DE STRESS PROJECT

SUPPORTING PATIENTS EXPERIENCING POVERTY-RELATED MENTAL DISTRESS

Felicity Thomas
Debbie Roche
Arunima Kisku
Daisy Parker
Joseph Ford
Rose McCabe
Richard Byng

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL
ESRC ES/N018281/1

RCGP ACCREDITED

UNIVERSITY OF EXETER | MEDICAL SCHOOL

CITY UNIVERSITY OF LONDON EST 1894

UNIVERSITY OF PLYMOUTH

NHS Health Education England

CONTENTS

INTENDED LEARNING OUTCOMES

- **An ability to understand how poverty and mental health are connected and why this matters within primary health care.**
- **An understanding of how to change consultation style in small ways to improve trust and engagement with low-income patients.**
- **An ability improve shared decision-making within consultations.**
- **An understanding of when to act to support rather than 'fix' patients presenting with poverty-related mental distress.**

CONTEXT

GPs commonly see patients who are affected by poverty-related mental distress. Despite recognising that the patient's problems are often largely psychosocial in nature, GPs face dilemmas over providing appropriate support and are often left with a sense of dissatisfaction with such cases.[1] Patients may feel unsupported, confused, judged, and upset. Such situations can lead to unproductive outcomes for both GP and patient.[2]

This guidance will highlight the importance of GPs trusting their own psychological abilities and the strengths of their therapeutic alliance with their patients; and also to have confidence to know when to act as 'supporters' rather than 'fixers'.

POVERTY AND MENTAL HEALTH

Living with poverty has inter-generational and intra-generational impacts: experiences such as family disruption, educational disadvantage and material deprivation contribute to poor health and social outcomes. People living in poverty can also experience stigma, prejudice and humiliation, leading to loss of dignity and pride, and further damaging health and well-being.[3]

There is a well-established association between poverty and mental ill health. Most explanations expound a two-way process or vicious cycle in which poverty is seen to cause mental ill-health, and mental ill-health may lead to, or exacerbate poverty. Evidence shows for example:

- people facing hunger and debt, and living in poor or overcrowded housing, have high levels of mental health problems;[4]
- possession of fewer material assets and poor employment is associated with depression;[5]
- people with mental illness are disproportionately represented amongst homeless populations;[6]
- children and adolescents with low socio-economic status are at higher risk of mental health problems than those in higher economic groups.[7]

As well as poverty and lack of resources being linked to mental health problems, it is clear that communities facing disadvantage also face more frequent interpersonal violence and relationship problems that can precipitate and prolong mental distress. Low paid and insecure employment can also exacerbate these issues.

WHY DOES THIS MATTER?

- Mental health now counts for up to 30% of GP consultations[8] – a figure that is greater in areas of very high deprivation.[9]
- The prevalence of mental health problems in England has increased since the onset of the recession in 2008, with increases greatest in people with low levels of education and people out of work.[10]
- Poverty continues to affect millions of people in the UK – the impacts of poverty will be exacerbated by the COVID-19 pandemic.[11]
- People living in poverty are less likely to access psychological therapy than other groups, and when they do, they are less likely to recover from depression and anxiety.[12]
- Annual costs of mental health in the UK exceed £11 billion.[13] Total costs are estimated to be between £70-100 billion.[14]

SO WHAT HELPS IN GP CONSULTATIONS?

CONNECTION

The primary care setting is the point of entry for most people into the health system. GPs are well placed to deliver support for mental distress, particularly when they have a long-term relationship and have built trust with patients and families.[15]

Even when a long-term relationship has not been established, it is important to connect with patients in a way that establishes rapport, shows respect, and allows patients to both tell their stories and feel listened to. Evidence from our studies suggests that GPs might be able to change their consultation style in small ways to make a big difference to enable individuals struggling with poverty-related stress to fully engage.

This can be difficult if patients feel uncomfortable and insecure within healthcare settings.[16,17] People from low-income backgrounds sometimes feel that they are being judged, or that they do not

have the authority or confidence to speak openly about their concerns. It is useful therefore, for GPs to:

- be aware of the fears and anxieties that patients might have – the box to the right provides some insights into what a patient might be thinking.
- be aware that for some patients, making and attending a GP appointment is perceived as an uncomfortable experience, and may have taken time and courage to action.[18] Research shows this is a common issue for men from low-income backgrounds.[19]
- be aware of the perceptions or assumptions that can exist on both sides of the relationship – this can be especially important when patients are presenting with an emotional, rather than physical health issue.[20]
- linked to this, be aware that as a practitioner who may come from a different social and economic background, you may have inaccurate ideas about what is important for individuals from more deprived areas.

