Original Research

Access to and Waiting Time for Psychiatrist Services in a Canadian Urban Area: A Study in Real Time

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Objective: To obtain improved quality information regarding psychiatrist waiting times by use of a novel methodological approach in which accessibility and wait times are determined by a real-time patient referral procedure.

Method: An adult male patient with depression was referred for psychiatric assessment by a family physician. Consecutive calls were made to all registered psychiatrists (*n* = 297) in Vancouver. A semistructured call procedure was used to collect information about the psychiatrists' availability for receipt of this and similar referrals, identify factors that affect psychiatrist accessibility, and determine the availability of cognitive-behavioural therapy (CBT).

Results: Efforts were made to contact 297 psychiatrists and 230 (77%) were reached successfully. Among the 230 psychiatrists contacted, 160 (70%) indicated that they were unable to accept the referral. Although 70 (30%) indicated that they might be able to consider accepting a referral, 64 (91% of those who would consider accepting the referral) indicated that they would need to review detailed, written referral information and could not provide estimates of the length of wait times if the patient was to be accepted. Only 6 (3% of the 230 psychiatrists contacted) offered immediate appointment times and their wait times ranged from 4 to 55 days. When asked whether they could provide CBT, most (56%) psychiatrists in clinical practice answered maybe.

Conclusions: Substantial barriers exist for family physicians attempting to refer patients for psychiatric referral. Consolidated efforts to improve access to psychiatric assessment are needed.

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Clinical Implications

- Family physicians are likely to experience significant barriers to accessing psychiatric assessment and treatment.
- Changes in referral procedures and psychiatric patterns of practice may be needed to improve access.
- Difficulties in referral procedures and access to psychiatrists may lead to delayed treatment, lost opportunities for early intervention, and poor outcomes.

Limitations

- Inability to determine wait times for those psychiatrists who required additional information to determine whether or not they would accept the referral.
- Findings may not be representative of other urban regions in Canada and cannot be considered relevant to nonurban areas.
- Findings may be limited on the basis of the specific age, sex, and diagnosis of the referred patient.

Key Words: *treatment access, wait times, psychiatry, mental health care, policy, practice, Canada*

Access to psychiatrist services in Canada is the subject of concern as evidenced by the findings of the most recent National Physician Survey.[1] When asked to indicate whether access to psychiatrists is excellent, very good, good, fair, or poor, Canadian family physicians most often rated access to be poor.[1] Access to psychiatrists was rated to be worse than to all other specialists addressed in the survey, including orthopedic surgeons and opthalmologists.[1] Similar concerns were found in a study undertaken in Ontario, in which family physicians and patients reported that they were frustrated by long waiting lists and communication barriers when seeking psychiatric assessment and treatment.[2] However, efforts to document information about access to and waiting times for psychiatrist services in Canada have been limited by the use of survey methods that obtain low response rates.

Results of the National Psychiatry Waiting List Survey, conducted by the Fraser Institute in 2009, indicate that the median waiting time to see a psychiatrist following referral by a family physician was reported to be 2.0 weeks for urgent referrals and 7.0 weeks for elective referrals.[3] The response rate was low at 11% (n = 458) and it is unknown whether or not the survey respondents differ significantly from most psychiatrists regarding their waiting times and patterns of practice.[3]

Another survey of waiting times was commissioned by the Canadian Waiting Time Alliance and conducted by a market research company, Ipsos Reid.[4] An online survey instrument was used to collect information from psychiatrists as well as 10 other specialist groups.[4] Psychiatrists reported a median waiting time of 5.7 weeks for people with MDD from the date of referral by a family physician to the date in which they were seen by the psychiatrist.[5] A response rate of 14.6% was reported for the survey.[5]

Owing to the low response rates obtained in these surveys, it remains unclear whether the survey findings provide representative estimates of waiting times for psychiatrists. In our study, we aim to improve the quality of information obtained regarding psychiatrist waiting times by use of a novel methodological approach in which accessibility and wait times are determined by a real-time patient referral procedure.

