



Final Report

Conversations *in motion* Series

Linking Physical Activity and Positive Mental Health: Sharing the Evidence

May 3, 2011
Millennium Library
Winnipeg, MB



Thank you to our sponsors:



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For presenter power points and more information on Conversations *in motion*, please go to: <http://umanitoba.ca/faculties/kinrec/research/conversations.html>

Conversations *in motion* Series
**Linking Physical Activity and Positive Mental Health:
 Sharing the Evidence**

Table of Contents

	Page
Conversations <i>in motion</i>	4
Overview	5
<i>Keynote Presentation: Dr. Kelly Arbour-Nicotopoulos</i>	
The Missing Link: Integrating Physical Activity into Positive Mental Health Practice	6
<i>Manitoba Research: Dr. George Kaoukis and Dr. Todd Duhamel</i>	
The Relationship between Physical Activity and Mental Health: Capitalizing on it for Cardiac Patients	8
<i>Demonstration Project: Centre de Santé Primary Care Team</i>	
Medical Services in Harmony with Community Services: A Winnipeg Experience!	11
Breakout Sessions	
Main Messages	13
Combining the Two Concepts.....	14
Barriers.....	14
Solutions to the Barriers	14
Partnerships/People	15
Barriers to Working in Collaboration.....	15
Examples of Groups that are Currently Collaborating.....	15
Infrastructure	16
Implementation	17
Future Recommendations	17
Summary of the Evaluations	18
References	19
Appendix A.....	20

Conversations *in motion*

Winnipeg *in motion* envisions a supportive community where residents include physical activity in their daily lives for health, well-being and enjoyment. To facilitate this vision, Winnipeg *in motion* employs complementary approaches such as physical activity promotion, health promotion, community development, social marketing, health communications, public information and education, economic development, active transportation, and urban and environmental planning. The *in motion* strategy also engages multiple sectors including education, business/corporate, transportation, governments, faith-based and cultural groups, fitness, recreation and sport, and health.

Research is an integral component of Winnipeg *in motion*, as the community-based initiative provides a natural opportunity to link research and best practice. Knowledge exchange underlies the circular model that connects research and evaluation to policy and practice (knowledge to action), and the reverse (action to knowledge). In response to the gap that often exists between research and practice, Winnipeg *in motion* developed "Conversations *in motion*," a series of two-way discussions between researchers, and practitioners and policy makers. Physical activity will be the primary focus of each conversation, however rapid expansion of research and knowledge, as well as unprecedented growth in opportunities for physical activity related practice, ensures a myriad of topics and a variety of participants.

Linking Physical Activity and Positive Mental Health: Sharing the Evidence

May 3, 2011, 8:45 am– 4:00 pm

Millennium Library

Winnipeg, MB

Overview

The first bi-annual “Conversations *in motion*” event “Linking Physical Activity and Positive Mental Health: Sharing the Evidence” took place at the Millennium Library in Winnipeg on May 3, 2011. 87 participants from a variety of disciplines including mental health workers, health promoters, kinesiologists, and many other professionals attended.

The day began with keynote speaker Dr. Kelly Arbour-Nicitopoulos from the Faculty of Physical Education and Health, University of Toronto who provided an overview of current research in mental health and physical activity.

Local research highlighted two researchers from the University of Manitoba: Dr. George Kaoukis (Clinical Psychologist, St. Boniface General Hospital; Assistant Professor, Faculty of Medicine), and Dr. Todd Duhamel (Assistant Professor, Faculty of Kinesiology and Recreation Management; Research Associate, Health Leisure and Human Performance Research Institute and Principle Investigator, Institute of Cardiovascular Sciences, St. Boniface Research Centre) who presented “The Relationship between Physical Activity and Mental Health: Capitalizing on it for Cardiac Patients”.

The final presentation featured a demonstration project, “Medical Services in Harmony with Community Services: A Winnipeg Experience!” presented by a multidisciplinary team from Centre de Santé. This panel described their 12-week lifestyle change program aimed at improving the mental health of their patients.

After lunch, participants broke into nine small discussion groups where they brainstormed answers to five questions related to physical activity and mental health. They also identified the messages found to be most salient from the morning presentations. Ideas for partnerships and the implementation of programming for physical activity and mental health were also discussed. The afternoon concluded with a plenary session where small group findings were presented, and Dr. Arbour-Nicitopoulos and event organizers summarized the day.

