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Interventions with Physical Exercise Programs in Psychiatric Inpatient Settings: Clinical and Formative Reflections

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Background: Psychiatric hospitalization is characterized by high clinical and institutional complexity, frequently associated with functional impairment and low levels of physical activity. In this context, structured physical interventions represent relevant complementary strategies in mental health care. The *objective* of this study was to report and reflect on the experience of implementing a multimodal physical exercise program in a psychiatric hospital setting, analyzing its clinical, institutional, and educational outcomes. **Methods:** This is an experience report with a qualitative, descriptive-reflective approach, developed in a philanthropic psychiatric hospital in southern Brazil, in male and female inpatient units. The intervention consisted of a multimodal physical exercise program, carried out twice a week, in the afternoon, over six months. Data production occurred through participant observation, post-session reflective records, and discussions with the multidisciplinary team. **Results:** Six thematic axes emerged related to adherence, clinical adaptations, social interaction, organization of the institutional routine, interdisciplinary articulation, and the clinical-formative dimension of the intervention. It was evident that the viability of the program was associated with methodological flexibility, continuous clinical reading, and integration with the team. **Conclusion:** Structured and contextualized physical exercise programs prove to be viable and powerful strategies in hospital mental health care, contributing to improving bodily practices in complex institutional contexts.

Keywords: Mental Health – Physical Activity – Psychiatry – Mental Disorders.

Intervenciones con programas de ejercicio físico en unidades de hospitalización psiquiátrica: reflexiones clínicas y formativas

Antecedentes: la hospitalización psiquiátrica se caracteriza por una alta complejidad clínica e institucional, frecuentemente asociada con deterioro funcional y bajos niveles de actividad física. En este contexto, las intervenciones físicas estructuradas representan estrategias complementarias relevantes en la atención de la salud mental. El *objetivo* de este estudio fue reportar la experiencia de implementar un programa de ejercicio físico multimodal en un entorno hospitalario psiquiátrico, analizando sus resultados clínicos, institucionales y educativos. **Métodos:** este es un informe de experiencia con un enfoque cualitativo, descriptivo-reflexivo, desarrollado en un hospital psiquiátrico filantrópico en el sur de Brasil, en unidades de hospitalización masculina y femenina. La intervención consistió en un programa de ejercicio físico multimodal, realizado dos veces por semana, por la tarde, durante seis meses. Las sesiones se organizaron en calentamiento, parte principal y enfriamiento, con intensidad moderada monitoreada por una escala de esfuerzo percibido. La producción de datos se realizó a través de la observación participante, registros reflexivos posteriores a la sesión y discusiones con el equipo multidisciplinario. **Resultados:** surgieron seis ejes temáticos relacionados con la adherencia, las adaptaciones clínicas, la interacción social, la organización de la rutina institucional, la articulación interdisciplinaria y la dimensión clínico-formativa de la intervención. Se evidenció que la viabilidad del programa se asoció con la flexibilidad metodológica, la lectura clínica continua y la integración con el equipo. **Conclusión:** los programas de ejercicio físico estructurados y contextualizados demuestran ser estrategias viables y eficaces en la atención de la salud mental hospitalaria, contribuyendo a mejorar las prácticas corporales en contextos institucionales complejos.

Palabras clave: Salud mental – Actividad física – Psiquiatría – Trastornos mentales.

Background

The psychiatric hospitalization regime constitutes one of the most complex scenarios in mental health care, as it brings together intense psychic suffering, clinical instability, multiple institutional intersections, and care demands that go beyond exclusively pharmacological interventions. Although the Brazilian Psychiatric Reform has promoted important shifts in the care model, the psychiatric hospital remains a necessary device in situations of crisis, risk, and severe subjective disorganization, requiring care strategies that simultaneously consider the clinical, functional, and psychosocial aspects of individuals in psychiatric hospitalization [19]. In this context, thinking about interventions that engage with the institutional daily routine becomes fundamental to improving the quality of care offered.

One of the aspects frequently neglected during psychiatric hospitalization refers to the impairment of physical functionality and the high sedentary lifestyle observed among people with severe mental disorders. It is known that individuals with schizophrenia, bipolar disorder, and major depression have significantly reduced levels of physical activity and more time spent in sedentary behavior, associated with a worse cardiometabolic profile, functional impairments, and increased premature mortality [9]. During hospitalization, these factors tend to intensify due to the restricted routine, the use of psychotropic drugs, and the institutional dynamics themselves, reinforcing the need for systematized body interventions in this environment.

