Latrobe Regional Health Service
Mental Health Triage

Program Evaluation

Latrobe Regional Hospital

FINAL REPORT

June 2010

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Latrobe Regional Health Service Mental Health Triage
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Mental Health Triage Program Evaluation

Deakin University
In collaboration with
Centre for Psychiatric Nursing,
The University of Melbourne

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This is the published version:

Sands, Natisha, Elsom, Stephen and Gerdtz, Marie 2010, Latrobe regional health service mental health triage program evaluation : final report [Deakin University in collaboration with Centre for Psychiatric Nursing, The University of Melbourne], [Melbourne, Vic.]

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Acknowledgements

This project was funded by Latrobe Regional Health Service, Mental Health Services.

The authors wish to acknowledge the contribution of the following people:

- Roshani Kanchana Prematunga, University of Melbourne – statistical support
- The LRH Mental Health Triage Staff
- The Regional Emergency Department staff
- The Consumers and Carers who agreed to be interviewed
- The LRH MH intake staff
- The LRH reception staff
- The LRH administration team
- Eileen Geary, Manager, LRH
- Cayte Hoppner, Director of Mental Health, LRH
- The Centre for Psychiatric Nursing
Aim and scope

Latrobe Regional Health Mental Health Triage (LRHMHT) program provides a single point of entry for 24 hour, seven day a week access to mental health services in the Gippsland region. In addition to facilitating access to mental health services for people with mental health problems, LRHMHT provides a range of services such as assessment, referral, information and secondary consultation to other healthcare providers and services in the region.

The aim of this evaluation was to investigate LRHMHT mental health triage service provision with the aim of identifying the accessibility, timeliness, responsiveness, consistency, accountability and quality of the current model of service delivery. The purpose of the evaluation was to identify key areas for LRHMHT service improvement.

The evaluation scoped a broad range of stakeholders including seven regional emergency departments, the Adult, Aged and Child and Adolescent Mental Health Intake teams, reception staff, consumers, carers, and the LRHMHT staff.

Setting

LRHMHT service provision covers a geographic area of 44,000 square kilometers and services a population of approximately 250,000. The profile of service delivery includes point of entry assessment and referral services for Child and Adolescent, Adult, and Aged persons seeking assistance with a mental health problem, in addition to assessment, referral and secondary consultation services for a range of other agencies and health providers in the region.

Approach

Program Evaluation methodology involving a retrospective review of 882 occasions of mental health triage, a series of stakeholder interviews, and policy analysis was employed to investigate the program's effectiveness, strengths, weaknesses, and the impact of the program on mental health triage service-users.

The methodological framework for the evaluation took into account the Victorian Government's key principles for effective mental health triage service provision, which include: access, responsiveness, accountability, timeliness and consistency.
Results

The evaluation identified a number of key areas for service improvement and also established that the LRHMHT service is highly valued by stakeholders in the region. Service-users expressed a high degree of satisfaction with the quality LRHMHT service provision, and also provided comment on the weaknesses in the present model.

Limitations

The evaluation was limited by the retrospective nature of the clinical file audit, the quality and depth of the clinical documentation reviewed, and the time lag between interviewing service-users and their episode of LRHMHT service in 2009.

Recommendations

Thirty-eight key recommendations for service improvement were identified in the evaluation:

1. Consultant Psychiatrist input into the continuous quality assurance and risk monitoring processes of LRHMHT

2. CMI Screening Register to be used to record all patient contacts with the service, replacing the Triage Referral Record Form

3. Implement a consistent model of care for LRHMHT service provision that clearly articulates the profile of service delivery and is underpinned by a consumer-centred approaches.

4. MHT staff requires skills training in the assessment of aged persons and children and young people to improve the accuracy and consistency of MHT screening assessment practice.

5. Improve community access to LRHMHT by allocating resources toward promoting the direct availability and accessibility of the service across the region.

6. Adopt the Department of Health (MHDD) AMHS Mental Health Triage Scale, which has been embedded in CMI to facilitate consistency in triage screening assessment and dispositions. Linked to this recommendation is the need for training in categorising urgency based on clinical need.

7. Update and improve clinical information systems to include an electronic medical record accessible to all arms of the service.
8. Introduce a consistent approach to risk assessment and management using standardised processes. Introduce a continuous cycle of review processes to ensure quality and ongoing monitoring of risk assessment processes.

9. LRHMHT requires training and support to assist them in the provision of secondary consultation to other service providers.

10. Provide training to LRHMHT on clinical documentation and communication of significant findings such as risk issues and related responsibilities to other health providers.

11. Review the use of reception staff to receive incoming calls for LRHMHT

12. Provide education to the Emergency Departments around the management of high risk and recommended patients

13. Review the protocol on the requirement for every mental health presentation to the emergency department to be medical cleared prior to assessment by the mental health service

14. Increase LRHMHT capacity to respond directly to Emergency Departments in provision of face-to-face assessments

15. Invest in shared clinical information systems to improve access to patient information

16. Invest in greater mental health presence in the Emergency Departments

17. Ensure that all Emergency Departments in the region are able to receive an overnight response (assessment) when required

18. Ensure management plans for complex patients are updated, communicated, and available to the Emergency Departments

19. Provide ongoing support to the Emergency Department’s medical and nursing staff in managing mental health presentations

20. Investing in increased Consultation and Liaison coverage to Emergency Departments during business hours

21. Ensure Child and Adolescent Mental Health Intake worker is available to undertake timely assessments of children in the Emergency Department

22. Provide clear guidelines for Emergency Departments for the management of mental health presentations to the Emergency Departments, including shared policies and protocols
23. Develop formal communication processes between the LRHMHT service and specialist services including APMHS, CAMHS and Adult intake services.

24. Paper-based communication processes, including faxing of copies of triage contacts and leaving patient referrals in “in-trays” should be replaced by an accessible system of electronic information management and communications.

25. Review the arrangement with Latrobe Regional Hospital Emergency Department regarding the policy of automatic assignment of Triage Category 2 response for all mental health related presentations.

26. Review the use of LRHMHT to arrange medical-to-medical (psychiatrist) consultation.

27. Review the faxed referral system from General Practitioners to LRHMHT

28. Reduce the amount of inappropriate use of triage resources (ie reporting all inpatient discharges/leaves to triage)

29. Invest in backfill to enable LRHMHT staff to undertake training and participate in relevant meetings

30. Invest in wireless headsets for triage staff

31. Consider investing in rotations through triage - succession planning and skills development

32. Consider increasing staff EFT to LRHMHT

33. Record all triage contacts on CMI database screening register

34. Develop clear governance framework for LRHMHT

35. Invest in ongoing psychiatrist consolation and support to LRHMHT

36. Facilitate MHT participation in relevant meetings and forums on clinical governance

37. Provide MHT with training in effective documentation

38. Provide MHT clinicians with training in family-sensitive practice.
INTRODUCTION AND BACKGROUND

1. Background

1.1 Area Mental Health Triage

Mental health triage services operate seven days a week, 24 hours a day across Victoria. These services provide assessment, support, and referral for people experiencing mental health problems. Mental health triage is the first point of contact with public mental health services for all potential consumers (or people seeking assistance on behalf of a person thought to have a mental illness). Triage is a clinical function that aims to provide an initial mental health screening assessment to determine whether the person has a mental health related problem, the urgency of the presentation, and the most appropriate service response. Where it is considered that Area Mental Health Services are not the most appropriate option for the person, he/she may be referred to another organisation, or given other advice. Where a mental health triage assessment indicates that specialist mental health services are required, a more comprehensive assessment is provided through the intake assessment service. Thus, the triage role encompasses mental health assessment, categorising urgency, facilitating referral, and the provision of health information and/or advice.

Mental health triage services have been operational in Area Mental Health Services (AMHS) in Victoria and across Australia since the early 1990’s, but to date there has been very little research that has investigated AMHS triage systems. AMHS triage services were established individually across the regional sectors of Victoria, and this has resulted in considerable variation in the way services have been operationalised, and inconsistencies in triage performance. Victorian AMHS triage systems currently lack uniformity and standardisation in clinical procedures for conducting risk assessment and categorising urgency.

1.2 Evaluation context

The Latrobe Regional Hospital Mental Health Service (LRHMHS) provides a diverse range of specialist public mental health services across the lifespan to the Gippsland region. LRHMHS covers a geographic area of 44,000 square kilometers and services a population of approximately 250,000. The profile of
service delivery scopes a range of bed-based and community mental health services across ten sites.

The LRHMHS Mental Health Triage (LRHMHT) program provides a single point of entry for 24 hour, seven day a week access to mental health services in the Gippsland region. As the primary interface between the community and mental health services, mental health triage is critical to appropriate, timely assessment and care for people requiring assistance with a mental health problem. In addition, the triage function extends to providing information, advice, support and appropriate referral for consumers, carers, other service providers, and the community.

An independent evaluation of LRHMHS conducted in 2008 identified a range of issues associated with LRHMHT service provision. In particular, the evaluation identified problems associated with access, inaccurate screening of referrals, a lack of referral pathways provided to callers, a lack of clarity on profile of MHT service delivery, and skills gaps in relation to triage assessment of children, young people, and aged persons. In addition, the evaluation identified that the lack of clarity around the LRHMHT profile of service delivery, role and function, was contributing to poor relations with other service providers in the region.

2. Evaluation Plan

2.1. Aims

LRHMHS aims to provide an accessible, consistent, accountable and responsive mental health triage service (MHTS) that operates within a strong framework of clinical governance.

The purpose of the evaluation is to investigate LRHMHS mental health triage service provision with the aim of identifying the accessibility, timeliness, responsiveness, consistency and accountability of the current model of service delivery. The evaluation seeks information on the strengths and weakness of the current service model, and aims to identify key areas for improvement.

This evaluation is underpinned by the overarching aim of producing findings that may contribute the development of consumer focused, contemporary mental health triage service provision that reflects best practice in the delivery of safe, high quality mental health care at point of entry (triage).
2.2 Specific aims

The specific aims of this evaluation are to investigate:

1. Current point-of-entry criteria for access to specialist mental health services
2. The LRHMHT model of service delivery
3. The LRHMHT activity profile (referral rates, referral types, referral times)
4. The LRHMHT clinical decision-making processes (urgency dispositions, clinical pathways, care planning)
5. The level concordance between triage urgency dispositions and LRHMHT (CASP) urgency/response framework guidelines
6. The responsiveness of LRHMHTS and LRHAMHS (from initial triage screening (urgency dispositions) to action- i.e. further assessment/intervention).
7. The LRHMHT processes, policies and procedures for clinical risk assessment and management
8. Process and scope for secondary consultation to other service providers (e.g. GPs, NGOs)
9. The interface between LRHMHT and the Emergency Department (ED) (role of LRHMHT in conducting mental health assessments in the ED, ED satisfaction with LRHMHT service provision/responsiveness)
10. Internal communication (processes, reporting, handover)
11. Attitudes and perceptions held by triage staff toward the current LRHMHT model of service delivery
12. Accountability (documentation, reporting, clinical governance structure/process)
13. The consumer and carer experience of the accessing LRHMHTS (satisfaction, responsiveness, perception of access)
14. Education and training requirements
3. Methodology

The methodology for the evaluation, Program Evaluation (outcome), provides a systematic way of collecting and analysing information about some/all aspects of health service programs, with the central aim of generating sufficient evaluative information about the program to inform decision-making on service development.

The main purpose of evaluation is to improve the quality of a program by identifying its strengths and weaknesses. Through evaluation processes, assessment is undertaken of the program's effectiveness in meeting its stated goals. In addition, Program Evaluation seeks to determine the impact of the program on the population the program is intended for (mental health service-users).

The methodological framework for the present evaluation takes into account the Victorian Government's key principles for effective mental health triage service provision, which include:

- Access
- Responsiveness
- Accountability
- Timeliness
- Consistency

3.1 Steps in Program Evaluation

1. Engage Stakeholders – A significant component of this step in the evaluation process was completed in the 2008 external review, which identified the areas for investigation for the present evaluation. Groups not engaged in the previous evaluation were the regional Emergency Departments, LRHMHT staff, and consumers and carers. As key stakeholders in LRHMHT, these groups will be engaged in the present evaluation.

2. Describe the program – Program descriptions set the frame of reference for the evaluation. This component of the evaluation process is partially completed. Information received from LRHMHS describes the geographical and demographic profile of the LRHMHT program, broadly overviews the program operations, and outlines the MHT framework for determinations of urgency (CASP). The present evaluation seeks to clarify
further the present model of service delivery, including the processes of decision-making and the core activities associated with the MHT function.

3. Focus the evaluation – The focus of this evaluation has been determined by the outcomes of the independent evaluation of LRHMHS conducted in 2008. The evaluation questions, data collection methods and indicators are described in the section below (sect. 2.4).

4. Gather evidence – The evaluation uses a range of data collection methods designed to meet the aims of the investigation. Data collection methods employed in the evaluation are described below (sect. 2.4).

5. Justify conclusions – This component of the evaluation involves making judgements about whether or not the program has achieved its intended goals and objectives. Comparisons between the findings of the evaluation and existing standards (WHO, DoHA, Vic DHS MHDD, research evidence) for mental health and (specifically) MHT service delivery are made.


3.2 Evaluation questions

Q1. a. What are the criteria used by LRH MHT to determine eligibility/ineligibility for access to LRHMHS? b. What are the outcomes (dispositions/referrals) for non-accepted referrals?

Data sources/collection: Patient medical records 3 month’s continuous data (triage contact sheets), LRHMHT policy and procedure documents, clinician survey and interviews

Indicators: Clinical indicators for service access eligibility/ineligibility evident in medical records, clinician interview data pertaining to access and decision-making on non-accepted referrals

Data analysis: Medical Records- (File Audit – Audit tool, content analysis), clinician survey and interviews (content analysis)

Q2. What is the current LRHMHT model of service delivery?

Data sources/collection: LRHMHT policy and procedure documents, patient flow mapping (referrals from triage point/dispositions), clinician interviews, focus group and survey, relevant findings from 2008 independent evaluation (stakeholder feedback), consumer and carer feedback attained via phone interview,

Indicators: Patient flow evident in medical records, clinician interview and focus group data pertaining to model of service delivery, consumer and carer feedback relevant to service delivery.
Data analysis: a. Medical Records (File Audit – Audit tool, content analysis) b. Interviews (content analysis), c. flow mapping

Q3. What is the pattern of service delivery/activity of LRHMHT?

Data sources/collection: LRHMHT data base (triage profile), relevant paper-based documentation

Indicators: referral rates, referral types, referral times, mode of referral

Data analysis: a. Data mining – descriptive analyses, b. Records- (File Audit – Audit tool, content analysis).

Q4. What are the clinical decision-making processes employed by LRHMHT clinicians?

Data sources/collection: LRHMHS Policy-governance framework, patient medical records (triage contact sheets), clinician survey and interview data pertaining to clinical decision-making

Indicators: Urgency dispositions, care pathways

Data analysis: a. Policy - Content analysis, b. Interview data (content analysis), c. triage dispositions - descriptive analysis (frequencies, percentages)

Q5. How responsive is LRHMHTS and LRHAMHS from initial triage screening to assessment/intervention? (i.e proportion of referrals that were acted on/assessed within time (CASP urgency scale).

Data sources/collection: Patient medical records 3 months continuous data (triage contact sheets, CCT patient records, Crisis/outreach team patient records

Indicators: Proportion of within time/outside time cases

Data analysis: Descriptive analysis – frequencies, percentages

Q6. What is the level of concordance between triage urgency dispositions and LRHMHT (CASP) urgency/response framework guidelines?

