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Waiting List Management and Initiatives

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As people become more aware of psychological problems, there arises an increasing service provision demand on psychological services leading to lengthy waiting lists, which are anecdotal in excess of 12 months. The purpose of this review is to highlight the importance of designing and implementing waiting lists according to ethical principles. A secondary goal is to discuss the advantages and potential limitations of various initiatives for reducing waiting lists. While the primary focus of the review is on mental health services, literature from a range of clinical health settings is referenced.

This review is divided into six sections. First, it considers the background literature surrounding the negative impact of waiting lists. Second, it investigates the issue of prioritisation. The advantages and disadvantages of managing waiting lists according to perceived urgency of cases and good clinical outcome are also discussed. Third, it examines various techniques for processing referrals and reducing waiting lists (e.g., offering initial appointments and brief therapeutic interventions). Fourth, the review explores some techniques for restricting access to services (e.g., “opt-in” procedures, clear referral guidelines and limiting the number of appointments offered). Fifth, the responsibilities of mental health providers in increasing attendance and reducing waiting lists are considered. The conclusion section presents a sequence of procedural recommendations to manage waiting lists.

Background

Waiting lists are inevitable in a public service (Bagust, 1994). Once the referral rate exceeds the service rate, a waiting list will form (Worthington, 1987). However, waiting time can sometimes result from a shortage of clients with similar needs rather than a shortage of treatment capacity as happens when a treatment programme treats only one group of clients at a time (Brown, Parker, & Godding, 2002).

A small percentage of clients drop out during the waiting time because their concerns gradually resolve over time (Brown et al., 2002). Indeed, findings from a study by Young (2006) suggests that for many there is no apparent harm in waiting for therapy and that only a very small minority of people show reliable deterioration.

However, the relationship between waiting time and outcome of psychological therapy has received very little attention and current research supports limited waiting times for a range of clinical health settings. For example, crisis intervention theory (Parad, 1965) suggests that an individual’s motivation to resolve his or her presenting concern is high in the early stages of a crisis, but is likely to fade rapidly within weeks if help is not forthcoming. Psychological concerns may also become more entrenched over time.

Grunebaum et al. (1996) highlight how long waiting times between referral and initial appointment date can lead to an increase in missed appointments. In the case of Child and Adolescent Mental Health Services (CAMHS), parents and carers may tolerate waiting lists of up to seven or eight weeks but no more. After 30 weeks, families may be unlikely to attend at all (Foreman & Hanna, 2000).

One of the effects of clinical health services waiting lists is an increased anxiety among clients (MacKillop, Bates, O’Sullivan, & Withers, 1996). In relation to psychological services, a study of referrals to a relationship counselling service indicated that there was a link between client distress and waiting time length (Hicks & Hickman, 1994). The majority of people seeking psychological services for potential intervention endure pain and discomfort associated with their unresolved concerns. Many may be uncertain about their progress through a waiting list and the lack of information about when they can expect an initial appointment (Herlihy, Bennett, & Killick, 1998).

Long waiting lists also increase anxiety among staff. General practitioners (GPs) place a high priority on short waiting lists (Jones & Bhadrinath, 1998). They cite long waiting lists as the second most frequently reported example of a poor mental health service. Long waiting lists also create large caseloads and thus make it difficult for clinicians to prioritise other responsibilities (Skinner & Baul, 1997).

In order to prevent these potential negative outcomes, as highlighted in the Irish Health Service Executive (HSE) National Service Plan (HSE, 2005), there is a need to improve access to mental health services.

Addressing Waiting List Management

Politicians sometimes try to solve the problem of excessive waiting lists by allocating additional resources (Hanning, 1996). For example, British surgeons have been paid an extra £500 for an afternoon’s work to run “Saturday surgeries” in a bid to cut National Health Service waiting lists (Goodman, 2006). However, contrary to the suggestion of the National Service Plan (HSE, 2005), managing waiting lists is not about spending more or working harder (which may lead to employee burnout or a low quality service to clients). As it stands, many clinicians carry caseloads of 30 or more complex cases (Carr, 2000).

Rather, reducing waiting lists involves developing formal procedures and policies and implementing them according to ethical and best-practice principles (Rastall & Fashanu, 2001). Brown et al. (2002) highlighted how the management of waiting lists is not standardised and often takes place on an ad hoc basis, lacking
in organisation and fairness. The inherent dilemma is how best to limit the disparity between supply and rising demand for mental health services without compromising the quality of those services (Heywood et al., 2003).

