General Practitioners' Views on Shared Decision-Making in the Treatment of Depression

Ioana Tofan

A thesis submitted for the degree of Doctorate in Clinical Psychology (D Clin Psych)

School of Health and Social Care

University of Essex

April 2026

Acknowledgements

Firstly, I would like to thank all the General Practitioners who provided their time and expertise. Your contributions are invaluable to this research.

I would like to express my gratitude to my thesis supervisor, Prof Susan McPherson, for her guidance, feedback, expertise, encouragement and efficient approach. It has been a privilege to complete this work under her supervision.

I am grateful for my friends, especially Rosie, for her encouragement and uplift. And my university friends, Elzi and Megan, with whom I shared laughter, achievements and milestones.

I am truly grateful to my family, especially my brother and grandparents for their continued love and support. To parents who have invested so much in me and supported me.

To my husband, my biggest supporter, thank you for your patience and for being by my side throughout this journey.

Finally, to my daughter, my greatest motivation. This is for you.

Abstract

Background: Depression is a highly prevalent mental health condition with a marked increase in prevalence in recent years. A new guideline for the treatment of depression was released in 2022 by the National Institute for Health and Care Excellence (NICE), introducing the idea of shared decision-making and patient choice. With primary care and more specifically General Practitioners remaining the most common first point of contact for patients suffering from depression, it is crucial to understand how this new guideline is implemented in primary care services.

Aim: The aim of this mixed-methods study is to understand how the 2022 NICE depression guideline is understood and enacted in GP practice, particularly in relation to shared decision-making in the treatment of depression and facilitators and barriers to a fuller implementation.

Method: The study employed an explanatory mixed-methods design. The quantitative part of the study used an online survey aiming to explore the GPs' awareness of the guideline, prior training, confidence in applying the guideline, and self-reported shared decision-making practice, experience and perceived importance. Data were analysed using descriptive and non-parametric statistics. The qualitative part of the study used a semi-structured interview focused on the perceived barriers in practice in implementing shared decision-making and patient choice. Interview data were analysed using reflexive thematic analysis.

Results: Survey findings indicated overall high guideline awareness and confidence in applying it in practice, and uptake of shared decision-making training, particularly in core medical training. Completion of shared decision-making specific CPD was associated with higher self-reported shared decision-making scores, whereas training received during medical training alone did not have an association with the scores. The reflexive thematic analysis

revealed four themes relating to time constraints, complexity of treating depression and cultural and clinical adaptations needed in practice.

Conclusion: The findings of this study support the importance of shared decision-making and patient choice in clinical practice. Barriers preventing a fuller implementation can be addressed through system-wide changes and continuing professional development.

Contents

1. Introduction 8

1.1. Chapter overview 8

1.2. Depression 8

1.3. Shared decision-making and patient choice 14

1.4. Current guidelines 17

1.5. GP context 19

2. Systematic literature review 23

2.1. Introduction 23

2.2. Method 23

2.3. Results 35

2.4. Line of argument synthesis 40

2.5. Discussions 42

2.6. Conclusions 45

2.7. Research aims 45

3. Methods 47

3.1. Chapter overview 47

3.2. Epistemological positioning and justification of methodology 47

3.3. Design 49

3.4. Sampling 51

3.5. Recruitment 52

3.6. Procedures and data collection 52

3.7. Measures....54

3.8. Analysis....58

3.9. Positionality statement....61

3.10. Limitations of methodology....62

3.11. Ethical issues....63

3.12. Dissemination....65

4. Results....66

4.1. Chapter overview....66

4.2. GP survey findings....66

4.3. Interview study findings....73

5. Discussion....112

5.1. Chapter overview....112

5.2. Research aims....112

5.3. Guideline awareness, implementation and previous training....112

5.4. Influence of previous training on shared decision-making practice....114

5.5. Barriers in guideline implementation in practice....116

5.6. Study Limitations....127

5.7. Study Strengths....130

5.8. Policy and clinical implications....131

5.9. Reflections....133

5.10. Conclusion....136

References **138**

Appendices **170**

Appendix A – PROSPERO record confirmation 170

Appendix B – HRA decision 171

Appendix C – Ethics Application – ERAMS 175

Appendix D – Recruitment poster 176

Appendix E – Qualtrics survey 177

Appendix F – Participant information form for interview 191

Appendix G – Consent form for interview 194

Appendix H – Interview schedule 195

Appendix I – Coded transcript example 196

Appendix J - Example of NVivo coding 198

1. Introduction

1.1. Chapter overview

This introductory chapter will frame the theoretical context of this study. Firstly, it will aim to build an understanding of depression, including historical perspectives and current diagnostic frameworks. It will then present the evolution of shared decision-making as a concept in care, transitioning from a paternalistic approach to the current approach that seeks an active involvement from patients in their care. The current guidelines implemented in the UK and developed specifically in relation to the treatment of depression will also be presented. Finally, the local healthcare system in which General Practitioners (GPs) observe and implement these guidelines will be detailed. Systemic barriers and complexities encountered in practice will be highlighted in order to anchor these concepts in the primary care setting.

1.2. Depression

Depression is believed to impact upwards of 332 million people worldwide (World Health Organisation [WHO], 2025a). A significant increase in the global prevalence was noticed since the COVID-19 pandemic, with figures rising from 264 million cases pre-pandemic (WHO, 2025b). In the United Kingdom, a marked impact was also noted, with a similar trend in the increase of cases during the same time period (ONS, 2022; Bu et al., 2023). With the understanding that these estimates are based on self-reported measures, these figures are presented to shape the context for the increase in prevalence of in recent years and widespread of depressive symptoms. While self-reported measures can offer a standardised assessment and reporting, they are limited by the complexity of depression, possible co-occurring difficulties and reliance on individuals' reporting of symptoms (Shorter, 2013). Therefore, these estimates might obscure the distinction between depressive symptoms and clinical diagnosis of depression, and the wider context in which those symptoms had

occurred. This is a particularly relevant consideration when observing the increase in depressive symptoms following the COVID-19 pandemic and in the socio-economic context of the global cost-of-living crisis (ONS, 2022).

While moderate to severe symptoms of depression were identified in one in six people in the UK, the prevalence is even higher in areas of greater deprivation where access to help is unequal (ONS, 2022; Lee, 2007; Morris et al., 2025). Studies identified that individuals from lower income backgrounds are less likely to access and receive treatment compared to individuals from higher income areas (Lee, 2007; Evans-Lacko et al., 2018; Morris et al., 2025). This provides a context for the distribution of depression, paired with the reality of social determinants and health inequalities experienced by individuals suffering from depression.

Beyond prevalence, depression is a substantial contributor to the global burden of disease. Being in the top 3 leading causes of healthy life expectancy loss, it is estimated that depression accounts for a 0.6-year loss in the global healthy life expectancy, and is among the top 5 leading causes for years lived with disability worldwide (WHO, 2025b; GBD 2016 Disease and Injury Incidence and Prevalence Collaborators [GBD 2016 Collaborators], 2017). In most severe cases, depression can also lead to suicide, comprising the second leading cause of death in 15–29-year-olds globally (WHO, 2025b).

In addition to the individual-level impact, depression is also understood to affect families and, more widely, social networks. Research indicates that family members of individuals with chronic depression can be impacted emotionally, physically, through increased morbidity and financially (Sobieraj et al., 1998; Cole et al., 2024). Implications extend to the dependants, with costly consequences on attachment formation and poorer educational outcomes (Brophy et al., 2021; Tumasian et al., 2023). Wider implications on a societal level

are incurred in the workforce through absence, impact on productivity, loss of wages and higher healthcare access needed (Pincus & Pettit, 2001; Greenberg et al., 2024). Taken together these findings frame the individual and societal implications that are associated with depression, rendering the deeper understanding, identification and treatment crucial at the earliest stages of accessing healthcare.

The current definition and understanding of depression is shaped by diagnostic manuals and classification systems such as the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and *International Statistical Classification of Diseases and Related Health Problems* (11th ed.), but at its roots it was encompassed by terms such as neurasthenia, neurosis and melancholia with symptoms being understood under the umbrella of wider psychiatric presentations (Hirshbein, 2009; Shorter, 2013; World Health Organization, 2019; American Psychiatric Association, 2022).

In the US, depression started to be contextualised as a diagnosis around the nineteenth century, mainly focused on the gendered assumptions rooted in biological dissimilarities between men and women (Hirshbein, 2009). Neurasthenia was largely used to describe exhaustion, while melancholia indicated more severe symptoms often requiring specialised treatment and care (Shorter, 2013). Melancholia, as summarised by Hirshbein (2009), differed from the present-day diagnosis of major depressive disorder by encompassing somatic symptoms and an element of thought disturbance with delusional thinking present. This initially emerged in the context of women's dissatisfaction with domestic responsibilities. However, it is still recognised as a significant step in understanding mental health and wellbeing (Misbach & Stam, 2006).

Shorter (2013) argued that the overarching label of "nerves" and "nervous illness" served a greater purpose in acknowledging the co-existence of a variety of symptoms that are

not limited to just the current understanding of major depressive disorder, such as anxiety, tiredness, somatic symptoms and delusional thinking.

The development of depression as a diagnosis was closely related to the emergence of psychometric tools, which faced the criticism of misdiagnosing sadness and reactions to life events (Horwitz & Wakefield, 2007; Johnston et al., 2007; Durà-Vilà et al., 2013).

In the 1980s, it was suggested that depression was being underdiagnosed by General Practitioners (GPs) in primary care services, with physical health concerns being prioritised and treated over any potential depressive symptoms (Zung et al., 1983). This led to the belief that depression was being missed in primary care, underdiagnosed and undertreated, and overshadowed by physical symptoms (Pincus & Pettit, 2001). This was followed by and further emphasised by extensive research validating depression screening scales for use in clinical practice, particularly in primary care (Löwe et al., 2005; Gilbody et al., 2007; Zainab & Pereira, 2007; Zuithoff et al., 2009). Findings of a UK-based study on previous depression guidelines in response to an increase in antidepressant prescription but not in compliance with the guideline revealed issues with the measurement of depression and recommended better ways to assess depression (Kendrick et al., 2005).

A commonly used and heavily researched measure is the Patient Health Questionnaire (PHQ-9), initially developed as a 9-item questionnaire, later adapted as a 2-item questionnaire, although less common in practice (Löwe et al., 2004; Löwe et al., 2005; Carroll et al., 2020; Gilbody et al., 2007; Zuithoff et al., 2009). Critique of these psychometric scales gravitates around themes of overdiagnosis, overtreatment and inaccuracy in detecting suicidality (Levis et al., 2020; Durà-Vilà et al., 2013; Berta et al., 2022).

The widespread use of screening tools was also met with criticism in relation to over-categorisation of symptoms, where over-reliance on patient classification systems paired with

scarcity can impede treatment choice and subsequent outcomes, opening a conversation around a more transdiagnostic approach in addressing the interconnectedness of mental health symptoms. (Cramer et al., 2010; Blanco et al., 2019; Fusar-Poli et al., 2019; Berta et al., 2022). The consequences of over-reliance on patient classification systems were found to have a negative impact on patient outcomes, especially when paired with a scarcity of treatment choice (Vinas et al., 2025).

However, the misattributions of mental health symptoms on physical complaints continue to be a problem, with a study finding that almost of 50% of patients presenting in primary care would only report their physical health concerns to their GP due to ongoing stigma in this respect (Pincus & Pettit, 2001; Heinz et al., 2021).

The biomedical framing of depression is supported and directly linked to responsiveness to antidepressants, and in their absence, depression is “demedicalised”, stepping away from this strict framing (McPherson & Armstrong, 2009).

The transition to a more diagnostic approach and coding depression has been argued to be linked to the expansion of the drug industry and profits that might influence decisions more than patient need, and secondary to the development of measurement technologies (Healy, 2004; Hirshbein, 2009; Shorter, 2013; McPherson & Armstrong, 2021).

A broad array of evidence emerged on suicidality and increased risk of suicide while taking antidepressant medication (Healy, 2000; Reeves & Ladner, 2010). In addition to risk, concerns with disinhibition and akathisia as a moderator in healthy controls arose, highlighting the crossover between symptoms and side effects.

The main references used in classifying depression at present are the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD-11), defining it as persistent low mood accompanied by anhedonia, sleep

changes, loss of concentration, and reduced energy levels and appetite (American Psychiatric Association, 2022; World Health Organisation, 2019). The diagnostic criteria for depression used in the UK are outlined by the ICD-11 (WHO, 2019). In order for a diagnosis to be made, a patient needs to meet 5 out of a total of 10 criteria within a timeframe of at least 2 weeks. The threshold of criteria to be met was increased from ICD-10 in order to align with the DSM-5 manual and to improve the accuracy of diagnosis, but this was met with a critique in regards to the actual reliability of the diagnosis and implications for the patient (Kalk & Young, 2017; Seemüller, 2023). In addition, McPherson & Armstrong (2006) argued that the development of depression labels can be linked to social and medical determinants rather than being grounded in new evidence.

With the acknowledged benefits of adopting a standardised diagnostic system, these models have also been met with criticism, especially when taking into consideration the strict categorical definition of depression, complexity of assessing comorbidities, and lack of continuity in treatment pathways (Watson & Clark, 1995; Widiger & Samuel, 2005; Cramer et al., 2010; Frances & Nardo, 2013; Kamens et al., 2017; Blanco et al., 2019). In diagnoses such as one for depression, the implications can mean that the personal experience is completely missed and can vary significantly in clinical presentations.

Similarly, the development of diagnostic manuals has directly influenced the focus of research with critiques on overestimation of prevalence with low diagnostic cut-off points, highlighting the need to keep in mind the specific symptoms rather than diagnostic labels (López-Muñoz et al., 2008). Cuthbert (2014) argued that a shift in research is needed from categorical definitions provided by diagnostic manuals such as the DSM-5 and ICD-11 to aim for a more dimensionally oriented design, transitioning from DSM/ICD categories to dimensionally oriented designs in research studies.

This indicates that while manualised classifications can be beneficial in proposing a standardised reference in the diagnosis of depression linked with the medical model, further considerations need to be made in relation to social, contextual and individual factors.

1.3. Shared decision-making and patient choice

The idea of patient choice and shared decision-making has its roots in the assessment of compliance with the prescribed treatment avenue, and it can be traced back in medicine under the umbrella of adherence and compliance to treatment options (Charles et al., 1997).

Earlier approaches were characterised by a prescriptive approach, placing the healthcare provider in a position of authority. With this, patients' views, individual characteristics and preferences were not actively sought, with little value placed on the patient's expertise and experience with their condition. The shift emerged from the observed non-concordance to prescribed treatment and a desire to improve compliance and adherence to treatment. However, the emphasis was still on patients following an imposed treatment plan (Lutfey & Wishner, 1999). While the initial aim was to achieve a measurable improvement in adherence and concordance to treatment, initial ideas around communication are founded in these concepts (Rae, 2021; Thummak et al., 2023). At the time, this represented a significant change to the existing paternalistic and unidirectional approach taken by healthcare providers.

High levels of non-adherence were linked to low patient involvement, emphasising once more the importance of clear terminology and the shift to a wider use of the term "concordance" was made, aiming to supersede "compliance" and "adherence" (Snowden & Marland, 2013). The argument was made that the previous terms were indicative of clinician decisions under a more paternalistic approach and measured against unilateral decisions made by professionals.

Building on this, elements of partnership and active involvement of patients in care were introduced with recommendations for healthcare professionals to allocate time to discussing and sharing elements of their decision-making in order to increase concordance (Snowden & Marland, 2013; Rae, 2021; Thummak et al., 2023). A concept analysis revealed that concordance is founded on three key attributes relating to the communication process, the therapeutic partnership between the patients and the healthcare providers, and a joint treatment agreement (Taiwong et al., 2024). Therefore, the doctor-patient concordance emerged as a more collaborative model where the patients' views and autonomy were respected in the decision-making process (Snowden & Marland, 2013; Taiwong et al., 2024).

The concept also evolved in line with national guidelines aiming to bring the patient to the centre of all decisions involving their care. In 2012, the Department of Health released "No decision about me, without me" as a new approach aiming to actively involve patients with a view to improving concordance to treatment (Department of Health, 2012). Key concepts outlined in this document emphasised patient choice and shared decision-making, with the understanding that the shift towards this and empowering patients will require a culture change.

The patient-centred approach is based on treating patients with dignity and respect and building on these values in order to deliver personalised care based on the patient's needs and preferences (Robinson et al., 2008). This conveys a shift in the focus from medication adherence alone towards supporting patients in making informed choices about their care (Robinson et al., 2008; Ng et al., 2018). With this understanding, patient-centred care is a close precursor of the structured model of shared decision-making. Particularly in the context of primary care, this structured approach benefits the integration of the multitude of treatment avenues highlighted by guidelines.

In the present day, shared decision-making was developed as a way to further make the shift to a more patient-centred approach, involving the patient's expertise and promoting an active engagement in their care (Stiggelbout et al., 2012; Hoffmann et al., 2014; Glas, 2022).

Shared decision-making was introduced as a structured approach with the set intention of seeking and pursuing the patient's views and choice. Some key steps involve identifying the decision that needs to be made in relation to the patient's care and treatment, sharing the treatment options with their pros and cons, seeking the patient's preference, views and individual characteristics that might shape their decision and finally reaching a joint decision (Légaré & Witteman, 2013; Stiggelbout et al., 2015).

The shift in this approach has proved difficult with earlier studies identifying low levels of shared decision-making in practice, however recent studies continue to explore its limitations while acknowledging the undisputed benefits in practice (Young et al., 2008; Hughes et al., 2018; Viñas et al., 2025). In the treatment of depression specifically, the benefits include improved long-term outcomes and patient satisfaction (Rossom et al., 2016; Camacho et al., 2018). Shared decision-making interventions have been recommended and trialled in order to promote patient views and choice (Raue et al., 2010; Barr & Elwyn, 2016).

Although at its roots shared decision-making emerged in a physical health context, it was soon adopted in mental health care with encouraging results both in terms of feasibility and effectiveness, with some acknowledged barriers (Patel et al., 2008). This further shifted from general mental health treatment implementation to more specific diagnoses such as anxiety and depressive disorders, schizophrenia and psychosis (Fiorillo et al., 2020; Huang et al., 2021; Marshall et al., 2021; Haugom et al., 2023).

The implementation continues to evolve with further efforts for a fuller implementation being made especially with patients from a minority backgrounds and underserved communities (Adams et al., 2014; Patel et al., 2014; Raue et al., 2019; Matthews et al., 2021).

In order to support shared decision-making implementation, shared decision-making aids were developed with the aim of improving patient involvement in care. While results support increased satisfaction with care with no change in consultation time, there is less evidence on improvement of clinical outcomes or symptoms (Loh et al., 2007; O'Connor et al., 2009; Dobler et al., 2019). This could be due to the standardised approach to the dynamic nature of shared decision-making but was also linked to the methodological approaches taken (Dobler et al., 2019).

More recently, with developments in technology and artificial intelligence (AI), new approaches have been explored to support the decisional aspect in the treatment of depression. Parameters such as biomarkers, behaviour monitoring with added patient-reported outcomes were trialled to facilitate monitoring of depression and to aid treatment decision (Stephenson et al., 2023; Zhuparris et al., 2023; Tatlı et al., 2025). While preliminary results indicate positive outcomes on symptom monitoring and use of mental health services, they do not serve as a replacement to the relational element of shared decision-making (Stephenson et al., 2023; Zhuparris et al., 2023).

1.4. Current guidelines

In the UK, the National Institute of Health and Care Excellence (NICE) provides evidence-based recommendations of care for healthcare providers. In 2022, a substantial change to the NICE guideline for depression was released (NICE, 2022). The key change proposed presented a "matched care model" in the care of depression, superseding the more

prescriptive “stepped care model”, introducing the idea of patient choice and shared decision-making. Implications for patient care involve matching patients with their preferred treatment choice, taking into account their clinical presentation and context and actively involving them in the decision-making process. The evidence-based treatment options include a range of psychological modalities, pharmacological approaches and lifestyle changes. Psychological therapies are recommended as a first line of treatment, and starting with guided self-help and group interventions, but including other options such as Cognitive Behavioural Therapy (CBT), Behavioural Activation (BA), counselling, Interpersonal Psychotherapy (IPT), counselling and short-term psychodynamic psychotherapy (STPP). A change in the recommendations for antidepressant prescription suggested use only in severe cases or on patient request if in their best clinical interest. The element of patient choice then involves a collaborative conversation on the treatment options and support in matching the patient with their preferred treatment choice.

A further update to the NICE depression guideline was released in 2026, introducing digitally enabled therapies as a treatment option, but with no change in the shared decision-making and patient choice aspect of care (NICE, 2026).

Since the 2022 depression guideline, a new patient decision aid was released in 2024, aiming to support patient choice and engage patient views in the treatment of depression (NHS England [NHSE], 2024). Patient decision aids have been developed over time to support and enable the decision-making aspect of consultations, helping patients in making informed decisions. The NHSE patient decision aid contains a definition of depression, an overview of options with key considerations for each option and self-rating tools to help patients identify their values and treatment goals. The main critique of this patient decision aid however highlights the lack of consideration of the relational aspect of shared decision-

making, health inequalities and system limitations, presenting an idealised scenario of care that might not be achievable in practice (McPherson et al., 2025).

Additionally, in 2021, a shared decision-making guideline was introduced, promoting implementation of collaborative work across all healthcare settings, with the exception of emergency and time-sensitive life-saving care decisions (NICE, 2021). The guideline outlines key concepts, use of decision aids, trainings, and practical recommendations to enable shared decision-making. The collaborative approach extends from presenting all the available treatment options to also taking into consideration the possibility of no treatment when appropriate.

The integration of patient-choice, and more specifically, in the depression guideline was however met with some criticism. A recent study looking at the newly introduced patient preference element in the treatment of depression highlighted the GPs' perceived undermining of professional expertise when prioritising patient choice (Davies & Read, 2026).

While multiple guidelines have been covered in this introductory chapter, in upcoming chapters, the use of the term 'guideline' refers to the 2022 NICE guideline for the treatment of depression introducing shared decision-making and patient choice (NICE, 2022).

1.5. GP context

Healthcare in the UK is described as an ecosystem comprising of primary, secondary, tertiary and community services (NHSE Digital, 2022). As a first point of contact, patients will present in primary healthcare services, which encompass general practice, alongside community pharmacy, dental and eye care services. General practitioners will assess, treat, signpost or refer and offer ongoing management. Referrals to more specialist services are seen in secondary services, which include mental health services, but also elective and

emergency care. Tertiary services are highly specialised and more limited geographically, with some examples being neurosurgery, transplants or forensic mental health services. Community services, on the other hand are more widely accessible, including district nursing and health visiting. Within this ecosystem, the importance of shared decision-making at the initial point of accessing services is crucial, starting with primary care.

In this context, the systemic psychological theory can provide a perspective on the complex interplay between the various levels of services (Dallos & Draper, 2015). This approach helps place primary care not as a point of entry into healthcare, but as a dynamic component as part of patients' care. According to Kaswa & von Pressentin (2025) a system-based approach can facilitate collaboration between services and feedback, while fostering connectiveness. Emerging evidence supports the use of system thinking in healthcare with long-term benefits on patients and system overall (Wright, 2024; Kaswa & von Pressentin, 2025).

Primary care services and specifically GPs remain the most commonly accessed initial point of contact with healthcare services in the UK. With a wide range of presentations and within short time frames, GPs provide assessment formulation, treatment and signposting to required services, balancing numerous guidelines and pathways RCGP (Royal College of General Practitioners, 2025). In the context of depression care, the care delivered by GPs can include but is not limited to antidepressant prescription, ongoing referral, including to secondary mental health services or NHS Talking Therapies, social prescribing and signposting.

For GPs, various complementary regulatory and professional bodies exist in the UK (RCGP, 2023). In order to practice as GP, after completing the core and specialty training doctors need to register with the General Medical Council's (GMC) GP Register. In addition

to the completion of the specialty training, GPs also require to be awarded a Certificate of Completion of Training (CCT). The British Medical Association (BMA) acts as the professional body for all medical doctors, including medical students. With focus on improving the work-life and experience of doctors, the BMA also represents and negotiates on behalf of medical doctors. The professional membership body for GPs specifically in the UK is the RCGP. With a broader role in the training, education and development of GPs, this membership body is set out to uphold high clinical standards and patient care (RCGP, 2023). Together, these regulatory and professional bodies provide the context in which shared decision-making takes place and is developed in practice, indicating the professional structure that GPs need to adhere to.

The context of GP practice has suffered significant pressures recently with increased numbers of appointments, pressures due to long waiting times and complexity of cases presenting in primary care (Armitage, 2024). This had a direct impact on GP wellbeing and job satisfaction. Recent reports indicate a decline in full-time equivalent (FTE) GPs which has been linked to burnout and mental health consequences due to work pressures (Owen et al., 2019; Khan, 2022; NHSE, 2025). While the BMA outlines a target of 25-35 patients to be seen per GP per day, research indicated that this differs in reality, and especially after the COVID-19 pandemic with direct implications on GP mental health and wellbeing (BMA, 2018; Owen et al., 2019; Trivedi et al., 2021).

While shared decision-making is a key component of medical training and medical practice across all presentations, competing demands such as administrative tasks can pose a barrier in clinical practice (Hoffmann et al., 2014; Hopwood et al., 2020; Sinnott et al., 2020; Khan, 2022; Sinnott et al., 2022; Glas, 2022; RCGP, 2025). Some studies suggest that more continuing professional development (CPD) is needed beyond medical training to help adapt shared decision-making practice in the reality of patient care (Hopwood et al., 2020).

Taken together, this indicates that GPs are practising under significant pressures, while maintaining high standards of care. In this context, the understanding of how the 2022 NICE guideline for depression was received and implemented is highly important. Barriers and facilitators in implementing shared decision-making and patient choice need to be understood. The next chapter will provide a systematic review of current literature in relation to shared decision-making enacted by GPs in primary care.

2. Systematic literature review

2.1. Introduction

This synthesis aims to explore the existing literature on shared decision-making being implemented in primary care services specifically by GPs when treating patients presenting with depression. Having established the benefits of shared decision-making, with some existing limitations, the hope is to identify how shared decision-making is applied in practice, especially in light of the change in the NICE depression guideline and the introduction of more shared decision-making training for GPs as continuing professional development and within medical training. The aim was to help shape the context for the current study and better frame and understand its findings.

In the context of shared decision-making in primary care, a meta-ethnography was conducted in order to gain a deeper insight into how the concept is currently practised in the treatment of depression from a GP perspective. The choice to conduct a meta-ethnography was guided by the need for interpretative methodology in order to develop a deeper conceptual understanding of the processes behind implementing shared decision-making in practice. In addition, the use of this particular methodology was also guided by existing evidence supporting and recommending it in healthcare research, informing policy making and guidelines creation (Sattar et al., 2021). Therefore, the research question that this systematic review aims to answer is: What is the GPs experience of employing shared decision-making or patient choice as part of the treatment for depression?

2.2. Method

2.2.1. Design

Conceptualised and outlined by Noblit & Hare (1988) and further developed, the purpose of a meta-ethnography in their definition follows seven stages of systematically screening and identifying relevant qualitative studies, familiarising with the studies,

translating the studies into each other, synthesizing the results and presenting them with the goal is to identify a deeper meaning beyond the findings of each individual study (Noblit & Hare, 1988; Noblit & Hare, 1999; France et al., 2019). This method allows the inclusion of studies that are either related in findings, leading to a reciprocal translation, or even opposed, leading to a refutational translation with the view of developing a new line of argument synthesis according to Noblit and Hare (1988).

2.2.2. Article selection

A thorough set of inclusion and exclusion criteria summarised in Table 1 below was developed prior to conducting the database search.

Table 1

Inclusion and exclusion criteria for the database search

Inclusion Criteria	Exclusion Criteria
Qualitative studies, including mixed methods studies where qualitative results can be isolated	Quantitative studies
Treatment for depression as the focus of the study	Study protocols
Studies examining the decision-making process, including shared decision-making or patient choice	Case studies
	Reviews of literature
Studies exploring the views of GPs, also known as physicians or family doctors)	Studies where other healthcare professional are included, and the views of GPs cannot be isolated

For the purpose of this synthesis, articles that covered the shared decision-making process and patient choice were included, in line with the 2022 NICE guideline for depression. Studies where the main focus was the treatment of depression were selected in order to align with the research aim. This resulted in two studies being excluded due to focusing on the end-of-life treatment, rather than specifically on the treatment of depression.

The selection of qualitative studies or mixed-methods studies where the qualitative results could be extracted was dictated by the methodological approach of the meta-ethnography. Furthermore, studies that did not include primary qualitative data, such as protocols, case studies or literature reviews were excluded.

Considering the aim of the systematic review, the studies included had to explore the views of GPs, also known as physicians or family doctors in other countries. Studies in which GP views were collected and analysed alongside those of patients or other healthcare professionals and where the findings could not be separated were excluded from the analysis in order to be able to isolate the perspectives provided by GPs directly.

Similarly, studies involving the treatment of young people where the results could not be separated for the over 18s group were also excluded due to the present NICE guideline detailing the treatment of adults, defined as over the age of 18.

The systematic search was conducted using the EBSCOhost research databases APA PsycInfo, APA PsycArticles, CINAHL Ultimate and MEDLINE Ultimate in June 2025 and again in February 2026 in order to ensure that all potentially relevant studies published up to this date were included.

The search terms were developed to help identify all the potentially relevant studies for this review. In terms of interventions and treatment of depression, the search terms were selected to reflect the current evidence base outlined in the 2022 NICE guideline, as well as the previous guideline and expanded to capture other possible variations. While the guideline underwent a new review in considering the treatment of new and further line treatments in 2026, no new treatment avenues were added. There was no time limit imposed for the publication date, given the limited research available on this specific topic.

The search terms developed and utilised to search the databases were:

TI depress* AND TI ("patient choice" OR "patient preference" OR "patient decision" OR "patient autonomy" OR "shared decision-making" OR "decision making" OR "decision-making" OR "patient's decision-making" OR "concordance")

AND (therap* OR psychotherap* OR Treatment* OR Intervention* OR CBT OR Behav#ral Activation" OR BA OR "Cognitive behav#ral treatment" OR IPT OR counselling OR "CBASP" OR STPP OR "Guided self-help" OR antidepress* OR "selective serotonin reuptake inhibitor*" OR SSRI* OR "serotonin-noradrenaline reuptake inhibitor*" OR SNRI* OR "tricyclic*" OR TCA* OR "monoamine oxidase inhibitor*" OR MAOI*)

AND ("general practitioner*" OR GP* OR "primary care" OR physician* OR "family medicine" OR "family doctor*").

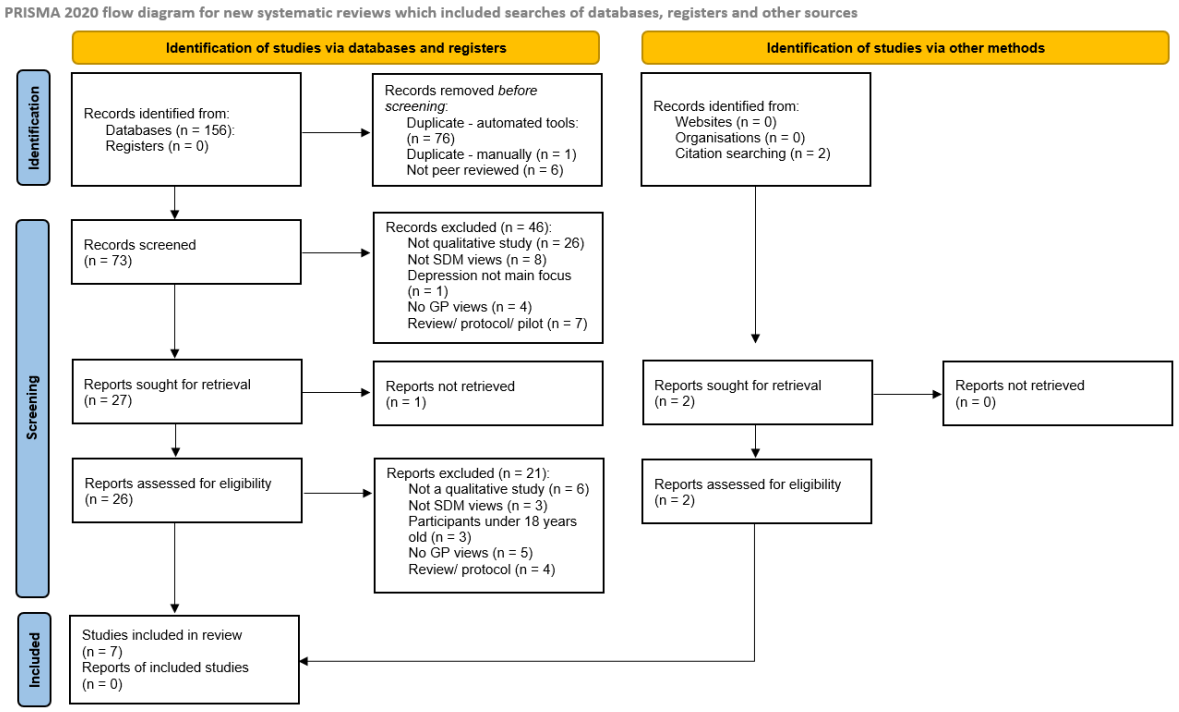
The database search with the above terms helped identify 156 papers. The initial step to separate duplicates using automated tools led to the exclusion of 76 papers, with one further study being identified through manual search, and 6 studies removed due to not being peer reviewed. This resulted in 73 studies that were assessed for eligibility. This was initially done using the title and abstract, where 46 studies were excluded due to not meeting the inclusion or exclusion criteria. Twenty-seven studies were then sought for retrieval, and eligibility was assessed across the whole text. At this point, one paper was not retrieved despite numerous attempts. While screening was still a priority, it is worth mentioning that this particular study was published in 1985, which is over two decades before the oldest study included in this systematic review of literature. Timelines of the shared decision-making concept development were also taken into account. The selection of papers resulted in 5 papers that were included in this review (McMullen, 2012; Adams et al., 2014; Patel et al., 2014; Zaini et al., 2018; Stallman et al., 2023).

Following the database search, a manual citation search was also conducted to identify any further studies that might have been missed at this stage. Two additional papers were identified through citation search and were included in the analysis and are presented in the right-hand side column of the PRISMA diagram (Johnston et al., 2007; Chong et al., 2013). The full details of the article selection are provided in Figure 1.

A further in-depth read of the selected papers was done and the key concepts and themes were collated using the structure provided by Britten (2002) and exemplified in Table 2.

