

**Evaluation Report on a  
Pilot Physical Activity Project for  
In-patients of a Mental Health Unit in  
Manchester, Edale Unit**

## Executive Summary

- Choosing Health, the national public health strategy, has prioritised mental health and recognises the need to improve the physical health of people with mental health problems as huge health inequalities exist.
- In Manchester part of the vision is to promote easier access to health improving initiatives in the community and develop pilot initiatives where none exist with the aim to support social inclusion. The physical activity pilot has served to address this need.
- The pilot was delivered over 10 weeks in 2006 employing a qualified exercise tutor (from outside the mental health sector). It comprised a two hour session, twice weekly.
- The exercise tutor employed had to be a high risk instructor, i.e., qualified to work around cardiac rehabilitation as well as trained as a fitness instructor.
- The target group were in-patients of a mental health unit, Edale Unit (now called Edale House) in Central Manchester. They are people with severe mental illness (SMI).
- The pilot was a partnership between the Occupational Therapy Service at Edale Unit and Manchester Public Health Development Service.
- The aims were:
  - To provide access to physical activity sessions for clients who are unable to make use of mainstream services because of either a mental health section and/or because of their mental health symptoms.
  - To determine whether it is a useful method to engage in-patients in physical activity.
  - To provide a stepping stone to in-patients making use of mainstream services as part of the process to support people back into the community.
  - To raise the awareness of in-patients about what they can access in the community in regard to improving their health.
- The pilot has been very well received by both in-patients and staff. Successes have been changes in motivation to attend, e.g., participants have been informing other patients about the sessions, asking for the sessions, some people have managed to come regularly to sessions and an in-patient on being discharged being motivated to join a leisure centre.
- This pilot demonstrates that access to physical activity whilst in a hospital setting is useful to people with SMI as part of a process of supporting people to engage in physical activity, i.e., from participating in a hospital setting to taking part in community settings.
- The pilot has provided useful learning on ways of working effectively with clients in this setting on physical activity, including ways to motivate and engage people and what to observe in terms of progress; this has been translated into guidelines (given in appendix 1).
- The exercise sessions gave the opportunity to provide other health messages to the participants.

- The pilot has highlighted:
  - In-patients can gain substantial benefit from taking part in physical activity in a short space of time.
  - Attendance at the sessions fluctuates and is unpredictable and at times small; various factors affect participation, particularly a client's state of mental health which fluctuates, whether a client can leave the ward and availability of staff to provide one to one support during sessions.
  - A small group is best to engage and motivate clients in sessions.
  - The need for more than one weekly group session to make a sustained impact on changing the culture of inactivity on the wards.
  - More sessions are needed to meet diverse needs, e.g., clients who require one to one sessions, people who are older and less fit, clients who would be better in a female only environment.
  - The usefulness of having in place a graded route of access to physical activity whilst clients are in hospital as part of the process of people returning to the community, i.e., progressing from one to one sessions, to group sessions and finally to physical activity in the community.
  - Making use of a non-mental health exercise tutor is part of normalising people's experience.
  - Staff training needs in making use of gym equipment and being able to promote physical activity; this is being explored. There may also be a need for training on the benefits of exercise to mental health.
- One weekly session is still being delivered as the pilot demonstrated that this provision was needed and useful, particularly through making use of a qualified non-mental health tutor.

# Contents

<b>1. Introduction</b>	<b>4</b>
<b>2. Description of pilot</b>	<b>5</b>
2.1 Aims of the pilot	5
2.2 The clients and Edale Unit	5
2.3 Staff involved	6
2.4 Evaluation	6
2.5 Space available	6
2.6 Setting up the pilot	6
2.7 Continuation of sessions	7
<b>3. Learning and outcomes</b>	<b>8</b>
3.1 Factors that governed participation of clients	8
3.2 Delivery of session	8
3.3 Attendance and issues	10
3.4 Benefits and achievements	11
3.5 Factors have helped sessions be successful and effective so far	12
<b>4. Issues and needs for further developments</b>	<b>13</b>
4.1 Benefit of providing health promotion within an in-patient hospital setting	13
4.2 Breaking a culture of inactivity and meeting diverse needs in different ways	13
4.3 Training needs of staff	15
4.4 Links with community exercise providers and sign-posting to services	16
4.5 Improvements	16
<b>5. Conclusion</b>	<b>18</b>
<b>Appendices</b>	
<b>Appendix 1</b>	<b>19</b>
Guidelines for setting and delivering physical activity sessions for in-patients	
<b>Appendix 2</b>	<b>24</b>
Training needs	
<b>Appendix 3</b>	<b>25</b>
Need to develop links between exercise referral schemes and specialist mental health services such as Edale Unit	

# 1. Introduction

Choosing Health, the national public health strategy, has prioritised mental health and recognises the need to improve the physical health of people with mental health problems as huge health inequalities exist.

