This newsletter is to update everyone on the association. It is sent direct to special interest groups as they become known. The idea for an association began in 1993 at an international course in Malta; was discussed at WCPT Washington in 1995 and at WCPT Yokohama in 1999 where a shadow committee and steering group were formed. The Foundation Meeting was held in Birmingham, UK, 2002. At WCPT Barcelona 2003, IPTOP was accepted as a WCPT subgroup. General meetings have been held in Barcelona 2003; Dublin 2004, Melbourne 2005, Istanbul 2006, WCPT Vancouver 2007 and Ankara 2009. Membership currently stands at 17 countries representing around 8,000 physical therapists in elderly care. The efforts of the association are directed towards member associations and their individual members working with older people through excellence, research, practice and clinical specialization. Officers traveling to international conferences are self-funded. This newsletter is published on our website six months after distribution to members. A summary is published in WCPT news.

Message from the chairperson.

Dear Colleagues,

The 2011 WCPT Congress in Amsterdam has been the main focus of the work of the executive team over the last 6 months. The chairs of each subgroup and WCPT officers (Brenda Myers, Tracy Bury and Marilyn Moffat), have had three teleconferences to discuss the scientific and social activities of the groups. (See P12 for more information).

I look forward to welcoming as many of you as possible to the WCPT 2011 Congress and to join the IPTOP general meeting where the election of officers will take place (See P12 for information on nomination, and voting).

Sadly I have to inform you that Greece had to withdraw as host country for the IPTOP 2010 congress because of their economic crises. I am sorry that we wont be able to have a congress this year since it is too late to organize another member country. I hope other member countries are interested in considering being a host country for a future IPTOP congress and look forward to hearing from you so I can explain the requirements (See P14 for more information).

Yours sincerely,

Filiz Can, PT, PhD, Prof.
Chair of IPTOP chair@iptop.wcpt.org
Clinical feature

Physiotherapy and Parkinson's; the development of clinically useful tools of assessment and measurement

Bhanu Ramaswamy, Independent Physiotherapy Consultant and Visiting Fellow at Sheffield Hallam University, UK

As we all know, physiotherapy primarily addresses the physical components of rehabilitation, whether for an acute or chronic condition. The end point of our interventions is to maximise a person's functional capacity so they can maintain a role within society. This is of particular importance in those with a longer-term or chronic condition, such as Parkinson’s.

Parkinson's is defined as a progressive neurodegenerative condition resulting from the death of dopamine containing cells of the substantia nigra. Dopamine-producing neurones in the substantia nigra are part of the basal ganglia (BG) system; a circuit thought to be involved in the smooth execution of complex motor tasks from automatically and internally generated movements. The condition has been traditionally viewed as a motor disorder where a person with Parkinson’s would be expected to present with classical signs of bradykinesia, tremor, rigidity, and in the later stages, postural instability. Over the past few years however, increasing recognition has been given to the development of pre-clinical signs and to non-motor symptoms such as psychiatric problems or those associated with autonomic dysfunction. This has an impact on the whole biopsychosocial environment of the person with Parkinson’s including their social network.

The loss of dopamine causes disruption to the neural pathways from the BG to the prefrontal, pre-motor and supplementary motor cortex areas. This is most evident where people demonstrate difficulty with internally generated movements during which the supplementary motor area (SMA) is activated. They begin to rely on externally generated cues and strategies using alternative pathways to initiate and guide movement (pre-motor areas) – and is one of the main ways physiotherapy techniques work in rehabilitation. The SMA is also thought to play a critical role in regulating neural activity prior to movement execution and also at the appropriate time to enable a movement to terminate.

BG dysfunction therefore results in any combination of the following:

- Impaired performance of well learned motor skills and movement sequences
- Impaired pre-movement preparation
- Delayed initiation and termination of activity
- Problems maintaining sufficient movement amplitude
- Difficulty with dual tasking e.g. walking and talking
- Difficulty with the sequencing and timing of movement
- Difficulty in shifting motor and cognitive sets e.g. walking and looking to locate the chair
- Impaired axial motor control
- Impaired balance reactions
- Slower mental processing.

The process of physiotherapy should be regarded as active, ongoing and centred on the individual's realistic goals; it lies alongside medical and surgical intervention to enhance the person’s potential, or can be used alongside other physical approaches such as the Alexander technique, yoga, conductive education or Pilates. All these are techniques that not only promote movement, but also are linked with social well-being.
The principles of physiotherapy for people with Parkinson’s have altered little since first listed by Turnbull in 1992.

- Early implementation of exercise programmes to prevent deconditioning and other preventable complications
- Utilisation of a meaningful and practical assessment procedure to allow monitoring and identification of rehabilitation priorities
- The identification of deterioration and timely, appropriate intervention
- The opportunity for targeted therapy for restoration or compensation of function
- The involvement of patients and carers in decision-making and management strategies.

Physiotherapists work toward five therapeutic expectations to:

1. Minimise effects of disease progression (neuroprotection)
2. Improve physiological effects (increased dopamine levels, endurance, flexibility, balance etc)
3. Affect functional status outcome (increased stride length, distance moved, independence)
4. Enhance psychological benefits (stress levels, well-being, sleep)
5. Improve socialisation (involvement, support)

In the earlier stages of the condition, physiotherapy might incorporate only education and advice to enable the diagnosed individual to maintain the necessary level of fitness and ability to minimise progression on Parkinson’s. The physiotherapist may also be involved at the early stage in prescribing specific exercises to the person with Parkinson’s so they can regain movement, prevent falls, maximise respiratory function or reduce pain.