In recent years, physical exercise has been progressively recognized as a relevant component of mental health care, with consistent evidence of its effects on depressive symptoms, anxiety, overall functioning, and quality of life in different clinical populations. Previous studies [9,21] indicate the benefits of physical exercise in people with mood disorders, psychotic dis-

orders, and in populations with persistent mental suffering, both as a preventive and therapeutic strategy.

Despite the advancement of the literature, it is observed that most of the research on physical exercise in mental health focuses on outpatient, community, or psychosocial rehabilitation program settings, with a scarcity of studies addressing the implementation of these interventions in psychiatric hospitalization contexts [2]. This gap is relevant, since the hospital environment imposes specific challenges, such as diagnostic heterogeneity, fluctuation in clinical status, patient turnover, and institutional limitations, which directly impact adherence to and management of interventions.

In this sense, the adoption of multimodal physical exercises has been pointed out as a particularly suitable approach for heterogeneous psychiatric populations [6,16]. This type of intervention promotes greater flexibility in adapting sessions to the clinical conditions of the participants, favoring safety, participation, and continuity of activities, a central aspect in inpatient contexts, considering the variability of the physical and mental state of patients throughout treatment [13].

In addition to the widely described physiological effects, group physical exercise can assume an expanded therapeutic function by operating as an organizing device for the institutional experience in mental health contexts. Collective body practice contributes to the structuring of time, the construction of shared routines, and the mediation of interpersonal interactions, aspects that are often weakened in people experiencing intense mental distress during hospitalization. Thus, group interventions based on physical exercise promote greater social engagement, a sense of belonging, and increased peer interaction, although their effects depend on the format of the intervention and the institutional context [11,3].

In this scenario, the inclusion of Physical Education professionals in multidisciplinary mental health teams has been discussed as a strategy to expand comprehensive care and improve body interventions, requiring technical flexibility and continuous interdisciplinary dialogue [12, 20]. The objective of this study was to report and reflect on the experience of interventions with physical exercise programs carried out in a psychiatric hospitalization context, discussing their clinical, institutional and formative developments, as well as the contributions of this practice to mental health care and interdisciplinary action.

Methods

Study design

This is an experience report with a qualitative approach, descriptive-reflective in nature, based on participant observation and systematization of records produced during the implementation of a physical exercise program in a psychiatric hospitalization setting. The design was adopted for its suitability to the analysis of clinical, institutional, and formative processes that emerge in interventions carried out in highly complex care services.

Context

The study was conducted in a philanthropic psychiatric hospital located in the state of Paraná, Brazil, in male and female inpatient units, within the context of care for adults with various psychiatric conditions. The service attends to patients with primary diagnoses belonging to the spectrums of mood disorders, psychotic disorders, personality disorders, and substance use disorders, under multidisciplinary care.

Participants

Participation was voluntary and conditional upon prior assessment of clinical and functional fitness. At the time of hospital admission, the patient's legal guardian was informed about the existence of the physical

exercise intervention as a complementary treatment strategy, and the guardian's consent was required before the patient could be invited to participate in the activities. In addition, inclusion was conditional upon the patient's own agreement, respecting their autonomy and availability at the time of the intervention.

Inclusion criteria were: (a) being hospitalized in the male or female units during the intervention period; (b) presenting stable clinical conditions that allowed participation in physical activities; (c) demonstrating a minimum understanding of the instructions, assessed using the Mini-Mental State Examination (MMSE); (d) not presenting absolute contraindications to the practice of physical activity, as screened by the Physical Activity Readiness Questionnaire (PAR-Q); and (e) expressing voluntary interest in participating in the sessions.

The following were considered temporary exclusion criteria: (a) presence of acute clinical instability on the day of the session (e.g., intense psychomotor agitation, adverse effects of medication, severe behavioral disorganization, exacerbated psychotic symptoms); (b) clinical incidents or physical complaints that could compromise safety during practice; (c) positive responses on the PAR-Q that indicated the need for prior medical evaluation; and (d) momentary conditions that limited the understanding or execution of the proposed activities. In these cases, participation was postponed and could be resumed when clinical conditions were considered adequate by the team.

The following were considered permanent exclusion criteria: (a) formal medical contraindications to the practice of physical activity; (b) severe cognitive impairment, evidenced by the MMSE, that made it impossible to minimally understand the instructions; and (c) refusal by the patient or legal guardian to authorize participation.

