

# Poverty, pathology and pills



**Final report**

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## Context

Mental health problems are currently viewed as constituting one of the greatest burdens on global health and wellbeing (WHO 2017). Recent years have witnessed a marked rise in mental health diagnoses and in the prescribing of mental health treatments across much of the economically developed world. Diagnosis for depressive disorders and anxiety disorders in particular, have shown a marked rise in recent years.

The provision of effective treatment and support for mental distress is a key aim of the British Government (HM Government 2011). In England, the number of antidepressant items prescribed has seen a decade on decade advancement in total antidepressant prescribing (600% in 25 years) to 68 million items per year in England. Alongside this, the government has committed strongly to the Improving Access to Psychological Therapies (IAPT) programme, with over 900,000 patients a year in England seen by 2008, with plans to expand this to upward of 1.5 million a year by 2020 (Clark 2011).

Poverty and deprivation are known to create and exacerbate mental distress (Rogers and Pilgrim 2014). Recent analyses demonstrate high levels of prescribing and use of psychoactive drugs in low-income communities, with poorer urban and rural areas such as Blackpool and rural Lincolnshire reaching average antidepressant prescribing of two items per person per year (see Fig 1). Alongside this, the prescription of drugs for pain relief (often associated with people experiencing poverty-related challenges) has also risen sharply. Pregabalin prescribing in England for example, saw a ninefold increase between 2007 – 2017 from 0.7 to 6.2 million items per year, whilst similar changes have been observed for gabapentin prescribing (1.4 million to 7.1 million) and a range of other drugs associated with the central nervous system (NHS Digital 2018).

One reading of these trends is that government-provided mental health services have successfully challenged the inverse care law by ensuring that widely recommended treatments are available to all who need them. In England, this stance appears to be backed up by an array of government policies committing to move toward parity of esteem between mental and physical health in terms of access to

services, quality of care and allocation of resources (NHS 2015, Parkin and Powell 2017). This form of ‘treatment justice’ may in turn, be a sign that mental health stigma has decreased, and that more people now feel comfortable asking for help for depression and anxiety.

