A survey of physiotherapy students’ experiences and attitudes towards treating individuals with mental illness
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DOI:
10.12968/ijtr.2014.21.7.324

Citation for published version (Harvard):

Link to publication on Research at Birmingham portal

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A survey of physiotherapy students' experiences and attitudes towards treating individuals with mental illness

ARTICLE · JUNE 2014
DOI: 10.12968/ijtr.2014.21.7.324

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A survey of physiotherapy students’ experiences and attitudes towards treating individuals with mental illness

**Introduction:** Very few research articles have considered the views and attitudes of student physiotherapists towards treating individuals with a mental illness (MI). Therefore, this study’s objective was to consider the experiences and attitudes of student physiotherapists towards treating individuals with MI.

**Methods:** A cross-sectional cohort design was used. One hundred and eighty one physiotherapy undergraduate degree students at UK institutions participated in the survey. The survey had been specifically designed for this study, and contained a mixture of open and closed questions.

**Results:** Seventy one per cent (123/173) of the students were exposed to less than 4 hours teaching time about MI, and 76% (131/173) wanted further education on MI. Students were concerned about limited knowledge of MI conditions and how to approach patients who have a MI. A summary of the specific concerns of students is identified within the text.

**Conclusions:** Further education about MI is required to give students greater confidence in treating patients who have an MI. Education would also likely benefit some students who identify negative characteristics of patients with MI.

**Key words:** Mental health, Education, Physiotherapy, Attitudes, Mental illness

Submitted 18 February 2014, sent back for revisions 3 April 2014; accepted for publication following double-blind peer review 18 June 2014

**Phisiotherapists working in mental health are well equipped to provide interventions to benefit the physical and mental health (MH) of people who have a mental illness (MI) (Chartered Society of Physiotherapy [CSP], 2008a; 2008b). Physiotherapeutic skills of benefit to patients with MIs include: exercise prescription; delivery of lifestyle and weight management programmes; expertise in motivation and physical healthcare; management of falls and mobility; identification of non-pharmacological pain treatment; and consideration of the patient’s functional abilities (Pope, 2009). Physiotherapists also play a central role in reducing the physical health disparity in people with mental illness (Stubbs et al, 2013; 2014a; 2014b) and in improving quality of life (Vancampfort et al, 2012). However, outside of specialist mental health services, physiotherapists’ knowledge about MH or MI is limited (Pope, 2009).

Research has identified that individuals with MI experience high levels of stigma, face stereotypical views of their MI and, as a consequence, can be rejected by others (Douglas and Sutton, 2010). This includes stigmatised attitudes from health professionals (Thornicroft, 2009) and students (Byrne, 2000; Wynaden et al, 2000; Happell and Gough, 2007). For people with a MI, this can mean being stereotyped as violent, unpredictable and less trustworthy than the average person (Dinos et al, 2004). Stigma affects a patient’s psychosocial wellbeing (Corrigan et al, 2006; Watson et al, 2007) and help-seeking behaviour (Clement et al, 2014). This in turn can impact on the long-term prognosis and recovery for the individual (Watson et al, 2007), resulting in a reduction of health service use (Dinos et al, 2004; Teachman et al, 2006). Research is needed to explore the views and attitudes of health professionals towards individuals with MI, as this naturally influences treatment and interactions (Hansson et al, 2013).

Understanding the attitude of physiotherapy students towards individuals with MI is important: as younger members of staff can often express more negative beliefs about people with mental illness (Hansson et al, 2013). Research has shown that education is an effective method of influencing student attitudes towards MH.
The attitudes of physiotherapy students towards people with MI have been considered in two studies; one of these studies was conducted in Belgium (Probst and Peuskens, 2010) and another in Sweden (Gyllensten et al, 2011). Probst and Peuskens (2010) assessed the attitudes of undergraduate physiotherapists by using the Attitudes Towards Psychiatry Questionnaire (Burra et al, 1982). This research suggested that physiotherapists have ‘a moderately positive’ attitude towards psychiatry, which compares favourably to other medically-related disciplines. In addition, the research identified the benefit of a specific training course on physiotherapists’ attitudes. However, this scale was originally written for psychiatrists, with its questions orientated towards this profession, e.g. question four on the scale states: ‘I would like to be a psychiatrist’ and question seven: states ‘psychiatrists seem to talk about nothing but sex’. Given the need to rate such statements, it is clear that the focus of the questions is aimed at understanding the attitudes of the psychiatric profession rather than understanding health professionals’ attitudes more broadly.