Data sources/collection: A random sample of 20 cases from each CASP urgency category for 3 consecutive months of triage data (n=882 July-September 2008) will be established. These cases will be categorised into two subgroups according to the standard of documentation (1. documentation adequate to assess/2. documentation insufficient to assess). Two independent expert raters will assess the extent to which the internal criteria are met for all randomly selected cases where documentation was categorised as ‘adequate to assess’ (see figure 1. below).
**Indicators:** Levels of concordance to the guideline (this will be expressed as proportion of randomly selected cases). Frequency and proportion.

**Data analysis:** a. Concordance (i.e. percentage of responses in the modal category), b. Descriptive statistical analysis.

*Figure 1. Concordance with CASP*  
(LRHMHT July-September 2008)

\[ n=882 \text{ (occasions of triage)} \]

\[ n=80 \text{ (20 randomly selected cases from each urgency category)} \]

Sort into 2 categories

- Documentation adequate
- Documentation inadequate

Two Raters evaluate adherence to CASP

Excluded from analysis

**Outcome:** Proportion of cases that concord with CASP

**Q7. What are the LRHMHT processes, policies and procedures for clinical risk assessment and management?**

**Data sources/collection:** LRHMHT policy and procedure documents, risk assessment screening tools, patient medical records (triage contact form), clinician survey and interviews

**Indicators:** Compliance/non-compliance with risk management policy and procedure, accurate use of and compliance/non-compliance with risk screening tools, proportion of cases inadequately screened at triage

**Data analysis:** Content analysis

**Q8. What are the processes and practices employed by LRHMHT in the provision of secondary consultation to other service providers?**
Data sources/collection: Relevant LRHMHT documentation pertaining to 'information/advice only' contacts with other service providers, clinician survey and interviews

Indicators: Evidence of secondary consultation practices present in clinical documentation, interview and survey data pertaining to secondary consultation

Data analysis: Content analysis

Q9. What is the scope of the clinical role and function provided by LRHMHT in providing service to the regional Emergency Departments?

Data sources/collection: Relevant LRHMHT policy, procedure and other documented guidelines, Emergency Department staff interviews, clinician survey and interview

Indicators: Documented policy and procedure pertaining to LRHMHT function and ED, clinician survey and interviews data pertaining to LRHMHT/ED assessment and related processes

Data analysis: Content analysis

Q10. What are the processes and practices employed by LRHMHT staff to facilitate communication with other clinical areas/teams within LRHMHS?

Data sources/collection: Relevant LRHMHS policy, procedure and other documented guidelines, triage contact sheets, clinician survey and interview

Indicators: Documented policy and procedure related to communication and reporting standards, clinician survey and interview data

Data analysis: Content analysis

Q11. What are the attitudes and perceptions held by triage staff toward the current LRHMHT model of service delivery?

Data sources/collection: Clinician survey and interviews

Indicators: Staff statements pertaining to attitudes and perceptions

Data analysis: Content analysis

Q12. What processes are employed by LRHMHT clinicians to ensure clinical accountability?

Data sources/collection: All triage clinical documentation, verbal handover

Indicators: Documentation meets/does not minimum standards

Data analysis: Content analysis, comparative analysis (against AQSC standards)
Q13. What is the consumer and carer experience (including satisfaction) in accessing LRHMHTS?

Data sources/collection: Consumer/carer telephone interview (n=200 (minimum) including 50 cases from each urgency category (2/3/4 and 50 non-referred cases). While the minimum numbers required are 200, we will aim to achieve 300 (75 per category).

Indicators: World Health Organisation indicators for 'responsiveness', consumer/carer satisfaction

Data analysis: Content analysis
4. Results

4.1 Introduction

The evaluation has scoped seven regional Emergency Departments, the MHT service, The CAMHS Intake Service, the APMHS Intake Service, and the Adult Intake Service, with written input into the evaluation by other components of the AMHS. A retrospective audit of three months of triage service from LRH was conducted by mining clinical and demographic data from a consecutive sample of triage referral records data spanning the months of July, August and September 2009, resulting in 882 occasions of triage. For each occasion of service, two individual raters used a standardised data abstraction tool to record a demographic description, clinical risk factors, diagnostic features, and the characteristics of the presentation. In addition, the Triage Ledger (a running communication book) was examined for contacts to the service by patients, carers/family not elsewhere recorded, yielding a further 130 contacts from patients (n=52) and carers/families (n=78). LRH policy documents and clinical directives were examined for contextual content relevant to the profile and framework for MHT service delivery.

4.2 Findings

The findings are grouped under the main areas of investigation outlined in the background, methods, and evaluation questions.

4.2.1. Access to LRHMHS

(Criteria used by LRH MHT to determine eligibility/ineligibility for service).

Facilitating access to services for those who require assistance, advice, or support from public mental health services is a key aim and function of 24 hour, 7-day a week mental health triage service provision.

The LRH Mental Health Triage Program aims to screen all incoming calls to determine if a mental health service response is required. In order to ascertain the criteria used by LRH MHT is determine eligibility or ineligibility for access to MHS the MHT clinicians were asked two specific questions regarding the typical factors affecting such decisions as part of structured individual interviews. Further structured interviews conducted with CAMHS, APMHS and intake clinicians provided descriptive data regarding the typical presentations referred by MHT clinicians to specialist adult, child and adolescent, and aged persons mental health services. Analysis of data obtained from interviews with MHT clinicians
and clinicians representing the CAMHS, APMHS and adult MHS reveal a pattern of service eligibility criteria. Patients typically accepted for service include the following categories:

- Patients displaying obvious psychotic symptoms, e.g. delusions, hallucinations
- Patients who have serious mental illnesses including: schizophrenia, depression, bipolar disorder, dual diagnosis, borderline personality disorder.
- Patients with risk factors for self-harm, harm to others, or deterioration of mental state. Some MHT staff spoke of the need to err on the side of caution when considering risk factors, especially when the degree of risk is unclear.
- Patients with mental illness who cannot be managed by other services e.g. GP or other community-based services.
- Patients referred for service by specialist clinics e.g. child and adolescent mental health service or aged persons mental health services.
- Patients who are referred by a GP seeking the opinion of a psychiatrist.

**Geographic variability**

Some MHT staff reported that the criteria by which referrals are accepted differ depending upon the geographic location of the patient and the availability of resources in that area. For example, it was reported that the threshold for service is lower in some geographically distant regions than it is in areas closer to the Latrobe valley. The lack of available services in more remote locations and the need to consider the needs of small rural communities result in the acceptance of referrals from these areas that may not have been accepted in regional centres such as the Latrobe valley where there are more resources available.

**Other influences on acceptance of referrals to MHT**

In addition to the patient's clinical presentation and history, the interviews with MHT staff revealed that other, non-clinical, factors commonly influence their decisions. These include factors such as the insistence of a GP, or an accepted practice of automatically categorising all referrals from the LRH ED as response 2.

**Specialist referrals**

The LRH MHT service provides assessment and referral service for patients across the lifespan. Some occasions of difference of opinion between MHT clinicians and the mental health services to which patients were referred was evident. Some specialist services (e.g. CAMHS) were of the opinion that, because the MHT clinicians lacked their specialist expertise, some referrals were unnecessary or inappropriate. The CAMHS respondents expressed the view that
MHT tended to “under-triage” some presentations, especially those aged 0-9 years, and inappropriately refer some presentations because of perceived risk factors not backed up with appropriate initial screening.

Presentations typically not accepted for service by MHT

MHT clinicians described a range of clinical presentations that would routinely be not accepted for service by the mental health service. Many of these cases are directed to other services, for example, GPs, non-government agencies or other community-based services. The absence of identifiable risk factors for self-harm or aggression/violence was a commonly cited reason for not accepting referrals. The list below identifies a variety of clinical presentations received by MHT but which are usually not accepted for service;

- Alcohol and other drug problems with no psychiatric symptoms.
- Generalised anxiety disorder with no obvious risk factors.
- Grieving patients.
- Patients requiring sexual assault counselling.
- Patients with eating disorders.
- Patients with depression or anxiety disorders with no immediate risk factors evident.
- Relationship breakups (in the absence of risk factors).
- Acute anxiety states, which can be managed in the ED, etc.
- Intoxicated people who are found to be without risks when later assessed.
- Social problems that can be addressed by other services e.g. counselling etc.
- Antisocial personality disorders.
- Intellectually disabled patients with no comorbid mental health problems.

One MHT clinician highlighted the gate-keeping function of the MHT service with the comment that they typically do not accept for service “Anything that can be managed by other services”.

MHT clinicians also described providing a brief crisis-intervention service (by telephone) for some presentations, but do not accept them for service. An example provided was a situational crisis where there were no obvious indications of mental illness. Some interviewees also noted some regional variations. These variations focussed on the differential availability of services between remote and regional centres.

4.2.2. Category 5: deferred and non-accepted referrals

Deferred referrals

There were 24 occasions of patients being assigned a triage Category 5, or ‘deferred referral’ status. Essentially this means that the contact is recorded on
the Triage Referral Form but the patient is not accepted for service. Deferred referrals are defined by the LRH CASP as presentations in which there is no psychiatric problem evident, there are drug or alcohol issues, a grief reaction, social or domestic problems, and relationship difficulties as the primary presenting problems.

The presenting problem in 11 of the 24 cases was suicidal/self harm thoughts 46% (n=11), and violence/ideas of harm to others in 8% (n=2), and 11 (46%) had a previous history of a major mental illness. The outcome of these cases is unclear from the documentation; however, most were not actioned for service as the patient said they were now ‘feeling safe’.

Comments were received from specialist mental health service providers (e.g. CAMHS and APMHS) regarding the lack of any method for collecting information about those presentations that are not referred for further assessment and service. CAMH observed that no infants or patients with eating disorders are accepted for service via triage, and concern was expressed about the lack of review process for non-referred cases.

4.2.2.1 Recommendation

A key finding from this evaluation is the need for psychiatrist input into the continuous quality assurance and risk monitoring of non-referred cases. At present there is no system of review in place and no method of tracking clinical outcomes for those not accepted for service.

Non-accepted contacts

A further 52 self-referred patients who made contact with MHT during the period of evaluation were documented in the Triage Ledger. The Triage Ledger serves the purpose of a communication book across the shifts, and between teams (e.g. APMH and CAMH) and a mixture of operational and clinical information is communicated here. A number of the contacts recorded in the Ledger are registered clients seeking after hours support, and brief clinical information is collected.

4.2.2.2 Recommendation

A recommendation arising from the evaluation is that a Triage Contact Form is completed for each patient contact, as the Ledger is not an official medical record. Insufficient capture of patient information places the service at risk of inadequate documentation of clinically related information, which is particularly important in the event of a critical incident or adverse event. It is recommended that CMI be used to record all patient contacts with the service.
4.2.3. LRHMHT model of service delivery

The analysis of interview findings suggests that the present MHT model of service delivery and care is poorly defined and understood by stakeholders.

Interview data revealed that no formal model of care has been used to guide practice since the inception of MHT 15 years ago. MHT clinicians were unable to define a coherent model of care, and described triage as "just a clinical model based on protocols and guidelines that we have to follow". Three MHT clinicians noted that "we don't actually use a model of care". One MHT clinician noted that a Falloon-based model of care has been in operation since 1992. Feedback from the specialist services confirmed that the MHT model of care is perceived as unclear, with comments indicating that MHT clinicians are not consistent in their approaches to service delivery, and that MHT is largely crisis driven and underpinned by a gate-keeping approach.

It was apparent from the interview data that MHT clinicians tend to view MHT as a referral service only, rather than a model of service delivery in itself. This is also demonstrated by inconsistencies in approaches to service delivery, whereby some individual MHT clinicians will undertake assessments in the ED overnight, and others hold the view that MHT does not directly provide service. In addition, several clinicians commented, "triage is not a counselling service", implying that ongoing support of registered clients is not a part of triage profile of service delivery. The audit data revealed that very few patients and carers contact MHT directly for service. From 882 triage contacts, only 5.2% (n=46) contacts were direct self-referrals, and only 9.5% (n=84) contacts were made by carers/families. This is inconsistent with the Department of Health's stated functions of triage, which include providing registered clients and the community with access to ongoing support, information and advice in addition to screening assessment and referral.

Emergency Department data strongly indicates that there is a lack of clarity around the MHT model of service delivery, indicated by comments such as ..."we do not fully understand the MHT clinician's role", and "there is lots of variability in the MHT clinicians' own perspectives of their roles. Some say they just answer the phone whereas some will do everything and work with the ED staff as a part of the team", and the "MHT role is unclear, especially at night". MHT is viewed by the ED's as "arranging services" but not actually providing a service as such.

The lack of a defined, consistent model of care for MHT is problematic in that it gives rise to inconsistencies in practice, and variable quality of service provision.
4.2.3.1 Recommendation

A recommendation arising from the evaluation is to implement a consistent model of care for MHT service provision that clearly articulates the profile of service delivery and is underpinned by a consumer-centred approaches.

4.2.4 Key role functions of mental health triage

While the model of care for MHT was poorly articulated, interviews with mental health triage clinicians and with clinicians from specialist services such as CAMHS and APMHS revealed a high level of agreement regarding the key role functions of the mental health triage service. These functions included:

- Conducting assessments and gathering information in order to determine the most appropriate service response.
- Deciding whether a response from the mental health service is required and with what urgency.
- Screening to determine appropriateness for mental health service or for referral to other services.
- Collecting, processing and dissemination of information.
- Conducting face-to-face assessments on night shift (all information collection and assessment is conducted by telephone during the morning and afternoon shifts).
- Crisis intervention for currently case-managed clients of the mental health service.
- Providing a telephone consultation service to the public and to other health services.
- Educating ED staff regarding the role of MHT.
- Providing a single point of entry to mental health services that is accessible 24 hours/day.

Less frequently described role functions included:

- Providing a liaison service for other services regarding the appropriateness of referrals and the availability of other services utilising local geographical knowledge regarding resources available in the community.
- Gathering of statistics for the mental health service.
- Debriefing service for mental health and general hospital staff.

4.2.5 Primary aims of the mental health triage service

The main aims of the mental health triage service identified by MHT and other clinicians reflect the role functions described in the previous section. These aims include:
• To provide the public with a safe, central point of entry into mental health services.
• To ensure that people making contact with the service “have a good impression”, that they are seen in a timely fashion and that they get the appropriate referrals and treatment.
• To find appropriate care and treatment path for any client that has been referred

4.2.6 MHT screening assessments

There was variability observed in data relating to the consistency and quality of MHT screening assessment practices. APMH team noted that checklists are not always completed at the time of screening, resulting in insufficient information upon which to determine an appropriate service response. This finding was also evident in CAMH data, which described the process as somewhat “hit and miss”. Comment was made by specialist services that screening assessments often lack depth and thoroughness, leading to inappropriate referrals and at times, inappropriate assigning of triage urgency categories. Specialist services highlighted the importance of data capture at triage to assist in informing decisions for further assessment and treatment.

The ages of patients referred to MHT (see Figure 2) follow an expected pattern of service use and demonstrate that MHT clinicians are required to assess and formulate an appropriate service response for presentations across the lifespan from infants to those aged over 90 years. Lifespan triage is defined in the literature as complex, requiring specialist skills in assessment. It was reported by some interviewees that the MHT team are adult focussed, and lack specific expertise in APMH and CAMH assessment, which may effect the quality and accuracy of initial triage screening. As previously noted, the evaluation identified complexities around accurate assessment of aged and younger persons by MHT, and this has implications for training of MHT staff.

4.2.6.1 Recommendation

MHT staff requires skills training in the assessment of aged persons and children and young people to improve the accuracy and consistency of MHT screening assessment practice.