WHAT IS YOUR PATIENT THINKING?

Research has found that people living low-income communities often feel the following when they visit their GP:

- **Inferior and stupid – people may be worried about not understanding what is said, and may feel unable to express their own experiences and concerns.**
- **Embarrassed, ashamed and undeserving.**
- **That they will be perceived as time wasters, especially when the issue is mental rather than physical.**
- **That they may be judged because of their background circumstances and their appearance.**
- **Fear that divulging information about their mental health might lead to their children being taken into statutory care.**
- **That they will not be listened to, and their concerns will be dismissed.**

Interpersonal skills are an important and integral part of GP practice. These are summarised before examining their relevance for patients in low-income areas. There is a large body of evidence supporting the value of core attributes and skills such as showing empathy and compassion, and in being able to provide patient support.[21,22] These competencies are relevant for reducing patient distress, and studies have also found that doctors who possess and demonstrate such skills are more effective,[23-28] even when consultation times are short.[17] Patients have better faith in their doctors and are more willing to adhere to their treatments, ultimately resulting in better mental and physical wellbeing.[29,30]

Techniques such as the Cambridge-Calgary method, which emphasises active listening skills, and the BATHE technique as a method for assessing a patient's psycho-social status have been shown to result in more effective GP consultations and increased patient satisfaction.[31] Formal training of doctors and medical students is effective in enhancing empathy and patient-centred care, and in reducing burnout.[32]

Conversely, looking at the computer when the patient enters the room may indicate to them a lack of interest, and may deter patients from raising and discussing important issues.[33] Patients from low-income backgrounds report that some behavioural questions asked by GPs (e.g. around drug use or sexual health) make them feel unfairly judged.

KEY METHODS TO GENERATE TRUST AND CONNECTION WITH PEOPLE IN LOW-INCOME AREAS

Building on active listening and interpersonal skills that demonstrate warmth, interest, respect, empathy and non-judgemental support is important to overcome any perceptions that doctors might not be interested in a patient's mental health:

- A warm introduction and greeting, with an opening question that provides the patient with a cue to start talking e.g. How can I help? What's brought you in today?
- Explain the rationale for the standard questions that you need to ask about employment, drug and alcohol use etc. – 'we know how our distress can be linked to our social situation' - to overcome feelings of stigma.
- Attentive body language can also help overcome any feelings that the practitioner does not care: facial expressions; eye contact; gestures to show engagement and interest.
- To help you understand the individual's perspective and background (especially if different from yours) use open-ended questions; attentive silences; facilitative responses.
- Avoid attending to the computer when the patient is talking, and explaining to the patient what is being recorded in their notes.
- Be even more vigilant about picking up on cues which may be very tentative and expressed in ways that are unfamiliar, for example expressions of frustration or unspecific complaints such as 'I feel really bad'.
- Reflecting skills can be useful to check you understand what may be being said: paraphrasing, summarising or repeating back what has been said to clarify and show understanding and reflect back feelings.

- Help show patients that they are 'legitimate' – phrases such as 'I'm glad you came to see me today' can be helpful.
- Ensuring that patients know that they can use emergency consultations for psychological issues can also help validate concerns.[34]

IT ***DOESN'T*** HELP TO:

- Ignore or miss psychological cues.
- Assume you know what the patient wants.
- Respond defensively to cues that indicate a lack of trust.

IT ***DOES*** HELP TO:

- Be alert to cues and prompts, sensitively accept them and let the patient expand on them.
- Remember that some individuals may not feel able to say what they want until feeling trusted and cared for.
- Try not to take distrust personally as it's normally born out of problematic interactions with others elsewhere.

THE BATHE TECHNIQUE

The BATHE technique has been found to be effective in starting a conversation about a patient's psycho-social status, which can then be used in developing a shared understanding in the next section:

B ACKGROUND: e.g. 'what's going on in your life?'; 'tell me what's been happening.'

A FFECT: e.g. 'how does that make you feel?; 'how has this affected you?'

T ROUBLE: e.g. 'what troubles you about this?'; 'what bothers you most about this situation?'

H ANDLING: e.g. 'how are you handling that?'; 'how have you been managing this problem?'

E MPATHY: Instil hope by expressing your understanding of what the patient is going through e.g. 'I imagine that could be difficult'; 'you seem to be going through a lot.'

