National Institute for Health and Care Excellence

Draft for consultation

Depression in adults

[I] Patient Choice

NICE guideline CG90 (update)

Evidence review underpinning recommendations 1.3.1 to 1.3.6 in the NICE guideline

November 2021

Draft for consultation

This evidence review was developed by the National Guideline Alliance which is a part of the Royal College of Obstetricians and Gynaecologists

Disclaimer

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Local commissioners and/or providers have a responsibility to enable the guideline to be applied when individual health professionals and their patients or service users wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.

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ISBN:

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Patient choice

Review question

What are the facilitators and barriers that can enhance or inhibit choice of treatment for adults with depression?

Introduction

There are a wide range of treatments for depression, ranging from low intensity interventions such as self-help, guided self-help and physical activity to higher intensity psychological interventions such as cognitive behavioural therapy, interpersonal therapy and behavioural activation. In addition, there are a range of pharmacological treatments and physical interventions such as electroconvulsive therapy and acupuncture. Many of these treatments are often used in combination, and may be delivered in a variety of settings (for example, individually or in groups, in primary care or secondary care), adding further complexity to the choice of treatment.

While other evidence reviews that form part of this guideline provide evidence on the relative efficacy of these treatments to help inform choice, the process of decision-making may rely on broader human and organisational factors including patients' perceptions of their condition, the information provided about different treatment options, attitudes to therapeutic modalities, and the management of uncertainty. For example, some people may prefer a psychological therapy, while others may prefer medication, at least as an initial treatment, and enabling that choice as far as possible within an informed therapeutic relationship is fundamental to the management of depression in adults.

The aim of this review is to identify facilitators and barriers to patient choice of treatment from the perspective of adults with depression and from the perspective of practitioners.

Summary of the protocol

See Table 1 for a summary of the population, phenomenon of interest and context of this review.

Table 1: Summary of the protocol

Population or problem	Adults with a diagnosis of depression according to DSM, ICD or similar criteria, or depressive symptoms as indicated by baseline depression scores on validated scales (and including those with subthreshold [just below threshold] depressive symptoms)
Perspective	Service users (adults with depression) and practitioners
Phenomenon of Interest	• Elements that adults with depression think are important to choice of pharmacological treatment • Elements that adults with depression think are important to choice of non-pharmacological treatment • Elements that adults with depression think are important to choice between pharmacological and non-pharmacological treatment • Factors or attributes (at the individual-, practitioner-, commissioner- or service- level) that can enhance or inhibit patient choice of treatment
Context	Studies published between 2000 and the date the searches were run were sought. Studies from OECD-member countries.
Review strategy	Synthesis of qualitative research. Results presented in narrative and table format. Quality of the evidence was assessed using a GRADE CerQual approach for each review finding.

For further details see the review protocol in appendix A.

Methods and process

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual. Methods specific to this review question are described in the review protocol in appendix A.

Declarations of interest were recorded according to NICE's 2014 conflicts of interest policy until 31 March 2018. From 1 April 2018, declarations of interest were recorded according to NICE's 2018 conflicts of interest policy. Those interests declared until April 2018 were reclassified according to NICE's 2018 conflicts of interest policy (see Register of Interests).

Clinical evidence

Included studies

Forty-six qualitative studies were included in this review (Anderson & Roy, 2013; Anderson 2015; Anthony 2010; Badger & Nolan 2006; Badger & Nolan 2007; Barney 2011; Bayliss & Holttum 2015; Burroughs 2006; Buus 2012; Chambers 2015; Chew-Graham 2002; Chew-Graham 2012; Chew-Graham 2018; Cramer 2014; Dickinson 2010; Dumesnil 2018; Garfield 2004; Green 2017; Iglesias-González 2021; Jaffray 2014; Johnson 2017; Johnston 2007; Jones 2013; Keeley 2014; Keller 2016; Kirkpatrick 2020; Lawrence 2006; Macdonald 2007; Maxwell 2005; Mercier 2011; Parker 2020a; Patel 2014; Poleshuck 2013; Pollock & Grime, 2003; Railton 2000; Rogers 2001; Schofield 2011; Simon 2007; Stark 2018; Sterner 2020; Turner 2017; van Geffen 2011; van Grieken 2014; Ward 2014; Wilhelmsen 2014; Wittink 2011). Twenty-five studies included adults with depression, 15 included practitioners (GPs

and primary care clinicians) who care for adults with depression, and 6 studies included both adults with depression and practitioners. The included studies are summarised in Table 2.

See the literature search strategy in appendix B and study selection flow chart in appendix C.

Excluded studies

Studies not included in this review are listed, and reasons for their exclusion are provided in appendix K.

Summary of studies included in the evidence review

Summaries of the studies that were included in this review are presented in Table 2. See appendix D for the full evidence tables.

Table 2: Summary of included studies.

Study	Aim of the study	Population	Data Collection	Data Analysis Method
Anderson 2013 Secondary qualitative analysis (of in-depth narrative interviews from Healthtalkonline) UK	To explore patient experiences of taking antidepressants for depression	Adults with depression N=80 Diagnostic status: Unclear (participants who identified as having had depression, and feeling relatively well and symptom free) Age range (mean): 16-75 (33.0) Gender (% female): 66 Ethnicity (% BME): NR	Method: Interview (face-to-face) Setting: Home	Thematic analysis
Anderson 2015 Secondary qualitative analysis (combines data from 3 qualitative studies) UK and Australia	To examine the views, emotions and experiences of people starting antidepressants	Adults with depression N=114 Diagnostic status: Unclear (participants who had started taking antidepressants for depression) Age range (mean): NR	Method: Interview (face-to-face) Setting: Home	Grounded theory: Constant comparative approach (CCA)

Study	Aim of the study	Population	Data Collection	Data Analysis Method
		Gender (% female): 61 Ethnicity (% BME): 11		
Anthony 2010 Qualitative component of mixed-methods study US	To identify conditions that influence primary care clinicians' referral decisions related to depression care	Practitioners N=40 Type of practitioner: Primary care clinician (general internist, nurse practitioner, physician) Age range (mean): NR Gender (% female): 68 Ethnicity (% BME): 37	Method: Interview (face-to-face) Setting: Primary care (at work during lunchtime)	Grounded theory: Constant comparative approach (CCA)
Badger 2006 Primary qualitative study UK	To examine patient perspectives on their depression care and the role that medication and medication management played in their recovery	Adults with depression N=60 Diagnostic status: Unclear (participants prescribed antidepressant medication for an episode of unipolar depression) Age range (mean): NR Gender (% female): 62 Ethnicity (% BME): NR	Method: Interview (format NR) Setting: NR	Framework analysis
Badger 2007 Primary qualitative study	To describe the use of and attitudes towards self-chosen	Adults with depression N=60	Method: Interview (face-to-face)	Framework analysis

Study	Aim of the study	Population	Data Collection	Data Analysis Method
UK	treatments for depression	Diagnostic status: Unclear (participants prescribed antidepressants in the past 12 months for a new episode of unipolar depression) Age range (mean): 24-68 (46.7) Gender (% female): 62 Ethnicity (% BME): NR	Setting: Home or primary care	
Barney 2011 Secondary qualitative analysis (of discussion forums on an online depression bulletin board; blueboard.anu.edu.au) Australia	To investigate the explicit and implicit information needs of users of an online depression support forum	Adults with depression N=134 Diagnostic status: Unclear (posts whose reports indicated they had experienced depression) Age range (mean): NR Gender (% female): NR Ethnicity (% BME): NR	Method: Free-text written response Setting: Online posts in depression support forum	Thematic analysis
Bayliss 2015 Primary qualitative study UK	To determine the experiences of people undergoing combined treatment with antidepressant medication and CBT for depression	Adults with depression N=12 Diagnostic status: Diagnosis of depression according to DSM, ICD or similar criteria (diagnosed with depression and experience of	Method: Interview (face-to-face) Setting: Secondary care or home (patient preference)	Grounded theory: Constant comparative approach (CCA)

Study	Aim of the study	Population	Data Collection	Data Analysis Method
		CBT and antidepressant medication) Age range (mean): 22-58 (44.7) Gender (% female): 42 Ethnicity (% BME): 0		
Burroughs 2006 Qualitative study embedded within a feasibility trial (of a new model of care for late-life depression [PRIDE Trial: PRimary care Intervention for Depression in the Elderly]) UK	To explore how primary care professionals and patients view the causes and management of late-life depression	Adults with depression N=20 Diagnostic status: Clinically important depression symptoms (GDS score ≥5) Age range (mean): NR Gender (% female): NR Ethnicity (% BME): NR Practitioners N=15 Type of practitioner: Primary care professional (GP N=9; practice nurse N=3; district nurse N=2; community nurse N=1) Age range (mean): NR Gender (% female): NR	Method: Interview (face-to-face) Setting: Home (patients); primary care or researcher's office (practitioners)	Grounded theory: Constant comparative approach (CCA)

Study	Aim of the study	Population	Data Collection	Data Analysis Method
		Ethnicity (% BME): NR		
Buus 2012 Qualitative component of mixed-methods study Denmark	To gain insight into depressed patients beliefs about their illness and antidepressant treatment, and how these beliefs related to their self-reported level of adherence to treatment	Adults with depression N=16 Diagnostic status: Diagnosis of depression according to DSM, ICD or similar criteria (ICD-10, F32.0-F33.9 and a prescription for antidepressant) Age range (mean): 22-69 (median 49.5) Gender (% female): 63 Ethnicity (% BME): NR	Method: Interview (face-to-face) Setting: Home	Thematic analysis
Chambers 2015 Primary qualitative study UK Note: Study also included 2 focus groups (N=7 in total) in order to validate interview findings but demographics and data not reported or included here	To understand how people with longer-term depression manage the condition, how services can best support self-management and whether the recovery approach is a useful concept	Adults with depression N=21 Diagnostic status: Diagnosis of depression according to DSM, ICD or similar criteria (participants with dysthymia or major depressive disorder confirmed through a structured diagnostic interview; MINI) Age range (mean): NR Gender (% female): 71	Method: Interview (face-to-face) Setting: Home or university	Interpretative phenomenological analysis (IPA)

Study	Aim of the study	Population	Data Collection	Data Analysis Method
		Ethnicity (% BME): 14		
Chew-Graham 2002 Primary qualitative study UK	To explore GP attitudes to the management of patients with depression (views of GPs in socio-economically deprived areas compared to those serving more affluent populations)	Practitioners N=35 Type of practitioner: GP	Method: Interview (face-to-face) Setting: NR	Grounded theory: Constant comparative approach (CCA)
Chew-Graham 2012 Secondary qualitative analysis (combines data from 2 study datasets) UK	To explore reasons why older people with depression may not present to primary care	Adults with depression N=19 Diagnostic status: Unclear (older people participating in a primary care study of collaborative care or in receipt of old age psychiatry services) Age range (mean): 58-84 (72.2) Gender (% female): NR Ethnicity (% BME): 21	Method: Interview (format NR) Setting: NR	Framework analysis
Chew-Graham 2018 Qualitative study embedded within a RCT (comparing mirtazapine + SNRI or SSRI antidepressants versus SNRI/SSRI therapy alone [MIR trial]) UK	To explore patients' perspectives on being invited to participate in a trial of a second antidepressant for TRD and the acceptability of combination drug treatments for depression to patients and GPs	Adults with depression N=46 Diagnostic status: Unclear (people who were invited to participate in the MIR trial, but declined, and trial participants	Method: Interview (telephone/face-to-face) Setting: Telephone or home	Thematic analysis

Study	Aim of the study	Population	Data Collection	Data Analysis Method
		[those who completed the trial, and who withdrew]) Age range (mean): 27-83 (NR) Gender (% female): 63 Ethnicity (% BME): NR Practitioners N=14 Type of practitioner: GP Age range (mean): NR Gender (% female): 21 Ethnicity (% BME): NR		
Cramer 2014 Primary qualitative study UK Note: Study also included practitioners but no relevant data to extract. Study also included men with anxiety but data not extracted for this group	To examine men's experiences and perception of depression groups and the role of health professionals in accessing support	Adults with depression N=5 Diagnostic status: Unclear (men experiencing depression who attend groups for support) Age range (mean): NR Gender (% female): 0 (all male) Ethnicity (% BME): NR	Method: Focus group and interview Setting: Community setting	Grounded theory: Constant comparative approach (CCA)
Dickinson 2010	To explore the attitudes of GPs to older patients' taking	Practitioners N=10	Method: Interview (format NR)	Framework analysis

Study	Aim of the study	Population	Data Collection	Data Analysis Method
Primary qualitative study UK Note: Data extracted for practitioners only as patients had mixed diagnoses and disaggregated data cannot be extracted	long-term antidepressant therapy	Type of practitioner: GP Age range (mean): 34-60 (NR) Gender (% female): 60 Ethnicity (% BME): NR	Setting: Primary care	
Dumesnil 2018 Primary qualitative study France	To explore GPs' opinions about psychotherapy, their relationships with mental health professionals, their perceptions of their role and that of psychiatrists in treating depression, and the relations between these factors and the GPs' strategies for managing depression	Practitioners N=32 Type of practitioner: GP Age range (mean): NR (66% ≥50 years) Gender (% female): 41 Ethnicity (% BME): NR	Method: Interview (face-to-face) Setting: NR	Thematic analysis
Garfield 2004 Primary qualitative study UK	To identify the information needs and the level of involvement in decision making desired by patients beginning courses of antidepressants	Adults with depression N=51 Diagnostic status: Diagnosis of depression according to DSM, ICD or similar criteria (WHO International Classification of Disease Criteria) Age range (mean): 19-61 (41) Gender (% female): 57	Method: Interview (face-to-face) Setting: Home, researchers office, or surgery (based on participant preference)	Grounded theory: Constant comparative approach (CCA)

Study	Aim of the study	Population	Data Collection	Data Analysis Method
		Ethnicity (% BME): NR		
Green 2017 Qualitative component of mixed-methods follow-up of a study assessing the effectiveness of a collaborative care programme US Note: This paper reports on patient experiences and Kirkpatrick 2020 on practitioner experiences from same study. Data not extracted for telephone follow-up phase as no open-ended qualitative questions included	To explore depressed Latino immigrant primary care patients' knowledge about, and experiences with, antidepressant medications	Adults with depression N=12 Age range (mean): NR Gender (% female): NR Ethnicity (% BME): 100	Method: Focus group Setting: Primary care	NR
Iglesias-Gonzalez 2021 Primary qualitative study Spain	To explore barriers and opportunities in non-pharmacological treatment of depression in primary care from the perspective of family physicians	Practitioners N=36 Type of practitioner: GP Age range (mean): 31-64 (NR) Gender (% female): 83 Ethnicity (% BME): NR	Method: Focus group Setting: NR	Thematic analysis
Jaffray 2014 Primary qualitative study UK	To explore views and experiences of patients recently initiated on antidepressants and to consider the influences on early discontinuation	Adults with depression N=29 Diagnostic status: Unclear (patients recently [in the last 6 months] initiated on antidepressant treatment for depression)	Method: Interview (face-to-face) Setting: General practice, university research centre, or home (based on participant preference)	Framework analysis

Study	Aim of the study	Population	Data Collection	Data Analysis Method
		Age range (mean): Median 49 (IQR 40-56.5) Gender (% female): 69 Ethnicity (% BME): NR		
Johnson 2017 Primary qualitative study UK	To explore factors influencing GPs' use of antidepressants and their doses to treat depression	Practitioners N=28 Type of practitioner: GP Age range (mean): 33-60 (median 43) Gender (% female): 50 Ethnicity (% BME): NR	Method: Interview (face-to-face) Setting: Primary care	Grounded theory: Constant comparative approach (CCA)
Johnston 2007 Primary qualitative study UK Note: Study reports data for supporters of patients with depression but that has not been extracted. The patient population (and demographics) also includes 15 people who had never been depressed but disaggregated data used	To identify issues of importance to GPs and patients regarding depression management	Adults with depression N=61 Diagnostic status: Unclear (28 were experiencing an episode of depression at the time of the interview, 18 had a past history of depression, and 15 had never been depressed) Age range (mean): 18-83 (NR) Gender (% female): 72	Method: Interview (face-to-face) Setting: Home or primary care	Grounded theory: Constant comparative approach (CCA)

Study	Aim of the study	Population	Data Collection	Data Analysis Method
		Ethnicity (% BME): 5 Practitioners N=32 Type of practitioner: GP Age range (mean): 30-58 (NR) Gender (% female): 38 Ethnicity (% BME): 3		
Jones 2013 Primary qualitative study Australia	To explore GPs' understanding of the definitions of and management guidelines for difficult-to-treat depression (DTTD), and their experiences of diagnosing and managing patients with DTTD	Practitioners N=10 Type of practitioner: GP Age range (mean): NR Gender (% female): 20 Ethnicity (% BME): NR	Method: Focus group or interview (telephone) Setting: NR	Framework analysis
Keely 2014 Primary qualitative study US	To compare primary care clinicians' and their patients' perceptions of the patients' experiences, expectations and preferences as they try to achieve care for depression	Adults with depression N=30 Diagnostic status: Diagnosis of depression according to DSM, ICD or similar criteria (met ICD-9 criteria for depression in last 12 months) Age range (mean): NR	Method: Interview (telephone) Setting: Telephone	Template analysis

Study	Aim of the study	Population	Data Collection	Data Analysis Method
		Gender (% female): NR Ethnicity (% BME): NR Practitioners N=6 Type of practitioner: Primary care clinician Age range (mean): NR Gender (% female): NR Ethnicity (% BME): NR		
Keller 2016 Primary qualitative study US	To explore experiences of disclosure of depressive symptoms to primary care providers among self-identified African American, Hispanic and non-Hispanic White women	Adults with depression N=34 Diagnostic status: Clinically important depression symptoms (PHQ-8 score ≥10) Age range (mean): 18-58 (40) Gender (% female): 100 Ethnicity (% BME): 58	Method: Interview (format NR) Setting: NR	Content analysis
Kirkpatrick 2020 Qualitative component of mixed-methods follow-up of a study assessing the effectiveness of a collaborative care programme	To describe providers' experiences in working with depressed Latino immigrants, and practical solutions for	Practitioners N=12 Type of practitioner: Primary care providers (physicians, nurse	Method: Focus group Setting: Primary care	Thematic analysis

Study	Aim of the study	Population	Data Collection	Data Analysis Method
US Note: Data not extracted for GP interpretations of patient perceptions as not first-hand accounts (and patient perspectives from this study reported in Green 2017)	primary care practices to address barriers to care facing depressed Latino immigrants	practitioners, and physician assistants) Age range (mean): NR Gender (% female): 83 Ethnicity (% BME): NR		
Lawrence 2006 Primary qualitative study UK Note: Study also included non-depressed participants but data only extracted for the depressed (treated and not treated) participants	To explore older adults' attitudes and beliefs regarding what would help someone with depression, and to consider how these may facilitate or deter older people from accessing treatment	Adults with depression N=67 Diagnostic status: Clinically important depression symptoms (HADS score ≥7) Age range (mean): NR (≥65 years) Gender (% female): NR Ethnicity (% BME): 60	Method: Interview (face-to-face) Setting: Home	Grounded theory: Constant comparative approach (CCA)
MacDonald 2007 Qualitative study embedded within a RCT (of guided self-help) UK	To explore patient attitudes, by examining patient expectancies of psychological therapy and their experiences with a 'minimal intervention' (guided self-help)	Adults with depression N=24 Diagnostic status: Clinically important depression symptoms (mean baseline BDI score 26.1) Age range (mean): 21-56 (39) Gender (% female): 83	Method: Interview (face to face) Setting: Home	Framework analysis

Study	Aim of the study	Population	Data Collection	Data Analysis Method
		Ethnicity (% BME): 0		
Maxwell 2005 Primary qualitative study UK	To explore women's and GPs' experiences of recognising depression and their experiences of the management of depression	Adults with depression N=37 Diagnostic status: Unclear (women attending the GPs' surgeries who the GPs defined as having current/previous or new/likely depression Age range (mean): 19-72 (40) Gender (% female): 100 Ethnicity (% BME): NR Practitioners N=20 Type of practitioner: GP Age range (mean): NR (35% 30-40; 50% 40-50; 15% 50-60) Gender (% female): 50 Ethnicity (% BME): NR	Method: Interview (format NR) Setting: NR	Grounded theory: Constant comparative approach (CCA)
Mercier 2011 Primary qualitative study France	To explore how GPs declare they use antidepressants in daily practice and understand	Practitioner N=56 Type of practitioner: GP	Method: Focus group Setting: NR	Interpretative phenomenological analysis (IPA)

Study	Aim of the study	Population	Data Collection	Data Analysis Method
	their reasons for prescribing them	Age range (mean): 25-65 (40) Gender (% female): 31 Ethnicity (% BME): NR		
Parker 2020a Primary qualitative study UK	To explore how GPs care for patients experiencing emotional concerns within the constraints of busy clinical practice	Practitioner N=7 Type of practitioner: GP Age range (mean): NR Gender (% female): 71 Ethnicity (% BME): NR	Method: Focus group Setting: Primary care	Thematic analysis
Patel 2014 Primary qualitative study US	To explore primary care professional's perspectives on treatment decision-making for depression with African Americans and Latinos in primary care practice	Practitioner N=15 Type of practitioner: Primary care healthcare professionals (nurse practitioners, psychiatrists, primary care physicians, social workers and practice administrators) Age range (mean): NR (39) Gender (% female): 87 Ethnicity (% BME): NR	Method: Interview (format NR) Setting: NR	Grounded theory: Constant comparative approach (CCA)
Poleshuck 2013 Primary qualitative study	To understand women's health patients' experiences of depressive	Adults with depression N=23	Method: Interview (face-to-face)	Thematic analysis

Study	Aim of the study	Population	Data Collection	Data Analysis Method
US	symptoms and perspectives on the low uptake of psychotherapy	Diagnostic status: Unclear (screened positive for depression using the PGQ-2) Age range (mean): 18-49 (32.9) Gender (% female): 100 Ethnicity (% BME): 70	Setting: Women's health clinic	
Pollock 2003 Primary qualitative study UK	To investigate GP perspectives on consultation time and the management of depression in general practice	Practitioner N=19 Type of practitioner: GP Age range (mean): NR Gender (% female): 32 Ethnicity (% BME): NR	Method: Interview (face-to-face) Setting: Primary care	Thematic analysis
Railton 2000 Primary qualitative study UK	To explore how GPs approached the care of patients with depression in relation to their skills, knowledge and attitudes	Practitioner N=15 Type of practitioner: GP Age range (mean): 33-56 (NR) Gender (% female): 13 Ethnicity (% BME): NR	Method: Interview (face-to-face) Setting: Primary care	Grounded theory: Constant comparative approach (CCA)
Rogers 2001 Primary qualitative study UK	To explore the ways that doctors and patients conceptualise and respond to depression as a problem in the	Adults with depression N=27 Diagnostic status: Unclear (GPs referred	Method: Interview (format NR) Setting: NR	Thematic analysis

Study	Aim of the study	Population	Data Collection	Data Analysis Method
	specific organisational context of primary care	names of people who had consulted with them for moderate depression over a 1-month period) Age range (mean): NR Gender (% female): NR Ethnicity (% BME): NR Practitioners N=10 Type of practitioner: GP Age range (mean): 31-56 (NR) Gender (% female): 70 Ethnicity (% BME): NR		
Schofield 2011 Primary qualitative study UK	To explore factors that influence patients' decisions about taking antidepressant medication	Adults with depression N=61 Diagnostic status: Unclear (prescribed antidepressants for depression or mixed anxiety and depression in the past year) Age range (mean): 23-95 (48.7)	Method: Interview (face to face) Setting: Home (or patient preference)	Grounded theory: Constant comparative approach (CCA)

Study	Aim of the study	Population	Data Collection	Data Analysis Method
		Gender (% female): 70 Ethnicity (% BME): 34		
Simon 2007 Qualitative study (conducted as pre-clinical trial research study within 1 of a series of 10 projects implementing shared decision-making in various medical conditions) Germany	To investigate depressed patients perceptions of the treatment decision-making process with GPs (within a goal of informing the design of a shared decision-making intervention)	Adults with depression N=40 Diagnostic status: Diagnosis of depression according to DSM, ICD or similar criteria (ICD-10 diagnoses from F.31 to F.39) Age range (mean): 18-70 (43.2) Gender (% female): 60 Ethnicity (% BME): NR	Method: Interview (face-to-face) Setting: Not reported	Framework analysis
Stark 2018 Qualitative study embedded within a multicentre, primary care-based, cohort study (AgeMooDe) Germany	To explore older patients' knowledge, beliefs, attitudes and experiences with depression	Adults with depression N=12 Diagnostic status: Clinically important depression symptoms (GDS score ≥6) Age range (mean): 77-91 (median 81) Gender (% female): 58 Ethnicity (% BME): NR	Method: Interview (face-to-face) Setting: Home or primary care	Content analysis
Sterner 2020 Qualitative study following baseline	To explore experiences of depression in early late life	Adults with depression N=16	Method: Focus group Setting: NR	Thematic analysis

Study	Aim of the study	Population	Data Collection	Data Analysis Method
examination of 70-year-olds in the population-based Gothenburg H70 Birth Cohort Studies (the H70 study) Sweden		Diagnostic status: Diagnosis of depression according to DSM, ICD or similar criteria (diagnosis [according to DSM-5] confirmed by psychiatrist based on clinical record) Age range (mean): 71-72 (71.8) Gender (% female): 75 Ethnicity (% BME): NR		
Turner 2017 Secondary analysis (combined data across 3 qualitative studies embedded within large, primary care depression trials) UK	To bring together participants' accounts of their experiences following randomisation in order to assess whether there are differences between the experiences of individuals in different trial arms that researchers may want to consider when designing future trials and evaluating complex interventions	Adults with depression N=37 Diagnostic status: Unclear Age range (mean): NR (16% 20-29; 35% 30-39; 22% 40-49; 14% 50-59; 14% 60+) Gender (% female): 68 Ethnicity (% BME): NR	Method: Interview (format NR) Setting: NR	Thematic analysis
van Geffen 2011 Primary qualitative study Netherlands	To explore the experiences and beliefs of SSRI users in relation to initiation and execution of treatment	Adults with depression N=18 Diagnostic status: Unclear (started treatment with	Method: Interview (face-to-face) Setting: Home or pharmacy (patient preference)	Grounded theory: Constant comparative approach (CCA)

Study	Aim of the study	Population	Data Collection	Data Analysis Method
		an SSRI prescribed by a GP within the previous 4 months and had obtained the SSRI for a minimum duration of use of 2 months) Age range (mean): 19-83 (51.4) Gender (% female): 72 Ethnicity (% BME): NR		
van Grieken 2014 Primary qualitative study Netherlands	To explore patients' perspectives on impeding characteristics of professional treatment for the recovery of MDD	Adults with depression N=27 Diagnostic status: Remitted depression (MDE and recovery status were confirmed by the Structured Clinical Interview for DSM-IV) Age range (mean): 22-63 (46) Gender (% female): 63 Ethnicity (% BME): NR	Method: Interview (face-to-face) Setting: Home (or patient preference)	Grounded theory: Constant comparative approach (CCA)
Ward 2014 Primary qualitative study US	To examine older African American women's lived experiences with depression and coping behaviours	Adults with depression N=13 Diagnostic status: Clinically important depression	Method: Interview (face-to-face) Setting: NR	Phenomenological research analysis

Study	Aim of the study	Population	Data Collection	Data Analysis Method
		symptoms (CES-D score ≥16) Age range (mean): 60-78 (71) Gender (% female): 100 Ethnicity (% BME): 100		
Willhelmsen 2014 Qualitative study following training package (3-day course) introducing a Norwegian translation of the computerised CBT programme MoodGYM Norway	To explore aspects perceived by GPs to affect the implementation of guided computerised CBT in daily practice	Practitioners N=11 Type of practitioner: GP Age range (mean): 33-58 (45) Gender (% female): 82 Ethnicity (% BME): NR	Method: Interview (face to face) Setting: Primary care	Thematic analysis
Wittink 2011 Qualitative study embedded within 2 RCTs (Primary Care Research in Substance Abuse and Mental Health for the Elderly trial [PRISM-E] or Prevention of Suicide in Primary Care Elderly: Collaborative Trial [PROSPECT]) US	To explore how primary care providers describe the process of discussing depression care with older adults	Practitioners N=15 Type of practitioner: Primary care provider (N=9 internists; N=4 family doctors; N=2 specialised in geriatric medicine) Age range (mean): NR (67% <50 years) Gender (% female): 67 Ethnicity (% BME): NR	Method: Interview (telephone) Setting: Telephone	Grounded theory: Constant comparative approach (CCA)

BDI: Beck depression inventory; BME: black, minority, ethnic; CBT: cognitive–behavioural therapy; CES-D: centre for epidemiologic studies depression scale; DSM: diagnostic statistical manual; GDS: geriatric depression scale; GP: general practitioner; HADS: hospital anxiety and depression scale; IQR: interquartile range; MDD: major

depressive disorder; MDE: major depressive episode; MINI: mini-international neuropsychiatric interview; NR: not reported; PHQ: patient health questionnaire; SNRI: serotonin-noradrenaline reuptake inhibitor; SSRI: selective serotonin reuptake inhibitor; TRD: treatment-resistant depression; WHO: world health organisation

Summary of the qualitative evidence

Qualitative data was meta-synthesised using a thematic analysis approach. This was guided by the 6 phases outlined by Braun and Clarke (2006): familiarizing yourself with the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; producing the report. Thematic maps were used as an aid to think about the relationship between codes, between themes, and between different levels of themes (for example, main overarching themes and subthemes within them), and to inductively identify, review and refine the themes and subthemes that describe the qualitative data.