All decisions regarding the inclusion, exclusion, or postponement of participation were made in coordination with the multidisciplinary team, prioritizing the safety, care, and respect for the individual conditions of the patients.

Throughout the intervention period, approximately 160 patients of both sexes, with different psychiatric diagnoses, participated, considering the dynamic nature of the psychiatric hospitalization context and the heterogeneity of the group. Due to the hospital admission and discharge regime, the composition of the participant group was open and variable over time, so that new patients were continuously invited to participate in the sessions as they entered the units and met the eligibility criteria. Correspondingly, patients who were discharged from the hospital ceased to participate in subsequent activities. In each session, the number of participants varied, on average, between approximately 20 and 35 individuals, depending on the occupancy of the units, the current clinical conditions, and the availability of patients on the day of the intervention.

Description of the intervention

The intervention consisted of implementing a multimodal physical exercise program, conducted twice a week in the afternoon, lasting approximately 50 minutes per session, from August to December 2024. It was considered a multimodal physical exercise intervention, being a set of exercises that combines different physical capacities and motor components — for example, activities that may integrate functional movements, cardiorespiratory stimuli, strength/muscle endurance exercises, elements of coordination, balance, joint mobility, and stretching, with variations according to the objective of the session and the clinical state of the participants.

The sessions were structured in three stages: (1) warm-up (global preparation,

activation, and mobility); (2) main part (execution of the planned multimodal block); (3) cool-down (progressive reduction of intensity, breathing/body orientation, and light stretching when applicable). The intensity was planned for a moderate level, with monitoring using the Borg Rating of Perceived Exertion (RPE) scale applied at the end of each session, on a scale of 1 to 10. Across all sessions, the median score reported by participants was 5, consistent with moderate effort in the self-reported model.

Team, roles, and clinical adaptations

The sessions were conducted by a Physical Education professional with prior experience in psychiatric inpatient settings. The researcher (author) was present at all meetings, assisting with screening, administering instruments, systematically observing the sessions, and helping to conduct the sessions when necessary. Planning and execution considered the need for adaptations according to the clinical state of the day, respecting variations in mood, medication effects, agitation, psychotic symptoms, physical complaints, and functional limitations. Thus, although there was a standardized session structure, the exercises were flexible and adaptable to preserve safety, feasibility, and adherence.

Data collection and recording procedures

The systematization of the report was based on multiple sources of records produced during the course of the intervention: (a) observations during the sessions, paying attention to aspects of participation, engagement, social interaction, need for adaptation, and relevant clinical events; (b) post-session records, prepared after each meeting, describing the conduct, group behavior, adjustments made, team perception, and points for improvement; (c) discussions with the multidisciplinary team, used for planning, care alignment, and implementation evaluation. These discussions involved, according to the

organization of the service, professionals such as psychiatrists, nurses, and social educators, focusing on the organization of the space, materials to be used, communication of what would be done, potential benefits and risks, and the relevance of the intervention as a complementary strategy to the treatment offered. It should be noted that, although the patients already performed physical activities in their institutional routine, the intervention described in this study was implemented as a complementary strategy to the treatment, with a session structure and intensity monitoring, and with multidisciplinary coordination.

Data Analysis

The recorded information was organized and interpreted through reflective thematic analysis, guided by a clinical-institutional perspective, suitable for systematizing experiences in complex contexts with predominantly textual data. The analysis followed sequential steps: (1) chronological organization of records by session; (2) complete reading and familiarization with the material; (3) initial coding of units of meaning (adherence, interaction between peers, clinical fluctuation, risk management, adaptations, role of the team, formative elements); (4) grouping of codes and construction of provisional themes; (5) review of themes for internal consistency and coherence with the material as a whole; (6) definition and naming of final themes and elaboration of interpretive syntheses, prioritizing dense and contextualized description. Rigor was sought through triangulation between different sources (session observation, post-session records, and multidisciplinary discussions), in addition to explicit recording of the researcher's role in the field, in order to support transparency and reflexivity in the interpretation.

Ethical aspects

The physical exercise program intervention described in this study was part of

a broader research project developed at the State University of Londrina (UEL) in the context of mental health care. This larger project was structured as a central investigative platform, from which different evaluation approaches were conducted, resulting in multiple studies and scientific publications with specific designs and objectives, all derived from the same institutional intervention experience.

