



## Research report

# Predictors of patient non-attendance at Improving Access to Psychological Therapy services demonstration sites



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## ABSTRACT

**Background:** Improving Access to Psychological Therapy (IAPT) services have increased the number of people with common mental health disorders receiving psychological therapy in England, but concerns remain about how equitably these services are accessed.

**Method:** Using cohort patient data ( $N=363$ ) collected as part of the independent evaluation of the two demonstration sites, logistic regression was utilised to identify socio-demographic, clinical and service factors predictive of IAPT non-attendance.

**Results:** Significant predictors of IAPT first session non-attendance by patients were: lower non-risk score on the Clinical Outcomes in Routine Evaluation–Outcome Measure (CORE-OM); more frequent thoughts of “being better off dead” (derived from the CORE-OM); either a very recent onset of common mental health disorder (1 month or less) or a long term condition (more than 2 years); and site.

**Limitations:** The small sample and low response rate are limitations, as the sample may not be representative of all those referred to IAPT services. The predictive power of the logistic regression model is limited and suggests other variables not available in the dataset may also be important predictors.

**Conclusions:** The clinical characteristics of risk to self, severity of emotional distress, and illness duration, along with site, were more predictive of IAPT non-attendance than socio-demographic characteristics. Further testing of the relationship between these variables and IAPT non-attendance is recommended. Clinicians should monitor IAPT uptake in those they refer and implement strategies to increase their engagement with services, particularly when referring people presenting with suicidal ideation or more chronic illness.

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## 1. Introduction

### 1.1. Background

Improving Access to Psychological Therapy (IAPT) services were introduced in 2006 to address the limited availability of psychological therapy for people with common mental health disorders (CMHD) in England (Layard, 2005; for a contextual account, see Layard and Clark (2014)). The rationale for setting up this initiative was based on the disparity between the high prevalence and economic burden of CMHD disorders in the UK, in the context of evidence that specific psychological interventions were both clinically and cost effective with these conditions (Layard et al.,

2007). National Institute for Health and Care Excellence (NICE) guidelines described effective psychological therapy treatments and recommended that they should be available to everyone with CMHD apart from those with the very mildest or most recent onset of problems. However, insufficient services were available, resulting in unnecessary distress to a large proportion of the UK population (Centre for Economic Performance, 2006). The difficulties of accessing psychological therapy were highlighted further by the 2007 English adult psychiatric morbidity household survey finding fewer than 10% of people with CMHD received psychological therapy and only 5% an evidence-based psychological therapy (McManus et al., 2009). It was argued that investment in psychological therapy would pay for itself through reduced use of National Health Service (NHS) services and incapacity benefit payments (Centre for Economic Performance, 2006).

Since its inception, IAPT has trained over 3000 practitioners to deliver NICE-recommended psychological therapies (Department

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of Health, 2012). The 1-year evaluation of the IAPT rollout reported a median recovery rate of 42% with a range across the 32 sites from 24% to 57% (Gyani et al., 2013). The report on the first million people receiving treatment in IAPT services cited recovery rates to be over 45% (Department of Health, 2012). Studies have suggested that IAPT is probably cost effective (Department of Health, 2012; Mukuria et al., 2013), reducing use of some other health services (de Lusignan et al., 2012) and, it is claimed, moving IAPT users off benefits and into work (Clark et al., 2009; Department of Health, 2012).

### 1.2. Improving Access to Psychological Therapy (IAPT): the issue of access

Despite the achievements of the IAPT initiative, questions remain about how equitably the service is being used; therefore improving equitable access has become a focus for service improvement (Department of Health, 2012). Studies have found various groups underrepresented in IAPT services: men (Glover et al., 2010; de Lusignan et al., 2012; Parry et al., 2011), older people (Glover et al., 2010; de Lusignan et al., 2012; Parry et al., 2011) people from some minority ethnic groups (Glover et al., 2010; de Lusignan et al., 2012; Parry et al., 2011) and people presenting with certain anxiety disorders (Clark, 2011). All IAPT services monitor the age, gender, ethnicity, deprivation, religion/belief, sexual orientation, physical health, diagnosis, illness severity, employment, and duration of current illness episode of their service users. However, evaluations of IAPT services using routinely collected data do not include all those referred to IAPT, and have found data to be incompletely recorded, limiting validity (Glover et al., 2010). Other IAPT evaluations of equity of access are limited by only investigating differences within IAPT attenders (Clark, 2011; Gyani et al., 2009, 2013).