The British Medical Association suggests that organising waiting lists according to a principle of “first come, first served” is not the best way of limiting the negative effects of this disparity. This method of assessment is not necessarily the best indicator of the potential benefits to be derived from treatment and cannot be the key consideration in their management (Fricker, 1999). Aside from the criterion of time spent waiting, employing prioritisation criteria is a better means of managing waiting lists (Meiland, Danse, Wendte, Gunning-Scheipers, & Klazinga, 2002).

Prioritisation
The British Medical Association proposes that prospective clients be given “severity scores” in order to determine admission to waiting lists and to select clients from treatment waiting lists (Fricker, 1999). Scores are typically organised according to either the implications of delaying treatment (i.e., urgency coding) or the likely benefit from treatment (i.e., priority scoring).

Urgency Coding
Urgency coding is determined on the basis of whether or not a consumer can “afford” to wait, with the cost of waiting expressed in terms of the expected deterioration of his or her presenting concerns (Mullen, 2003).

Criteria for Higher Urgency Codes
In a study by George (2003) the position of a client on the waiting list for admission to a nursing home depended on the assessed urgency code. These codes were determined by a geriatrician and a mental health nurse. The criteria applied included a decline in the health status of the client and/or a decline in the capabilities of the informal caregiver. Some urgency codes changed during the waiting period, with clients being registered as having “normal” urgency and then re-categorised to greater urgency. Alternatively the level of urgency may have been downgraded.

Benefits of Urgency Coding
Urgency coding can be an effective strategy for managing waiting lists because clients coded with “high/ highest” urgency can be admitted sooner to nursing homes (George 2003). In another study, Startup (1994) recommended that severely distressed clients be selected first for treatment by psychologists, while less distressed clients receive standard treatments from trained healthcare personnel under the supervision of a psychologist.

Limitations of Urgency Coding
There are several potential risks in using an urgency coding system. First, in controlling a psychologist’s workload, the workload of other team members may be increased. Second, “normal” urgency clients may be overtaken by “high” urgency cases and hence may only receive treatment after an excessively long waiting period, if ever at all. Third, clinical cases are more likely to be prioritised as urgent if the referral letter highlights predictors of negative outcome (Woodhouse, 2006). However, it is precisely such referrals that are least likely to respond to psychological interventions (Carr, 1999).

Fourth, the wait-listed cases are likely to increase in the number of poor outcome predictors by the time they are seen (e.g., chronicity, de-motivation, non-engagement). These findings indicate, therefore, that management of waiting lists by the application of urgency coding assessment potentially reduces the likelihood of achieving positive client outcomes.

Priority Scoring
This method of prioritisation derives from the perceived importance of treatment rather than from the effects of waiting (as is relevant with urgency coding). It involves a new designation of “priority” to replace the term “urgent”. The term “priority” pertains to cases requiring immediate intervention.

What is priority scoring?
In an attempt to better use scarce resources, prioritisation criteria are reorganised to ensure that those cases most likely to respond to psychological interventions are seen more quickly. The severity of the presentation, therefore, does not necessarily determine the weighting of the client’s score.

Factors that might be considered when deciding on a priority score include: (a) the client’s capacity to benefit and (b) the cost/benefit ratio of treatment (Mullen, 2003). One method of scoring is to rank clinical characteristics by importance and then rank clients according to their position in the most important characteristic (Rodriguez-Miguez, Carmen Herrero, & Pinto-Prades, 2004).

In a study by Woodhouse (2006) case characteristics predicting a good outcome were used to create criteria that could be applied to information available at the point of referral. These included short duration, younger age, parental well-being, flexible family functioning, single-agency involvement and family requests for help. He suggested that cases be placed on the “soon” waiting list when they fulfilled four of these criteria. Cases featuring three or less of these criteria were regarded as routine. Thus, when expected benefits were small, clients faced a long wait time.

Alternatively, in a Compensatory Point System, as implemented in the management of waiting lists in New Zealand (Seddon et al., 1999), priority can be given to clients on the basis of their clinical and social characteristics. This means that clients are prioritised according to
the expected benefit they (or society) may derive from timely care. For example, in the case of fertility services, some characteristics that are used to prioritise among clients have been probability of success, age and number of children (Gillett & Peek, 1997).

