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Identifying the core competencies of Mental Health Telephone Triage

Victorian Collaborative Psychiatric Nursing Conference 2011

Investigators
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Kathryn Henderson, The Alfred Hospital Melbourne, Australia
Sandra Keppich-Arnold, The Alfred Hospital Melbourne, Australia
1. Mental Health Triage: definition and background
2. Project background
3. Key findings
4. Recommendations
5. Summary
In Australia, access to specialist mental health services is facilitated through triage services, which operate 24/7.

All enquiries and referrals from the public and other service are subject to MHT screening, from which a decision will be made about which service the client needs and in which timeframe.

MHT provides assessment, referral, advice, support, secondary consultation.
Triage is the basic structure in which all incoming patients are categorised into groups using a standard urgency rating scale or structure.

A triage system The process by which a clinician assesses a patient’s clinical urgency.

Urgency: is determined according to the patient’s clinical condition and is used to ‘determine the speed of intervention that is necessary to achieve an optimal outcome’
Principles

The triage process is underpinned by the principle that a reduction in the time taken to access care will improve patient outcomes.

Underpinned by principles of equity, the only criteria for care being clinical urgency

Expediting patient care for those most in need
Triage function and aim

A single entry point for all incoming patients

All patients are subjected to a consistent assessment process

Aims to ensure patients are treated in the order of their clinical urgency

That treatment is timely and appropriate
Telephone triage

The majority of all initial mental health triage screening occurs via the telephone.

MH Telephone Triage developed in an ad hoc manner in Australia.

Little empirical research has investigated the practices, processes, and competencies for safe effective triage – thus the evidence base is minimal.
Aims

To identify the core competencies of Mental Health Telephone Triage clinicians are required to be competent in to perform safe and effective triage:

- key role tasks
- skills
- knowledge
- responsibilities

Research question

‘What are the core competencies required for effective telephone-based mental health triage’?
Setting

• The Alfred Hospital is a 350-bed acute tertiary referral hospital that treats 50,000 inpatients and 200,000 emergency patients annually.

• The Mental Health Triage Service commenced in 1996, and is situated within the hospital Emergency Psychiatry programs incorporating the Crisis Assessment and Treatment Team, Enhanced Crisis Assessment Team, and Consultation Liaison Psychiatry
Rationale for the study

- Department of Health – mandate to deliver quality, uniform, telephone triage across the lifespan
- Telephone Triage was experiencing sustained and unprecedented demand
- Seeking an evidence based frameworks to benchmark all intake areas against to ensure clients would receive quality interventions no matter which part of the service they contacted
- Develop a framework to provide adequate training and support to clinicians working in mental health telephone triage
Methodology

2 phase project

• Phase 1
  • preliminary reliability testing of the MHTS. Participants were asked to review and assign a triage category to a set of 20 hypothetical MHT scenarios

• Phase 2
  • structured observations were undertaken on a total of 197 occasions of mental health telephone triage over a 12-week period in 2010-2011.
  • dual wireless headsets
  • Legal issue re interception of calls
### Phase 1

**Table 1.**

<table>
<thead>
<tr>
<th>Triage Category</th>
<th>Kappa</th>
<th>Statistic</th>
<th>SE Kappa</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>0.78</td>
<td></td>
<td>0.0218</td>
</tr>
<tr>
<td>B</td>
<td>0.45</td>
<td></td>
<td>0.0218</td>
</tr>
<tr>
<td>C</td>
<td>0.15</td>
<td></td>
<td>0.0218</td>
</tr>
<tr>
<td>D</td>
<td>0.17</td>
<td></td>
<td>0.0218</td>
</tr>
<tr>
<td>E</td>
<td>0.08</td>
<td></td>
<td>0.0218</td>
</tr>
<tr>
<td>F</td>
<td>0.47</td>
<td></td>
<td>0.0218</td>
</tr>
<tr>
<td>G</td>
<td>0.53</td>
<td></td>
<td>0.0218</td>
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<tr>
<td><strong>OVERALL</strong></td>
<td><strong>0.48</strong></td>
<td></td>
<td><strong>0.0104</strong></td>
</tr>
</tbody>
</table>

