BJGP OPEN

Sustaining poverty-aware mental health practice: evaluating the long-term impacts of DeStress-II

Berzins, Kathryn; Christian, Danielle; Aspinall, Georgia; Hansford, Lorraine; Thomas, Felicity

DOI: https://doi.org/10.3399/BJGPO.2026.0031

To access the most recent version of this article, please click the DOI URL in the line above.

Received 11 Febuary 2026

Revised 09 April 2026

Accepted 05 May 2026

© 2026 The Author(s). This is an Open Access article distributed under the terms of the Creative Commons Attribution 4.0 License (http://creativecommons.org/licenses/by/4.0/). Published by BJGP Open. For editorial process and policies, see: https://bjgpopen.org/authors/bjgp-open-editorial-process-and-policies

When citing this article please include the DOI provided above.

Author Accepted Manuscript

This is an 'author accepted manuscript': a manuscript that has been accepted for publication in BJGP Open, but which has not yet undergone subediting, typesetting, or correction. Errors discovered and corrected during this process may materially alter the content of this manuscript, and the latest published version (the Version of Record) should be used in preference to any preceding versions

Sustaining poverty-aware mental health practice: Evaluating the long-term impacts of DeStress-II.

Berzins, K., Christian, D.L., Aspinall, G., Hansford, L & Thomas, F.

AUTHORS:

1. Dr Kathryn Berzins*, Applied Health Research hub, University of Lancashire, Preston, Lancashire, PR1 2HE, United Kingdom (kberzins@lancashire.ac.uk).
2. Dr Danielle L Christian, Applied Health Research hub, University of Lancashire, Preston, Lancashire, PR1 2HE, United Kingdom (dchristian@lancashire.ac.uk).
3. Ms Georgia Aspinall, Applied Health Research hub, University of Lancashire, Preston, Lancashire, PR1 2HE, United Kingdom (gaspinall2@lancashire.ac.uk).
4. Ms Lorraine Hansford Department for Health and Community Sciences, St Luke's Campus, University of Exeter, EX4 4QH, UK (l.j.hansford@exeter.ac.uk)
5. Prof Felicity Thomas, Department for Health and Community Sciences, St Luke's Campus, University of Exeter, EX4 4QH, UK (f.thomas@exeter.ac.uk)

*Corresponding author

Accepted Manuscript - BJGP Open - BJGPO.2026.0031

Abstract

Background: Deepening poverty in the UK is associated with high levels of antidepressant prescribing in economically deprived areas. Primary care practitioners often do not feel confident to address the socioeconomic causes of distress. The *DeStress-II* training programme was co-developed with primary care practitioners and people from low-income communities to improve consultations, but evidence of long-term sustainability is required.

Aim: To explore practitioners' perspectives on sustained changes to practice one year after DeStress-II training.

Design and setting: Qualitative follow-up study in English primary care practices.

Method: Semi-structured interviews with 30 multidisciplinary practitioners12 months post-training. Data were analysed using thematic analysis, framed by Normalisation Process Theory to explore the embedding of new practices.

Results: Practitioners reported that DeStress-II principles were generally retained, with sustained confidence in asking about patients' socioeconomic circumstances. Reported impacts included increased referrals to social prescribers, strengthened multi-disciplinary teamwork, and a perceived shift towards non-pharmacological alternatives. Training provided professional legitimisation for holistic care and reinforced existing values, although full normalisation was hindered by systemic challenges such as limited consultation times, language barriers and patient expectations around the prescribing of antidepressant medication.

Conclusion: The DeStress-II training intervention facilitates the embedding of socioeconomic determinants of health into consultations, aligning with the ambitions of the 10 Year Health Plan and the NICE guidelines for Depression. While practitioners perceive a positive shift in practice maximising the benefits requires integrated care approaches which support broader community service networks.