Use of resources can be included in prioritisation. Culley and Cullis (1976) suggested that clinical needs scores be divided by expected length-of-stay in hospital. This produces priority scores that optimise benefits from available resources. In addition, the status of a potential client’s social situation may be taken into account (e.g., the availability of informal caregivers and formal home care possibilities).

Limitations of Priority Scoring
One limitation of priority scoring may be the degree of arbitrariness in deciding the points categories. Indeed, there is debate about whether such social factors should influence waiting list prioritisation. Carr (2000) stressed the importance of equality so that all clients with similar service needs have the same access to services and standard of treatment regardless of “where they live, where they are treated, their income or religious beliefs” (p. 88).

From the client’s perspective, priority scoring may be unsatisfactory due to a lack of transparency. Clients may perceive a wide disparity in the way they are prioritised and a lack of standardisation (Brown et al., 2002) and impartiality in some individual cases (Rodriguez-Miguez et al., 2004). For example, when used as a strategy to eliminate waiting lists in New Zealand, priority points were found to be poorly validated and clients protested that these thresholds were inconsistent and regulated by “economic restrictions rather than clinical judgment” (Rotstein & Alter, 2006, p. 3159).

These findings also raise concerns about the ethical issues of not responding to crises. In addition, clients judged as being non-priority by their clinician may be delayed repeatedly and perhaps indefinitely. Finally, clinicians may not accept such a prioritisation system as they may perceive it as imposing upon their clinical autonomy (Hanning, 2000).

Benefits of Priority Scoring
In order to redress the above mentioned ethical issues, in a study on clinical prioritisation for curative radiotherapy (Martin, Ryan, & Duchesne, 2004), clients were given an extra half point to a maximum of four points for each week they remained on the waiting list. This allowed recognition of delay as well as clinical status in determining their treatment starting time. Each week, starting slots were allocated to the clients with the highest scores according to a points system, taking into account the duration of waiting time.

As emphasised by Woodhouse (2006), priority scoring does not mean that crisis cases are not seen, but that simply they are not prioritised. Cases requiring shorter interventions allow more cases to be taken off the waiting list more frequently. Woodhouse thus argued that early intervention for treatable cases is more effective than early intervention for crisis or complex cases and that delaying intervention for treatable cases has more detrimental long-term effects than delaying intervention for complex cases.

A points system seems to offer clients reassurance that they are not “lost in the system” (Martin et al., 2004, p. 305) and a guarantee of internal consistency. There is also some recognition for clients who have conditions with greater need, ensuring that they receive treatment in a timely manner.

In addition, when presented to a group of medical doctors, Rodriguez-Miguez et al. (2004) found that, by justifying their decision according to a set of objective principles, a points system took away some of the pressures that clients tended to apply in order to receive higher priority. The doctors acknowledged that without a points system the process was quite subjective and sometimes inconsistent. They also acknowledged that in some cases they were already taking into account other characteristics apart from waiting time. Another benefit of this model is an increased opportunity to work with treatable cases that can contribute to improved morale (Woodhouse, 2006).

Therefore, according to the available literature, a points system challenges the traditional “first-come-first-served” method of prioritising clinical health presentations and has been well received by both clients and staff. It facilitates transparency and consistent decision making about access to services.

However, consideration must be given to how and why some clients are given priority over others. If several client characteristics are to be used in order to manage waiting lists, one must decide how to use those characteristics in order to establish priorities. This would result in a more transparent and evidence-based approach for waiting list prioritisation. To succeed, a points system needs a technique of processing referrals so that enough information is provided to determine which cases are priorities. Triage clinics are one such technique.

Triage Clinics
Clemente, McGrath, Stevenson and Barnes (2006) advocate the introduction of a new way of processing referrals. An “Initial Assessment” (IA) system, also known as triage or screening clinics, can aid in determining the severity of cases and the nature of clinical needs prior to first appointments (Pumaregia et al., 1997). Triage clinics can also include a brief solution-focused approach that offers clients an immediate, one-off therapeutic appointment that is more than an assessment. At the first meeting – known as the “choice” appointment – various choices can be made by the client, including whether they wish to be placed on a waiting list for further treatment.

