Title: **Patient referral from primary care to psychological therapy services: a cohort study.**

Running title: Primary care patient referral into IAPT

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Key messages

- The referral process for anxiety/depression patients has changed over time
- Circa 50% of patients asked to self-refer by a GP do indeed follow this advice
- Type of referral and patient demographics do not influence IAPT attendance
- Some patients may lose out on appropriate treatment due to this 'gap' in care

Abstract

Background

Improving Access to Psychological Therapy (IAPT) services in England offer psychological therapy for patients with mental health issues such as depression and anxiety disorders.

Objective

How are primary care patients referred to IAPT, to what degree does this correlate with subsequent attendance, and how is the referral process perceived by patients?

Methods

Retrospective analysis of medical records covering June 2018 – June 2019 in seven general practices servicing 96,000 patients, to identify and survey patients with anxiety and/or depression.

Results

Records of 6545 patients were appraised; 2612 patients were deemed suitable for IAPT intervention by the GP. Of those, 1424 (55%) attended at least one IAPT appointment whereas 1188 (45%) did not. These 'attender' and 'non-attender' cohorts did not differ in age, gender or level of deprivation; neither did GP advice to self-refer rather than making a direct GP referral influence the attendance rate. The most common reasons for IAPT non-attendance include symptom improvement (22%), lack of belief in psychotherapy effectiveness (16%) or a patient feeling too unwell to either refer themselves or attend (12%).

Conclusion

Neither certain age or gender, nor the mode of patient referral to IAPT are associated with eventual attendance. Future research is indicated to identify in more detail if any specific mental health conditions are more likely to lead to non-attendance. Furthermore, there may be scope for a

targeted approach for sub-groups of patients, e.g. those who indicate they are feeling mentally too unwell, to enable them to attend IAPT screening and therapy appointments.

Key Words: anxiety, depression, general practice, Improving Access to Psychological Therapy, IAPT, psychology.

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Background

Improving Access to Psychological Therapy (IAPT) services were introduced in England over 10 years ago. On average, recovery rates for people who attend IAPT services are around 50% and 500,000 people are treated each year.[1,2] Furthermore, approximately 70% of patients experience some benefit from IAPT treatment.[2,3] However, there is still scope for improvement in terms of optimising patient access to psychological intervention. In one publication, patient access to IAPT was indeed improved when two GP practices conducted an audit and re-audit concerning adherence to national guidelines around referral rates.[4] They found that highlighting recommendations in staff meetings, such as relevant patients with mild to moderate depression should be offered psychological therapy, led to improved referral rates.[4] Conversely, another study highlighted clinical practice that impeded optimal patient referral; it found that there is a reluctance amongst GPs to refer older patients to IAPT, because in their eyes it would be distressing and onerous for said patient population.[5] In view of the generally positive outcomes associated with IAPT attendance and a proven link with a subsequent reduction in emergency department attendances, sickness absence and improvements seen in adherence to drug treatment[6], it is important that patients are given the option to use the service.

IAPT is one of the few NHS mental health services to which patients can refer themselves. There is a paucity of data that will allow conclusions to be drawn whether or not GP-initiated self-referral is an acceptable method. Only recently has this subject been broached in a small scale qualitative study, which showed there is a potential discourse between GPs and (low income) patients.[7] The primary objective of this study is therefore to assess by what method patients enter IAPT services, focusing on the scale of self-referral rates ('pure' self-referral and GP-recommended self-referral) and its correlation with actual IAPT attendance.

Methods

- Study design

This concerns a cohort study where the relevant patient population was identified through a retrospective search of general practice medical notes and the resulting cohort was approached for a prospective survey study. Approvals were obtained from the relevant bodies before the project commenced, namely the Health Research Authority (reference 250583), North East – York Research Ethics Committee (18/NE/0261), North Cumbria Clinical Commissioning Group and North Cumbria Integrated Care NHS Foundation Trust.

- Sample and survey

The sampling period was 1 June 2018 – 31 May 2019 and involved seven general practices in Cumbria, UK, that cover a population of 96,000. Four practices were rural (each practice < 10,000 patients) and three urban (each practice > 10,000 patients). Using sample size determination for surveys, and applying a cohort population of the seven practices, a confidence level of 95%, and a margin of error of 10%, a sample of 96 for the IAPT attender and IAPT non-attender surveys, respectively, was sufficient to make the responses representative of the wider population. The definition of 'IAPT attender' being a patient who had at least an initial telephone assessment with an IAPT practitioner.

