Alberta Centre for Active Living

Research and education for the promotion of physical activity

Mental Health and Physical Activity Workshop Summary

By Tanya Berry, PhD, Research Associate, Alberta Centre for Active Living

Although growing evidence suggests that regular physical activity can help prevent and treat mental illnesses, there are few suitable physical activity programs. In response to this need, on May 16, 2006, the Alberta Centre for Active Living, in partnership with the Alberta Mental Health Board, offered a one-day workshop on physical activity and mental health treatment and prevention.

What the Research Says about Physical Activity and Mental Health

The research indicates that physical activity is effective across a wide spectrum of mental health issues. At one end of the continuum, physical activity is associated with positive mental health (Rohrer, Pierce, & Blackburn, 2005), including higher self-esteem (Fox, 2000), well-being (Biddle, Fox, & Boutcher, 2000), and health-related quality of life (Rejeski, Brawley, & Shumaker, 1996).

Other researchers have noted that physical activity can improve mood and lessen the symptoms of specific conditions such as depression and anxiety (Penedo & Dahn, 2005). Southwick and colleagues (2005) reviewed literature that showed the positive effects of exercise on depressive symptoms across a wide range of populations. These groups included healthy people and those with cancer, neuromuscular disorders, cardiac disease, or chronic pulmonary obstructive disease.

Southwick, Vythilingam, & Charney (2005) also discuss research showing exercise as effective in treating clinical depression across different ages, from young adults through middle-aged and older adults. At the other end of the spectrum, there is evidence that physical activity programs can benefit those with severe psychiatric problems such as schizophrenia (Ohlsen, Peacock, & Smith, 2005).

While Ohlsen and colleagues (2005) argue for the cost effectiveness of incorporating physical activity programs into clinical practice, they also comment on the great need to develop positive lifestyle programs for the mentally ill. Similarly, Richardson et al. (2005) outlined three reasons why physical activity programs should be integrated into mental health services.

- Frequent contact with mental health service providers offers the opportunity for frequent positive feedback about exercise.
- Mental health service providers are trained to understand the vagaries of mental illness and so can better address specific barriers those with mental illnesses might face.
- Physical activity may help in recovery.

Despite these recommendations, people with mental illness generally exercise less than the general population. In addition, the physical activity programs available to those with mental illnesses are often fragmented (Richardson et al., 2005). Faulkner and Biddle (2001) identified three barriers (see below) to integrating physical activity into mental health programs:

- mental health clinicians' lack of knowledge about the therapeutic benefits of exercise;
- the perceived simplicity of exercise programs;
- the incompatibility of exercise programs with traditional treatments.

These authors suggest that the challenge for physical activity and mental health specialists is to "seek a more unified approach to treatment" (p. 443). Such an approach fits with the direction that the province of Alberta is taking in its provincial mental health plan. This document "highlights the central role research can and must play in improving mental health services and outcomes" (Alberta Mental Health Board, 2005, p. 3).

Why We Held this Workshop

We wanted to begin a dialogue between physical activity researchers and mental health workers about how to incorporate physical activity into mental health prevention and treatment programs. This workshop was designed in part to support the key area outlined in Alberta's provincial mental health plan: "fostering strategic partnerships—Bridging academia, service organizations, care providers and policy makers" (Alberta Mental Health Board, 2005, p. 5).

The specific objectives of this workshop were to

- address physical activity interventions as alternative approaches to integrating services for those with mental illness as a way of further managing their disease;
- create networks to allow for the development of grant proposals to further research the relationship between mental health and physical activity, with a particular emphasis on practical applications.

Participants included

- physical activity researchers from the Universities of Alberta, Calgary, Saskatchewan, Toronto, and Lethbridge;
- representatives from the Alberta Mental Health Board, Alberta Health and Wellness, and Alberta Community Development;
- mental health promotion specialists;
- psychologists;
- occupational therapists; and
- physical activity practitioners.

Summing Up the Workshop

PRESENTATIONS

The workshop included presentations by Dr. Guy Faulkner, Val Mayes, Dr. Larry Brawley, and Beth Evans.

Dr. Faulkner is an assistant professor from the University of Toronto and an expert on the use of physical activity as a treatment for mental illness. He spoke on "Physical Activity and Mental Health: A Win-Win Consideration." His presentation included a discussion of

- physical health needs and schizophrenia;
- mental health promotion and depression; and
- reducing the social exclusion of those with mental illnesses.

