Depression, Physical Activity and Mental Health

Paul K. Miller & Rachel L. Ward

Details

- **An interpretative phenomenological analysis of general practitioners' experiences of exercise referral schemes in the North West.**
- **In press, next issue of the Cumbria Partnership Journal.**

Background

- The percentage of individuals aged 18+ suffering from any form of depression (bar postpartum) in 2009-2010:
- Nationally - **11.19%** (NEPHO, 2012a; NEPHO, 2012b)
- North West of England - **12.82%** (British Medical Association, 2009, pp.94-100).
  - Cumbria experiences a rate of **12.87%** (NEPHO, 2012a);
  - Lancashire fares slightly worse at **13.67%** (NEPHO, 2012b).

Exercise & Depression

- Exercise (structured or otherwise) has minimal impact on more severe forms of depression (Chalder et al., 2012). However:
- Structured physical activity can be very effective in the rehabilitation of many individuals with mild-to-moderate depression (Callaghan, Khalil, Morres, & Carter, 2011; Carter, Callaghan, Khalil, & Morres, 2012).
- Not least in terms of enhancing happiness with physical appearance and providing venues for positive social interaction (Daley, MacArthur, & Winter, 2007; Johnson & Taliaferro, 2011).

National Institute for Clinical Excellence (2009, p.211)

- "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."

ERSs

- Formal Exercise Referral Schemes (ERSs) have been developed throughout the UK to provide access to tailored programmes of physical activity (Carter, Callaghan, Khalil, & Morres, 2012).
  - "…many of [these] include depression as a referral criterion." (Lawlor & Hopker, 2001, p.1)
- **BUT** rates of referral to exercise-based programmes in the UK remains low, particularly when compared to the use of other avenues of treatment.
- Moore *et al.* (2011) call for greater qualitative investigation of the views of healthcare professionals on ERSs to help explain this.

Project

- Uses interpretative phenomenological analysis (IPA) to explore the experiences of a small sample of General Practitioners (henceforth GPs) in the North West of England.
- Inductive examination of the experience of four GPs with practical knowledge of the schemes offer opportunity 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, Flowers, & Larkin, 2009; Vachon, Fillion, Achille, Duval, & Leung, 2011).

Method

- Data were collected using semi-structured interviews.
- 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.
- Analysis proceeded in line with the standard idiographic techniques of IPA (see Smith & Osborn, 2008; Smith, Flowers, & Larkin, 2009):
  - **Free text analysis > Subordinate themes > Superordinate themes.**

Subordinate Themes

Themes.		Themes.	
1	GPs are not always made aware of ERSs in the area.	2	GPs have limited information on referral criteria or changes to ERSs themselves
3	There is limited feedback on the impacts of referrals, so efficacy is hard to judge.	4	What feedback is obtained is always positive.
5	Exercise is often advised but not actually prescribed.	6	Exercise seems valuable in the short and long term rehabilitation of depression.
7	Patients with depression can struggle to motivate themselves to begin exercise.	8	Patients can struggle to sustain exercise in the long-term without formal supervision.
9	Patients with depression can be averse to public or group activities.	10	There are fiscal constraints on many patients that preclude long-term engagement with structured exercise.
11	Counselling can facilitate a willingness to exercise.	12	Counselling can be counter-productive as a preparatory step.
13	Patients may not believe that ERSs work, they need evidence that makes sense to them.	14	The institutional need for 'Quick Fix' strategies constrains GPs in prescribing ERSs.
15	There are time constraints on GPs that can inhibit patient involvement in ERSs.	16	Exercise is still a 'fledgling' therapy for depression.

Superordinate 1

- ***"I believe that exercise helps treat depression, but better systems of information are needed around the schemes themselves."***

Sample Evidence

GP3: *"…I'd say [in] both the acute and long term setting it's a valuable therapy for helping them."*

GP2: *"I can think of cases where people have…adapted exercise as part of their depression plan to…maintain things in the long term with 'good effect."*

GP4: *"I think these alternative therapies like psychological interventions or exercise [are] probably better in the long term as well."*

But…

1. The information about ERSs is often absent or out of date.
2. The systems for referral are not always made clear to GPs.
3. Feedback: There is little way for GPs to know if and/or how the referral has benefited the patient, they need hard numbers.
4. Public relations: Patients may not see exercise as *proper* treatment, they need qualitative cases.

