Identifying the core competencies of mental health telephone triage : final report

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PUBLICATION DATE

01-01-2011

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Sands, N., Elsom, S., Gerdtz, M., Henderson, K., Keppich-Arnold, S. and Droste, Nick 2011, *Identifying the core competencies of mental health telephone triage : final report* Deakin University : Alfred Deakin Research Institute, [Melbourne, Vic.].

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July 2011

Identifying the Core Competencies of Mental Health Telephone Triage: Final Report

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DEAKIN UNIVERSITY

Identifying the Core Competencies of Mental Health Telephone Triage: Final Report

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EXECUTIVE SUMMARY

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). Mental health triage (MHT) services operate 7 days a week, 24 hours a day across Victoria to provide assessment, support, and referral for people experiencing mental health problems, and these services may be located within the Emergency Department of the general hospital, in the community mental health clinic, co-located at the psychiatric unit, or in a telephone call centre. The majority of all initial mental health triage occurs via the telephone.

Area Mental Health Services (AMHS) triage systems were established individually across the regional sectors of Victoria, and this has resulted in considerable variation in the way services have been operationalised. Victorian AMHS triage systems currently lack uniformity and standardisation in clinical procedures for performing triage, and the evidence base for the practice is underdeveloped. Mental health triage is identified in the literature as complex, requiring a high degree of knowledge and skill. At present, there is no standardised method for determining whether clinicians are competent to perform the triage role. This is largely due to the lack of clearly articulated competencies for the practice.

This research was commission by Alfred Psychiatry in 2009 in recognition of the need to develop evidence based frameworks for mental health telephone triage (MHTT) practice that promote safe, high quality service delivery. The project aimed to identify and articulate the core competencies of MHTT, including key role tasks, skills, knowledge and responsibilities clinicians are required to be competent in to perform safe and effective triage.

Summary of findings

Structured observations were undertaken on a total of 197 occasions of mental health telephone triage over a 12-week period in 2010-2011. The investigation found that experienced MHT clinicians use a structured approach to undertaking mental health telephone triage, involving four distinct phases of clinical activity. The study identified and articulated the 8 steps involved in *non-assessment calls*, and the 6 core areas of competency (and related elements) in *mental health triage telephone assessment*. In addition to these findings, the study identified the wide range of skills and specialized knowledge required for effective mental health triage. The report concludes with recommendations to support and strengthen mental health telephone triage service delivery.

1. Background

1.1 Mental Health Triage

Mental health triage services are the first point of contact for many Australians seeking assistance for a mental health problem. Mental health triage (MHT) services operate 7 days a week, 24 hours a day across Australia to provide assessment, support, and referral for people of all ages experiencing mental health problems. A key aim and function of MHT is facilitating access to timely, appropriate mental health care[1,2].

Mental health triage services may be located within the Emergency Department, in community mental health clinics, co-located at the psychiatric unit, or in a telephone call centre. [3,4,5,6] In metropolitan areas there are specialist services for young people and the elderly, however, most of these services operate within business hours, and after-hours service is provided by adult triage services.[7] Referrals to triage are subject to an initial screening assessment that aims to determine the nature and urgency of the presenting problem, and the most appropriate intervention or course of action[1,2]. The majority of initial triage assessments are conducted via the telephone.[2, 7] In recent years, a number of AMHS have established centralised lifespan MHT telephone delivered services. Telephone triage services provide access to mental health services for people spread across vast geographical regions, in particular for people living in regions with no access to other health care services.[5, 6]

Triage systems are used at the point of entry to health services to provide a systemic way of classifying the urgency and service response requirements to clinical presentations.[8,9] Triage is underpinned by the premise that a reduction in the time taken to access care will result in improved patient outcomes.[8,9] Inaccurate and inappropriate mental health triage can place consumers at greater risk of harm from themselves or others, result in poorer health outcomes, and reduce the likelihood of early intervention, especially in lower acuity cases.[10]

Triage systems have been investigated extensively in emergency medicine,[8,9,11,12, 13,14] and Australia has led the field in the development of Emergency Department (ED) mental health triage guidelines and tools.[15,16] There is very little peer-reviewed literature that specifically discusses AMHS triage systems. Studies from North America and Europe have tended to focus on triage performed by mental health professionals located in the emergency department,[17,18] disaster mental health triage,[19,20] rating scales pertaining to psychiatric emergencies,[21] and scales used within community mental health services.[22,23]

Mental health triage services have been operational in Area Mental Health Services (AMHS) 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 Australia, and this has resulted in considerable variation in the way services have been operationalised, and inconsistencies in triage performance.[3,4,25] AMHS triage systems currently lack uniformity in clinical procedures for conducting risk assessment and categorising urgency.[4,25,26] Given the high levels of complexity and acuity seen commonly in consumers seeking assistance from public mental health services,[27] this lack of consistency is problematic in terms of effectively managing risk and preventing harms associated with mental illness. In addition, ineffective or inaccurate triage may also preclude early identification of emerging (sub acute) mental health problems.

Recent global trends indicate an increased reliance on telephone-based health services[28] to facilitate access to health care across large populations. The expansion of MHTT systems to mediate access to services has meant that triage clinicians working at point of entry to the healthcare system have become pivotal to the early detection, secondary prevention and early management of a variety of mental health problems. Given the importance of MHTT to the early identification of mental health problems and their associated risks, it is essential that the evidence base is developed further to inform and guide best practice.

2. Aims and rationale

1.2 Aims

The primary aim of this study was to identify the core competencies of Mental Health Telephone Triage, including key role tasks, skills, knowledge and responsibilities clinicians are required to be competent in to perform safe and effective triage. The overarching aim of this work is to produce findings that may contribute to the evidence-base for mental health triage practice, which is currently under developed.

It is anticipated that strengthening the evidence-base for mental health triage practice will optimise the potential for safe and accurate triage, and improved outcomes for people with mental illness requiring mental health assessment and care.

1.1 Rationale

Mental health triage systems are used across Australia to facilitate access to public mental health services. To date, no previous studies have established the core competencies for MHT practice. Given the inherent complexity of the patient population and their associated risks, it is vital that evidence-based frameworks are established to provide effective systems for the delivery of safe, high quality MHT services. The rationale for this study, therefore, is to produce findings that can contribute to present understandings about the core competencies of the MHT role.

3. Methodology

3.1.1 Research question

The research sought to address the following question:

'*What are the core competencies required for effective telephone-based mental health triage'?*

3.1.2 Design

This study design involved two stages.

Stage 1: Involved preliminary reliability testing of the Mental Health Triage Scale (MHTS). Participants were asked to review and assign a triage category to a set of 20 hypothetical MHT scenarios, which were tested for content validity and inter-rater reliability in a previous study.[31]

Stage 2: An observational design was employed to address the research aims of identifying the core competencies of Mental HealthTelephoneTriage. Structured observations (using dual wireless headphones) were undertaken on 197 occasions of mental health telephone triage.

3.1.3 Setting

Observational data was collected from the mental health triage service of The Alfred Hospital, in Victoria, Australia. The Alfred is a 350-bed acute tertiary referral hospital that treats 50,000 inpatients and 200,000 emergency patients and outpatients annually. The Mental Health Triage Service commenced in 1996, and is currently is situated with the hospital emergency psychiatry programs incorporating the Crisis Assessment and Treatment Team, Enhanced Crisis Assessment Team, and Consultation Liaison Psychiatry.