4.2.7 Conducting a MHT telephone assessment

Mental health triage clinicians described the processes and procedures used to conduct triage assessments by telephone. These processes included: collection of information including the patient’s personal details, next of kin, any current treatments, presenting problems, and clinical history; conducting a risk assessment according to established protocols; and organising an appropriate service response or referral based upon clinical presentation and identified risk
factors. This was described as "deciding who will do what and within what time-frame".

Other information collected by MHT clinicians in the process of conducting a MHT telephone assessment included:

• Mode of referral (e.g. self-referral vs referral from the ED, police or other health professionals)
• Support structures available to the patient (e.g. family or other primary carers)

Some MHT clinicians commented that their approach to telephone triage depended to some extent upon who was providing the information. They described a need for a flexible approach depending upon whether assessment data was being collected from the patients themselves or from carers or other health professionals.

4.2.8 Patterns of service delivery/activity of LRHMHT

Results

Analysis of the Triage Referral Records provided description of some aspects of the MHT pattern of service delivery, and characteristics of presentations to LRH MHT. For 410/882 (46.5%) of the audit cases gender was recorded as male and for 453/882 (51.4%) occasions of triage gender was recorded as female. The mean age of service users was 39 years (median 35; range 92; SD 22 years) and most occasions of triage were for individuals aged 19-64 years (569/882). For males the mean age was 38 years (median 33; range 92; SD 22 years) and for females the mean age was slightly higher (mean 39; median 36; range 90; SD 21). Figure 2 displays the distribution of the demographic characteristics of the sample.

Figure 2. Distribution of the sample by age group (N=882)

* Missing data n=20
Table 1. Demographic description of population (N=882)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Count</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-18</td>
<td>169</td>
<td>19.2</td>
</tr>
<tr>
<td>19-64</td>
<td>569</td>
<td>64.5</td>
</tr>
<tr>
<td>≥65</td>
<td>124</td>
<td>14.1</td>
</tr>
<tr>
<td>*</td>
<td>20</td>
<td>2.3</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>410</td>
<td>46.5</td>
</tr>
<tr>
<td>Female</td>
<td>453</td>
<td>51.4</td>
</tr>
<tr>
<td>*</td>
<td>19</td>
<td>2.1</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>63</td>
<td>7.1</td>
</tr>
<tr>
<td>De facto</td>
<td>11</td>
<td>1.2</td>
</tr>
<tr>
<td>Separated</td>
<td>141</td>
<td>16.0</td>
</tr>
<tr>
<td>Divorced</td>
<td>76</td>
<td>8.6</td>
</tr>
<tr>
<td>Not married</td>
<td>470</td>
<td>53.3</td>
</tr>
<tr>
<td>Widowed</td>
<td>32</td>
<td>3.6</td>
</tr>
<tr>
<td>*</td>
<td>89</td>
<td>10.1</td>
</tr>
<tr>
<td><strong>Employment status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>8</td>
<td>0.9</td>
</tr>
<tr>
<td>*</td>
<td>874</td>
<td>99.1</td>
</tr>
<tr>
<td><strong>Housing status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeless</td>
<td>15</td>
<td>1.7</td>
</tr>
<tr>
<td>*</td>
<td>867</td>
<td>98.2</td>
</tr>
</tbody>
</table>

*missing
Of note in the demographic information collected at triage is missing data on employment and housing status. There is no provision (field of enquiry) on the LRH triage record form to capture this data, and these social factors were under reported in the triage clinical documentation.

In the three-month period 882 occasions of triage were recorded. More than half 522/882 (62.3%) of all occasions of triage were allocated to LRH Category 4. Figure 3 shows the distribution count for all occasions of service by LRH triage scale. Figure 4 displays the spread of LRH triage categories by age group. Most notably, most occasions of service involving children (n=169, 19.6%) and elderly persons, aged 65 years and over, (n=124, 14.4%) were assigned an LRH triage category 4 (to be seen within 24 hours).

Figure 3. Distribution of occasions of service by LRH triage scale

Figure 4. The distribution of LRH triage category by age group *
Tables 2 and 3 below presents the diagnostic and presentation characteristics of the total sample (N=882). Of note in these findings is the high percentage of referrals with a previous psychiatric diagnosis (52%) that are currently taken prescribed medication (48.6%). An interesting finding was the proportion of cases with a co-morbid medical condition (15.1%). Information about co-occurring medical conditions was infrequently recorded (missing data = 46.2%) in the clinical documentation; therefore the actual frequency of medical co-morbidity could not be determined.

Table 2. Diagnostic features (N=882)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>459</td>
<td>52.0</td>
</tr>
<tr>
<td>No</td>
<td>141</td>
<td>16.0</td>
</tr>
<tr>
<td>*</td>
<td>282</td>
<td>32.0</td>
</tr>
<tr>
<td>Psychiatric Medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>429</td>
<td>48.6</td>
</tr>
<tr>
<td>No</td>
<td>331</td>
<td>37.5</td>
</tr>
<tr>
<td>*</td>
<td>122</td>
<td>13.8</td>
</tr>
<tr>
<td>Medical condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>133</td>
<td>15.1</td>
</tr>
<tr>
<td>No</td>
<td>341</td>
<td>38.7</td>
</tr>
<tr>
<td>*</td>
<td>408</td>
<td>46.2</td>
</tr>
</tbody>
</table>
*missing data

Of the 882 Triage Referral Records analysed, the source of referral could be determined for 854 referrals. The largest number of referrals came from general practitioners (28.0% n=247) and emergency departments (24.7% n=218). Self-referrals and referrals by carers were less frequently recorded at 5.2 percent (n=46) and 9.5 percent (n=84) respectively. Other less common referrals ('other') were received from paediatricians, schools, government departments (e.g. Department of Education and Department of Human Services), community nurses, non-government workers, private psychologists, courts of law, and other public health services (see Figure 5 and Table 3).

The lack of self-referred contacts and contacts by families/carers is a significant finding of the evaluation, indicating that community access to MHT is minimal and mediated through presentations to Primary Health and the ED. This trend is inconsistent with patterns of MHT service usage observed in other AMHS, where self-referrals and referrals by carers/families are more highly represented, except in specialist services where referral by secondary sources is more prevalent.
4.2.9 Presenting problems

Analysis of data collected from a sample (N=882) of Triage Referral Records reveals that MHT encounter a broad range of presenting problems. Many referrals include a complex array of problems. For the purposes of this report and in order to present a clear description of the most frequently encountered reasons for referral to MHT, only the primary presenting problem for each patient referred has been extracted from the dataset. Of the 882 referrals the most common clinical presentations were suicidality or self-harming behaviours (n=316, 35.8%), and depression (n=190, 21.5%). Psychotic signs and symptoms were the primary presenting problem for only 8.5 percent of the sample (n=75). The primary presenting problems of this sample are presented in Figure 6 and Table 3).
Table 3. Presentation characteristics (N=882)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time of referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0900-1700</td>
<td>543</td>
<td>61.6</td>
</tr>
<tr>
<td>1701-0859</td>
<td>280</td>
<td>31.7</td>
</tr>
<tr>
<td>*</td>
<td>59</td>
<td>6.7</td>
</tr>
<tr>
<td>Previous admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>215</td>
<td>24.4</td>
</tr>
<tr>
<td>No</td>
<td>314</td>
<td>35.6</td>
</tr>
<tr>
<td>*</td>
<td>353</td>
<td>40.0</td>
</tr>
<tr>
<td>Mode of referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aged care</td>
<td>27</td>
<td>3.2</td>
</tr>
<tr>
<td>Carer</td>
<td>84</td>
<td>9.8</td>
</tr>
<tr>
<td>Case Management</td>
<td>34</td>
<td>4.0</td>
</tr>
<tr>
<td>Dept of Education/School</td>
<td>13</td>
<td>0.7</td>
</tr>
<tr>
<td>Doctor</td>
<td>19</td>
<td>2.2</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>218</td>
<td>25.5</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>247</td>
<td>28.9</td>
</tr>
<tr>
<td>Hospital &amp; related factors</td>
<td>54</td>
<td>6.3</td>
</tr>
<tr>
<td>NGO</td>
<td>21</td>
<td>2.5</td>
</tr>
<tr>
<td>Other</td>
<td>29</td>
<td>3.4</td>
</tr>
<tr>
<td>Other health professional</td>
<td>17</td>
<td>2.0</td>
</tr>
<tr>
<td>Pediatrician</td>
<td>17</td>
<td>2.0</td>
</tr>
<tr>
<td>Presenting problem</td>
<td>Count</td>
<td>Percentage</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>Police</td>
<td>11</td>
<td>1.3</td>
</tr>
<tr>
<td>Psychologist</td>
<td>14</td>
<td>1.6</td>
</tr>
<tr>
<td>Self</td>
<td>46</td>
<td>5.4</td>
</tr>
<tr>
<td>*</td>
<td>28</td>
<td>3.5</td>
</tr>
<tr>
<td>Aggression</td>
<td>69</td>
<td>7.8</td>
</tr>
<tr>
<td>Anxiety &amp; related disorders</td>
<td>29</td>
<td>3.3</td>
</tr>
<tr>
<td>Behavioral</td>
<td>32</td>
<td>3.6</td>
</tr>
<tr>
<td>BPAD</td>
<td>20</td>
<td>2.3</td>
</tr>
<tr>
<td>BPD &amp; related factors</td>
<td>4</td>
<td>0.5</td>
</tr>
<tr>
<td>Cognitive disorders</td>
<td>24</td>
<td>2.7</td>
</tr>
<tr>
<td>Depression</td>
<td>190</td>
<td>21.5</td>
</tr>
<tr>
<td>Developmental issues</td>
<td>12</td>
<td>1.4</td>
</tr>
<tr>
<td>Psychotic symptoms</td>
<td>75</td>
<td>8.5</td>
</tr>
<tr>
<td>Suicidal</td>
<td>316</td>
<td>35.8</td>
</tr>
<tr>
<td>OTHER</td>
<td>41</td>
<td>4.6</td>
</tr>
<tr>
<td>*</td>
<td>70</td>
<td>7.9</td>
</tr>
<tr>
<td>* missing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 4.2.9.1 Recommendation

In order to improve community access to MHT resources could be allocated toward promoting the availability and accessibility of the service across the region. In addition, the view of MHT as a referral service only requires review, as it appears that this precludes direct service provision to the public, and thereby reduces equity of access.

### 4.2.10 Categorisation of urgency using CASP

**Method**

The outcome of interest for this component of the evaluation was triage urgency categorisation. For the purpose of this analysis triage categorisation was conceptualised in two different ways:

1. According to the LRH triage scale (categories 1=to be treated immediately, 2=to be treated within two hours, 3=to be treated within eight hours, 4=to be treated within 24 hours, 5=Not for mental health service).

2. As two binary categories (urgency): to be seen within 2 hours (LRH scale 1 and 2), and to be seen within 24 hours (LRH scale 3 and 4).

For each occasion of triage the following independent variables were recorded:
1. Demographic description

1.1. Age (continuous and categorical; 0-18, 19-64, ≥65)
1.2. Gender (categorical; Male/Female)
1.3. Marital status (categorical; Married, De facto, Separated, Divorced, Not married, Widowed)
1.4. Employment status (categorical; Employed/Not employed)
1.5. Housing status (categorical; Homeless/Not homeless)

2. Clinical risk factors

2.1. History of violence (categorical; Yes/No)
2.2. History of self harm (categorical; Yes/No)
2.3. Suicide risk (categorical; None, Low, Moderate, High, Extreme)
2.4. Risk of harm to others (categorical; None, Low, Moderate, High, Extreme)

3. Diagnostic features

3.1. Previous Diagnosis (categorical; Yes/No)
3.2. Psychiatric Medication (categorical; Yes/No)
3.3. Medical condition (categorical; Yes/No)

4. Presentation characteristics

4.1. Time of referral (continuous and categorical; 0900-1700, 1701-0859)
4.2. Previous admission (categorical; Yes/No)
4.3. Mode of referral (categorical; Aged care, Carer, Case Management, Department of Education/School, Doctor, Emergency Department, General Practitioner, Hospital, NGO, Other, Other health professional, Pediatrician, Police, Psychologist, Self)
4.4. Presenting problem (categorical; Aggression, Anxiety & related disorders, Behavioral BPAD, BPD & related factors, Cognitive disorders, Depression, Developmental issues, Psychotic symptoms, Suicidal, other)

Analysis

Raw data was manually checked and entered into SPSS (version 18.0). Descriptive analysis was performed to determine frequency counts and percentages for categorical variables. For continuous data, measures of central tendency were determined by calculating mean, median and standard deviation.

The descriptive data was further explored to identify factors associated with the allocation of triage codes. For these analyses cases were combined to create the second outcome measure: urgency. In order to explore associations between
clinical risk factors and urgency, the data describing risk assessment 2.1-2.4 was further collapsed to form three new risk categories: low, moderate and high.

Univariate analysis was performed to identify significant correlations between continuous variables and urgency (Pearson’s Correlations: two-tailed) and cross-tabulations were conducted for categorical variables by urgency (Chi square and Fishers Exact tests).

To investigate the influence of significant factors arising from the univariate analysis, a logistic regression model was fitted using a forward stepwise procedure which included the variables Age, gender, homeless, history of violence, suicide risk, risk of harm to others, time of referral, mode of referral and presenting problem. The model tested the influence of demographic characteristics, clinical risk factors, diagnostic characteristics, and presentation characteristics on the binary outcome of urgency.

To explore the reliability of the LRH triage scale ratings were evaluated for a random sample of 80 occasions of service in LRH categories 2, 3, 4 and 5. LRH category 1 was not included in the sampling frame due to the low number of cases assigned to LRH triage category 1 (n=2). For each of the aforementioned categories 20 cases were randomly selected using the randomise function of SPSS. Ratings were assessed for spread (the number of categories chosen by each of the raters per occasion of triage), concordance (the percentage of ratings in the modal triage category) and agreement (concordance adjusted for chance).

Results

Assigning urgency

The results of the univariate analysis indicated a strong positive correlation between age and urgency (r= 0.109; p=0.002). Aged persons and youth were more likely to be allocated a triage category 4. Referrals received out-of-hours were assigned to more urgent categories than referrals received during office hours.

Table 4 displays the results of the Pearson’s Chi square test and Fisher’s exact test where significant associations were identified between the independent variables and urgency.

Table 4. Outcomes of univariate analysis: factors associated with assignment of urgency.

<table>
<thead>
<tr>
<th>Variable</th>
<th>df</th>
<th>N</th>
<th>( \chi^2 )</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless by Triage code *</td>
<td></td>
<td>792</td>
<td>0.018</td>
<td></td>
</tr>
<tr>
<td>History of self harm by Triage code *</td>
<td></td>
<td>595</td>
<td>0.000</td>
<td></td>
</tr>
<tr>
<td>Suicide risk by Triage code</td>
<td>2</td>
<td>798</td>
<td>176.206</td>
<td>0.000</td>
</tr>
</tbody>
</table>
The results of the logistic regression model are displayed in Table 5. This analysis shows that, taking into account the influence of all other variables in the model:

1. The odds of being assigned an urgency code to be seen within 24 hours are increased by a factor of 7.448 for those who have a suicide risk (low) compared to those who have a suicide risk (high). As would be expected, those who are assessed as having a high risk of suicide were more likely to be assigned to the more urgent triage categories.

2. The odds of being assigned an urgency code to be seen within 24 hours are decreased by a factor of 0.156 for those who are referred by the ED when compared to those who make a self referral. In other words, patients referred by EDs were more likely to be assigned to more urgent triage categories than those who self-referred.

3. The odds of being assigned an urgency code to be seen within 24 hours are increased by a factor of 38.216 for those whose presenting problem is aggression compared to those whose presenting problem is suicide & related factors. This means that patients whose primary presenting problem was a suicide attempt or other risk of self-harm were much more likely to be assigned to more urgent triage categories than those whose primary presenting problem was aggression.

