

**UNDERSTANDING CONSUMER  
PREFERENCES FOR  
COMMUNICATION CHANNELS  
TO CREATE CONSUMER-  
DIRECTED HEALTH  
PROMOTION EFFORTS  
IN PSYCHIATRIC  
REHABILITATION SETTINGS**

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ACKNOWLEDGEMENTS: THIS STUDY WAS PARTIALLY SUPPORTED BY FUNDING FOR THE UPENN COLLABORATIVE ON COMMUNITY INTEGRATION FROM THE NATIONAL INSTITUTE ON DISABILITY AND REHABILITATION RESEARCH (H133B031109). THE AUTHORS ARE GRATEFUL TO THE DEDICATED STAFF AND MEMBERS OF THE CONSUMER CENTERS OPERATED BY THE MENTAL HEALTH ASSOCIATION OF SOUTHEASTERN PENNSYLVANIA FOR THEIR COLLABORATION IN THIS EFFORT.

*People with serious mental illnesses experience increased rates of physical illnesses. Drop-in centers and psychosocial rehabilitation programs can serve as important settings for health promotion efforts, but such efforts should utilize communication strategies that are used by consumers and are perceived to be reliable. Focus groups involving 23 consumers at drop-in centers in Philadelphia were conducted to assess the perceived usefulness of health information from a variety of sources. Consumers especially liked getting information from other people, including health care professionals, friends, and family, and found the information to be reliable and useful. Print literature, the Internet, and a library had various limitations. Respondents were generally unfamiliar with community health fairs and related events. Consumers considered trustworthiness, proximity and availability, and the specificity and depth of information provided by a communication source when getting health information. Implications for health promotion efforts are discussed.*

People with serious mental illnesses, including schizophrenia, bipolar disorder, and major depression, have a higher risk and prevalence of having a physical illness (Dickey, Normand, Weiss, Drake & Azeni, 2002; Felker, Yazel & Short, 1996) and have a greater likelihood of having multiple physical disorders (Dickey et al., 2002; Dixon, Postrado, Delahanty, Fischer & Lehman, 1999) compared to the general population. Moreover, the illnesses they experience tend to involve chronic conditions, including cardiovascular and endocrine problems, hypertension and diabetes, infectious disease, obe-

sity, cancer, and vision and dental problems (Dixon et al., 1999; Felker et al., 1996; Lambert, Velakoulis & Pantelis, 2003). Not surprisingly, the presence of co-occurring psychiatric and physical disorders is associated with increased mortality. These individuals are almost three times more likely to die of natural causes than the general population (Dixon, Wohlheiter, & Thompson, 2001; Lambert et al., 2003). Lifestyle factors, such as smoking, a poor diet, lack of exercise and substance abuse significantly increase risks of developing physical health problems (Brown, Birtwistle, Roe &

Thompson, 1999; Dickey et al., 2002; Dixon et al., 2001; Lambert et al., 2003). Physical illnesses can also aggravate existing mental disorders (Sternberg, 1986). Recent research also indicates that poor physical health predicts lower quality of life and mental health for this population (Dixon et al., 1999).

Lack of integration between the physical and mental health care systems makes it difficult and less probable that people with mental illnesses receive essential health education and promotion (Druss & Rosenheck, 1998). Lifestyle choices, self-care practices, and disease management could be addressed through increased health education and promotion activities. Attention to physical health promotion is central to the goal of psychiatric rehabilitation to provide holistic care in order to support individuals living in the community. Psychiatric rehabilitation programs can play a critical role in providing individuals with opportunities to increase their physical health care knowledge and skills. Some programs, such as drop-in centers and clubhouses, may be especially effective environments in which to promote health education and positive health behaviors.

There is widespread consensus that health education and promotion efforts need to use state-of-the-art health communications strategies to disseminate information and change behavior (Institute of Medicine, 2002; U.S. Department of Health & Human Services, 2002). Poorly considered strategies will be less effective in increasing knowledge. Five critical health communication steps have been identified (Kreps, 1990): 1) Educational goal identification (What is the desired impact? i.e. increased knowledge, changed behavior, improved attitudes); 2) Message determination (What are

we going to say?); 3) Audience identification (To whom is our message targeted? i.e. patient, public, professional); 4) Communication channel identification (What channels are available to reach the desired audience? i.e. mass media, intermediaries, interpersonal); and 5) Evaluation criteria and strategies (How will impact be assessed?).

