

1 **Variation in referral and access to new psychological therapy services by age**

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53 **Abstract**

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55 **Background:** Older people with common mental health problems (CMHPs) are known to have
56 reduced rates of referral to psychological therapy.

57 **Aim:** We aimed to assess referral rates to the Improving Access to Psychological Therapies
58 (IAPT) service, contact with a therapist and clinical outcome by age.

59 **Design and Setting:** Empirical research using patient episodes of care from South West IAPT.

60 **Method:** By analysing 82,513 episodes of care (2010-2011), referral rates and clinical
61 improvement were compared to both total population and estimated prevalence in each age group
62 using IAPT data. Probable recovery of those completing treatment were calculated for each
63 group.

64 **Results:** Estimated prevalence of CMHPs peaks in 45–49 year olds (20.59% of population). The
65 proportions of patients identified with CMHPs being referred peaks at 20-24 years (22.95%) and
66 reduces with increase in age thereafter to 6.00% for 70-74 year olds. Once referred, the
67 proportion of those attending first treatment increases with age between 18 years (57.64%) and
68 64 years (76.97%). In addition, the percentage of those having a clinical improvement gradually
69 increases from the age 20 years (12.94%) to 69 years (20.74%).

70 **Conclusion:** Younger adults are more readily referred to IAPT services. However, as a
71 proportion of those referred, probabilities of attending once, attending more than once, and
72 clinical improvement, increase with age. It is uncertain whether optimum levels of referral have
73 been reached for young adults. It is important to establish whether changes to service
74 configuration, treatment options, and GP behaviour can increase referrals for middle-aged and
75 older adults.

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77 **Keywords:** IAPT, Age Factors; Mental Health; Referral; Psychological Therapy

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92 **How this fits in**

- 93 • We aimed to assess referral and access rates to the Improving Access to
94 Psychological Therapies (IAPT) service, as well as clinical outcome, by age.
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- 96 • Older adults with common mental health problems are known to have reduced rates
97 of referral to psychological therapy.
98
- 99 • This research shows that older adults with common mental health problems are being
100 under referred but benefit largely once obtaining access to the service.
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- 102 • This research highlights an imbalance in referral rates across age which should be
103 addressed at the referral stage by health care practitioners.
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135 **INTRODUCTION**

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137 In 2009, the Royal College of Psychiatrists suggested the UK currently provides more mental
138 health services for those younger than 65 years of age than older people[1]. Barriers to mental
139 health treatment are known to differ by age[2] and concerns that discrimination against older
140 adults may cause reduced access to mental health treatments including talking therapies are
141 expressed[3]. Data available from the Improving Access to Psychological Therapies (IAPT)
142 programme, which aimed to equitably improve access, allows us to explore the degree to which
143 inequalities persist across different age groups.

144

145 The Adult Psychiatric Morbidity Survey (APMS) provides data on the prevalence of psychiatric
146 disorder (treated and untreated) in the English adult population. 'Common Mental Health
147 Problems' (CMHPs) is an umbrella term describing difficulties in low mood and anxiety and is a
148 descendent of the term 'common mental disorders'. The APMS describes common mental
149 disorders as conditions comprising of different types of depression and anxiety[4]. Data from the
150 APMS suggest prevalence of depression reduces with age from middle-age onwards[4], a finding
151 supported by others[5] but not by Stordal and colleagues[6] who reported a linear increase of
152 depression with increasing age after carefully adjusting for confounders for individuals in
153 Norway. Whatever the truth about prevalence, inequity of access appears clear. In the 1990's
154 fewer than 3% of adults aged over 65 years reported seeing a mental health professional[7].
155 Using data from the APMS (2007), Cooper and colleagues[8] found younger adults (16-34 years)
156 to be 80% more likely than older adults (75+ years) with the same severity of common mental
157 health problems (CMHPs) to be receiving talking therapy. In contrast, older adults were more
158 likely than younger adults to receive anti-depressants or anxiolytics and hypnotics, suggesting
159 older adults are being prescribed medication rather than talking therapy and vice versa.

