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Article

Waiting Times in Clinical Psychology in Public Mental Health Units: Predictors of Attendance at the First Appointment and Early Dropout

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ABSTRACT

Background: Waiting lists in mental health are a growing problem. This study analyzes their impact on attendance and early dropout from treatment in the Santander health area of the Spanish National Health System. **Method:** A retrospective observational study was conducted with 2,765 patients referred from Primary Care to four Mental Health Units during 2021. Logistic regressions were applied to analyze the influence of waiting times on attendance at the first appointment and early dropout, and ROC curves were used to identify optimal cut-off points. **Results:** The median waiting time was 51 days for the first appointment and 35 between the first and second. A total of 84.6% attended their first session, with higher attendance in women, older individuals, those with work-related disability, and shorter waiting times. Early dropout (15.8%) was associated with longer time between appointments, being male, and being younger. The discriminative power of the cut-off points was poor. **Conclusions:** Waiting times exceed recommended standards and negatively affect treatment continuity. Structural reforms and more human resources are needed to improve access to and the effectiveness of psychological care.

Tiempos de Espera en Psicología Clínica de las Unidades de Salud Mental Públicas: Predictores de Asistencia a Primera Consulta y Abandono Temprano

Palabras clave:
Psicología clínica
Atención primaria
Listas de espera
Asistencia
Abandono

RESUMEN

Antecedentes: Las listas de espera en salud mental son un problema creciente. Este estudio analiza su impacto en la asistencia y el abandono temprano del tratamiento en el área de salud de Santander del Sistema Nacional de Salud español. **Método:** Se realizó un estudio observacional retrospectivo con 2.765 pacientes derivados desde Atención Primaria a cuatro Unidades de Salud Mental durante 2021. Se aplicaron regresiones logísticas para analizar la influencia de los tiempos de espera en la asistencia a la primera cita y el abandono temprano, y curvas ROC para identificar puntos de corte óptimos. **Resultados:** La mediana del tiempo de espera fue de 51 días para la primera cita y 35 entre la primera y segunda. Asistieron a la primera cita el 84,6%, siendo más probable en mujeres, personas de mayor edad, con incapacidad laboral y menor tiempo de espera. El abandono temprano (15,8%) se asoció con mayor tiempo entre consultas, ser hombre y menor edad. El poder discriminativo de los puntos de corte fue pobre. **Conclusiones:** Los tiempos de espera exceden las recomendaciones y afectan la continuidad del tratamiento. Se requieren reformas estructurales y más recursos humanos para mejorar el acceso y la efectividad de la atención psicológica.

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Waiting lists in healthcare services represent a major global challenge, significantly impacting both accessibility and quality of care. This issue is particularly critical in mental healthcare, where the high and growing prevalence of mental disorders continues to overburden healthcare systems worldwide. In 2019, one in every eight people—around 970 million individuals globally—were living with a mental disorder, with anxiety and depressive disorders being the most prevalent (Institute for Health Metrics and Evaluation, 2022). The situation worsened with the onset of the COVID-19 pandemic, which led to an estimated 26% increase in anxiety disorders and a 28% increase in major depressive disorders in just one year (World Health Organization [WHO], 2022). In 2020, 53.2 million additional cases of major depression and 76.2 million new cases of anxiety disorders were recorded worldwide (Santomauro et al., 2021). By 2021, the number of global cases of mental disorders exceeded 440 million (Fan et al., 2025).

In Spain, recent data reflects a worsening trend. According to the National Statistics Institute (INE, 2025), 14.6% of the population over 15 years old experienced depressive symptoms in 2023. Moreover, the Ministry of Health (2024) indicates that 34% of the population reported experiencing some type of mental health problem, with anxiety disorders (10%), sleep disorders, and depressive disorders being the most commonly reported conditions.

Access to public mental healthcare services is essential for the timely detection and treatment of mental health problems. In this context, within the National Health System (NHS) of Spain, Primary Care (PC) serves as the first point of contact with the healthcare system, where around 20 to 55% of total appointments address mental health problems (Alonso-Gómez et al., 2019). However, the strain for the treatment of these problems largely falls on Mental Health Units (MHU), consisting of healthcare teams including clinical psychologists, psychiatrists, mental health nurses, as well as social workers in some cases. Therefore, coordination between PC and MHU is essential to provide high-quality thorough healthcare.