Overall reliability = Fair to moderate
## Call sources

<table>
<thead>
<tr>
<th>Call Source</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation</td>
<td>8</td>
<td>4.1</td>
</tr>
<tr>
<td>APMHS</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>CAMHS</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Carer</td>
<td>25</td>
<td>12.7</td>
</tr>
<tr>
<td>CATT</td>
<td>14</td>
<td>7.1</td>
</tr>
<tr>
<td>CL/Ward</td>
<td>11</td>
<td>5.6</td>
</tr>
<tr>
<td>CM</td>
<td>23</td>
<td>11.7</td>
</tr>
<tr>
<td>Consumer</td>
<td>46</td>
<td>23.4</td>
</tr>
<tr>
<td>ED</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>GP</td>
<td>14</td>
<td>7.1</td>
</tr>
<tr>
<td>HOPS</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>NGO</td>
<td>5</td>
<td>2.5</td>
</tr>
<tr>
<td>Other Service</td>
<td>13</td>
<td>6.6</td>
</tr>
<tr>
<td>Police</td>
<td>12</td>
<td>6.1</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>9</td>
<td>4.6</td>
</tr>
<tr>
<td>Psychologist</td>
<td>5</td>
<td>2.5</td>
</tr>
<tr>
<td>Missing</td>
<td>5</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>197</td>
<td><strong>100</strong></td>
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</table>
# Results – phase 2

**Presenting problems**

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th>Frequency (n)</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Psychosis</td>
<td>15</td>
<td>21.4</td>
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<tr>
<td>Depression</td>
<td>4</td>
<td>5.7</td>
</tr>
<tr>
<td>Anxiety</td>
<td>2</td>
<td>2.9</td>
</tr>
<tr>
<td>Suicidal Ideation/Harm</td>
<td>20</td>
<td>28.6</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>3</td>
<td>4.3</td>
</tr>
<tr>
<td>AOD</td>
<td>4</td>
<td>5.7</td>
</tr>
<tr>
<td>Post Natal Depression</td>
<td>4</td>
<td>5.7</td>
</tr>
<tr>
<td>Violence</td>
<td>6</td>
<td>8.6</td>
</tr>
<tr>
<td>Homicidal</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Social Issues</td>
<td>6</td>
<td>8.6</td>
</tr>
<tr>
<td>Support</td>
<td>5</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>70</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Results – phase 2

Triage Categories

<table>
<thead>
<tr>
<th>MHT Category</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>3(4.7)</td>
<td>5(7.8)</td>
<td>10(15.4)</td>
<td>6(9.5)</td>
<td>4(6.3)</td>
<td>17(26.6)</td>
<td>19(29.7)</td>
</tr>
</tbody>
</table>

Risk Ratings

<table>
<thead>
<tr>
<th>Urgency/Risk Rating</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme</td>
<td>2(100)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>1(33.3)</td>
<td>2(66.7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td>2(14.3)</td>
<td>9(64.3)</td>
<td>2(14.3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td></td>
<td></td>
<td>1(3.4)</td>
<td>3(10.3)</td>
<td>3(10.3)</td>
<td>9(31.0)</td>
<td>13(44.8)</td>
</tr>
<tr>
<td>TOTAL (n)</td>
<td>3(6.3)</td>
<td>4(8.3)</td>
<td>10(20.8)</td>
<td>5(10.4)</td>
<td>3(6.3)</td>
<td>9(18.8)</td>
<td>14(29.2)</td>
</tr>
</tbody>
</table>
Results – phase 2

Summary: non-assessment calls (64.5%)
(information requests/transfer, support/advice, triage alerts):