The main project was previously evaluated and approved by a Research Ethics Committee with Human Beings, in accordance with current legislation and the ethical principles governing research involving human beings, under the title "Integration of a multimodal physical exercise program as a complementary treatment in patients hospitalized for mental disorders" (Opinion No. 7.026.968; CAAE: 81566824.7.0000.5231).

The physical exercise intervention presented in this article constituted a complementary strategy to traditional treatment, integrated into the institutional routine, without an invasive experimental character, with care, training, and research purposes. The data systematized in this experience report were used secondarily, based on observational and reflective records, without including information that would allow the identification of the participants. The principles of confidentiality, anonymity, and secrecy were rigorously respected, ensuring that the information presented was exclusively scientific and institutional in nature.

Results

The results presented derive from a reflective thematic analysis of the records produced throughout the intervention, including observations made during and after the sessions, systematized reflective records, and multidisciplinary discussions. From this material, six thematic axes were developed, constructed through the

identification of recurring patterns related to the conduct of the intervention, the participants' responses, the institutional dynamics, and the clinical and formative implications of the physical exercise program. These axes express central dimensions of the analyzed experience and are presented below.

Axis 1: Organization of participation and adherence to sessions

Patient participation in physical exercise sessions was characterized by significant variability, a phenomenon expected in the context of psychiatric hospitalization. Adherence was directly conditioned by the clinical state presented on the day of the activity. This pattern shows that, unlike outpatient settings, participation in physical exercise during hospitalization cannot be understood as stable or linear, requiring continuous clinical assessment.

It was observed that patients in moments of greater clinical stability demonstrated greater engagement, permanence, and initiative during the sessions, while those in phases of greater disorganization presented partial, intermittent participation or demanded temporary exclusion. This oscillation was not limited to presence or absence, but also to the quality of participation, varying between active involvement, passive participation, or the need for constant mediation by the team.

The structuring of the sessions into well-defined stages (warm-up, main part, and cool-down), associated with the multimodal nature of the exercises, proved relevant to sustain the possible adherence in that context. The predictability of the structure facilitated the organization of participation, even in the face of clinical heterogeneity, allowing patients to recognize the logic of the activity and remain engaged within their individual limits.

Axis 2: Clinical adaptations and management of group heterogeneity

The need for constant clinical adaptations emerged as a central element of the

intervention, reflecting the complexity of care in psychiatric inpatient settings. Fluctuations in mental state, motivation, psychomotor agitation, slowness, negative symptoms, and somatic complaints demanded frequent adjustments in the conduct of activities. These adaptations occurred both in the pre-planning and during the execution of the sessions.

Adaptation strategies included modifying the intensity, motor complexity, and programmed exercise, the execution time, and the spatial organization of the activities. In some cases, it was necessary to fragment tasks, reduce stimuli, or prioritize exercises with lower motor and cognitive demands. In specific situations, the temporary exclusion of certain patients proved necessary to preserve individual and collective safety, reinforcing the importance of clinical judgment in managing the intervention.

The diagnostic and functional heterogeneity of the group showed that the conduct of physical exercises in psychiatric hospitalization cannot rely on rigid protocols. Methodological flexibility and the ability to adapt in real time were key competencies in enabling the participation of patients with different levels of functionality, without compromising the group nature of the intervention.

Axis 3: Social interaction and group dynamics

Physical exercise sessions were configured as spaces for mediating social interaction in an institutional context where opportunities for spontaneous interaction are often modulated by the routines and norms of hospital care. It was observed that physical exercise, performed collectively, favored approaches between patients who, outside of the sessions, presented limited or non-existent social interaction.

During the activities, verbal and nonverbal

exchanges emerged, expressed through comments, encouragement, mutual observation, and recognition of peers' abilities. At different times, the joint performance of tasks promoted situations of cooperation and sharing, albeit in a punctual and variable way according to the group profile and the clinical state of the participants.

Although these interactions did not occur homogeneously or continuously, the perception that structured physical activity functioned as a mediator of interpersonal relationships was recurrent. The presence of a common bodily task seemed to reduce relational barriers and favor forms of interaction less mediated by traditional clinical discourse, contributing to the organization of group dynamics.

Axis 4: Organization of daily institutional life

Considering the complexity of organizing routines in a psychiatric hospital, the regular inclusion of physical exercise sessions in the weekly schedule contributed to the organization of time and the predictability of the activities offered to patients; however, this organization occurred in dialogue with a dynamic institutional context, in which the afternoon period concentrates multiple therapeutic, educational, and occupational actions.

