Investigating the validity and usability of an interactive computer program for assessing competence in telephone-based mental health triage.

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PERCEPTIONS OF CRISIS CARE IN POPULATIONS WHO SELF-REFERRED TO A TELEPHONE-BASED MENTAL HEALTH TRIAGE SERVICE

ABSTRACT

Although psychiatric crises are very common in people with mental illness, little is known about consumer perceptions of mental health crisis care. Given the current emphasis on recovery-oriented approaches, shared decision-making, and partnering with consumers in planning and delivering care, this knowledge gap is significant. Since the late 1990s access to Australian mental health services has been facilitated by 24/7 telephone-based mental health triage systems, which provide initial psychiatric assessment, referral, support and advice. A significant proportion of consumers access telephone-based mental health triage services in a state of crisis, but to date there has been no published studies that specifically report on consumer perceptions on the quality and effectiveness of the care provide by these services. This article reports on a study that investigated consumer perceptions of accessing telephone-based mental health triage services. Seventy-five mental health consumers participated in a telephone interview about their triage service use experience. An 8-item survey designed to measure the responsiveness of mental health services was used for data collection. The findings reported here focus on the qualitative data produced in the study. Consumer participants shared a range of perspectives on telephone-based mental health triage that provide invaluable insights into the needs, expectations and service use experiences of consumers seeking assistance with a mental health problem. Consumer perceptions of crisis care have important implications for practice; approaches and interventions identified as important to quality care can be used to inform educational and practice initiatives that promote person-centered, collaborative crisis care.

Keywords: Triage, mental health, crisis, consumers, telephone triage

INTRODUCTION

In spite of the ubiquity of telephone delivered mental health services, there is a paucity of research reporting on consumer perceptions of accessing telephone-based mental health triage services for help with a mental health problem. The use of telephone-based health services to manage a wide variety of health conditions has become increasingly wide spread in the past decade (Badger et al 2013; Steventon et al 2013; Wetta-Hall, Berg-Copas & Dismuke, 2005). Telephone-based health services have also grown exponentially in mental health settings, and there is now a wide range of mental health programs and interventions available via the telephone (Barnett et al 2009; Donker et al 2013; Kevin, 2002; McGrath et al 2011; Reid et al. 2011). Since the late 1990s telephone-based mental health triage services (MHTS) have been used Australia-wide as the 24/7 primary point of access to mental health services (Grigg et al 2004; Sands, 2004). All mental health referrals and requests for mental health assistance from the public are directed to MHTS, where multi-disciplinary mental health clinicians provide an initial telephone-based psychiatric screening assessment (Sands, 2009). Another important function of MHTS is to provide support, advice, and referral for people of all ages with mental health problems (Sands et al. 2013a). MHTS also provides initial screening for, and access to, crisis assessment and treatment services for people experiencing psychiatric crises (Sands et al 2013b).

Previous research investigating MHTS has focused predominantly on describing and defining the practice (Barnett et al 2009; Grigg et al 2004; Sands, 2004; Sands et al 2013a). There is little in the published literature that specifically reports on consumer perspectives of MHTS, which is surprising given the importance of consumer engagement to the process of conducting psychiatric assessment and facilitating appropriate care (Allen et al. 2003; Chaput et al. 2008). In addition, little is known about the quality of telephone delivered mental health triage and crisis

services, or consumer perceptions of accessing crisis care. A previous study investigating consumer and carer perceptions of the responsiveness of MHTS (Elsom et al. 2013) found that service-users valued and appreciated the service, but reported low levels of involvement in their care. Using a small sample of consumers (n=9) who were triaged at the point of entry to a community mental health service, Hird (2007) identified low levels of consumer perceptions of collaborative care between the assessing clinician and consumer, and the study concluded that further research is required to examine the qualities of the relationship between the assessor (clinician) and consumer.

This article reports the findings of a study that investigated the service-use perceptions of consumers who self-referred to a telephone-based mental health triage service in Melbourne, Australia. The study sought in-depth qualitative feedback from consumers about MHTS service use experience that could be used to further understanding the needs and preferences of consumers experiencing mental health crises.