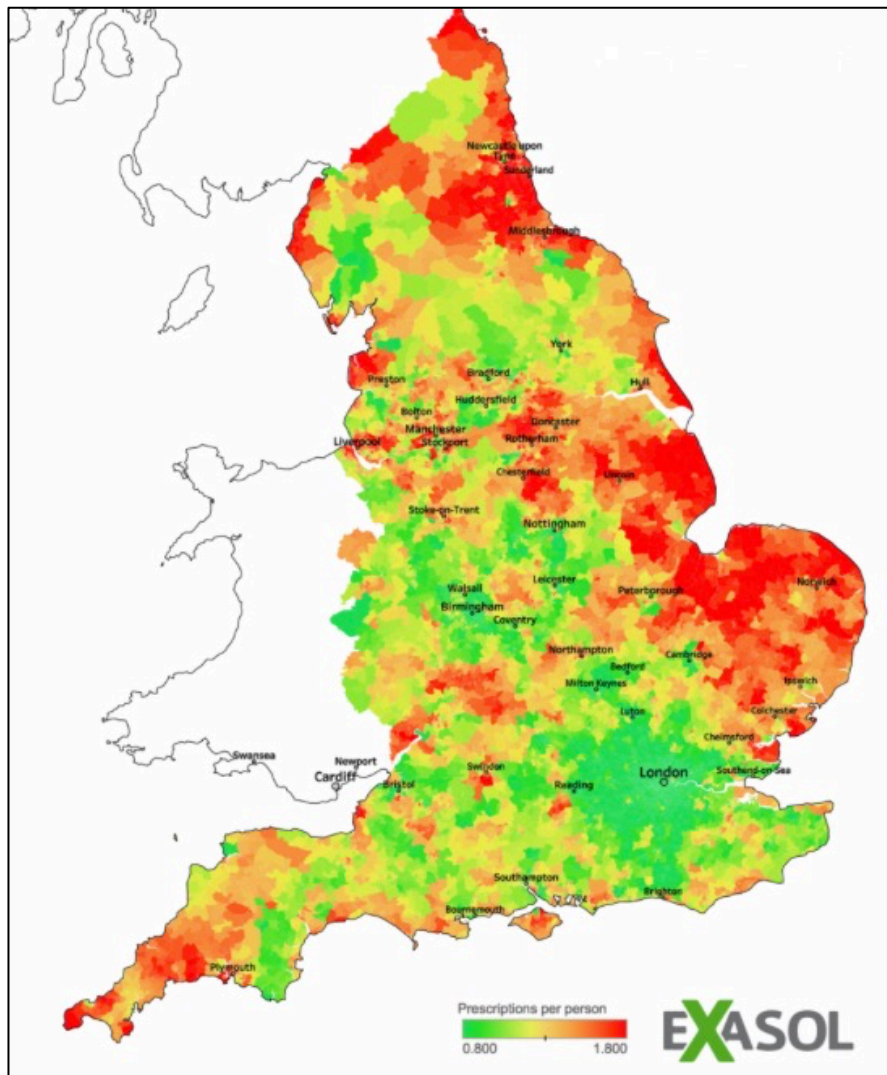


Fig. 1. Source: EXASOL 2017

However, many commentators have expressed concerns about these prescribing trends, fearing that these changes are part of an increasing shift towards the pathologisation and medicalisation of challenging life circumstances. Such concerns are amplified by the low effect rates of antidepressant medications for mild to moderate depression, and the association of these drugs with a wide range of potentially harmful side effects (Gøtzsche 2015; Kirsch et al. 2008).

Others have expressed concern that the medicalisation of distress absolves those with power from taking responsibility for the injustices caused by on-going economic, social and health inequalities. A key issue here relates to the ways in which efforts to promote mental health, and much of the literature upon which this are based, remain focused at the level of the individual, meaning that mental health concerns become framed as a pathological problem of the 'self' (Busfield 2011). This has two major implications. First, a stance that is psychologically and behaviourally focused will inevitably reinforce a level of individualised blame and reiterate stereotypical assumptions about the behaviour of people living in deprived circumstances, leading to the re-inscription of deficits-based thinking that sees distressed people who are living in poverty as somehow deficient and in need of 'correction' through medical or therapeutic intervention. Second, by pathologising individuals as having distinct and categorisable 'defects' within their brain or psychological functioning, mental health is viewed and treated in a disempowering apolitical vacuum, where the root causes of deprivation and social injustice that are known to sustain poverty and underpin the erosion of wellbeing become obscured (Shaw and Taplin 2007, Friedli and Stearn 2015).

The potential for this is especially pertinent in the current economic climate, where notions of self and self-responsibility have been progressively amplified through neo-liberally oriented government policies to encourage the uptake of employment and to restrict access to welfare entitlements. For over three decades, successive British governments have been claiming that the social security system has 'lost its way', and that large-scale reform is needed to abolish what George Osborne as Chancellor described as an entrenched 'something for nothing culture' (Blackburn 2013) in which people in receipt of benefits 'shamelessly' expect to be provided for whilst expecting others to go out to work. Similar narratives of responsibility have been evident in popular media, with tabloid headlines and programmes such as Channel 4's Benefits Street fuelling an already hostile environment. In a context in which success is largely measured through economic achievement, the narratives pushed by those in positions of influence perpetuate the conception of poverty as a failure of self-responsibility.

Recent decades have shown that this kind of rhetoric has popular appeal, and, by

rendering 'welfare' as a term of abuse, has facilitated a range of reforms that have led to wide-scale reductions in entitlements across the UK. Amongst other things, this includes a cap on the benefits available to an individual or household, the introduction of a controversial 'simplified' payment system through the roll-out of Universal Credit, the imposition of the 'bedroom tax', whereby people living in social housing that is deemed to surpass their basic needs now have to pay for any 'spare' bedrooms within the property, and the widespread use of punitive welfare sanctioning.

Austerity is not only impacting on people within the welfare system, but also on people in low paid employment, with almost 60% of those in poverty in the UK living in families where someone works (Alston 2018).

## Study aims

The main aim of the DeStress research study was to examine the impacts of austerity and welfare reform on mental health and wellbeing in low-income communities.