Thematic maps of the themes identified for adults with depression and practitioners are presented in Figure 1 and Figure 2 respectively.

Figure 1: Thematic map from the perspective of adults with depression

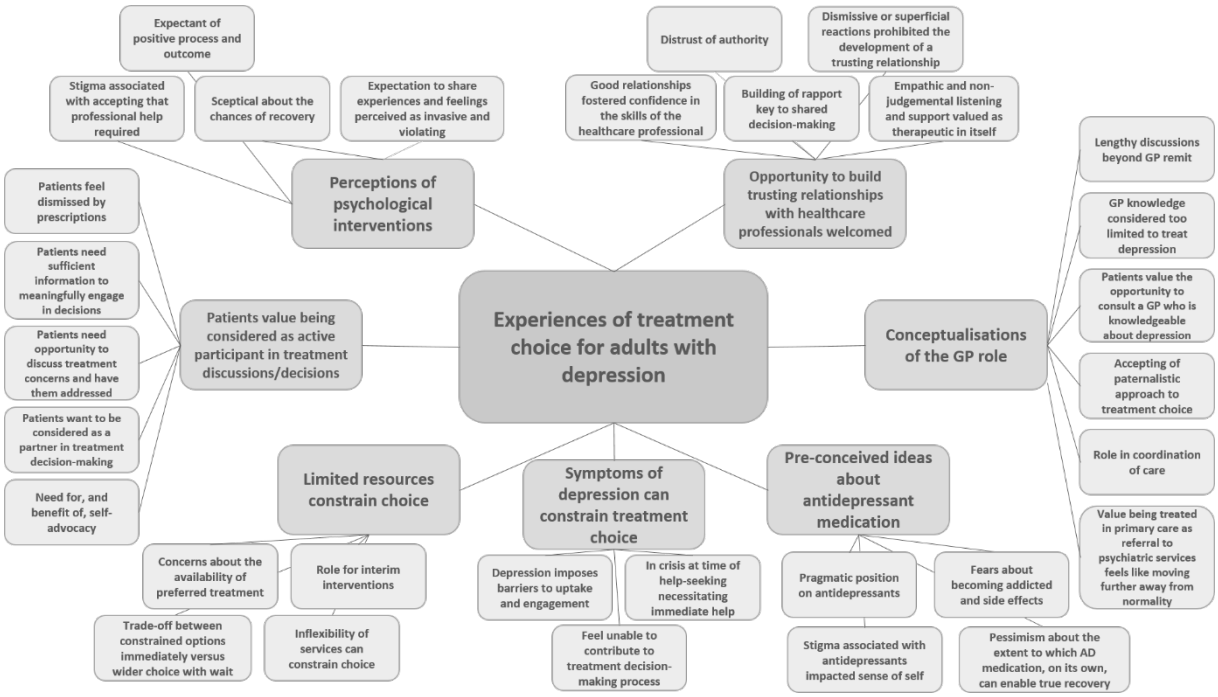
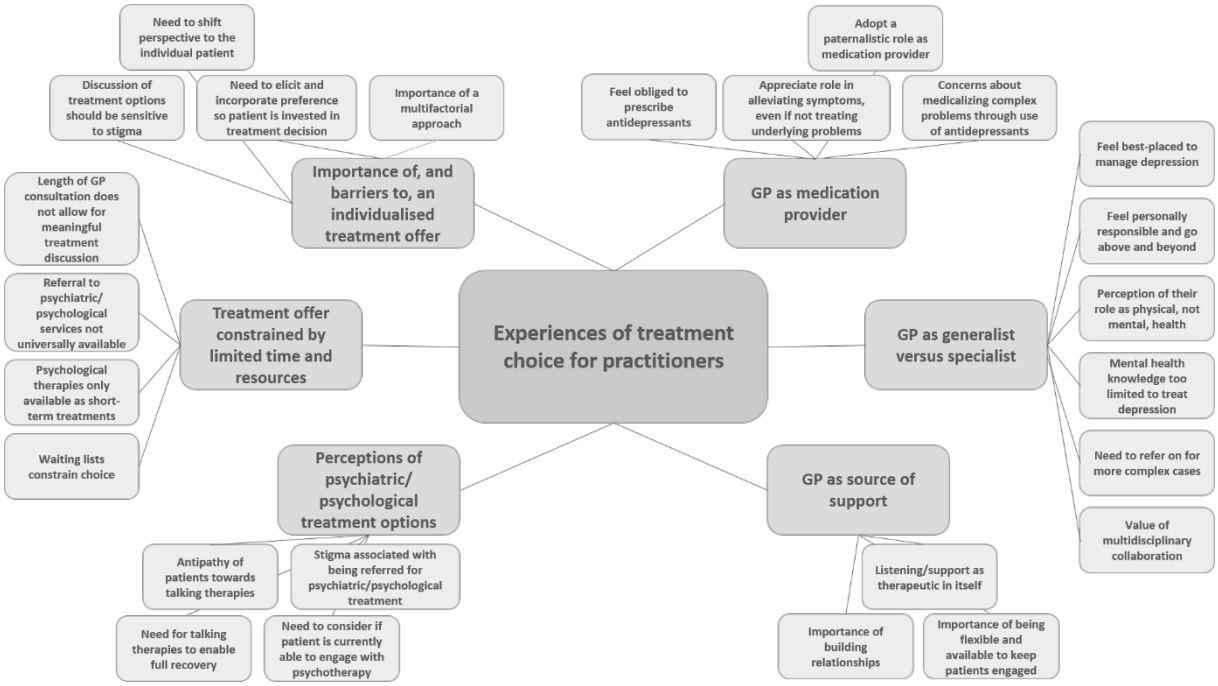


Figure 2: Thematic map from the perspective of practitioners



Narrative summary of review findings for adults with depression

Seven key themes were identified from the experiences and views of treatment choice for adults with depression: Opportunity to build trusting relationships with healthcare professionals welcomed; Conceptualisations of the GP role; Patients value being considered as active participant in treatment discussions/decisions; Limited resources constrain choice; Symptoms of depression can constrain treatment choice; Pre-conceived ideas about antidepressant medication; Perceptions of psychological interventions. These themes, and the sub-themes that contribute to them, are explored below.

1. Opportunity to build trusting relationships with healthcare professionals welcomed

1.1 Distrust of authority

One of the barriers to treatment choice that emerged from the experiences of adults with depression was a distrust of authority (Anderson 2013; Poleshuck 2013; van Grieken 2014; Stark 2018), for some this was reinforced by poor clinician-patient communication and a feeling that treatment decisions were being made on their behalf, including treatment beginning or ending without explanation and insufficient information (Anderson 2013; van Grieken 2014). For others, a distrust of psychotherapists was expressed, specifically perceptions that therapists might push patients to take steps they did not feel ready for (van Grieken 2014), or might 'manipulate people with words' (Stark 2018).

"You also feel very dependent. I actually felt growing smaller and smaller during that conversation. I absolutely did not have a good feeling then." (van Grieken 2014, pg. 157)

The confidence in this review finding (as assessed using GRADE CERQual) is high.

1.2 Dismissive or superficial reactions prohibited the development of a trusting relationship

People with depression described experiences of their clinicians not actively listening or not being fully engaged in treatment discussions, for example, seeming preoccupied with note-taking or offering superficial, glib or patronising responses (Anderson 2013; Anderson 2015; Barney 2011; Johnston 2007; Keller 2016; Macdonald 2007; Rogers 2001; Turner 2017) and creating the overall impression 'they were not that bothered' (Badger 2006; Keller 2016). This lack of attention and acknowledgement compromised the clinician-patient relationship, and left the patient feeling disempowered (Anderson 2013; Anderson 2015; Johnston 2007).

"I mean, I like doctor [X] he's fine, but ... I just don't get that personal thing with him, he's very, looking at his desk or the screen, he very rarely looks at you and I feel like I'm talking to the wall, basically. You know, when you're pouring your heart out to somebody [laughs], it kind of puts you off. If they're not ... showing any interest, it's like, sort of like, it makes it seem petty what you're saying ..." (Johnston 2007, pg. 11)

For some, these negative experiences had deterred them from seeking help (Barney 2011; Turner 2017).

"It was just something about the doctor, I don't know. She seemed very patronising.… [S]he made me feel little and stupid and thick, so I thought "oh, I'm not going back to see you again."… I know I need to see her because I know in myself I'm not feeling right. [This participant had previously attempted suicide.] But then I don't want to go.… [I]t was just her persona towards me, and I thought, "I can't, I'm not going to be able to come and talk to you if I'm really bad", and I knew that straight away." (Turner 2017, pg. 7)

The confidence in this review finding (as assessed using GRADE CERQual) is high.

1.3 Good relationships fostered confidence in the skills of the healthcare professional

Trust and reciprocity in the patient-clinician relationship helped to inspire confidence in the technical skills of the healthcare professional and meant that their advice was valued (Anderson 2013; Anderson 2015; Badger 2007; Chew-Graham 2012; Johnston 2007; Stark 2018).

"They take the time to talk to you ... my doctors, I know they're very busy and everything and that, but my doctor in particular likes to keep that personal side of things going and he's generally interested in how things are for you, how you're managing financially, and ... things like that. He does try and talk to you and get you to answer him and tell him what the root of the problems are, you know. He knows us very well, we've been going for about 17 years there" (Johnston 2007, pg. 10)

Positive experiences included discussions exploring opinions and concerns, being listened to, and being given sufficient time and information (Anderson 2015).

"If she hadn't been able to turn my thinking around in that first appointment in the way that she did, you know, I'm not convinced I would have been motivated to take the medication. And certainly, you know, knowing now that it does take sort of four to six weeks to really start to have an effect I might have—even if I had started taking it—I may well have given up after two weeks, you know. But her, her influence was powerful enough that, you know, it changed everything about the way I was looking at the illness and subsequently at myself…So she then spent the time explaining about depression and different causes and, and then the medications and all of that." (Anderson 2015, pg. 4)

The confidence in this review finding (as assessed using GRADE CERQual) is high.

1.4 Building of rapport key to shared decision-making

People with depression appreciated being informed and guided by their clinician with respect to treatment decision-making (Anderson 2015; Lawrence 2006). On top of that, a trusting and respectful patient-clinician relationship enabled patients to develop a sense of agency and become an active participant in treatment discussions and decisions (Anderson 2013; Anderson 2015; Keeley 2014; Keller 2016; van Geffen 2011).

"It has always been hard for me to open up to people, and I think for that to happen with someone who's kind of a complete stranger, I need to feel some kind of, I don't know if connection is the right word, but to feel confident that telling them will actually do something" (Keller 2016, pg. 532)

Good patient-clinician rapport encouraged people with depression to request further information (Anderson 2013; Anderson 2015; Turner 2017), gain deeper insight into their experiences (Anderson 2015; Lawrence 2006), and facilitated engagement with treatment (Anderson 2015; Chew-Graham 2012).

The confidence in this review finding (as assessed using GRADE CERQual) is low. There are only minor concerns about coherence and relevance. However, there are serious concerns about adequacy based on 5 of the studies including relatively small numbers of participants and all studies offering thin data. In addition, there are moderate concerns regarding methodological limitations. Two of the 8 studies contributing to the review finding are considered to be low quality, and the remaining studies considered moderate quality. A majority of the studies included failed to justify the research design, had no reflexivity, and reported insufficient detail or inadequate methods for recruitment and data collection.

1.5 Empathic and non-judgmental listening and support valued as therapeutic in itself

People with depression found that being given the opportunity and time to reflect on their difficulties was therapeutic in itself (Anderson 2013; Badger 2006; Johnston 2007; Macdonald 2007; Poleshuck 2013; Rogers 2001; Stark 2018; Turner 2017).

"He's not like a doctor that looks down on you, or he's rushing you, or waiting to tell you something before you go. He's just a person there to listen." (Rogers 2001, pg. 329)

Moreover, clinicians who responded empathically and non-judgmentally allowed patients to clarify and reframe their experiences (Anderson 2013) and to feel reassured, understood, valued and hopeful (Badger 2006; Chambers 2015; Johnston 2007; Keller 2016; Poleshuck 2013; Turner 2017).

"It is lovely to talk to somebody who doesn't look at you differently or you know that doesn't take for granted what you're saying, yeah so it feels good to talk to somebody that actually had and not judge me." (Poleshuck 2013, pg. 55)

The confidence in this review finding (as assessed using GRADE CERQual) is high.

2. Conceptualisations of the GP role

2.1 Lengthy discussions beyond GP remit

The limited time available in GP appointments led some people to feel that the GP could not adequately address their treatment concerns (Bayliss 2015; Johnston 2007; Keller 2016; Lawrence 2006; Rogers 2001; Stark 2018; Sterner 2020). This created feelings of frustration (Bayliss 2015; Lawrence 2006; Stark 2018; Sterner 2020).

"[doctors are] all about the medicines. . .we'd all like to think that we're visiting Frasier Crane but we're not, you don't get to lay on the couch, you don't get to discuss your problems. . .you get to go in for 10 minutes if you're lucky once every 3 months – 'How are you feeling?

Still taking medication? Sleeping alright? Well we'll leave you on that then'…and I've had that for 10 years so I guarantee you…that's what happens" (Bayliss 2015, pg. 326)

Some participants surmised that GPs may be able to prescribe less antidepressants if they were able to spend longer talking to people with depression (Lawrence 2006).

"You see the GPs are so tied up with so much work they don't have time to talk to their patients and they find a lot of people don't get the necessary benefit that they would get from the GP if the GP talked to them. Even give them less medication and have a talk because it makes them feel good within themselves you see and that feeling within themselves is like a self-healing power you know. That builds them up." (Lawrence 2006, pg. 1380)

For others there was a sense of guilt or lack of legitimacy associated with consulting GPs about depression (Johnston 2007; Rogers 2001). In response to the time constraints in primary care, some people chose to seek psychological therapy (Bayliss 2015; Johnston 2007; Rogers 2001).

"I wouldn't go to them to talk about my problems, just to talk to them. They haven't got the time for that, it's not fair on them. I mean, yes, they're doctors ... but ... if you want to sit and talk to somebody then you go to counselling sessions, they're not there to counsel you ... they got a lot on their plate ... if I want to talk to somebody about my problems, I'll go to my doctor and ask them to refer me on to somebody" (Johnston 2007, pg. 11)

The confidence in this review finding (as assessed using GRADE CERQual) is high.

2.2 GP knowledge considered too limited to treat depression

Some people with depression described low expectations about the limits of GP knowledge and the information and help they could provide to treat depression, and expressed a preference for specialist treatment advice (Anderson 2013; Barney 2011; Chambers 2015; Chew-Graham 2012; Green 2017; Keeley 2014; Keller 2016; Rogers 2001; Simon 2007; Stark 2018; Sterner 2020; Turner 2017; van Geffen 2011).

"Psychiatrists know about drugs, GPs don't know as much obviously...You could end up on so much...but it is serious stuff." (Anderson 2013, pg. 897)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate, there are only minor concerns about coherence and relevance. However, there are moderate concerns regarding methodological limitations. Seven of the 13 studies contributing to the review finding are considered to be low quality (5 moderate quality, and 1 high quality), with studies failing to justify the research design, failing to consider the researcher-participant relationship, and reporting insufficient detail, or inadequate, recruitment strategies and data collection and analysis methods. There are also moderate concerns regarding adequacy as although 13 studies supported the review finding, the number of participants in 11 of the studies was relatively low, and the studies offered thin data.

2.3 Patients value the opportunity to consult a GP who is knowledgeable about depression

Where patients were given the opportunity to consult a primary care clinician who was perceived as knowledgeable and skilled in the treatment of depression it was highly valued (Keeley 2014).

"The specific doctor [clinician b] that I see said, 'Hey, you know, [clinician c] is really up on this kind of stuff and you might really want to talk to her.' I did and I really found that she is way more in tune with depression and, basically, what she call the serotonin imbalance… she has apparently studied and reads up on it and just seems way more knowledgeable about what's going on in the treatment in that area." (Keeley 2014, pg. 10)

The confidence in this review finding (as assessed using GRADE CERQual) is low. There are only minor concerns regarding methodological limitations and coherence. However, there are serious concerns regarding adequacy, with only 1 study with a relatively small sample size supporting the review finding. In addition, there are serious concerns about relevance as demographics are not reported in the single study included.

2.4 Accepting of paternalistic approach to treatment choice

Some people with depression were happy to take a passive role in treatment decision-making and readily accepted the treatment option (predominantly antidepressant treatment) suggested by their GP (Anderson 2013; Anderson 2015; Badger 2007; Bayliss 2015; Garfield 2004; Johnston 2007; Keller 2016; Maxwell 2005; Rogers 2001; Schofield 2011; Simon 2007; van Geffen 2011).

"One of the things that I thought was very important to me in this process was the fact that the doctor said to me, "I'm going to get you out of this depression but don't expect a miracle. Don't expect to be okay tomorrow. It's a long process but I'll sort you out." Those were his words. That to me was very important." (Anderson 2013, pg. 893)

For some, this fitted with a general 'doctor knows best' belief (Anderson 2015; Badger 2007).

"I've heard there are things (other treatments) around but no, I thought my GP was the best person, I do tend to trust them." (Badger 2007, pg. 1347)

For others the paternalistic approach was accepted out of desperation and a feeling of being unable to actively participate in treatment decision-making (Bayliss 2015; Maxwell 2005; Schofield 2011; Simon 2007).

"Oh I've always got a choice but at the time I, I wanted help so anything they would have suggested." (Schofield 2011, pg. 144)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns about coherence, and only minor concerns about adequacy and relevance. However, there are moderate concerns regarding methodological limitations. Five of the 12 studies contributing to the review finding are considered to be low quality (and 7 moderate quality), with studies failing to justify the research design, failing to consider ethical issues or the researcher-participant relationship, and reporting insufficient detail, or inadequate, recruitment strategies and data collection methods.

2.5 Role in coordination of care

GPs were viewed as having a vital role to play in being able to maintain an overview of the care a patient may be receiving across services and providing consistency (Chambers 2015; Keeley 2014).

"It was having someone who was having an overview because I think previously what had happened was there were lots of individual people that you got referred to that you were seeing separately. But nobody was really bringing them together so there was duplication but no real way of bringing it together and she seemed to be able to bring the different strands together." (Chambers 2015, pg. 9)

The confidence in this review finding (as assessed using GRADE CERQual) is low. There are no or very minor concerns regarding methodological limitations, and only minor concerns about coherence. However, there are serious concerns regarding adequacy, with only 2 studies supporting the review finding, the number of participants in both of the studies is relatively low, and the studies offer thin data. There are also serious concerns about relevance as there is very limited information available about the participants included.

2.6 Value being treated in primary care as referral to psychiatric services feels like moving further away from normality

Some patients preferred to be treated in primary care. Being referred to a psychiatrist was associated with anticipated stigma, as it was seen as a testament to the severity of the depression (Lawrence 2006; Rogers 2001; Simon 2007).

"I would feel that if someone was to say we are going to make an appointment for you to see a psychiatrist, straight away I would think oh I am going off me rocker kind of thing." (Lawrence 2006, pg. 1381)

The confidence in this review finding (as assessed using GRADE CERQual) is very low. There are only minor concerns about coherence. However, there are serious concerns regarding methodological limitations. Two of the 3 studies contributing to the review finding are considered to be low quality (and 1 moderate quality), with studies failing to justify the research design, failing to consider ethical issues or the researcher-participant relationship, and reporting insufficient detail, or inadequate, recruitment strategies and data collection and analysis methods. There are also serious concerns regarding adequacy, with only 3 studies with relatively small sample sizes supporting the review finding. Finally, there are serious concerns about relevance as there is very limited information available about the participants included.

3. Patients value being considered as active participant in treatment discussions/decisions

3.1 Patients feel dismissed by prescriptions

Many raised concerns about the need for antidepressants, worried they were being used as a 'sticking plaster', and felt that medication was prescribed without giving them a choice (Anderson 2013; Anderson 2015; Bayliss 2015; Chambers 2015; Chew-Graham 2012; Cramer 2014; Johnston 2007; Keeley 2014; Lawrence 2006; Rogers 2001; Turner 2017; van Geffen 2011).

"I mean, I tried to discuss it with the doctor, but he just wants you in and out as soon as he can. And he just said, 'well, I'll put you on anti-depressants. And I said, well, I'm not really sure that that's the answer, but I'll do it." (Rogers 2001, pg. 329)

Some went further and described medication being forced on them (Anderson 2015; Chew-Graham 2012; Keller 2016; van Geffen 2011; van Grieken 2014).

"*This GP was particularly um insistent that I take her prescription. And I had said, 'no,' I had said 'no' about three times. In the end she said to me, 'um I don't know what's wrong with depressed people, why they always refuse to take um my prescriptions. I think depressed people like being depressed.' I felt like she'd shamed me into taking her um prescription."* (Anderson 2015; pg. 5)

Some patients attributed this to time constraints the clinician was working under, but still felt dismissed and that antidepressants were being used to 'get rid of them' (Anderson 2013; Johnston 2007; Keeley 2014; Lawrence 2006; Rogers 2001; Turner 2017; van Geffen 2011).

"...you know, sometimes when you go in you just feel the impression that they're wanting you straight out the door, or they're writing out a prescription for something ... silly and, and just wanting rid of you." (Johnston 2007, pg. 11)

The confidence in this review finding (as assessed using GRADE CERQual) is high.

3.2 Patients need sufficient information to meaningfully engage in decisions about their own treatment

People with depression described an unmet need for more information about depression and about treatment, this was most commonly described in relation to antidepressants where patients wanted more information about potential side effects, length of treatment, expected treatment outcomes, anticipated benefits, and alternative treatment options, in order to make an informed treatment decision (Anderson 2013; Anderson 2015; Badger 2006; Barney 2011; Buus 2012; Chambers 2015; Chew-Graham 2018; Cramer 2014; Garfield 2004; Green 2017; Rogers 2001; Simon 2007; Sterner 2020; Turner 2017; van Geffen 2011; van Grieken 2014).

"When I started with this medication, I didn't receive any information whatsoever, not even about side effects. They did tell me in passing that it could take a while before I would notice the intended effect. The doctors should be much keener about this. It would be so easy to just give the main messages, and refer to the information leaflet for more information. When I asked my doctor whether this medication has any side effects, he just grabbed a big book and said "If you like I can read them for you."" (van Geffen 2011, pg. 141)

Some participants expressed surprise at the slow speed of the recovery process, and would have liked to have been more prepared for this (Garfield 2004). The opportunity for information provision on a number of occasions (in addition to the initial consultation), a check that patients understand the information, written material to supplement the verbal information provided, greater clarity and explanation of treatment goals and structure, and more time in consultation with their healthcare provider were all identified as potential improvements that would allow more meaningful engagement with treatment decision-making (Garfield 2004; Green 2017; Rogers 2001; Simon 2007; Turner 2017; van Grieken 2014).

"At the time when I spoke to my doctor, the first time before she put me on to the medicine, I'm sure she might have said to me how it's going to affect me but I felt so kind of upset and confused . . . I couldn't really take in what she was saying, if she did say anything. So it was all a bit of a blur really after a point." (Garfield 2004, pg. 244)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns about coherence, and only minor concerns about adequacy and relevance. However, there are moderate concerns regarding methodological limitations. Eight of the 16 studies contributing to the review finding are considered to be low quality (4 moderate quality and 4 high quality), with studies failing to justify the research design, failing to consider the researcher-participant relationship, and reporting insufficient detail, or inadequate, recruitment strategies and data collection methods.

3.3 Patients need the opportunity to discuss treatment concerns and have them addressed

Patients valued their treatment concerns being taken into account by their healthcare professional (Anderson 2013; Badger 2006; Maxwell 2005; Poleshuck 2013; van Geffen 2011). Participants linked better adherence with antidepressant medication to the opportunity to discuss fears about addiction and side effects (Badger 2006; van Grieken 2014).

"After about 2 months, having been signed off from work for 2 months, I found myself getting worse and worse and approached the subject with them about going onto medication which I sort of...I didn't really...before I thought, "I didn't really want to go on medication" but I thought that I was at the point where I needed something to help me. They were very, very good in that they didn't just immediately give me a prescription. Actually, we went through the options of what kind of medication, what sort of...what they do, what they're designed for. And they said that they would rather monitor my situation before letting me go onto them which I think

was very responsible of them. I did eventually, because I wasn't getting any better, did go onto antidepressants." (Anderson 2013, pg. 888)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns about coherence, and only minor concerns about adequacy. However, there are moderate concerns regarding methodological limitations. Three of the 6 studies contributing to the review finding are considered to be low quality (2 moderate quality and 1 high quality), with studies failing to justify the research design, failing to consider ethical issues or the researcher-participant relationship, and reporting insufficient detail, or inadequate, recruitment strategies and data collection and analysis methods. There are also moderate concerns about relevance, with 5 studies failing to report the diagnostic status of participants, an over-representation of females in the sample, and very limited information available about ethnicity.

3.4 Patients want to be considered as a partner in treatment decision-making

Some people with depression felt excluded from treatment decision-making and described a lack of discussion and negotiation which gave rise to frustration (Anderson 2013; Anderson 2015). The importance of being recognised and treated as an individual, and being appreciated as an equal partner in treatment decision-making, was highlighted (Anderson 2013; Chambers 2015; Garfield 2004; Keller 2016; Macdonald 2007; Simon 2007; van Grieken 2014; Ward 2014).

"I think we're all different, aren't we? And I know what I am personally and, er, I know what's good for me, what isn't." (Chambers 2015, pg. 11)

Patients wanted the opportunity for emotional support, calm and objective discussions, and consideration of their expectations (Simon 2007; van Grieken 2014).

"'Then I was referred to a psychologist for [therapy] sessions. And I thought, I'd also find medication perfectly fine. But I thought, they'll know… I would have preferred to think along and be involved in the decision-making…" (van Grieken 2014, pg. 155)

The confidence in this review finding (as assessed using GRADE CERQual) is high.

3.5 Need for, and benefit of, self-advocacy

A need to negotiate, and fight for, the treatment of their choice was described by some people with depression (Anderson 2013; Bayliss 2015).

"when I came to the point where I was able to sort of "hang on this is my body here and this is me," speak up for myself and I started to question the psychiatrist what they were doing for me, or what they...and finding that suddenly I started getting respect from psychiatrists because I was starting to think for myself and questioning "is this right for me, is this not right for me" or "what do I think is right for me" and it was only though constant pressuring the psychiatrist and the NHS that I got psychotherapy. You have to fight for it, you have to fight for it. It's not a thing that is automatically given." (Anderson 2013, pg. 896)

Patients highlighted the hard work involved in trying to find the right treatment (Barney 2011; Chew-Graham 2018). Participants reported taking responsibility for the treatment choice (Garfield 2004; Johnston 2007; Keeley 2014; van Geffen 2011), and emphasised the importance of seeking out additional information for themselves, in the absence of information from their healthcare provider or in order to supplement or lend credibility to what they had been told (Anderson 2013; Anderson 2015; Badger 2006; Bayliss 2015; Chambers 2015; Keeley 2014; van Geffen 2011).

"So it was my decision. So I wasn't influenced by the doctor or the counsellor. It was a decision I felt ... I had to make so I was fully prepared." (Garfield 2004, pg. 245)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are only minor concerns regarding methodological limitations and coherence. However, there are moderate concerns about adequacy, as although 11 studies supported the review finding, the number of participants in 5 of the studies was relatively low, and the studies offered thin data. There are also moderate concerns about relevance, with 7 studies failing to report the diagnostic status of participants, an over-representation of females in the sample, and ethnicity either not reported or predominantly white.

4. Limited resources constrain choice

4.1 Trade-off between constrained options immediately versus wider choice with wait

Some people with depression were willing to accept the more limited treatment options available in primary care rather than wait longer for a wider treatment choice in secondary care (Keeley 2014; Macdonald 2007; Rogers 2001; Schofield 2011; Simon 2007).

