

AQUALINES



**Aquatic Therapy
Association of
Chartered
Physiotherapists**

ATACP

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Aquatic Therapy Association of Chartered Physiotherapists

Aqualines

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The *Aquatic Therapy Association of
Chartered Physiotherapists* (ATACP) was
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Chartered Physiotherapists* (HACP). It is
a Professional Network affiliated to the
UK Chartered Society of Physiotherapy
(CSP).

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**Journal of the
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Writing for Aqualines

- Articles on any aspect of aquatic physiotherapy and from all perspectives (e.g. clinicians, patients, assistants, people maintaining our pools) will be considered.
- Help and advice is available, from the editor, to develop ideas into a publication.
- Please e-mail ideas, letters or articles to the editor.
- We are interested in extremely short pieces up to longer papers to share your case studies or research.
- Preferred referencing is in author-date style (Harvard referencing) and punctuate as follows:
Geytenbeek J (2002) Evidence for effective hydrotherapy. *Physiotherapy* 88(9) 514–29.
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- All material for the next edition should reach the editor by **1 February 2021**.

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From The Editor

This edition contains papers from the presentations at the UK Aquatic Therapy Conference 2019.

A keynote speaker was Bruce E. Becker from the USA. His paper outlines a series of ‘elevator speeches’ giving the benefits of aquatic therapy. These are based on research, which is presented in his textbook on aquatic therapy. Please share the ‘elevator speeches’ to promote aquatic therapy and access Bruce E Becker’s original research via his references.

Other conference speakers included Lynda Keane and Susan Pattison. Lynda Keane’s paper on the fascial system is followed by reflection from delegates, Susie Grady and Anna Carter. Susan Pattison’s paper is about establishing a pathway for self-referral for people with neurological conditions in Bolton.

While these papers indicate exciting developments in the theory and practice of aquatic therapy, the conference celebrated 30 years of ATACP. Under its former name, the Hydrotherapy Association of Chartered Physiotherapists (HACP), it was formally recognised by the CSP in 1989. Annette Turner’s paper looks back to the start and outlines some key contributions of ATACP to aquatic physiotherapy practice in the UK. There is much to be proud of.

I hope you enjoy all the papers and that they inspire your practice and encourage you to be involved in ATACP. We need new leaders for the next 30 years of aquatic therapy.

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ATACP Chair's Report

Jacqueline Pattman

MCSP, ATACP co-chair, Accredited ATACP Tutor

Sarah Wratten

BSc (Hons), MMT, ATACP co-chair, Accredited ATACP Tutor

Welcome to your 2020 edition of Aqualines.

This is a challenging year and we are all affected by the coronavirus pandemic. Social distancing recommendations (hopefully temporally) closed many NHS aquatic physiotherapy pools and the demand on NHS services led to aquatic physiotherapy staff being redeployed. At the same time, many of our self-employed members have had to put their work 'on hold' and found themselves in a difficult financial situation. Going forwards, the uncertainties continue and Sarah and I send you our thoughts at this difficult time. Virtual aquatic physiotherapy treatment has its challenges!

Unfortunately the pandemic has meant cancelling our 2020 study days. However, this has led to initiatives including last week's ATACP webinar on legal issues in aquatic physiotherapy by Susan Filson. We hope that you found this useful and we will keep you updated on future events. Despite the pandemic, we remain committed to providing ongoing CPD to our members.

The ATACP Education Committee has met using virtual technology and is working to review the accreditation documents. The ATACP committee met virtually, on 10 June 2020. For both committees, virtual meetings have worked well and saved travel time and costs.

In case you have not seen them, Sarah and I have produced ATACP recommendations for safe aquatic physiotherapy practice during the pandemic and these are available on the PWTAG and ATACP websites <https://bit.ly/2Lx8nkW>

Following our 30th Anniversary conference last September, we have continued to work closely with the International Organisation of Aquatic Physical Therapists (IOAPT), chaired by César Sá. Using video conferencing, we have ATACP representation at international meetings.

In January 2020, the 'Hydrotherapy Pools – Expert Clinical Considerations in Planning and Design' document was made available for purchase on our ATACP website.

We are planning to have a register of 'Accredited Aquatic Physiotherapists' on the website, which will include physiotherapists who have been assessed in aquatic physiotherapy. We hope to form the register of accredited aquatic physiotherapist with an online questionnaire.

The future remains exciting and we will find ways around the challenges.

Please take care and stay safe.

Jackie & Sarah

The Remarkable Benefits of Aquatic Therapy: Explanations for Your Clients

Bruce E. Becker

MD, MS

Introduction

The many physiological effects of aquatic exercise and therapy are so remarkable and useful that it is truly amazing that they remain so little known and understood by the general public. Those of you that have heard my lectures or read my writings are familiar with those benefits. This article is written for your use in communicating to your clients, rather than in digging deeper into the physiology, with the goal of giving you quick “elevator speeches” that those clients can repeat to their friends and families, winning converts along the way.

