

Increasing equity of access to high-quality mental health services in primary care: a mixed-methods study

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Scientific summary

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Scientific summary

Background

Mental health problems impose substantial emotional, social and economic burdens on those who experience them, their families and carers and society as a whole. A range of interventions and initiatives has been shown to be effective in clinical trials in improving outcomes for people experiencing common but disabling mental health problems such as depression and anxiety. However, many people with high levels of mental distress are disadvantaged, either because care is not available to them in the right place and at the right time or because when they do access care their interaction with caregivers deters help-seeking or diverts it into forms that do not address their needs.

Developing interventions to improve access to mental health care is a policy priority in the UK. Current policy initiatives, such as the general practitioner (GP) Quality and Outcomes Framework and Improving Access to Psychological Therapies, tend to focus on supply-side factors. There is less consideration of demand issues and factors governing the journey of the patient in need. Quality improvement activities need to be based on rigorous theories and models that describe core concepts of relevance and which outline the mechanisms and relationships that underlie service delivery problems.

Aim and objectives

The aim of the Improving Access to Mental Health in Primary Care (AMP) programme was to increase equity of access to high-quality primary care mental health services for underserved groups.

We had six principal objectives:

1. to clarify the mental health needs of people from underserved groups who have been shown to receive inadequate primary care mental health services
2. to identify evidence-based primary care services that such people consider relevant to their needs
3. to identify barriers to, and facilitators of, access by such people to high-quality primary care mental health services
4. to develop and test a portfolio of interventions that are credible and acceptable for particular underserved groups
5. to establish effective strategies for dissemination of evidence about interventions for members of underserved groups with mental health problems that have demonstrable efficacy and acceptability
6. to begin to integrate into primary care effective and acceptable interventions for people with mental health problems from underserved groups.

We divided the AMP programme into three overlapping phases:

- understanding the problems and generating potential solutions
- testing potential solutions
- putting what works into practice.

Understanding problems and generating solutions

We examined and synthesised multiple sources of evidence about inequities in access to high-quality mental health services:

- A conceptual scoping review identified six key concepts: recursivity, candidacy, identity and morality, graduated access, adjudication and cultural competence.
- A structured scoping review of 105 published quantitative papers indicated that underserved patients could benefit from existing or modified interventions in terms of improved access. Initial evidence was most promising for the elderly and ethnic minorities.
- A meta-synthesis of 21 published qualitative papers concluded that engagement in mental health treatment requires significant personal investment and poses a threat to wider social identities.
- Dialogues with 53 stakeholders identified the need for change at both the systemic level and the service level.
- A review of 118 items of grey literature concluded that interventions should work to normalise mental health and to recalibrate the boundaries between mental health, physical health and social life.
- Secondary analysis of 92 transcripts from seven qualitative data sets found multiplied stigma and lack of effective information as the main barriers to, and developing acceptable services as the main facilitator of, improving equity of access.
- Interviews with 36 service users and carers emphasised the importance of continuity of care and the need to educate people about how to deal with their emotions.

Our synthesis of these seven sources of evidence produced key findings on ways in which (mental) health problems are formulated by people from underserved groups, including concepts of embodied suffering and double stigma; risks attached to engaging with mental health interventions offered through primary care; limitations in access to existing psychosocial interventions; and better understanding of the dimensions of access.

Our procedures for generating the candidate interventions involved a series of interactions between the research team and local stakeholders, actual and potential service user groups and national and international academic experts in the field of primary care mental health.

Testing potential solutions

We proposed the AMP Development Partnership as a new multifaceted model designed to improve access to primary care mental health services for people from underserved communities. Its three core components are community engagement, primary care quality and tailored psychosocial interventions.



The AMP Development Partnership.

We implemented the intervention in four disadvantaged localities. We focused on minority ethnic groups in Longsight (Manchester) and Picton (Liverpool) and on older people in Wythenshawe (Manchester) and Croxteth (Liverpool) in the UK.

We undertook a complex, multilevel evaluation to test the assumption that intervening at three levels would be mutually reinforcing. The evaluation was implemented following a quasi-experimental design by allocating a no-intervention comparator for each element of the AMP model and to test different degrees of intensity of the faceted intervention. We gathered quantitative information, including routine and project-specific data, and qualitative information through interviews, focus groups with key actors, ethnographies and case comparisons. We used mixed quantitative and qualitative methods to evaluate process and outcome. Qualitative evaluation findings were subjected to a framework analysis.

