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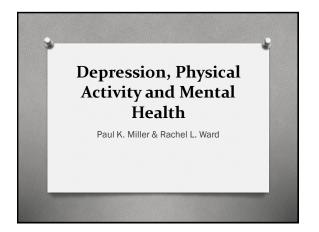
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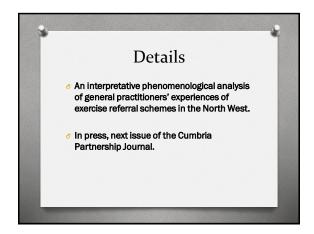
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Background The percentage of individuals aged 18+ suffering from any form of depression (bar postpartum) in 2009-2010: Nationally - 11.19% (NEPHO, 2012a; NEPHO, 2012b) North West of England - 12.82% (British Medical Association, 2009, pp.94-100). Cumbria 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."

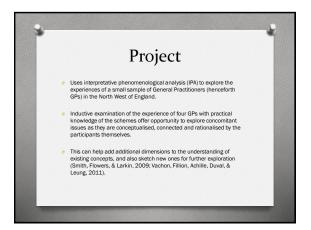
ERSs

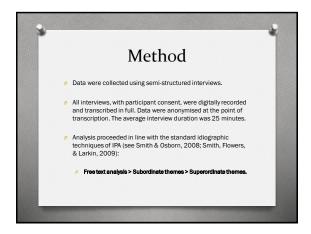
• Formal Exercise Referral Schemes (ERSs) have been developed throughout the UK to provide access to tailored programmes of physical activity (Carter, Callaghan, Khaill, & Morres, 2012).

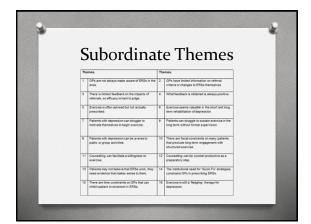
• "...many of [these] include depression as a referral criterion." (Lawlor & Hopker, 2001, p.1)

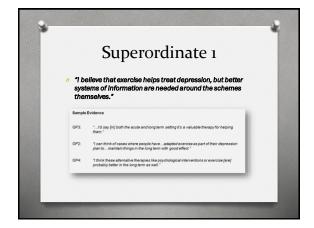
• BUT rates of referral to exercise-based programmes in the UK remains low, particularly when compared to the use of other avenues of treatment.

• Moore et al. (2011) call for greater qualitative investigation of the views of healthcare professionals on ERSs to help explain this.









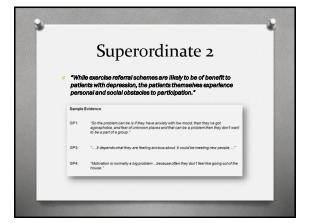
But...

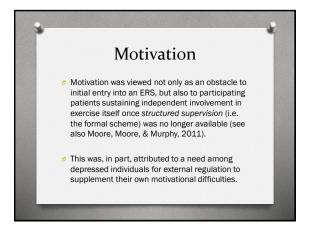
1. The information about ERSs is often absent or out of date.

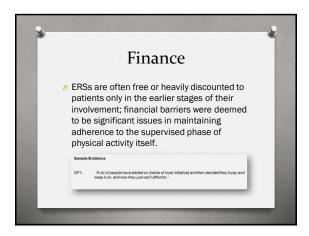
2. The systems for referral are not always made clear to GPs.

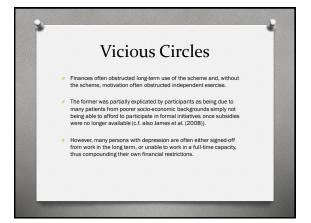
3. Feedback: There is little way for GPs to know if and/or how the referral has benefited the patient, they need hard numbers.

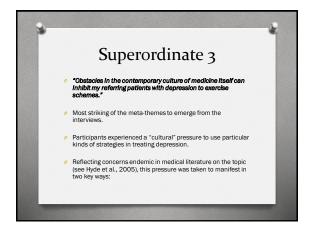
4. Public relations: Patients may not see exercise as proper treatment, they need qualitative cases.

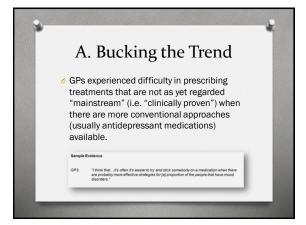


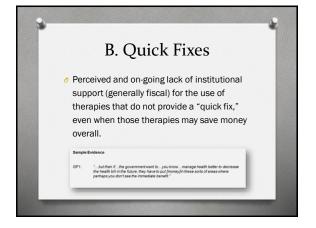












Culture and Science Participants thus felt a particular constraint in using ERSs (despite their own stated positive experiences) because ERSs were neither seen as a quick fix, nor as a mainstream approach in the treatment of depression (despite having been in use for over a decade). Attitudes highlight 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 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. 2 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). 2 Upholding of RCTs as the singular gold-standard of research by medical culture effectively obviates the possibility that AYY 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, Khaili, & Morres, 2012; James et al., 2008; Moore, Moore, & Murphy, 2011).