Canadian Psychiatric Association
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POLICY PAPER

Wait Time Benchmarks for Patients With Serious Psychiatric Illnesses

A series of recommendations made by Canada's psychiatrists
March 2006

Introduction

In August 2005, the physicians of Canada, through the Canadian Medical Association and the Wait Time Alliance for Timely Access to Health Care, published a report entitled "It's About Time!: Achieving Benchmarks and Best Practices in Wait Time Management" outlining medically acceptable wait times for a variety of conditions (1).

Access to specialist services for patients with psychiatric illnesses is a significant problem throughout the country. Not only are wait times for these services lengthy, but in many areas family practitioners have difficulty getting service at all. The rural service gap is especially significant. Yet, for patients who need care and are hesitant to request it because of stigma or feelings of shame, ease of appropriate access is essential.

If waiting for health service in general is difficult, waiting for psychiatric service is especially trying. For most of us, the worry of "losing your mind" is the greatest fear of all. Receiving a timely consultation and the knowledge that help is on the way are an enormous boon. It is equivalent to the relief experienced when treatment finally begins for any other serious health condition.

For this reason, the Canadian Psychiatric Association (CPA) has identified appropriate clinical benchmarks for what the waiting time for psychiatric care should be. If clinicians do not establish appropriate targets themselves, then no service can be evaluated against good clinical criteria.

Underlying Principles and Considerations

Following the approach used by other medical specialties, we have chosen to establish guidelines not for every condition, but rather for "sentinels". If services for these conditions can be consistently provided in a timely manner, then the system for care for the other conditions is more likely to also be working well.

The following considerations and principles underpin our specific recommendations on wait times:

1. When a patient and family practitioner agree that a consultation with a psychiatrist is necessary, that consultation should take place in a timely manner. Not all psychiatric conditions require specialist care; professionally evaluated and properly triaged referrals should be accorded the importance they deserve.
2. The illnesses listed here are not the only illnesses for which timely consultation and a definitive plan for treatment are important. They are our sentinels - our

canaries in the mineshaft. If we can get these right, then the system will likely be in place to deal with the many other illnesses requiring psychiatric care.

3. Following the example of approaches used by other medical groups, our recommendations are "evidence based, but not evidence bound". They are "performance goals that reflect a broad consensus on medically reasonable wait times for health services delivered to patients" (2).
4. We adhere to the principles for the development of wait time benchmarks proposed in the Wait Time Alliance for Timely Access to Health Care report "It's About Time", namely that:
   - Canadians have a right to timely and high quality care;
   - Benchmarks must be developed from the patient's perspective;
   - Benchmarks should be based upon a pan-Canadian approach;
   - Benchmarks should be based on the best available evidence, along with clinical consensus;
   - Benchmarks are dynamic, and should be refined and updated as necessary;
   - Benchmarks require the "early, ongoing and meaningful input of the practicing community";
   - Public accountability, through monitoring of benchmarks is extremely important to maintain the public's trust in the service delivery system;
   - Benchmarks and associated provincial targets should be sustainable;
   - Benchmarks should be accompanied by priorization and monitoring guidelines that are "fair, equitable and transparent to the patient" (3).
5. In establishing these guidelines, we have used the best evidence available to us, complimented by the wisdom and clinical experience of senior colleagues. They are clinical guidelines, reflecting our obligation to provide patients with good clinical care. Resource availability has not been a factor in establishing these clinical goals.
6. Consistently achieving systemic benchmarks of care across the country will be a challenge. There are rural and remote areas where resources simply don't exist in the locality. Inventive ways of service delivery (telepsychiatry and others) will have to be developed to deal with this geographic inequity of resources. Any monitoring system will, therefore, have to identify not only those patients referred for physician care and their wait times, but also those not referred because there is no specialist available to whom they can be referred. Getting this information may be a challenge for the system; yet it is vital for the patient concerned. If healthcare delayed is healthcare denied, then healthcare unavailable is a disgrace.
7. For many illnesses, onset may be gradual. As with the rest of the medical community, we believe that wait times must be based on discrete measurable events. Assuming easy access to a family practitioner, the wait time count will start when the patient and the physician both decide that such a referral is needed.
8. The problem should not be seen as one of a single wait time. Far too often, referral to a psychiatrist for serious and disabling illnesses is followed by a subsequent delay in access to inpatient or out-patient programs of care, rehabilitation, psychotherapy or behavioural therapy to address the predisposing factors that contributed to the development of the illness, or which contributed to its lingering difficulties.