MATERIALS AND METHODS

Ethical approval

The study was granted ethical approval by the Hospital Human Research and Ethics Committee and Deakin University Human Research and Ethics Committee.

Aims

The primary aims of this study were to:

- 1 Explore consumer perceptions of the responsiveness of telephone-based MHTS using the World Health Organization responsiveness domains (Elsom et al. 2013)
- 2 Attain in depth qualitative feedback from consumers on their service use experience and perceptions of telephone-based mental health triage.

The research questions used to guide this study were as follows:

- 1 Does telephone-based mental health triage provide *responsive* mental health care as defined by the World Health Organisation?
- 2 What is the consumer experience and perception of telephone-based mental health triage?

This focus of this article is on reporting the findings pertaining to the second research question on consumer perceptions of MHTS.

Design

An exploratory design using a telephone survey was used to meet the research aims.

Setting

This project was conducted at an adult Mental Health Triage Service in metropolitan Melbourne, Australia. The MHTS provides service for a population of approximately 250,000 in the region. A single point of entry is used to manage all referrals and public requests for mental health services, and access is facilitated through a universal telephone number (e.g. '1800' number). The MHTS is co-located with the Crisis Assessment and Treatment Team (CATT), and nested within the hospital and community emergency psychiatry program. Approximately 20 multi-disciplinary mental health clinicians staff the MHTS; the majority of staff holds postgraduate qualifications in health.

Participants

A convenience sample of 75 mental health consumers who self-referred to MHTS was used in this study. Eligible study participants included mental health consumers who self-referred to the MHTS during the period of January to December 2012. Recruitment to the study was via mail out that included a letter of invitation to participate in the study, a Participant Information Form, and an 'Opt Out' form with a reply paid envelope. People who returned Opt Out forms were not contacted to participate in the study. The inclusion criteria for the study were: a) consumers who were 18 years and over and had self-referred to MHTS in the previous month(s); b) not a current inpatient; c) not currently receiving treatment from the CATT; d) had not returned an 'Opt Out' form. Participation in the study was on a voluntary, anonymous basis.

Data collection

A researcher contacted eligible participants by telephone and attained their consent to participate in a brief telephone interview about their MHTS service use experience. Eligible participants included MHTS consumers screened using the inclusion criteria above, and who had read and understood the invitation letter and Participant Information Form and consented to participate in the study. An 8-item survey tool used in a previous study (Elsom et al. 2013) was used to collect the interview data. Elsom's telephone survey tool was purpose designed for use in populations who access telephone-based mental health triage, and previous research has established that MHT service users typically contact the service when they are experiencing psychiatric crises (Sands et al. 2013b). The tool measures consumer perceptions of the 'responsiveness' of the mental health service using the World Health Organization responsiveness domains; access, prompt attention, dignity/respect, consumer preferences, involvement in decision-making, communication, and satisfaction. The survey contains the seven WHO responsiveness items and one open-ended question on general consumer feedback about MHTS. The survey was administered as a brief a telephone interview. Qualitative comments were documented directly into an electronic version of the data collection tool.

Data analysis

Descriptive statistics were computed to describe the sample characteristics and report the survey responsiveness data (reported elsewhere). Qualitative data were analysed using conceptual content analysis method (Carley 1990). The conceptual content analysis method involved examining the frequency and concentration of phrases or words in text, identifying the core concepts present in the text, and then interpreting these concepts systematically and contextually to produce coherent, meaningful interpretations of the data (Carley 1990). Three iterations of the conceptual content analysis were undertaken on the qualitative data to achieve the final thematic categories. The first level of analysis involved grouping data into two broad categories of positive and negative themes, and measuring the frequency of key words and phrases in the text. The next level of analysis involved identifying and coding the core concepts identified in the text relevant to each category. Core concepts from each category were then compared relationally in the final level of analysis to produce a coherent interpretation and synthesis of the interview data. Two researchers reviewed the coding processes for determining the main conceptual categories, and the synthesis of concepts for the final interpretation of the data. Consensus was reached between researchers about the main concepts identified in the data, and the overall interpretation of findings.