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161 Inequities in access to talking therapies across age may be dependent on patient attitudes,
162 practitioner attitudes and/or system factors. Depressive symptoms are common in older adults,
163 but psychological adjustment to aging and chronic illness may mean symptoms are not
164 acknowledged or revealed[9]. It may be assumed by some health care professionals that older
165 adults experience psychological distress as a natural and inevitable consequence of aging[9, 10].
166 Ross and Hardy[11] found GP decisions were influenced by patients' help-seeking behaviours as
167 well as their representations of mental health problems. GPs may believe older adults are less
168 responsive to cognitive behavioural therapy than younger adults[12, 13]. Patients believing they

169 can 'manage themselves' increases with age, making it less likely they will disclose their mental
170 health problems to a GP, less likely they will be referred, and less likely they will accept offered
171 treatment[14, 15]. It is possible that older adults attribute their symptoms to physical complaints,
172 whereas younger adults have greater awareness of psychological problems[10]. Older adult's
173 inability to express their psychological problems, and greater self-stigma reduces the likelihood
174 they are to seek help[10], or be offered appropriate help by health care professionals[11], creating
175 further inequities in access to mental health treatment dependant on age.

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177 In 2008, the development of new psychological therapy services across England under the IAPT
178 programme, improved access to treatments for CMHPs[2] which included individuals with
179 obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) as well as the
180 more prevalent anxiety and depression. By 2011, 142 Primary Care Trusts (PCTs) had an IAPT
181 service and £400 million was being invested up to 2015. Targets for rates of access to
182 psychological therapy included services providing enough therapists to meet the needs of the
183 whole PCT population, with half of those who complete the programme moving to recovery[16].
184 IAPT services include routine collection of session by session outcome data for all individuals
185 referred. The IAPT data allows exploration of differences in access to mental health treatments
186 across age, allowing comparisons of referrals, access to the services and responses to treatment.

187

188 Previous audits and monitoring suggest access to talking therapies is greater for younger
189 individuals[8]. This paper aimed to accurately estimate differences in referral and access rates to
190 the IAPT service and to compare pathway through treatment across age bands, controlling for
191 predicted prevalence of CMHPs.

192

193 **METHOD**

194

195 Our overall design was to derive figures in each age band for total population, estimated
196 prevalence and numbers referred, seen, and patients who achieved the minimal clinical important
197 difference (MCID) in symptoms; and then to calculate rates using different key denominators.

198 The most recent APMS (survey three, 2007) data were analysed with data collected from IAPT
199 services in thirteen Primary Care Trusts (PCTs) from 2010-2011. The dataset was created for a
200 service evaluation project of the IAPT services commissioned by the South West Strategic Health
201 Authority.

202

203 Population and prevalence data were obtained from the APMS survey which used a robust
204 stratified, multi-stage probability sample of households which assessed and diagnosed psychiatric
205 disorder according to diagnostic criteria where possible. Participants completed the revised
206 Clinical Interview Schedule (CIS-R)[17] which measures symptoms linked to the diagnosis of
207 anxiety and depression, and provides an overall score for the presence of CMHPs (indicated by a
208 score of 12 or above). The APMS series is the largest, most detailed, and most recent (2007) data
209 available for comparison of IAPT service use. The APMS provided numbers on estimated
210 prevalence of CMHPs across gender (which we combined), as well as total population, in each of
211 the thirteen PCTs individually. Using this data, the numbers of people in each age group in the
212 South West and the numbers of people in each age group in the South West who were estimated
213 to have CMHPs were totalled, and these were used as denominators to calculate rates and
214 proportions.

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216 Numbers of people referred, obtaining access and the associated clinical outcomes were derived
217 from the South West IAPT evaluation database which includes information from the IAPT
218 service providers' databases relating to 13 South West PCTs. We included individuals aged
219 between 18 and 74 years of age in the study to reflect data taken from the APMS (which excludes
220 those in care homes). The anonymised referral, access and outcome data were generated from
221 82,513 individual episodes of care (76,734 patients). Patients' demographic information
222 (including age) and details of attendance, and health outcomes were recorded at every clinical
223 contact. The latter included the Patient Health Questionnaire (PHQ-9)[18] as a measure of
224 depression, and the Generalised Anxiety Disorder (GAD-7)[19] questionnaire as a measure of
225 anxiety.

