



An Evaluation of Telephone Triage in Mental Health Nursing

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ABSTRACT

Telephone triage in mental health plays an essential role in establishing links between consumers and mental health services. To date, little research has been conducted which explores the role of this service or the consumer's views regarding their level of satisfaction. This qualitative research study has found that the functions of telephone triage in a mental health context are numerous and open to interpretation amongst clinicians. Further, the clients who participated express significant dissatisfaction with some of the principles upon which telephone triage is based.

INTRODUCTION

The move to a more community based focus in mental health has been accompanied by a reconsideration of how to deliver a range of mental health services. One of the services which has undergone some change is that of triage. Traditionally based within an Admission area, triage has now been transformed, in some centres, to be initially conducted over the telephone. This paper reports on a research project which examined telephone triage within a mental health context.

There is no single model for mental health telephone triage to follow. While the telephone is common to all agencies, each venue has developed variations in the process. Generally speaking, telephone triage in mental health usually refers to a service operated by health professionals – primarily mental health nurses – which is designed to receive incoming calls from mental health clients and the general public. This service may be the primary contact point for anyone wishing to access mental health services. Alternatively, the service may have a role of only dealing with crisis scenarios.

The phone calls are documented in some way which usually incorporates a rating of 1 to 4 indicating the acuity or severity of the caller's situation. The category will dictate the response to be made by the mental health team. This response may involve calling police, sending out a crisis assessment team member to the caller, asking the caller to present to the local hospital for follow up or contacting community mental health workers to arrange a follow up call some time in the future.

LITERATURE REVIEW

There has been very little research performed in this area and so clinicians have limited guidance available from the literature although some direction can be sought from the research conducted within the context of Accident & Emergency wards.

Can Nurses perform mental health triage?

There is evidence to indicate that appropriately prepared nurses are well able to perform the role of triage. It has been estimated that by 1999 30 million people living in England would be

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covered by a 'nurse-led 24 hour advice and information helpline' (Donaldson, 2000). Similarly, in America, "consumer access to telephone nurse lines increased from 2 million...to approximately 35 million...over a 5-year period in the early 1990's..." (Larson-Dahn, 2001). This would indicate that nurses are able to offer mental health – related triage services. Further, in a study involving nurses making follow up phone calls to depression sufferers (Hunkeler, Meresman, Hargreaves, Fireman, Berman, Kirsch, Groebe, Hurt, Braden, Getzell, Feigenbaum, Peng & Salzer, 2000) it was found that these clients experienced their symptoms for a shorter period of time as compared to another of group of clients who did not receive this additional support. While this latter study is not directly related to triage, it does indicate that nurses can provide effective interventions over the phone in relation to mental health. Such a follow up service must also have involved a degree of assessment in order to be successful in reducing the severity of symptoms and so indicates that nurses are able to perform accurate mental health assessment over the phone.

Clinician expertise

Research conducted with staff who perform triage in Accident & Emergency areas identified that the clinician needed to learn telephone skills, crisis intervention strategies, & interviewing skills (Williams, Crouch & Dale, 1995; Hunkeler, et al 2000). Mental health nurses may well have some of these skills by virtue of their expertise, however the application of assessment skills to the phone could still be an area to develop in any training programs. Such skill development may be facilitated by utilising mock scenarios or performing the role under supervision – gradually

increasing the responsibility held by the trainee (Crouch, Woodfield, Dale & Patel, 1997; Evens & Curtis, 1983).

A number of authors (Darkins & Cary, 2000; Robinson, Anderson & Acheson, 1996; Williams, Crouch & Dale, 1995) have suggested that the triaging clinician, in an Accident & Emergency context, should be a senior nurse who also possesses additional postgraduate qualifications. There is no research published which provides suggestions as to the qualifications required for a mental health nurse to provide a triage role and guidance from the findings of research activity would be beneficial.

A minority of papers written about telephone triage consider the need for specific skills related to the use of the telephone. One paper, (Wilkinson, Przezzelski, Duff & Hite, 2000) describes the development of competency standards to be applied as the basis for a two week training program to prepare clinicians in the use of the phone within an Accident & Emergency setting. There has not been sufficient research conducted on the usefulness of such additional programs in order to conclude that such innovations are necessary.