Figure 1

PRISMA diagram for Systematic reviews and Meta-Analyses



From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. For more information, visit: http://www.prisma-statement.org/

Table 2

Sample of tabulated study details and key concepts

Study details	Stallman et al., 2013
Purpose	With antidepressant prescriptions and referrals for psychological therapies in Australia being most used by GPs, this study aims to establish how these treatment decisions are made in the primary care setting.
Setting	Australia
Sample	16 GPs
Data collection	Structured interviews
Key concepts	
Psychologist as default treatment option	*Therapy preferred by GPs and seen as a universal treatment option*
Risk is just too high	*Risk shifts the decision-making process and can supersede other options initially*
Medication as a supplement	*Prescribing to aid therapy engagement and participation*
Drivers of antidepressants	*Patient choice significantly impacting prescription of antidepressants, with no general preference*

While there is no consensus on the exclusion of papers from a meta-ethnography based on a quality assessment tool, the included studies were assessed using the Critical Appraisal Skills Programme tool for qualitative studies (CASP) in order to provide a context for the weight they brought to the analysis (Dixon-Woods et al., 2006; Atkins et al., 2008; CASP, 2018). Pursuing a critical appraisal of the papers revealed that while most studies used a convenience sampling, the recruitment strategy was not always clearly presented or justified. Some studies had a single-site recruitment while others had participants from multiple practices, however the strategy was not clear. With the studies rooted in a wide variety of countries, it was not always clear the setting and layout of the service. A clearer outline of the services could have aided in understanding the context of the studies and how they compare to the UK provision of primary care.

In relation to the context of the decision-making process, it was noted that most papers did not specify if the GPs' experiences were in relation to one patient interaction or reflecting on their practice in general. The variability of a more general approach versus unique clinical encounters was considered in the analysis process, which could potentially impact how the studies contribute to the synthesis according to the stance taken.

Most studies did not stratify participants based on ethnicity, except for two studies that reported specifically on the experiences of patients from racialised ethnic backgrounds. The inclusion of these studies was deemed particularly important given the acknowledged healthcare inequalities experienced by patients from ethnic minority groups in the UK (Adams, 2014; Patel, 2014). The addition of these perspectives in the synthesis therefore brought a significant contribution and richness to the analysis.

Overall, the studies included originated from a range of countries covering GP experiences from Malaysia, Australia, Canada, Australia, the US and the UK, presenting the views of 195 general practitioners. Table 3 provides a summary of the included studies. As per the inclusion and exclusion criteria, where studies recruited both patients and GPs, but the GP views could be separated in the findings, the table below only includes the details relating to the GP sample.

Table 3

Summary of included studies

Study	Setting	Aim	Methodology	Key Findings
Johnston et al., (2007)	UK based GP practices	To explore GPs' depression management views	Purposive sampling. 32 GPs (20 male, 12 female) from 28	Defining depression/ self/ 'normal' sadness. Importance of listening in the context of

Study	Setting	Aim	Methodology	Key Findings
		and treatment goals.	practices. Age range 30-58, 31 White, one South-Asian. Interviews were analysed using grounded theory.	diagnosis, goal setting and treatment decision. Pursuing achievable goals congruent with patients' views.
McMullen, (2012)	Midsized Canadian city	To examine how physicians view decision-making in the diagnosis and treatment of depression	Purposive sampling. Interviews (N=11). Physicians (6 males, 5 females). Age range 33-71 years. Discourse analysis of interview extracts.	Discourses relating to GPs' influence and patients' autonomy. Role of persuasion and professional expertise in the decision-making process. Value of patient autonomy in the final decision.
Chong et al., (2013)	Australia	To explore barriers and facilitators of shared decision-making in depression.	Purposive sampling. Semi-structured interviews, including 4 GPs. Thematic analysis.	System-related barriers and patient-related barriers were identified, with shared decision-making being limited by capacity and awareness of options. Information sharing and collaboration were identified as facilitators.
Adams et al., (2014)	UK and USA	To investigate GPs' decision-making in	Secondary data analysis. GPs'	Greater diagnostic uncertainty found when

Study	Setting	Aim	Methodology	Key Findings
		depression when consulting patients from an African American and African Caribbean background.	narrated accounts responding to video-simulated patients. 52 US and 56 UK GPs. Qualitative data analysis using CliniClass system developed by the authors.	assessing depression presentation in patients from African American or Caribbean backgrounds. Fewer potential outcomes are considered for patients from racialised backgrounds. GPs' existing views shaping decisions to treat or not to treat.
Patel et al., (2014)	Primary care centres in the USA	To explore barriers and facilitators to shared decision-making perceived by primary care providers when treating depression in patients from African American and Latino backgrounds	Random sampling. Interviews based on a recent patient and a vignette. Thematic analysis.	Decision-making was found to be influenced by stigma, role expectations and existing model of illness. Psycho-education and addressing the stigma were identified as a facilitator to shared decision-making.
Zaini et al., (2018)	Hospital in Malaysia	To identify key elements of shared decision-making in	Snowballing. Focus group (N=3) including 19 GPs (11	Shared decision-making facilitated by effective preparations and information

Study	Setting	Aim	Methodology	Key Findings
		depression with the view of developing a decision tool.	male and 8 female). Data were analysed using thematic analysis.	sharing. Value of discussing options and potential side-effects followed by a planned follow-up with an open approach towards reconsidering options if needed.
Stallman et al., (2023)	Australia	To examine cues taken into account by GPs in the decision-making process for depression treatment.	Structured interviews (N=16) with Australian GPs (8 male and 8 female). Age range 29-70. Data were analysed using content coding and latent thematic analysis.	GP views shaped the decision-making process. Lower risk presentations were defaulted to therapy referrals, while more severe cases were associated with antidepressant prescription. Other guideline informed options were used less frequently.

2.2.3. Determining how the studies are related

The key concepts identified in each study were extracted systematically, going beyond the descriptive themes and seeking the deeper interpretation. The comparison of concepts was achieved by extracting the key concepts from each study following the model proposed by Britten et al. (2002). This method enabled framing the results of each paper alongside the central theory as a context for interpretation.

As per France (2019), similar concepts present across multiple studies were grouped. The 6 recurring concepts identified were: shared expertise, preferred involvement, valuing the patient context, choice limited by system, building trust and mutual understanding.

2.2.4. Translating the studies into each other

Following the previous step of determining how the studies are related, second-order interpretations were extracted and compared in order to establish conceptual commonality or divergence. The concepts were organised in the tabular summary for each study.

Where possible, the original terminology from each study was taken into consideration and used in order to maintain the meaning provided by the authors. The key concepts included in the synthesis are presented below in Table 4, starting with the lower-level concepts in the first column and the presence of concepts across each study in subsequent columns. Cases where a concept was not present in a specific study are represented by a blank cell (Britten et al., 2002).

Table 4

Cross comparison of studies by concept

	Johnston et al., (2007)	McMullen, (2012)	Chong et al., (2013)	Adams et al., (2014)	Patel et al., (2014)	Zaini et al., (2018)	Stallman et al., (2023)
Shared expertise	x	x	x	x		x	x
Preferred involvement		x	x		x	x	x
Valuing patient context	x	x	x	x	x		x
Choice limited by system		x	x		x	x	x
Building the trust	x	x	x	x	x		
Mutual understanding	x	x	x	x	x	x	

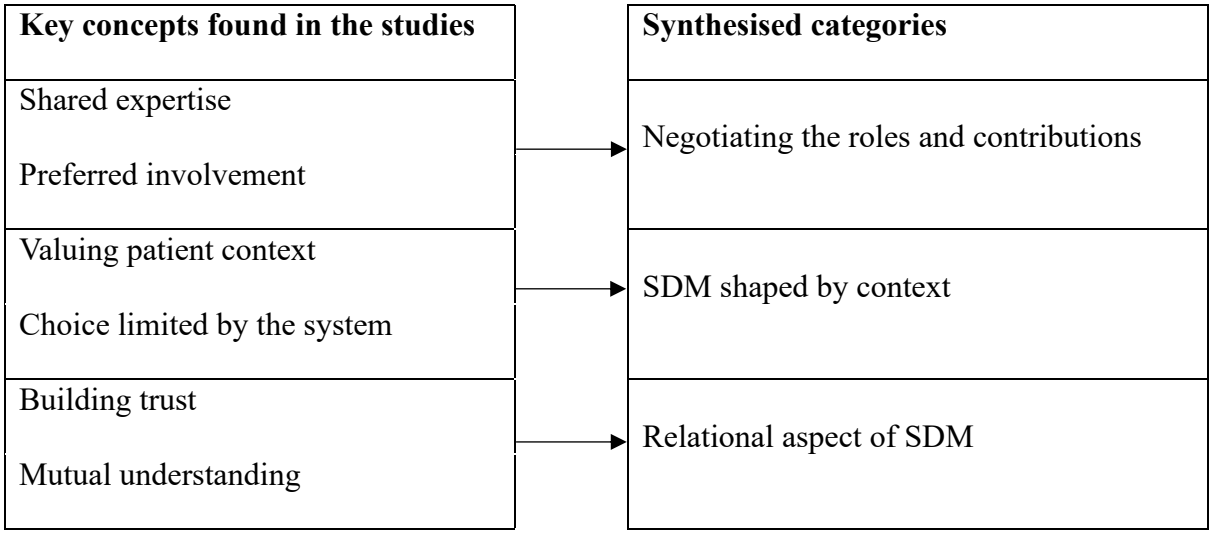
2.2.5. Synthesising the translations

Patterns of similarity and difference were identified by juxtaposing the translated concepts across all studies. A largely reciprocal relationship was identified which led to a reciprocal translation of concepts (France et al., 2019).

The overarching categories identified were negotiating the roles and contributions, shared decision-making shaped by context and relational aspect of shared decision-making (Figure 2). This contributed to the development of the third-order interpretation compiling the results of all included studies. The new model proposed by the line of argument synthesis transcends the findings of each individual study, generating a novel understanding (Noblit & Hare, 1999).

Figure 2

Overview of key concepts and synthesised broader categories



2.3. Results

2.3.1. Negotiating the roles and contributions

2.3.1.1.Shared expertise

Across the studies, the concept of shared expertise was present when it comes to the decisional aspect of patient care. Moving on from the authoritative stance and assumption that all the expertise lies with the GP, the value of the experience brought in by the patient was highlighted (McMullen, 2012; Chong et al., 2013; Zaini et al., 2018). Interestingly, this was not always part of standard care, with some GPs continuing to hold on to a more authoritative stance but opening the conversation around the value of patients' views sought (Chong et al., 2013; Zaini et al., 2018). Therefore, an asymmetry of involvement may still be present in the GP-patient interactions.

In addition, the roles were not seen as fixed, but described on a continuum, leading to a higher participation in the treatment plan from the patient (McMullen, 2012). Shared decision-making emerged as a longer process, at times not constrained by a single encounter.

Sometimes the shared expertise was beyond the isolated GP appointment, with external perspectives being sought and taken into consideration in the decisional process (Chong et al., 2013; Stallman et al., 2023).

Some studies framed the variability in roles depending on the severity of depression, stage in the recovery and options available (Chong et al., 2013; Stallman et al., 2023). Therefore, the patient's expertise remains valuable and sought by GPs with the understanding that some factors can impact the role the patient wishes to take but not limit their decision.

2.3.1.2. Preferred involvement

In addition to having a shared expertise, studies also spoke about a variable level of involvement expressed by GPs and noticed in patients. When it comes to decisions regarding

medications, GPs took on more of a decisional role especially when in cases of high severity or risk (Chong et al., 2013). Similarly, GPs spoke about noticing how at times patients prefer to make the decision independently, with support or want the decisional weight to be taken on altogether by them (McMullen, 2012; Chong et al., 2013). However, situations where the patient might ask for a more authoritative approach were an exception rather than the norm and was mediated by factors such as the severity of depression, or "patients' cultural attitudes towards providers" (Patel, 2014, p. 8) and previous experience and of accessing other healthcare systems where this is the norm (McMullen, 2012; Adams et al., 2014; Patel et al., 2014). The importance of individualised and patient-centred care is highlighted through these accounts, with recommendations to "empower patients, resolve ambivalence and activate [patients] to participate in their mental health care decisions" (Patel, 2014, p. 9).

Engaging the patients in the decision-making process was also described as a lengthy process, with GPs noting that at times patients might want to consider the presented information and treatment options in order to be fully engaged in the decision (McMullen, 2012; Patel et al., 2014).

2.3.2. Shared decision-making shaped by context

2.3.2.1. Valuing the patient context

Understanding the wider life events and patient context was described as the foundation to allow shared decision-making (Johnston et al., 2007; McMullen, 2012; Patel et al., 2014). This involved a collaborative approach in a differential assessment of depression and assessment of risk while actively seeking a patient-centred approach (Johnston et al., 2007; Stallman et al., 2023). Johnston (2007) further emphasised the difference in patients' goals versus GPs' goals when it comes to treatment options, stating that "GPs' curative goals may therefore be incongruous with patients' experiences of chronicity" (Johnston, 2007, p. 8),

with recommendations of an individualised exploration of patient goals and constant re-evaluation of GPs' own goals.

The investment in this aspect of shared decision-making was seen as a timely task, with GPs noting that at times patients might want to consider the presented information and treatment options in order to be fully engaged in the decision (McMullen, 2012; Patel et al., 2014). In practice, it could imply that subsequent visits are necessary in order to allow patients time for deliberation.

Notably, in the context of differential diagnosis and understanding the patients' needs, patients from minoritised ethnic groups and elderly patients were observed to delay access to support from their GPs, which in turn limited the range of treatment options available (Chong et al., 2013; Adams et al., 2014; Patel et al., 2014). Furthermore, depressive symptoms were more likely to present or be overshadowed by physical health concerns (Johnston et al., 2007; Adams et al., 2014; Patel et al., 2014). This indicated that a greater awareness of these issues is needed, paired with a more in-depth exploration and assessment of needs, in order to engage the patients' views.

2.3.2.2.Choice limited by the system

Compared to the patient context that had implications on an individual level, studies also explored system limitations that often felt to be outside the control of practitioners. Overall, system limitations were identified across multiple studies from different countries, indicating that this is a general issue rather a confined within a single country or geographical area (McMullen, 2012; Chong et al., 2013; Patel et al., 2014; Zaini et al., 2018; Stallman et al., 2023).

Time constraints emerged as a key systemic barrier, as an "important resource barrier for shared decision-making" (Chong, 2013, p. 376), limiting the opportunity to employ it

within the appointment time (Chong et al., 2013; Patel et al., 2014; Stallman et al., 2023). Tasks that were deemed likely to prolong the consultation time were information gathering, covering treatment options, assessing risk and discussing side effects (Johnston et al., 2007; Chong et al., 2013; Patel et al., 2014; Stallman et al., 2023). While these components were deemed of high importance, the knock-on effect on prolonged waiting times and management pressures to adhere to existing time frames was noted (McMullen, 2012; Patel et al., 2014; Zaini et al., 2018; Stallman et al., 2023).

General Practitioners also spoke about being limited by external services, including scarcity of options within mental health services, prescriptive recommendations from other healthcare providers and difficulty accessing interpreting and translation services, all of which were described to be outside of their control (Chong et al., 2013; Stallman et al., 2023). However, they also noted that in instances where inter-professional communication is successful, this can become a facilitator of shared decision-making implementation.

This indicates that addressing the wider systemic issues will not only improve service delivery and timeframes but will also facilitate integration of shared decision-making in practice.

2.3.3. Relational aspect of shared decision-making

2.3.3.1. Building trust

The relational aspect of shared decision making was grounded by most studies within a trust-based professional relationship between patients and GPs (Johnston et al., 2007; McMullen, 2012; Chong et al., 2013; Adams et al., 2014; Patel et al., 2014; Zaini et al., 2018).

In the incipient stages of patient interactions, a sense of connection can be fostered through an open approach, listening to the patient's concerns, by demonstrating that the

patients' views and concerns are taken into account (Johnston et al., 2007). Trust can therefore be established early in the consultation process.

> *"GPs acknowledged the importance of listening to patients with depression, and viewed empathy and support as constituting important aspects of their role in managing depression." (Johnston et al., 2007, p. 8)*

Trust was defined as a necessary component in the formulation of the patient presentation, highlighting that in some cases depression might not be recognised or even accepted by the patients upon accessing support for their health concerns (Johnston et al., 2007; Adams et al., 2014; Patel et al., 2014). At a higher risk of not having their views heard and understood are patients from racialised backgrounds, confirming that efforts to establish a connection are even more important in tackling health inequalities experienced by these patients (Adams et al., 2014; Patel et al., 2014).

The lack of trust was linked by GPs to poor treatment concordance, indicating that the shared aspect of decision and integration of patient views plays a pivotal role in ensuring treatment pathways are understood and ultimately followed (Johnston et al., 2007; McMullen, 2012; Adams et al., 2014; Patel et al., 2014).

2.3.3.2.Mutual understanding

Closely linked and built on the foundation of trust, seeking a mutual understanding was presented as another prerequisite to successful shared decision-making implementation. The studies indicated that a shared understanding needs to be pursued at every point of the consultation process, going beyond information gathering and expanding on treatment pathways, benefits and limitations of each option and individual factors (Patel et al., 2014; Zaini et al., 2018).

While decisional capacity in depression was debated in some studies, extensive efforts in presenting the information in an accessible manner were recommended, through simplified or tailored approaches (Chong et al., 2013; Zaini et al., 2018). Similarly, instances where the consultation did not take place in the patient's primary language, communication barriers should be addressed (Adams et al., 2014; Patel et al., 2014). This is also understood in the context of "increased clinical uncertainty" (Adams, 2014, p. 165) observed when treating patients from racialised backgrounds. Taken together, these accounts highlight the importance of addressing any potential obstacles to achieving a shared understanding (Chong et al., 2013; Adams et al., 2014; Patel et al., 2014; Zaini et al., 2018).

While some findings revealed limited shared decision-making in practice with a greater awareness being raised, others justified that elements of persuasion and recommendations from GPs are not always incompatible with shared decision-making (McMullen, 2012; Zaini et al., 2018). This further emphasises that the relational aspect of reaching a mutual understanding is the foundation of patient-centred care.

2.4.Line of argument synthesis

Based on these findings, a line of argument synthesis aims to explore the relationship between the themes transcending the findings of each individual study and aiming to reveal hidden concepts with the purpose of creating an overarching interpretation (Noblit & Hare, 1988).

The synthesis reveals that shared decision-making in depression care is a dynamic process moderated by the patient and system context, with ongoing negotiation of roles. The relational aspect was placed at the foundation of shared decision-making.

Shared decision-making is enacted by balancing the roles taken by GPs and patients, guided by the preferred level of involvement expressed by the patients and the shared

expertise. Patient preference can vary based on individual characteristics, severity of illness or awareness of treatment options, however this does not remove their participation in the decisional process altogether.

When it comes to the context, individual and systemic factors were taken into consideration. Although some might be outside of the clinician's control and can act as a barrier to implementation at times, successful navigation of such factors will elicit shared decision-making in practice.

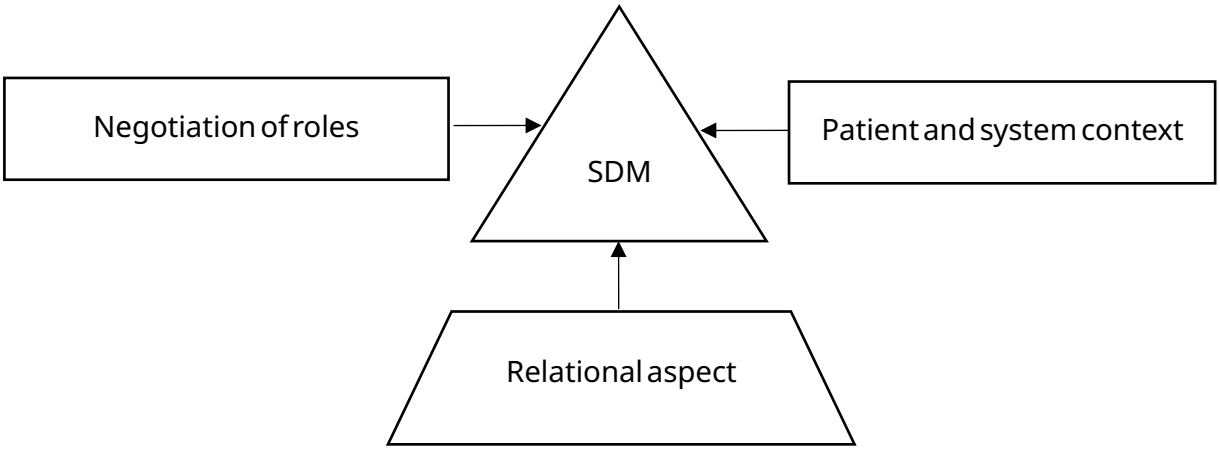
The relational aspect, while timely in some situations, is seen as the core foundation of shared decision-making implementation. Building trust, while initiated in the early points of patient interactions, can require time. However, when paired with a mutual understanding, it can overcome a set of obstacles imposed by the system or nature of depression care.

These three areas dynamically shape shared decision-making in practice, with no unique implementation expected. With the acknowledged complexity of navigating the challenges and the added longitudinal aspect, where it might be enacted over several patient encounters, the unidimensional protocolised approach is challenged.

Figure 3 presents the synthesis with shared decision-making at its centre, shaped by contextual factors and negotiation of roles, with the foundation of a strong relational aspect.

Figure 3

Line of argument synthesis: SDM Process



2.5.Discussions

This meta-ethnography focused on conceptualising the current understanding of shared decision-making in the care of patients with depression, taking into account GPs' views. The understanding that emerged from this synthesis is that shared decision-making is a dynamic process and not a protocolised, homogenous approach. Combining the findings of seven studies exploring GP views on shared decision-making, it revealed that it is continuously shaped by contextual and relational factors and requires ongoing negotiation of roles. Following on from previous research focusing on patients' views, this synthesis explores exclusively the views of GPs with the aim of building an understanding of how shared decision-making is moderated from their perspective.

The relational aspect of shared decision-making at the foundation of better implementation offers a new contribution to the existing knowledge. Previous studies that explored patients' views supported an open trust-based conversation being valued (Stacey et al., 2008; Matthews et al., 2021). Where concerns around lack of motivation or capacity emerged, a strong relationship with the GP mediated and minimised these limitations (Stacey

et al., 2008). Conversely, a lack of connection was directly linked to patient dissatisfaction and poorer outcomes (Marshall et al., 2021). This strengthens the position of the relational aspect as a necessary foundation.

The negotiation of roles is a complex undertaking, especially in primary care where a protocolised approach might be more suited, given the wide range of presentation that GPs will encounter in their clinical work. While literature described that some roles can be pre-defined or more common, such as GPs informing patients of treatment options and patients taking a more active role in the decision-making step, the shared expertise component identified in this synthesis proposes a negotiation at every step (Stacey et al., 2008; Matthews et al., 2021).

Although some of the studies included in this synthesis spoke about decisional capacity issues in depression, evidence shows low he prevalence of impaired capacity in this group (Simon et al., 2007; Chong et al., 2013). The discrepancy in results could be explained by the definition of capacity within each study and by the different opinions amongst patients and clinicians. Regardless, the recommendation to assume capacity and ensure clear and tailored communication remains (Owen et al., 2003; Rodenburg-Vandenbussche et al., 2020; Matthews et al., 2021).

The findings of this synthesis align with existing literature reviews including healthcare providers' views on shared decision-making, with large representation of GPs (Légaré et al., 2018). This systematic review identified a series of barriers and facilitators of shared decision-making with some concepts overlapping with the present synthesis. However, the contribution of the present findings is that the concepts identified were not classified solely as a barrier or a facilitator but were seen as a dynamic process.

2.5.1. Limitations and researcher positioning

Some limitations were considered in relation to the inclusion and exclusion criteria, search terms, quality assessment process and analytic procedure. Firstly, the inclusion and exclusion criteria were developed in connection to the research aim. Due to limited evidence in the UK, international studies were included. However, a limitation linked to this decision is that the results are based on different health systems, which might not follow the NHS structure comprising of primary, secondary and tertiary services, or having primary care as a possible first point of access for mental health difficulties. This could limit the transferability of results to the UK system. Therefore, special consideration needs to be allocated to the context of the studies when interpreting the results, particularly for international studies.

Secondly, the search terms covered some job titles such as “general practitioner”, “physician” and “family doctor”, but might not have covered all the terminology used across the world. At the same time, the terms around depression and shared decision-making were only searched in the title which if replicated in similar searches could limit the output. In the present study, a parallel abstract search was performed which resulted in no further studies. In relation to treatment options, one limitation is that these are linked to the UK NICE guidelines in line with the study aim. Although a comprehensive list of treatment options and search terms was used, this might have limited the results from other international studies from countries utilising alternative treatment avenues. In order to address this limitation, an additional citation search was carried out, which revealed two further studies that were included in the analysis.

The quality assessment process was conducted using the CASP checklist and revealed some limitations in terms of context of studies, recruitment strategy and clarity around the layout of services (CASP, 2018). While there is no consensus on excluding studies based on scores resulting from quality appraisal tools in meta-ethnographies, special consideration

needs to be allocated when approaching the results of this synthesis (Dixon-Woods et al., 2006; Atkins et al., 2008; CASP, 2018).

Finally, the analytic procedure can also pose a limitation. Having pursued a reciprocal translation, the commonality of the studies predominated the interpretation and translation of studies. This had potential to overlook some of the refutational elements present across the studies, especially considering the acknowledged heterogeneity of healthcare systems and contexts represented in the selected papers.

In terms of the researcher positionality, my own approach to this process was taken into consideration. My existing views on the benefits of shared decision-making and patient choice had potential to influence the interpretative process. Additionally, my background in psychology shaped my focus on elements of therapeutic relationships and negotiation of roles, themes that I have reflected on in my clinical work. Conversely, a primary care practitioners might have allocated more attention to the wider system limitations or pharmacological approaches. Therefore, the results of this synthesis need to be understood within this positionality, rather than from a completely neutral stance.

2.6.Conclusions

The results of this synthesis help define shared decision-making as a dynamic process, requiring a trust-based patient-clinician relationship and moderated by contextual factors and varying roles. Although complex and requiring a tailored patient-centred approach, clinical and wider system benefits are undisputed.

2.7.Research aims

Following on from this meta-ethnography and in light of the 2022 update of the NICE guidelines for depression recommending shared decision-making and patient choice as an integral part of depression care, the present study aims to explore GP views on shared

decision-making. With limited studies in the UK and more specifically after the 2022 guideline update, the focus of the study will be on GPs practising in the UK. With undisputed benefits of shared decision-making but acknowledgement that factors may limit implementation, it is important to understand specific barriers in the local healthcare context.

This mixed-methods study aims to provide a better understanding of how the guideline is viewed and applied by GPs in practice, particularly in relation to shared decision-making in the treatment of depression.

A second aim seeks to understand if previous training completed by GPs is associated with self-reported shared decision-making experience and practice.

Finally, the study aims to explore barriers experienced in practice in employing shared decision-making in the treatment of depression.

With limited evidence in the UK healthcare system following the publication of the new guideline, and with the acknowledged complexity of applying it in practice, the aim is to explore real-life challenges encountered by UK GPs in their clinical practice.

The research questions explored in this study are:

- To what extent are GPs in the UK aware of the 2022 NICE guideline for depression recommendations on patient choice and shared decision-making?
- Are self-reported experience, practice and perceived importance of shared decision-making associated with previous training?
- What are the barriers to implementing shared decision-making in primary care for patients with depression?

3. Methods

3.1. Chapter overview

The present study will aim to explore the implementation in practice of the NICE depression guideline (NICE, 2022) at the point of patients seeking support from their GPs. Holding in mind the complex nature of depression and the national context dominated by increased pressures on primary care, the approach will aim to employ a pragmatic stance looking at the best fit in terms of methodology.

This chapter will cover the research methods, providing a detailed account of how the study was conducted. It will begin with the epistemological positioning adopted and the justification for adopting this approach. It will then cover the design, sample and recruitment, procedures, data collection, measures, analysis approach, ethical considerations and dissemination plan.

3.2. Epistemological positioning and justification of methodology

This study employed an explanatory sequential design (Ivankova & Stick, 2006) under the overarching pragmatic epistemological approach in order to explore GPs' views on shared decision-making and patient choice and barriers to implementing it in clinical practice.

The positioning of an epistemology central to the research design has been questioned in studies with the term 'paradigm' being now understood as a summary of the researcher's beliefs in the process of creating new knowledge rather than a tool in itself (Morgan, 2007; Biesta, 2010). Other studies however continue to support a clear philosophical stance, considering it central to the coherence of the overall product of the research and foundation upon which the research can be grounded (Creswell & Plano Clark, 2011; Shannon-Baker, 2016).

Pragmatism has been defined and understood as an alternative to the wider employed positivism and constructivist approaches (Morgan, 2007). When it comes to mixed-methods studies, pragmatism prioritises answering the research question and practical applications in the real world, rather than adhering to a strict single methodology. In mixed-methods research, pragmatism was identified as the stance that allowed for a duality of methodology allowing for both qualitative and quantitative data to be collected (Creswell & Plano, 2018). This approach will enable a rich understanding of the complex concept of shared decision-making and patient choice and its applications in practice, especially when working with patients suffering from depression.

In addition to the practical considerations on research, pragmatism is also supportive of the integration of multiple sources of evidence in order to construct a shared meaning (Tashakkori & Teddlie, 2003; Morgan, 2007). In the present study, a pragmatic stance was adopted in order to integrate quantitative and qualitative perspectives in establishing GP views on shared decision-making and patient choice and further explore the barriers to guideline implementation in more depth with the use of semi-structured interviews.

The criticism attached to using a pragmatic approach in mixed-methods research lies in the lack of acknowledgement of the different assumptions that qualitative and quantitative studies employ, questioning the cross-validation concept when the same phenomenon is studied from a dual perspective (Sale et al., 2002). Hall (2013) further critiqued the lack of conceptual clarity in that when research employs “what works” it does not suffice with further definition of the concept needed. The added perspective suggests that a clear articulation is needed in this approach, going beyond the convenient justification of the pragmatic paradigm and engaging in a meaningful rationale and implication on the research (Biddle & Schafft, 2015).

While pragmatism remains a frequently employed paradigm in mixed-methods research, other proposed philosophical approaches include transformative-emancipation, dialectics, and critical realism (Creswell & Plano Clark, 2011; Freshwater & Cahill, 2013; Hesse-Biber & Johnson, 2013; Shannon-Baker, 2016). This has prompted the pursuit of a philosophical approach that will account for the integration of data used in mixed-methods research (Maarouf, 2019).

In recent years, adopting a pragmatic approach in healthcare studies has become more widely used, with applications even in randomised controlled trials with justification on the option to research real-world data and being embedded in routine practice (Hohenschurz-Schmidt, 2023; Capili & Anastasi, 2025). Similar to these studies, attempting to explore the views of GPs on current guidelines is best served from the same approach, enabling a rich and relevant perspective of the barriers experienced at the point of delivering care, with no disruption to normal care and treatment.

In conclusion, a pragmatic approach specifically used in mixed-methods studies offers the grounds to explore the complex concept of shared decision-making in a practical and action-oriented framework by prioritising the research question and diverse methodologies to produce richer, more actionable insights (Maarouf, 2019). Despite some criticism and alternative paradigms explored, the preferred one in mixed-methods studies remains pragmatism due to its focus on the practicality of the research questions and relevance in drawing new conclusions and applying new knowledge.

3.3. Design

A mixed-methods design in research allows for the integration of quantitative and qualitative data in order to reach a deeper understanding of the research question raised by the study (Tashakkori & Teddlie, 2003; Cresswell & Plano Clark, 2018). In addition to the

individual insights provided by quantitative results and qualitative experiences, it offers meaning behind the observed patterns. By collating multiple perspectives in answering complex research questions, the mixed-methods research model constitutes a suitable model in healthcare research (Wasti et al., 2022). In addition, a qualitative approach was found most appropriate for the research question to further quantitative findings (Potter & Hepburn, 2005).

The study used a mixed-method explanatory sequential design which involves a phased approach with an initial stage of collecting and analysing quantitative data, followed by a second stage of collecting and analysing the qualitative data (Ivankova & Stick, 2006). This research method has been employed in order to add further depth and meaning to the quantitative data, aiming to address potentially unanswered questions from the initial phase, and to integrate the results in order to better answer the research questions (Draucker, 2020). By adopting this approach, the explanatory sequential design establishes a context for the quantitative data, leading to more refined conclusions. The initial phase of the study involved a quantitative study that consisted of an online survey delivered via Qualtrics, which is an online platform for questionnaire design and data collection. This survey was designed for GPs across the UK, covering topics about their shared decision-making practices. It included Likert scales for participants to indicate, for example, how much they value patient choice and how often they practise shared decision making.

The second phase of the study consisted of a qualitative study involving interviews with a smaller sample of GPs, sampled based on their survey responses. The interview explored primary care professionals' experiences of offering patient choice; engaging in shared decision making; views on the value of patient choice; and barriers to practising shared decision-making in UK GP practices.

In practice, the preliminary findings from the quantitative part of the study were used to inform and further develop areas of the interview topic prior to commencing the second phase. The quantitative data was analysed iteratively alongside recruitment and emerging patterns from the survey were used to further develop the interview guide. Some of the limitations of the model include the longer timescales required, difficulties in sampling and the added time in analysing two separate datasets in sequential order. The validity of this model is however dictated by the rigour of its application (Creswell & Plano Clark, 2018).

3.4. Sampling

The aim was to recruit registered GPs involved in the assessment and treatment of patients presenting with depression. In addition, the inclusion criteria specified that the GPs had to be registered in the UK with the Royal College of General Practitioners (RCGP) and should be currently practising in the UK. The inclusion and exclusion criteria did not differentiate between GPs practising in the National Health Service (NHS) or those practising privately, with the growing number of GPs working in private practice (Pettigrew et al., 2025).

Purposive sampling was used in the recruitment of both stages of the study, which is a recognised strategy in identifying participants in mixed-methods studies (Palinkas et al., 2015). Factors taken into consideration at the point of recruitment included gender, area of practice and setting.

The intended sample size for the quantitative survey was 382, based on the estimated 46,921 registered GPs in the UK in 2024, using a 95% confidence level with a 5% margin of error using the Yamane formula to calculate samples representative of the population (Yamane, 1967; The Health Foundation, 2024). While the intended sample size of 382 GPs was not met, with 98 participants being recruited for this part of the study, the collected data

were still valued and retained considering the exploratory aim of GP implementation of shared decision-making (Lakens, 2022).

The intended sample size for the qualitative interviews was 10-20 (Braun & Clarke, 2013). While statistical representativeness does not guide intended sample sizes in qualitative research, the aim is to collect a sufficient amount of data to allow the exploration of the research question. The focus of qualitative research however is linked less to the volume of data, but rather the depth that would allow the exploration of the research aims (Braun & Clarke, 2013). Taking this into account, the present study intended to include 10-20 interviews, achieving a total of 13 interviews with an approximate one-hour duration, allowing an in-depth exploration of participants' views.

3.5. Recruitment

For the first part of the study involving the online survey, participants were recruited through a range of approaches such as professional networks, approaching professional bodies through their public profiles, social media, using a virtual poster (Appendix D) with a link to the questionnaires, in-person drop-ins using the advertising poster and snowballing.

In order to recruit participants for the second phase involving interviews, participants were given the option to express their interest at the end of the online survey. Participation in the initial phase of the research was not a requirement for participation in the interview stage of the study. Details on how to join the qualitative part of the study were provided on both the online survey and on the recruitment poster.

3.6. Procedures and data collection

In the first phase of the study (quantitative), a sample of professionals was recruited to take part in an online survey. The survey incorporated participant information and consent at the outset. The final part of the survey included an invitation for participants to leave their

details if they were willing to take part in a qualitative interview to discuss in more depth their views and perspectives on implementing shared decision-making and patient choice in relation to the 2022 NICE guideline for the treatment of depression.

