



## Moving Towards Wellness: Physical activity practices, perspectives, and preferences of users of outpatient mental health service



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### ABSTRACT

**Objective:** This study assessed the beliefs, barriers and preferences for physical activity (PA) among users of outpatient mental health (MH) services. Outpatient discussions with MH providers were also evaluated.

**Method:** Between September–December 2014, patient advisors approached adult and family members in an academic MH clinic's waiting room on high volume patient visit days during peak clinic hours; 83% participated in the survey. Analyses were restricted to MH services users ( $n = 295$ ).

**Results:** Fully 84% of respondents reported a link between PA and their mood or anxiety level and 85% wanted to be more active. Less than half currently met US PA guidelines ( $\geq 150$  min/week). Most (52%) reported their mood limited their involvement in PA. Only 37% reported their MH providers regularly discussed PA with them. Beliefs about the benefits of physical activity ( $p < 0.0001$ ), mood limiting their ability to be physically active ( $p = 0.03$ ), and wanting to be more physically active ( $p = 0.02$ ) were significant predictors of PA (min/week) in the multivariate linear regression model.

**Conclusions:** Most MH outpatients may need and want assistance in increasing PA. Patient-centered research could inform the development of PA programs in MH settings.

### 1. Introduction

Low physical activity levels are associated with increased risk of depressive disorders in adults [1]. Mental health service (MHS) users [2] and adults diagnosed with depression [3], anxiety [4] or bipolar disorders [5] are significantly less physically active than the general population. Among MHS users, a sedentary lifestyle contributes to an elevated risk of comorbid illnesses, such as hypertension, diabetes, cardiovascular disease, and obesity [6].

Physical activity (PA) is moderately effective for improving symptoms of depression [7] and anxiety [8]. American Psychiatric Association guidelines briefly mention PA as being helpful for depression, with recommendations that education for patients and family members

include information about the positive impact of exercise [9]. However, PA is not consistently recommended for MHS users as part of routine US outpatient MH care [10].

The relative lack of attention to PA on the part of US mental health providers (MHPs) may constitute a missed opportunity to improve both the physical and MH of MHS users. MHPs are well positioned to promote PA among their patients, given the frequency of visits, intimate knowledge of patient-specific barriers, and special behavioral counseling skill sets. Incorporating PA programs into MHS could potentially improve the physical health outcomes of MHS users and may also improve psychological and social outcomes [11]. However, understanding patients' perspectives and preferences is essential if PA is to be effectively integrated into the care for depression, anxiety, and other MH

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conditions. Hence, this report summarizes MHS users' current PA practices, beliefs and barriers; their experiences with PA counseling by MH clinicians; and their preferences for PA-related services with the goal of informing the development of PA services for MHS users at a MH clinic.

## 2. Methods

This project represents a collaborative effort between volunteer patient advisors for the Department of Psychiatry at a large university and faculty in psychiatry, health behavior, family medicine, public health, and kinesiology. Patient advisors and faculty collaboratively developed the Moving Towards Wellness (MTW) survey composed of 28 items that tapped domains of: current PA practices, beliefs and barriers to PA, discussion of PA with MH providers, and preferences for PA-related services provided as part of MH care.

### 2.1. Survey development and content

This project was initiated by patient and family advisors to assess outpatient PA practices, perspectives, and preferences for the development of patient-centered PA interventions at the university's outpatient clinic. Due to the lack of literature on this topic, the MTW survey was developed by a multidisciplinary team including psychiatrists, PA specialists, health services researchers, and patient and family advisors. The survey included the following domains: current PA practices, attitudes and opinions regarding PA, barriers to PA, discussion of PA with MH providers, and preferences regarding PA-related services provided in MH care. Pilot testing was completed (CAJ & KFB) with five patient volunteers, utilizing a cognitive interviewing process [12], with further refinement of survey items to increase clarity. Demographic, self-reported health status, and self-reported diagnostic information were also collected.

### 2.2. Data collection and survey response

Survey data was collected by the patient advisors in the university's outpatient MH clinic waiting room between September and December 2014. Patient advisors asked adult outpatients and family members waiting for scheduled appointments in the waiting area on high volume patient visit days during peak clinic hours if they had heard about the project, and if they would like to participate. Those familiar with the project usually offered "I already filled out that survey." All individuals approached received a healthy granola bar, regardless of whether they completed the survey. No personally identifiable information was collected, and the study was considered exempt by the university's Institutional Review Board.

