

COMMENTARY

Wait time to what? Could reducing wait times for child mental health services worsen outcomes?

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Addressing wait times for health interventions is a Canadian priority (Mendelsohn, 2002). In response, multiple wait time reduction initiatives have been launched. Chief among these is a key component of the federal-provincial “10-year Plan to Strengthen Health Care” (Health Canada, 2006) with associated monitoring to track progress in priority areas (Canadian Institute for Health Information, 2014). While mental illness was not one of the five priority areas (cancer care, cardiac care, diagnostic imaging, joint replacement, and sight restoration) identified in this initiative, mental illness has been designated in some priority lists, with some including a focus on children. A case in point exists in Alberta whereby children’s mental health was identified as one of six priority areas for access standards which led to child wait time benchmark recommendations (Access Standards Working Group Children’s Mental Health Subcommittee, 2009) and a performance indicator of percent of children receiving scheduled mental health treatment within 30 days (Government of Alberta, 2014). Unfortunately, reports of clinical outcomes from child mental health service wait time reduction initiatives seem nonexistent despite potential benefits and harms.

Unlike the structure of some medical and surgical wait time goals in which specific interventions are designated (e.g., hip arthroplasty), targets for mental illness tend to refer to wait times until contact with the service system, with no specification to accessing specific evidence-based interventions.

This contact focus is reflected in the wait time benchmarks proposed by the Canadian Psychiatric Association (2006), as well as, the Alberta initiative noted above, which both identify time from system contact to specialist assessment. What the typical patient receives after they make contact with various points in the service system for mental illness varies widely and specifics for the most part are unknown, especially in child mental health.

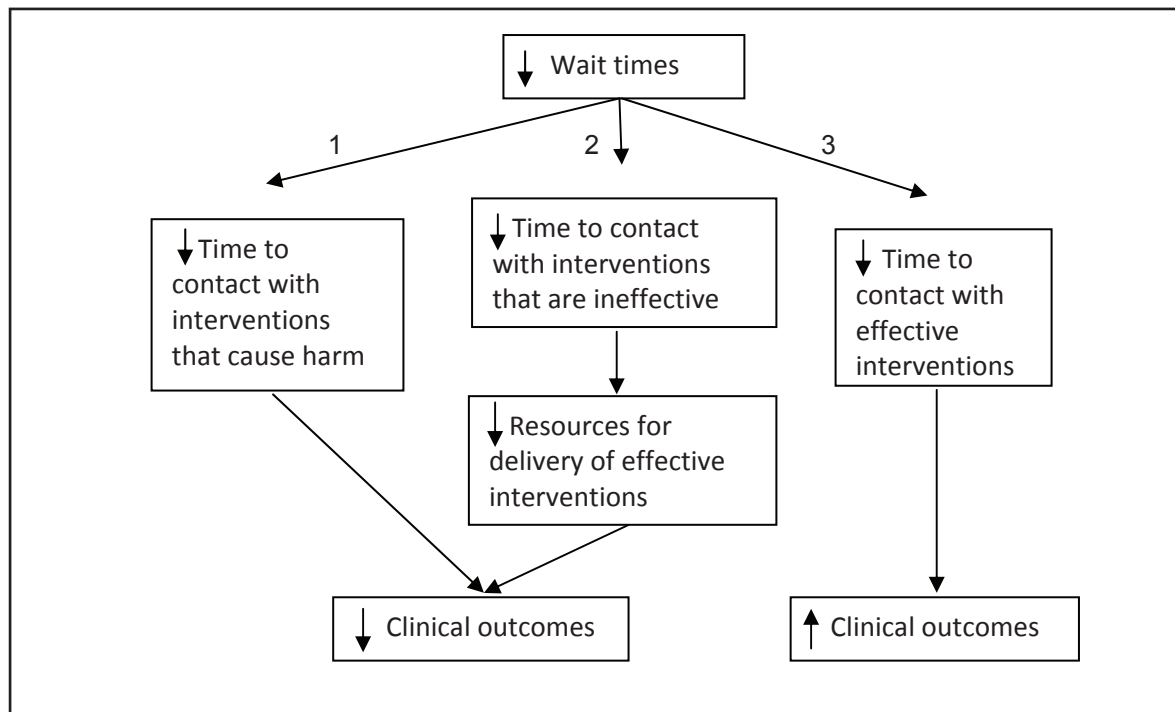
While the inclusion of mental illness in priority lists and the attempts to establish benchmarks for service access ought to be applauded given the often neglected state of mental health care, the failure to specify access “to what” in proposed wait time initiatives creates a situation that, paradoxically, could lead to more harm than good. While reduced time to effective interventions should result in reduced suffering and improved outcomes, there are at least two pathways whereby shortening wait times may worsen outcomes.

One pathway to worse outcomes could occur if the wait time is shortened to an intervention that has more harmful than beneficial effects (see #1 in Figure 1). It is acknowledged that there are few mental health interventions for which there is sufficient evidence identifying more harm than good. However, this is likely due in part to the failure to systematically assess most interventions for harmful effects, particularly psychosocial interventions (Nutt &

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Figure 1. Theoretical pathways linking shortened wait times to different clinical outcomes

Sharpe, 2008), which may be underpinned by the belief that something is always better than nothing. Bickman proposes that “the paradoxical problem with our mental health services is that they are not visibly harmful” (2008) and as such, ineffectiveness, or perhaps adverse impacts, may not be attributed to the intervention by families, clinicians, and/or administrative bodies.

