, Disaster/Trauma and Torture victims, anxiety and depression, unexplained signs and symptoms;

**Professional topics:** Education, Research, Government and Policy decision making, professional development and clinical expertise.

This is the second ICPPMH I have attended, enabling me to strengthen contacts and friendships developed at the previous conference (in Bergen, Norway in 2008). Links for support of practice knowledge, learning and teaching and research have been firmly established and already put into use since my return.

As a Physiotherapy lecturer, I have been able to bring back and integrate examples of good and varied mental health physiotherapy practice into undergraduate learning and teaching; providing a rich source of knowledge and inspiration for future physiotherapists. There has been a reciprocal exchange of materials and advice between myself and colleagues from home and abroad as a result of my attendance of this conference.

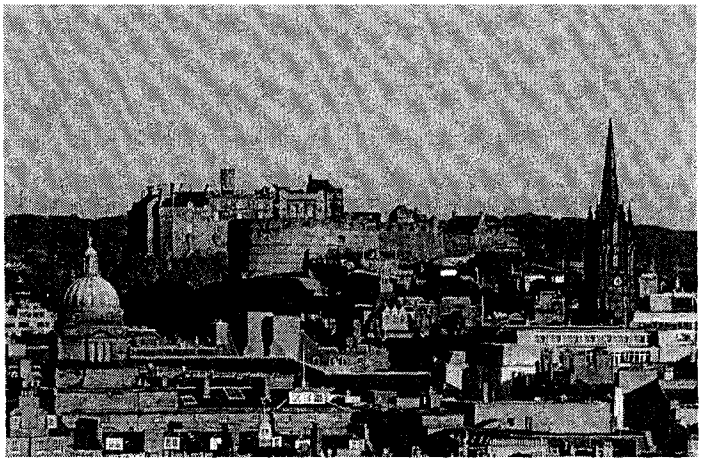
I recommend attending these conferences as part of professional development within the area of mental health. There has only been a handful of people from the UK in attendance so far, possibly due to the costs and issues of funding...
...HOWEVER... due to the hard work undertaken so far by Anne Parker up in Edinburgh, we all have a better chance of attending the next conference, as...

...the **4th International Conference for Physiotherapy in Psychiatry and Mental Health** will hopefully be taking place in **Edinburgh** in **2012**!

Please consider attending this conference! It is a fabulous experience and we would love to raise the profile of mental health physiotherapy practice from this country within this international forum.

Hope to see you there!
Bev Sarin
sarinbj@cardiff.ac.uk

## The 4th International Conference of Physiotherapy in Psychiatry and Mental Health – Edinburgh 8 -10 February 2012



***Quality of Movement – the contribution of physiotherapy to mental health and wellbeing***

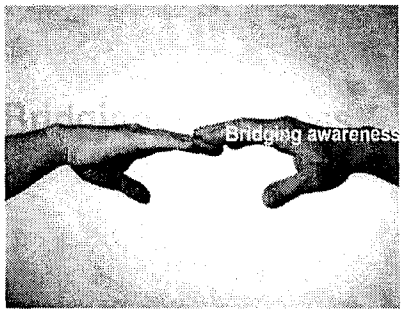
Abstracts have been arriving steadily for the conference from many countries for Platform Presentations, Posters and Workshops, describing the work of physiotherapists in mental health. The scientific committee consisting of colleagues from Belgium, Spain and Norway, Sweden and UK are preparing to read and evaluate the reports. The deadline for abstract submission is October 15th but we are still looking for entries – so if you have a project that you are working on please contact us: icppmh2012@nhslothian.scot.nhs.uk

Thanks to you and your colleagues' contributions the programme is gradually evolving for the conference that will last three days and is being held in the Roxburghe Hotel, Charlotte Square, Edinburgh. Being in such a friendly and central space will allow the delegates to network and share knowledge of experience from practice, education, professional issues and research in an atmosphere of international conviviality.
On behalf of the conference committee I wish you **WELCOME TO EDINBURGH!**

Anne Parker
Project manager
4th International Conference of Physiotherapy in Psychiatry and MH

# Developments in Mental Health this year

## The International Organisation of Physical Therapists in Mental Health is a Fact!

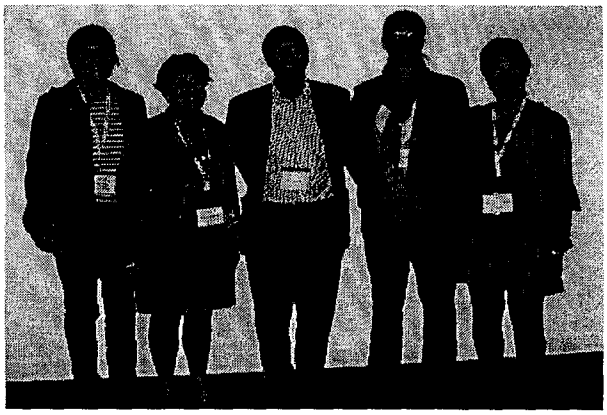



The elected board of the International Council of Physiotherapy in Psychiatry and Mental Health (ICPPHM ) is pleased to announce the birth of a new "International Organization of Physical Therapists in Mental Health (IOPTMH)".
Since the first conference of the ICPPMH in Leuven Belgium in 2006, the idea of gaining subgroup status within the World Confederation for Physical Therapy (WCPT) has been a stated aim. The work and preparation of the official file has been a huge achievement and thanks to the effort made by Liv Helvik Skjaerven and Elin Engeseth from Norway it has met with success.
On Saturday 18th of June 2011, the general meeting of the World Confederation of Physical Therapy recognized physical therapy in mental health as a subgroup of the WCPT.
This is a milestone for the future development of the field of physical therapy in mental health.

At the 3rd International Conference the International Council of Physiotherapy in Psychiatry and Mental Health elected a board. The primary aim of the organization is to promote the globalization of physical therapy in psychiatry and mental health. A secondary aim was to establish a subgroup of the World Confederation of Physical Therapy. In June 2011, the establishment of the subgroup became a fact.
Due to the requirements of the WCPT the name of the organization has to be changed to "International Organization of Physical Therapy in Mental Health" and a constitution has been drafted and approved by the founder member countries.
The member countries are in alphabetical order *Belgium, Denmark, Finland, Iceland, Japan, Norway, South Africa, Sweden, Netherlands, Turkey and United Kingdom.*
The inaugural general meeting was held on the 22nd of June in Amsterdam. Eight member countries attended the meeting. Individual physical therapists from New Zealand, Latvia and Malaysia attended the meeting as observers. The name, the constitution and the board were approved. Catherine Pope attended as our representative for UK.

**Members of the board are:**
From left to right:
Anne Parker,
Liv Helvik Skjaerven,
Michel Probst,
Nathalie Mulders,
Amanda Lundvik Gyllensten

President: Michel Probst, Belgium
Vice President: Liv Helvik Skjaerven.



***Editorial note: Catherine Pope gives her experiences on attending the WCPT.***

I had the privilege of attending WCPT in Amsterdam last week and was there for the inaugural general meeting of the International Organisation of Physical Therapists in Mental Health – as the UK official voting representative – how cool is that?!
Ann is the Treasurer and also organising the Conference

To put it in perspective there are only 12 of these groups – and areas such as education and management have yet to achieve this status. To achieve recognition you have to have 12 different organisations across 3 regions signed up, which has been a huge achievement since many countries do not offer physiotherapy within mental health at all
The members are; Iceland, South Africa, Spain, Norway, Netherlands, Finland, Sweden, Denmark, United Kingdom, Turkey, Japan, Belgium. In addition New Zealand and Latvia attended the meeting as non members and may join.