Potentially eligible patients were identified on the GP practices' IT system. Inclusion criteria were: a) patients $\geq$ 18 years; b) clinical code for (relevant READ code[8] in brackets) low mood (1BT-1), depressed mood (1BT), anxiety and anxiety & depression (Eu41), depressed mood (1BT), mood swings (1BO), mood disorders (Eu3 w/o Eu30 and Eu31), stress related problem (1B1L and 1B1T), stress at work (13JM-3), stress at home (13HT1) or anxiety states (E200); c) evidence in medical records of patient being recommended IAPT intervention and given information necessary for self-referral, referral to IAPT by the treating GP, patient self-referral to IAPT without consulting with their

GP. Exclusion criteria were: a) mental health disorders not covered by IAPT (bipolar disorder, schizophrenia, dementia, autism and alcohol/drug/substance abuse); b) IAPT attendance in three years preceding the study period; c) patients who explicitly stated their refusal to attend IAPT to their GP; d) patient, who at the time of planned invite, were deemed unsuitable for approach (e.g. incarceration). Actual IAPT attendance could be determined from the medical notes, including presentation to IAPT without seeing a GP first, since the local IAPT service sends a confirmatory letter of contact with the patient which is uploaded to the medical notes by the GP practice. Once the cohort had been defined through retrospective analysis of the GP practices' medical records, this cohort was approached with a survey to gather further information about these patients' experience with primary care and referral to IAPT.

Two different patient surveys were devised – one for those who at least attempted IAPT referral (either true self-referral or GP-mediated referral), and the other for those who didn't (following GP advice to self-refer or referral made by GP) – the latter survey differed only by an additional question concerning a patient's main reason for non-attendance. The survey focused on the referral process rather than the quality of the consultation per se, or any IAPT treatment outcomes. A semi-quantitative approach was taken, using Likert-scale questions. Apart from age, gender and postcode (to determine index of multiple deprivation, IMD, decile), the following questions were asked: How were you referred to the IAPT service?; How would you rate the IAPT referral process you experienced?; Do you agree with the statement: 'My GP (practice) gave me enough support to get further help for my psychological/mental health condition'; Do you agree with the following statement: 'It is easy to find out how to access IAPT services'; 'How would you prefer to have been referred to IAPT if you had the choice?'. The survey was piloted and feedback obtained from a panel of six volunteers associated with the local mental health NHS Trust who had in the past used the IAPT services.

Survey invites were sent between June and August 2019; a study invitation letter and patient information sheet accompanied the survey. It was made clear that completing the survey implied consent to participate in the study and for the anonymous survey data to be used for analysis. Patients were sent the survey by post once and were not sent reminders – cut-off for survey responses was six weeks after the last invite.

- Data analyses

Descriptive statistics were used to describe and compare the initial screened cohort, the patients eligible for survey invite and survey replies. For all screened patients, age, gender and index of multiple deprivation[9] decile were collated. The latter, obtained by means of patient postcode, was optional for responders. Multiple logistic regression was conducted with IAPT attendance as dependent, and the following as independent variables: patient age (reference: 18-24 yrs, see Table 1 for categories), patient gender (male [reference], female) , IAPT referral process rating by patient (poor [reference], fair, average, good, excellent), perspective of sufficient GP support by patient (strongly agree [reference], agree, neither agree nor disagree, disagree, or strongly disagree), perspective of easiness of accessing IAPT by patient (strongly agree [reference], agree, neither agree nor disagree, disagree, or strongly disagree), type of referral (self-refer [reference] or GP referral), and patient's future preference regarding mode of referral (self-refer [reference] or GP referral). Index of multiple deprivation score was excluded from this regression analysis due to the assumption that not all responders disclosing their full postcode (<80% completion rate anticipated). Instead, Mann-Whitney U-test was used to compare IAPT attender vs non-attender patient groups for their IMD decile (1, most deprived, to 10, least deprived). In light of findings by Thomas and colleagues[7], who identified a putative link between GP support and referral to IAPT, Spearman correlation analysis was conducted for the survey outcomes 'IAPT referral process' rating versus 'My GP gave me enough support' rating (see above for applied categories). Freetext replies for the surveys were collated and categorised as part of a quantitative analysis of said qualitative outcomes.

A two-stage approach was taken to identify themes; one author categorised free-text responses (LJ) and the resulting themes were verified after review by and discussion with the second (RT) and third author (SF). All data was first collated in Microsoft Excel before inferential analyses were conducted using SPSS v20.