Gyllensten et al (2011) examined how the type and volume of teaching across six health and social care degree programmes influenced attitudes towards MH. This research identified that duration of contact time, the examination of case studies and provision of lectures about MH were the most influencing factors for reducing stigma in undergraduate students. Given this, further research that considers UK cohorts is required as there is currently very little consideration towards the type, volume and experiences of MH or MI among UK physiotherapists as well as considering students’ attitudes towards MH. Importantly, any further research must consider the influence of personal experience on students’ attitudes as this has not yet been established (Probst and Peuskens, 2010).

In the UK, a brief scoping survey, conducted for the higher education academy considered teaching in MH at 11 of the total 29 physiotherapy teaching institutions (Spearing, 2012). Findings were generated through email responses from physiotherapy programme leaders and illustrated that: in most cases, teaching about MH was provided on a generic module, rather than through devoted MH or MI modules; delivery of MH teaching was similar across year groups; and where teaching about MH did occur, it focussed on the role of the physiotherapist, scope of practice and specific MI conditions. Despite these findings, several aspects have been reported that may prevent effective teaching of MH to physiotherapists, including: a shorter duration of course (2 and 3 years in the UK, compared with 4 years in most European institutions); the current scope of competencies demanded by the CSP learning principles framework (CSP, 2008b); and the requirement for a high number of clinical hours. Thus, it is unknown what current levels of teaching in the UK translate to physiotherapists’ experiences of and attitudes towards MI.

In summary, research exploring attitudes of UK physiotherapy students towards MH is lacking, as is research that considers the provision of teaching for students. Previous research focuses mainly on medical and nursing cohorts with the aim of increasing numbers of students who specialise in psychiatry. Two studies focus on physiotherapy cohorts, both of which use quantitative tools that are not designed for physiotherapy students. Indeed, Probst and Peuskens (2010) call for a specific physiotherapy questionnaire to be designed. It has been demonstrated that attitudes can be affected by educational input. However, it remains unclear exactly what volume of teaching is required to impact student attitudes and sense of preparedness for treating real-life patients.

Given the above points, the current study’s purpose was to describe the educational and personal experiences of physiotherapy students, and their attitudes towards working with people with a MI.

**METHODS**

A cross-sectional cohort design was used to explore the views and attitudes of student physiotherapists within the secure, online survey. All UK physiotherapy undergraduates undertaking an undergraduate physiotherapy course in the UK were invited to participate in this study (a provisional total accessible sample was 5,250). This range across undergraduate cohorts was selected to capture any changes in the courses over time.

An online survey by the primary and corresponding author was designed. The survey was designed to be brief to maximise response rates (De Leeuw, 2005), and sub-domains and questions were based on previous research (Happell and Gough, 2007; Probst and Peuskens, 2010). Following a pilot study of five final year physiotherapy students from the primary author’s institution (full details obtainable from primary author), no adjustments to the questionnaire were made. The final questionnaire consisted of five sections (see Appendix A): section 1–4 was used to identify an overview of the type and volume of...
Table 1. Students’ education and exposure to mental health

