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Using the COM-B Model and Theoretical Domains Framework to Understand Patients' Referral Compliance Following a Diabetes Screening in the Dental Setting

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Abstract

Background/Objectives: The dental setting has been suggested as a location for opportunistic diabetes screenings. Diabetes screening is a pathway consisting of several steps that must be completed to reach a diagnosis. Previous research has found that most patients in the dental setting, when offered the opportunity to screen for diabetes, are willing to do so; however, amongst those who are referred for medical follow-up, there is low compliance. If diabetes screening in the dental setting is to be effective, strategies are required to maximise uptake and ensure completion of the screening pathway. Methods: This qualitative study examined participants in a diabetes screening trial held at dental clinics in Victoria, Australia. Semi-structured interviews were conducted by telephone, transcribed and analysed thematically. The themes identified were then deductively mapped onto the Capability, Opportunity, Motivation, Behaviour (COM-B) model and Theoretical Domains Framework (TDF). Results: Ten individuals who were screened for diabetes and referred to their general medical practitioner (GP) for a diabetes diagnosis were interviewed. The themes identified from the interviews were mapped to five COM-B domains: reflective motivation and automatic motivation, social and physical opportunity and psychological capability. These were linked to eight TDF domains associated with issues related to knowledge, environmental context and resources, memory, attention and decision processes, social influences, beliefs about consequences, emotions, and beliefs about capability. Conclusions: This study investigated the determinants influencing individuals' decision to participate in diabetes screening and comply with referral advice. The results demonstrate the need to increase community knowledge around diabetes and screening for the condition, facilitate risk interpretation, and streamline the referral pathway between oral health professionals (OHP) and GPs. The study provides evidence that can be utilised for the development of future interventions that promote diabetes screening participation and maximise medical follow-up of referred individuals.

Keywords: type 2 diabetes; prediabetes screening; qualitative method; referral compliance

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1. Introduction

Type 2 diabetes (T2D) and prediabetes (PD) represent major global public health challenges, with an estimated 589 million adults in 2024 living with diabetes, and 1.1 billion

having impaired fasting glucose or impaired glucose tolerance (prediabetes). Nearly half of those adults with diabetes—251 million people—are unaware of their condition [1].

Opportunistic screening of asymptomatic individuals has been proposed as a strategy to mitigate the public health impacts of diabetes. Screening facilitates the early detection of PD and T2D, enabling timely interventions that may prevent or delay disease onset and related complications [2].

In Australia, diabetes screening typically follows a two-step process: initial risk stratification using the validated Australian Type 2 Diabetes Risk Assessment (AUSDRISK) tool, followed by diagnostic blood testing for individuals identified as high risk [3].

Primary care is the preferred setting for detecting undiagnosed diabetes [4]. Although patients and healthcare professionals widely support risk-based detection [5], screening remains underutilised. In Australian general practices, 45% of high-risk patients were not screened over a three-year period [6]. In the US, fewer than half of the 135 million people eligible for diabetes screening were tested [7].

Given that over half of Australian adults visit a dentist annually [8], and diabetes shares a documented bi-directional relationship with oral health, dental practices have been proposed as an alternative setting to address the screening shortfall. Studies also indicate strong support for routine diabetes screening during dental consultations among both patients [9] and oral health professionals (OHP) [10].

This study builds on the 'Identification of type 2 diabetes and prediabetes in the oral healthcare setting' (iDENTIFY) study [11], which invited eligible patients in Australian private dental practices to complete a diabetes risk assessment using the AUSDRISK tool. Participants identified as having elevated risk for prediabetes or type 2 diabetes were referred to their general medical practitioner (GP) for diagnostic confirmation. However, only one-quarter attended the follow-up [11], underscoring a significant limitation of the screening protocol. Prior studies similarly report that, despite initial consent for risk assessment, compliance with referral advice after a positive screen remains low [12].

Non-compliance with referral advice following diabetes screening in dental settings remains poorly understood, presenting a significant barrier to the effectiveness of such programmes [13]. While opportunistic screening offers an important opportunity for the early detection of T2D and PD, its success depends on patients completing the entire diagnostic pathway. This study seeks to address this gap by exploring participants' perceptions and experiences of the screening process and identifying behavioural determinants influencing their decision to comply with OHP's referral advice. To guide this analysis, we applied the Capability, Opportunity, Motivation–Behaviour (COM-B) model and the Theoretical Domains Framework (TDF), which provide a structured approach to understanding the psychological, social, and contextual factors shaping health behaviours [14]. Insights from this theory-informed approach will inform the design of targeted interventions to improve referral compliance and optimise the role of dental settings in diabetes prevention.