Legal Issues

Triage inherently requires some autonomy for the clinician because the phone call is personal and direct to the caller. As a result, there are some legal issues that require exploration. Specifically, there is a potential tension between the performance of a mental health assessment and the making of a diagnosis (Coleman 1997). This tension originates from the law regarding who is legally allowed to diagnose clients. (Although clinicians may argue that there is no need for diagnosis but rather to identify the health problems being experienced by

the caller). The underlying issue seems to revolve around the question of autonomy. How much autonomy should a mental health nurse hold? In the Accident & Emergency setting, the nurse will have the professional support of a doctor to assist in assessment of callers where necessary. Should the mental health area have the same principle? There have been no articles published which address this issue.

A second area of legal ambiguity is the issue of providing advice over the phone rather than encouraging the caller to come to a venue. The literature contains words of caution regarding the provision of advice over the phone and some authors believe that all callers should be encouraged to attend a hospital (Dale, Williams & Crouch, 1995). However, in regional areas, there may not be the option to have a psychiatrist available 24 hrs a day. Nor may there necessarily be the alternative of an Accident & Emergency clinic available outside of business hours and so the telephone service may be forced to perform an advisory role.

Clinical Decision Making

Another contentious issue in the literature is the use of protocols. Protocols are “*systematic, organised guidelines used to evaluate, classify, advise, educate and intervene in advice calls*” (Evens & Curtis, 1983). It has been suggested that these protocols can guide the clinician to ask the appropriate questions (Isaacman, Verdile, Kohen & Verdile, 1992; Srinivas, Poole, Redpath & Underhill, 1996; Verdile, Paris, Stewart & Verdile, 1989; Wilkins 1993) and so assist in clinical decision making. Protocols can also prompt the clinician to add certain educational information which may otherwise be forgotten

(Darkins & Cary, 2000). It has been suggested that a failure to develop protocols “*represents a fall in standards and a lack of recognition of the importance of this work*” (Glasper, 1993). Such guidance will reduce the risk of legal liability through negligence (Wilkins, 1993)

In contrast, there are other authors who believe that protocols are unnecessary if the triage is only performed by senior nurse clinicians (Edmonds, 1997). In a study involving nurses employed in an Accident & Emergency ward, and who were familiar with the protocols used in their hospital, it was found that, under simulated conditions, the nurses in the study varied in the choice of protocol to use in a given situation and how to apply the protocol (Wachter, Brillman, Lewis & Sapien 1999). One interpretation of this is that staff may be reaching the correct clinical outcomes without necessarily following the protocols in the way they were intended to be used. Both studies cited were conducted within Accident & Emergency settings and so the implication of protocols for the mental health area is unknown.

AIMS

To those external to mental health, it may seem strange that successful mental health assessment can be carried out over the telephone. With little in the literature to inform the reader, this paper reports a qualitative study which was conducted within two mental health venues who deliver a telephone triage service. The study involved semi structured interviews with clients, carers and clinicians. Four of the aims were:

- *To describe the functions and advantages of telephone triage in a mental health context.*
- *To identify the preparation required by clinicians to perform this role*
- *To identify the legal and ethical issues specific to this service*
- *To establish if there is a role for protocols in the clinical decision making process*

METHOD

After receiving ethics approval from each institution as well as from LaTrobe University, Bendigo, a Grounded Theory approach was utilised involving semi structured interviews with clients and staff from two venues. Data analysis was performed to identify common themes which were then analysed in comparison to the existing literature with the aim of identifying differences and similarities.

Staff were recruited by supplying an information sheet to each clinician who works in the triage area. These sheets provided a phone number to contact the researcher in order to find out more about the project. This contact was facilitated through the assistance of a selected staff member who acted as a liaison person.

The liaison person was also given the task of identifying potential clients who met certain criteria. This criteria included: able to offer informed consent, had utilised the triage service at least twice, and, were suffering from a long standing mental health problem. All but one of the clients who did consent to participate were on social benefits and lived in government – supplied housing. Only one of the nine participants was employed.

The client participants were provided with an information sheet about the project. Those who consented to consider the project further were then introduced to the researcher. All participants were asked to sign an informed consent sheet prior to beginning the interview. The interviews were conducted in a private room supplied by the venue and were based on a series of base questions. Each interview was tape recorded for later transcription. The prescribed set of questions initially posed to participants is listed below:

Generic Questions

- What are the advantages disadvantages of telephone triage for mental health clients?
- How can quality assurance be carried out?
- Please comment on telephone triage in a crisis situation.

Staff Questions

- What expertise is required to perform telephone triage?
- Are protocols needed in telephone triage? If so, which ones are specifically required?
- Please comment on the necessity of following up on callers.
- What are the ethical issues raised in providing telephone triage?
- Is the telephone a suitable medium for all callers?

