An Ethnographic Examination of the Influences on the Relationship between Mental Health Triage Nurses and Emergency Department Triage Nurses

By

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Certificate of authorship and originality of thesis

The work contained in this thesis has not been previously submitted either in whole or in part for a degree at CQUniversity or any other tertiary institution. To the best of my knowledge and belief, the material presented in this thesis is original except where due reference is made in the text.

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Abstract

Emergency Departments are increasingly the focal point of primary access to mental health services by clients with a mental illness. Developments in the initial emergency triage assessment are inextricably linked to improving the process of triage, where clients are assessed and referred to specialist mental health services.

This ethnographic study examined the interdisciplinary relationships between emergency department triage nurses and mental health triage nurses for clients presenting with a mental illness.

Using an ethnographic methodology, time was spent in an Australian Emergency Department and Mental Health Triage Service. Participant observation, individual and group interviews, organisational documentation and field notes were used to gather data that was analysed using the constant comparative method.

Four key themes were identified from this research. The practice environment, the process of triage assessment, referral and response, the roles and scope of practice and collegiate presence were influential factors in the relationship between the two participant groups.

Research findings conclude that culturally disparate groups cannot develop a functional and collaborative working relationship without a deep understanding of, and appreciation for, each other's culture. Developing such a relationship requires collegiate presence that is built on communication, mindfulness, education and time spent together to develop a practice community.

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List of Publications and Presentations From This Thesis to Date

Peer reviewed journal publications

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Additional publications by the researcher

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Peer reviewed conference abstracts

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Broadbent, M, Moxham, L & Dwyer, T 2009, 'Factors affecting referral and response for clients who present with a mental illness to the ED', paper presented to the *7th International Conference for Emergency Nursing*, 7-10 October, Gold Coast, Queensland.

Broadbent, M, Moxham, L & Dwyer, T 2009, 'The factors that influence the interactions between mental health triage nurses and emergency department triage nurses', paper presented to the *35th International Conference of the Australian College of Mental Health Nurses*, 29 September – 3 October, Sydney, New South Wales.

Broadbent, M, Moxham, L & Dwyer, T 2008, 'Emergency mental health care in Australia: policy and problems', paper presented to the *XIV World Congress of Psychiatry*, 20-25 September, Prague, Czech Republic.

Broadbent, M, Moxham, L & Dwyer, T 2007, 'Emergency triage and the mental health nurse', paper presented to the *33rd International Conference of the Australian College of Mental Health Nurses*, 8-12 October, Cairns, Queensland.

Presentations as invited speaker

Broadbent, M 2011, 'The client with a mental illness – the ED waiting room and stigma', presented to the *Mental Health Units Conference,* 20-21 June, Sydney, New South Wales.

Broadbent, M 2011, 'Triage reform: developing consistency in the emergency triage of clients with a mental illness in Australian emergency departments, presented to the *EPS International Conference on Emergency Medicine*, 1-2 June, Montreal, Canada.

Broadbent, M 2010, 'Still waiting: clients with mental illness in the emergency department', presented to the *Mental Health Units Conference*, 24-25 June, Sydney, New South Wales.

Broadbent, M 2006, 'Emergency mental health triage', presented to the *National Mental Health Triage Forum*, 13-14 November, Melbourne, Victoria.

Broadbent, M 2005, 'Mental health triage', presented to the *National Institute of Clinical Studies workshop on Emergency Mental Health Triage*, 5 October, Melbourne, Victoria.

Publications and presentations by the researcher that have informed this research

Marynowski-Traczyk, D, **Broadbent, M** 2011, 'What are the experiences of emergency department nurses in caring for clients with a mental illness in the Emergency Department?' *Australasian Emergency Nursing Journal,* vol. 14, pp. 172-179.

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Broadbent, M 2006*,* 'Emergency mental health triage - problems and solutions: the experiences of one regional emergency department and mental health service', paper presented to the *8th Annual Australian New Zealand College Mental Health Nurse Symposium*, 23-24 June, Yeppoon, Queensland.

Broadbent, M 2005, *'Emergency mental health triage: models of care and future directions*', paper presented to the *5th Annual Health and Medical Research Conference of Queensland*, 3-4 November, Brisbane, Queensland.

Research Title

An Ethnographic examination of the influences on the relationship between mental health triage nurses and emergency department triage nurses.

Research Aim

The aim of this research was to:

Better understand the relationships between emergency department triage nurses and mental health triage nurses.

Research Question

What influences the relationship between mental health triage nurses and emergency triage nurses in the continuum of emergency mental health triage?

Glossary of Terms

ATS: Australasian Triage Scale - A five tiered scale used nationally by emergency department triage nurses to determine the acuity of clients presenting to an emergency department.

ED: Emergency Department - an organisational component of a health service that delivers emergency care.

EDIS: Emergency Department Information System - a software package that is used by emergency department and other staff to record triage, demographic and other data that reflects client care in the ED.

EMHT: Emergency Mental Health Triage - the assessment, allocation of a triage score, and referral of clients with a mental illness to a mental health clinician.

MHT: Mental Health Triage - the process that is managed by a mental health clinician having responded to a referral from the ED triage nurse and occurs in either the ED or any other environment where clients with a mental illness are assessed.

MHTN: Mental Health Triage Nurse - a mental health nurse not permanently based in the ED, whose responsibility it is to assess, treat and refer clients referred to them from a variety of sources including the ED.

MHTS: Mental Health Triage Scale - A five tired scale used by emergency triage nurses nationally to determine the acuity of clients presenting to an emergency department with a mental illness.

NTS: National Triage Scale - the precursor to the ATS.

PEC: Psychiatric Emergency Centre - a mental health service collocated within the ED permanently staffed with psychiatric medical and nursing staff.

PCLN: Psychiatric Consultation Liaison Nurse - a mental health nurse working in a general hospital setting supporting general trained nurses. The PCLN may also attend the ED to assess clients presenting with a mental illness.

Conventions Used Within This Thesis

The following conventions are used as they appear throughout the thesis:

Client: The term client is used in this thesis with deliberate intent. ED triage nurses use the term patient to describe people they care for whereas contemporary mental health nomenclature uses consumer. The term client was selected for use by the researcher, for ease of readability and its status as a respectful term that does not reflect a bias towards either discipline.

(ED 12): Notations of this nature at the end of participant quotes indicates the participant group, ED – emergency department triage nurses, MH – mental health triage nurses, and the interview number. In this example, this would be the twelfth interview in the series of interviews, conducted with the ED triage nurses.

(FN): Field notes, denotes comments by the researcher taken from the field notes.

P: Participant, where there are multiple participants in a particular interview, they are identified numerically P1, P2 and so on.

R: Researcher, used when the comments from the researcher are included in a quote.

[ ]: Used when clarification is inserted into quotes by the researcher.

Introduction

This thesis presents a systematic acquisition and understanding of a substantial body of knowledge. The outcomes demonstrate knowledge that is at the forefront of the academic discipline area and professional practice of nursing. The overall aim in documenting this research is to inform and educate the reader and, by virtue of generating scholarly research papers and presentations, disseminate the findings of the research to the wider community. This thesis is sufficiently original that it has commanded the respectful attention of peers. This is demonstrated by the publication of articles in scholarly peer reviewed journals and the presentation of elements of this thesis at national and international conferences, which have emanated from this research journey as listed on pages X to XII.

The thesis is presented in such a way as to tell a compelling story cloaked in credible research process. It demonstrates the researcher's critical understanding of the research context, issues and the literature.

Chapter 1: Positioning the Research

1.1 Prologue: Emergency department triage in Australia - lessons from the Napoleonic wars and Sister Pink

The process of triage, and specifically emergency mental health triage, is central to this thesis. This chapter provides scholarly commentary on the process of triage from a historical perspective. Current issues around triage and facets of nursing practice and organisational structure that are imperative in contextualising the research and research findings are examined

Triage is a French word derived from the verb 'trier' meaning 'to sort' (Broadbent, Jarman & Berk 2004). As a process within health it has its origins in the Napoleonic wars where Baron Dominique Jean Larrey, Napoleon's Surgeon in Chief, removed large numbers of injured soldiers who could potentially be salvaged to fight again and delivered them from the battlefield to surgical services (FitzGerald 1996). The overriding principles of treatment were equity and efficiency, and, as Baron Larrey observed, this was essential as '…much confusion would have ensued had I not observed the order of dressing and arrangement observed by me in all battles' (Larrey n.d., p. 27). The purpose of military triage was to find the most cost effective way of offering troops treatment and returning them to the battlefield. Initially casualties were divided into three groups: those with large untreatable wounds and those near death, casualties with serious wounds such as those needing amputation, and those with treatable minor flesh wounds. Given that anaesthesia, aseptic

technique and advanced surgical techniques in cranial, abdominal and orthopaedic surgery were still in their infancy, treatment was directed at the troops who could be treated within the confines of the relatively primitive battlefield surgical conditions. Therefore, those with life threatening injury were left to die as scarce resources were directed to those that could be treated (Brentnall 1997).

Having been born from the requirements of battle, the notion of treatment priority was slowly emerging in emergency departments (EDs) in civilian hospitals in Australia (Pink 1977). Like the battlefield, EDs often experience large numbers of undifferentiated clients presenting simultaneously who require sorting based on principles of equity and efficiency (FitzGerald 1996). Prior to World War Two free treatment in the old ‘casualty’ departments was preserved only for the poor. Before the notion of free health care became entrenched in the Australian consciousness, payment for service was considered vitally important and, as such, the process of registration and documentation for billing took priority. Clerks and nurses were often the only permanent staff in the casualty departments and, consequently, became adept at ‘pointing out’ the sickest of those clients waiting to be seen. Brentnall (1997) argues that this process of identifying the sick was haphazard and did not contribute to timely and organised treatment.

The earliest formal triage system in Australia emerged around 1975 as the Director of the ED at Box Hill Hospital in Victoria, Dr Edward Brentnall, pondered the dilemma of managing increasing numbers of clients presenting with more complex illness and injury. Coupled with the fact that clients in the waiting room were developing serious symptoms while waiting for treatment, he realised that some method of sorting clients was required (Brentnall 1997). Together with the Sister-in-Charge, Mrs Noel Pink, they decided on a process of triage with three categories, numbered one, two and three. These numbers were allocated to clients identified as: one, those requiring urgent treatment; two, those with 'run of the mill' conditions; three, those with non urgent conditions. A triage desk was set up in the waiting room and only the most senior nurses were allocated to the role of triage to 'emphasise the importance of the post and the critically important nature of triage in the organisation of the whole department' (Brentnall 1997, p. 52). The nurses in this role became the known as triage nurses. Colours were assigned to categories; yellow for category one clients, blue for category two clients and white for category three clients. Coloured adhesive dots represented the category, therefore, the acuity of the clients was used in the register of patients to aid visual cueing. An examination of the register would consequently provide a rapid impression of the activity within the ED (Brentnall 1997). Thus a triage scale became a way of not only sorting clients to ensure treatment priority but a way of encoding and capturing ED workloads - a principle that remains critical in understanding contempory triage practice.

The next phase in the development of the triage scale at Box Hill Hospital emerged when red dots were allocated to ‘signal one’ clients arriving by ambulance who were critically ill. This new level of urgency replaced the existing category one clients. As a result of the category one (yellow) clients being relegated to a secondary position on the scale, the nurses at triage realised that there was a new group of clients who were difficult to differentiate. The triage nurses needed a new category between the existing yellow and blue categories to describe those clients with illnesses that could become life threatening if left untreated. Thus, a fifth category was added to the triage scale. Triage nurses began working with a five level triage scale: category one for clients with life threatening illness or injury, category two for clients with imminently life threatening conditions, category three for minor trauma or illness, category four for non urgent cases, category five for those clients with very minor conditions (Brentnall 1997).

The ED at Box Hill Hospital had established a very clear process to manage clients presenting for treatment based on the principles of equity and efficiency. The triage nurses were able to assign a client a category that represented the acuity of the client’s illness or injury, thereby ensuring they were seen in a timeframe commensurate with their presenting condition rather than being seen in order of presentation and the triage nurses having to deal with emerging illness while clients waited for treatment.

The final step in the initial development of this triage process was one that would define the work processes of EDs throughout Australia. Optimal times to treatment were added to the each of the five-triage levels within the scale. At a meeting between Brentnall, Pink and the Medical Director Dr Alan Davis, it was decided that the time between arrival and being seen by a medical officer should have nothing to do with the workload activity within the ED and should be independent of everything except the triage category (Brentnall 1997).

Table 1. Box Hill Hospital triage scale waiting lime limits

Triage Category	Colour	Waiting Time	Waiting Limit
1	Red	90 seconds	3 minutes
2	Yellow	5 minutes	10 minutes
3	Green	30 minutes	1 hour
4	Blue	1 hour	2 hours
5	White	2 hours	4 hours

Adapted from Brentnall (1997)

The waiting times, as depicted in Table 1, became the expected time for medical treatment to commence for clients in each of the categories. The waiting limit was designated so that during peak departmental activity when optimal waiting times were regularly breached and waiting limits reached, this became the impetus to call in extra medical staff to manage the workload (Brentnall 1997). This meant that the medical and nursing staff became more responsive to clients presenting to the ED based on the timeframe embedded within the triage category allocated to the client. By the late 1970s the triage system at Box Hill ED had

evolved to a point where it became the precursor to the system of triage as it is known today. However, as Brentnall (1997) describes, the whole system was purely intuitive. What was needed was a systematic review of the triage process.

In the latter half of 1985, a triage scale was introduced into the Ipswich General Hospital based on the scale used at Box Hill Hospital. Similar in design and intent to the Box Hill scale, it was based on the premise that the scale 'regularised the intuitive processes used by the nursing staff in receiving patients into the department' (FitzGerald 1996, p. 205) and in local testing was demonstrated to effectively and repeatedly describe patient populations. The scale became known as the Ipswich Triage Scale (ITS) and, in testing the scale across ED's at Ipswich and Fremantle its repeatability, relevance and outcome validity were confirmed (Jelinek 1995). In 1993 the ITS was modified slightly into the National Triage Scale (NTS), as evidenced in Table 2, having undergone enhancement as a result of further studies (FitzGerald 1996) and was adopted across Australia with the support of the Australasian College For Emergency Medicine (ACEM) (Broadbent, Moxham & Dwyer 2007).

Table 2. National Triage Scale for Australasian emergency departments

Numeric Code	Categories	Treatment Acuity
1	Resuscitation	Immediate
2	Emergency	Minutes (< 10 minutes)
3	Urgent	Half Hour
4	Semi Urgent	One Hour
5	Non Urgent	Two Hours

From; Monash Institute of Health Services Research (2001)

In 2000 the ACEM modified the NTS by broadening the descriptions of presentations within each category and changing its name to the Australasian Triage Scale (ATS) (Appendix 1) (Broadbent, Jarman & Berk 2004). In recognition of the omission in the NTS, brief descriptors for mental health presentations were included, Table 3.

Table 3. Australasian Triage Scale with mental health descriptors

ATS Category	Response	Description of Category	Mental Health Clinical Description
1	Immediate Simultaneous assessment and treatment	Immediately life threatening	Severe behavioural disturbance with immediate threat of dangerous violence
2	Assessment and Treatment within 10 minutes	Imminently life threatening Or Important time critical treatment	Violent or aggressive Immediate threat to self or others Requires or has restraint Severe agitation or aggression
3	Assessment and treatment start within 30 minutes	Potentially life threatening Or Situational urgency	Very distressed, risk of self harm Acutely psychotic or thought disordered Situational crisis, deliberate self harm Agitated/withdrawn
4	Assessment and treatment start within 60 minutes	Potentially serious Or Situational urgency Or Significant complexity or severity	Semi-urgent mental health problem Under observation and/or no immediate risk to self or others
5	Assessment and treatment start within 120 minutes	Less urgent Or Clinico-administrative problems	Known patient with chronic symptoms Social crisis, clinically well client

Modified from Guidelines for the implementation of the Australasian triage scale (Australasian College For Emergency Medicine 2005)

1.2 Triage of the client with a mental illness in Australia

The inclusion of mental health descriptors in the ATS came about as reports such as the New South Wales Government Working Group for Mental Health Care in Emergency Departments identified that mental health descriptors in the NTS were desirable and called for the inclusion of them in the NTS (NSW Health 1998). This change to the NTS was called for as the numbers of clients with a mental illness presenting to ED's was increasing. It was also identified that a substantial proportion of clients presenting to EDs have a psychiatric chief complaint or psychological problems that contribute to their presenting complaint, others may have a coexisting physical illness, which may in turn contribute to their mental illness (Broadbent 2001; NSW Health 1998). The emergence of this client group as a significant cohort of clients presenting to Australian EDs occurred as a direct result of the Australian Federal Government's decision to change the management of mental health services more than two decades ago.

The management of contemporary mental health service provision in Australia has been guided by the National Mental Health Strategy. Conceived in 1992 the initial component of the strategy was the First National Mental Health Plan. This plan attempted to develop national coordination of public mental health services, which prior to 1992 had been managed by the individual state and territory governments. The impetus for this was the increasing public criticism and formal enquiries into mental health services around Australia (Whiteford, Buckingham &

Manderscheid 2002). The most significant enquiry in Australia being the Report of the National Inquiry into the Human Rights of People with Mental Illness, initiated due to the erosion and violation of the human rights of individuals with a mental illness (Human Rights and Equal Opportunity Commission 1993). Two principle pillars of the National Mental Health Plan were to mainstream mental health services into general health services and to deinstitutionalise mental health care and move to a model of community based care (Australian Health Ministers 1992).

The broad intent of mainstreaming meant that changes such as the collocation of acute psychiatric units in general hospitals, the application of principles of general health management to mental health, and the provision of individual case management to those with complex mental health problems would bring mental health out of the asylums and into conventional health services. This would improve community understanding of mental health and provide a more equitable service (Williams 1995). Williams (1995) describes the fundamental principles of deinstitutionalisation as achieving a reduction of admissions into specialist psychiatric hospitals, treating people who were in specialist psychiatric hospitals in general hospitals and managing mental health disorders in general health services.

Through the processes of mainstreaming and deinstitutionalisation the First National Mental Health Plan set the agenda in reforming mental health care so that it could be accessed in the same way as general health care. The First National Mental Health Plan has been followed by subsequent documents, the Second National Mental Health Plan (Australian Health Ministers 1998), the National Mental Health Plan 2003-2008 (Australian Health Ministers 2003) and the Fourth National Mental Health Plan (Australian Health Ministers 2009). Each of these documents forms part of the National Mental Health Strategy aimed at promoting the mental health of the Australian community, prevention of mental illness, reducing the impact of mental illness on the community as well as assuring the rights of people with mental illness (Australian Health Ministers 2009).

Whiteford, Buckingham and Manderscheid (2002) suggest that while the National Mental Health Strategy has delivered some measurable success, the strategy initially failed in key areas. For instance poor funding arrangements between state and federal governments resulting in under funding and cost shifting; a poor information base of demographic and service utilisation data and a lack of attention to the involvement of the private health sector in mental health care. This has meant that because the processes of deinstitutionalisation and mainstreaming had not been properly resourced or funded (Moxham 2003) the intended improvements to service delivery had not been delivered. This important point challenges the assumption that mental health care should be comparable to care delivered to those with

physical injury or illness (Hayman-White, Silvana & Happell 2006). The conflict between the intent of the National Mental Health Strategy to deliver mental health care in general hospital and community settings and the ability to deliver care is manifest in emergency departments.

The number of clients with mental illness presenting to the ED have been increasing due to the effect of mainstreaming (McDonough et al. 2004). Hundertmark (2002) states that between 1996 and 2000 the number of adult clients with a mental illness presenting to the Flinders Medical Centre in South Australia rose 320 percent with a steady rise of 35 percent per year. A report on mental health presentations to EDs in Victoria found that between 1999 and 2001 there had been a 13.9 percent increase per year in mental health presentations to emergency departments. The report identifies the demand on community mental health care and the relatively low number of specialist inpatient psychiatric beds as putting increased pressure on the interface of these services (Department of Human Services 2006). These examples quantify the recurring theme that is evident in the literature that ED's have been subject to increased presentations by clients with mental illness who present with increased acuity (Broadbent, Jarman & Berk 2002; Kalucy, Thomas & King 2005; Stuhlmiller et al. 2005; Summers & Happell 2003; Webster & Harrison 2004). It is difficult to know exactly how many clients with a mental illness access the ED. The most current reporting tool for emergency healthcare in Australia, the Australian Hospital Statistics 2009-10: Emergency Department Care and Elective Surgery Waiting Times (Australian Institute of Health and Welfare 2011)

does not report on these data. Further evidence of the increase can be gleaned from mental health occasions of service for clients with a principal mental health diagnosis. It has been reported that this measure increased across Australia in the 2007-08 reporting period from the previous 2006-07 period by 4.1 percent to 258,500 mental health related ED occasions of service (Australian Institute of Health and Welfare 2010). However, this report highlights that reporting for data for mental health presentations may be incomplete and underreported due to a lack of nationally consistent approaches to data collection for this client group. Given that the number of ED occasions of service for the same period - 2006-07 - was 7.1million (Australian Institute of Health and Welfare 2009), an estimate of 258,500 mental health occasions of service represents four percent of all ED occasions of service, remembering that this number is likely to be greater due to the underreporting of presentations.

1.3 Clarification of terminology

The terms triage, mental health triage, psychiatric triage, consult–liaison and liaison psychiatry are used frequently in the literature surrounding the emergency assessment and management of clients with mental illness in the ED. Therefore clarification of the terms is required to ensure consistent descriptions of processes and roles.

Broadbent, Jarman and Berk (2004, p. 9) define triage as:

> ... a primary process. Clients present via ambulance, car or walk into the ED. A nurse assesses the client and makes…decisions [based on] an assessment of the client's problems, needs and potential for deterioration, then allocates a triage category from the triage scale. This process should take no longer than 5 minutes.

The ACEM suggest that triage should be conducted by a specifically trained and experienced registered nurse and the application of a triage score should be in response to the question 'This patient should wait for medical assessment and treatment no longer than…' (Australasian College For Emergency Medicine 2006, p. 1). The emergency triage process is, by nature, a brief process. Following rapid assessment, clients are moved into areas of the ED appropriate for their needs in order for ongoing nursing and medical management to begin.

Broadbent, Jarman and Berk (2004, p. 9) describe mental health triage as:

> … a secondary triage process. Having been referred from the ED the mental health triage worker conducts a full examination and assessment of the client and then refers the client to the most appropriate treatment facility such as community support or admission as an inpatient. This process may take hours.

These definitions highlight the differences between the two processes. However the term 'mental health triage' is used when discussing the assessment of clients with mental illness in the ED (Broadbent, Jarman & Berk 2002, 2004; Smart, Pollard & Walpole 1999) and when

describing the work of mental health nurses working in a variety of settings (Sands 2004).

Sands (2004) conducted a doctoral research project into mental health triage nursing in Victoria, Australia. Sand's thesis examines the development of the role of mental health triage nurse (MHTN) as a specialist role within the field of mental health nursing. Sand (2004) contends that emergence of the role of the MHTN occurred as a result of mainstreaming which necessitated the closure of psychiatric hospitals and the subsequent funnelling of mental health clients into community based mental health care facilities. Access to mental health services in Victoria became regulated by a single point of entry system known as 'duty' or 'triage' in which all mental health related enquiries are handled by the triage clinician. The research indicated that up 70 percent of all triage positions were occupied by nurses and that mental health triage nurses practice in a variety of triage settings such as ED's, community mental health clinics, inpatient units and a combination of the previously mentioned settings. The use of the term 'mental health triage' in this instance describes not only a unique position and role within the broad field of mental health nursing but also a process similar to ED triage where clients are assessed and acted on upon an acuity of needs basis (Sands 2004).

While the term mental health triage was probably first coined by Smart, Pollard and Walpole in 1999 for their paper describing the development of the first mental health triage scale (Smart, Pollard & Walpole 1999) it would seem that the term has been embraced by the community of mental health clinicians to describe both an emerging specialist role and a process of sorting and referring clients with mental health illness. Therefore, for the purposes of this research the term 'emergency mental health triage' will be used to differentiate between the primary ED triage process and the secondary mental health triage process as described earlier by Broadbent, Jarman and Berk (2004).

Emergency mental health triage is the process that happens in the ED and occurs within the context of normal triage practice. It uniquely describes the assessment, allocation of a triage score, and referral of clients with a mental illness to a mental health triage clinician, usually a nurse. It is the process that provides the functional boundaries within which the ED and mental health triage coexist and is central to this research. Mental health triage is the process that is managed by the mental health triage nurse having responded to a referral from the ED triage nurse and occurs in either the ED or any other environment where clients with a mental illness are assessed and referred on to a service that can meet their needs at the time.

1.4 Models of mental health nursing practice

Mental health nurses engage with ED's under the auspices of a range of titles reflecting roles with similar intent but with differing practice

orientation. The main roles will be examined in order to clearly articulate the role of mental health triage nurse as it is this title of the role in which, the mental health nurse participants in this research worked.

One of the practice domains of mental health nurses is that of the consult-liaison nurse or psychiatric consult-liaison nurse (PCLN). As a model of service delivery it grew from the notion that consultation is a process where one professional seeks assistance in solving a clinical problem from a professional who is an expert in the area (Caplan 1970). In the context of health and the practice setting of the PCLN the staff requesting assistance are non-mental health registered nurses seeking assistance on the management of clients with mental illness in the general hospital setting. The PCLN role grew from the recognition that medically focussed psychiatric consult-liaison model did not meet the needs of general nurses in the general hospital setting. Broadly, the role of the PCLN consists of assisting non-mental health trained nursing staff to intervene effectively when presented with a client with mental health problems and to provide guidance, advice and education on the needs of clients with a mental illness. The PCLN may work directly with the clients and their relatives or indirectly through the consulting team (Sharrock & Happell 2001). This model of care has been utilised in ED's across Australia (Wand 2005) and Europe (Eales, Callaghan & Johnson 2006; Sinclair et al. 2006); however, it has been criticised as a model of care for clients with mental illness in the ED due to long waiting times for assessment and discharge (Wand & White 2007) .

Wand (2005) suggests that the role of the PCLN in the ED is different to that of a PCLN working in a general hospital setting and describes the evolving role of the mental health liaison nurse (MHLN). While a PCLN assists with the management of clients with a primary medical or surgical condition and a co-morbid mental health problem the MHLN principally works with clients who present with a primary mental health problem. The roles of MHLN and the MHTN as described by Sands (2004) and are differentiated by the fact that the MHLN exists principally in the ED and the MHTN works in a variety of inpatient and community settings, which sometimes includes the ED (Wand & White 2007).

While the literature reviewed was quite prescriptive about the title and role of each of the models of mental health practice, it is acknowledged that the language and roles vary amongst health care facilities. However, for the purpose of this research the various models of practice are summarised in the following table.

Table 4. Models of mental health nursing practice

Model of care	Description
Psychiatric Consult-liaison Nurse (PCLN)	Any mental health nurse working in a general hospital setting supporting general trained nurses who may attend the ED when requested.
Mental Health Liaison Nurse (MHLN)	Any mental health nurse permanently located in an ED to care for clients with mental illness or associated presentation.
Mental Health Triage Nurse (MHTN)	Any mental health nurse not permanently deployed in the ED, whose responsibility it is to assess, treat and refer clients referred to them from a variety of sources including the ED.

1.5 Models of mental health nursing practice in the emergency department

Mental health nurses work in locations that are not always within or next to the ED and there are advantages and disadvantages with each of the models. The relative merits of location and geography have bearing on this research, as the model of mental health engagement, and the geographical positioning of the services at the research site, external to the ED, is believed to be the most common although this is not verifiable in the literature. Frank, Fawcett and Emmerson (2005) and Wand and White (2007) describe four models of emergency psychiatric care in Australia. These include the three models as described in Table 4, page 18, and psychiatric emergency centres (PECs) which are collocated within or next to the ED.

Much of the literature concerning PECs emerges from North America. The only Australian paper is a report on the development of a PEC at the Royal Brisbane and Women's Hospital, Brisbane, Australia (Frank, Fawcett & Emmerson 2005). Frank, Fawcett and Emmerson (2005) describe broad improvements in client care and improving relationship between the ED and mental health staff. The PEC provides three to four nurses per shift over 24 hours seven days a week, and a four-bed ward with associated facilities. The improvements to care are demonstrated by regular meetings with the PEC staff and the remainder of the mental health staff to foster effective admission/discharge processes and improvements in partnerships with alcohol and drug services, police,

ambulance and other services. Of benefit to the ED is that the PEC aids the rapid movement of clients out of the ED into the PEC for further assessment, thereby reducing access block in the ED and providing direct access to specialised mental health staff. The paper does not specifically detail changes to waiting times across the range of triage categories and, as described earlier, is the least common arrangement between the ED and mental health service. While there are some perceived advantages Wand and White (2007) argue that PECs are expensive, divert funds from other mental health imperatives, have no document evidence of their effectiveness and, due to the segregation of psychiatric and general emergency care, further stigmatise clients with a mental illness. This, they contend, is disparate with the intent of the National Mental Health Plan.

The MHLN model is described by Wand (2005; Wand & White 2007) and McDonough et al. (2004). Wand (2005) describes the model evolving from the requirement of The National Standards for Mental Health Services 1997, to respond to mental disorders and/or mental health problems as early as possible, and the New South Wales Health Centre for Mental Health 1998 call for mental health services to respond to emergency department referrals with equal clinical priority to other emergency requests. The MHLN is responsible for: assessment and care of clients with mental health issues in the ED, improving the efficiency of the ED by providing timely assessment and disposition of mental health clients, mental health education and training to the ED staff, mental health promotion and communication with mental health

inpatient staff. The benefit of the MHLN model described by Wand (2005) was that 40 percent of the MH clients were seen within one hour of arrival and a further 14 percent within three hours. Further examination of the literature suggests that the MHLN model reduces overall waiting time for clients with a mental illness (Wand & White 2007). There is no attempt to correlate these response times to those within the ATS or other mental health triage scales.

A further evaluation of the MHLN service was conducted by surveying ED staff on the effectiveness of the MHLN, the changes to client care and ED staff perception of their own deficits. The results indicate ED staff satisfaction with the MHLN model and an ability of the MHLN to see a significant number of clients close to or at the time of triage (Wand 2005). Further examination of the MHLN model suggests that ED staff felt more supported (Wand & White 2007) and that staff reported a more positive change in attitude towards and knowledge of, clients with a mental illness.

A similar study by McDonough et al. (2004) described the introduction of a MHLN into an ED overnight to counter a lack of mental health services after hours. The aims of the service reflect those described by Wand (2005). The service demonstrated a ninety four percent reduction in waiting times from 235 minutes pre MHLN, to 36 minutes following the introduction of the MHLN. Once again, this was not assessed in the context of the response normal required by the timeframes associated with normal triage practice. Other reported benefits included a high level

of satisfaction from the ED staff with the service in terms of service delivery and support at a time when only a very limited service had existed before.

Callaghan et al. (2003) conducted a meta-analysis of literature surrounding the PCLN, MHLN and MHTN models of service delivery and arrived at similar findings to the previous studies. Specifically they determined that MHLN presence in the ED eased the burden of ED staff, improved access to mental health services and reduced readmission rates. However, the study found that the presence of MHLN in EDs increased clients' use of mental health services and reduced the demands on other services. The authors determined that there was little evidence to support one model over another, suggesting a lack of rigorous evaluation of both the MHLN model and the mental health triage model. Since Callaghan et al. (2003) reported their findings, the MHTN model has undergone further examination (Sands 2004, 2007) and what is known about the MHLN model of practice in the emergency department has also been extended (Wand 2005, 2010).

Literature describing the final model of practice, the MHTN, as with the previous two models, is very limited. Wynaden et al. (2003) describe the implementation of a mental health triage consultancy service into practice in an Australian ED. They describe a range of positive outcomes including an improved level of service to clients presenting with a mental illness, including reduced waiting times. Improved support to ED staff was also reported including a reduction in client aggression in the ED

and the ED staff feeling more supported in their care for clients with a mental illness. The mental health triage consultancy service underwent further evaluation after a year of service in the ED (McDonough et al. 2004). McDonough et al. (2004) report that the mental health triage consultancy service continued to have a positive impact on clients with a mental illness requiring care in the ED and on ED staff confidence. This report, uniquely, contains qualitative data from the mental health triage consultancy nurses. The mental health triage consultancy nurses described benefits such as an improved understanding of teamwork and having expanded their skills in a 'most unusual environment for a mental health nurse' (McDonough et al. 2004, p. 35).

Webster and Harrison (2004) describe the operation and effects of a multidisciplinary team of mental health workers who support the ED staff and the clients with mental illness. The mental health triage team is located in the community away from the ED and a member of the team is rostered 24 hours a day to respond to referrals from the ED triage nurse. The relationship between the two services is underpinned by two principles. The first being that the mental health triage team will respond within the appropriate timeframe dictated by the triage code, the second is that through clear communication the expectations of how and when mental health services should be consulted are understood. The descriptions of outcomes are limited to a profile of client diagnosis, discharge destinations for the clients and data concerning clients who did not wait for mental health assessment and the follow up of clients following discharge. The authors indicate that anecdotal evidence

suggests the mental health triage team has had a positive effect on ED staff confidence in dealing with clients with mental illness and call for further research to understand the benefits of such a model of care. This current research, as outlined in this thesis, directly addresses the call for more research in this area of practice.

In a paper examining the outcome of the implementation of a mental health triage scale into practice Broadbent, Jarman and Berk (2002) reported on a project that used the implementation of a mental health triage scale (Appendix 2) into an ED and the effects of that implementation on ED staff and the MHTN who serviced the ED. The reported benefits to MHTN included the ability to prioritise workloads, improvements in time management and better referrals. This is in the context of improved communication and collaboration between the two services as a result of the introduction of the mental health triage scale. This paper presents detailed data indicating that the mental health triage scale had positive effects on the confidence and competence of ED staff to manage clients with mental health issues presentations but does not objectively explore improvements to service delivery or the structural requirements of sustaining a MHTN service in the ED. An omission common to nearly all the papers published to date surrounding the MHTN model of practice in the ED.

In the hierarchy of models described by Frank, Fawcett and Emmerson (2005) the PEC and the MHLN are described as being expensive due to the intensive allocation of resources. They contend that these models are suitable for medium to large and very large hospitals and the MHTN model is suitable only for small hospitals. The researcher contends that it is not the size of the hospital that determines the optimal service model but the number and profile of the clients presenting to the ED with mental illness that determines the optimal model of mental health service delivery. This notion is supported by Wand and White (2007) who suggest that the MHLN model is cost effective and easily transportable into most ED settings. While there has been research that describes the models of practice and illuminates the relative merits of each model, to date there has been no significant research into the processes and policies that underpin the relationship between mental health services and EDs. Therefore, this research will fill the literary void by undertaking a close examination of the factors that influence the relationship between ED and mental health triage nurses.

1.6 The capacity of emergency departments to manage clients with mental illness

It is estimated that one in five adult Australians will experience one of the common forms of mental illness (Australian Health Ministers 2009) and EDs have emerged as a significant point of access for mental health care for the population due to their accessibility (Broadbent, Moxham & Dwyer 2010). The desire to ensure equitable access to treatment in the

ED has been called for both nationally and internationally emphasising the significance of the problem facing clients with a mental illness accessing the ED for mental health care. The American Psychiatric Association (American Psychiatric Association 1995) recommended that the coordinated mental health and general medical assessments occur in the ED for clients with co morbid medical and mental health illness. These sentiments are consistent with the intent of the current National Mental Health Plan that calls for improved linkages and coordination between mental health and primary care to improve referral and treatment of clients with mental illness (Australian Health Ministers 2009). However, there is a growing body of evidence to suggest that the preparedness of ED staff and the culture of ED practice are lacking and inconsistent with the needs of people presenting with a mental illness.

EDs are designed, equipped and staffed to respond to patients with a wide range of physical injuries and illnesses (King et al. 2004). King et al. (2004) further suggest the ED culture of rapid assessment and short interactions with clients is contrary to the culture of care delivery required in order to successfully work with mental health clients. Mitchell and Dennis (2006) concur and claim that the busy and chaotic ED environment is not conducive to the sensitive assessment needs of clients with mental illness. Webster and Harrison (2004) suggest there exists an organisational mismatch between the requirements of people with acute mental illness and those with acute physical illness. Summers and Happell (2003) report that ED nurses do not have the skills and experience, nor have the appropriate facilities, to care for clients with

mental illness thus increasing the difficulty in providing effective clinical care to clients with a mental illness. Of importance for this research is the recent finding that the mental health triage scale of choice for most EDs, the ATS (Appendix 1), has poor interrater reliability, casting doubt on its effectiveness as a decision making tool for ED triage nurses and suggesting this is an area for reform (Broadbent et al. 2010).

There are a number of explanations for the lack of preparedness. Historically staff in EDs have not been orientated towards identifying mental health problems nor have EDs been equipped to provide the continuity of care required for clients with mental illness as a result, there is a growing concern about the ability of ED staff to adequately screen and appropriately refer clients with mental illness (Kinner et al. 2005). Underlying this concern is that it is generally accepted that most ED staff have limited psychiatric knowledge (Westwood & Westwood 2001) and, therefore, lack the skills to help people with mental illness (Bridges 2001; Heslop, Elsom & Parker 2000). This belief is underpinned by a lack of training and leads to a negative attitude toward, and a reluctance to engage with clients with mental illness (Hart, Colley & Harrison 2005). In a study of the educational preparation of triage nurses in a Victorian ED, Broadbent (2001) surveyed the 34 triage nurses and found that, of the seventy six percent (n=24) who returned questionnaires, all but one nurse described having no meaningful mental health education. This was surprising given that of those 24 nurses, 73 percent of them had completed postgraduate studies in emergency or critical care. This supports the idea that general trained nurses are poorly prepared to care

for clients with mental illness. ED nurses have identified specific issues that affect their ability to care for clients in the ED as being related to lack of time and its influence on the client and the nurse, the ED environment and its impact on the ability to provide care (Marynowski-Traczyk & Broadbent 2011). Lived experience research is gradually becoming more prominent in nursing research. With regard to clients who have a mental illness Marynowski-Traczyk and Broadbent (2011) identified that ED nurses lack an understanding of the personal journey of the client. Understanding the personal journey is a critical notion within a clients Recovery; a person centred approach that underpins mental health nursing care.

ED triage nurses are mostly general trained nurses who will have graduated from a comprehensive undergraduate program with a Bachelor of Nursing (BN) (Wand & Murray 2008). Wand and Murray (2008) contend that comprehensive nursing education in Australia is intended to produce graduates with a wide range of skills applicable across a wide range of settings. In regards to mental health it was intended to provide graduates with the knowledge and attributes to reduce the stigma associated with mental illness and address the poor physical outcomes experienced by people with a mental illness (Wand and Murray 2008).

This approach to undergraduate nurse education is also reflected internationally with curricula in the United States of America that claims to prepare nurses who can deliver client centred, comprehensive care to a variety of client groups including those with a mental illness (LaRocco 2010). Nurse education in the United Kingdom on the other hand, is founded on generic and specific competencies that Schafer, Wood and Williams (2010) argue, while intended to do so, do not help develop awareness of mental health issues amongst preregistration students. It can be seen that BN curricula in Australia and internationally aims at providing a broad knowledge base, often described as 'comprehensive' education. In Australia It is expected that graduates from comprehensive nursing programs can perform at a beginning level but that specialisation in mental health nursing would occur at a post graduate level (Happell & Cutcliffe 2011). ED triage of clients who present with a mental illness requires specialist knowledge and it is therefore no surprise that the lack of specialist professional development in mental health creates difficulties when ED triage nurses are faced with conducting rapid assessment and decision making for clients presenting with a mental illness.

The effects of lack of professional development for ED staff as well as the environmental influences that impact on their ability to provide care, mean that clients with a mental illness who present to the ED are the least popular with ED nurses and that ED nurses do not enjoy providing care to these clients (Marynowski-Traczyk & Broadbent 2011; Smart, Pollard & Walpole 1999; Webster & Harrison 2004).

People presenting to the ED with odd or extreme behaviour are stereotyped as mental health clients that leads to a disregard of their needs and avoidance by staff (Stuhlmiller et al. 2005; Webster & Harrison 2004). It has been reported that ED staff may not recognise presentations of a mental health nature especially those who exhibit cues indicating possible self-harming behaviour (Webster & Harrison 2004). This is of concern as suicide is one of the top five causes of acute admission to hospital in Australia (Barr, Leitner & Thomas 2005). Wand (2005) claims that ED staff do not generally have a good understanding of mental health services available to clients needing mental health assessment and care. Wand (2005) contends that even if ED staff were confident and competent in managing clients with mental illness the lack of awareness of referral and follow up knowledge could place this client group at risk. This risk could be mitigated by ensuring that the response by mental health services to clients in the ED is timely and proper assessment leads to appropriate discharge planning by experienced mental health clinicians. Another cause of the inadequacies in providing mental health care is that mental health diagnostic decisions are complex (Zarin & Earles 1993). The stress associated with making such decisions coupled with a lack of confidence about clients with mental illness may have deleterious effects on the attitudes of ED staff towards such clients (Bazarian, Stern & Wax 2004; Stuhlmiller et al. 2005). EDs play a pivotal role as the assessment venue and point of entry into mental health services, yet it has been shown that the intellectual and

organisational infrastructure needed to appropriately manage clients with mental illness in the ED is lacking.

1.7 Emergency mental health triage

Another cause for the organisational mismatch between the requirements of people with acute medical illness and those with acute mental illness is the process of triage in Australian EDs. This process is important to this research, as it is the process of emergency mental health triage, using a mental health triage scale, which has a significant influence on the relationship between ED and mental health triage nurses as it forms the functional construct of the relationship. Therefore, to deepen the contextual matrix surrounding this research, what follows is a discussion outlining the development of mental health triage scales in Australia.

In order to counter the previously described deficit in emergency care to clients with a mental illness, staff in EDs began to question the value of the NTS and in 1993 it became apparent to the staff of the Royal Hobart Hospital ED that the NTS was lacking a principle feature. Triage had its roots in physical injury and illness and the NTS did not cater for patients with a mental illness presenting to the ED (Smart, Pollard & Walpole 1999). Smart, Pollard and Walpole (1999) argue that the perceived unfairness of the existing triage system caused long delays to assessment for clients with mental illness due to the inadequacies of the NTS. Using the NTS to triage meant clients with mental health problems had longer waiting times and were likely to receive a lower triage

category than clients with physical injury and illness with an increased likelihood of patients leaving the ED without being seen. Broadbent Jarman and Berk (2002) also found that when using the NTS ED triage nurses were likely to underestimate the acuity of clients with mental illness and prescribe a lower triage category resulting in longer waiting times. An analysis therefore reveals that clients with mental illness have been poorly served by the NTS because it does not include mental health descriptors (Broadbent, Jarman & Berk 2002).

The effects of moving clients with mental illness out of psychiatric hospitals and care facilities and into community based care had resulted in more clients with increased acuity and particularly with disturbed behaviour presenting to EDs (Stebbins & Hardman 1993). This was complicated by the fact that, as part of an initial review of services, it was determined that there was an urgent need to train triage nurses in the assessment of clients with a mental illness (Smart, Pollard & Walpole 1999). This is consistent with the findings of Broadbent, Jarman and Berk (2002) who identified that ED nurses lacked confidence to assess and manage clients with mental illness.

Having implemented the NTS in January 1994 the staff in the Royal Hobart Hospital ED identified a need for mental health descriptors to be developed to aid triage nurses in the triage of clients with a mental illness. A review of the literature identified few references to mental health triage in emergency medicine and none to do with triaging and integrating mental health problems into a general emergency department

(Smart, Pollard & Walpole 1999 The bulk of the literature that was examined was from North America and Britain where the systems of assessing, treating and disposing clients with mental illness who present to EDs is not consistent with Australian practice. The literature from North America is typically represented by Rockland-Miller and Ells (2006) who describe the introduction of a triage process into a university mental health service in America. This was one of the few American papers that could be found that dealt directly with clinical mental health triage. The remainder of accessed articles concerned themselves with telephone triage. Similarly literature emanating from Britain was concerned with the triage of clients by mental health clinicians (Hird 2007) suggesting that the ED triage of clients with a mental illness as a research area is emerging in Australia but has yet to gain traction internationally.

A study was commenced at the Royal Hobart Hospital with the principal aim of developing a mental health triage scale that integrated into the NTS. Other important aims were to improve nursing assessment and effectiveness of the triage of clients with mental illness, reduce waiting times and improve the transit times (the time from triage to departure) for clients with mental illness (Smart, Pollard & Walpole 1999). The initial study was completed in mid 1994 and reviewed in 1996. In 1999 having met all the aims of the study, the results were published outlining the success of the project. The mental health triage scale from the Royal Hobart Hospital is a four tiered triage scale corresponding to categories two to five from the NTS with category one clients with mental illness

sharing the same descriptors as clients with physical illness as described by the NTS. The following table details the Royal Hobart Hospital mental health triage scale.

Table 5. Royal Hobart Hospital mental health triage scale

Triage Scale	Client Description	Treatment Acuity
2. Emergency	Patient is violent, aggressive or suicidal, or is a danger to self or others, or requires police escort	Within 10 minutes
3. Urgent	Very distressed or acutely psychotic, likely to become aggressive, may be a danger to self or others. Experiencing a situational crisis.	Within 30 minutes
4. Semi-Urgent	Long-standing or semi-urgent mental health disorder and/or has supporting agency/escort present (e.g. community psychiatric nurse)	Within 1 hour
5.Non-Urgent	Patient has long-standing or non-acute mental disorder/problem but has no supportive agency/escort. May require a referral to an appropriate community resource.	Within 2 hours

From Smart, Pollard & Walpole (1999)

Despite the exclusion of mental health criteria for category one clients, this triage scale and the associated educational material provides the ED triage nurse the opportunity to make an informed assessment of the needs of the client with mental illness. The educational material guides the ED triage nurse through the assessment of thought, content and process, mood and affect, perceptions, cognitive functioning, along with a discussion on common mental illnesses such as depression, suicide, anxiety, acute psychotic states and personality disorders (Broadbent,

Jarman & Berk 2004). The inclusion of this range of subject matter is important as it forms the basis of a comprehensive mental state assessment, which is an indicator to make a clinical judgement about mental illness.

As the staff at the Royal Hobart Hospital were working to complete their landmark study, staff of the Area Mental Health Program within the South Eastern Sydney Area Health Service (SESAHS) were considering their response to national and New South Wales (NSW) mental health policies that highlighted the need to improve the management of clients with mental health presentations to EDs. It was decided that the issue was important and in early 1998 staff of the Area Mental Health Program agreed to develop and pilot mental health triage guidelines (Tobin, Chen & Scott 1999). Tobin, Chen and Scott (1999) conducted a review of the literature and drew similar conclusions to Smart, Pollard and Walpole (1999) about the paucity of literature on mental health triage and the tendency of the international literature to represent processes that are not consistent with the Australian context. Tobin, Chen and Scott (1999) were also aware of the lack of confidence and competence in managing psychiatric emergencies that were reported in the literature.

Tobin, Chen and Scott (1999) reviewed the work from the Royal Hobart Hospital along with several other unpublished mental health triage scales from other hospitals. Tobin, Chen & Scott (1999) were critical of the existing mental health triage scales because of the lack of differentiation between symptoms and behaviour observed by the triage nurse and behaviour reported by a third party. This was seen to be a

problem for nurses not trained in the objective assessment of clients with a mental illness. Furthermore, they were concerned that existing scales used mental health terminology, thus requiring specialist knowledge by the ED triage nurse. They were also concerned that there was inconsistent management advice. Some scales included instructions for clinical care and others did not. Where it was provided it did not distinguish between ED and mental health teams and they felt this was not consistent with the NTS that did not concern itself with anything beyond the ED triage process. They concluded that none of the existing mental health triage scales had potential for generalisability across different settings as they were 'dependent on the local culture and resources' and that there was a need to remove parochial and mental health specific language (Tobin, Chen & Scott 1999, p. 12). This point is important as the ATS is designed for use in hospital based EDs across Australia and New Zealand (Australasian College For Emergency Medicine 2006) indicating that generalisability is an essential component of a mental health triage scale if it is to be used in Australian EDs.