Method

To undertake the study, we engaged the assistance of a group family physician practice, securing the agreement of family physicians to participate in the study by referring a patient judged to require psychiatric assessment and (or) treatment to the study. Our research protocol specified that the first patient identified by one of the family physicians to require psychiatric assessment and (or) treatment would immediately be enrolled in the study, if they agreed to participate. Both the family physicians and the identified patient provided informed consent. For purposes of confidentiality, information provided by the family physician's office to the research team was restricted to the patient's age, sex, provisional diagnosis, and the municipality in which the patient was residing. The patient was referred to the study in January 2010—a 39-year-old male with a provisional diagnosis of MDD, residing in Vancouver. Once the patient was identified, our research assistant undertook the task of contacting psychiatrists to request an assessment, replacing the usual procedure of the group family physician practice, in which a medical office assistant would contact one or a few psychiatrist offices to undertake the referral. The research protocol was approved by the Simon Fraser University Research Ethics Board, application No 38676.

The research assistant attempted to contact all psychiatrists (n = 297) listed in the College of Physicians and Surgeons of British Columbia medical directory to be in practice within the Vancouver area. Telephone calls were made to all psychiatrists listed in the directory over a 4-day period (January 11 to 14, 2010). The research assistant was able to reach 171 (58%) psychiatrists or medical office assistants by telephone on the first attempt; messages were left for the remainder indicating a referral request. The research assistant responded to all telephone calls returned by psychiatrists or medical office assistants over the subsequent 4 days using a dedicated telephone line. An additional 3-week period was provided to receive a response and undertake additional telephone calls to offices that had not yet responded (until February 8, 2010) providing the study with a 4-week data collection window. A semistructured call procedure was used to collect information about the psychiatrists' availability for receipt of referrals, obtain estimates of waiting times for assessment of the patient being referred, and identify factors that affect psychiatrists' accessibility. Additional information was collected regarding the availability of CBT—a form of psychotherapy found to be effective in the treatment of common mental disorders, including MDD. We recorded the number of telephone calls to psychiatrists' offices that were initiated by the research assistant to successfully establish contact.

Abbreviations

CBT	cognitive-behavioural therapy
MDD	major depressive disorder

Results

A total of 297 psychiatrists were listed in the directory and repeated efforts were made to contact each of their offices. Among the 297 psychiatrists listed, we were able to contact 230 (77%); whereas 67 (23%) psychiatrists could not be reached either owing to incorrect telephone listings or a lack of response to multiple messages left by our research assistant over the full 4-week period. Table 1 summarizes information regarding the number of telephone calls made in our efforts to contact as many offices as possible during the data collection period. A total of 521 calls were made and either 1 or 2 calls were required to reach most psychiatrist

offices. In counting the number of calls, we included busy signals, voice mail (in which case a message was left), and calls in which we were able to speak with the psychiatrist or medical office assistant. Most of the calls resulted in being able to speak to the psychiatrist or medical office assistant (69%), whereas 18% led to the research assisting leaving a voice mail message. Busy signals were encountered 3% of the time.

Figure 1 summarizes results regarding accessibility of the 297 psychiatrists and their availability to accept the referral that was requested.

Psychiatrists Unable to Accept the Referral

Among the 230 psychiatrists successfully contacted, 160 (70%) indicated that they were unable to accept the referral; 17 (7%) indicated that their clinical practices were permanently closed; 10 (4%) were not in clinical practice and undertook research, administrative, or other activities instead; whereas 7 (3%) stated that high referral volumes led them to close their practices. Thus 143 psychiatrists indicated that their clinical practices were not closed but they were unable to accept the referral (Table 2).

The 143 psychiatrists whose practices were not permanently closed were also asked to estimate wait times that could be anticipated once they were accepting referrals in the future; 97 of the 143 declined to provide an answer. Among the 46 that did answer this question, well over one-half only provided service to special groups of patients. Anticipated wait times were generally long whether the psychiatrist saw a limited group of patients or did not specialize, but tended to be a bit longer for the no specialization group. Table 3 presents the results.