The next presenter was **Val Mayes**, Executive Director of the Edmonton Chamber of Voluntary Organizations. Val shared her experience in trying to deliver a diabetes prevention program for people with chronic mental illness. The project faced many difficulties from which we can learn.

Dr. Larry Brawley is the Canada Research Chair in Physical Activity in Health Promotion and Disease Prevention at the University of Saskatchewan's College of Kinesiology. He presented on "Going Positively Mental: Getting more out of Being Physically Active." His presentation included research illustrations of physical activity and the link to aspects of mental health, including both asymptomatic people and those with chronic disease. He emphasized that individual differences matter and the importance of perceptions of control. Dr. Brawley also gave examples on how to increase adherence to see improvement in health-related quality of life.

Beth Evans, Director of the Alberta Mental Health Board, closed off the morning with an overview of the current state of mental health services in Alberta.

All of the speakers' presentation slides and a podcast of their lectures are available on the Alberta Centre for Active Living website (www.centre4activeliving.ca).

SMALLER GROUP SESSIONS

After lunch, break-out sessions with guided questions allowed experts in physical activity and mental health to work in smaller groups to discuss the following questions.

- How can physical activity contribute to or promote mental health and well-being (including consideration of any barriers)?
- How can physical activity contribute to preventing mental disorders (including consideration of any barriers)?
- How can physical activity contribute to recovering from mental disorders (again keeping in mind any barriers)?

In the last question, we asked participants to interpret recovery not as a cure, but as the person's ability to live well and find meaning in life even with a chronic and/or disabling mental disorder or mental illness.

Workshop participants broke into three groups to focus on one of the following topics:

- school settings;
- chronic diseases (e.g., cancer, cardiovascular disease, diabetes) and potential mental health comorbidities;
- severe and persistent mental illnesses.

Participants were also asked to recommend how best to incorporate physical activity into mental health programs for these groups. You will find the discussion summary for these three groups in Appendix 1.

In brief, the **school settings group** identified many different issues that face children and teens, including self-esteem, body image, bullying, and substance abuse problems. This group identified how physical activity can help improve self-esteem, allow for experiences of success, increase social inclusion, and help with stress management. However, the barriers include fear, the need for supportive adults, and a lack of time, priority, resources, and feasible programs.

The **chronic disease group** identified depression, motivation, self-esteem, and anxiety as the most pressing mental health issues. However, this group emphasized that the relationship between mental health and other chronic diseases depends on the timing of the disease (i.e., where people are in their life). This group identified the western medical model, lack of time, lack of sufficient buy-in, and lack of social support as key barriers. The group recommended that in addition to a safe, welcoming environment, positive messages about physical activity should be delivered in specific chronic disease meeting groups and by primary care physicians. The message should also be given to other sources (e.g., family, friends) and not just to the client.

The **group that discussed severe and persistent mental illnesses** argued that quality of life, normalization of the disease, and recognition of the mental illness as a chronic problem were key to moving forward. This group recognized that for many of these clients, obesogenic environments (i.e., environments that foster physical inactivity and poor diet) were a problem. They recommended emphasizing small manageable changes. This group felt that "the system" (e.g., policy-makers) needs to be educated on this topic and recommended forging links between researchers and practitioners and using an integrated teamwork approach.

The day concluded with each of the smaller groups presenting a summary of their group's discussion to the larger group.

This workshop allowed networking opportunities, and all the presentations helped to further knowledge about physical activity as a viable intervention within mental health programs. This workshop also started a dialogue between physical activity researchers and mental health

workers about how to incorporate physical activity into mental health prevention and treatment programs. We hope that further collaborations and discussions occur because of the opportunity provided by this the workshop in bringing participants together.

References

Alberta Mental Health Board. (2005). *A plan for a mental health research program for Alberta.* Retrieved June 1, 2006, from http://www.amhb.ab.ca/publications.

Biddle, S. J. H., Fox, K. R., & Boutcher, S. H. (Eds.) (2000). *Physical activity and psychological well-being*. London: Routledge.

Faulkner, G., & Biddle, S. (2001). Exercise and mental health: It's just not psychology! *Journal of Sports Sciences, 19,* 433–444.

Fox, K. R. (2000). The effects of exercise on self-perceptions and self-esteem. In S. J. H. Biddle, K. R. Fox, S. H. Boutcher (Eds.), *Physical activity and psychological well-being* (pp. 88–117). London: Routledge.

Ohlsen, R. I., Peacock, G., & Smith, S. (2005). Developing a service to monitor and improve physical health in people with serious mental illness. *Journal of Psychiatric and Mental Health Nursing, 12* (5), 614–619.