It was absolutely amazing to be in a room full of international mental health physiotherapists

Here are some highlights that might interest you;

- We have become evidence based without realising! I went to an extremely interesting pain seminar in which they talked about the cross over between biomedical and biopsychosocial approaches, and the importance of breaking down false concepts and paradigms in patients with chronic pain behaviour – so it is ok to use hands on if a patient holds the view that they require an intervention – you should treat what you see.
- A session on physical activity that repeated some key points from Stuart Biddle at Congress last year – that following the recommendations about 2-3 30 minute bursts of moderate exercise a week can have the opposite to intended effect because of behaviour compensation – better to introduce inconvenience into your life to increase incidental activity e.g. stairs, getting off the bus earlier etc.
- Gwyn Owen presented on the research she is undertaking for her PhD – it was entitled Is Physiotherapy Losing its Touch and was looking at the changing attitudes of physiotherapists to massage. The bit she presented was using discourse analysis to look at the recent debate in frontline about massage – I think this would make a really interesting topic at the conference and we should invite her to speak?
- Finally I went to a presentation about attitudes of students to mental health in South Africa and the person referenced my research!!!!! I was so excited I got up and thanked them – which probably ruined the effect really!

The next WCPT is in Singapore

# Clinical Developments

Editor's note: Please send us anything you believe would be of clinical interest to the community. This can include case studies, research, comments on articles you have read, national guidelines, new policies, feedback on courses, etc...

# Physiotherapy Guidance Notes for Exercise and Physical Activity in Adult Patients with Anorexia and Bulimia Nervosa

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## Table of contents

## 1. Aim and Scope of this Publication

### Aim

Inappropriate exercise behaviour is a common feature in patients with an eating disorder. These guidelines for Good Practice address excessive or over-exercise behaviour and also its management. The guidelines also make recommendations regarding healthy exercise and activity levels for all stages of the illness/recovery.

### Scope

These guidelines are written primarily for Physiotherapists who encounter patients with anorexia or bulimia nervosa.

The authors are a group of physiotherapists who are keen to share their wealth of experience and common practice working in the field of eating disorders.

A Physiotherapist has the knowledge and skills necessary to: assess and make recommendations on appropriate levels of physical activity and exercise within the context of a healthy lifestyle, help the patient to manage their exercise and activity levels and to advise on and treat any neuro-musculo-skeletal problems that may arise.

### Note on terminology

It should be recognised that the term physical activity includes:
Activities of daily living
Occupational activities
Recreational activities
Play
Sport
Exercise

## 2. Physiological and Psychological Benefits of Exercise

There is now worldwide acceptance among medical authorities that physical activity is an important measure of healthy living. It is also an effective therapy for many conditions, but the strongest effects are seen in the prevention of many common diseases, including cancer, stroke, heart disease, osteoporosis and type 2 diabetes. The critical message is that health benefits from physical activity occur concurrently across virtually the full range of diseases. (Department of Health 2004)

In addition to physical health benefits, those who engage in exercise frequently report a sense of well-being. More recently several academic books, consensus documents, reviews and studies have given weight to these anecdotal accounts and demonstrated that exercise can promote psychological benefits and, in some conditions, improve mental health ( Acevedo & Ekkekakis, 2006; Biddle et al., 2000; Biddle & Mutrie 2008; Craft & Landers, 1998; Daley, 2002; Donaghy, 2007; Faulkner & Biddle, 2001; Faulkner & Taylor, 2005; Martinsen, 1995; Martinsen & Stephens, 1994; Mutrie, 1998; Thien & Thomas et al., 2000). The dilemma, therefore, when treating someone with an eating disorder is how to obtain the desired psychological and physical benefits without encouraging dysfunctional, excessive exercise behaviour or counteracting the necessary programme of weight gain.

The Department of Health recommends 30 minutes a day of at least moderate intensity physical activity on five or more days of the week for the general population (Department of Health 2004). For the majority of people the most acceptable and easiest forms of physical activity are those that can be incorporated into everyday life, for example, walking, cycling, gardening, housework.

Whilst this current advice is applicable to the majority of the population, there are significant risks to someone with an eating disorder. This document will suggest appropriate forms of exercise and give guidance on when it is safe to progress activity levels.

A common concern, which can interfere with compliance during weight restoration treatment programmes, is weight distribution during the restorative process. Studies have shown significant central fat accumulation with spontaneous weight gain in women with anorexia nervosa. This gives credence to the anecdotal reports of so many patients that, *"It's all going to my stomach"*. Trunk fat accumulation is most pronounced in those patients with the greatest increases in the concentration of the stress hormone, cortisol. Addressing body image issues in conjunction with exercises that target the abdominal area, for example, core stability work may help the patient to continue with weight restoration because the professionals are acknowledging and thus, not denying, that central fat accumulation can occur, especially in the early stages (Grinspoon et al., 2001; Mayer, 2001).

## 3. Specific Risks

3. i Osteoporosis:
Osteoporosis is a common complication of anorexia nervosa, in both females and males, due to low body weight. Amenorrhea, caused by low levels of oestrogen, predisposes women to low bone density and therefore to the development of osteoporosis. As anorexia often occurs when peak bone mass is being acquired, many patients never reach optimum bone density. Even several years after recovery from anorexia nervosa, bone density may not increase to the normal range and consequently former patients remain at increased risk of painful fractures, kyphosis, loss of height and morbidity.

Significant bone loss does not usually occur within the first year of anorexia nervosa and so might not be evident on screening, but, thereafter, it is considered good practice that all patients should be offered a DEXA bone density scan (Mehler, 2003). However, some studies suggest that more than 50% of female patients with anorexia nervosa develop osteoporosis and severe bone loss can occur in patients who have had anorexia nervosa for less than a year (Madhusmita et al., 2002). Although exercise is known to have a beneficial effect on bone mineral density at a healthy weight, studies are conflicting and it cannot be said that exercise in those with anorexia nervosa is beneficial to bone density. If exercise contributes to further weight loss then the overall result will be detrimental to bone density (Mehler, 2003). Weight restoration is key in restoring bone mass. However, if it is felt that a planned exercise programme will help to encourage patients to engage with weight gain and, as long as the weight gain is occurring at a required rate, exercise is appropriate and should be allowed (Hausenblas et al. 2008). In a study undertaken in normal weight patients with Bulimia Nervosa, physical exercise was found to be more effective than CBT in reducing the pursuit of thinness (Sundgot-Borgen et. al. 2002). It has been shown that in an inpatient unit for anorexic women, those who were assigned to an exercise programme gained more than one third more weight than the control group who did not exercise. Also the women in the exercise group demonstrated significantly reduced obligatory attitudes to exercise (Calogero & Pedrotty, 2004) and patients often presented with a more relaxed attitude to treatment when they were engaged in a physical activity for some of the time (Carraro et al, 1998).

Any patient with osteoporosis should be advised against high impact exercise such as jumping, running, contact sports, horse riding, and any sport that may result in falling, such as ice-skating (NICE 2004).

It is helpful to have an understanding of DEXA scan results.

