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Supporting patients experiencing poverty-related mental distress: Development and evaluation of a training resource in general practices in eleven regions of England

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1. Introduction

Research shows strong links between poverty and poor mental health in England, with data demonstrating that those who are economically inactive or unemployed are more likely to report mental health problems than those on higher incomes or in employment (Baker and Kirk-Wade, 2023). As in many other western, neoliberal contexts, mental health strategies and clinical guidelines in England continue to draw heavily on a psychiatric diagnosis system in which diverse forms of mental distress[1] are framed as an individual psychological problem rather than as an understandable response to existing problems (Byng et al., 2019). This in turn means patients are encouraged to understand their distress as a disease, and that available support currently remains dominated by medical or psychological interventions that aim to 'fix' the person, rather than interventions that seek to address (at individual or community level) what are often broader social and structural stressors associated with poverty and disadvantage, for example, poor housing, low pay, unemployment, social isolation and substance misuse.

Whilst these kinds of poverty-related issues are associated with high levels of mental distress, research shows patients from low-income backgrounds frequently struggle to request and receive appropriate mental health support and often present late within healthcare services (Thomas et al., 2019, 2020a). Research has found antidepressant prescribing and referral to talking therapy can be deemed disempowering and inappropriate by people from low-income backgrounds, with patients reporting feeling de-legitimised and 'fobbed off' with these treatment options (Thomas et al., 2020a). At the same time, GPs have reported feeling 'morally distressed' (Molinaro et al., 2023) when confronted with patients experiencing social inequities, conflicted, and confused on how best to support them, and considerable frustration over the limited options and resourcing available to do so (Doran et al., 2016; Thomas et al., 2020a).

Concerns have been raised around increasing levels of antidepressant prescribing in England (Davies et al., 2023) with prescriptions estimated to have risen from 47.3 million items in 2011 to 85.6 million in 2022–23 (NHS Business Service Authority, 2023). In 2022/23, 2.14 million patients in the most deprived areas in England were prescribed antidepressants; 39.8% more than in the least deprived areas and a pattern that

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[1] The term 'mental distress' is used here in acknowledgement that mental health problems may be understood (by professionals and patients) in a variety of ways and may encompass a wider range of issues than diagnosed mental health disorders. Recognising diverse perceptions and experiences, the term includes common mental health problems (anxiety and depression), low mood, stress and/or anxiety that may be subclinical or not formally diagnosed, and low mood, stress and/or anxiety that may be attributed to challenging socio-economic circumstances.

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has remained consistent since 2015/16 (ibid). Whilst antidepressants can be helpful for some people, much of the efficacy evidence has come from studies of people with more severe depression; a finding often not clear in the marketing of these medications (Warren, 2020). Most patients in primary care are diagnosed with mild to moderate depression where evidence suggests the effect size of antidepressants is small (number needed to treat 7–9) (see Arroll et al., 2009; Herrman et al., 2022), and a placebo response more likely than a drug response (Kirsch, 2019; Turner et al., 2008). There are also no long-term randomised studies to examine the benefits or harms of antidepressant use over two years. Some (non-randomised) studies suggest poor outcomes from long-term treatment (Bansal et al., 2022).

In addition to limited effect, there may be substantial side effects for patients including weight gain, sexual dysfunction, insomnia, nausea, and diarrhoea (NHS, 2023). Studies have also found that 46–71% of antidepressant users have experienced emotional blunting (Goodwin et al., 2017; Read and Williams, 2018), with impacts on social connection and reduced motivation which can limit personal agency whilst doing little to improve health and wellbeing.

There is also a wide array of evidence describing the harms of antidepressant withdrawal symptoms (Horowitz and Wilcock, 2020; Hengartner et al., 2020). A review of dependence and withdrawal associated with various prescribed medicines (which included antidepressants) in England found that patients commonly felt there was limited information on medication risks, that medication reviews were insufficient, and patients were not always offered non-medical options (Public Health England, 2019) despite interventions such as exercise having shown a similar effect size to antidepressants (Cooney et al., 2013).

Recognition that mental distress underpinned by poverty and intersecting inequalities is likely to require social solutions beyond medication and therapy has gained considerable traction in recent years (Skivington et al., 2018) and is now implicit within core UK mental health strategy and guidance documents. The NHS Community Mental Health Framework for Adults and Older Adults, for example, emphasises the need to facilitate more integrated, placed-based, primary and community care going beyond biomedical treatment (NHS England et al. 2019), whilst the NICE Guidelines on Depression in Adults (NICE, 2022) encourage the use of non-medical treatment options, and specifically recommend antidepressants not be offered routinely as a first-line treatment for less severe depression unless this is the patient's expressed preference. More broadly, the NHS England Long Term Plan and the drive towards Universal Personalised Care have led to the increasingly diverse composition of primary care teams including the roll-out of social prescribing link workers.

Such shifts in thinking, particularly when backed up with resourcing to implement on-the-ground change, have potential to play a significant role in reducing inappropriate prescribing of antidepressants, as well as providing better support to patients, and reducing the workload of GPs. However, there is very little guidance available on what these approaches might mean for the delivery of the healthcare consultation itself, how health providers might move from a 'fixing' (through medication prescribing) to a 'supporting' role helping people take agency in finding what assists them in their own recovery, or how they can work most effectively alongside social prescribers and others within increasingly diverse primary care teams. At the same time, whilst often hailed as a panacea, it is important to recognise the limitations of social prescribing options, the uneven nature of their availability and the fact that health inequalities can limit people's capacity to engage with them (Gibson et al., 2021).

1.1. Study objectives

This paper describes the development, use and evaluation of the DeStress-II training resource. The overall objective of the training was to support primary health care providers to shift consultation practice away from inappropriate 'quick fix' antidepressant prescribing towards a more personalised bio-psycho-social approach to improve trust and engagement with low-income patients, foster shared and informed decision-making around treatment and support (including social interventions to address mental distress), and to recognise and seek to build on a patient's personal strengths.