Following implementation and evaluation, the resulting mental health triage scale from the SESAHS is a five-tiered scale consistent with the ATS in respect of its categories and expected time to be seen. It allows the triage nurse to assess 'observed' and 'reported' behaviours as indicators of acuity to determine a triage score without requiring specialist mental health knowledge or terminology. The scale also outlines the level of supervision required for clients in each of the categories.

Unlike the Royal Hobart mental health triage scale that was designed for use in one ED, the SESAHS mental health triage scale was designed for implementation across five general hospitals in the district, each with its own ED and four mental health services, each with its own acute inpatient unit, and one community based care team. This requirement for broader application of the mental health triage scale across a number of sites meant that generalisability was an important factor in the design of the mental health triage scale. The post implementation report describes the successful implementation across each of the five hospitals that make up the SESAHS (Tobin, Chen & Scott 1999). Table 6 shows the SESAHS mental health triage scale with its emphasis on observed and reported behaviours.

Table 6: South Eastern Sydney Area Health Service mental health triage scale

Triage Code	Description	Treatment Acuity	Typical Presentation
1	Definite danger to life (Self or others)	Immediate	OBSERVED Violent behaviour Possession of weapon Self destructive behaviour in ED
2	Probable risk of danger to self or others • Severe behavioural disturbance	Emergency Within 10 minutes	OBSERVED Extreme agitation/ restlessness Physically/ verbally aggressive Confused/unable to co-operate Requires restraint REPORTED Attempt at self harm/threat of self harm Threat of harm to others
3	Possible danger to self or others • Moderate behaviour disturbance • Severe distress	Urgent Within 30 minutes	OBSERVED Agitation/ restlessness Intrusive behaviour Bizarre/ disorganised behaviour Confusion Withdrawn and uncommunicative Ambivalence about treatment REPORTED Suicidal ideation Presence of Psychotic symptoms: Hallucinations Delusions Paranoid ideas Thought disorder Bizarre/ agitated behaviour Presence of Affective Disturbance: Severe symptoms of depression/ anxiety Elevated or irritable mood
4	Moderate distress	Semi Urgent Within 60 minutes	OBSERVED No agitation/ restlessness Irritability without aggression Co-operative Gives coherent history REPORTED Symptoms of anxiety or depression without suicidal ideation
5	No danger to Self or others • No Acute Distress • No behavioural disturbance	Non Urgent Within 120 minutes	OBSERVED Co-operative, Communicative Compliant with instructions REPORTED Known patient with chronic psychotic symptoms Known patient with chronic unexplained somatic complaints Request for medication Minor Adverse effect of medication Financial/Social/Accommodation /Relationship Problems

Adapted from: Tobin, Chen & Scott (1999)

The SESAHS mental health triage scale was implemented successfully into practice at Barwon Health ED Victoria (Broadbent, Jarman & Berk 2002) indicating that the scale is able to be used outside of the five SESAHS sites. It was the evidence from the Barwon Health experience that prompted the National Institute of Clinical Studies to implement this triage scale across nineteen Victorian EDs in 2005 (Potter & Huckson 2006). This is the largest implementation of a mental health triage scale in Australia yet the evaluation of this project does not detail the impact on ED performance or the change in mental health service responsiveness to clients with a mental illness presenting to the ED. It does, however, identify the need to review and develop policies and protocols to support the ED - mental health service relationship and acknowledges the complexity of this task. While the evaluation suggests an overall improvement in mental health triage and response, it identifies that many sites had difficulty reviewing and developing supportive policies and protocols. This may be due to the absence of any literature describing the mechanics of the relationships between EDs and mental health services. This important data is lacking and therefore this research will contribute to the lack of knowledge in regards to improving ED and mental health service delivery to clients with a mental illness by examining the relationships between EDs and mental health services.

1.8 Reported use of mental health triage scales in Australia

As indicated earlier, any examination of the relationship between ED and mental health triage nurses must include an understanding of the triage scales that frame the relationship. Despite the reported increase of mental health presentations to EDs throughout Australia and the issues surrounding the management of clients with a mental illness in EDs, there is very little evidence in the literature of the widespread use of a single mental health triage scale in Australia for clients with mental illness. This is in stark contrast to the situation for people who present with physical illness and injury. This is possibly because the ATS, with its limited mental health descriptors, was rapidly deployed into Australian EDs as a replacement for the NTS at a time when mental health triage scales were developing a level of sophistication suitable for general ED use (Broadbent, Moxham & Dwyer 2007). It could be speculated that ED triage nursing staff perceive the ATS sufficient in order to accurately triage clients with mental illness and as such may not perceive the need for a specific mental health triage scale. However, this premise has not been tested.

Another noticeable gap in the literature is that while there are reports of mental health triage scales in use that broadly describe general improvements in staff competence and service delivery, none of the reports examine the improvements in the ability or intent of the mental health service to respond to a triage referral from the ED within the triage timeframe. In the literature reporting improvements in the field of

emergency mental health triage, there is no description of how the working relationships between the ED and mental health service were improved or supported. The following discourse summarises documented processes for improving ED responsiveness and outcomes.

King, Kalucy, de Crespigny et al. (2004) identified a tenfold increase over ten years in clients with mental illness presenting to the Flinders Medical Centre ED. The authors found that while this client group represents less than five percent of the presentations to the ED they account for almost ten percent of the time spent in the ED by all their clients and, therefore, present a significant management challenge. They assert this is due to the impact of mainstreaming and identify that clients presenting with drug and alcohol problems are often experiencing a mental illness. The authors of the paper acknowledge the lack of preparation that ED staff have in order to deal with these clients. The focus of this study was to actually explore the effects of a training course aimed at improving knowledge and skills in mental health and drug and alcohol issues.

In conjunction with the Flinders University School of Nursing and Midwifery a three day course in emergency psychiatry and drug and alcohol issues was delivered to forty of the 43 ED triage nurses. During the course, the mental health triage scale from the SESAHS was introduced as a vehicle for potentially improving the assessment of clients with mental illness and drug and alcohol problems.

The course evaluation consisted of pre and post course self assessment questionnaire completed by the course participants and concentrated on measuring changes in the attitudes of participants to the client group and self ratings on the improvement in skills and knowledge needed for working with clients from this group in the ED. No attempt was made to measure changes in the quality of care delivered either from a service delivery or a consumer perspective (King et al. 2004).

Frank, Fawcett and Emmerson (2005) describe the implementation of the Royal Hobart mental health triage scale into practice in a PEC in Brisbane, Australia. The PEC is collocated in the ED and is the first site of entry for acute psychiatric assessment. The department is permanently staffed with mental health nurses, clinical nurse consultants, psychiatric registrars and psychiatrists (Frank, Fawcett & Emmerson 2005). The unique feature of this arrangement is that the mental health service is within the ED and exists for the client group presenting to the ED. Therefore, the issue of emergency triage and referral is not as taxing as in most other centres where the mental health service is usually located away from the ED. The Royal Hobart mental health triage scale was introduced into this context in 2000 as a referral tool from ED to the PEC. Clients allocated a category one by ED triage staff are sedated in the ED and are managed by ED staff until well enough to be transferred to the PEC. All others clients in categories two to five are directed straight to the PEC where they undergo secondary triage by mental health staff (Frank, Fawcett & Emmerson 2005). The collocation of the PEC removes the need for ongoing management of

clients by ED staff and as the ED triage is used only as an initial guide to acuity, the notion of allocating a definitive triage code that determines response times is lost in this context. The existence of an onsite PEC brings with it distinct benefits to the staff of the ED and, as the paper describes, a clear advantage to clients with metal illness because of its proximity to the ED and the ability of the staff to respond to presentations in rapid timeframe. Despite describing how clients within each triage category are managed, the review does not describe how well the service responds to the triage allocation within the prescribed timeframe. As the cost of such a centre is prohibitive to all but the biggest of health services (Frank, Fawcett & Emmerson 2005) it is no surprise that this is the one of a few of its kind in Australia. The operational context sets it apart from all other ED/mental health service arrangements and as such the relationship between the ED and mental health service is not typical as the authors point out that the most common model arrangement is where the mental health service is separate to the ED (Frank, Fawcett & Emmerson 2005).

Happell, Summers and Pinikahana (2003) report the Royal Hobart mental health triage scale being introduced into the ED of a large metropolitan teaching hospital in Melbourne as part of a study measuring the effectiveness of the mental health triage scale. The focus of their study was to measure the concordance between emergency nurses and mental health nurses in applying the mental health triage scale to clients presenting to the ED over a three-month period. They found a high level of discrepancy between the ED triage nurses and the mental health

triage nurses in the process of triaging clients with mental health related problems. The ED triage nurses were more likely to assign higher triage than the mental health triage nurses suggesting that they interpret common symptoms of mental health problems as more important. However, the ED nurses tended to assign less urgent triage categories to clients with mental illness compared to those with physical illness. The study found that the introduction of a mental health triage scale alone will not create agreement between ED and mental health triage nurses and that further research needs to be done to investigate the decision making processes of triage nurses in relation to the decision making processes at triage (Happell, Summers & Pinikahana 2003). The paper does lend weight to the importance of appropriate education to support the implementation of a mental health triage scale to improve the abilities of emergency nurses. The paper does not attempt to measure or describe improvements in service delivery to clients with mental illness, however, this was not a stated objective of the research.

In 2001 the SESAHS mental health triage scale was introduced into the ED of Barwon Health, Victoria (Broadbent, Jarman & Berk 2002). The stated aims of this project encompassed the implementation of a mental health triage scale, a desire to strengthen consultation between ED and mental health services and to ensure a timely and effective clinical outcome for clients with a mental illness presenting to the ED. Data in the paper was drawn from a retrospective analysis of triage scores given to clients using only the NTS and then an analysis of triage scores given in a three month period following the implementation of the mental health

triage scale. Pre and post implementation questionnaires were used to obtain quantitative and qualitative data from the ED and mental health triage nurses about a range of issues including triage experience, confidence in dealing with clients with mental health issues at triage, impressions of service delivery to clients with a mental illness, quality of referrals and impact of implementing a mental health triage scale on workload. Data were gathered that showed changes in the distribution of triage categories and these were compared to the results described by Tobin, Chen and Scott (Tobin, Chen & Scott 1999) as a means of demonstrating successful implementation. The study described improvements in the ED triage nurses' understanding of mental health assessment and positive changes in triage practice and attitude towards clients with mental illness. Mental health triage nurses reported improvements in the ability to prioritise and organise workload and improved client satisfaction. Improved collaboration, communication and a better relationship between services was reported by both mental health and ED triage nurses (Broadbent, Jarman & Berk 2002).

The paper by Broadbent, Jarman and Berk (2002) is the only paper to date to examine in detail mental health triage as system of assessment and referral between two groups of practitioners and, as such, stands alone in describing the impact of the implementation on ED and mental health triage staff. By describing the effects of implementation on clients with a mental illness in the ED and both ED and mental health triage nurses the authors have drawn attention to the fact that mental health triage in the ED is a non static process that goes beyond the

assessment and triage-making decision and involves groups of people within a continuum of care. However, while the paper demonstrates improvements in confidence and competence of the ED staff and a general improvement in the relationship between the two services it does not analyse the degree to which the mental health nurses responded within the timeframes dictated by the mental health triage scale categories. The implications of this study suggest that the changes to the operational context in the relationship between the ED and mental health service were achieved successfully. However, the paper does not describe how these changes were managed.

In 2004 the Victorian Department of Human Services (DHS) commissioned the National Institute of Clinical Studies (NICS) to improve the ED triage process for people presenting with mental health problems and to improve the collaboration between EDs and mental health services (Potter & Huckson 2006). NICS is a federal government body charged with the responsibility to improve clinical practice through closing gaps between the best available evidence and current clinical practice (National Institute of Clinical Studies 2006). The project was based on the recommendations from the Victorian Auditor General's Report on Managing Emergency Demand in Public Hospitals and the improvements to the process of mental health triage at Barwon Health (Broadbent 2001) and a forum convened by DHS.

The scope of the NICS project was to develop and introduce a mental health triage scale and provide support to nineteen EDs across Victoria with education and the development of policy and procedure to manage the mental health presentations based on the triage category. This is significant as the triage scales and the optimal time to be seen are central to the process of triage. While the literature previously reviewed indicates the benefits of implementation of a mental health triage scale on the ED staff, none of the papers addresses the issue of the response by mental health staff based on the triage category or the processes by which mental health staff were inducted into the role of responding to clients allocated a triage scale. Anecdotal evidence suggests that, as part of a wider national program, the mental health triage scale (Appendix 2) developed for the Victorian NICS project has been adopted in EDs across Australia although specific data detailing uptake is lacking (Nurses work with NICS to bridge the emergency/mental health chasm 2004). The State of Victoria, Australia appears to have attempted to introduce a consistent approach to emergency mental health triage. However, as stated previously, there still exists some ambiguity on improving the operational relationships between EDs and mental health services.

Underpinning operational relationships is the notion that interdisciplinary collaboration, or teamwork, is essential to ensure the success of primary health care (Ponte, Gross, Milliman-Richard et al, 2010). Despite the importance of interdisciplinary collaboration, Petri (2010) contends that there is wide variation in the qualities that are believed to constitute

interdisciplinary collaboration, especially between doctors and nurses. Amidst the uncertainty of what is understood to constitute effective collaborations are barriers that exist between health care professionals. Such barriers include, deficit in role knowledge, poor attitudes and a lack of respect and poor communication (Clarin 2007). Interdisciplinary communication is acknowledged as a critical component of team performance (Dayton & Henriksen 2007) and is pivotal in the reduction of errors in high-risk environments (Gillespie, Chaboyer, et al 210) such as the ED.

Petri (2010) argues that antecedents such as interprofessional education, role awareness, interpersonal relationship skills, deliberate action and support are qualities essential for effective collaboration. Of these, interprofessional education is noted to be the most important to overcome these barriers (Petrie 2010). However models such as interprofessional education that promote interdisciplinary collaboration are in a nascent form and require further research (Ponte, Gross, Milliman-Richard et al, 2010). Literature on interdisciplinary collaborations is focussed on disciplines that are aligned but by definition, separate such as medicine and nursing, physiotherapy and general practice. The absence of models to support and encourage interdisciplinary collaboration between culturally disparate groups within the same discipline as findings of this research would suggest, are indicative of the need for further research in order to improve operational relationships between these groups.

There has been very little literature published that could be found since these reports on improving service delivery to clients with a mental illness in Australian EDs.

What has been published concerns itself with the use of mental health triage scales (Broadbent et al. 2010), the development of the MHLN model of practice in the ED (Wand 2010) and issues associated with the care of clients in the ED (Marynowski-Traczyk & Broadbent 2011). There has been no published research concerning the responsiveness of mental health nurses, regardless of role, to the ED triage referral. Nor has there been any research that closely examines the factors that influence the relationship between ED and mental health triage nurses.

Chapter 2: Research Design

This chapter is presented in three parts. Firstly, the qualitative methodological framework of the study will be described. Secondly, the site of the research will be rationalised within the context of the methodology and, finally, the methods of conducting the research in the field will be outlined.

In order to better understand the interdisciplinary relationships necessary to sustain an emergency mental health triage service to clients with a mental illness presenting to the ED a mode of research was required that suited data collection related to the observation of mental health nurses and emergency nurses in the continuum of emergency mental health triage.

2.1 Methodology

2.1.1 Ethnography as a mode of enquiry

The basic tenet of qualitative research is that it is conducted to describe and interpret people's experiences and their culture (Lincoln & Denzin 1994). The methodology best suited to this research was ethnography as the research aimed to understand the interactions between two groups - mental health triage nurses and emergency nurses - who share the seemingly homogenous characteristic of being nurses but actually have different 'cultural' identities. In particular, ethnography is ideally suited to the examination of nursing work as the work nurses do, and ethnography, both share an emphasis on the here and now and the dynamics of the 'moment' (Nugus & Forero 2010). Specifically

ethnography, as part of the qualitative research tradition, adds value to further understanding of the ED world (Cooper, Endacott & Chapman 2009). Ethnography is a particular approach used to describe individual cultures and the cultural milieu (Lowery 2001) in order to extrapolate theories drawn from the study and to provide a rich description of the culture under study (Burns & Grove 2005).

Having its roots in anthropology, or the study of humanity (Tham 2003), cultural anthropologists have used ethnography for many years (Berg 2007) and researchers have described ethnography in various ways. Hammersley (1998) suggests that the term ethnography is ambiguous, lacks definition and is synonymous with qualitative research in general. Warren and Karner (2005) suggest ethnography has strong links to participant observation and is the written account of that observation. Zigarmi and Zigarmi (1980) describe ethnographers as anyone who enters a natural setting to conduct field research and Babbie (2004) argues that ethnography is a detailed representation of some natural setting.

There are specific ethnographic approaches that seek to serve a particular purpose and critical ethnography is an example of this. Critical ethnography is a method of inquiry that seeks to disrupt the status quo and empower disenfranchised groups (Baumbusch 2010). This research does not aim to achieve this, as the researcher does not know the status and power relationships of the two groups involved in this research, ED and mental health triage nurses. Moreover, the aim of this research was

to understand the relationships between the participant groups rather than to seek outcomes that empowered one group over the other. This ethnography is best described by the nature of the investigation, an examination of a discrete area of nursing practice that involves small groups of participants. Morse (1987) describes this as focused ethnography.

Ethnography, therefore, is used to describe both a process and a product that uses particular methods for the purpose of gathering data. However, ethnography as a mode of research must be more than simply observational and descriptive, it must lead to a tangible understanding of the lived experiences of the participants within the culture being studied as it does with this study. Brewer (2000) argues that ethnography is not a specific method of data collection but rather a style of research devoted to the richly descriptive study of cultures with the principle objective being to understand the activities and meanings of a social group. This view is supported by Creswell (1998, p. 58) who defines ethnography as a 'description and interpretation of a cultural group or system'.

The particular element that separates ethnography from other research traditions in qualitative research is that it provides a vehicle for studying both our own culture and the culture of others (Burns & Grove 2005). Understanding the culture or subculture of a group is central to the ethnographer, and its interpretation is the main aim (Fetterman 1998). Broadly culture is described as the way of life of a group evidenced by

the learnt patterns of behaviour that are socially constructed (Holloway & Todres 2006). More specifically the concept of culture can be distilled into behavioural and cognitive perspectives (Fetterman 1998). The behavioural perspective is reflected in the patterns of behaviour, customs, way of life, material artefacts and the way the members interact with them. The cognitive perspective consists of the values, beliefs, ideas, knowledge and rules of the group that dictate what to wear, what to eat and what to believe. It is by understanding these two perspectives that ethnographers determine what it is that people do, know and believe (Fetterman 2009; Roper & Shapira 2000). Hammersley (2002) claims that one of the most valuable features of ethnography lies in the commitment to understand the perspectives of others rather than judging them true or false.

Mental health nurses and emergency nurses form unique groups and have different cultural identities which are manifested by their disciplines and traditions - the language they use, the roles they perform, the clients they see, the 'tools of their trade' and the nature of the work they do. Crowley (2000) suggests that the cultural environment in which emergency nurses work is very different to the cultural environment in which mental health nurses work, particularly in respect of the capacity to deliver mental health care to clients. ED nurses provide care to clients with a mental illness in EDs that are usually not designed for such care and do so in a highly charged rapidly changing environment. Crowley (2000) suggests that this is a less than optimal place to provide care to clients with a mental illness compared to the relative calm and privacy of

a mental health unit.

Another perspective contributing to the understanding of a social or cultural group is that it is composed of individuals from a variety of backgrounds who have developed shared patterns of behavior and interactions based on common experience such as the participants in this study - emergency nurses and mental health nurses involved in the continuum of emergency mental health triage. Both share a common cultural background of nursing and the common experience of initial assessment and management of clients in the ED but they differ as a result of their disciplines and the philosophies that shape the care they deliver. In either context the concept of culture is distilled by Creswell (1998, p. 59) as '…something the researcher attributes to a group as he or she looks for patterns of daily living… [and] is inferred from the words and actions of… the group.'

Creswell's notion that a description of culture is something that the researcher attributes to a group is in contrast to the notion that culture is learnt and socially constructed (Holloway & Wheeler 2002). These differing perspectives highlight an important component of the ethnography – the emic and etic dimensions. The emic perspective is that of the participants, etic that of the external, scientific perspective represented by the researcher's own understandings and theoretical underpinnings of the study (Tham 2003). Fetterman (2009) claims that the emic perspective is at the heart of ethnographic research. It is the perspectives and realities of individuals or the multiple realties of

individuals within groups represented by thick descriptions of events using the words and thoughts of the participants. The etic perspective within an ethnographic approach thus allows the researcher to place the emic perspective in a scientific paradigm. The essential element in the writing of a good ethnography is that both emic and etic perspectives are represented (Fetterman 2009) as they are in this thesis.

No research is value free (Janesick 2003) and ethnography is no different. The etic perspective incorporates the researcher's knowledge, values, biases and opinions, considered as the researcher's worldview. Before they enter the field, research sites are chosen, research design and data collection techniques are identified, researcher's will have opinions on what people think and do and these are all subject to bias (Janesick 2003; Roper & Shapira 2000). It is essential that the ethnographer acknowledges their values and worldview at the beginning of the ethnography, as explicit explanation of bias will help mitigate negative effects on the ethnography (Fetterman 2009). However, as Fetterman (2009) states, while bias can have both a positive and negative influence, the ethnographer must enter the field with an open mind but not an empty head.

2.1.2 Epistemological considerations and rigour

As stated the worldview, sometimes known as bias, of the researcher must be declared at the beginning of the ethnography. For this particular ethnographic study, the researcher brings clinical and theoretical experience as an emergency nurse of over twenty-five years. Working in

this capacity, both nationally and internationally, the researcher has witnessed in some EDs and mental health services what they consider as a failure to deliver a standard of service at the point of triage to clients with a mental illness in the ED, commensurate to that delivered to clients with physical injury and illness. Recognition of this perceived inequality in service delivery was the main motivation and catalyst for this PhD research. These perspectives were declared in early reflexive conversations with the supervisory team and continued throughout the research in order to ensure that the researcher's worldview did not influence data collection and subsequent data analysis. The researcher was mindful about this perspective and encouraged the participants to tell their own stories. This ensured that the experiences were valued and that the research was informed and led by the participants. Insight into the role the researcher plays in the research and the positions and perspective of the researcher are known as reflexivity. Research findings become more credible if the researcher is reflexive (Liamputtong 2009) because the researcher's contribution to the research process becomes explicit (Johnson, R. & Waterfield 2004).

Strategies that were adopted in this research to ensure rigour are offered from two perspectives. One, research design and two, strategies involving participants, peer review and outsiders (Liamputtong 2009) Rigour in this research design is demonstrated by virtue of the fact the research was conducted ethically; that the methodological design of the research was appropriate for the research question, that sufficient time was spent in the field and that observation of the participants validated

what they were describing in interview. Further strategies involved were the use of rich, thick descriptions that allow the reader to make decisions about transferability of the findings and to judge the researcher's interpretation and subsequent analysis using evidence from the literature to support the thematic findings (Carpenter & Suto 2008).

This research has been subjected to multiple layers of peer review. Firstly, through the systemised and independent internal and external process of candidature confirmation and presentation of the research design to experts and secondly, through two Human Research Ethics Committees where research merit and integrity, risk, participants, recruitment and numerous other ethical considerations were reviewed. The third element associated with rigour is that some findings of this research have already been published in peer reviewed scholarly journals as well as presented at national and international conferences after successful peer review. Finally, the constant attention of the supervisory team and ongoing discussion of the research process and outcomes also ensured a rigorous process. Further to that discussed above, participants were invited to validate emerging ideas and themes. As the data collection proceeded and transcript and interview analysis commenced, emerging constructs from this were probed in further interviews to allow deeper discussion and to ensure that the understanding of the researcher was consistent with those of the participants (Liamputtong 2009). This process is not to be confused with participant validation. Participant validation is the process whereby transcripts of interviews are shown to participants to confirm their

veracity. While participant checking is affirmed by Lincoln and Guba (1985) as the final act of validation in the process of establishing rigour, Mero-Jaffe (2011) argues that there are methodological and ethical problems associated with this process and the advantages are outweighed by the disadvantages (Hagens, Dobrow & Chafe 2009). Therefore participant review of the transcripts was not undertaken in this research. These strategies, along with the reflexivity of the researcher support the rigorous process that was used in the conduct of this qualitative research (Liamputtong 2009).

2.1.3 Ethical considerations

In order to conduct the research in a manner consistent with contempory ethical standards for research the four pillars of ethical research - respect, research merit and integrity and justice and beneficence (National Health And Medical Research Council & Australian Vice-Chancellors Committee 2009) - were considered in the planning phase and adhered to in the execution of the research.

The dominant ethical principle underpinning this research is that of respect of the participants. Respect for participants is the central ethos in all research and must be evidenced throughout the research project at all times (National Health And Medical Research Council & Australian Vice-Chancellors Committee 2009). Fetterman (2009) suggests that the primary aim of the researcher is to do no harm to the people or setting under study and believes that respect for the society and participants is integral to ensuring the integrity of the ethnography. It is for these

reasons that the researcher made a conscious decision to involve himself with all staff in the departments under study, showing an interest in the daily lives off all staff, not just potential participants. The principle of respect was upheld by the researcher acknowledging the centrality of the participant's experiences to the research and valuing the participants as partners in the research. Respecting the right of staff not to participate following discussion with the researcher, where full and frank disclosure of the research aims and methods was given to ensure participation and consent was informed. All data collection was done overtly and participants had the right to listen to the taped conversations they participated in if they so desired. The presence of the researcher in the departments and the importance of observation was explained to reduce uncertainty and possible suspicion. Engaging with participants equally, modifying the approach to the research to suit the practice of nurses in each of the services was done to minimise harm. As was being mindful of not just how the researcher entered the field, but also exited it, in a manner that showed respect for all people in the setting was undertaken with the motivation to do no harm.

The principal of research merit and integrity was upheld through a number of processes. A thorough examination of the relevant literature was conducted to ensure that the research was justified and had benefit in terms of its contribution to knowledge. The research methodology was justified against the research aims and research question and the research methods used were consistent with the methodology. The research was carried out by an appropriately qualified researcher and, in

this case, supervised in a rigorous manner under the auspices of a bona fide research-training scheme. The research proposal was the subject of a peer review process that included an expert evaluation of the proposal and presentation of the project at a peer reviewed research colloquium. Ethical approval for the research was obtained from the CQUniversity Australia, Human Research Ethics Committee (Appendix 3) and the Human Research Ethics Committee of the Health Service in which the research was conducted. Permission to gain access to the organisation and conduct the research was gained from all levels of management in both services. Publication of the results as peer reviewed conference abstracts and in peer-reviewed journals that commenced during the research, ensured that the ultimate endpoint of the research - publication of findings - is achieved in a meritorious manner. These processes ensured the research has merit and integrity, and has followed recognised research conduct.

The principle of justice was upheld by ensuring that all potential participants who wished to contribute to the research were allowed to do so, and that participation was only limited by the choice of the individual. Information sheets explaining the research were given to all potential participants and a consent form was obtained from each participant. Interviews were conducted at times that best suited individuals or groups to reduce the burden of participation. Verbal agreement to begin the interview and permission to record interviews was sought prior to commencement of the interviews. The participants were encouraged not to use individual names during interviews. When that did occur the

names were edited out of the transcribed interviews. All participants had the opportunity to request a plain English statement of results. Those who elected to receive them were sent a copy to the address nominated on the consent form.

The process of minimising risk and therefore upholding the principle of beneficence was managed through a number of processes. The first step was to acknowledge that some risk did exist in researching two groups of nurses with different cultural backgrounds from different services. The risk was mitigated by following the process, as described in the previous paragraphs, on ethical standards. Ensuring the research had merit and was properly planned and executed, voluntary participation and full and frank disclosure of the research aim and methods to the participants were used to minimise risk. Access to data as it was being collected and ensuring the interviews stayed focused on the research question and did not concern individual performance or comments about individuals was a further risk management process. Specifically, it was critical that the research was conducted in a manner that did not affect the functional relationship between the groups. Therefore, nothing revealed in interviews with one group was taken back to the other group verbatim. Issues reported by one group were explored in a general sense with the other group and always introduced in a manner that ensured the confidentiality of the participants who raised the point or issue being discussed. Managers in both services were identified and the effects of the research in the workplace were monitored by the researcher via discussions with the managers. The

researcher provided avenues for reporting concerns about the research process and counseling if the participants required it. No participants reported harm from the research. Therefore, while it was identified that the research carried some risk, the methods used to mitigate risk and the processes used to support participants combined to ensure that participation in the research outweighed the potential for harm.

Beyond the formal processes that dictate ethical research, it is important to note that ethical issues are not restricted to research using participant observation. They are more likely to arise because of the close personal relationship between participant and researcher (Brewer 2000). This attention to valuing the feelings of all staff, including the participants, is important not only from an ethical perspective but also from the consideration that ethnographers must leave the setting in such a way that organisations and participants would welcome the presence of researchers in the future (Tham 2003).

Finally, data collected for this research are stored on a password-protected computer. Paper copies of documentation have been scanned into electronic files and stored similarly. Copies of all electronic documentation are kept on a disk in a locked filing cabinet in the researchers locked office. As per NHMRC policy (National Health And Medical Research Council & Australian Vice-Chancellors Committee 2009) all data will be kept for a period of five years following the publication of the last paper from this research. Following this period paper and discs relating to the project will be shredded and electronic

files deleted. This was the process approved by the relevant Human Research Ethics Committees.

2.1.4 The research setting

Ethnographers concern themselves with locating the cultural members in their specific setting in order to understand them within a specific context (Holloway & Todres 2006). This research concerns itself with the study of the lived experiences of mental health triage nurses and ED triage nurses. While these two groups belong to the culture of 'nursing' in which all nurses are uniquely bonded and within which they share tacit knowledge, there is cultural diversity. Fetterman (2009) describes this as intracultural diversity, where there are differences between subcultures in a culture. Therefore, it is imperative if this research is to understand the factors influencing the relationship between ED and mental health triage nurses, an appropriate cultural site be the basis of the study. The research question, what influences the relationship between mental health nurses and emergency nurses in the continuum of emergency mental health triage has a direct influence of the selection of a site to conduct the research (Fetterman 2009). Therefore, the obvious setting was an ED where mental health consumers are triaged by an ED triage nurse and referred to a mental health triage nurse.

2.1.4.1 The research site

The specific site of this study was a hospital in regional Australia. It had a large emergency department that sees more than 44,000 clients per

year, of which about four and a half percent are people requiring metal health assessment. The ED and mental health triage service operated twenty four hours per day, seven days per week, and the two interrelated yet distinct services interacted on a daily basis. The ED had 45 staff who were qualified to conduct triage out of nearly 100 full and part time staff. The mental health triage service was staffed by nine mental health nurses. In both the ED and mental health triage service there was a nurse manager who works from 0900 to 1700 hrs. Likewise in both services there was one triage nurse rostered to a morning shift, two triage nurses allocated to the afternoon shift and one triage nurse rostered to the night shift.

The ED was accessed by ambulatory clients or those brought in by ambulance, car or police. The mental health triage service was located close to the ED but was separated from the ED by buildings housing other health services. This is important to note in the context of this research, as the two services were not co-located. This will be discussed in detail. The ED was accessed via a covered walkway into the general hospital and it took about five minutes to walk from the mental health triage office to the ED. At this hospital, a mental health triage nurse was not located in the ED permanently. No data could be found to identify the dominant model of mental health service delivery to the ED in Australia. Evidence would suggest though that non ED based mental health triage teams or consultation liaison nurses provide the bulk of the mental health service to EDs (Frank, Fawcett & Emmerson 2005) and these are usually located away from the ED itself.

This made this setting an ideal place in which to conduct the research as it afforded the opportunity to study the participants in a natural setting where observations were made where they naturally occurred (Russell 2004). The selection of this setting was made not only because it was a naturally occurring setting but also for the enhanced applicability of the research findings to a wider context. The selection of the setting is a demonstration of typical case sampling. In this type of sampling participants are selected as they are regarded as being typical of a wider group (Llewellyn, Sullivan & Minichiello 2004).

2.4.1.2 The research participants, population and sampling

ED triage is a process that is dictated in Australia by policies from the Australasian College for Emergency Medicine (ACEM). These policies recommend the ideal geography and resources to be found in triage areas, the timeframe for triage decision making and the decision making tool, the ATS (Australasian College For Emergency Medicine 2006). Therefore, the process and environment in which ED triage is carried out in all but the smallest of hospitals is consistent across Australia. This makes the ED triage staff at the research setting an ideal cohort for an exploratory study of ED triage practice as it relates to the triage management of clients with mental illness in the ED.

All members of the ED triage nurse group and the mental health triage nurse group were suitable for the study. They were engaged with each other on a shift to shift basis. They all had experiences, opinions and

perceptions that are valid and which give voice to this research. The sample of participants was deliberately purposeful as they are representative of experienced practitioners in their specific fields and of interest to the scholarly enquiry as defined by the research question (Roper & Shapira 2000). While the site was chosen for its representativeness of a typical case and the participants purposefully selected, the final sample size was, due to the voluntary nature of the research, unknown to the researcher when entering the field, not uncommon in ethnographic research as the ethnographer must enter the field with the express permission of gatekeepers (Liamputtong 2009).

2.1.5 Engaging with participants

Prior to travelling to the research setting the total number of nurses in each group was obtained from the nurse unit managers of the respective areas once appropriate permissions had been obtained and clearance from the two Human Research Ethics Committees was obtained. Forty-five letters of invitation and consent forms were sent to the ED and fifteen to the mental health triage service. These were disseminated by administrative staff through the internal mail.

Shortly after the researcher's arrival at the research setting, it was acknowledged by both nurse unit managers that research of this nature was somewhat uncommon in the hospital suggesting to the researcher that the nurses may have been uncertain about the research and had therefore not responded to the initial letters of invitation to participants. The first two weeks of the researcher's time at the site was therefore

necessarily spent in the ED tearoom and mental health triage office proffering introductions and explaining the research. This process of building rapport and engaging with the nurses was central to them voluntarily agreeing to participate after they understood the purpose of the research. Rapport has been acknowledged as being critical to obtain participants involved in research (Minichiello et al. 2004). Importantly, the researcher as a novice ethnographer came to realise that the time it would take to develop rapport with the ED and mental health triage nurses was underestimated. The researcher identified this as an important learning component during this research apprenticeship. Other ethnographic researchers may also benefit from this and be sure to include 'extra' time in the field in order to develop the rapport and trust required to recruit participants. This experience was a significant part of the journey the researcher was undertaking and is discussed in detail shortly.

It was during this first two weeks that consent forms started to appear in the pigeonhole allocated to the researcher or were given to the researcher directly. The allocation of a pigeonhole was significant as one ED nurse commented *'you had to be pretty important around here to get one of those' (FN)*. This was felt to add legitimacy to the presence of the researcher, as it was an external sign of support by the senior manager who allocated such resources to staff. By the end of week two, seven mental health triage nurses and 21 ED nurses had volunteered to participate, knowing they could withdraw at anytime without prejudice. This number was sufficient to commence interviewing and observation -

processes integral to data collection in ethnographic research (Gobo 2011). By the middle of week four a further six ED nurses agreed to participate, bringing the number to 28. These numbers represent 78 percent of the mental health triages nurse on the roster at the time of the research and 62 percent of the ED nurses qualified to triage at the time of the research. Sample size in qualitative research plays a submissive role to the importance of choosing participants that are representative of the group under study (Holloway & Wheeler 2002). The sample size in this instance afforded the researcher the opportunity to talk to and observe a large percentage of participants throughout the conduct of the research.

2.1.6 Entering the field

For this research the researcher needed to enter two worlds, that of the ED and that of the Mental Health Triage Service. These services are part of a larger organisation and, therefore, a 'top down' approach was adopted in order to gain entry. This approach ensures that permission to conduct the research and enter the field is obtained from the executive managers of the respective areas before contacting the nurse unit managers. This was done out of respect for the protocols governing access to organisations and to ensure that all stakeholders are aware of, and approved of activities in areas for which they are responsible. These key individuals are known as gatekeepers as they have the power to grant or deny access to the field (Brewer 2000). In this instance, the executive managers of the respective services were contacted by phone

and email. Copies of the research proposal were sent to them and follow-up phone calls were made to discuss the research in order to gain in-principle support. This was also required in order to gain clearance from the CQUniversity Human Research Ethics Committee. Once ethical clearance was gained, phone calls were made to the Nurse Unit Managers of the service to discuss the proposal and gain their permission to conduct the research in their departments. Once approval at a service level was gained and a start date confirmed, arrangements were made to distribute letters of invitation to the participants three weeks prior to the commencement of the research.

Prior to entering the ED the researcher met with the Nurse Unit Manager and Nurse Educator and obtained a swipe access card that allowed unfettered access to the ED. Permission was gained to use the period of double staffing time for interviews and the researcher was shown around the department and introduced to staff. The ED is a busy place and it became apparent that the best time to meet the staff en masse was to be in the tearoom as staff gathered for the afternoon shift and as staff on the morning shift came for lunch. Building rapport and trust with the people ethnographers work with takes time; and relationships in the field must be predicated on honesty, friendliness, good communication and openness (Brewer 2000). To this end the researcher met as many nurses, doctors, cleaners, orderlies and volunteers in the ED as was possible, regardless of whether they were potential participants or not. The researcher felt it was important to be friendly and open to all staff, as they would be frequently encountered whilst in the ED. This ensured

the presence of the researcher and helped to demystify the research process. A secondary gain, therefore, was role-modeling research in action. The researcher ensured availability in the department during periods of peak staffing to meet as many people as possible. The researcher used prior experience as an ED nurse to enquire about the activity of the department and to share stories of life in the ED. It was felt that this helped staff and the researcher find common ground upon which to build mutual trust, confidence and respect. This evolving relationship was part of the process of managing personal relationships with participants that is inherent in ethnographic research (Roper & Shapira 2000).

Gaining the trust of the mental health triage nurses required a somewhat different approach. The researcher shared a common understanding with the ED triage nurses due to a history of ED nursing practice, however, the mental health nursing environment was a culturally different environment for the researcher and therefore warranted close attention whilst entering the mental health triage nurses world. This notion is supported by Gorman and Toombs (2009), who contend that the impact of cultural differences can create complexity for qualitative researchers and that cultural differences can create barriers. To manage this, the researcher made sure that potential mental health triage participants understood that the researcher sought an understanding of their practice and was keen to learn about their world through the eyes of a researcher and not with the bias of a former ED nurse. This occurred by engaging potential participants in conversation as and when

possible to build rapport and ensure potential participants understood the researchers intentions. These conversations also gave the researcher the opportunity to understand the concerns and perspectives of the potential mental health triage nurse participants. The researcher was fortunate that there was strong support for the research from the Director of Psychiatry who met with the researcher on the second day of the research and requested outcomes of the research to contribute to the services accreditation process. The Divisional Nurse Manager of the Mental Health Triage Service was equally enthusiastic to ensure the researcher had everything required, including access to the building, and that the staff were engaging with the research. Over the first week of the research, the researcher was introduced to the mental health triage nurses and spent from 0800 to 1300 hours three to five days per week in the office engaging in conversation and discussing the research as and when appropriate. In both cases, by the end of week two signed consent forms from the ED and mental health triage nurses were submitted. Whilst the researcher continued to develop on and sustain relationships with the staff during the entire course of the research it was interpreted that agreement to participate in the research was an indicator of trust on the part of participants. Both the research and the researcher had been accepted.

2.2 Methods

The methods used in the field to collect data will traditionally involve participant observation, formal and informal interviews, examination of documents and the collation of field notes (Roper & Shapira 2000; Tham 2003).

2.2.1 Participant observation

Participant observation is central to ethnographic research (Fetterman 2009) and the ethnographer must determine to what degree they will participate in the daily lives of those in the research setting. There are four positions that can be adopted by the researcher. The first position is the complete observer, who has no social interaction with participants, sometimes known as non-participant observation. The second position is that of the observer as participant, who has brief periods of interaction in a role but relies on observational records and others methods of data collection. The third position is the participant as observer, who may have many roles in the research setting other than researcher and the fourth position is the complete participant, where the researcher is completely concealed and the participants are unaware of the research objectives (Russell 2004).

The position that best reflects the role adopted for this research is that of observer as participant. Russell (2004) states that in this role the researcher has face to face interaction with the participants in the setting. The main purpose of the interaction is to gather data using other

methods. This is consistent with the description of this position by Tham (2003) that the role of the researcher is made public, that observation is the principal activity and participation is secondary. The factors influencing the adoption of this position in the research were varied. As this research aimed to understand the interdisciplinary relationships necessary to sustain an emergency mental health triage service to clients with a mental illness presenting to the ED it was necessary to observe those interdisciplinary interactions. The researcher therefore adopted an overt position while in the field and explained to participants the researcher's intention to observe the interactions of the two groups. Spending time in the field in this context allowed the researcher to observe the environments in which the two groups worked. It also afforded the opportunity to interview staff at times and in places that were convenient to them and allowed the researcher to engage in informal conversations and observations that were relevant to the research - both important strategies in approaches to interviews (Liamputtong 2009).

Three factors contributed to the decision to adopt this approach. Firstly, it was made clear to staff in both departments that the researcher was there to conduct research, not to act as a registered nurse. Secondly, as the research concerned nurses across disciplines the researcher could not participate as an ED nurse and not as a mental health nurse, an area of limited experience for the researcher. Finally, participation would have meant engaging with clients and the ethical clearances for this project did not, by design, include contact with clients.

The degree to which the researcher engaged with the participants is measured by the fact that, as well as positioning them self as a researcher, the researcher positioned them self in the field first and foremost as a member of the nursing profession. This meant that while engagement with the participants was principally as a researcher the language, attitudes and behaviors that were shared with the participants, that the researcher had grown accustomed to as a Registered Nurse with 24 years of nursing experience, were used to build relationships with the participants. This allowed the researcher to be accepted as a nurse in the field, whilst not actually working in the departments in a clinical capacity. Observation of the interactions between the groups occurred in both the ED and mental health triage office when phone contact was made, and was ceased when the mental health triage nurse made contact with the client. At all times the researcher was mindful of the impact of their presence during periods of observation and ensured observation was conducted discreetly and at a respectful distance to ensure the interactions between the two groups were not interrupted by the researchers presence.

The other methods used in the collection of data for this ethnography were individual and group interviews, the taking of field notes and the gathering of relevant documents.

2.2.2 Interviews

Fetterman (2009) states that the interview affords the ethnographer the opportunity to contextualise what they see and hear and, as such, is the ethnographer's most important tool for data collection. Interviews with the mental health triage nurses were conducted in the shared area of the office. They were conducted at various times of the day depending on when the mental health triage nurse had an opportunity to engage in a conversation. Interviews were occasionally interrupted as staff came and went however due to the conversational nature of the interviews this did not pose a problem to the data collection and the interview process. Occasionally interviews were ceased due to workload and again these were recommenced at a later stage. Interviews with the ED nurses were more problematic. The ED triage desk is rarely quiet, as demonstrated by 44,000 occasions of client service per year, and the opportunity to sit with ED triage staff and engage in conversation proved more difficult due to frequent interruptions. Ambulances would arrive, clients needing triage assessment, public enquiries at the triage desk and telephone calls occurred on a frequent, mostly constant basis. After a week of attempting this process was abandoned as it was felt that this was adding to the workload at triage by taking up rare moments of down time for the triage nurse. It was also difficult to maintain a focused conversation with so much activity. The best opportunity to interview ED triage staff occurred at 1400 hours each day. During this time of the day the staff on the afternoon shift commence work at 1300 and the staff on the morning shift have cease work and have lunch at 1330. At 1400

various activities occur; mandatory training and in-service education are typical. The researcher had discussed the use of this time with the ED Nurse Educator who gave approval to conduct interviews in this time slot. Therefore, the researcher would arrive at the ED in the morning and consult the shift allocation book to identify staff who had volunteered as participants. The researcher would then approach them and discuss if they would agree to an interview later in the day. This process worked well, with interviews of between one to five staff occurring two to three times per week over the course of the research. The use of double staffing time for professional development and other activities was institutionalised in this ED and the staff were most comfortable doing interviews at that time than they were having ad hoc discussions at the triage desk.

For this research, interviews begun with an open-ended reiteration of the research question and progressed at the pace and direction of the participants. The researcher allowed the participants time to pause and reflect on their comments. Interviews were based on a process of active and sensitive listening, important elements of interviewing method (Liamputtong 2009). An iterative approach, inherent in qualitative research methodology, was taken whereby fresh insights posited in early interviews by participants were integrated in later interviews. The intent behind this approach was to maximize the voice of the participant so that by capturing the fullness of the participant's lived experience the data would be enhanced (Minichiello et al. 2004). In total 12 individual and group interviews were conducted with the ED triage nurse participants

and ten with the mental health triage nurse participants, resulting in 16 hours of taped interviews.

2.2.3 Documents

The use of documents is an important element in ethnography (Holloway & Wheeler 2002). Roper and Shapira (2000) state that combined with participant observation and interviews, the use of documents such as policies, guidelines and educational materials provide an opportunity to capture rich and important configurations of human behaviour. This was important for this research as it contributed to the depth of understanding for which the researcher was aiming. Examples of documents sourced from the setting, with the permission of relevant managers, include a copy of the mental health triage scale, protocols for the mental health triage service and guidelines outlining the use of the mental health assessment room in the ED.

2.2.4 Field notes

Field notes were also made during the research documenting the researchers observations, conversations, feelings and interpretations of what they had seen and heard. Roper and Shapira (2000) suggest that the ethnographer must have a commitment to field notes and that participant observation cannot be accomplished without contemporaneous field notes being made. Notes were made in the presence of the participants following a conversation and following periods of participant observation. Recorded conversations were

reviewed and salient points and comments were made in the field notes for follow up in future conversations. The field notes became a record of the researcher's thoughts and feelings during the research - a running commentary, akin to a conversation with observations - and became a document that assisted the researcher to refine the specific pathways of enquiry during the research process. The researcher soon realised that field notes acted as memory and, that these notes contained rich information that contextualised and augmented the methods of participant observation and interviewing. Field notes were sent to the supervisory team and discussions about their meaning and use occurred.

2.3 Time in the field

The daily routine soon established itself. The researcher began the day in the mental health triage office or the ED at 0800hrs and remained there until 1200hrs. While located in the mental health triage office the researcher would go to the ED with the mental health triage staff whenever a referral came through from the ED. In the early afternoon, the researcher would go to the ED for double staffing time and then return to the mental health triage office in the afternoon for a couple of hours. This occurred three to five days per week and occurred quite intensively during weeks three to six of the fieldwork. Time not spent in the field was devoted to reviewing taped interviews and field notes, reflection, journaling reading and analysing documents.

While ethnographic research can occur over periods of time from six months to a year or longer (Fetterman 2009) this research was conducted over an intensive period of seven weeks as it concerned itself with a very discrete area of nursing practice. Roper and Shapira (2000) claim that ethnographies that aim to answer specific questions can be conducted in a shorter timeframe than traditional ethnography. This kind of ethnography, as was undertaken for this research, is known as a focused ethnography (Morse 1987) and is akin to most nursing ethnographies that concentrate on a specific circumstance amongst a small group of people (Roper & Shapira 2000). A total of seven weeks was allocated with a contingency for another two weeks if needed. While factors such as budgetary constraints and the researcher's personal commitments may influence the amount of time spent in the field, it is the point at which the ethnographer realises that the question has been answered and no new information is being solicited, known as saturation, that defines the time to leave the research setting (Roper & Shapira 2000).