The performance of activities in the afternoon proved, in many instances, to be strategic, functioning as a transitional element between different care proposals and contributing to the differentiation of days and to the subjective organization of time during the hospitalization period. However, in certain situations, there was a punctual overlap of activities, resulting from the simultaneous offering of courses, workshops, and other institutional interventions, which required adjustments in the conduct of the sessions and negotiation with the team to enable the participation of patients.

Over the course of the intervention, physical activity gradually came to be recognized as an integral part of the service's set of therapeutic practices, even though it was included in a broad and sometimes competing institutional agenda. This incorporation highlighted the need for continuous coordination between the different programs offered in the afternoon, reinforcing the complementary nature of the intervention and expanding the possibilities for care, without disregarding the challenges inherent in organizing daily life in psychiatric hospitalization settings.

Axis 5: Coordination with the multidisciplinary team

The implementation of the physical exercise program required continuous coordination with the multidisciplinary team, involving psychiatrists, nursing professionals, and social educators, in an institutional context marked by multiple simultaneous care demands. The meetings held before and after the sessions were fundamental spaces for assessing the patients' clinical conditions, organizing spaces and materials, and defining procedures, but they also revealed the need for constant alignment between different care logics present in the daily hospital routine.

This coordination did not occur in a linear or homogeneous way throughout the intervention period. At certain times, it was observed that physical activity was initially understood as secondary to other care priorities, requiring greater communication and mediation efforts to clarify its therapeutic objectives, limits, and safety criteria. The circulation of information about behavior, adherence, observed effects, and possible risks proved essential to adjust the conduct of activities to the clinical needs of patients and to sustain the legitimacy of the intervention within the team.

Gradually, as the intervention became more established and began to produce

observable effects in daily institutional life, there was a greater incorporation of physical activity into the service's clinical discussions. This movement favored the recognition of physical exercise as a complementary strategy in managing certain behaviors, organizing routines, and supporting the overall care of patients. This process demonstrated that the integration of physical exercise programs in psychiatric inpatient settings depends less on formal protocols and more on continuous processes of dialogue between different health professionals, reinforcing the centrality of interdisciplinary work in sustaining these interventions.

Axis 6: Clinical and formative dimension of the intervention

Experience has shown that working in this field goes beyond the application of technical content related to human movement, requiring a broader understanding of care, clinical sensitivity, and an understanding of the institutional context. Unlike other intervention scenarios, physical exercise in psychiatric hospitalization takes place in an environment marked by clinical instability, intense psychological suffering, and its own institutional dynamics, which demands that the professional be attentive to the singularities of the patients and the conditions of the service.

From a clinical point of view, conducting the sessions required continuous situational assessment skills, considering not only formal diagnoses but also the psychic and physical state presented on the day of the activity. Behavioral changes and functional limitations of the participants imposed the need for real-time decision-making, often mediated by clinical observation. In this sense, physical exercise ceased to be understood as a standardizable practice and began to assume an eminently clinical-adaptive character, in which safety and individual care guided the interventions.

The formative dimension of the experience proved particularly relevant in highlighting competencies that do not usually occupy a central place in traditional Physical Education training. The daily experience of psychiatric hospitalization highlighted the importance of different skills such as risk management, methodological flexibility, tolerance for unpredictability, and the ability to negotiate with different professionals. These elements constitute a set of practical and ethical knowledge that is built in the encounter with the field and that is fundamental for responsible practice in mental health, but which is rarely addressed systematically in initial training curricula.

Another relevant formative aspect concerns the need for the professional to shift their perspective on physical exercise itself. In the context of psychiatric hospitalization, physical exercise is not primarily guided by parameters of performance, progression, or measurable results. Beyond the benefits to physical and mental health, these interventions result in social interaction, organization of daily life, safe and positive bodily experiences, and increased possibilities for involvement in healthy habits. This change of perspective requires the professional to rethink expectations, review previously established practices, and develop interventions that are more sensitive to the subjective and institutional conditions of care.

Finally, the experience analyzed offers important insights for professionals and teams who work or intend to work with physical exercise in psychiatric inpatient settings. By highlighting the limitations, challenges, and concrete possibilities of the practice, this report reinforces that body interventions in this scenario demand technical preparation, an ethical and humanized approach, and a willingness to work interdisciplinarily. More than reproducing pre-established models, work in mental health requires situated practices,

built in dialogue with the institutional context and with individuals experiencing psychological distress, contributing to more comprehensive and realistic care.