FROM DIAGNOSIS TO SHARED 'BIO-PSYCHO-SOCIAL' UNDERSTANDING

Reaching a shared understanding of the issues faced by the patient lies at the centre of GP practice yet can be very challenging in mental health-based consultations. Often, consultations start with a physical presentation, with underlying mental health concerns presenting later or more indirectly.[1,35] GPs might be more worried about missing a physical diagnosis than a mental health diagnosis.[36] Some doctors do not feel comfortable dealing with mental health issues and may be reluctant to explore psycho-social issues in case they open up a multitude of complex issues that they do not feel they have the skills or resources to address effectively.[1]

Whilst GPs are generally trained to diagnose between either physical or mental health issues, recognition of the interconnection between physical, mental and social factors provides a more complete picture of the patient's experiences and needs.

For people experiencing mental distress, being listened to and understood can often be just as important as a diagnosis. However, having a diagnosis can be helpful for some people to help validate or explain their suffering, and to provide evidence needed to support a claim for various forms of welfare or social support.

GPs often identify symptoms and treat these with the options available to them. With mental health, these options are usually limited, and are not always very effective. A key challenge encountered is in case definition and deciding where the cut-off lies between psychological distress and clinical depression. GPs are usually able to recognise patients experiencing distress as a result of problems in their lives, but find it more difficult to decide whether the issues are clinically significant and whether or not to make an explicit mental health diagnosis.

IT ***DOESN'T*** HELP TO:

- Create false dichotomies between physical and mental health, or between mental and social issues.
- Completely medicalise mental distress – or discount distress as a purely social problem.

- Provide a diagnosis too rapidly or without an explanation.
- Only focus on symptoms .
- Be judgemental, blaming or critical, or oversimplify the explanation given for their distress.
- Use overly-complicated or medicalised terminology without explaining what is meant.

IT ***DOES*** HELP TO:

- Use a bio-psycho-social model that recognises the interconnections between physical, mental and social issues when they exist.
- Recognise that social problems can result in feelings of distress.
- Allow time to explore the issues. Acknowledge and validate the patient's suffering through empathic listening on the whole situation. This may be what the patient wants more than the diagnosis.

  Be aware of the broader (health, social, economic) implications of a diagnosis for the patient.

  If the patient only wants a diagnosis to gain statutory support, look at the option of demonstrating need through detailing the key symptoms.
- Treat the whole situation, not just the symptoms.
- Acknowledge the importance of the patient's perspective and circumstance – ask them what they think has led to their problems.
- Explain if using a diagnosis of depression or anxiety, that this is shorthand for recognising that the combination of emotional and physical symptoms are significant enough that treatment might be helpful.

  Use the patient's language to offer tangible explanations of what is causing their symptoms.

MANAGEMENT AND TREATMENT OPTIONS

Medication and talking therapies have been the mainstay of mental health treatment for many years, with some evidence also to support exercise. Effect sizes for all these NICE recommended options are small however, which affects decision-making and what we can promise if we want to be honest with patients.

More recently, social prescribing to address social causes of distress has been increasing in popularity, and commissioned; there are no high quality trials – but it does provide a rational response for distress where social problems appear to be critical causes. Patients also attest in qualitative studies to how important practitioner's actions in the consultation can be in affecting their wellbeing, although again there are no randomised trials to prove effectiveness.

The small numbers of studies, including our own, which have examined how GP-patient interaction and decision-making for depression are experienced, show that GPs:

- Tend not to dictate what patients do.
- Are happy to be led by patient's preferences.
- Often only offer one solution initially.