2.4 Exiting the field

By the middle of week five of the research, it became clear that saturation of data had occurred due to the repetition of themes emerging from the interviews and observations. Therefore, the research process continued up to the end of week six. During this time the researcher began to inform staff that they would probably be leaving at the end of the following week. This was done to introduce the fact that the research

period was ending but the researcher continued to conduct interviews and spend time in the setting. Shokeid (2007) argues that engagement in ethnographic research settings that are easily revisited or that are close to home require a holistic approach. This ensures that due attention and respect is paid to both the development, and ending of the relationships built while in the field. During the last week in the field the researcher visited the ED and mental health triage staff to say good-bye, to thank them for allowing the researcher to spend time with them and for their participation. Chocolates and a thank you card were left in the departments for staff as a way of saying 'thank you'. This kind of gift is typical of what is given when nurses and visitors leave departments having spent a period of time in them. The researcher also made a point of seeking out and saying a particular thank-you to the executive managers and Nurse Unit Managers who provided initial approval for the research.

During this phase of the research both ED and mental health triage nurses approached the researcher and enquired about the findings of the research and what changes they could expect. The researcher willingly shared information about some of the things that were obvious from the research. It was explained that there might be no direct immediate change from the research, as it would take time to analyse and publish the data. When requested by participants, the researcher openly discussed, in layman's terms, the rationale behind the methodology. Willingness to openly and honestly discuss the research and share information is a hallmark of the ethnographer's task and is a

basic underlying ethical standard in ethnography (Fetterman 2009). Both ED and mental health triage nurse participants commented to the researcher that it had been good for them to discuss the research topic. The following remarks, taken from the field notes following discussions with participants reflect the impression the research had on them as it made them '...think about the process' (FN) and that 'it was good to talk through the issues' (FN).

Reporting on the full cycle of the ethnographic project is important as it acknowledges the transformations that may have taken place in the setting and the patterns of mutuality between the researcher and participants. It is also important, as the ethnographic record reflects the researcher's own history and therefore has an impact on their professional standing and personal identity (Shokeid 2007).

2.5 Data analysis

Data analysis and verification occurred using the following process. Initial data analysis and verification commenced in the field as they are not procedures that should be attended to later in the ethnography (Roper & Shapira 2000; Van Maanen 2002). Data from recorded interviews were reviewed and memos made with regard to questions arising from the data and constructs to take back to participants for verification or further discussion (Roper & Shapira 2000). Field notes were reviewed against recorded interviews and memos made about areas for further observation, clarification or inquiry. Relevant documents were reviewed for both content and relevance to the themes and

constructs that emerged during both the initial and ongoing data analysis that occurred while in the field. This inductive process required immersion in the data (Roper & Shapira 2000), and as indicated previously, when not gathering data, time was spent by the researcher reviewing the data. Comparison of data during this phase of the research, and reflection on the old and new data is a cyclical process that is repeated throughout the data collection phase. When no new information comes to light data saturation has resulted (Boeije 2002) and the ethnographer may begin to withdraw from the field.

Once the fieldwork was complete a holistically oriented approach was taken to the analysis of the data. Thompson (2010) describes this as an eclectic process where the constant comparative method is used along with ideas and intuitions developed during the fieldwork and narratives from observed interactions to articulate data into categories of meaning that fit patterns of behaviour understood by the researcher.

Developed by Glaser and Strauss the constant comparative method lies as the core of analysis (Glaser & Strauss 1967). The constant comparative method has become the dominant analytical model in many of the traditions of qualitative research and may be supported with data matrices, displays and diagrams (Boeije 2002), as has been done in this thesis. The constant comparative method involves taking individual elements of the data and comparing them to all other pieces of data (Licqurish & Seibold 2001). In this research this was conducted based on a model described by Boeije (2002) where data was compared in the

following steps:

1) Data was compared within a single interview
2) Data was compared within interviews from the same group, either ED or mental health triage nurses
3) Data was then compared across the two groups
4) Field notes, documents and memos were then examined for elements that informed the substance of the emerging themes.

This process allowed the researcher to compare what was similar or different about a piece of data to the remainder of the data. This was conducted working from within a single interview in the early stages of data gathering and analysis in an ever expanding vortex until all data had been gathered and compared. Using this inductive method, meaning is drawn from the data and themes are developed (Licqurish & Seibold 2001). In order to facilitate this process the transcribed interviews, field notes, memos and documents were imported into the QSR NVivo computer package Version 8 (Appendix 4). The use of data management software such as QSR NVivo is an appropriate strategy to aid analysis in qualitative research as it allows the researcher to identify theories and relationships in the data that might otherwise be overlooked (Leech & Onwuegbuzie 2011). However, the main tool used for data analysis is always the researcher themselves (Denzin & Lincoln 2005). The use of software such as NVivo also allows for external examination of the process of theme development from raw data through to final themes, a critical component of an audit trail that enhances the legitimacy and rigour of qualitative research (Onwuegbuzie & Leech

2007).

2.6 Limitations of the study

This study was conducted at one site with two groups of nurses. While general ED triage is a standardised system across Australia, the model of mental health service delivery to the ED, a mental health triage service as described in Chapter Two is peculiar to the research site and is one of many varied models of care known to exist. The study represents a snapshot in time based on the lived experiences of the participants during the eight week period of fieldwork. The findings of this study are therefore required to be read in this context. They are not generalisable and nor are they intended to be.

Chapter 3: Findings

This chapter presents the findings as revealed after critical examination using the constant comparative method of data analysis. A number of core themes were uncovered which will be identified here. Given that the content of this chapter presents findings only, a more detailed discussion, incorporating the participants' voices is unveiled in the following chapters.

Overall, the relationship between ED triage nurses and mental health triage nurses is predicated by a number of factors. These factors include intrinsic, internal and extrinsic, external features. Intrinsic factors include concepts such as pre-existing knowledge, experience as a nurse, level of training, experience with clients who have a mental illness and personal standards of practice and an understanding of the cultural backgrounds of each of the groups of the participants. Extrinsic factors, which are different to but complimentary of intrinsic issues, include factors such as architecture, geography of the care setting, policies and procedures, established processes of communication and professional standards of practice in emergency care. These specific practice standards are determined by the Australasian College for Emergency Medicine (ACEM) and the College of Emergency Nurses Australasia (CENA). The complex interplay of these factors, elicited as a result of data analysis as described in chapter two are positioned within four core themes.

These core themes are

1. Practice Environment
2. Process
    2a. Assessment
    2b. Referral
    2c. Response
3. Roles and Scope of Practice
4. Collegiate Presence

The narrative presented within this chapter will report on the content of each of these key themes. This description will demonstrate to the reader the depth and breadth of the data, as obtained during the time in the field.

Throughout this chapter, images are presented in order to assist the reader visualise an emergency department and/or triage desk. The necessity for the reader to be able to conceptually locate or familiarise themselves within the research environment is an important consideration in ethnography (Golden-Biddle & Locke 1993). However, the researcher is cognisant of the importance of maintaining confidentiality, and as such, the images presented are indicative of the research setting and are not pictures of the actual site.

3.1Practice environment

3.1.1 The emergency triage area

The triage area in most emergency departments is often a very public space. Facing the front doors of the department and in full view of the waiting room, the exposed triage area examined for this thesis, consists of two desks for the triage nurses and two desks for the triage clerks. Each of these workspaces is equipped with a computer, document storage, cabinets and draws.

Illustration 1: Representation typical of an ED triage area

By design, as indicated in the picture above, many triage areas are surrounded by glass in order for the ED triage nurse to view the waiting room. The triage area at the study site was no exception. A sheet of glass extends from the surface of the desks to the ceiling and runs the full length of the triage area. The glass barrier at the research site was described by staff as having been installed for security reasons. At each

of the four points along the desk where a triage nurse or clerk is situated there is a 30 centimetre wide gap in this glass wall. This small gap runs vertically to the ceiling positioned in the centre of the desk and it is through this small gap in the glass that communication between the triage nurse/ clerk and the client occurs. Behind the triage desk, are filing cabinets filled with client notes, a clerical storage area and curtained cubicles for clients who need to lie down prior to being moved into the main assessment area of the ED.

Throughout the triage area vinyl flooring and non-sound attenuating ceiling tiles contribute to what can be described as a very noisy environment. During times of high activity staff need to speak quite loudly in order to overcome local noise. This necessary increase in vocal projection makes the area even noisier with staff and clients having to speak louder and louder in order to make themselves heard and understood. This acoustic phenomenon is known as ‘noise creep‘ (Field 2008) and decreases the ability to have a private conversation despite many personal details being gathered by both the clerk and/or nurse at this point.

Numerous fluorescent lights that make the area very bright, stark and clinical in appearance also light the triage area. Access to the rear of the triage desk is only available to internal ED and other hospital staff as well as police and ambulance personal. The triage area is then, very much a public space with the triage nurse having no control over the movement of staff in and out of this initial assessment space. The triage

nurses indicate they have no control over the ebb and flow of clients who present for care at the ED and those clients and family in the waiting room. This all contributes to a busy, noisy and non-private assessment area.

Illustration 2: Representation of an ED waiting area

There is one main triage desk that is exclusively allocated for use by the ED triage nurses at all times. During times of peak activity, typically during the afternoon, a second ED triage nurse may be deployed to the triage area and this nurse uses a separate desk so that the triage nurses can work independently, but be seated next to each other. Both triage desks have a chair for clients requiring triage assessment who sit facing the triage nurse. Clients are triaged by the ED triage nurse then asked to speak to the receptionist to complete admission paperwork, or bought directly into the ED for care if required. There are no walls or other barriers surrounding the client. On the staff side of the main triage desk

there is a small stool positioned to the left hand side of the triage nurse. This stool, in close proximity to the triage area, is used by various personnel regardless of whether there is a client providing information to the triage nurse or not. Anyone sitting on this stool can clearly hear what is being discussed at the point of triage, which further contributes to a lack of privacy.

It was also observed that the triage nurse has responsibilities beyond the actual triage assessment of clients. In addition to this clinical assessment, they provide ongoing care to clients waiting in the waiting room which includes taking regular observations of temperature, pulse and blood pressure. They were observed arranging transfers of pregnant women to the labour ward; re-directing clients arriving for booked admission to the appropriate ward; collecting specimens; administering pain relief and initiating first aid care such as splinting of broken limbs and bandaging of bleeding wounds. It was not uncommon for the triage desk to be surrounded by wardsmen waiting for direction, doctors requesting specimen collection or interventions be carried out; physiotherapists, doctors or other allied health staff requesting information or equipment. The triage nurses' desk was observed to be an epicentre of the triage area; a location of high people traffic, highly visible, very noisy and the locus of control of the triage area and waiting room.

3.1.2 The mental health triage service office

Illustration 3: Representation of the mental health service building

Situated on the same city block as the ED but somewhat distant from it, the mental health triage service operates from offices within a building that also houses the acute mental health inpatient unit and district mental health executive and administration. This building is about 400 metres from the ED inclusive of three flights of stairs. The researcher comfortably walked there in about five minutes, however, some mental health nurses felt the distance could take up to ten minutes to traverse.

In order to access the office that actually housed the mental health triage service, a swipe card was required. This was needed to enter the main building itself. Without a swipe card a client or visitor must rely on the receptionist, who sits at the desk facing the front doors, to open them remotely. Persons with no swipe card can only enter unannounced during business hours. Having secured initial entry to the foyer area, further access requires negotiation with the receptionist. Permanent

staff, in receipt of a swipe card, can make their way down a short corridor to the office of the mental health triage service. A door that is permanently locked further secludes this area.

The mental health triage office is approximately five metres by nine metres in size, is carpeted, and has windows that are covered by blinds. Within this area are five desks that have computers and shelving for paperwork and books similar to that shown in Illustration 4. The computers are loaded with the Emergency Department Information System (EDIS) software (Appendix 5), which enables the mental health triage staff to see the client profile currently in the ED. This instant information affords them the ability to immediately identify when a client who has a mental illness or related condition is triaged.

Illustration 4: Representation of the mental health triage service office

Further to the triage office, there are another two offices leading from the main office that is shared by the staff of the mental health triage service. One of these offices belongs to the Nurse Unit Manager and the other for the triage service Consultant Psychiatrist. The doors to these offices remain open unless there is a meeting being conducted. The mental health triage office area ensures staff have an environment that is quiet and private. Access is obtained only if you are authorised to carry a swipe card for the main entrance and a key to the triage service office. Authorised personal include mental health nurses, doctors and administrative staff. Movement in and out of the office is limited to the four or five mental health triage service staff rostered during office hours and the two or three staff on after hours. It can be described as a quiet, low people traffic area.

The mental health triage service provides care to clients referred to them by phone, from the ED 24 hours a day. They also receive referrals during business hours from General Practitioners, the acute general hospital inpatient units and clients that walk in off the street. However, it was observed that clients do not enter the triage service office. If the clients require assessment or care they are seen in the general hospital ED or in assessment rooms located across the corridor from the mental health triage service office. Unlike the ED triage nurse, the mental health triage nurse has a high degree of control over who enters their workspace. Further differentiation is that the mental health triage nurse does not provide first aid care for other 'waiting room' clients, collect specimens, re-direct clients and relatives or locate equipment for other

health personnel. As alluded to previously in this chapter, these descriptions are important within an ethnographic study as they provide a geographical orientation to the research environment in which the ED and mental health triage nurses work and interact. Discussion of the influence of the environment on the participants follows.

The ED triage nurses had recently moved into a new ED six months prior to this research being undertaken. In order to contextualise the findings it is worthwhile noting that the former ED had two waiting rooms, one of which was a smaller secondary waiting room that was visible, but away from the triage area. This area was used for clients waiting to be seen by the mental health triage team. The new ED only has one waiting room. The ED triage nurses were still assimilating this altered environment into their practice routines. The new ED does have a mental health assessment room with an attached office with desks, computers and other resources for the exclusive use of the mental health triage nurses. This was influential as it changed the options ED triage nurses had for managing waiting clients and provided the mental health triage nurses a dedicated space within the ED to work.

The management of clients waiting in the large public area was of concern to the ED triage nurses for reasons of privacy and security. Two components emerged within the concept of privacy. Firstly the impact that the lack of privacy has on the ED triage assessment process as previously described. Secondly the issues surrounding the lack of privacy for clients who are waiting for a mental health assessment.

Privacy was seen to be particularly important for this client group, as the ED triage nurses believed they would be more settled. Further to this, privacy was seen as being of utmost importance when the police accompanied the client. The minimisation of public scrutiny was thought of as imperative by the ED triage nurses. The use of a treatment cubicle within in the ED was not seen as being appropriate for clients to wait, as these cubicles are in a busy, noisy, public area. The ability to provide a quiet private place for clients who have a mental illness was seen as essential for maintaining the privacy of other clients in public in the waiting room particularly if the clients' behaviour was intrusive. Participants also revealed that they felt it was necessary and part of their role to protect children from swearing and other potentially offensive behaviours that were sometimes exhibited by this client group. Conversely, the mental health triage nurse participants offered different perspectives on the notion of privacy. Divergent views emerged with regards to the need for segregation. These views ranged from the belief that to separate clients with a mental illness from the general public was to further stigmatise an already stigmatised population, through to providing privacy to clients with a mental illness was essentially an act of kindness but could equally be about minimising disruption in the waiting room.

ED triage nurses identified the lack of a secure, private place for clients to wait as a risk to clients, staff and public in the waiting room. The ED triage nurses believed that clients who have a mental illness need a low stimulus environment or the potential for aggression would increase.

When verbalising this, participants described the security implications for those in the waiting room and the clients themselves. ED triage nurses were also concerned that they could not guarantee that clients would not abscond from the ED if left in the main waiting room. The ED triage nurses felt it was their responsibility to stop this from occurring. To manage this they were observed to place clients in the mental health assessment room to wait. This is contrary to the mental health triage service policy.

ED triage nurses indicated that putting clients with a mental illness with behavioural or emotional problems into a situation where members of the public saw them was reinforcing negative stereotyping of mental illness. Some mental health nurses indicated that managing clients in the waiting room (mainstreaming) was important as it reduced stigma by not dislocating the client from the general population and that the general population needed to see the effects of mental illness in order to understand and accept it.

Interview and observation revealed that ED triage nurses place a great deal of emphasis on privacy, security and management of clients in the waiting room. This was more evident in this group than in the mental health triage nurses. This is indicative of the fact that the waiting room and management of the clients in the waiting room is the responsibility of the ED triage nurse, and that mental health triage nurses believe they have no responsibility for those waiting clients until they are formally assessed.

Now that the reader has a clear picture of the research setting and the impact of the environment, what follows is a description of what was observed to be the first phase of engagement between the two groups when a client enters the emergency department and speaks to the ED triage nurse at the ED triage desk. This phase has been named 'Process' in this research and is further broken down into three sub sections. These are assessment, referral and response, which are described below.

3.2 Process

3.2.1 Assessment

Factors that affect assessment and decision making at the point of triage are influential on the ability of the ED triage nurse to fulfil their role correctly (Goransson, Fonteyn & Ehrenberg 2008). One of the more significant factors that affected triage assessment was the architectural design of the triage area and waiting room. The architecture of the triage area and the resultant lack of privacy influenced the type of questions asked and the information obtained. Similarly, the close proximity of the ED triage area to the waiting room and other ED staff and concern about compromising the clients' confidentiality was a significant issue for the ED triage nurses.

Decision-making at ED triage is predicated on the use of a mental health triage scale (Appendix 2). The use of this scale by ED triage nurses is well established, having been in place for seven years. One mental health triage nurse who participated in this research, believed the mental health triage scale was valuable in determining waiting times for clients and in providing an organisational approach to seeing clients who were waiting in the ED. Emergency department triage nurses mentioned that the mental health triage scale was of value, however, they did identify a factor that directly influenced their thinking during the triage decision making process while they were using the mental health triage scale. The following example explains this concept. When a client presents with symptoms suggestive of a particular condition such as chest pain, the ED triage nurse uses their past experience of caring for clients with this condition, and prior knowledge of likely outcomes as part of the measurement of acuity. For clients who have a mental illness, however, no such clinical knowledge could be drawn upon and as such, ED triage nurses were unsure of acuity or what questions to ask in order to elicit appropriate and accurate information. ED triage nurses, therefore, relied heavily on the mental health triage scale to guide their decision making and practice but struggled with contextualising the presentation in the same whey they might with a triage decision for a client with a physical injury or illness with whose treatment and outcome they are familiar. Other extrinsic factors influencing triage were identified by ED participants as, pressures inherent in the ED triage nursing role,

managing time, numbers of people in the queue waiting to be triaged and inward bound clients brought by ambulance and police.

These findings demonstrate that there are numerous influencing factors when assessing a client who has a mental illness in a general hospital emergency department. Participants identified many of the factors described above as being of more influence with regard to the quality of the information, which was seen as vital, which is obtained during the triage assessment. Some ED triage nurses identified that quality information is compromised, as clients would not divulge information about their presenting condition. There was also a perception that clients were not always honest about their presenting condition. ED triage nurses perceived that pursuing a detailed assessment was pointless, specifically for clients who have previously spoken to the mental health triage nurse for instance. Again, education and experience had a strong influence on ED triage nurses. Not knowing what to ask or what to do was identified as a limiting factor and the notion of ‘not knowing’ was consistently emphasised by the ED triage nurses as being a factor in their belief that they garnered information that was limited. Some ED triage nurses reported that they obtained limited information simply because they did not ask the right questions.

Workloads and limited assessment time at ED triage constantly emerged as themes that impacted upon the ability of the ED triage nurse to gather accurate information that is require to make a correct triage assessment. Workload and time constraints also contributed to a multifaceted concept described by the ED triage nurses as pressure. Furthermore, and as described in the research setting, the noise of the environment, the people traffic in and around the ED triage area, phone calls, medical and allied health staff and waiting clients wanting information, referrals, specimen collections, taking observations all contributed to “pressure”. The presence of a long queue of unwell, undifferentiated clients needing to be triaged was also raised as a major contributor to pressure. The feeling of being ‘snowed under’ and uncertain as to what to do with clients, in particular those with a mental illness also exacerbated the feeling of pressure described by ED triage nurses. Mental health triage nurses expressed the view that the nature of the client’s presentation and the preceding events (past history) also contributed to the ED triage nurse’s perceptions of the client and influenced the clinical triage decision that was made.

The triage decision is one that is uniquely owned by the ED triage nurse (Edwards & Sines 2007). However, the quality of the information obtained and the factors that influence the information gathering process affects both the ED and mental health triage nurses. It also affects the most important person in the process, the client. Because the mental health triage service receives referrals from a number of sources they may have information about the client prior to the client presenting to the

ED. The client who presents to the ED may have recently spoken to the mental health triage nurse and, as a result, may not wish to repeat the reason for their presentation to another person having just explained it to the mental health triage nurse. The ED triage nurses identified that, for the most part, they thought that the information they gathered from clients who have a mental illness was superficial. ED triage participants felt that this was a result of limited mental health knowledge and them not feeling comfortable with asking questions related to mental illness. This, they felt had a negative impact on their triage decisions. Clients opting to not divulge information or engage with the ED triage nurse were identified as reasons for obtaining limited information from clients. In contrast though, mental health triage nurses felt that the major factor contributing to the brevity of information was time constraints at the point of triage. They felt that such a limited amount of time to undertake a history was not appropriate to gather enough data on clients who are presenting with a mental illness.

Such limited information, regardless of its quality, is a significant issue for both ED and mental health triage nurses. Rapid assessment times and the workload at ED triage compromised the ability to obtain accurate and thorough information from clients. This point was not lost on the mental health triage nurses as they expressed a degree of sympathy for the ED triage nurses with respect to their workload. The second aspect of ‘process’ that will now be discussed is a role implicit in the act of triage assessment. That is the passing on of information to the mental health triage nurse. This is known as referral.

3.2.2 Referral

In this research, referral was observed to occur via two mechanisms. Firstly by the ED triage nurse entering the client on the Emergency Department Information System (EDIS) (Appendix 5) and secondly by the ED triage nurse making a personal phone call to the mental health triage nurse. The former (EDIS process) occurs one hundred percent of the time as all clients must be entered onto the EDIS. This is strict hospital policy and the procedure is adhered to at all times. The second type of referral, that is the phone call, should also occur one hundred percent of the time as it is officially recognised as the procedure within the study site for notifying the mental health triage nurse of the presence of client in the ED. However, the rapidly shifting priorities and overwhelming workload, described previously meant that on some occasions the phone call was either delayed or not made at all. This two staged referral process differs from that used by the ED triage nurse for clients with physical injury and illness. These presentations are recorded on EDIS only. Despite the EDIS entry it is the phone contact that was considered by mental health triage nurses as the point of referral and as the most important form of communication. The phone call was considered the official trigger for a response from the mental health triage nurses. Therefore, the making of a referral by phone and its receipt by the mental health triage nurse, in this instance, is considered vital within the triage process.

An underlying issue within the referral process that concerned mental health triage nurses was that of inappropriate referrals. Inappropriate referrals or 'soft' referrals as they were sometimes called, occurred as a result of ED triage process. For example, they believed the use of a mental health triage scale limited the questions asked by the ED triage nurse, the experience (or lack thereof) and busyness of the ED triage nurse and their inability to accurately determine the acuity of the client's presenting mental health condition. ED triage nurses identified that they felt mental health triage nurses had unrealistic expectations of them with regard to information gathering and history taken. Mental health triage nurses wanted more history and ED triage nurses had no time or expertise to collect it. This process of referral then set the tone for the response by the mental health triage nurse to the client in the ED.

3.2.3 Response

ED triage nurses are accustomed to a standard, and mostly unquestioning, response to their triage decisions for clients with physical injury and illness. Despite a triage category being applied and with it the treatment timeframes, mental health triage nurses identified a number of reasons why they could not always meet the set intervention parameters. These include the importance of obtaining and reading the client's history prior to assessment, the presence of other clients in their care and the geographical distance between the mental health triage offices and the ED. Some ED triage nurses reported a high degree of variability with the responses of the mental health triage team to the

timeframes within each category. It was identified that response times to triage categories varied accordingly amongst individuals within the mental health triage team, sometimes receiving a high level of responsiveness to the triage referral and sometimes not.

ED triage nurses described how they were challenged and /or questioned by the some of the mental health triage nurses with regard to the triage categories they had allocated to clients who had a mental illness. This behaviour was perceived as confrontational. Conversely, mental health triage nurses thought that overall the triage categories were well applied and had a valuable place in the referral process. Their request for more information (which was perceived by ED triage nurses as challenging) was just that. They felt they required more information in order for them to make a valid assessment.

Despite the organisation's policy of medical clearance not being required prior to mental health assessment (Appendix 6), the issue of some mental health triage nurses requiring medical clearance prior to mental health assessment was raised as an issue. Given the lack of mental health expertise by ED triage nurses participants described the reassurance they felt when there was a timely response by the mental health triage nurses. As described earlier, the process of triage that consisted of the assessment of clients, the referral to the mental health triage nurse and the consequent response forms the core process that dictates how ED and mental health triage nurses interact. This process is informed by the previously mentioned practice standards that dictate

emergency triage and response and the protocols of the organisation. These define the roles and scope of practice of the ED and mental health triage nurses.

3.3 Roles and scope of practice

The role of the ED triage nurse is to make a triage decision based on the criteria in the mental health triage scale, allocate a triage category, refer the client, place them in the most appropriate area to wait and care for them until the client is seen and treatment commenced (College of Emergency Nursing Australasia 2007a). Sometimes care will be provided by the ED triage nurse following the beginning of treatment if the client's condition is of low acuity or there are no other treatment spaces available. This role is clearly defined by professional standards and guided by a scope of practice that is competency driven. The roles and responsibilities of the mental health triage nurses are less well defined and more open to individual interpretation. Participants described their main responsibility as assessing and managing clients referred from a variety of sources and to arrange appropriate follow up, including referral and care.

ED triage nurses described their role as one in which they know a little about a lot of things, but that mental health was not one of these areas. In fact, there was widespread acknowledgement amongst the ED triage nurses towards the knowledge and experience of the mental health triage nurses. Participants also acknowledged that mental health triage nurses were more likely to have a more detailed knowledge of clients

who do present possibility due to prior involvement with those clients. Some ED triage nurses demonstrated a lack of understanding about what else the mental health triage nurses did when they were not in the ED. They falsely assumed that the ED was the bulk of their work and wondered why the mental health nurses were not located in the ED permanently. Some ED triage nurses also felt that the mental health triage nurses did not fully appreciate or understand the role of the ED triage nurses or ED systems and processes. What is evident here is that role confusion and a lack of understanding are endemic.

The notion of being untrained in the area of mental health emerged consistently in the data from ED triage nurses. This led to a lack of confidence and a reliance on the mental health triage nurses as a group of experts. Being untrained was closely aligned to the notion of not being able to provide appropriate care. This area was described as very troubling to the ED triage nurse as all of them said they wanted to provide the best care possible for the clients.

As described above, predominantly, the mental health triage nurses expressed a common understanding of their role, however, despite this overall understanding, some diverse opinions were evident. One mental health triage nurse indicated that their role had expanded from assessing clients with acute mental illness to assessing clients who presented with any emotional disturbance. Another believed their role was to provide care for clients in the ED and that triage was only a part of the role when there were conflicting priorities. A different participant

felt a strong allegiance to the acute mental health inpatient unit and saw their role as being a support to that unit as much as anything else. Yet another view was that the mental health triage nurse role was a consultative one, where a referral is made and a discussion occurs about the best thing to do with the client and, if the client did indeed require a mental health assessment, then they would respond. While there was a general consensus amongst the mental health triage nurses on their principal role, they had very personal perspectives on the role and how they went about it.

Administering interventions to promote comfort, reduce pain or to commence gathering assessment data is part of the ED triage nurses role. Some ED triage nurses expressed frustration that they were incapable of doing anything for clients with a mental illness other than at worst, applying restraint and sedation at the request of the mental health triage nurse. Again, this was strongly aligned to the idea that they were untrained, and many ED triage nurses expressed a desire for the mental health triage nurses to be part of the ongoing education in the ED in order to improve their capacity to therapeutically intervene. Ownership of clients emerged in the data as a point of contention between the two groups. ED triage nurses believed that mental health triage nurses should take more responsibility as part of their role for the ongoing care of clients with a mental illness in the ED, particularly if admission to the acute inpatient unit was delayed. This belief was premised on the understanding, that as ED triage nurses were untrained in mental health care, they could not provide therapeutic interventions for the clients and

at best could only afford the client basic hygiene, nutritional and safety care. Contrary to this, the mental health triage nurses believed that ongoing emergency care was a shared responsibility with their role being principally consultative and interventional only if indicated. Such opposing opinions had the potential to have an adverse effect on the relationship between the two groups that went beyond the interactions they have at the point of triage. Aligned with the notion of ownership is the concept of shifting responsibility. Participants from both groups identified that, as a result of the process of referral, responsibility was then shifted from the ED triage nurse to the mental health triage nurse. In practice, however, the responsibility for the care of the client still lay with the ED triage nurse until the mental health triage nurse had seen the client.

What became apparent from data and observational analysis was a difference in the orientation of the two groups. The ED triage nurses appeared to be much more process focussed. The process, in this instance, was assessment and consequent allocation of a triage category and referral to either ED physicians or mental health triage nurses. The mental health triage nurses on the other hand were more outcomes focussed. The outcome being the ultimate disposition of the client whether referred back to community care or admission as an inpatient. This orientation underpins professional practice and has an effect on the way in which information is both gathered and used.

The themes, as articulated so far are all factors that influence the relationship between the ED and mental health triage nurses. The effect of the impact of the environment, the process and the roles and scope of practice ultimately impact on the relationship. The nature of the impact revealed by this research - collegiate presence.

3.4 Collegiate presence

For this research, the relationship between the ED and mental health triage nurse is somewhat of a distant one. Although not excessive, the tyranny of distance means that the telephone was the main medium for communication, The reality of geographically separate buildings and only coming into contact with each other intermittently means there is no requirement for them to speak to each other apart from the referral phone call. This poses issues with the development of a professional therapeutic relationship that is vital for good client outcomes. Data revealed that although both discipline areas felt this to be important, ED triage nurses placed more emphasis on presence than did the mental health triage nurses.

The ED triage nurses spoke of how they valued seeing the mental health triage nurse at the beginning of the shift. They felt this contact was important and imperative for establishing a professional relationship for the remainder of the shift. The ED triage nurses spoke of how they valued the presence of the mental health triage nurse. Presence was described as supportive and gave them a sense of security. They also felt presence-improved communication by facilitating the ability to have

quick conversations that they considered aided assessment. ED triage nurses also felt that that the presence of the mental health triage nurse in the ED contributed strongly to a sense of teamwork and collegiality due to the ability to interact socially during meal breaks as well as the expert support that the mental health nurses were said to be able to provide. Comparisons were drawn by the ED triage nurses between previous mental health triage staff who elected to permanently deploy themselves in the ED and current staff who mostly worked from the mental health triage service office. ED triage nurses clearly preferred the mental health triage nurse to be located permanently in the ED. Caring and avoidance emerged as concepts in this discourse. Mental health triage nurses who were highly visible in the ED were perceived to be caring and keen to engage with the ED workload and those who weren't visible were perceived to not care and be avoiding work. ED triage nurses directly aligned collegiality with presence.

Interview analysis and observation revealed that mental health triage nurses had mixed opinions about the importance of being visible in the ED. Some saw value in the improved communication that occurs as a result of close proximity. Some felt that as the phone call was the primary mechanism for referral that close proximity was unnecessary, and others felt a stronger sense of identity with the staff of the acute mental health inpatient unit and, consequently, only went to the ED when absolutely necessary. Another participant indicated that they would feel uncomfortable being amongst ED staff who were seen to working physically hard when they were not doing psychomotor tasks. They felt

they would be judged as ‘not working as hard’. One mental health triage nurse believed that there was a perception that a greater presence in the ED would lead to extra work although that had not been proven by their past experience. Mental health nurses perceived presence as courtesy, touching base with the ED triage staff was the courteous thing to do at the beginning of the shift. It was also important for the person in charge of the ED to be known by the mental health triage nurses, as it was essential to know who to communicate decisions to. The ED triage nurses view was that of all the non-medical and nursing staff such as social workers and physiotherapists who work in the ED, the mental health triage nurses were the group who they relied on the most. However, it was this group that they felt the most disconnected from. Mental health triage nurses viewed the relationship from the perspective that they were delivering a service and having a physical presence in ED was not necessarily a factor for them to be able to deliver this service effectively.

ED triage nurses appreciated mental health triage nurses who were physically present, communicated frequently and contributed positively to the work in the ED. The ED triage nurses saw this as professional cooperation. Cooperation and presence relieved the sense of isolation felt by nurses at ED triage and provided them the security of knowing that ‘expert’ help was on hand. The ED triage nurses voiced the belief that the degree to which mental health nurses adopted the approach described above, was dependent on the personality of the individual

mental health triage nurse and was not a trait of the mental health triage service as a whole.

This was further exacerbated by the perception that as the mental health triage nurses existed out of the department they did not understand many of the issues of the ED triage staff and the difficulties they had managing certain clients. This became apparent in discussions about the use of restraint on agitated clients prior to mental health assessment. Again this represents the desire of ED triage nurses for a visible presence by mental health nurses. This ‘seeking of expertise’ resulted from the ED triage nurses feeling difficult situations could be avoided if there was greater collaboration and an increased presence of the mental health triage nurses in the actual ED. Strong personalities and the tension created by some opinionated people in both discipline groups who apparently had different agendas regarding client care, was described by participants from both groups as a reality of working in an environment such as a busy ED. This tension was described by a small number of ED nurse participants as making them feel intimidated and elicited the need for inner strength to deal with this. It was not a situation that some participants found pleasant. Mental health triage nurses though did not identify such emotional responses when describing their interactions with the ED triage nurses.

As outlined above, the notion of presence is strongly related to collegiality by the ED triage nurses whereas the mental health triage nurses contextualise presence as a construct of service delivery. Deeper examination of this issue revealed that within these constructs a number of operational and personality related issues also had an influence on collegiality. Both groups had identified different perspectives on how the degree to which communication was effective depended on the individual nurse. Mental health nurses identified that the busyness of the ED had a profound influence on communication. Both groups though, had very different perspectives of how communication affected them. The importance of social communication was clearly articulated by the ED triage nurses. They reported that the brief conversations that occur at the beginning of the shift or during meal breaks instilled a sense of teamwork, confidence and being part of a partnership for them. ED triage nurses described how they felt that these conversations gave them a sense that the mental health triage nurses understood them, the ED triage role and the factors that influenced the decision making at triage. For this social conversation to occur it was felt that mental health nurses needed to spend more time in the ED.

These social conversations helped enhance professional rapport. Both ED and mental health triage nurses identified that face to face conversations reduced confusion, allowed for consultations that reduced the incidence of inappropriate/soft referrals and that bringing the right attitude to these conversations resulted in getting a positive outcome. It was felt that the poor communication that occurs both in terms of quality

of information and the limited time for discussion over the phone, compromised the relationship between the two groups and that the phone call could be dispensed with face to face communication as a preference.

Of concern to many of the mental health triage nurses were the repeated telephone calls from the ED about clients. While many of these telephone calls related to ongoing management of clients in the ED, they related how they would often receive calls enquiring about their whereabouts in relation to when they will be attending the ED. The mental health triage nurses felt annoyed by this and felt 'hounded' that they received phone calls from separate ED nurses about the same issue all within a short space of time. Some participants from the mental health triage service identified that *not* receiving calls about clients on EDIS was equally as frustrating. The reader may recall that the phone call was deemed as the official notification, sparking the referral process. It was the content of the phone call that was the concern. One was seen as legitimate referral and the other was seen as harassment.

The ED triage nurses identified feedback as an issue that caused them some concern. Feedback, they suggested, about clients they have triaged, often does not happen regularly across all client presentations regardless of the aetiology of the presenting complaint. Participants felt that when a mental health triage nurse did provide feedback it was positive and useful because of the insights and knowledge they gained. The ability to receive feedback about clients and provide feedback about

performance, both from the ED triage nurses to the mental health triage nurses about responsiveness, and the mental health nurses to their ED colleagues about triage decisions, was, according to both groups, easier when the communication was in person. It was important for both discipline groups that this feedback loop was closed.

This chapter has described in detail the findings of the research and presented to the reader the beliefs, opinions and concerns of participants. It was presented via the four key themes that emerged through the process of the constant comparative method of data analysis. The relationship between the themes is detailed in Figure 1 below. The directions of the arrows indicating the direction of influence each of the themes have on the other.

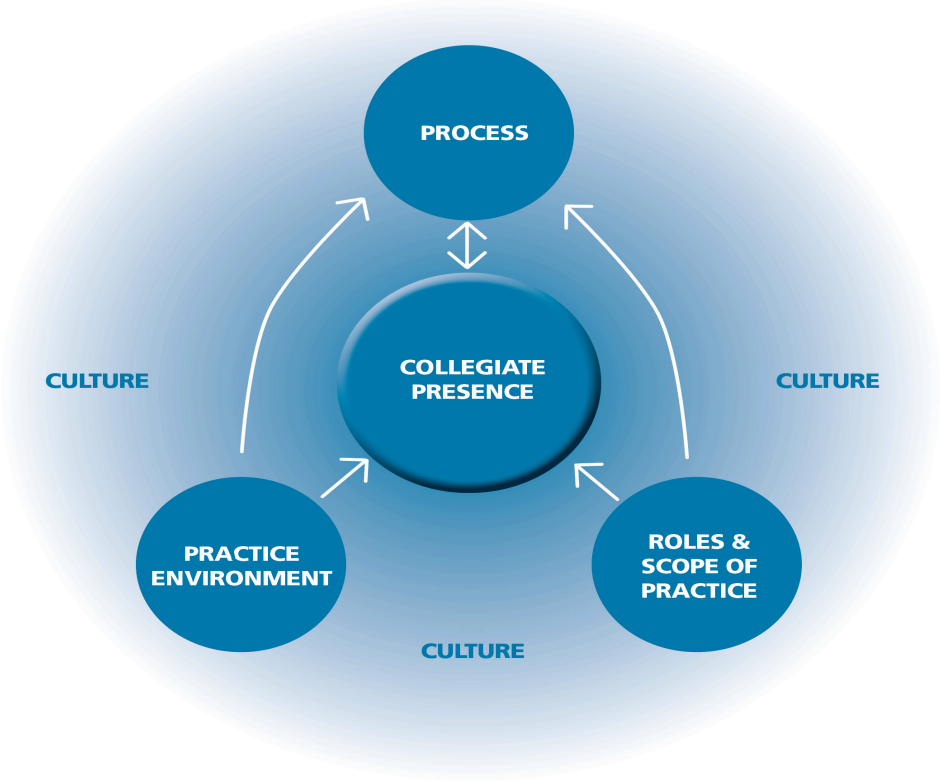

Figure 1: Conceptual map of the relationship of the key themes

A key feature of ethnography is that, in order to make sense of the findings, they must be represented using the words of the participants. The chapters which follow then, bring alive the lived experiences of the participants of this research. Participant voices are therefore situated at the centre of the discussion and are presented using the emic and etic perspectives.

Chapter 4: The Cultural Milieu

The following chapters will extrapolate the findings discussed in the previous chapter by privileging the participants' perspective and articulating this with comment from the literature. Chapter two of this thesis revealed that ethnography is not a specific method of data collection, but a style of research devoted to the richly descriptive study of cultures with the principle objective being to understand the activities and meanings of a social group (Brewer 2000; Creswell 1998). Ethnography, as a methodology, enables a rigorous process of investigating and understanding cultures. As this approach underpins this research design, the cultural milieu that defines the discipline areas of the two groups of nurses in question and the complex interplay of the factors identified in the findings, emerged as a central construct. The cultural milieu was found to have a profound influence on the practice of each nursing discipline and on the relationship that exists between them. This chapter then, begins a deep examination of the findings with a commentary on the cultural identities of ED and mental health nurses.

Leininger (1994) describes nursing culture as something that is learned and transmitted; involving lifeways, values, symbols, patterns, and normative practices such as triage and assessment and the provision of nursing care, of members of the nursing profession. Both the ED triage nurses and mental health triage nurses participate in their own culturally constructed normative practices. These define their nursing approach. The normative practices of both groups of nurses are discussed later in

this chapter as a means of illuminating the cultural differences between the two groups.

Culture is also influenced by context. This is important for this research as a contextual examination is unavoidable when considering the myriad of elements that combine to fashion an understanding of culture (Kaminski 2006). Nursing, its art and craft, is carried out in a context of highly bureaucratised organisations. These institutions both govern and implement health care that determines clinicians' way/s of thinking. This cognitive shaping is done via policies and procedure and by rules and regulations (Hunt 2004). These shape the stimuli and experiences to which clinicians are exposed (Gifford, Zammuto & Goodman 2002). This shaping becomes the context in which the clinicians practice.

4.1 Mental health triage nursing practice – the cultural milieu

Contemporary mental health nursing has matured from the days when treatment was custodial rather than caring (Happell et al. 2008). Historically mental health nurses were men who were required to work as supervisors within environments were people with 'bad blood' were incarcerated (Singh et al. 2007). During this time mental health nurses were not considered to have a therapeutic or caring role other than to provide basic care (Happell et al. 2008). As the understanding of psychiatry grew, so did the approach to the care and treatment of clients with a mental illness (Moxham, Robson & Pegg 2010). Consequently, clients were moved from prisons to asylums and female attendants were considered for the first time in the 1900s (Keane 1987). The 1950s saw

enormous changes in treatments particularly with the introduction of major tranquillisers and it was about this time that psychiatric nurses began to form therapeutic relationships with clients (Cade 1979). By the 1980s the large mental hospitals (asylums) were closing down and, via the process of deinstitutionalization and as described in chapter one, the care of clients with a mental illness was largely mainstreamed.

In comparison to their general nursing colleagues, mental health nurses practice in environments that are much less technical than those where clients with physical injury and illness are treated (Happell et al. 2008). Specifically, acute psychiatric units are designed to promote both physical safety and emotional wellbeing. There are no obvious electrocardiograph machines, suction units and other apparel of general hospitals. Instead, acute mental health units are often places of fairly low stimulus and within them staff are less intrusive while maintaining a watchful presence. Activities such as relaxation groups, cooking and exercise classes are often held (Barkway 2009).

Mental health triage nurses though practice in a variety of settings. These include community settings that are often near to an acute inpatient unit. These nurses are also occasionally called upon to attend the ED (Grigg et al. 2004; Sands 2004). Their nursing practice is principally conducted in environments that are culturally sympathetic to the mental health therapeutic milieu (Barkway 2009) which is couched in the notion of the therapeutic use of self and is founded in the framework of recovery oriented practice. In this study, the mental health triage

nurse participants were collocated next to the acute inpatient unit. This enabled them to spend the majority of their time in an environment staffed with other mental health colleagues and within a practice environment that they both understood and felt comfortable within.

For mental health nurses the essence of contemporary practice, or the act of caring, is not illuminated by the psychomotor tasks that mental health nurses do, rather, their practice is underpinned by the relationships they form (Elsom 2007). Therapeutic relationships are the central construct to their practice and it is this construct that differentiates mental health nursing from other areas of nursing practice (Happell et al. 2008; Jackson & O'Brien 2009). Wright (2010) describes therapeutic relationships as the shared understanding of the aims and expectations of both clinician and client. The mechanism that underpins the development of the therapeutic relationship is the therapeutic manner in which the mental health nurse conducts themselves during the interaction with the clients. This therapeutic conduct during the interaction is known as the therapeutic use of self (Jackson & O'Brien 2009) and is part of the normative practice as described earlier by Leininger (1994) that, in part, shapes the culture of mental health nursing.

The context of mental health nursing is equally important when considering the culture of mental health nursing. The framework of recovery-orientated practice is currently accepted as the dominant policy approach to the care of clients with a mental illness within Australia

(Australian Health Ministers 2009; Stanton & Tooth 2009). Mental health nurses have generally embraced recovery as a therapeutic tool with the therapeutic relationship at its centre (Happell 2010). Recovery, which is consumer focused rather than service driven, places an emphasis on client self-determination. This is achieved through appreciating the need to help oneself, to develop inherent self value through interactions with others, to manage symptoms and to develop optimism and connect with one's individual spirituality (Stanton & Tooth 2009). Recovery is not a cure, it is a journey and it is the role of the mental health nurse and the mental health service to promote rather than hinder these values (Stanton & Tooth 2009). It is from this position, this set of knowledge's and context that mental health nurses practice.

Mental health triage nursing is a specialist role within mental health nursing and as such should reflect the general practice of mental health nurses as described. However, the extent to which mental health triage nurses articulate the principles of recovery into their practice is largely unknown as the role of the mental health triage nurse lacks formal definition and description (Sands 2007). Sands (2007) conducted a doctoral study of mental health triage nurses in Victoria, Australia and this remains the only study of its kind that could be found, which describes the function of mental health triage nurses. Sands (2007) found that half of the mental health triage nurses cited unclear or inappropriate models that underpinned their practice, thereby indicating low levels of knowledge of the theoretical realms of mental health triage practice. Two reasons were cited for this: a lack of preexisting research

in the area and that only one third of the participants had any education or training relevant to the challenges of mental health triage.

As a result of this study Sands (2007) developed a model of mental health triage practice that assists with defining the core philosophical underpinning of practice. Central to the model of mental health triage nursing practice is the concept of caring. As described earlier, caring manifests itself as the therapeutic relationship between client and nurse and the nurse's ability to act as a therapeutic tool. While the role of the mental health triage nurse encompasses much more in the way of advocacy, knowledge and skills, equity and access and legalities (Sands 2007), the role should be underpinned by an approach that is inherent within mental health nursing practice in general (Jackson & O'Brien 2009).

4.2 Emergency triage nursing practice – the cultural milieu

Emergency nursing is distinguishable from other specialties in nursing in that it involves the care of clients who are usually undiagnosed and are so unwell that they seek emergency care. Emergency nurses provide acute, short term, episodic care (Johnson & Wilson 2007). Triage is a key role of the emergency nurse and is central to the role of the emergency nurse in organising emergency health care (Johnson & Wilson 2007).

The use of emergency department nurses adopting triage as part of their role in Australia was first described during the mid 1970s at the Box Hill Hospital, Victoria. It was here that senior emergency nurses were allocated to the role of triage in order to emphasise the importance and necessity of organising the whole department. This occurred as the first five-tiered emergency triage scale was being developed and implemented also at Box Hill Hospital in order to maximize departmental efficiency and improve client care (Brentnall 1997). Senior nurses are specifically selected as the triage nurse as this role requires a qualified and experienced Registered Nurse who maintains clinical expertise in emergency nursing (College of Emergency Nursing Australasia 2007a). The College of Emergency Nursing Australasia describes the triage role as being autonomous and essential to client safety. The triage nurse must also have the ability to think critically in an environment where information is often limited, incomplete or ambiguous (College of Emergency Nursing Australasia 2007a).

Emergency Departments are areas of high activity, tension and emotion and as the triage nurse is the first point of contact for nearly all clients presenting to the ED they are central to all of this high-pressured activity. Triage nurses practise in clinical environments that are visible to, and immediately accessible by the public and by many other staff members from within the hospital environment. EDs are busy places and as such they are usually well sign posted to make them as visible as possible, must be equipped with duress alarms for safety, have numerous pieces of emergency equipment and should facilitate client privacy

(Australasian College For Emergency Medicine 2006). It is recommended that the triage area be in close proximity to the acute treatment areas and to the resuscitation areas of the ED. The triage area should be designed to allow the triage nurse to carry out their role as part of the overall provision of emergency care with maximum efficiency.

Within this complex and busy environment, the triage nurse engages in a role that, at its simplest, requires them to deliver the correct clients to the correct place at the correct time; with the goal being that the client receives optimal care (Johnson, D. & Wilson 2007). This sounds like a simple process, but in a complicated ED environment, it is easier said than done. In order to achieve the goal and to standardise clinical decisions, triage nurses use the Australasian Triage Scale (Appendix 1). This national scale is based on principles of justice and efficiency (Australian Government 2007). Triage scales were developed to ensure that valuable health resources are used to provide the greatest benefit to the neediest (Johnson, D. & Wilson 2007). While emergency nursing has at its centre a holistic approach to client care (Johnson, D. & Wilson 2007), triage, by its very nature, is a brief clinical assessment lasting no more than two to five minutes. Triage as a process, assists the nurse to determine how long a client can wait for medical care (clinical urgency) via application of an appropriate triage scale that reflects urgency (Australasian College For Emergency Medicine 2005). As stated, the triage nurse practices in a highly structured, but often chaotic environment. Their role is well described and has at its core a central

purpose, that is, is to determine acuity. This process is the normative practice of triage nursing.