Despite the fact that the first recommended treatment approach for most mental disorders is psychological treatment (Gaudiano & Miller, 2013), it is necessary for patients to access these services within a reasonable time. Previous studies revealed an average waiting time for a first appointment in Clinical Psychology between 32 and 74 days in different Spanish cities, such as Pamplona (Goñi-Sarries et al., 2008), Burgos (Martín-Jurado et al., 2012), Madrid (Díaz et al., 2017), Badalona (Tejedo-García, 2018), and even clinical psychologists themselves have reported an average of 120 days for access to psychological care in Community of Madrid (Cuellar-Flores et al., 2022). The data on subsequent appointments is not encouraging either, as an average of 50 days has been recorded (Cuellar-Flores et al., 2022), which significantly hinders the implementation of formal psychological treatments. These studies highlight the significant variability and long waiting lists in the different regions of Spain, and are far from what the evidence recommends regarding the frequency of psychological treatment sessions. The study by Clark et al. (2018) found that interventions which started within the first six weeks from referral yielded better therapeutic outcomes, highlighting the urgent need to reduce waiting times to improve clinical results, as well as a weekly frequency to increase the effectiveness and efficiency of psychological treatments (Erekson, et al., 2015; 2022).

Long waiting lists in mental healthcare have significant repercussions, affecting both the care provided and the mental health of patients (Peipert et al., 2022). Delayed care may increase the chronicity of disorders and worsen the severity of symptoms (Cuijpers et al., 2021; Patel et al., 2015; Reichert & Jacobs, 2018; Wang, 2004). Furthermore, prolonged waiting times may demotivate patients, reducing their resilience and treatment response, and producing feelings of hopelessness regarding future interventions (Punton et al., 2022; Van Dijk et al., 2023). Additionally, limited and slow access to psychological therapies has led to a predominantly psychopharmacological first approach in PC, contrary to the recommendations of clinical guidelines from the National Institute of Health and Care Excellence (NICE, 2011). Previous studies in Spain found that 47% of patients referred to Clinical Psychology were already receiving psychopharmacological treatment (Díaz et al., 2017; Martín-Jurado et al., 2012). The situation not only goes against best practice, but also contributes to the chronicity of mental disorders and increased long-term costs (González-Blanch et al., 2023).

Following this line, prolonged waiting time is considered as one of the most determining factors in the attendance of clinical psychologist appointments (Gallucci et al., 2005; Loumidis & Shropshire, 1997; Miranda-Chueca et al., 2003; Vellisca et al., 2014). The negative impact of long waiting lists is reflected in lower attendance at the first appointment and higher early dropout (Steinert et al., 2017; Swift et al., 2012). Early dropout refers to the premature termination of the treatment without fulfilment of the therapeutic goals or possible benefits that may have been possible with normal termination of the therapy (Swift & Greenberg, 2012). Although attendance rates at the first appointment in Spain have been reported to range from 80% to 90% (García-Pedrajas et al., 2018; Miranda-Chueca et al., 2003; Tejedo-García, 2018; Vellisca et al., 2014), early dropout rates in psychological treatments are commonly observed to range from 20% to 25%; (García-Pedrajas et al., 2018; Hanevik et al., 2023; Swift & Greenberg, 2012).

Several sociodemographic and clinical variables have been examined in an attempt to explain attendance rates, although the results remain contradictory. For example, the study by Vellisca et al., (2014) found no significant association between attendance at the first appointment and various sociodemographic variables (i.e. sex, age and population type). However, other studies have found a significant relationship between attendance at the first appointment and older age (especially over 25 years old), having a temporary work disability or previous history of mental health treatment (Fenger et al., 2011; Loumidis & Shropshire, 1997; Moratalla & Lobo, 2002). Additionally, predictors of early dropout from psychological treatment have been found to include being under 45 years old, unemployed, lower educational level and poor social support, although severity of symptoms was not a predictor (Fenger et al., 2011; Hanevik et al., 2023; Swift & Greenberg, 2012).

Despite advancements in mental healthcare research, several gaps remain in the literature. First, previous studies have focused on specific centres within a region, hindering the capacity to capture the variability and representativeness of an entire healthcare area. Second, the lack of studies conducted after the COVID-19 pandemic limits the understanding of the evolution of healthcare demands and the population needs following the impact of the pandemic on public mental healthcare services. Finally, although previous

studies have found inconsistent results in the relationship between sociodemographic variables and attendance at the first appointment and early dropout, waiting times are considered central factors for both variables. These discrepancies highlight the need to focus our analysis on the impact of waiting times, since it is the index most influenced by the different Healthcare Services in Spain. Furthermore, studies that control for other variables potentially influencing attendance and early dropout are very limited.