MHT is a multi-disciplinary role involving nursing staff, social workers, psychologists, occupational therapists and a consultant psychiatrist. There is 2 staff rostered to telephone triage on both morning and evening shifts, and one staff rostered to night shift. All clinicians in the MHT team are provided with specific orientation and preparation for the MHT role. For the first 3 – 6 months clinicians are rostered to the CATT and depending on their experience level, will spend some shifts observing Triage. After 3 - 6 months they will have 3 days supernumerary time on the phones and will be rostered to Triage exclusively for 3 months, rostered with experienced MHT clinicians.

In July 2010 a Mental Health Triage Scale (MHTS) (Victorian Department of Health, 2009) was implemented across all specialist Area Mental Health Services. The MHTS is situated within CMI, the statewide psychiatric database, and this tool is utilized to assess the urgency

of all referrals to triage. Triage assessments are documented in the CMI screening register, where the final step of the documentation process requires clinicians to assign an triage urgency category to the case.

3.1.4 Ethical clearance

This project was granted ethical approval by The Alfred Hospital and Deakin University Human Research and Ethics Committees.

3.1.5 Instruments

Phase 1: A 20-item instrument comprised of (paper based) hypothetical MHT scenarios validated for reliability in a previous study[29] was used for Phase 1 of the project.

Phase 2: A 58-item instrument was developed to capture observational data. The items in the instrument were derived from two sources: a. The Victorian Department of Health[30] written guidelines on Mental Health Triage and b. National Health Call Centre Network[31] Standards for Mental Health Triage (see Appendix A: MHTT Competencies Observation Tool). The instrument was pilot tested for utility on the first 10 episodes of MHTT observed in the study.

3.1.6 Participants

Participation in this study was on a voluntary basis. All staff members working on the MHTT /CATT team who were undertaking triage as part of their clinical role were invited to participate in the study via the Participant Information and Consent Form, and via information sessions held at the hospital about the project.

3.1.7 Data Collection

The first component of the study involved preliminary reliability testing of the Mental Health Triage Scale, which was implemented across Victoria in July 2010. Thirteen particpants pa

Prospective data was collected over a three-month period during December 2010 and March 2011. Using dual wireless headsets, two researchers simultaneously undertook structured observations of MHTT clinicians performing triage. Observations were recorded on the MHTTCOT. Field notes were also taken on every occasion of MHTT to record information on the call type (caller source/type, presenting problem, caller response) and additional clinical activities and interventions.

3.1.8 Data Analysis

Phase 1: The formula for calculating agreement (Kappa) amongst raters (participants) used in this study was that provided by Fleiss.[32] The Kappa statistic is a statistical measure for assessing the reliability of agreement between a fixed number of raters when assigning categorical ratings to a number of items, it measures the overall agreement between all raters. Conventionally, a Kappa of <0.2 is considered poor agreement, 0.21-0.4 fair, 0.41-0.6 moderate, 0.61-0.8 strong, and more than 0.8 near complete agreement.[33] Given Kappa is

an estimate from a sample, the se=Standard Error provides an estimate of error. The 95% confidence interval is Kappa +/- 1.96 se. Although concordance is usually used as a scalar measurement of agreement, a 95% confidence interval of Kappa that does not cross the zero value does allow a conclusion that significant concordance exists.

Phase 2: Standard descriptive analysis (frequencies, means, percentages) were performed on the data to measure to what extent the competencies identified by the observer occur in practice, and to what extend these competencies match those in the MHTTCOT. Qualitative comments (additional observations/field notes) were analysed using content analysis method. Content analysis[34] provides a systematic way of determining the frequency, order or concentration of words or phrases as they appear in conversation. Researchers quantify and analyze the presence, meanings and relationships of such words and concepts, then make inferences about the messages within the texts. Codes are developed to assign to the identified data, which are then organized into specific units/idea categories. Inter-rater reliability is achieved by using two or more researchers/coders to analyze and code data, and establishing agreement or correspondence amongst coders.

4. Results

4.1 Introduction

Phase 1 of the study involved preliminary reliability testing of the MHTS. Participants were asked to review and assign a triage category to a set of 20 hypothetical MHT scenarios, which were tested for content validity and inter-rater reliability in a previous study.[31]

In Phase 2 of the study, structured observations were undertaken on a total of 197 occasions of mental health telephone triage over a 12-week period in 2010-2011. Using dual wireless headsets, two researchers simultaneously observed two MHT clinicians perform mental health telephone triage. In keeping with the Australian Telecommunications Act of 1979, callers to the service were advised that the telephone call may be monitored for training and research purposes, and were given the option of discontinuing the call. No callers to the service chose the option of discontinuing the call, thus all calls to the service during data collection phases were observed.

4.2 Sample

A total of 18 multi-disciplinary MHT clinicians consented to participate in the study, although the sample was predominantly comprised of nurses (n=16) and social workers (n=2). The gender distribution of the sample was 7 male and 11 female participants. Fourteen of the 18 participants held postgraduate qualifications in health, including three clinicians with Masters Degrees and 11 with Postgraduate Diplomas. The majority of clinicians on the team had significant clinical experience in working in MHT and the CATT, with the minimum numbers of years of post graduate experience being 5 years and the maximum numbers of years of post graduate experience being 34 years.

4.3 MHTS reliability testing

Thirteen clinicians participated in the MHTS reliability testing, which involved reviewing and assigning a triage category to 20 validated hypothetical MHT scenarios. The kappa score for each triage category, and the overall kappa for the MHTS are reported in Table 1 below.

Table 1.

MHTS inter-rater reliability

Triage Category	Statistic	
	Kappa	SE Kappa
A	0.78	0.0218
B	0.45	0.0218
C	0.15	0.0218
D	0.17	0.0218
E	0.08	0.0218
F	0.47	0.0218
G	0.53	0.0218
OVERALL	**0.48**	0.0104

The overall Kappa for the MHTS was 0.48, indicating that the MHTS has moderate inter-rater reliability. The inter-rater reliability of individual triage categories within the scale, however, varied considerably. The high (A) and low (G) urgency categories attained the highest level of agreement (A=0.78 and G=0.53), with categories C and D attaining slight agreement, and category E achieving poor levels of agreement. Landis and Koch[32] provide the following guideline for interpreting agreement using κ values.

κ	Interpretation
< 0	Poor agreement
0.01 – 0.20	Slight agreement
0.21 – 0.40	Fair agreement
0.41 – 0.60	Moderate agreement
0.61 – 0.80	Substantial agreement
0.81 – 1.00	Almost perfect agreement

Source: Landis and Koch[32]

4.4 Source of referrals

As the primary interface between the community, other service providers, and specialist mental health services, referrals to MHT are received from very diverse sources. Of the 197 occasions of MHTT observed, 35.5% (n= 70) of calls directly involved a telephone-based psychiatric assessment, and 64.5% (n=127) of calls were primarily related to the provision of various types information/and or communication, such as inter-service communication, and communication with other external healthcare providers, community-based services and agencies.

One of the major sources of referrals to triage was consumers (23.4%) and carers (12.7%). Please see Table 2 (below) for further details on sources of referrals to triage.

Table 2.