The following report highlights the research evidence presented, and the information compiled from the small groups. Based on this research and the ensuing discussion, recommendations are made on how to further ensure individuals with mental health concerns have access to appropriate physical activity opportunities.

The Missing Link: Integrating Physical Activity into Positive Mental Health Practice



Dr. Kelly Arbour-Nicitopoulos

Post Doctoral Fellow, Faculty of Physical Education and Health, University of Toronto

Dr. Arbour-Nicitopoulos began her presentation with the reasons why health promotion is so important in chronic disease management and how inactivity is rampant in North American society. She briefly discussed the benefits of regular physical activity for physical and mental health and outlined the difference between mental health and mental illness. It is imperative that the link between our bodies' health and our mind's health is found and this was referred to as "finding the neck".

Evidence supports the fact that physical activity participation does benefit one's mental health, but the mechanisms are not yet clear. Biochemical changes as well as physiological and psychological changes that occur in an individual when they regularly participate in physical activity. To promote physical activity as a management tool for mental health, we need to understand the challenges.

First, we need to identify the severity of the mental health issue as well as other co-existing conditions to be able to accurately prescribe physical activity for the individual. Those with mental illness have been found to have higher morbidity rates for heart disease, obesity, diabetes, cancer, respiratory disease, hypertension and infectious diseases and higher overall mortality (Allison et al, 2009; Brown et al, 2000; Hennekens et al, 2005).

Second, we need to move away from the medical model of treating disease to one of preventing illness. Patients are interested in being in charge of their own health and allied health professionals can give the patient some control over their positive health behaviours by adding physical activity to their chronic disease management plan. Last, we can promote service user advocacy. A chart was presented showing wait times for patients between the time they saw their GP's to receiving an appointment to see a psychiatric specialist (Canadian average of 7.0 weeks) as well as the wait time between seeing the specialist and being prescribed treatment (Canadian average of 9.8 weeks). This amount of time could be effectively used to add some physical activity into the patients' lives as an "interim treatment". In the United Kingdom, physicians use "exercise referral schemes" (ERS). With ERS, physicians refer patients with mild to moderate depression to an "exercise practitioner" who prescribes a program of regular physical activity to the patient. Although the physicians in the UK felt that exercise was moderately effective for the mental health of these patients, a very small

percentage of them (4%) admitted it was their preferred choice of treatment over antidepressants (45%) and counseling (36%) (Mental Health Foundation, 2009).

Several studies were presented that provided research-based evidence supporting the effectiveness of physical activity and exercise for the prevention and treatment of clinically defined depression. Recommendations for exercise prescription were also provided.

Dr. Arbour-Nicitopoulos concluded with an overview of one of her studies called HELPP (The Healthy Lifestyle Promotion Program for Women with Schizophrenia). HELPP was a 6-week physical activity and diet education program for obese women with schizophrenia led by a recreation therapist and a registered dietitian from the Centre for Addiction and Mental Health (CAMH) in Toronto. This group of 29 women diagnosed with schizophrenia or schizoaffective disorder met twice a week for 90 minutes; 60 minutes was dedicated to education and skill development along with 30 minutes for physical activity participation in the CAMH facilities (gym and meeting rooms). The skill development piece included self-regulatory skills aimed at goal setting, solving barriers and relapse prevention; and the education piece covered topics such as diet, heart health and diabetes, physical activity, stress management, and healthy body image. Physical activities included walking, dancing, yoga, circuit training, and some home-based exercises.

24 of the 29 women completed the program. The results indicated that the participants had an increased level of satisfaction with their physical functioning, an improved quality of life, as well as more confidence to eat well and participate in physical activity. The interprofessional program development and delivery contributed to the success of the initiative. The intervention was developed by a multidisciplinary team including a psychiatrist, a behavioural research team, a recreation therapist, and a dietitian. The program was delivered by the recreation therapist with the assistance of the dietitian, a nurse, and student volunteers. The contribution this study made to future programs for mentally ill individuals legitimized the role of physical activity in the treatment of mental illness. It makes these services accessible to the mentally ill population and allows individuals to develop self-regulatory skills that will help in every aspect of their lifestyles.