The discourse above is an important part of ethnographic research regarding the cultural settings that the ED triage nurses and mental health nurses have evolved from, and work within. The discussion demonstrates the key differences in the therapeutic perspectives and practice environments of the two groups under investigation in this research. It is with this understanding and framed by the knowledge of the unique nature of these two culturally disparate groups, that a deeper discussion of the findings of this research can now be undertaken.

Chapter 5: The Practice Environment

As outlined in the findings chapter the two clinical services (ED triage and mental health triage) were geographically separate. Co-located on the same city block the mental health triage service operated from a separate building to that of the ED. Located within the ED, however, is a separate mental health assessment room and mental health office. These spaces were specifically designed for use by the mental health triage staff. Despite these rooms being situated within the actual ED, the mental health triage staff conducted their service *to* the ED rather than *within* the ED. The mental health service was about a ten-minute walk.

5.1 Proximity and geography

Emergency department and mental health triage nurse participants expressed different views about the locale of the services. It was acknowledged by some ED triage nurses that the mental health triage nurses do have other and often competing responsibilities. This, thought some of the ED triage nurses, necessitated them being located away from the department. The following conversation from an ED triage nurse participant reflects this:

P: "… they have got the mental health room [in the ED], but you wouldn't expect them to spend all their time there. So they have got work to do over there, so a lot of the time that distance makes it a bit frustrating as well…" (ED 13)

Another participant though, indicated that as the mental health triage nurses' role was principally in the ED, the mental health triage nurses should be based there:

P: "Because they're not really needed as a triage person physically over there, they're needed as a triage person physically here and yes it would make life a huge amount easier if they were here". (ED 28)

ED triage nurses articulated a variety of reasons why they perceived the issue of not having the services co-located as problematic. This will be discussed later within the themes of collegiate presence and roles and scope of practice.

Ethnography is investigative and the researcher observed that as part of their practice ED triage nurses drew on a variety of resources to aid their decision-making. Human resources included security personnel, wardsmen, physiotherapists, ambulance officers, police, radiologists, social workers or they may have a quick consultation with an ED medical officer to clarify clinical questions. Non-personnel resources included ice packs and medication, and equipment such as pillows and blankets, stethoscopes, first aid supplies and vital sign machines. Accessing these resources as quickly as possible was necessary so that they could complete their triage decision-making and efficiently manage the waiting room. This amount of equipment and 'traffic' made the environment very busy. It was also observed that ED triage nurses perceived the mental health triage nurse to be a resource and were comforted by the notion of them being accessible:

P: "…they are technically; they are like a resource that is out of the department because of that geography." (ED 13)

P: "Even when there wasn't patients here for him, he'd come and have his tea down with us and I think we just, it felt better that he was around in case we needed him to see a patient or [something like] that. We knew he was accessible." (ED 38)

Although some ED triage nurse participants identified that distance impacted negatively, a mental health triage nurse participant thought that it could also be seen as positive:

P: "No, I don't think it does, actually. I mean, the separation between medical and psych has always been there. Whether you walk 400 steps, or 50 steps, or 10 steps, I don't think that really makes a, I don't perceive that makes that much of a difference. They don't necessarily need to know physically where we are. The majority of those, of triage staff in ED, or sorry, or even nursing staff in ED, wouldn't know where… Centre was. It's over there, somewhere. They don't really need to know that. What I think is valuable, is that 400 steps, on more than one occasion, has given me some clear thinking space. Like I, you walk out of the ED, it's a nice temperature, you walk out into, especially on nights or late evening, it's nice and cool, and it sort of wakes you up, and then you can think without all the pressures of ED around you. And you might come up with a different formula for what you're going to do with a patient, or how soon you'll go back and re triage, and how soon you'll touch base, whatever. I don't think, I don't think the locations a problem. Because

we've got, if we want to, I don't know whether… has an opinion about this, but if we want to, we don't have to even come near here during the shift. We've got our office and our interview space. We could go and spend the whole time over there, I suppose. That was quite possibly an intention when it was built like that." (MH 20)

Although acknowledging the potential for the mental health triage nurses to be located in the ED the participant above described the value of distance and contextualised this in the notion of facilitating clinical reflexivity. The following figure is representative of how the ED triage participants and mental health triage nurses as distinct cultural groups viewed proximity and geography.

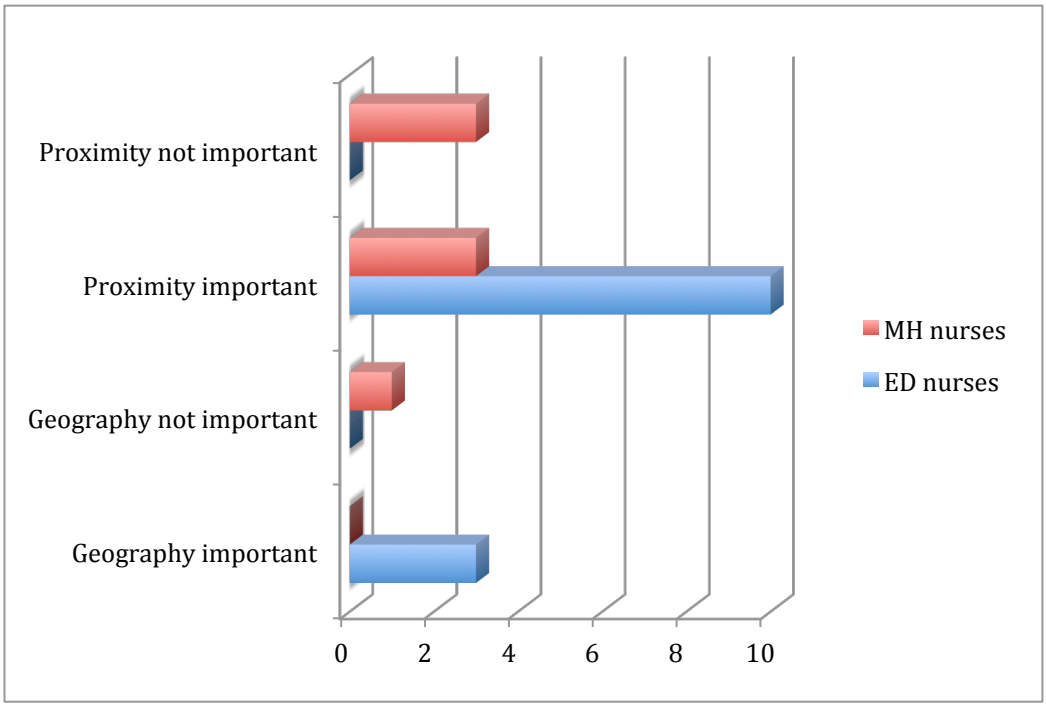

Figure 2: Perspectives of geography and proximity of ED and mental health triage nurses

Alternate perspectives such as those outlined above may contribute to tension but are indicative of the key differences in the roles and theoretical underpinnings of the two groups. The difference is 'the time imperative', vital in the ED, but not so often in mental health nursing. The decision making process for ED triage nurses must occur within minutes whereas the mental health triage process is a longer one. The latter involves reflection, discussion and negotiation with the client (Broadbent, Jarman & Berk 2004).

5.2 Isolation

Despite being the access point for the ED and designed in such a way as to have full view of the waiting room. ED triage nurse participants described the triage desk as being isolated. Even though the ED triage nurses were observed to interact with clerical staff, the general public and other ED staff at a sometimes frenetic pace, the ED triage nurse is rarely alone. They do though feel separated from internal departmental resources:

P: "Triage is actually a little bit a walk even from the main department. It is not huge, but you are looking at 10 or 15 meters and so just to get to a DD cupboard to get pain relief, you can be quite isolated out at triage… given that resource is all the way over at the other side of … [the department]" (ED 13)

This isolation or sense of separation, was felt more acutely during the night shift:

P: "And particularly nights and stuff, it is hard because you are a bit isolated and if things are going down you really need to be on your toes about it because …you are isolated behind a desk." (ED 13)

This sense of isolation is consistent with the findings of Gerdtz and Bucknall (1999) and Fry (2004) who found that ED triage nurses felt isolated and that often the physical organisation of the triage area contributed to its physically separation from other ED resources.

5.3 Managing waiting clients

Emergency department waiting rooms are places that clients who have been triaged as having low acuity illness or injury sit. They are often accompanied by family and or friends. Clients in the waiting room remain the responsibility of the ED triage nurse, until a health practitioner consults them. The general public, family and friends also remain the responsibility of the triage nurse until such time as they leave the waiting room. The ED waiting room under observation for this ethnographic research, was in a constant state of flux:

1600hrs – ED triage – large area – noisy – no sound attenuating tiles in the roof that means noise escalates easily. (FN)

The impact of the architectural design of this waiting room was that it is noisy and had many distractions. This is considered to be a less than optimal environment for clients with a mental illness to wait. One ED triage nurse participant commented:

P: "I don't think anyone with a mental health issue though is well cared for in a big waiting room with lots of people in it, where you're talking to them through glass, where you haven't got facilities where it is warm and cosy. It's a very open area, with everyone in their eyes…" (ED30)

As discussed earlier the ED triage staff previously had access to a second waiting room. This room was now lost to them as a result of the redevelopment of the ED. This second waiting room had been separate but clients within this waiting room were visible from the ED triage desk, by virtue of a glass door. This had been the waiting room of choice for clients with a mental illness. In order to compensate for the loss of this waiting room, clients with a mental illness were being placed in the mental health assessment room. This contravened a directive but was felt to be clinically necessary. The lack of a dedicated waiting area created tension and the directive was considered unhelpful:

P: "And that directive came from psych apparently because its our understanding that we'd be happy [to use the assessment room]… there's nothing there they can hurt themselves with, they can't get in and out so I'd be happy to leave patients there but mental health refuse. So then where do you put these patients? They sit in the waiting room being

disruptive or they sit in the back of a divvy van or their face planted on the concrete outside the ambulance bay, I mean it's not ideal." (ED 11)

This comment demonstrates operational issues ED triage participants perceive important when managing clients who have a mental illness and are waiting to be seen. This seemingly insignificant issue provides an insight into the cultural differences between the two groups. A mental health triage nurse who appears supportive of mainstreaming and non-segregation offered the following:

P: "So they [the clients] need to be kept in the waiting room. And yeah I think it has created some angst but I don't think that's a bad thing. I think that people, you know, need to start to think about the fact that mental illness is a real part of our society and that we need to, you know, just get comfortable with that in our own minds. You know because anybody who we're sitting next to could be suffering in some way psychologically." (MH 25)

Conversely, a different mental health nurse identified that allowing clients to wait in the assessment room was sometimes problematic. This participant said it complicated the assessment of other clients by having to find somewhere else to conduct the assessment. This was exacerbated, as the assessment room in the newly built ED was no longer under continual visual surveillance.

Observations conducted in the field for this research identified that the ED triage nurses felt it was imperative to find a private space for this client group. The provision of private space is regarded as an everyday part of nursing and in areas like emergency departments is seen as an essential skill (Andrews & Shaw 2008). Andrews and Shaw (2008, p. 471) argue that nurses can be the vehicles for the construction of therapeutic landscapes that are 'psychologically associated with restoration, rejuvenation and wellbeing' and are intentionally created by nurses as part of therapeutic practice. The desire by ED triage nurses to find a space for clients with a mental illness in which to comfortably wait was driven by a desire for safety and privacy, not only for the client, but also for the remainder of the people in the waiting room. Such concerns are exacerbated if the police bring in clients:

P: "Even if they're not settled it's [the assessment room] a place where the police don't have to sit holding their hand with the general public in full view. And it's got no distractions either; It's one of those rooms that's just very plain, [so the] mental health patient, if they're a bit manic or so forth it's not going to give them and distractions. It's safe, they can't hurt themselves… In the waiting room they abscond, other patients criticise them, security are yelling at them. It's not comforting and reassuring for the patient or their family." (ED 11)

Another ED triage nurse described the family of a young boy who presented with behavioral disturbances and a co-morbid mental illness. The family was distraught and to make matters worse the ED was full. This particular client required a low stimulus environment in order for them to settle. This then allowed an assessment to be undertaken, something that could not occur until the youth was settled. The following dialogue highlights the ED triage nurses' positive regard for quiet space:

P: "He's comfortable in there. He's comfortable and quietens down. It was quiet. Waiting room was totally inappropriate for him. It was nice and everything." (ED 19)

In both these cases the well being of the client and family was of primary concern to the ED nurses and was driven by the desire to provide a therapeutic environment. This approach, they felt was in the best interests of the clients and by default facilitated effective management of the dynamics of the waiting room. Providing a quiet and safe place for clients who may be distressed, exhibiting signs of agitation or who are in a situation that is best not observed by the general public, such as a client with a police escort, can be seen as an act of caring. Strathmann and Hay (2009) argue that an ED triage nurse helping clients to feel calm and assured thus demonstrating that, although not yet seen by a doctor, the 'caring' has commenced. ED triage nurses provide care for clients with physical illness and injury and feel comfortable doing this. At times they will consult with medical staff. ED triage nurse participants in this research identified that they feel as though they do not have the

nursing experience or specialist knowledge to provide mental health care. Exacerbating this was the fact that the mental health triage nurses are geographically distant and cannot easily be consulted. They felt then, that the only care they could provide for a client with a mental illness was a quiet, safe space. ED nurses found it distressing they could not provide such a therapeutic milieu.

One mental health triage nurse acknowledged the caring intent of providing a quiet private place. They did wonder though that sometimes it may be used as a way of 'getting rid' of clients that may disturb the waiting room. This response, although with a different intent, indicates the necessity to 'manage' the waiting area:

P: "I think there's a kindness. Probably to maintain a bit of dignity and to give a bit of privacy. I think I'm sure the reason for doing that [is] probably just about always out of kindness to the client. I think however it can also be about disruption to the waiting room you know? People who look like or who already have proven themselves to be difficult in the waiting room to be upsetting to other people perhaps or agitated or whatever are going into the assessment room." (MH 17)

Provision of a private, safe and quiet area to wait that is visible from the ED triage area therefore needs to be considered in ED design. This ensures everyone's wellbeing is considered.

The principles of visibility and surveillance are critically important to the ED triage process. The mental health triage scale (Appendix 1) which is used by the ED triage nurses in this service, but is not in use routinely around Australia, to assess clients presenting with a mental illness mandates that clients triaged into category one or two, must undergo continuous visual surveillance, and that those triaged into category three must be closely supervised. Clients who are allocated categories one to three are likely to be those people who have been brought in by police, are disturbed, possibly aggressive, agitated and may be exhibiting bizarre behavior. Typically, it is this client group that the ED triage nurse would want to provide a quiet safe space. However, by doing so, and using the assessment room, they are violating the general principles of mental illness management explicit within the mental health triage scale (Appendix 1), and by putting them in the assessment room, they are not under constant surveillance as ED management principles dictate.

Stigma was raised by both participant groups in relation to the management of waiting clients. Link and Phelan (2001) describe stigma as having four elements (1) the identification and labeling of a difference in personality or behavior; (2) stereotyping: the association of this difference with a negative stereotype i.e. clients with a mental illness are dangerous; (3) separation, ‘us versus them’, the classification of those negatively labeled people as being different; and (4) status loss and discrimination resulting from the three preceding elements. Given that that there is an increasing body of evidence that shows there is widespread stigma and discrimination towards people with a mental

illness (Bjorkman, Angelman & Jonsson 2008; Thoits 2011) it is not surprising that this emerged in the discussions around the management of waiting clients.

One of the mental health nurse participants articulated how they felt stigma is perpetuated by separating 'some' clients:

P: "And my point you know about that has always been but we don't want people segregated. We don't want them treated any differently. You know if someone's emotionally distressed then that needs to be relayed to us so that we can respond to them more quickly so they don't have to be distressed in front of other people. But we don't want people with a mental illness pushed away into a dark corner so that the general communities aren't subjected to it. Mental health is a huge issue that affects everybody and it should be seen that way…they're part of the community. They're people. They're people." (MH 25)

This impassioned plea is not surprising. By separating clients with a mental illness this mental health triage nurse participant felt that stigma was reinforced by treating this client group as different. This perspective resonates with the last two elements of stigma as described earlier by Link and Phelan (2001). The following conversation with some ED triage nurses provides a different perspective:

P1: "Its not the fact that they're mentally ill it's the fact that they are disruptive to everyone else in the waiting room and they take a lot of time, you've got to call the police, you've got to find security… sit with them… you've got to remove children from their vicinity."

P2: "Because you're trying to provide that safe environment for the other patients."

P1: "… Its really hard to talk to them sometimes when they're manic and you just can't get through to them they don't understand."

P3: "There's no reasoning."

P1: "And have the public perceive them as well has a negative impact on a mental health patient because if they perceive somebody to be mentally unwell and harassing other patients in the waiting room the public perceive that as…"

P2: "it gives them a bad name."

P3: "Yeah, it's not good for that either." (ED 11)

These participants felt that exposure to the general public of clients whose behaviour is potentially harmful or disruptive reinforces negative stereotyping of people with a mental illness and further stigmatises this already vulnerable client group. As with those offered by the mental health triage nurses, ED triage nurses opinions are influenced by their need to ensure client safety and the pragmatic demands of managing a usually full waiting room. These comments by the ED triage nurse participants reflect a desire to reduce stigma by addressing the first two elements of stigma as described previously by Link and Phelan (2001). Although the ED and mental health triage nurse participants had differing

perspectives on how waiting clients should be managed, both were intent on the same outcome, that is: reducing stigma. As this research has demonstrated, cultural differences and perspectives influence practice. Both the perspectives reflect the general principles of social inclusion as described in the Fourth National Mental Health Plan (Australian Health Ministers 2009). This principle requires the removal of stigma and negative public attitudes in health settings. However Figure 3, is representative of the emphasis the two disparate groups placed on issues such as aggression, client privacy, client safety, protection of the public, security and stigma, everyday practical concerns about the management of waiting clients is an issue for the ED triage nurses. The mental health triage nurses also reflected these concerns. It is only in the discussion around stigma that mental health triage nurses raise more discussion than ED triage nurses, again reflecting difference that is embedded in their own culture of practice, practice environment and professional knowledge.

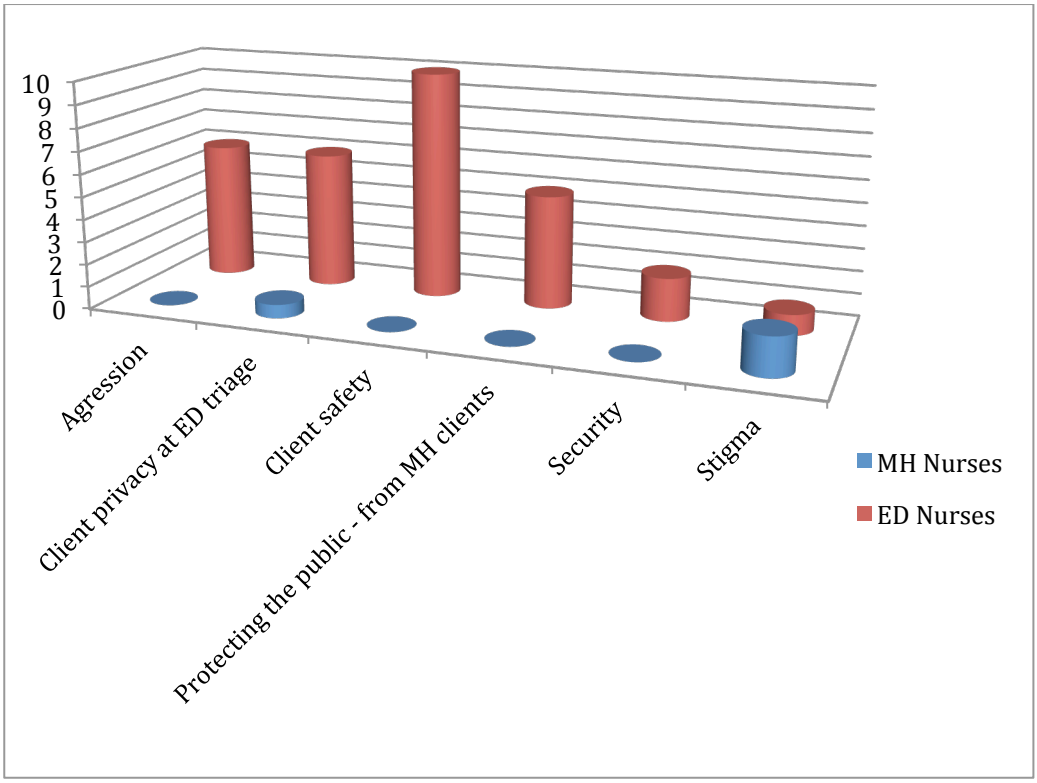

Figure 3: Concerns expressed by ED versus mental health triage nurses in relation to issues associated with the management of waiting clients

The discussion above highlights how the practice environment impacts on the relationship between the two groups. The nature of the work undertaken by each group and their experience and expertise in managing and treating clients who have a mental illness, reflects their different needs in respect of proximity. ED triage nurses work in an environment where they need to access human and capital resources quickly in order to facilitate their decision-making and to manage increasingly busy waiting rooms. Tensions arise when the architectural design of an ED affects care. This notion is supported by recent studies that reveal much of the built environment in health care disrupts effective communication thereby increasing staff and client stress (Foureur et al. 2010). Understanding of the impact of the practice environment as the

above discussion has provided, facilitates an examination of the next key theme: the process of assessment, referral and response.

Chapter 6: Process

6.1 Assessment

The practice environment has a direct influence on the relationship between ED and mental health triage nurses due to its impact on the process that lies at the heart of the relationship, that is, the collection of data for the determination of acuity. As described in the findings chapter, privacy was identified by the ED triage nurses as being a significant factor, particularly for clients who had a mental illness, inhibiting the collection of triage data:

P: "It makes it very hard to make an assessment in two or three minutes when you can't extract the information that they'd give you if you were in a room just with one more other person than them. Which makes it very hard for us to give them the appropriate mental health triage category and medical category as well. I think that's probably our biggest issue, is how we triage them because of the facilities that we've got." (ED38)

The previous chapter, which examined the ED triage environment, provides a point of reference for this comment. The ED triage area is an open public space that places considerable constraints on the ability to gather the information that is necessary for informed ED triage decision-making. ED triage nurses made it overtly clear that the lack of privacy was not just isolated to the fact that the client may be in a waiting room full of people, but that the ED triage nurses were sensitive to the fact that:

P: "Even within our side of the wall. The lack of privacy for that patient…" (ED 19)

The ED triage area is, as previously noted, a place where staff like wardsmen, clerks and ambulance officers often gather. Large amounts of staff gathering in one area can be problematic. The following field notes demonstrates this issue:

I'd hate to hear people speaking about me, there are 'multiple pairs of ears' – ambo, ward clerks, cleaners – [and this] compromises the transfer of information. (FN)

ED triage nurse participants concern about the impact that the triage assessment has on the client and how sensitive they needed to be, particularly due to the lack of privacy. They linked these to potentially poor client outcomes:

P: "I find that, you don't know how much you can ask about without them going off or walking out or so you've got to be very sensitive sometimes." (ED 19)

ED triage design is principally governed by two documents, the Policy on The Australasian Triage Scale (Australasian College For Emergency Medicine 2006) and the Position Statement Triage Nurse (College of Emergency Nursing Australasia 2007a). These documents recommend a variety of environmental considerations in relation to ED triage design. The document from the Australasian College of Emergency Medicine identifies that triage:

> …must be immediately accessible and clearly sign-posted. Its size and design must allow for patient examination, privacy and visual access to the entrance and waiting areas, as well as for staff security (Australasian College For Emergency Medicine 2006, p. 2).

The use of the word *must* in this context is important as it implies that the elements outlined above are mandatory. The document also identifies that there *should* be a range of facilities available within a triage area. These include emergency equipment, telephones and duress alarms. Therefore *should* implies that these facilities are desirable but not mandatory. The other policy document from the College of Emergency Nursing Australasia, lists six points necessary for ED triage design. The importance of the first five is also demonstrated by being prefixed with the word *must*. The five provisions are

- accessibility
- access to examination areas
- provision of equipment
- infection control measures and
- must be safe for staff and clients

The sixth consideration is prefixed by the word *should* and relates to the environment facilitating privacy for clients (College of Emergency Nursing Australasia 2007a). The fact that privacy concerns are *should*, and not *must* is surprising given the centrality of privacy and confidentiality to nursing practice (Nayeri & Aghajani 2010). Given the importance of the triage role to the function, efficacy, management and

workload of the ED there is a paucity of literature that critiques the architectural design surrounding the design of triage areas in emergency departments, and what little literature there is, concerns itself with general redesign occupancy of a new ED as described by Virtue (2009) and Flanagan and Haas (2005) or the redesign of emergency departments to improve client flow and ED processes such as the work of Spaite et al (2002). The issue of privacy is not just confined to the dealings of clients with a mental illness at triage. During the course of the data collection, an ED triage nurse suggested that privacy was an issue with all clients. The following data was gathered as part of a focus group interview conducted with a group of ED triage nurse participants:

P1: "Which is hard when there's no confidentiality at triage. At our triage…"

P2: "Yeah."

P1: "…there's nothing."

P3: "Yep."

P1: "…for anybody. So that makes it really hard for someone to open up and hard sometimes for you to listen, because this person's, you know, trying to give you some, you know, confidential and personal information and there's people standing right behind them. So yeah. That's why I'd like to be able to take them away and have a private conversation with them.

R: "Are those issues the same for people with physical illness and injury?" [general agreement amongst the participants]

P1: "There's no confidentiality there." (ED 22)

That the triage area was noted to lack any opportunities for privacy during the initial triage process indicating that triage design may be predicated on factors that put safety and functionality above the need for privacy. Yet the principal function of triage, is to obtain sometimes deeply personal and private information rapidly. In order to do this privacy needs to be considered equally with that of functionality and safety.

In their paper on decision making at triage Gerdtz and Bucknall (2001) identified both client and environmental factors that affect triage decision making. Environmental factors such as the frequency of interruptions, whether the client's arrival was expected or not and whether there were other clients waiting to be triaged were included in the list of environmental variables. Client factors included mode of arrival (ambulance, walk in, via the police), English or non-English speaking, mobility, injury and acuity. Factors such as privacy and the presence of a client with a mental illness were not amongst the variables considered in their study. This presents another example of the distinct lack of research regarding clients who have a mental illness and emergency departments. Andersson et al. (2006), in their research discuss the triage work environment and identify practical arrangements as having an influence on decision making. Their research focuses on arrangements needed to facilitate the triage of paediatric clients or clients with intellectual disability or those arriving with a police escort. Clients with a mental illness were, however, not focused on. Fry (2004) briefly mentions privacy as an issue in her thesis on triage however it is

not a pervasive theme in her discussions or recommendations. The significance that the participants in this ED placed on the triaging of clients with a mental illness and its lack of presence within the literature suggests that little research has been conducted into privacy and confidentiality at triage. This is especially so for clients who have a mental illness.

An appropriately trained and experienced Registered Nurse must assess all clients presenting to Australian Emergency departments and the assessment and triage category should be recorded (Australasian College For Emergency Medicine 2006). For clients with a mental illness who present to the ED that is the subject of this research, their triage assessment will be undertaken using the mental health triage scale (MHTS) that has been in place in this ED for seven years (Appendix 1). As alluded to previously though, despite this specialised triage scale being available, not all EDs use it. The following mental health triage nurse participants offered the following regarding the MHTS:

P: "I think it's an improvement on our system that wasn't there before. I guess it helps with some consistency and delivery of care from the ED starting there… Yeah, I think it's great for servicing the mental health public, I think it's fantastic." (MH 12)

The value of the MHTS as a tool for assessing clients was also identified by ED triage nurses. The following comments reflect opinions:

P2: "…you know mental health is not our strong point, but we've got great discriminators to work off."
P1: "Yeah."
P2: "Triage everyone into a set category for our best practice and their [the clients] safety…" (ED 29)

These comments are consistent with the finding of Broadbent, Jarman and Berk (2002) and earlier of Smart, Pollard and Walpole (1999) who found that the use of a MHTS improved the confidence and competence of ED triage nurses when triaging clients with a mental illness. However, despite the use of a MHTS, and in contrast to the findings described above, some of the ED triage nurses described a lack of confidence in decision making due to an inability to contextualise the client's presentation into what is often a known outcome. The following comment from an ED triage nurse describes how prior knowledge and expected outcomes affects triage decision-making:

P: "Thinking again with medical patients I do have in the back of my mind the outcome. I do think well okay this is going to need this and this and they'll probably end up with such and such." (ED 19)

Another ED triage nurse describes how they use general nursing knowledge to help frame their triage decision-making but how the lack of knowledge of mental illness means they have no frame of reference for determining possible outcomes. This makes assessing the acuity of the client's presentation difficult:

P: "…I don't have the knowledge in psych illness to be able to know the difference between certain conditions and all I can do is describe the presentation… And I just feel that with a medical patient there is more that you can access. You can take a set of obs and you can I suppose draw on history and certain classic symptoms… Whereas with psych, I guess I don't know enough about what to ask and what is significant about what they tell me." (ED 15)

Another ED triage nurse participant describes the similar impact their lack of knowledge about mental illness has on their triage decision-making:

P: "… with a medical patient there are things you pick up on. They've got this pain, they've taken this drug, they've done this, they've seen this person. Its all good information. With your psych patient [your] kind of guessing. Exactly. Yeah I mean you've used their words… and when I pass that information to the psych triage I, it kind of feels half assed. I mean it's all I can say, well this is what they've done." (ED 19)

Experience gained from exposure to clinical events is an important source of knowledge in nursing (Considine, Botti & Thomas 2007) and past experience is also reported to be influential in time critical decision making (Patel, Kaufman & Arocha 2001). However, studies have shown that years of experience do not improve triage decision-making and that there is very little difference in the triage decisions of less experienced triage nurses to their more experienced counterparts (Considine, Botti & Thomas 2007; Gerdtz & Bucknall 2001; Goransson, Fonteyn & Ehrenberg 2008). This notion is reflected in the fact that, while no specific demographic data was gathered about participants of this study, they represented a mix of triage experience in terms of years at triage. It was commonly reported in interviews that these participants had difficulty making triage decisions for clients who have a mental illness.

Contemporary work on decision-making identifies that decision models can be normative, prescriptive or descriptive. Bond and Cooper (2006) identify that normative models describe how decisions should be made. Prescriptive models also describe how decisions should be made but take a more positivist view based on decision analysis such as computer models and descriptive models use a more interpretive or naturalistic perspective on how decisions are made. It is the descriptive or naturalistic decision-making domain that ED triage nurses work within.

Elstein (2001) contends that naturalistic decision makers are proficient decision makers with experience in their domain. Conversely they can lack proficiency without experience. The context of decision-making tends to be characterised by high levels of uncertainty, with shifting

goals, time constraints and high stakes; characteristics that are inherent in the ED triage process. Thompson and Dowling (2002) suggest naturalistic decision models include heuristics which are rules of thumb or probability judgements that may be thought of as understandings without rationale. Another way of conceptualising this notion is intuition (Bond & Cooper 2006). Bond and Cooper (2006) suggest that intuition includes reasoning, comparison of information to other encounters, ease of recall of similar encounters for anchoring and adjustment where the decision is adjusted when new information comes to light. Leprohon and Patel (1995) suggest Heuristic principles are being central to decision-making in urgent telephone triage situations and are similarly evident in ED triage decision-making.

Therefore, triage experience measured in time alone, is a poor determinant for confident decision-making, but previous exposure and experiences do have a positive influence of the decision making ability of ED triage nurses (Andersson, Omberg & Svedlund 2006; Chung 2005; Cone & Murray 2002). The importance of previous experiences is that they provide tacit knowledge that allows us to know what we are doing without much thought (Jordi 2011). Handysides (1996) suggests that an effective triage nurse should have both a comprehensive knowledge of serious injury and illness that can be measured against the descriptors of a triage scale, and intuition developed through long time experience of nursing care. This need for clinical experience as a tool to assist in decision-making is reflected in the following comments of an ED triage nurse. This participant describes the value of feedback from the mental

health triage nurse in gaining a perspective on how understanding what went on with a client post triage and how this clinical reflection and consultation provides a reference point that can be used in the future:

P: "…Its really great when psych triage come down and they do give you feedback on somebody, you know we did admit that girl, yes she was showing this…when you delved into the background she's got this and this and she has a history as well. It's like great, thank you, and how did you pick that up? …it's really good to get that feedback because it adds to your knowledge and you know it's good." (ED 29)

Chung (2005) identified that constructive feedback from colleagues helped ED triage nurses to more effectively make triage decisions in the future. This notion is supported by Considine, Botti and Thomas (2007) who suggest that factual information remains a key influence in triage decision making. The mental health triage scale (Appendix 1) used by the ED triage nurses in this study was originally derived from the mental health triage scale developed at the South Eastern Sydney Area Health Mental Health Service in New South Wales. Incorporated in this scale are descriptors for assessing acuity that do not require specialist mental health knowledge to use (Tobin, Chen & Scott 1999). The ED triage nurse is only required to assess observed and reported behaviors to determine acuity. However, it has been shown that the gathering of this factual information such as this alone, is not enough. This is because the ED triage nurses are lacking the intuitive knowledge related to mental illness in order to contextualise the presentation as an index of acuity.

Considine, Botti and Thomas (2007) state that while factual knowledge is a key influence on triage decisions, little is known about the relationship between nursing experience and triage decisions.

The use of a mental health triage scale and prior knowledge combined with contextualisation are important components of decision making, and a correct or incorrect decision will have an impact on client outcomes as well as on workloads for the mental health triage nurse. There has been previous discussion regarding the tapestry of influences that affect ED triage nurses when making a decision, this is yet another thread.

In the following dialogue ED triage nurses highlighted time as an issue that contributed to the difficulty of triaging clients with a mental illness:

P1: "Yeah we don't have long enough to …"

P2: "Assess them properly."

P1: "Delve into their whole personal social situation."

P2: "And then they won't divulge to you and then you're running out of time because there are people still lining up behind them needing triage as well." (ED 11)

P: "Because you are asking them some personal questions and you have got a whole line of other people standing there, so you have limited time with them as well, so you basically need to be very direct and there is not much privacy out there, so you have got to take that into consideration as well." (ED 15)

The Australasian College for Emergency Medicine (2005) mandate that the triage decision should take two to five minutes and should be a balanced aim of speed and thoroughness. While this may appear to be a sufficient amount of time to conduct a brief assessment, particularly for a client with physical illness or injury, the added pressure of having a queue of undifferentiated clients waiting for assessment and the general business and complexity of the ED triage two to five minutes is not appropriate for most clients who have a mental illness and certainly not for those clients who may be agitated, disturbed or who are presenting with self harming behaviour. The following excerpts from the field notes attest to the added pressures at triage:

…the ED triage nurse must be able to see the waiting room and manage the clients in there – many verbal interruptions – doctors asking about equipment, physiotherapists asking about where they can place clients for a workup, doctors coming in with referrals from GPs who are sending clients in . No privacy, no control over work coming in (FN)

The triage desk is very busy – ambos, phone calls, doctors, physiotherapists, clients walking in – It changes minute by minute the role of the triage nurse seems to be about directing traffic as it is about assessing clients. (FN)

The following comment from one of the ED triage nurse participants provides a glimpse into the pressures at triage:

P: "You know that every person, you know that when it is busy, for every person that you take off the queue, two others are going to replace them, so you don't get too stressed about it. So you go… is there anyone there that is going to collapse in a hurry or anything like that and just go through, you know, just making sure that if it is not first come first serve. Yeah, so you are limited by your times and you sort of think, well people can change depending on who else joins the queue and what comes in on the ambulance and that, so you are sort of mindful, plus your waiting room, plus your paediatric waiting room now which is very hard to see into, so there are five things that are going through your brain, plus everything else that you have promised to do for people, but you can't get to because you just don't have the time…" (ED13)

This research has identified that the ED triage assessment of clients with a mental illness is problematic due to factors such as architecture, prior experience and understanding of mental illness as well as time and pressure.

Emergency mental health triage assessment is based on the appearance of the client, their behaviour and their conversation (Australian Government 2007). Conversation is an important part of the assessment process of people who have a mental illness given that an integral part of a mental health assessment includes thought form, thought content and thought processes (Moxham, Robson & Pegg

2010). These can only be determined by engaging the client in conversation. In addition to the above, ED triage nurses assess both observed and reported behaviour in order to determine acuity and allocate a triage category. Therefore, what the clients describe in response to the questions asked at triage compromises a large component of the assessment data collected by the ED triage nurse. The ED triage nurses articulated a range of issues surrounding this aspect of ED triage assessment for clients who had a mental illness. A common issue that the participants raised was that clients would not divulge information:

P: "And often they come and they don't want to tell you anything. That's part of their presentation, is that they are quite guarded in what they are prepared to say, so we have got limited knowledge often to make our, and it could be that your triage categories on much more on their actions than their words. It can be their eyes, it can be their breathing, it can be their pulse rate, it can be their agitation level. And that's part of the category as well. But they [the mental health triage nurses] want to know 'what have they told you?', well they haven't told me anything actually, they won't tell me anything or they've told me their name and that's it." (ED 30)

P: "It's a common presentation to say 'I want to speak to psych triage'. And to get only that, and then you just have to observe behaviour. You have a name, you have what you are seeing, and that's what you are basing your triage on". (ED30)

The inability to obtain a history commensurate with that obtained from a client with physical injury or illness means that the mental health triage assessment as described in the Emergency Triage Education Kit (Australian Government 2007) is incomplete. Some ED triage nurses also alluded to the impact of client insight and honesty as an issue:

P1: "They're not always honest with what's wrong with them. They've probably got a degree of denial about where they're mentally at."
P2: "And how forthcoming they are with the information they want to present to you." (ED 19)

Denial is described by Barkway (2009) as a defence mechanism used by clients to mitigate anxiety, principally by the blocking of information that may be painful. This in part may explain why some clients may be reluctant to divulge information, add to this a lack of privacy. A different, but recurring theme amongst the ED triage nurses that caused them frustration and may also contribute to the inability to obtain information for certain clients was the fact that the client may have already spoken to the mental health triage nurse:

P1: "Or they've just gone through the story completely with psych triage on the phone and they say to you 'Well I've just told someone', and they give you nothing."
P2: "Yeah [explaining what a client may say], 'I've presented, I've been having problems, I talked to psych triage, they told me to come in' [P2] Great so what's been happening? [Client] 'Well why don't you call them'." (ED 22)

The issue above related to clients having to repeat themselves and not wanting to, arises as a result of the nature of the service provided by the mental health triage team. The mental health triage nurses work in a service that accepts referrals from multiple sources. These include community clinics, general practitioners, families who are seeking guidance or advice about a family member or it may be the client who self presents. As such, it is not uncommon for the mental health triage nurse to have had some interaction with the client prior to them presenting at the ED. This is a model of service provision whereby the mental health triage worker acts as an intermediary access point to the mental health system (Sands 2004). So, unlike ED physicians who do not speak to clients prior to assessing, treating and discharging them into or out of the general health care system, the mental health triage nurses may have already spoken at length to a client prior to their actual presentation at the ED.

As demonstrated above, this complicates the ED triage process by making the clients unwilling to repeat themselves. The ED triage nurse is known as the gatekeeper to emergency care services and they assume that clients who present to the ED are aware of this (Edwards & Sines 2007; Fry 2004). Refusing to provide information to the ED triage nurse on the basis that they have already described their problems challenges the notion that the ED triage nurse will decide when and where a client will be seen (Edwards & Sines 2007). This can create tension between the client and the ED triage nurse and with the mental health triage

nurses who have already gathered information but may not have passed this to the ED triage nurse.

Despite evidence which suggests that the use of a mental health triage scale improves the confidence and competence of ED triage nurses in assessing clients with a mental illness (Broadbent, Jarman & Berk 2002; Smart, Pollard & Walpole 1999; Tobin, Chen & Scott 1999) some ED triage nurses articulated that 'not knowing' impacted on their ability to undertake a thorough assessment:

P: "And sometimes I'm not sure of the questions to ask either, you know I mean I can sort of go into some of their history but sometimes you're just not sure how to get the history out of them." (ED29)

P1: "Yeah I think in terms of quality of information [when] you're with a medical patient there are key things that you pick up on. They've got this pain, they've taken this drug…It's all good information. [With] you're psych patient you will…"
P2: "Just guess."
P1: "Kind of guessing yeah. Exactly." (ED19)

Uncertainty in triage decision-making, the poor design of ED triage areas, the pressure of undifferentiated clients waiting to be seen and time constraints add to the complexity of the triage process. While discussing the effect of these factors on ED triage assessment one ED triage nurse explained:

P: "To be perfectly honest, if someone comes up and directly asks to speak to mental health, I will determine a couple of things like, are you suicidal? Do you have thoughts of self-harm? But beyond that I probably won't dig any further… providing they are not a danger to themselves at the time or anyone else I would say 'Yeah go and sit in the waiting room' and I would call up [mental health triage] and it kind of makes life easier. That is being brutally honest, but…" (ED 15)

Here, thorough triage assessment is sacrificed for expediency and a desire to defer to specialist knowledge. This approach is counterintuitive to the notion that assessment of the client with a mental illness should be collaborative and that the initial assessment forms part of an ongoing accumulation of knowledge concerning the clients presentation and condition (Happell et al. 2008). Time constraints, interruptions and lack of training all influence the ED triage assessment process (Chung 2005) and that these are among many variables that can influence ED triage decision making (Gerdtz & Bucknall 2001).

It was observed during data collection in this research that the ED triage nurses and mental health triage nurses did not spend a lot of time together and that the interactions that they did have were brief. This was often due to workload demands. Despite this, the workload of the ED triage nurse and the impact this had on their ability to undertake an assessment was acknowledged by the mental health triage nurse participants. The following attests to this:

P: "In as much as triage, working at triage is a constant. Especially when you go over there [the ED] and there's a full house, and there's a queue standing at the window at the triage desk. Now in those cases I don't think they have the luxury of taking as much of a comprehensive history as they can. It's just a presenting fact. And I can understand that, when you've got people coughing and sneezing and sweating and burping behind them, I can see that they'll just take the presenting issue."
(MH 20)

ED triage is the system whereby all clients requiring care should be prioritised to ensure that the level of treatment provided is commensurate with clinical urgency (Australian Government 2007). This is the first and most important step in prioritising care, but as the above discourse related to the triage assessment has shown, for clients with a mental illness, the process is deeply flawed. The lack of privacy, pressure at triage, the inability to obtain assessment data from clients, uncertainty and lack of experience with regard to mental illness all contribute to assessments that are not as comprehensive or accurate, as they could be. The effect this has on the relationship between the ED and mental health triage nurses begins to manifest itself in the next phase of the triage process, that is, the referral.

6.2 Referral

As previously described in the findings chapter referral of clients from the ED triage nurse to the mental health triage nurse occurs in two ways. First the ED nurse enters the client's name, date of birth, presenting

complaint and triage assessment including a triage category onto the Emergency Department Information System (EDIS) (appendix 2). The mental health triage nurses have access to EDIS on the computers in their office allowing them to see in real-time when any client is triaged and are able, due to the triage assessment and 'MH' designation, to determine that the client requires a mental health assessment. However, as the mental health nurse may not always be in front of a computer, a phone call from the ED triage nurse to their mental health colleague is the 'official' mechanism for alerting the mental health triage nurse of the client, the presenting problem and assessment and the triage category that will determine the mental health triage nurse's response time.

All clients that present to ED are entered into EDIS and for clients with physical injury and illness that is the only referral mechanism from the ED triage desk to the ED physicians, nurse practitioners and allied health staff in this ED. This makes the process of a phone referral unique to the mental health triage nurses and they are dependent on this phone call being made to ensure clients are seen in the appropriate timeframe where possible. Here one ED nurse describes how during times of peak activity completing the phone call becomes problematic:

P: " …you know you need to do the ring in [referral] because they are caught up. There's a lot of time when we have two triage nurses, so one person [client] might give a story and then we just get snowed in. Ideally you would follow it through yourself but it doesn't always happen and its just the nature of the – especially with two triage nurses you can have

two queues of patients coming in from the street and ambulances at your back as well. So a lot of things can get a bit – it's not just psych stuff that can get pushed backwards, things like pain relief and stuff can get moved." (ED 13)

Occasional failure to receive phone referrals led the Mental Health Service executive to release a memo stating that no mental health response is to be initiated unless a phone referral has occurred. This has resulted in occasional instances where, despite being aware of a newly triaged client requiring assessment in the ED, due to the client appearing on EDIS, the mental health nurse would not respond until a phone call had been received and if the phone referral did not occur it has happened that the client would leave the ED without being seen. While not being a frequent problem this was a point of contention between those individuals who had experienced this situation. This was identified as a process issue getting in the way of common sense.

Having received the referral from the ED triage nurse it was then not uncommon for the mental health triage nurses to consult the clients history on the statewide database. They did this so as to elicit more information about the client prior to responding. This was part of the approved response process but could delay response times (Appendix 6). The importance of the ED triage referral and the gathering of information was reflected on by a mental health triage nurse in the following discussion:

P: "I think it probably gives you time to think about [things] even before you see the person… because we start to plan. Go into planning, you know, about what we're going to do with the person. What we're going to say. You know the types of interventions… So it starts to set the wheels in motion. The other relevant side to me is safety. You know if this person's got a history of, you know, aggravated assault or something that hasn't been determined by the ED, then it's nice for us to know given that we are going into a very small area on our own with a patient" (MH 25)

Most people with a mental illness pose no risk of violence, however, violence towards health care workers does occasionally occur and if anticipated can be managed effectively (Barling 2009) therefore it is an essential consideration in pre assessment planning. The tension though is that the client is already in the ED. The aim of the mental health assessment is to determine what is going on and what needs to be done for the client (Barling 2009) with the ultimate aim of the mental health triage assessment process being point of entry for specialist psychiatric assessment, provisional diagnosis and decisions about early treatment (Sands 2007). As mentioned, the phone referral is unique to the triage of clients with a mental illness presenting to the ED however as one mental health triage nurse noted phone conversations are:

P: "…poorly constructed and poorly set up and things change so rapidly [within] minutes of the conversation." (MH 23)

The parlous nature of telephone referral is described by Wadhwa and Lingard (2006) in their study of telephone referrals between doctors. They identified that the phone referral can create tensions when the caller is working from a context where they are dealing with a case outside their level of expertise. This lack of knowledge tends to increase the level of urgency by the caller. In this research, the mental health triage nurse may have a differing perspective and as such may not place as high priority on the referral. Wadhwa and Lingard (2006) also identify that telephone consultation processes may become fragmented as information may be missing or inaccurate, requiring the receiver of the call to place their trust in the subjective assessment of others. These issues are reflected in the experiences of the mental health triage nurses. A common issue amongst the mental health triage nurses was the lack of detail in the referral from the ED triage nurses:

P: "I think, the majority of the time you get superficial data…I think that a bit of a history could have been taken at times." (MH 20)

R: "Do you necessarily always get the information you need?"
P: "No. Vary rarely…Quite often the information you get is very scant and when you… press people for more information sometimes they get a bit irritated that you are asking them for more detail." (MH 25)

This perception by the mental health triage nurses is not surprising given the complexity associated with assessment. An ED triage nurse offers the following:

P: "...I personally feel as though I am skimming the top and then handballing it to psych triage for them to sort out what's going on."
(ED 19)

The need for a greater depth of information by the mental health triage nurses and the inability of the ED triage nurses to deliver the required information leads to further tensions. These are described by the ED triage nurses as:

P1: "They would like more of a history, which you don't have until they're [the client] actually registered and you can access their record, you don't have that."
P2: "Totally different, They've got unrealistic expectations of what we can gather in a short snapshot of what the person's presented with and what they are willing to tell us in an open waiting room… and they're asking us questions that I've got no background to. I think that's a big issue." (ED 30)

The nature of this disconnect lies in the fact that process of ED triage, the results of which are a brief description of the client's presentation and a triage score as an indicator of acuity, does not necessarily satisfy the needs of the mental health triage nurses. Mental health triage nurses rely on this information to begin their assessment process, a process that is described as a complex intellectual activity that requires the development of hypothesis about a person and the matching of data against the hypothesis and drawing conclusions that determines further action and outcomes (Schwartz 2000).