Despite the importance of health education and promotion for individuals with serious mental illnesses, few studies (e.g., MacHaffie, 2002) have examined the channels, modalities, and interventions that may be most effective for communicating health information. The goal of this study is to describe the communication channels (e.g., mass media, interpersonal relationships) and modalities (e.g., brochures, posters, classes, Internet) that individuals use and find most beneficial in obtaining health education information. Focus groups were conducted in drop-in centers as these settings are an important setting in which people socialize and obtain and share information. Drop-in centers are in a unique position to effectively disseminate health information to those who might otherwise have limited access. The information gathered from this project can be used to assist drop-in centers, and possibly other psychiatric rehabilitation programs, to develop appropriate and effective means of delivering desired physical health care information.

## Method

### Study Site

Participants in this study were recruited from three consumer drop-in centers in the city of Philadelphia. Consumer drop-in centers provide a range of services to participants including social, recreational, advocacy, and educational programming. The overarching goal of these centers is to

support people in living independently in the community by offering a safe accepting environment where they can access information and social resources (Mowbray, Robinson, & Holter, 2002).

Six to ten individuals were recruited for each of the three focus groups. One focus group was held at each of the three drop-in consumer centers. Administrative staff at the centers identified participants who could voluntarily consent to participate and who felt comfortable actively and constructively engaging in a group discussion. Participants either signed up for the group ahead of time or were recruited by researchers on the same day of the session. The groups took place in July 2004, and arrangements were made with each center to schedule the focus group at a time when the maximum number of consumers would be present, and when no other potentially conflicting activities were scheduled. Refreshments were offered as an incentive for participation. Participants were asked to report their age, gender, and race. In order to protect privacy, participants were not asked to report the nature of their mental health problem, current medications, or other personal information. Consent was obtained verbally from each participant, and the study was determined to be exempt by the institutional review boards of both the University and the City of Philadelphia.

The demographic composition of the three focus groups is presented in Table 1. Twenty-three people participated in the focus groups. Seven (30%) were female, fifteen (65.2%) were black/African-American, and over half of participants (52%) were between 35–50 years of age. The demographics in this sample are similar to descriptions of drop-in center users reported in the literature (Mowbray, et al., 2002).

**TABLE 1—DEMOGRAPHIC COMPOSITION OF THE FOCUS GROUPS**

	Number of Participants	Age*			Gender (%)		Race		
		<35	35–50	51–65	Male	Female	Black/African American	White	Some Other Race
FG1	8	2	5	1	6	2	1	6	1
FG2	7	0	2	4	5	2	7		
FG3	8	1	5	1	5	3	7	1	
TOTAL	23	3	12	6	16	7	15	7	1
% of Total		13%	52%	26%	70%	30%	65.2%	30.4%	4.4%

\*Not all participants reported age; breakdown does not always add up to total number of participants

**Data Collection and Analysis**

Each focus group was conducted on-site at the drop-in centers, using a library or conference room area with few interruptions. Each group lasted approximately one hour. Group moderators (ED and SB) used a semi-structured interview guide that included questions about which health problems they would like information about, and elicited the perceived usefulness of health information from a variety of sources. These sources included brochures, health books, magazines, posters, and Internet sources, didactic sources such as classes or group meetings, interpersonal sources such as family and friends, interactions with health and mental health professionals, and other community sources such as health fairs and bulletin boards.

Two note-takers recorded the responses of participants during the group using laptop computers. The moderator occasionally took notes of the conversation using a flipchart that was visible to the group. The moderator and note-takers convened following each group to debrief and reach consensus on the themes that emerged during the focus group conversation. In addition, the

debriefings noted general observations of the participants, conversation and other factors that may have been missed by the note-takers (Morgan, 1997). These notes from the debriefing sessions were combined with group notes and the flip chart sheets for analysis.

Content analysis of available data identified the communication channels used by consumers and described the perceived usefulness of these channels to drop-in center consumers. The first author conducted an initial analysis of the data and thoroughly discussed results with the co-authors. A consensus process was used if there was disagreement about the themes. In order to assess the credibility of results, the first author presented the findings to members of the drop-in centers and solicited feedback from these members in order to ensure accurate data interpretation and recommendations.