<table>
<thead>
<tr>
<th>Variable</th>
<th>Outcome variable</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undertaken at least one mental health placement</td>
<td>Yes</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>157</td>
</tr>
<tr>
<td></td>
<td>Not identified</td>
<td>4</td>
</tr>
<tr>
<td>Known someone with mental illness</td>
<td>Yes</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>105</td>
</tr>
<tr>
<td></td>
<td>Not identified</td>
<td>11</td>
</tr>
<tr>
<td>Has knowing someone changed the way you view mental illness (n=52 valid responses)</td>
<td>Yes</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>14</td>
</tr>
<tr>
<td>Hours teaching for all years</td>
<td>&lt;1 hours</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>1–4 hours</td>
<td>83</td>
</tr>
<tr>
<td></td>
<td>4–8 hours</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>8+ hours</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Not identified</td>
<td>17</td>
</tr>
<tr>
<td>Hours teaching for final year students (n=79 response from year cohort)</td>
<td>&lt;1 hours</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>1–4 hours</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>4–8 hours</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>8+ hours</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Not identified</td>
<td>2</td>
</tr>
<tr>
<td>Exposure (n=216 valid responses, as more than one response per student could be given)</td>
<td>Stand-alone module</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Within broader module</td>
<td>73</td>
</tr>
<tr>
<td></td>
<td>Within a lecture</td>
<td>88</td>
</tr>
<tr>
<td></td>
<td>Within a seminar</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Within a tutorial</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>With a service user</td>
<td>8</td>
</tr>
<tr>
<td>Wanting further education</td>
<td>Yes</td>
<td>131</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Not identified</td>
<td>12</td>
</tr>
<tr>
<td>Type of further education (n=83 valid responses)</td>
<td>Number giving correct details</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>Format of teaching</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Lecture</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Seminar</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Tutorial</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Placements</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Delivery of teaching</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Clinical specialist</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Service user involvement</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Online</td>
<td>1</td>
</tr>
</tbody>
</table>

One hundred and seventy three students (138 female and 35 male) provided answers to all the questions in the survey and were included in the analysis. This represented around 3.3% (173/5250) of the population of interest and a response rate of 5.6% (173/3150). The mean age of individuals was 22.0 ± 5.0 years. Forty nine students were in their first year of study, 45 were in their second year of study, and 79 were in their final year of study.

**Analysis**

Descriptive statistics were undertaken on sections 1–4 using SPSS (Version 19.0). Section 5 was analysed initially as a data-driven analysis (Gibbs, 2007). Due to the short nature of comments provided by students, the authors used a quantitative content analysis (Pope et al, 2007). As part of this analysis the authors sorted responses by vocabulary repetition (Soundy et al, 2011). The grouped responses were used to provide thematic categories and subcategories, which were grouped by the primary and corresponding author. The analysis was conducted in general for all responses and also split into six distinct groups to consider the interaction between time and personal exposure to MI (three groups on hours by two groups regarding exposure). The corresponding author acted as a critical friend in order to ensure and check the quality of the analysis (Soundy et al, 2014). This included checks for accuracy and representativeness, in order to ensure a rigorous approach to analysis. Further detailed comments are available from the corresponding author.

**RESULTS**

One hundred and seventy three students (138 female and 35 male) provided answers to all the questions in the survey and were included in the analysis. This represented around 3.3% (173/5250) of the population of interest and a response rate of 5.6% (173/3150). The mean age of individuals was 22.0 ± 5.0 years. Forty nine students were in their first year of study, 45 were in their second year of study, and 79 were in their final year of study.

**Descriptive statistics**

Only 7% (12/173) of students had undertaken a mental health placement. Nearly half of the respondents were final year students. Over a third (61/173, 35.3%) of respondents did not know someone with a MI. Seventy one percent (120/173) of all students and 72% (57/79) of final year students had undertaken less than 4 hours of training in mental health over their entire courses. Ninety three per cent (161/173) of responses suggested exposure was contained within a broader module (for instance, a module that was not ded-
icated solely to MI) or within a lecture. Three quarters (131/173, 75.7%) of students wanted further education in the area, with more lectures, placements and seminars most consistently called for. Table 1 provides the full breakdown of the demographics for the sample.

**Table 2. Participants’ comments regarding the concerns of treating individuals with mental illness organised into categorical groups**

