A MODEL OF EFFECTIVE INTERFACE BETWEEN TELEPHONE BASED MENTAL HEALTH SERVICES AND FACE TO FACE SERVICE DELIVERY

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ABSTRACT

Although it has long been accepted practice for a range of mental health services to be delivered via the telephone as part of the management of a client caseload, there has been a move to the delivery of mental health triage via a dedicated telephone based service in recent years.

Over the past five years McKesson Asia-Pacific, a provider of call centre solutions in healthcare, has developed a number of innovative service models that have integrated the functions of triage and case management via the telephone with the face-to-face services in a given area. The seamless integration of telephone-based services with those on the ground is an essential element of an effective service delivery mechanism. This paper will present The Greater Murray Accessline as an example of such a service and will also discuss the development of this service over time in response to policy changes and specific local issues.

INTRODUCTION

Call centres and the Internet have emerged quickly over recent years in diverse parts of the economy to provide ready access to services and information for large user populations. The use of health call centres to provide a single point of access for health services is a growing trend (Turner, Bentley, Hodgson, Collard, Drimatis, Rabune & et al., 2002; Wilson & Cullen, 2001). There are currently a number of established programs and various pilots operational both within Australia and overseas. Probably the largest public sector project to date operates within the United Kingdom as 'NHS Direct', a 24-hour telephone advice line staffed by nurses with the aim of triaging health problems and facilitating access to services (George, 2002). In Australia, a similar service, HealthDirect provides health information, advice and service access within the population of Western Australia, and HealthFirst provides similar services within the Australian Capital Territory (Turner, et al, 2002).

Perhaps unsurprisingly given the demand for mental health services within Australia, interest has steadily risen in the use of call centre and Internet technology within the mental health system. While it has long been accepted practice for a range of mental health services to be delivered via the telephone, this has generally been undertaken as part of the management of a client caseload rather than as a service in its own right with its own aims. There has, however, relatively recently been a move towards the delivery of mental health triage via a dedicated telephone based service (Alridge & Kanowski, 1999). Such a service offers timely and quality information and advice for consumers with mental health problems or concerns, with the aim of directing the caller to the most appropriate health care provider or practitioner.

'Triage' is the sorting of patient care and treatment according to severity of illness or injury (Happell, Summers and Pinikahana, 2002). The concept originated in the Crimea War in response to the desire to achieve the greatest good for the greatest number of patients, and later developed in emergency medicine (Smart, Pollard & Walpole, 1999). The use of triage began in association with physical illness and injury and has more recently been extended for use within mental health settings.

Evidence suggests that appropriate triage and assessment can better manage demand for services and reduce the need to face-to-face attendances, whilst ensuring quality of interactions (Gross, 1998; Domurat, 1999, cited in Wilson & Cullen, 2001). Data from HealthDirect in Western Australia has shown a very high consumer and provider satisfaction and improvements in patient flow-through the health system (Commonwealth of Australia, 2002). Further research shows that telephone assessments are reliable across a variety of Axis 1 and Axis 2 disorders (Rohde, Lewinshon & Seeley, 1997), and that telephone based treatment models are effective for depression in a general practice setting (Lynch, Tamburrimo & Nagal,

1997). These findings are of interest and importance to providers of mental health services and have positive implications for an increased role of call centre technology in the delivery of mental health services, where the provision of adequate community mental health service remains a challenge.

McKesson currently operates a number of mental health triage lines, including: The Greater Murray Accessline, the Mental Health and Counselling Line for the Far West Area Health Service in NSW, Rural Link for the Midwest and Murchison Health Region in WA, and SW24 for the Southwest Health Service in WA. While the service models of each of these programs differ slightly according to the particular service needs and the infrastructure of the Area Health Service with which the program is run, all of the Mental Health Triage Lines offer the following:

- A single point of entry for mental health, drug and alcohol and sexual assault;
- Case management support; and
- Support for non-mental health staff within the Area Health Service.

The aim of the mental health triage lines is the facilitation of improved access to services and continuity of care for consumers of mental health services. These programs demonstrate a model of effective interface between non-locally based telephone mental health services and face-to-face service delivery.

Call Centre Technology

The core technology components that facilitate improved outcomes for patients serviced by call centres can be briefly listed as:

- *PBX (switch)* – the technology that connects the call centre to the external telephone network. The switch should support a sufficient number of incoming trunks so that callers do not receive a busy signal.
- *Automatic Call Distributor (ACD)* – a device that will direct incoming calls to clinical staff using a set of user-defined rules e.g. calls from particular geographical areas, or of a certain type (patient enquiries vs., liaison with other health services) will be delivered only to clinicians with the skills required to service those enquiries.
- *Caller Database* – accessible by clinical staff from a desktop computer linked to a Local Area Network, all patients accessing services will have a unique clinical record saved in a database. The database should store details of all interactions with callers, including key identifying and demographic integration, clinical profile, and care plan.
- *Quality Systems* – reporting systems support resource planning, and indicators such as numbers of incoming calls, average speed of answer and the number of calls that hang-up (abandon) without being answered area available directly from the ACD. It should also be possible to interrogate the caller database to establish the clinical profile of callers, the types of interventions employed with callers and clinical outcomes for callers. The quality reporting system should allow for sufficiently detailed analysis that the performance of individual clinicians can be effectively evaluated.
- *Workforce Management System* – the software that analyses historical call arrival data to enable accurate forecasting of staffing requirements by time of day and day of week, such that callers should on average experience acceptable call answer times without lengthy delays.

THE CONTEXT OF THE DEVELOPMENT OF THE MENTAL HEALTH TRIAGE LINES

A recent review by the Auditor General in Victoria reported increasing difficulties for people experiencing a mental health crisis to gain timely access to appropriate mental health services. Consumers of mental health services and their carers reported that the response to people in mental health crisis is often slow and inappropriate (Auditor General Victoria, 2002) The consequences of difficulties with access to appropriate and timely mental health services are serious and may be include clinical, social, familial, economic factors. Notably, a delayed service response can increase the risk of self-harm, suicide or violence (Auditor General Victoria, 2002).