One potential wait time shortening strategy that ought to receive additional scrutiny is expanded offerings of group interventions (Vallerand & McLennan, 2013). This approach may allow more children to be seen in a shorter period of time using less clinical resources. While some group-based interventions for certain populations have empirical support for improving outcomes (e.g., CBT for anxiety disorders) (Flannery-Schroeder, Choudhury, & Kendall, 2005), there is an important empirical literature that has identified risks associated with grouping some high-risk youth together for interventions, particularly those demonstrating delinquent behaviour given the potential for a “deviancy training” effect (Dishion & Tipsord, 2011).

Unfortunately, there may be gaps in the oversight of components of mental health services which may undermine one’s confidence that potentially harmful interventions are systematically weeded out from public and private service offerings, with the exception of some extreme physical interventions such as “indiscriminate application of ablative brain procedures” (i.e., frontal lobotomies) (Sakas, Panourias, Singounas, & Simpson, 2007), being eliminated

after a time. The seeming lack of a requirement for clinical outcome reporting from typical child mental health services in many jurisdictions is suggested as one marker indicative of poor oversight. More typical monitoring appears to be the request for simple counts (e.g., number of patients seen in a period of time) (McLennan, 2010).

While direct harm may be uncommon, a much larger service concern may be the extent of delivery of interventions with minimal or no effect. The corollary is that the routine delivery of evidence-based mental health interventions is rare. It would not be going out on a limb to speculate that most children with mental health disorders in Canada do not receive a full-course of an evidence-based intervention. While now somewhat dated, findings from a meta-analysis of outcomes of a sample of typical community mental health services for child mental health estimated an effective size of around zero (Weisz & Jensen, 2001). There is scant new evidence to refute this past finding, and, unfortunately, a newer review also identifies serious concerns about the effectiveness of usual care delivered within child mental health services (Garland et al., 2013). While perhaps not evidence of direct harm, such service delivery represents an opportunity cost and thereby a potential indirect harm (McLennan, Wathen, MacMillan, & Lavis, 2006).

This situation leads to a potential second pathway whereby shortening wait times could lead to worse outcomes (see #2 in Figure 1). If the extent of attainment of wait time benchmarks is designated as a performance indicator, with

possible repercussions for failing to meet the benchmark, then service providers and agencies will be under pressure to adjust service delivery to try and meet these performance goals. Ignoring delivery of harmful interventions and assuming that service adjustments to meet wait time benchmarks results in no net service content change, there should be no net worsening. However, given the lack of content scrutiny of, and failure to systematically examine clinical outcomes from, most child mental health services, balanced against inadequate resources to meet mental health service needs, there is at least some likelihood of content changes under wait time pressures. The current lack of collecting of, and reporting on, details of service delivery impede the potential to examine this proposed mechanism.

Content changes of greatest concern would occur when resources are shifted from the delivery of evidence-based interventions to something less than that. This could occur if, for example, clinicians attempting to provide a full recommended course of an evidence-based psychotherapeutic intervention are pressured to shorten the course of treatment in order to take on more patients more quickly to shorten wait times. Unfortunately, this was not explicitly examined within a Canadian study of waitlist management strategies (Vallerand & McLennan, 2013). However, the reported practices of shifting to more “generic services tracks” (vs. “specialized service tracks”) and replacing more expensive care providers with less expensive providers noted in that study may require additional scrutiny.

One potential example of this second mechanism may occur if clinicians are asked to perform new delivery strategies, such as running mandatory orientation meetings for prospective patients and families (Wenning & King, 1995). While such an approach may have utility (e.g., efficient delivery of information), such orientation meetings may also be used strategically: (i) to stop the wait time clock quickly (if you count attendance at an orientation meeting as service contact); and/or, (ii) use attendance failure to eliminate a patient from the waitlist (a strategy that may disproportionately impact more vulnerable families). Unfortunately, the Wenning and King (1995) study of this approach did not report on what happened to the 34% of families who failed to attend the orientation meeting and hence were not given an intake appointment. A study by Michelson and Day (2014) found that through investment in engagement strategies for vulnerable families, attendance might improve (which could have the adverse consequence of lengthening wait times).

Strategies for reducing the potential risks of harm from child mental health service wait time reduction initiatives should be considered. First, we need to be able to answer the question “wait time to what?” Leaving it as wait time to any possible contact scenario should not be acceptable. Second, we need to measure clinical outcomes. If clinical outcomes are no better from our shortened wait times, then this

service effort was a failure and we ought to scrutinize the content of what is being delivered. If outcomes are worse, then our service effort was worse than a failure. Monitoring clinical outcomes with the implementation of wait time shortening strategies could also facilitate the identification of improved clinical outcomes. If such is found, the given initiative could be further scrutinized as a potential win-win strategy. This is identified as a third pathway in the Figure, one that could reduce suffering more rapidly and improve outcomes. The realization of this pathway should not be left to chance.

Acknowledgements/Conflicts of Interest

The author has no financial relationships to disclose.

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ERRATUM

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In the article “Explaining Odds Ratios” in the *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, by Magdalena Szumilas, MSc¹ on the PubMed Central database at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2938757/> an equation appeared incorrectly. The error is in the Example, part A, the correctly re-arranged equation appears below.

$$OR = \frac{(n) \text{ exposed cases} / (n) \text{ unexposed cases}}{(n) \text{ exposed non-cases} / (n) \text{ unexposed non-cases}} = \frac{(n) \text{ exposed cases} \times (n) \text{ unexposed non-cases}}{(n) \text{ exposed non-cases} \times (n) \text{ unexposed cases}}$$

The *Journal* regrets this error and any inconvenience caused.