3.ii Hypokalaemia: (low potassium)
Hypokalaemia, which is a result of dehydration and electrolyte imbalance, is caused by dieting, vomiting, laxative or diuretic abuse and a decrease in fluid intake. It can result in arrhythmias of the heart, heart failure, muscle weakness and loss of muscle tone. If a patient is deemed to be at risk of hypokalaemia, potassium levels must be monitored regularly and if the potassium level is abnormal the patient should not be exercising.

## 4. The Assessment

In addition to carrying out a routine physiotherapy assessment for participation in exercise, it is essential to consider specific risks and the patient's BMI. Patients' self reports are not always reliable so it is important to re-assess the risks regularly as each individual's condition might change rapidly.

The following table sets out the points to consider:

| System | Common Signs and Symptoms | Possible Causes |
|---|---|---|
| Musculoskeletal | Osteoporosis/Osteopaenia | Low oestrogen levels in women and low testosterone levels in men |
| | Stress Fracture | Walking and running in the presence of osteoporosis/ osteopaenia |
| | Soft Tissue Injuries | Muscle wasting and weakness due to low weight and excessive exercise |
| | Postural Problems | Muscle wasting and weakness<br>Depression |
| Nervous System | Peripheral Neuropathy e.g. Foot Drop, Altered Gait | Vitamin B12 deficiency |
| Cardiovascular/ Circulation | Hypotension | Heart muscle shrinkage and wasting |
| | Dizziness/Syncope/Fainting | Heart muscle shrinkage and wasting<br>Electrolyte imbalance due to:<br>• Vomiting<br>• Laxative or diuretic abuse<br>• Water loading or dehydration |
| | Bradycardia | |
| | Arrhythmias | |
| | Heart Failure | |
| | Oedema | |

In addition, consideration should always be given to the effects of medication.

A physical assessment cannot stand alone and attitudes towards exercise also need to be explored. The Exercise Behaviour Assessment Tool can be used in these circumstances. The tool is used to explore the complexity of why a patient over-exercises, in order to challenge unhelpful thinking and behaviours and guide individual activity programmes. It has been adapted by the authors over time from unknown sources. (See Appendix)

A physical activity diary can be useful to demonstrate the amount and type of activity and exercise undertaken, raising awareness of possible areas for change. An example can be found in the NHS Health Trainer Handbook. (Department of Health 2008)

## 5. Excessive Exercise and Activities

Exercise is deemed to be excessive when its postponement is accompanied by intense guilt or when it is undertaken solely to influence weight or shape (Mond et al., 2006).

Exercise problems can be categorised in three ways:
5. i Overt exercising
Some patients openly and deliberately engage in exercise to burn off calories and induce weight loss. It is usually in the form of strenuous high cardiovascular activity for example, swimming, cycling, running. Typically it is solitary and undertaken in a rigid, obsessive manner.

5. ii Covert exercising
Some patients may undertake rigid strenuous activities in secret, for example, star jumps or sit-ups behind closed doors. For others, the activity takes the form of going up and down stairs frequently on the pretext of fetching things; getting off public transport early and walking the rest of the way; and less obvious ways, such as adopting a position in a chair that expends more energy, maintaining constant muscle contractions or by pacing and excessive standing.

5. iii Persistent restlessness
This is another kind of over activity prevalent in severely emaciated patients. It is often associated with sleep disturbances and can appear to be beyond voluntary control. The movements are highly repetitious and constant, for example, tapping, pacing and rocking.

Patients who do undertake excessive exercising may engage in one, two or all of the three categories described above.

Signs and symptoms of excessive exercise to look for are:
Unexplained injuries
Joint pain
Bruising
Friction burns
Stress fractures
Muscular and ligament injuries

## 6. Strategies to Reduce Excessive Exercising Behaviour

Although patients might find exercise helps with the weight restoration process, excessive exercise is always counter-productive to its success.

Excessive exercise may be a problem for patients at any stage of recovery. Various strategies may be used to help the patient to stop or reduce the inclination to over-exercise. Increasing support, for example, through constant observation for a short period of time to prohibit over-exercising, may not only break the habit, but also appease the guilt. Patients often report that they feel a sense of relief, as they now have an excuse to give up the over-exercising which they had felt compelled to do.

It has been found that adopting a motivational stance is helpful in treating individuals with eating disorders and also in encouraging patients to adhere to a prescribed exercise programme (Vitousek et al, 1998).

Distraction techniques, particularly at the time of the urge to exercise, can be helpful for reducing excessive exercising behaviour. For some, verbalising thoughts and feelings is appropriate, while for others engaging in a sedentary activity, such as having a bath, can be more helpful. Education and advice play a key role in helping the patient to understand the consequences of over-exercising and in raising awareness about the benefits of change to their health and may help the patient to develop healthier, more appropriate exercise behaviour.

A CBT approach can be used to guide the patient in finding, new healthier ways of thinking regarding their exercise and activity and make changes to their behaviour.

## 7. BMI Related Guidelines

Though these general guidelines are graded according to the patient's BMI, all risks identified for each individual will need to be taken into consideration.
These guidelines are set up for progression on a weight restoration programme. Adjustments may need to be made to these guidelines taking the following into account: pre-morbid exercise behaviour (for example, over-exercise behaviour, sport enjoyment, occupation); future plans (for example, return to ballet, university); long term over-exercising behaviour in patients with a chronic eating disorder, whose bodies have adapted to functioning at a low body weight; decisions made by MDT on individual cases.

**Below BMI 14**
Exercise is not recommended because weight gain at this stage is the overriding priority. However, if an individual does have a particular physical problem, a schedule of activity or treatment plan may be prescribed. This may include gentle bed exercises, and a phased introduction to mobilising.

Typical physical problems may include:
Mobility difficulties
Balance impairment or risk of falls
Difficulty climbing stairs
Re-feeding oedema
Tissue viability / circulatory problems
Postural problems
Over-exercising

**Between BMI 14 and 15**
An individual is assessed and it may be appropriate to recommend exercises in lying and sitting, for example, gentle Pilates, relaxation techniques and gentle stretches.

**BMI 15 to 17**
At this stage there is a gradual progression to moderate weight bearing activities. Pilates, Tai Chi and Yoga type exercises can be introduced. Sessions should still be carefully monitored and supervised and preferably done in a group setting.

**BMI 17 and above**, towards a healthy weight
At this point patients are still on a weight-restoration programme and, therefore, any recommendations for exercise must not be allowed to compromise this. Sessions may become increasingly active and utilise community facilities, for example, badminton, swimming and dancing. Group exercises are preferable to solitary exercising.

**At a healthy weight**
There is some debate about what constitutes a healthy weight in the general population but the special considerations for people with eating disorders must be borne in mind (Sunday & Halmi, 2003; Weltzin et al., 1991). Patients need to find a healthy balance between activity levels and nutritional intake. The physiotherapist has a special role in formulating and constantly reassessing an activity/exercise regime. Adjustments must take into account the individual's physical health, pre-morbid exercise behaviour, occupation and recreational preferences.

## 8. Education and Advice

The Physiotherapist has an important role to play in imparting information to benefit patients' understanding of their bodies. In challenging their unhelpful and often faulty thinking, the Physiotherapist can help them to form healthier, alternative thoughts. In order to challenge patients' misperceptions regarding exercise and their body image, it is helpful to give basic information on the body's structure and physiology. Topics for discussion might include: body composition and muscles and bone functions and the shape that they give the body.

The Physiotherapist can advise on behaviours which are healthier and encourage the patients to adopt new alternative ways of managing their exercise and activities. Exercising with others is strongly advised, as it tends to limit uncontrolled activity, is time-limited and has the added benefit of social interaction. The exercise/activity programme should, above all, be enjoyable and include a wide variety of exercise to counteract possible previous negative associations.