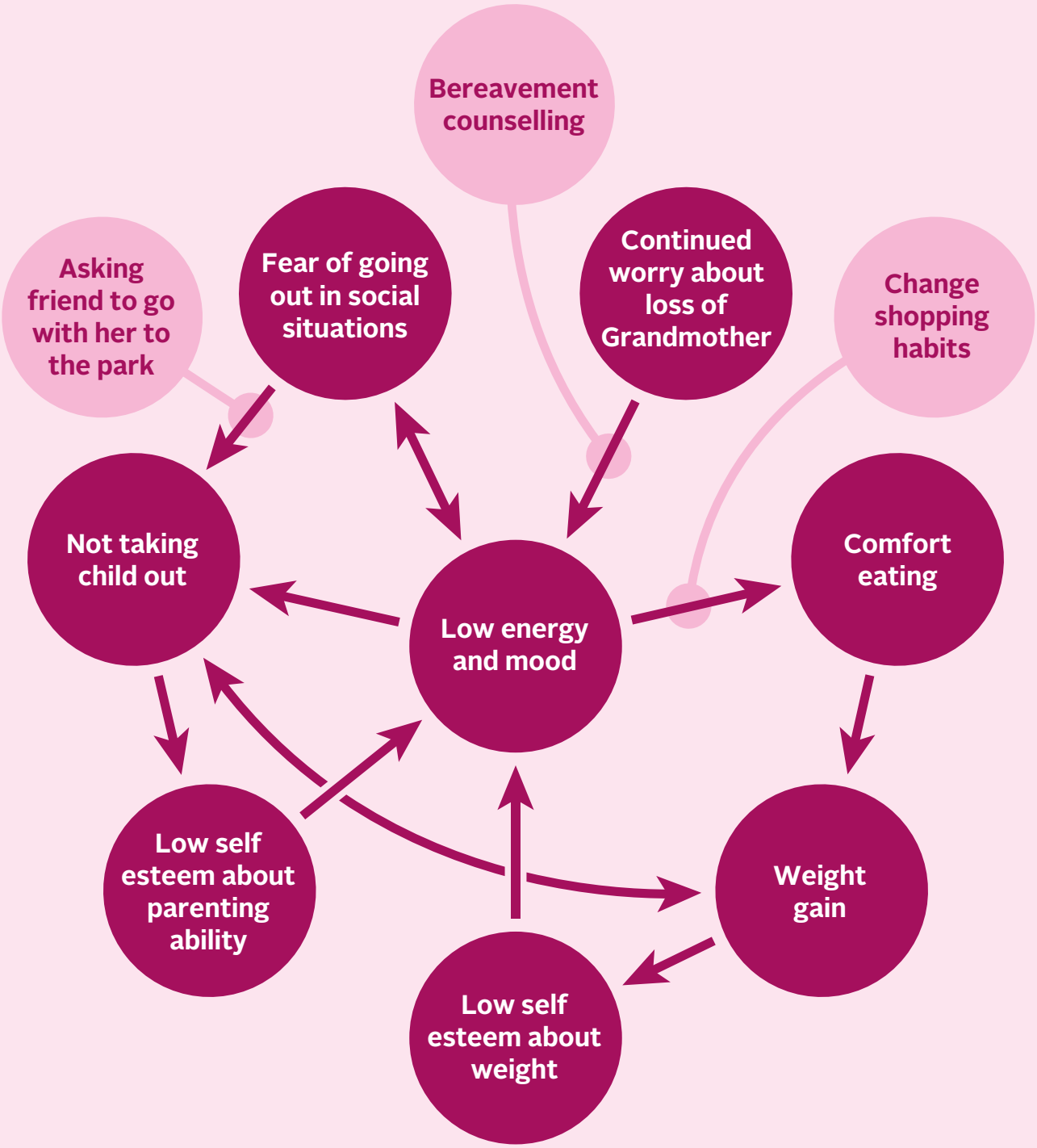
This does not appear to differ much by socio-economic group. Patients in contrast, while often accepting suggestions, are willing to make suggestions themselves, and will in about a third of cases indicate reluctance, which may or may not be recognised by GPs.

So shared decision making appears relatively well advanced, but could be further supported by:

- Working out which options make sense based on the shared bio-psycho-social understanding developed above (see example on the following page).
- Laying out a range of options rather than making offers or pronouncements.
- Giving patients clear information about what each of their options involves.
- Suggesting individuals have time to think and discuss with others if they wish to before making decisions.

EXAMPLE OF INTERVENTIONS LINKED TO A SHARED UNDERSTANDING

For a young mother with low mood, interventions might include: choosing counselling over CBT to address continued rumination about a bereavement; agreeing to ask a friend to accompany her to the park with her children in order to improve her personal identity as a 'good parent'. The below diagram depicts both the shared understanding and the components of a personal action plan which cuts across bio-psycho-social domains.



WE NOW CONSIDER DIFFERENT MANAGEMENT OPTIONS

The evidence base for treating mental health is weak. It is especially weak for cases in which the problem appears to be more psycho-social than physical in nature. This can lead to weak endorsement by GPs. Weak endorsement can make patients feel undermined and disincentivised, and can result in low uptake and adherence to recommended treatments.[37] Double-checking a patient's hopes and expectations and their understanding of the treatment options available to them (including non-medical options) can increase patient buy-in and adherence.[38]

However, rather than giving the impression of certainty about the best treatment option, being open and confident about uncertainty and being honest that the treatment plan may not work gives patients a route to come back and discuss what is or is not working for them.[39]

We recognise that avoiding both weak endorsement and avoiding certainty is difficult. Providing a confident assertion of uncertainty while promoting hope through being clear that most people do recover well and that you, or the practice, will be there, is important.