As the condition progresses, intervention moves from maintenance to promotion of independence by using a wider network of support, whether asking family to assist, or requesting formal Social Services intervention. Finally, in the palliative stages, input becomes necessary to relieve pain and pressure areas, treating symptoms as they occur.

**About exercise:**
Exercise is worth a separate mention as evidence is continuing to emerge that supports the importance of exercise, of sufficient intensity and regularity, as having a role in positively affecting the outcome of the disorder. Exercise appears to have a two-fold effect on brain-derived neurotrophic factor, increasing its availability so it:

1. Facilitates synaptic function by increasing plasticity in an injured central nervous system, promoting neuronal repair
2. It maintains neural function by neurotrophic support, enhancing learning and memory.

As exercise has the potential to augment plasticity, behaviour and counterbalance the deleterious effects of ageing, a person exercising appropriately may decrease the rate of progress of the Parkinson’s or at the least, decrease the rate at which medication doses have to be increased.

**Main symptoms of Parkinson’s**
These can be considered as motor and non-motor. The motor symptoms include:

1. The ‘kinesias’ i.e. bradykinesia (slowness in movement), hypokinesia (small amplitude of movement) dyskinesia (uncontrolled movements) and akinesia (cessation of movement). Physiotherapists have the most lasting effect on these symptoms
2. Rigidity – our input can ease the stiffness and increase flexibility and speed so that movement becomes more efficient, however, the effect is not long-lasting
3. Tremor initially only seen at rest and described classically as ‘pill rolling’; as the condition worsens, for some people, so does the tremor. There is little that can be done for this by a physiotherapist, although there are some
techniques that can quieten the excess movement for a few minutes. This is useful if the person has to do specific
task that would be affected by the tremor, such as paying for purchases at a shopping store till. The action to quieten
the movement overloads and increases the tone in the shoulder-girdle to a maximum tension e.g. pushing clasped
hands together tightly for a few seconds, or sitting on your hands but pushing them downwards into the chair as hard
as possible.

4. In the later stages, postural instability resulting in balance losses and falls.

Non-motor symptoms include cognitive, sensory and autonomic disturbances. Common non-motor symptoms are depression,
anxiety, sleep disturbance, fatigue and postural hypotension. These can be even more debilitating for the person with
Parkinson’s than the motor symptoms.

It has become increasingly recognised that Parkinson’s presents as different syndromes, with the following classifications
identified:

1. Primary (idiopathic) Parkinson’s
2. Secondary (acquired, symptomatic)
3. Heredo-degenerative Parkinsonism
4. Multiple system degeneration (Parkinson plus syndromes)

The features, such as tremor, early gait abnormality, postural instability, non-motor symptoms and response to dopamine are
used to differentiate the disorders.

The variable course of progression and symptoms imply different biochemical degenerative mechanisms and the following
subtypes are emerging:

1. Early disease onset (25%) – longest duration till death, delays before falls and cognitive decline
2. Tremor dominant (31%) – same life expectancy, falls history and hallucinations as those with non-tremor dominant
   presentation
3. Non-tremor dominant (sometimes called bradykinetic-rigid) (36%) – strong association with cognitive impairment
   (Lewy Body pathology)
4. Rapid disease progression without dementia (8%) – older, early depression, midline symptoms, often tremulous
   onset; increased mentation, freezing and ADL sub-scores in the UPDRS Part 1 & 2 sections

The longer a person has been diagnosed and is on medication for the condition, the worse the symptoms.

People with Parkinson’s have changing needs throughout the different stages of the condition, hence it is important that
practitioners understand the multiple problems associated with the condition and provide timely and appropriate
interventions.

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<th>Key areas for patient assessment:</th>
<th>Physical Examination:</th>
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<tr>
<td>History taking</td>
<td>Strength and power</td>
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<td>Expectations</td>
<td>Range of movement</td>
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<td>Impairments</td>
<td>Posture</td>
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<td>Falls</td>
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<tr>
<td>Cognitive issues</td>
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<td>Psychosocial issues</td>
<td>Transfers including turning</td>
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<td>Physical activity levels</td>
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<td>Fatigue</td>
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Evidence based physiotherapy guidelines have been developed in the Netherlands with four core areas including assessment and outcome measurement identified and divided into four intervention strategies:

1. **Cueing strategies to improve gait**
   Extrinsic cues can be visual or spatial and are used to facilitate gait. Visual cues, such as floor markings can help to increase step length when steps become small or freezing occurs. Auditory cues, such as a metronome, can be used to initiate and maintain movement.

2. **Cognitive movement strategies to improve transfers**
   Intrinsic cues or ‘cognitive movement strategies’ are self-generated using mental rehearsal. This requires attention and concentration and the ability to visualise the movement. Internal dialogue, such as that used in conductive education, can aid patients by developing staged movement sequences for functional activities. Internal cueing, by their nature require a reasonable level of cognitive ability in order to learn the individual strategies.

3. **Balance training**
   Balance training should be dynamic, using visual and vestibular feedback, and combined with strength training. The inclusion of compensatory stepping training may be effective at improving gait and stepping reactions.

4. **Improving physical capacity by increasing range of movement and muscle power.**
   Physical capacity and functioning can be improved by exercise programmes that utilise strength, balance and flexibility training, as well as functionally orientated exercises.

Whenever treating a person with PD it is important to consider the most appropriate environment for treatment as people with PD often find it difficult to transfer skills learned in one environment to another.