The objectives of this study, conducted in the healthcare area of Santander, Cantabria (Spain), are threefold: (i) to examine waiting times for a first and second appointment, (ii) to analyze the influence of waiting times in the attendance at the first appointment and early dropout from psychological treatment, while controlling the effect of several sociodemographic and clinical variables, across all referral received throughout an entire year in every MHU within a healthcare area, and (iii) to determine an optimal cut-off for waiting times at the first and second appointments which maximises attendance and minimises early dropout.

Method

Participants

The sample study included all patients aged 18 years and older referred by a general practitioner for a first treatment appointment with a clinical psychologist of the four MHUs belonging to the Healthcare Area of Santander between 1st January to 31st December 2021. Patients were selected during a whole year to remove any seasonal effect from the sample recruitment. A first treatment appointment was considered as those patients attending a clinical psychologist appointment for the first time in the Cantabrian Healthcare Service or, in cases with a history of prior psychological care, when more than one year had passed since their last appointment at the MHU. Patients were excluded if (i) they were referred from other mental health professionals from the same MHU, such as a psychiatrist or from other healthcare services different from PC, (ii) they had notified the MHU in advance to cancel the appointment before attending, and (iii) the reason for referral should be addressed in other healthcare facilities more appropriate or in specialised programs.

Instruments

An ad-hoc protocol for data collection was elaborated, based exclusively on information retrieved from electronic health records (EHRs). The protocol included the following variables:

Sociodemographic Variables

Sex, age, civil status, maximum level of education attained, and current employment status.

Clinical Variables

History of psychological care (defined as an appointment in any mental healthcare resource in the Cantabrian Healthcare Service prior to referral), reason for the appointment recorded by the general practitioner according to the International Classification of Primary Care (ICPC-2), which was recoded in accordance with the International Classification of Diseases-10 (ICD-10) diagnoses to improve categorization, prescription and type of psychopharmacological treatment at the time of referral, and the existence of a temporary work disability at the time of referral.

Healthcare Variables

MHU handling the demand, waiting time (defined as the number of days between the referral of the general practitioner and the first appointment with the clinical psychologist), attendance at the first appointment, and clinical discharge at the first appointment. Finally, for patients who were offered a second appointment, the time between appointments was recorded (defined as the number of days between the first and second appointments). Early dropout was registered in patients who were not clinically discharged in the first appointment, but did not attend the second appointment nor resume follow-up within a year from the first appointment.

Procedure

A single-group retrospective observational cohort design was conducted in the Healthcare Area I of Cantabria, corresponding to the city of Santander, during the year 2021. This Healthcare Area includes 20 health centres and 40 clinics that refer patients to four MHUs (Puertochico, López Albo I and II and Nueva Montaña), assisting a predominantly urban population of over 315,000 habitants in the year 2021. The characteristics of the different MHUs are displayed in Table 1.

When a general practitioner identifies a mental health problem in a patient and considers that the patient may benefit from psychological treatment, an electronically recorded referral is made to the corresponding MHU assigned to their PC centre. Subsequently, the patient is scheduled for a first in-person appointment with the

Table 1

Characteristics, Population and Resources of the Mental Health Units of Santander in 2021

Variables	MHU López Albo I	MHU López Albo II	MHU Nueva Montaña	MHU Puertochico	Healthcare Area I (Santander)
Population[a]	75,320	100,073	76,115	63,908	315,416
Population above 14 years old[a]	66,104	87,406	66,030	57,028	276,568
Number of Health Centres	5	5	4	6	20
Number of CP per MHU	2	3	2	2	9
CP of MHU per 100.000 habitants	2.66	2.99	2.63	3.13	2.85

Note. CP = clinical psychologist; PC = primary care; MHU = mental health unit.

[a]Number of healthcare cards in the year 2021 obtained through internal correspondence with Primary Care Management of the Cantabrian Healthcare Service.

clinical psychologist who has the earliest availability. To maximize attendance, the Cantabrian Healthcare Service contacts the patient via phone to inform the date of their appointment, and a mobile message is sent to remind them two days before. In this study, data collection was conducted by retrieving EHRs from the Cantabrian Healthcare Service using specific software programs (VisorCorp for PC and Altamira for specialised care). Due to the retrospective nature of the study, general practitioners were not informed about the study nor its objectives, ensuring that their referral and treatment criteria were not influenced.