Although this study focuses on diabetes, the applied model is broadly relevant to screening for other chronic conditions. Dental settings have also been used to screen for cardiovascular disease, obstructive sleep apnoea [15], HIV [16], and gastro-oesophageal reflux [17], with strong support from both patients [18] and OHPs [19].

2. Materials and Methods

A qualitative study design, using semi-structured interviews, was implemented to examine the perspectives and experiences of patients who participated in the iDENTIFY diabetes screening programme.

2.1. Ethical Considerations

Approval for this study was obtained from the Human Research Ethics Committee at the University of Melbourne (Ethical approval no: 22246). Participants were recruited via an email invitation which included a Plain Language Statement explaining the study, and a consent form, which could be signed and returned via email. Alternatively, informed consent could be provided verbally prior to the commencement of the interview.

2.2. Data Collection

Participants were recruited from the iDENTIFY study after undergoing diabetes screening in a private dental setting, using the purposive sampling method. To reduce the risk of a sampling bias, a maximum variation method was used for selected key demographic variables for participants that potentially may influence their view and experience of the screening process. Eligible individuals had attended the private dental setting, accepted an invitation to be screened, screened positive using the AUSDRISK tool (intermediate or high diabetes risk) and were referred for medical follow-up; the gender of participants, location of the screening (metropolitan and rural), and diabetes risk varied, as well as whether participants complied with referral recommendations or not. Email invitations were sent to 285 individuals. Of these, 35 email addresses were incorrect, 12 participants replied and agreed to take part, and 21 replied but declined to be interviewed.

Telephone interviews were conducted between 9 August 2023 and 19 February 2024, with data collection ceasing when no additional new themes were generated by the data [20]. All interviews were audio-recorded using an OM-Systems DM-720 Voice Recorder. The audio files were uploaded to Otter.ai (Version 3.68.1, Otter.ai, Mountain View, CA, USA) online portal, which is an artificial intelligence voice-to-text transcription software. To ensure accuracy, the transcripts were reviewed and edited by comparing them with the original audio files to achieve a verbatim transcription of the interview [21].

2.3. Data Analysis

The data was coded inductively, and thematically analysed following the six-step approach described by Braun and Clarke for data familiarisation, the identification of initial codes, theme generation, reviewing themes, defining and naming themes, and reporting findings [22]. The analytical process was managed in NVivo 14 (NVivo, QSR International, Victoria, Australia) software by the primary researcher (AP). To enhance the credibility and validity of the findings, eight transcripts were double-coded. AP coded all transcripts, and one of PL, RM or ID independently coded each of the eight. The initial codes were then compared, discussed and revised to resolve differences and reach a shared interpretation of the data [23]. AP subsequently applied the agreed coding framework to the final two transcripts. When the reviewers observed that the codes were consistent and no new codes were emerging across the interview data—indicating that code saturation had been reached—they then proceeded to identify the themes arising from those codes.

Themes may be described as "abstract and subtle expressions/patterns/processes that explain a phenomenon [24]." As new understandings and patterns were detected across the dataset, new themes were added, and existing themes deleted and refined [25]. At this stage, the COM-B model and TDF were not used as coding frameworks; codes and themes were developed solely from the interview data. We monitored for thematic saturation throughout data collection and stopped recruiting participants when two consecutive interviews produced no new themes relevant to our research questions and instead only reflected existing themes (i.e., theme saturation). This indicated that our sample size was

sufficient for our research objectives. The final themes and sub-themes, once identified, were then mapped to a table consisting of the COM-B model constructs, and the TDF domains.

2.4. Theoretical Frameworks

When developing interventions to influence a target behaviour, theoretical and evidence-based frameworks should be used [26]. This study applied the COM-B model, and the TDF to understand the influences on individuals' diabetes screening participation and referral compliance. The COM-B model is at the core of the Behaviour Change Wheel, an intervention development framework based on behavioural science [27]. The COM-B model proposes that for a behaviour to occur, three necessary conditions are required: (1) capability, (2) opportunity, and (3) motivation [28].