**Results**

Analysis of available data indicated focus group participants desired information on a range of mental and physical health issues including diabetes, cancer, psychotropic medications, blood pressure, arthritis, muscle spasms, heart disease and foot problems. Participants identified the communica-

tion channels that they have used to gain information about health issues and the usefulness of these channels in obtaining health information.

**Printed Literature**

Participants found printed literature, such as brochures, books, and magazines to have varying levels of usefulness in supplying information on health topics. Participants reported that they read brochures to learn about health topics such as depression, Narcotics Anonymous, and cancer. However, the limited information available in brochures made them less attractive than other sources of information. Respondents stated that brochures are “not in depth enough” and “don’t cover enough information.” Respondents were frustrated that brochures only lightly touched on certain issues—as one person said, “they tell me what they want to but not everything that they know” and another said that in general “information is held back.” As a result, brochures are often passed over as sources of health information. Brochures seem to be picked up only if conveniently located and if they pertain to a topic of interest—many agreed with one person who stated he “won’t go out of (his) way to pick them up.” In contrast to brochures, magazines were felt to generally be

“too involved,” providing too much detail on a particular health topic.

Health reference books were trusted sources of information. Many participants mentioned having access to these books through a family member or friend, or through the public library. Participants discussed using the books to look up diagnoses, new medications they were taking, and the side effects of these medications, particularly if it was difficult to talk to a health professional to get that information. One participant noted that these books provide “a great wealth of information.” In some cases, respondents were referred to these books by health professionals.

#### **Drop-In Centers and Other Mental Health Providers**

Participants indicated that staff at the drop-in centers offered generalized support in dealing with health issues through direct contact or through various programs offered at the centers. A registered nurse had been providing psycho-education on health issues to individuals and groups at the drop-in centers for a few years, but stopped being available during the period when the focus groups were conducted. The nurse attended the centers once a week to answer questions about their health problems, provide group health education classes, first aid, triage, and referrals. Respondents indicated that general and personal information was discussed during these interactions with the nurse and that the nurse competently fielded their questions in regards to medications and particular health topics. Participants stated they felt the information provided was reliable because it was coming from a nurse.

The sharing aspect of group interactions facilitated by the nurse was seen as a particularly beneficial aspect of the program. One respondent commented that sometimes the presenta-

tion would “hit a button” and other participants felt these meetings were a chance to “learn that there are people going through a lot worse” and to “benefit from hearing others’ experiences, or could help someone else with your feedback,” and that the facilitator of the group made “it comfortable to share.”

Other group psycho-education was also conducted by invited lecturers on topics such as harm reduction, hepatitis, diabetes and HIV. Some of the educators involved “people with actual illness,” which was viewed as a helpful part of these presentations. In addition, health topics are often discussed during other programs, including groups on specific health topics for men and women.

The drop-in centers also provided health information posted on bulletin boards. Participants agreed that bulletin boards provide too much information in one concentrated area, which makes it difficult to get information and increases the possibility that they will “miss information you would otherwise look at.” These boards were considered to “get on your nerves” because they are overcrowded, or “not laid out enough.” However, it did seem that respondents used bulletin boards as a resource for health information as well as for learning about activities at the drop-in centers.

Respondents identified their psychiatrists, therapists, or counselors as additional sources of health information. Information from these sources was provided when solicited by participants, but in general, was not discussed on a regular basis.

#### **Other Health Professionals**

Few respondents in the group mentioned primary care physicians or other health professionals as providers of health information, primarily due to infrequent contacts with these profes-

sionals or frustration with their providers’ availability to answer questions when they do meet. While some respondents had regular medical care and visited physicians and other practitioners for monitoring of chronic conditions or general health concerns, several respondents reported a lack of primary care or that they only go to the doctor if something is wrong. For example, participants mentioned they don’t go to see a doctor “until it hurts” or waits to go “if aspirin don’t cure it.” A particular respondent complained that every time he went to the doctor it was inconsistent, that there was a new resident every time, and so he didn’t really go unless there was something wrong. One respondent talked of not being able to get regular foot care because he didn’t always have insurance. He commented, “Even when you try to take care of yourself...even though I took every step and precaution...I still got turned away.” This statement drew nods of agreement and sympathy from other members in the group.