Comments and Questions:

- A volunteer co-ordinator asked how volunteers and/or students might play a role in program delivery as a cost-saving measure, and asked how to recruit students into those roles. Dr. Arbour-Nicitopoulos explained that she had access to students through a course she taught, and agreed that student use reduced the client-provider ratio resulting in greater attention provided to the participants. Students also benefit by gaining practical experience (and potentially course credit).
- A mental health nurse asked HOW to motivate individuals to be physically active as amotivation is such a predominant symptom of mental illness. Dr. Arbour-Nicitopoulos

explained the use of motivational interviewing to encourage her participants to “think more” about the health choices they could make for themselves.

- A comment was also made from a member of a mental health team regarding not using weight loss as a measurable outcome in studies on mental health and physical activity but rather promoting the idea of “health at every size” to reduce the stigma surrounding obesity and mental health issues. Dr. Arbour-Nicitopoulos agreed to this concept and referred to her use of very specific and successful action planning with her study participants that outlined detailed goals such as “I will get to the gym on Monday, Wednesday and Friday this week for 30 minutes after work” rather than the longer-term, much harder to achieve “I will lose 20 pounds”.
- A health promoter and kinesiologist asked about the selection criteria and fitness testing used in the HELPP study. Dr. Arbour-Nicitopoulos explained that the study was not a randomized controlled trial but more of an intervention or feasibility study and that she had used the Hamilton Depression Scale but no standard fitness tests. She did comment, however, that the participants were not highly active at the start of her intervention.

The Relationship between Physical Activity and Mental Health: Capitalizing on it for Cardiac Patients



Dr. George Kaoukis

Clinical Psychologist, St. Boniface General Hospital
Assistant Professor, Faculty of Medicine, University of Manitoba



Dr. Todd Duhamel

Assistant Professor, Faculty of Kinesiology and Recreation Management,
University of Manitoba
Research Associate, Health Leisure and Human Performance Institute
Principle Investigator, Institute of Cardiovascular Sciences, St. Boniface Research Centre

Dr. Kaoukis began the presentation by explaining how negative emotional states can be damaging to our physical health. Up to 25% of cardiac patients experience clinical depression after a cardiac event and 17-40% experience subclinical depression. Many others suffer from increased stress, panic attacks, and irritability. Stress and other negative emotional states are also linked to poorer physical states including higher heart rate and blood pressure, an increased concentration of blood fats and sugars, and heart vessel dysfunction elevating their risk for cardiovascular disease. To make this population even more challenging to treat,

patients with depression, anxiety, and poor social supports may not comply with the necessary healthy lifestyle changes that could decrease their risk of further illness.

Dr. Duhamel then made the connection between insufficient physical activity participation and cardiac risk by explaining that if an individual is not doing the minimum amount of physical activity (presented as 4 hours a week), chronic disease states are inevitable with time (the less active an individual, the faster they show symptoms of chronic disease). Dr. Duhamel also emphasized that depression is an independent risk factor for heart disease, and that being depressed increases the chance of early mortality after cardiac surgery. If patients are depressed and sedentary then they have a much higher chance of cardiac death. Those patients who do attend cardiac rehabilitation programs but do not increase their level of fitness also have a higher risk of death.

The neurological basis for a relationship between depression and physical activity was outlined explaining that exercise has the same effect on the brain as antidepressant medication. Exercise increases serotonin, dopamine and norepinephrine levels in the brain. It regulates the hypothalamic-pituitary-adrenal (HPA) axis that becomes out of balance with large amounts of stress and/or depression. By being active, one can increase beta-endorphin concentrations as well as IGF-1 and decrease the detrimental inflammatory response that comes with inactivity. Besides the biochemical relationship between depression and physical activity, there is also a psychological relationship so that when one exercises they increase their self-efficacy levels, have opportunities for social reinforcement and may be distracted away from distressing thoughts.

Even with a lack of randomized controlled or longitudinal studies and other methodological issues, there is a consistent positive relationship between increased physical activity participation and decreased levels of depression and mood disorders in community samples across the lifespan. Some of the tentative conclusions stemming from this research that have implications for physical activity prescription are that supervised physical activity programs appear to be more effective than non-supervised programs, moderate intensity exercise appears more effective than vigorous intensity, and that mood improvement is not always accompanied by physical improvements (increased cardiovascular endurance, strength, etc). Specific parameters to optimize mental health for cardiac patients are to conduct 3-4 training sessions a week of approximately 30 minutes duration for at least 8-14 weeks and again, physical activity should be initially supervised and ideally take place in an exercise facility. Other informal gatherings and social opportunities should also be included for maximum benefit to the participant.