A) MEDICATION

The most common method used to manage common mental health disorders in primary care is with psychotrophic medications. A key predictor of prescription relates to a GP's perception that this is what the patient wants.[40] Evidence shows that the magnitude of benefit of antidepressant medication increases a little with severity of depression symptoms but is small with a number needed to treat of about 7.[41] As most patients in primary care are in the mild to moderate range, only a small proportion of patients will benefit from antidepressants.[42] Improvements are more

likely to be due to a placebo response rather than a medication response. Circumstantial changes can also bring about improvements. However, patients may give the medication the credit. In other cases, individuals stop medication soon after prescription because they do not want to be reliant on them, or because of adverse side effects.

Antidepressant medication appears to have unpredictable effects on individuals – some feel no effect, others get uncomfortable physical side effects, and the frequently reported effects of numbing and sedation can be found beneficial or problematic depending on the situation.[43] All this places GPs and patients in difficult situations when making decisions about medication.

Overuse of antidepressants can also have a negative impact on patient health and create dependencies, representing an inefficient use of health care resources.[44] There are no long-term randomised studies to examine benefits or harms over more than two years and non-randomised studies show that most individuals relapse despite medication.

Evidence suggests that prescribing of psychotropic medications in the UK is especially high in areas affected by poverty and deprivation.[9] Rates of use vary nearly three-fold between white, deprived, stable localities such as Blackpool and Lincoln, and more affluent, ethnically mixed communities such as London and South-East. Reasons for this are not clear-cut. However, there is some evidence from our studies to suggest that this situation can be influenced by patient reluctance to use alternative treatment such as counselling services, logistical difficulties facing patients (e.g. travel and childcare costs, reluctance to take time out of low-paid or zero hour contract employment), and by perceptions held by some GPs that patients from low-income backgrounds will find medication easier to use than counselling. Research has shown that whilst levels of initial adherence are low,[45] long-term use of antidepressants is often high amongst patients from areas of deprivation.

Before prescribing antidepressants, it is beneficial for GPs to:

- Consider, perhaps over several consultations, how the patient can best be supported, including via non-medical options, as per NICE guidance which suggests talking treatments first for most people.
- Talk through the potential benefits of different treatment options, including non-medical options, and be open and honest about their strengths and limitations.
- Explain that antidepressant medications may make a patient feel worse initially, and be clear on possible side effects.
- Be aware of patient circumstances which might impact on medication uptake and adherence.
- Explain to patients the risk of addiction and any possible withdrawal effects.
- Remember that some patients expect a prescription, or have been advised by others to get one, so may make different decisions if more considered approach is used.

- Recognise that there is no need to rush to 'fix' a patient. Early prescribing can risk a patient: feeling misunderstood and not returning; having difficulty adhering to or stopping their medication; overdosing, or having adverse effects from medicine use.
- Explain to patients that antidepressant medications do not have a standard effect, and that different people can have very different experiences whilst taking them.

Long-term antidepressant use is high amongst low-income patients.[37] Rather than assume that on-going use of medications is benefiting the patient, it can be helpful for GPs to:

- Factor in regular medication reviews which ask patients how they feel about the medications they are taking and whether they feel the medicines are having a positive impact on them.
- Be clear when medication is likely to be stopped.
- Ensure people know there may be a brief or more prolonged discontinuation of symptoms when stopping.
- Ensure that patients know they can ask for a medication review at any point.
- Ensure that patients remain aware of alternatives to medication.
- Ensure that patients wishing to stop taking medications are supported to do this safely.

B) TALKING THERAPIES

Evidence suggests that self-referral for IAPT can result in positive attendance and outcomes.[46,47] However, our research with low-income groups has shown that people often feel 'fobbed off' or 'dismissed' when they are handed an information leaflet on IAPT, and that this, and logistical challenges, mean they are unlikely to follow up on the referral. To help counter this, it can be useful for GPs to:

- Explain to patients clearly what they think the purpose of the treatment agreed upon is.
- Familiarise themselves with the specificities of the local IAPT service so that they can talk more confidently about this treatment route.
- Check with the patient that they feel able to self-refer for an IAPT appointment – emotionally, and in terms of resourcing e.g. having sufficient phone credit.
- Consider making a referral for a patient.

C) OTHER OPTIONS AND SOCIAL INTERVENTIONS

Other forms of non-medical response that promote relaxation, mindfulness and exercise may be appropriate – think about the shared understanding with the patient and develop a plan together about what might help.

Incorporating an activity plan is feasible in a routine GP consultation, and achievable goals should be negotiated with the patient. Activities could include day-to-day essentials (eating, sleeping, shopping) alongside social activities e.g. meeting up with a friend, and activities that can promote self-esteem e.g. volunteer work, gardening, involvement in local activities.