What is a triage clinic?
In one mental health study time was allotted for multi-disciplinary team members to discuss each case (Clemente et al., 2006). Typically, two clinicians assessed each case with the aims of increased flexibility and provision of a broader professional perspective (Parkin, Frake, & Davison, 2003). Up to 90 minutes were allocated to clinical assessment. The team then discussed the initial assessments, proposed outcomes, and any clinical dilemmas before advising the family of the outcome, which was done by telephone or letter as soon as possible. The clinicians who saw the client for the initial assessment generally continued with any subsequent work unless another discipline was considered more appropriate.

Parkin et al. (2003) described five possible outcomes following a screening appointment. First, in the case of non-attendance, a letter is sent to the referrer and
the case is closed in most instances. Second, in the case of inappropriate referral, the client may be redirected to another agency. For this reason, Brown et al. (2002) suggested that screening procedures need to take place as early as possible.

Third, if the clinicians decide that they do not have sufficient information available at triage to make an informed decision, they may carry out additional assessment with the client. The fourth option after assessment is to place the client on a treatment waiting list. Finally, the clinicians may decide to continue further intervention without a further wait. In an Irish study with a child and adolescent service, a further option was an agreed management plan for the parent or carer to implement (Lynch & Hedderman, 2006).

The one-off (triage) appointment can also help to profile a client’s requirements, current coping strategies and strengths, thus empowering the client. It can also highlight the useful aspects of what he or she does (Kingsbury & York, 2006). At these appointments, clients can also be supplied with written information about treatment, temporary coping strategies and self-help materials. Such written information (i.e., bibliotherapy) may facilitate improved self-management (Foster, 2005).

Clients can also attend a support group (Carr, 2000). Alternatively, subsequent to an initial screening interview, Assistant Psychologists can provide training in the use of relaxation techniques as temporary wait-list measures. Such training can also include skills learning and problem sharing (Cawley & Read, 1999).

Limitations of Triage Clinics
Rastall and Fashanu (2001) outlined how, although initial triage clinics are a short-term initiative and can potentially clear the waiting list backlog of clients, these lists typically increase soon again. These clinics can also mask spontaneous improvements that may take place while on a waiting list, thereby undermining the competence of families to find their own solutions to problems (Parkin et al., 2003). A significant initial investment in time and in planning and development of clinical and administrative protocols is also required. There is also a personal time commitment and financial cost for the client in engaging in these clinics.

Parkin et al. (2003) reported clinician concerns about subjecting clients to an extensive assessment and then informing them that they may have a lengthy wait for treatment. Denner and Reeves (1994) highlighted the obligation that therapists often feel to offer therapy following initial contact as they perceive that a relationship has been initiated. Clinicians may also have concerns about overwhelming the service with cases that need continued intervention. Hanning (1996) reported physician reluctance to achieve short waiting lists as lengthier waiting lists can make for good leverage when negotiating for more resources. Clinicians may also have less time to plan and prepare for appointments (Clemente et al., 2006), and to fulfil other responsibilities (e.g., report writing).

Benefits of Triage Clinics
Triage clinics can be used to identify the likelihood of positive medical findings in young people who have been sexually abused (Hibbard, 1998) and in the mental health assessment of children and adolescents post-trauma (Pynoos, Goenjian, & Steinberg, 1998). Triage has also been shown to result in increased referrer satisfaction (Jones, Lucey, & Wadland, 2000). Moreover, triage clinics may potentially allow the organisation to redirect inappropriate referrals, thereby preventing unsuitable clients from taking places on the waiting list unnecessarily (Carr, 2000).

Cawley and Read (1999) found that there was a significant decline in mean anxiety and depression levels following training in the use of relaxation techniques, skills learning and problem solving. This suggests that an initial group treatment was of benefit to the majority of clients and improves client perception of psychological intervention. Such group treatment is also a cost-effective strategy due to the large number of clients invited and the potential use (of supervised) Assistant Psychologists.

For some clients, such minimal intervention can lead to significant improvement (Carr, 2000). Research involving physiotherapy department waiting lists indicated that, relative to those kept waiting for an appointment for six weeks, “chronic” clients had statistically significant reductions in pain and the severity of their problem five to six weeks following a “one-off” assessment and advice session (Rastall & Fashanu, 2001).

Initial therapeutic intervention can also present an image of a service as being responsive and receptive. Indeed, Irish referrers and families have given positive feedback about the triage system and in particular about not having to wait for a lengthy period to be seen (Lynch & Hedderman, 2006). They have also acknowledged an altered perception of their presenting problems following consultation (Heywood et al., 2003).