There is little evidence from research relating to anxiety and physical activity. Overall there is a small effect size relative to control groups, but yoga and other mild to moderate intensity physical activity seems to decrease clinical anxiety.

In Manitoba, fewer than 30% of cardiac surgery patients attend a centre-based cardiac rehabilitation program even though 100% are encouraged to attend. The big question is: WHY? Is it because they are physically active enough on their own? Are they too depressed to attend? Or is it a combination of a number of factors? Drs. Duhamel and Kaoukis are currently conducting a study titled “Impact of Physical Activity on Depression following Cardiac Surgery” (IPAD-CS) gathering information on 500 subjects after cardiac surgery to assess their levels of depression and physical activity. Some preliminary data suggests 42% of the patients at baseline (after cardiac surgery) had mild depressive symptoms, 2% indicated moderate levels of depression and 3% indicated severe depressive symptoms. As well, 69% of these patients were not physically active enough to meet Canada’s Physical Activity Guidelines.

Being physically active after cardiac surgery controls both the risk factors for heart disease as well as manages the potential stress, depression and anxiety that may accompany cardiac events. Physical activity also has the benefit of incurring little financial cost, and few, if any, negative side effects. All patients should have access to appropriate cardiac rehabilitation programming.

This presentation concluded with future challenges that included understanding the exercise parameters that optimize mental and cardiac health, matching the type(s) of exercise with specific mental health problems, improving participant adherence, and understanding when it is best to intervene along the trajectory of cardiac patients – should the intervention occur prior to cardiac surgery as “prehab” or post cardiac surgery as “rehab.”

Comments and Questions:

- The audience asked questions around accessibility to the three cardiac rehabilitation programs in Manitoba. The big question during the presentation was: “why are only 30% of cardiac patients attending?”
- Observations from the audience outlined various populations (Jewish Child and Family Services, Aboriginal Health and Wellness and Homelessness initiative) that were being underserved. Barriers that were discussed included finances, the location of programs, and other social determinants in addition to the high numbers of people suffering from depression being a possible significant barrier.
- Different delivery models have to be implemented (and some are in the works) for populations with mental health issues as well as online cardiac rehabilitation education, and programming for aboriginal populations.
- Dr. Kaoukis clarified that if someone in Manitoba has had a cardiac event, they are “in the system” and have access to programming. There is funding and financial support available for participation in a cardiac rehabilitation programs through the Centres (Reh-fit Centre and Seven Oaks Wellness Institute) and through third party insurance.

- Dr. Arbour-Nicitopoulos commented that patients may assume that it is “normal” to feel depressed after a cardiac event and that there should be some patient education that this is not the case.
- Dr. Kaoukis commented that every cardiac patient in Winnipeg, on the third day after admission, is screened for anxiety and depression. Mental health intervention options are offered at that point.

Medical Services in Harmony with Community Services: A Winnipeg Experience!



Centre de Santé team:

Dr. Danielle de Moissac, PhD

Christine Johnston, BAKin, CSCS, CATC

Michelle Arpin Molinski, RD

Dr. Melanie Saint Hilaire, MD

The afternoon session began with an overview of an existing Winnipeg physical activity and mental health intervention entitled, “**Agir! Pour ma santé,**” a community based, interdisciplinary intervention for French-speaking adults over the age of 18 identified as having moderate depression. The interdisciplinary team consisted of a lead researcher, family physician, physical activity coach, dietitian, counselor, and the program’s operations manager. Participants were patients at Centre de Santé who, once identified by screening through the Beck Depression Inventory, were sent a letter by the program staff inviting them to a 12 week individual lifestyle program to improve both their mental and physical health. The theory behind this intervention was that depression is quite prevalent in adults, however when self-care for lifestyle behaviours is taught and followed up on, patients can improve their levels of depression and quality of life.