An important message for patients returning to normal exercise is to appreciate that an extra drink or a snack before/ during or after exercise is common practice.

Empowering patients to "listen" to and respect their bodies is crucial. Patients must allow themselves to give exercise a miss when they have injuries, feel unwell, are too busy or simply do not feel like it.

Solitary, rigid or secretive exercising such as the use of home videos or repetitive floor exercises should be positively discouraged, as this may be associated with an increased risk of over-exercising behaviour and a danger of relapse.

For those patients with osteoporosis, high impact exercise or high risk taking activity, for example, horse riding, ice-skating or running is not recommended and should be avoided ( NICE Guidelines 2004).

Patients with anorexia and bulimia nervosa have complex physiological and psychological problems. There are few physiotherapists working as members of eating disorder teams in the UK. This means that physiotherapists, working in other settings, may be asked to provide treatment and/or advice for a patient group of whose condition they have limited understanding. Issues associated with physical activity are a major feature in these disorders and these guidelines provide information on the effects of over-activity and offer ways of helping clients to modify their exercise behaviour.

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## Appendix: Exercise Behaviour Assessment Tool

| Exercise Behaviour Assessment Tool | | |
|---|---|---|
| | **Do You Exercise** | **Please tick if Yes** |
| 1 | To burn calories? | |
| 2 | Because you must? | |
| 3 | Then once you start you can't stop? | |
| 4 | Alone? | |
| 5 | Daily, missing rest days? | |
| 6 | For health or fitness? | |
| 7 | Then feel fatigued by exercising? | |
| 8 | To inhibit other personal/social/educational/or vocational activities? | |
| 9 | Because it helps you maintain your weight? | |
| 10 | Repetitively and rigidly? | |
| 11 | Because you are annoyed, angry, or upset about something? | |
| 12 | Because it prevents deterioration in your osteoporosis? | |
| 13 | To lose weight? | |
| 14 | Because you feel guilty? | |
| 15 | To punish yourself? | |
| 16 | To increase your self worth? | |
| 17 | To feel a sense of power or control? | |
| 18 | Because it improves your mood? | |
| 19 | Even if you are unwell, too tired, don't feel like it, or have other things to do? | |
| 20 | In secret, e.g. bathroom? | |
| 21 | Because you enjoy exercising and find it fun? | |
| 22 | Because you feel great anxiety if you are unable to exercise? | |
| 23 | Because it reduces your stress levels? | |
| 24 | Because it improves your body image? | |
| 25 | To feel worthy enough of eating? | |
| 26 | Because it helps you gain weight? | |

## Can lessons learned from Pain science be interpreted in a way that aids the understanding, justification & treatment of Conversion Disorders?

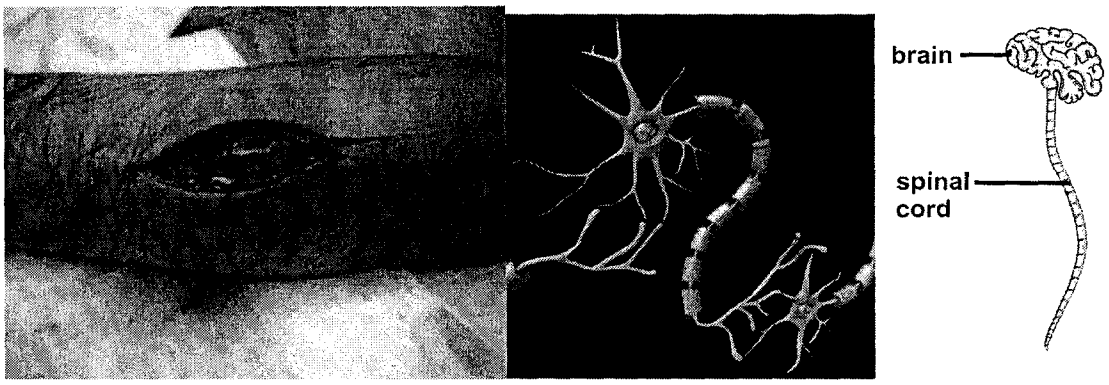
For a long time I have had a great interest in pain; a statement that outside of the NHS can raise a few eyebrows. However, it is my genuine belief that by trying to understand the individual's neurological experience we can create an effective treatment program.

*This brief summary aims to show how rigorous research in the world of pain can be used to explain our interventions with conversion disorders in an evidence based manner. It is to be used only as an adjunct to current practice.*

***You may find it easier to follow if you change the word pain for physical limitation or something equivalent***

The story starts with NORMAL pain.

Every time we injury ourselves a process is set in motion.

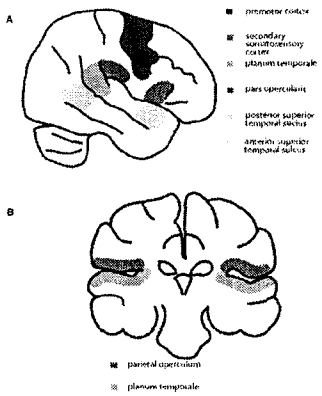



We are all familiar with the idea of noxious stimuli and nociceptors but just to clarify. NOCIOCEPTERS do not equal PAIN. Instead they inform about the bad in life. As a result most things they communicate about do result in a pain but that relationship is not fixed.

Let us forget about nociceptors for the time being. Instead, let's think about the other nerves in your skin. After a laceration there might be messages to the brain portraying a drop in local temperature as heat is lost. Skin integrity is broken and as such stretch receptors may be firing. What about local blood pressure, that is likely to have dropped.

So lets bundle these messages together, send them off to the dorsal horn of the spinal cord and shoot on up to the brain.

Here things get exciting!




In the brain we know that a modulation process takes place. That is, all the varying bits of information being reported by the various nerves innervating the affected part of the body are combined and a picture of the scenario produced. If life was straight forward this would mean that a break in the skin would result in pain. But this is not always the case, how many times have you had a bruise that you can't remember obtaining, or why do paper cuts hurt so much?!

MODULATION!!!

All the information is processed against a backdrop of;

| | | |
|---|---|---|
| Experience | - | what happened last time? |
| Understanding | - | blood is bad |
| Context | - | I'll lose my job if this stops me working |
| Environment | - | I'm alone and surrounded by sharks |
| Knowledge | - | Bob lost his arm when this happened to him |
| Anxiety | - | stress sensitises nerves |
| Depression | - | stress sensitises nerves |
| Fears | - | this is just the start |
| Beliefs | - | I believe the diagnosis is wrong |

You could go as far as to argue that PAIN is SOCIAL CONSTRUCTED! But that's a whole new story.

TANGENT

*A man once took a walk in the Australian outback and felt a scratch on his ankle. He thought nothing of it assuming is was some bracken. 20 minutes later he collapsed on the ground in agony; he was vomiting, sweating and shaking. He had been bitten by a snake! After a near life or death scenario he survived.*

*A few years later the same man was playing football in the garden with the kids at a bar-b-q. He retrieved the ball from some bushes with his foot and suddenly dropped to the floor. His heart was racing; he was sweating, felt nauseous and was in incredible pain. He looked down on the same ankle that had been bitten some years earlier to see no more than a little scratch (story stolen from Lorimer Moseley).*

The morale of this story... pain can occur just by the belief, understanding, past experience, knowledge and fear that you are in danger!