While poor quality information was identified by mental health triage nurses, a different but comparative and recurring theme was the issue with 'soft' or inappropriate referral. An example of an inappropriate referral would be an elderly person with a behavioral disturbance referred for mental health assessment. However, the aberrant behaviour is later found to be secondary to a urinary tract infection that was not assessed correctly by the ED triage nurse:

P: "It doesn't make me feel anything really, that kind of referral, I wish it would not happen, because it's not appropriate and probably a little bit more experienced questioning by the triage nurse would have avoided us even knowing she [the client] was there…" (MH 21)

Mental health triage nurses reported that inappropriate referrals could be reduced by education of the ED triage nurses. This, they believed, would increase the confidence in ED triage nurses to make clear-cut decisions about mental health presentations. Mental health triage nurse participants felt that addressing the ED triage nurses knowledge deficits could reduce the tendency they had to refer clients to mental health simply because they may have a previous history of mental illness. If this was the case, a referral tended to be made despite the fact that on the current presentation, the client was there for other reasons. Mental health triage nurse participants also identified that it would be beneficial to educate the ED triage nurses regarding symptoms of delirium or the effects of drug and alcohol. This would enable them to discriminate these disorders from that of a mental illness. This divergence of opinion

about what constitutes appropriate referral could contribute to the development of tension between the ED and mental health triage nurses (Wadhwa & Lingard 2006). One mental health triage nurse participant did indicate, however, that in his clinical practice he was not concerned about the nature or content of the referral:

P: "Well I mean a referral is a referral. I mean if someone comes to the ED and they ask us to go and see them, you know, they ask us to go and see them. To me its not a big deal if we go over and clarify whether we need to see them or not and make that decision in collaboration with them. And I much prefer to look at it that way than think of it as being and inappropriate thing." (MH 25)

Discourse earlier in this thesis has identified how the use of a specialised mental health triage scale has been demonstrated to improve both the confidence and competence of ED triage nurses assessing clients with a mental illness (Broadbent, Jarman & Berk 2004; Smart, Pollard & Walpole 1999; Tobin, Chen & Scott 1999). Research findings were elucidated from research conducted following the implementation of a mental health triage scale into practice. Research outcomes, however, suggest that while confidence and competence is improved in the first instance, over time these improvements are eroded by other factors.

This chapter has previously discussed how effective assessment and data gathering by ED triage nurses is confounded by a number of factors and how this leads to referrals to the mental health nurse that, at times are of poor quality and sometimes appear to be inappropriate to the mental health triage nurses. It was acknowledged by some mental health triage nurse participants that factors such as time and workload pressures *"…impact on how our communication might flow" (MH 25)* and do have a negative influence on the referral process. As well as impacting on communication and the flow of necessary clinical information and the failure of the referral process can lead to misunderstandings and discontent between the two groups. The following excerpt from the field notes, recalling a discussion, demonstrates this:

I remember about ten days ago I got a call from [name removed] in ED triage. I got a bunch of information all rattled off quickly and as I was about to ask for more info to clarify the situation when she hung up. I was amazed and upset [not his words but words to that effect] so I stormed off and when I got to the ED I saw young [name removed] with a waiting room full of people and a line ten deep [to triage], she had been dropped into it. So all the brouhahas left and I sat down quietly until I had an opportunity to have a quiet chat about the patient. (FN)

This is an example of one of the discursive features of telephone referral that can create tensions amongst professional groups (Wadhwa & Lingard 2006). Telephone communication can be an effective tool to

disseminate clinical information (Carr, Lhussier & Wilcockson 2008) but can also fail to convey effective messages and extraneous factors, such as clients ten deep in a line waiting to be triaged, which would go unnoticed via telephone conversation. Words can be said, but context is harder to convey.

The process of referral from ED triage nurse to the mental health triage nurse by telephone has been demonstrated to have elements that can confound the relationship between the two groups. Poor assessment leads to poor data, poor data leads to frustration about information received and the process of telephone referral is problematic due to poorly constructed conversations and the impost of the time it takes to make the call. This was identified as especially frustrating when the ED was busy and there was already a means of alerting colleagues to a client's presence. There is also a disconnect between the groups about the nature of the telephone referral. The ED triage nurses believe it to be a brief interaction to notify mental health triage nurses of the clients' presentation. The mental health triage nurses, on the other hand, for the most part expect more detailed information from the telephone call. This information was identified as informing their decision-making and with which they can commence planning. Much has been written about telephone triage (Purc-Stephenson & Thrasher 2010; Sutherland & Sananought 2011; van Ierland et al. 2011) but there is a paucity of literature that illuminates the issues of telephone referral between professional groups. These understandings detail the context for the final phase of the process, response.

6.3 Response

The responsiveness of ED medical and nursing staff to all clients triaged should not be subjective. Response is predicated on the five tiered triage scale, and as such response time is dictated by the timeframes embedded within the ATS (Australasian College For Emergency Medicine 2005). Situated in this context, the ED triage nurses have, at the core of their decision making the following question, 'This patient should wait for medical assessment and treatment no longer than…' (Australasian College For Emergency Medicine 2006, p. 1). These timeframes and the rationale for their use are included in the mental health triage orientation package. The following extract from the package states that mental health triage nurses will, when possible respond to a referral from the ED within the mandated timeframes. The following rationale is provided for this dictum:

The codes are representative of the client's presenting condition and the potential for deterioration in their physical and/or mental health. They are designed to ensure that the resources of the ED and the MH triage service are used to the best advantage and directed to those clients/patients with the greatest need. (Appendix 6)

This explicitly stated policy directive mandates a level of responsiveness to clients with a mental illness presenting to the ED that is commensurate with that experienced by clients with physical illness and injury. One important point of difference between ED medical and nursing staff and the mental health triage nurses in this study, is that ED

staff only care for clients presenting to the ED. This affects response rates from mental health triage nurses as they also see clients who are referred to them from multiple sources. The ED triage nurses acknowledged this:

R: "So does that limit their ability to respond in a timely fashion do you think?"
P2: "It depends what else they have got on."
P1: "It depends on what they have got on and that is the same with anything here…it is just a priority." (ED 13)

There was agreement amongst the ED triage nurses that on the whole the mental health triage nurses responded to see clients within a reasonable time:

P: "…I have found mostly that it has been a really good relationship and it has been 'right you have cat threed [category three] them, I will be seeing them within this amount of time and we will be over shortly.' Or, 'We have heard about them and we will be over soon.' But that side of thing is good and I suppose it seems like a reasonable understanding that there are other stressors." (ED 13)

The notion that the mental health triage nurses responded to clients as best they could was pervasive throughout the analysed data. However, ED nurses are accustom to ED staff responding in a consistent manner to the triage scale – it is not an option and so the lack of a consistent

response by the mental health triage nurses could be frustrating. This was highlighted by the ED triage nurse participants who said:

P: "If you had a cat two that was a straight medical patient, I mean, even if they didn't get sort of medically commenced treatment immediately, they hit a cubicle get a set of obs [vital signs] and you know a nurse would be with them… If we had a mental health cat two, you know that was just a straight mental health there's just no way that they'd be seen within that ten minute framework, no way on earth." (ED 29)

This places the ED triage nurses in a difficult situation. Put very simply, clients are not being seen within the timeframe dictated by the triage scale. In answer to this, the mental health triage nurses faced real issues when it came to responding within these mandated timeframes. In deference to the requirement for mental health triage nurses to start their data gathering the following extract from the mental health triage orientation manual identifies that:

As the MH triage is not based in, or exclusive to, the ED, there exists a need for MH triage to respond to the needs of the clients in ED and the clients in their care at any given time.
Responses: In the event of an MHTS code one or two it is expected that the mental health triage nurse will respond in person as quickly as possible. It is understood that it is of benefit to consult the client's history (if applicable) prior to responding in person to ensure the best management of the client. (Appendix 6)

Therefore, as the following mental health triage nurse participant explains, geography and established nursing practice affect responsiveness:

P: "I guess it [the triage scale] helps [with] some consistency and the delivery of care from the ED starting there. Personally I used to present as quick as I could anyway after reading a history. So there's a chance that if someone's allocated a category four or five, I know I have that period of time before I have to get there. And that may affect my decision making as to when I get there. So it may have a detrimental affect for some people at the wrong end of the waiting scale [suggesting that a person with a lower triage category may wait longer simply because there is no requirement to respond any quicker than the within the one or two hour time limit.] But I still, I mean I usually still try to get there as soon as I can after checking a history and stuff. So, I think it's useful, it has provided structure but I think a person in acute distress gets cared for in the ED regardless of what numbers next to their name. And I'm going to check their history first. So category one [immediate response] doesn't mean a lot to me. Category two [response within ten minutes] doesn't mean a lot. It takes more than 10 minutes to walk there [the ED] from here. So I can't fulfil a category two from here regardless." (MH 12)

The ED triage nurses comprehend the issue about inconsistent response as being a generalised lack of consistency in the responsiveness of the mental health triage nurses. ED triage nurses believe the triage scale to be of no consequence to the mental health

triage nurses. This approach is not something that sits comfortably with them. ED triage nurses are used to ED physicians basing their response time on the ATS, whereas mental health triage nurses do not:

P: "Because at the moment, and I don't know if you've done any research on our stats, but at the moment I don't know if there'd be a lot of correlation between the triage category and the time they've been picked up… I think they just turn up whenever, the majority [of the time]." (ED 31)

Comments such as *"response time varies" (ED 16)* were commonly made by the ED triage nurses. However, as indicated earlier, the ED triage nurses articulated that the significant issues associated with ability to respond by the mental health triage nurses were usually associated with the higher categories (one or two) where an immediate response or a response within ten minutes was expected. This is likely as clients requiring immediate mental health triage assessment and treatment are those clients most likely to impact on the resources of the ED due to their high acuity and the risk they may pose to themselves and others (FitzGerald et al. 2010).

There is, however, an overarching organisational imperative that ED triage nurses would be aware of and that which the mental health triage nurses may not be fully cognisant of. EDs report their activity to state governments on a regular basis (Australian Institute of Health and Welfare 2011). One of the measures that EDs report against is response time to triage scale. It is an imperative within this clinical milieu that ED

staff work to improve their responsiveness as a measure of improved performance. Not only is ED performance measured as a quantitative assessment of response times but ED funding is predicated on the resultant performance (Broadbent, Moxham & Dwyer 2010). Therefore, this perceived lack of responsiveness by the mental health triage staff to triage timeframes is contrary to the importance placed by the ED staff on improving performance. In fact, mental health triage nurses not responding on time has a direct negative effect on ED performance reporting indicators. Despite the plethora of valid reasons as indicated in the above discussion, accountants and finance officers see that response time against triage categories were not met.

The discourse above highlights that despite there being policy directives which are designed to ensure a particular time limited response, the mental health triage scale was not considered to be priority for the mental health triage nurses and did not dictate their practice. This was particularly evident when there was disagreement about the nature and acuity of the client's presentation. This difference in nursing approach and philosophy helps crystallise the notion that using a mental health triage scale in clinical practice forces a response by mental health triage nurses that they may not be comfortable with. Indeed, this research has identified that it is not conformed to anyway.

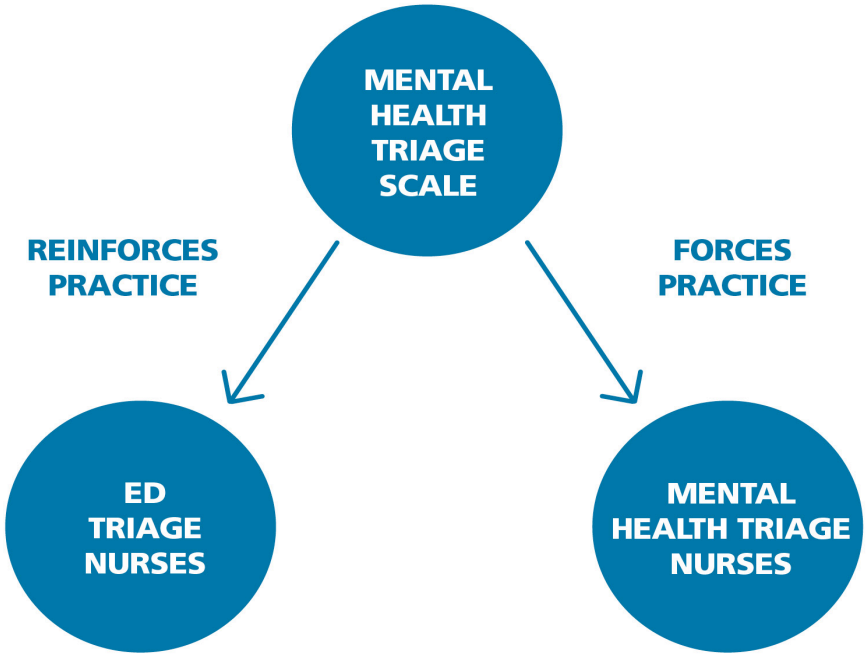

Figure 4: The effect of the mental health triage scale on the two groups

These findings build on previous research that reports mental health triage service response to clients based on the timeframes dictated by a mental health triage scale is poorly reported in the literature (Broadbent, Moxham & Dwyer 2010). The growing demand on EDs to provide care for clients who have a mental illness has seen the development of Psychiatric Emergency Centres and specialised mental health nursing roles within the ED to provide care to this client group (Wand 2005). These approaches now exist alongside contemporary service delivery models such as mental health consultation liaison (Sharrock & Grigg 2004). As indicated very little is known about the effectiveness of any of these groups in respect to their ability to see clients within the timeframes of any of the triage scales used to assess clients with a mental illness presenting to Australian EDs. What is even more confounding is that the triage scale used most commonly in Australia for

ED triage assessment, the Australasian Triage Scale, has mental health descriptors that have poor inter-rater reliability (Creaton, Liew & Wright 2006). This suggests that if the initial ED assessment of acuity of clients is poorly done, then the response by whatever model of mental health service delivery will be inherently inconsistent (Broadbent, Moxham & Dwyer 2010). This reinforces the call for further research into the triage practice and process for clients with a mental illness who present to Australian ED's (Broadbent et al. 2010).

A further theme that emerged was the disquiet felt by ED triage nurses when they had their triage decisions questioned by the mental health triage nurses. This is reflected in the following dialogue with ED triage nurses:

R: "Am I hearing correctly that they're not necessarily agreeing with that [triage] decision all the time?"

P1: "Yeah. Yeah some of them do. Some will question you. They'll question why you've given them the category four psych triage as opposed to less. And then they change it."

R: "Why do you think they do that?"

P: "Because we're not qualified…I don't care about the patient's history you need to come and see this patient, clearly it's a psych issue come and see them. 'Why, I don't need to'. So this makes it difficult which gives a fairly bad rapport I think. But again it's who you speak to as well, some people [mental health triage nurses] are very welcoming and they're more than happy to come down at your beck and call." (ED 11)

It was identified later in this interview that even though ED triage nurses were occasionally questioned by the ED medical staff about their triage decisions, this questioning happened “less, a lot less” (ED11) than the frequency that the mental health triage nurses questioned the triage category. ED triage staff posited that the reasons for this included the presence of preceding events that they may not be aware of such as the client already having spoken to mental health triage. The mental health triage nurse having prior experience of the client was also identified as an impetus for the mental health triage nurse trying to influence the triage decision:

P: “And I think a lot of the time it’s questioning such as, ‘Oh we know her.’ You’ll say the patients turned up, this is her presentation, this is the category I’ve given her and this is the other things that are going on at the time. And you’ll often get the old ‘Oh we know her, she’s a whatever and you know she always does this, you can tell her I’ll be over when I get there’ sort of thing. Which isn’t really helpful for us at all… to get the patients seen to and out again. A lot of the time I think they feel pressured by the triage categories as well. So if we say make them a category two, which… are only for those with significant risk, there’s a lot of pressure to actually down triage them. As opposed to just accepting our thoughts on why. Or if you say, look they’re threatening self-harm they’ll often say things like ‘oh we know her, she’s just an attention seeker…’ or whatever. So they’ll often use their knowledge or their history or whatever to get you to down triage. And I don’t know, maybe it’s their workload.”

R: "That sort of interaction doesn't normally occur for non mental health patients?"

P: "No"

R: "By and large you make a triage decision and that triage decision is accepted by the department."

P: "Yep… in all reality a doctor will never criticise a triage nurse for over triaging. They will always come up and give you feedback if you have under triaged, because it's putting the patient at risk. But with mental health it seems to be in reverse." (ED 13)

The impact of having prior knowledge of the clients on the decision making process of mental health triage nurses is described by Grigg et al (2004) who identified that mental health triage workers sometimes ignored clients who were well known to the mental health service. This was particularly so for those clients who contacted the service frequently with suicidal thoughts, particularly if they had a borderline personality disorder. Such a client presenting to an Australian ED would receive a triage category of two or three, depending on the degree of agitation and presence of other symptoms (Australian Government 2007) requiring a response by mental health triage nurses from between ten minutes to half an hour. It is clear to see why a client who is consistently presenting might provoke a questioning response by a mental health triage worker if they knew the client and they considered the presentation inconsequential. This example demonstrates the concept that a mental health triage scale enforces a clinical practice that is not considered

appropriate at times by the mental health triage nurses. As such, it is, at times, not adhered to.

ED triage systems are designed to 'serve the value of life and health … and they do this by determining who will not be disadvantaged by longer waiting times…' (FitzGerald et al. 2010, p. 86). A common, but not well-documented process, but one that is well understood in EDs and is known to the researcher from personal practice, is that it is an acceptable process to err on the side of caution and to over triage a client rather than to under triage them:

P: "…in all reality a doctor will never criticise a triage nurse for over triaging. They will always come up and give you feedback if you've under triaged, because it's putting the patients at risk. But with mental health it seems to be in reverse." (ED 31)

This is understood by ED medical and nursing staff as under triaging clients and exposing clients to lengthy waiting times may jeopardise their well-being. ED triage nurses find being challenged about triage decisions counterintuitive to established practice. As indicated earlier the processes of the ED are well established in the context of physical emergency care. These same practices, as they relate to the mental health triage nurses are dependent on the individual:

P: "Well usually the response is already made for you in the category that you're given then you have to be comfortable with that process. But if you're not comfortable with that process you have that one on one

conversation about how did it get to that situation because if you allow it to go to say cat one or cat two, whatever the situation is and it needed to be cat three that discussion needs to happen with that individual."
(MH 24)

In the worst cases ED nurses reported feeling distressed at the response by the mental health triage nurse to the referral that they had made:

P: "It depends on who you speak to really, some are really good, some will say give me the little bit that you know, hand it over and I'll be there in whatever timeframe. Others will be completely demoralising. Just the way they question you saying have you done this, have you done that but you've only got that period of time to assess." (ED11)

The degree to which the triage process between the ED and mental health triage nurses had become personalised is reflected in the following extract from the field notes:

So why should a concrete process like triage become personal with the mental health triage nurses when it doesn't for ED nurses and doctors? (FN)

At the core of this tension between these two cultural groups are the management of risk and the notion of client safety. Cooke (2009) contends that the preeminent anthropological approach to risk and safety is 'grid – group' analysis developed by anthropologist Mary Douglas. Grid-group cultural theory acknowledges that culture is an essential component of an organisation or social group and that the 'grid'

and ‘group’ dimensions have a decisive influence on the overall culture of an organisation.

In this model articulated by Douglas (1992) ‘grid’ represents hierarchy and structure within an organisation on a vertical plane. It is expressed through rules and procedures, organisational structures and role differentiation (Cooke 2009). ‘Group’, the horizontal plane, describes the boundaries around a group (Douglas 1992) and informs us of the identities of the group through the shared rituals, symbols and values (Cooke 2009). This map, presented in Figure 5 provides a method of contextualising social environments.

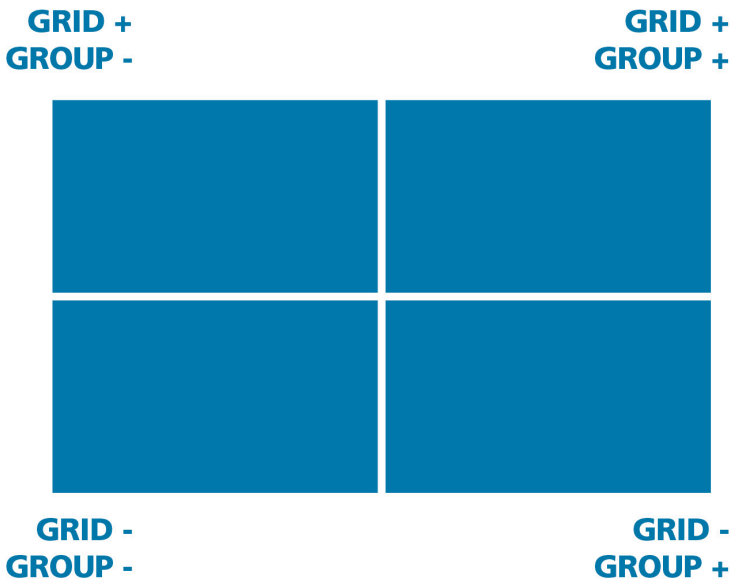

Figure 5: The Grid – Group Map (Douglas 1992)

Douglas (1992) contends that the higher up the vertical axis that a group exists, the tighter the group structure is and the narrower the scope for individual negotiation becomes. The lower down the vertical access a greater degree of negotiation becomes possible.

The act of ED triage is a highly structured and systemised process, while autonomous, individual decisions are at the centre of the process, the decision-making is constrained by the limits imposed by the ATS. Relating this to the grid above it is placed on the vertical grid axis (high structure). The mental health nurses however do not conduct their nursing practice within these constraints. Their scope for autonomy in a less structured role is greater than the ED triage nurses and, therefore, the mental health triage nurses appear to sit lower on the vertical axis in a social environment where life would seem to be open to negotiation' (Douglas 1992,p. 201). The cultural environment they exist within, however, places them high on the grid as the mental health triage nurses are still required to follow rules and procedures and within a highly structured organisational environment.

The horizontal group axis describes the degree of social cohesion between groups. Previous discussion has explained how the ED and mental health triage nurses are geographically distant, communicate mostly by phone and have differing perspectives regarding the management of risk. Understanding how the two groups respond to the triage timeframes, identifies the ED and mental health triage nurses as quite separate groups with low social cohesion. This places them as a 'low' group on the horizontal axis. Even within the groups, there is a degree of isolation. This is because each individual ED or mental health triage nurse works in isolation, only occasionally sharing the workload with colleagues at times of peak activity. Therefore they are high grid,

low group (grid + and group -) or to summarise, highly structured with low social cohesion as represented in Figure 6.

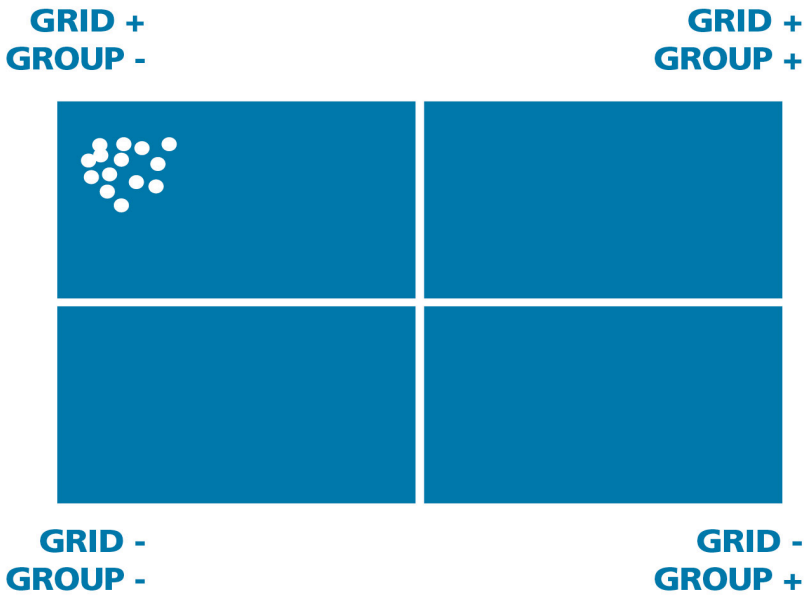

Figure 6: Location of participants on the grid – group map

Applying this concept to this research and using the grid – group analysis Cooke (2009) identifies four cultural biases emanating from Douglas work and based on the interactions of the grid and group characteristics. The previous analysis of the ED and mental health triage nurses based on Douglas grid-group cultural theory identifies them as being high grid and low group. Using this understanding then, they fit into the category of isolated and fragmented groups (Figure 7). Cooke (2009, p. 262) describes these as groups who reflect cultural biases where 'status hierarchies are strong but there are low levels of social cohesion. Individuals are isolated and there are low levels of shared values'.

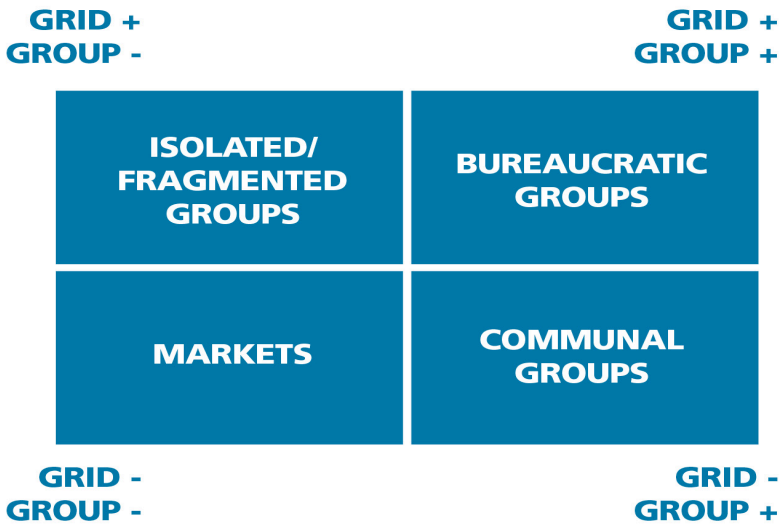

Figure 7: Cultural Biases. Adapted from (Cooke 2009)

In these fragmented groups the attitude to risk is passive and fatalistic. This can be evidenced by the notion of ED physicians accepting both the ED triage decision and over triaging as an acceptable process to manage the risk of client's health deteriorating. Compared to mental health nurses who at times actively contest ED triage decisions on the basis of their understanding of risk associated with mental illness and prior experience with clients. This illustrates how ED and mental health triage nurses work with different perspectives of risk and different approaches to risk management. These diverse practice philosophies contribute fragmentation in the relationship between the two groups.

A further area of conflict based around perceptions of risk, is the issue of medical clearance. Medical clearance as it relates to this research is the phase of care that extends beyond the responsibility of the ED triage nurse. That ED triage nurses identify it as an issue is no surprise given that ED staff alternate between triage and the cubicle area where these

clients are cared for. It is therefore an influential issue that exists as part of their broader practice in the ED. However, it was not considered an issue by the ED triage nurses or mental health triage nurses with regard to the care of clients at triage with purely psychiatric symptoms.

Medical clearance refers to the medical evaluation of clients with symptoms of a mental illness prior to referral to psychiatric care (Korn, Currier & Henderson 2000). Clients who presented to the ED with purely psychiatric symptoms were triaged and asked to wait in the waiting room. This was established practice and is consistent with research that finds there is no need to medically clear this cohort (Korn, Currier & Henderson 2000). Clients who present with history or symptoms suggesting co-morbidity, such as psychosis and drug or alcohol use, overdose or self-harm, were triaged and ongoing care was provided in an appropriate area within the ED. These clients received ongoing care from ED nursing staff within the ED and were not the responsibility of the triage nurse. The process for the response to triage decisions for clients with co-morbid presentations is described in the following extract from the mental health triage service orientation manual:

There is no need to medically clear clients who are intoxicated by drugs or alcohol and exhibit suicidal or other mental health symptoms prior to mental health assessment. If, as part of the MH assessment, a complicating physical condition is suspected, or the client needs medical treatment for their intoxication, the client may be referred back to the ED medical staff following the MH assessment. (Appendix 6)

The policy goes on to say that response will be within the time frames of the mental health triage scale. Despite this policy the ED triage nurses expressed frustration at the request from mental health triage nurses for medical clearance, as they perceived it rendered the triage decision-making futile:

P1: "So therefore now I find that they will go oh well they need their wrist you know sutured and then I'll come down and chat to them, even though they could have been a category three [to be seen within thirty minutes] mental health triage and a category five [to be seen within two hours] medically, it still seems to be that cycle not to near them until they're medically."
P2: "Cleared"
P1: "Cleared which if you look at triage it defeats the purpose of even triaging into those categories." (ED 29)

ED and mental health triage nurses did not identify medical clearance as an issue at the point of triage for the clients who presented with purely psychiatric presentations. However, the application of a higher triage score for the psychiatric component of the presentation than that for the physical component of the presentation for clients with co-morbidity indicates an ED triage assessment that puts the precipitating circumstance, such as psychosis or depression, as a greater concern than the sequelae, minor self harm or overdose with a non lethal medication. Again, the perception of risk was dependent on prior knowledge of the client and mental health experience. The mental health

triage nurses will consult the client's records or may have had prior experience with the client. These insights provide a context for their response that may differ to the assessment of acuity as decided by the ED triage nurse. This means that there was no imperative for the mental health nurses to respond until the medical treatment is complete.

Having unpacked the cause and effect of delayed response by the mental health triage it is not surprising then that ED nurses spoke positively when the referral was met with positive intent from the mental health triage nurses:

R: "So their [mental health triage nurses] response gives you security in your role?"
P: "Yeah absolutely and it makes the ATS worthwhile because then I know that I'm … starting the process…" (ED 29)

This research has identified that mental health triage nurses accept that a mental health triage scale is a worthwhile tool for assessing clients with a mental illness. However, the response by mental health triage nurses is confounded by a number of factors that mean their responses within the triage timeframes are inconsistent and not aligned with the responses expected by ED triage nurses. The following comment from the field notes clarifies this issue:

Info determines the response [by the mental health triage nurse] – not triage scale. Information received [from the ED triage nurse] determines the degree of urgency – whether it's an appropriate presentation – not the triage scale. (FN)

At the source of the multiple issues described in this section lie expectations about information and performance that are rooted in very tribal understandings. The highly process orientated ED systems that rely on a single number with a brief assessment which drives ED service response, is counterintuitive to the mental health triage nursing practice that relies heavily on different information to inform their decision making. Conflict between these two culturally disparate groups emerges as assessment is complicated by architectural, environmental and knowledge limitations. Referral is problematic due to geography, the limitations of technology and misunderstandings about the nature of presentations. Further, response is mired in the mismatched perception of risk, the limitations of distance and geography and how two services have different performance measures.

The process of ED triage that consists of the assessment of clients, the referral to the mental health triage nurse and the consequent response, underpins the core process that defines how ED and mental health triage nurses interact. This defines the relationship. This important process and the issues described in the examination of the cultural milieu and the practice environment provide an operational context for

the remainder of the themes that influence the relationship between the two groups that have been unveiled by this research.

Chapter 7: Roles and Scope of Practice

The process of ED triage provides an explanation of the interactions between the two groups. However, it is the broader policy and procedural influences that provide the overarching dictum in regards to who does what and when. This chapter examines the roles and scope of practice of the participants and outlines the factors that emerged from the research, which impacted on the relationship between the two groups.

7.1 Role and scope of practice

A professions scope of practice includes the: Roles, functions, responsibilities, activities and decision-making capacity that individuals within the profession are educated, competent and authorised to perform (Australian Nursing and Midwifery Council 2007, p. 2).

An individual within a profession may have a scope of practice that is more specialised than the overall scope of practice of the profession itself (Australian Nursing and Midwifery Council 2007). This recognises professional specialities and their expertise. These understandings provide a point from which an examination of the roles and scope of practice of the ED and mental health triage nurses is now undertaken.

As illuminated by the exploration of the cultural milieu offered in the previous chapters, the role of the ED triage nurse is highly specialised and well described in the Policy Document – The Australasian Triage Scale (Australasian College For Emergency Medicine 2006), the Practice Standards for the Emergency Nursing Specialist (College of

Emergency Nursing Australasia 2007b) and the Position Statement – triage nurse (College of Emergency Nursing Australasia 2007a). Emergency nurses, unlike the mental health triage nurses in this study, are not employed into a specific role of triage nurse as an independent position within the emergency department. Rather they are assigned to that position as part of a rotation through various roles in the ED, which may include working in the resuscitation area and/or in the general treatment area. Therefore there is no employment position description per se and nurses are employed in the ED on the understanding they will perform triage as part of a broader role. ED nurses who work at triage do so after gaining experience in emergency nursing and specialised training (Australasian College For Emergency Medicine 2006). As indicated, the role of the ED nurse as triage nurse is quite specific. The ED triage nurse will conduct a brief assessment of the client, lasting no longer than two to five minutes (Australasian College For Emergency Medicine 2006) to determine clinical urgency. This culminates with the allocation of an ATS category. It is at triage where care in the ED begins and is central to the effective and efficient operation of the ED (College of Emergency Nursing Australasia 2007a). Although highly structured and supported by specialised decision making tools, the role is autonomous and can have a significant impact on the flow of workload in the ED and on the health and wellbeing of clients seeking care (College of Emergency Nursing Australasia 2007a).

The scope of practice of the ED triage nurse, is much broader than fulfilling the central role of triage decision-making. The scope of practice includes roles such as initiating first aid and emergency interventions stabilising injuries, continually reassessing and managing clients waiting to be seen by a health professional once triaged, providing client and public education and acting as a liaison between the public and other health professionals (College of Emergency Nursing Australasia 2007a). Triage nurses are the 'face' of the ED. They provide 'front of house' service. The scope of practice of the ED triage nurse may also extend to more specialised roles such as ordering nurse initiated analgesia, x-rays and pathology (Johnson, D. & Wilson 2007).

The employment and scope of practice for the mental health triage nurses is somewhat different to that of the ED triage nurses. The policies and protocols that frame their practice, while governed by the relevant Mental Health Act, are developed within local health service policies and procedures and nurses in this research site are directly employed into positions to function in the role of a mental health triage nurse. The role of the mental health triage nurse, while variable, incorporates the following elements: the screening of referrals of clients with complex psychiatric illness to determine suitability for intensive community intervention or inpatient admission, undertake initial mental status examinations and perform risk assessment of referrals from the community and the ED, develop acute management plans, respond to requests and referrals from general practitioners, private psychiatrists, drug and alcohol agencies, police, consumers and carers, and the

provision of support and education to staff in relation to mental health assessments and psychiatric nursing care (Austin Health 2010).

The role of the mental health triage nurse is a relatively new one, the evolution of which having been first described in detail in a study in Victoria, Australia in 2004 by Sands. Unlike ED tirage nurses, mental health triage nurses practise in a variety of settings and therefore the models of service delivery vary due to the geographical and procedural variations from setting to setting (Sands 2004). Therefore, while the role is well described, local issues and contexts will influence the manner in which mental health triage nurses carry out their role. Their scope of practice is however, well defined.

7.2 Role uncertainty

While the function of the relationship between the ED and mental health triage nurses is to work within the framework related to the assessment of clients, referral of clients and the subsequent response to the ED referral, both groups identified issues associated with their respective roles and scope of practice. One mental health nurse described the changing nature of their role thus:

P: "We used to be psychiatric nurses dealing with major mental illness and psychiatric conditions. We now seem to be mental health nurses dealing with any emotional disorder whatsoever, whether it's an illness or not. And I think anyone that's emotionally distressed in emergency because of a physical illness is referred to psych straight away" (MH 12)

This diversification of role is reflected in the following discourse when another mental health triage nurse participant offers the following:

P: "…They [ED staff] know what I'm there for. I'm not there for anything else. I'm there to do a mental state assessment of the patient, find out what is wrong with them and decide what to do with them, that's all I'm there for…I often think you should have a social worker on always in there, in ED, on every shift, a real good social worker because there's so many family issues and stuff like that we have to get involved in."
(MH 21)

At the time of the fieldwork there was a social worker that was employed in the ED but not across a twenty-four hour period. This may explain why mental health triage nurses were being asked to be involved in these clinical situations from time to time. The quote from participant MH 21, described their involvement in this sort of scenario as being inappropriate. This extends the understanding about inappropriate referrals previously described in chapter six in the process of referral of clients to mental health from ED triage. This understanding demonstrates that inappropriate referrals complicate the relationship between the two groups from a process perspective, and they do so because it is understood by the mental health nurses that unless the referral is specifically mental health related, it is beyond their role to be involved.

The genesis of this lies in the notion that ED nurses do not have a complete understanding of the role of the mental health triage nurse beyond that of responding to referrals from the ED. One ED triage nurse described it in the context of an ED that is growing its services:

P: "I think we are developing into a far more extended department in that we've got a physio service, and we've got the social workers and everybody is involved, and I just can't see that we could leave mental health out of that… Maybe there's a lack of understanding, certainly from my point of view, I don't know what they do external to the department. Whether they are required in other areas to do what they do, or whether they just work here. I don't know what they do." (ED 16)

Having staff with expertise in other areas embedded in the ED affords a greater understanding of their role and this will be further explored in the following chapter. Suffice to say the role of the mental health triage nurse in ED was blurred. The different mental health practitioners who had differing perspectives on the role and how it was carried out contributed to this lack of understanding.

The range of perspectives of the mental health triage nurses on their role reflected their own understandings of their scope of practice. One mental health nurse preferred to act:

P: "in a consultative capacity rather than referring people, having a conversation with us about whether it would be appropriate or not for us to be involved with this person." (MH 25)

Another participant indicated that their response to the triage category applied by the ED triage nurse was dependent on whether they felt:

P: "…comfortable with the process. But if you're not comfortable with the process you have to have that one on one conversation about how did it get to that situation because if you allow it to go say cat one or cat two, whatever the situation is, …then that discussion needs to happen with the individual." (MH 20)

This perspective is counterintuitive to the mental health triage service position on responding to triage referral from the ED within the timeframes dictated by the mental health triage scale. It is another example of questioning the triage decision making of ED triage nurses. Another participant expressed how their allegiance was tied to the acute inpatient unit:

P: "But I'm very aware that I work very close to the ward, and psych triage and ward staff work hand in hand for a number of reasons. Always have and probably always will. You are there to support. You know there's usually not as many male staff on a shift as female…It's a big team. There's no real separation [between triage and the inpatient unit]. I can't imagine anyone in here saying 'oh no I won't help you because I'm working in triage now.' Don't want to do that." (MH 20)

This position was reflected by another of the mental health triage nurse participants who indicated:

P: "…being located here has advantages for us as it means we maintain our relationship with the acute unit, our inpatient unit. Otherwise we would probably, we would almost be ED staff if you like." (MH 17)

These mental health triage nurses demonstrate a strong desire to remain affiliated with a culturally similar group, that is, with other mental health nurses. This is explained by the similarity – attraction effect, that states quite simply, people like those who are like themselves and that this is emphasised when taking into consideration cultural identities (Heine, Foster & Spina 2009). The degree to which the mental health triage nurses have differing perspectives on approaches to their role as it pertains to the ED, creates uncertainty and inconsistency. ED triage staff expect a consistent, similar approach. Contributing to this discord was the fact that a previously employed mental health triage nurse had, unlike the currently employed cohort of mental health triage nurses, decided to base themself in the ED. This had demonstrated to the ED staff that the role could be carried out whilst located in the ED. This added to the misunderstanding about the current issues associated with geography and distance.

This discourse illuminates a profile of two groups of nurses who are working together in an environment where there is uncertainty about role, particularly as it relates to the mental health triage nurses. While the mental health triage nurses are cognisant of their main role they demonstrated individual perspectives on the approach to the role.

The role of the mental health triage nurse in Australia was first reported in research findings in 2004 (Sands 2004). The role of mental health triage clinician arose in response to deinstitutionalisation and mainstreaming that necessitated a single point of entry into mental health services (Sands 2004). At the time, Sands identified ambiguity about the legal dimension of the role and the lack of an evidence base on which to base practice. Apart from a further contribution by Sands in 2007, that identified that the role of the mental health triage nurse would increase in use, scope and responsibility (Sands 2007). There is no national or state wide consistent approach to the role of mental health triage and that ambiguity surrounding the role and scope of practise may continue to exist. This is not uncommon in the development of new roles that will sometimes emerge as a response to improving service delivery (Duffield et al. 2011). They often lack evaluation as a mechanism of defining and improving the role and as the role becomes embedded in the culture of the organisation the number of positions may increase (Duffield et al. 2011). This then allows attitudes and practices to become embedded in the culture of practice. Duffield et al. (2011) contend that as roles become blurred staff become confused as to the particular tasks and competencies expected of them. This also leads to staff being expected to perform tasks that do not fall within the domain of job description.

7.3 Ownership and education

This phenomenon is evident in what emerged as the most contentious issue between the ED and mental health triage nurses. This revolved around the management of clients with a mental health illness once in the ED. While this aspect of the relationship between the two groups is beyond the scope of this research that focused on triage, the antagonism and uncertainty surrounding ongoing ownership and care of the clients in the ED posed difficulties in the overall relationship between the two groups. The following dialogue offers the ED triage nurses perspective:

R: "So what I'm hearing is that the psych triage come down and do an assessment and then there may be a period of time before the patient is actually discharged or admitted, and what I'm hearing is that there's no ongoing mental health care of that patient in terms of someone down here providing care."

P: "We do the best we can but we're not trained."

R: "So do you see that as part of the role of the mental health triage nurse?"

P: "Surely it's got to be better for the patient to have a psych nurse here. Definitely if someone could be down here [in the ED] until their problem is resolved otherwise they're just left in our hands." (ED 11)

Many of the ED triage nurse participants expressed concern about this. They wanted 'psych nurses' to come to the ED and this was largely due to what they felt was their lack of training and expertise in providing care to clients with a mental illness. The magnitude of this issue is reflected in an observation that was documented at the time of occurrence and was recorded while in the field:

There is a big issue in this ED about the ongoing care and management of mental health clients in the ED. Bed block to mental health inpatient beds means that mental health inpatients are now in the ED for many hours/days prior to admission and care delivery is being done by 'specials'. Specials are usually enrolled nurses who provide basic care – provide basic safety and hygiene needs. The ED staff perceive there is no therapeutic intervention as the mental health triage staff only see the client once or twice. The mental health triage nurses do not see it as their responsibility. (FN)

The following comment, this time from a mental health triage nurse participant typifies the perspective of this cultural group:

P: "If the client stays in the ED for whatever reason, I see our role as providing care in a consulting manner. I don't see myself as a special or someone who should stand beside the client for a long period of time, which I believe, differs from the emergency nurse's perspective. I've got a phone that rings regularly, I've got other people to see and I've got a job to do. So I can't provide that direct ongoing primary nursing care. But

absolutely provide an ongoing caring role with regard to consultation discussions, medications and management, absolutely. Yep." (MH 12)

The mental health triage service orientation package offers no considerations or suggestions for the provision of ongoing mental health care in the ED by the mental health triage nurses. This lack of clarity is consistent with the broad descriptions of the role as reflected in the job description and discussions of the role within the literature (Austin Health 2010; Sands 2004, 2007). The ED triage nurses' palpable concern about their perceived inability to provide anything other than basic care due their lack of education and training in mental health reflects extensive commentary in the literature that indicates general trained nurses are poorly equipped to care for clients with a mental illness (Broadbent, Jarman & Berk 2004; Broadbent, Moxham & Dwyer 2007). The literature also suggests that mental health care is outside of their scope of practice and that there is a reluctance to get too involved with clients who have a mental illness (Olasoji & Maude 2010). Recent research suggests that issues specific to the ED such as the care environment, time and the lack of understanding of the personal journey of the client with a mental illness (Marynowski-Traczyk & Broadbent 2011) also contribute to the barriers that ED nurses face in caring for clients who have a mental illness. It is not surprising then that ED triage nurses turn to mental health triage nurses for support and desire a greater degree of engagement with clients in the ED. Conversely, it is also not surprising that the mental health triage nurses refuse regular and ongoing

involvement on the basis of their role and the fact they have other clients to service.

The tension that permeates the relationship between the two groups arises due to the presence of conflicting role boundaries which is problematic when policy or procedure, in this case the role description of the mental health triage nurses, are not supportive of the therapeutic imperatives (ongoing care in the ED) as perceived by practitioners, in this instance the ED triage nurses (Brown, Crawford & Darongkamas 2000). In response the mental health triage nurses assert their role and scope of practice as a strategy to regulate and limit the demands made on them (Brown, Crawford & Darongkamas 2000).

7.4 Process versus outcome orientation

As described in chapter six a defining element of the relationship of the two groups is the process of assessment, referral and response. The ED triage nurses are firmly embedded in this process and it is their normative practice that drives their decision-making and sculpts their behaviour and patterns of communication. During the course of the fieldwork it became clear that as much as the ED nurses were embedded in process, the mental health triage nurses were not. The two cultural groups were dichotomous. The mental health triage nurses saw themselves as outcome orientated while ED triage nurses are process oriented. The following dialogue explores this:

R: "And perhaps that whole process driven focus, do you think that might also contribute to the fact that there's not that consultative thing going on as well, that they just don't even think about it in the first instance because they are so focussed on process?"

P: "Yeah, I think so. I think they've got a very narrow sort of view of what their role is to be honest. I think that they are very task orientated in terms of following the process. You know, why are they [the client] here, who do they need to see? Tick, tick, tick. Tick all the boxes and that's it. You know it's a bit like sorting, it's a bit like a mail centre I think."

(MH 25)

In describing themselves as outcome orientated the mental health triage nurses alluded to having to take into consideration factors such as the kinds of immediate clinical interventions the client may need, the likely outcomes for the client in terms of community based care or admission and the availability of inpatient beds both locally and around the state. This manner of thinking is based on knowledge of the system in which they work and familiarity with the client's presenting condition and likely outcome. It is a longitudinal perspective of client care, one that is based on a psychosocial approach rather than a medical approach. When the notion of process and outcome orientation was posited to the ED triage nurses there was general consensus that they were very process driven. The following dialogue illuminates an important finding relating to this proposition:

R: "So as a general rule the notion is one of process oriented versus outcome oriented, would you agree with that?"

P1: "Yeah I think so. I think even in triage you do, no, I've changed my mind. Thinking again with medical patients I do have in the back of my mind the outcome. I do think well okay this person is going to need this and that and then they'll probably end up with such and such."

P2: "It's a change of thought pattern. They'll be admitted or."

P1: "And that does influence where you go from there but, yeah, again with the psych, and again I'm one of those with limited knowledge, it's up in the air for me. I never second-guess, I never think, gee this patient's going to need this and this and they'll end up admitted or discharged. So the process there is very important. It's like well they're [the client] here now, I'll call this person [mental health triage] and hopefully they will be here and that's as far as it goes."

P2: "Like I'd have no idea. They [mental health triage] go we're going to admit them cause they're whatever and you go okay that's fine, they're gone, case closed. Whereas with your medical patients you know what's going to happen. No idea with psych." (ED 19)

The longitudinal, outcome orientated manner of thinking is present in the ED triage nurses when they are triaging clients with a physical illness and/or injury. These are clients with illnesses and injuries the ED triage nurses are comfortable with because they have knowledge of, and are familiar with these presentations. This is because, having cared for these clients within a general health system and having been educated to do so, it alters their perspective on the triage decision making process.