Results

In total 6545 patient notes were appraised, of which 2612 patients were deemed suitable for IAPT intervention by the treating GP. Of said 2612 eligible patients, 1424 (55%) attended IAPT whereas the other 1188 (45%) did not. Table 1 summarises the demographics for the initial sampling cohort, the IAPT-eligible cohort, and also the subsequent non-attender and attender cohorts of survey responders. Ethnicity was recorded for all patients that were screened; the population was > 95% white British and therefore any association between ethnicity and outcomes was not explored further. The response rates for the two postal surveys were 19% (IAPT attenders; 272 out of 1424) and 11% (IAPT non-attenders; 129 out of 1188), respectively. Figure 1 shows the difference in the proportion of survey respondents who attended or did not attend IAPT categorised by referral type; the distribution of proportions does not differ markedly per mode of referral, with the exception of true-self-referral (i.e. a referral made independent of GP).

The median IMD did not differ between survey responders who did and did not attend IAPT (p-value 0.88, Mann-Whitney U-test). Multiple logistic regression was performed to determine if any variables were associated IAPT non-attendance. Table 2 shows a link between patient rating of the IAPT referral process and ultimate unsuccessful referral to IAPT; a more negative rating is associated with a higher probability of non-attendance. GP support rating was not significantly associated with IAPT attendance in the regression analysis; however, individually, IAPT referral process rating and GP support rating are significantly correlated (Spearman's rho -0.50, p-value <0.001; coefficient negative due to inverse grading of outcomes of the referral process rating variable) with a higher

degree of GP support being linked with a better opinion of IAPT. It also indicates that the type of referral (GP-referral more so than GP-suggested self-referral and true self-referral) is linked to IAPT non-attendance. This result is skewed by the presence of true direct self-referrals in the attender cohort, but not in the non-attender cohort; true self-referrers can by definition only be attenders. As a result it introduces a case of self-selection bias within this study. Despite the lack of evidence that one referral method is superior to the other in terms of eventual IAPT attendance, patients do have a strong stated tendency to prefer a direct GP/ referral if they required IAPT in the future. Table 3 shows the past (i.e. index episode for this study) mode of referral and the patients' future preference. The past mode of referral tends to be the preferred mode of referral for any future referral the patient may need to IAPT (for example, 60% of patients who were true self-referrers would self-refer again without GP input). Furthermore, in the population that was asked to self-refer by GPs, there was still a preference to be referred by a GP in future; this was particularly the case in responders who has ultimately not actually attended IAPT, 72% versus 48% of the attenders.

If a patient did not attend IAPT, they were asked to identify a main reason why they did not attend; 120 out of 129 responded to this question. Twenty-eight patients (22%) answered with 'My symptoms improved' and 21 patients (16%) selected 'I do not see benefit in attending IAPT or talking therapy'. Fifteen patients (13%) selected the answer option 'I am/was too unwell to attend IAPT'. Of those 15 responders who indicated being too unwell, 10 were advised to self-refer by their GP. Further assessment of free-text comments confirmed that the respondents in question felt mentally too unwell, rather than physically infirm. Seven patients (5%) felt that IAPT appointment times/locations were not suitable, and five patients (4%) indicated that they preferred medication for their mental health condition. The remaining answers were 28 responses (22%) of 'other reason' (including patient being unaware that they have been advised to self-refer to IAPT, and use of an alternative counselling service provider) and 'no reason' in 16 cases (12%). As part of the survey, patients were asked to identify possible improvements to the IAPT referral process and were also given the opportunity to record additional free text comments. The themes contained in the

answers to both questions overlapped considerably and therefore a semi-quantitative assessment was made for all responses collectively. Table 4 shows the most common themes and representative quotes by participants; apart from specific feedback, 44 IAPT attenders who completed the survey indicated that there were no improvements required concerning the referral process to IAPT.

Discussion

Nearly fifty percent of patients deemed suitable for IAPT treatment by their GP do not enter the IAPT service and the method of referral does not influence their attendance decision. In the cohort studied, no specific demographic profile was identified to pinpoint those patients vulnerable to IAPT non-attendance, although the more positively the patient perceived the support received by their GP, the more positively they rated the IAPT referral process. Lack of advertisement (i.e. awareness posters and advertisements showing information about IAPT services), information on what IAPT means, and the initial telephone call with IAPT for screening were all reported barriers to eventual IAPT attendance.