226

227 We estimated the proportions of the total populations having CMHPs; being referred to IAPT;
228 obtaining access by attending their first session with an IAPT therapist; treatment engagement by
229 attending at least one further session; and those achieving MCID in both the PHQ-9 and the
230 GAD-7. We calculated the proportions of those estimated to have CMHPs being referred to
231 IAPT; obtaining access by attending their first session with an IAPT therapist; treatment
232 engagement by attending at least one further session; and those achieving MCID. We then
233 calculated the proportions of referred patients obtaining access; treatment engagement by
234 attending at least one further session; and those achieving MCID. MCID was also shown as a
235 proportion of those with two or more treatment sessions.

236

237 To calculate the MCID patients must have attended two or more (valid) clinical contacts and
238 improvement was measured by comparing final therapy session score with baseline session score
239 on the following outcome measures. The MCID value for PHQ-9 is a reduction of 5 or more
240 points between first and last session and for GAD-7 it is a reduction of 4 or more points between
241 first and last session[20]. The proportion achieving the MCID in both PHQ-9 and GAD-7 by
242 those with more than two therapy sessions in each age group was then calculated.

243

244 **RESULTS**

245

246 There were 82,513 treatment episodes recorded across the 13 IAPT services in the South West of
247 England. The number of people in each age group in the study area is shown in table one along
248 with the estimated number of people with CMHPs and the numbers of people referred to IAPT
249 services, attending at least one session with an IAPT practitioner, uptake of treatment by at least
250 one further session and achieving MCID. The numbers are also expressed as proportions of
251 estimated prevalence, of referrals and of those seen.

252

253 Estimated prevalence of CMHPs peaks in 45-49 year olds (20.59%), with lowest estimated
254 prevalence in 70-74 year olds (9.47%). Referral rates as a proportion of CMHPs peak in 20-24
255 year olds (22.95%) and then decreases from this point until 74 years of age (6.00%). Attendance
256 rates as a proportion of referrals peak in 60-64 year olds (79.97%) with lowest attendance rates in
257 20-24 year olds (57.34%). For those with two or more treatment sessions, there is a peak in
258 MCID in 65 – 69 year olds (46.17%) with lowest improvement rates in 20-24 year olds (37.08%).
259 Further detail can be found in table one.

260

261 The proportions of the population being referred, obtaining access, engaging with treatment and
262 achieving MCID each peak in 25-29 year olds and decline thereafter, with lowest numbers for 70-
263 74 year olds. Figure one shows the contrast graphically. Figure two depicts a *vertically magnified*
264 version of Figure one showing the proportion of the population referred, obtaining access,
265 continuing with treatment and achieving MCID from the total population.

266

267 Access uptake, continued treatment and achieving MCID, represented as a proportion of referrals
268 is depicted in figure three. Of those referred: proportions of people obtaining access increases
269 until 64 years (76.97%); proportions of people with 2+ treatment sessions increases until 59 years
270 (35.31%); proportions of people achieving MCID increases until 69 years (15.86%).

271 The age group with the lowest proportion achieving MCID is 70-74 year olds (32.77%) but
272 otherwise the percentage with MCID gradually increases from those aged 20-24 (37.08%) to
273 those 65-69 years (46.17%), this age group having the highest proportion achieving MCID. This
274 is depicted in Figure four.

275

276 In summary, more referrals are made for younger adults with a peak age of 25-29 years as a
277 proportion of the total population and a peak age of 20-24 years as a proportion of those with
278 CMHPs, but once referred, a higher proportions of older adults are engaging with and benefiting
279 from treatment than 20-29 year olds.

280

281 **DISCUSSION**

282

283 *Summary*

284 Concerns about discrimination against older adults leading to reduced access to talking therapies
285 have been widely shared[2, 3]. Our research has shown, taking estimated prevalence into account,
286 that access is indeed lower for older adults and middle age compared to younger adults. The
287 estimated prevalence of CMHPs peaks in 45-49 year olds but the proportions of those being
288 referred peaks in 20-24 year olds. This is an important finding as it is possible that, given lower
289 uptake, retention and improvement, there is over-referral of younger patients who either find it
290 difficult to engage, or who are less likely to improve if they do engage or do not see the value of
291 talking therapies at this point in their lives.