Distribution of sample by call sources. (*n=197)*

Call Source	Frequency	Percentage
Accommodation	8	4.1
APMHS	1	0.5
CAMHS	2	1
Carer	25	12.7
CATT	14	7.1
CL/Ward	11	5.6
CM	23	11.7
Consumer	46	23.4
ED	2	1
GP	14	7.1
HOPS	1	0.5
NGO	5	2.5
Other Service	13	6.6
Police	12	6.1
Psychiatrist	9	4.6
Psychologist	5	2.5
Missing	5	2.5
TOTAL	197	100

4.5 Presenting problems

The observations under taken on MHT clinical practice indicate that MHT clinicians assess and manage a broad range of acute mental health presentations across the lifespan via the telephone. Of the 70 telephone assessments observed, the presenting problems most frequently assessed included presentations related to suicidal ideation/self harm (28.6%) and psychosis (21.4%) (See Table 2 for details).

An important observation made in relation to types of clinical presentations typically assessed at triage was their complexity. Co-morbidly was a significant feature of a large proportion (60%) of triage assessments, for example, patients presenting with a history of multiple diagnoses, such as psychosis and co-morbid substance use problems. In addition, a feature of many of the presentations was significant risk issues; in particular 28.6% of presentations involved patients who were suicidal or had thoughts of self harm, 10% of cases had a history of/ current risk of violence (includes homicidal), 5.7% of cases involved pregnant women, and 4.2% of cases involved youth/adolescents and aged persons (4.2%).

Table 3 (below) reports on the distribution of presenting problems in assessment calls.

Table 3

Distribution of presenting problems in assessment calls. (*n=70)*

Presenting Problem	Frequency (*n*)	Percentage
Psychosis	15	21.4
Depression	4	5.7
Anxiety	2	2.9
Suicidal Ideation/Harm	20	28.6
Bipolar Disorder	3	4.3
AOD	4	5.7
Post Natal Depression	4	5.7
Violence	6	8.6
Homicidal	1	1.4
Social Issues	6	8.6
Support	5	7.1
TOTAL	70	100

4.6 Assessment of urgency

Table 4 (below) displays the distribution of triage categories that were assigned to cases. In total, 64 cases from the sample of assessment consultations were assigned a triage category at the time of the observation. In six cases, the triage category was not assigned at the time of the observation, thus these data are not available.

Table 4.

Triage Category distribution (*n=64)*

MHT Category

	A	B	C	D	E	F	G
TOTAL	3(4.7)	5(7.8)	10(15.4)	6(9.5)	4(6.3)	17(26.6)	19(29.7)

Table 5 (below) presents the distribution of triage urgency categories by the call source. These results indicate that consumers, carers, police and CATT referred the most urgent cases to triage, and the least urgent cases were received by consumers, general practitioners, and case-managers.

Table 5.

Distribution of Triage Category by call source (*n=64)*

Call Source	Triage Category *n (% of call source)*						
	A	B	C	D	E	F	G
Accommodation (*n=3)*						3(100)	
APMHS (*n=1)*						1(100)	
Carer *(n=8)*	1(12.5)	1(12.5)	1(12.5)	1(12.5)	1(12.5)	2(25)	1(12.5)
CATT (*n=2)*	1(50)					1(50)	
CM (*n=8)*			1(12.5)		1(12.5)	3(37.5)	3(37.5%)
Consumer (*n=18)*	1(5.6)	3(16.7)	3(16.7)	2(11.1)		3(16.7)	6(33.3)
ED (*n=1)*							1(100)
GP (*n=8)*			2(25)			2(25)	4(50)
NGO (*n=1)*				1(100)			
Police (n=4)		1(25)			1(25)	1(25)	1(25)
Psychiatrist (*n=5)*			2(40)	2(40)		1(20)	
Psychologist (*n=2)*					1(50)		1(50)
Other service			1(33.3)				2(66.7)
TOTAL (*n*)	**3(4.7)**	**5(7.8)**	**10(15.6)**	**6(9.4)**	**4(6.3)**	**17(26.6)**	**19(29.7)**

A total of 50 cases from the sample of assessment consultations were assigned a risk rating (see Table 6.). The majority of cases (62%) were assigned a ‘moderate’ risk rating, with very few cases assessed as being ‘extreme’ risk (4%) or ‘high’ risk (6%).

Table 6

Distribution of risk ratings (*n=50)*

	Risk rating: *n (% of call source)*			
	Extreme	High	Moderate	Low
TOTAL (*n*)	**2(4.0)**	**3(6.0)**	**31(62.0)**	**14(28.0)**

Table 7 (below) shows the distribution of risk/urgency ratings by triage category. In total, 48 cases had both a triage category and risk/urgency rating recorded. Of these it can be seen that urgency ratings and triage categories are highly congruent. That is, cases that were appraised as being high or extreme risk were all allocated to triage category A (emergency) or B (high urgency), categories. Cases appraised moderate to low risk were all distributed across categories C to F, indicating a less urgent response.

Table 7

Distribution of Triage Category Urgency/risk ratings. (*n=48)*

Urgency/Risk Rating	Triage Category *n (% of urgency/risk rating)*						
	A	B	C	D	E	F	G
Extreme	2(100)						
High	1(33.3)	2(66.7)					
Moderate		2(14.3)	9(64.3)	2(14.3)			1(7.1)
Low			1(3.4)	3(10.3)	3(10.3)	9(31.0)	13(44.8)
TOTAL (*n*)	**3(6.3)**	**4(8.3)**	**10(20.8)**	**5(10.4)**	**3(6.3)**	**9(18.8)**	**14(29.2)**

4.7 The process of MHT telephone assessment

An overall finding of the study was that the MHT telephone assessment has a defined structure and several phases. This structure varied according to the type of call, with the main differences found between calls resulting in an assessment and those calls concerned predominantly with the transfer of information between teams and other services.

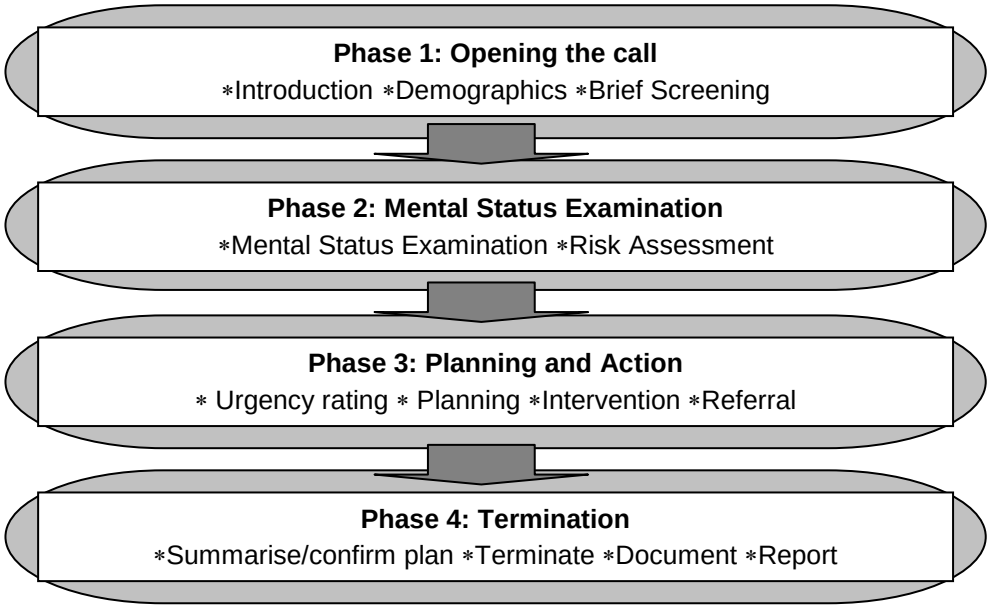
The findings confirmed that in *non-assessment calls* (information requests/transfers, support/advice, triage alerts), the triage consultation typically takes the following steps;

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

In calls that result in a *telephone psychiatric assessment*, the process of triage is extended to include an in depth mental health assessment.