**Tools to help a physiotherapist:**

1. A copy of the Dutch guideline can be accessed free at: [https://www.kngfrichtlijnen.nl/downloads/Parkinsons_disease.pdf](https://www.kngfrichtlijnen.nl/downloads/Parkinsons_disease.pdf)


3. Information about the Association of Physiotherapists in Parkinson's Disease Europe (APPDE) can be accessed at [http://www.appde.eu/](http://www.appde.eu/)

4. Information about cues and strategies to assist movement can be found on the RESCUE site, informed by multi-centre research trials undertaken to look into the impact of cues and physiotherapy: [www.rescueproject.org](http://www.rescueproject.org)

5. The National Institute of Health and Clinical Excellence published a guideline about the diagnostic and early management of Parkinson’s for the English health system. Various versions can be found online, and the document provides background information about the condition, diagnostic investigations and also a chapter that includes what the role of physiotherapy should be. [http://www.nice.org.uk/page.aspx?o=cg035fullguideline](http://www.nice.org.uk/page.aspx?o=cg035fullguideline)

6. Finally, a Professional’s Guide was published by the Parkinson’s UK team in 2007, with a chapter dedicated to physiotherapy assessment and intervention. This can be found on line at: [http://www.parkinsons.org.uk/advice/publications/professionals.aspx](http://www.parkinsons.org.uk/advice/publications/professionals.aspx)
**Main feature**

The Future: Moving towards European implementation of the Dutch guideline for physiotherapy in Parkinson’s disease

Dr Anna Jones, Reader, Northumbria University, UK; Bhanu Ramaswamy, Independent Physiotherapy Consultant and Visiting Fellow at Sheffield Hallam University, UK.

The Association of Physiotherapists in Parkinson's Disease Europe (APPDE) is an association for physiotherapists, other professionals, people with Parkinson’s and their carers that facilitates dialogue between researchers and clinicians to promote best clinical practice in physiotherapy and Parkinson’s. One of the current APPDE projects is to support member countries adapt *Guidelines for Physical Therapy in people with Parkinson’s disease*, developed by a research team in the Netherlands (Keus et al 2004), into country-specific guidance. On 4th - 5th June 2010, 26 people from across Europe came together for the 1st APPDE Guideline Implementation Workshop.

An innovative feature of the Dutch guideline is the inclusion of four Quick Reference Cards (QRCs) designed to directly support clinical practice at any stage of Parkinson’s disease – in the clinic, on the ward or in community settings. These are of particular importance, as most physiotherapists do not work in specialist centres where they have the opportunity of working with large numbers of people with Parkinson’s. In the UK adaptation of the QRC was carried out last year for two main reasons: firstly, to standardise and encourage best practice for physiotherapists working with Parkinson’s; and secondly in preparation for a profession-specific audit to be conducted for the National Institute of Clinical Excellence and Health (NICE) due in 2011 – 12. NICE is a national organisation that provides guidance, sets quality standards and manages a national database to improve people’s health and prevent and treat ill health. In 2006 they produced guidance for professionals who manage Parkinson's. Parkinson's UK are now leading a group of multi-professional organisations, including the UK national bodies for physiotherapy, speech and language therapy, occupational therapy, nursing and doctors to conduct an audit of how well these NICE guidelines have been implemented through the National Health Service.

As a team of physiotherapy clinicians, academics and researchers from the UK was the first group to receive permission and to adapt the four clinically relevant QRCs from the Dutch guideline for use by clinicians. The two UK delegates - Dr Anna Jones, Reader at Northumbria University and myself, an Independent Physiotherapy Consultant, who led the development, were invited to present at the guideline implementation workshop.

The workshop participants invited from across Europe included representatives from Czechoslovakia, Denmark, Ireland, Italy, Sweden, Switzerland and Portugal. Members of the organising committee came from the Netherlands, Luxembourg, Belgium and the UK. The two-day workshop was well received, with enthusiastic networking and sharing of ideas. It was all made so much more pleasant against the backdrop of the hotel, set within woodlands and by a canal, resulting in a refreshing environment to keep the brain charged!

Having established the demographics of Parkinson’s as well as some aspects of physiotherapy practice in these individual countries, the Dutch team began the second day by outlining the development and implementation of the original guideline, to include discussion of amendments required when it is updated. The UK presentation aimed at sharing ideas about how they might implement the guideline in their respective countries’ healthcare systems. The remaining four countries will have the opportunity of developing and presenting their own plans at a future workshop. The APPDE, the Dutch team and KNGF will provide advice and support.

In the UK where adaptation of the QRCs is complete, work is to be undertaken to help clinicians implement their use, with the aim of raising the quality of history taking, assessment, goal setting and treatment planning. Workshop participants expressed a willingness to work together on the development of a European guideline for physiotherapy and Parkinson’s.


**Contact:** Bhanu Ramaswamy b.ramaswamy@shu.ac.uk
Political feature

The Toronto Charter for Physical Activity: A Global Call for Action

The Toronto Charter for Physical Activity: A Global Call for Action was launched on Saturday 8 May 2010 at the 3rd International Congress for Physical Activity and Health in Toronto Canada.

The Toronto Charter is a call to all countries to help make physical activity a priority for all. The Charter provides a framework for action and partnerships across multiple sectors and with communities to build healthier, active, environmentally sustainable communities. It is a result of two years of international drafting and large scale global consultation. The global consultation received responses from over 400 individuals and organisations from 55 countries and provided over 1700 comments and suggestions.

The Toronto Charter was ratified by delegates at the 3rd International Congress for Physical Activity and Health with overwhelming support for its call to all countries to seek greater political commitment, resources and community action to support health enhancing physical activity for all. The Charter itself is an advocacy tool, designed for use with decisions makers and to build partnership towards achieving political commitment and resources towards increasing participation in health-enhancing physical activity throughout the world.

There is then a request for support either from individuals or organisations with the address of the website to sign up to www.globalpa.org.uk.