Back to the original story. So, messages have been sent to the brain, interpreted in the background of many emotional and cognitive concerns and the outcome here is... PAIN.

Healing times; remember that soft tissue injuries take 6-12 weeks to heal and bony injuries 12 weeks (a rough guide – excluding remodelling phases which can take up to a year).

WHAT HAPPENS WHEN THINGS DON'T GET BETTER?!

After a couple of days certain efficiencies start to occur in the above process (still NORMAL). The threshold required by the nerves sending information to the spinal cords lowers. Therefore the area becomes sensitised, or to put it another way, information is more easily sent to the brain where it is then MODULATED into an appropriate response.

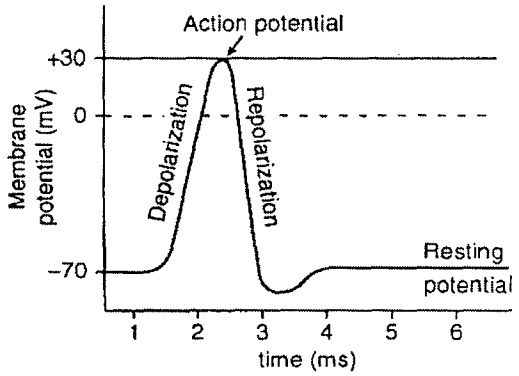
This process should then undo and return to normal in line with healing times. However, if the recovery process is interrupted by;

A second injury
A medical complication / infection
Lack of diagnosis
Fear
Losing your job
A dramatic change if lifestyle
A disputed legal position

Then it will continue and the threshold (PAIN THRESHOLD) will continue to lower. At its extreme this leads to ALLODYNIA where the effected area of the body results in a pain response even in the presence of non-noxious or normal stimulus.

TANGENT

*When people say "I have a really high pain threshold" what they actually mean is they have a high tolerance to pain. Pain threshold is a fixed point at which an action potential is stimulated and a response sent along a nerve to the brain to inform about damage or potential injury.*




NEUROPLASTICITY

Hopefully this is a term we are all familiar with. However, it is worth noting that this is the other factor in ongoing pain. The brain can change the way the physical body is represented and it can also change it back!

If this is a term you are unfamiliar with then look to the reasons for '*phantom limb pain*'.

WHAT ABOUT CONVERSION DISORDERS?

If we apply the above logic to a patient scenario;

- 21 year old male
- Basketball player
- Recent family dysfunction
- Acquires a viruses and is bed bound for a few days
- (presentation to physio – 5 year later with quadriplegia)

For the patient his illness results in a more harmonious home environment whilst the parents look after him. It is no longer in the young mans interest to recover (most likely at a subconscious level).

As with many viruses, no diagnosis or treatment is prescribed. This results in uncertainty over the severity, its potential duration (adverse symptoms can be present for several weeks in normal cases) and its nature. This uncertainty leads to fear and anxiety which is well known to sensitise the nervous system lowering the threshold at which information is sent via the spinal cord to the brain.

Already we are in a position where the original symptoms and information being sent to the brain may be being modulated into a more extreme version.

This is heightened by playing "the sick role". A favourite example of mine is when you see people reporting pain stand up really slowly. If you try and do it yourself, the effort you have to put in to looking in pain is exhausting. Try going from sit to stand 3 times as if you are in the world's worst pain, using furniture and moving precisely. Then try doing 3 times normally. You quickly realise that if you're moving in a pained way that you are actually making things difficult for yourself.

So... back to our example. The young man is in bed. Every movement requires heroic amounts of effort and it becomes harder and harder to motivate oneself to move. Therefore, you move less. The neuromuscular pathways involved in initiating and controlling movement become less stimulated. The body's efficiency systems kick in and those now unused pathways start to become dormant. Movement becomes harder still and we end up in a negative multiplier...

...just add time and the opportunity to remain in the sick role (e.g. you won't lose your job and your house if you do not turn up to work tomorrow) and there you have a PERFECT STORM!

HOW DO YOU RECOVER?

There are many blockages to recovery. These often fall under the categories of blue, black and yellow flags (employment, family, social circumstances, etc). Until the barriers are addressed then the environment will never be conducive to recovery.

TANGENT

*In some cultures, once you've become a grandparent – regardless of age, you are seen as being at the head of the household. It is perfectly acceptable for you to be waited upon and not partake in physical activity. Eventually, all that sitting around results in the inevitable back pain and you go to see the physio. There they are given exercises to do 3 times a day and to everyone's surprise they don't get better and end up with chronic pain! The reason for this is that because when they are in pain they are waited upon even more. They do less. The muscles supporting the spine are constantly in a seated stretched position where they are at a mechanical disadvantage, which they inform the brain about resulting in the output of pain (with the goal of trying to get you to change position or move).*

*Hence, the appropriate treatment would be to educate the family, show them what the family elder can do in a clinical environment and emphasise the importance of them continuing with an active lifestyle at home and in the community.*

Once the obstacles to recovery have been removed the next step is to engage the brain in the process. After all, the disability experienced is exclusively driven by the brain. If you don't believe that lets provide an example.

TANGENT

*Chronic Regional Pain Syndrome (aka CRPS) occurs most frequently in a hand or wrist after a nasty fracture. The person is slow to recover and after a couple of weeks the affected hand starts to look swollen, clammy and mottled whenever moved, the patient reports a burning sensation. Mr. L. Moseley conducted a fantastic piece of research where they rested the affected hand in the lap of the patient. They then put the good hand in a mirror box and made the patient watch its reflection as it was moved. To the brain this looked like the affected hand was moving and this resulted in the swelling, pain, mottled and clammy hand that is usually only present with movement. This lead to the coining of the phrase "virtual body" and fits really nicely with phantom limb pain to prove that pain is a purely cognitive process!*

To engage the brain is rather simple. You need to explain all of the above to the patient. That is, to get them to understand that there is;

No physical element to their disability
It occurred through normal body processes
It is 'not in their head'
Rather all physical pain / control is a cognitive process

Next, its time to rehab the body. Unlike a stroke patient this can be done rather quickly. This because there is no damage that has taken place. Instead, we have a system of efficiency measures (familiar saying to those of us in the NHS!) which need to be reversed. Or in more medical terms, we need to facilitate the opening up of those dormant neuromuscular pathways.

TANGENT

*During my A levels I remember reading that javelin throwers would throw the first 1500 javelins of the season in their mind before every picking up a javelin. This gave them the opportunity to ensure they new the exact technique they were aiming for. A study (and I unfortunately have no reference for this) showed that during this mental rehearsal phase of training the athlete's strength improved my 17% by purely firing up the neuromuscular pathways and imbedding them.*

In our example the young man used to be a basketball player. Something he had missed and would love to return to. Therefore, to start the rehabilitation and stimulation of the neuromuscular pathways we could start by talking about the sport. Followed up with watching the sport on television. A really nice step would be to watch oneself playing the sport to really imbed the potential to return (it should be noted that this could be a very emotive experience).

Then we think about the rehab. We start with the usually things needed for sitting balance and transfers. Where possible we try and tie in positive past experiences e.g. reaching up becomes a basketball shot, balance transfer could be blocking manoeuvres. As soon as gait resumes we start to get sport specific as early as possible.