### 2.3. Data analysis

Data management and analyses were conducted using SAS software (version 9.4, SAS Institute, Triangle Park, NC). Descriptive statistics included means for continuous variables and frequencies for categorical variables. To ensure parsimony, a composite index of beliefs about PA and mood was constructed from 3 survey items. Each item used a 5-point Likert scale (1 = No, not at all to 5 = Yes, very often) and stems were: [1] physical activity improves my mood; [2] being physically active helps me feel less anxious; [3] I have used physical activity to manage my moods; Cronbach's alpha was 0.85. We summed the item scores for a composite score for beliefs about the benefits of PA.

An estimate of min/week engaged in PA was calculated using outpatients' midpoint usual engagement in PA (0, 1.5, 3.5, or 6 days/week) multiplied by the mid-point of the range of min/PA session they endorsed (i.e., 10, 25, or 45 min/week). Endorsement of being physically active over 60 min/PA session was coded as 75 min/session for the min/week of PA calculation.

Linear regression was used to determine the relationship between min/week engaged in PA (dependent variable) and the following predictors modeled continuously; how often their MHP discussed PA with them (1 = Never to 5 = Always), their beliefs about the benefits of PA (composite score), whether their mood limited their ability to be physically active (1 = No, not at all to 5 = Yes, very often), and whether they wanted to be more physically active (1 = No, not at all to 5 = Yes, very often). Age, gender, overall general health, and self-reported prior diagnosis of an SMI (diagnosis of bipolar disorder or schizophrenia (yes/no)) were included as covariates in the linear regression model.

For an additional exploratory analysis examining the association between whether patients met the PA guideline and whether they talked to the MHP about exercise, we constructed a binary variable for achieving US PA guidelines (engaged in PA for at least 150 min/wk. or < 150 min/wk). A chi-square test was used to assess the association between achieving US PA guidelines and how often a MH provider discussed PA with the patient (1 = Never to 5 = Always).

## 3. Results

Eighty-three percent (412 of 497) of the individuals approached in the clinic waiting room completed the survey, including 295 adult outpatients and 117 family members. The analytical sample for this report was restricted to adult outpatients ( $n = 295$ ).

### 3.1. Outpatient demographics; clinical and functional status

Survey respondents were predominantly middle-aged, white women with diagnoses of depression and/or anxiety disorders (Online Appendix A). The majority of respondents self-reported multiple MH diagnoses that they managed with medications and/or received group or individual therapy. On the day the survey was completed, the majority (74%) of outpatients were waiting for a return appointment while 26% were waiting for a new patient visit.

### 3.2. Current involvement in PA

Nineteen percent of the outpatients reported engaging in PA on five or more days/week, 34% on three or four days/week, 32% on one or two days/week, and 15% indicated that they typically did not usually engage in PA on any day of the week. Typical PA sessions averaged < 20 min for 14% of outpatients; 20–30 min for 30% of outpatients; 31–60 min for 40% of outpatients and > 60 min for 15% of outpatients. US guidelines of engaging in PA for 150 min per week was achieved by 43% of outpatients. Intensity of the typical PA session was gentle for 39%, moderate for 33%, and intense for 21% of the outpatients. Resources used for PA in the past 12 months included walking in the neighborhood (81%), home or yard activities (69%), using parks (51%), gym/recreation facilities (48%), bike paths or bike routes/lanes (30%), and participating in fitness classes (21%).

### 3.3. Reported use of PA to manage mood; barriers and facilitators

The majority of outpatients indicated that PA improved their mood and decreased their anxiety (Table 1). Beliefs about the benefits of PA were shared by the majority of the outpatients (composite score mean  $\pm$  std. =  $12 \pm 3$ ). However, among those who recognized the benefits of PA for mood or anxiety, only 66% (162 out of 244) reported actually using PA to manage their moods. The majority of outpatients indicated that they wanted to be more physically active.

Approximately 64% of outpatients reported that physical or MH issues interfered at least moderately with their normal daily activities during the past four weeks. Approximately 25% of the outpatients indicated that both mood and physical conditions limited their ability to be physically active, with a higher proportion of outpatients indicating that mood alone (27%) rather than physical conditions alone (12%)

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