Each of the team members outlined their role within the program including their work with clients as it related to patient outcomes. Michelle Arpin Molinski, a Registered Dietitian, is responsible for recruiting clients referred by the physician. With each client, she conducted a nutritional intervention evaluating and assessing their current eating habits, appetite, dieting history, and emotional eating tendencies while considering their relevant medical history (hypertension, lipids, etc). Michelle also aimed to change the client’s relationship to food by encouraging techniques to moderate food intake for increased physical activity as well as including nutrients purported to assist in energy, mood, and brain function. Clients were provided with follow up nutritional counseling sessions as required.

Christine Johnston, the Physical Activity Coach, assessed the client’s readiness for behavior change ensuring appropriate documentation and follow up. Most clients chose to train from 1-3 hours each week for about 60 minutes each session. Clients received a 12-week free pass to

Sportex (the gym facility located at College St. Boniface) during which they were provided personalized exercise programs and workout supervision. Upon completion of the 12 weeks, clients were encouraged to purchase a reduced-rate pass (15% discount) to continue as members of Sportex.

Dr. Danielle de Moissac conducted the research portion of this intervention with 35 clients who met the inclusion criteria. The clients were 80% female, between 22 and 73 years of age. The control group consisted of people who would be provided with the program at a later date. Standardized measures included the Beck Depression Inventory II and the SF-36 to measure quality of life. Physical activity was measured using the International Physical Activity Questionnaire (IPAQ) and clients wore accelerometers for 2 weekdays and 2 weekend days for a minimum of 10 hours each day. Participants also completed a program satisfaction questionnaire.

Preliminary data showed a significant increase in the level of physical activity post-intervention in the experimental group compared to both pre-intervention levels and as compared to the control groups pre and post-intervention as measured by the IPAQ. Accelerometer levels show a small decrease in total activity after the 12-week program, however there was an increase in moderate activity after the intervention compared to pre levels and to control groups. Also, depression levels were decreased post-intervention and quality of life increased on both the mental health and the physical health sections of the SF-36. Overall, clients gave the program an A+ relating to program satisfaction.

Some of the challenges faced in this intervention centered around recruitment and retention of subjects, contacting and scheduling clients, addressing the stigma of depression within the small francophone community, and developing rapport with clients. There was also a small amount of resistance from physicians to “buy in” and refer their patients to the program as this added some paperwork and time to appointments.

Comments and Questions:

- A nurse with no connection to either mental health care nor to physical activity asked how the group addressed compliance with their program participants. Christine and Michelle agreed that this was a challenge and that they typically contacted the participant 3 times before giving up. They emphasized the importance of gaining rapport with the potential participants.
- Dr. Arbour-Nictopoulos also suggested the use of Motivational Interviewing (MI) over the phone to encourage participation in the program. Each team member of the AGIR program was trained in MI.
- Another comment made from the audience addressed the fact that there was little social interaction as the intervention was individualized. The group addressed this through their one-time relaxation group activity, but also suggested that participants

were hesitant for others in their close-knit community (St. Boniface) to know that they were in the “program for depressed people”. Some informal interaction did occur when participants met in the hallways and in the Sportex gym.

Breakout Sessions

Nine breakout sessions each comprised of 8-14 participants and led by a facilitator convened in the surrounding rooms to discuss predetermined questions as well as network and brainstorm some possible collaborative opportunities and partnerships (see Appendix A for the list of topics).

Main Messages

The first question asked the participants to identify the main messages that they took away from the earlier presentations.

- Family physicians have to “buy in” to the prescription (or at least the discussion) of physical activity for those patients they have identified as having mental health issues
- The concept of connecting the mind to the body, and the graphic presented in Dr. Arbour-Nicitopoulos’ lecture on “finding the neck”
- The idea of physical activity benefiting those with anxiety and depression must be presented to the general public so everyone understands the potential benefits
- The research and statistics on the number of Manitobans who participate in cardiac rehabilitation, and the positive effects of physical activity on mental health which gave participants the confidence and affirmation that their current programming was supported by evidence-based research
- The need for innovative physical activity programming and cardiac rehabilitation programs for traditionally harder to reach groups such as the aboriginal community, those with lower socioeconomic status and the homeless, as well as those with re-occurring severe mental illness
- The idea of inter-professional collaboration was identified in each group as being crucial for the proper care of those with mental illness so that related health care professionals do not find themselves working in “silos”
- The need to put funding towards non-medical approaches to whole-person care

- Focusing on short-term health outcomes of physical activity participation such as trying to improve an individual's self-esteem and not focusing on fitness or body composition outcomes

Combining the Two Concepts

The second set of questions revolved around combining mental health and physical health initiatives, whether or not that has been done successfully in any program so far, and the barriers experienced.