Community engagement

Our community engagement model had four steps:

1. information gathering involved entry into the field, key informant interviews and mapping and collation of existing resources
2. community champions (CCs) were the interface between the AMP team and the needs of the local community
3. consultative focus groups (CFGs) were forums to negotiate the aims and agenda of the intervention with local people, agencies and wider stakeholders
4. the community working group (CWG) was to implement the action plan formulated by the CFGs.

Information gathering was undertaken in all four localities. It enabled us to create initial models of mental health understandings within the community, develop key engagement messages, create databases of contacts, projects and resources and identify local community nodes and key actors.

Community champions were appointed and CFGs set up in the two intervention localities, Croxteth and Longsight. Each CFG met four times. In Longsight the CC worked with a CWG to implement actions agreed by the CFG, which included collaborative production of calendars, Facebook and Twitter pages and a relaxation compact disc, all focused on the mental health needs of South Asian people. In Croxteth the main activities were disseminating information about locally available services for older people and strategic involvement with city-wide mental health policy.

We found evidence of engagement in both localities from third-sector organisations. Primary care practitioners engaged more in Longsight, whereas health commissioners were more involved in Croxteth. Our evaluation indicated that the AMP model provided opportunities for stakeholders to share experiences, rebuild links between third-sector organisations in a context of instability and uncertainty and develop links between these organisations and primary care. Our phased approach gradually built trust with local people and organisations. Establishing a focused agenda achievable within a limited time frame was seen as valuable by stakeholders. The specific remit of the research team enabled local communities to raise the agenda of mental health and well-being among many other priorities in areas of multiple deprivation.

Primary care

We developed an interactive training package, AMP training*plus*, with three interlinked strands:

- knowledge transfer included a training component of up to six sessions, initially chosen from a menu of subject options
- systems review: intensive observation centred on reception and appointment systems to identify organisational and structural features that may impede or promote access by underserved groups
- active linking: raising awareness of other relevant organisations and resources that had been mapped and logged by the AMP team.

Our intended outcomes were to increase staff awareness of, recognition of and respect for diversity; change the consultation or encounter style, content and outcomes; and change practice processes and systems.

We identified four practices in each intervention locality ($n = 16$) and randomly allocated two per locality ($n = 8$) to be offered AMP training*plus*. Following an intricate process of engagement, seven practices agreed to participate.

We undertook 200 hours of ethnographic observation, mainly in reception areas. We found the roles of receptionists to be complex. They played a major role in negotiating access, the difficulties of which were compounded or facilitated by organisational structures and the actions of other primary care team members.

The training element began with a standard session and then developed according to the needs of particular practices. Topics covered included cultural understandings of mental health and health care, legal problems for asylum seekers and linking with local resources.

Engagement varied between practices, with the number of training sessions ranging from one to seven. Engagement was facilitated by the reputation of the research team, previous contact and the presence of a practice champion. The work involved for the practice needed to be seen as coproduction rather than the practice 'being researched', and the practice needed to accept the basic premises of the AMP programme.

We collected routine data on mental health referrals in intervention and control practices and found some evidence that the offer of AMP training*plus* was associated with an increased number of referrals to voluntary agencies.

Psychosocial intervention

We synthesised data from previous work streams and focus group findings to design a well-being intervention based on cognitive-behavioural principles, with an emphasis on social participation. Well-being facilitators were trained to deliver a patient-centred assessment leading to a choice of individual (up to eight sessions), group (8–10 sessions) or signposting pathways. Delivery mode and site depended on patient preference.

We conducted an exploratory randomised trial of the effectiveness and acceptability of the intervention in underserved patients with symptoms of depression and anxiety, compared with treatment as usual. We focused on older adults in Croxteth and Wythenshawe, South Asian people in Longsight and Somalis in Picton.