Definitions: Urgency Levels for Access and Sentinel Illnesses

Urgency Levels

For the illnesses outlined in these benchmarks, the CPA identified three general urgency levels for access. They have been chosen to equate to the categories described in the report issued by the Wait Time Alliance for Timely Access to Health Care. The CPA has tried to ensure that levels of pain and disability experienced by patients with psychiatric illnesses are categorized in a manner equivalent to the pain and disability levels described by our surgical colleagues.

1. Emergent

Traditionally, this implies danger to life, limb or organ within a very short time frame, hours or days. Behaviourally, the most obvious example might be the person with active suicidal ideation. However, there are others. Acute mania may put a person at immediate risk (within the next few hours or days) by affecting his/her judgment in driving, in interpersonal judgments, and in sexual activities to the extent that he/she cannot appreciate the dangers in his/her behaviour.

The response to this level of urgency would be best facilitated by hospital-based evaluation and urgent referral (or its equivalent).

2. Urgent

This category includes clinical conditions that are unstable, with the potential to deteriorate quickly and result in emergency admission. While waiting, such patients will need monitoring of their clinical condition by their practitioner. If the course proves fluctuating, with significant changes either in symptomatology or their level of

adaptive functioning, it may require that the patient be moved up the referral list, or lower, as appropriate.

The response to this level of urgency would be best facilitated by an expedited consultation within two weeks, such consultation being best facilitated by a program of care with ready access to inpatient resources, if necessary.

3. Scheduled

This category involves stable symptoms, with tolerable disability or dysfunction in the roles of everyday life, one that is unlikely to deteriorate quickly and where the person has adequate and appropriate social support in the community.

Sentinel Illnesses

The onset of many medical and psychiatric conditions is gradual and insidious. Those illnesses chosen to act as sentinels have the characteristics of:

a. Ease of identification, with little merging with "normal" variants;

b. Clear, identifiable onset;

c. Identifiable deterioration if the treatment is not started in a timely manner.

The following conditions fit the three sets of criteria.

1. First Episode Psychosis

Presenting generally in adolescence or young adulthood, untreated schizophrenia is characterized by a chronic course of deterioration. There is a breakdown of many mental functions, with often-repeated hospitalization. Social and interpersonal disability may be extreme. Death, by suicide or by increasing the vulnerability to other fatal conditions, is a significant risk.

In many instances, this course can be prevented with early treatment. Many industrialized nations have established early psychosis programs to initiate treatment and to prevent this deterioration. The CPA's recommendations are consistent with these practices.

2. Mania

Acute mania involves a profound change in the person's behaviour. It affects not only emotions (feeling "high" or invincible), but also the ability to think clearly, to make rational judgments, and to keep safe. Fatalities can occur from lack of judgement. Mania may be accompanied by chaos in normal relationships with families, marriages and friends. It is rare to find a patient who, on recovery, does not feel shame and guilt about his/her out-of-character behaviour when he/she was ill.

Without early and effective treatment, mania is accompanied by mental, physical and social deterioration, as well as an increased likelihood of relapse and decreased likelihood of return to normal function.

3. Hypomania in Those Previously Diagnosed With Mania

In those previously diagnosed with mania, the onset of hypomania may herald the onset of a further episode in their bipolar illness. It signifies a very unstable mental state.

4. Post-Partum Illnesses

Childbirth should be a happy event. For most, it is; but for approximately 10 per cent of women who give birth, the post-partum period will be associated with significant psychiatric difficulties, including depression and psychosis. Severe post-partum illnesses may require psychiatric hospitalization; and inadequate treatment increases the risk of morbidity in both mother and infant.