Where comparisons with non-attenders have taken place, differences in attendance rates have been described in relation to only a small number of variables and predictive analyses have not been carried out (de Lusignan et al., 2012; Mukuria et al., 2013; Parry et al., 2011). Studies of equity of access to IAPT have also tended to focus on more stable patient characteristics such as age, ethnicity and gender; whereas one of the key reviews into equity of therapy use found a wider range of more transient characteristics influential on attendance (Clarkin and Levy, 2004). Indeed, research into non-IAPT psychological therapy has found clinical severity (Bebbington et al., 2000; Fleury et al., 2012; Simon and Ludman, 2010), risk (Burns et al., 2003; Sales, 2003), relationship status (Briffault et al., 2008; Chen and Rizzo, 2010; Estupiñá et al., 2012) and caring responsibilities (Issakidis and Andrews, 2004) among the variables affecting attendance.

To address these limitations in establishing how equitably IAPT has increased access to psychological therapy, we analysed socio-demographic and clinical data on patients referred to the service by their GP and, whether or not they accessed IAPT services, thereby enabling us to identify predictors of non-attendance. We used data from a cohort study that formed part of an independent evaluation of the two IAPT demonstration sites (Parry et al., 2011). The data were chosen as they contained information on a wider range of socio-demographic and clinical factors than previous analyses had used and enabled us to investigate predictors of first session non-attendance (hereafter referred to only as non-attendance). In addition, the data quality was high (over 95 per cent complete for 16 out of 19 variables). Accordingly, the aim of the current study was to identify which socio-demographic and clinical factors were predictive of non-attendance in those referred to IAPT by their GP in the IAPT demonstration sites.

## 2. Method

### 2.1. Design and procedures

This study was a secondary analysis of cohort study data collected as part of a United Kingdom National Institute of Health Research funded evaluation of the two IAPT demonstration services: Doncaster and Newham (Parry et al., 2011). We matched IAPT service use data with participants' self-report socio-demographic and clinical data, obtained by postal questionnaires.

Recruitment packs were mailed out to potential participants by GP practices as soon as possible after participants had been seen by GPs or identified from patient records (as having been seen by GPs in the last four weeks). Reminder letters were sent two weeks later. Recruitment packs contained a covering letter from the GP practice, invitation letter from the University conducting the study, participant information sheet, consent form, questionnaire consisting of a battery of baseline outcome measures and socio-demographic questions, offer of a £10 voucher for returning the questionnaire, and a prepaid response envelope. Questionnaires were to be completed as soon as possible after referral to IAPT services. However, as participants were responsible for returning their questionnaires and there was variation in waiting times for IAPT services, timings between seeing GP, completing questionnaires and seeing IAPT services were inconsistent.

UK research governance procedures were adhered to; all aspects of the study (including capacity for consent and permission to use secondary analysis of data) were subject to ethical scrutiny through the regional Research Ethics Committee (REC ref: 07/Q1205/54). Written consent was obtained from both GP practices and individual participants. Whether or not participants chose to take part in the evaluation did not affect the treatment they received and was not known to those providing treatment.

### 2.2. The IAPT services

The IAPT service model is described extensively elsewhere (e.g., Clark et al., 2008). The current study is based on the first 3 years of the first two IAPT services, Doncaster (South Yorkshire) and Newham (East London) which were set up in 2006 to demonstrate the IAPT service model. The services differed slightly, in Doncaster patients were contacted by telephone and offered a face to face consultation in a GP surgery or other community location. The majority (90.0%) of referrals came via GPs and most people received low intensity interventions (93.2% initially allocated to guided self-help), with very few people receiving one-to-one CBT. The Newham service specifically targeted groups traditionally under-served by psychological therapy. It tried to make all materials culturally appropriate and available in multiple languages, up to five phone calls and three letters were provided to each person referred, to encourage engagement. Whilst the majority of referrals still came from GPs (65.6%), many people (22.7%) self-referred to the service. Similar numbers of people were assigned to step 2 (mostly consisting of guided self-help) (47.7%) and step 3 (one-to-one CBT) (45.6%) interventions.

### 2.3. Sample

All GP practices in Doncaster and Newham were invited to take part in this study. Of the 70 GP practices, 34 (48.6%) agreed. Participating GPs were asked to identify patients who met study criteria: being of working age (16–64 years), newly presenting (or re-presenting) with anxiety or depression in the last four weeks, and who they had referred to the IAPT service. These criteria set as anxiety and depression were the focus of IAPT referrals; other diagnoses were not excluded either from IAPT or this study, with

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