This Charter for Physical Activity will form the basis of the lunchtime Older People education session being supported by IPTOP at the World Confederation for Physical Therapy (WCPT) Congress on 20th June 2011 (See P 12 of this newsletter for more information)

World Roundup

Ireland -- Chartered Physiotherapists in Neurology and Gerontology (CPNG). 236 members. Anne-Maria Scanlon Ireland@iptop.wcpt.org

CPNG is a clinical interest group representing physiotherapists who have an interest in neurology and/or gerontology. The role is to support continuing professional development in these areas through evening lectures, workshops, courses, research and education bursaries as well as the provision of a discussion forum and access to physiotherapists with expertise in the areas of neurology or gerontology. In Newsletter 14, we brought a flavour of the Irish National Audit of Stroke Care (INASC). Following on from this, the Irish Heart Foundation have launched a media campaign to raise awareness of Stroke among members of the public. FAST encourages the public to watch out for signs of weakness in the Face, Arm, Speech and know that it is Time to call 999. The campaign is aided by a website dedicated to stroke www.stroke.ie. CPNG has also developed a stoke leaflet which members can use to highlight the benefits of stroke rehabilitation in hospitals and clinics around the country. CPNG has had active input in national consultation documents including the National Positive Ageing Strategy, Strategy for the Provision of Rehab Services, and Towards a Restraint Free Environment.
Turkey -- Turkish Geriatric Physiotherapy Association -- 42 members. Nuray Kirdi
Turkey@iptop.wcpt.org

A representative of the Turkish Geriatric Physiotherapy Association was invited by the Turkish Health Ministry to be a member of the core group for “Home Care for the Elderly” in Turkey. There were 6 multidisciplinary groups who each worked on a different topic and presented a final report pointing out the importance of physical therapists in the “Home Based Rehabilitation for the Geriatric Care” in addition to prevention and environmental adjustment. In March, we had a “Council of Elderly” organized by “Elderly Platform”. Representative delegates came from governmental and civil organizations and Universities and raised suggestions and opinions for the health care of older people.

Feliz Can, IPTOP Chair, attended the Congress of Turkish Academic Geriatry Association held in Northern Cyprus between 26-30 May 2010 and acted as a moderator, panel member and platform presenter on “the correlation of fear of falling and activities of daily living in the elderly” and “the effect of balance on functional performance level in older people”. Dr. Jean Pierre Michel, Chair of European Union Geriatric Medicine Society, made the opening speech and talked about the importance of multidisciplinary care systems.

In taking part in such events we not only learn but also can share and promote our expertise.

UK -- AGILE (Chartered physiotherapists working with older people) 555 members. Ms Bhanu Ramaswamy b.ramaswamy@shu.ac.uk

AGILE is a clinical interest group of the Chartered Society of Physiotherapy. As a representative body of physiotherapists, the group aims to assist members in delivering the highest possible practice with older people by:

- Promoting high standards through education, research and efficient service delivery
- Providing a supportive environment, facilitating the exchange of ideas and information
- Encouraging and co-coordinating relevant activities regionally and nationally

Ongoing activities include:
- production of twice yearly journal (Agility) plus a newsletter following each of the three national committee meetings.
- overseeing the moderation of a national interactive Blog run through the CSP
- administering information to the AGILE regions enabling courses to be run across the nations of UK.
- co-option of individuals onto the committee to act as project officers on short working parties of national relevance to the Association.
- production of guidance for exercises and outcome measures for OA Knee.
- organizational partner of the World Parkinson's Congress held in Glasgow in September 2010
- working with the National Coalition of Active Ageing on producing a UK manifesto from the International Physical Activity Charter;
- involved in national audits and projects such as Falls, Smart engineering and Parkinson's disease, and
- co-badging the multidisciplinary day of the British Geriatrics society Autumn meeting

Finland -- The Finnish Association of Geriatric Physiotherapy. 141 members. Karin Stahl
Finland@iptop.wcpt.org

The Board of GerGer meet 4-6 times a year. This meeting takes place in southern Finland because all of its 9 members come from that part of the country. Being a small association, we had to start finding ways to lower costs. As an example we reduced our mailing costs by emailing a newsletter. This received positive feedback from our members.

Another way is to find alliance partners especially for our educational days.
Activities:
As an association we think it is really important to educate people. Due to this, almost every year we have participated in a large expo: Tools of daily living and Good aging. Here are some examples of educational days we have organized or been part of:

- Last autumn we had an educational day concerning rehabilitation of Dementia patients at home. This was organized in conjunction with the Association of Occupational Therapists in Finland.
- This spring we organized an educational day together with the Finnish Association of People with Physical Disabilities. The main discussion point was rehabilitation of aging CP-therapy patients. Both events were successful, gathering participants from other health groups.
- We participated in a project called “The well-being and life-long rehabilitation of adults with CP-diagnosis”. This project was organized by the Finnish Association of People with Physical Disabilities. The project "Cerebral Palsy and Aging" aims to increase the understanding of specific issues related to aging among adults with Cerebral Palsy. This project was executed in collaboration with the GeroCenter Foundation for Research and Development, the Association for Promoting Rehabilitation and the Finnish Cerebral Palsy Society. To assist with this project, GerGer sent a questionnaire about the rehabilitation of CP-adults to our members. The Finnish Association of People with Physical Disabilities has now established a report regarding the above subject. GeroCenter is an institute that does a lot of research about well being among older people in Finland. Please visit their website for more information [www.gerocenter.fi](http://www.gerocenter.fi). Some of the above information was taken from the Gerocenter website.
- GerGer has also been consulted by the head organization of physiotherapy in Finland on various issues, for example planning the upcoming National Healthy Aging Congress next spring.