RESULTS

A total of 75 consumers participated in the study. There was an even number of male and female study participants, predominantly in the under-45 age group. Participants presented to MHTS with a wide range of mental health problems, and most were categorised as low urgency at triage. Most participants were satisfied with the service they received and reported high levels of responsiveness on most domains of the WHO derived interview schedule. However, only 33 percent of participants reported being offered choices and 53 percent reported involvement in decision-making. Some interesting insights into these figures were provided by consumers who offered qualitative feedback about their needs, desires and expectations during times of crisis. Table 1 below reports the demographic and clinical characteristics of the sample: INSERT TABLE 1 HERE:

Consumer feedback on MHTS

A total of 64 participants (85%) provided qualitative feedback about the MHTS. Overall, the frequency of negatively themed comments (n=58) was found to be similar to that of positively themed comments (n=61). The in depth analysis of key words and phrases identified a number of core themes related to perceptions of crisis care that continued to recur thematically in the text. Following is a summary of the pertinent themes identified in the content analysis.

Perceptions of access and timeliness

Themes related to the perceived accessibility and timeliness of MHTS were prominent in both the negatively and positively themed interview data. The frequency of comments related to perceptions and service-use experiences of accessing services indicates that people experiencing mental health crises derive benefits from the ease of access to mental health care afforded by 24-hour telephone-based MHTS. The following brief extract from a participant interview provides an example of the typical of comments offered by participants that point to the perceived benefits of after hours access to mental health services: “Good to know they are there to call when you need them. Especially if it’s late at night or on the weekend.” The following quotation from another participant echoes this view: “The fact that someone is there to answer the phone is great... Anytime, 24/7. I needed someone and they were there.”

Related to the concept of ease of access to mental health services was the recurring theme of *timeliness*. It was clear from the accounts of a number of participants that people in crisis experience a sense of urgency in their situation, and value prompt attention and easy access to crisis services, especially when feeling suicidal. The following example from an interview with a participant who was suicidal when they called triage encapsulated this theme: “Very grateful that the service is there... If had to wait, I wouldn’t have done it [waited].” On the other hand, some participants reported negative MHTS service use experiences where wait times and delays resulted in perceptions of care that were less than satisfactory. The following brief interview excerpts from two participants illustrated the sense of frustration associated with having to wait and being placed on hold, or being unable to connect to the triage worker promptly when experiencing crisis: “The amount of time you sometimes wait on hold would be a problem for some people.” “I got really frustrated and hung up. Things need to be a bit quicker.” Another participant comment exemplified the dissatisfaction that may be experienced by consumers who perceive the service to be slow in responding to their needs in crisis: “[I was] dissatisfied that there wasn’t more immediate care available to someone in [my] circumstances.” One participant comment suggested that the lack of timeliness of the crisis response may have contributed to developing a more complex crisis, or further deterioration of mental state, as evidenced in the following interview excerpt: “A little bit of help earlier would save resources down the track. Twenty-four hours could be too long. [A] quick response is really critical.”

Perceptions of crisis

A significant proportion of participant feedback focused on service use experiences and perceptions, both positive and negative, of care received when the consumer was in crisis. Several participants reflected a view of MHTS as highly responsive to crisis situations, describing MHTS as ‘life saving’, as illustrated in the following sample of brief quotes from participant interviews: “I think they saved my life.” “They are a lifeline.” “It’s a life saving service for [me].” “Probably wouldn’t be here without him [MHTS clinician].” While the majority of comments on crisis care were favourable, several participants provided feedback that indicated that there could be a divide between what the caller and MHTS clinician perceive to be a *significant* crisis. The following examples from the interview data highlighted this point: “They think you are well enough not to need help if you can call.” “One time I had a problem and was told to call the police. I feel like they don’t give you help unless you are very bad or suicidal.” Related to this theme was the perception held by some participants that the severity and acuity of their condition needed to be extreme to be able access MHTS, and the inference that, at times, callers need to escalate their concerns in order to receive services. The feedback from two participants illustrated this point: “The staff said [I] wasn’t allowed to call unless I was having a break down. Feels like falling through the cracks. Do you have to actually self-harm to get treatment?” “[I feel] pushed to ‘victimize’ to get help.”