Effects on the Heart and Blood Vessels

Because water is much denser than air and is incompressible, the human body in water becomes compressed by the pressure of that water. This pressure squeezes blood, lymph and other external tissue fluids upward, as the pressure is increased with depth. This upward flow results in an increase in blood inside the chest, about 2/3rds of which goes

into the lungs, and the rest into the heart. It is a pretty large amount of fluid, almost a quart (1 litre), when the person is in chest-depth water. The heart responds to this increased volume by pumping out more blood per contraction, which means that the heart rate does not need to increase, and usually heart rate decreases. As a result, the heart becomes more efficient in moving blood through the body.

As the heart pumps more blood, the circulatory system responds to a signal from the brain to relax the arterial system so that the arteries dilate, allowing the blood to have an easier pathway, improving blood flow through the body, but also generally lowering systolic blood pressure (the top number of a blood pressure reading). The speed of blood flow has powerful positive effects on the actual structure of the arteries, giving them greater elasticity and fighting the effects of aging which tends to create artery stiffness.

Effects on the Lungs and Respiration

The effects of water pressure on the chest wall act to slightly compress the chest, at the same time as the increased volume of blood inside the chest cavity occupies space that the lungs would have usually filled with air. As a consequence, the muscular work of breathing is increased considerably. So even at rest during immersion, the muscles of ventilation have to work harder to overcome these effects. This has been shown to improve both respiratory muscle endurance and strength on repeated immersion over weeks.



Bruce E. Becker

During exercise both in and out of water, the body's demand for increased oxygen sends a signal to the brain to increase respiratory effort, both through faster breathing and deeper breaths. Since the body has to work harder to breathe in water, the effects of this extra respiratory work can strengthen the respiratory musculature even more. We have used these effects very successfully in elite athletes doing high intensity deep water exercise training.

Effects on the Bones and Joints

Because water is much denser than air and incompressible, the weight of the body is offloaded during immersion due to the effects of buoyancy. During immersion to the waist, approximately 50% of the body weight is offset by this buoyancy, reducing the load on the knees, ankles and feet. This effect can be very useful for arthritic joints. During neck depth immersion, only the weight of the head (about 16lb or 7.3 kg) is carried by the body so the spine can be hugely offloaded, which is especially useful for individuals with spine pain, hip pain and other problems where gravity loading causes discomfort.

At the same time, the circulatory effects discussed above improve blood flow to the bones and joints, increasing oxygen availability to these structures. This can be very helpful in the management of arthritis, joint damage, and stress fractures.

Effects on the Kidneys and Endocrine System

A considerable amount of the increased blood flow is directed to the kidneys during immersion. The kidneys act to remove waste products carried by the blood, but also remove sodium, carrying water with it. Consequently, there is an increase in urine production during immersion that is quite significant. For aquatic instructors working long days in the water, they must increase their fluid intake to offset this fluid loss, and all individuals exercising in the water

may feel the effects of increased bladder filling.

The increase in blood flow to the kidneys is of course accompanied by an increase in oxygen, which seems to be an important part of why aquatic exercise has been shown to benefit individuals with kidney disease.

During immersion, the brain alters the biological effects of the hormones that regulate stress responses, which tends to create a calming effect on blood pressure, as well as a reduction in anxiety for most people. Perhaps this is why during an aquatic exercise class, smiles are so common. Immersion has been shown to positively affect the autonomic nervous system balance between the sympathetic nervous system (the central nervous system component that acts in response to stress) and the parasympathetic nervous system (the component that creates calm and relaxation).

At the same time, the increased blood flow to the muscles and other processes seems to open up the channels that supply glucose and insulin to the musculature. The earlier effect on reducing arterial stiffness is also an important positive benefit, especially in diabetes. These effects can be very useful; science has shown that individuals with diabetes doing regular aquatic exercise have reduced insulin need, improved blood sugar levels, and improved arterial function when doing regular aquatic exercise over months.

Effects on the Brain and Nervous System

An effect that has only recently been demonstrated is that during immersion (both at rest and during exercise), the blood flow to the brain is increased. This increase in brain blood flow may have some very useful effects in the management of neurological disease and brain health. There is much research ongoing into this potentially huge effect. There are a number of published articles demonstrating quite amazing results from people with both very early dementia and advanced Alzheimer's disease working with aquatic exercise. The reasons for these

benefits may be partly due to the improvement in blood flow, and also to alterations in the autonomic nervous system. In Australia, there are programmes specifically designed for these populations and it is to be hoped that such programmes become more widespread internationally.