292

293 We have also shown that, once referred, older adults may benefit more from the IAPT service. Of
294 those referred; the proportion of those obtaining access increases until 64 years, engaging with
295 treatment increases until 59 years and achieving MCID increases until 69 years. Once referred,
296 adherence to and recovery from treatment increases with increase in age and higher proportions
297 of older adults are accessing and engaging with treatment than the 20-24 year olds who are being
298 referred more frequently.

299

300 *Comparison with existing literature*

301 Patients can be signposted to the IAPT service by any appropriate referrer, and the main source of
302 referrals is the GP. As such, GP decision making and practices regarding referral to psychological
303 therapy services will have a large impact on access for patients. Cooper and colleagues[8] found
304 younger adults (16-34 years) more likely than older adults (75+ years) with the same severity to

305 have seen their GP regarding a mental health issue and to be receiving talking therapy treatment.
306 A combination of factors may contribute to lower referral rates of older adults by health care
307 professionals: self-stigma towards mental health in older adults leading to reduced disclosure and
308 requests for help[11, 14, 15]; increased likelihood in receiving prescribed medication(s)[8];
309 professional attitudes[10]; multi-morbidity reducing recognition; and system factors which
310 prevent access to those who are frail or homebound. It seems likely that reasons for the reduced
311 referral we have shown are multi-factorial. However given the greatly higher contact rates
312 between older adults and GPs than for younger adults, the reduced referral rates are even more
313 striking. While there are good grounds for believing that GPs may not be offering the opportunity
314 of referral to older adults, it is also likely that patients may believe they can ‘manage themselves’,
315 making them less likely to disclose information to their GP, or accept suggested help[14, 15].

316

317 The estimated capacity of the patient to benefit from psychological therapy is a prominent feature
318 included in a GP’s referral decision[21] and they may also assume certain age groups will not
319 engage with the service. Our study should demonstrate to GPs that older patients are both more
320 likely to attend and more likely to benefit once engaged in treatment. GPs should perhaps
321 therefore work to discuss mental health problems with older adults and increase awareness of the
322 different available therapies, and their potential benefits. IAPT services may also need to take
323 note. While those who were referred attended more reliably it is also possible that the nature of
324 services are more suited to young people and that this is a disincentive to referral. These
325 recommendations may also apply to those in mid-age. It is harder to draw conclusions about
326 younger people and it is not clear as to whether, in some high referring PCTs, more numbers of
327 young people are presenting with distress or access for younger people has achieved an optimum.
328 It is also possible that if we can improve therapy engagement in these younger age groups they
329 will be more likely to benefit from these types of treatments.

330

331 *Limitations and Strengths*

332 The data represent populations who have been referred to the IAPT service, and not those using
333 other primary or secondary care services. It is important to note that the APMS only included
334 those living in private households, excluding those in care homes[22]. Nonetheless, the APMS
335 series is the most recent and detailed data available for comparison of IAPT service use.

336

337 The data described above is purely quantitative and although we can speculate, it is difficult to
338 explain why these differences in referral, engagement and outcome exist between patients from

339 different age groups. Other studies have indicated some of the potential reasons in relation to
340 service configuration but have not focussed on older adults[23].

341

342 *Implications for practice*

343 A number of factors are likely to affect access to IAPT services. Where possible, these need to be
344 considered when evaluating the ability of new IAPT services to achieve their access targets.

345 When considering age and specific age groups facing barriers to IAPT service use, the main
346 inequity seems to be at the referral stage. Although 20-29 year olds are being referred in the
347 largest numbers, the proportion remaining engaged with treatment increases with age. Barriers to
348 engagement with the IAPT service in younger populations may be overcome by using different
349 technologies, for example. Older adults are being under referred but benefit largely once
350 obtaining access to the service. This suggests these inequities need to be acknowledged and
351 addressed. Several barriers to treatment associated with age have been identified in recent work,
352 including older patients' own perceptions, attitudes and behaviours towards mental health and
353 associated talking treatments, and communication problems between the patient and doctor.

354

355

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362 conflict of interest to declare.