However, the process orientated mindset becomes apparent when they are no longer in their comfort zone. It is expressed when it comes to triaging clients with a mental illness, which they have little, or no knowledge of or experience with. In these cases, the practice of assessment and referral with no, or little contextualisation becomes the dominant orientation in decision-making.

The metaphor used by the mental health triage nurse about the ED triage nurse simply 'ticking the boxes' or 'sorting' and having a view that there is little thought in the triage decision making process, is unsurprising when ED triage nurses default to a simplistic process. This is equally understandable as ED triage nurses lack the knowledge of mental illness that is needed as the basis of their decision. The development of tacit understanding of the needs of clients is learnt from experience and practice situations (Lake, Moss & Duke 2009), something the ED nurses lack in these particular circumstances. The confidence and proficiency in making decisions in regards to the need of clients is a sign of expertise (Lake, Moss & Duke 2009). Expertise in this area is central to the position of working as a mental health triage nurse (Austin Health 2010). This situation further highlights the tensions that the process of ED triage brings to the already complex relationship between two very distinct cultural groups. The sometimes simplistic, uninformed, decision making of the ED triage staff forces a response by skilled and knowledgeable mental health triage nurses that may seem, to them, to be inconsistent with the client's presentation.

This chapter has unwoven the factors pertaining to roles and scope of practice as they influence the relationship between the ED triage nurses and mental health triage nurses who participated in this study. It can be seen that what should be a straightforward understanding of roles and responsibilities is confused by the blurring of roles, particularly the diverse role of the mental health nurses and the differing perspectives held by individuals. Lack of education and its impact on the provision of care to clients with a mental illness in the ED and the effect of experience and knowledge within the triage ED triage decision making process also contributes to this blur. The final chapter in this dissertation will discuss the central premise of working together and being as effective as two disparate groups can be. This concept has been termed, collegiate presence.

Chapter 8: Collegiate Presence

The findings of this research as elucidated in the chapters of environment, process and roles and scope of practice provides us an understanding of how the 'bricks and mortar', the cultural milieu, the operational processes and how the roles and scope of practice influence the relationship between the two groups that form the essence of this research. That is, the ED and mental health triage nurses. The following discussion presents in detail, two very closely interrelated concepts that emerged from this research - collegiality and presence. Such was the difficulty in separating the two concepts, due to the intertwined relationship between the two, that they were merged to form the theme titled collegiate presence. This chapter commences with an exploration of the notion of collegiate presence and then examines the factors uncovered by this research that affect this phenomenon between ED and mental health triage nurses.

8.1 Understanding collegiate presence

The search for a working concept of collegiality revealed that collegiality was mostly associated with collaboration and that the literature is replete with papers on interdisciplinary collaboration. Examples include interdisciplinary collaboration between teams that share common cultural identity such as surgical and medical nurses (Fernandez et al. 2010) and teams that have traditionally worked together such doctors, nurses and social workers as in hospice care (Baldwin et al. 2010). Petri (2010)

identifies that collaboration is the act of working together in an atmosphere of mutual trust and respect.

The concept of collegiality is more commonly witnessed in the literature with regard to education. Campbell and Southworth (1992) contend that collegiality has been frequently promoted as a conceptual ideal, and suggest that those who promote collegiality do so on the basis of a perceptual understanding of the notion rather than a prescriptive understanding. Ayo and Fraser (2008), in their search for an understanding of transformative collegiality state that there remains a definitional ambiguity about the institutional and personal components of a collegial relationship that makes it difficult to know what one actually looks like. Therefore, for the purposes of this research the definition put forward by Ayo and Fraser (2008, p. 58) will be used to understand the notion of collegiality, '…collegial relationships are defined as the professional interactions which arise from on-going communication between two or more individuals who share the same workplace, or work interests.' This definition is appropriate to use for this research as the two groups, ED and mental health triage nurses, contribute to a common process. This process includes the assessment, referral and management of clients presenting to an ED with a mental illness and the fact that they work together in one organisation. However there is a further dimension that is critical in the discourse that relates to culture that is not addressed in the Ayo and Fraser definition. Mariano (1989) contends that teams with a strong cultural affinity for autonomy will tend to support individualisation and specialisation rather than collaborative

practice. This notion is critical to this discussion as the previous examination of the cultural milieu of both ED and mental health triage nurses exposed two groups of highly specialised, but culturally disparate practitioners who exhibited low social cohesion, as highlighted by the exploration of risk using Cooke's (2009) assessment of cultural bias. Therefore an understanding of collegiality must include an element that takes into account these trans-cultural issues.

Presence - the other issue - is a multi faceted concept. In nursing, presence, as it is associated with client care, is described by Finfgeld-Connet (2006) as an interpersonal process involving sensitivity, holism, intimacy, vulnerability and adaptation to unique circumstances where the nurse is in a sole place with the client. In order for clients to benefit from presence, nurses must practise in an environment that is conducive to it. They must possess personal and professional maturity and demonstrate practice based on moral principles of commitment and respect for individual differences. When presence is experienced it is said to benefit the mental well being of nurses and clients alike (Finfgeld-Connett 2006). It is suggested that the same principles can be applied to interdisciplinary relationships and that in doing so, when people commit to the interdisciplinary relationship and actively look to embrace these principles within it, the interdisciplinary relationship will be one that is effective and beneficial to both parties.

However, unlike relationships with clients, an overtly caring presence is not required as a focus of the interdisciplinary relationship that occurs between groups or individuals at work. A way of understanding occupational presence is a state of consciousness of being aware of one's self (Reid 2008). Reid (2008) describes occupational presence as a felt experience that occurs as a result of workplace engagement. It varies in its intensity, from low presence to high presence and can be experienced during both positive and negative experiences. Place and choice also influence the degree to which an individual feels presence in the workplace. Factors such as connection, interaction, attention, realness, predictability and dramatic involvement contribute to occupational presence (Reid 2005). Because caring is an innate characteristic of nursing and nurses, presence requires the nurse to draw from both caring presence and occupational presence and display awareness of self and others, respect for individual differences, interaction and involvement.

The final aspect essential to understanding collegiate presence is the concept of cultural intelligence. First developed as a theory by Earley and Ang (2003) cultural intelligence is a trait that people working in multicultural environments must possess for effective relations and operational problem solving to occur in multicultural environments (Amiri, Moghimi & Kezemi 2010). The concept of cultural intelligence emerged from theories of intelligence and is defined as an individual's capacity to function and manage effectively in situations where race, ethnicity and nationality provide a culturally diverse work environment. It requires a

person to understand the principles of intercultural interaction, to adopt a thoughtful approach to such interactions and to adopt a set of behaviours that allow a person to be effective in intercultural situations (Thomas & Inkson 2004). While race and ethnicity were not aspects of culture considered in this research, it has been established that the ED and mental health triage nurses are culturally diverse and as such, the underlying principles of cultural intelligence are important considerations

The ability to interpret and act on the elements of collegiality and presence and of cultural intelligence as discussed, requires mindfulness. Mindfulness is a state of openness to information and points of view, increasing control to change the surrounding context with the goal of being aware of one's own mental processes, recognising bias and judgements while acting with principles and compassion (Horton-Deutsch & Horton 2003). The elements of mindfulness are critical to collegial presence as they require self-awareness and the testing of prejudices during the process of trying to understand others. This allows cross cultural understanding between any two distinct human cultures (Davis 2009; Wang & Xu 2009). The two distinct cultures in this research are ED and mental health nurses.

Collegial presence, therefore, is a conglomeration of all of these concepts and can be considered in the following way; it is a relationship between two or more professional individuals or groups, who share a common work focus that is enhanced by both parties being mindful of the other. Mindfulness allows for a mutual connection, a shared understanding that is developed by insightfulness into cultural

differences and that exhibits care and involvement with the other party. Existing theories and their relationship to collegiate presence are represented in the following diagram.

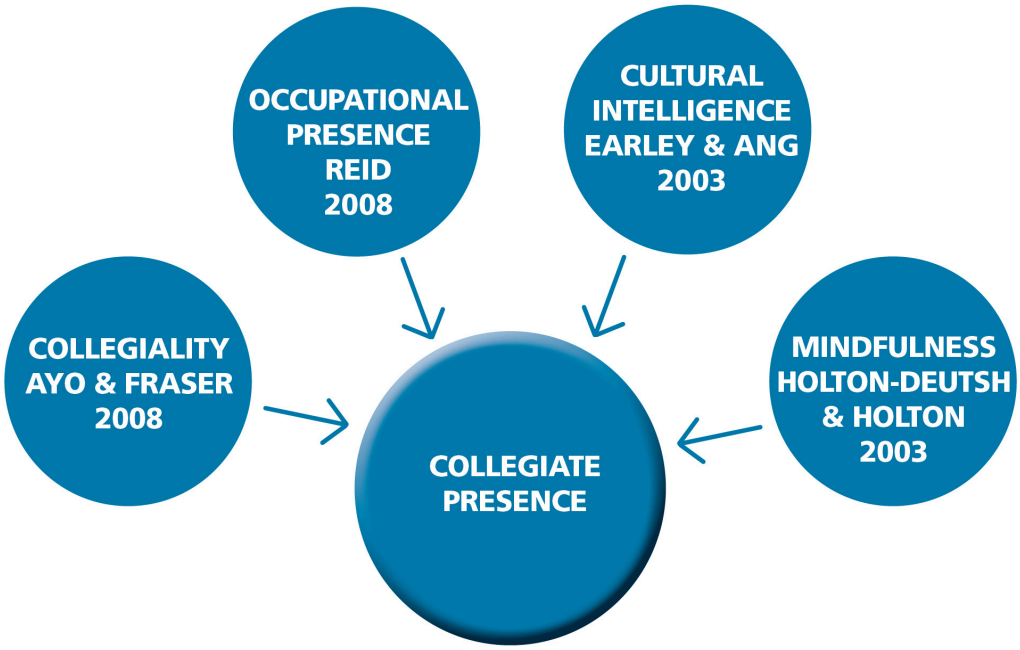

Fig 8: Existing theories and their relationship to collegiate presence

In a simplified sense collegial presence is as much about being culturally aware as being culturally 'there'. It is through this lens that we now examine the factors that affect this notion of collegial presence between the ED and mental health nurses.

8.2 Communication

Effective communication is considered as the most essential element of teamwork and anything that interferes with necessary communication has the potential to lead to interdisciplinary conflict and poor client outcomes (Dewitt, Baldwin & Daugherty 2008). Kilner and Sheppard (2010) state that teamwork and communication are closely linked and that in an ED environment, are paramount. Communication can then impact on collegial presence as it affects the common work focus, mutual connection and shared understanding that is embedded within the notion.

As identified in the earlier discussion on referral of clients from the ED triage nurse to the mental health triage nurse, the telephone conversation is the official and main form of communication between these two groups. It was shown that the telephone conversations are often poorly constructed, and problematic due to the lack of detail conveyed and also because of time constraints. It was also observed that there was little face-to-face conversation following the referral *"probably because they can see we are busy" (ED 22)*.

The mental health triage nurses identified a number of issues that affected communication between themselves and the ED triage nurses. The failure to document the initial phone referral meant that the ED would ring the mental health triage staff on more than one occasion resulting in frustration in both departments:

P: "And it fills the phones, it frustrates you and it frustrates them of course because they're frustrated from the other end, but they're not talking to each other." (MH 10)

A mental health triage nurse described receiving multiple phone calls as *"extremely frustrating and detrimental to our relationship" (MH 12)*. The lack of information from the ED triage nurse as outlined in the discussion on referral *"…debilitates the ongoing working relationship" (MH 23)*. This resonates with the findings described earlier of the importance mental health nurses placed on the quality of the information they received and needed for their decision-making. It also demonstrates that collegial presence is affected as it also alters the way mental health nurses felt about their colleagues in the ED. The ED nurses were more pragmatic about the phone call, as these ED nurses explain:

P: "The phone call…well it's one on one you know, the intentions are, they [MH] know what the patient's about, and then you have an understanding that okay I've let them know, you can tell the patient… and that's usually enough." (ED 22)

P; "You just kind of think, well I'm just doing my job [making the phone call]. I've still got to triage the patient, I still need to notify you, and if I don't notify you I get in trouble. Just accept it OK." (ED 16)

Having satisfied the requirements of the official process, that is referring the client by phone, the ED nurses, believing they have established what they believe to be a common understanding with the mental health triage

nurse about the client, then move onto to whatever awaits them. They do this on the assumption that the mental health triage nurse has been informed of the client. However, there was no recognition on behalf of the ED triage nurses about the relative benefits for the mental health triage nurse regarding the quality of information being passed on. This indicates a lack of mindfulness of the needs of the mental health nurses as required for collegial presence. This research has, however, uncovered a further layer of communication that impacts on collegial presence that is more in keeping with the elements of mindfulness and involvement inherent is collegial presence, social conversations.

8.3 Social conversations

At the heart of collegial presence is the relationship between two groups or individuals. Just as telephone conversations have been demonstrated to be perfunctory at best and damaging at worst to the relationship between ED and mental health triage nurses, this research highlighted the value of face-to-face communication. It has been previously stated that in the process of assessment, referral and response face-to-face conversations occurred infrequently. This was largely due to the busyness of the ED staff or the fact that the client was located away from the triage area while waiting to be seen by the mental health triage nurse. However, it was both observed by the researcher and reported by the ED and mental health participants that conversations occurred socially and that the value of these ‘talks’ to both the ED and mental health triage nurses is expressed below:

P1: "I find that it just starts at the start and they [mental health] are approachable and even if they are not coming down for business, you know there is no one in the department, which is very rare, even if there is no one around they will just come in, "how's it going at triage?" and that is just a nice partnership. That's just how you would be expected to be treated as a person much less a staff member… They are very friendly approachable guys"

P2: "If they [mental health] have been up to something on the weekend they will come out and have a bit of a chat or something like that and that collegiality breaks down the barriers doesn't it?"

P1: "I think it does and it helps a lot and I suppose it is more, they [mental health] learn how you triage and you know the kinds of things you are thinking and your concerns, and while we [the ED triage nurses] have all been trained similarly it does help that they know you and they can put you to a face and go "oh yeah she is worried", or "she is a sensible girl or whatever"." (ED 13)

This discourse reveals that social communication provides an opportunity for mutual connection that makes the ED nurses feel valued in their own right, not just as staff members. Whether the mental health triage nurses are aware of it or not, the informal conversations and social chats, demonstrate an element of care for, and involvement with, the ED nurses which is a necessary requirement of collegial presence. The ED nurses are also aware of the value of being able to talk through their issues with the mental health triage nurses in a way that makes them feel they have a mutual understanding with the mental health nurses of

not only their work practices and processes but of themselves as individuals. Like the ED triage nurse participants, the mental health triage nurses also found benefit in social conversations:

P: At the start of the shift I go down and say hello, not because its more about courtesy, its more about the aspect that they [ED nurses] can actually recognise that you are actually an individual coming in and you're still there. And then you can turn around and say "look I'll be there in five minutes"." (MH 23)

P: "Face to face tends to minimise the us and them. No matter what environment you are in… I think its about getting around, you know, being there from a profile perspective and actually saying hello to a few people just to make sure they know you are actually around."
I: "So there are some efficiencies just by having a high profile"?
P: "It's just like a community…You know I don't like going around and spruiking for business but the other thing I find is that if you're not out there spruiking for work people have a perception of what you're supposed to be doing and it's the wrong impression you know " (MH 24)

Likewise the mental health triage nurse participant identified that having a presence in the ED allows for discussion about their role with the ED triage staff and one which also enables ED triage staff to more fully understand their role. The reference to a community is sympathetic with the meanings of a collective understanding and working together in collegial presence. Of course, social communication is facilitated by physical presence.

8.4 Physical presence

Physical presence clearly allows for both longer and more personal communication between the two groups. During the fieldwork for this research, it was observed that all the mental health triage nurses based themselves in the mental health triage office as described previously in the chapter on environment. However, the ED triage nurses made frequent reference to a previously employed mental health triage nurse who elected to base themself in the ED. The perceived benefits of this were alluded to by the ED triage staff. To maintain anonymity the persons identity has been changed:

P: "Kelly for example. I can say Kelly because nobody would ever than (sic) [do anything other than] speak highly of Kelly. Fantastic, they'd hang around the whole time… They'd like to hang around and just observe. You know like it was perfect, it was just fantastic. They just had a good rapport, and it is, the ones that do hang around, or when they did more than now; it was just great cause you could just bounce off them.
P3: "Cause you could build up a good rapport with staff and communication is freely open. It's a very simple process." (ED19)

The following passage of discourse occurred when the researcher was discussing the effect that Kelly's permanent presence had in the ED with a group of ED triage nurse participants:

P: "That's what I think would improve the relationship, not so much, I don't think that the time they see the patients would improve or that sort of thing would improve, I think they would still make their own assessment at the moment, but I think the communication, like the incidental communication would improve, the relationship would improve and the idea of."

P2: "Education would improve."

P: "Educate, and incidental education over the tea room sort of thing, and I think the mateship and not letting down a team member would improve… and I think that would improve the way the patient is seen…" (ED29)

Increased physical presence by the aforementioned mental health triage nurse in the ED created opportunities for getting to know each other and building rapport. This contributed to the relationship essential for collegiality; it facilitates social and spontaneous opportunities that allow for a sharing of knowledge to occur which in turn builds a common understanding. This then improves client care, which in this instance is the common work focus of the assessment, referral and response of and to clients with a mental illness. Wang and Xu (2009, p. 327) describe the benefits of intercultural communication thus:

> Mutual understanding between two distinct cultures necessarily involves a constant movement back and forth between one cultural language and the other cultural language. It would eventually reach a fusion of the two cultural horizons, which can serve as a moving common ground between

> the two cultures. Of course, all those have to proceed during the process of constant cultural dialogue or conversation.

The term ‘mateship’ used by the ED triage nurse in the previous participant quote colloquially symbolises the fusion of two cultural horizons. Whether it be incidental physical presence by the mental health triage staff in the ED or presence on an ongoing basis, both groups indicated that the interactions and experiences that it affords between the two groups encourages a deeper understanding of each other that transcends the cultural barriers (Wang & Xu 2009), a critical element of collegial presence.

Underpinning the concept of collegial presence is the understanding of intercultural hermeneutics. Araiarajah (2005, p. 92) suggests that hermeneutics ‘relates to the principles of interpretation to approach, and understand the reality around us’. Intercultural hermeneutics, the way of understanding the culture of others, emerges in the genuine interaction between people of different cultures as they ‘struggle to discover purpose and meaning of life together in a fractured world. Such a hermeneutic does not produce, but arises out of, life in a community.’ (Araiarajah 2005, p. 101). For collegial presence to be enhanced there needs to be a community of practice that allows for a deeper understanding and awareness of the other culture. This culture of practice is a third position, underpinned by intercultural hermeneutics, where dualistic and dichotomous mentalities are transgressed and cultural boundaries are transcended. It is a place where, both parties

place themselves in the intercultural encounter and not exist above it (Marotta 2009).

The influences on the ED and mental health triage nurses that affect perspective is understood at a deeper level if the model below, first presented in chapter six in the discussion on process, is developed based on the following discussion.

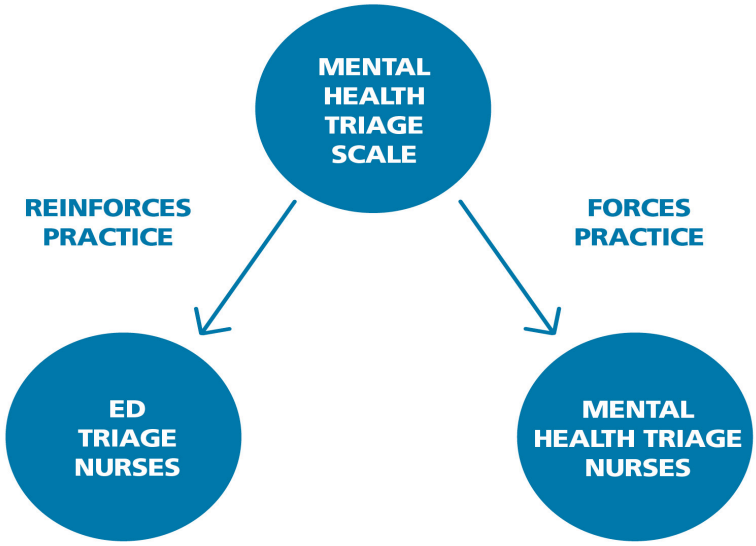

Figure 9: The effect of the mental health triage scale on the two groups

Added to this construct can be an important finding from this research; the notion of presence is strongly related to collegiality by the ED triage nurses due to the position of relative dependency whereas the mental health triage nurses contextualise presence as a construct of service deliver. Previous discussion has highlighted that both participant groups found value in social communication. This in turn both, contributes to, and builds collegial presence. However, the dissonance between the two groups as a result of the tensions created by the influences of process and environment complicate the construction of collegial presence.

Time in the field allowed the researcher to develop insights into the relationship between the ED and mental health triage nurses that affected the development of this culture of practice and subsequent collegial presence. As has been explained, the cultural milieu exposes the two groups who have dualistic worldviews, a different practice environment and who have differing perspectives on distance. This creates a dichotomous perspective on proximity, the process of assessment, referral and response contains inherent tensions that do not engender a sense of teamwork and, despite acknowledgment that being together has benefits, one group operates from a position of dependency, the other from a position of service delivery (Figure 10). It is this perspective that will now be explored.

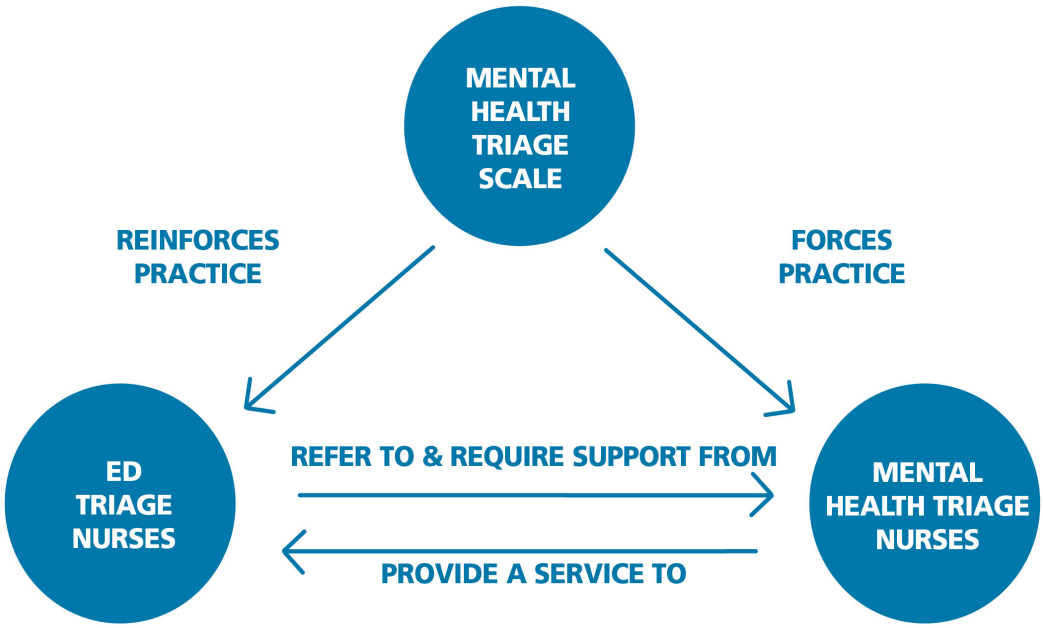

Figure 10: Diagrammatic representation of practice

8.5 Perspectives on a practice community

As discussed earlier, intercultural hermeneutics, or the approach to understanding the reality surrounding us, occurs as a result of life in a community (Araiarajah 2005). The community is the third position as described previously by Marota (2009) and is conceptualised here, in the context of collegial presence as a practice community. It, the place where parties exist, occurs in the practice environment where working relationships occur physically and the intellectual space where working relationships are conceptualised and understood. The ED and mental health triage nurses populate the practice community in this research. A practice community differs to a community of practice that exists when groups of people come together to explore concerns, passions and problems about a specific topic in order to deepen their knowledge (Wenger, McDermott & Snyder 2002). Although there is a shared purpose in both a community of practice and a practice community, participants in a community of practice are there usually voluntarily while people in a practice community are there because of their work role. This means that the multiple factors that are inherent in the cultural and professional perspectives of both the ED and mental health triage nurses influence the practice community.

The mental health triage nurse participants expressed a range of views about closer physical and intellectual engagement with the ED. Here a participant describes the disquiet that the difference of workload would have on them if there were a closer alignment between the two groups:

P: "…Because we have a lot more time down in that ED. I think for our staff too, they're concerned about being exposed to a group. How do you feel sitting there in front of your computer when around you there's a group of your colleagues [ED nurses] working very, very physically hard? You don't have a particular role to play at that time but how does that sit?... I would feel a bit weird about that." (MH 17)

Another mental health triage nurse discusses the fear of an increased workload, based on previous experience, when asked about a closer alignment between the two groups:

P: "The fear, I did a workforce audit two and a half years ago because the managers placed our triage into the ED much to the dissatisfaction of staff for two reasons, one they thought their referrals [from the ED] were going to go higher, increased referrals, and they'd get the old tap on the shoulder… So there's a culture of the tap on the shoulder, a belief that there's going to be more work coming our way…" (MH 23)

Here another participant outlines a view on closer association between the ED and themselves:

P: "I mean the separation between medical and psych has always been there. Whether you walk 400 steps or 50 steps or 10 steps, I don't think that it makes that much of a difference. They [ED triage nurses] don't need to know physically where we are. The majority of those, of those triage staff in ED…wouldn't even know where the mental health centre was. 'It's over there somewhere". (MH 20)

Some participants indicated wariness about a close association based on perceptions of potential increased workload. Participant MH20 was happy to maintain a separation based on tradition delineations. This demonstrates an outlook that inhibits a willingness to place them in the intercultural encounter and not as Marotta (2009) describes, exist above it. The perspective of participant MH20 reflects a very traditional view of the ED mental health relationship and it reinforces Mariano's (1989) contention that teams with a strong cultural affinity for autonomy will tend to support individualisation and specialisation rather than collaborative practice.

These then, are positions that prevent a practice community being developed. The premise for this is that, despite earlier evidence that working in a community and developing relationships is an appealing and beneficial proposition for both groups; there is no imperative for the mental health triage nurses to do so, other than personal desire, because they are ultimately charged with the responsibility for providing a service to the ED. This service as it relates to ED triage is to pick up a phone and consult when a referral is made from the ED, one of many sources of referrals. The service construct is one that is extrinsic to the ED rather than intrinsic. The relative importance of presence to the two participant groups is represented in the following figure.

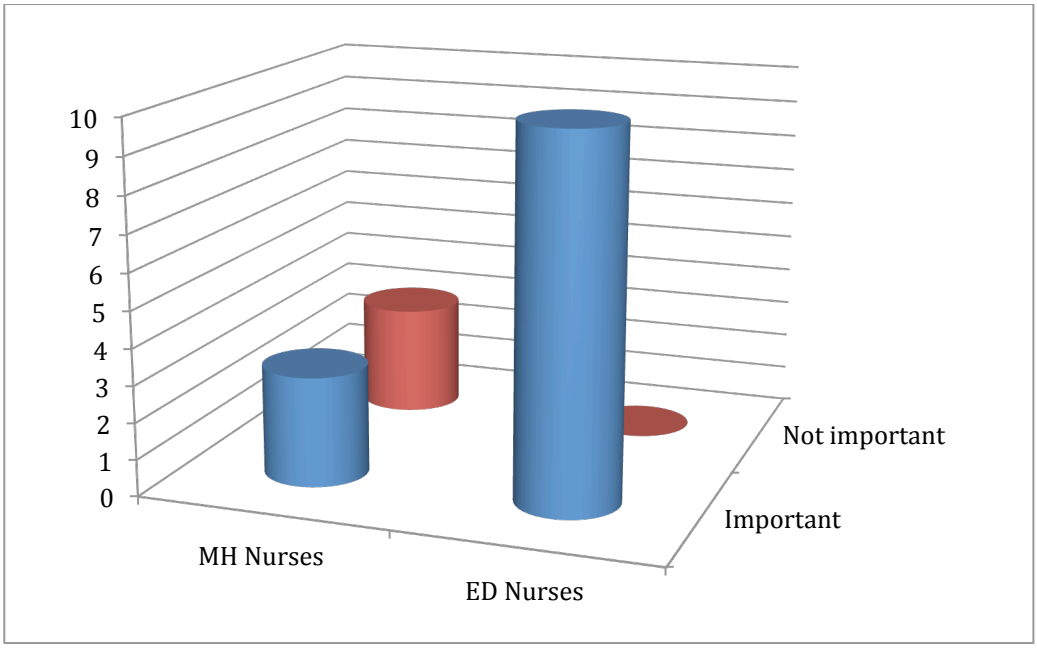

Figure 11: Perspective of the importance of presence as reported by participants.

In terms of developing a practice community that allows for intercultural understanding there are biases and perspectives that the mental health triage nurses express that are informed by their cultural indoctrination and role delineation. These factors impact on their mindfulness, which in turn inhibits the development of a practice community and collegial presence.

As outlined in Figure 10, the diagrammatic representation of practice, and as expressed in the findings and the chapter six on Process, the ED triage nurses rely on the mental health triage nurses to respond to their referrals within the specified time frame and perceive the mental health triage nurses as expert resources on whom they can depend on for support when triaging clients who are poorly trained to assess. ED triage nurses reported feelings of reassurance and increased confidence in having mental health expertise on hand:

R: "Yeah? In what way does it instil confidence?"

P1: "I think it's just nice to know that you've got someone who appears to respond quicker and get onto these particular patients earlier."

P2: "It's just having that expertise, right there, on hand." (ED 16)

There was a deep acknowledgement among the ED triage nurse participants that the presence of mental health triage nurses in the ED facilitated access to mental health expertise, and this provided security. The following statement by one of the ED triage nurses summarises the frustration expressed by many of the ED triage nurses about the absence of mental health triage nurses in the practice community within the ED:

P: "I think we are developing into a far more extended department in that we've now got a physio service, and we've got the social workers and everybody is involved, and I just can't see that we could leave mental health out of that. So I mean, they've got the write up room [mental health office in the ED]. Maybe there's a lack of understanding, certainly from my point of view, I don't know what they do external to the department. Whether they are required in other areas to do what they do, or whether they just work here. I don't know what they do." (ED 16)

In the ED that was the focus of this study, social workers and physiotherapists are based in the department and form an important allied health component of the ED service delivery. They were observed to work in tandem with the ED triage nurses and mixed with the ED staff

in the tearoom and general work area. While not the focus of this research it was noted by the researcher that they were well integrated into the department and, as indicated by the voice of the previous participant, were part of the practice community. The lack of understanding of the role of the mental health nurse further separates the two groups. The absence of the mental health triage nurses in the practice community does not facilitate the genuine interaction between people of different cultures as they aim to understand each other and find a way to work together. It also inhibits the development of shared values that, as outlined in chapter six, is central to minimising risk. The two groups of nurses in this research struggle to find collegial presence because they operate from two constructs. One is service delivery and the other is reliance and dependence. These tensions create friction in the relationship between the ED and mental health nurses and prevent opportunities for meaningful discussions that enhance the intercultural encounter.

This chapter has conceptualised the notion of collegiate presence. It draws from the theories of collegiality (Ayo & Fraser 2008), occupational presence (Reid 2008), cultural intelligence (Earley & Ang 2003) and mindfulness (Horton-Deutsch & Horton 2003) to describe a new way of conceptualising intercultural understanding in the workplace. The discourse in this chapter has reflected the impact of the content of the previous chapters as they affect the notion of collegiate presence. Understanding that culturally disparate groups cannot necessarily develop a functional and collaborative working relationship without a

deep understanding of, and appreciation for, each other's culture is the main finding of this research. Developing such a relationship requires collegiate presence that is built on communication, mindfulness, education and time spent together to develop a practice community.

Chapter 9: Summary and Recommendations

The aim of this research has been to better understand the relationships between ED triage nurses and mental health triage nurses. The impetus for undertaking the study emerged as a result of experiences by the researcher while working as a clinician, where it was observed that in some EDs, there appeared to be a different standard of service at the point of triage to clients with a mental illness to that delivered to clients with physical injury and illness. By deeply examining the influences on the relationship between mental health triage nurses and ED triage nurses it has afforded the researcher the opportunity to better understand the factors that influence the relationship between the ED and mental health triage nurses. This has enabled the acquisition of knowledge that will, through the publication and presentation of findings, deepen the scholarly understanding of the factors that influence the relationship between ED and mental health triage nurses and, in doing so, may contribute to improvements in service delivery to clients at the point of triage in the ED.

The research was conducted in an ethical manner consistent with the National Statement on Ethical Conduct in Human Research (National Health And Medical Research Council & Australian Vice-Chancellors Committee 2009) using an ethnographic methodology. An ethnographic approach was appropriate as mental health and ED triage nurses share the seemingly homogenous characteristic of being nurses but are also heterogeneous by virtue of different ‘cultural’ identities. The ethnographic

method enabled the researcher to extrapolate theories drawn as a result of the study and to provide a rich description of the culture under study. In keeping with the tenets of the methodological approach, field work was undertaken in an Australian ED and mental health triage service using participant observation, individual and group interviews, organisational documentation, including policies and procedures as well as extensive field notes were used to gather data. This large volume of information was managed using NVivo software and analysed using the constant comparative method.

Four key themes were identified as a result of systemised rigorous analytical process. These were, the practice environment, the process of triage assessment, referral and response, the roles and scope of practice and collegiate presence. These themes were all noted to be influential factors in the relationship between the two participant groups.

9.1 The practice environment

Examination of the research site identified that the ED and mental health triage nurses were geographically separate. Their workplaces were sited on the same city block but were distant to each other. The respective workplaces of each of the participant groups reflected the cultural milieu of each of the groups. ED triage nurses worked in public spaces that were busy, often noisy and where they had little control over the ebb and flow of clients and the public. The research identified that the architecture of ED impacted on the ED triage nurses by creating what they described as a sense of isolation. So while ED triage nurses worked

in often chaotic environments, the juxtaposition was that they did so as isolated practitioners. In contrast, while the mental health triage nurses occasionally worked in the ED when required in a dedicated assessment room, they were primarily based in offices that afforded them a high degree of control over who they engaged with and when. The implications of the geographical separation of the two groups were different for each participant group. ED triage nurses valued the presence of other health professionals whose practice is also embedded in the ED. Although the ED triage nurses felt isolated they felt that access to other staff aided their triage practice, which is predicated on rapid decision making and managing clients waiting to be seen. ED triage nurses viewed the mental health triage nurses as a resource to whom they referred, and were reliant on. ED triage nurses felt that mental health triage nurses could make a valuable contribution to their triage practice. This opportunity, they felt, which was often required without much notice, was lost due to the services being geographically distant. Mental health triage nurse participants on the other hand spoke more positively about the separation and indicated that distance allowed them the time to reflect on their planned assessment and ongoing management of the client to whom they were about to deliver care. They did not perceive the geographical separation to be an issue in the delivery of their service to the ED. The practice environment in the ED, as it affected the management of waiting clients, created tensions between the ED and mental health triage nurses in relation to the places clients should wait. This was reflected through the differences in

perceptions of stigma between the two groups, a notion that both groups recognised.

As shown in Figure 12, the practice environment influenced the relationship between the ED and mental health triage nurses as it was found to be influential on both the process of emergency triage and *collegiate presence*. Physical separation left the ED triage nurses feeling vulnerable in their practice as it relates to the process of triaging and the management of clients with a mental illness. Separation allows the mental health triage nurses to function solely as providers of a service to the ED but does not afford the opportunity to gain a deep understanding of the practice of the other group, a critical component of *collegiate presence*.

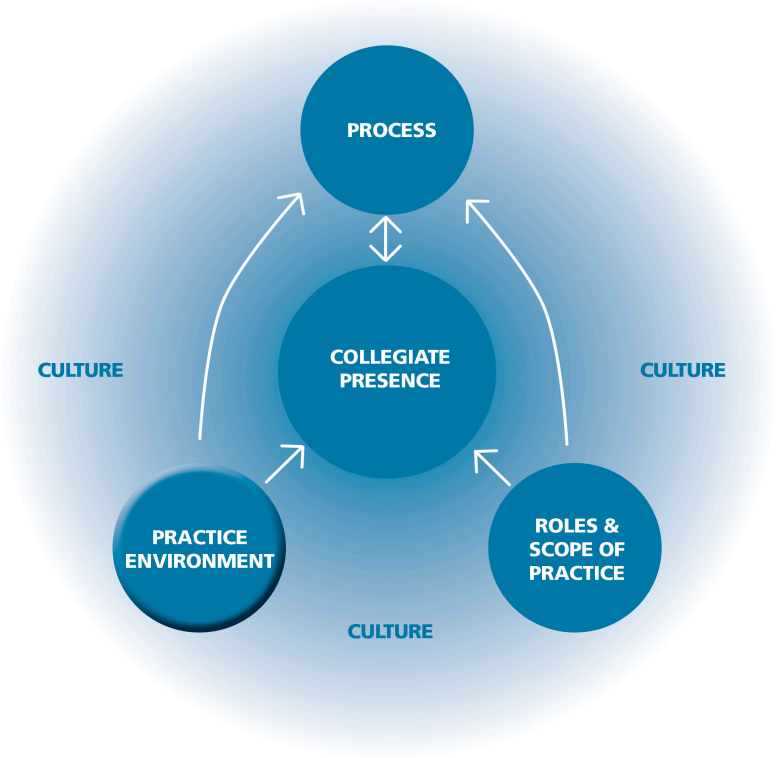

Figure 12: The relationship of Practice Environment to the other themes

9.2 Process

The process of emergency mental health triage was found to have three distinct phases. These are the assessment of the client by the ED triage nurse, referral of the client to the mental health triage nurse and the response to the referral by the mental health triage nurse. The confluence of these three phases that form 'process' influence the relationship between the ED and mental health triage nurses.

Examination of the three phases involved in emergency mental health triage revealed that the poor design of ED triage area compromised the privacy of the client. This lack of confidentiality during the triage assessment, coupled with The ED nurses' lack of insight into mental illness was found to affect information gathering. The triage process as practiced by the ED triage nurse, and the mental health triage scale that supports their decision making is highly structured. The mental health triage scale, used to ascertain the acuity of the client and to allocate a triage score that determines response time, was acknowledged by both groups to be useful in practice. However, ED triage nurses identified issues such as privacy, time and the client's illness as factors that compromised their ability to collect assessment data. This contributed to the collection of data that was sometimes superficial.

The referral of clients by telephone was problematic as such conversations were often brief, poorly constructed and at times provided insufficient assessment details of the client by the ED triage nurses. This meant that mental health triage nurses did not always get the information

they needed to begin planning their assessment and management of the client. This created tension as more information was often requested of the ED triage nurse despite them being unable to conduct further assessment. More information was often requested when the referral was considered by the mental health triage nurses to be inappropriate or inadequate. It was found that the mental health triage scale reinforced and affirmed the practice of the ED triage nurses as they felt they had completed their part of the process, but it forced a response by the mental health triage nurse that was sometimes contrary to what they believed to be correct.

Response by the mental health triage nurses was often predicated by the information received during the phone referral as opposed to a dependence on the triage score alone. The geographical separation of the mental health triage nurses rendered them incapable of seeing the client in the expected timeframe. This created tension between the two groups as the ED triage nurses believed that a timely response as identified by the mental health triage scale timeframes was expected as part of contempory emergency care. However the mental health triage nurses were more inclined to respond according to their perception of the client based on information garnered from the ED triage referral. An analysis of the perceptions of risk undertaken as part of this research using an anthropological framework identified that the ED and mental health triage nurses belonged to two distinct isolated and fragmented cultural groups and work with different perspectives of risk and via

different approaches to risk management. These approaches are informed by and based on cultural influences.

As shown in Figure 13, Process was influenced by both the practice environment and roles and scope of practice. Process was also influenced by, and had an influence on, the notion of *collegiate presence.* The emergence of *collegiate presence* as having a significant two-way relationship with process is understood by the fact that it is the three phases of process that guides the functional relationship between ED and mental health triage nurses. The degree to which the relationship between the two groups is functional within the three phases of process, assessment, referral and response, depends on the existence of *collegiate presence*. A high level of *collegiate presence* may improve the relationship and therefore the process. Conversely, a low level is thought to negatively impact the process due to misunderstandings by each of the two groups on key philosophical and practice imperatives that are underpinned by the cultural milieu of each of the groups.

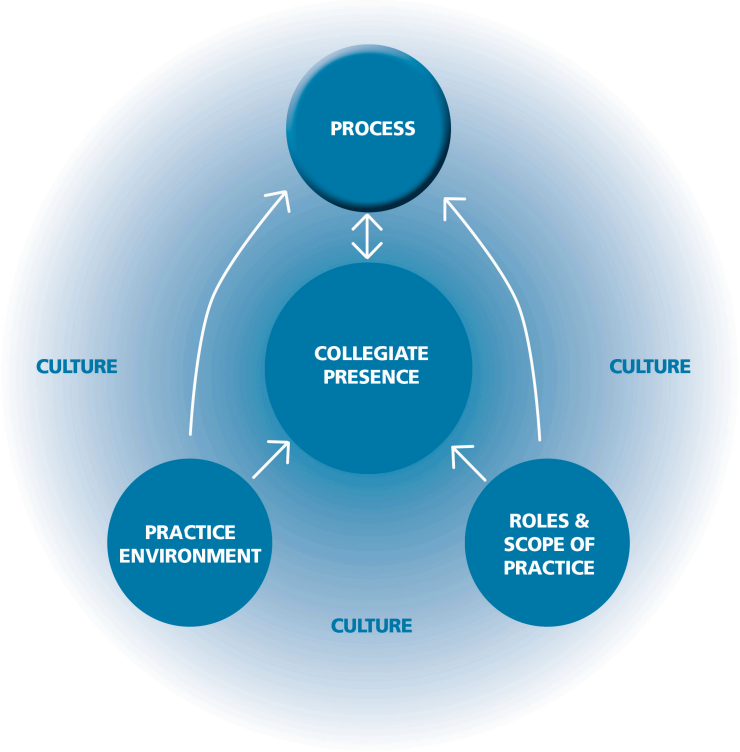

Figure 13: The relationship of Process to the other themes

9.3 Roles and scope of practice

Roles and scope of practice emerged as an influence on the relationship between the ED and mental health triage nurses due to the policy and procedural influences that provide the overarching dictum with regards to who does what and when.

It was found that ED triage nurses worked in a structured environment dictated by specific processes and procedures that clearly defined their role. This structure is essential to assess and refer clients presenting for emergency care and to care for those clients within the waiting room until an ED doctor sees them. Their scope of practice extends to the provision of first aid, monitoring of clients and acting as a liaison person

between the public and other health professionals. The mental health triage nurses were also found to have a clearly defined role of mental health triage assessment of clients and subsequent referral to external agencies or facilitating the admission of the client to inpatient units. However, there was variation between the mental health triage nurses as to how they perceived the way they would carry out their role. The scope of practice was closely aligned with their role.

Role uncertainty emerged as a confounding factor for both ED and mental health triage nurses. The mental health triage nurses believed that their role was diversifying and that other health professionals such as a social worker would better undertake some aspects. Similarly, the ED triage nurses expressed uncertainty about the role of the mental health triage nurse given they were mostly absent from the ED. ED triage nurse participants verbalised confusion as to what the mental health triage nurses did when not in the ED, given the clarity of the roles of other specialised staff based in the ED. The mental health triage nurse participants expressed differing perceptions about what they believed their role to entail and where their allegiances lay, which was outside of the ED.

Ownership of clients once in the ED emerged as an issue of some contention with ED nurses believing that responsibility for the care of the client should lie with the mental health triage nurse. This belief was underpinned by the self-declared lack of mental health knowledge and the lack of experience in providing specialist mental health care to this

client group. Limited understanding of the acuity of the client's illness meant that they could not conceptualise the likely outcome for the clients in the same manner as they could for clients with physical injury and illness. Mental health triage nurse participants articulated the view that the client 'belonged' to the ED for the time that the client remained in the ED and that their role was consultative and supportive rather than providing direct care to clients waiting in the ED.

The disparate roles and scope of practice of the ED and mental health triage nurses influenced the relationship between the two cultural groups, which in turn affected both process and *collegiate presence* (Figure 14). Roles and scope of practice of the two participant groups influenced process as mental health triage nurses performed their role in a manner that was not consistent with that expected by the ED triage nurses. This was confounded by the absence of the mental health triage nurses from the ED. Mental health nurses perceived that the assessment undertaken by the ED triage staff as part of their role was at times insufficient and that, at times, some referrals were inappropriate. This impacted on *collegiate presence* due to misunderstandings surrounding the immediate management and ongoing care of clients. This lack of understanding and appreciation of each group's culture created tensions between the two groups.

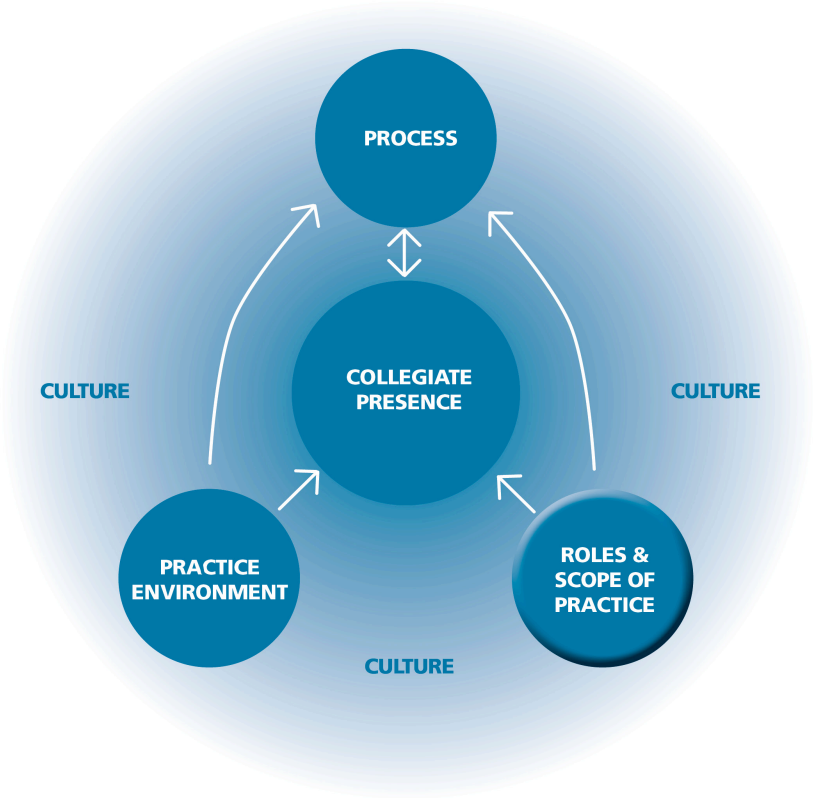

Figure 14: The relationship of Roles and Scope of Practice to the other themes

9.4 Collegiate presence

The final and central theme identified in this research is that of *collegiate presence*. As described collegiate presence has a close two-way relationship with the theme of process and is influenced by the practice environment and the roles and scope of the ED and mental health triage nurses. *Collegiate presence* is a new concept that has emerged from this research. It is underpinned by the previously described theories of collegiality, occupational presence, cultural intelligence and mindfulness.

Collegiate presence is affected by a number of factors including communication, social conversations, physical presence and the existence of a practice community. *Collegiate presence* is noted when social cohesion between the two groups existed. *Collegiate presence* was impacted upon by distant and intermittent conversations and a lack of social and professional interaction. *Collegiate presence* was enhanced when the ED and mental health triage nurses had a close and ongoing presence allowing social communication to occur. This facilitated the development of a practice community in which each group had a better and closer understanding of each other.