Conclusions

For millennia, the positive effects of aquatic immersion have been recognised. Most individuals doing aquatic exercise programmes notice an increase in energy levels, sleep quality and general well-being. We don't need science to prove these effects but science fully supports them with proven

explanations for many of the physiological processes behind them. People doing aquatic exercise are working in a very powerful setting to maintain and improve their health. The water is a uniquely beneficial environment for healthy living.

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Aqua FLOW

Part 1: the fascial system

Lynda Keane

MSc, PgC, BSc (hons) GSR, AEA, ATRI, STA, RSM

The fascial system is the connective tissue that connects everything to everything else. It has the potential to influence every muscle, bone, nerve, blood vessel, organ and cell of the body and is made up of connective tissue protein with rubber like properties.

Fascia separates, supports, connects and protects everything.

The Myofascial Web

The fascial system is one continuous, uninterrupted, three dimensional, web-like structure, running from the top of the head to the bottom of the feet. Everything sits within the fascial system.

It is omnipresent and has been so ignored by anatomists over the years that it has been scrapped away during dissections and surgery; it has only been since the nineties that fascia has started to be studied.

This three dimensional web of connective tissue is alive and ever-changing in as many ways as the body demands. Thus, it is a network for information exchange, influencing and influenced by every structure, system



Lynda Keane

and cell in the organism. The superficial layer of fascia just beneath the skins surface is often described as a fibrous layer of loose connective tissue. It is described as loose because there is no strong regular pattern to its organisation. This superficial fascia lies just under the superficial adipose layer, and under the skin. It is fibrous yet highly elastic with variable fat content. It separates the skin from the muscles to allow for normal slide and glide. This superficial fascia is involved in thermoregulation, circulation and lymphatic flow. It is also connected to the deeper layers of fascia.

A human body is a tensegrity structure, which means our movement integrity depends on tension and balance of our soft tissues, and not on just skeletal alignment. The body is made up of compressional struts in a sea of continuous tension; we make maximal use of the materials we are made of.

Fascial Tissue

Fascia is made up of:

- **Collagen**, a fairly dense fibre type and the main component of connective tissue, which is extremely strong and forms the primary components of tendons; connective tissue structures that link muscles and bones
- **Elastin** the second most common structural protein. The connective tissue produces enzymes and messenger substances that fibroblasts interact with
- **Ground substance** as well as structural proteins. The connective tissue produces enzymes and messenger substances that fibroblasts interact with.

Fascia consists primarily of protein and water, the texture of the tissue depends on the function it serves and location in our body.

Connective Tissue Facts:

- Each person carries between 18–23 kg connective tissue
- It stores $\frac{1}{4}$ of the total amount of water in the body
- It provides cells and organs with food
- It responds to stress and strain and adapts accordingly
- It slowly renews itself constantly. Therefore after 1 year about 50% of collagen fibres will have been replaced.

The Lines

Superficial front line (SFL)

The SFL runs from the top of the feet to the side of the skull. The front line has two sections, feet to pelvis, and pelvis to skull. These lines function as one continuous line of integrated fascia when the hip is extended.

The overall postural function of the SFL is to create flexion of the trunk and hips, extension of the knee, and dorsiflexion of the foot. It also performs complex neck actions. The need to create sudden and strong flexion movements at various joints requires the muscular portion of the SFL to contain a higher proportion of fast twitch fibres.

Superficial back line (SBL)

The SBL runs from the bottom of the foot to the eyebrows. The postural function of this line is to support the body in full extension. This ‘all day posture’ requires high proportion of slow twitch endurance muscle fibres in the muscular portion of the myofascial band and extra heavy sheets and bands in the fascial portion.

With the exception of the knee and plantarflexion of the ankle, the SBL prevents flexion.

Working together, the SBL and the SFL support the body’s anterior and posterior postural balance.

Lateral line

The lateral line traverses each side of the body from the medial and lateral mid-point of the foot, around the outside of the ankle, and up the lateral aspect of the leg and thigh. It passes along the trunk in a criss cross pattern to the skull close to the ear.

The postural function of this line is to balance all the other superficial lines.

This line creates lateral bends, lateral trunk flexion, abduction at the hip and eversion of the foot but also acts as an adjustable brake for lateral and rotational movement. It is primarily a stabiliser of body movement. With each heel strike, adjustments are made along the length of the lateral line to maintain an upright posture.

Spiral line (SPL)

The SPL loops around the body in 2 opposing helices. It joins each side of the skull across the upper back, goes to the opposite shoulder, around the ribs to the front, crosses again at the naval and onto the hip. From the hip it goes down the anterolateral side of the thigh, across the shin, to the medial longitudinal arch. It passes under the foot, runs up the posterolateral side of the leg to the ischium, and into the erector spinae myofascia. The SPL ends close to where it started.

The SPL’s function is to maintain balance across all planes. Dysfunction of the SPL can affect functioning in the other lines and issues including knee and back pain.