Figure 1 below provides a summary of the phases of the MHT telephone assessment, which is described below.

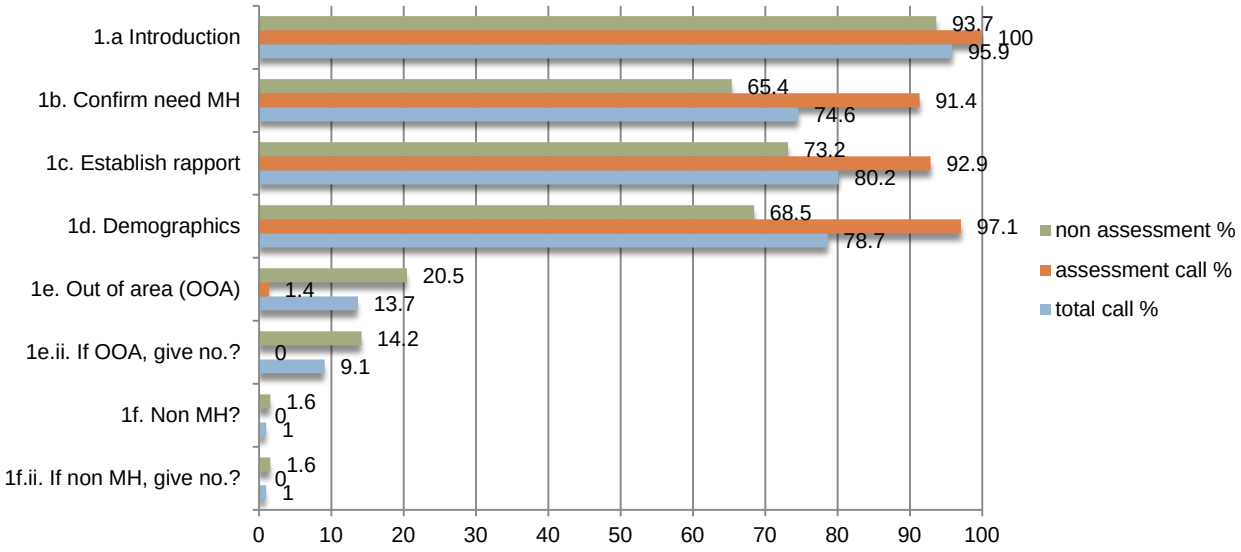
Figure 1. The Phases of the MHT telephone assessment



4.7.1 Opening the call

The first phase of the MHT telephone assessment involves the clinician introducing self and service (100%), collecting demographic information (97.1%), forming a rapport with the caller (92.(%), and confirming the need for mental health services (91.4%). Table 8 (below) presents the results for opening the call.

Table 8: Opening the call



Clinicians used a variety of approaches to establish a rapport with the caller, including adopting a friendly and encouraging tone of voice, and indicating that they were actively listening to the caller. In cases where the caller was distressed and tearful, clinicians used interventions such as reassurance and support to help the caller gain control and continue with the consultation.

Mental health service provision in Victoria is organised into regions, thus the triage clinician must first establish that the caller is from the region they provide service for, if not the caller was directed to the appropriate service provider. The demographic information required by triage includes the consumers' name, address, and date of birth. It is essential to collect demographic information prior to commencing the assessment phase of the consultation, as without identifying information triage is unable to initiate a service response.

Once demographic information has been collected and it has been confirmed that the caller is from the correct regional area, clinicians commence the consultation with an initial brief screen that seeks to confirm whether the main reason for the call to triage is related primarily to a mental health problem. The aim of this phase of the consultation is to encourage the caller (who may be a carer or family member) to describe the current situation or presenting problem in his or her own words. Researchers observed that clinicians typically used open-ended questioning as an effective method of facilitating the caller's self-report. The initial subjective account given by the caller provides important baseline assessment data from which to conduct mental status examination (MSE). The following box-point gives examples of the types of open-ended questions triage clinicians typically employ in the opening phase of the assessment consultation to establish whether the call is primarily related to a mental health problem.

Sample opening questions

1. "*Let's just start by you telling me what happened today or recently that has led you to call the mental health service today".*

2. "*Tell me about you current situation. What made you call triage tonight?"*

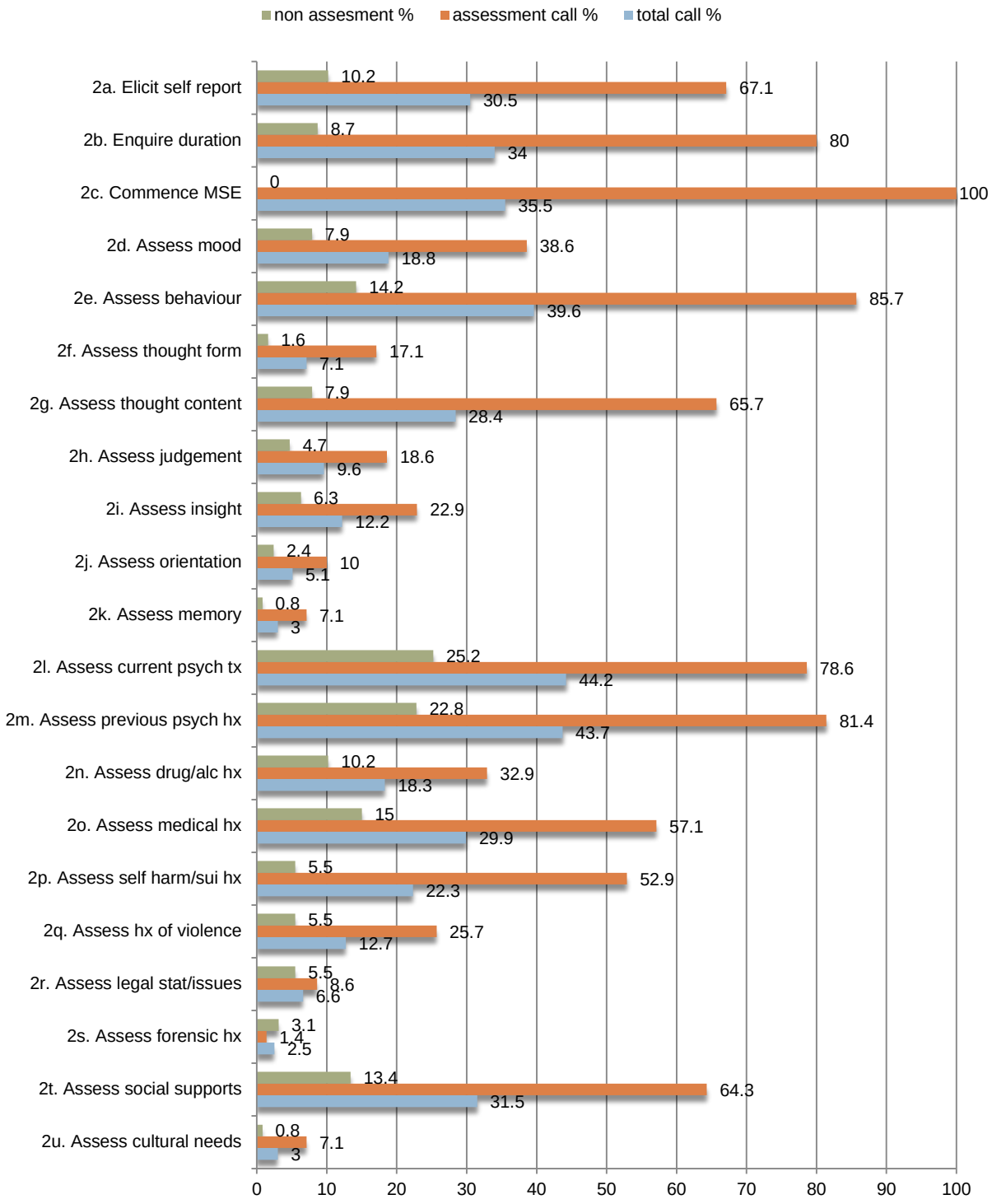
3. *"Can you tell me what is happening for you at the moment?"*