The findings reported here focus on the perceived acceptability and feasibility of the training for primary care practitioners, the barriers and enablers to implementing the learning, and early impact on practice and on the experiences of patients who received a consultation influenced by the training. We were guided by ideas from the theoretical domains framework of behaviour change (Francis et al., 2012) to help us to define and specify intervention components.

2. Methods

2.1. Developing the training resource

The need for a training resource was identified through a thirty-month qualitative study (see https://destressproject.org.uk/home/) undertaken in the South West of England (from 2016 to 2019) examining how dominant mental health treatment options at that time (i.e. antidepressant prescribing, talking therapies) were experienced by low-income patients and perceived by primary care professionals (primarily GPs) overseeing them. Two workshops were run as part of that project with GPs and other primary healthcare practitioners ($n = 60$) to establish key topics where practitioners felt more information and support would help. Themes identified were: better understanding of the links between poverty and mental health; the efficacy and limitations of medical and non-medical treatment/support options; using a bio-psycho-social approach; shared and informed decision-making with patients. We then used these themes to develop a short learning document for GPs in the study area (Thomas et al., 2020b).

In order to test the relevance of this learning beyond the initial study area, a two stage approach was used between 2021 and 2023 to further develop and test key messages (Stage 1) and, ultimately, in Stage 2, to develop an online resource that could be made available to GP practices across England.

2.2. Stage 1 training delivery

Stage 1 of the DeStress-II study was undertaken across three English regions selected to include diverse poverty-affected populations: the South West (including rural, coastal and post-industrial areas of Somerset, Devon and Cornwall); North Thames (including inner-city areas of north London and the urban and semi-urban areas of South Essex) and the North West Coast (including inner city Liverpool, and post-industrial and coastal areas of Lancashire).

2.2.1. Identification of practices

Analysis of local prescribing and health inequalities data within each region (using OpenPrescribing.net for antidepressant prescribing and local Indices of Multiple Deprivation scores) were used to identify GP practices with high levels of antidepressant prescribing and encompassing populations with high socio-economic deprivation. These practices were targeted for recruitment to the study via a callout from the local Clinical Research Networks, or by the research team contacting a Practice Manager. To ensure sufficient recruitment, practices with high antidepressant prescribing but lower widespread deprivation were also included in the sample where they indicated that their patient catchment encompassed pockets of poverty.

2.2.2. Training delivery

In each region, a training team of GPs and community partners were recruited to the study. In most instances, these GPs already held positions as health educators, and/or had a specialist interest in health inequalities. Community partners were recruited from community groups

in each of the three regions and had lived experience which resonated with the core messages of DeStress-II. GPs and community partners came from a wide cross section of backgrounds based on age, gender and ethnicity. In total, 19 GPs and 17 community partners were trained to deliver the DeStress-II training. Trainers attended a half-day training session where the messages in the initial learning document were discussed, and learning objectives for the training were agreed. From this discussion, a set of Powerpoint slides were developed by the research team to guide the training sessions.

Our initial focus had been on training GPs. However, discussions with practice staff during the recruitment phase revealed that the training was deemed relevant to the increasingly wide range of staff within practice teams. All practice staff were therefore invited to participate in and feedback on the training.

Where possible, training was undertaken in-person within GP surgeries. However, at the time this stage of the study took place, parts of the UK were under periods of COVID-19 lockdown, necessitating that some sessions be held online and our recruitment target (originally 108 practices) reduced. In total, 508 primary care professionals attended the training from 53 GP practices across the three regions. Three hundred and eighty-seven (387) were GPs, and 113 were allied health professionals including social prescribers, nurses and pharmacists.

2.2.3. The training resource

The training comprised a presentation by a GP trainer, insights into lived experience led by a community partner, and questions for group discussion facilitated by a researcher. Recognising extreme pressures on primary care systems across England, the training advocated small adaptations to usual care that could take place within the confines of existing consultations as and when deemed appropriate. It did not advocate that GPs or other health professionals stop prescribing medication; rather that they consider adapting consultation practice so that non-medical responses which identify and draw on personal strengths were also given full consideration. The training was based on high volume knowledge of key concepts to bring about changes in the current culture of consultation and prescribing practice. These concepts included that: i) generating trust may need more than traditional consultation models and can be facilitated with openness, body language and brief consultation 'scripts' that engender empathy and create space for patients to feel listened to and heard; ii) there is a middle road between medicalised 'fixing' (i.e. through prescribing), paternalistic approaches which often undermine patient agency and approaches in which health professionals dismiss social and economic problems as 'not our business'; iii) personal goals and evidence of what an individual believes makes a difference can form the basis of brief supported self-care.

2.2.4. Capturing impact on patient consultations

Trainees were asked to reflect on core messages in the training and make the suggested adaptations within consultations with patients where appropriate. Trainees were also asked to give patients in these consultations a QR code which linked to a brief online survey so they could provide anonymised feedback on the adapted consultation directly to the study team (see Table 1). Paper copies with stamp-addressed envelopes were provided to patients where required.

2.2.5. Feedback and refinement of stage 1 training

Feedback on the core messages and delivery style of the DeStress-II training in Stage 1 formed part of a reflective discussion with participating practices at the end of each training session. This was supplemented through semi-structured interviews with health professionals (n = 22) to understand how they had perceived the training and improvements they felt could optimise its effectiveness within primary care. This feedback helped to iteratively shape ongoing training in Stage 1 (delivered February 2021–April 2022) and also identified an online training resource as being the most effective way of reaching a large volume of primary care practitioners, being both a core medium through which they were used to receiving training and one over which they felt they had some control in terms of timing.

2.3. Stage 2 - online resource development

Using the feedback from Stage 1, we developed an online resource comprising information slides, film clips of professional and patient experiences, consultation role play, scripts for use within consultations and questions for reflective group discussion. This was assembled with the support of an online education specialist and film maker. Table 2 provides an overview of the resource content and the delivery medium.

To test its acceptability and feasibility in impacting primary care practice, an opportunity for thirty practice teams to use the online resource was advertised via England's Clinical Research Networks (CRNs). Eleven CRNs identified practices who were interested in participating. Thirty general practices from across England were then recruited to test the online resource and provide feedback between May–September 2023. As in Stage 1, practices recruited in Stage 2 encompassed catchment areas with high levels of socio-economic deprivation and high antidepressant prescribing.