The SPL helps create rotation, twisting and oblique spirals. In addition, during eccentric and isometric muscle contractions, the SPL steadies the trunk and keeps the leg from folding into rotational collapse.

Superficial and Deep arm lines

The superficial arm lines run anteriorly from the sternum and ribs to the thumb. The superficial back arm line runs from the thoracic and cervical spinous process. It encases the scapula, and runs down the triceps to the little finger.

The superficial front and back arm line will allow the shoulders to sit naturally in the socket, allowing the head to rest on top of the spine. A head thrown forward by a tight “pec line” of fascia will never be able to relax.

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FaceBook: Aquatic Rehabilitation Exercise Academy
www.aquaticacademy.co.uk

Aqua FLOW

Part 2: Delegate reflection on fascial release optimised in water

Susie Grady

Senior physiotherapist, Ramsay Healthcare. Neurological, aquatic and equine physiotherapist

Anna Carter

MCSP HCPC, aquatic physiotherapy specialist anna@aqpt.info

Following the presentation on the theory of the fascial system, Lynda Keane demonstrated Aqua FLOW, that is, a technique to release the myofascial system in the water. This technique was developed by George Eversaul, in Las Vegas, after he suffered a serious accident and found that the pool allowed him to exercise with reduced pain.

Aquastretch, as it is also known, uses myofascial release techniques. Gentle traction is applied as the patient's body is moved through the water. Movement is controlled by the patient, and is only in their comfortable range of motion. The movement is multi directional because, as described above, the myofascia works in spiral, lateral, transverse and longitudinal lines.

It was interesting to see Aqua FLOW being used to treat the hip, lumbar spine and pelvis demonstrated in the pool. For this technique, a large pool space was required to move the patient's whole body through the water. This was a 1:1 therapist to patient

intervention and so would be less suitable in a busy NHS pool where several people are normally treated concurrently. However, other techniques demonstrated were performed in standing with the patient holding onto the hand rail and these could more easily be an everyday tool for NHS aquatic physiotherapist.

The movements themselves were slow and controlled and they were clearly explained and demonstrated. Some techniques, for example, those to treat the hip joint, used similar principles to 'mobilisations with movements', which many clinicians already use in the pool.

This is a relatively new technique and there is very little research to support its use, but Lynda plans a PhD to change this. To date, there are only a handful of trainers and therapists using Aqua FLOW. For interested colleagues, Lynda Keane runs courses on Aqua FLOW. There is scope for further practical sessions on this technique at future ATACP study days.

A pathway for self-referral for people with neurological conditions in Bolton and surrounds

Susan Pattison

BSc Ord Physio, chartered physiotherapist specialising in neurology and director of 'SP Therapy Services'

Marie Oxtoby

BSc (sociology), PhD, chair/coordinator Bolton Neuro Voices Project Initiator and Fund Raiser

The Challenge

Create a reliable self-referral pathway to enable people living with a neurological condition to try hydrotherapy (defined here as aquatic exercises) and, if it proves suitable, to progress to a self-funding Continuation Programme. The aim was to help participants to contribute to their own health and well-being within the budgetary, staffing and time constraints.

Background

In 2012, Bolton Neuro Voices (BNV)*, a local voluntary group, approached 'SP Therapy Services' to discuss the possible provision of a hydrotherapy course for people with neurological conditions and injuries. The request was sparked by the opening of a new state of the art hydrotherapy pool at Bolton One Leisure Centre. There is no NHS hydrotherapy service in Bolton for adults with neurological conditions. Discussions between the physiotherapists and the chairs of BNV, and its member groups, clarified their understanding and expectations of hydrotherapy.

Methods

- Design group exercise programmes for 5-week physio-led courses
- Design a self-referral form empowering participants to select their own goals

**BNV links several local support groups for specific conditions but also welcomes people with rarer conditions who have no local support group.*



Susan Pattison

- Establish a telephone pre-assessment by a physiotherapist
- Allocate people to similar ability groups
- Provide detailed pre-course information packs
- Collate weekly feedback from participants to physiotherapist
- Run an end-of-course questionnaire.

In January 2014, a continuation programme (supported by co-ordinators and dry side volunteers) was developed for those able to continue without the presence of physiotherapists.

Outputs and Outcomes

Between 2012 and 2016, there were seven courses for a total of 140 people of all ages and levels of mobility representing 20 different neurological conditions. Participants received 5 × 30 minutes of aquatic physiotherapy exercise led by one physiotherapist and one physiotherapy assistant from 'SP

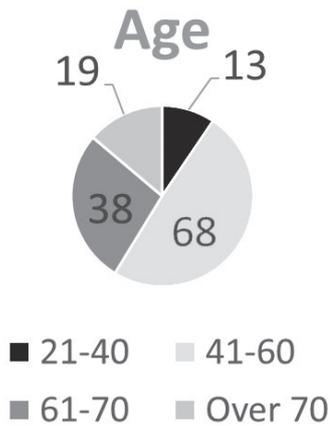


Figure 1. Age of participants.