Participants were initially asked to answer a series of demographic and descriptive questions related specifically to the NICE guideline for depression and training. The demographic data included their gender, age, ethnicity, job title or role, setting of work (NHS, private sector or both), years in practice and area of practice. The descriptive information asked if they had been made aware of the updated NICE guideline, with a description of what the guideline entailed and if they had discussed the changes with their practice partners.

Participants were then invited to rate their confidence in using shared decision-making in practice with patients with depression, being provided with the following prompt:

What is shared decision making?

"Shared decision making" is defined as a process which is collaborative between the patient and healthcare worker to reach a joint decision about their care. This decision should be reached taking into account the evidence base and the patient's own preferences and beliefs. To enable this, full information should be given on risks and benefits of each intervention as part of a discussion, with the option of no treatment included as an option. It is also important to acknowledge that some patients may want less input on the decision making process, and therefore an important part of shared decision making is to discuss how much input each individual would like to have within the process. (NICE, 2022).

Based on this prompt, they were invited to measure their confidence in the understanding of the concept, application in practice and effectiveness when applied in practice.

3.7. Measures

The measures used in the online survey involved two questionnaires aimed at measuring shared decision-making and patient involvement: the Shared Decision Making Questionnaire – physician version (SDM-Q-Doc), UK (Scholl et al., 2012) and the OPTION Scale. All measures are attached in Appendix E.

3.7.1. Shared Decision-Making Questionnaire – physician version (SDM-Q-Doc)

The SDM-Q-Doc questionnaire consists of 9 items scored from 1 to 6 with the following options: completely disagree, strongly disagree, somewhat disagree, somewhat agree, strongly agree and completely agree.

This tool has been widely used to assess the concept of shared decision-making applied in practice, specifically by health care professionals (Scholl et al., 2012). The physician version covers more in-depth the interactions between primary care providers, looking at their take on shared decision-making when assessing and treating patients. The questionnaire was adapted from the initial Shared Decision-Making Questionnaire (SDM-Q-9), which was a 9-item questionnaire developed for patients (Kriston et al., 2010). Initially developed in German, the tool has been adapted and validated for English use with a high level of acceptance, item discrimination and a Cronbach's alpha of .88 (Scholl et al., 2012).

In terms of practicality, the SDM-Q-Doc proved to be an efficient measure of shared decision-making easily applied in practice with is an easy questionnaire to use consisting of 9 brief items relating to a specific complaint that a patient presented with. Thus far, it has been used on a wide range of presenting problems, including oncology (Goss et al., 2013; Savelberg et al., 2015), diabetes (Drewelow et al., 2012; den Ouden et al., 2015), vascular surgery (Santema et al., 2016), and depression (Tan et al., 2023).

The questionnaire instructs the practitioner to rate their agreement to each statement looking at specific aspects of shared decision-making, providing a 6-point scale ranging from their complete agreement to their complete disagreement to the statement.

3.7.2. Option (Observing Patient Involvement in Decision Making) Scale

The Option Scale is an observational tool which is aimed to establish the level of involvement that a patient has in decisions regarding their healthcare (Elwyn et al., 2003). The scale was attested to be a valid tool in measuring shared decision-making in practice with a Cronbach's alpha of 0.79, an inter-rater agreement kappa score of 0.71 and an inter-rater intraclass correlation coefficient of 0.62, all scores being above the acceptable value.

As opposed to the SDM-Q-Doc questionnaire, which is designed to be completed by the health care provider, the Option scale is used retrospectively to rate the extent of shared decision-making practiced by professionals during specific interactions with patients. The parameters observed in this scale include the exploration of existing treatment options, patient preferences, expectations, concerns, outline of pros and cons of decisions etc.

In this study, the Option scale was adapted to a self-report scale in order to assess the practitioner's view on the level of shared decision-making utilised in their session. In order to establish this, we first asked the clinician to rate their overall shared decision-making related behaviour when offering a choice of treatment to patients presenting with depression. They were then invited to rate the same statements again, but this time in regards to the importance that they assigned to each aspect of shared decision-making in their clinical work. By combining the two stances of which aspects of shared decision-making they are able to employ in practice and which aspects they find most important, it provides a robust insight into the application and limitations of shared decision-making in practice.

The adapted Option scale consists of 12 items and it was completed by participants twice, first relating to their experience of employing shared decision-making in practice (I never do this, I make minimal attempt to do this, I do this to a minimally acceptable level, I think I do this fairly well, and I think I do this very well). The questionnaire was then completed again, rating the perceived importance of shared decision-making using the same items with the options: not at all important, slightly important, moderately important, very important and extremely important. The scores on the answers ranged from 0 to 4.

3.7.3 Semi-structured interview

For the second part of the study involving the qualitative data collection, a semi-structured interview was developed to guide the interviews (Appendix H). The use of semi-structured interviews was informed by the balance offered between structure and flexibility, allowing for a focused exploration of a set topic, alongside an exploration of participants' views as recommended in primary care research (DeJonckheere & Vaughn, 2019).

The interview schedule was developed in accordance with the study aims, methodological approach, existing research and the NICE guideline for depression (2022). The interview topics followed a typical GP appointment flow, starting with the information gathering stage, discussion of options and deliberation. This allowed the exploration of barriers in implementing shared decision-making at every stage of the consultation process. The quantitative part of the study was used to further shape the interview part of the study. The survey data provided an insight into the level of awareness that the GPs had on the guideline and level of shared decision-making in their practice. This informed the focus on the barriers of further implementation and allowed greater depth to be reached.

Each interview commenced with an initial overview of the 2022 NICE guideline for depression, which followed a similar structure for each participant. The aim was to account

for a potential lack of full awareness of the guideline, with the understanding that GPs need to review numerous NICE guidelines for each presentation that they might encounter in primary care. The example used to frame the NICE guidelines is provided below:

> *"I am not sure if you are aware but the 2022 NICE guideline moved from a "stepped care" model to a "matched care" model which is supposed to allow for more shared decision making and patient choice – not just between medical and psychological treatments but also a wider range of psychological treatments. Have you come across these new ideas in the guideline?"*

Participants were then invited to share their familiarity and experience with this guideline change, as well as changes made in practice or potential changes that could be made. This was followed by the interview topics that were developed in relation to a typical GP consultation and shared decision-making components: information exchange, deliberation and choosing treatment options.

For the information exchange topic, areas explored included how GPs might engage patients and seek their perspective, barriers to information sharing and how treatment options are laid out as part of their consultations.

The deliberation topic focused more specifically on how the information that has been collected in the initial stage of the consultation is used to inform treatment options. Prompts were provided on what type of treatments patients prefer and individual influences based on a patient's gender, age, cultural background or context in order to include potential areas of health inequalities.

The final topic looked specifically at choosing treatment options and how the decision is made. Barriers in the decision-making process were explored here alongside individual preferences that they had noticed in patients. The interview schedule was designed to allow

adaptations based on participants' terminology and responses to allow a flexible approach, supported by the structure of the choice of interview.

3.8. Analysis

3.8.1. Quantitative data analysis

The quantitative data analysis was exploratory in nature and was therefore guided by research questions rather than specific hypotheses. This was informed by the limited evidence around GPs' views on shared decision-making following the 2022 NICE guideline update in the UK (Ghasemi et al., 2025). Therefore, the aim was to gain a better understanding of the guideline implementation by looking at the overall levels of awareness and the reported levels of shared decision-making. The limitation of this approach is in the potential over-interpretation results, linked to the exploration the data through multiple tests (Nosek et al., 2018). This can be mitigated by well-constructed research questions following the research aims (Nosek et al., 2018; Bahadoran et al., 2025).

The survey data were analysed using the IBM SPSS package. The first research questions aimed to explore GPs' awareness in the UK of the 2022 NICE guideline for depression recommendations on patient choice and shared decision-making. Participant demographic data and contextual characteristics looking at the experience of using shared decision-making in practice, awareness of the guideline, training background and confidence in understanding of shared decision-making, application and effectiveness were analysed using descriptive statistics.

Similarly, descriptive statistics were initially used to summarise the responses on the SDM-Q-Doc and the adapted Option scale rated on experience and perceived importance of shared decision-making. Cronbach's alpha coefficient was used to establish internal consistency and reliability of each scale. Following this step, a series of inferential statistical

tests was performed. Due to the modest sample size, a causal relationship between variables could not be pursued, associations were explored to help identify patterns in the data. Normality of distribution testing was done using Shapiro-Wilk test which is the accepted test to assess for normality in sample sizes under 2000 participants (Razali & Wah, 2011). This led to the decision to conduct non-parametric tests, due to the assumption of normality not being met for the Option scales.

To explore the association between self-reported experience (SDM-Q-Doc) and perceived importance and practice (Option scale) reported using continuous scores, Spearman's rank-order correlation was used.

The second research question aimed to explore if self-reported experience, practice and perceived experience measured with the SDM-Q-Doc and Option scales was associated with previous training. In order to establish group differences between two independent groups with ordinal scores on the shared decision-making measures and shared decision making completed in medical school as well as CPD completed post-qualification (with the two nominal categories 'yes/no') the Mann-Whitney U test was used.

The area of practice with the three levels: NHS, private or both, was compared to the shared decision-making measures using the Kruskal-Wallis H test. This exploratory analysis aimed to identify associations between variables in order to identify patterns across the dataset directly linked to the research questions.

3.8.2. Qualitative data analysis

The qualitative data collected using the semi-structured interviews was analysed using reflexive thematic analysis (Braun & Clarke, 2013; Braun & Clarke, 2023). The choice of methodology was directed by the compatibility with the research aim of exploring barriers in implementing shared decision-making in practice, allowing for the exploration of complex

subjects such as healthcare-related topics. Reflexive thematic analysis was developed more recently incorporating key concepts of thematic analysis, while acknowledging the active participation of the researcher in the stages of interpreting and analysing the data.

The analysis process followed the six phases described by Braun & Clarke (2023), with the understanding that the stages described are not discrete unidirectional categories and that in practice the researcher can navigate from one stage to a previous stage as needed to better understand and interpret the data.

Transcription of data was done based on the automated output of the video platform used to record the interviews (Zoom), followed by a manual check of each transcript against the original recording. At this point, any potential further identifiers on geographical area or services were anonymised.

A first step involved data familiarisation by listening to the recordings of the interviews and reading the transcripts several times to allow immersion into the dataset.

The second stage of reflexive thematic analysis involves the systematic coding of the data. Data were analysed using the NVivo software, where the initial coding was done. All set stages of a reflexive thematic analysis involving coding were set up in NVivo in order to allow navigation between them (Braun & Clarke, 2023). During this second step, further familiarisation with the data was at times required in order to better shape the understanding of the emerging patterns of meaning.

A third step involved initial grouping of codes, at which point candidate themes emerged from the dataset. This was initially done using the NVivo software, but as the themes were refined, additional software (Microsoft Excel Package) and manual grouping were used due to limitations within the NVivo software. The following two steps of reviewing and defining the themes were done in a fluid manner, ensuring overarching themes

were a good representation of the data. Once the themes were shaped and organised, the following stage involved the report writing.

In this approach, a reflexive stance was maintained throughout the process, with the researcher maintaining a reflexive diary, which helped inform and interpret the data providing depth to the analysis.

3.9. Positionality statement

When taking into consideration the researcher positionality, I reflected on my stance of being both an insider and outsider. As a psychologist in training, I often worked with patients suffering from depression, being involved in their care planning and treatment. This allowed me to have some familiarity with the research topic. Having worked in various mental health services across the NHS, I also reflected on the limitations of the system when accessing help, in terms of timeframes and availability of services. At the same time, I was not as familiar with the primary care environment, and more specifically the work that GPs undertake and the role that they play in the assessment and treatment of depression. On a larger scale, the reality of their work especially in the context of a stretched system was not something I had encountered prior to this research.

Within my profession, a stronger emphasis is placed on the role of psychological therapies in the care of patients presenting with depressive symptoms. This led to me placing a greater emphasis on how psychological interventions are perceived within the primary care setting, adopting by default a more positive regard when associated themes emerged from the interviews. I therefore reflected that perhaps a researcher with a different background, such as a GP, might have assigned a different meaning and focus throughout the research process. Themes around use of antidepressants, taking into account the multiple lines of treatment, and other treatment avenues would have been explored in more depth. Limitations or

preferences would have potentially been emphasised when shifting the focus on these themes. Having reflected on this in the early stages of recruitment through the use of a reflective diary, I aimed to actively try to acknowledge my positioning, while holding curiosity around the GPs' narratives. Actively identifying the assumptions that I was holding mediated the impact of my positioning, while acknowledging my individual impact and influence on the research process.

3.10. Limitations of methodology

While the methodology was chosen in close relation to the research aims and nature of the research topic, some limitations need to be taken into consideration. For the quantitative part of the study, the aim was to explore GPs' views on shared decision-making. This was achieved using self-report measures. The Option scale was adapted from an observational tool to a self-reported measure in order to allow the exploration of the research question. However, although this offered the opportunity for GPs to evaluate their practice, it might not necessarily be a clear representation of their observed practice.

For the quantitative part of the study, the choice methodology and structure of the semi-structured interview could also pose a limitation. Although the sequence of the interview guide aimed to follow the flow of a GP consultation with the view of exploring shared decision-making and patient choice at every step, it might have limited further exploration of specific areas that might have been meaningful for the GPs. However, this did not include the preparatory stages of a consultation or potential follow-up tasks or appointments. In addition, it might have obscured the overall sense of engagement in shared decision-making practices across the care of a patient which in some cases is not limited to a singular appointment.

These limitations were taken into consideration throughout the various stages of research, including when analysing, interpreting and reporting the data, as well as when discussing the results with recommendations for future research.

3.11. Ethical issues

3.11.1. Ethical approval

Ethical approval was sought prior to commencement of any data collection. Approval was initially sought from the Health Research Authority (HRA), however the decision taken as part of a committee meeting was that the study does not qualify as research, therefore university approval only was needed for the present study (Appendix B). Ethical approval was provided by the University of Essex sub-committee 1 (Appendix C). Procedures were conducted in accordance with the granted approved protocol.

3.11.2. Informed consent

For the GP survey study, a participant information form was included on the online survey, and consent had to be provided prior to commencing the questionnaire (Appendix E). The participant information form contained a description of the studies and optional participation in the interview, expected duration, confidentiality of answers, inclusion and exclusion criteria, benefits and risks of taking part, details on ethical approval and contact details for the researchers. Participants had to confirm having read and understood the participant information sheet, the voluntary nature of the study, the inclusion of their data in research and publication, and finally provide consent to participate.

For the interview part of the study, participants who expressed interest in the allocated question built into the online survey from the quantitative study were contacted via their preferred method. Their contact details were stored securely and separately from their survey answers to ensure anonymity. Participants who agreed to participate in the interview were

emailed the participant information form (Appendix F) and consent form (Appendix G), allowing time to read and consider participation. Consent was confirmed prior to the interview.

3.11.3. Confidentiality

Participants' anonymity was maintained and where identifiable data were collected as part of the online survey to either express interest in interview participation or be informed of study results, this was stored separately from the main dataset.

Although the study did not recruit patients, by the nature of the topic, further considerations had to be taken into account to ensure no potential patient-identifiable data was disclosed during the interviews. Participants were reminded that no patient-identifiable data can be disclosed at any stage during the interview and research. Where specific services or geographical locations were inadvertently mentioned in the interview, these were redacted at the point of transcription to avoid any identifiable details.

3.11.4. Data protection

Data were handled in accordance with the General Data Protection Regulation (GDPR) and in concordance with the ethical approval granted by the University of Essex subcommittee-1 (Appendix C). Survey data was stored on the Qualtrics platform and anonymised at the point of being downloaded. Contact details for interview participation were stored separately, on a password protected Microsoft Excel file on a password protected device.

The participant information forms included contact details for data protection officers at the University of Essex in accordance with the granted requirements and approval.

Similarly, recordings were also stored securely on a password protected device. Interviews were anonymised at the point of transcription with pseudonyms allocated to each participant.

3.11.5. Risk

While participation was not expected to cause any harm or distress, participant information forms acknowledged the personal and emotive nature of the research topic with further guidance to contact the researching team should the study cause any distress.

3.12. Dissemination

The study was part of the Doctoral Programme in Clinical Psychology and was therefore written up as a thesis which will be made available on the University of Essex repository.

The study was also presented at University of Essex Conference in 2024 and 2025 through poster presentation, and at a GP conference in 2025.

The aim is to disseminate the results in a journal that would be accessible to professionals delivering care in the primary care setting. It would also be important to evaluate at the time where related research is being published in order to build on existing evidence.

4. Results

4.1. Chapter overview

The results of this mixed-methods study will be presented in this chapter, summarising the findings of the two data sources: the online survey completed by GPs and the semi-structured interview with a smaller sample of GPs. The chapter will commence by describing the demographic characteristics of the survey participants. It will then cover the quantitative data analysis and main findings, followed by the qualitative data analysis summarising the four main themes identified as well as the sixteen subthemes. Key quotes from the interview that reflect the selected themes will be included.

4.2. GP survey findings

The quantitative data for this study were collected using an online survey. Of the 199 participants who have commenced the survey, 96 have completed it and were eligible.

Data cleaning was undertaken prior to the analysis stage. Out of the 199 participants who accessed the survey, 63 records were void, and a further 15 only provided consent but no further data. Incomplete answers where participants either did not reach the end of the survey or a significant number of items were missing were excluded from the analysis. Partially completed datasets that were included in the analysis are reflected in the sample size for that item (n). The eligibility criteria were checked, and 4 further participants were removed (three were GPs in training and one was not a GP). Consent was also re-checked at this point. This resulted in 96 eligible participants who were included in the analysis.

4.2.1. Survey participant characteristics

The recruitment for the online survey took place between September 2024 and November 2025.

A total of 96 GPs took part in the survey (51% male, 48% female, 0% non-binary and 1% preferred not to state their gender), with a mean age 43 years (SD = 10.2) ranging between 27 and 75 years old. The majority of respondents worked in the NHS (73%), with a much smaller representation of the private sector (3%) and GPs working across both sectors (22%). The average years of practice was 12.7 years (SD = 9.7) with a wide range (1-42) indicating an ample experience base.

The area of practice data were collected using the standard UK classification by region. However, due to the low frequency in some of the categories, these were then collapsed into North of England (North-East England, North-West England and Yorkshire and the Humber), Midlands (East Midlands and West Midlands), South of England (South-East, South-West, East of England), London, Devolved nations and Multiple/Other. While most classifications will include London in the South of England region, in this study, participants from London accounted for a largest proportion and therefore were reported separately.

The detailed breakdown of the sample is presented in Table 5 below.

Table 5

Demographic characteristics of survey participants

Participant Characteristics	Number of Participants						Total
Gender	Male N = 49	Female N = 46	Non-binary N = 0	Prefer not to say N = 1	Other N = 0		N = 96
Age	25-34 N = 17	35-44 N = 43	45-54 N = 21	55-64 N = 9	Over 65 N = 4		N = 94
Ethnicity	Asian or Asian British N = 38	Black, Black British, Caribbean or African N = 7	Mixed or multiple ethnic groups N = 6	White N = 35	Other Ethnic Group N = 6		N = 92
NHS/ Private	NHS N = 68	Private N = 3	Both N = 21				N = 94
Years in practice	0-4 N = 16	5-9 N = 22	10-14 N = 17	15-19 N = 13	20-24 N = 9	Over 25 N = 11	N = 91
Area of practice	North of England N = 24	Midlands N = 15	South of England N = 16	London N = 28	Devolved nations N = 7	Multiple N = 3	N = 93

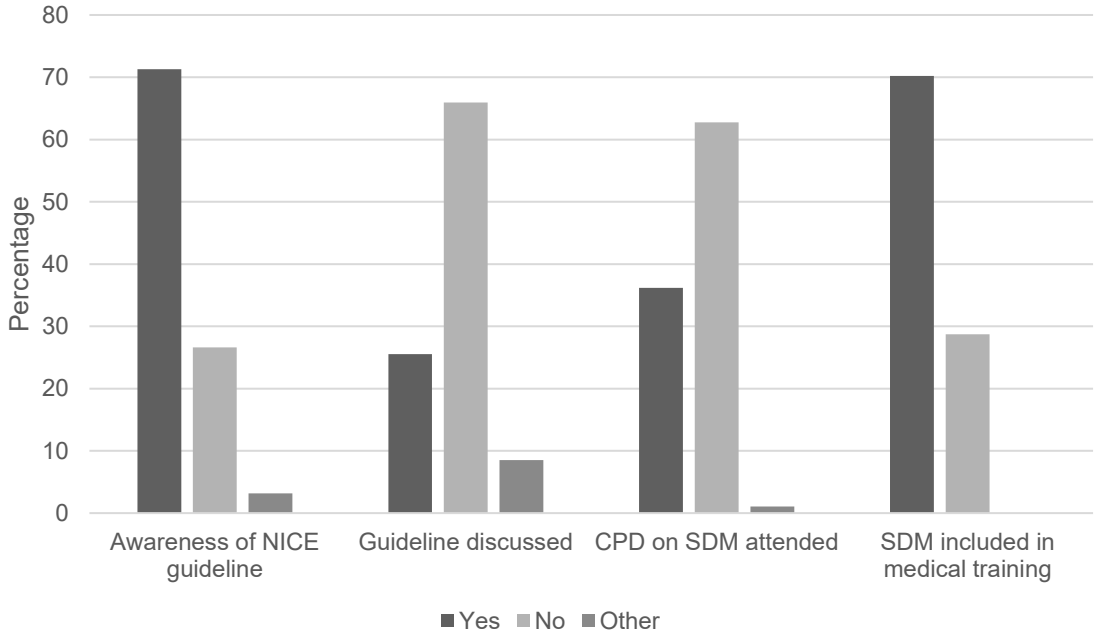
4.2.2. SDM training and background

After the initial demographic questions, participants were invited to answer a series of questions regarding their awareness of the new NICE guidelines for depression and any training received during and post their medical training, in order to better understand the context in which this guideline was received. This was linked to the first research question, aiming to explore to what extent GPs in the UK are aware of the new guideline for depression outlining the role of patient choice and shared decision-making.

Seventy-one percent of respondents reported that they had been made aware of the changes suggested in the guideline, however only 26% responded positively when asked if they had discussed making the changes in relation to shared decision making with their practice partners. In terms of shared decision-making, most participants (71%) said that they received specific training during their medical training, with a smaller percentage having undertaken shared decision-making specific CPD post-qualification (37%).

Figure 4

Training and awareness of NICE guideline



Note. These results are based on a total of 94 participant responses.

Participants were then invited to rate their confidence in using shared decision-making in practice with patients with depression from 0 to 100, where zero represents not being confident at all and 100 being extremely confident and the results are presented in Table 6 below.

Table 6

Confidence in using SDM in depression

	N	Mean	Range	SD
Understanding	94	85.73	26-100	13.85
Applying	94	82.5	21-100	15.91
Effectiveness	94	78.03	15-100	18.38

4.2.3. SDM measures

The SDM-Q-Doc aimed to explore the GPs' self-reported shared decision-making practice (SDM-Q-Doc; Scholl et al., 2012). The total scores ranged from 35 to 54, with an overall mean score of 45.69 (SD = 4.77).

The adapted Option scale was completed twice, firstly focusing on the self-reported experience of employing shared decision-making in practice and secondly on the perceived importance. The overall mean score for the adapted Option scale was 39.09 when rating their experience (SD = 5.64) and 38.90 when rating the importance (SD = 5.51).

Six participants were excluded from the analysis using listwise deletion due to missing data points (between one to three items were missing per participant) in their completed questionnaires, resulting in 88 complete responses included in the analysis below. Replacing the missing values with a mean score was considered but ultimately not used in

order to avoid distortion in distribution (Field, 2024, p. 252). Missing values were minimal and did not follow a pattern, most likely indicating data entry error in missing a response.

A minor negative skew was noticed in all three scales, but more pronounced in the Option scale therefore the median scores were also taken into consideration (Field, 2024).

All measures were assessed for internal consistency using Cronbach's alpha, which revealed good reliability for the SDM-Q-Doc scale (α = .824), Option scale – experience (α = .883) and Option scale – importance (α = .878).

In order to check the normality of the scales, the Shapiro-Wilk test was used, which is the accepted test to assess for normality in sample sizes under 2000 participants (Razali & Wah, 2011). The results assumed normality for the SDM-Q-Doc questionnaire (W = .974, p = .66), but not for the Option scale – experience (W = .969, p = .031) or Option scale – importance (W = .969, p = .029). With two of the scales deviating from normality, non-parametric tests were used for the analysis.

Table 7

Descriptions for SDM Measures

	N	M	Range	SD	Skew (SE)	Cronbach's α	S-W test	p-value
SDM-Q-Doc	88	45.69	35-54	4.77	-0.02 (0.25)	.824	.974	.66
Option Scale – Experience	88	39.09	22-48	5.64	-0.25 (0.25)	.883	.969	.031
Option Scale – Importance	88	38.90	23-48	5.51	-0.30 (0.25)	.878	.969	.029

Note. The assumption of normality was violated by all variables.

4.2.4. SDM measures association

Associations between the shared decision-making measures were undertaken using Spearman's rank order, considering that normality could not be assumed for the Option scales.

A significant positive association was observed between the scales, and the full correlation coefficients of Spearman's rank order are presented in Table 8.

Associations between shared decision-making measures and years of experience were also examined using Spearman's rank-order correlations. Overall, there were no significant associations observed between years of experience and SDM-Q-Doc ($r_s = -.11$, $p = .318$), Option – experience ($r_s = .14$, $p = .187$), or Option – importance ($r_s = .08$, $p = .466$).

Table 8

Correlation Coefficients between variables

Variable		SDM practice	*SDM Experience*	*SDM Importance*
SDM Practice	r_s	1.000	.62	.45
	p	< .001	< .001	< .001
SDM Experience	r_s	.62	1.000	.56
	p	< .001	< .001	< .001
SDM Importance	r_s	.45	.56	1.000
	p	< .001	< .001	< .001
Years of practice	r_s	-.11	.14	.08
	p	.318	.187	.466

Note. All tests are two-tailed.

4.2.5. Group differences

In order to examine the difference between the shared decision-making questionnaires and prior knowledge of shared decision-making gathered during medical training a, series of Mann-Whitney U tests were conducted. This analysis was conducted in order to address the

second research question aiming to explore if self-reported experience, practice and perceived importance of shared decision-making is associated with previous training. The results indicated no significant differences between groups for the SDM-Q-Doc (U = 850.50, z = −0.45, p = .651), Option-experience (U = 890.50, z = −0.12, p = .907), or Option-importance scores (U = 860.00, z = −0.37, p = .709). All the tests that were performed were two-tailed.

Similarly, Mann–Whitney U tests were conducted to explore the difference between the shared decision-making scores and completion of shared decision-making specific CPD. There was no significant difference found for SDM-Q-Doc scores (U = 856.00, z = −1.38, p = .166). However, significant differences were observed for both Option-experience (U = 693.00, z = −2.66, p = .008) and Option-importance (U = 685.00, z = −2.73, p = .006), indicating higher scores among participants who had completed shared decision-making related CPD after finishing the medical training. Group differences are presented in Table 9.

Table 9

Group Differences

Category		N	*U*	*z*	*p*
Medical Training	SDM Practice	94	850.50	-0.45	.651
	SDM Experience	94	890.50	-0.12	.907
	SDM Importance	94	860.00	-0.37	.709
CPD	SDM Practice	94	856.00	-1.38	.166
	SDM Experience	94	693.00	-2.66	.008
	SDM Importance	94	685.00	-2.73	.006

Area of practice (NHS, private or both) and shared decision-making scores were explored using Kruskal-Wallis H tests. The analysis revealed that no significant differences

were observed between groups for SDM-Q-Doc (H(2) = 1.36, p = .506), Option-experience scores (H(2) = 0.41, p = .815), or Option-Importance scores (H(2) = 0.63, p = .731).

4.3. Interview study findings

4.3.1. Demographic characteristics

Thirteen GPs took part in the one-to-one interview. Their demographic characteristics are presented in Table 10 below. To maintain anonymity, pseudonyms were used and only key demographic characteristics are presented.

Table 10

Interview Participant Demographic Information

Participant Pseudonym	Age	Gender	Ethnicity	NHS/Private	Years of Practice	Area of Practice
Arun	42	Male	British-Sri Lankan	Both	17	London
Meena	51	Female	British Asian	NHS	27	Midlands
Sanjay	36	Male	British Asian, South Asian, Indian	NHS	6	London
Alex	39	Male	White British	NHS	11	Midlands
Louis	46	Male	White British	NHS	23	North of England
Amina	46	Female	Asian	NHS	19	London
Michael	45	Male	White	NHS	18	Midlands
Samuel	34	Male	Black African	NHS	2	Midlands
Simon	36	Male	White British	NHS	1	North of England
Catherina	64	Female	White British	NHS	19	London
Yasmin	38	Female	Egyptian	NHS	4	North of England
Lucie	35	Female	White British	NHS	2	South of England
Thomas	39	Male	White British	NHS	6	South of England

4.3.2. Reflexive thematic analysis

The interviews were analysed using a Reflexive Thematic Analysis (Braun & Clarke, 2021) with the view of identifying practical barriers in implementing the NICE guideline for depression in practice encountered by GPs, building on the previous quantitative results presented earlier in this chapter.

Initial data familiarisation was undertaken by listening to the interviews and reviewing the transcripts to allow immersion into the dataset. The initial coding phase focused on capturing patterns across the data and resulted in approximately 430 codes. Conceptually overlapping codes were reviewed for common meaning with a reflexive lens and where appropriate collapsed into a single code (for example, “Trust” and “Building Trust”, or “Continuity” and “Continuity of care in primary care”, or “Patient treatment preference – therapy” and “Patient preferring therapy”). This process was led by an analytic judgement and interpretation of meaning, rather than a structured approach towards homogeneity.

Overall themes and subthemes

Four themes and 16 sub-themes emerged from the analysis underpinning the direct barriers that GPs face in implementing the NICE guideline, and they are presented in Table 11 below. Although the barriers were structured into separate themes, the interrelatedness was noticed throughout the analysis process.

Table 11

Overall themes and subthemes

Theme	Subtheme
"Very hard to do any shared decision, anything in 10 minutes": Time constraints affecting meaningful guideline implementation.	Working within short appointment times Managing the invisible labour of a consultation Risk management within an already unrealistic timeframe Working overtime to make care possible
"So it's just the time and the sensitivity of the conversation, I think, is the difference, really.": Complexity of treating depression requiring continuity and sensitivity.	Treating depression is a long-term process Revolving door nature of treating depression Relying on follow ups to make care possible Building trust in order to reach the sensitivity of treating depression
"We kind of got a one-size-fits-all": Understanding the guideline in the context of system limitations.	Recommended options not available limiting SDM Long waiting times as a barrier to care Mental health services operating beyond capacity Gaps in services preventing patient choice
"It's hard. It depends on the patient": Shared decision-making requiring cultural and clinical adaptations in practice.	Patients preferring GP's guidance Supporting patient with the weight of decision-making Antidepressants still preferred by patients and seen as a quick fix Needing to negotiate divergent views on treatment

The table below reflects the participants' contribution towards each theme and subtheme. While reflective thematic analysis focuses on the patterns of shared meaning emerging from the data rather than prevalence of themes, this table aims to provide an overall sense of each participant's engagement with the themes identified (Braun & Clarke, 2023).

Table 12

Participant contribution to subthemes

Subtheme	Participants
Theme 1: Time constraints affecting meaningful guideline implementation.	
Working within short appointment times	Alex, Amina, Arun, Catherine, Louis, Lucie, Meena, Michael, Samuel, Sanjay, Simon, Thomas, Yasmin
Managing the invisible labour of a consultation	Alex, Amina, Arun, Catherine, Louis, Lucie, Meena, Michael, Sanjay, Simon, Thomas, Yasmin
Risk management within an already unrealistic timeframe	Alex, Amina, Arun, Catherine, Louis, Lucie, Meena, Michael, Samuel, Sanjay, Simon, Thomas, Yasmin
Working overtime to make care possible	Amina, Arun, Louis, Lucie, Meena, Michael, Sanjay, Simon, Thomas
Theme 2: Complexity of treating depression requiring continuity and sensitivity.	
Treating depression is a long-term process	Amina, Catherine, Louis, Lucie, Meena, Samuel, Sanjay, Thomas, Yasmin
Revolving door nature of treating depression	Alex, Amina, Catherine, Louis, Lucie, Meena, Samuel, Simon, Thomas, Yasmin
Relying on follow ups to make care possible	Alex, Amina, Catherine, Louis, Lucie, Meena, Michael, Samuel, Simon, Thomas, Yasmin
Building trust in order to reach the sensitivity of treating depression	Alex, Amina, Arun, Catherine, Louis, Lucie, Meena, Michael, Samuel, Sanjay, Simon, Thomas, Yasmin
Theme 3: Understanding the guideline in the context of system limitations.	
Recommended options not available limiting SDM	Alex, Amina, Arun, Catherine, Louis, Lucie, Meena, Michael, Samuel, Sanjay, Simon, Thomas, Yasmin
Long waiting times as a barrier to care	Alex, Amina, Arun, Catherine, Louis, Lucie, Meena, Michael, Samuel, Sanjay, Simon, Thomas, Yasmin

Subtheme	Participants
Mental health services operating beyond capacity	Alex, Amina, Arun, Catherine, Louis, Lucie, Meena, Michael, Samuel, Sanjay, Simon, Thomas, Yasmin
Gaps in services preventing patient choice	Alex, Amina, Arun, Catherine, Louis, Lucie, Meena, Michael, Samuel, Sanjay, Simon, Thomas, Yasmin
Theme 4: Shared decision-making requiring cultural and clinical adaptations in practice.	
Patients preferring GP's guidance	Amina, Louis, Lucie, Meena, Michael, Sanjay, Simon, Thomas
Supporting patient with the weight of decision-making	Amina, Catherine, Louis, Meena, Michael, Simon, Thomas
Antidepressants still preferred by patients and seen as a quick fix	Alex, Amina, Arun, Catherine, Louis, Lucie, Samuel, Sanjay, Simon
Needing to negotiate divergent views on treatment	Amina, Arun, Catherine, Louis, Lucie, Samuel, Sanjay, Simon, Yasmin

Theme One: 'Very hard to do any shared decision, anything in 10 minutes': Time constraints affecting meaningful guideline implementation.

This initial theme reflects the impact of time pressure shaping GP practices and describes a range of different ways time is limited for GPs in practice, which leads to practices recommended in guidelines being de-prioritised. This structural constraint was described by participants through how their consultation time is limited not only by the short appointment time dictated by their respective practice, but also by the administrative and logistical work that needs to take place within the same appointment and the added complexity of risk management.

The time pressure is therefore not only a fundamental constraint in applying the guideline in practice, but also the context in which all other barriers need to be framed and understood.

Working within short appointment times

Participants consistently described time limitations as a barrier to a meaningful implementation of the guideline with GPs speaking about how the 10- or 15-minute appointments (varying from practice to practice) can be a barrier in conducting a thorough consultation, especially in the context of exploring and treating depression.

