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Depression, Physical Activity and Mental Health
Paul K. Miller & Rachel L. Ward

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 13.87% (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.” (Lauver & Rapier, 2001, p.3).
  - “ERS rates of referral to exercise-based programmes in the UK remain 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 & O’Brien, 2008; Smith, Flowers, & Larkin, 2009):
  - Free text analysis > Subordinate themes > Superordinate themes.

Subordinate Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Example Statements</th>
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<tbody>
<tr>
<td>1.</td>
<td>I believe that exercise helps treat depression, but better systems of information are needed around the schemes themselves.</td>
</tr>
<tr>
<td>2.</td>
<td>While exercise referral schemes are likely to be of benefit to patients with depression, the patients themselves experience personal and social obstacles to participation.</td>
</tr>
<tr>
<td>3.</td>
<td>The information about ERISs is often absent or out of date.</td>
</tr>
<tr>
<td>4.</td>
<td>The systems for referral are not always made clear to GPs.</td>
</tr>
<tr>
<td>5.</td>
<td>Feedback: There is little way for GPs to know if and/or how the referral has benefited the patient, they need hard numbers.</td>
</tr>
<tr>
<td>6.</td>
<td>Public relations: Patients may not see exercise as proper treatment, they need qualitative cases.</td>
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But...

1. The information about ERISs 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.
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.

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.

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.
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 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, & Memee, 2012; James et al., 2008; Moore, Moore, & Murphy, 2011).