Evidence In-Sight:
SELECTED STRATEGIES TO HELP MANAGE MENTAL HEALTH SERVICE WAITING LISTS

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The following Evidence In-Sight report involved a non-systematic search and summary of the research and grey literature. These findings are intended to inform the requesting organization, in a timely fashion, rather than providing an exhaustive search or systematic review. This report reflects the literature and evidence available at the time of writing. As new evidence emerges, knowledge on evidence-informed practices can evolve. It may be useful to re-examine and update the evidence over time and/or as new findings emerge.

Evidence In-Sight primarily presents research findings, along with consultations with experts where feasible and constructive. Since scientific research represents only one type of evidence, we encourage you to combine these findings with the expertise of practitioners and the experiences of children, youth and families to develop the best evidence-informed practices for your setting.

While this report may describe best practices or models of evidence-informed programs, Evidence In-Sight does not include direct recommendations or endorsement of a particular practice or program.

This report was researched and written to address the following question(s):

- According to the literature, are advanced access, computerized cognitive-behavioral therapy, and brief services evidence-informed strategies to manage waitlists?

We prepared the report given the contextual information provided in our first communications (see Overview of inquiry). We are available at any time to discuss potential next steps.

We appreciate your responding to a brief satisfaction survey that the Centre will e-mail to you within two weeks. We would also like to schedule a brief phone call to assess your satisfaction with the information provided in the report. Please let us know when you would be available to schedule a 15-minute phone conversation.

Thank you for contacting Evidence In-Sight. Please do not hesitate to follow up or contact us at evidenceinsight@cheo.on.ca or by phone at 613-737-2297.
1. Overview of inquiry

This request is from a large, regional organization that provides a wide variety of mental health services to children, youth, and their families. Like other service providing agencies in Ontario they are struggling with managing and reducing long waiting lists for services.

Within this scenario, the mood and anxiety team is exploring options to reshape the way in which services are delivered in order to provide more efficient and timely support to clients. A preliminary search on waitlist reduction has been compiled and presented to the team outlining validated methods of triage and an ‘opt-in’ system requiring families to confirm in advance attendance to their initial appointment. Another potential strategy for a shortening wait times is the advanced access model.

The organization is asking Evidence In-Sight to conduct a literature search to confirm that the selected wait-list management approaches have evidence for effectiveness.

2. Answer search strategy

Search tools: PracticeWise database, in addition to The National Guideline Clearinghouse, Turning Research Into Practice (TRIP) database, the Campbell Library and the Cochrane library (Cochrane Database of Systematic Reviews, the Database of Abstracts of Reviews of Effects (DARE), Health Technology Assessment (HTA) database, the Cochrane Central Register of Controlled Trials (CENTRAL), the Cochrane Methodology Register (CMR) and the NHS Economic Evaluation Database (NHS EED).

3. Findings

A previous Centre policy ready paper on access and wait times provided some policy relevant information, including general recommendations. The paper can be found at:

http://www.excellenceforchildandyouth.ca/sites/default/files/policy_access_and_wait_times.pdf

To support the strategies identified by the requesting agency we limited our search to advanced access, computerized cognitive-behavioural therapy, and brief interventions.

3.1 Advanced access

Large and small primary care practices have been using an approach known as advanced access, open access or same-day scheduling to reduce wait times and delays (Murray & Berwick, 2003). This model promotes patient-driven scheduling instead of pre-arranged appointments by allowing patients to seek and receive care at the time of their choosing (Health Quality Ontario, 2011; Murray & Tantau, 2000). Advanced Access has three aims (Knight & Lembke, 2013):

- start the day with enough appointments to meet demand that day
- reduce restrictions on making future appointments
- prioritize continuity (improving outcomes and reducing demand)

Proponents of advanced access suggest that it can reduce wait times and improve continuity of care and non-attendance rates (Health Quality Ontario, 2011; Murray and Tantau, 2000; Murray et al., 2003).
Rather than an absolute lack of resources, analyses have shown that problems with wait times often occur in matching practitioners’ capacity to offer appointments with patient demand on a day-to-day basis (Murray and Tantau, 2000). Delays are often the result of mismatches between supply and demand. This can be worsened when supply is reduced by diverting time from clinicians and their team in the process of triage (Murray & Berwick, 2003). With the advanced access model, clients calling to see a clinician are offered an appointment the same day. It also rejects the idea of dividing demand into routine or urgent categories. As long as client demand for appointments is not permanently greater than clinician capacity to offer appointments, this method of reducing wait times can be sustained (Murray & Berwick, 2003).