TANGENT

*This ties in with a process referred to as 'schema'. This is the mapping of certain physical movements (can also be applied to emotional responses) which allow a certain degree of transferable skills. E.g. the schema for hitting a tennis ball is similar to that of hitting a squash ball. Although individual training is required to master both sports, they are to a certain degree transferable and if you have a schema for one, you will quickly be able to pick up the other. These schemas stay with us and we can use them to very quickly get someone standing or walking rather than having to teach them the gait cycle.*

It is only once we get to this point that we can start to nit pick in our physio way about which muscle is shortened or weak. Once we have the patient's body and most importantly their mind engaged!

For a better understanding of this topic I can recommend reading and buying;

1) Butler, D. S. & Moseley, G. L. Explain Pain. NOI Group Publications.
2) Moseley, G. L. 2008. Painful Yarns: Metaphors and stories to help understand the biology of pain. Dancing Giraffe Press.

Anyone interested in this topic please feel free to contact me: ross.farmer@slam.nhs.uk

Ross Farmer
Head of Physiotherapy & Clinical Exercise
South London & Maudsley NHS Foundation Trust

# CPMH News

Editor's note: Please send in any local branch news, upcoming study days or networking opportunities.

## Special Interest Group Update

As you may be aware the thirty nine special interest groups were becoming a little unwieldy for the CSP to liaise and monitor. After extensive consultation the following structure has been proposed.

There are now 6 clinical alliance groups.

Lesley Dawson takes over as rep for all professional networks alliances from the CSP

Currently the individual alliances have no chair but contact details have been provided;

1) Neuroscience – Siobhan MacAuley neurophysio@btinternet.com , Marousa Pavlou marousa.pavlou@kcl.ac.uk

2) Therapeutic Skills – Sarah Bazin sbazin@csp.org.uk

3) Occupational Roles – Annie Karim annie.karim@hcahealthcare.co.uk

4) Neuromusculoskeletal – Annette Bishop a.bishop@cphc.keele.ac.uk

5) Client Groups – Louise Tisdale Louise.tisdale@wolvespct.nhs.uk

6) Cardio Respiratory – Melanie Reardon m.reardon@nhs.net

The CPMH will fall in 'client groups' along with learning disability, amputees, paediatric, agile and women's health.

## Committee members representation

Sharon Greenshill
Chair CPMH
CSP Council
Chair of CSP Professional Practice and Service Delivery Committee ( from January)
Chair Professional Networks Implementation group

Catherine Pope
For the CSP -
CSP Council Representative for the East Midlands
Chair CSP Human Resources Group and Member of CSP Management Group
for the NHS Confederation
Director of Therapies Mental Health Network Board, NHS Confederation

Caroline Griffiths
CIGLC as chair persons alternate
CIGLC rep on Communications Group
UK rep ICPP

# Heather Grimwade
# Membership Secretary

Hello All ☺

I would like to take this opportunity to introduce myself to those of you that aren't aware of the change in the CPMH membership secretary – which happened at the beginning of this year.

My name is Heather Grimwade and I am a Physio Technical Instructor based in Warwick, Warwickshire at St Michaels Hospital which is solely Mental Health.

This is my 2nd tour in office (so to speak), I was the Congress co-ordinator the 1st time round but due to personal circumstances I had to withdraw from the committee but I'm back now and in full swing! Taking on the membership secretary role has suited me down to the ground as I love to organise things, but I have to say it is a bigger task then I initially envisaged!

One of new changes that have happened since taking on this role is the change in the membership year. This has changed from August to September to now being January to December . . . so for all of you out there who have set up a Standing Order with your banks – please could you now ensure you notify them of the change. If your bank has already made this payment, have no fear this will count as your 2012 membership fee and the overlapping months are yours free! New cards have yet to be printed, but as soon as this is done – you will receive it in the post . . . a mammoth task I've yet to look forward to ☺

Well with all this said, I'd like to thank you all for your continued support of the CPMH because without it's members we would cease to exist and it is such a worthwhile professional network as I'm sure you all agree.

All the best for the New Year!!

# Branch Updates

## Scottish Branch

The next meeting will be on the 12th of January.

The mental health strategy for Scotland 2011-2015 is out for consultation and has to be responded to. For this reason it is really important that there are as many attendees as possible.

Edinburgh is hosting the 4th ICPPMH conference in February 2012. Please see the advert earlier in the journal for details.

There is now a joint chair between June Parker and myself.

Wishing you all the best for 2012!

Ann Parker
Superintendent Physiotherapist
Royal Edinburgh Hospital
Anne.parker@nhslotian.scot.nhs.uk

## London Branch

We have held 4 meeting during the last year. We continue to offer an exciting series of presentations and discussions on Mental Health (MH) areas affecting physiotherapists. Membership is made up of any physiotherapists, students or assistants who are working in the field of MH and are keen to obtain support or working in the field of psychiatry.

We offered 2 study days this year. The first was an introduction to mental health and the second, recovery in mental health. This is a hot topic at present with 6 pilot sites across England. Unfortunately numbers were low for these two events and were cancelled. However we plan to keep offering these CPD opportunities covering the issues that matter to physiotherapists working in this area.

We welcome both members and visitors to the Home Counties Branch meetings and network. The officers of the Branch are:

Kashif Munir (Secretary, based CNWL)
Tony Hegarty, (Chair, National Branch Liaison Representative based at West London Mental Health Trust)
Jean Picton-Bentley (National Branch Representative, based at SLAM).

Email contacts:
jean.picton-bentley@slam.nhs.uk
Anthony.hegarty@wlmht.nhs.uk

Our next meeting will be held on 12 March 2012 at Springfield Hospital Tooting, 0900-1200. If you are interested in attending, please contact Angela.slade-smith@wlmht.nhs.uk for more details.

The following meetings will be held 12th June 2012 at the Maudsley hospital, Denmark Hill, Southwark, London, SE5 8AZ.

11/9/2012 and the 11/12/2012 venue TBC

## Welsh Branch

The next meeting will be in Swansea on the 20th February.

Topics for discussion will be; current drivers, service changes and case study presentations.

The Welsh branch usually meets twice a year and the second meeting is pencilled in for November. It has been a difficult year when many of us seeing financial measures eating into our services. However, it is important that we continue to support each other and the people we serve, after all they are a vulnerable population who are not always able to access alternative sources of healthcare

Liz John

## Midlands Branch

Chair: Lauren Fordham MCSP of Derbyshire Healthcare NHS Foundation Trust
Treasurer: Srikanth Kota MCSP of Leicestershire Partnership Trust
Secretary: Natalie Younger MCSP of Leicestershire Partnership Trust
Education Lead: Kerry Gibson MCSP of Birmingham and Solihull Mental Health NHS Foundation Trust
Education Link: Ann Childs MCSP of Nottingham University

Chair's Report

The Midlands Branch of CPMH has received some enthusiastic support from physiotherapists who work in mental health as well as those who work in community and other areas but whom have an interest in mental health. We have arranged a number of study and networking days around the midlands and the feedback is that they have been useful for both continuing professional development and network about local projects and events. In 2011 we have said goodbyes to our secretary Gemma Cottrill who has resigned to pursue her MSc in Manual Therapy and specialist work with skiing injuries. We have also welcomed Srikanth Kota, Natalie Younger and Ann Childs to the committee and are grateful for their enthusiasm and support.

In the year ahead we hope to gain more involvement from our colleagues who work in mental health. We hope to increase membership and networking links. This is a difficult time in healthcare and there are many new challenges and changes, which can be unsettling. The Midlands Branch hopes to continue to be a network for people

with shared interests so we can keep our focus on providing high quality specialist care. We look forward to working as part of the CPMH, along with the London Branch and Scottish Branch.