<table>
<thead>
<tr>
<th>Hour groupings (known someone with a mental illness)</th>
<th>Interacting with patients *</th>
<th>Understanding of condition **</th>
<th>Safety ***</th>
<th>The provision of treatment ****</th>
<th>Patient characteristics *****</th>
<th>Total concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 (yes)</td>
<td>7 (41%)</td>
<td>4 (24%)</td>
<td>3 (18%)</td>
<td>2 (12%)</td>
<td>1 (6%)</td>
<td>17</td>
</tr>
<tr>
<td>&lt;1 (no)</td>
<td>7 (23%)</td>
<td>3 (10%)</td>
<td>7 (23%)</td>
<td>9 (29%)</td>
<td>3 (10%)</td>
<td>29</td>
</tr>
<tr>
<td>1–4 (yes)</td>
<td>16 (38%)</td>
<td>11 (26%)</td>
<td>4 (10%)</td>
<td>11 (26%)</td>
<td>0 (0%)</td>
<td>42</td>
</tr>
<tr>
<td>1–4 (no)</td>
<td>12 (22%)</td>
<td>13 (24%)</td>
<td>7 (13%)</td>
<td>9 (16%)</td>
<td>12 (22%)</td>
<td>53</td>
</tr>
<tr>
<td>4+ (yes)</td>
<td>3 (21%)</td>
<td>3 (21%)</td>
<td>4 (29%)</td>
<td>1 (7%)</td>
<td>2 (14%)</td>
<td>13</td>
</tr>
<tr>
<td>4+ (no)</td>
<td>6 (29%)</td>
<td>5 (24%)</td>
<td>0 (0%)</td>
<td>4 (19%)</td>
<td>0 (0%)</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>51 (30%)</td>
<td>39 (23%)</td>
<td>25 (14%)</td>
<td>36 (20%)</td>
<td>18 (10%)</td>
<td>169</td>
</tr>
</tbody>
</table>

Notes: Percentages are given per row; * = being able to engage with patients in a clinical setting within the role of a student physiotherapist; ** = the students’ generic understanding of the range of mental illnesses and disorders; *** = students’ concerns regarding their own safety during treatment; **** = knowing what treatment individuals would be required to provide for patients with MI; ***** = negative characteristic that a patient with MI may have, e.g. being dangerous

Comments considering students’ concerns in treating patients with MI

Students were asked if they had concerns regarding treating patients with a MI. One hundred and seventy eight comments were made by 144 students. These comments fell into five categories: interaction with patients; understanding of condition; the provision of treatment; patient characteristics; and safety. Table 2 provides a summary of these concerns. Finally, some students reported no concerns or identified that they didn’t know what concerns they had.

**Interacting with patients**

Nineteen participants (19/144, 13%) identified concerns around not knowing how to approach the patient, how to act, or saying the wrong thing and having a negative impact on the patient. Eight participants (8/144, 6%) just stated the word ‘communication’. Eight (8/144, 6%) comments identified a lack of knowledge about how to communicate effectively or how to adjust communication to meet the patient’s needs. Ten (10/144, 7%) comments identified barriers to communication, with three identifying that there may be an uncertain reaction from the patient. Three participants (3/144, 2%) identified a concern for not knowing how to deal with or manage challenging situations.

**Understanding of MH conditions**

Twenty one (21/144, 14.6%) students highlighted a concern about their knowledge of MH conditions. Fifteen (15/144, 10.4%) students highlighted the problem of not knowing what to do for patients in the rehabilitation setting when providing patients care. This included concerns over the aim and scope of treatment, capabilities of patients and their responses and reactions to treatment. Two (2/144, 1.4%) students wanted to know about users’ attitudes towards treatment and one student just stated that help was required.

**The provision of treatment**

Nineteen comments (19/144, 13%) identified not knowing how best to treat patients with MIs, what is appropriate for treatment or how physiotherapy influences treatment, because of a lack of knowledge. Nine (9/144, 6%) comments suggested students were unsure of the benefits of treatment, concerned that a patient would not respond, or even that treatment could harm a patient. Four (4/144, 3%) comments mentioned a concern about the skills needed during treatment, such as the need to provide goals, or what to do if a patient is self-harming, and knowing the side effects of medication. Four (4/144, 3%) comments suggested a worry about the patient’s ability to consent or comply with treatment if they had an MI. Two (2/144, 1%) comments suggested that the patient’s understanding of physiotherapy would be limited if they had an MI. One (1/144, 1%) comment considered the clinical history of patients a potential problem.

**Patient characteristics**

Seven (7/144, 5%) comments expressed concern about anger, aggression or violence. Eight (8/144, 6%) comments were concerned about unpredictable behaviour or mood swings or behavioural issues among people with MI. Finally, one comment suggested that stereotypes
may overshadow and impact their treatment, while one comment (1/144, 1%) identified a need to guard against stereotypes.