Despite clinicians’ concerns, initial appointments and assessments do not lead to greater waiting times for families. They also improve the knowledge available to clinicians to help them plan their time more effectively. In addition, Lynch and Hedderman (2006, p. 106) found that “without the burden of the long waiting list, the potential for creative thinking around research and development expanded.”

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"... clinician [had] concerns about subjecting clients to an extensive assessment and then informing them that they may have a lengthy wait for treatment."
that clinicians have a positive attitude to triage clinics. Clinician concern about delayed intervention only occurred in a small minority of cases. Even then, they distinguished these personal feelings from their clinical judgment as they reported these wait-listed families were capable of waiting. Clinician concern about overwhelming the service was not reported. Only 28% of cases required immediate continued intervention. Clinicians were confident that cases were given priority on the basis of a thorough assessment and there was greater flexibility in matching therapeutic need with clinical skill sets. In addition, the triage clinic offered opportunities for training and improved multi-disciplinary teamwork.

Other studies have found that a screening interview initiative can effect an 85% reduction in a CAMHS’s waiting list (Hayes & Caygill, 2004) and that up to 40% of clients who receive self-help packages may require no further intervention (White, 1995). Therefore, it may be that both clinicians and clients can be helped by assessment and solution-focused intervention at the pre-treatment stage (Hayes & Caygill, 2004). Rather than endure the effects of long waiting lists, the client can prepare for treatment and be helped in the short-term. Solutions to problems may be discussed and venting of presenting concerns can be facilitated. This may be sufficient to address clients’ presenting concerns and they may no longer require treatment (Brown et al., 2002). Brief therapeutic intervention can also reduce the work to be done by the clinician once therapy is started.

In summary, the triage clinic is a potentially powerful intervention in containing mental health service waiting lists (Lynch & Hedderman, 2006). It can also help clients to take the initial steps in understanding their difficulties and to make some changes. This contrasts with methods focused on restricting access that are now discussed in the next section.

Restricting Access
In order to deal with the ever-increasing demand for clinical health services, clinicians may restrict access by employing a number of measures including opt-in systems, clear referral guidelines and/or by placing less emphasis on individual or long-term work.

“Opt-In” Systems
What is an “opt-in” system? An “opt-in” system described by Woodhouse (2006) requires clients to confirm by post or telephone if they want to be placed on the waiting list. Apart from eliciting motivation to attend future appointments, it facilitates clients knowing they are still on the waiting list and the likely waiting time for an appointment. Furthermore, the distribution of the letter to other professionals ensures that they are kept informed.

Benefits of “Opt-In” Systems
Stallard and Sayers (1998) in implementing “opt-in” systems found that service efficiency is improved in CAMHS. This contact provided an update on waiting list status and information regarding the service. It also provided prospective clients with a clear description of what was on offer and what the therapy entailed, which, according to Ward (2003), is needed prior to first attendance. In addition, motivation was increased and the readiness to receive treatment was enhanced.

Indeed, Yeandle (1999) found that the benefits of an opt-in appointment system included reduced waiting times, improved cost effectiveness (in terms of a reduction in unused appointment times), improved relationships with referral agencies, improved morale among psychologists and a targeting of resources where they are most needed.

Clemente et al. (2006) reported agreement among mental health team members that the greater responsibility given to families in deciding whether to opt-in to their first appointment was not detrimental to therapeutic engagement. Indeed, it can lead to a more collaborative therapeutic alliance. It also allows the early identification by clinicians of those clients unlikely to attend and their removal from the system. This can free up appointments for other wait-listed clients.

Clear Referral Guidelines
What are clear referral guidelines? In order for waiting lists to be reduced, clear referral guidelines are needed. GPs respond to high waiting times by reducing general referrals, but continue to refer the most complex cases (Shannon, Gillespie, McKenzie, & Murray, 2001). The increased complexity of the presenting concerns means that more psychological appointments may be required. This may result in increased waiting times despite the low referral levels. Hence, GPs (and other referrers) need to be regularly informed about the extent of service waiting lists (Shannon et al., 2001).