The project objectives were:

1. to understand how austerity and welfare reforms are affecting mental health and wellbeing in low-income communities
2. to understand the role of narratives of responsibility in the medicalisation of poverty-related distress
3. to understand how antidepressants and talking therapies are being used within low-income communities, and how this impacts on people's health and wellbeing
4. to understand the challenges GPs face in supporting patients experiencing poverty-related distress in times of austerity and associated resource cuts

5. to understand what good practice in supporting patients experiencing poverty-related distress might look like and to develop resources to help deliver this practice

The project was run as a joint collaboration between the University of Exeter, University of Plymouth and City, University of London, and took an interdisciplinary approach drawing on perspectives and approaches from social sciences, psychology, biomedical sciences and public health. It was supported by a project Advisory Board comprised of residents, health professionals, civil society groups, policy sector representatives and academics.

## Methodology

The project was undertaken in two urban study sites within south-west England. Both study sites represented the least affluent quintile as determined by the Indices of Multiple Deprivation. Both sites were characterised by a high proportion of families in receipt of benefits and facing an array of challenges that exacerbated poor health, providing appropriate settings in which the research objectives could be fully addressed and potentially translated to a wider level.

A mixed methods approach was undertaken to address the research objectives and included:

- Sixteen focus groups with 97 residents in the study sites to gain understanding of the ways that narratives of responsibility manifest and impact on health and wellbeing;
- Eighty (80) in-depth interviews with 57 study site residents to understand their experiences of, and responses to, poverty-related distress;
- Interviews with 10 GPs in and around the study sites, to understand the challenges they face providing effective mental health support within low-income communities;

- Conversation analysis<sup>1</sup> of 52 video-recorded GP-patient consultations for mental health to understand how mental distress and poverty are discussed and responded to, and to identify examples of positive consultation practice.

The project was underpinned by an engaged research approach. This involved researchers and people outside the university meaningfully working together throughout the research process in order to understand the nature of the issues being researched, co-creating focus group and interview questions, analysing the data, and delivering and disseminating the research in partnership in a way that aimed to ensure outcomes which could be beneficial for all partners.

## Findings

### Stigma and moral judgement

- Residents in the study sites felt that the challenges of poverty and deprivation had 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 were widely associated with increases in mental distress.
- Three interlinked types of narrative were identified as influencing the way that people in low-income communities experience mental distress and the ways that patients and GPs respond to this:
  - A 'neoliberal narrative', where people with distress are seen by others as having social or behavioural problems that they need to attend to in order to be seen as responsible citizens. This type of narrative can lead to people feeling guilty and helpless.

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<sup>1</sup> Conversation analysis (CA) involves the study of social interaction, looking at both verbal and non-verbal interactions between people, in this case, between people with mental health concerns and GPs, to examine how they communicate about mental health problems and treatments e.g. how a person discloses mental distress; how GPs ask if someone has thoughts about harming themselves; how GPs recommend treatments and how patients respond to this. Microanalysis of interactions identifies what people do, rather than what they say they do, to reveal patterns in the data that are unlikely to be identified through other research methods. This enables better understanding of good communication in practice. We analysed consultations from the One in a Million dataset held at Bristol University (see Barnes et al. 2017).



- A 'shame narrative', in which people who are not considered to be contributing to society are seen as engaging in reckless and irresponsible behaviour. This also leads to a fear of being judged and can result in the avoidance of help seeking.
- A 'medicalisation narrative', in which mental distress is seen as a medical issue requiring medical intervention.

These narratives – alone and in combination – have an array of negative impacts on the ways that people understand and respond to poverty-related mental distress, impacting on people's behaviour and self-identity and reducing people's trust and willingness to seek support.

### **Systemic stressors**

- People in low-income communities commonly feel that others frame them through a deficits-approach in which material deprivation is equated with deficiency and recklessness. During interactions with service providers who they had hoped could assist them, people felt they were continually blamed for their life circumstances, with negative comments frequently made on issues such as their diet and their parenting skills, as well as on circumstances beyond their direct control e.g. the condition of their housing. Being frequently told that they were 'lucky' to have anything had negative impacts on people's self-esteem and mental wellbeing.
- Narratives of responsibility pervaded many aspects of everyday life. The extent of this varied 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 were reported to come from staff in job centres, health and social workers, schools, and, albeit to a lesser extent, from GPs. A further and important source of judgement was felt to come from within the community itself. Most residents felt that this judgement and shame had intensified in recent years and that this was linked to a hardening attitude against people in receipt of welfare support.