Building upon the COM-B model, the factors that influence referral compliance may be described by the TDF. This framework consists of 14 domains that were derived from the integration of 33 behavioural change theories [29]. The 14 domains of the TDF are: 'knowledge', 'skills', 'social/professional role and identity', 'beliefs about capabilities', 'optimism', 'beliefs about consequences', 'reinforcement', 'intentions', 'goals', 'memory, attention and decision processes', 'environmental context and resources', 'social influences', 'emotions' and 'behavioural regulation' [30]. The TDF's 14 domains may be mapped onto the COM-B components of capability, opportunity, and motivation, providing an understanding of factors that are likely to influence behaviour change and informing the development of interventions [31].

Previous studies used the COM-B and TDF to help understand the barriers and facilitators to screening women with gestational diabetes for T2D [27], diabetes health behaviours [32], and the development of interventions to address other health issues [33].

3. Results

The ten interviews conducted were between 19 min and 62 min in duration, with a mean length of 33 min. Male and female gender were equally represented in the sample. Three participants attended dental practices in rural locations and seven visited metropolitan locations. Seven participants were categorised as high risk of developing diabetes, three were in the intermediate-risk category, and all were referred for medical follow-up. Six of the participants did not attend medical follow-up. The characteristics of the study population are presented in Table 1.

Table 1. Participant Characteristics.

Participant	Gender	Age	Rural/ Metro	AUSDRISK Risk Category	Results Received by OHP *
1	Male	51	Metro	High	No
2	Female	73	Rural	High	No
3	Female	69	Metro	High	Yes
4	Female	62	Metro	High	Yes
5	Male	53	Metro	High	No
6	Male	48	Rural	High	No
7	Female	80	Metro	High	Yes
8	Female	59	Metro	Intermediate	No
9	Male	52	Metro	Intermediate	Yes
10	Male	44	Rural	Intermediate	No

*: OHP—oral health professional.

The initial step in developing an intervention is to understand the behaviour that needs to change. This begins with describing the problem that the intervention seeks to address in behavioural terms [34]. The objective of this study is to increase the number of individuals that complete all steps in the screening pathway; thus, the target behaviour selected for this study was as follows: all individuals identified at an elevated risk of developing PD and T2D attend medical follow-up to determine their glycaemic status.

The Action, Actor, Context, Target, Time (AACTT) framework (Table 2) was then used to specify the target behaviour. This framework is a key step in identifying who needs to do what differently, modifiable barriers and facilitators regarding the behaviour, and the intervention development needed to address these [35].

Table 2. Target Behaviour: An individual who screens positive attends medical follow-up (GP) to determine diabetes status.

Action	**Screen Positive Individual Complies with Referral Advice and Attends GP**
Actor	Dental patient who screens positive in diabetes risk assessment
Context	Private dental setting
Target	Dental patient who screens positive in diabetes risk assessment
Time	Within 6 months of referral from an OHP

Following the specification of the target behaviour, an analysis was undertaken to understand the key influences on referral compliance behaviours using data generated from the interviews. The final themes and sub-themes, once identified, were then mapped to a table consisting of the COM-B model constructs and the TDF domains. The key inductive themes and subthemes generated were then individually deductively mapped onto the COM-B model and TDF domain [28]. The themes and subthemes for the target behaviour, mapped to their COM-B constructs and TDF domains, are summarised in Table 3.

Table 3. Themes, subthemes, COM-B components and TDF domains for referral compliance.

Themes	**COM-B Constructs**	**TDF Domains**
1. Accepting the screening invitation 1.1. Diabetes knowledge: complications 1.2. Diabetes is a very serious condition 1.3. Attitude to disease prevention 1.4. Perception of the OHP's role 1.5. OHP's endorsement of screening	Psychological capability Reflective motivation and social opportunity Automatic motivation	Knowledge Beliefs about consequences Beliefs about capabilities Social influences Social/professional role and identity Emotions
2. The screening protocol 2.1. The risk assessment tool is acceptable 2.2. Waist measurement creates discomfort 2.3. Too many steps in the screening pathway	Physical opportunity Reflective motivation Automatic motivation	Environmental context and resources Beliefs about capabilities Emotions
3. Diabetes risk discussion 3.1. Diabetes knowledge: risk factors 3.2. Misunderstood the risk result 3.3. OHPs risk communication 3.4. Perceived susceptibility to diabetes	Psychological capability Reflective motivation	Knowledge Memory attention and decision processes Beliefs about consequences Beliefs about capabilities
4. Attending medical follow-up 4.1 Misunderstood the referral process 4.2. Difficult to make a GP appointment 4.3 Receiving reminders encourage action	Psychological capability Physical opportunity	Knowledge Memory, attention and decision processes Environmental context and resources