Training sessions were overseen by a facilitator nominated within each practice who was provided with a short instruction manual to guide the session and oversee the reflective practice team discussions. Forty-nine health professionals participated in a semi-structured telephone or online interview to feedback on acceptability of the online training resource, perceived barriers and enablers to implementing core messages and any early impact on practice. This involved discussion of their personal experience, as well as any feedback they had gathered from others within their practice team.

As with Stage 1, health professionals attending the training were asked to provide patients they felt had received a consultation influenced by the DeStress-II training with a link to the patient survey so that insights could be gained into patient experience (see Table 2). Thirty-eight patient surveys were received in Stage 2.

Table 1
Patient survey questions.

What town/city do you live in/near to?
What is the name of your GP practice?
What was good about the experience you had in your most recent consultation at your GP practice?
What was less good?
Is there anything that you would have liked to discuss or happen in the consultation? If yes, what?
Do you feel the consultation was appropriate to your needs? If not, why not?
What is your:
Gender
Ethnicity
Age
Option for patients in Stage 1 to leave contact details for an interview with the study team

Table 2
Overview of the DeStress-II online training resource.

Training	Content	Medium
Introduction	• Overview of training. • Intended learning objectives: - Understanding of how poverty and mental health are connected. - Understanding the challenges low-income patients face, and how small changes to consultation style can improve patient trust and engagement. - Ability to improve shared decision-making which considers a range of treatment/support options using a bio-psycho-social approach. - Understanding how a team-based approach can most effectively support patients experiencing poverty-related mental distress.	• Film clip narrated by GP • Information slide
Societal distress	• Discussion on high levels of distress in society and impact on practice. • Questions for reflective team-based discussion on experiences of patients presenting with mental distress and impact on practice.	• Film clip narrated by GP • Narrated questions
Overprescribing	• Overprescribing of antidepressants; debates around efficacy and links with distress and depression. • Information on the evidence for antidepressant use. • Questions for reflective team-based discussion on: prescribing within the practice, practice prescribing aims, factors impacting prescribing decision-making, how antidepressant effectiveness is communicated to patients.	• Film clip narrated by deprescribing expert • Information slide • Narrated questions
Patient experience	• Why some people find it difficult to contact with their GP. • Challenges patients have experienced consulting a GP and talking about mental distress as well as what made a positive difference. • Questions for reflective team discussion on techniques used to support patients with poverty-related mental distress and how consultation style can be improved.	• Film clip narrated by GP • Film clips of patient lived experience • Narrated questions
Shared understanding	• Practical advice and recommendations on how to manage consultations and explore different support options. • Suggested scripts for use within consultations	• Film clip narrated by expert in deprescribing • Information slides
Supporting the patient	• Addressing patient expectation around antidepressants. • Using an empathic approach and empowering patients to identify and address underlying causes of their distress. • Approaches GPs have found helpful within consultations. • Questions for reflective team discussion on how to elicit information on what is important to a patient and techniques they have found helpful to support their patient.	• Film clips narrated by GPs • Narrated questions
GP consultation	• A (simulated) GP consultation where the patient discusses how they feel going to a GP consultation and the GP uses a bio-psycho-social approach to empower and validate his experience. • Techniques and scripts to increase engagement and trust.	• Short film of a simulated consultation between patient and GP • Information slides
Your practice team	• The role of social prescribers and other allied health professionals; approaches to team working. • Questions for reflective team discussion about the composition of and roles within the practice team, how communication and follow-up processes can be enabled to better support patients and staff.	• Film and audio clips narrated by GP and social prescriber • Narrated questions
Learning objectives	• Recap of learning objectives • Acknowledgements	• Information slides
Extra resources	• Links to additional learning resources	• Information slide

2.4. Ethical considerations

National Health Service/Health Research Authority ethical approval was obtained via Frenchay Research Ethics Committee (reference IRAS 303179).

2.5. Analysis

This paper focuses on analysis of data generated through patient survey responses and from interviews with healthcare professionals using inductive thematic analysis (Braun and Clarke, 2006). The analysis was data-driven, with interpretation of concepts and patterns aligned closely to participants' expressed views and experiences. A recursive six step analytical approach was taken; first, familiarising ourselves with the data; second, generating initial codes which helped to organise data; third, searching for themes through examining coded data to trace repetition, as well as distinct features within and across participant data and how these related to questions around patient and professional experience (including disconfirming cases), barriers and enablers to implementing learning and any impact on practice; fourth reviewing initial themes, making adjustments and clarifications. The fifth and sixth phases involved defining and naming themes and confirming findings. Four authors undertook thematic analysis on a subset of data and then cross-checked one another's coding and overall theme generation. Participants have been anonymised in the reporting of findings.

3. Results

3.1. Patient survey findings

One hundred and seven patient surveys were completed over Stages 1 and 2 of the study. Thirty-three respondents identified as male, and 74 as female, with ages ranging from 18 to 75 years old. Sixteen respondents listed their ethnicity as British Asian, Indian, Pakistani, Bangladeshi or Sri Lankan, 4 as Black or Caribbean, 16 as British, 42 as White British, 15 as White, 4 as English; ten listed other responses or had left this blank.

Responses to the DeStress-II style consultation were overwhelmingly positive with 102/107 (95%) respondents stating the consultation they received was appropriate for their needs. A clear theme emerging from the survey data was the value that patients placed on feeling a human connection within their consultation, with 76 of those surveyed making comments explicitly praising the health professional's skills in listening, showing compassion and empathy as intrinsically therapeutic. The following quotes were typical of these responses.