#### **Family and Friends**

Most respondents had at least one family member or friend that they went to for health information and often mentioned a family member who worked in health care, as a nurse, doctor, or technician. One participant stated that loved ones “know you better than you know yourself.” Whether consumers went to a friend or a family member seemed to depend on who would be most knowledgeable or experienced about a particular subject, who had an open mind and would not “judge and lecture me,” and someone who would “keep it confidential” and could be trusted. There was consensus about not wanting to go to someone who might not be open-minded, but would instead be judgmental or “othering,” a term they used to describe how some people treat them like something other than an adult capable of making

informed life choices. One respondent was hesitant, though, stating that “sometimes family is misinformed...will steer you in the wrong direction.”

With friends, the focus seemed to be on peers at the center. One respondent mentioned that she herself had previously worked as a home health aide, and that “lots of people here (at the drop-in center) are knowledgeable about health.” There was consensus in one group around the notion that “it’s a good idea to talk to people here at the center...hearing others’ experiences is comforting and enlightening.” The feeling of shared experiences and open-mindedness among participants seemed to be an important factor that established closeness and a level of trust, and led them to believe that their peers were knowledgeable and a reliable source for health information.

#### **Other Sources in the Community**

Focus group participants mentioned using public libraries to access reference books, and the Internet to get information on health topics. Participants used free Internet connections at the library to look up medications, what to do with an illness, and general medical information and research. The Internet was perceived as being more up to date than printed materials, although most participants didn’t know how to access information on the Internet or felt uncomfortable using this technology. Respondents were questioned about the usefulness of community events such as health fairs, and, with few exceptions, seemed unfamiliar with these events. Posters displayed in the community were generally liked if they were eye-catching and had pictures or illustrations, and respondents reported seeing very interesting posters advertising the dangers of smoking and other health-related behaviors. Many mentioned seeing posted advertisements for med-

ications at their doctors’ office, but that these posters lack information on side effects, making them less interesting to consumers. Overall, they “don’t get a lot of information from posters.”

### **Discussion**

According to Kreps’ health education model (1990), the ability to effectively deliver health education information relies on health promoters’ awareness and use of appropriate channels that are most likely to reach their intended audience. The purpose of this study was to describe the communication channels used by participants in a community drop-in center to gain health information. Focus group data also identified the perceived usefulness of these channels. Participants’ perceptions on usefulness were influenced by the trustworthiness, proximity and availability, and the specificity and depth of information communicated.

First, participants considered the trustworthiness of the information source in determining the usefulness of various channels. Professionals within and outside the drop-in center, individuals with experiences in the health professions, and health reference books were deemed by consumers to offer reliable information. These preferred sources are in line with primary sources of health information of the general population of Philadelphia; however, participants in this study appeared to rely more heavily on family and friends (Philadelphia Health Management Corporation, 2003). Family members, friends and drop-in center peers were not always viewed as the most reliable sources, but were used because of their availability and proximity. Because they are more accessible than other sources, these informal social networks emerged as an important source of information for drop-in center participants, although there remains

the likelihood that health information from these sources may be misguided or contradictory to health information available through professional networks (Kreps, 1990).

Participants also desired information that is specific to their particular problems and seemed chiefly concerned with information pertaining to psychotropic medications and their side effects, or disease processes. Resources such as medical health reference books, where they can find detailed information on a particular health issue were valuable to respondents. Communicating with health professionals also provides the depth of information that many are seeking. Many health information sources that are available in the drop-in centers and elsewhere, such as brochures, bulletin boards and posters, do not contain in-depth information and therefore did not meet the needs or capture the interest of drop-in center members.

In light of these findings, health promotion activities for participants of drop-in centers or other psychiatric rehabilitation programs that focus on trustworthiness, proximity and availability, and the specificity and depth of information will likely be more effective in promoting healthy behaviors because consumers will be more likely to utilize the information. Several methods of assuring that health communication is delivered appropriately and effectively in drop-in centers and elsewhere are suggested as well as some directions for future research based on these findings.