Barriers

- Income, stigma of mental illness, reading level, transportation, overall accessibility to facilities and comfort in using them)
- Larger barriers such as the fact that society (workplaces and schools) does not value free time or play as being important to health and healthy development
- Both schools and workplaces talk a lot about the value of physical activity for mental health but little action takes place
- The perceived safety of children playing outdoors or walking to school, and the recommendation to “check with your physician first” before starting an exercise program that discourage people from participating in physical activity
- Some professionals may be wary of suggesting physical activity as a way to manage mental health because they personally do not appear active, they don't know what to suggest, they are concerned that the client will get injured, or they don't have time to discuss it

Because the participants in this workshop were already very knowledgeable, it was easy for them to see the benefit of suggesting physical activity as a means of improving an individual's mental health by boosting their self esteem and self worth, and having physical activity as a means of connecting to the community including to others with similar health and social backgrounds

Solutions to the Barriers

- Having home visits for people with mental illness (meeting the clients where they are)
- Having a list of programs that are user friendly and accessible to the majority of citizens
- Having programs that focus on long term behavioural change and not those that focus on short term change

- There is a need for drop-in centres and community walking groups
- Working to ensure specific training about the benefits of physical activity for those working in the mental health field, as well as training about mental health issues for those working in the physical activity field

Partnerships/People

All groups made it very clear in their discussions that they greatly valued working collaboratively and noted the following groups they felt would be valuable partners:

Family Physicians	Dietitians	Nurses
Kinesiologists	Counselors	Psychologists
Kinesiology students	Therapists	Health Promoters
Physiotherapists	Occupational Therapists	Daycares
Schools	All levels of government	Family members
Businesses	Cultural groups	Workplace wellness groups
Sport governing bodies		
Societies that represent mental health (Schizophrenia society, ADAM, etc.)		

Barriers to Working in Collaboration

- Groups having different mandates and visions and some falling under different jurisdictions (municipal vs. provincial vs. federal).
- Getting the message into the schools. Is it possible to have a “champion” in each school division, or is it better to try to connect with each school through their parent councils?
- A perceived lack of resources in rural areas and a shortage of staff time to deal with mental health when it is not seen as the “main issue”
- Needing to share resources
- A current lack of policies or a provincial strategy to address mental health

Could there be a “wellness facilitator” who could connect individual clients to services and existing groups?

Examples of Groups that are Currently Collaborating:

- The Manitoba Fitness Council who are volunteering their time to staff the gym at Siloam Mission a few hours a week
- Youville clinic who collaborate and connect their clients to existing holistic programs that contribute to overall health

- North East Health region that runs multidisciplinary wellness programs that address the holistic needs of their clientele.

There was a reminder that Manitoba *in motion* provides start up grants for groups looking to begin any wellness programming.

Every group also suggested that this conversation should continue in some manner, and next time would benefit from inviting other groups not yet represented (social work was given as one example).

Infrastructure

What exists in your environment that would support a collaborative approach to link physical and mental health?

- Making effective use of current programs, trails, churches and schools, telehealth and telecare technology, community clubs and community gardens.
- Adding community kitchens, a bike-sharing program, more intergenerational programming (community gardening for seniors paired with youth for example), and more tools such as a “walk across Canada”-type program that could be used in schools, workplaces and communities to encourage movement
- The continued use of media to break down the stigma of mental illness and the positive connection to being physically active
- Programs that come from the “top down” but there also has to be “buy in” as well as active participation from the top (principals, bosses, managers, owners) to validate the program

A few programs were highlighted that are already making contributions to mental and physical wellness through collaboration which are the “Girls on the Move” (www.youville.ca) program at Youville Clinic in Winnipeg; the “Get Better Together” program for chronic disease management (www.wellnessinstitute.ca/gbt) available at various locations throughout Manitoba; and the “Vibrant Communities” initiative (www.vibrantcommunities.ca) that aims to decrease poverty across Canada.