"So the cost to go to a psychiatrist is just ridiculous, and so I stayed within the bounds of what the primary care physician would do because I could get treated right away…" (Keeley 2014, pg. 8)

The confidence in this review finding (as assessed using GRADE CERQual) is low. There are only minor concerns about coherence and relevance. However, there are serious concerns about adequacy, given that 5 studies with relatively small sample sizes supported the review finding and the studies offered thin data. In addition, there are moderate concerns regarding methodological limitations. Three of the 5 studies contributing to the review finding are considered to be low quality (1 moderate quality and 1 high quality), with studies failing to justify the research design, failing to consider the researcher-participant relationship, and reporting insufficient detail, or inadequate, data collection and analysis methods.

4.2 Concerns about the availability of preferred treatment

Concerns about the availability of services were felt by patients with depression. In some cases this was due to the lack of services in rural areas (Barney 2011). Others mentioned how limited resources meant that receiving the particular therapy they wanted was down to luck (Chambers 2015). For some a lack of access to psychological services was emphasised, and patients expressed that one had to be severely ill in order to receive adequate treatment (Sterner 2020).

"I mean you get referred don't you, from your GP and it's like pot luck really, cos you know obviously the resources aren't limitless are they?" (Chambers 2015, pg. 11)

The confidence in this review finding (as assessed using GRADE CERQual) is low. There are only minor concerns about coherence and relevance. However, there are serious concerns about adequacy, given that only 3 studies supported the review finding and the number of participants in 2 of the studies was relatively low, and the studies offered thin data. In addition, there are moderate concerns regarding methodological limitations. Two of the 3 studies contributing to the review finding are considered to be low quality (and 1 high quality), with studies failing to justify the research design, failing to consider ethical issues or the researcher-participant relationship, a lack of clarity in the findings, and reporting insufficient detail, or inadequate, data collection and analysis methods.

4.3 Role for interim interventions

Waiting lists demotivated patients with depression from seeking or beginning treatment, and could lead to a significant worsening of their condition (van Grieken 2014).

"A three month-waiting list! And one week afterwards I attempted suicide. Exactly because you're going there to ask for help because you can't deal with it anymore." (van Grieken 2014, pg. 157)

Some participants highlighted the role for interventions such as guided self-help, to provide interim help while people are waiting for their treatment of choice (Macdonald 2007).

"The waiting list is a hell of a long time . . . and I was so desperate . . . it's like a stepping-stone – a café half-way on your journey. It's like there's something and you are being lifted up and being kept afloat . . ." (Macdonald 2007, pg. 27)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns regarding methodological limitations, and only minor concerns about coherence and relevance. However, there are serious concerns about adequacy, given that only 2 studies with relatively small sample sizes supported the review finding, and the studies offered thin data.

4.4 Inflexibility of services can constrain choice

The importance of organisational processes being flexible to individual needs was highlighted by people with depression, for example, the importance of not penalising a person if they are unable to attend a specific appointment time (Chambers 2015).

"I think she was the CBT person I was referred to her, got on the waiting list, an appointment came through…I said 'I'm sorry I can't make that appointment because it's my first week starting a new job' and she sounded very huffy about it. And I said, but I would like to, you know, continue on the waiting list and I never heard from her again, so she'd taken me off the waiting list, just because I said, I'd rather not have an appointment (laugh) during my first week at a new job." (Chambers 2015, pg. 9)

The confidence in this review finding (as assessed using GRADE CERQual) is low. There are no or very minor concerns regarding methodological limitations and coherence. However, there are serious concerns about adequacy, with only 1 study with a small sample size supporting the review finding. There are also serious concerns about relevance, with an over-representation of females and a predominantly white population in the single study that supported this review finding.

5. Symptoms of depression can constrain treatment choice

5.1 Depression imposes barriers to uptake and engagement

People with depression highlighted how symptoms of the disorder itself constructed barriers to accessing and engaging with treatment (Barney 2011; Bayliss 2015; Keeley 2014; Macdonald 2007; Poleshuck 2013).

"Catching the bus … that's a hard thing to you know be out in the public and just like I'm so nervous." (Poleshuck 2013, pg. 54)

Difficulties in finding sufficient motivation or concentration to embark on psychological therapy, given the active involvement required, were emphasised (Barney 2011; Macdonald 2007; Poleshuck 2013).

"I hear you! I know that if I do my CBT work and start to challenge my negative thoughts that I will start to feel better, but why can I never be bothered to do it??? ... We have a double whammy of an illness, in that to feel better we have to take action, but to take action we have to "feel" like taking action. It's some sort of a cruel joke." (Barney 2011, pg. 3)

Some reflected upon the role of antidepressants in getting themselves into a mental state that was receptive to attending and engaging with talking therapy (Bayliss 2015; Chew-Graham 2018).

"CBT without drugs…wouldn't have worked for me because I would have just lain in bed and…phoned…and said "sorry I can't come in I'm too miserable"…I wouldn't have noted down any of my thoughts, I wouldn't have changed anything because I would have just been….so low" (Bayliss 2015, pg. 328)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are only minor concerns regarding methodological limitations, coherence, and relevance. However, there are moderate concerns about adequacy, with 6 studies supporting the review finding and the number of participants in 5 of the studies was relatively low, although the studies do offer moderately rich data.

5.2 In crisis at time of help-seeking necessitating immediate help

At the time of seeking help for depression, participants described themselves as having 'hit rock bottom' in feeling overwhelmed by symptoms and unable to cope, and this made them willing to try whatever treatment was offered (Badger 2006; Chew-Graham 2018; Keeley 2014; Schofield 2011; Simon 2007; van Geffen 2011; van Grieken 2014).

"…I needed to do whatever it took to, you know, get well again, quite simply. So I, I would do whatever it takes. When you - I think when you really hit rock bottom you are prepared to do whatever it takes and I have absolute faith in my doctor" (Chew-Graham 2018, pg. 7)

The confidence in this review finding (as assessed using GRADE CERQual) is low. There are no or very minor concerns about coherence. However, there are moderate concerns regarding methodological limitations. Four of the 7 studies contributing to the review finding are considered to be low quality (1 moderate, and 2 high, quality), with studies failing to justify the research design, failing to consider the researcher-participant relationship, and reporting insufficient detail, or inadequate, data collection and analysis methods. There are also moderate concerns about adequacy, with 7 studies with relatively small sample sizes supporting the review finding, although the studies did offer moderately rich data. Finally, there are moderate concerns about relevance, with 4 studies failing to report the diagnostic status of participants, an over-representation of females in the sample, and very limited information available about ethnicity.

5.3 Feel unable to contribute to treatment decision-making process

Some people with depression perceived their symptoms as stopping them from contributing to treatment decision-making (Buus 2012; Keeley 2014; Schofield 2011; Simon 2007; van Geffen 2011). Perceived barriers included difficulties in taking in information, not being able to maintain a conversation because of symptoms, a belief that they lacked the necessary insight, or a feeling of ambivalence about the treatment choice.

"He told me "This is better for you," so then I went ahead and started using it. Not really a conscious decision. You don't really know why, or for how long; you don't really know anything." (van Geffen 2011, pg. 138)

The confidence in this review finding (as assessed using GRADE CERQual) is low. There are no or very minor concerns about coherence. However, there are moderate concerns regarding methodological limitations. Three of the 5 studies contributing to the review finding are considered to be low quality (1 moderate, and 1 high, quality), with studies failing to justify the research design, failing to consider ethical issues or the researcher-participant relationship, and reporting insufficient detail, or inadequate, data collection and analysis methods. There are also moderate concerns about adequacy, with 5 studies with relatively small sample sizes supporting the review finding, although the studies did offer moderately

rich data. Finally, there are moderate concerns about relevance, with an over-representation of females in the sample, and very limited information available about ethnicity.

6. Pre-conceived ideas about antidepressant medication

6.1 Pragmatic position on antidepressants

People with depression expressed a wide range of pre-conceived ideas about antidepressant medication, including a pragmatic view that they were necessary to help them feel better (Anderson 2015; Badger 2006; Jaffray 2014; Johnston 2007; Keeley 2014; Lawrence 2006; Schofield 2011; Stark 2018; Sterner 2020; van Geffen 2011).

"I actually didn't have an ideological or philosophical position about medication. For me medication was a means to an end" (Anderson 2015, pg. 3)

For some, there was an initial reluctance and a view of antidepressants as a 'temporary crutch' (Chew-Graham 2018; Lawrence 2006; Schofield 2011; Sterner 2020).

"It gets you over that hurdle." (Schofield 2011, pg. 145)

Others saw antidepressants more positively, arguing equivalence to medication for any other health condition (Anderson 2015; van Geffen 2011), and associating feelings of relief, legitimacy, agency, and empowerment with antidepressant treatment (Anderson 2015).

"I don't put my hands up in horror with psychiatric drugs…there's a lot of people turning against them…they wouldn't have the same attitude towards insulin or other drugs that were lifesaving." (Anderson 2015, pg. 3)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns about coherence, and only minor concerns regarding methodological limitations and adequacy. However, there are moderate concerns about relevance, with 7 studies failing to report the diagnostic status of participants, an over-representation of females in the sample, and limited information available about ethnicity.

6.2 Fears about becoming addicted and side effects

Common reservations about antidepressant treatment included a fear of the potential for dependency (Anderson 2015; Green 2017; Lawrence 2006; Maxwell 2005; Rogers 2001; Schofield 2011; Simon 2007; Stark 2018; Sterner 2020; Turner 2017; van Geffen 2011).

"But I didn't know if antidepressants were the right things for us because you hear so much about them. Because like once you get on to them you get addicted to them and like I have heard loads of like bad reports." (Schofield 2011, pg. 144)

Concerns about side effects were also expressed (Anderson 2013; Anderson 2015; Chew-Graham 2018; Lawrence 2006; Poleshuck 2013; Simon 2007; Stark 2018; Sterner 2020; Turner 2017; van Geffen 2011).

"I didn't want to start with the side effects what I got from the first one [uh-huh]. I didn't want to start with new side effects and things" (Chew-Graham 2018, pg. 6)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns about coherence, and only minor concerns regarding adequacy. However, there are moderate concerns regarding methodological limitations. Eight of the 14 studies contributing to the review finding are considered to be low quality (5 moderate, and 1 high, quality), with studies failing to justify the research design, failing to consider ethical issues or the researcher-participant relationship, and reporting insufficient detail, or inadequate, recruitment strategies or data collection and analysis methods. There are also moderate concerns about relevance, with 9 studies failing to report the diagnostic

status of participants, an over-representation of females in the sample, and limited information available about ethnicity.

6.3 Pessimism about the extent to which antidepressant medication, on its own, can enable true recovery

Some people with depression worried that antidepressants may mask rather than resolve the depression, with descriptors including 'sticking plaster' and 'papering over the cracks' (Anderson 2013; Anderson 2015; Bayliss 2015; Burroughs 2006; Chambers 2015; Green 2017; Rogers 2001; Stark 2018; van Geffen 2011).

"Taking medication and feeling better is great… however, it is necessary … to be able to function without medication…." (Green 2017, pg. 9)

"The only way you can avoid pain is by...well part of just getting away from the incident that's causing the pain but the...the only other way is just to cut down your awareness which is what, what medication is mostly for, it's really to cut down your...your feeling of pain. But the thing is the pain is nature's way of showing you what's wrong, and without it you're in the dark. And the thing is we've been given the ability to know what's wrong with us ourselves. But if we keep taking pills, if we keep taking things that are going to stop us being aware, if we keep getting drunk, if we use anything as a drug to reduce our awareness, then our ability to be healthy is cut down. So the first necessity to be healed is to raise your awareness" (Anderson 2013, pg. 894)

The confidence in this review finding (as assessed using GRADE CERQual) is high.

6.4 Stigma associated with antidepressants impacted sense of self

Reluctance to use antidepressant medication was often associated with a fear of stigma (Anderson 2013; Anderson 2015; Badger 2006; Barney 2011; Chew-Graham 2012; Garfield 2004; Jaffray 2014; Lawrence 2006; Maxwell 2005; Rogers 2001; Schofield 2011; Simon 2007; Turner 2017; van Geffen 2011). People worried that taking antidepressants could be seen as a sign of weakness, 'failure' or 'defeat' (Anderson 2015; Chew-Graham 2012; Maxwell 2005; van Geffen 2011).

"I actually wanted to fix it myself. If you can resolve it without medication then you're part of the regular people, but now I no longer belong to that group. Taking medication means admitting failure." (van Geffen 2011, pg. 139)

Others were resistant to the medicalisation of their problems (Anderson 2013; Garfield 2004), did not want to become a member of a denigrated 'mentally ill' category or accept that they were depressed, or believed being a 'pill popper' signified the severity of their condition (Anderson 2015; Chew-Graham 2012; Jaffray 2014; Lawrence 2006; Maxwell 2005; van Geffen 2011).

"The first mention of medication and antidepressants. And um I don't think she'd even finished saying the word before I said 'not a chance.' I said 'do you know who you're talking to here? I'm a detective. I think—this is—you can't do that.' And there was no way I, I'd entertain um just the label of the drug. Just the term antidepressant to me was ah you just can't hack it. Um and I thought 'well that's what I think so everybody else must think that.' So I said 'nup, not a chance.'" (Anderson 2015, pg. 4)

A related concern was that antidepressants would change their personality (Maxwell 2005; Simon 2007).

"... although I wanted to be better, I didn't want to lose my, you know, I didn't want my character to change. I didn't want to be so falsely happy or sad." (Maxwell 2005, pg. 67)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns about coherence, and only minor concerns regarding adequacy. However, there are moderate concerns regarding methodological limitations. Eight of the 14 studies contributing to the review finding are considered to be low quality (6 moderate quality), with studies failing to justify the research design, failing to consider the researcher-participant relationship, and reporting insufficient detail, or inadequate, recruitment strategies or data collection and analysis methods. There are also moderate concerns about relevance, with 11 studies failing to report the diagnostic status of participants, an over-representation of females in the sample, and very limited information available about ethnicity.

7. Perceptions of psychological interventions

7.1 Expectant of positive process and outcome

People with depression expressed strong beliefs about the potential benefits of talking therapies (Chew-Graham 2018; Green 2017; Lawrence 2006; Macdonald 2007; Poleshuck 2013), often advocating for their role alongside antidepressants (Chew-Graham 2018; Green 2017).

“Sometimes you need to talk to someone and then you feel better. It would be helpful to have that along with the medicine.” (Green 2017, pg. 9)

Participants recognised the potential to gain insight and understanding, even though it may be difficult to discuss feelings and experiences (Poleshuck 2013).

"I know I must deal with it. I can’t hang onto this. Then maybe I can go on with my life and do some things in my life … even if I have to live through them … maybe that won’t hold me back to the point where it’s holding me back now." (Poleshuck 2013, pg. 55)

Others particularly valued the opportunity to talk to a professional who is not part of their life (Lawrence 2006).

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are only minor concerns regarding methodological limitations, coherence, and relevance. However, there are moderate concerns about adequacy, with only 5 studies with relatively small sample sizes supporting the review finding, and the studies offered thin data.

7.2 Stigma associated with accepting that professional help required

Difficulties with coming to accept that professional help was needed (Simon 2007; Ward 2014), and scepticism and apprehension around discussing personal problems with a stranger (Lawrence 2006) were described.

"Who wants to talk about stuff like that? That’s embarrassing stuff. I was a career woman, okay. Anybody with any kind of decent reputation, I’m an accountant, and I’ve got clients, and many people under me, you know, and people looking up to me. Who wants to talk about something like that (depression)? I mean, it was degrading to me." (Ward 2014, pg.12)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns about coherence, and only minor concerns regarding methodological limitations and relevance. However, there are moderate concerns about adequacy, with only 3 studies with relatively small sample sizes supporting the review finding, although the studies did offer moderately rich data.

7.3 Sceptical about the chances of recovery

Some worried that psychological interventions would not 'work' (Macdonald 2007; Poleshuck 2013; Stark 2018; van Grieken 2014).

"I was open to trying anything . . . I thought it [guided self-help] would help a little bit but I didn't think it would cure me." (Macdonald 2007, pg. 27)

This fear was tied to a number of different factors, including concerns around therapist expertise (Macdonald 2007), disagreements about the focus of therapy (van Grieken 2014), or pessimism that talking could bring about meaningful change and recovery (Macdonald 2007; Poleshuck 2013; Stark 2018).

"With no disrespect to [the assistant psychologist], who's doing what she's doing, I could be wrong here [but] perhaps somebody with more experience, shall we say, would be able to give me the advice that perhaps her lack of experience hasn't enabled her to do . . . She personally didn't offer me anything other than the pages and the advice that was in the book." (Macdonald 2007, pg. 27)

"Because then if I went into therapy, very frequently I had to go through my whole childhood, family, and work, whereas that's not where the problem was. It lay primarily with the way I was thinking and incorrectly reacting to situations. You don't solve that directly by discussing your marriage, parents, or childhood, that in fact had nothing to do with it." (van Grieken 2014, pg. 155)

"I'm still upset over stuff that happened 20 years ago and I've talked to people about it before you know. Usually they say if you talk about it you're gonna feel better. Well I just don't." (Poleshuck 2013, pg. 54)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns regarding methodological limitations, and only minor concerns about coherence and relevance. However, there are moderate concerns about adequacy, with only 4 studies with relatively small sample sizes supporting the review finding, and the studies offered thin data.

7.4 Expectation to share experiences and feelings perceived as invasive and violating

The requirement to talk about difficult experiences and feelings was very confronting for some participants, and responses included avoidance (Poleshuck 2013; Simon 2007; Ward 2014).

"I got some deep rooted ugly childhood stuff. I don't think that counseling will do anything for me but stir that crap up and make me feel even worse. I'd rather just leave it alone and go on with my life." (Poleshuck 2013, pg. 54)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are only minor concerns regarding methodological limitations, coherence, and relevance. However, there are moderate concerns about adequacy, with only 3 studies with relatively small sample sizes supporting the review finding, although the studies did offer moderately rich data.

Narrative summary of review findings for practitioners

Six key themes were identified from the experiences and views of treatment choice for practitioners who care for people with depression: GP as medication provider; GP as source of support; GP as generalist versus specialist; Perceptions of psychiatric/psychological treatment options; Treatment offer constrained by limited time and resources; Importance of, and barriers to, an individualised treatment offer. These themes, and the sub-themes that contribute to them, are explored below.

1. GP as medication provider

1.1 Adopt a paternalistic role as medication provider

GPs who perceived depression as 'treatable', and viewed antidepressants as safe and effective, readily adopted a paternalistic role as medication provider (Dumesnil 2018; Johnston 2007; Mercier 2011; Parker 2020a; Patel 2014; Wittink 2011).

"I mean my experience with antidepressants is, they all work, it doesn't matter if it's the old tricyclics or whether, as long as you have the levels high enough, then you've just got to balance that against side-effects. I can virtually say, I can guarantee that you'll feel better er just you know, just I suppose you could say trust me, um just give it time and we can make it better." (Johnston 2007, pg. 7)

For some, this included a responsibility to convince patients to accept antidepressants (Parker 2020a; Wittink 2011).

"[Patients] don't take [antidepressants] because they mistrust them, other times they're just in denial that there's anything wrong… Sometimes if they don't want to take any medication you say "well how about you just give it a trial because you're going to know in two, three, four weeks whether it's going to be effective" and then at three weeks you see them again and usually they've turned a corner." (Parker 2020a, pg. 264)

The confidence in this review finding (as assessed using GRADE CERQual) is high.

1.2 Feel obliged to prescribe antidepressants

GPs described a pressure, from patients, to prescribe antidepressants (Chew-Graham 2018; Dickinson 2010; Johnson 2017; Mercier 2011).

"They think they're coming here [pause] for me to do something for them [empathetically said]. And that, they almost feel as if there needs to be a physical display of that, like the prescription or whatever." (Johnson 2017, pg. 6)

From the GPs' point of view patients were often looking to them to provide validation or to 'fix' their depression (Dickinson 2010; Johnson 2017).

"They feel that unless they are on a tablet for it then they are not having any treatment. There are a lot of those kinds of people." (Dickinson 2010, pg. 149)

Another imperative to provide medication was expressed in relation to referral to psychiatry where there were fears that a patient would not be accepted if unmedicated (Iglesias-Gonzalez 2021).

"From my point of view we are conditioned to a degree, aren't we? Because when you try to refer the patient to psychiatry you know that obviously if the patient is not medicated, he or she will not be accepted" (Iglesias-Gonzalez 2021, pg. 615)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns about relevance, and only minor concerns regarding methodological limitations and coherence. However, there are moderate concerns about adequacy, with only 5 studies with relatively small sample sizes supporting the review finding, although the studies did offer moderately rich data.

1.3 Appreciate role in alleviating symptoms, even if not treating underlying problems

GPs described the desire to 'do something to help' patients with depression and considered antidepressants to be beneficial, even whilst acknowledging that they might not be treating

underlying problems (Chew-Graham 2002; Dickinson 2010; Johnson 2017; Johnston 2007; Keeley 2014; Maxwell 2005; Pollock 2003).

"If the cause is a social factor I can't get rid of that ... but I might alleviate their symptoms a little bit." (Dickinson 2010, pg. 146)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns about relevance, and only minor concerns regarding methodological limitations and coherence. However, there are moderate concerns about adequacy, with 7 studies with relatively small sample sizes supporting the review finding, and the studies offered thin data.

1.4 Concerns about medicalizing complex problems through use of antidepressants

Although GPs acknowledged that antidepressants could provide a solution for some patients' difficulties, they also questioned whether prescriptions were medicalizing complex social problems (Burroughs 2006; Dickinson 2010; Iglesias-Gonzalez 2021; Maxwell 2005).

"I think they have horrible lives, a lot of them ... I think it's a combination of all things, their health, their social circumstances ... I think a lot of people are on antidepressants because of everything put together. And you can't ... change most of the factors that cause it." (Dickinson 2010, pg. 149)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are only minor concerns about coherence and relevance. However, there are moderate concerns regarding methodological limitations. Two of the 4 studies contributing to the review finding are considered to be low quality (1 moderate, and 1 high, quality), with studies failing to justify the research design, failing to consider ethical issues or the researcher-participant relationship, and reporting insufficient detail, or inadequate, recruitment strategies or data collection methods. There are also moderate concerns about adequacy, with only 4 studies with relatively small sample sizes supporting the review finding, although the studies did offer moderately rich data.

2. GP as source of support

2.1 Listening/support as therapeutic in itself

GPs identified listening, empathising, supporting, and advising, as central to their role in the management of depression. Non-specific therapeutic benefits that GPs associated with non-judgmental listening, included providing a safe space for patients to express their emotions and normalising patients' experiences (Dumesnil 2018; Iglesias-Gonzalez 2021; Johnson 2017; Johnston 2007; Keeley 2014; Maxwell 2005; Mercier 2011; Parker 2020a; Pollock 2003; Railton 2000; Wilhemsen 2014).

"Well I think we do a lot just by talking to people ...so, I mean, we see a lot of people, just to support them really ... to talk about things. Well I think it's our bread and butter of our job actually" (Johnston 2007, pg. 9)

"[We give] what we call supporting consultations in general practice, but actually it is just talking without any…I wouldn't say meaning, but no concrete agenda in a way. I mean, there is no…It is just: How is it going? What have you been doing lately? It is more the patient talking in a free way about how they are and stuff. But no actual therapy really." (Wilhemsen 2014, pg. 5)

The confidence in this review finding (as assessed using GRADE CERQual) is high.

2.2 Importance of building relationships

GPs emphasised the therapeutic relationship as an integral component of caring for patients with depression. The building of trust and rapport were highlighted as crucial to facilitating shared decision-making, and fostering belief in the treatment and potential for improvement (Anthony 2010; Chew-Graham 2002; Iglesias-Gonzalez 2021; Johnson 2017; Johnston 2007; Jones 2013; Mercier 2011; Parker 2020a; Pollock 2003; Wittink 2011).

"After so many years, often this trust and knowledge of the person [develops], us with them and them with us. I think that with trust we can achieve specific things." (Iglesias-Gonzalez 2021, pg. 614)

"Half of treatment isn't necessarily just the tablets, it's the interaction with the patient, the fact that you listen to their story, you give them time." (Johnston 2007, pg. 9)

The confidence in this review finding (as assessed using GRADE CERQual) is high.

2.3 Importance of being flexible and available to keep patients engaged

Being flexible and available to patients were identified by GPs as vital to initiating and maintaining engagement with depression treatment. Extending treatment decision-making over several consultations was mentioned as a way of overcoming limited consultation time while still ensuring that patients felt acknowledged and had time to process the information provided (Patel 2014; Pollock 2003).

"What you have to do is make it clear to people that they have done the right thing about coming in, you are interested and you are going to try and sort it out, because then if necessary you can get them to come back. But what you mustn't do is . . . shut the door in their face and then they don't come back . . . The main thing is to make it clear on the first consultation that you are interested and you can, to be honest, you can actually, when you are used to dealing with people you can actually achieve an awful lot in sort of ten to fifteen minutes." (Pollock 2003, pg. 266)

The confidence in this review finding (as assessed using GRADE CERQual) is low. There are only minor concerns about coherence and relevance. However, there are serious concerns about adequacy, given that there are only 2 studies with relatively small sample sizes supporting the review finding. In addition, there are moderate concerns regarding methodological limitations. One of the 2 studies contributing to the review finding is considered to be low quality (1 moderate quality), with either one or both of the studies failing to justify the research design, failing to consider ethical issues or the researcher-participant relationship, a lack of clarity in the findings, and reporting insufficient detail, or inadequate, recruitment strategies or data collection methods.

3. GP as generalist versus specialist

3.1 Feel best-placed to manage depression

GPs regarded themselves as best-placed to manage depression, because of the relationships they had formed with patients (Dumesnil 2018; Railton 2000), and because the knowledge and skills acquired through experience compensated for the lack of specialist training (Chew-Graham 2002; Railton 2000).

"… I really don't think there's anything a psychiatrist can offer these people, apart from the placebo effect of seeing a specialist. But in all truth, any patients of mine who've seen psychiatrists for depressive illness, by and large they'll say, it's no better than coming here, sort of thing, or, they didn't like him, you know" (Railton 2000, pg. 122)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns about relevance, and only minor concerns regarding methodological limitations and coherence. However, there are moderate concerns about adequacy, with only 3 studies with relatively small sample sizes supporting the review finding, and the studies offered thin data.

3.2 Feel personally responsible and go above and beyond

GPs felt personally responsible for patients and this compelled them to invest extra time and effort in order to provide the best care, for instance, checking that patients had attended follow-up appointments, finding additional time to talk to patients, home visits, and additional training (Burroughs 2006; Johnson 2017; Jones 2013; Parker 2020a; Wilhemsen 2014).

"I think if you're the GP that they've come to see and you can see there's a situation and you're worried about it you just keep them coming back to see you until you can see that they're out of the woods… And if you're worried you put on a little reminder to check that they've been back." (Parker 2020a, pg. 265)

"I visited him every week for a bit, which is very unusual" (Burroughs 2006, pg. 373)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are only minor concerns regarding methodological limitations, coherence, and relevance. However, there are moderate concerns about adequacy, given that only 5 studies with relatively small sample sizes supported the review finding, although the studies did offer moderately rich data.

3.3 Perception of their role as physical, not mental, health

Conversely, some GPs were not comfortable with managing depression, and rejected the concept that mental and physical illnesses should be treated analogously. The subjective nature of depression was specifically highlighted as making it difficult to manage (Anthony 2010; Dickinson 2010; Dumesnil 2018).

"Personally, I don't like treating it that much. I would be happy if I never saw another patient who wants an antidepressant for the rest of their life. How do you measure it? They're not going to live longer if I give them Prozac. Whereas, if I lower their blood pressure I know they will live longer. I have no good way to measure outcome or measure response" (Anthony 2010, pg. 118)

The confidence in this review finding (as assessed using GRADE CERQual) is low. There are only minor concerns about coherence and relevance. However, there are serious concerns regarding methodological limitations. Two of the 3 studies contributing to the review finding are considered to be low quality (1 moderate quality), with at least 2 of the studies failing to justify the research design, failing to consider the researcher-participant relationship, and reporting insufficient detail, or inadequate, recruitment strategies or data collection methods. In addition there are moderate concerns about adequacy, given that there are only 3 studies with relatively small sample sizes supporting the review finding, although the studies did offer moderately rich data.

3.4 Mental health knowledge too limited to treat depression

Some GPs perceived their mental health training, knowledge and skills as inadequate to manage depression (Anthony 2010; Burroughs 2006; Dumesnil 2018; Iglesias-Gonzalez 2021; Johnson 2017; Jones 2013; Pollock 2003).