Thematic analysis of participant interviews found the following themes related to the participants' diabetes knowledge, their decision to accept the screening invitation and

participate, their interpretation of the risk result, and their completion of the screening pathway by attending their GP for a confirmatory result.

1. Accepting the Screening Invitation

1.1. Diabetes knowledge: complications (COM-B construct: psychological capability; TDF domain: knowledge).

Hyperglycaemia results in diabetes-related complications, and many of the participants correctly indicated that foot, limb and eye problems were complications related to diabetes.

> *"Can cause all sorts of bad health problems. I think to do with heart disease . . . having problems with their limb, extremities, and stuff like that."* P10

However, none of the participants in this study was aware of the relationship between diabetes and oral health prior to their involvement in the diabetes screening.

> *"I've never associated dental health with diabetes before."* P8

1.2. Diabetes is a very serious condition (COM-B constructs: psychological capability and automatic motivation; TDF domains: knowledge, beliefs about consequences and emotions).

All participants agreed that diabetes is a serious condition, which adversely impacts an individual's overall health.

> *"Diabetes is a horrible disease. . . . What it does, it takes you down slowly."* P5

1.3. Attitudes to disease prevention (COM-B construct: reflective motivation; TDF domains: beliefs about consequences and beliefs about capabilities).

For some participants, the decision to undertake the diabetes screening and attend the follow-up provided an opportunity to prevent or delay the onset of diabetes, or at least mitigate the consequences of developing the condition.

> *"If I don't do something about it, sooner or later, then probably something like diabetes, you know, might become a reality in the future."* P10

1.4. Perception of OHPs' responsibilities (COM-B construct: social opportunity; TDF domain: social/professional role and identity).

Some of the screening participants were surprised that a diabetes screening was being offered in the dental setting.

> *"It's a little bit outside of their usual lane. It was a little bit surprising."* P10

> *"You don't . . . walk into a dentist to order milk."* P5

Despite their surprise, several participants viewed an opportunistic diabetes screening in the dental setting as a convenient and valuable additional service.

> *"I . . . get my new glasses, and they give me a hearing screening. What's an optometrist doing screening my hearing? Well, it makes sense. You're already in a little booth, they can claim . . . it back on Medicare, and that'll offset the cost of my other appointment. Fine. Job done. So, I don't think it's that weird. It's better a dentist screens for diabetes."* P1

1.5. OHP's endorsement of screening (COM-B construct: reflective motivation; TDF domain: social influences).

For several participants, the OHP's recommendation of screening influenced their willingness to proceed with the diabetes risk assessment and comply with referral advice.

> *"If a doctor or a specialist says, 'look I want you to do this'. I will I'll go and do it."* P6

Additionally, for some participants, the primary reason for undertaking the diabetes risk assessment was to support medical research (COM-B construct: automatic motivation; TDF domain: emotions).

> *"When it comes to studies . . . I'm quite happy to do my bit to sort of contribute to the knowledge out there. And if that results in improvements for whether it's me or anyone else . . . I'm happy to help."* P6

2. The Screening Protocol

2.1. Risk assessment tool is acceptable (COM-B construct: physical opportunity; TDF domain: environmental context and resources).

All participants indicated that the AUSDRISK tool was convenient, quick and easy to complete as part of a routine dental visit (COM-B constructs: physical opportunity; TDF domain: environmental context and resources).

> *"No, I thought it was pretty easy. I don't think it was very hard."* P5

2.2. The waist measurement may cause discomfort (COM-B construct: automatic motivation; TDF domain: emotions). The AUSDRISK screening tool requires the measurement of an individual's waist, and some participants suggested there was potential for discomfort and embarrassment when having this performed in a dental setting by an OHP.