> *I was heard. Very good advice, referrals, support. Advised nil meds so far but use running as medicine and I must exercise as it is medicine. Review in 6 weeks.* Female, South East England, age 46-50

> *My GP listened and actually understood. She also implemented a practical solution for me.* Male, South West England, age 46-50

> *Feel like there was a more positive outcome to the appointment. For example, feeling heard, feeling understood and supported with next steps.* Female, East Midlands, age 25-30

> *Purely the fact that she listened actively to what I was saying to her and didn't feel that she was just doing a job. I felt that she was genuinely interested in what I was saying and did care about me. And was looking for solutions and possible avenues of support for me.* Female, South East England, age 60-65

When asked about less positive aspects of the consultation, twelve people said they would have liked more time within the consultation or criticised the lengthy wait period to see a health professional. Three people commented on not being able to see the same professional at each consultation. Only two patients commented on the consultation style, saying they did not feel their mental health concerns had been taken as seriously as they had wanted.

When asked if there was anything else that they would have liked within their consultation, responses were more mixed. Of 72 people who answered this question, 52 responded that they did not have additional requirements. Five commented they would have liked more time to discuss broader socio-economic circumstances, and two wanted an onward referral. The following themes were mentioned by one of each of the remaining six people: their wider medical issues; next-steps for support; more listening by the GP; to be taken more seriously; a longer appointment; access to an interpreter.

3.2. Feedback from health practitioners

Healthcare practitioners interviewed in Stage 2 were overwhelmingly positive about the DeStress-II online training resource, with all interviewees saying they recommended it to others. Scripts and film clips of patient lived experience and reflective group discussion were highlighted as especially helpful. Opportunities for practice teams to come together to specifically focus on issues relating to poverty and mental distress were uncommon, despite these concerns taking up considerable practice workload. As one GP commented,

> *Without doubt, it will be an issue that that every GP practice is coming across, particularly in the current economic climate […] Just the opportunity to really focus on this as an issue and really thinking about how we consult and how we offer different options and how we facilitate patients thinking about what will help them, I think that's useful.* GP South Coast

Whilst the training was welcomed, a number of factors that health professionals perceived might impact on their learning being successfully implemented in practice were identified. Emergent themes across interviews that were felt to either constrain or enable the delivery of a DeStress-II style consultation were as follows: conceptions of consultation time; waiting times for other services; the perceived remit of primary healthcare; understandings around treatment effectiveness; and possibilities for practice team working.

3.2.1. Conceptions of consultation time

Research indicates that GPs frequently experience tensions between what they believe is high quality care and what they feel able to achieve within general practice (Doran et al., 2016; Parker et al., 2019). This is in large part due to patient frustrations over lengthy wait times for appointments within England's NHS, which can be exacerbated further when long-awaited consultations with GPs are then limited to 10–15 min. Not all GPs felt that developing the kind of therapeutic relationship with a patient recommended by the DeStress-II resource was feasible within time available in a regular consultation, with some explaining that this possibility became even less likely as the day went on and consultations fell further behind schedule:

> *If I'm seeing somebody at the start of the day and I feel I have more time I will make a little bit more of an effort resisting a prescription, and on communication and trying different things and [life] coaching. But if I'm short of time, it's towards the end [of the day], you know almost always running about 20 or 30 minutes late then yeah, I'm more likely to then issue a prescription if I feel that's what the patients come in for.* GP, South East England

Others stressed how the 'treadmill' and daily time limitations could result in a 'protocol-driven' rather than 'patient-driven' consultation style,

> *As a GP, you've got a ten-minute appointment, you've got a bit of a treadmill, like I've got to sort this problem out in ten minutes, and you get a bit of a speech – 'we can do this, this and this'. With the best will in the world, a consultation can become like a protocol-driven consultation rather than patient-driven.* GP, South East England

Time limitations were considered a particular barrier in more complex consultations such as those with patients requiring an interpreter, when notions of patient agency and shared decision-making were not considered the norm (commonly associated with patients from overseas), and when patients had been on antidepressants for many years. A small number of people also felt time limitations were more problematic when locum doctors were used, feeling they may be less invested in their patients than permanent staff.

Despite widespread agreement around the problem of short consultations, some GPs explained that this could be assuaged if the notion of time was extended beyond initial consultations. For these GPs, being able to explore broader patient circumstances, pick up on patient cues and provide empathic responses in a longer first consultation not only enabled them to feel confident they were appropriately supporting their patient's needs, but commonly resulted in shorter follow-up consultations, as typified in the following quotes,

> *I'm not sure that this DeStress-II way of working lengthens or makes that problem any worse, and in fact I think if you get to the nitty-gritty sooner that probably helps […] I think it's an easy thing to say isn't it whenever everyone suggests a change, 'all that's 'gonna take longer'. But I don't really see how what you're suggesting would take longer. It's just a different way of getting to the same point. That's not a longer way.* GP South West England

> *[It's] looking more at the bigger picture and more holistic level of care, which in the initial stages may take a bit more time. But in the long run has a better outcome for the patients -therefore for us as well because it means they don't need to keep coming back.* Mental Health Practitioner, South East England

3.2.2. Waiting for other services

As reported elsewhere (Doran et al., 2016; Thomas et al., 2020a), lengthy waiting times for alternative support or referral into secondary care were also considered core factors explaining persistently high rates of antidepressant prescribing, with health professionals feeling a moral obligation to offer something tangible (and readily available) to

patients. The following quotes demonstrate how waiting times were also considered as an explanation for the increasingly lengthy time frames over which people were prescribed antidepressants,

> *We refer to CBT, to counselling, but often there's a lot of barriers that come up. So that doesn't help because then the person's often in a lot of distress, and it feels like nobody's doing anything. And that's where the pressure then comes on to us that to just make that token sort of gesture, to make the person feel like somebody's done something about it.* GP, South East England

> *When patients disclose and you think you would really benefit from DBT* [dialectical behaviour therapy]*, EMDR* [eye movement desensitisation and reprocessing] *trauma-focused therapy and you do a referral, you're waiting two years to get an appointment. You can't leave a patient for two years with nothing, so sadly that's where the prescribing of antidepressants or beta blockers to help with anxiety comes in […] you're looking probably at being on treatment for two years before you even start any therapy.* Advanced Nurse Practitioner, South West England