We took measures to ensure the privacy and confidentiality of the data throughout the study. Given the de-identified nature of the data and the practical challenges of obtaining informed consent from every individual whose data was included in the study, we did not request informed consent from participants. We believe that the absence of identifiable personal information in the EHRs and the impracticality of obtaining consent for large datasets justifies the exemption. Recognizing that the use of EHRs for research purposes involves ethical considerations, we followed best practices to minimize any potential risks to participants. This approach was reviewed and approved by the local Ethics Committee (2021.410).

Data Analysis

Descriptive analyses included the mean (*M*), standard deviation (*SD*), Median (*Mdn*) and interquartile range (*IQR*) for quantitative variables, while frequency (*n*) and percentage (%) were reported for categorical variables. Due to the violation of normality assumption in every continuous variable, the non-parametric Mann-Whitney *U* test was used to make comparisons with two different groups. Then, multiple logistic regression assumptions (linearity in the logit for continuous predictors, absence of multicollinearity, independence of errors, and absence of overly influential outliers) were confirmed and it was used to calculate the relationships between attendance at the first appointment and waiting time, as well as early dropout and time between first and second appointments, while statistically adjusting for the confounding effects of other sociodemographic, clinical and healthcare variables of relevance according to the literature. We used the adjusted odds ratio (*aOR*) as effect size for every variable included in the models. A $p < .05$ was considered as the minimum threshold for statistical significance. To assess the discriminative capacity of waiting times in predicting attendance at the first appointment and early dropout, receiver operating characteristic (ROC) curve analyses were conducted. The area under the curve (AUC), sensitivity and specificity was reported. The Youden Index (*J* = Sensitivity + Specificity – 1) was also calculated to determine optimal cut-off points. Every analysis was carried out using the statistical program Statistical Package for the Social Sciences (SPSS) version 25.0.

Results

Descriptive Analyses

The final sample of the study consisted of 2,765 patients. The sociodemographic and clinical characteristics of the sample are displayed in Tables 2 and Table 3, respectively.

Table 2
Sociodemographic Characteristics of the Study Sample

		n	%
Age		2,765	
	18-24 years	377	13.6
	25-39 years	773	28.0
	40-65 years	1,409	41.0
	> 65 years	206	7.4
Sex		2,765	
	Women	1,953	70.6
Civil Status		2,233	
	Single	518	23.2
	In a relationship	470	21.1
	Married	880	39.4
	Divorced	291	13.0
	Widowed	74	3.3
Level of Education		1,092	
	Primary education	89	8.1
	Secondary education	135	12.4
	Upper secondary education	165	15.1
	Vocational training	358	32.8
	College Diploma	345	31.6
Current employment status		2,319	
	Student	224	9.7
	Working	906	39.1
	Unemployed	290	12.5
	Temporary work Disability	529	22.8
	Permanent Work Disability	38	1.6
	Retired	171	7.4
	Homemaker	88	3.8
	Working and Studying	41	1.8
	Other	32	1.4

Note. The mean age of the study sample was 43.1 years old (*SD* = 14.9)

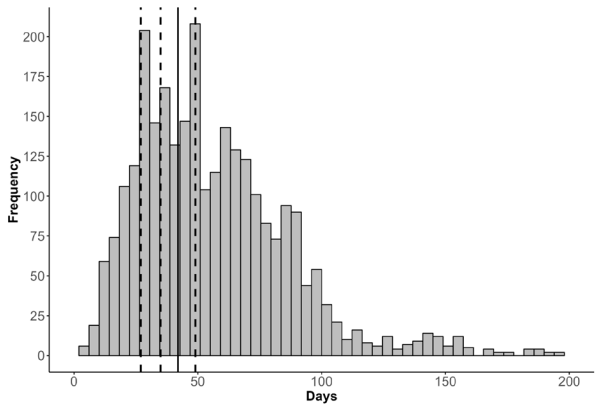
Table 3
Clinical Characteristics of the Study Sample

		n	%
History of psychological care		2,763	
	Yes	953	34.5
Reason for appointment		2,765	
	Anxiety disorders	1,440	52.1
	Adjustment disorders	496	17.9
	Depressive disorders	418	15.1
	Other disorders	411	14.9
Psychopharmacological treatment at the time of referral medication		2,763	
	Yes	1,744	63.1
Type of psychopharmacological treatment		1,744	
	Anxiolytic	717	41.1
	Anxiolytic and antidepressant	659	37.8
	Antidepressant	317	18.2
	Others	51	2.9

