Improving access to physical health care & exercise for patients in seclusion

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Aims of the session

- Problems of long-term segregation
- The Positive Intervention Programme (PIP)
- What are the benefits of exercise and improved access to health care
- How have we improved access
- Concluding comments
Seclusion

• Small group of patients in HSS who are chronically challenging and demonstrate the propensity for extreme violence

• Often have severe and enduring mental health, namely paranoid schizophrenia & treatment with antipsychotic medication

• Definition of seclusion: Code of Practice (2008) “the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.”

• Little agreement on, or evidence for, the utility and benefit of seclusion (Busch & Shore, 2000)
Long term risks of seclusion

• Practice may be influenced by history & culture (locally and nationally) and the perception of patient risk
  – Practice variation (Forquer, et al., 1996; Fischer, 1994)
  – Staff beliefs and perceptions of risk (Gudjonsson et al., 2004; Plutchik et al., 1978)
• Seclusion cycle can create:
  – social skills deprivation & a lack of cognitive and psychological stimulation
• Problems include:
  – Reduced insight & social tolerance (possible social phobia)
  – Increased psychological resistance to treatment
  – Exacerbation of negative symptoms of psychosis
  – Patient internalisation for the need of seclusion
  – Systemic dependence on seclusion to contain risk
Psychological & Physical Effects

- Long term **social isolation** gives rise to:
  - Emotional, cognitive and psychological functioning
  - Negative harmful effects upon the individual (Garassian, 1983; Brodsky & Scogin, 1988); Haney, 2003; Arrigo & Bullock, 2008)

- Can maintain social withdrawal, exacerbates impulse control problems leading to powerlessness (Haney, 1994; 2006)

- Maintains hallucinations & persecutory beliefs (Grassian & Friedman, 1986)

- Aggression-coercion cycles (Patterson & Forgatch, 1985)

- Reduced opportunity for engagement in physical activity with lack of motivation and reduced self-esteem; poor physical health and lifestyle choices; obesity (Wirshing, 2004)
The Positive Intervention Programme

• Developed out of a need to re-socialise this hard to reach patient group

• Funding was secured from the hospital

• Consists of a multi-disciplinary team with medical, psychology & nursing leads

• Integrated within individual patient care teams

• Systematic and co-ordinated plan of programmes, with monitoring and a live feedback process

• Part of an overall patient treatment programme that includes pharmacological, psychological and psycho-social components
Aims of the Positive Intervention Programme

- To intervene at a systems level
  - Modelling work with secluded patients to shift & challenge perceptions of risk
  - Training to improve skills in managing violence & aggression

- To intervene at patient level
  - To lessen the potential effects of seclusion
  - Provide purposeful activity
  - Increase adherence to the milieu through engagement and promote termination of seclusion
  - To promote social skills & social boundaries
  - Pro-social role modelling & improve quality of life
  - Access to physical health care & exercise
Why is exercise important?

• National Policy – White Paper Choosing Health (DOH, 2006)
  – Improve access to Physical Health Care for people with severe mental illness
  – Emphasis should be on individual health checks
  – People with mental health more likely to die prematurely (Tetlie et al., 2008; Beebe et al., 2005)

• Severe mental illness and the impact of treatments
  – Weight gain is associated with treatment with atypical antipsychotic medication as well as increased risk of diabetes and cardiovascular diseases (Lowe, 2008)
  – Detrimental effects on forensic mental health patients well being, occupational performance and quality of life (Bacon et al., 2012)

• Obesity as a consequence
  – Psychological counselling and psychotherapies (Taylor et al., 2012)
  – Psychiatric nurses are taking first steps in incorporating exercise into their recommendations and interventions in populations with psychiatric illnesses
  – A long journey remains to make a significant difference in patient’s lives (Weber, 2010)
Patient benefits?

• Benefits of Exercise (Callaghan, 2004; Penedo et al., 2005; Stathopoulou et al., 2006; Alexandtratos et al., 2012)
  – There is evidence to suggest that exercise may be a neglected in intervention in mental health care
  – Can improve mental health well-being, reduction in depression and anxiety and enhanced cognitive functioning
  – Improvement in symptoms; including mood, sleep patterns, psychosis and alertness
  – Better social skills, empowerment
  – Meaningful and purposeful activity & use of time

• Qualitative statements from forensic patients
  – “I know it is only exercise, but to me it is something that keeps me going” (Crone & Guy, 2008)
  – “When I play football I don’t think about being here” (Rosenberg et al., 2012)
Typical Programme

Programme structure

- Development of trusting relationship with patient
- Overcame staff fears and anxieties
- Engaged with clinical staff to break barriers
- Access to physical health care facilities & health promotion advice
- Easily achievable goals to promote motivation
- Pro-social modelling, team activity, non contact sports
- Support, reflective practice & supervision for all staff
- Protective strategies & lessening of social anxieties
- Worked at the patient’s own pace
- Re-formulation of risk following each session
- Close liaison with clinical team
- De-briefing following each session
PIP progress to date

Running since May 2008
Facilitated over 3751 sessions – access to health care & exercise
Number of incidents of violence 12
Current capacity of 39 sessions per week

Joint working to improve access to Psychological Treatments & Recreational activities
Ward based links created across the service to improve collaboration
Training Package developed & delivered
36 long term segregation patients re-integrated
Final thoughts....

• Small number of challenging and highly disturbed patients within HSS who are the most marginalised and stigmatised patients in psychiatric services

• Positive Intervention Programme was designed just under 5 years ago to combat the negative effects of seclusion through decompression

• Utilising methods of pro-social modelling and a highly skilled and co-ordinated team, it has been possible to engage and re-associate patients through improved access to physical health care and exercise

• Provided patients with opportunities to establish professional attachments, promote social skills awareness, insight and social tolerance

• Ultimately leading to compliance with pharmacological, physiological and psychological treatments

• Process of researching the efficacy of different elements of the programme
Conclusion

• Team consists of dedicated, enthusiastic and passionate clinicians who are driven to improve the quality of life of long-term segregation patients with the ultimate goal of terminating seclusion

• “Yes, you can be a dreamer and a doer too, if you will remove one word from your vocabulary: impossible.”
  Robert Schuller
The Team

- Danny Angus (Team Leader)
- Mark Hughes (Therapist)
- Stephen Hickson (Risk Therapist)
- Elaine Watkins (Practitioner)
- Ged Griffin (Practitioner)
- Stephen Lake (Practitioner)
- Ian Murphy (Modern Matron)
- Dr Ben Johnson (Consultant Psychiatrist)
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ANY QUESTIONS?

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