"I am by no means a mental health professional. I may identify the problem, which does not mean that I know how to fix the problem." (Anthony 2010, pg. 118)

"We are clearly not in the same league. . .it's their specialty. . .everything that is a hard case, in quotes, mental illness, that's their domain (. . .) there is a reason that it's a specialty in its own right, and there's a reason we call them when we can't manage with some patients" (Dumesnil 2018, pg. 8)

The confidence in this review finding (as assessed using GRADE CERQual) is high.

3.5 Need to refer on for more complex cases

GPs felt unable to adequately treat depression when patients had failed to respond to antidepressants (Anthony 2010; Johnston 2007; Keeley 2014), required augmentation of antidepressants (Johnson 2017), when depression was complex or severe (Anthony 2010; Dumesnil 2018; Johnston 2007; Jones 2013), or in an older age group due to concerns about polypharmacy and side effects (Burroughs 2006).

"I am willing to try a number of antidepressants...Beyond that, you need to see somebody else - a psychiatrist or therapist." (Anthony 2010, pg. 118)

"I suppose some of the more chronic ones …um, I can think of one person in particular at the moment who I found exceptionally difficult over the years to manage who hasn't responded to pharmacological therapies, hasn't responded to psychological therapies, hasn't responded to supportive therapies, hasn't responded to anything and is chronically depressed, and I suppose … my problem is that I assumed, naively, that one can, in the majority of cases, one can…control or cure, well, probably control depression." (Johnston 2007, pg. 8)

"I've used fluoxetine, but again they get very agitated and it can be a bit disturbing to elderly people" (Burroughs 2006, pg. 373)

The confidence in this review finding (as assessed using GRADE CERQual) is high.

3.6 Value of multidisciplinary collaboration

GPs valued the opportunity for good communication and collaboration with mental health specialists, with perceived benefits including being able to match patient needs with the skills and techniques of the specialist, being kept informed about a patient, providing a channel to seek advice, and improving accessibility (Anthony 2010; Dumesnil 2018; Iglesias-Gonzalez 2021; Jones 2013; Keeley 2014; Railton 2000).

"There is perhaps not enough dialogue between general practitioners and private-practice psychiatrists. Nonetheless, I would really like for us to succeed in talking more often and better. I think it would be good, it could only be useful for everyone" (Dumesnil 2018, pg. 6)

"I like for my patients to be seen by somebody I know. Somebody I think will be a good match for this particular patient." (Anthony 2010, pg. 120)

"…I use the Primary Mental Health Team; it's a useful concept when, with this sort of complicated cases [and] you're not quite sure, they will feed back information, then assist you in the management" (Jones 2013, pg. 8)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are only minor concerns about coherence and relevance. However, there are moderate concerns regarding methodological limitations. Three of the 6 studies contributing to the review finding are considered to be low quality (3 moderate quality), with studies failing to justify the research design, failing to consider ethical issues or the researcher-participant relationship, and reporting insufficient detail, or inadequate, recruitment strategies or data collection methods. There are also moderate concerns about adequacy, given that the 6 studies that contribute to this review finding have relatively small sample sizes and offer thin data.

4. Perceptions of psychiatric/psychological treatment options

4.1 Stigma associated with being referred for psychiatric/psychological treatment

Primary care clinicians believed fear of stigma may deter some patients with depression from seeking specialist help, and this barrier may be particularly hard to overcome for men (Anthony 2010; Keeley 2014).

"Sometime they will accept a visit to a social worker or psychologist to discuss certain situations they are having. Rarely will they agree to see a psychiatrist because the word psychiatrist is in there." (Anthony 2010, pg. 119)

"Many males will find it easier to take a pill than to go to counseling…" (Keeley 2014, pg. 9)

The confidence in this review finding (as assessed using GRADE CERQual) is low. There are only minor concerns about coherence. However, there are serious concerns about adequacy, given that only 2 studies with relatively small sample sizes supported the review finding and the studies offered thin data. In addition, there are moderate concerns regarding methodological limitations. One of the 2 studies contributing to the review finding is considered to be low quality (1 moderate quality), with one or both of the studies failing to justify the research design, failing to consider the researcher-participant relationship, and reporting insufficient detail, or inadequate, recruitment strategies or data collection methods. Finally, there are moderate concerns about relevance, with both studies based in the US and demographic details only reported for 1 of the studies.

4.2 Antipathy of patients towards talking therapies

Primary care clinicians perceived some patients to be averse to psychotherapies, either because of an antipathy towards non-pharmacological treatments (described in older patients) or for practical reasons due to work and family commitments (Burroughs 2006; Dickinson 2010; Johnson 2017; Jones 2013; Mercier 2011).

"The majority of [patients] have lived through the Second World War and they have an antipathy to counselling" (Dickinson 2010, pg. 147)

"Yeah, especially for people who are maybe very busy and are in full-time work with a family. They just don't feel that they've got the time to...[engage with other treatment options] Even when you go through the fact that, perhaps the outcome would be better, and a tablet is not going to fix the rest of their issues. They're still going to try it in the hope that they might do something for them." (Johnson 2017, supplementary appendix pg. 2)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns about relevance, and only minor concerns regarding methodological limitations and coherence. However, there are moderate concerns about adequacy, given only 5 studies with relatively small sample sizes supported the review finding and the studies offered thin data.

4.3 Need to consider if patient is currently able to engage with psychotherapy

GPs highlighted the need to consider if a patient has sufficient motivation and insight to engage with psychological interventions (Dumesnil 2018; Wilhemsen 2014).

"[The patients] must be capable of reflection, of analysis (…), have some minimum level of education (…). It's not accessible to everyone." (Dumesnil 2018, pg. 5)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns about relevance, and only minor concerns regarding methodological limitations and coherence. However, there are moderate concerns about

adequacy, given only 2 studies with relatively small sample sizes supported the review finding and the studies offered thin data.

4.4 Need for talking therapies to enable full recovery

Some GPs perceived talking therapies as necessary in order to achieve full recovery (Burroughs 2006; Chew-Graham 2002; Dumesnil 2018; Johnson 2017; Mercier 2011).

"It's no point stuffing people full of antidepressants, when they are still left with the problem…sometimes it helps to have a counsellor who puts, kind of, strategies out and enables them to move on." (Chew-Graham 2002, pg. 635)

The confidence in this review finding (as assessed using GRADE CERQual) is high.

5. Treatment offer constrained by limited time and resources

5.1 Length of GP consultation does not allow for meaningful treatment discussion

GPs saw the time and workload constraints in primary care as a barrier to exploring depression and discussing non-pharmacological treatment options (Anthony 2010; Burroughs 2006; Chew-Graham 2002; Iglesias-Gonzalez 2021; Johnson 2017; Johnston 2007; Keeley 2014; Kirkpatrick 2020; Parker 2020a; Pollock 2003; Railton 2000).

"I have time to write for medicine. I don't have time to give counseling." (Anthony 2010, pg. 119)

The confidence in this review finding (as assessed using GRADE CERQual) is high.

5.2 Referral to psychiatric/psychological services not universally available

Inadequate access to mental health specialists was identified by primary care clinicians as limiting the treatment that could be offered to patients with depression (Anthony 2010; Burroughs 2006; Jones 2013; Mercier 2011; Pollock 2003; Rogers 2001; Wilhemsen 2014). Specific barriers to accessing secondary care included high thresholds for accepting patients into services (Burroughs 2006), geographical variability (Jones 2013; Pollock 2003; Rogers 2001), and insufficient staffing (Mercier 2011).

"There isn't really any further care...the mental health service won't see anybody who hasn't got severe and enduring mental illness" (Burroughs 2006, pg. 374)

"I think to some extent we probably use more medication than we would do in an ideal world. If we had free access to rapid psychological services we would probably use them (i.e. the services) more." (Pollock 2003, pg. 267)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns about relevance, and only minor concerns about coherence. However, there are moderate concerns regarding methodological limitations. Four of the 7 studies contributing to the review finding are considered to be low quality (1 moderate, and 2 high, quality), with studies failing to justify the research design, failing to consider the researcher-participant relationship, and reporting insufficient detail, or inadequate, recruitment strategies or data collection methods. There are also moderate concerns about adequacy, the 7 studies that supported the review finding have relatively small sample sizes and the studies offered thin data.

5.3 Psychological therapies only available as short-term treatments

GPs raised the time-limited nature of the psychotherapies that they could offer, and questioned whether a relatively small number of sessions over a short timescale would be sufficient for all people with depression (Johnston 2007; Mercier 2011).

"Our remit here [counselling for depression] inhouse is short-term treatment. So in the main, we're looking at things, er, at depression or other emotional problems which probably have an identifiable cause that can be treated in a relatively short time span, or addressed, or that you can address in a relatively short time span." (Johnston 2007, pg. 7)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns regarding methodological limitations and relevance, and only minor concerns about coherence. However, there are serious concerns about adequacy, given only 2 studies with relatively small sample sizes supported the review finding and the studies offered thin data.

5.4 Waiting lists constrain choice

GPs expressed frustration at the long waiting times for psychological therapies, which made it more likely that symptoms would worsen and increased the risk of patients losing contact with services (Anthony 2010; Chew-Graham 2002; Dickinson 2010; Dumesnil 2018; Iglesias-Gonzalez 2021; Parker 2020a; Pollock 2003; Rogers 2001).

"Counselling has got quite a long waiting list, with people with low mood and depression and anxiety they've probably spent a few months contemplating coming, they've got up the courage to come, and then saying "oh yeah you can see a counsellor in three months" isn't what they were hoping for, which can then lead to their mood going even further down…" (Parker 2020a, pg. 264)

GPs sometimes prescribed antidepressants in an attempt to mitigate some of the risks associated with delayed treatment (Parker 2020a; Rogers 2001).

"It's about 4 months at the moment [waiting list to see a psychiatrist]. So that's a problem. A lot of people end up being put on medication. Perhaps if they could see a psychologist within 2 weeks then they wouldn't need medication. But there is a feeling that you've got to do something…" (Rogers 2001, pg. 327)

The confidence in this review finding (as assessed using GRADE CERQual) is high.

6. Importance of, and barriers to, an individualised treatment offer

6.1 Need to shift perspective to the individual patient

GPs stressed the greater complexity associated with treating depression relative to physical illnesses, and the increased need to consider the individual in order to find the best patient-treatment match (Chew-Graham 2018; Dickinson 2010; Johnson 2017; Johnston 2007; Railton 2000; Wittink 2011).

"In emotional medicine you are much more predisposed to the individual patient. In cardiology where essentially every patient comes into the sausage factory and gets an aspirin and a beta blocker and an ACE inhibitor and they all come out at the other end, you can't do that with the emotional illness." (Dickinson 2010, pg. 147)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns about relevance, and only minor concerns about coherence and adequacy. However, there are moderate concerns regarding methodological limitations. Three of the 6 studies contributing to the review finding are considered to be low quality (1 moderate, and 2 high, quality), with studies failing to justify the research design,

failing to consider ethical issues or the researcher-participant relationship, and reporting insufficient detail, or inadequate, recruitment strategies or data collection methods.

6.2 Discussion of treatment options should be sensitive to stigma

Primary care clinicians described a number of strategies that they have adopted in order to address the stigma that patients may associate with antidepressant treatment, including focusing on the physical symptoms of depression, making comparisons with other chronic conditions, framing treatment recommendations as if the patient were a family member or friend, and offering reassurance about confidentiality and consequences of engaging in treatment (Burroughs 2006; Kirkpatrick 2020; Patel 2014).

"I'll use the comparison that …when you have diabetes, your pancreas isn't working well. There are certain chemicals that are not working well in your body. Depression can also be a chemical imbalance…That's why an antidepressant can help you." (Kirkpatrick 2020, pg. 240)

"When I do prescribe, I always ask people, "Do you have friends that have depression that have told you about their medicines?" Because the word on the street is way more authoritative than my word." (Patel 2014, pg. 6)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns about coherence, and only minor concerns regarding methodological limitations. However, there are serious concerns about adequacy, given only 3 studies with relatively small sample sizes supported the review finding. In addition, there are moderate concerns about relevance, with questions about generalisability to the UK context given that 2 of the 3 studies are US-based, and there is a high percentage of female participants relative to general gender distribution amongst GPs.

6.3 Need to elicit and incorporate preference so patient is invested in treatment decision

GPs emphasised the importance of eliciting and incorporating patient preference into treatment decisions to ensure that the patient is fully invested in the treatment process (Johnson 2017; Patel 2014).

"You aim to certainly do it [prescribe] in partnership with the patient. At the end of the day, if you don't do it in partnership with them and you prescribed it, then they won't take it anyway, so you do it in partnership with the patient…" (Johnson 2017, pg. 7)

However, some GPs expressed uncertainty around how to empower patients to become active participants in treatment decisions (Patel 2014).

"Sometimes I just tell them, "This is your body. I can't make these decisions for you." With just the medical stuff too, like the patients with diabetes who are like, "I'll do whatever I want and you just increase my medication." It's like, "No. This is your body. You are doing this to your body." But sometimes I really don't know how to give them that power, have them create that power. I really don't know how to do that." (Patel 2014, pg. 6)

The confidence in this review finding (as assessed using GRADE CERQual) is moderate. There are no or very minor concerns regarding methodological limitations and coherence, and only minor concerns about relevance. However, there are serious concerns about adequacy, given only 2 studies with relatively small sample sizes supported the review finding, and the studies offered thin data.

6.4 Importance of a multifactorial approach

GPs characterised optimal treatment for depression as comprehensive, flexible, multifactorial and patient-centred (Dumesnil 2018; Johnson 2017; Jones 2013; Keeley 2014; Kirkpatrick 2020; Parker 2020a; Railton 2000; Wittink 2011). A broad range of non-medicalised approaches were championed (in combination with or without antidepressants), including sickness certification to ease pressure, promoting physical activity, signposting to practical help, social support, nutritional advice, and sleep hygiene (Johnson 2017; Keeley 2014; Kirkpatrick 2020; Parker 2020a; Railton 2000).

"It's the core of our work …): we are constantly obliged to adapt to each of our patients, to deal with their history, their family, their situation. Each patient is unique, each decision we make must also be unique" (Dumesnil 2018, pg. 8)

"I saw [a woman] a week ago, she has had depression in the past but it was years and years ago. She came in last week. She was in tears. Her mood was low. She's not sleeping. Classical symptoms of recurrence of her depression. Really stressed at work, changes in her relationships… So, actually I said, "Take the week off work and come back and let's speak about it. I'd like to take the pressure off there." Again, she's not wanting to go onto antidepressants. She's quite able to make that decision at the moment. She's seeking counselling and she's coming back here for regular review and that's fine." (Johnson 2017, supplementary appendix pg. 1)

"…Social prescribing, where you're sort of saying "get out there", and whether it's just walking your dog or getting some exercise at a class." (Parker 2020a, pg. 264)

"I try to sound sympathetic and perhaps suggest some strategies for them to help, or maybe refer them to other people, say if they've got debt, and I sometimes get them to prepare a plan for things and if their depression seems to be related to specific causes, I'd ask them to make a simple list of things they could do something about and things that they can't and see if I can help them chip away at some of these things." (Railton 2000, pg. 124)

The confidence in this review finding (as assessed using GRADE CERQual) is high.

Quality assessment of studies included in the evidence review

See the evidence profiles in appendix F.

Economic evidence

Included studies

A single economic search was undertaken for all topics included in the scope of this guideline but no economic studies were identified which were applicable to this review question. See the literature search strategy in appendix B and economic study selection flow chart in appendix G.

Excluded studies

A list of excluded economic and utility studies, with reasons for exclusion, is provided in supplement 3 - Health economic included & excluded studies.

Economic model

No economic modelling was undertaken for this review because the committee agreed that other topics were higher priorities for economic evaluation.

Evidence statements

Clinical evidence statements

Perspective of adults with depression:

Theme 1. Opportunity to build trusting relationships with healthcare professionals welcomed

- **1.1: Distrust of authority.**
  Some people with depression were wary of clinicians, perceiving them as figures of authority who made treatment decisions on their behalf.
  High quality evidence from 4 studies reported this sub-theme.
- **1.2: Dismissive or superficial reactions prohibited the development of a trusting relationship.**
  People with depression described feeling disempowered by clinicians not actively listening or fully engaging in discussions, and giving dismissive or superficial responses.
  High quality evidence from 9 studies reported this sub-theme.
- **1.3: Good relationships fostered confidence in the skills of the healthcare professional.**
  By listening, acknowledging and addressing patient concerns, clinicians could inspire confidence in their skills and patients could trust their advice.
  High quality evidence from 7 studies reported this sub-theme.
- **1.4: Building of rapport key to shared decision-making.**
  Good patient-clinician rapport helped people with depression to develop a sense of agency with respect to treatment decision-making, by informing and guiding but also enabling active participation in discussions and decisions.
  Low quality evidence from 8 studies reported this sub-theme.
- **1.5: Empathic and non-judgmental listening and support valued as therapeutic in itself.**
  People with depression found that being given the opportunity and time to reflect on their difficulties, and receiving an empathic and non-judgmental response, was therapeutic in itself.
  High quality evidence from 11 studies reported this sub-theme.

Theme 2. Conceptualisations of the GP role

- **2.1: Lengthy discussions beyond GP remit.**
  Depression treatment concerns could not always be adequately addressed in GP appointments due to time constraints. This could provoke feelings of frustration or a sense of guilt or lack of legitimacy.
  High quality evidence from 7 studies reported this sub-theme.
- **2.2: GP knowledge considered too limited to treat depression.**
  Low expectations about GPs' knowledge of depression, and the information and help available from primary care, caused some to express a preference for specialist treatment advice.
  Moderate quality evidence from 13 studies reported this sub-theme.
- **2.3: Patients value the opportunity to consult a GP who is knowledgeable about depression.**
  Where patients were given the opportunity to consult a primary care clinician who was perceived as knowledgeable and skilled in the treatment of depression it was highly valued.
  Low quality evidence from 1 study reported this sub-theme.
- **2.4: Accepting of paternalistic approach to treatment choice.**

Some people with depression readily accepted a paternalistic approach to treatment decision-making, based on a 'doctor knows best' belief or because they did not feel up to the demands of active participation in decision-making.
Moderate quality evidence from 12 studies reported this sub-theme.

- **2.5: Role in coordination of care.**
  People with depression recognised a vital role for GPs to play in maintaining an overview of care across services and providing consistency.
  Low quality evidence from 2 studies reported this sub-theme.
- **2.6: Value being treated in primary care as referral to psychiatric services feels like moving further away from normality.**
  Some patients preferred to be treated in primary care as there was anticipated stigma associated with referral to a psychiatrist, as it was seen as a testament to the severity of the depression.
  Very low quality evidence from 3 studies reported this sub-theme.

Theme 3. Patients value being considered as active participant in treatment discussions/decisions

- **3.1: Patients feel dismissed by prescriptions.**
  People with depression felt that antidepressants were prescribed too readily, used as a 'sticking plaster' and a way to 'get rid of them', and described a lack of choice. Some went further and believed medication was forced on them.
  High quality evidence from 14 studies reported this sub-theme.
- **3.2: Patients need sufficient information to meaningfully engage in decisions about their own treatment.**
  People with depression described an unmet need for more information about depression and about treatment, this was most commonly described in relation to antidepressants where patients wanted more information about potential side effects, length of treatment, expected treatment outcomes, anticipated benefits, speed of recovery, and alternative treatment options, in order to make an informed treatment decision.
  Moderate quality evidence from 16 studies reported this sub-theme.
- **3.3: Patients need the opportunity to discuss treatment concerns and have them addressed.**
  Patients valued their treatment concerns being taken into account by their healthcare professional, and associated better antidepressant adherence with the opportunity to discuss fears about addiction and side effects.
  Moderate quality evidence from 6 studies reported this sub-theme.
- **3.4: Patients want to be considered as a partner in treatment decision-making.**
  People with depression wanted to be recognised and treated as an individual, and appreciated as an equal partner in treatment decision-making.
  High quality evidence from 9 studies reported this sub-theme.
- **3.5: Need for, and benefit of, self-advocacy.**
  A need to take a pro-active approach in researching, deciding on, and negotiating for, the treatment of their choice was emphasised by people with depression.
  Moderate quality evidence from 11 studies reported this sub-theme.

Theme 4. Limited resources constrain choice

- **4.1: Trade-off between constrained options immediately versus wider choice with wait.**
  Some people with depression were willing to accept the more limited treatment options available in primary care rather than wait longer for a wider treatment choice in secondary care.
  Low quality evidence from 5 studies reported this sub-theme.
- **4.2: Concerns about the availability of preferred treatment.**

Patients with depression emphasised the lottery-like nature of accessing the particular therapy they wanted, highlighting particular issues in rural areas and for psychological services.
Low quality evidence from 3 studies reported this sub-theme.

- **4.3: Role for interim interventions.**
  Waiting lists demotivated patients with depression from seeking or beginning treatment, and could lead to a significant worsening of their condition. Participants highlighted the role for low intensity interventions to provide interim help while people are waiting for their treatment of choice.
  Moderate quality evidence from 2 studies reported this sub-theme.
- **4.4: Inflexibility of services can constrain choice.**
  The importance of organisational processes being flexible to individual needs was highlighted by people with depression, for example, the importance of not penalising a person if they are unable to attend a specific appointment time.
  Low quality evidence from 1 study reported this sub-theme.

Theme 5. Symptoms of depression can constrain treatment choice

- **5.1: Depression imposes barriers to uptake and engagement.**
  Symptoms of depression, such as difficulties with motivation and concentration, can construct barriers to accessing and engaging with psychological treatment. For some, antidepressants were helpful to get into a mental state more receptive to attending and engaging with talking therapy.
  Moderate quality evidence from 6 studies reported this sub-theme.
- **5.2: In crisis at time of help-seeking necessitating immediate help.**
  People with depression described having 'hit rock bottom' at the time of seeking help, and this made them willing to try whatever treatment was offered.
  Low quality evidence from 7 studies reported this sub-theme.
- **5.3: Feel unable to contribute to treatment decision-making process.**
  Symptoms of depression made some people feel like they could not contribute to treatment decision-making. Perceived barriers to decision-making included difficulties in processing information or engaging in conversation, a lack of necessary insight, or a feeling of ambivalence.
  Low quality evidence from 5 studies reported this sub-theme.

Theme 6. Pre-conceived ideas about antidepressant medication

- **6.1: Pragmatic position on antidepressants.**
  Many people with depression perceived antidepressant treatment pragmatically, as 'a means to an end' and equivalent to medication for any other health condition. Some had to overcome an initial reluctance, while others had more positive pre-conceptions and perceived antidepressant prescription as validating and empowering.
  Moderate quality evidence from 11 studies reported this sub-theme.
- **6.2: Fears about becoming addicted and side effects.**
  Common reservations about antidepressant treatment included fear of the potential for dependency and concerns about side effects.
  Moderate quality evidence from 14 studies reported this sub-theme.
- **6.3: Pessimism about the extent to which antidepressant medication, on its own, can enable true recovery.**
  Some people with depression worried that antidepressants may mask rather than resolve the depression.
  High quality evidence from 9 studies reported this sub-theme.
- **6.4: Stigma associated with antidepressants impacted sense of self.**
  Reluctance to use antidepressant medication was often associated with a fear of stigma. Specific concerns included a sense of failure, feeling 'crazy', and personality-altering potential.

Moderate quality evidence from 14 studies reported this sub-theme.

Theme 7. Perceptions of psychological interventions

- **7.1: Expectant of positive process and outcome.**
  People with depression expressed strong beliefs about the potential benefits of talking therapies, either alone or in combination with antidepressants. The opportunity to gain insight and understanding, and to talk to a professional who is not part of their life, were particularly valued.
  Moderate quality evidence from 5 studies reported this sub-theme.
- **7.2: Stigma associated with accepting that professional help required.**
  Difficulties with coming to accept that professional help was needed, and scepticism and apprehension around discussing personal problems with a stranger were described.
  Moderate quality evidence from 3 studies reported this sub-theme.
- **7.3: Sceptical about the chances of recovery.**
  Some worried that psychological interventions would not 'work', either because of concerns about therapist expertise or content of specific therapies, or a general scepticism that talking could bring about meaningful change and recovery.
  Moderate quality evidence from 4 studies reported this sub-theme.
- **7.4: Expectation to share experiences and feelings perceived as invasive and violating.**
  The requirement to talk about difficult experiences and feelings was very confronting for some participants, and responses included avoidance.
  Moderate quality evidence from 3 studies reported this sub-theme.

Perspective of practitioners:

Theme 1. GP as medication provider

- **1.1: Adopt a paternalistic role as medication provider.**
  GPs who perceived depression as 'treatable' and antidepressants as safe and effective, willingly adopted a paternalistic role as medication provider. If medication was considered to be in the best interests of the patient, GPs saw it as their responsibility to persuade patients to accept the treatment recommendation.
  High quality evidence from 6 studies reported this sub-theme.
- **1.2: Feel obliged to prescribe antidepressants.**
  GPs described a pressure to prescribe antidepressants. This was sometimes in order to meet eligibility criteria for referral to psychiatry. More commonly, the imperative to prescribe was a response to the perception that the patient wanted to be validated or 'fixed'.
  Moderate quality evidence from 5 studies reported this sub-theme.
- **1.3: Appreciate role in alleviating symptoms, even if not treating underlying problems.**
  GPs described the desire to 'do something to help' patients with depression and considered antidepressants to be beneficial, even whilst acknowledging that they might not be treating underlying problems.
  Moderate quality evidence from 7 studies reported this sub-theme.
- **1.4: Concerns about medicalizing complex problems through use of antidepressants.**
  Although GPs acknowledged that antidepressants could provide a solution for some patients' difficulties, they also questioned whether prescriptions were medicalizing complex social problems.
  Moderate quality evidence from 4 studies reported this sub-theme.

Theme 2. GP as source of support

- **2.1: Listening/support as therapeutic in itself.**
  GPs identified listening, empathising, supporting, and advising, as central to their role in the management of depression.
  High quality evidence from 11 studies reported this sub-theme.
- **2.2: Importance of building relationships.**
  GPs emphasised the therapeutic relationship as integral to facilitating shared decision-making, and fostering belief in the treatment and potential for improvement.
  High quality evidence from 10 studies reported this sub-theme.
- **2.3: Importance of being flexible and available to keep patients engaged.**
  Being flexible and available were identified by GPs as vital to keeping patients engaged in the treatment process.
  Low quality evidence from 2 studies reported this sub-theme.

Theme 3. GP as generalist versus specialist

- **3.1: Feel best-placed to manage depression.**
  Some GPs regarded themselves as better placed to manage depression than secondary care, because of the relationships formed with patients, and experience compensated for the lack of specialist training.
  Moderate quality evidence from 3 studies reported this sub-theme.
- **3.2: Feel personally responsible and go above and beyond.**
  GPs felt personally responsible for patients and this compelled them to invest extra time and effort in order to provide the best care.
  Moderate quality evidence from 5 studies reported this sub-theme.
- **3.3: Perception of their role as physical, not mental, health.**
  Conversely, some GPs were not comfortable with managing depression. They were frustrated with the subjective measure of response, and rejected the concept that mental and physical illnesses should be treated analogously.
  Low quality evidence from 3 studies reported this sub-theme.
- **3.4: Mental health knowledge too limited to treat depression.**
  Some GPs perceived their mental health training, knowledge and skills as inadequate to manage depression.
  High quality evidence from 7 studies reported this sub-theme.
- **3.5: Need to refer on for more complex cases.**
  Circumstances in which GPs would refer patients on to secondary care included when depression was complex or severe, patients had failed to respond to antidepressants, or in an older age group due to concerns about polypharmacy and side effects.
  High quality evidence from 7 studies reported this sub-theme.
- **3.6: Value of multidisciplinary collaboration.**
  GPs valued the opportunity for good communication and collaboration with mental health specialists.
  Moderate quality evidence from 6 studies reported this sub-theme.

Theme 4. Perceptions of psychiatric/psychological treatment options

- **4.1: Stigma associated with being referred for psychiatric/psychological treatment.**
  Primary care clinicians believed fear of stigma may deter some patients with depression, particularly men, from seeking specialist help.
  Low quality evidence from 2 studies reported this sub-theme.
- **4.2: Antipathy of patients towards talking therapies.**

Primary care clinicians perceived some patients to be averse to psychotherapies, either because of an antipathy towards non-pharmacological treatments (described in older patients) or for practical reasons due to work and family commitments.
Moderate quality evidence from 5 studies reported this sub-theme.

- **4.3: Need to consider if patient is currently able to engage with psychotherapy.**
  GPs highlighted the need to consider if a patient has sufficient motivation and insight to engage with psychological interventions.
  Moderate quality evidence from 2 studies reported this sub-theme.
- **4.4: Need for talking therapies to enable full recovery.**
  Some GPs perceived talking therapies as necessary in order to achieve full recovery.
  High quality evidence from 5 studies reported this sub-theme.