The distributions of the waiting time for the first and second appointment are presented in Figures 1 and 2, respectively. The average waiting time for the first appointment with a clinical psychologist was 58.2 days (*SD* = 35.5), with a median of 51 days (*IQR* = 40), a minimum of 2 days, and a maximum of 329 days. Notably, in 65.6% of the sample (*n* = 1,727) the waiting time for the first appointment exceeded the recommended clinical standard of 6weeks. The attendance rate for the first appointment was 84.6% and clinical discharge at the first appointment was provided to 21.3% of the patients. Additionally, the average waiting time for a second appointment was 40.9 days (*SD* = 23.4), with a median of 35 days (*IQR* = 22), a minimum of 3 days, and a maximum of 220 days. Among patients who were offered a second appointment, the

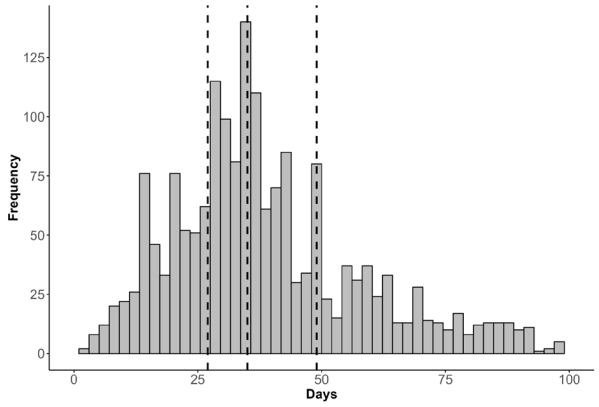
attendance rate was 84.2%, thus 15.8% did not attend the second appointment, nor resumed subsequent care within the 1-year follow-up period (i.e., early dropout).

Figure 1
Waiting Time Distribution for the First Appointment



Note. Straight line placed in 42 days to represent the recommended clinical standard for a first appointment with a clinical psychologist. Dashed lines indicate the 25th (34 days), 50th (51 days), and 75th (74 days) percentiles. Values exceeding 200 days were grouped into the 200 category to improve visualisation.

Figure 2
Waiting Time Distribution Between First and Second Appointment



Note. Dashed lines indicate the 25th (27 days), 50th (35 days), and 75th (49 days) percentiles. Values exceeding 100 days were grouped into the 100 category to improve visualisation.

Predictors for the Attendance at the First Appointment

The main variables associated with attendance at the first appointment were analysed. The Mann-Whitney test found statistically significant differences in the waiting time ($U = 531002.5$; $p = .022$; $r = .07$) between the group that did not attend the first appointment ($Mdn = 53$; $IQR = 37$) and the group that did attend ($Mdn = 51$; $IQR = 32$). A multiple logistic regression was performed to predict attendance at the first appointment based on waiting time, while statistically controlling for the variables of age, sex, history of psychological care, presence of a temporary work disability and psychopharmacological treatment. The model statistically predicted attendance at the first appointment ($\chi^2(2750) = 66.58$; $p < .001$; Nagelkerke $R^2 = .024$) and correctly classified 84.7% of the cases. The coefficients of the variables included in the model are presented in Table 4. The results indicate that attendance at the first appointment was significantly influenced by shorter waiting time, but also by being female, older age and the presence of a temporary work disability, with each of these variables making an independent contribution to the prediction.

To evaluate the discriminative ability of waiting time in predicting attendance at the first appointment, a ROC curve analysis was performed. The AUC was 0.535 (95% CI [0.506–0.564]), indicating a poor discriminative performance. Consistently, the Youden Index did not identify any clinically meaningful threshold, with the highest value observed at 44 days ($J = 0.082$). At this threshold, sensitivity was 0.682 and specificity was 0.399, further reflecting a limited ability of waiting time to distinguish between attendees and non-attendees.

Predictors for Early Dropout

Main predictors of early dropout at the second appointment were examined. Statistically significant differences were found in the waiting time for the second appointment ($U = 156993$; $p < .001$; $r = .27$) between individuals who dropped out ($Mdn = 42$; $IQR = 26$) and those who did not drop out ($Mdn = 35$; $IQR = 23.75$). A multiple logistic regression model was performed to predict dropout at the second appointment based on waiting time and time between appointments, while statistically controlling for age, sex, history of psychological care and presence of a temporary work disability. The results indicated that the model was statistically significant in predicting early dropout ($\chi^2(1812) = 53274$; $p < .001$; Nagelkerke $R^2 = .029$). The coefficients for the variables included in the model are presented in Table 3. Statistically significant predictors of early dropout were longer waiting time between appointments, but also younger age and being male, which played a significant predictive role in the likelihood of early dropout.