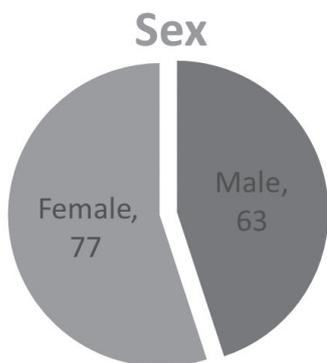


Figure 2. Sex of participants.

Therapy Services'. BNV provided a co-ordinator and two dry-side assistants. The cost of a 5-week course for about 20/25 participants is around £3500, most of which is raised by BNV from local funders. Participants pay just £25. The average cost

per participant was £153 or £128 when the participant contribution is subtracted.

Discussion

This BNV project recognised that people living with a neurological condition or injury face many obstacles to accessing appropriate exercise. Its brief was maximum inclusion (anyone with a neurological condition living in Bolton and surrounding areas, able to provide their own transport and, if required, a carer) and minimum exclusion (anyone unsafe or unsuitable for aquatic therapy). That seven courses have been fully booked and that attendance (83% overall) by these disabled and vulnerable people is high, shows that the service is meeting a need. Satisfaction with the course and the available facilities and support was also high.

The keys to the success of this project, and its continuation programmes, are the constant dialogue between 'SP Therapy Services' and BNV, the feedback received from participants after every session, and the end-of-course questionnaire. An example of the response to participant feedback was the increase in session length from 20 to 30 minutes after the first two courses. Improvements to the parking situation have also been achieved.

Conditions

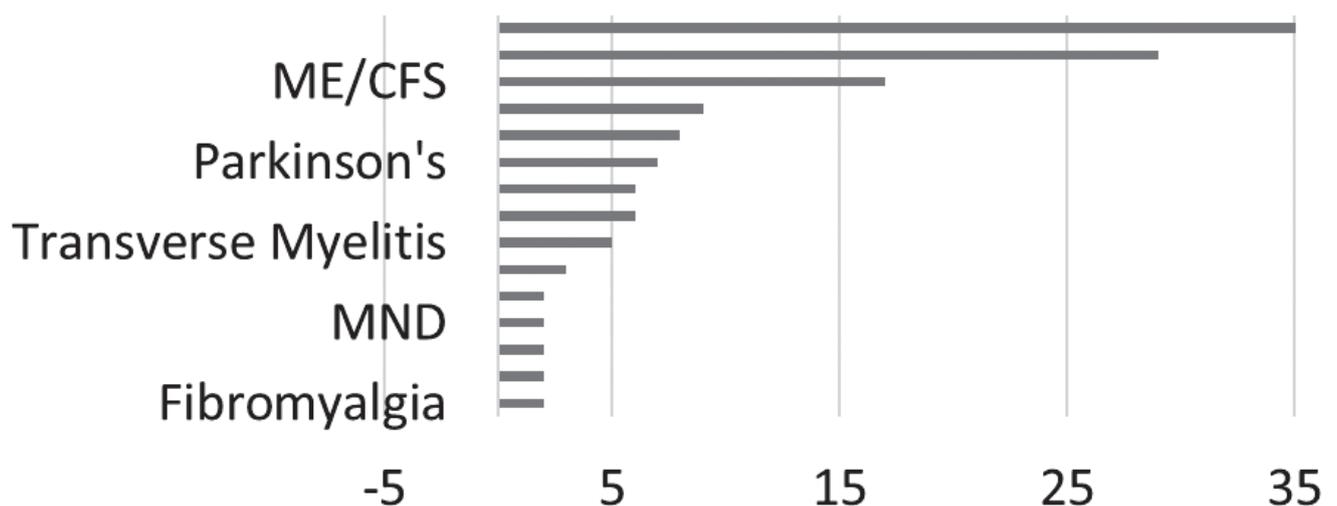


Figure 3. Medical conditions of participants.

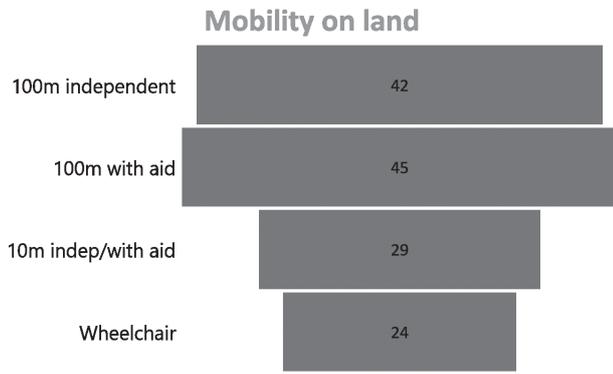


Figure 4. Mobility of participants.