Theme 5. Treatment offer constrained by limited time and resources

- **5.1: Length of GP consultation does not allow for meaningful treatment discussion.**
  GPs saw the time and workload constraints in primary care as a barrier to exploring depression and discussing non-pharmacological treatment options.
  High quality evidence from 11 studies reported this sub-theme.
- **5.2: Referral to psychiatric/psychological services not universally available.**
  Treatment options that could be offered to patients with depression were limited by inadequate access to mental health specialists, specifically geographical variability, inflexible thresholds for accepting patients into services, and insufficient staffing.
  Moderate quality evidence from 7 studies reported this sub-theme.
- **5.3: Psychological therapies only available as short-term treatments.**
  GPs raised the time-limited nature of the psychotherapies that they could offer, and questioned whether a relatively small number of sessions over a short timescale would be sufficient for all patients with depression.
  Moderate quality evidence from 2 studies reported this sub-theme.
- **5.4: Waiting lists constrain choice.**
  GPs expressed frustration at the long waiting times for psychological therapies, and sometimes prescribed antidepressants to mitigate the risk of worsening symptoms, loss of faith or discontinuation from treatment all together.
  High quality evidence from 8 studies reported this sub-theme.

Theme 6. Importance of, and barriers to, an individualised treatment offer

- **6.1: Need to shift perspective to the individual patient.**
  GPs stressed the greater complexity, and need for individualised treatment, associated with managing depression relative to physical illnesses.
  Moderate quality evidence from 6 studies reported this sub-theme.
- **6.2: Discussion of treatment options should be sensitive to stigma.**
  Strategies that primary care clinicians advocated in order to address the stigma that patients may associate with antidepressants, included focusing on physical symptoms and comparing to other health conditions, framing recommendation as if talking to a friend or family member, and dispelling misconceptions and fears.
  Moderate quality evidence from 3 studies reported this sub-theme.
- **6.3: Need to elicit and incorporate preference so patient is invested in treatment decision.**
  GPs emphasised the importance of empowering patients to become active participants in treatment decisions, but were not always sure how to do this.
  Moderate quality evidence from 2 studies reported this sub-theme.
- **6.4: Importance of a multifactorial approach.**
  GPs characterised optimal treatment for depression as comprehensive, flexible, multifactorial and patient-centred, and championed a broad range of non-medicalised approaches.

High quality evidence from 8 studies reported this sub-theme.

Economic evidence statements

No economic evidence was identified which was applicable to this review question.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

This was a qualitative review and so the most important themes emerged from the data rather than being predefined in the protocol.

The aim of the review was to identify facilitators and barriers to choice for people with depression and the themes which emerged were divided into those from the perspective of people with depression, and those from the perspective of practitioners. Both groups reported that conceptualisations of the role of the GP, resources (time, waiting lists), the opportunity to build a trusting patient-clinician relationship, and pre-conceived ideas about pharmacological and psychological interventions could impact on choice.

The committee did not prioritise any of the themes above others but considered all the evidence valuable in making their recommendations.

The quality of the evidence

The quality of the evidence supporting each emerging theme was assessed using GRADE CERQual, and the overall confidence in the review findings ranged from high to very low.

Methodological limitations of the primary studies were assessed with the CASP checklist. For the majority of studies some, if not all or most, of the checklist criteria had been fulfilled, and where they had not been fulfilled the conclusions were judged to be very unlikely to change. However, for some of the review findings there were "moderate" or "serious" concerns regarding methodological limitations. The most common issues were: insufficient justification of the research design (for example, not discussing how they decided which method to use); potential for recruitment bias; insufficient justification for data collection methods and setting; lack of consideration for the relationship between researcher and participants; or insufficient consideration of ethical issues (for example, no discussion of informed consent or no detail on how research was described to participants).

Concerns about coherence ranged from "no or very minor" to "minor". For the majority of review findings there were no or very minor concerns about coherence, as there were no data that contradicted the findings nor were there ambiguous data. A small number of review findings demonstrated minor concerns due to vaguely described data in the underlying body of evidence, or data that was defined in different ways.

Concerns about relevance for the context and population of interest to this guideline ranged from "no or very minor" to "moderate"; for the majority of review findings concerns were minor. The most common reason for concern was under-reporting on ethnicity, gender, age, or diagnostic status which made it difficult to gauge the applicability of evidence, or themes that emerged from a small number of participants which represented one country, gender and/or ethnicity.

Concerns about adequacy ranged from "minor" to "serious". There were serious concerns for review findings which were based on relatively small sample sizes and where all studies

offered thin data. All other review findings were based on studies that offered moderately rich data. The number of studies used for each review finding ranged from 1 to 11.

Facilitators and barriers

The committee discussed the facilitators and barriers to treatment choice that had been identified by the evidence and used these to make specific recommendations aimed at promoting choice and minimising barriers. Although this review was focused on treatment choice, choice was considered in the broadest sense and the committee also considered this qualitative evidence more generally, weaving the emerging themes and principles through the guideline so that the findings were reflected in any recommendations where there is uncertainty about the best treatment or where there is a choice between treatments, and highlighting the importance of taking patient preferences into consideration.

A prominent theme that emerged from the experiences of both people with depression (Theme 3) and practitioners (Theme 6), was the need to establish a shared understanding of depression, and the importance of providing the opportunity to explore the person's views on their depression, any possible causes or contributing factors, and to outline priorities and facilitate choice, rather than the practitioner 'telling' the person with depression about their condition and what is needed to treat it. This is reflected in the recommendation that practitioners should explore with people with depression views on the possible causes of their depression, ideas or preferences about preferred treatment options, the person's experience of any prior episodes of depression or depression treatments, and what people with depression would like to gain from treatment.

There was evidence from the practitioners' perspective that time constraints may impair their ability to discuss depression and treatment options so the committee made a recommendation to ensure that adequate time was allowed, particularly at initial consultations.

Another theme that was reflected by both the people with depression and practitioners was the importance of a trusting relationship. For people with depression this fostered confidence in the skills of the healthcare professional, and an empathic and non-judgemental response was in itself therapeutic. For practitioners, there was evidence that GPs recognised the therapeutic value of listening and support and that being flexible and available kept people engaged in treatment. The committee were aware that building a trusting relationship required an ongoing relationship and so it was important that continuity of care was maintained by enabling people with depression to see the same practitioner or by ensuring that views and preferences were recorded and shared. The committee also recognised that building a trusting relationship requires people to have options to work with a professional with whom they think they can build a relationship, or to see an alternative professional if the relationship is not working and integrated this into the recommendations. This was also based on the experience of the committee that some people with depression fear being excluded from a service or seen as refusing treatment if they request an alternative professional. There was no evidence on more nuanced options, such as the gender of the healthcare professional providing treatment, but the committee were aware that this was very an important of building a trusting relationship for some people with depression (for example women may prefer to see a woman therapist) and so added that people should be able to express a preference for the gender of the healthcare professional.

There was evidence from several themes that people with depression want to be partners in shared decision-making and to enable this they need to be informed about treatment choices. However, they had realistic expectations about the delivery of services, and recognised that there may be limited resources which might constrain their choice, so the committee reflected this in their recommendations but agreed that people should be informed about what interventions were available, how they would be provided and issues such as waiting times, or what next steps would be in their treatment pathway. The committee agreed

this was such an important point, particularly in relation to psychological therapies, that they reiterated this in the section of the guideline on the delivery of the psychological therapies.

People with depression expressed an unmet need for more information about depression and about treatment, this was most commonly described in relation to antidepressants where patients wanted more information about potential side effects, length of treatment, expected treatment outcomes, anticipated benefits, speed of recovery, and alternative treatment options, in order to make an informed treatment decision. The evidence suggested that people with depression felt that antidepressants were prescribed too readily, used as a 'sticking plaster' and a way to 'get rid of them', and described a lack of choice. However, scepticism about the chances of recovery were also expressed in relation to psychological interventions, and the expectation to share experiences and feelings was perceived as invasive and violating by some people with depression. Fear of stigma was also associated with both pharmacological and psychological interventions. The committee did not make specific recommendations about these issues, but took them into consideration when wording their recommendations about choice of treatments in other sections of the guideline.

There were themes from the perspective of people with depression relating to their views on the role of the GP, with some people valuing the care coordination role of the GP and being treated in primary care as referral to psychiatric services can feel like moving further away from normality, whereas others expressed the view that the role of the GP was limited due to their lack of time or lack of expert knowledge. The evidence from the healthcare professionals' perspective reinforced these themes. The committee did not make specific recommendations on the role of the GP but agreed that these views confirmed that choices for care needed to be discussed with people with depression and personalised.

There were themes from the perspective of healthcare professionals about the importance of a multifactorial approach with optimal treatment for depression characterised as patient-centred, sensitive to factors such as the possible stigma attached to treatment, and the need to elicit and incorporate individual's preferences so that people were invested in their treatment. The committee also emphasised the need not to make assumptions that people with depression form a homogenous group, and recommended that clinicians explore with people with depression whether they think that treatment is necessary and that declining an offer of treatment is considered as an option.

A prominent barrier to choice identified by people with depression were the symptoms of depression itself that made it difficult to contribute to the decision-making process and to access and engage in treatment due to difficulties with motivation and concentration, feelings of ambivalence or because people had 'hit rock bottom' and this made them willing to try whatever treatment was offered. The committee agreed that this reinforced the need to take time for listening and discussion, and that it may also be helpful to involve family members or other supporters in these discussions. It also reinforced existing recommendations in the guideline about reducing the impact of stigma,

As shared decision-making was such an important theme, the committee made a recommendation to link to the NICE guideline on shared decision-making.

Cost effectiveness and resource use

The committee discussed that offering people choice of treatments and discussing treatment options may require longer consultation times and that this may have a resource impact for the NHS. However, they expressed the opinion that the benefits from such an approach outweigh potential costs associated with increased consultation times, and therefore they agreed that recommendations ensure efficient use of resources.

The committee also discussed that, based on people's expressed preferences for treatments and in order for there to be a true choice, a range of effective and cost-effective treatment options would need to be commissioned and available for people with depression. The

committee agreed that these choices should be based on the treatments recommended in the guideline and that commissioners and services should monitor access to them as availability and accessibility of preferred effective and cost-effective treatments improves outcomes and users' satisfaction, and ensures efficient use of resources.

Other factors the committee took into account

The committee discussed that some of the included studies were conducted before the Improving Access to Psychological Therapies (IAPT) programme had been introduced or while it was in the early stages, and that this may have changed the context, as these therapies should now be more widely available.

The committee also discussed the relevance of studies which had been conducted in the US, as Primary Care Physicians do not undertake the same training as GPs, and may have limited knowledge on depression.

Recommendations supported by this evidence review

This evidence review supports recommendations 1.3.1 to 1.3.6 in the NICE guideline.

References

Anderson 2013

Anderson, C., & Roy, T. Patient experiences of taking antidepressants for depression: a secondary qualitative analysis. Research In Social & Administrative Pharmacy, 9(6), 884-902, 2013

Anderson 2015

Anderson, C., Kirkpatrick, S., Ridge, D., Kokanovic, R., & Tanner, C. Starting antidepressant use: a qualitative synthesis of UK and Australian data. BMJ Open, 5(12), 2015

Anthony 2010

Anthony, J. S., Baik, S. Y., Bowers, B. J., Tidjani, B., Jeffrey Jacobson, C., & Susnman, J. Conditions that influence a primary care clinician's decision to refer patients for depression care. Rehabilitation Nursing, 35(3), 113-122, 2010

Badger 2006

Badger F, Nolan P. Concordance with antidepressant medication in primary care. Nurs Stand. 6-12;20(52):35-40, 2006

Badger 2007

Badger, F., & Nolan, P. Use of self-chosen therapies by depressed people in primary care. Journal of clinical nursing, 16(7), 1343-1352, 2007

Bayliss 2015

Bayliss P, Holttum S. Experiences of antidepressant medication and cognitive-behavioural therapy for depression: a grounded theory study. Psychol Psychother, 88(3):317-34, 2015

Buus 2012

Buus, N., Johannessen, H., & Stage, K. B. Explanatory models of depression and treatment adherence to antidepressant medication: a qualitative interview study. International Journal of Nursing Studies, 49(10), 1220-1229, 2012

Chambers 2015

Chambers, E., Cook, S., Thake, A., Foster, A., Shaw, S., Hutten, R, Ricketts, T. (2015). The self-management of longer-term depression: Learning from the patient, a qualitative study. BMC Psychiatry, 15 (1) (no pagination)(172), 2015

Chew-Graham 2012

Chew-Graham, C., Kovandzic, M., Gask, L., Burroughs, H., Clarke, P., Sanderson, H., & Dowrick, C. Why may older people with depression not present to primary care? Messages from secondary analysis of qualitative data. Health & Social Care in the Community, 20(1), 52-60, 2012

Cramer 2014

Cramer, H., Horwood, J., Payne, S., Araya, R., Lester, H., & Salisbury, C. Do depressed and anxious men do groups? What works and what are the barriers to help seeking? Primary Health Care Research & Development, 15(3), 287-301, 2014

Dickinson 2010

Dickinson R, Knapp P, House AO, Dimri V, Zermansky A, Petty D, Holmes J, Raynor DK. Long-term prescribing of antidepressants in the older population: a qualitative study. Br J Gen Pract, 60(573):e144-55, 2010

Garfield 2004

Garfield S, Francis SA, Smith FJ. Building concordant relationships with patients starting antidepressant medication. Patient Educ Couns. 55(2):241-6, 2004

Jaffray 2014

Jaffray, M., Cardy, A. H., Reid, I. C., & Cameron, I. M. (2014). Why do patients discontinue antidepressant therapy early? A qualitative study. European Journal of General Practice, 20(3), 167-173, 2014

Johnson 2017

Johnson CF, Williams B, MacGillivray SA, Dougall NJ, Maxwell M. 'Doing the right thing': factors influencing GP prescribing of antidepressants and prescribed doses. BMC Fam Pract, 18(1):72, 2017

Johnston 2007

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. British Journal of General Practice, 57(544), 872-879.

Jones 2013

Jones, K. M., Castle, D. J., Curran, E. M., & Piterman, L. (2013). Difficult-to-treat-depression: what do general practitioners think? Medical Journal of Australia, 199(6 Suppl), S6-8.

Keeley 2014

Keeley, R. D., West, D. R., Tutt, B., & Nutting, P. A. (2014). A qualitative comparison of primary care clinicians' and their patients' perspectives on achieving depression care: implications for improving outcomes. BMC family practice, 15, 13. doi:http://dx.doi.org/10.1186/1471-2296-15-13

Keller 2016

Keller, A. O., Valdez, C. R., Schwei, R. J., & Jacobs, E. A. (2016). Disclosure of Depression in Primary Care: A Qualitative Study of Women's Perceptions. Womens Health Issues, 26(5), 529-536.

MacDonald 2007

Macdonald, W., Mead, N., Bower, P., Richards, D., & Lovell, K. (2007). A qualitative study of patients' perceptions of a 'minimal' psychological therapy. International Journal of Social Psychiatry, 53(1), 23-35.

Maxwell 2005

Maxwell, M. (2005) Women's and doctors' accounts of their experiences of depression in primary care: the influence of social and moral reasoning on patients' and doctors' decisions. Chronic Illness, 1, 61-71

Mercier 2011

Mercier, A., Auger-Aubin, I., Lebeau, J. P., Van Royen, P., & Peremans, L. (2011). Understanding the prescription of antidepressants: a Qualitative study among French GPs. BMC family practice, 12, 99.

Poleshuck 2013

Poleshuck, E. L., Cerrito, B., Leshoure, N., Finocan-Kaag, G., & Kearney, M. H. (2013). Underserved women in a women's health clinic describe their experiences of depressive symptoms and why they have low uptake of psychotherapy. Community Mental Health Journal, 49(1), 50-60.

Rogers 2001

Rogers A, May C, Oliver D (2001) Experiencing depression,experiencing the depressed: The separate worlds of patients and doctors, Journal of Mental Health, 10:3, 317-333

Schofield 2011

Schofield, P., Crosland, A., Waheed, W., Waquas, A., Aseem, S., Gask, L., . . . Tylee, A. (2011). Patients' views of antidepressants: from first experiences to becoming expert. British Journal of General Practice, 61(585), 142-148.

Simon 2007

Simon, D., Loh, A., Wills, C. E., & Harter, M. (2007). Depressed patients' perceptions of depression treatment decision-making. Health Expectations, 10(1), 62-74.

Turner 2017

Turner, K. M., Percival, J., Kessler, D., & Donovan, J. (2017). Exploring patients' treatment journeys following randomisation in mental health trials to improve future trial conduct: a synthesis of multiple qualitative data sets. Trials [Electronic Resource], 18(1), 279.

Van Geffen 2011

van Geffen, E. C., Hermsen, J. H., Heerdink, E. R., Egberts, A. C., Verbeek-Heida, P. M., & van Hulten, R. (2011). The decision to continue or discontinue treatment: experiences and beliefs of users of selective serotonin-reuptake inhibitors in the initial months--a qualitative study. Research In Social & Administrative Pharmacy, 7(2), 134-150.

van Grieken 2014

van Grieken, R. A., Beune, E. J., Kirkenier, A. C., Koeter, M. W., van Zwieten, M. C., & Schene, A. H. (2014). Patients' perspectives on how treatment can impede their recovery from depression. Journal of Affective Disorders, 167, 153-159.

Wilhelmsen 2014

Wilhelmsen M, Høifødt RS, Kolstrup N, Waterloo K, Eisemann M, Chenhall R, Risør MB. Norwegian general practitioners' perspectives on implementation of a guided web-based cognitive behavioral therapy for depression: a qualitative study. J Med Internet Res. 2014 Sep 10;16(9):e208.

Wittink 2011

Wittink, M. N., Givens, J. L., Knott, K. A., Coyne, J. C., & Barg, F. K. (2011). Negotiating depression treatment with older adults: primary care providers' perspectives. Journal of Mental Health, 20(5), 429-437.

Appendices

Appendix A – Review protocol

Review protocol for review question: What are the facilitators and barriers that can enhance or inhibit choice of treatment for adults with depression?

Table 3: Review protocol

Field (based on PRISMA-P)	Content
Review question	RQ 4.0 What are the facilitators and barriers that can enhance or inhibit choice of treatment for adults with depression?
Type of review question	Qualitative review
Objective of the review	To review the facilitators and barriers to patient choice in terms of treatment from the perspective of adults with depression and practitioners
Condition or domain being studied	Adults with a diagnosis of depression according to DSM, ICD or similar criteria, or depressive symptoms as indicated by baseline depression scores on validated scales (and including those with subthreshold [just below threshold] depressive symptoms) If some, but not all, of a study's participants are eligible for the review, where possible data will be extracted for only eligible participants. If this is not possible then the study will be included if at least 80% of its participants are eligible for this review.
Exclude	Trials of women with antenatal or postnatal depression Trials of children and young people (mean age under 18 years) Trials of people with learning disabilities Trials of people with bipolar disorder Trials of adults in contact with the criminal justice system (not solely as a result of being a witness or victim) Trials that specifically recruit participants with a physical health condition in addition to depression (e.g. depression in people with diabetes)
Perspective	Service users (adults with depression) and practitioners
Phenomenon of interest	Elements that adults with depression think are important to choice of pharmacological treatment Elements that adults with depression think are important to choice of non-pharmacological treatment Elements that adults with depression think are important to choice between pharmacological and non-pharmacological treatment Factors or attributes (at the individual-, practitioner-, commissioner- or service- level) that can enhance or inhibit patient choice of treatment

Field (based on PRISMA-P)	Content
Comparison	None
Study design	Primary qualitative studies Systematic reviews of primary qualitative studies (for identification of studies) Excluded: Commentaries, editorials, vignettes, books, policy and guidance, and non-empirical research
Include unpublished data?	Conference abstracts, dissertations and unpublished data will not be included
Restriction by date	Studies published between 2000 and the date the searches are run will be sought
Study setting	Primary, secondary, tertiary and social care settings. Studies from any OECD member country will be included. However, applicability to the UK service setting will be considered during data analysis and synthesis. Non-English-language papers will be excluded (unless data can be obtained from an existing review).
Evaluation	Experience and views of facilitators and barriers that can enhance or inhibit choice of treatment for adults with depression
The review strategy	**Data Extraction (selection and coding)** Citations from each search will be downloaded into EndNote and duplicates removed. Titles and abstracts of identified studies will be screened by two reviewers for inclusion against criteria, until a good inter-rater reliability has been observed (percentage agreement =>90%). Initially 10% of references will be double-screened. If inter-rater agreement is good then the remaining references will be screened by one reviewer. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). **Data Synthesis** Qualitative data extraction and synthesis will be guided by a thematic analysis approach. This approach was selected as the review question is explorative in nature. Primary participant quotes pertaining to experience of choice of treatment will be extracted from the papers. Included studies will be divided between at least two reviewers, and each reviewer will examine the quotes in detail and develop their own coding framework. These individual analyses will be shared and a joint coding framework will be agreed and applied to the data. Quality at the individual study level will be assessed using the Critical Appraisal Skills Programme (CASP) quality-assessment tool, and each qualitative review finding will be assessed using the GRADE-CERQual (Confidence in the Evidence from Reviews of Qualitative Research) approach.
Information sources – databases and dates	Database(s): Embase 1980 to 2019 Week 17, Emcare 1995 to present, Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily 1946 to April 29, 2019, PsycINFO 1806 to April Week 4 2019 The Cochrane Library: Cochrane Database of Systematic Reviews, issue 4 of 12, April 2019 HE - Database(s): Embase 1980 to 2019 Week 08, Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily 1946 to February 26, 2019, PsycINFO 1806 to February Week 1 2019

Field (based on PRISMA-P)	Content
	NIHR Centre for Reviews and Dissemination: Health Technology Assessment Database (HTA) CINAHL Plus (Cumulative Index to Nursing and Allied Health Literature) 1937-current, EBSCO Host
Identify if an update	This is a new question added to scope of update of CG90 (2009)
Author contacts	For details please see the guideline in development web site.
Highlight if amendment to previous protocol	For details please see section 4.5 of Developing NICE guidelines: the manual 2014
Search strategy – for one database	For details please see appendix B.
Data collection process – forms/duplicate	A standardised evidence table format will be used, and published as appendix D (clinical evidence tables) or H (economic evidence tables).
Data items – define all variables to be collected	For details please see evidence tables in appendix D (clinical evidence tables) or H (economic evidence tables).
Methods for assessing bias at outcome/study level	Standard study checklists were used to critically appraise individual studies. For details please see section 6.2 of Developing NICE guidelines: the manual 2014.
Criteria for qualitative synthesis	For details please see section 6.4 of Developing NICE guidelines: the manual 2014
Methods for qualitative analysis – combining studies and identifying themes	For details please see the methods chapter
Meta-bias assessment – publication bias, selective reporting bias	For details please see section 6.2 of Developing NICE guidelines: the manual 2014.
Confidence in cumulative evidence	For details please see sections 6.2 and 9.1 of Developing NICE guidelines: the manual 2014
Rationale/context – what is known	For details please see the introduction to the evidence review.
Describe contributions of authors and guarantor	A multidisciplinary committee developed the evidence review. The committee was convened by the National Guideline Alliance (NGA) and chaired by Dr Navneet Kapur in line with section 3 of Developing NICE guidelines: the manual 2014. Staff from the NGA undertook systematic literature searches, appraised the evidence, conducted meta-analysis and cost effectiveness analysis where appropriate, and drafted the guideline in collaboration with the committee. For details please see the methods chapter.
Sources of funding/support	The NGA is funded by NICE and hosted by the Royal College of Obstetricians and Gynaecologists.
Name of sponsor	The NGA is funded by NICE and hosted by the Royal College of Obstetricians and Gynaecologists.
Roles of sponsor	NICE funds NGA to develop guidelines for those working in the NHS, public health and social care in England
PROSPERO registration number	CRD42019151352

GRADE: Grading of Recommendations Assessment, Development and Evaluation; HTA: Health Technology Assessment; NGA: National Guideline Alliance; NHS: National health service; NICE: National Institute for Health and Care Excellence; RoB: risk of bias

Appendix B – Literature search strategies

Literature search strategies for review question: What are the facilitators and barriers that can enhance or inhibit choice of treatment for adults with depression?

Clinical search

Database(s): Embase 1974 to 2019 Week 17, Emcare 1995 to present, Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily 1946 to April 29, 2019, PsycINFO 1806 to April Week 4 2019

Date of search: 30/04/2019

Search updated: 03/03/2021

#	Searches
1	(depression/ or agitated depression/ or atypical depression/ or depressive psychosis/ or dysthymia/ or endogenous depression/ or involutional depression/ or late life depression/ or major depression/ or masked depression/ or melancholia/ or "mixed anxiety and depression"/ or reactive depression/ or recurrent brief depression/ or treatment resistant depression/) use oemezd, emcr
2	(Depression/ or Depressive Disorder/ or Depressive Disorder, Major/ or Depressive Disorder, Treatment-Resistant/ or Disorders, Psychotic/ or Dysthymic Disorder/) use ppez
3	("depression (emotion)"/ or exp major depression/ or affective disorders/ or atypical depression/) use psyh
4	(depress* or dysthym* or melanchol* or ((affective or mood) adj disorder*)).tw.
5	((sever* or serious* or major* or chronic* or complex* or critical* or endur* or persist* or resist* or acute) adj2 (anxiet* or (mental adj2 (disorder* or health or illness* or ill-health)) or (obsessive adj2 disorder*) or OCD or panic attack* or panic disorder* or phobi* or personality disorder* or psychiatric disorder* or psychiatric illness* or psychiatric ill-health*)).tw.
6	or/1-5
7	(decision making/ or drug choice/ or drug preference/ or patient decision making/ or patient preference/ or professional-patient relationship/ or shared decision making/ or treatment refusal/) use oemezd, emcr
8	(Choice Behavior/ or Consumer Advocacy/ or Decision Making/ or exp "Dissent and Disputes"/ or Patient Advocacy/ or exp Patient Acceptance of Health Care/ or Patient Preference/ or Professional-Patient Relations or Treatment Refusal/) use ppez
9	(advocacy/ or choice behaviour/ or client participation/ or decision making/ or doubt/ or group decision making/ or treatment barriers/ or treatment dropouts/ or treatment refusal/ or uncertainty/ or volition/) use psyh
10	((adult* or carer* or caregiver* or care-giver* or consumer* or client* or famil* or inpatient* or in-patient* or outpatient* out-patient* or patient* or user*) adj3 (choice* or choos* or decid* or decision* or judg* or option* or prefer*) adj5 (accept* or adher* or advoca* or agree* or barrier* or certain* or clear or coerc* or collaborat* or complain* or concern* or concord* or consult* or contribut* or empower* or encourag* or engag* or enhanc* or evaluat* or experienc* or facilitat* or inhibit* or involv* or non-adher* or nonadher* or opinion* or participat* or partner* or perception* or perspective* or prefer* or refer* or refus* or sure or uncertain* or unclear or unsure or view*)).tw.
11	or/7-10
12	6 and 11
13	Letter/ use ppez
14	letter.pt. or letter/ use oemezd, emcr
15	note.pt.
16	editorial.pt.
17	Editorial/ use ppez
18	News/ use ppez
19	exp Historical Article/ use ppez
20	Anecdotes as Topic/ use ppez
21	Comment/ use ppez
22	Case Report/
23	case study/ use oemezd, emcr
24	(letter or comment*).ti.
25	or/13-24
26	randomized controlled trial/
27	random*.ti,ab.
28	26 or 27
29	25 not 28
30	(animals/ not humans/) use ppez
31	(animal/ not human/) use oemezd, emcr
32	nonhuman/ use oemezd, emcr
33	exp animals/ use psyh
34	"primates (nonhuman)"/ use psyh