When negotiating a plan, it is helpful for GPs to:

- Remain mindful of the resource limitations affecting low-income patients and the challenges people face when placed in unfamiliar settings – options should therefore be negotiated realistically and sensitively.
- Be aware that patients in distress may perceive such suggestions as patronising and therefore explain to patients why this activity plan may be beneficial.
- Recognise that online activities and self-help tools may be helpful, but may be inaccessible or unappealing to some patients.
- Have a good and up-to-date knowledge of local organisations, community groups and telephone helplines to which patients can be referred. Whilst some services may have an explicit focus on mental health, evidence suggests that services with a broader based focus can often be helpful and less stigmatise.[48] Community connectors have been found to play a beneficial and cost effective role in linking patients to local activities and groups.[49]
- An awareness of freely available mobile phone apps which support self care e.g. 5 Ways to Wellbeing, Elefriends, RCPsych Mental Health App, may also be beneficial.
- Accept the limits of their own knowledge, skills and remit and actively seek support if they are out of their depth, cognitively or emotionally. A 'reflective pause' prior to each consultation can help GPs to establish their readiness to see incoming patients.[50]

CONTINUITY, FOLLOW UP AND ENDINGS

Following up patients experiencing mental distress can provide reassurance and solidarity. This can also be useful in helping patients feel that their experiences are being taken seriously.[20] As part of the patient's on-going treatment plan, it can be helpful for GPs to:

- Consider a phone call to the patient between visits. Evidence suggests that this kind of support improves clinical outcomes and patient satisfaction.[42,51]
- See the patient again in a week or negotiate an interval that seems appropriate and is acceptable to the patient. There is no evidence base for choosing such a time interval – however, it is important to recognise that the passing of time can feel very slow for people experiencing mental distress.

  Follow up appointment in two weeks or to contact the patient if follow up appointment is not attended is recommended by NICE.
- Book patient's follow-up appointments for them – this can help a patient to feel supported.
- Ensure patients feel able to return when they want to – they do not need to feel at crisis point first. Patients who are waiting for counselling need to know they can return to their GP at any point, and have not been 'passed on' out of the service.
- Patients may benefit from accompanied consultations. GPs should ensure that patients are aware that such consultations are welcome. Although there is limited evidence available, triadic consultations can be beneficial for patients in helping with recall of information.[52]
  - In triadic consultations, GPs should be mindful of any agenda setting by non-patients. An ability to read cues, both verbal and non-verbal, is very important in this situation.

REFERENCES

1. Dew K, Dowell A, McLeod D, Collings S, Bushnell J. 'This glorious twilight zone of uncertainty': Mental health consultations in general practice in New Zealand. Soc Sci Med. 2005;61(6):1189-1200.
2. Williams S, Weinman J, Dale J, Newman S. Patient expectations: What do primary care patients want from the GP and how far does meeting expectations affect patient satisfaction? Fam Pract. 1995;12(2):193-201. doi:10.1093/fampra/12.2.193.
3. Boardman J, Dogra N, Hindley P. Mental health and poverty in the UK--time for a change? BJPsych Int. 2015;12(2):27-28.
4. Drentea P, Reynolds JR. Neither a borrower nor a lender be: the relative importance of debt and SES for mental health among older adults. J Aging Health. 2012;24(4);673-695.
5. Rai D, Zitko P, Jones K, Lynch J, Araya R. Country- and individual-level socioeconomic determinants of depression: multilevel cross-national comparison. Br J Psych. 2013;202(3):195-203.
6. Fazel S, Geddes JR, Kushel M. The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. Lancet. 2014;384(9953):1529-1540.
7. Reiss F. Socioeconomic inequalities and mental health problems in children and adolescents: a systematic review. Soc Sci Med. 2013;90:24-31.
8. Sartorius N, Ustün TB, editors. Mental Illness in General Health Care: An International Study. Chichester: Wiley; 1995.
9. EXASOL (2017) EXASOL Analyzes: Research shows that over 64m prescriptions of antidepressants are dispensed per year in England: visualised for the first time. Available from: https://www.exasol.com/en/company/newsroom/news-and-press/2017-04-13-over-6-million-prescriptions-of-antidepressants-dispensed-per-year-in-england/
10. Barr B, Kinderman P, Whitehead M. Trends in mental inequalities in England during a period of recession, austerity and welfare reform 2004 to 2013. Soc Sci Med. 2015;147:324-331.
11. Mackley, A., Kennedy, S. and Hobson, F. (2020) Coronavirus: support for household finances, House of Commons Library Briefing Paper 8894, 22 June 2020
12. Delgadillo J, Asaria M, Ali S, Gilbody S. On poverty, politics and psychology: the socioeconomic gradient of mental healthcare utilisation and outcomes. Br J Psychiatry. 2016;209(5):429-430.
13. National Health Service (UK). Mental Health Five Year Forward View Dashboard [Internet]. National Health Service; [cited 2018 Oct 05]. Available from: https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/
14. Davies SC. Chief medical officer's summary. In Davies SC, editor. Annual report of the chief medical officer 2013, public mental health priorities: investing in the evidence. London: Department of Health; 2014. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/413196/CMO_web_doc.pdf
15. Wittchen H-U, Mühlig S, Beesdo K. Mental disorders in primary care. Dialogues Clin Neurosci. 2003;5(2):115-128.
16. Lester HE, Tritter JQ, Sorohan H. Patients' and health professionals' views on primary care for people with serious mental illness: focus group study. BMJ. 2005;300:1122.
17. Pollock K, Grime J. Patients' perceptions of entitlement to time in general practice consultations for depression: qualitative study. BMJ. 2002;325(7366):687.
18. Staiger T, Waldmann T, Rüsch N, Krumm S. Barriers and facilitators of help-seeking among unemployed persons with mental health problems: A qualitative study. BMC Health Serv Res. 2017;17:39. doi:10.1186/s12913-017-1997-6.