Discussion

The objective of this study was to report and reflect on the experience of interventions with physical exercise programs carried out in a psychiatric hospitalization context, discussing their clinical, institutional and formative developments, as well as the contributions of this practice to mental health care and interdisciplinary action.

When the focus of the literature shifts from outpatient and community settings to the psychiatric hospitalization regime, a substantially different scenario is observed from that frequently portrayed in efficacy studies. Although there is growing recognition of the potential of the hospital environment to support changes related to physical activity — especially in terms of supervised access and care structure — relevant gaps persist regarding the definition of which intervention models are most appropriate, under what conditions they operate sustainably and what contextual elements condition their implementation [22]. The evidence base in this field remains limited and heterogeneous, being strongly influenced by institutional, organizational and clinical characteristics specific to inpatient services, which gives special relevance to studies that detail processes and conditions of viability, rather than isolated results of effectiveness [4,17].

In this context, it is worth highlighting the distinction between clinical effectiveness and implementation effectiveness, especially in the field of mental health. Evidence [1,24] continues to demonstrate that physical exercise in different modalities and intensities can reduce psychiatric symptoms in different mental disorders, however, such evidence, although fundamental, does not fully answer the central question

faced in psychiatric hospitals: how to operationalize these interventions in scenarios marked by structured routines, marked clinical fluctuation and limitations of human and material resources. It is precisely at this point that the implementation literature becomes decisive to move from “knowing that it works” to “being able to make it work”.

When it comes specifically to the implementation of physical exercise interventions in hospital mental health services, recent literature has highlighted the need for minimum structures capable of supporting these practices, including systematic screening and clinical stratification processes, clear safety criteria and well-defined care flows [10,18]. This body of evidence points to a movement within the field toward reducing reliance on individual initiatives and bringing physical exercise closer to an institutionalized care system, supported by greater clinical governance, organization of care processes, and multi-disciplinary integration.

Based on these contributions, it is suggested that more consistent programs in psychiatric inpatient settings tend to balance two requirements that, at first glance, may seem contradictory: structure and plasticity. The presence of structure favors the team’s recognition of the intervention as safe, legitimate, and aligned with the therapeutic plan, while plasticity is essential to deal with fluctuations in mental state, adverse effects of psychotropic drugs, and functional heterogeneity—conditions that are particularly frequent in psychiatric hospitalization. This balance dialogues with broader public health and clinical recommendations [24] that guide general principles of physical activity, but explicitly recognize the need for adaptation to the specific capacities and conditions of the populations served.

Another relevant axis to be discussed concerns the social environment and the

way exercise is delivered, especially in group formats, emphasizing that optimizing the effects of physical activity on mental health depends less on choosing an “ideal” modality and more on factors related to adherence, enjoyment, instructional style, and the quality of the social environment of the intervention [8]. In psychiatric inpatient settings, this aspect takes on particular importance, since the hospital profoundly reorganizes the use of time, social interactions, and the possibilities of agency for patients, making body interventions potential structured spaces for participation and engagement within a highly regulated routine [23].

The perspective of professionals in inpatient services has been consistent in pointing out that the main barriers and facilitators to the implementation of physical exercise are less attributable to the individual motivation of patients and more to organizational, cultural, and institutional factors, describing that variables such as time availability, resources, clarity of professional roles, team support, and risk perceptions shape the feasibility of interventions, contributing to understanding why, in environments with multiple therapeutic offerings and competing demands, physical exercise needs to be continuously negotiated and legitimized as a component of care, and not treated as a peripheral or optional activity [5,15].

This debate is linked to a broader discussion about the institutionalization of physical exercise as mental health care, in contrast to its reduction to recreational or occupational activity. In psychiatric hospitalization, the way the intervention is understood by the team directly influences its access, its priority on the institutional agenda, and its sustainability over time. Although there is potential for benefits, there is still scarce evidence indicating which interventions are most successful in this context, reinforcing the centrality of delivery factors and service organiza-

tion. In this sense, studies that describe agreements, flows, adjustments, and institutional tensions contribute concretely to translating scientific knowledge into viable practices [13].