3.2.3. Perceived remit of primary healthcare professionals

The DeStress-II training resource encourages health professionals to adopt a personalised bio-psycho-social approach that improves trust and engagement with low-income patients and fosters shared decision-making around treatment and support. Being able to do this effectively requires professionals to have insight into patients' broader circumstances, and opportunities and constraints which impact on their decision-making. Whilst this by its very nature requires health professionals to ask questions and respond to patient cues around socio-economic circumstances, it was not something all GPs and allied health professionals felt comfortable doing. As others have reported (Dew et al., 2005; Parker et al., 2019), some GPs are reluctant to explore psycho-social issues in case they open up a multitude of complex issues they do not feel they have skills, resources or time to properly address. Additionally, and as the following quote suggests, a small minority of GPs interviewed in this study explicitly stated that supporting people with mental distress caused by socio-economic issues was beyond their remit, and something they perceived that allied health professionals were better placed to attend to,

> *Inherently we're clinicians. So, the social side of things is not something that we really should be, you know - yes, it becomes a part of our role - yes, it influences the health and the wellbeing of the people we look after, but it's not really - there is this sort of feeling that it's not really our job or our role. It's our role to acknowledge it, but that's where it ends.* GP, South East England

However, many of the GPs interviewed felt the training messages resonated with what they aimed to deliver within consultations. For these GPs, the training was welcomed for its role validating and legitimating their practice, particularly when they felt they were working outside the remit of what was dominant and widely accepted practice,

> *If you feel like you are being a maverick, if you feel like you're getting push back from patients, which you will do because it's different to what their expectations are, then it's really powerful to have somebody come along and say 'it's okay to do that'.* GP, South West England

Many health professionals interviewed commented that the scripts and lived experience film clips in the DeStress-II training resource had raised their awareness of poverty as a causal influence of mental distress and given them confidence to ask patients questions about their broader circumstances - as one GP explained, 'it's made me brave in thinking about asking.' This, they explained, had in turn helped them to recognise how to unpick some of the tensions and complications they had faced in understanding whether their patient was experiencing clinical depression or distress as an outcome of broader circumstantial stressors. One GP registrar for example, commented that rather than using the PHQ9 or GAD7 'where the person is feeling vulnerable and they say 'yes' to everything, they score high and we give medication', the training helped him see how to 'decouple deep clinical depression' from distress caused by circumstances 'rather than always mixing stress and depression and going to a single root of treatment' in the form of antidepressant prescribing.

Others, particularly allied health professionals, commented that scripts within the training had given them confidence to ask about issues which they previously felt uncomfortable broaching for fear of offending the patient. Finance was an area all health professionals found difficult to raise, despite recognition this would be central to the patient's circumstances. In follow-up interviews after the training several health professionals described how their newly found confidence to ask questions around issues such as finance had led to deeper insights about patients' everyday challenges as well as facilitating better signposting to support services.

Allied health professionals also explained how the training had emboldened them to ask questions which enabled them to assist the patient themselves rather than necessarily referring them to a GP, as highlighted in the following quotes,

> *Before it would have been a case of whether they were on antidepressants or not - if they were telling me they're depressed, I was telling them that they needed to see a GP. Now I'm emboldened to ask questions and try and identify what the issue is. Okay, if it's to do with poverty then let's try signposting and the social prescribers. […] And yeah, I'm getting a better response - more than just trotting out the old 'we need to book and see a GP' line.* Healthcare Assistant, East Midlands.

> *Before they've come in and said, 'I'm feeling this way', I'd then straight away have to go and get a GP […]. I need to know what advice to give because I can't just sit there and say, well, let me go and get someone. I need to know how to direct it. And now I've been given resources. It [training] definitely helped me be able to know what to say rather than sit there blankly. Now I feel so much more confident in saying 'right, this is what we'll do'. Whereas before, I felt like I'd straight away say this is a GP issue - now I feel like I could take it a bit more on board.* Practice Nurse, North West England.

Through asking questions around a patient's circumstances and demonstrating active listening skills, health professionals reported (and patient surveys confirmed) they had been able to enact empathy with their patients in a way enabling a more humanising and supportive consultation without the need to resort to medicalisation. Key to this was the validation of patients' experiences through explicitly acknowledging challenges faced, and normalising their responses and reactions as 'what most people in your situation would feel' rather than framing them as psychological problems requiring medical solutions,

> *I found it useful. And I think other people found it useful as well to reiterate the importance of validating a person's experience and actually feeding back to them that you know, yes, your experience is difficult. That doesn't mean you're unwell. That doesn't mean there's anything wrong with you.* Mental Health Nurse, South East England

3.2.4. Understanding the limitations of antidepressants

Practices targeted for study recruitment had high levels of antidepressant prescribing (based on OpenPrescribing.net data). Yet it was clear from the professional interviews that routinely reflecting on individual or practice team prescribing for antidepressants was uncommon, and there were significant gaps in knowledge around the evidence base for antidepressant use, particularly for non-severe depression. Elements of the DeStress-II training focusing on the evidence base, the gaps within this and challenges patients may face withdrawing from antidepressants were found to be especially helpful, as were lived experience testimonies from patients challenging commonly held perceptions that low-income patients necessarily came to a doctor wanting these drugs. As the

following quote demonstrates, the training also enabled recognition of potentially negative messaging that could be associated with antidepressant prescribing for people experiencing stress caused by socio-economic factors,

> *By giving an antidepressant, you're saying that something is wrong with you rather than wrong with your situation – it's a very powerful message, and it's quite a simple concept that I think I don't think I had as clear in my head before doing this training as I do now.* GP, South West England

Interviewees also felt the training raised awareness of the possible side effects of antidepressants and the value of discussing these with patients; raised confidence amongst professionals to consider other approaches before prescribing; and helped prompt them to review medications with patients and to talk about alternative options,

> *I've had a couple of memorable patients who have had discussions around antidepressants, and they've expressed a desire to perhaps come off them. And I've been a bit more confident about saying 'yes, let's, they're not working, we need to look at other things.'* GP, South West England

3.3. Practice team working

As discussed, it became clear during Stage 1 of the training that to be effective, the online resource needed to be targeted at the entire practice team, reflecting the significant shifts in the composition of primary care teams recently to include posts such as social prescribers, mental health and advanced care practitioners, mental health nurses and pharmacists. Interviews revealed many primary care staff are not fully aware of the remits and responsibilities of all team members, a factor participants felt impacted negatively on effective patient and team level support. This issue could be exacerbated when staff worked across multiple practices meaning they had limited time on each site. Additionally, the one-to-one consultations which form the basis of primary care encounters meant people often worked in isolation and, as one nurse explained, 'don't often get to see how other people manage consultations for something similar'. Social prescribers and nurses explained how the training (which includes discussion with GPs and a simulated consultation) had helped to them to better understand what went on within GP consultations for mental distress. At the same time, GPs felt that as a result of the training, they better understood the roles of the wider team, and in particular the relevance of the social prescribers in supporting patients experiencing poverty-related mental distress.