**People with poor mental health tend to experience worse physical health than the rest of the population. Yet there is evidence that a healthier lifestyle will help improve not just physical health, but also mental health, mood and wellbeing. For example, regular physical activity reduces the risk of depression and has positive benefits for mental health including reduced anxiety, enhanced mood and self-esteem. We need to do more to promote a more joined-up approach to NHS support for people with poor mental health. One early priority for NIMHE's anti stigma and discrimination programme is to address the physical health inequalities experienced by people with mental health problems.**

**People with severe mental illness (SMI) are 1.5 times more likely to die prematurely than those without; partly due to suicide, but also to death from respiratory and other diseases.**

**Depression is consistently been linked to mortality following a myocardial infarction; it increases the risk of heart disease fourfold, even when other risk factors like smoking are controlled for.**

**People with severe mental illnesses also tend to have a poor diet; they are more likely to be obese; to smoke more; to access routine health checks less frequently, and get less health promotion input than the general population.**

**Choosing Health-Making Healthy Choices Easier. Department of Health 2004**

In Manchester the two main local strategies which provide a framework for producing the much needed changes are:

- The Physical Health of People with Mental Health Problems Strategy.
- The Manchester Mental Health Promotion Strategy (2004-2010); a section on improving the health of people with recognised mental health problems, is included in theme Five, tackling health inequalities.

Part of the vision is to promote easier access to health improving initiatives in the community and develop pilot initiatives where none exist with the aim to support social inclusion. This pilot physical activity project has served to address this need.

The target group were in-patients of a mental health unit, Edale Unit (now called Edale House) in Central Manchester. They are people with severe and enduring mental illness (SMI).

## 2. Description of Pilot

The physical activity pilot was delivered over 10 weeks, comprising two weekly exercise sessions of two hours each.

The pilot arose from a partnership between the Occupational Therapy Service at Edale Unit in Central Manchester and Manchester Public Health Development Service.

### 2.1 Aims of the pilot

- To provide access to physical activity sessions for clients who are unable to make use of mainstream services because of either a mental health section and/or because of their mental health symptoms.
- To see whether it is a useful method to engage in-patients in physical activity.
- To provide a stepping stone to in-patients making use of mainstream services as part of the process to support people back into the community.
- To raise the awareness of in-patients about what they can access in the community in regard to improving their health.

The Occupational Therapy Service have a clear social inclusion agenda for clients and this includes:

- Providing an external professional as an exercise tutor, not part of the mental health team.
- Clients being offered mainstream activities; there is a need to improve links with mainstream providers and enable clients to have consistent access to these services.

### 2.2 The Clients of Edale Unit

- The people that come into the Unit are in crisis. There are many patients who are very unwell. Significant numbers are homeless and have no where to go. They are very demotivated and tend to be withdrawn. Vast majority are on mental health sections and therefore on compulsory detention.
- The majority in the Unit are male. Some are fairly overweight and unfit. Many smoke, and some medications have the side effect of making clients more hungry which in turn leads to significant increases in weight.
- In-patients often do not have access to community leisure and sports facilities during phases of their admission and they often do not have the skills or motivation to access facilities without prompting and guidance.

A few of the in-patients are confident in making use of leisure facilities but others because of the above reasons need some input on the premises. These are the people who were particularly targeted.

- Low grade activity does happen on the wards and sporadic health promotion goes on. Consistency of activity is lacking though. A few clients go to Moss Side Leisure centre, art groups and relaxation groups in the community.

## 2.3 Staff involved

### Exercise Tutor

Because of the clients' physical health needs and mental health issues the exercise tutor employed had to be a high risk instructor, i.e., qualified to work around cardiac rehabilitation as well as trained as a fitness instructor. Her qualifications included exercise to music, BOWLER weights instruction (to give weights instruction) and BACR, British Heart Association for Cardiac Rehabilitation, Phase IV and gym experience of 4 years. It was necessary for her to be CRB checked.

### Edale Unit Staff

A member of the Occupational Therapists (O.T.s) team took part at each session, including a Technical Instructor (support worker) and nursing assistants took part if a participant required one to one supervision.

## 2.4 Evaluation

Each session was evaluated through two forms for staff to give their feedback and observations for each participant and for each session. Evaluation proformas were devised for this purpose.

At the end of this 10 week period the main support staff involved in this pilot provided written observations and /or were interviewed for their observations. Participating staff also obtain verbal reports from both patients and staff in an ongoing way to ensure the effectiveness of sessions.

## 2.5 Space Available

The physical activity space at Edale Unit could hold a maximum of 6 people given the need to have some patients supervised because of risk assessment issues.

## 2.6 Setting up the pilot

A great deal of planning was involved in the initial stages:

- **Finding an appropriately qualified tutor:** the O.T. service ideally wanted input from Manchester Leisure as part of their social inclusion agenda, so that the tutor could inform clients of what was available to them in the community.

This process revealed a lack of fitness instructors with the necessary skills within Manchester Leisure at that time. In addition Manchester Leisure had not explored working in a hospital setting and there would still have been cost implications.

Therefore other options were explored, such as freelance instructors who were appropriately qualified.

- **Choosing the best time for the sessions;** afternoons were chosen as most clients have problems getting up in the morning and are slow to engage in any activity. Much of this is to do with a reversal of their sleep pattern, in getting to bed late and getting up late, generally not having much to get up for and some taking their medication in the morning which can make them drowsy.
- **Preliminary meetings** took place involving the Occupational Therapist, Public Health Development Advisor and the Exercise Tutor to ensure the smooth running

of the sessions; these served to make clear their expectations of the sessions, provide induction on the mental health environment for the tutor, and negotiate the format of the sessions.

## **2.7 Continuation of sessions**

One of the sessions is currently continuing at present because at the end of the pilot the exercise tutor was able to take on the session as part of her core work within Manchester Public Health Development Service through an expansion of her job. This report is therefore written in the context of this positive development.