363

364 **Ethical approval**

365

366 The dataset was created for a service evaluation project of the IAPT services commissioned by
367 the South West Strategic Health Authority. Ethical approval was sought from and granted by the
368 Cornwall and Plymouth Research Ethics Committee (Approval no. 09/H0203/91).

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373 contributions from the NIHRs PenCLAHRC. The views expressed in this paper are those of the
374 authors and not necessarily those of the NHS or the NIHR. None of the authors have a conflict of
375 interest to declare.

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Table 1: Detail of population and referrals in the South West across age including: total population; total number of referrals; referrals as a proportion of population; and estimated prevalence

Age	(years)	18-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
Population	(count)	253,936	293,070	260,578	299,820	354,084	361,746	324,621	307,731	345,264	285,479	243,231	214,057
Estimated CMHP cases	(count)	35,001	44,942	49,269	51,344	63,188	72,673	66,849	62,190	55,179	43,676	23,892	20,270
	(% of pop.)	13.78	15.33	18.91	17.12	17.85	20.09	20.59	20.21	15.98	15.30	9.82	9.47
Referrals	(count)	3,527	10,313	10,199	9,568	9,582	10,071	8,885	6,681	5,152	3,595	2,321	1,217
	(% of pop)	1.39	3.52	3.91	3.19	2.71	2.78	2.74	2.17	1.49	1.26	0.95	0.57
	(% of CMHP cases)	10.08	22.95	20.70	18.64	15.16	13.86	13.29	10.74	9.34	8.23	9.71	6.00
Attendees	(count)	2,033	5,913	6,205	6,155	6,438	6,916	6,400	4,868	3,954	2,767	1,774	905
	(% of pop)	0.80	2.02	2.38	2.05	1.82	1.91	1.97	1.58	1.15	0.97	0.73	0.42
	(% of CMHP cases)	5.81	13.16	12.59	11.99	10.19	9.52	9.57	7.83	7.17	6.34	7.43	4.46
	(% of referrals)	57.64	57.34	60.84	64.33	67.19	68.67	72.03	72.86	76.75	76.97	76.43	74.36
Completers (>=2 sessions)	(count)	675	2,384	2,492	2,486	2,716	2,949	2,723	2,139	1,819	1,266	797	412
	(% of pop)	0.27	0.81	0.96	0.83	0.77	0.82	0.84	0.70	0.53	0.44	0.33	0.19
	(% of CMHP cases)	1.93	5.30	5.06	4.84	4.30	4.06	4.07	3.44	3.30	2.90	3.34	2.03
	(% of referrals)	19.14	23.12	24.43	25.98	28.34	29.28	30.65	32.02	35.31	35.22	34.34	33.85
	(% of attendees)	33.20	40.32	40.16	40.39	42.19	42.64	42.55	43.94	46.00	45.75	44.93	45.52
Reliable improvement	(count)	263	884	983	994	1,121	1,269	1,143	906	789	560	368	135
	(% of pop)	0.10	0.30	0.38	0.33	0.32	0.35	0.35	0.29	0.23	0.20	0.15	0.06
	(% of CMHP cases)	0.75	1.97	2.00	1.94	1.77	1.75	1.71	1.46	1.43	1.28	1.54	0.67
	(% of referrals)	7.46	8.57	9.64	10.39	11.70	12.60	12.86	13.56	15.31	15.58	15.86	11.09
	(% of attendees)	12.94	14.95	15.84	16.15	17.41	18.35	17.86	18.61	19.95	20.24	20.74	14.92
	(% of completers)	38.96	37.08	39.45	39.98	41.27	43.03	41.98	42.36	43.38	44.23	46.17	32.77