#	Searches
35	exp Animals, Laboratory/ use ppez
36	exp Animal Experimentation/ use ppez
37	exp animal experiment/ use oemezd, emcr
38	exp experimental animal/ use oemezd, emcr
39	exp Models, Animal/ use ppez
40	animal model/ use oemezd, emcr
41	animal models/ use psyh
42	animal research/ use psyh
43	exp Rodentia/ use ppez
44	exp rodent/ use oemezd, emcr
45	exp rodents/ use psyh
46	(rat or rats or mouse or mice).ti.
47	or/29-46
48	12 not 47
49	Meta-Analysis/
50	exp Meta-Analysis as Topic/
51	systematic review/
52	meta-analysis/
53	(meta analy* or metanaly* or metaanaly*).ti,ab.
54	((systematic or evidence) adj2 (review* or overview*)).ti,ab.
55	((systematic* or evidence*) adj2 (review* or overview*)).ti,ab.
56	(reference list* or bibliograph* or hand search* or manual search* or relevant journals).ab.
57	(search strategy or search criteria or systematic search or study selection or data extraction).ab.
58	(search* adj4 literature).ab.
59	(medline or pubmed or cochrane or embase or psychlit or psyclit or psychinfo or psycinfo or cinahl or science citation index or bids or cancerlit).ab.
60	cochrane.jw.
61	((pool* or combined) adj2 (data or trials or studies or results)).ab.
62	(or/49-51,53,55-60) use ppez
63	(or/51-54,56-61) use oemezd, emcr
64	(or/49,53,55-60) use psyh
65	or/62-64
66	qualitative research/
67	nursing methodology research/
68	exp interview/
69	questionnaire/
70	exp verbal communication/
71	health care survey/
72	(or/66-71) use oemezd, emcr
73	exp qualitative research/
74	Nursing Methodology Research/
75	Interviews as Topic/
76	"Surveys and Questionnaires"/
77	Narration/
78	exp Health Care Surveys/
79	(or/73-78) use ppez
80	qualitative research/
81	exp interviews/
82	questionnaires/
83	exp surveys/
84	exp verbal communication/
85	group discussion/
86	(qualitative study not "literature review").md.
87	(or/80-86) use psyh
88	interview.pt.
89	(qualitative* or interview* or focus or group* or questionnaire* or narrative* or narration* or survey*).tw.
90	(ethno* or emic or etic or phenomenolog* or grounded theory or constant compar* or (thematic adj4 analys*) or theoretical sampl* or purposive sampl*).tw.
91	(hermeneutic* or heidegger* or husser* or colaizzi* or van kaam* or van manen* or giorgi* or glaser* or strauss* or ricoeur* or spiegelberg* or merleau*).tw.
92	(metasynthes* or meta-synthes* or metasummar* or meta-summar* or metastud* or meta-stud* or metathem* or meta-them*).tw.
93	"critical interpretive synthes*".tw.
94	(realist adj (review* or synthes*)).tw.
95	(noblit and hare).tw.
96	(meta adj (method or triangulation)).tw.
97	(CERQUAL or CONQUAL).tw.
98	((thematic or framework) adj synthes*).tw.
99	or/88-98
100	72 or 79 or 87 or 99
101	65 or 100

#	Searches
102	48 and 101
103	limit 102 to english language
104	limit 103 to yr="2000 -Current"

Database(s): The Cochrane Library: Cochrane Database of Systematic Reviews, issue 4 of 12, April 2019

Date of search: 30/04/2019

Search updated: 04/03/2021

ID	Search
#1	MeSH descriptor: [Depression] this term only
#2	MeSH descriptor: [Depressive Disorder] this term only
#3	MeSH descriptor: [Depressive Disorder, Major] this term only
#4	MeSH descriptor: [Depressive Disorder, Treatment-Resistant] this term only
#5	MeSH descriptor: [Affective Disorders, Psychotic] this term only
#6	MeSH descriptor: [Dysthymic Disorder] this term only
#7	(depress* or dysphori* or dysthym* or melancholl* or ((affective or mood) next disorder*)):ti,ab
#8	((sever* or serious* or major* or acute or chronic* or complex* or endur* or persist* or resist*) next/2 anxiety or (mental next/2 (disorder* or health or illness* or ill-health)) or (obsessive next/2 disorder*) or OCD or "panic attack*" or "panic disorder*" or phobi* or "personality disorder*" or "psychiatric disorder*" or "psychiatric illness*" or "psychiatric ill-health*"):ti,ab
#9	{or #1-#8}
#10	MeSH descriptor: [Choice Behavior] this term only
#11	MeSH descriptor: [Consumer Advocacy] this term only
#12	MeSH descriptor: [Decision Making] this term only
#13	MeSH descriptor: [Dissent and Disputes] explode all trees
#14	MeSH descriptor: [Patient Advocacy] this term only
#15	MeSH descriptor: [Patient Acceptance of Health Care] this term only
#16	MeSH descriptor: [Professional-Patient Relations] this term only
#17	MeSH descriptor: [Patient Preference] this term only
#18	MeSH descriptor: [Treatment Refusal] this term only
#19	((adult* or carer* or caregiver* or care-giver* or consumer* or client* or famil* or inpatient* or in-patient* or outpatient* out-patient* or patient* or user*) near/3 (choice* or choos* or decid* or decision* or judg* or option* or prefer*) near/5 (accept* or adher* or advoca* or agree* or barrier* or certain* or clear or coerc* or collaborat* or complain* or concern* or concord* or consult* or contribut* or empower* or encourag* or engag* or enhanc* or evaluat* or experienc* or facilitat* or inhibit* or involv* or non-adher* or nonadher* or opinion* or participat* or partner* or perception* or perspective* or prefer* or refer* or refus* or sure or uncertain* or unclear or unsure or view*)):ti,ab
#20	{or #10-#18}
#21	#9 and #19 with Cochrane Library publication date Between Jan 2000 and Apr 2019, in Cochrane Reviews, Cochrane Protocols

Health Economics search

Database(s): Embase 1974 to 2019 Week 08, Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily 1946 to February 26, 2019, PsycINFO 1806 to February Week 1 2019

Date of search: 27/02/12019

Search updated: 02/03/2021

#	Searches
1	(depression/ or agitated depression/ or atypical depression/ or depressive psychosis/ or dysphoria/ or dysthymia/ or endogenous depression/ or involutional depression/ or late life depression/ or major depression/ or masked depression/ or melancholia/ or "mixed anxiety and depression"/ or "mixed depression and dementia"/ or premenstrual dysphoric disorder/ or reactive depression/ or recurrent brief depression/ or seasonal affective disorder/ or treatment resistant depression/) use oemezd
2	((Depression/ or exp Depressive Disorder/ or Adjustment Disorders/ or Affective Disorders, Psychotic/ or Factitious Disorders/ or Premenstrual Dysphoric Disorder/) use ppez
3	("depression (emotion)"/ or exp major depression/ or affective disorders/ or atypical depression/ or premenstrual dysphoric disorder/ or seasonal affective disorder/) use psyh
4	(depress* or dysphori* or dysthym* or melancholl* or seasonal affective disorder* or ((affective or mood) adj disorder*)).tw.
5	or/1-4
6	Letter/ use ppez
7	letter.pt. or letter/ use oemezd
8	note.pt.
9	editorial.pt.

#	Searches
10	Editorial/ use ppez
11	News/ use ppez
12	exp Historical Article/ use ppez
13	Anecdotes as Topic/ use ppez
14	Comment/ use ppez
15	Case Report/
16	case study/ use oemezd
17	(letter or comment*).ti.
18	or/6-17
19	randomized controlled trial/
20	random*.ti,ab.
21	19 or 20
22	18 not 21
23	(animals/ not humans/) use ppez
24	(animal/ not human/) use oemezd
25	nonhuman/ use oemezd
26	exp animals/ use psyh
27	"primates (nonhuman)"/ use psyh
28	exp Animals, Laboratory/ use ppez
29	exp Animal Experimentation/ use ppez
30	exp animal experiment/ use oemezd
31	exp experimental animal/ use oemezd
32	exp Models, Animal/ use ppez
33	animal model/ use oemezd
34	animal models/ use psyh
35	animal research/ use psyh
36	exp Rodentia/ use ppez
37	exp rodent/ use oemezd
38	exp rodents/ use psyh
39	(rat or rats or mouse or mice).ti.
40	or/22-39
41	5 not 40
42	Economics/
43	Value of life/
44	exp "Costs and Cost Analysis"/
45	exp Economics, Hospital/
46	exp Economics, Medical/
47	Economics, Nursing/
48	Economics, Pharmaceutical/
49	exp "Fees and Charges"/
50	exp Budgets/
51	(or/42-50) use ppez
52	health economics/
53	exp economic evaluation/
54	exp health care cost/
55	exp fee/
56	budget/
57	funding/
58	(or/52-57) use oemezd
59	exp economics/
60	exp "costs and cost analysis"/
61	cost containment/
62	money/
63	resource allocation/
64	(or/59-63) use psyh
65	budget*.ti,ab.
66	cost*.ti.
67	(economic* or pharmaco?economic*).ti.
68	(price* or pricing*).ti,ab.
69	(cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)).ab.
70	(financ* or fee or fees).ti,ab.
71	(value adj2 (money or monetary)).ti,ab.
72	or/65-70
73	51 or 58 or 64 or 72
74	Quality-Adjusted Life Years/ use ppez
75	Sickness Impact Profile/
76	quality adjusted life year/ use oemezd
77	"quality of life index"/ use oemezd
78	(quality adjusted or quality adjusted life year*).tw.
79	(qaly* or qal or qald* or qale* or qtime* or qwb* or daly).tw.

#	Searches
80	(illness state* or health state*).tw.
81	(hui or hui2 or hui3).tw.
82	(multiattibute* or multi attribute*).tw.
83	(utilit* adj3 (score*1 or valu* or health* or cost* or measur* or disease* or mean or gain or gains or index*)).tw.
84	utilities.tw.
85	(eq-5d* or eq5d* or eq-5* or eq5* or euroqual* or euro qual* or euroqual 5d* or euro qual 5d* or euro qol* or euroqol*or euro quol* or euroquol* or euro quol5d* or euroquol5d* or eur qol* or eurqol* or eur qol5d* or eurqol5d* or eur?qul* or eur?qul5d* or euro* quality of life or european qol).tw.
86	(euro* adj3 (5 d* or 5d* or 5 dimension* or 5dimension* or 5 domain* or 5domain*)).tw.
87	(sf36 or sf 36 or sf thirty six or sf thirtysix).tw.
88	(time trade off*1 or time tradeoff*1 or tto or timetradeoff*1).tw.
89	Quality of Life/ and ((quality of life or qol) adj (score*1 or measure*1)).tw.
90	Quality of Life/ and ec.fs.
91	Quality of Life/ and (health adj3 status).tw.
92	(quality of life or qol).tw. and Cost-Benefit Analysis/ use ppez
93	(quality of life or qol).tw. and cost benefit analysis/ use oemezd
94	(quality of life or qol).tw. and "costs and cost analysis"/ use psyh
95	((qol or hrqol or quality of life).tw. or *quality of life/) and ((qol or hrqol* or quality of life) adj2 (increas* or decreas* or improv* or declin* or reduc* or high* or low* or effect or effects or worse or score or scores or change*1 or impact*1 or impacted or deteriorat*)).ab.
96	Cost-Benefit Analysis/ use ppez and cost-effectiveness ratio*.tw. and (cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.
97	cost benefit analysis/ use oemezd and cost-effectiveness ratio*.tw. and (cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.
98	"costs and cost analysis"/ use psyh and cost-effectiveness ratio*.tw. and (cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.
99	*quality of life/ and (quality of life or qol).ti.
100	quality of life/ and ((quality of life or qol) adj3 (improv* or chang*)).tw.
101	quality of life/ and health-related quality of life.tw.
102	Models, Economic/ use ppez
103	economic model/ use oemezd
104	or/74-101
105	73 or 104
106	41 and 105
107	limit 106 to english language
108	limit 107 to yr="2016 -Current"

1 Database(s): NIHR Centre for Reviews and Dissemination: Health Technology Assessment
2 Database (HTA)

3 Date of search: 26/02/2019

#	Searches
#1	MESH DESCRIPTOR: depressive disorder EXPLODE ALL TREES
#2	((depres* or dysphori* or dysthymi* or melancholi* or seasonal affective disorder* or affective disorder* or mood disorder*))
#3	#1 or #2 IN HTA FROM 2016 TO 2019

4 Database(s): CINAHL Plus (Cumulative Index to Nursing and Allied Health Literature) 1937-
5 current, EBSCO Host

6 Date of search: 26/02/2019

7 Search updated: 02/03/2021

#	Query	Limiters/Expanders
S31	S4 AND S30	Limiters - Publication Year: 2016-2019; Exclude MEDLINE records; Language: English Search modes - Boolean/Phrase
S30	S10 OR S29	Search modes - Boolean/Phrase
S29	S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28	Limiters - Exclude MEDLINE records; Language: English Search modes - Boolean/Phrase
S28	(MH "Quality of Life") AND TX (health-related quality of life)	Search modes - Boolean/Phrase
S27	(MH "Quality of Life") AND TI (quality of life or qol)	Search modes - Boolean/Phrase
S26	AB ((qol or hrqol or quality of life) AND ((qol or hrqol* or quality of life) N2 (increas* or decreas* or improv* or declin* or reduc* or high* or low* or effect or effects or worse or score or scores or change*1 or impact*1 or impacted or deteriorat*)))	Search modes - Boolean/Phrase
S25	(MH "Cost Benefit Analysis") AND TX ((quality of life or qol) or (cost-effectiveness ratio* and (perspective* or life expectanc*))	Search modes - Boolean/Phrase

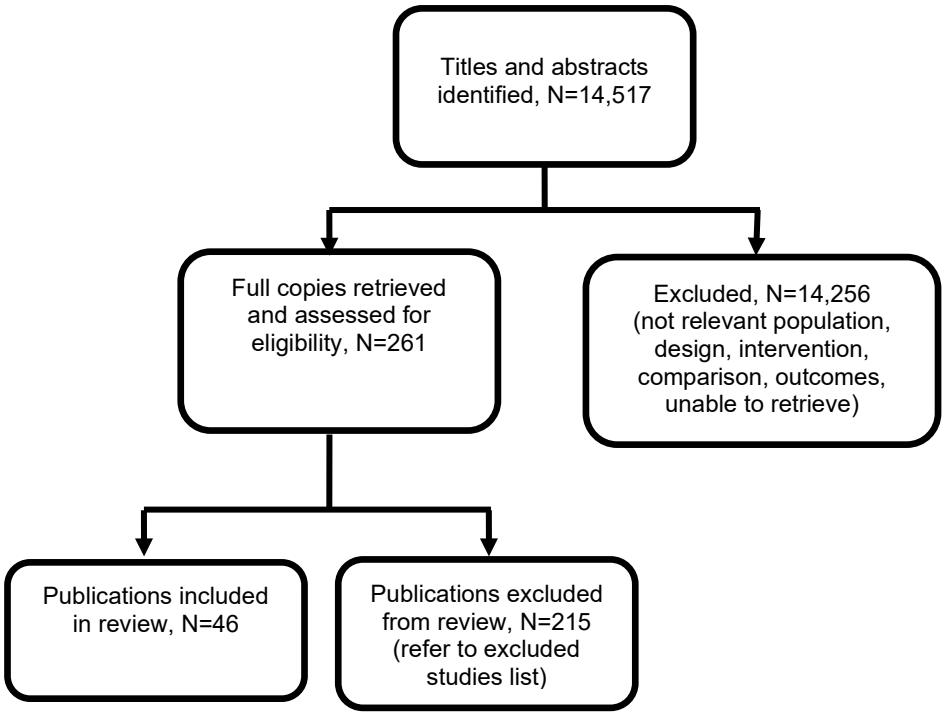
#	Query	Limiters/Expanders
S24	(MH "Quality of Life") TX (health N3 status)	Search modes - Boolean/Phrase
S23	(MH "Quality of Life") AND TX ((quality of life or qol) N (score*1 or measure*1))	Search modes - Boolean/Phrase
S22	TX (time trade off*1 or time tradeoff*1 or tto or timetradeoff*1)	Search modes - Boolean/Phrase
S21	TX (sf36 or sf 36 or sf thirty six or sf thirtysix)	Search modes - Boolean/Phrase
S20	TX (euro* N3 (5 d* or 5d* or 5 dimension* or 5dimension* or 5 domain* or 5domain*))	Search modes - Boolean/Phrase
S19	TX (eq-5d* or eq5d* or eq-5* or eq5* or euroqual* or euro qual* or euroqual 5d* or euro qual 5d* or euro qol* or euroqol*or euro quol* or euroquol* or euro quol5d* or euroquol5d* or eur qol* or eurqol* or eur qol5d* or eurqol5d* or eur?qul* or eur?qul5d* or euro* quality of life or european qol)	Search modes - Boolean/Phrase
S18	TI utilities	Search modes - Boolean/Phrase
S17	TX (utilit* N3 (score*1 or valu* or health* or cost* or measur* or disease* or mean or gain or gains or index*))	Search modes - Boolean/Phrase
S16	TX (multiattibute* or multi attribute*)	Search modes - Boolean/Phrase
S15	TX (hui or hui2 or hui3)	Search modes - Boolean/Phrase
S14	TX (illness state* or health state*)	Search modes - Boolean/Phrase
S13	TX (quality adjusted or quality adjusted life year*or qaly* or qal or qald* or qale* or qtime* or qwb* or daly)	Search modes - Boolean/Phrase
S12	(MH "Sickness Impact Profile")	Search modes - Boolean/Phrase
S11	(MH "Quality-Adjusted Life Years")	Search modes - Boolean/Phrase
S10	S5 OR S6 OR S7 OR S8 OR S9	Limiters - Exclude MEDLINE records; Language: English Search modes - Boolean/Phrase
S9	TX (value N2 (money or monetary))	Search modes - Boolean/Phrase
S8	TX (cost* N2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*))	Search modes - Boolean/Phrase
S7	TI cost* or economic* or pharmaco?economic*	Search modes - Boolean/Phrase
S6	TX budget* or fee or fees or finance* or price* or pricing	Search modes - Boolean/Phrase
S5	(MH "Fees and Charges+") OR (MH "Costs and Cost Analysis+") OR (MH "Economics") OR (MH "Economic Value of Life") OR (MH "Economics, Pharmaceutical") OR (MH "Economic Aspects of Illness") OR (MH "Resource Allocation+")	Search modes - Boolean/Phrase
S4	S1 OR S2 OR S3	Limiters - Exclude MEDLINE records; Language: English Search modes - Boolean/Phrase
S3	TX (depress* or dysphori* or dysthym* or melanchol* or seasonal affective disorder)	Search modes - Boolean/Phrase
S2	(MH "Adjustment Disorders+") OR (MH "Factitious Disorders") OR (MH "Affective Disorders, Psychotic")	Search modes - Boolean/Phrase
S1	(MH "Depression+") OR (MH "Premenstrual Dysphoric Disorder") OR (MH "Seasonal Affective Disorder")	Search modes - Boolean/Phrase

1
2

Appendix C – Clinical evidence study selection

Study selection for review question: What are the facilitators and barriers that can enhance or inhibit choice of treatment for adults with depression?

Figure 3: Study selection flow chart



Appendix D – Clinical evidence tables

Evidence tables for review question: What are the facilitators and barriers that can enhance or inhibit choice of treatment for adults with depression?

Please refer to the evidence tables in supplement I – Clinical evidence tables for Evidence Review I Patient choice

Appendix E – Forest plots

Forest plots for review question: What are the facilitators and barriers that can enhance or inhibit choice of treatment for adults with depression?

This was a qualitative review therefore there are no forest plots.

Appendix F – GRADE CERQual tables

GRADE CERQual tables for review question: What are the facilitators and barriers that can enhance or inhibit choice of treatment for adults with depression?

Service Users – Adults with depression

Table 4: Evidence profile for Theme 1. Opportunity to build trusting relationships with healthcare professionals welcomed

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
1.1 Distrust of authority								
Some people with depression were wary of clinicians, perceiving them as figures of authority who made treatment decisions on their behalf.	4: Anderson 2013; Poleshuck 2013; Stark 2018; van Grieken 2014	4: Interview (face-to-face)	"You also feel very dependent. I actually felt growing smaller and smaller during that conversation. I absolutely did not have a good feeling then." (van Grieken 2014)	No or very minor concerns regarding methodological limitations	No or very minor concerns about coherence	Minor concerns regarding adequacy (4 studies supported the review finding, the number of participants in 3 of the studies was relatively low, however studies offered moderately rich data)	Minor concerns about relevance (ethnicity only reported in 1 study)	HIGH
1.2 Dismissive or superficial reactions prohibited the development of a trusting relationship								

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
People with depression described feeling disempowered by clinicians not actively listening or fully engaging in discussions, and giving dismissive or superficial responses.	9: Anderson 2013; Anderson 2015; Badger 2006; Barney 2011; Johnston 2007; Keller 2016; Macdonald 2007; Rogers 2001; Turner 2017	4: Interview (face-to-face); 4: Interview (format NR); 1: Free-text written response	"I mean, I like doctor [X] he's fine, but ... I just don't get that personal thing with him, he's very, looking at his desk or the screen, he very rarely looks at you and I feel like I'm talking to the wall, basically. You know, when you're pouring your heart out to somebody [laughs], it kind of puts you off. If they're not ... showing any interest, it's like, sort of like, it makes it seem petty what you're saying ..." (Johnston 2007	Moderate concerns regarding methodological limitations (according to CASP appraisal 4 studies considered low quality, 4 moderate quality, and 1 high quality)	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Minor concerns about adequacy (6 studies supported the review finding and the majority of studies had reasonable sample sizes, however, the studies offered thin data)	Minor concerns about relevance (diagnostic status unclear in 7 studies, females over-represented in sample, and ethnicity either not reported or predominantly white)	HIGH
1.3 Good relationships fostered confidence in the skills of the healthcare professional								
By listening, acknowledging and addressing patient concerns, clinicians could inspire confidence in their skills and patients could trust their advice.	7: Anderson 2013; Anderson 2015; Badger 2007; Chew-Graham 2012; Johnston	5: Interview (face-to-face); 1: Interview (format NR); 1: Focus group	"They take the time to talk to you ... my doctors, I know they're very busy and everything and that, but my doctor in particular likes to keep that personal side of things going and he's generally interested in how things are for you, how you're managing	Minor concerns regarding methodological limitations (according to CASP appraisal all 7 studies considered moderate quality)	No or very minor concerns about coherence	Minor concerns regarding adequacy (7 studies supported the review finding, the number of participants in 3 of the studies was	Minor concerns about relevance (diagnostic status unclear in 6 studies, females over-represented in sample, and ethnicity either not	HIGH

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
	2007; Stark 2018		financially, and ... things like that. He does try and talk to you and get you to answer him and tell him what the root of the problems are, you know. He knows us very well, we've been going for about 17 years there" (Johnston 2007)			low, however studies offered moderately rich data)	reported or predominantly white)	
1.4 Building of rapport key to shared decision-making								
Good patient-clinician rapport helped people with depression to develop a sense of agency with respect to treatment decision-making, by informing and guiding but also enabling active participation in discussions and decisions.	8: Anderson 2013; Anderson 2015; Chew-Graham 2012; Keeley 2014; Keller 2016; Lawrence 2006; Turner 2017; van Geffen 2011	4: Interview (face-to-face); 1: Interview (telephone); 3: Interview (format NR)	"My relationship with our GP is really good. He is always willing to listen to my side of the story. He understands my situation; I think that's important." (van Geffen 2011)	Moderate concerns regarding methodological limitations (according to CASP appraisal 2 studies considered low quality and 6 studies considered moderate quality)	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Serious concerns regarding adequacy (5 studies had relatively small sample sizes, and all studies offered thin data)	Minor concerns about relevance (diagnostic status unclear in 5 studies, and females over-represented in sample)	LOW
1.5 Empathic and non-judgmental listening and support valued as therapeutic in itself								

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
People with depression found that being given the opportunity and time to reflect on their difficulties, and receiving an empathic and non-judgement response, was therapeutic in itself.	11: Anderson 2013; Badger 2006; Chambers 2015; Johnston 2007; Keller 2016; Macdonald 2007; Poleshuck 2013; Rogers 2001; Stark 2018; Turner 2017	6: Interview (face-to-face); 4: Interview (format NR); 1: Focus group	"He's not like a doctor that looks down on you, or he's rushing you, or waiting to tell you something before you go. He's just a person there to listen." (Rogers 2001)	Minor concerns regarding methodological limitations (according to CASP appraisal 3 studies considered low quality, 6 studies moderate quality, and 2 studies high quality)	No or very minor concerns about coherence	Minor concerns regarding adequacy (11 studies supported the review finding, the number of participants in most of the studies was relatively low, however studies offered moderately rich data)	Minor concerns about relevance (diagnostic status unclear in 7 studies, and females over-represented in sample)	HIGH

Abbreviations: CASP: critical appraisal skills programme; NR: not reported

1 Methodological limitations refer to the extent to which there were problems in the design or conduct of the studies that contributed evidence to the findings of the review.

2 Coherence of findings is assessed by looking at the extent to which the review findings are well grounded in data from the contributing primary studies

3 Adequacy is assessed by looking at the degree of richness and quantity of data supporting the findings of the review

4 Relevance refers to the extent to which the body of data from the primary studies supporting a review finding is applicable to the context specified in the review question

Table 5: Evidence profile for Theme 2. Conceptualisations of the GP role

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
2.1 Lengthy discussions beyond GP remit								
Depression treatment concerns could not always be adequately addressed in GP appointments due to time constraints. This could provoke feelings of frustration or a sense of guilt or lack of legitimacy.	7: Bayliss 2015; Johnston 2007; Keller 2016; Lawrence 2006; Rogers 2001; Stark 2018; Sterner 2020	4: Interview (face-to-face); 2: Interview (format NR); 1: Focus group	"[doctors are] all about the medicines. . .we'd all like to think that we're visiting Frasier Crane but we're not, you don't get to lay on the couch, you don't get to discuss your problems. . .you get to go in for 10 minutes if you're lucky once every 3 months – 'How are you feeling? Still taking medication? Sleeping alright? Well we'll leave you on that then'…and I've had that for 10 years so I guarantee you…that's what happens" (Bayliss 2015)	Moderate concerns regarding methodological limitations (according to CASP appraisal 2 studies considered low quality and 5 studies considered moderate quality)	No or very minor concerns about coherence	Minor concerns regarding adequacy (7 studies supported the review finding, the number of participants in 5 of the studies was relatively low, however studies offered moderately rich data)	No or very minor concerns about relevance	HIGH
2.2 GP knowledge considered too limited to treat depression								
Low expectations about GPs' knowledge of depression, and the information and help available from	13: Anderson 2013; Barney 2011; Chambers 2015; Chew-	5: Interview (face-to-face); 4: Interview (format NR); 2: Focus group; 1:	"Psychiatrists know about drugs, GPs don't know as much obviously...You could end up on so much...but it is serious stuff." (Anderson 2013)	Moderate concerns regarding methodological limitations (according to CASP appraisal 7 studies	Minor concerns about coherence (some concerns about the fit between the	Moderate concerns about adequacy (13 studies supported the review finding, the	Minor concerns about relevance (diagnostic status unclear in 6 studies, females over-	MODERATE

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
primary care, caused some to express a preference for specialist treatment advice.	Graham 2012; Green 2017; Keeley 2014; Keller 2016; Rogers 2001; Simon 2007; Stark 2018; Sterner 2020; Turner 2017; van Geffen 2011	Interview (telephone); 1: Free-text written response		considered low quality, 5 moderate quality, and 1 high quality)	data from primary studies and the review finding)	number of participants in 11 of the studies was relatively low, and the studies offered thin data)	represented in sample, and ethnicity predominantly not reported)	
2.3 Patients value the opportunity to consult a GP who is knowledgeable about depression								
Where patients were given the opportunity to consult a primary care clinician who was perceived as knowledgeable and skilled in the treatment of depression it was highly valued.	1: Keeley 2014	1: Interview (telephone)	"The specific doctor [clinician b] that I see said, 'Hey, you know, [clinician c] is really up on this kind of stuff and you might really want to talk to her.' I did and I really found that she is way more in tune with depression and, basically, what she call the serotonin imbalance… she has	Minor concerns regarding methodological limitations (according to CASP appraisal the 1 study considered moderate quality)	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Serious concerns regarding adequacy (only 1 study with a relatively small sample size supported the review finding, although the	Serious concerns about relevance (demographics not reported in single study included)	LOW

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
			apparently studied and reads up on it and just seems way more knowledgeable about what's going on in the treatment in that area." (Keeley 2014)			study offered moderately rich data)		
2.4 Accepting of paternalistic approach to treatment choice								
Some people with depression readily accepted a paternalistic approach to treatment decision-making, based on a 'doctor knows best' belief or because they did not feel up to the demands of active participation in decision-making.	12: Anderson 2013; Anderson 2015; Badger 2007; Bayliss 2015; Garfield 2004; Johnston 2007; Keller 2016; Maxwell 2005; Rogers 2001; Schofield 2011; Simon 2007; van Geffen 2011	9: Interview (face-to-face); 3: Interview (format NR)	"One of the things that I thought was very important to me in this process was the fact that the doctor said to me, "I'm going to get you out of this depression but don't expect a miracle. Don't expect to be okay tomorrow. It's a long process but I'll sort you out." Those were his words. That to me was very important." (Anderson 2013)	Moderate concerns regarding methodological limitations (according to CASP appraisal 5 studies considered low quality and 7 studies considered moderate quality)	No or very minor concerns about coherence	Minor concerns regarding adequacy (12 studies supported the review finding, the number of participants in 6 of the studies was relatively low, however studies offered moderately rich data)	Minor concerns about relevance (diagnostic status unclear in 7 studies, females over-represented in sample, and limited information available about ethnicity)	MODERATE