### 3. Learning and outcomes

#### 3.1 Factors that governed participation of clients

The sessions were run in the context of various factors that govern whether in-patients could take part or not. A consequence of these factors was that the numbers in attendance fluctuated.

The factors that govern participation are:

- Clients are engaged in many other activities, i.e., appointment with a doctor or Community Psychiatric Nurse (C.P.N.), or community appointments.
- Clients and the exercise group numbers are restricted due to risk management issues:
  - A client's "leave" from the hospital ward may be subject to having an escort to support/supervise their attendance in the gym, e.g., if there is a risk of someone absconding, if they have a mental health section 3, if they are very unwell.

It is difficult to know before the session how many people are so ill that they require one to one support as illness is fairly unpredictable.

- Rapid changes can occur in a patient's risk management.

Clients can lose their leave from the ward because of risk issues occurring, e.g., a client having drunk alcohol and having an impact on their mental health; someone having a confrontation with another patient.
- The group numbers are restricted due to the number of clients who can safely be accommodated in the gym.
- If clients have bipolar disorder they can be quite high in mood. The group have to limit numbers of people because of this.
- Availability of nursing staff to accompany clients requiring one to one support during sessions.
- Clients' mental health tends to fluctuate; they have good days and bad days, they can be well in the morning but unwell by the afternoon and vice versa.
- Clients cannot be forced to attend activities and motivation is a significant factor particularly in schizophrenia; this is a negative symptom of schizophrenia and makes people isolative, removes their desire to do things and disengages them from life as well.
- Over the 10 week period some sessions did not take place because of lack of staff, sickness and holidays.

## **3.2 Delivery of sessions**

Each session involved adequate time to set up, a process of recruiting and collecting participants from the wards, delivering the physical activity session and having an evaluation debrief at the end. Fruit and water were provided during each session.

The exercise tutor had to have someone with her all the time; a nurse or an O.T.

### **3.2.1 Recruitment onto pilot sessions**

- Colour posters were put up in each ward. However these had minimal impact and were unlikely to be a motivator.
- Risk assessment is on-going on the wards and figured importantly in the process of recruiting onto the sessions and during the delivery, (as explained in section 3.1).
- Both exercise tutor and O.T. went onto the wards to recruit and collect participants. Nursing staff on each ward were approached initially to identify interest and receive a handover regarding the suitability of clients for the activity, who had “leave” from the ward and those who needed one to one support/supervision. They had to ascertain whether any staff could accompany those requiring supervision and sometimes there was none. Clients were then taken to the gym together.

The participation of nurses in this process depended on their time availability, e.g., if they were too busy they were then unlikely to be motivated to stop and give recruitment information.

- Ward staff were generally very supportive and interested.
- This process enabled them to eventually know regular participants and be proactive in asking for them.
- To encourage involvement they explained the positive benefits about engaging in physical activity and emphasised that people can do the session as long as they want. It depended on each individual if this input worked.
- All wards took part: Brook, Grafton, Nelson and Oxford. They did not proactively recruit participants from Oxford Ward as it is the intensive care/secure ward in which patients generally require calm and minimal stimulation. Clients from this ward therefore only took part if it was a planned intervention.

### **3.2.2 Improvements to the recruitment process**

The process of gathering clients to start the session takes an hour. This process could be improved if nurses were prompted /forewarned before the two hour session or had the session registered in their minds to remind patients about it and to have already identified suitable candidates. However nurses tend to be very busy.

### **3.2.3 Exercise carried out**

The structured exercise sessions were used comprising warm up, circuit type sessions to build cardio-vascular strength (using a number of different stations) and cool down stretch. This was subject to the needs of the group.

### 3.2.4 Exercising in between sessions

- Generally no measures were set up for participants to continue exercising in between sessions, although it is regarded as a good idea. There are factors that may make this difficult, e.g., nursing staff are very busy.

The only exception to this was that the exercise tutor gave participants warm up sheets to take away to do in between sessions. There is no feedback on whether anyone did this. This would also require the full co-operation of nurses on the ward to work well.

- The exercise tutor suggested the possibility of doing a session on the ward; the feasibility of this has not been explored. For example, the exercise tutor did teach salsa steps, and given there is music on the wards clients could do this on the wards.
- Staff have always engaged clients in physical activity, e.g., table tennis, football, going for a walk and badminton. This takes place in an adhoc way and generally on a one to one basis. It may be related to someone's mental health state, e.g., to cool off as part of symptom management or to get a client motivated.
- There is generally need for more exercise sessions involving a qualified exercise tutor (see section 4.2 below).