> *"It felt unusual, but because I had known them for . . . many years . . . I was comfortable with it. But it did seem a bit strange."* P8

2.3. Screening pathway has too many steps (COM-B construct: physical opportunity; TDF domain: environmental context and resources).

While acknowledging the ease of undertaking the risk assessment, most of the participants believed there were too many additional steps required to complete the screening pathway and obtain a diagnosis.

> *"It's a pain . . . because you got to get the doctor's appointment. Then they've got to give you a blood test. Then you got to go get a blood test. Then you got to wait for the results. Half the time they don't ring you back for the results. So, you do all the running around. Right? And you've got no result. It's a lot of work to get a result, isn't it?"* P5

3. The diabetes risk discussion

3.1. Incomplete diabetes knowledge: risk factors (COM-B construct: psychological capability; TDF domain: knowledge).

Overall, participants demonstrated incomplete knowledge of the pathogenesis of T2D and its risk factors and complications. Many correctly identified excess weight, sedentary behaviour and a family history of diabetes as risk factors. However, most participants incorrectly believed that a suboptimal, high-carbohydrate diet was a key contributor to developing diabetes. Notably, none of the participants identified older age, a history of gestational diabetes, PD, or cardiovascular disease as factors that increase the risk of developing T2D.

> *"I guess lifestyle practices. Lack of exercise, diet. Too much sugar, too much carbs, I suppose. That's about it."* P2

3.2. Perceived susceptibility to diabetes (COM-B construct: reflective motivation; TDF domain: beliefs about consequences).

A common belief amongst participants was that, despite the risk assessment result, they perceived themselves at a low risk of developing T2D.

"And I don't feel that I'm in risk of diabetes. Of course, I didn't know if people are at risk of diabetes, they feel it, or they see the signs." P6

This perceived invulnerability to T2D was influenced by many of the participants reporting that they felt well and had no signs or symptoms of illness. Therefore, investigating their diabetes status was not a priority and they could justify delaying medical follow-up.

"That's the problem I've got no symptoms so why I should take time out of my day spend my hard-earned cash on something I've got no symptoms for?" P1

3.3. Misunderstood the risk result (COM-B construct: reflective motivation; TDF domain: memory, attention and decision processes).

Notwithstanding all participants screening positive (intermediate risk/high risk for diabetes) and medical follow-up being indicated, there was a misunderstanding amongst several participants regarding their risk score result and what it meant.

"I guess it's because my result was borderline . . . it's probably preferable for me to punish myself with diet and lose five kilograms, than it is to spend an afternoon in the GP's waiting room." P10

3.4. Risk discussion with OHP (COM-B constructs: reflective motivation and psychological capability; TDF domains: belief about consequences and memory, attention and decision processes).

Several participants could not recall receiving the results of their risk assessment despite being referred by their OHP for medical follow-up.

"I don't think I ever got a result. No, I've never had any feedback." P3

The language the OHP chose to convey the test result and referral recommendation influenced the participants' decision to comply with the referral advice or not. Some participants commented that the OHP did not convey a sense of urgency to follow-up, nor did they set a specific timeline, resulting in the individual delaying making an appointment.

"Now if he said 'Hey, you got a high likelihood of diabetes . . . in five years time all your teeth are going to fall out.' Oh, . . . maybe I better do something about that." P1

Furthermore, some participants recalled little or no discussion explaining the steps in the screening pathway.

"Ah, how's this going to work? And I don't recall her explaining anything." P4

4. Attending medical follow-up

4.1. Misunderstanding the referral process (COM-B construct: psychological capability; TDF domains: knowledge and memory, attention and decision processes).

Many study participants misunderstood or could not recall the steps following completion of the risk assessment and the referral process. Two participants, for example, believed their risk assessment results would be directly provided to their GP and were surprised when their GP did not act upon the information at subsequent visits.

"And I've been back to my GP since then, half a dozen times. She's never highlighted this. And also, I haven't even thought to ask her about it." P1

4.2. Difficult to arrange a GP appointment (COM-B construct: physical opportunity; TDF domain: environmental context and resources).

Some of the participants reported difficulty accessing GPs, and frustration at the time spent in the waiting room for appointments, as a barrier to complying with the referral advice.