- People reported that they consciously moderated the ways that they presented themselves to others in order to avoid being negatively judged. This included the ways that they spoke, behaved and sometimes even how they dressed, according to what was and was not considered to be socially acceptable for people on low incomes, and in particular for those receiving welfare. People also explained how they restricted their engagement in activities that gave them pleasure and reduced their mental distress e.g. going to the cinema or taking a short holiday, when expenditure on these activities was likely to draw criticism from others.

*'I want to go away but even if I find any money to go away, even for a weekend, if I just stay in a hotel by the sea somewhere cheap, not even in season, I'm going to be judged aren't I, because I've spent that money that way. Even if I can claw that money together, they won't see it as a fact that I am trying to get myself mentally well'*

- Many people, particularly parents of young children, reported that they actively avoided seeking support when they felt that they would be judged because of their background and circumstances for fear of being seen through a 'framework of risk' and having their children removed. For example, one woman who had sought help for post-natal depression stated:

*'I was made to feel, because I had some sort of depression, that I was obviously a danger to myself and to my child...I just stopped going'* (female participant)

- Engaging with the welfare system was felt to be dehumanising and constituted a key source of stress. The need to attend regular appointments which do not take into account unreliable and costly public transport, caring responsibilities or medical appointments, to provide sufficient evidence of job seeking (requiring access to computer and Internet) for limited and usually precarious work opportunities, to keep in line with the array of changes to benefits and associated rules that have been enforced in recent years, to deal with and challenge what many described as frequent under- or delayed payments or benefits sanctions, to be shown to be 'bettering' yourself through voluntary work placements and to display the necessary 'work ready' psychology to convince benefits advisors of

your credibility were just some of the challenges that people felt added to the stresses of their lives.

- The imposition of Universal Credit meant people were forced to wait long periods without payment with extremely adverse consequences. People reported having to make stark choices over expenditure e.g. between food and heating, between toothpaste and toilet roll. Experiences of benefits sanctioning were common, and were usually reported to be for minor errors or for failure to attend meetings that claimants were not aware of. The ‘digital by default’ system in which claimants are expected to access welfare services online was found to be major source of stress.
- The Work Capability Assessment (WCA) process and its focus on ‘work at any cost’ (usually in low paid work on insecure or zero hours contracts) was considered to be especially stressful for those being assessed. Undertaken by people that did not know the person or their circumstances; set up to examine physical rather than mental health; and often over-ruling the medical evidence of GPs, these assessments were felt to be particularly traumatic for participants. In cases, the extreme stress of the WCA process left people feeling unable to pursue benefits claims. Others reported self-harming and feeling suicidal because of the stress they experienced.
- People reported that a ‘guilty until proven innocent’ approach dominated welfare provision. Claimants reported being frequently disbelieved, having their explanations thrown out and their lived experiences dismissed. Several GPs interviewed also commented on the increasingly punitive and dismissive way in which patients from low-income backgrounds were treated. One GP commented

*‘I’ve never done this before this year, but now I find myself having to wade in to prevent patients being interviewed and having their benefits stopped. And I’m having to do that because the people [WCA assessors] don’t believe them now. If I write a letter saying this person is unwell, that should be enough. I shouldn’t have to write a letter saying ‘Please don’t threaten this very vulnerable person with this action because all you do is make their illness worse and prolong it’. And that’s almost a standard letter I could write – I could send that out every week’*  
(GP)

- The impacts of austerity and resource cuts had resulted in widespread deterioration of public services within both study sites. The closure of key social infrastructures e.g. libraries, Citizen's Advice Bureaus and support groups that had previously offered the possibility for connection and community, as well as welfare reforms that have displaced people from the communities in which they once lived, left people with few places to go to receive social or emotional connection and support. Feelings of social isolation were commonplace. This situation places increased pressure on the services that remain, and in particular, on GP surgeries.
- GPs reported that increasing proportions of their patient caseload are experiencing what are primarily social/structural rather than medical issues per se. GPs estimated that this reflected the situation of between 10% - 50% of their patients.

*'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' (GP)*

- GPs clearly articulated the association they saw between benefits assessment / re-assessment and an exacerbation of mental distress, and expressed frustration at being asked to act as gatekeepers for welfare claims.