Key Words

Mental health, Poverty, Socioeconomic factors, Primary health care, Normalisation Process Theory, Referral and Consultation, Antidepressive Agents

How this fits in

The DeStress-II intervention encourages a more holistic approach to poverty-related mental distress by improving GP consultations. Initial evaluation found the intervention had positive impacts on health care practitioners which impacted treatment, referral options and provision of appropriate support. However, there is a need to understand if these changes are perceived to be maintained over time. This qualitative study uses Normalisation Process Theory to explore implementation and sustainability of DeStress-II over time.

Accepted Manuscript - BJGP Open - BJGPO.2026.0031

Introduction

Background

Evidence shows deepening poverty in the UK(1) and ongoing health inequalities(2). Concurrently, there are high, and increasing, levels of antidepressant prescribing in areas of socio-economic deprivation(3). While medication may offer initial relief, the persistence of social stressors and long waiting lists for talking therapies(4) often lead to patients in low-SES communities remaining on prescriptions for years(5). In England, annual spending on antidepressants has reached approximately £230 million(6).

GPs and other primary care practitioners have a key role to play in identifying and supporting patients experiencing adverse health effects caused by poverty(7). Patients from low socioeconomic backgrounds place importance on having a therapeutic, interpersonal relationship with their GP, effective communication, and continuity of care(8). Despite this, in-depth discussions about patients' socio-economic circumstances are not standard practice(9). This lack of discussion is potentially exacerbated by the 'Inverse Care Law' (10, 11) where deprived areas often have fewer GPs and greater population need. Research has shown that clinicians can feel trapped by these systemic constraints, including short consultation times; consequently, prescribing can become a pragmatic response to a lack of available alternatives(4). Research reports that health professionals feel these discussions are potentially outside of their medical remit, bar mandatory social histories, and they lack the skills or confidence to enquire at a deeper level(9).

National policy increasingly mandates shifts toward non-medicalised, community-based care, reinforced by the 'Fit for the Future: 10 Year Health Plan for England' which sets out three strategic shifts: from hospital to community, analogue to digital and crucially for this study – from sickness to prevention(12). This is supported by NICE guideline NG222 that recommends people presenting with new episodes of less severe depression should not be offered antidepressant medication as a first-line treatment but instead offered support identifying social and psychological stressors(13). Despite this, primary care practitioners do not always feel confident having discussions about people's socio-economic circumstances.

The DeStress-II training resource was co-developed with GPs and community partners (with lived experience) to encourage a more holistic approach to poverty-related mental distress within low-income communities(14). Main features of the resource include information slides, videos on patient and professional experiences, consultation scripts, consultation role play and reflective questions for group discussion.

Initial evaluation found the training helped health care practitioners to recognise the importance of asking patients questions about their socioeconomic circumstances and fostered the confidence to do so(9, 14). This in turn impacted treatment, referral options and provision of appropriate support. However, while these short-term impacts are documented, there is a need to understand if changes are maintained over time.

This study uses Normalisation Process Theory (NPT)(15) to explore implementation and sustainability. NPT captures how new practices become integrated into routine activity through analysing the cognitive and social factors at play. In this study NPT is used to examine the process of practitioners implementing the messages of the DeStress training one-year post-intervention.

Aim

Accepted Manuscript – BJGP Open – BJGPO.2026.0031

To explore health care practitioners' perspectives on long-term changes to practice following the DeStress-II training and factors influencing sustainability.

Method

Study design

This study reports on follow-up interviews with health care practitioners a year after undertaking the DeStress-II training(9). To analyse the longer-term integration of the intervention we used a qualitative design framed by Normalisation Process Theory (NPT)(15). NPT was selected because it provides a theory-based framework for understanding the work people do, individually and collectively, to implement and sustain a new practice. We used NPT to examine the dynamic process of embedding changes into routine clinical activity in the context of increasing pressures in primary care. The interviews explored if and how consultations have changed since undergoing the training and if those changes have been maintained. The study is reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist(16).