Happy New Year to all from the CPMH Midlands Branch

Lauren Fordham

Senior Physiotherapist
Derbyshire Healthcare NHS Foundation Trust

## Study Days

**Congress 2012**
Congress 2011 was again a success with excellent speakers and presentations. If you know of any speakers that you feel you would like to recommend or any topics that you would like to see at congress please let us know.
For a number of years we held our AGM at congress, we are seeking member's views whether they would like us to return to this of whether members feel that a separate study day is preferable.

**Study days**
We are looking in 2012 to deliver study days/workshops and are keen to hear from anyone who would like to host an event or who would like to become involved through speaking, organising etc..
If you have any burning topics that you would like to see delivered please contact us

## CPMH National Study Day

The Chartered Society of Physiotherapists in Mental Health (CPMH) is holding its National Study Day on 'Outcome Measures for Physiotherapy in Mental Health' on Friday 29 June 2012 at the Chartered Society of Physiotherapists (14 Bedford Row, London, WC1R 4ED).

The cost of the day is:
£55 for non CPMH members – this fee includes membership of CPMH up to 31 December 2012
£45 for CPMH members (please state membership number)
£30 for students and retired CSP members (please state membership number)

Please see iCSP for more details including application form or contact angela.slade-smith@wlmht.nhs.uk for more details on the day. Please submit your applications ASAP to reserve your place.

# CPMH WEBSITE UPDATE

The good new is the new CSP websites have gone live now. All the previous information that was in the old CPMH website we have been told reliably from Nigel Senior at the CSP, who is overseeing the whole project, will be merged into the new CSP mental health web pages. So all your previous good work has not gone to waste.

This means that the old CPMH website has been closed down. We are no longer paying for this site to be maintained through an annual licence. That would explain why some of you have not been able to get through to our old web pages in case you were wondering!

The maintenance of the CPMH mental health web pages through the CSP will be updated and maintained by the CPMH mental health moderators of which I am the first point of contact. There are two other moderators so three of us altogether. I understand that a vacancy has arisen for a new moderator if anyone is interested in acting as a moderator for the CSP Mental Health web pages. Full training has been offered by the CSP team if anyone is interested. I can offer more information if anyone is interested please contact me for further information.

We were hoping that we might be able to transpose the old "Healing hands" logo to the front of the new web pages for those of you that remember it from the old CPMH website. Nigel Senior at the CSP has told me that we need to have copyright permission from whoever arranged for the original logo for the CPMH web pages all those years ago.

If we can't provide the logo then we will have to go with one of the many logos that the CSP have available but not our healing hands emblem which I feel is synonymous with the work of the CPMH historically. If anyone like old serving committee members can remember where we got the emblem from and who has copyright I would appreciate it if they would let me know so that we can use the old logo in out new web pages!! I need your help if any of you can search your memory banks as to where our logo came from originally.

I now need your help please!! We need to start to add information to the new website. Like interesting articles for physiotherapists working in mental health, including diary dates, branch meeting, old journals of interest etc to the web site. This is so that we can store and build up our data base for future members. It will also act as a permanent resource for anyone interested in the work of physiotherapist in mental health.

Just how effective our mental health website becomes depends on how much information we can put on it and how much of a useful resource we can make it be. We need your help now.

Please spend some time going on line and having a look at the website and send in your information as much as you like and we can place it on the website for information sharing for members.

Yours sincerely
Tony Hegarty
CPMH Website Key Moderator

## AGM Derby - 26 May 2010

Present

| | |
|---|---|
| Sharon Greensill | RDASH |
| Caroline Griffith | |
| Jean Picton-Bentley | SLAM |
| Christine Marsh | DMHT |
| Rod Newsome | NHS Barnsley |
| Heather Cameron | Derbyshire Mental Health Trust |
| Tom Gregg | RDASH |
| Rosemary Newberg | St Andrew's Healthcare. |
| Heather Grimwade | |

Apologies from Chair regarding the lateness of this event.

Apologies: Clare Leonard, Tony Haggerty, Catherine Pope, Ann Parker, Lilian Mapeza

CHAIR ACTIVITIES List shown – 2009-2010. Chair outlines the activities that both she and other members of the committee had been involved in during the past 12 months.

SEC REPORT
Feedback given in Clare's absence. Clare has written report 'working with older people'.

TREASURERS REPORT
Handouts given. Request to be made for clarification on certain aspects ? on figures – subs high, no cap fee shown.

CIG Rep report
- Caroline now the rep.
- Caroline spoke about the ongoing CIG review outlining the key aims and objectives. There was a discussion on the proposal and of the potential benefits/impact for CPMH
- Condensed version of scenario to be post and used.- should prove helpful.
- Discussion on Education –higher and student reps, helpful to have Mental Health aspect represented.
- Caroline spoke of her activities for CPMH during the past year. Caroline stated that she was representing CPMH at international conference .

Journal Editor - Jean fed back.

Now doing Winter and Summer journal.
Will advertise forthcoming events, information etc. Features included – open to suggestion.
Question asked by Christine Marsh in reference to Treasurer's Report – production of journal is very costly – do we still need this in the paper format, or send it electronically. Discussion held around this . It was felt that we needed to have something and whether this would be electronic. If we were to follow this avenue then

we would need a template. It was discussed re seeking further advice from CSP Nigel Senior / Jackson Dempsey (Jean to contact JD) with regards to this linking into the proposed new websites for CIGs.

Action

- Review of the Journal.
- With few members, costs difficult to meet, if continues CIG could fold. Need to generate monies?

Committee members– identified positions becoming vacant this year. Highlighted gaps identified.
Victoria had asked to come off the committee due to now working outside mental health. Discussion held regarding the role of the treasurer. Chair advised regarding the requirements in line with CSP governance. No nominations for committee received prior to the AGM.

Positions required to be filled:

Treasurer. Rod Newsome indicated that he would be willing to join the committee and consider the post of treasurer. This proposed by Caroline, seconded by Sharon, all present agreed
Rod (01226 434066) - roderick-newsome@barnsleypct.nhs.uk

Education (link) Discussion held around role of education . Lauren indicated that she would be keen to join the committee and have a role involved in education. Proposed by Jean seconded by Caroline all agreed. Further discussions at the first committee meeting re how education and research can be taken forward.

Discussed the need for an events team. Currently Tony , Jean and Lilia are involved in arranging events. Need to have a group that will organise and deliver events UK wide.
Christine Marsh, Heather Cameron and Tom Gregg indicated that they would be keen to be involved in organising events. It was suggested that this could sit as a subgroup of CPMH and work virtually

Heather Grimwade stated that she would be keen to rejoin the committee. Poposed and seconded by Caroline and Sharon. There was discussion around the key drivers Health and Wellbeing/ Public health and whether there was a need to have a policy/health and wellbeing lead. Heather indicated that this would be an area she would be keen to be involved with. Decision made that this would be discussed further at committee meeting

Discussion that some members of the committee were involved in a lot of work and around the importance for more volunteers to share the workload.

What have we done? List shown
Update given on proposed 2012 – Conference – Edinburgh
Dementia Audit – links with AGILE – not out yet.

2010/2011
Went through shown list of future aspects to be covered.
Introductory Course –? Doncaster November 2010/January 2011
Action plan from Strategy – needs working party?

