

Understanding and Dealing with Stress



Interim report

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Overview of study

De-Stress is a 2.5 year research study looking at the impact of welfare reforms and austerity on mental health and wellbeing in low-income communities.

The project objectives are:

1. to understand how moralising narratives linked with welfare reforms and austerity are impacting on mental health and wellbeing within low-income communities
2. to understand how the use of antidepressants and talking therapies are impacting on people's wellbeing in low-income communities
3. to understand the challenges facing GPs in providing effective mental health and wellbeing support for patients from low-income communities

The project is being run as a joint collaboration between the *Universities of Exeter and Plymouth* and takes an interdisciplinary approach drawing on perspectives and approaches from social sciences, psychology, biomedical sciences and public health. It is supported by a project Advisory Board comprised of residents, service providers, policy sector representatives and academics.

Methodology

De-Stress uses on a mixed methods approach to address the research objectives. This involves:

- Focus groups with residents in the study sites to gain understanding of the way that moral narratives manifest and impact on wellbeing;
- Interviews with study site residents to understand their experiences of, and responses to, poverty-related distress;
- Interviews with GPs in and around the study sites, to understand the challenges they face providing effective mental health support within low-income communities;
- Conversation analysis of video-recorded GP-patient consultations to understand how mental distress and poverty are discussed and responded to, and to identify examples of positive consultation practice.

Findings

Data analysis is on-going. To date 97 people have participated in sixteen focus group discussions. One-to-one interviews have been undertaken with 67 study site residents, and 10 GPs from within and around the two study sites. In addition, 52 GP-patient video-recorded consultations for mental distress have been analysed using conversation analysis techniques.

Below are the overarching themes that are emerging from the data:

Stigma and moral judgement

- Residents in the study sites feel that the challenges of poverty and deprivation have intensified in recent years, with many attributing this to a lack of employment opportunities, an increase in insecure and zero hours contracts, poor housing, social isolation, welfare reforms and an upsurge in welfare sanctioning. These circumstances are widely associated with increases in mental distress.
- Moralising narratives around health and responsibility pervade many aspects of life for people in the study sites. The extent of this varies across demographic groups, with those with young children and those within the welfare system most commonly reporting feeling judged and shamed by others. Key sources of moralising and judgement are reported to come from job centre workers, health and social workers, schools, and, albeit to a lesser extent, from GPs. A further and important source of judgement is felt to come from within the community itself. Most residents feel that this judgement and shame has intensified in recent years and that this is linked to a hardening attitude against people in receipt of welfare support.
- Some people report that they consciously moderate their behaviour so that they do not expose themselves to harmful judgement by others. Parents of young children in particular, report that they do not always access services set up to support them for fear of being seen through a framework of 'risk' and having their children removed.
- Several GPs have used emotive language when describing people's lives and speak of their 'anger' at what they feel is an 'uncompassionate' system.

'I have noticed that some people who are socially deprived feel that they are not listened to, that the system's failed them and they feel very degraded, treated with a bit of less self-worth...that attitude towards patients who are, who are punished for, you know who aren't working needs to be really challenged and changed' [Female GP, Plymouth, age 30-40]

Poverty-related distress

- Links between poverty and mental distress are clearly evident in the study sites. Few options for formal help for this distress exist in the study sites and it is universally agreed that important community-focused services e.g. Citizen's Advice Bureau (CAB), have become harder to access.
- Access to support and to statutory services is an issue for residents in both study sites. In Teignmouth, residents now have to find additional time and funds to travel to Newton Abbott to visit housing offices, attend the job centre, and access services such as the CAB. In Plymouth, residents in the study sites report being adversely affected by recent changes to GP surgery provision, in particular, the closure of the Cumberland Centre surgery, and the staff shortages that have affected the Stirling Road/Ocean View surgery.