In the field of Physical Education applied to mental health, the need for a broader set of professional skills stands out, going beyond the prescription of exercises. Risk assessment, clinical communication, interdisciplinary work, and decision-making in contexts of uncertainty are skills repeatedly highlighted as central axes for working in hospital settings, reinforcing that physical exercise in psychiatric hospitalization is not an isolated technical practice, but a situated clinical intervention, whose safety and effectiveness depend on the care ecosystem in which it is embedded [14].

It is equally relevant to consider that the therapeutic potential of physical exercise is not limited to the symptomatic axis, where interventions aimed at promoting a healthier lifestyle can impact multiple dimensions of mental illness, including overall functioning, quality of life, and organization of daily life. This framework is particularly relevant to psychiatric hospitalization, where therapeutic objectives often include clinical stabilization, reorganization of routine, and preparation for continuity of care after discharge [7].

At the same time, the literature recommends interpretive caution. Even in areas where the evidence of exercise effectiveness is robust, methodological limitations related to bias, heterogeneity of protocols, and expectation effects still persist. For experience reports, this caution is even more necessary: their contribution does not lie in attributing causality, but in offering contextual density and formulating plausible hypotheses about institutional, organizational, and psychosocial mechanisms that may mediate the observed effects. Thus, the analytical strength of

this type of study lies precisely in the interpretative discipline and the avoidance of undue extrapolations.

From the point of view of practical implications, this study converges in some directions that can guide teams interested in implementing similar programs in psychiatric hospitalization: the incorporation of simple and safe screenings, the clear definition of responsibilities and communication channels, the choice of formats guided by feasibility and adherence, the appreciation of the social environment of the intervention, and realistic planning in the face of competing agendas and institutional demands. These elements appear consistently in both implementation studies and qualitative investigations with mental health teams.

As a strength, this experience report fills a gap explicitly recognized by recent literature: the lack of detailed descriptions of how physical exercise interventions are effectively integrated into psychiatric inpatient services, what conditions favor their continuity, and what elements are critical for multidisciplinary coordination and the clinical safety of individuals. By making explicit institutional processes and dimensions that are frequently absent in studies focused solely on outcomes, the work contributes to the advancement of the field in a dimension that is still little explored.

As a limitation, the nature of the experience report prevents causal inferences and statistical generalizations, in addition to depending on observational and reflective records, which are susceptible to interpretive biases. Furthermore, the literature on psychiatric inpatient care itself shows the heterogeneity of interventions and the scarcity of methodological standardization, which restricts comparisons between services. Nevertheless, by situating the experience within the contemporary debate on implementation and by de-

scribing real-world conditions of hospital care, the study offers relevant insights for other teams and for designing more robust future research, such as mixed-methods studies and implementation evaluations aligned with recent recommendations in the field.

Conclusion

The reflections presented throughout this study reinforce that the implementation of physical exercise programs in psychiatric inpatient settings demands a perspective that goes beyond traditional clinical efficacy, centrally incorporating the institutional, organizational, and relational dimensions that permeate mental health care. In environments marked by high clinical complexity, patient turnover, and multiple simultaneous therapeutic demands, physical exercise cannot be sustained as an isolated or accessory practice, but as an intervention that requires continuous agreement, clinical governance, and effective integration into the institutional therapeutic project.

The experience discussed shows that the therapeutic potential of physical exercise in inpatient care is not limited to symptom modulation, but is linked to broader clinical objectives, such as the organization of daily life, the expansion of patient participation, and the strengthening of care practices that consider the body as a constitutive dimension of the experience of mental illness. In this sense, body interventions can function as situated clinical devices, capable of mediating processes of engagement, temporal structuring, and social interaction, provided they are conducted in a way that is sensitive to the conditions of the service and the clinical fluctuations inherent to that context.

Finally, this study contributes to the contemporary debate by explaining the processes, challenges, and feasibility conditions associated with the implementation of physical exercises in psychiatric

hospitals, addressing the gap identified in the literature regarding the need for more detailed descriptions of “how to do it” in real-world care settings. By systematizing this experience, it is hoped to provide support for professionals and teams interested in developing body interventions in mental health, as well as to stimulate future research that advances the evaluation of implementation models, institutional sustainability, and long-term clinical and psychosocial impacts in the context of psychiatric inpatient care.

Data Availability Statement

The dataset generated during and/or analyzed during the current study are available from the corresponding author on reasonable request.

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Conflicts of Interest

The authors declare no conflicts of interest.

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