The 143 psychiatrists that were not able to accept the referral were also asked, once they were accepting referrals, whether there were specific types of patients that they were able to accept. Among the 143 psychiatrists, 103 (72%) psychiatrists were specializing in certain types of patients other than our sample patient and would thus not have considered seeing the particular patient in any case.

Psychiatrists Potentially Able to Accept the Referral

Among the 230 psychiatrists that we initially contacted, 70 (30%; or 24% of the 297 psychiatrists listed in the medical directory) responded that they may be able to accept the referral. If psychiatrists indicated they were able to see the patient, they were asked when the earliest available appointment could be booked. Most (64 of the 70 or 91%) would not commit to a date and indicated that they would get back to the patient (or our office) at a later date following receipt of a faxed referral form. Some of the psychiatrists worked in agencies that provided treatment to people who lived in specific catchment areas within Vancouver and would not consider referrals from outside of these areas. The 6 psychiatrists (9%) who would provide firm dates had a median waiting time of 4.5 weeks. Two could see the patient within the week (in 4 or 7 days). The other 4 had waiting times for an earliest appointment of 27, 46, 49, or 55 days. The mean waiting time for these 6 psychiatrists was thus 31 days. The patient was able to accept 1 of the 2 appointments available within the week and the appointment was successfully booked.

Table 4 summarizes the responses obtained from the 230 psychiatrists or medical office assistants that were reached regarding the availability of CBT.

Table 1 Number of telephone calls required

Calls made, *n*	Psychiatrists, *n*	%	Calls, *n*
0[a]	14	5	0
1	116	39	116
2	120	40	240
3	30	10	90
4	13	4	52
5	1	0	5
6	3	1	18
Total	297		521

[a] The telephone numbers listed in the medical directory were not in service.

Table 2 Reasons provided for inability to accept referral

Area of specialization	Psychiatrists, *n*	% (of 113)
Inpatients	23	20
Women	11	10
Children and adolescents	30	27
Geriatric patients	8	7
Specific diagnoses	19	17
Medical, legal, forensics	8	7
Other[a]	14	12
Total with information	113	
Total not able to accept patient	160	

[a] Includes university or college students or staff, emergencies (that is, suicidal ideation), group psychotherapy, Cantonese-speaking, Farci-speaking, second opinions and veterans, and police or emergency responders.

Discussion

Our study provides evidence to support concerns regarding the unacceptable status quo in access to mental health care[6] and indicates that there is a wide range in the wait times associated with individual psychiatrist practices. Some opportunities may exist to access prompt psychiatric assessment; however, it is very challenging for family physicians to find these. Perhaps not quite as tricky as finding a needle in a haystack, family physicians would nevertheless need to allocate unreasonably large amounts