Participants and recruitment

We used a purposive sampling strategy to recruit from practices across three regions of England selected for their demographic variation (South West, North West and North London) who had previously participated in the DeStress-II training. DeStress-II was delivered to whole practice teams so to ensure a whole-team perspective, eligible staff included GPs, pharmacists, nurses, social prescribers and administrative staff. Administrative staff were included to provide a whole-system perspective on how the intervention was operationalised across the practice. Practices were invited to nominate staff members willing to share insights into their experiences after the training over the longer-term. Thirty practitioners were invited by email participated (see Table 1), a 61% follow-up from the initial evaluation. We were not able to ascertain reasons for non-participation. All practices were either in areas of high economic deprivation or had pockets of high deprivation within their catchment. Staff provided written consent and undertook online interviews via Microsoft Teams with nobody else present and lasted between 13 and 45 minutes. Interviews were incentivised with gift vouchers.

Data collection and analysis

Semi-structured interviews sought to explore practitioners' perspectives on whether consultations had undergone any changes since their participation in the training a year earlier. Questions focused on changes in practice, facilitators and barriers to sustaining change and longer-term impacts for staff, organisation and wider networks and were piloted during the first few interviews with no changes required. Interviews were conducted by LH, recordings were transcribed verbatim and identifiable data removed to ensure anonymity. No field notes were taken and neither transcripts nor findings were returned to participants for correction. We adopted a systematic thematic analysis approach(17), supported by NVivo14, to interpret data. Following initial open coding by authors LH, KB, DC, GA we applied an abductive approach to map identified themes onto the four constructs of NPT. This involved an iterative process of moving between the participant transcripts and the theoretical framework to examine how the DeStress approach was being 'made sense of' (Coherence); 'bought in to' (Cognitive participation); 'enacted' (Collective action) and 'appraised and adapted' (Reflexive monitoring). To minimise individual bias, the coding framework was discussed and refined by the multidisciplinary research team.

Accepted Manuscript - BJGP Open - BJGPO.2026.0031

The multidisciplinary research team included female social science and health services academic researchers with extensive qualitative expertise. Our collective orientation aligns with a bio-psycho-social model of health, while acknowledging the clinical utility of antidepressants.

Results

Table 1 Participant demographics

Characteristic	n (%)	Mean (SD) / Range
Gender		
Female	24 (80.0%)	
Male	6 (20.0%)	
Age (years)		46.2 (SD 6.9)
Missing	2 (6.7%)	
Ethnicity		
White British	20 (66.7%)	
Asian / Asian British*	8 (26.7%)	
White Other	2 (6.7%)	
Role		
General Practitioner	19 (63.3%)	
Nursing (General & Mental Health)	3 (10.0%)	
Care & Health Coordination**	2 (6.7%)	
Pharmacy	1 (3.3%)	
Administration	2 (6.7%)	
Social Prescribing	3 (10.0%)	
Years Since Qualification		17.1 (SD 8.9)
Missing	10 (33.3%)	
Region		
London	13 (43.3%)	
South West	9 (30.0%)	
North West	8 (26.7%)	

Findings from the 30 interviews are presented by NPT domain.

1. Coherence: Sense-making and differentiation

The intervention coherence was mediated by the intersection of practitioner values and established clinical habits. For many, the training did not introduce entirely new concepts but rather reassured them that their existing holistic values were valid. Sustainability was

Accepted Manuscript - BJGP Open - BJGPO.2026.0031

underpinned by this alignment with practitioner values and experiences, which supported the shift away from a purely medical model. This sense-making process was characterised by a negotiation between these underlying values and practice habits. One GP noted that for many in the practice, the intervention legitimised work they already aspired to do:

"They [colleagues] mentioned to me they felt they'd be doing a lot anyway... it just re-emphasised it, and they were happy" (GP, NTGP1202).