19. Johnson JL, Oliffe JL, Kelly MT, Galdas P, Ogrodniczuk JS. Men's discourses of help-seeking in the context of depression. Sociol Health Illn. 2012;34(3):345-361.

20. Kravitz RL, Paterniti DA, Epstein RM. Relational barriers to depression help-seeking in primary care. Patient Educ Couns. 2012; 82(2):207-213.

21. Cooper L, Brown C, Vu HT, et al. Primary care patients' opinions regarding the importance of various aspects of care for depression. Gen Hosp Psychiatry. 2000;22(3):163-173. doi:10.1016/S0163-8343(00)00073-6

22. Shattell MM, Starr SS. 'Take my hand, help me out': Mental health service recipients' experience of the therapeutic relationship. Int J Ment Health Nurs. 2007;16(4):274–84.

23. Izquierdo A, Sarkisian C, Ryan G, Wells KB, Miranda J. Older depressed Latinos' experiences with primary care visits for personal, emotional and/or mental health problems: a qualitative analysis. Ethn Dis. 2014;24(1):84-91.

24. Jani B, Bikker AP, Higgins M, et al. Patient centredness and the outcome of primary care consultations with patients with depression in areas of high and low socioeconomic deprivation. Br J Gen Pract. 2012;62(601):e576-81.

25. van Os TWDP, van den Brink RHS, Tiemens BG, Jenner JA, van der Meer K, Ormel J. Communicative skills of general practitioners augment the effectiveness of guideline-based depression treatment. J Affect Disord. 2005;84(1):43-51.

26. Cape J. Patient-rated therapeutic relationship and outcome in general practitioner treatment of psychological problems. Br J Clin Psychol. 2000;39(4):383-395.

27. Malt UF, Robak OH, Madsbu HP, Bakke O, Loeb M. The Norwegian naturalistic treatment study of depression in general practice (NORDEP)-I: randomised double blind study. BMJ. 1999;318(7192):1180-1184.

28. Kelley JM, Kraft-Todd G, Schapira L, Kossowsky J, Riess H. The influence of the patient-clinician relationship on healthcare outcomes: A systematic review and meta-analysis of randomized controlled trials. PLoS One. 2014;9(4):e94207. doi:10.1371/journal.pone.0094207.

29. Loh A, Leonhart R, Wills CE, Simon D, Harter M. The impact of patient participation on adherence and clinical outcome in primary care of depression. Patient Educ Couns. 2007;65(1):69-78.

30. Thompson L, McCabe R. The effect of clinician-patient alliance and communication on treatment adherence in mental health care: a systematic review. BMC Psychiatry. 2012;12:87. doi:10.1186/1471-244X-12-87.

31. Leiblum SR, Schanll E, Seehuus M, DeMaria A. To BATHE or not to BATHE: patient satisfaction with visits to their family physician. Fam Med. 2008;40(6):407-411.

32. Griffin SJ, Kinmonth AL, Veltman MW, Gillard S, Grant J, Stewart M. Effect on health-related outcomes interventions to alter the interaction between patients and practitioners: a systematic review of trials. Ann Fam Med. 2004;2(6):595-608.

33. Bensing JM, Tromp F, van Dulmen S, et al. Shifts in doctor-patient communication between 1986-2002: a study of videotaped General Practice consultations with hypertension patients. Fams Pract. 2006;7:62.