In Finland an individual physiotherapist can be nominated as a specialized physiotherapist in certain fields of physiotherapy. This year GerGer started to make the criteria together with some experts in geriatric physiotherapy. The specialization groups, like GerGer, must first make the criteria, apply it and have it accepted by the head organization of physiotherapy. Head organization keeps a list of the accepted experts and that way it is easier to find them when needed for example giving consultation and lectures.

Another important thing is that we have decided to support our members by giving them a chance to apply for support from us to develop their work or studies in geriatric physiotherapy. A prerequisite is that they supply a full report of their study.

There will be changes in the physiotherapy organization in Finland which will significantly affect our association; for example change of regulations and membership.

If you have any questions regarding GerGer activities please don't hesitate to contact us.

**Iceland**——The association of Icelandic physical therapists working with the elderly. 65 members.

Aðalbjörg Íris Ólafsdóttir Iceland@iptop.wcpt.org

Of its 65 members, two have been awarded recognition as geriatric physical therapists. The past year has proved an eventful one for the association. The annual general meeting was held in March 2009 and saw the complete renewal of the board, both the chairman and the other three board members. The meeting was followed by three informative meetings and finally a very enjoyable visit to a nursing home in the southwest of the country in October. Key issues for our association are as follows:

- The Icelandic Physical Therapy Association celebrates its 70th anniversary this year in various ways.
- The board of our association has been given the role of encouraging the elderly to use the park benches dotted around Reykjavik, as well as encouraging the city’s authorities and citizens to add more benches.
- Two members of the association have published a video on balance training.
- The Nordic Congress of Gerontology was held in Iceland in May 2010. Members of our association both participated in and gave talks at the congress.
- The 2010 annual general meeting of our association was held in March. A new chairman was elected as well as one new board member.

We aim to keep offering a constructive agenda.
**New Zealand**---Older Adult Special Interest Group of the NZ Society of Physiotherapists. 150 members. Ann Newsom NewZealand@iptop.wcpt.org

In May 2010, Physiotherapy New Zealand held its biennial conference in Auckland. The theme was *Working together: research and practice* and taking part were a great range of excellent speakers from New Zealand and overseas. There were several presentations which were relevant to the older person.

**Professor Ngaire Kerse** from the School of Population Health at the University of Auckland spoke on Older People and Activity. She reminded us that housework can be life saving. Many elderly people move to smaller homes and their activity level tends to drop unless they take up exercise outside the home. There is no reason not to remain or start becoming active even in very old age. In the 85-90 age group it is important to manage frailty as well as specific diseases. It may take only a small decrease in muscle strength to move the older person from coping to non-coping. Physiotherapists are able to assess the client has the capacity to participate in different activities and treat underlying conditions, then designing an activity programme in a variety of settings tailored to the persons needs. In studies on depression it has been shown that people with depression are more prone to falls. Exercise can improve walking ability. Improve quality of life (QOL) and reduce falls. Research has also demonstrated that the Otago Exercise Programme can reduce falls especially in the over 80 age group.

**Professor Elizabeth Dean** from the University of British Columbia stated that western medical systems needed to re-orient towards health rather than illness. Professor Dean challenged physiotherapists to be powerful drivers of change in population health. Physiotherapy can be the magic bullet in fighting chronic conditions because it is non-invasive, without the expense of drugs or surgery.

**Dr Gwen Lewis** from AUT University demonstrated how Virtual Reality can enhance motivation and improve attention in stroke patients. It can incorporate motor learning and rehabilitation principles and is becoming affordable for home use with a standard computer.

**Dr Barbara Gibson** from the University of Toronto spoke about QOL outcome measures which are not neutral but reflect deeply rooted social norms and expectations. QOL is not the same as health status as it only looks at function. In physiotherapy research and practice QOL is equated with physical function and independence, however she argued some dependence in clients with complex needs is not always bad. Critical approaches can be used to reconsider dependency, focusing on connectivity and living well in the present.

**Older Adult Symposium – Auckland, New Zealand**

This is being held on November 27th and will focus on the move towards community based physiotherapy services to cope with the increasing numbers of older adults with chronic illnesses.

**Europe**---Ms Bhanu Ramaswamy, European representative. b.ramaswamy@shu.ac.uk

**WCPT Congress**

As the congress falls in Europe next year, I am assisting the IPTOP executive in developing a programme of relevance and interest to physiotherapists working with older people across the world.

**Older adults - specific clinical standards from IPTOP member countries. A request for help**

I am trying to gauge which clinical interest groups have standards of practice specific to older people. So far, I have had responses from the following:

1. Canada - no older person specific documentation
2. Germany - no older person specific documentation
3. Ireland - no older person specific documentation
4. Switzerland - currently developing standards and educational content for physiotherapist working with older people
5. UK - have specific clinical standards for physiotherapists working with older people
6. USA - have specific clinical standards for physiotherapists working with older people

For various reasons, I have been unable to get a response from the following countries:

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<tr>
<th>Australia</th>
<th>Bulgaria</th>
<th>Finland</th>
<th>Greece</th>
<th>Iceland</th>
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<th>New Zealand</th>
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Could reps from these countries please contact me to help with the completion of this IPTOP project.
**General Information**

**IPTOP web page**

We now have our own web page within the WCPT website. It can be accessed direct through [http://www.iptop.wcpt.org](http://www.iptop.wcpt.org) or via the WCPT website [www.wcpt.org](http://www.wcpt.org). Each officer (eg chair@iptop.wcpt.org) and each member organization representative (e.g. germany@iptop.wcpt.org) has an IPTOP address with mail automatically redirected to personal e-mails. These are all listed on the front page of the site. Our web page has 5 sections: contact details; about IPTOP (our leaflet); Newsletters—current and past; Meeting notes; and Conferences. Please encourage members to visit the IPTOP and WCPT websites. Officers and member organization representatives are advised to install a Spam Catcher to block unwanted use of our IPTOP e-mail addresses.