Proposed changes to Constitution:-

- Changes to cessation clause.
- Change of meetings from 4x yearly to 3x yearly, have joint meeting with AGILE ? ACPIN?

All present agreed with these changes. Proposed: Caroline
Seconded: Chris M

Educational Awards

Sharon feels that this is not working. When financial support was given there was a requirement that the recipient would provide a talk/presentation/course in return to CPMH. It was felt that this was not happening and that we needed to review this arrangement especially given the current climate with regards to finance . It was felt that we needed to ensure financial stability fo the group
It was agreed to put this award 'on hold' for the present time, and to discuss further at committee meeting.

Yorkshire and Humber English Network

Sharon feedback from the local English network. Sharon advised that Catherine was involved in the Midlands network.
Study looking at competencies pf amongst physios' working in mental health.
Jean mentioned Jo Bell – may have done this already. Sharon to check.
Mindfulness – Jean P-B spoke about.

DATES FOR NEXT COMMITTEE MEETINGS

- September
- November
- March

# CPMH Accounts

**CPMH Accounts**

| | | | |
|---|---|---|---|
| | **Accounts for period** | **1st September 2010** | **31st august 2011** |
| | **Income and Expenditure Account** | | |
| | | **2010/11** | **2009/10** |
| **Income** | | | |
| | | £ | £ |
| | Subs | 1,252.50 | 1,710.00 |
| | Bank Interest | £ 8.39 | £ 9.02 |
| | | | £ |
| | Course fees/Congress | | 1,115.00 |
| | | | £ |
| | Other | | 1,332.05 |
| | Cash/Subs | £ 15.00 | |
| | | £ | £ |
| | **Total income** | 1,275.89 | 4,166.07 |
| **Expenditure** | | | |
| | | | -£ |
| | Accountancy | | 125.00 |
| | | -£ | -£ |
| | Committee Expenses | 1,668.67 | 2,311.10 |
| | | | -£ |
| | Journal Expenses | | 752.72 |
| | Education Grant | | |
| | | -£ | -£ |
| | Courses | 60.50 | 427.10 |
| | | -£ | |
| | Other | 176.02 | |
| | | -£ | -£ |
| | **Total Expenditure** | 1,905.19 | 3,615.92 |
| | **Surplus/Defict for period** | -£ 629.30 | £ 550.15 |
| | **Balance Sheet** | | |
| **Assets** | | | |
| | | £ | £ |
| | Bank: Current Acc | 1,326.43 | 1,979.12 |
| | | £ | £ |
| | Bank: Deposit Acc | 8,416.79 | 8,408.40 |
| **Funded by** | | | |
| | | | £ |
| | Opening Reserves | £10,387.52 | 9,837.37 |
| | | -£ | £ |
| | Surplus/Defict for period | 629.30 | 550.15 |
| | | | £ |
| | End of year reserves | | 10,387.52 |

**corrections Uncashed cheques 970 £42**

# WRITING FOR THE CPMH JOURNAL

## Guidelines for authors

### Aims of the CPMH Journal

The CPMH Journal is produced twice yearly for members of the group of Chartered Physiotherapists in Mental Health. The next journal is due for completion in Autumn 2012. If you would like to submit a piece for this journal please ensure it arrives no later than 1st September 2012.

The aim of this journal is to inform members of clinical and business developments that particularly affect physiotherapy in mental health. It aims to keep members in touch with each other and local and national issues. Regular features of the journal include editorial, clinical articles, case histories, business-related articles, information, conference reviews, book and product reviews, product news, letters to the editor, small advertisements and useful addresses.

### Format of articles

Articles up to 3,000 words are acceptable, in case where this is exceeded the editor may chose to split the content over more than one journal. Book, product reviews and course reviews should be between 500-750 words long.

The use of tables, illustrations and photographs are encouraged. Any identifiable photographs must be accompanied by written permission. It is the responsibility of the author to obtain copyright permission for any pictures or photographs taken from the internet. This permission must accompany the manuscript.

Any pieces that do not stick to the word count will be treated on a case by case basis.

Formatting of the text, spacing and titles will be adjusted y the editor and does not need to be done by the submitter.

If you reference a paper in your article it should appear in the Harvard referencing format.

Example:
In the text both the surname of the primary author and the year should appear (Farmer 2011).

Mosley, GL. 2004. Evidence of a direct relationship between cognitive and behavioural change during an education intervention in people with chronic low back pain. *European Journal of Pain*. Vol. 8 Pg 39-45.

If the material has appeared in another publication, this must be declared before any agreement on publication is reached.

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If the material has appeared in another publication, this must be declared before any agreement on publication is reached.

Material accepted for publication will be edited at the Editor's sole discretion.

All articles submitted will be treated as though all authors have read and approved the manuscript. The responsibility for checking for typographical errors and for correct content rests with the author.

If an error is noted in the text of an article after publication, through oversight by either the author or the Editor, the error should be reported to the Editor, together with information about its possible cause and the best way to correct it. Any action taken as a result of such notification is at the absolute discretion of the Editor.

Each author should give his or her name, the address and appointment current at the time the work was done, plus a current address for correspondence including telephone, fax numbers and e-mail address.

The author provides the CPMH journal with a licence to republish the article, to include presentation on the website, without the need to seek further permission.

**Submitting an article**

Please send your manuscript, including original photographs to the Editor. Hard copies of text are acceptable, but it is preferred that all material to be printed is sent electronically using Microsoft Word. If this is not feasible, then please submit on CD or floppy disc, as well as sending a hard copy.

Tables, illustrations and digital photographs should be submitted as high-resolution PDF, tiff or jpg files.

If you require any further guidance or need more information, please contact either the person who invited you to write in the first place, or: -

Editor CPMH Journal
Jean Picton-Bentley,
Physiotherapy Department,
Maudsley Hospital,
Denmark Hill,
London SE5 8AZ
Tel: 0203 228 5028
E-mail: Jean.picton-bentley@slam.nhs.uk.

# Chartered Physiotherapists in Mental Health Professional Network

## MEMBERSHIP APPLICATION/RENEWAL FORM

### 1. PERSONAL

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

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

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

### 2. CONTACT DETAILS

Address: . . . . . Telephone: . . . . . .

. . . . . E-mail: . . . . . .

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

Country: . . . . . .

### 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?. . . . . .

### 5. DECLARATION

The CPMH occasionally receive requests for information from physiotherapy students and other physiotherapy professionals. Contact information supplied on this form will be used only for the purposes of the Professional Network Group and the Chartered Society of Physiotherapy.

In order to be able to access the iCSP (Mental Health section) and CPMH page, we will need you to give us your CSP number in section 5.

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

## 6. PAYMENT: (PLEASE MAKE CHEQUES PAYABLE TO CPMH)

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 January 1st to December 31st.

For iCSP and CPMH website access – please give us your CSP number here .....

I enclose my cheque for £ . . . . . in payment of the subscription for membership year .....
Please send cheque to Heather Grimwade, Physiotherapy Dept. St. Michaels Hospital, St Michaels Road, Warwick, Warks CV34 5QW

OR

I wish to pay by Standing Order and have completed a Standing Order form and given to my Bank for action.

Bank Details as follows:

Santander Commercial Bank

Sort Code: 09-01-51

Account Number: 8475 8300

Please return this form together with your remittance or completed SO form to:
Heather Grimwade, Physiotherapy Dept. St. Michaels Hospital, St Michaels Road, Warwick, Warks CV34 5QW
heather.grimwade@covwarkpt.nhs.uk