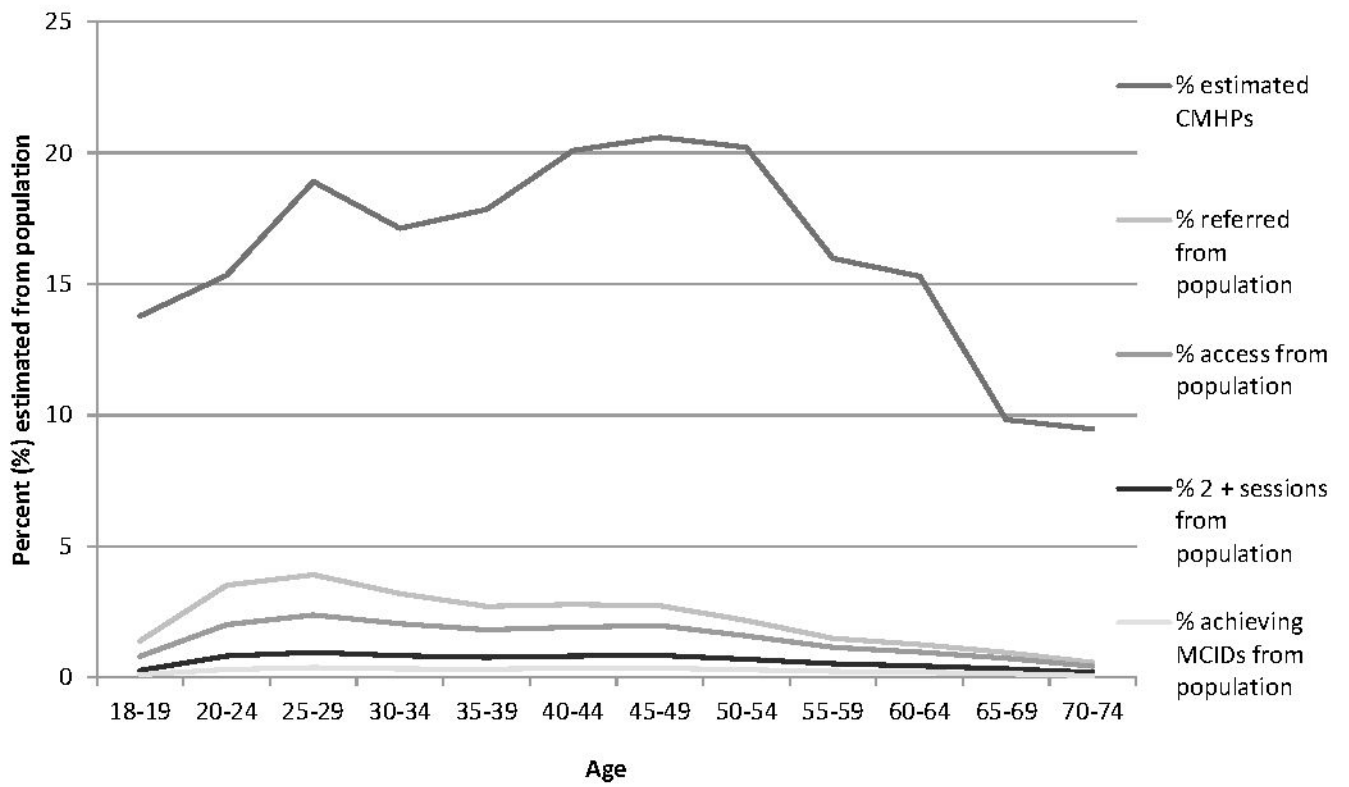


Figure 1: Estimated percent of CMHPs and number of those: referred, with access, with 2+ sessions, achieving MCID as a proportion of total population across age in the South West