#### **Consumer Assessments**

Psychosocial rehabilitation providers should be responsive to the expressed needs for health information and understand which communication channels they find most useful for obtaining health information. Even within drop-in centers, recognizing that center popu-

lations can vary greatly depending on external factors such as location, staff members are encouraged to incorporate assessments within their own centers to meet perceived needs and match preferred methods among their clientele, thus holding true to the meaning of “consumer-directed” services. In addition, providing regular forums that allow people to openly discuss their health needs and subsequently the health information that would be valuable to them can assist service providers in targeting health promotion efforts and even funding initiatives to meet these identified needs.

### **Wellness Programs**

The focus groups all reported favorably on the activities conducted by the nurse at the drop-in centers. Nurses, other trained drop-in center staff, or guest speakers from other health service agencies can lead health education classes, provide one-on-one meetings with members about health promotion, and suggest other health-related group activities to stimulate health-promoting behaviors, perhaps focusing on a different topic of interest every month and involving participants in identification of relevant health topics. Promoting physical health and wellness programs need to be better integrated and supported as part of a comprehensive mental health system (Richardson et al., 2005). Several studies have discussed the merits of coordinated walking programs and other physical activities in which drop-in center members can exercise with their peers, providing social support and enhancing their social networks (Camann, 2001; McManus, 1996). Due to their social nature, these types of group activities may be of more interest to people with mental illnesses and may be a better incentive to encourage more discussion about and practice of healthy behaviors.

### **Coordinating Health Promotion Efforts with Other Service Organizations in the Community**

Using library resources was identified as a common means of accessing health information among focus group participants. Commonly used resources on health topics of interest to this population can be made more accessible by working with local libraries and informing them of where to go, when to go, what to look for, when to ask for assistance, etc. Libraries may even have group tours, classes, or similar activities that, if identified for them, can help individuals navigate available community health resources. In addition, other group organizations may exist in the community that can present health information on identified topics of interest to groups at the drop-in centers. Our focus groups showed a preference for these groups, due in part to their informal and interactive format, especially when these groups consisted of other consumers of mental health services.

### **Coordinating Health Promotion Efforts and Resources for Use within Drop-In Centers**

Whether available in a library or a drop-in center/clubhouse setting, a collection of thorough and updated listings of local, regional, state and national resources on health information can also be beneficial to consumers. Our focus groups indicated that participants are much more likely to pay attention to such resources if they are from trusted professional organizations, and again, they should be relevant to their perceived health care information needs. While they may not be very interested in brochures, magazines and the like, other sources such as videos, books or community activities may stimulate interest. The Internet, though not widely utilized among the focus group participants we talked to, was seen as a valuable

source of information by some. Providing training and in-person guidance (i.e. a list of recommended health information websites) may encourage drop-in center clients to use this communication channel.

### **Limitations**

This study examined preferred communication channels for individuals with serious mental illnesses, a key step in developing health promotion strategies for this population. However, this research was not able to explore other issues for planning effective health promotion including the desired goals and outcomes of health promotion as described by these persons, providers, and policy-makers. In addition, participants were asked to comment on a predetermined list of communication channels. As such, other relevant channels used by participants may have been missed, even though participants were free to mention other channels if they came to mind.

This is a descriptive study and several factors limit the generalizability of the findings to other populations of persons outside of drop-in centers. Respondents present at the drop-in centers volunteered to participate in the focus groups, and therefore the sample may be biased towards frequent users of the centers, or those who are more comfortable participating in group discussions for research purposes. In addition, data on participants' mental health diagnosis, and severity of physical and mental illness were not collected. Therefore, it is unclear if participants in this study differed significantly from the general population of drop-in center members or if these factors had an impact on preferences for sources of health promotion. However, based on conversations with agency staff, we feel somewhat confident that the individuals who participated did generally rep-

resent the population of individuals who attend the three centers. Future research that included more personal incentives to participate in focus groups might draw a larger range of opinions and experience, and possibly range of mental health diagnoses to a discussion on preferred health communication channels.

### Future Research Directions

Future research should include the use of complimentary research methods, such as large-scale surveys, that would enhance the generalizability of these findings to a larger population of individuals with mental illnesses. The focus of this future research should examine what communication channels are preferred for use in addition to what people use. This will yield more information on establishing a health promotion program that consumers desire. Information about what should be presented would also be enhanced by gathering data on what health-related topics consumers are interested in hearing about. Finally, more research is desperately needed to assess the impact of various health education and promotion efforts to enable our field to begin the process of disseminating evidence-based practices.

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