Munro and MacPherson (2001) emphasised the need for referrals that are appropriate, fit the service criteria and pertain to clients who are interested in engaging with services. In order to maximise optimal referrals, referral agencies must be offered guidance on inclusion and exclusion criteria. The accuracy of this information is vital (Carr, 2000). They must also be firm about boundaries and use simple, brief and clear referral forms. A service must also be positive and straightforward about the nature of the service and ensure that all referrers (including self-referrers) have up-to-date information on the service, its criteria, and its referral form. A service also needs to make every effort to develop amiable relationships with referrers and be willing to use telephone and email as well as letters (and possibly text messages) in communicating with referrers.

Benefits of Clear Referral Guidelines
With clear criteria and good publicity, a referral system can work well. Smith (2002) examined referrals in a service and found that when healthcare professionals and non-professionals, including clients, carers and voluntary groups used an open referral system it enabled early intervention for high-risk groups.

In addition, how these referrals are subsequently managed can impact on the length of waiting times (Trusler, Doherty, Grant, Mullin, & McBride, 2006). Multiple waiting lists can be created where practitioners are located in designated practices (or geographical sectors) and see only clients referred by that practice (or sector). Consequently, once referred, clients may wait varying lengths of time for assessment depending on the capability of the practitioner allocated to that practice (or sector).

By contrast, single service waiting lists result from referrals being managed by a central administration team member (e.g.,
a Clerical Officer). Here, clients may not necessarily be allocated to a practitioner based in their practice (or sector), but rather the practitioner who has the earliest available assessment in a location that is relatively accessible for the client.

**Limiting Number of Appointments Offered**

Traditionally, psychological therapies have been open-ended. However, clients with long therapeutic contracts can increase waiting times for others (Douglas, 2000).

**Benefits of Limiting Number of Appointments Offered**

Therapists sometimes find it difficult to start therapy with a specified limited cap on the number of appointments they will make available. However, growing evidence indicates that a brief model of psychological therapy may be most able to negotiate clear and realistic goals, monitor progress, and early termination where appropriate. Brief solution-focused therapy is an option (Macdonald, 2007). Others have also highlighted how brief, focused work can facilitate a reduction in appointment numbers (e.g., Trusler et al., 2006).

While therapists may not wish to decide on length of treatment based upon resource limitations, teams that are willing to adapt these approaches to their own service can reduce appointment numbers or those that are labelled “DNA” or “Did not attend”. These appointments can then be offered to another client. Waiting lists can thereby be shortened without any loss of respect to clients.

Munro and MacPherson (2001) profiled a waiting list initiative that used a large-group format. Designed to maximise the availability of clinical time and manage waiting lists, their group intervention focused on educating clients with regard to cognitive and behavioural principles. Indeed, much research shows that group formats are effective in treating clinical problems in the immediate and longer term (White, 1995).

**Limitations of Restricted Access**

Startup (1994) has argued that while the use of initiatives such as “opt-in” strategies, clear referral guidelines and short-term group interventions are effective in reducing waiting times, they bypass the problem of waiting list volume rather than solving it.

The most prominent cause of pressure for clinicians may be the challenge of reducing the number of therapeutic appointments (Skinner & Baul, 1997). Many clinicians are of the opinion that there is little consideration given to clients’ needs for long-term work. Clemente et al. (2006) also reported concerns by some staff that an opt-in system might be detrimental for disorganised families who really want to attend and simply forget to reply or mislay their appointment letter(s).

Bearing these concerns in mind, it behoves clinicians to ensure that opt-in systems are not detrimental to clients who have the greatest need of services (but who do not want to engage). When treatment does become available, clinicians must make a reasonable effort to contact those clients who are perceived to be in most need of support. This can be facilitated by sending a second appointment letter to clients who do not turn up or contacting them after they fail to attend. Providing reminders one week prior to the appointment may also be effective in significantly reducing non-attendance rates (Jolly, CHANDNA, & RUDDUCK as cited in Waskett, 2007). Additional and more assertive efforts must be made to contact individuals with other disabilities such as cognitive or physical impairment (Brown et al., 2002).

Notification of appointment non-attendance must be routinely addressed and communicated to other team members (and referral source) both by means of information given to clients prior to therapy and by practitioners at assessment and contracting (Trusler et al., 2006). If there is a weekly appointment schedule, services must also have policies regarding how long they will hold on to someone’s “weekly therapeutic slot”.

By placing less emphasis on individual or long-term intervention, clinicians can move towards being educators and organisers of services and, in turn, deal with the ever-increasing demand for psychological services. Carr (2000) suggested that standardising the number of appointment is challenging but possible.