*'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' (GP)*

- There was considerable frustration over the lack of support available to address the constellation of issues that people were facing that were associated with mental distress e.g. alcohol and substance abuse. Support available tended to address single behaviours with further support only being available once these single issues had been resolved.
- Analysis of GP and patient interviews and the video-recorded consultation data found that there was no unified response to poverty-related distress. Often, GPs would completely medicalise mental distress, or conversely, would discount

distress as a purely social problem, even if they then prescribed medications as a response.

### Medicalising distress

- Most people sought medical help because they had got to the point where they were struggling to cope, did not know where else to go to get help, and had been encouraged to see a GP by their family and friends. The very nature of clinical settings means that the likelihood of poverty-related distress being medicalised is increased.
- People felt pressure to legitimise their distress to family, friends, and service providers, and saw a mental health diagnosis as a necessity to remain within the welfare system. People explained that feeling continually blamed and judged for their circumstances of deprivation influenced the way that they made sense of their mental distress as a pathological problem, rather than as an issue stemming from broader structural inequalities. In such situations, people felt they were actively encouraged to seek medical help by family and friends, or had themselves invested in narratives around the ‘normalcy’ and ‘need’ to see and act upon themselves as ill and in need of treatment.
- For some people, being diagnosed with a mental health condition was deemed helpful in enabling them to make sense of and more effectively deal with their lives. However, people also felt that they needed to be seen to be ‘taking control’ of their lives through seeking medical support or by sorting out their problems without recourse to public services. There was widespread feeling that those who did not do this would be considered defective and undeserving.

*‘I felt like if I turned around and said ‘well I don’t want the tablets, then they would probably turn round and go ‘well you’re not that depressed then are you if you don’t need the help [...] I took them or three months just to keep – to pacify people really’ (female participant)*

## Dissatisfaction with the medical model

- Despite the medicalisation of distress, there was widespread dissatisfaction amongst GPs and patients with the current medical model for mental health. Analysis of consultations found that GPs did not strongly endorse antidepressants or talking therapies. Lack of endorsement can impact negatively on patients when they leave a consultation unconvinced that the treatment they have been given is going to work, and can increase the potential for stress and burnout amongst GPs when they repeatedly see patients that they do not feel able to help.
- GPs faced a range of conflicting pressures in their role as gatekeepers to the welfare system. Clinical guidelines and a desire to help people access welfare placed pressure on them to diagnose the patient and to try to prescribe treatment.

*'I will say this [depression and anxiety] is what I'm going to put on the form, but I know in my heart of hearts that it's not a medical problem' (GP)*

- Analysis of consultations showed that GPs were less likely to offer sick notes (now officially called 'fit notes') for mental than physical health issues, and that patients experiencing mental distress needed to 'work harder' in the consultation to be granted these.
- GPs seeking to support patients experiencing poverty-related distress felt they had very limited options available to them. Despite the lack of endorsement for these treatments, in the vast majority of cases, the complexities of patients' circumstances were reduced to a choice between antidepressant medications, talking therapies or a combination of the two.

## Antidepressant medications

- Use of antidepressant medications in the study sites was high. Of those interviewed, 81% had been prescribed antidepressant medications at some point

in their lives. A further 7% had been offered antidepressants but had refused them.

- Experience with long-term antidepressant use was commonly reported. For a minority of patients, this involved continuous medication use over a period of several years. More commonly, people had experienced long episodes of antidepressant use over the course of a decade or longer. There was a general feeling amongst patients from both groups of having been ‘forgotten’ or ‘written off.’ Concerns were frequently raised by participants over what they felt was a lack of opportunity for medication review within GP consultations. The following comments from patients were typical,

*‘I think especially in the towers there are a lot of people that feel very, very isolated, and very much like society’s forgotten them [...] once they’re on antidepressants that’s it for life’*

*‘A lot of GP surgeries have gone from here now. Whatever surgeries are in existence now, because their workload has increased, I think it’s the easiest, quickest thing to give people medication and get them out the door’*

- Despite the high level of antidepressant use within the study sites, a significant proportion of study participants reported surprise at being prescribed these medications. The feeling of being ‘fobbed off’ with medicines was very commonly reported, with people feeling that most GPs did not have the time or resources to listen and respond appropriately to their needs.
- GPs interviewed for the study recognised that medications are often a ‘sticking plaster’ approach (sometimes in response to patient’s requests for immediate action and sometimes for GPs to feel like they are doing something), but explained that they had 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’ (GP)*