1. Provide callers with an introduction to self and the service;
2. Establish a rapport with the caller;
3. Determine the primary purpose of the call;
4. Take the necessary actions to complete the call
   (information/advice, information transfer, referral);
5. Discuss the plan with the caller;
6. Terminate the call;
7. Communicate information (refer, hand-over, transfer call)
8. Document the call
<table>
<thead>
<tr>
<th><strong>Competency</strong></th>
<th><strong>Element</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Opening The Call</strong></td>
<td>1a. Introduction</td>
</tr>
<tr>
<td></td>
<td>1b. Establish rapport</td>
</tr>
<tr>
<td></td>
<td>1c. Demographics</td>
</tr>
<tr>
<td></td>
<td>1d. Confirm need for MH (brief screen)</td>
</tr>
<tr>
<td><strong>2. Mental Status</strong></td>
<td><strong>Examination</strong></td>
</tr>
<tr>
<td></td>
<td>2a. Elicit Self Report</td>
</tr>
<tr>
<td></td>
<td>2b. Enquire duration</td>
</tr>
<tr>
<td></td>
<td>2d. Assess mood</td>
</tr>
<tr>
<td></td>
<td>2e. Assess behaviour</td>
</tr>
<tr>
<td></td>
<td>2g. Assess thought content</td>
</tr>
<tr>
<td></td>
<td>2h. Assess judgment</td>
</tr>
<tr>
<td></td>
<td>2i. Assess insight</td>
</tr>
<tr>
<td></td>
<td>2l. Assess current psych tx.</td>
</tr>
<tr>
<td></td>
<td>2m. Assess previous psych tx.</td>
</tr>
<tr>
<td></td>
<td>2n. Assess drug/alc hx</td>
</tr>
<tr>
<td></td>
<td>2o. Assess medical hx.</td>
</tr>
<tr>
<td></td>
<td>2p. Assess self harm/suicide hx</td>
</tr>
<tr>
<td></td>
<td>2t. Assess social supports</td>
</tr>
</tbody>
</table>

3. Risk assessment
2t. Assess social supports

3. Risk assessment

3a.i. Assess risks
3a.ii. Harm to self
3a.iii. Harm to others
3a.iv. Mental deterioration
3b.i. Determine overall risk level
3c. Assign triage cat.
3e. Decide disposition
3f. Discuss plan with caller

4. Call termination

4a. Summarise main issues
4b. Confirm caller understood
4c. Terminate call

5. Refer and Report

5a. Communicate plan to team
5b. Verbal handover
5c. Refer to services

6. Document call

6a. Complete CMI database
6b. Complete Med records
Results – phase 2

Summary: Assessment calls

Phase 1: Opening the call
* Introduction * Demographics * Brief Screening

Phase 2: Mental Status Examination
* Mental Status Examination * Risk Assessment

Phase 3: Planning and Action
* Urgency rating * Planning * Intervention * Referral

Phase 4: Termination
* Summarise/confirm plan * Terminate * Document * Report
**Additional Findings**

<table>
<thead>
<tr>
<th>MHTT Skills and Knowledge</th>
<th>Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis assessment /intervention</td>
<td>Community resources</td>
</tr>
<tr>
<td>Therapeutic approaches /interventions</td>
<td>Psychopharmacology</td>
</tr>
<tr>
<td>Negotiating</td>
<td>Co-morbidity and complexity</td>
</tr>
<tr>
<td>Time management</td>
<td>Youth and aged specific</td>
</tr>
<tr>
<td>Resource management</td>
<td>Drug and alcohol</td>
</tr>
<tr>
<td>Communication /information transfer</td>
<td>Legal</td>
</tr>
</tbody>
</table>
Outcomes from the research: The Alfred

- Participate in developing/testing a Mental Health Triage Competency Tool
- Use of dual telephone head-sets for staff training
- Staff training in CAMH assessment
• MHTT plays a pivotal role in providing a timely access to specialist mental health care.
• skilled MHT clinical work is critical to assuring that service provision is safe, effective, and high quality.
• competencies in MHTT have been identified
• baseline for development of competency/training tools
• evidenced-based framework for MHTT practice
The Consumer and Carer experience of accessing a rural mental health triage telephone

Victoria Collaborative Psychiatric Nursing Conference 2011

Investigators
A/Prof Nathalie Sands, Deakin University
A/Prof Stephen Elsom, CPN University of Melbourne
Cayle Hopner, Director Mental Health, Latrobe Regional Hospital

Outline of presentation
1. Mental Health Triage: overview
2. Project background and context
3. Findings
4. Recommendations
5. Summary

Mental Health Triage: background
In Australia, access to specialist mental health services is facilitated through triage services, which operate 24/7.

All enquiries and referrals from the public and other service are subject to MHT screening, from which a decision will be made about which service the client needs and in which timeframe.

MHT provides assessment, referral, advice, support, secondary consultation.

Mental Health Triage Overview
Triage is the basic structure in which all incoming patients are categorised into groups using a standard urgency rating scale or structure.

A triage system is the process by which a clinician assesses a patient’s clinical urgency.

Urgency is determined according to the patient’s clinical condition and is used to ‘determine the speed of intervention that is necessary to achieve an optimal outcome’.

Mental Health Triage Overview
Principles
The triage process is underpinned by the principle that a reduction in the time taken to access care will improve patient outcomes.