**IPTOP research** (please send your comments on this item to Jennifer Bottomley (vicechair@iptop.wcpt.org))

**PHYSIOPEDIA**

While attending the American Physical Therapy Association’s Annual Conference in Boston, Massachusetts – I had the wonderful opportunity of attending a half day session on Physiopedia ([www.physio-pedia.com](http://www.physio-pedia.com)). The creators of this wonderful physiotherapy/physical therapy on-line resource, Rachel Lowe and Eric Robertson provided an instructional on the content of this remarkable website and on how to use and navigate Physiopedia. The face page provides an easy means of signing up for the many services this site offers. You will not be disappointed… it is one of the BEST research resources I’ve found on the internet AND just like Wikepedia – you are encouraged to add to the site.

Physiopedia is an ambitious project which aims to eventually offer an evidence-based knowledge resource for rehabilitation professionals throughout the world. Through utilizing collaborative wiki technology Physiopedia is a place where all physiotherapists can participate by contributing, sharing and building knowledge to develop a global understanding. For educators Physiopedia offers an opportunity to involve their students in this knowledge creation process as part of an educational program.

Of great interest to those of us working in Geriatrics is a current Physiopedia project: The AGILE Project. This project is evolving and originates from the Chartered Society of Phythotherapy Clinical Interest Group of Physiotherapists working with Older People.

Physiopedia is always looking for new ways to develop Physiopedia resources that will be beneficial to physical therapists individually and the profession as a whole. Rachel and Eric are exploring continuing education, mentoring, and the establishment of clinical networks to facilitate communication with all professionals in Physical Therapy. I encourage each of you to explore this site.

**Treasurers Report** (please send your comments on this item to Nancy Prickett aspenp@voicenet.com)

Nancy has taken over as acting Treasurer. Information regarding member country dues has been sent to member liaisons. Payment was due September 1, 2010. If there are any questions regarding dues payment, please contact Nancy

Any new country wanting to be member country for IPTOP should let Nancy know as soon as possible so that their membership application can be approved at the general meeting in Amsterdam.
Conferences (contributions to editor@iptop.wcpt.org)

IPTOP Conferences linked to Member Organization Conferences (offers please to Filiz chair@iptop.wcpt.org). To date we have had excellent joint conferences with Irish, Australian and Turkish member associations) (see below “IPTOP conferences – links to Member Organization Conferences”). We are looking for a joint conference for 2012.

Amsterdam Update
Jennifer Bottomley, IPTOP Vice President vicechair@iptop.wcpt.org

2011 WCPT Amsterdam (June 20-23)  http://www.wcpt.org/congress/
Registration for WCPT 2011 Amsterdam commenced in September 2010, after which you can access accommodation, the most economical and convenient being taken up very quickly---so advice is to register early. Some IPTOP members have already booked into Novotel---details are on the WCPT website.

Preconference Course:
Despite the efforts of our past President, Olwen Finlay, our proposal for a preconference course on “Active Aging” was not accepted by WCPT for the Amsterdam conference in June 2011. The good news is that Dr. Carole B. Lewis is presenting an orthopaedic-based preconference about Knee Pathology in Older Individuals on 20 June, and has offered IPTOP time within her program to present. We will have two time slots – one over lunch and the second at the end of the day. Our tentative plan is to have a lunch time (lunch provided) a round table discussion on active aging. The subject will be about supporting the Toronto Charter for Physical Activity: A Global Call for Action(see P7 for details). After introducing the Toronto Charter, discussions will be facilitated by the IPTOP committee members present to review how physiotherapist worldwide might support the adoption and implementation of this internationally launched document.

We are in the process of developing talking points for these discussions and will look forward to any suggestions you may have. The purpose of these discussions will be to ascertain practices in different countries directed towards promoting active, healthy models of aging and discuss obstacles and concerns therapist around the world have regarding models of care providing health promotion initiatives. From the discussions, a panel discussion will be formulated to summarize points from each table and to facilitate further group discussion.

Satellite Program Education Sessions
IPTOPs involvement in satellite program education is pending. Details are being finalized by WCPT with course organizers and venues being confirmed, with the aim to finance 30 satellite programs. Where appropriate, WCPT subgroups are being incorporated into these proposals. Topics for discussion panels and debates submitted by subgroups are being considered and WCPT program organizers are currently trying to reduce the many proposals and amalgamate topics to ensure they cover the “big picture” issues.

Networking Session
Subgroups will be provided with a networking session of 1.5 hours during the main congress. Further details will be provided as planning progresses.

Business Meeting and AGM
WCPT has received requests from each subgroup for business meetings and will contact us to fine tune the details. Our hope is to hold the Business Meeting and the IPTOP Annual General Meeting on the 21st June, but watch this space. The AGM is open but only fully paid up countries are eligible to vote and each country has to nominate their one voting representative. Jill McClintock, IPTOP Secretary, will be sending out constitution changes, election details and nomination forms.

Subgroups’ Chairs/Presidents Meeting
WCPT has established a chair, Laetitia Dekker Bakker, to head the meeting of subgroup chairs and presidents. The time and location of this meeting is pending

Joint Subgroup Reception
A reception is being planned for subgroups and will take place at the Novotel Hotel. Rebecca Stephenson (IOPTWH) and Barbara Connolly (IOPTP) have agreed to take a lead for this event. Details are pending.
**IPTOP evening function**…this is still under discussion

**Shared Exhibition Space**
WCPT will provide more detail regarding the incorporation of WCPT regions and subgroups into a shared exhibition booth. Further information will be provided to you as details become available.