Figure 1 Summary of availability of psychiatrists to accept referral

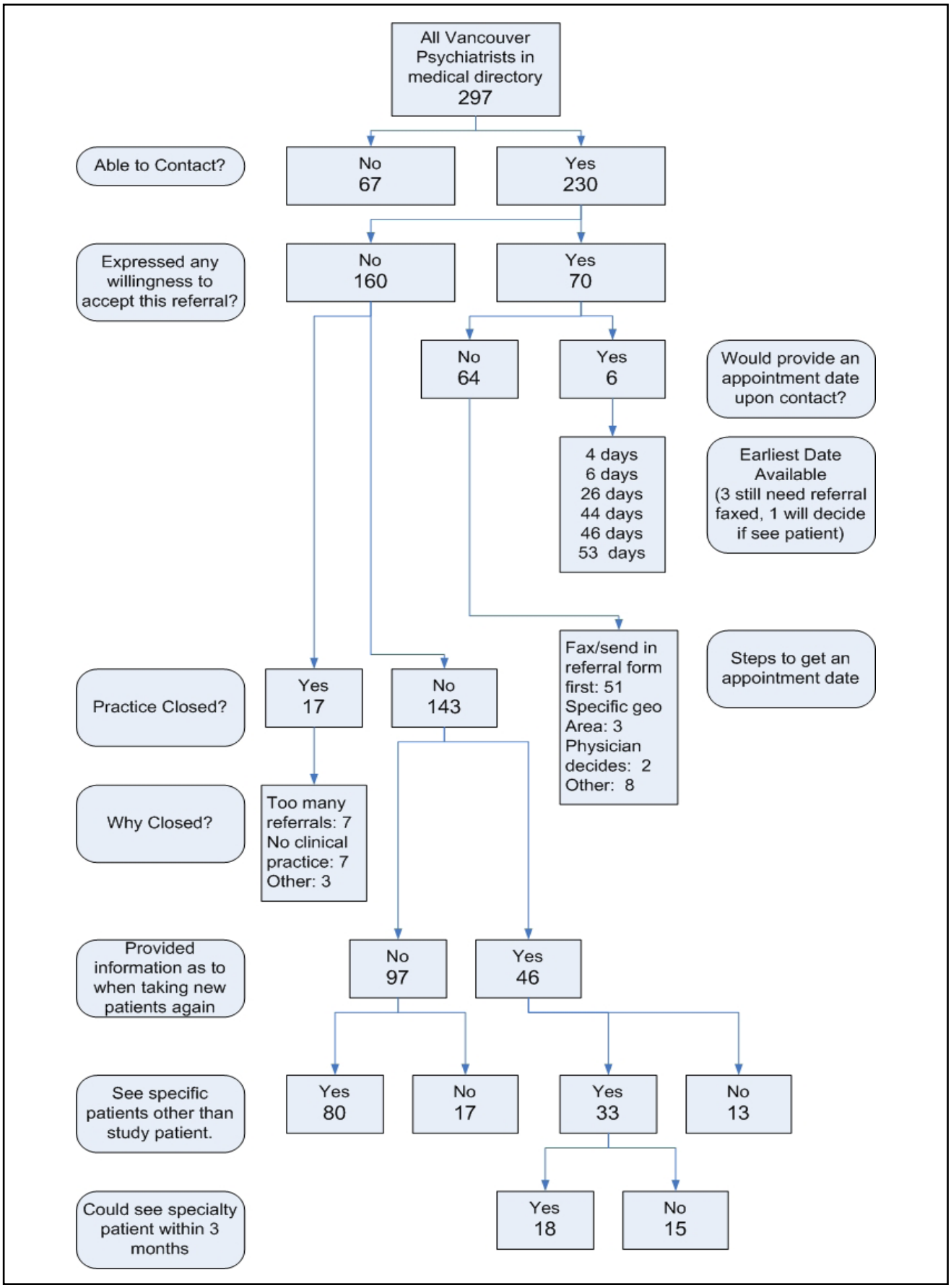

Table 3 Estimates of wait times given

Wait time	Specialty area: Yes		Specialty area: No	
See new patient in:	*n*	%	*n*	%
<1 month	5	15%	0	0%
1 to 3 months	13	39%	3	23%
3 to 6 months	4	12%	5	38%
6 to 9 months	7	21%	1	8%
9 to 12 months	2	6%	2	15%
>1 year	1	3%	2	15%
n/a[a]	1	3%	0	0%
Total	33		13	

[a] A psychiatrist that only does consultations

Table 4 Availability of CBT

Provide CBT	Psychiatrists, *n*	% (of 213)
Yes	59	28
Yes (limited)	6	3
Maybe	119	56
No	21	10
Not answered	8	4
Subtotal	213	
No clinical practice	17	
Total	230	

of human resource time to contact psychiatrists' offices to identify any timely openings that might exist.

Less than one-third of the psychiatrists contacted would consider accepting the referral of the patient in our study. This was due, in part, to extensive subspecialization in which psychiatrists limit their practices to specific subpopulations. In view of subspecialization by psychiatrists, the findings of the study would have undoubtedly differed had a patient with different characteristics been referred. More extensive review of access and wait times for various groups is needed, for example, for children, older adults, women, and people with various diagnostic problems.