Underpinned by principles of equity, the only criteria for care being clinical urgency.

Expediting patient care for those most in need.

Mental Health Triage Overview
Triage function and aim
A single entry point for all incoming patients.

All patients are subjected to a consistent assessment process.

Aims to ensure patients are treated in the order of their clinical urgency.

That treatment is timely and appropriate.
Mental Health Triage Models

Key requirements for effective service delivery

- Community resources
- Legal & ethical frameworks
- Education & training
- Staff support & supervision
- Emergency services
- Multidisciplinary input
- Policy and governance
- Community resources

Project background: Evaluation context

Latrobe Regional Health Service Mental Health Triage Program

- LRHMHIS Provides a diverse range of specialist public mental health services across the lifespan to the Gippsland region of Victoria Australia
- LRHMHIS covers a geographic area of 44,000 square kilometers and services a population of approximately 250,000.
- An independent evaluation in 2008 identified problems with access, inaccurate screening, a lack of referral pathways and lack of clarity on MHT service delivery

Project background: Evaluation aims

- Point-of-entry criteria for access
- Model of care/ service delivery
- Referral rates, referral types, referral times
- Clinical decision-making processes
- Secondary consultation to other service providers (e.g. GPs, NGOs)
- Documentation, reporting, clinical governance structure/process
- Consumer and carer experience
- Education and training requirements

Project background: Methodology

- Program evaluation
  - Policy audit/analysis
  - File audit (N=852)
    - Binary logistic regression
  - Stakeholder interviews
    - MHT clinicians
    - Regional Emergency departments (n=7)
    - Intake, CAMHS & APMHS clinicians
    - Consumer & carer telephone interviews

Project background: Methods

Consumer/Carer perspectives

- 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 the evaluation.
- Contact was made with 47 carers and 27 consumers (n=74) and 130 were disconnected or wrong numbers
General statement

Overall, MHHT was viewed by Consumers and Carers as a very important source of support and access to mental health services.

Findings

Accessing the mental health triage service

- "Was the referral made within the allocated time?" 
- "Was the process of communication between you and the triage worker effective?"

Communication with triage worker

- "The majority of consumers (68%) reported good communication between the triage communicator and the triage worker."
- "Most of the consumers (82%) reported that they were satisfied with the triage process."

Findings

Collaborative decision-making

- "Less than half (44%) of the consumers reported being involved in the decision-making process."
- "Most of the consumers (79%) reported that the communication between the triage worker and the triage communicator was effective."

Findings

We explored the following domains:

1. Accessing the mental health triage service
2. Communication with the triage worker
3. Collaborative decision-making
### Findings

#### Positive Comments from Carers
- Extremely happy with the service
- They are wonderful, I can't speak highly enough of them
- 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
- They followed up with phone call
- They did a good job under difficult circumstances
- 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 back control which was excellent
- The triage staff are compassionate

#### Negative Comments by Carers
- "The worker didn't ring me back"
- "It was a weekend and no one 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 reassuring"
- "People living in more geographically remote locations 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 spent weeks trying to get help"
- "Don't take sufficient time to assess properly"
- "The number should be more accessible. It was hard to find, especially as I was agitated."
- "The wait time is too long for service."

#### Positive Comments by Consumers
- "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 by Consumers
- "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"
- "They didn't seem to have much knowledge about grief, how to help someone who had just lost someone close. They need to be more 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 psychiatric"
- "They [triage] need access to a psychiatrist"
- "Rude, unhelpful"

### Outcomes of the evaluation

- The outcomes from this evaluation included 38 key recommendations for LRHMHT service improvements.
  - Developed a "front end" team of Triage/CL/ED
  - Appointed a Manager, Consultant Psychiatrist and Registrar to the team
  - Established clinical governance processes
  - Implemented screening register and MHTS
- Conducted specialist triage training and cultural competence training
- Secondary consult service to GPs
- Section 10 and Patient Flow from ED pathways to improve access for consumers
- Child and Youth Intake/triage role
- Increased presence in ED to reduce wait times
- Community information in newspapers, NGOs, CHCs - improve consumer/carer knowledge
• The evaluation highlighted a number of areas of MHT practice and service delivery that required further development;
• Since the evaluation, many of the key recommendations have already been met.
• Further investigation of consumer and carer perspectives using larger sample sizes will yield greater insights into the needs of service users.