> *"It's generally pretty hard to get into the GP, and my GP is always running behind. So that's part of the reason you avoid going there. Because you know, you're going to spend upwards of 45 min in the waiting room every time you go."* P10

Many participants complained that the reduced number of GP clinics offering bulk-billed (healthcare at no cost) appointments was a disincentive to attend.

> *"It would be difficult getting an appointment, and also difficult financially . . . because a lot of GPs aren't bulk billing at the moment."* P8

Several participants believed paper referrals were an outdated modality and were a barrier to them seeking follow-up.

> *"Well referral letter, is very 1980s. There's a thing called the internet and email now. So why make me carry around the piece of paper?"* P1

4.3. Receiving reminders encourage action (COM-B construct: psychological capability; TDF domain: memory, attention and decision processes).

Although study participants offered many reasons for delaying a follow-up appointment with their GP, most participants suggested that receiving prompts from their OHP, would increase their referral compliance.

> *"So, maybe the dentist could say in six months . . . 'Oh, by the way remember what you filled in last time, did you follow that up?'"* P4

A summary of the barriers and facilitators to complying with referral advice and completing the screening protocol are summarised in Table 4.

Table 4. Barriers and facilitators to completing the screening pathway.

Barriers to Completing the Screening Pathway	Facilitators to Complete the Screening Pathway
Incomplete awareness and knowledge of diabetes	General awareness that diabetes is a very serious disease
Inaccurate risk perception	Positive attitude to disease prevention
** OHP's risk and referral communication ambiguous	OHP's endorsement of screening
Misunderstanding the screening protocol	Screening tool is acceptable
Waist measurement required	Receiving reminders to attend medical follow-up
Too many steps in the screening pathway	
Difficulty making a * GP appointment	

* GP—General Medical Practitioner, ** OHP—oral health professional.

4. Discussion

Diabetes screening in the dental setting is not a single test but a multistep pathway that ultimately requires attendance at a GP for confirmatory diagnosis. This qualitative study applied the COM-B model and the TDF to identify factors influencing patients' compliance with referral advice following a diabetes risk assessment. We identified factors affecting patients' ability, opportunity, and motivation to complete the screening protocol.

Recognition that diabetes is a serious condition, and awareness of the consequences of delayed detection facilitated the decision to accept the screening invitation and attend medical follow-up (COM-B: psychological capability, reflective motivation; TDF: knowledge, beliefs about consequences). The perceived severity of a condition is a known determinant of preventive action [36], and belief in one's ability to influence health outcomes through a proactive attitude towards disease prevention and viewing screening as an opportunity to mitigate future health risks are also associated with higher screening participation [37].

Conversely, a fatalistic outlook, in which individuals view outcomes as predetermined and unchangeable, is often associated with lower screening completion rates [38].

The endorsement of screening by OHPs was also an important enabler of referral compliance (COM-B: social opportunity; TDF: social influences). Research indicates that a recommendation from a healthcare professional (HCP) can be a decisive factor influencing patients' willingness to participate in a screening [39]. Following the HCP's advice may reduce decisional conflict [40] and the associated psychological distress when individuals are faced with multiple options [41].

Because this screening occurred in a research context, several participants reported that they undertook the risk assessment primarily to support the study (COM-B: automatic motivation; TDF: emotions). Altruistic motives—such as contributing to scientific knowledge or helping others—are recognised facilitators of research participation [42]. This may explain why some individuals completed the initial risk assessment but did not proceed with subsequent steps to confirm their glycaemic status.

Although many participants were initially surprised to be offered a diabetes screening in a dental setting, all supported its inclusion (COM-B: social opportunity; TDF: social influences). Several also highlighted the convenience of integrating the screening into routine dental visits (COM-B: physical opportunity; TDF: environmental context and resources). All participants reported that the risk assessment tool was easy to use (COM-B: physical opportunity; TDF: environmental context and resources, beliefs about capabilities), consistent with previous studies suggesting that most people consider diabetes screening during dental consultations to be acceptable and beneficial [10]. Effective screening programmes require tests that are quick, simple, convenient, low-cost, and minimally intrusive [43]. While some participants expressed discomfort with the waist measurement (COM-B: social opportunity; TDF: social influences), they accepted it once its purpose was explained, consistent with findings from prior research [44].

