UTJMS 2026 February 16, 15(S1):e1-e3 doi:10.46570/utjms-2026-1679

Impact of Wait Times on Psychiatric Outcomes: A Mini-Review

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Received 7/30/2025

Accepted for publication 10/23/2025

Published 2/16/2026

Abstract

Prolonged wait times in psychiatric care (in the emergency department, outpatient setting, or between diagnosis and treatment initiation) have been associated with worsening clinical outcomes. This mini-review explores how wait times in psychiatric care contribute to worsening symptoms and emphasizes the need for earlier intervention. Psychiatric patients admitted through the emergency department stayed in the emergency department 3.2 times longer compared to nonpsychiatric admission. Following in-patient psychiatric care, patients are typically referred to outpatient visits. From 2011 to 2022 an increase in the median waiting time for outpatient psychiatic visits from 15 to 50 days was reported. After outpatient visits, patients still experience delays in their treatment initiation. Longer intervals between diagnosis and treatment initiation have been associated with worsening clinical outcomes. All these delays in psychiatric care highlight critical periods where early intervention can improve symptom progression and clinical outcomes.

Keywords: Psychiatric Wait Times, Symptom Progression, Mental Health Care Delays

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1. Introduction

Wait time in medicine is a common source of frustration for patients. Wait times delay medical care and serve as a barrier to adequate behavioral health care. Longer wait times were linked to a decreased likelihood of appointment attendance, with a 5% reduction in attendance per additional week of waiting (1). Wait times for psychiatric treatment can be categorized into three phases: in the emergency department, awaiting outpatient clinic visits, and the interval between clinic assessment and treatment initiation. A retrospective cohort study from 2007–2008 found that psychiatric patients admitted through the emergency department (ED) remained in the ED 3.2 times longer than nonpsychiatric admissions, with average stays of 1,089 minutes vs 340 minutes (2). Similarly, an Australian observational study comparing data from 2011 and 2022 reported a rise in median wait times for in-person outpatient clinical psychiatric care, from 15 to 50 days, highlighting a growing delay in outpatient access (3). Additionally, longer intervals between diagnostic assessment and treatment initiation in patients with major depressive disorder (MDD) were associated with worse treatment outcomes, underscoring the clinical implications of delayed care (4).

2. Discussion

Prolonged wait times in psychiatric care occur across various settings, including emergency departments, outpatient clinics, and the interval between diagnosis and treatment initiation. These delays are consistently associated with worsening clinical outcomes, regardless of where they occur. The ED is often the frontline resource for patients in psychiatric crisis. However, the ED is a suboptimal setting for individuals seeking psychiatric care due to limited psychiatric resources and a busy atmosphere. Geriatric and pediatric patients, two vulnerable populations, have experienced longer ED wait times for psychiatric consultation, alongside a rise in mental health–related visits, respectively (5, 6). These increased wait times for psychiatric consultation increase their risk of experiencing worsening symptoms and prolonged stay in the hospital (5, 6).

doi:10.46570/utjms-2025-1679

After hospital discharge, patients are typically referred for follow-up with a psychiatrist. Many report the time between discharge and the first outpatient appointment feels “too long,” highlighting a critical window for targeted intervention (7). These prolonged wait times were significantly associated with increased psychological distress, worsening symptoms, and engagement in maladaptive coping behaviors (7). A cohort study of 139,694 children and adolescents found that patients who received mental health follow-up within seven days showed a significant reduced risk of suicide during the initial 6-month discharge period (8). Being able to efficiently help patients during these critical windows could improve psychiatric outcomes. Additionally, the long wait times for outpatient psychiatric appointments does not only affect patients, but also adds strain on providers, limiting their ability to provide adequate care (3).
Delays between appointments and treatment initiation are another form of “wait time” that patients experience. Studies exploring both MDD and psychosis show that delayed intervention results in worse long-term outcomes (4, 9). The delay in treatment initiation represents a critical window during which symptoms could be addressed, yet many patients are left waiting. A 2024 systematic review found that brief, low-intensity interventions (e.g., psychoeducation, parental coaching, remote support, etc.) can mitigate symptom deterioration during high-risk delays in patient care (10). Minimizing the delay in treatment initiation can allow for improved treatment outcomes.

3. Conclusion

Increased wait times for patients with psychiatric symptoms result in worse clinical outcomes. Delays in patient care represent critical periods during which early interventions could improve symptom progression and overall prognosis. Despite studies showing that simple, brief interventions can help improve psychiatric symptom progression, systemic reform is needed to help reduce wait times across all aspects of psychiatric care. Increased support for telepsychiatry, rapid-start treatment pathways, and access to urgent care clinics where psychiatric needs can be met should be prioritized. Addressing these wait times through meaningful systemic reform and targeted interim interventions will help alleviate the growing burden of psychiatric illness.

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Acknowledgements

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