Some GPs reflected on the discrepancy between what can realistically be achieved in an appointment, versus what they would ideally want to achieve:

"And I think most of us really know what we should be doing and we just don't, can't do it, haven't got time to do it. That's all." (Amina)

> So yeah. so it's, the shared decision making isn't very hard in one way. It's the amount of time you've got to do all of that assessment, you know, the NICE guidance, you read the NICE guidance, it'd probably take you as long as a whole consultation to just read it. (Louis)

This reflects that while they are well informed and aware of what is recommended, the reality of the structural barriers that they encounter prevents a meaningful implementation. Meena noted that the 10-minute appointment times would be challenging even for some other medical professionals, sharing her firsthand experience of changing specialities:

"I came from hospital medicine where I could have as long as I wanted. I usually had 30, 40, 60 minutes with a patient. And so to go from that to 10 minutes was just such a culture change." (Meena)

Alongside the systemic issue of short appointment times, GPs commented on how the time limits particularly impact appointments for patients presenting with depression which require more depth, exploration and trust building:

“And I think the, it's challenging to I would say that I can do a half decent straightforward depression consultation in 14 minutes.” (Catherine)

This emphasises that while some GPs agreed that it is possible to fit everything into a 10-minute appointment, sometimes the consultation might not reach the desired depth, and to the standard laid out in the guideline that they are aware of.

Attempts to request longer appointments are not always allowed and can be vastly practice-specific, as Amina highlighted:

> But because of demand capacity problems, if I ask my practice manager to give me an extra 10 minutes because this person, this person's really complicated, they always cry, they're often very suicidal or whatever. I know, I have a few people that will take up a lot of my time. If I said, can I book 20? If they just look at me like, are you mad? It's not going to happen. (Amina)

These accounts illustrate how the short appointment times form a structural problem that GPs face in primary care, with the added complexity of a lack of control to challenge and change the system, with administrators and managers preventing the changes that should be taking place. As a consequence, this is limiting the depth to which shared decision-making can be employed.

Managing the invisible labour of a consultation

The overarching theme of time pressures is not only defined by the physical time imposed by practices for each appointment, but also the invisible labour attached to each consultation that GPs undertake. The participants shared their experience of navigating the system through liaison work with mental health services, referrals and bounced back referrals, on top of the required administrative responsibilities, all of which need to ideally take place within the allocated time. In return, this will limit even more the consultation time.

> So, we have to get everything done. And unfortunately, it would be lovely to sit down and have an hour with them and go through everything. But we don't have that time. By the time they've answered and we've written up notes and things, we might have 5 minutes of actual conversation. (Thomas)

This reflects not only the time-consuming nature of additional administrative tasks but also emphasises that these need to take place at the expense of clinical time, which is already limited. In addition to liaison work and getting advice on a case, navigating the referral system was also defined as a laborious process.

In some cases, participants noticed how the investment put into the liaison work that would ideally ensure a smooth transition for the patient does not yield the expected results with some services being very hard to reach.

> And I would tend to... I try to call and hand over, but the truth is often you can't get through to anybody. You're calling, calling, you're bleeping. And I've got a clinic full of patients and I can't sit there. I don't have the benefit of it. (Amina)

"Clinic full of people. So if I have to start making secondary and, secondary phone calls […] Again, the difficulty with that is you could be sat on hold for 15 minutes just waiting to speak to them." (Thomas)

As highlighted by Thomas, the lack of liaison work or miscommunication with services deprives GPs from the opportunity to express their professional opinion in making and supporting that referral and is impacting not just the patient in front of them, but also the other patients for whom they hold the duty of care.

The other end of this issue presented by GPs are bounced back referrals, which is augmented by the limited liaison time.

“And then we get letters bouncing back again saying she's not feeling, she's not fulfilling the criteria.” (Yasmin)

“He'd been discharged by the mental health services. […] It's a matter of weeks, possibly months beforehand. I think for non-engagement. So what are we supposed to do?” (Catherine)

This reflects how the lack of a thorough liaison and handover can become at times the leading cause for unsuccessful referrals, that are then defaulted back to GPs in order to bridge the gap in services.

This phenomenon was well described by Louis who explained that referring back to the GP is metaphorically associated with a ‘wild card’ that each healthcare professional gets upon starting their career.

“We joke that, you know, when every healthcare professional qualifies, they get a special card that says, flip this card when you don't know what to do. And it just says, tell the patient to see the GP.” (Louis)

These accounts position the invisible and unpredictable labour that GPs face as a further time limiting barrier and pressure imposed by the system.

Risk management within an already unrealistic timeframe

In addition to the invisible labour experienced by GPs, risk management while a normal component of each appointment has the potential to shift the focus of a patient interaction altogether, further compressing the limited appointment time. When the complexities of treating depression come into play, instances where risk is identified will result in prioritising crisis management, steering away from the desired guideline-informed care.

“And all this time you're running late because you're trying to help someone who you think is a suicide risk.” (Thomas)

As Thomas highlighted, risk management can extend far beyond the allocated appointment time and shift an entire clinic. External support in these situations can be slow and difficult to reach.

“Again, the difficulty with that is you could be sat on hold for 15 minutes just waiting to speak to them.” (Amina)

“So it was a really complex, horrible case, but trying to get support in an emergency was just impossible. Ambulances weren't interested.” (Alex)

As Amina described, sometimes the attempts to contact emergency or crisis services could exceed the time of an appointment or be unsuccessful altogether. Even when persisting and getting through, in some instances, help can be limited as described by Catherine and Lucie.

“He was discharged to GP through non-engagement. Well, what am I supposed to do about that? […] I mean, I don't know what the answer is, but discharging to GP is definitely not the answer.” (Catherine)

“And arguably, I mean, general practice is not set up to be an emergency service. I do think that we're often in the severe patients, left carrying quite a lot of risk.” (Lucie)

With the wider system limitations rendering crisis and emergency services unable to support the patients, they are being defaulted back to primary care. General Practitioners are then left carrying a significant amount of risk within an already stretched timeframe.

“Unfortunately, with a lot of these consultations, GPs have to look after themselves as well, because we need to make sure that we make the right decision to protect our careers. And, you know, I think that gets overlooked.” (Amina)

“We need to protect ourselves and our clinics.” (Thomas)

As Amina and Thomas shared, GPs are forced into a very difficult position, having to defend their professional integrity. Considering patient safety within the structural limitation of time, guideline implementation is superseded by the complexities of managing risk.

Working overtime to make care possible

Within these existing and accepted time constraints, participants spoke about how often the only way to make guideline-informed care possible is by working overtime. Some GPs spoke about having to conduct these longer appointments at their own expense beyond the contracted hours, working overtime and giving up their breaks. Some participants spoke about planning their clinic strategically, already expecting these appointments to take longer.

“So I tend to book them at the end of my […] surgery. So it doesn't matter if I overrun, it's only me, my lunch break that's affected.” (Amina)

“And we do that, but that's in our lunch break, that's after work.” (Arun)

Working overtime is therefore normalised, expected and not an isolated event. In some cases, GPs have to conduct a whole clinic during their day off, as exemplified by Simon below, in order to compensate for long mental health appointments and required follow-ups.

“So say today I'm not actually at work today, but I've got I've got a 14-patient clinic of telephone calls that I've arranged for reviews because I didn't have time during my normal working week to review them. So I'm just doing that from home...” (Simon)

“I have to see them weekly other way, you know, and we do that, but that's in our lunch break, that's after work.” (Arun)

Therefore, the reality of being able to deliver care to the standard expected by GPs and guidelines comes at a great expense, not only in their professional lives but also personal lives, as described by Amina:

“It's very hard to find that, strike that medium of being really happy at work and really happy at home.” (Amina)

The personal sacrifice made by GPs is ultimately the only avenue left in a rigid system, in order to allow them to deliver the care that they desire for their patients.

“And if it needed a little bit longer, well, then you run late. But you run late being satisfied knowing that you've made the impact that you wanted to make rather than stuck to a clock.” (Michael)

The personal sacrifice made by GPs is ultimately the only avenue left when working in a rigid system, in order to allow them to deliver the care that they desire for their patients, aligned with the recommended guidelines.

From a wider perspective, these subthemes define the barrier of time, limiting a more thorough implementation of the NICE guideline through short appointment times, with the added cost of the invisible labour and unaccounted for risk management, that is only compensated through the individual sacrifice of working extended hours.

Theme Two: ‘So it's just the time and the sensitivity of the conversation, I think, is the difference, really.’: Complexity of treating depression requiring continuity and sensitivity

The second theme approaches the specific complexities of treating depression as a barrier to guideline implementation. While at points it will resurface barriers covered in the first theme, the objective remains to highlight the difficulties encountered, specifically when treating patients presenting with depression, some of which would not be reconciled even with a longer appointment time.

Treating depression is a long-term process

Participants spoke about depression not being a one-off appointment, but requiring a process of actively trialling treatment options, monitoring and reviewing, often over a long period of time. This sub-theme aims to elaborate on how depression is a particularly complex diagnosis to treat.

“Yeah, but that's the same with all the GP encounters. And sometimes you can fix stuff for them quite quickly... With mental health, it's a bit different. Yeah, it's challenging.” (Louis)

As highlighted by Louis, upon a direct comparison to other presentations seen in primary care, treating depression is inherently more complex to treat, with no expectation of a quick fix. Amina reflected that in some cases, this can take years.

“And then sometimes you look back and you think, oh my God, this person's been depressed for like 15 years on and off. And that's the nature of it.” (Amina)

This emphasises the chronicity and extended care needed for these patients. The extra layer mentioned by participants is exploring and understanding depression in the context of wider life events:

“No amount of Sertraline is going to treat that.” (Sanjay)

> And actually, when you get into it, turns out that they've recently been bereaved, or they've had a relationship breakdown, or they've lost their job, or they hate their job, or they've got a lot of family illness and huge amounts of competing priorities in their life. (Lucie)

Among many examples of financial stressors, family concern, bereavements, and employment difficulties, participants emphasised the vast context in which some patients might experience depression. And while Sanjay's quote focuses specifically on antidepressants, it shows a wider issue of trying to distil the treatment of depression into a categorical and defined option.

While the guideline can be seen as implying a standardisable decision, the participants often spoke about the imperative need for individualised care.

"It's not like a blood pressure algorithm where it's you start this medication, then it's this one, then it's this one. I see depression and mental health as being much more individualized." (Thomas)

> And this is where over protocolizing it can be kind of like counterproductive and experience. And the operator, the clinician's intuition on the backdrop of, a structured kind of approach is necessary. If you try and over protocolize it all, then people feel like they've been dealt with like they're a machine. (Louis)

These quotes clearly reflect that in some instances the assumption of prompt deliberation and decision-making when it comes to the complex care of depression is not the reality that GPs find through their experience.

"It's the end of the consultation is not the end of the story." (Catherine)

In Catherine's words, the treatment can transcend the boundaries of a single appointment. Therefore, in the context of the recommended guideline, this barrier speaks about the reality of a fluid, complex and ongoing process, rather than a discrete choice.

Revolving door nature of treating depression

With the understanding that depression is inherently complex to treat, one phenomenon described by participants was around patients returning to them even after having contact with mental health services and thus going through multiple cycles of care.

"It's like a revolving door and you don't get anywhere." (Meena)

"They need to be handheld for weeks, months, years and times where it'll get better for a bit and then it will get worse for a bit." (Amina)

These accounts position once again the GPs as the default provider of care and the point of return upon unsuccessful episodes of care or increased need. With each cycle, there was a sense that patient choice becomes more and more limited.

"But a lot of those patients are multiple attendances, have tried multiple medications, have tried therapy on a number of occasions, have suffered with recurrent depressive episodes for 10, 20, 40, 50, 60 years." (Simon)

"Now, in some cases, patients who have had long-standing mental health issues, they've been on different antidepressants, they've stopped them, they've come back again." (Samuel)

The narrowing of treatment paths is perceived not only by patients, but also by GPs who inherit the care co-ordination responsibility. They are often faced with a limited arsenal after multiple cycles of care.

"Like some people like already tried the talking therapy, already tried the CBT." (Yasmin)

> Although if somebody says that a particular tablet didn't work before, then I would be unlikely to try that again, partly because I do have others. But I can be in control of that. I can't be in control of the talking therapies. (Catherine)

These accounts highlight that this phenomenon significantly reduces the amount of choice that can be offered or accepted by the patient.

One area identified by GPs that does offer more choice at this point is medication, with antidepressants being quoted as widely available and immediately accessible.

"I think the medication wise, because we're very comfortable with the range of medications we can offer, we're quite comfortable, if Sertraline doesn't work, we can get Mirtazapine." (Arun)

"So that's where a doctor can make a decision to say, you know, let's try an alternative antidepressant." (Michael)

Therefore, while GPs would strive to continue offering the guideline informed therapy-based choice, they might reach a point after multiple cycles of care of having the options reduced to medication.

Relying on follow ups to make care possible

In the wider context describing the complexities of treating depression as an important factor in understanding limitations of guideline implementation, the sub-theme of follow-up appointments emerged from the presented narratives. Participants spoke about the necessity to review plans, allow deliberation time and monitor the patient beyond the remit of a single appointment.

Depression treatment was often described as a multi-stage process rather than a single-point decision approach.

“So, we usually have an initial appointment doing that sort of thing, and then I'd bring them back to discuss where they want to go next.” (Lucie)

“It's not a one hit consultation. You never explore everything in one go.” (Alex)

Participants described a sense of normality in providing depression care over several appointments, due to the multiple areas that need to be covered as part of the treatment.

“I say we can talk a little bit about one of them now and start some treatment and I can call you back in a week or a few days to follow the urgency and talk about some of the others if you want to.” (Simon)

“So for that patient, you're going to spend more time, and you may not have the time to talk through all the different therapies. That might have to be a second consultation.” (Louis)

This indicates that subsequent appointments are needed to allow time to understand where the patient is coming from, but also to trial the various lines of treatment. An initial appointment may therefore appear incomplete or not fully in concordance to the guidelines just because of the complexity of depression treatment, with further consultations solidifying the shared decision element and use of the recommended treatment options.

Participants also highlighted the challenges of presenting therapy as an option.

“But then that requires several consultations of getting the patient on board and agreeing that talking therapy is the way forward.” (Amina)

“I'll send you a link to the talking therapies, have a think about it and get back to us.” (Catherine)

As described by Amina and Catherine, as well as the previous accounts, the complexity of treating depression requires a systematic approach and not a single consultation and treatment pathway, even more so when it comes to discussing therapy.

GPs also spoke about the practicalities of ensuring continuity of care by having patients book a follow-up appointment with them:

"When are we going to see you again? How are we going to follow this up? And how am I going to know that you're not going to get lost to follow up? and maybe booking in those appointments." (Alex)

"But the duty is for you to review there from time to time… the duty of you is to see him again, to make sure things are getting better." (Samuel)

The pressure to materialise these follow-ups falls once again on GPs, often in a system that is not built to enable that. This emphasises how important the follow-up appointment is as part of depression care.

Taken together, these accounts speak on the complexity of treating depression and considering the many lines of treatment, with no expectation to be completed in a unique 10- or 15- minute appointment, requiring more guidance at times based on the GPs expertise.

Building trust in order to reach the sensitivity of treating depression

The final sub-theme reflecting the intricacy of treating depression steers away from some of the systemic barriers presented in the previous sub-themes and brings in the relational element of care. Building trust was described by GPs as the key factor in approaching the sensitivity and complexity of treating depression.

"No medication, no talking therapy, just building trust between me and the patients." (Samuel)

"Sometimes it's about building trust and seeing if you can meet them where they are." (Sanjay)

These accounts introduce trust as a prerequisite in the treatment of depression and a solid ground for subsequent guideline implementation. Linking in with the previous sub-theme, it is within that longer sequential appointment structure that trust is developed.

> I try not to say no. Not because I'm going to give them the prescription, but more as a, I see that that's what you want. And I hear you that you're looking for that prescription. Let's have a think about that. (Lucie)

This reflects how trust can mediate the shared decision-making process, especially when further advice and guidance are needed. Furthermore, the trust-building process is seen as an investment for future consultations:

“When we came to you that time, you really helped with that, whatever it was. And so they will come back to us in a trust kind of way.” (Meena)

With this example, the understanding that trust is a cumulative process is shaped. Some participants reflected on the fact that some cultures might need more sensitivity, if they are more familiar with a paternalistic approach, where trust emerges from a prescriptive guidance:

“And I don't know if that's cultural or whether that's just continuity of care. And they just know us so well that they've built up this trust.” (Meena)

This reflects that gaining that faith from patients might differ and GPs will make the extra step in order to ensure the element of shared decision-making is employed.

In the absence of trust, some participants noted that patients might turn to other sources they might value more.

“But you have to have a relationship with them for them to trust you. Otherwise, they will trust their Facebook friend more than you.” (Meena)

More interestingly, trust was also defined as a two-way street, which perhaps reinforced that element of importance of trust in GPs.

“I would give him two weeks and I'll see him again pretty soon to make sure that as time goes on, the risk is less. We can build a trust and I can give him much longer ones.” (Samuel)

“Part of sort of helping navigate people with treatment is sometimes seeing them serially to gain their trust that the system can work for them sometimes.” (Sanjay)

Therefore, building trust was recognised as a laborious but necessary step in the complex assessment and treatment of depression, shaping the shared decision-making element of the guideline. The consequence of not reaching it is a mechanical exchange of options and potentially non-engagement, in addition to limited guideline implementation.

Theme Three: ‘We kind of got a one-size-fits-all’: Understanding the guideline in the context of system limitations

The third theme introduces some barriers to a fuller implementation of the guideline caused by limitations imposed specifically by the system. These range from lack of options in practice, long waiting times for therapy, stretched mental health services and gaps in services encompassing options that are altogether not available.

Recommended options not available limiting SDM

Although the guidelines suggest a wide variety of evidence-based treatment options, such as various therapy modalities, pharmacological options and lifestyle changes, participants spoke about the scarcity of these options in practice and the consequences of limited choice.

“In reality, that limits the ability for us to give a real choice because the options just aren't available.” (Alex)

“They don't ever think about the fact that we, that we may wish to refer, but they may not be services that we can refer to.” (Catherine)

“We kind of got a one-size-fits-all, I think, as a problem.” (Sanjay)

As captured by Alex and Catherine, the unavailability of choice constrains the GPs’ abilities for a fuller guideline implementation, with a much more limited ‘one-size-fits-all’ offer at the point of making the referrals or signposting.

One area where the mismatch between guideline recommendations and the actual offer encountered in practice is psychological therapies. Participants spoke about CBT being the most common therapy they can offer, with very limited availability of family therapy, counselling, trauma therapy and other modalities.

“Most of the provision of therapy in the area that I work in is CBT focused.” (Lucie)

“Being able to access what patients really need is actually quite difficult.” (Alex)

Therefore, while the intention is to practice shared decision-making and make use of the recommended options when it comes to therapy, GPs recognised that they are met with limited choice. As a result, the wide availability of CBT can offer the illusion of therapy as an option, although at times it might not be what the patient needs or their preferred option.

Participants emphasised that the system barriers will also limit their professional autonomy, being unable to ask for specific modalities due to the way that services are built.

> But if you contact, if we were to make a referral, there's no option to say, I think as a GP that family therapy did the right thing for this person. Instead, what I have to do is send them into a single point of access. (Alex)

“It's challenging for the patient to choose because we don't give them the informed choices because we don't know… what these therapies, what these services are going to provide them...” (Yasmin)

This indicates that GPs feel devalued in their professional expertise, and while they possess the experience and have heard first-hand the patient’s preference, they are unable to materialise it.

In the absence of therapy options being available within the NHS, private care seems like a more sought-after alternative, but this is limited by their income and abilities to fund it.

“The private sector will often give some form of counselling, but there's a payment towards that.” (Alex)

“I think the NHS used to say you cannot recommend anyone, but we're like, we're desperate, we need to send them somewhere. And if patients are willing to pay…” (Arun)

This indicates that while private therapy could be an option for some and offer more choice, it is very much conditioned by the patients’ ability to fund it, and not a feasible option for everyone. It also speaks of the GPs’ ambivalence on even suggesting it to patients, due to the recognised financial barrier.

In addition to the scarcity of therapy options, the lifestyle changes and social arm of treatment also faced limitations. While being recognised as a harder change to implement, participants spoke about it being dependent on local provision, which can be variable from practice to practice and over time.

> I think it's difficult at the moment with there's so much underfunding of like social things and, really big socio-economic issues that present with symptoms of depression that you think yes, this person has symptoms of depression, but is the treatment that I have for them

> going to help it? Because their life is such that actually these huge factors that are impacting on their emotional well-being are not going away. (Lucie)

This reveals that while the lifestyle interventions are on the GPs' radars, the limited implementation stems from yet another system barrier, leading to the patients' needs not being materialised.

In the absence of access to the suggested options, the one option that is readily available and accessible on the same day is antidepressant medication.

> They say, GPs are trying to medicate the whole population or sedate the whole population. They don't ever think about the fact that we, that we may wish to refer, but they may not be services that we can refer to. (Catherine)

"Thinking about antidepressant medication as a result of those things, rather than necessarily because they don't have a different kind of therapy." (Lucie)

This indicates that antidepressants can subtly become the default alternative in the lack of other accessible options despite multiple attempts to pursue the guideline.

This struggle in offering choice resulted in participants wondering about the feasibility of the guideline in practice, which is very much contingent on system provision and funding.

"And will the shared plan actually meet their needs when you consider what services are really available?" (Catherine)

"I think a lot of these guidelines, as I said before, are just fantasy. It would be lovely to have. In practice, it doesn't work." (Louis)

Across these accounts, shared decision-making emerged as a desirable and sought-after modality of reaching a treatment path, but was inhibited by the barriers posed by the system through a lack of recommended options.

Long waiting times as a barrier to care

While the guideline describes the recommended treatment options that should be delivered in a timely manner, participants named the delay that they have faced when it comes to accessing help, more specifically, psychological therapies.

Therefore, the issue of delayed treatment is not just an inconvenience but a barrier for patients in accessing support and for GPs in delivering care. Participants spoke about patients having to wait months in order to be seen by service providers and start therapy.

"And so you kind of figure out what are the loose interventions about what could be done at that point, because you know everything's going to take months to work or be available, if available at all." (Sanjay)

This once again can produce the illusion that help is available, when in reality, therapy can be clinically irrelevant by the time patients reach the top of the waiting list.

> So say the depressive episode might last for 8 weeks, say, well, if the IAPT waiting list is 16 to 20 weeks, which it is in the area at the moment, that first episode of the person just feels let down by the service. (Simon)

> And I think of the people who engage, about half will drop out. Right. And I think they drop out for various reasons. Number one is talkworks are very busy. So they'll say, we'll give you a telephone appointment for an hour in a month. (Thomas)

The key observation that Simon made highlights that, in some cases, help might arrive too late, which could also increase the number of dropouts as noticed by Thomas.

Anticipating this, GPs might resort once again to some readily available options as described in the previous sub-theme, such as suggesting private care or antidepressant medication.

“Start them on medications when if you, if there was an appointment in two weeks for a counsellor, I perhaps wouldn't have chosen medication.” (Samuel)

“If I give them, it's 8 weeks or 16 weeks, they're like, is there a private option?” (Arun)

This undermines the element of shared decision-making by being unable to deliver what the patient might wish to receive. It also undermines the GPs’ ability to engage the patient meaningfully in a conversation about what treatment should and could look like.

“It's challenging for the patient to choose because we don't give them the informed choices because we don't know when they are going to be seen.” (Yasmin)

Yasmin’s reflection also speaks on the moral distress that GPs experience upon realising that the care that they might wish to deliver is not available.

Taking all of these accounts into consideration, the narrative that emerges is that the long waiting times for therapy become an obstacle in accessing help and care, contrary to what the guideline highlights as recommended treatment.

Mental health services operating beyond capacity

In addition to the previous sub-theme addressing the impact of the long waiting times for therapy, participants expressed wanting to deliver guideline-informed care, but having a limited mental health system around them. At some points, accessing mental health services can feel next to impossible, especially for a specific presentation:

> And I guess secondary care, mental health services are so stretched that I feel that they basically are only able to take on people who have catatonic depression or have tried to

> take their life and require admission or are psychotic and not actually within the kind of depression category at all. (Lucie)

"They normally take on patients who they're already under their care previously, so they know of." (Arun)

Lucie's and Arun's accounts highlight that while the options exist in theory, they might only be available in severe cases of depression or patients who are already known to services. Choice is much more limited when it comes to mild or moderate cases or new presentations, with the specialist level of care no longer available for them. But the difficulty in accessing help also stretches to crisis or urgent cases at times:

> They'll kind of coach you to say, well, if it's urgent for day, call the on-call psychiatrist or tell them to get into A&E… So they kind of push it that way. And so, but I know everyone's under pressure. (Arun)

Participants reflected on the reality of services being stretched and limitations of the system within their set structures.

> Single point of access ends up being a hub by which they make the decisions. And 9 times out of 10, the decision that hub will make will not be what based on patient choice or patient need. It will be based on service demands. (Alex)

Shared decision-making is then faced with service capacity prioritisation and fragmented pathways, going beyond the issue of long waiting times, creating a mental health system that at times seems inaccessible.

This indicates the internal struggle that GPs will face in the attempt to offer patients their preferred choice of treatment, but realising they might be unable to do so due to the mental health services being stretched beyond capacity. This pressure builds the impending

need for action, and participants spoke about resorting once again to medication as a tangible option for the patient:

“I'm starting on Sertraline because you guys respectfully don't have capacity. That's what we have to do. But that's the reality on the ground.” (Arun)

Therefore, the element of patient choice is significantly impacted and shaped by what the system can offer, with GPs having to resort to a less desirable choice as the only available treatment option.

The structure of the systems also proved to be a barrier in accessing meaningful help with mental health services, being described as constantly changing and opaque.

“We've had rearrangements of mental health services on a frequent basis.” (Michael)

> I did a referral through the single point of access. He self-referred to talking therapies. And on the same day, I received a letter from talking therapies saying he was more appropriate for the spa and from the spa saying he was more appropriate for talking therapies. (Catherine)

Beyond the element of capacity, due to the ongoing changing nature of the service layout, GPs and patients must overcome multiple obstacles to even attempt to identify which service would have capacity to provide the care. In order to compensate for the stretched mental health services, participants spoke about having to step up as therapists, but without the supervision, support or training that they should have.

“I've had like, I've had to do marriage counselling at 7.38 because the husband wanted to jump off a cliff… We as doctors also feel bad for the patient. We want to help them.” (Arun)

“You become their counsellor, basically. You're not doing a lot. Some of it is like, in some ways, I don't feel qualified to give some of some of that stuff is like life advice.” (Sanjay)

This highlights the emotional labour and guilt that GPs face. Shared decision-making is replaced with containment and trying to fill in the void created by the overstretched mental health services.

Together, the narrative created is that in the absence of the required robust support system and treatment options, GPs are forced to hold the distress, risk and responsibility of the care of their patients in a system that is not built for it. The system limitations of mental health services operating beyond capacity become more than an inconvenience, and rather a significant barrier in pursuing patient choice and shared decision-making.

Gaps in services preventing patient choice

In addition to the stretched mental health services, participants also spoke of services and areas that are just not available. While these can vary from one locality to another, this sub-theme captures the implications of the lack of some much-needed treatment options.

Participants spoke about a significant gap in what they can offer patients who are not in a crisis, but also not able to wait for months in order to access help.

> There is a middle ground there between crisis services and people with significant mental health problems, but no service exists for that group. They just have to sit on the waiting list like the people with mild or moderate depressive episodes do as well. (Simon)

"I guess that kind of, they're not suicidal, but they can't also wait six weeks. It's that gap…" (Arun)

With no services to support these patients, care is once again defaulted to GPs who are unable to collaboratively provide the expected treatment to their patients and settle for containment and short-term strategies in order to help their patients.

This gap is further emphasised by what therapies are available upon accessing mental health services. While the consensus is that CBT is the most common modality, participants spoke of some therapies not being available as an option upon referring patients on from primary care.

“Family therapy and things like that, there just isn't anything for kind of family therapy that we directly refer into.” (Thomas)

“There is next to no support in terms of psychodynamic therapy, proper CBT, face-to-face group therapy. All that stuff seems to have just disappeared.” (Alex)

This limits the ability to offer patient choice and have a conversation about what help could look like, even if it was further down the line. In the absence of accessibility to specific therapy modalities beyond CBT, decisions can become dichotomous between pursuing therapy or not, without knowing what this will look like or if the patient’s preferred treatment can even be pursued.

In other circumstances, patients presenting with co-morbidities can further limit what can be accessed.

“I mean, that's it. They often come with two things, of course.” (Louis)

> I think another barrier is people who are using drug and alcohol. that's automatically seems to be a kind of, oh, well, if they're using drugs and alcohol, they can't be mentally unwell. It's the alcohol and the drugs that are causing it. And we get loads of rejections of referrals, basically saying they need to get alcohol support before we'll see them… I feel like the two should be married together. (Alex)

Therefore, while these accounts highlight that the presence or co-occurring difficulties are not an isolated issue in primary care, the absence of services to address them is a recurrent

issue. The fragmentation and the strict criteria that mental health services hold, with no alternatives in care, can then undermine patient choice.

“These services are, they all tend to be quite fragmented.” (Louis)

“The joining up is probably the most frustrating and big barrier, and it's really complex for a GP who's left trying to negotiate and navigate that area.” (Alex)

With continuity as a core principle of care for GPs, the fragmentation of mental health services became even more noticeable. This gap is not only a meaningful barrier in offering patient choice but might result in GPs being left with no options altogether and in some cases waiting for the patient to meet the threshold for the desired service.

Furthermore, GPs spoke about the lack of culturally appropriate services as another significant gap in care.

“There's definitely a gap in terms of cultural sensitivities.” (Meena)

“I mean, the only way you can do that is if you do if you do co-creation with those communities.” (Sanjay)

In an already limited system, GPs reflected on the fact that shared decision-making might be a privilege that is not even considered for patients from a different cultural background, where therapy options are further limited.

“We talk to someone who doesn't speak English and they go, oh, we need something, but we don't have any therapists who speak our language literally and metaphorically.” (Sanjay)

“And I feel like it's a very vulnerable group not being able to access health care in their own language necessarily.” (Lucie)

With the current approach being to refer to local services, this can pose a difficulty where English is not the first language.

“So we have some patients who are asylum seekers and they're much more likely to present with depression.” (Lucie)

“We use the interpreter service for them. And I've not really thought about how they will be able to access IAPT.” (Samuel)

Participants highlighted that care is even more limited in these situations, leading to health inequalities and steering further away from meaningfully employing guideline-based care.

The lack of options and gaps in services therefore creates an imbalance in the attempted shared decision-making process, with GPs being left to choose from inadequate treatment options that are not in line with their professional judgement and not preferred by patients.

Theme Four: ‘It's hard. It depends on the patient’: Shared decision-making requiring cultural and clinical adaptations in practice

While the previous theme covered limitations imposed by the system, the fourth theme captures the conditionality of shared decision-making in practice. General Practitioners spoke about specific circumstances in which shared decision-making needs to be adjusted. This could be due to a more paternalistic approach being preferred by patients, the decisional element being affected due to depression, medication being preferred where other treatment avenues could be explored and where the patient’s preferred treatment choice does not align with clinical judgement and guideline-informed care. This theme therefore encapsulates the specific circumstances where participants felt it was necessary to adapt their approach in order to deliver the safest possible care.

Patients preferring GP's guidance

The first sub-theme described a specific situation where the patient's choice might be to defer the decision to the GP as the authority. While the GPs did not undermine the power and importance of shared decision-making in their consultations, they spoke about how, at times, the patients might be seeking more of a paternalistic approach, deferring the decision to them.

While it might seem to be contrary to guideline expectations, GPs spoke about continuing to strive to provide patients with informed choices while seeking their permission to act in their best interest.

"This patient does not want to be involved in a shared decision-making process. Therefore, I will act in their best interests with their permission." (Michael)

"And if I was to try and attempt shared decision making, they would see that as me not being confident in what I know rather than good practice." (Amina)

These accounts highlight the importance of understanding the patient's preference, while continuing to consider the ethical considerations of acting in the patient's best interest, while also maintaining the confidence that patients have in them as professionals.

A specific circumstance identified by participants is where they need to take into consideration the patient's cultural background and expectations of healthcare professionals.

> You're very much guided by the patient and it's a very much British cultural thing on this side of the planet. I know in other, you know, I know in China it's very different. It's sort of, if you give people options, the patients don't have faith in you. (Sanjay)

> Essentially the science and the patient's expectations, there's a mismatch… Essentially, something has to change to change the person's expectations and that mismatch. And that's

> a cultural change. And the cultural change can't be brought about by a doctor or a clinician. That would need to be a societal change. That takes time (Amina)

Going beyond the individual level of patients preferring a paternalistic approach, the examples provided by Amina and Sanjay speak of a societal change that would need to take place in order to normalise shared decision-making in healthcare. Challenging the patient's expectations in the short remit of a consultation would therefore be counterproductive without these wider changes having taken place.

Similarly, the generational aspect was also quoted as an important characteristic that might influence how patient choice is presented.

"Older patients … I find, prefer [a] more paternalistic approach." (Lucie)

"I think sometimes elderly patients can prefer to be told what to do." (Amina)

In these circumstances, participants value the patient's preferred approach, with shared decision-making being accepted as a newer approach that their patient might not be familiar with.

Therefore, while shared decision-making remains the desirable option and GPs are trying to steer away from a more paternalistic approach, these accounts taken together highlight a pursue to continue respecting and offering the patient's choice even when it comes down to their preferred approach of care.

Supporting patients with the weight of decision-making

Another crucial element that has to be taken into account when thinking about delivering guideline-informed care identified by participants is the weight of a decision, specifically when a patient is presenting with depression.

A clear barrier identified to shared decision-making was motivation, especially in moderate to severe cases of depression.

> I think what sometimes people find difficult, especially if you're in a moderate or a severe depressive episode, is that it's often really difficult to make decisions because your motivation is really low. And so they need a little bit more in my opinion, help making a decision. (Simon)

> But there is still the motivation issue. And although it might seem You know, I suppose initially I thought of it as more of a problem with depression. You know, almost by definition, people with depression will lack motivation. On the other hand, if they have sufficient motivation to talk to me, they've got over some sort of a hurdle. (Catherine)

As described by Simon and Catherine, motivation is understood beyond a general sense of determination to change, and it comes more in the context of choice and being able to make an informed decision. Furthermore, participants shared that considering the multiple lines of treatment in depression can become problematic in itself.

“So put it all out on the table. It's a balance to be met because the person may not be at a stage where they can process it all.” (Louis)

In order to avoid overwhelming patients with too many choices, adapting the options and striking the right balance for the patient might, in reality, enable and facilitate patient choice at the level tolerated by them at that point in their journey.

Shared decision-making is not abandoned altogether in these instances, but rather scaffolded with GPs guiding the patients to a place where they can make better use of the variety of treatment options recommended by the guideline.

“In the early stages, obviously, that insight may well not be there.” (Michael)

They need a little bit more in my opinion, help making a decision. And again, that's where it becomes quite difficult because often they'll get told what to do. And so if they're not, this is the whole part of shared decision making, if they're not fully engaged with that treatment option, they're not going to do it. (Simon)

The crucial part is carefully balancing the decisional element, with the risk of non-concordance clearly framed by Simon. With this awareness, as the patient becomes more prepared to make use of the presented options, GPs can pivot back to the desired shared decision.

Overall, this sub-theme highlights a phased approach to shared decision-making in cases where a full implementation might not be clinically appropriate in the context of motivation difficulties that can occur at times in the incipient stages of treating depression.