- Most people seek medical help from their GP because they feel that this will provide them with appropriate mental health support. However, many report that they go to their GP because there is nowhere else to go to get help.
- For some people, being diagnosed with a mental health condition is deemed helpful, and can help them to make sense of, and more effectively deal with what is happening within their lives. Alongside this however, many people in the study sites feel that their distress is being overly-medicalised. This is particularly evident for those within the welfare system who need to provide medical evidence to legitimate their benefits claims.
- With one exception, all GPs interviewed report a significant rise in cases of poverty-related distress in the past five years. They clearly articulate the association they see between benefits assessment / re-assessment and an exacerbation of mental health issues, and express clear frustration at being asked to act as gatekeepers for welfare claims.
- GPs state that increasing proportions of their patient caseload are experiencing what are primarily social/structural rather than medical issues, with estimates here ranging from 10% to 50% of patients.

'We shouldn't be responsible for the budget [welfare support], the money the government can give to people, but we are the people that know the patients best. But we shouldn't be judging who should get the money and who shouldn't' [Male GP, Plymouth, age 40-50]

'I think what I am seeing now is a different level.... there's a gross underestimate of quite how much distress we are talking about' [Male GP, Plymouth, age 50-60]

- GPs seeking to support patients experiencing poverty-related distress feel they have very limited options available to them. In the vast majority of cases, patients have been offered antidepressant medications, talking therapies or a combination of the two.
- GPs also expressed frustration regarding the lack of support to address other behaviours associated with mental distress such as alcohol and substance abuse; they felt there was a lack of support for addressing the constellation of issues people may be facing, rather, any support tended to address single behaviours, and often further support could only be accessed once such behaviours had been addressed.

Antidepressant medications

- Use of antidepressant medications in the study sites is high. A large proportion of people involved in the study have been prescribed, and have taken, antidepressant medications at some point in their lives.
- Experience with *long-term* antidepressant use is commonly reported in the study sites. For a minority of patients, this involves on-going medication use over a period of several years. Commonly, people have experienced episodes of antidepressant use over the course of a decade or more. There is a general feeling amongst patients from both groups

of having been ‘forgotten’ or ‘written off.’ Concerns have also been raised by participants over what they feel is a lack of opportunity for medication review within GP consultations.

- Despite the high level of antidepressant use within the study sites, a significant proportion of study participants have reported surprise at being prescribed these medications. The feeling of being ‘fobbed off’ with medicines is very commonly reported, with participants feeling that most GPs do not have the time or resources to listen and respond appropriately to their needs.
- GPs interviewed for the study recognise that medications are often a ‘sticking plaster’ approach (sometimes in response to patient’s wanting something to be done immediately and sometimes for GPs to feel like they are doing something), but explain that they have few other viable options available to them.

‘You know by doing that [prescribing antidepressants] you feel that at least you have tried to give something when you can’t change their... you can’t get their, you can’t give them a roof over their heads, you can’t change the fact that they don’t have any support or family around’ (Female GP, Plymouth, age 50-60)

- There is broad agreement amongst most GPs interviewed that medications constitute an ‘easier’ and more realistic option for patients with complex needs, requiring less input, commitment and ‘work’ for this group than IAPT. In some cases, GPs feel that medications are required as a first line of treatment to enable a patient to get to the stage where IAPT may be possible.

IAPT

- Most interview participants have been offered IAPT through Options (Plymouth) or the DAS (Teignmouth). However, waiting times, a reluctance to talk to a stranger, or in a group, and the logistical difficulties of attending appointments deter many from attending. Attending appointments is a particular issue for people in insecure employment/zero hour’s contracts, and people who need childcare, where the cost and logistical implications make this difficult.
- Most people do not know what IAPT is, what it will entail and hence can be reluctant to sign up for an unknown entity.
- There is an expectation that patients will self-refer for IAPT and this is commonly cited by GPs as an important first step on the road to recovery. Self-referral is also thought to lead to fewer DNA instances. Interviews with GPs reveal that they will make a referral on behalf of a patient if they feel there is good reason to. However, this is uncommon, and GPs prefer to avoid doing this, particularly if they are not convinced the person will attend.