Client/Carer Questions:

- Are you able to compare telephone triage to the previous service conducted on a face to face basis?
- Describe your experiences with telephone triage
- Has telephone triage been found to meet your needs?
- These questions were then followed up by subsequent discussion and questioning which was determined by the comments made.

RESULTS

The responses were examined to identify common themes. Although the data was collected from staff and clients of three separate hospitals, the data was extremely similar and so combined to be reported here. Validation of the data is achieved though noting that similar findings had been obtained in various internal studies conducted by one of the two venues involved. Reports were also circulated to participants in a further attempt at ensuring an accurate interpretation of the data had been made. Further validation of the findings is obtained by having obtained saturation for most of the comments contained within this paper. The exception is in the responses regarding the purpose of telephone triage which are more of a collation of the comments made by the participants.

The functions and advantages of telephone triage

The main advantage of a telephone triage service for mental health callers is the ease of access for clients in mental health crisis and so allowing access to assessment and crisis intervention services. This service is also made uniform by being centralised at one location and operating according to one set of principles. The centrality of the service also allows for a small team to handle all calls and so freeing up other clinicians to perform the roles of crisis assessment and case manager. The telephone service overcomes geographical barriers to access so that a central service can facilitate the caller accessing a clinician.

The telephone also allows for the delivery of immediate therapeutic interventions. Such intervention may be sufficient to defuse some situations – an “ice breaker” which allowed the

client to become “less defensive” as described by one staff participant - and so possibly not require the need to send a clinician to the home. It was suggested that the anonymity of the phone and the comfort of being at home were factors which can help a caller to relax during the call. Alternatively, somebody else can contact the service on a client’s behalf in the situations where the client is experiencing an increased severity in symptoms and appropriate interventions can then be initiated.

Staff described another function to be the filtering of calls so that those callers with mental health problems can be identified from those who have problems which are best met by another organisation – eg Alcoholics Anonymous – and so a referral service is provided by the triage clinician who can provide contact details for such organisations. This filtering function goes further to then also have the calls categorised according to level of urgency. This allows for the clinicians to prioritise and so respond immediately to those in full crisis and to then attend to the needs of those in less acute states of distress at a later time. One staff participant described her previous experience in a ‘shop front’ triage clinic and stated that such a service did not allow the clinician to rank the clients in order of priority because they were all in the room at the one time.

Other roles were identified which originated from the fact that the triage service was telephone based and so allowed for easier access to mental health clinicians. One potential feature of the phone service is that it provides advice to the community. The service can provide education to family or friends of a client who is suffering a mental illness.

Another role that is possibly more related to rural locations is that of the triaging clinician acting as a resource person to the clinician who has gone to see a client. This advice can take the form of a second opinion which is of particular benefit in communities that do not have continual access to a psychiatrist. This communication link also has the advantage of allowing the clinician on the road to call the triage desk for help if a client's condition is assessed as being threatening.

While there was agreement that the service was designed to meet the needs of those in acute crisis, or at least experiencing a profound severity in symptoms, there seemed to be confusion regarding other functions that the service should provide. While clinicians believed that primarily the service was for assessment and crisis situations, the clients in two venues seemed united in also wanting an opportunity to talk over issues which were less urgent. In fact the clients were primarily the group who identified disadvantages to the telephone service. While most clients believed that the service was of benefit in the crisis situation, they also expressed disappointment that they were unable to have a conversation with the clinician at other times. Clients indicated that the clinician made a decision as to whether or not the reason was a "*mental health issue*". The call would be terminated by the clinician if the client was not assessed as suffering a mental health problem which required the triage service. The comment was also frequently made that the clinicians were inconsistent in that some would be prepared to talk for a period of time while others would not do so. All clients who participated in this study were known to the mental health service and most of them had case

managers. This level of dissatisfaction may indicate either that the case managers were not meeting the client's needs or that the clients had unrealistic expectations of what the telephone service should offer.

What preparation is required for clinicians to perform the role of triage?

No staff participant suggested that higher education was required. They were unanimous in suggesting that the clinician needed to have extensive experience in a variety of mental health settings. This experience could then be drawn upon when facing the various situations encountered through telephone triage.

The expertise primarily identified is to be able to do a systematic mental health assessment in a short time frame. Such skill, it was suggested, can only come from experience. In addition, many staff referred to the need for skills in crisis intervention along with a high level of organisational skill and the ability to prioritise.