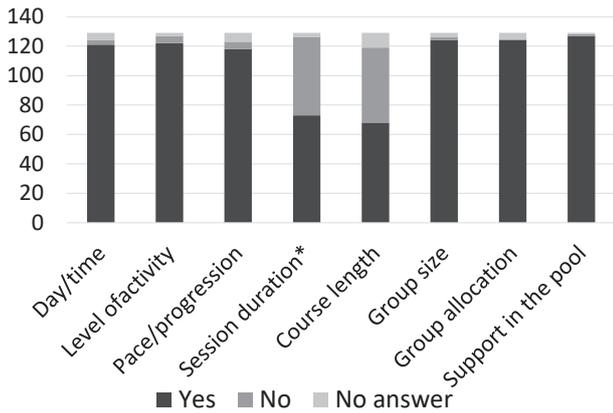


Figure 5. Did the course meet your needs?

Campaigns to assist people with neurological conditions to ‘Live long, Live well’ (CSP) should be a national priority; however there are very limited resources. The nature and diversity (stable, relapsing/remitting and progressive) of neurological conditions makes finding and signposting to appropriate and safe activities difficult for

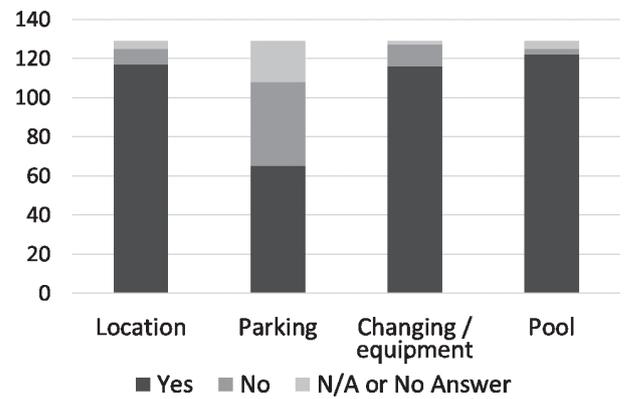


Figure 6. Did the facilities meet your needs?

professionals. Engaging people in voluntary and community sector activities is cost effective and inclusive. Self-referral and signposting should not be prescriptive or be about objective markers, but focus on whether an individual engages. The challenge for any professional attempting to conduct person-centred research is to ensure that, at a time when many patients feel abandoned by statutory services, we remove barriers to their involvement in voluntary and community activities.

Sample Participant Feedback

“My legs felt lighter . . . I have been able to transfer more easily . . . Today I got into the car without help”

“. . . took me outside my comfort zone and challenged me . . . absolutely brilliant . . .”

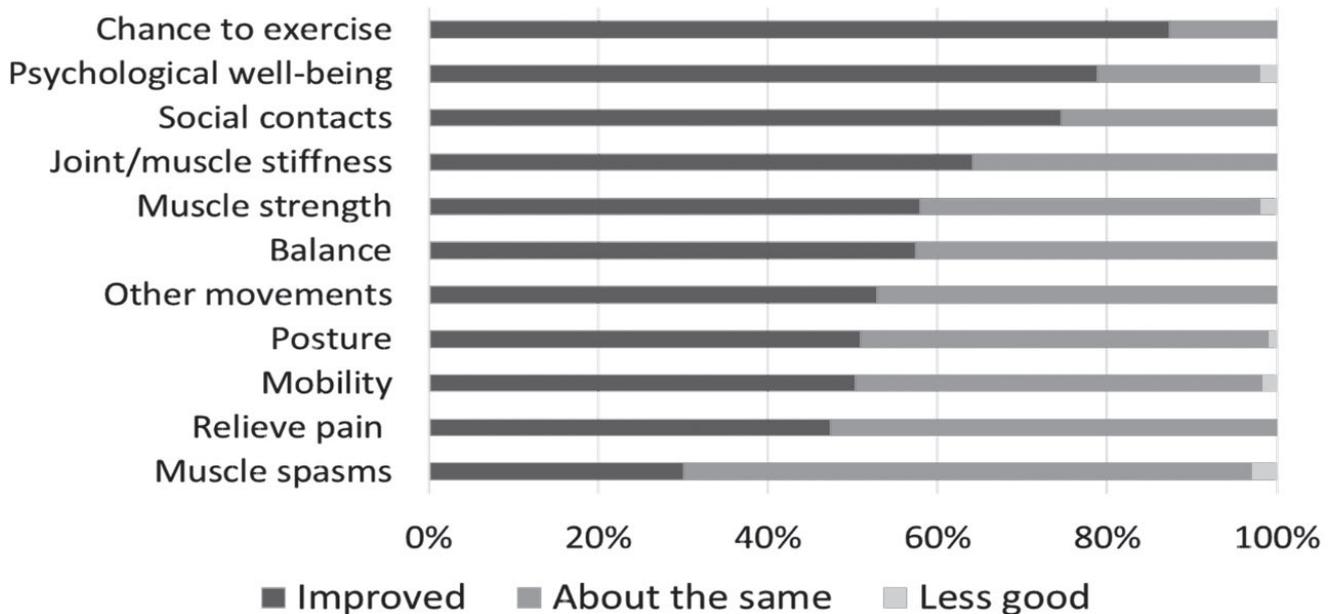


Figure 7. Participant Reported Outcomes for those attending 3 or more sessions (n=116).