To complement these findings and further assess the discriminative utility of waiting time between appointments, a second ROC curve analysis was conducted. The AUC was 0.633 (95% CI [0.601–0.666]), suggesting a modest discriminative ability to distinguish individuals at risk of early dropout. The Youden Index identified 36 days as the optimal cut-off point ($J = 0.203$), corresponding to a sensitivity of 0.668 and a specificity of 0.536. This suggests that when the interval between appointments exceeds approximately one month, the risk of early dropout increases significantly.

Discussion

The aim of the study was to analyse waiting times for access to specialised psychological care from PC and its relationship with attendance at the first appointment and early dropout from psychological treatment while controlling for several sociodemographic and clinical variables. The study revealed that the median waiting time for specialised psychological care at MHU is 51 days for the first appointment and 35 days for the second. The attendance rate for the first appointment was 85%, which was influenced by shorter waiting time, being female, older age and the presence of a temporary work disability. On the other hand, an early

Table 4
Logistic Regression Models to Examine Potential Predictors of Attendance at the First Appointment and Early Dropout

	Attendance at the first appointment (n = 2,757)				Early dropout (n = 1,820)			
Variables	***aOR***	**95% CI**		***p***	***aOR***	**95% CI**		***p***
		LL	*UL*			*LL*	*UL*	
Age	1.018	1.011	1.026	<.001	0.986	0.977	0.995	.004
Sex	0.789	0.629	0.989	.040	1.404	1.058	1.863	.019
History of psychological care	0.840	0.675	1.045	.118	1.206	0.917	1.587	.180
Presence of a TWD	1.835	1.360	2.476	<.001	0.789	0.569	1.095	.156
Presence of any psychopharmacological treatment	1.116	0.891	1.397	.340	0.986	0.728	1.288	.825
Waiting time	0.996	0.993	0.998	.002	0.997	0.993	1.001	.107
Time between appointments		—			1.016	1.011	1.021	<.001

Note. aOR = adjusted odds ratio; CI = confidence interval; *LL* = lower limit; TWD = temporary work disability; *UL* = upper limit.

dropout rate of 16% was found after the first appointment, being mainly related to longer waiting time for a second appointment, being male and younger age.

These findings reflect a concerning reality in the field of public mental healthcare and highlight a significant structural problem regarding access to psychological care. The results indicate access difficulties, with waiting times reaching seven weeks for a first appointment and five weeks for a second. Although our data fall within an intermediate range compared to other national studies—where waiting times for the first consultation range from 30 to 120 days (Cuéllar-Flores et al., 2022; Díaz et al., 2017; Goñi-Sarries et al., 2008; Martín-Jurado, 2012; Tejedo-García, 2018)—they still exceed current recommendations. On the other hand, research on waiting times for a second appointment is scarce. Some recent studies, such as that by Cuéllar-Flores et al. (2022), report an average of seven weeks in the Community of Madrid, while Benítez-Ortega et al. (2021) report an eight-week interval in Andalucia. Although our study shows slightly shorter waiting times, they remain above the recommended thresholds and could negatively impact the therapeutic process and patient recovery (Reichert & Jacobs, 2018; van Dijk et al., 2023). Overall, patients experience significant delays, exceeding the recommended six-week timeframe for a first appointment (Clark et al., 2018), as well as the one-week interval for subsequent sessions (Erekson et al., 2015, 2022).

Regional heterogeneity in waiting times may stem from differences in healthcare resources, Clinical Psychology staffing, and the internal organization of each regional system. Social determinants such as socioeconomic status, education, and community context also shape mental healthcare demand and access, contributing to observed inequalities (Kirkbride et al., 2024). Although the number of clinical psychologists has increased since 2003—reaching 6,010 professionals under age 65 by 2021 (Ministry of Health, 2022)—only 2,615 are estimated to work in the public healthcare system, resulting in a ratio of 5.56 per 100,000 inhabitants (Duro-Martínez, 2021; Fernández-García, 2021). This shortage, combined with the growing prevalence of mental disorders, has led to longer waiting lists for both initial and follow-up appointments. While structural and social factors are essential to understanding these disparities, certain interpretations of them may conflict with the need to ensure access to psychological treatments in the public system, ultimately reinforcing existing inequalities (González-Blanch, 2025).