Can protocols be adopted in a mental health context?

While there were protocols on some procedures such as involuntary admissions, the majority of staff did not support the use of protocols to guide decisions because they are seen to be distracting. Further, the clients who rang were described as having such diverse needs and associated issues that it would be difficult to compose protocols to cover every situation. Experienced staff were described as possessing 'internal decision trees' and so do not require such guidance. There was no indication that protocols would be of benefit to the venues involved with this study.

What are the legal or ethical issues which arise in a mental health context?

There were few issues raised by staff participants. In the absence of a psychiatrist, the triaging clinician possesses additional responsibility when a caller with complex needs contacts the service. The dilemma lies in the best course of action to take in a situation where the triage nurse may feel that hospitalisation is indicated but the law requires a medical opinion before such action can be taken. Access to a doctor may not be possible if the triage service is conducted from a small office which is separate to the main hospital area. Access to a psychiatrist was not possible 24 hrs a day in one venue and those staff participants expressed concern in trying to obtain assistance from the doctor on duty in the venue.

The second significant ethical issue is that the relatives and friends of clients will contact the service to discuss the client's condition. Information given to family or friends may be a breach of confidentiality. While the law may be fairly clear as to what is required of the clinician, the ease of access to the service allows for this situation to arise and the result is potential conflict with family and friends.

It was also suggested that the clinician should always stress that the option of seeing a clinician at the hospital is available. This strategy presumably addresses the chance that an incorrect assessment may occur in which case the client may be told that medical treatment is simply not available. The consequences of such an approach are obviously serious.

DISCUSSION

Some unique aspects of telephone triage included the provision of a second opinion, providing 'back up' for clinicians on the road, and, to convey information to the relevant case worker. The roles of assessment, health advice and referral to other services were three roles mentioned by participants which are also identified in the literature from research conducted within the area of Accident & Emergency. In summary, the functions identified in this research seem to be more diverse than those ascribed to the triage role in an Accident & Emergency ward setting.

This study has collected data which suggests that telephone triage is able to offer an effective mental health assessment service. It would appear that the clients and staff who participated would agree that the service works quite well for those in a serious condition. The significant area of disagreement between the two groups of participants was regarding access to the service when the client was feeling the need for a talk but not in a state of crisis. The literature based in Accident & Emergency areas does not indicate any distinction amongst callers - all callers will be assessed and advice be provided. However, in the area of mental health triage, there seems to be some disappointment from client participants regarding access issues. The concerns expressed by clients from both venues in this study may be related to a perception that they do not receive an appropriate level of support to maintain their health. Support for this suggestion is found in the significant level of disquiet expressed by many client participants in relation to obtaining access to allocated case managers. Future research could examine the

relationship between client satisfaction and models of community support to ascertain if there is such a relationship. If such a relationship were to exist, it may be found that this has a direct impact on telephone triage usage by established clients.

Mental health triage workers in this study believed that protocols are not seen to be necessary because there is much more diversity in the situations presented and so it would be impossible to write protocols for all situations. This is the complete opposite to the literature originating from an Accident & Emergency setting. The emphasis in mental health is to have senior staff perform the triage role because of established clinical decision making skills. This opinion is congruent with a minority of studies previously cited and supports the view that triaging clinicians require well developed skills in mental health assessment.

The triaging clinicians in this study worked in isolation and so legal issues seem to arise secondary to increased responsibility – particularly in the venue without 24hr access to a psychiatrist. The issues revolve around the pressure to diagnose and to make decisions regarding clinical care. This isolation could be overcome by considering the development of telemedicine links to larger hospitals who do have a psychiatrist available 24 hrs a day. Such an initiative may facilitate reduced delay in resolving the situation along with better clinical outcomes.

LIMITATIONS

This study consisted of clients who were primarily suffering serious mental health problems. The consequent needs of these clients may not be representative of other people who utilise the mental health triage service. Further research is required with other mental health clients to verify the findings documented in this paper.

The study involved small numbers of participants – nine clients and ten staff members – and so the data would need to be confirmed by further research before the findings could be applied to the clinical area.

CONCLUSION

Telephone triage has made a significant contribution to mental health care. The roles are potentially more diverse than that of Accident & Emergency and the staff are placed in situations which are not mirrored in the Accident & Emergency setting. This study is the beginning for research to be conducted in this area by providing a qualitative discussion of the process, the priorities and the problems.

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