34. Parker D. "Every structure we're taught goes out the window": general practitioners' experiences of providing help for common mental health problems. Forthcoming.

35. Brown C, Schulberg HC. Diagnosis and treatment of depression in primary medical care practice: The application of research findings to clinical practice. J Clin Psychol. 1998;54(3):303-314.

36. Glew S, Chapman B. Closing the gap between physical and mental health training. Br J Gen Pract. 2016;66(651):506-507.

37. DeStress Project. Project background. Available from: http://destressproject.org.uk/project-background/ [Accessed 2018 Nov 10]

38. van Shaik DJF, Klijn AFJ, van Hout HPJ et al. Patients' preferences in the treatment of depressive disorder in primary care. Gen Hosp Psychiatry. 2004;26(3):184-189.

39. Bultman DC, Svarstad BL. Effects of physician communication style on client medication beliefs and adherence with antidepressant treatment. Patient Educ Couns. 2000; 40(2):173-185.

40. Cockburn J, Pitt S. Prescribing behaviour in clinical practice: patients' expectations and doctors' perceptions of patients' expectations--a questionnaire study. BMJ. 1997;315:520-3.

41. Fournier JC, Rubeis RJ, Hollon SD et al. Differential change in specific depressive symptoms during antidepressant medication or cognitive therapy. Behav Res Ther. 2013;51(7):392-398.

42. Arroll B, Chin WY, Moir F, Dowrick C. An evidence-based first consultation for depression: nine key messages. Br J Gen Pract. 2018;68:200-201.

43. Moncrieff, J. (2013) The Bitterest Pills: The Troubling Story of Antipsychotic Drugs, Basingstoke: Palgrave MacMillan.

44. Spence R, Adams R, Cono A, Bardsley M. Focus on: antidepressant prescribing: trends in the prescribing on antidepressants in primary care. Health Foundation and Nuffield Trust [cited 2018 Oct 04]. Available from: https://www.health.org.uk/sites/health/files/QualityWatch_FocusOnAndidepressantPrescribing.pdf

45. Lawrenson RA, Tyrer F, Newson RB, Farmer RDT. The treatment of depression in UK general practice: Selective serotonin reuptake inhibitors and tricyclic antidepressants compared. J Affect Disord. 2000;59(2):149–57

46. IAPT three-year report: the first million patients [Internet]. Department of Health; 2012 [cited 2018 Oct 05]. Available from: http://www.mhinnovation.net/sites/default/files/downloads/innovation/reports/Three-year-report.pdf#page=13

47. NICE (2009) Depression. The treatment and management of depression in adults (NICE guideline). Clinical guideline 90. National Institute for Health and Care Excellence.

48. RCPSYCH (2019) Position statement on antidepressants and depression, PS04/19, Royal College of Psychiatrists

49. Psychological therapies: annual report on the use of IAPT services England, further analyses on 2016-2017 [Internet]. NHS Digital; 2018 [cited 2018 Oct 05]. Available from: https://files.digital.nhs.uk/publication/s/n/psyc-ther-ann-rep-2016-17_add.pdf

50. Connecting communities to tackle loneliness and social isolation [Internet]. Co-Op, British Red Cross and Kaleidoscope; 2018 [cited 2018 Nov 10]. Available from: https://www.redcross.org.uk/-/media/documents/about-us/research-publications/health-social-care-and-support/connecting-communities-learning-report.pdf

51. One Ilfracombe community connector: one year report [Internet]. One Ilfracombe; 2016 [cited 2018 Nov 10]. Available from: http://www.oneilfracombe.org.uk/wp-content/uploads/2016/07/Connector-Report-v3.pdf

52. Napier J. Wellbeing for GPs: the importance of looking after ourselves. GP Online; 2017 [cited 2018 Oct 04]. Available from: https://www.gponline.com/wellbeing-gps-importance-looking-ourselves/article/1440405

53. Simon GE, Vonkorff M, Rutter C, Wagner E. (2000). Randomised trial of monitoring, feedback, and management of care by telephone to improve treatment of depression in primary care. BMJ. 2000;320:550-554.

54. Schilling LM, Scatena L, Steiner JF et al. The third person in the room: frequency, role, and influence of companions during primary care medical encounters. J Fam Pract. 2002;51(8):685-690.

Contact

DeStress Project
University of Exeter Medical School,
St Luke's Campus, Heavitree Road, Exeter EX1 2LU

f.thomas@exeter.ac.uk

s.hughes@exeter.ac.uk

destressproject.org.uk

Please visit the DeStress website **destressproject.org.uk/resources-for-gps/** to leave your feedback on this RCGP accredited learning resource. This will help ensure these materials can be improved and kept updated.