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
2.5 Role in coordination of care								
People with depression recognised a vital role for GPs to play in maintaining an overview of care across services and providing consistency.	2: Chambers 2015; Keeley 2014	1: Interview (face-to-face); 1: Interview (telephone)	"It was having someone who was having an overview because I think previously what had happened was there were lots of individual people that you got referred to that you were seeing separately. But nobody was really bringing them together so there was duplication but no real way of bringing it together and she seemed to be able to bring the different strands together." (Chambers 2015)	No or very minor concerns regarding methodological limitations	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Serious concerns regarding adequacy (only 2 studies supported the review finding, the number of participants in both of the studies was relatively low, and the studies offered thin data)	Serious concerns about relevance (very limited information available about the participants included)	LOW
2.6 Value being treated in primary care as referral to psychiatric services feels like moving further away from normality								
Some patients preferred to be treated in primary care as there was anticipated stigma associated with referral to a psychiatrist, as it	3: Lawrence 2006; Rogers 2001; Simon 2007	2: Interview (face-to-face); 1: Interview (format NR)	"I would feel that if someone was to say we are going to make an appointment for you to see a psychiatrist, straight away I would think oh I am going off me rocker kind of thing." (Lawrence 2006)	Serious concerns regarding methodological limitations (according to CASP appraisal 2 studies considered low quality and 1	Minor concerns about coherence (some concerns about the fit between the data from primary	Serious concerns regarding adequacy (only 3 studies with relatively small sample sizes supported the	Serious concerns about relevance (very limited information available about the participants included)	VERY LOW

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
was seen as a testament to the severity of the depression.				study considered moderate quality)	studies and the review finding)	review finding, although the studies offered moderately rich data)		

Abbreviations: CASP: critical appraisal skills programme; NR: not reported
1 Methodological limitations refer to the extent to which there were problems in the design or conduct of the studies that contributed evidence to the findings of the review.
2 Coherence of findings is assessed by looking at the extent to which the review findings are well grounded in data from the contributing primary studies
3 Adequacy is assessed by looking at the degree of richness and quantity of data supporting the findings of the review
4 Relevance refers to the extent to which the body of data from the primary studies supporting a review finding is applicable to the context specified in the review question

Table 6: Evidence profile for Theme 3. Patients value being considered as active participant in treatment discussions/decisions

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
3.1 Patients feel dismissed by prescriptions								
People with depression felt that antidepressants were prescribed too readily, used as a 'sticking plaster' and a way to 'get rid of them', and described a lack of choice. Some went further and	14: Anderson 2013; Anderson 2015; Bayliss 2015; Chambers 2015; Chew-Graham 2012; Cramer	8: Interview (face-to-face); 4: Interview (format NR); 1: Interview (telephone); 1: Focus group and interview	"This GP was particularly um insistent that I take her prescription. And I had said, 'no,' I had said 'no' about three times. In the end she said to me, 'um I don't know what's wrong with depressed people, why they always refuse to take um my prescriptions. I	Minor concerns regarding methodological limitations (according to CASP appraisal 3 studies considered low quality, 9 studies considered moderate quality, and 2	No or very minor concerns about coherence	Minor concerns regarding adequacy (14 studies supported the review finding, the number of participants in 10 of the studies was relatively	Minor concerns about relevance (diagnostic status unclear in 8 studies, and limited information available about ethnicity)	HIGH

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
believed medication was forced on them.	2014; Johnston 2007; Keeley 2014; Keller 2016; Lawrence 2006; Rogers 2001; Turner 2017; van Geffen 2011; van Grieken 2014		think depressed people like being depressed.' I felt like she'd shamed me into taking her um prescription." (Anderson 2015)	studies considered high quality)		low, however studies offered moderately rich data)		
3.2 Patients need sufficient information to meaningfully engage in decisions about their own treatment								
People with depression described an unmet need for more information about depression and about treatment, this was most commonly described in relation to antidepressants where patients wanted more	16: Anderson 2013; Anderson 2015; Badger 2006; Barney 2011; Buus 2012; Chambers 2015; Chew-Graham 2018;	8: Interview (face-to-face); 3: Interview (format NR); 2: Focus group; 1: Interview (telephone/face-to-face); 1: Focus group and interview; 1: Free-text written response	"When I started with this medication, I didn't receive any information whatsoever, not even about side effects. They did tell me in passing that it could take a while before I would notice the intended effect. The doctors should be much keener about this. It would be so easy to just give the main messages, and	Moderate concerns regarding methodological limitations (according to CASP appraisal 8 studies considered low quality, 4 moderate quality, and 4 high quality)	No or very minor concerns about coherence	Minor concerns regarding adequacy (16 studies supported the review finding, the number of participants in 11 of the studies was relatively low, however studies offered	Minor concerns about relevance (diagnostic status unclear in 9 studies, and ethnicity predominantly not reported)	MODERATE

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
information about potential side effects, length of treatment, expected treatment outcomes, anticipated benefits, speed of recovery, and alternative treatment options, in order to make an informed treatment decision.	Cramer 2014; Garfield 2004; Green 2017; Rogers 2001; Simon 2007; Sterner 2020; Turner 2017; van Geffen 2011; van Grieken 2014		refer to the information leaflet for more information. When I asked my doctor whether this medication has any side effects, he just grabbed a big book and said ‘‘If you like I can read them for you.’’" (van Geffen 2011)			moderately rich data)		
3.3 Patients need the opportunity to discuss treatment concerns and have them addressed								
Patients valued their treatment concerns being taken into account by their healthcare professional, and associated better antidepressant adherence with the opportunity to discuss fears about addiction and side effects.	6: Anderson 2013; Badger 2006; Maxwell 2005; Poleshuck 2013; van Geffen 2011; van Grieken 2014	4: Interview (face-to-face); 2: Interview (format NR)	"After about 2 months, having been signed off from work for 2 months, I found myself getting worse and worse and approached the subject with them about going onto medication which I sort of...I didn’t really...before I thought, “I didn’t really want to go on medication” but I	Moderate concerns regarding methodological limitations (according to CASP appraisal 3 studies considered low quality, 2 moderate quality, and 1 high quality)	No or very minor concerns about coherence	Minor concerns regarding adequacy (6 studies supported the review finding, the number of participants in 4 of the studies was relatively low, however studies	Moderate concerns about relevance (diagnostic status unclear in 5 studies, females over-represented in sample, and very limited information available	MODERATE

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
			thought that I was at the point where I needed something to help me. They were very, very good in that they didn't just immediately give me a prescription. Actually, we went through the options of what kind of medication, what sort of...what they do, what they're designed for. And they said that they would rather monitor my situation before letting me go onto them which I think was very responsible of them. I did eventually, because I wasn't getting any better, did go onto antidepressants." (Anderson 2013)			offered moderately rich data)	about ethnicity)	
3.4 Patients want to be considered as a partner in treatment decision-making								
People with depression wanted to be recognised and treated as an individual, and appreciated as	9: Anderson 2013; Anderson 2015; Chambers 2015;	8: Interview (face-to-face); 1: Interview (format NR)	"I think we're all different, aren't we? And I know what I am personally and, er, I know what's good for me, what isn't." (Chambers 2015)	Minor concerns regarding methodological limitations (according to CASP appraisal 1 study	No or very minor concerns about coherence	Minor concerns regarding adequacy (9 studies supported the review	Minor concerns about relevance (females over-	HIGH

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
an equal partner in treatment decision-making.	Garfield 2004; Keller 2016; Macdonald 2007; Simon 2007; van Grieken 2014; Ward 2014			considered low quality, 4 moderate quality, and 4 studies considered high quality)		finding, the number of participants in 6 of the studies was relatively low, however studies offered moderately rich data)	represented in sample)	
3.5 Need for, and benefit of, self-advocacy								
A need to take a pro-active approach in researching, deciding on, and negotiating for, the treatment of their choice was emphasised by people with depression.	11: Anderson 2013; Anderson 2015; Badger 2006; Barney 2011; Bayliss 2015; Chambers 2015; Chew-Graham 2018; Garfield 2004; Johnston 2007; Keeley 2014; van	7: Interview (face-to-face); 1: Interview (telephone); 1: Interview (format NR); 1: Interview (telephone/face-to-face); 1: Free-text written response	"So it was my decision. So I wasn't influenced by the doctor or the counsellor. It was a decision I felt ... I had to make so I was fully prepared." (Garfield 2004)	Minor concerns regarding methodological limitations (according to CASP appraisal 3 studies considered low quality, 6 moderate quality, and 2 studies considered high quality)	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Moderate concerns about adequacy (11 studies supported the review finding, the number of participants in 5 of the studies was relatively low, and the studies offered thin data)	Moderate concerns about relevance (diagnostic status unclear in 7 studies, females over-represented in sample, and ethnicity either not reported or predominantly white)	MODERATE

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
	Geffen 2011							

Abbreviations: CASP: critical appraisal skills programme; NR: not reported
1 Methodological limitations refer to the extent to which there were problems in the design or conduct of the studies that contributed evidence to the findings of the review.
2 Coherence of findings is assessed by looking at the extent to which the review findings are well grounded in data from the contributing primary studies
3 Adequacy is assessed by looking at the degree of richness and quantity of data supporting the findings of the review
4 Relevance refers to the extent to which the body of data from the primary studies supporting a review finding is applicable to the context specified in the review question

Table 7: Evidence profile for Theme 4. Limited resources constrain choice

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
4.1 Trade-off between constrained options immediately versus wider choice with wait								
Some people with depression were willing to accept the more limited treatment options available in primary care rather than wait longer for a wider treatment choice in secondary care.	5: Keeley 2014; Macdonald 2007; Rogers 2001; Schofield 2011; Simon 2007	3: Interview (face-to-face); 1: Interview (format NR); 1: Interview (telephone)	"So the cost to go to a psychiatrist is just ridiculous, and so I stayed within the bounds of what the primary care physician would do because I could get treated right away…" (Keeley 2014)	Moderate concerns regarding methodological limitations (according to CASP appraisal 3 studies considered low quality, 1 study considered moderate quality, and 1 study considered high quality)	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Serious concerns about adequacy (5 studies with relatively small sample sizes supported the review finding, and the studies offered thin data)	Minor concerns about relevance (females over-represented in the sample, and limited information available about ethnicity)	LOW
4.2 Concerns about the availability of preferred treatment								

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
Patients with depression emphasised the lottery-like nature of accessing the particular therapy they wanted, highlighting particular issues in rural areas and for psychological services.	3: Barney 2011; Chambers 2015; Sterner 2020	1: Interview (face-to-face); 1: Focus group; 1: Free-text written response	"I mean you get referred don't you, from your GP and it's like pot luck really, cos you know obviously the resources aren't limitless are they?" (Chambers 2015)	Moderate concerns regarding methodological limitations (according to CASP appraisal 2 studies considered low quality, and 1 high quality)	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Serious concerns regarding adequacy (only 3 studies supported the review finding, and the number of participants in 2 of the studies was relatively low, the studies also offered thin data)	Minor concerns about relevance (females over-represented in the sample, and limited information available about ethnicity)	LOW
4.3 Role for interim interventions								
Waiting lists demotivated patients with depression from seeking or beginning treatment, and could lead to a significant worsening of their condition. Participants highlighted the	2: Macdonald 2007; van Grieken 2014	2: Interview (face-to-face)	"The waiting list is a hell of a long time . . . and I was so desperate . . . it's like a stepping-stone – a café half-way on your journey. It's like there's something and you are being lifted up and being kept afloat . . ." (Macdonald 2007)	No or very minor concerns regarding methodological limitations	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Serious concerns regarding adequacy (only 2 studies with relatively small sample sizes supported the review finding, and the studies	Minor concerns about relevance (females over-represented in sample, and ethnicity either not reported or all white)	MODERATE

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
role for low intensity interventions to provide interim help while people are waiting for their treatment of choice.						offered thin data)		
4.4 Inflexibility of services can constrain choice								
The importance of organisational processes being flexible to individual needs was highlighted by people with depression, for example, the importance of not penalising a person if they are unable to attend a specific appointment time.	1: Chambers 2015	1: Interview (face-to-face)	"I think she was the CBT person I was referred to her, got on the waiting list, an appointment came through…I said 'I'm sorry I can't make that appointment because it's my first week starting a new job' and she sounded very huffy about it. And I said, but I would like to, you know, continue on the waiting list and I never heard from her again, so she'd taken me off the waiting list, just because I said, I'd rather not have an appointment (laugh) during my first week at a new job." (Chambers 2015)	No or very minor concerns regarding methodological limitations	No or very minor concerns about coherence	Serious concerns regarding adequacy (only 1 study with a small sample size supported the review finding, although the study offered moderately rich data)	Serious concerns about relevance (females over-represented, and a predominantly white population, in the single study)	LOW

Abbreviations: CASP: critical appraisal skills programme; NR: not reported
1 Methodological limitations refer to the extent to which there were problems in the design or conduct of the studies that contributed evidence to the findings of the review.
2 Coherence of findings is assessed by looking at the extent to which the review findings are well grounded in data from the contributing primary studies
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4 Relevance refers to the extent to which the body of data from the primary studies supporting a review finding is applicable to the context specified in the review question

Table 8: Evidence profile for Theme 5. Symptoms of depression can constrain treatment choice

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
5.1 Depression imposes barriers to uptake and engagement								
Symptoms of depression, such as difficulties with motivation and concentration, can construct barriers to accessing and engaging with psychological treatment. For some, antidepressants were helpful to get into a mental state more receptive to attending and engaging with talking therapy.	6: Barney 2011; Bayliss 2015; Chew-Graham 2018; Keeley 2014; Macdonald 2007; Poleshuck 2013	3: Interview (face-to-face); 1: Interview (telephone); 1: Interview (telephone/face-to-face); 1: Free-text written response	"I hear you! I know that if I do my CBT work and start to challenge my negative thoughts that I will start to feel better, but why can I never be bothered to do it??? ... We have a double whammy of an illness, in that to feel better we have to take action, but to take action we have to "feel" like taking action. It's some sort of a cruel joke." (Barney 2011)	Minor concerns regarding methodological limitations (according to CASP appraisal 1 study considered low quality, 3 studies considered moderate quality, and 2 studies considered high quality)	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Moderate concerns about adequacy (6 studies supported the review finding, and the number of participants in 5 of the studies was relatively low, however the studies offered moderately rich data)	Minor concerns about relevance (diagnostic status unclear in 3 studies, and females over-represented in the sample)	MODERATE
5.2 In crisis at time of help-seeking necessitating immediate help								

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
People with depression described having 'hit rock bottom' at the time of seeking help, and this made them willing to try whatever treatment was offered.	7: Badger 2006; Chew-Graham 2018; Keeley 2014; Schofield 2011; Simon 2007; van Geffen 2011; van Grieken 2014	4: Interview (face-to-face); 1: Interview (telephone); 1: Interview (telephone/face-to-face); 1: Interview (format NR)	"…I needed to do whatever it took to, you know, get well again, quite simply. So I, I would do whatever it takes. When you - I think when you really hit rock bottom you are prepared to do whatever it takes and I have absolute faith in my doctor" (Chew-Graham 2018)	Moderate concerns regarding methodological limitations (according to CASP appraisal 4 studies considered low quality, 1 moderate quality, and 2 studies considered high quality)	No or very minor concerns about coherence	Moderate concerns regarding adequacy (7 studies with relatively small sample sizes supported the review finding, however the studies offered moderately rich data)	Moderate concerns about relevance (diagnostic status was unclear in 4 studies, females over-represented in the sample, and very limited information available about ethnicity)	LOW
5.3 Feel unable to contribute to treatment decision-making process								
Symptoms of depression made some people feel like they could not contribute to treatment decision-making. Perceived barriers to decision-making included difficulties in processing	5: Buus 2012; Keeley 2014; Schofield 2011; Simon 2007; van Geffen 2011	4: Interview (face-to-face); 1: Interview (telephone)	"He told me ''This is better for you,'' so then I went ahead and started using it. Not really a conscious decision. You don't really know why, or for how long; you don't really know anything." (van Geffen 2011)	Moderate concerns regarding methodological limitations (according to CASP appraisal 3 studies considered low quality, 1 moderate quality, and 1 study considered high quality)	No or very minor concerns about coherence	Moderate concerns regarding adequacy (5 studies with relatively small sample sizes supported the review finding, however the studies offered	Moderate concerns about relevance (females over-represented in sample, and very limited information available about ethnicity)	LOW

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
information or engaging in conversation, a lack of necessary insight, or a feeling of ambivalence.						moderately rich data)		

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3 Adequacy is assessed by looking at the degree of richness and quantity of data supporting the findings of the review
4 Relevance refers to the extent to which the body of data from the primary studies supporting a review finding is applicable to the context specified in the review question

Table 9: Evidence profile for Theme 6. Pre-conceived ideas about antidepressant medication

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
6.1 Pragmatic position on antidepressants								
Many people with depression perceived antidepressant treatment pragmatically, as 'a means to an end' and equivalent to medication for any other health condition. Some	11: Anderson 2015; Badger 2006; Chew-Graham 2018; Jaffray 2014; Johnston 2007;	7: Interview (face-to-face); 1: Interview (format NR); 1: Interview (telephone); 1: Interview (telephone/face-to-face); 1: Focus group	"I actually didn't have an ideological or philosophical position about medication. For me medication was a means to an end" (Anderson 2015)	Minor concerns regarding methodological limitations (according to CASP appraisal 4 studies considered low quality, 6 studies considered moderate	No or very minor concerns about coherence	Minor concerns about adequacy (11 studies supported the review finding, the number of participants in 5 of the studies was	Moderate concerns about relevance (diagnostic status was unclear in 7 studies, females over-represented in the sample, and limited	MODERATE

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
had to overcome an initial reluctance, while others had more positive pre-conceptions and perceived antidepressant prescription as validating and empowering.	Keeley 2014; Lawrence 2006; Schofield 2011; Stark 2018; Sterner 2020; van Geffen 2011			quality, and 1 study considered high quality)		relatively low, however the studies offered moderately rich data)	information available about ethnicity)	
6.2 Fears about becoming addicted and side effects								
Common reservations about antidepressant treatment included fear of the potential for dependency and concerns about side effects.	14: Anderson 2013; Anderson 2015; Chew-Graham 2018; Green 2017; Lawrence 2006; Maxwell 2005; Poleshuck 2013; Rogers 2001; Schofield 2011; Simon	8: Interview (face-to-face); 3: Interview (format NR); 2: Focus group; 1: Interview (telephone/face-to-face)	"But I didn't know if antidepressants were the right things for us because you hear so much about them. Because like once you get on to them you get addicted to them and like I have heard loads of like bad reports." (Schofield 2011)	Moderate concerns regarding methodological limitations (according to CASP appraisal 8 studies considered low quality, 5 moderate quality, and 1 high quality)	No or very minor concerns about coherence	Minor concerns regarding adequacy (14 studies supported the review finding, although the number of participants in 10 of the studies was relatively low, the studies offered moderately rich data)	Moderate concerns about relevance (diagnostic status was unclear in 9 studies, females over-represented in the sample, and limited information available about ethnicity)	MODERATE

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
	2007; Stark 2018; Sterner 2020; Turner 2017; van Geffen 2011							
6.3 Pessimism about the extent to which antidepressant medication, on its own, can enable true recovery								
Some people with depression worried that antidepressants may mask rather than resolve the depression.	9: Anderson 2013; Anderson 2015; Bayliss 2015; Burroughs 2006; Chambers 2015; Green 2017; Rogers 2001; Stark 2018; van Geffen 2011	7: Interview (face-to-face); 1: Interview (format NR); 1: Focus group	"Taking medication and feeling better is great… however, it is necessary … to be able to function without medication…." (Green 2017)	Minor concerns regarding methodological limitations (according to CASP appraisal 3 studies considered low quality, 4 studies considered moderate quality, and 2 studies considered high quality)	No or very minor concerns about coherence	Minor concerns regarding adequacy (9 studies supported the review finding, although the number of participants in 7 of the studies was relatively low, the studies offered moderately rich data)	Minor concerns about relevance (females over-represented in sample, and limited information available about ethnicity)	HIGH
6.4 Stigma associated with antidepressants impacted sense of self								
Reluctance to use	14: Anderson	8: Interview (face-to-face);	"I actually wanted to fix it myself. If you can	Moderate concerns	No or very minor	Minor concerns	Moderate concerns	MODERATE

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
antidepressant medication was often associated with a fear of stigma. Specific concerns included a sense of failure, feeling 'crazy', and personality-altering potential.	2013; Anderson 2015; Badger 2006; Barney 2011; Chew-Graham 2012; Garfield 2004; Jaffray 2014; Lawrence 2006; Maxwell 2005; Rogers 2001; Schofield 2011; Simon 2007; Turner 2017; van Geffen 2011	5: Interview (format NR); 1: Free-text written response	resolve it without medication then you're part of the regular people, but now I no longer belong to that group. Taking medication means admitting failure." (van Geffen 2011)	regarding methodological limitations (according to CASP appraisal 8 studies considered low quality, and 6 moderate quality)	concerns about coherence	regarding adequacy (14 studies supported the review finding, although the number of participants in 7 of the studies was relatively low, the studies offered moderately rich data)	about relevance (diagnostic status was unclear in 11 studies, females over-represented in the sample, and very limited information available about ethnicity)	

Abbreviations: CASP: critical appraisal skills programme; NR: not reported

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2 Coherence of findings is assessed by looking at the extent to which the review findings are well grounded in data from the contributing primary studies

3 Adequacy is assessed by looking at the degree of richness and quantity of data supporting the findings of the review

4 Relevance refers to the extent to which the body of data from the primary studies supporting a review finding is applicable to the context specified in the review question

Table 10: Evidence profile for Theme 7. Perceptions of psychological interventions

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
7.1 Expectant of positive process and outcome								
People with depression expressed strong beliefs about the potential benefits of talking therapies, either alone or in combination with antidepressants. The opportunity to gain insight and understanding, and to talk to a professional who is not part of their life, were particularly valued.	5: Chew-Graham 2018; Green 2017; Lawrence 2006; Macdonald 2007; Poleshuck 2013	3: Interview (face-to-face); 1: Interview (telephone/face-to-face); 1: Focus group	"Sometimes you need to talk to someone and then you feel better. It would be helpful to have that along with the medicine." (Green 2017)	Minor concerns regarding methodological limitations (according to CASP appraisal 1 study considered low quality, 2 studies considered moderate quality, and 2 studies considered high quality)	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Moderate concerns about adequacy (only 5 studies with relatively small sample sizes supported the review finding, and the studies offered thin data)	Minor concerns about relevance (females over-represented in the sample)	MODERATE
7.2 Stigma associated with accepting that professional help required								
Difficulties with coming to accept that professional help was needed, and	3: Lawrence 2006; Simon 2007; Ward 2014	3: Interview (face-to-face)	"Who wants to talk about stuff like that? That's embarrassing stuff. I was a career woman, okay. Anybody with any kind	Minor concerns regarding methodological limitations (according to CASP appraisal	No or very minor concerns about coherence	Moderate concerns about adequacy (only 3 studies with	Minor concerns about relevance (females over-	MODERATE

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
scepticism and apprehension around discussing personal problems with a stranger were described.			of decent reputation, I'm an accountant, and I've got clients, and many people under me, you know, and people looking up to me. Who wants to talk about something like that (depression)? I mean, it was degrading to me." (Ward 2014)	1 study considered low quality, 1 moderate quality, and 1 high quality)		relatively small sample sizes supported the review finding, although the studies offered moderately rich data)	represented in the sample, and ethnicity either not reported or predominantly non-white)	
7.3 Sceptical about the chances of recovery								
Some worried that psychological interventions would not 'work', either because of concerns about therapist expertise or content of specific therapies, or a general scepticism that talking could bring about meaningful change and recovery.	4: Macdonald 2007; Poleshuck 2013; Stark 2018; van Grieken 2014	4: Interview (face-to-face)	"I was open to trying anything . . . I thought it [guided self-help] would help a little bit but I didn't think it would cure me." (Macdonald 2007)	No or very minor concerns regarding methodological limitations	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Moderate concerns about adequacy (only 4 studies with relatively small sample sizes supported the review finding, and the studies offered thin data)	Minor concerns about relevance (females over-represented in sample, and limited information available about ethnicity)	MODERATE

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
7.4 Expectation to share experiences and feelings perceived as invasive and violating								
The requirement to talk about difficult experiences and feelings was very confronting for some participants, and responses included avoidance.	3: Poleshuck 2013; Simon 2007; Ward 2014	3: Interview (face-to-face)	"I got some deep rooted ugly childhood stuff. I don't think that counseling will do anything for me but stir that crap up and make me feel even worse. I'd rather just leave it alone and go on with my life." (Poleshuck 2013)	Minor concerns regarding methodological limitations (according to CASP appraisal 1 study considered low quality, 1 moderate quality, and 1 high quality)	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Moderate concerns about adequacy (only 3 studies with relatively small sample sizes supported the review finding, although the studies offered moderately rich data)	Minor concerns about relevance (females over-represented in the sample, and ethnicity either not reported or predominantly non-white)	MODERATE

Abbreviations: CASP: critical appraisal skills programme; NR: not reported
1 Methodological limitations refer to the extent to which there were problems in the design or conduct of the studies that contributed evidence to the findings of the review.
2 Coherence of findings is assessed by looking at the extent to which the review findings are well grounded in data from the contributing primary studies
3 Adequacy is assessed by looking at the degree of richness and quantity of data supporting the findings of the review
4 Relevance refers to the extent to which the body of data from the primary studies supporting a review finding is applicable to the context specified in the review question

1 **Practitioners**

2 **Table 11: Evidence profile for Theme 1. GP as medication provider**

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
1.1 Adopt a paternalistic role as medication provider								
GPs who perceived depression as 'treatable' and antidepressants as safe and effective, willingly adopted a paternalistic role as medication provider. If medication was considered to be in the best interests of the patient, GPs saw it as their responsibility to persuade patients to accept the treatment recommendation.	6: Dumesnil 2018; Johnston 2007; Mercier 2011; Parker 2020a; Patel 2014; Wittink 2011	2: Focus group; 2: Interview (face-to-face); 1: Interview (telephone); 1: Interview (format NR)	"I mean my experience with antidepressants is, they all work, it doesn't matter if it's the old tricyclics or whether, as long as you have the levels high enough, then you've just got to balance that against side-effects. I can virtually say, I can guarantee that you'll feel better er just you know, just I suppose you could say trust me, um just give it time and we can make it better." (Johnston 2007)	Minor concerns regarding methodological limitations (according to CASP appraisal 1 study considered low quality, 4 studies considered moderate quality, and 1 study considered high quality)	No or very minor concerns about coherence	Minor concerns about adequacy (6 studies with relatively small sample sizes supported the review finding, although the studies offered moderately rich data)	No or very minor concerns about relevance	HIGH
1.2 Feel obliged to prescribe antidepressants								
GPs described a pressure to prescribe antidepressants.	5: Chew-Graham 2018; Dickinson	2: Focus group; 1: Interview (face-to-face); 1: Interview	"They think they're coming here [pause] for me to do something for them	Minor concerns regarding methodological limitations	Minor concerns about coherence	Moderate concerns about adequacy	No or very minor concerns	MODERATE

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
This was sometimes in order to meet eligibility criteria for referral to psychiatry. More commonly, the imperative to prescribe was a response to the perception that the patient wanted to be validated or 'fixed'.	2010; Iglesias-Gonzalez 2021; Johnson 2017; Mercier 2011	(telephone/face-to-face); 1: Interview (format NR)	[empathetically said]. And that, they almost feel as if there needs to be a physical display of that, like the prescription or whatever." (Johnson 2017)	(according to CASP appraisal 1 study considered low quality, 1 moderate quality, and 3 high quality)	(some concerns about the fit between the data from primary studies and the review finding)	(only 5 studies with relatively small sample sizes supported the review finding, although the studies offered moderately rich data)	about relevance	
1.3 Appreciate role in alleviating symptoms, even if not treating underlying problems								
GPs described the desire to 'do something to help' patients with depression and considered antidepressants to be beneficial, even whilst acknowledging that they might not be treating underlying problems.	7: Chew-Graham 2002; Dickinson 2010; Johnson 2017; Johnston 2007; Keeley 2014; Maxwell 2005; Pollock 2003	4: Interview (face-to-face); 2: Interview (format NR); 1: Interview (telephone)	"If the cause is a social factor I can't get rid of that ... but I might alleviate their symptoms a little bit." (Dickinson 2010)	Minor concerns regarding methodological limitations (according to CASP appraisal 3 studies considered low quality, 3 moderate quality, and 1 high quality)	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Moderate concerns about adequacy (7 studies with relatively small sample sizes supported the review finding, and the studies offered thin data)	No or very minor concerns about relevance	MODERATE
1.4 Concerns about medicalizing complex problems through use of antidepressants								