4. The odds of being assigned an urgency code to be seen within 24 hours are increased by a factor of 2.565 for those whose presenting problem is depression compared to those whose presenting problem is suicide and related factors. Predictably, patients whose presenting problem was suicide and related factors were more likely to be assigned to a more urgent triage category than those whose primary presenting problem was depression.
Table 5. Outcomes of logistic regression model: odds associated with assignment of urgency.

<table>
<thead>
<tr>
<th></th>
<th>Odds Ratio (OR)</th>
<th>95% C.I. for OR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower</td>
<td>Upper</td>
</tr>
<tr>
<td>Suicide risk (ref:=suicide risk (high))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide risk (LOW) *</td>
<td>7.448</td>
<td>2.117</td>
</tr>
<tr>
<td>Suicide risk (MODERATE)</td>
<td>.875</td>
<td>.281</td>
</tr>
<tr>
<td>Risk of harm to others (ref:=risk of harm to others (high))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of harm to others (LOW)</td>
<td>1.295</td>
<td>.199</td>
</tr>
<tr>
<td>Risk of harm to others (MODERATE)</td>
<td>.288</td>
<td>.038</td>
</tr>
<tr>
<td>Mode of referral (ref:=mode of referral (self))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mode of referral (Aged care &amp; related factors)</td>
<td>2.059</td>
<td>.183</td>
</tr>
<tr>
<td>Mode of referral (Carer &amp; related factors)</td>
<td>1.386</td>
<td>.321</td>
</tr>
<tr>
<td>Mode of referral (ED) *</td>
<td>.156</td>
<td>.046</td>
</tr>
<tr>
<td>Mode of referral (Other)</td>
<td>1.068</td>
<td>.282</td>
</tr>
<tr>
<td>Mode of referral (Physician)</td>
<td>.802</td>
<td>.223</td>
</tr>
<tr>
<td>Mode of referral (Police)</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>Mode of referral (School)</td>
<td>1.222E8</td>
<td>.000</td>
</tr>
<tr>
<td>Presenting problem (ref:=presenting problem (suicide &amp; related factors))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presenting problem (Aggression &amp; related factors) *</td>
<td>38.216</td>
<td>3.930</td>
</tr>
<tr>
<td>Presenting problem (Anxiety &amp; related factors)</td>
<td>1.112</td>
<td>.186</td>
</tr>
<tr>
<td>Presenting problem (Behavioural issues)</td>
<td>2.375</td>
<td>.276</td>
</tr>
<tr>
<td>Presenting problem (BPAD)</td>
<td>3.943</td>
<td>.395</td>
</tr>
<tr>
<td>Presenting problem (BPD &amp; related factors)</td>
<td>.773</td>
<td>.069</td>
</tr>
<tr>
<td>Presenting problem (Cognitive disorders)</td>
<td>2.589E8</td>
<td>.000</td>
</tr>
<tr>
<td>Presenting problem (Depression) *</td>
<td>2.565</td>
<td>1.201</td>
</tr>
<tr>
<td>Presenting problem (Developmental issues)</td>
<td>2.283E17</td>
<td>.000</td>
</tr>
<tr>
<td>Presenting problem (Other)</td>
<td>2.463</td>
<td>.233</td>
</tr>
<tr>
<td>Presenting problem (Psychotic symptoms)</td>
<td>.641</td>
<td>.243</td>
</tr>
<tr>
<td>Constant</td>
<td>2.182</td>
<td></td>
</tr>
</tbody>
</table>

* P-value <= 0.05
Reliability of CASP

Evaluation of the reliability of the LRH triage scale (CASP) showed that overall concordance was 73.75% (category 2=66.66%; category 3=69.99%; category 4=81.66%; category 5 76.66%).

In respect to spread (ie the range of triage response codes assigned to a clinical scenario by a group of raters), there were 23/80 (28.75%) occasions of triage in the sample where all three triage ratings were identical, 43/80 (53.75%) where ratings were spread across 2 categories, and 14/80 (17.5%) where the ratings were spread over 3 triage categories. Table 6 shows the spread for LRH triage category assignment across the 4 levels of the LRH triage scale for the random sample of 80 occasions of triage.

Table 6 Spread for LRH triage category assignment (N=80)

<table>
<thead>
<tr>
<th>LRH triage category</th>
<th>Spread</th>
<th>Totals</th>
</tr>
</thead>
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Using Fleiss’s kappa, agreement between the two independent raters using the LRH triage guidelines showed fair levels of agreement for the 80 occasions of triage assessed (κ=0.366; p=0.000).

<table>
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<th>κ</th>
<th>Interpretation</th>
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<tr>
<td>0.61 — 0.80</td>
<td>Substantial agreement</td>
</tr>
<tr>
<td>0.81 — 1.00</td>
<td>Almost perfect agreement</td>
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Triage urgency categorization showed a strong trend towards triaging patients at the lower of the urgency scale. A disproportionately high number of Category 4 (respond within 24 hours) responses were allocated (n=522, 59.2%) and a disproportionately small number of Category 1 responses (n=2, 0.2%) were allocated. The assignment of triage code 4 to a large proportion (81.5%) of people aged over 65 years was a surprising finding and does not reflect the expected range of severity and acuity typical of this population. The CASP urgency framework is limited, in that it does not provide options for service beyond a within 24-hour response. Triage response code 4 requires a response within 24 hours and triage code 5 is, in effect, a decision to not accept the referral for service. The process of testing inter-rater reliability confirmed that in many cases, the caller might require a non-urgent mental health response (e.g. review within one week/fortnight). The present urgency framework does not provide a time-to-assessment parameter to accommodate such a response. The CASP urgency framework has not been subject to formal reliability testing, and may not be the most appropriate tool for MHT assessment.

It is clear from these findings that the categorization of urgency is influenced by a number of competing demands. The analysis of MHT interview data revealed that, in particular, resource availability directly influences dispositional decision-making. The central construct of MHT is determining the urgency of the presentation, that is, deciding the optimal timeframe with which the patient should be further assessed and/or commence treatment. Triage literature on this topic is unequivocal, and clearly articulates that determinations of urgency must be based on assessments of clinical need rather than availability of resources. The underpinning aim of assessing urgency based on clinical need is to optimise the safety and accuracy of mental health triage to ensure equity of access, and timely, responsive service delivery.

Triage scales are clinical tools used at point of entry to health services to provide a systematic way of classifying the urgency and service response requirements of clinical presentations. Triage scales aim to increase the accuracy and consistency of clinical decision-making, thereby optimising the potential for appropriate, responsive service provision that meets the needs of health care consumers, carers, referrers and other service providers. Inaccurate and inappropriate mental health triage can place consumers at greater risk of harm, result in poorer health outcomes, and reduce the likelihood of early intervention, thus it is imperative that triage systems are available to support clinicians in triage clinical decision-making.

The need for a more standardised approach to mental health triage has been identified in a number of studies and reports. The (imminent) implementation of a statewide AMHS triage scale seeks to address the current issues related to the consistency of mental health triage service provision.
4.2.10.1 Recommendation

A recommendation arising from this evaluation is to consider adopting the Department of Health's AMHS Mental Health Triage Scale, which has been embedded in CMI to facilitate consistency in triage screening assessment and dispositions. Linked to this recommendation is the need for training in categorising urgency based on clinical need.

4.2.11 Clinical decision-making

As discussed above, data analysis indicates that MHT clinical decision-making processes are strongly influenced by availability of resources and other competing drivers.

Independent raters reviewing a random sample of 80 triage referral records tended to assign more urgent triage response codes than MHT clinicians. Decision-making around the assignment of triage urgency categories by MHT clinicians is influenced by local policies, availability of resources, and expectations of referrers including emergency departments and general practitioners. Two examples are described below to illustrate this influence on decision-making:

MHT clinicians reported that it is an expectation of the Latrobe Regional Hospital Emergency Department (LRH ED) that all patients referred to MHT are categorised as response 2 (i.e. to be seen within 2 hours). This policy is in contrast with other regional emergency departments serviced by the LRH MHT, such as Bairnsdale and Orbost Hospital EDs where patients are typically categorised as response 4, especially at night, due to the lack of availability of on-call intake clinicians and/or transportation. This practice places the burden of managing patients requiring mental health assessment and care onto emergency department staff with limited or non-existent mental health expertise. The director of one regional ED commented that it was not unusual for the overnight management of one patient with severe behavioural disturbance to require all of the available resources of that community including ED staff, ambulance and police services.

Some MHT clinicians reported that a policy directive had been issued some years ago, by the clinical director of MHS, that all referrals from general practitioners were to be accepted. This included those cases where the GP had simply requested that the patient be assessed by a psychiatrist.

Both of these examples illustrate that the MHT clinicians' assessment, decision-making and subsequent allocation of triage urgency categories are influenced or, in some cases, overridden by factors other than the patient's clinical presentation and the MHT clinicians' assessment of risk. Such practices represent an underutilisation of the MHT clinicians' expertise and a sub-optimal use of
resources. A patient, who would, if based purely on clinical urgency, be assessed by an MHT clinician as requiring a triage urgency response category 3, would be automatically assigned response 2 if referred from the LRH ED and would be assigned response 4 if referred from a more geographically distant ED.

The following summary data describes the factors that MHT clinicians report as being significant to their clinical decision-making:

- Ensuring the patient safety
- Availability of resources (time of day/week and resultant availability of services)
- The family’s ability to manage and cope with the person
- Social and environmental factors.
- Geographic location (e.g. Warragul has an on-call worker only until midnight)
- Availability of supports
- Whether EDs will keep patients until morning
- Whether the caller is a known client (previous history of contact with MH service)
- Identified risks
- History – in the case of known clients
- Attitude of the patient e.g. “unrealistic expectations and impaired judgement may warrant referral”
- Outside influences e.g. “GP demanding patient be admitted when it is clear that patient does not require admission”

4.2.12. Responsiveness

The following section describes responsiveness of MHT as perceived by the regional EDs. There was a strong level of consensus across the participating EDs that response times are often delayed, especially overnight. Several EDs noted that they have difficulty coping with behaviourally disturbed patients with the resources available ... “the response is often much longer than we can manage” and “We sometimes feel that we get the short end of the stick”.

ED clinicians and managers noted that although they are able to contact the MHT service on a 24 hour-per-day basis, calls to MHT are often taken by reception staff and it is necessary to wait for a call back to speak to a triage clinician. ED staff reported that there was often a delay of up to two or more hours between calling MHT and receiving a call from the MHT clinician and sometimes they needed to re-contact the MHT service to prompt a more timely response. In cases where the MHT clinician deemed that an urgent assessment by mental health services was necessary, further delays were often experienced due to variability in the availability of on-call intake clinicians. Such delays were the product of distance between the ED and the mental health service and a consequence of varying availability of on-call intake clinicians after hours. For
example, an on-call clinician is not available after midnight for several regional areas serviced by the LRH MHT service.

The service response delays described above had significant consequences for ED staff who reported having to manage complex mental health presentations in the ED whilst awaiting an appropriate specialist mental health service response. One ED manager reported that the management of a mentally ill patient with severe behavioural or psychological disturbance could consume all the resources, not only of the ED but the whole community (ambulance, police, etc). Other ED clinicians reported relying on police to assist with the management of some clients in the absence of available mental health services.

Regional ED staff reported that their preferred solution to delays in mental health service responsiveness would be to have dedicated MH consultation nurses (e.g. ECATT or CL nurse) available to the ED at all times. Essentially, ED staff held the view that specialist mental health clinicians should be available on a 24-hour-per-day basis to provide care and treatment for patients with mental health problems in the ED. It was further noted that the provision of mental health services in the ED required the availability of physical resources such as a dedicated assessment area as well as the resources to staff it.

Other issues in the responsiveness of MHT to EDs identified by ED staff included the need for appropriate information management systems. Several interviewees commented that access to electronic patient records would facilitate the provision of an appropriate service response and that a computerised information management system could enable case management plans, in place for existing mental health service clients, to be regularly updated and accessible to ED and MHS clinicians. ED clinicians in some regional centres reported having established relationships with local community mental health teams and that they sometimes contacted such services directly for current or previously known MHS clients rather than await a delayed response via the MHT service.

4.2.12.1. Recommendation

Consider resource allocation toward updating and improving clinical information systems to include an electronic medical record accessible to all arms of the service. This would ensure that adequate information was available to inform treatment decisions, and represent significant improvements to time management.

4.2.13. Clinical risk assessment and management

The LRH MHT service Triage Referral Record contains a risk assessment checklist to be completed for all clients referred for mental health assessment and treatment. Some MHT staff reported that this checklist had been adapted from an assessment tool originally implemented when the LRH mental health
service had adopted the Falloon-based approach to mental health service delivery in the early 1990s, whereas other MHT clinicians reported that the tool had been introduced more recently by a previous clinical director of the mental health service. The absence of a standardised risk assessment instrument in LRH MHT resulted in considerable variability in the approaches to risk assessment and management reported by MHT clinicians. It is also noteworthy that of the 882 Triage Referral Records analysed, 205 (34.9%) had incomplete risk assessments (mostly failure to record history of self harm n=264, 29.9%).

The processes reported by MHT staff that they used in conducting risk assessments included:

- Looking up CMI regarding history of aggression or suicidality
- Ask all relevant questions and “use your gut feeling”.
- Asking questions regarding: suicidal intent, plan, history, means, nature of recent attempt (if applicable); antecedents of the episode
- Aggression – history, current mental state, etc.

Some MHT staff commented that the risk assessment tool in the Triage Referral Record has several shortcomings including having some important items missing (e.g. history of aggression) and some items being difficult to assess during a telephone contact. It was also noted by some interviewees that the tool is not designed for and not suitable for telephone assessment, and that a further risk assessment is undertaken by intake clinicians.

Analysis of the audit data showed that 15% of referrals had a history of violence, 25% had a history of self harm, and 36.8% (see Table 7) were assessed as having a moderate level of suicide risk.

Table 7. Risk Factors and risk ratings

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<td>*</td>
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MHT clinicians reported collecting other information, not included in the risk assessment checklist included in the Triage Referral Record. The collection of such information was not consistent between MHT clinicians but included such factors as:

- History of violence and/or verbal aggression
- Drug and alcohol issues including current intoxication
- Environmental factors including the availability of support networks including family/carers
- Family history

Overall, the MHT clinicians were guided in their approach to risk assessment and management by the risk assessment instrument incorporated in the Triage Referral Record. The identified shortcomings of this instrument resulted in considerable variability in the approaches to risk assessment reported by MHT staff. These shortcomings were confirmed by the examination of the rates of concordance between two independent raters and the MHT clinicians.

4.2.13.1 Recommendation

The introduction of a consistent approach to risk assessment and management using standardised instruments is a recommendation of this evaluation report. It is also recommended that a continuous cycle of review processes (e.g., consultant psychiatrist input) be implemented to enable the quality of risk assessment processes to be monitored on a regular basis.
4.2.14. Secondary consultation

As the 24-hour, 7-day a week access and entry point for mental health services, there is an expectation that MHT has a role in the provision of secondary consultation. Responses from MHT staff, ED and specialist service staff indicate some differences of view regarding the role of the MHT staff in providing secondary consultation.

MHT clinicians were universally of the opinion that they have an important role in the provision of secondary consultation. They reported regularly receiving requests for advice from GPs and other external agencies regarding the management of clients with mental health problems. Some reported that they sometimes offer advice and at other times will arrange for a psychiatrist to speak directly with the GP concerned. They also reported that secondary consultation was particularly required for the LRH ED during night shifts when the MHT clinicians routinely conduct face-to-face assessments of patients with mental health presentations. Some MHT staff also commented about the expectations of GPs for an immediate response and about a local policy of accepting all referrals from GPs, which they noted was effectively circumventing the MHT clinician’s role of making triage decisions based upon clinical urgency and risk assessment factors.