Understanding that culturally disparate groups cannot necessarily develop a functional and collaborative working relationship without a deep understanding of, and appreciation for, each other's culture is the main finding of this research. Developing such a relationship requires *collegiate presence* that is built on communication, mindfulness, education and time spent together to develop a practice community. The conceptual map, that follows, demonstrates the centrality of *collegiate presence* and how it is both influenced by, and has an influence on the themes uncovered by this research that describe the factors that influence the relationship between ED and mental health triage nurses.

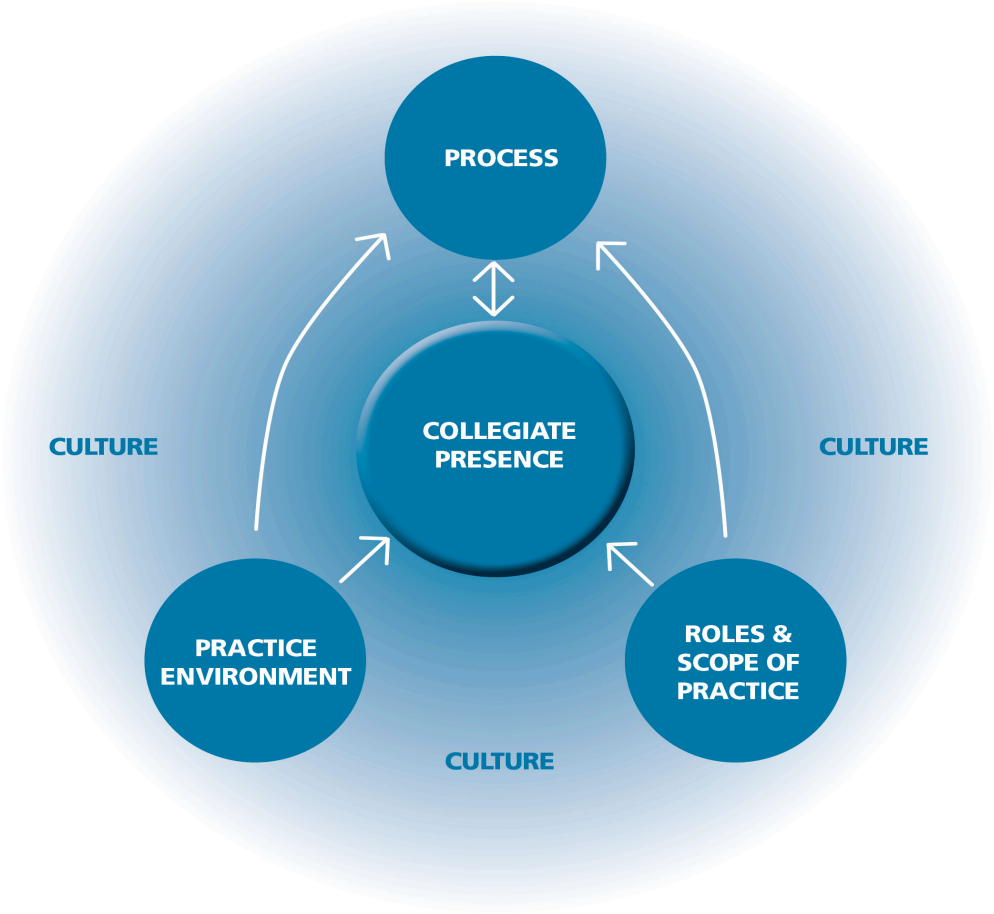

Figure 14: Conceptual map of the relationship of the key themes

9.5 Recommendations

Based on consideration of the extensive literature review, and of the research findings, the following recommendations are made:

1) This research has detailed the significance of the influence of the practice environment and its impact on the relationship between ED and mental health triage nurses. It is therefore recommended that:
    - Future design of ED triage areas consider incorporating a private place for the ED triage assessment of all clients, particularly those with a mental illness in order to maintain confidentiality and improve information gathering by ED triage nurses.
    - Provision is made in ED waiting areas for a quiet, private waiting room, separate from the main waiting room but visible and accessible from the ED triage desk. For use by all clients needing such a facility to ensure their safe and appropriate management.
    - More research be conducted into the implications of ED triage areas and waiting room design from a consumer perspective in order to ensure that consumers voices are heard in continually improving emergency care.
    - Further research be done to examine the skills and attributes required by ED triage nurses to meet the needs of specialist populations of clients they care for such as clients with a mental illness

2) This research has examined and explained the importance of *collegiate presence* as a central requirement for a functional and collaborative working relationship. It is therefore recommended that:

- Mental health nurses be permanently deployed into the ED where possible and that roles be clearly defined.
- Frequent and ongoing conversations occur between professional groups in order to deepen the understanding of the others perspectives as part of the development of a practice community.
- Education on mental illness and recovery for ED nurses and emergency care and triage for mental health triage nurses be part of a continuing calendar of professional development.
- Mental health nurses adopt positions as leaders and mentors in the ED to improve the capacity of all staff to care for clients with a mental illness as well as provide care for clients with acute mental illness.
- More research on telephone referral be conducted to improve information delivery and general communication where phone communication is the principal mode of contact between professional groups.

3) This research identified the numerous models of mental health care in the ED and that there remains a lack of evidence to support one model over another. It is therefore recommended that:

   - Further research be undertaken that examines the capacity of the various models of mental health service to the ED, in particular their ability to respond to referrals within the timeframes dictated by the mental health triage scale and the degree to which the models positively contribute to *collegiate presence*.
   - In order for service delivery within the ED to be consistent with the current national mental health plan, mental health care as practised by all staff reflect the principles of mental health recovery and that further research examine ED nurses conceptualisation of recovery.

4) This research has demonstrated that the use of a mental health triage scale has both a positive and negative influence on the relationship between ED and mental health triage nurses. It is therefore recommended that:

   - A nationally consistent approach to emergency mental health triage is established with a national mental health triage scale to ensure equity for clients with a mental illness.
   - As part of the development of a national mental health triage scale, the perceptions of risk and acuity are researched to develop a scale that both affords the accurate assessment of

client acuity and address the differing perceptions of risk between ED and mental health clinicians.

- Where mental health clinicians cannot be embedded in the ED that other technologies are explored to facilitate the notification of a client's presence in the ED other than a telephone call.
- Research be undertaken to examine the effect of time on the erosion of confidence and competence on ED triage assessment following the introduction of mental health triage scale.
- The relationship between nursing experience and triage decision-making be further researched in order to establish if, as part of ED triage training, time should be spent in a mental health service to provide a longitudinal perspective of mental health care and outcomes.

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Appendices

Appendix 1: The Australasian Triage Scale

AUSTRALASIAN TRIAGE SCALE: DESCRIPTORS FOR CATEGORIES

ATS Category	Response	Description of Category	Clinical Descriptors (indicative only)
Category 1	Immediate simultaneous assessment and treatment	**Immediately Life-Threatening** Conditions that are threats to life (or imminent risk of deterioration) and require immediate aggressive intervention.	Cardiac arrest Respiratory arrest Immediate risk to airway – impending arrest Respiratory rate <10/min Extreme respiratory distress BP< 80 (adult) or severely shocked child/infant Unresponsive or responds to pain only (GCS < 9) Ongoing/prolonged seizure IV overdose and unresponsive or hypoventilation Severe behavioural disorder with immediate threat of dangerous violence
Category 2	Assessment and treatment within 10 minutes (assessment and treatment often simultaneous)	**Imminently life-threatening** The patient's condition is serious enough or deteriorating so rapidly that there is the potential of threat to life, or organ system failure, if not treated within ten minutes of arrival **or** **Important time-critical treatment** The potential for time-critical treatment (e.g. thrombolysis, antidote) to make a significant effect on clinical outcome depends on treatment commencing within a few minutes of the patient's arrival in the ED or Very severe pain Humane practice mandates the relief of very severe pain or distress within 10 minutes	Airway risk – severe stridor or drooling with distress Severe respiratory distress Circulatory compromise - Clammy or mottled skin, poor perfusion - HR<50 or >150 (adult) - Hypotension with haemodynamic effects - Severe blood loss Chest pain of likely cardiac nature Very severe pain - any cause BSL < 3 mmol/l Drowsy, decreased responsiveness any cause (GCS< 13) Acute hemiparesis/dysphasia Fever with signs of lethargy (any age) Suspected meningococcaemia Acid or alkali splash to eye – requiring irrigation Major multi trauma (requiring rapid organised team response) Severe localised trauma – major fracture, amputation High-risk history: - Significant sedative or other toxic ingestion - Significant/dangerous envenomation - Severe pain suggesting PE, AAA or ectopic pregnancy Behavioural/Psychiatric: - violent or aggressive - immediate threat to self or others - requires or has required restraint - severe agitation or aggression

ATS Category	Response	Description of Category	Clinical Descriptors (indicative only)
Category 3	Assessment and treatment start within 30 mins	**Potentially Life-Threatening** The patient's condition may progress to life or limb threatening, or may lead to significant morbidity, if assessment and treatment are not commenced within thirty minutes of arrival **or** **Situational Urgency** There is potential for adverse outcome if time-critical treatment is not commenced within thirty minutes **or** Humane practice mandates the relief of severe discomfort or distress within thirty minutes	Severe hypertension Moderately severe blood loss – any cause Moderate shortness of breath SAO2 90 – 95% BSL >16 mmol/l Seizure (now alert) Any fever if immunosupressed eg oncology patient, steroid Rx Persistent vomiting Dehydration Head injury with short LOC- now alert Moderately severe pain – any cause – requiring analgesia Chest pain likely non-cardiac and mod severity Abdominal pain without high risk features – mod severe or patient age >65 years Moderate limb injury – deformity, severe laceration, crush Limb – altered sensation, acutely absent pulse Trauma - high-risk history with no other high-risk features Stable neonate Child at risk of abuse/suspected non-accidental injury Behavioural/Psychiatric: - very distressed, risk of self-harm - acutely psychotic or thought disordered - situational crisis, deliberate self harm - agitated / withdrawn - potentially aggressive

ATS Category	Response	Description of Category	Clinical Descriptors (indicative only)
Category 4	**Assessment and treatment start within 60 mins**	**Potentially serious** The patient's condition may deteriorate, or adverse outcome may result, if assessment and treatment is not commenced within one hour of arrival in ED. Symptoms moderate or prolonged. **or** **Situational Urgency** There is potential for adverse outcome if time-critical treatment is not commenced within hour **or** **Significant complexity or Severity** Likely to require complex work-up and consultation and/or inpatient management **or** Humane practice mandates the relief of discomfort or distress within one hour	Mild haemorrhage Foreign body aspiration, no respiratory distress Chest injury without rib pain or respiratory distress Difficulty swallowing, no respiratory distress Minor head injury, no loss of consciousness Moderate pain, some risk features Vomiting or diarrhoea without dehydration Eye inflammation or foreign body – normal vision Minor limb trauma – sprained ankle, possible fracture, uncomplicated laceration requiring investigation or intervention – Normal vital signs, low/moderate pain Tight cast, no neurovascular impairment Swollen "hot" joint Non-specific abdominal pain Behavioural/Psychiatric: - Semi-urgent mental health problem - Under observation and/or no immediate risk to self or others
Category 5	Assessment and treatment start within 120 minutes	**Less Urgent** The patient's condition is chronic or minor enough that symptoms or clinical outcome will not be significantly affected if assessment and treatment are delayed up to two hours from arrival or **Clinico-administrative problems** results review, medical certificates, prescriptions only	Minimal pain with no high risk features Low-risk history and now asymptomatic Minor symptoms of existing stable illness Minor symptoms of low-risk conditions Minor wounds - small abrasions, minor lacerations (not requiring sutures) Scheduled revisit eg wound review, complex dressings Immunisation only Behavioural/Psychiatric: - Known patient with chronic symptoms - Social crisis, clinically well patient

TRIAGE CODE	DESCRIPTION	TREATMENT ACUITY	TYPICAL PRESENTATION	GENERAL PRINCIPLES OF MANAGEMENT
3	➢ **Possible danger to self or others** ➢ **Moderate behaviour disturbance** ➢ **Severe distress**	**Urgent** Within 30 minutes	**Observed** ➢ Agitated / restless ➢ Intrusive behaviour ➢ Bizarre / disordered behaviour ➢ Confused ➢ Withdrawn / uncommunicative ➢ Ambivalence about treatment **Reported** ➢ Suicidal ideation **Presence of Psychotic symptoms** ➢ Hallucinations ➢ Delusions ➢ Paranoid ideas ➢ Thought disorder ➢ Bizarre / agitated behaviour **Presence of Mood Disturbance** ➢ Severe symptoms of depression ➢ And / or anxiety ➢ Elevated or irritable mood	**Supervision** Close observation * **Action** Alert Mental Health Triage **Consider** ➢ Re-triage if evidence of increasing behavioural disturbance ▪ Restlessness ▪ Intrusiveness ▪ Agitation ▪ Aggressiveness ▪ Increasing distress

TRIAGE CODE	DESCRIPTION	TREATMENT ACUITY	TYPICAL PRESENTATION	GENERAL PRINCIPLES OF MANAGEMENT
4	➢ **Moderate Distress**	**Semi Urgent** Within 60 minutes	**Observed** ➢ No agitation / restlessness ➢ Irritable without aggression ➢ Cooperative ➢ Gives coherent history **Reported** ➢ Symptoms of anxiety or depression without suicidal ideation	**Supervision** Intermittent observation * **Action** Inform Mental Health Triage **Consider** ➢ Re-Triage if evidence of increasing behavioural disturbance ▪ Restlessness ▪ Intrusiveness ▪ Agitation ▪ Aggressiveness ▪ Increasing distress
5	➢ **No danger to self or others** ➢ **No acute distress** ➢ **No behavioural disturbance**	**Non Urgent** Within 120 minutes	**Observed** ➢ Cooperative ➢ Communicative ➢ Compliant with instructions **Reported** ➢ Known patient with chronic psychotic symptoms ➢ Known patient with chronic unexplained somatic symptoms. ➢ Request for medication ➢ Minor adverse effect of medication ➢ Financial/social/accommodation/relationship problems.	**Supervision** General observation * **Action** Alert Mental Health Triage **Consider** ➢ Referral to treating team if case managed ➢ Referral to treating GP ➢ Referral to social worker ➢ Connect with support network – family, NGOs, other community supports

Appendix 3: Human Research Ethics Committee Letter of Approval

MEMORANDUM

From the Office of Research,
Human Research Ethics Committee Secretary

Central Queensland
UNIVERSITY

Ph:07 4923 2603

Fax:07 4923 2600

Email:ethics@cqu.edu.au
4 April 2008

Mr Marc Broadbent
Health & Innovation
CQU Noosa Campus

Dear Mr Broadbent

HUMAN RESEARCH ETHICS COMMITTEE ETHICAL APPROVAL PROJECT: H08/02-010, TOWARDS AN UNDERSTANDING OF EMERGENCY MENTAL HEALTH TRIAGE

The Human Research Ethics Committee is an approved institutional ethics committee constituted in accord with guidelines formulated by the National Health and Medical Research Council (NHMRC) and governed by policies and procedures consistent with principles as contained in publications such as the joint Universities Australia and NHMRC *Australian Code for the Responsible Conduct of Research.*

On 4 April 2008, the Human Research Ethics Committee of the Central Queensland University acknowledged compliance with the conditions placed on ethics approval for the research project, *Towards an understanding of emergency mental health triage* **Project number H08/02-010**

The period of ethics approval will be from 4 April 2008 to 31 December 2009. The approval number is H08/02-010; please quote this number in all dealings with the Committee.

The standard conditions of approval for this research project are that:

- you conduct the research project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments required to be made to the proposal by the Human Research Ethics Committee;
- (b) you report immediately anything which may warrant review of ethics approval of the project, including:
- serious or unexpected adverse effects on participants;
- proposed changes in the protocol;
- unforeseen events that might affect continued ethical acceptability of the project;

- *(A written report detailing the adverse occurrence or unforeseen event must be submitted to the Committee Chair within one working day after the event.)*
- you provide the Human Research Ethics Committee with a written "Annual Report" by no later than 28 February each calendar year and "Final Report" by no later than one (1) month after the approval expiry date;
- *(A copy of the reporting pro formas may be obtained from the Human Research Ethics Committee Secretary, Sue Evans please contact at the telephone or email given on the first page.)*
- if the research project is discontinued, you advise the Committee in writing within five (5) working days of the discontinuation;
- you make submission to the Human Research Ethics Committee for approval of any proposed variations or modifications to the approved project before making any such changes;
- you comply with each and all of the above conditions of approval and any additional conditions or any modification of conditions which may be made subsequently by the Human Research Ethics Committee;
- you advise the Human Research Ethics Committee (email: ethics@cqu.edu.au) immediately if any complaints are made, or expressions of concern are raised, in relation to the project.

Please note that failure to comply with the conditions of approval and the *National Statement on Ethical Conduct in Human Research* may result in withdrawal of approval for the project.

You are required to advise the Secretary in writing within five (5) working days if this project does not proceed for any reason. In the event that you require an extension of ethics approval for this project, please make written application in advance of the end-date of this approval. The research cannot continue beyond the end date of approval unless the Committee has granted an extension of ethics approval. Extensions of approval cannot be granted retrospectively. Should you need an extension but not apply for this before the end-date of the approval then a full new application for approval must be submitted to the Secretary for the Committee to consider.

The Human Research Ethics Committee wishes to support researchers in achieving positive research outcomes. If you have issues where the Human Research Ethics Committee may be of assistance or have any queries in relation to this approval please do not hesitate to contact the Secretary, Sue Evans or myself.

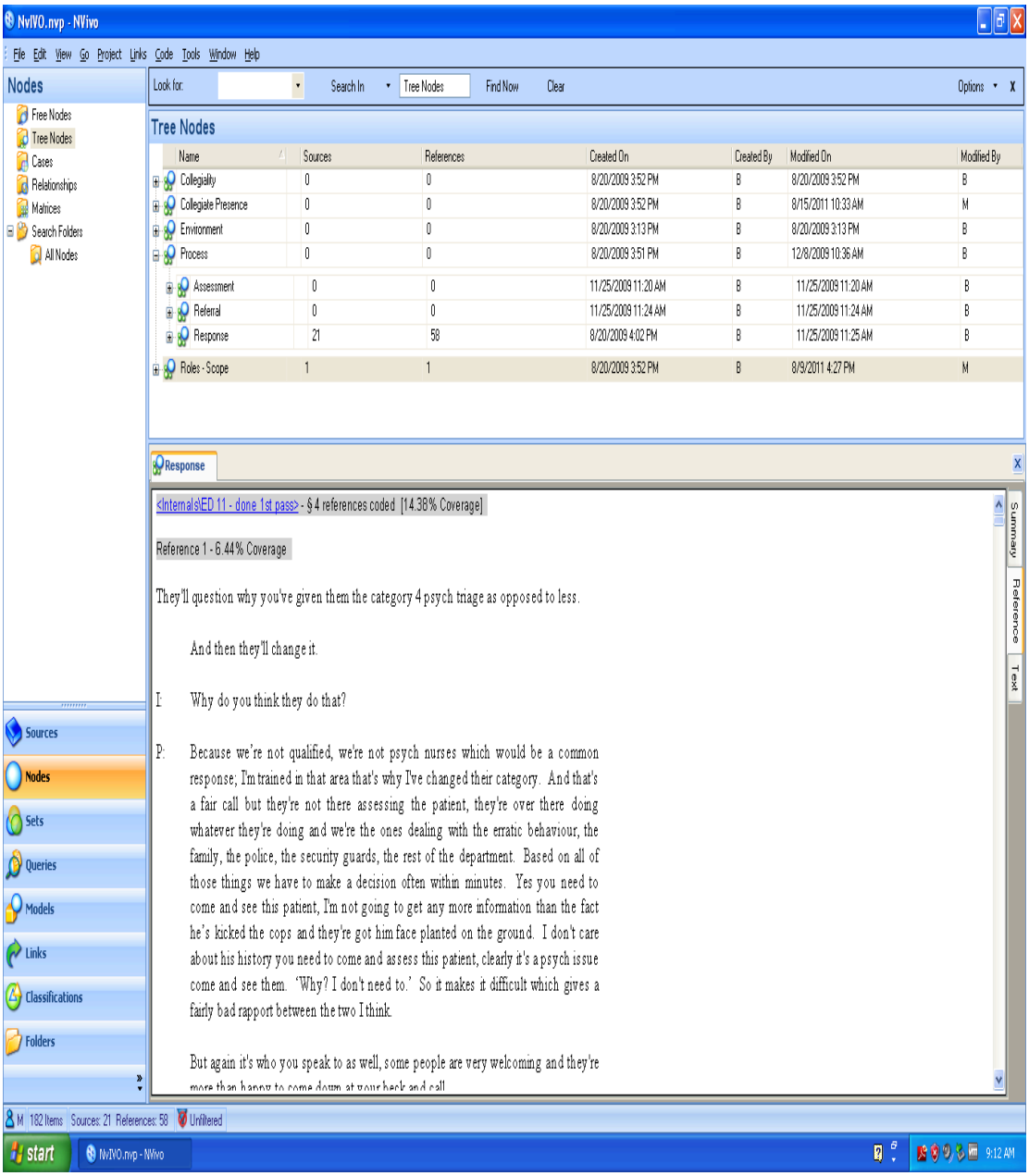
Yours sincerely,

Dr Teresa Moore
Acting Chair, Human Research Ethics Committee

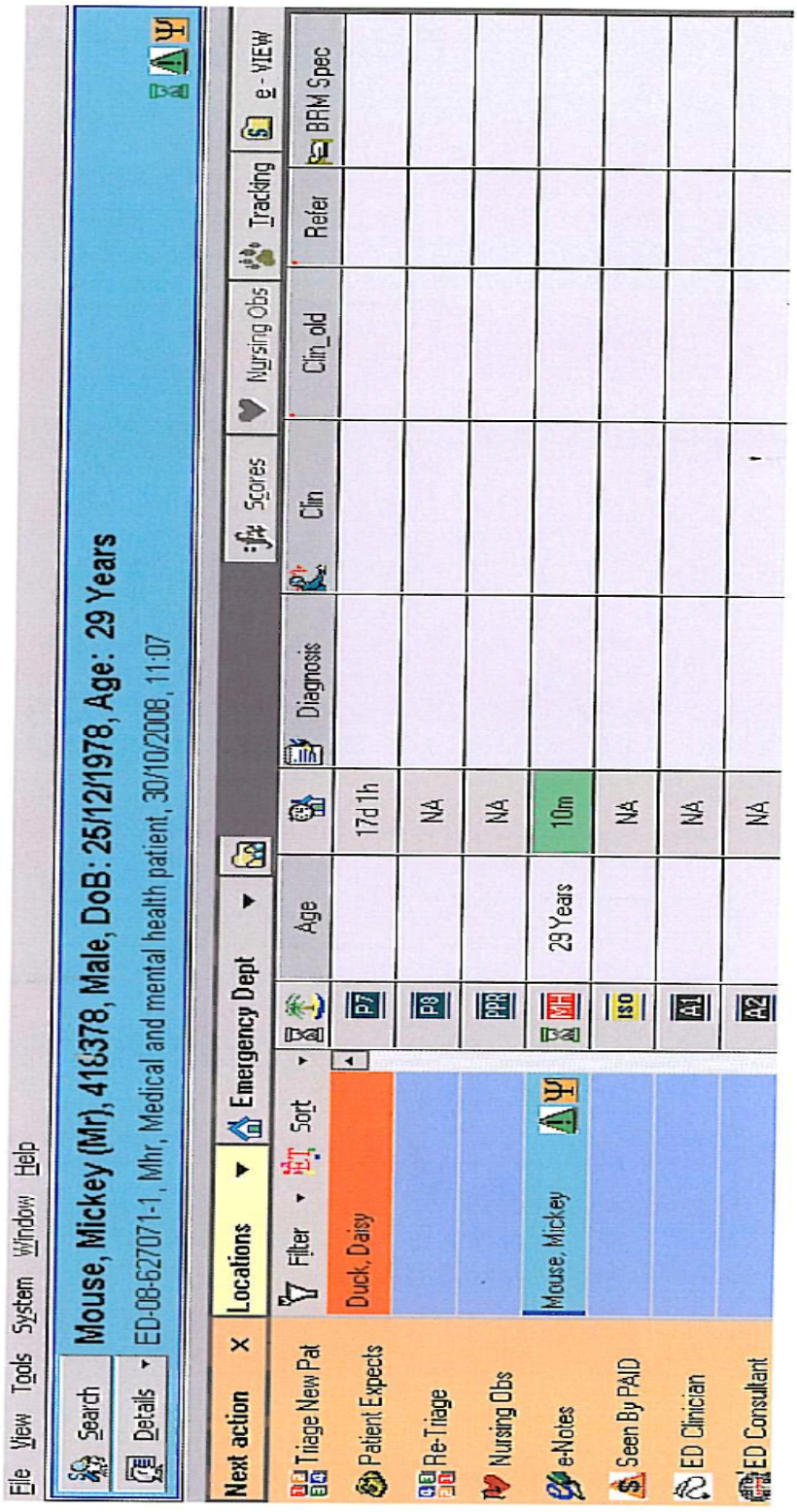
Cc: Dr Lorna Moxham
Project File

Application Category: A

Appendix 4: Coding within NVivo



Appendix 5: Image of the Emergency Department Information System



Community Mental Health and ED Protocol Orientation Manual

As Revised March 2004

BACKGROUND

The ED is an important contact point for people with mental health problems yet the development of clinical tools for the assessment and management of individuals with mental health (MH) problems has to date been adhoc and isolated to individual Emergency Departments (ED's) developing their own protocols and policies. The National Triage Scale (NTS) was developed in 1993 and is accepted and used Australia wide for the assessment and management of people presenting to ED's with physical problems. Clinical descriptors for people with mental health presentations were not included. This has led to a sense of ambiguity amongst the ED staff in regards to the application of the NTS to clients with mental health problems.

The problems associated with the lack of guidelines relating to the assessment and management of people with mental health illness in the ED and the inadequate staff knowledge and skills in dealing with people with MH illness were recognised by key ED and MH staff. Coupled with a need to review the relationship between the Mental Health Triage Service and the ED it was agreed that action should be taken to improve service performance and client outcomes. To achieve this the Community and Mental Health Program received funding to develop, implement and evaluate a Mental Health Triage Scale (MHTS).

This scale is now in use and provides the operational framework for the referring of clients from the ED to the Mental Health Triage Service.

The advantages of using a triage scale are that it provides a structured approach to MH assessment for non-MH trained staff and therefore referrals are consistent and reflect the acuity of the client's presentation.

The specific timeframes allow you to plan your workload. By giving you an indication of the acuity of the client in ED you can measure this against any clients you may be expecting or are currently engaged with,

and prioritise your workload accordingly. The fact that the scale exists does not automatically mean that non-ED clients take second place. If you believe that the client you are with have needs that are greater or more immediate than the client in ED, then the client you are with takes priority. You need to make the triage nurse in ED aware of your situation so they can manage the client in ED appropriately. Communication, collaboration and common sense are the cornerstones of a successful ED – MH triage relationship.

The following information introduces you to the triage scale that is in use in the ED and guidelines that were developed to ensure consistent practice. Please familiarise yourself with the information in this folder, as it will enhance your practice and the delivery of care to the client

GUIDELINES FOR PRACTICE

TRIAGE CODES

Triage codes are given to all clients/patients who present to ED's throughout Australasia, based on the Australasian Triage Scale (ATS), developed by the Australasian College for Emergency Medicine. The codes and their respective timeframes are as follows:

Code 1: immediate response
Code 2: response within 10 minutes
Code 3: response within 30 minutes
Code 4: response within 60 minutes
Code 5: response within 120 minutes

The codes are representative of the clients presenting condition and the potential for deterioration in their physical and/or mental health. They are designed to ensure that the resources of the ED and the MH triage service are used to the best advantage and directed to those clients/patients with the greatest need.

RESPONSE TO A REFERRAL FROM ED

As the MH triage is not based in, or exclusive to, the ED, there exists a need for MH triage to respond to the needs of the clients in ED and the clients in their care at any given time.

Responses:

- In the event of an MHTS code 1 or 2 it is expected that the MH triage nurse will respond *in person* as quickly as possible. It is understood that it is of benefit to consult the client's history (if applicable) prior to responding in person to ensure the best management of the client.

- It is extremely important that the MH triage nurse informs the ED staff of their intentions in response to a MHTS code 1 or 2 so that ED medical and nursing staff are aware of what is going on. Plans can then be made for the best management of the client.

RESPONSE TIME BY MH TRIAGE

This is the time that the Mental Health Triage Nurse actually sees the client. This is the time that will be documented on the computer. The time should fall within the timeframes as dictated by the MHTS. These are:

Triage Code 1:	Immediate response
Triage Code 2:	Response within 10 minutes
Triage Code 3:	Response within 30 minutes
Triage Code 4:	Response within 60 minutes
Triage Code 5:	Response within 2 hours

CLIENTS PRESENTING TO THE ED AT THE REQUEST OF THE MH TRIAGE NURSE

The Mental Health Triage Nurse should inform the ED triage nurse of any clients they have asked to present to ED for assessment. In this instance the clients will be given a MHTS commensurate with their presentation. The MH Triage Nurse will inform the client of any potential delays between presenting to ED and being assessed by MH triage.

MEDICAL CLEARANCE

Background:

Mental illness and substance abuse are a potentially fatal combination. The MHTS addresses this issue with appropriate behavioural descriptions and a requirement to consider a higher triage category when concurrent drug and/or alcoholic intoxication exist. In the past there has been a requirement to have the client treated and medically 'cleared' prior to MH assessment.

The issue of intoxication is dealt with in the Key Service Requirements for Enhanced CAT Services, 18/05/99 (In the *Chief Psychiatrist Clinical Guidelines, Assessment of Intoxicated Persons,* December 1999). The guidelines state that:

"The [mental health] service will directly assess all persons referred from the community as being suicidal or….at risk of suicide….this includes those who are intoxicated as a result of alcohol or other drugs"

In order to incorporate this recommendation the following protocol has been implemented:

There is no need to 'medically clear' clients who are intoxicated by drugs or alcohol and exhibit suicidal or other mental health symptoms prior to mental health assessment. If, as part of the MH assessment, a complicating physical condition is suspected, or the client needs medical treatment for their intoxication, the client may be referred back to the ED medical staff following the MH assessment. Or, if the client is very ill the MH assessment will be conducted in collaboration with the medical assessment and treatment. In this instance ongoing MH assessment can be planned in conjunction with the ED staff.

CLIENTS WITH COMBINED MH AND PHYSICAL ILLNESS

Background:

A significant number of clients present with comorbid presentations. Often their physical need outweighs their MH need, such as someone that has overdosed or is unconscious or has an altered mental state from overdose or serious physical self-harm. The priority is to ensure the clients physical needs are attended to in the normal triage process. However the physical dilemma of the client exists as a direct result of the client's inability to cope with a mental health crisis and the response by mental health services should reflect the gravity of the situation. The Mental Health Branch of the Department of Human Services, Victoria, supports this view in a paper on Suicide Prevention Funding (July, 2000 pg. 22) that states,

> *The [mental health] worker will provide immediate comprehensive, psychiatric assessment of **all** persons presenting with intentional self harm or who are suicidal or identified as a suicide risk at emergency departments in that [Area Mental Health Services] AMHS catchment. (The immediacy of the assessment will depend on the person's need for urgent medical treatment and their level of consciousness; however, it should be conducted in a timely manner as part of the overall assessment of the person's condition.)*

In order to incorporate this recommendation the following protocol has been implemented:

Mental Health Triage will be contacted by ED triage as soon as it is possible following the client's presentation. The client will be given an ATS code commensurate with their physical condition, and the MHTS code will be assigned according to usual descriptors.

This protocol achieves 3 important points in intention and practice.

- It ensures that Mental Health Services are advised of the client's presence in ED sooner rather than later.

- The MH triage nurse then consults the client's mental health history and offers relevant information to the treating ED staff for consideration as part of the medical and nursing assessment.
- The MH triage nurse will respond within the MHTS code and provide initial assessment and then document in ED notes.

Steps 2 & 3 are to be completed within the MHTS code.

In practice this protocol initiates a stream of dialogue and documentation between ED and MH staff that ensures the appropriate interventions and personnel are engaged in a timely and efficient manner.

USING THE ED COMPUTER PROGRAM

The ED computer program, FeTelnet, runs on the computer in the triage office. You will find it is of use to see which clients/patients are in ED at any given time (the information on the screen is real time).

As part of your role in seeing clients in ED it is important that you document the date and time you responded to a referral from ED. Most of the time this will be the time you actually see the client in ED. You are required to enter this data into the ED program.

One point that is important to understand, is that a major source of funding for the ED is dependent on the abilities of the staff to see the clients/patients *within the timeframes of the triage codes dictated by the triage scale*. This means that if the client is referred to you as a code 3 and you see the client within 30 minutes you should put this into the computer. If however, you are unable to meet the timeframe, i.e. you saw the client outside of the required timeframe, due to workload or some other reason, then enter the time you saw the client even if it is outside the triage time requirements. This data only affects performance targets and funding *when the client is referred directly to you as their primary treatment*. If you see someone who has, for example, overdosed, the triage code that matters is the one that the ED medical staff must respond to. So in this instance the date and time you saw the client is important but not essential for meeting performance targets.

The data must reflect actual conditions and is a good source of information for assessing ED workload and requesting further funding if triage timeframes are consistently not being met. So please be honest with the data you put into the computer program, and the ED staff will appreciate your efforts.

It is good practice to enter your details on all the clients you see in ED regardless of how they were referred to you. Every health care provider who sees a person in ED is expected to enter his or her details in the patient screen. This builds a profile of who saw the client/patient and when.

Appendix 7: Participant information sheet

Central Queensland UNIVERSITY

Towards an Understanding of Emergency Mental Health Triage

Principal Investigator: Marc Broadbent, Central Queensland University

Thank you for taking the time to read this information sheet and considering participating in this research.

As the name of the research topic indicates this research aims to understand the factors that affect the process of emergency triage of clients with a mental illness in the Emergency Department (ED) and the referral to, and response by, mental health triage nurses. In particular I am interested in understanding the relationship that exists between ED and mental health nurses and the factors that affect that relationship.
All Registered Nurses who are rostered to work at triage in the ED or who hold positions in the Mental Health Triage Service are invited to participate.

Who has approved the research?
This research is being conducted under the auspices of the Central Queensland University (CQU) Office of Research and has been approved by the CQU and Organisations Human Research Ethics Committees. I have gained approval from your Nurse Manager to conduct this research in your department.

What will be required if I participate?
Participation in this research is voluntary and you may leave the research at any stage and where possible, data will be withdrawn. Likewise it is your choice to participate or not.
By agreeing to be part of this research you will be included in group interviews that will occur during your working day at a time negotiated with your nurse manager. I will also be spending time with you at triage during which I may ask you questions when it is convenient to do so. Group interviews that you are in will be taped and when appropriate individual interviews will be taped also. I will be observing the triage process however I will not be observing or participating in your interactions with clients and do not require you to discuss the care provided to individual clients when they present. I will not be making any judgements about the care you provide or your triage decisions in any way; I am interested in professional relationships.
I will be examining documents such as policy and procedures and triage forms that relate to the triage process and asking you about them and

how they impact on the process. I will look at triage documents but not ones that contain client information.

How will confidentiality be maintained?

I will not be asking you to divulge your name, experience, qualifications or any other personal demographic details during this research as what I am interested in is your experiences in clinical practice as they relate to the process of emergency mental health triage.

Should you mention your name or the name of a colleague during the interviews, when that data is transcribed from tape to paper the names and any other personal identifiers will be removed so that comments cannot be attributed to an individual. The taped interviews will be kept as an electronic file on a CD stored in a locked filing cabinet or a password protected computer in the principal investigators' secured office. Only the principal investigator will have access to the taped recordings of the interviews.

Will I be informed of the results of the research?

I will send you a plain English summary of the findings if you indicate on the consent form that you wish to receive the summary.

Deidentified research findings based on the data collected will be published in a thesis, journal articles and conference proceedings.

How do I enrol in the research?

If you would like to participate in this research please complete the attached consent form and return it to me in the envelope provided.

If you have any concerns or questions about the way in which this research has been conducted please contact Office of Research at Central Queensland University, phone 07 4923 2607, fax 4923 2600 or research-enquiries@cqu.edu.au .

Thanks you for taking the time to read this information sheet. Please feel free to contact me if you would like to know more about the research on 07 5440 7018 or m.broadbent@cqu.edu.au

Regards

Marc Broadbent RN

Central Queensland UNIVERSITY

CONSENT FORM

Project Title: Towards an Understanding of Emergency Mental Health Triage

I ……

Of (Address/Email)……

Agree to participate in a research study explained to me by the researcher about the management of clients with a mental illness in the emergency department at the point of triage and the working processes between emergency triage and mental health triage nurses.

I understand that:

- I am to participate in an interview/s which may be as part of a group or as an individual and that the interviews will be taped
- My privacy will be protected. Any personal information that I provide will not be made public in any form that could reveal my identity to an outside party i.e. I remain anonymous
- I am free to withdraw my consent at any time during the study and where possible data will be withdrawn
- I have had the opportunity to discuss this study and I am satisfied with the answers I have been given
- I know who to contact if I have any questions about the study
- I am aware that support and counselling is provided by the researcher if needed
- Research findings will form the content of a PhD thesis and may be presented at conferences and/or journal articles

Date: ....
Signature of participant

Please indicate if you would like to receive a plain English summary of results when the study concludes sent to the above address.

Yes☐ No☐

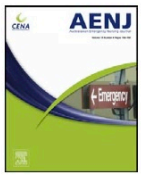
Appendix 8: Peer reviewed publications arising from this thesis

Australasian Emergency Nursing Journal (2010) 13, 117—123

available at www.sciencedirect.com

ScienceDirect

journal homepage: www.elsevier.com/locate/aenj



LITERATURE REVIEW

Issues associated with the triage of clients with a mental illness in Australian emergency departments

Marc Broadbent, RN, MED*, Lorna Moxham, RN, PhD, Trudy Dwyer, RN, PhD

Institute for Health and Social Science Research, CQUniversity Australia, Building 18, CQUniversity, Bruce Highway Rockhampton, Qld 4702, Australia

Received 12 January 2010; received in revised form 20 August 2010; accepted 23 August 2010

KEY WORDS
Emergency nursing;
Psychiatric nursing;
Triage;
Emergency service hospital;
Emergency service psychiatric;
Mental illness

Summary
Purpose: This paper provides a summary of the issues associated with the emergency triage of clients who have a mental illness in order to demonstrate the complexity inherent in contempory emergency triage practice to this client group.
Procedures: A review and analysis of English language peer-reviewed literature and research was undertaken.
Findings: Since 1993, there have been a range of initiatives implemented in Australian emergency departments that were aimed at improving the assessment and management of clients presenting with a mental illness. The assessment and subsequent response for clients presenting with a mental illness are highly variable. Currently the terminology related to mental health emergency triage is poorly defined. Many improvements in mental health service delivery have been acknowledged as beneficial to staff and clients in emergency departments. Despite this there remains a dearth of literature about mental health services operating within the specific time constructs as prescribed by the Australasian Triage Scale. Recent research suggests that the mental health descriptors within the Australasian Triage Scale may not be a reliable tool for accurate mental health triage assessment.
Conclusions: These assertions suggest there is an imperative for further research into the practices and processes that underpin the emergency triage of, and response to, clients who have a mental illness and who present to an emergency department.

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doi:10.1016/j.aenj.2010.08.087

What is known

- The triage of clients with a mental illness remains a problematic proposition across Australia. Multiple triage scales are in use and the ATS has been demonstrated to have low inter rater reliability when used for mental health assessment.
- The response by mental health services to ED presentations is unknown and has not been described in terms of the ability to meet triage time frames.

What this paper adds

- A summary of the key issues from the literature associated with the triage of clients with a mental illness
- Discussion of the ATS and its value in triage assessment of clients with a mental illness.
- Recovery is the dominant paradigm for the care of clients with a mental illness and is introduced as a model of care for clients with a mental illness in the ED.

Introduction

Improvements in the initial assessment and management of clients in the Emergency Department (ED) are inextricably linked to improvements in the process of triage.[1] Triage is a French word derived from the verb 'trier' meaning to pick or cull[2] and within health, it has its origins in the Napoleonic wars.[3] As a process within ED's, triage is dynamic and has been evolving since 1975. It is now the primary process within Australian ED's with regard to initial assessment and categorisation of patient acuity. The principle tool which is the current method of choice is the Australasian Triage Scale (ATS).[4] Since 1993 work has been undertaken to improve the responsiveness of ED's to the increasing number of presenting clients who have a mental illness. The principle mechanism of assessment to adapt to this increasing cohort has been the introduction of a specialised mental health triage scale (MHTS).[5–7] Along with the introduction of specialist mental health triage scales changes have also been made to models of service delivery to the ED by mental health departments. These initiatives, designed to improve mental health service delivery in the ED, have evolved as direct result of the escalating use of emergency departments by clients who have a mental illness.

The increasing use of EDs as a focal point of primary access to mental health services has been increasing since the implementation of deinstitutionalisation and mainstreaming as mental health policy.[8] Between 1996 and 2000 there was a three hundred and twenty percent rise in the number of adult clients with a mental illness that presented to the Flinders Medical Centre in South Australia.[9] It has also been reported that in Victoria, between 1991 and 2001, there was a fourteen percent increase per year in mental health presentations to EDs in that state.[10] These examples demonstrate the theme that is also evident in the literature that EDS have been subject to increased presentations by clients with a mental illness.[5,11–14] Given that twenty percent of the Australian population will experience a mental health problem in any given year,[15] it is likely that EDs will be the subject of sustained use as a point of access for mental health care due to their accessibility. It is important then that emergency nurses stay abreast of contemporaneous issues associated not only with the care of clients with a mental illness but the impact these issues may have on the most critical of nursing roles in the ED, that of triage.

This paper then collates contempory discourse relating to emergency mental health triage. The conflicts in terminology that exist within emergency department practice are discussed and mental health nursing practice in relation to the triage of clients who have a mental illness are detailed and explained. Further, literature is drawn upon to examine the interaction of mental health services in Australian ED's and the efficacy of the ATS as a triage scale for clients who have a mental illness. Other issues such as the influence of contempory policy measures in relation to mental health and the triage of clients with a mental illness are also discussed.

Procedures

A comprehensive literature search reviewing the years 1993—2010 was conducted using Proquest, Cinahl and Google Scholar. 1993 was the year that the first report of changes to ED triage practice in regards to assessment of clients with a mental illness was published. The key terms used to conduct the search were mental health, mental illness, triage, emergency nursing, mental health nursing and emergency departments. These were entered and combined for the process of the search. Articles selected for use in this paper were chosen using the following criteria; published in peer-reviewed journal within the time frame specified and of direct relevance to the Australian context. Other literature such as textbooks and reports known to the authors were also used.

Findings

The use of mental health triage scales in Australia

The principle mechanism for improving triage assessment to clients presenting to the ED with a mental illness has been the introduction of a specialised mental health triage scale (MHTS).[5–7]

Development of triage scales in Australian ED's began at the Box Hill Hospital in 1975.[16] The Box Hill triage scale was designed as a system for improving emergency assessment and was subsequently adapted and tested to develop the National Triage Scale (NTS).[3] The NTS was the precursor for the ATS that is now used in emergency departments throughout Australasia.

In the early 1990s it became apparent to staff within the emergency department at the Royal Hobart Hospital, Tasmania, and to staff within the South Eastern Sydney Area Health Service (SESAHS) that as a consequence of the NTS having its roots in physical injury and/or illness, it was not adequate or appropriate for clients who had a mental illness and who were, in increasing numbers, presenting to

emergency departments.[6] These realisations lead staff from these sites to concurrently develop a MHTS as a vehicle for improving triage service delivery to clients who had a mental illness in the ED.[6,7] In 2001 the SESAHS triage scale was incorporated into practice at the Geelong Hospital ED, in the state of Victoria as a means of improving service delivery to people who had a mental illness.[5]

In 2004 the Victorian Department of Human Services (DHS) commissioned the National Institute of Clinical Studies (NICS) to further improve the ED triage process for people presenting with mental health problems and also to improve collaboration between ED's and mental health services.[17] The scope of the NICS project was to develop and introduce a MHTS and to provide support to nineteen ED's across Victoria. This was to be achieved by professional education and the development of policies and procedures that would facilitate the management of people who were presenting based on the triage category which they were given. The SESAHS MHTS as adapted by Broadbent et al.[5] in Geelong was articulated with the mental health descriptors from the ATS to create the Victorian Emergency Department Triage Tool (VEDTT). The Royal Hobart Triage Scale, the SESAHS triage scale, and the Victorian Emergency Department Triage Tool were designed to articulate with the ATS in terms of their ability to measure acuity and therefore time to assessment and treatment. As a result existing MHTS are similar to the ATS in respect of the principles upon which they are based.[10]

Despite the inclusion of mental health descriptors within the ATS, the use of a specialised MHTS has gained increasing acceptance in clinical practice across Australia.[11] Reviews of the Royal Hobart MHTS[19–21] describe its use in clinical practice from a number of perspectives. These reviews though, lack analysis related to measurement or description of improvements in operational service delivery to clients who have a mental illness.[18] The SESAHS MHTS has also been reported as being in widespread use across Victoria, Australia.[17] Notwithstanding the widespread use of MHTS other than the ATS across Australia, most ED's continue to use the ATS for mental health triage assessment instead of adopting a specialised MHTS into their systems of clinical assessment.[18] This continued use is despite evidence that using the specialised MHTS improves the competence and confidence of general trained nurses in the assessment of clients who have a mental illness in the ED[1,6] and the dissemination of a MHTS in the Emergency Triage Education Kit.[22]

The ED and mental health service interface

As indicated, the introduction of specialised MHTS into practice has been shown to improve the confidence and competence of triage nurses in the assessment and management of clients who have a mental illness and who present to the ED.[1] The literature and research surrounding the development and use of these MHTS reflects that there is an inconsistent approach to the triage of clients who have a mental illness. Further, the research and literature highlights a growing number of issues related to mental health service delivery in Emergency Departments. These issues are related to terminology, models of care and those associated with referral and response.

The processes and intentions of triage in the ED and that of mental health triage are quite distinct. The emergency triage process is, by its very nature brief, taking no longer than 2—5 min.[23] Following this very rapid assessment, conducted at a triage desk by a generalist nurse, clients are then moved into areas within the ED that are deemed appropriate to their assessed need. This geographical movement acknowledges the need for ongoing nursing and medical management. As alluded to, the mental health triage process is different. This difference can best be explained by the definition offered by Broadbent et al.[1] He defines mental health triage as

> ''. . . a secondary triage process. Having been referred from the ED the mental health triage worker conducts a full examination and assessment of the client and then refers the client to the most appropriate treatment facility such as community support or admission as an inpatient. This process may take hours.''

This highlights the differences between the two processes. However, the term 'mental health triage' is used when discussing the triage assessment of clients who have a mental illness and who present to the ED[1,5,6] and is also used when describing the work of mental health nurses working in a variety of settings.[24] This adds to the confusion.

In order to clarify the two processes it is necessary to discriminate between the triage of clients who have a mental illness and who are in the ED and the subsequent specialist care these clients receive by mental health clinicians. The following definitions then are recommended as a point of differentiation and as a way to overcome the confusion. Language and its subtleties have important outcomes in client care, so ensuring clear unambiguous meaning enables better service delivery. 'Emergency mental health triage' is the title given to the process that happens in the ED and occurs within the context of normal emergency triage practice. It is most often undertaken by a nurse who does not have mental health expertise and uniquely describes the assessment, allocation of a triage category, and referral of clients who have a mental illness to a mental health triage clinician.

'Mental health triage' then, should be conceptualised as the process that is managed by the mental health clinician having responded to a referral from the ED triage nurse. This process typically occurs in the ED or an environment where clients who have a mental illness are assessed. After this longer process the clients are then often referred to a specialist mental health service that can better meet their needs. Thus, one flows from the other.