> *I must say, when the initial role of social prescriber came, I was very wary, and the attendees also felt that we will not use them. But it was interesting, especially when we talk about poverty related issues or mental health, I do feel they do play an important role and we must involve them as a part of our team.* GP, South East England

Staff from a number of practices also explained they had already increased their cross-team referrals as a result of the discussions facilitated during the training, as is typified in these quotes from a social prescriber and pharmacist,

> *I don't think the GP really understood my role. So, he said, like he felt that he'd underestimated what we do […] I think the relationship between myself and the doctors has got better and you know, he has sent me a few referrals since [the training].* Social Prescriber, South East England

> *I've had a couple of patients who came in for medication reviews […] so using the training I kind of opened up to them and showed support […] I did refer them to social prescribers because even though they were on medication, they still need support with other things. I listened to them, and I didn't just focus on the medication.* Pharmacist, South East England

4. Discussion

The DeStress-II online training resource was well received by primary care teams and by patients who had received a consultation the professional felt had been influenced by the training. The scripts and film clips of patient lived experience were felt to be relatable, relevant and timely given pressures within primary care and the ongoing challenges of England's cost-of-living crisis. The mode and duration of the training were found to be appropriate for time-pressured practitioners. The group discussion engendered by the training was highlighted as a rare but welcome opportunity for reflection on individual and team practice as it related to patient engagement and antidepressant prescribing. All interviewees stated they would recommend the training resource to others.

4.1. Re-conceptualising consultation time

Intense practice workloads and resource pressures that restrict consultation time are widely recognised challenges within England's primary care system. Within this context, research has found that patient risk assessment often takes priority in GP consultations over more therapeutic approaches (Parker et al., 2019) such as that advocated through the DeStress-II training. However, there was some evidence in our study to suggest that appropriate patient support could be achieved if conceptualisations of time were extended beyond the initial consultation. For the GPs concerned, provision of a longer first appointment could result in more appropriate patient support early on which then saved time in the longer run. Further research is needed to understand the conditions that enable or hinder this kind of longer-term approach to patient consultations. As primary care teams diversify, it is also important to better understand how staff with longer consultation times are being utilised, and with what outcomes.

4.2. Strengthening understanding of the evidence base

The research found a lack of awareness within primary care teams around the evidence base for antidepressant use, and in particular the nuances associated with efficacy. Knowledge in this area appeared to rely on evidence drawn from studies with people with more severe depression rather than from those with more moderate mental health needs where evidence suggests the effect size of antidepressants is relatively small. The lack of robust evidence around long-term antidepressant use was identified as an area where health professionals were not fully cognizant, despite clear implications this has for prescribing and opportunities for medication review. Our research suggests health professionals welcomed the concise information on the nuanced benefits and limitations of antidepressant prescribing that were provided in the training, and this had resulted in many developing confidence to explore alternative avenues for patient support. These findings resonate with current evidence on deprescribing antidepressants where interventions to support their discontinuation have an educational element (for GPs and patients) regarding long-term effectiveness and possible withdrawal symptoms as well as shared decision-making and wider support to enable discontinuation (Coe et al., 2022; Wentink et al., 2019). It is likely that strengthening the evidence base to support non-medical options for alleviating mental distress (through for example, exercise or social prescribing), would also support the perceived legitimacy and take-up of such approaches within primary care.

4.3. Understanding the possibilities and limitations of social prescribing

Social prescribers usually have more consultation time allocated to each patient than GPs, and as such, provide a crucial space to explore patient circumstances and needs and link patients to forms of non-medical and community-based support. However, as Husk et al. (2019) highlight, effective health team working around social

prescribing relies on a series of relationships, *all* of which need to function together if they are to successfully meet patient need. We found that practice staff did not always have full oversight of the roles and remits of other team members and that awareness and understanding of the social prescribers' function and responsibilities varied widely, resulting in large discrepancies in their use across practices. Some GPs disclosed that prior to the training they did not always know who the social prescribers in their practice were, what they did, or how relevant the onward-referral options might be for their patients. Others had not realised that social prescribers could themselves have long waiting lists despite this having negative implications for the support available to their patients. There was also little evidence to suggest that GPs were routinely following up with patients once they had referred them on to the social prescriber, or that social prescribers routinely fed patient information back to GPs.

The DeStress-II training was found to raise awareness of the social prescriber role and prompted team reflection on the mechanisms supporting or inhibiting patient referral into this service and potential opportunities for cross-team follow up. However, current evidence indicates that the availability and quality of social prescribing opportunities vary widely, and socio-economic inequalities can both influence the kinds of support on offer and shape participants' capacity to engage with an intervention in the first place (Gibson et al., 2021). For all these reasons, the DeStress-II training resource was cautious not to uncritically promote the use of social prescribing, but instead to create a space for reflective team discussion of these issues and ways in which they could be explored within joint decision-making with patients. At the same time, we were careful to stress the importance that patients placed on empathy and feeling listened to in their interactions with *all* health providers, rather than implying the social prescriber role absolved others such as GPs from supporting patients with their experiences of socio-economic and circumstantial distress.

