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Depression, physical activity and mental health: An interpretative phenomenological analysis of general practitioners’ experiences of exercise referral schemes in the North West

Rachel L. Ward & Paul K. Miller

CITATION
Depression, physical activity and mental health: An interpretative phenomenological analysis of general practitioners' experiences of exercise referral schemes in the North West

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Abstract
While there is compelling evidence which demonstrates that physical exercise can have beneficial impacts on mild-to-moderate cases of depression, and strong beneficial impacts on subthreshold depressive symptoms, rates of referral to exercise-based programmes in the UK remains low, particularly when compared to the use of other avenues of treatment. This paper reports findings from an interpretative phenomenological study of semi-structured interviews with a small sample (N=4) of General Practitioners (GPs) in the North West, exploring their experience-based attitudes and assumptions pertaining to the status and value of formal exercise referral schemes.

Keywords
depression; exercise referral; professional attitudes; interpretative phenomenological analysis

Introduction
Depression is, today more than ever, a profoundly serious public health concern in the UK, impacting upon the lives of individuals from all social backgrounds and strata (NICE, 2009; Tylee & Jones, 2005). The national statistics are striking. The percentage of individuals aged 18+ suffering from any form of depression (bar postpartum) in 2009-2010 (see British Medical Association (BMA), 2009, pp.94-100) was an estimated 12.82% in the North West of England, above the national average of 11.19% (NEPHO, 2012a; NEPHO, 2012b), with Cumbria experiencing a rate of 12.87% (NEPHO, 2012a), and Lancashire faring slightly worse at 13.67% (NEPHO, 2012b). Moreover, according to the BMA’s Quality and Outcomes Framework "The total annual cost of adult depression in England has been estimated at over £9 billion, of which £370 million represents direct treatment costs." (BMA, 2009, p.94). Consequently, a number of commentators argue for the more concerted exploration of a variety of prevention, treatment, and rehabilitation strategies to address this widespread and multifaceted problem, at both local and national levels.

Although recent studies suggest that exercise (structured or otherwise) has minimal impact on more severe forms of depression (Chalder et al., 2012), there is a growing body of evidence which indicates that structured physical activity can be effective in the rehabilitation of many individuals with mild-to-moderate depression (Callaghan et al., 2011; Carter et al., 2012), not least in terms of enhancing happiness with physical appearance and providing venues for positive social interaction (Daley et al., 2007; Johnson & Taliaferro, 2011). Even the traditionally (and necessarily) conservative NICE guideline on the treatment and management of depression in primary care summarises findings in this domain affirmatively: "Taken together, these studies suggest a benefit for physical activity in the treatment of subthreshold depressive symptoms and mild to moderate depression, and, more specifically, a benefit for group-based physical activity. Physical activity also has the advantage of bringing other health gains beyond just improvement in depressive symptoms." (NICE, 2009, p.211).

As a corollary of widened academic interest in the efficacy of exercise for the treatment of a range of health complaints, formal Exercise Referral Schemes (ERSs) have been developed throughout the UK to provide access to tailored programmes of physical activity (Carter et al., 2012): "many of which include depression as a referral criterion" (Lawlor & Hopker, 2001, p.1).

This paper, following the call from Moore et al. (2011) for greater qualitative investigation of the views of healthcare professionals on ERSs, uses interpretative phenomenological analysis (Pringle et al., 2011; Smith et al., 2009) to explore the experiences of a small sample of GPs in the North West of England. It should be noted at this point that the authors do not claim a study of this form can evidence - in anything other than an anecdotal manner - the propositional 'effectiveness' of ERS use as a rehabilitative strategy for depression. Rather, through the inductive examination of the experience of four GPs with practical knowledge of the schemes, it is intended to explore concomitant...
issues as they are conceptualised, connected, and rationalised by the participants themselves. This can help add additional dimensions to the understanding of existing concepts, and also sketch new ones for further exploration (Smith et al., 2009; Vachon et al., 2011).

Method

Framework

Interpretative phenomenological analysis (IPA) is a relatively new methodology within the arena of qualitative research, providing a structured means of exploring in detail “how participants are making sense of their personal and social worlds, and the meaning attached to them.” (Rhodes & Smith, 2010). There is, of the experiences, events, states hold for participants

IPA studies typically use small samples to facilitate higher definition investigation of the particular, with users' experiences of a variety of conditions (Hamill et al., 2010; Todd et al., 2011), including the meaning of depression itself (Rhodes & Smith, 2010). There is, however, a growing body of work in the field dedicated to exploring the experiences of healthcare professionals (Arvinen-Barrow et al., 2010; Vachon et al., 2011).

Participants

IPA studies typically use small samples to facilitate higher definition investigation of the particular, with some commentators actually advocating a single-case method (Smith et al., 2009). In this paper, and following procedures in line with institutional ethical guidelines, a small sample (N=4) of GPs was purposively recruited. All participants, at time of writing, were practising in the North West of England and had practical experience in the use of exercise referral schemes.

Procedure

As recommended by Smith and Osborn (2008) data were collected using semi-structured interviews, and largely open questioning, either in person (at a sense of the participant’s choosing) or via the telephone. All interviews, with participant consent, were digitally recorded and transcribed in full. Data were anonymised at the point of transcription. The average interview duration was 25 minutes.

Data analysis

Analysis proceeded in line with the standard idiographic techniques of IPA, in which an initial free textual analysis is condensed into linked (subordinate) themes, and finally into a smaller number of master (superordinate) themes that hold across the data corpus (see Smith & Osborn, 2008; Smith et al., 2009). Analytic themes were initially developed by the first author, revised by the second, and reviewed by a third academic with strong qualitative analysis experience, in a process of triangular consensus validation (Pettson, 1990).