Just as this illness has been recognized throughout history, so have the serious consequences if it is not treated. Suicide and infanticide; family break-up as a result of the psychotic behaviour; failure of mother-infant bonding - all can occur at greater likelihood if treatment is not instituted early and vigorously.

5. Major Depression, Unipolar or Bipolar

This condition represents the major cause of disability amongst young adults in our community.

Within some impoverished and socially deprived subgroups, including some First Nations groups, it is endemic. It is a major cause of death in young adults. For Aboriginal Canadians, the fatality rate from suicide is approximately three times that of the general population; for Aboriginal adolescents, the rate is approximately five or six times that of the equivalent non-Aboriginal population. Simply put, an Aboriginal teenager is more likely to die by suicide than to go to university.

For most, it is treatable.

Without early and effective treatment, the illness deteriorates into chronicity, with a relapsing course and risk of fatality through suicide. In many cases, resistance of the illness to treatment can be avoided by early and comprehensive care.

Not all depressive illnesses will require a referral to a psychiatrist. Such referrals should include those who have a more difficult to manage illness, or those whom the family doctor feels lie outside his level of expertise.

Key Variables

In addition, the CPA feels it important to underscore two other points:

Recommended Benchmarks

Indication	Emergent	Urgent	Scheduled
Access to family practitioner			
Acute or urgent mental health concerns	As deemed appropriate after triage	Within 24 hours	Within 1 week
Access to psychiatrist after referral by family physician			
First Episode Psychosis	Within 24 hours	Within 1 week	Within 2 weeks
Mania	Within 24 hours	Within 1 week	Not generally applicable
Hypomania, with previous diagnosis of mania	Not generally applicable	Within 2 weeks	Within 4 weeks
Post-partum severe mood disorder or psychosis	Within 24 hours	Within 1 week	Within 4 weeks
Major Depression	Within 24 hours	Within 2 weeks	Within 4 weeks
Diagnostic and management consultation (including consultations for child and geriatric conditions not otherwise noted above)	Within 24 hours	Within 2 weeks	Within 4 weeks

1. In most instances, patients do not visit their primary care practitioner with a diagnosis already made.

In cases where the patient is suffering significant emotional distress, such that the patient and the doctor jointly decide that a referral should be made, this referral should occur in a timely fashion. As is the case for specialist referrals for any other medical condition, the time frame must reflect the level of safety risk, the pain and the disability experienced by the patient.

2. Access to a family practitioner.

In any treatment system for psychiatric illnesses, access to a family practitioner is the first essential point of contact. This individual can evaluate not only the mental, but also the physical well-being of patients. He/she will also have an important and continuing role in monitoring the patient for changes while waiting to make sure that if the condition changes the patient may be appropriately reclassified.

Speed of access will depend on a triage system for acuity. For acute or urgent conditions, access to their family practitioner within 24 hours (one working day) is recommended.

Qualifiers

The recommended benchmarks are representative only. Within a patient-centered approach to care, there will be many identifiable wait times. Waiting to be seen by a specialist may just be the start. The wait time for admission to hospital, or to a rehabilitative program of therapy, among others, should also be identified and tracked. In an organized system of care, it is as important to manage each of these as it is to manage the wait until the first visit.

If there are not enough primary care practitioners to identify the need in the first place and to provide clinical monitoring while a patient is waiting; if there are not enough psychiatrists to whom family physicians can refer patients in need of specialized care so that referrals are not even attempted; if there are not enough supports within treatment and follow up programs so that once a diagnosis is made, curative treatment and rehabilitation can be instituted, then these recommendations might seem out of place.

To think so, however, would be wrong. The clinical need of the individual patient is independent of the resource availability. The whole underpinning of the "10-Year Plan to Strengthen Health Care", an agreement signed by the First Ministers in September 2004, recognizes that the necessary first step for improvement is to establish what the key benchmarks should be. These recommendations constitute that necessary first step.

References

1. Wait Time Alliance for Timely Access to Health Care, "It's About Time!: Achieving Benchmarks and Best Practices in Wait Time Management: Final Report by the Wait Time Alliance for Timely Access to Health Care", Ottawa: Canadian Medical Association, 2005.
2. Ibid.
3. Ibid.