Conclusion

140 people, of all ages and levels of mobility, with 20 different neurological conditions had the opportunity to try hydrotherapy. Attendance was high (83% overall), as was satisfaction with the facilities, course, organisation and support.

Participant-reported outcomes showed impressive evidence of improvements, especially in social contacts and psychological-well-being, but also in pain, stiffness, mobility, balance and posture. More than half the participants continued with some form of exercise.

The introduction of our Continuation Programmes (132 sessions enjoyed by more than 60 participants since 2014) not only ensures the sustainability of this service but also strengthens the physical, psychological and social benefits already described. There is a palpable sense of achievement,

enjoyment and mutual support which is also a source of great satisfaction to the professionals and volunteers involved.

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Note:

Figures 1–5 describe the participants. Figures 6–7 give detail of participant reported outcomes.

A pool practical session at the UK aquatic therapy conference 2019

Sarah McKeown

BSc (Hons), MCSP, MAACP, MACPSEM

It was a beautiful sunny day at The Burford Bridge Hotel in Dorking, perfect for our outdoor pool practical session with Sophie Heyward. This followed Sophie Heyward's keynote presentation on functional lower limb exercise in aquatic rehabilitation. Sun loungers and sun glasses at the ready... here we go!

Sophie challenged delegates to consider ways to achieve maximal output in the pool (while comparing this to exercising on land) and to record exercise load. Some examples of her points are below.

Analysis of single leg calf rises

While repetitions on land might be around 25–30, in the pool 50 plus repetitions may be achieved. Increase speed to gain strength.



Single leg calf rises.

Squats

Delegates were instructed to squat in the pool and consider the effect on ankle dorsiflexion and loading on the hip and the knee. In water, deep squats are easier to rise from because there is an increased effect of buoyancy to support the movement. On land a deeper squat is harder to rise from.

To activate the gluteal muscles, hip flexion/extension should be added. Adding speed will increase muscle activation, calf muscles will work harder with the motion beginning to look more like a jump as the speed increases.

Walking

A slow comfortable pace promotes relaxation and balance.

For strengthening you must increase speed. Sophie instructed, 'Faster, Faster, Move!'. This resulted in less control and greater need for trunk muscle activation. Activation of extensors and plantar activation was prompted to help improve control.



Analysis of walking.

Other activities

These included:

- comparing muscle activation and effort during vertical and horizontal skipping
- hop scotch, including change of direction.

Sophie said that practitioners must record strengthening and how exercises are progressed or modified. For example, length of time exercising, number of repetitions and fatigue. She advised:

- asking our patients searching questions, for example, ‘where do you feel that?’
- observing all movement closely
- palpating, where possible, to ensure that we are achieving the desired effect.

This was one of several practical sessions from keynote speakers, all of which made us reflect on our own practice and gave us added tools for future practice.

Looking back over 30 years of ATACP

Annette Turner

MCSP

Annette looks back to the initial meeting in 1985, of the group that was formally (in 1989) recognised by the CSP as the Hydrotherapy Association of Chartered Physiotherapists (HACP) and became today's Aquatic Therapy Association of Chartered Physiotherapists (ATACP) committee

It began in November 1985 when 18 physiotherapists, with a passion for hydrotherapy, met to scope the viability of a new clinical interest group in hydrotherapy.

The previous year, I had qualified as a physiotherapist at Oswestry Orthopaedic Hospital, which had an abundance of hydrotherapy pools. I started work in Shreswbury, under a senior 2 physiotherapist who had just completed the Bath Hydrotherapy Course. She told me of this planned meeting of physiotherapists interested in hydrotherapy. I went to the meeting and it influenced the direction of my physiotherapy career.

At this first meeting in 1985, the Hydrotherapy Association of Chartered Physiotherapists (HACP), which later became the ATACP, was born. Officers were elected, Isobel Francis was secretary and typed up the meeting notes, Shiela Ingerfield was the chairperson and Alison Skinner the treasurer. All three names have remained synonymous with hydrotherapy, and Alison Skinner continues to be our treasurer. To be recognised by the CSP as a clinical interest group, 50 members were needed. To encourage members, we needed an exciting programme of study days to share aquatic information and knowledge.