4.4. Recognising patient lived-experience

The emphasis on patient lived-experience within the film clips was consistently cited by research participants as an insightful and important element within the DeStress-II resource. Healthcare practitioners explained that outside of formal practice-based patient forums there were few opportunities to hear the experiences of patients, and as a result, few opportunities for them to know how their consultation was received. A number of those interviewed explained that prior to the training they had not considered the anxieties their patient may experience about coming to a consultation around mental health or the more practical challenges they may face in attending (e.g., financial/transport barriers). Some GPs felt the insights they had gained were particularly valuable when they themselves came from very different socio-economic backgrounds from the patients in question. They explained that the training had raised their awareness of poverty as a causal influence of mental distress and helped embolden them to ask questions about a patent's broader life circumstances in ways that would enable them to both provide more informed and personalised support and work with patients to encourage self-advocacy.

5. Limitations

The initial DeStress-II training delivery (Stage 1) coincided with parts of the UK being subject to Covid-19 restrictions. Considerable pressures placed on primary care affected the management of distress at this time, with fewer in-person appointments meaning more restricted opportunities to pick up on non-verbal cues, and limited access to psychological services. It is possible this may have influenced health professional feedback on the relevance of the training and patient feedback on the consultation they had received. Whilst some GPs did comment on the challenges of building trust and offering personalised support via phone/online, patient surveys during this time did not indicate any clear difference in patient response relative to type of consultation received.

Throughout the study, GP practices in England were operating under severe resource pressures. It is likely this influenced the sample of GP practices who participated, particularly in Stage 1 of the study. Whilst practices with high levels of deprivation and high antidepressant prescribing were targeted for recruitment, a minority of practices reported pockets of poverty rather than widespread socio-economic deprivation within their patient catchment area. However, that there were no notable differences in either professional or patient feedback across these sites suggests the DeStress-II resource is suitable for use in a wide diversity of settings.

It is likely that pressures on health professionals also impacted on the likelihood of them giving patients the QR code that linked to (or a hard copy of) the patient survey. However, surveys on consultation experience were returned by a diverse cross-section of patients based on age, gender and (self-reported) ethnicity, with no prominent differences in patient experience across these demographics. We do, however, recognise that a high proportion (59%) of respondents providing racial/ethnic information identified as White or White British (with some of those identifying as English or British also likely to be White) and that this limits the representativeness of the study findings. We also recognise that research practices can act as a barrier to inclusion to some people. For example, whilst efforts were made to provide paper copies of the survey, resource restrictions meant we were unable to translate them in advance into other languages. More targeted research seeking to understand the primary care experiences of people from diverse backgrounds would provide important insights to help inform any further refinement of the DeStress-II training resource.

6. Conclusions

The DeStress-II training resource was well received by primary health care teams across diverse areas of England. It helped to raise awareness of poverty as a causal influence of mental distress. It provided academic evidence, insights from lived experience and scripts to build trust and demonstrate empathy with patients. It also sparked team-based reflection on issues relating to antidepressant prescribing, non-medical support options, and effective practice team working. Time limitations within consultations and lengthy waits for other services were identified as barriers to implementing learning. The perceived remit of healthcare professionals could also act as a barrier but was perceived positively when staff felt more confident to ask patients questions about their broader life circumstances. Better understanding of the limitations of antidepressant efficacy was an enabler to implementing learning, as was improved awareness around practice team working. Patient feedback demonstrates that consultations influenced by the DeStress-II training were overwhelmingly experienced as appropriate and supportive of patient need.

CRediT authorship contribution statement

Felicity Thomas: Writing – review & editing, Writing – original draft, Supervision, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Katrina Wyatt:** Writing – review & editing, Supervision, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis. **Kathryn Berzins:** Writing – review & editing, Supervision, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Ilse Lee:** Writing – review & editing, Supervision, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Jane Horrell:** Writing – review & editing, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Alison McLoughlin:** Writing – review & editing, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Oliver Hamer:** Writing – review & editing, Methodology,

Investigation, Formal analysis, Data curation. **Susanne Hughes:** Writing – review & editing, Supervision, Project administration, Methodology, Investigation, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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References

Arroll, B., Elley, C.R., Fishman, T., Goodyear-Smith, F., Kenealy, T., Blashki, G., Kerse, N., 2009. Antidepressants versus placebo for depression in primary care. Cochrane Database Syst. Rev. 8 (3), CD007954 https://doi.org/10.1002/14651858.CD007954.

Baker, C., Kirk-Wade, E., 2023. Mental Health Statistics: Prevalence, Services and Funding in England. House of Commons Library, 13 March 2023, accessed online (01/12/23) at. https://researchbriefings.files.parliament.uk/documents/SN06988/SN06988.pdf.

Bansal, N., Hudda, M., Payne, R.A., Smith, D.J., Kessler, D., Wiles, N., 2022. Antidepressant use and risk of adverse outcomes: population-based cohort study. BJPsych Open 8 (5), e164.

Braun, V., Clarke, V., 2006. Using thematic analysis in psychology. Qualitative Research in Psychology 3, 77–101.

Byng, R., Groos, N., Dowrick, C., 2019. From mental disorder to shared understanding: a non-categorical approach to support individuals with distress in primary care. Br. J. Gen. Pract. 69 (680), 110–111. https://doi.org/10.3399/bjgp19X701777.

Coe, A., Gunn, J., Kaylor-Hughes, C., 2022. General practice patients' experiences and perceptions of the WiserAD structured web-based support tool for antidepressant deprescribing: protocol for a mixed methods case study with realist evaluation. JMIR Research Protocols 11 (12), e42526. https://doi.org/10.2196/42526. Dec 29.

Cooney, G.M., Dwan, K., Greig, C., Lawlor, D.A., Rimer, J., Waugh, F.R., McMurdo, M., Mead, G.E., 2013. Exercise for depression. Cochrane Database Syst. Rev. 9 https://doi.org/10.1002/14651858.CD004366.pub6.

Davies, J., Read, J., Kruger, D., Crisp, N., Lamb, N., Dixon, M., et al., 2023. Reversing the the rate of antidepressant prescribing: politicians, experts, and patient representatives call for the UK government to reverse the rate of antidepressant prescribing. BMJ 383, 2730.

Dew, K., Dowell, A., McLeod, D., Collings, S., Bushnell, J., 2005. This glorious twilight zone of uncertainty: mental health consultations in general practice in New Zealand. Soc. Sci. Med. 61 (6), 1189–1200. https://doi.org/10.1016/j.socscimed.2005.01.025.