### 3.3 Attendance and issues

- Clients from all wards participated. Most people attending had bipolar disorder or schizophrenia. Many had high heart rates due to their medication.
- The participants were not always the same at each session because of the unpredictability of people's mental health state, risk assessment issues and people being discharged from the hospital.
- At least 30 people went through the programme during the 10 weeks; some did attend regularly over a few sessions and three attended 7-8 sessions. During this period only 4 women took part.
- The average maximum attendance was six (as indicated above this was the maximum limit possible in the physical space available and given some people need one to one supervision). Numbers were often smaller than six given the factors indicated in section 3.1.
- Participants vary in relation to their level and length of participation depending on how they are. Some participants just observe, some leave after a few minutes and some may stay for all the session. Some people can only cope with 30 minutes and then wish to leave.
- Some men coming to the pilot sessions looked deceptively fit but they were not, i.e., they looked young, lean and muscular; they exercised over intensively for 5 minutes and then had to have a rest. They informed the tutor that they had done little or no physical activity in the last 3-6 months.
- Participants had various issues:
  - Poor attention span
  - Poor ability to socialise

- Poor motivation
  - Poor concentration
  - Lack of co-ordination
  - Lack of motivation
  - Boundary less at times
  - Being quite chaotic
  - Break through symptoms
- Even though participants are risk assessed for attendance they still need to be assessed during each session, e.g., they can become aroused or psychotic because they are in a group environment.
  - The pattern of attendance observed by O.T. staff has been:
    - Clients whom have attended regularly and have developed a routine; they are very motivated, are clearly gaining a huge benefit and are moving on, being discharged from the hospital.
    - Those that are in a period of convalescence attend as they start to get better. Once they have convalesced they start to not engage as they move onto their usual life, e.g., see their families, take on other responsibilities.
    - Those that do not attend are really unwell.

### 3.4 Benefits and achievements

- **Progression in relation to motivation to attend class**, from being prompted to eventually becoming part of their daily life. For example clients:
    - Have been giving other clients positive feedback about the sessions.
    - Have tried to motivate other patients.
    - Have been waiting in the wards for the sessions.
    - Have expressed to staff that they were looking forward to the class and asking when the next session would be.
    - Have returned to participate in further sessions.
- An example of a dramatic change in motivation:**  
 One client would be in bed and initially required a lot of prompting to take part in the sessions.  
  
 Subsequently he would leap out of bed even though he had been asleep so that he could participate.
- **Progression observed during sessions included changes in individuals** in:
    - Animation, e.g., from client being “straight faced” when the tutor interacted with them to becoming a bit more animated in the voice to becoming more and more relaxed.
    - Emotional and mental state, e.g., client coming in tearful to becoming more composed, less shaky and ready to cope with what she had to deal with outside of the session.
    - Level of participation, e.g., one person just observed in the first session, in second session participated in and out, in third session completed all the session, (and was more animated and not as “flat”).
  - **Progression of the whole group** was reflected by:
    - Participants moving from making initial monosyllabic responses, i.e., “flat” conversation to becoming more relaxed and more engaged.
    - The tutor being able to converse with clients more, draw a little more from them, and people becoming less defensive and creating laughter in the group.

- After each session clients have felt a bit brighter in mood and up lifted, ready to have a shower and have some food.
- Clients have recognised the value of participating in structured exercise activity, e.g., several have vocalised positive benefits to staff, stating that they “felt better”, “more relaxed”, “less tense” and “more awake” after sessions.
- Exercise has made them more motivated to do other activities outside of the session including activities offered by the staff.
- Exercise sessions have prompted clients to ask staff for other physical activity, e.g., 1-2 clients expressed interest to make use of Moss Side Leisure Centre.
- All the men that were regular attendees, about 5, were discharged from hospital because they became well enough to leave; the question is whether this was due to the exercise or was it part of their mental health improvement that they accepted exercise. Staff perception is the exercise helped them get better alongside everything else offered to them during their time in hospital.
- The exercise tutor did a salsa class which was enjoyed; it was accepted by two men who the tutor thought would not take to it because they lacked co-ordination and who to their surprise really enjoyed it. Even though they lacked coordination and the steps were complex, they were successful in learning the steps as the tutor paced the teaching to suit them and gave them adequate time to learn.
- The exercise sessions were always attended.
- Staff that have been at the sessions felt great afterwards saying that they as staff could do something for themselves.
- The tutor gained valuable experience of ways of working effectively with clients with severe mental illness enabling the guidelines mentioned in section 3.5 to be drawn.

### **3.5 Factors that have helped sessions be successful and effective**

Various factors have contributed to the sessions being successful and effective:

- Employing ways to motivate and engage clients during the sessions.
- Working partnership between the exercise tutor, the O.T. staff and the ward staff.
- The qualities and skills of the exercise tutor; the exercise tutor’s keen and enthusiastic attitude towards how the exercise can benefit people and engage people was one of the main factors sited by one of the co-workers.
- Evaluation; using evaluation sheets have made the group sessions more effective.
- Blood pressure monitoring.
- Size of the group; a small group proved best to motivate people.
- Explaining the benefits of exercise to their health and well being.
- Giving positive feedback during sessions to clients on doing well added to the success of sessions.
- A friendly environment; this was helped and created by the positive relationship between the exercise tutor and O.T. staff.

The pilot has provided valuable learning which has been translated into guidelines which are given in appendix 1.

## **4. Issues and needs for further developments**

### **4.1 Benefit of providing health promotion within an in-patient hospital setting**

There are many reasons why an in-patient setting is as important for health promotion as in the community which this pilot supports:

- Many mental health service users are socially isolative and therefore may be harder to reach when back in the community.

Whilst in hospital they are a captive audience and health improvement activity on-site is likely to be a motivating factor as they have easy access to it. Other positive factors to motivate them are:

- They are in a familiar setting.
- They have the support of staff on hand.
- The activity is likely to fill a gap in their day.

This pilot demonstrates that clients can engage and benefit from physical activity provision whilst in hospital.