4. *"You have called the mental health service. Do you have any concerns about your mental health at the moment?"*

4.7.2. Mental Status Examination

Phase two of the MHT telephone assessment involves conducting an in depth mental health assessment. Table 9 (below) presents the findings in relation to the types of MSE related information sought in this phase of the consultation.

Table 9. Mental Status Examination



Once the clinician has determined that the primary problem is related to a mental health issue, more information is sought about the specific nature and urgency of the problem. Not all items of MSE are routinely screened for at triage; for example cognitive items such as memory and orientation were only screened for in aged persons.

The areas of assessment most frequently assessed were behaviour (85.7%), previous psychiatric history (81.4%), thought content (65.7%), mood (38.6%), drug and alcohol history (32.9%), history of self-harm/suicidiality (52.9%), social supports/status (64.3%), medical history (57.1%), and current treatment (78.6%).

As previously described, in the brief initial screen, clinicians typically ask open-ended questions designed to attain the caller's impressions and understandings of the situation. When performing MSE, clinicians tended to follow up on the information gained in the initial screen, and using MSE as a framework, use more prescriptive or directive types of questions to seek specific information about the history of the problem and psychiatric signs and symptoms.

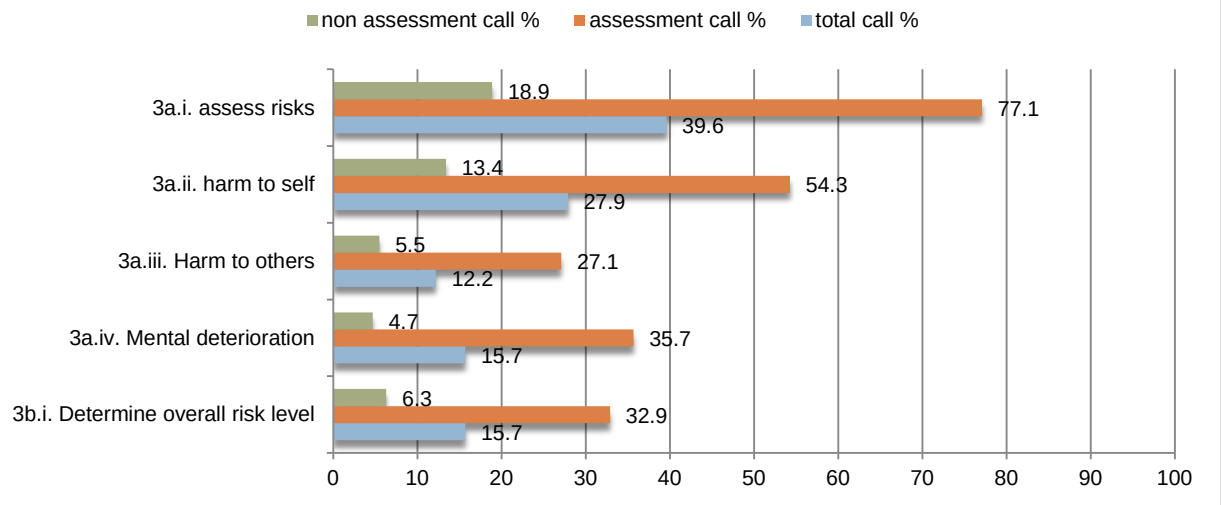
The following box-point gives examples of the types of directive questions triage clinicians typically employ in conducting mental status examination via the telephone.

1. "*How has your mood been lately?"*
2. "*How has your sleep and appetite been in the past couple of weeks?"*
3. *"Have you had any problems with your thinking?"*
4. *"Have you been hearing voices?"*
5. *"How have you been coping with your day to day living activities?"*

Risk assessment

As part of the process of MSE, clinicians frequently (77.1%) seek information about current and pasts risks. The dimensions of risk most frequently assessed include risk of self-harm/suicide (54.3%), risk of mental deterioration (35.7%), and risk of harm to others (27.1%). Table 10 (below) presents the findings in relation to risk assessment practice.

Table 10. Risk assessment



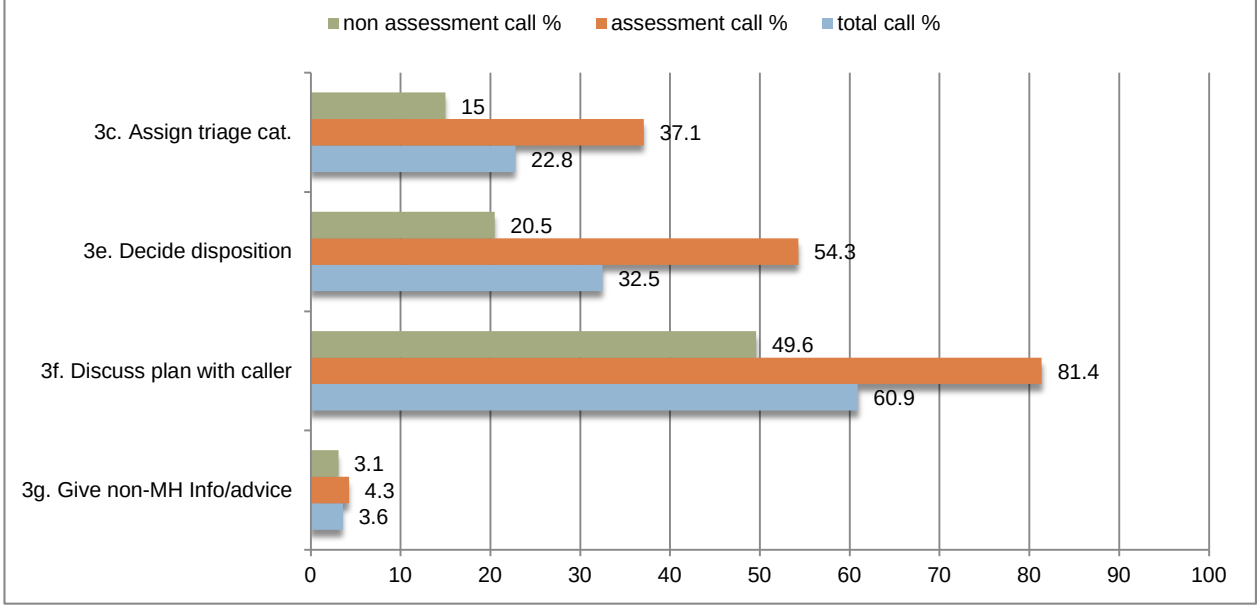
4.7.4. Planning and Action

Once sufficient information has been gathered from the caller to inform MSE and risk assessment, the clinician considers the patient's needs for service, taking into account the risks and protective factors (such as social supports, housing), and deciding the course of action most appropriate to meet the needs the patient.