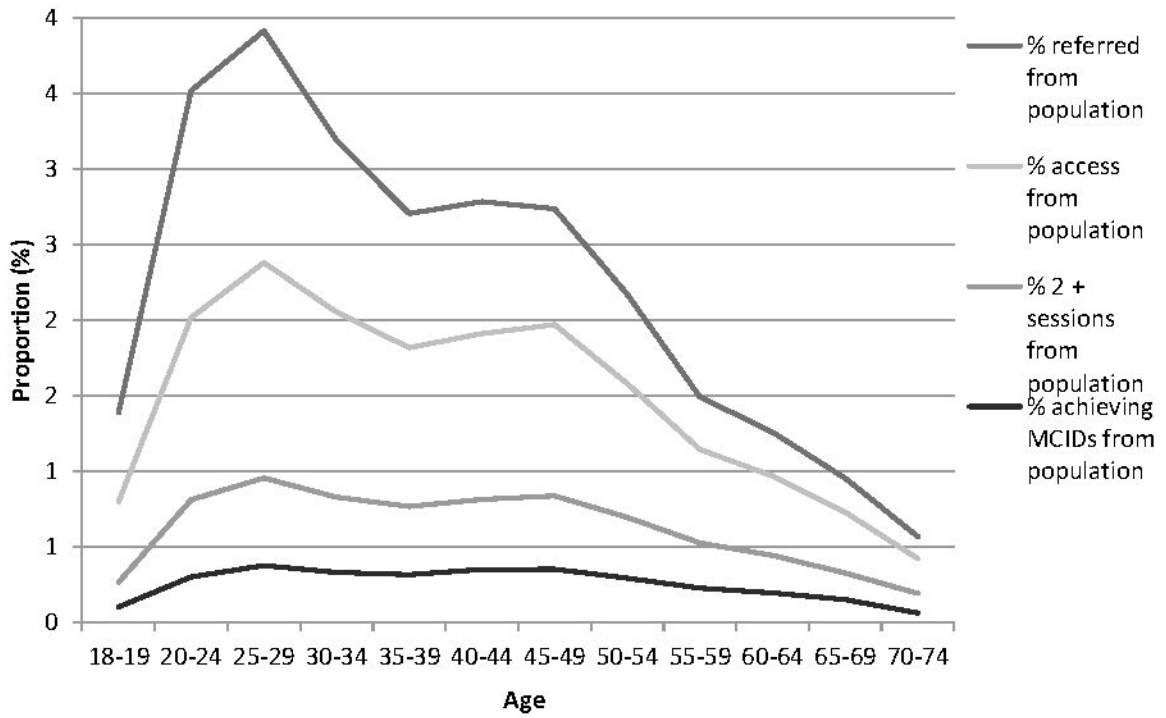


Figure 2: Number of those: referred, with access, with 2+ sessions, achieving MCID as a proportion of total population across age in the South West