There is therefore huge benefit in offering in-patients intensive health promotion services, support and information while they are in hospital so that this can be more easily taken up once they return to the community.

- There is likely to be people who stay much longer in the wards because their needs for specialist housing can take a while to be met.
- Access to physical activity in the hospital would form an important part of a graded route of access to physical activity for people with SMI (as described in section 4.2.3).

Given these reasons despite future changes (a) in length of stay for in-patients, a reduction from 90 days to 28 days and (b) much of the mental health service provision moving from specialist mental health services to the community there is a case to equally invest in an in-patient setting.

### **4.2 Breaking a culture of inactivity and meeting diverse needs in different ways**

The pilot demonstrates that the two group exercise sessions have been well received and this continues to be the case with the single session that is currently been provided. However more sessions are needed because of the following factors:

- In general there has been a culture of inactivity on the wards and to break this culture requires a level of input which is not currently achieved with only one session.
- Many people with severe mental illness on the wards tend to find group situations difficult. However the pilot has identified that in-patients in common with people in the community have diverse needs:
  - There are people who are socially isolative and will not go into a group situation; they do not build relationships easily, dealing with

communication with people is difficult, they can misinterpret information and tend to isolate themselves.

- There are those who will engage in group activities when they are well.
- In between there is a spectrum of clients in the process of getting well; their mental health can fluctuate and this governs whether they participate in group situations.

#### 4.2.1 Need for one to one physical activity support

There are people requiring one to one support and a low stimulus environment. In addition there are others who may want exercise but it would be best provided through one to one support:

- People can be really psychotic but still have physical health needs.

At present in the evening a nursing assistant may take a patient from Oxford Ward, the intensive care/secure ward into the gym to play e.g., table tennis.

- Some clients can have risks around being with people; they have “good” weeks as well as “bad” days.

When people are not well they can be very problematic but they can have times when they are well and can make use of physical activity.

- People who are paranoid, not dangerous and of no risk but would engage better on one to one.
- People who can become sexually disinhibited (boundary less) and a bit inappropriate but they can concentrate well in a low stimulus environment, e.g., for 20 minutes.
- With bi-polar disorder, if a client becomes aroused and elated, it can be very interfering to others and detrimental to their own mental state and to others, e.g. if in an atmosphere with music and people.
- At times people with schizophrenia cannot understand communication. Group situations can be complex and difficult for them and they can find it difficult to interpret what’s going on, particularly in the gym which is very different to the ward, e.g., it is echoey, may have loud music and therefore can be very daunting for clients.

#### 4.2.2 Need for different exercise groups

Within the exercise groups there are people with different needs:

- **Some people who attend are younger and fitter;** they tend to have the most difficult management problems with their mental health symptoms and need a faster pace of exercise. This group tend to “take over” in group situations and need a great deal of input.
- **People who are older, slower, less fit** and tend to be heavy smokers require a low stimulus environment with lower level exercise. They need encouragement to

engage in physical activity but at a different pace. They tend to be long term patients and they have less management problems with their symptoms.

- **20-30 % of the in-patient clientele at Edale Unit are female** but they are not well represented in the exercise group because of the nature of the group; there is a predominance of males who are quite loud and boisterous and the women tend not to want to engage in this environment. In addition the group can have an emphasis on activity such as football which may not appeal to women.
- **Young women** on the wards tend to be very difficult to engage and work with; offering them appropriate activities on a regular basis may engage them, e.g., an aerobics class; there is a need however to consult them on what would be appropriate, e.g., through women who are much better.
- There are some people who are more motivated and some people more capable than others exercise-wise such as the younger people.
- **Patients tend to become fully alert in the evening**, after 5-6pm and an evening session is likely to be well received.

In a group with diverse needs the tendency is to maintain the engagement of the most difficult person to engage, e.g., someone with poor concentration and the whole session becomes more tailored to their need.

#### **4.2.3 Proposed model of exercise provision for in-patients**

In relation to the diverse needs outlined above:

- **Graded route to introduce clients to physical activity**  
As part of the process to re-integrate clients into society and be back in their own homes there is a need to grade their engagement in exercise:
  - On admission people are not able to engage in much activity but as they become stable and are able to engage they can have access to one to one exercise sessions (10-20 minutes) with the tutor.
  - They can then progress to making use of the group sessions
  - They can then move on to more socially inclusive options such as sports drop-ins, the Aquatic Centre and exercise on referral schemes.
- **The provision of various group activities** to meet the different needs outline above, e.g., an evening group, a group for beginners and people who want to lose weight, an intermediate group for sporty exercise, a young women's group, etc.
- **Ideally patients should be consulted** on what they would like to do.

### **4.3 Training needs of staff**

The pilot highlighted training needs for staff in physical activity especially in relation to:

- Making use of gym equipment which Edale House, the new hospital site acquired. Exercise in health practitioners were consulted to determine whether:
  - Staff could be trained in supervising users in making use of the equipment.
  - What physical activity unit staff could safely support patients in.
- Promoting physical activity on the wards.

Developments in regard to this are given in appendix 2.

### **4.4 Links with community exercise providers and sign – posting to services**

There is a need for in-patients to access services provided in the community such as the exercise on referral schemes and their health trainers.

In general there have been issues with people with severe and enduring mental health problems making use of these services, although some people with mental health problems have been benefiting, particularly referrals from primary care.