In deciding the best course of action, the triage clinician typically discusses the plan with the caller (81.4%), decides on a disposition (54.3%), and assigns a triage category (37.1%). Observations of this phase of the triage process revealed that clinicians, on occasions, discuss potential dispositions or care pathways with colleagues, seeking to identify the best option available to meet the immediate needs of the patient.

In the assigning of a triage category, clinicians tended to refer to MHTS guidelines, and match presenting problems with the clinical descriptors in the MHTS, and decide the optimal timeframe within which the person should be seen for further assessment/ or commence treatment. Table 11 (below) presents the results for the planning and action phase of the telephone assessment.

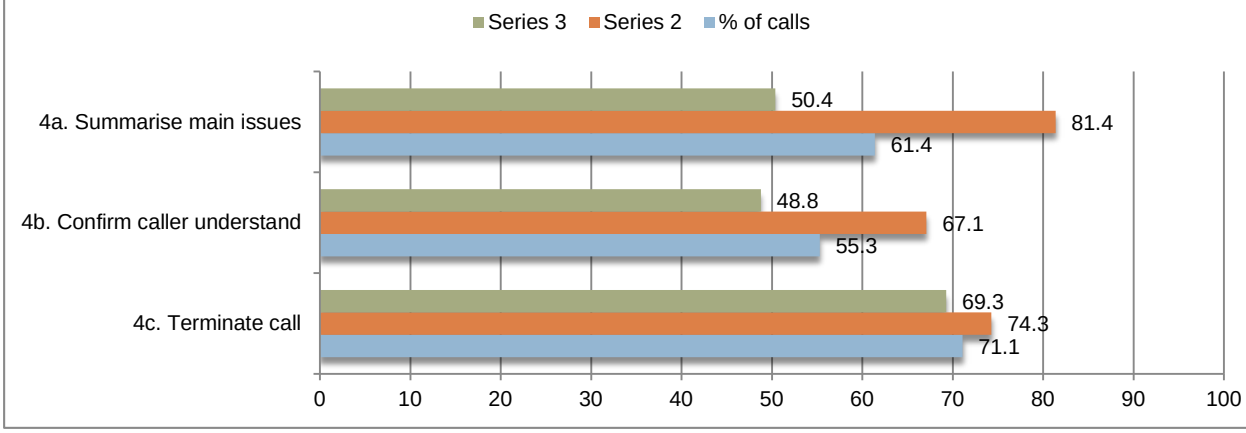
Table 11. Planning and Action



4.7.5 Termination

In the final phase of the MHT telephone assessment, the clinician summarises the main issues (81.4%), confirms the caller has understood the information or plan (67.1%), and terminates the call (74.3%). Clinicians used a variety of approaches to indicate to the caller that the call was nearing completion, including segueing into a summary of the key points of the telephone conversation, and indicating to the caller that they now had sufficient information to instigate a response. Table 12 (below) presents the results for the termination phase of the telephone assessment.

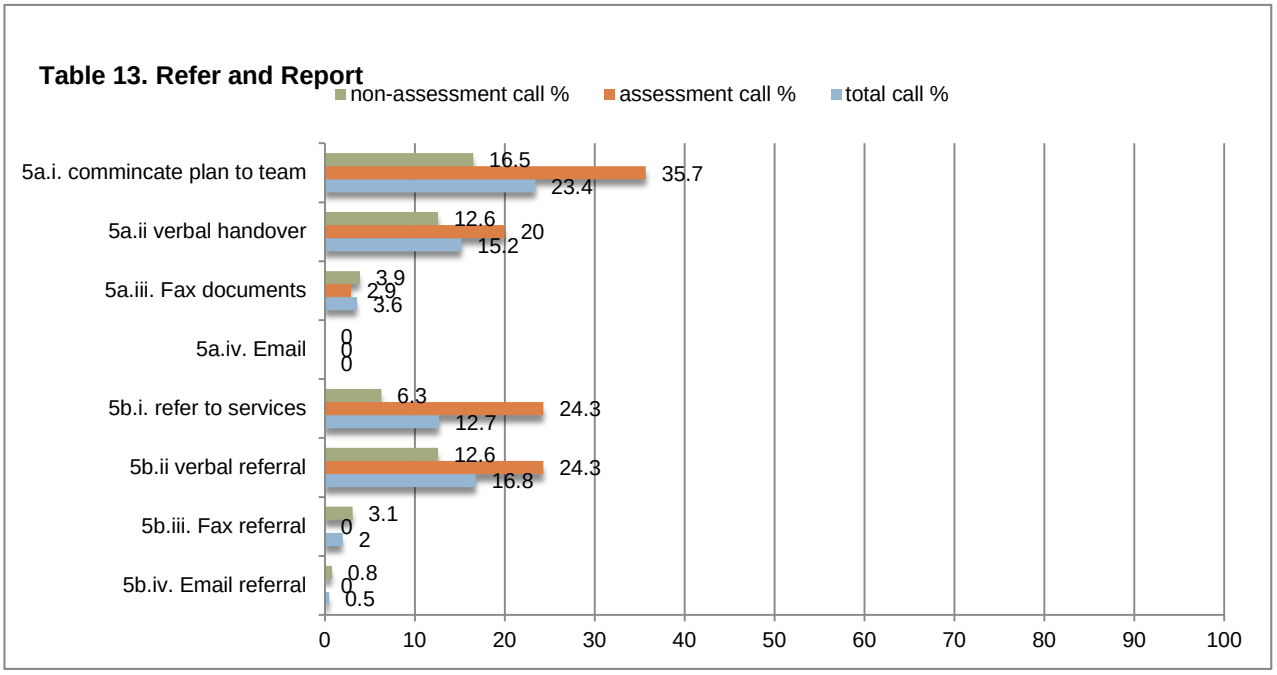
Table 12. Termination



Referral and reporting

On completion of a call**,** information is communicated to relevant teams and/or a referral is made to other services. In the sample of assessment calls, 24.3% of cases were referred to other services. Completing a referral required clinicians to firstly identify the appropriate service response, then prepare the clinical information (document) and report /hand over these assessment findings to the service provider with a request for service. See Table 13 (below) for results on referral and reporting.