- There was broad agreement amongst 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 talking therapy, even when it was recognised that they would not solve the problems causing the distress,

*'I think the perception is that – certainly amongst GPs – that something like fluoxetine is a very safe, fairly clean drug, and won't do very much harm. So it feels like a kind thing to do if you've got somebody in a situation that can't be changed – to prescribe them with medication that makes them feel slightly better about their situation. There isn't good evidence to support it, but we still do it'*  
(GP)

- Patients expressed doubts about the effectiveness of antidepressant medications, and were worried about medication dependency, side effects, and attending talking therapy. Yet despite three-quarters of patients initially resisting treatment, 76% of those in video-recorded consultations were given a prescription for antidepressants or encouraged to refer themselves to therapy.

### **Talking therapies**

- Most interview participants had been offered talking therapy through their local Improving Access to Psychological Therapies (IAPT) provider. However, a range of logistic and socio-cultural barriers to the use of talking therapies in low-income communities were identified. Waiting times for substantive therapy, a reluctance to talk to a stranger, or in a group, and the logistical difficulties of attending appointments deterred many from attending. Attending appointments was a particular issue for people in insecure employment/zero hours contracts, and people who needed childcare, where the cost and logistical implications made this difficult.
- There was a commonly held expectation amongst GPs that patient self-referral for therapy was an important first step on the road to recovery. Self-referral was also thought to lead to fewer DNA (non-attendance) instances. GPs confirmed that they would be willing to make a referral on behalf of a patient if they felt there was good reason to do so. However, this was uncommon, and GPs preferred to avoid doing this, particularly if they were not convinced the person would attend.



*'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' (GP)*

- Patients overwhelmingly felt that self-referral was a key deterrent to attending talking therapy. Patients explained that when they were feeling distressed, they did not feel confident or well enough to self-refer. Given the challenges many patients felt even raising mental health issues within a GP consultation, there was a widespread feeling of rejection when a GP responded by handing over a leaflet for IAPT. For some patients, the giving of the IAPT leaflet constituted a 'symbolic dismissal' that undermined and de-legitimised 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.

*'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'*

- Experiences of attending IAPT services varied across participants. However, only three people involved in the study felt that talking therapy has actually been beneficial to their health and wellbeing, and even then, only parts of the experience were seen as effective.
- A range of problems and frustrations associated with IAPT provision are reported by both residents and GPs, namely: perceived waiting times for IAPT, 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; previous experiences of IAPT being unhelpful; difficulties 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 the limited (usually six) sessions allocated; patient perception that therapists over-emphasise and make assumptions about childhood trauma rather than focusing on the present-day situation; 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.

- GPs expressed frustration at the 'fractured' nature of mental health provision and the difficulties they faced referring patients to appropriate secondary mental health care. Patients were commonly refused access to IAPT services if their needs were considered too high, and were then referred back to their GP rather than on to specialist care. This was 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 had attended private counselling or other forms of therapy that they had accessed via their workplace, or via their own funds. All reported 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 had experienced social prescribing via their GP. GPs felt that it would be helpful to have up-to-date information on activities, support and advice services that are available within the locality so that they can refer patients on.
- There was strong evidence from the study that involvement in informal community groups and activities was beneficial, with participants frequently claiming peer group support to be effective in enhancing their mental 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.

### Key points

- Whilst official data on mental health treatment look fairly positive, in reality people from low-income backgrounds face difficulties accessing support, and when they do, the support is often not appropriate to their needs.
- Effective support is undermined by a system of rules, or 'messages', which seem to contradict each other. People are made to feel they are a 'problem' (particularly those claiming benefits) and do not deserve support, or that they are a risk. This drives them away from seeking care. At the same time however, the need to prove 'entitlement' within the benefits system pushes people to seek diagnosis and treatment that is often inappropriate and/or disempowering.
- GPs currently have few options available to them to support people experiencing poverty-related distress that do not over-medicalise. 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. Talking therapies are generally felt to be hard to access and to be of little benefit when the source of distress remains.
- There is a need to reconceptualise the way that health professionals respond to poverty-related distress. This requires a response that recognises the bio-psycho-social and reduces pressures on GPs to make rapid decisions around diagnosis and prescribing.
- Support for poverty-related mental distress should not fall to GPs alone. There is a need for responsibility to be shared across sectors and to recognise that empowered communities are often well placed to overcome adversity through non-medical routes.