To address this gap various interventions need to be explored:

- Improving sign posting about community activities through:
  - Access to information on the Internet.
  - Provide a rack of leaflets about community activities and health information.
  - Develop some supporting health information packs.
  - Access to training for staff on what is available in the community through Manchester Public Health Development Service.
- Developing links between the exercise on referral schemes and specialist mental health services.

Some developments in regard to this are given in appendices 2 and 3.

### **4.5 Improvements**

Further needs have been highlighted to improve the provision of physical activity in the hospital:

- Information for staff about the benefits of physical activity as some staff may not know why exercise is useful.
- More time to prepare for sessions.

#### **Cover for exercise tutor**

There is a need to cover for the tutor when she is on holiday or sick rather than cancel sessions.

## **Supervision**

The exercise tutor needs to have access to supervision from a mental health practitioner whenever this is needed given the nature of this client group and their issues.

## **More training for the exercise tutor**

Although the tutor has been through an induction she may find it useful to have further input on mental health. For example:

- Simple explanation of mental illnesses, how people feel when they become unwell and how to respond to difficult situations such as aggression. This may re-iterate some of the experience the tutor has acquired as she is very aware.
- Effects of medication, e.g., if people are sedated.

There is the possibility of the tutor accessing training that the Manchester Mental Health and Social Care Trust deliver.

## **Future support for physical activity sessions**

The Occupational Therapy Service has provided much of the support to sustain the delivery of the sessions. It is hoped that in future responsibility for the sessions can be passed to other professions.

## 5. Conclusions

The pilot was undoubtedly a success; as one group session has continued the staff and clients have begun to expect this activity regularly which is a reflection of the change in culture.

The pilot has highlighted:

- Clients do engage and respond positively to organised physical activity whilst they are in-patients.
- In-patients can gain substantial benefit from taking part in physical activity in a short space of time.
- The group exercise model is useful in engaging in-patients in physical activity.
- The need for more than one weekly group session to make a sustained impact on changing the culture of inactivity on the wards.
- More sessions are needed to meet diverse needs, e.g., clients who require one to one sessions, people who are older and less fit, clients who would be better in a female only environment.
- The usefulness of having in place a graded route of access to physical activity whilst clients are in hospital as part of the process of people returning to the community, i.e., progressing from one to one sessions, to group sessions and finally to physical activity in community .
- Making use of a non-mental health exercise tutor is part of normalising people's experience.
- Ways to work successfully with in-patients in motivating them in exercise.
- Ways in which other aspects of health can be integrated in the sessions.
- Numbers can fluctuate and be small because of factors such as risk assessment issues, the unpredictability of client's state of mental health which can fluctuate from day to day and over a period of a day and the availability of staff to escort those who need one to one support during sessions. It is therefore hard to predict who is able to take part before each session.
- A small group is best to engage and motivate clients in sessions.
- The need to improve:
  - Links between physical activity providers and specialist mental health services; this is being explored.
  - Sign-posting to community services through improving access to information via e.g., the Internet, leaflets, training for staff.
- Staff training needs in making use of gym equipment and being able to promote physical activity; this is being explored. There may also be a need for training on the benefits of exercise to mental health.

**An in-patient setting is very useful** to engage people in health promotion activity before they are discharged as they are easy to access and are engaged in the therapeutic process. This provides the opportunity for patients to become motivated in taking an interest in their health and this may then continue on returning to their homes through being given relevant information and links/referrals to services in the community.

## **Appendix 1**

### **Guidelines for setting and delivering physical activity sessions for in-patients**

#### **Working relationship**

- There should be a close working relationship between the exercise tutor and hospital staff member(s) to ensure sessions are successful and safe, especially when the tutor is not from a mental health background and familiar with the clients.
- The tutor should have a regular contact person(s) in the hospital.
- The tutor should carry out the exercise sessions with a regular member of staff in addition to staff that provide one to one support for participants on the sessions.
- Different aspects need to inform this relationship:
  - Communicating well with each other and having trust.
  - On going discussions between staff involved on anything to improve sessions/situation.
  - An introduction to the tutor of participants by their nurse/carer/support worker is useful to develop rapport and ease with the respective client.
  - Information and feedback from the staff to the tutor about clients, gaining insight into their behaviour, their state of mental health and their progress in order for the tutor to increase empathy and awareness about clients and their needs, know that the exercise is making an impact, gain insight into difficulties and handle situations well.
  - Part of the hospital staff role should be to observe and be responsible for the clients.
  - Good clinical handovers from nursing staff, i.e., on who is appropriate to come to sessions.

#### **Exercise tutor**

- Having an external exercise tutor (i.e., from outside the mental health field) is supportive of social inclusion as it gives clients the sense that this is just a normal session and therefore normalises their experience.
- The exercise tutor needs to be:
  - A high risk fitness instructor, i.e., qualified to work around cardiac rehabilitation as well as trained as a fitness instructor.
  - An experienced mature instructor; who projects a certain presence that they can handle the group.
  - Enthusiastic, warm, friendly.
  - Highly skilled and motivated.
  - Able to keep the participants focussed and work with the dynamics in the group.
  - Able to adapt the delivery to different groups and individual needs
  - Have an awareness of and be able to deal with boundary issues, e.g., males with bipolar disorder can intrude into other people's personal space.