A further issue identified by MHT staff in respect of their role in providing secondary consultation concerned the large number of inexperienced medical officers and GPs in the area. These doctors relied upon advice and telephone support from MHT clinicians.

MHT staff reported commonly providing support and advice to carers and case-managed clients. They also noted differences in the expectations of the various regional EDs, usually based upon the availability of local resources. For example, they commented that more geographically remote EDs were more likely to manage difficult situations themselves than the local ED which expected immediate attention and acceptance of referrals by the MHT service. Because of the lack of resources in remote regions, one MHT interviewee commented that “the outer agencies are used to being the jack-of-all-trades”.

Clinicians from Aged Persons Mental Health Service regarded secondary consultation as a vital aspect of the MHT role. This included education for GPs and other service providers. These interviewees also commented that there was a need for a systematic approach to secondary consultation and also the need for MHT representatives to attend consultation meetings, which they currently do not attend.

Similarly, Child and Adolescent Mental Health Service staff reported that secondary consultation is a large part of their role and that MHT also should have a greater role in this aspect of service provision.
Adult Intake clinicians commented that the provision of secondary consultation varies between MHT clinicians with some taking a more active role than others in this regard. It was also noted that MHT has a role in providing education to GPs and other service providers and that appropriate resources should be assigned to support this important function.

ED staff reported that MHT clinicians routinely provide advice and support, particularly at night, regarding the management of patients with mental health problems. They described having ready access to advice from MHT clinicians as an important resource, especially in the management of clients with chronic mental health conditions.

Overall, it is evident that MHT clinicians are routinely involved in the provision of secondary consultation to emergency departments, GPs and other service providers. It is also evident that the extent and processes employed in this secondary consultation lack a systematic approach and that increased resources are required to support MHT clinicians in this important aspect of their role.

4.2.14.1. Recommendation

MHT require training and support to assist them in the provision of secondary consultation to other service providers.

4.2.15. Accountability

Structured interviews were conducted with a range of stakeholders who have regular contact with MHT services including staff from specialist child and adolescent mental health services, aged persons mental health services, adult mental health intake clinicians, and ED clinicians and managers. These stakeholders were invited to comment regarding their perceptions of the accountability of the MHT service. Responses from interviewees indicated a variety of views in relation to this issue.

CAMHS clinicians reported that the accountability of MHT was unclear. They further noted that the MHT staff is not involved in most existing communication structures such as clinical governance meetings. Clinicians from APMHS reported that because MHT clinicians lack specialist expertise in aged persons mental health they sometimes do not detect important pieces of information and that they lack sensitivity to aged-specific issues. By contrast, the MHT service was described by an adult intake clinician as "highly accountable", however this clinician also noted that the information provided by MHT staff was sometimes incorrect or out-of-date as a result of failure to check to see whether information previously recorded was still current.
Emergency department interviewees commented that the clinical credentials of on-call MH staff are variable and often unknown to ED clinicians. For example, a highly experienced mental health nurse might attend or another occasions an allied health professional (e.g. social worker) with little skill in assessment and management of complex mental health presentations may attend. Further comments from ED staff included the identification that there are sometimes issues regarding the clarity of expectations of MH staff and ED staff when patients are referred e.g. communication of risk assessment issues.

ED staff also commented that some aspects of accountability are beyond the control of MHT staff including the lack of resources in some regional centres. They noted, for example, that they often had to wait for hours for ambulance transport. "The people are great but the resources just don’t exist" was a comment by one senior ED clinician.

Several EDs also expressed concern about accountability for high risk and recommended patients in the ED. They held the view that once triaged/medically cleared from ED every effort should be made by mental health services to provide management of these patients. ED triage nurses in particular expressed concern about the lack of feasibility of maintaining visual observations on high risk patients in a busy ED, and were concerned about medic-legal liabilities.

Some other issues raised by ED staff included:

- The need for MHT staff to receive education and support regarding mental health issues for ED nurses.
- All local service providers should to be involved in designing models and solutions for MH/ED triage services. A view was expressed that the Department of Health don’t always appreciate the realities and issues of rural services.
- Some ED clinicians viewed that MHT service use of reception staff as problematic. “Get rid of the MHT receptionists. It would be good to always speak to a mental health professional when you call MHT”.
- As a final point, ED staff noted that night MHT staff do not provide much written documentation about MH patients in the ED. They may write notes for their own records, but not anywhere that is accessible by ED staff.
- Several ED staff commented that the accountability of the LRH mental health triage service has improved in the last 12months.

4.2.15.1. Recommendations

1. Provide training to MHT around clinical documentation and communication of significant findings such as risk issues and related responsibilities to other health providers.

2. Review the use of reception staff to receive incoming calls for MHT
3. Provide education to ED around management of high risk and recommended patients

4. Review the protocol around medical clearance requirement for every MH presentation

4.2.16. MHT service provision to Emergency Departments

Seven regional Emergency Departments in the region were consulted with in respect to a number of domains of MHT service provision. On the whole, it was noted that relationships between the ED and MH services have improved considerably in the past two years; however, a number of areas for improvement were identified across the region.

Emergency Departments noted a number of general issues pertaining to managing mental health presentations, these are summarised below:

- No funding to support MH response in the ED
- No security to manage extremely disturbed persons
- Lack of transport options for overnight admissions to Flynn
- Shortage of after hours ambulance transport
- Patients having to wait in ED overnight
- Lack of allied support services
- Police reluctance to transport patients after hours
- Lack of knowledge about psychiatric medications
- Lack of education/training for ED staff in managing mental health
- No funding available to support ED staff to attend mental health training
- Prioritising and categorising risk in MH presentations compared to medical presentations is difficult.
- MH patients are time-consuming.
- No overnight service - drains ED resources
- Lack of availability of support services – GPs send patients to the ED
- No onsite mental health services - no resources to manage psychiatric patients
- Bed availability
- Provision of information and support services

Two EDs reported that 'code blacks' sometimes occurred as a result of MH patients being forced to wait for medical clearance. Their mental state often deteriorates while they are waiting, and ED staff does not have the expertise to manage them. Further to this, some EDs questioned the need for every patient to receive medical clearance prior to being referred to triage, stating that this is often unnecessary (not indicated) and results in significant delays in patient flow.
More acute patients are perceived by ED as easier to manage – more clear-cut in terms of their need for service, however, the lower acuity cases are more complex – and EDs are often very unclear how to manage them.

EDs report that patient information is often inadequate from case managers and MHT “all we know is that this patient is coming in”. We then depend on the CL nurse to round up paperwork because MHT do not provide sufficient documentation. The following quotation from a regional ED manager highlights the need for improved communication systems between EDs and MHT: “The clinicians are good but MHT should let us know how long we will need to wait. When we refer someone e.g. call ambulance etc. we need proof that we have done this. MHT should send faxes to authenticate what has happened”.

EDs also complained about a lack of expedient management of recommended patients, stating that they should be able to be transferred immediately once recommended. EDs were unanimous in the view that the ED is not a safe place for these patients, as they don’t have the resources to provide the level of observation and support required to keep them safe.

Medical staff from the ED suggested that direct access to a psychiatrist for consultation with ED medical staff would be highly beneficial, citing lengthy waits for these requests to be triaged and acted upon causing significant delays to patient flow.

ED staff identified that management plans for frequent service users and complex cases were often out of date and not adequately communicated to ED. ED staff describes feeling out of their depth in terms of managing complex cases, and in the absence of clear management plans, unsure as to how to manage appropriately.

Typical mental health presentations referred to MHT

There was a wide variety of diagnoses and levels of acuity in mental health presentations reported by EDs. The types of patient typically referred to MH services from the ED include:

- Dual diagnosis (drug and alcohol)
- Suicidal patients
- Borderline personality disorder with self harm
- Frequent service users
- Depression
- Severe behavioural disturbance
- Psychosis
- Disturbed adolescents especially those who are aggressive
- Overdoses
- Medical support for acute psych patients inadequate
Accessibility of MHT to the ED

MHT is generally perceived to be accessible to the ED in terms of telephone response; and the phone support and advice given is greatly appreciated by ED, especially advice on how to manage behavioural disturbance. However, there was strong consensus in the data that attaining a timely assessment was often problematic “yes there is 24 hour access to MHT – but usually they cant do much”. The main issues tend to arise overnight. Some EDs suggested that the variability in overnight accessibility is dependant on the personalities of individual MHT clinicians, with some clinicians very willing to perform face-to-face assessments and others unwilling. There was suggestion from two EDs that MHT staff lack flexibility, that there is a long established culture of the way things are done which is difficult to change. MHT is reported to be at times, somewhat dismissive of known clients, without acknowledging the difficulties of the presentation for ED.

Access to MHT in the mornings was also identified as problematic, as staff are in meetings and unable to respond to requests for assessment. ED staff was particularly concerned about paediatric referrals being forced to wait up to two hours in the morning for assessment, as this contravenes the ED policies of expediting care for children.

Mental Health Triage Clinicians’ perspective on their relationship with Emergency Departments

Most MHT staff interviewed described their relationships with the various EDs in their service catchment area as generally good. This was attributed to the low rate of staff turnover in the MHT service which has enabled MHT clinicians to become well known to many ED staff. It was also attributed to the provision of support and advice to ED staff by MHT clinicians regarding the management of patients with mental health problems. MHT clinicians did, however, note some variations between EDs and commented about some issues affecting their relationships with some EDs. These issues included:

- Some ED staff have misunderstandings regarding the role and function of MHT. Interviewees commented that ED staff sometimes have difficulty differentiating the roles of MHT, intake staff and other mental health services. A common example of such misunderstandings is the expectation of ED staff that MHT clinicians will undertake face-to-face assessments of referred patients, a role that is performed by intake clinicians from the relevant mental health team.
- Personality clashes between MHT clinicians and some ED staff were reported as causing problems on occasions.
- Variations between the regional EDs in the services provided by LRH mental health services was noted by several MHT interviewees as a
source of some difficulties in relationships with the EDs. For example, the role of the MHT clinician working night shift has evolved to providing face-to-face assessments of clients presenting with mental health problems to the LRH ED. This service is not provided by MHT to any other EDs. This practice in the LRH ED has contributed to the misunderstanding by LRH ED staff regarding the role of MHT. Other variations between EDs included the availability of on-call intake clinicians. For some EDs there is an on-call intake clinician available to assess patients on a 24 hour-per-day basis whereas for some EDs this service is not available at night. MHT staff also spoke about the usual practice of some regional EDs to manage patients with mental health problems overnight whereas others would arrange ambulance transport to the LRH ED rather than manage such patients in their own ED.

- One MHT clinician commented that “They [ED staff] think mental health first whereas we tend to think mental health last”. This comment referred to the difference in clinical orientation of ED staff and MHT staff and highlighted the gate-keeping function of the MHT service. Another interviewee commented that MHT sometimes respond to inappropriate referrals in order to maintain a good working relationship with the EDs.

4.2.16.1. Recommendations

1. Increase MHT capacity to respond directly to ED in provision of face-to-face assessments

2. Invest in shared clinical information systems to improve access to patient information

3. Invest in greater MH presence in ED

4. Ensure that all EDs in the region are able to receive an overnight response (assessment) when required

5. Ensure management plans for complex patients are updated, communicated, and available to the ED

6. Provide support to ED medical and nursing staff in terms of specific training in managing mental health presentations

7. Consider investing in greater CL coverage to EDs during business hours

8. Ensure CAMH Intake worker is available to undertake timely assessments of children in the ED
9. Provide resources and clear guidelines regarding the management of MH presentations to the ED (for all staff including medical officers), including shared policies and protocols.

4.2.17. Communication between MHT and other clinical areas/teams within LRHMHS/LRHS

Interviews with staff from Aged Persons Mental Health Service, Child and Adolescent Mental Health Service, and adult intake clinicians revealed various informal and effective communication processes with MHT staff but a lack of formal communication systems. Some of the comments by interviewees regarding the communication processes with MHT were:

- We have a good working relationship, assist each other, helpful
- We have regular (especially) informal contact with MHT
- Sometimes we use MHT for support/debriefing.
- APMH meets with MHT (seeks them out) and enquires after Aged referrals
- We collect contact sheets/referrals
- MHT are usually accessible
- The APMH and CAMHS Checklists have been instituted to assist with MHT referrals to these specialist services. Some interviewees noted that these checklists were completed only inconsistently.
- MHT attempts contact with CMHS by phone or fax, this is generally well done but electronic communication would enhance information transmission as would direct entry by MHT clinicians of clinical information into the CMI database. This would also facilitate better access to statistics regarding patient referrals to specialist services.
- APMH feedback could be better to triage (i.e. more positive) – there is usually only communication when something goes wrong.
- There are no regular communication forums, no regular feedback – too busy, understaffed
- Interviewees from specialist services reported that noone from MHT attends Clinical Governance meetings, which is problematic.
- Intake clinicians commented that they generally have a good working relationship with MHT staff.
- Some interviewees commented that moving MHT away from current location (as is planned) may impact on access through the loss of physical proximity between CAMHS, APMHS and MHT. They also commented that the move may be of benefit to the LRH ED at the expense of specialist services and other EDs.
- Intake clinicians suggested that communication with MHT could be improved and misunderstandings avoided if there were more formal structures in place for communication providing opportunities for feedback in both directions.
Some interviewees from specialist services commented that some information from the triage contact ledger concerns their clients but that they do not hear about these.

MHT provide de-briefing for staff working in specialist services (CAMHS, APMHSD) and this is appreciated.

Outlying areas rely on MHT as a source of information and support

Changes to the allocation of intake duties have had some impact on relationships and communications with MHT. There are no longer dedicated intake workers. All community mental health team clinicians rotate through intake duty responsibility. As a consequence, MHT staff are dealing with a lot of workers who are unfamiliar with the processes and have different understandings of how things work, which impacts on the relationship with MHT.

Written referrals are left by MHT in the ‘in tray’ for intake – these are collected daily by intake staff. Urgent referrals are phoned through by MHT eg for Cat 2 & 3 presentations

4.2.17.1 Recommendations

1. The main issues that require immediate attention are the need for more formal communication processes between the MHT service and specialist services including APMHS, CAMHS and Adult intake services. This will require the allocation of resources to enable participation by MHT staff in formal meetings such as the regular clinical governance meeting, which currently is not attended by any representatives of the MHT team.

2. Paper-based communication processes, including faxing of copies of triage contacts and leaving patient referrals in “in-trays” should be replaced by an accessible system of electronic information management and communications.

4.2.18. Mental Health Triage Reception

Two members of the Latrobe Regional Hospital Mental Health Service administrative staff who provide reception services to the Mental Health Triage service were interviewed. A semi-structured interview schedule was used to explore the receptionists’ understandings of their role functions and their views regarding the strengths and limitations of the current service.

Background Information

All telephone calls to the mental health triage service are answered by reception staff between the hours of 0800 and 2230 on a 7-days-per-week basis. On Monday to Friday two receptionists work until 1630. After 1630 and on weekends there is one receptionist on duty.
Reception receives over 400 calls per day. Of these and on average, approximately 50 percent are mental health triage calls. Others are general reception for the Latrobe Valley Mental Health Service. The proportion of triage calls increases on the weekends.

Role functions of MHT reception staff

Reception staff described their role as an administrative function. "We offer no clinical advice. We offer a person rather than a machine on the end of the phone". The receptionists also reported that part of their role was to reassure callers that a triage clinician would return the call if they are not able to take the call immediately. "It is comforting for callers to speak to a real person".