Antidepressants still preferred by patients and seen as a quick fix

Throughout the interviews, a narrative was shaped around patients' views on medication as a desired treatment option at times and as a quick solution. This represents another important barrier constraining shared decision-making with non-pharmacological interventions being suggested by the NICE guideline before antidepressants in mild to moderate presentations of depression.

Antidepressants were favoured among the treatment options due to patients seeing it as a quicker option to full recovery.

"I want instantly to feel better." (Sanjay)

"People just want a quick fix. They feel it's like a magical pill that would just make them better." (Samuel)

The pre-existing views on medication, paired with the immediate availability, can make the shared decision element difficult, due to the need to reshape the patient's health belief system altogether.

Furthermore, this seems to be even more prevalent in the younger generation, with the influence of social media and consumerism quoted as a strong influence.

"Younger people prefer options, or prefer more the consumer model where the patient says, I want this. And the doctor provides it. It's very much the consumerism. It's the Amazon culture of I want this and I want it now." (Simon)

"Younger people much prefer having a conversation about things because they've just read it on TikTok or social media or whatever, they want to know, they could specifically come and ask me about certain things." (Amina)

While useful in reducing stigma, it can limit the views of other treatment options and be difficult to shift in the younger generation, when antidepressants are seen as a quick and effective option.

Similarly, participants spoke about the influence of culture and experience of previous health systems that might differ from the local recommended guidelines.

"People expecting a prescription because that's, you know, if you go to the doctor in another country. prescription, then that's what happens." (Lucie)

"We have a very, very biological view of old medicine. And they tend to, they are more likely to think that problems will be caused, will be cured by tablets." (Catherine)

This indicates that antidepressants can be seen as the only reliable treatment option, with therapy and lifestyle changes being significantly devalued.

Overall, taking into account the pre-existing health belief views, influence of social media and cultural expectations, the decision on treatment seems to be made at times even before an appointment can take place, limiting the GPs' ability to present all the guideline-informed treatment options equally with the view of jointly reaching a decision.

Needing to negotiate divergent views on treatment

Following from the previous sub-theme, this final sub-theme will focus specifically on the complex dynamic of negotiating and discussing different views on treatment. With shared decision-making still valued and at the core of delivering care, participants shared their experience of needing to navigate situations where pursuing the patient's preferred treatment options was not in their best interest or clinically recommended.

"Some things that people ask me to prescribe are dangerous and I'm not prepared to do so. They're extraordinarily expensive in this country or outwith local guidelines." (Catherine)

"We can acknowledge that that's what they want, but it's not necessarily what I'm going to give." (Lucie)

These situations can be difficult to navigate due to risk and safety issues identified in the patient's choice of treatment. In such situations, GPs spoke about needing to employ their expertise to negotiate and carefully present and consider the options.

"So the patient consented eventually, but wasn't having so much hopes like, okay, reluctantly, okay, fine." (Yasmin)

> You can, I think it's sort of like you're planting seeds and you see what grows. So you can say, oh, talking to them might help. They'll be like, I don't really believe in that. You'll say, well, just have a think about it. (Sanjay)

Although shared decision-making might seem to be held back, as Yasmin and Sanjay exemplified, this is employed carefully in order to facilitate a more clinically indicated choice, even if a longer deliberation is needed. This reflects that the patient's choice is not dismissed altogether, but rather that their initial stance is used as a starting point in shaping and defining the outcome jointly.

Participants also highlighted the ethical responsibility that they hold as a significant factor to the power shift when it comes to making decisions.

"However, the responsibility of the effectiveness and efficacy of that decision lies with the clinician because patients can want something that might not be necessarily what they need at the time." (Samuel)

"We're doctors at the end of the day, we give people treatments that are medically based and those other factors just wash it all away." (Louis)

This indicates a strong ethical and professional responsibility held by GPs which can sometimes lead to having to refuse the patient's preferred treatment option.

Shared decision-making is therefore shaped by the GPs' role and accountability in delivering care in order to reconcile pre-existing treatment views when they do not appear to be in the patient's best interest.

Synthesis of results

In summary, the results formulate the barriers to implementing shared decision-making from a dual perspective. On one hand, systemic limitations were presented that are outside the control of GPs, encompassed by time limits, and limitations of choice by lack of options and pressures on other services. On the other hand, another set of barriers is more individual, focused specifically on the treatment of depression and patient preference, calling

for personalised care. The latter falls more within the reach and control of GPs, but equally important as they can shape what shared decision-making can look like in practice.

5. Discussion

5.1. Chapter overview

The following chapter will focus on summarising and discussing the findings of this mixed-methods study in relation to current literature and theories. First, the results of the quantitative data will be discussed in relation to the research aims. Secondly, interview findings that relate to the third study aim will be covered. It will then present the strengths and limitations of the work, followed by the policy and clinical implications. The researcher's reflections and final conclusions will be presented at the end of this chapter.

5.2. Research aims

This mixed-methods study aimed to investigate how shared decision-making is applied in practice following the 2022 NICE guideline update in relation to the treatment of depression. The quantitative part of the study aimed to better understand GPs' current guideline awareness and implementation through self-reported measures of shared decision-making, exploring their experience, practice, and perceived importance of key shared decision-making elements. A second aim was to explore if self-reported shared decision-making elements were associated with previous training completed by GPs through medical school and CPD. The quantitative aspect of this study aimed to explore barriers experienced in practice by GPs in employing shared decision-making in the treatment of depression.

5.3. Guideline awareness, implementation and previous training

Overall, participants reported being aware of the updated 2022 NICE guideline for depression (71%), however a much smaller proportion of participants responded positively when asked if changes in relation to the guideline were discussed with their practice partners (26%). These results indicate that while a good awareness of the guideline was observed on an individual level, steps towards wider service-level implementation are more reserved. In order to understand the discrepancy between individual professional development and service

level development, it is important to refer to the context of GP work. Armitage (2024) argued that the increase in the number of appointments, long waiting times and complexity of cases presenting in primary care was directly linked to pressures perceived by GPs. This could potentially indicate that immediate clinical responsibilities can supersede service development. Additionally, evidence shows that general practice can be an isolated profession, and with this acknowledged limitation, recommendations are made for GPs to participate in group continuous education (Cox & Holden, 2009; Dowling et al., 2019).

A similar pattern was observed in relation to training on shared decision-making, with individuals having covered the concept as part of their medical training, but with more limited ongoing development. Most participants (71%) reported having covered shared decision-making as part of their clinical training, with a smaller proportion (37%) having attended CPD post qualification. This could indicate that the additional pressures on GPs can leave limited opportunity for GPs to discuss and further develop the practical implementation, including potential barriers of shared decision-making within local practices (Armitage, 2024). While these findings are primarily descriptive, paired with a modest sample, they can shape the understanding of shared decision-making training opportunities that GPs have.

Participants reported overall high levels of confidence when using shared decision-making in depression, specifically when rating their understanding, application and effectiveness of the concept. There was some variation in responses, with effectiveness being rated lower (78.03) than understanding (85.73) and confidence in applying shared decision-making (82.5) when asked to rate out of 100. The scores, however, had a wide range and standard deviation, indicating variability in individual scores. The small sample did not allow a further exploration of the factors influencing this variability.

The findings suggest that overall, participants reported high levels of confidence, experience and attributed importance of shared decision-making, in line with previous research (Hughes et al., 2018; Viñas et al., 2025).

5.4.Influence of previous training on shared decision-making practice

The survey also aimed to provide the context needed to understand how shared decision-making is viewed and applied in clinical practice, and if factors around training and continuing professional development can be associated with higher guideline implementation.

It was explored if previous shared decision-making training obtained through medical school and CPD would impact shared decision-making scores reported by GPs. The results indicated that completion of shared decision-making during medical school was not associated with higher scores on shared decision-making measured through self-reported experience, practice and importance. While in the UK shared decision-making is embedded within medical training, feedback on training indicates that it needs to include more clinical and real-life scenarios to shape its understanding and application (Nyamapfene et al., 2023; Shrivastava et al., 2024). This supports the results of this study and provides a potential explanation as to why generic shared decision-making training completed during core training alone might not be sufficient in applying it specifically for patients presenting with depression.

On the other hand, GPs who responded positively to having attended a CPD course in the last five years were observed to score higher on the self-reported shared decision-making measures, revealing a positive association. This could make the argument for prioritising CPD and ongoing development of skills as a way towards a more meaningful implementation. However, it is important to note that a much smaller percentage of GPs reported having completed further CPD focused on shared decision-making. Having taken

this into consideration, this could reflect nonetheless that navigating the real-life challenges of clinical practice can help shape and build shared decision-making (Nyamapfene et al., 2023). It may also reflect that CPD courses are selectively attended by GPs who have an expressed interest in the topic, while the medical training syllabus has to be attended by all, irrespective of their individual inclination. This could potentially indicate that the GPs' views on shared decision-making who choose to attend further CPD training are the ones who might already view it as important.

When it comes to experience defined by years in practice and self-reported shared decision-making scores, there was no association observed in the present study. These results align with earlier research employing the Option scale, indicating that seniority in practice was not associated with a higher score of shared decision-making observed practice (Young et al., 2008).

Taken together, these results show that initial training and experience alone are not indicative of higher implementation, however completion of CPD was associated with higher scores on self-reported shared decision-making measures.

While no differences in scores were observed based on the practice setting (NHS, private or both), it is important to note that GPs practicing in the private sector were under-represented in the sample. In the current context of increased waiting times in the NHS and an increasing number of patients that are reportedly seeking private care, the BMA released a guidance covering the interface between NHS and private healthcare (British Medical Association [BMA], 2023). Given the small sample in the present study, this could warrant further research in order to better understand implementation differences based on areas of practice.

In summary, these findings indicate generally high rates of guideline-informed care and awareness on an individual level, with shared decision-making being valued in practice. They also indicate that effective implementation is associated with continuing development grounded in clinical work, and less so with core medical training or years of experience alone. Implications could suggest that investment in shared decision-making CPD could lead to fuller guideline implementation.

5.5.Barriers in guideline implementation in practice

The results of the interview study highlight that while GPs are committed to guideline-informed practice and are trained to use shared decision-making as a standard in care, barriers to implementation are shaped by wider systemic context and include time limits within appointments and limited choice. The added layer focuses more on an individual level, with the complexity of assessing and treating depression and adjustments needed according to patient preference and severity of depression. While the importance of shared decision-making was not disputed, accounts reinforced the need for adaptation when it comes to the treatment of depression in primary care.

5.5.1. Implications of time constraints in primary care

Time constraints were considered to be a systemic challenge preventing implementation of shared decision-making. Most GPs spoke about having around 10-15-minute appointments. While in some circumstances GPs spoke about the flexibility of offering double appointments, this was not described as common practice across all accounts. The implications specifically for the care of depression and in the context of shared decision-making are that a longer time frame might be needed to define the problem and formulate, with some participants making direct comparisons to other presentations that might not require as much time. Similarly, with the guideline presenting multiple lines of treatment, these would impose additional demands in weighing the benefits and limitations of each

treatment option. This indicates that perhaps patients may benefit from being offered two appointments with a gap in between and clear information on treatment avenues that could take the form of a patient decision aid to support their deliberation before returning to the GP to better engage in the shared decision-making process.

Regarding the barrier of short appointment times, earlier research indicates that shared decision-making in depression does not lengthen the appointment, where the average consultation time was found to be approximately 16 minutes, with almost 80% of the consultation allocated to the information gathering and formulation aspect of shared decision-making (Loh et al., 2007). However, as further evidence-based treatment options for depression have been introduced, more recent research suggests that the considerations of treatment pathways can also require more time for exploring, therefore prolonging the consultation time (McMullen, 2012; Patel et al., 2014; Simmons et al., 2017). Taken together, these findings reiterate the pressures that GPs face, where they are already operating on a tight timeframe with little manoeuvrability.

When it comes to the treatment of depression specifically, one time-sensitive and consuming task that can override other priorities is assessing and managing risk. Participants described the complexity of risk management, especially with limited support from external services and delays in accessing emergency services, adding to the time pressure. This can exceed the short time frame allocated for the appointment, with the safety of the patient being prioritised. Some participants expressed more confidence in managing risk, which is supported by literature which indicates that risk management can largely fluctuate based on GP awareness, experience and confidence (Stallman et al., 2023). In addition, the fear of litigation and damage to professional reputation remains a concern for GPs, restricting their practice and leading to defensive practice (Hawkes et al., 2015; Abdollahi & Mobasher, 2024). In turn, this can directly impact their practice and decisions and limit positive risk-

taking behaviours. While there is ample evidence on specific components of shared decision-making being constrained by short appointment times, there is a gap in research when it comes to the exploration of how risk management disrupts patient choice and shared decision-making.

In addition to complex clinical tasks, participants spoke about the invisible labour that is not usually accounted for in their consultations. This includes administrative tasks, documentation, liaison work, and making onward referrals. Participants recognised that these tasks are essential components of patient care, not often accounted for in their allocated appointment time. The literature supports the findings of this study, highlighting the impact of this invisible labour in addition to the existing clinical responsibilities that GPs have (Owen et al., 2019; Sinnott et al., 2020; Khan, 2022; Sinnott, 2022; Woolford et al., 2024). Even though efforts have been made to recognise this and provide further administrative support, the benefits are yet to be recognised by GPs (Owen et al., 2019; Sinnott et al., 2020; Royal College of General Practitioners [RCGP], 2025). Echoing this, the present study's findings suggest that the unrecognised invisible labour continues to be an issue in GP practice. Therefore, when it comes to shared decision-making and meaningful engagement of patient choice, the issue of time constraints goes beyond the management of clinical time, with wider competing responsibilities that GPs need to undertake.

With the acknowledged benefit and importance of the guideline, and with limited external support felt by GPs, participants described compensating through unpaid labour and working overtime, which is a recognised issue in general practice (Owen et al., 2019; Sinnott et al., 2020; Royal College of General Practitioners [RCGP], 2025). The consequence of the added workload has significant impacts on GPs, worsened post-pandemic, in terms of stress and mental health, with some seeking reduced hours as a way to manage the added pressures (Owen et al., 2019; Trivedi et al., 2021; Khan, 2022).

The relevance in the context of the depression guideline is extremely important, helping understand the pressures that GPs are facing. These leave limited time for development and practice improvement and directly impact the feasibility of guideline implementation. This can be explained through the normalisation process theory (May & Finch, 2009). According to this theory, the journey from change to routine practice requires considerable effort, and focus and it extends beyond individual capacity. The core principles conceptualised by May & Finch (2009) that lead to sustainable changes in healthcare involve sense-making, individual engagement in the process, collaborative implementation through collective action and time to appraise and reflect. This could help hypothesise that the implementation potential for such a guideline can be inhibited by the limited cognitive capacity to participate in new practices and the reflexive space to evaluate them, despite its acknowledged value. Therefore, while attempts are being made to support GPs from an administrative point of view, equal efforts should be invested in protecting and fostering a positive learning environment for them. Further opportunities for reflective spaces, ongoing learning, and collaborative approaches towards collective action could be more efficient in making sustainable changes towards guideline-informed care.

5.5.2. The complexity of treating depression

When considering treatment for depression in primary care, this was described by participants as a long-term, complex process, with participants noticing that this is rarely achieved in a single appointment. Therefore, the expectation of reaching a decision on treatment at the end of one brief consultation might need to be challenged, with patients being offered time to consider their options before returning for a follow-up appointment.

The complexity of depression is particularly important when guideline implementation and outcomes are assessed and expected on a singular consultation level. This also assumes full decisional capacity from patients and the ability to take in a large

amount of information within a short time frame, which sometimes can be minutes. The patients need to then engage in a balancing of priorities and preferences and followed by the decision-making stage, all within the remit of one short appointment. While the implications of short appointment times were recognised across multiple presentations in primary care, it became apparent that this is even more relevant in the context of depression.

The long-term nature of depression was noted by participants, who shared that at times the treatment can unfold over a longer period of time, sometimes years. While this is not true for all presentations of depression, studies indicate that persisting symptoms and chronicity leading to recurrence in depression is as high as 50% in patients, with the recommendation for ongoing care even in remission (Simon et al., 2002; Ali et al., 2017; Moriarty et al., 2020; Nuggerud-Galeas, 2020). This long-term process might contradict the inherited beliefs that GPs hold, largely shaped by medical training and the profession, which emphasise seeking answers rather than embracing uncertainty, with a call for a shift to prevent overdiagnosis and overmedication (Heath, 2014).

The complexity of depression was also linked by participants to the identification and formulation of the symptoms that the patients are presenting with. While in some cases participants noticed that depression might present as a physical complaint, others spoke about it presenting among other conditions. Literature reflects these findings, highlighting that especially when it comes to somatisation, a more in-depth exploration, understanding and at times psychoeducation is needed (Katon, 2004; Zainab & Pereira, 2007; Adams et al., 2014). Similarly, when considering comorbidities, a flexible and thorough transdiagnostic approach was recommended (Cramer et al., 2010; Fusar-Poli et al., 2019; Berta et al., 2022). In the context of the guideline, such complexities are difficult to define in a set treatment pathway. They might require more groundwork as a prerequisite to future patient-informed choice and shared decision-making.

To facilitate these complex dynamics, the theme of building trust emerged as a foundation in care mentioned across all accounts. This is further evidenced by studies employing the perspective of patients when looking at shared decision-making in depression care (Simon et al., 2007; Horevitz et al., 2015; Rodenburg-Vandenbussche et al., 2020; Matthews et al., 2021). In the context of depression, where stigma continues to exist, patients sought a connection with their healthcare provider in order to be able to talk about their symptoms and the circumstances surrounding them (Johnston et al., 2007; Durà-Vilà et al., 2013). In the context of long-term care, where care might be fragmented and accompanied by unsuccessful episodes of care, trust needs to be re-established (Roca et al., 2011).

Cultural sensitivity was also spoken about in this context, with the need to first scaffold trust-building within the system, where patients may not be familiar with shared decision-making approaches (Adams et al., 2014; Patel et al., 2014; Horevitz et al., 2015). The studies, however, do not diminish the importance of continuing to engage patient views but propose strategies to make this possible, with foundational barriers of language and access being addressed as an imperative. In terms of barriers to guideline implementation, a shift in the perception of health services, especially at a time of mental health distress, can be complex and challenging and might incite some GPs to revert to a less guideline-informed practice.

A theory underpinning the complexity of treating depression is the Differential Activation Hypothesis (Teasdale, 1988). This theory frames depression as recurrent in nature, where previous episodes or depression can increase the risk of reactivating cognitive patterns, making the patient more vulnerable. It was presented as a step further from Aaron Beck's cognitive model, going beyond the content of thoughts and drawing attention to longstanding impact of negative thinking patterns (Beck, 1976). Within this framework, the treatment of depression can be understood more clearly as a long-term process because it involves the

challenging of negative thinking styles that are closely connected to wider life events and the patient's context. Through this lens, participants' accounts on the revolving door nature of depression further emphasise the need of continuity in care. Although Teasdale (1988) highlights the need of ongoing care, the current healthcare system is not built to provide this level of support. This helps underpin the complexity of treating depression not only on an individual basis, but also when taking into account the realities of available services and wider systemic barriers, which will be discussed in the next section.

5.5.3. Limitations imposed by the system

A recurrent theme brought up by participants was around the scarcity of guideline-informed choices, long waiting times and gaps in services experienced in practice, with a mismatch between what the guidelines recommend and what is available.

Some participants spoke specifically about therapeutic interventions, such as family therapy or psychodynamic interventions, being largely inaccessible. Therefore, while attempts will be made to employ shared decision-making and offer the guideline and evidence-informed selection of choice, this is just not possible in practice. Although the guideline supports psychological therapy as a primary line of treatment, with different modalities recommended, the narrative presented was one of dichotomous choice.

From participant accounts, the most frequently cited service for accessing psychological therapies by patients was NHS Talking Therapies. While the most recent report covering April 2024 to 31st March 2025 indicates that 91.6% of patients accessed the service within 6 weeks of referral, approximately half of the patients complete treatment with no breakdown of uptake for each therapeutic modality (NHSE, 2025). Participants spoke about the ongoing inaccessibility of therapies beyond CBT, most commonly delivered in a group or remote format, which is not always preferred by patients. In this circumstance, they have to

adjust the patient's expectations in terms of what therapy they will be able to access. This frames the scarcity of therapeutic treatment options not only as a barrier but also as an issue compelling GPs to bypass patient choice altogether when the options are simply not available.

The long waiting times were also framed as a systemic barrier, which extended to access to secondary mental health services. This can be framed in the context of a recent increase in the use of talking therapies and has been associated with negative psychological impact, exacerbating existing conditions (ONS, 2022; Punton et al., 2022; Morris et al., 2025). This defaults the responsibility of care to GPs during the wait, who spoke about not being set up to offer such support and monitoring. While studies support continuity of care even in remission with the accepted high risk of relapse in depression, continuity at the moment only exists within primary care for patients who are well known to services (Ali et al., 2017; Moriarty et al., 2020).

The gap is even more significant in the context of inequality of care, with areas of deprivation and patients from racialised or minoritised backgrounds limiting further access to treatment for depression, including antidepressant medication and therapy (Delgadillo et al., 2018; Gebhardt, 2023; Rathod et al., 2024).

A recent British Medical Association (BMA, 2024) report called for more funding to address fragmented mental health services, leading to consequences on patient care. Within this context, the choice of treatment is constrained, with GPs having the laborious task of having to navigate the system in order to identify possible options. Added to this, the different approaches and expectations between primary care services and secondary mental health services can also lead to different expectations on responsibility of care provision and ultimately miscommunication (Hutschemaekers et al., 2014).

This particular theme can also be seen through a broader systemic lens. This can further help understand the impact of the pressures currently experienced in healthcare beyond a single GP appointment. Within the systemic framework, the individual is seen in close relation to the wider systems surrounding them, experiencing circular and reciprocal influences (Bronfenbrenner, 1979; Dallos & Draper, 2010). While shared decision-making is assessed and aimed to be implemented in a single 10-minute interaction, this system thinking approach focuses on understanding that individuals operate as part of a complex system (Wright, 2024; Kaswa & von Pressentin, 2025). Therefore, the unique interaction of a patient consultation is dependent on the larger picture, involving the services and people involved in their care. The patient's experience of seeking help might differ from what on paper looks like a guideline-adhering practice. Even in instances where shared decision-making and patient choice are pursued within the timeframe of an appointment, on a larger scale they might face an unpredictable and lengthy process contradicting these principles. This could impact their views on the healthcare system and potential of receiving help in a time of distress. It also indicates that the responsibility of carrying out guideline-informed care goes beyond the responsibilities of GPs, extending to the systems surrounding them as an essential context in which care is provided.

These findings collectively shape a fundamental barrier in guideline implementation, reducing the opportunity of patient choice to a limited set of treatment avenues, with medication becoming, at times, the only readily available and option-rich choice.

5.5.4. Individualised care at the foundation of shared decision-making

While guideline-informed care frames the standard of care, participants spoke about some exceptions that require an individualised approach, helping shape shared decision-making as a conditional and negotiated process. In this context, shared decision-making is

felt to be shaped by patient preference for a more paternalistic approach, decisional capacity and clinical context.

Although shared decision-making and offering patient choice remain the standard, participants spoke of specific clinical interactions where patients were perceived to expect more authority from GPs. These expectations can emerge from previous experiences of healthcare, with patients finding a paternalistic approach more trustworthy (Patel & Bakken, 2010; Matthews et al., 2021). The patient's cultural background can also favour placing the GP in a more authoritative position, with research supporting trust-building and removal of communication barriers as a prerequisite in successful guideline implementation (Adams et al., 2014; Patel et al., 2014). In both instances, the emphasis is made that decisions should not be removed altogether, as patients can express the wish to be involved at different stages of their care (Stacey et al., 2008; Patel & Bakken, 2010; McMullen, 2012).

Another instance where shared decision-making needs to be tailored is in the context of depression impacting decision-making capacity, where there is ample evidence of difficulty in decision-making (Chong et al., 2013; Hamann et al., 2016; Rodenburg-Vandenbussche et al., 2020). Some participants spoke about needing to take more of an authoritative approach in cases of severe depression in the initial encounters, folding the decisional aspect back to the patient as they progress in their recovery journey. Shared decision-making is therefore shaped as a dynamic process observed over time rather than in a single patient interaction.

Additionally, participants observed that the patient's decisional capacity can be impacted during the acute stages of depression, where the burden of choice cannot be tolerated. A systematic review revealed low decision-making capacity scores in patients with depression, with some variations based on acuity of illness (Hindmarch et al., 2013).

However, incapacity should not be assumed, even in the most severe cases, with the need for ongoing monitoring of preferences highlighted (Owen et al., 2003; Moise et al., 2017; Guidry-Grimes, 2020).

In other situations, participants expressed that the need for a more authoritative stance can appear when divergent views of treatment emerge. Decisions are then shaped by clinical judgement and evidence-based where the patient's preference for treatment is deemed to be against the GP's professional advice. Examples provided by participants included patients opting for specific antidepressant medication that might not be advised in the context of their existing comorbidity or treatment or opting for a single treatment option in severe cases of depression, when the guideline recommends a combination of therapy and antidepressants.

Equally, negotiation is also needed when the long-term benefits are not taken into account by patients. In this context, participants spoke about patients often requesting antidepressant medication, while this might not be indicated in their case, nor is it a feasible long-term solution. Research supports that although medication can be seen as a 'quick fix' by both clinicians and patients, evidence of long-term benefits is lacking (McPherson & Hengartner, 2019; Ormel et al., 2022). The added complexity is that, without a trust-based relationship and in a time-limited space, the lack of patient involvement can lead to poor concordance, indicating that the efforts of the work should be on building the foundation of shared decision-making (Lin et al., 2005; Hamann et al., 2015; Simmons et al., 2017; Rodenburg-Vandenbussche et al., 2020).

These shape shared decision-making as a process negotiated over time, delivered in close collaboration with the patient and requiring continuous assessment of their needs.

5.6.Study Limitations

One limitation of this study related to the positionality of the researcher, with no background in general practice, which may have limited the researcher's insight into the reality of GP training and understanding of the day-to-day role of a GP. This was mitigated with the use of a personal reflective diary and engagement with the general practice context, through professional networking, conference participation and ongoing exposure to relevant events and literature. Although a limitation, paired with the employed strategies, it also posed a positive in approaching the interviews with an open stance and not having pre-formed assumptions about the role of the interviewed participants.

The relatively small sample size can pose a limitation on the transferability of the results. As this was a known limitation in GP research in general, steps were taken from the beginning, starting with the ethical approval, to allow for a wide selection of recruitment methods. Considerable efforts were then made to employ all of these strategies. These involved but were not limited to in-person and online recruitment through social media, snowballing techniques, attending GP events and a conference.

A low completion rate was noticed, especially in the early stages of recruitment, with participants commencing the questionnaires and dropping out. This was potentially attributed to the long questionnaire and the overall survey flow. Adjustments were made in the flow of the questionnaire due to identifying that the question block asking about awareness of the NICE guidelines and implementation in personal and local practice was identified as a dropout point before reaching the other questionnaires. Moving this question block to the end did not compromise data completion and reduced the overall attrition.

The design of some survey questions might have posed a constraint in the options provided as an answer. Where items were provided with categorical responses, it might have

narrowed the opportunity for a more nuanced response and could have encouraged desirability in answers. Although the qualitative part of the study allowed a deeper exploration of the topic, future studies could support the collection of some qualitative data through surveys too.

A limitation particularly related to the qualitative component of the study could be linked to self-selection bias. Interview participation might have been impacted by existing views on shared decision-making, experience of depression care and awareness of the NICE guideline. It is possible that where some participants were not aware of the guideline or had a different level of implementation, they would have been less likely to participate in a one-hour interview exploring this topic. The data collected were nonetheless invaluable in helping understand the awareness, barriers and facilitators of a fuller implementation, especially through the lens of GPs who could have potentially had an inherited interest in shared decision-making or depression treatment. However, it is important to note that other themes could have emerged from the perspective of GPs that might have held different views on this topic.

Finally, some themes emerged only tangentially, such as treatment preferences in lower-income settings and the current economic climate with the rise in the cost of living. While some participants referenced these issues directly in connection with treatment preferences or help-seeking styles in this particular subgroup, the interview schedule did not allow for a deeper exploration of this theme. Future studies may consider shaping the interview structure to include impact on lower-income perspectives, as opposed to most focusing on the general 'typical' presentation. In the treatment of depression specifically, the impact of patients' socio-economic background was explored by Evans-Lacko (2018), revealing health inequalities in patients from lower-income backgrounds and higher access and engagement in therapy as a treatment for depression in patients from higher economic

backgrounds. This emphasises that while the guideline promotes therapy as a first line of treatment in most presentations of depression, the impact on underserved populations needs to be explored. It can therefore open avenues to be explored in future research in terms of guideline implementation and disparities according to socioeconomic background.

With hindsight, there are a number of aspects that I would have done differently. Starting with the research design, I would take in consideration the feedback received regarding the lengthy questionnaire for the quantitative part of the study. Practical steps in reducing participant burden could have involved seeking feedback or piloting the survey prior to data collection. Although the changes in the survey flow have helped improve the early drop out rates, addressing this issue at an earlier stage would have helped include the views of multiple GPs who might have been limited by the long-time frame required.

In addition, given the slow recruitment, I would have focused my efforts on the earlier stages of the research working on my recruitment strategy, expanding my professional network and identifying potential professional events. Similarly, for the qualitative part of the study I would have made some changes when it came to the recruitment strategy. Having noticed the self-selection bias as a possible study limitation, I would have considered a more targeted recruitment aiming to invite participants with lower levels of awareness of guideline or implementation. While this would not have mitigated fully the self-selection bias, it might have allowed a broader range of views to be included. I would also consider different data collection methods, rather than the one-hour interview, having gained a better understanding around the time pressures GPs are already facing.

Finally, having completed this research, I have gained a deeper understanding around the impact of social determinants towards access to health care and overall healthcare

inequalities. As some of these themes only came up tangentially, I would have imbedded them in my survey and interview schedule in order to explore them further.

5.7.Study Strengths

The methodological design of this study poses a strength by addressing the complex topic of views and barriers on patient choice and shared decision-making through a dual and complementary perspective. This mixed-methods design allowed for the initial capture of quantitative data on the current context in which GPs practice, their level of awareness, understanding and application of shared decision-making, paired with the awareness of the guideline and measures of their current practice, views and experience of shared decision-making. It was then followed by a more in-depth approach of the perceived barriers to a fuller implementation in practice, explored qualitatively. Taken together, these two approaches provided a deeper understanding of the topic and exploration of the research question.

Another strength of the present study is the GP sample recruited for both the interviews, but especially for the online survey. While recognised as a difficult participant group to reach and engage in research studies, a meaningful sample was recruited in this study. Although the sample might appear modest, for this participant group, it represents a significant accomplishment.

The driving force behind pursuing a GP-only sample was to isolate GP views and perspectives, which this study has successfully managed to do. Capturing this unique perspective was deemed to be very important, especially when it comes to understanding the barriers to guideline implementation, which can be followed by clear clinical implications.

In light of the updated NICE guideline in the UK healthcare system, this perspective has not yet been explored prior to this study and can hopefully set the foundation for more research and potentially more perspectives.

5.8.Policy and clinical implications

This is the first study that explored patient choice and shared decision-making in depression following the NICE guideline update, specifically targeting barriers to implementation in GP practice. While promoted in the guideline, this study revealed that further implementation is hindered by short appointment times, system limitations, the complexity of treating depression and individual factors. Therefore, this indicates that further efforts should be made to address the systemic challenges surrounding depression care.

The systemic barriers in implementation identified in this study revealed issues around recommended options not being available, long waiting times and fragmentation of mental health services. The restricted range of options and accessibility of timely treatment diminishes the power of patient-informed choices, leading GPs to seek what is available rather than what is needed. This barrier to shared decision-making can have significant implications for patient outcomes (Lin et al., 2005; Hamann et al., 2015; Simmons et al., 2011; Rodenburg-Vandenbussche et al., 2020). The feasibility of shared decision-making should also involve a stronger collaboration between primary and secondary mental health services, with an understanding of the offer available and different roles taken by clinicians in the care of patients presenting with depression (Légaré et al., 2011; Chong et al., 2013; Hutschemaekers et al., 2014). Further investment in guideline-informed and accessible treatment options is needed in order to address the scarcity of timely options and fragmentation of services (BMA, 2024).

Findings support ongoing professional development past the remit of medical training. This can be grounded in the current clinical context and address real-life scenarios in order to support the development of skills in the complex reality of clinical work. As such, the negotiation aspect and instances where risk concerns arise can be further developed, integrating them within guideline-informed care. The implications on psychological practice

could involve a collaborative approach, aiming to seek a shared expertise through liaison work, training, consultation in a bidirectional professional relationship. This would enable collaborative learning while navigating the system barriers and complexities in assessing and treating depression. A potential role for inter-professional education during training and CPD would facilitate the implementation of shared decision-making and patient choice across the multiple levels of care experienced by patients, consolidating the treatment avenues that are realistically available. In the initial phases of seeking support for depression, this approach could also have a preventative benefit, enabling a more cohesive experience of services.

Within the remit of clinical work, it can also help define shared decision-making as a dynamic process, not confined to the remit of a singular appointment, but developed in a staged approach requiring scaffolding where patient preference and clinical presentations might require it. In practice, this might require additional time provided to the patients to consider the treatment options that have been clearly presented in their initial appointment and the opportunity to return for a follow-up appointment aimed towards making a decision regarding their treatment.

One potential facilitator in supporting treatment discussion and patient deliberation is the use of patient decision aids, such as the one released in 2024 by NHSE. This depression-specific patient decision aid was a practical step taken towards improving patient choice and shared decision-making following the 2022 NICE depression guideline update (NICE, 2022; NHSE, 2024). Although the decision aid is framed as a support tool, acknowledging individual differences rather than a universal use, a limitation posed is in the advertised availability of options. This could, in turn, create unachievable expectations in patients and confusion around what can be accessed. By extension, it does not accept the heterogeneous distribution and accessibility of treatment, which can vary significantly in time and location. More recent studies identified that guideline implementation continues to remain low despite

efforts, such as that of a patient decision aid, raising the point that efforts should be focused on increasing the availability of stated treatment options and patient experience rather than on choice (McPherson et al., 2025). Therefore, while patient decision aids can be considered a facilitator in offering patient choice, they need to be paired with a conversation around available options in order to achieve a realistic care and treatment planning.

In light of health inequalities experienced by patients from minoritised backgrounds, further research is needed to develop appropriate interventions rather than adopting a "one size fits all" approach. Multiple accounts highlighted the scarcity of culturally appropriate services and interventions, paired with language barriers that are difficult to navigate. As a minimum, communication barriers need to be removed in the access to care in order to take a step towards a more inclusive practice (Patel et al., 2014; Horevitz et al., 2015).

Finally, as highlighted in many accounts, a more flexible approach needs to be taken in the development of national guidelines, taking into account the reality of clinical practice experienced by GPs. While extensive efforts in reviewing evidence-based treatment lines for depression have been made, this evidence needs to be accessible, especially when taking into account the impact of the GP's view on treatment planning (Guidry-Grimes, 2020).

In the absence of consideration of these clinical implications, guideline implementation will continue to encounter barriers in primary care practice.