- Flexible, able to think on his/her feet and react fast enough particularly in relation to boundary issues, e.g., in giving exercise instructions which people do not want to follow.
  - Sensitive and aware of the needs of individuals.
  - Have mental health awareness training.
- A female tutor needs to be aware of what she is wearing as clients can be disinhibited because of their mental state; their mental boundaries may be down because of their illness and staff have to be aware and compensate for that.

### **Attendance on sessions**

Attendance is likely to be inconsistent and variable, and consequently sometimes very small because:

- The nature of people's mental illness is unpredictable; their mental health can fluctuate during the period of a day and from one day to another.
- In order to take part they may require one to one support/supervision to leave the ward; this is subject to staff availability.
- They do not have leave from the ward because either they are so unwell or they have lost their leave for other reasons, e.g., behaving inappropriately even though they may be keen to take part

### **Recruitment**

- Involvement of hospital staff who have a relationship with the client is important to motivate people.
- Exercise tutor should ideally accompany staff members onto wards to assist in the recruitment process whenever possible so that:
  - Clients become familiar with her/him.
  - They see the clients in their every day situation and environment.
  - Meet people that participants link with.
  - Obtain extra information from the staff about the well being of clients.
- The nursing staff should be fully involved in the recruitment process to indicate which clients are suitable to approach, i.e., those who have leave and who need support/supervision. Ideally nursing staff should already have identified suitable clients for attendance and escorts if necessary.
- The exercise tutor should not approach patients without first checking with nursing staff about their suitability.

### **Briefing and debriefing**

- Adequate time is required before each session to have a handover and briefing and to set up the room and gather people. About 15-20 minutes is needed for a handover. The purpose of the handover is to share on needs and issues in regard to in-patients and to be adequately prepared and focussed for the session.
- A debrief should be in place at the end of the session to monitor and review how the session goes. About 45 minutes-one hour 15 minutes is needed to ensure thorough evaluation during the initial sessions.

### **Evaluation**

- Having a formal evaluation structured in at the end of each session to monitor and make alterations/ improvements is ideal.
- Evaluation should be about each client and in relation to the whole session.

- Evaluation should be carried out consistently for the first 10 sessions and then can be tailed off to once or twice within a 4 week period so that information is still obtained on anything that should be altered or improved.

### **Type of exercise sessions**

- In-patients are likely to have diverse needs in relation to their state of mental health and level of fitness; a group with diverse needs is likely to be hard to manage. Activities set up should be sensitive to this, e.g., more fit, older, less fit, women.
- One to one sessions are likely to be useful for clients who need low stimulus environments and /or are high risk; this has not been piloted to assess usefulness and effectiveness.
- A graded route may be useful in which in-patients have access to one to one sessions, then can move onto in-patient group activity and then onto more community based activity.

### **Engaging and motivating patients during exercise**

To keep participants engaged and motivated:

- Exercise sessions need to:
  - Be simple and clear to understand
  - Use simple movements requiring not much coordination as co-ordination movements are likely to be hard to follow and mirror e.g., people with schizophrenia have difficulty in motor control and co-ordination.

Circuits like banging the football on the wall and some running, but with a great deal of structure to the activity are very well received.

- Be structured but be very flexible so as to not demotivate participants and decrease their confidence., e.g.,
  - If someone cannot complete the full session they can stop, have a rest, observe or leave.
  - If a client does not want to do something to not force them but offer other alternatives.
  - Do not correct a client from their own interpretation of the activity so long as they are not injuring themselves.
- Emphasise that people can rest if they want and also continually keep an eye on people needing a rest.
- Keep verbal information brief as participants do not respond well to being stood around and need to get started with the activity as soon as possible.
- Keep participants physically active but have breaks (as appropriate) to allow for rest, social interaction and smoking (in line with no smoking policies); breaks also serve to slow down clients overdoing exercise and allows people that need to take a rest to do so without being noticed by others and feeling guilty.
- Breaks should be short, e.g., 2 minutes
- Breaks should provide water and can be a useful opportunity to integrate other health messages, such as provision of fresh fruits .
- Breaks allow the exercise tutor to explain and reiterate certain benefits.

- Include opportunities for the tutor to develop trust and rapport with the clients, e.g., through breaks, providing fruit and through blood pressure monitoring
  - Best to do circuit exercises as a group because of people's lack of motivation
  - Staff should understand the value of physical activity to encourage participants.
  - Staff should ideally participate in the session to:
    - Reflect to participants that physical activity is enjoyable and to therefore maintain their interest and participation.
    - Maintain momentum during the session.
- Clients will relate to seeing staff engaging in exercise; this makes it easier for participants to not sit out and to be involved.
- Clients may need prompting continually throughout the session to remain focussed, e.g., verbal encouragement.
  - One to one mirroring with a client helps if they are struggling to do a movement.
  - Boundaries need to be clearly set to avoid disruption and maintain participation.
  - Some clients need activities that are a bit silly to relax and engage.
  - Clients need to be observed continually for break through symptoms, e.g., if some one is disturbed to give them a "prod" in order to sustain their involvement.
  - Some clients have a great deal of energy to channel and therefore to be able to shout and know its acceptable is useful.
  - A small group is best (see "size of group" below).