Some GPs choose to utilise the IAPT self-referral pathway during consultation by encouraging patients to self-refer rather than referring the patient themselves. Responses from patients in our survey and patients interviewed by Thomas and colleagues seem to indicate that patients favour a GP to initiate the referral process.[7] Nonetheless, our data suggests that GP-initiated referrals do not lead to improved attendance rates at IAPT. Despite a lack of difference in subsequent attendance rates, the practice of GPs suggesting to patients to self-refer does potentially carry a risk for those patients who do not follow their GP's advice to self-refer to IAPT as part of their treatment package, especially if they are not later reviewed in surgery. Further deterioration in the patient's condition may potentially occur if an evidence-based psychological intervention does not take place.[10]

If a patient, directly referred by their GP, does not attend their initial IAPT appointment, their GP will then be informed of this non-attendance by the IAPT service. However, this safety-netting is absent if it concerns a patient who was advised to self-refer by their GP. As with the management of all conditions, it is essential for GPs to adhere to clinical guidelines, such as those issued by NICE[11] in England, to optimise patient care and minimise the risk of complaints, inquests and/or claims.[12] The issues observed here around patient 'non-compliance' with a physician's advice are not unique to psychological therapy. In relation to medication, adherence by patients is not optimal either; for example, approximately 20% of prescriptions are not even filled.[13]

The response rates for the two surveys in our study are comparable to the di Bona study, who achieved 14% with an incentive offered to patients.[14] The population studied here was near 100% white British, and from a single region in England, which hampers the ability to draw conclusions for a wider population. Furthermore, other non-identified factors may differ between study survey responders and non-responders, and IAPT attenders and non-attenders respectively. In our study, the patient's corresponding diagnosis could not recorded and included in analyses. The reason for this is that there was inconsistency in READ coding by GPs in the medical notes; many patients were given a different diagnostic code every time they visited their GP, and only for IAPT attenders was a more definitive diagnosis – made by IAPT staff - available.

A previous cohort study on the theme of IAPT attendance included only patients who were known to the IAPT service, and they did not identify any 'patient profile' associated with improved attendance rate.[14] These results contradict findings from previous studies where e.g. men were found to be less likely to attend.[15,16] In line with recent published research, we uncovered the significance of a positive perceived GP (surgery) support as a predictor of their IAPT referral satisfaction.[7] Furthermore, we discovered symptom improvement was the most commonly reported reason for patients not to go ahead with their IAPT referral. Since this was based on patient self-reporting, it cannot be concluded that this was indeed the case from a clinical perspective; the GP consultation

itself may have been a contributor to the easing of symptoms.[17,18] Some patients reported they would have self-referred if they had been aware of this option. Additionally, some patients would have appreciated more information about exactly what IAPT offers and what the proposed process entails. Both these findings echo previous reports from an evaluation of London IAPT services.[19] The Cumbrian IAPT referral method is very similar to many other IAPT services in England, although some divergence exists; e.g. NE London NHS foundation Trust only accepts self-referrals, not direct GP referrals (Dr E Aguirre, personal correspondence).

Our findings could not identify a specific population of patients who is less likely to attend IAPT. The patient's perceived degree of GP support may influence a patient's preconceptions of IAPT and therefore their level of engagement. Future research could focus on whether the method of referral influences completion and recovery rates within IAPT although published data suggests that there is no difference in recovery rate as a function of referral method.[19] An evaluation of the role of the actual condition that a patient may have in the referral process and eventual IAPT attendance may help to home in on needs for specific patients. Likewise, giving consideration to alternative arrangements for the subset of patients who feel too mentally unwell to take the first step to contacting and engaging with IAPT may further optimise psychological therapy attendance rates.

Ethical Standards The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional guidelines on human experimentation (Health Research Authority, UK) and with the Helsinki Declaration of 1975, as revised in 2008. This research project obtained approval from Health Research Authority (reference 250583), North East – York Research Ethics Committee (18/NE/0261), North Cumbria Clinical Commissioning Group and Cumbria Partnership NHS Foundation Trust

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Conflict(s) of Interest None.

