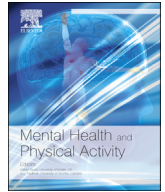




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The development of a questionnaire to investigate the views of health professionals regarding exercise for the treatment of mental illness

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ABSTRACT

Objectives: The knowledge, attitudes, beliefs and behaviours of health professionals are important in the successful application of exercise programs for the treatment of people with mental illness. We developed the Exercise in Mental Illness Questionnaire-Health Professionals Version (EMIQ-HP) in response to the lack of a comprehensive, valid and reliable instrument to assess the knowledge, attitudes, beliefs and behaviours of health professionals.

Methods: Content validation was achieved by expert consensus. Test–retest reliability was calculated using intraclass correlation coefficients.

Results: Thirty health professionals completed the questionnaire on two occasions separated by seven days. With the exception of one item, ICCs ranged from 0.61 to 1.00 suggesting excellent test–retest reliability.

Conclusions: We propose the EMIQ-HP may be used to assess the knowledge, attitudes, beliefs and behaviours of health professional regarding the prescription of exercise of people with mental illness. Further trialling and psychometric testing is recommended.

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1. Introduction

In recent years there has been increasing interest in the physical health of people with mental illnesses such as depression, schizophrenia, bipolar disorders, post-traumatic stress disorder and anxiety disorders. Findings to date suggest that this vulnerable population experience significantly poorer physical health and quality of life compared to people without a mental illness (Barnes, Murphy, Fowler, & Rempfer, 2012; Kerling et al., 2013; McCloughen, Foster, Huws-Thomas, & Delgado, 2012; Scott et al., 2012; Young & Grunze, 2013). Factors that have been proposed to explain this poorer physical health status include the predominance of risky lifestyle behaviours (Happell, Scott, Hoey, & Stanton, 2013; Scott & Happell, 2011), reduced access to physical health care (Cunningham, Peters, & Mannix, 2013; Druss, Rask, & Katon, 2008; Pomerantz, Cole, Watts, & Weeks, 2008), poor diet (Dipasquale et al., 2013; Kilbourne et al., 2007) and lack of exercise (Nyboe & Lund, 2013; Scott, Happell, Strange, & Platania-Phung, 2013). Taken together, these factors contribute to an early mortality of up

to 25 years compared to the general population (Hoang, Goldacre, & Stewart, 2013; Lawrence, Kisely, & Pais, 2010).

Lifestyle interventions have been shown to improve both the mental and physical health of people with a mental illness (Happell, Davies, & Scott, 2012; Happell, Platania-Phung, & Scott, 2013; Jensen, Decker, & Andersen, 2006; Park, Usher, & Foster, 2011). In particular, exercise lowers the risk of developing mental illness, aids in managing symptoms, improves physical health and returns quality of life in people with mental illness (Mammen & Faulkner, 2013; Rosenbaum, Tiedemann, Sherrington, Curtis, & Ward, 2014). Because exercise may be implemented at low cost and often requires no or minimal resources, training and skills on the part of the consumer, it may be attractive to both people with a mental illness and health care practitioners, either as a stand-alone or co-intervention.

Despite the potential benefits of exercise and physical activity for mental health consumers, promotion in mental health settings is often hampered by competing priorities, lack of time and resources, and lack of training (Happell, Platania-Phung, & Scott, 2011; Happell, Scott, Platania-Phung, & Nankivell, 2012; Phongsa- van, Merom, & Bauman, 2007; Soundy, Stubbs, Probst, Hemmings, & Vancampfort, 2014). These barriers are consistent with other studies investigating the barriers to physical activity counselling by

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health care practitioners in other domains such as primary care (Buchholz & Purath, 2007; Hébert, Caughy, & Shuval, 2012). In contrast to these barriers, Soundy et al. (2014) recently reported the importance of the therapeutic relationship, the capacity to provide individualised consumer support with respect to self-esteem and confidence, and the opportunity for individualised exercise, sensitive to the consumers' needs. Underpinning these constructs, are the health professionals' knowledge, attitudes and personal exercise behaviours.

A number of studies have investigated the relationship between personal exercise behaviours and exercise counselling in primary care settings. In general, physicians who engage in greater levels of exercise are more likely to prescribe exercise to their patients (Abramson, Stein, Schaefele, Frates, & Rogan, 2000; Frank, Segura, Shen, & Oberg, 2010; Livaudais et al., 2005), particularly when the patients undergo assessment and where exercise programs were available within those primary care services (Florindo et al., 2013). A recent review concluded that the personal exercise behaviour of health care professionals was an independent predictor of exercise counselling (de Quevedo & Lobelo, 2013). Similar studies of nurses report that exercise counselling is more likely to be offered to those who will benefit the most, such as those with cardiometabolic disease (Lamarche & Vallance, 2013). However, studies such as these are limited in that they do not comprehensively address the knowledge, attitudes and beliefs of the health professional or assess the way in which these factors contribute to clinicians' exercise counselling behaviours for specific conditions or a range of related conditions.