The risk assessment is only the first step in the diabetes screening protocol. The need to attend additional locations (GP practices and pathology services) to complete the pathway (COM-B: physical opportunity; TDF: environmental context and resources) was identified as a deterrent to referral compliance. Many participants advocated reducing the number of steps required, thereby simplifying the process and improving the likelihood that they would complete it. The inconvenience associated with the multistep protocol has previously been identified as a barrier to referral compliance [45], indicating that streamlining the screening process and providing clear guidance on each step could enhance participant compliance and satisfaction.

Most participants did not perceive themselves as at risk of diabetes before screening, as they were asymptomatic and generally regarded themselves as healthy. Limited knowledge of diabetes risk factors (COM-B: psychological capability; TDF: knowledge) likely contributed to this underestimation. Evidence indicates that public understanding of diabetes risk factors is often inaccurate and incomplete [46]. While overweight status and family history are commonly recognised as increasing risk, other factors—such as cardiovascular disease—are rarely associated with elevated personal risk [47]. Such misperceptions present a barrier to referral compliance, as accurate risk perception is a key determinant of health-seeking behaviour [48]. This highlights the need for targeted educational initiatives that address common myths and provide comprehensive information on diabetes risk factors.

Many participants misunderstood their high or intermediate risk results and their implications (COM-B: reflective motivation; TDF: beliefs about consequences). Eborall et al. found that individuals in stepwise diabetes screening programmes tend to minimise their personal risk even after receiving a positive result [49]. Several participants

reported that OHPs' communication around risk and referral lacked clarity, urgency, and specific timelines, which contributed to delays in arranging medical follow-up (COM-B: reflective motivation; TDF: beliefs about consequences). The content and tone of risk discussions can substantially shape patients' risk perceptions and engagement in preventive behaviours [50]. Effective communication should not only convey information but also prompt action [51] and help individuals manage uncertainties, for example by explaining procedures or addressing concerns about screening results [52]. Inadequate communication may create uncertainty about both the diagnosis and the recommended actions [41].

In addition, many participants perceived the screening process as confusing or overly complex (COM-B: psychological capability; TDF: memory, attention, and decision processes). To act on referral advice, patients must understand and retain the information provided [53]. Ambiguity about the objectives and steps of the screening pathway can undermine programme effectiveness [54]. Furthermore, several participants reported no recollection of any discussion about the screening steps or their risk assessment results (COM-B: psychological capability; TDF: knowledge; memory, attention, and decision processes). Previous research in oral health settings has similarly documented poor patient recall of information given by OHPs [55], which may contribute to uncertainty about screening outcomes and required follow-up.

Within the diabetes screening pathway, GPs are responsible for confirming glycaemic status. Participants identified consultation costs, difficulties scheduling appointments, and long waiting times as major barriers to attending a GP appointment (COM-B: physical opportunity; TDF: environmental context and resources). Although GPs are the most frequently accessed healthcare providers in Australia [56], limited appointment availability and booking delays are commonly reported obstacles [57]. Several participants were reluctant to incur the consultation fees for the follow-up, consistent with national data showing a recent increase in cost-related delays or avoidance of GP visits [56]. This, together with the misalignment between perceived and actual risk, can further delay seeking medical follow-up.

This study adds to the limited research exploring the determinants of referral non-compliance following a diabetes screening. Nonetheless, the present findings are consistent with a study of chronic disease screening in Singapore, which identified several barriers to medical follow-up, including a lack of awareness of the health consequences, financial costs, the absence of symptoms, competing priorities, and difficulties in communication and scheduling an appointment [58]. On the other hand, unlike several studies exploring disease screening uptake [48,54], fear of diagnosis was not reported as a barrier to referral compliance amongst our study participants.

Awareness campaigns have been shown to heighten interest in diseases [59], increase screening participation [60], and encourage adoption of preventive behaviours [61]. Based on the patients' interview data, interventions aimed at enhancing awareness of diabetes prevention and early detection through targeted informational initiatives could focus on educating patients about their eligibility for screening and the benefits of early detection.

Interviews reveal that patients felt comfortable with technology. Therefore, developing written or web-based Patient Decision Aids can enhance shared decision-making, and improve patients' understanding and risk perception [62]. Patient Decision Aids have been shown to reduce decisional conflict [63], strengthen patient–clinician communication, increase health-related knowledge, and improve satisfaction with care [64].