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
Although GPs acknowledged that antidepressants could provide a solution for some patients' difficulties, they also questioned whether prescriptions were medicalizing complex social problems.	4: Burroughs 2006; Dickinson 2010; Iglesias-Gonzalez 2021; Maxwell 2005	2: Interview (format NR); 1: Interview (face-to-face); 1: Focus group	"I think they have horrible lives, a lot of them ... I think it's a combination of all things, their health, their social circumstances ... I think a lot of people are on antidepressants because of everything put together. And you can't ... change most of the factors that cause it." (Dickinson 2010)	Moderate concerns regarding methodological limitations (according to CASP appraisal 2 studies considered low quality, 1 moderate quality, and 1 high quality)	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Moderate concerns about adequacy (only 4 studies with relatively small sample sizes supported the review finding, although the studies offered moderately rich data)	Minor concerns about relevance (high percentage of female participants relative to general gender distribution amongst GPs)	MODERATE

Abbreviations: CASP: critical appraisal skills programme; NR: not reported
1 Methodological limitations refer to the extent to which there were problems in the design or conduct of the studies that contributed evidence to the findings of the review.
2 Coherence of findings is assessed by looking at the extent to which the review findings are well grounded in data from the contributing primary studies
3 Adequacy is assessed by looking at the degree of richness and quantity of data supporting the findings of the review
4 Relevance refers to the extent to which the body of data from the primary studies supporting a review finding is applicable to the context specified in the review question

Table 12: Evidence profile for Theme 2. GP as source of support

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
2.1 Listening/support as therapeutic in itself								

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
GPs identified listening, empathising, supporting, and advising, as central to their role in the management of depression.	11: Dumesnil 2018; Iglesias-Gonzalez 2021; Johnson 2017; Johnston 2007; Keeley 2014; Maxwell 2005; Mercier 2011; Parker 2020a; Pollock 2003; Railton 2000; Wilhemsen 2014	6: Interview (face-to-face); 3: Focus group; 1: Interview (telephone); 1: Interview (format NR);	"Well I think we do a lot just by talking to people ...so, I mean, we see a lot of people, just to support them really ... to talk about things. Well I think it's our bread and butter of our job actually" (Johnston 2007)	Minor concerns regarding methodological limitations (according to CASP appraisal 3 studies considered low quality, 6 studies considered moderate quality, and 2 studies considered high quality)	No or very minor concerns about coherence	Minor concerns about adequacy (11 studies supported the review finding, although the number of participants in each study was relatively small, the studies offered moderately rich data)	No or very minor concerns about relevance	HIGH
2.2 Importance of building relationships								
GPs emphasised the therapeutic relationship as integral to facilitating shared decision-making, and	10: Anthony 2010; Chew-Graham 2002; Iglesias-Gonzalez	5: Interview (face-to-face); 3: Focus group; 1: Interview (telephone); 1: Focus group or interview (telephone)	"After so many years, often this trust and knowledge of the person [develops], us with them and them with us. I think that with trust we can achieve specific	Moderate concerns regarding methodological limitations (according to CASP appraisal 4 studies	No or very minor concerns about coherence	Minor concerns about adequacy (10 studies supported the review finding,	No or very minor concerns about relevance	HIGH

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
fostering belief in the treatment and potential for improvement.	2021; Johnson 2017; Johnston 2007; Jones 2013; Mercier 2011; Parker 2020a; Pollock 2003; Wittink 2011		things." (Iglesias-Gonzalez 2021)	considered low quality, 4 moderate quality, and 2 high quality)		although the number of participants in each study was relatively small, the studies offered moderately rich data)		
2.3 Importance of being flexible and available to keep patients engaged								
Being flexible and available were identified by GPs as vital to keeping patients engaged in the treatment process.	2: Patel 2014; Pollock 2003	1: Interview (face-to-face); 1: Interview (format NR)	"What you have to do is make it clear to people that they have done the right thing about coming in, you are interested and you are going to try and sort it out, because then if necessary you can get them to come back. But what you mustn't do is . . . shut the door in their face and then they don't come back . . . The main thing is to make it clear on the first consultation that you	Moderate concerns regarding methodological limitations (according to CASP appraisal 1 study considered low quality, and 1 moderate quality)	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Serious concerns about adequacy (only 2 studies with relatively small sample sizes supported the review finding, although the studies offered moderately rich data)	Minor concerns about relevance (limited demographic information available, with no details about ethnicity, in the 2 included studies)	LOW

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
			are interested and you can, to be honest, you can actually, when you are used to dealing with people you can actually achieve an awful lot in sort of ten to fifteen minutes." (Pollock 2003)					

Abbreviations: CASP: critical appraisal skills programme; NR: not reported
1 Methodological limitations refer to the extent to which there were problems in the design or conduct of the studies that contributed evidence to the findings of the review.
2 Coherence of findings is assessed by looking at the extent to which the review findings are well grounded in data from the contributing primary studies
3 Adequacy is assessed by looking at the degree of richness and quantity of data supporting the findings of the review
4 Relevance refers to the extent to which the body of data from the primary studies supporting a review finding is applicable to the context specified in the review question

Table 13: Evidence profile for Theme 3. GP as generalist versus specialist

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
3.1 Feel best-placed to manage depression								
Some GPs regarded themselves as better placed to manage depression than secondary care, because of the relationships formed with	3: Chew-Graham 2002; Dumesnil 2018; Railton 2000	3: Interview (face-to-face)	"… I really don't think there's anything a psychiatrist can offer these people, apart from the placebo effect of seeing a specialist. But in all truth, any patients of mine who've seen psychiatrists for depressive illness, by	Minor concerns regarding methodological limitations (according to CASP appraisal 1 study considered low quality and 2 studies	Minor concerns about coherence (some concerns about the fit between the data from primary	Moderate concerns about adequacy (only 3 studies with relatively small sample sizes supported	No or very minor concerns about relevance	MODERATE

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
patients, and experience compensated for the lack of specialist training.			and large they'll say, it's no better than coming here, sort of thing, or, they didn't like him, you know" (Railton 2000)	considered moderate quality)	studies and the review finding)	the review finding, and the studies offered thin data)		
3.2 Feel personally responsible and go above and beyond								
GPs felt personally responsible for patients and this compelled them to invest extra time and effort in order to provide the best care.	5: Burroughs 2006; Johnson 2017; Jones 2013; Parker 2020a; Wilhemsen 2014	3: Interview (face-to-face); 1: Focus group; 1: Focus group or interview (telephone)	"I think if you're the GP that they've come to see and you can see there's a situation and you're worried about it you just keep them coming back to see you until you can see that they're out of the woods… And if you're worried you put on a little reminder to check that they've been back." (Parker 2020a)	Minor concerns regarding methodological limitations (according to CASP appraisal 1 study considered low quality, 2 moderate quality, and 2 high quality)	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Moderate concerns about adequacy (only 5 studies with relatively small sample sizes supported the review finding, although the studies offered moderately rich data)	Minor concerns about relevance (high percentage of female participants relative to general gender distribution amongst GPs)	MODERATE
3.3 Perception of their role as physical, not mental, health								
Conversely, some GPs were not comfortable with managing depression. They were frustrated with	3: Anthony 2010; Dickinson 2010; Dumesnil 2018	2: Interview (face-to-face); 1: Interview (format NR)	"Personally, I don't like treating it that much. I would be happy if I never saw another patient who wants an antidepressant for the rest of their life. How do you measure it?	Serious concerns regarding methodological limitations (according to CASP appraisal	Minor concerns about coherence (some concerns about the fit	Moderate concerns about adequacy (only 3 studies with relatively	Minor concerns about relevance (only 1 UK study, and high	LOW

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
the subjective measure of response, and rejected the concept that mental and physical illnesses should be treated analogously.			They're not going to live longer if I give them Prozac. Whereas, if I lower their blood pressure I know they will live longer. I have no good way to measure outcome or measure response" (Anthony 2010)	2 studies considered low quality, and 1 moderate quality)	between the data from primary studies and the review finding)	small sample sizes supported the review finding, although the studies offered moderately rich data)	percentage of female participants relative to general gender distribution amongst GPs)	
3.4 Mental health knowledge too limited to treat depression								
Some GPs perceived their mental health training, knowledge and skills as inadequate to manage depression.	7: Anthony 2010; Burroughs 2006; Dumesnil 2018; Iglesias-Gonzalez 2021; Johnson 2017; Jones 2013; Pollock 2003	5: Interview (face-to-face); 1: Focus group; 1: Focus group or interview (telephone)	"I am by no means a mental health professional. I may identify the problem, which does not mean that I know how to fix the problem." (Anthony 2010)	Minor concerns regarding methodological limitations (according to CASP appraisal 3 studies considered low quality, 2 considered moderate quality, and 2 studies considered high quality)	No or very minor concerns about coherence	Moderate concerns regarding adequacy (7 studies supported the review finding, but the number of participants in the studies was relatively low and studies offered thin data)	No or very minor concerns about relevance	HIGH
3.5 Need to refer on for more complex cases								
Circumstances in which GPs would refer	7: Anthony 2010; Burroughs	5: Interview (face-to-face); 1:	"I am willing to try a number of antidepressants...Beyond	Minor concerns regarding methodological	No or very minor concerns	Minor concerns about	No or very minor concerns	HIGH

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
patients on to secondary care included when depression was complex or severe, patients had failed to respond to antidepressants, or in an older age group due to concerns about polypharmacy and side effects.	2006; Dumesnil 2018; Johnson 2017; Johnston 2007; Jones 2013; Keeley 2014	Interview (telephone); 1: Focus group or interview (telephone)	that, you need to see somebody else - a psychiatrist or therapist." (Anthony 2010)	limitations (according to CASP appraisal 2 studies considered low quality, 3 considered moderate quality, and 2 studies considered high quality)	about coherence	adequacy (7 studies supported the review finding, although the number of participants in each study was relatively small, the studies offered moderately rich data)	about relevance	
3.6 Value of multidisciplinary collaboration								
GPs valued the opportunity for good communication and collaboration with mental health specialists.	6: Anthony 2010; Dumesnil 2018; Iglesias-Gonzalez 2021; Jones 2013; Keeley 2014; Railton 2000	3: Interview (face-to-face); 1: Interview (telephone); 1: Focus group; 1: Focus group or interview (telephone)	"There is perhaps not enough dialogue between general practitioners and private-practice psychiatrists. Nonetheless, I would really like for us to succeed in talking more often and better. I think it would be good, it could only be useful for everyone" (Dumesnil 2018)	Moderate concerns regarding methodological limitations (according to CASP appraisal 3 studies considered low quality and 3 studies considered moderate quality)	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Moderate concerns regarding adequacy (6 studies with relatively small sample sizes supported the review finding and the studies offered thin data)	Minor concerns about relevance (only 1 UK study)	MODERATE

Abbreviations: CASP: critical appraisal skills programme; NR: not reported
1 Methodological limitations refer to the extent to which there were problems in the design or conduct of the studies that contributed evidence to the findings of the review.
2 Coherence of findings is assessed by looking at the extent to which the review findings are well grounded in data from the contributing primary studies
3 Adequacy is assessed by looking at the degree of richness and quantity of data supporting the findings of the review

4 Relevance refers to the extent to which the body of data from the primary studies supporting a review finding is applicable to the context specified in the review question

Table 14: Evidence profile for Theme 4. Perceptions of psychiatric/psychological treatment options

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
4.1 Stigma associated with being referred for psychiatric/psychological treatment								
Primary care clinicians believed fear of stigma may deter some patients with depression, particularly men, from seeking specialist help.	2: Anthony 2010; Keeley 2014	1: Interview (face-to-face); 1: Interview (telephone)	"Many males will find it easier to take a pill than to go to counseling…" (Keeley 2014)	Moderate concerns regarding methodological limitations (according to CASP appraisal 1 study considered low quality, and 1 study considered moderate quality)	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Serious concerns regarding adequacy (only 2 studies with relatively small sample sizes supported the review finding and the studies offered thin data)	Moderate concerns about relevance (both studies based in the US and demographic details only reported for 1 of the studies)	LOW
4.2 Antipathy of patients towards talking therapies								
Primary care clinicians perceived some patients to be averse to psychotherapies, either because of an antipathy towards non-pharmacological treatments	5: Burroughs 2006; Dickinson 2010; Johnson 2017; Jones 2013; Mercier 2011	2: Interview (face-to-face); 1: Interview (format NR); 1: Focus group; 1: Focus group or interview (telephone)	"The majority of [patients] have lived through the Second World War and they have an antipathy to counselling" (Dickinson 2010)	Minor concerns regarding methodological limitations (according to CASP appraisal 2 studies considered low quality, and 3 high quality)	Minor concerns about coherence (some concerns about the fit between the data from primary studies and	Moderate concerns about adequacy (only 5 studies with relatively small sample sizes supported the review	No or very minor concerns about relevance	MODERATE

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
(described in older patients) or for practical reasons due to work and family commitments.					the review finding)	finding and the studies offered thin data)		
4.3 Need to consider if patient is currently able to engage with psychotherapy								
GPs highlighted the need to consider if a patient has sufficient motivation and insight to engage with psychological interventions.	2: Dumesnil 2018; Wilhemsen 2014	2: Interview (face-to-face)	"[The patients] must be capable of reflection, of analysis (…), have some minimum level of education (…). It's not accessible to everyone." (Dumesnil 2018)	Minor concerns regarding methodological limitations (according to CASP appraisal both studies considered moderate quality)	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Moderate concerns about adequacy (only 2 studies with relatively small sample sizes supported the review finding, and the studies offered thin data)	No or very minor concerns about relevance	MODERATE
4.4 Need for talking therapies to enable full recovery								
Some GPs perceived talking therapies as necessary in order to achieve full recovery.	5: Burroughs 2006; Chew-Graham 2002; Dumesnil 2018; Johnson	4: Interview (face-to-face); 1: Focus group	"It's no point stuffing people full of antidepressants, when they are still left with the problem…sometimes it helps to have a counsellor who puts, kind of, strategies out	No or very minor concerns regarding methodological limitations	No or very minor concerns about coherence	Minor concerns about adequacy (5 studies supported the review finding, although the	No or very minor concerns about relevance	HIGH

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
	2017; Mercier 2011		and enables them to move on." (Chew-Graham 2002)			number of participants included in each study was relatively small, the studies offered moderately rich data)		

Abbreviations: CASP: critical appraisal skills programme; NR: not reported
1 Methodological limitations refer to the extent to which there were problems in the design or conduct of the studies that contributed evidence to the findings of the review.
2 Coherence of findings is assessed by looking at the extent to which the review findings are well grounded in data from the contributing primary studies
3 Adequacy is assessed by looking at the degree of richness and quantity of data supporting the findings of the review
4 Relevance refers to the extent to which the body of data from the primary studies supporting a review finding is applicable to the context specified in the review question

Table 15: Evidence profile for Theme 5. Treatment offer constrained by limited time and resources

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
5.1 Length of GP consultation does not allow for meaningful treatment discussion								
GPs saw the time and workload constraints in primary care as a barrier to exploring depression and discussing non-	11: Anthony 2010; Burroughs 2006; Chew-Graham 2002; Iglesias-	7: Interview (face-to-face); 3: Focus group; 1: Interview (telephone)	"I have time to write for medicine. I don't have time to give counseling." (Anthony 2010)	Minor concerns regarding methodological limitations (according to CASP appraisal 4 studies considered low quality, 5	No or very minor concerns about coherence	Minor concerns regarding adequacy (11 studies supported the review finding, although the	No or very minor concerns about relevance	HIGH

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
pharmacological treatment options.	Gonzalez 2021; Johnson 2017; Johnston 2007; Keeley 2014; Kirkpatrick 2020; Parker 2020a; Pollock 2003; Railton 2000			considered moderate quality, and 2 considered high quality)		number of participants in each study was relatively small, the studies offered moderately rich data)		
5.2 Referral to psychiatric/psychological services not universally available								
Treatment options that could be offered to patients with depression were limited by inadequate access to mental health specialists, specifically geographical variability, inflexible thresholds for accepting patients into	7: Anthony 2010; Burroughs 2006; Jones 2013; Mercier 2011; Pollock 2003; Rogers 2001; Wilhemsen 2014	4: Interview (face-to-face); 1: Interview (format NR); 1: Focus group; 1: Focus group or interview (telephone)	"I think to some extent we probably use more medication than we would do in an ideal world. If we had free access to rapid psychological services we would probably use them (i.e. the services) more." (Pollock 2003)	Moderate concerns regarding methodological limitations (according to CASP appraisal 4 studies considered low quality, 1 study moderate quality, and 2 high quality)	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Moderate concerns about adequacy (7 studies with relatively small sample sizes supported the review finding and the studies offered thin data)	No or very minor concerns about relevance	MODERATE

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
services, and insufficient staffing.								
5.3 Psychological therapies only available as short-term treatments								
GPs raised the time-limited nature of the psychotherapies that they could offer, and questioned whether a relatively small number of sessions over a short timescale would be sufficient for all patients with depression.	2: Johnston 2007; Mercier 2011	1: Interview (face-to-face); 1: Focus group	"Our remit here [counselling for depression] inhouse is short-term treatment. So in the main, we're looking at things, er, at depression or other emotional problems which probably have an identifiable cause that can be treated in a relatively short time span, or addressed, or that you can address in a relatively short time span." (Johnston 2007)	No or very minor concerns regarding methodological limitations	Minor concerns about coherence (some concerns about the fit between the data from primary studies and the review finding)	Serious concerns about adequacy (only 2 studies with relatively small sample sizes supported the review finding, and the studies offered thin data)	No or very minor concerns about relevance	MODERATE
5.4 Waiting lists constrain choice								
GPs expressed frustration at the long waiting times for psychological therapies, and sometimes prescribed antidepressants to mitigate the	8: Anthony 2010; Chew-Graham 2002; Dickinson 2010; Dumesnil 2018; Iglesias-	4: Interview (face-to-face); 2: Interview (format NR); 2: Focus group	"Counselling has got quite a long waiting list, with people with low mood and depression and anxiety they've probably spent a few months contemplating coming, they've got up the courage to	Moderate concerns regarding methodological limitations (according to CASP appraisal 4 studies considered low quality, and 4	No or very minor concerns about coherence	Minor concerns about adequacy (8 studies supported the review finding, although the number of	No or very minor concerns about relevance	HIGH

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
risk of worsening symptoms, loss of faith or discontinuation from treatment all together.	Gonzalez 2021; Parker 2020a; Pollock 2003; Rogers 2001		come, and then saying “oh yeah you can see a counsellor in three months” isn’t what they were hoping for, which can then lead to their mood going even further down…” (Parker 2020a)	studies considered moderate quality)		participants included in each study was relatively small, the studies offered moderately rich data)		

Abbreviations: CASP: critical appraisal skills programme; NR: not reported
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Table 16: Evidence profile for Theme 6. Importance of, and barriers to, an individualised treatment offer

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
6.1 Need to shift perspective to the individual patient								
GPs stressed the greater complexity, and need for individualised treatment, associated with managing depression	6: Chew-Graham 2018; Dickinson 2010; Johnson 2017; Johnston 2007;	3: Interview (face-to-face); 1: Interview (telephone); 1: Interview (telephone/face-to-face); 1: Interview (format NR)	"In emotional medicine you are much more predisposed to the individual patient. In cardiology where essentially every patient comes into the sausage factory and	Moderate concerns regarding methodological limitations (according to CASP appraisal 3 studies considered low	Minor concerns about coherence (some concerns about the fit between the data from	Minor concerns regarding adequacy (6 studies supported the review finding, although the	No or very minor concerns about relevance	MODERATE

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
relative to physical illnesses.	Railton 2000; Wittink 2011		gets an aspirin and a beta blocker and an ACE inhibitor and they all come out at the other end, you can't do that with the emotional illness." (Dickinson 2010)	quality, 1 considered moderate quality, and 2 considered high quality)	primary studies and the review finding)	number of participants in each study was relatively small, the studies offered moderately rich data)		
6.2 Discussion of treatment options should be sensitive to stigma								
Strategies that primary care clinicians advocated in order to address the stigma that patients may associate with antidepressants, included focusing on physical symptoms and comparing to other health conditions, framing recommendation as if talking to a friend or family member, and dispelling	3: Burroughs 2006; Kirkpatrick 2020; Patel 2014	1: Interview (face-to-face); 1: Interview (format NR); 1: Focus group	"I'll use the comparison that …when you have diabetes, your pancreas isn't working well. There are certain chemicals that are not working well in your body. Depression can also be a chemical imbalance…That's why an antidepressant can help you." (Kirkpatrick 2020)	Minor concerns regarding methodological limitations (according to CASP appraisal 1 study considered low quality, 1 study moderate quality, and 1 high quality)	No or very minor concerns about coherence	Serious concerns about adequacy (only 3 studies with relatively small sample sizes supported the review finding, although the studies offered moderately rich data)	Moderate concerns about relevance (2 US-based studies, and high percentage of female participants relative to general gender distribution amongst GPs)	MODERATE

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
misconceptions and fears.								
6.3 Need to elicit and incorporate preference so patient is invested in treatment decision								
GPs emphasised the importance of empowering patients to become active participants in treatment decisions, but were not always sure how to do this.	2: Johnson 2017; Patel 2014	1: Interview (face-to-face); 1: Interview (format NR)	"You aim to certainly do it [prescribe] in partnership with the patient. At the end of the day, if you don't do it in partnership with them and you prescribed it, then they won't take it anyway, so you do it in partnership with the patient…" (Johnson 2017)	No or very minor concerns regarding methodological limitations	No or very minor concerns about coherence	Serious concerns about adequacy (only 2 studies with relatively small sample sizes supported the review finding, and the studies offered thin data)	Minor concerns about relevance (high percentage of female participants relative to general gender distribution amongst GPs)	MODERATE
6.4 Importance of a multifactorial approach								
GPs characterised optimal treatment for depression as comprehensive, flexible, multifactorial and patient-centred, and championed a broad range of	8: Dumesnil 2018; Johnson 2017; Jones 2013; Keeley 2014; Kirkpatrick 2020; Parker 2020a;	3: Interview (face-to-face); 2: Interview (telephone); 2: Focus group; 1: Focus group or interview (telephone)	"It's the core of our work …): we are constantly obliged to adapt to each of our patients, to deal with their history, their family, their situation. Each patient is unique, each decision we make must also be unique" (Dumesnil 2018)	Moderate concerns regarding methodological limitations (according to CASP appraisal 4 studies considered low quality, 3 studies considered moderate	No or very minor concerns about coherence	Minor concerns about adequacy (8 studies supported the review finding, although the number of participants included in each study	No or very minor concerns about relevance	HIGH

Summary of review finding	Study information		Example of Finding	CERQUAL Quality Assessment				
	Number of studies	Methods		Methodological Limitations[1]	Coherence[2]	Adequacy[3]	Relevance[4]	Overall Confidence
non-medicalised approaches.	Railton 2000; Wittink 2011			quality, and 1 study considered high quality)		was relatively small, the studies offered moderately rich data)		

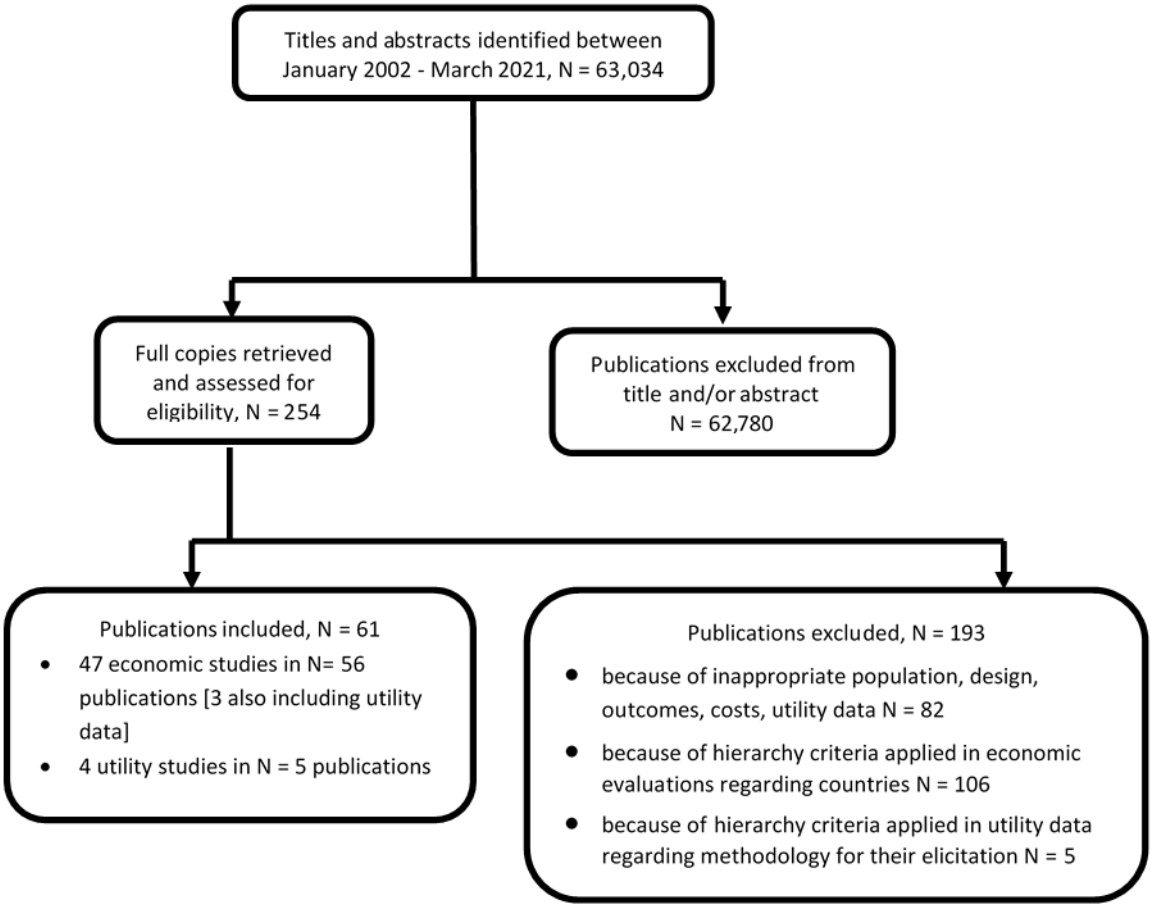
Abbreviations: CASP: critical appraisal skills programme; NR: not reported
1 Methodological limitations refer to the extent to which there were problems in the design or conduct of the studies that contributed evidence to the findings of the review.
2 Coherence of findings is assessed by looking at the extent to which the review findings are well grounded in data from the contributing primary studies
3 Adequacy is assessed by looking at the degree of richness and quantity of data supporting the findings of the review
4 Relevance refers to the extent to which the body of data from the primary studies supporting a review finding is applicable to the context specified in the review question

Appendix G – Economic evidence study selection

Economic evidence study selection for review question: What are the facilitators and barriers that can enhance or inhibit choice of treatment for adults with depression?

A global health economics search was undertaken for all areas covered in the guideline. Figure 2 shows the flow diagram of the selection process for economic evaluations of interventions and strategies for adults with depression and studies reporting depression-related health state utility data.

Figure 4. Flow diagram of selection process for economic evaluations of interventions and strategies for adults with depression and studies reporting depression-related health state utility data.



Appendix H – Economic evidence tables

Economic evidence tables for review question: What are the facilitators and barriers that can enhance or inhibit choice of treatment for adults with depression?

No economic evidence was identified which was applicable to this review question.

Appendix I – Economic evidence profiles

Economic evidence profiles for review question: What are the facilitators and barriers that can enhance or inhibit choice of treatment for adults with depression?

No economic evidence was identified which was applicable to this review question.

Appendix J – Economic analysis

Economic evidence analysis for review question: What are the facilitators and barriers that can enhance or inhibit choice of treatment for adults with depression?

No economic analysis was conducted for this review question.

Appendix K – Excluded studies

Excluded studies for review question: What are the facilitators and barriers that can enhance or inhibit choice of treatment for adults with depression?

Clinical studies

Please refer to the excluded studies in supplement I – Clinical evidence tables for Evidence Review I Patient choice

Economic studies

Please refer to supplement 3 - Economic evidence included & excluded studies.

Appendix L – Research recommendations

Research recommendations for review question: What are the facilitators and barriers that can enhance or inhibit choice of treatment for adults with depression?

No research recommendations were made for this review question.