The lower waiting times reported in previous studies may be due to differences in the time periods during which they were conducted, as there has been a progressive increase in the prevalence of mental disorders (WHO, 2017). In this regard, the possible discrepancies with earlier research reflect pre-pandemic realities, whereas the COVID-19 pandemic led to a significant rise in the demand for mental health care (Pfefferbaum & North, 2020), thereby contributing to the prolonged waiting times observed in our study. Moreover, the organizational structure of the healthcare system may also play a role, particularly the tendency to prioritize the intake of new patients by increasing the number of weekly first appointments in an effort to reduce its waiting time. While this approach is understandable from an accessibility standpoint, it may have adverse effects on long-term treatment quality, as it limits the system's ability to provide continuous and structured subsequent care.

These structural limitations may also help explain the high proportion of patients who were already receiving psychopharmacological treatment —nearly two-thirds—with anxiolytics being the most frequently prescribed medications. Although our study does not establish a direct link between waiting times and the prescription of psychopharmacological treatments, prolonged delays in accessing psychological care—along with other limitations in PC—may contribute to the continued reliance on medication as a faster and more accessible solution (Marquina-Márquez et al., 2022). Clinical guidelines, such as those from NICE (2022), recommend psychological therapy as the first-line intervention for anxiety and depression. However, the high rates of psychopharmacological prescription observed in our sample—despite these guidelines—point to a persistent gap between recommended practice and actual clinical implementation.

The results of this study highlight that prolonged waiting times not only affect accessibility to psychological treatment but also compromise its continuity, increasing the risk of early dropout. In line with previous literature (Gallucci et al., 2005; Loumidis & Shropshire, 1997; Miranda-Chueca et al., 2003; Vellisca et al., 2014), the longer the delay for a first appointment, the higher the absenteeism rate. However, when examined more closely through ROC curves, waiting time showed a limited capacity to establish a clinically useful cut-off point for distinguishing between attendees and non-attendees. While the regression analysis confirmed that shorter waiting times were significantly associated with higher attendance, the ROC results indicate that no single cut-off point offers sufficient sensitivity and specificity to identify a critical threshold beyond which the risk of non-attendance increases markedly. The optimal threshold identified was 44 days, but

it presented very low discriminative capacity, suggesting that attendance at the first appointment is not determined solely by structural factors such as waiting times.

In this regard, sociodemographic and clinical characteristics appeared to play an important role. Being female, older age, and those in the situation of temporary work disability were more likely to attend the first appointment. These results are consistent with previous studies, such as those by Moratalla and Lobo (2002), Fenger et al., (2011) and Loumidis and Shropshire (1997). Specifically, in the case of temporary work disability, these patients may experience greater functional impairment, which could justify both the referral and the motivation to receive treatment (Lau et al., 2016). Additionally, they have more flexibility to attend since they are not subject to a work schedule that could interfere. However, the role of other external factors, such as institutional pressure to justify the temporary work disability, cannot be ruled out, as it may be related to a poorer response to psychological treatment (González-Blanch et al., 2021).

Similarly, a longer time interval between the first and second appointment is associated with a significant increase in the likelihood of early dropout. In this case, the ROC analysis showed a modest improvement in discriminative capacity, identifying a threshold of approximately 36 days beyond which the risk of early dropout increases notably, offering more informative guidance for service planning. This finding could be explained by a progressive loss of motivation, as well as feelings of frustration or distrust towards the healthcare system (Punton et al., 2022; van Dijk et al., 2023). Additionally, prolonged waiting time between appointments may create a sense of discontinuity, affecting the perception of treatment effectiveness (Swift & Greenberg, 2012). On the other hand, these delays, particularly between appointments, could interfere with the consolidation of a strong therapeutic alliance, which is especially important during the early clinical encounters. The absence or fragility of this alliance may negatively influence the progress of the psychotherapeutic process and increase the risk of dropout (Flückiger et al., 2018; Horvath et al., 2011; Roos & Werbart, 2013; Sharf et al., 2010). As a result, this could lead to the chronicity of disorders, the worsening of symptoms, and a growing sense of helplessness regarding future interventions (Cuijpers et al., 2021; Patel, 2015; Peipert et al., 2022; Reichert, 2018; Wang, 2004). Alternatively, it is also possible that during the waiting time, there could be spontaneous remission of symptoms, which may reduce the perception of the need for intervention and contribute to either not accessing treatment or dropping out once it has begun.