Both receptionists reported their primary function as "buffering and traffic control". This function was illustrated by several examples. "We collect information from GPs or other callers about whether the 'patient' has a case manager or other history of treatment by MHS. This enables the triage clinicians to look up CMI and be more informed" [buffering function]. The receptionists reported that the value of this function was not appreciated by all callers. For example, "GPs sometimes get impatient with us and want to immediately speak to the MHT clinician". An example given of the 'traffic control' function was as follows. "We deflect calls from case-managed clients [current clients of the mental health service] to their case managers rather than putting them through to MHT clinicians".

A further example of the receptionists' buffering and traffic control function involved the receptionists' assessment and management of incoming calls. They reported that they often take several calls while the triage clinicians are busy with other calls. The receptionists record the nature of these calls and communicate the priority of the calls to the triage clinician who then returns the calls. The processes and criteria used by the reception staff to determine the priority of received calls were unclear. Despite their expressed views that their function is administrative and not clinical in nature, the work described by the receptionists included elements of mental health triage that are an integral aspect of the role of mental health triage clinicians. An example of the receptionists' prioritization of incoming calls was provided in the context of describing their approach to managing crisis calls. "If a caller is in crisis we keep them on the telephone and inform the triage clinician that they need to take this call immediately and that it should take priority over whatever else they [the clinician] are currently doing".

The receptionists reported that as well as providing the reception service for mental health triage they also support the mental health service's case managers and teams. For example, some case managers call to give reception their mobile phone numbers and whereabouts on weekends. This was described as a safety function for community clinicians: for example, "a clinician will call to say that they are about to enter someone's house and that if we [reception] do not hear from
them within 10 minutes they should call the clinician”. Note that this is described as a function of Triage in the Mental Health – Crisis Assessment and Treatment (CAT) On-call Services Protocol.

**Perceived Strengths of Current Operations**

The receptionists reported that all reception staff enjoy the work and work well with the triage clinicians. “I love the job and the triage team, both reception and clinicians. The team members support each other, for example, after a difficult call (especially if MHT clinicians are busy on another call).”

The receptionists’ views regarding the strengths of the current model were expressed in the context of their concerns regarding proposed changes, which involve the geographic relocation of the triage clinical team and the reduction in the reception service to one staff member on duty. They were concerned that the changes will mean that many calls will go to the answering machine (voicemail). For example, “If there was no reception staff the MHT clinicians would not know the priority of missed calls without listening to them all on an answering machine”. The receptionists were also concerned that if the reception function is removed or reduced, calls may be received by general hospital reception staff who lack experience and expertise in managing calls to triage. The triage receptionists believed that the proposed changes (reduction or removal of reception staff) pose safety issues for both consumers and clinicians.

**Suggestions for improvement**

The community’s understanding of the mental health triage service’s function was poor according to the receptionists. “We educate as we go but community education could be improved”.

The reception staff noted that they have learned to perform their duties ‘on-the-job’ with little formal educational preparation for the role. “Receptionists have a high level of responsibility and, dealing with families, for example, can be difficult. We [reception staff] have all undertaken ASSIST training but more education would be good.”

**4.2.19. Attitudes and perceptions held by triage staff toward the current LRHMHT model of service delivery**

The MHT staff identified a number of strengths and weaknesses in the present model for MHT. The following list summarises the strengths, as perceived by staff, of the current model:

- The MHT team has a lot of knowledge and experience.
- We are a cohesive team – we get on with and support each other
- We have a good understanding of MH issues.
• We have a good system for communicating with each other
• MHT staff support each other
• Accessibility, flexibility and responsiveness.
• We provide a service to the public
• Accessible 24/7
• Responsive
• Consultation service – we provide 24/7 advice
• Respected by colleagues because we provide other services such as
debriefing, defusing situations, provide advice
• We provide informal educational support for newer/junior staff.
• Extensive clinical experience of the MHT staff
• Knowledge of the mental health act, the area, the clients
• Single point of entry to mental health services works well
• Use of reception staff to take enquiries

The following list summarises the weaknesses, as perceived by staff, of the
current model:

• Inadequate information systems
• No access to patient information after hours for current MHS clients or
patients who are in the ED. The information is all paper-based and this is
dangerous e.g Someone seen yesterday will not be on the system yet,
thus the risks are not known
• Culture- there is an expectation that the on-call worker for LRH will not be
called after midnight (and that the MHT staff will deal with it)
• MHT work is often overridden by the expectations of the community.
• Faxed communications during the day regarding a request for a
psychiatrist consultation – this all has to be recorded by MHT staff when it
should really be a clerical role. Often the clinical information we receive
with such requests is minimal (e.g. only a single line). Because GPs do not
have direct access to a psychiatrist they send such consultation requests
to MHT
• Lack of staff training
• MHT should be doing face-to-face assessments
• Insufficient access to consultation with psychiatrists
• Insufficient support for sole practitioners “Someone to bounce ideas off
would be good”.
• Overuse of MHT for a range of clinical functions “MHT is a tick box on
everybody’s forms e.g. when a patient is discharged from Flynn or
PSARCS etc they call MHT to inform them, for no obvious reason”
• All psychiatric consultations are now assessed by the Primary Mental
Health team, which causes delays in service provision.
• Faxed referral system for local external GPs, effectively bypasses MHT
“You are required to take the referral”
• LRH expectations regarding Category 2 allocations are inappropriate
• Failings of the whole mental health system are often blamed on triage because community and other agencies don't understand the role of MHT in relation to the rest of the mental health service e.g. assessment and intake
• MHT) are unable to participate mandatory training due to lack of backfill
• Headsets to assist in triage performance are currently unavailable or unusable

4.2.19.1. Recommendations

1. Review the arrangement with LRH regarding automatic assignment of Category 2 to all MH patients

2. Review the use of MHT to arrange medical-to-medical consultation.

3. Review the faxed referral system from GPs

4. Reduce the amount of inappropriate use of triage resources (ie reporting all discharges/leaves to triage)

5. Improve triage information systems

6. Invest in backfill to enable MHT to undertake training and participate in relevant meetings

7. Invest in wireless headsets for triage staff

8. Consider investing in rotations through triage – succession planning and skills development

9. Consider increasing EFT to MHT

4.2.20. MHT Staff survey

Survey tool

In addition to a personal interview about MHT practice, the MHT staff was distributed the Victorian Psychiatric Triage Nursing Survey (Sands, 2003), a 3-part 33-item survey questionnaire (see Appendix D) that seeks information about a number of domains of triage practice. Due to the small sample size and potential for identifying participants, results from Section A of the survey (demographic information, items 1-14) are not included in this report. Items 28, 29 and 30 of Section C of the survey seek participant's opinions on aspects of the Mainstreaming and Integration Policy, and this information was considered irrelevant to the aims of this evaluation, thus these results are not presented in
this report. The findings from items 15–27 of Section B and items 31-33 of Section C of the survey are discussed below.

Results

Less than 50 percent of the staff completed the survey, thus the findings presented may not be representative of all MHT staff.

Item 15 confirmed that triage clinicians usually work in pairs, except on night shift, where the triage clinician is a sole practitioner. Results from item 16 confirmed that during morning and evening shift, triage clinicians perform telephone only psychiatric assessment, but may perform face-to-face assessment on night shift. Item 17 confirmed that face-to-face assessments are usually conducted with the clinician and patient alone. In response to item 18 on opportunities for professional development to support triage practice, the majority of participants stated that they had not been provided with opportunities for professional development specific to triage practice, although one participant noted having attended the ASIST suicide prevention program in addition to aggression management training.

The majority of participants, in response to items 20 and 21 which sought information on whether theoretical models are used to guide MHT practice, responded in the affirmative. The theoretical models identified by participants included 'nursing model', 'medical model' and Falloon's model'.

Using a likert scale of 1 (none) to 4 (high), item 22 required participants to rate the level of support to triage by a range of disciplines. The majority of participants rated the support of medical officers to be low, the support of psychiatrists to be low to moderate, the support of allied health to be low to moderate, the support of nursing staff to be moderate to high, and the support of management to be low.

Using a likert scale of 1 (none) to 4 (high), item 23 asked participants to rate their experience of the level of responsibility, autonomy, decision-making, stress, and confidence in the triage role. The majority of participants rated the level of responsibility to be high, the level of autonomy to be moderate, the level of decision-making to be moderate to high, the level of stress to be moderate, and the level of confidence as high.

Using a likert scale of 1 (none) to 4 (high), item 24 asked participants to rate the frequency of ethical dilemmas, verbal assault, physical assault, conflict with other agencies, conflict with medical staff, and conflict with management in their triage practice. The majority of participants rated the frequency of ethical dilemmas as low, the frequency of verbal assault as moderate, the frequency of physical assault as low, the frequency of conflict with other agencies as moderate, the frequency of conflict with medical staff as moderate, and the frequency of conflict with management as low.
Using a likert scale of 1 (none) to 4 (high), item 25 asked participants to rate the accessibility to triage of community agencies such as police, ambulance, private psychiatrists, general practitioners, NGO agencies, and other public health agencies. The majority of participants rated the accessibility of police as moderate, the accessibility of ambulance as moderate, the accessibility of private psychiatrists as low, the accessibility of general practitioners as high, the accessibility of NGOs as moderate to high, and the accessibility of other health agencies as moderate.

Using a likert scale of 1 (none) to 4 (high), item 26 asked participants to rate the availability of community resources such as adult emergency accommodation, youth emergency accommodation, women's refuges, counselling services, and drug and alcohol services. The majority of participants rated the availability of adult emergency accommodation as being none to low, the availability of youth emergency accommodations as being low, the availability of women's refuges as low, the availability of counselling services to be low, and the availability of drug and alcohol services to be moderate.

Using a likert scale of 1 (none) to 4 (high), item 27 asked participants to rate the impact of MHT on areas of medical domain such as early diagnosis, early treatment, prescription of medication, decisions to admit, decisions to certify, decisions to discharge, and decisions to use restraint. The majority of participants rated the impact of MHT on early diagnosis as moderate, early treatment as moderate, prescription of medication as moderate, decisions to admit as moderate, decisions to certify as moderate, decisions to discharge as none, and decisions to use restraint as low.

The following section reports on the findings from items 31, 32, and 33 from Section C of the survey.

Item 31 asked participants to list the most positive aspects of MHT practice, which were identified as:

- Forging close ties with other agencies
- Providing advice and support to co-workers
- Attaining positive outcomes for consumers
- Good working environment
- General job satisfaction
- Being able to draw on clinical experience in practice

Item 32 asked participants to list the most negative aspects of MHT practice, which were identified as:

- Being "caught in the middle of people wanting assessment and assessing clinicians"
- A lack of recognition and respect for MHT by management and other health professionals
• The perception that MHT “is the central point of everything”
• A lack of understanding by others of the actual role MHT performs
• Searching for available beds for admissions
• The lack of consultation with MHT regarding changes to MHT

Item 33 asked participants to provide comments, suggestions or recommendations about MHT practice. The majority of participants declined to provide additional feedback, however one participant suggested that further tertiary level education would be of benefit to MHT staff.

4.2.21. Clinical Governance

Interview and file audit data revealed that clinical governance frameworks for MHT are currently unclear e.g. “If there is a formal one I don’t know it” and “We govern our own standards and manage our own team situations”. The analysis of LRH policies found no documented evidence of a defined governance framework for MHT. In a sample of 543 triage referral forms, there is only evidence of one occasion of MHT consulting with medical staff about a case. MHT clinicians were unable to articulate governance structures, and expressed the view that there are currently none in place. Of particular concern is the lack of psychiatric consultant support to MHT. MHT staff felt they would benefit from greater medical support to the role to ensure safety in terms of managing risk. In addition, it was noted that MHT do not participate in reporting at Clinical/Quality/Risk meetings – they have minimal interaction with the rest of the service around governance issues.

4.2.21.1. Recommendations

1. Develop clear governance framework for MHT
2. Invest in psychiatrist consolation and support to MHT
3. Facilitate MHT participation in relevant meetings and forums around governance

4.2.22. Processes for communicating and recording triage activities

Interviews with all MHT clinicians revealed several processes in place for recording and communicating triage activities. These included a mixture of paper-based, electronic and face-to-face processes.

The contact register (sometimes referred to as the triage ledger)

The contact register is a paper folio book into which MHT clinicians enter brief notes regarding all telephone contacts with MHT. These include clinician contacts and other communications as well as calls from patients, carers and referring
agencies. For presentations that are deferred or not accepted for service, the contact register is often the only record of contact.

A copy of the most recent day's entries is faxed daily to each mental health team of the LRH mental health service. One MHT clinician reported that the contact register is also used for checking and quality assurance purposes but it was unclear how this was achieved.

Handover

Verbal handover occurs between each MHT shift using the contact register as an aid in this process. The handover is conducted face-to-face between morning and afternoon shifts and by telephone between night and morning shifts.

The Triage Referral Record

The Triage Referral Record is a locally developed electronic database into which all referrals are entered. It is not linked to CMI and is only accessible by MHT and intake clinicians. No Triage Referral Record is completed for existing (case managed) clients so they would not be recorded on the computer database.

Telephone Communications

MHT staff reported that they routinely telephone or leave voicemail messages for mental health teams when MHT have contact with known (case-managed) clients. MHT staff reported that they sometimes also contact services to which they have referred clients. This may be done by telephone of facsimile transmission. MHT staff also notify referring services, for example EDs, regarding the expected length of time for a mental health service response.

4.2.23. Documentation

Occasions of triage are recorded on the Triage Referral Record (TRR) (Microsoft EXCEL database), and non-referred contacts may also be recorded in the Triage ledger (and not recorded on the TRR).

MHT Clinicians complained about the utility of the documentation suite, noting difficulties in capturing social factors such as employment and living situation, which have a bearing on risk.

Documentation standards

Of the 882 triage referral sheets reviewed, 29.9% had incomplete risk assessments (mostly failure to record history of self harm n=264).

Other issues identified with documentation standards are listed below:
• Some use of subjective language was identified in the audit.
• The use of the Triage Ledger to record contact with registered clients was identified as problematic.
• The failure to complete checklists was identified by specialist services as problematic.
• Incomplete, insufficient documentation of contacts.
• In-house system using Microsoft Excel is used for recording MHT referrals (not contacts that are not referred i.e. category 5).
• MHT clinicians access CMI for information about earlier contact with MHS but they do not enter information into CMI (this is done by administrative staff of LRH).
• MHT clinicians reported that they have no access to records related to patients who have had very recent contact with the service. This is caused by delays in entry of data into the CMI.
• Insufficient account of protective factors in risk assessment, e.g. social supports, and employment status, housing status.

4.2.23.1. Recommendations

1. Use of CMI screening register to record and document all triage contacts.

2. Provide MHT with training in effective documentation.

4.2.24 Service-user perspectives

Triage referral records and the triage contact register were used to identify the calls made by people seeking assistance for themselves (referred to here as consumers) or for family members or friends (referred to here as carers) to the mental health triage service. During the sample period, July to September 2009, 128 calls were received from carers and 76 were received from consumers. All 204 carers and consumers were eligible for inclusion in this component of the evaluation.

Procedures

Using the telephone numbers recorded by the triage workers, the researchers attempted to contact and invite all of these callers to participate in a semi-structured interview about their perceptions of accessing the MHT service.

Interviews by telephone were scheduled during office hours (0900-1700) and evenings (1700-2100). Successful contact was made with 47 carers and 27 consumers and 130 were disconnected or wrong numbers, not answering or the calls went to message banks. In order to optimise the number of participants, telephone numbers that were either not answered or went to message bank on
the first attempt were re-called at a different time of day, (e.g. evening if the first call had been made during office hours). Upon successful contact the researchers explained the purpose of the call and invited participation in a telephone interview of approximately 10 minutes duration. Of the 47 carers and 27 consumers who were successfully contacted by the researchers, three carers and one consumer declined to participate.