While the model was developed and tested for primary care, components of advanced access may be considered in secondary care such as the mood and anxiety clinic. In order to implement this method within a clinic, the advanced access model must be driven by data with a strong understanding of client population size, level of client demand for visits and number of appointment slots available. Changes that must be made in the implementation process include (Murray & Berwick, 2003):

1. **Balancing supply and demand**: Demand must be measured prospectively, requiring inquiry and record-keeping about the types of appointments clients need. Measure supply by examining how much clinician time is available and what units of service clinicians can provide.
2. **Work down the backlog**: This one-time step is crucial to start a new system and requires the temporary task of doing more work each day through extra sessions, more work hours or bringing in a clinician to work temporarily. Other strategies include using alternate forms of supply such as phone calls, email interaction between client and clinician, or outside referrals.
3. **Reduce the number of appointment types**: If possible, simplifying a schedule by combining two short appointments when a long one is needed.
4. **Develop contingency plans**: When appointment surges occur due to increased demand or reduced supply, adopt methods such as dividing the work of absent clinicians or expanding the use of staff.
5. **Reduce and shape the demand for visits**: Strategies include covering multiple issues in a single session, phone calls or email to respond to questions, follow-up care (Noffsinger & Scott, 2004).
6. **Increase the effective supply**: Maximize efficiency by transferring tasks that can be done by other staff members. Under well-designed guidelines, transfer higher levels of responsibility (under well-designed guidelines) to other members of the team.

Research from the Australian Primary Care Collaborative on access systems lists advantages of advanced access as timely access, flexibility for both patients and clinicians, and responsiveness to acute concerns (Knight & Lembke, 2013). Disadvantages include a counterintuitive process and major changes to typical clinical systems. The authors also note that advanced access has generally been poorly implemented around the world (Knight & Lembke, 2013).

A systematic review on the outcomes of advanced access concluded that wait times and non-attendance rates were reduced with the scheduling approach described above. However, effects on overall patient satisfaction were mixed and data on clinical outcomes and potential harm were lacking (Rose, Ross, & Horowitz, 2011). A comprehensive evaluation
Waiting list management of advanced access in clinics throughout England found that the model was able to offer patients appointments slightly faster than clinics that employed a different model (Salisbury et al., 2007).

3.2 Computerized cognitive behavioural therapy

Computerized cognitive behavioural therapy (CCBT) is an alternative method of delivering cognitive behavioural therapy (CBT) via a computer (internet or CD ROM), tablet or telephone (National Health Service, 2006) with minimal to no therapist involvement. This type of self-help technology uses a structured format including educational lessons, homework assignments and supplementary resources (Titov, Andrews, & Sachev, 2010) to teach users to apply CBT.

Some of the problems in mental health clinics such as long wait lists or a shortage of therapists can be overcome by using CCBT (Kaltenthaler et al., 2008) and can be an option for stepped care (treatment that can be adjusted in steps by level of intensity) to alleviate demand for resources so that children and youth can receive some form of intervention while on a waiting list (National Health Service, 2006). More quality randomized controlled trials are needed with adolescent populations (Ahmed, & Bower, 2008), but some forms of CCBT for depression and/or anxiety have been well evaluated with adults. MoodGYM is an internet-based self-administered intervention for preventing and coping with symptoms of depression with five interactive modules. The intervention was effective in reducing symptoms of depression and significantly improved dysfunctional thinking compared to the control (Christensen, Griffiths, & Jorm, 2004). Another form of CCBT, Beating the Blues is an interactive multimedia therapy package for depression and/or anxiety including an introductory video with eight one-hour therapy sessions and homework. In a clinical trial, outcomes included a decrease in depression, anxiety and negative attributions, improved work and social adjustment, positive attributions increased (Proudfoot et al., 2004). Studies also found that women responded better to Beating the Blues than men (Cavanagh, et al., 2009). Beating the Blues was also found to be effective in the management of mild to moderate depression (National Health Service, 2006).