Safety
The most frequently-reported concern participants raised was for their own safety or other physiotherapists’ safety (14/144, 10%); this was followed by seven (7/144, 5%) comments having a concern for the safety of other patients. Four comments (4/144, 3%) suggested a concern for patients with MIs’ own safety. One (1/144, 1%) mentioned a concern for the safety of treatment.

No concerns
Seven comments in total reported no concerns. This included five participants who had received 4 hours or more of training and two who had received up to 1 hour of training. Two (2/144, 1%) comments stated that students had no concerns specifically as they had undertaken a placement in a MH setting. One (1/144, 1%) stated that treatment would be the same as a normal patient.

Don’t know
Two (2/144, 1%) comments suggested they didn’t know what concerns they had.

The value of knowing someone personally and number of hours of teaching received
Table 2 provides a breakdown of the number of comments by hours and themes. This table highlights that, in general, the most frequent concerns made by all students related to interaction with patients (51/169, 30%), understanding of conditions (39/169, 23%) and the provision of treatment (36/169, 21%). In general, individuals who knew someone with MI personally had fewer concerns (72/169, 43%) than individuals who did not know someone with a MI (99/169, 59%). Over 20% of students who had at least 1 hour of training expressed a concern about their understanding of a MI. Of the individuals who did not know someone with a MI, those with more than 4 hours of training had more concerns about interacting with patients and regarding their understanding of the MI than those with less than 1 hour of training.

DISCUSSION
To the best of the author’s knowledge, this study represents the first attempt at conducting a national survey of physiotherapy students’ attitudes toward treating individuals with MI. The majority of students (71%) reported receiving less than 4 hours of training in MH, often within a broader module or within a single lecture. A similar number would have liked more training on their course. The main concerns of students included limited knowledge of MH conditions, not knowing how to provide treatment or how to interact with patients and, additionally, many had safety concerns. There were fewer concerns among students who personally knew someone with a MI. For those who did not know someone with MI personally and had less training (comparing more than 4 hours of training to up to 1 hour of training), there were greater concerns about interacting with these patients, and a greater need for more understanding about MI. This may suggest that when students do not have personal experience of someone with a MI, the volume of teaching can provide an awareness of MI but can also raise concerns about their lack of knowledge and ability to interact with patients.

Over 70% of all respondents had less than 4 hours of training around MH. This may explain why, outside of specialist MH services, the knowledge of physiotherapists towards MH or MI is limited (Pope, 2009). Further, these current results fall below the volume of teaching reported in previous studies of physiotherapy students (Probst and Peuskens, 2010; Gyllensten et al, 2011) and go against findings reported regarding the volume of teaching reported by programme leads (Spearing, 2012). Although previous studies have reported positive attitude changes following a MH teaching programme (Probst and Peuskens, 2010), it is not possible to generalise these findings to UK populations. One reason for this is because of the variation between the MH teaching input reported in these studies.

Lectures and seminars were reported to be the most common modality of MH teaching in this study, supporting previous research (Spearing, 2012). However, despite the amount of MH teaching students had received, the majority of respondents wanted further education on MI. Despite some institutions providing teaching that considers knowledge of specific MH conditions and the role of the physiotherapist (Spearing, 2012), a greater number of lectures and teaching methods are required. Previous research has identified two factors that positively influence attitudes towards mental health, including length of time devoted to teaching MH (Gyllensten et al, 2011), and modules devoted to MH (Probst and Peuskens, 2010). The current results support these statements,
suggesting that a greater number of MH placements, and a greater use of MH service users within the curriculum may also benefit students’ confidence and attitudes around MH.

Previous studies of nursing students have shown a link between levels of anxiety towards MH and lack of knowledge around MH (Happell and Gough, 2007; Thornicroft, 2009). Phrases such as ‘unpredictable behaviour’ and ‘risk of violence’ were common within the current results. This supports the theory that negative stereotyping may exist amongst some students (Byrne, 2000; Dinos et al, 2004; Thornicroft, 2009) and that it could be stereotypes that are fostering students’ anxiety or concerns within the treatment setting. Removing such concerns could be easily achieved through additional training.