In many jurisdictions, there may be pressure for psychiatrists to address only the most complex and seriously ill patients. Thus psychiatrists may tend to decline referrals of patients with uncomplicated common mental disorders (that is, depression and anxiety disorders) with the view that they would be most appropriately served by other resources within the mental health system. Nevertheless, it is not clear that other sectors and resources are in place to provide appropriate treatment for this group. There appear to be gaps in both the policy and the services required to address the large proportion of the Canadian population who experience common mental disorders each year.[7]

Another possible barrier to access may be a concern by psychiatrists that they will be asked to provide or arrange ongoing treatment services for the referred patient, such as psychotherapy. Some psychiatrists may be reluctant to provide an appointment if they are apprehensive about expectations that family physicians may have regarding provision of ongoing care.

Family physicians report that they spend a substantial portion of their time during patient visits (26% to 50%) addressing mental health issues.[2] Indeed, health services research studies in Canada indicate that family physicians provide assessment and treatment to a large proportion of people with mental health problems[8–11] and they are more widely consulted for mental health problems than psychiatrists, psychologists, or any other group of health care providers, therapists, spiritual advisers, or practitioners.[8] When more extensive or specialized assessment or treatment is needed, family physicians look to psychiatrists. Poor access to psychiatrist services, when required, is likely to result in delayed treatment, lost opportunities for early intervention, and suboptimal clinical outcomes for a sizable sector of the population.

A simple remedy to achieve a more efficient matching of available psychiatric services involves the creation of and maintenance of up-to-date databases that could provide family physician offices with crucial information about psychiatrists' availability, areas of specialization, and patterns of practice. For example, many psychiatrists further subspecialize in assessment or treatment of particular age groups, types of mental disorder, and forms of treatment. Such information would be helpful to family physicians trying to find appropriate services. Although electronic databases with information of this type are being created in a few jurisdictions, they do not appear to have been widely developed or used.

The level of access to psychiatrists found in our study may be inflated owing to a general acquiescence by family physicians to the inaccessibility of psychiatrists and a consequent limiting of referrals for psychiatric assessment. Providing information that would help family physicians obtain easier access to timely services might result, over time, in an increased referral rate and a paradoxical lengthening of waiting times for psychiatric assessment.

To achieve more effective and robust access to and use of psychiatric assessment, many have identified the need for a more substantial restructuring of psychiatric services, applying models that provide collaborative care, integration of services, and a reconfiguration of psychiatric patterns of practice.[12–16] A systematic review of interventions to improve outpatient referrals from primary to secondary care concluded that local educational interventions involving secondary care specialists and structured referral sheets have impact on referral rates and indicated that promising practices included in-house second opinions and other

intermediate primary care-based alternatives to outpatient referral.[17]

Information regarding provision of CBT was collected in our study because family physicians sometimes seek out psychiatrists who provide particular treatments that have been found to be effective in treatment of depression and other conditions. Although psychotherapies other than CBT have been found to be effective in the treatment of depression (for example, interpersonal therapy and behaviour therapy),[18] we had to limit our question to the availability of CBT to keep to the time restraints of our research protocol. The responses obtained from the 205 psychiatrists who responded as to whether they provide CBT are difficult to interpret. The most common response was maybe and it is unclear whether the uncertainty in this response refers to potential availability that may be influenced by assessment of the psychiatrists regarding suitability of applying CBT or, instead, refers to uncertainty as to whether or not the type of treatment provided is accurately defined as CBT. More complete information would need to be obtained and analyzed to assess the availability of CBT provided by psychiatrists.