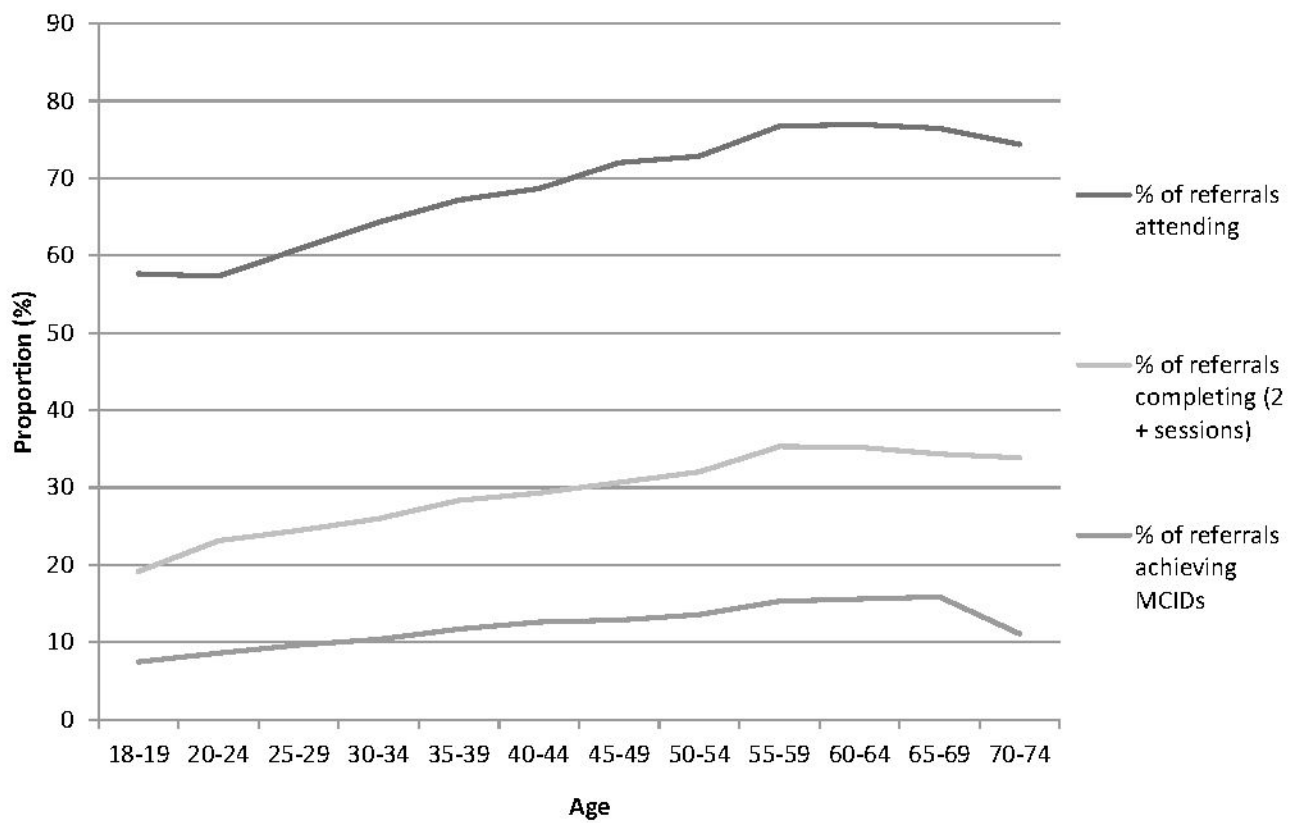


Figure 3: Number of those: with access, with 2+ sessions, achieving MCID as a proportion of those referred across age in the South West

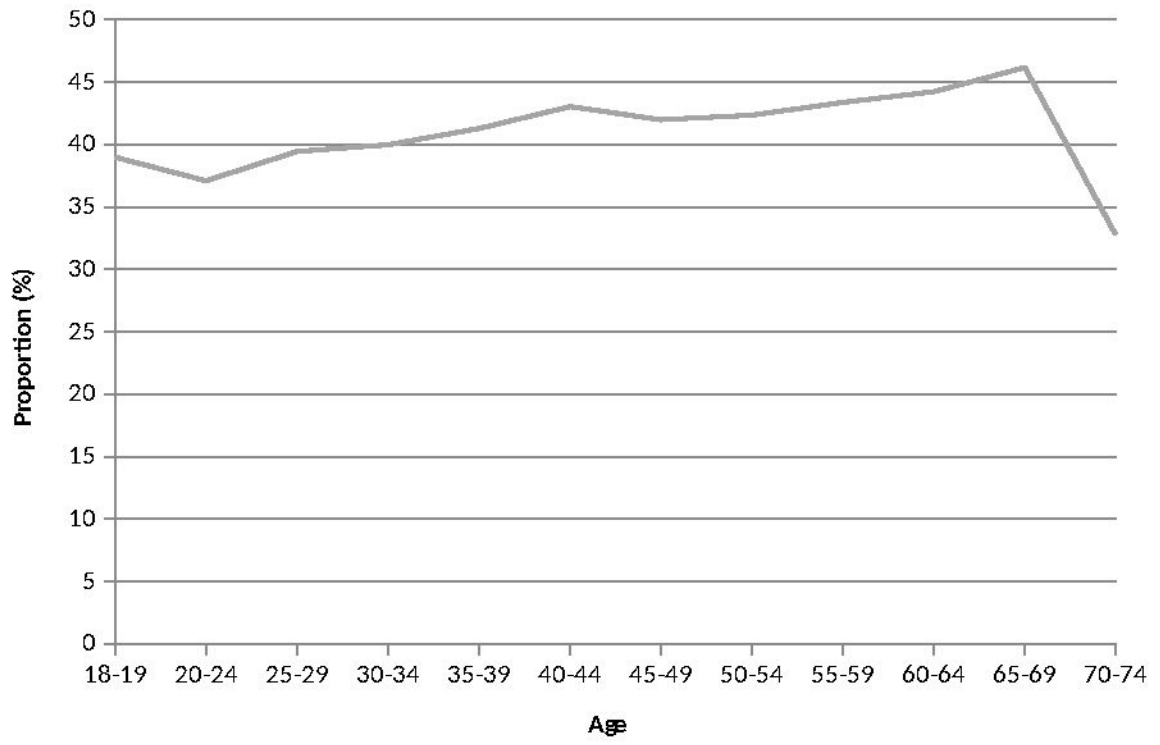


Figure 4: Those achieving MCID as a proportion of those with 2+ treatment sessions across age in the South West