Personal exposure of MH has been shown to have a positive effect on attitudes towards MH in other health professions, including student nurses and medical students (Dixon et al, 2008; Markström et al, 2009; Schafer et al, 2011). One study of medical students revealed that students who knew someone with MI expressed increased empathy towards patients with MH problems (Dixon et al, 2008). The current study would support a need to encourage and include more training and education in MH. Training should include teaching from service users, more placements in MH or alternative types of experiences, e.g. students gaining clinical experience from volunteering (Soundy et al, 2013).

Limitations

This study has a number of limitations. A very low response rate to the survey was obtained from the population of interest and the psychometric properties of the survey had not been established. Asking for ‘concerns’ invites a negative viewpoint to be expressed by students and this was not balanced by questions probing for positive attitudes. This suggests a degree of question bias may have been introduced into this study.

Without examining the programme documents for each course, it is difficult to say for certain how limited the teaching is. The knowledge of students in years one and two regarding the course and module content is partially dependent on whether they have read their course handbooks. Thus, conclusions regarding the optimal hours of teaching must be viewed with some caution. Caution is required when considering the number of contact hours relating to MH reported by students as students may have reported fewer hours if they had attended less teaching. Also, this study could not identify the variability in teaching between institutions.

The term MI was not defined by authors for the students in order to capture a wide range of open responses and to avoid limiting the responses or attitudes from students. However, a lack of definition may impact on the generalisability of the findings; in this study, the thematic analysis was designed to collect similar findings so this may be less problematic, since any generalisations are specific to responses made. Different outcome measures have been used in past studies, making direct and specific comparisons with other countries more difficult.

CONCLUSION

The findings of this study suggest that many UK physiotherapy undergraduates feel their skills and knowledge around MH are lacking. Qualitative information regarding students’ feelings about treating patients with a known MI revealed concerns regarding the ability to communicate with patients effectively, a lack of knowledge and skills, and a lack of understanding of a patient’s cognition and behaviours. Future studies need to use more rigorous exploratory research and investigate associations between the hours taught, clinical exposure and personal exposure.

Ethical approval: Ethical approval was gained following ethical review from the University of Birmingham (Protocol reference number: ERN 11-1151).

Funding: The study was funded by authors.

Conflict of Interest: There are no conflicts of interest.


Chartered Society of Physiotherapy (2008a) Commissioning Mental Health Services: The contribution of physiotherapy to integrated services for health and wellbeing.

**KEY POINTS**

- Low levels of specific training in mental health (MH) were reported in UK undergraduate physiotherapy programmes.

- Training alone was insufficient to allay student concerns when treating people with a mental illness (MI).

- Experience of knowing someone with a MI reduced student concerns.

- Learning strategies should be adopted which increase students’ knowledge and exposure to people with MI.
Appendix A. Online questionnaire used for this research

Section 1

Age

Gender

Male □ Female □

Current year of course:

Section 2 – Personal experience

Do you have a family member or close friend with a mental health condition?

□ Yes □ No

If yes, has this changed the way you view mental health?

Section 3 – Professional experience

Have you undertaken mental health placement over your physiotherapy degree?

□ Yes □ No

What was the setting for this?

□ Inpatient □ Outpatient □ Private

Other please explain:

Section 4 – Type of teaching

What exposure have you had of mental health during your physiotherapy degree?

Please tick as many boxes as appropriate.

Type of teaching

□ Stand alone module □ Within a broader module □ Lecture □ Seminar □ Tutorial □ Service user seminars

Other — please explain:

Number of hours

□ 1 hour or less □ 1–4 hours □ 4–8 hours □ 8–12 hours □ 12 hours

Who delivered the sessions?

□ Clinical specialist □ Lecturer with special interest □ Lecturer □ Additional education

Would you like any further education on the topic of mental health?

□ Yes □ No

If you answered yes, in what form?

Section 5 – Your views

What concerns would you have if you were treating someone with a known mental health condition?

Chartered Society of Physiotherapy, London
Spearring RM (2012) Scoping exercise for mental health teaching in physiotherapy: The Higher Education Academy; Mental Health in Higher Education Department

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