Table 13. Refer and Report



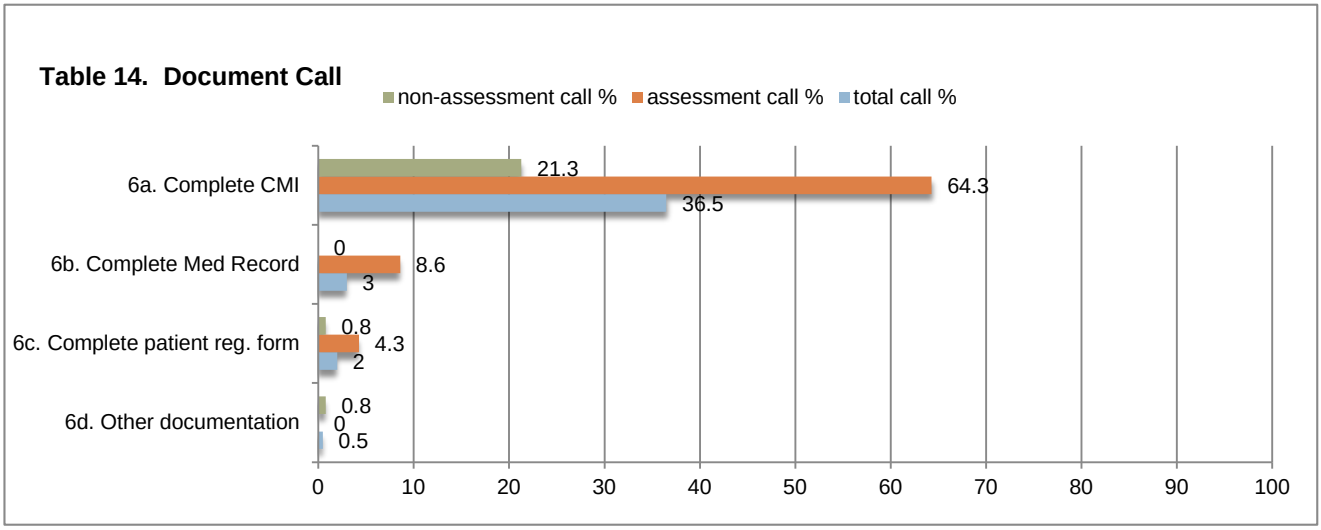
Clinicians also typically made several phone calls seeking collateral information to further inform the case (e.g. to family, GP, other service providers), or seeking information about potential referral or follow-up for the patient. Of the assessment calls, information was communicated to the team in 35.7% of cases, with verbal handover being the most common form of team communication (20%), and verbal referral more common than faxed referral (0%) or email information transfer (0%).

Documentation

The final activity performed to complete an episode of triage is documenting the call. Clinician's consistently took notes during the consultation, and a clear aim was to complete the documentation as soon as possible after terminating the call. MHT clinicians demonstrated proficiency in using multiple electronic patient information systems for both information search and retrieval and for documenting an occasion of triage.

The majority of assessments were documented directly into the triage screening register of the CMI database (64.7%). A number of cases (35.3%) were not documented at the time of the observation, which was largely due to the high volume of calls clinicians received requiring immediate attention, or other interruptions to workflow. Table 14 (below) reports on the results related to documentation.

Table 14. Document Call



5. Other findings

There were a number of additional observations were made about MHT clinical practice that were not accounted for in the observational tool used for data collection. Analysis of the field notes collected on each observation identified a range of practices and skills clinicians use in the MHT telephone assessment/consultation.

5.1 Brief interventions and therapeutic approaches

As previously noted, MHT clinicians assess and manage a wide range of acute mental health problems across the lifespan. Many of these patients are in crisis when they call MHT and are significantly distressed at the time of the call. Clinicians used a range of therapeutic interventions to manage caller distress. The most common therapeutic approaches used by clinicians included demonstrating empathy, speaking in a calm, soothing tone of voice, using clear unambiguous language, assisting the caller to gain control of rapid breathing or crying with clear step-by-step guidance.

Several clinicians used therapeutic skills derived from Cognitive Behavioral Therapy (CBT) based approaches, such as thought stopping and motivational interviewing. Some clinicians used solution focused approaches, whereby the caller is encouraged to focus on the ‘here and now’, and is guided in exploring strengths and past successful coping methods that may be helpful in managing in the present situation. Counselling skills were also regularly employed by clinicians in therapeutic work with patients in crisis, and were also used to provide support for distressed families and carers.

In addition to crisis responses, MHTT provides service to registered clients who call triage for support or advice, either periodically or regularly. Clinicians typically employ supportive counseling techniques to manage these calls, and may also provide basic health advice such as strategies for managing insomnia or coping with psychiatric symptoms.

The observations of caller/patient responses to interventions provided by MHT clinicians confirmed that these crisis interventions are very important elements of the triage function. Callers were observed to be very responsive to the therapeutic approaches and interventions offered by MHT clinicians. This was evidenced by the caller’s behavioural responses to the interventions, such as cessation of crying, reduction in distress, and restoration of inner control. A number of callers also expressed their appreciation for the advice and interventions provided by triage, especially family and carers.

5.4 Medication knowledge

A number of calls to triage were related to questions and concerns about prescribed medications. To effectively manage these calls and provide appropriate advice on the management of side effects and related issues, MHT clinicians are required to have a working knowledge of current psychopharmacology.

5.3 Knowledge of community resources

For effective mental health triage, clinicians require a range of referral options. It was observed that clinician knowledge of the range and type of community-based services available in the regional area facilitated a timely and appropriate service response. In addition to drawing on general knowledge of services in the region, clinicians were observed to access information on service availability via the internet, and from paper-based resources such as resource folders and wall charts.

5.4 Knowledge of drug and alcohol related problems and co-morbidity.

Many of presentations observed involved high levels of complexity. In particular, a high proportion of patients had mixed presentations involving a primary mental health problem and co-morbid drug and alcohol use/misuse, or multiple psychiatric diagnoses. Clinicians demonstrated skills in conducting a brief drug and alcohol assessment, which involved enquiring about:

1. The overall history of substance use
2. The type and frequency of substances used
3. The duration of substance use/abuse
4. The level of current intoxication of the caller
5. Any previous treatment received for substance abuse.

5.5 Time management skills

Observations of MHT confirmed that time management skills are critical to effective triage. Due to the high volume of calls, clinicians are required to balance the need to expediently process the call with the need for accuracy and thoroughness in assessing and responding to callers needs. Evidence of skilled time management included clinicians effectively segueing into the termination phase of the call when sufficient information had been collected. This was achieved by using appropriate verbal cues indicating the call was coming to a close, such as moving into summarizing the key points, or indicating to the caller that they had sufficient information and would now close the call and commence to take action on the problem.

5.6 Resource management skills

Appropriate use of limited resources was observed to be another important MHTT skill. Clinicians were noted to rank the urgency and priorities of cases they were managing, and deploy crisis responses to those most urgent cases first. Decisions to deploy CATT, involve

emergency services, or facilitate Emergency Department assessment were predominantly based on balancing the need for risk management and patient safety with considerations for the patients potential for community based assessment and treatment, and the availability of services to meet these needs.

5.7 Negotiation skills

A key feature of MHT clinical work is the broad range of stakeholders clinicians typically liaise with in the course of a triage shift. As evidenced by the results describing the types of calls to triage, more than 50% of calls in the sample were related to information transfer within service and with external service providers and agencies. Observations of this component of the work confirm that negotiation is often a key feature of these interactions. Clinicians typically negotiated with other service providers around accepting referrals (e.g police involvement), transfer of care, accessing or using out of area beds, and the provision of information. Within service negotiations were predominantly related to bed access/admission (eg use of HDU beds), negotiating time frames for medical review or other medical services, and referral to other services within the AMHS (e.g. Aged beds/assessment, CAMH assessment).