### **Delivering exercise sessions**

- Need to recognise that it is not a predictable group of people
- Cannot have a preconception; have a structured programme but be prepared to be flexible, depending on someone's:
  - Mood
  - Level
  - Capability
  - Likes / dislikes
- Thinking on your feet is needed and reacting fast enough, taking account of:
  - What the participant wants
  - Safety element
  - You do not want to lose the engagement of the individual
  - How you can be flexible
- Avoid the martial arts movements, i.e. punching and kicking exercises unless you know the group members.
- Need to keep the group together, i.e., acknowledging what is going on in the group, such as someone having break through symptoms without letting it break down the group.

### **Measuring progress**

- Progress is not so much about changes in people's fitness level. Fitness level should be looked at in terms of:
  - How well an individual can keep up with a movement
  - How long they can sustain it
  - How many rests they require.
- Progress can be measured through:
  - Changes in how motivated people are to come to the class, e.g., eagerness to take part

- Changes in staying power in class to exercise, i.e., how long they stayed in the class.
- Changes in how they feel about the class and how relaxed they are; depending on how comfortable they feel in the class they are likely to come back.
- Changes in individuals e.g., more animated facially and verbally, more stable emotionally and mentally, less defensive, more up lifted in mood
- Changes in the group, e.g., conversation becoming more relaxed and engaged, laughter
- Changes outside the group, e.g., more willing to engage in other activities
- Changes in attendance, e.g., regularity
- Feedback from nursing staff, Occupational Therapists and Technical Instructors about positive changes observed outside of sessions

### **Size of the group**

- A small group is best as it:
  - Enables staff to observe the group better and pick up on individual needs.

There is a great deal for staff to “watch/keep an eye” on in the group, e.g., when someone becomes symptomatic, such as “staring out”, they have to be diverted as it can otherwise take the client away from the session; exercise is a good tool to distract them from their mental health symptoms.

  - Enables the group to be more conducive to conversation especially for those attending regularly.
  - Allows the tutor more interaction with individuals which is necessary to develop rapport and trust.
- A small group may also be necessary to allow the physical space for those clients who need to be accompanied by a nursing staff supervisor.

### **Blood pressure monitoring**

- Clients are likely to be interested in having their blood pressure monitored as it informs them and adds to their awareness about their general health.
- Blood pressure monitoring requires a flexible approach by the exercise tutor as it needs to:
  - Be done with awareness of clients that tend to worry.
  - Avoid having clients waiting around in case they get demotivated.

Therefore whether, when and how blood pressure monitoring is done needs careful consideration.

- Blood pressure monitoring provides the tutor with the opportunity to provide information about other health issues, e.g., how smoking reduction and exercise benefits blood pressure

### **Staff training**

- All staff should have awareness and knowledge of the benefits of physical activity to improving mental health. This is useful to recruit clients onto the sessions and motivate them during sessions.

## **Appendix 2**

### **Training needs**

#### **Training to use gym equipment**

Gym cardio-vascular equipment is being used in the on-going sessions. Some difficulties have been highlighted in using the equipment in a group setting as there is a need to support participants on a one to one basis as they are chaotic. The group cohesiveness is lost because people need a lot of support.

For the rest of the week the equipment is not being used although there is the desire for staff to support patients to make use of it. Exercise in health practitioners revealed that as a rule hospital staff should only supervise in-patients in low risk exercise unless they are adequately trained; this would require them to have a high risk instructor qualification and be trained in cardiac rehabilitation as their clients have complex needs. Staff need to have knowledge and skills on, for example:

- Principles of warming people up
- If heart rate increased rapidly what to do

Otherwise they may be open to liability.

One solution that is likely to be taken forward is a half day training session on “supervising the use of the exercise bikes” for Edale House staff by the Public Health Development Advisor (CHD Prevention) and the Exercise Tutor. This has been assessed as feasible given bikes have fairly restrictive movement that could allow vigorous activity and would be fairly easy to observe how people are reacting to it.

#### **Further training needs**

The Public Health Development Advisor (CHD Prevention) met with the O.T. Team leader to discuss their training and development needs and has provided:

- Information on what the staff can access via the department’s training programme, providing copies of the Training Programme brochure

Staff are busy all the time and attending training would be at the discretion of their manager.

As there is continual staff turn over another possibility is to set up promoting physical activity as part of the staff induction training. This has yet to be explored.

- Contact information on the three Exercise on Referral Schemes in Manchester

## **Appendix 3**

### **Need to develop links between exercise referral schemes and specialist mental health services such as Edale Unit**

Developments are in progress to improve access to the three exercise on referral schemes for people with severe mental illness.

The three exercise referral schemes, the Health Trainer Project and specialist mental health services have met to develop links and mechanisms. There will be a process of training for the exercise on referral schemes and their health trainers on mental health awareness, impact of medication, and structure of mental health services, followed by networking, development of closer links and relationships and visits to mental health services to develop an understanding of people's experiences.

This will be consolidated with a discussion on what mechanisms need to be set up so that people with SMI can access the services, what support needs to be in place for the client and the exercise referral schemes so that both are safe and what can be set up so that mental health services know what clients can access.

**Produced by Shamin Malik, Public Health Development Advisor (Mental Health)  
Manchester Public Health Development Service, Mauldeth House, Mauldeth Road  
West, Chorlton, Manchester, M21 7RL  
Tel: 0161 882 2309  
E-mail: [shamin.malik@manchester.nhs.uk](mailto:shamin.malik@manchester.nhs.uk)  
December 2006**