Penedo, F. J., & Dahn, J. R. (2005). Exercise and well-being: A review of mental and physical health benefits associated with physical activity. *Current Opinion in Psychiatry, 18* (2), 189–193.

Rejeski, W. J., Brawley, L. R., & Shumaker, S. A. (1996). Physical activity and health-related quality of life. *Exercise and Sport Sciences Reviews, 24,* 71–108.

Richardson, C. R., Faulkner, G., McDevitt, J., Skrinar, G. S., Hutchinson, D. S., & Piette, J. D. (2005). Integrating physical activity into mental health services for persons with serious mental illness*. Psychiatric services, 56* (3), 324–331.

Rohrer, J. E., Pierce, J., & Blackburn, C. (2005). Lifestyle and mental health. *Preventive Medicine: An International Journal Devoted to Practice and Theory, 40* (4), 438–443.

Southwick, S. M., Vythilingam, M., & Charney, D. S. (2005). The psychobiology of depression and resilience to stress: Implications for prevention and treatment. *Annual Review of Clinical Psychology, 1* (1), 255–291.

Appendix 1: Summary Comments from Break-Out Groups

Group 1: School Settings

Most pressing issues

- Self-esteem
- Suicide
- Substance abuse
- Mental health connection
- Economics as they relate to social inclusion and exclusion
- Related costs/access to programs and activities
- Body image
- Self-harm
- Obesity
- Bullying (including Internet and chat rooms)
- Family issues

How could physical activity contribute to/promote mental health and well-being?

- Maintain weight and improve health and self-esteem
- Helps with stress management
- Promotes socialization or individual time
- Intrinsic joy
- Personal efficacy and achievement
- Promotes academic performance
- Note: these are all associations and not cause and effect!

Barriers?

- Schools—lack of qualified individuals to teach physical activity and health
- Lack of time, priority, and resources
- Availability of programs that are feasible
- Lack of support to adults (i.e., resources, workload, mental illness)
- Demands on adults—societal, materialism, parenting skills/priorities, lack of community, insurance and liability

How could physical activity contribute to preventing mental disorders?

- Help with achievement and success in a developmentally appropriate way
- Expectations from parents for kids to win

- Not a cure, part of a very complex issue
- Teach life skills
- What is the correct dosage? Is it adult driven?
- Part of routine activity

How could physical activity contribute to recovery?

- Increase intrinsic control
- Improve self-esteem by giving a sense of achievement
- Physiological effects/Social inclusion
- Help kids to interpret success
- Problem-solving—learning self-care strategies
- Promoting own creativity in activity and self-care
- Adults as role-models providing safety, security, and love

Barriers?

- Need adult involvement participation and support
- Community development
- Options/choice
- Fear
- Lack or workplace flexibility

How do you see moving forward?

- Need multi-levels to each to impact broad resources (i.e., need increased funding and resources)
- Need more access to recreation in the community/More available people and programs that are developmentally appropriate
- Advocacy to macro levels
- Consult people involved, plan to move forward
- Kids drive the program/increase involvement/Offer variety of activities
- More collaboration, coordination of activities

Group 2: Chronic Diseases

Most pressing issues

- Depends on timing of disease—"life niche" or developmental stage
- Depression—motivational concern a barrier to activity
- Self-esteem
- Anxiety

Barriers?

- Medical model
- Role of physician and other health-care professionals
- Access to health-care professionals
- Buy in
- Time
- Desire (client not motivated to participate in physical activity)
- Transportation/access
- Social support
- Stigma of mental illness—what message to give?
- Social isolation

Recommendations

- Apply delivery model: training, economics, reaching underserved populations
- Gain-framed messages
- Need safe, social, welcoming environment
- Need culture of physical activity, capacity for community delivery
- Message needs to be delivered within specific chronic disease meeting groups and by primary care physician
- Message given to other sources (family, friends) not just client
- Need screening tool for mental health issues
- Learn from other successes in other health-behaviour programs

Group 3: Severe and Persistent Mental Disorders

Recommendations:

- Educating the "system":
  - Policy/decision-makers
  - Research consensus
  - Common language
  - Outcomes
  - Links to powerful outcomes such as readmissions
  - Developing database
  - Broadening evidence sources
  - Network development
  - Links between research and practice—Dissemination

- Obesogenic environments
- Continuity of care: Rapport
- Integrated teamwork:
  - Skills and competency
  - Leisure/CMHT
- Quality of life
- Recovery
- Normalization
- Personal experience of above
- Chronic problem—ongoing care required
- Client centred
- Small manageable change