Negotiating crisis care: Choices and options

Some participants gave feedback about the *process* of negotiating crisis care with MHTS, and themes related to navigating choices and options whilst in crisis were discussed in these comments. Several participants noted the MHTS typically provide (helpful) options, strategies, and

advice, as noted in the following quotes from participants: “[Triage] gave options, offered advice, suggested a referral” “[Triage] always gives me coping strategies and choices.” Being offered ‘choices’ whilst in crisis was not perceived as helpful by several participants, especially in periods of crisis where the ability to make decisions was impaired or difficult. The following quotes exemplified this theme: “By the time [I] call I don’t know which way is up.” “I wanted help...not choices.” Other participants described the tension between helpful exploration of choices and options, and interventions perceived by the consumer as disempowering. The following quotes from participants provide an example of this feedback: “There is a fine line between empowering and disempowering.” “[I have] been deprived of choices... When you refuse help they section you.” “I rang for general advice, to run a few things past them. The CAT team were sent out and [I] was sectioned. Completely taken out of [my] hands.”

Caring

Related to the theme of crisis care, the concept of ‘caring’ was noted to be a strongly recurrent theme. The positively themed feedback was replete with comments that emphasised the importance of feeling cared for in a mental health crisis. Following is a sample of participant comments that demonstrated the critical importance of caring in crisis situations: “I felt like they care. Calling [me] by first name. Like talking to a friend. I didn’t feel like a patient.” “It didn’t feel like they were going through the motions. They really cared. People really cared. It’s really what you need.” “I found them caring and considerate. I feel like I can trust them.” “I found [triage] to be sympathetic, supportive. Not at all belittling or patronizing.” Equally, the negatively themed interview data contained a number of comments about perceived lack of caring by MHTS, exemplified in the following participant quotes: “Threatened suicide while on call and care factor was zero.” “Perfunctory engagement. Not an empathetic or compassionate response.” “[I] felt very stigmatized. [there was] no empathy.” “Already feeling like a burden, hard to ask for help. They just need to understand that when people are in that situation they need to be treated as a human being not as a case or number.” “Don’t follow the process – treat the person.”

Support and reassurance

Support to manage distress was another key concept relevant to crisis care that featured in participant feedback about MHTS. A number of participants gave feedback intimating that support and reassurance is a critical component of effective crisis care. The following excerpts from participant interviews illustrated these concepts: “They helped me when I was quite distressed. Made me feel at ease considering what I was going through.” “Helped through a difficult time.” “The worker said to call if needed, which was very reassuring. It makes things easier when you have someone to talk to.” “They are there for me. They comfort me. I usually feel better after the call.” “They tried to reassure me... suggested ... that [I] not give up hope.”

Listening

A substantial proportion of participants gave feedback about the ways in which MHTS provide support in times of distress. Communication strategies such as listening featured prominently in the feedback, as evidenced in the following quotes: “They responded and listened to what [I] said.” “Found them really good. They listened to what happened.” “[I] speak and tell them the situation and they listen. The listening is just as important validation.” The negatively themed feedback contained a number of references to unsatisfactory MHTS service use experiences related to poor communication, and several of these comments pertained directly to listening. The following excerpts provide an example of this theme: “A bit more care and patience would be good. Listen to the person. Some acknowledgement of the person.” “If you present well they think you’re OK. [They are] not really listening.” “Should listen more – more human approach instead of a checklist approach.”

Helpfulness

The notion of helpfulness as a practical tool in crisis care was also a recurrent theme in the interview data. Participant feedback indicated that a sense of feeling ‘helped’ is an expected outcome when they call MHTS. Consumers expect MHTS to be helpful and responsive to their needs, as is evidenced in the following excerpts from the interview data: “They are pretty helpful. Try to get to the bottom of things quickly when I ring

up.” “I found them very helpful and responsive to me and my partner’s needs.” “[MHTS] is helpful when I’m in trouble”. “The service is always great and they’re generally very helpful.” “Gives advice that is helpful. Always willing to help.” “[I] was in a terrible situation[MHTS] really helped.” Several participants also provided feedback about less helpful interactions with MHTS, but these comments were predominantly made in the context of not receiving an expected service or intervention, such as a visit by CATT or admission to hospital.