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Table 1, Demographic description and comparison of different sub-cohorts (primary care patients, collated in 2019)

Cohort / Variable	**Age, mean (n)**	**Gender, %male/%female (n/n)**	**IMD decile, median (n)**
All screened patients	44 (6545)	37% / 63% (2441/4104)	4 (6470)
All eligible patients	43 (2612)	36% / 64% (952/1660)	4 (2576)
All 'attenders', invited	43 (1424)	36% / 64% (513/911)	4 (1405)
All 'attenders', responders	45 – 54* (271)	33% / 67% (89/180)	5 (189)
All 'non-attenders', invited	39 (1188)	37% / 63% (439/749)	4 (1171)
All 'non-attenders', responders	35 -44* (129)	27% / 73% (34/94)	5 (80)

*Age distributed on a Likert scale (18-24, 25-34, 35-44, 45-54, 55-64, 65+) and hence median indicated; IMD, index of multiple deprivation

Table 2 multiple logistic regression analysis, using IAPT non-attendance as dependent outcome (primary care patients, collated in 2019)

Sample: Attender n = 241; non-attender 106	**p-value**	**Odds ratio**	**95% CI minimum**	**95% CI maximum**
Patient age[#] (reference: 18-24 yrs, see Table 1 for all categories)	0.64	1.04	0.88	1.23
Patient gender* (male [reference], female)	0.13	1.53	0.89	2.64
IAPT referral process rating by patient[#] (poor [reference], fair, average, good, excellent)	<0.01	0.59	0.46	0.75
Patient perspective GP support[#] (strongly agree [reference], agree, neither agree nor disagree, disagree, or strongly disagree)	0.28	0.86	0.65	1.14
Patient perspective accessing IAPT[#] (strongly agree [reference], agree, neither agree nor disagree, disagree, or strongly disagree)	0.53	1.10	0.82	1.47
How referred* (self-refer [reference] or GP referral)	0.07	1.72	0.95	3.09
Future referral preference* (self-refer [reference] or GP referral)	0.07	1.59	0.97	2.61

*Binary outcome; #Ordinal outcome

Table 3, Past referral mode to IAPT and future preference, survey responders (primary care patients, collated in 2019)

Past referral		Future preference*		
		Self-referral (after being advised to self-refer by GP)	**Referred by GP**	**True self-referral w/o GP input**
Self-referral (after being advised to self-refer by GP), % (n) attender / % (n) non-attender	⇨	41% (66) / 24% (20)	48% (77) / 72% (61)	11% (18) / 5% (4)
Referred by GP, % (n) attender / % (n) non-attender	⇨	13% (5) / 31% (8)	64% (25) / 62% (16)	23% (9) / 8% (2)
True self-referral w/o GP/nurse, % (n) attender / % (n) non-attender	⇨	14% (6) / na	26% (11) / na	60% (25) / na

*Total percentage and number of responders for all three response columns regarding future referral is based on total number of responses for each single past referral category row; na = not applicable, since none of the true self-referrers can be a non-attender.

Table 4, semi-quantitative interpretation of free text responses by primary care patients in relation to IAPT referral (primary care patients, collated in 2019)

Overarching theme concerning referral	**Number of responses, n* (n IAPT attenders / n non-attenders)**	**Representative quotations**
GP to refer patient	62 (32 / 29)	"If the GP truly believes the patient should utilise [IAPT], then the process should be instigated by the GP instead of the patient."; "If it is a 'treatment' then my GP should 'prescribe' it"
Reduce IAPT waiting times	54 (36 / 18)	"Referral is a lengthy process. The waiting times are too long. It takes a lot to accept you didn't feel yourself. It should be quicker."; "Some people might be dead by the time they get an appointment. If it was that good as a treatment why make people wait so long!"
More advertisements for IAPT	45 (32 / 13)	"Getting a GP appointment when I am unwell and not be told 'no appointments. I didn't know I could self-refer so more awareness of this?"
Lack of support GP / issues accessing GP	37 (24 / 13)	"Nurse just suggested it as I was walking out of the door, so I didn't think it was useful"
Fewer screening questions for IAPT	24 (21 / 3)	"Less questions; it made me more anxious and I couldn't go to work that day because the phone call made me so anxious."

Face-to-face appointments, no telephone screening	20 (12 / 8)	"To get a face-to-face appointment would be so much better, when you are in a dark place it seems more difficult to reach out."
More information regarding IAPT	17 (10 / 7)	"More information about what they [IAPT] offer and for who."
Referral mode is case dependent	8 (8 / 0)	"It should be well advertised so people know and can self-refer, but GP should also be quick to refer if self-referral is missed."
Other themes, non-referral related responses and generic feedback	202	"Self-referral is very hard to do the first time. It depends what mental state you are in"

*Responders could mention more than one theme

Figure 1, Difference in proportion of survey respondents who attended or did not attend IAPT categorised by referral type.