Doran, N., Fox, F., Rodham, K., Taylor, G., Harris, M., 2016. Lost to the NHS: a mixed methods study of why GPs leave practice early in England. Br. J. Gen. Pract. 66 (643), e128–e135. https://doi.org/10.3399/bjgp16X683425.

Francis, J.J., O'Connor, D., Curran, J., 2012. Theories of behaviour change synthesised into a set of theoretical groupings: introducing a thematic series on the theoretical domains framework. Implement. Sci. 7, 24.

Gibson, K., Pollard, T.M., Moffatt, S., 2021. Social prescribing and classed inequality: a journey of upward health mobility? Soc. Sci. Med. 280, 114037 https://doi.org/10.1016/j.socscimed.2021.114037.

Goodwin, G.M., Price, J., De Bodinat, C., Laredo, J., 2017. Emotional blunting with antidepressant treatments: a survey among depressed patients. J. Affect. Disord. 221, 31–35. https://doi.org/10.1016/j.jad.2017.05.048.

Hengartner, M.P., Davies, J., Read, J., 2020. Antidepressant withdrawal – the tide is finally turning. Epidemiol. Psychiatr. Sci. 29, e52. https://doi.org/10.1017/S2045796019000465.

Herrman, H., Patel, V., Kieling, C., Berk, M., Buchweitz, C., Cuijpers, P., 2022. Time for united action on depression: a lancet-world psychiatric association commission. Lancet 399, 957–1022.

Horowitz, M., Wilcock, M., 2020. New generation antidepressants and withdrawal effects: reconsidering the role of antidepressants and helping patients to stop. Drug Therapeut. Bull. 60 (1) https://doi.org/10.1136/dtb.2020.000080.

Husk, K., Blockley, K., Lovell, R., Bethel, A., Lang, I., Byng, R., Garside, R., 2019. What approaches to social prescribing work, for whom, and in what circumstances? A realist review. Health and Social Care 28 (2), 309–324.

Kirsch, I., 2019. Placebo effect in the treatment of depression and anxiety. Front. Psychiatr. 10, 407. https://doi.org/10.3389/fpsyt.2019.00407.

Molinaro, M.L., Shen, K., Agarwal, G., Inglis, G., Vanstone, M., 2023. Family physicians' moral distress when caring for patients experiencing social inequities: a critical narrative inquiry in primary care. Br. J. Gen. Pract. https://doi.org/10.3399/BJGP.2023.0193.

NHS Business Services Authority, 2023. Medicines used in mental health – England – 2015/6 to 2022/3. accessed 5/3/34) at. https://www.nhsbsa.nhs.uk/statistical-collections/medicines-used-mental-health-england/medicines-used-mental-health-england-201516-202223.

NHS England and NHS Improvement and the National Collaborating Centre for Mental Health, 2019. The community mental health framework for Adults and older Adults. accessed online (22/07/21) at. https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf.

NHS, 2023. Side effects – antidepressants. accessed online (01/12/23) at. https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/medicines-and-psychiatry/antidepressants/side-effects/.

NICE, 2022. Depression in Adults: Treatment and Management. NICE guideline, 29 June 2022, accessed online (01/12/23) at. https://www.nice.org.uk/guidance/ng222/resources/depression-in-adults-treatment-and-management-pdf-66143832307909.

Parker, D., Byng, R., Dickens, C., McCabe, R., 2019. 'Every structure we're taught goes out of the window': general practitioners' experiences of providing help for patients with emotional concerns. Health Soc. Care Community 28 (1). https://doi.org/10.1111/hsc.12860.

Public Health England, 2019. Dependence and withdrawal associated with some prescribed medicines: an evidence review. accessed online (10/09/2022) at. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/940255/PHE_PMR_report_Dec2020.pdf.

Read, J., Williams, J., 2018. Adverse effects of antidepressants reported by a large international cohort: emotional blunting, suicidality, and withdrawal effects. Curr. Drug Saf. 13 (3), 176–186. https://doi.org/10.2174/1574886313666180605095130.

Skivington, K., Smith, M., Chng, N.R., Mackenzie, M., Wyke, S., Mercer, S.W., 2018. Delivering a primary care-based social prescribing initiative: a qualitative study of the benefits and challenges. Br. J. Gen. Pract. 68 (672), e487–e494.

Thomas, F., Hansford, L., Ford, J., Wyatt, K., McCabe, R., Byng, R., 2019. How accessible and acceptable are current GP referral mechanisms for IAPT for low-income patients? Lay and primary care perspectives. J. Ment. Health 29 (6), 706–711.

Thomas, F., Wyatt, K., Hansford, L., 2020a. The violence of narrative: embodying responsibility for poverty-related stress. Sociol. Health Illness 42 (5), 1123–1138.

Thomas, F., Roche, D., Kisku, A., Parker, D., Ford, J., McCabe, R., Byng, R., 2020b. Supporting patients experiencing poverty-related mental distress. accessed online (15/04/24) at. https://destressproject.org.uk/wp-content/uploads/2020/12/DeStress-SupportingPatients_Booklet_WEB.pdf.

Turner, E.H., Matthews, A.M., Linardatos, E., Tell, R.A., Rosenthal, R., 2008. Selective publication of antidepressant trials and its influence on apparent efficacy. N. Engl. J. Med. 17 (358), 252–260. https://doi.org/10.1056/NEJMsa065779, 3.

Warren, J.B., 2020. The trouble with antidepressants: why the evidence overplays benefits and underplays risks—an essay by John B Warren. Br. Med. J. 370, m3200 https://doi.org/10.1136/bmj.m3200.

Wentink, C., Huijbers, M.J., Lucassen, P.L., van der Gouw, A., Kramers, C., Spijker, J., Speckens, A.E., 2019. Enhancing shared decision making about discontinuation of antidepressant medication: a concept-mapping study in primary and secondary mental health care. Br. J. Gen. Pract. 69 (688), e777–e785. https://doi.org/10.3399/bjgp19X706001. Oct 31.