3.3 Solution focused brief therapy (SFBT)

Brief interventions are another approach to improve wait times in mental health clinics. Solution-Focused Brief Therapy (SFBT) is a competency-based model that places emphasis on helping clients construct solutions instead of solving problems by focusing on strengths and previous successes (Trepper et al., 2007). Treatment is brief, with usually less than six sessions (Bond et al., 2013), and therefore relatively inexpensive to implement. The main therapeutic task in this approach is to help the client imagine how they would like things to be different and what it would take to make that happen (Gingerich & Eisengart, 2000). SFBT can be used in mental health settings, schools, child welfare, hospitals, prisons and organizational planning groups (Trepper et al., 2006). The basic principles of SFBT are:

- Based on solution building rather than problem-solving
- To focus on the desired future rather than on past or current conflicts
- Encouragement to increase useful behaviours
- Co-constructing solutions between the client and others
- Helping clients find alternatives to undesired patterns of behaviour, thinking and interactions
- The assumption that solution behaviours already exist for clients
- The assertion that small increments of change lead to large increments of change
- That solutions are not necessarily directly related to the identified problem
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- That conversational skills needed to build solutions are different from those needed to diagnose and treat client problems

In response to ongoing difficulties with long wait times, a community mental health clinic in Alberta introduced SFBT as part of a pilot project. Results found that after a year of SFBT enrollments, wait times had dropped from 39 days to 17 (Taylor, Wright, & Cole, 2010). A systematic review of SFBT found strong evidence towards its effectiveness in a variety of health and social concerns, such as child behavior problems, mental health, and delinquency (Gingerich & Peterson, 2013). A meta-analysis by Kim (2008) found that SFBT was effective in dealing with internalizing behaviour problems but not externalizing behaviour problems or family/relationship problems. It should be noted that the meta-analysis itself may have been subject to reviewer bias and error in its methodology (i.e., the analysis was conducted by a single reviewer). Furthermore, the poor quality and variability of the studies examined and author’s conclusions may not be reliable as is supported by the DARE quality assessment (Database of Abstracts of Reviews of Effects, retrieved 2011).

4. Next steps and other resources

Knowing what works and receiving training on an evidence-informed practice or program is not sufficient to actually achieve the outcomes that previous evaluations indicate are possible. A program that has been shown to improve mental health outcomes for children and youth but that is poorly implemented will not achieve successful outcomes (Fixsen et al, 2005). In order for a program to be evidence-informed, it needs to be applied with fidelity to the design and it needs to be implemented using supportive “drivers” related to staff competency, organizational leadership and organizational capacity. These drivers include assessing and monitoring the outcomes of your practice using evaluation or performance measurement frameworks, which are particularly important when there is insufficient evidence in the literature to guide clinical decisions. Choosing a practice is an initial step toward implementation, but the implementation drivers are essential to ensure that the program reaches appropriate clients, that outcomes are successful and that clinical staff members are successful in their work.

The Ontario Centre of Excellence for Child and Youth Mental Health has a number of resources and services available to support agencies with implementation, evaluation, knowledge mobilization, youth engagement and family engagement. For more information, visit:

http://www.excellenceforchildandyouth.ca/what-we-do or check out the Centre’s resource hub at

For general mental health information, including links to resources for families:

http://www.ementalhealth.ca
References


Murray, M., & Tantau, C. (2000). Same-day appointments: exploding the access paradigm. *Family*
Practice Management, 7(8), 45-50.