Follow-up

A recurrent and cohesive concept in many of the interviews was the significance of follow-up care and continuity for people experiencing a mental health related crisis. The following interview excerpts provide a sample of the types of comments that highlight the perceived benefits of follow-up: “[MHTS] Went above and beyond. They called [my] doctor and arranged an appointment.” “I received a follow up call as well.” “The triage worker rang back to see if [I]was really suicidal.” “First time [I] called they called [me] back which [I] appreciated.” “Got a follow up visit. Someone came everyday. It really helped.” The importance of follow-up was also evident in negatively themed comments: “No continuity.” “Better if they reached out to people and provided follow up help.” “[MHTS]don’t follow up the next day to see how you are.” “Would be really good if they followed you up after an admission. As an outpatient they should keep in contact with us.” “A follow up call would have been great. Next day or a couple of days later would be great.”

Preventing hospitalisation

A few participants commented that the crisis care they received from MHTS played an important role in preventing hospitalisation or unscheduled arrivals at the emergency department, as noted in the following quotes: “[Triage] sorted me out over the phone until I could get to my psychologist the next day.” “Didn’t need to go to hospital which was great.” “It offered an option other than going to the emergency department.” “[I] find that the telephone service is better than turning up at the emergency department”.

Medication advice

A small number of participants provided feedback about the quality of medication advice provided by MHTS. A sample of the comments is provided here to illustrate these concepts: “Told [me] to take medication but I really wanted someone to listen to me.” “She shouldn’t have told me to take Valium. Going to the ED [sedated] and waiting 8 hours is not good.” “[MHTS] suggested medication. She didn’t ask about any other medical conditions. The medication suggested was incompatible with [my] medical condition. They should be careful advising medication over the phone when they don’t have the full history.” “[My] main concern was that the advice was ‘take some valium’. One size fits all and call back.”

DISCUSSION

The study met its overall aim of attaining in-depth consumer feedback on perceptions of accessing crisis care from MHTS. Some of the attributes consumers consider to be important to quality MHTS service provision include ease of access, helpfulness, providing choices and options, and follow-up care. The significance of communication strategies such as listening, and the vital role of caring and providing psychological support to manage distress for people in crisis were central themes to arise from the study. The findings concur with those of Griswold et al (2008) regarding the importance to many service users of the clinician’s communication skills, particularly in regard to listening.

Our findings support earlier reports (Bramesfeld et al. 2007a; Bramesfeld et al. 2007b) that service users place high importance on autonomy and the ways that they are involved in decision-making regarding treatment options. Consistent with previous exploration of service-user expectations of mental health triage services (Elsom et al, 2013) we found differing service-user expectations in relation to their autonomy with some reporting feeling disempowered by being excluded from decisions about their care, while others reported being given choices and feeling supported to be involved in decision-making. The importance of supported decision-making in recovery-oriented practice has been recognised (Davidson et al., 2015) and enshrined in many policies and legislation [e.g. Mental Health Act 2014 Victoria]. Our findings and those of a recent

systematic review (Davidson et al., 2015) highlight the need for further investigation to identify the barriers to supported decision-making at the point of access to mental health care, and ways in which these barriers may be minimised or overcome.

An important finding to emerge from this study was that some consumers held the view that the triage clinician had not recognized or acknowledged the level of crisis they were experiencing. This is consistent with the recent report by Miyamoto et al (2015) that consumers and staff held differing perceptions of mental health service needs. We support the call by Mishara et al (2007) for targeted training to improve collaborative, patient-centred care for mental health triage clinicians.

The first hand experiences and observations of consumers of telephone-delivered mental health triage provide invaluable insights into the *experience* of crisis care. In the current health context, consumer participation in mental health service evaluation, planning and policy development is increasingly drawn on to guide quality service provision (Brunero, Lamont & Fairbrother, 2009; Simpson & House, 2002). Hopkins, Loeb and Fick (2009) note that the perspectives of consumers and health professionals often differ regarding the consumers' treatment needs and priorities. By shedding light on the elements of crisis care that consumers perceive as helpful (or unhelpful/harmful), the study findings have potential to inform practice and educational initiatives that promote person-centered, collaborative crisis care. The study is limited in its generalisability due to its small sample size, and the recruitment of participants from a single site. Further research is required to develop deeper understandings of the needs, wishes and preferences of people experiencing mental health crises, and the crisis care approaches and interventions that produce optimal consumer outcomes.