This re-emphasis allowed practitioners to distinguish a 'poverty-aware' approach from more orthodox, medicalised ways of doing things, NPT terms this as 'differentiation'. Crucially, this differentiation was facilitated by the wider policy context; by aligning the intervention with the Health Plan's strategic shift from 'sickness to prevention'(7) and NICE guidelines around not prescribing as a first line response to mild-moderate depression, practitioners felt their individual values were supported by a broader systemic mandate. Practitioners noted that while specific training details faded over time, the core 'coherence' of the intervention principles endured:

"…most of us were self-reassured that that's what we had been doing anyway" GP, North West (B02)

"We don't really link the connection between mental health and deprivation, but this training helped us to see actually that there is a big connection and work more on that than we used to". Health and Wellbeing Coach, South West, (B01)

One GP noted that ease of integration of new approaches was not uniform but mediated by existing clinical habits. Experienced practitioners had an established 'style' of consultation that a new approach would need to be retrofitted into, whereas those in the formative stages of their career might more easily internalise the approach:

"…because I've been a GP now for a few years, you develop your own consultation style... but if I were a trainee GP I would have picked them up more… They [Trainee GPs] will absorb that better". GP, London, (1202)

This suggests that while practitioner values provide the 'buy-in,' the sustainability of the intervention depends on how well it can either successfully disrupt or align with practice habits. While this is an individual reflection it shows the potential for early career intervention to help normalise the discussion of social stressors within primary care. By anchoring these changes in both individual practitioner experience and the community-focused model of care set out in the Health Plan, the intervention creates a 'coherent' professional logic that justifies the effort required to overcome what are significant structural constraints.

2. Cognitive Participation: 'Buy in' and legitimation

The data suggests that one year post training, the intervention provided legitimation to discuss potentially sensitive socioeconomic issues. Some practitioners described how this led to a shift in their remit, 'allowing' them to engage with financial distress as a primary concern:

"I've always been a little bit anxious about talking about money. So… now, I feel a bit empowered... I'm braver to ask, especially in the context of the cost-of-living crisis, to say, you know, is finances something you're worried about?". GP, London, (1210)

Accepted Manuscript - BJGP Open - BJGPO.2026.0031

This sense of bravery supports the enacting of the NICE guideline NG222 that specify non-pharmacological approaches(13). By providing specific tools to shift consultations away from medicalised responses, the training helps practitioners bridge the gap between policy and practice. While the training had influence across the multidisciplinary team, its impact on those with prescribing powers was that it specifically supported resistance to writing a prescription when under time pressure. As one GP noted, the training served as a form of professional permission when navigating patient expectations:

"It's made me brave in thinking about asking… if you feel like you're getting push-back from patients, which you will do because it's different to [their] expectations, then it's really powerful to have somebody come along and say 'it's okay to do that'." GP, North West (B01).

Furthermore, practitioners reported adopting the DeStress II approach changed the nature of the consultation to become more strengths-based:

"I think some of those sorts of positive statements… recognising people's strengths... it's just bringing that from a place of where you've really listened and it's being sincere… that kind of giving a compliment essentially or recognising someone's strengths… that can be really powerful". GP, North West, (B11)

Cognitive Participation was sustained because the training provided 'legitimation' to practitioners to consider patients' living circumstances. This led to a greater 'buy-in' from the practice team, as it reframes this inquiry not as an extra but an essential component of the consultation.

3. Collective Action: Operationalising the work

The most significant shift observed was a move away from the primary responsibility being with the GP towards more evenly distributed multidisciplinary care. The intervention was stated to influence how practitioners interacted with the wider system to encourage alternatives to medication**:**

"I definitely am more proactive at using kind of the social prescribing and signposting to other services rather than going straight into medication..." GP, North West (B012)

The shift toward collective action was not facilitated by training in isolation, but by a change in the practice's operational context. By involving the whole practice team, the intervention established a shared language that allowed for more effective team working. This ensured that knowledge was not just held by the GP but was shared across the practice, allowing those with more time, such as Care Coordinators or Social Prescribers to be brought in to support the patient.