Coupled with the increased interest in the role of exercise in the prevention and treatment of mental illness, there has been increasing study of the exercise counselling practices of health professionals who treat people with mental illness. Early studies suggest that physical activity promotion by mental health professionals was often unplanned and unstructured (Faulkner & Biddle, 2002) and usually informed by the clinician's knowledge, beliefs and experience (Faulkner & Biddle, 2001). Indeed, a qualitative study of UK-based physicians indicates that physicians' justification for the inclusion of exercise in the treatment of people with depression is based on anecdotal, rather than empirical evidence (Searle et al., 2012). It also seems the rates of exercise prescription for people with mental illness are poor. For example, Australian data indicates mental illness accounts for only 7% of all conditions for which General Practitioners (GPs) provide exercise advice (Robertson, Jepson, Shepherd, & McInnes, 2011). Moreover, evidence from the psychology profession suggests that generic physical activity advice is commonplace, yet the rates of individualised exercise prescription vary dramatically from 12% (Burton, Pakenham, & Brown, 2010) to 83% (Burks & Keeley, 1989). More recently, the role of physical therapists in the provision of exercise for people with mental illness has been explored (Stubbs, Soundy, Probst, De Hert, De Herdt, Parker, et al., 2014; Stubbs, Soundy, Probst, De Hert, De Herdt, & Vancampfort, 2014). This group of professionals indicate they are ideally placed to deliver exercise to people with mental illness given their theoretical knowledge and clinical skills. However, physical therapists in mental health settings may not be universally available and other professions may be better suited in some countries. Taken together, while these studies provide data on patterns of exercise counselling, inconsistencies in the use of data collection instruments limits our capacity to compare and contrast the knowledge, attitudes, beliefs and behaviours of health professionals regarding exercise in the treatment of mental illness.

Data obtained using a comprehensive instrument which addresses the knowledge, attitudes, beliefs and behaviours of health

professionals regarding exercise in the treatment of mental illness may assist in career planning and professional development for health professionals, and in providing contemporary treatments for people with mental illness. Moreover, a recent review (Lobelo & de Quevedo, 2014) supports the role of physicians as role models for physical activity promotion and argue the need to develop and evaluate interventions targeting physical activity counselling behaviours by physicians and other health professionals. Since other clinicians including mental health nurses, psychologists, physiotherapists, physical therapists, and exercise physiologists are often in a position to offer exercise advice for people with mental illness, interventions aimed at physical activity counselling may be more wide-reaching. To better inform the development of such interventions, a comprehensive valid and reliable questionnaire exploring the knowledge, attitudes, beliefs and behaviours of health practitioners regarding the prescription of exercise for people with a mental illness is required. This paper describes the development of a new instrument for this purpose.

2. Aims

Given the interest and the significant role exercise may play in improving the physical and mental health of people with a mental illness, it is important to understand health practitioners' knowledge, attitudes and behaviour towards providing exercise advice to this population. In addition, there is a need to understand how the health professionals' patterns of exercise may influence these other factors. Therefore, the aim of this study was to describe the development, discuss and assess the content validity, and determine the test–retest reliability of an instrument to investigate the knowledge, attitudes, beliefs and exercise behaviours of health professionals regarding the prescription of exercise for people with mental illness.

3. Methods

3.1. Instrument overview

We have developed the 'Exercise in Mental Illness Questionnaire-Health Professional Version (EMIQ-HP)' to investigate the knowledge, attitudes, beliefs and exercise behaviours of health professionals regarding the prescription of exercise for people with mental illness. The questionnaire is available as an online supplement (Supplement 1). This 68-item instrument is divided into six domains: exercise knowledge, exercise beliefs, exercise prescription behaviours, barriers to exercise, personal exercise habits and demographics. The EMIQ-HP draws items from previously validated questionnaires, along with items specifically developed for this instrument. For the purpose of this questionnaire, the term 'mental illness' means any mental illness including but not limited to depression, schizophrenia, bipolar disorders I and II, post-traumatic stress disorder, and anxiety disorders.

3.1.1. Part 1. Exercise knowledge

This section comprises 10 items. We adapted the *Australian Health Behaviour Knowledge and Attitudes Questionnaire* (AHKAQ) (Happell, Scott, et al., 2013) originally developed from the *European Health and Behaviour Survey* (Wardle & Steptoe, 1991) for the purposes of this survey. We adapted the exercise knowledge section specifically to address the knowledge of health practitioners regarding the benefits of exercise. We also included questions asking if the health professionals have had formal training in exercise prescription, where that training was undertaken, and their self-reported level of knowledge and confidence in prescribing

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