Additionally, replacing handwritten with electronic referrals can minimise delays, prevent documentation loss, and improve workflow efficiency [65]. Simplifying the referral process is essential for enhancing referral compliance among individuals who screen

positive for diabetes, and electronic referrals can also improve patients' overall experience of the referral pathway [66].

Employing patient navigators, such as dental nurses or reception staff, can guide individuals through the referral process, strengthen self-efficacy, and help ensure the referral loop is closed [67]. Navigation programmes have been shown to significantly improve screening uptake [68]. Finally, automated reminders via electronic health records, supplemented by letters, text messages, and phone calls, can improve referral compliance [69] and increase disease screening rates [70].

Strengths and Limitations of Current Study.

The current study contributes to filling a notable evidence gap. Few studies have examined factors affecting referral compliance after diabetes screening in primary care, and none have explored this in dental settings regarding the barriers and facilitators to medical follow-up. Our approach's strength lies in using a theory-informed methodology to identify factors influencing referral compliance in patients at high risk of T2D in dental settings. The COM-B behavioural model and TDF helped us explore these factors, providing a basis for future interventions to improve referral compliance.

Although this study provides valuable insights into referral compliance, participants were all residents from the Australian state of Victoria, which may limit the applicability of the results to other jurisdictions. Additionally, there are important contextual factors that substantially limit the transferability of these findings to routine clinical screening. For example, several participants reported taking part at least partly to support the research, so their motivations may not reflect those of individuals undergoing opportunistic clinical screening. Consequently, the generalisability of our findings is impacted, as diabetes screening within a research context may differ from screenings offered in primary care. Interviewing patients retrospectively about a multistep screening pathway is also likely to introduce recall bias. Furthermore, the current study recruited individuals whose diabetes screening occurred during the COVID-19 pandemic and its aftermath. The pandemic affected every aspect of life, and studies investigating its effect on emotional wellbeing and cognition have reported subjective memory impairments and distortions in sense of time [71]. Autobiographical memory is the capacity to recall personal experiences and situate them within one's life history [72], and the pandemic's effect on memory and recall must be considered and may affect the reliability of our results. Future studies could further refine transferability to routine clinical screenings and more clearly characterise determinants specific to non-attendance and non-compliance. This could include different population demographics, healthcare systems, or clinical practice settings.

However, while this study may have had limitations, richly textured responses were received from participants with varied demographic backgrounds and data adequacy was achieved. Use of the COM-B and TDF in oral health research remains limited, with most studies focusing on OHPs' behaviours, and rarely are both frameworks applied together. This study used COM-B and TDF in combination to provide an in-depth behavioural analysis of patients' referral compliance following a diabetes screening in a dental setting, offering insights that could inform future diabetes screening pathways.

5. Conclusions

Referral compliance barriers occur at multiple levels, including patients, OHPs, GPs and the broader health system. This study focused on patient-related factors, identifying gaps in diabetes knowledge, limited recall of screening information, inaccurate risk perception, and difficulties accessing GPs as key contributors to non-compliance. This thematic analysis of participant interviews provides valuable insights into the complexities surrounding diabetes screening in a dental setting. The findings reveal a multifaceted interplay of

knowledge, beliefs, and systemic barriers that influence individuals' decisions to accept screening invitations, interpret risk results, and complete the necessary follow-up with general practitioners (GPs). By linking these themes to the COM-B model constructs and the Theoretical Domains Framework (TDF), we can better understand the psychological and contextual factors that shape health behaviours related to diabetes screening.

Several strategies and further research are recommended to address these barriers and enhance patients' psychological capabilities, reflective motivation, and physical opportunities that allow them to successfully engage in diabetes screening and complete the referral pathway. These efforts will also enhance the transferability of the findings and strengthen the evidence base underpinning the recommendations.

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Abbreviations

The following abbreviations are used in this manuscript:

COM-B	Capability, opportunity, motivation–behaviour
GP	General medical practitioner
HCP	Healthcare professional
OHP	Oral healthcare professional
PD	Prediabetes
T2D	Type 2 diabetes
TDF	Theoretical domains framework

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