However, for many practitioners, this did not represent a binary choice between social support and pharmacological treatment. Instead, there could be a parallel approach to manage distress:

"It's not necessarily an 'either/or'. Sometimes you are doing the social prescribing and the referral, but you're also maintaining that medical support while they wait for those community links to kick in." GP, London (NT1211).

Accepted Manuscript - BJGP Open - BJGPO.2026.0031

"We're looking at the whole picture now. I might still prescribe if they are in crisis, but the conversation is no longer just about the tablets; it's about 'who else is helping you with the housing?'" GP, London (NT1217).

This evidence of changes in team working is further reflected in how the training influenced specific changes to the practice schedule and meeting culture:

"It changed the dynamic of the MDT meeting. We're talking more about social stressors as clinical facts now, rather than just 'background' noise." ANP, London (NT1215).

By legitimising social factors, the training supported GPs to manage the structural barrier of limited consultation time by distributing the work to team members with longer appointment allocations:

"The training meant we were all on the same page. Now, the GP doesn't feel they have to solve the poverty bit in 10 minutes; they know they can send them to me, and I have the 45 minutes to actually look at their benefits or their housing." Care Coordinator, London (NT1203).

The use of social prescribers directly links to the wider Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector and this link was further reinforced by practice-level changes in networking allowing practitioners to better navigate an ever-changing local service 'ecosystem'. One participant reported the training may have prompted more active engagement with the VCFSE sector:

"we've been given half a day a month… where we will actually go and meet some of these charitable third sector, local authority organisations… I think that could well have come from the training reminding me just how important it is to have a network and understand how that network works". Social Prescriber, North West (B10)

This indicates that the training promoted a more collaborative way of working with external partners that supports a social model of health.

4. Reflexive Monitoring: Appraisal and structural barriers

Practitioners felt that although their mindsets aligned with the training principles in theory, there were structural barriers preventing full normalisation into practice. In particular the time barrier of not feeling able to risk opening a "can of worms remained the primary challenge:

"The way this happens is the patient comes in... 'I want you to give me some antidepressants because I'm feeling really terrible'. And if you're running late, or you're having a hard day... it's a lot easier to be like, 'well it might help, here you go'". GP, North West (B01)

As also illustrated by the previous quote, participants noted that patients could have expectations of receiving a prescription.

"…a lot of our patients' expectation is for antidepressants. And so, I think even if we're doing other things… I haven't noticed my rate for prescribing change..." GP, South West, (M01)

The data suggests that for some practitioners, a broader view of patient difficulties did not always result in reduced prescribing but supported a parallel approach. In some instances, multidisciplinary support accompanied a prescription rather than replacing it, particularly

Accepted Manuscript - BJGP Open - BJGPO.2026.0031

when navigating patient expectations. This indicates that the normalisation of the DeStress-II approach may occur in stages, where the introduction of social support serves as an addition to care with the shift away from pharmacological dominance being more gradual. Ultimately normalisation remains contingent on shifting this wider cultural and systemic landscape in which the consultation occurs.

Discussion

Summary of findings

This study demonstrates that the DeStress-II training positively influenced perceptions of patient consultations over a one-year period, shifting practitioners towards being more poverty-aware and legitimised their facilitation of social support. By applying NPT, we showed that the coherence of the intervention came from its close alignment with existing values and that cognitive participation was achieved through supporting practitioners to engage with poverty-related mental distress. The sustainability of the intervention was underpinned by collective action throughout the multidisciplinary primary care team.