REFERENCES

- Allen M, H., Carpenter, D., Sheets, J. L., Miccio, S. & Ross, R. (2003). What Do Consumers Say They Want and Need During a Psychiatric Emergency? *Journal of Psychiatric Practice*, 9(1), 39-58.
- Badger, T. A., Segrin, C., Hepworth, J. T., Pasvogel, A., Weihs, K., & Lopez, A. M. (2013). Telephone-delivered health education and interpersonal counseling improve quality of life for Latinas with breast cancer and their supportive partners. *Psycho-Oncology*, 22(5), 1035-1042.
- Barnett, T., Henderson, S., Henry, D., Gumpold, A., Foote, P., & Gallop, S. (2009). Nurse-led telephone triage in an Australian rural mental health service. *International Journal of Nursing Practice*, 15(5), 389-393.
- Bramesfeld, A., Klippel, U., Seidel, G., Schwartz, F. W. & Dierks, M. (2007). How do patients expect the mental health service system to act? Testing the WHO responsiveness concept for its appropriateness in mental health care. *Social Science & Medicine*, 65, 880-889.
- Bramesfeld, A., Wedegärtner, F., Elgeti, H., & Bisson, S. (2007). How does mental health care perform in respect to service users' expectations? Evaluating inpatient and outpatient care in Germany with the WHO responsiveness concept. *BMC health services research*, 7(1), 99.
- Brunero, S., Lamont, S. & Fairbrother, G. (2009). Using and understanding consumer satisfaction to effect an improvement in mental health service delivery. *Journal of Psychiatric and Mental Health Nursing*, 16, 272-278.
- Carley, K. (1990). Content analysis. In R.E. Asher (Ed.), *The Encyclopedia of Language and Linguistics*. Edinburgh: Pergamon Press.
- Chaput, Y., Paradis, M., Beaulieu, L. & Labonte, E. (2008). A qualitative study of a psychiatric emergency. *International Journal of Mental Health Systems*, 2(9). Accessed 10-5-15. Retrieved from <http://www.ijmhs.com/content/2/1/9> doi:10.1186/1752-4458-2-9
- Davidson, G., Kelly, B., Macdonald, G., Rizzo, M., Lombard, L., Abogunrin, O., Clift-Matthews, V. & Martin, A. 2015. Supported decision making: A review of the international literature. *International Journal of Law and Psychiatry* 38: 61-67
- Donker, T., Petrie, K., Proudfoot, J., Clarke, J., Birch, M. R., & Christensen, H. (2013). Smartphones for smarter delivery of mental health programs: a systematic review. *Journal of medical Internet research*, 15(11). Accessed online 15-5-15. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3841358/> doi: 10.2196/jmir.2791
- Kevin, J. (2002). An examination of telephone triage in a mental health context. *Issues in Mental Health Nursing*, 23(8), 757-769.
- Elsom, S., Sands, N., Roper, C., Gerdtz, M. & Hoppner, C. (2013). A telephone survey of service-user experiences of a telephone-based mental health triage service. *International Journal of Mental Health Nursing*, 5, 437-43.
- Grigg, M., Endacott, R., Herrman, H., & Harvey, C. (2004). An ethnographic study of three mental health triage programs. *International Journal of Mental Health Nursing*, 13(3), 146-151.

Griswold, K. S., Zayas, L. E., Pastore, P. A., Smith, S. J., Wagner, C. M., & Servoss, T. J. (2008). Primary care after psychiatric crisis: a qualitative analysis. *The Annals of Family Medicine*, 6(1), 38-43.

Hird M. (2007). Service user involvement in mental health assessment: comparing people's experiences of mental health triage assessments with theoretical perspectives on user involvement. *The International Journal Of Psychiatric Nursing Research*, 13(1), 1561-77.