One specific group working on a project at the University of Cape Breton called Sustainable Happiness (www.sustainablehappiness.ca) encourages active transportation on the way to school and measures the psychological benefits of the trip by asking parents “Does your child’s mode of travel affect their mental health?”. Others also decided that in order to make a sustainable change in people’s mental health, we must make the active choice the easy choice

so that when walking into a building, the first thing seen is a gorgeous, wide staircase and not the elevators.

Implementation

The final question asked in the small group breakout session was “What course of action do you plan to take to combine the two concepts of mental health and physical activity?”

- Information learned today needs to be shared with colleagues, departments, friends, families and clients
- Ensure that the information on mental health and physical activity is provided to as many clients in as many ways possible (individual and group counseling for example)
- Implement a physical activity program while the client is waiting for other services
- Discuss this concept with every group or client we work with, or actually develop a physical activity component within group programs that do not yet include one
- Bring active opportunities TO the people rather than develop programs and wait for them to come (waiting room videos for example, or activity breaks in a workplace)
- Recognize “pre-contemplators” and give them print material on the benefits of physical activity on mental health.
- Encourage active transportation
- Promote the Manitoba Fitness Council (MFC) and The Manitoba Exercise Professionals Association (MEPA) to clarify their mandates and the roles each can play within workplaces and organizations

Future Recommendations

The overwhelming response to this day was an appreciation for the collaboration between the mental health professionals, the physical activity professionals, and all other stakeholders. To take the next steps, professionals identified the following:

- Develop a list of classes and services revolving around physical programs aimed at mental health outcomes;
- Connect kinesiology students from both universities to aid in program delivery;
- Continue to push for non-traditional program delivery to effectively reach marginalized groups;

- Shift focus from weight loss to decreasing sedentary behaviours;
- In physical activity programs, professionals should be conscious of the messaging being presented to people;
- Develop a web-based platform to post current studies, effective interventions, and grant opportunities;
- Encourage interprofessional education for anyone working in the health care field that includes evidence-based research on physical activity and mental health.

Summary of the Evaluations

87 individuals registered for this event with participants representing the WRHA, the Provincial and Federal Governments, the Universities or other academic institutions, non-governmental organizations and others identified from nursing, sport, coaching, fitness, senior's associations, research, for profit business, and more.

The organizing committee would like to thank everyone for taking the time to complete the evaluations. There was an 84% response rate to the evaluation form and some very useful comments were made. Overall the participants and the organizing committee members believe that the first "Conversations *in motion*" event was a successful knowledge exchange.

Every participant expressed an interest in "sharing the information about physical activity and mental health with others" and many participants indicated that they could take away parts of the presentations to implement in their own areas with their clients/patients/ students and among their co-workers. Everyone would recommend this event to a colleague.

Comments to be considered for future events included evaluating the registration process, having a contact list (for those willing to be on one) to identify participant areas. Suggestions were also provided regarding logistics such as the venue, the length of time devoted to small group breakout sessions, and the room set up.

Participants will be contacted in November, 2011 to complete a short electronic survey to assess whether any of the concepts learned in this event have been implemented and in what ways. This will further the knowledge of what programs exist in the city as well as knowledge gaps. The organizing committee thanks you in advance for participating in this survey.

References

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Appendix A

Questions covered in the breakout sessions:

Introductions: What was the main message you learned from the morning sessions that you thought you might like to implement, explore further in your context?

Combining the two concepts: When planning initiatives, how do you take into account mental health? Physical Activity?

What types of barriers or challenges do you experience re: combining mental health and physical activity?

What are the benefits of making this type of linkage between these two concepts?

What methods do you use to find solutions?

What have you tried that does or does not work?

Partnerships/People: In your sphere of work, with whom do you collaborate?

What are your opportunities to collaborate?

With whom **could** you collaborate?

What are the barriers to collaboration?

How can you overcome the barriers? (perceived benefits to collaboration)

Infrastructure: What exists in your environment that would support a collaborative approach to link physical and mental health?

Think outside the box and beyond people.

Are there infrastructures there that assist making this linkage?

Are there natural collaborations?

Are there current opportunities?

Implementation: What course of action do you plan to take to combine the two concepts of mental health and physical activity?