5.9.Reflections

Throughout this study, I have kept a log of my own reflections with the view of helping understand how I approached the research process. Attempting to explore a research topic on GPs' views as a non-GP meant that I had to explore my own assumptions on the profession, role and system as an outsider. The selected reflections presented below focus on

the various stages at which this was revealed, the challenges faced during the research journey, and how these were addressed.

The recruitment process has indeed been one of the main challenges encountered from the very early stages of my research. Despite multiple efforts, recruitment was very low in the first year. At points, I even wondered if this study was achievable. Pursuing this meant that I had to revisit and renew my passion for this topic and remind myself of its importance. On a practical note, it helped reveal better recruitment avenues that, in the end, made this study possible. As a high achiever, the smaller than anticipated sample for the quantitative part of the study was initially perceived as a disappointment or perhaps even a failure. However, this process helped me understand and value the voice of each participant. With this in mind, I have revisited my drafts many times, aiming to reflect the limitations of a smaller sample without diminishing the value of my participants' voices.

When it comes to the qualitative part of the study and the interview findings, a recurrent reflection on the early stages of data familiarisation and coding was that the incipient stages of the interviews were very descriptive in nature of the role of a GP and their service ("GPs trained for 10 minutes appointments", "Ideal scenario", "Importance of information gathering"). Therefore, rather than directly addressing the research question and revealing barriers to implementing the guideline, it provided a detailed account of the average GP appointment and how the system works. My personal eagerness to understand the system (not being a GP) might have had an impact on my open invitation to listen to that information and gather it, although on a surface not related directly to my research aims. On reflection, a deeper knowledge of the system and perhaps someone from a similar background as the participants might have yielded some more focused questions. However, taking a step back, what these themes revealed was a bigger picture: a demanding system, a stretched workforce

trying to make allowances to their own detriment to deliver good patient care, with limited, palpable results.

It also revealed a bigger barrier that was not named but rather observed at the point of developing and reviewing themes, which was in the inequality of how services are funded. Some GPs praised how beneficial they found in-house mental health practitioners and social prescribers, while others did not have this resource. Similarly, some spoke about the flexibility of having double appointments, 15-minute appointments instead of 10-minute or systems that allowed patients to book follow-up appointments with them, but this was not a common theme across other interviews. While they were not directly conveying barriers in implementing the NICE guideline, it perhaps set the scene in which such guidelines are built, having to hold in mind the heterogeneity of GP practices across the UK.

Another reflection in the early stages of data coding was around separating or noticing my views and experience accessing the system and working within community mental health teams while analysing the data. A good example is that upon coding the second interview, a tendency to code antidepressants by default as the weaker option and with a negative nuance was noticed (“Limitation of medication”, or “GP scepticism of antidepressants”), and while placing higher trust in references relating to therapy (GPs supporting therapy). Noticing this helped me not only move back into a more neutral stance with an open approach but also try to understand the deeper meaning of what the GPs were trying to convey. In this particular example, the underlying message was around the difficulty of accessing therapy, matched with antidepressants being a readily available treatment option. As a consequence, this required GPs to go the extra mile to promote therapy and equally emphasise the limitations of opting for antidepressants as a quick option.

This triggered a re-evaluation of all the existing codes up to that point, and similarly, a considerable number were quite nuanced, mentioning “limits”, “lack”, or “importance”. By doing so, all upcoming references were added under this umbrella, although they might not have necessarily elicited the same intensity. Some new codes emerged from this reflection, such as “Meeting in the middle” and “Understanding the patient’s views”.

Another reflection that emerged in the analysis stage was in relation to my attitude towards decision-making and uncertainty. Through my clinical training, I have developed a more comfortable approach to uncertainty than I have observed doctors to have, requiring a shift in order to see things through their lens rather than my own (Heath, 2014). Implications reflect on the fact that while deferring decisions to another session, extending the assessment and information gathering, and sitting with the uncertainty might be more familiar to me, this might not align with the expectations that GPs have, who might tend to expect a clear outcome.

These reflections helped and informed the research process, providing depth to my work. By continuously challenging my position and assumptions, I have navigated this journey with an open approach and gained resilience through uncertain and difficult times, of which there were many.

5.10. Conclusion

This study aimed to explore the implementation of the updated NICE guideline for depression (2022) and barriers encountered in practice by GPs delivering care for depression in primary care. The main findings indicate that while shared decision-making is foundational in the medical training that GPs undertake and its implementation associated with continuing professional development, it is also faced with a set of barriers in practice. The fuller

implementation is subject to having some key barriers addressed, in terms of systemic, relational and individual factors.

The results shape shared decision-making as a dynamic approach, requiring ongoing adjustments in clinical practice to allow a patient-centred approach. The existing short appointment times and limitations within the system reinforce the need for an investment in depression care. In addition, the complexity of treating depression and individual factors calls for a tailored continuing professional development

This thesis contributes to the body of research supporting the benefits of shared decision-making, taking a step further in defining its implementation and barriers within the UK primary care setting. Where systemic and contextual barriers arise, it is crucial that investment in timely, accessible and culturally appropriate options is made. Equally, investing in ongoing development and dissemination of guidelines is necessary in order to make patient choice and shared decision-making a reality in the treatment of depression.

References

Abdollahi, A., & Mobasher, M. (2024). How can physicians' professional reputation be damaged? Patients', nurses' and physicians' viewpoints. *Journal of medical ethics and history of medicine*, *17*, 1. https://doi.org/10.18502/jmehm.v17i1.15389

Adams, A., Vail, L., Buckingham, C. D., Kidd, J., Weich, S., & Roter, D. (2014). Investigating the influence of African American and African Caribbean race on primary care doctors' decision making about depression. *Social science & medicine (1982)*, *116*, 161–168. https://doi.org/10.1016/j.socscimed.2014.07.004

Ali, S., Rhodes, L., Moreea, O., McMillan, D., Gilbody, S., Leach, C., Lucock, M., Lutz, W., & Delgadillo, J. (2017). How durable is the effect of low intensity CBT for depression and anxiety? Remission and relapse in a longitudinal cohort study. *Behaviour research and therapy*, *94*, 1–8. https://doi.org/10.1016/j.brat.2017.04.006

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Armitage R. (2024). Pressure on GPs in England: appointments, workforce, and patient complexity. *Postgraduate medical journal*, *100*(1189), 866–868. https://doi.org/10.1093/postmj/qgae050

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: lessons learnt. *BMC medical research methodology*, *8*, 21. https://doi.org/10.1186/1471-2288-8-21

Bahadoran, Z., Mirmiran, P., Kashfi, K., & Ghasemi, A. (2025). Biomedical Research: Formulating a Well-Built and Worth-Answering Research Question. *Addiction & health*, *17*, 1564. https://doi.org/10.34172/ahj.1564

Barr, P. J., & Elwyn, G. (2016). Measurement challenges in shared decision making: putting the 'patient' in patient-reported measures. *Health expectations : an international journal of public participation in health care and health policy*, *19*(5), 993–1001. https://doi.org/10.1111/hex.12380

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. International Universities Press.

Berta, A., Miguel Ángel, C., Clara, G. S., & Rubén, H. (2022). A bibliometric analysis of 10 years of research on symptom networks in psychopathology and mental health. *Psychiatry research*, *308*, 114380. https://doi.org/10.1016/j.psychres.2021.114380

Biddle, C., & Schafft, K. A. (2015). Axiology and Anomaly in the Practice of Mixed Methods Work: Pragmatism, Valuation, and the Transformative Paradigm. Journal of Mixed Methods Research, 9(4), 320-334. https://doi.org/10.1177/1558689814533157

Biesta G. (2010). Pragmatism and the philosophical foundations of mixed methods research. In Tashakkori A., Teddlie C. (Eds.), *Sage handbook of mixed methods in social & behavioral research* (2nd ed., pp. 95-118). Thousand Oaks, CA: Sage.

Blanco, I., Contreras, A., Valiente, C., Espinosa, R., Nieto, I., & Vázquez, C. (2019). El análisis de redes en psicopatología: conceptos y metodología [Network analysis and psychopathology: Concepts and methodology]. *Behavioral Psychology, 27*(1), 87–106.

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis?. *Qualitative research in psychology, 18*(3), 328-352.

Braun, V., Clarke, V., Hayfield, N., Davey, L., & Jenkinson, E. (2023). Doing reflexive thematic analysis. In *Supporting research in counselling and psychotherapy: Qualitative, quantitative, and mixed methods research* (pp. 19-38). Cham: Springer International Publishing.

Braun, Virginia, and Victoria Clarke. Successful Qualitative Research : A Practical Guide for Beginners. *London: SAGE*, 2013. Print.

British Medical Association. (2018). *Workload control in general practice: Ensuring patient safety through demand management*. https://www.bma.org.uk/media/1145/workload-control-general-practice-mar2018-1.pdf

British Medical Association. (2023, August 31). *General practice responsibility in responding to private healthcare*. https://www.bma.org.uk/advice-and-support/gp-practices/managing-workload/general-practice-responsibility-in-responding-to-private-healthcare

British Medical Association. (2024, June 28). *Failing mental healthcare system.* British Medical Association

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: a worked example. *Journal of health services research & policy*, *7*(4), 209–215. https://doi.org/10.1258/135581902320432732

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.

Brophy, S., Todd, C., Rahman, M. A., Kennedy, N., & Rice, F. (2021). Timing of parental depression on risk of child depression and poor educational outcomes: A population based routine data cohort study from Born in Wales, UK. *PloS one*, 16(11), e0258966. https://doi.org/10.1371/journal.pone.0258966

Bu, F., Steptoe, A., & Fancourt, D. (2023). Depressive and anxiety symptoms in adults during the COVID-19 pandemic in England: A panel data analysis over 2 years. *PLoS medicine*, *20*(4), e1004144. https://doi.org/10.1371/journal.pmed.1004144

Camacho, D., Estrada, E., Lagomasino, I. T., Aranda, M. P., & Green, J. (2018). Descriptions of depression and depression treatment in older Hispanic immigrants in a geriatric collaborative care program. *Aging & mental health*, *22*(8), 1050–1056. https://doi.org/10.1080/13607863.2017.1332159

Capili, B., & Anastasi, J. K. (2025). Pragmatic Clinical Trials: A Study Design for Real-World Evidence. *The American journal of nursing*, *125*(2), 56–58. https://doi.org/10.1097/AJN.0000000000000014

Carroll, H. A., Hook, K., Perez, O. F. R., Denckla, C., Vince, C. C., Ghebrehiwet, S., Ando, K., Touma, M., Borba, C. P. C., Fricchione, G. L., & Henderson, D. C. (2020). Establishing reliability and validity for mental health screening instruments in resource-constrained settings: Systematic review of the PHQ-9 and key recommendations. Psychiatry research, 291, 113236. https://doi.org/10.1016/j.psychres.2020.113236

Charles, C., Gafni, A., & Whelan, T. (1997). Shared decision-making in the medical encounter: what does it mean? (or it takes at least two to tango). *Social science & medicine (1982)*, *44*(5), 681–692. https://doi.org/10.1016/s0277-9536(96)00221-3

Chong, W. W., Aslani, P., & Chen, T. F. (2013). Shared decision-making and interprofessional collaboration in mental healthcare: a qualitative study exploring perceptions of barriers and facilitators. *Journal of interprofessional care*, *27*(5), 373–379. https://doi.org/10.3109/13561820.2013.785503

Cipriani, A., Furukawa, T.A., Salanti, G., Chairmani, A., Atkinson, L., Ogawa, Y.,…Geddes, J. R. (2018). Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis. Lancet, 391, 1357–66. https://doi.org/10.1016/S0140-6736(17)32802-7

Cole, A., Pooley, J. A., & Whitehead, L. (2024). Family members' experiences with depression through the lens of Frank's illness narratives. *Collegian*, 31(6), 392–403. doi.org

Cox, S. J., & Holden, J. D. (2009). Isolation and insight: practical pillars of revalidation?. *The British journal of general practice : the journal of the Royal College of General Practitioners*, *59*(564), 550–551. https://doi.org/10.3399/bjgp09X453675

Cramer, A. O., Waldorp, L. J., Van Der Maas, H. L., & Borsboom, D. (2010). Comorbidity: A network perspective. *Behavioral and brain sciences*, *33*(2-3), 137-150.

Creswell J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W. (2014). Research design: *Qualitative, quantitative, and mixed methods approaches* (4th ed.). Thousand Oaks, CA: Sage.

Creswell, J. W., & Plano Clark, V. L. (2011). Designing and conducting mixed methods research (2nd ed .). Thousand Oaks, CA: Sage.

Creswell, J. W., & Plano Clark, V. L. (2018). Designing and conducting mixed methods research (3rd ed.). Thousand Oaks, CA: SAGE.

Critical Appraisal Skills Programme. (2018). *CASP qualitative checklist*. https://casp-uk.net/casp-tools-checklists/

Cuthbert B. N. (2014). The RDoC framework: facilitating transition from ICD/DSM to dimensional approaches that integrate neuroscience and psychopathology. *World psychiatry official journal of the World Psychiatric Association (WPA),* 13(1), 28–35. https://doi.org/10.1002/wps.20087

Dallos, R., & Draper, R. (2010). *An introduction to family therapy: Systemic theory and practice* (3rd ed.). Open University Press.

Davies, J., & Read, J. (2025). Should antidepressants be prescribed simply if it is the patient's preference? Why NICE guidelines must be revised. *The British Journal of General Practice*, *76*(762), 7.

DeJonckheere, M., & Vaughn, L. M. (2019). Semistructured interviewing in primary care research: a balance of relationship and rigour. *Family medicine and community health*, *7*(2), e000057. https://doi.org/10.1136/fmch-2018-000057

Delgadillo, J., Farnfield, A., & North, A. (2018). Social inequalities in the demand, supply and utilisation of psychological treatment. *Counselling and Psychotherapy Research*, 18(2), 114–121. https://doi.org/10.1002/CAPR.12169

den Ouden, H., Vos, R. C., Reidsma, C., & Rutten, G. E. (2015). Shared decision making in type 2 diabetes with a support decision tool that takes into account clinical factors, the intensity of treatment and patient preferences: design of a cluster randomised (OPTIMAL) trial. *BMC family practice*, *16*, 27. https://doi.org/10.1186/s12875-015-0230-0

Department of Health. (2012). *Liberating the NHS: No decision about me, without me: Government response*. Department of Health. https://assets.publishing.service.gov.uk/media/5a7c80cde5274a2674eab180/Liberating-the-NHS-No-decision-about-me-without-me-Government-response.pdf

Dixon-Woods, M., Cavers, D., Agarwal, S., Annandale, E., Arthur, A., Harvey, J., Hsu, R., Katbamna, S., Olsen, R., Smith, L., Riley, R., & Sutton, A. J. (2006). Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. *BMC medical research methodology*, *6*, 35. https://doi.org/10.1186/1471-2288-6-35

Dobler, C. C., Sanchez, M., Gionfriddo, M. R., Alvarez-Villalobos, N. A., Singh Ospina, N., Spencer-Bonilla, G., Thorsteinsdottir, B., Benkhadra, R., Erwin, P. J., West, C. P., Brito,

J. P., Murad, M. H., & Montori, V. M. (2019). Impact of decision aids used during clinical encounters on clinician outcomes and consultation length: a systematic review. *BMJ quality & safety*, *28*(6), 499–510. https://doi.org/10.1136/bmjqs-2018-008022

Dowling, S., Last, J., Finnegan, H., Daly, P., Bourke, J., Hanrahan, C., Harrold, P., McCombe, G., & Cullen, W. (2019). Impact of participation in continuing medical education small group learning (CME-SGL) on the stress, morale, and professional isolation of rurally-based GPs: a qualitative study in Ireland. *BJGP open*, *3*(4), bjgpopen19X101673. Advance online publication. https://doi.org/10.3399/bjgpopen19X101673

Draucker, C. B., Rawl, S. M., Vode, E., & Carter-Harris, L. (2020). Integration Through Connecting in Explanatory Sequential Mixed Method Studies. Western journal of nursing research, 42(12), 1137–1147. https://doi.org/10.1177/0193945920914647

Drewelow, E., Wollny, A., Pentzek, M., Immecke, J., Lambrecht, S., Wilm, S., Schluckebier, I., Löscher, S., Wegscheider, K., & Altiner, A. (2012). Improvement of primary health care of patients with poorly regulated diabetes mellitus type 2 using shared decision-making--the DEBATE trial. *BMC family practice*, *13*, 88. https://doi.org/10.1186/1471-2296-13-88

Driever, E. M., Stiggelbout, A. M., & Brand, P. L. P. (2020). Shared decision making: Physicians' preferred role, usual role and their perception of its key components. *Patient education and counseling*, *103*(1), 77–82. https://doi.org/10.1016/j.pec.2019.08.004

Durà-Vilà, G., Littlewood, R., & Leavey, G. (2013). Depression and the medicalization of sadness: conceptualization and recommended help-seeking. *The International journal of social psychiatry*, *59*(2), 165–175. https://doi.org/10.1177/0020764011430037

Elwyn, G., Edwards, A., Wensing, M., Hood, K., Atwell, C., & Grol, R. (2003). Shared decision making: developing the OPTION scale for measuring patient

involvement. *Quality & safety in health care*, *12*(2), 93–99. https://doi.org/10.1136/qhc.12.2.93

Enright S. J. (1997). Cognitive behaviour therapy--clinical applications. *BMJ (Clinical research ed.)*, *314*(7097), 1811–1816. https://doi.org/10.1136/bmj.314.7097.1811

Evans-Lacko, S., Aguilar-Gaxiola, S., Al-Hamzawi, A., Alonso, J., Benjet, C., Bruffaerts, R., Chiu, W. T., Florescu, S., de Girolamo, G., Gureje, O., Haro, J. M., He, Y., Hu, C., Karam, E. G., Kawakami, N., Lee, S., Lund, C., Kovess-Masfety, V., Levinson, D., Navarro-Mateu, F., … Thornicroft, G. (2018). Socio-economic variations in the mental health treatment gap for people with anxiety, mood, and substance use disorders: results from the WHO World Mental Health (WMH) surveys. *Psychological medicine*, *48*(9), 1560–1571. https://doi.org/10.1017/S0033291717003336

Field, A. (2024). Discovering statistics using IBM SPSS statistics (6th ed.). SAGE Publications.

Fiorillo, A., Barlati, S., Bellomo, A., Corrivetti, G., Nicolò, G., Sampogna, G., Stanga, V., Veltro, F., Maina, G., & Vita, A. (2020). The role of shared decision-making in improving adherence to pharmacological treatments in patients with schizophrenia: a clinical review. *Annals of general psychiatry*, *19*, 43. https://doi.org/10.1186/s12991-020-00293-4

France, E. F., Cunningham, M., Ring, N., Uny, I., Duncan, E. A. S., Jepson, R. G., Maxwell, M., Roberts, R. J., Turley, R. L., Booth, A., Britten, N., Flemming, K., Gallagher, I., Garside, R., Hannes, K., Lewin, S., Noblit, G. W., Pope, C., Thomas, J., Vanstone, M., … Noyes, J. (2019). Improving reporting of meta-ethnography: the eMERGe reporting guidance. *BMC medical research methodology*, *19*(1), 25. https://doi.org/10.1186/s12874-018-0600-0

Frances, A. J., & Nardo, J. M. (2013). ICD-11 should not repeat the mistakes made by DSM-5 [Editorial]. *The British Journal of Psychiatry, 203*(1), 1–2. https://doi.org/10.1192/bjp.bp.113.127647

Freshwater, D., & Cahill, J. (2013). Paradigms Lost and Paradigms Regained. *Journal of Mixed Methods Research*, *7*(1), 3-5. https://doi.org/10.1177/1558689812471276

Fusar-Poli, P., Solmi, M., Brondino, N., Davies, C., Chae, C., Politi, P., Borgwardt, S., Lawrie, S. M., Parnas, J., & McGuire, P. (2019). Transdiagnostic psychiatry: a systematic review. *World psychiatry : official journal of the World Psychiatric Association (WPA)*, 18(2), 192–207. https://doi.org/10.1002/wps.20631

GBD 2016 Disease and Injury Incidence and Prevalence Collaborators (2017). Global, regional, and national incidence, prevalence, and years lived with disability for 328 diseases and injuries for 195 countries, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet (London, England)*, *390*(10100), 1211–1259. https://doi.org/10.1016/S0140-6736(17)32154-2

Gebhardt, B. (2023). Socio-demographic differences in access to psychological treatment services: evidence from a national cohort study. *Psychological Medicine*, 1–12. https://doi.org/10.1017/s0033291723001010

General Medical Council. (2020, September 30). *Shared decision making is key to good patient care - GMC guidance*. https://www.gmc-uk.org/news/news-archive/shared-decision-making-is-key-to-good-patient-care---gmc-guidance.

Glas, G. (2022). Person-centred care in psychiatry: a clinical and philosophically informed approach. *BJPsych Advances*, *28*(5), 333–341. doi:10.1192/bja.2021.75

Ghasemi, A., Hosseinpanah, F., Kashfi, K., & Bahadoran, Z. (2025). Research Hypothesis: A Brief History, Central Role in Scientific Inquiry, and Characteristics. *Addiction & health*, *17*, 1623. https://doi.org/10.34172/ahj.1623

Gilbody, S., Richards, D., & Barkham, M. (2007). Diagnosing depression in primary care using self-completed instruments: UK validation of PHQ-9 and CORE-OM. *British Journal of General Practice*, *57*(541), 650-652

Goss, C., Ghilardi, A., Deledda, G., Buizza, C., Bottacini, A., Del Piccolo, L., Rimondini, M., Chiodera, F., Mazzi, M. A., Ballarin, M., Bighelli, I., Strepparava, M. G., Molino, A., Fiorio, E., Nortilli, R., Caliolo, C., Zuliani, S., Auriemma, A., Maspero, F., Simoncini, E. L., … Zimmermann, C. (2013). INvolvement of breast CAncer patients during oncological consultations: a multicentre randomised controlled trial--the INCA study protocol. *BMJ open*, *3*(5), e002266. https://doi.org/10.1136/bmjopen-2012-002266

Greenberg, P., O'Callaghan, L., Fournier, A. A., Gagnon-Sanschagrin, P., Maitland, J., & Chitnis, A. (2024). Impact of living with an adult with depressive symptoms among households in the United States. *Journal of affective disorders*, 349, 107–115. https://doi.org/10.1016/j.jad.2023.12.040

Guidry-Grimes L. (2020). Overcoming Obstacles to Shared Mental Health Decision Making. *AMA journal of ethics*, *22*(5), E446–E451. https://doi.org/10.1001/amajethics.2020.446

Hall, J.N. (2013), Pragmatism, Evidence, and Mixed Methods Evaluation. New Directions for Evaluation, 2013: 15-26. https://doi.org/10.1002/ev.20054

Hamann, J., Kohl, S., McCabe, R., Bühner, M., Mendel, R., Albus, M., & Bernd, J. (2016). What can patients do to facilitate shared decision making? A qualitative study of patients with depression or schizophrenia and psychiatrists. *Social psychiatry and psychiatric epidemiology*, *51*(4), 617–625. https://doi.org/10.1007/s00127-015-1089-z

Hawkes, N. (2015). Doctors increasingly practise “defensive” medicine for fear of litigation, says regulator. *BMJ, 350*, h87. https://doi.org/10.1136/bmj.h87

Healy, D. (2000). Emergence of antidepressant induced suicidality. *Primary Care Psychiatry, 6*(1), 23–28. https://doi.org/10.1185/135525700543163

Healy, D. (2004). *Let Them Eat Prozac: The Unhealthy Relationship Between the Pharmaceutical Industry and Depression*. New York, NY: New York University Press.

Heath, I. (2014). Role of fear in overdiagnosis and overtreatment--an essay by Iona Heath. *BMJ (Clinical research ed.)*, *349*, g6123. https://doi.org/10.1136/bmj.g6123

Heinz, I., Baldofski, S., Beesdo-Baum, K., Knappe, S., Kohls, E., & Rummel-Kluge, C. (2021). "Doctor, my back hurts and I cannot sleep." Depression in primary care patients: Reasons for consultation and perceived depression stigma. *PloS one*, *16*(3), e0248069. https://doi.org/10.1371/journal.pone.0248069

Hesse-Biber, S., & Johnson, R. B. (2013). Coming at things differently: Future directions of possible engagement with mixed methods research. *Journal of Mixed Methods Research*, *7*(2), 103-109.

Hindmarch, T., Hotopf, M., & Owen, G. S. (2013). Depression and decision-making capacity for treatment or research: a systematic review. *BMC medical ethics*, *14*, 54. https://doi.org/10.1186/1472-6939-14-54

Hirshbein L. D. (2009) *American Melancholy: Constructions of Depression in the Twentieth Century.* New Brunswick, NJ: Rutgers University Press.

Hoffmann, T. C., Légaré, F., Simmons, M. B., McNamara, K., McCaffery, K., Trevena, L. J., Hudson, B., Glasziou, P. P., & Del Mar, C. B. (2014). Shared decision making: what do clinicians need to know and why should they bother?. *The Medical journal of Australia*, *201*(1), 35–39. https://doi.org/10.5694/mja14.00002

Hohenschurz-Schmidt, D. J., Cherkin, D., Rice, A. S. C., Dworkin, R. H., Turk, D. C., McDermott, M. P., Bair, M. J., DeBar, L. L., Edwards, R. R., Farrar, J. T., Kerns, R. D., Markman, J. D., Rowbotham, M. C., Sherman, K. J., Wasan, A. D., Cowan, P., Desjardins, P., Ferguson, M., Freeman, R., Gewandter, J. S., … Vollert, J. (2023). Research objectives and general considerations for pragmatic clinical trials of pain treatments: IMMPACT statement. *Pain*, *164*(7), 1457–1472. https://doi.org/10.1097/j.pain.0000000000002888

Hopwood M. (2020). The Shared Decision-Making Process in the Pharmacological Management of Depression. *The patient*, *13*(1), 23–30. https://doi.org/10.1007/s40271-019-00383-w

Horevitz, E., Organista, K. C., & Arean, P. A. (2015). Depression Treatment Uptake in Integrated Primary Care: How a "Warm Handoff" and Other Factors Affect Decision Making by Latinos. *Psychiatric services* (Washington, D.C.), 66(8), 824–830. https://doi.org/10.1176/appi.ps.201400085

Horwitz, A. V., & Wakefield, J. C. (2007). *The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder*. Oxford University Press.

Horwitz, A. V., & Wakefield, J. C. (2023). Two sides of depression: Medical & social. *Daedalus*, *152*(4), 212–227. https://doi.org/10.1162/daed_a_02039

Haugom, E. W., Benth, J. Š., Stensrud, B., Ruud, T., Clausen, T., & Landheim, A. S. (2023). Shared decision making and associated factors among patients with psychotic disorders: a cross-sectional study. *BMC psychiatry*, 23(1), 747. https://doi.org/10.1186/s12888-023-05257-y

Huang, C., Lam, L., Zhong, Y., Plummer, V., & Cross, W. (2021). Chinese mental health professionals' perceptions of shared decision-making regarding people diagnosed with

schizophrenia: A qualitative study. *International journal of mental health nursing*, *30*(1), 189–199. https://doi.org/10.1111/inm.12771_1

Hughes, T. M., Merath, K., Chen, Q., Sun, S., Palmer, E., Idrees, J. J., Okunrintemi, V., Squires, M., Beal, E. W., & Pawlik, T. M. (2018). Association of shared decision-making on patient-reported health outcomes and healthcare utilization. *American journal of surgery*, *216*(1), 7–12. https://doi.org/10.1016/j.amjsurg.2018.01.01

Hutschemaekers, G. J., Witteman, C. L., Rutjes, J., Claes, L., Lucassen, P., & Kaasenbrood, A. (2014). Different answers to different questions: exploring clinical decision making by general practitioners and psychiatrists about depressed patients. *General hospital psychiatry*, *36*(4), 425–430. https://doi.org/10.1016/j.genhosppsych.2014.02.003

Ivankova, N. V., Creswell, J. W., & Stick, S. L. (2006). Using Mixed-Methods Sequential Explanatory Design: From Theory to Practice. Field Methods, 18(1), 3-20. https://doi.org/10.1177/1525822X05282260

Johnston, O., Kumar, S., Kendall, K., Peveler, R., Gabbay, J., & Kendrick, T. (2007). Qualitative study of depression management in primary care: GP and patient goals, and the value of listening. *The British journal of general practice : the journal of the Royal College of General Practitioners*, 57(544), 872–879. https://doi.org/10.3399/096016407782318026

Kalk, N. J., & Young, A. H. (2017). Footnotes to Kraepelin: Changes in the classification of mood disorders with DSM-5. *British Journal of Psychiatry Open*, *3*(3). https://doi.org/10.1192/BJPO.BP.117.004739

Kamens, S. R., Elkins, D. N., & Robbins, B. D. (2017). Open Letter to the DSM-5. *Journal of Humanistic Psychology*, *57*(6), 675-687. https://doi.org/10.1177/0022167817698261

Kaswa, R., & Von Pressentin, K. (2025). Primary health care strengthening through the lens of healthcare system thinking. *South African family practice : official journal of the*

South African Academy of Family Practice/Primary Care, *67*(1), e1–e6. https://doi.org/10.4102/safp.v67i1.6039

Katon W. J. (2004). The many faces of depression in primary care. *Journal of general internal medicine*, *19*(8), 893–895. https://doi.org/10.1111/j.1525-1497.2004.40601.x

Kendrick, T., King, F., Albertella, L., & Smith, P. W. (2005). GP treatment decisions for patients with depression: an observational study. *The British journal of general practice : the journal of the Royal College of General Practitioners*, 55(513), 280–286.

Kendrick, T., Stuart, B., Newell, C., Geraghty, A. W., & Moore, M. (2015). Did NICE guidelines and the Quality Outcomes Framework change GP antidepressant prescribing in England? Observational study with time trend analyses 2003-2013. *Journal of affective disorders*, *186*, 171–177. https://doi.org/10.1016/j.jad.2015.06.052

Khan N. 'Hidden' no more: the real work of the 'part-time' GPs working full-time hours. Br J Gen Pract. 2022 Dec 21;73(726):26-27. doi: 10.3399/bjgp23X731625. PMID: 36543544; PMCID: PMC9799354.