McGrath, P. J., Lingley-Pottie, P., Thurston, C., MacLean, C., Cunningham, C., Waschbusch, D. A., ... & Chaplin, W. (2011). Telephone-based mental health interventions for child disruptive behavior or anxiety disorders: randomized trials and overall analysis. *Journal of the American Academy of Child & Adolescent Psychiatry*, 50(11), 1162-1172.

Mishara, B.L., Chagnon, F., Datgle, M., Balan, B. , Raymond, S., Marcoux, I., Bardon, C., Campbell, J.K., & Berman, A. 2007. Which Helper Behaviors and Intervention Styles are Related to Better Short-Term Outcomes in Telephone Crisis Intervention? Results from a Silent Monitoring Study of Calls to the U.S. 1-800-SUICIDE Network. *Suicide and Life-Threatening Behavior* 37(3): 308-21

Miyamoto, Y., Hashimoto-Koichi, R., Akiyama, M. & Takamura, S. 2015. Mental health and social service needs for mental health service users in Japan: a cross-sectional survey of client- and staff-perceived needs. *International Journal of Mental Health Systems* 9:19 DOI 10.1186/s13033-015-0009-7

Reid, S. C., Kauer, S. D., Hearps, S. J., Crooke, A. H., Khor, A. S., Sanci, L. A., & Patton, G. C. (2011). A mobile phone application for the assessment and management of youth mental health problems in primary care: a randomised controlled trial. *BMC family practice*, 12(1), 131.

Sands, N. (2004). Mental health triage nursing: An Australian perspective. *Journal of Psychiatric and Mental Health Nursing*, 11(2), 150-155.

Sands N. (2009). An exploration of clinical decision making in mental health triage. *Archives of Psychiatric Nursing*, 23(4), 298-308.

Sands N, Elsom S, Gerdtz M, Henderson K, Keppich-Arnold S, Droste N, Prematunga RK, Wereta ZW. (2013a). Identifying the core competencies of mental health telephone triage. *Journal of Clinical Nursing*, 22 (21-22), 3203-16.

Sands N, Elsom S, Marangu E, Keppich-Arnold S, Henderson K. (2013b). Mental Health Telephone Triage: Managing Psychiatric Crisis and Emergency. *Perspectives in Psychiatric Care*, 49(1), 65-72.

Simpson, E. L. & House, A. O. (2002). Involving users in the delivery and evaluation of mental health services: Systematic review. *British Medical Journal*, 325, 1265–1268.

Steventon, A., Tunkel, S., Blunt, I., & Bardsley, M. (2013). Effect of telephone health coaching (Birmingham OwnHealth) on hospital use and associated costs: cohort study with matched controls. *BMJ*, 347. Accessed 13-5-15. Available at: <http://www.bmj.com/content/347/bmj.f4585.full>.

Wetta-Hall, R., Berg-Copas, G. M., & Dismuke, S. (2005). Help on the line: Telephone-triage use, outcomes, and satisfaction within an uninsured population. *Evaluation & the Health Professions*, 28(4), 414-427.

World Health Organisation (2000). *World health report 2000 health systems: Improving performance*. WHO. Geneva.

Table 1. Demographic and clinical characteristics (N=75)

Gender	n	%
Male	37	49.3
Female	38	50.7
Total	75	100.0
Age range		
18-25	7	9.3
26-35	24	32.0
36-45	19	25.3
46-55	12	16.0
56-65	8	10.7
65+	5	6.7
Total	75	100.0
Presenting problem		
Depression	16	21.3
Adjustment disorder	3	4.0
Anxiety	10	13.3
Eating disorder	1	1.3
Bipolar Disorder	5	6.7
Situational crisis	2	2.7
Substance disorder	4	5.3
Schizophrenia	17	22.7
Psychosis (other)	1	1.3
Eating Disorder	1	1.3
Borderline PD	9	12.0
Suicidal	6	8.0
Total	75	100.0

Triage Urgency Category		
A	4	5.3
B	5	6.7
C	15	20.0
D	5	6.7
E	12	16.0
F	11	14.7
G	23	30.7
Total	75	100.0

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