---**manning the stand**---IPTOP reps will be required to man our stand for a short time each day. Amanda will coordinate the timetable in Amsterdam once we have seen the overall programme.
---**member country leaflets**---any member country wishing to contribute leaflets to the stand should do so on day 1. These must be of good quality and in English. About 300 is adequate and not too heavy to carry.
---**pop up banners**---A pair of pop up banners are also being produced for our stand, one will be brief text about IPTOP and one will have 2 or 3 pictures linked to the theme of active aging around the world. Contributions of photographs as soon as possible would be welcome to editor@iptop.wcpt.org.

**Abstract Awards**
Certificates for outstanding presentations will once again be awarded in Amsterdam. Subgroups are encouraged to consider awards in our field of interest. WCPT is developing criteria to standardize our recommendations for these awards. Subgroup awards may be presented at the subgroup reception and acknowledged at the congress closing. Subgroups are to provide input to the development of award criteria. The details will be provided in a subsequent Newsletter.

**Poster award**
IPTOP will present an award for the best poster regarding older people. We have contributed special age related criteria to the independent panel who are judging all posters.

**So, in summary:**

- Register as soon as possible and book your accommodation and travel to be in Amsterdam for 20 June
- Look out for further information regarding IPTOP constitution changes and executive officers nomination forms
- Review your national leaflets with a view to circulating them in Amsterdam
- Send photographs of active ageing to editor@iptop.wcpt.org, as soon as possible
IPTOP conferences – linked to Member Organisation Conferences

IPTOP as an International organisation of Physical Therapists working with Older People encourages collaboration between its member organisations. Member organisations come from each of the World Confederation of Physical Therapists Regions and represent member organisations at differing stages of development when working with older people. The constitution requires a four yearly meeting to be held in conjunction with the WCPT congress.

To facilitate business progress and ensure members organisations in all regions have an opportunity to cost effectively participate in the organisation, IPTOP seeks invitations from member organisations willing to collaborate with IPTOP to include a meeting within their programme so members can attend a local annual conference and an IPTOP meeting.

The Purpose of this briefing: To provide guidance to member Organisations interested in adding an international dimension to their congress by holding it in collaboration with IPTOP.

Collaboration means: Some IPTOP involvement in the programme planning; Time for an IPTOP delegate meeting; IPTOP assistance in promotion.

Organisation: The organisation, funding and profit from the national conference remain that of the organising country. However, IPTOP may be able to provide help with organisation and will negotiate in advance a pro rata share of any profit.

Benefits to Host Organisation; increased participation---international delegates attend on same basis and for the same fee as national delegates; international profile; possibility of increased national profile; opportunity for local members to expand international contacts. Members of the host country get a unique opportunity to hear international speakers / papers

Benefits to IPTOP: Expand awareness of, and increase participation in, IPTOP; facilitates progress of business; helps to build the financial resources of IPTOP; IPTOP members may be international experts. National members also have the unique opportunity to meet and share professional knowledge both formally and informally with international colleagues.

Financial issues: negotiate a pro rata organisation fee to IPTOP e.g. % of the delegate fee (or perhaps the international delegate fee); seek sources of funding to assist delegates from organisations that would not otherwise be represented. Any financial help that the national organisers can obtain to enable IPTOP members from organisations, which normally could not afford to sponsor a delegate within its region to attend the conference, would be much appreciated, and equitable allocation would be managed by IPTOP.

Contact Filiz Can (chair@iptop.wcpt.org) for more information.
International continuing professional development for physical therapists working with older people.

Collaboration between WCPT and the United Nations Institute on Ageing has resulted in a two week residential course curriculum with the following aims, objectives and themes:

**Aims:**
1. To improve the healthcare of older persons by developing relevant PT attitudes, knowledge and skills
2. To develop PT skills to influence policy both locally and nationally

**Objectives**
1. To increase awareness of and sensitivity to the process of ageing and its implications
2. To adopt realistic and professional attitudes
3. To highlight the need for
   a. a comprehensive approach to the care of older persons
   b. a multidisciplinary approach
   c. community oriented health services
4. To promote the value of physical therapy services for older persons.

**Themes:**
- Demography and epidemiology
- Ageing---biological, psychological, social,
- Health services, health promotion, illness prevention, community and government support
- Physiotherapy specific including legal and ethical issues
- Leadership, communication, negotiation, education and training skills.

The course is presented as formal lectures and facilitated learning followed by small group work. It is not a clinical practice course. Participants are encouraged to share their own areas of expertise formally and informally. Each course ends with each participant presenting their action plan for a work based project which is followed up by the tutors. Two courses have been held (1993 for physiotherapists, 1997 for physiotherapists and occupational therapists) both hosted by Malta. All students found it beneficial, especially to be with colleagues from the same specialty for an extended period. Students stated "it was enriching, inspiring and confidence building ."