To avoid confusion and therefore leading to better client outcomes, these two terms, 'emergency mental health triage' and 'mental health triage' are recommended as the nomenclature of choice and best practice when describing each of these processes.

The model of care used in ED's for clients with physical injury and/or illness is straightforward. Clients are triaged and referred to emergency medical staff, nurse practitioners or allied health staff that are working within the ED. The response by these clinicians is dictated by the ATS as each triage category is underpinned by the fact that the time dictated by the triage code is the time to medical assessment and treatment.[23] The process for clients who have a mental illness is however, more complex.

A comprehensive literature review indicates that there are a number of models of mental health care within emergency departments. One of these as described by Sharrock and Happell[25,26] is the Psychiatric Consultation Liaison Nurse (PCLN). The PCLN assists nurses who do not have any formal mental health education or qualifications to intervene effectively when a client who has a mental health problem presents to the ED. The PCLN provides expert and specialist guidance, advice and education. This model has been utilised in ED's across Australia[27] and Europe.[28,29] Wand and White[30] suggest that the role of the PCLN in the ED is different to that of a PCLN working in a general hospital setting and describes the evolving role of the mental health liaison nurse (MHLN) that is based on the or of the PCLN. While a PCLN assists with the management of clients with a primary medical or surgical condition and a co-morbid mental health problem the MHLN principally works with clients who present to the ED with a primary mental health problem. As the MHLN is embedded in the ED, staff have reported feeling more supported in their dealings with clients with a mental illness as the MHLN plays a role in staff education and acts as a resource to staff. The roles of MHLN and the mental health triage nurse (MHTN) as described by Sands[24] are differentiated by the fact that the MHLN exists principally in the ED and the MHTN works in a variety of inpatient and community settings.

While the literature reviewed is quite prescriptive about the title and role of each of the models of mental health care there remains variability amongst health care facilities. For example the MHLN may work in the ED and provide initial assessment and ongoing care until the client is discharged or admitted to an inpatient unit or, alternatively they may be located in a psychiatric emergency centre (PEC) within the ED and respond to triage referrals from the PEC.[31] The variability regarding the model of mental health service delivery to the ED is dependent on a number of factors. These include local resources and historical factors. At the time of the development of the MHTS at The Royal Hobart Hospital the PCLN model was used.[6] Similarly at Barwon Health when the SESAHS triage scale was implemented, their ED was serviced by a MHTN from the nearby mental health service.[5] Frank et al.[31] suggest that integrating a PEC into the ED is prohibitive due to the cost in all but the largest of health services. PEC's have also received criticism as they divert funds away from community based health care, further stigmatise clients with a mental illness as a result of separation of health care delivery and the lack of evidence of their effectiveness.[30] The presence of a PEC may also have the effect of segregating mental health and ED staff, further reducing a collaborative approach to client care. Regardless of the model of service delivery, improvements in service delivery in the ED have been documented across a number of ED's all with differing models of mental health care.[5,6,7,27,31] Such improvements need to continue for this client group, the most vulnerable of all health service users.

Once a triage score has been allocated it is accepted and expected that the resources of the ED will be focussed on ensuring clients are seen within the timeframes dictated by the triage score.

The principles embedded within emergency triage underpin the assessment by the ED triage nurse and the subsequent response by ED staff. The ability of the ED staff to assess correctly, and then to respond appropriately, is measured by reviewing the ATS scores against diagnosis and disposal. The ED response is assessed by examining the frequency that clients are seen within the timeframes dictated by the ATS.[32] This is not a measurement of client outcomes, but is a quantitative measurement of response times. This is important as ED's are funded using this model.

In order for service provision to clients who have a mental illness in the ED to be consistent with that given to clients with physical injury and illness it is necessary for the process of assessment by emergency triage nurses and then the resultant response by mental health services to be the same. That is, the ATS category, acuity and performance indicator threshold need to be consistent.

As discussed earlier, the use of specialised MHTS have been shown to increase the competence and confidence of non-mental health trained nurses in the ED triage who are assessing clients who present with a mental illness.[1] No matter how confident and/or competent the ED staff may be at the assessment component of emergency mental health triage, the success of the triage process ultimately depends on a timely response by specialist mental health services. Where mental health clinicians have been co-located in ED's improvements have been shown in terms of reduced waiting times for clients who have a mental illness.[6] Such improvements in response times have been identified in qualitative evaluations but have not been specifically measured.[5] There are several reports of mental health triage scales being introduced into practice that contain no discussion of improvements in response times.[19–21] Improvements in ED waiting times for clients who have a mental illness have been described by McDonough et al.[8] and Wand[27] who describe the improvements to mental health care in the ED as a result of having mental health nurses permanently located in the ED. A limitation though is that neither of these papers indicates if a MHTS was in use or not at the time of triage assessment. The improvement in response times are described as overall reductions in time to mental health assessment and no determination is made to describe waiting times for clients within each triage score. The review of the literature demonstrates that reductions in ED waiting times for clients who have a mental illness are possible in a generalised sense when ED staff are provided with a framework to be able to correctly assess and refer clients and when the mental health service is positioned to respond to those referrals in a timely manner. Provision of such a framework will mostly likely also improve clinical confidence. What is not evident in the literature though is a review of mental health service delivery based on the capacity to respond to clients within each of the triage categories. This is important as while correctly attributing a triage score using a properly constructed mental health triage scale reflects the acuity of a client and thus demonstrates some equity, true equity in terms of service responsiveness to clients who have a mental illness is only achieved with documented evidence that mental health services are operating within the operational constructs of the ATS and associated timeframes. Put simply, clients are triaged and should then be responded to within the ATS framework as outlined in Table 1. Accepting less for clients who have a mental illness is providing an inferior standard of care.

Table 1 Australasian Triage Scale categories, waiting times and performance indicators.[4]

Australian Triage Scale category	Acuity (maximum waiting time)	Performance indicator threshold
ATS 1	Immediate	100%
ATS 2	10 min	80%
ATS 3	30 min	75%
ATS 4	60 min	70%
ATS 5	120 min	70%

The use of the ATS as a triage tool for clients who have a mental illness

This paper has demonstrated that triage is a critical process in emergency departments and every effort needs to be made to ensure that the triage of clients who have a mental illness is as consistent as the triage assessment of clients who have a physical ailment. Mechanisms need to be in situ to ensure assessment and response consistency and could include the use of objective documentation and criteria based assessment.[33] Creaton et al.[33] argue that a triage scale must be both reliable and valid, that is, it should have high inter- and intra-rater reliability and accurately correlate with morbidity and other measures of clinical urgency. Previous studies have examined ATS reliability for general ED presentations. However the ATS as it relates to mental health presentations has not, until now, undergone the same testing.[33]

In their seminal paper examining the inter-rater reliability of the mental health components of the ATS, Creaton[33] played video vignettes of mental health triage scenarios to triage nurses from a range of public hospitals. The videos portrayed intermediate clinical urgency against a background of very high or very low ED activity. Using the ATS the triage nurses were asked to allocate a triage score based on perceived urgency. While this study was not designed to measure ATS validity for mental health presentations, which may have been done using measures such as correlation with admission rates, the results did indicate that the ATS, as it relates to mental health presentations, demonstrates poor inter-rater reliability, and that reliability is impacted on by factors that are unrelated to the actual clinical presentation.[33] This finding is of critical importance as its questions the consistency of mental health triage assessments made by triage nurses using the current ATS. The consequence then is that there may be an adverse affect on client waiting times which then delays further clinical intervention. This could have negative impacts on clinical outcomes for the client and may also misrepresent ED workloads and affect data pertaining to ED performance.

There is conclusive evidence that for those EDs using specialised MHTS, improvements across a range of parametric measures relating to the care of clients who have a mental illness in the ED have occurred.[5–7] Coupled with the findings of Creaton et al.[33] that cast doubt on the reliability of the mental health criteria within the ATS this paper presents a case for a comprehensive review to be undertaken of the national approach to the triage of clients who have a mental illness and who present to an emergency department.

This finding also brings into question the expectation that, where the ATS is used as the sole referral tool for clients who have a mental illness, mental health services need to respond to the time frames in the ATS given the poor reliability of the mental health descriptors in the ATS.

Discussion

There is much evidence to suggest that since Smart et al.[6] conceived the first MHTS that here has been a concerted effort to improve mental health service delivery in ED's consistent with the aims of the National Mental Health Strategy. However it has been demonstrated that significant issues remain that must be overcome if there is to be equity between the triage assessment and response to clients who have a mental illness and that, which currently exists for those clients with physical illness and injury. Consistent terminology must be adopted nationally to ensure a clear understanding of process. Models of mental health service delivery have developed and, while variations occur according to local practice and resource availability there is no clear indication that mental health services operate within the timeframes of the ATS or MHTS where it is in use. While this data may be captured locally in departmental data sets, as yet there is no critical examination of the alibility for mental health services in whatever form to respond to clients within the timeframe dictated by the use of a triage scale. One common thread about the provision of mental health service delivery to the ED is that where a mental health clinician is permanently deployed in the emergency department, ED staff have reported feeling more supported.[27] This could be a result of the MH worker being seen as a resource and someone who brings specialist skills and knowledge and there is no doubt that is the case. The integration of mental health services into the ED is a practical way of ensuring mental health clients in the ED receive equitable treatment as people with medical conditions. The most recent mental health plan[15] poses a new challenge to those who work in Australian EDs. The plan calls for mental health services to adopt a recovery-orientated framework underpinned by appropriate values and service models, and the implications for EDs are significant. The framework of recovery-orientated practice is currently accepted as the dominant policy approach to the care of clients with a mental illness within Australia.[34,35] Mental health nurses have generally embraced recovery as a therapeutic tool with the therapeutic relationship at its centre.[36] Recovery places an emphasis on client self-determination through realising the need to help themselves, self-value through

interactions with others, management of symptoms, optimism and spirituality.[35] It is the role of the mental health nurse and the mental health service to promote rather than hinder these values.[35]

By situating mental health services into the ED there is an imperative for non-mental health staff in EDs to support the work of their mental health colleagues by not only understanding the notion of recovery but by adopting it into practice. This acceptance of the Recovery Model will support both the work of the mental health triage nurse and allow ED staff to care for clients with a mental illness more effectively and compassionately. The implications of this for the process of emergency mental health triage are unknown and represent a new research area in emergency care.

The finding that the ATS has been shown to demonstrate poor inter-rater reliability, and that reliability is impacted on by factors unrelated to clinical presentation[33] is significant to both ED and mental health clinicians. This evidence indicates that it is imperative that EDs have a triage system that is comparable to those used for clients with physical injury and illness. As argued, this is currently not the case. The ATS demonstrates poor inter-rater reliability and that factors unrelated to clinical presentation, such as busyness of the ED and the state or territory in which triage nurses practice, have an impact on reliability.[33] The SESAHS scale has good inter-rater reliability[7] and improves performance across a range of measures.[5,7,37] In Australia clients with physical injury and illness will be triaged against one set of criteria, the ATS. Clients with a mental illness however may be triaged against one of four MHTS currently known to be in use. It is time for a consistent and national approach to the triage of clients with a mental illness presenting to the ED. This starts with an accurate and consistent triage process. Current evidence would suggest the SESAHS MHTS is the scale of choice given its widespread dissemination and effectiveness, however more research into triage practices and processes for clients with a mental illness would strengthen this recommendation.

Conclusion

As progress is made in improving ED care to clients who have a mental illness and as mental health services improve service delivery to clients referred to them, there is a need for further research examining the ED/mental health service interface in order to establish optimal operational relationships. There is also an imperative for research surrounding the principles of recovery as a framework for the care of clients with a mental illness in the ED and its relationship to the process of emergency mental health triage. The development of a nationally accepted and rigorous mental health triage scale is also clearly an imperative to ensure equity of both assessment and access to care. The triage, and subsequent care, of clients with a mental illness in the ED remains one of the biggest unresolved issues in contempory emergency care. Further research will guide different but connected services in order to work more collaboratively. When this happens better service delivery will occur leading to better client outcomes. Is not that what health care is all about?

Competing interests

The paper is derived from a PhD study undertaken by Mr Broadbent. The second and third named authors are the supervisors of this study. Mr Broadbent is an Associate Editor (Mental Health) with the Australasian Emergency Nursing Journal, but had no part in the review or editorial decisions relating to this manuscript. There are no other competing interests.

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CLINICAL ISSUES

Review of triage reform: the case for national consensus on a single triage scale for clients with a mental illness in Australian emergency departments

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Aims and objectives. The aim of this paper is to examine the use of mental health triage scales in Australian emergency departments (EDs) and to explore the use of the Australasian Triage Scale (ATS) with existing mental health triage scales.
Background. Since the introduction of mainstreaming and deinstitutionalisation in Australian mental health care, the number of clients presenting to Australian EDs has been increasing. It has become apparent that the lack of mental health descriptors in existing triage scales diminishes the ability of ED triage staff to accurately assess clients with a mental illness. In response to this, specialised mental health triage scales have been developed and introduced into practice. Concurrently, mental health descriptors have been incorporated into the ATS used across Australian EDs.
Design. A review of English language literature was conducted.
Method. The data bases Proquest, Synergy and CINAHL were searched using the key words 'emergency department', 'triage', 'mental health' and again using the term 'emergency mental health triage'.
Results. There is a paucity of literature surrounding the use of mental health triage scales in Australian EDs; 18 articles were found to be directly relevant to the subject matter.
Conclusion. Currently clients with a mental illness presenting to the ED may be triaged against one of four mental health triage scales. Research has shown that the mental health descriptors in the ATS are not as reliable as a specialised mental health triage scale.
Relevance to clinical practice. This has implications for clinical practice on two levels. First, it affects the initial triage assessment in the ED and the ability for mental health clinicians to respond in a timely manner and this will have an impact on clinical outcomes. Second, the use of the mental health triage criteria in the ATS may misrepresent ED workloads and affect data pertaining to ED performance.

Key words: Australia, emergency department, mental health, nursing, review, triage

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Introduction

Improvements in the initial assessment and management of clients in the ED are inextricably linked to improvements in the process of triage. Triage is derived from the French verb 'trier' meaning to pick or cull (The Macquarie Concise Dictionary 2003). In health, it has its origins in the Napoleonic wars (FitzGerald 1996). As a process in EDs, triage has been evolving since 1975 and is now a primary process in Australian EDs. The principal tool that is used is

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the five tiered Australasian Triage Scale (ATS) (Australasian College For Emergency Medicine 2000b). Since 1993 work has been done to improve the responsiveness of EDs to the increasing number of clients presenting with a mental illness. The principal mechanism for this has been the introduction of a specialised mental health triage scale (MHTS) (Smart *et al.* 1999, Tobin *et al.* 1999, Broadbent *et al.* 2002). This paper examines the use of the ATS against the use of MHTS across Australia.

Background

The Australian foundation triage scale implemented at the Box Hill Hospital in 1975 (Brentnall 1997) was designed as a system for improving initial emergency assessment. The Box Hill Triage Scale has subsequently been adapted and tested to develop the National Triage Scale (NTS) (FitzGerald 1996), the precursor for the ATS which is used in EDs throughout Australasia.

In the early 1990s it became apparent to the staff of the Royal Hobart Hospital ED, Tasmania and the South Eastern Sydney Area Health Service (SESAHS) that because the NTS had its roots in physical injury and illness it did not cater for patients with a mental illness who were increasingly presenting to the ED (Smart *et al.* 1999). Consequently staff from the ED and mental health service collaboratively developed a MHTS as a vehicle for improving service delivery to clients with a mental illness presenting to the ED (Smart *et al.* 1999, Tobin *et al.* 1999). In 2001 the SESAHS triage scale was successfully incorporated into practice in Barwon Health ED, Victoria, as a way of improving service delivery (Broadbent *et al.* 2002).

In conjunction with the development of specialised MHTS, mental health triage nursing has emerged as a specialty in the profession of mental health nursing. It is a complex, stressful role that involves high levels of responsibility, clinical decision making and multiple role functions (Sands 2004). It is therefore important that the referral of clients from the ED to Mental Health practitioners is consistent and accurately reflects client acuity. The importance of this cannot be overestimated, particularly as the number of clients with a mental illness presenting to the ED has been increasing due to the effect of mainstreaming (McDonough *et al.* 2004). Hundertmark (2002) states that between 1996–2000 the number of adult clients with mental illness presenting to the Flinders Medical Centre in South Australia rose three hundred and twenty percent with a steady rise of thirty five percent per year. A report on mental health presentations to EDs in Victoria found that between 1999–2001 there had been a 14% annual increase in mental health presentations to emergency departments. The report identifies the demand on community mental health care and the relatively low number of inpatient beds as putting increased pressure on the interface of these Victorian ED's (Department of Human Services 2006). These examples help quantify the recurring theme that is evident in the literature that EDs have been subject to increased presentations by clients with mental illness (Broadbent *et al.* 2002, Summers & Happell 2003, Webster & Harrison 2004, Kalucy *et al.* 2005, Stuhlmiller *et al.* 2005).

The use of MHTS in Australia

Clients with physical injury and illness presenting to EDs across Australia are triaged using a well established triage scale, the ATS. Clients with mental illness presenting to EDs across Australia, however, are triaged by ED triage nurses using one of the four principal MHTS; (1) The ATS with its mental health descriptors, (2) Victorian Emergency Department Mental Health Triage Tool (Potter & Huckson 2006), (3) The South Eastern Sydney Area Health Service (SESAHS) MHTS (Tobin *et al.* 1999), or (4) The Royal Hobart MHTS (Smart *et al.* 1999). Locally developed MHTS such as the triage risk assessment tool as described by Heslop *et al.* (2000) are in use, but these have not achieved the same widespread acceptance.

It is postulated that this disparate situation arose because, while Smart *et al.* (1999) and Tobin *et al.* (1999) were developing and reporting on their MHTS, the Australian College of Emergency Medicine released the newly revised ATS that contained mental health descriptors (Australasian College For Emergency Medicine 2000a). Thus EDs were now able to use the ATS to assess clients with mental illness without having to refer to a separate although more specialised MHTS (Broadbent *et al.* 2007).

Despite the inclusion of mental health descriptors in the ATS, the use of specialised MHTS has gained increasing acceptance in clinical practice across Australia (Broadbent *et al.* 2007). Reviews of the Royal Hobart MHTS (Happell *et al.* 2003, King *et al.* 2004, Frank *et al.* 2005) describe its use in clinical practice from several perspectives. These reviews though, lacked measurement or description of improvements in operational service delivery to clients with a mental illness (Broadbent *et al.* 2007). The SESAHS MHTS has also been reported as being in quite widespread use across Victoria, Australia (Potter and Huckson 2006). This particular triage scale was successfully implemented into practice in The Geelong Hospital (Broadbent *et al.* 2002) and outcome data were used by the National Institute of Clinical Studies as evidence to drive change in the ED triage and management of clients with a mental illness across nineteen EDs in Victoria

(Potter & Huckson 2006). The central part of this project was the Victorian Emergency Department Triage Tool which blended the mental health descriptors from the ATS with the SESAHS MHTS as adapted by The Geelong Hospital (Broadbent M 2001 Unpublished report). This blended triage scale has now been included in the Emergency Triage Education Kit (ETEK) (Commonwealth Department of Health and Aging 2007) in a chapter devoted to emergency mental health triage. This educational resource has been released nationally to standardise the training of registered nurses in the practice of emergency triage. Training such as this can increase the understanding and confidence of triage staff and ultimately improve the quality of service delivery resulting in better client outcomes.

Notwithstanding the widespread use of MHTS other than the ATS across Australia, most EDs continue to use the ATS for mental health triage assessment instead of adopting a specialised MHTS into their systems of clinical assessment. This is despite the evidence that the use of specialised MHTS improves the competence and confidence of general trained nurses in the assessment of clients with mental illness in the ED (Smart *et al.* 1999, Broadbent *et al.* 2004) and the national dissemination of the MHTS in the ETEK.

Need for change

Triage is a critical process in EDs and every effort needs to be made to ensure that triage of clients with a mental illness is as consistent as the triage assessment of clients with physical conditions. Mechanisms for ensuring consistency include the use of objective documentation and criteria based assessment (Creaton *et al.* 2006). Creaton *et al.* (2006) also argue that a triage scale must be both reliable and valid, that is, it should have high inter- and intra-rater reliability and accurately correlate with morbidity and other measures of clinical urgency. This is essential for access to healthcare and prioritisation of resource use. ATS data allows casemix comparison between organisations and waiting time by triage category is a key performance indicator for EDs. Previous studies have examined ATS reliability for general ED presentations. However the ATS as it relates to mental health presentations has not, until now, undergone the same testing (Creaton *et al.* 2006).

In their seminal paper examining the inter-rater reliability of the mental health components of the ATS, Creaton *et al.* (2006) played video vignettes of mental health triage scenarios to triage nurses from a range of public hospitals. The videos portrayed intermediate clinical urgency against a background of very high or very low ED activity. Using the ATS the triage nurses were asked to allocate a triage score based on perceived urgency. While this study was not designed to measure ATS validity for mental health presentations, which may be done using measures such as correlation with admission rates, the results indicated that the ATS, as it relates to mental health presentations, 'demonstrates poor inter-rater reliability and that reliability is impacted on by factors unrelated to clinical presentation' (Creaton *et al.* 2006, p. 2). This finding is of critical importance as its questions the consistency of mental health triage assessments made by triage nurses using the current ATS and consequently may affect client waiting times. This has an impact on clinical outcomes and may misrepresent ED workloads and affect data pertaining to ED performance.

Apart from the ATS with its mental health descriptors, the other MHTS most widely adopted across Australia is the scale developed by the SESAHS (Tobin *et al.* 1999). Initially adapted by Broadbent (2001) to reflect practice requirements under the Victorian Mental Health Act (1986) it was embraced by the Victorian Department of Health and the National Institute of Clinical Studies and adapted for The Victorian Mental Health Triage Project by using it in conjunction with the ATS (Potter & Huckson 2006). This MHTS, known as the Victorian Emergency Department Mental Health Triage Tool, was introduced throughout 19 EDs in Victoria. The evaluation of this project demonstrated that the introduction of a specialised MHTS improved the confidence of ED triage nurses in the assessment of clients with a mental illness presenting to the ED (Potter & Huckson 2006). This finding is consistent with that of Broadbent *et al.* (2002) following the introduction of the SESAHS MHTS at Barwon Health, Victoria and against a review of all published results of MHTS implementation (Broadbent *et al.* 2004). It is important to note that these findings of increased clinician confidence made following the publication of the work of Smart *et al.* (1999) and Tobin *et al.* (1999) were done in the context that the ATS was in use in the ED prior to the MHTS being introduced. Other reported outcomes of the use of the SESAHS MHTS include improved triage practice as it relates to clients with a mental illness, improved collaboration between ED and mental health nurses and improved patient outcomes (Tobin *et al.* 1999, Broadbent 2001, Potter & Huckson 2006).

There is conclusive evidence that, for those EDs using the SESAHS MHTS, improvements across a range of parametric measures relating to the care of clients with a mental illness in the ED have occurred (Smart *et al.* 1999, Tobin *et al.* 1999, Broadbent *et al.*2002). Coupled with the findings of Creaton *et al.* (2006) that cast doubt on the reliability of the mental health criteria in the ATS there is now a case for a review of the national approach to the triage of clients with mental illness in the ED.

Conclusion

This evidence indicates that it is imperative that EDs and mental health services have a triage system that is comparable to those used for clients with physical injury and illness. As argued, currently this is not the case. The ATS demonstrates poor inter-rater reliability and that factors unrelated to clinical presentation have an impact on reliability (Creaton *et al.* 2006). The SESAHS scale has good inter-rater reliability (Tobin *et al.* 1999) and improves performance across a range of measures (Broadbent M 2001 Unpublished report; Broadbent *et al.* 2002, Tobin *et al.* 1999). In Australia clients with physical injury and illness with be triaged against one set of criteria, the ATS. Clients with a mental illness however may be triaged against one of four MHTS currently in use. It is time for a consistent and national approach to clients with a mental illness presenting to the ED. This starts with an accurate and consistent triage process. Current evidence would suggest the SESAHS MHTS as the scale of choice given its widespread dissemination and effectiveness, however more research into triage practices and processes for clients with a mental illness would strengthen this recommendation.

Contributions

Study design: MB; data collection and analysis: MB, AC and manuscript preparation: MB, LM, TD.

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FEATURE ARTICLE

The development and use of mental health triage scales in Australia

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ABSTRACT: *In Australian emergency departments, the triage of people with physical illness and injury is well developed and supported by the Australasian Triage Scale. The Australasian Triage Scale contains brief descriptors of mental illness and it is unknown if these provide the same reliability in triage decision-making for emergency triage nurses assessing people with a mental illness. Specialist mental health triage scales have been developed to cater for this deficit and to aid emergency staff who have lacked training in the assessment and management of people with a mental illness. A review of the development of mental health triage scales and their use in Australia identifies that using a mental health triage scale improves the competence and confidence of emergency department staff in triaging people with mental illness. Despite this, there is no consistent national approach to the emergency triage of people with a mental illness. There is ad hoc use of mental health triage scales and there are few reports of improvements in service provision to this client group as a result of the use of a mental health triage scale. These findings suggest that despite the intentions of the National Mental Health Strategy, a lack of equity remains in emergency departments in the provision of care to people with a mental illness who make up one in five of adult Australians. Consideration should be given to the introduction of a national approach to the use of a mental health triage scale in Australian emergency departments.*

KEY WORDS: *development, emergency, equity, mental health, triage.*

INTRODUCTION

Mental health triage scales (MHTS) have been in use in Australia since 1993. This paper describes the development of MHTS and the current activity surrounding the assessment and management of clients with mental illness in emergency departments (EDs).

BACKGROUND

Triage is a French word derived from the verb 'trier' meaning 'to sort' (Brentnall 1997; Broadbent *et al*. 2004). As a process within health, it has its origins in the Napoleonic wars where Baron Dominique Jean Larrey, Napoleon's Surgeon in Chief, removed large numbers of injured soldiers from the battlefield who could potentially be salvaged to fight again and delivered them to surgical services (FitzGerald 1996). As a process within EDs, triage has been evolving since 1973 when staff at the Box Hill Hospital, Victoria, realized that there was a need to systematically sort clients presenting with more complex illness and injury. A three-tiered triage scale was

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developed to sort clients into 'urgent', 'run of the mill', and 'non-urgent'. As a result of the degree of the sophistication of clinical decision-making required by triage nursing staff at Box Hill hospital, this scale eventually evolved into a five-level scale (Brentnall 1997).

In the latter half of 1985, a triage scale was introduced into the Ipswich General Hospital, Queensland, based on the five-level scale used at Box Hill Hospital, Victoria. Similar in design and intent to the Box Hill scale, it was based on the premise that the scale 'regularized the intuitive processes used by the nursing staff in receiving patients into the department' (FitzGerald 1996; p. 205). In local testing at Ipswich Hospital, the scale was demonstrated to effectively and repeatedly describe patient populations. The scale became known as the Ipswich Triage Scale (ITS) and in testing the scale across EDs at Ipswich, Queensland and Fremantle, Western Australia, its repeatability, relevance, and outcome validity were confirmed (Jelinek 1995). In 1993, the ITS was modified slightly into the National Triage Scale (NTS), the NTS was implemented in EDs across Australia with the support of the Australasian College for Emergency Medicine (ACEM) (see Table 1).

THE DEVELOPMENT OF MHTS

As ED triage for clients with physical injury and illness was evolving as an important element of emergency care, changes to the management of people with a mental illness was imminent as Australian State and Federal Health Ministers moved to develop a strategy to improve mental health care. Originally conceived in 1992, the initial component of the strategy was the First National Mental Health Plan. This plan attempted to develop national coordination of public mental health services which before 1992 had been managed by the individual state and territory governments. The impetus for this was increasing public criticism and formal enquiries into mental health services around Australia (Whiteford & Manderscheid 2002). Two principle pillars of this plan were to mainstream mental health services into general health services, to deinstitutionalize mental health care and move to a model of community-based care (Australian Health Ministers 1992). One of the effects of moving clients with mental illness out of psychiatric hospitals and care facilities and into community-based care was that more clients with increased acuity and particularly with disturbed behaviour presented to EDs where many staff were unsure of their clinical mental health needs (Stebbins & Hardman 1993). Clients with a mental illness waiting in the ED report that they believe mental health presentations are triaged at the bottom of the list and that the ED environment is frightening and adds to feelings of agitation (Clarke *et al*. 2007). These reports from clients indicate that both the ED environment and the inability of the ED staff to care for them contribute to a suboptimal clinical environment.

TABLE 1: *National Triage Scale for Australasian Emergency Departments*

Numeric code	Categories	Treatment acuity†
1	Resuscitation	Immediate
2	Emergency	Minutes (<10 min)
3	Urgent	Half hour
4	Semi-urgent	1 hour
5	Non-urgent	2 hours

From Monash Institute of Health Services Research (2001). †Treatment acuity is defined as the maximum time to the commencement of medical treatment.

In 1994, Smart *et al.* at the Royal Hobart Hospital, Tasmania, recognized that ED triage had its roots in physical injury and illness and that the NTS did not cater for people with mental illness presenting to the ED as it contained no mental health descriptors to aid its triage decision-making. This was complicated by the fact that, as part of an initial review of services, it was determined that there existed an urgent need to educate triage nurses in the assessment of clients with mental illness (Smart *et al*. 1999). This is consistent with the findings of Broadbent *et al*. (2002) who identified that the lack of confidence in nurses to assess and manage clients with a mental illness is well documented in the literature. Having implemented the NTS in January 1994, the staff in the Royal Hobart Hospital ED identified a need for mental health descriptors to be developed to aid ED nurses in the triage of clients with mental illness.

Smart *et al*. (1999) conducted a review of literature that identified few references to mental health triage in emergency medicine and none to do with triaging and integrating mental health problems into a general ED. The bulk of the literature that existed was from North America where the systems of assessing, treating and discharge of clients with mental illness who present to EDs are not consistent with Australian practice and therefore of little value to the problem in Australia (Smart *et al*. 1999).

Consequently, a study was commenced in 1994 at the Royal Hobart Hospital with the principal aim of developing a MHTS which articulated with the NTS. Other important aims were to improve nursing assessment and effectiveness of the triage of clients with a mental illness,

to reduce waiting times, and to improve the transit times (the time from triage to departure) for clients with a mental illness (Smart *et al*. 1999). The initial study was completed in mid-1994, reviewed in 1996, and in 1999 having met all the study aims the results were published outlining the success of the project (Smart *et al*. 1999). The MHTS from the Royal Hobart Hospital is a four-tiered triage scale corresponding to categories two to five from the NTS with category one clients with mental illness sharing the same descriptors as clients with physical illness as described by the NTS (Table 2). Despite the exclusion of mental health criteria for category one clients in the Royal Hobart triage scale, the associated educational material provides the triage nurse the opportunity to make an informed assessment of the needs of the client with a mental illness. As Broadbent *et al*. (2004) describe, the educational material from the Royal Hobart training manual guides the triage nurse through the important components of a mental state assessment such as assessment of thought, content and process, mood and affect, perceptions, cognitive functioning, along with a discussion on common mental illnesses such as depression, suicide, anxiety, acute psychotic states, and personality disorders.

As the Royal Hobart Hospital staff were working to complete their landmark study, staff from the Area Mental Health Program within the South Eastern Sydney Area Health Service (SESAHS) were considering their response to national and New South Wales state mental health policies. These polices highlighted the need to improve the management of clients with mental health presentations to EDs. The staff of the Area Mental Health Program decided that the issue was an important one and in early 1998 agreed to develop and pilot mental health triage guidelines (Tobin *et al*. 1999).

Tobin *et al*. (1999) conducted a review of the literature and drew similar conclusions to Smart *et al*. (1999) about the paucity of information on mental health triage and the tendency of the international literature to represent processes that are not consistent with the Australian context. Tobin *et al*. (1999) were also aware of the lack of confidence and competence in managing psychiatric emergencies that was reported in the literature. Typical of the literature surrounding the capacity of ED staff to manage clients with a mental illness is a study by Bailey (1998), who found widespread negative attitudes in ED staff towards clients with a mental illness. Lack of education was said to contribute towards feelings of inadequacy and fear in dealing with this client group. This claim is supported by Brinn (2000) who determined that general nurses are not adequately prepared by their training to cope with clients who have mental illness.

Tobin *et al*. (1999) were critical of the existing MHTS because of the lack of differentiation between symptoms and behaviour observed by the triage nurse and behaviour reported by a third party. This was seen to be a problem for nurses not educated in the objective assessment of clients with a mental illness. Furthermore, they were concerned that existing scales used mental health terminology, thus requiring specialist knowledge by the ED triage nurse. They were also concerned by what they called inconsistent management advice. Some scales included instructions for clinical care and others did not. Where it was provided it did not distinguish between ED and mental health teams. This is not consistent with the NTS which did not concern itself with management of the client beyond the ED triage process. They concluded that none of the existing MHTS had potential for generalizability across different settings as they were 'dependent on the local culture and resources' and that there was a need to remove parochial and mental health specific language (Tobin *et al*. 1999; p. 12).

Following implementation and evaluation, the resulting MHTS from the SESAHS consisted of a five-tiered scale consistent with the NTS in respect of its categories and expected time to be seen. The revised five-tiered scale allowed the triage nurse to assess 'observed' and 'reported' behaviours as indicators of acuity to determine

TABLE 2: *Royal Hobart Mental Health Triage Scales*

Triage scale	Patient description	Treatment acuity†
2. Emergency	Patient is violent, aggressive, or suicidal, or is a danger to self or others, or requires police escort	Within 10 min
3. Urgent	Very distressed or acutely psychotic, likely to become aggressive, may be a danger to self or others. Experiencing a situational crisis	Within 30 min
4. Semi-urgent	Long-standing or semi-urgent mental health disorder and/or has supporting agency/escort present (e.g. community psychiatric nurse)	Within 1 hour
5. Non-urgent	Patient has long-standing or non-acute mental disorder/problem but has no supportive agency/escort. May require a referral to an appropriate community resource.	Within 2 hours

From Smart *et al*. (1999). †Treatment acuity is defined as the maximum time to the commencement of medical treatment.

a triage score without requiring specialist mental health knowledge or terminology. The scale also outlined the level of supervision required for clients within each of the categories.

Unlike the Royal Hobart MHTS that had been implemented in one ED, the SESAHS was designed for implementation across five general hospitals in the district, each with its own ED, and four mental health services, each with its own acute inpatient unit, and one community-based mental health team (Table 3). This requirement for broader application of the MHTS across a number of sites meant that generalizability was an important factor in the design of the MHTS and the post-implementation report describes the successful implementation across the five sites (Tobin *et al.* 1999).

Thus, it emerged that by the end of 1999 there were two MHTS in use in Australia. Both MHTS had been conceived from the dominant paradigm of the conventional physical medical model of triage assessment, the concomitant lack of mental health descriptors within the NTS, and the increasing demands on EDs to assess and treat clients with mental illness.

In 2000, the ACEM altered the NTS by broadening the descriptions of presentations within each category and consequently changed its name to the Australasian Triage Scale (ATS) (Broadbent *et al.* 2004). The ATS was introduced across Australian EDs as the replacement for the NTS and in recognition of the omission in the NTS, included brief descriptors for mental health presentations (Table 4).

In 2001, the SESAHS MHTS was introduced into the ED of Barwon Health, Victoria (Broadbent *et al.* 2002). The stated goals of this project encompassed the implementation of a MHTS, a desire to strengthen consultation between ED and mental health services and to ensure a timely and effective clinical outcome for clients with a mental illness presenting to the ED. The project aimed to measure a range of changes associated with the implementation of a MHTS. A close examination of ED and mental health triage practice was undertaken to establish baseline practice and to then assess changes in practice. Data were drawn from a retrospective analysis of triage scores given to clients using only the NTS and then an analysis of triage scores given in a 3-month period following the implementation of the MHTS. Pre- and post-implementation questionnaires were used to obtain quantitative and qualitative data from the ED and mental health nurses about a range of issues including triage experience, confidence in dealing with clients with mental health issues at triage, impressions of service delivery, quality of referrals, and impact of implementing a MHTS on workload. Data were gathered that showed changes in the distribution of triage categories and these were compared with the results described by Tobin *et al.* (1999) as a means of demonstrating successful implementation. The Barwon Health study identified improvements in the ED triage nurses understanding of mental health assessment and positive changes in triage practice and attitude towards clients with a mental illness. Mental health triage nurses reported improvements in the ability to prioritize and organize workload. Increased and more positive collaboration, communication, and a better relationship between services were reported by both mental health and ED triage nurses (Broadbent *et al.* 2002).

In 2004, the Victorian Department of Human Services commissioned the National Institute of Clinical Studies (NICS) to improve the ED triage process for people presenting with a mental health problem and to improve the collaboration between EDs and mental health services (Potter & Huckson 2006). The new mental health triage project was based on the recommendations from the Victorian Auditor General's Report on Managing Emergency Demand in Public Hospitals and the improvements to the process of mental health triage as implemented and researched at Barwon Health.

The scope of the NICS project was to develop and introduce a MHTS and provide support to 19 EDs across Victoria with education and the development of policy and procedure to manage the mental health presentations based on the triage category. This final point is important as the triage scales and the time to be seen are principal components of a successful triage process. The SESAHS MHTS as modified and adapted by Broadbent (2001) was articulated with the mental health descriptors from the ATS to create the Victorian Emergency Department Triage Tool. Anecdotal evidence suggests that, as part of a wider national programme, the MHTS developed for the Victorian NICS project has been adopted in EDs in some hospitals across Australia although specific data detailing uptake is lacking (Anonymous 2004).

THE USE OF MHTS IN AUSTRALIA

There is very little evidence in the literature to date suggesting widespread uptake of specific MHTS across Australia. While the ATS contains brief descriptors for clients with a mental illness, the need for more detailed guidelines for the triage and management of these clients has been demonstrated through improvements in staff competence and confidence and better service delivery as a result of their use (Broadbent *et al.* 2002; Smart *et al.* 1999; Tobin *et al.* 1999). This has served to increase

TABLE 3: *South Eastern Sydney Area Health Service Mental Health Triage Scale*

Triage code	Description	Treatment acuity†	Typical presentation
1	Definite danger to life (self or others)	Immediate	OBSERVED Violent behaviour Possession of weapon Self-destructive behaviour in ED
2	Probable risk of danger to self or others	Emergency	OBSERVED
	• Severe behavioural disturbance	Within 10 min	Extreme agitation/restlessness Physically/verbally aggressive Confused/unable to cooperate Requires restraint REPORTED Attempt at self-harm/threat of self-harm Threat of harm to others
3	Possible danger to self or others • Moderate behaviour disturbance • Severe distress	Urgent Within 30 min	OBSERVED Agitation/restlessness Intrusive behaviour Bizarre/disorganized behaviour Confusion Withdrawn and uncommunicative Ambivalence about treatment REPORTED Suicidal ideation Presence of psychotic symptoms: Hallucinations Delusions Paranoid ideas Thought disorder Bizarre/agitated behaviour Presence of affective disturbance: Severe symptoms of depression/anxiety Elevated or irritable mood
4	Moderate distress	Semi-urgent within 60 min	OBSERVED No agitation/restlessness Irritability without aggression Cooperative Gives coherent history REPORTED Symptoms of anxiety or depression without suicidal ideation
5	No danger to self or others • No acute distress • No behavioural disturbance	Non-urgent within 120 min	OBSERVED Cooperative Communicative Compliant with instructions REPORTED Known patient with chronic psychotic symptoms Known patient with chronic unexplained somatic complaints Request for medication Minor adverse effect of medication Financial/social/accommodation/relationship problems

Adapted from Tobin *et al.* (1999). †Treatment acuity is defined as the maximum time to the commencement of medical treatment.

clinical outcomes for this marginalized and stigmatized group. The number of clients with a mental illness presenting to the ED has been increasing because of the effect of mainstreaming (McDonough *et al.* 2004). Hundertmark (2002) states that between 1996 and 2000, the number of adult clients with mental illness presenting to the Flinders Medical Centre in South Australia rose 320% with a steady rise of 35% per year. A report on mental health presentations to EDs in Victoria found that between 1999 and 2001 there had been a 14% increase

TABLE 4: *Mental health descriptors from the Australasian Triage Scale (ATS)*

ATS category	Response	Description of category/treatment acuity†	Clinical description
1	Immediate Simultaneous assessment and treatment	Immediately life-threatening	Severe behavioural disturbance with immediate treat of dangerous violence
2	Assessment and treatment within 10 min	Imminently life-threatening Or Important time critical treatment	Violent or aggressive Immediate threat to self or others Requires or has restraint Severe agitation or aggression
3	Assessment and treatment start within 30 min	Potentially life-threatening Or Situational urgency	Very distressed, risk of self-harm Acutely psychotic or thought disordered Situational crisis, deliberate self-harm Agitated/withdrawn
4	Assessment and treatment start within 60 min	Potentially serious Or Situational urgency Or Significant complexity or severity	Semi-urgent mental health problem Under observation and/or no immediate risk to self or others
5	Assessment and treatment start within 120 min	Less urgent Or Clinico-administrative problems	Known patient with chronic symptoms Social crisis, clinically well client

Adapted from Australasian College for Emergency Medicine (2000a). †Treatment acuity is defined as the maximum time to the commencement of medical treatment.

per year in mental health presentations to EDs. The report identifies the demand on community mental health care and the relatively low number of inpatient beds as putting increased pressure on the interface of these Victorian EDs (Department of Human Services 2006). These examples help quantify the recurring theme that is evident in the literature that EDs have been subject to increased presentations by clients with mental illness (Broadbent *et al*. 2002; Kalucy *et al*. 2005; Stuhlmiller *et al*. 2005; Summers & Happell 2003; Webster & Harrison 2004). Despite the reported increase of mental health presentations to EDs throughout Australia and the issues surrounding the management of clients with mental illness in EDs, there are only a few examples of reported use of MHTS.

King *et al*. (2004) identified a 10-fold increase over 10 years in clients with mental illness presenting to the Flinders Medical Centre ED. The authors found that while this client group represents less than 5% of the presentations to the ED, they account for almost 10% of the time spent in the ED by all their clients and therefore present a significant management challenge. They assert this is due to the impact of mainstreaming and draw a parallel between clients with a mental illness and drug and alcohol misuse. The authors of the paper acknowledge the lack of preparation that ED staff have had in order to deal with these clients with the focus of this study being to explore the effects of a training course aimed at improving knowledge and skills in mental health and drug and alcohol issues. In conjunction with the Flinders University School of Nursing and Midwifery, a 3-day course in emergency psychiatry and drug and alcohol issues was delivered to 40 of the 43 ED triage nurses. During the course, the MHTS from the SESAHS was introduced as a vehicle for improving the assessment of clients with mental illness as well as those with drug and alcohol problems.

The course was evaluated using a pre- and post-course self-assessment questionnaire completed by the course participants. This survey concentrated on measuring changes in the attitudes of participants to the client group and self-ratings on the improvement in skills and knowledge needed for working with this client group in the ED. No attempt was made to measure changes in the quality of care delivered from either a service or consumer perspective (King *et al*. 2004). The relationship between the ED and mental health service was not considered nor were changes to triage practice or responsiveness of the MHS.

In a paper describing the development of the first psychiatric emergency centre (PEC) in Australia, Frank *et al*. (2005) report the use of the Royal Hobart MHTS in practice. The PEC is collocated in the ED and is the first site of entry for acute psychiatric assessment (Frank *et al*.

2005). The department is permanently staffed with mental health nurses, clinical nurse consultants, psychiatric registrars, and psychiatrists. The unique feature of this arrangement is that the emergency mental health service is within the ED and exists for the client group presenting to the ED. Therefore, the issue of emergency triage and referral is not as taxing as in most other centres where the mental health service is often located away from the ED. The Royal Hobart MHTS was introduced into this context in 2000 as a referral tool from ED to the PEC. Clients allocated category one by ED triage staff were sedated in the ED. All other clients in categories two to five were directed straight to the PEC where they undergo secondary triage by MH staff (Frank *et al*. 2005). The collocation of the PEC removes the need for ongoing management of clients by ED staff and as the ED triage is used only as an initial guide to acuity, the notion of allocating a definitive triage code that determines response times is lost in this context. The existence of an onsite PEC brings with it distinct benefits to the staff of the ED and as the paper describes, a clear advantage to clients with metal illness such as direct access to mental health professionals and short-term assessment without the need for inpatient admission (Frank *et al*. 2005). The report does concentrate on discussing the benefits of the PEC in terms of service delivery and does not allude to the specific benefits of using a MHTS in practice.

Happell *et al*. (2003) report the Royal Hobart MHTS being introduced into the ED of a large metropolitan teaching hospital in Melbourne as part of a study measuring the effectiveness of the MHTS. The focus of this study was to measure the concordance between emergency nurses and mental health nurses in applying the MHTS to clients presenting to the ED over a 3-month period. They found a high level of discrepancy between the ED triage nurses and the mental health triage nurses in the process of triaging clients with mental health-related problems. The ED triage nurses were more likely to assign higher triage category than the mental health nurses, suggesting that they interpret common symptoms of mental health problems as more urgent. However, the ED nurses tended to assign less urgent triage categories overall to clients with mental illness compared with those with physical illness. This study found that the introduction of a MHTS alone does not create agreement between ED and mental health triage nurses and that further research needs to be done to investigate the decision-making processes of triage (Happell *et al*. 2003). Once again no attempt was made to measure or describe improvements in operational service delivery to clients with a mental illness.

Despite the overall improvements to practice and confidence that the introduction of a MHTS has on triage practice within the ED (Broadbent *et al*. 2004; Smart *et al*. 1999; Tobin *et al*. 1999), the literature surrounding the use of MHTS in Australia suggests ad hoc uptake of MHTS across Australia and a limited exploration of their use. This may be due to the fact that the ATS, with its limited mental health descriptors, was rapidly deployed into Australian EDs as a replacement for the NTS at a time when MHTS were developing a level of sophistication suitable for general ED use. ED triage nursing staff may find the use of the ATS sufficient to accurately triage clients with a mental illness and as such do not perceive the need for a specific MHTS. However, this premise has not been researched. It is necessary for the mental health component of the ATS to be tested in order to examine if used alone can it reproduce the same interrater reliability and improvements in competence and confidence in ED triage nurses that the use of an existing MHTS has demonstrated.

The ATS is a useful casemix measure and provides ability for users to measure and analyse a range of performance measures in the ED such as operational efficiency and utilization (Australasian College for Emergency Medicine 2000b). Because the Royal Hobart Hospital, the SESAHS MHTS, and the Victorian Emergency Department Triage Tool were developed to align with the triage scales existing at the time, it can be assumed that using a MHTS and the data generated from their use can be used to identify patient populations and gauge the ability of mental health triage workers to respond in a time that is consistent with the triage score as well as being consistent with the clients needs. None of the literature reviewed suggests that the ability to determine operational capacity to respond to clients with a mental illness in ED is assessed using the framework of a MHTS by either ED or mental health staff.

CONCLUSION

Specialist MHTS have evolved in response to both the increasing utilization of EDs as a point of entry for people with mental illness, and the acknowledgement that the training and ongoing education of general trained ED staff in mental health is lacking. Currently, the process for the assessment and management of clients with physical illness and injury is well established in EDs across Australia. However, the same cannot be said for clients with mental illness. There is no national approach to ED mental health triage and the reported use of MHTS in the literature does not widely describe improvements to

service delivery. In order for clients with mental illness in the ED to receive the same level of assessment and management as clients with physical injury and illness, it is necessary to use a triage scale that incorporates mental health descriptors. For those EDs relying on the ATS as the assessment tool of choice, further work needs to be done to ensure that the mental health components of the ATS can be relied on to produce the same triage assessment outcomes for clients as achieved by the MHTS in use. Given that within a 12-month period approximately 20% of the Australian population meet the criteria for a mental illness (McGorry 2005), consideration should be given to the introduction of a national approach to the use of a MHTS in Australian EDs.

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