Superordinate 2

- ***"While exercise referral schemes are likely to be of benefit to patients with depression, the patients themselves experience personal and social obstacles to participation."***

Sample Evidence

GP1: *"So the problem can be is if they have anxiety with low mood, then they've got agoraphobia, and fear of unknown places and that can be a problem then they don't want to be a part of a group."*

GP3: *"….It depends what they are feeling anxious about. It could be meeting new people …"*

GP4: *"Motivation is normally a big problem…because often they don't feel like going out of the house."*

Motivation

- Motivation was viewed not only as an obstacle to initial entry into an ERS, but also to participating patients sustaining independent involvement in exercise itself once *structured supervision* (i.e. the formal scheme) was no longer available (see also Moore, Moore, & Murphy, 2011).
- This was, in part, attributed to a need among depressed individuals for external regulation to supplement their own motivational difficulties.

Finance

- 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.

Sample Evidence

GP1: *"A lot of people have started on [name of local initiative] and then decided they'd pay and keep it on, and now they just can't afford to."*

Vicious Circles

- Finances often obstructed long-term use of the scheme and, without the scheme, motivation often obstructed independent exercise.
- The former was partially explicated 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 (c.f. also James *et al*. (2008)).
- However, many persons with depression are often either signed-off from work in the long term, or unable to work in a full-time capacity, thus compounding their own financial restrictions.

Superordinate 3

- ***"Obstacles in the contemporary culture of medicine itself can inhibit my referring patients with depression to exercise schemes."***
- Most striking of the meta-themes to emerge from the interviews.
- Participants experienced a "cultural" pressure to use particular kinds of strategies in treating depression.
- Reflecting concerns endemic in medical literature on the topic (see Hyde et al., 2005), this pressure was taken to manifest in two key ways:

A. Bucking the Trend

- GPs experienced difficulty in prescribing treatments that are not as yet regarded "mainstream" (i.e. "clinically proven") when there are more conventional approaches (usually antidepressant medications) available.

Sample Evidence

GP3: *"I think that…it's often it's easier to try and stick somebody on a medication when there are probably more effective strategies for [a] proportion of the people that have mood disorders."*

B. Quick Fixes

- Perceived and on-going 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.

Sample Evidence

GP1: *"…but then if…the government want to…you know…manage health better to decrease the health bill in the future, they have to put [money]in these sorts of areas where perhaps you don't see the immediate benefit."*

Culture and Science

- Participants thus felt a particular constraint in using ERSs (despite their own stated positive experiences) because ERSs were 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).
- Attitudes highlight an issue of circularity stemming from entrenched proof-procedures in medical science itself:
- Medically, 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 a very particular *type* of evidence:
  - Randomised controlled trials (Lawlor & Hopker, 2001, p.6).

RCTs

- RCTs good for pharmacology, less appropriate for interventions such as exercise where issues of effect are inextricably 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).
- Upholding of RCTs as the singular gold-standard of research by medical culture effectively obviates the possibility that ANY community-oriented treatment for depression - such an ERS - ***could*** attain a truly "proven" status within that medical culture.

Cyclical Perpetuation of:

1. The difficulties in referring for individual healthcare professionals described above;
2. The corollary tokenistic funding also described, and;
3. Ultimately, still fewer robust academic investigations.

Pulling it Together

- The primary novelty to emerge relates to the links between research, information, culture and attitude.
- Manner in which the participants weave together key matters relating to ERSs and depression rehabilitation both implies, and directly calls, for attention to the character of research and dissemination at the ***local* level** as much as the grand scale.

Conclusions and Recommendations 1:

- Formalised systems of structured feedback from patients with depression who have taken part in ERSs – ideally in survey form - would provide GPs with more robust and systematic evidence with which to inform their own future treatment decisions, and potentially improve their confidence in local decision-making by making available local (rather than general) data.

Conclusions and Recommendations 2:

- For cases in which referral to an ERS is deemed suitable by a GP, the production of qualitative case-study data could prove invaluable in the allaying of patient scepticism and also patient anxiety.
- "Humanising" the schemes through the dissemination of previous participants' own stories, giving a voice to others "in the same boat," may help form a valuable bridge between knowing about a scheme and actually feeling ready to take part in it.

Conclusions and Recommendations 3:

- Department of Health (2001) recommended that formal academic evaluation of exercise referral schemes should not confine itself to use of the RCT format; largely ignored in medical circles.
- Standard quantitative methods alone may prove something of a blunt instrument for the investigation of ERSs on the **grand scale** (James et al., 2008).
- Much wider array of research forms should be considered if more three-dimensional understandings of impact in this domain are to be generated (Carter, Callaghan, Khalil, & Morres, 2012; James et al., 2008; Moore, Moore, & Murphy, 2011).