Strengths and limitations

A strength was the high retention rate of practitioners for the 12-month follow-up (61%), demonstrating sustained level of engagement DeStress-II training principles. The multi-disciplinary nature of participants, including GPs, social prescribers and pharmacists, provided a diverse perspective on how the intervention was integrated across the whole primary care team. The use of NPT allowed understanding of the work required to implement these practices amid service pressures. However, the study is limited by selection bias with those with more positive views being potentially more likely to participate in interviews. While this study provides insight into practitioner perspectives on changed practice and confidence, qualitative methodology alone cannot definitively measure changes in prescribing or referral rates.

Comparison with existing literature

Previous research on the DeStress II training established short-term impacts on practitioner knowledge, skills and confidence(9, 14). This 12-month follow-up builds on those findings by showing evidence of normalisation. Our findings suggest that providing practitioners with a 'poverty-aware' approach offers a viable alternative to the medicalisation of social suffering(18), this is important given the financial burden of antidepressant prescribing(6) . Even though prescribing often remains a pragmatic response to a lack of alternatives(4), our data suggest that DeStress-II provides support required to shift the consultation focus toward non-pharmacological options, even within the constraints of high-deprivation practice.

A notable finding of the initial evaluation was the popularity of specific consultation scripts to support therapeutic consultations(14). While direct recall of these scripts had faded over the year this can be seen as a transition from ‘acting out’ a script to internalising the principle and sustaining it through one’s personal consultation style. Our findings show training can reframe professional boundaries within consultations to normalise this more holistic inquiry. However, the frequently identified barrier of limited consultation time reflects the structural constraints of a primary care system under pressure and reflects the long-established 'Inverse Care Law'(10). However, the use of parallel care where multidisciplinary support from the wider team accompanies rather than replaces prescribing offers a pragmatic response to structural pressures. Finally, applying NPT(15) suggests that the sustainability

Accepted Manuscript - BJGP Open - BJGPO.2026.0031

of DeStress-II was achieved because the intervention moved beyond individual 'coherence' and into 'collective action.' By influencing MDT dynamics and treating social stressors as clinically significant, the intervention facilitated the embedding of new practices into routine clinical activity.

Implications for policy and practice

The findings show that there can be a collective shift towards non-medical responses from practitioners to poverty-related mental distress within primary care as already mandated by NICE guidelines(13) and the 10 Year Health Plan(12). To promote this transition from sickness to prevention, professional education should be targeted at early career practitioners as this may support the development of a more preventative model of care from the start. Learning from initiatives like TrainDEEP suggests that focused training and shadowing within a 'Training Practice' model can reduce burnout and aid staff retention in Deep End settings(19). Furthermore, as the success of non-medical initiatives often depends on a practice's prior exposure to social determinants(20), the development of a Neighbourhood Health Service must prioritise the resourcing of these community networks to ensure sustainability.

Finally, any policy shift must account for patient's experience and expectations; if non-pharmacological approaches are to become normalised, public education might be required to help better align patient expectations of primary care with social and psychological support promoted by current clinical guidelines.

Future Research

Future studies should triangulate these perceived benefits with longitudinal prescribing data to confirm if the shift toward social models is measurable in practice. In line with the concept of reflexive monitoring, research into the general public's views on antidepressant prescribing may help further support these consultations. If practitioners are to successfully move away from prescribing antidepressants, we must understand how to better align patient expectations with the non-medical approaches promoted by the NICE guideline(13). Finally, while this study highlighted the potential of early career intervention, further research is required to explore whether the timing of interventions impact the long-term adoption of non-medical approaches within professional identities.

Conclusion

Despite ongoing systemic pressures facing primary care in the UK, the DeStress-II training intervention demonstrated an ability to positively influence perceptions of approaches to consultations, prescribing and MDT working. By achieving long term normalisation, the intervention offers a practical mechanism to support the policy shifts to better recognise social determinants of health in primary care.

Funding:

This research was funded by the NIHR Research Inequalities Consortium 2021–2023.and the NIHR Applied Research Collaboration North West Coast (NIHR ARC NWC). The views expressed in this publication are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

Ethical approval:

NHS ethical approval was provided by Frenchay REC (ref: IRAS 303179).