Using the World Health Organisation's framework for responsiveness in the provision of health services, the interviews were designed to explore the consumers' and carers' experience of their contact the mental health triage service. The concept of responsiveness, as defined by WHO, consists of eight domains. They include:

1. Confidentiality of personal information.
2. Autonomy (involvement in decisions).
3. Clarity of communication.
4. Dignity (respectful treatment, communication).
5. Access to family and community support (contact with outside world, continuing regular activities).
6. Quality of basic amenities (surroundings).
7. Prompt attention (convenient travel, short waiting times).

The WHO responsiveness constructs were used as the basis of a structured telephone interview schedule (See Service-User Interview schedule Appendix F):

- Access- How easy to access was the triage service?
- Prompt attention – Did you receive prompt attention from the service?
- Dignity – Do you feel you were treated with respect by the triage worker?
- Autonomy - Did the person you spoke to on the phone ask you about your preferences? Were you involved in the decision-making about what would happen to you/your loved one?
- Clarity of communication – Was the information or instructions you were given clear? Did you feel like there was a good level of communication between you and the triage worker? Did you feel understood?
- Satisfaction- Overall how satisfied were you with the service you received from triage?

Summary data and comments made by the consumers and carers in response to each of the questions are presented below.
Carer interviews (n=44)

Q1. How easy or difficult was it to access MHT?

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<tr>
<th>Easy</th>
<th>Difficult</th>
<th>Unsure or could not remember</th>
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<tr>
<td>n=23</td>
<td>n=17</td>
<td>n=4</td>
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</table>

Accessing the mental health triage service was easy for more than half (n=23, 52%) of the carers. Difficulty finding the number was reported by 17 carers. Comments such as: “I couldn’t find it on the internet or the telephone book”; “I was bounced around a few numbers until I got a service”; “There were too many channels to go through”; and “We had no experience doing this and no idea where to call” were typical of those who reported difficulty in accessing the mental health triage service.

Q2 – Did you receive prompt attention from the service?

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<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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<tbody>
<tr>
<td>n=28</td>
<td>n=10</td>
<td>n=6</td>
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</table>

The majority of carers interviewed reported that they received prompt attention from the triage service. Of the ten who reported not receiving prompt attention, comments such as: “I was told to ring the police because they [mental health triage] were unable to respond”; “I waited over an hour to be called back”; and “We needed urgent help – the person was dangerous” were typical.

Q3 – Do you feel you were treated with respect by the triage worker?

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<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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<tbody>
<tr>
<td>n=37</td>
<td>n=4</td>
<td>n=3</td>
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</tbody>
</table>

Most of the carers (n=37, 79%) reported feeling treated with respect by the triage worker who answered their calls. Comments such as: “they were very professional” and “They were very compassionate even though they couldn’t really help me” illustrate this positive experience.

Q4 Did the person you spoke to ask you about your preferences?

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<tr>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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<tbody>
<tr>
<td>n=18</td>
<td>n=18</td>
<td>n=16</td>
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Equal numbers of carers reported being asked about their preferences in relation to the mental health triage response.
Q 5 Were you involved in the decision making about your relative or friend?

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<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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<tr>
<td>n</td>
<td>17</td>
<td>18</td>
<td>9</td>
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</table>

Less than half (n=17, 36%) of the carers reported being involved in decision-making about their relative or friend. One carer noted that "I was out of ideas and wanted someone else to make the decisions". The difference in the degree to which the carers wanted to be involved in decision-making was evident in some of the comments offered. For example: "No, I was just given advice"; "I was given very little options"; and "I was very frustrated that my wishes were not taken into account".

Q6 Did you feel that there was good communication between you and the triage worker?

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<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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</thead>
<tbody>
<tr>
<td>n</td>
<td>30</td>
<td>9</td>
<td>5</td>
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</table>

The majority of carers (n=30, 68%) reported good communication between themselves and the triage workers. A typical comment to this effect was "Yes, they understood me and communicated very well". Conversely, of the nine carers who were less than satisfied with communication, comments such as: "They had poor communication skills and they evidently were not listening" and "I felt I wasn't really understood which was very frustrating", were illustrative.

Q7 Overall, how satisfied were you with the service you received from triage?

<table>
<thead>
<tr>
<th></th>
<th>Very satisfied</th>
<th>Satisfied</th>
<th>Unsatisfied</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>21</td>
<td>8</td>
<td>9</td>
<td>6</td>
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</table>

As presented in the table above, the majority of carers reported that, overall, they were satisfied with the service they received from mental health triage.

General Comments

In addition to responses to the specific questions outlined above, the carers were also invited to make other general comments about their experience of accessing the mental health triage service. It is worth restating here that the majority of carers (n=29, 66%) reported being satisfied with the service they received and only a relatively small number (n=6, 14%) expressed overall dissatisfaction. The verbatim statements presented below are grouped into positive and negative comments and were selected as representative of the comments made by both satisfied and dissatisfied carers.
Positive Comments

• “Extremely happy with the service”
• “They are wonderful. I can’t speak highly enough of them”
• “They are part of our family”
• “They were very helpful”
• “They worked wonders”
• “They were very calm when we were all very stressed”
• “We felt very reassured by them”
• “Very caring and understanding”
• “Very good at their job”
• “They followed up with phone call”
• “They did a good job under difficult circumstances”
• “We can’t fault them”
• “They are very understanding and supportive of families”
• “The triage worker asked us how we were feeling and coping with the situation and called us back to see if we were OK. We really appreciated that”
• “Triage took control which was excellent”
• “They are overworked”
• “The triage staff are compassionate.”

Negative Comments

• “The worker didn’t ring me back”
• “They sent a suicidal patient home on his own with no supports. This was dangerous as he was too sick to be allowed to go home”
• “After hours the service is hopeless”
• “It was a weekend and noone was interested in our problem”
• “They said they couldn’t help him unless he actually agreed to talk to them. I tried to explain he was suicidal and that he had two kids in the house. He ended up attempting to kill himself and the police were involved”
• “They need more resourcing”
• “The system itself has failed us; not the triage staff. They are generally good people.”
• “This region needs a crisis team providing a 24 hour-per-day response. People living in a more geographically remote location should not be disadvantaged just because of where they live. In this situation police had to become involved because of the lack of mental health service resources.”
• “I live 40 kilometres out of town. If someone could have come to see us it would have prevented a lot of the problems that arose.”
• “We spend weeks trying to get help”.
• “Underqualified people who don’t take sufficient time to assess properly”.
• “The number should be much more accessible. It was hard to find; especially as I was agitated.”
• “They are compassionate but they haven’t got the right pathways to care.”
• “The wait time is too long for service.”

Consumer interviews n=30

Q1. How easy or difficult was it to access MHT?

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<th>Easy</th>
<th>Difficult</th>
<th>Unsure or could not remember</th>
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<td>n=5</td>
<td>n=21</td>
<td>n=4</td>
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</table>

The majority (n=21, 70%) of the consumers interviewed reported some difficulty in accessing the mental health triage service. These difficulties related to difficulty in finding the triage telephone number and in waiting for a call back from a triage clinician after the consumer had spoken to the triage service receptionist. Comments such as: “I got the number from the GP”; “I had to call several numbers to get through”; “I waited over three hours. By then I was suicidal”; “Sometimes they don’t call me back. I know they are busy”; and “Staff are not available to talk”, illustrate some of the difficulties encountered by the consumers.

Q2 – Did you receive prompt attention from the service?

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<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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<td>n=20</td>
<td>n=7</td>
<td>n=3</td>
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Most of the consumers (n=20, 67%) reported that they received prompt attention from the service. Comments such as: “They tried to help immediately”; “There is usually someone to talk to”; and “Even if I have to wait they will always get back
to me”, were typical of those offered by consumers who reported receiving prompt attention. Of those who felt that the attention they received was not timely, comments such as: “Promises to call back are not kept” and “Sometimes there is no response at all and you wait hours for them to call back” were illustrative.

Q3 – Do you feel you were treated with respect by the triage worker?

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<tr>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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<tbody>
<tr>
<td>n=25</td>
<td>n=2</td>
<td>n=3</td>
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</table>

As presented in the table above, 83 percent (n=25) of the consumers interviewed felt that they had been treated with respect by the mental health triage worker who answered their call. Examples of comments offered by these consumers were: “Excellent” and “They were very respectful of my situation”.

Q4 Did the person you spoke to ask you about your preferences?

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<tr>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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<tr>
<td>n=12</td>
<td>n=14</td>
<td>n=4</td>
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</table>

Forty percent (n=12) of the consumers reported that they were asked about their preferences by the triage worker.

Q5 Were you involved in the decision making about your care/treatment?

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<th>Yes</th>
<th>No</th>
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<tr>
<td>n=6</td>
<td>n=13</td>
<td>n=11</td>
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Only 20 percent (n=6) of consumers reported being involved in decision-making. It is notable that a large proportion (n=11, 37%) were unsure or could not recall whether they had been involved in decision-making. Comments made by consumers in response to this question included: “Yes, they asked for my opinion” and “I tried to tell them I was sick and what I needed but they didn’t listen”. As reported by carers, consumers varied in the extent to which they either wanted or felt prepared to be involved in decision-making. One consumer commented “By the time you ring triage you’re looking for answers. You want them to make the decisions”.

Q6 Did you feel that there was good communication between you and the triage worker?

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<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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</thead>
<tbody>
<tr>
<td>n=18</td>
<td>n=7</td>
<td>n=5</td>
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</table>
The majority of the consumers (n=18, 60%) felt that there was good communication between themselves and the triage worker. These consumers offered comments such as: "Very good communication; always very helpful". Of the minority (n=7, 23%) who were not satisfied with communication, comments such as: "I was desperate at the time. I didn't feel like they were specific enough in their communication. I needed more direction about what I should do, for example, ring an ambulance" and "I felt like they were trying to fob me off, like I wasn't bad enough to talk to them", were representative.

Q7 Overall, how satisfied were you with the service you received from triage?

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<thead>
<tr>
<th></th>
<th>Very satisfied</th>
<th>Satisfied</th>
<th>Unsatisfied</th>
<th>Unsure</th>
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<td></td>
<td>14</td>
<td>6</td>
<td>9</td>
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Two thirds (n=20, 67%) of the consumers interviewed were satisfied or very satisfied, overall, with the service they received from triage. The following comments illustrate the various views expressed by consumers regarding their overall satisfaction with the triage service: "I felt a lot better. They calmed me down a lot on the phone"; "They didn't help at all; just gave me another number to call"; "Not at all. I won't bother calling again"; "10! They were fantastic"; and "If they had helped me when I needed it, I wouldn't have had a full psychotic episode".

General Comments

In addition to responses to the specific questions outlined above, the consumers were also invited to make other general comments about their experience of accessing the mental health triage service. Two thirds (n=20, 67%) of the consumers provided general comments in response to this question. The verbatim statements presented below are grouped into positive and negative comments and were selected as representative of the comments made by both satisfied and dissatisfied consumers.

Positive Comments

- "When they say they will do something they do!"
- "They explained what they were doing and why, which was good"
- "They have helped me through many crises. Thank you triage"
- "They sort of helped me get back on track"
- "They are very helpful and caring"
- "Thanks for all the help"
• “Doing a great job”
• “Very grateful. They’re wonderful!”

Negative Comments

• “They need to be more professional”
• “They should be more careful discussing confidential information”
• “They were too late with calling back. It should have been quicker. By the time they called me back it was too late”
• “The ED wait times are much too long”
• “They didn’t seem to have much knowledge about grief; how to help someone who had just lost someone close. They need to be much more supportive with that sort of thing”
• “They need to be much quicker with a viewpoint”
• “They need more empathy about our situation”
• “They don’t take crises seriously enough”
• “They need to learn how to recognise the signs of early relapse. I ended up very psychotic”
• “They [triage] need access to a psychiatrist”
• “Rude, arrogant, unhelpful”

4.2.25. Education needs of MHT

Both interview and audit data identified a number of key areas of educational support required by MHT. The following list summarises educational requirements for MHT:

• CAMH specific training - Developmental knowledge – what is appropriate/inappropriate behaviour
• APMH specific training – especially physical health screening, delirium screening
• Training in family sensitive practice - How to help families manage their situations
• Secondary consultation – how to do this effectively
• Training in use of MHT scales
• Training in more standardised approaches to risk assessment
• Training in effective documentation of triage contacts
- Training in medico-legal issues pertinent to MHT practice
5. Recommendations

The following list summarises recommendations arising from the project:

1. A key finding from this evaluation is the need for psychiatrist input into the continuous quality assurance and risk monitoring of non-referred cases. At present there is no system of review in place and no method of tracking clinical outcomes for those not accepted for service.

2. A recommendation arising from the evaluation is that a Triage Contact Form is completed for each patient contact, as the Ledger is not an official medical record. Insufficient capture of patient information places the service at risk of inadequate documentation of clinically related information, which is particularly important in the event of a critical incident or adverse event. It is recommended that CMI be used to record all patient contacts with the service.

3. A recommendation arising from the evaluation is to implement a consistent model of care for MHT service provision that clearly articulates the profile of service delivery and is underpinned by a consumer-centred approaches.

4. MHT staff requires skills training in the assessment of aged persons and children and young people to improve the accuracy and consistency of MHT screening assessment practice.

5. In order to improve community access to MHT resources could be allocated toward promoting the availability and accessibility of the service across the region. In addition, the view of MHT as a referral service only requires review, as it appears that this precludes direct service provision to the public, and thereby reduces equity of access.

6. A recommendation arising from this evaluation is to consider adopting the Department of Health (MHDD) AMHS Mental Health Triage Scale, which has been embedded in CMI to facilitate consistency in triage screening assessment and dispositions. Linked to this recommendation is the need for training in categorising urgency based on clinical need.

7. Consider resource allocation toward updating and improving clinical information systems to include an electronic medical record accessible to all arms of the service. This would ensure that adequate information was available to inform treatment decisions, and represent significant improvements to time managemen
8. The introduction of a consistent approach to risk assessment and management using standardised instruments is a recommendation of this interim evaluation report. It is also recommended that a continuous cycle of review processes be implemented to enable the quality of risk assessment processes to be monitored on a regular basis.

9. MHT require training and support to assist them in the provision of secondary consultation to other service providers.

10. Provide training to MHT around clinical documentation and communication of significant findings such as risk issues and related responsibilities to other health providers.

11. Review the use of reception staff to receive incoming calls for MHT

12. Provide education to ED around management of high risk and recommended patients

13. Review the protocol around medical clearance requirement for every MH presentation

14. Increase MHT capacity to respond directly to ED in provision of face-to-face assessments

15. Invest in shared clinical information systems to improve access to patient information

16. Invest in greater MH presence in ED

17. Ensure that all EDs in the region are able to receive an overnight response (assessment) when required

18. Ensure management plans for complex patients are updated, communicated, and available to the ED

19. Provide support to ED medical and nursing staff in terms of specific training in managing mental health presentations

20. Consider investing in greater CL coverage to EDs during business hours

21. Ensure CAMH Intake worker is available to undertake timely assessments of children in the ED

22. Provide resources to clear guidelines regarding the management of MH presentations to the ED (for all staff including medical officers), including shared policies and protocols.
23. Develop formal communication processes between the MHT service and specialist services including APMHS, CAMHS and Adult intake services. This will require the allocation of resources to enable participation by MHT staff in formal meetings such as the regular clinical governance meeting, which currently is not attended by any representatives of the MHT team.

24. Paper-based communication processes, including faxing of copies of triage contacts and leaving patient referrals in “in-trays” should be replaced by an accessible system of electronic information management and communications.