## Conclusions

Recent years have seen a commitment amongst policy makers in England to increasing parity of esteem between mental and physical healthcare and to make mental health treatment more available to all in need. Yet the findings of the DeStress project show that there has been inadequate critique of the diagnostic assumptions that underpin the evidence upon which such data and such strategies are based, as well as a lack of consideration of the broader economic and political circumstances in which treatment for mental distress are being administered. This becomes deeply problematic when the distress caused by the challenges of poverty and deprivation is increasingly interpreted as clinical depression requiring medical intervention. Indeed, very real questions around justice are brought to the fore when moralising and stigmatising strategies designed to reform the system of welfare support overlap with and impact on those aimed at supporting mental health and wellbeing.

Far from supporting those most in need, the DeStress project found that the increasingly punitive nature of current welfare reform exacerbates underlying vulnerabilities to mental distress for many people through the wide-scale reduction of benefit entitlement, the questioning and de-legitimisation of people's medical or disability status and the dehumanising experience and repercussions of dealing with 'the system' itself. At the same time, current treatment options have been shown to have a range of impacts on mental health and wellbeing. The use of antidepressant medications can numb the realities of poverty and can help enable people to cope with daily life in austerity Britain – yet for many participants in the DeStress study, their uptake has led to the long-term use of what are often stigmatised, potentially ineffective and even harmful medications, with what patients feel has been little opportunity for review to help them reduce or come off medications. For others, the offer of 'therapy' to 'improve' or 'recover' an individual's pathology and their ability to cope can prove unhelpful and upsetting when it fails to address the broader social circumstances which fuel the person's underlying distress.

We certainly do not wish to point a finger of blame at GPs, who in the UK are increasingly working in severely resource constrained environments with few options to provide other forms of support to those experiencing poverty-related mental

distress. Indeed, most GPs involved in the DeStress project expressed anger and frustration at the way that they had become caught up in current and previous Government drives to cut costs through reducing welfare entitlements. Rather we recognise that whilst the delivery of wide-scale mental health treatment must be applauded in circumstances where it genuinely and effectively responds to need, its current entanglement with wider political agendas has resulted in the pathologisation and medicalisation of what are inherently social and structural issues, which can in turn increase stigma, blame and injustice against those in low-income communities.

At the heart of these issues are questions about where responsibility for health and wellbeing should lie. Governments can facilitate responsibility in citizens when they provide the material and structural resources required for this to become feasible. Yet, within the current neo-liberally oriented era, government and popular rhetoric around individual responsibility feed directly into strategies aimed at reducing welfare support, blaming and shaming individuals and communities, and deflecting attention from the responsibilities of those with the power and remit to effect positive change. Such a situation is clearly inequitable and in fact damaging to people's mental health and wellbeing.

Whilst solutions to this situation ultimately require a fundamental shift in the culture and language of policy and practice, more immediate - and ultimately cost-effective, strategies do exist that may help alleviate, and more effectively respond to, distress within low-income communities. As part of DeStress, we have been working with Health Education England, health practitioners and community partners to develop training materials for GPs on how to use the limited time available within consultations to more effectively engage with people experiencing poverty-related distress. A key aspect of this work involves enabling GPs to feel better able to play a supportive and empathic role that encourages patients to reflect on their situation and identify positive ways forward, rather than feeling that they necessarily need to 'fix' patients through diagnosis and rapid prescriptions for treatment. The training materials that have been developed will be made available on the project website (<http://destressproject.org.uk>) and are currently under review for accreditation by the Royal College of GPs.

There is also strong evidence from DeStress that a great deal of distress within low-income communities is caused or exacerbated by social isolation and stigma. Where local community groups (often informal in nature) exist, they have been shown to act as powerful support mechanisms that give people reassurance and a sense of purpose and belonging. Successive UK governments have reduced funding for these activities – yet reinstating and bolstering funding for these kinds of groups would undoubtedly contribute to better wellbeing and more just outcomes.

Further resources on the project including more detailed publications on our findings can be found on our website at <http://destressproject.org.uk>, or by contacting the project lead, Felicity Thomas [f.thomas@exeter.ac.uk](mailto:f.thomas@exeter.ac.uk)

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