**Guaranteed Waiting Time**

In one Swedish hospital, contracting to see clients within a specified time subsequent to referral meant that clients who are placed on a waiting list by a physician for any of 12 different procedures are offered treatment within 3 months. If the hospital with primary responsibility for the patient could not offer treatment within this waiting time, the patient had a right to be treated in another hospital or by a private clinic at the expense of the hospital (Hamming, 1996). The study found wide variations in waiting times among hospitals, allowing clients to receive procedures at other hospitals with shorter waiting times. This can be viewed as a potentially effective incentive for the hospitals with long waiting lists to either start referring clients, or to focus on efficiency and better management of their waiting lists.

This system is similar to the current National Treatment Purchase Fund (NTPF) in Ireland for surgical procedures whereby clients who are longer than three months on a public hospital waiting list are written to directly and offered treatment options by other service providers. In addition, the NTPF provides clients and GPs with easy access to wait time information for surgical procedures in hospitals to assist with referral decisions. Waiting list information is collated and assists hospitals, the HSE and the Department of Health and Children to plan health care services and delivery.

Such external purchasing is increasingly used by HSE Local Health Managers to access (typically private) psychological services for “crisis cases” if in-house waiting lists are unacceptably lengthy.

Brown et al. (2002) described a strategy that involved allowing the client to decide how long they waited for services (e.g. if a client requested a therapist of a certain age, gender or race). The clinician then gave the client the choice of waiting until the preferred therapist was available or starting treatment with the next available clinician. Currently, there is no such choice available in mental health services as, at best, there is typically only one psychologist per sector-area Community Mental Health Team (CMHT). However, the proposed expanded CMHTs (of A Vision for Change) may facilitate a choice between two psychologists
per each defined geographical area of 50,000 people (Department of Health & Children, 2006).

**Conclusion**
When queues for health services become too long, the regulators of supply (i.e., the HSE) are held responsible. The current recruitment embargo means that the number of staff recruited is set to decline. Therefore, no matter how efficient the service, if the volume of referrals continues to rise, demand will outstrip supply. Waiting lists can never be eliminated in such circumstances. Nevertheless, both research and common sense advocate limited waiting times for mental health services. Therefore, the difficult dilemma for clinical health services is how to limit the discrepancy between supply and ever increasing demand, while maintaining the quality of those services.

Reasons for avoiding prolonged waiting times include the fading of client motivation, an entrenchment of the presenting concern over time and higher rates of non-attendance when an appointment is finally offered. Long waiting times also increase anxiety among clients, GPs and clinicians, with the last-named finding it difficult to prioritise other responsibilities.

Therefore, instead of focusing on the elimination of waiting lists, the current review has discussed the management of these lists. It has highlighted that in order to reduce waiting times, waiting lists must not be used merely as administrative tools. Formal procedures and policies must be developed and implemented according to ethical principles. Therefore, initiatives to better treat those clients facing long waiting times are needed (e.g., bibliotherapy, relaxation training, regular contact and information regarding likely waiting time), as profiled in this review.

Accordingly, the following sequence of procedural recommendations incorporating the various initiatives is suggested to facilitate appropriate and efficient management of waiting lists.

1. Put in place clear referral guidelines, including eligibility criteria, in order to maximise optimum referrals and ensure early intervention for clients that fit the service inclusion criteria.
2. Keep a single service waiting list.
3. Offer clients an initial screening appointment (i.e., first step of triage) soon after referral in order to gather further information and redirect inappropriate referrals.
4. Offer a one-off brief therapeutic appointment (i.e., second step of triage) in order to supply the client with written information about treatment
5. Provide the client with evidence-based bibliotherapy material and temporary coping strategies.
6. The client can then decide whether he or she wants to “opt-in” to joining the waiting list in order to access further treatment.
7. Priority code the client according to transparent and consistent criteria surrounding perceived importance of treatment.
8. If possible offer clients a guaranteed waiting time after which the client has the right to be treated in another service.
9. Maintain regular contact with the clients on the waiting list and keep them informed of likely waiting time for appointment.
10. Prior to treatment, routinely address non-attendance policy.
11. Periodically review the waiting list and ask clients to “opt-in” to remaining on the list.
12. Make a reasonable effort to contact the client when therapeutic appointments become available.
13. Make clear to the client the limited number of sessions provided, or offer treatment in a group format.
14. Remove from the active caseloads clients who disengage and inform referral source of same.

**References**