25. Review the arrangement with LRH regarding automatic assignment of Category 2 to all MH patients

26. Review the use of MHT to arrange medical-to-medical consultation.

27. Review the faxed referral system from GPs

28. Reduce the amount of inappropriate use of triage resources (ie reporting all discharges/leaves to triage)

29. Invest in backfill to enable MHT to undertake training and participate in relevant meetings

30. Invest in wireless headsets for triage staff

31. Consider investing in rotations through triage – succession planning and skills development

32. Consider increasing EFT to MHT

33. Record all triage contacts on CMI database screening register

34. Develop clear governance framework for MHT

35. Invest in psychiatrist consolation and support to MHT

36. Facilitate MHT participation in relevant meetings and forums around governance

37. Provide MHT with training in effective documentation

38. Provide MHT clinicians with training in family-sensitive practice.
6. Conclusion

This comprehensive program evaluation of Latrobe Regional Hospital Mental Health Triage Service used data collected from multiple sources to examine current clinical practices, perspectives of stakeholders, service users, clinical governance arrangements, the model of care, relationships with regional emergency departments, documentation standards, service responsiveness, and reporting and accountability.

Analysis of stakeholder input into the evaluation identified LRHMHT as a valuable resource to the community, with high levels of satisfaction reported by consumers and carers accessing the service. Issues were identified with access to mental health services, particularly in relation to after hours service provision to regional emergency departments, the need to increase LRHMHT capacity to undertake face-to-face assessment in the ED, and the low level of self-referrals by service-users such as consumers and carers. An important finding was the LRHMHT perspective of mental health triage as a predominantly referral service, rather than a model of service delivery in itself.

The evaluation highlighted a number of areas of practice and service delivery that require further development, including documentation standards, processes for risk assessment and clinical governance, and the categorisation of the urgency of mental health presentation using triage scales. The outcomes from this evaluation include 38 key recommendations for LRHMHT service improvements.
7. Appendices

1. Appendix A: Mental Health Triage Staff Interview Schedule
2. Appendix B: Emergency Department Interview Schedule
3. Appendix C: CAMH, APMH, Intake Interview Schedule
4. Appendix D: Mental Health Triage Survey
5. Appendix E: CASP Urgency Categories
6. Appendix F: Service-user Interview Schedule
1. Appendix A: Mental Health Triage Staff Interview Schedule

1. How would you describe the key role functions of triage?

2. What are the main aims of triage?

3. How would you describe the model of care underpinning triage service delivery?

4. What type of patient/presentation is typically accepted for MH service? (what are the criteria for service?)

5. What type of patient/presentation is typically NOT accepted for MH service (what are the criteria?)

6. What processes/procedures/practices/methods do you employ to conduct a MHT telephone assessment?

7. What processes/procedures/practices/methods do you employ to conduct a risk assessment?

8. How do you determine the urgency of the presentation? (ie timeframe for assessment/treatment from the triage point)

9. What factors influence your triage decision-making?

10. What is the role of MHT in the provision of secondary consultation?

11. How would you describe the MHT relationship with ED?

12. What are the processes for communicating and recording triage activities?

13. Can you describe the clinical governance framework or process relevant to triage?

14. What are the strengths of the current MHT model of service delivery?

15. What are the weaknesses of the current MHT model of service delivery?

16. What, if anything, would you change about MHT? Why?

17. What education and training would be of benefit to MHT staff?

18. Do you have any further comments/feedback?
2. Appendix B: Emergency Department Interview Schedule

1. What are some of the issues related to mental health presentations to the ED?

2. What type of patient is typically referred to MH services?

3. What process do you employ to refer a patient for assessment to mental health triage?

4. How accessible is mental health triage/mental health services?

5. How responsive is mental health triage?

6. Describe the communication processes between ED and MHT. Are there any communication issues in the present model?

7. How accountable are mental health triage?

8. What are the strengths in the current model of MHT service provision?

9. What are the weaknesses in the current model of the current MHT model of service delivery?

10. Is there anything in the current model/approach you would like to change? If yes, specify.

11. Do you have any other feedback or comments?
3. Appendix C: CAMH, APMH, Intake Interview Schedule

1. How would you describe the key role functions of triage?

2. How would you describe the model of care underpinning triage service delivery?

3. What type of patient/presentation is typically referred by MHT service? (what are the criteria for service?)

4. What, if any, is the role of MHT in the provision of secondary consultation?

5. How would you describe the MHT relationship with CAMH/APMH/Intake?

6. What are the processes for communication with triage?

7. How accountable are MHT?

8. What are the strengths of the current MHT model of service delivery?

9. What are the weaknesses of the current MHT model of service delivery?

10. What, if anything, would you change about MHT? Why?

11. What education and training would be of benefit to MHT staff?

12. Do you have any other comments/feedback?
4. Appendix D: Mental Health Triage Survey

Thank you for taking the time to complete this survey. Please follow the written instructions on how to fill in your responses to the questions. The instructions are in bold text. All information gathered in this questionnaire is strictly confidential.

Section A: Demographic information

The following section requires you to tick (or write) the appropriate response(s)

1. What is your age? ________

2. What is your gender? Male ( ) Female ( )

3. How would you classify the location of your work place?
   Metropolitan ( ) Non metropolitan ( )

4. How would you describe your working environment (triage)?
   Emergency department of a general hospital ( )
   Community Mental Health Clinic ( )
   Inpatient Psychiatric Unit ( )
   Other (please specify) __________________________

5. What classification / grade (nursing position) are you currently employed at?
   Gr. 1 ( ) Gr. 2 ( ) Gr. 3a ( )
   Gr. 3b ( ) Gr. 4a ( ) Gr. 4b ( )
   Gr. 5 ( ) Gr. 6 ( ) Gr. 7 ( )
   Other (eg RPN 3) __________________________

6. How would you classify your position? (Tick all applicable)
   Permanent ( ) Full-time ( )
   Part-time ( ) Casual contract ( )
   Casual (agency) ( ) Other__________________________

7. In an average week, how many hours of triage would you perform? __________________________
8. How many years of experience as a registered nurse have you had? ________________

9. What nursing qualifications do you hold?
   - R.P.N
   - R.N
   - Other _________

10. What tertiary qualifications do you hold? (*tick highest qualification*)
    
    If none go to question 11
    - Diploma
    - Grad. Cert
    - Grad. Dip
    - Bachelor
    - Masters
    - PhD

11. What are your areas of experience (post-registration) in mental health nursing? (Tick all applicable)
    - Acute adult psychiatry
    - Child and adolescent psychiatry
    - Psychogeriatrics
    - Drug and alcohol
    - Forensic psychiatry
    - Psychiatric rehabilitation
    - Community mental health
    - Management/administration
    - Teaching
    - Other (please specify) _____________

12. How were you recruited for your triage position?
    - Applied for externally advertised triage position
    - Seconded into the position
    - 'Acting' temporarily in the position
    - Working in triage as a part of C.A.T duties
    - Working in triage as a part of normal/expected duties
    - Other (please specify)

13. In your role as a triage nurse, are you employed as?
    - A triage nurse (no C.A.T duties, no other duties except triage)
    - A C.A.T/ triage clinician/ nurse
    - A duty-worker based at a community mental health service
    - A psychiatric liaison nurse working in a General hospital
    - Other (please specify)

14. What types of shifts /hours do you work? (Tick all applicable)
    - Rotating roster
    - Fixed shifts
Section B: Clinical information

The following section requires you to tick (or write) the appropriate response(s)

15. When performing the triage role, how do you usually work?
   - As a sole practitioner (one person triaging on the shift) ( )
   - As a team member (several persons triaging on same shift) ( )
   - As a C.A.T clinician (as part of other C.A.T duties) ( )
   - Other (please specify) ______________________________________

16. How do you conduct psychiatric assessment on triage clients?
   - Only via the telephone ( )
   - Only via face-to-face interview ( )
   - Both ( )

17. When you conduct a face-to-face psychiatric assessment interview do you?
   - See the client with another staff member ( )
   - See the client alone ( )
   - Both ( )
   - Not applicable ( )

18. Has your employer offered you any opportunities for professional development in your triage practice?
   - Yes ( )
   - No ( )

19. If you responded ‘yes’ above, please specify the nature of the professional development
   ______________________________________

20. In your psychiatric triage practice, do you use nursing/psychiatric/other theoretical models (such as the medical model) to guide your practice?
   - Yes ( )
   - No ( )

21. If you answered ‘yes’ to the previous question, please specify the theoretical models you use to guide your triage practice ______________________________________

The following section requires you to rate your responses from 1 to 4 (i.e. 1 = none, 4= high). Please tick to indicate your response.
22. How would you rate support to the triage role from the following health professionals? (i.e. Support defined as; cooperation, willingness to work collaboratively with triage staff)

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<tr>
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</thead>
<tbody>
<tr>
<td>a. Medical officers</td>
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<tr>
<td>b. Psychiatrists</td>
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<td>c. Allied health</td>
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<tr>
<td>d. Nursing staff</td>
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<tr>
<td>e. Management</td>
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</table>

23. How would you rate the following experiences in triage?

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<tr>
<th></th>
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<tbody>
<tr>
<td>a. Level of responsibility</td>
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<td>b. Level of autonomy</td>
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<td>c. Level of decision making</td>
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<td>d. Level of stress</td>
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<tr>
<td>e. Level of confidence</td>
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24. How would you rate the frequency of the following situations in your triage practice?

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<tr>
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</thead>
<tbody>
<tr>
<td>a. Ethical dilemmas</td>
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<tr>
<td>b. Verbal assault</td>
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<td>c. Physical assault</td>
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<td>d. Conflict with other agencies</td>
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<tr>
<td>e. Conflict with medical staff</td>
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<td>f. Conflict with management</td>
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</table>

25. How would you rate the accessibility of the following community agencies in your triage experience/practice

<table>
<thead>
<tr>
<th></th>
<th>Police</th>
<th>Ambulance</th>
<th>Private psychiatrists</th>
<th>General practitioners</th>
<th>N.G.O healthcare agencies</th>
<th>Other public health agencies</th>
</tr>
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<tbody>
<tr>
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26. How would you rate the availability of the following community resources in your region?

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<tr>
<th></th>
<th>Adult emergency accomm.</th>
<th>Youth emergency accomm.</th>
<th>Women's refuges</th>
<th>Counseling services</th>
<th>Drug and alcohol services</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

27. How would you rate the impact of nurses performing psychiatric triage on the following traditional areas of medical dominance?

<table>
<thead>
<tr>
<th></th>
<th>Early diagnosis</th>
<th>Early treatment</th>
<th>Prescription of medication</th>
<th>Decision to admit</th>
<th>Decision to certify</th>
<th>Decision to discharge</th>
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</tbody>
</table>

83
Section C: Policy information (Mainstreaming and Integration)

The following section requires you to rate your responses from 1 to 4 (i.e. 1 = zero, 4 = high). Please tick to indicate your response.

28. How would you rate the effectiveness of the following aspects of Mainstreaming and Integration policy (deinstitutionalisation) in your regional sector?

<table>
<thead>
<tr>
<th></th>
<th>1.(zero)</th>
<th>2.(low)</th>
<th>3.(moderate)</th>
<th>4. (high)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Gate keeping role</td>
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<tr>
<td>b. Suicide prevention</td>
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<tr>
<td>c. Timely service delivery</td>
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<td>( )</td>
</tr>
<tr>
<td>d. Community support for clients</td>
<td>( )</td>
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<td>( )</td>
</tr>
<tr>
<td>e. Home treatment (C.A.T, M.S.T)</td>
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<td>( )</td>
</tr>
<tr>
<td>f. Client satisfaction</td>
<td>( )</td>
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</tr>
<tr>
<td>g. Psychiatric triage</td>
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<tr>
<td>h. Integration with generalist health</td>
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</table>

29. In your opinion, which ‘stakeholders’ have benefited most from mental health reform (i.e. Mainstreaming/deinstitutionalisation)? (Please rate from 1 – 4, i.e. 1 being the least benefit, 4 being the most benefit)

<table>
<thead>
<tr>
<th></th>
<th>1.(zero)</th>
<th>2.(low)</th>
<th>3.(moderate)</th>
<th>4. (high)</th>
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</thead>
<tbody>
<tr>
<td>a. Clients/ consumers</td>
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<td>b. Non-government agencies</td>
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<tr>
<td>c. Private health care providers</td>
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<tr>
<td>d. Public health care providers</td>
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<tr>
<td>Other (please specify)</td>
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</table>
30. How would you rate the perceived value of psychiatric triage nurses by the following groups? (i.e. how much do you think you are valued by the following groups)

(a) The general public
(b) Consumers
(c) Nursing colleagues
(d) Medical staff (incl. Psychiatrists)
(e) Allied health
(f) Management

<table>
<thead>
<tr>
<th></th>
<th>1.(zero)</th>
<th>2.(low)</th>
<th>3.(moderate)</th>
<th>4.(high)</th>
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</thead>
<tbody>
<tr>
<td>a. The general public</td>
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<td>b. Consumers</td>
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<td>c. Nursing colleagues</td>
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<tr>
<td>d. Medical staff (incl. Psychiatrists)</td>
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<tr>
<td>e. Allied health</td>
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<tr>
<td>f. Management</td>
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31. Briefly list the most positive aspects of psychiatric triage nursing

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

32. Briefly list the most negative aspects of psychiatric triage nursing

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

33. Are there any comments, suggestions or recommendations about psychiatric triage practice that you would like to contribute to this study?

____________________________________________________________________________________
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85
<table>
<thead>
<tr>
<th>Triage Category</th>
<th>Response Time</th>
<th>Clinical Descriptors</th>
<th>Service Response</th>
</tr>
</thead>
</table>
| Cat 1           | 10 minutes   | • high risk of harm to themselves or others.  
• overdose                                                  | • Emergency services                                                                |
| Cat 2           | 1 hour       | • severity of psych condition  
• Mental state may deteriorate further if not dealt with promptly.  
• Person to person counselling/assessment required.  
• Insufficient support system in place  
• Past history of early warning signs indicate prompt intervention. | • Case managed clients refer to CM  
• New referral – duty clinician to assess |
| Cat 3           | Same day     | • requires a psychiatric assessment but risk to themselves or others is containable  
• potential to escalate  
• Police, hospital ward, casualty department, general practitioner, etc have requested assessment that day.  
• Distress of client, family or carer is taken into account.  
• Client unable to guarantee safety that day. | • Case managed clients refer to CM  
• New referral – duty clinician to assess same day and complete registration |
| Cat 4           | Within 24 hrs| • Risk to themselves or others is low and not expected to escalate.  
• Has access to a sufficient stable support base.  
• Has requested intervention during normal business hours.  
• Is a known registered and case managed client.  
• Has problems of an ongoing nature.  
• Has problems of a non-urgent social nature, eg accommodation/financial.  
• Has a problem with medication that is non-urgent.  
• Requires counselling that is not of a crisis nature. | • Sometime in the next business day.  
• the timing of the assessment is discussed with the person referred and made at their convenience. |
| Cat 5           | Deferred response | • no psychiatric symptoms are evident  
• person may require intervention best provided by another service provider | • provide the information necessary for the client to access other service providers |
| Drug or alcohol issues | Grief reaction | Social or domestic problems | Relationship difficulties | record the contact for review at the intake meeting |
APPENDIX F: SERVICE-USER INTERVIEW SCHEDULE

1. How easy or difficult was it to access was the triage service?

2. Did you receive prompt attention from the service?

3. Do you feel you were treated with respect by the triage worker?

4. Did the person you spoke to on the phone ask you about your preferences?

5. Were you involved in the decision-making about what would happen to you/your loved one?

6. Was the information or instructions you were given clear? Did you feel like there was a good level of communication between you and the triage worker? Did you feel understood?

7. Overall how satisfied were you with the service you received from triage?

8. Do you have any other feedback about the MHT service?