Results and discussion

Analysis revealed 16 subordinate themes, as displayed in Table 1 (below).

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Superordinate themes 1: nI believe that exercise helps treat depression, but better systems of information are needed around the schemes themselves.

In terms of the use of formal ERSs, however, several key problems were identified in terms of practically available information. These were:

a) A lack of information provided to GPs pertaining to the existence of local ERSs, and changes in local schemes, i.e., “The information is often absent or out of date.”

b) A lack of formal information provided to GPs pertaining to the exercise referral process itself, i.e., “The systems for referral are not always made clear to GP1.”

c) A lack of formal survey feedback from ERSs and the patients who have taken part in them, i.e., “There is little way of knowing if and/or how the referral has benefited the patient.”

d) A lack of information suitable for patients themselves, to help convince them that an ERS is a suitable therapeutic method, i.e., “Patients may not see exercise as proper treatment.”

It was strongly acknowledged, regarding point (c), that the little feedback that had actually been received had been very positive, but that a formalised system for its collection was imperative for both GPs and prospective users of the schemes.

Superordinate theme 2: nWhile exercise referral schemes are likely to be of benefit to patients with depression, the patients themselves experience personal and social obstacles to participation.

Besides the generally positive attitude towards ERSs held by the participants, there was some further issues that were conceptualised as likely reasons that patients with depression would themselves resist exercise referral which, in turn, were viewed as obstacles to referral itself.

Regarding the corollary point (d), meanwhile, it was argued that more compelling, patient-focused research and evidence needed to be produced, ideally “case studies and examples” (GP1) showing successful interventions. This raises the broader issue of difficulties promoting patient engagement with exercise referral schemes. While there is to date very little robust research that investigates issues specifically pertinent to points (a)-(d) above, engagement is a commonly occurring topic throughout the broader literature on ERSs (see Carter et al., 2012; James et al., 2008; Moore et al., 2011; Morgan, 2005), and is further addressed by participating GPs in terms of
Participants in the current study spoke extensively of the barriers to motivation that depression itself can erect with regards to such involvement (see sample evidence above).

In short, finances often obstructed long-term use of the scheme and, without the scheme, motivation often obstructed independent exercise. As also evidenced by participants as being due to many patients from poorer socio-economic backgrounds simply not being able to afford to participate in formal initiatives once subsidies were no longer available. However, it was individuals for external regulation to supplement their own motivational difficulties. However, given that ERSs are often free or heavily discounted to patients only in the earlier stages of their involvement, financial barriers were deemed to be significant issues in maintaining adherence to the supervised phase of physical activity itself.

In the inductive analysis above, participants can be seen to raise a number of issues closely allied to those arising in extant literature, but also some hitherto given limited attention. The primary novelty to emerge relates to the links between research, information, culture, and attitude. At the level of broader academic research, and as discussed above, it has for some time been noted that the use of particular quantitative methods alone may prove something of a blunt instrument for the investigation of ERSs on the grand scale (James et al., 2008). However, the manner in which the participants weave together key matters related to ERSs and depression rehabilitation both implies and directly calls for attention to the character of research and dissemination at the local level:

1. Formalised systems of structured feedback from patients with depression who have taken part in ERSs - ideally in survey form - would provide GPs with

Perhaps the most striking of the meta-themes to emerge from the interviews related to the manner in which participants experienced a cultural 'pressure' to use particular kinds of strategies in treating depression. Reflecting concerns evident in the literature on the topic (see Hyde et al., 2005), this pressure was taken to manifest in two key ways. The first related to the notion of bucking medical trends, i.e., the experienced difficulty in prescribing treatments that are not as yet regarded ‘mainstream’ (which is to say not fully ‘clinically proven’) when there are more conventional approaches (usually antidepressant medications) available. The second, and closely related to the first, was a perceived and ongoing lack of institutional support (generally fiscal) for the use of therapies that do not provide a ‘quick fix’, even when those therapies may save money overall:

Since exercise referral was neither seen as a quick fix, nor as a mainstream approach in the treatment of depression (despite having been in use for over a decade), participants thus felt a particular constraint in using it (despite their own stated positive experiences). These putatively contradictory attitudes, in particular, highlight an issue of circularity stemming from entrenched proof procedures in medical science itself. Across a range of quantitative studies, the efficacy of ERSs for a variety of interventions is deemed largely ambiguous, not due to a lack of evidence per se, but a lack of very specific evidence of that emergent of randomised controlled trials (Lawler & Hopker, 2001, p.6). However, while randomised controlled trials (RCTs) provide evidence per excellence for the monitored assessment of pharmaceutical treatments, they are rather less appropriate for investigating interventions such as exercise where issues of efficacy are intrinsically bound up with sociological and psychological questions pertaining to uptake, adherence, and interaction. RCTs are, simply, “not designed to answer such questions as they lack the external validity necessary to faithfully replicate practice” (James et al., 2008, p.218). The upholding of RCTs as the singular gold standard of research by medical culture effectively obviates the possibility that a community-oriented treatment for depression - such an ERS - could attain a truly ‘proven’ status within that medical culture. This, in turn, has the potential to cyclically perpetuate (a) the difficulties in referring for individual healthcare professionals described above; (b) the corollary taking financial savings also described; and (c) ultimately, still fewer robust academic investigations. As originally recommended by the Department of Health (2001), formal academic evaluation of exercise referral schemes should not confine itself to use of the RCT format; to these ends, a much wider array of research forms should be considered if more three-dimensional understandings of impact in this domain are to be generated (Carter et al., 2012; James et al., 2008; Moore et al., 2011).