Further courses for can be arranged by IPTOP. Requesting countries should consider the following:
1. The programme is delivered in the country/region requesting it.
2. Allow 2 years set up time from IPTOP agreement to proceed. Consider pre/post WCPT/IPTOP conference.
3. Presentations will be by an international core tutor group with local academic and physiotherapy specialist tutors
4. Educational credits may be pursued locally by the requesting country/region
5. A local “clerk to the course” is required to liaise with the IPTOP course organiser
6. Advertising is the responsibility of the requesting country
7. Consider joining with another relevant profession (e.g. OT) to increase numbers, expertise and impact
8. The language is English in which participants must be fluent in both understanding and speaking (a comprehensive interpretation service to be included in costs might be considered)
9. A steering group (IPTOP course leader, course clerk and representative of joining profession if relevant) agree a course plan with dates, tasks and responsibilities; adapt the course length to meet local needs although the full course is internationally recommended; revise the curriculum; select tutors; manage the course.
10. A telephone conference call with core tutors and steering group will be needed at the early planning stage
11. Steering group will meet with core tutors preferably AT the facility 3 months prior to the event to finalise programme and participants.
12. The minimum 20/maximum 30 participants are chosen on level of experience, international (work/leisure experience, active participation, ability to cascade knowledge, ability to influence policy makers and/or teach other physical therapists, and geographical coverage.
13. The programme should include professional and cultural visits and opening/closing by a “high level” figure
14. Accommodation should have individual study bedrooms, restaurant, main conference room with full a/v facilities and 6 break out rooms (number dependent on course size), photocopy facilities, recreation facilities.
15. All costs (e.g. bullets) are born by the requesting country. Costs to participants should cover their accommodation and all meals plus apportioned full conference overheads (i.e. administration, tutor travel/accommodation/meals etc.).
16. Grants and bursaries may be sought by the requesting country/region from e.g. professional bodies, government departments, and charities.
17. The requesting country may wish to consider a feedback presentation at next WCPT/IPTOP conference.

Further information from IPTOP editor, Amanda Squires, (editor@iptop.wcpt.org)
Summary of IPTOP objectives as at September 2010

<table>
<thead>
<tr>
<th>Priority</th>
<th>Objective</th>
<th>Lead</th>
<th>Detail</th>
<th>Timescale</th>
<th>Progress updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>WCPT Link</td>
<td>Filiz</td>
<td>To continue links with WCPT</td>
<td>Ongoing</td>
<td>Teleconference Nov 09</td>
</tr>
<tr>
<td>2</td>
<td>Sponsorship</td>
<td>Jennifer</td>
<td>List potential sponsors. Act as liaison for these bodies regarding advertising</td>
<td>September 07</td>
<td>No progress to date</td>
</tr>
<tr>
<td>3</td>
<td>Website management</td>
<td>Amanda</td>
<td>New IPTOP officer to be appointed to keep all IPTOP information up to date on the website</td>
<td>Post to be included in 2011 elections</td>
<td>Job description completed</td>
</tr>
<tr>
<td>4</td>
<td>New member Organisations</td>
<td>Filiz</td>
<td>To encourage representation from all the WCPT regions, To encourage the setting up of new member countries.</td>
<td>Ongoing</td>
<td>No report received to date.</td>
</tr>
<tr>
<td>5</td>
<td>Promotion of IPTOP and the services it provides</td>
<td>Filiz</td>
<td>Upwards to WCPT, outward to member bodies and new members to promote the Newsletter &amp; CPD opportunities</td>
<td>Ongoing</td>
<td>Work in progress</td>
</tr>
<tr>
<td>6</td>
<td>Other International disciplines</td>
<td>Jennie &amp; Leah</td>
<td>To establish liaison with similar international bodies in nursing, OT and medicine</td>
<td>Ongoing</td>
<td>No report received to date.</td>
</tr>
<tr>
<td>7</td>
<td>EBP/Specialisation</td>
<td>Bhanu</td>
<td>To collate examples of Standards of Practice in member countries for PT with Older people</td>
<td>Ongoing</td>
<td>Started Summer 2009</td>
</tr>
<tr>
<td>8</td>
<td>Carers &amp; Elders</td>
<td>Filiz</td>
<td>Establish contact with International organisations representing Elders and Carers. UN has Standards so ensure IPTOP principles conform</td>
<td>Ongoing</td>
<td>No report received to date.</td>
</tr>
<tr>
<td>9</td>
<td>Annual Reports</td>
<td>Filiz &amp; Jill</td>
<td>Timely production of the IPTOP annual report</td>
<td>Ongoing</td>
<td>Confirmation required that 2007/2008/2009 Reports have been sent to WCPT. Four yearly report needed prior to Amsterdam 2011</td>
</tr>
<tr>
<td>10</td>
<td>Annual Conferences</td>
<td>Filiz</td>
<td>To confirm IPTOP involvement in a member country conference for 2012</td>
<td>Ongoing</td>
<td>Greece had to withdraw from hosting 2010 due to economic pressures.</td>
</tr>
<tr>
<td>11</td>
<td>WCPT Amsterdam 2011</td>
<td>Filiz</td>
<td>Planning all aspects of this conference</td>
<td>Ongoing</td>
<td>Started in Ankara 2009. Teleconferences with WCPT have taken place</td>
</tr>
<tr>
<td>12</td>
<td>Subgroup reconfirmation every four years</td>
<td>Filiz &amp; Jill</td>
<td>Send to Brenda Myers</td>
<td>Before WCPT 2011</td>
<td>Due January 2011</td>
</tr>
</tbody>
</table>

The full version together with timescales and quarterly progress is available from secretary@iptop.wcpt.org
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**Next edition details** Copy date for the next edition is 31 December 2010. The editorial board retains editorial rights. Length for a “feature” article is 1,000 words. We welcome world news (200 words) from member countries, conference information and contributions from the Committee as relevant. Contributions should be in English language and WORD format with references in Harvard Style, any websites hyperlinked in and sent by e: mail to the editor.

We are in the process of developing an advertisement protocol and rate. In the meantime suggestions from members of potential advertisers would be welcome to Jennifer Bottomley (vicechair@iptop.wcpt.org)