Kriston, L., Scholl, I., Hölzel, L., Simon, D., Loh, A., & Härter, M. (2010). The 9-item Shared Decision Making Questionnaire (SDM-Q-9). Development and psychometric properties in a primary care sample. *Patient education and counseling*, *80*(1), 94–99. https://doi.org/10.1016/j.pec.2009.09.034

Lakens, D. (2022). Sample size justification. *Collabra: Psychology, 8*(1), Article 33267. https://doi.org/10.1525/collabra.33267

Lam, R. W., Kennedy, S. H., Adams, C., Bahji, A., Beaulieu, S., Bhat, V., Blier, P., Blumberger, D. M., Brietzke, E., Chakrabarty, T., Do, A., Frey, B. N., Giacobbe, P., Gratzer, D., Grigoriadis, S., Habert, J., Ishrat Husain, M., Ismail, Z., McGirr, A., McIntyre, R. S., … Milev, R. V. (2024). Canadian Network for Mood and Anxiety

Treatments (CANMAT) 2023 Update on Clinical Guidelines for Management of Major Depressive Disorder in Adults: Réseau canadien pour les traitements de l'humeur et de l'anxiété (CANMAT) 2023 : Mise à jour des lignes directrices cliniques pour la prise en charge du trouble dépressif majeur chez les adultes. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, *69*(9), 641–687. https://doi.org/10.1177/07067437241245384

Lee S. (2007). Is depression overdiagnosed: Global perspectives. *BMJ (Clinical research ed.)*, *335*(7617), 413–414. https://doi.org/10.1136/bmj.39317.492130.BE

Légaré, F., Adekpedjou, R., Stacey, D., Turcotte, S., Kryworuchko, J., Graham, I. D., Lyddiatt, A., Politi, M. C., Thomson, R., Elwyn, G., & Donner-Banzhoff, N. (2018). Interventions for increasing the use of shared decision making by healthcare professionals. *The Cochrane database of systematic reviews*, *7*(7), CD006732. https://doi.org/10.1002/14651858.CD006732.pub4

Légaré, F., Stacey, D., Pouliot, S., Gauvin, F. P., Desroches, S., Kryworuchko, J., Dunn, S., Elwyn, G., Frosch, D., Gagnon, M. P., Harrison, M. B., Pluye, P., & Graham, I. D. (2011). Interprofessionalism and shared decision-making in primary care: a stepwise approach towards a new model. *Journal of interprofessional care*, *25*(1), 18–25. https://doi.org/10.3109/13561820.2010.490502

Légaré, F., & Witteman, H. O. (2013). Shared decision making: examining key elements and barriers to adoption into routine clinical practice. *Health affairs (Project Hope)*, *32*(2), 276–284. https://doi.org/10.1377/hlthaff.2012.1078

Levis, B., Benedetti, A., Ioannidis, J. P. A., Sun, Y., Negeri, Z., He, C., Wu, Y., Krishnan, A., Bhandari, P. M., Neupane, D., Imran, M., Rice, D. B., Riehm, K. E., Saadat, N., Azar, M., Boruff, J., Cuijpers, P., Gilbody, S., Kloda, L. A., ... & Thombs, B. D. (2020). Patient Health Questionnaire-9 scores do not accurately estimate depression

prevalence: individual participant data meta-analysis. *Journal of Clinical Epidemiology*, 122, 115-128.e1. https://doi.org/10.1016/j.jclinepi.2020.02.002

Lin, P., Campbell, D. G., Chaney, E. F., Liu, C. F., Heagerty, P., Felker, B. L., & Hedrick, S. C. (2005). The influence of patient preference on depression treatment in primary care. *Annals of behavioral medicine: a publication of the Society of Behavioral Medicine*, 30(2), 164–173. https://doi.org/10.1207/s15324796abm3002_9

Linden, M. (2005). Leitlinien und die Psychologie medizinischer Entscheidungsprozesse bei der Behandlung depressiver Erkrankungen [Guidelines and the psychology of medical decision making in the treatment of depressive disorders]. *Fortschritte der Neurologie-Psychiatrie*, *73*(5), 249–258. https://doi.org/10.1055/s-2004-830145

Loh, A., Simon, D., Hennig, K., Hennig, B., Härter, M., & Elwyn, G. (2006). The assessment of depressive patients' involvement in decision making in audio-taped primary care consultations. *Patient education and counseling*, *63*(3), 314–318. https://doi.org/10.1016/j.pec.2006.04.006

Loh, A., Simon, D., Wills, C. E., Kriston, L., Niebling, W., & Härter, M. (2007). The effects of a shared decision-making intervention in primary care of depression: a cluster-randomized controlled trial. *Patient education and counseling*, *67*(3), 324–332. https://doi.org/10.1016/j.pec.2007.03.023

López-Muñoz, F., García-García, P., Sáiz-Ruiz, J., Mezzich, J. E., Rubio, G., Vieta, E., & Alamo, C. (2008). A bibliometric study of the use of the classification and diagnostic systems in psychiatry over the last 25 years. *Psychopathology*, 41(4), 214–225. https://doi.org/10.1159/000125555

Löwe, B., Kroenke, K., & Gräfe, K. (2005). Detecting and monitoring depression with a two-item questionnaire (PHQ-2). *Journal of psychosomatic research*, *58*(2), 163–171. https://doi.org/10.1016/j.jpsychores.2004.09.006

Löwe, B., Unützer, J., Callahan, C. M., Perkins, A. J., & Kroenke, K. (2004). Monitoring depression treatment outcomes with the patient health questionnaire-9. *Medical care*, *42*(12), 1194–1201. https://doi.org/10.1097/00005650-200412000-00006

Luong, V., Bearman, M., & MacLeod, A. (2023). A Beginner's Guide to Meta-Ethnography. *Journal of graduate medical education*, *15*(1), 46–47. https://doi.org/10.4300/JGME-D-22-00958.1

Lutfey, K. E., & Wishner, W. J. (1999). Beyond "compliance" is "adherence". Improving the prospect of diabetes care. *Diabetes care*, *22*(4), 635–639. https://doi.org/10.2337/diacare.22.4.635

Maarouf, H. (2019). Pragmatism as a supportive paradigm for the mixed research approach: Conceptualizing the ontological, epistemological, and axiological stances of pragmatism. *International Business Research, 12*(9), 1-12. https://doi.org/10.5539/ibr.v12n9p1

Marchand, C., & Peckham, S. (2017). Addressing the crisis of GP recruitment and retention: a systematic review. *The British journal of general practice : the journal of the Royal College of General Practitioners*, 67(657), e227–e237. https://doi.org/10.3399/bjgp17X689929

Marshall, T., Stellick, C., Abba-Aji, A., Lewanczuk, R., Li, X. M., Olson, K., & Vohra, S. (2021). The impact of shared decision-making on the treatment of anxiety and depressive disorders: systematic review. *BJPsych Open*, *7*(6), e189. https://doi.org/10.1192/bjo.2021.1028

Matthews, E. B., Savoy, M., Paranjape, A., Washington, D., Hackney, T., Galis, D., & Zisman-Ilani, Y. (2021). Shared Decision Making in Primary Care Based Depression Treatment: Communication and Decision-Making Preferences Among an Underserved

Patient Population. *Frontiers in psychiatry*, 12, 681165. https://doi.org/10.3389/fpsyt.2021.681165

May, C., & Finch, T. (2009). Implementing, embedding, and integrating practices: An outline of normalization process theory. *Sociology*, *43*(3), 535–554. https://doi.org/10.1177/0038038509103208

McMullen L. M. (2012). Discourses of influence and autonomy in physicians' accounts of treatment decision making for depression. *Qualitative health research*, *22*(2), 238–249. https://doi.org/10.1177/1049732311420738

McPherson, S., & Armstrong, D. (2006). Social determinants of diagnostic labels in depression. *Social science & medicine (1982)*, *62*(1), 50–58. https://doi.org/10.1016/j.socscimed.2005.05.021

McPherson, S., & Armstrong, D. (2009). Negotiating 'depression' in primary care: a qualitative study. *Social science & medicine (1982)*, *69*(8), 1137–1143. https://doi.org/10.1016/j.socscimed.2009.05.032

McPherson, S., & Armstrong, D. (2021). Psychometric origins of depression. *History of the Human Sciences*, *35*(3-4), 127-143. https://doi.org/10.1177/09526951211009085 (Original work published 2022)

McPherson, S., & Hengartner, M. P. (2019). Long-term outcomes of trials in the National Institute for Health and Care Excellence depression guideline. *BJPsych Open*, *5*(5), e81. doi:10.1192/bjo.2019.65

McPherson, S., Wicks, C., & Beresford, P. (2025). Patient Choice in Depression: Are We Failing to Implement NICE Guidelines?. *Journal of patient experience*, *12*, 23743735251325132. https://doi.org/10.1177/23743735251325132

Misbach, J., & Stam, H. J. (2006). Medicalizing melancholia: exploring profiles of psychiatric professionalization. *Journal of the history of the behavioral sciences*, *42*(1), 41–59. https://doi.org/10.1002/jhbs.20133

Moise, N., Ye, S., Alcántara, C., Davidson, K. W., & Kronish, I. (2017). Depressive symptoms and decision-making preferences in patients with comorbid illnesses. *Journal of psychosomatic research*, *92*, 63–66. https://doi.org/10.1016/j.jpsychores.2015.12.001

Morgan D. (2007). Paradigms lost and pragmatism regained: Methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Methods Research*, 1(1), 48-76. https://doi.org/10.1177/2345678906292462

Moriarty, A. S., Castleton, J., Gilbody, S., McMillan, D., Ali, S., Riley, R. D., & Chew-Graham, C. A. (2020). Predicting and preventing relapse of depression in primary care. *The British journal of general practice : the journal of the Royal College of General Practitioners*, *70*(691), 54–55. https://doi.org/10.3399/bjgp20X707753

Morris, S., Hill, S., Brugha, T., McManus, S. (Eds.). (2025). *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4.* NHS England. DOI: 10.13140/RG.2.2.24367.39840

Munkholm, K., Paludan-Müller, A. S., & Boesen, K. (2019). Considering the methodological limitations in the evidence base of antidepressants for depression: a reanalysis of a network meta-analysis. British Medical Journal, 9(6), 1-9. https://doi.org/10.1136/bmjopen-2018-024886

National Institute for Health and Care Excellence (NICE). (2021, June 17). *Shared decision making* (NICE guideline NG197). https://www.nice.org.uk/guidance/ng197

National Institute for Health and Care Excellence. (2022). *Depression in adults: treatment and management* (NICE Guideline NG222). https://www.nice.org.uk/guidance/ng222 (Original work published 2022; reviewed and verified 2026)

NHS Digital. (2022, October 26). *The healthcare ecosystem*. https://digital.nhs.uk/developer/guides-and-documentation/introduction-to-healthcare-technology/the-healthcare-ecosystem

NHS England. (2024, September 4). *Making decisions about managing depression*. https://www.england.nhs.uk/publication/decision-support-tool-making-decisions-about-managing-depression/

NHS England. (2025, March 27). *Quality and outcomes framework (QOF) guidance for 2025/26*. https://www.england.nhs.uk/publication/quality-and-outcomes-framework-guidance-for-2025-26/

NHS England. (2025, September 25). *NHS Talking Therapies, for anxiety and depression, annual reports, 2024-25*. NHS Digital

Ng, Y. K., Shah, N. M., Loong, L. S., Pee, L. T., Hidzir, S. A. M., & Chong, W. W. (2018). Attitudes toward concordance and self-efficacy in decision making: a cross-sectional study on pharmacist-patient consultations. *Patient preference and adherence*, *12*, 615–624. https://doi.org/10.2147/PPA.S159113

Nicolai, J., Moshagen, M., Eich, W., & Bieber, C. (2012). The OPTION scale for the assessment of shared decision making (SDM): Methodological issues. *Zeitschrift für Evidenz, Fortbildung und Qualität im Gesundheitswesen*, 106(4), 264–271. https://doi.org/10.1016/j.zefq.2012.03.002

Noblit, G. W., & Hare, R. D. (1988). Meta-Ethnography: Synthesizing Qualitative Studies. *In Google Books*. SAGE.

Noblit, G. W., & Hare, R. D. (1999). Chapter 5: Meta-Ethnography: Synthesizing Qualitative Studies. *Counterpoints*, *44*, 93–123.

Nosek, B. A., Ebersole, C. R., DeHaven, A. C., & Mellor, D. T. (2018). The preregistration revolution. *Proceedings of the National Academy of Sciences of the United States of America*, *115*(11), 2600–2606. https://doi.org/10.1073/pnas.1708274114

Nuggerud-Galeas, S., Sáez-Benito Suescun, L., Berenguer Torrijo, N., Sáez-Benito Suescun, A., Aguilar-Latorre, A., Magallón Botaya, R., & Oliván Blázquez, B. (2020). Analysis of depressive episodes, their recurrence and pharmacologic treatment in primary care patients: A retrospective descriptive study. *PloS one*, *15*(5), e0233454. https://doi.org/10.1371/journal.pone.0233454

Nyamapfene, T., Butterworth, J., Merchant, H., & Eaton, M. (2023). GPs' perceptions of teaching methods in shared decision-making training: a qualitative study. *The British journal of general practice : the journal of the Royal College of General Practitioners*, *73*(729), e310–e317. https://doi.org/10.3399/BJGP.2022.0194

O'Connor, A. M., Bennett, C. L., Stacey, D., Barry, M., Col, N. F., Eden, K. B., Entwistle, V. A., Fiset, V., Holmes-Rovner, M., Khangura, S., Llewellyn-Thomas, H., & Rovner, D. (2009). Decision aids for people facing health treatment or screening decisions. *The Cochrane database of systematic reviews*, (3), CD001431. https://doi.org/10.1002/14651858.CD001431.pub2

Office for National Statistics. (2022, December 6). *Cost of living and depression in adults, Great Britain: 29 September to 23 October 2022*. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/mentalhealth/articles/costoflivinganddepressioninadultsgreatbritain/29septemberto23october2022

Ormel, J., Hollon, S. D., Kessler, R. C., Cuijpers, P., & Monroe, S. M. (2022). More treatment but no less depression: The treatment-prevalence paradox. *Clinical psychology review*, *91*, 102111. https://doi.org/10.1016/j.cpr.2021.102111

Owen, G. S., Richardson, G., David, A. S., Szmukler, G., Hayward, P., & Hotopf, M. (2008). Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study. *BMJ (Clinical research ed.)*, *337*(7660), a448. https://doi.org/10.1136/bmj.39580.546597.BE

Owen, K., Hopkins, T., Shortland, T., & Dale, J. (2019). GP retention in the UK: a worsening crisis. Findings from a cross-sectional survey. *BMJ open*, *9*(2), e026048. https://doi.org/10.1136/bmjopen-2018-026048

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., McGuinness, L. A., … Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ (Clinical research ed.)*, *372*, n71. https://doi.org/10.1136/bmj.n71

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. *Administration and policy in mental health*, *42*(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Patel, S. R., & Bakken, S. (2010). Preferences for participation in decision making among ethnically diverse patients with anxiety and depression. *Community mental health journal*, *46*(5), 466–473. https://doi.org/10.1007/s10597-010-9323-3

Patel, S. R., Bakken, S., & Ruland, C. (2008). Recent advances in shared decision making for mental health. *Current opinion in psychiatry*, *21*(6), 606.

Patel, S. R., Schnall, R., Little, V., Lewis-Fernández, R., & Pincus, H. A. (2014). Primary care professional's perspectives on treatment decision making for depression with African Americans and Latinos in primary care practice. *Journal of immigrant and minority health*, *16*(6), 1262–1270. https://doi.org/10.1007/s10903-013-9903-8

Pettigrew, L. M., Bharmal, A. V., Akl, S., Exley, J., Allen, L. N., Petersen, I., Cromwell, D. A., & Mays (2025). Trends in the shortfall of English NHS general practice doctors: repeat cross sectional study. *BMJ (Clinical research ed.)*, *390*, e083978. https://doi.org/10.1136/bmj-2024-083978

Pincus, H. A., & Pettit, A. R. (2001). The societal costs of chronic major depression. *The Journal of clinical psychiatry*, 62 Suppl 6, 5–9.

Potter, J., & Hepburn, A. (2005). Qualitative interviews in psychology: Problems and possibilities. *Qualitative Research in Psychology, 2*(4), 281–307. https://doi.org/10.1191/1478088705qp045oa

Punton, G., Dodd, A. L., & McNeill, A. (2022). 'You're on the waiting list': An interpretive phenomenological analysis of young adults' experiences of waiting lists within mental health services in the UK. *PloS one*, *17*(3), e0265542. https://doi.org/10.1371/journal.pone.0265542

Rae, B. (2021). Obedience to collaboration: Compliance, adherence and concordance. *Journal of Prescribing Practice*, 3(6), 235-240. 10.12968/jprp.2021.3.6.235. https://doi.org/10.12968/jprp.2021.3.6.235

Rathod, S., Skórniewska, Z., Engelthaler, T., Fell, B., Sajid, S., & Phiri, P. (2024). Treatment resistant depression: A comparative study of access, pathways, and outcomes between

Caucasian and ethnic minority individuals. *Journal of Affective Disorders*. https://doi.org/10.1016/j.jad.2024.02.027

Raue, P. J., Schulberg, H. C., Lewis-Fernandez, R., Boutin-Foster, C., Hoffman, A. S., & Bruce, M. L. (2010). Shared decision-making in the primary care treatment of late-life major depression: A needed new intervention? *International Journal of Geriatric Psychiatry, 25*(11), 1101–1111. https://doi.org/10.1002/gps.2444

Raue, P. J., Schulberg, H. C., Bruce, M. L., Banerjee, S., Artis, A., Espejo, M., Catalan, I., & Romero, S. (2019). Effectiveness of Shared Decision-Making for Elderly Depressed Minority Primary Care Patients. *The American journal of geriatric psychiatry : official journal of the American Association for Geriatric Psychiatry*, *27*(8), 883–893. https://doi.org/10.1016/j.jagp.2019.02.016

Razali, N. M., & Wah, Y. B. (2011). Power comparisons of Shapiro-Wilk, Kolmogorov-Smirnov, Lilliefors and Anderson-Darling tests. *Journal of Statistical Modeling and Analytics*, 2(1), 21-33.

Reeves, R. R., & Ladner, M. E. (2010). Antidepressant-induced suicidality: an update. *CNS neuroscience & therapeutics*, *16*(4), 227–234. https://doi.org/10.1111/j.1755-5949.2010.00160.x

Robinson, J. H., Callister, L. C., Berry, J. A., & Dearing, K. A. (2008). Patient-centered care and adherence: definitions and applications to improve outcomes. *Journal of the American Academy of Nurse Practitioners*, *20*(12), 600–607. https://doi.org/10.1111/j.1745-7599.2008.00360.x

Roca, M., Armengol, S., García-García, M., Rodriguez-Bayón, A., Ballesta, I., Serrano, M. J., Comas, A., & Gili, M. (2011). Clinical differences between first and recurrent episodes

in depressive patients. *Comprehensive psychiatry*, *52*(1), 26–32. https://doi.org/10.1016/j.comppsych.2010.04.011

Rodenburg-Vandenbussche, S., Carlier, I., van Vliet, I., van Hemert, A., Stiggelbout, A., & Zitman, F. (2020). Patients' and clinicians' perspectives on shared decision-making regarding treatment decisions for depression, anxiety disorders, and obsessive-compulsive disorder in specialized psychiatric care. *Journal of evaluation in clinical practice*, 26(2), 645–658. https://doi.org/10.1111/jep.13285

Rossom, R. C., Solberg, L. I., Vazquez-Benitez, G., Whitebird, R. R., Crain, A. L., Beck, A., & Unützer, J. (2016). Predictors of Poor Response to Depression Treatment in Primary Care. *Psychiatric services (Washington, D.C.)*, *67*(12), 1362–1367. https://doi.org/10.1176/appi.ps.201400285

Royal College of General Practitioners. (2023, July). *GP training registration: Who's who*. Retrieved April 9, 2026, from https://www.rcgp.org.uk/blog/gp-training-registration-whos-who

Royal College of General Practitioners. (2025, December). *Uncovering the GP workload burden: A study of the drivers and costs of "unnecessary" and hidden workload*. https://www.rcgp.org.uk/getmedia/26330bb5-eecc-4e25-84b3-bbc0f5614dd7/Uncovering-the-GP-workload-burden-A-study-of-the-drivers-and-costs-of-unnecessary-and-hidden-workload-%E2%80%93-December-2025.pdf

Sale, J. E., Lohfeld, L. H., & Brazil, K. (2002). Revisiting the Quantitative-Qualitative Debate: Implications for Mixed-Methods Research. *Quality & quantity*, *36*(1), 43–53. https://doi.org/10.1023/A:1014301607592

Santema, T. B., Stubenrouch, F. E., Koelemay, M. J., Vahl, A. C., Vermeulen, C. F., Visser, M. J., & others. (2016). Shared decision making in vascular surgery: An exploratory study.

European Journal of Vascular and Endovascular Surgery, 51(5), 587–593. https://doi.org/10.1016/j.ejvs.2016.01.021

Sattar R, Lawton R, Panagioti M, Johnson J. Meta-ethnography in healthcare research: a guide to using a meta-ethnographic approach for literature synthesis. BMC Health Serv Res. 2021 Jan 8;21(1):50. doi: 10.1186/s12913-020-06049-w. PMID: 33419430; PMCID: PMC7796630

Savelberg, W., Moser, A., Smidt, M., Boersma, L., Haekens, C., & van der Weijden, T. (2015). Protocol for a pre-implementation and post-implementation study on shared decision-making in the surgical treatment of women with early-stage breast cancer. *BMJ open*, *5*(3), e007698. https://doi.org/10.1136/bmjopen-2015-007698

Scholl, I., Kriston, L., Dirmaier, J., Buchholz, A., & Härter, M. (2012). Development and psychometric properties of the Shared Decision Making Questionnaire--physician version (SDM-Q-Doc). *Patient education and counseling*, 88(2), 284–290. https://doi.org/10.1016/j.pec.2012.03.005

Seemüller F. (2023). ICD-11 and mental disorders: important changes, controversies, and future directions. *BMC psychiatry*, *23*(1), 698. https://doi.org/10.1186/s12888-023-05186-w

Shannon-Baker, P. (2016). Making Paradigms Meaningful in Mixed Methods Research. Journal of Mixed Methods Research, 10(4), 319-334. https://doi.org/10.1177/1558689815575861

Shorter E. (2013). *How Everyone Became Depressed: The Rise and Fall of the Nervous Breakdown*. Oxford: Oxford University Press.

Shrivastava, S. R., Shrivastava, P. S., Bankar, N., Bandre, G., & Mishra, V. (2024). Training Undergraduate Medical Students in Shared Decision Making: A Systematic

Review. *Journal of pharmacy & bioallied sciences*, *16*(Suppl 2), S1033–S1037. https://doi.org/10.4103/jpbs.jpbs_1231_23

Simon, G. E., Goldberg, D. P., Von Korff, M., & Ustün, T. B. (2002). Understanding cross-national differences in depression prevalence. *Psychological medicine*, *32*(4), 585–594. https://doi.org/10.1017/s0033291702005457

Simon, D., Loh, A., Wills, C. E., & Härter, M. (2007). Depressed patients' perceptions of depression treatment decision-making. *Health expectations : an international journal of public participation in health care and health policy*, *10*(1), 62–74. https://doi.org/10.1111/j.1369-7625.2006.00424.x

Simmons, M. B., Hetrick, S. E., & Jorm, A. F. (2011). Experiences of treatment decision making for young people diagnosed with depressive disorders: a qualitative study in primary care and specialist mental health settings. *BMC psychiatry*, *11*, 194. https://doi.org/10.1186/1471-244X-11-194

Sinnott, C., Georgiadis, A., & Dixon-Woods, M. (2020). Operational failures and how they influence the work of GPs: a qualitative study in primary care. *The British journal of general practice : the journal of the Royal College of General Practitioners*, *70*(700), e825–e832. https://doi.org/10.3399/bjgp20X713009

Sinnott, C., Moxey, J. M., Marjanovic, S., Leach, B., Hocking, L., Ball, S., Georgiadis, A., Lamé, G., Willars, J., & Dixon-Woods, M. (2022). Identifying how GPs spend their time and the obstacles they face: a mixed-methods study. *The British journal of general practice : the journal of the Royal College of General Practitioners*, *72*(715), e148–e160. https://doi.org/10.3399/BJGP.2021.0357

Snowden, A., & Marland, G. (2013). No decision about me without me: Concordance operationalised. *Journal of Clinical Nursing*, 22(9-10), 1353-1360. 10.1111/j.1365-2702.2012.04337.x

Sobieraj, M., Williams, J., Marley, J., & Ryan, P. (1998). The impact of depression on the physical health of family members. *The British journal of general practice: the journal of the Royal College of General Practitioners*, 48(435), 1653–1655.

Stacey, D., Menard, P., Gaboury, I., Jacobsen, M., Sharif, F., Ritchie, L., & Bunn, H. (2008). Decision-making needs of patients with depression: a descriptive study. *Journal of psychiatric and mental health nursing*, 15(4), 287–295. https://doi.org/10.1111/j.1365-2850.2007.01224.x

Stallman, A., Sheeran, N., & Boschen, M. (2023). A Qualitative Exploration of General Practitioners' Treatment Decision-Making for Depressive Symptoms. *Medical decision making : an international journal of the Society for Medical Decision Making*, *43*(4), 498–507. https://doi.org/10.1177/0272989X231166009

Stephenson, C., Jagayat, J., Kumar, A., Khamooshi, P., Eadie, J., Pannu, A., Meartsi, D., Danaee, E., Gutierrez, G., Khan, F., Gizzarelli, T., Patel, C., Moghimi, E., Yang, M., Shirazi, A., Omrani, M., Patel, A., & Alavi, N. (2023). Comparing clinical decision-making of AI technology to a multi-professional care team in an electronic cognitive behavioural therapy program for depression: protocol. *Frontiers in psychiatry*, *14*, 1220607. https://doi.org/10.3389/fpsyt.2023.1220607

Stiggelbout, A. M., Van der Weijden, T., De Wit, M. P., Frosch, D., Légaré, F., Montori, V. M., Trevena, L., & Elwyn, G. (2012). Shared decision making: really putting patients at the centre of healthcare. *BMJ (Clinical research ed.)*, *344*, e256. https://doi.org/10.1136/bmj.e256

Stiggelbout, A. M., Pieterse, A. H., & De Haes, J. C. (2015). Shared decision making: Concepts, evidence, and practice. *Patient education and counseling*, *98*(10), 1172–1179. https://doi.org/10.1016/j.pec.2015.06.022

Taiwong, A., Uppor, W., & Vibulchai, N. (2024). Concordance in the healthcare context: A concept analysis. *Belitung nursing journal*, *10*(3), 252–260. https://doi.org/10.33546/bnj.3343

Tan, X., He, Y., Ning, N., Peng, J., Wiley, J., Fan, F., Wang, J., & Sun, M. (2023). Shared decision-making in the treatment of adolescents diagnosed with depression: A cross-sectional survey of mental health professionals in China. *Journal of Psychiatric and Mental Health Nursing*. https://doi.org/10.1111/jpm.12990

Tashakkori A., Teddlie C. (2003). *Handbook of mixed methods in social and behavioral research*. Thousand Oaks, CA: Sage.

Tatlı, S. Z., & Atagün, M. İ. (2025). Rethinking Treatment-Resistant Depression: A Systematic Review of Novel Therapeutic Strategies and Precision Medicine Approaches. *Actas espanolas de psiquiatria*, *53*(6), 1395–1409. https://doi.org/10.62641/aep.v53i6.1946

Teasdale, J. D. (1988). Cognitive vulnerability to persistent depression. *Cognition and Emotion*, *2*(3), 247–274. https://doi.org/10.1080/02699938808410927.

The Nuffield Trust, 2023 data found at https://www.nuffieldtrust.org.uk/nhs-staffing-tracker/general-practice#:~:text=In%20December%202023%2C%20there%20were,link%20workers%20by%202023%2F24.

Thummak, S., Uppor, W., & Wannarit, L.-O. (2023). Patient compliance: A concept analysis. *Belitung Nursing Journal*, 9(5), 421-427. https://doi.org/10.33546%2Fbnj.2807

Trivedi, N., Trivedi, V., Moorthy, A., & Trivedi, H. (2021). Recovery, restoration, and risk: a cross-sectional survey of the impact of COVID-19 on GPs in the first UK city to lock down. *BJGP open*, *5*(1), BJGPO.2020.0151. https://doi.org/10.3399/BJGPO.2020.0151

Tumasian, R. A., 3rd, Galfalvy, H. C., Enslow, M. R., Brent, D. A., Melhem, N., Burke, A. K., Mann, J. J., & Grunebaum, M. F. (2023). Avoidant attachment transmission to offspring in families with a depressed parent. *Journal of affective disorders*, *325*, 695–700. https://doi.org/10.1016/j.jad.2023.01.059

Vinas, A., Blanco, F., & Matute, H. (2025). The combined effect of patient classification systems and availability of resources can bias the judgments of treatment effectiveness. *Scientific reports*, *15*(1), 15915. https://doi.org/10.1038/s41598-025-01043-w

Voineskos D, Daskalakis ZJ, Blumberger DM. Management of Treatment-Resistant Depression: Challenges and Strategies. Neuropsychiatr Dis Treat. 2020 Jan 21;16:221-234. doi: 10.2147/NDT.S198774. PMID: 32021216; PMCID: PMC6982454.

Wasti, S. P., Simkhada, P., van Teijlingen, E. R., Sathian, B., & Banerjee, I. (2022). The Growing Importance of Mixed-Methods Research in Health. *Nepal journal of epidemiology*, *12*(1), 1175–1178. https://doi.org/10.3126/nje.v12i1.43633

Watson, D., & Clark, L. A. (1995). Depression and the melancholic temperament. *European Journal of Personality, 9*(5), 351–366. https://doi.org/10.1002/per.2410090505

Widiger, T. A., & Samuel, D. B. (2005). Diagnostic categories or dimensions? A question for the Diagnostic And Statistical Manual Of Mental Disorders--fifth edition. *Journal of abnormal psychology*, *114*(4), 494–504. https://doi.org/10.1037/0021-843X.114.4.494

Woolford, S. J., Watson, J., Reeve, J., & Harris, T. (2024). The real work of general practice: understanding our hidden workload. *The British journal of general practice : the journal of the Royal College of General Practitioners*, *74*(742), 196–197. https://doi.org/10.3399/bjgp24X737061

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.). https://icd.who.int/en/

World Health Organization. (2025a). *World health statistics 2025: monitoring health for the SDGs, Sustainable Development Goals*. Geneva: World Health Organization. https://iris.who.int/handle/10665/381418.

World Health Organization. (2025b, August 29). *Depressive disorder (depression)* [Fact sheet]. https://www.who.int/news-room/fact-sheets/detail/depression.

Wright, M. (2024). A need for systems thinking and the appliance of (complexity) science in healthcare. *Future Healthcare Journal*, *11*(4), 100185.

Yamane, T. (1967). *Statistics: An introductory analysis* (2nd ed.). Harper and Row

Young, H. N., Bell, R. A., Epstein, R. M., Feldman, M. D., & Kravitz, R. L. (2008). Physicians' shared decision-making behaviors in depression care. *Archives of internal medicine*, *168*(13), 1404–1408. https://doi.org/10.1001/archinte.168.13.1404

Zainab, A., & Pereira, X. (2007). Depression in primary care, part 1: screening and diagnosis. *Malaysian family physician : the official journal of the Academy of Family Physicians of Malaysia*, *2*(3), 95–101.

Zaini, S., Manivanna Bharathy, H. A., Sulaiman, A. H., Singh Gill, J., Ong Hui, K., Zaman Huri, H., Shamsudin, S. H., & Chong Guan, N. (2018). Development of a Strategic Tool for Shared Decision-Making in the Use of Antidepressants among Patients with Major Depressive Disorder: A Focus Group Study. *International journal of environmental research and public health*, *15*(7), 1402. https://doi.org/10.3390/ijerph15071402

Zhuparris, A., Maleki, G., van Londen, L., Koopmans, I., Aalten, V., Yocarini, I. E., Exadaktylos, V., van Hemert, A., Cohen, A., Gal, P., Doll, R. J., Groeneveld, G. J., Jacobs, G., & Kraaij, W. (2023). A smartphone- and wearable-based biomarker for the estimation of unipolar depression severity. *Scientific reports*, *13*(1), 18844. https://doi.org/10.1038/s41598-023-46075-2

Zuithoff, N. P., Vergouwe, Y., King, M., Nazareth, I., Hak, E., Moons, K. G., & Geerlings, M. I. (2009). A clinical prediction rule for detecting major depressive disorder in primary care: the PREDICT-NL study. *Family practice*, *26*(4), 241–250. https://doi.org/10.1093/fampra/cmp036

Zung, W. W., Magill, M., Moore, J. T., & George, D. T. (1983). Recognition and treatment of depression in a family medicine practice. *The Journal of clinical psychiatry*, *44*(1), 3–6.

Appendices

Appendix A – PROSPERO record confirmation


NIHR | National Institute for Health and Care Research

PROSPERO
International prospective register of systematic reviews

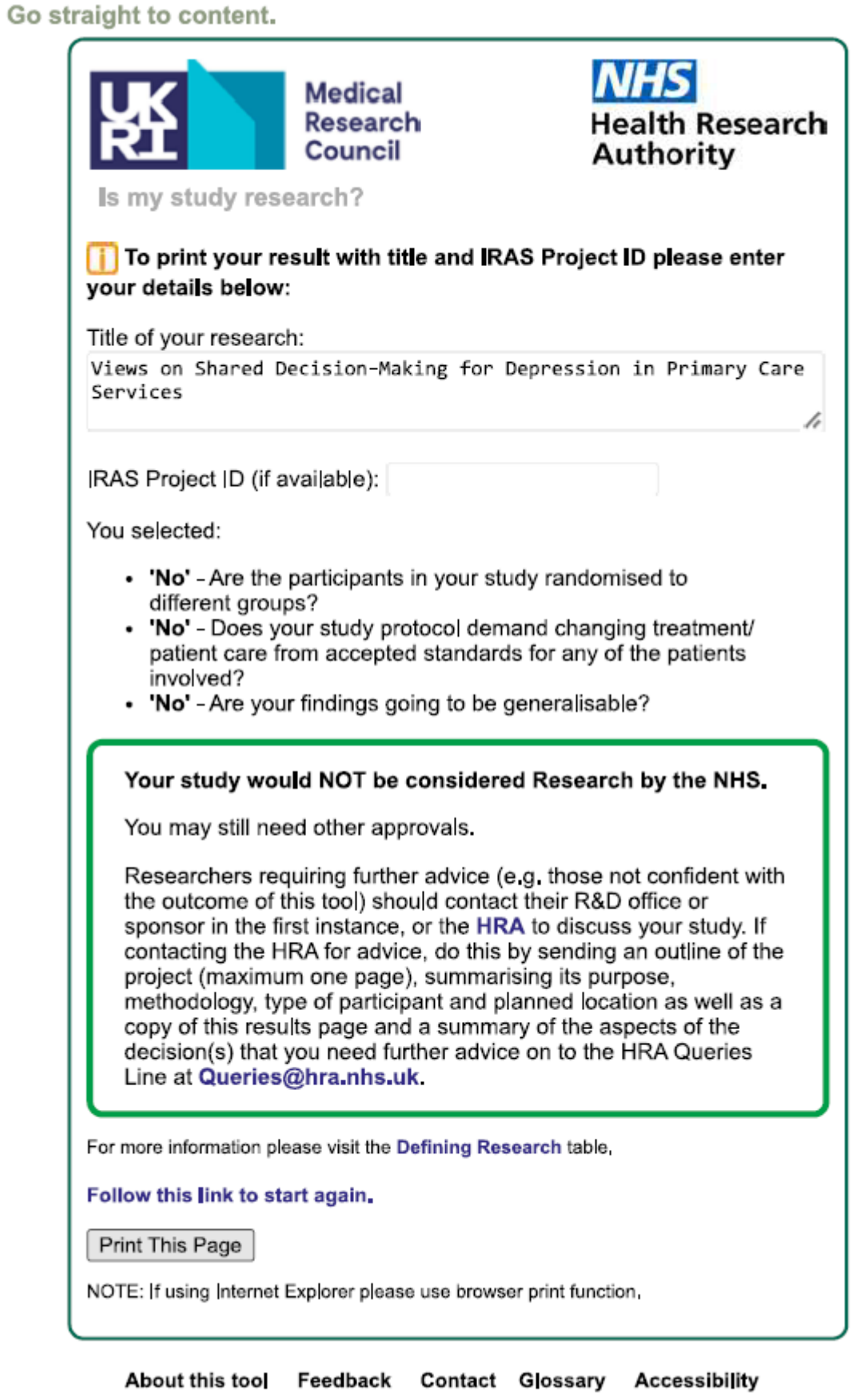
Shared decision-making being implemented in primary care services by GPs when treating patients presenting with depression

Ioana TOFAN [redacted]

Citation

Ioana TOFAN, Susan McPherson. Shared decision-making being implemented in primary care services by GPs when treating patients presenting with depression. PROSPERO 2026 CRD420261352288. Available from https://www.crd.york.ac.uk/PROSPERO/view/CRD420261352288.

Appendix B – HRA decision



Go straight to content.

Medical Research Council

NHS Health Research Authority

Is my study research?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

Views on Shared Decision-Making for Depression in Primary Care Services

IRAS Project ID (if available):

You selected:

- **'No'** - Are the participants in your study randomised to different groups?
- **'No'** - Does your study protocol demand changing treatment/ patient care from accepted standards for any of the patients involved?
- **'No'** - Are your findings going to be generalisable?

Your study would NOT be considered Research by the NHS.

You may still need other approvals.

Researchers requiring further advice (e.g. those not confident with the outcome of this tool) should contact their R&D office or sponsor in the first instance, or the HRA to discuss your study. If contacting the HRA for advice, do this by sending an outline of the project (maximum one page), summarising its purpose, methodology, type of participant and planned location as well as a copy of this results page and a summary of the aspects of the decision(s) that you need further advice on to the HRA Queries Line at **Queries@hra.nhs.uk**.

For more information please visit the **Defining Research** table.

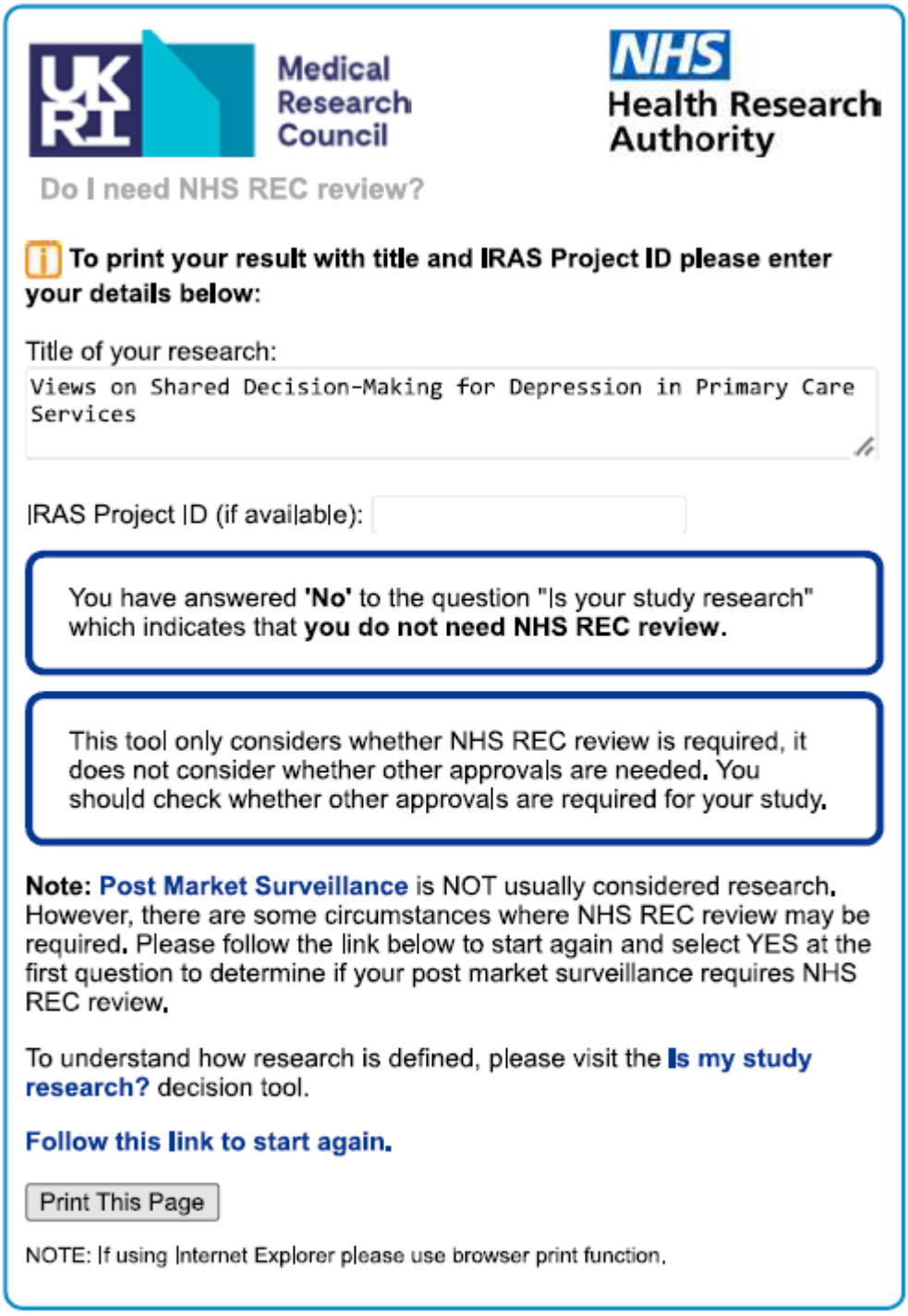
Follow this link to start again.