It should be noted that our study examined waiting times for psychiatric assessment in one Canadian urban centre. Clearly, the findings cannot be construed to represent the situation in rural and remote areas of the country.[19] Moreover, waiting times and access to psychiatric assessment may vary significantly among urban centres in Canada. As the delivery of health care services in Canada is organized primarily by provincial or territorial governments and medical associations, substantive differences may exist across provinces and territories in patterns of practice, referral procedures, and use of stepped care protocols. The organization of mental health service delivery has been found to differ markedly across numerous provinces in terms of characteristics such as governance, network structure, and centralization of access.[20] A study by Lesage et al[8] that analyzed data collected by Statistics Canada in a national survey found significant variations among provinces regarding human resources deployed to address mental health care. For example, in Quebec, the proportion of the population who reported seeing psychiatrists over the previous year was found to be significantly lower (1.3%; 95% CI 0.9% to 1.6%) than for all Canadian provinces (2.0%; 95% CI 1.8% to 2.2%). Conversely, the proportion of the population who reported seeing psychologists over the previous year in Quebec was significantly higher (3.9%; 95% CI 3.2% to 4.6%) when compared with all Canadian provinces. The study[8] found that use rates in British Columbia for both psychiatrists (2.0%; 95% CI 1.4% to 2.5%) and psychologists (1.7%; 95% CI 1.2% to 2.2%) did not differ significantly from rates estimated for all Canadian provinces.

Our study was not able to estimate wait times for the 64 psychiatrists who indicated that they might be able to accept the referral but who required detailed, written information to determine whether they could accept the patient and provide an appointment. Ethical considerations prevented the investigators from taking the step of providing written information, both because of the confidential nature of the patient information (which was not shared with the investigators or research assistant in the study) and because this was considered an unacceptable burden of time for psychiatrists and their medical office assistants as only 1 of 70 psychiatrists would ultimately see the study patient. Regarding ethical considerations in our study, it should be noted that the calls to the psychiatrist offices constituted a bona fide referral and the identified patient (who provided consent for participation) was referred to the psychiatrist with the shortest wait time for assessment (4 days). This is a period much shorter than the average waiting time for psychiatric assessment experienced by patients in the group family practice, and thus constituted a benefit of the study to the patient.

In conclusion, there appears to be a compelling need to examine the current interface of primary and secondary mental health care services in Canada. Despite efforts to raise awareness of these issues, and progress toward improved collaboration and efficient service delivery that have been accomplished in some jurisdictions, consolidated efforts to improve the unacceptable status quo in access to mental health care[6] are required in Canada.

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Résumé : L'accès aux services d'un psychiatre et les temps d'attente dans une région urbaine canadienne : une étude en temps réel

Objectif : Obtenir une information de meilleure qualité concernant les temps d'attente d'un psychiatre en utilisant une nouvelle approche méthodologique dans laquelle l'accessibilité et les temps d'attente sont déterminés par une procédure d'aiguillage des patients en temps réel.

Méthode : Un patient masculin adulte souffrant de dépression a été adressé par un médecin de famille pour une évaluation psychiatrique. Des appels consécutifs ont été effectués à tous les psychiatres inscrits (n = 297) à Vancouver. Une procédure d'appel semi-structurée a servi à recueillir l'information sur la disponibilité des psychiatres à recevoir ce patient et d'autres patients pareillement recommandés, à identifier les facteurs qui influent sur l'accessibilité des psychiatres, et à déterminer la disponibilité d'une thérapie cognitivo-comportementale (TCC).

Résultats : Tout a été mis en œuvre pour joindre 297 psychiatres et 230 (77 %) ont été joints avec succès. Parmi les 230 psychiatres joints, 160 (70 %) ont indiqué qu'ils ne pouvaient pas accepter le patient recommandé. Bien que 70 (30 %) aient indiqué qu'ils pourraient envisager d'accepter une recommandation, 64 (91 % de ceux prêts à envisager d'accepter une recommandation) ont indiqué qu'il leur faudrait lire l'information écrite détaillée sur le patient recommandé, et qu'ils ne pouvaient pas fournir d'estimation de la durée des temps d'attente, si le patient était accepté. Seulement 6 (3 % des 230 psychiatres joints) ont offert immédiatement des heures de rendez-vous, et leurs temps d'attente variaient de 4 à 55 jours. Lorsqu'on leur a demandé s'ils pouvaient offrir la TCC, la plupart (56 %) des psychiatres de pratique clinique ont répondu peut-être.

Conclusions : Des obstacles substantiels existent pour les médecins de famille qui tentent d'adresser des patients à des psychiatres. Il faut renouveler d'efforts pour améliorer l'accès à l'évaluation psychiatrique.