Recruitment was through GPs (practices identified in the AMP training*plus* part of the programme), other health professionals, the voluntary sector or self-referral. We aimed to recruit 100 patients and randomise in a ratio of 2 : 1 (intervention to control). Outcomes measured were depression [Patient Health Questionnaire (PHQ)-9], anxiety [Generalised Anxiety Disorder 7-item (GAD-7) scale], functioning [Work and Social Adjustment Scale (WSAS)], quality of life [European Quality of life-5 dimensions (EQ-5D)] and well-being [*Clinical Outcomes in Routine Evaluation* (CORE-OM)].

We recruited 57 patients (57% of target), mainly through GPs. Recruitment was highest in Wythenshawe ($n = 24$) and lowest in Picton ($n = 1$). Recruitment was helped by the presence of waiting lists for primary care mental health services, good relationships with primary care teams, extensive advertising, short waiting times for the AMP intervention and the ability to see patients in their own homes. It was hindered by limiting access to AMP-related practices, erratic information flow, lack of confidence in referral ability amongst voluntary organisations, and perceived stigma and cultural incongruence.

The intervention was taken up by 34 out of 37 (92%) patients, mainly for individual sessions (mean number of sessions attended 6.3). We found high levels of unmet need in terms of mental and physical multi-morbidity and severity of mood symptoms. Patients were generally positive about the content of the therapy and noted the importance of cultural congruence and having a rapport with therapists.

The results of the feasibility trial suggest that the group receiving the well-being intervention improved compared with the group receiving usual care. For elders, the largest effects were found for the CORE-OM and PHQ-9 outcomes. For black and minority ethnic patients the largest effect was found for PHQ-9.

Integrating the AMP model

Referrals to the AMP psychosocial intervention were more likely in localities offered the community engagement intervention. However, recruitment was associated with the offer of AMP training*plus*. Although awareness of the psychosocial intervention was enhanced by community engagement, authority to refer was commonly seen to reside with the GP.

The quality of mental health care for underserved groups within primary care was enhanced by the information-gathering element of our community engagement strategy (enabling more active linkages with community-based resources) and by the offer of access to the AMP psychosocial intervention.

Putting what works into practice

Implementation strategies

We have initiated educational, policy and service developments on the basis of our evaluation of the AMP Development Partnership:

- *Educational.* We have created a dedicated website (see www.amproject.org.uk; accessed 10 June 2013) to provide a resource pack on how to implement the AMP model. This is aimed at primary care mental health staff, researchers and policy-makers.
- *Policy.* At a local level we worked with one primary care trust to implement a strategic change in its model of primary mental health care. Nationally, our early findings directly influenced the content of a National Institute for Health and Care Excellence clinical guideline on pathways to care for common mental disorders.
- *Service.* We have embedded aspects of the AMP interventions in several intervention localities. New service developments for a different minority ethnic community in another locality have been informed by the AMP model.

Recommendations for research

- Innovative and complex interventions aimed at service redesign need an innovative and complex combination of methods to enable robust assessment and evaluation.
- The AMP Development Partnership needs to be tested in other settings and with other underserved groups before the extent of its generalisability can be established. It is important to be mindful of its contextual nature and the tension between core research aims and the flexibility to meet the needs of local stakeholders.
- Scaled-up studies of our community engagement intervention would allow testing of the separate and combined benefits of all of its four steps.
- Scaled-up interventions based on AMP training*plus* would allow for testing of the synergies between its components and provide sufficient routine data to allow more rigorous hypothesis testing.
- Evidence from our pilot study of well-being interventions should inform new substantive trial designs. Further qualitative research is needed into cultural variations in help-seeking.

Implications for policy and practice

Mental health expertise exists in communities but needs to be nurtured. At a time of uncertainty and change, focused community interventions provide opportunities for local organisations to build and rebuild contacts and develop knowledge, relationships and trust.

Primary care is necessary but not sufficient. GPs retain a position of authority within underserved communities but are not always the fulcrum of activity regarding common mental health problems. Primary care is one of a number of points of access to high-quality mental health care.

Psychosocial interventions can and should be adapted to meet the needs of underserved groups. We have demonstrated that it is possible to create acceptable, effective and culturally appropriate versions of validated psychosocial interventions.

It is possible to intervene simultaneously at three different levels: community engagement, primary care quality and tailored psychosocial interventions. A multilevel intervention can be greater than the sum of its parts and can serve to increase equity of access to high-quality mental health services through primary care.

Study registration

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