The first study day was planned and held on Saturday 15 November 1986 at Franklin Delano Roosevelt School in London. The focus was on Halliwick and Bad Ragaz

techniques, and the treatment of people with haemophilia.

Following this successful day, further study days were arranged at Standish Hospital Gloucester and The Middlesex Hospital. In May 1988, Ron Harrison organised a weekend event at the Royal National Hospital for Rheumatic Diseases (known as 'the Min') in Bath. The programme included a historical aspect of hydrotherapy, hygiene for hydrotherapy pools, the physiology of immersion, and practical pool work with a focus on treating people with ankylosing spondylitis. By this time, with enough members to become a recognised CSP clinical interest group, we had an AGM and a constitution as agreed by the CSP.

Sheila Ingerfield continued as the chair, Alison Skinner as treasurer and Gail Crutchfield became the secretary. Committee member were Lesley Acres, Ron Harrison, Lesley Watchel and me (Annette Turner).

In November 1988, the CSP invited the committee to submit an application for CSP recognition. In 1989, the Hydrotherapy Association of Chartered Physiotherapists (HACP) officially became a recognised clinical interest group.

From the beginning, we had introduced a newsletter to inform our members and we called this Aqualines. It started as a photocopied booklet that was produced by committee members. It has since evolved to into its current professional format, that is, an eagerly awaited publication containing papers on lectures from study days, current research, aquatic therapy practice, equipment, and much more. Over the years Aqualines editors have included Heather Maling, Anne Jackson and Cecilia de Villiers.

A key focus of the newly established HACP, was to ensure the education of the next generations of specialist physiotherapists in hydrotherapy. The gold standard Bath Hydrotherapy Course, run at 'the Min', which I attended in 1988 and I learnt so much from, was to stop. This would end post-graduate hydrotherapy education in the UK. Mike Maynard, Heather Epps, Ankie Postma, Heather Maling, and Helen Whitelock joined the HACP committee and scoped what was happening by distributing questionnaires to all physiotherapy schools. The results demonstrated that most newly qualified physiotherapists began their working lives without practical skills in hydrotherapy. In response, the HACP committee developed and presented the Foundation Course in Hydrotherapy. This course continues to run across the country and is a recommended introduction for physiotherapists delivering aquatic therapy services across the UK and beyond.

At the same time, ongoing study days were required to keep skilled aquatic therapists up to date, and to enable them to

learn new skills, and to network with their peers. Initially, many study days were delivered in London and the South. Later, they were run in other parts of the country with a view to involving members from further afield, while ensuring they were presented in an accessible location. An early study day in Manchester was a great success with over 70 attendees. The current strategy is to have one study day per year in the South and another in the Midlands or the North.

Over time, the HACP became the Aquatic Therapy Association of Chartered Physiotherapists (ATACP). Our current committee is involved in many projects but key successes have been the foundation course to educate new generations of aquatic therapists, and promoting CPD through study days and the UK Aquatic Therapy Conference 2019, and Aqualines.

We have come a long way since 18 physiotherapists, including me, met in 1985! Going forwards, I'm confident that ATACP will keep aquatic physiotherapy practice afloat in the UK.

A final word from aquatic ‘Therapy World’

Keith Simmonds

The ‘TherapyWorld’ stand became a regular feature at the ATACP (previously HACP) study days 20 or more years ago, when they were held at Arthur Stanley House, an annexe of the old Middlesex Hospital in London with an aquatic therapy pool. Sadly neither the hospital nor the pool remains.

Parking was non-existent at Arthur Stanley House. On one occasion, I unloaded display items and returned, minutes later, to find my car being loaded for dispatch to a compound and it cost me £200 to retrieve it!

Despite this experience, I have enjoyed coming to pretty well every twice-a-year ATACP study day, in a variety of hospital venues. It was Alison Skinner, your respected treasurer, who was instrumental in ensuring my attendance. I would load my car, with all the aquatic therapy equipment I could squeeze in on a Friday. On the Saturday, I would leave my home in Derbyshire at 5.30am, get to the venue at 8.00am, set up the display, and be bright

and cheery to greet the physiotherapists when they arrived. After a long day I would be home in time for a pint at our local pub at about 7.00pm.

I provided background colour to the lecture room with buoyancy aids and other equipment. Attendees had the opportunity to touch and feel the products and to ask me questions. I had a ‘commercial break’ to talk about new and popular products. I must thank the ATACP committee for the sales, leads and recommendations that the study days gave me.

Now, at 76 years old, I have sold ‘Therapy World’ to ‘MGC Lighting Group’ and they intend to continue the brand. I was honoured that my final stall was at the UK Aquatic Therapy Conference 2019. I give many thanks to Jackie Pattman for mentioning me in her chair’s speech, and to Sarah Wratten for presenting me a small gift from ATACP.

I shall miss you and it was all worth every one of those 5.30am starts.



Keith Simmonds.