However, while waiting time appears to play a relevant role in early dropout, it is also important to consider individual factors. In this regard, early dropout was more common among men and younger individuals. The higher dropout observed in men could be explained by their lower tendency to seek professional help (Nam et al., 2010; Wang et al., 2007), which may hinder their commitment to treatment. Regarding age, it has been observed that younger patients have a lower adherence rate to psychological interventions, possibly due to higher levels of stigma towards mental disorders in this age group (Benjet et al., 2022; Clarkin et al., 2024).

Finally, it is important to highlight the strengths and limitations of the present study. One of its main strengths is, firstly, the extensive data collection period, which spans an entire year, allowing for a more robust and less biased representation of the healthcare reality. Additionally, direct access to information through the thorough review of all referrals via the EHR ensures precise and reliable data collection. Moreover, the fact that the study includes the entire healthcare area of an autonomous community broadens its applicability within the regional context and provides a more comprehensive and representative view of the functioning of a mental healthcare service. However, some limitations should be considered. Firstly, the sample is limited exclusively to referrals from PC, excluding other routes such as specific hospital programs or psychiatrists from the same MHU. Although these represent a small percentage of the total patients attended, their exclusion means that the results do not fully reflect all the entry pathways into the psychological care system. Secondly, although the study focused on waiting times, which are one of the most system-dependent factors, variables such as the patient's level of motivation, perceived need, or personal practical barriers (e.g., work schedule, family care, transportation, etc.) were not recorded and could enhance the analysis of predictors for attendance and dropout in future studies. Finally, it should be noted that, although the study encompasses an entire healthcare area within one autonomous community—specifically, Area I of Cantabria—, the findings regarding the impact of waiting times on adherence may not be generalizable to other regional healthcare contexts with different organizational structures or levels of resource allocation.

In conclusion, this study highlights the importance of addressing waiting times not only as an indicator of healthcare system efficiency but also as a clinically relevant factor that affects access to and adherence to psychological treatment. The situation described calls for a thorough review of the healthcare system, promoting structural reforms that enable more accessible, continuous, and effective psychological care.

In this regard, one of the key actions to achieve these goals involves increasing the number of clinical psychologists by expanding the availability of specialised training positions. This would help address growing demand and improve access to evidence-based psychological treatments. Additionally, it is essential to promote strategies that improve the efficient use of available resources, strengthen coordination across different levels of care, and support the development of quality assessment plans to evaluate the system's performance and identify service needs.

Among these approaches, stepped-care models are increasingly being implemented as a way to organise mental health services to maximise the effectiveness and efficiency of allocation of resources by ensuring that the intensity of intervention matches the individual's clinical needs (McGorry & Mei, 2021). The treatments following this model are structured along a continuum of intensity ranging from low-intensity (e.g. self-help or group therapy) to high intensity (e.g., specialised or multidisciplinary intervention) and have been shown to improve the treatment response and remission of depressive and anxiety disorders (Jeitani et al., 2024).

In Spain, the PsicAP project has demonstrated the effectiveness of brief psychological interventions in PC (Cano-Vindel et al., 2022). Based on this experience, Cantabria began integrating clinical psychologists into PC centres in 2023, which could represent a significant change in the structure and functioning of Mental Health Units. Future studies should evaluate the impact of these measures on reducing waiting times and improving care continuity.

Author Contributions

María del Mar Miras-Aguilar: Conceptualization, Methodology, Funding acquisition, Investigation, Data curation, Formal analysis, Visualization, Writing – Original draft, Writing – Review & editing. **Jose Ruiz-Gutiérrez:** Conceptualization, Methodology, Funding acquisition, Investigation, Data curation, Formal analysis, Visualization, Writing – Original draft, Writing – Review & editing. **Sandra Martínez-Gómez:** Conceptualization, Methodology, Funding acquisition, Investigation, Data curation, Writing – Review & editing. **Saioa Pérez-García-Abad:** Conceptualization, Methodology, Funding acquisition, Investigation, Data curation, Writing – Review & editing. **Carmen Ramos Barron:** Funding acquisition, Supervision, Writing – Review & editing. **Emilio Pariente Rodrigo:** Funding acquisition, Supervision, Writing – Review & editing. **Lourdes Piñán Setién:** Funding acquisition, Supervision, Writing – Review & editing. **Noelia Otero Cabanillas:** Funding acquisition, Supervision, Writing – Review & editing. **César González-Blanch:** Conceptualization, Methodology, Funding acquisition, Writing – Review & editing, Supervision, Project administration.

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Conflict of Interests

The authors declare that there are no conflicts of interest.

Data Availability Statement

Data available on request from the authors.

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