Accepted Manuscript - BJGPO.2026.0031

Competing interests

The authors declare no conflicts of interest.

Acknowledgements

The authors would like to thank everyone who participated in this project, particularly the community partners and the wider DeStress-II training team.

References

1. Joseph Rowntree Foundation. UK poverty 2024: The essential guide to understanding poverty in the UK. Joseph Rowntree Foundation London; 2024, accessed. https://www.jrf.org.uk/uk-poverty-2024-the-essential-guide-to-understanding-poverty-in-the-uk 9th April 2026.
2. Shahid HJ. Poverty and health: The challenges for GPs. InnovAiT. 2018;11(2):109-14.
3. NHS Business Service Authority. Medicines Used in Mental Health – England – 2015/6 to 2022/3. 2023, accessed. https://www.nhsbsa.nhs.uk/statistical-collections/medicines-used-mental-health-england/medicines-used-mental-health-england-annual/medicines-used-mental-health-england-201516-202223 9th April 2026.
4. Kelly D, Graffi J, Noonan M, et al. Exploration of GP perspectives on deprescribing antidepressants: a qualitative study. BMJ Open. 2021;11(4):e046054.
5. Bansal N, Hudda M, Payne RA, et al. Antidepressant use and risk of adverse outcomes: population-based cohort study. BJPsych Open. 2022;8(5):e164.
6. NHS Business Service Authority. Medicines Used in Mental Health — England Quarterly Summary Statistics. 2025.
7. Shahid HJ. Poverty and health: The GP's role and opportunities. InnovAiT. 2018;11(5):277-84.
8. MacPherson N, Ta B, Ball L, et al. What makes a good general practice consultation? An exploratory pilot study with people from a low socioeconomic background. BJGP Open. 2024;8(2).
9. Thomas F, Wyatt K, Berzins K, et al. Discussing poverty within primary care consultations: implications for mental health support. BJGP Open. 2025.
10. Hart JT. The inverse care law. The lancet. 1971;297(7696):405-12.
11. Mercer SW, Watt GC. The inverse care law: clinical primary care encounters in deprived and affluent areas of Scotland. Ann Fam Med. 2007;5(6):503-10.
12. UK Government. Fit for the future: 10 year health plan for England. 2025, accessed. https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future 9th April 2026.
13. National Institute for Health and Care Excellence. Depression in adults: treatment and management. London. 2022, accessed https://www.nice.org.uk/guidance/ng222 9th April 2026.
14. Thomas F, Wyatt K, Berzins K, et al. Supporting patients experiencing poverty-related mental distress: Development and evaluation of a training resource in general practices in eleven regions of England. SSM Mental Health. 2024;5:100320.
15. May CR, Mair F, Finch T, et al. Development of a theory of implementation and integration: Normalization Process Theory. Implement Sci. 2009;4(1):29.
16. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349-57.
17. Boyatzis RE. Transforming qualitative information: Thematic analysis and code development: Sage; 1998.

Accepted Manuscript - BJGP Open - BJGPO.2026.0031

18. Thomas F, Wyatt K, Hansford L. The violence of narrative: embodying responsibility for poverty-related stress. Sociol Health Illn . 2020;42(5):1123-38.
19. Gupta A, Sirisena M, Vance G, et al. Professionals' views and experiences of the TrainDEEP (TRaining Assistance INitiative in DEep End Practices) pilot: transforming GP practices into training practices in disadvantaged areas in the North East of England. BJGP Open. 2025.
20. Sirisena M, Gupta A, Hassan S, et al. P66 Addressing wider determinants of health within deep end general practices serving communities experiencing high levels of socioeconomic disadvantage: the CareDEEP initiative J Epidemiol Community Health 2025;**79:**A69-A70.

Accepted Manuscript - BJGP Open - BJGPO.2026.0031