Print This Page

NOTE: If using Internet Explorer please use browser print function.

About this tool **Feedback** **Contact** **Glossary** **Accessibility**

Go straight to content.



About this tool Feedback Contact Glossary Algorithm Accessibility

Re: HRA approval query

Queries [redacted]

Mon 10/06/2024 14:40

To:Tofan, Ioana <it23662@essex.ac.uk>

[redacted]

ENQUIRY TO QUERIES LINE

Dear Ioana,

Your query was reviewed by our Decision Panel Advisors

RE: GP and primary care staff Views on Shared Decision-Making for Depression

Thank you for your email seeking additional clarity on whether your project should be classified as research and whether it requires ethical review by an NHS Research Ethics Committee (REC).

You provided the following information:

- A study summary
- A PDF / screenshot of the results page of the decision tool(s)
- An explanation of why you disagree with the outcome of the decision tool(s)
- A copy of any previous correspondence/advice, with the HRA or another organisation, in relation to this query

Based on the information you have provided, our advice is that the project is **not considered to be research and does not require review by an NHS Research Ethics Committee.**

Based on the information you provided, the project does not require HRA and HCRW Approval or NHS/HSC R&D Permissions

This advice is based on the information provided. The advisors agreed that this project was not considered research and could be categorised as a service evaluation due to the following:

- This project does not appear to be deriving generalisable or transferable new knowledge to answer questions.
- The project intends to compare against a NICE guideline.

The advisors agreed that this project does not require NHS REC review or HRA and HCRW Approval or NHS/HSC R&D Permissions as this project was not considered research.

This decision/advice is in line with:

- Governance Arrangements for Research Ethics Committees
- UK Policy Framework for Health and Social Care Research
- The Research Ethics Service (NRES) Defining Research table (linked to from the first page of the 'Is it research?' Decision Tool)
- Algorithm Does my project require review by an NHS Research Ethics Committee? (linked in the footer of the 'Do I need NHS REC review?' Decision Tool)

This decision/advice should not be interpreted as giving a form of ethical approval or endorsement to your project on behalf of the HRA. However, it may be provided to a journal or other body as evidence if required.

Please note that this decision/advice was based on the information provided to us as listed above. If any changes are made to information you provided, this may alter the decision/advice.

You should also be aware that:

- This response only covers whether your project is classified as research and whether it requires review by an NHS REC. You are strongly advised to consider other approvals that may be required for your project.

- All types of study involving human participants should be conducted in accordance with basic ethical principles, such as informed consent and respect for the confidentiality of participants. Also, in processing identifiable data there are legal requirements under the Data Protection Act (2018). When undertaking an audit or service/therapy evaluation, the investigator and his/her team are responsible for considering the ethics of their project with advice from within their organisation.

Regards,

Queries Line
REF 1432/133/134/81

The Queries Line is an email-based service that provides advice from HRA senior management, including operations managers based in our regional offices throughout England. Providing your query in an email helps us to quickly direct your enquiry to the most appropriate member of our team who can provide you with an accurate written response. It also enables us to monitor the quality and timeliness of the advice given by the HRA to ensure we can give you the best service possible, as well as use queries to continue to improve and to develop our processes.

Health Research Authority

[redacted]

Appendix C – Ethics Application – ERAMS

University of Essex ERAMS

06/09/2024

Miss Ioana Tofan

Health and Social Care

University of Essex

Dear Ioana,

Ethics Committee Decision

Application: ETH2324-1557

I am pleased to inform you that the research proposal entitled "GP Views on Shared Decision-Making for Depression " has been reviewed on behalf of the Ethics Sub Committee 1, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Extensions and Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.

Yours sincerely,

REO Research Governance Team

Ethics ETH2324-1557: Miss Ioana Tofan

Appendix D – Recruitment poster

[redacted]

PARTICIPANTS needed



GP VIEWS ON SHARED DECISION-MAKING FOR DEPRESSION

THE RESEARCH PROJECT

My name is Ioana Tofan and I am a Trainee Clinical Psychologist at University of Essex. For my thesis I aim to explore the applications and barriers in using the new 2022 UK NICE guideline for depression in primary care services.



WHAT IT INVOLVES?

PART 1
An online survey that will take approximately 10-15 minutes exploring views on shared decision-making.

PART 2 (Optional)
An interview conducted remotely aiming to explore barriers in implementing shared decision-making.



CAN I TAKE PART?

You are invited to take part if you are:

- a registered GP;
- currently practicing in the UK;
- involved in decision making for patients presenting with depression.

INTERESTED?

To take part, please scan the QR code or click the link below:

[redacted]

Any questions? Please get in touch:
it23662@essex.ac.uk
This research project is supervised by

[redacted]

ETHICAL APPROVAL

This project has been approved by the University of Essex Sub-Committee 1 Ethics Reference: ETH2324-1557

Appendix E – Qualtrics survey



Welcome Page

Exploring GP views on Shared Decision Making for Depression

We are interested in understanding your experience of implementing patient choice and shared decision making when working with depressed patients.

We have created this online survey as the first part of a research project to explore this question.

The survey should take about 5-10 minutes to complete.

At the end of the survey there is some information about another part of our research project (interviews) in case you would like to be involved further.

All responses will be kept completely confidential. If you would like to contact one of the researchers involved in the study to discuss or ask questions, please contact: **Ioana Tofan it23662@essex.ac.uk**

By clicking the "Next" button below, you will move to the next screen which provides more details about the research so you can decide whether or not to take the survey.

Participant Information Page

GP views on Shared Decision Making for Depression

Information for participants

We are a team of researchers at the University of Essex. We are interested in the experiences and views of GPs on patient choice in managing patients presenting with depression. We are additionally interested in barriers in applying shared decision-making in practice.

Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

There are two parts of the study. You may take part in Part 1 only (the online survey); or you may take part in both (online survey plus an individual interview). If you only wish to take part in the interview, you can contact me directly.

Part 1: Online survey

The first part of the project involves completing this online survey. If you tick the consent box on the next page, you will be guided through an online survey which includes a range of questions starting with demographic information and then moving on to explore level

of knowledge about shared decision making and current practices. Completing this online survey should take no longer than 5-10 minutes to complete.

Part 2: Interview (optional)

At the end of the survey there will be an opportunity to let us know if you would be interested in taking part in a further interview about your experiences. If you want to take part in an interview, you can enter your contact details and one of the researchers will get in touch to arrange a convenient time and place for the interview. The interview would be audiorecorded and transcribed.

PARTICIPANT INFORMATION: ONLINE SURVEY

What is the purpose of the study?

This study aims to explore the extent to which the 2022 UK NICE guideline for depression is being applied in primary care practice, specifically in relation to shared decision making and patient choice and the barriers that might be preventing fuller implementation.

Who can take part?

General Practitioners (GPs) currently practicing in the UK and registered with the General Medical Council

AND

Experience of working with patients presenting with depression.

Do I have to take part?

No. It is your choice to participate or not. No one will mind if you choose not to take part. If you do not wish to complete this survey, you can close the browser.

What is involved in taking part?

Taking part in the online survey involves answering some questions on the current online form by clicking through each page in turn and typing your answers or selecting a response from a set of options.

What are the possible disadvantages and risks of taking part?

Participating in the research is not anticipated to cause any harm or distress. However, survey questions about personal or emotive topics may bring up feelings for some. Please let us know if taking part in the project causes you any distress.

What are the possible benefits of taking part?

Taking part in this research will help advance the understanding of this new guideline being applied in practice and any potential barriers preventing a fuller implementation.

Will my information be kept confidential?

All of your answers to the survey will be kept confidential. Your name or details will not be mentioned. All information will be stored securely in password protected files to which only the researchers will have access to.

What is the legal basis for using the data and who is the Data Controller?

The legal basis for processing your data is consent. The "data controller" is the University of Essex and if you wish to contact anyone about data protection, please email the University Information Assurance Manager: [redacted]

What if I'm not sure whether to take part?

If you have questions about the project or if you would like to talk more about it before you take the survey or before you decide whether you want to be interviewed, you can contact a member of the research team by email (details below).

What will happen to the results of the research study?

All the information from all the people who take part will be compiled and then analysed. The findings will then be written up and (if you choose to provide contact details) will be shared with you and other people who took part. The project will be written up in an academic journal article.

Who has reviewed the study?

The study has been reviewed and approved by the University of Essex Ethics Sub-Committee 1.

Concerns and Complaints

☐ If for any reason you feel unhappy with the process or treatment you receive when participating in the project, you can contact one of the lead members of the research team: Ioana Tofan and [redacted]. If you are still not satisfied, please contact the University of Essex Research Integrity Manager, [redacted]

☐ **Name of the Research Team Members**

☐ Ioana Tofan: it23662@essex.ac.uk

[redacted]: [redacted]

By clicking the "Next" button below, you will move to the next screen which asks you to indicate your consent to take part in the online survey. If you do not want to take part you may close your browser now.

Consent to Survey

Before completing the survey, please read the statements below and indicate your consent by checking ALL of the boxes.

If you would like to contact the researcher in this study to discuss this research before you complete this survey, please contact:

Ioana Tofan
it23662@essex.ac.uk

I confirm that I have read and understood the participant information on the previous screen

I understand that my participation is voluntary and I am free to withdraw at any time, without giving a reason and without any penalty.

I understand that my fully anonymous data will be used in research publications I agree to take part in this study

By clicking the "Next" button below you will move to the first set of online survey questions. You may close your browser if you do not wish to continue.

Demographics

About you

Gender

- ○ Male
- ○ Female
- ○ Non-binary / third gender
- ○ Prefer not to say
- ○ [ ] Other

Age

[ ]

Ethnicity

[ ]

Job title/ Role

[ ]

Do you practice as an NHS GP or privately

- ○ NHS only
- ○ Private only
- ○ NHS and private

Years in practice

[ ]

Area of current practice

- ☐ North East England
- ☐ North West England
- ☐ Yorkshire and The Humber
- ☐ East Midlands
- ☐ West Midlands
- ☐ East of England
- ☐ London
- ☐ South East
- ☐ South West
- ☐ [ ] Other

SDM-Q-Doc

Shared Decision Making Questionnaire - Physician Version

Please consider a recent patient you saw who presented with depression and answer the following questions about how the consultation went.

I made clear to my patient that a decision needs to be made.

- ◯ Completely disagree
- ◯ Strongly disagree
- ◯ Somewhat disagree
- ◯ Somewhat agree
- ◯ Strongly agree
- ◯ Completely agree

I wanted to know exactly from my patient how he/she wants to be involved in making the decision.

- ◯ Completely disagree
- ◯ Strongly disagree
- ◯ Somewhat disagree
- ◯ Somewhat agree
- ◯ Strongly agree
- ◯ Completely agree

I told my patient that there are different options for treating depression.

- ◯ Completely disagree
- ◯ Strongly disagree
- ◯ Somewhat disagree
- ◯ Somewhat agree
- ◯ Strongly agree
- ◯ Completely agree

I precisely explained the advantages and disadvantages of the treatment options to my patient.

- ◯ Completely disagree
- ◯ Strongly disagree
- ◯ Somewhat disagree
- ◯ Somewhat agree
- ◯ Strongly agree
- ◯ Completely agree

I helped my patient understand all the information.

- ◯ Completely disagree
- ◯ Strongly disagree
- ◯ Somewhat disagree
- ◯ Somewhat agree
- ◯ Strongly agree
- ◯ Completely agree

I asked my patient which treatment option he/she prefers.

- ◯ Completely disagree
- ◯ Strongly disagree
- ◯ Somewhat disagree
- ◯ Somewhat agree
- ◯ Strongly agree
- ◯ Completely agree

My patient and I thoroughly weighed the different treatment options.

- ◯ Completely disagree
- ◯ Strongly disagree
- ◯ Somewhat disagree
- ◯ Somewhat agree
- ◯ Strongly agree
- ◯ Completely agree

My patient and I selected a treatment option together.

- ◯ Completely disagree
- ◯ Strongly disagree
- ◯ Somewhat disagree
- ◯ Somewhat agree
- ◯ Strongly agree
- ◯ Completely agree

My patient and I reached an agreement on how to proceed.

- ◯ Completely disagree
- ◯ Strongly disagree
- ◯ Somewhat disagree
- ◯ Somewhat agree
- ◯ Strongly agree
- ◯ Completely agree

Option

Your experiences of shared decision-making and offering patient choice

Please use the scale below to reflect on your overall experience of offering choice to clients with depression. Please do not base these answers on a specific case but reflect on how often you believe you demonstrate each area on average across all clients.

	0 (I never do this)	1 (I make a minimal attempt to do this)	2 (I do this to a minimally acceptable level)	3 (I think I do this fairly well)	4 (I think I do this very well)
I draw attention to an identified problem as one that requires a decision making process	○	○	○	○	○
I state that there is more than one way to deal with the identified problem ('equipoise').	○	○	○	○	○
I assess the patient's preferred approach to receiving information to assist decision making (e.g. discussion, reading printed material, assessing graphical data, using videotapes or other media).	○	○	○	○	○
I list 'options', which can include the choice of 'no action'.	○	○	○	○	○
I explain the pros and cons of options to the patient (taking no action is an option)	○	○	○	○	○
I explore the patient's expectations(or ideas) about how the problem(s) are to be managed.	○	○	○	○	○
I explore the patient's concerns (fears) about how the problem(s) are to be managed	○	○	○	○	○
I check that the patient has understood the information	○	○	○	○	○
I offer the patient explicit opportunities to ask questions during the decision making process	○	○	○	○	○

	0 (I never do this)	1 (I make a minimal attempt to do this)	2 (I do this to a minimally acceptable level)	3 (I think I do this fairly well)	4 (I think I do this very well)
I elicit the patient's preferred level of involvement in shared decision making	○	○	○	○	○
I indicate the need for a decision making (or deferring) stage	○	○	○	○	○
I indicate the need to review the decision (or deferment)	○	○	○	○	○

For this section you will be presented with the scale again, but this time please indicate how important you think each aspect of the scale is for your clinical work.

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
I draw attention to an identified problem as one that requires a decision making process	○	○	○	○	○
I state that there is more than one way to deal with the identified problem ('equipoise').	○	○	○	○	○
I assess the patient's preferred approach to receiving information to assist decision making (e.g. discussion, reading printed material, assessing graphical data, using videotapes or other media).	○	○	○	○	○
I list 'options', which can include the choice of 'no action'.	○	○	○	○	○

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
I explain the pros and cons of options to the patient (taking no action is an option)	○	○	○	○	○
I explore the patient's expectations(or ideas) about how the problem(s) are to be managed.	○	○	○	○	○
I explore the patient's concerns (fears) about how the problem(s) are to be managed	○	○	○	○	○
I check that the patient has understood the information	○	○	○	○	○
I offer the patient explicit opportunities to ask questions during the decision making process	○	○	○	○	○
I elicit the patient's preferred level of involvement in shared decision making	○	○	○	○	○
I indicate the need for a decision making (or deferring) stage	○	○	○	○	○
I indicate the need to review the decision (or deferment)	○	○	○	○	○

Views on Shared Decision-Making and Patient Choice

This section asks you about your perspectives on shared decision making and patient choice when working with patients presenting with depression.

In 2022, a new NICE guideline for the management and treatment for depression in adults was published which put much greater emphasis on the importance of shared decision making and, in particular, offering patients a choice among a range of talking therapies. This was a move away from the previous "stepped care" model.

Have you have been made aware of these changes in your practice?

○ Yes
○ No
○ [ ] Other

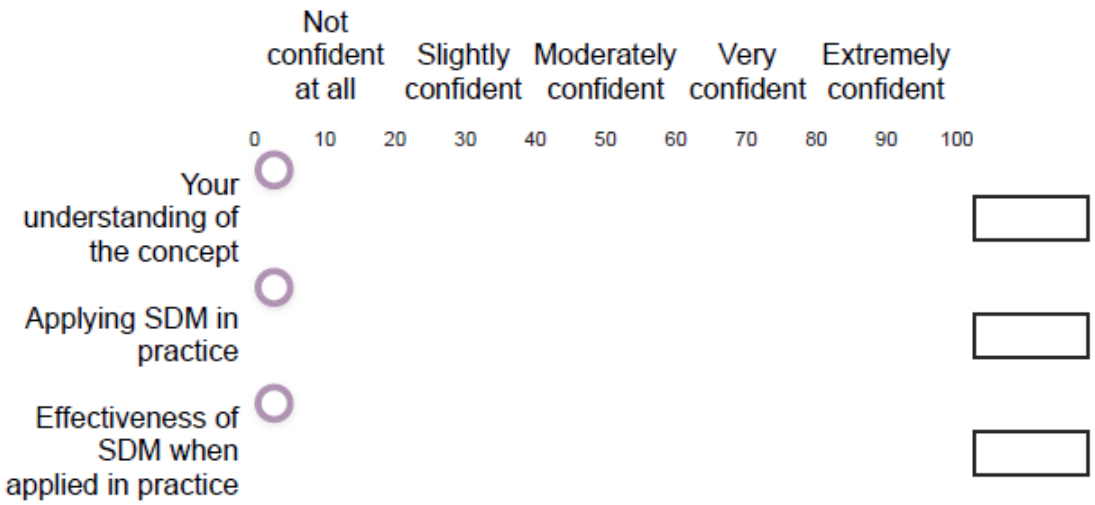
If you have been working since 2022, have your partners in the practice discussed making changes in relation to shared decision making with patients with depression?

- ○ Yes
- ○ No
- ○ Other [ ]

What is shared decision making?

"Shared decision making" is defined as a process which is collaborative between the patient and healthcare worker to reach a joint decision about their care. This decision should be reached taking into account the evidence base and the patient's own preferences and beliefs. To enable this, full information should be given on risks and benefits of each intervention as part of a discussion, with the option of no treatment included as an option. It is also important to acknowledge that some patients may want less input on the decision making process, and therefore an important part of shared decision making is to discuss how much input each individual would like to have within the process. (NICE, 2022)

Considering the definition above, please rate your confidence in relation to shared decision-making with patients presenting with depression



Have you attended any training/CPD on shared decision-making in the last 5 years?

- ◯ Yes
- ◯ No
- ◯ [ ] Other

Did your medical training include any training on shared decision-making?

- ◯ Yes
- ◯ No
- ◯ [ ] Other

Optional

End of Part 1: Thank you for completing this survey.

Would you like to take part in an interview?

We would like to talk to individuals in more detail about their thoughts on implementing patient choice and shared decision making when working with depressed patients.

If you want to take part in an interview, you can enter your contact details below and a member of the research team will get in touch to arrange a convenient time for the interview. The interview would take place by Zoom or telephone, last about an hour, be audio-recorded and transcribed.

What if I'm not sure whether to take part?

If you have questions about the project or if you would like to talk more about it before you decide whether you want to be interviewed, you can contact one of the researchers by email.

Researcher contact details

Ioana Tofan: it23662@essex.ac.uk

Please select a response

- ◯ I would like to take part in an interview
- ◯ I do not want to take part in an interview
- ◯ I would like to ask some questions/discuss before deciding whether to take part in an interview

Contact details (optional) If you would like to take part in an interview or to discuss this before you decide, please enter your name, contact details (email and/or phone) and best times to call you.

Full Name

Email address

Telephone number

Preferred contact method (email/phone)

Best time to contact

Would you like to be informed of the results of this study?

- ◯ Yes (if yes, please provide the email address to which you wish the results to be sent)
- ◯ No

Appendix F – Participant information form for interview



Participant Information Sheet

Project title

GP Views on Shared Decision-Making for Depression

Part 2 - The Interview Study

Information for participants

We are a team of researchers at the University of Essex. We are interested in the experiences and views of GPs on patient choice in managing patients presenting with depression. We are additionally interested in barriers in applying shared decision-making in practice.

Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?

This study aims to explore the extent to which the 2022 UK NICE guideline for depression is being applied in primary care practice, specifically in relation to shared decision making and patient choice and the barriers that might be preventing fuller implementation.

Who can take part?

General Practitioners (GPs) currently practicing in the UK and registered with the Royal College of General Practitioners
AND
Experience of working with patients presenting with depression.

Do I have to take part?

No. It is your choice to participate or not. No one will mind if you choose not to take part. You can also change your mind at any time during the interview. You can let us know at any time that you no longer wish to take part.

What will happen to me if I take part?

This part of the study will involve an online interview that will be conducted via a video call or telephone where we will explore your experiences of using SDM in practice. If you wish to take part, one of the researchers will get in touch to arrange a convenient time and place for the interview. The interview will be audio-recorded and transcribed.

The interview would take place by video call or telephone and will take approximately one hour.

What are the possible disadvantages and risks of taking part?

Participating in the research is not anticipated to cause any harm or distress. However, discussion of any personal or emotive topics may bring up feelings for some. Please let us know if taking part in the project causes you any distress.

What are the possible benefits of taking part?

Taking part in this research will help advance the understanding of this new guideline being applied in practice and any potential barriers preventing a fuller implementation.

Will my information be kept confidential?

All of your answers will be kept confidential. Your name or details will not be mentioned. All information will be stored securely in password protected files to which only the researchers will have access to.

If you decide to take part in an interview, this will be recorded. The recording will be kept securely, and any personal details will be changed. Everything you say will be kept confidential and if something you say is quoted in a report, you will not be identifiable to others.

What is the legal basis for using the data and who is the Data Controller?

The legal basis for processing your data is consent. The "data controller" is the University of Essex and if you wish to contact anyone about data protection, please email the University Information Assurance Manager: [redacted]

What if I'm not sure whether to take part?

If you have questions about the project or if you would like to talk more about it before you want to be interviewed, you can contact a member of the research team by email (details below).

What will happen to the results of the research study?

All the information from all the people who take part will be compiled and then analysed. The findings will then be written up and (if you choose to provide contact details) will be shared with you and other people who took part. The project will be written up in an academic journal article.

Who has reviewed the study?

The study has been reviewed and approved by the University of Essex Ethics Sub-Committee 1.

Concerns and Complaints

If for any reason you feel unhappy with the process or treatment you receive when participating in the project, you can contact one of the lead members of the research team: Ioana Tofan and [redacted] If you are still not satisfied, please contact the University of Essex Research Integrity Manager [redacted] mail: [redacted]. Please include the ERAMS reference which can be found at the foot of this page.

Name of the Research Team Members

Ioana Tofan: it23662@essex.ac.uk

[redacted]

Appendix G – Consent form for interview

[redacted]

Consent Form

Title of the Project: GP Views on Shared Decision-Making for Depression

Part 2 - The Interview Study

Research Team: Ioana Tofan

[redacted]

Please initial box

1. I confirm that I have read and understand the Participant Information Sheet dated 18/08/2024 for the above study. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw from the project at any time without giving any reason and without penalty. I understand that any data collected up to the point of my withdrawal will be destroyed. ☐
3. I understand that the identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project, and that confidentiality will be maintained. ☐
4. I understand that my fully anonymised data will be used for a research publication. ☐
5. I agree to take part in the above study. ☐

Participant Name	Date	Participant Signature
_____	_____	_____

Researcher Name	Date	Researcher Signature
_____	_____	_____

Appendix H – Interview schedule

I. Views on NHS Talking Therapies and new NICE Guideline (if not aware, provide brief summary on the guideline).

e.g. I'm not sure if you are aware but the 2022 NICE guideline moved from a "stepped care" model to a "matched care" model which is supposed to allow for more shared decision making and patient choice – not just between medical and psychological treatments but also between a wider range of psychological treatments. Have you come across these new ideas in the guideline?

· Has this change your practice? How?

· Do you have any thoughts on whether your practice is already aligned with this new model, or would this be a change to your current practice?

· Do you have thoughts on how/whether it would be possible to make changes like that?

· Are there barriers to implementing SDM in general practice for patients with depression or low mood?

II. Information exchange

· How do you give information to patients?

· Can you describe to me how you lay out treatment options for patient including the pros/cons and your opinions?

· What are barriers you face in informing patients?

· How do you get information about patients?

· How do you get their perspectives?/ How do you engage patient opinions?

· What do you do with that?

III. Deliberation

· What happens after you have all the information you need?

· How do you use the information?

· What types of treatments do patients with depression prefer? What approach do they prefer?

· How is this affected by their cultural, age, gender, and educational background?

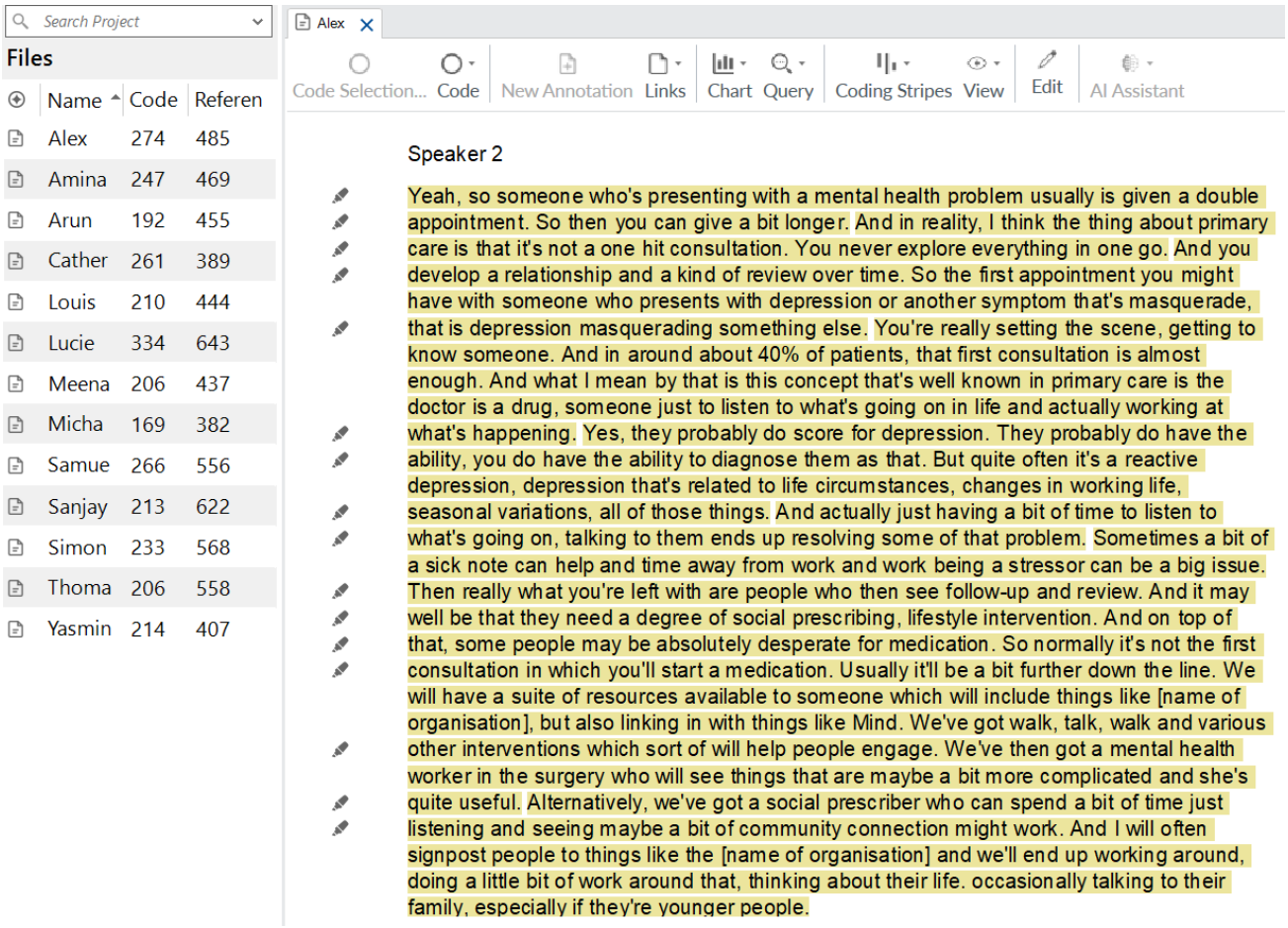
· What problems do people with depression encounter in seeking help and using those services?

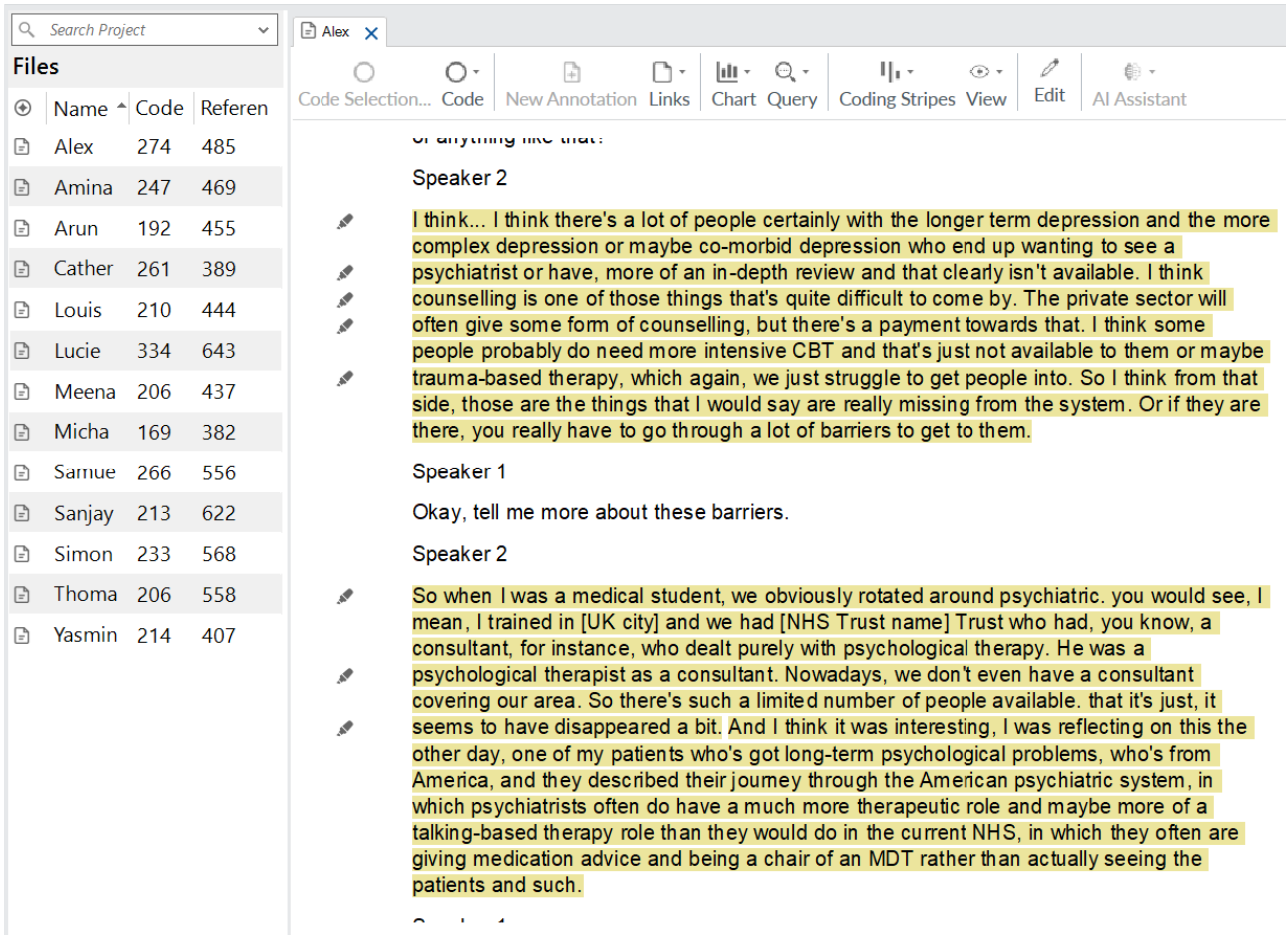
IV. Choosing treatment options

· How is a decision usually made in the end about what treatment option to pursue?

· What is easy/ difficult about the treatment decision-making process with patients who have low mood or other depressive features?

Appendix I – Coded transcript example




Search Project
Files
Name
Code
Referen
Alex 274 485
Amina 247 469
Arun 192 455
Cather 261 389
Louis 210 444
Lucie 334 643
Meena 206 437
Micha 169 382
Samue 266 556
Sanjay 213 622
Simon 233 568
Thoma 206 558
Yasmin 214 407
Alex
Code Selection...
Code
New Annotation
Links
Chart
Query
Coding Stripes
View
Edit
AI Assistant
Speaker 2
I think... I think there's a lot of people certainly with the longer term depression and the more complex depression or maybe co-morbid depression who end up wanting to see a psychiatrist or have, more of an in-depth review and that clearly isn't available. I think counselling is one of those things that's quite difficult to come by. The private sector will often give some form of counselling, but there's a payment towards that. I think some people probably do need more intensive CBT and that's just not available to them or maybe trauma-based therapy, which again, we just struggle to get people into. So I think from that side, those are the things that I would say are really missing from the system. Or if they are there, you really have to go through a lot of barriers to get to them.
Speaker 1
Okay, tell me more about these barriers.
Speaker 2
So when I was a medical student, we obviously rotated around psychiatric. you would see, I mean, I trained in [UK city] and we had [NHS Trust name] Trust who had, you know, a consultant, for instance, who dealt purely with psychological therapy. He was a psychological therapist as a consultant. Nowadays, we don't even have a consultant covering our area. So there's such a limited number of people available. that it's just, it seems to have disappeared a bit. And I think it was interesting, I was reflecting on this the other day, one of my patients who's got long-term psychological problems, who's from America, and they described their journey through the American psychiatric system, in which psychiatrists often do have a much more therapeutic role and maybe more of a talking-based therapy role than they would do in the current NHS, in which they often are giving medication advice and being a chair of an MDT rather than actually seeing the patients and such.

Appendix J - Example of NVivo coding

