

Could not prescribing exercise for depression be psychiatric malpractice?

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The prevalence of depression is increasing, with 290 185 742 people with a documented depression globally in 2019.¹ People with depression experience a significantly increased risk of numerous physical diseases, such as obesity, diabetes, high blood pressure and heart failure, among others.² Traditionally, the primary treatment modalities for depression include antidepressants and psychotherapy. While effective in some instances, a considerable portion of the population (30%–50%) does not respond to these treatments. Further, these interventions do not target and may instead exacerbate physical ailments in some instances.³

There has been increasing recognition of the use of exercise as a treatment for depression. Recent meta-analyses have demonstrated that exercise has antidepressant effects comparable to those of medications or psychotherapy, with simultaneous multisystem benefits to one's physical health.^{4,5} Beyond depressive symptoms, exercise has established efficacy in preventing and managing a plethora of physical comorbidities, many of which disproportionately affect people with depression.⁶ Exercise has also demonstrated potential to reduce suicide attempts in those with depression.⁷ As such, exercise has been adopted as a first-line treatment in guidelines for depression globally with good acceptability and safety.^{6,8} Despite this, clinically, exercise is uncommonly prescribed or prioritised in the psychiatric setting.⁹

In a survey of mental health professionals, most (92%) stated that they had received no formal training in exercise prescription.⁹ While medication was perceived to be the most beneficial treatment, exercise was ranked as fifth, with almost half (41%) stating that they never prescribe exercise to their patients. The largest barriers to prescribing exercise were the notion that it should be left to

exercise professionals (73%) and lack of knowledge surrounding how to implement exercise into their clinical practice. However, those who themselves met the recommended physical activity levels had fewer barriers to prescribing exercise and did so with much greater frequency.⁹ Evidently, there is a disconnect between the exercise literature for depression, highlighted importance in guidelines and actual application in clinical practice. Given the multitude of literature now available regarding the effectiveness and safety of exercise for depression, is failure to prescribe and support this for patients not a serious failure? By comparison, it would be considered unacceptable for a psychiatrist to be unequipped to prescribe medication or refer to or perform effective psychotherapy to their patients, so why do we accept that exercise, a first-line treatment for depression, is rarely prescribed to patients? At what point does this disconnect between the evidence, policy and patient preferences and what a psychiatric service offers become malpractice?

So, how does one 'prescribe' exercise for depression? Simply telling people to 'be active' or 'go exercise' rarely works and can be potentially perceived as condescending. This would be akin to telling your patient to 'just take an antidepressant' or 'go to therapy' when presenting with depression. When prescribing an antidepressant, the physician would be expected to specify the medication, dose, route, frequency and titrate the dose over time to achieve an appropriate clinical effect. When recommending therapy, a provider will discuss particular modalities, necessary durations and help them find a good fit over multiple sessions. Similarly, when prescribing exercise, a structured approach based on the frequency, intensity, time and type (FITT) framework can be used to discuss the details of the exercise prescription, to personalise and to maximise adherence and anti-depressant effects.¹⁰ Importantly, exercise requires support and motivation in the early stages, and it is incumbent on psychiatric professionals to develop services with equipped exercise professionals who may initially deliver the training.

What needs to be done to ensure exercise is considered and ultimately more frequently prescribed? First, this disconnect needs to be recognised through consistent education early on starting from medical school, during psychiatric training and as a staff psychiatrist. It is not enough to learn that 'exercise is good for depression'; this is non-actionable and does not lead to changes in prescribing patterns.⁹ Instead, psychiatrists should learn about exercise physiology, the practical methods of an effective exercise prescription via the FITT framework¹⁰ and how to tailor these exercise interventions to individual patient needs, preferences and enjoyment. Second, exercise must be included in all guidelines as a first-line treatment for depression, with evidence-based protocols and guidance for navigating barriers. Third, we must advocate for change at the policy level. Similar to medications, exercise should be a reimbursable mental health intervention, whether that be through subsidised gym memberships or structured interventions delivered by an exercise professional. At the physician level, policy changes should include changes to reimbursement for exercise prescription as a financial incentive for change. Fourth, psychiatrists must collaborate more with allied health professionals, particularly in the outpatient setting. Direct referral pathways must be established to exercise physiologists, physical therapists or certified trainers who can implement and tailor exercise prescriptions to patient needs, which has been demonstrated to increase adherence and antidepressant effects.⁵ Finally, due to the progression of technology, data from wearable devices (ie, smartwatches) can be leveraged to track progress to adjust exercise prescriptions and provide feedback for patient motivation in real-time.

Critics may argue that exercise prescription exceeds the scope of psychiatric practice or that patient non-adherence limits its feasibility. However, these objections falter under scrutiny. Psychiatrists routinely manage complex interventions, from polypharmacy to behavioural therapies, and patient non-adherence is a universal challenge, not unique to exercise. The ethical imperative to offer evidence-based treatments supersedes such concerns. Failure to prescribe exercise denies patients a safe, effective intervention with multisystem benefits, perpetuating suboptimal care and exacerbating health disparities.

In the same way that failing to offer medication, psychotherapy or metabolic monitoring when clearly indicated is

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considered below the standard of care, and in some cases constitutes malpractice, the continued neglect of exercise, despite compelling evidence, fails to align with current best practices. For psychiatric practice to be genuinely holistic, integrating exercise warrants inclusion as standard practice. Our ethical responsibility is to provide the full spectrum of effective, evidence-based treatments.

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