5.8 The core competencies of mental health telephone triage

Each phase of the MHT telephone assessment was observed to contain a number of elements or components, observable in the activities performed for each step. Table 15 (below) provides a summary of these competencies and their related elements.

Table 15

Core Competencies of Mental Health Triage Telephone Assessment

Competency	Element
1. Opening The Call	
	1a. Introduction
	1b. Establish rapport
	1c. Demographics
	1d. Confirm need for MH (brief screen)
2. Mental Status Examination	

	2a. Elicit Self Report
	2b. Enquire duration
	2d. Assess mood
	2e. Assess behaviour
	2g. Assess thought content
	2h. Assess judgment
	2i. Assess insight
	2l. Assess current psych tx.
	2m. Assess previous psych tx.
	2n. Assess drug/alc hx
	2o. Assess medical hx.
	2p. Assess self harm/suicide hx
	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

In addition to these core competencies for MHT telephone assessment, clinicians require specific skills and knowledge to provide a high quality service for a diverse group of service-users. The following table summarises some of the skills and knowledge pertinent to effective MHTT.

Table 16	
MHTT Skills and Knowledge	
Skills	**Knowledge**
Crisis assessment /intervention	Community resources
Therapeutic approaches /interventions	Psychopharmacology
Negotiating	Co-morbidity and complexity
Time management	Youth and aged specific
Resource management	Drug and alcohol
Communication /information transfer	Legal

5.9 Summary

Through an observational research design, this study has identified that experienced MHT clinicians use a systematic approach to undertaking mental health telephone triage. The study identified the 8 steps involved in *non-assessment calls*, and the 6 core areas of competency (and related elements) in *mental health triage telephone assessment*. In addition to these findings, the study identified the wide range of skills and types of specialized knowledge required for effective mental health triage.

5.10 Limitations

This study was conducted in one AMHS thus its generalisabilty to other settings may be limited. A larger sample of assessment calls including more age and youth specific presentations would have provided more depth of data from which to understand the core domains and competency requirements for effective MHTT in specialist populations**.**

6. Recommendations

There are a number of recommendations arising from this study that aim to advance the specialist practice of mental health triage, in particular telephone-based MHT, and contribute to improving the overall quality of MHTT service provision.

1. This study was limited to a sample of MHT clinicians working in one Victorian metropolitan mental health service. Further multi site research is required with a larger sample of telephone assessments to confirm these findings and to investigate any differences between, for example, metropolitan and rural/remote services, MHT clinicians from different disciplinary backgrounds and with varying levels of education and experience.
2. Further research and development of the Mental Health Triage Scale (MHTS) is necessary to improve reliability across all categories
3. Targeted research is required to investigate the efficacy of telephone-based therapeutic interventions used by MHT clinicians.
4. A Mental Health Triage Competency Tool, based on the core competencies identified in this study, should be developed and tested for use in training novice clinicians and for periodic professional development and quality assurance processes.
5. The use of dual telephone head-sets is recommended for clinician training and practice development purposes. The dual head-sets enable novice clinicians to be supervised in vivo by expert colleagues as they undertake MHT.
6. Further investigation into service-user experience and satisfaction with MHTT to inform practice development
7. Investigation into service-user experience and satisfaction with MHTT to inform practice development. An important method of informing service improvement is seeking direct feedback from service-users.
8. Workforce practice development activities such as specific professional development in CAMH and Aged specific assessment

7. Conclusion

As the point of entry to the health service, Mental Health Triage 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. This study has identified the domains of practice clinicians are required to be competent in to perform effective mental health telephone triage, and the additional skills and knowledge clinicians draw on to provide a range of services to a diverse population. An overarching aim of this study is to use these findings to inform future development of MHT standards and frameworks for professional practice, in particular, a reliable way to assess competence to practice MHTT. The findings

from this study provide important evidence from which to further the aims of advancing practice in the specialty.

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9. Appendices

Appendix A: Data Collection Tool.

Competencies	Tick box (Not relevant – write N/A)		Other observations
1. OPENING THE CALL			
1a. Introduce self and service	Yes	No	
1b. Briefly confirm caller requires MH service	Yes	No	
1c. Establish a rapport/engage with caller	Yes	No	
1d. Collect patient demographic information	Yes	No	
1e. If out of area patient- provide correct number	Yes	No	
1f. If non mental			

health provide alternative number (where relevant)	Yes	No	

2. MENTAL HEALTH TRIAGE SCREENING ASSESSMENT			
2a. Elicit caller's perception of the Presenting Problem	Yes	No	
2b. Enquire about duration of problem	Yes	No	
2c. Commence Mental Status Examination	Yes	No	
2d. Assess mood	Yes	No	
2.e Assess behaviour	Yes	No	

2f. Assess thought: *Form*	Yes	No	
Content	Yes	No	
2g. Assess perception	Yes	No	
2h. Assess judgment	Yes	No	
2i. Assess insight	Yes	No	
2j. Assess orientation	Yes	No	
	Yes	No	

2k.Assess memory			
2l. Assess current psychiatric treatment	Yes	No	
2m. Assess previous psychiatric history	Yes	No	
2n. Assess drug and alcohol history	Yes	No	
2o. Assess medical history	Yes	No	
2p. Assess history of self-harm/suicide attempts	Yes	No	
2q. Assess history of violence	Yes	No	
2r. Assess legal status/issues	Yes	No	

2s. Assess forensic history	Yes	No	
2t. Assess social supports	Yes	No	
2u. Assess cultural needs	Yes	No	
3. FORMULATE ACTION PLAN			
3a. Assess risks	Yes	No	
Harm to self	Yes	No	
Harm to others	Yes	No	
Mental deterioration	Yes	No	
Other risks	Yes	No	*name risks identified

3b. Determine overall risk level (circle low, moderate, high, extreme)	Yes	No						
	LOW	MOD	HIGH	EXTREME				
3c. Assign a triage urgency category	Yes	No						
3d. Category assigned (circle)	A	B	C	D	E	F	G	NONE
3e. Determine disposition (outcome/action)	Yes	No						
3f. Discuss plan with caller	Yes	No						
OR 3g. Provide information/advice/ support (when a mental health response is not required)	Yes	No						
4. CLOSING THE CALL								
4a. Segue into call closure by briefly summarising main issues	Yes	No						

4b. Confirm that caller has understood plan	Yes	No	
4c. Terminate call	Yes	No	
5. REPORT AND REFER			
5a. Communicate plan to relevant team	Yes	No	
	Yes	No	
Verbal handover	Yes	No	
Fax documents	Yes	No	
Email			
5b. Refer to appropriate service:	Yes	No	
Verbal referral	Yes	No	
	Yes	No	
Fax referral	Yes	No	
Email referral			

Service type (name/type)			
6. DOCUMENT CALL			
6a. Triage screening register (CMI)	Yes	No	
6b. Hospital medical record /database	Yes	No	
6c. Patient Registration Form	Yes	No	
6d. Other (specify)	Yes	No	