'It has to be up to the patient to make that change [attend counselling] but when they're feeling low, it is so hard for them to do that. Like often they need good support around them to encourage them to, for example, even get out of bed in the morning.... the thought of their getting to the appointment is so overwhelming'

'when we used to refer them they just used to DNA all the time, not go to appointments all the time, and that's part of you getting better. If they say 'oh I don't like picking up the phone', just sort of encouraging them to try and help themselves' [Male GP, Teignmouth, age 40-50]

- Patients from the study sites overwhelmingly feel that self-referral is a key deterrent to attending IAPT. Patients explain that when they are feeling distressed, they do not feel confident or well enough to self-refer. Given the challenges many patients feel even raising mental health issues within a GP consultation, there is a widespread feeling of rejection when a GP responds by handing over a leaflet for IAPT. For some patients, the giving of the IAPT leaflet constituted a 'symbolic dismissal' that undermined and delegitimised their concerns.
- GPs routinely emphasise the 'ease' of self-referral within consultations. Phrases such as 'it's just a phone call' or 'just go online' were widely evident in video recorded data and in GP interviews, despite most doctors recognising that self-referral was not an option many patients from the study sites felt comfortable with or able to action. Further analysis will be undertaken to identify more effective and supportive language around IAPT within consultation practice, and this will be fed in to the training materials for GPs that we will be developing with Health Education England over the coming year.
- Experiences of attending IAPT varied across participants. However, only three people involved in the study feel that IAPT has actually been beneficial to their health and wellbeing, and even then, only parts of the experience are seen as effective.
- A range of problems and frustrations associated with IAPT are reported by both residents and GPs, namely: perceived waiting times for IAPT when someone is depressed and unable to get on with day to day living can exacerbate difficulties, and the delay between assessment and referral to Step 3 support; the 'one-size fits all' approach with its rigid protocols and focus on cognitive behavioural therapy which fails to address or find solutions to the underlying problems of poverty-related distress; difficulty patients experience making an emotional connection with a therapist, and the perception that they will be unable to build a trusting relationship with them in six sessions; patient perception that therapists over-emphasise and make assumptions about childhood trauma rather than focusing on the present-day situation; the set and limited number of IAPT sessions available, and the delay and lack of continuity if a patient returns for further support; the lack of joined-up provision between primary care, IAPT provision and third sector providers; an on-going disconnect at the interface of primary and secondary mental health care.
- All GPs interviewed for the study express particular frustration at the 'fractured' nature of mental health provision and the difficulties they face referring patients to appropriate

secondary mental health care. Patients in Plymouth are commonly refused access to IAPT services if their needs are considered too high, and are then referred back to their GP rather than on to specialist care. This is demoralising for already distressed patients, and considered by GPs to be an unnecessary burden on their time and resourcing.

- A handful of patients in the study sites have attended private counselling or other forms of therapy that they have accessed via their workplace, or via their own funds. All report positive experiences, explaining that the service has been individually tailored to their needs, and that they had a say in who they worked with.

Social prescribing

- No-one interviewed in the study sites has experienced social prescribing via their GP. GPs report that it would be helpful to have up-to-date information on activities, support and advice that are available within the locality so that they can refer patients on.
- There is strong evidence from the study that involvement in informal community groups and activities is beneficial, with participants frequently claiming peer group support to be effective in enhancing health and wellbeing. Despite running costs for these groups being very low (covering basic room hire, refreshments and materials e.g. for craft or gardening) most of these groups were constrained by insecure funding, meaning that they met only sporadically, or for time-limited periods.

Emerging critical issues

- Data is showing that people may avoid accessing support services if they feel they will be unfairly judged because of their background and circumstances.
- It is clear that austerity and welfare reforms are impacting adversely on poverty-related stress and well-being, and that this is adding burden to GP workloads.
- GPs have limited options to offer patients from low-income groups experiencing poverty-related distress. It is widely recognised that anti-depressant medications are being used, often on a long-term basis, to alleviate what are essentially social and structural issues.
- Accessing IAPT services can be problematic for patients from low-income backgrounds. Residents widely consider self-referral to be a barrier to access.
- It is widely agreed that the current one-size fits all approach to IAPT is not effective, and that people from low-income groups may benefit more from personalised and solution-focused approaches that aim to alleviate the everyday pressures of hardship e.g. debt, unemployment.
- Although waiting times for initial IAPT assessment are quite rapid, waits for more substantive therapy remain unacceptably long.
- There is an almost universal perception that mental health provision is fractured, and that a deeply problematic disconnect exists between primary and secondary care.

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